



State Health Watch

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The Newsletter on State Health Care Reform

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In This Issue

Changes in managed care could be made in states

A recent Supreme Court ruling determined that the managed care system is functioning as it was designed by the federal government, and that if consumers want change, the state courts may be the proper forum for redress of grievances. The ruling in *Pegram v. Herdrich* confirmed financial incentives for doctors to hold down costs in managed care organizations are proper and HMOs are not necessarily liable in federal court for putting the organization before patients Cover

Constitutionality of ADA is questioned in high court

A case now before the Supreme Court has advocates of the Americans With Disabilities Act (ADA) concerned that many of the act's protections could be overturned. The case revolves around individuals seeking payments from the state of Alabama for violating the ADA. The state argues that Congress doesn't have the power to make states pay damages for injuries caused when states violate the ADA. One ADA advocate says the act could lose half of its constitutional underpinning if the court rules in the state's behalf . . . Cover

Profiles reveal gaps in health care access

The Health Resources Services Administration has just released profiles, state by state, on residents'

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Supreme Court ruling leads battle from federal court to state

The recent Supreme Court decision that narrows litigation possibilities against managed care facilities in the federal courts leaves the state courts open as an option for those with grievances.

The unanimous ruling, announced June 12, is a complex piece of turf on the battleground of managed care that has been quarreled over for more than 25 years. The Supreme Court's decision firmly upholds the belief that the managed care system is running as it should on the federal level and that if consumers want change, that change must come from somewhere else, preferably individual states.

The ruling essentially confirms

financial incentives for doctors to hold down costs in managed care organizations are proper, and HMOs are not necessarily liable in federal court for putting the organization before patients.

"The Supreme Court was very smart about this case," Steven Epstein, leader of the health practice group of the law firm Epstein Becker & Green, in Washington, DC, tells *State Health Watch*. "It's not better medicine to have a system that says more care is better care."

The court ruled on *Pegram v. Herdrich*, which originated in 1991

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Could high court strike down ADA protections?

Advocates are concerned that an Americans With Disabilities Act (ADA) case — currently before the Supreme Court — could lead to the elimination of many of the protections that have come about under the ADA as well as a number of other laws.

The high court will hear *University of Alabama v. Garrett*, which is challenging the constitutionality of the ADA. Garrett actually is two cases that were combined at the trial level. In one case, Patricia Garrett sued the University of Alabama Medical Center for demoting and then firing her as a supervising nurse after she was treated for breast cancer. In the

second case, Milton Ash, who has asthma, sued the Alabama youth corrections agency for failing to accommodate him by enforcing the agency's no-smoking rule and failing to service vehicles emitting noxious fumes that he was required to drive.

The cases are attracting nationwide attention because in both instances, the individuals sought payments from the state for violating the ADA, and the state argued that Congress did not have the power to require states to pay monetary damages for injuries caused when states violate the ADA.

"Those who are supporting

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health status, ability to access health care, and causes of death to improve the delivery of health services to all who need them. The profiles are intended to help state officials find the gaps in their health care systems. 3

The complex system of Medicaid enrollment isn't getting simpler

A new study of 13 American cities shows that Medicaid recipients often aren't aware of the many options they have when choosing from their ranges of care. For the system to function properly, the study finds, beneficiaries must understand the Medicaid system; instead, distrust and confusion reign 4

Language barrier may block enrollment in Medicaid

The biggest difference between Medicaid-eligible children who are enrolled in the program and those who are not is language, a new study said. Researchers found that more than 25% of families surveyed have employer-sponsored health insurance but don't take advantage of it and don't enroll their children in Medicaid. 8

Federal officials offer advice to docs on fraud and abuse

The Office of the Inspector General recently issued a draft compliance program to help individual and small-group physician practices combat fraud and abuse in government health programs, with the focus on Medicare and Medicaid 9

Clarification

The story 'Washington state using technology to go after improper payments' (*State Health Watch*, July 2000, p. 11) said the state had implemented a \$12 million system to combat fraud and abuse. The actual figure is \$2.645 million. Also, the story said the state could be expected to save \$55 million from its fraud and abuse program. The actual figure is \$5.5 million.

This issue of *State Health Watch* brings you news from these states:

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Supreme Court

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when Cynthia Herdrich complained to her managed care company of severe pain in her abdomen. The pain grew worse while she waited for her doctor to schedule an ultrasound of her inflamed abdomen. Eight days after her original complaint, her appendix burst and peritonitis set in. Her condition was eventually brought under control, and she survived. She sued Carle Clinic Association of Urbana, IL, contending her peritonitis could have been prevented if the doctors had conducted tests on her sooner. She alleged that the financial incentives the clinic offered for doctors to hold down costs had caused her harm.

