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Commercial insurers shun Medicaid market: Is it a bailout or a shakeout? Nobody's sure—yet

Hospital-based Medicaid-only HMOs step in to fill the gap but face rocky future

Major commercial health maintenance organizations (HMOs) have been dropping out of Medicaid managed care programs in high-profile departures over the past year. Analysts say it's unclear whether the HMOs' actions represent a general exodus from Medicaid or merely a shakeout among companies that found the program less profitable than they had hoped.

"There was an effort by the states when they got serious about managed care to bring in as many HMOs as possible," said William Waldman, executive director of the American Public Human Services Association in Washington D.C., until recently known as the American Public Welfare Association.

"The HMOs began to recognize that this was an important part of the marketplace, and they all wanted to compete. But the number of people to be enrolled didn't support the number of HMOs, so the marketplace itself began to shake out." (For more information on what HMO flight is doing to states' efforts to manage plans for dual-eligibles, see related story, below.)

Aetna U.S. Healthcare, for one, took a close look earlier this year at its Medicaid-funded business in New York and Connecticut — and decided it was time to get out.

"We made a business decision," company spokeswoman Stacey Jones said. "We really didn't have the critical mass necessary to make it profitable. We decided as a corporation to focus on our core business, the commercial and Medicare managed care plans."

Aetna was hardly alone in making that decision. At least one-third of states have seen some commercial HMOs

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In This Issue

Medicare HMO retrenchment hampers efforts to link Medicare, Medicaid for dual-eligibles

The will-of-the-wisp dream of integrating Medicaid and Medicare for the poor and elderly got a little more elusive this fall with the defection of several Medicare health maintenance organizations (HMOs) from markets across the country.

"There's absolutely no question it's a tough environment," said Mark Meiners, Ph.D., director of the Robert Wood Johnson Foundation Medicare/Medicaid Integration Program. In October, Virginia received a $300,000 grant to become the 12th foundation project to receive planning or assistance support.

Recent Medicare pullbacks among major HMOs had an impact on these programs' ability to link community-based, nursing home, and acute care services for the poor, elderly, and disabled, he said. "The participants are trying to build on the managed care structure. To the extent there are cutbacks or reshuffling, all that affects the program. It doesn't help integration, to say the least. When you don't have both pieces under integration, it's not as good as when you do."

Officials in integration projects seek to contract with Medicare HMOs to create a single organization that provides a full continuum of care for enrollees. Enrollees can't be required to join a Medicare HMO, but there is hope that a Medicare HMO responsible for community-based,

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The jury is in: Welfare reform shrinks Medicaid rolls

States must rethink traditional Medicaid entry points, Kaiser Family Foundation study contends

Welfare reform policies are deterring persons from receiving Medicaid benefits for which they are eligible, concluded a study published by the Kaiser Family Foundation.

"There's no doubt about it," said Vernon K. Smith, principal of Lansing, MI-based Health Management Associates, when addressing a gathering of state Medicaid directors in late October.

Recent federal policies have removed the most popular avenue to Medicaid eligibility for the past 30 years — cash assistance through Aid to Families with Dependent Children — and dramatically curtailed cash assistance itself. Unlinking Medicaid eligibility and cash assistance has brought about the first decline in Medicaid rolls in the decade, even in the face of Congressional action to ensure medical coverage was unaffected by welfare reform (see "Despite safeguards," *State Health Watch*, July 1998).

Even before welfare reform, managed care expansions may have anticipated the break between Medicaid and cash assistance: Between 1994 and 1996, the percentage of people on Medicaid who also received cash assistance fell from 69% to 64%.

But because Medicaid and cash assistance remain linked in the minds of both government officials and people who are eligible for Medicaid, enrollment cutbacks in welfare are dragging down the Medicaid population along with it, the study contended. The effect is an unprecedented decline in Medicaid enrollment from 41.7 million in 1995 to 41.3 million in 1996, when welfare reforms were first enacted.

"The national numbers are not yet available for 1997, but the indications we have would suggest a continuation of the downward trend," Mr. Smith told *SHW*. The break between cash assistance and Medicaid forces both policy-makers and those implementing health programs to replace welfare programs with another entry point into Medicaid, Mr. Smith said. His conclusions challenge a recent General Accounting Office report that suggested a common application and eligibility entry point would boost Medicaid enrollment (see "No major disruption," *SHW*, April 1998).

"We need to make enrollment in Medicaid into something that — if people are not proud of — at least they're not ashamed of," Mr. Smith said.

