

LOUISE LAMPHERE
University of New Mexico

Providers and Staff Respond to Medicaid Managed Care: The Unintended Consequences of Reform in New Mexico

In 1997 a new Medicaid managed care (MMC) program called Salud! was implemented by the State of New Mexico. This article serves as an introduction to a special issue of Medical Anthropology Quarterly that assesses the unintended consequences of this reform and its impact on providers and staff who work in clinics, physician offices, and emergency rooms where Medicaid patients are served. MMC fused state and corporate bureaucracies, creating a complex system where enrollment and access was difficult. The special issue focuses on providers' responses to these new structures, including ways in which staff buffer the impact of reform and the role of the discourses of medical necessity and accountability in shaping the way in which MMC functions. [Medicaid managed care, bureaucracy, privatization, women health care workers, buffering strategies]

It was a nightmare when we changed . . . It has improved dramatically, but it is still a pain in the neck. [Hispanic female administrative assistant, rural clinic]

We are doing a lot of the patient education on our end, and that is time we should really spend providing care. Instead we are helping patients negotiate the system. [Anglo female physician assistant, rural clinic, 4/5/2000]

I was spending my energy doing ISD [Income Support Division] work. I think my time is more valuable than being used as a clerk. Initially, you know, they were going to pay people to do this . . . and they were going to hire welfare-to-work women to do it . . . But to have all these agencies doing it on their own money is just unbelievable—they should be hiring more people at the ISD. [Urban female application assistant, 3/1/2000]

These quotes mark the typical responses from providers, staff, and application assistants who deal with Salud!, the Medicaid managed care (MMC) program implemented by the State of New Mexico in 1997. Most providers and staff acknowledge the positive aspects of Salud!—for example, patients now have a primary care provider (PCP) that helps ensure continuity of care. However, interviewees

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were more intent on providing examples of how they have to struggle with the system, help patients cope with a confusing number of policies and rules, and devise strategies that will allow them to provide adequate levels of health care to Medicaid recipients.

Several anthropologists (Rylko-Bauer and Farmer 2002; Ware et al. 2000) have called for critical evaluations of health care reform and for an ethnography of managed care.¹ They argue that anthropology has a great deal to contribute to the current debates about managed care. Anthropology broadens these discussions by examining the health care system in relation to larger economic forces, on the one hand, and by analyzing the impact of reform on individual lives, minority communities, and health care providers, on the other. These articles are a response to their call. We use ethnography to examine MMC as it was instituted in New Mexico between 1997 and 2000.²

A case study of MMC³ as implemented in New Mexico is significant for two reasons. First, it helps us assess the successes and difficulties of using a neoliberal, privatized model of health care delivery for a low-income, predominantly minority population.⁴ New Mexico has always been ranked among the poorest states in the nation, but it may also be a bellwether of what is beginning to happen in other states because here the so-called minority populations are actually a numerical majority. If large proportions of minority populations receive their health care in the publicly financed health care system (Medicaid, Medicare, the Indian Health Service) and if changes in the financing or delivery of health care poses barriers to patients, these changes will contribute to greater health care disparities for minorities (Smedley, Stith, and Nelson 2003). Second, because it has a large rural population, New Mexico allows us to make comparisons between rural and urban areas in order to evaluate the impact of a model where managed care organizations (MCOs) rather than a primary care case management (PCCM) system has been implemented. Case management systems, a less aggressive form of managed care used in most states with large rural populations, requires a patient to have a provider, but providers are not contracted with full-risk MCOs that “manage” care through techniques that are aimed at cutting costs and eliminating unnecessary and expensive procedures and specialty care.

Ethnographic research (participant-observation and qualitative interviewing) is key here. We were able to examine how new structures operated and how providers and staff responded to them, uncovering processes, problems, and issues that were not revealed in the telephone surveys conducted as part of the same project. Rather than examine patient experiences or the provider-patient dyad, we studied health care sites (clinics, emergency rooms, and doctors' offices) and then placed the roles of providers, staff, and eligibility workers within the MMC system as a whole. Our ethnographic study particularly focused on mid-level professionals (nurses, nurse practitioners, and physician assistants) and clerical workers. Many of these workers are women and minorities, whose roles have often been overlooked in the analysis of health care reform. We observed their strategies for dealing with the problems that the new system created and heard their analyses of how difficult MMC was for their patients and for their own institutions. We argue that the efforts of these individuals were crucial in “making the system work” and creating the high levels of satisfaction and utilization that our surveys revealed (Waitzkin et al. 2002).

The Privatization of Health Care: Fusing and Growing State and Corporate Bureaucracies

It is important to see MMC in the context of a larger set of transformations. Over the past 20 years, the U.S. economy has changed from one based on a “Fordist” model dominated by large unionized manufacturing firms to a more flexible economy, with downsized firms and outsourcing to low-wage nonunionized areas of the United States and overseas. This has created a polarized workforce of highly paid professionals versus low-paid service workers. Workers have become disconnected from employers who provide health care, as the gap between rich and poor has become wider. The number of Americans without health insurance has continued to grow.

At the same time, neoliberal policies have been set in motion to dismantle many of the programs of the welfare state (Goode and Maskovsky 2001; Harvey 1989). There are two processes embedded in these policies and their accompanying legislation. The first is devolution or “the transfer or decentralization of government functions from higher to lower levels of the federal hierarchy” (Kodras 1997). In practice, devolution means that individual states, using federal- and state-generated tax funds, have increased control over and responsibility for social programs. The second is privatization or the shift of state services, assets, and functions to the private sector or primarily for-profit corporations.

Anthropologists have already examined neoliberal policies in the area of welfare reform and health care reform at a broader level. In this special issue, we focus on MMC and bring to this set of changes the kind of ethnographic insight that has characterized the anthropological literature on welfare reform (Kingfisher and Goldsmith 2001; Morgen 2001; Morgen and Maskovsky 2003; Newman 2001).

In the private sector, after the collapse of the Clinton health care reform initiative, for-profit corporations expanded quickly, continuing to acquire community hospitals and offering managed care (i.e., administrative control over the organization and delivery of health care services) (Waitzkin 2001:159). During the 1990s, employee-based health insurance converted to health care administered by health maintenance organizations (HMOs). There are some similarities between the privatization of Medicaid and the growing impact of managed care in the private sector. In both, patients choose a PCP who provides primary care and refers them to specialists. The provider acts as a gatekeeper, as does the HMO/MCO that employs utilization review before authorization to determine whether a test, procedure, or specialist care meets the test of “medical necessity.” MCOs regulate drug formularies, and patients may only use pharmacies or labs authorized by the HMO/MCO. These procedures are designed to cut costs and, in the case of Medicaid clients, keep them from using expensive emergency room facilities. In many cases, the same corporation has both employer-insured patients and Medicaid clients. However, because the transformation of Medicaid involves federal tax funds and the devolution of responsibility, the role of the state looms much larger in MMC (as I explain in more detail below).

The privatization and devolution of Medicaid occurred in the mid-1990s when states, using a waiver system set in place by the Health Care Financing Administration (HCFA), began contracting with both for-profit and nonprofit MCOs to deliver health care to Medicaid patients (Fossett 1998). These patients were

primarily women and children, but also, in some states, the mentally ill or disabled, and, in the case of New Mexico, Native Americans. During the 1980s, less than 10 percent of all Medicaid recipients were in managed care plans (Iglehart 1995; Provost and Hughes 2000:150), but by 1998 this number had expanded to 54 percent of the Medicaid population, or 16.5 million people (see Ku et al. [1998] for an discussion of the various types of waivers and Thompson and DiIulio [1998] for an overview of devolution).⁵ This number has grown only slightly, with 59.11 percent in managed care in 2003 (CMS website: <http://cms.hhs.gov>).

