State Health Watch

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In This Issue

Continued on page 2

Medicaid enrollment increases as states work with welfare reform

Children fare better than parents

An increase in Medicaid enrollment — seen in a recent survey of 21 states by the Kaiser Commission on Medicaid and the Uninsured in Menlo Park, CA — appears to be primarily the result of states getting used to the changes brought by welfare reform and an easing of the pressures of trying to run two new programs at once.

"The Kaiser numbers are quite credible," says Trish Riley, executive director of the National Academy of State Health Policy in Portland, ME. "Our experience has been more anecdotal, but it is in line with what the Kaiser survey found."

The Kaiser analysis looked at Medicaid enrollment for selected months from June 1997 to June 1999 in 21 states: Arkansas, California, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Massachusetts, Michigan, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, Tennessee, Texas, Utah, and Wisconsin. Those states represent nearly 75% of national Medicaid enrollment.

From June 1997 to June 1998, overall Medicaid enrollment

See Medicaid enrollment on page 2

New Mexico's managed mental health care program under attack by Bazelon Center

Mental health advocates and New Mexico officials are in sharp disagreement over the success of the state's managed care Medicaid program in providing behavioral health services.

The dispute went national March 30 when Washington, DC-based Bazelon Center for Mental Health Law issued a report stating that the behavior health component of New Mexico's Salud! managed care program was so deficient that its Health Care Financing Administration (HCFA) waiver should not be renewed.

The center followed up with an April 24 report outlining what it said were more detailed deficiencies.

Bazelon explained that it based its evaluation on analysis of data gathered by the state. Mental health advocates in New Mexico say they have have asked to see program statistics, but state officials have been unwilling to provide data. The advocates say the Bazelon charges square with anecdotal reports they have received.

Bazelon said it reviewed a Gallup Organization survey of members and providers associated with the three contracted managed care organizations — Lovelace Health Plan, Cimmaron HMO, and Presbyterian

See New Mexico on page 4

Continued from page 1

Fewer poor parents are offered health insurance

A survey by the Center for Studying Health Change shows that the number of low-income parents being offered health insurance through their employers has dropped. In addition, the number of low-income parents accepting coverage when it is available declined, too. . . 6

States get a boost in making retroactive payments

The states that are making retroactive payments to individuals and families improperly terminated from Medicaid rolls are getting backing from the federal government. Federal officials emphasized that states have a continuing obligation to provide Medicaid to everyone who has not been properly determined ineligible for Medicaid. 7

Feds need more outcomes measurements

A lack of clinical outcomes data and other statistical information often blocks efforts to answer questions about the value of Medicaid managed mental health services, a report from the Department of Health and Human Services says. The report recommends that the Health Care Financing Administration develop measurement systems that can be used as a condition of waiver approval 9

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

Arizona	pp. 1, 9	New Jersey	p. 1
California	pp. 1, 6, 10	New Mexico	p. 1
Colorado	p. 9	New York	p. 1
Florida	p. 1	North Carolina	pp. 1, 9
Georgia	p. 1	Ohio	p. 1
Illinois	p. 1	Oklahoma	p. 1
Indiana	p. 1	Pennsylvania	p. 1
Iowa	pp. 1, 9	Tennessee	pp. 1, 4
Kansas	p. 1	Texas	pp. 1, 6
Massachusetts	pp. 1, 9	Utah	p. 9
Michigan	pp. 1, 11	Washington	p. 9
Minnesota	p. 6	Wisconsin	p. 1

Medicaid enrollment

Continued from page 1

decreased 2.7% in the 21 states, a decline of some 620,000 individuals. But from June 1998 to June 1999, total enrollment increased by 1.4%, or 320,000 people, with more than half of the states showing an upturn in enrollment. Despite the progress, net total enrollment over the two-year period declined in the 21 states by 1.3%.

A study recently released by the Urban Institute, which used 1997 data, confirmed the downward trend that year. Those data suggested that some people leaving welfare were unintentionally and inappropriately dropped from Medicaid, says John Holahan, director of the Urban Institute Health Policy Center in Washington, DC. Federal law guarantees at least six months and up to 12 months of Medicaid coverage to those who leave welfare because of increased earnings. And state provisions allow even longer Medicaid eligibility for many.

But according to the Urban Institute's National Survey of American Families, slightly more than half the women who left welfare were still on Medicaid or other state health insurance in the first six months after leaving, and one-third had no health insurance at all. By the time they had been off welfare for a year or more, less than one-quarter of the women were receiving Medicaid benefits and about one-half were without health insurance.

"I don't think it was intentional that states missed transitional people [from welfare reform]. A lot of what happened was a real 'oops.' New programs create chaos and confusion, and it takes some time for things to settle down."

Trish Riley

Executive Director
National Academy of State Health Policy
Portland, ME

Children appear to fare better than their parents because they are more likely to be eligible for Medicaid coverage than their mothers, the report says. Of the children whose families left Medicare, almost 75% were still on Medicaid and only 20% lacked health insurance

six months later. However, of the children whose families were off welfare for a year or more, less than half had Medicaid coverage and one-third were uninsured.

