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Is Medicaid a burden or a boon? Is it time to reinvent the program?

A report prepared for the National Governors' Association in Washington, DC, says that over time, Medicaid "has become burdened with new requirements and the costs for states have become greater than ever expected. Medicaid has grown to be larger than Medicare in terms of program costs and the number of persons served annually. The cost of Medicaid borne by states has become so large as to raise a question about the ability of states to pay their share in the future."

The solution, according to Vernon Smith, a principal with Health Management Associates in Naples, FL, who prepared the report, lies in a number of options that would restructure financing of the program so states could afford to contribute to its financing in the future.

Mr. Smith tells *State Health Watch* that one goal the National Governors Association had in publishing his analysis was to give those who work on public policy and can do something about the situation a sense of urgency. "States can't continue to support Medicaid at current levels, and by design, the situation is going to get worse," Mr. Smith says. "Real consideration needs to be given to finding ways to bring fiscal relief to the states."

*See **Medicaid report** page 2*

Illinois takes aim at prescription drug waivers in an effort to save state's taxpayers money

For years, the hard-to-prove conventional wisdom has been that money spent on wellness, preventive services, and medications ultimately benefits the health care system by reducing the cost of expensive hospitalizations, nursing home care, and other high-end treatments.

The state of Illinois has received approval from the Centers for Medicare & Medicaid Services (CMS) to test that theory by giving senior citizens a comprehensive prescription drug benefit to be paid for through Medicaid savings.

The waiver allows Illinois to extend comprehensive prescription drug coverage to seniors with income up to 200% of the poverty line using federal Medicaid matching funds. The coverage replaces a significant portion of a state-funded pharmacy program that helped some 50,000 seniors pay for prescription drugs needed to treat selected conditions in fiscal year 2001.

Gov. George Ryan says the new program should be seen as a national model for providing assistance for all prescription medications to low-income senior citizens. The waiver

Fiscal Fitness: How States Cope

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Medicaid report

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Matt Salo, National Governors' Association's director of health legislation, tells *State Health Watch* that he thinks there are a lot of people who care about the difficulties facing states, but "unfortunately, it's a big, big problem. There are a lot of stakeholders with a lot invested in the status quo. Also, there is the natural fear that comes with trying to change something that is as large as Medicaid."

Medicaid has significant impact

Mr. Smith says it is difficult to overestimate the importance and impact of Medicaid in American life today because the program is so large, it serves so many people in many different population groups, and it plays a role in helping to finance virtually every state program that relates to health. "By any measure, Medicaid makes a great positive difference, even a critical difference, in the lives of millions of low-income persons," he says. "By its design, Medicaid's impact is greatest among specific groups that are targeted for coverage, including children, families, pregnant women, adults and children with disabilities, persons with chronic medical and mental problems, and the elderly."

Medicaid expenditures will total $245 billion in federal FY 2002. Total Medicaid spending is higher than that for Medicare and is increasing at a faster rate than Medicare. Medicaid spending has increased dramatically since the late 1980s, causing Medicaid's share of state budgets to almost double in 10 years.

Medicaid spending growth has been much greater than the increases in overall state spending categories, causing it to increase as a share of state budgets. From 1987 to 1997, Medicaid general fund spending increased from 8% to 15% of state general fund budgets. When federal funds are included, total Medicaid spending increased from 10% to 20% of total state spending from all sources. Medicaid's percentage share held steady in the late 1990s, but is increasing again now that Medicaid spending is increasing faster than spending for other state programs. In 2002, almost every state is dealing with budget shortfalls. "In some cases, the shortfall in the overall state budget is caused in significant part by increases in Medicaid spending," Mr. Smith reports.

Beneficiaries deserve the best

He says that because of the amount of money spent on Medicaid, taxpayers and beneficiaries alike deserve the best possible program. "There are ways to make Medicaid a better program so it is more effective at covering the low-income uninsured," Smith declares, "and so it better reflects the ability of states to continue to finance it."

He says that from a state perspective, there is an urgent need for significant changes in Medicaid financing. "The most needed changes are those that would increase federal funding for Medicaid because states simply are not in a position to increase funding for Medicaid faster than for other programs, year after year. Nor can states increase funding for Medicaid when other programs are being cut."

Changes that would allow states to become prudent purchasers of medical coverage and responsible administrators of public funds fall in several categories, according to Smith:

1. Changes to improve federal financial support for Medicaid
2. Changes to allow states to structure Medicaid coverage and reimbursement policies so states can be prudent purchasers of medical coverage and responsible administrators of public funds
3. Changes to allow states the ability to structure eligibility to simplify program administration and to cover more low-income uninsured individuals and families
4. Changes that would rationalize the relationship between Medicaid and other coverages, including Medicare, State Children's Health Insurance Program (SCHIP), and employer-sponsored health insurance

Mr. Smith recommends policymakers to first look at the relationship between Medicaid and Medicare. "There is general agreement that the federal government has primary responsibility for health care for senior citizens through Medicare and Social Security," he says. "But today, 35% of Medicaid expenditures go for people who also are on Medicare. We need to look at restructuring the financial relationship between the two programs. We need to find ways that the federal government can pick up a greater share of the cost from the states."

