



State Health Watch

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The Newsletter on State Health Care Reform

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Battle for uninsured children is bittersweet for the states

Forty states will lose the federal money extended to them through the Children's Health Insurance Program because they could not find ways to spend it. The unspent funds are set to go to the 10 states that did manage to spend the money allocated to them through the program. But while many children go uninsured, states say more children than ever are now receiving health care insurance . . . Cover

More Americans insured, but the poor still suffer

Officials applaud the latest drop in the number of uninsured Americans, but U.S. Census Bureau statistics show that the improvements come mostly from the ranks of upper-income families. The ranks of uninsured children have also decreased, accounting for more than half of the drop. The statistics highlight the fact that the poor continue to dominate the ranks of the uninsured. Cover

States receive grants for uninsured access

The federal government has given one-year grants totaling \$13.6 million to 11 states to develop plans to provide access to affordable health insurance to the uninsured. The state agencies receiving the grants are to conduct studies first to better identify the characteristics of the uninsured. 3

While more children are now insured, more money goes unspent

The number of uninsured children in America is declining, but that's a bittersweet fact for those watching 40 states lose millions of dollars of federal money that has gone unspent.

When the Children's Health Insurance Program (CHIP) was created by Congress in 1997, \$4.2 billion was made available to states to insure those children in families who were ineligible for Medicaid but still could not afford private insurance. Now \$1.9 billion of that unspent money will be siphoned off to the 10 states that did manage to spend their allotment.

"From our perspective, it's frustrating that the money hasn't been spent," Gregg Haisley, deputy director of the health division of the Children's Defense Fund of Princeton, NJ, tells *State Health Watch*. "But, to put it in context, more than 2 million kids have been covered since CHIP was created in 1997. That's success. The downside is that the unspent dollars represent a missed opportunity. While there are good things happening, we'd like to see the pace picked up."

State programs have plenty of hurdles in front of them that keep children under age 18 from receiving

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More upper-income children insured, census says, but not so for the poor

New data from the U.S. Census Bureau indicating a drop in the overall number of Americans without health insurance is welcome news, but it still highlights problems faced by poor citizens, according to the Center on Budget and Policy Priorities in Washington, DC.

"Our main concern is that despite generally good news, it's pretty much confined to upper-income people," Center senior fellow Leighton Ku tells *State Health Watch*. "We see some improvement in participation among low-income children, but it's hard to say why that is."

The Census Bureau said the number of uninsured fell in 1999 from 44.3 million to 42.6 million, the first decline since 1987. More than half the drop was driven by improvements in health care coverage for children, some analysts said. Many of the children who gained coverage were poor children, suggesting to some that efforts to enroll more Medicaid-eligible children in coverage and to implement state Children's Health Insurance Programs (CHIPs) are beginning to show results.

But the Center on Budget and

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CHIP

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the health insurance coverage that the federal and state governments would like them to get. They include children who have dropped off the enrollment list and must be re-enrolled, or families that have no idea the program exists so their children remain uninsured.

The Urban Institute in Washington, DC, has an explanation for the problem. In a recent study, “Three Years Into SCHIP: What States Are and Are not Spending,” the institute says state spending falls short because of the nature of the funding, which is described as having a U-shaped pattern.

Typically, Urban Institute officials say, new program spending has an upward trajectory, followed by lower spending in its first years as programs are honed, then more spending follows as the programs gain momentum. CHIP has a different look, the institute says, that changes the dynamic of the program and results in the unspent dollars that are planned to flow from the 40 states that have not spent their allocations to the 10 states that have.

“When CHIP came along, a lot of states simplified their Medicaid benefits. You used to have to go to a welfare office for an interview. With CHIP, you mail in the applications; there is no interview at a welfare office. Many states also eliminated asset tests. Most states eliminated all those barriers and began to treat CHIP as the medical program that it really is.”

Gregg Haisley
*Deputy Director
Health Division
Children’s Defense Fund
Princeton, NJ*

Don’t judge the program by how well the states have spent their allotments, the authors of the study conclude.

“Two other questions need answers,” says Genevieve Kenney, one of the study’s authors. “Policy-makers need to know how well state CHIP and Medicaid programs

reach their target populations, and to what extent mature state CHIP programs ensure new low-income programs.”

With 10 million children going uninsured in America that could be covered by CHIP, according to the Children’s Defense Fund, a simplification of state programs over time will lower the numbers.

