State

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Consumer advocacy group criticizes CHIP for restrictions on extending coverage to parents

Families USA argues for more flexible applications in reaching uninsured children

Editor's note: The Children's Health Insurance Program (CHIP) is proving a classic Catch-22. The regulations governing this $24 billion program to cover uninsured children are so restrictive, they often block cost-effective use of the funds. In this issue of State Health Watch, *we look at the Massachusetts program using CHIP to cover parents through supplements to employer health plans. We talk to experts who explain why most state programs will not be able to duplicate what Massachusetts did, and who offer other approaches. Our special report also looks at unexpected problems in the Virginia and Florida plans.*

SPECIAL REPORT: CHIP

Well-intentioned though it may be, the federal government's Children's Health Insurance Program (CHIP) may not provide adequate protection for uninsured children because it restricts states' options in providing coverage to parents, according to a new report from the Washington, D.C.-based advocacy group Families USA.

While it's important to expand health insurance to cover uninsured children, it's also important to recognize that the well-being of children is tied closely to the health of their parents, according to Vicky Pulos, associate director of health policy at Families USA. Unfortunately, that's where CHIPs falls down, the report contends. Here are a few of the findings that led Families USA to make that criticism:

• More than 75% of uninsured children live with parents who are uninsured.

• More than 90% of uninsured children live in families in which at least one parent works.

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In This Issue

Forget Massachusetts! Do your own CHIP thing: Expand Medicaid eligibility without waivers

An increasing number of states are searching for ways to provide insurance coverage to uninsured parents whose children can qualify for the new Children's Health Insurance Program (CHIP) or Medicaid, and many state program directors are erroneously assuming modeling their own program after Massachusetts' is the best way to go. Thus far, only Massachusetts has an approved plan to expand coverage to parents, which it is accomplishing through a combination of CHIP funds and a Medicaid expansion through an 1115 waiver.

"Massachusetts officials present [at meetings] and everybody drools, but they can't do what Massachusetts is doing," said Trish Riley, executive director of the National Academy for State Health Policy. "They've invested in the infrastructure for the uninsured for a long time with state funds and they have a waiver. Massachusetts is doing fascinating stuff, but it's just not replicable."

But there are other options open to states, which can take several forms other than waivers or CHIP, according to Cindy Mann, a senior fellow at the Center on Budget and Policy Priorities in Washington, D.C. These options spring from the fact that the welfare reform laws of 1996, which severed cash assistance from Medicaid, expanded states' options to set Medicaid income eligibility requirements.

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State Health Watch

Land mines: Does your CHIP have some?

Two minor technicalities may derail Virginia's program, a Medicaid lookalike

Just days before Virginia's Children's Health Insurance Program (CHIP) was to have taken effect, state officials learned in late September that the program would be derailed by their strategies for covering abortion services and generating the local CHIP match.

At issue is the extent of Virginia's Title XXI abortion coverage and the state's use of a provider tax to fund its share of the CHIP program. CHIP officials at both the federal and state level say they hope to reach a resolution on the issues by the end of this month.

"We're not at a standstill," said Debbie Chang, co-chair of the Health Care Financing Administration (HCFA) Steering Committee on CHIP Implementation. "We're really working hard with the state to pursue these two issues."

While Virginia has chosen to implement its children's health expansion outside Medicaid, it has elected to use Medicaid to define the benefit package. Under the federal Hyde amendment, Medicaid benefits can include coverage for abortion services only if the life of the woman is threatened or in the case of rape or incest.

Virginia officials say that because separate state funds are used to provide abortion in the case of rape or incest, those services are not officially part of its Medicaid package and do not need to be included in CHIP coverage. Federal officials dismiss the distinction.

"Although the state has not chosen to use federal funds to match payments for abortions performed in cases of rape or incest, this service is nonetheless a service required to be included under Medicaid," HCFA Deputy Director Richard Fenton wrote in a Sept. 9 letter to Virginia Department of Medical Assistance Services Director Dennis Smith.

In 1994, the most recent year for which statistics are available, the state-only plan paid for 132 abortions, House Appropriations Committee legislative analyst Susan Massart said. The state-only coverage also pays for abortions in instances in which the health—not only the life—of a woman is endangered, she said.

Virginia has sought approval for its children's insurance plan under a so-called "secretarial-approval" route, which gives broad approval power to the secretary of the Department of Health and Human Services and requires the state to meet very specific coverage standards, federal officials wrote.

"In order for the state to meet the requirement for Secretarial-approved coverage, it must provide exactly the same benefits of the Medicaid program, which the state has selected as its benefit package, and include the full coverage of the abortion services mandated under the Hyde amendment," Mr. Fenton wrote.

Virginia holds firm

Virginia officials contend that the Hyde amendment does not mandate abortion coverage, but only restricts the instances in which it can be offered if states do fund abortion.

One way to resolve the abortion issue would be for Virginia officials to give up pursuit of secretarial approval of its plan and redefine the CHIP benefit package as something other than a Medicaid-lookalike, HCFA's Ms. Chang said.

Federal officials also are questioning Virginia's use of a provider tax to generate the state's 33.9% share of annual expenditures for the program, dubbed locally as the Virginia Children's Medical Security Insurance Plan (CMSIP).

The use of provider taxes to fund state Title XXI matches is not novel and mirrors the strategy other states have used to attract Medicaid matching funds. As with the Medicaid program, HCFA requires that any provider tax used to fund CHIP implementation be broad-based, uniform, and redistributive in nature. The federal law cited by HCFA officials was designed initially to prevent Medicaid programs from boosting state Medicaid funds with provider taxes and returning those funds—augmented with a federal Medicaid match—directly back to the providers who paid the taxes.

Federal officials' concern with Virginia's match is that it is generated from health insurance premium taxes that arguably are assessed at different rates for different insurers. Since 1988, Blue Cross/Blue Shield of Virginia—now, Trigon—has taken advantage of a state law that gives a premium tax break on contracts offered to Virginia residents under open enrollment. Open-enrollment contracts are taxed at 0.75% of gross subscriber income; other contracts are taxed at 2.25% of gross subscriber income.

