



Vol. 8 No. 9

# Health Watch

*The Newsletter on State Health Care Reform*

September 2001

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## They asked and then they received: States get more health care options

**M**id-summer turned into a time of change as politicians in Washington, DC, set a new tone for state policy-makers, who usually end up taking whatever the federal government parcels out.

While the Bush administration will allow states more flexibility in how they spend health care dollars, it sent up and then hauled back what appears to be a trial balloon regarding health coverage for unborn children.

Tommy Thompson, Health and Human Services secretary debuted the new plan on Aug. 4 that he says will allow states to provide health insurance

to many now-uninsured people without increasing costs to Medicaid and the state Children's Health Insurance Program (CHIP).

The plan, the Health Insurance Flexibility and Accountability Initiative, gives states the opportunity to cut optional benefits and use that money on other ways to help the uninsured. Ideally, Mr. Thompson says, the Medicaid and CHIP money will work in tandem with private insurance coverage to create health care coverage.

In exchange for upfront flexibility,

*See States page 2*

## New research could help CHIP reach and enroll additional eligible families

**N**ow that the Children's Health Insurance Program (CHIP) has been operating for a few years, states are starting to turn their attention to steps that need to be taken to significantly increase the number of families enrolling and remaining in the program. And they are being aided in this effort by much of the research now being undertaken by public policy think tanks.

Among the newest studies are two from the Urban Institute in Washington, DC, on how familiar low-income parents are with Medicaid and CHIP and why more children aren't enrolled in the programs.

Using data from the 1999 National Survey of America's Families, researchers found that although 88% of low-income children have parents who have heard of either the Medicaid or CHIP programs in their state, only 38% have parents who have heard of at least one of the programs and also know that children can participate even if the family is not on welfare. Also, while 86% of low-income uninsured children in states with separate CHIP programs had parents who had heard of the Medicaid program, by 1999

*See CHIP research on page 5*

## **States**

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the federal government says, states will be required to set goals for reducing the number of residents without health care coverage and then document their progress toward reaching that goal.

The way to do that is through a 14-page waiver form available on-line at [www.hcfa.gov/medicaid](http://www.hcfa.gov/medicaid). The program offered through the waiver, according to Centers for Medicare and Medicaid Services (CMS; formerly HCFA) spokeswoman Mary Kahn, goes into effect immediately and does not require any congressional action to make it official.

"Flexibility has been a high priority and this waiver initiative offers states the flexibility that has been requested," Vernon Smith, principal of Health Management Associates, in Lansing, MI, tells *State Health Watch*. "It's a positive change and initiative for states. It's not everything that governments and states have asked for. It's a step toward that."

Medicaid is a niche program that serves many groups but hasn't found its way to properly cover adults with no children, Mr. Smith says, but the new federal wrinkle would allow that.

"To expand to this population, perhaps states would tailor Medicaid benefits packages that are similar to that offered by small business. It might involve a small premium, copays, limits on benefits packages such as limited prescriptions or doctor's services," Mr. Smith says. "Potentially, this is very significant. Watch how states use their creativity to take advantage of this."

Critics of the new initiative say that it is possible that states might try to save money by trimming benefits; that's an option that each state would have to contemplate on its own. But flexibility in how to spend Medicaid

and CHIP money is at the heart of the argument. The initiative was announced during the August National Governors Association meeting in Washington, DC, playing to a group that had requested similar changes last February. The governors then asked the federal government to find a way to allow states to find new ways to cover America's 40 million uninsured people during a time that tax revenues are falling.

"This is similar to the National Governors Association proposals," Julie Hudman, associate director of the Kaiser Commission on Medicaid and the Uninsured in Washington, DC, tells *SHW*. "It gives governors a lot of flexibility, but it's not everything they want."

What else do they want? "States would like some relaxation of budget neutrality in covering new programs," Greg Vadner, director of the Division of Medical Services for Missouri, tells *SHW*. "The governors' proposal has enhanced match rates, but that would require congressional action to approve."

### **How long?**

It will take a year to plan and implement the new waiver before Missouri takes advantage of the new initiative, Mr. Vadner adds. "We haven't been able to study it yet, but it's a large improvement on the process of applying for an 1115 waiver. Now when we apply for the 1115, we have no direction as to what the administration is looking for. We're just shooting in the dark. We throw up an idea, and they agree or they don't. Where this gives guidance, gives a target, so if we're within parameters within the process, you'll be OK."

In a more controversial move, the Bush administration mulled the idea of introducing legislation that would allow states to cover a fetus with CHIP funds. The idea was floated in a

draft letter written by Department of Health and Human Services Director Dennis Smith. (See insert.) The letter said the fetus may be considered a "targeted low-income child" and that the rule would be proposed "in the near future" in the *Federal Register*. It didn't make it that far. "The letter was withdrawn from the clearance process," Ms. Kahn says. "It is not under current consideration."

