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New Texas law gives physicians a foot in the door to negotiate fees, other plan provisions with MCOs

Managed care companies can walk away from the table

Landmark Texas legislation signed in late June allows physicians to get together to negotiate managed care contracts, but falls short of a true unionization law and won't touch the Medicaid program that spends $10 billion annually to care for 2.5 million state residents.

Also in late June, federal regulators moved to ease the concentration of health plan power in the only two Texas markets where such concentration was likely to trigger physicians' rights under the new law to negotiate managed care fees.

Still, physician groups are pleased to get a foot in the door.

"It's an awareness that the current system is a failure," says Jack Seddon, executive director of the Tallahassee, FL-based Federation of Physicians and Dentists, which has supported collective bargaining efforts nationally and throughout the states.

Perhaps to soften the law's blow to the state's health plans, the joint-negotiation law also prohibits physicians from getting together to talk about much-despised contract provisions requiring them to take all of a health plans' products if they want the commercial business.

The bill Texas Gov. George W. Bush signed, SB 1468, gives physicians the right to negotiate jointly on a variety of quality of care issues, ranging from patient education to reimbursement methodology. If and only if the health plan has "substantial market power," and those terms and conditions have already affected or threaten to adversely affect the quality and availability of patient care, can physicians negotiate fees, capitation rates, and specific fee considerations. The new law says the attorney general shall

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In This Issue

High court gives states some flexibility in expanding health services for disabled

The landmark U.S. Supreme Court disability decision in June appears to give something both to advocates for the disabled who demand increased availability of community-based services and state Medicaid programs that must pay for institution- and community-based care.

The question being posed now by advocates for the disabled, state budget officials, and think tanks is just how it will all play out. The main point of agreement is that it will take some time to see what happens—and the possibility of additional litigation certainly exists.

The high court ruled in the case of *L.C. v. Olmstead*, brought under the Americans with Disabilities Act (ADA) by two Georgia women with mental retardation as well as psychiatric conditions who were patients in a state psychiatric hospital. Doctors at the hospital agreed they were appropriate for discharge into community programs, but no slots were available. The patients won their case in the U.S. District Court and again in the 11th Circuit Court of Appeals, to which the State of Georgia appealed the District Court decision.

Georgia then asked the Supreme Court to decide whether the public

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make the determination of what constitutes substantial market power.

Federal and Texas regulators in June moved to slow the growth of Texas' dominant health plan, Aetna U.S. Healthcare, by attaching conditions to Aetna's controversial plan to acquire Prudential HealthCare. A proposed consent decree filed in Dallas U.S. District Court in June allows the acquisition provided Aetna gives up the covered lives of its NYLCare subsidiaries in Houston and Dallas.

The proposed divestiture will affect 260,000 Houston enrollees and 167,000 Dallas enrollees. The proposed merger, according to the regulators' complaint in the case, would have given Aetna control of 63% of the HMO and related HMO-based point-of-service business in Houston and 42% of the market in Dallas-Fort Worth. The divestiture maintains Aetna at its premerger market share of 44% in the Houston area and 26% in Dallas-Fort Worth, says a spokeswoman for the Texas attorney general.

The House Research Organization, which conducts bipartisan bill analyses for the Texas Legislature, noted the concern of opponents that the bill doesn't define "substantial market power" and that the definition "could change with every election cycle."

Aetna is the only Texas health plan with a so-called "all products" provision in Texas, which raises doctors' ire almost as much low fees. Although Aetna doesn't contract with the state's Medicaid program, some physicians say putting the "all products" provision off limits was sold as a way to protect low-income residents.

"The fear was that if physician organizations or individual physicians are not somehow compelled to participate in HMO products serving Medicaid, or children's health insurance, or other low-income populations, that those physicians will only participate in more lucrative contracts such as PPOs," says Helen Kent Davis, director of governmental affairs for the Texas Medical Association.

"As an association, we have seen no evidence of that, but in the interest of moving the bill, that language was included." The TMA has no problems with requiring physicians to take all HMO products, but objects to linking HMO and PPO products, Ms. Davis says.

"The other concern was, of course, that Medicaid premium rates and many of their quality-of-care provisions are set by federal and state laws. There was a concern that in coming together to negotiate for those plans, there would be untoward pressure to raise rates, in particular, and that's not something you can do in a public program," she says.

A representative for state Sen. Chris Harris (R-Arlington), sponsor of the bill, goes even further, saying comparable reimbursement between Medicaid and commercial plans makes the all-products provision unnecessary.

"I think it was played . . . that if you have the cheaper plans, the HMO plans, physicians wouldn't participate in that unless they were forced to. That's not the current situation," says Darren Whitehurst. "I have looked at the numbers for all the plans and I have seen no problems," he says.

