

1992: A Year of Change for Our Health Care System

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It is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.¹

Solutions are being proposed for the health care "crisis" without [a] thorough understanding of the present problems, without answering questions . . . and without a clear vision of what we are trying to create.²

Health care reform is a topic that is frequently discussed at legislatures, round table discussions, universities, hospitals, workplaces, and dinner tables. The debate begins with "basic" concepts, such as: "Is health care a right or a privilege?" Although to some the answer seems obvious, resolution of the question is something Americans have been unable to grasp. While legislators discuss the specifics of funding health care programs and health services researchers analyze the effects of various payment methodologies on the market, the "average" American asks: "What will happen if I get sick?"

State legislators have been unable to provide solutions because their budgets simply cannot cover the costs of initiatives that will provide health insurance for a state's entire citizenry. Although some point to Canada or Massachusetts or Hawaii as models for health care reform, the answers may lie elsewhere. In fact, the answers may lie in Indiana.

This Article will discuss the initiatives for change proposed for our state's health care system. This Article will first survey the cases involving the state's Medicaid and Hospital Care for the Indigent programs. It will then provide a summary of the proposed eligibility requirements and benefits for the program for children with special health care needs.

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1. *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).

2. Indiana Commission on State Health Policy, *HoosierHealth Reform 4-3* (Nov. 1992) [hereinafter *Health Policy Report*] (on file with the author).

Finally, the Article will examine the proposals for change made by Governor Evan Bayh and the Indiana Commission on State Health Policy (Health Policy Commission) and the possible direction that will be given to reforming our state's health care system.

I. ELIGIBILITY FOR INDIANA'S MEDICAID AND HOSPITAL CARE FOR THE INDIGENT PROGRAMS

An understanding of the state's Medicaid program is required before change can be discussed.³ The state is required by federal law to provide benefits to the "mandatory categorically needy."⁴ The mandatory categorically needy include recipients of Aid to Families with Dependent Children (AFDC); aged, blind, and disabled recipients of Social Security Income; and some low-income persons ineligible for AFDC or Social Security Income (SSI).⁵ A state's categorically needy population must also include children under one year old who are at or near the federal poverty level and children under age seven born after 1983 whose family income meets the state established income level.⁶ State Medicaid programs must provide the categorically needy with a variety of benefits, including hospital, skilled nursing, rural health clinic, laboratory, X-ray, children's health, and family planning services.⁷

The states also have the option of providing a medically needy program.⁸ A state medically needy program must provide benefits for certain pregnant women and children and may provide benefits for the aged, blind, and disabled whose incomes are below the federal poverty level.⁹ In general, state medically needy programs provide benefits to persons who meet the age and family requirements of the state's categorically needy program, but who, after the payment of medical services, have incomes less than 133 1/3% of the maximum AFDC payment for the same size family.¹⁰

3. For a general discussion of the federal Medicaid program, see CONG. RES. SERV., 103D CONG., 1ST SESS., MEDICAID SOURCE BOOK: BACKGROUND DATA AND ANALYSIS (A 1993 UPDATE) (Comm. Print 1993).

4. 42 U.S.C. § 1396a(a)(10) (1988 & Supp. III 1992); 42 C.F.R. §§ 435.100-435.138 (1992).

5. 42 U.S.C. § 1396a(a)(10); 42 C.F.R. §§ 435.100-435.138. *See generally* 3 Medicare & Medicaid Guide (CCH) ¶ 14,311 (1992).

6. 42 U.S.C. § 1396a(a)(10); 42 C.F.R. § 435.117.

7. 42 U.S.C. §§ 1396a(a)(10)(C), 1396d(a); 42 C.F.R. § 440.210. *See generally* 3 Medicare & Medicaid Guide (CCH) ¶ 14,511 (1992).

8. 42 U.S.C. § 1396a(a)(10)(A)(ii); 42 C.F.R. §§ 435.301-435.350. *See also* 1993-1 Medicare & Medicaid Guide (CCH) ¶ 40,984 (new final regulations concerning Medicaid eligibility for optional groups).

9. 42 U.S.C. § 1396a(a)(10)(A)(ii); 42 C.F.R. § 435.301.

10. 3 Medicare & Medicaid Guide (CCH) ¶ 14,311 (1992).

The federal Medicaid laws require that a state medically needy program provide certain benefits,¹¹ but any additional benefits may include a variety of preventive, diagnostic, and rehabilitative services. However, the benefits provided under the state's medically needy program cannot exceed the benefits provided under its categorically needy program.¹² Indiana does not provide a medically needy program, although the idea of implementing such a program has support from various circles.

Benefits under Indiana's Medicaid program are provided to persons receiving monthly assistance payments or medical services and persons eligible for AFDC or the state supplemental assistance program for the aged, blind, or disabled.¹³ Other persons who are eligible for state Medicaid benefits include patients in institutions for the mentally ill or mentally retarded, participants in the Indiana long-term care program,¹⁴ and certain pregnant women and children.¹⁵ The Indiana Medicaid program provides a variety of services that are not required under federal law, including optometric services, nonmedical nursing care given in accordance with religious tenets of a recognized church, and podiatry services.¹⁶

The state's Medicaid program has become the primary target for change. Two Medicaid-related cases decided in 1992 are worthy of note: the first involves the resource spend-down requirement, and the second involves the ongoing debate over the validity of the Medicaid rate-setting system under the Boren Amendment.

A. Medicaid Eligibility

In 1992, the Indiana Court of Appeals was given the opportunity to examine the resource spend-down requirement under Indiana's Medicaid program and concluded, in *Indiana Department of Public Welfare v. Payne*,¹⁷ that the Department of Public Welfare¹⁸ must allow applicants

11. If a state elects to establish a program for the medically needy, that program must provide prenatal care and delivery services, ambulatory services for individuals under 18 years old and individuals entitled to institutional services, home health services for individuals entitled to skilled nursing facility services, and certain services if the state elects to provide services for the institutionalized mentally ill or mentally retarded. 42 C.F.R. § 440.220 (1992). See also 3 Medicare & Medicaid Guide (CCH) ¶ 14,511 (1992).