Mr. Smith says it never was intended that Medicaid should spend an enormous share of its resources as a coinsurer for persons on Medicare. But federal law now requires that Medicaid pay for Medicare premiums, for Medicare coinsurance and deductibles, and for services not covered by Medicare.

Possible initial fixes, he says, include a prescription drug benefit under Medicare or providing an enhanced federal match rate (possibly 90% or even 100%) for low-income seniors who are on Medicare and also receive Medicaid services.

A second area he recommends looking at is to use the SCHIP match rate for the same type of children who are enrolled in Medicaid. Using the SCHIP rate could be justified, Mr. Smith says, by the fact that many children and families move back and forth between the two programs.

"It is difficult to justify a lower federal matching rate for families and children on Medicaid when these families are in lower-income households and in greater need, compared to SCHIP," he says.

"Using the SCHIP federal matching rate would provide equity, administrative simplification, and financial relief to states," he adds.

Laundry list of other options

Other options advanced by Mr. Smith include:

- Prohibit states from obtaining federal matching funds for any payments in an upper payment limit arrangement.
- Calculate the federal match for territories with the same methodology as used for the states.
- Limit to 0.5% any annual decrease in the federal match when it is recalculated each year.
- Change federal Medicaid law to allow a state plan option for coverages and cost-sharing similar to those offered by employers in that state for persons at or above the federal poverty level.
- Change federal law to allow states the option to define eligibility for Medicaid based only on state-defined income levels without regard to arbitrary eligibility categories.
- If Medicare doesn't assume all or most responsibility for the cost of medical care for dual eligibles (Medicaid and Medicare), federal law could allow states to require dual eligibles to be subject to state Medicaid policies relating to coverages, cost-sharing, and managed care enrollment.
- Simplify the administrative relationship between Medicaid and Medicare to minimize the burden placed on Medicaid.
- Change federal SCHIP law to allow the parents of children who apply for SCHIP and are found eligible for Medicaid to choose enrollment in SCHIP.
- Remove the prohibition on SCHIP enrollment for children who are covered by employer-sponsored health coverage that is not as comprehensive as SCHIP, and allow SCHIP to wrap-around the employer-sponsored coverage as Medicaid does.
- Allow Medicaid payments to subsidize and encourage the use of health coverage offered through employers.

Mr. Smith tells *State Health Watch* that because both Medicaid and Medicare are relatively young and have been evolving continuously since their founding in 1965, shifting the responsibility for dual eligibles to the federal government "would be a logical direction for continued evolution." He says discussions about the need for financial relief for states has "gained some currency" in Washington and could be a first-step toward a long-term solution.

How long do we have to fix the problems before Medicaid threatens to implode? No one can say for sure.

Mr. Smith says states have demonstrated their commitment to keeping the program going as much as possible, but says pressures are mounting to find ways to constrain the rate of Medicaid growth, possibly even taking it back to the growth rate of other programs.

There are 15 to 20 states that have a particular problem, he says, because restrictions on upper-payment limits are affecting state revenues and the states have to find ways to replace the lost money.

Mr. Salo says that realistically it is not likely that any major reform will occur this year, but there can be a good start at debating the issues.

The Governors Association, he says, has called for creation of a Medicaid commission to look at the big-picture financing issues and how to make Medicaid viable for the future.

Mr. Salo says he thinks it is realistic to expect that more federal money will ultimately be made available, and

NASBO says state budgets still struggling

The National Association of State Budget Officers (NASBO) in Washington, DC, says in its latest *Fiscal Survey of States* that recent economic data suggest the economy is recovering, but states still are experiencing "dismal budget situations. Revenue growth is anemic, spending pressures continue to rise, and states are facing massive budget shortfalls."

NASBO says that an examination of state budget shortfalls and total state revenues during the recession in the early 1990s suggests there will be a lag of 12 to 18 months between national economic recovery and the time when growth is strong enough to be reflected in healthier state budgets.

Looking specifically at Medicaid, NASBO says that expenditure growth continues to exceed budgeted amounts. Medicaid expenditures in FY 2002 are increasing 13.4% over the fiscal 2001 level, the report says. And that follows an increase of about 11% in 2001. The 25% growth rate over two years compares with about 5% revenue growth over the FY 2000 to FY 2002 period.