“In the overall picture, this is a problem that is a partisan outgrowth of the creation of a new program. We realize there is some ramp-up time for starting a new program,” Mr. Haisley adds. “At a certain point, in a couple years, we expect states to spend all their money.”

There are proposals before Congress that could change the way the money is allotted to states, according to the Urban Institute. Allowing states more time to spend their money is one and increasing the amount available to each state is another. Also, institute officials say, there may be a move to allow adults to be covered by unspent CHIP money.

Mr. Haisley says Congress, in the concluding days of its recent session, was considering a proposal that would allow states to keep the federal CHIP money that they had not spent, giving them another three years to find ways to insure children. “You can bet the ranch there will be an extension,” he says.

As it stood before Congress’s expected recess in October, states that have used their allotments were Alaska, Indiana, Kentucky, Maine, Massachusetts, Missouri, New York, North Carolina, Pennsylvania, and South Carolina. Each will have until Sept. 30, 2001, to spend the money from the other 40 states. After that, the unspent dollars go back to the U.S. Department of the Treasury.

The Children’s Defense Fund says states could find more children that are eligible for the program by

increasing outreach funding and expanding their partnerships with community-based organizations.

“When CHIP came along, a lot of states simplified their Medicaid benefits,” Mr. Haisley says. “You used to have to go to a welfare office for an interview. With CHIP, you mail in the applications; there is no interview at a welfare office. Many states also eliminated asset tests. Most states eliminated all those barriers and began to treat CHIP as the medical program that it really is.”

With the lessons that states have learned, Mr. Haisley adds, the program is becoming easier to administer and much more family-friendly. “They are trying to keep children in CHIP,” he says. “And once they are in, that is really only the beginning of trying to keep them in.”

In Alabama, according to state

officials, many children went without health insurance because:

- Insurance costs too much.
- They were no longer eligible for Medicaid.
- Family wage earners either lost or changed their jobs.
- Employers dropped their health coverage.

There are plenty of reasons states say they cannot spend the money allocated by the federal government. “If we enrolled every single eligible child in Colorado, we still couldn’t spend our full allocation of federal money. Our economy is doing so well, there are fewer eligible kids than what was estimated when the federal government did its initial allocation of money,” William N. Lindsay, head of the board that supervises the program in Colorado, told the Associated Press. ■

States get grants for uninsured access

The federal government has given one-year grants totaling \$13.6 million to 11 states to develop plans to provide access to affordable health insurance to the uninsured. Secretary of Health and Human Services Donna Shalala says the state agencies receiving the grants are first to conduct studies to better identify the characteristics of the uninsured. They then are to use that information to determine what will be the most effective methods to provide them with high-quality, affordable health insurance similar to plans that cover government employees or other benchmark plans.

The grantees are to submit reports detailing their proposals for expanding public-private partnerships to cover all uninsured citizens so other states can profit from their experience.

States receiving the grants are:

- Arkansas;
- Delaware;
- Illinois;
- Iowa;
- Kansas;
- Massachusetts;
- Minnesota;
- New Hampshire;
- Oregon;
- Vermont;
- Wisconsin. ■

Every state has its way to reach special needs children

State activities to provide services to children with special health care needs under Medicaid managed care vary and do not always conform with interim criteria for such services issued by the federal government in June 1999, according to a recent survey of six states.

The National Academy for State Health Policy in Portland, ME, conducted site visits in Colorado, Connecticut, Delaware, Massachusetts, Michigan, and New Mexico last fall, talking with officials from Medicaid and other state agencies, managed care organizations (MCOs), parents of children identified as eligible for services, providers, and advocates.

The goal was to inform federal agencies of the fit between the states' activities and the interim criteria, to determine whether the criteria should be adjusted as the Health Care Financing Administration (HCFA) applied them to state waiver requests. At the time the study was conducted, the criteria did not apply to any of the states visited. The academy looked at current state services in terms of definition of children with special health care needs; identification and tracking of such children; enrollment and disenrollment; provider capacity, access to specialists, and access to benefits; quality of care; coordination of care; payment methodology; and stakeholder input:

• **Definition.** The academy found that states use various methods to define children with special health care needs (CSHCN), depending on the purpose and objectives of their initiatives. States may use diagnostic criteria, presence of risk, functional status, or utilization of services to define CSHCN, and also may use one or more of the categories set forth by Congress in the Balanced Budget Act of 1997:

- receiving SSI;
- eligible under 1920 (e)(3);
- in foster care;
- receiving foster care or adoption assistance payments;
- receiving Title V-funded care coordination services.