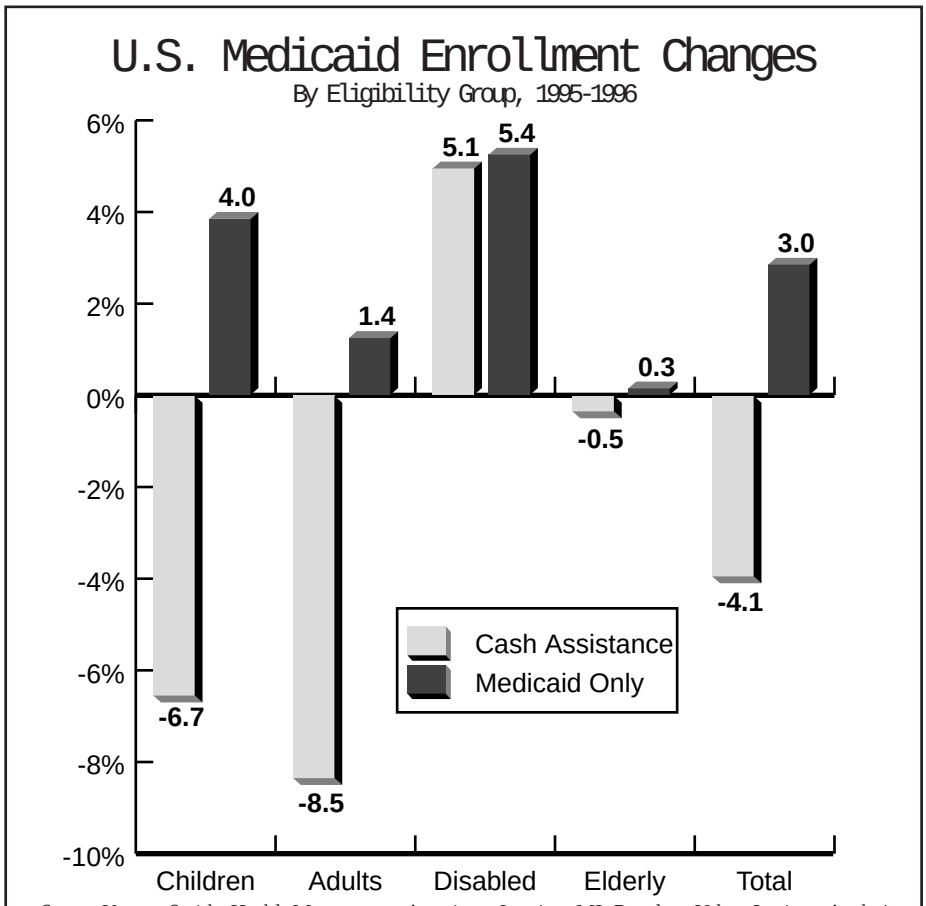
Reform hits adults hardest

The largest single decline by eligibility group was among adults receiving both Medicaid and cash assistance. This group declined by 8.5% between 1995 and 1996. At the same time, adults receiving Medicaid without cash assistance increased by just 1.4% (see chart).

Although some of the decline in the Medicaid only caseload can be attributed to a gains in private-sector health coverage, researchers mainly point to outreach problems and negative attitudes toward publicly funded programs. The aversion to Medicaid is so strong that some families already in the program are willing to pay a monthly premium to switch coverage to the federal Children's Health Insurance Program (CHIP), some state officials report. Under federal law, CHIP is not available to children who qualify for Medicaid benefits.

Human service officials, researchers, and state Medicaid directors participating in focus groups in the summer of 1998, attributed the shifting demographics in Medicaid to these changes in policies and the national economy:

• Recipients still link Medicaid to welfare and believe the new tougher welfare reform policies also apply to Medicaid.



Source: Vernon Smith, Health Management Associates, Lansing, MI. Based on Urban Institute Analysis of HCFA 2082 reports.

• Aggressive jobs programs for former welfare recipients have channeled some people away from Medicaid enrollment. Jobs can increase income levels above the threshold for Medicaid eligibility, but they don't necessarily provide employer-sponsored health insurance to replace the lost coverage.

• Administrative procedures don't always continue Medicaid for eligible children or adults who work their way off welfare.

• People don't know they're eligible for Medicaid because both they and state workers lack information or are confused about eligibility rules, given all the recent policy changes.

• Unless there is a medical need, potential beneficiaries often delay applying for Medicaid.

States that have expanded Medicaid enrollment through 1115 managed care waivers offer a model for increasing enrollment, said Neva Kaye, director of the Medicaid Managed Care Resource Center at the National Academy for State Health Policy. In particular, she noted that eligibility requirements for waiver populations often are less stringent than requirements imposed on traditional Medicaid enrollees.

Name changes that distance the program from traditional Medicaid appear to be particularly effective in removing the stigma from publicly funded health programs. Texas Medicaid director Linda Wertz relayed a story about a woman who insisted she was not on Medicaid but rather in the "STAR" program. "STAR" is an acronym for State of Texas Access Reform, which is the state's Medicaid managed care initiative.

Through the end of the century and beyond, HMA's Mr. Smith predicts the downward trend in Medicaid enrollment will slow. In fact, official estimates from the Congressional Budget Office (CBO) anticipate an annual rate of growth of 1.7% between 1998 and 2002. The largest increases in both percentage and absolute numbers are expected to be among children and the disabled.

By 2008, according to the CBO, Medicaid enrollment will climb by about 8 million, to 49.2 million enrollees.

The Dynamics of Current Medicaid Enrollment Changes *was completed by Health Management Associates and The Lewin Group for the Kaiser Commission on Medicaid and the Uninsured. A copy is available from Kaiser at 800-656-4533. Contact Mr. Smith at 517-482-9236.* ■

Kentucky protects traditional providers in its rollout of the state's managed Medicaid program

Local provider groups also suffer traditional start-up problems

Kentucky's Partnership Program, unique among Medicaid managed care demonstration projects for its reliance on a single provider-operated plan in a geographic region, is experiencing some very ordinary health plan start-up problems.

State officials are optimistic about the program and plan to target statewide implementation by mid-1999. By then, they expect, early losses and operational snafus will be resolved and the faith they placed in teaching hospitals and traditional Medicaid physicians will be justified.

To date, the program has enrolled some 150,000 Medicaid recipients in two of eight regions of the state—through Kentucky Health Select in Lexington (Region 5) and Passport in Louisville (Region 3). The state reports that few consumers are complaining, although it is awaiting completion of a provider satisfaction survey for a more complete picture of the program, which began Nov. 1, 1997. (For more information on how Kentucky officials promote quality improvement in the state's Medicaid managed care plan, see "Kentucky plans offered financial reward for meeting health outcome measures," page 8, this issue.)

Total plan membership represents about a third of the state's eligible Medicaid population of 499,000.

The Kentucky Partnership Program was designed to improve care for recipients, control costs, and preserve its existing indigent care system and traditional Medicaid provider relationships. In contrast to all other states, it chose not to use commercial managed care organizations, and instead opened participation only to "partnerships" of local, traditional Medicaid providers who could contract with an HMO for risk-management expertise.

"Our belief was that if the providers who ought to know the [Medicaid] health care system can figure this out, that's who we really wanted," said Rich Heine, director of the state's division of managed care development. Kentucky took to heart "horror stories" from states in which a shift to Medicaid managed care left health departments and teaching hospitals financially strapped. "One of our objectives was to ensure that we did not destroy the state's ability to take care of the indigent."

To these ends, Kentucky decided to award contracts to only one plan in a region and to have that plan be locally controlled by a provider organization. Passport and Health Select began enrolling members on Nov. 1, 1997, with a phase-in of all area members expected by March 1. The state plans to bring the Kentucky Partnership up in the other six regions of the state by July 1999.

Launching the partnership program was something of a risk because the state had little experience with HMOs. Managed care is new to Kentucky Medicaid recipients and most commercially insured state residents as well. Prior to the Partnership program, the state had no Medicaid-only managed care organizations. Commercial managed care penetration in Kentucky is about 30%, Mr. Heine said.

Kentucky required the provider

sponsors to have either previous risk-bearing experience or to contract for administrative services with an organization that had a track record in managing financial risk.

