down its own hospital, or drove an independent hospital out of business? During 1985-97, there were 575 independent hospitals that shut down, permanently impairing the health infrastructure of America. And Columbia/HCA played a prime role.

George W. Bush and Richard Rainwater

The May 19 *Wall Street Journal* reported, "While the government had originally raised the specter of indicting high-level executives, what transpired was the indictment of four mid-level managers in Tampa, Florida." It would appear the DOJ had enough evidence to indict and prosecute Rainwater, but it appears that the DOJ will not do that. That is more than peculiar.

After Rainwater founded Columbia in 1987, he supervised its expansion. At one time, he and his wife, Darla Moore, held more than one-quarter of a billion dollars in stock in Columbia/HCA, and he drained a lot of money out of the company in earnings. The managers of the hospitals in the Columbia/HCA chain took orders from Rainwater and Scott. Columbia/HCA was one of the most centralized businesses in the United States. For example, with regard to the "upcoding" practice, which was at the center of the hundreds of millions of dollars of fraud that Columbia/HCA committed against Medicare, the March 27, 1997 *New York Times* reported: "At Columbia, employees responsible for billing Medicare recalled being presented with lists of focus [billing] codes." These codes were the more lucrative ones that the employees were supposed to use, i.e., the practice came from the top. On a witness stand, if Rainwater could "not recall" authorizing the focus codes, there apparently are many employees who can detail how indeed he did authorize them.

Why wasn't Rainwater indicted? Could it be that Rainwater, assigned by Wall Street the task of building up the personal fortune of George W. Bush, is protected? It was Rainwater who brought Bush into part ownership of the Texas Rangers baseball team, in which "Dubya" made more than $14 million when he sold his stake. It was Rainwater who structured Bush's investment into Rainwater's Crescent Real Estate Equities, whose worth grew to up to $1 million—while Bush was invested in Crescent, Crescent bought up and destroyed Charter Behavioral, the largest chain of private psychiatric hospitals in America. In turn, in 1995, it was Gov. George W. Bush who vetoed the Patients Protection Act, passed by the Texas state legislature. When provisions of the Act passed over his veto, Bush ordered the state Insurance Commissioner to make a notable exemption, to protect Columbia/HCA's profits. Rainwater and Bush share the same shareholder-value ideology.

It would appear that a faction of the Justice Department fears that a vigorous prosecution of Rainwater and top levels of Columbia/HCA could shine light on the shareholder-value policy—which the oligarchy does not wish exposed.

HMOs Put American Children at Risk

by Linda Everett

Children represent well over one-third of enrollees in managed health-care plans in the United States. Yet there is a growing body of evidence that managed-care policies are responsible for harming, maiming, or killing children, undermining the nation's most advanced pediatric treatment protocols and its critical safety net of pediatric services.

Children's hospitals annually provide inpatient care for half a million children suffering from sudden trauma, critical illness, or chronic illness and/or permanent disability, with major teaching hospitals also providing another huge component of total inpatient pediatric services. Both types of facilities have been hard hit by constricted payment rates by as health maintenance organizations (HMOs), as well as by Federal and state budget cuts. The Federal Balanced Budget Act of 1997, for example, slashed Medicare and Medicaid payments to hospitals, including funding for treatment of disproportionately high numbers of indigent patients, and for the extra costs of training doctors.

The cuts are increasingly forcing general community hospitals to reduce the number of pediatric beds, among others, or to close their pediatrics units entirely, and shifting those patients to children's hospitals. So, at the same time that there is a greater need for more highly specialized pediatric care, along with specialized outpatient medical staff and services, we are witnessing the most extreme pressures yet on these facilities, whose mission it is to never turn away a sick child (they are often filled to 100% capacity). This is a direct result of managed care's parasitical policies.

We refer to "managed care" as essentially an insurer's or HMO's interference with a physician's—or, a nation's—ability to deliver medically necessary treatment. The strictest managed-care plans include the HMO capitated system, in which a flat rate is paid to a primary care doctor (the "gatekeeper"), per person per month, which is supposed to cover all medical care the person needs, with tight control over prescription drugs, and referrals for specialists or tests. If the cost of care exceeds the HMO's limits, the doctor or hospital loses financially in any number of ways. Less strict managed-care plans may utilize an array of rules, restrictions, and preferred lists of doctors or hospitals to restrict care and costs. To make a profit, they (and the insurers behind them) must continually ratchet up the looting process, and compete for pools of patients or facilities to loot.