"HCFA's a little beyond the state of the art on quality.

State agencies would like to go there, but they're not sure how to do it and could use some technical assistance. It's clear that states have been thinking about capacity issues and access to specialists, and there's the least for them to do in that area."

Neva Kaye
*Director
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Those interviewed told the academy that while the congressional criteria can be useful for identifying groups of children for whom a state must seek a waiver and develop certain safeguards prior to enrolling them in mandatory managed care, a strict application of the criteria isn't sufficient to identify some children with the greatest need for safeguards. Specifically excluded from the criteria are special needs children who qualify for Medicaid under different eligibility categories than those in the definition

or who received Title V-funded services without care coordination. Those participating in the survey also cautioned against using the congressional criteria to attempt to produce a consistent count of CSHCN across states or to get an unduplicated count within a state since the groups overlap.

• **Identification and tracking.** State sources at the sites said they were using their own definitions of CSHCN, all of which differed from HCFA's interpretation of the congressional definition in the interim criteria. The sources explained that they considered it more important to use a definition that would allow them to identify and track individual children and their care needs rather than simply identifying aggregate groups of children. The Medicaid agencies said they could identify all children in the five groups in the congressional definition if they had to, although none were doing so at the time of the visit.

• **Enrollment and disenrollment.** State agencies said their processes for enrollment and disenrollment generally were not specific to CSHCN, but rather applied to all populations enrolling for managed care. The agencies said they found it difficult to conduct more targeted activities specific to CSHCN because of the difficulty in identifying those children prior to enrollment and insufficient information about their health status, current provider, or contact information. Many stakeholders said the availability and transfer of information in the enrollment process was a key concern. Families wanted to know which, if any, aspect of their children's care would be disrupted by the move to managed care and wanted to know how to access care in their new managed care organization. Managed care organizations wanted accurate and complete contact information for new

enrollees, as well as information from claims or encounter data about services the children were receiving prior to enrollment so they could prevent disruption in care.

• **Provider capacity, access to specialists, and access to benefits.** The academy says states reported contract provisions in place with their managed care organizations to assure sufficient provider capacity and access to specialty care. Although their policies were not identical to those in the interim criteria, states put considerable importance on the availability of qualified providers who can serve all managed care enrollees, including those with special needs. Interviewers found that the importance of experienced providers goes beyond physicians to include all who come in contact with a special needs child, from personal care assistants to child welfare agency staff to durable medical equipment suppliers, to X-ray technicians and the managed care organization staff.

Parents said they were as interested in availability of services such as wheelchairs, in-home therapy, diapers and other supplies, private duty nursing, and pharmacy services as they were concerned about access to appropriate physicians. Parents and providers want to know that there is an established and ongoing system of care, whether it is provided through managed care or fee-for-service, that can respond to the chronic nature of a child's illness or disability and the ongoing needs of the family.

• **Quality of care.** Few of the Medicaid agencies surveyed had implemented performance measures specific to CSHCN, as envisioned in the interim criteria, although all had conducted qualitative studies and measured MCO performance in areas of concern to special needs children. The states said that low enrollment numbers from the target population and lack of performance measures

specific to that population were barriers to implementing quality programs such as envisioned in the criteria.

• **Coordination of care.** Those interviewed said that the interim criteria leave unaddressed many important elements that could ultimately affect the impact of care coordination on a beneficiary's health status and care needs. They said that some of the terms used in the criteria — such as assessment, treatment plan, and case management — have different meanings to different stakeholders, leading to confusion about who should receive care coordination, what is to be provided, and what the outcomes of care coordination should be.

• **Payment methodology.** All Medicaid agencies interviewed said they were adjusting payments by demographic factors such as age, sex, and eligibility category, and those would meet the requirements of the interim criteria. The academy reported there was a growing consensus among the agencies to move beyond these factors and to base capitation payments on enrollee health status and use payments to provide incentives to improve MCO performance. Other concerns raised included adequacy of overall payments to MCOs to accommodate the special needs and frustration about the difficulty in establishing payment responsibility for specific services among the multiple agencies that serve children with special needs.

• **Stakeholder Input.** The agencies surveyed said they had processes in place for development of the managed care program similar to those in the interim criteria. States typically involved those responsible for caring for children with special needs, including families, advocacy groups, providers, MCOs, and Medicaid and other state agencies. Those interviewed said it was important to involve stakeholders in all aspects of managed care

program operation and evaluation, not just program development, and to measure the results of stakeholder input by assessing the changes that come from their involvement.