To meet that requirement, Passport contracted with Amerihealth-Mercy of Philadelphia to provide administrative services for its 95,000 members. Passport's parent company, University Health Care, is owned by the University of Louisville Medical School Practice Association, three Louisville hospitals, and a group of publicly funded health centers.

Pharmacy costs take a toll

During the year ending Sept. 30, Passport lost $1.6 million, exceeding projected losses of just under $300,000. Much of the loss was due to higher-than-expected pharmacy costs, a problem that plagues many managed care organizations nationwide. Passport's owners recently infused $2.5 million into the plan and is implementing measures to bring down pharmacy costs.

In addition, Passport is struggling to coordinate information systems with the state. For example, while the state sends the plan a daily list of new members, it is still 30 days behind in notifying Passport of newborns, Executive Director Joyce Schifano said.

The region 5 plan, Kentucky Health Select, is part of an organization that had three years of experience managing commercial lives before launching its Medicaid product. Health Select's parent, CHA Health, is owned by seven health care organizations, the largest local entity of which is the University of Kentucky Hospital. Health Select has 62,000 Medicaid members and CHA has 110,000 commercial members under a separate HMO license, according to Shawn Crouch, Health Select project manager.

State requires its say-so

The biggest change in operating a Medicaid plan vs. a commercial one has been the state-required governance structure, Mr. Crouch said. To make the plan more responsive locally, a 24-member governing board, composed of hospital, physician and ancillary providers and consumer representatives meets monthly to set policy.

Health Select still is working out several operational issues, including newborn eligibility problems similar to those Passport has experienced. Additionally, Health Select is struggling with care for dual eligibles. Because members eligible for both Medicare and Medicaid are not required to select a primary care physician, coordination of benefits and delivery of care is complicated, Mr. Crouch said. For example, pharmacy benefits are the plan's responsibility under Medicaid, but Health Select has little power to oversee what medications are dispensed if the member does not have a PCP.

The two plans have taken divergent methods of paying their providers, with Passport capitating its primary care physicians and Health Select paying through a combination of fee for service and a 20% withhold.

Passport is for profit; Health Select is a not-for-profit plan. The state may contract with commercial HMOs in other regions of the state if local providers fail to form partnerships, but thus far, there seems to be sufficient interest to prevent the state from having to go that route, Mr. Heine said. Kentucky will seek to limit the amount of profit or surplus that can be earned by requiring a relatively high medical loss ratio of about 90%.

While Medicaid recipients have only one plan from which to choose in their region, provider choices are wide open. The state has an any-willing-provider law, and asked that the plans make participation "available to all existing Medicaid providers," Mr. Heine said. The plans' provider panels include more than 90% of primary care providers who had participated in Medicaid previously as well as all the hospitals in the two regions.

The next development in the Partnership program will be a bid solicitation for a behavioral health carve-out, which is likely to follow the medical model of local providers working together, Mr. Heine said.

Contact Mr. Heine at 502-564-7940, Ms. Schifano at 502-585-7983, and Mr. Crouch at 606-257-9049. ■

Commercial insurers shun Medicaid market

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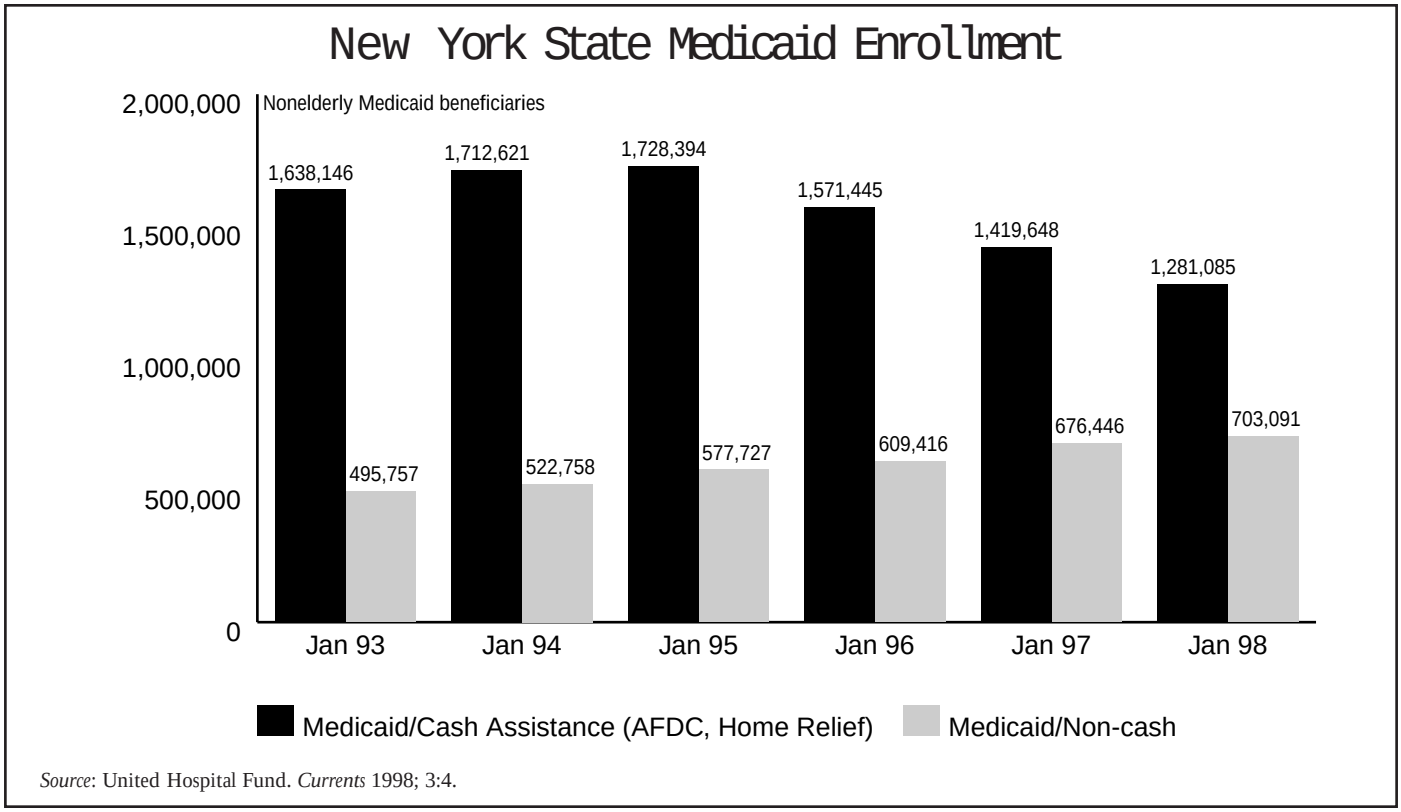
withdraw from Medicaid programs this year. According to a report by the National Academy for State Health Policy, the growth rate for Medicaid managed care among commercial HMOs has fallen by 12% since 1996.

