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The Newsletter on State Health Care Reform

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In This Issue

Proposed privacy regs would allow 'trolling' through patient records

Advocates offer qualified support, chide Congress for lack of legislation

Long-awaited federal regulations on medical privacy made their debut in early November to some protests from a leading physician group and the cautious approval of the health insurance industry. Key advocates seemed equivocal.

"The Administration has made significant headway where Congress could not to restore public trust and confidence in our nation's health care system," said a statement from Janlori Goldman, director of the Health Privacy Project at Georgetown University in Washington, DC. "When finalized, these landmark regulations will be the first enforceable federal health privacy rules," she said.

The proposed regulations implement the federal 1996 Health Insurance Portability and Accountability Act (HIPAA), which calls for Health and Human Services (HHS) to develop such rules given Congress' failure to approve privacy legislation by Aug. 21 of this year.

Activities covered by the proposed privacy protections fall into two broad categories. (See fact sheet,

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Disabled workers move toward broader health benefits in current Medicaid expansion bill

Figuring out how to foot the bill is holding up congressional help for disabled employees trying to hang on to government health benefits.

The Work Incentives Improvement Act, which passed both houses of Congress this year by overwhelming bipartisan margins, broadens the availability of Medicaid and Medicare benefits for disabled people who go back to work. After House approval in October, congressional conferees began meeting to resolve differences in the scope of the expansions as well as strategies to make the expansions budget-neutral.

Medicaid is the chief stumbling block, says Andrew Sperling, director of public policy for the National Alliance for the Mentally Ill (NAMI) in Arlington, VA. The entire cost of the bill is roughly estimated at about $800 million over five years. Conferees have found offsetting savings for about three-fourths of those costs, he says. "Those offsets have to be found in order to bring this back to the House and Senate floor."

The legislation allows states to expand their Medicaid programs to working people between 16 and 65 years of age who otherwise would receive Social Security Disability Insurance (SSDI). Medicaid benefits,

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This issue of *State Health Watch* brings you news from these states:

Privacy regs

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p. 3.) The first category consists of treatment, payment, and health care operations. The second category addresses other purposes such as law enforcement, oversight of the health care system, research, and public health. The draft regs acknowledge that HHS' scope is limited in this second category.

The rules would apply to certain kinds of information, not to specific records, and the protections would kick in once this information is transmitted or maintained electronically, regardless of whether it is later printed, spoken, or transferred to some other form. The protections also apply to the original paper version of information that is converted to electronic form.

While recognizing they provide some privacy protections with regard to financial and similar uses of identifiable data, the American Psychiatric Association in Washington, DC, has "grave concerns" about the proposed regulations, says association vice president Paul S. Appelbaum, MD. He's appalled that the regulations would appear to allow physicians to go "trolling" through medical records of individuals other than their patients. He cites HHS language in the preamble on the right to use and disclose protected health information for treatment purposes:

We intend that the right to use and disclose protected health information be interpreted to apply for treatment and payment of all individuals. For example, in the course of providing care to a patient, a physician could wish to examine the records of other patients with similar conditions. Likewise, a physician could consult the records of several people in the same family or living in the same household to assist in diagnosis of conditions that could be contagious or that could arise from a common environmental factor. A health plan or a provider could use the protected health information of a number of enrollees to develop treatment protocols, practice guidelines, or to assess quality of care. All of these uses would be permitted under this proposed rule.

The ability of providers under the regulations to share identifiable health data with consultants, lawyers, accountants, and other "business partners" raises a red flag with James Hodge, JD, LLM, adjunct professor of law at Georgetown University Law Center. He's not comforted knowing that the regulations require a contractual relationship between the providers and their business partners before the data could be shared. "I'll be the first to tell you, when you open the door to that type of exchange of data — to unidentified business partners

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Summary of Proposed Rules Regarding Medical Privacy

HHS Recommendations

The recommended rule addresses five main areas: consumer control, accountability, public responsibility, boundaries on the use of the data, and security.

Consumer Control

Under the Health and Human Services (HHS) rule, patients would have significant new rights to understand and control how their health information is used:

- Providers and health plans would be required to give patients a clear written explanation of how they will use, keep, and disclose information.
- Patients would be able to see and get copies of their records and request corrections.
- A history of most disclosures would have to be maintained and be made accessible to patients.
- A patient's authorization to disclose information would have to meet specific requirements.
- A provider or payer generally would not be able to condition treatment, payment, or coverage on a patient's agreement to disclose health information for other purposes.
- Patients would have right to restrict uses of their information.

Accountability

There would be punishment for covered entities that misuse personal health information. The statute provides the following penalties for misuse of health information:

- There would be federal criminal penalties for health plans, providers, and clearinghouses that knowingly and improperly disclose information or obtain information under false pretenses. Penalties would be higher for actions designed to generate monetary gain.
- Health plans, providers, and clearinghouses that violate these standards would be subject to civil liability.
- The statute includes new penalties for violations of a patient's right to privacy. These penalties include, for violations of the privacy standards by the persons subject to them, civil monetary penalties of up to $25,000 per person, per year, per standard. There are also substantial criminal penalties applicable to certain types of violations of the statute that are done knowingly: up to $50,000 and one year in prison for obtaining or disclosing protected health information; up to $100,000 and up to five years in prison for obtaining protected health information under "false pretenses"; and up to $250,000 and up to 10 years in prison for obtaining protected health information with the intent to sell, transfer or use it for commercial advantage, personal gain, or malicious harm.

