State Health Watch
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Efficiency at the heart of quest to ensure hospitals are funded

Balanced Budget Act cuts in the Medicaid disproportionate share hospital (DSH) program are inspiring a hunt for new ways to fund hospitals that treat the poor and uninsured.

"You've got desperate providers all over the place beating their brains out to be creative," says Jan Gorrie, JD, a Tallahassee, FL, attorney who represents the state's six statutorily defined teaching hospitals.

For states, the process involves not so much maximizing reimbursement as making sure Medicaid payments are appropriate and Medicaid DSH programs are efficient, says Michael Spivey, JD, a Washington, DC, attorney who has been working with providers in this field for more than a dozen years.

"Providers always have been concerned they're paid fairly, [but] the BBA has focused people's attention on this," he says.

Creativity counts

Creativity is crucial as the hospitals try to increase reimbursement without having to ask for increases in state general revenue funding. The first part of the post-BBA strategy is

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Winners in the scramble for DSH dollars are hospitals that are owned by the states

It's time to rethink federal and state policies that guide the Medicaid disproportionate share hospital (DSH) program, says a Washington, DC, attorney who has worked in the field for more than a dozen years.

"We really need to look at DSH policy in the aftermath of the Balanced Budget Act, when payments have been cut across the board. It makes those DSH dollars even more valuable," says Michael Spivey, JD. Mr. Spivey is affiliated with the Capitol Alliance, a coalition of health care policy consultants in the Washington, DC, area.

As states look for opportunities in the Medicaid DSH program, there is inevitable grumbling that DSH money, once boosted with the federal match, doesn't necessarily make its way back to providers in a fashion that reflects who is providing a disproportionate share of services to the poor and uninsured.

Who are the winners? State-owned hospitals are, says Mr. Spivey. In Texas, for example, state-owned facilities are paid 100% of their uncompensated costs, collectively about $600 million annually, through the DSH program, he says. All other facilities share what's left of a DSH pot of approximately $1.5 billion.

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Hospital funding

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reclassifying certain payments out of the disproportionate share program, which has been capped since the early 1990s, to conventional Medicaid reimbursement, which has no comparable limitations.

"When the limits went into place, that really changed the game," says Gary Redding, head of Georgia's Division of Medicaid Assistance, which administers Georgia's Medicaid program. For the current year, Georgia reclassified about $75 million as conventional Medicaid that, under the previous year's payment scheme, would have been counted as disproportionate share.

About half of the payments reclassified in Georgia's recent initiative relate to allowable payments for graduate medical education, Mr. Redding says. Federal law allows states to boost conventional Medicaid payments up to what providers would have received if the care had been covered under the Medicare program, and payments must be "reasonably related" to the cost or volume of services.

"I want to make clear that I think that was a different time. There are absolute caps now; it's not like the Wild West days of the early '90s."

Michael Spivey, JD

Attorney at Law
Washington, DC

"You can interpret that pretty broadly," says Mr. Redding. "We have some flexibility and try to take advantage of it."

Tweaking the Medicaid disproportionate share program to snag increased provider payments is not new. Disproportionate share dates from the early 1980s, and it was states' successes in boosting these Medicaid payments that led the federal government in 1991 to restrict the kinds of funds that could be used for the state DSH match, as well as to apply brakes on the growth of the program.

"I want to make clear that I think that was a different time," says Mr. Spivey. "There are absolute caps now; it's not like the Wild West days of the early '90s."

The second part of the strategy that is picking up speed is tapping government sources other than general revenue for the state DSH match. Georgia has looked to public hospitals for the intergovernmental transfer of funds allowed for that purpose. While the state now sends 100% of the funds contributed by a given hospital back to that hospital — with the federal match — participating organizations get no guarantees that will always happen, he says.

"The trick is to get the hospitals to buy into it. When we first did this, we had to say 'Trust us,'" he says.

As in other states, South Carolina's federal contribution to Medicaid DSH payments dropped in 1999-2000, cutting total DSH payments some $59.2 million or 13.3% over the previous year. At the same time, this year's plan calls for the state to pay a larger share of Medicaid providers' costs, boosting conventional Medicaid payments for inpatient services by $44 million and outpatient services by $20.5 million.

A key feature of South Carolina's DSH plan is a "high-volume Medicaid adjuster" that is neither fish nor fowl — not conventional Medicaid or DSH payment. The three hospitals that had at least 35,000 Medicaid days in 1997 will share a $29 million pot "to ensure the continued viability of these high-volume Medicaid providers," says the public notice announcing the fund.

While the Health Care Financing Administration has not approved the proposed plan amendments, the federal government hasn't rejected them either, notes Marianne Melton, director of acute care reimbursement for South Carolina's Medicaid agency.