NASBO says that Medicaid is second only to elementary and secondary education as a percentage of state expenditures, and notes that the Centers for Medicare and Medicaid Services says that Medicaid growth will remain strong through 2011, outpacing growth in total national health expenditures. ■

says it is likely that any rational bipartisan group of people on the study commission will agree that states can't continue with things as they currently are in terms of Medicaid financing.

Meanwhile, an Urban Institute analysis by John Holahan reported in the on-line edition of *Health Affairs* says that it is likely that Medicaid and SCHIP will survive the current recession largely intact, but will face serious problems extending well into the future.

Mr. Holahan says that the number of uninsured people has not increased much since the mid-1990s, primarily because of substantial growth in employer coverage. But the recession is likely to cause this source of insurance coverage to decline, as unemployment rises. And there is growing evidence of increases in health care costs and in insurance premiums that employers pay, increases that could affect employers' decision to continue to pay the same share of the premiums or even to offer coverage.

The report says that states have found that Medicaid managed care no longer greatly reduces the rate of growth in acute care spending. Hospital costs are rising and states also face rising prescription drug costs and have a limited array of tools to use in addressing the problems.

Aging population to consider

Further, the aging of the population is going to increase long-term care costs and the Supreme Court's *Olmstead* decision may lead to increased spending for home and community-based services.

At a time when Medicaid spending is likely to increase, Mr. Holahan says, disproportionate-share payments and upper-payment limit programs are likely to decline as a source of revenue. "In the face of these pressures, states could have a hard time maintaining current eligibility levels under Medicaid and SCHIP."

He projects that states will have limited ability to take advantage of Section 1931(b) or SCHIP waivers because they require additional spending and says the Health Insurance Flexibility and Accountability demonstration initiative may be of limited benefit.

Cuts in optional acute-care benefits are not likely to yield enough savings to allow any appreciable expansion in coverage, and reductions in spending on services to aged and disabled populations would yield more savings but could have an adverse impact on sicker and more vulnerable populations.

Struggle to maintain coverage

"States will have to work hard just to maintain current coverage commitments," Mr. Holahan explains, "and it seems unlikely that they will go much further in extending coverage. Additional incentives, perhaps at the federal level, may be required to reduce the number of uninsured persons. These initiatives could include allowing states to cover all adults below an established income threshold, increasing the matching rate on current Medicaid beneficiaries, and permitting more flexibility in benefit packages.

"Higher matching rates would give states some fiscal relief and greater incentives to expand coverage. More flexibility could include providing broad benefit packages to the most vulnerable populations but allowing more flexibility in benefits and use of cost-sharing for higher income groups," he says. "The current system may be reaching its limits, and there are good reasons to believe that states will struggle greatly in the foreseeable future."

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Illinois drug waivers

Continued from page 1

program is modeled on the state's Circuit Breaker/Pharmaceutical Assistance program administered by the Department of Revenue. Once enrolled, individuals would remain eligible for 12 months and have cost-sharing responsibilities. The Circuit Breaker program will continue to serve those who earn between 200% and 250% of the poverty level and disabled citizens.

Participants will pay a nominal copay averaging $3 per prescription. When an individual's pharmaceutical costs exceed $1,750, the new program will pay 80% of the cost of additional prescriptions, with participants paying the other 20%. Included will be a full range of drugs such as antibiotics, gastrointestinal, anti-anxiety, antihistamine, and antidepressant therapies. The program also will make diabetic testing supplies, hypodermic syringes, ostomy supplies, and selected over-the-counter medications available to eligible seniors.

Andy Kane, rate development and analysis chief for the Department of Public Aid, tells *State Health Watch* the waiver request was developed because "we believe that this approach will be good for the population we are trying to serve. Nationally, pharmaceutical coverage for seniors is a very big issue. Our program with a limited formulary is growing extensively, and we wanted to expand it."

While a lot of attention has been paid to the notion of expanding pharmaceutical coverage for seniors at a time when most states are struggling with the burden of drug costs in their Medicaid program, equally interesting is the fundamental change that Illinois is promoting in the financing of its Medicaid program.

To pay for the new prescription

drug program, Illinois has proposed dropping the federal government guarantee that it will match, as needed, the amount the state spends on its elderly Medicaid population. Rather, this demonstration project establishes an upper limit or cap on the amount the federal government will match of Illinois' spending on its elderly Medicaid population over the next five years.

The cap is based on the amount the state anticipated it would need to cover its elderly Medicaid population without the new demonstration project. Illinois is betting that it can pay for the cost of the elderly Medicaid population and the new prescription drug program out of the capped amount of federal funding.

According to Washington, DC-based Kaiser Commission on Medicaid and the Uninsured analysis of the waiver, the state's theory is that its demonstration project will prevent a significant number of seniors from becoming sick and/or poor enough to qualify for full Medicaid coverage, and that the savings generated by diverting seniors from Medicaid eligibility will be enough to pay for the new prescription drug program.

