State Health Watch

Vol. 5 No. 9 — *The Newsletter on State Health Care Reform* — September 1998

Magellan, providers compromise on Montana's managed mental health care; payments to be cut 8.5%

In a last-ditch effort to save Montana's hemorrhaging managed mental health program, more than 30 nonprofit providers have agreed to give for-profit Magellan Health Services the authority to cut the rates it pays them.

The decision was a major concession by the Care Coalition, which represents the nonprofits and voiced strong opposition to Atlanta-based Magellan's proposal to cut payments to psychiatrists and other care providers by 8.5% in an effort to save $310,000 a month.

Montana Community Partners (MCP), the partnership between Magellan and the Care Coalition established to oversee the program, previously had voted to oppose the cuts. Magellan, which responded to the earlier vote by announcing plans to cancel its five-year, $400 million contract with the state, released audited financial statements this summer showing a loss of $15.7 million for the year ended March 30, 1998.

In exchange for the concession on rates, the Care Coalition was guaranteed a voice in policy, while the board of Montana Community Partners will have authority to set goals and directions for the managed care program. Such partnerships between nonprofit human service providers and for-profits have been tried elsewhere with varying degrees of success, but Montana's attempt to introduce managed care to a rural state with little managed care experience has been plagued with difficulties since its April 1, 1997, inception.

The provider coalition initially partnered with CMG Health, which has been widely criticized for lacking the public-sector experience needed to run the program. CMG subsequently was purchased by Merit Behavioral Care, which, in turn, was purchased by Magellan in February 1998.

Shortly after purchasing Merit, Magellan decided to scrap the CMG computer information system and to switch the Montana program to Magellan's system, based in St. Louis. Top

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In This Issue

OIG crackdown on excluded physicians, suppliers raises states' oversight burden

The Department of Health and Human Services' Office of the Inspector General (OIG) has backed away from excluding providers for not offering Medicare and state health programs the lowest price. However, the OIG intends to clamp down on excluded physicians, manufacturers and distributors, which undoubtedly will add considerably to state program directors' oversight headaches.

A proposed OIG rule, intended to implement portions of the Health Insurance Portability and Accountability Act (HIPAA) legislation, would have permitted exclusion of providers that charged Medicare/Medicaid "substantially in excess" of what they charged other customers. That provoked an outcry from providers who feared they could be sanctioned for discounted arrangements with HMOs.

"This would have destroyed any chance of offering flexible pricing," explained attorney Bill Sarraille, JD, of law firm Arent Fox in Washington, DC. OIG eliminated the provision from a package of final rules, published in the Sept. 2 *Federal Register*.

But if OIG has closed one avenue to exclusion, it's opened another. Now, manufacturers and distributors that don't file Medicare or Medicaid claims face the ultimate sanction. OIG had previously maintained that while it had the authority to exclude manufacturers and distributors that didn't submit claims, it wouldn't do so for logistical reasons. "We have now

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OIG cracks down on physicians

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concluded that such exclusions should be undertaken, when warranted by the conduct of such entities, notwithstanding the administrative burdens," the agency said.

Program managers must check

In addition, because OIG can penalize anyone who deals with an excluded company, program directors and providers will have to check and keep checking who's on OIG's excluded list, which is posted monthly on the agency's site on the World Wide Web (http://www.hhs.gov/progorg/oig/cumsan/cumsanc.html).

"The government is going to take the position that because the lists are public, it's [the providers'] responsibility to look at them," Sarraille predicted.

However, the federal watchdogs did hedge a little. "We wouldn't expect that manufacturers would often be convicted and subject to a mandatory exclusion," the agency said. Indeed, OIG spokeswoman Judy Holtz claims the agency has never taken such an action.

Because excluding a manufacturer might hurt customers, OIG says it's "committed to exercising this sanction authority carefully and prudently, and acting only where the excluded provider's product can be clearly identified."

Waivers will be given, for example, to a pharmaceutical company that makes a unique drug. Still, anyone who submits claims that involve items made by an excluded indirect provider is subject to a civil monetary penalty. But OIG will only come down on those who "knew or should have known" they were submitting those claims. Plus, providers will be allowed to bill for products for up to 30 days after the effective date of the manufacturer's exclusion, and up to 60 days until October 1999.

State program directors also should be aware that the new set of rules, which takes effect Oct. 2, also:

• Lengthens exclusions. OIG now will use any adverse actions by any federal, state or local agency or board when deciding the length of exclusions.

• Blocks voluntary withdrawals. Providers under investigation by state agencies can't avoid OIG exclusion by withdrawing from the state program. OIG now requires that if a state agency serves a provider with a written notice of charges or allegations, the agency also must report the action to OIG for an exclusionary review regardless of whether the provider withdraws from the state program.

• Penalizes officers and managing staff. OIG is sticking by its plan to exclude the officers and managing staff of excluded companies, as well as any owners. State programs will have to monitor providers and suppliers to make sure there's no overlap in ownership by excluded individuals.

Harsh penalties for barred doctors

The federal watchdogs particularly want to crack down on hospitals that hire excluded doctors, according to the proposed rules. "The OIG has been made aware of situations where individuals who have been excluded from Medicare or state health care program participation have been able to obtain (or retain) employment, staff privileges or other affiliation with various health care entities, and to render services that are ultimately paid for by the programs," said OIG.

The agency proposes a civil monetary penalty of up to $10,000 for any provider that bills for the services of excluded employees. The exact fine would depend on whether the billing provider knew or should have known of the exclusion, any potential harm to Medicare/Medicaid or patients, and a history of prior sanctions.

In addition, an excluded person could no longer work for a federal agency that funds a federal health care program. Thus the Defense Department, which funds CHAMPUS, no longer would have any discretion to pay excluded parties for any services, nor may it pay them a salary. "In most instances, the effect of an OIG exclusion will preclude the employment of an excluded individual in any capacity by a federal or state agency," OIG noted. Many private payers also will not deal with anyone excluded by Medicare, added Sarraille. ■

Compromise

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Magellan officials promised the move would bring dramatic improvements in both speed of reimbursement and quality of services. Six weeks after completing the computer conversion, "The information processing ability has improved beyond what it was in the first 15 months," said Steve Niemi, senior vice president in Magellan's Public Sector Division. "We now have a claims processing system that is stable."