Unlike welfare reform where federal oversight was replaced by a system of block grants, HCFA (now renamed the Center for Medicare and Medicaid Services, or CMS) still has oversight over state Medicaid services, so there are two layers of public bureaucracy in addition to the bureaucracies of private MCOs (both for-profit and nonprofit). As noted above, rather than having a purely public or private system, we have a concatenation of the two where business interests are at work as well as federal- and state-level mandates. Health care in the public sector increased in bureaucratic complexity in the 1960s when Medicaid and Medicare were created, and both hospitals and physician offices were increasingly consolidated into larger and larger units. Much of this bureaucracy was a result of growth through the addition of new populations mandated to be served through Medicaid. With privatization, there is not only growth in the number of enrollees, but new layers of bureaucracy. Medicaid reform puts together three characteristics that lead to many of the issues we explore in the articles in this issue: a large-scale public and private bureaucracy that includes several levels (state, enrollment agents,⁶ MCOs, providers), the attempt to manage care through utilization review where some treatment forms are not financially covered because they are deemed not medically necessary, and the incorporation into this system of many vulnerable patients (children in low-income families, pregnant mothers, the mentally ill, and the disabled). Because income levels and other eligibility requirements of this population are always changing, there is a constant "churning" as new patients become eligible and others (usually because of a change in parental employment status) drop out of the program.⁷

Much of the analysis of MMC has focused on the business aspects of reform: issues of efficiency and cost cutting. However, our interviews and observations at health care sites where staff and providers were so vocal about the problems they faced after reform led us to examine the organizational aspect of MMC and to search for a framework within the social science writing on bureaucracy. Sociologists and anthropologists studying public bureaucracies have emphasized the role of "street-level bureaucrats" (teachers, welfare workers, police officers, and functionaries) in rationing services and controlling clients (Handelman 1995; Heyman 1995; Lipsky 1980). Kingfisher's ethnography of welfare offices in the 1980s shows that while some clients are seen as "good" and "trying to make something of themselves," many clients get constructed negatively as being "maneuvering," "lazy," or even "unclean." Even though such assessments may be a response by caseworkers to large caseloads and reduced autonomy, they nevertheless also legitimize gatekeeping and the rationing of services (Kingfisher 1996:99–116).

It seems reasonable to argue that this analysis applies to health care bureaucracies, especially under managed care. Gatekeeping and controlling which services get paid by insurers has long been part of medical care. Clerical workers in

doctors' offices, hospitals, and clinics have checked the insurance coverage of patients, and billing clerks and other business office personnel have submitted requests for payment, questioned rejected bills, and negotiated with third-party payers such as private insurance companies or federally mandated programs. Managed care, however, not only involves checking an insurance card, but making sure that the patient is seeing her or his PCP or has the appropriate referral to an approved specialist. In addition, medical tests or other treatment protocols are subject to utilization review. These protocols can be particularly extensive in the case of behavioral health patients who may need partial hospitalization or inpatient care over a lengthy period of time (see Willging and Wagner, this issue). Thus, under managed care, gatekeeping includes additional submission of forms, phone calls, faxes, and adjudication over contested payments.

Those who have studied service jobs (whether or not they are embedded in service bureaucracies) have emphasized how they differ from industrial jobs and have stressed the importance of emotional labor that is essential to successful job performance for flight attendants and waitresses (Hochschild 1983; Leidner 1999). Still other work has stressed the importance of an ideology of care as an integral part of many service occupations (England and Folbre 2003; Glenn 2000; Ruddick 1998). Both emotional labor and an ethic of care are characteristics of health care occupations, from clerical workers who assist clients when they arrive at a clinic to nurses, nurse practitioners, and physicians who attend to sick children and pregnant mothers. The importance of these aspects of health care jobs could make them prime targets for transformation under a reform effort that emphasized efficiency, streamlining, and a financial bottom line.

Many changes in service occupations over the past 20 years have been made possible through changes in technology and mechanization. Thus, sales and information services have been conglomerated into large workplaces such as call centers, where emotional labor has been scripted and relations with clients carefully controlled (Gutek 1995). A few jobs, located at the top of new information technology hierarchies have actually become more autonomous, for example, computer service representatives who hold highly skilled and well-paid positions (Batt 2000). Most workers in call centers, fast-food restaurants, and other new service occupations, however, are in jobs that emphasize economic transactions and speed rather than the quality of personal relationships with a client.

Health care workers (clerical workers, nurses, and nurse practitioners) have escaped both of these changes. Service work in clinics, doctors' offices, and emergency rooms and the attendant emotional labor required has not been controlled and scripted under managed care reform. Most jobs remain complex, relational, and tailored to the individual needs of clients. The ethic of care has remained vital, especially in community health centers (CHC) and federally qualified health centers (FQHCs). If anything, reform has strengthened discourses of patient responsibility and accountability that were probably always present in welfare offices and health care sites but now are supported by a system that seeks more patient responsibility in choosing their health care.

This new emphasis on responsibility and accountability means that MMC reform does share one characteristic that has been typical of new or recently restructured service organizations, especially those in the private sector. There has been an increase in what labor economists call "labor shifting," that is, shifting

labor outside the workplace and changing the position of the customer to one of part-time employee rather than a consumer of services (Batt 1998). Labor shifting may sound like transferring work from one occupation to another, but instead it signals an attempt to move tasks to those who will not be paid for accomplishing them. For example, travelers now check airline websites where they find schedules and ticket prices, rather than using a travel agent. Customers at retail outlets must find the merchandise they want, rather than having an employee show them a number of products.

Under MMC, patients are asked to take over much of the work of gaining access to the system, enrolling themselves, and finding their way through the bureaucracy so that they can obtain direct services. And once they see their own PCP, they are often required to obtain an appointment with an appropriate specialist. How patients, providers, and staff handle the increasing complexity and bureaucracy of Medicaid under managed care along with the structural demands of labor shifting are carefully analyzed in several of the articles in this issue. The continuing importance of both emotional labor and an ethic of care have meant that providers and staff often take over the new responsibilities the system intended to assign to patients. We think of these dynamics in terms of the interplay between provider strategies for dealing with the new structure of Salud! and the discourses they use concerning their own behavior and that of their patients.

Creating an MMC System in New Mexico

In July 1997, Republican governor Gary Johnson initiated Salud!, a managed care program for Medicaid recipients in New Mexico. The state contracted with three MCOs to provide medical services, including behavioral health, for pregnant women and low-income mothers, and children (from households with incomes up to 185 percent of the federal poverty level [FPL]). The incorporation of treatment programs in mental and behavioral health, into Salud! rather than into a separate “carve out” system⁸ was unusual and led to difficulties that are described in articles by Wagner and Willging. Native Americans were required to enroll in Salud! rather than remain in the fee-for-service system.⁹ Later, children who came from families between 185 percent and 225 percent of the FPL became eligible through the State Children’s Health Insurance Plan (SCHIP), a program authorized in the 1997 Balanced Budget Act. By 1998, all Medicaid-eligible children were being recruited through a program called New MexiKids (see López, this issue). This effort was aimed at the new SCHIP eligibles as well as children who, though still qualified for Medicaid, had been dropped off the rolls when their mothers entered the labor force through the new welfare reform program, Temporary Assistance to Needy Families.

At the same time, the state embarked on welfare reform, a rocky and conflict-ridden process that was not fully completed until March 1998. The three MCOs, in turn, contracted with most of the safety-net providers that had served Medicaid clients in the past. These providers included the CHCs and FQHCs, as well as some private physicians and public hospitals. To provide other Medicaid services, each MCO initiated contracts with often different pharmacies, transportation companies, and laboratories. Because the MCOs had little experience with behavioral health, each MCO contracted with a behavioral health organization (BHO) to

administer mental health facilities. These, in turn, hired regional coordinators who managed the facilities and providers who actually treated Medicaid clients. Finally, the state contracted with an enrollment provider (an organization we will call Dial-a-Med), to maintain the enrollment database.