While the Kaiser analysis raises some questions about the validity of the assumptions and the state's ability to make it work, Mr. Kane says the state is very confident about what it is doing.

"People tend to think of Medicaid as having a set number of people who derive benefits. But we have a large inflow and outflow of people over the course of a year. They spend down their income to cover some out-of-pocket expenses and become eligible for Medicaid support for their health care bills. We think that when we provide this prescription drug benefit, we will have savings from people who would otherwise be applying for Medicaid through a spend-down. But that's a relatively small savings. The big savings will come from allowing individuals to access the medical care they need and stay in community settings, being diverted from nursing facilities."

Mr. Kane says the Illinois Medicaid program currently pays for two-thirds of the people in nursing facilities in the state. "There are limited studies indicating that any type of drug benefit produces an outstanding rate of diversion from institutional care. We've projected what we think is a conservative rate of 5%. Given that every Medicaid person in a nursing home costs us $30,000 a year, we think there is opportunity to save a lot of money and also have better health outcomes for the individuals."

Illinois could be on the hook

Kaiser senior policy analyst Jocelyn Guyer says that if the state's spending for the two programs exceeds the capped amount, it will have to pay for the extra costs on its own, without the benefit of federal matching funds, creating a potentially strong incentive for the state to do whatever is necessary to avoid hitting the cap.

Noting that it's not possible at the outset to assess whether Illinois' bet is a safe one, Ms. Guyer reports that, "If it appears that the state's need for federal funds might outstrip what is available under the cap for any reason, it will face competing pressure to cut back prescription drug coverage for low-income seniors and/or to cut back comprehensive services for low-income elderly beneficiaries. This could occur if costs are higher than expected for the new prescription drug program or if the cost of serving elderly beneficiaries under Medicaid is higher than anticipated.

"Even if Illinois' experiment succeeds, it is notable that Illinois' demonstration project sets a precedent by replacing open-ended federal matching funds for a state's elderly Medicaid population with an overall cap on federal funding in order to generate resources that can be spent on prescription drugs for a different group of seniors," she says.

The state projected that it would spent a total of $14.6 billion on its

Illinois' Projected Spending on Elderly Medicaid Beneficiaries and Prescription Drug Program

Source: Kaiser Commission on Medicaid and the Uninsured, Washington, DC.

elderly Medicaid population from FY 2003 through FY 2007 without the new prescription drug program. The federal government would be expected to provide 50% of that amount through its match. To arrive at the $14.6 billion, state officials assumed that the number of elderly people on its Medicaid program would increase 5% a year, while the per-capita cost of serving them would increase by 5.5% a year.

Taken together, these assumptions result in an average annual rate of increase in spending on the state's elderly Medicaid population of 10.8% a year. By comparison, according to Guyer, the Congressional Budget Office assumes that national spending on elderly Medicaid beneficiaries will increase at an average annual rate of 8.7% in the same five-year period.

Large numbers must be diverted

To make its waiver work, Illinois is assuming that its new prescription drug program will deter 7,500 elderly people from becoming sick and/or poor enough to qualify for Medicaid in the demonstration project's first year. Those 7,500 people represent 5% of the 162,000 elderly individuals the state anticipates would have enrolled in Medicaid without the demonstration. By the fifth year of the project, the state assumes that 41,400 elderly people will be deterred from enrolling in Medicaid because of the prescription drug program. Those 41,400 represent 21% of the 197,000 individuals who would have enrolled in Medicaid in the absence of the drug program.

As seen in the chart on page 5, Illinois expects that the demonstration project will be budget neutral over its five-year life, as required by CMS, but not in the early years.

In the first, second, and third years, the state expects it will spend more on the prescription drug program and the elderly Medicaid population than is allowed under the cap. But by the fourth and fifth years, it expects to spend less than allowed.

Ms. Guyer says there are any number of reasons why Illinois could find that the cost of operating either the drug program or the Medicaid benefit for the elderly could exceed the budgeted amount it anticipated needing. For instance, the number of elderly individuals eligible for Medicaid or the cost of serving them could go up more rapidly than expected.

"Given that the prescription drug program provides a low-income population with a popular benefit and is expected eventually to serve nearly twice as many elderly people as Medicaid, it appears likely that the state may face particular pressure to reduce spending on elderly Medicaid beneficiaries."

Jocelyn Guyer
Senior Policy Analyst
Kaiser Commission on Medicaid and the Uninsured
Washington, DC

"If it appears that Illinois' need for federal funds might exceed the amount available under the cap, the implications for elderly Medicaid beneficiaries could be significant," Guyer writes in her analysis.

"The state would likely need to choose between cutting spending on elderly Medicaid beneficiaries, cutting spending on its prescription drug program, or reaching the federal funding cap and paying for any unanticipated program costs entirely with state funds. Given that the prescription drug program provides a low-income population with a popular benefit and is expected eventually to serve nearly twice as many elderly people as Medicaid, it appears likely that the state may face particular pressure to reduce spending on elderly Medicaid beneficiaries," she continues.

