

West Virginia State Health Plan

Financing/Cost Control

I. BACKGROUND

West Virginia has 55 general acute hospitals and 10 specialty psychiatric and rehabilitation hospitals. In total the financial situation of these hospitals is quite good, with revenues exceeding expenses by \$170 million (7%) in 1997. However, 17 of the hospitals lost money in 1997. Bad debts comprise 3.46% of the total gross revenue and charity care an additional 2.64%, for a total of 6.1% in uncompensated care.

The health care financing system is in a state of flux, both in West Virginia and in the United States as a whole. The high level of health care inflation that was experienced from the 1970s through the early 1990s has been brought under control, at least temporarily, partly as a result of the expansion of managed care, i.e., health insurance products in which there is some control over the use of resources (for example, requiring that all nonemergency specialty services and hospital services be approved in advance by a designated primary care provider). The levels of hospital costs and charges in West Virginia compare favorably with those of the neighboring states and the United States. West Virginia has lower cost per inpatient discharge, cost per outpatient visit, and charge per outpatient visit than all the neighboring states and is second only to Maryland in charge per inpatient discharge (see Charts 1 - 4). This cost and charge performance may be due, at least in part, to the effect of the rate setting system in West Virginia, which requires hospitals to justify their costs and charges annually.

The concern about control over costs has been replaced, however, with concerns about the fairness of the payment system, ensuring access to individuals who lack health insurance or have inadequate health insurance, and the preservation of health care providers that act as a "safety net" for the uninsured and underinsured. West Virginia, like other largely rural states, has a low penetration of managed care, but this can be expected to increase over time. In 1997 West Virginia had 12% managed care penetration¹, which was lower than any of the neighboring states and considerably lower than the national figure of 19%. This can be seen clearly in Chart 5. HMO enrollment in the state was 10.6% in 1998, down slightly from 1997. Also, many small employers are unable to obtain health insurance for their employees, and as a result many employees of small businesses are uninsured. West Virginia has a high proportion of its workers employed by small businesses -- of the 39,000 business located in West Virginia, 95% employ fewer than 50 people so this is a particular problem.

¹ Data from the West Virginia Insurance Commission, 1997 Data, Financial Conditions Division.