'Institutional Negligence'

On May 18, the Illinois Supreme Court handed down a landmark decision that may change how HMOs deliver care. The decision, which overruled an appellate court, said that HMOs *may* be held liable for "institutional negligence." The case highlights yet another deadly HMO cost-cutting policy: tightly restricting the number of doctors available, thereby making it impossible for all enrollees to get the care they need when they need it (*Jones v. Chicago HMO Ltd. of Illinois,* Docket No. 86830). On Jan. 18, 1991, Sheila Jones, the mother of a sick three-month-old infant, called her HMO primary physician about her daughter's symptoms. Office staff told her to give Shawndale castor oil. When the doctor returned her call that night, he, too, ordered castor oil. Hours later, when the child's symptoms worsened, Jones took the infant to a hospital emergency room, where she was immediately admitted with a diagnosis of bacterial meningitis, secondary to an ear infection. A medical expert testified that the HMO had deviated from the standard of care: The symptoms involved required that a physician schedule an immediate appointment to see the infant or to arrange for immediate care.

According to court papers, Chicago HMO Ltd., a for-profit corporation, paid Dr. Robert A. Jordan, Jones's doctor, a capitated rate of $34.19 per month for each female patient under the age of two, regardless of whether he treated her or not. The HMO also utilized an incentive fund for Dr. Jordan. Inpatient hospital costs were paid from this fund, and 60% of any remaining balance of the fund at year's end was then paid

Children's Hospital of Philadelphia Fights Back

Children's Hospital of Philadelphia, which provides world-renown medical and surgical care to children from around the world, is a teaching hospital that functions principally as an intensive care facility, treating the very sickest children. (For instance, Children's Hospital has separated the largest number of conjoined twins of any hospital in the United States. Polish twins, joined at the chest and hips, were separated earlier this year, and returned with their mother to Poland in February.) The hospital admits more than 15,000 patients and handles more than 600,000 emergency and other outpatient visits annually. Yet, this leader in research, with the second-largest research budget among America's pediatric hospitals, is forced to spend considerable resources to defend itself against managed care's looting practices, which hamper its critically needed specialist care.

Sixty-five percent of Children's patients are enrolled in managed-care plans, two-thirds of these are in health maintenance organizations (HMOs) and preferred provider organizations (PPOs); one-third are in indemnity or commercial plans. The remaining 35% of patients are covered by medical assistance (Medicaid or Medicare), two-thirds of which are managed-care plans and one-third fee-for-service.

On May 9, Children's Hospital filed for a preliminary injunction in Federal court to bar Independence Blue Cross (IBC), the region's largest insurer, from illegal practices, including falsely telling its members that Children's Hospital is part of its network. This is the second time in six months that the hospital has sought court intervention against Blue Cross. The court upheld its actions against the insurer. IBC uses the hospital's prestigious logo and name to lure in subscribers—although the hospital has not been part of IBC's network since its contract ended in June 1999. The hospital continues to treat IBC patients, but is reimbursed at the lower 1996 rates! That is just one reason why IBC refused to negotiate a new contract with the hospital. Only after the hospital alerted large employers with self-insured plans to deal directly with Children's Hospital, and to bypass IBC altogether, did the threat bring IBC scurrying to the negotiating table, where contract talks are now under way.

Here are some of the practices, by which IBC has been looting the hospital:

- "No pays": IBC retroactively denies claims after the hospital has already provided treatment. In one case, a three-year-old girl with a dangerous blockage of ducts draining the liver and pancreas needed surgery and 41 days of treatment. IBC denied coverage for days 22 through 27 and 31 through 35 of the child's hospitalization.
- "Slow pays": IBC refuses to pay claims in a timely way (within 45 days) as required by state law, and refuses to pay 10% interest on late claims, also required by law. The hospital is then forced to negotiate and renegotiate through a labyrinth of IBC administration, before claims are honored.
- "Unilateral changes in contracts": IBC cuts reimbursement rates for surgery and other procedures, without telling the hospital, and ignoring the terms of payments in existing contracts, causing the loss of several millions of dollars each year.
- IBC unilaterally terminated cash advance payments to the hospital five years ago, which significantly and adversely affected the hospital's cash flow. These advances, negotiated in the contract, provide cash to the hospital, while it awaits the insurer's final payment.