"The state could do so by rolling back eligibility for optional elderly Medicaid beneficiaries, making it more difficult for eligible individuals to apply for and retain coverage, cutting provider reimbursement rates, eliminating selected benefits, increasing the cost-sharing obligations that these beneficiaries face, or taking other steps, such as increasing the efficiency with which it provides prescription drugs to elderly Medicaid beneficiaries that would reduce Medicaid expenditures," Guyer writes.

Ms. Guyer says it's possible the federal government would decide not to enforce the cap if it looks like Illinois is running into trouble, but it would be risky for the state to rely on that as a fallback position.

Support from stakeholders

But Mr. Kane says state officials are going into the program with their eyes open and have support from key stakeholders.

"We've worked with [the American Association of Retired Persons] in developing the demonstration, and they're very glad to see us doing it," he points out.

"They're helping with outreach and being very supportive. I'm not aware of any challenges to the program design or structure. We honestly believe we can make this work and not jeopardize our programs or the people who depend on us," Mr. Kane adds.

[Contact Mr. Kane at (217) 785-0710 and Ms. Guyer at (202) 347-5270.] ■

Proposed HIPAA changes draw fire *and* support

Although the Department of Health and Human Services (HHS) has tried to position proposed changes to health privacy regulations as necessary to ensure strong privacy protections and correct unintended consequences, it has drawn fire from those concerned about patient privacy. But some provider representatives have said the changes are necessary.

HHS Secretary Tommy Thompson says the changes would accomplish the following:

1. Strengthen notice provisions and remove consent requirements that hinder access to care
2. Maintain the "minimum necessary" rule, while allowing treatment-related conversations among health care professionals
3. Assure appropriate parental access to their children's records
4. Prohibit use of records for marketing, while allowing appropriate communications
5. Assure privacy, without impeding research
6. Provide model business associate provisions
7. Simplify authorizations

"The president believes strongly in the need for federal protections to ensure patient privacy, and the changes we are proposing . . . will allow us to deliver strong protections for personal medical information while improving access to care," Mr. Thompson explained.

But the Health Privacy Project, a private research and monitoring organization in Washington, DC, takes a dim view of the proposed changes. "Although the HHS press release claims that the department's proposed changes to the [Health Insurance Portability and Accountability Act] HIPAA privacy rule would tighten the marketing provisions, the changes actually make it easier for health plans and providers, like chain drug stores, to engage in activities that a consumer would consider marketing without first asking for permission. HHS proposes an authorization requirement for the use and disclosure of health information for marketing purposes, but the new expansive definition of what is not marketing leaves very few marketing activities subject to this authorization requirement," the group said in a call for consumers to write letters of protest.

"What people care about most at the core of the law is now in danger. The regulations, as initially finalized, had significant limitations and weaknesses, and it's disturbing that they now want to weaken them even further."

Janlori Goldman
Founder
Health Privacy Project
Washington, DC

Health Privacy Project founder Janlori Goldman tells *State Health Watch* the group is "extremely concerned that the department is proposing to gut the privacy regulations." Her reading is that HHS would eliminate the requirement completely for patient consent, one of the key provisions relating to release of health information.

"That provision already was too weak because doctors could condition care on getting consent for release of information. HHS is saying it is too burdensome to doctors, so the consent provision has to be eliminated. We're urging that it keeps the requirement and fix the problems in a more targeted way."

Another key provision that would be changed, Ms. Goldman says, is the marketing provision that also was too weak in its original form because it gave marketers one free shot at patients before they could opt out of receiving additional materials. While the HHS proposed change would require an upfront initial authorization, the trade-off is that they would re-label a lot of what are considered marketing activities and call them treatment activities that don't require patient consent.

An example she cites is when a pharmacy wants to send letters to patients suggesting that they consider switching the antidepression drug they are taking. (Pharmacies often are hired by drug companies to send such letters.) Ms. Goldman says most consumers would consider such a letter to be a marketing tool rather than a treatment tool.

"I don't think there's any malice on the part of HHS staff, but we're concerned that their explanation of the changes is very misleading," she tells *State Health Watch*. "What people care about most at the core of the law is now in danger. The regulations, as initially finalized, had significant limitations and weaknesses, and it's disturbing that they now want to weaken them even further."

Support for the changes came from the American Association of Health Plans in Washington, DC, whose president and CEO Karen Ignani says that the proposal addresses many concerns that were raised with the agency.

"With these proposed modifications, the administration has taken a major step toward crafting a balanced,

workable rule that will protect the privacy of patients without undermining their health care," she explains.