Chart 1 Gross Charge per Inpatient Discharge

Data from the 1998-99 Almanac of Hospital Financial and Operating Indicators

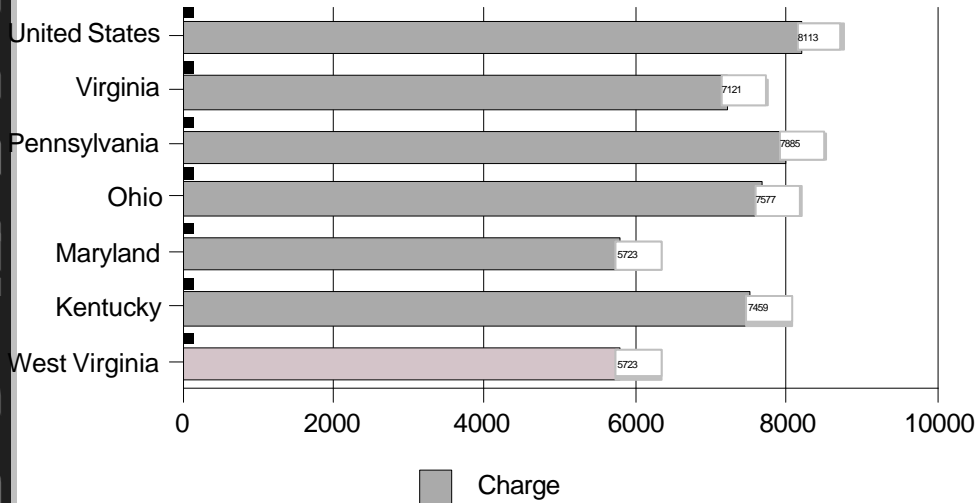


Chart 2 Cost per Inpatient Discharge

Data from the 1998-99 Almanac of Hospital Financial and Operating Indicators

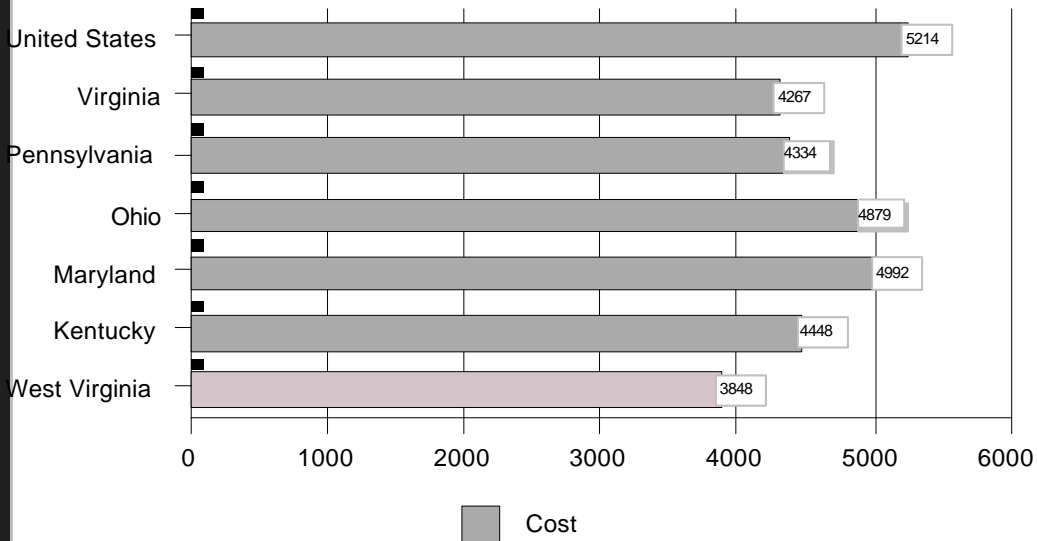


Chart 3

Gross Charge per Outpatient Visit

Data from the 1998-99 Almanac of Hospital Financial and Operating Indicators

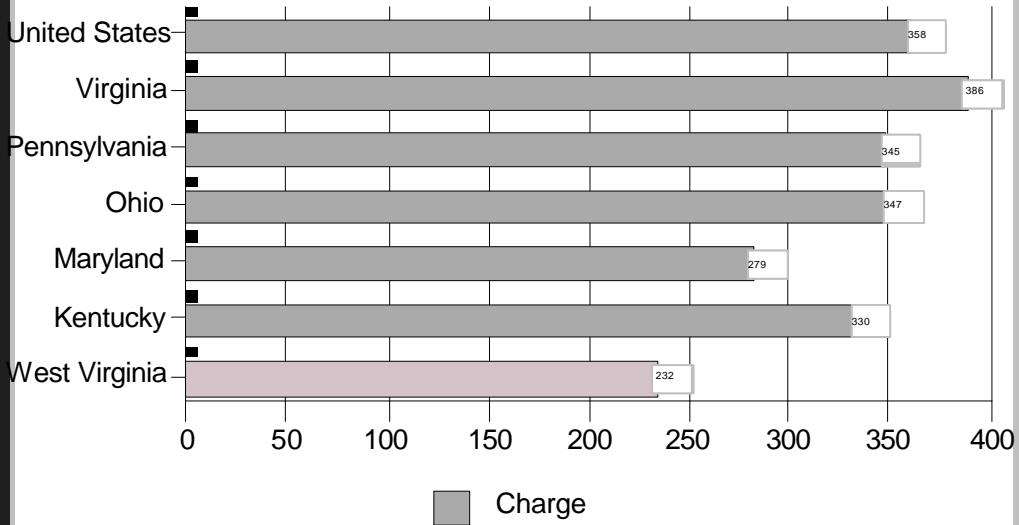
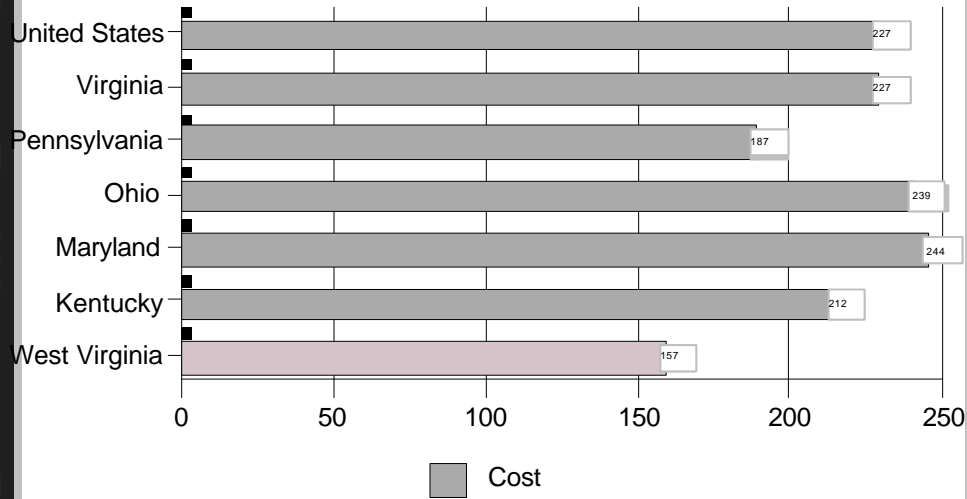


Chart 4

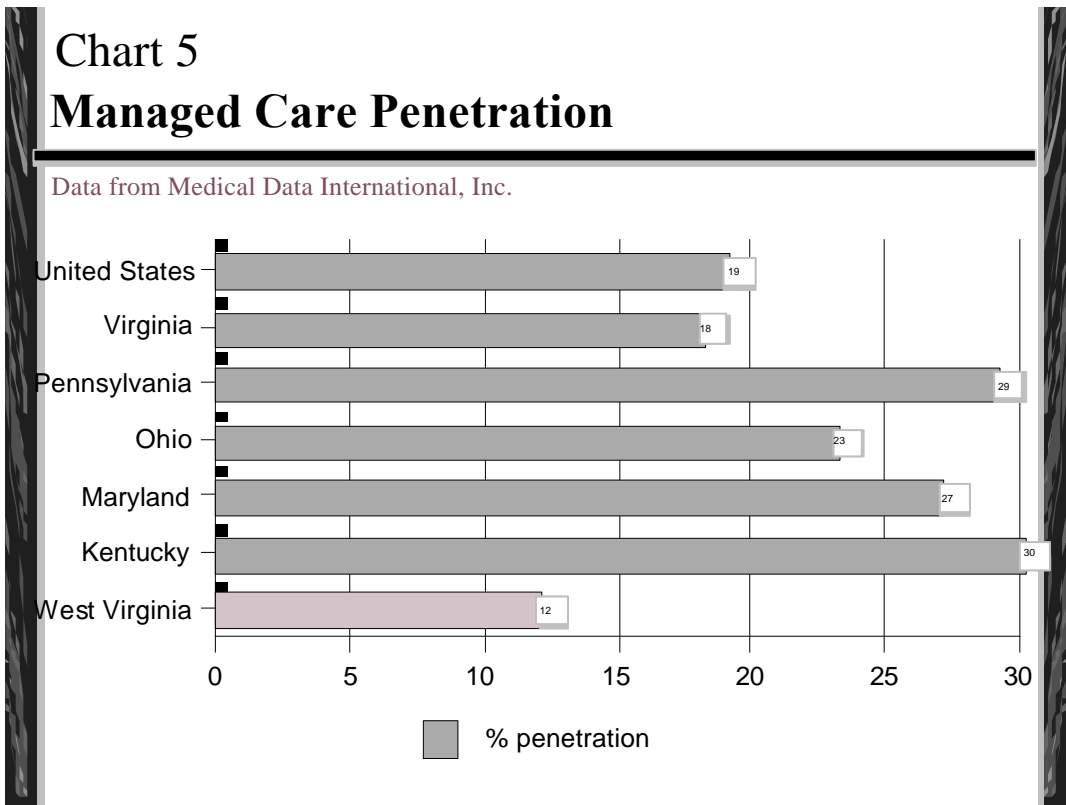
Cost per Outpatient Visit

Data from the 1998-99 Almanac of Hospital Financial and Operating Indicators



The

Medicaid program is a joint state and federal program that pays for health care and long-term care for certain categories of poor individuals, notably families with dependent children, pregnant women, and the elderly. Expansion of this program is a natural way to increase the availability of health insurance to residents of West Virginia as the federal government pays a substantial portion of the costs of care provided to Medicaid beneficiaries, and so state dollars can go farther. Medicaid coverage of the poor in West Virginia is much more sparse than in the United States as a whole. Of the population of West Virginia with incomes below 200% of the federal poverty level (FPL), only 16.8% are enrolled in Medicaid, compared with a national figure of 38.9%. This concern is exacerbated by the fact that West Virginia has a greater proportion of its population below 200% of the FPL, 42.2% compared with a national average of 31.2%².