But many providers question the level of improvement, noting that there is still a substantial amount of claims outstanding for more than 30 days. Meanwhile, the huge losses sustained over the past year hang over the program. The audit note from the Arthur Andersen accounting firm accompanying the bleak earnings report in July was ominous: MCP "has suffered a significant net loss and has net equity and working capital deficiencies that raise substantial doubt about its ability to continue as a going concern."

Before announcement of the compromise, Magellan's Public Sector Division chief C. Richard Orndoff stressed in a letter to the state that the company was "anxious to continue working with the state to make the program successful, but, frankly, we agree with the independent auditors and are deeply concerned about the fiscal viability of the program."

Prompted by Magellan's attempt to cut rates paid providers, Montana's medical, psychiatric, and hospital associations had lobbied Gov. Marc Racicot to cancel the contract with MCP. "The underlying problem is patient care," said Don Harr, MD, a member of the Montana Psychiatric Association. "There is also the frustration of individuals and institutions having to continue care without remuneration or at least with delay in remuneration."

Some Montanans involved with mental health care have begun public discussions of possible alternatives to the MCP contract, such as setting up regional networks to be run by Montana organizations. The discussions included members of the program oversight committee who

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had been appointed by the state to make recommendations on MCP's work.

Regardless of MCP's future viability, key players say they have learned from the experience. Bob Ross, executive director for one of four regional mental health centers in Montana, said the partnership of providers and a corporate manager hasn't been anything like what Montana providers envisioned when they agreed to partner with CMG in the bidding for Montana's contract.

"We bought into individuals who really understood mental health care, what we proposed, and what they promised. Then the accountants came out to run the contract," said Mr. Ross.

Royal Johnson, a Montana legislator who served on the advisory committee that reviewed all four bids and ranked CMG's proposal as the best of the bunch, said the reasons for wanting to change Montana's mental health system are still valid. In the early 1990's, Montana saw state spending on mental health care increase 20% a year for three consecutive years. "Everybody could see that couldn't last," he noted. Implementing the contract four months from the bid award was too ambitious, as well. "If the state had stayed in the business, we could have integrated them by degrees, starting with hospital care," Mr. Johnson said.

Randy Poulsen, head of the state Managed Care Bureau, offered this advice for states: Choose carefully, do site visits and check references. And he suggested state staff need to monitor the contractor vigilantly from day one. "The tendency is to start out with a degree of faith in the company you have chosen. Set that aside. Let them know you have to watch them. Establish from the outset a zero tolerance for mistakes," Mr. Poulsen said.

"Maybe we should have done more micromanagement," he added, noting that the state had been prepared to look at outcomes and overall program structure. "Instead, we had to deal with the minutiae of claims and poor communication." Montana's rural character presented additional challenges for managed care. Before the mental health contract started, managed care was rare in both private and public health programs in Montana. Additionally, there are no psychiatrists practicing in the eastern third of the state. Even in population centers, psychiatrists are in short supply and patients depend on primary care professionals to write prescriptions and check medications. Yet primary care professionals were left out of plans for the provider network.

"CMG didn't understand what it meant that Montana is a frontier state," Mr. Poulsen said. Bill Emmet, chief operating officer for the National Alliance for the Mentally Ill, sees in Montana some difficulties other states have experienced. "To look at managed care coming into a state as the solution to rising costs alone sets up unrealistic expectations," he observed. "The rush to managed care a few years ago almost universally failed to take local conditions into account," as experiences in Tennessee and Iowa proved, he said.

Contact Mr. Emmet at (703) 516-7970; Mr. Ross at (406) 252-5658; Mr. Olsen at (406) 442-1911; and Mr. Poulsen at (406) 444-2706. ■

NYC delays implementation of Medicaid managed care

The New York State Department of Health has asked the Health Care Financing Administration (HCFA) to delay its readiness review of Medicaid managed care implementation in the boroughs of Brooklyn, Manhattan and Staten Island in New York City, by waiting to mail notification letters until at least the end of 1998.

"We experienced delays in contracting with our enrollment broker," said Frances Tarlton, spokeswoman for the Health Department, "and thought it would be best to hold the review in mid-October."

Tom McGraw, vice president for managed care of MAXIMUS, Inc., the McLean, VA, company that will provide benefits education and enrollment services, said the firm had experienced delays in leasing and renovating office space but would be ready to operate as of Sept. 21. MAXIMUS originally had planned to be operational Sept. 2.

Sue Kelly, the Medicaid associate regional administrator in HCFA Region 2, said the HCFA review will examine adequacy of the provider networks among plans in the ZIP code areas that will first implement the mandatory program — Brooklyn, Manhattan and all of Staten Island — with an estimated 240,000 people to be enrolled. The review also will examine marketing, education and outreach to beneficiaries, enrollment systems, quality monitoring systems, the complaints process and the mechanism for excluding or exempting beneficiaries.

"The whole point of the readiness review is to ensure that people will be making informed choices for their health care," Ms. Kelly said.

Judy Wessler, policy coordinator for the Commission on the Public's Health System, praised the decision to move cautiously. "There will be a lot of people with serious illnesses pushed into Medicaid managed care," she said. "We need to be sure that what is needed is in place when the program starts."

One of the biggest concerns raised about Medicaid managed care in New York City has been adequacy of provider networks for those who must participate. Ms. Kelly said while HCFA will look at each geographic area as a site with its own unique needs, the agency has some idea of what it wants to see in terms of the number of enrollees each primary care physician can reasonably be expected to be responsible for.

"Some studies have been done, both nationally and locally," she reported. "The City of New York commissioned New York University to research the situation in the initial ZIP code areas, and they gave us their independent assessment. We also make use of analyses done nationally regarding level of capacity that is appropriate."

While the New York University study looked at ratios of 900-1,500 to 1, the ratio chosen was 1,500 enrollees per primary care physician, said Daniel Walsky, HCFA's New York branch director. That is a "fairly standard ratio nationally," he said.

Ms. Wessler, the consumer advocate, said many consumer organizations had been "actively involved in recommending changes to the program and are pleased that some of their recommendations were accepted." She said the consumer groups

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had raised concerns that the proposed ratio of primary care providers to enrollees was too high and patients would not be able to get appointments, and state and city officials had agreed to lower the ratio.

Leslie Moran, senior vice president of the HMO Council and Conference of New York, said plans have been committed to the program since its inception because they believe it is the "right approach for providing health care services to this population and will offer better access and higher quality."