The general concern about Medicaid participation among Texas physicians seems to have merit. Survey data from the TMA itself suggest physicians are less and less

Provisions of Texas' Joint Negotiation Law

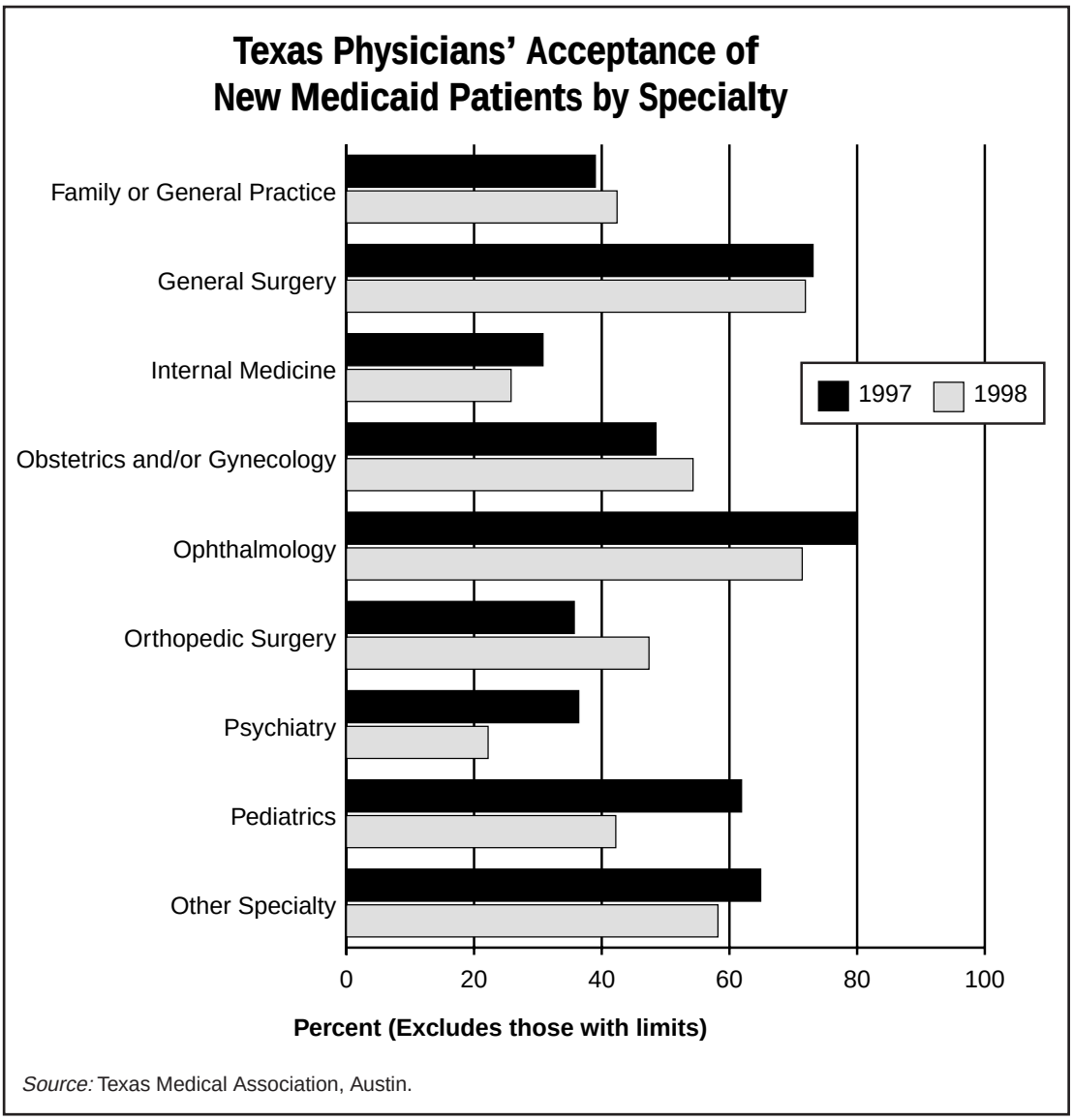
Discussions related to the following topics are allowed:

- practices and procedures to assess and improve the delivery of effective, cost-efficient preventive health care services, including childhood immunizations, prenatal care, and mammograms and other cancer screening tests or procedures;
- practices and procedures to encourage early detection and effective, cost-efficient management of diseases and illnesses in children;
- practices and procedures to assess and improve the delivery of women's medical and health care, including menopause and osteoporosis;
- clinical criteria for effective, cost-efficient disease management programs, including diabetes, asthma, and cardiovascular disease;
- practices and procedures to encourage and promote patient education and treatment compliance, including parental involvement with their children's health care;
- practices and procedures to identify, correct, and prevent potentially fraudulent activities;
- practices and procedures for the effective, cost-efficient use of outpatient surgery;
- clinical practice guidelines and coverage criteria;
- administrative procedures, including methods and timing of physician payment for services;
- dispute resolution procedures relating to disputes between health benefit plans and physicians;
- patient referral procedures;
- formulation and application of physician reimbursement methodology;
- quality assurance programs;
- health service utilization review procedures;
- health benefit plan physician selection and termination criteria. ■

likely to accept new Medicaid patients. The trend is most pronounced among ophthalmologists, psychiatrists, and pediatricians. (See chart depicting Texas physicians' acceptance of new Medicaid patients, at right.)