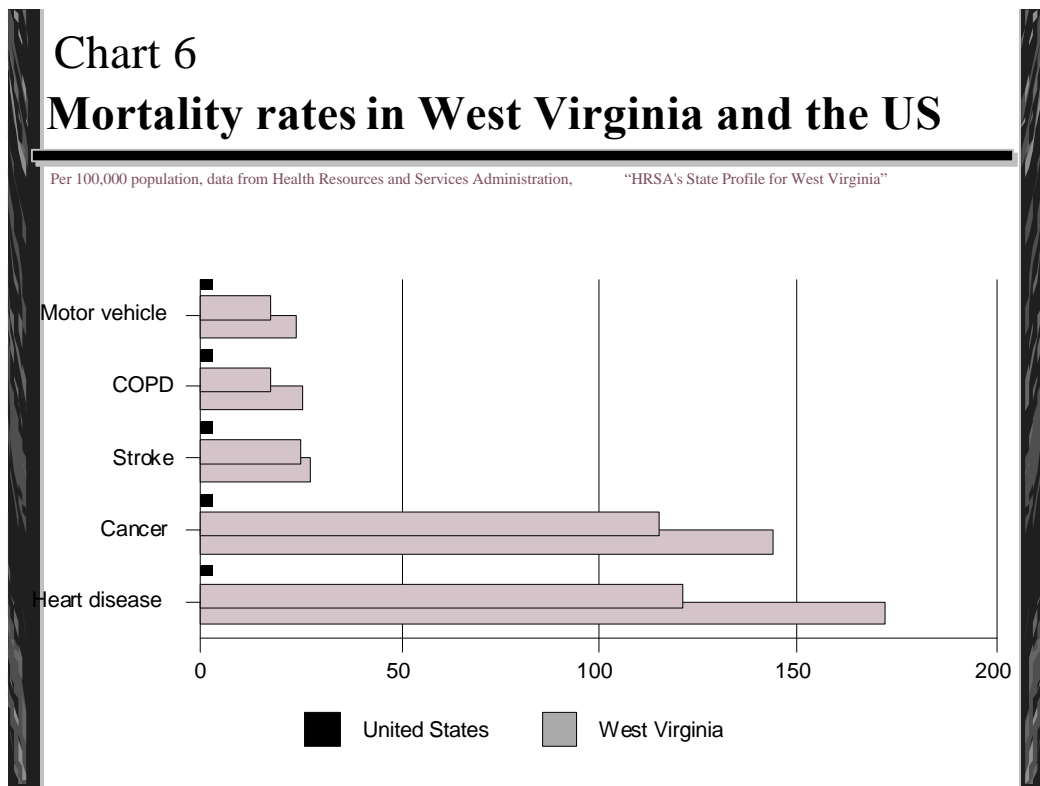
HMO enrollment in the Medicaid program and among other public payers in West Virginia is relatively low, but there are plans for expansion. In 1996 only 5.1% of the Medicaid population of West Virginia was enrolled in managed care, while nationally 38.9% of the Medicaid population was in managed care. Since then the state has implemented a managed care program on a pilot basis. As of June 1999, about 10% of the Medicaid population was enrolled in HMOs and the remainder in the PASS program, under which care is managed by a primary care provider.

The State of West Virginia is provided with a substantial opportunity to improve the health status of its population by judicious use of the funds that will be made available through the “tobacco settlement.”

² The data in this paragraph and the next paragraph are from “HRSA’s State Profile for West Virginia, “ Health Resources and Services Administration, U.S. Department of Health and Human Services.

The tobacco industry has agreed to make substantial payments to many states to recompense them for the Medicaid costs incurred as a result of tobacco-related illnesses. West Virginia is to receive \$57 million in the year 2000, \$61 million in 2001, and similar amounts in subsequent years. Given the source of the funds, it seems natural that a portion of the funds should be used to fund smoking prevention programs, smoking cessation programs, and to pay for some of the costs associated with tobacco-related illnesses. In this context it is worth noting that West Virginia has higher death rates than the nation as a whole in many of the disease categories that are known to be related to smoking: heart disease, cancer, chronic obstructive pulmonary disease, and stroke (Chart 6). The mortality rate from motor vehicle accidents in West Virginia is also substantially higher than the U.S. rate. Many motor vehicle accidents are alcohol related. Increasing the taxes on both alcohol and tobacco would have the double benefits of increasing funds available to the state and discouraging use of these products.

West Virginia has a higher proportion of its population reporting lack of access to a primary care provider (29.5% compared with a national average of 16.3%). Forty counties in West Virginia have been designated as Health Profession Shortage Areas by the federal government, and 49 counties as Medically



Underserved Areas³. Telemedicine involves the provision of medical services remotely, for example, by video link or by means of data or image transfer to a physician or other health professional. It has the potential to increase access to care in remote areas or where there are shortages of health care professionals. West Virginia has had a health care telecommunications network, MDTV, in place for over five years, and there are some other networks that include video-conferencing, but expansion of telemedicine networks has been inhibited by the cost of putting the necessary infrastructure in place and lack of adequate payment for the services.

³ "HRSA's State Profile of West Virginia," Health Resources and Services Administration, U.S. Department of Health and Human Services.

Seven action steps are suggested to improve access, quality of care, and cost containment. These actions steps are discussed in more detail in the balance of this chapter. The issues involved are complicated and not amenable to simple solutions. The approach to resolving them must be multifaceted, trying to break down as many of the barriers to care as possible. Some of the changes to be discussed to solve one problem may actually exacerbate other of the problems, so the entire package of changes is interrelated, with some activities helping to alleviate problems that are inadvertent consequences of other activities.

If some or all of these suggestions are implemented, it will be necessary to monitor and evaluate them, and to determine whether they should be continued, expanded, modified, or terminated. The evaluation of any such program requires that quantitative goals be established to measure whether the changes are having a beneficial impact and, if so, how much of a beneficial impact. It is much easier to evaluate programs if expected results, the data to be collected to evaluate success, and how success will be quantified are defined in advance of implementation. The evaluation can involve both process measures and outcome measures. For each of the potential solutions both process and outcome measures will be suggested, if feasible.