Tapping local governments

Florida's teaching hospitals are trying to convince county governments to increase their contributions to the Medicaid DSH program. If successful, the funds will be used to offset some of the $45 million extra the state would be asked to kick in to conventional Medicaid in the upcoming year, a hike that would boost conventional Medicaid payments by $185 million.

In a total Medicaid budget of $7 billion, the boost doesn't seem like much. For the state's statutory teaching hospitals, though, it's crucial, says Ms. Gorrie.

"The first round of BBA cuts has really hit the fan," says Ms. Gorrie, an associate in the Tallahassee firm of Pennington, Moore, Wilkinson, Bell and Dunbar. "We're doing it for the people who are caring for Medicaid recipients and the uninsured."

She says she hopes the four large Florida counties that tax residents for health care services accept her premise — that their contributions to the state Medicaid program ultimately will make their way back home enhanced with the federal match.

"When you have a sophisticated health care program and mission, they get it," says Ms. Gorrie.

To help restore BBA's Medicaid DSH funding cut, hospital groups nationally are lobbying Congress on behalf of three bills: HR 3698, HR 3710, and SB 2299, says Lynne Fagnanni of the National Association of Public Hospitals and Health Systems in Washington, DC. The BBA cut out $10.4 billion in absolute funding compared to 1995 spending levels, she says, and reduced what would have been spent in 2002 by 37%.

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Feds tell states to restore improperly cut Medicaid benefits

In a move that could help hundreds of thousands of poor people, the Clinton administration ordered states on April 7 to restore Medicaid benefits to families who were improperly deprived of their health insurance when they left the welfare roles.

The action was announced by Donna E. Shalala, secretary of health and human services, who said many low-income people lost Medicaid coverage as an unintended consequence of the 1996 welfare law. In approving that law, Congress wanted to restrict eligibility while preserving access to Medicaid.

In an April 7th letter to state Medicaid directors, the Clinton administration said, "All states must take steps to identify individuals who have been terminated improperly from Medicaid and reinstate them," according to an article in *The New York Times.* ■

States struggle to measure success of health coverage

As state agencies take more responsibility for overseeing health care coverage for those under age 65, they are being asked by federal program officials, state legislators, and federal and state policy-makers for massive amounts of statistical information and analysis to document and evaluate the results of their actions. States, however, face major obstacles in collecting the needed information and performing evaluations that are both pertinent and timely.

Now, there is a new resource available. Marsha Gold, a senior fellow at Mathematica Policy Research in Washington, DC, has written *Evaluation of State Healthcare Coverage Expansion*, a manual published by the Alpha Center, also in Washington, DC, to help state officials respond to requests and overcome some of the barriers to evaluation.

"Most policy-makers and program officials are not researchers," Ms. Gold says. "Yet, they increasingly are asked to respond to a variety of questions that only can be answered with appropriately targeted research. Often these questions are difficult to answer, even without the considerable constraints of limited resources, time, and data that apply in real-world settings." Ms. Gold says her manual is intended to help policy-makers and their staffs become sophisticated users of existing research findings as well as effective participants in shaping future evaluation strategies so that the results are relevant and can help answer questions that arise in the context of state policy.

"The demand for evaluation varies from state to state," she tells *State Health Watch*. "One of our goals was to address this issue — less in a crisis mode and more in a capacity-building mode for states. Having the right analytical tools has always been a problem for states, but the current environment seems to be a good time to promote building needed capacity to do this work."

The manual is intended to give people tools to think about what's most important in what they're evaluating and also to demonstrate how evaluators think about their research.

State, local levels are target areas

She targets those working at the state and local levels because that's where problems are arising now.

"We've built an elaborate set of monitoring systems at the national level, but decisions are made and programs conducted at the state and community levels. The question is now to support the need for analysis at that level. States vary a lot in their capacity for good research and evaluation, and it's often hard to get this work done uniformly and in a way that's sensitive to local communities and still have something that can be compared with another program or locale," adds Ms. Gold. "We want to be able to help states make their cases for funding for research and evaluation."

Ms. Gold provides two classic, consistent definitions of evaluation:

• determining the value or amount of success in achieving a predetermined objective;

• measuring the effects of a program against the goals it sets out to accomplish as a means for contributing to subsequent decision making about the program and improving future programming.

However, she says agreeing on a definition is ultimately less important than encouraging a common understanding among stakeholders about the information needed to make decisions and when it is likely to be required. "Thus, it is important to be concerned less with terminology than with whether (1) you and your audience are thinking of evaluation the same way and (2) what you propose to answer matches the most relevant questions in a timely and appropriate way."