The 1997 decline was "partly due to the fact that people get Medicaid through the welfare offices, and with welfare reform, states tried to divert people," Mr. Holahan says. "It took states a while to understand what was happening. Now they're starting to take steps [to restore people to the rolls]."

Major contributing factors

Previous Kaiser Commission studies have identified changes in immigration policy and high employment rates as the major factors contributing to the Medicaid enrollment decline along with welfare reform.

"I don't think it was intentional that states missed transitional people [from welfare reform]," Ms. Riley says. "A lot of what happened was a real 'oops.' New programs create chaos and confusion, and it takes some time for things to settle down."

While all states surveyed, except Arkansas, Massachusetts, and Oklahoma, experienced an enrollment decrease between June 1997 and June 1999, 12 states showed an increase between 1998 and 1999. Indiana led the states with nearly a 23% increase from June 1998 to June 1999. Despite that positive trend, enrollment continued to decline in nine of the states studied: Iowa, Michigan, New Jersey, New York, Ohio, Pennsylvania, Texas, Utah, and Wisconsin.

Vernon Smith, principal of Health Management Associates in Naples, FL, who conducted the survey for the Kaiser Commission, says the numbers give an early indication of the relationship between Medicaid and the Children's Health Insurance Program (CHIP).

When Congress enacted CHIP in 1997, states were given the option to expand their Medicaid program, create a separate CHIP program, or do both. Of the 21 states included in this study, 14 had implemented a Medicaid expansion program by June 1999 (including five states that also created a separate CHIP program). The remaining six states only implemented separate CHIP programs.

The effects of CHIP

From December 1998 to June 1999, Medicaid enrollment increased by 216,900 people. Increases in Medicaid-expansion CHIP programs accounted for 28% of the total, while enrollment in the regular Medicaid program was 72%.

"The implementation of CHIP programs, often accompanied by substantial outreach, appears to be contributing to the identification and enrollment of children and families eligible for Medicaid," Mr. Smith says.

Ms. Riley says that while Medicaid enrollment may have reversed its downward trend, it's hard to predict where it will go from here.

"There are problems with enrollment and retention," she says, "and we're likely to see some dips and changes as the economy dips and changes. We'll also see movement back and forth between Medicaid and CHIP."

[Contact Mr. Holahan at (202) 833-7200, Ms. Riley at (207) 874-6524, and Mr. Smith at (517) 482-9236.] ■

Families USA says welfare reform stripped 675,000 people of their Medicaid coverage

Using "Census Bureau Current Population Study" data, Families USA in Washington, DC, says some 675,000 people — 62% of them children — lost Medicaid coverage and became uninsured by 1997 due to welfare reform. Most of the children were, in all likelihood, still eligible for coverage under Medicaid, the advocacy group says.

The survey found that:

- ❒ Children under age 19 were the majority of those who became uninsured as a result of welfare reform.
- ❒ More than half of both children and adults who would have been enrolled in Medicaid if there were no welfare reform were instead uninsured in 1997.
- ❒ Poor people are more likely than those just above the poverty line to become uninsured as a result of welfare reform.
- ❒ Minority children are more likely to become uninsured as a result of welfare reform than are white children.
- ❒ The number of people becoming uninsured as a result of welfare reform is likely to increase considerably in the years following 1997. ■

New Mexico

Continued from page 1

Health Plan — and reviewed an analysis of HMO compliance with state Medicaid regulations compiled by the Independent Peer Review Organization. From its analysis, Bazelon raised five broad concerns:

1. lack of access to behavioral health services;
2. excessive administrative costs;
3. inadequate grievances/appeals/denial of care;
4. lack of key data to monitor;
5. low Early and Periodic Screening, Diagnosis, and Treatment rates.

The Gallup poll of providers found that 56% of behavioral health specialists reported that Salud! members were worse off than they had been under the previous fee-for-service program. That's twice as high as the report from primary care providers and all specialists. Only 6% of behavioral health specialists said Salud! members were better off now. Concerns also were raised about a growing scarcity of services, providers either withdrawing from participation in the program or actually moving from the state, and a lack of inpatient beds.

Bazelon also cited a report from the William H. Mercer auditing firm that said the state's unusual, multitiered administrative structure involving regional entities, health plans, and subcontractors was eating up 51 cents of every dollar, only leaving 49 cents to pay for services to clients. The organization said that under fee-for-service plans, 67 cents of each dollar went to providing services.

"New Mexico is one of only two states that put all the Medicaid population in its waiver from the beginning, including those with high and special health needs," says Bazelon policy research analyst Rafael Semansky. The other state is Tennessee. "Other states tended to roll the more difficult cases in later, after the administration, provider, infrastructure, and other problems had been worked out. New Mexico moved quickly into Medicaid managed care. The issue seems to be an unusual structure with several administrative levels."

