State Health Watch

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Governors prompt feds to take a new look at revamping Medicaid

It's an old request. State policymakers want flexibility from the federal government for delivering health care. Time and again states have asked and time and again they have been told, "Not now. Maybe later." But the political planets are now in the proper alignment to not only ask the bureaucratic behemoth in Washington, DC, once again for change but perhaps even to expect a response that is not entirely discouraging.

The federal government is starting to look pliant when it comes to Medicare and Medicaid. Newly installed President Bush strides through the Federalist camp strongly urging Congress to not only revamp Medicare but to make more than just cosmetic changes. While you're at it, Bush adds, take a long look at Medicare's basic structure and look more broadly than just adding a prescription drug benefit.

Tommy Thompson, Health and Human Services (HHS) secretary, is also a popular figure among many of the state governors. He was, after all, one of them for 14 years. He was also one of the more successful ones as he wrestled with Washington in designing and delivering Medicaid through BadgerCare in Wisconsin.

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Bush administration reverses decision on New Mexico behavioral health

The Health Care Financing Administration's (HCFA) decision last Oct. 19 to reject the state of New Mexico's request for a two-year renewal of a waiver to operate the behavioral health component of its Salud! Medicaid managed care program has been reversed by the Bush administration — to cheers from the state agency and expressions of concern from advocates.

"We are grateful to Health and Human Services Secretary Tommy Thompson for reinstating the waiver under terms that we have mutually agreed to," Robin Otten, state Human Service Department deputy secretary, said in a prepared statement. "We are also grateful that this issue has been resolved, so we can focus on providing excellent services to our clients. There are a number of ways this can be accomplished, and we are determined to find the best one for New Mexico by working collaboratively with others who care about this issue."

What state officials didn't discuss in their upbeat media release was the tight leash HCFA has applied in its decision to treat the state's approach as a new request for modification of

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Revamping Medicaid

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The National Governors Association, at its February meeting in Washington, DC, has stepped up to its own pulpit and announced that it plans to take advantage of this welcome change in attitude and timing. The association has asked the feds to widen access to Medicaid so that, according to Gov. Parris Glendening of Maryland, more people can receive basic health care, not just a relative few.

The request encourages more state and local design of education programs, such as creating more flexibility to work with established managed care networks. At issue, the governors contend, are federal rules that increase health care costs at a time when tax revenues in states are falling. The most recent batch of rules was imposed by the Clinton administration in the last weeks of its existence. Sweep those new regulations away, the governors have asked Bush, and help create a benefits package that gives states the power to widen the Medicaid net by offering help to more people with higher incomes.

Any state's attempt to do anything outside of federally established Medicaid requirements means a Sargasso Sea of paperwork and bureaucratic maneuverings. New prescription drug discount programs created, after much strain and sweat, by Maine and Vermont are an example.

How much of a chance does the governors' plan have of getting the support of Congress and the president?

"It'll get a decent ear. It puts a concept on the table that hasn't been talked about much," Debbie Chang, Maryland's Medicaid director, tells *State Health Watch*. Ms. Chang, who has seen the federal-state tug of war from both vantage points, administered the Children's Health Insurance Program (CHIP) for the Clinton administration. She recognizes that both sides have an agenda and that striking a balance on the issue is the key to success.

"No one side is better. On the Hill side, you are looking for broad principles. With Clinton, I was the lead in CHIP. I tried to implement a lot of flexibility to the states," Ms. Chang says. "We recognized that states have a different way of doing things. Where the line was crossed perhaps on the other side was with managed care regulations, where very specific guidelines or requirements really delve into the operations of programs. . . . Even for expanding coverage, this balancing act is the key and it's something that the governors appreciate."

Matt Salo, director of health legislation for the National Governors' Association, emphasizes his belief that the timing of the governors' proposal does not have much to do with having a new Congress, a new president, or a new HHS secretary.

"Really, it comes out of other factors unrelated to politics, one of which is a severe budget crunch regarding Medicaid. Our informal surveys show 25 states with some form of shortfall in the budget for the Medicaid program. That's out in the last couple of months," Mr. Salo tells *State Health Watch*. "About 25 states are proposing some expansion of coverage. Some programs are over the top, where Medicaid budgets are proposing expansions and running budget shortfalls. This would give states the tools to shore themselves up."

Medicaid spending is growing faster than is sustainable, Mr. Salo says. Medicaid spending is about 20% of any given state's budget, he says, and it had been growing in the mid- to late 1990s from 3% to 5% a year. But now many states are growing their health budget from 9% to 11% a year. "Even in a good economy, that's unsustainable," he adds. "The pharmaceutical component of the budget is growing at 20% a year. They say we can maintain this, but when the economy goes down, it's going to be bad news."

The goal of the governor's proposal, Mr. Salo says, is to streamline an unwieldy system, thereby cutting unnecessary costs. "We would like to make it easier to get waivers. We have had a number of states that have petitioned HCFA [the Health Care Financing Administration] for major Medicaid waivers for years and were told no. It's stifling real innovative changes."