PURCHASING POOLS TO REDUCE THE NUMBER OF UNINSURED

A relatively high percentage of West Virginia's population lacks health insurance. Nationally the number of people without health insurance has been growing steadily over the past decade, and there is no reason to assume that the situation is different in West Virginia. The Urban Institute estimated that, in 1996, 15% to 20% of the non-elderly population of West Virginia lacked health insurance⁴. This is higher than all the neighboring states except Kentucky. Part of the explanation for the increase in the number of uninsured is a decline in the percentage of the non-elderly population with employment-based health insurance coverage. Small employers are less likely to be able to purchase health insurance than larger employers, and a large proportion of West Virginia's working population is employed by small employers.

However, research has shown that the major reason for the decline in health insurance is the increased cost of health insurance relative to personal income^{5,6}. To address this basic problem it is critical to reduce the cost of health insurance. Managed care has been shown to reduce the rate of increase in health care costs, so encouragement of managed care is an obvious strategy, but expansion of managed care raises issues of access for the uninsured, and Medicaid maximization.

Potential solution. States have adopted different approaches to improving the availability of health insurance. Some have specified a standard benefit package and required that insurers offer this package to small businesses. Other states have adopted the approach of providing subsidized insurance to individuals who are unable to afford health insurance. Yet another approach is to form purchasing pools. By forming a pool, purchasers gain more leverage with insurers and reduce the variability in health expenditures. This may be necessary just to make it possible to purchase health insurance and is likely to enable the purchasers to obtain health insurance at a lower cost.

The state has a number of options available on how to set up purchasing pools. The approach can be either private sector or public sector. Adopting a public sector approach, the state can establish and administer the pool itself, possibly in conjunction with the purchase of insurance for state employees, which results in a large pool with a great deal of market influence. An alternative approach is to encourage a private organization to administer the pool. This can be an existing business coalition, the Chamber of Commerce, or an organization set up for the specific purpose of administering the pool. Legislation is likely to be required to enable the pool and to require or encourage participation by insurers. The state may want to adopt a phased-in policy for participation, with voluntary participation by insurers at the start. After one or two years, if participation is not sufficiently broad, then additional requirements could be placed on insurers. If the pool is combined with the state employees, no additional incentives to participate may be required; otherwise, some incentives, or mandatory participation, may be required.

Maryland has adopted the approach of defining a Comprehensive Standard Health Benefit Plan (CSHBP), which is required to have an average premium of no more than 12% of the average annual wage in the

⁴ Urban Institute, unpublished estimates generated using the CPS data.

⁵ Richard Kronick and Todd Gilmer, "Explaining The Decline in Health Insurance Coverage, 1979-1995," *Health Affairs*, Volume 18, No. 2, March/April 1999, 30-47.

⁶ Kenneth E. Thorpe and Curtis S. Florence, "Why Are Workers Uninsured? Employer-Sponsored Health Insurance in 1997," *Health Affairs*, Volume 18, No. 2, March/April 1999, 213-218.

state. Carriers are required to offer this plan in order to do business in the state, and currently 400,000 lives are covered by 55 different carriers.

Recommended action. The state should encourage the establishment of purchasing pools to enable small businesses and self-employed individuals to purchase health insurance. This may be done in cooperation with business coalitions or Chambers of Commerce.

The state should require that insurers offer coverage to the purchasing pools as a condition for participating in the state employees insurance program.

Feasibility and potential barriers. Setting up purchasing pools is very feasible and has been done in other states. The main issue to be addressed is the extent to which the purchasing pools will expand the availability of health insurance coverage at an affordable price. If the price is too high, or the benefit package too limited, the product will have a limited appeal. Also, if participation by insurers is low, or they are allowed to have stringent underwriting criteria for enrollment, there will be a limited enrollment, and those in most need of health insurance will still be unable to obtain it. If participation by insurers is mandated, the insurers will lobby against the pool, or at least against the mandatory participation requirements. Combining the pool with the state employees group would reduce the need to mandate participation but could increase the cost to the state, making it an unattractive option.

Accountability factors/evaluation. The process measure would be whether purchasing pools were actually established. The outcome measures could be (i) the number of people obtaining health insurance through the purchasing pool who did not have health insurance previously and (ii) the change in the number of uninsured, or the proportion of the population remaining uninsured in the state. In evaluating the change in the number of uninsured, it will be necessary to take into account other factors such as the situation of the state's economy, the level of unemployment, and the change in the number and proportion of the population without health insurance in neighboring states.

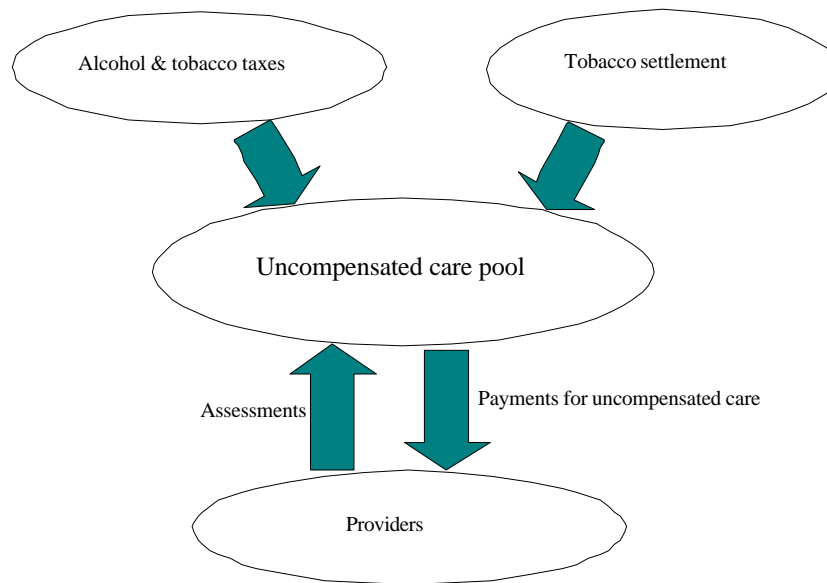
UNCOMPENSATED CARE POOLS

As managed care grows, hospitals with a high level of uncompensated care will be placed at a competitive disadvantage in competing for managed care business. In addition, the number of uninsured is steadily growing, placing financial burdens on providers. This combination of problems may place some providers in financial jeopardy. The development of mechanisms to alleviate this problem can take many months and must involve a broad range of stakeholders.