Sally Moore, project director for the New Mexico chapter of the National Alliance for the Mentally Ill (NAMI), says advocates have asked for data but have not seen any until the Bazelon report came out. "Many of the concerns Bazelon talks about are supported by anecdotal comments we've received," she says. "Case services are cut back when people are functioning well, and there is no offer of case management for those who are released from the hospital. If what the reports say is true, changes are needed in the program because the intent of Medicaid managed care is to help health care, not decimate it."

Too fast and furious

Ms. Moore agrees with Mr. Semansky's analysis that part of the problem stems from the speed of the state's implementation. "It was done very fast. All provider input was ignored. The advocates were ignored. They tried to do too much too fast without learning from the experience as they went along. New Mexico historically has had a poor mental health system, with money going to residential treatment and other tertiary care and no investment in a continuum of care. Salud! cut back on the residential services but still is not providing the continuum."

Pat Tyrell is the executive director for the National Association of Social Workers, New Mexico chapter. Mr. Tyrell's group participates with other providers in the Coalition for Effective Mental Health Care. Each time the coalition meets, he hears stories of providers not being paid or having difficulty obtaining a higher level of treatment for individuals who need it, he adds.

"Bazelon has connected the dots for us," Mr. Tyrell says. "I'm not surprised at anything that came out. We've seen a reduction in services and providers choosing not to participate or leaving the state. Before Salud! there were 600 residential beds for kids. Now there are 150. It's hard to tell whether there were too many beds before, but we know there are people complaining now that there are long delays in finding an available bed. The test is to compare the quality of mental health services today to the Jan. 1, 1997, start of the program, and all the indicators are negative. Salud! is one of the biggest state contracts ever awarded, and we can't afford a poorly designed system that is not delivering services to clients."

State officials contacted by New Mexico media when the Bazelon report first came out expressed resentment over an out-of-state organization becoming involved and questioned the credibility of the Bazelon analysis without specifically responding to the charges.

New Mexico Human Services Department deputy secretary Barry Bitzer tells *State Health Watch* that the issue of overhead expense has been hard to address. Under managed care, there are costs — information and outreach brochures, educational materials, utilization review and management, and quality control oversight and reporting — that were not a significant part of the former fee-for-service program.

"At any rate, our most recent analysis demonstrates that more than 80% of funding attributable to behavioral health for the year ending June 30, 1999, entered the door at the direct service provider level," he says.

Mr. Bitzer says mistakes in the Bazelon report, such as misidentifying the plan a subcontractor works for, challenge the quality and veracity of

the work as a whole. And he charges that Bazelon has failed to give the state credit for changes it has made.

"Where this Bazelon outfit has been correct, they nonetheless have been less than forthcoming. They cited a report that 'it was acknowledged that there were still problems collecting useful encounter data from the MCOs . . . [and] without useful encounter data, we do not believe the state can adequately monitor the Salud! program,'" he says. "But they ignored the fact that, per our response in that report, we agreed with the finding and had taken steps to alleviate the problem through the use of sanctions in the MCO contracts. In fact, now we do have encounter data that we have publicly announced are available for inspection. [Bazelon] has never come here to review, nor have they requested a copy."

Mr. Bitzer says that while he questions Bazelon's role, "If any bona fide New Mexico advocate wants good answers, I'm always 100% accessible by phone and e-mail. I've published my direct dial number in Albuquerque and Santa Fe papers, and it is printed on my business card."

It's unclear how the controversy will be resolved. Mr. Tyrell says that since the program is a major part of Gov. Gary Johnson's privatization efforts, it is becoming a political issue that may not be resolved until there is a new administration. He also talks about using the courts to find a solution, questioning whether the program is meeting federal standards. Ms. Moore says she hopes HCFA will take a hard look at the data and the Bazelon analysis and determine where the truth lies.

She says NAMI is considering taking its concerns to the federal agency. Meanwhile, Mr. Bitzer says that he believes the state has a "constructive working relationship [with HCFA] and that we will reach a satisfactory conclusion." ■

States vary widely in percentage and composition of uninsured

While much attention is paid to the problems of children without health insurance, there is a higher rate of uninsured adults whose problems do not get nearly as much notice.

According to a recent Urban Institute analysis of 1997 National Survey of America's Families data, 17% of adults lacked health insurance that year, compared with 12% of children. There were 27 million uninsured adults, nearly three times as many as uninsured children. The Urban Institute is based in Washington, DC.

Of those with incomes below the federal poverty level, 42% of adults lacked health insurance, compared with 21% of children. Of those with incomes between 100% and 199% of the federal poverty level, 34% of adults lacked insurance vs. 21% of children. The Urban Institute policy brief breaks out the adult uninsured population by a variety of demographic characteristics:

• Income and family type. Compared with adults without children, those with children are more likely to be covered by Medicaid and less likely to have employer-sponsored or private, nongroup coverage. As income rises, public coverage is replaced by private coverage, and the number of those who are uninsured declines. A noticeable shift in employer-sponsored coverage occurs at the poverty level, below which only 22% of all adults report employer-provided coverage, compared with 47% of those living in families with incomes between 100% and 199% of the poverty level.