Before making recommendations for improving evaluations, the manual looks at problems that can interfere with or prevent effective evaluation. Obstacles to collecting needed information and performing useful evaluations include:

• data challenges when reliable estimates of current insurance coverages at the state and local level don't exist, especially on particular target populations;

• concurrent changes that occur at the same time as coverage expansion, making it difficult to determine which factors are actually influencing coverage levels;

• programs that evolve over time, often in response to comments from beneficiaries, advocates, providers, state staff, legislators, the news media, and others, often making it hard to determine exactly what is being evaluated;

• the state staff resources available to perform evaluations;

• the lag time between data collection and analysis that makes it difficult for policy-makers to provide real-time responses to legislative inquiries.

While the techniques she recommends "will not remove these constraints," Ms. Gold says, "with a better grasp of evaluation methods, policy-makers can think more carefully about ways to address questions, think through their feasibility, and decide how best to position their agencies to respond."

The manual identifies six ways in which state policy-makers can leverage their resources to respond more effectively to evaluation questions, even when those resources are limited:

1. Become a sophisticated user of existing studies. Ms. Gold recommends reviewing earlier studies for their applicability and synthesizing insights from them as a basis for responding to policy questions and as a vehicle for identifying key issues to evaluate in any state. "Sometimes, there's stuff available and it's unused, but it wouldn't take much work to be able to use it."

2. Leverage operational processes and systems. If policy-makers think strategically about the logic of their programs and the kinds of information that may be relevant to future evaluations, they often can tweak operating systems to provide operational measures of program performance. For instance, a program might have low enrollment rates for a number of reasons. Problems with education and outreach might suggest better targeting or more effective message development. Problems with enrollment might suggest an easier enrollment process or targeted campaigns to address specific concerns. Problems with retention/transition might lead to a review of policies on duration of eligibility, premiums, or incentives for continuity of enrollment.

3. Collaborate with other agencies. Evaluations can be more effective if staff in various agencies share their information and expertise. Ms. Gold cites examples of collaboration in Wisconsin, Mississippi, and Rhode Island that led to improved evaluations in a number of efforts.

4. Develop a public-private partnership with local universities and other sources. "States, at times, may be able to develop partnerships with local universities or others that can be used as a vehicle to expand the capacity for evaluation," the manual says. "Such partnerships should be actively managed to encourage relevant and rewarding work for both partners despite their different needs and incentives. States that develop partnerships with outsiders should invest in qualified internal staff who can oversee the work and encourage its relevance and timeliness." Ms. Gold says such arrangements cannot replace the need to develop sufficient internal resources, but can lend credibility to state efforts because outsiders may be viewed as more independent and unbiased.

5. Capitalize on the potential for external funding to support evaluation. Ms. Gold says program money sometimes can be directed to evaluation analyses as can grants from organizations such as the Robert Wood Johnson Foundation.

6. Cooperate with and use external evaluations as targeted opportunities. Often there are outside agencies that evaluate a program regardless of the views of the executive agency or program offices, such as federal- and foundation-funded CHIP evaluations, 1915(b) and 115 waiver evaluations, and legislative audits and evaluations. "State policymakers can identify whether such evaluations present an opportunity to obtain useful data and analysis," the manual says. "These evaluations are likely to have more public impact than internally generated evaluations. Agencies will want to take time to help evaluators understand their programs by providing documentation, data, information, perspectives or accomplishments and challenges, and feedback on the accuracy of drafts. Reacting defensively or withholding information from evaluators is not good practice; they are likely to learn about these issues from others, and policy-makers will want to provide their perspective on the issue."

Ms. Gold believes that even though policy-makers are not researchers or evaluators by training, if they spend some time understanding the concepts that underlie effective evaluations, they will be better able to effectively use and guide evaluations. To set a context, she defines policy-making as "the process for resolving policy issues and the competing claims for resources among the various public and private parties that have a stake in the outcome." Evaluation results often are used in different ways, according to Ms. Gold, reflecting differences in needs at different stages of the policy process. Uses of evaluation include help for making decisions, providing support to substantiate decisions already made, and acting as a tool to establish and alter attitudes in ways that may influence future decisions.

Evaluation influences agendas

Uses of information also vary as the policy-making process progresses. Some observers note that evaluation generally has a greater influence in agenda-setting when issues are being raised and compete for attention, rather than when specific proposals are being considered and stakeholders are negotiating specific concerns.

Since a key characteristic of evaluation is that it reflects analytical thinking, Ms. Gold calls for explicitly considering and providing analysis in three areas — technical effectiveness (will the option achieve its intended results), political acceptability (what are the main sources of support and opposition), and operational feasibility and cost (what will it take to implement and how much will it cost).

"Both the design and interpretation of evaluations are best determined in context," Ms. Gold asserts. "One key element of context involves a good understanding of what the initial goals were and what compromises were made in enactment or implementation that could influence the

state's ability to achieve these goals. Goal-based evaluation is inherently difficult, since policy often evolves from multiple unstated or hard-to-acknowledge compromises."