Mr. Salo contends that Mr. Thompson will give the governors' proposal appropriate consideration. He says the new secretary understands the system well, that he has heard plenty of stories of frustrations of dealing with the HCFA bureaucracy. It was the last term of the Clinton administration that highlighted some current problems with Medicaid, he suggests.

"We saw 1,115 waivers approved, such as the Hawaii plan, and in Vermont, an explosion of progressive state reforms that have tapered off," Mr. Salo says. "I don't know why that was. There was no political motivation."

"We think people have been struggling to understand the rules. There are layers of complications. The governors say we need to simplify and point out that even in CHIP, it's possible to cover more low-income families and adults without creating a service package that's not all that different than Medicaid."

Elaine Ryan

Acting Executive Director
American Public Human Services Association
Washington, DC

The governors' association proposal had its genesis at a recent executive committee meeting in Utah. Howard Dean, governor of Vermont, told the committee that in his state Medicaid covered children up to 300% of poverty level with a great benefits package but that there were adults at 150% of the poverty level who got absolutely nothing. They may simply need eyeglasses to remain a functioning member of the work community, but they are not eligible for the program.

Elaine Ryan, acting executive director of the American Public Human Services Association in Washington, DC, agrees that the role of adults in Medicaid is an agent for the governors' proposed changes.

"Frankly, it was a sense that there was an increase in Medicaid costs at the state level certainly with prescription drugs that was creating pressure on state budgets," Ms. Ryan tells *State Health Watch*. "It also made state policy-makers stop to ponder what was causing that increase. It was not necessarily mothers and children, but it had to do with the breadth of people in the Medicaid program. When you look at why Medicaid costs are rising, the costs are in the elderly and disableds' prescription drugs."

There is also the belief that the current rules linking state and federal governments regarding Medicaid are more of a bowl of spaghetti, tangled and often limp. Ms. Ryan would like to see simplification of the regulations which, she says, would benefit everyone. "We think people have been struggling to understand the rules. There are layers of complications. The governors say we need to simplify and point out that even in CHIP, it's possible to cover more low-income families and adults without creating a service package that's not all that different than Medicaid."

The fundamentals in the new proposal open possibilities to broader Medicare reform discussions, Ms. Ryan adds. "We know that in the next several months, after the tax bill, Medicare reform will be a prime piece of legislation. You have two former governors who understand this issue. But with Thompson, he not only understands this issue, but he was a leader among governors trying to seek additional waiver authorization from the federal government in order to cover people more comprehensively. . . . It's courageous that the president is willing to take this on." ■

States balk at HCFA plan amendment process change

While they support the notion of cleaning up the Health Care Financing Administration's (HCFA) large backlog of plan amendments awaiting approval, states are protesting a Jan. 2, 2001, letter to state Medicaid directors from Tim Westmoreland, Medicaid director.

The letter explained that HCFA is changing its process in dealing with plan amendments, including prohibiting drawing down federal financial participation (FFP) until amendments are approved.

David Parrella, medical care administration director for the Connecticut Department of Social Services, tells *State Health Watch* the change could create significant cash-flow problems for states.

Mr. Westmoreland's letter was intended to correct a situation in which, he said, there is an increasing number of state plan amendments that are in a pending file because the state has not provided additional information requested by HCFA. Under that announced process change, HCFA has set a time limit for states to respond to its requests for additional information. If states don't respond within 90 days, the agency will start disapproval action on the amendment.

In his letter, Mr. Westmoreland wrote that the number of pending amendments exceeds 300. In the past, while HCFA has had a 90-day period in which to act on a plan amendment by approving, disapproving, or seeking additional information, states have had an indefinite time in which to respond to information requests. Often, Westmoreland wrote, a state draws down FFP while its amendment requests are in pending status. Once the state finally responds, HCFA again has 90 days in which to make its determination. If the agency does not act within the set time period, the state may assume that the amendment is approved.

Mr. Westmoreland said the backlog of hundreds of amendments for which new information is being sought creates a number of problems.

"The complicated process of trying to determine which plan pages precede the new pages often hampers our review of new amendments," he wrote. "Problems arise when states make efforts to resolve older pending amendments because expertise on the older amendments is often lost due to staff turnover. Further, states are at risk of lawsuits from providers as they are operating under a state plan that is not yet approved." he stated. "Finally, should a plan amendment be ultimately disapproved, the law requires HCFA to recover all funds drawn down under the amendment, which may be potentially large sums of money for unapproved services."

Time limit is needed

He added that setting a time limit for state action was in the best interest of the states, the federal government, and the public by assuring that all plans are acted on in a timely fashion. "Under our new procedures for timely resolution of these amendments," Mr. Westmoreland said, "we do not believe this will generally be a hindrance to drawing FFP. However, this will prevent us from advancing funds on pending amendments that may be subsequently disapproved."

