

ABSTRACT

Title of dissertation: HEALTH CARE DISPARITIES IN MARYLAND IN THE
“CONTRACT WITH AMERICA” ERA

Sari Siegel, Doctor of Philosophy, 2007

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In the early 1990s, the Medicaid budget expanded dramatically. In response, federal and state policymakers implemented changes to curb patient demand. Taken together, these policies may have impeded low-income health care access in Maryland more effectively and less equitably than anticipated.

Research question: Did access-affecting policy changes in the mid-1990s alter Maryland’s low-income health care market differently for different racial and ethnic groups?

Following extensive document and literature reviews, semi-structured interviews were conducted with stakeholders and experts in Maryland’s low-income health care market. A content analysis of interview transcripts was performed. HCUP SID hospital discharge data from Maryland and New Jersey was then used to test for treatment delay. A quasi-temporal measure was devised using patient-level racial/ethnic differences in incidences of appendicitis, appendiceal perforation, and prolongation of hospital stay following appendicitis with and without perforation.

Qualitative analysis indicated that implementation of policy changes initially widened gaps in Maryland’s health care safety net. This continued to hamper access to care disproportionately for homeless persons and immigrants. HCUP data indicated that Maryland’s black appendicitis patients in 1996 were more likely (by 6 percentage points,

$p<0.05$) than their white counterparts to suffer appendiceal perforation. In 2003, black patients no longer showed higher incidence; similar trends emerged for Hispanics and other groups. However, hospitalizations for black appendicitis patients increased from 0.58 days longer than their white counterparts ($p<0.01$) in 1996 to 0.65 days longer ($p<0.01$) in 2003. Most notably, insurance status disparities revealed that, in 1996, Maryland's uninsured were more likely than the privately-insured to experience perforation (by 2.3 percentage points). By 2003, Maryland's uninsured were 6.7 percentage points ($p<.01$) more likely than the privately-insured to suffer perforation. Hospitalizations for uninsured appendicitis patients were accordingly longer than for privately-insured patients, although length of stay data failed to achieve statistical significance in both years.

This research suggests demand was decreased largely by impeding access, disproportionately to the disadvantage of racial/ethnic minorities, the homeless, and immigrants. Data confirm that access declined for the uninsured. As this population continues to grow, insufficient access to care for the uninsured will remain an urgent problem.

HEALTH CARE DISPARITIES IN MARYLAND IN THE “CONTRACT WITH
AMERICA” ERA

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Chapter 1: Introduction: Disparities and Medicaid

A. Framing Health Care as a Civil Rights Issue

For much of this country's post-Civil War history, governmental concern regarding health care for racial and ethnic minorities and for the poor stemmed from the risk these populations posed to the health of wealthier white populations.¹ Indeed, many programs aimed at improving public health have an unsavory history of using black patients, in particular, as laboratory test cases.² Even such seemingly philanthropic endeavors as the establishment of Medicaid have, some suggest, been influenced by Jim Crow. Signed into law in 1965 during the heat of the civil rights movement, Medicaid was created with an unusual funding structure that required states to put up funds before the federal government offered any contributions. This allows states to decide for themselves what priority they would attribute to the health care of their poor.

Many states, Maryland included, chose to participate with Medicaid from the outset. But some states resisted adopting Great Society programs that were perceived as improving the quality of life for racial and ethnic minorities at the expense of whites. To explain why some states had not yet opted to implement Medicaid three years after the program's inception, a 1968 report by the U.S. Commission on Civil Rights observed: "Alabama Negro leaders believe that Medicaid has been resisted by white powers because it would aid black poor on a nondiscriminatory basis, perhaps encouraging them to stay where they were born instead of emigrating to a Northern ghetto."³ The report also cites state experts who proclaimed that:

Alabama could have a Medicaid program for about \$35 million with the federal government paying 83 percent of the cost... But like many other states, North and South, the Alabama government feels little commitment

to those poor and black. It spends hundreds of millions building superhighways with about the same percentage of federal aid that it refuses to accept for Medicaid.⁴

In his testimony before a 1968 hearing of the U.S. Commission on Civil Rights, one state health officer expressed that “there seems to be more interest in highways than in health.” The commission concluded: “A sense of Congressional priority might suggest halting funds to lay down highways past shackfuls of sick children until Alabama shows twentieth century concern for all her children.”⁵ The impact of what can be identified at best as libertarian policy and the subsequent legacy of distrust from the poor and vulnerable remains palpable today.

B. Disparities in Health Care Access

Rising health care costs make the days of a \$35 million Medicaid program seem quaint. Today’s health care inflation and rising costs in both the public and private sectors are, in fact, unmatched in U.S. history. These monies are funding previously unimaginable progress in medical and pharmaceutical research, high-tech health care tools, and revolutionary public health campaigns. In the last decade, the U.S. has achieved significant reductions in infant mortality and teenage parenthood. Vaccinations for children are at the greatest levels ever recorded. Use of tobacco, alcohol, and illicit drugs is leveling off. Mortality rates for coronary heart disease and stroke have waned.⁶ But such improvements are not reaching all Americans equally.

Our society aspires to equality of opportunities for all our citizens and abhors the notion that the degree of access to high quality health care should be dependent upon one’s race, ethnicity, or socioeconomic status. In this way, persistent inequities in health care access and quality are directly inconsistent with basic American values. Health care

disparities, therefore, can be viewed as the latest and ultimately most profound manifestation of a long national history of discrimination in health care provision for the disenfranchised.

Consider the groundbreaking 1999 Georgetown University study, in which a team of researchers showed doctors videotaped interviews with “patients” (portrayed by actors) with identical medical and social histories about identical chest pain and asked to recommend treatment. Schulman et al found that physicians are significantly less likely to refer women and blacks than white men presenting with identical chest pain for invasive cardiac procedures, attributing the disparate care to “subconscious perceptions rather than deliberate actions or thoughts” on the part of physicians.⁷

Also consider the 2003 Institute of Medicine’s publication, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*,⁸ and the federal Department of Health and Human Services’ (DHHS) annual *National Healthcare Disparities Report*.⁹ Both extensively document persistent and, in some cases, growing health care disparities. Such differences are the latest frontier of racial equality in health care and an important public policy problem.

1. What are Health Care Disparities?

First, note the wording of the phrase “health care disparities.” This differs from health disparities, which are differences in health status. Health disparities between racial or ethnic groups can be attributed to genetic factors; for example, blacks have higher rates of sickle cell anemia than whites and Ashkenazi Jews have higher rates of Tay Sachs Disease than people of other ethnicities. It is therefore useful to think of racial and ethnic “health disparities” as the comparison of disease incidence by racial and ethnic

groups in the population as a whole. Disparities in *care*, however, considers a population of individuals who are all sick, and measures differences by racial and ethnic group in treatments received.

Beyond the distinction between “health disparities” and “health care disparities,” there is no universal consensus on the definition of the latter term. For example, *Unequal Treatment* defined health care disparities as differences remaining after accounting for patient needs and preferences and the availability of health care (notably, after an exhaustive literature review, the author has concluded that no published study has met this rigorous definition), yet the DHHS considers all differences by race or ethnicity in its measures as evidence of disparities.¹⁰ Other researchers associate health care disparities with differences exclusively stemming from physician prejudice.¹¹ This dissertation uses the DHHS’s definition.

In *Unequal Treatment*, the IOM finds racial and ethnic disparities in health care, even after accounting for characteristics typically associated with disparities such as health insurance coverage and income. However, the IOM also emphasizes that health care disparities are not only a minority health issue. A large body of literature documents health care disparities based upon socioeconomic status, geography, gender, age, and disability status.¹² Low-income groups, including Medicaid beneficiaries, have historically lacked access to the most basic care, in part because reimbursements to clinicians who provide care to Medicaid patients were so low. For example, as recently as 1997, only two private dentists were enrolled as Medicaid-funded caregivers in the entire state of Delaware.¹³

2. What Causes Health Care Disparities?

Although the causes of health care disparities are not well understood, a variety of individual, institutional, and health system factors likely contribute to their existence. As noted in a recent GAO report, “information on the non-financial causes of health care disparities is incomplete.”¹⁴ Some believe such differences are primarily clinician-driven, others attribute them to patient preferences, while still others blame the financing and delivery of health care. Indeed, the literature on disparity causation can be grouped into three categories: patient factors, clinician factors, and institutional factors.^{15, 16} There remains significant debate over the relative role of these factors.

a. Patient Factors

Patients themselves may be responsible for causing or exacerbating health care disparities. This may happen for any number of reasons, such as mistrust in the health care system, cultural beliefs about Western medicine or the American approach to health and medical care, or even patient preferences to refrain from seeking care. Other factors may be more directly driven by patient demographics, such as socioeconomic status—which may impact one’s ability to take the time to see a clinician for diagnosis and treatment, transportation availability, or one’s ability to pay for care. Other related considerations may include comorbidities, stage of disease at presentation to clinician,¹⁷ family or other social network support, and insufficient “health care literacy.” (The U.S. Department of Health and Human Services defines “health literacy,” through its *Healthy People 2010* project, as “The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.”¹⁸)

b. Clinician Factors

Physician perceptions, bias, racism, racial or ethnic stereotyping, or an inadequate understanding of the cultural health norms of a patient can also contribute to health care disparities. Other clinician factors may include the ability to judge a patient's pain or availability to provide care during evenings or weekends for those who cannot leave work to seek care during regular working hours. Clinical uncertainty about the findings in the medical history or symptom presentation of minority patients can also play a role.¹⁹

c. Institutional Factors

Institutional contributors to health care disparity proliferation may include features of the health care system such as health insurance availability, de facto policies about differential treatment of uninsured patients, health care delivery site, an insufficient emphasis on primary care, screening, and prevention, or low Medicaid reimbursement rates—which makes clinicians less likely to see low-income patients.²⁰ Other societal problems may include overrepresentation of minorities among low-income populations, which are more likely to lack private health insurance and to be concentrated in urban areas.

Another institutional factor is that racial and ethnic minorities and low-income populations may be more likely to face access barriers, such as inadequate insurance or the inability to pay for care, which inhibit entrance to the health care system. These individuals therefore may be more likely to delay care or to receive it in overcrowded facilities with little integration or coordination of services.²¹ The fact that non-white populations are growing faster than white populations, combined with indicators that minorities are at greater risk for access barriers means that health care disparities based

upon race, ethnicity, and socioeconomic status are likely to grow wider. Hence the urgency to examine the problem.

i. A Closer Look at Institutional Factors

While public policy solutions may be able to play a part in ameliorating clinician- and patient-based causes, they are critical in helping to combat the institutional causes of disparities. Institutional factors that impact health care access and disparities in services, much like the factors that cause poverty, can differ significantly from one part of the country to another or one market to another. Health care costs and infrastructure in the rural Southeast, for example, may look radically different from the urban Northeast, yet health care disparities may be pervasive in both parts of the country. Given that safety net health care financing differs by state, it may be more useful to examine institutional factors that can contribute to health care disparities on a less national and more local level. It is with this regionalism in mind that we will examine a critical piece of the health care system infrastructure and consider the main safety net health care financing system in the United States: Medicaid.

C. What are Useful Measures of Access to Care?

1. Ambulatory-Care-Sensitive Conditions

AHRQ defines “ambulatory-care-sensitive conditions” as “conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease.”²² While most ambulatory-care-sensitive conditions are associated with avoidable hospitalization, an important and relative newcomer to the universe of disparities measurement research is the timely surgical treatment of appendicitis to avoid appendiceal perforation.

2. Appendiceal Perforation Rates

As explained by the National Digestive Disease Information Clearinghouse (NDDIC), a service of the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) at the National Institutes of Health, appendicitis is an inflammation of the appendix. No medical therapy has proven effective to control the condition once it is initiated, so appendicitis is considered a medical emergency. Most patients recover without difficulty if they receive care in a timely manner. Delays in treatment can result in appendiceal perforation, which may lead to peritonitis (an infection that occurs when bacteria from the appendix leaks into the abdomen), and can be life threatening.²³ The main symptom of appendicitis is abdominal pain, which usually grows more severe over the course of six to twelve hours and eventually becomes excruciating.²⁴ Blood and urine tests, as well as X-rays or other imaging tests are used to diagnose appendicitis in most cases, and the standard treatment is surgical removal.²⁵

Anyone can develop appendicitis, but it most often strikes people between the ages of ten and thirty. Appendicitis is one of the most common reasons for emergency abdominal surgery in children.²⁶ That said, older appendicitis patients tend to experience more complications than children. The elderly in particular often have lower fever and less significant than their young counterparts. Many older adults are unaware of the severity of the situation until the appendix is nearly perforated.²⁷

The literature indicates that appendiceal perforation is more prevalent among racial and ethnic minorities as well as low-income populations, and even suggests its use as a possible new measure of access to care for the U.S. National Healthcare Disparities Report.²⁸ Bratton et al.²⁹ and O'Toole et al. found that children covered by Medicaid and uninsured children had significantly higher rates of appendiceal perforation. In O'Toole's

study, compared with privately insured children, those covered by Medicaid presented later (47.3 +/- 4.1 hours vs. 23.1 +/- 2.5 hours; $P<.01$), had a higher risk of appendiceal perforation (44 percent vs. 23 percent; $P<.05$), and required a longer hospital stay (7.9 +/- 0.9 days vs. 4.6 +/- 0.44 days; $P<.01$).³⁰ Similar findings were made in the adult population.³¹

Moreover, later research indicates a relationship between race and appendiceal perforation among children. Smink et al. found that appendiceal perforation disproportionately affected children of minority race (29.7 percent of whites compared with 38.6 percent of blacks, 34.6 percent of Asians, 39.5 percent of Hispanics, and 35.4 percent of patients of other races). They also found that appendiceal perforation was more common among patients covered by Medicaid (39.9 percent) and uninsured patients (34.6 percent) compared with privately insured patients (29.7 percent).³² Another study found that minority children had between 24 percent and 38 percent higher odds of appendicitis rupture than white children, adjusting for age and gender, and remaining significant after adjusting for other factors.³³ Kokoska et al., too, concluded that black children have higher rates of perforation, a greater delay to surgical management, and lower laparoscopic rates, while Hispanic children more frequently experienced complex appendicitis—and both Hispanics and blacks had longer hospital stays and higher charges.³⁴

These issues will be explored in the quantitative analysis described in Chapter 8.

D. Medicaid: The Federal Role in State Low Income Health Care Markets (LIHCMs)

1. What is a Low-Income Health Care Market?

A market can be defined as “a social arrangement that allows buyers and sellers to discover information and carry out a voluntary exchange of goods or services... The function of a market requires... that both parties expect to become better off as a result of the transaction.”³⁵ It is “the world of commercial activity where goods and services are bought and sold.”³⁶ Markets are comprised then of buyers (who exhibit demand) and sellers (who exhibit supply). In the health care market considered in this dissertation, we can think of patients as “buyers,” or consumers, of health care, making the “sellers” components of the health care delivery system. As demand for low-cost health care increases (in response to growth of uninsured patients, a worsening economy, health care inflation, and other contributors), supply will decline and prices will rise.

Indeed, this is how the system works. As the number of poor people seeking care increased in the early 1990s, the Medicaid budget was stretched. State and federal policymakers sought to implement changes to curb demand. These changes affected access to care for buyers in the Maryland low-income health care market. What the literature does not indicate is whether the changes impacted buyers of different racial and ethnic groups equally.

2. What is Medicaid?

Medicaid, an entitlement program established under the 1965 Social Security Act (SSA), is the largest public source of payment for health care services to the poor. As an “entitlement program,” it is not subject to a budget cap; anyone eligible may enroll in the program, regardless of cost to the government. Prior to its passage, low-income

populations were frequently outside of mainstream medical care and dependent upon the charity of physicians, hospitals, or clinics. The poor, as a result, were often discriminated against in their attempts to access services.³⁷

3. Medicaid Funding: Federal Contributions Vary by State

Unlike Medicare, a federal entitlement program that was also established by the 1965 SSA, Medicaid is jointly funded by federal and state governments. The structure set forth by the SSA enabled states to participate in Medicaid by pledging their own money, which the federal government then matched with additional funding. By creating different funding structures for Medicare and Medicaid, Congress effectively mandated that while the entire population of the nation's elderly would be eligible for government-sponsored health insurance, only the poor who reside in states that chose to use a portion of its own funds were to be given access to public health coverage. Not all elected to participate at first; the last state to do so, Arizona, did not offer Medicaid coverage until October 1982.³⁸

The federal government annually calculates its matching rate, the federal medical assistance percentage (FMAP), by comparing the state's average per capita income level with the national income average. States that exceed the national average are reimbursed for a smaller share of their costs than are poorer states. Law prohibits the FMAP to fall below 50 percent or to exceed 83 percent. In fiscal year 2004, FMAPs varied from 50 percent (in 12 states) to 76 percent (in Mississippi).³⁹

4. Medicaid Eligibility Varies by State

As of December 2005, Medicaid enrollment stood at just about 45 million people,⁴⁰ funding one-third of all births and one-half of all nursing home costs

(contributing to the cost of care for two-thirds of all nursing home residents).⁴¹ It is the largest federal grant program, representing over 41 percent of total federal-to-state grants.⁴²

Federal law identifies 27 different Medicaid eligibility categories, which can be grouped into five broad coverage categories: children, pregnant women, adults in families with dependent children, individuals with disabilities, and the elderly in long-term care. (The elderly are also covered by Medicare, and the low-income elderly can be “dually eligible” for both programs.) To be eligible for Medicaid, applicants must also earn below a certain income (which varies by state) and, for the most part, cannot not be an immigrant who arrived in the U.S. after August 1997, as discussed in later chapters. The federal government requires that certain groups must be covered, while others may be covered at state discretion.

5. Medicaid-Funded Services Vary by State

The federal government requires that all participating states cover specific services under Medicaid, such as physician and hospital services, nursing home and home health services for persons who qualify for nursing home care, pregnancy-related services, “early and periodic screening, diagnosis, and treatment” (EPSDT) for those under age 21, care provided by federally qualified health centers and rural health clinics, and emergency services for non-citizens.⁴³ However, non-mandated services vary greatly by state. For example:

- 44 cover podiatrist services;
- 44 cover dental care;
- 34 cover psychologist services;
- 43 cover eyeglasses;
- 33 cover screening services;

- 16 cover respiratory care for the ventilator-dependent; and
- 12 cover religious, non-medical health care institutions.⁴⁴

States have flexibility in determining eligibility levels and whether and how to expand Medicaid coverage. For example, Medicaid covers 35 percent of the non-elderly low-income population in Massachusetts, but only 15 percent of its counterpart population in Colorado.⁴⁵ Additionally, annual Medicaid per capita spending varies nearly threefold from the most generous to the least generous states. (To wit: Colorado and Wisconsin spend the least on a per-person annual basis, \$197 and \$219, respectively. Massachusetts and New York spend the most, \$435 and \$692, respectively.)⁴⁶

Medicaid costs also vary by beneficiary type. In 2001, for example, payments for the 23.3 million Medicaid-enrolled children (i.e., 50 percent of all beneficiaries) averaged approximately \$1,305 per capita, while payments for the 11.6 million adults (i.e., 25 percent of all beneficiaries) averaged \$425 less at \$1,725 per person. The average jumps, however, for the 7.7 million disabled (16 percent of beneficiaries) to \$10,455 per person, and for the 4.4 million elderly (9 percent of all beneficiaries) to \$10,965 per person.⁴⁷

6. Health Care Costs

Health care costs are on a sharp and steady incline in both the private and public sectors. The United States has seen a 47 percent increase in health care expenditures from 1990 to 2000. In 2003 alone, the nation spent 15.3 percent of its gross domestic product (GDP) on health care. Experts anticipate that the U.S. will spend 18.7 percent of the GDP on health care annually within 10 years, which amounts to a projected 75 percent increase from 1990 to 2010.⁴⁸

a. Rising Costs of Medicaid

Researchers estimate that Medicaid accounted for 17 percent of all U.S. health expenditures in the early 2000s,⁴⁹ up from 6 percent in 1988.⁵⁰ Rising Medicaid costs are due to several factors. The federal Centers for Medicare and Medicaid Services [CMS, formerly the Health Care Financing Administration (HCFA)] cites the following: an the increasing population of Medicaid-eligible individuals as a result of federal mandates, population growth, economic recessions, expanded coverage and use of services, inappropriate use of disproportionate share hospital (DSH) payments (which may result in greater federal payments to states), an increase in the number of elderly and disabled individuals who require extensive acute and/or long-term health care and related services, technological advances that keep critically ill individuals alive and in need of costly care, the growth of new and expensive drugs, and clinician reimbursement rates, which have grown faster than inflation.⁵¹ The changing Medicaid case mix is another possible cause; when Medicaid rolls decreased after welfare reform, those who remained in the program, on average, were higher-cost beneficiaries.⁵²

The Congressional Budget Office identifies health care cost inflation as another culprit. It asserts that health care costs in both the private and public sectors are increasing due to advances in and greater use of technology, reductions in managed care savings, and rising prescription costs. Indeed, about two-thirds (65 percent) of the growth in Medicaid cost reflects general increases in health care costs for those currently enrolled.⁵³ Aetna, a prominent health insurance company, also attributes cost increases to the rise of “blockbuster drugs” and aggressive direct-to-consumer ads.⁵⁴

Another important component to rising Medicaid costs: demographic changes. Today, there are more aged and disabled Americans than ever before, and they account

for roughly 60 percent of current Medicaid expenditures. The Congressional Budget Office actually projects virtually no increase in Medicaid costs due to cost of children and non-elderly, and thus attributes nearly all projected cost increases to the elderly and disabled.⁵⁵ The combination of weak state revenue growth, increasing health costs, and growing eligible populations has prompted some to refer to the current Medicaid financial crunch as “the perfect storm.”⁵⁶

b. Cost Containment Mechanisms

Officials at both the state and federal levels of government are eager to contain health care costs. The cost containment mechanisms that have received the greatest attention include block grants, waivers, and managed care.

i. Block Grants

Medicaid is currently an entitlement program, which means that the government is obliged to finance it for a prescribed population with no preset budget limit. Anyone eligible for the program must be accepted, regardless of cost to the government. Social security is another example of an entitlement program. Block grants, on the other hand, transfer a set amount of funds from the federal to the state governments. The guaranteed, fixed-dollar block grant, which would grow to keep up with inflation, eliminates any guesswork about how much funding a state will receive. Block grants also give states increased autonomy to determine funding, benefits, and eligibility. However, if state predictions of increased case loads come to pass, block-granted Medicaid would result in capped funding to cover services for more people. This could lead to potentially sharp reductions in the breadth of services available to each enrollee.

There have been three noteworthy attempts to turn Medicaid from an entitlement to a block grant. The first came from President Reagan in 1981; the second from Newt Gingrich and other drafters of the Contract with America in 1995; the third from President Bush in 2003.⁵⁷ All three efforts failed. Notably, since that time, there have been no serious congressional initiatives aimed at establishing a Medicaid block grant.

ii. Waivers and Capitated Managed Care Systems

Waiver authority under sections 1915(b) and 1115 of the SSA plays a critical role in state flexibility to contain Medicaid costs. Section 1915(b) waivers, or “Freedom of Choice” waivers, enable states to develop innovative health care delivery or reimbursement systems for the same federal contribution. Section 1115 waivers permit statewide health care reform experimental demonstrations that expand coverage to uninsured populations and test changes to delivery systems while maintaining cost neutrality.⁵⁸ Nineteen states have expanded their Medicaid eligibility via use of managed care under 1115 waivers.⁵⁹

Table 1.1
National Medicaid Managed Care (MMC) Trends

Year	Medicaid Managed Care	Percent of Medicaid in Managed Care	Medicaid Fee-For-Service	Percent of Medicaid in FFS	Total Medicaid
1996	13,330,119	40.1	19,911,028	59.9	33,241,147
1997	15,345,502	47.8	16,746,878	52.2	32,092,380
1998	16,573,996	53.6	14,322,639	46.4	30,896,635
1999	17,756,603	55.6	14,183,585	44.4	31,940,188
2000	18,786,137	55.8	14,904,227	44.2	33,690,364
2001	20,773,813	56.8	15,788,754	43.2	36,562,567
2002	23,117,668	57.6	17,029,871	42.4	40,147,539
2003	25,262,873	59.1	17,477,846	40.9	42,740,719

Source: CMS, 2004. See <http://www.cms.hhs.gov/medicaid/managedcare/trends04.pdf>.

As Table 1.1 indicates, Medicaid managed care expanded enormously during the 1990s.⁶⁰ Between 1991 and 2004, the number of beneficiaries enrolled in some kind of managed care grew from 2.7 million to 27 million, an increase of 900 percent.⁶¹ Of the total Medicaid enrollment in the United States in 2004, approximately 60 percent received Medicaid benefits through managed care.⁶² All states except Alaska, New Hampshire, and Wyoming have all, or a portion of their Medicaid population enrolled in an MCO.⁶³

iii. Other cost containment strategies:

In addition to continued MMC experimentation, states are cutting costs by:

- Restricting eligibility (18 states);
- Reducing benefits (15);
- Increasing copayments (15);
- Freezing or reducing payments to doctors (29); and
- Changing pharmaceutical coverage (40).⁶⁴

E. What, if any, Relationship Exists Between Disparities and Policy Changes to LICHMs?

The research question considered in this dissertation is as follows: Did access-affecting policy changes in the mid-1990s alter Maryland's low-income health care market differently for different racial and ethnic groups? This phrasing contains two important implications:

1. Changes occurred in the market, and
2. Those changes affected access to care.

Before we can consider if different demographic groups had different experiences, we first must corroborate these statements.

Part One of this dissertation explores in detail the changes posed by watershed federal legislation enacted in the mid-1990s. These include a comprehensive welfare

reform package that eliminated automatic enrollment of welfare recipients into Medicaid, and the Balanced Budget Act, which created a new health insurance program for poor children. Congress also passed several measures during that time period that curbed health benefits for poor immigrants.

Part Two builds upon this foundation by identifying how these and other policy changes affected both supply and demand for health care services among poor Marylanders. It provides background into Maryland's demographics and racial and ethnic health care disparities before the time period of interest, describes the state's Medicaid program from the early 1990s, outlines the de jure and de facto changes that occurred in the mid-1990s, describes the impact of those changes, and presents a qualitative content analysis of transcripts from interviews conducted with key stakeholders in Maryland's low-income health care market. In doing so, Part Two provides insights by those implementing both the federal and state policy changes about how access to health care changed for Maryland's poor.

Part Three asks the two key questions: did changes in the mid-1990s affect access to care among Maryland's low-income populations as the stakeholders predicted? And if so, were certain racial or ethnic groups affected differently than others? This section reports on a quantitative analysis of perforated appendicitis and length of hospitalization for appendicitis, measures of access to care, using hospital discharge data.

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Chapter 2: Methodology

A. Description of Qualitative Analysis

1. Literature Review

The author conducted several comprehensive literature searches dating from 1990 through 2004. Sources included the Federal Register, Library of Congress, PubMed, Lexis-Nexis (both the News Articles database and the U.S. Law Reviews and Journals, Combined database), and the Internet (using Google and Yahoo). Search terms included (independently and in combination):

- Balanced Budget Act of 1997
- Balanced Budget Refinement Act of 1999
- Maryland Medicaid
- Children's Health Insurance Program
- Contract with America
- Health care disparities
- HealthChoice (Maryland's Medicaid managed care program)
- Health disparities
- Immigrant health
- Medicaid managed care
- Personal Responsibility and Work Reconciliation Act of 1996 (PRWORA)
- Welfare reform

These searches revealed thousands of documents (836 from Lexis-Nexis alone) including news articles, reports, proposed legislation, proposed regulations, final regulations, testimony, and academic and professional conference presentations. Culling the articles based upon their relevancy to changes in Maryland's low-income health care market in the mid-1990s, the author selected over 950 documents (original documents and secondary research) for inclusion into a bibliographic database that the author set up in Microsoft Access. By December 2004, the 85 key articles were coded and included in

the database. Such materials formed the basis of Part One and informed much of Part Two.

2. Interviews

In accordance with the University of Maryland Internal Review Board's (IRB) approval received on May 19, 1994, personal interviews were conducted with 14 stakeholders during the period of February 2005 through September 2005. Each interview was tape recorded, transcribed, read, and coded (by theme).

Table 2.1

Interviewee Descriptions

Interviewee Number	Description of Interviewee	Date of Interview	Length of Transcript in Single-Spaced Pages
1	Researcher at Washington, D.C. think tank	8/5/2005	9
2	Executive Maryland Medicaid agency official	3/17/2005	40
3	Former Maryland Medicaid agency staff member and attorney	2/23/2005	18
4	Executive with Maryland Medicaid data contractor	4/29/2005	29
5	CEO of Federally Qualified Health Center in Maryland	3/11/2005	13
6	Senior Lobbyist at Non-Profit Advocacy Organization	9/1/2005	9
7	Senior staff with Health Care for the Homeless	7/27/2005	30
8	Executive with Maryland Department of Social Services	9/1/2005	18
9	Staff with Maryland Department of Social Services	3/10/2005	14
10	CEO of Federally Qualified Health Center in Maryland	3/24/2005	25
11	Academic Researcher of Maryland economic trends	8/5/2005	7
12	CEO of association of managed care organizations	7/28/2005	20
13	Staff with Maryland Medicaid data contractor (with expertise in disparities)	4/29/2005	14
14	CEO of managed care-related organization	8/30/2005	2
			Total: 248

These themes and relevant interview sections were then entered into an Access database and integrated into the qualitative analysis. Interviewee selection was conducted using a snowball sampling methodology, beginning with a professional contact at the Maryland Medicaid office that provided names of additional contacts. Each interviewee was asked for additional names of people to interview and stopped when the names overlapped. See Table 2.1.

B. Description of Quantitative Analysis: HCUP Dataset

To triangulate findings of the document review and the interviews, the author sought a quantitative approach to evaluate the research question. After investigating other data sources (particularly the Behavior Risk Factor Surveillance Survey sponsored by the Centers for Disease Control), the Healthcare Cost and Utilization Project (HCUP, pronounced “H-Cup”) was determined to provide the most appropriate source of comprehensive Maryland data before and after the critical policy changes explored in this study. More robust than the BRFSS survey’s small sample size of low-income racial and ethnic minorities, HCUP captures all hospitalizations in Maryland, and provides consistent preventive care variables over the relevant years.

HCUP is a set of related databases and software tools sponsored by the U.S. Department of Health and Human Services’ Agency for Healthcare Research and Quality (AHRQ). These databases include patient-level health care data collected from state data organizations, among other sources, and represent the largest collection of longitudinal hospital care data from 1998 onward in the U.S. HCUP enables research on, among other topics, access to health care at the national and state market levels.⁶⁵

1. Data Process

As per AHRQ's regulations for HCUP use, a data use agreement was filed with the HCUP Central Distributor in 2005 explaining the nature of this project. At that time, the SID HCUP data for New Jersey and Maryland for 1996 and 2003 were purchased. In the spring of 2006, the author attended two HCUP workshops at the AcademyHealth Annual Research Meeting conference in Seattle, Washington and received approximately 10 hours of training in HCUP data manipulation.

2. Justification of Years and Databases Selected

The year 1996 was selected as the baseline year for several reasons. First, the new Maryland Medicaid managed care program, HealthChoice, and the Balanced Budget Act of 1997 were not yet implemented. Secondly, it was important that the datasets across the years include common variables, and several variables changed from the 1995 to the 1996 iteration. Although Maryland's welfare reform package was implemented in mid-1996, using 1996 data provides the latest (albeit partial year) data before the policy changes took effect.

3. Avoidable Hospitalizations and Prevention Quality Indicators (PQIs)

One approach to evaluating the research question is to identify a quantitative measure of access to care. With that measure, one can conduct several analyses: a) determine to what extent there racial and ethnic disparities *before* the study period for that measure, b) determine to what extent there racial and ethnic disparities *after* the study period for that measure, and c) consider what factors can explain the differences in access by race and ethnicity from the pre- to the post-study period.

The category of measures that presented itself as the most logical assessment tool are hospitalizations for ambulatory-care-sensitive-conditions, i.e., “conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease.”⁶⁶ Such so-called “avoidable hospitalizations” are an inefficient use of health care resources because they provide costly and more invasive care than would have been necessary had the health problem been identified earlier, and are therefore a widely accepted proxy for access to care.

To help track care provided for such conditions, investigators at Stanford University and the University of California developed a set of “prevention quality indicators” (PQIs), a set of measures that are used with inpatient discharge data to identify the level of health care quality for ambulatory-care-sensitive conditions. PQI software, distributed by AHRQ, can be applied to hospital inpatient administrative data (e.g., billing data available through HCUP SIDs). While PQIs rely upon hospital inpatient data, they provide insight into the health care delivery system outside of the hospital setting. Indeed, according to AHRQ’s PQI Overview, they “provide a window into the community—to identify unmet community health care needs, to monitor how well complications from a number of common conditions are being avoided in the outpatient setting, and to compare performance of local health care systems across communities.”⁶⁷

Examples of hospitalizations for ambulatory-care-sensitive conditions include lower limb amputations for diabetes patients or inpatient care for vaccine-preventable illnesses like pneumonia. Relatedly, patients suffering with appendicitis who lack access

to surgical evaluation can experience delays in obtaining necessary care, which can result in perforated appendicitis, a life-threatening condition.

The complete list of PQIs includes:

- Diabetes, short-term complications (PQI 1)
- Perforated appendicitis (PQI 2)
- Diabetes, long-term complications (PQI 3)
- Chronic obstructive pulmonary disease (PQI 5)
- Hypertension (PQI 7)
- Congestive heart failure (PQI 8)
- Low birth weight (PQI 9)
- Dehydration (PQI 10)
- Bacterial pneumonia (PQI 11)
- Urinary infections (PQI 12)
- Angina without procedure (PQI 13)
- Uncontrolled diabetes (PQI 14)
- Adult asthma (PQI 15)
- Lower extremity amputations among patients with diabetes (PQI 16).⁶⁸

This study looks at perforated appendicitis, PQI 2. Perforated appendicitis is an ideal measure for several reasons. First, virtually every case of appendicitis will rupture if left untreated, making those who fail to receive treatment in a timely fashion readily apparent. Secondly, there is no evidence that appendicitis strikes certain races or ethnicities more frequently. Assuming that this condition affects racial and ethnic groups equally, increased appendiceal perforation among a particular racial or ethnic population would indicate insufficient access to appendicitis care. Finally, the primary symptom of appendicitis is abdominal pain that grows increasingly more severe as time passes. Given that virtually all successfully-treated cases involve hospital visits and surgery, if we hypothesize that those with less ability to pay delay coming to the hospital in the hopes that the pain will dissipate on its own, we should see increased likelihood of appendiceal perforation among low-income and uninsured populations.

4. Differences-in-Differences Approach

The HCUP database used in this study is the state inpatient database (SID), which contains inpatient discharge abstracts from 22 participating states, including Maryland. The possibility of conducting the same research on both Maryland level and national level data was explored. This strategy would indicate if results in Maryland were consistent with the nation as a whole, or if there were variations in Maryland that were attributable to state-specific policies or approaches to implementing new national policies. Such a “differences-in-differences” approach, however, proved problematic due to limited state data availability and data cost. The SID only included 15 states in 1996 (at a total cost of \$6,795) and 20 states in 2003 (at a total cost of \$12,175).⁶⁹ Efforts to use other HCUP data failed. Although HCUP’s “National Inpatient Survey” database includes a sampling of hospitals from most states for both 1996 and 2003 and offers nationally representative data, it lacks critical variables, including race and ethnicity data, which preclude the relevant analyses.

To overcome these problems, and in consultation with both Dr. Mark Lopez and Dr. R. H. Sprinkle, another state was selected with similar demographics and a similar Medicaid structure: New Jersey. The quantitative findings compare Maryland with New Jersey for both 1996 and 2003. While not a perfect differences-in-differences methodology, assessing trends in a similar state allows for identification of disparate trends that would require additional study before concluding that the policy changes described herein were a primary driver in observed outcomes.

5. Analyses Conducted

The HCUP data distributor, Social and Scientific Systems, Inc. (SSS), created a dataset using PQI software derived from the New Jersey and Maryland SID for both 1996 and 2003, converted from a SAS to a STATA software format. In consultation with Dr. Sprinkle, Dr. Lopez, and an SSS consultant, the author selected one PQI, ruptured appendicitis, as the primary quantitative indicator for access to care. With Dr. Lopez's assistance, the data was further cleaned.

Using the combined Maryland and New Jersey 1996 and 2003 dataset, this study includes probit regression models and ordinary least squares regression models using, respectively, perforated appendix and length of hospital stay as dependent variables. Results appear in Chapter 8 and are discussed in Chapter 9.

Notes

⁶⁵ See the HCUP Overview website at <http://www.hcup-us.ahrq.gov/overview.jsp>. Last accessed: 12/24/2006.

⁶⁶ *Prevention Quality Indicators Overview. AHRQ Quality Indicators*. July 2004. Agency for Healthcare Research and Quality (Rockville, MD [cited 24 December 2006]).
http://www.qualityindicators.ahrq.gov/pqi_overview.htm

⁶⁷ *Ibid.*

⁶⁸ *Ibid.*

⁶⁹ Amounts calculated using the cost schedule in the HCUP Application, available at http://www.hcup-us.ahrq.gov/db/state/SIDSASDSEDD_28Jul2006.pdf. Last accessed 12/24/06.

Part One: Federal Legislation Affecting Access to Care for Vulnerable Populations

Chapter 3: Federal Legislation and its Effects on States' Low Income Health Care Markets

A. Background on Welfare Reform

One of the ideological drivers behind the conservative congressional agenda of the mid-1990s was the desire to devolve power from the federal government to the states, where it could be, in Ronald Reagan's language, "closer to the people."⁷⁰ Stronger state governments, the rhetoric suggests, imply a smaller and leaner federal government. Indeed, as the Contract with America itself reads, "This year's [1995] election offers the chance [to] transform the way Congress works. That historic change would be the end of government that is too big, too intrusive, and too easy with the public's money."⁷¹ The Personal Responsibility Work Opportunity Reconciliation Act (PRWORA, or HR 3734), which transitioned welfare from an entitlement to a block grant program, is an example of such an effort.

In his remarks introducing PRWORA, Representative John Kasich (R-OH) summarized the new Congress' outlook when he noted:

Judeo-Christianity says it is a sin not to help people who need help, but it also says it is equally a sin to continue to help people who need to learn how to help themselves.... If we have a program that traps people in dependence, it is wrong.... I think we have created some systems, including the current welfare system, that have provided too many of the wrong incentives for people to avoid work or to be lulled into a sense of dependency.⁷²

This sentiment was embraced by both parties. Indeed, it was President Clinton who declared four years earlier his intent to "change welfare as we know it."⁷³ PRWORA set

out to accomplish this lofty goal not only by transforming welfare into a block grant, but also by imposing a five-year lifetime limit for cash assistance, and ending the historic connection between Aid to Families with Dependent Children (AFDC) and Medicaid.

B. PRWORA and How it Affects Access to Care Nationally

1. Decoupling Medicaid and Welfare Eligibility

Prior to 1997, eligible families received cash awards via AFDC, and AFDC recipients were automatically eligible to enroll in another social program—Medicaid. In its effort to amend one but not the other, the new law severed the automatic link between AFDC and Medicaid eligibility, enabling individuals to qualify for the latter but not the former. PRWORA froze Medicaid eligibility criteria such that individuals who could enter the program prior to its passage would be able to enter the program in the future. Therefore, the most direct route to post-PRWORA Medicaid eligibility would be to meet the criteria in place on the day PRWORA passed, July 16, 1996.

A secondary route to Medicaid enrollment is for the individual to qualify for Transitional Medical Assistance (TMA). On the books since Congress passed the Family Support Act of 1988, TMA allows families leaving welfare to continue Medicaid coverage for 6 months, regardless of income, and for six more months if their income falls below 185 percent of the federal poverty level.⁷⁴ PRWORA reauthorized the 1988 law, extending states' obligation to provide TMA through 2001.⁷⁵ For reasons discussed below, however, TMA is frequently underutilized.⁷⁶

In support of HR 3734, Rep. Zach Wamp (R-TN) asserted that:

We [the Republicans] said, “let us disconnect Medicaid, health care for the poor, from welfare, and do what the President asked us to do and send a

clean welfare reform bill....” We did make that decision on this side of the aisle to disconnect the two [i.e., welfare reform and Medicaid].⁷⁷

By decoupling the two programs, Wamp and his colleagues’ goal was to put greater limits on eligibility and benefits for the welfare program without affecting Medicaid.