Ms. Herdrich sued Carle in state court for fraud, and Carle contended that the Employee Retirement Income Security Act of 1974 (ERISA) pre-empted the counts of fraud. The case moved to federal court, which granted Carle summary judgment on one count of fraud but also allowed Ms. Herdrich to move ahead with another count alleging that ERISA had been breached. The breach came, she contended, by creating an incentive for doctors to make money-saving decisions in their own interest rather than for participants in the HMO.

"It is an equally resounding defeat for suit-happy trial lawyers who seek through class action suits to destroy the country's private health care system. The court's decision today validates the principle that the legal system is not the place to make health care work."

Karen Ignagni
President
American Association of Health Plans
Chicago

Nine years after Ms. Herdrich's appendix scare, the Supreme Court upheld the clinic's strategy to hold down costs. Karen Ignagni, president of the American Association of Health Plans in Chicago, termed the ruling a victory for maintaining affordable care. "It is an equally resounding defeat for suit-happy trial lawyers who seek through class-action suits to destroy the country's private health care system. The court's decision today validates the principle that the legal system is not

the place to make health care work.”

But the Supreme Court left the door open for legal action in state courts, shifting the battle to where the high court says the fight should be waged.

“If such suits are filed, state courts should employ the same two pillars of wisdom the Supreme Court used in reaching its decision,” *The Plain Dealer*, a Cleveland newspaper, wrote in its June 16 editorial pages. “First, HMOs exist to cut medical costs and they do a marvelous job, just as the legislative branch intended. Second, though the problem of HMOs so zealous about cutting costs that they damage patients cannot be ignored, a legislative body is the proper venue to tackle that problem, not a courtroom.”

ERISA, which pre-empts state law, is the dividing line between the federal and state courts, Mr. Epstein contends, and that’s the best place to view fights that may come along later.

“Financial incentives to contain costs are inherent in HMOs,” Mr. Epstein tells *SHW*. “If you take that away and allow the decision to overturn, that leaves open questions, like maybe it’s not an ERISA violation but the failure to disclose that there are incentives that may be improper. What is adequate for disclosure is separate, and that gives plaintiffs’ lawyers a lot of heart.”

ERISA disallows damage awards in federal court for the improper allowance of benefits by HMOs. Speaking for the Supreme Court, Justice David H. Souter wrote, “Recovery against for-profit HMOs for their mixed decisions would be warranted simply upon a showing that the profit incentive to ration care would generally affect such decisions, in derogation of the fiduciary standard to act in the patient’s interest without possibility of conflict. And since the provision for profits is what makes a for-profit HMO a proprietary organi-

zation, Ms. Herdrich’s remedy—return of profit to the plan for the participants’ benefit would be nothing less than elimination of the for-profit HMO.”

Allowing health plans to be sued isn’t the issue, contends Susan Pisano, spokeswoman for the American Association of Health Plans, but the number of reasons and ways HMOs can be sued is the issue.

“There has been this myth on which an entire argument about adding more liability bills has been based,” Ms. Pisano tells *SHW*. “In fact, as a recent Fifth Circuit Court decision suggests, you can sue your health plan.

“The court must make the decision about the quality of care or about if a particular benefit is a covered benefit or not. A lot of analysts and policy-makers suggest that employers will be liable under

expanded liability provisions that have been proposed in Congress, that it’s difficult to craft a decision to carve employers out of expanded liability,” she adds.

It is time for Congress to make changes to federal laws that do not address emerging managed care issues, according to *The New York Times* June 13 editorial page.

“Several states have enacted laws barring financial incentives for HMO doctors to deny patients necessary medical care,” *The Times* wrote. The court’s decision “underscores the need for Congress to set standards for how the managed care industry operates and to expand the rights of patients who have been harmed by managed care decisions, including the denial of care.”

In its June 17 editorial page, the *Dayton Daily News* wrote that “the ruling correctly sends the right-to-sue debate back to Congress and the state

Profiles point out gaps in health care access

State officials can use newly released profiles of residents’ health status, ability to access health care, and causes of death to improve the delivery of health services to all who need them, according to the federal official whose agency produced the reports.

“Data in these state-by-state profiles will help officials find the gaps in their health care systems and move to plug them,” says Claude Earl Fox, MD, MPH, administrator of the Health Resources Services Administration (HRSA), part of the Department of Health and Human Services.

Health care access is supported through a diverse set of local health care institutions, including public hospitals, health departments, clinics, and HRSA’s 3,000-plus community and migrant health centers and health care for the homeless programs, that provide health care to the nation’s poor and uninsured.

HRSA profiles respond to a call for better data in a recent Institute of Medicine (IOM) study, *American’s Health Care Safety Net: Intact But Endangered*. IOM committee members said they were struck by the lack of reliable data that can be used to assess the relative health of safety nets in communities across the country. To read the report on-line, go to: www.hrsa.gov/newsroom/releases/2000%20Releases/iomstudy.htm.