12. 42 C.F.R. § 440.240.

13. IND. CODE § 12-15-2-3 (Supp. 1992).

14. *Id.* §§ 12-10-9-1 to -11. See also 16 Ind. Reg. 1145-59 (1993) (adding IND. ADMIN. CODE tit. 760, r. 2-20-1 to -43).

15. IND. CODE §§ 12-15-2-8 to -16 (Supp. 1992).

16. *Id.* § 12-15-5-1.

17. 592 N.E.2d 714 (Ind. Ct. App. 1992).

18. Although the cases described refer to the Department of Public Welfare, the state Medicaid program is now administered by the Office of Medicaid Policy and Planning. IND. CODE §§ 12-8-6-1, 12-15-1-1 (Supp. 1992).

to spend down their resources to become eligible for Medicaid benefits.¹⁹ Litigation to determine eligibility for Medicaid benefits in some cases is legitimate, but it also illustrates a growing concern that potential program recipients and their lawyers are manipulating the eligibility rules to gain access to the program's many benefits.

Hazen Payne was a construction laborer who developed leukemia and was hospitalized at the Indiana University Medical Center for five months, accumulating medical bills of approximately \$150,000. Payne applied for Medicaid benefits to cover these expenses, but was denied eligibility for the period for which he was hospitalized because he owned resources in excess of the Department's financial eligibility requirements.²⁰

The trial court reversed the Department's decision, and the court of appeals affirmed.²¹ The court's decision was based on the status of Indiana's Medicaid program as a "section 209(b)" program.²² Section 209(b) of the federal Medicaid statute allows state legislatures to elect to provide Medicaid benefits only to persons who would have been eligible under the state's Medicaid plan as it existed on January 1, 1972.²³ This provides state legislatures with the option of using more restrictive criteria for Medicaid eligibility than the SSI eligibility criteria, which tend to be more generous.²⁴

When Payne applied for benefits, the Department used its resource limitation regulation, which requires the valuation of resources on the first day of the month, to determine his eligibility for benefits.²⁵ The

19. *Payne*, 592 N.E.2d at 724. In other words, once an applicant applies his or her excess resources toward any incurred but unpaid medical bills, under Indiana's rules in 1972, the remaining bills will be eligible for Medicaid reimbursement. *See also* Roloff v. Sullivan, 975 F.2d 333, 338 (7th Cir. 1992) (explaining the resource spend-down rule).

20. Payne owned a wooden wagon, a buggy, a nonmotorized camper, and a stock trailer.

21. *Payne*, 592 N.E.2d at 726.

22. *Id.* at 721-22.

23. 42 U.S.C. § 1396a(f) (1988 & Supp. II 1990); 42 C.F.R. § 435.121 (1992). *See* Schweiker v. Gray Panthers, 453 U.S. 34, 38-39 (1981).

24. On rehearing, the court stated that section 209(b) requires a state to provide Medicaid benefits to persons who would be eligible under the criteria as they existed on January 1, 1972, and these criteria apply even if they are more liberal than the criteria used in SSI states. *Indiana Dep't of Pub. Welfare v. Payne*, 598 N.E.2d 608, 610 (Ind. Ct. App. 1992) (citing 42 U.S.C. § 1396a(r)(2)).

25. An applicant or recipient is ineligible for medical assistance for any month in which the total equity value of all nonexempt resources exceeds the applicable limitation, set forth below, *on the first day of the month*:

(1) \$1,500 for the applicant or recipient, including the amount determined in (b) below, if applicable; or

(2) \$2,250 for the applicant or recipient and his spouse.

Payne, 592 N.E.2d at 720 (quoting IND. ADMIN. CODE tit. 470, r. 9.1-3-17(a) (1988)) (emphasis added).

court rejected the Department's argument that its regulation is based on a statute providing the resource limitations for Medicaid eligibility because the statute concerns only money, stocks, bonds, and life insurance.²⁶ The court also noted that the statute does not prohibit a resource spend-down, although such a spend-down would be consistent with its principles.²⁷ The court added that a resource spend-down requirement is not inconsistent with the first day of the month rule because the applicant's resources would still have to meet the \$1,500 limitation as evaluated on the first day of the month.²⁸

The court also determined that the state's plan on January 1, 1972,²⁹ and the Department's Medicaid Manual allowed a resource spend-down.³⁰ The court concluded that because the Department may not use more restrictive criteria than those in place on January 1, 1972, it was required to allow Payne to spend down his resources to attain eligibility for the state Medicaid program.³¹

Transfers of property to attain eligibility for the state's Medicaid program are a target for change in the reform of our state's Medicaid program. This term, legislation was introduced to prevent potential

26. *Id.* at 721. At the time of this case, the statute read:
An applicant for, or recipient of, medical assistance, is ineligible for that assistance if the total cash value of money, stocks, bonds and life insurance owned by:

(1) the applicant or recipient exceeds fifteen hundred dollars (\$1,500), in the case of medical assistance to the aged, blind, or disabled.

(2) the applicant, or recipient, and his spouse exceeds two thousand two hundred fifty dollars (\$2,250), in the case of medical assistance to the aged, blind, or disabled.

Id. (quoting IND. CODE § 12-1-7-18.5(a) (1988)).

27. *Id.*

28. *Id.* at 723. The first day of the month rule has been found not to violate the "reasonable standards" requirement of 42 U.S.C. § 1396a(a)(17). *Roloff v. Sullivan*, 975 F.2d 333, 342 (7th Cir. 1992). The *Roloff* court refrained from giving blanket approval to Indiana's first day of the month rule, but left open the possibility that a resource spend-down may be allowed for persons with resources below the SSI eligibility limit. *Id.* at 341.

29. The state's plan contained the following regulatory provisions:

(c) Possession of intangible personal property with an available liquid cash value in excess of the standard resource allowance shall render an applicant ineligible for assistance, and *utilization of some of the resources down to the amount of the standard resource allowance is necessary before the applicant can be found eligible.*

(d) Possession of intangible personal property with an available cash value which has increased to be in excess of the standard resource allowance shall not make a recipient ineligible for assistance providing the recipient is willing to make the necessary adjustments and has taken immediate steps to do so.