The draft letter was seen as another scuffle in the abortion battle and particularly viewed by some as a way for the Bush administration to restrict rights given under Roe vs. Wade. The White House called it a way to give prenatal care to the working poor. Abortion rights groups took the stance that this was unnecessary health care legislation and a blatantly political move.

The population they are talking about insuring — pregnant women — is already covered by Medicaid or CHIP, Laurie Rubiner, vice president of the National Partnership for Women and Families in Washington, DC, tells *SHW*.

"Under Medicaid, states are required to cover pregnant women up to 133% of poverty, but they can go up the income scale as high as they want. Some states go as high as 250%. . . . It sounds like prenatal care but the most telling thing is there is no mention of women anywhere [in the letter] at all. It's bizarre."

Elizabeth Cavendish, legal director of the National Abortion and Reproductive Rights Action League, also in Washington, DC, says her group supports efforts to expand public assistance for low-income women, but not in this way. "We've long said that Bush is anti-choice and that there are several other events in public policy that reveal a strategy to elevate a fetus to the status of a full human being. This doesn't surprise us. It looks like a trial balloon." ■

# Centers for Medicare and Medicaid Services eases requirements in restraint, seclusion interim final rule

While the Centers for Medicare and Medicaid Services (CMS; formerly the Health Care Financing Administration) published an interim final rule on Jan. 22 establishing requirements for use of restraints and seclusion in some residential facilities that provide psychiatric services to children and youth under 21, an interim rule published in May makes changes, which were requested during the rule's comment period.

The interim final rule had been scheduled to take effect March 23, but implementation was delayed until May 22 as a result of the Bush administration decision to reconsider many regulations proposed in the waning days of the Clinton administration.

The May 22 *Federal Register* notice for the interim final rule made significant changes in response to comments the agency received to the interim final rule it published in January.

The January publication established a definition of a "psychiatric residential treatment facility" that is not a hospital and may furnish covered Medicaid inpatient psychiatric services for individuals under 21. The May 22 document clarifies that the interim final rule applies only to facilities whose payment includes compensation for a resident's room and board as well as a comprehensive package of services. It does not apply to other providers that receive Medicaid compensation on a service-by-service basis and do not receive Medicaid payment for an individual's room and board.

The regulation says that under Medicaid conditions of participation for psychiatric residential treatment facilities providing inpatient psychiatric

services to individuals under age 21, all resident children and youth now have the right to be free from restraint or seclusion as a means of coercion, discipline, convenience, or retaliation.

Specifically, restraint and seclusion may only be used to ensure safety of a resident or others during an emergency safety situation and must terminate when the emergency safety situation has ended. The least-restrictive emergency safety intervention likely to be effective must be used, and written standing orders or "as needed" orders are not allowed for either restraint or seclusion.

"We're pleased that the regulation is out there with a relatively high level of protection, although we're concerned about who can order restraints and seclusion. . . ."

Laurel Stine

*Director  
Federal Relations  
Bazelon Center  
for Mental Health Law  
Washington, DC*

The initial publication had provided that use of restraint or seclusion could only be ordered by a board-certified psychiatrist or licensed physician with specialized training and experience in the diagnosis and treatment of mental disorders. However, the federal government changed that provision after hearing concerns that a nationwide shortage and unavailability of psychiatrists and registered nurses could make it impossible for a

facility to comply with the requirement. The change in the May 22 document specifies that use of restraints or seclusion also can be ordered by other licensed practitioners whose state licensure allows them to write such orders.

If a resident's treatment team physician is available, only he or she can order restraint or seclusion. Verbal orders must be followed up with a signed written form in the patient's record. The physician or other licensed practitioner who issues the order must be available to staff for consultation, at least by phone, throughout the period of the emergency safety intervention.

If an emergency safety situation extends beyond the time limit included in the restraint or seclusion order, a licensed staff person must contact the licensed professional who issued the initial order for further instructions.

According to the revised interim final order, a physician or other licensed practitioner trained in the use of emergency safety intervention and permitted by the state and facility to evaluate a resident's well-being must conduct such an evaluation immediately after a restraint is removed or a resident is removed from seclusion.

Finally, the revised interim final rule requires that facilities report the death of any resident to CMS.

Laurel Stine, director of federal relations for Bazelon Center for Mental Health Law in Washington, DC, tells *State Health Watch* that while her organization was pleased that the regulation was released by the administration, there is concern about broadening the types of staff who can order use of restraints or

seclusion because they may not have sufficient clinical experience.

It will be important, she says, to see additional guidelines and other materials from CMS to get a better sense of how the regulation will be implemented and enforced. "We're pleased that the regulation is out there with a relatively high level of protection, although we're concerned about who can order restraints and seclusion. We look forward to getting more information from the agency."