Conformity with the criteria is easier on some than others, according to Neva Kaye, director of the Medicaid managed care resource center at the National Academy for State Health Policy.

“The biggest potential problem is in the definition,” says Ms. Kaye. “It was good for where it started — to decide if a waiver is needed. But when you try to apply it to the other criteria, it can create problems.”

Another problem area is quality. “HCFA's a little beyond the state of the art on quality. State agencies would like to go there, but they're not sure how to do it and could use some technical assistance,” she adds. “It's clear that states have been thinking about capacity issues and access to specialists, and there's the least for them to do in that area.”

Ms. Kaye says there could be problems tracking clients. States can identify people at enrollment, but then there is a question of whether they are the right people to be tracked. And that goes back to the definition. “Everyone agrees that coordination of care is important, and everyone believes they can do it better. The terms are not well-defined, so states may or may not be meeting the criteria.”

Ms. Kaye says states are doing particularly well on stakeholder input. Some involve people not just in waiver development but also in program operations and some hire stakeholders to work on staff in the programs. She says the academy did its best to pick a representative sample and adds that it gives a good picture of what's going on in all the states. HCFA is revising its criteria based on the report, but Ms. Kaye has not had feedback yet on specific revisions and is unsure when they will be issued. ■

Internet program speeds eligibility check

Census Bureau

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Nearly half of the population of Washington state — up to 3 million people — is expected to enjoy faster and more hassle-free health care thanks to an Internet-based program being implemented by a group of several of the state's largest health care organizations.

The new program, created by members of the Washington Health Care Forum, allows physicians and hospitals across the state to devote more of their resources to patient care and less to unneeded administrative processing.

"The first of the four health plans has put patient eligibility on the system," says Tom Curry, executive director/CEO of the Washington State Medical Association and a Forum member.

"The potential savings in time, money, and hassle are enormous. The patient benefits by getting better health service and lower costs. And this is just the first step."

Leo Greenawalt
President
Washington State
Hospital Association
Seattle

"Now a question about who is eligible for service can be answered over a secure Web connection in just four seconds. That's four seconds — instead of making a phone call, getting a voice mail, making alternative command selections, being placed on hold, and other hit-and-miss procedures that often consume a lot of valuable time. The new system works just great and protects patient

confidentiality," adds Mr. Curry.

All four participating health plans should be up and running on the eligibility portion before the end of the year, adds Leo Greenawalt, president of the Washington State Hospital Association in Seattle. "The potential savings in time, money, and hassle are enormous. The patient benefits by getting better health service and lower costs. And this is just the first step."

As soon as eligibility verification is on-line at all four participating health plans, the next step is to create secure Web connections for authorizing referrals of patients to specialists and to assure prompt payment of claims to minimize patient frustration. Forum CEOs have assigned staff to simplify other administrative processes that now add time and take money away from patient care.

The Washington Health Care Forum is a group of leaders from health care provider organizations and health plans, including the Washington State Hospital Association, the Washington State Medical Association, First Choice Health Network, Group Health Cooperative of Puget Sound, Premera Blue Cross, and Regence Blue Shield. Work on developing the Web-based eligibility verification system began late last year, with the overall goal to make the health care system simpler and more efficient to navigate for consumers, physicians, and hospitals.

Representatives of the member organizations first met in early 1999 to set goals and develop a work plan, Mr. Greenawalt says. "All of us in health care need to remember that our fundamental goal is to provide good service to consumers with as little administrative hassle and as much care and compassion as we possibly can. Those of us who are members of the Washington Health Care Forum are taking action to make sure we deliver on that goal." ■

Policy Priorities says the data also indicate that states are still struggling to ensure that welfare reform does not have the unintended consequence of causing families with children to miss out on coverage. Although children in poor families are gaining ground, they still are more likely to be uninsured than they were before enactment of 1996 welfare reform legislation. In addition, according to Center policy analyst Jocelyn Guyer, the parents' insurance situation still appears to be deteriorating. Unlike children in poor families, she says, it appears that parents in poor families have not yet started to regain the ground lost in the wake of welfare reform.

The Census Bureau's data indicate that more than half of poor adults between the ages of 24 and 34 were uninsured in 1999. They were from one of the few groups among which the proportion of the uninsured increased. The data also indicate that employment does not protect poor adults against being uninsured. Close to half of poor workers lacked coverage in 1999, compared with two out of five who were not working.