Public Responsibility

Some existing uses of information would not be affected at all, such as reporting births and deaths and reporting abuse such as child abuse. After balancing privacy and other social values, HHS is proposing rules that would permit disclosure of health information without individual authorization for the following national priority activities and for activities that allow the health care system to operate more smoothly:

- Oversight of the health care system, including quality assurance activities
- Public health
- Research
- Judicial and administrative proceedings
- Law enforcement
- Emergency circumstances
- Information to next-of-kin
- Identification of the body of a deceased person, or the cause of death
- Governmental health data systems – as authorized
- Facility patient directories
- Banks and other financial institutions to process health care payments and premiums
- Activities related to national defense and security

Boundaries

With few exceptions, an individual's health care information would be used for health purposes only. It would be easy to use health information for health purposes, and difficult to use it for other purposes.

- Patient information could be used by a health plan, provider, or clearinghouse only for purposes of health care treatment, payment, operations, and some limited public policy priorities.
- All disclosures of information would be limited to the minimum necessary for the purpose of the disclosure.
- Disclosures with patient authorization would have to meet standards that would ensure that the authorization is truly informed and voluntary.
- The proposal would permit, but does not require, these types of disclosures. If there is no other law requiring that information be disclosed, physicians and hospitals will still have to make judgments about whether to disclose information, in light of their own policies and ethical principles.

Security

Covered entities that are entrusted with health information would be required to protect the information against deliberate or inadvertent misuse or disclosure. Security measures would be required to establish policies to protect the information against improper use by employees, or threats from outside. The following entities would be covered by the proposed rule:

- Health plans
- Health care providers that transmit health information electronically
- Health care clearinghouses

Impact on Existing Confidentiality Laws

This proposal 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 except for certain public health activities specified in the statute. The confidentiality protections would be cumulative, and the proposed rule would provide "floor preemption." The aim is to give individuals the benefit of all laws providing confidentiality protection.

Source: Department of Health and Human Services, Washington, DC. November 1999.

Privacy regs

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— I think you begin to weaken the effect of the regulation," he says.

Intended use of the data for government purposes also concerns Mr. Appelbaum, who serves as professor and chair of the department of psychiatry at the University of Massachusetts Medical Center in Worcester, MA. According to the preamble to the regulation, HHS intends to "permit covered entities to disclose protected health information for inclusion in state or other governmental health data systems without individual authorization when such disclosures are authorized by state or other law in support of policy, planning, regulatory, or management functions."

It would be hard to find a government agency that would not have a use for identifiable information for "policy, planning, or regulatory functions," Mr. Appelbaum says.

The regulations supercede any conflicting state laws, but allow states to pass tougher privacy regulations if they so choose. So-called floor preemption is a "very responsible approach," says Mr. Hodge, who directed a project at the law center, separate from Ms. Goldman's Health Privacy Project, to develop a model state privacy act.

He says he's not sympathetic to the concern of the Health Insurance Association of America about the burden of complying with a patchwork of privacy laws in 50 states and the District of Columbia. "They've been living with that for the last 100 years, and they can continue to deal with that."

Mr. Hodge notes that the regulations expand an individual's access to his or her own health data and, importantly, ought to boost the public's confidence that health data are private. But he does join advocates, the insurance industry, and HHS in noting that the HIPAA and the proposed regulations address only part of the full range of protections needed to ensure the privacy of health information.

"This is not a comprehensive health privacy act that applies to all health data regardless of the source or regardless of the purpose for which they are exchanged. This is an important part of the privacy puzzle, but it's not the complete part," says Mr. Hodge.

Still, the publication of the regs seems to be an acknowledgement by the Health Care Financing Administration of what is voiced by observers on all sides of the issue — that given other health care priorities, Congress is unlikely to take up privacy legislation again anytime soon.

> "This is an important part of the privacy puzzle, but it's not the complete part."
>
> James Hodge, JD, LLM
> *Adjunct Professor of Law, Georgetown University Law Center*
> *Washington, DC*

The proposed rule was published in the *Federal Register* on Nov. 3 and will be open for public comment until Jan. 3, 2000. The full text of the proposed rule is found at http://aspe.hhs.gov/ admnsimp/.

Contact Mr. Appelbaum at (508) 856-3066 and Mr. Hodge at (202) 543-2992. Mr. Hodge is lead author of a recent analysis of legal issues in health data privacy. (See: Hodge Jr. JG, Gostin LO, Jacobson PD. Legal issues concerning electronic health information-Privacy, quality, and liability. JAMA *1999; 282:1,466-1,471.)* ■

Disabled workers

Continued from page 1

in the House version, would be available to persons under this option up to 250% of the federal poverty level; the Senate's version of the program also allows Medicaid coverage for the disabled above 250% of the federal poverty limit.