Policy-makers should choose a type of evaluation to support a specific need. Evaluations could cover relevance and progress of a program to assess whether it is needed and/or whether it is the right strategy, and to ensure data will be available to track progress in implementation. In assessing implementation, Ms. Gold says, policy-makers will benefit from data that are appropriate measures of progress against relevant goals and expectations.

Another type of evaluation focuses on effectiveness and efficiency, emphasizing intermediate measures of performance. Such an evaluation measures the direct outputs of a policy or product, what it costs to generate such outputs, and other intermediate performance measures. It often is useful, the manual says, to calculate key measures of output and intermediate performance based on age, insurance status/eligibility, category, geography, or other relevant characteristics for which data exist.

The criterion for internal validity gets to the issue of showing a causal relationship in a program and ensuring that the relationship will stand up to scrutiny.

Ms. Gold suggests that policy-makers can become more sensitive to alternative explanations for a given change and limitation of a study if they ask themselves how they would want to explain a less favorable outcome. And the criterion for study feasibility focuses on the practicality of a given study and whether it can be completed with the available data and resources, and within a relevant time frame.

Contact Ms. Gold at (202) 484-9220. ■

DSH program

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"If state-owned facilities are first in line, I don't think that's irrational from the perspective of a state budgeter," he concedes.

He quickly adds that state facilities in Texas are not the "most disproportionate" providers of care to the program's target population, either in dollar amount or volume. Moreover, inflation and cuts in DSH funding will gradually whittle away over time at the funds available to facilities not owned by the state and likely will reduce the proportion of their indigent care costs that DSH can pick up, says Mr. Spivey.

Funding formula

But what about the fact that state-owned facilities in Texas can and do make an intergovernmental transfer (IGT) that composes the "state" portion of the Medicaid DSH payment? To make sure they are not treated unfairly, does the funding formula have to take that payment into account?

"That would be a legitimate point, but the state-owned facilities are being treated better than 'not unfairly,'" Mr. Spivey says.

Even within the group of Texas hospitals not owned by the state, other disparities pop up, he says. Nine tax-supported hospital jurisdictions, all of which provide an IGT, get a net return on their DSH contributions amounting to about 38% to 40% of their nonreimbursed costs for indigent care, he says. The remaining 140 or so nonstate facilities participating in the disproportionate share program, none of which contribute to the DSH program, see about 90% of their uncompensated costs covered through DSH.

"There is cross-subsidization from the heavy disproportionate share to the less disproportionate share," says Mr. Spivey. "Should those be the policy goals in Texas? It leads to some very interesting and excited policy debate."

Medicaid programs often work with the hospital industry to rationalize the distribution of DSH funds in their respective states, taking into account facilities' public contributions through IGTs and taxes. Still, the process can be more art than science, especially when the state defers to the industry to come up with a distribution scheme.

That's the process in South Carolina, where both the hospital industry and the Medicaid program are looking carefully at the allocation of DSH funds, says Marianne Melton, director of Medicaid acute care reimbursement. She notes one instance in which their work so far has not addressed disparities in a hospital's public contribution and its DSH reimbursement.

"The 501(c)3 hospitals that don't pay taxes get away with murder," she says.

No requirement

Ms. Melton points out that all of South Carolina's DSH money goes back to providers, a claim that not all states can make. Under DSH law and regulation, there is no requirement that IGTs used to attract the federal match will be returned to providers for services provided.

"You can end up with a policy in which providers get to keep nothing," notes Mr. Spivey. "There's really nothing to prevent a state from doing that right now. For all the legislating, there hasn't been much of an attempt to rationalize DSH policy."

Contact Mr. Spivey at (202) 383-9497 and Ms. Melton at (803) 898-1030. ■

Medicare dropping supervision requirement for nurse anesthetists

Despite the vehement objections of anesthesiologists, the Health Care Financing Administration (HCFA) is poised to drop a Medicare requirement that nurse anesthetists with advanced training be supervised by a physician when administering anesthesia in a hospital setting.

HCFA administrator Nancy-Ann DeParle has notified Congress that the change, the most controversial among many changes proposed to hospital regulations (drawing more than 30,000 comments), will be announced in the *Federal Register* before June.

To anesthesiologists who have lobbied heavily against the proposal over the two years since its initial introduction, the issue is patient safety and the risk that comes when physicians do not supervise nurses during the administration of anesthesia for surgery. The issue is not directly an economic one since Medicare reimburses both nurse anesthetists and anesthesiologists the same amount for the same services.

Having failed to convince HCFA not to change the requirement, the anesthesiologists are turning to Congress and seeking legislation to prevent HCFA from making the change. Sponsors of the Safe Seniors Assurance Study Act say the bill is needed because it appears to them that HCFA has not sufficiently reviewed current data or carried out new studies to ensure that seniors will be safe if the requirement for physician supervision of nurse anesthetists is removed.