• Age. Adults between the ages of 18 and 34, particularly males, have a higher uninsurance rate (47%) than older age groups. Females in that age group have an uninsurance rate of 38%. The institute report says the lower rate for females is primarily due to the greater likelihood of Medicaid coverage. Older adults ages 55 to 64 are only a small segment of the uninsured. Low-income adults ages 55 to 64 are uninsured at a rate of 23% but account for only 8% of the low-income uninsured population and 5% of all uninsured.

• Race/ethnicity. The Urban Institute says there is a strong relationship between race/ethnicity and lack of health insurance among low-income adults and adults in general. Of low-income white non-Hispanics, 31% are uninsured, accounting for 50% of the low-income uninsured and 31% of the entire uninsured population. Black non-Hispanics have a 34% uninsurance rate, accounting for 16% of the low-income uninsured. The highest rate of uninsurance, 53%, is among low-income Hispanics, who account for 29% of the low-income uninsured and 19% of the total uninsured population.

• Family structure. The likelihood of being uninsured does not vary greatly by family structure for low-income adults. Because they have more public coverage, low-income single parents have the lowest uninsurance rate of the four groups at 33%. Low-income single adults without children have an uninsurance rate of 40%, accounting for 25% of all uninsured adults.

• Work status. The data show that most of the uninsured are in families with at least one full-time worker. Among those with incomes below 200% of the federal poverty level, 39% of families with a full-time worker are uninsured, and those with

two or more full-time workers are uninsured at a 37% rate. Low-income adults in families with at least one full-time worker accounted for 65% of the low-income uninsured and 41% of the total uninsured population. By contrast, low-income adults in families with no workers accounted for only 21% of the low-income uninsured and 13% of the uninsured population totally.

• Health status. Those reporting excellent or very good health status have a lower rate of noninsurance (32%) than those who said they were in good, fair, or poor health (41%). The Urban Institute says this is surprising since those in fair or poor health could be assumed to be more willing to pay for coverage.

• Access to care. Even after controlling for a number of factors that might affect health care access and utilization, there is a strong relationship between the lack of health insurance and various measures of access. For instance, the uninsured are more than twice as likely to say they don't have a usual source of care (even including a hospital emergency department) and to lack confidence in their ability to access health care services. In addition, the uninsured are significantly more likely to be in fair or poor health, to have unmet needs for medical care or surgery, not to have had a physician or other health professional visit, and to lack satisfaction in quality of care received. The Urban Institute says these data show that good health or lack of a need to access health care services are not the reasons why low-income adults lack health insurance and run counter to the perception that the uninsured are able to obtain needed health care.

• Variation across states. The noninsurance rate among low-income adults varies considerably across states, the survey data show.

The proportion of uninsured adults ranged in 1997 from a low of 21% in Minnesota to highs of 44% in California and 50% in Texas. In general, the Urban Institute says, there is an inverse relationship between employer-sponsored coverage and the uninsured rate in each state. Also, coverage by Medicaid and state programs also clearly matters. For example, Minnesota has an above-average, 44% employer-sponsored coverage and 23% Medicaid/state coverage, resulting in a low rate of uninsurance among low-income adults. At the other end, Texas has below-average rates of employer-sponsored and Medicaid/state coverage (32% and 11%), leading to a high uninsurance rate. ■

Fewer poor parents are offered health insurance

Survey data of families and individuals from 1996-97 and 1998-99 indicate that fewer low-income parents are being offered health insurance coverage through their employers and that fewer are accepting the coverage when it is offered. Analysts from the Center for Studying Health Change in Washington, DC, say the reason for the drop in employer-sponsored health coverage is unclear, but it is not that fewer low-income people are employed.

Left unanswered by the survey data is the key public policy question of whether the decrease in private insurance coverage resulted from expanded eligibility for public programs (substituting public for private coverage) or whether it occurred independently of the expansion of public programs.

"If the decrease in private insurance was largely due to substitution of public for private insurance, it would suggest that public coverage expansions have benefited primarily children who already had private insurance by providing them with a lower-cost alternative," the center's report says. "This explanation would also imply that the public dollars required to reduce the number of uninsured children through these programs are considerably higher than expected."

If the decrease in public coverage occurred independently of public program expansion, it would imply that expansion of public coverage provides an important safety net to many low-income children whose parents no longer can afford private insurance coverage.

Center analysts say that some amount of substitution of public for private coverage is to be expected in any type of incremental health insurance expansion that targets the uninsured. Because Children's Health Insurance Program implementation was still in its early stages during the survey, it's too early for a substantial amount of substitution to have taken place, especially given the fact that the vast majority of new enrollees in Medicaid and other state coverage previously were uninsured, the analysts say.