Advocates had fought to eliminate the income cap, pointing out that under the Balanced Budget Act (BBA), states already can expand Medicaid up to 250% of poverty to working people with disabilities. However, two years after implementation of the BBA, notes a NAMI fact sheet, only a handful of state Medicaid programs have elected to pursue this option. (See related story, *State Health Watch*, January 1999, p. 1.)

Another argument for removing the cap, says Mr. Sperling, is that under section 1619 of the Social Security Act, some states already provide Medicaid to Supplemental Security Income recipients with incomes that meet or exceed 250% of poverty.

The legislation also makes available infrastructure grants to encourage states to offer Medicaid coverage to the disabled. The grants, tentatively set at a minimum of $500,000 each, would be used to help states establish and maintain the infrastructure for providing coverage and publicize the existence of such programs.

The version of the bill approved by the House sets aside $20 million for the infrastructure grants in fiscal year 2000 and increases the amount by $5 million for the next four years. Increases for the fiscal years 2005 through 2010 are tied to the Consumer Price Index. It is likely that the state infrastructure grants will survive as "mandatory" spending not subject to future congressional appropriations, says Mr. Sperling.

A proposed demonstration program would allow states to provide Medicaid

to employed persons with a "potentially severe disability" in the hopes of preventing that person from turning to SSDI. Advocates say early Medicaid coverage could forestall medical complications and far greater expenditures for a wide range of conditions.

One of the issues being addressed in the conference committee is whether to require state Medicaid programs to implement the other Medicaid buy-ins to take advantage of the demonstration program. About eight to 10 Medicaid programs are seriously considering expanding Medicaid coverage under the Work Incentives Improvement Act, says Lee Partridge, staff director for the National Association of State Medicaid Directors. The most likely candidates are states that already have taken the plunge under the Balanced Budget Amendment, such as Wisconsin, Oregon, and Minnesota, and that their experience may inspire others to do so, she says. "None of [the enrollment] seems to be huge; they don't seem to be flooded with hundreds of thousands of new potential eligibles."

Mr. Sperling says that getting Medicaid programs to take up the options offered under the work incentives legislation may be challenging in light of states' responsibilities under the recent *Olmstead* decision. The U.S. Supreme Court in *Olmstead* broadened the duty of state Medicaid programs to offer home and community-based services to the disabled. (See related story, *State Health Watch*, August 1999, p. 1.)

"States are going to have to put a lot of resources into *Olmstead* compliance," he says, "but I would make the argument that the Work Incentives Improvement Act is completely consistent with *Olmstead* and that states ought to look at doing these Medicaid options as part and parcel of their *Olmstead* plans."

Contact Mr. Sperling at (703) 516-7222 and Ms. Partridge at (202) 682-0100. ■

California nurses win minimum staffing law, limitations on scope of unlicensed personnel

California's move to establish minimum nursing staffing ratios last month so rattled the hospital industry and so delighted the nursing profession that neither group called much attention to related, and significant, pieces of the law signed by Gov. Gray Davis.

In addition to setting up the regulatory process for defining minimum nursing ratios in hospitals, AB 394 also wrests from the purview of unlicensed assistive personnel seven specific tasks that nurses say belong only in the realm of licensed nurses.

'Substantial' skills needed

"That's a huge change," says Jill Furillo, RN, director of government relations for the California Nurses Association in Oakland. "I don't see how they're going to implement it without staffing up unless they make the nurses work like crazy."

Except for the provisions dealing with the ratios, the staffing law goes into effect Jan. 1, 2000.

The tasks taken away from unlicensed personnel, which the legislation says "require a substantial amount of scientific knowledge and technical skills," including the following:

- administration of medication;
- venipuncture or intravenous therapy;
- parenteral or tube feedings;
- invasive procedures including inserting nasogastric tubes, inserting catheters, or tracheal suctioning;
- assessment of patient conditioning;
- educating patients and their families concerning the patients' health care problems, including postdischarge care;
- moderate complexity laboratory tests.

Legislators also made it tougher for hospital administrators to float nurses from one unit to another, forbidding the practice unless the nurse has "received orientation in that clinical area sufficient to provide competent care to patients in that area, and has demonstrated current competence in providing care in that area."

The provision for establishing the minimum staffing ratios is set now to go into effect Jan. 1, 2001, but is likely to be pushed back to 2002 during next year's legislative session to allow time for the technical tasks involved in rule promulgation. The new law requires minimum patient-to-nurse ratios for each classification of nurse — registered nurse or licensed practical nurse — and for each hospital unit — critical care, burn, labor and delivery, postanesthesia service, emergency department, operating room, pediatrics, step-down, specialty care, telemetry, general medical care, subacute care, and transitional inpatient care.