In a study released shortly before the Census Bureau's report, Mr. Ku said he had found that expanding state Medicaid programs to provide coverage for parents also increased the number of low-income children protected by health insurance.

While more than nine of 10 children from families with incomes below twice the poverty level are now eligible for Medicaid or CHIP, 25% of them (7.9 million children) remained uninsured in 1998. Part of the reason, Mr. Ku says, is the ineligibility of the children's parents for public insurance. Medicaid eligibility for parents typically ends at about 60% of the poverty line or about \$10,000 for a family of four. As a

result of this low eligibility limit and substantial gaps in employer coverage for low-wage workers, 34% of low-income parents are uninsured. Most of those people work but earn low wages.

"Including parents [in government coverage] is a good strategy not only because it reduces the uninsured population generally and supports work, but also because it helps assure that children have needed coverage," Mr. Ku says.

Data support the notion that allowing an entire family to apply at the same time will increase the probability that the children in the family will be covered.

In the past two years, 10 states have broadened their Medicaid programs to include coverage for parents in low-income families, an option available to them through the 1996 welfare reform law. The Clinton administration and some members of Congress have proposed legislation that would lead to expansion of coverage in a larger number of states. The Health Care Financing Administration said it will consider waivers that would allow states to use CHIP funds to provide coverage to parents.

Mr. Ku says his research found that in three states that expanded Medicaid coverage to parents early, Hawaii, Oregon, and Tennessee, coverage of young children rose by 16% between 1990 and 1998. In 1998, in those three states, 67% of the eligible low-income children under age 6 had Medicaid coverage, up from 51% in 1990. But in states that did not expand coverage, the percentage of low-income children covered through Medicaid only rose from 51% to 54%.

The survey also found that states can reduce the uninsured population with broad Medicaid expansions that include parents without significantly discouraging employer-provided coverage, Mr. Ku says, and the survey found that family-based Medicaid

expansion substantially improves health care access and utilization for both adults and children.

Mr. Ku looked at Medicaid expansions in Tennessee and Minnesota and found that reductions in private coverage were very modest and the result was a substantial increase in the overall size of the insured population.

In regard to the most recent Census Bureau data, Ms. Guyer says the disparity between the progress among poor children and the stagnation or deterioration in coverage among poor adults in prime child-rearing years suggests the importance of the initiatives under consideration in many states and at the federal level to transform children's health programs

into family health programs.

Analyzing the data, the March of Dimes reported that Arizona and Texas lead the nation in the percentage of uninsured children with 25% each, while Vermont and Rhode Island had the lowest percentage, 7.2% and 7.5% respectively. March of Dimes president Jennifer Howse says the data show that "states must move much faster to enroll eligible children and take full advantage of available federal funds." The organization says it has identified increasing access to health coverage for women, infants, and children as a top priority for its chapters across the country.

Contact Mr. Ku at (202) 408-1080. ■

Cumbersome workloads increase errors

A new report says that more traffic volume in physician offices makes workloads more cumbersome, increasing the potential for medical errors.

The report, from The St. Paul (MN) Companies, outlines ways to reduce patient injuries and medical liability costs by focusing on reducing the frequency of diagnostic errors and improving patient care and safety. By following the model in the report, "Does Clinical Risk Modification Make a Difference?" health care groups can reduce the costs of each closed claim by an average of \$36,500, according to The St. Paul Companies. Findings of the report include:

- Risk control helps significantly reduce liability claim frequency and costs for health care organizations.
- Certain clinical practices are key to reducing risk in clinical areas.
- Quality improvements can be achieved in a health care organization within three years after implementing risk control measures. Once achieved, that level of quality can be sustained over time.

Other highlights of the report include how to accurately maintain patient care records and documentation that supports care and how to make certain providers work closely with their patients during the informed decision-making process. "Our work substantiates the value of not only having a solid risk control program in place, but following it," says Dorothy Berry, vice president for St. Paul Health Care, part of The St. Paul Companies. "By doing so, tremendous progress can be made toward improving overall patient safety and reducing costs associated with professional medical liability claims. Understanding the practice patterns that precede adverse events and modifying these practices holds the most promise for improving patient outcomes and safety."

[To receive a copy of the report, call Chris Redenius at (800) 328-2189. E-mail: chris.redenius@stpaul.com.] ■

Whether the estimated number of medical errors is high or low, forum searches for new answers

Since the Institute of Medicine's controversial report about the high number of medical errors that occur every year, the debate about the actual number of errors continues. Is it higher than the institute's numbers of between 44,000 and 98,000 deaths annually? Are the institute's numbers too high?