The impact of the contraction in the Medicaid managed care market is evident in both the largest and smallest Medicaid programs. In New York City, where the nation's most ambitious Medicaid managed care expansion is about to be set in motion, commercial HMOs cover only about 40% of the 386,000 Medicaid beneficiaries who voluntarily enrolled in a managed care program. Most of New York City's Medicaid managed care is provided by provider-sponsored health plans (PSHPs) established by hospitals and other providers.

The situation is unlikely to change when New York City expands its Medicaid managed care program to cover the remainder of the city's 1.2 million Medicaid recipients. Only five commercial insurers are expected to participate when the mandatory program begins later this year. On the other side of the country, Utah this summer became the only state without a single commercial HMO providing Medicaid coverage.

Welfare reform has put even more of a squeeze on HMOs' ability to make a profit on Medicaid, as the number of beneficiaries has dropped significantly over the past couple of years. At the same time, states began squeezing Medicaid rates, said Mr. Waldman, who until a few months ago was head of New Jersey's Medicaid program. Though he thinks the pendulum will stop swinging before most states become unable to sign up commercial HMOs, he acknowledged it



Source: United Hospital Fund. *Currents* 1998; 3:4.

is not yet clear what the final picture will look like. "The question is, does this represent an abandonment or a shaking out? It's too early to tell."

New York Department of Health spokesman Robert Hinckley is more confident about the continued Medicaid participation of commercial HMOs. He notes that while 18 HMOs have dropped out of New York's Medicaid managed care program since April 1996, eight have expanded their coverage, and another dozen have applied to the state for permission to expand.

Still, so-called "Medicaid-only" organizations increasingly are stepping in where commercial HMOs have abandoned the Medicaid market. Such organizations often are hospital-based networks whose participants have long been in the business of providing care to the poor. There is disagreement about whether an increased reliance on these groups would be a positive or negative development.

Hospital-based managed care organizations usually are locally based and run by people with a longstanding commitment to the community, noted Kay Johnson, editor of a Medicaid managed care analysis for George Washington University Medical Center's Center for Health Policy Research in Washington, DC.

"The question is, is it more localized, and does having it be more localized make it better for the consumer?" Ms. Johnson said. A more critical issue than who operates the HMO, she said, is how well the state regulates it. "It appears the state legislatures are beginning to recognize them more as insurers. In the past, they were frequently regulated only as providers. Now states are saying that any risk-bearing entity should be regulated under the same rules as the HMOs. The states' approach now is, 'If you're a risk-bearing entity, you're a risk-bearing entity.'"

While states are subjecting Medicaid-only HMOs to stringent solvency requirements, some health policy experts have more than financial concerns about Medicaid-only insurers. The report by National Academy for State Health Policy director of special initiatives Alicia Fagan and executive director Trish Riley says relying on these entities may "constitute a retreat to the days and difficulties of a two-tier health care delivery system, the ills of which Medicaid managed care was designed to cure." Even if they are financially solvent, these organizations also may be so strapped for funds — given the fact they can't spread their costs over a large, commercially paying base of customers — that they may not be able to offer a full range of services, the authors wrote.

The report also noted, however, that many states have had good experiences with these plans. In fact, even before the federal Balanced Budget Act of 1997 expanded states' flexibility to hire non-commercial managed care entities, nearly half of all Medicaid beneficiaries were enrolled in plans with customer bases composed of at least three-fourths public assistance recipients.

"There was a point in time when I was very strongly opposed to Medicaid-only HMOs," Mr. Waldman said. "One of the things that offsets that now is the state standards. As long as you make sure, even if it's a Medicaid-only plan, that it has to meet the same regulations and standards for care, I don't think it makes a difference."

Contact Mr. Waldman at 202-682-0100 and Ms. Johnson at 802-482-3005. A copy of Transitioning to Medicaid Managed Care: Medicaid-Only Managed Care Organizations, *by Ms. Fagan and Ms. Riley, is available through the National Academy for State Health Policy. Telephone: 207-874-6524.* ■

Medicare HMO retrenchment hampers linkage efforts

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nursing home, and acute care can coordinate care most effectively for dual-eligible residents. Integration projects typically pay for Medicaid nursing home and community-based services through a single capitated amount.

'It was a nightmare. We spent a lot of time understanding what had happened.'

Lyn Bodiford

In Florida, state officials were hoping to use a single provider for community-based services, nursing home services and acute care services for dual-eligibles, those who qualify for both Medicare and Medicaid. When United HealthCare withdrew its Medicare HMO from the Orlando market, state officials withdrew its stipulation that vendors in its so-called "nursing home diversion" project be Medicare HMOs.

"It was a nightmare," project director Lyn Bodiford said. "We spent a lot of time understanding what had happened. We determined that the Medicare managed care market was so volatile that we would not couple Medicare to the diversion project."

The HMO remains interested in Medicaid risk programs that integrate community and institutional care for the elderly, said Cathy Halverson, United's vice president for Medicaid development. "We feel that's the way to get started taking care of these people."

BBA caps rate increases

Like United, other HMO plans leaving the Medicare market attribute the move to caps in rate increases generated by the Balanced Budget Act (BBA) of 1997. Mr. Meiners, associate director of the Center on Aging at the University of Maryland Center on Aging, said the shake-up in the Medicare market highlights a long-standing struggle in the integration project, that of encouraging Medicare managed care in markets where its development has been spotty or nonexistent. "There need to be the right dollars on the table to have people step up," he said.

In Colorado, state officials hope to have an integrated program available to Mesa County's 10,000 Medicaid recipients within the year. For about $2,200 per member per month (PMPM), the Colorado Integrated Care Project will deliver capitated community-based and nursing home care to Medicaid-only members and dual-eligibles who clinically qualify for nursing home services but who may also live in the community. For dual-eligibles who are disabled but ineligible for nursing home care, the PMPM is about $33.