The new law also requires when administrators assign personnel above the minimum, they do so using a patient classification system that considers the severity of the illness of the patient; the need for specialized equipment and technology; the complexity of the clinical judgment needed to design, implement, and evaluate the patient care plan and the ability for self-care; and the licensure of the personnel required.

Too much of a good thing?

"Hospitals absolutely do not do it now," says Ms. Furillo. "We went around the country and found out that they look at their census and that's how they determine the number of nurses. Period."

California's approach to hospital

staffing is misguided, says a consultant who helps health care institutions analyze their personnel requirements. "I don't understand how they would presume to judge that many levels above the place where the decision is being made whether the ratio is appropriate or not," says Frank Brady, managing partner of Brady & Associates in Kansas City, MO.

"My belief is that this is an extraordinarily bad idea. I think it's very tough within a single institution to mandate an appropriate, and I underline appropriate, nurse-to-patient staffing ratio because in the end, those judgments I think are best left to professional judgment," he adds.

"If you mandate a fixed staffing ratio, as sure as God made little green apples, you're going to wind up ratcheting this thing the other way. If it's bad to have too few staff, it's bad to have too many staff."

Ms. Furillo notes that California hospitals have worked under selected statutory nursing staffing ratios for more than two decades. Intensive care units are required to have two nurses for each patient, and there must be at least one circulating nurse for every operating room.

Both sides of the staffing question recognize that the nursing profession is feeling enormous changes, driven largely by managed care. Over the last decade and a half, employment growth among hospital RNs flattened much more dramatically in states with high managed care penetration than it did in low managed care states, according to an analysis in the January/February 1999 *Health Affairs*. At the same time, though, the authors noted that the ratio of registered nurses per hospital bed has grown from .651 in 1983 to 1.115 in 1996.

> "My belief is that this is an extraordinarily bad idea. I think those [decisions] are best left to professional judgment."
>
> Frank Brady
> *Managing Partner*
> *Brady & Associates*
> *Kansas City, MO*

The ratio of nurses to 1,000 residents in California is about 2.3, or roughly 70.5% of the national average, according to a study completed for the California Nurses Association. The ratio is not adjusted for factors such as the age and sex of a population, which may affect residents' need for nursing services.

Contact Ms. Furillo at (916) 446-5019, ext. 24 and Mr. Brady at (816) 587-2120. (See: Buerhaus PI, Staiger DO. Trouble in the nurse labor market? Recent trends and future outlook. Health Affairs *1999; 18:214-222.) The California Nurses Association report, "California Health Care: Sicker Patients, Fewer RNs, Fewer Staffed Beds," is available at www.igc.org/cna/press/92099.html.* ■

New law gives California elderly a break on prescription drug prices

About 1 million elderly California residents are expected to get a break on their prescription drug costs as a result of a law recently approved by the governor.

As a prerequisite for participating in Medi-Cal, California's Medicaid program, pharmacies as of Jan. 1 will be able to charge no more than the Medi-Cal price to Medicare beneficiaries without prescription drug coverage. An estimated one-third of California's Medicare beneficiaries do not have insurance coverage for prescription drugs.

Tough competition among commercial plans has made Medi-Cal, which pays for about 50 million prescriptions a year, the most generous third-party payer for prescription drugs in California, says Carlo Michelotti, RPh, MPH, chief executive officer of the California Pharmacists Association in Sacramento. Overall, the cap means about a 10% reduction in drug costs to those eligible, he says.

The legislation also mandates a study of drug dispensing fees under Medi-Cal, which have not been changed in regulation since 1982.

Pharmacists were divided on the legislation, but Mr. Michelotti is convinced that it will reap long-term benefits for the profession in California. Successful implementation of the discount would illustrate that Medicare drug coverage reform can be accomplished without an Internet-only or mail-order drug benefit, he says.

"The pharmacists of California, reluctantly or otherwise, came to the plate and offered a discount for people, without any government interference, without a means test or anything being set up. When there's a Medicare national program, that makes California a player and puts California pharmacists at the negotiating table.

"I'm willing to play ball with the expectation that somewhere down the line that we'll eventually get ours," he says.

Contact Mr. Michelotti at (916) 444-7811. ■

Be careful what you ask for: SC health center struggles with the flip side of successful CHIP implementation

Successful implementation of the Children's Health Insurance Program (CHIP) can have a downside. Ask Family Health Centers in Orangeburg, SC. The federally qualified health center is bracing for a cut in Medicaid payments the state says it needs to care for children newly insured by CHIP.

South Carolina's program, a Medicaid expansion without a separate "pure CHIP" initiative, covers about 100,000 previously uninsured children in the state. About half are newly eligible under Medicaid expansions, the remaining half already were eligible but unenrolled.

Family Health Centers, a federally qualified health center in an economically depressed corner of the state, is a major player in CHIP implementation, according to a recent report from the Department of Health and Human Services Office of the Inspector General (OIG). Children and adolescents comprise some 43% of the center's patients, says the OIG, the highest such proportion among all federally qualified health centers in South Carolina. Federal researchers give at least part of the credit to the state's simplified enrollment process and aggressive outreach activities, the state's early start in CHIP (South Carolina's plan was among the first) as well as a specific focus on reaching potential CHIP enrollees.