An Aetna U.S. Healthcare representative says the plan has no intention of getting into the Medicaid market, but rather wants the provision to protect its ability to develop and maintain provider panels for its commercial contracts, particularly as members move between HMOs and PPOs.

"The primary reason is for continuity of care and flexibility for our members," says Bobby Peña, director of public relations for Aetna U.S. Healthcare's western region in San Ramon, CA. Of the plan's 2.5 million covered lives in Texas, about 1 million are in HMO plans; the rest are in other products.



Source: Texas Medical Association, Austin.

Under the law, a group of physicians negotiating with a health plan generally can't represent more than 10% of the physicians in a health benefit plan's defined geographic service area, and physicians can't meet to organize "any cessation, reduction, or limitation of health care services" such as strikes or slowdowns. It is possible, though, that even a small physician group could constitute a monopoly of that particular specialty without approaching the 10% threshold.

Mr. Seddon was in San Antonio during June, meeting with the 65 orthopods (of the 70 in the entire market) he says are represented by his group. He calls SB 1468 "a major step in the right direction, no matter how you look at it," but points out that simply because physicians have the right to bargain collectively for certain working conditions does not mean health plans have to entertain the request.

"What happens when the insurance company says, 'The hell with you, I'm not talking with you?' That's one of the problems now across the board. The doctors are going to have to use mechanisms within the scope of the law to force them to bargain."

The law requires the negotiating parties to notify or get approval from the state attorney general during several points in the process. The attorney general, for example, can set the parameters of the negotiation as well as reject a proposed contract.

Paul Handel, MD, chair of the Texas Medical Association's Council on Socioeconomics, says legislators in the future might be convinced to require negotiations if managed care companies refuse to come to the table now. The current legislation, he says, is a victory more of "form than substance."

The bill takes effect Sept. 1. Physicians are working in other statehouses to expand their right to negotiate, most notably Pennsylvania, and

backing federal legislation (HR 1304) that would allow physician collective bargaining.

Contact Mr. Seddon at (850) 942-6636, Mr. Handel at (713) 796-8892, Ms. Davis at (512) 370-1401, and Mr. Whitehurst at (512) 463-0110. ■

AMA votes for 'national labor organization'

Saying they are not interested in a "traditional labor union," delegates of the American Medical Association (AMA) voted in late June to establish a "national labor organization" representing employed physicians and residents.

"Our objective here is to give America's physicians the leverage they now lack to guarantee that patient care is not compromised or neglected for the sake of profits," said Randolph D. Smoak, Jr., MD, chair of the Chicago-based AMA.

Specifics of the organization's agenda are yet to be developed. General goals of the organization include the following:

- advocating on the state level for laws such as Texas legislation that gives independent physicians the opportunity to "collectively bargain";
- challenging what they call "abusive and unfair" contract provisions such as those requiring physicians to participate in all or none of a health plan's products;
- advocating for HR 1304, the federal legislation allowing physicians to bargain collectively;
- supporting independent housestaff organizations.

The AMA has about 291,000 members, approximately 35% percent of the nation's licensed physicians. ■

Medicare HMO leaves Virginia market, jeopardizing Medicare/Medicaid integration site

The newest participant in a national demonstration project to integrate Medicare and Medicaid has hit a familiar problem: Medicare HMO partners leaving the market because of low reimbursement.

Architects of Virginia Cardinal Care are exploring how best to deal with the late May departure of Sentara Healthcare's Medicare HMO from Virginia's Tidewater market. While the health system says it will stay on as a "consultant" and "provider," it's a far cry from the role state officials hoped Sentara would play in the two-year, $450,000 Robert Wood Johnson Foundation project. Of that, $150,000 is provided by the Virginia Department of Medical Assistance Services (DMAS).

The loss of Sentara doesn't automatically kill the effort, but it has forced state officials and the foundation to re-evaluate if and how to go forward.

"It's certainly very unfortunate because they were an interested and appealing partner and an important reason why we felt good about being involved in Virginia," says Mark Meiners, PhD, director of the foundation's Medicare/Medicaid Integration Project. "So where we go from here is an open question."