The center says that financial pressures on low-income families steer them to dropping employer coverage independently of public coverage expansion. These financial pressures are likely to increase as the cost of living goes up along with health insurance premium costs.

"This will make it even more difficult to determine in the future whether the primary effect of public coverage expansion is to draw low-income persons away from private coverage, or whether these programs act as a safety net for families who no longer can afford private insurance," the report states.

The report's authors expressed disappointment at the data indicating a reciprocal decline in private coverage along with an increase in public coverage, yielding no net change in the overall percentage who are uninsured.

"We were expecting to see some gains in public coverage for low-income children given recent expansions," says Peter J. Cunningham, senior researcher with the Center for Studying Health System Change and the study's author. "Perhaps the most troubling trend is the increase in uninsurance for low-income parents who, unlike their children, do not have access to public programs."

[Contact Mr. Cunningham at (202) 554-7549.] ■

Medicaid will help pay medical expenses for improperly terminated beneficiaries

States that make retroactive payments for health services received by individuals and families who were improperly terminated from Medicaid can receive federal help with the payments.

Medicaid director Timothy Westmoreland says federal financial participation (FFP) money will be available for state payments even to people for out-of-pocket payments for services that would have been covered by Medicaid had the individual not been terminated.

A long way to go

FFP, in direct payments, will be based on the full payment amount, Mr. Westmoreland says. FFP in payments to participating Medicaid providers will be at the Medicaid rate.

Announcement of the federal aid for retroactive payments was included in an April 7 letter from Mr. Westmoreland to state Medicaid directors outlining requirements states must follow to identify individuals and families who were improperly terminated, to reinstate them to Medicaid, and then re-determine Medicaid eligibility.

While states have made great progress in recent years in increasing access to health care coverage for low-income working families, there's still a long way to go, Mr. Westmoreland says.

"At the same time that states have made expansion of coverage a priority, instances in which eligible children and parents have lost out on coverage have come to light," he says.

In particular, the detachment of Medicaid from cash assistance has made it possible for states to offer low-income families health care coverage regardless of whether the family is receiving welfare, but it has created challenges as well as opportunities for states, Mr. Westmoreland explains.

"We are concerned that some families who left the Temporary Assistance for Needy Families [TANF] program and who remain eligible for Medicaid or Transitional Medical Assistance [TMA] benefits may have lost coverage. In addition, it appears that some children who became ineligible for Supplemental Security Income [SSI] benefits due to a change in the SSI disability rules may not have been continued on Medicaid despite congressionally mandated requirements," the letter says.

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>
> Timothy Westmoreland
> *Director*
> *Federal Medicaid Program*
> *Baltimore*

Mr. Westmoreland says states have a continuing obligation to provide Medicaid to everyone who has not been properly determined ineligible for Medicaid. That includes people whose Medicaid coverage was terminated through computer error or without a proper re-determination of eligibility.

Mr. Westmoreland says states should follow these procedures:

1. Determine whether individuals and families lost Medicaid coverage when their TANF case was closed, or when their TMA coverage period ended without a proper notice or without a proper Medicaid determination, including an ex parte review.

States must see particularly if their computer system improperly terminated Medicaid coverage when TANF benefits were terminated and should consider whether families whose TANF termination was due to earnings were evaluated with respect to ongoing Medicaid eligibility, including TMA.

2. Identify and reinstate children who became ineligible for SSI due to the 1996 change in the SSI disability rules and then were terminated from Medicaid either without adequate consideration of their eligibility under Section 4913 of the Balanced Budge Act of 1997 or without a proper re-determination, including an ex parte review.

States are to compare the Social Security Administration list of children whose Medicaid eligibility was protected by Section 4913 and determine which, if any, of the children are not currently receiving Medicaid or are receiving Medicaid but are not identified as a Section 4913 child.

3. Consider identifying and enrolling eligible individuals applying for Medicaid and TANF who may have been denied Medicaid improperly because eligibility determinations continued to be linked.

4. Develop a timetable for reinstating coverage and conducting follow-up eligibility reviews as appropriate if the statewide examination of enrollment policies and practices indicates there have been improper terminations since the TANF plan went into effect.

Coverage should be reinstated as quickly as possible. States that find that problems in policy or practice caused individuals to lose Medicaid improperly may reinstate coverage without making a specific finding that an individual termination was improper.

FFP is available for up to 120 days of coverage after reinstatement, pending a redetermination of ongoing eligibility, regardless of the re-determination outcome.

5. Make active outreach efforts to identify and contact individuals and families who have not been in contact with the Medicaid agency in some time.

Possible steps include checking food stamp records for current addresses, alerting caseworkers to refer individuals who are in touch with the agency for other reasons, sending notices to families receiving child care services, and broadcasting public service announcements.

6. Re-determine eligibility after reinstatement to assess whether the individual or family still is eligible for Medicaid.