The profiles contain a six-page document for each state, plus the District of Columbia. ■

Complex Medicaid system is unclear to beneficiaries

As Medicaid's involvement with managed care becomes more pervasive, the system becomes more unwieldy. Patients often have little idea of their options of care, many are excluded or exempt from mandatory enrollment, and programs change their policies as often as they tear pages from the calendar. The result is often a distrust of the system by the people the system was created to help.

"Everything is under pressure — pressure to get started, pressure to get people enrolled," Chris Molnar tells *State Health Watch*. "It's rare that you get evaluation efforts. There is no replication of successes within the system." Ms. Molnar is one of the authors of *Educating Medicaid Beneficiaries About Managed Care: Approaches in 13 Cities*. She is a researcher with the Community Service Society of New York in New York City.

The study of 13 cities does note some successes, but it mainly tells a tale of a varied set of interpretations of what is good for Medicaid patients who sign up for care. The cities studied were Chicago; Detroit; the District of Columbia; Houston; Los Angeles; Memphis, TN; Miami; Newark, NJ; New York City; Philadelphia; Phoenix; Portland, OR; and Seattle. The research was sponsored by The Commonwealth Fund in New York City.

"The most exciting place was Seattle. It had a good infrastructure; it had real-time data about health plans; and its health provider was on-line," adds Ms. Molnar. "It had a healthy kids program that subcontracts with county health departments. [The city] got money down to the community level for its outreach program; it reproduced information that was multilingual and multiethnic."

At the other end of the spectrum, according to Ms. Molnar, was

Memphis, where one agency simply sent out a list of managed care plans for potential recipients to choose from. Overall, in all 13 test cities, once a Medicaid recipient signed up for a managed care plan, education about options came to a variety of halts. More emphasis on educating recipients tends to come when managed care plans are new because there is more of a political will to put money into the transition, she explains.

"I heard it time and time again from beneficiaries, 'I got that information, and I threw it out. I couldn't handle it.'"

Chris Molnar
Researcher
Community Service Society
of New York
New York City

Ideally, managed care heads off rising costs by eliminating specialty and acute hospital care and replacing them with primary and preventive care. But to make competition among managed care companies a reality — to hold down costs — Medicaid beneficiaries need to know how to make the best decisions for themselves. Beneficiaries must know how to choose the right plan, how to work their way through the managed care system, and how to avoid getting sick in the first place. But the system as administered through the 13 test cities has fostered a distrust of the system, and beneficiaries don't get the full benefit that is intended.

The cities that were studied had a variety of approaches designed to bring beneficiaries into the fold. Mailings, telephone banks, public awareness campaigns, and outreach

efforts via community-based organizations are examples, and none seem to work as well as intended. "We don't know what works," a broker representative said in the study.

The study concluded all 13 cities had basically the same weaknesses, and many of their problems could be solved. The main weaknesses, according to the study, were:

- a failure to tailor outreach programs to the specific educational needs of the Medicaid population;
- poor quality information about providers and plans;
- an inability to monitor program performance on educational objectives;
- reliance on a single intervention to convey information about such a complex set of topics.

One solution, suggested in the study, is that Medicaid programs should tailor their educational messages to meet the needs of beneficiaries. Few programs in the cities studied sought educational expertise or advice in developing enrollment materials or outreach strategies. As a result, education materials don't suit the needs of Medicaid beneficiaries.

"In New York and Los Angeles, they are contractually required to provide beneficiaries with a certain amount of information," Ms. Molnar says. "They give out a packet explaining the program, then five weeks later more information follows. There are multiple reminder letters. All that is sort of difficult to get through. I heard it time and time again from beneficiaries, 'I got that information, and I threw it out. I couldn't handle it.' Sometimes, the information packets were the size of phone books."

The study also recommended that Medicaid programs develop up-to-date provider databases and provide appropriate plan-specific information. None of the 13 cities studied had a satisfactory way to make this information

available. Distributing provider directories is expensive and inefficient, too, according to the study. Many managed care companies share the opinion that beneficiaries are not capable of understanding quality measures and comparative information about consumer satisfaction, the study noted, but that is exactly the information that beneficiaries are interested in. Much of the problem is the language used — too much jargon and many technical terms never become translated to everyday, understandable language for beneficiaries.

“The challenge that states and counties face is that lawyers say this and that must be in the material, and

the education people are the ones who say, ‘You’ve got to be kidding,’” Ms. Molnar says. “In New York, there is an effort to make sure the information about the program is written at the fourth-grade reading level. There is white space, big print, and pictures. On the other hand, there is a tremendous number of technical terms and jargon. Couldn’t it be simplified?”

“In programs like these, where there are public purchasers and there is no employer as an intermediary, people say, ‘How do I get through this? Help me wade through this material.’ These are the most vulnerable and least prepared beneficiaries.”