But state officials see a major problem arising. Mr. Parrella says Connecticut and many other states regularly file plan amendments after their legislatures approve changes in reimbursement methodology for hospitals or nursing homes. "There can be millions of dollars involved in these changes, and, in the past, we've always assumed that if we followed the proper notice requirements and submitted a state plan amendment that is approvable, and almost all of our amendments are approved, then we could draw down FFP as we file our monthly claims during the 90 to 120 days it takes to get the amendment approved. For example, our nursing homes could be drawing down $200 million to $250 million every quarter. If they have to wait one or two quarters before they can get that money, that could be a big cash-flow problem. And it would be much worse in larger states. Even if they borrowed in anticipation of getting the FFP, there would be a significant interest cost to be paid," he explains.

"Historically, it has not been federal policy to hold FFP. Just about every year we've filed plan amendments for the hospital and/or nursing home section, and we've never had to wait to draw down FFP. In the unlikely event that a plan amendment is not approved, we negotiate a change and HCFA goes back to adjust the claims," adds Mr. Parrella.

The National Governors Association and the National Association of State Medicaid Directors have expressed concern about the letter to Tommy Thompson, new Health and Human Services secretary.

A letter from the governors said the change "represented a major shift in federal policy without any consultation with the states" and asked Thompson to "move swiftly to prevent significant loss of state flexibility and sovereignty." The governors also asked for review of other last-minute Medicaid director letters from the Clinton administration and final regulations issued on Medicaid managed care, the state Children's Health

Insurance Program, and Medicaid upper payment limits.

The Medicaid directors and the American Public Human Services Association said in their letter that while the directors had had an informal discussion with Mr. Westmoreland about the desirability of clearing the plan amendment backlog, "the final policy set forth in this letter was developed without input from the states. Some of the issues we have identified may be easily resolved with further clarification; others probably require a revision of the policy."

They also asked that the Jan. 2 letter be withdrawn until there is an opportunity for the HCFA staff and the Medicaid directors to discuss the issue and devise a process that is effective and equitable for HCFA and the state Medicaid programs.

Mr. Parrella says that while the association executive committee has usually met with Mr. Westmoreland quarterly to discuss issues and concerns, there had been no such meetings since July, partly because of the coming change in administrations after the protracted November general election.

"It's taking longer than in past years for the new administration to get to their second- and third-tier appointments. This isn't the only issue out there. During the last two weeks of the Clinton administration, we were getting Medicaid directors daily and sometimes more than one a day. I've been ignoring a lot of them so far. Are those letters the policy of the Bush administration? Who knows?" he adds.

HCFA spokeswoman Joyce Winslow tells *SHW* that HCFA considers the requirements of the letter to be in force at this time.

[Contact the National Governors Association at (202) 624-5300 and the National Association of State Medicaid Directors at (202) 682-0100.] ■

Decision reversed

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the existing Salud! program to include behavioral health and then approve it.

The Feb. 16 letter from Mike Fiore, director of the Division of Integrated Health Systems' Family and Children's Health Programs Group, said the agency's decision "was not taken lightly. We considered a number of possibilities for addressing the serious deficiencies in the New Mexico waiver, including maintaining the original schedule of moving to fee-for-service system or extending the waiver with terms and conditions.

"The advantage of a waiver extension with strong terms and conditions is the provision of a strong set of beneficiary protections designed to assure access to appropriate care that would not be present in a fee-for-service system," the letter stated.

A key contingency in the waiver approval is a redesign of the behavioral health system under Salud! designed to establish a system based on stakeholder input that addresses the concerns of beneficiaries and providers that were raised under the current system. Assistance in modifying the program design is to come from an advisory committee with beneficiaries, providers, and other representatives. There is to be a public process that will seek participation in the development and ongoing operation of the behavioral health program from:

- beneficiaries;
- family members;
- advocates;
- the state's juvenile justice system;
- the state children, youth, and families agency;
- the state department of health;
- providers;
- managed care organizations.

HCFA says the state also must "specify how it will reduce the administrative layers in the current system [such as eliminating some of the layers or by establishing a separate carve-out system, a regionally-based program, or by some other design], how it will develop standard authorization forms, how it will ensure appropriate funding for behavioral care services directly to behavioral health providers, how it will ensure coordination of behavioral health services with those provided by its sister agencies, and address other concerns raised by stakeholders."

"We are particularly encouraged by requirements of an external review focused on behavioral health services, a 15% cap on administrative costs, and the development of an early warning system. [State action to fulfill all the terms and conditions could] significantly improve access to and quality of mental health services in New Mexico."

Lee Carty
Spokesman
Bazelon Center for Mental Health Law
Washington, DC

Salud! must ensure that at least 85% of the payments made to managed care organizations for behavioral health care and services will be paid to behavioral health providers for beneficiary behavioral health care and services. The program also

will review statewide availability of community-based services for adults with serious mental illness and children with serious emotional disturbance, and will consider exempting from managed care enrollment those individuals who are at the highest risk of institutionalization.