'The process is probably slower than many people would like, but we don't want to go ahead and then see people not being well-served because too many people came in too quickly.'

— Leslie Moran

"Plans are working extremely hard to ensure that the provider panels are adequate," she said. "You can't move forward without sufficient capacity. The process is probably slower than many people would like, but we don't want to go ahead and then see people not being well-served because too many people came in too quickly."

A second major concern has been over the work to be provided by MAXIMUS, the benefits broker with a two-year, $24 million contract to provide education, outreach and enrollment services. Mr. McGraw said while finalizing office space, his firm has screened more than 1,000 resumes and hired more than 300 people for initial start-up at the end of September. More people will be added as the mandatory program moves into full swing, he said. Ms. Wessler said it appears MAXIMUS has hired "some good people who have a community and consumer perspective."

MAXIMUS is responsible for providing information on managed care plans and their provider networks to recipients, for staffing a city- and statewide help line, and for working with managed care plans to assist callers with their health care questions and issues. The contract includes incentives for in-person benefits counseling and presentations.

Mr. McGraw said MAXIMUS has completed drafts of policy and procedures manuals, a training curriculum and client enrollment and educational materials for city and state approval. Much of the system programming has been done, he said, and capabilities for interchanging files with the state have been tested.

With the delay of the HCFA readiness review, Mr. McGraw said MAXIMUS would be operational for voluntary enrollments with managed care plans until approval of the Section 1115 waiver. He noted that the enrollment packets are similar for both voluntary and mandatory enrollment, varying only in the cover letter. And the call center will be available to help those interested in enrolling voluntarily.

Mr. McGraw said plans call for an initial mailing of enrollment letters with two follow-up mailings if needed. A third follow-up mailing would be for mandatory assignment to a primary care provider if the recipient hasn't chosen one. Mailings will be complemented by a media campaign based on radio advertisements and billboards. There also will be outreach efforts through a wide variety of community-based agencies and organizations.

While there are no plans for a concentrated phone follow-up of those who do not respond, phone calls will go to those who start the process but whose paperwork is not completed. MAXIMUS also will do phone follow-up for those recipients who enroll through a health plan.

Ms. Tarlton, the spokeswoman for the Department of Health, said the goal is to enroll 20,000 people a month as the program is phased in over a three-year period.

Contact Ms. Kelly at (212) 264-2058; Ms. Tarlton at (518) 474-5422; Mr. McGraw at (212) 290-2211; Ms. Wessler at (212) 749-1227; and Ms. Moran at (518) 462-2293. ■

TX experiments with dual service under capitated Medicaid plan

Texas officials are experimenting with a program that provides community-based services and long-term institutional services to aged and disabled Medicaid recipients under a single capitated payment. Effective April 1, approximately 60,000 Houston-area residents were converted to Star+Plus, a mandatory managed care program for Supplemental Security Income (SSI) residents in the state's Medicaid program. Incentives are offered to attract other Medicaid enrollees into the program as well.

"We think we're getting better access and certainly getting the right amount and type of care," Texas deputy commissioner of Medicaid Cathy Mossberg said.

Three health maintenance organizations (HMOs) are participating in the project: Access, a joint venture between the Memorial Sisters of Charity Hospital and the University of Texas Medical Branch; Americaid, a Medicaid HMO; and HMO Blue, a Blue Cross/Blue Shield plan offered in conjunction with Managed Care Solutions, a managed care long-term care provider.

Enrollment is mandatory for nursing home residents receiving SSI as of April 1, 1998. In order to avoid disrupting long-established patterns of care, the mandatory assignment to a health maintenance organization was waived for residents who had been in a nursing home for more than 12 months as of the effective date of the program.

Program is budget neutral

While cost control is one of the goals of Star+Plus, the program is designed to be budget-neutral. Star+Plus capitation rates are discounted 2% from projected fee-for-service nursing facility costs and 5% from projected fee-for-service acute and community care costs.

HMOs retain the first 3% of any profit, but split equally with the state any profit between 3% and 7%. Any profit over 7% must be paid back to the state.

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California health care bills are stymied by lame duck governor set on protecting HMOs

The California legislature passed a wide range of bills on managed care before it adjourned Aug. 31, but the most fundamental proposals to restructure the way health plans are regulated either died on the floor or were headed for veto by Gov. Pete Wilson.

Legislation to create a new government agency to oversee health plans passed both houses on nearly party-line votes, but Gov. Wilson has pledged to veto the bill. His main objection is to its administrative setup: The new agency would be run by a board, with members appointed by the governor and legislature. Gov. Wilson supports the idea of a new agency, but his plan would put it under the control of a commissioner appointed by the governor.

In fact, there was no dispute that the current system, which puts regulation of managed care plans in the hands of the Department of Corporations, needs to be replaced. A task force appointed by the Republican governor had recommended formation of a new agency, an idea which the Democratic-controlled legislature heartily endorsed. But legislative leaders, urged on by consumer groups, wanted a board-run agency that would, they argued, give average citizens more input. Consumer groups raised other concerns about Gov. Wilson's proposal as well.

"It was not as simple as just whether it should be a board vs. a single person," said Peter Lee, director of consumer protection programs for the Center for Health Care Rights, a Los Angeles-based consumer advocacy organization. "There were questions about the adequacy of agency staff [in the governor's reorganization] and a clear reporting function to the legislature."

"We feel they just wanted to politicize the process," said Maureen O'Haren, executive vice president of the California Association of Health Plans. "Regulation is supposed to be an executive function, and good government usually dictates that the governor have executive power."

Two other issues that became entangled in election-year politics, according to lobbyists and lawmakers, were proposals to allow patients to sue health plans for damages under medical malpractice law and to set up external panels to review cases when patients and HMOs disagree over whether a medical procedure should be done. But these were further complicated by the Democrats' insistence that the two be linked together in a single bill — even though Gov. Wilson had pledged to veto any legislation that held health plans liable for medical malpractice.

"Many of us felt half a loaf wasn't going to be of any good use to consumers," said Assemblyman Martin Gallegos, chairman of the Assembly Health Committee. "Independent external review was not going to be successful without the additional deterrent of liability to the health plans."

That's not how the HMOs saw it, however. Ms. O'Haren pointed out that the health plan association sponsored a bill for external review — and both she and Steven Thompson, vice president for government affairs at the California Medical Association, said the malpractice liability section was added by Democrats only at the urging of the state's trial lawyers. The wording of the bill not only would have made health plans liable for their practitioners' malpractice, but would have circumvented existing California law putting a limit on pain and suffering awards in such cases.