It’s not just the English language that presents problems. Reaching non-English-

speaking beneficiaries has its own challenges. The study found that basic Medicaid terms, such as primary care provider, primary care doctor, personal doctor, and primary care practitioner, had no equivalents in Spanish, Chinese, or Cambodian.

Medicaid programs need to develop tools to determine how effective educational efforts are, the study concluded. Many programs put the cart in front of the horse by conducting studies of their material, and they come up with a tremendous amount of information. But

Enrollment Packet Characteristics

Source: The Commonwealth Fund. *Educating Medicaid Beneficiaries About Managed Care: Approaches in 13 Cities*. New York City; 2000.
Web site: www.cmf.org.

most state officials interviewed said they still don't understand how to properly reach beneficiaries.

"We visited places where there were voluminous data collected. In California, they had massive piles of information and providers were saying, 'It's taking time away from my work.' There is so much information being captured, but no one knows how to use the system," Ms. Molnar says.

Many state officials and broker staff contend that outreach through existing community-based organizations is a viable avenue to communication. Local groups know the communities better than the state does, one former state administrator admitted in the study. In Houston, Detroit, Los Angeles, and New York City, the broker subcontracts with community-based organizations for outreach and education. Others, such as Philadelphia, Miami, and Phoenix, use such organizations to present information to groups.

The study also concluded that Medicaid managed care education should be ongoing — extending much further than the initial signing up of beneficiaries. "Most brokers and states acknowledge the need for continual education, but no one knows who will pay for it." Plus, half the patients enrolled in Medicaid are in the program for less than a year, so the urgency to continue education on the program withers steadily. In Chicago, the District of Columbia, Houston, Los Angeles, Newark, Philadelphia, and Portland, the providers no longer use marketplace incentives to get the plans to educate beneficiaries.

The strategy now is to have providers create a comprehensive health education program.

"What is needed is a series of clear and focused messages tailored to the needs of Medicaid beneficiaries and delivered through multiple approaches and settings — all of which are periodically and systematically evaluated," the study said. ■

ADA protections

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Alabama say the case is just about obtaining money damages from states," Ira Burnim tells *State Health Watch*. Mr. Burnim is an attorney with Washington, DC-based Bazelon Center for Mental Health Law. "That's the immediate question, but an adverse decision can have a much wider impact. At stake is half of the constitutional underpinning for Congress to require states to comply with the ADA."

A federal district court had accepted Alabama's argument, but that decision was reversed by the 11th Circuit Court of Appeals, setting the stage for Supreme Court consideration of the case. The appeals court ruled that Congress has the power under the 14th Amendment to the Constitution to require states to pay money damages for violations of the ADA. (Passed after the Civil War, the 14th Amendment guarantees all citizens equal protection of the law and due process of law.)

The Bazelon lawyers say the state's position may get a sympathetic hearing from the Supreme Court, which lately has been attentive to arguments based on states' rights. Earlier this year, for example, the court ruled that Congress lacked the power to require states to pay damages for violations of the Age Discrimination in Employment Act.

Mr. Burnim says an adverse Supreme Court decision could go beyond the ADA's protections governing public employment and eliminate all of Title II, which bans discrimination in access to public services such as education, health, mental health care, and other programs operated by states and localities. Also, while Section 504 of the Rehabilitation Act imposes similar obligations on states and localities where federal funds are involved, if

the court were to rule against the ADA, it could, in a later case, declare Section 504 unconstitutional.

If all of that happens, the Bazelon attorneys say, it could have these results:

1. States would not have to comply with the ADA's integration mandate upheld in last year's Olmstead decision, and there would be no requirement to move people unnecessarily institutionalized in state hospitals, nursing homes, and other institutions.

2. States would not have to make their buildings and services accessible.

3. State employers could refuse to hire people with physical or mental disabilities and could fire them at will.

"That's the immediate question, but an adverse decision can have a much wider impact. At stake is half of the constitutional underpinning for Congress to require states to comply with the ADA"

Ira Burnim
Attorney
Bazelon Center for
Mental Health Law
Washington, DC

While states could always adopt their own laws with the same protections, Bazelon attorneys fear that many would not do so.

In its brief submitted to the Supreme Court, Alabama says it does not take lightly its assertion that Congress has exceeded its authority. "The ADA achieves a commendable objective — mandatory accommodation of the disabled — and does so at the end of a lawmaking process that is as deserving of respect as each of the

state lawmaking processes that it purports to displace. But the ADA's attempted "expansion of Congress' powers . . . would work a reallocation of the federal-state balance that, in the end, would pose more threats to the cause of liberty than it would cure."

The state notes that while neither Title I nor Title II of the ADA applies generally to the federal government, the law says that states cannot be immune from suits under Title I and Title II and "it is this attempted abrogation that became the prologue to this dispute."