Payne, 592 N.E.2d at 722 (quoting Ind. State Dep't of Public Welfare, r. 2-114).

30. *Id.* (citing IND. ADMIN. CODE tit. 470, r. 9-3-2(22.2), 9-4-3(12) (1979)).

31. *Id.* at 724.

applicants from engaging in certain transfers of property to obtain Medicaid eligibility.³² Under the proposed legislation, the Office of Medicaid Policy and Planning would be instructed to promulgate rules that:

- (1) Establish policies and procedures that improve the state's ability to verify ownership and interests in a Medicaid recipient's property and transfers of property;
- (2) Define terminology involved in Medicaid estate planning;
- (3) Define impermissible trusts established to shelter assets for purposes of obtaining Medicaid eligibility;
- (4) Specify that the transfer of asset restrictions apply to all of a Medicaid recipient's property, including property exempt from Medicaid eligibility determination; and
- (5) Establish methods to increase the documentation of sheltered assets to assure that the asset values and dispositions can be traced by the Office.³³

Any health reform measures considered for the state should include a review of the Medicaid eligibility requirements and the means by which potential recipients may shelter funds. With the introduction of this legislation, the General Assembly started to take this step.

B. Boren Amendment

The second Medicaid case decided in 1992 involves the adequacy of the program's rate-setting methodologies for extended care facilities. This case is merely another decision in the ongoing litigation by various extended care facilities located throughout Indiana over the legality of the state's rate-setting system for nursing homes.³⁴ Unfortunately, although state resources are being used to litigate an alleged wrong under the state's Medicaid regulations, state legislators and the Office of Medicaid Policy and Planning have been unable to find a solution to resolve

32. S.B. 232, 108th Gen. Assembly, 1st Reg. Sess. (1993) (adding IND. CODE 12-15-38); H.B. 1921, 108th Gen. Assembly, 1st Reg. Sess. (1993) (adding IND. CODE 12-15-38).

33. S.B. 232, 108th Gen. Assembly, 1st Reg. Sess. (1993) (adding IND. CODE § 12-15-38-15); H.B. 1921, 108th Gen. Assembly, 1st Reg. Sess. (1993) (adding IND. CODE § 12-15-38-15). Indiana has adopted the federal transfer of assets provisions, which apply only to nursing home and equivalent medical institution services. 16 Ind. Reg. 1783 (1993) (adding IND. ADMIN. CODE tit. 405, r. 2-3-1(i)). See also 42 U.S.C. § 1396p(c) (1988 & Supp. III 1992).

34. *Indiana State Bd. of Pub. Welfare v. Tioga Pines Living Ctr., Inc.*, 592 N.E.2d 1274 (Ind. Ct. App. 1992).

the issues concerning the state's rate-setting system for extended care facilities. The Governor has also stated that our state must fight "the attempt by some nursing home owners to get more than \$150 million in unjustified payments from the taxpayers."³⁵

In last year's article on health care law, the authors discussed the case of *Indiana State Board of Public Welfare v. Tioga Pines Living Center, Inc.*,³⁶ which dissolved a preliminary injunction against the state in an action challenging a regulation linking increases in Medicaid reimbursement for nursing homes to the Gross National Product Implicit Price Deflator.³⁷ The promulgation of this regulation resulted from the enactment of the Boren Amendment, which requires state Medicaid programs to provide for "reasonable and adequate" rates to meet the costs of care provided.³⁸ Last year's article noted that "[a] decision on the merits in this case will have important implications for future Medicaid payment policy in Indiana."³⁹ While undoubtedly true, practitioners anticipating the final chapter in the *Tioga Pines* case must wait a little longer.⁴⁰

This year, in the latest published decision in the *Tioga Pines* case, the Indiana Court of Appeals held that computer simulations reflecting Medicaid reimbursement methodologies that were considered, but not adopted, by the Department of Public Welfare were protected by the work product doctrine.⁴¹ These methodologies were a part of the state's

35. Governor Evan Bayh, 1993 State of the State Address: Cornerstones of Progress (Jan. 26, 1993) (transcript on file with the author).

36. 575 N.E.2d 303 (Ind. Ct. App. 1991). See Vaneeta M. Kumar & Eleanor D. Kinney, *Indiana Lawmakers Face National Health Policy Issues*, 25 IND. L. REV. 1271, 1279-81 (1992).

37. *Tioga Pines*, 575 N.E.2d at 307.

38. A State plan for medical assistance must—

(13) provide—

(A) for payment . . . of the hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded provided under the plan through the use of rates . . . for lower reimbursement rates reflecting the level of care actually received . . . which the State finds . . . are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards to assure that individuals eligible for medical assistance have reasonable access . . . to inpatient hospital services of adequate quality

42 U.S.C. § 1396a(a)(13)(A) (1988 & Supp. III 1992).

39. Kumar & Kinney, *supra* note 36, at 1281.

40. The Indiana Supreme Court heard arguments in this case on April 28, 1993. *High Court Hears Arguments on State Nursing Home Payments*, INDIANAPOLIS STAR, April 29, 1993, at C4.

41. *Indiana State Bd. of Pub. Welfare v. Tioga Pines Living Ctr., Inc.*, 592 N.E.2d

attempt to promulgate a new reimbursement scheme after the trial started. Given the provision in Trial Rule 26(B)(3) protecting "documents and tangible things" prepared in anticipation of litigation or for trial,⁴² the court's decision is not surprising.