In 1997, Virginia legislation that implemented the federal Health Insurance Portability and Accountability Act (HIPAA) did away with the preferential tax treatment, as HIPAA required all carriers to provide guaranteed issue in the small group market, defined as employers with two to 50 employees. The funds that support Virginia's CMSIP are generated from the equalization of the tax on small-group-market insurers.

Insurers in the individual market who offer open enrollment still are given preferential treatment, but no individual market tax revenues are used to fund the state's CMSIP match. The rates are uniform within each class, e.g., open-enrollment contracts or other contracts, and therefore meet the definition of uniformity within federal law, Smith wrote.

The CMSIP trust fund predates approval of the federal CHIP law and was established originally to provide preventive and primary care to children up to age 18.

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Virginia officials expect CMSIP to serve about 63,200 previously uninsured children by June 30, 2001. The program plans to cover children under the age of 19 in families earning up to 185% of the federal poverty level, $16,450 for a family of four, with cost-sharing phased in for families above 150% of the federal poverty level. To address the crowd-out issue, the Virginia plan states that a child must have been without health insurance for 12 months in order to be eligible for CHIP coverage.

For the two-year period ending in 2000, Virginia officials plan to spend a total of $93.8 million in coverage for newly eligible children under CMSIP and expansion of Medicaid to children currently eligible but not yet enrolled. The state's CMSIP trust fund will contribute $7.2 million toward the CHIP match, $6.2 million in Medicaid outreach and enrollment, and $1.9 million in Department of Social Services eligibility determination. Federal contributions consist of $38.8 million in CHIP funding and an additional $18.5 million in increased Medicaid match.

Contact Ms. Chang at 410-786-0587 and Mr. Smith at 804-786-7933. ■

Just how much "wiggle-room" will HCFA allow in CHIP? Florida will test regulators' flexibility

Florida officials are plowing ahead with their plan to increase children's coverage under the Children's Health Insurance Program (CHIP) by subsidizing employer plans, despite their misgivings about how the plan can be tailored for Florida's market.

The biggest concern among Florida officials is a Health Care Financing Administration (HCFA) requirement that employers contribute at least 60% toward the cost of dependent coverage.

"A brief and unscientific poll of insurers/HMOs … indicated Florida employer contributions for family coverage (when offered at all) may average only 50%," Florida Deputy Insurance Commissioner Susanne Murphy wrote to Department of Health Secretary James Howell, M.D.

Documenting cost-effectiveness

Florida officials appear ready to "play chicken" with HCFA and submit a plan that falls short of the 60% threshold. Their hope is that HCFA will approve the plan if they can come up with a way to meet the more important requirement: documenting that employer-sponsored CHIP coverage is more cost-effective than insuring the child through other programs.

"There appeared to be some wiggle room there," Florida Hospital Association General Counsel Bill Bell said.

In fact, a concept paper approved Oct. 8 by Florida's KidCare Coordinating Council anticipates the problem and cautions that an exception to the 60% rule approved for employer-sponsored coverage in Massachusetts may be predicated on state-specific circumstances that Florida will be unable to replicate.

However, the legislatively authorized coordinating council sent the issue back to a smaller study group without suggesting a minimum employer contribution and without any strategies on how Florida could meet the cost-effectiveness test. Details for submission of the plan will be worked out in future study group meetings after the November election, Department of Insurance senior management analyst Noelle Mahone said.

Family contributions and other components of employer-sponsored coverage are modeled after provisions of Florida Healthy Kids, the state's private-public partnership for expanding children's health insurance coverage. A family's premium will be capped at $15, without regard to the number of children in the family. Subsidy amounts will vary according to an individual employer's insurance cost and the amount of employer subsidy already in place. The benefit package also will mirror that of Florida Healthy Kids.

The FHA's Bell suggested that study group members may try to meet HCFA's cost-effectiveness test by comparing projected expenditures for employer-sponsored coverage to those of the Florida Healthy Kids program. The program's per child per month premiums range from $46.28 to $85.22 for two different benefit packages, Florida Healthy Kids External Affairs Director Jennifer Lloyd said.

Florida lowers estimates

Florida legislators originally estimated in setting up the program that employer-sponsored insurance would cover about 48,000 of the 254,000 children targeted in the state's CHIP expansion, but the budget for the fiscal year that began Oct. 1 lowers the target to 7,500 children. Ms. Mahone said state officials have shifted available CHIP funds to other program components that already have gotten up and running while state officials continue to work on employer-sponsored coverage.

"It's taken us quite a while to figure out what HCFA wants," she said.

At the same time, HCFA officials also wondered privately how Florida would find and enroll children in the employer-sponsored portion of the CHIP expansion, given its generous benefits in other components of the program. Florida Healthy Kids, Medicaid, and Medicaid-lookalike portions of Florida's program cover virtually all children under age 19 in families with incomes under 200% of the federal poverty level.

Contact Ms. Murphy at 850-413-5914 and Ms. Lloyd at 888-352-5437. ■

Consumer group wants more flexibility in CHIP

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• The majority of parents of uninsured children don't have access to employer-based insurance.

• About 2.8 million uninsured parents of uninsured children have incomes below the poverty line; 2.3 million more have incomes between the poverty line and 200% of poverty.

The $24 billion CHIP program is supposed to provide coverage for children in families whose income is too high for traditional Medicaid but not high enough to pay for private insurance. Unfortunately, the program provides only limited authority for states to use CHIP money to cover parents, too.

That limited authority comes via what's known as the Family Coverage Variance. According to Ms. Pulos, however, states can only use the variance if they demonstrate to the Health Care Financing Administration (HCFA) that:

1. The family contains "targeted low-income children" who are eligible for coverage under CHIP.

The problem here is that "Medicaid covers children at higher income levels than parents; therefore, the uninsured parents of children eligible to receive Medicaid prior to any CHIP expansion [of the Medicaid program] will not be eligible for family coverage," according to the report.

2. Family coverage will be "cost-effective" compared to the costs of just covering eligible children in the family.

So far, HCFA hasn't clarified what it means by "cost-effective," but most experts believe it means that family coverage should be "no more costly" than simply covering eligible children in a family. And, according to the report, "HCFA has identified only one circumstance in which it may be no more expensive to cover an entire family … and that is when the family has access to employer-sponsored coverage in which the employer contributes to the premium costs."