Another patient advocacy group, the National Association of Protection and Advocacy Systems (NAPAS), also in Washington, DC, says changes to the regulation didn't address concerns the group had raised when it first came out. Gary Gross, senior public policy counsel, tells *SHW* his group is "positive about the regulations in general because there have been disproportionate deaths among children and no oversight until now."

However, Joy Midman, executive director of the National Association of Psychiatric Treatment Centers for Children (NAPTCC) also in Washington, DC, says there has not been a disproportionate number of deaths among children and that several states already have exercised oversight, although there has not been federal oversight.

In comments submitted to CMS on March 22, a coalition of national disability groups chaired by NAPAS made very specific recommendations on definitions of restraints, including suggesting there be a distinction between restraint and a physical escort that is not resisted by a patient. CMS responded to that suggestion by clarifying that in its interim final rule, "personal restraint" does not include briefly holding, without undue force, a resident in order to calm him or her, or holding a resident's hand to safely escort him or her from one area to another. The agency says it made that and other changes because it was

concerned that reading the definition too broadly could prevent facilities from participating in the Medicaid program and result in needless displacement of Medicaid beneficiaries.

" . . . Preventing a child from running into the street, biting, or throwing chairs requires the ability to act in emergency situations and prevent them from escalating. . . . This requirement would be less of an issue if brief holds were excluded from the definition of personal restraint."

Joy Midman

*Executive Director  
National Association of  
Psychiatric Treatment  
Centers for Children  
Washington, DC*

The coalition says it supported a provision prohibiting simultaneous use of restraint and seclusion, but urged a change to also prohibit use of mechanical restraints on children under 13. According to the coalition, children under 13 who present an emergency safety situation should be secluded, held, or subject to continuous in-the-room monitoring. "Children who are so seriously and acutely ill that they require further protection against hurting themselves or others even while in seclusion should be transferred to a psychiatric hospital."

Commenting from the perspective of treatment facility staff, NAPTCC had expressed concerns that the standards don't recognize that residential treatment facilities are not part of the traditional medical model. Ms. Midman says that because there are differences in state licensing, there is no

consistency throughout the country.

When the Child Health Act of 2000 was being written, she says, her group worked hard on the section relating to reporting requirements for various entities, hoping to achieve a balance and consistency and a recognition that the world has changed in terms of treatment models. She now is looking forward to the regulations that will be written to implement that act in hopes that they will be consistent with the interim final rule.

In March 20 comments on the January publication of the rule, NAPTCC expressed "great disappointment with its tone." The association said reference to media reports and other accounts of improper use of restraints "sets an adversarial tone and stage for a proscriptive and even punitive regulation. It ignores the tireless and thankless commitment of front-line providers who work with seriously disturbed children . . . as well as the reality that the reported abuses do not typify the majority of treatment programs or organizations."

NAPTCC also said that the rule was harder on residential treatment facilities than it was on hospitals, and pointed out the inconsistency in being applied only to those programs that are required by their states to maintain a contract with the state Medicaid agency for that distinct service, including residential room and board payments.

In specific comments, the group challenged the rule's requirement that an emergency safety situation be unanticipated. Ms. Midman says staff in residential facilities continually monitor patient behavior and must be prepared to intervene to avert an unsafe situation regardless of whether the behavior was anticipated or unanticipated. She also had asked that the definition of personal restraint be changed to exclude therapeutic holds that, she says, are brief, calming, and effective in protecting a child from an

impulsive or momentary outburst.

Of particular concern to NAPTCC were the requirements on who may order restraints. Requiring an order from a board-certified psychiatrist, she says, was "impractical, inefficient, and medically unnecessary. No less so [was] the requirement that a registered nurse obtain the doctor's order by phone if the doctor [was] not present. Preventing a child from running into the street, biting, or throwing chairs requires the ability to act in emergency situations and prevent them from escalating. Physicians and/or nurses are not present on the playgrounds, in the schoolrooms, or on the buses, but rather the milieu and support staff are, who work with these children on a regular basis. This requirement would be less of an issue if brief holds were excluded from the definition of personal restraint."

The association had recommended that a facility be allowed to authorize qualified registered nurses or other qualified and trained staff members who are not licensed independent practitioners to initiate use of restraints or seclusion. Verbal or written orders would then be required as soon as possible from the physician or other licensed professional.

Other NAPTCC concerns dealt with the requirement for a face-to-face assessment within one hour, monitoring of a child in restraints or seclusion, notification of parents, post-intervention debriefings, facility reporting, and education and training.

While all sides on this issue talk about their desire for patient safety and facility accountability in a variety of circumstances, they seem far apart on the best way to meet their shared goals, and CMS may have a difficult time reaching an acceptable compromise.

*[Contact Ms. Stine at (202) 467-5730, ext. 3, Mr. Gross at (202) 408-9514, and Ms. Midman at (202) 857-9735.]* ■

## CHIP research

*Continued from page 1*

just 47% had parents who had heard of the separate CHIP program in their state. (For a graph showing awareness of Medicaid and separate CHIP programs among low-income families nationally, broken out by insurance status, see box, p. 6.)