"It is obvious now that all concern for patient safety has been lost to bureaucracy," says Ronald A. MacKenzie, DO, president of the American Society of Anesthesiologists in Washington, DC. "HCFA has said that it has made this proposal based on reasoning that anesthesia is 'relatively safe' now and that there is no evidence to compare the differences between anesthesiologists' care and nurses' care. That reasoning is dangerously flawed. If HCFA goes ahead and removes this safeguard, seniors stand to lose not only a critical Medicare benefit, but, even more frightening, people will die."

Nonsense, say officials of the Park Ridge, IL-based American Association of Nurse Anesthetists (AANA), representing certified registered nurse anesthetists.

"It is obvious now that all concern for patient safety has been lost to bureaucracy."

Ronald A. MacKenzie, DO
President
American Society of Anesthesiologists
Washington, DC

"Senior citizens will be just as safe as they've always been," says Jan Stewart, CRNA, the association president. "This decision removes the supervision requirement for a hospital to be paid by Medicare. It doesn't affect providers. I think that if you walk down a hospital corridor six months after this takes effect, you won't see any difference. This is not a change in practice, just in billing. I think the opposition has blown it all out of proportion. Doctors may believe there is some control slipping away from them, but they never really had it."

Historically, nurse anesthetists were the initial providers of anesthesia during surgery, according to AANA director of practice Sandra Tunajek. For many years, they worked under surgeons, until the physician specialty of anesthesiology came about. Over the years, many state boards of nursing looked at what nurses were doing, assumed a physician would be present during any operation in which anesthesia is used, and decided there was no need for a state requirement for physician supervision of the nurse anesthetist.

As a result, 29 states — Alaska, California, Colorado, Delaware, Hawaii, Idaho, Illinois, Iowa, Kentucky, Maine, Maryland, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New York, North Carolina, North Dakota, Oregon, Pennsylvania, South Carolina, Texas, Utah, Vermont, Washington, and Wyoming — plus the District of Columbia, Puerto Rico, and the Virgin Islands have no supervision or direction requirement concerning nurse anesthetists in nurse practice acts, board of nursing rules and regulations, medical practice acts, board of medicine rules and regulations, or their generic equivalents.

Nurse anesthetists currently administer 65% of all anesthesia in hospitals, and 70% of all anesthesia in rural hospitals, according to Ms. Tunajek. For many rural hospitals, nurse anesthetists are the only professionals available to provide anesthesia, and HCFA's decision is motivated by a desire to recognize that situation officially and give hospitals more flexibility in determining a provider mix that meets their particular needs, she adds. The change also is responsive to federal government initiatives to defer to state law on such issues.

And the move recognizes a trend that has been under way for some time regarding advanced practice nurses, Ms. Tunajek says. Medicare already reimburses nurse midwives, and both the armed forces and

Veterans Affairs have policies for advanced nurse practitioners.

The AANA has no plans to seek changes in state laws in the remaining 21 states, according to Ms. Stewart, because "we try not to meddle in state affairs, and the local level is the correct place to determine practice regulations."

Although the change has no direct impact on physicians, it "may ease the minds of some surgeons who believed erroneously that they had some liability for the actions of nurse anesthetists," Ms. Stewart adds.

Payment policies differ

Payment policies for nurse anesthetists vary depending on the payer and state, according to Ms. Tunajek. "Basically, third-party payers will pay nurse anesthetists, although in some states, Medicaid will not pay us. Medicare pays nurse anesthetists directly at the same rate as an anesthesiologist if the nurse anesthetist works alone without an anesthesiologist being present. The largest component of Medicare's payment usually goes through an anesthesia care team."

In hospitals where anesthesiologists supervise nurse anesthetists, the physicians usually monitor several operating rooms simultaneously, with a nurse anesthetist present in each room continuously. While the anesthesiologists do not talk about it, some observers have raised the possibility that behind their vehement objections lies a fear that hospitals will use the change as an excuse to cut back on the number of anesthesiologists.

"Could it happen?" asks Ms. Stewart. "I suppose it's possible. But I have a hard time imagining that any hospital would decide now to drop anesthesiologists."

Contact Mr. MacKenzie at (202) 289-2222 and Ms. Stewart and Ms. Tunajek at (847) 692-7050. ■

State insurance programs separate families seeking mental health services for their kids

An unintended consequence of many state and federal coverage programs for children is that parents are forced to relinquish custody of their children to the state in order to obtain needed intensive mental health services for their kids. "Many people don't realize this is happening," says Tracy M. Delaney, behavioral health policy associate with the National Conference of State Legislatures (NCSL) in Washington, DC.