The contractor in Colorado's project is Rocky Mountain HMO, a managed care organization that enjoys 42% penetration among Mesa County's Medicare market, 80% among its Medicaid population, and 60% in the commercial market. It will deliver Medicare acute care services on a fee-for-service basis rather than a capitated arrangement because state and federal officials failed to agree on how Rocky Mountain would be reimbursed by Medicare.

Reimbursement cut 25% to 30%

Rocky Mountain HMO is one of the nation's 37 mostly rural Medicare HMOs, which are paid on a fee-for-service rather than a capitated basis. For the dual-eligible project, state officials pushed for Medicare reimbursement based on fee-for-service utilization, similar to the adjusted average per capita cost (AAPCC) approach in place for more urban HMOs. Federal officials promoted capitation based on a risk-adjustment methodology mandated by the BBA for HMOs by the year 2003.

"It would mean a 25% to 30% reduction" from current reimbursement, said Dann Milne, manager of delivery system development for the Colorado Department of Health Care Policy and Financing. Instead, the project calls for Rocky Mountain to provide fee-for-service acute care services under Medicare and capitated community-based and nursing home care under Medicaid.

"If they do a really good job, Medicare gets the savings, not the health plan," Mr. Milne said. "Still, this is a step in the right direction."

General fear derails expansion

The BBA's rate hike reductions may be hardest on mature managed care markets, where years of aggressive managed care have held the line on Medicare's AAPCC and the fee-for-service utilization on which it was based. In Minnesota, officials in the Senior Health Options program (MSHO) hoped to expand its seven-county program for integrating Medicare and Medicaid into Scott County. The expansion was derailed when the intended contractor, Blue Cross & Blue Shield of Minnesota, pulled out of the local market. "There's just a general fear of the Medicare market here," MSHO program director Pam Parker said.

'There's actually a financial benefit to providing integrated care. You have to take a long-run view of these things.'

Dann Milne

Minnesota's program is notable for the degree to which it has been able to integrate financing of Medicare and Medicaid services for the dual-eligible population. Despite general concern over Medicare reimbursement rates, evidence exists that some Medicare HMOs may be willing to take on the task of caring for dual-eligibles. In Colorado, Mr. Milne said he is having "conceptual" discussions with two Denver HMOs interested in joining the project.

"There's actually a financial benefit to providing integrated care. You have to take a long-run view of these things," he said.

Contact Mr. Meiners at 301-405-1077, Ms. Bodiford at 850-414-2096, Mr. Milne at 303-866-5912, and Ms. Parker at 612-296-2140. ■

States grapple with collecting, publishing survey data on managed care organizations

States can use information to 'discipline the market' and keep costs down

Don't expect Medicaid enrollees to change their health plans based on the results of state health maintenance report cards, say the authors of the massive Consumer Assessment of Health Plans Study (CAHPS), a joint effort of the Rand Corporation, Harvard Medical School, and the Research Triangle Institute.

Nevertheless, the information is invaluable for states in evaluating HMOs and directing covered lives to plans that win high marks from enrollees, Rand research scientist Matthew Lewis told state Medicaid directors gathered in Bethesda, MD, in late October. "By doing that, you start disciplining the market," he said.

Mr. Lewis cautioned that survey data do not come cheap, with the cost per completed response likely to come in at the high end of a range between $5 and $20. Comparative data must be based on at least 300 to 400 completed responses per plan in order to be reliable, he said.

Results measured against average

When presenting the results, CAHPS researchers compare answers for a given plan against the average calculated from all health plans. For example, information about whether an enrollee would recommend a plan describes whether enrollees would recommend it less frequently, about as often, or more frequently than all health plans overall.

Don't be surprised if enrollees disparage individual features of a plan but give it high marks overall, Mr. Lewis said. "It's a interesting phenomenon. People can go and rag on the plan but give it a pretty high rating. People aggregate the data in their heads and it tends to be a more positive outcome."

While most states provide the results of plan surveys in booklet or newspaper format, the CAHPS study has allowed New Jersey and Florida to experiment with computer kiosks for that function. One advantage of a computer-based system is that it organizes plan information according to the features an individual enrollee defines as the most important.

Lewis pointed out the following key issues officials must consider when implementing computerized plan information:

- **Motivation.** State officials must

Primary care case management programs demand state-of-the-art quality measures

As states focus on evaluating the quality of health maintenance organizations (HMOs), the performance of their cousins—primary care case management (PCCM) programs—often gets overlooked.

That's a shame, say the administrators of Massachusetts' Primary Care Clinical Plan, because PCCM programs deserve and demand the kind of quality assessment typically given exclusively to HMOs.

"Primary care case management programs can be molded to what the state needs and wants," asserted Massachusetts plan director Beth Tortolani. "They can be more than 'managed care lite.'"

Massachusetts' strategy to promote quality in its primary care case management plan is centered around Health Plan Employer Data and Information Set and in-house data collection, quality improvement projects and provider profiling.

Quality assessment functions are kept almost completely separate from audit functions and provider relations functions. Occasionally, a problem noticed during a quality assurance visit may be referred to an auditor. More often, a quality assurance official may be called upon to resolve a provider relations issue before quality improvement can be tackled.

"There was no way you were getting into a doctor's office if they had a billing issue or a provider relations issue. There's no way they're talking quality," Ms. Tortolani said.

PCCM programs are compared head-to-head with HMOs in the publication of quality report cards, although administrators admit some limitations in the presentation. For example, even though about 80% of the state's disabled Medicaid population has chosen primary care case management over an HMO, no risk adjustment is made to account for the difference in the clinical status of patients in the two types of plans. In addition, there are few reliable external benchmarks against which to measure the quality of a Medicaid PCCM program, said Anthony Asciutto, the plan's assistant director for quality management.

Ms. Tortolani attributed much of the success of Massachusetts' approach to treating primary care case management providers collectively as a managed care plan. Every six months, Massachusetts' Medicaid officials use data from paid claims to profile the PCCM plans in five broad areas: well-child care, breast cancer screening, cervical cancer screening, asthma care, and emergency department utilization. Plan and state officials jointly develop an individualized "action plan" to improve the PCCM program's performance in one or more of the five targeted areas.