Even after the efforts discussed in this chapter, there will still be some individuals who do not have health insurance and are unable to pay for their health care. The hospitals serving a large proportion of such patients will be placed at a financial and competitive disadvantage as managed care becomes more prevalent in the state. This may limit their ability to provide uncompensated care. Cunningham⁷ concluded that "efforts to achieve cost savings under managed care may result in financial pressures that limit cross-subsidization of care to the medically indigent, particularly for those providers who are heavily dependent on Medicaid revenue."

⁷ Peter J. Cunningham, "Pressures on Safety Net Access: The Level of Managed Care Penetration and Uninsurance Rate in a Community," *Health Services Research* 34:1, April 1999, Part II, 255-270.

Uncompensated Care Pool: Funds Flow



Potential solutions. The state should establish an uncompensated care pool to pay for hospital (and possibly other health care providers) uncompensated care. The source of funds for this pool could be:

- an assessment on the hospitals (and possibly other health care providers);
- proceeds from the tobacco settlement;
- proceeds from the taxes on alcohol and tobacco discussed earlier, or
- a combination of these sources.

This pool would pay for some or all of the reasonable uncompensated care incurred by the participating providers and so would more evenly distribute the burden of uncompensated care.

Recommended action. To ensure continued access to care for the uninsured and underinsured, the state should establish an uncompensated care pool for hospitals.

Feasibility and potential barriers. The administrative process of setting up an uncompensated care pool is straightforward, and West Virginia could look to other states that have set up such pools for their experience and advice. More difficult to deal with are the political issues that surround the redistribution of funds that occurs with an uncompensated care pool. If the pool is funded by an assessment on the hospitals, the hospitals that are net contributors to the pool are likely to object, particularly if they see the pool going to hospitals they consider to be competitors or hospitals in better financial condition than themselves. Setting the level of the assessment and the thresholds for receiving payments from the pools can be a controversial process and should involve as many of the stakeholders as possible. If the funds come from other sources such as taxes on tobacco and alcohol or the tobacco settlement, either in lieu of or in addition to an assessment on the hospitals, then the level of resistance may be reduced.

In calculating payments from the pool, care must be taken to ensure that providers still have incentives to bill and collect revenue effectively. Some states that established uncompensated care pools with inadequate safeguards found that hospitals reduced their billing and collection efforts knowing that any shortfalls would be made up from the pool.

Accountability factors / evaluation. A process measure of success could be whether an uncompensated care pool was set up, and the level of support it received from the various stakeholders. Outcome measures could be the percentage of uncompensated care paid from the pool, the extent to which the financial condition of hospitals with high rates of uncompensated care was stabilized by the presence of the pool, and improvements in access to health care for individuals lacking health insurance. The measurement of access is rather difficult, but there are some proxy measures available such as the number of hospital admissions for conditions that are sensitive to the availability of good primary and preventive care (“ambulatory sensitive conditions”).

INCENTIVES/DISINCENTIVES TO MANAGED CARE FOR PUBLIC PAYERS

As discussed in the Background section, West Virginia has a low penetration of managed care. The level of managed care penetration can be expected to increase somewhat in the next few years, but managed care has difficulty in achieving substantial market share in rural areas and the largely rural nature of West Virginia will limit that growth. Increased managed care can result in an increase in access problems for the uninsured and in financial problems for safety net providers, as providers are put under increased financial pressure due to lower payment rates from managed care organizations. Also, managed care organizations usually contract with a limited number of providers and their enrollees are shifted to the providers with which they have contracts. Since the growth in managed care is expected to be relatively slow, this is not an immediate problem, but as it will be growing over time, and the development of solutions may take some time, activities to deal with it should be commenced in the near future.

The state has two federal waivers that allow for managed care programs for the Medicaid population. One of these allows the state to require its Medicaid beneficiaries to enroll in HMOs. This program, the Mountain Health Trust, is currently in operation in 15 counties (out of 55 counties in West Virginia), and as of June 1999 they enrolled about 10% of the total Medicaid population. This program will be expanded to another county (Wood County) in July, and the state has federal approval to extend it to another seven counties. Federal approval will soon be requested to expand this program to the remainder of the state, except for the Eastern Panhandle, which may be added once the provisions of the Balanced Budget Act of 1997 are implemented in regulations. West Virginia is also considering a voluntary program for those areas where a federal waiver may not be forthcoming because of a lack of multiple HMOs to provide a choice to beneficiaries. In those areas not covered by the Mountain Health Trust, the state is using a case management approach under another federal waiver (under Section 1915b of the Social Security Act). Under this approach, the PAAS program, primary care providers are paid \$3 per beneficiary per month to manage the care of the Medicaid beneficiaries.

The expansion of Medicaid managed care can work against maximization of federal matching funds and preservation of access. Some of these issues are discussed by Coughlin et al.⁸, who argue that the efforts

⁸ Teresa A. Coughlin et al., “A Conflict of Strategies: Medicaid Managed Care and Medicaid Maximization,” *Health Services Research* 34:1, April 1999, Part III, 281-293.

made by some states to maximize Medicaid revenues may interfere with the cost containment aspects of managed care. Managed care has been slow to develop in West Virginia; in 1995-96 there was no Medicaid or Medicare HMO or prepaid health plan enrollment in West Virginia⁹. However, the state now has Medicaid beneficiaries enrolled in HMOs in 15 counties, with expansion planned to include most of the remaining counties. The Balanced Budget Act of 1997 (BBA) made implementation of Medicaid managed care easier for states by eliminating the need for a federal waiver in some instances and allowing states to offer a single plan in rural areas¹⁰. Nationally HMOs have been slow to move into rural areas, but an alternative managed care approach that appears to be more feasible in rural areas is primary care case management (PCCM). This is a form of managed care in which the provision of care is managed by a primary care provider but without financial risk to the provider, allowing providers without large financial reserves to participate. West Virginia's Medicaid program is using an approach of this type in those counties in which it does not have a Medicaid HMO program; however, the state is having some problems recruiting providers because of the requirement for 24-hour coverage and the low payment rate.

Medicare managed care has also achieved little penetration in rural areas, and the areas in which it has penetrated are usually adjacent to urban areas. Part of the reason for this lack of interest on the part of HMOs was that the Medicare payments rates for rural areas were low and were liable to change dramatically from year to year because of problems with the method used to calculate payment rates (the average annual per capita cost or AAPCC method). There are only two HMOs currently enrolling Medicare beneficiaries in West Virginia, and their enrollments are quite small. The first HMO to enroll Medicare beneficiaries in West Virginia, the Health Plan of the Upper Ohio Valley, is currently based in nine counties and has 1,000 members in its Medicare Choice product and 7,000 in its cost-based contract (to be phased out by December 31, 2002).