The Republicans’ decision to separate welfare reform from any kind of Medicaid reform was a political necessity;⁷⁸ President Clinton had already vetoed two previous welfare reform efforts that he believed had ominous implications for Medicaid enrollees. In one such veto, exercised against the FY 1996 budget bill — which would have transformed both Medicaid and AFDC into a block grant — the president commented:

The Republican budget ... would ... end the guarantee of quality medical care that now exists for 26 million Americans.... I will not permit the repeal of guaranteed medical coverage for senior citizens, for disabled people, for poor children and pregnant women. ... We cannot, we must not do this. ... if it continues to be a part of the budget... I would veto it again.... We cannot destroy Medicaid.⁷⁹

Yet for all the effort on both sides of the aisle to preserve Medicaid, the measure would prove to have significant, albeit unintended consequences to this safety net health care program for the poor.

a. Loss of AFDC Frequently Meant Loss of Medicaid

Congress expected that separating Medicaid and welfare eligibility would shrink welfare rolls while Medicaid participation would remain steady. In fact, because PRWORA de-linked eligibility for the two programs, the Congressional Budget Office anticipated no decrease in Medicaid enrollment or spending.⁸⁰

The Congressional Budget Office, however, was wrong: post-1995 declines in welfare caseloads are correlated with declines in Medicaid enrollment, particularly among parents.⁸¹ Perhaps those who moved from welfare to work were dropped from

Medicaid because Transitional Medical Assistance had expired before they were able to secure a job that offers health insurance. Or perhaps they were never offered Transitional Medical Assistance when they made the transition from welfare.⁸² A 1995 study of two states found that at least half of children and half-to-two-thirds of parents leaving welfare also left Medicaid (despite many remaining eligible).⁸³ Indeed, the trend was strong enough that, despite state efforts to expand Medicaid eligibility, Medicaid enrollment for both children and parents were declining.⁸⁴ A 1997 GAO study of three states found that the Medicaid participation rates among welfare recipients (i.e., ranging from 84-to-100 percent) fell to 26-to-61 percent after their welfare benefits were revoked.⁸⁵ Similarly, in a meta-analysis of “welfare leavers” studies, researchers noted a consistent pattern among former AFDC and Temporary Assistance for Needy Families (TANF) recipients:

When families cease receiving AFDC/TANF, Medicaid enrollment goes down. The magnitude of the decline varies between studies, but often, one-third or more of children and most adults in families that have exited are no longer reported to be receiving Medicaid when exiters are surveyed some months after leaving.⁸⁶

Keeping with this national trend, Maryland’s Medicaid rolls fell as the state’s welfare reform was implemented. Maryland’s welfare reform program, entitled Temporary Cash Assistance or TCA, was begun in January 1995 and used less restrictive eligibility determinations than the PRWORA would allow. The state’s welfare rolls declined 51 percent from TCA’s initial implementation through the end of the decade, and Medicaid enrollment by those who had been eligible for AFDC over that same period fell by approximately 23,000.⁸⁷

b. As Medicaid Enrollment Falls, Uninsurance Rates Increase

Misperceptions about the program have long been a barrier to Medicaid enrollment. Some eligible individuals refrain from applying because they are currently healthy and are confident that they can get Medicaid at some future date should they need it.^{88, 89} Others are resistant because they feel that the stigma associated with welfare carries over into Medicaid.^{90, 91} This section will set those factors aside and focus instead on the administrative concerns arising from PRWORA (either through the confluence of multiple issues or, in some cases, the resulting domino effect) that hamper Medicaid enrollment and contribute to increased rates of uninsurance.

The notion that those losing Medicaid coverage generally become uninsured is not unique to post-PRWORA America; it was occurring on a smaller scale as early as 1988.⁹² So perhaps not surprisingly, as former welfare beneficiaries fell off the Medicaid rolls, uninsurance rates correspondingly increased. Uninsurance among the poor rose throughout the PRWORA implementation period; while approximately 33 percent of poor women were uninsured in 1994, more than 40 percent were uninsured in 2001.⁹³

It appears that the longer former welfare recipients are off Medicaid, the greater the likelihood that they will become uninsured. In one study, 23 percent of women were uninsured one year after leaving AFDC. Three years later, however, 45 percent were uninsured.⁹⁴ In another study, 41 percent of women (and 25 percent of children) who had left welfare between 1995 and 1997 were uninsured in 1997. One year or more after leaving welfare, 49 percent of women (and 29 percent of children) were uninsured.⁹⁵ In the words of a third study: “If state Medicaid programs could increase the number of children and parents leaving welfare who continue on Medicaid, uninsurance rates might decline.”⁹⁶

The prognosis: more of the same. In the words of two prominent researchers:

Short of major state reforms or changes in federal legislation, it seems likely that more adults (primarily mothers) will lose Medicaid coverage in the future. Welfare reform, in conjunction with a strong economy, may lead more welfare recipients to jobs, and some of them will obtain health benefits. However, many low-wage workers are not offered coverage or cannot afford it. Thus it seems likely that more adults will become uninsured.⁹⁷

c. Transitional Problems Arising from Medicaid/TANF De-Linking

i. Complexity and Variation in TANF and Medicaid Eligibility Rules

Confusion about Medicaid eligibility, which varies from state to state, is a problem that has plagued the program for years. In 1981, a District Court opinion labeled Medicaid eligibility rules “an aggravated assault on the English language, resistant to attempts to understand it.”⁹⁸ PROWRA’s additional complications did little to alleviate the Court’s concern. State workers charged with implementing the law are frequently confused about the latest changes in eligibility requirements.^{99, 100} This confusion is shared by applicants, who are often deterred from applying because they perceive that the eligibility determination is burdensome, demeaning, or too complex to understand.^{101, 102} In many cases, families leaving welfare assumed that they were no longer eligible for Medicaid.¹⁰³

A related problem for AFDC/TANF and Medicaid administrators are the differing rules for TANF and Medicaid eligibility. After PRWORA, entry into the two programs may have different standards for income, disregarded earnings, asset levels, two-parent families, time limits, and work requirements. This can be particularly problematic when eligibility determinations are done manually using paper applications (rather than an automated, computerized eligibility determination process).¹⁰⁴ Although PRWORA set

aside \$500 million in enhanced matching federal funds to help states change their systems and perform outreach activities, there have been few takers. The federal government lifted the expiration date for states to spend these funds, and in January 2000, HCFA urged state Medicaid directors to take advantage of the extension and of the availability of the funds.¹⁰⁵

ii. Confusion Between TANF and Medicaid

Case workers across the country were frequently confused about the application of new TANF eligibility rules to Medicaid. Some thought Medicaid is exclusively for families on welfare, is subject to the TANF lifetime limits, is time-limited, or is subject to TANF work requirements.¹⁰⁶ As one report noted,

Because of the historical link between eligibility for cash assistance and Medicaid, unless instructed to process applications for TANF and Medicaid separately and carefully monitored, eligibility workers may deny an application for Medicaid based on failure to comply with a TANF work requirement or fail to inform applicants about alternative options for Medicaid coverage, especially for children (i.e., applicants will “fall through the cracks”).¹⁰⁷

Interviews with state officials confirmed that such confusion exists among some of Maryland’s eligibility workers.¹⁰⁸

While PRWORA requires Medicaid and TANF eligibility to be determined independently, agency administrative systems may view Medicaid as “an extra welfare benefit,” such that when people lose welfare benefits, their Medicaid case frequently is simultaneously closed.

Because the two programs remain connected in the minds of caseworkers and recipients as well as in state computer eligibility systems, the new emphasis on closing welfare cases as quickly as possible is causing many families to be cut off Medicaid, even when they are still eligible.¹⁰⁹

Housing the TANF and Medicaid programs under one agency and requiring the same staff to determine eligibility for both may further exacerbate this confusion. For example, Wisconsin's Medicaid enrollment is handled by the Department of Workforce Development, which also oversees TANF and food stamp applications. Department of Workforce Development staff members handle an average of 400 cases each. Some fear that the combination of this heavy caseload and the variations in program eligibility creates a situation ripe for incorrect eligibility determinations.¹¹⁰

Furthermore, the new requirement that state agency staff verify an applicant's immigration status before declaring an applicant eligible for Medicaid further complicates the case worker's tasks.¹¹¹

d. Incidents of Misdiagnosed Eligibility

In Pennsylvania, 32,000 ex-welfare beneficiaries (including 24,000 children) were dropped from the Medicaid rolls erroneously. In March 1997, when Pennsylvania's welfare reform went into effect, roughly one-sixth of the 186,000 people who no longer received welfare benefits mistakenly also lost health benefits. Approximately 20 percent of the 32,000 in question received restored Medicaid coverage for six months. The remaining 80 percent were slated to receive benefits for just two months.¹¹²

Pennsylvania's story is not unique. As many as 3 million people were dropped from Medicaid nationwide between 1995 and 1998. The culprit: "...the reduction of welfare rolls, computer glitches in welfare offices, confusing information about eligibility and recipients' decisions to curtail dependence on state programs."¹¹³

A 1999 Families USA report concluded that welfare reform is responsible for the loss of health care insurance for hundreds of thousands of Americans. This report

highlighted three main reasons: (a) upon transitioning from welfare to work, many beneficiaries lose Medicaid eligibility; (b) Medicaid services are illegally eliminated despite continued eligibility; and (c) state efforts to dissuade people from applying for welfare results in limited opportunity to apply for Medicaid.¹¹⁴

States are allowed to ‘divert’ people from completing their welfare applications by requiring them to undertake job search activities or to seek other forms of private help before applying for assistance.... Although such ‘diversion’ processes are becoming routine in the context of cash welfare assistance, they can improperly divert people from applying for Medicaid as well... [and] these diversionary practices may constitute a barrier to coverage for both new applicants and those who have left the Medicaid rolls but need coverage again.¹¹⁵

In response to these stories, HCFA sent a letter in April 2000 asking all state Medicaid directors “to review their records to be sure no one who is entitled to Medicaid lost their benefits after leaving welfare and to reinstate anyone who was improperly terminated from the Medicaid program.”¹¹⁶

e. State use of Separate Application Forms for all Means-Tested Programs

Research indicates that separate applications for Supplemental Security Income (SSI) and Medicaid can reduce Medicaid participation.¹¹⁷ HCFA guidance indicates that states may continue to enroll automatically all TANF beneficiaries into Medicaid without a separate determination for Medicaid eligibility, and that they may use a single application for both programs.¹¹⁸

2. Unintended Consequences of PRWORA

a. Redeterminations of Medicaid Eligibility Can Cause “Churning”

PRWORA requires that states redetermine Medicaid eligibility at least every 12 months, or whenever the beneficiary experiences a change that might affect eligibility.

This can result in “churning,” or short-term interruptions in eligibility. Frequently this occurs when beneficiaries do not respond quickly enough to notices about continued eligibility.

Churning puts tremendous strain on health care providers and insurers... because substantial resources are required upfront for enrollment and intake each time a beneficiary enters or re-enters the system... In addition... no health care provider can “manage” care without ongoing access to the patient. When patients enter and quickly exit the system, perhaps to re-appear yet again if Medicaid eligibility is reestablished, care is most likely fragmented instead of well coordinated.¹¹⁹

Some states choose to conduct redetermination assessments even more frequently than PRWORA requires. For example, in Wisconsin, Medicaid eligibility is tied to food stamp recertification, and the state redetermines eligibility for food stamps every three months.¹²⁰ This exacerbates the churning phenomenon. Furthermore, many families disappear from the welfare system upon losing welfare or Medicaid eligibility without undergoing a formal redetermination process, thus foregoing 12 more months of transitional Medicaid.¹²¹ In short, states are not sufficiently effective at keeping families enrolled in Medicaid until a redetermination occurs.

Yet another concern is that states may fail to reassess a child’s Medicaid eligibility when the parents are no longer eligible. This can lead to significant declines in children’s enrollment, despite continued eligibility.¹²²

b. Jobs Held by Former Welfare Beneficiaries Often do not Offer Health Insurance

Those leaving welfare tend to work at jobs that pay less than \$8 per hour and do not offer such benefits as health insurance or paid sick leave.¹²³ Indeed, although 56 percent of female former welfare recipients reported employment, only 33 percent had

private or employer coverage.¹²⁴ In those cases where health insurance is offered for the employee, benefits may not include coverage for dependents. In fact, the majority of welfare beneficiaries who find employment earn below the poverty level, but in most states, even a low-wage and part-time job renders parents ineligible for Medicaid.¹²⁵

c. Harder for Recipients to Apply

As welfare recipients move from welfare to work, the steps that applicants must follow before the state determines Medicaid eligibility are often prohibitively onerous. For example, mandated in-person interviews at a welfare office between 9:00 am and 5:00 pm may be impossible for newly working people to manage.¹²⁶ Similarly, despite the requirement that redetermination (see above) be conducted *ex parte*, that is, without the involvement of the recipient in the initial review, most states require that families report in person to the state benefits office to file redetermination paperwork, and thus create another barrier to continued Medicaid access.¹²⁷

d. Problems with Transitional Medical Assistance (TMA) Administration

As noted above, TMA provides a blanket extension to all Medicaid enrollees, but is not without its own administrative problems. For example, because an outdated federal mandate prohibits individuals from receiving TMA unless they have received welfare payments for a period of months, Maryland and other states that provide lump-sum welfare payments to beneficiaries are banned from offering TMA to those who would otherwise be eligible. As a result of this and other administrative difficulties, two studies indicate that “very few families who leave welfare actually receive Transitional Medicaid,”¹²⁸ despite their automatic eligibility. The exact scope of the problem, however, remains unknown because states do not systematically track TMA enrollment.

e. More Strain on the Safety Net and Federally Qualified Health Centers Because Less Reimbursement for More Patients

As more people lose Medicaid coverage, more low-income patients will rely upon safety-net institutions, such as federally qualified health centers (FQHCs) and public hospitals, who offer care either for free or at reduced cost. This means that such sites are receiving smaller Medicaid reimbursement even as the numbers of uninsured clients increase. Without supplemental state or local funding, safety net institutions simultaneously are facing a decreased supply of funding and resources and an increased demand for services—a dangerous equation to the financial health of the safety net.^{129, 130}

f. Changing Case Mix Among Remaining Medicaid Enrollees

States are experiencing significant turnover in Medicaid caseloads, but those who leave the program are not identical to those who stay. Research indicates that former welfare recipients leaving Medicaid are disproportionately low-cost users, while those who remain on Medicaid are more likely to accrue higher costs. Indeed, a person's health status is an important determinant of whether a person's Medicaid coverage persisted after leaving welfare.^{131, 132} This suggests that the Medicaid case mix may be evolving into a higher-need and higher-cost group for whom current capitated payments may not be adequate.¹³³ Medicaid managed care programs, then, may be at a significant disadvantage unless capitation rates are updated to keep pace with the changing case mix. This changing case mix may affect states' efforts to implement large-scale Medicaid managed care.¹³⁴

PRWORA also had significant implications for immigrant health care, which is discussed in detail in later chapters.

C. BBA and How it Affects Access to Care Nationally

Congress passed the Balanced Budget Act of 1997, which included several provisions with significant implications for low income health care markets. Specifically, the BBA:

- Established the children's health insurance program;
- Made significant reductions in federal Medicaid spending;
- Altered federal reimbursement formulas for safety net providers;
- Allowed states to experiment with managed care in their Medicaid programs without seeking federal approval;
- Changed residency program and graduate medical education funding;
- Restored certain benefits to legal immigrants that were taken away by PRWORA (discussed in detail in later chapters); and
- Made changes to states' authority over their Medicaid programs.

1. Established the State Children's Health Insurance Program (SCHIP)

Perhaps the most significant change posed by the BBA was the establishment of a new program aimed at covering health care costs for low-income children. Subtitle J of the BBA created the SCHIP Program (Title XXI of the Social Security Act), a child health care block grant which would give states \$20.3 billion in new federal funds over five years to extend health insurance coverage to children.¹³⁵ States were given the option either to expand Medicaid eligibility or to create a separate program to provide this coverage.

2. Made Significant Reductions in Federal Medicaid Spending

The BBA included the steepest decline in the federal Medicaid budget since 1981.¹³⁶ These cuts came from several BBA provisions, including newly-imposed limits on the federal match to states to reimburse disproportionate share hospitals (DSH) for care to Medicaid beneficiaries.¹³⁷ Established by congress in the early 1980s, the DSH funding initiative mandated that state Medicaid agencies make allowances when

establishing reimbursement rates for hospitals serving a disproportionate number of Medicaid or low-income patients. Indeed, most of the BBA's federal Medicaid spending cuts stemmed from reductions in payments to safety net institutions, particularly DSH hospitals.¹³⁸

Additionally, the BBA allows states to mandate that clinicians and other providers pay Medicare deductibles and copayments for low-income Medicare beneficiaries. (Before BBA, Medicaid frequently paid these costs). States may, under the BBA, count Medicaid reimbursement as payment-in-full for services rendered to qualified Medicare beneficiaries and people who are dually eligible for Medicaid and Medicare.¹³⁹

Further Medicaid savings come from reduced payments for physicians' services, inpatient and outpatient hospital services, hospitals' cost of capital, clinical laboratory services, and durable medical equipment.¹⁴⁰ The BBA also establishes that Veterans' pensions be considered as income, thus reducing Medicaid's contribution to the cost of veterans' institutional care.¹⁴¹

3. Altered Federal Reimbursement Formulas for Safety-Net Institutions and Clinicians

The expansion of managed care into the Medicaid market complicated the health care delivery and reimbursement process for clinicians and hospitals accustomed to traditional fee-for-service Medicaid, such as FQHCs and rural health clinics. FQHCs are federally mandated to provide care to all patients, including the uninsured and those on Medicaid. To provide incentives to care for Medicaid (and Medicare) patients, FQHCs and rural health clinics received higher reimbursement rates under the "Boren Amendment" (i.e., 100 percent of all "reasonable and customary" costs for providing care to Medicaid beneficiaries). This led to widespread cost-shifting whereby FQHCs covered

their expenses for treating the uninsured with the augmented reimbursement they received for Medicaid patients.

The BBA contained provisions for phasing out the Boren Amendment. This meant that, over a five-year period, FQHCs and rural health centers would no longer receive reimbursement for 100 percent of costs for services provided to Medicaid patients. The reduction in Medicaid caused financial difficulty for many of these centers.¹⁴²

Savings are also derived from the repeal of federal minimum payment protections for other safety net institutions, such as hospitals and nursing homes. (The previous law imposed minimum payment standards that states had to meet when setting reimbursement rates for these care delivery sites).¹⁴³

Other cost-related changes under the BBA included new payment methods for rehabilitation hospitals, nursing facilities, outpatient hospital and therapy services, and home health service;¹⁴⁴ an increase in the federal share of Medicaid payments to Washington, D.C.; and a new state entitlement grant program of \$100 million over four years (FY 1998 through FY 2001) for emergency services to each of the twelve states with the highest number of undocumented aliens,^{*} as determined by the Immigration and Naturalization Service [(INS), subsequently reorganized under the Department of Homeland Security (DHS)].¹⁴⁵

^{*} The term “alien” is synonymous with “immigrant,” and is more frequently used in legislative language.

4. Allowed States to Experiment with Managed Care in their Medicaid Programs without Seeking Federal Approval

Before the BBA, states seeking to move a portion of its Medicaid population into managed care had to obtain federal approval under a Section 1115 or 1915(b) waiver from HCFA (subsequently renamed the Center for Medicare and Medicaid Services, or CMS) within the U.S. Department of Health and Human Services. The BBA changed this requirement by allowing states to move most Medicaid enrollees from fee-for-service to managed care arrangements without obtaining federal approval. Rather than waivers, states need only to amend their Medicaid State Plan with HCFA/CMS to reflect the role of managed care in their Medicaid programs.¹⁴⁶

While the Congressional Budget Office did not project this aspect of the BBA to be responsible for any federal cost savings, it was likely, in the words of one researcher, “to have a major impact on access to covered hospital and physician services by low-income families. These provisions also had important implications for the hospitals, physicians, and health centers from which low-income families have traditionally obtained needed care.”¹⁴⁷

The BBA also lifted the so-called “75/25 Rule,” which held that no managed care organization (MCO) could have more than 75 percent of its membership comprised of Medicaid beneficiaries, and no less than 25 percent of its membership comprised of privately paying patients, thereby barring Medicaid-only MCOs. In other words, the BBA permits states to establish Medicaid-only MCOs, and to require most of its Medicaid beneficiaries to enroll in managed care organizations that do business only with Medicaid.¹⁴⁸

5. Changed Graduate Medical Education Funding For Residency Programs

The BBA cut funding for residency programs, limiting available funds and consequently exerting downward pressure on residency programs and cultural-competency training. FQHCs and hospitals operating under traditional fee-for-service Medicaid typically rely upon residency programs for low-cost professional services. Residency programs, indeed, have long been a mainstay of the health care safety net.

These cuts, therefore, have implications for the health care safety net and for access to care for poor minorities. Aside from smaller residency classes, which diminish supply, reductions in GME funding could have other unintended results. For example, research suggests that racial and ethnic disparities in health care may stem in part from poor understanding among clinicians of the populations they serve.¹⁴⁹ “Cultural-competency training” in medical and nursing schools and in residency programs is cited as an important component of any campaign to eliminate disparities.^{150, 151, 152} Such initiatives are in their infancy, but preliminary findings indicate that they have been effective at promoting better health outcomes, particularly in Medicaid managed care settings.¹⁵³ Budget cuts for such programs, therefore, affect both the supply of safety net clinicians and the degree to which all clinicians are trained to care for culturally diverse populations.

Overview of Graduate Medical Education Changes in the BBA:

First, the BBA made several important changes to graduate medical education funding mechanisms that affect the number and mix of residents trained. Pre-BBA, Medicare offered two funding mechanisms to support training programs in teaching hospitals: Direct Medical Education defrays direct costs of training physicians (e.g.,

salaries, fringe benefits of residents and faculty), and Indirect Medical Education funds additional operating costs that teaching hospitals incur in patient care (e.g., costs associated with offering a broader range of services using more intensive treatments, treating sicker patients, and using a costlier staff mix). These payments effectively served as an incentive for hospitals to increase their number of residents, since residents are cheaper labor than nurses or physicians, particularly when associated costs are defrayed by Medicare. However, the BBA put a ceiling on the number of Direct Medical Education reimbursements. Experts suggest that assessing the role that the BBA has had in containing graduate medical education cost growth is difficult to ascertain because of insufficient data, confounding factors, and difficulty in ascribing cause and effect.¹⁵⁴

6. Restored Certain Benefits that were Eliminated in PRWORA

The BBA restored Medicaid to certain children who were receiving SSI and Medicaid when Congress enacted PRWORA on August 22, 1996, but subsequently lost their SSI coverage as a result of changes brought about by the welfare reform law. Those children who continue to meet the previously applicable SSI disability criteria, family income ceilings, and other conditions of eligibility may be reinstated into Medicaid under the BBA.¹⁵⁵

For more on restoration of benefits for immigrants, please see chapter 4.

7. Made Changes to States' Authority over their Medicaid Programs

The BBA expanded state authority in several areas, and limited it in others. Examples of state authority expansions are as follows. The BBA:

- Provided states with more options to allow additional children and disabled persons to be eligible for Medicaid;

- Gave states the option of providing twelve months of continuous eligibility to children under 19 years of age;
- Offered states new authority to grant presumptive (i.e., temporary) Medicaid eligibility to children up to age 19 while the state processes their applications for Medicaid or SCHIP;
- Allowed states to guarantee six months of Medicaid coverage to managed care enrollees;
- Created a “Medicaid Part B” block grant, which offers states funding to cover Medicare Part B premiums for low-income individuals;
- Established a new state option to allow disabled SSI beneficiaries with incomes up to 250 percent of the federal poverty level and who otherwise are ineligible for benefits to buy into the Medicaid program on a sliding scale premium basis; and
- Enabled states to pay the Medicaid reimbursement rate to Medicare providers for services provided to qualified Medicare beneficiaries and dual eligibles.^{156, 157}

Congress also used the BBA to limit state authority by increasing consumer protections.¹⁵⁸ Specifically, it:

- Required that states provide auto-enrolled Medicaid managed care beneficiaries a 90-day grace period within which they may switch plans;
- Established a new right for an MCO contracting with the state Medicaid agency to be given notice and a hearing before the state may terminate its contract; and
- Created a “prudent layperson” definition of an “emergency medical condition.”¹⁵⁹

The BBA also made other changes to state low-income health care markets around the country. It expanded premium assistance for low-income Medicare beneficiaries, included a new primary care case management (PCCM) benefit option, and liberalized eligibility requirements for Medicaid assistance under home- and community-based care waivers.¹⁶⁰

D. Subsequent Federal Legislation

Implementation of the BBA began in 1998, but the full impact of the BBA’s reimbursement phase-out ultimately was never realized. The Medicare, Medicaid, and

SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) established that, as of January 1, 2001, state Medicaid plans (i.e., plans submitted by states to the Center for Medicare and Medicaid Services describing their Medicaid programs) be amended to provide payment to health centers equal to 100 percent of FQHC average costs for fiscal years 1999 and 2000. Such amounts would serve as the baseline for subsequent fiscal years, and in FY 2001 and beyond, BIPA requires that FQHCs also receive an increase in percentage costs as measured by the Medicare Economic Index.¹⁶¹

E. Conclusion

This chapter discusses the impact of two major federal legislative initiatives on low-income health care markets across the country. The next chapter discusses the impact of these and other federal measures specifically on immigrants' access to health care.

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Chapter 4: National Impact of Congressional Changes on Immigrants' Access to Care

A. Background: Political Context of PRWORA's Immigrant Restrictions

1. Immigrants and Health Care

For many reasons, immigrants are among the nation's most vulnerable demographic groups. Compared with the U.S. born, they are poorer, less likely to be covered by employer-based insurance, less likely to have a usual source of care, and their use of health care services tends to be lower. They also have cultural and linguistic barriers to care,¹⁶² and are also less likely than non-immigrants to see a physician or a nurse, seek care in emergency departments, or visit a dentist.¹⁶³

Like other minority demographic groups, immigrants are not spread equally across the U.S., but are instead concentrated in a handful of states. Several states with the largest and fastest-growing immigrant communities, including Arizona,¹⁶⁴ California,¹⁶⁵ Florida,¹⁶⁶ New Jersey,¹⁶⁷ New York,¹⁶⁸ and Texas,¹⁶⁹ have filed suits against the federal government for reimbursement for health care and other social services for undocumented aliens.¹⁷⁰ This became an important factor in the welfare reform debate of the mid- to late 1990s, and in the BBA, Congress tried to ameliorate the excess fiscal burden by awarding states supplemental funding to offset health care costs for their foreign-born populations.

2. Immigrant Access to Health Care

As recently as the 1980s, most safety-net clinicians around the country either were not subject to or chose to disregard prohibitions against providing care to

immigrants. Indeed, evidence shows that clinicians generally ignored whatever statutory barriers were in place that limited access to care for non-citizens, and provided care to immigrants regardless of their citizenship status.¹⁷¹ This de facto policy continued through the late 1980s, when the relaxation of federal immigration policy (including amnesty to undocumented immigrants and liberalization of rules regarding family reunification)¹⁷² and simultaneous state Medicaid expansions led to a dramatic influx of poor immigrants into a handful of states and onto their Medicaid rolls.¹⁷³

Before PRWORA, immigrant health care fell under the “Permanently Residing Under Color of Law” (PRUCOL) doctrine, which held that an immigrant whose status was “ambiguous, under consideration, or even clearly irregular, could be eligible for government-sponsored benefits,” provided that the immigrant was not under active INS pursuit for deportation.¹⁷⁴ In 1992, this sentiment was reinforced when the U.S. Supreme Court determined in *Plyer v. Doe*¹⁷⁵ that state and local governments must extend basic public benefits (including, until 1996, health care) to residents regardless of immigration status.¹⁷⁶

Most legal immigrants, therefore, were eligible for Medicaid on the same basis as U.S. citizens prior to PRWORA,¹⁷⁷ and various state efforts to provide care to these newcomers resulted in large immigrant enrollment in benefit programs. For example, by 1994, immigrant women comprised 60 percent of all deliveries funded by Medi-Cal (i.e., California’s Medicaid program).¹⁷⁸

A powerful populist backlash emerged in response. California’s Proposition 187, which was approved by voters in 1994 and had been a central campaign theme for successful gubernatorial candidate Pete Wilson, sought to prevent illegal immigrants

from benefiting from a range of tax-funded social welfare benefits. Anti-immigrant activists in other states, including Arizona, Florida, and Oregon, attempted similar initiatives.¹⁷⁹ These efforts set the stage for the drama that was to play out two years later when the Republicans won a majority in the U.S. House of Representatives and initiated its “Contract with America” agenda.

When Representative John Kasich introduced HR 3734 (PRWORA) on June 22, 1996,¹⁸⁰ Congress had just passed the Antiterrorism and Effective Death Penalty Act (signed into law April 26, 1996),¹⁸¹ and was debating the Illegal Immigration Reform and Immigrant Responsibility Act (signed into law September 30, 1996).¹⁸² These new laws exemplified the growing national anti-immigrant sentiment by limiting non-citizens’ rights of residence and judicial appeal, as well as the ability of undocumented immigrants to adjust to legal status.¹⁸³

a. Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA) of 1996

The two major changes posed by IIRIRA were the establishment of procedures for requiring proof of citizenship prior to receipt of federal public benefits, and the tightened requirement for the “Affidavit of Support” required for sponsored immigrants.¹⁸⁴

INS’s guidelines for implementing the IIRIRA made the Affidavit of Support, a long-time requirement for immigrant sponsors, an enforceable contract. Previously, the courts had determined that the affidavit represented a “moral” rather than legal, commitment.¹⁸⁵ The guidance explains that:

To ensure that the immigrants are not likely to rely on public benefits, sponsors must demonstrate on the new form that they meet minimum income requirements and can be financially responsible for the sponsored

immigrants. Sponsors must complete the new Affidavit of Support form for relatives who will file applications for immigrant visas or for adjustment of status on or after December 19, 1997.¹⁸⁶

Under IIRIRA, a sponsor must be at least 18 years of age and a U.S. citizen or a lawful permanent resident domiciled in the United States (including territories and possessions). Additionally, the sponsor must offer proof of employment, provide federal income tax returns for the three most recent tax years indicating an income level at or above 125 percent of the federal poverty level,^{187, 188} and maintain the income of his charge at a level at least 125 percent of the federal poverty level.¹⁸⁹ The sponsor will remain liable for his charge until the immigrant either: a) becomes a U.S. citizen, b) can be credited with 40 quarters (i.e., approximately 10 years) of work, c) leaves the United States permanently, or d) dies.¹⁹⁰ In this way, post-IIRIRA sponsors take on a more active role than ever before in supporting the immigrants they bring to the United States. Failure to provide this support is, for the first time, actionable: delinquent sponsors may be sued not only by the sponsored immigrant, but also by federal or state agencies to reimburse the cost of any means-tested public benefits that the sponsored immigrant received.¹⁹¹

B. PRWORA's Changes Affecting Immigrants' Access to Health Care

Major goals of both PRWORA and the IIRIRA were to discourage immigrants likely to seek public benefits from entering the United States, and then shift responsibility for immigrant support away from the government and onto the newcomers' sponsors. An intended byproduct would be overall cost savings. According to a Congressional Budget Office analysis, the immigrant provisions would generate approximately 40 percent of PRWORA's overall savings of \$54 billion (despite the fact that immigrants represented

only 15 percent of all welfare recipients in the US).¹⁹² The Congressional Budget Office also estimated that, if PRWORA had been fully implemented, the government would have denied Medicaid to approximately 260,000 elderly legal immigrants, 65,000 disabled immigrants, 175,000 other adult immigrants, and 140,000 children who would otherwise qualify for Medicaid by 2002.¹⁹³

Upon signing PRWORA into law, President Clinton expressed:

strong objections to certain provisions.... I am deeply disappointed that this legislation would deny Federal assistance to legal immigrants and their children, and give States the option of doing the same. My Administration supports holding sponsors who bring immigrants into this country more responsible for their well-being. Legal immigrants and their children, however, should not be penalized if they become disabled and require medical assistance through no fault of their own.¹⁹⁴

Nonetheless, approximately 935,000 non-citizens lost benefits under PRWORA,¹⁹⁵ and use of welfare by legal immigrants and refugees declined significantly by the end of the decade. Indeed, immigrants represented 15 percent of all welfare recipients when PRWORA was signed into law in 1996, but despite the growth of the total immigrant population, that proportion fell to 12 percent by 1999.¹⁹⁶

1. Changes in State Authority over Medicaid

A primary theme of the Contract with America agenda was the decentralization of program implementation from the federal to the state level. PRWORA accomplished this in several ways, perhaps most obviously in its transition of the AFDC cash assistance entitlement program to a TANF block grant to the states. Similarly, the law transitioned to states the authority to provide Medicaid to immigrants. But in important ways, PRWORA also expanded federal authority into immigration policy in areas that have traditionally been within a state's jurisdiction.

a. Expansions in State Autonomy

Post-PRWORA expansions allow states to determine individually whether they will provide federal benefits (including Medicaid) to current legal immigrants, or future immigrants after the mandatory five-year ban, and whether to provide state or local funds allowing future immigrants to participate in Medicaid during the five-year moratorium. It also gives states the power to determine what mix of state and local funded services they will extend to current and future legal immigrants.

States can choose to either provide Medicaid to immigrants based upon his or her own eligibility, or to limit access by employing outright bans, state residency requirements, or “deeming.”¹⁹⁷ Deeming refers to the state’s use of the combined income and assets of the sponsor, sponsor’s spouse, and the immigrant when determining the immigrant’s eligibility for Medicaid or state-sponsored means-tested programs.¹⁹⁸ By artificially raising the immigrants’ income above the eligible range, deeming renders most applicants’ income as too high to qualify for Medicaid.¹⁹⁹ (Before PRWORA, deeming was not applicable to Medicaid, but was used in determining eligibility in other social programs, including Food Stamps, Supplemental Security Income, and cash assistance.²⁰⁰)

b. Expansions of Federal Authority

However, PRWORA also places some new restrictions on state authority. For example, PRWORA requires states, subsequent to August 1996, to enact a law explicitly proclaiming the state’s intent to provide services to undocumented and other “non-qualified” immigrants, even though such services would be funded with state or local dollars only. States are also forbidden from retaining “sanctuary laws” that prohibit state or local officials from reporting illegal immigrants to the INS. (This PRWORA provision

remains in force after an unsuccessful challenge by NYC Mayor Rudolph Giuliani who claimed it violated the Tenth Amendment and jeopardized public health.) Finally, PRWORA requires states to verify not only legal status, but citizenship status of applicants for all “federal public benefits programs which provide direct federal expenditures.”²⁰¹ PRWORA, in this way, hastens the trend of immigration-related federal expansion into historically state domains, which began with the passage of the 1986 Immigration Reform and Control Act.²⁰² (That measure required the federal government to confirm the legal status of non-citizens before providing federal benefits.)

2. Classes of Immigrants under PRWORA

Before PRWORA was passed, legal immigrants and permanent U.S. residents were entitled to full Medicaid coverage. Today, a state’s ability to provide immigrants with Medicaid coverage breaks down differently based on date of arrival (i.e., before or after August 23, 1996) and whether they are “qualified” or “unqualified,” as described below. This simplification of immigration status places classes of legal immigrants (e.g., applicants for asylum or adjustment of status) in the same “unqualified” status as undocumented aliens. In doing so, PRWORA blurs the distinction between those immigrants who are in the United States with the government’s consent and those who are here without it.²⁰³

Table 3.1

Medicaid Eligibility for Immigrants Under PRWORA

	Qualified Immigrants		Unqualified Immigrants	
	<i>LPRs^a</i>	<i>Asylees/Refugees^b</i>	<i>Non-immigrants^c/ Undocumented^d</i>	<i>PRUCOL^e</i>
Arrived pre-8/23/96	State option	Eligible for 1 st 7 years	Emergency only*	Emergency only*
Arrived post-8/23/96	Barred for 1 st 5 years; then at state option	Eligible for 1 st 7 years	Emergency only*	Emergency only*

Note: * Emergency medical conditions are defined as: “a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: (A) placing the patient’s health in serious jeopardy, (B) serious impairment to bodily functions, or (C) serious dysfunction of any bodily organ or part.”²⁰⁴

^a Legal permanent residents (LPRs), also called “permanent residents,” are green card holders and may live in the United States indefinitely unless they commit a “deplorable act.”

^b “Refugees & Asylees” status is based on individualized persecution abroad and may eventually adjust to permanent residency. Includes Cuban/Haitians and Amerasians.

^c “Nonimmigrants” refers to those admitted temporarily for a limited purpose (e.g., students, visitors, and temporary workers).

^d “Undocumented immigrants” are also called illegal immigrants, and include those who are in the United States in violation of immigration law for whom no legal relief or recognition has been extended.

^e PRUCOL stands for Persons Residing Under Color of Law.

Sources: PRWORA language and Congressional Record Service (CRS) Report for Congress, “Alien Eligibility for Public Assistance,” 1998.

a. Qualified Immigrants

PRWORA defines two categories of immigrants as “qualified”: 1) Legal Permanent Residents (LPRs), also called “permanent residents,” and 2) Refugees and Asylees. The first group are green card holders and, under PRWORA, may live in the United States indefinitely, unless they commit a “deplorable act.” The “Refugee and Asylee” status is based on individualized persecution abroad and may eventually adjust to permanent residency. In addition to LPRs, PRWORA specifically enumerates the following as qualified immigrants: refugees, asylees, Cuban or Haitian entrants, persons

granted withholding of deportation, persons granted conditional entry, certain parolees and certain victims of domestic violence.²⁰⁵

i. Qualified Immigrants Arriving before August 23, 1996

Even those qualified immigrants who entered the country before PRWORA was enacted may be denied Medicaid permanently, at state option. Wyoming is the only state that has chosen to do so;²⁰⁶ forty-nine states and the District of Columbia opted instead to cover all qualified immigrants who resided in the United States before August 22, 1996, the date the welfare law was enacted. Refugees and asylees are exempt from these limitations for seven years after receiving their status. Beyond that, Medicaid is provided at state discretion.²⁰⁷

ii. Qualified Immigrants Arriving after August 23, 1996

Qualified immigrants arriving after August 23, 1996 are ineligible for Medicaid and Children's Health Insurance Program (CHIP) for their first five years in the United States, after which time states can decide whether to include them in the Medicaid program. States may choose to include qualified post-PRWORA-arrivals in the Medicaid eligibility pool outright or sparingly by, for instance, limiting eligibility with sponsor deeming requirements. In other words, the state may allow into the Medicaid eligibility pool only those post-August 23, 1996 qualified immigrants if the combined income of the immigrant and his sponsor and his sponsor's spouse qualifies for Medicaid. (The deeming period ends only after the immigrant becomes a citizen or has worked in a qualified job for 40 quarters—approximately 10 years.) Alternatively, states may choose to withhold Medicaid or CHIP to qualified immigrants entirely after the five-year ban has expired.^{208, 209}

Under PRWORA, even pregnant immigrant wives of U.S. citizens who came to the United States legally, but after August 23, 1996, are ineligible for publicly-funded prenatal care during the two-year “conditional resident status” period.²¹⁰

PRWORA also excluded qualified immigrants arriving after August 23, 1996 from SSI and food stamps, but subsequent legislative language struck this provision when the BBA was enacted a year later.

b. Unqualified Immigrants (Regardless of Arrival Date)

Unqualified immigrants fall into three categories: illegal immigrants, “non-immigrants,” and PRUCOL. “Illegal immigrants,” also called “undocumented immigrants” or “undocumented aliens,” include those who are in the United States in violation of immigration law for whom no legal relief or recognition has been extended. “Non-immigrants” are those who are admitted temporarily for a limited purpose (e.g., students, visitors, and temporary workers). PRUCOL status means that the government is aware of the immigrant’s presence, the immigrant is permanently residing in the U.S., and the government has provided written assurance that deportation is not planned.²¹¹

The three groups are unaffected by PRWORA, which is to say that they remain eligible for the same health care benefit as before PRWORA’s enactment: emergency coverage only.²¹²

C. BBA’s Changes Affecting Immigrants’ Access to Health Care

The BBA reversed some of the impact of PRWORA on immigrant access to care. Specifically, it:

- Restored Medicaid and Supplemental Security Income (SSI) to elderly and disabled poor legal immigrants who, on August 22, 1996, both lived in the

United States and were receiving assistance. Those populations lost coverage under PRWORA.

- Allows non-disabled legal residents who were in the United States as of August 22, 1996 to receive SSI and Medicaid if they become disabled in the future. Those who were legally within U.S. borders in August 1996 remain ineligible to receive SSI based upon income and old age, but under BBA are now eligible for both programs if they become disabled. According to the Center for Budget and Policy Priorities, at least two-thirds of those over age 65 can meet the disability standard, and only “very few” of the over-75 population will fail to meet the disability criteria.²¹³ Note also that those who arrived after August 22, 1996 or who were not lawfully present on that date are banned from SSI eligibility unless they gain 40 quarters of work history or become citizens.²¹⁴
- Established that Cuban-Haitian entrants will be treated like refugees with respect to eligibility for federal benefits;
- Required that Americasians (children fathered by U.S. citizens during Southeast Asian conflicts in the 1960s and 1970s) will be treated as refugees and granted the ability to immigrate to the United States;
- Set forth that certain North American Indians born in Canada (i.e., tribes with long-established rights to enter and re-enter the U.S.) will have access to Medicaid and will have SSI restored;
- Included Filipino war veterans who fought under U.S. command in WWII, and Hmong and Highland Lao veterans who fought on behalf of U.S. forces during the Vietnam war as U.S. military veterans (that is, they will be exempt from bans on federal benefits);
- Established that a parent of a battered child who is not a perpetrating parent may also receive assistance along with the child. Those agencies that offer services to battered spouses and children are permitted, under the BBA, to make certain determinations that the individuals are eligible to be treated as qualified aliens [also called qualified immigrants] for the purposes of federal benefit eligibility;²¹⁵ and
- All provisions of the BBA amending PRWORA were effective as though included at enactment. In other words, individuals in the categories described above who have been terminated from or denied benefits may obtain assistance retroactive to August 22, 1996.²¹⁶

D. How Did These Medicaid Eligibility Changes Contribute to Declining Access to Care?

Consider the mathematical reality that the proportion of immigrants who arrived after 1996 is perpetually growing, while the percentage that arrived before 1996 and therefore are eligible for Medicaid is shrinking. As the post-1996 population increases,

more individuals will be affected by PRWORA's restrictions and a greater proportion of immigrants will lack access to care. But that is not the entire story; there are those immigrants who were in the U.S. in 1996 and are eligible for Medicaid, but for reasons described below, choose not enroll. The following section will explore this phenomenon.