to Jordan. Chicago HMO's agreement says that patients with "urgent problems" must be provided same-day service, and that "emergency treatment shall be available on an immediate basis, seven days a week, 24 hours a day." It also requires that there be one full-time equivalent primary care physician for every 2,000 enrollees. The HMO told the court that it used Federal guidelines to determine that an HMO's physician is capable of handling a maximum of 3,500 patients—yet, the HMO had assigned to Jordan 4,527 patients. Jordan was also under contract to treat 1,200 enrollees with 20 other HMOs, and had his own practice of non-HMO patients. The court noted that the HMO was actively soliciting new members door-to-door, at the same time that it knew it lacked physicians who were willing to serve members in that largely African-American area of Chicago Heights—and despite its contract with the Department of Public Aid, which requires the HMO to have one full-time equivalent primary care physician for every 2,000 enrollees.

The court ruled that the HMO had a duty to its enrollees "to refrain from assigning an excessive number of patients to Jordan. It is thus reasonably foreseeable that assigning an excessive number of patients to a primary care physician could result in injury, as that care may not be provided . . . the likelihood of injury is great." Indeed, it was, for young Shawndale Jones. Today, at age nine, she is severely and permanently disabled, weighs just 45 pounds, and is unable to feed herself. The Supreme Court ruling means that the case will now go to trial.

As the Jones case demonstrates, even basic care is often lacking in HMOs that contract with state medical assistance programs; yet, states dramatically slashed their budgets by ordering even their most indigent and disabled populations to sign up with underfunded, experimental Medicaid managed-care plans, that have little or no Federal oversight or intervention. Medicaid is the state-Federal insurance program for indigent and disabled individuals.

A review of the impact of mandatory Medicaid managed-care plans on 20 children's hospitals, to assess the magnitude of problems involved, found that state laws meant to rein in egregious managed-care policies such as "no pays," "slow pays," and "carve-outs" are largely ineffective. There are some 180 children's hospitals and pediatric specialty care facilities in the country. All must now shift more resources from providing care to acutely ill children, to fighting with managed-care plans to get them to approve and pay for needed treatment. Some children's hospitals in Tennessee's mandatory managed-care Medicaid program received no payments for six months. When scores of such state plans went bankrupt or left the Medicaid program, they left children's hospitals, 45% of whose patients are covered by Medicaid, with hundreds of millions in unpaid bills.

A study by the National Association of Children's Hospitals and Related Institutions (NACHRI) reports that managed care's financial incentives:

- subject fragile newborns to multiple referrals and transfers between hospitals—sometimes to other states–in the first critical hours of life;
- delay appropriate referral to specialist expert care at a neonatal intensive care unit (NICU) "until it's dangerously late";
- promote inappropriate early discharge from NICUs, risking readmission as a result of failure to thrive or life-threatening cardiopulmonary events or heart failure; and
- disregard the need to invest in comphrehensive follow-up, such as 24-hour coverage of home ventilation, and home health visits by specially trained neonatology nurses.

Insurers and managed-care plans determine whether a treatment is "medically necessary," and the number of days needed for hospital care based on guidelines developed by actuarial firms such as Ernst & Young or Milliman & Robertson. The aim of such guidelines is to cut the insurer's or HMO's costs. The guidelines for the shortest length of hospital stay (LOS) ensure greatest profits for the insurer or HMO. It's a simple, genocidal, trade-off, of human life for dollars.

For instance, the guidelines allow two days hospitalization for an adult who undergoes amputation below the knee. That's a death sentence for a diabetic (diabetics are among the most frequent amputees), with no help at home and unlikely access to specialist nursing care in a rural area.

The guidelines have no basis in sound medical practice. A study published in the April 2000 journal *Pediatrics* was highly critical of the Seattle-based Milliman & Robertson's guidelines, which they compared to actual hospital stays in New York in 1995 for 16 childhood diseases. The study concluded that the more dangerous the disease, the more Milliman & Robertson strayed from established treatment practices, mainly because they recommend in-home, outpatient care and monitoring for diseases that involve prolonged antibiotic treatment, such as bacterial meningitis (as in the Jones case) and osteomyelitis.

Milliman & Robertson's target LOS for a child with bacterial meningitis is 3 days, with 10-14 days of in-home antibiotics and assessment of whether the child is still critically ill (13 days of hospital care is considered typical). A child stricken with osteomyelitis is allowed 3 days hospital care (11 to 12 is the norm). Other "recommended" hospital LOS goals allow 1 day for diabetic coma; 4 days for complicated appendectomy (11.7 is typical). Milliman & Robertson claims that pediatricians developed the LOS guidelines. In fact, two doctors who reviewed the data said, "They're dangerous, kids could die because of these guidelines"—and demanded that they be changed. Even Milliman & Robertson's definition of a day is arbitrary—it no longer means 24 hours, but "stages of recovery progress." These "guidelines" have no scientific basis.