Genevieve Kenney, researcher with the Urban League and the lead researcher on the two studies, tells *State Health Watch* that there should not be concern that many people still are not familiar with CHIP because "it takes several years for a new program to take root and grow. So it's not surprising that not all the members of a targeted population are aware of the program despite the innovations in outreach. We're impatient and want results now, but a good assessment will come two to three years from now. Don't forget that the 1999 data we're working with was just one year into the new program."

Ms. Kenney's report says it is encouraging that the vast majority of low-income parents have heard of at least one public health insurance program in their state. But it is surprising how many people had heard of the CHIP program by 1999. Ms. Kenney says she takes that as evidence that the new program was quickly becoming an established part of the landscape.

A problem is that many low-income parents still were not aware of the existence of the non-Medicaid CHIP program in their state or were confused about whether participation in welfare programs was a prerequisite for health insurance coverage under CHIP. And the confusion wasn't only among families who don't participate in the programs. Almost one-third of all children enrolled in either Medicaid or CHIP had parents who were unsure whether they needed to be receiving welfare in order to participate.

Reducing barriers to Medicaid participation is critical to increasing coverage, given that 60% of all uninsured children are eligible for Medicaid under Title XIX, Ms. Kenney says. Her second study looked at some of the obstacles, finding that knowledge gaps were a primary barrier to enrolling one-third of low-income uninsured children and that administrative hassles were a primary barrier to enrolling another 10% of low-income uninsured children.

She calls for continued state investment in outreach efforts, especially in states where awareness and understanding of Medicaid and CHIP programs are low, and even in the face of potential budget reductions, if there is a continuing economic downturn.

But outreach efforts will not solve the problem by themselves because there are significant segments of the population not reporting knowledge gaps or administrative hassles. Ms. Kenney and her colleagues found that 22% of low-income uninsured children had parents who said that public health insurance coverage was not wanted or needed. Another 18% who were uninsured at the time of the survey had been enrolled in Medicaid or CHIP at some point during the previous year, but had not stayed in the program.

"Those who choose not to participate in the program are tough from a public policy standpoint," Ms. Kenney explains. "Their actions may be somewhat rational. If their kids are very healthy, they may feel they don't need the coverage. They see insurance as dealing with acute episodes and don't understand the importance of ongoing monitoring of their children's health. But without coverage, they're not getting well child care and dental coverage."

It's difficult to know how to reach

such families, she says. State officials need to consider whether it would be better to try to meet their needs through an expanded school health program or some other avenue. "Maybe states need to work more on promoting the benefit of continuous coverage and monitoring."

The other difficult population is the group that is enrolled in Medicaid or CHIP and then leaves. The researchers were surprised at the number of uninsured who had been covered and dropped their coverage, but cannot assess the reasons because there were no follow-up questions in the survey, Ms. Kenney says. The extent of the problem means that those questions will definitely be asked in the next survey, she adds.

"We don't know if they moved into private coverage, were disenchanted with the program, had problems re-enrolling, or believed that they didn't need the services, perhaps because they weren't using them. We think they are a real good target audience if we can learn why they've gone

from being covered to being uninsured. States should be able to turn this into a positive because there's clearly not an information problem with this group," she says.

The Urban League findings complement those in a recent study by the Center for Studying Health System Change, which recommends targeting outreach efforts in communities that have high rates of uninsured children.

Peter Cunningham, an Urban League researcher, found that uninsured children tend to be concentrated more heavily in some areas of the nation. While only one-fourth of all children live in high uninsurance areas, about 40% of all uninsured children live in such areas. Conversely, while about 40% of all children live in low-uninsurance areas, only one-fourth of all uninsured children live there.

Mr. Cunningham's surveys find that lower enrollment rates in Medicaid and CHIP in high-uninsurance communities reflect a combination of higher costs for employer-sponsored

coverage, lower incomes among families with children, and noneconomic factors. Since it might be expected that enrollment in government programs would be higher when cost of private coverage is high, he says, it appears that the noneconomic factors are significantly affecting enrollment, including the perceived stigma of government programs and lower preferences for health coverage among the population.

Particularly troubling is the relatively high percentage of Hispanic children who are uninsured in high-uninsurance communities. Hispanics typically have lower enrollment rates in health insurance programs for which they are eligible, Mr. Cunningham says, possibly because of immigration concerns, language barriers, lack of awareness of public programs, or not understanding the role that insurance coverage plays in the United States in securing access to high-quality health care.

*[Contact Ms. Kenney at (202) 833-7200, and Mr. Cunningham at (202) 484-5261.] ■*

### Awareness of Medicaid and Separate SCHIP Programs among Low-Income Families, Nationally, by Insurance Status, 1999

Source: Urban Institute, Washington, DC.