Mr. Meiners says problems with Medicare reimbursement are "not uncommon," but were not expected in the 12-site demonstration project.

"The world in which we got started was one in which the biggest barrier was the waiver process. What's happened since then is that the Balanced Budget Act came into effect and basically took dollars off the table, changed the rate-setting system, changed the rules in a lot of ways that are fundamental or at least uncertain," he says.

The future of the project will depend upon how Virginia copes with "upheavals" in the Medicare market, as well as Health Care Financing Administration priorities that treat these kinds of new programs as being less important than implementing the Balanced Budget Act (BBA) and anticipating Y2K problems.

"Virginia is an example that raises these questions in a more fundamental way than perhaps some other states, but it comes down to—what is the state commitment? If there is a firm commitment on people's part to it, then that's what we want. And I think the jury's out in Virginia," he says.

State 'remains committed'

Virginia "remains committed to improving the health care delivery system for dually eligible beneficiaries," says a statement from DMAS director Dennis Smith. The first phase of the project, which involved Sentara, had projected 2,500 enrollees in the Tidewater area. The second phase anticipated expansion with another provider in northern Virginia, DMAS project manager Regina Anderson-Cloud says.

States in the integration demonstration sites generally seek to contract with Medicare HMOs to create a single organization that, in coordination with the Medicaid program, provides a full continuum of care for residents eligible for both programs. Enrollees can't be forced to join a Medicare HMO, but state officials hope that a Medicare HMO responsible for community-based services, nursing home care, and acute care can coordinate care most effectively for dual-eligible residents. Integration projects typically pay for Medicaid nursing home and community-based services through a single capitation amount.

Among the options left to Virginia officials is partnering with the

Medicare fee-for-service delivery system, similar to what Massachusetts did in its Senior Care Options program. (See related story in *State Health Watch*, December 1998, p. 4.)

"I think that's what we need to be more open-minded to than we were when we got this off the ground," says Mr. Meiners. "What clients really still need is something that is better than what's generally out there. You could think in terms of two fee-for-service worlds and imagine introducing more effective care management that works better with the client."

At the same time, he says he doesn't think the ultimate answer is a system that relies on fee-for-service Medicare and leaves Medicare and Medicaid separate but equal.

"That's not the goal we had in mind, I think. We feel like it's only when you get the systems of care and the money pooled that you're really going to be able to have some flexibility and creativity and expansion of benefit package that you're really going for here."

Sentara decided to give up its Medicare+Choice product effective Dec. 31 after looking at the $377 risk-adjusted, per-member per-month reimbursement it could expect to receive in the upcoming year, says Colleen Grimes, Sentara's director of Medicare products. The reimbursement paled in comparison to the $700 to $800 calculated for more urban areas, she said.

Sentara's product, the only Medicare HMO in the Hampton Roads area, serves about 14,000 beneficiaries.

As the largest Medicaid contractor to the state and the owner of five hospitals in the Tidewater area, Sentara undoubtedly will continue to play a part in the state's efforts to retool services for the dually eligible, but not in the role of financing partner.

Contact Ms. Anderson-Cloud at (804) 371-6448, Ms. Grimes at (757) 552-7393, and Mr. Meiners at (301) 405-1077. ■

High court gives states some flexibility

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services portion of the ADA "compels the state to provide treatment and habilitation for mentally disabled persons in a community placement, when appropriate treatment and habilitation can also be provided to them in a State mental institution." At one point, 30 states had filed "friend of the court" briefs supporting Georgia's position, but advocates for the disabled persuaded 19 of them to withdraw their petitions, raising hopes that many states may be willing to look for ways to implement the decision rather than continue the fight.

Writing for a 6-3 majority, Justice Ruth Bader Ginsburg said that under Title II of the ADA, states are not required to fundamentally alter their programs, but must make "reasonable modifications" to them to place persons with mental disabilities in community settings rather than in institutions. The requirement applies when the state's treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources of the state and the needs of others with mental disabilities.

"This is a landmark decision," says Curt Decker, executive director of the National Association of Protection and Advocacy Systems. Mr. Decker notes that while the Olmstead case involved individuals with mental health problems, it has much broader applicability to those with physical and other disabilities. At least 15 cases waiting for guidance from the Supreme Court in federal and state courts now will move forward, he says. "There should be a flurry of court decisions in the next few months on a variety of populations. We expect those cases will be decided consistent with the Olmstead ruling, but we also expect there will be more litigation coming."

Even as Mr. Decker and other advocates were issuing statements claiming victory in the court's ruling, those responsible for state budgets were sounding a cautionary note and asking for patience.

"State budget processes require time," says Gloria Taylor, executive director of the National Association of State Budget Officers, "and many legislatures have already approved their FY 2000 budgets and aren't even in session now. This decision can't be fully implemented right away. Some states will be better able to handle it than others. It will depend on each state and the kinds of policies they have implemented over the last decade."