"It's caused by a lack of access to services, a lack of needed community-based treatment, and a lack of insurance coverage. It can be very frustrating for parents when they have a child in need of intensive, possibly long-term care and they can't afford or obtain it unless they relinquish custody of the child to the state," she adds.

The situation is getting attention from the NCSL and other advocacy and policy organizations now as a result of an 84-page report on the problem, *Relinquishing Custody*, issued by the Bazelon Center for Mental Health Law in Washington, DC. Nationwide, the report says, "one in five families who seek mental health care for a child faces this Draconian dilemma. Many of these children have health insurance coverage. However, the combination of limited mental health coverage in private plans and unenforced entitlements in public plans deprives them of access to needed mental health care unless they become wards of the child welfare system."

The report's author, Bazelon staff attorney Mary Giliberti, says the problem is systemic, caused by a private health insurance system that limits its mental health services and doesn't provide the home-based services and family support that people need. "We hear about so many people who are insured, but we don't hear that they are vastly uninsured for mental health."

In addition, state and federal programs contain entitlements that often are not provided, and it would be necessary for families to sue the state to try to force compliance with the law. To compound the problem, states have flexibility in deciding what services to provide and there is no consistency. Even under the Children's Health Insurance Program (CHIP), states can decide whether to follow Medicaid or design their own plan. Many of those that have developed their own non-Medicaid program don't include adequate mental health services, Ms. Giliberti says.

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>
> *Relinquishing Custody*
> Bazelon Center for Mental Health Law
> Washington, DC

"In the process of desperately seeking help for their children, good, caring parents are treated as abusive or neglectful and deprived of the ability to raise their children consistent with their values," the report states. The most frequent incidences of custody relinquishment occur in Colorado, Indiana, Iowa, Nebraska, Tennessee, and West Virginia. Families living in Arizona, California, Florida, Illinois, Kentucky, Louisiana, Maryland, Michigan, Missouri, New York,

Ohio, Texas, and Utah also are forced to relinquish custody, according to the report.

From Ms. Giliberti's perspective, the global solution lies in providing all children access to all needed mental health services. Absent a total fix, however, what seems to work best are state solutions that expand access to services through waiver programs that increase eligibility, through systems of care that integrate funds to serve patients through a consortium of agencies, and through individual demonstration projects.

Eleven states now prohibit their child welfare agency from requiring custody relinquishment to access mental health services. Bazelon says that while this stops the problem at its point of origin — the child welfare system — by itself it is insufficient because it does not increase availability of mental health services. Seven states allow voluntary agreements between parents and the child welfare system for out-of-home care placement without custody relinquishment. Four states have obtained Title IV-E waivers for the child welfare system to address the mental health needs of children in or at risk of entering state care. But parents are still forced to work with a bureaucracy designed for abuse and neglect cases, and children lose contact with their family and community because placements are out of the home.

Three states have given their courts jurisdiction to order mental health treatment or care for children in an effort to avert the need for out-of-home placements. Ms. Giliberti says the disadvantage in this approach is that parents are required to seek help from the juvenile court, often an intimidating forum. "However, a concerned judge who is well-informed about children's mental health and family support issues can be a family's powerful ally in obtaining services."

Twenty-one states and two territories have expanded their Medicaid program under CHIP, and 13 states have a combination of state-designed and Medicaid CHIP programs. Of the states that have created separate plans, two are covering wraparound services. Three states are using home- and community-based Medicaid waivers to provide an array of intensive services for children with serious mental health needs.

It's often difficult to get families to speak out about what's happening to them because they are so busy dealing with their child's mental health crisis.

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Bazelon Center for Mental Health Law
Washington, DC

But Ms. Giliberti cautions that in several states whose Medicaid programs have adopted a managed behavioral health care model, the shift appears to be exacerbating the problem of custody relinquishment. Tennessee has tried to resolve that problem by adding an amendment to the managed care contract imposing a fine when failure to provide a covered service results in a child enrollee entering state custody. And in Arkansas, stakeholders made sure the request for proposal for services clearly defined such a wide array of community-based mental health services for children that families would not have to encounter the child welfare system.

The report gives an in-depth review to a Kansas Medicaid waiver that holds great promise and an Oregon law that prohibits custody relinquishment for residential mental health treatment. Ms. Giliberti says the Kansas waiver has enabled many more children to access services without entering state custody by adding four new services:

1. family training and support;
2. wraparound facilitation/community support;
3. living skills services;
4. respite care.

The waiver has reduced custody relinquishment and led to positive outcomes in schools, the report states. "Some problems have arisen in providing services throughout the state and in making some of the services in the plan available because of difficulties recruiting staff. Generally, however, parents are very pleased because the waiver allows them to raise their children at home without court involvement."