1. "Public Charge" Determination

a. Background on Public Charge

Although the words "public charge" do not appear anywhere in PRWORA, the concept casts a shadow over all of Title IV: "Restricting Welfare and Public Benefits for Aliens."²¹⁷ The opening section sets the tone for the rest of the Title:

The Congress makes the following statements concerning national policy with respect to welfare and immigration:

(1) Self-sufficiency has been a basic principle of United States immigration law since this country's earliest immigration statutes.

(2) It continues to be the immigration policy of the United States that (A) *aliens within the Nation's borders not depend on public resources to meet their needs, but rather rely on their own capabilities and the resources of their families, their sponsors, and private organizations* and (B) the availability of public benefits not constitute an incentive for immigration to the United States... (Emphasis added).

[Part 3 Omitted Intentionally]...

(4) Current eligibility rules for public assistance and unenforceable financial support agreements have proved wholly incapable of assuring that individual aliens not burden the public benefits system.

(5) It is a compelling government interest to enact new rules for eligibility and sponsorship agreements in order to assure that aliens be self-reliant in accordance with national immigration policy.

(6) *It is a compelling government interest to remove the incentive for illegal immigration provided by the availability of public benefits...*²¹⁸ (Emphasis added).

The idea that aliens ought not to depend upon the government has been on the immigration law books for more than one hundred years, but had rarely been enforced for

most of the 20th Century.²¹⁹ In the wake of the anti-immigrant sentiment that arose in the 1990s, however, potential dependence became sufficient cause to justify denying citizenship applications and, in rare instances, deportation. Despite the severity of its impact, until the INS issued its guidance in May 1999,²²⁰ nowhere in PRWORA or in related agency guidance did the government indicate how public benefit consumption could comprise a determination of public charge. This left public charge determinations to the discretion of individual governmental agents.

b. Fear and the Public Charge Label

While low immigrant enrollment in Medicaid and CHIP is undoubtedly due to multiple factors, fear of being labeled a public charge (and subsequent citizenship or deportation implications) may be the paramount issue that dissuades immigrants from seeking publicly funded health benefits. INS and State Department officials frequently refused immigrant applications if they determined the applicant was “likely to become a public charge.”²²¹ PRWORA effectively gave the responsibility to enforcing the law’s immigrant provisions to the INS. These federal agents were empowered to label an immigrant as a public charge, and such a finding could lead to the denial of applications for green cards or re-entry to the United States after a trip out of the country.²²²

i. Collaboration of INS and State Public Benefits Offices

Prior to the guidance publication, some INS and federal State Department officials made public charge determinations purely on the basis of past or current use of non-cash public assistance programs. These officials were explicit that Medicaid receipt would harm an immigrant’s chances to adjust their status or become citizens.²²³

Frequently, immigrants refrain from seeking even those health care services to which they or their children are entitled, and some speculate the cause to be federal regulations that require Medicaid agencies to share all information they receive from applicants with the INS and, subsequently, the federal Department of Homeland Security (DHS). The DHS now can legally access all data submitted on Medicaid applications, including income, assets, and state residency status.²²⁴ State welfare agency staff, in fact, were *mandated* to report anyone they suspect may be an illegal alien to the DHS.²²⁵ As a result, undocumented immigrants reportedly are frequently too fearful of possible immigration consequences to apply for aid to cover either themselves or even their American-citizen children.^{226, 227} Fear of being defined as a public charge and thus potentially excluded from citizenship or, in extreme cases, even deported keeps immigrants wary of using any public health service.²²⁸

It was not uncommon for county health departments to submit to the INS all data regarding documentation status for any immigrant who applies for TANF, Food Stamps, or General Relief. Medicaid applications were completed and submitted in offices bearing signs that caution: “Please be aware that we can send any information you give us to INS.” Although the last sentence of such signs explains that: “We will not send information from people who are applying for [Medicaid] only,” many immigrants walk out before reading that far.²²⁹

ii. Port of Entry Detection Programs

Some of the most proactive and well documented INS programs occurred in one state: California, where officials made public charge determinations exclusively on the immigrant’s use of Medicaid and other means-tested health care benefits from 1994

onward.²³⁰ Such campaigns may inform immigrants' decisions about seeking out health care services beyond the Golden State's borders.

For example, INS and state officials did not simply exchange information, but worked together to exclude entry of potential public charges into the U.S. One effort, to identify immigrants and force them to reimburse California for Medi-Cal benefits before allowing them to return to the state, was the INS's "Port of Entry Detection" programs. The first such program began in 1994 and sought to identify and, subsequently, inform welfare agency staff about primarily Hispanic immigrants who may have illegally obtained Medi-Cal coverage. Collaboratively, state officials worked with INS to identify possible residency fraud cases.²³¹

The California Airport Residency (CAR) program was yet another initiative. Through CAR, which began in 1994 at the international airport in Los Angeles and two years later was expanded to the international airport in San Francisco, state health department officials questioned immigrants returning through these airports about their use of Medi-Cal-funded services. Those who had received benefits in the last five years were frequently barred from re-entry until Medi-Cal benefits were fully reimbursed. After a court injunction eventually stopped the state from making these illegal demands, CAR continued an amended version of its practice: state officials suggested that immigrants may "wish" to refund the state for its health service coverage.²³² One state health department official reported that, of those detained through CAR, most were racial and ethnic minorities: 50 percent were Asian, 25 percent were Latino, and 25 percent were of other nationalities.²³³

The California Bureau of State Audits subsequently published a report finding these programs “unjustified,” and noted that 86 percent of the individuals investigated by the Port of Entry programs were women between the ages of 21 and 40. “The profiles of people investigated by the[Port of Entry Detection] and CAR programs contrasted sharply with the general profile of people eligible for MediCal benefits,” the report notes, adding that “women accounted for 50 percent of the people eligible for Medi-Cal benefits but comprised over 97 percent of the Port of Entry Detection and CAR program investigations.”²³⁴ This suggests that the INS and Department of Health Services officials may have targeted immigrant women of childbearing age, those perhaps most visibly in need of health care services.²³⁵

iii. Public Charge Lookout System

Confusion over PRWORA implementation caused immigration officials in California to illegally prevent immigrants who had received Medicaid and other benefits from re-entering the United States.²³⁶ In the mid-to-late 1990s, the State Department and the INS jointly implemented the now-defunct “Public Charge Lookout System” which, in violation of Medicaid law and policy, obtained information on individual immigrants’ past use of state and/or federally-funded public benefits. This information was channeled to consular offices, which then barred immigrants seeking to enter the country (or in the case of permanent residents, re-enter after a visit abroad) from doing so until they repaid the total amount of the benefits received by the immigrant or members of the immigrant’s family.

For example, between July 1997 and April 1998, legal immigrants who had received Medi-Cal services in the past and were seeking visas to re-enter the United

States were directed to refund the state for costs of health care services paid for by Medi-Cal. The U.S. State Department had also collected Medicaid use data on legal immigrants from nine other states for the same purpose.²³⁷ The Public Charge Lookout System effectively separated parents from children for months as sponsoring families pooled their resources to reimburse public coffers for legally-obtained social services.²³⁸

When the Public Charge Lookout System was disbanded, and in response to a class action lawsuit,²³⁹ California's health department reported that as many as 2,000 legal immigrants were due refunds totaling \$3.5 million.²⁴⁰ In the words of one study, "The [Public Charge Lookout System] system was recently terminated, but news of these practices spread widely through immigrant communities and continues to have a devastating impact on immigrants' access to public health services."²⁴¹

iv. Deportation Fears Heightened After September 11, 2001

Advocates for immigrant communities have long argued that both individual and the public health are jeopardized when concerns about immigration status deters immigrant families from seeking care. Since September 11, 2001, worries about deportation have become more pronounced. Groups such as the Asian/Pacific American Legal Center, the Broward Immigration Coalition, the California Primary Care Association, the Mexican American Legal Defense and Education Fund, and the National Immigration Law Project and others wrote a letter to the CMS Administrator raising these issues. "Our organizations often hear reports of immigrant families who avoided needed health care because of fears that family members will be reported to the Department of Homeland Security."²⁴²

Indeed, this phenomenon has been recognized by the Department of Justice: “‘Federal and State benefit granting agencies’ had reported that immigrants’ concerns about using health services were creating ‘significant negative public health consequences across the country... This situation is becoming particularly acute with respect to the provision of emergency and other medical assistance, children’s immunization, and basic nutrition programs, as well as the treatment of communicable diseases.’” Immigrants’ fears of obtaining these necessary medical and other benefits are not only causing them considerable harm, but are also jeopardizing the general public.”²⁴³

c. INS Guidance on Public Charge

In May 1999, INS for the first time defined “public charge” as an alien who has become (for deportation purposes) or is likely to become (for admission or adjustment of status purposes) “primarily dependent on the government for subsistence, as demonstrated by either the receipt of public cash assistance for income maintenance, or institutionalization for long-term care at government expense.”²⁴⁴

The guidance sought to reassure immigrants that Medicaid receipt (except for long-term care institutionalization) would not define them as a public charge. “The focus of public charge is on cash benefits for income maintenance and institutionalization for long-term care at government expense,” it noted, specifying that “[the] INS and [the] State [Department] will not consider participation in Medicaid or CHIP, or similar state-funded programs, for public charge purposes.”^{245, 246} The inclusion of long-term institutional care receipt in the definition of “public charge” as the sole Medicaid-funded service included in the INS guidance was supported by the U.S. Department of Health

and Human Services.²⁴⁷ In a May 1999 memo clarifying the public charge guidance, INS regional directors were told that, “... if there is no reimbursement requirement under law, the alien cannot be said to be a public charge.”²⁴⁸

That it took the federal government almost three years from PRWORA’s passage to clarify the impact of public benefits receipt on INS public charge determinations was significant both to immigrants and to state Medicaid agencies. Prior to May 1999, needy immigrants—even pregnant women whose children would be American citizens—had to guess what health care services INS and state Medicaid agency staff would consider worthy of the feared public charge determination that could thwart a citizenship application or cause deportation. Frequently, they refrained from accepting benefits altogether.^{249, 250} This seemed especially true of undocumented aliens: one study concluded that fear of immigration-related consequences resulted in deferred treatment, and another found that “...undocumented individuals consistently indicated that they would refrain from seeking care or delay care due to fear of the immigration consequences.”²⁵¹ Mixed-status families faced similar barriers, such that even eligible family members delayed seeking care for fear of the possible impact on undocumented relatives.²⁵²

d. Impact of the Guidance

When INS issued its guidance, HHS Deputy Secretary Kevin Thurm noted that:

‘We have been concerned for quite some time about the confusion and fear in immigrant communities that accepting certain government benefits would jeopardize their ability to become legal U.S. residents.... I am particularly pleased that virtually all health services and benefits—including Medicaid and the Children’s Health Insurance Program (CHIP)—are exempt from the public charge test for admission, adjustment, or deportation.’²⁵³

In a memo from INS's Executive Associate Commissioner for Field Operations dated May 20, 1999—the day that INS issued its guidance—all INS regional directors were informed that “IIRIRA did not create any requirements that aliens repay benefits received in the past in order to avoid being found inadmissible on public charge grounds, nor has such a requirement existed in the past. *Accordingly, officers should not instruct or suggest that aliens must repay benefits previously received as a condition of admission or adjustment, and they should not request proof of repayment as a condition of finding the alien admissible to the United States.*”²⁵⁴ (Emphasis mine.)

The memo goes on to state that, “If an INS officer finds evidence of possible benefit fraud in the course of performing his or her immigration duties, that information should be forwarded through official channels to the appropriate benefit-granting agency for possible investigation and enforcement action. In such cases, *absent a determination of fraud by the benefit-granting agency, immigration benefits to which the alien is otherwise entitled should not be withheld or denied.*”²⁵⁵ (Emphasis mine)

Dissemination of the guidance to immigrant communities was the next step.²⁵⁶ But in light of the highly-publicized stories of INS and Medicaid agency collaborations, many immigrants continue to fear that enrolling in Medicaid or allowing their children to enroll in SCHIP is dangerous. Until they see that their neighbors are obtaining green cards despite receiving publicly-funded health benefits that they are not forced to repay, many immigrants are likely to continue avoiding any government-funded health care.²⁵⁷

²⁵⁸ This chilling effect on Medicaid enrollment and access to care for immigrants would have disturbing consequences on public health.

2. Confusing Eligibility Requirements

Another way in which Medicaid eligibility changes contributed to declining access to care is the slow penetration of policy changes at the agency level. County clinic administrators complained that, because of the multi-year lag between the passage of federal legislation and its ultimate implementation on the state and local levels, there are no consistent, reliable information sources regarding eligibility. INS and Medicaid agency staff frequently offered conflicting guidance.²⁵⁹

Evolving policy changes that accompanied PRWORA and BBA implementation also made it difficult for Medicaid agency staff to determine eligibility.²⁶⁰ These staff were not well-informed of the ever-emerging distinctions in immigrant Medicaid eligibility. As a result, Medicaid applications of pregnant immigrants seeking prenatal care in California were not approved for almost nine months.²⁶¹ Confusion over new policies may be responsible for the sharp mid-1990s decline in new Medicaid cases.²⁶²

3. Language Barriers

Talk has been called the “main ingredient in health care” and “the fundamental instrument ... by which therapeutic goals are achieved.”²⁶³ Lack of linguistic concordance, therefore, is a well-documented barrier to both effective communication and effective care. Studies have found that interpreter services and culturally-sensitive care are essential components of high-quality care for non-English speaking immigrants,²⁶⁴ but the insufficient supply of bilingual clinicians and the lack of third-party reimbursement for interpreter services can make language barriers insurmountable.²⁶⁵ Compounding these problems further is the heterogeneity of immigrant minority communities. For example, “Asian and Pacific Islanders” are defined

as a single group for census calculations, but this category includes fifty different population groups and 150 language and dialects.²⁶⁶

A related problem is the complexity of the Medicaid application process which, as difficult as it is for English-speakers, can be overwhelming for immigrants. In many cases, Medicaid is the only way that low-income qualified immigrants who legally resided in this country when PRWORA passed are able to access health care. Indeed, in 1997, non-English speakers comprised 25 percent of those eligible for Medicaid in California.²⁶⁷

Consciousness of patient population's cultural norms is another critical factor in both outreach and care. One hospital sought actively to bring in Medicaid patients in a largely Chinese-speaking community, but was largely unsuccessful, in part because the hospital's main telephone number was comprised mainly of the number four—which in Mandarin is the numerological equivalent of the word “death.”²⁶⁸ Factors such as these may seem obscure to policy-makers, but are critical to increasing access to care among immigrant communities.

4. Administrative Barriers

a. Old Medicaid Application Forms Still in Use

Another barrier to Medicaid for immigrants is the use of pre-PRWORA Medicaid application forms, which in some states remained in use for years after the law passed. These outdated forms often required parental immigration status and incorrectly stated that an applicant's residency status could be impacted by enrollment in Medicaid.²⁶⁹

b. Residency is Often Fluid or Impossible to Prove

Particularly in urban areas where rent may be above the means of a single family, it is common for multiple families of immigrants to reside at one address. Not every surname may appear on the utility bills or the rental agreement, which are often required to prove state residency for Medicaid eligibility. Similarly, seasonal workers frequently live in makeshift housing alongside fields in which they work during the harvest. There is no way to identify a formal address for such immigrants.²⁷⁰

c. Seasonal Workers' Incomes Exceed Eligibility Limits During Harvest Periods

An applicant's household income must be assessed in order to determine Medicaid eligibility, but this can be a challenging task when seasonal workers earn wages within the "informal economy," where there are no written records of their salaries or of the hours they worked.²⁷¹ Further compounding this problem is the introduction of assessing Medicaid eligibility quarterly (post-PRWORA) rather than annually (as was done pre-PRWORA). While seasonal workers' gross annual incomes usually fall substantially below the federal poverty level, their income accrues unevenly during the year. Medicaid eligibility may be easy to prove during the winter, when many are out of work. However, during the harvest season when seasonal workers' incomes are at their peak, incomes may exceed the Medicaid income threshold for a short while. This phenomenon, according to those providing prenatal care, leads pregnant immigrant women to postpone seeking prenatal care until the harvest season ends.²⁷²

d. Determination of Eligibility for Emergency Services

There are barriers to emergency services for post-1996 immigrants because most states will not declare that immigrants are eligible until after the emergency has occurred.

While some states (such as California) allow all immigrants, even undocumented, to apply for an “emergency-only” Medicaid card, most states (such as New York, Texas, and Florida) offer Medicaid coverage for emergencies only *after* the emergency occurred. The latter model serves as a deterrent for seeking care because immigrants do not know whether there will be any assistance in paying for it.²⁷³

E. Consequences, Intended and Unintended, of PRWORA on Immigrants

As Congress came to recognize some of the unintended consequences of PRWORA, it made efforts to reverse policies that were particularly onerous for immigrants. The Agricultural Research, Extension, and Education Act of 1998 for example, which was approved by Congress on June 4, 1998, restored food stamp eligibility to immigrants who are children, elderly, or disabled and who resided in the U.S. before August 1996. Subsequently, the Farm Security and Rural Investment Act of 2002 reinstated food stamp eligibility to several groups, regardless of when they arrived in the U.S., including legal immigrants residing in the country for five years, children, and legal immigrants who receive disability benefits.^{274, 275} The Immigrant Children’s Health Improvement Act of 2003 now allows immigrants to become eligible for assistance after demonstrating five years of work history. This last measure revises the PRWORA requirement that immigrants demonstrate ten years of work history.²⁷⁶ In the meantime, however, PRWORA affected many aspects of the safety net for America’s newest residents.

1. Declines in Immigrant use of Social Services

Immigrants are more likely than non-immigrants to need Medicaid coverage for several reasons: immigrants are poorer (see Table 3.2), less likely to be covered by employer-based health insurance, less likely to have a usual source of care, and have lower health care service utilization rates than their U.S.-born counterparts.²⁷⁷

Table 3.2

*Percentage of women 15–44 who are covered by Medicaid*²⁷⁸

	<u>Poor*</u>		<u>Total</u>	
	1994	2001	1994	2001
United States (Total)	46.5	35.0	12.6	10.1
Native born	48.8	38.9	12.4	10.3
Immigrants (Total)	36.0	20.6	14.8	9.0
Naturalized citizens	35.4	27.6	6.7	7.3
Non-citizens (Total)	36.0	19.4	17.1	9.6
Long-standing residents**	41.1	23.2	17.3	10.5
Recent immigrants***	25.6	15.3	16.4	8.3

*Women in families with incomes under federal poverty level (\$15,260 for family of three in 2003).

**Long-standing residents in 1994 were those who had been in the United States prior to 1990; long-standing residents in 2001 were those who had been in the United States prior to 1996.

***Recent immigrants in 1994 were those who had arrived in 1992 or later; recent immigrants in 2001 were those who arrived in 1997 or later.

Note: CPS data include some information on undocumented immigrants, although that information is generally acknowledged to be a considerable undercount of that population group.

Source: The Alan Guttmacher Institute, tabulations of data from U.S. Census Bureau Current Population Survey, 1995–2002.

However, immigrants are disproportionately less likely than U.S.-born residents to use social service benefits. In fact, a University of Maryland study concluded that immigrants pay between \$12,000 and \$20,000 more in taxes than they use in social services over their lifetimes.²⁷⁹ Using 1993 Census Bureau data, only 6 percent of immigrants collected any type of cash welfare benefit (i.e., AFDC, SSI, or General Assistance). This uptake, while slightly higher than U.S.-born residents, was concentrated among refugees and elderly immigrants. Among the poor, immigrants were less likely (16 percent) than their US-born counterparts (25 percent) to receive welfare benefits.²⁸⁰

2. Immigrant Usage of Medicaid Declines

PRWORA limited the eligibility of certain immigrant subgroups from the Medicaid program, but it appears to also have affected Medicaid enrollment by the still-eligible immigrant population. After its enactment, the gap between enrollment of qualified immigrants and U.S.-born citizens grew, even after controlling for socioeconomic status, state policies, and unemployment rates.²⁸¹ Indeed, use of Medicaid by immigrants has been steadily declining since the mid-1990s.²⁸² Throughout the country, clinics are providing preventive care to fewer children and pregnant women.²⁸³

The same phenomenon began occurring in public hospitals. In order for public hospitals to receive Medicaid reimbursement for emergency care delivered to nonqualified aliens, they must verify immigration status; failure to do so prohibits them from reimbursement for services rendered.²⁸⁴

Many immigrants responded to inquiries by hospital staff by simply avoiding care and withdrawing from the Medicaid program. The proportion of poor non-citizen women enrolled in Medicaid decreased by almost half, from 36 percent in 1994 to 19 percent in 2001. In fact, the decline of legal immigrants' participation in all welfare programs between 1994 and 1999 were substantial: TANF (-60 percent), food stamps (-48 percent), SSI (-32 percent) and Medicaid (-15 percent).²⁸⁵

Despite a Center for Immigration Studies (CIS) report that suggests the opposite, Medicaid enrollment among non-citizens did decrease after welfare reform. (Several studies noted that the CIS report relied upon improper methodology.)^{286, 287} Not only were non-citizens less likely to receive Medicaid, but the *percentage* of non-citizens enrolled in the program declined from 1996 to 2001. Furthermore, non-citizen enrollment

remained constant between 2001 and 2002, during which time enrollment rate among non-immigrants increased.²⁸⁸

Similar analysis of the CPS for March 1995 through 2000 indicates that there were reductions in non-citizen use of Medicaid from 1994 through 1999. Among LPR alien families, there was a 15 percent decline in Medicaid use. Among low-income (i.e., incomes below 200 percent of the federal poverty level) refugee families, Medicaid usage decreased 36 percent from 1994 to 1999.²⁸⁹ When the unit of analysis is the individual, rather than the family, Medicaid use fell by 23 percent among individual LPR aliens, and 58 percent among refugee aliens during the same time period.²⁹⁰

3. Loss of Medicaid for Immigrants Means More are Uninsured

With respect to health insurance status, immigrants have been a particularly vulnerable group, even before welfare reform. Prior to PRWORA, nearly 43 percent of non-citizen immigrants were uninsured—which is three times the national average,²⁹¹ and uninsurance among immigrants continued to grow,²⁹² even among children. By 1999, American-born offspring of LPRs (27.4 percent) and undocumented immigrants (39.3 percent) experienced higher uninsurance rates than children of U.S. citizens (20 percent),²⁹³ even though all three groups of youngsters shared U.S. citizenship status.

The loss of Medicaid exacerbated the problem. Immigrant participation in Medicaid declined more sharply than the overall Medicaid population.²⁹⁴ To wit, in 1995, 54 percent of low-income non-citizens immigrants were uninsured, but with the PRWORA-imposed loss of Medicaid coverage, uninsurance rates for this group rose to 59 percent by 1998.²⁹⁵

Rising numbers of uninsured immigrants is a logical consequence of PRWORA, which relied upon non-citizens to shoulder a disproportionately high amount of the measure's total savings. Restrictions on welfare benefits for immigrants were expected to total \$23 billion, or nearly half of the total federal savings anticipated from PRWORA.²⁹⁶ This monetary goal, however, was thwarted by the BBA, which restored Supplemental Security Income (SSI) and Medicaid benefits to all disabled and elderly immigrants receiving SSI when PRWORA was enacted. The BBA also restored SSI and Medicaid to all immigrants who resided on U.S. soil when PRWORA was enacted who become disabled in the future. Additionally, the BBA restored additional benefits to refugees while simultaneously widening the pool of immigrants treated as refugees.²⁹⁷

4. Increased Uninsurance Means Lower Utilization among Immigrants

For immigrant populations, not only did Medicaid enrollment fall, but usage of health care services declined, as well. Research conducted in states with large immigrant populations provides important information about the use of health care services by uninsured and poor immigrants during the mid-to-late 1990s and beyond. For example, evidence indicates that California immigrants, concerned about legal repercussions of Proposition 187, refrained from hospital or clinic use until their conditions became severe. Rates of child immunizations went down while rates of catastrophic illness went up.²⁹⁸ Indeed, in the weeks after Prop 187 became law, many hospital outpatient clinics experienced significant drops in patient visits. Four Los Angeles public clinics reported declines of 50 to 75 percent during the week after the new law was passed.²⁹⁹

Uninsured immigrants in Texas faced similar issues. A July 2001 decision rendered by then-Texas Attorney General John Cornyn stated that PRWORA prohibited

the Harris County Hospital District in metropolitan Houston from providing free or reduced-fee nonemergency health care to undocumented immigrants. He noted that violation of this provision may result in sanctions to the district, as well as possible “legal consequences pursuant to state law for spending public funds for an unauthorized purpose.”³⁰⁰

Cornyn supported his position with language from PRWORA, which requires post-August 22, 1996 enactment of a state law explicitly making illegal immigrants eligible for any state or local public benefit.³⁰¹ The seventy-seventh session of the Texas Legislature ended on May 28, 2001, nearly two months before Cornyn’s statement, and would not meet again to consider legislation clarifying its position on health care for undocumented immigrants until January 2003.³⁰² In the interim, at least two of Texas’s county hospitals stopped serving undocumented persons pursuant to Cornyn’s opinion.³⁰³ Just north of Houston, the Montgomery County Hospital District trustees voted unanimously to remove over 400 illegal aliens from its indigent care program because they “feared prosecution if the district continued to provide such care.”³⁰⁴

In 2003, the Texas legislature in its seventy-eighth session enacted legislation that met Cornyn’s requirements.³⁰⁵ The Legislature’s House Research Organization’s bill analysis for that measure notes that:

Texas has a public health interest in treating immigrants to prevent the spread of infectious disease. ...Federal exemptions to PRWORA allow undocumented immigrants to obtain vaccinations and treatment for communicable disease. However, these services alone are not sufficient to protect the public health, and communities should be able to offer access to preventive health care for legal immigrants....³⁰⁶

Further interpretation by Attorney General Greg Abbott indicates that Texas law, with this new provision, “permits, *but does not require*, a hospital district to provide

nonemergency public health services to undocumented persons who are otherwise ineligible for those benefits under federal law.”³⁰⁷ (Emphasis mine.)

5. Clinicians Unnecessarily Burdened

a. Hurts Patient/Clinician Relationship

Requiring that clinicians effectively act as an agent for the state by reporting patients they believe are undocumented aliens, some fear, can weaken the doctor–patient relationship, create an incentive for patients to lie to their caregivers,³⁰⁸ and erode the trust that is critical between clinicians and those in their care.³⁰⁹ It also puts physicians in the sometimes contradictory role of policeman and advocate for his or her patients. “If physicians report illegal immigrants to help enforce the law and balance the state budget, why not also identify tax evaders, traffic-ticket scofflaws, or parents who fail to pay child support?”³¹⁰

b. Determining What is “Communicable”

There is not always a clear and immediate delineation between patients with communicable diseases and those with other conditions. For example, a chronic cough could be a consequence of a lung tumor, asthma, or tuberculosis. The presence of a communicable disease can only be established after a clinical evaluation, which often requires tests and therapy.³¹¹ PRWORA does not address how such interventions are to be funded.

c. Medical Ethics Violations

PRWORA mandates that clinicians only provide care for communicable diseases, such that if two patients present with identical symptoms (e.g., a chronic cough), but one is due to documented asthma and the other documented tuberculosis, the physician may

only provide care to the latter one. In the words of one hospital's chief of pediatrics, "“This is morally reprehensible, and it is contrary to every canon of modern medical ethics of which I am aware.”” The Hippocratic Oath, he notes, makes no reference to citizenship status.³¹²

d. Hurts Safety Net

In the words of two researchers, removing people from Medicaid eligibility does not alter their need for health care, but instead:

shifts the burden from the Medicaid system to the network of safety-net providers... who will have to try to stretch their already scarce revenues even farther. Complicating the situation even more, immigrants may be a particularly expensive group to serve, as reflected in the dramatic increases in expenditures for language assistance....³¹³

Hospitals report that they are unable to receive reimbursement for even emergency Medicaid services because patients fear possible INS-related consequences if they file Medicaid application forms.³¹⁴ FQHCs and hospitals serving immigrant communities are thus faced with even greater uncompensated care than other delivery sites within the safety net.³¹⁵ In this way, rather than reducing illegal immigration, in the words of one commentator, PRWORA's restrictions on Medicaid-funded health care for immigrants threatens the survival of the safety net and therefore the health of the greater community.³¹⁶

To address this concern, the American Medical Association (AMA) will “actively lobby the federal and state governments to restore and maintain funding for public health care benefits for all legal immigrants,” and will “lobby Congress to adequately appropriate and dispense funds for the current programs that provide reimbursement for the health care of undocumented aliens.” Moreover, the AMA is calling for the federal

government to provide reasonable payment for federally mandated medical screening examinations and further examination and treatment needed to stabilize a condition in patients presenting to hospital emergency departments when payment from other public or private sources is not available.³¹⁷

6. Potential Impact on Health Care Disparities

In general, as poor immigrants face greater barriers to care and as these populations simultaneously continue to be disproportionately members of racial and ethnic minority groups, a greater proportion of racial and ethnic minorities will be facing access barriers. There are, however, also some very specific ways in which PRWORA impacts access to health care services disproportionately for minority groups, and thereby furthering health care disparities. PRWORA establishes that, for example, treatment for breast and cervical cancer are only covered by Medicaid in emergency situations, and screening services are not covered at all. Research from the Centers for Disease Control indicates that low use of screenings may be why Hispanic women, who have a higher incidence of cervical cancer, have a greater likelihood of presenting in a more advanced phase than non-Hispanic women. Unequal access to screenings across racial and ethnic groups can result in different health outcomes.³¹⁸

7. Emergency Department Overcrowding

Under the Emergency Medical Treatment and Labor Act (EMTALA) of 1986, emergency departments (also called “emergency rooms”) must provide care for all, regardless of citizenship status. But hospitals must decide in most states whether to provide emergency care for post-PRWORA immigrants without first knowing if they will

be reimbursed by Medicaid. It is an unfair burden on ERs in areas with high concentrations of post-PRWORA immigrants.

8. Care May be More Expensive in the Long Term

Proscriptions against preventive and primary care for immigrants may not encourage the most evidence-based or the most cost-effective practices. It may be less expensive, for instance, to offer a patient with diabetes ongoing primary care and avoid the expensive emergency treatment needed for the kidney failure caused by untreated diabetes. Similarly, costs of prenatal care for even undocumented immigrants may be lower than the costs of providing ongoing care for their U.S.-born children, whose health conditions may have been preventable with prenatal care.³¹⁹

Disallowing immigrant prenatal care, in most cases, is not cost-effective, since children born in the United States, regardless of parental citizenship status, are American citizens and therefore eligible for publicly-funded health benefits. In other words, health conditions that were preventable and less expensively treated with prenatal care will become the burden of U.S. taxpayers, unless the child dies as a result of those preventable conditions.

F. Conclusion

This chapter outlined in depth the impact of major federal legislation (including the IIRIRA, PRWORA, and the BBA) on immigrant health care. Specifically, it explored the background of PRWORA's immigrant restrictions, how some restrictions were reversed by the BBA, and how the measures appear to have resulted in diminished access. Different classifications of immigrants under PRWORA are described. Additionally, this section explored immigrants' barriers to care, including fear of a

“public charge” determination and of repaying the state the cost of any Medicaid benefits before being considered for citizenship. It highlighted several major administrative barriers to accessing care, and then discussed consequences of PRWORA, including diminished use of health care. Finally, it looked at the burdens PRWORA placed on clinicians, and suggests that PRWORA’s intent to control Medicaid costs have actually backfired. chapter 5 will build on the foundation of federal changes established in chapters 3 and 4 by looking at how these changes in federal policy translated into changes within Maryland.

Notes

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¹⁶³ Landers, 2000.

¹⁶⁴ *Arizona v. United States*, No. 94-0866 (D. Ariz. Apr. 18, 1995), aff'd, 104 F.3d 1095 (9th Cir. 1997), petition for cert. filed, No. 96-1595 (Apr. 7, 1997).

¹⁶⁵ *California v. United States*, No. 94-0674-K (S.D. Cal. Mar. 3, 1995), aff'd 104 F.3d 1086 (9th Cir. 1997), petition for cert. filed, No. 96-1596 (Apr. 7, 1997).

¹⁶⁶ *Chiles v. United States*, 874 F.Supp. 1334 (S.D. Fla. 1994), aff'd, 69 F.3d 1094 (11th Cir. 1995), cert. denied, U.S., 116 S. Ct. 1674 (1996).

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¹⁶⁸ *Padavan v. United States*, No. Civ.A.94-CV1341 (N.D. N.Y. Apr. 18, 1995), aff'd 82 F.3d 23 (2d Cir. 1996).

¹⁶⁹ *Texas v. United States*, No. B-94-228 (S.D. Tex. Aug. 7, 1995), aff'd 106 F.3d 661 (5th Cir. 1997).

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¹⁷⁵ 457 U.S.C 202 (1982).

¹⁷⁶ Costich, "Legislating a Public Health Nightmare," 1043.

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Part Two: Maryland's Low-Income Health Care Market

Chapter 5: Maryland Social Policy Landscape Before the Study Period

A. Overview of Maryland Demographics

1. Racial and Ethnic Profile in Maryland, Pre-1996

For the 30 years preceding the study period, Maryland was significantly less white, more black, roughly as Asian, and less Hispanic than the nation as a whole.

Table 4.1
Total and Minority Populations in U.S., 1970–1990

UNITED STATES	1970	%	1980	%	1990	%	% Change, 1970– 1990*
Whites	177,748,975	87.5	188,371,622	83.1	199,686,070	80.3	12.3
Asians	1,538,721	0.8	3,500,439	1.5	7,273,662	2.9	372.7
Blacks	22,580,289	11.1	26,495,025	11.7	29,986,060	12.1	32.8
Hispanic Origin (of any race)	N/A	N/A	14,608,673	6.4	22,354,059	9.0	53.0*
White, Non-Hispanic	N/A	N/A	180,256,366	79.6	188,128,296	75.6	4.4*
American Indian/Eskimo/ Aleut	827,255	0.4	1,420,400	0.6	1,959,234	0.8	136.8
Total	203,211,926	100	226,545,805	100	248,709,873	100	22.4

* Denotes Percent Change 1980–1990; Source: U.S. Census^{320, 321}

Table 4.2 indicates that Maryland had a smaller proportion of whites in 1970 (81.5 percent) compared with the U.S. (87.5 percent), a 6.0 percentage point difference. That difference grew to 8.2 percentage points by 1980 and 9.3 percentage points by 1990. Black Marylanders accounted for 17.8 percent of the state's total population in 1970 (compared to 11.1 percent in the U.S.—a 6.7 percentage point difference), 22.7 percent in

1980 (compared with 11.7 percent in the U.S.—an 11.0 percentage point difference), and 24.9 percent in 1990 (compared with 12.1 percent in the U.S.—a 12.8 percentage point difference).

Table 4.2
Total and Minority Populations in Maryland, 1970–1990

MARYLAND	1970	%	1980	%	1990	%	% Change, 1970– 1990*
Whites	3,194,888	81.5	3,158,838	74.9	3,393,964	71.0	6.2
Asians	17,944	0.5	64,278	1.5	139,719	2.9	678.6
Blacks	699,479	17.8	958,150	22.7	1,189,899	24.9	70.1
Hispanic Origin (of any race)	N/A	N/A	64,746	1.5	125,102	2.6	93.2*
White, non-Hispanic	N/A	N/A	3,116,160	73.9	3,326,109	69.6	67.3*
American Indian/Eskimo/Aleut	4,239	0.1	8,021	0.2	12,972	0.3	206.0
Total	3,922,399	100	4,216,975	100	4,781,468	100	21.9

* Denotes percent change 1980–1990; Source: Maryland Department of Planning³²² and U.S. Census³²³

The percentage growth of Asian Marylanders has almost identically mirrored the percentage of Asian Americans since 1970. Although Asians represented 0.5 percent of the state population (and 0.8 percent nationally) in 1970, Asians comprised 1.5 percent of the population of both the state and the U.S. in 1980 and nearly doubled a decade later to make up 2.9 percent of both the state and national population in 1990.

Although data on Hispanics are not available for 1970, in 1980 Maryland's Hispanic population of any race (1.5 percent) lagged significantly behind that of the U.S. (6.4 percent). The gap grew from 4.9 percentage points in 1980 to 6.4 percentage points

in 1990, when Hispanics comprised 2.6 percent of the state and 9.0 percent of the national populations.

a. Baltimore

Baltimore is Maryland's only large urban center, although when the low-income populations of the small urban towns near the Washington, DC border are combined, the numbers rival those of Baltimore. Like many inner city urban areas, Baltimore has concentrated pockets of poor minorities. In the 20 year period from 1970 to 1990, the total population of the city declined nearly 19 percent while the white population fell by about 40 percent. Unemployment remained high throughout that period, with the percentage of Baltimoreans in the labor force hovering at about 60 percent.

Table 4.3
Baltimore Demographics

BALTIMORE	1970	1980	1990	Percent change 1970–1990
White	479,837	345,133	289,041	-39.8
Non-White	425,922	441,662	446,973	4.9
Total Population	905,759	786,795	736,014	-18.7
Percent in labor force	58.6	57.0	60.7	3.6
Per capita income (2000\$)	\$15,013	\$18,152	\$22,277	48.4

Source: U.S. Census³²⁴ and Maryland Department of Planning.³²⁵

2. Immigrant Profile in Maryland, Pre-1996

The state's immigrant communities were and continue to be concentrated in the DC suburbs, particularly in Montgomery County. In some DC suburbs, immigrants comprise the majority of the local population.³²⁶ Indeed, the greater Washington, DC area is considered one of the three emerging immigrant gateways according to immigration

researchers, along with Atlanta and Dallas, because of the sharp increase of immigrants in these regions over the last twenty years.³²⁷

Table 4.4

Foreign Born in Metro-Baltimore and Metro-Washington, 1970–2000

	1970		1980		1990	
	Total	%	Total	%	Total	%
Baltimore	57,374	2.8	73,759	3.4	87,660	3.7
Washington (DC, MD, VA, WV)	130,328	4.5	253,329	7.8	489,668	11.6

Source: The Brookings Institute.³²⁸

Metropolitan Baltimore, as indicated by Table 4.4, also has a growing immigrant community, though it is not growing as quickly as the metropolitan DC population.

Baltimore also has a sizable refugee population, and a refugee health clinic sits across the street from the main Maryland Department of Social Services office.³²⁹

B. Maryland's Low-Income Health Care Market

1. Key Players

There are several key players in Maryland's low-income health care market. Each plays a separate and critical role in ensuring access to care for low-income populations.

In no particular order, critical stakeholders include:

- Poor Marylanders, located throughout the state and found in concentrated pockets within Baltimore,
- The Maryland Department of Health and Mental Hygiene (DHMH), which administers the Medicaid program,
- The Maryland Department of Social Services, which administers the state's welfare program (including the delinking of cash assistance from Medicaid),
- The Maryland Insurance Administration (MIA), which regulates the managed care companies in the state,
- Each of the managed care companies that contract with the state to provide care to Medicaid beneficiaries, which will be described in greater detail in later chapters,
- Care delivery sites that historically have provided care to the state's Medicaid population, particularly the state's community health centers and federally qualified health centers (including Health Care for the Homeless clinics),

which for decades have been providing care to low-income Marylanders regardless of insurance status or ability to pay,

- Others providing care to Maryland's Medicaid and non-Medicaid poor populations,
- The University of Maryland, Baltimore County's (UMBC) Center for Health Program Development and Management, which conceptualized the state's mandatory Medicaid managed care program and currently contracts with the state to maintain and analyze program data on utilization, and
- The groups of consumer advocacy organizations, such as the Maryland Alliance for the Poor and Catholic Charities, who work with low-income populations to ensure access to health care services.

2. Financing the Low-Income Health Care Market: Rising Costs of Medicaid

Maryland is, in many ways, a microcosm of the nation, and its reaction to national economic and political trends frequently reflects other states' experiences. For example, personal health care expenditures in Maryland rose steadily from 1991 to 1998, with an average annual increase of 4.7 percent, which almost exactly reflects the national average.³³⁰ This has been driving both Maryland's and the nation's desire to pursue managed care, in both the private and public sectors, as a key cost containment measure.

a. Maryland's Struggling Economy

The beginning of the 1990s was not kind to Maryland's economy. According to the Maryland Department of Fiscal Services (now the Maryland Department of Legislative Services), construction and service industries suffered setbacks as federal defense spending declined. From 1990 to 1992, the state lost 109,600 jobs, roughly 5 percent of its workforce.³³¹ The result: simultaneous increases in state spending and sluggish growth of state revenues.³³²

By the mid-1990s, Maryland was facing a serious fiscal crisis. The state's Medicaid program covered only half of the state's residents with income below the

federal poverty level, yet Medicaid costs were spiraling out of control. Indeed, although eligibility levels for Maryland Medicaid throughout this time period were below the national averages,³³³ combined rising Medicaid enrollment and health care inflation doubled the Medicaid budget in six years (1989 to 1994), and by fiscal year 1994, Medicaid was the greatest single expenditure of state government.³³⁴ Officials throughout the state feared the fallout of a federal reduction in Medicaid coverage. This anxiety was heightened during the congressional welfare reform debate, when federal lawmakers considered establishing a Medicaid block grant to states—which would have wreaked havoc on Maryland’s efforts to cover costs for its poor populations.³³⁵ It was in this context that Medicaid managed care’s promise of cost reductions became so attractive.

b. Historic Medicaid Care Delivery Sites

During the 1980s, both expansions in Medicaid coverage for pregnant women and children and then the establishment of the federally qualified health center (FQHC) program led to a symbiotic relationship between Medicaid and community health centers (CHCs). The FQHC program enabled CHCs to expand coverage to larger Medicaid and Medicare populations, for whom they were getting a “reasonable cost-based” governmental reimbursement.