This term, Senator Johnson introduced Senate Bill 353, which would establish a Medicaid reimbursement methodology for nursing homes at rates that are reasonable and adequate to meet the costs of efficiently and economically running facilities.⁴³ The bill required that payment rates for reimbursement of resident care facilities "be reasonable and adequate to meet the costs (determined annually using generally accepted accounting principles) that must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, rules, regulations, and quality and safety standards."⁴⁴ In addition, "[r]eimbursement for capital facility costs must be based on an objectively determined fair rental value of property, determined by an independent expert."⁴⁵ Although this bill failed to pass a third reading by the Senate, similar language was also introduced in Senate Bill 232 and House Bill 1921.⁴⁶

C. *Hospital Care for the Indigent*

Another target for change is the state's Hospital Care for the Indigent (HCI) program. The HCI program provides benefits to persons who meet the applicable resource and income guidelines for

any part of the cost of care provided in a hospital in Indiana that was necessitated after the onset of a medical condition that was manifested by symptoms of sufficient severity that the absence of immediate medical attention would probably result in any of the following:

1274, 1278 (Ind. Ct. App. 1992). The defendant class was allowed to discover only some personal notes and presentation materials of a consultant hired by the state to analyze the nursing home rate-setting system in Indiana. The consultant was hired to assist the state in the preparation of its defense.

42. IND. R. TR. PROC. 26(B)(3).

43. S.B. 353, 108th Gen. Assembly, 1st Reg. Sess. (1993) (amending IND. CODE § 12-15-14-2).

44. *Id.* (amending IND. CODE § 12-15-14-2(b)(2)(A)).

45. *Id.* (amending IND. CODE § 12-15-14-2(c)).

46. *See* S.B. 232, 108th Gen. Assembly, 1st Reg. Sess. (1993) (amending IND. CODE § 12-15-14-2); H.B. 1921, 108th Gen. Assembly, 1st Reg. Sess. (1993) (amending IND. CODE § 12-15-14-2). The provisions in these bills will be the subject of a special session of the General Assembly this term.

- (1) Placing the individual's life in jeopardy,
- (2) Serious impairments to bodily functions, or
- (3) Serious dysfunction of a bodily organ or part.⁴⁷

The HCI program is funded with property tax dollars and allocations of the financial institutions and motor vehicle excise taxes.⁴⁸

Two cases were decided in 1992 involving eligibility for benefits under the HCI program. In *County Department of Public Welfare of Vanderburgh County v. Deaconess Hospital, Inc.*,⁴⁹ Deaconess Hospital disputed the denial of its claim for payment of HCI benefits provided to a woman with suicidal tendencies. The woman was described as "dejected and depressed," but was not suffering from delusions or hallucinations and had not formulated a suicide plan. The County Department of Public Welfare denied the payment of HCI benefits to Deaconess, claiming that the patient's condition did not satisfy the statute's emergency hospitalization requirement. The State Department of Public Welfare agreed, basing its decision in part on a letter from the Medical Director—Medicaid to the Director of the County Department of Public Welfare that stated:

Qualifying emergency medical criteria, as applied to a diagnosis of depression with suicidal considerations, seeks documentation of a suicidal gesture rather than ideation alone. [Dr. Reigman's notes on Walker] record substantial indication of depression with suicidal thoughts or ideation, but no gesture. In addition, paranoid and psychotic symptoms were not noted. Thus, the medical review opinion [denied HCI benefits because "hospital admission does not meet the emergency criteria specified by state law."]

I would like to add that this decision is in no way meant to indicate that the hospitalization and treatment were inappropriate. Actually, the decision is based upon restrictive emergency criteria because of limitations in HCI funding.⁵⁰

The trial court reversed. On appeal, the Indiana Court of Appeals affirmed the decision of the trial court because the State Department of Public Welfare based its opinion on the unpromulgated standard that a suicidal patient must also evidence a "suicidal gesture."⁵¹ The court added that, although a hospital may be left without reimbursement if

47. IND. CODE § 12-16-3-1(a)(1)-(3) (Supp. 1992).

48. *Id.* § 12-16-14-1 to -9.

49. 588 N.E.2d 1322 (Ind. Ct. App. 1992).

50. *Id.* at 1327 (alterations in original).

51. *Id.*

the HCI program is underfunded, the State Department of Public Welfare cannot modify the statutory criteria for program eligibility to filter out some claims so that others may be reimbursed.⁵²

In *Lutheran Hospital of Indiana, Inc. v. Indiana Department of Public Welfare*,⁵³ the Indiana Court of Appeals held that persons suffering from drug or alcohol abuse qualify for HCI benefits for emergency medical treatment if the condition becomes life-threatening.⁵⁴ The HCI program, however, is not designed to provide rehabilitative care for drug and alcohol addiction.⁵⁵ The court also concluded that failure to provide benefits under the HCI program once the patient is physically stable does not mean that the HCI Act discriminates against persons who suffer from drug or alcohol abuse.⁵⁶

Litigation under the HCI program has not gone unnoticed. The Health Policy Commission's report states:

Indiana spent approximately \$33 million in total county funds for providing emergency services under the Hospital Care for Indigent (HCI) Program. HCI is underdefined and misaligned. The program is inadequate in addressing the health care needs of the uninsured in Indiana.

If Indiana were to use this money under the Medicaid program, the state would have approximately \$66 million more to serve the health care needs of Indiana's uninsured⁵⁷

Any health reform measures considered for the state should include a review of smaller programs, such as the HCI program, and a decision should be made concerning whether the funds from these programs should be diverted elsewhere to provide more comprehensive and efficient health care system. The Health Policy Commission Report and the cases leading to expensive litigation illustrate that taxpayers' dollars should not be spent on these types of programs.

II. CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Another program of interest is the program for children with special health care needs (CSHCN program).⁵⁸ This program will provide medical

52. *Id.* at 1328.

53. 597 N.E.2d 1301 (Ind. Ct. App. 1992).

54. *Id.* at 1306.