But Sara Nichols, the chief counsel to the Assembly Health Committee, said there were numerous flaws in the HMO-sponsored external review proposal. "There were a number of barriers [for patients] in their bill," she explained. "For one thing, there was a $1,000 threshold on the cost of the treatment being challenged. Consumers would also have to pay a fee to get a review."

Mr. Lee said consumer groups objected strenuously to the $1,000 threshold. "First of all, it's higher than any other state. Second, a test that costs $500 can have a life-saving benefit for a patient. And for patients with really low incomes, $500 could make the difference between whether they get the test done or not."

Electoral politics played a big part in hardening resistance to compromise on all sides, not only regarding the legislation on the new agency, but also on several other key bills. "The big piece in all these issues is that we have a governor who's leaving office in a few short months," Mr. Lee noted. "There was a feeling among a number of consumer groups of, 'Why should we trust an administration whose track record has been not too stellar on consumer issues to set in motion something we're going to have to live with for the next 10 years?'"

Mr. Thompson says, "Certainly on the reorganization bill, the fact that the governor is leaving had a big impact." The gubernatorial election "was a big part of why certain advocacy groups were unwilling to make reasonable compromises," added Ms. O'Haren.

The political infighting even threatens several key bills that made it to Gov. Wilson's desk. The health plans association has asked the governor to veto a number of them, including:

- a bill that would require HMO medical directors to be licensed physicians in California and hold them personally liable for malpractice suits based on decisions to withhold treatment;
- a bill that would set statewide standards for utilization review procedures (an approach the health plans association supported until it was linked to another bill requiring the plans to give out clinical decision-making criteria they've developed);
- a bill requiring plans to give doctors what the HMOs consider proprietary data on capitation rates.

Other bills either already signed by the governor or with more promising prospects for his approval would enable patients to continue receiving previously prescribed medications even if a health plan drops them from their formularies; grant women direct access to their obstetrician/gynecologist without first having visits approved by another gatekeeping doctor; guarantee patients with chronic conditions direct access to their specialists; and require plans to provide a second opinion from another participating physician if a patient disputes a diagnosis. ■

Texas experiments with capitation system

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The limitation on the profit available to HMOs is "based on the idea that there's a certain amount of money that has to be spent to do a good job," Medicaid project analyst Hope Morrison said. "There's probably not a lot that can be squeezed out of this."

Traditional providers given hedge

To attract HMO providers, Texas Medicaid officials gave bidders hoping to serve its traditional Temporary Assistance to Needy Families (TANF) clients extra points if they agreed to serve the elderly and disabled in the Star+Plus program.

HMOs are capitated for Star+Plus on a per member per month basis by client risk group. The largest group of enrollees, about 45,000, are those who are not institutionalized and who are expected to receive community-based services.

For residents who are receiving health services exclusively through the Medicaid program, reimbursement is set at $616.31 per month. This rate covers acute and long-term care services.

State officials hope the single capitation rate for community, long-term and acute care services will create an incentive for HMOs to coordinate care and maintain enrollees in their homes as long as possible.

If the person also is on Medicare, the HMO will provide only long-term care services. For community residents who are eligible for Medicare, the capitation rate is set at $77.06 per month. Reimbursement for nursing home clients who are not eligible for Medicare ranges from $2,992.31 to $3,295.60 per month. For residents also on Medicare, the monthly reimbursement ranges from $1,460.95 to $1,709.96.

Half are eligible for Medicare HMO

One goal of the program is to attract dual-eligible residents, about half of the Star+Plus enrollment, into a Medicare HMO. Two of the three companies in the program, Access and Blue Cross/Blue Shield, offer Medicare risk products.

One powerful inducement for dual eligibles to join a Medicare HMO is the prescription benefit. Prescriptions for dual eligibles in the conventional Star+Plus program are limited to the standard benefit under Texas Medicaid of three per month. The Medicaid benefit for Star+Plus is expanded to unlimited prescriptions.

"I think that's why I'm so popular," said Henry Parsons, director of Senior Blue, the Blue Cross/Blue Shield Medicare risk product in Texas. Senior Blue started operations in the Houston market on July 1. Within two months, about 250 of its 450 enrollees were dual eligibles in the Star+Plus program.

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>
> — Don Hall

"We, like everybody in managed care, are re-evaluating what we believe managed care is all about," said Don Hall, Blue Cross/Blue Shield vice president of strategic business development. "What we want to do is move managed care up the continuum to people that are sick, to people who need a lot of services. That's where we believe managed care can be a positive."

Even this early in the program, the Blue Cross/Blue Shield officials have spotted some unexpected developments. Children receiving SSI, who were not required to enroll, have joined in larger than expected numbers. Star+Plus program director Sherry Rohlfing attributes the children's enrollment to the variety of community-based services available and a growing confidence on the part of parents that services will not be cut back under Star+Plus.

Formal evaluations of the program have not yet been completed, but Ms. Mossberg is encouraged by anecdotal reports of the program's flexibility in delivering care. She cited the example of the purchase of a prosthesis for a person who was using a wheelchair. The prosthesis, which would not have been covered under the conventional Medicaid program, allowed the person to discontinue the use of a wheelchair as well as extensive personal care services.

Formal evaluations will focus on specific populations in the Medicaid program, e.g., patients with diabetes. "Diabetes is one of the top diagnoses in long-term care. We have patients come into the hospital four or five times a year with complications. If we can do a better job up front, we'll probably save some money," Ms. Mossberg said.

Alternative to runaway costs

Cost savings, however, are not the primary goals of the program. The legislative directive to the Texas Health and Human Services Commission was to create a more effective, budget-neutral alternative to the current system of care for the aged and disabled on Medicaid. Legislators were prodded into action by a large and growing demand on the state's Medicaid budget.

Aged and disabled clients represent 23% of the state's Medicaid population but almost 60% of its expenditures. Texas' population overall is expected to increase by about 50% by 2020, while the elderly population will almost double, from 1.9 million to 3.8 million. The program is supported by a $293,000 grant from the Robert Wood Johnson Foundation.