3. Family coverage won't substitute for private group coverage.

Essentially, HCFA doesn't want parents dropping private insurance to enroll in the CHIP program. It also wants to keep employers from reducing their contribution toward the cost of dependent coverage or stopping contributions altogether.

4. The coverage provided to children meets minimum standards for benefits and affordability and otherwise complies with the CHIP law.

"CHIP requires that all plans provide a certain minimum level of benefits, and limits costs imposed on families," the report says. "States must identify the benefits and cost sharing in employer-based plans and have some way to supplement inadequate benefits or subsidize excessive costs."

States also can apply to HCFA for a research and demonstration waiver under Section 1115 of the Social Security Act. That act authorizes the Department of Health and Human Services to waive statutory requirements "for experimental, pilot, or demonstration projects that will assist in promoting the objectives of the Act." Unfortunately, HCFA has discouraged states from applying for 1115 waivers until the CHIP program becomes more established.

Given the stringent requirements for obtaining a family coverage variance, it's not surprising that only one state—Massachusetts—has been approved to subsidize premium costs for families with access to employer-based coverage. *(See related story on what states are doing, page 1.)* Massachusetts did it primarily by showing HCFA that it was cost-effective for the state to subsidize premium costs for employer-sponsored insurance for families near the poverty line.

"We were in the midst of an expansion anyway," says Sharon Torgerson, director of external relations for the Massachusetts Division of Medical Assistance (DMA) in Boston. Under an 1115 waiver, the state began expanding its health program in July 1997 by raising its eligibility guidelines to 133% of the federal poverty level. That added 152,000 people to the state's medical assistance caseload. A month later, using CHIP money, the state expanded further, to 200% of the poverty level.

"I think that because we were in the midst of expansion, we were able to win family coverage approval from HCFA by showing that it was cost-effective for us to purchase a family plan through an employer-sponsored program," Ms. Torgerson says.

According to HCFA, a number of states are interested in exploring employer-based coverage—especially because the agency has indicated that such an approach may be the only way to meet the cost-effectiveness criteria. "About the only other circumstance people have been able to think of is where there is a difference between individual coverage and family coverage and you have a really huge family," Ms. Pulos says. "In that situation, the cost of covering six kids might be less than the cost of family coverage."

The problem with employer-based coverage, however, is that it tends to exclude lower-income families. Ms. Pulos cites several studies which show that the percentage of families with employer-based insurance decreases as income decreases. "So a lot of these working poor families that the CHIP program is designed to address are probably in jobs where they don't have access to coverage from their employer, or their employer doesn't subsidize much of the cost.," Ms. Pulos says. "So those folks are out of the picture as far as using children's health insurance family coverage variance resources."

Ms. Pulos says that, rather than pushing for a Massachusetts-style employer-based approach to providing care to families, states should consider adapting their approach to mimic their Medicaid programs. "The traditional Medicaid program is a more flexible avenue for states to provide health insurance coverage to lower income families than the CHIP program—and the federal government pays a share of the cost," Ms. Pulos says.

Contact Ms. Pulos at 202-737-6340. ■

Massachusetts' program is not easily duplicated

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"Medicaid actually has much greater potential for covering parents than CHIP does," Ms. Mann said. "CHIP was intended to be almost exclusively for children, with one narrow exception—if you could prove it was cheaper to get a family policy than to cover just the kids."

Under welfare reform, enacted through the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, states had to provide Medicaid coverage to parents who met the Aid to Families With Dependent Children (AFDC) requirements in effect in that state as of July 16, 1996. "But those are minimum standards," Ms. Mann pointed out. "States can go up the income scale and cover more parents."

For example, states can disregard, or not count, more of a family's income toward eligibility standards. By law, states must subtract at least $90 per month in transportation costs from a worker's income when determining what counts toward eligibility. A state can choose to boost that to $180, according to Ms. Mann. An increased "disregard" income amount also could be used to make parents eligible for transitional Medicaid benefits for a longer period than is required under current law, she added.

Pennsylvania has a 50% disregard for people applying for Temporary Assistance to Needy Families as well as those seeking Medicaid benefits. New York disregards as much of a Medicaid recipient's earnings as is necessary for him or her to remain eligible for Medicaid, until income reaches the poverty line. The federal poverty level is an income of $1, 137 a month for a family of three.

States also can eliminate the "asset test," under which the family usually had to have less than $1,000 in assets. Previously, states could only eliminate the asset requirement when determining whether children were eligible for Medicaid. Now they can do away with it for all members of a family. They also are able to offer Medicaid to two-parent working families, not just those with a single parent.

North Carolina, for example, has loosened asset requirements in two ways. It disregards the first $2,000 of countable assets, effectively raising the standard to $3,000. It also allows $5,000 in fair market value for a car.

Another way of expanding eligibility may be available to states that have had AFDC waivers approved as of July 1, 1997. Some of these waivers may have been designed to change work requirements, or set time limits on the provision of benefits. Regardless of the purpose of the waiver, a state can choose to stick with only the provisions of the waiver that addressed income and resource and family composition rules for the purposes of determining Medicaid eligibility.

> "... states are fearful of a recession. [With CHIP] ... they can put a limit on their financial liability."
>
> Trish Riley

The final and "least significant" way to expand eligibility, according to Ms. Mann, is to invoke the right, provided by federal law, to raise income and resources standards "by as much as the increase in the consumer price index" since July 1996. This might not result in much of a bump, but taken with other measures, could help ensure eligibility standards keep pace with inflation.

States that have expanded coverage include Rhode Island, which plans to cover uninsured parents/caregivers of children in Medicaid managed care plans and under the fee-for-service system, whose incomes are up to 185% of the poverty level. As of Oct. 1, the District of Columbia also increased its Medicaid eligibility to all parents of children under age 19 with incomes at 200% of the federal poverty level. While both Rhode Island and Washington, D.C., have 1115 waivers, those states did not have to invoke their waiver authority to make these changes.

State must contact employers

In Massachusetts' case, the program to cover working parents will be fairly labor-intensive, and time will tell if it can be administered effectively. The state will have to contact every employer whose employee may quality for coverage to determine if benefits, cost sharing, and other features are comparable to what is required under CHIP. Only then would the state be able to contribute 50% or more of the employee portion of the premium, not to exceed $30 per month, the amount specified in Massachusetts' Medicaid expansion plan.