While some parents have been helped by Oregon's law banning custody relinquishment for the sole purpose of obtaining services for a child's emotional, behavioral, or mental disorder or physical disability, it does not address the underlying lack of mental health services outside the court system. Ms. Giliberti says there also have been difficulties implementing the law because caseworkers know too little about it, families are unaware of their rights and responsibilities under it, the voluntary placement forms are confusing, and the child welfare agencies have not tracked implementation.

Ms. Giliberti says part of the problem is that people aren't aware of the situation, and Bazelon hopes its report will help increase public consciousness. It's often difficult to get families to speak out about what's happening to them because they are so busy dealing with their child's mental health crisis, she says.

Contact Ms. Giliberti at (202) 467-5730, ext. 15, and Ms. Delaney at (202) 624-3577. ■

State health insurance reforms have plateaued

While state health insurance reforms have been neither the panacea nor the ruination that some observers predicted they would be, they appear to have gone as far as they are going to, at least until after this fall's presidential election.

"The states are exhausted with CHIP and Medicaid," says Len Nichols, a senior analyst with the Urban Institute's health policy research group. "I don't expect any more changes in small-group or individual insurance reform. To expand coverage any further, we're going to have to spend some money. States are waiting for the presidential election to see who's going to win and how much federal money will be available for reforms."

Mr. Nichols recently studied state efforts at individual insurance reform and distilled some of the lessons learned by states in the process. His report was published in the February 2000 issue of the *Journal of Health Politics, Policy and Law*. The first lesson, he tells *State Health Watch*, is that individual reform has been neither as good as people had hoped nor as bad as people had feared.

"What we found is that state insurance reforms are not going to move coverage a lot one way or the other, nor will they move premiums tremendously for most people. The experiences of the states do not support the argument that all insurance markets need is a little reform and then there will no longer be any reason to worry about the uninsured. Premiums did increase on average, as theory predicts, and coverage did decline somewhat on net. But the premium movements, while substantial in most cases, appeared to settle down over time and produced relatively small net coverage effects," he says.

Another lesson gained from states' experiences is that there always are tradeoffs involved when reforms are attempted — some people are better off and some are worse off, says Mr. Nichols. The most common reforms enhance the welfare of those who are relatively sick and force the relatively healthy to pay higher premiums, he adds.

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>
> Len Nichols
> *Senior Analyst*
> *Urban Institute*
> *Washington, DC*

"That kind of tradeoff gives a lot of help to the few at the expense of the many," he says. "One's judgment about the wisdom of this tradeoff depends both on one's world view and on a detailed assessment of who gained and who lost. This tradeoff is politically tough and works only when it's invisible to the many who are paying more, which comes from having a large base. We can see that small business insurance reforms created less of a problem because they had a bigger base."

Enrollment in the individual market has dropped in response to reforms that guaranteed issue of all products and pure community rating, says Mark A. Hall, professor of law and public health at the Wake Forest University School of Law in Winston-Salem, NC. However, the reforms "have not created an adverse selection death spiral, nor have they caused the collapse of the individual market. Instead, these reforms tend to create an individual market that resembles a large high-risk pool, one with widespread and substantial enrollment, but in which is more difficult for younger, healthier people to find affordable coverage.

"In the individual market, the stringency of rating restrictions has a dramatic effect on the willingness of insurers to remain in the market and on adverse selection effects against the market. Generally, states that have adopted pure community rating in the individual market have experienced significantly worse problems," he says.

In community rating, the expected claims of the entire covered group are estimated. An average premium is calculated dependent on what amount would be sufficient to pay the claims of the entire group.

Mr. Hall says that pure community rating in the individual market often leads insurers to adopt risk-avoidance techniques, such as trying not to have the most comprehensive benefits or the most attractive prices, much more aggressively. "This can create a perverse market dynamic in which insurers compete by trying to avoid attracting subscribers." To offset this insurer tendency, states with pure community rating in the individual market must set minimum benefit standards and require prior approval for significant rate increases, Mr. Hall suggests.

Mr. Nichols' third recommendation for states considering insurance reforms — that they make sure there is a political consensus for the reforms being considered — is based on what he considers to be a disastrous experience in Kentucky.

"The simple fact is that insurance market reforms change almost every

life in a state a little bit, and, thus, there must be a critical mass that shares the goals of social solidarity [considering health care a right and moving toward universal coverage] or there will be strong pressures for immediate repeal," Mr. Nichols says. Kentucky adopted a relatively comprehensive set of reforms while relatively few people involved understood the magnitude of what had been done. "Those who did understand were well-intentioned and thought that things could be worked out if everyone would just calm down," he says. "But they didn't realize all the problems they would face."