The outcome of these structural changes can be summarized as follows:

- (1) A change from a fee-for-service system to one dominated by three commercial MCOs
- (2) The incorporation of safety-net providers through multiple contracts with MCOs rather than affiliation with only one
- (3) MCO contracts with selected and often different laboratories, pharmacies, and transportation companies, replacing a system where patients could use any of these facilities willing to provide the service to a Medicaid client or their provider
- (4) The incorporation of BHOs and regional care coordinators within each MCO's structure in order to administer the behavioral health care that each MCO was obligated to provide
- (5) The creation of New MexiKids as an enrollment structure to recruit additional children eligible for SCHIP funds and those who inadvertently had been dropped from the rolls during welfare reform. These new patients were recruited by application assistants who were trained through a state program, but they were already employed in a wide variety of clinics, schools, and other sites who served low income children (see López, this issue).
- (6) A shift in the site where most Medicaid recipients were enrolled from the state welfare offices to a network of application assistants

These changes resulted in a much more complex system (see Figures 1 and 2).

The charts outline the restructuring of enrollment and the insertion of MCOs between providers and the state agencies that administer Medicaid. Figure 1 in Willging's article (this issue) shows how the addition of behavioral health added two additional layers of bureaucracy.

The Ethnographic Study of Health Care Sites in an Urban and Rural County

Ethnographic fieldwork in health care sites with substantial number of MMC patients was part of a larger project in which we used three research methods (survey, ethnography, and analysis of sentinel events).¹⁰ Each focused on a different level of impact: individuals (survey), health care sites (ethnography), and the state population (sentinel events data). Ethnographic observations helped elucidate the results of both sentinel events and survey portions of the project, suggesting the utility of a multimethod approach.

First, the sentinel events component uncovered a drastic fall in immunization rates after MMC was instituted, so that New Mexico fell from a rank of 30 to 51 among all states and the District of Columbia. Ethnographic observations suggested possible reasons for this decline. Clinic nurses at public health clinics cited a reduction in funding that led to fewer immunizations, while staff of community health clinics reported that MCO practitioners often referred Medicaid patients to

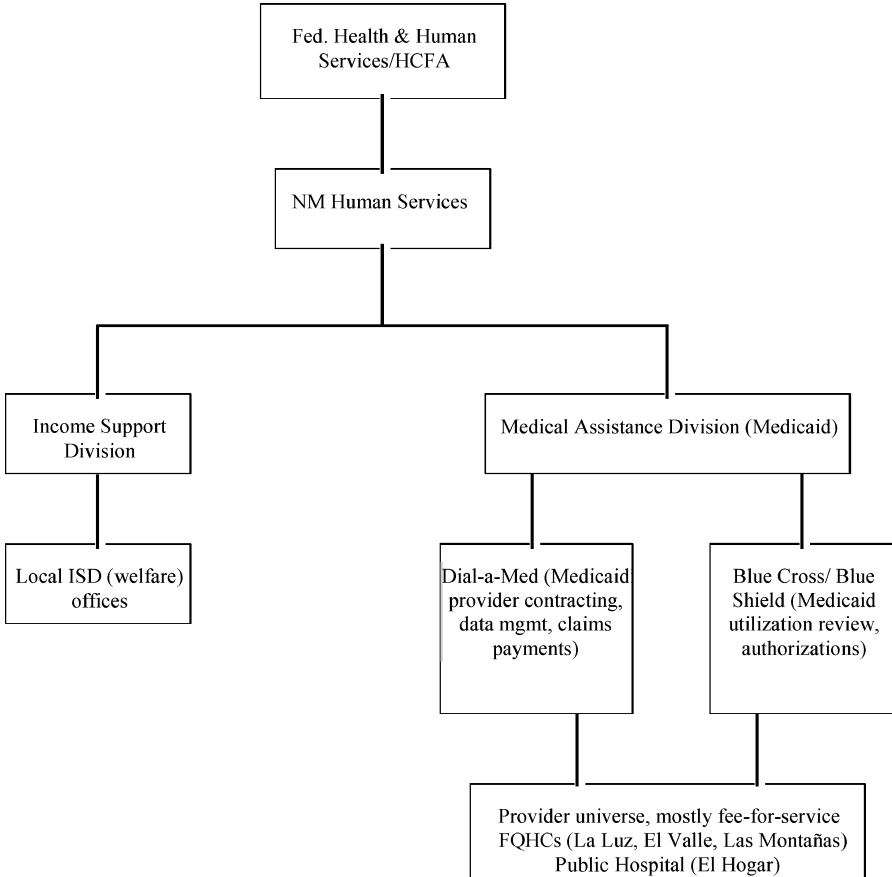


Figure 1

1994–1997: New Mexico Medicaid System before Reform. The system is relatively simple and is accessed through the local ISD office.

community clinics (FQHCs) rather than giving the immunizations themselves or sending them to an MCO clinic. These referrals led to the possibility that some mothers did not follow up and obtain the immunizations once they had been referred (Schillaci et al. 2003; Waitzkin 2002).

In a second example, our surveys suggested that MMC had little impact on clients, while ethnographic observations emphasized the severe impact on community health care clinics (including FQHCs) and other safety-net organizations. Surveys of low-income households at 9, 18, and 27 months after MMC reform found that Medicaid clients were much more like those who had insurance in terms of levels of access and utilization. In contrast, the uninsured reported important barriers to their health care access and lower utilization of health care providers

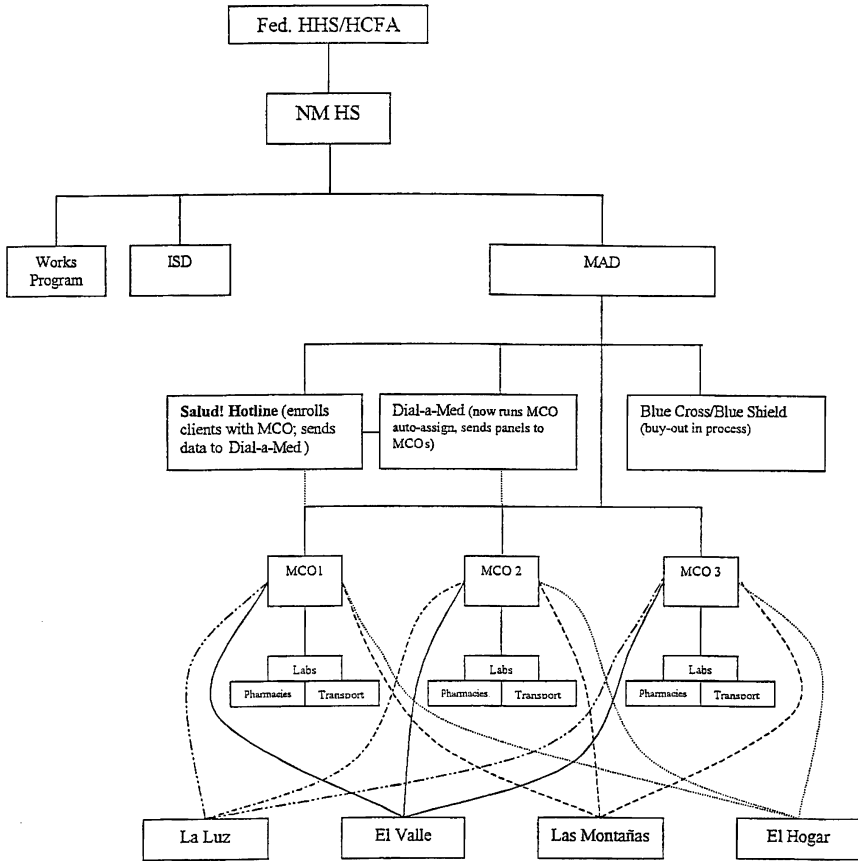


Figure 2

1997–Present: The Much More Complex MMC System. The three MCOs form an added layer of bureaucracy and each MCO has contracts with different laboratories, transportation providers, and pharmacies. Most FQHCs (La Luz, El Valle, Los Montañas, El Hogar) are contracted with all three MCOs.