Minnesota system similar

Minnesota also has announced a program to attract dual eligibles (see *State Health Watch*, December 1997, "Acute, long-term care providers team up to manage Minnesota's dual eligibles," p. 3). Each of three participating plans — Medica, Metropolitan Health Plan and Ucare Minnesota — have set up arrangements with provider networks and community-based service providers. While cost savings have yet to be documented, early reports on the program's progress are positive, from both providers and plan executives.

Contact Ms. Mossberg at (512) 424-6511 and Mr. Hall at (972) 766-6809. ■

Wisconsin program grapples with training, access

Wisconsin's welfare reform program, known as Wisconsin Works or W-2, continues to be hailed by many analysts as a national model. However, like many states, Wisconsin has been struggling with how to ensure that many residents who have moved off welfare still receive Medicaid benefits.

Some health centers have reported a significant decrease in their medical assistance recipients, in part because clients no longer realize they are eligible for services or because they have been confused or discouraged by the recertification process. Wisconsin has responded by launching an aggressive outreach program to communicate with former welfare recipients.

Central to the state's efforts is a plan to "outstation" county eligibility workers in the community, including federally qualified health centers. Susan Wood, chief of the Medicaid Eligibility Section for the Wisconsin Department of Health and Family Services, said there have been some delays waiting for legislative approval, but the agency has spending authority and is finalizing contracts with county agencies.

"Most outreach workers are in place in Milwaukee and Kenosha counties, which have the highest concentration of Medicaid eligibles," she said, "although we are still working to resolve technology problems at some of the sites so workers can access the databases."

Other keys to the outreach effort include the following:

• pilot-testing expanded evening and weekend hours and redesigning notices to applicants and recipients about their eligibility status;

• analysis of caseload trends and Wisconsin Family Health Survey data to identify characteristics of low-income uninsured families and to provide county-specific data;

• enrolling more than 1,000 county and W-2 staff in a course on the basics of eligibility and how to apply for Medicaid;

• targeting a mailing to 17,000 Medicaid families who had cases closed in 1997 with information on how employment affects Medicaid eligibility and the differences between Medicaid and W-2.

Celeste Schulz, a health care advocate with Community Advocates, Milwaukee, said that while the state is trying to reach out, she is "still seeing a lot of cases of people who are not getting access to caseworkers."

"Lots of things are supposed to happen," she said, "but they haven't happened yet. Caseworkers have been switched for many clients because of new regions for the Wisconsin Works welfare reform program, but the clients don't know that and they can't find their worker. It's confusing because people don't know they can apply for Medicaid without being on welfare."

Linda Hall, a health care policy analyst for the Wisconsin Council on Children and Families, said that while the "precipitous drop in the number of children on Medicaid" is starting to level out, the caseload is still far below what it had been.

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>
> — Celeste Schulz

Some of the state's outreach efforts were dealt a setback in August when the Health Care Financing Administration (HCFA) rejected much of the state's BadgerCare program to provide 50,000 low-income, non-Medicaid-eligible families with health insurance by combining federal Child Health Insurance Program money, state funds and premiums paid by BadgerCare participants. The state was planning to link its advertising efforts for BadgerCare and Medicaid outreach. HCFA gave the state approval to cover only children between the ages of 14 and 18 under BadgerCare.

Ms. Hall said she hopes state officials will move aggressively to resolve technology problems over the next few months so workers will have computer access to all the database information they need. She also is seeking to ensure that Department of Health and Family Services staff work with administrators of the W-2 program and local offices to inform people that children are eligible for health-care services.

Ms. Hall said she also hopes to ensure that people who do sign up are actually enrolled. "During outreach for the Healthy Start program, there were assertions that the numbers seen never equaled the projected caseload, and rumors that county officials in Milwaukee County actually told staff not to work too hard at enrolling people," she said.

Sharon Cabraal, a staff attorney with Legal Action of Wisconsin, sees problems implementing outreach to Medicaid eligibles because of a "tug-of-war" between the Department of Health and Family Services and the Department of Workforce Development over authority and funding to do the work.

She noted that the state's Medicaid enrollment was at an all-time high in 1994 and in 1997 hit an all-time low. It has remained at the low number, with some increase in Healthy Start enrollment and some increase in a Medicaid extension program that gives workers without benefits an extra year of Medicaid coverage.

As an example of problems that have arisen, Ms. Cabraal said 65% of the letters from the state advising people who were dropped from the Medicaid rolls when W-2 was implemented to reapply for Medicaid were returned as undeliverable. "These people move a lot," she said, "and they should be sending letters using addresses from the school lunch program because they would be more current."

Ms. Cabraal praised training that has been given to caseworkers to help them better understand the new eligibility rules and said it needs to be ongoing, noting a case when a supervisor didn't understand

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the rules and denied an application for Medicaid extension to which a client was entitled.

She expressed hope the state will soon follow through on a promise to establish a special unit of workers trained to resolve eligibility problems and available to help caseworkers and advocates on particular cases. She said the staff at the Medicaid recipient hotline, who had been a good source of information, now can only say if a case is open and can't give eligibility or other information.

The attorney said that while the state has published some informational materials on the changes, it is necessary to actually identify people at the places where they are. Many people have the idea that they're not eligible for Medicaid and that notion is not being corrected by the workers, she said.

Outstations ready by December

Ms. Wood of the Department of Health and Family Services said the department expects to complete the process of outstationing eligibility workers in the state by the end of the year. She noted that a letter has been sent to all counties, telling them what services are available and urging them to take advantage of the offer to post and financially support outreach workers in their locale.

Other priorities for the rest of the year include continuing to train eligibility workers on the "very complicated" regulations that apply and offering training to community agencies so they can help their clients; ensuring that caseworkers have computer query access to the database so they can resolve problems; and issuing a request for proposals to community-based agencies for outreach efforts that can be funded through a $500,000 appropriation.

Ms. Hall of Wisconsin Council on Children and Families said state officials "have designed a reasonable program. We just have to be sure that it works." She said the council worked hard to have evaluation funded as part of the new outreach program. The legislature agreed, and there will be a determination of which outreach elements do and do not work.

Contact Ms. Wood at (608) 266-5635; Ms. Schulz at (414) 449-4777; Ms. Hall at (608) 257-5939; and Ms. Cabraal at (414) 278-7722 ■

Maryland commission investigates charges of unlawful claims denials

The Maryland Insurance Administration is looking into charges by the state's hospitals that two managed care companies illegally delay or deny payment for providers' claims for payment.

The conduct review is the most recent shot fired in Maryland providers' battle against alleged systematic violations of professional standards and state statutes regarding payment for medical services.