55. *Id.*

56. *Id.*

57. Health Policy Report, *supra* note 2, at 21-24.

58. This program was implemented as a part of the national initiative to provide programs for mothers and children. These programs are funded by the Maternal and

benefits for persons under twenty-one years of age who have a physical condition that is expected to last at least two years if not treated and that necessitates more health care services than are generally required to treat the condition.⁵⁹ In addition, the physical condition must result in, or potentially result in, disability, disfigurement, limitation of function, or the need for a special diet or assistive device.⁶⁰ If none of these criteria are met, the child is eligible for benefits if nonintervention will lead to a chronic disabling physical condition within one year.⁶¹ Some examples of physical conditions that may qualify the child for benefits are apnea, arthritis, asthma, cerebral palsy, congenital anomalies, and cystic fibrosis.⁶² To qualify for benefits, the child must also apply for Medicaid benefits.⁶³

The CSHCN program is an example of a program that will provide benefits for children who might not otherwise be eligible for health care benefits. Although any proposal for change must include a determination of whether smaller programs should be allowed to survive, cost alone should not be the deciding factor. Recipients of benefits under the CSHCN program may not be eligible for other benefits to correct conditions that may create hardship throughout the child's life. In addition, the CSHCN program is partially funded by federal funds, unlike the HCI program, which is funded by local tax dollars.

These are the kinds of considerations that must be balanced in determining which programs the state can afford to maintain and which programs serve the greatest number of people in need. Only by identifying

Child Health Services Block Grant. 42 U.S.C. § 701 (1988 & Supp. II 1990). The statutory mission of the program is to "[e]xtend and improve services for locating children and for providing medical, surgical, corrective, and other services and care, and facilities for diagnosis, hospitalization, and aftercare for children who are suffering from conditions that lead to special health care needs." IND. CODE § 16-6.5-2-2(b)(1) (Supp. 1992). *Cf.* 42 U.S.C. § 701(a)(3)(F) (Supp. III 1992) (to develop and expand "outpatient and community based services programs . . . for children with special health care needs whose medical services are provided primarily through inpatient institutional care"). Additional appropriations for this program were proposed during this legislature session, but did not survive a reading by the House Ways & Means Committee. *See* H.B. 1189, 108th Gen. Assembly, 1st Reg. Sess. (1993).

59. 15 Ind. Reg. 2483-84, 2493 (1992) (adding IND. ADMIN. CODE tit. 410, r. 3.2-6-2(a)) (proposed rule).

60. *Id.* (adding IND. ADMIN. CODE tit. 410, r. 3.2-6-2(a)(3)).

61. *Id.*

62. Financial eligibility is based on the poverty income guidelines published by the Department of Health and Human Services. *Id.* at 2483-84, 2486, 2492-93 (adding IND. ADMIN. CODE tit. 410, r. 3.2-1-24, 3.2-6-1).

63. The State Department of Health will complete the processing of a child's application if the child is denied enrollment in the Medicaid program. *Id.* at 2483-84, 2488 (adding IND. ADMIN. CODE tit. 410, r. 3.2-2-4(a), (d)).

the benefits needed by our state's residents can the legislature make effective decisions concerning which programs to fund.

III. IMPLEMENTING CHANGE IN OUR STATE'S HEALTH CARE SYSTEM

In the judicial and administrative settings, the health care topics for 1992 were the resource spend-down requirement for the Medicaid program, the rate-setting formula for Medicaid reimbursement for nursing homes, eligibility for the Hospital Care for the Indigent Program, and the implementation of the program for children with special health care needs. When examined alone, these topics seem unrelated. Indeed, they are illustrative of the complex, patchwork-type approach used in structuring health care systems both nationally and within the state.

Any attempt at state health reform cannot look merely to the state's Medicaid program, or any other single program, as a means of cutting costs or streamlining care. Only if we first determine who is in need of care, and identify the benefits that we as a society are willing to provide, will any state health reform measure be successful. All too often, the legislature attempts to solve problems by focusing on only one program at a time. Instead, we must look at the residents of our state, and then, one by one, determine which programs will survive. This is not an easy task, and it requires the assistance of economists, health care providers, and health services researchers.

This term, the General Assembly faced an immense task as it struggled to tame the so-called "Medicaid monster." Medicaid expenditures are quickly crowding out other state health care initiatives, and state legislators are anxious to enact change. Yet, Medicaid is not the only concern whenever state policy reform is discussed in our state or elsewhere. Now is the time for our state to look at the entire package of health care programs offered through tax initiatives and to identify not only the changes that are needed, but also to identify the ways in which those changes can be implemented.

The cornerstone for health policy reform in Indiana has been set by Governor Evan Bayh. Governor Bayh's State of the State address⁶⁴ identified ten points for Medicaid reform as well as other ambitious means of providing a streamlined system of health care that will provide quality care to all those in need. The Governor proposed the following ten steps to ensure that Medicaid spending is decreased:

Number One: We must decrease the amount the State pays for Medicaid services. . . . If we reduce what Indiana spends per

64. Governor Evan Bayh, 1993 State of the State Address: Cornerstones of Progress (Jan. 26, 1993) (transcript on file with the author).

Medicaid recipient to just the national average, we would save nearly \$300 million annually. If we reduced our spending to that of Ohio, we would save nearly \$300 million annually, or Illinois or Michigan or Kentucky, nearly \$400 million every year.

Number Two: We must curtail Medicaid coverage for optional services not essential to good, basic health care and must more strictly regulate abuse of those optional services we keep.

Number Three: We must consider using money currently in other health care programs for the poor to pay Medicaid expenses.

Number Four: We must consider imposing co-payments on Medicaid patients to discourage unnecessary treatments and help offset costs.

Number Five: We must stop the manipulation of Medicaid eligibility rules by patients and their attorneys.

Number Six: We must consider limiting eligibility for the Indiana Medicaid program only to those individuals who are required by the federal government to be covered by Medicaid.

Number Seven: We must consider using only providers of health care services willing to give taxpayers the best price.

Number Eight: We must set limits on the kinds and number of health care procedures for which Medicaid will pay.

Number Nine: We must consider changing from a fee-for-service Medicaid system to a fixed payment approach. This would give both health care providers and recipients an incentive to provide only medically necessary care in the most cost effective way.