(Waitzkin 2002:11–18, Tables 1 and 3). The articles in this issue emphasize that providers and staff went to great lengths to buffer the impact of MMC on patients and used a variety of strategies to accommodate, “work around,” and even challenge the new system. Though causal links are difficult to establish, it seems likely that the buffering work of providers and staff contributed to the high levels of access, utilization, and satisfaction on the part of Medicaid patients that the surveys documented.

Ethnographic observations were carried out in Bernalillo County (population 556,678), where Albuquerque is located, and in Rio Arriba County, in the northern

portion of the state (population 40,731). In contrast to Albuquerque and Bernalillo County, the most densely populated region of the state, Rio Arriba is a sparsely populated rural area. Rio Arriba is dominantly Hispanic (72.9 percent), while Bernalillo County is 48.3 percent Anglo and 42.0 percent Hispanic. Rio Arriba has a higher unemployment rate than the Albuquerque area (7.2 percent compared to 4.5 percent in March 2004), a higher poverty rate (20.3 percent compared to 13.7 percent in 1999), and a larger proportion of the population enrolled in Medicaid (26.2 percent compared to 14.7 percent). The medical safety net in Rio Arriba is much more fragile than in Albuquerque (see McCloskey 2003).

We began our qualitative research just as MMC was being introduced in July 1997 in Bernalillo County and in October 1997 in Rio Arriba County. Team members returned to the sites at 9-, 18-, and 27-month intervals to parallel the three phases of the survey research. We studied 15 different health care and welfare office sites and 13 solo physician practices. In 1999, we expanded our project to include the research of Cathleen Willging and William Wagner on behavioral health services in Albuquerque and Rio Arriba County (see Wagner and Willging, this issue). During each phase of research in both Bernalillo and Rio Arriba counties, each researcher spent at least 30 hours at his or her particular research sites conducting participant-observation and open-ended interviews. In many cases, they also attended community meetings and public forums that focused on MMC. Each researcher conducted 15 to 20 interviews at each site in each of the three phases. They also interviewed 5 to 10 patients. The team developed three interview schedules: one to be used with the clinic director, the emergency room administrator, physicians, and other health care providers (nurses, nurse practitioners, physician assistants). A second interview was developed for clerical staff, and a third interview was adapted to the experiences of patients.

Over the course of almost 3 years, between July 1997 and June 2000, members of our ethnographic team conducted approximately 734 interviews. Some interviews were repeat or update interviews with administrators, physicians, and nurses who were still working at a clinic, doctor's office, or emergency room when a researcher returned. Two-thirds of these interviews ($n = 481$) were with clinic providers and staff, and one-third were with patients ($n = 253$).¹¹ Women constituted 80 percent of all interviewees, and 60 percent of the females who were interviewed were Hispanic. In general, physicians and a few clinic administrators were male, primarily Anglo, while professional staff (nurse, nurse practitioners, and physician assistants) were predominantly female, both Anglos and Hispanics in about even proportions. Clerical staff and clients (mostly pregnant women or mothers of Medicaid children) were almost entirely Hispanic and female.

Field notes and interview notes were coded using the software package, ATLAS.ti. Team members constructed "bullets" that summarized the trends at their research site so that cross-site and cross-county comparisons could be made at biweekly team meetings. At the end of a fieldwork period in each county, each member wrote up a summary of his or her interviews and observations, and the team coordinator used these to write a 9-month interim report of ethnographic findings. Nancy Nelson drafted the analysis of ethnographic findings that was incorporated into the project's final report (Waitzkin 2002).

The Unintended Consequences of Reform

The articles in this special issue focus on the unintended consequences of MMC that emerged from our interviews with providers, staff, and application assistants in two counties. They include the following consequences:

- (1) Access to MMC (i.e., initial enrollment) became much more complex and difficult for potential recipients
- (2) Providers and staff faced increased bureaucracy and constantly changing rules and procedures that added to their workload
- (3) Although MMC was designed to shift more responsibility for health care to clientele, in actual practice, providers, staff, and eligibility workers assumed the responsibility of helping buffer their clients from the new complexities
- (4) Safety-net clinics (CHCs and FQHCs) took on more hidden tasks within the system thus contributing to Salud!'s success but to some detriment to clinic staff and providers
- (5) Rural populations experienced increased difficulties in utilizing MMC, partly due to a diminished provider base
- (6) Mental health facilities closed and utilization review by MCOs shortened treatment times and restricted treatment modalities

Any plan or policy will always result in some form of unintended consequences. However, because ethnography enables people to understand change at various levels and see the complex interaction between policy and practice, it also reveals significant and heretofore unrecognized dimensions of these unintended consequences. I will emphasize two dimensions not covered in the articles in this issue: (1) the adverse impact of MMC on the rural health care safety net and (2) the subtle differences across sites in the strategies they used to handle MMC and in the discourses that they utilized to interpret the reform, their own motivations, and the behavior of their clients.

The Impact on Rural Health Care Providers

Our study suggests that the health care safety net in rural areas was eroding during the first 3 years after MMC reform (McCloskey 2003; Todd 2001). In Rio Arriba, as in other parts of the state, FQHCs contracted with all three MCOs, which led to a number of unintended consequences, particularly in the area of prescription drugs and transportation. In the years after the inception of Salud!, the initial competition between the three MCOs began to wane as one MCO closed its new clinic and a second attracted the bulk of the Medicaid clients in Rio Arriba County. On the other hand, Salud! encouraged physicians to change their practices. The extra administrative burden of Salud! pushed some small private practices to join a local physician hospital organization, move part of their practices to Santa Fe, or quit taking Medicaid patients altogether.¹² Competition for clients increased at the same time that provider panels were beginning to fill up, and some physicians left the area or refused Medicaid clients. In a climate where more children were being added to Medicaid rolls, these decisions increased the burden on clinics and the emergency rooms. We make a "straw that broke the camel's back" argument. The loss of even a few providers in a rural county where virtually all clinics,

solo physicians, and the hospital emergency room are part of the safety net has a large impact. With fewer physicians and full panels, patients had difficulty getting appointments and they continued to use the emergency room, especially for follow-up and after-hours treatment.

In addition, rural Medicaid clients had increased difficulties with transportation and prescriptions under MMC, primarily because of the contracting relationships that MCOs established with transportation companies and local pharmacies. Medicaid provides transportation for those who have no other way of getting to appointments or pharmacies. Because Rio Arriba County has no taxi or bus service, MCOs contracted with out-of-state transportation companies, which, in turn, contracted with local drivers. These drivers often proved unreliable, and patients missed appointments and had to wait long hours for a ride home. Emergency rooms had difficulty getting patients to hospitals in Santa Fe or Albuquerque. A contractor in Phoenix initially thought it was possible to send a taxi to Española (over 70 miles away) to transport a suicidal patient to Albuquerque, but finally the clinic was able to arrange an ambulance.

MCOs originally refused to contract with the state-licensed “drug rooms” that were attached to many of the Rio Arriba FQHCs. Between 1997 and 2000, only three pharmacies in the Española area would take Medicaid prescriptions. These pharmacies were often many miles from clients who lived in small rural villages, and patients faced long waits once they were able to arrange transportation to get to town. Even after one MCO contracted with clinic drug rooms, the procedures were so tedious that two of the clinics dropped this service. In sum, the additional burdens on providers and patients alike that were experienced in this sparsely populated county where FQHCs and solo practitioners were all part of a fragile safety net indicates that the new MMC structure left much to be desired.