In addition to the complaint by the Maryland Hospital Association, the state insurance commission also is investigating similar complaints by MedChi (the state medical society) and the Maryland chapter of the American College of Emergency Physicians (ACEP).

"Our complaint [filed] with the insurance commissioner has nothing to do with problems with the law, but rather ensuring compliance with the law," ACEP lobbyist Barbara Brocato said.

The complaint that triggered the market conduct review alleges that Mid-Atlantic Medical Services, Inc. (MAMSI) and Blue Cross/Blue Shield of Maryland repeatedly rejected legitimate claims for covered services, e.g., denied coverage for lengths of stay that were clinically justified based on the individual case history of a patient.

The consolidated complaint was filed by MHA, the Maryland Association of Hospitals and Health Systems, on behalf of the state's 50 acute care hospitals. At this point, however, the review is limited to Blue Cross/Blue Shield of Maryland and MAMSI. The review is not expected to be complete before the end of the year.

Simply utilization management?

"The contention that we're not paying bills for no good reason just is not valid," said Blue Cross/Blue Shield of Maryland Director of Corporate Communications Jeff Valentine. "We want to pay for appropriate care that's provided in the right place at the right time and of the right quality. That's the definition of utilization management."

The association estimates that 10% of hospital insurance claims in 1997 were denied payment, MHA spokeswoman Nancy Fiedler said. "Ninety percent of that is rejected with a common rejection letter saying the care is not medically necessary. We certainly believe the care is necessary." She said denials of hospital claims in Maryland of the seven largest health insurers and HMOs in the state rose from 9,617 in 1996 to 19,842 in 1997.

> 'In Maryland we have a unique situation where the payors have a stake in the cost of health care and the physicians have a stake, but the hospitals are outside of the competition loop, if you will.'
>
> — Jeff Valentine

"This is a market conduct investigation unlike anything we've done before," Maryland Associate Commissioner for Life and Health Insurance Donna Imhoff said. "It took quite a bit of planning to determine even how to go about it."

Mr. Valentine partially attributes the clash between Blue Cross/Blue Shield of Maryland and the hospital association to Maryland's hospital rate-setting system. He said the system insulates hospitals from market forces and removes incentives to increase efficiency. "In Maryland, we have a unique situation where the payors have a stake in the cost of health care and the physicians have a stake, but the hospitals are outside of the competition loop, if you will," he said.

Continued on next page

Violations of the professional standards, which require payment for care under circumstances a prudent layperson would consider an emergency, form the basis of the complaint by the Maryland chapter of ACEP. Maryland became the first state in 1993 to incorporate the "prudent layperson" guideline into statute.

HMOs required to pay for EMTALA screenings

Maryland emergency physicians also are protected under expansions to the law passed in 1996 and 1998. Two years ago, legislators required that HMOs must pay for emergency department care when they direct a patient to such care, e.g., when a patient is told by a clinician to proceed to the emergency room after hours. Revisions in that year also require HMOs to pay for screening mandated under the federal Emergency Medical Treatment and Active Labor Act (EMTALA).

Further 1998 revisions require HMOs to pay for assessments and screenings mandated under EMTALA and give the Maryland insurance commissioner the latitude to impose fines of up to $5,000 per violation of the statute.

In the emergency physicians' case, 15 physician groups have submitted about 1,000 complaints for review by the state, associate commissioner for consumer complaints Joy Hatchette said. "That one is obviously going to take a lot longer because of the magnitude of the complaint itself. If someone wants to give me a pot of money to hire some more people, I'd love to have it."

The focus of the complaint by Med Chi, the Maryland State Medical Society, is the interpretation of a law that prohibits health insurers and health maintenance organizations from recouping overpayments by denying current reimbursements if the original payment is more than six months old.

When does six-month window begin?

A May 1 interim order from the Maryland Insurance Administration clarified that the law's Oct. 1, 1997, effective date applies to denials on or after that date, not merely claims. The order rejected claims by MAMSI that the law applies only to new claims from the Oct. 1 effective date and established that claims paid from April through September of 1997 are protected by the six-month window. In the second part of the case, the Maryland Insurance Administration is in the process of investigating 75 complaints of illegal retroactive collections by MAMSI under the law.

MAMSI is complying with the interim order but withholding comment on the decision until the resolution of the investigation of the 75 claims, MAMSI spokeswoman Elizabeth Sammis says. A suit in circuit court would be MAMSI's vehicle for challenging a final order, associate commissioner Ms. Hatchette said.

A May 28 opinion from the Maryland Attorney General concurred with the interpretation of the law by the Maryland Insurance Administration. It also clarified that the legislation does not prevent payers from recouping overpayments after six months through other means, e.g., sending a demand letter or suing for payment.

Contact the MHA at (410) 321-6200; Blue Cross/Blue Shield of Maryland at (410) 998-5182; and the Maryland Office of the Attorney General at (410) 576-7003. ■

Clip file/News from the states

Each month, this column features selected short items about state health care policy digested from publications from around the country.

Mississippi reimbursement pilot for pharmacists incites national turf war on credentialing

JACKSON, MS—In May, when the Baltimore-based Health Care Financing Administration (HCFA) approved a plan by Mississippi's state pharmacy board and Medicaid program to pay pharmacists for clinical disease management in that state, the program was hailed as a breakthrough with national implications. But when HCFA told the state it had to establish a pharmacist credentialing process by July 1 or the plan couldn't go forward, the breakthrough threatened to break down.

No one disagreed that credentialing can help assure payers, patients and physicians that pharmacists are qualified to run clinics in the four approved disease states — asthma, diabetes, dyslipidemia, and anticoagulation — but credentialing for pharmacists had never been done in Mississippi.

Not wanting to lose momentum, the state board turned to the National Association of Boards of Pharmacy (NABP) in Park Ridge, IL, as well as the National Association of Chain Drug Stores (NACD) and the National Community Pharmacists Association (NCPA), both in Alexandria, VA, for help. To start with, NABP looked to an existing set of clinical objectives already drawn up by NCPA under the auspices of its National Institute for Pharmacist Care Outcomes, then went on to produce credentialing tests and workshops for Mississippi pharmacists to take for three of the four approved disease states: asthma, diabetes and dyslipidemia.

The three organizations decided to expand the Mississippi effort by forming the National Institute for Standards in Pharmacist Credentialing (NISPC) and began positioning its credentialing process as a national model. To say that the other dozen or so national pharmacy organizations were caught off guard is an understatement.