"While these modifications will substantially improve the overall rule on medical privacy, several concerns remain. First, we urge the administration to continue to work toward establishing uniformity so that confusion and inconsistency between the federal rule and the individual laws of 50 states do not complicate the ability to provide quality health care. Second, the April 14, 2003, deadline for implementing this rule does not take into account the enormous undertaking of overhauling administrative systems across the health care system, a process that will require substantial time and resources," Ignani says. "We urge the administration to work with health plans and providers on a transition schedule that reflects the challenges we all face in implementing these rules."

A California HealthCare Foundation survey of 100 health care organizations operating in that state concluded that some changes are needed to implement the rule successfully, but eliminating major components is not warranted.

The foundation said key responses included:

- Planning for compliance is progressing, although implementation progress varies.
- The minimum necessary requirements are "somewhat workable."
- Health care organizations believe the consent and minimum necessary requirements limit access to information needed for quality assessment.
- Health care organizations view the business associates provision as "burdensome."
- Health care organizations need additional resources to analyze preemption of state medical privacy rules by HIPAA.
- Health care organizations have not allocated resources to fund compliance efforts completely.
- There is a "general need" for clarification and/or modifications to the rule.

Provider pros and cons

On the physician side, Donald Palmisano, American Medical Association (AMA) secretary-treasurer, says doctors are concerned that HHS is proposing to remove the patient consent requirement rather than modifying it to make it more workable.

"If the final privacy rule will be issued without a consent provision, the AMA urges the administration to strictly limit the activities for which patient information could be used without consent," he says.

"Right now, patient information can be used without consent for a wide range of business activities . . . and there is no incentive to de-identify patient records. De-identified information should be used whenever possible to best protect patient privacy," Palmisano adds.

However, other provider groups, such as the American Academy of Family Physicians, the American Academy of Nurse Practitioners, and the American Academy of Physician Assistants, said they supported the proposed changes, including elimination of the prior consent provision. They said the changes strike a fair balance between protecting privacy and autonomy of patients and removing unnecessary barriers to health care delivery.

At a Senate Health, Education, Labor, and Pensions Committee hearing on the proposed changes, Democratic committee members were harsh in their criticism, while department officials defended the steps they want to take.

Committee chairman Edward M. Kennedy (D-MA) called elimination of the prior consent requirement a "serious step backward" for patient privacy. But Claude Allen, HHS deputy secretary, contended that "mandating consent is coercive [and] a hurdle to health care."

The prior consent provisions would have required providers to obtain written consent from patients before using their personal information for treatment, payment, or other health care operations. Under the revised plan, health care organizations would only have to notify patients of their privacy rights. Mr. Kennedy also said changing the definition of marketing would create a "major loophole." He threatened to introduce legislation to reinstate the prior consent requirement if it is dropped from the final rule, and Sen. Ernest Hollings (D-SC) introduced a bill to require on-line businesses to get users' permission before collecting medical information or other sensitive data.

"You may think privacy rights are the major overriding issue," Mr. Allen told the committee. "But we stepped back and concluded that it's far more important that we do nothing to impede access to care. Having privacy means little if you don't have access to care."

[For HHS information about the HIPAA changes, go to www.cms.gov.

Contact Mr. Goldman at (202) 687-0880, Ms. Ignani at (202) 778-3200, and Mr. Palmisano at (202) 789-7447.] ■

EWP identifies managed care problems quickly

Recognizing that problems can occur as managed care programs are designed and then operated, some states have experimented with an early warning program that uses limited, readily available data sets to identify potential problem areas and allows a rapid response. A prompt resolution of managed care problems can have both health care quality and economic implications for states.

Howard Dichter, MD, a Philadelphia-based consultant who created a Medicaid managed care Early Warning Program (EWP) while employed at the former Health Care Financing Administration [now the Centers for Medicare & Medicaid (CMS)], tells *State Health Watch* he first became interested in the crises that can occur in large health systems and wanted to find a way to help identify when problems are occurring.

His work on a District of Columbia physical health program and behavioral health programs in Pennsylvania and Vermont is described in a working paper issued by the Center for Health Care Strategies in Lawrenceville, NJ, under a Robert Wood Johnson Foundation Medicaid managed care grant.

Mr. Dichter says that while there are a number of programs that can evaluate state Medicaid efforts, they don't provide quick information that can be used to identify emerging problems and facilitate corrective action. For instance, HEDIS (Health Plan Employer Data and Information Set) data only are available annually. In contrast, the EWP was able to identify problems very quickly in the District of Columbia, Pennsylvania, and Vermont, and thus efforts could begin to resolve the problems in a more timely way. While EWP structures vary depending on each state's needs, reports generally can come out quarterly, giving enough data to be able to identify trends but not taking so long as to miss the point of early identification of problems, he says.