Managed care's physician financial incentives and disincentives actively create barriers that deny or delay needed pediatric specialist care, critical interventions, and timely diagnostic testing, such as the Federally mandated Early Periodic Screening, Diagnosis and Treatment program (EPSDT). Yet, if children experience even a brief delay in such developmental screening, which detects emerging disabilities, chronic illnesses, or birth defects, they risk preventable lifelong injury or death.

New York, New Jersey, and Maryland have found that Medicaid managed-care plans failed miserably in providing even basic childhood immunizations in a timely manner. As a State of Minnesota study emphasizes: "Children require comprehensive services to promote physical, emotional, and intellectual growth. Unlike adults, for whom the goal of treatment is to return the patient to his/her pre-disorder condition, children need uninterrupted progress in their development. That is, at the end of treatment, children should not return to 'normal'; but, rather, arrive at a more advanced level of development." Some managed-care plans deny disabled children with complex health-care needs, basic tests that could prevent death. Children with spina bifida, for example, are denied basic urinary tests that could save them from renal failure and death.

If we give the managed-care system any credibility, we are subjecting tens of millions of our children to a *known* cause of injury or death. It's time to stop the epidemic of managed-care deaths.

A Dangerous Place for Disabled Children

The U.S. General Accounting Office (GAO) reports that, since 40% of Medicaid payments go for the care of disabled people, states are quickly enrolling this "more costly population" into capitated managed-care organizations (MCOs), which deliver medical services for a fixed fee per person ("Medicaid Managed Care, Challenges in Implementing Safeguards for Children with Special Needs," March 2000). Medicaid is the Federal-state health care program for indigent families and elderly, blind, and disabled persons. But, managed care's focus on primary care, with strict control over the use of services, "raises concern for Medicaid's approximately 7 million disabled beneficiaries," who have serious physical or mental disabilities or chronic conditions requiring frequent access to specialized doctors and significant amounts of medical care or around-the-clock nursing care.

The Balanced Budget Act of 1997 (BBA) gave states the authority, after obtaining a Federal waiver, to require that disabled children enroll in Medicaid managed-care plans. But, as Dr. Kathy McGinely of the Consortium of Citizens for Disabilities (CCD) told *EIR,* "Managed care is still a dangerous place for people with high health care costs. Managed care, in an era of trying to save money, can only be threatening to people with disabilities." The CCD, a consortium of 100 national disability organizations, worked with Sen. Charles Grassley (R-Iowa) to include language in the BBA to require the Federal government to undertake a study about how managed care works for children with disabilities. The impetus for the study was to keep all disabled people out of managed care.

The Health Care Financing Administration (HCFA), which oversees Medicare and Medicaid, published voluntary interim guidelines for the states that include a few generic patient protections, but not others. The GAO found that HCFA's guidelines do not provide education for health plans and doctors on the particular needs of children with disabilities—especially regarding developmental needs and adaptation of medical equipment. The real issue is, why are MCOs, completely inexperienced in the needs of disabled children, even allowed to contract with states to provide their care? The failings of HCFA's guidelines directly affect the survival of these children. They call for states to devise and monitor the application of a "medical necessity" definition (which HMOs determine as they choose), but it does not require a written definition reflecting the access to services required by Early Periodic Screening, Diagnosis, and Treatment (EPSDT—see accompanying article), which is infrequently spelled out in MCO contracts. MCOs are often ill-equipped to meet the wide-ranging EPSDT requirements. Nor does HCFA's medical necessity definition require MCOs to provide specific health services for children with chronic and disabling conditions in order for them to maintain a reasonable level of function, but which may not lead to a cure or significant improvements. HMOs are notorious for denying such treatment/therapy, claiming that a disabled child "won't ever walk" or "won't improve significantly."

In 1998, some 150 national advocacy organizations urged HCFA to incorporate 12 pages of new patient protections in its managed-care rules and to make those protections *mandatory*. But, no Federal or state rules, nor enforcement measures, can turn managed-care sharks in the middle of a feeding frenzy, into advocates committed to the welfare of the nation's most vulnerable population.