Buffering Strategies and Discourses of Care and Responsibility: Contrasts across Health Care Sites

New structures, provider strategies for dealing with these structures, and the discourses and ideologies that provide the language through which transformations are understood, are the focuses of the articles in this special issue. This threefold emphasis on structures, strategies, and discourses allows us to uncover relationships and processes that rarely are analyzed in discussions of MMC. Many of the strategies providers forge amount to buffering the impact of MMC. We found that providers and staff often intervened in order to undo a ruling or ease a process that has become especially cumbersome given a new set of procedures. These buffering practices make the system work. Discourses are also an important part of this picture. A discourse of care can summarize powerful motivations for service on the part of providers and staff. In contrast, discourses of responsibility and autonomy apply mostly to patients and derive from neoliberal emphasis on the market, competition, and choice that sees patients as “customers” who have ultimate responsibility for their own health and who exercise “free choice.” Such discourses can unintentionally stigmatize the less powerful within the system, particularly patients and parents. How both sets of discourses are used, by whom, and in which settings adds new dimensions to our understanding of power and how it is manifest.

Overall, our ethnographic team found that application assistants,¹³ clerical staff, and mid-level professionals (a largely Hispanic, female labor force) have borne the brunt of MMC reform. However, there were nuanced differences across health care sites in terms of workload and buffering. We also found that discourses of care and responsibility were differentially distributed. FQHCs and solo physician offices were settings where a discourse of care was emphasized, while staff and providers at MCO clinics and emergency rooms often emphasized patient responsibility.

Workloads increased at community health clinics (including FQHCs) and solo physician offices. In the summer and fall of 1997 when MMC was first being introduced, women workers mentioned the lack of training, the busy phone lines, and the general confusion of this period. Not only were there new rules and procedures but, because most FQHCs were contracted with all three MCOs, there were three sets of referral forms, the pharmacy formularies, and three sets of billing operations (something we have called the “complexity of three”). Contrary to our expectations, staff and provider frustrations did not go away over the next 2 or 3 years, even though additional workers were hired and some of the regulations were simplified. Phone lines were still busy and arranging referrals still took time away from patients. Rates of auto-assignment (where newly eligible mothers or children were assigned an MCO or provider by computer because of a missed deadline) remained high, even after 3 years, which often meant that the patient’s regular clinic had to send them away until a change could be made.

Such work simultaneously provided gatekeeping and buffering. Sometimes clerical workers and nurses found it easier to take on the job themselves and fix an eligibility or auto-assignment problem. At other times, staff and providers spend extra time “educating the patients,” that is, helping mothers and pregnant women understand the rules and procedures and take steps to rectify a situation. Without initial training, MMC staff and providers had to first learn the new system and then become “frontline educators,” becoming “bilingual” in medical–bureaucratic language (Rapp 2000) or using educational material in Spanish or Vietnamese prepared by their own clinics (Horton, interview with Anglo clinic director, 2/23/98).

The most extreme examples of buffering were what we have termed “going the extra mile,” that is, taking additional time and effort to deal with a patient’s MMC problem. This involved, for example, a physician assistant who wrote letters to help a patient threatened with loss of Medicaid benefits (McCloskey, interview with Hispanic female, 5/13/99) and a clinic employee who drove a patient to an appointment with a new provider until the patient was able to switch back to being a patient at the clinic (Boehm, interview with Hispanic female clinic manager, 1/28/00).

These unintended consequences took a different shape in the two MCO clinics and the emergency rooms we studied. Even though these two clinics did not have to deal with the complexity of three, they experienced an increase in administrative burden with Salud! because each MCO had created their own internal bureaucracy to process eligibility, referrals, and billing. At both clinics, clerical staff complained that phone waits were long and that there was an inordinate amount of work surrounding the referral system, but one clinic was able to add additional clerical staff and a referral specialist (interviews by Stocker, 7/6/97 and 7/9/97; McCloskey, 2/17/98; and Nelson, 2/29/00).

Only a few physicians and staff at one MCO clinic exhibited an ethic of care based on their past experience with working-class patients. At the MCO clinics there were no statements that “we can’t deny care,” few examples of staff “buffering the system” for patients, and few instances of going the extra mile. Instead, some staff (including a number of clerical assistants) used a discourse of responsibility, often blaming the patients rather than the system. As one MCO clerk said, “They are still uneducated. They don’t know the rules, and they’re also lazy and won’t want to find out what the rules are. They want someone to tell them (Stocker, interview with Anglo female, 7/12/97). Even 2 years later, there was still some sense that patients were “abusing the system” (Adams, interview with Hispanic female, 12/2/99). One clerk complained about women with “cell phones, long nails, and better hair” who nevertheless utilized Medicaid for themselves or their children (Nelson, interview with Hispanic female, 3/9/00).

The Rio Arriba and Albuquerque emergency departments we studied¹⁴ were extremely busy, overloaded places even after MMC reform.¹⁵ Like MCO clinics, emergency rooms experienced increased workloads because of the new procedures that governed Medicaid patients and because each hospital was part of an MCO with an internal bureaucracy. Yet, new staff were added to handle the extra clerical work and case management. One of the purposes of MMC was to discourage Medicaid clients from using their facilities, so it is not surprising that staff talked about patients “abusing the system.” As one Anglo nurse said, “I know that health care should be a right, but there are some people who abuse the system and expect us to go out of our way for them. I think they should be cut off from our services” (Wagner, interview, 5/28/99).

In sum, although all sites we studied experienced increased bureaucratization and heavier workloads, FQHCs and solo physician offices were more overburdened than MCO clinics and emergency rooms. MCO clinics and emergency rooms dealt with only one MCO bureaucracy rather than three and were less likely to have auto-assigned patients who wished to change their providers. In addition, FQHCs and solo physician practices were less able to add new clerical and case management staff. Female staff and providers in the FQHC clinics were more likely to engage in buffering the system for Medicaid patients, while emergency room and MCO staff were more likely to feel that Medicaid patients often abused the system and were unable to follow the new rules.

Case Studies in Structural Change, Provider Strategies, and Discourses of Care and Accountability

All authors in this special issue examine unintended consequences, yet give slightly different emphases to the role of structural changes, provider strategies, and discourses. The first article, by Leslie López, “De Facto Disentitlement in an Information Economy: Enrollment Issues in Medicaid Managed Care,” focuses primarily on the structural aspects of the new system and the difficulties these pose for Medicaid patients, a vulnerable and constantly changing population of low-income women, children, the mentally ill, and the disabled. We present this article first because it provides an overview of how clients gain access to Medicaid. López outlines how MMC moved enrollment from the welfare office to a “deterritorialized” network of phone banks and computers. The lack of information about

how to navigate the new system (with busy phone lines and long waiting times) left new patients unable to meet enrollment deadlines. As a result, they were often auto-assigned to an MCO or a provider. At the same time, more children were being added to Medicaid through SCHIP, boosting enrollments overall. The state put in place a new network of application assistants in order to sign up these new enrollees and to recapture women and children who had fallen off the Medicaid roles because of welfare reform but who were still eligible for health insurance. This new application assistance program brought back the case management function, but these workers, rather than being paid directly by the state ISD, were public employees in other organizations (local school systems, FQHCs, public health offices, and nongovernmental organizations with low-income child clients). Their work remained uncounseled in the official cost of Medicaid managed care. Overall, the impact for clients was positive, but for enrollment workers and their employers there were communication gaps, ad hoc arrangements, and increased workloads. López argues even the efforts of committed application assistants could not overcome the “de facto disenfranchisement” that characterized the new enrollment system.