This expansion and assured reimbursement also allowed CHCs to care for more of the increasing uninsured populations. In fact, CHCs nationally identified grants and Medicaid (35 and 34 percent, respectively) as their two greatest revenue sources in the early 1990s.³³⁶ Maryland’s CHCs, however, were even more dependent upon Medicaid, which comprised nearly 46 percent of CHC revenues during the same time period.³³⁷ A GAO study cautioned that CHCs are financially vulnerable if they grow dependent on

Medicaid prepaid managed care for a substantial percentage of their revenues, if they negotiate inadequate capitation rates, or if they assume risk outside of primary health care.³³⁸

3. Overview of the State's Medicaid Managed Care Programs as a Cost Containment Strategy

Maryland has one of the longest histories of Medicaid managed care of any state.³³⁹ In the City of Baltimore, the state began contracting with Medicaid health maintenance organizations (HMOs) in 1974.³⁴⁰ Medicaid costs stabilized as enrollment stayed steady at approximately 340,000 per month during the late 1980s and early 1990s, but by fiscal year 1994, average enrollment was roughly 444,000 per month.³⁴¹ As noted above, this doubled the Medicaid budget in the six years between 1989 and 1994, making it the largest single expenditure of state government.³⁴² As Maryland's Medicaid budgets continued to rise annually, managed care companies were attracted to the state with the hopes of capitalizing on Medicaid's growing market share.

The state responded to rising enrollment and costs by pursuing more aggressive managed care strategies to contain Medicaid costs. By the late 1980s, Maryland was a national leader in developing a primary care case management (PCCM) model for its Medicaid program as a way to contain cost, but the PCCM program proved inadequate during the budget crisis of the early 1990s. The financial crunch became the primary factor driving the Maryland Medicaid program toward exploration into various new forms of managed care. The state initiated three separate managed care systems for its Medicaid population in the 1990s alone: the PCCM system, which was a combination of case management and support services, then an integrated delivery systems for patients with severe and costly conditions (which was only partially implemented and then

abandoned), and finally, mandatory enrollment of beneficiaries in competing, capitated MCOs. Despite the existence of these programs in Maryland, prior to the 1996 introduction of mandated Medicaid managed care programs, only about 21 percent of Maryland's Medicaid enrollees opted for full-risk managed care.³⁴³ Nonetheless, the push to contain Medicaid costs would substantially alter Medicaid's health care delivery structure in Maryland and throughout the country.

a. Maryland Access to Care (MAC) Program

In 1991, the state began MAC, a PCCM system operating under a federal waiver to Section 1915 of the Medicaid law. Its goals were to improve access to primary and preventive services, promote appropriate use of medical services, improve continuity of care, increase clinician participation, and reduce costs. At the time of its inception, MAC was the largest mandatory Medicaid PCCM program in the country.³⁴⁴

Each enrollee was assigned to (i.e., was not permitted to select) a primary care provider (PCP), that is, a physician or clinical group to serve as a “gatekeeper.”³⁴⁵ (A gatekeeper is a clinician who coordinates all aspects of patient care and provides referrals to laboratories, hospitals, and specialists.) MAC required preauthorization for emergency room or other specialty services, and PCPs were paid on a fee-for-service basis with augmented reimbursement to encourage participation. All Medicaid enrollees were assigned to MAC except the following exempt groups: those eligible for Medicare; voluntary HMO enrollees; those in institutional, foster, or hospice care; and participants in special programs for diabetes, sickle cell, and corrective case management. By December 1992 (twelve months after MAC began operations), 70 percent of the

Medicaid eligible were enrolled (i.e., 300,000). In its first year, the state estimated that it had saved \$35 million on patient services.³⁴⁶

b. Voluntary MCO Program

In addition to the MAC program, between 1988 and 1995 a statewide HMO option became available to Medicaid beneficiaries who volunteered to participate. Voluntary MMC enrollment in HMOs increased fourfold to 126,000 by late 1995,³⁴⁷ possibly because beneficiaries wanted to take advantage of attractive incentives (e.g., adult eyeglasses and adult dental benefits, which are not otherwise available to this population). One state source noted that Medicaid beneficiaries could opt in and out of managed care, such that they could receive the incentive benefits when they need it, but then opt out when they wanted choice of clinicians. This led to participants cycling in and out on managed care participation.³⁴⁸ Voluntary managed care also meant that enrollees tended to be healthier than the Medicaid population as a whole.

c. High-Cost User Initiative

Medicaid costs continued to rise, despite MAC and the voluntary MCO program. A 1992 analysis of the state's Medicaid program found that more than half of expenditures were attributable to five percent of total beneficiaries.³⁴⁹ In response, the Maryland Department of Health and Mental Hygiene (DHMH) began investigating approaches to address this high cost group. In 1994, the state received funding from the Robert Wood Johnson Foundation to explore methods to cut costs and improve outcomes of this five percent. The resulting program, the High Cost User Initiative (HCUI), received federal approval as an 1115 waiver program.

MAC did not allow for support services for those patients needing better housing, nutrition, counseling, supervision, or suffering from multiple conditions. The HCUI, however, focused on broader social services for this high cost population. Specifically, the HCUI relied upon enhanced case management teams both to review Medicaid patients identified as high cost cases within 24 hours of hospital admission and to prepare discharge plans with supplemental services (including physical therapy, dental care, outpatient addiction therapy, nutritional supplements, assisted living services, transportation, and family training). The HCUI's administrative component was the creation of the Center for Health Program Development and Management (CHPDM) at UMBC. The CHPDM, established in 1995 under a cooperative arrangement between the University of Maryland and the Maryland DHMH, developed the federal waiver application and was charged with operating the HCUI and providing technical assistance to the state health department.³⁵⁰

d. Integrated Care Management System

Another component of HCUI, which was never implemented due to changes in the state's political leadership subsequent to the 1994 election,³⁵¹ was the Integrated Care Management System (ICMS). In effect, this would have been a specialty HMO that received capitation payments for comprehensive care of patients with a history of high-cost Medicaid episodes. The ICMS would have been organized around clinical needs, such as uncontrolled hypertension, diabetes, congestive heart failure, pediatric asthma, and late-stage cancer.

4. A New Twist on an Old Idea: Mandatory Medicaid Managed Care

In January 1995, the new incoming secretary of the DHMH suspended ICMS development and began plans for a new Section 1115 waiver, entitled HealthChoice. This new program would establish mandatory enrollment of Medicaid enrollees in competing, capitated MCOs. The Maryland legislature enacted a bill in May 1995 directing the DHMH to formulate plans for comprehensive Medicaid reforms to be submitted to the legislature in its 1996 session. During the summer of 1995, Congress passed a budget resolution that would cut an estimated \$2.8 billion from Maryland's Medicaid program over 7 years, forcing additional pressure on the DHMH Secretary to come up with a cost-cutting plan for Medicaid.³⁵²

DHMH responded by establishing a broad-based, 131-member advisory committee³⁵³ to ensure buy-in from all the major stakeholders.³⁵⁴ This was a uniquely inclusive process, and a majority of those involved in the HCFA waiver development process hoped to participate in the resulting program, particularly current Medicaid providers like the University of Maryland and Johns Hopkins University health care systems.³⁵⁵

C. Conclusion

Medicaid is a complicated program, operated both by the federal and state governments, which funds health care services for very low-income populations. As an entitlement program, Medicaid is extremely expensive, and states have been seeking innovating approaches to reduce its budget. Maryland has a long history of Medicaid reforms aimed at containing costs. The MAC initiative was a PCCM program that provided all participating Medicaid beneficiaries with a primary care clinician who

served as the gatekeeper. By the mid- to late 1990s, Maryland state officials had conceived of HealthChoice, a mandatory Medicaid managed care initiative that would radically change the delivery and reimbursement structure of the Medicaid program.

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- ³⁴⁰ Oliver. "The Collision of Economics and Politics in Medicaid Managed Care."
- ³⁴¹ Ibid.
- ³⁴² Ibid.
- ³⁴³ Gold, Mittler, and Lyons. *Managed Care and Low-Income Populations*, p.4.
- ³⁴⁴ Jonathan P. Weiner, Anthony M Tucker, A. Michael Collins, et al., "The Development of a Risk-Adjusted Capitation Payment System: The Maryland Medicaid Model." *Journal of Ambulatory Care Management*, 21, no. 4 (1998): 29–53.
- ³⁴⁵ The American Heritage® Stedman's Medical Dictionary, 2nd Edition (Boston: Houghton Mifflin, 2004 [cited 10 October 2006]). medical-dictionary.thefreedictionary.com/gatekeeper
- ³⁴⁶ Oliver, "The Collision of Economics and Politics in Medicaid Managed Care."
- ³⁴⁷ Ibid.
- ³⁴⁸ Interview with Interviewee 2
- ³⁴⁹ Oliver, "The Collision of Economics and Politics in Medicaid Managed Care."
- ³⁵⁰ Interview with Interviewee 4
- ³⁵¹ Lawery, Shi, Weiner, et al. "Money, mission, and Medicine." See also Oliver, "The Collision of Economics and Politics in Medicaid Managed Care."
- ³⁵² Oliver, "The Collision of Economics and Politics in Medicaid Managed Care."
- ³⁵³ D. I. Chang, A. Burton, J. O'Brien, et al., p. 392.
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Chapter 6: Changes in Maryland’s Low-Income Health Care Market

The mid-1990s represented a tumultuous period for Maryland’s low-income health care market. Many factors that affected the market sought to alter the health care delivery system, such as the new mandatory Medicaid managed care program, HealthChoice. Other intentional or “de jure” changes include the loss of cost-based financing for safety net institutions, the implementation of federal immigration policy, and the state’s new welfare reform program. At the same time, there were “de facto” changes to the market—that is, changes that were not developed by policymakers seeking to create a certain result, such as evolving demographics and unforeseen problems with HealthChoice implementation.

A. De Jure Changes

1. A New Medicaid Program: HealthChoice

a. Goals of HealthChoice

In 1996, Maryland’s General Assembly began consideration of (January 11) and ultimately approved (April 6) HealthChoice, which would require nearly all of the Medicaid population to enroll in managed care plans. Within six months of submission to the federal Health Care Financing Administration (HCFA, now Centers for Medicare and Medicaid Services, or CMS), HealthChoice received federal approval on October 30, 1996. The program was established with five goals:

- “Develop a patient-focused system featuring a medical home;
- Create comprehensive, prevention-oriented systems of care;
- Build on the strengths of Maryland’s existing health care delivery system;
- Hold MCOs accountable for delivering high-quality care; and

- Achieve better value and predictability for state dollars.”³⁵⁶

The state anticipated that making a single clinician responsible for a patient’s health would eliminate fragmented and episodic care. Initially, another goal was program growth.³⁵⁷ The savings generated from HealthChoice were originally slated to fund benefit or eligibility expansions, but federal threats of Medicaid block grants and the state’s tightening budget rendered that aim unachievable.³⁵⁸ So while other states used managed care as a cost containment method where savings were converted into broader coverage, HealthChoice instead focused upon lowering costs and improving the quality of care for those currently eligible to participate,³⁵⁹ and eligibility expansions were tabled at the program’s outset.

b. Unique Attributes of the HealthChoice Program

Highlights of the program include its unique risk adjustment mechanism, the “Adjusted Clinical Groups,” or ACGs, which sought to enhance reimbursement to those providing care to sicker patients. HealthChoice is also different from most state Medicaid managed care programs in that it allows health care clinicians to establish their own MCOs.³⁶⁰ A related key provision allows historical safety net institutions to establish MCOs to compete with the private MCO market for Medicaid business.

Another progressive aspect of HealthChoice is the particular attention it devotes to seven “special populations,” including children with special health care needs, the physically disabled, the developmentally disabled, pregnant and postpartum women, the homeless, HIV and AIDS patients, and those with substance abuse problems.³⁶¹ Under HealthChoice, these groups enjoy enhanced benefits, and MCOs may receive higher capitation rates for these population groups.

i. Medicaid Enrollees Not Eligible for HealthChoice

Maryland required that individuals who are eligible and who qualify for HealthChoice (i.e., most Medicaid recipients) participate in the program. As of June 30, 2005, approximately 67 percent (or 482,749) of the Maryland's 716,158 Medicaid beneficiaries were enrolled HealthChoice.³⁶² Medicaid eligibles that are not in HealthChoice consist of those ineligible to participate, and include:

- Individuals who receive Medicare;
- Individuals who are 65 years or older;
- Individuals who are eligible for Medicaid under spend down;
- Medicaid recipients who have been or expected to be continuously institutionalized for more than 30 successive days in a long-term care facility or in an institution for mental diseases;
- Individuals institutionalized in an intermediate care facility for mentally retarded persons;
- Recipients enrolled in the Model Waiver; and
- Recipients enrolled in limited coverage categories, such as women who receive family planning services through the Family Planning Waiver.³⁶³

ii. The Rare and Expensive Case Management (REM) Program

Medicaid enrollees with specific conditions are included in the Rare and Expensive Case Management (REM) Program. Maryland offers fee-for-service reimbursement to clinicians caring for these beneficiaries. REM program participants are also eligible for a larger package of benefits. Once enrolled in the program, beneficiaries are assigned a case manager who assesses their needs, directs them to appropriate clinicians, works with multidisciplinary teams to ensure that the patients' needs are met, develops plans of care, monitors clinical care and services, assists in service coordination and family supports, addresses changing clinical and other needs, and recommends transfers out of the program, when appropriate.³⁶⁴

d. HealthChoice Payment Structure

i. Reimbursement for MCOs

MCOs receive a capitated (i.e., per-member) fee, risk-adjusted according to the beneficiary's age, sex, location, parental status, and disability status. Another risk-adjustment factor is medical history.

The capitation amount an MCO is offered for a particular patient is calculated using an innovative algorithm based upon "adjusted clinical group" (ACG) category. Specifically, the state assigns each Medicaid enrollee into an ACG category, which provides graduated fixed capitation rates such that MCOs receive higher reimbursements for the sickest and costliest patients.³⁶⁵ ACG determination is based on the patient's Medicaid claims history. When insufficient data prevents an ACG determination, the state assigns the beneficiary to a demographic category, which reflects each beneficiary's age, residence, eligibility group (i.e., families with children and the disabled), and gender. MCOs also receive a lump sum for delivery costs for pregnant women, children under one year of age, and people with HIV or AIDS.³⁶⁶

Under HealthChoice, therefore, Medicaid MCOs are not only required to provide care, but also must collect a substantial amount of data on medical history and patient visits. At HealthChoice's outset, one state official noted that the dependency of reimbursement upon encounter data offers MCOs a strong incentive to collect detailed information on each patient visit. Indeed, insufficient encounter data means that a beneficiary with costly health problems may be rated as healthy and therefore may fetch a lower capitated rate.^{367, 368}

ii. Reimbursements for FQHCs

Under HealthChoice, MCOs pay FQHCs a predetermined “market rate” for each visit the FQHC reports to the MCO. The MCO, in turn, reports that encounter to the Maryland Department of Health and Mental Hygiene (DHMH), which issues an additional payment to the FQHC to cover the difference between the FQHC’s “reasonable cost” and the market rate.³⁶⁹ Further description of how the FQHC reimbursement process actually worked is described below.

e. MCOs Additional Obligations and Regulations Under HealthChoice

The state is responsible for multiple oversight activities over HealthChoice MCOs. Prospectively, the state’s DHMH must review any organization seeking to become a participating MCO for system adequacy, and the Maryland Insurance Administration is responsible for the applicant’s financial solvency. Retrospectively, the state must hire an external quality review organization, or EQRO, to ensure that each MCO is providing high quality care to HealthChoice enrollees.³⁷⁰

In addition to primary health care coverage, the state requires MCOs that contract with the HealthChoice program to offer other related services. These include language interpretation, educating enrollees on prevention and good health habits, case management, outreach and home visits for certain special needs and hard-to-reach populations, and coordinating needed services such as transportation and the Supplemental Nutritional Program for Women, Infants, and Children. MCOs are permitted to offer additional services not already in the benefit package as an incentive to attract enrollees, but the State does not provide reimbursement for them. For example, all of the MCOs cover adult preventive dental services, which are not included in the Maryland Medicaid benefits package.³⁷¹

2. Changes in Funding for FQHCs: Loss of Cost-Based Reimbursement

a. Cost-Based Reimbursement Ends

In 1998, FQHCs lost the cost-based reimbursement that they had been receiving since 1990. The state did not begin to compensate for this loss until 2001, 3.5 years later, when it began phasing in a multi-year reinstated cost-based reimbursement. This gap put a financial strain in FQHCs and, in turn, the entire safety net throughout the state.³⁷²

b. Loss of Medicare Pilot Funding

Another change in the low-income health care market affected the state's largest FQHC, Baltimore Medical Systems (BMS). BMS grew out of a Medicare demonstration project that began in the late 1970s, and a substantial amount of its patient base had always been the elderly. Through 1998, Medicare volume accounted for roughly \$25 million of BMS's revenue, but this changed with the implementation of the federal Balanced Budget Act of 1997 (BBA). The federal Centers for Medicare and Medicaid Services interpreted the language in the BBA in a way that fundamentally changed the demonstration project. What had been an open-enrollment, cost-based reimbursement program with no patient cost participation and no managed care became a closed-enrollment managed care program with significant cost sharing.

3. De Jure Changes Affecting Health Care for Immigrants

The impact of changes arising from new federal immigration laws on Maryland's immigrants was greatly tempered by a state-only program for those immigrants who arrived after August 1997. One must be eligible for TANF in every way other than length of time in the country in order to qualify for the state program.³⁷³ As a result, health care and other social services were still available for certain legal immigrants.

Table 5.1

Comparison of Maryland Immigrant Benefits Based Upon Arrival Date

Legal Immigrants Here Before 8/22/1996	Legal Immigrants Here ON/After 8/22/1996
- Family eligible for TCA	- Family eligible for TCA
- Family Eligible for Medical Assistance	- Children/pregnant women eligible for Medical Assistance
- Children eligible for Food Stamps	- Children eligible for Food Stamps.

Source: "Guide to Welfare in Maryland," Welfare Advocates, 2005.³⁷⁴

However, as more time passes, the percentage of immigrants in the state before August 1996 will continually shrink and a greater proportion of the adult, non-pregnant immigrant community will lack access to health care coverage.

4. Changes in Welfare Policy and Implications for Health Care

Maryland's Medicaid rolls fell as the state's welfare reform plan was implemented. The state's primary welfare reform program, entitled Temporary Cash Assistance (TCA), began in January 1995 and used less restrictive eligibility determinations than the PRWORA would allow.³⁷⁵ Although it was enacted a few months before PRWORA, the TCA program was implemented as the state's version of PRWORA. Like its federal counterpart, TCA also divorces welfare from Medicaid eligibility.

One of the goals of PRWORA was to decrease by at least 50 percent the number of welfare recipients on the rolls in 1996 by the year 2002. Using this as a measure, Maryland, like most states, was very successful. It achieved that goal by 1997, five years ahead of schedule.³⁷⁶

Maryland's welfare reform efforts include the Family Investment Program (FIP) and the Temporary Cash Assistance (TCA) program. One of the key features of these programs is local flexibility, whereby the Local Departments of Social Services (LDSS) offices are empowered to allocate funds for welfare avoidance grants (i.e., one-time

payments that help poor families cover unexpected needs, like car repairs, without which the family would lose its ability to thrive and would become eligible for TCA).³⁷⁷

In 1999, there was a surplus of \$156 million in unspent federal TANF block grant dollars.³⁷⁸ While within about a year after PRWORA was enacted, 42 states changed their welfare rules affecting how recipients could combine work with cash assistance, but the changes in Maryland are among the most severe. For example, Maryland was one of only four states that eliminated eligibility for cash assistance when earnings were less than half of the FPL for a family of three (17 states permitted recipients who entered the workforce to attain a poverty-level income level before cutting eligibility). According to one analysis, Maryland reduces benefits by \$0.74 for every dollar earned, ranking the state among the five with the fastest benefit reduction rate.³⁷⁹ Moreover, of those five states, only Maryland begins reductions at the first dollar of earnings.³⁸⁰

B. De Facto Changes

1. Changes in Demographics

Evolving demographic factors, such as an increase in immigrant and minority populations, further altered the demand side of Maryland's low-income health care market.

Table 5.2

Total and Minority Populations Growth in Maryland, 1990 to 2004

	MD 1990	Percent of MD 1990	MD 2004	Percent of MD 2004	Increase, 1990 to 2004	Percent change, 1990 to 2004
Total population	4,781,468		5,311,531		530,063	11.1
White	3,393,964	71.0	3,500,045	65.9	106,081	3.1
Black	1,189,899	24.9	1,505,045	28.3	315,146	26.5
Hispanic	125,102	2.6	230,332	4.3	105,230	84.1

Source: Maryland Department of Planning^{381, 382}**a. Growth of Racial and Ethnic Minorities**

Earlier, we saw the 1990 Census data depicted in Tables 5.2 and 5.3. It is useful to see these data again to provide a baseline against which to measure the growth of minority populations. These tables indicate a growth in the black and Hispanic populations both in the nation and in Maryland by 2004. In 14 years, Maryland's white population decreased from 71 percent to 66 percent, while blacks increased 3 percentage points and Hispanics grew nearly 2 percentage points.

Table 5.3

Total and Minority Populations Growth in U.S., 1990 to 2004

	US 1990	Percent of U.S. 1990	U.S. 2004	Percent of U.S. 2004	Increase, 1990 to 2004	Percent change, 1990 to 2004
Total pop	248,709,873		293,655,404		44,945,531	18.1
White	199,827,064	80.3	220,535,208	75.1	20,708,144	10.4
Black	29,930,524	12.0	36,119,615	12.3	6,189,091	20.7
Hispanic	21,900,089	8.8	36,706,926	12.5	14,806,837	67.6

Source: U.S. Census^{383, 384}

The tables also demonstrate that both the state's total population (11.1 percent) and its white population (3.1 percent) grew during that 14-year period, but not at the rate of the rest of the nation. The total U.S. population increased in that time period 18.1 percent, and the nation's white population rose 10.4 percent. But the reverse trend occurs for racial and ethnic minorities. Maryland's rates of increase among its black population

was 26.5 percent (compared with 20.7 percent nationally) and among its Hispanic population was 84.1 percent (compared with 67.6 percent nationally).

Table 5.4
Demographics in Baltimore, MD, 1990 and 2000

BALTIMORE	1990	2000	Percent change 1990–2000
White	289,041	210,842	-27.1
Non-White	446,973	440,312	-1.5
Total Pop	736,014	651,154	-11.5
Percent in labor force	60.7	56.6	-6.8
per capita income (2000\$)	\$22,277	\$24,789	11.3

Source: U.S. Census³⁸⁵ and Maryland Department of Planning.³⁸⁶

Figure 5.1 graphically depicts this growing racial diversity of Maryland. Figure 5.2 indicates that black birth rates, while generally decreasing over the last decade, remain well above white birth rates.

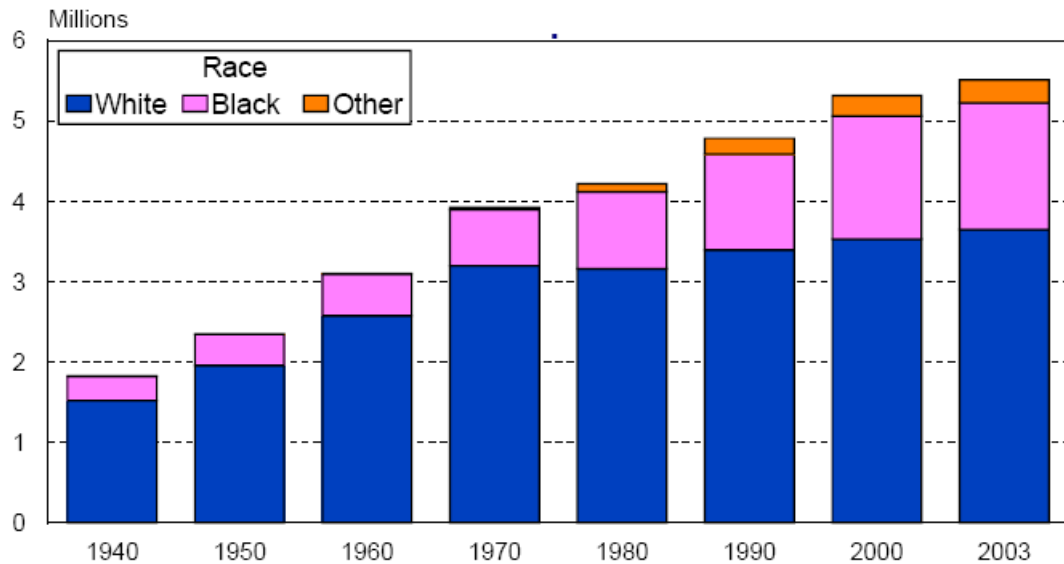


Figure 5.1. Distribution of the Population by Race, Maryland, 1940–2003.

Source: Maryland Vital Statistics Annual Report (2003). Maryland Department of Health and Mental Hygiene, Vital Statistics Administration.

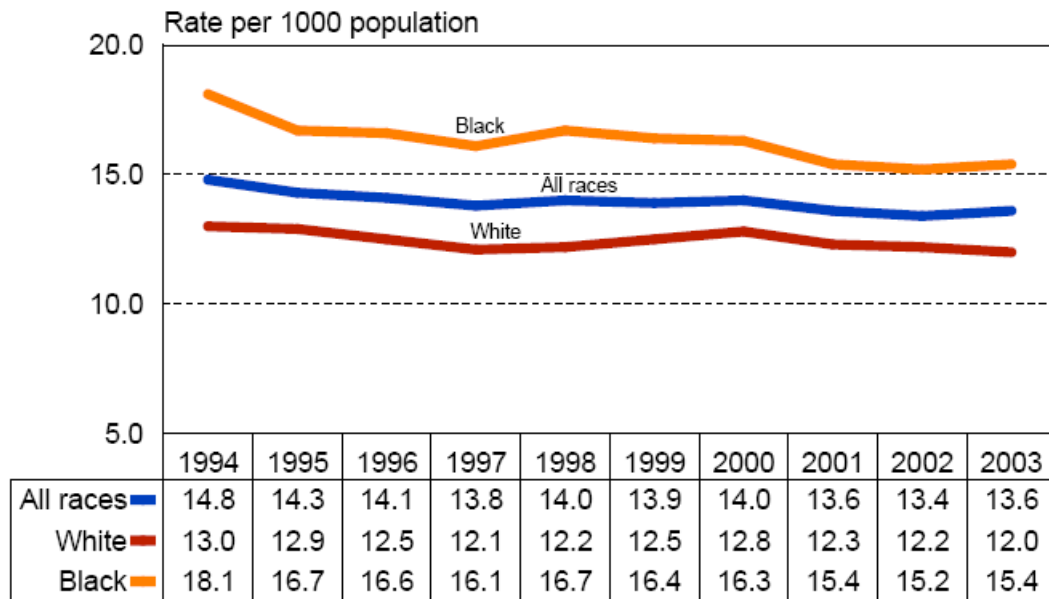


Figure 5.2. Birth Rates by Race, Maryland, 1994–2003.

Source: Maryland Vital Statistics Annual Report (2003). Maryland DHMH, Vital Statistics Administration.

Hispanics are also a fast-growing demographic both in Maryland and in the United States as a whole. Figure 5.3 illustrates that the birth rate for Hispanics is more than twice that of whites. As blacks and Hispanics continue to grow at a faster rate than whites, poorer access and quality of care for racial and ethnic minorities has the potential to grow from a serious public health issue to a public health crisis.

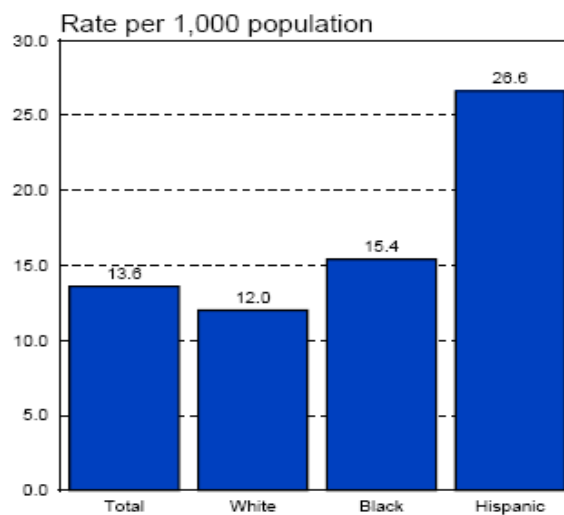


Figure 5.3. Birth Rates by Race and Hispanic* Origin, Maryland, 2003.

Source: Maryland Vital Statistics Annual Report (2003). Maryland DHMH, Vital Statistics Administration.

* Persons of Hispanic origin may be of any race.

2. De Facto Changes Affecting Health Care for Immigrants

a. Immigrants and Health Care: Uninsurance Rates

An analysis by the state indicates that only half of Maryland's Hispanic population has employment-based health insurance coverage, and 40 percent of Hispanics are uninsured. Interestingly, minorities in Maryland are less likely to have health insurance than are whites, regardless of income. Hispanics and blacks are disproportionately represented among the state's uninsured population.³⁸⁷

b. Growth in Maryland's Immigrant Communities

Both in the United States and in Maryland, immigrants are one of the fastest growing population groups. The foreign-born population in the state grew 65.3 percent between 1990 and 2000 (nationally, the growth was 57.4 percent). In 2000, Maryland had the thirteenth largest foreign-born population in the U.S.³⁸⁸ (i.e., 9.8 percent of Maryland's population were foreign-born, up from 6.6 percent in 1990).³⁸⁹ When measuring the percent of foreign born in the total population in 2000, Maryland ranked 15 out of 51 (50 states plus the District of Columbia).³⁹⁰ According to the Maryland Office for New Americans (MONA), an average of 16,000 immigrants resettle in Maryland each year.³⁹¹ Although their numbers sound small, during the 1990s, a full 76 percent of the labor force growth in Maryland was attributable to new immigrants.³⁹²

The Washington metropolitan area, including the Maryland suburbs, attracted 575,000 immigrants between 1980 and 2000. By 2000, 832,000 immigrants comprised roughly 17 percent of the area's population, making it the seventh-largest immigrant gateway in the nation. New immigrants make up about half of the overall population growth in the last decade, and approximately 47.5 percent of the area's immigrant

population arrived in the 1990s. Indeed, the number of immigrants in the Greater Washington area quintupled between 1970 and 2000. In Langley Park, Maryland, immigrants represent nearly two-thirds of the total population.³⁹³

As of the 2000 Census, most Maryland immigrants resided in the Washington, DC suburban counties: Montgomery County (46 percent) and Prince George’s County (24 percent). The next largest immigrant counties include Baltimore (nine percent), Baltimore City (six percent), Howard (five percent), and Anne Arundel (4 percent). All other counties combined account for six percent.³⁹⁴

i. Legal Categories of Maryland’s Immigrants

Most of Maryland’s foreign-born are naturalized citizens (44 percent) or Legal Permanent Residents (26 percent). (See Table 5.5.) However, undocumented immigrants are estimated to comprise approximately 20 percent of the state’s alien population.³⁹⁵

Additionally, a small but growing demographic within the immigrant community in Maryland is the refugee population. “International developments... have dramatically affected the population of a relatively small state like Maryland,”³⁹⁶ reads a MONA report. Since 1975, 15 states (of which Maryland is one) resettled 70 percent of the total population of refugees in this country. In that time, Maryland became home to 29,494, or 1.4 percent, of the U.S.’s refugee population.³⁹⁷

Table 5.5
Maryland Foreign Born in 2000

Type of immigrant	Number	Percent
Naturalized Citizens	233,000	44
Legal Permanent Residents	140,000	26
Undocumented Immigrants	108,000	20
Temporary Legal Residents	29,000	5
Refugees	22,000	4
TOTAL	530,000	100

Source: Immigration Studies Program, The Urban Institute, 2005, based in part on 2000 Census.³⁹⁸

ii. Immigrants Racial Characteristics

Racially, immigrants are a diverse mix. As shown in Table 5.6, the majority of the foreign born in Maryland reported either white alone (33.5 percent) or Asian alone (30.1 percent).

Table 5.6
Maryland and U.S. Foreign Born by Race

Maryland foreign born, 2002			US foreign born, 2002		
Subject	Total N	Percent	Subject	Total N	Percent
MD Total foreign born	518,315	100.0	US Total foreign born	3.1 mil.	100.0
White alone	173,717	33.5	White alone		43.0
Black alone	99,868	19.3	Black alone		6.8
AI/AN alone	1,457	0.3	AI/AN alone		0.4
Asian alone	156,046	30.1	Asian alone		22.5
NHOPI alone	483	0.1	NHOPI alone		0.2
Some other race alone	57,674	11.1	Some other race Alone		21.5
Two or more races	29,070	5.6	Two or more races		5.5

Source: Migration Information Source³⁹⁹

A diverse set of languages spoken in Maryland's homes. As of the 2000 Census, of the 623,000 total non-English speakers, 37 percent speak Spanish, 32 percent speak other Indo-European tongues, and 22 percent speak languages native to Asia.⁴⁰⁰

According to the 2000 Census, in the United States, as a whole, the majority of the foreign-born came from Latin America (51.7 percent), but roughly the same proportion of Maryland's immigrants hail from Latin America (34.0 percent) as from Asia (35.0 percent). Europe accounts for 16.8 percent (down from 24.5 percent in 1990), while 12.1 percent of the state's foreign-born population arrived from Africa (up from 7.6 percent in 1990).⁴⁰¹

The evolving demographic picture in Maryland is clearly one of increasing diversity. If poor immigrant and racial and ethnic minority communities continue to grow

at the same time such groups face greater barriers in accessing health care, an ever-increasing number of state residents will be affected by changes in Maryland's low-income health care market.

3. Problems with HealthChoice Implementation

Establishing a massive and complicated new mandatory Medicaid managed care program obviously creates many changes in the low income health care market. Other unforeseen changes came about due to significant problems during the programs initial implementation.

HealthChoice was to begin on January 1, 1997, but the state delayed implementation until June 2, 1997 because neither the state, the participating managed care organizations (MCOs), nor the beneficiaries were prepared. Despite concerns that key stakeholders remained unprepared in June, statewide implementation of HealthChoice nonetheless began at that time.⁴⁰²

Initial implementation was chaotic for several reasons. First, many more than the anticipated number of people enrolled in the program's first two months, which overwhelmed participating MCOs' system.⁴⁰³ When developing the HealthChoice program, the state originally anticipated transferring a total of 75 percent of the Medicaid population from PCCM to the enrollee's choice of participating MCO.⁴⁰⁴ That goal increased steadily, and by the time the program was actually implemented in June 1997, the state directed almost 90 percent of all non-institutionalized and non-dually-eligible Medicaid recipients to enroll in one of eight MCOs.⁴⁰⁵ By March 1998, more than 305,000, or the state's original goal of three-quarters of Maryland's Medicaid population, were enrolled in a HealthChoice MCO.⁴⁰⁶

Other problems abounded. Many enrollees did not receive the enrollment material due to missing address data. Directories of clinicians and affiliated health care delivery sites were incomplete and even erroneous. These factors caused high rates of auto-assignments, making PCP assignments confusing for both patients and clinicians. An annual lock-in feature further complicated the situation.⁴⁰⁷

C. Time Line of National and Maryland-Specific LIHCM Changes

This time line is included here to clarify the de facto and de jure changes to the low income health care market that occurred before, during, and after the study period. It includes activities that affected the nation, as well as those whose scope was limited to Maryland.

Table 5.7
Time Line of Selected Activities Affecting Low-Income Health Care Markets

When	What Happened Nationally	What happened in Maryland
July 30, 1965	President Lyndon Johnson signs Medicaid and Medicare into law, stating that "...no longer will this Nation refuse the hand of justice to those who have given a lifetime of service and wisdom and labor to the progress of this progressive country.... [B]ecause of this document--and the long years of struggle which so many have put into creating it--in this town, and a thousand other towns like it, there are men and women in pain who will now find ease. There are those, alone in suffering who will now hear the sound of some approaching footsteps coming to help. There are those fearing the terrible darkness of despairing poverty--despite their long years of labor and expectation--who will now look up to see the light of hope and realization." ⁴⁰⁸ Medicaid is	

	authorized under Title XIX of the Social Security Act.	
1967	The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) health services benefit is established for all Medicaid-enrolled children under age 21.	
1972	All states except Arizona began participating in the Medicaid program. (Arizona began participating in 1982.) Also, states are provided the opportunity to link Medicaid eligibility for elderly, blind and disabled residents to eligibility for the newly enacted federal Supplemental Security Income (SSI) program. ⁴⁰⁹	
1977	Federal Department of Health, Education and Welfare established the Health Care Financing Administration (HCFA) to administer the Medicaid and Medicare programs. ⁴¹⁰	
1981	Reagan Administration proposal to convert Medicaid into a block grant fails. Meanwhile, the Omnibus Reconciliation Act of 1981 (OBRA 81) cuts federal matching payments to states for FY 1982-1984 as part of required federal budget savings. ⁴¹¹ Additionally, Freedom of choice waivers (1915b) and home and community-based care waivers (1915c) are established; states are required to provide additional payments to hospitals treating a disproportionate share of low-income patients (DSH hospitals). ⁴¹²	
1982	Arizona becomes last state to opt into the Medicaid program. ⁴¹³	

1984-1985	<p>The Deficit Reduction Act of 1984 requires that children born after 9/30/1983 in AFDC-eligible families receive Medicaid coverage. Also mandates coverage for AFDC eligible first-time pregnant women and pregnant women in two-parent unemployed.</p> <p>The Consolidated Omnibus Budget Reconciliation Act of 1985 mandates coverage for all remaining AFDC eligible pregnant women.⁴¹⁴</p>	
1986	<p>Omnibus Reconciliation Act of 1986 (OBRA 86) requires states to cover treatment of emergency medical conditions for illegal immigrants otherwise eligible for Medicaid.⁴¹⁵</p>	
1987	<p>Omnibus Reconciliation Act of 1987 (OBRA 87) allows states to cover pregnant women and children under age 1 in families with income up to 185 percent of FPL.⁴¹⁶</p>	
1988	<p>The Medicare Catastrophic Coverage Act of 1988 (MCCA) requires states to phase in coverage for pregnant women and infants (up to age one) in families with income up to 100 percent of FPL. Special eligibility rules are established for institutionalized persons whose spouse remains in the community to prevent “spousal impoverishment;” Qualified Medicare Beneficiary group is established (QMBs).⁴¹⁷</p> <p>The Federal Family Support Act of 1988 required states to extend 12 months transitional medical assistance (TMA) to families losing AFDC cash assistance due to earnings from work.⁴¹⁸</p>	

1989	<p>Omnibus Budget Reconciliation Act of 1989 (OBRA 89) mandated coverage for pregnant women and children under age 6 in families with incomes at or below 133 percent of the FPL, whether or not they were receiving AFDC cash assistance. OBRA 89 also required states to cover services provided by federally-qualified health centers (FQHCs).⁴¹⁹</p>	<p>Total Health Care, a Maryland-based HMO, is formed by a union of several Baltimore FQHCs to provide primary care to Medicaid patients. Separately, these health centers have been providing care in the city's poorest areas since the late 1960s.⁴²⁰</p>
1990	<p>Omnibus Budget Reconciliation Act of 1990 (OBRA 90) mandated coverage of children ages 6 through 18 in families with incomes at or below 100 percent of FPL (whether or not they were receiving AFDC cash assistance) with coverage phased in one year at a time and completed by 2002.⁴²¹ Additionally, the Medicaid prescription drug rebate program began; it includes limitations on states' use of formularies to restrict access to prescription drugs.</p>	
1993	<p>Congress passes the Omnibus Budget Reconciliation Act of 1993 (OBRA '93), permitting states to implement prior authorization for any prescription medication under federal standards.</p> <p>Also, HCFA begins approving Section 1115 waivers to states, allowing them to implement statewide expansion demonstrations. States begin to conduct experimental, pilot, or demonstration projects. Most such efforts experiment with Medicaid managed care and expand coverage to previously uninsured populations. Oregon and Tennessee blaze the trail for mandatory managed care for most beneficiaries.⁴²²</p>	
Winter 1993- Spring 1994		<p>High Cost User Initiative (HCUI) is developed and approved by the General Assembly</p>

Summer 1994		<p>HCUI submitted to HCFA for approval</p> <p>UMBC forms the Center for Health Program Development and Management (CHPDM)</p>
Fall 1994		<p>Parris Glendening (D) is elected governor</p> <p>Integrated Care Management System (ICMS) program development begins</p>
Winter 1994-Spring 1995		<p>Decision to pursue a Section 1115 waiver for a system-wide and statewide Medicaid managed care program (and suspension of work on the ICMS program)</p> <p>Introduction and passage of SB 694 (Senator Hollinger's bill) directing DHMH to develop a Section 1115 waiver and present it in the 1996 legislative session.</p> <p>Maryland welfare reform becomes effective (two-year time limit for cash assistance begins)</p>
1995	The U.S. Congress passes as part of the budget process and President Bill Clinton vetoes legislation converting Medicaid to a block grant to states. ⁴²³	<p>PrimeHealth Corporation, a minority-owned HMO based in Lanham, is formed to sell to Medicaid patients mainly in Prince George's County.⁴²⁴</p> <p>HMOs were sued in the state, as were state employees, for selling names of Medicaid beneficiaries to HMOs.⁴²⁵</p>
May 1995	Congress called for \$182 billion in Medicaid reductions over seven years (H Con Res 67). ⁴²⁶	
Summer 1995-Fall 1995		UMBC oversees the public hearing process, involving a committee of 100+ members and other community

		<p>forums, intended to identify and discuss key issues in the waiver design</p> <p>UMBC and DHMH develops recommendations for the Section 1115 waiver</p> <p>HCUI is approved by HCFA</p>
September 19, 1995	House Republicans released details of their “Medi-Grant” proposal to end Medicaid’s entitlement status and provide block grants to states instead. (States would have to cover certain populations, but could decide how robust a benefits package to offer, and would also be freed from expensive federal mandates such as staffing and inspection requirements enacted in 1987 to improve the quality of nursing home care.) ⁴²⁷	
November 20, 1995	Medi-Grant bill passed Congress. ⁴²⁸	
December 6, 1995	President Clinton vetoed Medi-Grant bill. ⁴²⁹	
Winter 1995-Spring 1996		DHMH submits the Medicaid reform proposal to the legislature. Legislative committee hearings in the House and Senate result in modifications to the proposal, which are negotiated through the joint committee process into SB 750
April 30, 1996		SB 750, the Medicaid reform proposal, is signed by Governor Glendening into law
May 3, 1996		Section 1115 waiver is submitted to HCFA

July 18, 1996	Senate agreed to drop Medi-Grant” Medicaid reform provisions from welfare reform bill (S 1956); House effectively did same when it adopted the rule for floor consideration of the welfare bill (HR 3734) on the same day. ⁴³⁰	
July-August 1996	<p>President Clinton signs the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) law. It repeals AFDC individual entitlement to cash assistance, replacing it with the Temporary Assistance for Needy Families (TANF) block grant to states. This ends the formal link between cash assistance welfare and Medicaid eligibility, and requires states to cover families meeting the AFDC eligibility standards on July 16, 1996. (Welfare enrollees began falling off rolls ahead of schedule, and there was a simultaneous drop in Medicaid enrollment, despite continued eligibility.)</p> <p>PRWORA also imposes a moratorium on non-emergency Medicaid and other social welfare benefits for legal immigrants who enter the U.S. on or after August 22, 1996, for five years. After that 5-year ban, coverage is permitted by state discretion.</p>	
October 30, 1996		HCFA approves Maryland’s Section 1115 waiver, making it the 14 th states to receive approval. Approved plan allows Maryland to enroll about 75 percent of its 440,000 Medicaid beneficiaries into managed care plans. ⁴³¹
November 8, 1996	Medicaid regulations are made public November 8, 1996	November 21, 1996: Johns Hopkins HealthCare and the Maryland Community Health System form Priority Partners, a provider-based Medicaid-only MCO. ⁴³²

Winter 1996- January 1997		January 1 intended start date for HealthChoice delayed to give all parties additional time to develop infrastructure
Late 1996 to 1997	HMOs begin to shy away from Medicaid contracts and instead pursue Medicare market, which offers higher reimbursements and less administrative costs. Nine HMOs in New York alone discontinued Medicaid contracts due to low reimbursement rates. ⁴³³	In 1996, Mamsi attributed part of its \$64 millions losses to its participation in Maryland's Medicaid program and subsequently withdrew from that market. ⁴³⁴ Greenbelt-based NYLCare, one of Maryland's largest HMOs, opts not to bid for Medicaid contract, and Rockville-based Mid Atlantic Medical Services pulls out of Medicaid market after losing millions of dollars.
January 2, 1997		Green Spring Health Services and CMG Health begin a 3-year contract with the state to manage mental health benefits under Maryland's Medicaid managed care program
June 2 – November 1997		Enrollment period for the state's 330,000 Medicaid beneficiaries to sign up with an approved MCO
July 1, 1997		HealthChoice program is implemented in June with a six month enrollment phase-in (the first enrollees become effective on July 1)
July 1997		PrimeHealth Corp., a minority-owned HMO based in Lanham, is approved to sell care to Maryland HealthChoice program, thus becoming the 8th HMO approved as a HealthChoice provider. ⁴³⁵ Later, scandal emerges that PrimeHealth was unqualified, but DHMH approved because of its ties to then-State Senator Larry Young.