The state brief makes lengthy constitutional arguments that Congress overstepped its authority and acted illegally in allowing suits for money damages against states under ADA.

Mr. Burnim says he believes the Supreme Court has been staging cases to consider various states' rights issues.

He points out that when the court agreed to hear the *Olmstead* case, it first said it would consider both the interpretation of the regulations and the constitutional support for the law but later issued an order limiting its review to the regulations. He says he believes the court first wanted to hear a case under the Age Discrimination in Employment Act before moving on to the ADA.

If the court were to throw out 14th Amendment support for the ADA, a case would soon arise asking if Congress had authority to compel state compliance as part of its regulation of interstate commerce. And if that were also thrown out, there would effectively be no ADA as applied to state governments, adds Mr. Burnim.

In addition, he warns, other disability laws such as the Individuals with Disabilities Education Act also would be at risk, and cases would likely be raised challenging them.

Bazon attorneys say that under the Supreme Court's current approach, the

question of whether a particular civil rights statute exceeds Congress' power largely depends on two factors:

1. whether, when the statute was enacted, there was a significant problem of unconstitutional discrimination;
2. whether the requirements of the law are proportionate and reasonable responses to the problem that Congress sought to remedy.

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if that were also thrown out, there would effectively be no ADA as applied to state governments.

Ira Burnim
Attorney
Bazon Center for
Mental Health Law
Washington, DC

The Bazon Center is coordinating "friend of the court" briefs from states and other organizations to make the argument that, contrary to what Alabama says in its brief, the ADA qualifies under both points. Mr. Burnim says there may be a significant number of states filing briefs supporting the law, since they had asked for such a national standard before the ADA was passed.

He points out, although 36 states filed briefs supporting the Violence Against Women Act, the Supreme Court still said "it was going to

support states' rights even if the states don't want them" and threw out the law.

The National Association of Protection and Advocacy Systems is organizing a grass-roots effort to attempt to influence the filing of "friend of the court" briefs by states either supporting or opposing Alabama's position. The association says some states will be filing a brief with the Supreme Court, urging the court to find that the ADA does not apply to them. Others, led by the state of Minnesota, will be filing a brief in support of the ADA. It calls on advocates to:

- educate disability rights advocates in their states that the threat to the ADA is real and there is a need to act;
- work in coalition with other disability rights advocates in their state;
- determine the best way to approach their state leaders in terms of the state's politics;
- ask their state to sign on to a brief supporting the constitutionality of the ADA;
- if the state will not sign on to a brief supporting the ADA, ask state officials to at least stay neutral on the issue and not sign on to a states' rights brief;
- take advantage of any promises for future consultation and involvement made during advocacy around *L.C. v. Olmstead*;
- secure a commitment from the state to continue meeting and working on disability rights issues.

Oral argument will be scheduled for this fall, and a decision should be announced early next year.

Mr. Burnim says the case has implications for the upcoming presidential election because whoever wins will appoint one or more justices to the Supreme Court who would either overturn an adverse decision or make it even harder for advocates to win on states' rights issues. ■

Language barrier may prevent Medicaid enrollment

While those who work with government programs such as Medicaid often complain about the bureaucratic language used in regulations, manuals, and other documents, researchers have found that a more fundamental language problem may stand in the way of people enrolling for the benefits to which they are entitled — unfamiliarity with English.

“In comparing the populations of children who are enrolled in Medicaid with those who are eligible but not enrolled, we found the most significant difference was language related,” Chyongchiou J. Lin tells *State Health Watch*. Ms. Lin is assistant professor of health services administration at the University of Pittsburgh Graduate School of Public Health.

Among Medicaid-eligible children, 29% of Hispanics were uninsured, compared with 19% of whites, 17% of African-Americans, and 12% of Asian-Pacific or others. Of the nonenrolled eligible Hispanics, 75% chose to be interviewed in Spanish, Ms. Lin reports, suggesting that difficulty with the English language may be responsible for nonenrollment.

Many not fluent in English

“While we cannot say definitively that the parents of eligible children not enrolled in Medicaid do not speak English, the study results do show that a significant number of individuals in this group feel more comfortable communicating in Spanish,” she says. “Because Medicaid enrollment applications are fairly complicated, it is possible that someone with a limited ability to speak English would also have a limited understanding of the enrollment procedure.”

Funded by the Robert Wood

Johnson Foundation of Princeton, NJ, the study analyzed data gathered by the Center for Studying Health System Change’s 1996-97 Community Tracking Study Household Survey, eligibility data from state Medicaid programs, and the 1999 Area Resource File.

The review of 13,168 families with children under age 21 in 60 randomly selected communities found that approximately 23% of the children were eligible for Medicaid, with 48% of those eligible having Medicaid coverage, 35% with private or other health insurance, and 17% with no coverage. Compared to children enrolled in Medicaid, a higher proportion of uninsured Medicaid-eligible children were located in the South and West regions of the United States, lived in two-parent families, lived in families with income below the federal poverty level, and were Hispanic Americans.