And for formidable players like the Washington, DC-based American Pharmaceutical Association; the American Association of Colleges of Pharmacy and the Academy of Managed Care Pharmacy, both in Alexandria; and American Society of Health-System Pharmacists (ASHP) in Bethesda, MD, for example, injury was added to insult in this case when the newly formed NISPC sent out a letter in late June asking these and four other national groups to join their effort.

So far, the Mississippi effort is getting a decidedly cold shoulder from other pharmacy groups, but in the meantime, things are moving forward in Mississippi. Sixty-three pharmacists have taken a total of 95 exams in one or more of the three disease states available for testing. The total cost of testing is $125, and recertification will be required every two years.

Pharmacists who pass will be listed with the state Medicaid program as credentialed in a specific disease state. They will receive a Medicaid provider number for filing claims and then can begin seeing physician-referred patients. Newly certified

pharmacists will be listed on both the state pharmacy board and NABP Web sites as having passed the testing for each disease state sought.

In Mississippi, the state's Medicaid program expects to pay about $20 for a 15- to 30-minute office visit, with that payment going directly to the pharmacist as opposed to the pharmacy department to which he or she belongs.

—*Drug Utilization Review,* September 1998

Study shows locality makes big difference in ability of uninsured people to get health care

WASHINGTON, DC—If you are uninsured, where you live can make a big difference in whether you get the health care you need, according to a new study released in the Sept. 7 issue of *The Journal of the American Medical Association.*

While only 18% of the uninsured in Orange County, CA, and just 25% of those without health coverage in Newark, NJ, said they had difficulty obtaining health care, more than 40% of uninsured people in Lansing, MI, and Cleveland did have problems.

The researchers, Drs. Peter Cunningham and Peter Kemper, of the Center for Studying Health System Change in Washington, DC, report that nationally, 14% of those who were uninsured did not obtain needed medical care and 29% delayed getting care.

The findings are derived from data obtained from the 1996-1997 Community Tracking Study Household Survey of 60,446 people living in 60 communities, and included 7,200 individuals without health insurance. It is not clear why obtaining health care was easier in some communities, the researchers said, but it appeared to be unassociated with the urgency of the patient's need or other patient-related factors.

The authors speculated that the "higher-than-average supply" of physicians in Orange County and Newark, wealthy regions with small pockets of poverty, may have something to do with it. Doctors in those areas "may not feel as threatened financially by the uninsured and may be more willing to treat them for free or reduced cost," the authors suggested.

The researchers predicted that the problem will only grow because the federal government is increasingly shifting care of the uninsured to state and local government. "As a result, variation across communities in access to care for the uninsured is likely to persist or grow even larger," they concluded.

—*The Journal of the American Medical Association* 1998; 280: 921-927

Floridas uninsured population is 6th largest in nation, according to states hospitals

FT. LAUDERDALE, FL—A new study by the Florida Hospital Association says the state's uninsured population is the sixth largest in the nation. The report says that at least 2.8 million of Florida's 14.7 million residents (19%) have no health insurance, and the cost of treating the uninsured has increased by 24% since 1990 to $940 million in 1996.

The report also chronicles the story of doctors and patients frustrated with the domination of HMOs in the Florida market place. HMOs are projected to increase their market share to 70% of covered lives over the next 12 years.

Florida Medical Association President-elect Mathis Becker, MD, is quoted as saying: "Doctors are having to see more patients a day for shorter periods of time, so patients are unhappy. And doctors are unhappy because that's not the way they want to take care of their patients."

The competition is already taking its toll on managed care companies in the state; less than half recorded a profit last year. The report goes on to predict that the surviving HMOs will probably raise premiums, "which will bump more Floridians into the ranks of the uninsured." Other major findings include:

• An estimated 25% of the population under 65 will be uninsured by 2002.

• Teen pregnancy and infant mortality rates surpass the national average.

• A high death rate is largely attributable to the large number of citizens over age 65.

• Rates of "suicides, firearms deaths, poisonings, falls, drownings and pedestrian/vehicle deaths" are all higher than the national average.

• The HIV/AIDS rates among adults and children are the third and second highest in the nation, respectively.

However, the state's insurance program for children, KidCare, got high marks. It is projected to cover 256,000 of the state's estimated 823,000 uninsured children.

—*Fort Lauderdale Sun Sentinel,* Sept. 14

Study finds high rate of uninsured in Nevada

LAS VEGAS—Nearly 20% of Nevada's residents are uninsured, according to a study commissioned by the Nevada Legislature. Data from the Center for Business and Economic Research at the University of Nevada-Las Vegas indicates that 81.7% of adults and 81.3% of children are continuously covered; 9.6% of adults and 10.4% of children have had temporary lapses in coverage from three to six months.

Researchers say that while the survey did not indicate the number of children that would be eligible for Nevada's children's health insurance plan, known as Nevada Check Up, data would be available within several months. Estimates of the number of uninsured children have ranged from 10,000 to 45,000.

—*Las Vegas Sun (*Associated Press), Sept. 12

Montana childrens health insurance program is approved; qualifies for $9 million grant

HELENA, MT—Montana received approval Friday from the Department of Health and Human Services for its program to expand insurance coverage to uninsured children, qualifying for up to $9 million in matching federal funds under the federal Children's Health Insurance Program. The state plans to insure more than 9,000 children by June 2000 through a new, non-Medicaid insurance program.

Children under age 18 in families earning less than 150% of the federal poverty level ($16,450 for a family of four) will be eligible. An estimated 27,000 Montana children do not have health insurance, the majority of whom come from working families that earn too much to qualify for Medicaid but not enough to afford private insurance.

In conjunction with the pilot program, Montana Gov. Marc Racicot plans to ask the 1999 state legislature to appropriate a 20% match that will enable Montana to qualify for about $10 million in federal funding. If lawmakers approve the long-term program, Montana will receive $47 million over five years. When fully enacted, the state will be able to provide insurance to about 9,000 children.

—Montana Department of Health and Human Services release, Sept. 11

Highlights of national health expenditure projections, 1997-2007, show average 6.8% rise

BALTIMORE—The nation's total spending for health care is projected to increase from $1 trillion in 1996 to $2.1 trillion in 2007, with average annual increases of 6.8%, according to a report released by the Health Care Financing Administration. Over this period, health spending as a share of gross domestic product is estimated to increase from 13.6% to 16.6%. The Balanced Budget Act (BBA) of 1997 is expected to slow growth in Medicare spending between 1998 and 2002.