The approval also requires a review of service authorization decisions by qualified health professionals working for an independent organization such as a professional review organization. The contractor is to audit a statistically valid sample of reductions, terminations, and denials of behavioral health service decisions to determine if authorized service levels are appropriate with respect to accepted standards of clinical care. The state must take timely corrective action with managed care organizations as needed based on the audit reports.

By May 1, 2001, New Mexico must set up separate toll-free telephone lines for providers and beneficiaries to use to report concerns related to behavioral health service authorization denials or reductions. State officials also have to explain how they will respond to all concerns in a timely manner and work with managed care organizations to resolve problems when possible.

An early warning system that tracks and reports key variables of program performance related to behavioral health services must be established by July 1, 2001. "The state will involve key stakeholders in considering the key variables of program performance to be included in the tracking system," the study stated.

The state's plan also must ensure that each managed care organization provides quarterly reports on the network capacity of behavioral health providers and facilities beginning July 1, 2001.

The Salud! analysis is to show an unduplicated count of network providers and facilities and their capacity to provide care and services to beneficiaries. If HCFA determines, after discussions with state officials, that network capacity is below reasonable standards in any area of the state, based on the customary capacity standard in that area, the state must permit beneficiaries to go out of network for behavioral health care and services in that particular area until the state can demonstrate to HCFA that the network capacity complies with the appropriate standard for the area.

HCFA's decision to reinstate the waiver was met with a statement of regret issued by one of the chief critics of Salud! behavioral health — the Bazelon Center for Mental Health Law in Washington, DC. The center opened an area on its web site containing all of its reports from last year that had criticized the Salud! behavioral health program and had called for rejection of the waiver extension.

But Bazelon center spokesman Lee Carty says, "We are particularly encouraged by requirements of an external review focused on behavioral health services, a 15% cap on administrative costs, and the development of an early warning system."

Mr. Carty adds, "[State action to fulfill all the terms and conditions could] significantly improve access to and quality of mental health services in New Mexico." ■

Nurse anesthetist controversy continues

The dispute over a proposed Medicare rule that would allow certified nurse anesthetists to provide services without physician supervision in states where such practice is allowed by state law shows no sign of abating. (For more on the controversy, see *State Health Watch*, March 2001, cover story.)

In the latest salvo, the American Society of Anesthesiologists released the results of a survey the group sponsored that found that 92% of Medicare beneficiaries want to have the "same benefits and quality of care" in all 50 states and 94% of adults who are not yet covered by Medicare but will be some day said benefits and care should be the same regardless of where patients live.

The survey, conducted by The Tarance Group in Alexandria, VA, also found that 75% of seniors surveyed had had an operation requiring general anesthesia, most of them while covered by Medicare, and 86% of those who had an operation said they were very satisfied or extremely satisfied with the care they received under the current Medicare physician supervision rules.

Neil Swissman, MD, society president, said the doctors' concern has been that "by leaving it up to the states to decide who will care for Medicare patients, a patchwork-like quilt of regulations will result. A patient ends up with various degrees of medical coverage depending on where that patient lives or visits. In essence, people are then forced into the unrealistic position of anticipating their illnesses and injuries and then picking where they will occur."

Swissman said that almost 80% of those surveyed oppose or strongly oppose dropping the rule that requires nurse anesthetists to be supervised by a doctor.

The anesthesiologists are calling on the Bush administration to reverse what they say was a "politically motivated decision" to approve the rule in the waning days of the Clinton administration. ■

Surging economy and public coverage are credited for decline in numbers of uninsured, says EBRI

The numbers of the uninsured in America had stopped growing and was actually declining, according to a recently released study completed with census figures from March 2000.

But the researchers caution that, one year later, a sag in the economy and the reemergence of health care cost inflation could cause the ranks of the uninsured to start growing again.

Surging now, but later?

The study, from the Employee Benefit Research Institute (EBRI) in Washington, DC, casts a spotlight on a moment in time when the economy was surging and the past year's steady drop in corporate profits and key economic indicators was only a month away from rearing its head.

"The March [2001] data come out, I think, in October," Rachel Christensen, EBRI research analyst, tells *State Health Watch*. "I think the economy probably started weakening late last year, so there might be interesting effects coming."

Conclusions from the study include:

• For the first time since 1987, the percentage of Americans with health insurance increased in 1999.

• The overall drop in the number of Americans without health insurance is credited to low employment and a strong economy.

• While states added thousands more children to the Children's Health Insurance Program (CHIP), public health insurance coverage did not increase between 1998 and 1999.