The Balanced Budget Act of 1997 changed the calculation of the capitation rates paid by Medicare in an attempt to resolve some of the problems that have discouraged HMOs from enrolling Medicare beneficiaries in rural areas. The changes have already resulted in an increase in the rates that would be paid in many rural counties and have decreased the volatility of these rates from year to year so the payments are now much more predictable¹¹. However, nationally some HMOs are dropping out of the Medicare managed care business due to concerns about the adequacy of the rates and the rate updates, so these changes may still not be sufficient to result in much of an increase in managed care in rural areas. It may be prudent to simply observe the impact of the BBA on Medicare managed care enrollment in West Virginia for a couple of years and be prepared to respond if the enrollment does not increase to an acceptable level. In the process of expanding managed care, support should be provided to local providers and HMOs should be encouraged to contract with small local providers to the extent practical.

Potential solutions. The Medicaid program plans to expand the use of HMOs by the Medicaid population to most of the state. Currently there is Medicaid HMO enrollment in 15 counties, with Wood County to be added in July 1999. The Medicaid program has approval to add an additional seven counties, and a

⁹ Ira Moscovice, Michelle Casey, and Sarah Krein, "Expanding Rural Managed Care: Enrollment Patterns and Prospects," *Health Affairs*, Volume 17, No. 1, January/February 1998, 172-179.

¹⁰ Rebecca T. Slifkin et al., "Medicaid Managed Care Programs in Rural Areas: A Fifty-State Overview," *Health Affairs*, Volume 17, No. 6, November/December 1998, 217-227.

¹¹ The AAPCC system, and the Balanced Budget Act changes and their impact are discussed in: Julie A. Schoenman, "Impact of the BBA on Medicare HMO Payments for Rural Areas," *Health Affairs*, Volume 18, No. 1, January/February 1999, 244-254.

new waiver request would expand the program further. Medicaid is also considering a voluntary program for the balance of the state where there are currently fewer than two available HMOs. The HMOs offering enrollment to Medicare beneficiaries also have expansion plans. The state should observe the growth in the HMO enrollment of the Medicaid and Medicare populations.

PCCM programs have been more successful in penetrating rural areas, but providers may be inhibited from participating by the requirement for 24-hour emergency coverage. This issue can be resolved by the sharing of on-call coverage by a number of providers or by allowing more liberal use of hospital emergency departments when the primary care provider is not available.

Recommended action. West Virginia should monitor the use of managed care by public payers. The use of a PCCM program may be more feasible than achieving substantial HMO penetration in rural areas so thus should be explored. Provided it is compatible with the overall goals of the health care system to improve quality of and access to care, the state should encourage the expansion of managed care for Medicare beneficiaries in West Virginia by encouraging Provider Sponsored Organizations (PSOs) if the changes enacted in the BBA are insufficient to substantially increase Medicare managed care participation. This may require some changes in the state's insurance legislation and regulations, which currently are inimical to PSOs. Barriers to the establishment of PSOs should be studied and remedied.

The reductions in utilization associated with managed care should be observed closely to ensure that they do not result in underutilization of services, and so in reduced quality of care, since the maintenance, and preferably the improvement, of quality of care is another state priority.

Feasibility and potential barriers. Managed care involves having a "gatekeeper" primary care physician who authorizes most services. If the patient uses a nonemergency service without preapproval, then they are responsible for some or all of the charges incurred. A major problem in applying managed care concepts to the Medicaid population is that federal requirements severely limit the amounts that Medicaid beneficiaries can be required to pay. The Medicaid beneficiaries have almost no copayments, so it is difficult to provide financial incentives to have services managed by their primary care physician and disincentives for obtaining services that are not approved and even not required. Refusal to pay for services that have not been preapproved hurts the provider of services but not the patient.

Encouraging increased managed care may be quite difficult due to the geography and population distribution of West Virginia. HMOs have a low penetration in rural areas for reasons including:

- the expense of enrolling beneficiaries and administering the system in an area with low population density;
- the lack of competing providers, which limits the ability to redirect patients and so limits the ability of the HMO to negotiate discounts with providers;
- the generally low level of the capitation payment rates for the Medicare population, and
- the unpredictability of the payment rates from year to year (although this is being corrected by changes being made to the Medicare payment system as a result of the BBA).

Primary care providers may be inhibited from participating because of the requirements for 24-hour coverage. This burden can be reduced by sharing of on-call coverage between multiple providers and allowing less restricted use of hospital emergency rooms when the primary care physician is unavailable. Telephone triaging by nurses may be an additional option to alleviate this problem.

Accountability factors/evaluation. A process measure could be the removal of legislative and regulatory barriers to the formation of Provider Sponsored Organizations (PSOs). Outcome measures

could include the number of beneficiaries enrolled in managed care by public payers, i.e., Medicaid, Medicare, and PEIA.

Issues for the future and certificate of need revisions. The changes implemented in the BBA have made it more attractive for HMOs to enroll Medicare beneficiaries in rural areas. However, it remains to be seen whether the changes are sufficient to overcome the administrative, provider recruitment, and beneficiary enrollment problems that exist in rural areas. The Health Care Authority should monitor Medicare HMO participation in West Virginia, particularly in rural areas. If this enrollment does not increase over the next couple of years, the state should consider providing information and technical support to providers who might be interested in establishing PSOs, as this may be the only viable mechanism for providing managed care in many rural areas. The Insurance Commissioner should collect data on the financial viability of providers involved in risk sharing contracts and ensure that the level of risk being accepted is commensurate with the reserves available.

TAXES ON PRODUCTS THAT ARE DETRIMENTAL TO HEALTH

West Virginia has relatively high mortality rates in categories that are known to be associated with tobacco and alcohol use. This suggests that there is also considerable morbidity associated with tobacco and alcohol use, which will result in heavy health care expenditures.

Potential solutions. The State of West Virginia should increase the taxes on alcohol and all tobacco products, including cigarettes, cigars, chewing tobacco, and snuff. The funds resulting from these increased taxes should be dedicated to increasing the availability of health care insurance and improving health care access. The funds could be contributed to an uncompensated care pool or used to pay the state share of Medicaid expansions, which are discussed below.

Recommended action. In order to discourage use of products that are detrimental to health and provide funds for the treatment of health problems resulting from the use of these products, the state should increase the level of taxes on alcohol and tobacco.