States need to be able to monitor their managed care programs, he says, because the Medicaid population has limited financial resources, complex social service needs, and a high incidence of chronic illness, meaning they are particularly vulnerable to delays in treatment arising from failure to access quality health services. And ethnic minorities may face even greater barriers to securing health services as a result of language or cultural differences. "This population can ill afford having to overcome obstacles to secure needed services," Mr. Dichter declares.

The EWP provides early warning detection and fosters resolution of problems arising out of key aspects of managed care performance. It uses a limited set of measures and administrative processes to oversee the health system and provide real-time, performance-based reporting to state, federal, and local governments; consumers; families; providers; advocates; and other stakeholders.

Data on the measures chosen to fit local circumstances and interests are collected quarterly or more frequently by a state. (**For typical data sets, see box, below.**) The information is quickly analyzed and problems identified usually are addressed within weeks or months. Mr. Dichter stresses that the EWP relies heavily on the involvement of stakeholders who routinely

Early Warning Program Measures

Source: Center for Health Care Strategies, Lawrenceville, NJ.

receive monitoring data and help the state identify problems or trends warranting additional attention. "The stakeholder role cannot be overemphasized because they assist the state in developing strategies to remedy identified problems and remain involved to ensure that corrective action is taken," he says.

While states initially were concerned that rapid problem identification could lead to lawsuits filed by advocates, that has not been the case to date. Rather, according to Mr. Dichter, enhanced information flow has increased advocates' confidence that a particular health system was functioning properly and that problems were promptly identified and then addressed. "Overall, collaboration with advocates has improved," he says.

The three pilot EWPs preferred to select data that came from regular managed care organization operations, rather than burden the plans with the need to prepare special reports. The information collected usually was found to be reliable, especially when it also was used by the managed care organization in regular business operations.

Because it was difficult to get timely encounter data, particularly during the first two years of a new program, service authorization data were used to measure access to clinical services. Authorization data were available almost immediately, could be retrieved easily, and could be reviewed in a short time. Evaluating and trending data from the EWP measures was challenging, Mr. Dichter reports. At the onset of the monitoring programs, national standards were not available for most measures of access to services and the quality of services. Whenever possible, results were compared to contractual performance standards,

State pilots vary in EWP use

Pennsylvania developed an early warning program (EWP) to provide oversight for its behavioral health managed care program. Service authorization data that were collected identified some counties with low rates of authorizations for services compared with adjacent counties. This was seen in several service categories, including outpatient mental health services and intensive case management. Authorizations increased after it was found that there weren't enough providers and additional providers were recruited.

A discrepancy also was seen between the percentage of African-Americans authorized to receive mental health services relative to other populations. State officials assumed that distribution of mental illness and the need for behavioral health services was equal among all groups and suspected that the low service authorization numbers reflected barriers to care. The county and contracted managed care organization started actions to ensure that access to needed services was improved for this minority group.

In reviewing claims payment data, Pennsylvania officials identified problems with one managed care organization's payments to providers. The state requested and received a plan of correction that included advancing funds to providers with cash-flow problems, hiring additional staff, developing educational forums to assist providers, and modifying policies for dealing with third-party benefits, which had been delaying provider payments.

Data derived from the EWP's grievance measure showed that one managed care organization had more than 50% of grievances denied. Follow-up revealed that the denials were related to providers' untimely submission of clinical information to the managed care organization. When the submission procedures were corrected, there was a 67% drop in the percentage of denials that were grieved.

In Vermont, an EWP was developed to oversee the Community Rehabilitation Treatment program that managed care for 2,700 serious mentally ill adults statewide. One of the measures used in this program was average client service hours, and considerable variation was found from agency to agency during the first full year of case rate payments. The average number of service hours used for beneficiaries in community agencies with high average service hours declined after introduction of case rates, while there was little change of hours in agencies with lower average service hours. State officials saw this shift as one of the desired outcomes in the introduction of case rates.

One of the top priorities for state officials was to reduce the rate of involuntary commitments. Using the EWP, the state was able to monitor this activity for the first time. Also, the number of program participant admissions for inpatient services was an EWP measure. Hospital admissions declined 43% during the first year of the program, suggesting to state officials that the program was limiting the need for hospital admissions and that needed services were being provided in the community.

Washington, DC, started its EWP to assure that health services in a waiver program that began in April 1998 were available as intended and that problems were addressed quickly. Member complaint data allowed the District to quickly identify and ameliorate problems with beneficiary primary care provider selection and pharmacy benefits. The District also used data from proxy telephone calls to improve access to treatment providers. ■

managed care organization internal standards, or federal and state regulations. For most measures, however, pre-existing agreements, standards, or regulations did not exist.