A recent gathering of 14 state and federal health care officials, convened by the National Academy for State Health Policy in Portland, ME, didn't come to a consensus about exact numbers of deaths and errors. No matter what the figures, the group decided, there are too many incidents and something needs to be done to solve the problem.

"There was no clear road map that emerged for what should be done," Trish Riley, the academy's executive director, tells *State Health Watch*. "They thought there might be an underestimation on the numbers because the figures were only for hospital-based errors. But most thought it didn't matter if the number was high or low."

The members of the forum remained anonymous in the report the academy recently issued, "Improving Patient Safety: What States Can Do About Medical Errors." In Ms. Riley's opinion, the lack of names and titles allowed the attending health care officials to speak their minds without fear of their words coming back to haunt them. The result, she says, is a document that dares to be honest about a public health epidemic that desperately needs attention.

Since states are at the front lines, and woefully underfinanced to fight the battle, forum members say, ways need to be found to shed light on

why the errors occur. Getting accurate reporting of adverse events, whether involving mandatory or voluntary reporting, was a concern of forum members. Mandatory reporting, however, according to the forum, does not now provide significant reporting of medical errors.

"Participants discussed the issues of confidentiality of data and the possibilities of extending peer review protections which, by shielding information from discovery, could encourage reporting," the report states. "It was noted that creating voluntary systems may not eliminate underreporting; for instance, the JCAHO [Joint Commission on Accreditation of Healthcare Organizations] reporting system offers JCAHO peer review protection but still does not get significant reporting of errors. While hospitals have had a long history in which they could have established voluntary systems, they have failed to do so, and medical errors remain a serious problem."

By looking beyond the number of adverse events in hospitals, Ms. Riley says, the Institute of Medicine's estimation may seem low. Clinics and doctors' offices are a new and expanding realm of potential errors.

"Doctors are doing more and more what was done in hospitals," Ms. Riley says. "If you consider the adverse [potential] there, the numbers may be considerably higher."

The forum noted and approved the move by New York state's public health commissioner, Antonia Novello, who has made a commitment to following the Institute of Medicine's recommendation of reducing errors in the next three years. But how would states know if they are reducing the number of adverse events

if they do not have a baseline of medical errors to work with? Many of the participants in the forum say mandatory reporting may be the only way to grab reliable statistics.

"States participating in the forum feel that an important first step in addressing medical errors is to examine current data collected by all state agencies to determine which of that data can be used to improve patient safety and gain reliable and validated statistics," the report states. "Participants identified value in having both mandatory and voluntary reporting systems. They noted that the approach taken by the aviation industry in which a mandatory system exists for serious accidents that result in death or serious harm and a voluntary one for 'near misses' may be a good model for medical errors as well."

As always when it comes to the intertwining of state and federal government and oversight, there was concern about who should wield the most influence. Forum members generally felt the federal government needs to consider the roles of states in reducing medical errors before it gets too involved. Health reform in the past 25 years, the report states, was led by the states, and it notes that the Health Insurance Portability and Accountability Act and the State Children's Health Insurance Program only came about after a majority of states had similar programs already up and operating.

Hospital oversight of medical errors by state government is fragmented, forum members agreed, but regulatory agencies and purchasers can make an impact by working together to solve the problem. That work should start with hospitals, they said.

Seeking consensus about medical errors, their numbers and causes is a step toward solutions, the forum members said, and they back the states that have created coalitions that include state governments and hospital associations.

Other suggestions made by forum members to reduce medical errors include:

- Pilot programs in states to develop improved systems of hospital oversight and data collection and analysis.

- Assistance in creating and funding centers for patient safety, like those established in New York and in Massachusetts, to coordinate various state functions related to safety, create or strengthen reporting systems, establish a public relations campaign, focus group testing to get a better sense of the public's understanding of patient safety, and provide appropriate public education.

- Research projects to assist states in analyzing their data and determining how best to use data to improve patient safety. Similarly, states sought assistance in developing appropriate reporting and data-sharing systems despite conflicting confidentiality and other requirements from differing funding sources and public laws.

- Patient advocacy/ombudsman programs to work on behalf of patients.

- A revolving loan fund or challenge grants for hospitals to upgrade and start patient safety initiatives, such as computerized order-entry systems.

- Trustee education to assure that hospital governing boards are informed about and involved in the issue.