The downside is that higher than expected CHIP enrollment and utilization has contributed to an anticipated $64 million Medicaid deficit in South Carolina for the year that ends June 30, 2000, and may force state legislators to implement a 5% reduction in the health centers' cost-based Medicaid payments. If a cut implemented Oct. 1 sticks, it means legislators will be going back on their promise not to take the first cut in a ratcheting down of cost-based payments to federally qualified health centers allowed by the Balanced Budget Act of 1997.

"We don't think it was a wise decision, because although they may be taking 5% from what they pay out, there's the federal match that's been lost by reducing what's been paid to us," observes Family Health Centers president and CEO Carolyn Emanuel-McClain. The federal Medicaid match in South Carolina is 70%; for the Medicaid expansion under CHIP, the federal match is 80%. For Family Health Centers alone, the 5% cut means an annual loss of $119,000, enough to fund about 4,100 patient encounters, she says.

At the same time, the number and proportion of uninsured in the community is growing, says Ms. Emanuel-McClain. One of Orangeburg's leading employers, a lawn mower manufacturer, is relying more heavily on temporary employees who don't have health benefits, she says.

South Carolina's health centers are trying to negotiate a deal under which they get the 5% back and work out a "relationship" with nearby hospitals to care for patients who arrive at hospital emergency departments with non-emergent conditions, Ms. Emanuel-McClain says. South Carolina's deficit and state officials' responses tell a cautionary tale for other states swelling the ranks of the insured through CHIP, she says. "They're saying we have the deficit because CHIP is serving more kids than they thought it would. States are going to have to put money in the budgets to help out. If not, you're going to be facing deficits like we're facing in this state."

The spike in Medicaid enrollment "didn't surprise anyone," but it did come on fast, says Frank Adams, spokesman for the South Carolina Department of Health and Human Services. "We began getting a spike in our April numbers. We're not in a deficit, but we're flat running into one."

The 5% cutback to community health centers will address only a small part of the budget shortfall, Mr. Adams says. The state also delayed from July to October implementation of budgeted hospital rate increases. It is reallocating money used to guarantee

Health centers focus on long-term funding

Multiyear congressional funding and a prospective Medicaid payment system for community health centers are among the priority issues for the incoming chair of the Washington, DC-based National Association of Community Health Centers, Carolyn Emanuel-McClain.

"We do what we can do from year to year. I'd really like to roll out a long-term strategy and get Congress to appropriate enough for us to expand out into areas where there aren't any community health center and where there's need."

A more immediate concern is legislation being considered in Congress that would implement a Medicaid prospective payment system for community health centers. (See related story, *State Health Watch*, September 1999, p. 1.) In early November, the House Commerce Committee approved a Medicaid prospective payment system as part of a bill amending the Balanced Budget Act of 1997. ■

nursing home construction loans, and increasing the discount from Medicaid pharmacy vendors from 10% to 13%. With all those measures, the legislature still will be asked to approve a supplemental appropriation of $26 million when it reconvenes in January.

"In a large sense, we're victims of our own success, but the dollars we spend with those children today should pay off in the classroom later," he says.

Full implementation of CHIP programs could end up costing states even more than they're bargaining for now, suggests Linda Bilheimer, PhD, a senior program officer with the Robert Wood Johnson Foundation. That's because point estimates of the number of uninsured children at any one time don't reflect the "tremendous churning" of children in and out of the ranks of the uninsured.

For example, a study of health insurance coverage among children during 1992-1994 showed that 12% to 13% had no health insurance at any given point in time, but fully one-fourth of the children were uninsured at some time during the study period.

"This is a terribly important finding as we look at why we are expanding programs successfully and why we aren't making a bigger dent," she told participants at the annual meeting of the National Association of State Medicaid Directors in Bethesda, MD, in late October. "We may be in a situation where we are enrolling a lot of children in our programs, and at the same time, the number of uninsured kids is growing all the time. Maintaining the line on the number of uninsured kids may be quite an accomplishment."

Contact Ms. Bilheimer at (609) 452-8701, Ms. Emanuel-McClain at (803) 533-0731, and Mr. Adams at (803) 898-2500. The full report describing successful CHIP implementation among six federally qualified health centers can be found at http://www.dhhs.gov/progorg/oei/reports/a417.pdf. ■

Even with CHIP, nation is losing ground in insuring kids, says Families USA study

A "disturbing picture" emerges from an analysis of health insurance coverage among children during the past two years, says a recent report from Families USA.

Two years after passage of the landmark Children's Health Insurance Program (CHIP) and three years after welfare reform, federally funded programs cover fewer children in 12 large states than Medicaid alone covered in 1996, says the report.

Difficult, but necessary

"It will not be easy to reverse the damage done by welfare reform and put the nation back on track to expanded health coverage for children, but it must be done," Families USA says in "One Step Forward, One Step Back."