The second article, “The Safety Net of the Safety Net: How Federally Qualified Health Centers ‘Subsidize’ Medicaid Managed Care,” highlights the strategies of providers and staff and underlines the importance of a discourse of care in motivating these strategies. Deborah Boehm recounts the ways in which FQHCs subsidize or underwrite the new system by performing functions that other providers are reluctant to take on. Besides buffering clients from the new and complex MMC system, clinic staff also provided vaccinations to infants (a service that should have been provided by a baby’s regular PCP) or offered young women birth control when they were reluctant to approach their own providers. Staff and providers emphasized their commitment to patients and their willingness to do whatever they could to provide health care. Many had been clinic employees for 5, 10, or 15 years and have roots in local communities within Rio Arriba County or the South Valley of Albuquerque. Though it is important not to overromanticize these sentiments, this discourse of care motivates staff and providers to undertake the kind of buffering strategies that makes the system work and hides internal contradictions, including the gap between neoliberal emphasis on efficiency and cost effectiveness and the underlying reality of overworked employees in FQHCs.

Two articles focus on the impact of MMC on the behavioral health system on New Mexico. MMC brought profound structural changes as over 60 facilities closed in the state. William Wagner, in his article “Confronting Utilization Review in New Mexico’s Medicaid Mental Health System: The Critical Role of ‘Medical Necessity,’” identifies utilization review as the key process in the new MMC behavioral health structure whereby treatment plans for Medicaid clients are scrutinized by utilization reviewers in BHOs. If the plan meets the standard of “medical necessity” (a time-honored concept employed in a new bureaucratic context), the patient is admitted to care for a specified period of time and the clinician or mental health program is compensated. Although BHO administrators argued that the new system has improved services and eliminated expensive and ineffective residential treatment centers, providers found treatment plans truncated and services denied their needy clients. Providers devised strategies to work around new regulations or to directly appeal MCO decisions. Some clinicians Wagner interviewed

contested the decisions of reviewers or helped clients battle the BHOs while continuing to provide treatment. Others became frustrated and quit treating Medicaid clients.

Cathleen Willging, in her article “Power, Blame, and Accountability: Medicaid Managed Care for Mental Health Services in New Mexico,” examines mental health structures put in place in New Mexico between 1997 and 2000 from a different angle that emphasizes the key role of discourse. Willging views the new structures as a set of nested hierarchies where the state government oversaw the performance of MCOs that, in turn, regulated the activities of BHOs. The BHOs then determined what services clinicians and other providers would offer. In such a public–private “partnership,” both the state and the MCOs and BHOs deflected responsibility for maintaining financial and professional accountability. Willging uses three examples: the state’s monitoring of MCOs and BHOs, the demise of residential treatment centers and the use of utilization review to regulate services, and the use of taxis rather than shuttle buses to transport young children to a partial treatment program. In each case, the more powerful units are able to thwart monitoring or dampen down opposition while continuing to pursue policies in their own interests and exploiting the ambiguities inherent in a discourse of accountability. Fearing that MCOs would pull out of MMC, the state was reluctant to monitor MCOs and worried about losing referrals from BHOs, so clinicians and administrators did not criticize the taxi system that had clear negative impacts on children and was frustrating for parents. In the first two cases, state officials and corporate administrators blamed clinicians and providers for deficiencies in the system and in the third case, clinicians and treatment center administrators blamed parents. In all three instances, the discourse of accountability was used to shift blame downward to a unit or group of persons in a more subordinate situation.

Implications and Wider Perspectives

The final article of this collection, “Ideologies of Aid, Practices of Power: Lessons for Medicaid Managed Care,” serves as an epilogue. In it, Nancy Nelson widens our perspective on structures and discourses beyond health care. She begins with a broad historical discussion showing us how the notion of aid with regard to policies on economic development with health care show a parallel trajectory. On the one hand is the discourse of foreign aid (and all that entailed about the economic development of non-Western countries); on the other hand is the discourse of aid within the United States, that is, programs for the low income and the poor, for example, Medicaid. In the second half of her paper, Nelson uses recent anthropological theories that examine the foreign aid and development policies to explore the ways in which power is deployed in the MMC system we have been studying in New Mexico. By applying these new insights to the evidence offered by the articles in this special issue, she shows us various unintended consequences when privatized forms are imported into the public realm of health care but, more importantly, demonstrates how these unintended consequences continue to reinforce existing sources of power.

The Limits of Reform

In many ways, New Mexico embarked on a bold experiment in 1997 when it privatized Medicaid using three for-profit MCOs in a state with a relatively small population, large rural areas, and a high level of poverty. Kronik et al. (1993) argued that managed care systems would not work in rural areas with populations of less than 360,000, the amount necessary to sustain three MCOs, the minimal number necessary for competition. New Mexico put in place a model that has worked well for small, urban states like Rhode Island and Delaware (Jacobson and Droskoski 1998; Ku et al. 1998).¹⁶ Most states that have populations of less than 3 million and have large rural areas have adopted a MMC system that includes for-profit MCOs in urban areas and PCCM in rural areas. In contrast, the New Mexico system relies entirely on for-profit commercial MCOs. This has forced safety-net clinics and hospitals to contract with for-profit MCOs, and, in order to maintain some flexibility, most contracted with all three MCOs, which, in turn, spawned the burdens of the complexity of three.

Our ethnographic analysis delivers a powerful critique of the implementation of neoliberal policies that have created a bureaucratically complex system buttressed by discourses that emphasizes competition, efficiency, and individual choice. These notions seem hollow when juxtaposed against the difficulties complexity has posed for access (the barriers mothers faced in enrolling their children) and for utilization (especially in rural Rio Arriba County, where clients had difficulty obtaining transportation or easily filling prescriptions). More importantly, the amount of effort that providers and staff expended in buffering the system for clients added to their workloads and may have even diverted them from direct health care tasks.

The behavioral health system was even more adversely affected as facilities closed and utilization review curtailed services at the same time that powerful interests dampened down avenues for complaints or alternative pathways for delivering care. In 2001, after hearings and a great deal of controversy, the CMS eliminated the BHOs (see Willging, Semansky, and Waitzkin 2003) and a revamped Medicaid mental health program is under consideration. The new system will combine all state agencies responsible for behavioral health into an “interdepartmental behavioral health purchasing collaborative” that will contract with a statewide entity (e.g., a BHO) that will coordinate, administer, and oversee the delivery of all mental health services. These latest efforts constitute an even more ambitious reform than that of 1997. Based on what we have learned from our own study, there is a need to look critically at this implementation effort as well, documenting its impact on the fragile safety net and the vulnerable population it serves.

In the meantime, New Mexico, like most other states, continues to face rising health care costs. There is already a move in a majority of states to control the costs in one or more ways, by cutting prescription drugs benefits, restricting eligibility, reducing benefits, freezing payments to providers, or increasing copayments (Iglehart 2003:2342). New Mexico has implemented similar cost-cutting strategies, requiring Medicaid recipients to verify eligibility every 6 months rather than every year (a regulation that will diminish the Medicaid rolls). The state also is implementing a new fee schedule for physicians that cuts reimbursement for

some procedures and reducing dental benefits and some transportation services (Quigley 2004).

Our study has uncovered not just the complexity of the MMC program in New Mexico and its unintended consequences, but also the variety of strategies that providers (including mid-level professionals) and staff have used to buffer Medicaid clients from these consequences, many of which have surfaced as barriers to care. We have also elucidated subtle tensions between providers and the new financial bottom line, the use of discourses to shift blame, and unacknowledged ways that community health clinics are subsidizing or underwriting the new program. Perhaps most importantly, we have stressed the way committed providers and staff have managed increased workloads and additional stress to “make the system work” and to deliver what they consider to be adequate health care services to Medicaid clients. Policy analysts need to consider the impact of increased bureaucracy on Medicaid clients’ access to care but must also pay attention to the impact of burnout on medical workers as well.