The next challenge for the PCCM programs will be to develop carve-outs for specific services and integrate medical care more effectively with behavioral health services, Ms. Tortolani said. ■

Kentucky plans offered financial reward for meeting health outcome measures

As part of Kentucky's Medicaid managed care initiative, called the Partnership Program, Kentucky established a series of seven health care outcomes the plans must monitor in the first and second years. In the third year, plans are expected to meet specific outcome goals.

Measures address normal body weight for both adults and children; reduced incidence of anemia and dental caries in children; reduced incidence of hypertension and depression in adults; normal glucose and hemoglobin levels in all members ; and normal growth and development in children.

Some of the outcome goals are aggressive. For example, the expectation in year two is that 40% of a plan's population is screened for dental caries by age 3, and that 80% of those screened will be free of caries by the third year of the program. Similarly, a plan must show that 80% of members who receive a new prescription for an antidepressant are "personally seen" to evaluate their response to the medication between two and eight weeks from the date of the prescription.

In addition, plans can receive a bonus equal to 1% of the capitation payment for four outcome measures of their choice. From among 10 options, plans can choose to pursue health promotion measures such as ensuring appropriate birthweights, prenatal care, and immunizations.

Kentucky also measures some more unusual outcomes, including the goals that 25% of infants receive breast milk during their first six months of life, and that 80% of children under age 6 receive fluoride supplements if their water supply has less than .6 parts per million.

Other goals are to provide counseling about unintended pregnancies to 75% of women at risk of pregnancy, and to counsel 75% of members ages 9 to 21 about the risk of alcohol and drug use, sexual activity, and safety belt use. ■

remember an information kiosk typically has to compete for attention with the noise and cramped conditions of a typical government office waiting room. "People have kids pulling on them and they're waiting for their number to come up," Mr. Lewis said. "How do you motivate people to actually use this thing?"

• Accessibility. Use of a touch screen makes the system easy to use among people at all levels of skill and literacy.

• Efficient use of time. "If you're lucky, you're going to get 10 or 12 minutes with a person sitting down at a kiosk in a benefits office," Mr. Lewis said. A system should direct an enrollee to relevant information as quickly as possible, he said.

• Individualized information. A computerized system is uniquely capable of highlighting plan results that reflect the features an enrollee considers the most important. A printed version of the plan allows enrollees to discuss the information with others before making a decision. Enrollees often return for benefits counseling two or three times before making a decision, said Martha Walters, regional director of benefits counseling firm Benova Inc. in Philadelphia.

• Links to other databases. In Florida's computer system, enrollees can link to a provider database that lists the plans in which individual physicians participate. ■

Proposed Medicaid reg for BBA provisions includes a few surprises

HCFA has some expensive suggestions for your programs

The proposed federal regulation implementing the Medicaid provision of the Balanced Budget Act (BBA) of 1997, issued late last month, contains many requirements that plans and states already meet, as well as a few surprises. However, the proposed regulation could change significantly in response to public comment, which the Health Care Financing Administration is soliciting until Nov. 30.

One of the surprises is a proposal requiring Medicaid plans to complete a health assessment of every enrollee within the first 90 days of membership, which coincides with the 90-day period during which a member may disenroll without cause. Pregnant women and members with complex medical needs would have to be assessed sooner, within a time period to be established by each state.

While some states have been required under their waivers to complete health risk assessments, the practice generally has been restricted to special-needs populations. This is the first broad-based requirement for health assessments and likely will present difficult logistical and financial problems for many states and plans, experts say.

"A lot of states have managed care programs that focus on the traditional Aid to Families with Dependent Children population," Lewin Group vice president Terry Savela said. "This is a significant new burden for states and plans. It could be an administrative nightmare to monitor and a significant fixed cost that you can't recover from if the member disenrolls."

In general, the proposed regulation reflects HCFA's desire to provide specificity on Medicaid requirements and standards while fulfilling the Clinton administration's promise of more flexibility and control for the nation's governors. For instance, the proposal mandates that states have some type of quality assessment and improvement system of their own choosing. The mandated features, according to the reg, look and feel a lot like Quality Improvement System for Managed Care (QISMC), the system that HCFA itself helped to

design. While QISMC is mandatory for Medicare plans, it is optional for Medicaid plans.

The regulation's prescriptive sections generally reflect certain congressional "hot buttons" that were pushed last summer during discussions of the BBA, such as the provisions governing emergency services, acknowledged Sally K. Richardson, director of HCFA's Office of Medicaid and State Operations.

For instance, health plans would not be able to dispute emergency room bills if the member's symptoms initially appeared to but ultimately did not constitute an emergency. A plan would have one hour from the time it is contacted to approve or deny the provision of post-stabilization services.

Failure to respond incurs penalty

If the plan fails to respond or cannot be reached for approval, the plan must pay for the care, according to the proposed regulation. The plan also would not be able to challenge the determination of the attending physician or practitioner regarding whether the member is "sufficiently stabilized for transfer or discharge."

Such a provision could undercut a plan's ability to control emergency room utilization, generally the most costly proportion of the overall cost of providing care to plan participants.

The proposed regulation also requires that women in Medicaid managed care plans be allowed direct access to "women's health specialists" for routine care, and prohibits plans from imposing "gag" clauses in physicians' contracts.

Another significant new provision affects plans in rural areas. The proposed regulation gives states the authority to mandate a program even if only one health plan is available to beneficiaries, provided the member can switch physicians within the plan. The sticking point comes when the law says members have the option of going out of the network for services not provided by the network, or when a provider "is not part of the network but has an existing relationship with the beneficiary."

This provision could lead to a plan having to include virtually every area provider in its network or being put at unlimited financial risk because it won't be able to anticipate or manage out-of-network services, Lewin senior manager Lisa Chimento said.

The whole question of what constitutes a rural area also is up for debate, according to HCFA's proposal. The agency provides three possible definitions and asks which (or another altogether) might be most appropriate.

The Lewin analysts also noted that plans that do not operate with a gatekeeper model, or any that are offering "open access" options, will have to move closer to a primary care physician model. Under the new regulation, plans would be required to "provide each enrollee with an ongoing source of primary care . . . and a health care practitioner who is primarily responsible for coordinating the enrollee's overall health care."