Number Ten: We must consider . . . imposing access charges on the health care industry to assist taxpayers in paying the state's share of Medicaid.⁶⁵

Governor Bayh also suggested further steps for reforming the state's health care system based on the recommendations of the Health Policy Commission. The Commission, which was chaired by Ben Lytle, President and CEO of Associated Insurance Companies, Inc., was formed in 1989 as a result of Senate Bill 385.⁶⁶ The legislature gave the Health Policy Commission the task of studying health policy in Indiana and making recommendations to improve the effectiveness of health care programs

65. *Id.*

66. Health Policy Report, *supra* note 2, at 2-1.

and the delivery of health care services in the state.⁶⁷ Specifically, the Health Policy Commission was asked to study access to health care, the cost of health care and its underlying factors, and preventive health care.⁶⁸ The Health Policy Commission did just that. In a report totalling almost 700 pages entitled *HoosierHealth Reform*, the Health Policy Commission outlined its strategy for change.

Based on the conclusions in this report, Governor Bayh recommended that the state legislature initiate reforms to permit health care providers to: (1) form networks to reduce costs; (2) improve access to health care and enhance quality of care; (3) reduce duplication of expensive technologies; (4) establish "best practice" guidelines for treating the most expensive illnesses; (5) fight our shortage of doctors, especially family practitioners, by encouraging graduates of Indiana University's medical school to remain in Indiana and practice family medicine; and (6) provide more extensive information to the public so we can be more knowledgeable health care consumers.⁶⁹

The Health Policy Commission's report outlines multiple strategies for implementing a comprehensive system of health reform in Indiana. The *HoosierHealth Reform* system consists of a primary care system of provider teams who are the primary point of access into the health care system,⁷⁰ a critical care system of competitive procurement among providers to treat patients whose diagnoses fall within a list of seventeen diagnoses that account for thirty-five percent of all health care costs,⁷¹ and an acute care system consisting of a hospital network system.⁷² The proposal also calls for establishing a clinical panel system to recommend clinical practice guidelines⁷³ and recommends antitrust law reforms to allow providers to network and to provide regional high technology care.⁷⁴ In addition, the plan calls for licensing reforms and management system and policy panels for the aggressive management of benefit plans.⁷⁵

In terms of Medicaid reform, the Health Policy Commission's report recommends the implementation of a medically needy program and expansion of the categorically needy program.⁷⁶ Funding for these pro-

67. *Id.*

68. *Id.*

69. Governor Evan Bayh, 1993 State of the State Address: Cornerstones of Progress (Jan. 26, 1993) (transcript on file with the author).

70. Health Policy Report, *supra* note 2, at 8-1 to 8-38.

71. *Id.* at 12-1 to 12-19.

72. *Id.* at 9-1 to 9-15.

73. *Id.* at 7-1 to 7-26.

74. *Id.* at 11-8.

75. *Id.* at 14-1 to -35, 16-1 to -3.

76. The Health Policy Commission recommended expanding Medicaid eligibility to children who are at or below 100% of the federal poverty level, through age 14 in 1994, and through age 18 by 1996. *Id.* at 21-2.

grams would come from state money currently dedicated to the HCI program, savings from streamlining health care services, and the adoption of a coordinated care model for the Medicaid program.⁷⁷ To support these proposals, the Commission stated its belief that by the year 1996, a medically needy program could provide health care benefits to 71,314 people who are at or below fifty percent of the federal poverty level.⁷⁸

The Health Policy Commission recommended a coordinated care model for the state's Medicaid program.⁷⁹ The coordinated care features of the program would include primary care case management, preferred provider networks, utilization management, and the use of clinical practice guidelines.⁸⁰ Medicaid recipients would be required to enroll with a primary care team that would provide all nonemergency care to the recipient.⁸¹

Implementation of the system proposed by the Health Policy Commission was the subject of this year's legislative session. The notion that our health care system should operate through a coordinated system of provider networks was supported by the proposal of legislation to allow cooperative agreements among hospitals. Legislation was introduced that would allow hospitals to enter cooperative agreements "if the probable benefits resulting from the cooperative agreements outweigh disadvantages attributable to a reduction in competition that may result from the cooperative agreements."⁸² These agreements could be for "the sharing, allocation, merger, or referral of patients, personnel, educational programs, support services and facilities, or medical, diagnostic or laboratory facilities or procedures, or other services generally offered by a hospital."⁸³ The intent of this legislative proposal was to provide sufficient

77. *Id.* at 21-1.

78. *Id.* at 21-2. A bill was introduced this session to establish a medically needy program in Indiana, but it failed to pass a first reading in the House of Representatives. See S.B. 595, 108th Gen. Assembly, 1st Reg. Sess. (1993) (adding IND. CODE 12-15.5).

79. Health Policy Report, *supra* note 2, at 21-6.

80. *Id.*

81. *Id.*

82. H.B. 1800, 108th Gen. Assembly, 1st Reg. Sess. (1993) (adding IND. CODE § 16-10-9-4(a)). See also H.B. 1921, 108th Gen. Assembly, 1st Reg. Sess. (1993) (also adding IND. CODE § 16-10-9-4(a)) (containing language that was substantially the same as that proposed in H.B. 1800); S.B. 232, 108th Gen. Assembly, 1st Reg. Sess. (1993) (adding IND. CODE § 16-10-9-4(a)) (also including substantially similar language). Similar legislation has been passed in Maine, Minnesota, Ohio, Washington, and Wisconsin. Melinda Amberg-Vajdic, *Indiana Bills Offer Hospitals Exemption from Antitrust Laws*, INDIANAPOLIS BUS. J., March 29-April 4, 1993, at 11A. House Bill 1800 failed to pass a third reading in the Senate; however, Senate Bill 232 and House Bill 1921 will be the subject of a special session of the General Assembly this term.