“More than 25% of the families surveyed have employer-sponsored health insurance but are not taking advantage of it, and they are not enrolling their children in Medicaid,” Ms. Lin says. “Single parents are more apt to seek out social services such as Medicaid for their children.”

Ms. Lin cannot explain why children living with a single mother are more likely to be enrolled in Medicaid than those living in two-parent families, but she speculates that it could be because single women do not feel as secure and have less financial resources.

Compared to children enrolled in Medicaid, a higher proportion of uninsured Medicaid-eligible children reported no hospital stays, no doctor visits, no surgeries, unmet medical needs, and postponement of medical treatment, while a smaller proportion of them reported mental health visits

and a doctor’s office as the usual source of care.

A companion study looked at baseline characteristics of children who would be presumptively eligible for the State Children’s Health Insurance Program (SCHIP). Among all children in the study sample under age 21, approximately 15% were thought to be SCHIP-eligible, with 25% of them not having any health insurance coverage.

Uninsured parents, kids

“If the parents are uninsured, then the children are more likely to be uninsured, especially if they have no access to employer-sponsored health insurance,” Ms. Lin explains. Those without coverage also were more likely to live in the South and West, live in families with incomes less than the federal poverty level, and be Hispanic Americans. Again, a higher percentage of Hispanic families with uninsured SCHIP-eligible children were interviewed in Spanish.

A higher proportion of the SCHIP-eligible children reported limitation in moderate activities and postponement of medical care, while a smaller proportion of uninsured SCHIP-eligible children reported at least one hospital stay, one doctor visit, one surgery, home health visits, and a doctor’s office as the usual source of care.

Ms. Lin says that as states crank up outreach efforts seeking to enroll eligible children in Medicaid and their CHIP programs, it will be important for them to understand the potential barriers and realize that it may be necessary to work in different languages when there are large populations who use English as a second language.

Contact Ms. Lin at (412) 624-3625. ■

Federal officials give doctors detailed fraud and abuse guidance

In a move that health care attorneys say is remarkable for its depth of detail, the Health and Human Services Department's Office of the Inspector General (OIG) has issued a draft compliance program to help individual and small group physician practices combat fraud and abuse in government health programs.

The focus of the program will center on Medicare and Medicaid. June Gibbs Brown, inspector general, said the OIG also went to great pains to demonstrate the government's belief that the vast majority of physicians are honest and trying to comply with the law, as well as to say that honest mistakes, and even negligence, are not punished.

Like preventive medicine

The draft was published in the June 12 *Federal Register*, with comments due by July 27. It can be viewed on the Internet at <http://www.hhs.gov/progorg/oig/medadv/cpgphynr.htm>.

"Adopting a voluntary compliance program is a lot like practicing preventive medicine," said Ms. Brown. "It helps identify and treat small problems before they become big problems.

"Strong enforcement and strong voluntary prevention are equally important in safeguarding the government health programs from fraud and abuse. And the cornerstone of our prevention efforts is the development of voluntary compliance guidance that, in partnership with the private sector, will help the health care community develop effective compliance programs," she added.

The draft acknowledged "significant misunderstandings among physicians regarding the critical differences

between fraudulent [intentionally or recklessly false] health care claims . . . and innocent 'erroneous' claims . . ."

The OIG said its office does not disparage physicians, other medical professionals, or medical enterprises. Rather, it stated, "In our view, the great majority of them are working ethically to render high-quality medical care to our Medicare beneficiaries and to submit proper claims to Medicare."

"Adopting a voluntary

compliance program is a lot like practicing preventive medicine. It helps identify and treat small problems before they become big problems.

Strong enforcement and strong voluntary prevention are equally important in safeguarding the government health programs from fraud and abuse."

June Gibbs Brown

*Inspector General
Department of Health
and Human Services
Washington, DC*

The OIG also explained that under the law, physicians are not subject to civil or criminal penalties for innocent errors, or even negligence. Both the Civil False Claims Act and the Civil Monetary Penalties Law — the two main enforcement tools available — cover only offenses that are committed with actual knowledge of

the falsity of the claim, reckless disregard, or deliberate ignorance of the falsity of the claim, the draft said.

The False Claims Act "simply does not cover mistakes, errors, or negligence. When billing errors, honest mistakes, or negligence result in erroneous claims, the physician practice will be asked to return the funds erroneously claimed, but without penalties. In other words, erroneous claims result only in the return of funds claimed in error," according to the OIG.

Reducing error rate

Because innocent billing errors are a significant drain on the program, all parties — physicians, providers, carriers, fiscal intermediaries, government agencies, and beneficiaries — need to work cooperatively to reduce the overall error rate.