Individuals and families whose most recent Medicaid eligibility determination or re-determination occurred less than 12 months before reinstatement may be continued on Medicaid until 12 months from the date of the last eligibility review, without any new re-determination of eligibility.

[Contact Mr. Westmoreland at (410) 786-3870.] ■

Modify computer systems to reduce eligibility errors

If states have not properly modified their computerized eligibility systems in response to changes in eligibility rules affecting cash assistance and Medicaid, some applicants may be erroneously denied Medicaid enrollment, says federal Medicaid director Timothy Westmoreland. Also, some beneficiaries may lose coverage even if they are still eligible.

Federal law requires states to ensure that their computer systems are not improperly denying enrollment in, or terminating clients from, Medicaid.

In his April 7 letter to state Medicaid directors regarding identifying and reinstating those who were improperly dropped from Medicaid, Mr. Westmoreland makes clear that the need to use resources for Y2K programming changes is not a satisfactory reason for not promptly reprogramming for de-linking.

"States have an obligation to move expeditiously to correct computer programming problems that are leading to erroneous Medicaid denials and terminations," he says. "In the meantime, no person should be denied Medicaid inappropriately due to computer error, and no person should have his or her Medicaid coverage terminated erroneously due to computer error. Once a problem with a state's computerized eligibility system has been identified, the state must take immediate action to correct the problem. If programming changes cannot be made immediately, an interim system to override computer errors must be put in place to ensure that eligible individuals are not denied or losing Medicaid."

Based on reports from various states, Mr. Westmoreland says that the most direct way to fix the problem is to make the necessary programming changes as quickly as possible. While programming changes are being made, states must still ensure that improper adjudications don't occur.

These are four approaches states have used:

1. Assign supervisors to review all Temporary Assistance for Needy Families (TANF) case closures before any Medicaid termination can proceed.

2. Assign local supervisors and a state-level task force the responsibility for reviewing all Medicaid denials and terminations that coincide with a TANF denial or termination.

3. Give cases to be terminated a next-day audit by caseworkers and managers, reinstating cases that continue to be eligible for Medicaid before they are scheduled to be closed.

4. Put a short-term hold on Medicaid case closings based on certain computer codes pending implementation of other solutions.

Mr. Westmoreland reminds states that prior HCFA authorization is required for them to receive federal matching funds for changes in their computer systems. Federal funding is available from computer modifications related to de-linking.

[Contact Mr. Westmoreland at (410) 786-3870.] ■

Mental health programs need outcomes measures

A report by the Department of Health and Human Services Office of the Inspector General (OIG) said efforts to answer questions about the value of Medicaid managed mental health services are hampered by the lack of clinical outcomes data and other statistical information.

The report recommended the Health Care Financing Administration (HCFA) work with the Substance Abuse and Mental Health Services Administration "to develop outcome measurement systems that can be used as a condition of waiver approval."

HCFA said it disagrees with the recommendation because no reliable and cost-effective outcome measurement system currently exists and requiring states to develop such a system will stall the waiver process.

But the National Alliance for the Mentally Ill in Arlington, VA, says the recommendation mirrors its view that outcome measurement is a necessity.

The OIG studied Medicaid managed health care programs in seven states — Arizona, Colorado, Iowa, Massachusetts, North Carolina, Utah, and Washington — to take an early look at the changes that mandatory managed care has had on state Medicaid mental health services for people with serious mental illness. Five of the states had been under a mandatory mental health managed care program for at least three years as of April 1997. Iowa and Colorado were chosen by HCFA because of their innovative programs.

Managed care has allowed state officials to offer more specialized and creative outpatient services, and overall use of mental health services has increased, the OIG found. Costs have been reduced by setting limits for mental health costs in managed care contracts and by shifting care from inpatient to outpatient settings. Cost savings often are returned to a state's general fund or used to expand services to those ineligible for Medicaid and help fund managed care administration.

Among new services documented by the OIG in the states studied were group home residential services, vocational services, respite care services, in-home programs, club house/day services, personal services, and evaluation and treatment centers.

"State officials cited the flexibility to provide [such] services . . . as one key advantage of managed care over their previous fee-for-service system," the report stated. "They said that such services generally would not have been offered by states

OIG's Recommendations for State Medicaid Mental Health Programs

In addition to the three core recommendations for state Medicaid managed mental health programs, the Office of the Inspector General (OIG) also made recommendations to address specific issues in moving from fee for service to managed care. As of July 1998, 36 states had implemented mandatory Medicaid mental health managed care programs.

The OIG recommended that states starting mental health programs take the following steps:

- ✔ Separate mental health services from other health services.
- ✔ Phase in the conversion.
- ✔ Exclude the pharmacy formulary from managed care.
- ✔ Use the existing public mental health system.
- ✔ Keep contract language specific.

As programs transition from fee for service to managed care, they should:

- ✔ Provide community education early and often.
- ✔ Involve beneficiaries in the conversion process.
- ✔ Involve beneficiaries and their families in treatment planning.
- ✔ Ensure timely payment of providers.