In the past 10 years, some states have started moving people from institutions to community-based programs, although advocates often have complained that the pace has been too slow and long waiting lists have developed without any relief in sight for their clients.

While the Supreme Court's majority opinion is clear that undue institutionalization is discrimination, it also appeared to recognize the difficulties states may face in balancing needs and resources and their need for some leeway in making reasonable modifications to their programs.

"This ruling has something in it that is encouraging to both sides," says Thurbert Baker, attorney general for Georgia, the state on the losing side of the decision. "It will allow states around the country a way to address this in a more even-handed approach."

If a state could demonstrate that it had a comprehensive, effectively working plan for placing qualified

people with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the state's endeavors to keep its institutions fully populated, it would meet the requirements of the ADA, according to the court's majority opinion. In such an instance, courts could not order those who had brought suit to be moved to the top of the waiting list.

Ms. Taylor hopes those who have been advocating change will be willing to give the states three to five years to carry out a transition so the costs are not prohibitive. While many people say community-based programs cost less than institutional care, Ms. Taylor says that's not necessarily so.

"The potential for additional costs is there. Unless you close institutions, the cost per client goes up a lot. And if you do close an institution, you need to have a place where people can be treated. I generally don't believe the costs will be less unless you are running a full hospital with very few clients."

In addition, she says, community-based group homes may have to be built in some communities, and that takes time, planning, and resources.

Some observers hope the decision will provide a needed impetus for states to look at new and more effective ways to deal with the disabled and their needs.

Denver-based ADAPT, one of the most visible and vocal advocacy groups, is looking for members of Congress to sponsor its Medicaid Community Attendant Services and Supports Act. The bill would require coverage of community attendant services under Medicaid and also would provide for grants to develop and establish what its advocacy materials call "real choice" systems and initiatives for change.

States that have been working to move people to community-based programs have had to obtain approval from the Health Care Financing Administration through a waiver to spend Medicaid funds on such efforts. ADAPT's bill would eliminate the waiver process and authorize spending directly on community-based attendant and support services.

"The potential for additional costs is there. Unless you close institutions, the cost per client goes up a lot."

Gloria Taylor

Executive Director, National Association of State Budget Officers

ADAPT says it is necessary to change the long-term care service system in recognition of the fact that Medicaid and Medicare are based on medical models that no longer apply to all individuals. It recommends, as does Ms. Taylor, that money follow an individual and not be directed to any facility or provider. ADAPT also wants national policy not to favor one setting over another, instead letting users choose where to receive their services.

States will be looking for a means to control costs as they implement the transition to more community-based programs, says Stephen A. Somers, president of the Center for Health Care Strategies in Princeton, NJ.

Waivers can be one means of control, he says, but there also may be opportunities for creative use of mandatory Medicaid managed care to develop "a new entity that could apply the technology of managed care to community-based services, including health care, social services, and maybe even room and board." Institutions have managed all the needs of people with severe disabilities, Mr. Somers says, and now states should want to find a way to replace that management and coordination as they move people out of institutions.

He notes that in the movement of individuals out of mental hospitals into community settings in years past, needed services did not develop as much as many people would have wanted or thought necessary. The perception is that a lack of services has forced many of the mentally ill into poor care or homelessness, a situation that states and advocates are on guard against in the wake of the Olmstead decision, he says.

Among other concerns Mr. Somers sees are issues around devolution of programs from the federal government to the states. "If there are to be significant new expenditures, who is going to be responsible for them? We may see states negotiating with the federal government and making trade-offs on expenditures."

For advocate Curt Decker, whose National Association of Protection and Advocacy Systems was holding its annual meeting when the opinion was handed down, the decision was at the center of every conversation the delegates held. He voiced cautious optimism.

"The court said it was concerned about patient dumping, and so are we. We want to see community systems that are good quality. We know there will be negotiations over transition time and a reasonable approach. If a state has a plan and good-faith checkpoints along the way and lives up to those checkpoints, NAPAS would be willing to accept it. I'm hoping we'll see a resolution of the pending cases consistent with *Olmstead* and can then go to states and say, '*Olmstead* reaffirms the right of the disabled to have community-based treatment. Let's negotiate how to do that.'"

Contact Mr. Decker at (202) 408-9514, Ms. Taylor at (202) 624-8804, Mr. Somers at (609) 279-0700, and ADAPT at (303) 333-6698. ■

Telemedicine comes to rural California in Blue Cross demonstration project

Five specialty facilities and 37 primary care clinics in rural California are linking up in what organizers say is the first time a commercial health plan has been funded to establish a telemedicine program.