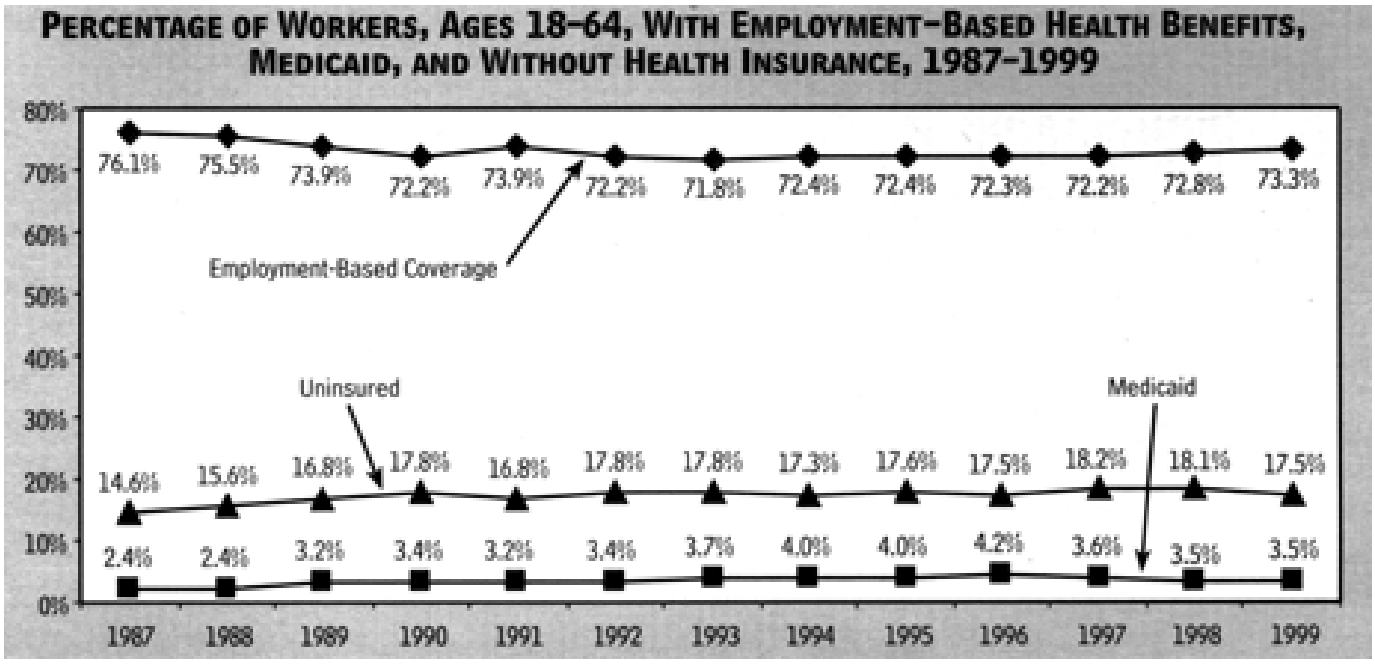
"The percentage of children in families just above the poverty level without health insurance coverage declined dramatically, from 27.2% uninsured in 1998 to 19.7% uninsured in 1999," the study notes.

"Some of the decline can be attributed to expansions in Medicaid and CHIP, but it appears that expansion in employment based health insurance and individually purchased coverage had an even larger effect than expansion of CHIP," according to the study.

• More than 42 Americans, in 1999, were without health insurance.

"Should a severe downturn in the economy occur, causing the uninsured to represent 25% of the nonelderly population, 63 million Americans would be uninsured," the study concludes.

This is also the first time that the numbers of Americans without health insurance has dropped.



Source: Employee Benefit Research Institute, Washington, DC. Estimates from the March 1988-2000 Current Population Surveys.

Between 1987 and 1993, the rise in the number of those without health insurance rose because of the an erosion of employment-based benefits, the study notes.

Employers started picking up the pace between 1993 and 1998, the study continues, and more people were covered, but a "decline in public sources of health insurance would mostly explain the increase in the uninsured population," the study points out.

Return of inflation

Employment-based health insurance coverage grew between 1997 and 1998, according to the study, producing some expected and unexpected results.

"It is not surprising because the strong economy and low unemployment rates have caused more employers to provide health benefits in order to attract and retain workers," the study notes, "and also may have resulted in more workers being able to afford health insurance. It is surprising because 1998 saw the return of health care cost inflation, and this inflationary trend accelerated in 1999."

More competitive health care markets and alternative forms of third-party reimbursement arrangements (capitation, fee scheduling, and discounting, for instance), make it tougher for providers to shift the costs to other health care payers, the study notes.

"As a result, the nature of cost shifting may be changing," according to the study.

Figures used in the study were taken from the March 2000 Current Population Survey, which is conducted every year by the U.S. Census Bureau. The numbers and the conclusions from EBRI are collated and presented to inform health care policy and policy-makers, Ms. Christensen explains. ■

Health-e-App, an Internet enrollment program for child health insurance, tested in California

Officials are assessing results of a one-month pilot test of Health-e-App, the nation's first effort to use the Internet to enroll low-income children and expectant mothers in public health insurance programs.