1997	President Clinton signs the Federal Balanced Budget Act of 1997 (BBA) into law. BBA established the State Children's Health Insurance Program (SCHIP), and permits states to mandate that most Medicaid beneficiaries enroll in managed care plans without obtaining a federal waiver. Most states offer SCHIP coverage to kids in families whose incomes are at or below 200 percent of the FPL (which is roughly \$36,800 for a family of 4).	However, because HealthChoice received federal approval before BBA passed, its mandated managed care components continue to operate under the waiver.
October 1997		National Committee for Quality Assurance (NCQA) released "report cards" for all licensed HMOs doing business in Maryland.
Winter 1997-Spring 1998	CHIP initiative is developed	
June 1, 1998		Benova replaces Foundation Health as the HealthChoice enrollment broker
July 1, 1998		Medicaid expansion to kids under age 19 in families up to 200 percent of the FPL becomes effective; expansion was funded via the State Children's Health Insurance Program (SCHIP)
Summer/Fall 1998		Governor Glendening is re-elected First plan announces its withdrawal from HealthChoice.
October 1998		Maryland Insurance Administration places PrimeHealth in receivership.
January 1999		The first cohort of persons receiving temporary cash assistance (TCA) reach the two-year time limit

February 1999		Maryland Hospital and Health Care Institute study found overpayments to HMOs and underpayments to newer MCOs; HMO overpayments were 20-32 percent and other MCOs had reductions of 7-9 percent.
August 27, 1999		DHMH announced imposition of more than \$640,000 in sanctions on five of the eight participating Medicaid MCOs, in response to an independent quality of care audit. The audit, conducted by the Delmarva Foundation, revealed unsatisfactory diabetes and prenatal care. ⁴³⁶
1999	The Federal Emergency Supplemental Appropriations for FY 1999 transferred the federal share of \$240 billion, 25-year master settlement between states and tobacco manufacturers to state governments. Much of these funds are used to cover health care programs for low-income populations.	Amerigroup bought Prudential's Medicaid business in Maryland ⁴³⁷
2000	The Federal "Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act directs the Secretary of DHHS to issue regulations tightening upper payment limits (UPLs). This continues a trend of the federal government clamping down on state financing practices." ⁴³⁸	
2001	Bush Administration announces the Section 1115 waiver initiative, Health Insurance Flexibility and Accountability (HIFA), which allows states to demonstrate comprehensive state approaches that will increase the number of individuals with health insurance coverage using current-level Medicaid and SCHIP resources. ⁴³⁹	

May 1, 2001		Amerigroup Maryland, Inc. received more than 17,000 Medicaid beneficiaries who lost coverage when PrimeHealth pulled out of the Medicaid market. Maryland Insurance Commissioner selected Amerigroup to take over PrimeHealth's membership on April 17, 2001. ⁴⁴⁰
September 2002	UnitedHealth Group purchased the managed Medicaid company AmeriChoice (360,000 members), increasing UnitedHealth's MMC enrollment to 1.2 million nationwide.	
2003	The Federal Jobs and Growth Tax Relief Reconciliation Act of 2003 "raises all state Medicaid matching rates by 2.95 percentage points for the period of April 2003 through June 2004 as temporary federal fiscal relief for states due to the downturn in the economy. Congress recognized that state revenue collection had declined just when Medicaid programs were facing increased enrollment by low-income families." ⁴⁴¹	
2003	The Federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) transfers Medicaid drug coverage for dual eligibles to Medicare, effective January 1, 2006.	
2005	<p>Congress passes a budget resolution calling for a \$10 billion cut in the Medicaid program.</p> <p>Federal DHHS Secretary Michael Leavitt established advisory Medicaid Commission, which will submit a report on September 1, 2005 outlining recommendations for Medicaid to simultaneously achieve \$10 billion in</p>	

	savings over the next five years and begin “meaningful long-term enhancements” that can better serve beneficiaries. A second Commission report, due December 31, 2006, offers recommendations to help ensure the long-term sustainability of the Medicaid program. ⁴⁴²	
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SOURCES: MPR interviews conducted the week of October 13, 1998; Oliver and Oliver (1998); Kaiser Family Foundation’s “Medicaid: A Timeline of Key Developments 1965-2009. See also endnotes for cell-specific citations.

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Part Three: Impact of Changes in Maryland's Low-Income Health Care Market on Access to Care

Chapter 7: Qualitative Analysis

Part Two provided a history of Medicaid managed care in Maryland, giving the reader background on how the system worked prior to the study period. It also identified key changes to the low-income health care market that occurred during the mid-1990s. Part Three will offer an analysis of those changes and their impact on access to health care among poor Marylanders. The current chapter will examine the qualitative data.

A. Impact of HealthChoice

Medicaid managed care (MMC) offers many conceptual advantages over a Medicaid fee-for-service (FFS) reimbursement system. Under a MMC structure, for example, it becomes a corporate responsibility to ensure that beneficiaries have access to care, which arguably should enable enrollees to experience more continuous and regular care.⁴⁴³ The state also has a greater role to play under MMC. Whereas it was merely the bill payer under the old system, MMC empowers the state to hold MCOs accountable for performance standards. Indeed, asserts one state official, beneficiaries “are getting a lot more preventive care than they did under the old [FFS] system.”⁴⁴⁴ Furthermore, in a capitated MMC structure, financing is equal for minorities and whites, so in theory, MMC should take cost out of the disparities equation.⁴⁴⁵

Did these advantages improve access to care among low-income Marylanders, or did the reality of HealthChoice's implementation prevent their actualization? This next section looks at unfortunate circumstances that may have undermined the aforementioned benefits.

1. Interviewee Observations about Access to Care

According to one HealthChoice expert, researchers at the University of Maryland at Baltimore County (UMBC) found that, for children, access was improved and emergency department use was decreased under HealthChoice compared with the old FFS structure. Improvements, moreover, were consistent at every age below 18.⁴⁴⁶

This is consistent with reports from one FQHC, which suggests that access for Medicaid enrollees was not significantly affected at its clinics:

*I don't think they [MCOs] were able to apply their rules in what is a typical managed care mode of operation (which is to really control the network utilization and deny care when it's out of network or that sort of thing) because there was such craziness in the marketplace and nobody really knew who belonged to whom. I don't think a lot of rules applied. So I don't think that access was denied, although it was probably a little more inconvenient. And probably a lot more expensive, but I'm not sure the population suffered for that. They went back utilizing in all their old ways...[Although] I am only looking at it from my vantage point [as an FQHC]. I can't speak for the hospitals and other places where maybe there was some access denial, but I didn't see it here and I didn't hear it with any other FQHCs.*⁴⁴⁷

However, another FQHC observed that HealthChoice significantly lowered access for the uninsured because the program's rigidity eliminated its previous ability to negotiate services.

*When you're a poverty program, you ought to be able to leverage your spending power and your relationships with vendors.... I have no leverage whatsoever. If I send five paying patients to a specialist and I want to slip one non-paying patient, it does not work that way anymore. Can't do it.*⁴⁴⁸

This FQHC official also believes that HealthChoice lowered the quality of care for all patients because, under the MMC model, a greater portion of the total funding to a health clinic must be spent on administrative overhead.

*Because the MCOs call all the shots, you are really practicing medicine as the MCO dictates that you practice medicine.... Way too much money is being invested in the administrative infrastructure [under] Medicaid managed care. There is a whole lot more energy being put into the business aspects than into the clinical aspects, and I cannot help but believe that the patient is getting the short end, because the amount of money that used to be invested in the actual clinical care has got to decrease. If somebody takes a critical look at that, they're going to see that the amount of money spent on clinical services had to go down. It just had to. And it's going for all administrative things, and people are not getting any more care than they did before.... [Indeed,] I don't see what contribution [HealthChoice] has made to low-income people. I think it's taken money away from direct medical care. I think we could have spent the money more wisely on direct services.*⁴⁴⁹

A state government employee agrees, noting that fewer refugees receive care in HealthChoice than in the old FFS model.⁴⁵⁰

a. Factors Negatively Influencing Access to Care at Initial Implementation of HealthChoice

i. Implemented before Stakeholders were Ready

A source from the Maryland DHMH pointed out that, at the time of HealthChoice's implementation, not much was known yet about mandatory Medicaid managed care. There were no studies yet on how to best implement such programs, and as a result, Maryland found itself on the wrong side of a steep learning curve.⁴⁵¹ Indeed, says one Medicaid managed care expert, the problems encountered in the program's implementation stemmed from transitioning to HealthChoice, not from HealthChoice intrinsically.⁴⁵²

All interviewees agreed that the initial start-up period was problematic. According to one interviewee affiliated with the state, the initial implementation process was "really painful."⁴⁵³ A representative of a safety net institution contact echoed this sentiment, noting that the initial implementation was difficult for all stakeholders:

I think the first almost two years, maybe three years of the program were really tough on providers, tough on the MCOs, tough on the individuals covered, tough on people trying to get into the program. It was just immensely hard for the state to organize itself to deal with all the issues that they were dealing with. Now that whole period of time, I think a lot of providers suffered with not getting paid. MCOs probably suffered with getting bad lists of people that took them years and years to reconcile. The ombudsman and the hotline and all the other mechanisms were overwhelmed and they were not all that helpful to begin with. And patients were darned confused about what they were supposed to do and where they were supposed to go. The cost savings of the program, at least in those early years when it was in such disarray, were never realized.⁴⁵⁴

Perhaps this was the fundamental issue that plagued the implementation process: unrealistic expectations and naivety. One example of unrealistic expectations, as noted in the previous chapter, was the program's start date. HealthChoice was to begin on January 1, 1997, but the state delayed implementation until June 2, 1997 because neither the state, the participating managed care organizations (MCOs), nor the beneficiaries were prepared.

They [the DHMH] did make certain changes and in fact when it became very clear that they were not ready to go with the program on the original implementation schedule, they pushed back about six months to give themselves a little bit more time, particularly to gather the information they were going to gather, to put together credible books of provider networks that the MCOs were going to put on the table. The MCOs were also just trying to organize themselves.⁴⁵⁵

Despite concerns that key stakeholders remained unprepared in June, and against the advice of many in the provider community who sought a staggered implementation based upon geographic regions of the state,⁴⁵⁶ statewide implementation of HealthChoice nonetheless began at that time.⁴⁵⁷

ii. Massive Early Enrollment Overwhelmed the System

Although the state had planned to transfer Medicaid beneficiaries on a graduated schedule, many more than the anticipated number of people enrolled in the program's first two months, and a full 75 percent of the Maryland Medicaid program was enrolled in HealthChoice within nine months,⁴⁵⁸ overwhelming participating MCOs.⁴⁵⁹ Why did beneficiaries enroll so quickly? Perhaps, asserts one expert in Maryland's Medicaid managed care program, because clinicians encouraged their patients to enlist within their affiliated MCO.⁴⁶⁰

*The first 6 months was really painful. The pace at which people enrolled surprised people within the bureaucracy. I was there when it happened and I thought these were reasonable assumptions. Most people assumed that the population would respond slowly to the changeover, and that ... the big bulk of people would be comfortable staying where they were and they would not make a change until they had to... And when you were expecting 30,000 people the first month and you got 90,000 it overwhelmed the system.*⁴⁶¹

iii. Errors in Provider Directories

Inaccurate provider directories, which incorrectly identified which clinicians and institutions had contracts with each managed care company, confused those lucky enough to receive provider directories in the mail.⁴⁶² An annual lock-in feature further complicated the situation.⁴⁶³ Says one safety net clinic:

The MCOs who were supposedly turning in lists of their contracted providers, they either were not able to gather the information the way they should or the communication with the state was problematic. The books that the state was using to describe the networks and the offerings of the primary care providers that you could select to be your primary care provider were incomplete. And it was wrong in many cases. Not only incomplete, but actually incorrect.... For FQHCs in particular, this was a problem because most of our patients know us more by our site location than they do by our physicians... Our patients are not necessarily going to hunt through these books. Their reading skills are not all that strong... so by not having the provider name and the site name listed separately, our

*patients could get easily confused... It took a year or a year-and-a-half for that to [be resolved].*⁴⁶⁴

iv. Inaccurate Beneficiary Address Information

Access to care became a problem for the many enrollees for whom the state lacked address data and who subsequently did not receive enrollment material. This caused high rates of auto-assignments, making provider assignments confusing for patients and clinicians alike.⁴⁶⁵

b. Ongoing Concerns About HealthChoice-Imposed Access Barriers

i. New Bureaucratic Requirements Means Less Patient Care

Before HealthChoice, reports an interviewee from a health care safety net delivery site, clinicians were able to spend more time providing care.

*There was no pre-authorization so nurses were actually doing nursing and there was no need to hire people to be referral coordinators and nurses managing utilization... there was a lot more freedom to provide care to your patients, and a lot fewer administrative requirements, a lot fewer administrative expenses associated with providing the care. At the point in time that the Medicaid program went to managed care, all of that stopped. A nurse who used to see an OB patient to get vital signs and do patient education is pulled from that to get on the telephone to justify what we want to do.... We don't have the nurse teaching anymore. She's in the office talking to people on the telephone.*⁴⁶⁶

ii. Lack of Information of Poverty Programs Across State Government

In addition to the natural growing pains that were caused by the establishment of a more bureaucratic system, other concerns stem from insufficient knowledge of poverty programs both by the Maryland governmental agencies that administer programs for the poor and by the beneficiary population. In Maryland, the Department of Health and Mental Hygiene (DHMH) has primary oversight of the Medicaid program and the

Department of Human Resources (DHR) administers the various welfare programs, including Temporary Assistance for Needy Families, cash assistance, and food stamps. However, the DHR employs the case workers that make eligibility determinations for Medicaid.⁴⁶⁷

*You have a lot of situations where [a homeless patient] would go to DSS and say, 'I need to get this prescription filled,' or 'I have a toothache.' [The response is] 'You have to apply for benefits... Sorry, Pal, I can't help you.' They don't know the other agency's resources and programs... Both agencies are charged, among other things, with serving poor people, but neither is really able to have [one voice].... The average client low-income person seeking help doesn't know that they're two different agencies. Doesn't care that they're two different agencies. They just want help now. You know, it's a real problem.'*⁴⁶⁸

Another manifestation of this problem is the insufficient awareness by social workers who determine eligibility for HealthChoice of the eligibility rules for various groups, particularly refugees.⁴⁶⁹

iii. Delays in Correspondence Between all Stakeholders May Impact Access

Confusing and delayed applications are compounded by bureaucratic problems at the MCO level, such as delays in mailing enrollment documentation to newly-accepted HealthChoice members. One state government official notes that, by the time beneficiaries she works with receives the Medical Assistance card and documentation sent by the MCO informing them of their enrollment in the program, it is frequently time for re-eligibility determination.⁴⁷⁰

Erroneous letters sent by MCOs informing members of PCP auto-assignments and changes to those auto-assignments is another problem that one former state government interviewee came across in his dealings with the MCOs.⁴⁷¹ This interviewee also noted

inefficiencies that occurred within the Medicaid agency that affected and delayed correspondence between MCOs, beneficiaries, and state⁴⁷²

Reimbursement delays, reports one FQHC, have been a major problem with the HealthChoice program.

*It took [one MCO] three months after nagging and cursing and going up to their offices and banging on their door [to receive reimbursements the MCO owed the FQHC]. When I submit my claim to them, they should pay me in 30 days. So they paid me in 90 days.*⁴⁷³

Compounding the problem are persistent problems with the both the state's and many of the MCOs' electronic claims software that, says one interviewee, results in significant payment delays.⁴⁷⁴

*We [FQHCs] have this market-based rate, and then if the MCO sends the claim to the state, the state will pay us the rest. If the MCO denies the claim, then we don't get paid for it. If the MCO loses the claim, we don't get paid for it. And so we have claims all the way back to 2003 that the MCO has not honored and one MCO in particular [name omitted] has claims that it has mismanaged and the reason they give is us because their information system has some problems.*⁴⁷⁵

But another FQHC disagrees that this remains a major problem.

*We get our payments, we still have a few problems here and there but overall it's working as it should.... Really after two or three years of pandemonium they got the thing working right.*⁴⁷⁶

iv. Eligibility Determination Problems

The establishment of MMC did not alter one of the major characteristics of Medical Assistance: the fact that financial eligibility for Medicaid in Maryland is, in the words of one interviewee, "abominably low: 50 percent of the FPL. We're basically talking about the homeless with minor children or the disabled homeless."⁴⁷⁷ Indeed, according to the Kaiser Commission on Medicaid and the Uninsured, Maryland's

Medicaid program only covered about half of the state's residents with incomes under the poverty level in 1995, and eligibility levels for Maryland Medicaid remain below the national averages.⁴⁷⁸

Although financial eligibility thresholds did not change, the frequency of eligibility determination did; and as documented in previous chapters, frequent redetermination of eligibility in many states has resulted in churning (i.e., on-again-off-again enrollment that fluctuates with seasonal earning cycles). According to one anti-poverty lobbyist⁴⁷⁹ and corroborated by a state employee,⁴⁸⁰ churning remains a problem for HealthChoice enrollees in Maryland. In some cases, access may have been hindered because of inaccurate eligibility determinations. One FQHC representative explains that the most vulnerable may be particularly at risk of losing Medicaid coverage.

“One of the things that we note here is that it is particularly hard to get people who are dually or triply diagnosed for Medicaid. The [Medicaid State Review Team, which reviews eligibility for Medicaid] doesn't do their job with these cases... If somebody has, let's say, diabetes, high blood pressure, a substance abuse problem and some other problems, they're particularly likely to turn such a person down.”⁴⁸¹

Indeed, at the time of the interview, a lawsuit was pending against the State Review Team for inappropriately denying Medicaid eligibility.⁴⁸² A University of Maryland researcher noted that, in fact, eligibility was narrowed for the disabled under HealthChoice as compared with its predecessor FFS Medicaid structure.⁴⁸³ Moreover, the state is working to eliminate Medicaid payments for non-emergent care provided in hospital emergency departments because of budget concerns,⁴⁸⁴ which may have the unintended consequence of lowering access to services for low-income populations.

c. State's 2002 HealthChoice Evaluation's Assessment of Program's Impact on Access to Care

Maryland's Department of Health and Mental Hygiene conducted an evaluation in 2002 of the program thus far, which generally showed improvement in use of services among children, who at that time represented 75 percent of the program's population.⁴⁸⁵
⁴⁸⁶ The evaluation found that the number of services per person has decreased, but overall HealthChoice made "discernible," albeit modest progress between 1997 and 2000 in improving access to care for MCO enrollees. It also noted that improvement in access was "not always uniform across population groups, regions of the state, or MCOs."⁴⁸⁷ For example, children in foster care appeared to have fewer well-child visits in HealthChoice than they had in the 1997 baseline FFS period.^{488, 489} Additionally, although the report found that the proportion of children receiving dental care visits increased substantially under HealthChoice, access to dental services remained a serious concern.⁴⁹⁰

d. Interviewee Observations about HealthChoice's Impact on Access to Specialty Care

Interviewees from multiple FQHCs agreed that specialty care has become a "serious problem under HealthChoice."⁴⁹¹ One former Maryland Medicaid official agreed that network adequacy was always of great concern in the mid-late 1990s. Indeed, one interviewee recalls a decision to drop a project to counter HealthChoice fraud because of agency fears that addressing the problem would result in providers getting dropped from MCOs and decreasing the already fragile network adequacy.⁴⁹²

This affected not only the HealthChoice population, but also the uninsured. One FQHC reports that:

Those OBs who used to do surgery for my [FQHC's] uninsured people [prior to HealthChoice] now will not. I used to have it in my contracts with them. If you see one of my uninsured people, and that person needs surgery, you will do it at no cost to me, but he made me take it out [of their new contracts]. He said, I can't do that anymore. Increased expenses, a decrease in reimbursement. He's just closing down his uncompensated care [practice].”⁴⁹³

Another interviewee from a different FQHC also believes specialists dropped out of FQHC-owned MCOs because of poor reimbursement.⁴⁹⁴ This was the conclusion of a departmental study on provider profit margins, states a former Medicaid employee, adding that “the report found that HealthChoice providers were not covering basic costs. In fact, Medicaid providers could expect to lose money delivering care to the Medicaid population.”⁴⁹⁵ Indeed, agreed an official with one Medicaid MCO that exited the market, “If it costs you \$10 and you only get \$8, you cannot make it up, and the program is seriously underfunded.”⁴⁹⁶ This interviewee noted that, “The specialist pool has gotten smaller... what I find is absolutely missing is the mental health sector. Cannot find a psychiatrist, period We have also had a terrible time finding dental hygienists.”⁴⁹⁷

A researcher with the state, however, disagrees. Specialty care may be hard to access in certain parts of the state, but he asserts that it is no worse now under HealthChoice than it was under Medicaid FFS.⁴⁹⁸

e. Interviewee Observations about Impact of HealthChoice on Health Care Disparities

Although one FQHC was outspoken about the persistence of disparities in access and quality of care for racial and ethnic minorities,⁴⁹⁹ two researchers who were interviewed separately cited different studies indicating that disparities have narrowed state-wide under HealthChoice. One noted the University of Maryland at Baltimore

County's evaluation for the state Department of Health and Mental Hygiene, which "finds nearly no" persistent disparities.⁵⁰⁰

Another interviewee's own research evaluated measures of well-child access, adult preventive ambulatory care access (chosen because it captures some men within the disabled male population), and breast cancer screenings (which tends to have racial disparities in outcomes). His research found that, relative to FFS in the days prior to HealthChoice, disparities among adults were nearly eliminated under managed care and, in an unexpected finding, black and Hispanic children and adolescents surpassed white children in the use of preventive services. That said, he found that black and Hispanic children are more likely to live in an area with fewer practicing physicians, and he is planning additional research investigating his concern that the preventive services that they receive may be shorter in duration and possibly less beneficial.⁵⁰¹

B. Establishment of Medicaid MCO Market

The quality of care in a Medicaid managed care program is determined in large part by the quality and quantity of the MCOs that participate. In turn, the quality of the MCOs is only as high as the quality and quantity of the clinicians with whom they contract. Historic Medicaid providers (i.e., individual physicians, FQHCs, Maryland Qualified Health Centers,⁵⁰² rural health clinics, school-based health centers, local health departments, and family planning clinics), as well as the two university medical centers in Baltimore (Johns Hopkins and the University of Maryland at Baltimore) sought to continue having Medicaid beneficiaries comprise large portions of their patient pools.

Prior to HealthChoice, Johns Hopkins and the University of Maryland at Baltimore together accounted for nearly 33 percent of all Medicaid general hospital revenues.⁵⁰³ These historic providers, however, feared having to compete on even footing with the private clinicians that had more resources to attract new patients at their disposal.⁵⁰⁴ Indeed, black physicians reported challenges negotiating to join MCO networks, and FQHCs feared that the MCOs would oppose contracting with them.⁵⁰⁵

1. New Provider-Formed MCOs

The state, having every incentive to keep the provider pool as robust as possible, agreed to designate those with a history of caring for Medicaid enrollees as “historic providers” who, at minimum, would be assigned to one MCO. Under HealthChoice, providers are also permitted to create their own MCOs.⁵⁰⁶ On November 21, 1996, Johns Hopkins did just that: together with the Maryland Community Health System, it formed Priority Partners, a provider-based Medicaid-only MCO.⁵⁰⁷ Other Maryland FQHCs, working with Health Care for the Homeless, Blue Cross/Blue Shield, the University of Maryland, and Mercy Hospital formed Care Partners, another provider-based MCO.⁵⁰⁸ Two more MCOs were founded by FQHCs, and many were founded by hospitals.⁵⁰⁹

A short time later, Green Spring Health Services and CMG Health began a three-year contract with the state to manage mental health benefits under HealthChoice. In July 1997, just as HealthChoice enrollment began, PrimeHealth Corp., a minority-owned MCO, was approved to sell care to Maryland HealthChoice enrollees.⁵¹⁰

2. MCO Concerns about Viability Under HealthChoice

But some MCOs, however, grew concerned about their ability to stay afloat in the new managed care environment. Several companies chose not to compete for Medicaid

contracts while others hastily pulled out of the Medicaid market in Maryland and elsewhere. MAMSI, a national managed health care company, attributed part of its \$64 millions losses in 1996 to its participation in Maryland's Medicaid program and subsequently withdrew from the market just before the state instituted HealthChoice.⁵¹¹,⁵¹² Care Partners, which had grown to be the second-largest Medicaid MCO in the state, folded.⁵¹³ In 1996 and 1997, the NYLCare, one of the state's largest MCOs, opted not to bid for a Medicaid contract for fear of unwieldy state regulations. Nine MCOs, in total, applied for Medicaid contracts with the state of Maryland and all nine received contracts.⁵¹⁴ (For a comprehensive list, see Table 5.4.)

Table 7.1

The Nine MCOs Contracting with HealthChoice at the Program's Inception

1. Prudential Health Care Plan
2. United Healthcare of the Mid-Atlantic, also known as Chesapeake Family First
3. Freestate/Total Healthcare (the latter contracted with Freestate Blue Cross Blue Shield)
4. Priority Partners
5. Maryland Physicians Care
6. Helix Family Choice
7. New American
8. Prime Health
9. JAI Medical Systems

Source: Gold et al.⁵¹⁵

3. Consolidations in the Market

Over the course of several years, there were multiple changes to the MCO market. Said one University of Maryland health policy researcher, "We had a number of turnovers early on in the system and the most painful one was probably Free State because that was probably the largest number that had to be picked up and moved around."⁵¹⁶

In chronological order, New American Health was the first to pull out of the HealthChoice program, followed by Prudential (Maryland's largest MCO), which sold its provider network to Amerigroup. At that point, all Prudential enrollees were given the option to go to any participating MCO. Total Health, a community health center-based plan, was bought out. Prime Health went out of business. Then came the largest blow in 2001: BlueCross/Blue Shield's "Free State" left Maryland.⁵¹⁷

One interviewee, a national observer of Medicaid managed care trends, talked about the proliferation and then the withdrawal of MCOs in the Medicaid market.

You saw when the BBA was first enacted the elimination of the 75/25 rule. [The 75/25 Rule required that a minimum of 25 percent of an MCO membership must be comprised of private, non-Medicaid payers] And that is when you saw a lot of Medicaid only plans begin to sprout up... They were successful financially. And you started to see some of the larger firms and entities begin, you know, merging, acquiring some of these small plans... And it makes it tougher for the smaller plans, the individually owned plans ... to compete with them, because they don't have the economies of scale, you know, that the larger groups have.... You saw a number of the commercial plans pull out of Medicaid managed care.⁵¹⁸

The state was very eager to keep Free State in the market. In the words of one of the key players:

For two years, Free State was considering pulling out. It was like, oh, they're the statewide blah, blah, blah, and you know, the state bent over backwards to try to keep them to participate in the program. And then they left anyhow, and [laughing] oh, my goodness. It wasn't so bad! ... We should have just said, this is the rate, we think they're fair rates and if you can't make it go, you know, good luck to you. Go off and do whatever you want to do... The departure of any big plan is a big hassle because you've got to reassign all these people, and you've got to get everything squared away and I think that was painful, but by the same token, probably one of the things that if people in Maryland had it to do over again, they would not have worked so hard to keep Free State in.⁵¹⁹

4. What Caused the Departures?

Why did so many MCOs leave the program? Stakeholders have different opinions, but several common themes emerge. A Health Choice program evaluator believes that the departures were part of the “Medicaid managed care shake-out” that occurred across the country in the wake of the BBA.⁵²⁰

One FQHC-owned MCO believed the problem had to do with insufficient reimbursement. “MCOs pulled out of the market because it cost them \$10 to provide the care and we only got \$8 for it, and they just can’t make it up. You’re going to continue to run deficits.”⁵²¹ A reimbursement rate study completed by the state corroborated the MCO complaints that the current rates were not covering cost of providing care.⁵²²

Providers complained about the HealthChoice reimbursement policy, which called upon FQHCs to submit claims to the MCOs, which pays a “‘market fee’ that does not even cover the cost of sterilizing the room. Then the state pays us the remainder. So you have got to chase down a claim twice.” In the first year of the HealthChoice program, the market rate was just over \$15 per visit. It was not until January 2005 that the state reorganized its reimbursement structure such that the MCO pays the FQHC the entire rate at one time.⁵²³

Indeed, FQHC-owned MCOs had the double burden of implementation problems affecting providers and implementation problems affecting MCOs. An interviewee from one such organization explained that when FQHCs lost their cost-based reimbursement in Maryland after the BBA’s implementation in 1998, it was “a huge hit” to the safety net.⁵²⁴ Indeed, it was several years before Maryland decided to reinstate the funds with state dollars.⁵²⁵

An observer of national Medicaid MCO trends thought that over-regulation played a significant role in the market shake out.

*Maryland ...has a reputation for not being the friendliest state to insurance entities. And that carries over to the MCOs that are in the Medicaid business as well. So, I would imagine that that probably adds to the overall business decline that the plans are under.*⁵²⁶

In one example of what MCOs deemed over-regulation, prior to HealthChoice, no more than 33 percent of an FQHC's total budget could be spent on administration. That ratio did not change under HealthChoice. "Our cap of 33 percent stayed the same, in spite of the fact that they forced us to increase our administrative burden. So they don't allow us to be efficient, but then they complain about our costs."⁵²⁷

A then-analyst with the Maryland Medicaid agency agreed that MCOs left both because of frustrations about new regulatory requirements and their inability to make a profit.⁵²⁸ A HealthChoice official acknowledged that it probably had to do with the state placing a lot of new administrative burdens on MCOs to provide data on health care quality, which was much more than the requirements had been required of them under FFS. This official also attributed the market changes to concerns from the MCOs over turnover within their provider networks.⁵²⁹

*Providers were promised less money in exchange for no claims form or other paperwork, but then the MCOs reneged, and actually wanted more data and more paperwork. MCOs denied a lot of claims to providers who did not provide this data. As a result, physician groups that had formed to compete for Medicaid contracts with MCOs disbanded.*⁵³⁰

A University of Maryland researcher concluded that, whatever the issues were that caused such instability in the program's first few years, the market has stabilized.

The departure of plans is a problem, which is why I would argue [the low-income health care market is at a good point] right now. You've got seven

*players in the market... no one having more than a quarter of the market share.... They've been relatively stable, they're able to make a margin every year....*⁵³¹

C. Impact of Welfare Reform on Maryland

1. Declining Welfare Enrollment

The number of families that received Maryland's Temporary Cash Assistance (TCA) fell sharply (65 percent) between January 1995 and July 1999, decreasing the caseload to its smallest level since 1969.⁵³² Medicaid enrollment by those who had been eligible for AFDC over that same period fell by approximately 23,000.⁵³³

2. Declining Medicaid Enrollment

In 2001, researchers at the University of Maryland found that Medicaid rolls declined "at a surprisingly high rate in given years, particularly given the recent federal and state efforts to expand medical coverage." Potential causes include declining welfare caseloads, an improving economy, and changes to the state's welfare policies including diversion programs and the divorce between cash and medical assistance.

Data from Maryland's Department of Human Resources (DHR) indicate that 50 percent of former welfare beneficiaries have Medical Assistance coverage within the first three months after exiting welfare,⁵³⁴ leaving researchers wondering what happened to the other 50 percent. For purposes of tracking employment or health records, the other half of former Maryland welfare recipients have "disappeared."⁵³⁵ Of those for whom the state has data, only half of workers (i.e., 25 percent of all welfare "leavers") are earning more than \$800 per month.⁵³⁶ Indeed, fewer than 40 percent of leavers work continuously, and among those who do, median earnings were roughly \$2,000 per quarter, suggesting that most families who exit welfare continue to earn incomes well

below the FPL.⁵³⁷ Concludes one researcher: “there is information from some states that former welfare recipients are being cut off from Medicaid despite their continuing eligibility.”⁵³⁸

One FQHC reports that its patient base tripled from 1995 to 2005, but its Medicaid patient base is lower than its 1995 levels.

*[Why?] Because of welfare reform... [a lot of people have begun working]. Now that's a good thing, but the bad part is the health insurance part. You have high deductibles and your medicine costs a lot of money. What we see is that somebody does not want to come back in because there's a copay associated with every visit.... If you have no insurance, [out-of-pocket costs] may be less because you're on a sliding fee scale.... So yeah, they do have jobs, but do they have access?*⁵³⁹

D. Impact of Implementation of the Balanced Budget Act of 1997 on Maryland

1. Computer Problems

The simultaneous HealthChoice and welfare reform implementation caused problems. For example, information technology staff in DHMH (the agency responsible for Medicaid enrollment) and DHS (the agency responsible for welfare enrollment) had not yet resolved electronic data transfer concerns by June 1997, and as a result, individuals who were entitled to and were receiving Medicaid erroneously were expelled from the program when they lost welfare benefits. Likewise, according to staff at the DHMH, some Marylanders remained on the Medicaid rolls much longer than they should have because of similar administrative errors subsequent to and resulting from the Medicaid/welfare delinking.⁵⁴⁰

According to one DHS staff member, technological limitations prevented the TANF eligibility screen to be sent to Medicaid eligibility computers.

Once [the eligibility worker] gets [a refugee] eligible and she finds that with TANF families, there is some kind of a disconnect with the computer system that keeps them from automatically taking information from the TANF screen and sending it over to the Medical Assistance Screen. She checks a few days later and no, it didn't go over, so she has to hand-fill out papers and fax them over to someone, who then has to hand-ender it in all over again. If the worker is not diligent, that family will simply not get Medical Assistance... And the worker thinks they did their job, and they originally did – they put their information in there, but it didn't convert over to the Medicaid screen.⁵⁴¹

Staff with one FQHC agreed that eligible enrollees were being cut off inappropriately, particularly in the early years of HealthChoice. One such episode had to do with the loss of Social Security eligibility.

We had people being cut off of SSI and being evicted and becoming homeless. [At the same time,] we had people mistakenly having their Medicaid cut off, which wasn't supposed to happen. It was just supposed to be their [SSI] benefits. The clients were supposed to be given notification that they had three months to provide documentation for what their other impairments were, to try and make sure they weren't cut off when they had many other problems as well. It didn't go well, and many, many thousands of people lost their benefits and could not get them returned.⁵⁴²

Some believed that the problems with initial implementation were eliminated as the program matured, but others maintain that new and more fundamental issues emerged and plague the program even today.

2. The Medicaid Population Became Younger

As noted in previous chapters, the Balanced Budget Act of 1997 established the State Children's Health Insurance Program (or SCHIP). Maryland implemented SCHIP by expanding the Medicaid program to include SCHIP eligibles, which changed the demographics of the Medicaid population, in the words of one interviewee, "from a program for women and children to a program for children and children."⁵⁴³ Indeed, the

state's 2002 self-evaluation of the HealthChoice program noted that the percentage of Maryland children enrolled in Medicaid statewide grew from 12.7 percent in 1990 to 22.2 percent in 2000. Growth was particularly sharp among children on the Eastern Shore, where the percentage of children served by Medicaid grew from 12.4 percent in 1990 to 28.7 percent in 2000.⁵⁴⁴ For a breakdown of Medicaid enrollment by group, see Table 7.2 and Figures 7.1 and 7.2.

Table 7.2

Percent of growth of eligible children in Maryland Medicaid from 1999 to 2003.