It is clear that patchwork reforms are inadequate. They simply do not address the larger systemic issues that flaw MMC as a whole, and stop-gap measures create further difficulties in other areas. While the discourses of choice, accountability, and responsibility behind Medicaid and welfare reforms present a plausible but simplified picture of aid for predominantly poor women and children, the reality is far more complex and the beneficiaries of that aid are not necessarily those for whom it is intended. Ultimately, the intertwining of state and commercial bureaucracies has not been a successful systemic change.

NOTES

1. Other studies include Donald 2001; Kirschner and Lachicotte 2001; Maskovsky 2000; Robins 2001.

2. Our project “Multi-Method Assessment of Medicaid Managed Care” was initially funded by the UNM Division of Community Medicine and the New Mexico Department of Health (1997–98). A grant from the Agency for Health Research and Quality (AHRQ) funded the project between 1998 and 2001 (RO1 HS9703).

3. Our study did not include Medicaid patients who were in nursing homes or the elderly who are both Medicaid and Medicare recipients, approximately one-third of those on Medicaid in New Mexico.

4. I use the term *privatization* as shorthand for a more complex system. Most states have a mixed public–private or profit–nonprofit system that includes some combination of two or three components: commercial MCOs, most of which are for-profit entities; Medicaid MCOs that provide services only to Medicaid recipients and are often nonprofit; and PCCM networks of providers are usually operated by a state government. Between 1997 and 2000, New Mexico’s Salud! was composed of three commercial, for-profit MCOs and a commercial enrollment agency and, as such, was on the more privatized end of the spectrum (like Delaware and Rhode Island), and contrasted with states with mixed systems like Kansas (with one commercial MCO and a PCCM network) or Maryland (with six Medicaid MCOs).

5. The waiver system allowed states to override the “freedom of choice” aspect of Medicaid where patients were able to choose their physician (Medicaid Source Book 1993:Appendix H.P. 1041) and to put in place a system where Medicaid recipients were mandated to enroll in MCOs. The Balanced Budget Act of 1997 (BBA) eliminated the need for waivers,

but because many states already had these in place, they continued to renew their waivers and did not take advantage of this aspect of the BBA (Silberman et al. 2002).

6. Enrollment agents are usually for-profit firms that contract with a state to handle Medicaid enrollment and manage databases of clients. In New Mexico, we call the enrollment agent Dial-a-Med.

7. Interestingly, one of the most vulnerable populations, elderly Medicaid patients in nursing homes, has generally not been incorporated into managed care. Medicaid beneficiaries over 65 in 1998 were only 11 percent of all Medicaid recipients but accounted for 31 percent of the total Medicaid expenditures (Provost and Hughes 2000:147, 160–161). Disabled individuals (often in managed care programs) accounted for over 43.6 percent of total provider payments in 1998, partly because of the growing number of AIDS patients served by Medicaid (Provost and Hughes 2000:147, 162–163).

8. When behavioral health is “carved out,” the state contracts with entities (e.g., BHOs) that manage mental health services in a system that is separate from the rest of the MMC program.

9. There was little consultation with Navajo, Pueblo, and other Native American leaders at a local level. The state adopted an “opt-out,” policy whereby Native Americans were incorporated into Salud! unless they explicitly choose to opt-out of the program. This led to high rates of auto-assignment and to a tangle of paperwork at Indian Health Service clinics or tribally run clinics, difficulties with provider credentialing, and billing problems (Manuelito 2001). Tribal officials argued that mandatory Salud! enrollment violated tribal sovereignty and they were able to convince Governor Gary Johnson to change the policy. As of January 1, 2000, Native Americans were allowed to “opt-in,” that is, remain as Medicaid patients on a fee-for-service basis, unless specifically enrolling in the Salud! program, selecting an MCO, and choosing a contracted MCO provider. From a high of 75 percent Salud! enrollment in December 1999, Native American participation was completely reversed, so that by August 2002, 82 percent of Native American Medicaid recipients were under a fee-for service option (Native American Opt-out Report 1/99, 1/00, 3/02).

10. Sentinel events were defined as preventable, adverse sentinel health outcomes. Data included New Mexico birth and death records, New Mexico hospital inpatient discharge data, the New Mexico Tumor Registry, the National Immunization Survey, and reportable diseases reported by the State Laboratory Division of the New Mexico Department of Health.

11. These included 58 administrators, 105 physicians, 127 nurses, physician assistants, and nurse practitioners, and the 49 others including dentists, dental assistants, ISD caseworkers, pharmacists, and lab technicians. Team members also interviewed 142 clerical workers including universal interviewers, receptionists, referral clerks, and medical assistants.

12. Of the 13 physicians Caroline Todd interviewed (Todd 2001), five had changed practices over the course of 3 years. Three were no longer seeing Medicaid clients, and two had become employees of MCOs or other health care organizations. The latter were responding, in part, to the bureaucratic difficulties of handling their Medicaid clients and to the work overload their small office staff encountered.

13. The actual name is the Presumptive Eligibility-Medicaid Onsite Application Assistance program, but because this is such a cumbersome title, we have called it application assistance and its employees, application assistants.

14. Team members conducted interviews and participant-observation in the main emergency unit and the pediatric emergency unit at a large public hospital in Albuquerque and in the emergency room and adjacent urgent care center at the local hospital in Rio Arriba County. The Albuquerque hospital was affiliated with the Rio Grande MCO and the Rio Arriba hospital was part of the Del Norte MCO.

15. Although we do not have the trend data to support our observations, it is our impression that emergency room use in the units we studied was not declining after MMC reform, but for different reasons. The Albuquerque hospital, which traditionally treated large numbers of uninsured and Medicaid patients, became the only Trauma 1 center in the state in March 1998, adding to the number of patients treated. In addition, one physician told us that Medicaid patients assigned to another MCO were returning to the Rio Grande facility, now that the hospital had contracts with all three MCOs. "They have sent patients back to us. It was not a profitable thing for the other MCOs" (McCloskey, interview with Anglo male, 3/2/99). In Rio Arriba, the safety-net system (FQHCs and solo physician practices) was so overburdened that patients could not get appointments with their own providers or could not be seen for follow-up treatment after an emergency room visit. Therefore, they kept returning to the emergency room or the urgent care unity (Wagner, interview with Hispanic female nurse practitioners, 5/28/99 and 6/4/99).

16. But even in these states, some for-profit MCOs have left Medicaid managed care, considerably weakening the competition within these programs.

REFERENCES CITED

Batt, Rosemary

1998 *The Changing Nature of Work in Services*. Paper prepared for the Committee on Techniques for the Enhancement of Human Performance, National Research Council, Washington, DC.

2000 *Strategic Segmentation in Front-Line Services: Matching Customers, Employees and Human Resource Systems*. *International Journal of Human Resource Management* 11(3):540–561.

Donald, Alistair

2001 *The Wal-Marting of American Psychiatry: An Ethnography of Psychiatric Practice in the Late 20th Century*. *Culture, Medicine and Psychiatry* 25:427–439.

England, Paula, and Nancy Folbre

2003 *Contracting for Care*. In *Feminist Economics Today [Ten Years Beyond Economic Man]*. Marianne Ferber and Julie Nelson, eds. Pp. 61–80. Chicago: University of Chicago Press.

Fossett, James

1998 *Managed Care and Devolution*. In *Medicaid and Devolution: A View from the States*. Frank J. Thompson and John DiIulio, eds. Pp.106–195. Washington, DC: Brookings Institution Press.

Glenn, Evelyn Nakano

2000 *Creating a Caring Society*. *Contemporary Sociology* 29(1): 84–94.

Goode, Judith, and Jeff Maskovsky, eds.

2001 *The New Poverty Studies: The Ethnography of Power, Politics, and Impoverished People in the United States*. New York: New York University Press.

Gutek, Barbara A.

1995 *The Dynamics of Service: Reflections on the Changing Nature of Customer/ Provider Interactions*. San Francisco: Jossey-Bass.