The Washington, DC, advocacy organization recommends several strategies to prevent Medicaid declines due to welfare reform. (See list of strategies to prevent Medicaid declines, p. 9)

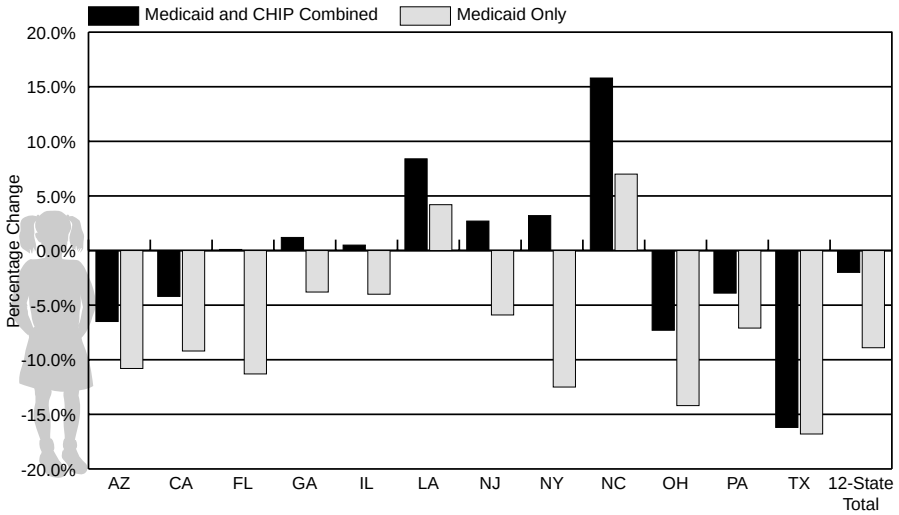
The report notes that Pennsylvania, Maryland, and Washington state have taken steps to remedy unlawful Medicaid terminations due to the states' failure to effectively de-link cash assistance and Medicaid subsequent to the 1996 overhaul of welfare.

Families USA focused its attention on the 12 states with the largest number of uninsured children: Arizona, California, Florida, Georgia, Illinois, Louisiana, New Jersey, New York, North Carolina, Ohio, Pennsylvania, and Texas. (See chart, below.)

In aggregate, the number of children covered by Medicaid and CHIP in these 12 states declined by 219,910 to 10.9 million between 1996 and 1999. The number of children in Medicaid alone dropped almost 1 million during the same time period.

A full copy of the report is available at www.familiesusa.org/child.htm. ■

Change in Children's Enrollment in Medicaid and CHIP for 12 States, 1996-1999



Source: Families USA, Washington, DC.

What Can States Do to Prevent Medicaid Declines Related to Welfare Reform?

Finding and Enrolling Children

- Develop Medicaid-only application forms for regular Medicaid and Medicaid expansions under CHIP (M-CHIP) and make them available at district or local offices as an alternative to long, combined applications for welfare, food stamps, and Medicaid.
  - — Keep forms simple; ask no more than needed to determine eligibility and gather basic demographic information.
  - — Keep third-party documentation requirements to a minimum.
  - — Inform families of the choice between the Medicaid-only form and a longer form covering more programs.
- In states that try to divert people from applying for welfare, process the Medicaid portion of a combined welfare-Medicaid application independently and make Medicaid applications available.
- Accept Medicaid applications by mail without requiring a face-to-face interview.
- Offer assistance filling out application forms and answering questions about Medicaid at convenient times and places. Offer:
  - — toll-free help lines staffed during convenient hours;
  - — outstationed eligibility sites with state workers who can make eligibility determinations and with community workers who can help with preliminary processing;
  - — convenient office hours at local or district offices (on at least some weekdays, open early or late, and always stay open over the lunch hour);
  - — minigrants to community groups for innovative application assistance initiatives.
- Provide application materials and assistance in Spanish and other languages spoken in the community.
- Adopt "presumptive eligibility" for children to provide Medicaid while the application is being processed.
- Offer education to the community about the wide availability of Medicaid and CHIP — even for two-parent working families.
- Enlist the help of community–based groups in providing outreach — particularly to immigrants, minorities, and other underserved populations.
- Monitor denial rates and revise procedures if a high percentage of Medicaid and CHIP applications are being denied for procedural reasons.

Retaining Children on Medicaid

- Adopt 12-month continuous eligibility for children.
- Simplify redetermination procedures.
- Make sure computer systems do not automatically terminate Medicaid when cash welfare is cut off.
- Before terminating Medicaid assistance, comply with legal requirements to review all families losing cash welfare to see if they are eligible for other Medicaid categories, including:
  - — transitional Medicaid for the entire family;
  - — children's Medicaid;
  - — Medicaid expansions under CHIP (also review eligibility under separate insurance programs, stand-alone CHIP programs);
  - — "medically needy" coverage for the entire family.
- Reprogram computers to do as much of the review as possible automatically.
- Update termination notices to clearly reflect current Medicaid policy.
- Require supervisory approval before authorizing any welfare-related Medicaid terminations until computer systems are working smoothly.
- Assure that if families are sanctioned under welfare work rules, children do not illegally lose Medicaid.
- Take advantage of options to offer families moving from welfare to work continued Medicaid coverage:
  - — extend the time for transitional Medicaid;
  - — raise income thresholds by using liberal income disregards in regular Medicaid and M-CHIP;
  - — eliminate asset tests in Medicaid.
- Educate families, vocational service providers, and other contractors about the continued availability of Medicaid when families leave cash welfare.
- Design quality control pilot studies to test the effectiveness of state systems for retaining Medicaid when families lose cash welfare.