With $2 million in grant funds from California's Managed Risk Medical Insurance Board, Wellpoint, the for-profit parent of Blue Cross/Blue Shield of California, is installing hardware, phone lines, and infrastructure needed to link Medi-Cal and Children's Health Insurance Program (CHIP) providers and patients in 23 of California's 58 counties.

"If you understand how telemedicine is delivered and see it in action, you see this is the wave of the future," says Dawn Wood, MD, medical director in California for Blue Cross' Medi-Cal and CHIP programs.

At full implementation, telemedicine services will be available to about 45% of Blue Cross' half-million Medi-Cal enrollees through a variety of live and off-line audio and video modalities. Specific installations will be determined by the particular needs of a patient population. Tools available include an ophthalmoscope and dermascope, with the use of an electronic stethoscope, Ms. Wood said. Radiology, the mainstay of many telemedicine projects, will take a back seat—at least at the start of the project—to the primary care-related services.

Telemedicine services also will be offered in the project counties to those who sign up with Blue Cross to get coverage from California's fledgling CHIP, the Healthy Families Program.

Adequate reimbursement is crucial in getting physicians to sign on to the telemedicine project. Blue Cross project manager Nicolette Worley says the health plan's reimbursement structure is more generous than that of Medi-Cal, which places significant administrative demands on physicians to be reimbursed for store-and-forward consults.

While Medi-Cal generally splits a single telemedicine fee 25/75 between the primary care and specialist physician, Ms. Worley says Blue Cross, by comparison, will pay standard office visit rates to both the referring and specialist physician, regardless of whether the consult is conducted live or is a review of data that are stored and forwarded to the consulting physician for later review.

> "Telemedicine isn't going to happen unless you pay the people who are involved in it."
>
> Dawn Wood, MD
> *California Blue Cross*

The company also will help subsidize the telephone charges of primary care physicians who initiate a live consult, particularly important for a mental health counseling session or a similarly lengthy visit.

"Telemedicine isn't going to happen unless you pay the people who are involved in it," says Ms. Wood. "It does increase the cost of a consulting visit through telemedicine, but we feel overall this is going to deliver better care."

Blue Cross doesn't know exactly how many primary care telemedicine visits it will pay for in the project, but hazards a very rough estimate of about 400 primary care referrals per month at $15 each. "We're not talking about a lot of money here," acknowledges Ms. Wood. Project managers says even if telemedicine increases the rate of referrals to specialists, they expect the savings from early detection and treatment of diseases will produce long-run costs savings for them and their enrollees.

"Our role is to figure out how to make it cost-effective," Ms. Wood says. "Even though right now I can't say to you, 'This is how it's going to be cost-effective,' my belief is that this will be a cost-effective technology."

Initial installation of the telemedicine hardware is done at no cost to the participating primary care clinics and the five "hub" specialty facilities: Childrens' Hospital Los Angeles, Cedars Sinai Medical Center in Los Angeles, Pediatric Diagnostic Center in Ventura, the University of California-Davis campus in Sacramento, and Eureka Pediatrics. The primary care clinics range in size from one physician and one nurse practitioner to a clinic with 10 primary care physicians. Many of the primary care sites are organized through the Northern Sierra Rural Health Care Network.

Additional specialty clinics may be added, but probably will be asked to bear the cost of the technology themselves, says telemedicine project manager Kathleen Brown.

"We believe that if we bring the specialists the members, they are going to pay their own way and join up," says Ms. Brown. "Almost every day I'm contacted by another group of specialists who are interested in providing services."

Although Blue Cross' reimbursement obviously is limited to services for its own members, the hardware is available for patients in any health plan.

Blue Cross' managed care networks are unlikely to interfere with the development of telemedicine referrals within the plan, says Ms. Wood, because only 20% of the company's members are served by capitated provider groups.

Five specialist areas were targeted for

the telemedicine rollout: dermatology, endocrinology, mental health, orthopedics, and neurology. Long-standing shortages in some clinical areas, e.g., dermatology and orthopedics, helped define the project design. In some cases, shortages are particularly acute in defined geographic areas or among providers fluent in certain languages.

Reimbursement was only one of several obstacles that Blue Cross anticipated in establishing the network. Project managers have sought to make the technology easy and quick for both physicians and other providers at both the sending and receiving ends of the consult. A third problem, overcoming primary care physicians' fear that they will lose their patients to urban specialists, is a bit tougher.

"The way to address that is to get the physicians to aggressively participate and see that this does nothing but help their practice, and, in fact, because they have access to telemedicine subspecialty services, they are perceived as the provider of choice in that community," says Ms. Brown.

Counties are scheduled to come online with the project throughout the summer, though in what order depends upon a complication Blue Cross had not anticipated: the ability of local phone companies to string high-speed integrated services digital network (ISDN) lines to the rural clinics.