Year	No. of Kids	All Enrollees	Percent of kids vs. all
1999	306,891	628,458	49
2003	418,297	825,492	51
Growth	111,406	197,034	Percent growth attributable to children: 57

Source: Centers for Medicare and Medicaid Services.^{545, 546}

However, one University of Maryland interviewee notes that the establishment of Maryland's SCHIP program has not significantly improved child health outcomes because the sickest and/or poorest children were already receiving Medicaid-funded care via Supplemental Security Income (SSI), a federally-funded welfare program. MCHIP is a popular program, however, for two reasons. First, it covers a sympathetic group: children living in families of the working poor. Secondly, the program is inexpensive because the covered population is generally healthier than the very poor and because unlike Medicaid, which offers the state a 50 percent federal match, MCHIP fetches a 65 percent federal matching rate.⁵⁴⁷

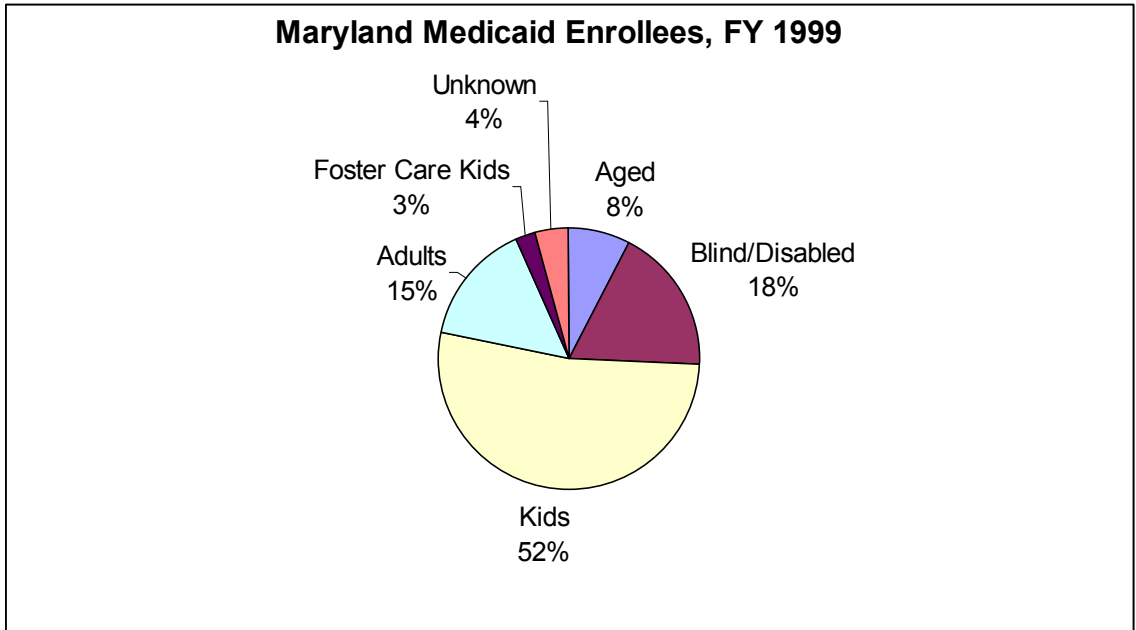


Figure 7.1. FY 1999 Medicaid Enrollees in Maryland.
Source: Centers for Medicare and Medicaid Services.⁵⁴⁸

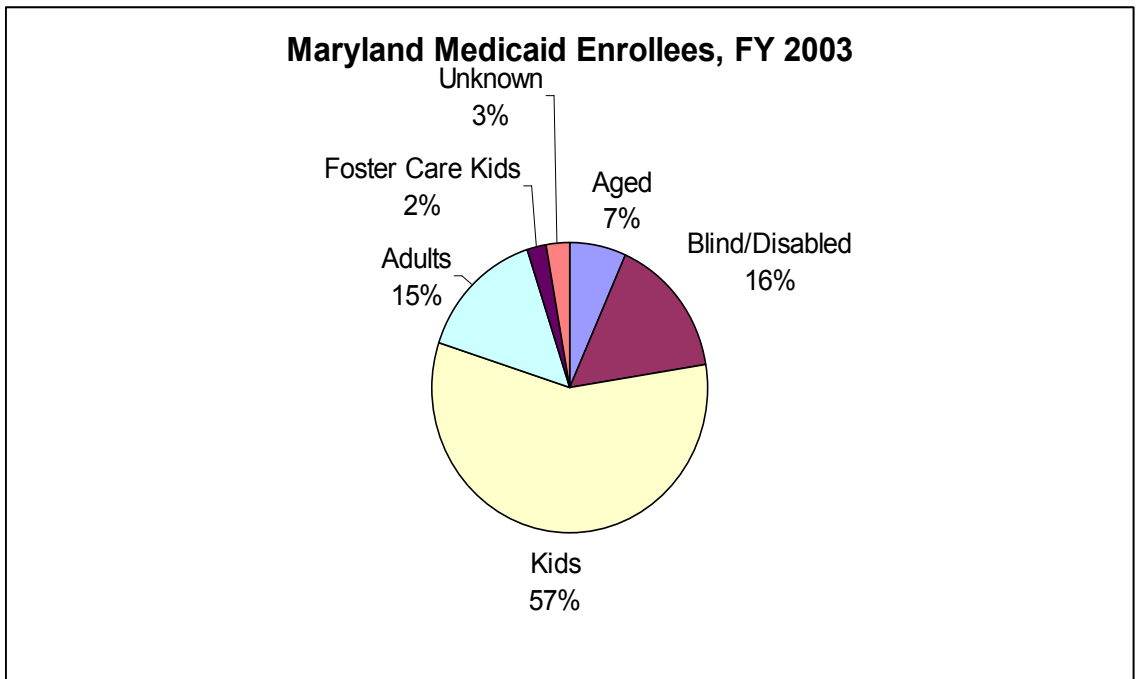


Figure 7.2. FY 2003 Medicaid Enrollees in Maryland.
Source: Centers for Medicare and Medicaid Services.⁵⁴⁹

3. Loss of Medicare Pilot Funding for Baltimore Medical Systems

As noted above, Baltimore Medical Systems (BMS), the state's largest FQHC, grew out of a Medicare demonstration project that began in the late 1970s, and a substantial amount of its patient base has always been the elderly. Through 1998, Medicare volume accounted for roughly \$25 million of BMS's revenue, but this changed with the implementation of the BBA.

The Centers for Medicare and Medicaid Services interpreted the language of the BBA in a way that fundamentally changed the demonstration project. What had been an open-enrollment, cost-based reimbursement program with no patient cost participation and no managed care became a closed-enrollment managed care program with significant cost sharing. As a result, BMS's poor elderly patients were suddenly required to participate in the cost of the care that for twenty years they received without having to pay.

This drove many Medicare patients out of the system, leaving BMS with excess geriatric capacity and, with closed enrollment, no way to rebuild it. BMS provided only \$14 million in Medicare services in 1999, a loss of \$11 million from the previous year. The main cause of lost revenues was from Medicare, but "the fact that occurred simultaneously [with the cut in cost-based reimbursement and the establishment of HealthChoice] was very problematic."⁵⁵⁰ Between 1999 and 2000, BMS lost an additional \$4 million, closed two of its sites, and nearly went out of business. It took the FQHC until 2004 to fully recover.⁵⁵¹

E. Impact of Changes on the Most Vulnerable: Maryland's Homeless and Immigrant Populations

1. Homeless

According to the Maryland Department of Health and Mental Hygiene, MCOs that participate with HealthChoice must meet specific standards set forth in the regulations⁵⁵² for treating seven special needs populations. These include 1) children with special health care needs; 2) individuals with a physical disability; 3) individuals with a developmental disability; 4) pregnant and postpartum women; 5) individuals who are homeless; 6) individuals with HIV/AIDS; and 7) individuals with a need for substance abuse treatment. It further states that participating MCOs “must attempt to identify homeless individuals and link them to the appropriate service provider.”⁵⁵³ However, according to one interviewee with extensive experience in working with the homeless population, there are problems in the system:

*HealthChoice is really designed for somebody who has a phone, a home, and the capacity to keep appointments... The [HealthChoice] program has been very difficult for the homeless populations. Homelessness both causes health problems and health problems can cause homelessness. When people need care, they seldom have the resources to take public transportation or get a ride to their primary provider. That has a big impact. When it was fee-for-service, they could get care wherever they were. The way it is now, there's frequently people that can't get care and don't know how to resolve it.*⁵⁵⁴

The homeless have unique problems with a Medicaid managed care delivery system. First, they do not have a mailing address, and therefore cannot receive the HealthChoice enrollment package or Medical Assistance membership card. They frequently need more involved social services than traditional primary care providers offer, including psychiatric services and assistance in scheduling visits with specialists.

Homeless individuals can neither make nor receive phone calls to coordinate appointments. If they are auto-assigned to doctors that are not conveniently located near public transportation, they cannot access their primary care providers. Transportation is frequently a barrier, even to those whose doctors are in the urban center, because they do not have the ability to pay for bus fare or cab rides.⁵⁵⁵ This may have significant implications for their access to services.

*We do see HealthChoice as having created its own access to care problems, above and beyond the problems that homelessness creates. For example, the average provider needs appointments. For the average person experiencing homelessness, you need walk-in hours.*⁵⁵⁶

It also has administrative implications for safety net providers, who have trouble under the HealthChoice reimbursement structure. Even if a patient sees multiple providers offering completely separate health care services during a single encounter at the clinic, the provider can only bill for one appointment.

*For example, if someone's a walk-in for addiction, and they're down there with the addiction counselor and they [exhibit psychiatric care needs], our addiction counselor says, you know, I think you need to see a mental health provider. They have the capacity to go upstairs and say [to a mental health provider], 'hey, I got one you really ought to see.' To do that is hard. That's one thing that's hard to do from a system standpoint. And it's hard to build in the capacity to do that... you just bill for one visit... the client may have seen three different teams here, but on paper it goes down as one visit.*⁵⁵⁷

2. Immigrants

Evolving demographics within Maryland have played an important role in the state's low-income health care market. An interviewee and immigration researcher explains that there has been a significant growth in the immigrant population in Maryland, particularly in Montgomery and Prince Georges Counties.⁵⁵⁸ This has put a

strain on hospital emergency departments (EDs or ERs), which is frequently the default site of care for the uninsured.

One official with the Maryland Office for New Americans also reports that many uninsured immigrants seek care from the ER, but there are efforts to bring care to this population in more cost effective ways.

*The Health Alliance of Howard County, for example, is a free clinic established by some local docs and the Howard County General Hospital to address the ER overcrowding issue. The docs volunteer services, and the hospital waives fees. In this way, it serves both the community and the hospital because it provides less expensive care than they were covering in the ER.*⁵⁵⁹

A University of Maryland researcher comments that, via the ER, the state provides immigrants with “inefficient health care,” which he characterizes as “a real problem.”⁵⁶⁰ One Health Care for the Homeless staff member agrees about the magnitude of the problem, and is working to expand access in other ways.

*We’ve seen a lot more [homeless] people that are immigrants in the past couple of years than we had previously.... Our [new] clinic is going to be for day laborers, which addresses both the documented and undocumented. They work all day, but in all likelihood have no health insurance, and probably are more likely to go to an ER for a problem because it is open weekends and evenings and we’re not. So we’re trying to expand to be able to serve that ...both working people who are homeless and people who are either migrant or undocumented. There are a lot of those... It’s a growing demographic and it’s a growing unserved and underserved demographic.*⁵⁶¹

Many immigrants, both insured and uninsured, seek care in FQHCs. An FQHC CEO concurs that there have been more immigrants in his clinics, noting that there are many more refugees and fewer adults since the pre-Balanced Budget Act (BBA) period. He adds that, since Medicaid and the BBA-created Children’s Health Insurance Program (which provides reimbursement for care to low-income children through Medicaid) came

into existence, Medicaid accounts for twice as much of his FQHC's revenue stream. "The Medicaid program is covering more kids, immigrants, and refugees that weren't here [pre-HealthChoice] in '97."⁵⁶²

A HealthChoice administrator agrees. There is a costly and "hugely increasing alien population" in Maryland.⁵⁶³ For example, HealthChoice funds a multi-language injury and complaint information hotline, which offers beneficiaries free and linguistically appropriate advice.⁵⁶⁴ Montgomery County, in particular, has printed much of its Medicaid materials in multiple languages.⁵⁶⁵ These efforts are in response to "language access laws,"⁵⁶⁶ which are expensive to maintain. Maryland also provides non-emergency care for certain undocumented aliens (see Table 7.3) and has an unusual state-funded hospital uncompensated care structure, which asserts one state official, makes it an attractive home to undocumented pregnant women; that funding is in jeopardy, however, because of massive budget cuts to the program.⁵⁶⁷

Table 7.3

Post-PRWORA Services Available to Certain Legal Immigrants

Legal Immigrants in Maryland Before 8/22/1996	Legal Immigrants in Maryland ON/After 8/22/1996
Family eligible for TCA	Family eligible for TCA
Family Eligible for Medical Assistance	Children/pregnant women eligible for Medical Assistance (state-funded) ⁵⁶⁸
Children eligible for Food Stamps	Children eligible for Food Stamps.

Source: Welfare Advocates⁵⁶⁹

Eligibility workers had difficulty differentiating refugees (whose federal share of Medicaid funding comes in part from the U.S. Office of Refugee Resettlement) from immigrants (whose federal share of Medicaid funding comes exclusively from the Centers for Medicare and Medicaid Services).

*We discovered that eligibility workers were extremely confused about who qualifies for Medical Assistance, TANF, etc., because they saw so few refugees and they fit them in their head under the immigrant category, and said, 'you have to wait five years or you're not eligible at all.' Under refugee medical assistance, they're eligible only for 8 months.... It seemed to me, pre-HealthChoice, that it rarely happened that a person would get their Medical Assistance cared with more than a few weeks left on it.*⁵⁷⁰

Another concern is that the package of information that HealthChoice sends out both to refugees⁵⁷¹ and to the general beneficiary population⁵⁷² is complicated and unclear.

*[Refugees enrolled in HealthChoice] will receive a packet of information that is extremely confusing. Some do nothing about it, and if they don't do anything of course they are assigned a provider, who may be on the other side of town and who they might not be able to get to because they don't drive or they don't know the bus system.*⁵⁷³

a. Post-PRWORA Pregnant Women and Children Medicaid Provision

In the eight years since the BBA was enacted, Medicaid funding for Maryland's immigrants has remained a political hot potato. In 2004, Maryland's DHMH Secretary estimated that Medicaid is funding as much as \$12 million worth of health care services to aliens who came to the area seeking health care. According to the Baltimore Sun, Maryland spent \$34 million for health care services to non-U.S. residents in 2003.⁵⁷⁴ The DHMH responded by issuing a policy alert informing clinicians that emergency care they provide to Maryland "visitors" will not be eligible for Medicaid reimbursement. The Secretary further suggested that the state develop a system to verify the visa status of Medicaid applicants. Such a national requirement actually came to pass when Congress enacted language in the Deficit Reduction Act of 2005 mandating proof of citizenship upon submitting a Medicaid application.

By 2005, there was a contentious debate over whether the Maryland governor would cut a \$7 million program for pregnant women and children classified as permanent legal residents for less than five years. Legislative analysts anticipate that the full cut would affect 4,000 people statewide. In response, the General Assembly set aside \$1.5 million to continue prenatal coverage for uninsured pregnant immigrant women, but the governor was undecided if he would spend the funds for this purpose.^{575, 576} Although prenatal care would no longer be covered by Medicaid, the program would continue to cover labor and delivery charges.⁵⁷⁷ This may cause parents to sacrifice routine checkups and wait until health conditions deteriorate enough to qualify for emergency care in hospital emergency rooms, suggested the health officer for Montgomery County's Department of Health and Human Services, adding that "we are effectively removing preventive care for them and that's only going to end up costing the county more."⁵⁷⁸

The governor chose to maintain prenatal care coverage for all pregnant women enrolled in Medicaid as of July 1, 2005 (for which the administration allocated \$3 million), but would not extend the coverage to any new enrollees,⁵⁷⁹ thus bringing Maryland in line with Medicaid policies that are in place in most other states.⁵⁸⁰ On July 1, 2005, funding was removed from the Maryland budget for State-only Medical Assistance coverage for certain aliens, namely children or pregnant women who qualify technically and financial for Medical Assistance or the Maryland Children's Health Program except that they are qualified aliens subject to the five-year ban who have not lived in the U.S. for that amount of time.⁵⁸¹

However, in response to a state Court of Appeals ruling in October 2006, Maryland reinstated the \$7 million program, upholding a Montgomery County Circuit

Court's injunction that blocked the cuts. In the lawsuit, filed by the Maryland Legal Aid Bureau, families of 13 immigrant children claimed discrimination against non-U.S. citizens over the removal of a Medicaid provision that provided benefits for 4,000 legal permanent residents. The Governor also reinstated enrollment for pregnant women.⁵⁸²

b. Immigrants Remain Largely Uninsured

The impact of PRWORA's anti-immigrant flavor and resentment of immigrants grew stronger in the aftermath of the tumultuous 1990s. Immigrant advocates are concerned that aliens have been and continue to avoid seeking health care services for fear of public charge labels, demands to pay back monetary worth of the services received, or of possible citizenship or deportation-related ramifications for themselves or family members. Data from Maryland's DHMH indicate that, regardless of family income, Maryland's non-citizens are significantly less likely than Maryland's citizens to have health insurance. In fact, although non-citizens comprise only 9 percent of the state's non-elderly population, it comprises nearly one-third of Maryland's uninsured population.⁵⁸³ Post welfare reform, Maryland's mixed status families still frequently do not get themselves or their children enrolled in Medicaid, despite eligibility.⁵⁸⁴ Indeed, says a University of Maryland researcher, the safety net for immigrants are often public hospitals and ERs only. The state is providing immigrant care, but it is doing so inefficiently and very expensively.⁵⁸⁵

Notes

⁴⁴³ Interview with Interviewee 4, p. 5.

⁴⁴⁴ Interview with Interviewee 2, p. 17.

⁴⁴⁵ Interview with Interviewee 4, p. 19.

⁴⁴⁶ Interview with Interviewee 4, p. 3.

⁴⁴⁷ Interview with Interviewee 5, p. 2.

⁴⁴⁸ Interview with Interviewee 10, pp. 5–7.

⁴⁴⁹ Interview with Interviewee 10, pp. 5–7.

⁴⁵⁰ Interview with Interviewee 9, p. 4.

⁴⁵¹ Interview with Interviewee 2, p. 2.

⁴⁵² Interview with Interviewee 4, p. 6.

⁴⁵³ Interview with Interviewee 4, p. 7.

⁴⁵⁴ Interview with Interviewee 5, p. 1.

⁴⁵⁵ Interview with Interviewee 5, p. 1.

⁴⁵⁶ Interview with Interviewee 5.

⁴⁵⁷ Gold, Mittler, and Lyons. *Managed Care and Low-Income Populations*.

⁴⁵⁸ *State Oversight of Integrated Health Systems: Maryland* (New York: Milbank, 1998 [cited 6 December 2005]). www.milbank.org/reports/stateoversight/990922soihs.html

⁴⁵⁹ Gold, Mittler, and Lyons. *Managed Care and Low-Income Populations*, pp. viii–xv.

⁴⁶⁰ Interview with Interviewee 4, p. 8.

⁴⁶¹ Interview with Interviewee 4, pp. 11–12.

⁴⁶² Interview with Interviewee 5, p. 3.

⁴⁶³ Gold, Mittler, and Lyons. *Managed Care and Low-Income Populations*, pp. xiv.

⁴⁶⁴ Interview with Interviewee 5, p. 3.

⁴⁶⁵ Gold, Mittler, and Lyons. *Managed Care and Low-Income Populations*, pp. 27–28.

⁴⁶⁶ Interview with Interviewee 10, pp. 1–2.

⁴⁶⁷ Interview with Interviewee 9, p. 3.

⁴⁶⁸ Interview with Interviewee 7, p. 6.

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- ⁴⁶⁹ Interview with Interviewee 9, p. 5.
- ⁴⁷⁰ Interview with Interviewee 9, pp. 4–5.
- ⁴⁷¹ Interview with Interviewee 3, p. 4 and 8.
- ⁴⁷² Interview with Interviewee 3, p. 8.
- ⁴⁷³ Interview with Interviewee 10, p. 9.
- ⁴⁷⁴ Interview with Interviewee 10, p. 10.
- ⁴⁷⁵ Interview with Interviewee 10, p. 2.
- ⁴⁷⁶ Interview with Interviewee 5, pp. 5–6.
- ⁴⁷⁷ Interview with Interviewee 9, p. 2.
- ⁴⁷⁸ The Kaiser Commission on Medicaid and the Uninsured. State Facts: Health Needs and Medicaid Financing KFF: Washington, DC: February 1998. As cited in Gold, Mittler, and Lyons. *Managed Care and Low-Income Populations*, p. 17.
- ⁴⁷⁹ Interview with Interviewee 6, p. 1.
- ⁴⁸⁰ Interview with Interviewee 9, p. 6.
- ⁴⁸¹ Interview with Interviewee 7, p.4.
- ⁴⁸² Interview with Interviewee 7, p.4.
- ⁴⁸³ Interview with Interviewee 4, pp. 4–5.
- ⁴⁸⁴ Interview with Interviewee 2, p. 18.
- ⁴⁸⁵ Maryland Department of Health and Mental Hygiene, HealthChoice Evaluation, Final Report & Recommendations. (January 15, 2002., Baltimore, MD [cited 17 December 2006]). <http://www.dhmf.state.md.us/mma/healthchoice/hcevalprestabcon.html>
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- ⁴⁸⁷ *Ibid*, p. 399.
- ⁴⁸⁸ Maryland Department of Health and Mental Hygiene, HealthChoice Evaluation, Final Report
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- ⁴⁹⁰ *Ibid*, p. 401.
- ⁴⁹¹ Interview with Interviewee 7, p. 11.
- ⁴⁹² Interview with Interviewee 3, p. 8.

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- ⁴⁹³ Interview with Interviewee 10, p. 9.
- ⁴⁹⁴ Interview with Interviewee 10, p.4.
- ⁴⁹⁵ Interview with Interviewee 3, p. 2.
- ⁴⁹⁶ Interview with Interviewee 10, p.4.
- ⁴⁹⁷ Interview with Interviewee 10, pp. 10–11.
- ⁴⁹⁸ Interview with Interviewee 4, pp. 6–7.
- ⁴⁹⁹ Interview with Interviewee 10, p. 14.
- ⁵⁰⁰ Interview with Interviewee 4, p. 18.
- ⁵⁰¹ Personal Correspondence with TE, March 23, 2006. Also see interview with Interviewee 13, p. 9.
- ⁵⁰² Maryland Qualified Health Centers are similar in structure to Federally Qualified Health Centers, but are located in areas that meet lower thresholds for provider-to-patient ratios.
- ⁵⁰³ Thomas R. Oliver, “The Collision of Economics and Politics in Medicaid Managed Care: Reflections on the Course of Reform in Maryland”; *Milbank Quarterly*, Vol. 76, No. 1, 1998, p. 85.
- ⁵⁰⁴ Interview with Interviewee 5.
- ⁵⁰⁵ Oliver, “The Collision of Economics and Politics in Medicaid Managed Care: Reflections on the Course of Reform in Maryland,” pp. 83–86.
- ⁵⁰⁶ Ibid pp. 83–86.
- ⁵⁰⁷ “Hopkins, Maryland Community Health System Establish Managed Care Organization for Maryland’s Medicaid Patients.” Press release, November 21, 1996. Contact listed: Gary Stephenson [cited 19 September 2005]. URL: www.hopkinsmedicine.org/press/1996/NOVEMBER/19966.HTM
- ⁵⁰⁸ Interview with Interviewee 10, p. 2.
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- ⁵¹⁰ John Morrissey, *Modern Healthcare*, 8/9/99, Vol. 29, Issue 32, p. 19.
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- ⁵¹³ Interview with Interviewee 10, pp. 3–4.
- ⁵¹⁴ Oliver, 1998.
- ⁵¹⁵ Gold, Mittler, and Lyons. *Managed Care and Low-Income Populations*, p. 31.
- ⁵¹⁶ Interview with Interviewee 4, pp. 22–23.

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- ⁵¹⁷ Interview with Interviewee 2, p. 16.
- ⁵¹⁸ Interview with Interviewee 12, pp. 3–4.
- ⁵¹⁹ Interview with Interviewee 4, p. 23.
- ⁵²⁰ Interview with Interviewee 4, p. 22.
- ⁵²¹ Interview with Interviewee 10, p. 15.
- ⁵²² Interview with Interviewee 3, pp. 1–2.
- ⁵²³ Interview with Interviewee 10, pp. 2–4.
- ⁵²⁴ Interview with Interviewee 5, p. 2.
- ⁵²⁵ Interview with Interviewee 5, p. 5.
- ⁵²⁶ Interview with Interviewee 12, pp. 2–3.
- ⁵²⁷ Interview with Interviewee 10, p. 6.
- ⁵²⁸ Interview with Interviewee 3, pp. 8–9.
- ⁵²⁹ Interview with Interviewee 2, p. 17.
- ⁵³⁰ Interview with Interviewee 2, p. 23.
- ⁵³¹ Interview with Interviewee 4, p. 22.
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- ⁵⁴¹ Interview with Interviewee 9, pp. 4–5.
- ⁵⁴² Interview with Interviewee 7, p. 4.
- ⁵⁴³ Interview with Interviewee 5
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- ⁵⁴⁷ Interview with Interviewee 4, p. 13.
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- ⁵⁴⁹ Ibid, Table 9.
- ⁵⁵⁰ Interview with Interviewee 5.
- ⁵⁵¹ Interview with Interviewee 5.
- ⁵⁵² See COMAR 10.09.65.08 -.11.
- ⁵⁵³ Maryland Department of Health and Mental Hygiene. *HealthChoice*.
- ⁵⁵⁴ Interview with Interviewee 7, p. 7.
- ⁵⁵⁵ Interviews with Interviewee 7, pp. 7–8, 10, and Interviewee 4, p. 14.
- ⁵⁵⁶ Interview with Interviewee 7, p. 16.
- ⁵⁵⁷ Ibid, p. 16.
- ⁵⁵⁸ Interview with Interviewee 1, p. 1.
- ⁵⁵⁹ Interview with Interviewee 9, p. 2.
- ⁵⁶⁰ Interview with Interviewee 4, pp. 15–16.
- ⁵⁶¹ Interview with Interviewee 7, pp. 14–15.
- ⁵⁶² Interview with Interviewee 5, pp. 11–12.
- ⁵⁶³ Interview with Interviewee 2, p. 9.
- ⁵⁶⁴ Interview with Interviewee 2, p. 14.
- ⁵⁶⁵ Interview with Interviewee 1, p. 1.
- ⁵⁶⁶ Interviews with Interviewee 1, p. 1 and Interviewee 9, p. 8.

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Chapter 8: Quantitative Analysis

This chapter looks first at the growth of uninsured in the nation and in Maryland. It then considers the prevalence of racial and ethnic disparities in Maryland generally, and finally examines the HCUP data and regression analyses looking at appendicitis care for patients in Maryland hospitals.

A. Population of Uninsured Grows

The significance of the growth in the uninsured population is perhaps obvious, but critical enough to state explicitly. Uninsured individuals face substantial access barriers to and have lower utilization of health care services.^{586,587, 588, 589} Because this study examines the impact of changes in the low-income health care market, which affects both the Medicaid and the uninsured populations, it is important to note population trends of both groups.

From 1987 through 2006, the uninsurance rates in Maryland and in the nation resemble a rollercoaster. The late 1990s and early 2000s saw declines in uninsured populations across the country, as illustrated in Figure 8.1. That trend, however, reversed itself by 2001, when the rates and the numbers of the uninsured population rose.

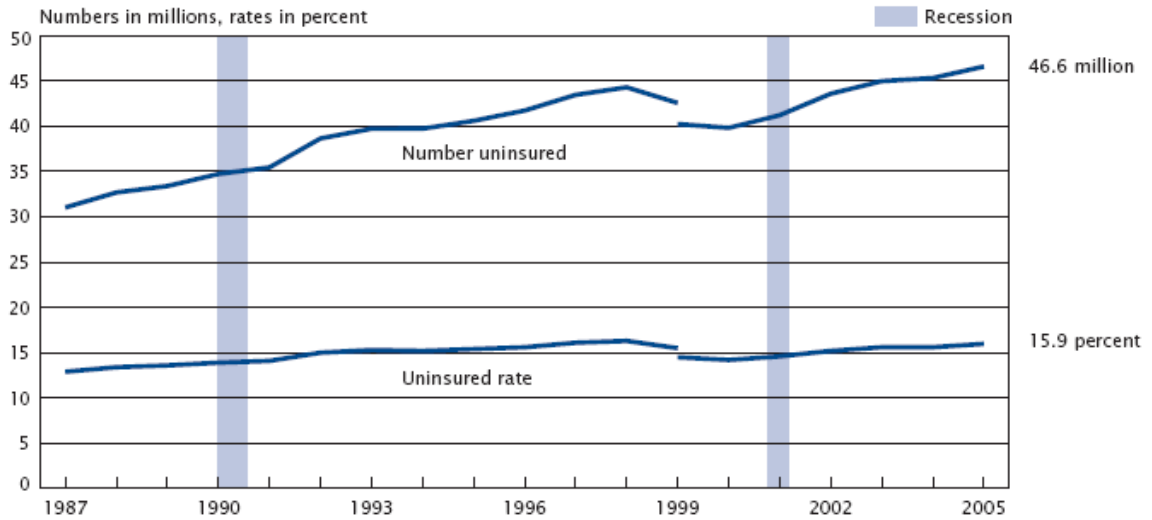


Figure 8.1. U.S. Number Uninsured and Uninsured Rate: 1987 to 2005.^{590, 591}
Source: U.S. Census Bureau, Current Population Survey, 1988 to 2006 Annual Social and Economic Supplements.⁵⁹²

The trends in Maryland closely mirror those of the United States. The percentage of uninsured Marylanders grew steadily from 1987 (10.9 percent of the state population) to 1995 (17.2 percent). Maryland's uninsured population rate dropped dramatically to its lowest point in nearly a decade (12.8 percent) in 1996, but as illustrated in Table 8.1, by 1998, it was at an all-time high at 18.9 percent.⁵⁹³ By 2000, the percent of uninsured Marylanders followed the national trend and fell substantially—to 11.8 percent.⁵⁹⁴ That trend was to reverse quickly, however. From 2001 to 2006, the percentage of Marylanders without health insurance increased 44 percent, and the associated medical bill exceeds \$2.4 billion annually.⁵⁹⁵

Table 8.1

Uninsured Rates in the United States and Maryland

Year	National Uninsured (%)	Maryland Uninsured (%)
2005	15.9	N/A
2004	15.7	16.1*
2003	15.6	16.1*
2002	15.2	15.0
2001	14.6	13.8
2000	14.0	11.8
1999	15.5	12.5
1998	16.3	18.9
1997	16.1	14.9

Source: U.S. Census⁵⁹⁶, National Center for Health Statistics^{597, 598}

*Number reflects 2003–2004 average as reported by the Kaiser Family Foundation.⁵⁹⁹

1. Immigrant Uninsurance Rates

The national picture for immigrants' access to insurance is even more concerning.

In 2005, the uninsured rate was 13.4 percent for the U.S. native population, 17.9 percent for naturalized citizens, 33.6 percent for the foreign-born population, and 43.6 percent for noncitizens. Indeed, in 1995, the proportion of the foreign-born population lacking health insurance coverage was about two and a half times that of the native population.⁶⁰⁰

2. Medicaid Enrollment

As more poor children in Maryland were being enrolled in Medicaid as a result of the Children's Health Insurance Program, which began in 1998, the percentage of uninsured state residents fell. To wit, the number of Maryland's Medicaid recipients increased from 339,000 in 1996—just before the federal Balanced Budget Act of 1997 passed—to 665,000 in 2000, and the percent of Maryland's Medicaid beneficiaries in managed care grew dramatically from 1996 (64 percent) to 2000 (81 percent). The number of Maryland Medicaid recipients per 100 persons below the federal poverty level grew from 74 in 1989–90 to 170 in 1999–2000.⁶⁰¹

B. Racial and Ethnic Health Care Disparities in Maryland

Racial and ethnic populations have been growing much faster than the white population. As noted in Table 5.2, while the total population increased 11 percent from 1990 to 2004, the growth rate was three percent for whites, 27 percent for blacks, and 84 percent for Hispanics.^{602, 603} Consider this growth within the national context of growing uninsurance rates, by race, as described in Table 8.2. As the uninsured population continues to grow, and to do so disproportionately among Hispanics, greater numbers of racial and ethnic minorities are at risk to lack access to health care.

Table 8.2

Uninsured (“Not Covered at Any Time”) in the United States by Race, 2003–2005 (in thousands)

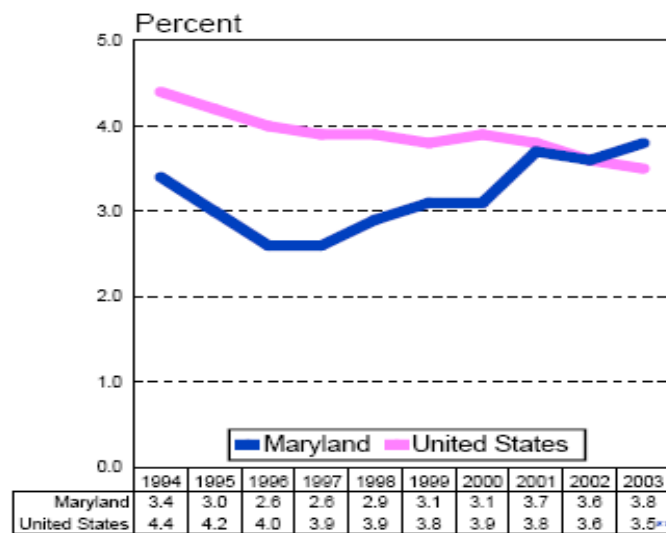
Racial Group	2003	2004	2005	Percent Change (2003-2005)
White, non-Hispanic	21,582	21,983	22,144	2.6
Black	7,080	7,186	7,228	2.1
Hispanic (any race)	13,237	13,678	14,122	6.7

Source: Bureau of Labor Statistics and the Bureau of the Census, 2003,⁶⁰⁴ 2004,⁶⁰⁵ and 2005⁶⁰⁶

Consider next the pervasive problem of disparities in health care delivery. Health care disparities exist in Maryland, as in the rest of the country. As quantified in the illustrations below, when compared to whites, blacks are less likely to receive prenatal care, are more likely to have low birth weight babies, greater percentages of low birth weight babies, higher infant mortality rates, higher death rates from various diseases, and shorter life expectancies. This was true before, during, and after the study period. Indeed, black Marylanders were three-to-four times as likely as their white counterparts to experience delays in receipt of, or simply to do without, prenatal care in each year between 1994 and 2003.

1. Prenatal Care

Access to prenatal care for American women as a whole improved steadily from 1994 to 2003. In Maryland, however, this trend was reversed in 1998, and that began a period of decreasing access among Marylanders that remained through 2003. Despite historically enjoying more frequent prenatal care access than their national counterparts, Maryland women experienced either late or no prenatal care at the same rate as U.S. women in 2002, and actually had poorer access by 2003 (see Figure 8.2).



*Figure 8.2. Percentage of Women Receiving Late or No Prenatal Care, Maryland & the United States, 1994–2003.**

Source: Maryland Vital Statistics Annual Report (2003). Maryland DHMH, Vital Statistics Administration.

* Maryland figures exclude women for whom timing of prenatal care was unknown. Late care refers to prenatal care which begins during the third trimester of pregnancy. The percentage of women receiving late or no prenatal care in Maryland has been increasing in recent years, in part as a result of more complete reporting of this variable on the birth certificate.

**2003 U.S. data preliminary.

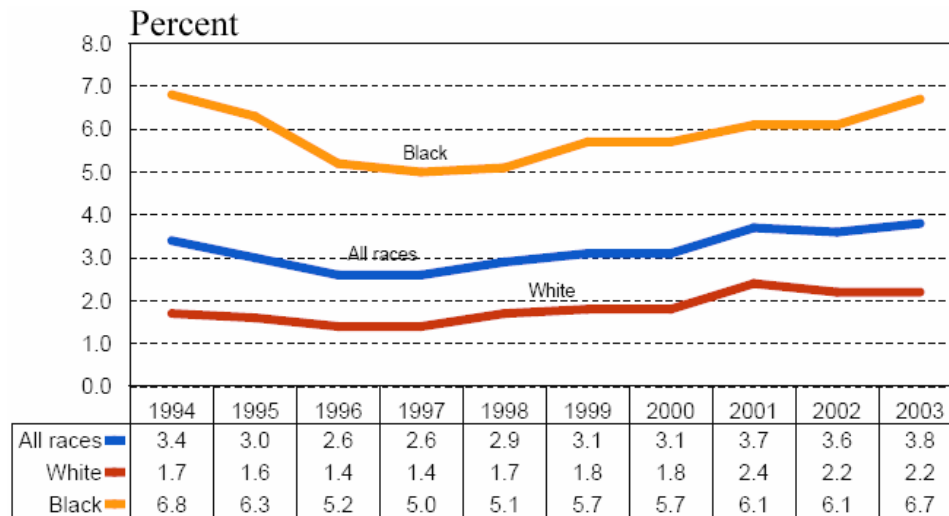
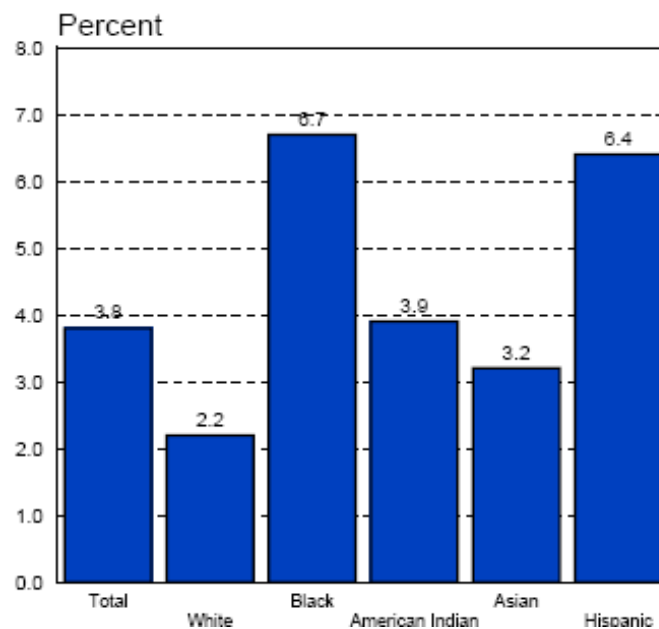


Figure 8.3. Percentage of Births to Women with Late or No Prenatal Care by Race, Maryland, 1994–2003.*

Source: Maryland Vital Statistics Annual Report (2003). Maryland DHMH, Vital Statistics Administration.

* Maryland figures exclude women for whom timing of prenatal care was unknown. Late care refers to prenatal care which begins during the third trimester of pregnancy. The percentage of women receiving late or no prenatal care in Maryland has been increasing in recent years, in part as a result of more complete reporting of this variable on the birth certificate.



*Figure 8.4. Percentage of Births to Women Receiving Late or No Prenatal Care by Race & Hispanic Origin***, Maryland, 2003.**

Source: Maryland Vital Statistics Annual Report (2003). Maryland DHMH, Vital Statistics Administration.

* Maryland figures exclude women for whom timing of prenatal care was unknown. Late care refers to prenatal care which begins during the third trimester of pregnancy. The percentage of women receiving late or no prenatal care in Maryland has been increasing in recent years, in part as a result of more complete reporting of this variable on the birth certificate.

***Persons of Hispanic origin may be any race.

Figure 8.3 demonstrates that prenatal care access was not distributed evenly across all races during the period from 1994 to 2003. In the last year of that window, blacks (6.7 percent) and Hispanics (6.4 percent) continued to be more likely than whites (2.2 percent) to suffer from delayed or no prenatal care (see Figure 8.4).

2. Infant Mortality

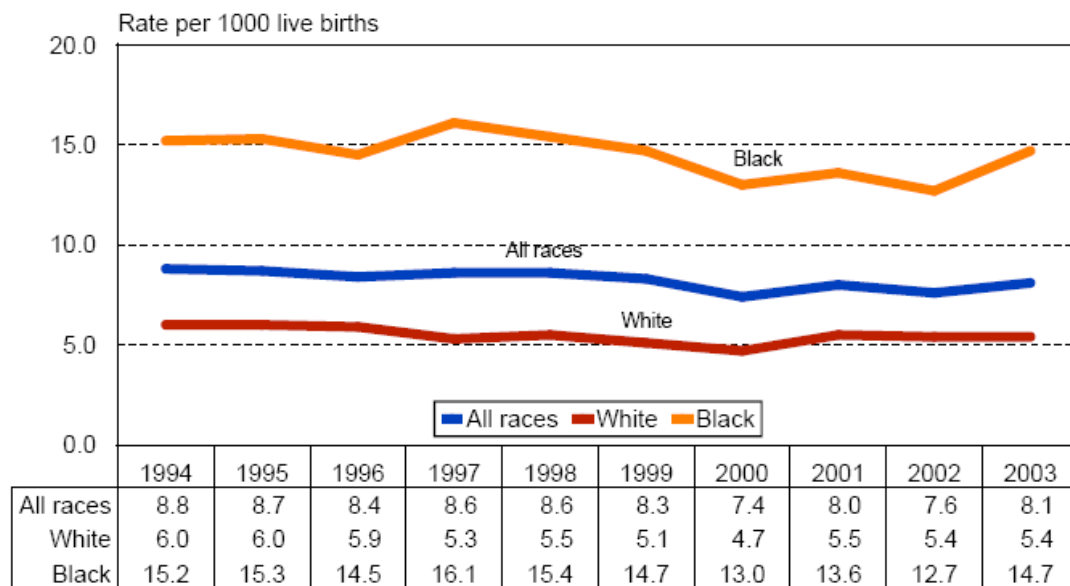


Figure 8.5. Infant Mortality by Race, Maryland, 1994–2003.

Source: Maryland Vital Statistics Annual Report (2003). Maryland DHMH, Vital Statistics Administration.

Figure 8.5 shows that whites experienced little variation in infant death rates from 1994 to 2003; the ten-year white mortality rate among peaked in 1994 and 1995 (6.0/1,000 births), recorded its lowest rate of the decade in 2000 (4.7/1,000), and rose again in 2001 (5.5/1,000). Infant mortality rates among blacks were more volatile during this time period, decreasing in 1996 (14.5/1,000), rising and peaking in 1997 (16.1/1,000), decreasing again from 1998 (15.4/1,000) through 2000 (13.0/1,000), increasing in 2001 (13.6/1,000), falling in 2002 (12.7/1,000), and finally gaining its greatest one-year increase in 2003 (14.7/1,000).

Infant death rates in Maryland exceed the national average in each year between 1994 and 2002. While the national rate fell slightly each year (until a slight increase from 6.8/1,000 in 2001 to 7.0/1,000 in 2002), the Maryland rate rose and fell three times—most sharply in 2000, when it dropped to its lowest level of the decade (7.4/1,000). Both the national and statewide peak was in 1994, at 8.0/1,000 and 8.8/1,000, respectively (see Figure 8.6).