# Be prepared for plan exits as well as the entrances

Contract negotiations with Medicaid managed care plans often are so long and difficult that state officials may be prone to breathe a sigh of relief and close the file folder once they are done. But that can be a significant mistake if no preparation has been made for when a plan exits a state.

By now, nearly every state has experienced at least one plan exit and the disruption to patients and providers that can be the result of an exit. A new study by the Center for Studying Health System Change looks at the issue of plan exits and the best practices states can follow to ease the pain of a plan's departure.

Anne Jacobs, a consultant in the Washington, DC, office for Tucker Alan, who drafted the report for the center, tells *State Health Watch* that states often don't have enough time to deal with a pending plan exit because nothing in the contract specifies how much notice state officials should be given. "We think that six months' advance notice is appropriate from a plan that is going to leave a market. The contract should also have as much detail as possible on transition steps and responsibilities."

When plans exit state programs, she says, their clients may lose their primary care providers and specialists or special services such as eyeglasses and medications. Clients with special needs are especially vulnerable to problems as a result of disruption of care.

Ms. Jacobs says states have found that addressing the following issues has helped foster smooth client transitions:

- determining enrollment options into other managed care or fee-for-service plans;
- determining whether new enrollment will be open or by auto assignment;

- taking steps to preserve provider-client relationships, such as forwarding the name of each client's providers to receiving plans and telling clients which other plans their providers accept;
- specifying exit and transition tasks in contract language;
- holding plans responsible for materials and data such as medical records and other important administrative documents;
- notifying clients through a variety of communication channels;
- notifying providers;
- notifying the public and other stakeholders;
- taking special steps to serve clients with special needs.

"The most important policy reason for Medicaid managed care is to give beneficiaries access to a medical home that will be available to them for an extended period of time, every hour of every day."

Kathryn Haslanger

*Vice President  
United Hospital Fund  
New York City*

Ms. Jacobs says that good advance planning may be of little help when a health plan is in financial collapse and seized by the state. In such an instance, it can be hard for state officials to get the information they need from the plan executives, and it is imperative that the state has a contingency plan ready so officials know what to do.

Communication with plan members and providers is very important, she says, and the message needs to get

out in as many ways as possible to as many entities as possible, saying, "The more consistent the message is, the easier it will be to understand."

She adds that some states have drafted message points and given them to advocates to be used in the advocates' newsletters. States also have had advocacy groups review proposed communication pieces in advance and have revised them heavily based on feedback from the advocates.

Maintaining continuity of care is the biggest issue facing patients during a plan exit, Ms. Jacobs says, while providers are most concerned about being able to maintain their patient base and being paid for outstanding claims. Patients with special needs require the most attention and assistance. Best practices for this population seen in several states include:

1. one-on-one client notification;
2. care coordinators and case managers assessing needs and transition clients;
3. special transition plans for clients with special needs;
4. continuity of care for pregnant clients in the third trimester.

Ms. Jacobs says the transition can be eased if both the state agency and the managed care organization specifically name a key contact person who is readily available and can be reached quickly as issues arise. She notes that large managed care organizations typically have the resources needed to carry out a transition better than do smaller local groups. This difference can become important as more large, national plans bail out of Medicaid managed care, leaving the field to smaller, local, Medicaid-only plans.

Colorado's director of managed care Patrick Gordon tells *SHW* his state has experienced some loss of partial service areas, but so far has not had a full plan exit. Many years

ago, he says, the state was in a contract dispute with a plan and offered to terminate the contract. But providers raised concerns about loss of access and reduced reimbursements that made it into the political process, and the state's legislature encouraged both sides to find ways to resolve their differences.

One thing working in Colorado's favor, Mr. Gordon says, is that rates in the state have been adequate. He says it's his understanding that in states that have experienced plan exits, the cause often has been competitive bidding and inadequate rates.

Kathryn Haslanger, vice president of New York City's United Hospital Fund, tells *SHW* her organization has had considerable experience with plan exits. In addition to the mechanics of transition, she is concerned about why plans leave and the impact on the program of the departure of commercial plans in particular.

One reason for the departures was a change in state law that eliminated a financial penalty imposed on HMOs — including those with commercial accounts — that failed to demonstrate a willingness to serve the Medicaid population. At the same time as the requirement changed, there were steep cuts in Medicaid managed care premiums and a move to a request for proposal process for selecting plans.

"Plans saw the state as a difficult and unpredictable business partner," Ms. Haslanger says. "Now we have a much smaller commercial plan presence for many reasons, not just money. There have been concerns about inappropriate and uncompensated regulatory and reporting demands, and commercial plans have wanted to concentrate on their core business."

She says there is a value in encouraging national commercial plans to participate in Medicaid managed care, not necessarily because of a higher quality of care, but because

they potentially bring in a different set of providers. "Giving clients a broader range of choices is a good thing. Community-based plans are very valuable, but I think it's important to have broad choice. Also, commercial insurers bring different eyes and voices to the policy discussions about how Medicaid managed care should operate. If they leave, all that are left are the safety net providers. I think the other plans strengthen the program."