- Studies that address building and sustaining effective mandatory reporting systems, studies on using voluntary systems' near-miss data, studies on the impact of reporting systems on litigation, and system change. ■

Final OIG compliance guidance eases small-practice concerns

In an attempt to resolve fears that small physician practices would be overwhelmed by trying to meet federal recommendations, the government says its voluntary compliance program is simply a road map for practices to follow.

But the actual map shows plenty of twists and turns. The Department of Health and Human Services Office of Inspector General (OIG) maintains the program is intended "to provide a road map to develop a program that best meets the needs of the individual practice. The guidance provides great flexibility as to how a physician practice could implement compliance efforts in a manner that fits with the practice's existing operations and resources."

When a draft guidance first was issued in June (see *State Health Watch*, August 2000, p. 9), health care attorneys said it was remarkable for its depth of detail on how individual and small-group physician practices could combat fraud and abuse in government health programs, especially Medicare and Medicaid. Although nothing in the draft was mandatory, there was a clear intention for physicians to implement a seven-step program designed to reduce the overall billing error rate. At that time, the Medical Group Management Association (MGMA) in Englewood, CO, said it had asked the OIG not to issue the guidance out of fear that many small practices would have difficulty meeting its expectations.

Aaron Krupp, government affairs representative for MGMA, had told *State Health Watch* that the organization was concerned about suggestions that practices conduct a baseline audit, which could be too costly for many small practices, and maintain a library of regulations and other materials,

since practices don't have the financial or human resources to spend on researching and assembling materials.

Overall, he tells *SHW*, the association was concerned that while the OIG said the guidance was not mandatory, the way it set forth recommended essential elements of a compliance program sent a mixed message, raising the possibility that practices that didn't have all the

"[The agency] is encouraging physician practices to adopt the active application of compliance principles in their practice, rather than implement rigid, costly, formal procedures. Our goal . . . was to show physician practices that compliance can become a part of the practice culture without the practice having to expend substantial monetary or time resources."

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

elements in place would be considered to not have a good compliance program.

In releasing the final guidance, Inspector General June Gibbs Brown said the agency is "encouraging physician practices to adopt the active

application of compliance principles in their practice, rather than implement rigid, costly, formal procedures. Our goal in issuing this guidance was to show physician practices that compliance can become a part of the practice culture without the practice having to expend substantial monetary or time resources.”

The OIG reiterated its assumption that the majority of physicians are honest and committed to providing high-quality medical care to Medicare beneficiaries.

The agency said a voluntary compliance program can help physicians identify both erroneous and fraudulent claims and help ensure that submitted claims are true and accurate. A program also can assist a practice by speeding up and optimizing proper payment of claims, minimizing billing mistakes, and avoiding conflict with self-referral and anti-kickback statutes.

Recognizing the concerns raised by MGMA, the OIG said the final guidance does not suggest that physician practices implement all seven standard components of a full-scale compliance program. While saying the seven components provide a solid basis upon which a physician can create a compliance program, the OIG acknowledged that full implementation of all components may not be feasible for smaller practices. So it emphasized a step-by-step approach for those practices to follow in developing and implementing a voluntary compliance program.

As a first step, the OIG said, physician practices could begin by identifying risk areas that, based on a practice’s specific history with billing problems and other compliance issues, might benefit from closer scrutiny and corrective or educational measures.

The seven steps suggested by the OIG include:

1. conducting internal monitoring

and auditing through performance of periodic audits;

2. implementing compliance and practice standards through development of written standards and procedures;

3. designating a compliance officer or contact to monitor compliance efforts and enforce practice standards;

4. conducting appropriate training and education on practice standards and procedures;

5. responding appropriately to detected violations through investigation of allegations and disclosure of incidents to appropriate government bodies;

6. developing open lines of communication such as discussions at staff meetings regarding erroneous or fraudulent conduct issues and community bulletin boards to keep practice employees updated on compliance activities;

“[The association] will continue to urge the OIG to make laws and regulations relevant to compliance more accessible on the Internet.”

William Jessee, MD
*President and CEO
Medical Group Management
Association
Englewood, CO*

7. enforcing disciplinary standards through well-publicized guidelines.

The final guidance identifies four specific compliance risk areas for physicians:

- following proper coding and billing procedures;
- ensuring that services are reasonable and necessary;
- using proper documentation procedures;
- avoiding improper inducements, kickbacks, and self-referrals.

Those are areas in which the OIG has focused its investigations and audits related to physician practices.