Source: Families USA. "One Step Forward, One Step Back." Washington, DC; October 1999.

Clip files / Local news from the states

Congress moves to override Oregon's physician-assisted suicide law

WASHINGTON, DC—The U.S. House of Representatives in late October overwhelmingly approved a measure that would override Oregon's groundbreaking law allowing physician-assisted suicide.

The bill, which passed 271 to 156 sets new national standards for palliative care and provides $5 million in grants to medical schools and hospices to develop training programs for doctors on easing pain among the terminally ill.

The Clinton administration is generally in favor of the bill, but Assistant Attorney General Robert Raben told Congress he was concerned about the "harsh, mandatory penalties" for doctors convicted of assisting with suicide.

—*Miami Herald*, Oct. 28

Innovations in Medicaid payment strategies analyzed by NASHP

PORTLAND, ME—Payment strategies to increase the performance of Medicaid contractors is the topic of a recent publication from the National Academy for State Health Policy (NASHP).

NASHP surveys activities in 28 states and highlights three that have the most experience with performance-based Medicaid contracting — Iowa, Massachusetts, and Rhode Island. The report, *Innovations in Payment Strategies to Improve Plan Performance*, is the fourth volume of NASHP's *Medicaid Managed Care — A Guide for States*. It is available by calling (207) 874-6524.

—NASHP release, Oct. 29

Organized crime increasing its presence in health care industry, says GAO

WASHINGTON, DC—The shadow of organized crime in health care is growing, according to a General Accounting Office report issued Nov. 4.

GAO auditors described seven groups that set up, between 1992 and 1998, a total of 160 sham clinics, labs, and equipment supply companies in Florida, North Carolina, and Illinois. The criminal groups received payment for fraudulent claims to Medicare, Medicaid, and private insurers ranging from $72,000 to $32 million.

—AP/NewsEdge Corp., Nov. 4

Advocates blast new requirements for reporting EPSDT data

WASHINGTON, DC—"Immensely disappointing" is how advocates at the National Health Law Program (NHeLP) view new federal reporting requirements for Medicaid Early and Periodic Screening, Detection, and Treatment services. Revisions in the Health Care Financing Administration (HCFA) Form-416 will "reduce the ability to track trends in preventive services for children," says a recent report by Jane Perkins and Kristi Olson of the program's Child Health Law and Policy Project.

The report is a response to a July letter describing the changes from HCFA to state Medicaid directors. Rather than "assist HCFA and states to capture more reliable EPSDT data in both fee-for-service and managed care settings" as suggested by HCFA, the new forms will "render comparisons across time and across states virtually impossible and could result in overinflated results," says NHeLP.

The report requests a series of stop-gap measures and a review of their concerns before implementation of the changes.

—National Health Law Program, Oct. 18

The bottom line on Washington state's health and health care system: A mixed bag

SEATTLE—Rising costs and declining enrollment of employment-based health insurance are among the trends that "bear watching" in Washington state's annual snapshot of health and health services. *The Pulse Indicators: Taking the Pulse of Washington's Health System* also noted that insurers in Washington state collectively incurred increasing net losses since 1995.

On the bright side, the study by the University of Washington Health Policy Analysis Program reported that the proportion of state residents with employer-sponsored insurance — 65%, and the proportion of residents who are uninsured — 9.5%, both compare favorably with national average.

—*The Pulse Indicators: Taking the Pulse of Washington's Health System*, October 1999

Tennessee's governor would require employers to offer health insurance

NASHVILLE, TN—Tennessee employers would have to offer health insurance to their employees under legislation filed in early November by Gov. Don Sundquist. The legislation would become effective Jan. 1, 2000, for employers with 200 or more employees in Tennessee; on Jan. 1, 2001, for companies with 100 or more workers;

and on Jan. 1, 2002, for companies with 25 or more workers.

The proposal also would impose a 1% premium tax on Tennessee health insurance companies and plans that do not participate in TennCare. The levy would not be applied to an insurance company medical service plan, hospital service corporation, or hospital and medical service corporations if at least 25% of its clients are TennCare recipients or if it covers at least 2,000 TennCare enrollees.

—*Nashville Tennessean*, Nov. 5

Smoking rate among adults 'virtually unchanged' in the 90s, says CDC

ATLANTA—Public health efforts are likely to fall short of the national goal reducing smoking to no more than 15% of the population by the year 2000, the Centers for Disease Control and Prevention reported in early November.