Ms. Haslanger credits state officials with good work in easing a transition upstate, particularly through letters to the enrollees in the exiting plan, advising them of their need to pick a

new plan and identifying available physicians and the plans in which they participated.

"The most important policy reason for Medicaid managed care is to give beneficiaries access to a medical home that will be available to them for an extended period of time, every hour of every day. There is a lot of overlap in provider panels and it's good when state officials try to help patients stay with their physicians when possible," she says.

[Contact Ms. Jacobs at (202) 326-9210, Mr. Gordon at (303) 866-4092, and Ms. Haslanger at (212) 494-0700.] ■

## ***Adverse-events data shared in Minnesota***

**A** new law in Minnesota will allow hospitals, doctors, and health care professionals from across the state to share patient safety information in ways that previously were impossible.

The law changes the Minnesota Peer Review Statute, which previously inhibited the exchange of information from one hospital to the next for fear of litigation. In essence, Minnesota hospitals could learn from adverse events within their own organizations, but not others.

Senate File 560 was championed by the Minnesota Hospital and Health care Partnership (MHHP), an association representing Minnesota's 142 hospitals and 20 health systems. Signed into law recently by Gov. Jesse Ventura, the new measure allows hospitals, doctors, and medical staff to anonymously report medical errors in a web-based registry that can be aggregated and accessed by other health care professionals and the public.

Individual patient and caregiver information is not provided, only the data needed to learn from the event, says Bruce Rueben, president of MHHP.

"This law will improve patient safety," Mr. Rueben says. "Minnesota hospitals fought hard to create this web-based registry. By capturing and sharing information on medical accidents regardless of whether or not a patient is harmed, hospitals can provide safer care and prevent mistakes before they happen."

Scott Anderson, vice president of information services with MHHP, says a key aspect of the system is that it is voluntary.

"Hospitals understand the importance of learning from each other," Mr. Anderson says. "This system will help facilitate that process because it is designed to capture both adverse events and near misses."

MHHP launched a pilot program with a few hospitals in June, with plans for a statewide rollout later in 2001. The new law was scheduled to take effect Aug. 1, 2001. ■

# Oregon hospitals standardize their aid applications

In what appears to be an unprecedented effort, hospitals throughout Oregon have agreed to use a standard form for patients to apply for financial assistance.

As part of the collaborative effort, the hospitals have said they will post prominent signs and offer pamphlets and bilingual business cards telling patients how to apply for the monetary help, explains Barbara Wegner, CHAM, regional director of access services for Providence Health System in Portland.

Prompted by a consumer group, the initiative began with four hospitals in the Salem area and then moved to Portland, Ms. Wegner says. "It's nationally unprecedented," she adds, "that competing hospitals would get together and do something this substantive for patients who don't have coverage."

Although Providence and other nonprofit health care organizations already had procedures for applying for financial help, the agreement makes the process simpler for patients and for access personnel, Ms. Wegner points out. "If a patient had been seen recently at another facility and had filled out a form, that person could present the form to a registrar and help facilitate the whole process."

In line with the guidelines, she says, Providence makes business cards available in waiting areas to inform patients of the financial assistance program in four different languages — English, Vietnamese, Spanish, and Russian. Applications also can be translated into other languages as needed, Wegner notes.

The project had its impetus about two years ago, when an advocacy group called the Oregon Health Action Campaign (OHAC) did a study to identify barriers to health care, says Tim Miller, MA, program

manager and organizer for the Salem-based group.

"One of the problems we discovered was that people accessing health care didn't know anything about charity care or free care," Mr. Miller notes.

Although nonprofit hospitals are not explicitly required to give charity care per se in exchange for their exemption from income and property taxes, he explains, they must by law provide "community benefits." Those benefits can take various forms, such as supporting a women's clinic, for example, or providing free care to those unable to pay, Mr. Miller adds.

## Eligible recipients missing out

In the course of the study, he says, OHAC documented several cases of patients who would have been eligible for charity care according to the guidelines of the hospitals who treated them, but who never learned about that option. Instead, they accumulated huge debts, were threatened by collections agencies and, in one case, declared bankruptcy, Mr. Miller says.

"The law is there, but the hospitals had different ways of [fulfilling] it and different standards," he adds. "Nothing was uniform. The community didn't know about it, and wouldn't know unless they found out by accident."

After hearing about the study findings, Mr. Miller says, the Salem hospitals and later the Portland hospitals agreed to work on a uniform charity policy. Eventually, the Oregon Association of Hospitals and Health Systems (OAHHS) adopted a voluntary agreement that set the standard for all Oregon hospitals in regard to free care, he says. The OAHHS board approved a booklet developed by the Portland hospitals, *Financial Assistance Guidelines: A Suggested Policy for Oregon*

Hospitals

for distribution statewide. When the issue came before the OAHHS board about a year ago, the hospital association saw it as an opportunity to suggest common language that could be used in hospitals across the state, says Karen Normandin, communication director for the Lake Oswego-based association. "It took several months to hash over definitions and come up with a set of guidelines and to make the information available in several languages."