The rural demonstration project runs for one year, after which Blue Cross has the option of discontinuing the effort, applying for additional funding, or shouldering the burden on its own. Project managers expect a positive outcome, though, and already are considering how to tackle the next major hurdle: state laws that prohibit interstate telemedicine consults without state-specific licensure.

"The states will need to be the ones to take the lead because the professional organizations tend to be state-oriented," Ms. Wood says.

Contact Ms. Wood at (805) 384-3510. ■

HCFA sets performance standards for enrolling seniors in Medicaid

Part of effort to expand coverage to dual-eligibles

States should increase their Medicaid enrollment of low-income Medicare beneficiaries by 4% in the upcoming year, according to new guidelines released for comment by the Health Care Financing Administration (HCFA).

The guidelines carry neither incentives or penalties, but are part of a much-needed effort to get Medicaid benefits to elderly patients who are entitled to them, says JoAnn Lamphere, DrPH, a senior policy advisor with the American Association of Retired Persons in Washington, DC.

"There's a whole series of steps they're taking. Each individually isn't much, but together it's far more than HCFA has ever done," says Ms. Lamphere.

In addition to the two-year target enrollment initiative, HCFA has a variety of projects to help states increase Medicaid enrollment among the so-called dual-eligible population. HCFA also is working with a seven-state effort by the Social Security Administration to streamline the program's outreach and enrollment efforts. (See related story, *State Health Watch*, June 1999, p. 8.)

Estimated Dual-Eligible Enrollment as of September 1998

Alaska	7,000	Montana	24,000
Alabama	124,000	Nebraska	28,000
Arizona	54,000	New Hampshire	6,000
Arkansas	78,000	New Jersey	142,000
California	775,000	New Mexico	38,000
Colorado	53,000	Nevada	12,000
Connecticut	48,000	New York	470,000
District of Columbia	7,000	N. Carolina	212,000
Delaware	3,000	N. Dakota	12,000
Florida	319,000	Ohio	142,000
Georgia	46,000	Oklahoma	64,000
Hawaii	19,000	Oregon	53,000
Iowa	50,000	Pennsylvania	85,000
Idaho	4,000	Rhode Island	18,000
Illinois	150,000	S. Carolina	141,000
Indiana	80,000	S. Dakota	13,000
Kansas	39,000	Tennessee	172,000
Kentucky	101,000	Texas	350,000
Louisiana	115,000	Utah	13,000
Massachusetts	136,000	Vermont	13,000
Maine	34,000	Virginia	109,000
Maryland	62,000	Washington	81,000
Michigan	126,000	W. Virginia	13,000
Minnesota	57,000	Wisconsin	72,000
Mississippi	87,000	Wyoming	6,000
Missouri	117,000	All states	5,381,000

Source: Health Care Financing Administration, Baltimore.

Low-income Medicare beneficiaries are eligible for a wide variety of Medicaid programs that either expand health care coverage or provide assistance with Medicare's cost-sharing requirements. A General Accounting Office report this spring estimated that the two largest programs, the Qualified Medicare Beneficiary program and the Specified Low-Income Medicare Beneficiary program, reach only about 57% of those eligible.

"There's a whole series of steps they're taking. Each individually isn't much, but together it's far more than HCFA has ever done."

JoAnn Lamphere, DrPH
Senior Policy Advisor, American Association of Retired Persons

Because of the difficulty in developing reliable estimates of the number of potential enrollees by state, HCFA officials did not set state-specific targets for the first year, which ends in August 2000. Instead, HCFA expects progress among the states to be "commensurate" with the national target of 4%. Proposed baseline numbers, subject to revision, use estimated dual-eligible enrollment as of September 1998. (See chart depicting state-by-state dual-eligible enrollment, p. 8.)

HCFA officials relied on state-reported data for baseline enrollment, eschewing their own Medicaid data.

Contact Ms. Lamphere at (202) 434-3902. More information is available from HCFA at www.hcfa.gov/medicaid/smd6799a.htm. ■

Pharmaceutical firms call a short truce in legislative battle over substitutions

Medicare drug benefit proposals more pressing

Regulating the use of brand-name pharmaceutical drugs, particularly those touted as having a narrow therapeutic range of effectiveness, promised to be one of the burning issues of the 1999 spring legislative season. As state legislatures wind up their 1999 sessions, though, the parties to the would-be legislative duel seem to have moved on, at least temporarily.

"We have found that we are able to educate legislators," says Carol Cox, spokeswoman for generic pharmaceutical manufacturer Barr Laboratories in Pomona, NY.