Access to care can be improved by:

- ✔ eliminating copayments;
- ✔ assigning health care coordinators;
- ✔ allowing any accredited provider to participate;
- ✔ encouraging liberal prior authorization policies;
- ✔ initiating outreach programs;
- ✔ developing rural services;
- ✔ initially sharing financial risk to encourage development of services.

The OIG's recommendations for children's mental health are:

- ✔ Specify services for children's mental health in managed care contracts.
- ✔ Develop interagency agreements to promote coordination. ■

under fee-for-service [programs]."

The report also cited innovative steps that could be taken when more flexibility is available, including providing residential telephone service for a beneficiary in an isolated rural area, making it possible for the person to call managed care providers and support networks, reducing costly hospital emergency department visits. In another instance, a plan called for a fence to be built around the home of a beneficiary with serious mental illness, reducing paranoiac episodes to the point that the individual could remain employed in the community and remain out of the hospital.

Four of the seven states documented increased overall use of mental health services due to the conversion to managed care and its shift of focus to community-based outpatient programs.

"While states reported decreased use of inpatient care, they reported larger increases of outpatient care. Importantly, several states noted that the time beneficiaries had to wait to receive services was less under managed care than it was under their prior fee-for-service plan," the report stated.

Plans reported that costs remained stable or were reduced as a result of contracting with managed care organizations for mental health services under capitated arrangements. Some states set the contracted capitation rate lower than the anticipated fee-for-service rate, while others allowed the contracted rate to match the expected fee-for-service rate. All seven claimed dramatic declines in inpatient costs by shifting the emphasis to outpatient programs and by reducing length of stay for those still hospitalized.

However, the report noted that psychiatric hospital readmission rates were generally higher under managed care, and stakeholders expressed concern that too many hospital beds are being eliminated from the system too quickly. Stakeholders also are concerned about the reduction in length of stay, fearing that the higher readmission rates mean that people are being discharged too soon.

The ultimate question is whether managed care is improving the health of persons with serious mental illness, and the OIG found that question can't be answered because "none of the states included in our study had working outcome measures in place before or after they converted to managed care. Even basic utilization data, such as lengths of hospital stays, and number of visits, were inconsistently reported by states. Therefore, HCFA and states have no systematic way to determine the impact of managed care on the health of persons with serious mental illness."

"[The recommendations] push the quality envelope by establishing accountability for the outcomes of care. . . ."

Jerome Vaccaro, MD
Vice President
Corporate Medical Director
PacifiCare Behavioral Health
Laguna Hills, CA

The OIG reported that state officials, providers, and stakeholders in all seven states said they believe that overall mental health care has improved, but there is little quantifiable proof. While beneficiary satisfaction surveys and grievance reports exist, they may not be reliable indicators of a program's success, the OIG added.

In addition to calling for development of outcome measures, the OIG report said HCFA should encourage states to establish independent, third-party mental health systems for conducting beneficiary satisfaction surveys, and should ensure that states obtain an 1115 waiver before using savings from managed care operations to expand services to non-Medicaid populations. HCFA disagreed with both of these recommendations, as well.

Clarke Ross, deputy executive director for public policy of the National Alliance for the Mentally Ill, says, "[The group] is extremely pleased with the report. It reflected our advocacy points, especially in calling for independent, third-party systems."

Mr. Ross tells *State Health Watch* that HCFA's disagreement with the OIG recommendations demonstrates that the agency "just wants to get along with the states and not significantly improve state performance in the federal-state partnership in an election year."

Jerome Vaccaro, MD, vice president and corporate medical director for PacifiCare Behavioral Health in Laguna Hills, CA, looks at the OIG report from a provider perspective. "[The recommendations] push the quality envelope by establishing accountability for the outcomes of care; support the transition from uncontrolled fee-for-service systems to managed care, facilitating the development of systems of care and making our fragmented nonsystems a thing of the past; and recognize the importance of behavioral health care."

Both Mr. Ross and Mr. Vaccaro say the call for outcomes measurement is the most important recommendation in the report. PacifiCare has developed a system that not only measures outcomes but improves them, Mr. Vaccaro says. "This is the future of our industry."

[Contact Mr. Ross at (703) 524-7600 and Mr. Vaccaro at (818) 782-1100.] ■

Clip files / Local news from the states

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

State AIDS drug assistance programs growing in clients and costs

WASHINGTON, DC—Despite increases in the national budget for AIDS Drug Assistance Programs (ADAPs) and improved program administration, ADAPs continue to face the challenge of meeting the needs of an increasing client base and high drug costs in an area of rapidly changing treatment standards.

A survey of the nation's ADAPs also found significant variation in these programs across states, and that access to ADAPs is highly dependent upon where one lives. The survey, the fourth in a series, was conducted for the Kaiser Family Foundation in Menlo Park, CA, by the National Alliance of State and Territorial AIDS Directors and the AIDS Treatment Data Network.