## Educating ED employees

There's also a piece that has to do with employee education, Ms. Normandin notes. Employees in admitting, the emergency department and clinic areas are to be prepared to provide information on the program, she adds. "When eligible consumers are in the organization, they can ask questions about financial help and [these employees] can direct them."

Plans are, Normandin says, for participating hospitals to get back together in a year and see how the program is doing. "One of the purposes is to network and collaborate so that everyone benefits."

From Mr. Miller's point of view, "the bad part [of the program] is that it's only voluntary. The good part is, it's the first agreement on a statewide basis in the nation." His organization's next step, he says, is to determine what can be done to make sure all hospitals participate.

However, Ms. Normandin says the financial assistance guidelines "would be pretty complicated to mandate. We have about 65 member hospitals, and about 40 of those are small, not as stable [as the larger participants]. It's a different situation in a lot of communities. We're participating in it as a voluntary program."

Oregon residents who make less

## **Clip files / Local news from the states**

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

### **Cost of Medicare's business in Maine is higher than the reimbursement**

PORTLAND, ME—The federal Medicare program reimbursed Maine hospitals \$115 million less than what it cost them to care for elderly patients in 1999, according to a new report done for the Maine Hospital Association.

The shortfall has prompted hospitals to make up the difference by charging other patients more money, a practice that pushes up the price of health insurance in the private market for individuals and businesses.

"There is now broad consensus," the report stated, "that the Medicare shortfall is one of the major contributors to Maine's high health-insurance premium rates."

Hospital charges in Maine could be cut 12%, the report said, if hospitals were paid what it actually cost them to provide care to Medicare patients. Hospital charges for all patients added up to \$2.44 billion in 1999, so a 12% reduction would amount to \$300 million, a figure that reflects the markups hospitals take to cover their shortfalls.

—*Portland Press Herald*, July 17

### **Times are tough in Buckeye state, but welfare cases hit a low mark**

COLUMBUS, OH—Despite reports of layoffs and a sluggish manufacturing base, Ohio's welfare caseload last month hit its lowest mark in more than 34 years.

Largely rural Huron County, south of Sandusky, has become the first Ohio county since the 1960s to clear its adult caseload completely. Not a single adult was on the county's cash-assistance rolls in June, a milestone it had briefly reached in January.

The zero-caseload achievement was short-lived. A former resident of Ottawa County just moved into Huron, raising its caseload to one, according to Judy Fegen, director of the Huron Department of Job and Family Services.

In all, 196,622 adults and children were on Ohio's welfare rolls last month, the lowest figure since March 1967. The rolls peaked in March, 1992, at 748,717.

—*Toledo (OH) Blade*, July 19

### **Rural health association members tell Congress that without more money many hospitals will close**

WASHINGTON, DC—Members of the National Rural Health Association (NRHA) went to Capitol Hill in late July to tell lawmakers that their hospitals need help. After a session on rural health issues held by the American Hospital Association, NRHA members fanned out to try to convince lawmakers of their urgent need for relief on several of those issues. The hospital representatives planned to inform their congressional delegation of such issues as work force shortages, especially for nurses; cost competition with urban hospital pay scales; transportation and ambulance diversion issues; and the need for more adequate Medicare reimbursement.

than 150% of the federal poverty level — about \$27,000 for a family of four — are eligible for the Oregon Health Plan, the state's health insurance plan for the poor. But they may be excluded for other reasons — for example, if they have more than \$2,000 in cash or bank accounts.

The voluntary guidelines adopted by the Oregon hospitals state that financial assistance is generally secondary to all other financial resources available to the patient, including insurance, government programs, third-party liability, and assets. They also state, however, that full financial assistance usually will be provided to a responsible party with gross family income at or below 150% of the Federal Poverty Guidelines.

Under the newly adopted policy, uninsured patients with incomes between 150% and 200% of the poverty level are eligible for aid on a sliding scale to help pay hospital bills. The details of that scale are left up to each hospital, says Ms. Normandin.

The financial assistance given is specific to each admission, and the patient will be screened for changes in eligibility when there is a readmission or new episode of care, Mr. Miller says.

However, Ms. Normandin indicates, that screening process is greatly streamlined by the standardized application form. "My understanding is that the patient would have a copy of what was filled out [for earlier hospital visits] and that the information would be transferable. "There is a shared responsibility on the part of the patient and the person helping the patient fill it out," she adds. "There is a requirement in the guidelines that the form be filled out completely."

The effort has generated "lots of positive comments," she says. "Folks are enthusiastic about using common language, not having to reinvent the wheel." And, she points out, [providing assistance] is part and parcel of their mission." ■

Without help from Congress on these issues, several members said that their hospitals would soon have to begin shutting down beds and that some would have to close altogether.