Handelman, Don

1995 *Comments on "Putting Power in the Anthropology of Bureaucracy: The Immigration and Naturalization Service at the Mexico–United States Border,"* by Josiah McC. Heyman. *Current Anthropology* 36(2):280–281.

- Harvey, David
1989 *The Condition of Postmodernity: An Enquiry into the Origins of Cultural Change*. Oxford: Blackwell.
- Heyman, Josiah McC.
1995 *Putting Power in the Anthropology of Bureaucracy: The Immigration and Naturalization Service at the Mexico–United States Border*. *Current Anthropology* 36(2):261–287.
- Hochschild, Arlie Russell
1983 *The Managed Heart: Commercialization of Human Feeling*. Berkeley: University of California Press.
- Iglehart, John K.
1995 *The American Healthcare System: Medicaid*. *New England Journal of Medicine* 340(5):403–408.
2003 *The Dilemma of Medicaid*. *New England Journal of Medicine* 348:2190–2148.
- Jacobson, Eric D., and Amy B. Droskoski
1998 *The Diamond State Health Plan: Delaware’s Experience with Medicaid Managed Care*. In *Medicaid Reform and the American States*. Mark R. Daniels, ed. Pp. 66–91. Westport, CT: Auburn House.
- Kingfisher, Catherine Pélissier
1996 *Women in the American Welfare Trap*. Philadelphia: University of Pennsylvania Press.
- Kingfisher, Catherine Pélissier, and Michael Goldsmith
2001 *Reforming Women in the United States and Aotearoa/New Zealand: A Comparative Ethnography of Welfare Reform in Global Context*. *American Anthropologist* 102(2):714–732.
- Kirschner, Suzanne R., and William S. Lachicotte
2001 *Managing Managed Care: Habitus, Hysteresis and the End(s) of Psychotherapy*. *Culture, Medicine and Psychiatry* 25:441–456.
- Kodras, Janet
1997 *Restructuring the State: Devolution, Privatization and the Geographic Redistribution of Power and Capacity in Government*. In *State Devolution in America*. Lynn Staeheli, Jane Kodras, and Colin Flint, eds. Pp. 79–96. Thousand Oaks, CA: Sage.
- Kronik, R. D., C. Goodman, J. Wennberg, and E. Wagner
1993 *The Marketplace in Health Care Reform—the Demographic Limitations of Managed Competition*. *New England Journal of Medicine* 328(2):148–152.
- Ku, Leighton, Judith Wooldridge, Shruti Rajan, Marilyn R. Ellwood, Lisa Dubay, Teresa A. Coughlin, Sheila D. Hoag, and Susan Wall
1998 *Medicaid Managed Care Programs in Hawaii, Oklahoma, Rhode Island, and Tennessee*. In *Remaking Medicaid*. Stephen M. Davidson and Stephen A. Somers, eds. Pp. 147–178. San Francisco: Jossey-Bass.
- Leidner, Robin
1999 *Emotional Labor in Service Work*. *Annals of the American Academy* 561:81–95.
- Lipsky, Michael
1980 *Street Level Bureaucracy*. New York: Russell Sage Foundation.
- Manuelito, Brenda
2001 *The Effect on This Community Was Kinda Like Panic*. Unpublished site report. University of New Mexico, Albuquerque.

Maskovsky, Jeff

2000 "Managing" the Poor: Neoliberalism, Medicaid HMOs and the Triumph of Consumerism among the Poor. *Medical Anthropology* 19:121–146.

McCloskey, Joanne

2003 New Mexico's Health Care Safety Net under Medicaid Managed Care: A Comparison of Rural and Urban Experiences. Unpublished paper.

Medicaid Source Book

1993 Medicaid Source Book: Background Data and Analysis: A Report Prepared by the Congressional Research Service for the Use of the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, U.S. House of Representatives, Washington, DC. Appendix H, p. 1041.

Morgen, Sandra

2001 The Agency of Welfare Workers: Negotiating Devolution, Privatization, and the Meaning of Self-Sufficiency. *American Anthropologist* 103(3):747–761.

Morgen, Sandra, and Jeff Maskovsky

2003 The Anthropology of Welfare "Reform": New Perspectives on U.S. Urban Poverty in the Post-Welfare Era. *Annual Review of Anthropology* 32:315–338.

Native American Opt-out Report

1999, 2000, 2002 Medical Assistance Division, New Mexico Department of Human Services, Santa Fe. December, January, August.

Newman, Katherine

2001 Hard Times on 125th Street: Harlem's Poor Confront Welfare Reform. *American Anthropologist* 103(3):762–778.

Provost, Christie, and Paul Hughes

2000 Medicaid: 35 Years of Service. *Health Care Financing and Review* 22(1):141–174.

Quigley, Winthrop

2004 New Medicaid Rules Raise Coverage Fears. *Albuquerque Journal*, July 5, p. 1.

Rapp, Rayna

2000 Testing Women, Testing the Fetus: The Social Impact of Amniocentesis in America. New York: Routledge.

Robins, Cynthia S.

2001 Generating Revenues: Fiscal Changes in Public Mental Health Care and the Emergence of Moral Conflicts among Care-Givers. *Culture, Medicine and Psychiatry* 25:457–466.

Ruddick, Sara

1998 Care as Labor and Relationship. *In Norms and Values: Essays on the Work of Virginia Held*. Joram A. Haber and Mark S. Halfon, eds. Pp. 3–25. Oxford: Rowman & Littlefield.

Rylko-Bauer, Barbara, and Paul Farmer

2002 Managed Care or Managed Inequality? A Call for Critiques of Market-Based Medicine. *Medical Anthropology Quarterly* 16:476–502.

Schillaci, Michael A., Howard Waitzkin, E. Ann Carson, Cynthia M. López, Deborah A. Boehm, Leslie A. López, and Sheila F. Mahoney

2003 Immunization Coverage and Medicaid Managed Care in New Mexico: A Multi-Method Assessment. Unpublished paper.

Silberman, Pam, Stephanie Poley, Kerry James, and Rebecca Slifkin

2002 Tracking Medicaid Managed Care in Rural Communities: A Fifty-State Follow-Up. *Health Affairs* 21(4):255–263.

- Smedley, Brian D, Adrienne Y. Stith, and Alan R. Nelson, eds.
2003 *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: Institute of Medicine.
- Thompson, Frank J., and John DiIulio, eds.
1998 *Medicaid and Devolution: A View from the States*. Washington, DC: Brookings Institution Press.
- Todd, Caroline
2001 *Changing Roles, Changing Practices: Private Physicians in New Mexico's Medicaid Managed Care*. Paper presented at the Society for Applied Anthropology meeting, Mérida, Mexico.
- Waitzkin, Howard
2001 *At the Front Lines of Medicine: How the Health Care System Alienates Doctors and Mistreats Patients . . . and What We Can Do about It*. Lanham, MD: Rowman & Littlefield.
2002 *Multi-Method Assessment of Medicaid Managed Care: Final Report*. June. Submitted to the Agency for Healthcare Quality and Research.
- Waitzkin, Howard, Robert L. Williams, John A. Bock, Joanne McCloskey, Cathleen Willging, and William Wagner
2002 *Safety-Net Institutions Buffer the Impact of Medicaid Managed Care: A Multi-Method Assessment in a Rural State*. *American Journal of Public Health* 92(4): 598–610.
- Ware, Norma, William S. Lachicotte, Suzanne R. Kirschner, Dharma E. Cortes, and Byron J. Good
2000 *Clinician Experiences of Managed Mental Health Care: A Rereading of the Threat*. *Medical Anthropology Quarterly* 14(1):3–27.
- Willging Cathleen, Rafael Semansky, and Howard Waitzkin
2003 *New Mexico's Medicaid Managed Care Waiver: Organizing Input from Mental Health Consumers and Advocates*. *Psychiatric Services* 54(3):289–291.