Some states and policy experts are awaiting further guidance from the Health Care Financing Administration (HCFA) on CHIP, particularly the "Family Coverage Variance" provision, but HCFA officials have been silent about when the regulation will be released, saying they're busy enough approving plans and plan amendments.

While states may avail themselves of expanding eligibility through Medicaid, some still are going to find CHIP alluring, Ms. Riley said. "Medicaid is seen as an entitlement, and states are fearful of a recession," she said. With CHIP, "they can put a limit on their financial liability."

The intensive outreach that is supposed to accompany CHIP is likely to turn up a significant number of Medicaid-eligible children, Ms. Riley said, boosting state costs and making governors less likely to feel generous with their Medicaid money.

However, Ms. Mann pointed out that states could roll back or freeze Medicaid expansion if that were to become financially necessary, just as they could impose waiting lists for CHIP eligibles.

Contact Ms. Mann at 202-408-1080 and Ms. Riley at 207-874-6524. ■

Feds crack down on mental health centers

Investigation could trigger state probes, provider exclusions

After uncovering $229 million worth of allegedly fraudulent Medicare claims from community mental health centers (CMHCs) in five states, federal investigators are pushing for Congress to dump Medicare's partial hospitalization benefit. It's not yet clear how Medicaid funding for mental health centers will be affected, but some state officials already are in talks with the Health Care Financing Administration (HCFA) to find out.

Recently, HCFA informed twenty CMHCs that the agency intends to terminate their Medicare provider agreements, and 60 more centers are expected to face termination over the next few months, HCFA officials say. HCFA has indicated that as many as 1,000 CMHCs eventually may be kicked out of Medicare.

In addition, HCFA has informed individual states about which CMHCs received notification letters. States will have to decide for themselves whether to terminate Medicaid agreements with these providers or initiate Medicaid-based fraud investigations, says Ben Jackson, audit director, field operations for Medicare and Medicaid at the Department of Health and Human Services Office of the Inspector General (OIG).

Mr. Jackson notes that federal investigators are leaving the question of Medicaid fraud enforcement to the states because rules regarding partial hospitalization may differ among states and between Medicare and Medicaid. "The other issue obviously would be if there are [patients who are] dual-eligibles," Mr. Jackson says. In that case, HCFA wouldn't pay for the Medicare portion of a claim submitted by a terminated provider. "States really would have to be aware of whether there are any crossover claims," he says.

John Searcy, MD, medical director at the Alabama Medicaid Agency in Montgomery, has been working recently with HCFA through the agency's Technical Advisory Group to coordinate a state-level response to the CMHC issue. "Right now, we don't know if there's an impact on us directly," he says. "We've started trying to look at our program as compared to the Medicare program and cooperate with them on their investigation. We're working with them to see what they have found and to see if they need any information from us." Mr. Searcy adds that Alabama could launch its own investigation of possible Medicaid fraud, but nothing's been decided yet.

> "Our state Mental Health Authority asked that Medicare quit enrolling these providers because we were concerned about oversight and quality of care."
>
> Deana Stoner

The larger issue for most states will be what impact the Medicare exclusions have on their state program provider systems. HCFA doesn't want excluded Medicare providers in any state programs that receive federal funding. State directors can ignore the exclusions at their own risk: A HCFA audit might uncover them and make the state liable for huge reimbursements, or the press might uncover them and give the programs a black eye. Neither prospect is attractive.

Meanwhile, the OIG intends to pursue civil and criminal cases against CMHCs nationwide, says Ben St. John, an OIG spokesman. If sanctioned by the OIG, mental health centers would face exclusion not just from Medicare but from all federally funded health care programs, including Medicaid.

Mr. St. John notes that the OIG already has taken action against some CMHCs that provide partial hospitalization services. In at least one instance, a facility was hit with a monetary settlement and the imposition of a corporate integrity program. "Under those circumstances, they would avoid being sanctioned or excluded," Mr. St. John says. "But there would be a fairly close oversight through the implementation and monitoring of that integrity program to make sure there was future compliance."

Mr. St. John adds that, despite HCFA's notification letters, the federal government recognizes "that this type of service is important and should be continued to the extent that it can be. Therefore, HCFA's trying to terminate only the worst offenders and work with other ones who haven't been compliant to ensure the continued availability of this kind of care in the community setting."

That's good news to officials at the National Mental Health Association in Alexandria, VA, who worry that Congress might "throw the baby out with the bath water," according to Robert Gabriele, senior vice president of the association. "HCFA is right in weeding out … fly-by-night operations posing as community mental health centers," he says. "But people need to know that the vast majority of [these centers] do a great job and help localities avoid expensive long-term hospitalization."

HCFA's actions against CMHCs come on the heels of a recently released OIG report that scrutinized Medicare claims filed by CMHCs in five states: Florida, Texas, Colorado, Pennsylvania, and Alabama. According to the OIG, these states accounted for about 77% of all CMHC payments under the partial hospitalization program in 1996. OIG investigators reviewed 250 claims, which contained 6,736 units of partial hospitalization services and accounted for $252 million in payments. The investigators found that 92% of the claims submitted, for a total of $229 million, failed to meet Medicare reimbursement requirements. According to the report, most of the unallowable services were provided to beneficiaries who were not eligible for partial hospitalization services under Medicare.

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HCFA admits that its policies in setting up eligibility requirements for the partial hospitalization program helped create the potential for massive fraud. Essentially, the agency relied "exclusively on the integrity of the applicants to certify that they comply with requirements of the Social Security Act and are in compliance with state licensure laws," according to the report. Because only 40% of states even have licensure requirements for CMHCs, "the lack of state oversight and the use of a self-attestation process permitted unscrupulous providers to participate in the Medicare program."

Indeed, Deana Stoner, senior policy analyst for the Health and Human Services Commission in Austin, TX, says none of the seven CMHCs targeted for termination in her state are real mental health facilities. "These are people who put themselves forward as CMHCs, and because of a kind of loophole in the regulation and some ambiguity at the federal level, they were put on the roster," she says. "Our state Mental Health Authority asked that Medicare quit enrolling these providers because we were concerned about oversight and quality of care."

In a second OIG study, investigators performed on-site reviews of 700 CMHCs in nine states and found that "a large number" of them failed to meet Social Security Act requirements and therefore don't qualify to bill Medicare. (Exact figures aren't available because the study hasn't been completed.)