The pilot was conducted in a variety of settings in San Diego County, CA, including community clinics and community-based organizations that conduct outreach and enrollment at schools; Women, Infants, Children program sites; and other enrollment locations, Oxana Smith, deputy director of the San Diego County Health and Human Services Agency, tells *State Health Watch*.

Efforts to develop an Internet application process started in October 1998 when the Medi-Cal Policy Institute released a report on improving the Healthy Families/Medi-Cal application process. The report provided guidance to the state on simplifying the original 28-page joint Healthy Families/Medi-Cal application and streamlining the enrollment process for both programs. In November 1998, the California HealthCare Foundation issued a request for proposals for development of an automated system for enrolling women and children in Medi-Cal and children in the Healthy Families program. In January 1999, Deloitte Consulting was awarded the contract to build an interactive, interview-style web-based application.

Program sponsors say automating the enrollment process can have a number of benefits, including:

• a more consumer-friendly way to apply for public health insurance programs by providing applicants with real-time preliminary eligibility determinations, confirming submission and receipts of applications by the state, and offering on-line selection of health plans and providers;

• reduced error rates on applications by improving the accuracy and completeness of applications;

• improved efficiencies in the enrollment process by eliminating manual data entry and unnecessary handling of applications, removing the need to mail applications, and speeding the time it takes for eligible applicants to receive health benefits;

• reduced enrollment costs;

• increased enrollment in Healthy Families by word-of-mouth promotion of the consumer-friendly enhancements, especially real-time notification and instantaneous application submission, and an electronic mechanism for counties to transfer qualified share-of-cost Medi-Cal cases to Healthy Families, which has an enhanced federal match;

• improved accountability by creating an administrative system for government agencies to track and report payments to enrollment entities and to track application disposition and payment status;

• on-line selection of providers and health plans for Healthy Families applicants;

• more complete and accurate enrollment data, which will improve the quality of Health Plan Employer Data and Information Set and other reports that use encounter data in Medi-Cal and Healthy Families.

When fully implemented, Health-e-App will offer families the ability to apply for Healthy Families or Medi-Cal from anywhere they have access to the Internet, whether at home, in a library, at a school, or while visiting a community health clinic. While individuals can access and use the application themselves, its greatest use may be in locations at which trained staff

are available to assist families.

Health-e-App initially has been made available in English, Spanish, and read-aloud text for the visually impaired. The program prompts applicants on the specific information needed and ensures that essential information is not left out. Families receive immediate, on-line feedback about their eligibility, and the complete application is submitted electronically to the state with an electronic signature. Applicants also can select physicians and health plans on-line based on criteria important to them such as language, medical specialty, and how far they are able to travel to see a doctor.

Ms. Smith says there was an initial two-week pilot at one San Diego site last year to find and resolve bugs in the system. The one-month test at six sites began January 2001.

Where assistors were available in community settings, applicants were given a choice of using the on-line application or the traditional paper form. Most people, Ms. Smith says, chose the on-line form. "From what we can see so far in a fairly small pilot in limited applications, we're getting many more applications back. It seems to be achieving the purpose of getting people more engaged in the application process. The on-line form is pretty faithful to the paper application. Edits and controls are in place to be sure the information is cleaner and more legible than we get with the paper application."

She says Health-e-App appears to have proven itself to be "better, cheaper, faster," and notes the applicants particularly like "learning pretty quickly if they are eligible." Once the pilot data have been analyzed, she says, officials will be "thinking about how to finance, fund, and make the process happen at thousands of sites statewide."

[Contact Oxana Smith at (619) 685-2577.] ■

Tennessee, with $109.4 million, still doesn't cover its health costs

Tennessee's TennCare Medicaid managed care program has sent $109.4 million to more than 100 hospitals and more than 1,500 individual and group providers who supplied most of the TennCare coverage last year.

The January 2001 payments came nearly five months after the state legislature promised the money.

While they say they are grateful for the payments, health care providers said the money covered only a portion of their TennCare losses.

> For many hospitals, the payments were the difference between a bad loss and a break-even year. "These payments were crucial for the survival of some facilities."
>
> Craig Black
> *President*
> *Tennessee Hospital Association*
> *Nashville*

John Tighe, state Finance Department deputy commissioner, says the agency was glad to be able to mail checks "to the providers who have helped us make this program work for the people we all serve, the members of TennCare. At the heart of TennCare are the doctors, hospitals, clinics, and the people who work in them, and they are the ones who truly serve the TennCare members."

The legislature appropriated $90 million in special funds to pay essential access hospitals, plus $5 million for a pediatric primary care pool, $2 million for community health centers, and $5 million for specialty outpatient providers — HIV/AIDS clinics, orthopedics, neurology, and dental. A separate allocation of $7.4 million will be paid to federally qualified health centers.

The formula for distributing the funds was developed by the comptroller of the treasury and the commissioner of finance and administration.

Under the formula for essential access hospitals, $38 million went to safety-net facilities, defined as a Level I trauma center and a regional perinatal center.