While the per capita consumption of cigarettes dropped by 50% between 1963 and 1998, the smoking rates among adults — calculated at 24.7% in 1997 — is "virtually unchanged" during the 90s, says the Nov. 5 issue of *Morbidity and Mortality Weekly Report*. A climb in smoking during the 1990s among 18 to 24 year olds, though not statistically significant, concerned CDC researchers and prompted a call for increased smoking cessation efforts among this age group.

—*MMWR*, Nov. 5

DHHS proposes greater patient protections for children covered under CHIP

WASHINGTON, DC—Access to health care specialists, access to emergency services, an assurance that doctors and patients can openly discuss treatment options, and access to an appeals process are among the Children's Health Insurance Program (CHIP) protections proposed Nov. 1 by Department of Health and Human Service (DHHS) Secretary Donna Shalala.

The proposed regulation would codify policies and procedures already worked out between DHHS and the states during implementation of CHIP. They have a 60-day comment period.

—DHHS release, Nov. 1

Midwest states come to consensus on interstate sharing of organs

MILWAUKEE—Transplant surgeons representing five Midwestern states agreed in early November on a system for sharing livers across state lines.

Programs in Illinois, Wisconsin, Minnesota, North Dakota, and South Dakota were under orders from the Richmond, VA-based United Network for Organ Sharing to resolve disputes regarding the sharing of livers, particularly concerns that busy Chicago programs would drain resources in other states.

The agreement, which applies only to the sickest "Status 1" patients, calls for a cap of four livers that any state would send to another before the recipient had to start repaying the transfer. In a major concession by Wisconsin and Minnesota, states with relatively high rates of organ donation, the surgeons agreed to forgive the "debt" at the end of a year.

—*Milwaukee Journal Sentinel*, Nov. 4

Washington managed care plans agree to offer independent review

OLYMPIA, WA—Washington state managed care plans covering about 3.8 million people have agreed to implement a binding, independent review process for their enrollees by March 31, 2000.

The review process will be available after an enrollee has exhausted a plan's internal grievance procedures and its cost of the review will be borne by the plan.

The plans agreeing to the voluntary review are the one associate and nine full members of the Association of Washington Healthcare Plans (AWHP).

"There's been a lot of recent discussion in Congress about patient protections. Our plans believe independent review is the best possible patient protection initiative," said Margaret Lane, chair of the AWHP board.

—Business Wire, Nov. 3

Healthy Florida Hospital to close obstetric services in Kissimmee

KISSIMMEE, FL—It's time to pay the piper for Florida Hospital's Kissimmee facility.

The financially healthy facility is closing its maternity ward Nov. 8 for at least six years, thus meeting the terms of a unique agreement that allowed Florida Hospital to open a hospital at Disney World's planned community, Celebration.

To placate competitors contesting the Certificate of Need (CON) required to open Celebration Health, Florida Hospital agreed to curtail certain services in Kissimmee if the new hospital caused its competitors to lose market share in the community.

The three-way deal was signed by Florida Hospital,

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Group Publisher: ***Brenda Mooney****, (404) 262-5403, brenda.mooney@medec.com.*

Executive Editor: ***Susan Hasty****, (404) 262-5456, susan.hasty@medec.com.*

Senior Editor: ***Elizabeth Connor****, (404) 262-5457, elizabeth.connor@medec.com.*

Production Editor: ***Ann Duncan****.*

Columbia/HCA Healthcare Corp., Orlando Regional Healthcare System and the state Agency for Health Care Administration. Florida Hospital was especially anxious to complete a deal, as the company had built Celebration Health before obtaining a CON and could not operate the facility as a hospital without such approval.

When Columbia's Osceola Regional saw its obstetrics market share drop from 72.9% to 70.6% in the last two years, Columbia exercised its option to force Kissimmee's cutback in services. The effect is that Columbia's Osceola Regional becomes the sole provider of obstetric services in downtown Kissimmee.

—*Orlando Business Journal*, Nov. 1

Plastic surgeons call for mandatory coverage of reconstructive services for children

WASHINGTON, DC—The professional association representing 92% of the nation's plastic surgeons has renewed its efforts to mandate insurance coverage for treating children's deformities.

The American Society of Plastic Surgeons (ASPS) is backing the Treatment of Children's Deformities Act, introduced into the Senate on Oct. 28 by Sen. John McCain (R-AZ) and Sen. Olympia Snowe (R-MA).

The bill would require insurance companies to cover reconstructive surgical procedures for those children with congenital or developmental deformities, diseases, or injuries. Coverage would be required for surgical procedures designed to improve the function of abnormal body structures, or to restore those body structures to a more normal appearance.

Currently, 15 states have laws that address insurance coverage for children's deformities or craniofacial disorders, with Texas the most recent to pass such legislation.

The Treatment of Children's Deformities Act was first introduced in the House of Representatives near the end of the last congressional session and was re-introduced on Jan. 6, 1999 by Rep. Sue Kelly (R-NY) as H.R. 49.

—PRNewswire/NEWSdesk, Nov. 3