83. H.B. 1800, 108th Gen. Assembly, 1st Reg. Sess. (1993) (adding IND. CODE §

state action to bring these agreements outside the reach of the federal antitrust laws and to reduce health care costs by eliminating unnecessary duplication.⁸⁴

Under this proposal, a hospital contemplating a cooperative agreement would apply for a certificate of public advantage from the State Department of Health.⁸⁵ The Department of Health would review the application for the certificate of public advantage to determine the extent to which competition would be reduced, patients would be adversely affected, or other less restrictive arrangements could be implemented.⁸⁶ The decision of the Department of Health on the application for the certificate of public advantage would be final, although the hospital could proceed with the agreement notwithstanding the decision of the Department of Health.⁸⁷

Legislation was also introduced to provide for a clinical panel system.⁸⁸ This proposal included the establishment of the Academy of Health Care Science and Practice to adopt and disseminate clinical practice guidelines to assist health care providers in Indiana with medical decisionmaking.⁸⁹ Like the proposal by the Health Policy Commission, the clinical practice guidelines would be voluntary.⁹⁰ The clinical panel members would be persons with demonstrated knowledge and leadership selected by the Board of Directors of the Academy of Health Care Science and Practice.⁹¹

In terms of the Health Policy Commission's recommendations for the state's Medicaid program, the implementation of a coordinated care system was also discussed in the Indiana General Assembly. In 1987,

16-10-9-1). *See also* S.B. 232, 108th Gen. Assembly, 1st Reg. Sess. (1993) (adding IND. CODE § 16-10-9-1); H.B. 1921, 108th Gen. Assembly, 1st Reg. Sess. (1993) (adding IND. CODE § 16-10-9-4).

84. Amberg-Vajdic, *supra* note 82, at 11A.

85. H.B. 1800, 108th Gen. Assembly, 1st Reg. Sess. (1993) (adding IND. CODE § 16-10-9-5). *See also* S.B. 232, 108th Gen. Assembly, 1st Reg. Sess. (1993) (adding IND. CODE § 16-10-9-5); H.B. 1921, 108th Gen. Assembly, 1st Reg. Sess. (1993) (adding IND. CODE § 16-10-9-5).

86. H.B. 1800, 108th Gen. Assembly, 1st Reg. Sess. (1993) (adding IND. CODE § 16-10-9-7(c)). *See also* S.B. 232, 108th Gen. Assembly, 1st Reg. Sess. (1993) (adding IND. CODE § 16-10-9-7(c)); H.B. 1921, 108th Gen. Assembly, 1st Reg. Sess. (1993) (adding IND. CODE § 16-10-9-7(c)).

87. H.B. 1800, 108th Gen. Assembly, 1st Reg. Sess. (1993) (adding IND. CODE § 16-10-9-7(d), (e)). *See also* S.B. 232, 108th Gen. Assembly, 1st Reg. Sess. (1993) (adding IND. CODE § 16-10-9-7(d), (e)); H.B. 1921, 108th Gen. Assembly, 1st Reg. Sess. (1993) (adding IND. CODE § 16-10-9-7(d), (e)).

88. H.B. 1921, 108th Gen. Assembly, 1st Reg. Sess. (1993) (adding IND. CODE 16-47).

89. *Id.* (adding IND. CODE §§ 16-47-2-1, -2).

90. *Id.* (adding IND. CODE § 16-47-3-2).

91. *Id.* (adding IND. CODE § 16-47-3-5).

the Indiana legislature passed a statute allowing Medicaid recipients to receive care from a managed care provider.⁹² Unfortunately, this statute has not been utilized. In order to implement a primary care case management system under the statute, the state must seek a waiver from the requirements of the federal Medicaid program.⁹³ The legislature is considering seeking such a waiver, and a system of contracting with a network of managed care providers has been proposed.

Under the proposed network system, a Medicaid recipient would select a primary care physician who is a member of the Medicaid network.⁹⁴ If the recipient failed to specify a primary care physician, the Office of Medicaid Policy and Planning would assign the recipient to a primary care giver.⁹⁵ The recipient could not receive care from any other provider unless the recipient's primary care physician made a referral to another provider in the network or treatment was rendered in an emergency.⁹⁶

The network system would also include a critical care network of health care providers.⁹⁷ Patients to be seen by providers in the critical care network would include those with catastrophic,⁹⁸ chronic,⁹⁹ or ter-

92. IND. CODE §§ 12-15-12-1 to -11 (Supp. 1992) (formerly IND. CODE § 12-1-7-16.1).

93. 42 U.S.C. § 1396n(b)(1) (1988); IND. CODE § 12-15-12-11 (Supp. 1992). To obtain a waiver, the governor, state cabinet members responsible for state Medicaid agency activities, or the Director of the state Medicaid program must submit a request to the Health Care Financing Administration (HCFA). See 42 C.F.R. § 431.55 (1992); 3 Medicare & Medicaid Guide (CCH) ¶ 14,625 (1992). President Clinton recently issued an immediate order limiting the requests that HCFA can demand from a state seeking a waiver so that the states can have more freedom to provide alternative systems in administering their Medicaid programs. Gilbert A. Lewthwaite, *President Grants Governors Freedom to Adapt Medicaid*, INDIANAPOLIS STAR, Feb. 2, 1993, at 1-2. In response, HCFA plans to develop a list of standard initiatives that will receive automatic approval. *Clinton's Short-Term Initiatives*, HEALTHSPAN, March 1993, at 15, 16.

94. S.B. 232, 108th Gen. Assembly, 1st Reg. Sess. (1993) (adding IND. CODE § 12-15-11-8); H.B. 1921, 108th Gen. Assembly, 1st Reg. Sess. (1993) (adding IND. CODE § 12-15-11-8).

95. S.B. 232, 108th Gen. Assembly, 1st Reg. Sess. (1993) (amending IND. CODE § 12-15-12-1); H.B. 1921, 108th Gen. Assembly, 1st Reg. Sess. (1993) (amending IND. CODE § 12-15-12-4).

96. H.B. 1921, 108th Gen. Assembly, 1st Reg. Sess. (1993) (amending IND. CODE § 12-15-12-5).

97. *Id.* (adding IND. CODE 12-15-37).

98. Catastrophic illnesses include: (1) burns on more than 50% of the body; (2) premature birth; (3) low birthweight; (4) malignancy requiring chemical or radiation therapy; and (5) medical diagnosis or medical condition with projected treatment costs of more than \$150,000 in a 12-month period. *Id.* (adding IND. CODE § 12-15-37-1).