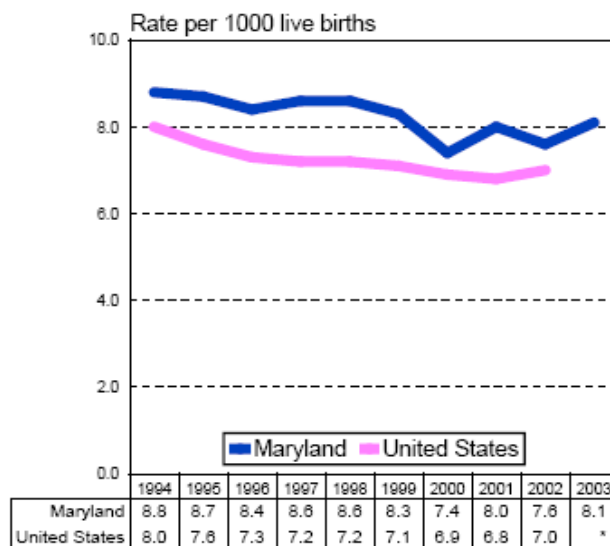


Figure 8.6. Infant Mortality, Maryland and United States, 1994–2003.

Source: Maryland Vital Statistics Annual Report (2003). Maryland DHMH, Vital Statistics Administration.

* 2003 U.S. data not available.

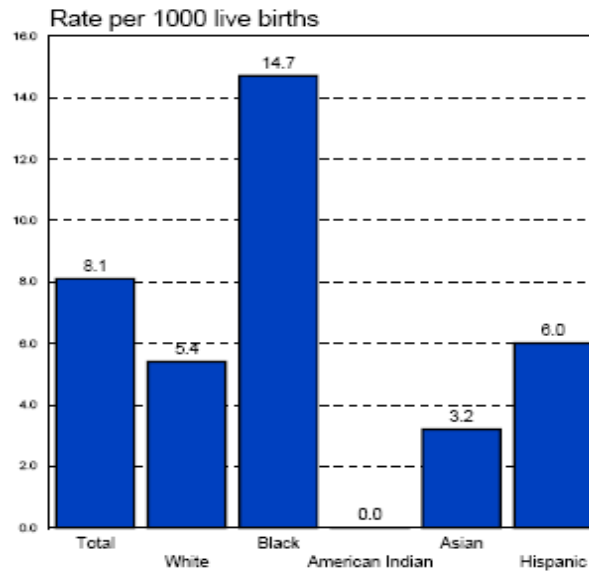


Figure 8.7. Infant Mortality by Race and Hispanic Origin Maryland, 2003.*

Source: Maryland Vital Statistics Annual Report (2003). Maryland DHMH, Vital Statistics Administration.

* Persons of Hispanic Origin may be of any race.

As Figure 8.7 demonstrates, the black infant mortality rate in 2003 (14.7/1,000) was nearly three times that of whites (5.4/1,000), and more than twice the rate for Hispanics (6.1/1,000). It is interesting to note that, while a similar percentage of blacks (6.7 percent) and Hispanics (6.4 percent) receive late or no prenatal care, black infants are so much more likely than Hispanic infants to suffer from LBW (13.1 percent versus 7.0 percent) or infant mortality (14.7/1,000 versus 6.0/1,000).

Adult minorities do not fare much better than their younger counterparts.

Although average life expectancy among Marylanders in 2003 was 77.0 years, it varies significantly by gender and race. Specifically, life expectancy was more than seven years lower for black males (68.7) than white males (76.0) and nearly five years lower for black females (76.0) than white females (80.9).⁶⁰⁷ The figures below indicate that blacks have been consistently dying at faster rates from heart disease, cerebrovascular disease, respiratory diseases, diabetes, and HIV/AIDS than are whites.

4. Heart Disease Deaths

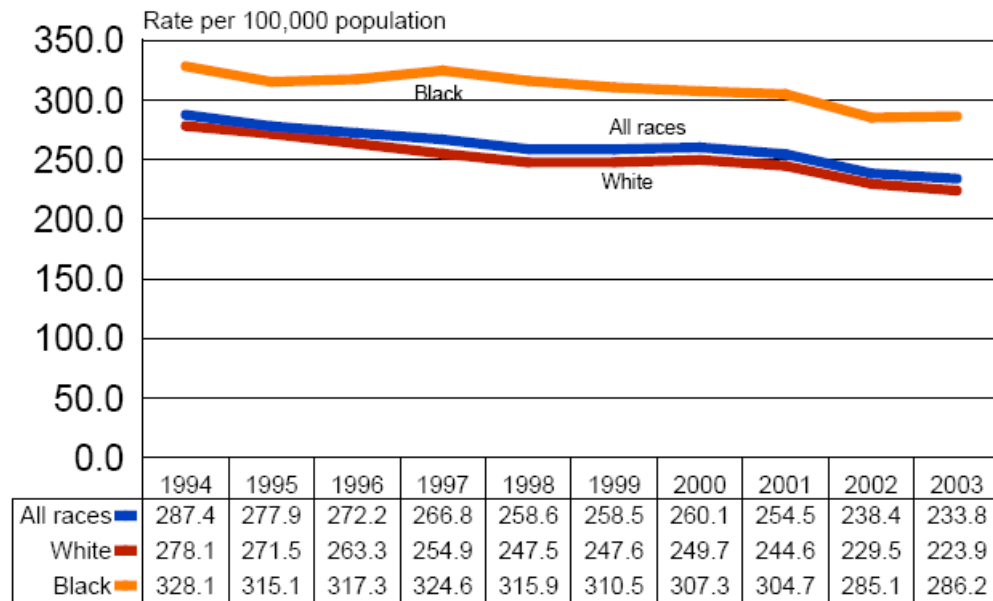


Figure 8.8. Age-Adjusted Death Rate for Diseases of the Heart by Race, Maryland, 1994–2003.*

Source: Maryland Vital Statistics Annual Report (2003). Maryland DHMH, Vital Statistics Administration.

*Death rates are age adjusted to the 2000 projected U.S. population.

As indicated in Figure 8.8, the age-adjusted death rate for heart disease in Maryland during 1994–2003 was consistently higher for blacks than whites. In 1994, the death rate for heart disease was at its ten-year height for whites (at 278.1/10,000), and fell steadily until landing at its lowest point (223.9/10,000) in 2003. The rate for blacks followed a similar pattern from 1994 to 1996 and 1998 to 2002, but peaked in 1997 (324.6/10,000); it ebbed in 2002 (285.1/10,000) and rose slightly in 2003 (286.3/10,000).

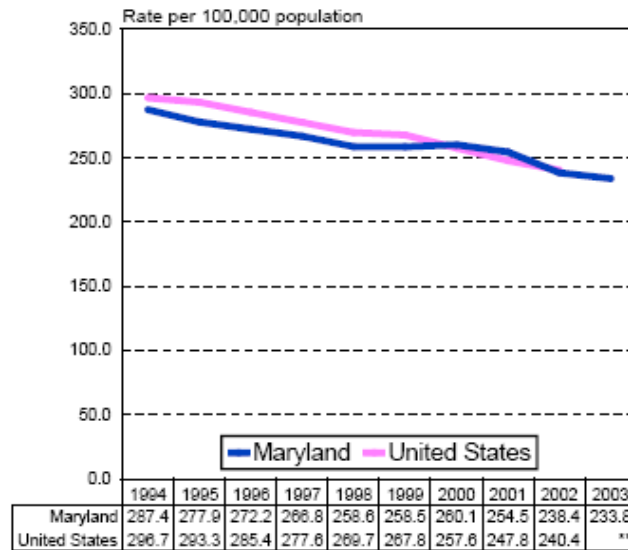


Figure 8.9 Age-Adjusted Death Rate* for Diseases of the Heart, Maryland and the United States, 1994–2003.

Source: Maryland Vital Statistics Annual Report (2003). Maryland DHMH, Vital Statistics Administration.

*Death rates are age adjusted to the 2000 projected U.S. population.

** 2003 U.S. data not available.

Figure 8.9 demonstrates that the death rate for heart disease fell nearly every year in Maryland, as it did in the United States, but the decline was faster on the national level. In 2000, Maryland's rate (260.1/100,000 population) exceeded that of the United States (257.6/100,000) for the first time during this period.

As indicated in Figure 8.10, males have a higher death rate for heart disease than do females, and rates for blacks again outpace those for whites. Specifically, black men (355.1/100,000) suffer a higher death rate for heart disease than white men (272.8/100,000), and black women (238.5/100,000) suffer a higher rate than white women (180.5/100,000).

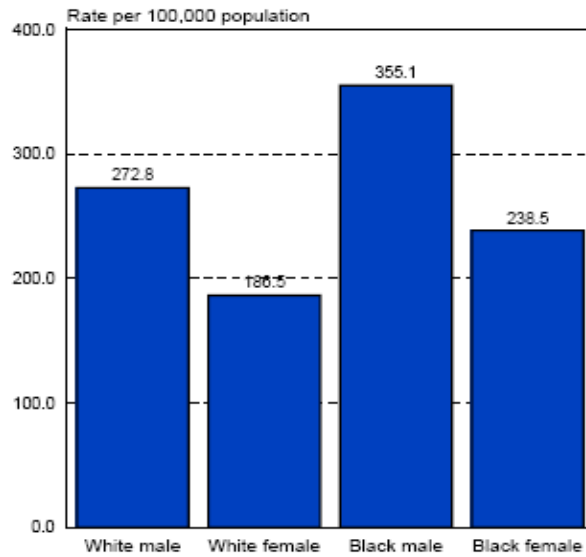


Figure 8.10. Age-Adjusted Death Rate for Diseases of the Heart by Race and Sex, Maryland, 2003.*

Source: Maryland Vital Statistics Annual Report (2003). Maryland DHMH, Vital Statistics Administration.

*Death rates are age adjusted to the 2000 projected U.S. population.

5. Cerebrovascular Disease Deaths

As with heart disease, the death rate from cerebrovascular diseases is higher for blacks for each of the ten years examined. Figure 8.11 shows that the rate declined slowly for whites for most of this period, remaining relatively stable from its height in 1995 (63.0/100,000) until it began to fall off more sharply in 2000 (at 59.2/100,000) and finally reached its low point in 2003 (49.9/100,000). During this window, the black death rate was highest in 1994 (84.2/100,000), declined steadily through 1998 (74.2/100,000), rose again in 1999 (78.7/100,000) again decreased until coming to its lowest point in 2002 (64.0/100,000), and finally turned upward again in 2003 (67.0/100,000).

Both the Maryland and the U.S. data in Figure 8.12 indicate sharp decreases from the nearly identical 1994 cerebrovascular disease death rates of 66.1/100,000 and 67.1/100,000, respectively. In 2002, the rates in Maryland and the United States again were nearly identical: 56.5/100,000 and 56.3/100,000. The decline was steadier for the United States, while Maryland experienced a lull between 1997 (63.1/100,000) and 2000

(63.0/100,000). By 2001, the Maryland rate again began to fall again and reached its low point in 2003 (53.3/100,000). Gender breakdowns in 2003 indicate no significant difference between the sexes (see Figure 8.13).

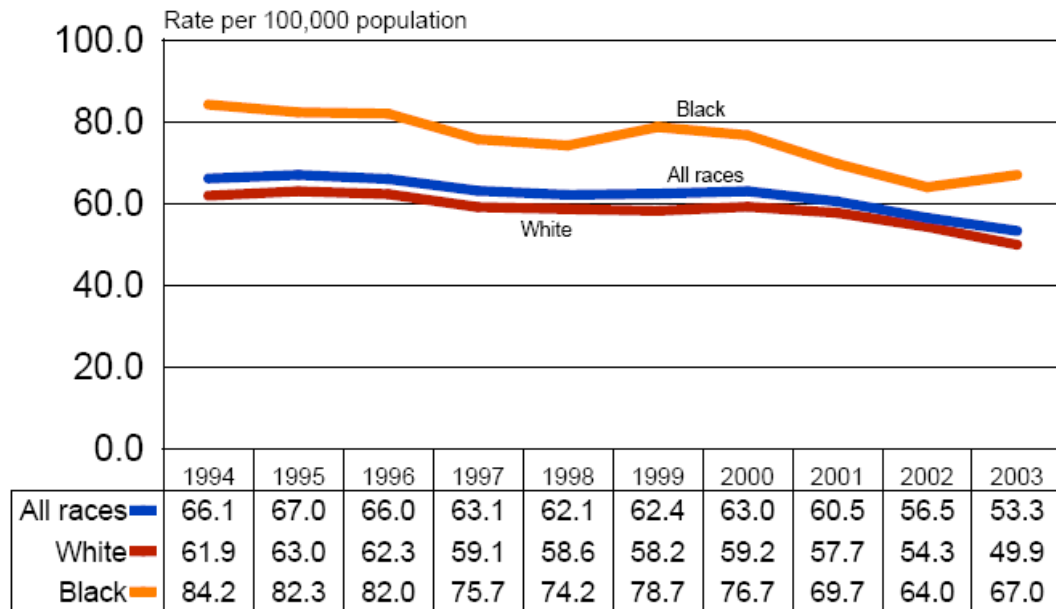


Figure 8.11. Age-Adjusted Death Rate for Cerebrovascular Diseases by Race, Maryland, 1994–2003.*

Source: Maryland Vital Statistics Annual Report (2003). Maryland DHMH, Vital Statistics Administration.

*Death rates are age adjusted to the 2000 projected U.S. population.

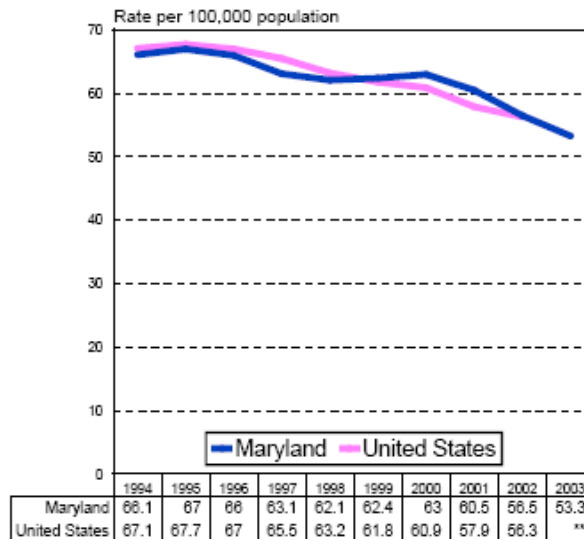


Figure 8.12. Age-Adjusted Death Rate for Cerebrovascular Diseases, Maryland and the United States, 1994–2003.*

Source: Maryland Vital Statistics Annual Report (2003). Maryland DHMH, Vital Statistics Administration.

*Death rates are age adjusted to the 2000 projected U.S. population.

** 2003 U.S. data not available.

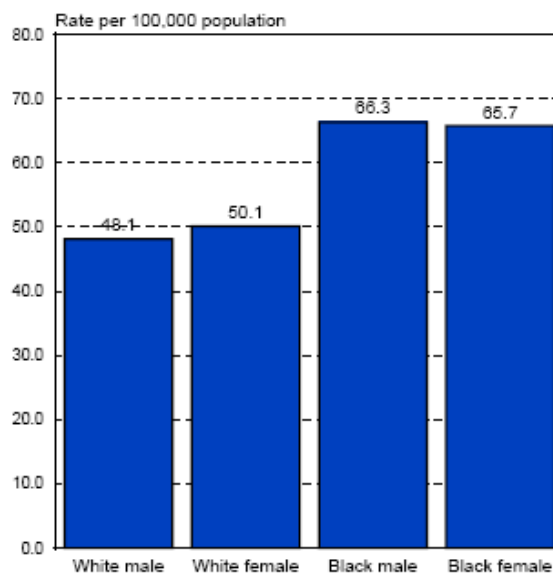


Figure 8.13. Age-Adjusted Death Rate for Cerebrovascular Disease by Race and Sex, Maryland, 2003.*

Source: Maryland Vital Statistics Annual Report (2003). Maryland DHMH, Vital Statistics Administration.

*Death rates are age adjusted to the 2000 projected U.S. population.

6. Chronic Lower Respiratory Disease Deaths

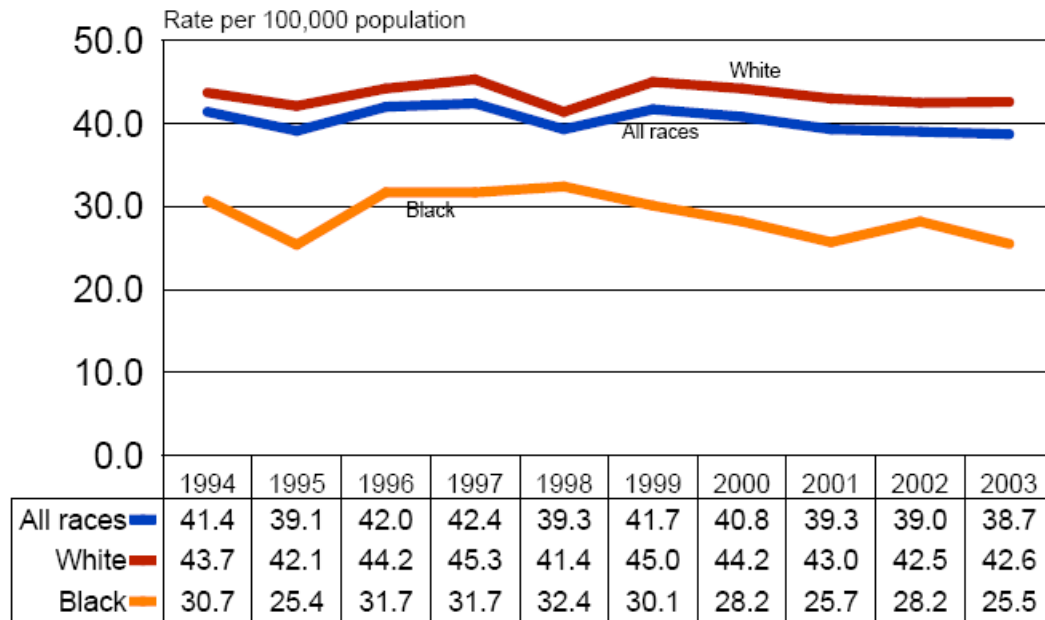


Figure 8.14. Age-Adjusted Death Rate* for Chronic Lower Respiratory Diseases by Race, Maryland, 1994–2003.

Source: Maryland Vital Statistics Annual Report (2003). Maryland DHMH, Vital Statistics Administration.

*Death rates are age adjusted to the 2000 projected U.S. population.

Chronic Lower Respiratory Disease (CLRD) is one of only three examples of data included in the Maryland Vital Statistics Annual Report for which the death rate for whites exceeds that for blacks. (The other two conditions, not included in this analysis, are Alzheimer's Disease and suicide.) As indicated in Figure 8.14, 1995 is the year of the greatest gap between CLRD death rates for blacks (25.4/100,000) and whites (42.1/100,000), and the time when the black rate is at its lowest point of the ten-year window (and the white rate is at its second-lowest point).

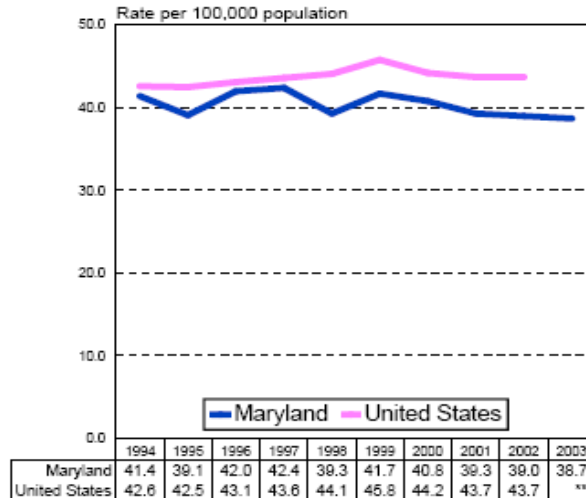


Figure 8.15. Age-Adjusted Death Rate for Chronic Lower Respiratory Diseases, Maryland and the United States, 1994–2003.*

Source: Maryland Vital Statistics Annual Report (2003). Maryland DHMH, Vital Statistics Administration.

*Death rates are age adjusted to the 2000 projected U.S. population.

** 2003 U.S. data not available.

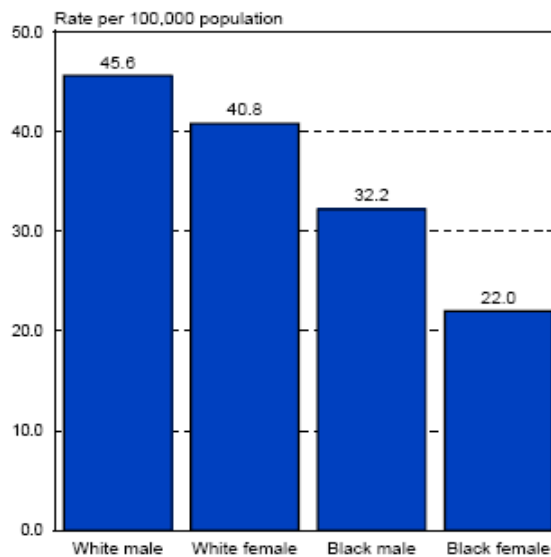


Figure 8.16. Age-Adjusted Death Rate for Chronic Lower Respiratory Diseases by Race and Sex, Maryland, 2003.*

Source: Maryland Vital Statistics Annual Report (2003). Maryland DHMH, Vital Statistics Administration.

*Death rates are age adjusted to the 2000 projected U.S. population.

While 1994 saw similar CLRD death rates in Maryland (41.4/100,000) and the United States (42.6/100,000), their trends did not mirror each other again until they both rose in 1999 and then both slowly declined. Maryland's rates remained below those for each of the nine years for which data was available (see Figure 8.15). Figure 8.16

demonstrates differentiation by race and gender in 2003, such that white males experienced the highest CLRD death rate (45.6/100,000), followed by white females (40.8/100,000), black males (32.2/100,000), and black females (22.0/100,000).

7. Influenza and Pneumonia Deaths

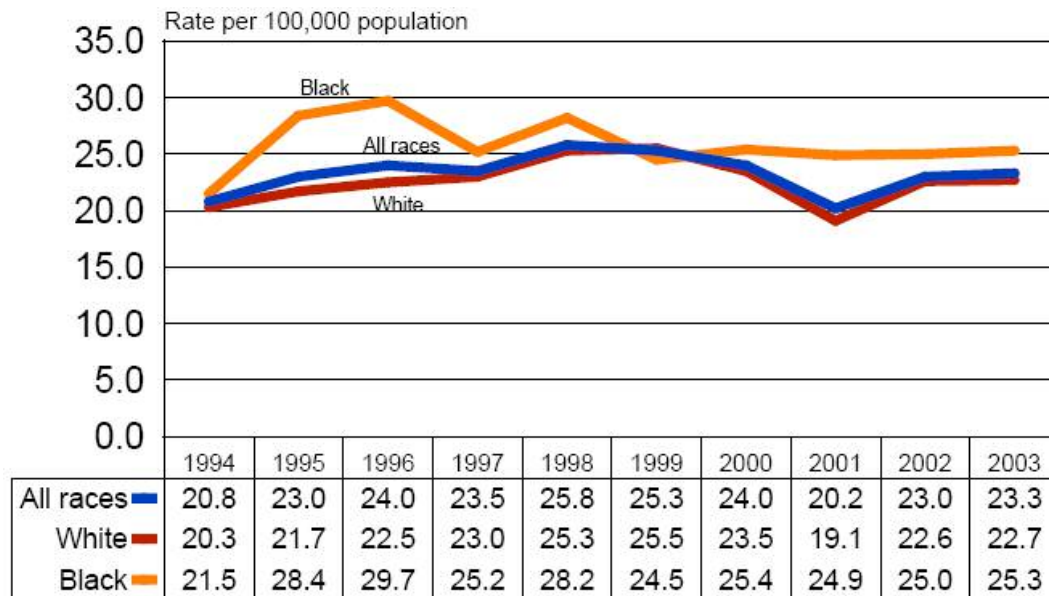


Figure 8.17. Age-Adjusted Death Rate from Influenza and Pneumonia by Race, Maryland, 1994–2003.*

Source: Maryland Vital Statistics Annual Report (2003). Maryland DHMH, Vital Statistics Administration.

*Death rates are age adjusted to the 2000 projected U.S. population.

Influenza and pneumonia are diseases for which there are vaccinations. Deaths from these illnesses, therefore, are often used as a proxy for poor access to primary care clinicians, who are able to provide patients with such immunizations. The data in Figure 8.17 indicate that the death rate for blacks was at its lowest point at the start of this ten-year window, in 1994 (21.5/100,000), and peaked just two years later in 1996 (at 29.7/100,000). It declined in 1997 (25.2/100,000), rose in 1998 (28.2/100,000), fell again in 1999 (24.5/100,000), increased again in 2000 (25.4/100,000), once again declined in 2001 (24.9), and then began climbing again in 2002 (25.0/100,000) and 2003

(25.3/100,000). The trend of influenza and pneumonia death rates for whites was smoother, increasing slowly from 1994 (20.3/100,000) until it peaked in 1999 (at 25.5/100,000), began its descent in 2000 (23.5/100,000), fell to its low point in 2001 (19.1/100,000), and again began rising again in 2002 (22.6/100,000) and 2003 (22.7/100,000). Interestingly, as the white rate peaked in 1999 (at 25.5/100,000), the black death rate for influenza and pneumonia dipped below it (to 24.5/100,000), apparently reversing the racial disparity for a 12-month period.

Over this ten-year period, Maryland's influenza and pneumonia death rate varied greatly, at times both dropping below and exceeding the national average (see Figure 8.18). The state death rate grew from 1994 (20.8/100,000) through 1996 (24.0/100,000), fell slightly in 1997 (23.5/100,000), peaked in 1998 (25.8/100,000), fell to its low point in 2001 (20.2/100,000), and began growing again in 2002 and 2003. Nationally, the death rate grew more slowly, but also peaked in 1998 (24.2/100,000).

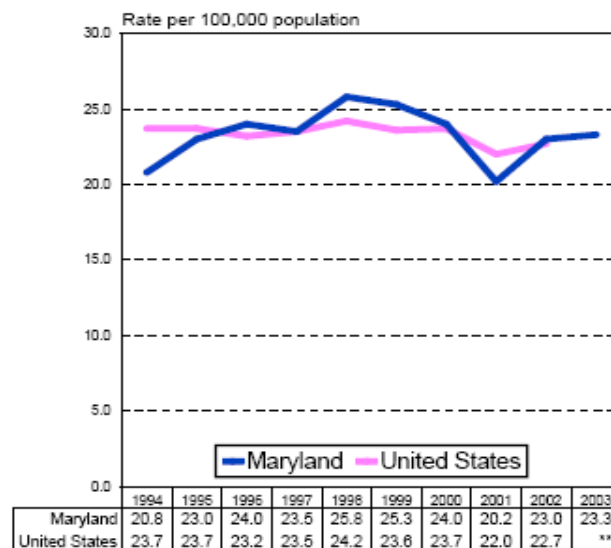


Figure 8.18. Age-Adjusted Death Rate from Influenza and Pneumonia, Maryland and the United States, 1994–2003.*

Source: Maryland Vital Statistics Annual Report (2003). Maryland DHMH, Vital Statistics Administration.

*Death rates are age adjusted to the 2000 projected U.S. population.

** 2003 U.S. data not available.

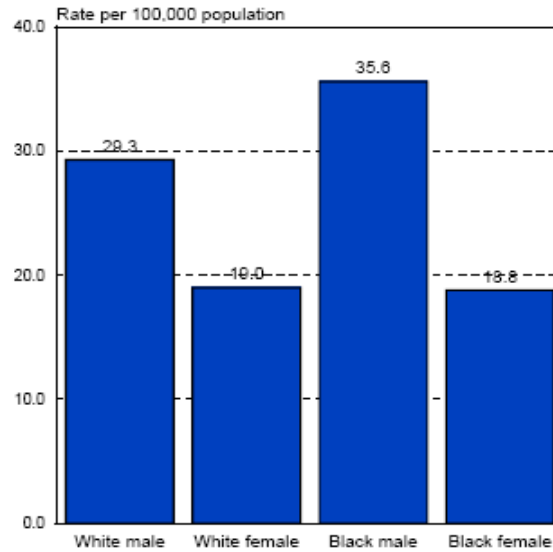


Figure 8.19. Age-Adjusted Death Rate from Influenza and Pneumonia by Race and Sex, Maryland, 2003.*

Source: Maryland Vital Statistics Annual Report (2003). Maryland DHMH, Vital Statistics Administration.

Maryland data from 2003, depicted in Figure 8.19, indicates virtually no difference between black and white women (18.8/100,000 and 19.0/100,000, respectively), but the male death rates vary more meaningfully by race; the influenza and pneumonia death rate for black men (35.6/100,000) exceeds that for white men (29.3/100,000).

8. Diabetes Deaths

Although the diabetes death rate for blacks is much greater than for whites throughout this period, Figure 8.20 indicates that the black rate steadily declined after 1999 (when it was 58.1/100,000). The high point for the diabetes death rate among blacks during this ten-year window occurred in 1995 (59.1/100,000), and its lowest point was in 2003 (49.9/100,000). Similarly, although there is some fluctuation over the decade, the white diabetes death rate peaked in 1994 (26.3/100,000) and its low point, like that of the black rate, was in 2003 (22.7/100,000).

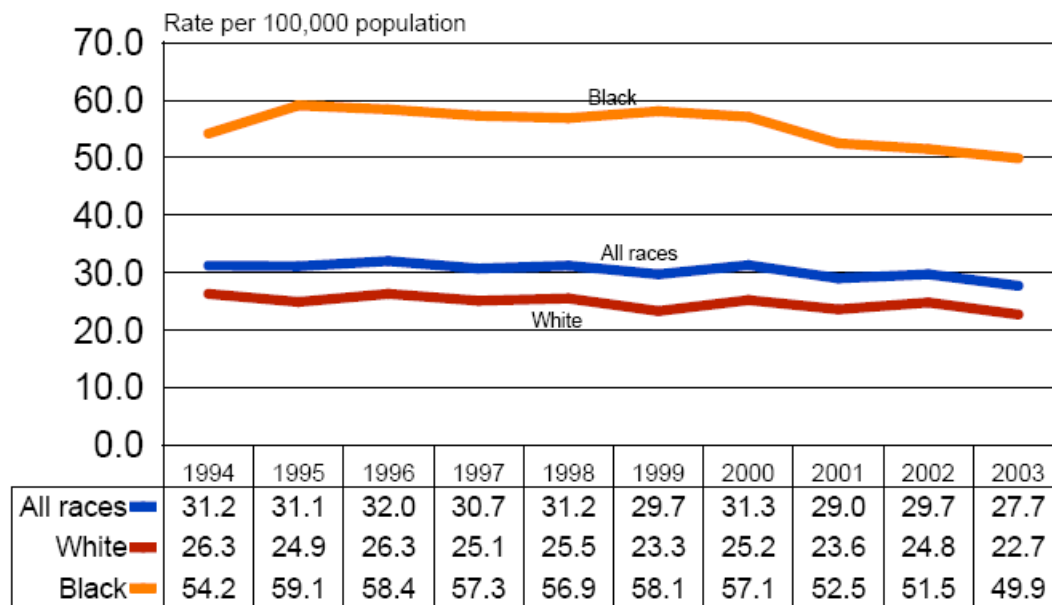


Figure 8.20. Age-Adjusted Death Rate for Diabetes by Race, Maryland, 1994–2003.*
Source: Maryland Vital Statistics Annual Report (2003). Maryland DHMH, Vital Statistics Administration.
*Death rates are age adjusted to the 2000 projected U.S. population.

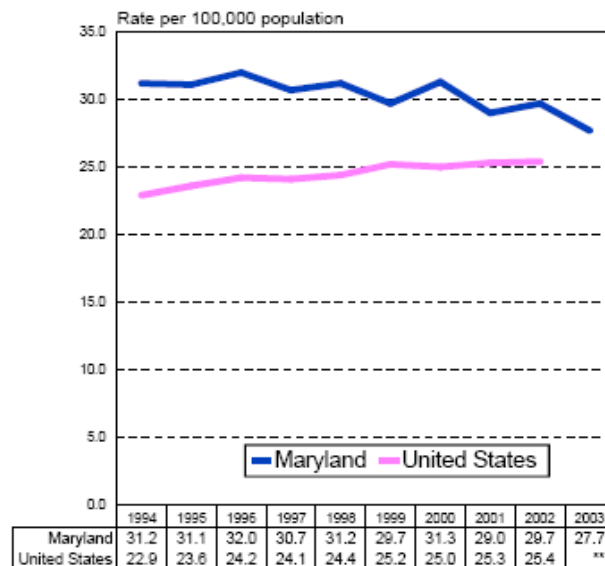


Figure 8.21. Age-Adjusted Death Rate for Diabetes, Maryland and the United States, 1994–2003.*
Source: Maryland Vital Statistics Annual Report (2003). Maryland DHMH, Vital Statistics Administration.
*Death rates are age adjusted to the 2000 projected U.S. population.

Figure 8.21 demonstrates that, while the U.S. rate climbed steadily from its lowest reading of the period in 1994 (22.9/100,000) to its height in 2002 (25.4/100,000), Maryland experienced the opposite trend; the state began in 1994 at its second-highest

level (31.2/100,000) and ended the decade in 2003 (27.7) at its lowest rate. Despite falling as the national rate rose, Maryland's diabetes death rate remained higher than the national rate for all nine years for which national data is available.

Race and gender differentials are evident in Figure 8.22, which depicts Maryland's diabetes death rates in 2003 by race and sex. Women experience lower death rates from diabetes than men, although the gender gap is smaller among blacks and whites. Black men have the highest diabetes death rate (54.2/100,000), followed by black women (46.8/100,000), white men (28.0/100,000), and white women (18.6/100,000).

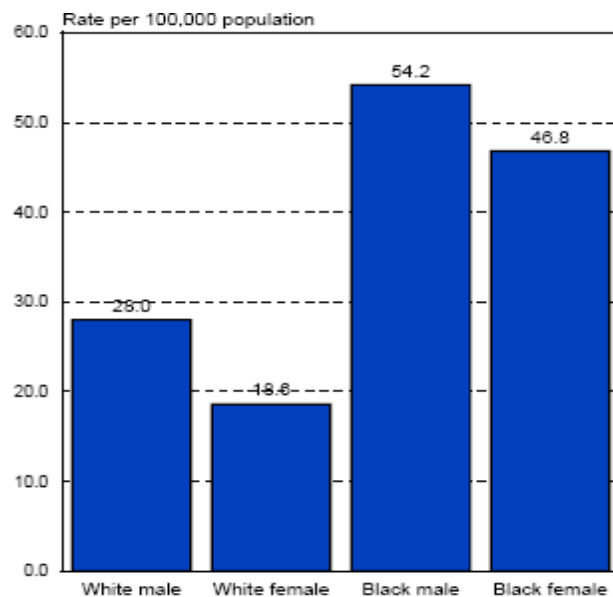


Figure 8.22. Age-Adjusted Death Rate for Diabetes by Race and Sex, Maryland, 2003.*
Source: Maryland Vital Statistics Annual Report (2003). Maryland DHMH, Vital Statistics Administration.
*Death rates are age adjusted to the 2000 projected U.S. population.

9. HIV Deaths

As illustrated in Figure 8.23, for both whites and blacks, the end of the ten-year period indicate far lower HIV death rates than in the earlier years. 1995 was the high point for both whites (8.6/100,000) and blacks (73.7/100,000), as well as for the substantial racial gap between the two. Racial disparities in the HIV death rate persist

during the entire decade, and for both whites and blacks, the rates creep up slightly toward the end of the window. Perhaps most profound in this data is the near-elimination of HIV deaths among whites, contrasted with the stubborn persistence of high rates of HIV deaths among Maryland's black population.

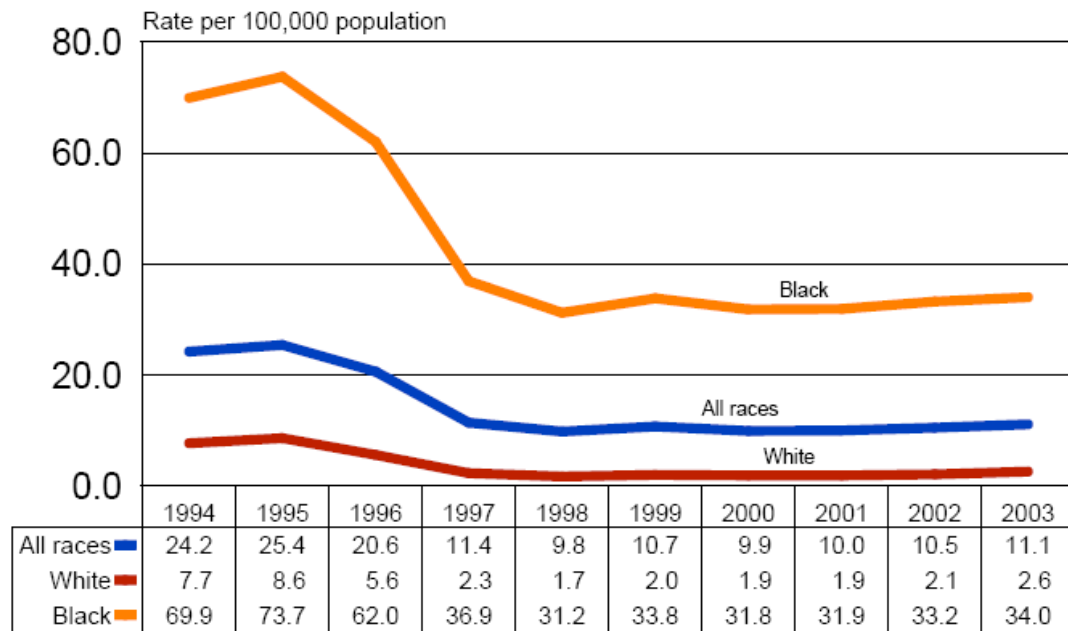


Figure 8.23. Age-Adjusted Death Rate for Human Immunodeficiency Virus (HIV), Maryland, 1994–2003.*

Source: Maryland Vital Statistics Annual Report (2003). Maryland DHMH, Vital Statistics Administration.

*Death rates are age adjusted to the 2000 projected U.S. population.

Both the United States and the state of Maryland experience the same pattern: very high death rates in 1994 and 1995, then dramatic decreases by 1997 and 1998 (see Figure 8.24). Maryland's HIV death rate began to rise slightly from 1999 (10.7/100,000) through 2003 (11.1/100,000), while the U.S. rate continued to drop.

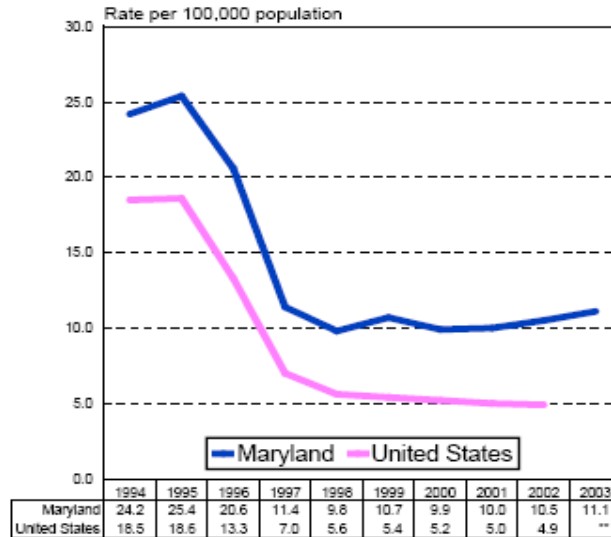


Figure 8.24. Age-Adjusted Death Rate for HIV, Maryland and the U.S., 1994–2003.*
Source: Maryland Vital Statistics Annual Report (2003). Maryland DHMH, Vital Statistics Administration.
*Death rates are age adjusted to the 2000 projected U.S. population.

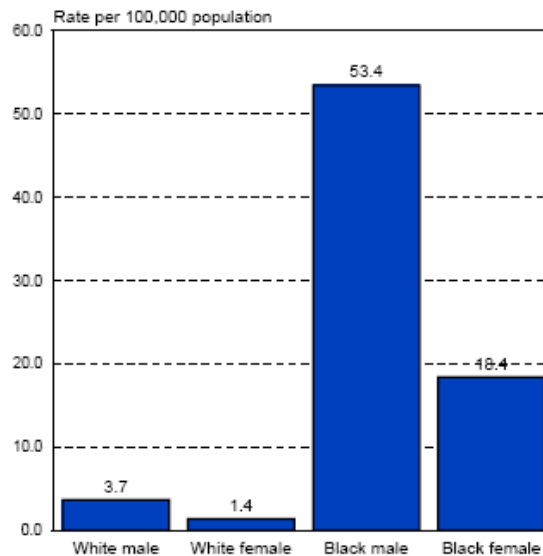


Figure 8.25. Age-Adjusted Death Rate for HIV by Race and Sex, Maryland, 2003.*
Source: Maryland Vital Statistics Annual Report (2003). Maryland DHMH, Vital Statistics Administration.
*Death rates are age adjusted to the 2000 projected U.S. population.

Data from Maryland in 2003 (see Figure 8.24) indicate that white women have the lowest rate (1.4/100,000), followed by white men (3.7/100,000), which is then juxtaposed to the significantly higher death rates among black women (18.4/100,000) and black men (53.4/100,000).