The proposed rule also has a modified form of a lock-in enrollment period. Currently, members can disenroll at any time without giving cause. Under the proposed rule, members may leave without cause only in the first 90 days of membership. If they do enroll in another plan, members get another 90-day "try-out" period to see how it fits them.

Many states are exempted

States with 1115 and 1915b waivers issued before Aug. 5, 1997, will not have to comply with the BBA provisions in general except in instances where the regulation addresses an area that the waivers do not. Ms. Richardson acknowledged that the exemption affects a large number of states but said Congress' intention was to permit the various demonstrations allowed under the waivers to continue.

Another requirement sure to catch plans' attention is the proposed requirement that managed care organizations (MCOs) have in place "procedures designed to guard against fraud and abuse," including a system to report suspected violations to the state Medicaid agency, HCFA and the Office of Inspector General. The reporting mechanisms would have to address potential violations by the MCO itself, subcontractors or enrollees.

The proposal acknowledges that meeting this requirement will require MCOs to expend "additional resources and procedures" to be able to detect and report suspected fraud and abuse.

The proposal does not clarify whether plans must have a full-blown compliance plan, as Medicare plans and hospitals are expected to have. Ms. Richardson said the proposal gives states the flexibility to impose a specific reporting system of their choosing.

Changes ahead for PCCMs

Primary care case management (PCCM) programs and other forms of managed care plans, such as HMOs, generally will be subject to the same standards pertaining to access, enrollment and disenrollment, and referrals to other providers. This provision is likely to cause states to modify their PCCM programs, which generally have fewer and less strict standards than HMOs.

With the exception of those prepaid health plans (PHPs) specifically exempted by Congress, PHPs are considered to be MCOs and subject to the same requirements as HMOs, according the proposal. A PHP thus would be required to be licensed by its state as a risk-bearing entity, which usually involves obtaining an HMO license. Some four million Medicaid beneficiaries are enrolled in PHPs, Ms. Richardson said.

Because the regulation was issued as a proposed rule, a comment period is allowed, after which a new regulation will be published with implementation dates. At press time, the National Association of State Medicaid Directors (NASMD) had no formal statement on the regulation, but planned to submit comments by Nov. 30.

Texas Medicaid Director Linda Wertz, vice chairwoman of NASMD's executive committee and a member of its managed care technical assistance group, said Medicaid directors planned to have a series of phone calls to discuss the regulations, with the goal of presenting a draft to the executive committee by early November. She added that she expected that "a number" of states will independently submit comments to HCFA.

Contact Ms. Richardson at 410-786-3870, Ms. Savela and Ms. Chimento at 703-218-5500, and Ms. Wertz at 512-424-6517. ■

FOLLOW-UP REPORT

Virginia wins CHIP approval; limited abortion benefit

If your state is having problems getting your programs through regulatory channels, you might want to tap available congressional support. That seems to have worked in one recent case.

Virginia will begin covering the health care costs of up to 63,000 children because of a high-level political compromise that ended a six-week standoff between state and federal officials that ultimately hinged on payment for some teen abortions. (See "Land mines," *State Health Watch*, October 1998, p. 2.)

Virginia says the Health Care Financing Administration's (HCFA's) approval of the state's new child health insurance program (CHIP) will allow the state to draw almost $88 million in federal funds to help pay for the coverage over the next four years. Federal estimates are lower—$68 million in federal aid to help cover more than 54,000 children by 2000.

Federal and state officials were in agreement that Virginia's children's health insurance plan would cover abortion in cases in which a woman's life was threatened, but disagreed on extending such coverage in the event of rape or incest. Virginia had proposed a benefit package that was a Medicaid lookalike and argued that it did not need to cover abortion in the event of rape or incest because such services are provided to Medicaid recipients through a separate state-only fund.

HCFA's main argument was that the federal Hyde Amendment required the extended coverage for abortions, and thus for any CHIP plan that purported to be a Medicaid "look-alike." The argument became moot when, instead of a Medicaid look-alike, Virginia officials proposed a CHIP benefit plan that was actuarially equivalent to the plan offered to state employees.

The program was set to begin enrollment immediately after the compromise was announced.

The Wall Street Journal said the federal approval was part of the Clinton administration's efforts to win Senate approval for the nomination of Jane Henney, M.D., to lead the Food and Drug Administration.

Conservatives trade concessions

State and federal officials don't agree on how it happened, but the impasse was broken after high-ranking conservatives in Congress, including Virginia Rep. Thomas J. Bliley Jr., R-7th, traded concessions with the Clinton administration on the abortion issue.

Federal regulators also had questioned Virginia's use of health insurance premium taxes to help pay for the program. The state's strategy was approved as presented, a spokesperson in the Virginia Department of Medical Assistance Services said.

—*Richmond Times-Dispatch*, Oct. 23, and staff reports ■

Congress is likely to enact federal legislation that will pre-empt state confidentiality, for better or worse

Otherwise, expect HHS Secretary Donna Shalala to dictate regulations that offer compromises

Activists on both sides of the issue say it is likely that federal legislation soon will pre-empt state confidentiality laws regarding medical records, but they differ sharply on whether that is going to be a good or a bad thing. Depending on whom you listen to, federal pre-emption could be either a big step forward from a mish-mash of state laws that sometimes don't offer enough protection, or a concession to managed care plans that will rob patients of much of their privacy rights.

Efforts to enact federal legislation that would somehow pre-empt state confidentiality laws have been around for years, starting as early as the Carter administration. In the 1980s, the federal government offered a model of uniform state legislation that could be enacted to eliminate differences among states, but states did not adopt the model. The 105th Congress toyed with the idea again by trying to pass several bills that would have involved creating federal laws that usurp state confidentiality laws, but the bills did not pass before the session ended.

Deadline may force action

It looks now as though the next session of Congress will see some sort of action on the issue. Most observers say either Congress will pass a law that pre-empts federal legislation, extend the deadline it is under for addressing confidentiality concerns, or punt the matter to the Secretary of Health and Human Services (HHS).

A deadline imposed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will force some resolution of the issue, said Kathleen Frawley, J.D., M.S., R.R.A., vice president of legislative and public policy services with the American Health Information Management Association in Washington, DC. HIPAA requires Congress to pass legislation regarding uniform state confidentiality laws by August 1999.