99. Chronic illnesses include: (1) severe neuromuscular disease; (2) end stage renal disease with dialysis when care is not covered by the Medicare program; (3) an organ

minal illnesses. A medical panel would be created jointly by the Office of Medicaid Policy and Planning and the State Department of Health that would provide advice concerning when a Medicaid patient with a critical care diagnosis would no longer be eligible for care within the network.¹⁰⁰

The proposed Medicaid network system could also prevent the recurrence of the issues raised in the *Tioga Pines* case because nursing facility services would be reimbursed prospectively in a manner that recognizes the costs of complying with federal statutes that provide the requirements for services in nursing facilities.¹⁰¹

Another drastic change for our health care system was presented in House Bill 1273, which was submitted this session by Representative Charlie Brown.¹⁰² This bill provided that any health insurance contract entered into after December 1996 would be unenforceable.¹⁰³ In the place of traditional health insurance, the bill created the Indiana Health Insurance Plan.¹⁰⁴ The Plan was designed "to provide insurance against the cost of health care services on uniform terms and conditions available to all residents of Indiana."¹⁰⁵ This attempt to provide universal health care in Indiana came to a halt when House Bill 1273 failed to make it out of the Senate Planning and Public Services Committee.

Unfortunately, at this time, the legislative process has come to a standstill.¹⁰⁶ Governor Bayh's attempt to include a one percent tax on hospital gross revenues forced a division in the legislature that could not be remedied before the legislative term was complete.¹⁰⁷ How, and

transplant for an individual for whom it is necessary to have a transplant within 30 days or who has had a transplant in the last two years; (4) cirrhosis of the liver; (5) severe insulin dependent diabetes; (6) end stage cardiomyopathy; (7) end stage chronic obstructive pulmonary disease; (8) hemophilia or a related disorder; (9) severe autoimmune deficiency; (10) severe cystic fibrosis; (11) severe polycystic kidney; (12) ventilator dependency with little or no likelihood of returning to normal respiratory function; and (13) illness that costs more than \$250,000 in a year to treat. *Id.* (adding IND. CODE § 12-15-37-2).

100. *Id.* (adding IND. CODE § 12-15-37-11(a)(2)). See also Health Policy Report, *supra* note 2, at 21-13.

101. S.B. 232, 108th Gen. Assembly, 1st Reg. Sess. (1993) (amending IND. CODE § 12-15-14-2); H.B. 1921, 108th Gen. Assembly, 1st Reg. Sess. (1993) (amending IND. CODE § 12-15-14-2).

102. H.B. 1273, 108th Gen. Assembly, 1st Reg. Sess. (1993).

103. *Id.* (adding IND. CODE § 27-12-10-4).

104. *Id.* (adding IND. CODE § 27-12-5-1).

105. *Id.* (adding IND. CODE § 27-12-5-2).

106. Nancy J. Winkley, *Medicaid Settlement Will Be Centerpiece of Special Session* INDIANAPOLIS STAR, May 2, 1993, at B1; Nancy J. Winkley, *State Lawmakers Fail to Avert Special Session*, INDIANAPOLIS STAR, April 30, 1993, at A1.

107. See S.B. 232, 108th Gen. Assembly, 1st Reg. Sess. (1993) (adding IND. CODE 12-15-39). This tax would be imposed on the gross revenues of all hospitals, regardless

when, the health reform issues raised this term will be resolved is anyone's guess. The state has not moved much further in its struggle to provide quality health care services to its citizens: we have ventured, but we have not gained. As long as the need for health care services is examined solely through the political process, our state cannot pull free from the patchwork-type approach that is now in place.

IV. A LOOK TOWARD THE FUTURE

The proposals for health care reform are confusing and provide little satisfaction when examined on their face. It is apparent, however, that in order to provide health care benefits for the residents of our state, the legislature must examine proposals to provide for a complete renovation of our state's health care system. Any change must consider cost, access, and the economic consequences inherent in the manipulation of consumer behavior.

Currently, the legislature is faced with the challenge of halting the increase in Medicaid expenditures while continuing to provide access to health care for those whose incomes are below the poverty level. This task includes eliminating the provision of duplicitous services through programs such as the HCI program and diverting those funds elsewhere. It also includes nurturing programs that provide benefits to persons who would not have access under any program, such as the program for children with special health care needs.

Many holes exist in our current system. Yet, without a clear vision of a health care system that is tailored to an accurate profile of the health care needs of our state, the dilemma will continue. Currently, multiple pieces of legislation have been introduced that propose change. The problem is that, with so many proposals, the residents of Indiana may again be left with a fragmented health care system.

The implementation of change requires the consideration of not only the legal ramifications and administrative burdens that are inherent in these proposals, but an economic and sociologic analysis of the proposed

of whether a hospital provides care to Medicaid recipients. The purpose of the tax is to provide a mechanism through which the state would receive additional federal matching funds. See Medicaid Program; Limitations on Provider-Related Donations and Health-Care Related Taxes; Limitations on Payments to Disproportionate Share Hospitals, 57 Fed. Reg. 55118 (1992) (to be codified at 42 C.F.R. pts. 433, 447). See also Nancy J. Winkley, *Democrats Rip GOP Alternatives to Hospital Tax*, INDIANAPOLIS STAR, April 27, 1993, at B1; Nancy J. Winkley, *Senate GOP Seeking Alternatives to Bayh's Medicaid Hospital Tax*, INDIANAPOLIS STAR, April 22, 1993, at B3; Nancy J. Winkley, *Bayh Losing His Support for Plan to Tax Hospitals*, INDIANAPOLIS STAR, April 16, 1993, at A1; Nancy J. Winkley, *Medicaid Fight Looms This Week: Hospital Tax Spurs Name-Calling, Anger*, INDIANAPOLIS STAR, April 12, 1993, at D1; Eric B. Schock, *Hospital Profit Figures Contradict Bayh's Claims*, INDIANAPOLIS STAR, April 8, 1993, at A1.

program as a whole. This kind of coordinated change cannot take place when different people are considering different portions of the health care program in different locations. The legislature needs to consider the bills proposed as a whole and discuss the effects of change in terms of a complete reform package. Until this occurs, we cannot formulate a clear vision of what we are trying to create, and we can never hope to be the laboratory for change that will provide the care our residents need, and perhaps, provide a model for other states.