The remaining $52 million went to other essential access hospitals defined as other participating hospitals, Medicare-defined "sole community hospitals," children's hospitals (allocated $4 million of the $52 million), and private psychiatric hospitals (allocated $2 million of the $52 million).

Factors for qualification of the "other essential access" hospitals were those with at least 14% TennCare utilization, based on TennCare-adjusted days, and those with more than 10% TennCare utilization, based on TennCare-adjusted days and more than 3,000 TennCare-adjusted days.

Factors for disqualification included hospitals with no unreimbursed costs (TennCare loss plus charity care and bad debt are greater than $0) or hospitals no longer participating in TennCare at the time of payment.

Craig Black, president of the Tennessee Hospital Association in Nashville, says that for many hospitals, the payments were the difference between a bad loss and a break-even year. "These payments were critical for the survival of some facilities," he adds. ■

Clip files / Local news from the states

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

Deep in the heart of Texas, a fight over privacy of medical records rages

AUSTIN, TX—Veterans of battles over health care reform and patient protection that date to the early 1990s are gearing up for another fight in the Texas legislature.

This time, the debate is over how far to go to keep Texans' medical records private. After months of negotiations that have intensified in recent weeks, lawmakers took their first look at proposed privacy laws recently at a joint meeting of the Senate Business and Commerce and Health and Human Services committees.

On one side are doctors and consumer groups, who want tough laws to keep private medical data — ranging from patients' lab results to their family history to their prescription records — from being disclosed without their permission.

"People are terrorized about their private health care data," said Rep. Glen Maxey (D-Austin) who filed a bill Feb. 2 that would require patient consent before medical data are used by anyone but health care providers and insurance companies. "We want to put a state protection in place."

On the other side are health insurers, drug companies, and business groups, who say new privacy restrictions would make it harder for them to control costs and do business in Texas. They are especially concerned about a proposal to give patients the right to sue any entity — including an employer — that violates the confidentiality of their medical records.

—*Austin American-Statesman*, Feb. 28

In Minnesota, a new bill is introduced to give patients more power

St. Paul, MN—Minnesota lawmakers have vowed to try again to pass a bill giving patients more power over the decisions of health maintenance organizations.

The measure passed the Senate last session but died in the House amid concerns about a provision that would allow patients to sue their insurers. It was known then as the "Patients Bill of Rights," but this session lawmakers gave the plan a new name: "The Fairness in Health Care Act."

The bill by Sen. Don Samuelson is patterned after one under consideration in Congress and a similar law in Texas that has withstood a challenge in federal court.

Among other things, the plan would require health plans to hire medical specialists licensed in Minnesota for any reviews of decisions by state physicians. Backers say under current practice, health plans can use out-of-state reviewers who are not specialists.

Associated Press, Feb. 28

Prescription drug skirmish in Illinois involves two parties and osteoporosis

SPRINGFIELD, IL—A bill to further expand a state program that helps low-income senior citizens pay for prescription drugs recently led to a partisan dogfight in an Illinois House Revenue subcommittee.

Lee Daniels, House minority leader, is sponsoring House Bill 5, which would expand Illinois' circuit-breaker program for the poor to cover prescription drugs to treat osteoporosis and other diseases. It also would raise the income threshold to qualify more people.

Democrats had a different idea, though, and Rep. Joe Lyons of Chicago amended the Republican bill to cover all prescription drugs and remove the age barrier to qualify.

Mr. Daniels contended the change would cost the state $2 billion to $4 billion annually. Barbara Flynn Currie, House majority leader, who is not a member of the subcommittee, said the amendment would cost much less.

"I think, Rep. Lyons, you are unfortunately being caught up in some extreme negative politics that are very harmful to our senior population," Mr. Daniels said. "I think you are going to regret this move. There are 370,000 women over the age of 65 who need this state's help because they're suffering a crippling disease."

Providence Journal, March 1

If you're paying cash for prescriptions in Hawaii, policy-makers have a new offer

HONOLULU—House lawmakers in Hawaii want the state to address sky-high prescription drug costs for the first time with a proposed discount program for people who pay cash for their medicine.

Officials with the state's largest health insurer said they aren't sure how much the program will actually save consumers, but Rep. Roy Takumi said he hopes the effort will cut participants' drug costs by 15%.

"It's just good public policy," said Mr. Takumi. "Should we try to have a program that allows our residents to enjoy the same savings that all of us in a drug plan now enjoy? It's a no-brainer."

Mr. Takumi said the program would be open to any-

one, but the biggest beneficiaries would be 220,000 Hawaii residents who have no drug coverage. Others who might benefit are people who exceed the limits of their drug coverage and have to pay for additional prescriptions out of pocket.

Under the bill, experts hired by the state would negotiate with pharmaceutical companies to develop a list of discounted prices for people in the program. The logic is that the consumers' combined purchasing power would give the group leverage in the price negotiations.