"In most states, ADAP programs have been able to fill the gaps in access to prescription drugs for the nation's low-income HIV-infected population. Federal contributions to ADAPs have been growing, but as treatment standards continue to call for newer, more expensive drugs in combination, these programs will continue to be challenged to meet the needs of their clients," said Drew Altman, president of the Kaiser Family Foundation.

Expenditures for antiretroviral drugs have been the main driver of overall expenditure increases, representing almost 90% of all expenditures in June 1999 and increasing 25% since June 1998. Notably, expenditures for drugs for the treatment and prevention of opportunistic infections and for other non-antiretroviral drugs also increased by 21% in this same period.

Findings from the report show that ADAPs continue to serve clients who are largely low-income and uninsured and represent a mix of racial and ethnic population groups. Specifically, the report found:

• 80% of ADAP clients served in June 1999 had incomes at or below 200% of poverty, and almost half had incomes below the poverty level.

• Only 7% of clients in June 1999 were reported also to be Medicaid beneficiaries, and only 7% were reported to have private health insurance that included some level of prescription drug coverage.

• 40% of ADAP clients in June 1999 were white, almost one-third were African American (31%), and one-quarter were Hispanic (25%).

• Uninsured and underinsured people living with HIV face significant variation in access to ADAP. For example, financial eligibility to ADAPs ranges from a low of 125% of the federal poverty level in Georgia and North Carolina, to a high of more than 500% in New York (in 1999, the Federal Poverty Level was $8,240 for an individual).

—Henry J. Kaiser Family Foundation release

Feds claim Medicaid payments for schools being wasted by states, consulting firms

WASHINGTON, DC—Medicaid payments meant for schools that provide counseling, hearing tests, and other health care for poor children are being siphoned off by states and consultants, leaving some schools with a small fraction of their share, congressional auditors say.

The General Accounting Office (GAO) said it found schools in one state ended up with less than a dime for every dollar spent on health care services for poor students.

About 13 million school-age children are eligible for Medicaid, the federal health program for low-income Americans that is funded with state and federal money.

Schools are entitled to federal reimbursements to recover their costs of providing health care for these children. Expenses incurred with enrolling kids in the program and arranging their appointments are also reimbursable. States spent $2.3 billion for school-based health care in the latest years for which data were available, 1998 and 1999, the GAO said in a report released April 5 at a Senate Finance Committee hearing.

Under the advice of private billing companies, schools charged Medicaid for groups of services, not all of which actually were provided to students, auditors said.

The GAO said the arrangements with consultants, made by both states and school districts, are creating "an environment for opportunism that drains funds away from their intended purposes."

Auditors found $28 million in improper payments in Michigan and questioned an additional $33 million in reimbursements. Federal officials acknowledged that there have been problems with the Medicaid reimbursements and said new policies have been initiated to correct them.

—*Los Angeles Times*, April 5

CDC reports U.S. birth rate increasing for first time since 1998

WASHINGTON, DC —The number of births in the United States rose in 1998 for the first time since 1990, according to a report released in late March.

State Health Watch

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"Births: Final for 1998," prepared by the Centers for Disease Control and Prevention's National Center for Health Statistics, shows that 3,941,553 babies were born in 1998, a 2% increase from 1997.

The birth rate (the number of births per 1,000 population) and the fertility rate (the number of births per 1,000 women ages 15 to 44) also increased slightly in 1998. The increase in the number of births was fueled by increases in birth rates for women in their 20s, the principal childbearing ages, and for women in their 30s. According to the report, the birth rate for women in their early 20s (20 to 24) increased in 1998 after falling 6% during the 1990s, and birth rates for women in their 30s are now at their highest levels in at least three decades.

Meanwhile, the overall birth rate for teens ages 15 to 19 dropped 2% in 1998, to 51.5 per 1,000. Overall, the teen birth rate declined by 18% from 1991 to 1998, with all states recording a decline in the birth rate of 15- to 19-year-olds between 1991 and 1998.

Twin births also continued to increase in 1998, rising 6% to 110,670 — the largest single year increase in several decades — and the number of triplets and other higher order multiple births climbed 13% to 7,625. Since 1980, the twin birth rate has risen 49%, and the triplet and other higher order multiple birth rate has risen 423%.

Driven by the growing number of unmarried women of childbearing age (15 to 44 years), the number of births to unmarried women also rose to 1,293,567 in 1998. The percent of all births to unmarried women also increased from 32.4% in 1997 to 32.8% in 1998, while the birth rate for unmarried women increased slightly to 44.3 births per 1,000 unmarried women ages 15 to 44 in 1998. However, the teen out-of-wedlock birth rate dropped again in 1998, to 41.5 births per 1,000 unmarried teens ages 15 to 19, down 11% from its high in 1994.

—"Births: Final Data for 1998," CDC's National Center for Health Statistics