C. Quantitative HCUP Data Analysis: Perforated Appendicitis

The Healthcare Cost and Utilization Project (HCUP) offers a useful source of comprehensive Maryland data before and after the critical policy changes explored in this study. HCUP's State Inpatient Database (SID) provides patient-level demographic, diagnosis, and billing information that lends itself well to this study.

1. Avoidable Hospitalizations and Prevention Quality Indicators (PQIs)

“Ambulatory-care-sensitive conditions” can be thought of as “conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease.”⁶⁰⁸ To help track inpatient care provided for such conditions, investigators at Stanford University and the University of California developed a 16 “prevention quality indicators” (PQIs), a set of measures that are used with inpatient discharge data to identify the level of health care quality for ambulatory-care-sensitive conditions. PQI software, distributed by the U.S. Department of Health and Human Services’ Agency for Healthcare Research and Quality, can be applied to hospital inpatient administrative data (e.g., billing data available through the HCUP SID).⁶⁰⁹

While PQIs rely upon hospital inpatient data, they provide insight into the health care delivery system outside of the hospital setting. Indeed, these measures “provide a window into the community—to identify unmet community health care needs, to monitor how well complications from a number of common conditions are being avoided in the outpatient setting, and to compare performance of local health care systems across communities.”⁶¹⁰

2. Perforated Appendicitis

One such ambulatory-care-sensitive condition is perforated appendicitis. As explained in detail in Chapter 1, patients suffering with appendicitis who lack access to surgical evaluation can experience delays in obtaining necessary care, which can result in appendiceal perforation, a life-threatening condition.⁶¹¹

Appendicitis that progresses to appendiceal perforation is an ideal measure to explore for several reasons. First, virtually every case of appendicitis will rupture if left untreated, making those who fail to receive treatment in a timely fashion readily apparent. Secondly, there is no evidence that appendicitis strikes certain races or ethnicities more frequently. Therefore, assuming that this condition affects racial and ethnic groups equally, increased appendiceal perforation among a particular racial or ethnic population would indicate insufficient access to appendicitis care. It is also an informative measure because appendicitis is most frequently recognized by abdominal pain that grows increasingly more severe as time passes, and virtually all successfully-treated cases involve hospital visits and surgery. If we hypothesize that those with less ability to pay delay coming to the hospital in the hope that the pain will dissipate on its own, we should see increased likelihood of appendiceal perforation among low-income and uninsured populations.

Perhaps the most compelling reason to consider appendicitis is that HCUP uniquely captures delays in access to care along a gradation by using two measures: prevalence of appendiceal perforation and length of hospital stay for appendicitis. If we think of perforation as a stage of appendiceal inflammation, we can measure the condition as a continuous rather than a binary variable. This allows us to identify appendicitis patients

at advanced stages of inflammation whose appendices do not rupture (i.e., patients with near-perforation), as measured by length of stay for appendicitis treatment. This is explained in greater detail, below.

a. Appendiceal Perforation Prevalence and Length of Hospital Stay

This analysis examines two outcomes to measure disparities in appendiceal perforation by race and ethnicity. The first is prevalence of appendiceal perforation among appendicitis hospitalizations in 1996 and 2003, which indicates the degree to which racial and ethnic disparities existed in this condition before and after the study period. A second outcome is the length of stay appendicitis patients experience in the hospital, which is meant to capture the severity of the appendicitis (i.e., how close it is to rupture), variation in the degree of complications that patients may have encountered, as well as the patient's overall health upon entering the hospital.

Indeed, the measures of appendiceal perforation and length of stay due to appendicitis represent different levels of severity of the same problem: delayed presentation. As an appendicitis patient delays seeking care, the lining of the abdomen becomes increasingly inflamed and tender, and the infected appendix progresses closer to rupture. If the delay is long enough, the appendix will ultimately rupture, but poor outcomes from appendicitis occur along a continuum. If the delay is substantial and the appendix is extremely inflamed, the surgery is more complicated, requiring additional care to ensure that the appendix does not rupture during the appendectomy. The level of disease and infection can increase with delay, resulting in longer hospital stays.⁶¹²

b. Differences-in-Differences

To determine if variations in the outcome measures in Maryland were truly attributable to state-specific circumstances, data from another state with similar demographics and a similar Medicaid structure was selected and analyzed. If the same results occurred there, the findings may be generalizable to other states. If the results are different, perhaps there is something unique about Maryland that is worthy of attention. By comparing the two states, we can identify disparate trends that would require additional study before concluding that the policy changes described herein were a primary driver in observed outcomes. This “differences-in-differences” analysis is conducted by comparing Maryland to New Jersey for both 1996 and 2003.

3. Descriptive statistics

The combined New Jersey and Maryland database for both years indicate that a total of 18,120 individuals were hospitalized with appendicitis. Although more people had appendicitis in both states in 2003 than in 1996, the likelihood of appendiceal perforation decreased in both states during the interim seven years. (See Table 8.3.) Length of stay data is described as frequency of multi-day hospital stays for appendicitis in Tables 8.4 and 8.5, below.

In Maryland in 1996, most patients stayed 2 days (25 percent) or five or more days (30 percent). By 2003, the percentage of one-day stays in Maryland hospitals increased from 19 percent to 37 percent, and the number of 5 or more days decreased from 30 percent to 18 percent. New Jersey experienced similar trends. One-day hospital stays in the Garden State rose from 11 percent in 1996 to 26 percent in 2003, while hospital stays of 5 or more days decreased from 32 percent in 1996 to 22 percent in 2003.

Table 8.3

Number and Percent of Patients with Perforated Appendices (With Mortality Data)

	Year	Total	Not Perforated	Perforated	Percent Perforated	Number Died	Percent Died
Maryland	1996	2,462	1,548	914	37	13	.5
Maryland	2003	3,705	2,451	1,254	34	16	.4
New Jersey	1996	4,615	3,051	1,564	34	34	.7
New Jersey	2003	7,338	5,242	2,096	29	35	.5
Total		18,120	12,292	5,828	32	98	.5

Source: Author's tabulations from HCUP SID data.

Table 8.4

Number of Days in Hospital (Zero Through Two)

	Year	Total	No Stay	Percent with No Overnight Stay	1 day	Percent 1 day stay	2 days	Percent 2 day stay
Maryland	1996	2,462	39	0.02	477	0.19	617	0.25
Maryland	2003	3,705	128	0.03	1,364	0.37	843	0.23
New Jersey	1996	4,615	6	0	511	0.11	1,069	0.23
New Jersey	2003	7,338	31	0	1,919	0.26	2,001	0.27
TOTAL		18,120	204	0.01	4,271	0.24	4,530	0.25

Source: Author's tabulations from HCUP SID data.

Table 8.5

Number of Days in Hospital (Three Through Five or More)

	Year	Total	3 days	Percent 3 day stay	4 days	Percent 4 day stay	5 or more days	Percent 5+ day stay
Maryland	1996	2,462	351	0.14	240	0.10	738	0.30
Maryland	2003	3,705	438	0.12	261	0.07	671	0.18
New Jersey	1996	4,615	884	0.19	572	0.12	1,573	0.32
New Jersey	2003	7,338	1,128	0.15	653	0.09	1,606	0.22
TOTAL		18,120	2,801	0.16	1,726	0.1	4,588	0.25

Source: Author's tabulations from HCUP SID data.

From this preliminary analysis, it appears that the rate of appendiceal perforation has decreased slightly in recent years in both Maryland and New Jersey. Furthermore, there appears to be some decrease in the length of hospital stays for appendicitis patients.

4. Insurance Coverage and Appendiceal Perforation

An important consideration in explaining the degree of illness with which the patient presents at the hospital is the relationship between insurance coverage and appendiceal perforation. To ascertain this, chi square tests were performed to identify whether the type of insurance is related to appendiceal perforation. If insurance type does not matter, the incidence of patients with appendicitis that result in ruptures should be evenly distributed across the three insurance status categories: private, Medicaid, and uninsured.

Table 8.6

Cross Tabulations of Insurance Type and Appendiceal Perforation, Maryland

State & Year	Total	Type of Insurance	Percent With Perforated Appendix	Percent Without Perforated Appendix	P Value
MD 1996					0.07
		Private	37.35	62.65	
		Medicaid	42.55	57.45	
		Uninsured	32.49	67.51	
	<i>Total Percent Patients with Rupture</i>		37.12	62.88	
MD 2003					0.523
		Private	34.2	65.8	
		Medicaid	31.03	68.97	
		Uninsured	33.61	66.39	
	<i>Total Percent Patients with Rupture</i>		33.85	66.15	

Source: Author's tabulations from HCUP SID data.

Table 8.6 indicates that, in 1996, 42.6 percent of Maryland Medicaid-enrolled appendicitis patients experienced appendiceal perforation, compared with 37.4 percent of Maryland's privately-covered appendicitis patients. In New Jersey (see Table 8.7), 35.3 percent of patients with private insurance ruptured appendices while 29.8 percent of those on Medicaid experienced appendiceal perforation. By 2003, every insurance category experienced lower perforation rates, including the uninsured. Interestingly, for both years in both New Jersey, and Maryland, private insurance was most highly-correlated with appendiceal perforation. The chi-square test indicates that insurance status and the incidence of perforated appendicitis are statistically independent of each other in Maryland. No relationship exists between insurance status and likelihood of perforation in either year.

Table 8.7

Cross Tabulations of Insurance Type and Appendiceal Perforation, New Jersey

State and Year	Total	Type of Insurance	Percent With Perforated Appendix	Percent Without Perforated Appendix	P Value
NJ 1996					0.00
		Private	35.33	64.67	
		Medicaid	29.79	70.21	
		Uninsured	28.19	71.81	
	<i>Total % Patients with Rupture</i>		33.89	66.11	
NJ 2003					0.026
		Private	29.30	70.70	
		Medicaid	27.92	72.08	
		Uninsured	25.70	74.30	
	<i>Total % Patients with Rupture</i>		28.56	71.44	

Source: Author's tabulations from HCUP SID data.

In New Jersey, the story is slightly different. As indicated in Table 8.7, there appears to be a relationship between insurance type and likelihood of perforated appendicitis in 1996 and 2003, with those who have private insurance the most likely to have experienced a perforated appendix, though rates are lower in 2003 than in 1996.

Possible reasons for this could include improved access under managed care in both the Medicaid and private markets, greater awareness of the dangers posed by appendicitis symptoms, or perhaps shorter delays from the point of entry in the hospital to the appendectomy.

The next two tables offer data on racial distributions of perforated appendices in 1996 and 2003 in both Maryland and New Jersey. Data in the first, Table 8.8, indicates that 37 percent of Maryland's appendicitis patients in 1996 experienced appendiceal perforation. Moreover, while the results are not statistically significant, racial and ethnic differences exist. Maryland's Black and Hispanic appendicitis patients in 1996 were more likely than white patients to experience rupture, while Asian patients were nine percentage points *less* likely than white patients to suffer appendiceal perforation. By 2003, Maryland's Asian appendicitis patients were only about two percentage points less likely than white patients to experience rupture, but we see an interesting reversal with other groups: appendicitis patients who are blacks and Hispanics are now *less* likely than white patients to suffer a rupture.

New Jersey's black appendicitis patients, as described in Table 8.9, were more likely than whites in 1996 to experience perforation, but like their Maryland counterparts, were *less* likely to do so in 2003. Meanwhile, patients who are Asian, Hispanic, or of

other races were significantly less likely than whites to have a perforated appendix in both years.

Table 8.8

Cross Tabulations of Race and Ethnicity and Appendiceal Perforation in Maryland.

State and Year	Total	Racial and Ethnic Categories	Percent Perforated	Percentage Point Racial or Ethnic Disparity, vs. White	P Value
MD 1996					0.286
		White	36.32	0.00	
		Black	40.39	4.07	
		Asian	27.27	-9.05	
		Hispanic	40.96	4.64	
		Other Races	38.46	2.14	
	<i>Total % Patients with Rupture</i>		37.12	0.80	
MD 2003					0.093
		White	35.10	0.00	
		Black	32.64	-2.46	
		Asian	33.33	-1.77	
		Hispanic	28.72	-6.38	
		Other Races	27.20	-7.90	
	<i>Total % Patients with Rupture</i>		33.85	-1.25	

Source: Author's tabulations from HCUP SID data.

Unlike the Maryland cohort, the 2003 New Jersey data indicate that ruptures decreased during the seven-year interim for each racial and ethnic group. Moreover, Hispanics in New Jersey fared much better than their Maryland counterparts in both 1996 (when this group experienced a 27 percent perforation rate) and in 2003 (when the rate fell to 23 percent). Statistical power is greater in New Jersey, where we can reject the null hypothesis and conclude that race and ethnicity is correlated with appendiceal rupture for both 1996 and 2003. This indicates that there are likely different issues at play in the two states, particularly among the Hispanic populations.

Table 8.9

Cross Tabulations of Race and Ethnicity and Appendiceal Perforation in New Jersey.

State and Year	Total	Racial and Ethnic Categories	Percent Perforated	Percentage Point Racial or Ethnic Disparity, vs. White	P Value
NJ 1996					0.001
		White	35.46	0.00	
		Black	35.62	0.16	
		Asian	26.55	-8.91	
		Hispanic	27.23	-8.23	
		Other Races	30.03	-5.43	
	<i>Total % Patients with Rupture</i>		<i>33.89</i>	<i>-1.57</i>	
NJ 2003					0.00
		White	30.92	0.00	
		Black	28.78	-2.14	
		Asian	23.26	-7.66	
		Hispanic	22.59	-8.33	
		Other Races	25.32	-5.60	
	<i>Total % Patients with Rupture</i>		<i>28.56</i>	<i>-2.36</i>	

Source: Author's tabulations from HCUP SID data.

5. Multivariate Analyses

a. Perforated Appendicitis as Dependent Variable

Race and ethnicity, however, is only one factor among many that predict appendiceal perforation. For this reason, several multivariate probit regression analyses were conducted using race and ethnicity, as well as gender, age, and insurance status variables. Ultimately, this analysis explores the link between insurance coverage and appendiceal perforation in a multivariate model. The most comprehensive regression results are shown in Table 8.10, below. It asks the question: controlling for other factors, to what degree does race, ethnicity, or insurance status affect likelihood for appendicitis to worsen into appendiceal perforation?

i. Maryland 1996

The results reported in table 8.10 indicate that in 1996 and holding age, gender, race, and ethnicity constant, Maryland Medicaid patients with appendicitis were 11 percentage points more likely than privately insured patients to experience a ruptured appendix ($p<.05$). Moreover, older patients are more likely than their younger counterparts to experience perforation. Specifically, compared to those aged 18 to 29, those aged 30 to 44 (by 13 percentage points, $p<.01$), and those 45 to 59 (by 30 percentage points, $p<.01$), and those aged 60 or older (by 46 percentage points, $p<.01$) are all more likely to have an appendiceal perforation.

Three other interesting findings that fall shy of statistical significance: blacks (by 6 percentage points) and Hispanics (by 10 percentage points) are more likely than whites, and men were more likely than women (by 5 percentage points) to experience appendiceal perforation once insurance type, gender, and age are controlled.

While the coefficients for “other race” are not statistically significant, and the coefficient for “black” is only statistically significant in 1996, it is important to note that patients of these racial groups are more likely than white patients to have a ruptured appendix once other factors are controlled. Similarly, Asians are less likely than whites and the uninsured are more likely than the privately insured to experience appendiceal perforation, but again, these results fall short of statistical significance.

ii. Maryland 2003

By 2003, the picture was very different. In a multivariate model controlling for race, ethnicity, gender, age, and insurance type, gender and age are the only statistically significant factors that can predict rupture. Men continued to be more likely than women (6 percentage points) to experience appendiceal perforation, and this finding is

statistically significant ($p < .01$). Similarly, older patients are statistically more likely ($p < .01$) than those aged 18 to 29 to experience perforation.

Table 8.10

Regressions Using Perforated Appendicitis as Dependent Variable, by Year and State

	MD 1996	MD 2003	NJ 1996	NJ 2003
Black	0.064	-0.009	0.029	-0.009
	(2.37)*	-0.42	-1.12	-0.42
Hispanic	0.097	-0.017	-0.022	-0.042
	-1.68	-0.55	-0.87	(2.67)**
Asian	-0.082	-0.003	-0.058	-0.058
	-1.06	-0.07	-1.6	-1.72
Other Race	0.018	-0.045	-0.019	-0.028
	-0.26	-1.02	-0.68	-1.56
Female	-0.052	-0.059	-0.06	-0.038
	(2.55)*	(3.69)**	(4.15)**	(3.53)**
Age 30–44	0.125	0.106	0.121	0.045
	(5.03)**	(5.01)**	(6.53)**	(3.16)**
Age 45–59	0.303	0.274	0.304	0.211
	(9.96)**	(11.74)**	(13.60)**	(13.15)**
Age 60 or +	0.46	0.39	0.452	0.379
	(13.46)**	(13.50)**	(18.41)**	(19.01)**
Medicaid	0.112	0.029	-0.005	0.01
	(2.79)**	-0.95	-0.12	-0.28
Uninsured	0.023	0.067	0.02	0.041
	-0.73	(2.67)**	-0.99	(2.64)**
Observations	2462	3705	4615	7338

Source: Author's tabulations from HCUP SID data.

Z statistics in parentheses. All standard errors have been corrected for heteroscedasticity.

* significant at 5 percent; ** significant at 1 percent.

A new story emerges for different insurance categories: the Medicaid effect evens out, and the uninsured become 7 percentage points more likely than the privately insured to experience appendiceal perforation ($p < .01$). Medicaid is associated with a slight increased risk of perforation (3 percentage points), but the finding is no longer statistically significant. Also noteworthy, although not statistically significant, is that all examined racial and ethnic minorities are less likely than whites to experience ruptures.

iii. New Jersey 1996

The same multivariate analysis indicates that in New Jersey in 1996, gender and age are the only statistically significant factors predicting appendicitis perforation. As in Maryland, and holding race, ethnicity, gender, and insurance status constant, men are more likely (by 6 percentage points) than women to do so, as are older populations.

Racial and ethnic factors are not statistically significant, and tell a somewhat different story from Maryland. All minority racial and ethnic group appendicitis patients fare better than white patients. To wit, compared with whites, blacks are 2 percentage points more likely, while Hispanics (by 2 percentage points), Asians (by 6 percentage points), and others (by 2 percentage points) are less likely to experience appendiceal perforation. Also of note: Medicaid patients are one percentage point more likely and the uninsured are two percentage points less likely to suffer from a rupture, though this difference is not statistically significant.

iv. New Jersey 2003

Seven years later, the story changed slightly. Holding race, ethnicity, gender, and insurance status constant, men continue to be more likely than women (by 4 percentage points), and that those aged 45–59 and 60 and above are more likely than 18–29 year olds (here, by 21 percentage points and 38 percentage points, respectively) to have a perforated appendix. Also statistically significant is that Hispanics are 4 percentage points less likely than whites ($p < .01$), 30–44 year olds are less likely than 18–29 year olds ($p < .002$), and the uninsured are 4 percentage points more likely than the privately insured to experience appendiceal perforation.

v. Discussion of Race and Ethnic Differences in Appendiceal Perforation Rates

When holding gender, age, and insurance status constant, the racial and ethnic disparities for appendiceal perforation have virtually disappeared in both Maryland and New Jersey. Before the changes in Maryland's low-income health care market (LIHCM) that occurred in the mid-1990s, Maryland black appendicitis patients were 4.07 percentage points more likely to suffer appendiceal perforation. By 2003, this group was actually 2.46 percentage points *less* likely to experience appendiceal perforation. The same trend is observed for Hispanics, who in 1996 were 4.64 percentage points more likely than whites to have appendiceal perforation, but in 2003 were 6.38 percentage points *less* likely to do so—an improvement of 11.02 percentage points. These trends are repeated in the New Jersey data, where the data achieve statistical significance.

If managed care actually improves access to care, the reversal of racial and ethnic disparities in appendiceal perforation rates may be explained by the fact that racial minorities are disproportionately in health systems that operate under a managed care structure (either via Medicaid or the private sector).

vi. Appendiceal Perforation by Insurance Type, Controlling for Race, Ethnicity, Gender, and Age

The multivariate regression analysis provides a more robust picture than the Chi Square analysis on the importance of insurance status as a predictor of appendiceal perforation. In Maryland, perforation in Medicaid appendicitis patients was more likely than their privately insured counterparts for both 1996 and 2003, but the degree of the difference decreased by 2003. This suggests that managed care could be providing better access to Medicaid patients than the former fee-for-service Medicaid model. These results are very different in New Jersey, where patients covered by Medicaid were *less*

likely in 1996 and *more* likely in 2003 to experience perforation compared to those with private insurance. Perhaps New Jersey's Medicaid managed care program is not performing as well as HealthChoice.

The story is similar in both states for uninsured appendicitis patients: holding race, gender, and age constant, the uninsured are more likely than the privately insured to experience appendiceal perforation in both Maryland and New Jersey in both years. Moreover, the likelihood of appendiceal perforation among the uninsured increases in 2003 for both states, and the difference is statistically significant at the .01 level. This supports the author's hypothesis that those less able to pay probably delay coming to the hospital. It also corroborates the qualitative findings that, as the reimbursement mechanisms for Medicaid became more rigid and, in Maryland, improved the outcomes for Medicaid patients, uninsured patients fared worse.

Uninsured Populations: Racial and Ethnic Disparities?

Examining at the uninsured population in isolation of the other insurance types suggests that race and ethnicity are not a major determinant. In Maryland in 1996, controlling for race, gender, and age, uninsured black appendicitis patients are 3 percentage points more likely and uninsured Hispanic appendicitis patients are 14 percentage points more likely to experience perforation than their white counterparts. (These differences do not reach statistical significance.) However, by 2003, Maryland's uninsured black and uninsured Hispanic appendicitis patients are actually *less* likely than their white counterparts to experience perforation. (Again, the differences are not statistically significant.)

In New Jersey, uninsured black appendicitis patients are less likely than their white counterparts to suffer appendiceal perforation in both 1996 and 2003. New Jersey's Hispanic appendicitis patients are only slightly more likely (i.e., by .02 percentage points) than whites to experience perforation in 1996, and as in Maryland, actually become *less* likely than white appendicitis patients to suffer perforation in 2003.

The sample sizes are very small, (see Table 8.11), but even when combining Maryland and New Jersey for each of the years, the trend remains the same: blacks and Hispanics are more likely in 1996 and less likely in 2003 to experience appendiceal perforation. This indicates that insurance status, rather than race, is the core indicator of access to care.

Table 8.11
Sample Sizes for Uninsured with Perforated Appendicitis, by Black and Hispanic

State	Year	Black	Hispanic
Maryland	1996	27	17
Maryland	2003	39	28
New Jersey	1996	23	53
New Jersey	2003	30	131

Source: Author's tabulations from HCUP SID data.

b. Multivariate Results for Length of Stay

Perhaps a more revealing picture is evident when examining another dependent variable: length of stay in the hospital for appendicitis. This analysis asks the question: to what degree does race, gender, age, or insurance status affect the length of stay for appendicitis patients? For the purposes of this analysis, we ignore the incidence of perforation and consider solely length of hospitalization.

Table 8.12

Length of Stay as Dependent Variable

	MD 1996	MD 2003	NJ 1996	NJ 2003
Black	0.576	0.649	0.465	0.44
	(7.51)**	(9.95)**	(6.71)**	(6.19)**
Hispanic	0.058	0.01	0.194	0.2
	-0.35	-0.1	(2.94)**	(4.24)**
Asian	-0.291	-0.018	-0.047	-0.052
	-1.3	-0.12	-0.47	-0.51
Other Race	-0.053	-0.241	0.062	0.193
	-0.29	(2.06)*	-0.77	(3.53)**
Female	-0.03	-0.032	-0.108	-0.002
	-0.51	-0.68	(2.75)**	-0.06
Age 30–44	0.513	0.35	0.402	0.249
	(7.36)**	(6.20)**	(8.21)**	(6.32)**
Age 45–59	1.222	0.811	1.068	0.826
	(14.18)**	(12.22)**	(18.42)**	(17.72)**
Age 60 or +	2.03	1.749	1.69	1.64
	(23.92)**	(20.36)**	(29.55)**	(29.34)**
Medicaid	0.467	0.305	0.422	0.223
	(4.37)**	(3.43)**	(3.93)**	(2.18)*
Uninsured	0.082	0.122	0.155	0.067
	-0.92	-1.63	(2.87)**	-1.46
Constant	2.221	1.703	2.719	2.126
	(35.90)**	(33.39)**	(62.16)**	(58.38)**
Observations	2,462	3,075	4,516	7,338
R-squared	0.19	0.14	0.16	0.13

Source: Author's tabulations from HCUP SID data.

T statistics in parentheses. All standard errors have been corrected for heteroscedasticity.

* significant at 5 percent; ** significant at 1 percent.

i. Maryland 1996

Holding race, gender, age, and insurance status constant, black appendicitis patients in Maryland are hospitalized .576 days longer than their white counterparts in 1996 ($P < .01$). Medicaid patients, too, were hospitalized for .47 days more than privately insured patients ($P < .01$). As we saw with the perforated appendix analysis, older patients also fare worse on this measure than younger ones. Specifically, those aged 30–44 (by .5

days), those aged 45-59 (by 1.2 days) those 60 or older (by 2.0 days) have longer lengths of stay than those 18-29.

ii. Maryland 2003

Seven years later, the length of stay for black appendicitis patients increased to .649 days longer than their white counterparts. Hispanics, too, have longer hospital stays than their white counterparts, although the difference is not statistically significant. Patients who are Asian or of other races have shorter lengths of stay than whites, and women have shorter hospitalizations than men, but the differences are not statistically significant.

iii. New Jersey 1996

Black and Hispanic appendicitis patients were hospitalized for .47 and .19 days, respectively, longer than white patients. As expected, older populations also have longer lengths of stay than the younger populations: those aged 30-44 (by .4 days), those aged 45-59 (by 1.1 days), and those aged 60 or older (by 1.7 days) are hospitalized longer than those aged 18-29. Insurance status also matters: Medicaid patients and the uninsured have longer lengths of stay (by .42 days and .16 days, respectively) than their privately-insured counterparts. Finally, the data also indicate that women have shorter lengths of stay than men—by .11 days. All of these findings are statistically significant.

iv. New Jersey 2003

Despite the passage of seven years, the 2003 data looks relatively similar to the 1996 for many of the groups. Patients who are black, Hispanic, and of other races have greater lengths of stay than white patients (by .44, .20, and .2 days, respectively). Similarly, 30-44 year olds, 45-59 year olds, and those 60 and over have greater lengths of

stay than those 18-29 years old (by .25, .83, and 1.64 days, respectively). Those covered by Medicaid still have longer lengths of stay than those who are privately insured (by .22 days), but that does represent a decrease from the lengths of stay in 1996. All of these results are statistically significant.

In short, across both states and over time, Medicaid patients uniformly have statistically significantly longer lengths of stay than privately insured patients. Uninsured patients follow the same trend, but the differences are not always statistically significant.

v. Discussion of Race and Ethnic Differences in Length of Hospital Stay

The regression analysis of lengths of stay indicates that race is correlated with longer periods of hospitalization. In Maryland, black appendicitis patients' hospitalizations are longer than the white appendicitis patients' stays in 1996, and despite the trends observed above that find fewer blacks experiencing ruptures, the lengths of stay for blacks increased in 2003. In New Jersey in both years, blacks experienced longer hospitalizations than whites, although the disparity fell slightly from a length of stay of .465 days' longer in 1996 to .440 days' longer in 2003.

Hispanics, also, have longer hospitalizations than whites, though the disparity shrinks over time in Maryland, where the findings fall short of statistical significance. The Hispanic length of stay grows slightly in New Jersey, however, and is statistically significant at the .01 level. Asians have lower lengths of stay across both states and years, although the disparity does not reach statistical significance. The "other race" category in Maryland indicates shorter lengths of stay while in New Jersey, this group has longer lengths of stay. This may be due to state differences in the composition of this category.

vi. Length of Stay for Appendicitis Patients by Insurance Type, Controlling for Race, Ethnicity, Gender, and Age

Again, Medicaid patients in Maryland have different experiences from those in New Jersey. In Maryland, Medicaid-covered appendicitis patients had longer lengths of stay than those with private insurance in both 1996 and 2003, but the disparity decreased. This again implies that managed care is improving care for Medicaid populations. In New Jersey, however, Medicaid-covered appendicitis patients had *shorter* lengths of stay than their privately insured counterparts in 1996, but longer lengths of stay than privately insured appendicitis patients in 2003. New Jersey's Medicaid patients seem to be doing worse under Medicaid managed care than the old Medicaid fee-for-service structure in that state.

Uninsured appendicitis patients, once again, share the same experience in both states: their lengths of stay were longer than the privately insured in both 1996 and 2003, and again, the disparity between them and the privately insured grew larger during the seven year period.

vii. Low-Income Black Appendicitis Patients, Controlling for Insurance Type, Race, Ethnicity, Gender, and Age

In both Maryland and New Jersey, black appendicitis patients were more likely than white appendicitis patients in 1996 to experience perforation. By 2003, however, black patients were *less* likely to suffer appendiceal perforation. This result may suggest that blacks were concentrated in the Medicaid and privately-insured populations and had increasing access to care.

The length of stay variable provides additional information. In Maryland, the length of stay for black appendicitis patients was longer than that of their white

counterparts in both 1996 and 2003. The racial disparity grew larger during those seven years, and these findings are statistically significant in both years. Also statistically significant in both years is the length of stay data for black appendicitis patients in New Jersey. As in Maryland, New Jersey's black appendicitis patients had longer hospitalizations than their white counterparts in both years, although the disparity decreased minutely during the seven year interim.

viii. Low-Income Hispanic Appendicitis Patients, Controlling for Insurance Type, Race, Ethnicity, Gender, and Age

Maryland's Hispanic appendicitis patients were more likely than white appendicitis patients to suffer perforation in 1996, as the author hypothesized. However, Hispanic appendicitis patients were *less* likely than white patients experience perforation by 2003. In New Jersey, Hispanic appendicitis patients were *less* likely than their white counterparts to experience appendiceal perforation in either year. This suggests that Hispanic appendicitis patients had better access to care in Maryland after the policy changes of the mid-1990s. Perhaps Hispanics were more likely to be either privately insured or covered by Medicaid than uninsured.

Again, the length of stay variable provides a fuller picture. Hispanic appendicitis patients in both Maryland and New Jersey had longer lengths of stay than their white peers in both years. In Maryland, the disparity was decreasing, while in New Jersey, the disparity was on the rise.

6. Discussion

a. Racial and Ethnic Disparities

As noted in Chapter 1, appendicitis is an inflammation of the appendix. While most patients recover without difficulty if they receive care in a timely manner, delays in treatment can result in a perforated appendix, which may lead life threatening infections.⁶¹³ The main symptom of appendicitis is abdominal pain, which usually grows more severe over the course of six to twelve hours and eventually becomes excruciating.⁶¹⁴

To the best of the author's knowledge, this is the first study examining insurance status and race on appendiceal perforation and length of stay in the adult population. Several researchers have found that appendiceal perforation is more prevalent among racial and ethnic minority children.^{615, 616, 617} Researchers also found that children covered by Medicaid and uninsured children had higher rates of juvenile appendiceal perforation than privately insured appendicitis patients.^{618, 619, 620, 621} One study found that appendiceal perforation was more prevalent among Medicaid-covered and uninsured adults than privately insured adults.⁶²²

In this dissertation, the first part of Chapter 8 found that there is a growing uninsured population in the U.S. and Maryland, and that one vulnerable population, immigrants, are overrepresented among the uninsured. Chapter 8 also identified data on a wide range of health conditions for which racial and ethnic disparities existed both in Maryland and in the nation.

Finally, the first regression analyses found that there were racial and ethnic disparities in both the likelihood that appendicitis patients would develop appendiceal

perforation in both years and both states. It shows that, holding age, gender, and insurance status constant, the largest racial and ethnic minorities fared worse than whites in 1996, but actually fared better than whites in 2003. If we ended the analysis here, we would conclude that events of the interim seven years helped eliminate a) the racial and ethnic access to care gap that left minorities faring worse than whites, and b) the Medicaid handicap, bringing access to care relatively equally to those with private, public, or no health insurance.

By measuring lengths of stay, we learn that Medicaid appendicitis patients in both states have longer hospitalizations than privately insured patients, independent of whether the appendix is perforated. That difference remains statistically significant across both states and both years. Moreover, black appendicitis patients also experience greater lengths of stay across both states and both years. Whereas New Jersey's rate of perforation among Hispanics is lower than that of whites, Hispanics have longer lengths of stay in both 1996 and 2003, and the rate is virtually identical, despite the passage of time.

What do greater lengths of stay indicate? Perhaps Hispanic and black patients present with appendicitis that is closer to rupture than white patients. Maybe Hispanic, black, and Medicaid patients are in worse health and need to be hospitalized for longer to stabilize comorbidities. Or it might imply higher complication rates among these latter groups.

b. Insurance Disparities

Arguably the most compelling information gleaned from this data analysis, however, is that the uninsured are more likely than the privately insured to suffer

appendiceal perforation. The uninsured experience appendiceal perforation grows worse in both Maryland (by 4.4 percentage points) and in New Jersey (by 3.9 percentage points) during the 7 year period studied, as indicated in Table 8.10. Maryland's length of stay data over this 7 year period correspondingly became longer (from .082 days to .122 days) for the uninsured, and the fact that the length of stay does not keep pace with the increasing number of uninsured appendiceal perforation patients in New Jersey raises serious concerns about the pressure hospitals are feeling to release uninsured patients sooner than may be clinically appropriate.

7. Limitations

a. Differences-in-Differences Proxies

The data used in this analysis has several limitations. First, and as discussed in the Methods chapter, there is no comparable national data for a true differences-in-differences approach. Data from another Northeastern state, New Jersey, was used in place of national data. The quantitative findings compare Maryland with New Jersey for both 1996 and 2003. This poses several issues. First, the New Jersey Medicaid managed care (MMC) program began in 1995, so the 1996 Medicaid data consists largely of MMC rather than Medicaid fee-for-service enrollees. The MMC program in Maryland, however, did not commence until July 1997. Therefore, the Medicaid 1996 data for Maryland included in this analysis completely consists of pre-HealthChoice Medicaid enrollees.

Secondly, although similarly demographically diverse, New Jersey is a wealthier state. Compared with Maryland, the data indicate that a greater percentage of the New Jersey population in both 1996 and 2003 sought inpatient care at the hospital. The

reasons for this are unclear, though perhaps more of the New Jersey hospitalizations are for elective surgery.

While not a perfect differences-in-differences methodology, assessing trends in a similar state allows for identification of disparate trends that would require additional study. It provides a frame of reference to compare the Maryland findings against, but analysis on the full number of states for whom there is HCUP SID data would be more powerful.

b. Sample Sizes

Although sample sizes were significant enough to make determinations about blacks and whites in both states and about Hispanics in New Jersey, a third limitation in this study is the small number of Hispanics in Maryland who suffered from appendicitis in 1996 (i.e., 49). Furthermore, sample sizes were too small to consider Asians. Much consideration was given to the choice of prevention quality indicators used in this study. Given that appendicitis is characterized by a pain of ever-increasing severity coupled with the fact that every case of appendicitis can lead to a rupture if not diagnosed and extracted within a short amount of time, it is a useful way to evaluate how likely it is that people across racial and ethnic lines will access care. Yet appendicitis strikes a relatively small portion of the population. Small sample sizes also prevent analysis of potential racial or ethnic disparities within appendicitis mortality rates.

c. Insufficient Data on Clinical Confounders

HCUP data uses administrative hospital billing data, which does not include clinical confounders, such as whether the patient is a smoker. This is an important

limitation because, using this example, smoking impedes healing and might actually lengthen stays measurably on a population basis.

Notes

- ⁵⁸⁶ *Care Without Coverage: Too Little, Too Late*. Committee on the Consequences of Uninsurance, Board on Health Care Services, Institute of Medicine, National Academy of Sciences. (Washington, DC: National Academies Press, 2002).
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Chapter 9: Discussion

This dissertation sought to answer the question: Did changes that occurred in the mid-1990s to Maryland's low-income health care market (LIHCM) affect access to health care differently for different racial and ethnic groups? Let us consider the evidence.

As noted in Chapter 1, this phrasing contains two important implications:

- A. Changes occurred in the market, and
- B. Those changes affected access to care.

Both of these issues are addressed throughout Parts One, Two, and Three of this study. Part One, "Federal legislation affecting access to care for vulnerable populations," identified in detail the changes posed by federal legislation enacted in the mid-1990s, particularly the Personal Responsibility and Workforce Opportunity Reconciliation Act of 1996 (PRWORA, or "welfare reform"), and the Balanced Budget Act of 1997. It also discussed several congressional measures from that time period that limited or eliminated health benefits for poor immigrants. In addition, Part One outlined the impact of each of these federal measures on access to care for the poor nationally.

Part Two, "Maryland's low-income health care market," considered how these and other policy changes affected access to health care services for poor Marylanders. It opened with a history of the Maryland LIHCM, and provided a list of "de jure" and "de facto" changes that occurred during the mid-to-late 1990s. Part Two concludes with a comprehensive time line of the national and Maryland-specific LIHCM changes.

Finally, Part Three, "Impact of changes to Maryland's low-income health care market on access to care," consists of qualitative and quantitative analyses of the research question. The qualitative section includes a content analysis of transcripts from

interviews conducted with 14 stakeholders in Maryland's LIHCM. Themes that emerged from the interviews included concerns about access barriers posed both by HealthChoice's initial implementation and its current manifestation, stories about how some safety net clinics are no longer able to negotiate free care for uninsured patients, and poor communication between governmental agencies. This latter point became particularly problematic after PRWORA eliminated the automatic enrollment into Medicaid for welfare beneficiaries, when social workers in one agency determined eligibility for participation in programs run by the other agency.

Interviewees discussed their observations about the relatively steady access for Medicaid patients throughout this period, but noted that the eligible Medicaid population became younger after the Children's Health Insurance Program was implemented in 1997. Errors in interpretation of the welfare reform efforts caused some adults who were still eligible for Medicaid to be dropped from the rolls. Moreover, those adults who remained in Medicaid were costlier and less healthy than the Medicaid case mix in the program at the start of HealthChoice, causing distortions in fiscal projections of the cost of care. Interviewees also discussed the increase in uninsured adults and described at length the holes in the safety net through which two populations in particular fell through: immigrants and the homeless.

It was critical to do a qualitative analysis to answer this question because many immigrants and homeless are not included in quantitative data sources. However, using the Hospital Cost Utilization Project (HCUP) data, quantitative analyses bring out the same concerns about the uninsured, a category that captures most of the immigrant and homeless populations. In both 1996 and 2003, uninsured appendicitis patients in both

Maryland and New Jersey were more likely than privately insured appendicitis patients to experience perforation, and the disparity increased during the seven year interim.

Similarly, lengths of stay were longer for uninsured appendicitis patients than for privately insured appendicitis patients in both 1996 and 2003, and again, the disparity grew larger during that time.

This supports the author's hypothesis that those less able to pay probably delay coming to the hospital. It also corroborates the qualitative findings that, as the reimbursement mechanisms for Medicaid in Maryland became more rigid, the outcomes for uninsured patients grew worse.

Conclusion

Did changes that occurred in the mid-1990s in Maryland's LIHCM affect access to care differently for different racial and ethnic groups? Evaluation of the qualitative and the quantitative data suggests that the policy changes referenced above affected different demographic groups differently. The qualitative data indicate that the uninsured, immigrants, and the homeless, fared worse than they had prior to these policy changes. Couple this with the quantitative data, which indicate that Maryland's uninsured are disproportionately black (26 percent of the uninsured were black in 1996; 25 percent in 2003) and Hispanic (13 percent of the uninsured were Hispanic in 1996; 19 percent in 2003).

Moreover, the quantitative multivariate regression analyses, particularly the length of stay analyses, illustrate how black and Hispanic appendicitis patients had different and in nearly all cases worse access to care than their white counterparts. It can

therefore be concluded that changes in Maryland's LIHCM affected access to care differently for members of different racial and ethnic groups.

That said, the main finding of this research is a disparity based not upon race or ethnicity, but on insurance status. The qualitative and quantitative data consistently indicate that the uninsured fare worse than the privately insured. Initiatives that became law during the Contract with America era had a predictable if unintended consequence: the uninsured are less likely to access health care services, which is resulting in greater severity of disease at presentation. As the number of uninsured Marylanders (and Americans) continues to rise, in part because of the impact of PRWORA, the BBA, and the proliferation of Medicaid managed care, as documented in this study, poor access for the uninsured will become an increasingly urgent public policy problem.

Future Research

Given the expense of the data sets, the author selected two states and two years only: Maryland and New Jersey, 1996 and 2003. Future research could collect data from all 33 states that have information available and conduct a more thorough differences-in-differences analysis. Additionally, obtaining data from additional years would permit time series analyses, which could help pinpoint more exactly when in this seven-year time period the perforation rates and lengths of stay changed. This would help to correlate which policy changes were responsible for each variation.

This quantitative analysis focused upon appendiceal perforation as the proxy for access to care. Other Prevention Quality Indicators (i.e., measuring avoidable hospitalizations or hospitalizations for ambulatory-care-sensitive conditions) that are available to use with the HCUP data set include complications from diabetes, lower

extremity amputations among patients with diabetes, angina without procedure, adult asthma, and more. Although it may be challenging to find adequate denominator data to conduct some of these analyses, future research looking into these factors would be a welcome addition to the literature.

Furthermore, collection of quantitative data identifying immigrants would be extremely helpful to ascertaining impact of policies on this particular demographic group.

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