—*Honolulu Advertiser*, March 1

Day care centers in Tennessee may begin requiring vaccinations

KNOXVILLE, TN—The state is considering requiring a new vaccine — one that could eliminate some life-threatening childhood illnesses and painful inner-ear infections — for all children entering day care.

Marketed under the brand name Prevnar, it is a sort of kids' version of what's commonly called the "pneumonia vaccine" for adults. It attacks the seven most common kinds of pneumococcal infections that strike children under the age of 2, including deadly pneumococcus meningitis.

"We are talking about a vaccine that not only keeps a child well, but prevents [him or her] from developing absolutely devastating illnesses," said Jerry Narramore, director of immunization with the state department of health.

It has been offered for several months at Metro's Lentz Health Center by the county health department.

"It will also reduce the occurrence of the most severe sort of middle-ear infection, which, though not life-threatening, is hugely bothersome," said Bill Schaffner, MD, infectious diseases specialist at Vanderbilt University Medical Center in Nashville.

In most cases, it will eliminate the need for placing tubes in a child's ears, a common practice to promote drainage. It also will eliminate the need for multiple doses of antibiotics to cure infection.

—*The Tennessean*, March 6

Illinois state government has questions about contract

SPRINGFIELD, IL—Senate Republicans pressed for hearings so state welfare officials and the Rev. Jesse Jackson can explain a controversial $763,000 no-bid state contract awarded to his Rainbow/PUSH Coalition.

The Public Aid Department signed the pact last summer with Jackson's organization to promote and help enroll poor children in the state's KidCare health insurance program. But agency officials have no way of measuring how many kids the organization has enrolled in the program.

"I don't think you can let a $750,000 contract pass without asking for some accountability," said Sen. Steve Rauschenberger (R-Elgin), chairman of the Senate Appropriations Committee.

Rauschenberger indicated he would call Public Aid officials and perhaps Jackson himself before the Senate panel to justify the deal, which pays Rainbow/PUSH differently than other organizations that sign up KidCare recipients. Jackson's organization receives a set amount. Other community organizations get $50 per child enrolled in KidCare.

—*Chicago Sun-Times*, March 7

Maryland officials seek more money for prescription drugs

ANNAPOLIS, MD—Maryland legislative leaders plan to ask Gov. Parris N. Glendening to add as much as $20 million to the state budget to help tens of thousands of senior citizens afford the rising cost of prescription drugs.

In the Senate, Finance Committee Chairman Thomas L. Bromwell said he expects his committee to vote on a bill to spend as much as $20 million to help 100,000 Maryland residents who lack adequate prescription drug coverage.

In the House of Delegates, Economic Matters Committee Chairman Michael E. Busch said leaders there decided to devote an extra $13 million to $16 million to prescription drug programs, with a goal of assisting 30,000 to 40,000 people.

"We're trying to craft a program that will provide some relief for our priority, which is senior citizens," said Busch, who expects his committee to approve a bill as early as mid-March.

—*Washington Post*, March 7

The state of New York hospitals: Critical condition and declining

ALBANY, NY—The sorry state of hospital finances took center stage as the Healthcare Association of New York State (HANYS) held its Lobby Day at the Empire State Plaza.

A report issued by HANYS shows that New York hospitals bled red ink to the tune of $539 million in 1999 and $149 million in 1998, while the operating and bottom-line margins at the hospitals plunged to 49th in the

State Health Watch

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nation. Only Rhode Island fared worse, HANYS officials said.

"The hospitals are clearly going into critical condition," said Daniel Sisto, president of HANYS, an East Greenbush-based trade group that represents more than 550 hospitals and health care facilities in the state. "The Crouse-Irving [Hospital in Syracuse] bankruptcy is symptomatic of an industry in general decline."

The data have prompted officials with HANYS to ask the state for $500 million to help recruit and retain health care workers.

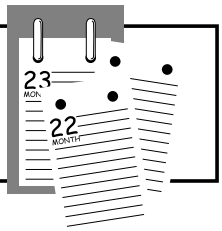
Nurses, technicians and other caregivers are in short supply, as industry executives have not been shy in saying. "Manpower is one of the major issues that we're facing," said G.B. "Sam" Serrill, president of Ellis Hospital in Schenectady.

Ellis, anticipating a 2000 deficit in the millions, is closing its maternity ward and three primary-care centers. Other area institutions, including Albany Medical Center, are also bracing for bad news once auditors get through crunching last year's numbers.

Containing labor costs is a key to reining in expenses, said Gary Lang, vice president and chief financial officer of St. Peter's Health Care Services, parent to St. Peter's Hospital in Albany.

—*Albany Times Union*, March 7

CALENDAR



• The National Academy for State Health Policy holds it first Coast Kids Conference in Portland, ME, May 29-31.

Conference topics include: fragmentation of children's services, seamless systems of care, collaborative delivery approaches, and access to care.

For more information, call (207) 874-6524. Web site: www.nashp.org. ■