"I've been involved in this issue for seven years and I'm surprised that it is taking this long to get something done on a federal level," Ms. Frawley said. "We'll probably get something done in the next Congress because they have to. They could extend the deadline, but if they can't settle on legislation, I think they're more likely to let the Health and Human Services secretary do it."

If Congress hands the issue off to

HHS Secretary Donna Shalala, the result may be a change that falls somewhere between the extremes of the debate. In her recommendation to Congress required by HIPAA, Ms. Shalala said on Sept. 11, 1997, that the country needs a new national standard for protecting the privacy of health information. She went on to say that, under her recommendation, "This new national standard would not limit or reduce other stronger legal protections for confidentiality of health information. Stronger state laws (such as those covering mental health and HIV infection and AIDS information) would continue to apply."

Federal law and state law would apply simultaneously so that if either forbade disclosure of the information, it could not be disclosed. The goal would be what Ms. Shalala calls "floor pre-emption" of state laws so that everyone is assured the protection afforded in the federal law. But in some cases, they would be afforded an extra measure of protection from their own state laws.

"Floor pre-emption" is a goal that seems acceptable to those on both sides of the debate, with some seeing it as the most they would accept and others seeing it as the least they would accept. On one side of the debate is Donald Palmisano, M.D., J.D., a member of the American Medical Association Board of Trustees and a surgeon in New Orleans. Representing the official views of the AMA, Mr. Palmisano is a strong opponent of any measure that would threaten the privacy of medical records. He says floor pre-emption might be the way to settle the debate.

"We have seen bills so far that handled the issue in different ways, with some establishing a ceiling and some establishing a floor," he said. "We say it must be a floor. We support efforts that improve the protection of medical information, but some of the proposals have sacrificed some state confidentiality laws in favor of uniformity. Uniformity is not sufficient cause to weaken a state's laws."

The AMA could support federal legislation that would establish more privacy protection than is currently found in any state, but Mr. Palmisano says that is unlikely.

Many of Mr. Palmisano's concerns about federal pre-emption are related to the way patients must confide in their doctors regarding delicate health matters. If federal laws take away some rights to the confidentiality of that information, patients may be reluctant to tell their doctors about mental health problems, drug and alcohol abuse, and similar issues. Some proposed legislation has included provisions that would allow managed care companies to collect such data on a routine basis without obtaining specific permission from the patient, such as for the purpose of accounting research, marketing, medical research, law enforcement or other ends that do not directly benefit the patient.

'We're not Luddites. We're not anti-technology. But at the same time, we don't want to violate basic rights of our patients just because that makes it easier to use some types of technology.'

Donald Palmisano

"We recognize the importance of medical research and don't want to impede it. We also recognize the importance of technological efficiency, but those needs do not supersede the patient's right to confidentiality of health information," Mr. Palmisano said. "We're not Luddites. We're not anti-technology. But at the same time, we don't want to violate basic rights of our patients just because that makes it easier to use some types of technology."

In particular, Mr. Palmisano said, whatever law is passed should not put the burden on the patient to prevent the release of information. Patients will be harmed, he says, by catch-all phrases that would allow the health care plan to use information about patients "to further the activities of the health plan," for instance. Patients also should not be asked to sign a blanket statement that allows the health plan to use information in that way, he says.

"We don't want any kind of default in favor of the insurance company so that the patient has to protest if he doesn't want information used in that way," he said. "Whatever the phrasing, it should put the burden on the health care plan to ask for that information if it wants to use it in some way."

AHIMA favors uniformity

AHIMA's Ms. Frawley does not dispute much of what Mr. Palmisano said about the need to protect patient privacy, but said the nature of health care and management of medical records has changed dramatically in recent years. Information is flowing between states much more than it did previously because of the upsurge in managed care, so matters are complicated by conflicting state laws, she said.

"Our recommendation would be to get the strongest federal regulation possible and you wouldn't need the state legislation," she said. "States are all over the place in terms of what they've done. If one rule applies in this state, what happens when that information goes to an insurer in another state? The notion of preserving existing state statutes and protections is probably comforting to individuals, but it doesn't give the patient better protection."

Interstate commerce often can leave insurers, providers and patients wondering what restrictions apply to a particular situation, and Ms. Frawley said the individual patient rarely is present or capable of arguing about the fine points of one state law vs. another. A strong federal law would eliminate the ambiguity and protect the patient, she said.

"A lot of other issues have been worked out in the previous bills we've seen, but pre-emption is a very complex issue," she said. "States are responsible for the health of their citizens, so Congress is reluctant to intrude in an area that has long been reserved for state action."

Contact Ms. Frawley at 312-573-8508 and Mr. Palmisano at 312-464-4016. ■

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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.

Louisiana CHIP plan to cover 28,000 children; Pennsylvania CHIP expansion boosts income limit

WASHINGTON, D.C.—Louisiana won Health Care Financing Administration (HCFA) approval to initiate a Children's Health Insurance Program (CHIP), and Pennsylvania was granted federal approval to expand its CHIP operations, HCFA announced in late October.

Louisiana officials estimate they will enroll over 28,000 children by the end of fiscal year 2000 and could be eligible for as much as $102 million in new funds under the program. The state will expand Medicaid by raising the income eligibility level for children ages 6 through 18 whose family income is at or below 133% of the federal poverty level (the federal poverty level for a family of four is $16,450). Currently, Louisiana's Medicaid program covers children ages 6 through 14 whose families have incomes of 100% of federal poverty or less. The program also covers children ages 14 through 18 only if their family incomes are at or below 10% of poverty. The benefit package will be the regular state Medicaid program.

Pennsylvania won approval of a CHIP amendment that will enable the program to cover more than 46,000 children by September 1999. This is in addition to the 63,000 children expected to be covered under the state's initial plan, which was approved on May 28. The amendment to Pennsylvania's CHIP plan will further expand eligibility for children from birth to age 18 in families with incomes up to 200% of the federal poverty level.

Pennsylvania's program now covers children ages 1 to 16 in families with incomes at or below 185% of poverty. The benefit package under the amendment will be the same as that currently offered through the Pennsylvania CHIP program and includes a full range of inpatient and outpatient services. This amendment also eliminates the $5 copayment for prescription drugs that had been in the original plan. There are no other cost-sharing requirements on families.

Pennsylvania is one of three states that had the benefit package of their existing state children's health programs grandfathered under CHIP.

—Health Care Financing Administration releases, Oct. 20, Oct. 29