According to the report, the false Medicare claims from CMHCs fell into five main categories:

1. Beneficiaries were ineligible.

To be eligible for partial hospitalization services, patients must exhibit a severe or disabling mental condition, be able to benefit from a coordinated plan of care, have an adequate support system outside the program, have an ICD-9 diagnosis of mental illness, not be dangerous to themselves or others, and not require 24-hour care. In the majority of the false claims identified by the OIG, beneficiaries didn't meet these criteria.

2. Services were not reasonable and necessary.

Medicare's partial hospitalization program requires that services be reasonable and necessary for the diagnosis and treatment of the patient's condition, and can reasonably be expected to improve the patient's functional level. In contrast, however, OIG investigators found that many of the services provided were only "recreational or diversionary" in nature or were not tailored to the needs of specific patients.

3. Services were not authorized.

In 18 of the claims sampled, the services performed were never authorized or supervised by a physician. Further, some medical records didn't contain physician evaluations, certifications, signed plans of care, orders for services, or physician progress notes.

4. Documentation was inadequate.

A couple of claims contained incomplete assessments, admission orders, physician certifications, treatment plans, and physician notes.

5. Providers were under investigation, suspended, or terminated.

For 10 claims, the providers in questions already were being investigated by the OIG Office of Investigations. For 28 others, providers already had been suspended or terminated from participation in the Medicare program.

In response to the OIG's report, HCFA has released a "10-Point Action Plan" to "curb abuse and protect beneficiaries and taxpayers." The plan's points include terminating those CMHCs the agency considers the worst offenders and increasing its scrutiny of new applicants to the partial hospitalization program.

The complete report from the Office of the Inspector General is found on the Web at: http://www.hhs.gov/progorg/oas/reports/regiona4/49802145.pdf. ■

Pennsylvania's Medicaid managed care unravels as providers flee

Pharmacies defect after cuts in drug reimbursements

While HealthChoices, Pennsylvania's massive Medicaid managed care program, is set to expand to Pittsburgh and western Pennsylvania in just three months, the four Philadelphia health plans participating in the first phase of the program are still reeling from severe financial losses and provider defections 18 months into the program.

The most glaring problems with HealthChoices Southeast are the continuing financial losses of the plans and the resulting squeeze that at least three of them have placed on their pharmacy benefits manager (PBM), Eagle Managed Care, a subsidiary of Rite Aid Corp.

Today, four managed care plans enroll some 500,000 Medicaid recipients in the five-county area surrounding Philadelphia. The largest plan has about half the recipients: Keystone Mercy Health Plan's current HealthChoices enrollment is about 240,000. The other plans participating in HealthChoices are Health Partners, owned by seven hospitals, with 108,000 members; Healthcare Management Alternatives (HMA), with about 65,000 members; and Oxford Health Plans, which also has about 65,000 members. However, Oxford is exiting the market.

HealthChoices is due to expand into the 10-county Pittsburgh region on Jan. 1, 1999, where three plans will compete for 290,000 members. There is no crossover between the Philadelphia and Pittsburgh plans. The southwest or Pittsburgh plans are the University of Pittsburgh Medical Center/Best Health Care; Gateway Health Plan Inc.; and Three Rivers Health Plan/Medplus. By the time these recipients are rolled in, about 60% of the state's Medicaid beneficiaries will be in a managed care plan.

All four original plans have reported losing millions on HealthChoices business, although the true extent is masked because they do not separate Medicaid losses or profits in filings to the state Department of Insurance. However, the performance of HMA, as a Medicaid-only plan, illustrates other plans' problems. According to state records, HMA lost $2.49 million during calendar year

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1997 on revenues of $191 million, compared to a 1996 profit of $3.6 million. Its most recent filing, for the first six months of 1998, shows a profit of $577,890 on revenues of $115 million.

Health Partners, which engages almost exclusively in Medicaid business, reported a net loss of $3.6 million on revenues of $225 million in 1997, on top of a 1996 loss of nearly $4.3 million. Its second quarter 1998 filing showed a year-to-date profit of $1 million on revenues of $133 million.

Oxford reported an $11.6 million loss on revenues of $118 million in 1997, compared to a 1996 profit of $913,000. Filings for the first two quarters show a loss of $3.5 million on $70.6 million in revenues. Oxford, however, is quitting HealthChoices (and Pennsylvania) altogether. The Norwalk, Conn.-based plan announced Oct. 14 that it was selling the Pennsylvania plan for $10.4 million to Health Risk Management, which has been managing the risk for the plan since April.

Keystone Health Plan East, of which Keystone Mercy Health Plan is a subsidiary, showed a 1997 profit of $39 million on revenues of $1.6 billion. The plan's 1996 profit was $23 million. Its

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Plans negotiate new pharmacy reimbursement rates

All three of southeast Pennsylvania's original managed Medicaid plans maintain their pharmacy networks are adequate and meet the state's requirement that members have at least two pharmacies to choose from within a 30-minute radius. And all contend they are doing the best they can with inadequate rates.

Help is on the way in the form of a state-mandated increase, but it remains to be seen if the extra dollars will be enough to keep the plans in the program.

An actuarial review of the payment rates, ordered by the Pennsylvania legislature and completed by Arthur Andersen in February 1998, found that the health plans were losing money on three categories of Medicaid recipients with disabilities, amounting to a total of $25.6 million based on February to September 1997 data alone. The report also chided the state for basing the rates on old, and sometimes incomplete, fee-for-service data.

The state has never conceded that its payments were inadequate, and maintains today that the ups and downs the plans are experiencing are not out of the ordinary for any new line of business. Others, however, charge that the problems are not the result of inexperience on the part of the plans.

Managing Medicaid services and risk for a voluntary population and a mandatory one are very different, said Christine Bowser, director of the bureau of managed care under the state Department of Public Welfare. She said industry experts say plans need three to five years to be successful with a Medicaid product.

While the state seems convinced that the plans will do well eventually, at least one high-ranking Philadelphia official wasn't so sure. Estelle Richmond, commissioner of health for Philadelphia County, told State Health Watch she was very concerned that the pharmacy reductions could present a hardship to people with HIV/AIDS who could no longer get prescriptions filled at a drug store of their choosing.