MGMA president and CEO William Jessee, MD, says small medical practices “are pleased to see that the final compliance guidance is now more realistic and doable, especially for groups that lack the extensive resources needed to set up formal compliance programs.”

He says the document reflected a number of suggestions the association had made, including emphasizing that following the guidance is voluntary rather than mandatory and clearing up confusion about the role of a compliance officer.

Due to the nature and responsibilities of an office manager in a small practice, MGMA had told the OIG it would be virtually impossible for one individual to serve as both office manager and compliance officer without violating the language in the draft guidance on conflicts of interest. That language was dropped from the final guidance.

Mr. Jessee says the association “will continue to urge the OIG to make laws and regulations relevant to compliance more accessible on the Internet since the guidance suggests that practices could develop their own written standards and procedures by creating a binder containing relevant Health Care Financing Administration (HCFA) directives and carrier bulletins and summaries of all informative OIG documents.”

Mr. Jessee says that it would be difficult for many small medical groups to find the time to research and locate all relevant documents to put in such a binder and adds that he hopes the OIG “will strongly consider working with HCFA to establish one central location on the Internet where practices can access all pertinent documents.”

[Access the final guidance at <http://www.hhs.gov/oig/new.html>. Contact MGMA at (303) 397-7870.] ■

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Clip files / Local news from the states

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

Congestive heart failure added to Florida Medicaid program

TALLAHASSEE, FL—Florida's Agency for Health Care Administration has extended its preventive care program for state Medicaid beneficiaries to cover disease management services for patients with congestive heart failure.

Under a three-year contract, the administration signed with health management services company LifeMasters Supported SelfCare, and will offer such services as vital sign and symptom monitors, health education, lifestyle modification coaching, and regular patient interaction with registered nurses.

—*AHA News Now*

Regulation proposed to close Medicaid loophole

WASHINGTON, DC—Secretary of Health and Human Services Donna Shalala announced on Oct. 5 a proposed rule that would close a loophole in Medicaid that costs taxpayers billions of dollars by revising Medicaid's "upper payment limit" rules.

Current upper payment limit regulations allow states to pay facilities in aggregate as much as Medicare would pay for the same services. According to the Department of Health and Human Services, some states use this flexibility to pay excessive rates to a few county or municipal facilities and then require those facilities to return some or all of the money after the state has claimed federal Medicaid matching funds based on those payments.

—American Health Lawyers Association

Declining welfare caseloads, sicker Medicaid beneficiaries

WASHINGTON, DC—As healthier beneficiaries leave the Medicaid program and less healthy adults continue to receive coverage, Medicaid may be left with a sicker group of individuals remaining in the program, according to a new report by the Urban Institute's Assessing the New Federalism project.

A sicker Medicaid caseload may require states to increase



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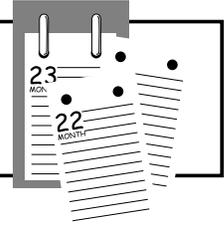
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their per-enrollee expenditures, including the capitation rates paid to managed care organizations, to maintain the same level of access and quality of care Medicaid beneficiaries currently receive.

—Center for Health Care Strategies Inc.

CALENDAR



• **The Fifth Annual Congress on Managed Medicaid and Medicare** will be held Jan. 22-24 at the Hilton Washington Towers in Washington, DC. Keynote presentations will be made by Patricia MacTaggart, senior advisor, the Center for Health Plan and Providers of the Health Care Financing Administration; Ray Hanley, director, Division of Medical Services, Arkansas Department of Human Services; Kevin Piper, vice president of the Alpha Center; and Alan Weil of the Urban Institute. To register, call Mark McKeever at (781) 663-6595 or e-mail Mmckeever@nmhcc.com for details.

• **The National Association of Health Data Organizations** holds its 15th anniversary meeting Dec. 4-5 at the Omni Shoreham Hotel in Washington, DC. The conference is designed to highlight up-to-date practices in health data, research, information technology, and health policy. Keynote speakers include Kenneth Kizer, president and CEO, National Quality Forum, and James Bagain, director, the Veterans Association's National Center for Patient Safety in Ann Arbor, MI. For more information, call (801) 587-9104.

• **The Harvard Conference on American Health Care** is scheduled for Nov. 2-3 in Boston. The conference is titled "Current Challenges and Drivers of Change: The Human Genome, eHealth, Medical Errors, Health Benefit Redesign, and More." For more information, call (617) 720-9545. ■

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