The draft guidance lists seven basic elements the OIG said should be considered in any physician practice compliance program:

- developing a code of conduct with written policies and procedures;
- assigning compliance monitoring efforts to a designated compliance officer or contact;
- conducting comprehensive training and education on practice ethics and policies and procedures;
- conducting internal monitoring and auditing, focusing on high-risk billing and coding issues through periodic audits;
- developing accessible lines of communication, such as staff meeting discussions, to keep practice employees updated on compliance activities;
- enforcing disciplinary standards by ensuring that employees are aware that compliance is treated seriously and that violations will be dealt with consistently and uniformly;
- responding appropriately to

detected violations through investigation of allegations and the disclosure of incidents to appropriate government entities.

While not officially prescriptive, nothing in the guidance is mandatory for physician practices, the guidance is useful in giving very detailed explanations of many parts of each of the seven elements.

The OIG said it realizes there is no one-size-fits-all compliance program and that applicability of any of the recommendations depends on the circumstances of each particular practice.

“Each practice should undertake reasonable steps to respond to each of the seven elements of this guidance, depending on the size and resources of the practice. Compliance programs not only help to prevent fraudulent or erroneous claims, but they may also show that the physician practice is making a good faith effort to submit claims appropriately,” explained Ms. Brown.

Developing policies

An effective program also puts practice employees on notice, the guidance said, that while the practice recognizes that mistakes will occur, employees have an affirmative, ethical duty to come forward and report fraudulent or erroneous conduct so that it may be corrected.

To help physicians develop policies and procedures covering the fraud and abuse topics that are most applicable to their own practices, the OIG provides a list of potential risk areas affecting physician providers, including:

1. coding and billing;
2. reasonable and necessary services;
3. documentation;
4. improper inducements, kickbacks, or self-referrals.

The OIG said its list should be seen as a starting point for a practice’s

internal review of potential vulnerabilities to ensure that key practice personnel are aware of the risk areas and are taking steps to minimize, to the extent possible, the types of problems identified.

“Each practice should undertake reasonable steps to respond to each of the seven elements of this guidance, depending on the size and resources of the practice. Compliance programs not only help to prevent fraudulent or erroneous claims, but they may also show that the physician practice is making a good faith effort to submit claims appropriately.”

June Gibbs Brown
*Inspector General
Department of Health
and Human Services
Washington, DC*

Ms. Brown said that while physicians clearly are very busy, “We hope they will take the time to review the draft guidance and provide us with thoughtful comments. Practicing physicians can offer invaluable insights about how they and their colleagues can put voluntary compliance plans into place in their practices.”

Initial reviews of the compliance document by health care attorneys and practice trade associations indicated support for its flexibility and helpfulness, and for the distinction between fraudulent and erroneous

claims, although at least one group still has some concerns.

The Medical Group Management Association (MGMA) in Englewood, CO, had recommended the OIG not issue the guidance out of fear that many small practices would have difficulty meeting its expectations.

Making it easier

Aaron Krupp, government affairs representative for MGMA, tells *State Health Watch* that his organization recognizes that in preparing the draft the OIG included some of the group’s earlier recommendations, such as not mandating a toll-free telephone hotline for employees to use to anonymously report violations, allowing two or more practices to share a compliance officer, or permitting a practice to contract out that responsibility.

Mr. Krupp says MGMA is still concerned about the guidance’s call for a baseline audit, which may be too costly for many small practices, and the recommendation that practices maintain a library of regulations and other materials.

Maintaining such a library will be hard for them to do because they often don’t have Internet access and don’t have the financial or human resources to spend on researching and assembling materials, he adds.

Overall, MGMA is concerned that while the OIG says the guidance is not mandatory, the way it lays out recommended essential elements sends a mixed message, raising the possibility that practices that don’t have all the elements will be considered to not have a good compliance program.

Mr. Krupp also says any guidance needs as much flexibility as possible to meet the needs of small practices.

Contact Mr. Krupp at (202) 293-3450. ■

Clip files / Local news from the states

This column features selected short items about state health care policy.

Hearing loss, America's leading birth defect, under siege under new Florida law

ORLANDO, FL—A new state law will require that all babies receive hearing screenings before leaving the hospital.

Every baby across the state, along with its first coo, first taste of milk, and first grip of his mother's finger will — beginning this fall — also undergo his first hearing test. Effective Oct. 1, a new state law will require that babies receive a hearing screening before they leave the hospital. More than 25 states have similar requirements in place.

Leaders in pediatrics and audiology rank hearing impairment as the leading birth defect in the United States, affecting one in 200 newborns. Often, parents don't realize their child has trouble hearing until months, or even years, after the child should have been learning how to speak. Testing all babies will prevent them from playing catch-up in their learning skills.