The choices are going away, she said. Whether it's the HMOs or Eagle [Managed Care, the pharmacy benefits manager], there's a problem somewhere. She added, In reality, it's the HMO that gets hurt if the members don't get their prescriptions filled or receive inadequate education from pharmacists about correct dosing and usage, she said.

The four Philadelphia-area plans got a 7% boost in rates this year, and are negotiating 1999 rates now. Those may reflect an increase when they go into effect in January. Although she would not release actual rates, Ms. Bowser says they are based on more updated data, which follow trend lines that show fee-for-service costs increasing. We pulled entirely new fee-for-service data, updated it, added a year, and developed new rate ranges, Ms. Bowser said.

We looked carefully at other state experiences with mandatory managed care programs, carefully assessed marketplace trends. We concentrated a great deal of effort in the pharmacy area and reviewing HIV/AIDS payment experience. I can say that the marketplace has been very volatile, and the market trends overall are up, and that is reflected in the data we've collected.

Ms. Bowser would not discuss the development of rates to be paid to the three plans in the new southwest Pennsylvania program, except to say it does not represent major changes from the way rates were established for the Philadelphia-area plans. One change is the establishment of a risk pool from which plans can be paid monthly for HIV/AIDS patients whose cost of care exceeds a set amount established by the state.

Others have been advocating the use of a risk-adjusted payment system, which they say would more fairly compensate the plans for people with higher-cost illnesses. This type of payment system is being used by Maryland and Colorado. Ms. Bowser said the state must be able to collect more accurate data before it can consider such a payment system, adding that the new southwest contracts have tougher data-reporting requirements than the southeast plans face.

The state operates HealthChoices under federal authority, which gives advocates an arena to air their concerns. Pennsylvania applied for a separate Medicaid waiver for the southwest area with a target implementation date. The state's HealthChoices waiver, granted for the southeast region in December 1996, is due to expire in January 1999. It can be renewed for another two years.

At the very least, local hospital groups say they will lobby HCFA to impose tighter requirements on what constitutes adequate pharmacy access such as mandating that the two drug store choices be under different ownership. Ms. Forbes added that the greatest concern, however, is that they fix the rates. That's got to happen first.

Contact Ms. Forbes at 215-985-4448, Ms. Bowser at 717-772-6300, Mr. Cabrey at 215-636-6660, and Ms. Tortu at 215-849-9606. ■

year-to-date profit as of June 30, 1998, was $25.6 million. Matt Cabrey, Keystone Mercy spokesman, maintained the plan has lost money on HealthChoices since its inception, but he declined to say exactly how much. Financial officers at Keystone estimate that the four plans collectively had lost $50 million on HealthChoices business from February 1997 to July 1998, he said.

In an effort to stem the red ink, all the plans began to take a hard look at their high-cost areas, and not surprisingly, pharmaceutical costs were near the top of the list. Health Partners, for example, saw its medication costs climbing steadily and turned to Eagle because it was the only PBM that was willing to share financial risk with the plan, according to spokeswoman Debbie Tortu. Health Partners' per member per month (PMPM) drug costs went from $22.92 in 1996, prior to the start of the mandatory program, to $40.69 PMPM by September of this year, when its contract with Eagle took effect.

The state does not regulate what the HealthChoices plans pay for medications, according to Christine Bowser, director of the bureau of managed care under the Department of Public Welfare, which runs HealthChoices. A federal judge recently threw out the state's rates for fee-for-service Medicaid pharmaceutical payments.

Pharmacies drop out

Health Partners, Keystone, and HMA all contract with Eagle. HP and Keystone confirm that the new payment rate Eagle offered the pharmacies is equal to the average wholesale price minus 16.5%. The new rate set the pharmacy chains screaming, and all three plans have seen their pharmacy networks shrink as a result. The hardest hit was Health Partners, which lost nearly half its participating pharmacies. The number of drug stores that accept HealthChoices prescriptions from Health Partners members dropped from 969 to 533. The busiest stores stayed in, Tortu contended. She said the plan found that of the top 50 participating pharmacies in terms of volume, only one dropped out of the network.

Keystone has lost a third of its pharmacies since Eagle lowered payments to pharmacies, Mr. Cabrey acknowledged. The biggest loss was from CVS, a national chain that pulled all its stores from the three plans' HealthChoices business. The Eckerd Corp. quickly followed suit. However, Rite Aid's stores all stayed in HealthChoices, which prompted critics to level conflict-of-interest accusations against Eagle.

The pharmacy changes have placed a "major hardship" on HealthChoices participants, according to the Working Group on HIV/AIDS and HealthChoices, which has been documenting incidences of prescriptions being filled incorrectly, mostly at Rite Aid locations. The group also says members' access to pharmacies has been restricted as a result of reliance on Rite Aid stores.

"There's a difference between network adequacy on paper and adequacy in real life," said Anna Forbes, spokeswoman for the Working Group, which describes its membership as 45 hospital- and community-based service provider and advocacy organizations. She noted that some plan members are used to getting to their caregivers and pharmacies on foot because they have no other source of transportation.

Financial pressures at HealthChoices HMOs also have led to changes in hospital networks. Forbes said her members have experienced 11 changes in the hospital network since the program's inception. "It's really a devastating loss to lose access to your hospital," she said.

Ms. Forbes contended the hospitals that aren't participating are based where there is a "concentration of indigent folks who have asthma, diabetes and HIV/AIDS—and they're expensive."

Mr. Cabrey acknowledged that finances led Keystone to drop five hospitals over a three-month period that were part of the Jefferson Health System and collectively cared for about 6,000 Keystone HealthChoices members. Half of those members disenrolled, according to Mr. Cabrey. "We were unable to come to an agreement on rates," Mr. Cabrey said of the split, but he added that the plan has "nearly 60" other hospitals in its network.

Health Partners also has seen some defections very close to home. Sixteen physicians affiliated with Temple University withdrew from the program because of low payments, and Temple—a Health Partners co-owner—has complained that Medicaid payments dropped by $22 million or 8% of its budget in 1997 alone.