Difficulties arose immediately because doctors were being paid less by Medicaid for reasons unrelated to insurance reform and the state moved to a system of gender-specific rating in which coverage for women cost more than for men. Both issues were extraneous to the cause of insurance reform, but they dominated the political landscape and created an impression in the minds of many that the whole reform package was very bad, he says. And with that, political support for the insurance reforms unraveled. With no political consensus to withstand the storm, the state repealed all of its reforms, Mr. Nichols says. "No politician is going to touch this again for about 10 years, and that's a crime because a state like Kentucky has such a great need."

Asked about states that have had good results, Mr. Nichols points to Vermont and New Jersey. Reforms in Vermont appear to have worked, and New Jersey seems to have overcome some initial bumps in the road, he says. One sign of sufficient political consensus there was the states' ability to require insurers who wanted to participate in the group market to also be in the individual market.

Contact Mr. Nichols at (202) 261-5697 and Mr. Hall at (336) 758-4476. ■

Clip files / Local news from the states

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

State worker accused of Medi-Cal bribes is first to be implicated in FBI probe

SACRAMENTO, CA—The first state worker to be implicated in the FBI's investigation of Medi-Cal fraud was accused in early April of accepting bribes from doctors who submitted false billings to the program.

U.S. Attorney Paul Seave filed bribery charges against Mildred V. Jackson, 51, a veteran state worker who was in charge of processing applications from doctors seeking to enroll in the program.

Ms. Jackson, an office technician in the Department of Health Services, was accused of accepting $1,000 bribes on six occasions in return for expediting applications so doctors would not have to wait the normal 30 days before submitting claims. Medi-Cal provides medical services for the poor.

Assistant U.S. Attorney Daniel Lindhardt said Ms. Jackson's actions allowed the doctors to file false claims much sooner than they could have if she had followed normal procedures.

Mr. Linhardt said several other government employees are under investigation and he expects to file charges in those cases in the next few months. During the last year, the U.S. Attorney's Office has filed criminal charges against more than 90 people as part of its probe of fraud in the $18-billion Medi-Cal program.

Nearly all the cases have been centered in Los Angeles, where medical equipment providers, pharmacies and blood laboratories have been accused of submitting hundreds of millions of dollars in false claims.

In most instances, they were accused of billing for supplies or services that were never provided. FBI officials expect to uncover more than $1 billion in fraudulent billings by the time the investigation is completed.

—*Los Angeles Times*, April 5

California to begin nursing home crackdown through surprise inspections, enforcing laws

LOS ANGELES—In a move to prevent abuse and neglect of California's elderly, officials announced in late March the creation of a multi-agency effort to conduct surprise inspections in the state's 1,500 nursing homes.

Named "Operation Guardians," the program will first target Los Angeles, where the General Accounting Office and congressional investigators recently reported serious problems. The investigation will later expand to San Francisco and San Diego.

Inspections, which supplement routine checks every 15 months, will focus on nursing homes with the worst records, state Attorney General Bill Lockyer and City Attorney James K. Hahn said. Felonies, misdemeanors and civil citations will be vigorously enforced, officials said. Nearly one-third of California nursing homes caring for Medicare/Medicaid patients were cited for serious care violations, according to a 1998 General Accounting Office report that reviewed federal and state data from 1995 through 1998.

A congressional report issued last November found less than 3% of the 439 nursing homes serving 34,000 Los Angeles County residents were in full or substantial compliance with federal standards during the most recent annual

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inspections. Almost one in five nursing homes had violations that caused actual harm to residents or placed them at risk of death or serious injury.

—*Los Angeles Times*, March 28

State HMOs could force public hospitals, clinics to close or reduce services

WASHINGTON, DC—Public hospitals and clinics serving the poor are cutting back on services and struggling to survive as they lose patients to HMOs and take on more of the uninsured, said a panel of health experts that recommended spending $2.5 billion during the next five years to keep the facilities afloat.

Many public facilities or safety net providers, which are legally obligated to provide care to people who cannot afford it, started losing money when states began converting Medicaid to managed care to cut costs, inviting health maintenance organizations and other private providers to compete for patients. Medicaid is the biggest source of revenue for many safety net providers and though estimates vary, more than 8 million Americans get basic health care from these providers.

Some hospitals and clinics have joined managed care groups to compete, but reimbursement rates for Medicaid patients under those plans are sometimes less than what it costs to provide care, according to an Institute of Medicine report.

Most safety net providers have been able to survive by cobbling together grants, the report said. Federal officials said more needs to be done to stabilize the safety net.

A $25 million pilot program for consortiums of safety net providers aims to improve coordination of care for the uninsured, said Claude Earle Fox, MD, head of the Health Resources and Services Administration at the Department of Health and Human Services, which commissioned the report. The Clinton administration has asked Congress for $1 billion to expand the program during the next five years.

—*Los Angeles Times*, March 31