The new law — the issue received unanimous support in both the state House and Senate — requires that babies born at home be referred within 30 days by their health care providers to an audiologist who can perform a hearing test. "There's just this huge harm done to children when you deny them the opportunity to learn a language during the early stage of their life," said John Zeigler, an audiologist and director of Lake County Hearing Clinic in Tavares. "We want to start to identify these children and hopefully get them amplified with hearing aids or cochlear implants by the time they are 18 months old."

The effort will mean a big boost in business for audiologists in Lake County and across the state. "There are not enough audiologists in the state to test all the babies," said Dr. Holle Whitaker, an audiologist and manager of the infant-hearing program at Arnold Palmer Hospital for Children & Women in Orlando. There are 689 practicing audiologists in Florida. There are more than 195,000 babies born each year in the state.

—*The Orlando Sentinel*

New PA state study says many hospitals lost money and 'meltdown' is occurring

HARRISBURG, PA—About 40% of Pennsylvania's hospitals lost money in 1999 and a growing number are relying on stock investments and charitable contributions to stay afloat, according to a recent state report. The report highlights a continual downturn. In 1998, 30% of the hospitals lost money.

Hospitals' overall net income last year dropped 31% statewide, while profits earned solely from treating patients, or operational income, fell to nearly zero due in part to the rising expense of treatment, according to the study by the Pennsylvania Health Care Cost Council. "Clearly what we saw is a troubling sign for hospitals," said council spokesman Joe Martin. "The loss to hospital earnings has continued and gotten worse. In addition, more and more the average hospital is unable to make money on patient care alone and is utilizing investments and endowments."

Carolyn F. Scanlan, president and chief executive officer of The Hospital and Healthsystem Association of Pennsylvania, called the report "frightening evidence" that the hospital system is in "meltdown." She said hospitals have been hurting after Medicare reimbursements declined under the federal Balanced Budget Act of 1997 and as Pennsylvania reduces the number of Medicaid-eligible recipients. Hospitals dependent on stock investments, meanwhile, are at risk should the market soften. "This report is very frightening," she said. "If Pennsylvania hospitals don't get relief soon, the result may be catastrophic — fewer hospitals, longer trips to the hospital, and more anxiety for you and your neighbors."

The council said it was difficult to determine what was specifically to blame for hospitals' continuing losses, but pointed to the growing rate of uncompensated care and declining Medicare reimbursements as likely factors. The rate of uncompensated care, which makes up about 4.9% of a hospital's net revenue, rose 9.9% to \$834 million last year, according to the report. Uncompensated care includes both charity care to patients who can't afford services and bad debt from patients who are supposed to pay but don't. The report also found a "predominant shift" in terms of fewer hospitals with a healthy net income in the 4% to 6% range in 1999, and a greater number in the 0% to 2% income range. That demonstrates that hospitals must find new ways to stem costs, Mr. Martin said.

"They need to keep their expenses below their revenue, whether that means other ways to maximize revenue streams or ways to cut expenses without hurting patients," he said.

—The Associated Press



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Gore calls for increased mental health coverage for children

CHEVY CHASE, MD—Vice President Al Gore on May 31 proposed requiring health insurers to offer children the same level of coverage for mental illness as they provide for other medical needs. The proposal was part of a broader plan by the presumed Democratic nominee for president to combat the stigma of mental illness and expand access to treatment. “Mental illness is nothing to be ashamed of,” Gore told several dozen advocates for the mentally ill. “But stigma, discrimination, and ignorance shame us all.”

The release of Gore’s mental health agenda was the latest in a series of events this week to outline his positions and flesh out his personal background after weeks of attacking his presumed Republican rival, Texas Gov. George W. Bush. Gore unveiled the plan at a mental health forum co-hosted by his wife, Tipper, who disclosed last year that she took medication for depression after their only son was struck by a car and nearly killed in 1989.

Gore called for training teachers to spot symptoms of mental illness, expanding programs for the homeless and strengthening protections of patient privacy.

The government’s total cost, which would be covered by the federal budget surplus, would be \$2.5 billion over 10 years, a Gore aide said. The cost of health insurance to employers and consumers would rise by roughly 1%. Gore’s key proposal was to expand insurance coverage for children so that mental illness is treated the same as heart disease, diabetes, or other physical ailments. The requirement would apply to employer-sponsored health plans and to the Children’s Health Insurance Program, which covers youngsters in families with incomes too high to qualify for Medicaid.

Mental health experts say children with mental disorders who get treatment are less apt to commit suicide, drop out of school, abuse drugs, or turn to violence. Gore cited the two boys who shot and killed 12 schoolmates, a teacher, and themselves last year at Columbine High School in Colorado. “As Columbine taught us, we cannot wait until tragedy strikes to reach out effectively to troubled young people and give them help and hope,” Gore said.

— *Los Angeles Times*

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