States found that comparing findings and significant variations among similar populations was the most effective strategy to identify problems. Useful strategies include comparing subgroups within a covered population and comparing regions with similar populations or the same population over time. Once a trend was identified and deemed significant, Mr. Dichter says it was important to verify the accuracy of the data and then determine the reason there were outlier groups. Trends usually were associated with problems, but not always. For example, a low number of complaints for one managed care organization was associated with misunderstanding the definition of complaints, which led to underreporting.

EWP data also identified positive performance, indicating system strengths and giving confidence to the efficacy of the health care program. State interest in early warnings program has reached enough intensity that CMS held a summit earlier this year in Washington, DC. The National Academy for State Health Policy in Portland, ME, is preparing the proceedings from that meeting, which should be available by the end of the summer.

Neva Kaye, program director, tells *State Health Watch* that the summit enabled state officials to share with each other the steps they had taken and what had worked for them. "All states are interested in evaluating access, and then there are other things that are specific to individual states. States are interested in being able to rapidly identify issues. There's a lot of raw material available, and they need help in putting it together."

[Contact Mr. Dichter at (215) 849-8133 and Ms. Kaye at (207) 874-6524.] ■

Coverage leads to better health

Doubts about the value of health insurance coverage should disappear with the release of *Care Without Coverage*, a report from the Institute of Medicine's Committee on the Consequences of Uninsurance. The report summarizes findings from 130 research studies that considered (1) health insurance status as an independent variable and (2) its effect on health-related outcomes for adults ages 18 to 64.

Health insurance emerges in the research as a key that provides access to high quality health care and consequently to better health. "It is not the only key that opens these doors, nor is access to them guaranteed if one has coverage," the report says. "But health insurance is the mechanism that most Americans rely upon to obtain the care that they want and need. The health benefits of insurance are strongest when coverage is continuous rather than sporadic."

The main findings are that working-age Americans without health insurance are more likely to receive too little medical care and receive it too late, be sicker, and die sooner, and receive poorer care when they are in the hospital even for acute situations like a motor vehicle crash.

The research studies reviewed found that people without health insurance often go without appropriate care. For example, the uninsured more often go without cancer screening tests, delaying diagnosis and leading to premature death; do not receive care recommended for chronic diseases like timely eye and foot exams to prevent blindness and amputation in persons with diabetes; lack regular access to medications to manage conditions such as hypertension or HIV infection; and receive fewer diagnostic and treatment services after a traumatic injury or heart attack, resulting in an increased risk of death even when in the hospital.

Based on the consistency among the research studies reviewed and evaluated, the committee reached these conclusions:

- Health insurance is associated with better health outcomes for adults and with their receipt of appropriate care across a range of preventive, chronic, and acute care services. Adults without health insurance experience greater declines in health status and die sooner than do adults with continuous coverage.
- Adults with chronic conditions and those in late middle age stand to benefit the most from health insurance coverage in terms of improved health outcomes because of their generally greater need for health care.
- Racial and ethnic minorities and lower-income adults would particularly benefit from increased health insurance coverage because they more often lack stable health insurance coverage and have worse health status. Increased coverage would likely reduce some of the racial and ethnic disparities in use of appropriate health care services and also may reduce disparities in morbidity and mortality.
- Health insurance that ensures adequate provider participation and that includes preventive and screening services, outpatient drugs, and specialty mental health care is more likely to facilitate receipt of appropriate care.
- Broad-based health insurance strategies across the entire uninsured population would be more likely to produce these benefits than would "rescue" programs aimed only at those who are seriously ill.

If the uninsured were provided with coverage, the report suggests, they would be likely to use more services

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like timely preventive care and chronic disease care that match professional guidelines. They also would be more likely to have a regular source of care. And if they were insured continuously, their health would be expected to be better and their risk of dying prematurely would be reduced.

However, the survivor benefits derived from insurance coverage can be achieved in full only when health insurance is acquired well before development of advanced disease. For example, insuring women once cancer is diagnosed will not solve the problem of later diagnosis and higher mortality among uninsured women with breast cancer.

(To download a summary of the report, go to: www.iom.org.) ■

Clip files / Local news from the states

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

Children's insurance copayments revised

CHARLESTON, WV—West Virginia families covered by the Children's Health Insurance Program (CHIP) would no longer have to pay a copayment for generic drugs if a revised payment structure is approved. State officials say eliminating the copayment would give CHIP members an incentive to use generic drugs instead of more expensive brand medications. Currently, some members pay a $5 copayment for a generic drug and $10 for a brand drug, while others are exempt from copayments. Copayments are based on income. Under the proposed changes, all members would pay a $10 copayment for a brand drug and a $15 copayment for a brand drug that is not in CHIP's formulary. The revised payment structure, along with a new pharmacy benefits manager, is expected to save the program $846,000. "This new copay system is a fiscally prudent move," said Sharon Carte, CHIP executive director. "It will allow us to hold down individual member costs so we can serve more of the working families of West Virginia."

—*Charleston Gazette*, May 16

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