Health and Human Services Secretary Tommy Thompson announced the formation of a Health and Human Services Rural Task Force that will examine how the department can better serve rural communities. In his announcement, Thompson said the internal task force would search for existing regulatory and statutory barriers to serving individuals and families in rural areas. The task force will explore ways to improve state health and social service delivery systems and identify places where additional funding may be needed. The task force will begin work immediately and is expected to complete its review within three months. Marcia Brand, director of the Health Resources and Services Administration's Office of Rural Health Policy, will head the task force.

—American Hospital Association, July 26

### Clerical errors blamed in overcharging AIDS patients in West Palm Beach

WEST PALM BEACH, FL—The Palm Beach County Health Care District has been ordered to reimburse \$108,291 to Medicaid for improperly charging for care provided to AIDS patients who are poor.

State auditors found the district billed Medicaid for AIDS patients at the county's nursing home in 1999 and 2000 without getting prior approval from the state Medicaid office. The district had 31 HIV-positive residents in 1999. The home averages 143 residents.

District officials blamed clerical errors and said the money would be repaid.

In a separate review, Palm Beach County's internal auditor found further evidence that the district mishandled Medicaid billings.

Checking bills for patients in May 2000, auditors found instances where Medicaid was both overcharged and undercharged, according to a report released last month. District officials acknowledged that billing procedures were lacking. They also blamed computer glitches in the billing system.

—*The Palm Beach Post*, July 26

### In Montana, many fall between crack when it comes to Medicaid eligibility

HELENA, MT—Nearly 67,000 low-income Montana adults lack health insurance and don't qualify for Medicaid because eligibility requirements are too high, a health care advocacy group says.

The report, conducted by Families USA, is part of a national survey of health insurance needs.

As with other states, the study concluded that income standards for Medicaid eligibility in Montana are at such levels that many lower-income people who don't have health insurance also do not qualify for the government health insurance program.

The U.S. Department of Health and Human Services puts the poverty level for an adult at \$8,590 a year, and \$14,630 a year for a family of three.

The Families USA study defines "low income" as up to double the poverty level, meaning that an adult making up to \$17,180 a year and a family of three making up to \$29,260 would be considered low-income.

Based on its definition, the study concluded more than 47,000 low-income Montanans without children lack insurance and do not qualify for Medicaid.

In addition, 27,618 low-income parents in Montana lack insurance, and 67.4 % of them also are ineligible for Medicaid, the study said.

—*Associated Press*, July 20

### The past year has been tough on states, and a new report says the future is tight, too

WASHINGTON, DC—The slowing economy hit many state governments hard in the past year as income weakened, spending rose, budget gaps increased, and savings shrunk, according to a new report.

The immediate financial future promises to be even tighter, although the National Conference of State Legislatures concluded states were managing the shortfall well. The group's annual review also found that states overall continued to cut taxes despite the worries.

The study assessed the finances of 46 states for the fiscal year that — for most — ended in June and the current year that began in July. Massachusetts, New York, and North Carolina had not passed budgets in time for the report, and Tennessee's budget remains unresolved.

In the fiscal year that ended in June, states' spending was up 9.1%, but revenue grew only 4.5%. Economists blamed a significant part of the spending rise on growing Medicaid costs, although prisons and schools accounted for cost overruns in several states, too.

As the fiscal year ended in 2000, budget surpluses were the states' biggest financial headaches. Autumn brought the first signs of weakness, with weak holiday sales taxes in the winter and revenues clearly sliding by February.

By midyear, budget shortfalls were a problem for more than a third of the states. Nine states slashed budgets, with Kentucky cutting \$121 million from its budget, Alabama slicing 6.2% from its education trust fund, and South



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**State Health Watch** (ISSN 1074-4754) is published monthly by American Health Consultants®, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. First-class postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **State Health Watch**, P.O. Box 740059, Atlanta, GA 30374.

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Carolina passing an across-the-board 1% cut for state agencies. The economy made balancing the states' 2001-02 budget difficult, too, as 20 states had to either tap reserves, cut spending, increase taxes or delay purchases.

—Associated Press, Aug. 1

## Six states add cancer coverage for women

WASHINGTON, DC—Uninsured women in Utah, Idaho, South Dakota, Illinois, Indiana, and Montana are now eligible for medical coverage for breast and cervical cancers, as each state has taken advantage of the federal Breast and Cervical Cancer Prevention and Treatment Act. The federal legislation, which was signed into law in October 2000, allows states to offer medical benefits to uninsured women suffering from either cancer who have been diagnosed through the Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program. Other states participating in the program are Rhode Island, New Hampshire, West Virginia, and Maryland. For more information, go to [www.hcfa.gov/Medicaid/bccpthm.htm](http://www.hcfa.gov/Medicaid/bccpthm.htm).

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