Feasibility and potential barriers. Increasing taxes on alcohol and tobacco products requires that the legislature be persuaded to enact the required legislation, and that the governor sign it. There will be opposition from the alcohol and tobacco lobbies to any increase in these taxes.

Accountability factors/evaluation. A process measure would be whether additional taxes on alcohol and tobacco taxes were enacted. An outcome measure would be the impact of the increased taxes on the use of these products.

USE OF TOBACCO SETTLEMENT FUNDS TO PROMOTE SMOKING CESSATION AND TREAT TOBACCO-RELATED ILLNESSES

The amount to be available in tobacco settlement funds is now known. These funds were intended to cover Medicaid expenditures on tobacco-related illnesses, and the federal government paid a share of those expenditures. The federal government may demand that the federal matching share of the settlement be paid back to the federal government, which would cut the amount of funds available dramatically. Also, there will be many different demands on these funds, and so it is essential to develop

priorities and plans for their use quickly before the funds are diverted to other, non-health-care-related, uses.

Reduction in smoking has the potential to reduce acute health care costs, and more importantly, to improve the health status and reduce the mortality rate of the population. Smoking is known to cause cancer, heart disease, stroke and chronic obstructive pulmonary disease, all of which are major concerns in West Virginia. It also causes many other health problems which people do not normally associate with smoking, such as osteoporosis, cataracts, and glaucoma¹². Smoking by pregnant women results in lower birth weight and other problems for the child, so pregnant women should be a particular focus of smoking prevention efforts¹³.

Potential solutions. The tobacco settlement funds were intended to repay the state for increased health care costs incurred as a result of treating illnesses caused by tobacco use. The availability of these funds provides a unique opportunity to allocate money to promote smoking cessation programs and to discourage adolescents from starting to use tobacco products. A portion of the settlement funds should be allocated for these purposes.

The state should be selective in allocating funds for the treatment of tobacco-related illness. Specifically, if other sources of payment are available, the state should not be paying for the treatment. A possible use of the settlement funds would be to pay for the portion of uncompensated care costs of hospitals that are attributable to the costs of treatment of tobacco-related illnesses. Some of the settlement funds could also be used for prevention and diagnosis of conditions that are caused or exacerbated by tobacco use, such as lung and other cancers, emphysema, and heart disease.

Recommended action. Substantial amounts of revenue will be provided to the state as a result of the tobacco settlement. A portion of this revenue should be devoted to promoting smoking cessation programs and to treating tobacco-related illness.

Feasibility and potential barriers. There should be no problem in having the proceeds of the tobacco settlement assigned, at least in part, to these purposes. The legislature has already indicated its intent that the funds should be used in these ways. The major concern is that the federal government may demand that a substantial portion of the funds be paid to them as recoupment of the federal share of the Medicaid expenditures these settlement payments are intended to represent. The federal government may also place restrictions on the way in which the proceeds can be used, although smoking cessation programs and the treatment of tobacco-related illnesses may well be permissible under these restrictions.

Accountability factors/evaluation. Process measures could include whether some of the tobacco settlement funds were allocated for these purposes and whether smoking cessation programs were actually started or expanded. Outcome measures would include the impact of the programs on the level of smoking and other tobacco use and, longer term, on the health status of the community, particularly the incidence of diseases known to be caused by smoking.

¹² George Adatsi, BSN, RN, "Health Going Up in Smoke," *American Journal of Nursing*, Volume 99, No. 3, March 1999, 63-67.

¹³ Lorraine V. Klerman, DrPH and Judith P. Rooks, CNH, MPH, FACNM, "A Simple, Effective Method that Midwives can use to help Pregnant Women Stop Smoking," *Journal of Nurse-Midwifery*, Volume 44, No. 2, March/April 1999, 118-123.

Issues for the future and certificate of need revisions. It is generally accepted that reduction in smoking reduces health care costs in the short term. However, nonsmokers tend to live longer than smokers, and in the longer term health care costs are actually increased for a population in which all smokers give up smoking¹⁴. This is largely due to the fact that they would then live long enough to suffer from chronic conditions. For example, 78% of nonsmokers survive to the age of 70 compared with 57% of smokers, and 50% of nonsmokers survive to the age of 80 compared with 21% of non-smokers¹⁵. Combining this with the general aging of the population that is occurring, chronic and long-term care costs are likely to increase dramatically in the next couple of decades. This suggests that consideration should be given to how to deal with the high costs likely to be incurred in the future for chronic and long-term care. Support mechanisms should be developed to assist the frail elderly to remain relatively independent in the community.

EXPANSION OF MEDICAID TO MAXIMIZE FEDERAL FUNDS

West Virginia has a relatively low proportion of its population with incomes under 200% of the federal poverty level enrolled in the Medicaid program. As a result, the amount of federal matching funds coming to the state is not as high as it might be. There are a variety of ways in which states increase the federal payment for health care, including the following:

- Help those who do not have insurance coverage because (1) they are unemployed, (2) their employer does not offer coverage, or (3) they cannot afford to purchase insurance. This would involve expanding the Medicaid program to cover more individuals and possibly also expanding the scope of services covered.
- While Medicaid expansion would bring more federal matching funds into the state, it also requires the state to spend more of its own money. To minimize the additional funds that would be required, analyze the current state health expenditures to determine whether they are being used to the maximum extent to generate federal matching funds. For example, different types of services have different federal matching rates – are the services being classified in a manner that results in the highest matching rate and so the greatest amount of federal funds to the state?
- Increase federal matching funds by using “intergovernmental transfers” or by having a portion of the payments from an uncompensated care pool qualified as Medicaid disproportionate share payments.
- Expand enrollment in the Child Health Insurance Program (CHIP), which has a high rate of federal matching.

The expansion of Medicaid coverage by increasing eligibility levels would complement efforts to make it easier for small businesses to purchase health insurance for their employees. Several states have engaged consultants to review state expenditures for health care to ensure that the maximum amount of federal matching funding is being claimed. Maryland is currently engaged in such a study. States may not claim the maximum amount because administrative expenditures that could qualify as Medicaid administrative costs are not being classified in that way, or because beneficiaries eligible for more than one category of coverage are not being assigned to the category with the highest matching rates. For example, for a child

¹⁴ JJ Barendregt, L Bonneux, and PJ van der Maas, “The health care costs of smoking,” *New England Journal of Medicine*, 1997:337:1052-7.