These projections are presented in an article titled "The next ten years of health spending: What does the future hold?" published in the September/October 1998 issue of *Health Affairs*. The projections were produced by the Health Care Financing Administration's Office of the Actuary.

National health spending growth is expected to accelerate beginning in 1998, growing at an average annual rate of 6.5% from 1998 to 2001. This compares to 5.0% average annual growth from 1993 to 1996. The slower growth over the past few years was due mostly to slow spending growth in the private sector (2.9%), while public-sector spending grew more quickly (7.5%). However, between 1998 and 2001, this pattern is projected to reverse, with private sector health expenditures growing at faster average annual rates (7.2%) than the public sector (5.7%).

The article notes that real per capita private-sector health spending growth is projected to accelerate as "recent stronger growth in real per capita income is expected to boost underlying demand for medical services, and higher medical inflation is expected to fuel increasing health spending growth. An anticipated slowdown in the growth of private-sector managed care enrollment and a pause in the downward trend for private health insurance coverage also are expected to contribute to the acceleration in health spending growth."

Real per capita public-sector health spending growth is expected to decelerate between 1998 and 2002, primarily as a result of the Balanced Budget Act (BBA) of 1997 and its effect on Medicare. The introduction of prospective payment systems for different services and cutbacks in payment formulas are expected to slow the rate of increase in Medicare expenditures. However, growth in Medicare managed care enrollment as a result of the BBA is not expected to reduce growth in overall Medicare spending.

For 2001-2007, average annual growth is expected to be similar for both the private and public sectors. Private sector spending growth is estimated to slow from the 1998-2001 period as income growth slows and the number of uninsured people begins to rise again. Public sector spending growth is estimated to accelerate after 2002 because the BBA will no longer affect payment updates.

Patterns of growth will differ substantially across types of services. While all health providers will be affected by rising costs, hospitals are expected to continue to face relatively slow growth in labor compensation as downsizing in this sector continues. Hospital growth is projected to lag increasingly behind growth in drugs and physician and other professional services as the trend away from the inpatient setting toward ambulatory care settings is reinforced by the movement of Medicare beneficiaries into managed care. The rapid rise in outpatient hospital services will be tempered as the potential for further substitution for inpatient services declines.

Expenditures for drugs are expected to grow at fairly rapid rates through 2007 as a result of rising utilization (number of prescriptions) and intensity (including changes in size and mix of prescriptions). For extended care, both nursing home and home health expenditures growth are expected to slow as provisions of the BBA that implement PPS systems and introduce new limits and caps are felt in the public sector.

—Health Care Financing Administration release, Sept. 15

Rhode Island plans to cut uninsured rolls

PROVIDENCE, RI—Rhode Island Gov. Lincoln Almond has announced an aggressive three-part plan to reduce by 25% the number of state residents without access to health insurance by the year 2000.

The three legs of the plan are: 1) organize an outreach program to enroll the state's eligible 17,000 uninsured children in the Rite Care plan; 2) get the federal government to waive a requirement that funding provided for the Children's Health Insurance Program only be used to cover children (the governor wants to use some of the money to cover approximately 8,000 uninsured adults); 3) have the state contract with health insurers to provide health insurance for small businesses and individuals.

The governor, who is running for re-election, points to the state's Rite Care plan's success in improving care for residents formerly covered by Medicaid. He released a report showing that 97% of the recipients were happy with the plan; the number of pregnant women receiving prenatal care rose from 55% in 1993 to 69% in 1996; and the number of inner-city infants receiving immunizations increased from 88% to 95% between 1993 and 1996.

The state's experience with Rite Care proves it can create programs that work and provide quality care, Almond maintains.

—*Providence Journal-Bulletin*, Sept. 10

State Health Watch

On line access / Index

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Preliminary data suggest CHIP crowds out private insurers

WASHINGTON, DC—Preliminary data from a study documenting low-income children's health insurance status indicate the $24 billion Children's Health Insurance Program drowns out some employment-based insurance for some Medicaid-eligible children. But the study notes the current data are inconclusive, said the Employee Benefit Research Institute (EBRI). The study checked Census Bureau data from October 1994 to September 1995 for sources of children's coverage and time uninsured. The most prevalent source of coverage for children and adults was employment-based coverage. But Medicaid was the most prevalent source for children with family incomes below 125% of the poverty level.

—EBRI release, Sept. 1

Federal judge strikes down Medicaid drug reimbursement program

PHILADELPHIA—A federal judge has ruled that Pennsylvania Medicaid program administrators violated federal law in 1995 when they changed Medicaid payment rates for prescription drugs, and has barred reimbursements based on those changes after Oct. 1. The court said the Pennsylvania Department of Public Welfare failed to comply with a federal requirement disallowing revisions in Medicaid pharmacy reimbursement rates unless its methods or procedures for ensuring its payments are "efficient, economical, maintain quality of care, and provide equal access.

"All of three methods used by the Department to evaluate efficiency and economy are improper or deficient," according to Judge Harvey Bartle III of the U.S. District Court for the Eastern District of Pennsylvania, who granted summary judgment to Rite Aid of Pennsylvania Inc. and the Pennsylvania Pharmacists Association in their lawsuit challenging the new rate schedule.

The court also concluded that the Welfare Department had not considered quality of care in its decision-making process, "but even if it did, the administrative record does not support the department's decision." The court said the way the department patterned its reimbursement schedule after 13 commercial third-party payers in Pennsylvania for brand-name drugs was "arbitrary and capricious." The court was equally dismissive of comparisons with other states' reimbursement formulas and Medicaid program expenditures. The Health Care Financing Administration said, "each state should establish a dispensing fee to reflect the characteristics of that state."

—BNA, Inc. *Medicare/Medicaid Reimbursement Alert*, Sept. 22

State Health Watch *(ISSN 1074-4754) is published monthly by American Health Consultants®, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to* ***State Health Watch****, P.O. Box 740059, Atlanta, GA 30374.*

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World Wide Web: *http://www.ahcpub.com.*
Subscription rate: *$267 per year.*
Government subscription rate: *$225.*
One to nine additional copies, $134 per year; 10 or more additional copies, $80 per year. Back issues, when available, are $25 each.

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