Contact Ms. Forbes at 215-985-4448, Ms. Bowser at 717-772-6300, Mr. Cabrey at 215-636-6660, and Ms. Tortu at 215-849-9606. ■

Court says lawyers can counsel patients on how to secure Medicaid benefits

A federal law prohibiting lawyers from advising clients on how to secure Medicaid benefits by shielding assets is unconstitutional, a New York U.S. District Court judge has ruled.

Northern District Chief Judge Thomas J. McAvoy rejected the U.S. Justice Department's contention that, because the federal government has acknowledged the law as unconstitutional and has not enforced it, the issue is moot.

The court accepted the argument of the State Bar Association of New York—that allowing the law to stand would have a "chilling" effect on lawyers.

The law, §1128B(a)(6) of the Social Security Act, was enacted last year in an attempt to protect state and federal Medicaid budgets from the costs of nursing home services for middle-income residents.

The so-called "Medicaid gag rule," made it a misdemeanor for a lawyer or other professional to accept payment for assisting in the disposal of assets to meet the Medicaid wealth tests "if disposing of the assets results in the imposition of a period of ineligibility." An applicant is ineligible if he or she transfers assets and fails to wait for a specified period before applying for Medicaid. ■

Clip file / Local news from the states

Each month, this column features selected short items about state health care policy digested from publications from around the country.

North Dakota, Nebraska get approvals for launching and expanding CHIP programs

WASHINGTON, D.C.—North Dakota in early October became the 42nd state to receive Health Care Financing Administration approval for its Children's Health Insurance Program. The state plans to use up to $5 million in federal funds to expand Medicaid to 18-year-olds in families with incomes up to 100% of poverty.

Nebraska received approval to expand its CHIP, dubbed "Kids Connection," to cover an additional 16,000 children by October 2000.

North Dakota's Medicaid program currently covers children age seven through 17 in families with incomes up to 100% of poverty and children through age six in families with incomes up to 133% of the poverty level. The federal poverty level is $16,450 for a family of four.

Benefits will be those available under the existing Medicaid program. A second phase of the CHIP implementation is under development.

The second phase of Nebraska's Kids Connection will expand Medicaid eligibility for children under age 19 in families with incomes up to 185% of the federal poverty level. The benefit package will be the same as for others enrolled in the Medicaid program.

There will be no cost to families. The amendment builds on Nebraska's original plan to expand Medicaid eligibility for children age 15 through 18 in families with incomes up to 100% of poverty. Prior to the CHIP program, children in that age group could only be covered if their family income was between 33% and 58% of poverty. The first phase alone was expected to cover nearly 1,000 children by July 1, 1999.

—Health Care Financing Administration releases, Oct. 9, Oct. 13

Iowa providers seek decentralization of state-sponsored indigent care

DES MOINES, IOWA—Improvements in telemedicine and advances at community hospitals make obsolete Iowa's strategy of centralizing indigent care at the University of Iowa Hospitals and Clinics in Iowa City, a coalition of the state's hospitals and physicians has told a legislative committee.

"Lead us in finding a way to provide all Iowans with the superior care they deserve, but without the hardship and indignities of long-distance travel, isolation, and separation," Iowa Health System Vice President for Public Affairs James Zahnd told a six-member legislative study panel in early October. Iowa Health System affiliates include St. Luke's Hospital in Cedar Rapids, Finley Hospital in Dubuque, and Allen Memorial Hospital in Waterloo.

Zahnd praised a 1987 measure that allowed pregnant women receiving state-sponsored indigent care not to be required to travel to Iowa City for care and supported keeping the administration of the program with University Hospitals.

The panel agreed to refer the question to the full legislature for further consideration, but not before skeptics defended the current funding and delivery.

"It's an integrated plan," said panel member Sen. Robert Dvorsky, D-Coralville. "You pull out one part, the rest of the system is going to collapse."

Critics said a change could jeopardize federal matching funds that leverage about $20 million on top of the state's $10 million appropriation, as well as $40 million in unreimbursed services provided through the university system.

—*Cedar Rapids Gazette*, Oct. 6

Federal individual-level data on employment, insurance available on the Web

WASHINGTON, D.C.—Individual-level 1996 data on demographics, employment, health status, health insurance, and health care utilization is available for downloading from a recently updated Agency for Health Care Policy and Research (AHCPR) Web site: http://www.meps.ahcpr.gov.

The Medical Expenditure Panel Survey Web site also provides documents on nursing homes and children's health.

—AHCPR release, Oct. 1

Court rulings expand HMO consumer protections, latitude to sue in Pennsylvania, Texas

DALLAS—Court rulings in Pennsylvania and Texas have boosted consumers' latitude to sue their health plans over complaints of inadequate care. The rulings signal the expansion of the role of health plans from insurance providers to entities with significant decision-making latitude in the provision of health care.

A Pennsylvania Superior Court ruled Oct. 5 that health maintenance organizations can be held liable for medical malpractice in the instance of vicarious negligence (mistakes on the part of employees) as well as corporate negligence (mistakes on the part of the corporation itself).

The case involves a 1994 suit against HealthAmerica of Pennsylvania filed by a Butler County couple who charged the HMO and its medical personnel with negligence in the premature birth and death of their first child.

"While [HMOs] do not practice medicine, they do involve themselves daily in decisions involving their subscriber's medical care," wrote Judge Joan Orie Melvin. "We see no reason why the duties applicable to hospitals should not be equally applied to an HMO when that HMO is performing the same or similar functions as a hospital."

Hospitals, and now HMOs, are liable for malpractice in Pennsylvania if they fail to follow four regulations set by the state Supreme Court in 1991: to use "reasonable care" in maintaining

safe facilities; to hire only "competent physicians"; to monitor all personnel providing medical care within its buildings as to "patient care"; and to adopt and enforce "adequate rules to ensure quality care."

The case had been dismissed without a decision by the lower Court of Common Pleas and appealed to the Superior Court. The decision brings the case back to the original court. Health America is considering appealing the decision to the state Supreme Court and will not comment, said Daniel Stefko, HealthAmerica's attorney from the Pittsburgh-based firm Dickie, McCamey & Chilcote.

Aetna Inc. meanwhile announced Oct. 5 that it would not appeal a federal judge's decision affirming Texans' right to sue for HMOs with charges of improper care. The decision by U.S. District Judge Vanessa Gilmore in late September upheld the validity of existing law, but restricted its applicability to "cases in which an HMO actually delivers poor care, not disputes over HMO treatment decisions."