¹⁵ D Cohen and G Barton, “The cost to society of smoking cessation,” *Thorax*, 1998:53 (supplement 2): 538-542.

who is eligible for both Medicaid and CHIP, the federal government would pay 82.13% of CHIP expenditures, but only 74.74% of Medicaid expenditures.

Payments from an uncompensated care pool may qualify as Medicaid disproportionate share payments, and thus be eligible for federal matching. Connecticut defines a substantial portion of the payments made from their uncompensated care pool to be Medicaid disproportionate share payments and receives a federal match on that portion. Other states, e.g., Wisconsin, have identified payments being made by county and local governments for health care, including nursing home care, and qualified these payments for federal match. This type of activity is often referred to as an “intergovernmental transfer.”

There are 10,000 uninsured children in the state. The federal government pays for 82.13% of the expenditures on CHIP. Phase One of this program involved a Medicaid expansion for children in the age range 1 to 5 and enrolled 792 children in HMOs, 700 of whom had been totally uninsured. Phase Two involved providing private health insurance for additional children through the PEIA program. Enrollment for this phase commenced on April 1, 1999; 1,608 had been signed up by June 1, with more applications being received and processed.

Potential solutions. There are several opportunities to increase federal funds coming to the state:

- consider increasing the eligibility limits on existing categories of beneficiary to increase the number of beneficiaries;
- study methods to expand the Children’s Health Insurance Program (CHIP), which is currently only taking advantage of a fraction of the potential federal funds available;
- examine the benefits being paid on behalf of existing beneficiaries;
- identify areas in which the federal payments are not being maximized, and explore ways to maximize the federal payments without increasing state payments, and
- any combination of the above options, as they are complementary.

Not all of these may be opportunities for West Virginia, but the state should study which options are available and the extent to which they could be used, with particular emphasis on ways in which federal payments could be increased without increasing state expenditures.

Recommended action. All the potential options listed in the previous paragraph should be considered. In particular, the state should engage in an evaluation of ways in which the federal funds can be maximized in the Medicaid and related programs.

Feasibility and potential barriers. There are federal restrictions on the scope of enrollment in the Medicaid program, the types of services that can be paid, and the level of payments. These restrictions will have to be studied in conjunction with the state Medicaid program to determine the scope for expansion in each of these areas. The expansions will generally require an increase in the state funds being paid, so the state will have to be willing to appropriate additional funds to the Medicaid program in order to be eligible for increased federal funds. The one exception to this is that the state may not be maximizing the federal participation in Medicaid and other governmental health care programs. For example, it may be possible to define some expenditures being made within the juvenile justice system as Medicaid expenditures to receive federal matching, or it may be possible to reclassify services to categories that receive a higher rate of federal matching. Several states have engaged in such revenue maximization programs, so it is clear that they are quite feasible. Expenses being incurred by county or city government and by other agencies of the state government may be able to be classified as Medicaid expenditures and thereby become eligible for federal matching (“intergovernmental transfers”). A study on Medicaid payments for disproportionate share hospitals documented that West Virginia had

considerable scope for increasing these payments and thereby increasing the federal contribution to the Medicaid program¹⁶.

Accountability factors/evaluation. Process measures could include whether a review was done to determine the potential for increased federal matching of state funds and whether expansions of the Medicaid program were implemented. An outcome measure would be the amount by which federal payments to the State of West Virginia were increased as a result of expansions of the Medicaid program or by the actions taken as a result of the review.

EXPANSION OF TELEMEDICINE SERVICES

West Virginia has a shortage of health professionals, with 40 counties designated by the federal government as Health Professional Shortage Areas (HPSAs). In addition, 49 counties are designated as Medically Underserved Areas, and 29.5% of the population report problems with access to a primary care provider.

There is a telemedicine network, MDTV, that allows specialist physicians in Morgantown to provide consultations to patients elsewhere. This has been in operation for over five years. In addition, there are some provider service networks that provide video-conferencing, and teleradiology is available in the state. However, expansion of telemedicine is inhibited by the cost of the required infrastructure and the inadequate payment levels for the services provided.

Potential solutions. Telemedicine offers opportunities to improve access to care in isolated, medically underserved regions of the state. Medicare will pay for telemedicine services if they are provided to residents of HPSAs, so payment for those services is available in those areas. The state has a number of options on how to aid the expansion of telemedicine services:

- provide technical assistance to providers wanting to apply for telemedicine grants and/or set up telemedicine programs;
- provide educational materials to providers to inform them of the applicability of telemedicine and availability of payments and other resources;
- encourage the academic medical centers to expand telemedicine consulting services in order to make specialty services available to more rural providers and areas, and
- ensure that Medicaid pays adequately for telemedicine services and encourage other payers to do similarly.

Recommended action. The state should provide technical assistance to providers wanting to initiate telemedicine services and attempt to reduce barriers to the provision of services by encouraging Medicaid and private payers to pay adequately for services provided in this manner.

Feasibility and potential barriers. Telemedicine is an expanding field, although its expansion has been limited by a lack of payment for remotely provided services. Recent changes in the Medicare payment system now allow for payment to specialists for services provided by telemedicine (albeit at a rate that many consider too low), provided that the services are to residents of health professional shortage areas. Other payers may start paying for telemedicine services now that Medicare has set a precedent. The

¹⁶ Teresa A. Coughlin and David Liska, "Changing State and Federal Payment Policies for Medicaid Disproportionate-Share Hospitals," *Health Affairs*, Volume 13, No. 3, May/June 1998, 118-136.

academic medical centers should be eager to participate in telemedicine projects. The major barrier is likely to be resistance from primary care physicians and other practitioners in rural areas who are uncomfortable with the new technology. The capital costs associated with required infrastructure and telemedicine equipment are not paid by Medicare and other payers and may also be a barrier to entry into this type of service.

Accountability factors/evaluation. The process measure could be whether any new telemedicine programs were established, or current programs expanded, as a result of this effort. Outcome measures could include the number of telemedicine consultations/treatments and the savings to the patients in time and discomfort as a result of not having to travel to a distant location for a consultation. Equally important is the improvement in access resulting from the availability of the service.

Issues for the future and certificate of need revisions. West Virginia should ensure that the growth of telemedicine is not inadvertently inhibited by state regulations or policies. Examples of regulations or policies that might have an inhibiting effect are

- certificate of need restrictions placing barriers to rapid and easy adoption of telemedicine;
- Medicaid and other payer restrictions on payments for telemedicine services, and
- professional licensure issues, particularly if the consultant is out of state.