The state, however, will appeal the decision to the Fifth U.S. Circuit Court of Appeals. Although state officials generally prevailed in the decision, they are challenging the finding that Texas independent review process for HMO members violates the federal 1974 Employee Retirement Income Security Act. Certain ERISA provisions exempt from state regulation health plans that are sponsored by self-insured employers.

Through a spokesman, state Attorney General Dan Morales defended the right of citizens to be protected from lawyers or accountants or persons not qualified to make medical decisions on their behalf.

"Members of HMOs also should have the security in knowing that there is a remedy if HMOs make coverage decisions that adversely affect their health care," spokesperson Ron Dusek said

While Aetna, Morales' office and the state Department of Insurance "are working together to ensure the review process stays intact, state officials and the insurer are at odds whether the review should be binding.

—*Dallas Morning News*, Oct. 6, *Ft. Worth Star-Telegram*, Oct. 6, *Pittsburgh Post-Gazette*, Oct. 10

Washington, D.C., curbs runaway Medicaid expenditures, but expands rolls by 15,000

WASHINGTON, D.C.—With the highest per capita spending on Medicaid of any jurisdiction in the country, Washington, D.C. last year cut spending by $20 million to $852 million and is projecting even further cost savings, according to the district's Medicaid chief, Paul Offner.

"We clearly are spending much more than we need to be spending," he said. "I actually think we can go further with the efficiencies we've effected to date. We're still one of the most expensive Medicaid programs in the country."

At the same time, the program is expecting an increase of 15,000 to its current caseload of 123,000, he said.

Officials attribute the cost savings to increased use of Medicaid managed care, cutting hospital reimbursement, seeking alternatives to nursing home services, and stricter enforcement of Medicaid eligibility rules. Congress last year increased the federal government's contribution to D.C. Medicaid from 50% to 70% of total spending.

Health officials wary of the budget cutbacks point out that the health status of poor D.C. residents, particularly men, ranks at the bottom of the nation.

Medicaid spending in D.C. grew an an annual rate of 16% and doubled overall during the first half of the decade. Experts pegged the program as the most expensive per capita in the county, even when compared to those with similar demographics.

But the District's doctors and hospital officials, who have borne the brunt of the pressure of reduced spending, say the savings come at a time when the health status of D.C. residents is almost at rock bottom. Men in Washington have nearly the shortest life span of any population group in the United States. In 1990, the 57.9-year life expectancy of black men in D.C. ranked only above that of a native American tribe in South Dakota.

"They're really cutting, cutting, cutting," said Gary C. Dennis, President of the Medical Society of the District of Columbia. "But do we have more patients with tuberculosis on the streets? More patients with AIDS who haven't been diagnosed? What is the savings achieved? Has it improved health care in the city? That will be my indicator."

The chief of the D.C. Hospital Association is similarly cautious. "Hospitals are hopeful it will work out well," Robert A. Malson said. "But whenever the city tries to enroll a massive number of people in a new program, it takes a while for the community to become familiar with the process."

—*Washington Post*, Oct. 3

Hospice reimbursement to be based on location of service, not providers office

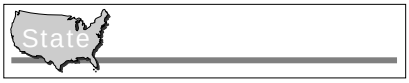
WASHINGTON, D.C.—Reimbursement for Medicaid hospice services must be based on where the service is given, not the provider's office location, the Health Care Financing Administration (HCFA) has clarified in a letter to state Medicaid directors.

The Medicare hospice wage index adjustments published in the Aug. 8, 1997, *Federal Register* will be used to determine payment for hospice services, according to the letter from HCFA Director Sally Richardson. Medicaid directors are instructed to make any necessary retroactive billing adjustments for the period Oct. 1, 1997, through Sept. 30, 1998.

The requirement stems from an interpretation of the Balanced Budget Act of 1997 (BBA), which establishes the payment methodology for Medicare hospice services. HCFA is reminding hospice providers that Medicaid hospice reimbursement is determined using the same methodology as Medicare, and thus is affected by the BBA.

The BBA's Medicare hospice benefit periods do not apply to Medicaid, but HCFA notes that many state Medicaid programs adopt the Medicare benefit for ease of administration. The new Medicare hospice benefit periods consist of two 90-day periods followed by an unlimited number of 60-day periods.

— Health Care Financing Administration release, Aug. 13



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Quality of most Michigan nursing homes deemed inadequate by federal, state officials; state may mandate consultation

DETROIT—Almost 95% of Michigan's 450 nursing homes are not in substantial compliance with federal quality regulations, according to the results of the latest Health Care Financing Administration review released in September. Release of the facility-specific information came after a suit by the *Detroit Free Press* against the state's Department of Consumer and Industry Services.

Since January 1998, the Michigan Department of Consumer and Industry Services has used a new computerized scoring system, called the Resident Protection Initiative, to identify and evaluate the poorest-quality nursing homes in the state. The most serious offenders can be directed to hire consulting assistance from the Michigan Public Health Institute, a quasi-governmental nonprofit organization led by Michigan Department of Community Health Director James Haveman.

During its first eight months of operation, the scoring system has spurred an order for consulting assistance at about 70 homes. In addition, the state has temporarily denied payment for new admissions at 35 homes, temporarily banned all admissions at 11 homes, appointed temporary advisers or managers at 16 homes, and imposed increased state monitoring at 47 homes.

Quality in Michigan's nursing homes has been the subject of federal and state scrutiny. Michigan Attorney General Frank Kelley in February brought 71 felony charges against three nursing homes and nine employees for patient care violations. The cases have not yet gone to trial. Meanwhile, the Michigan House of Representatives is forming a task force to investigate nursing-home care in hearings around the state. The goal of the task force, to be chaired by Rep. Thomas Kelly, D-Wayne, is to draft comprehensive reform legislation for next year.

A U.S. General Accounting Office report is investigating whether regulators in Michigan and three other states—California, Texas and Pennsylvania—adequately enforce federal nursing home laws. The report is expected to be published in January.

Industry officials defended the quality of care at their facilities. "The vast majority of homes are providing good care and people need not feel anxious about that," said Reg Carter, executive vice president of the for-profit industry trade group, Health Care Association of Michigan.

—*Detroit Free Press*, Oct. 7

State Health Watch