In late fall, Barr representatives were girding for legislative catfights to maintain or ease the use of anticoagulant warfarin sodium, generic for DuPont Pharmaceuticals Co.'s Coumadin. But for the fiscal year that ended in March, Barr reported that its $1.2 million in "government affairs" expenses was a decline of 14% over the previous year. The company says the decline is directly related to a lower-than-expected number of legislative battles where DuPont Pharmaceuticals has attempted to prevent generic substitution of Barr's warfarin sodium.

Barr fought over warfarin sodium in about 30 states during the 1997 legislative session, around 15 in 1998, and fewer than 10 in the current year, Ms. Cox says.

The main pharmaceuticals industry lobbying group, the Washington, DC-based Pharmaceutical Research and Manufacturers of America (PhRMA), confirmed the slowdown in state activity over so-called "narrow therapeutic index" (NTI) drugs. Proposals to expand prescription drug benefits under Medicare may have diverted some of the attention away from the NTI drug issue, says PhRMA assistant general counsel Marjorie Powell.

One exception is Massachusetts, where Ms. Powell in late June monitored a spirited committee debate on a proposal to define and regulate the distribution of NTI drugs. The bill, HR 1935, would require the prior consent of the physician and patient before a pharmacist could substitute between the generic and branded version of warfarin sodium and five other products.

"So it appears things are not totally dead in the states," Ms. Powell says.

$500 million at stake

The shift in focus away from the NTI issue in state legislatures may favor the generic firms, because much of the legislative activity in recent years was initiated by brand-name pharmaceutical companies. Meanwhile, DuPont Pharmaceuticals is maintaining its efforts to protect Coumadin—which brings DuPont $500 million annually in revenue—and its other products. At least part of the company's strategy will be to make it more difficult for pharmacists to substitute drugs at the point of purchase, regardless of whether the prescribed drug is generic or a branded product, says Thomas Barry, a spokesman for the Wilmington, DE-based company.

"This is not a branded vs. generic issue," he says. "The relevant issue is keeping people on the same product."

Contact Ms. Cox at (914) 348-6808, Ms. Powell at (202) 835-3592, and Mr. Barry at (320) 992-5020. ■

Clip files / Local news from the states

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

AIDS drug assistance programs face budget shortfall generated by better access to drugs

WASHINGTON, DC—State AIDS drug assistance programs (ADAPs) are facing a projected $90.2 million shortfall for fiscal year 2000, advocates testified to Congress in late June.

The projected shortfall is generated, at least in part, by advances in HIV therapy and easier access to medications, said Johns Hopkins University infectious disease specialist Richard Moore, MD.

Total national expenditures for AIDS drug assistance programs in fiscal year 1998 was $510.2 million, of which 76.6% was federal funding and 23.4% was state funding, according to the March 1999 annual report from the National ADAP Monitoring Project. At that time, 26 states reported that they either faced program restrictions or budget shortfalls.

The impact of expanded use of antiretrovirals and other drugs shows up in dramatic improvements in mortality and morbidity associated with HIV. The death rate from AIDS fell 44% from 1996 to 1997, and AIDS is no longer the leading cause of death among Americans ages 25-44, according to 1998 statistics from the Centers for Disease Control and Prevention.

—ADAP Working Group release, June 22; National ADAP Monitoring Project Annual Report, March 1999

Ohio health systems agencies face funding cut in 1999-2001 legislative budget proposals

Funding at about half their current level is the best offer Ohio's health systems agencies (HSAs) are likely to get as they begin a two-year funding cycle this summer.

The most generous funding proposal for the HSAs as legislators headed into budget conference committee in mid-summer was $300,000 for the fiscal year beginning July 1, 1999, ratcheted back to $150,000 for the subsequent year. The funds would be divided among Ohio's 10 HSAs, seven of which are active.

"I would just as soon cut them off now," says Dale Van Vyven (R-Sharonville), co-chair of the Health Systems Agency study committee. Despite a study committee recommendation that the HSAs should continue to be funded, Mr. Van Vyven is convinced that the organizations "don't seem to be players" since Ohio eliminated Certificate of Need regulation in 1996 for all but nursing home expenditures.

The funding recommendation is included in the Senate version of the budget. Neither the House of Representatives nor the Ohio Department of Health recommended funding for HSAs.

—Staff report

U.S. House of Representatives takes up expansion of health services for disabled

WASHINGTON, DC—With a victory in the U.S. Senate behind them, advocates are turning their attention to the House of Representatives in their quest for expanded Medicaid and Medicare benefits for the disabled.

By late June, when the Senate approved 99-0 a bill expanding government health benefits for the disabled who return to work, the legislation already had secured 179 sponsors in the House. A bill nearly identical to the Senate legislation was approved in the House Commerce Committee in late May.

The Senate's Work Incentives Improvement Act (S. 331) would create several options, including allowing disabled workers to buy Medicaid coverage even if they earned income above Medicaid thresholds or lost cash benefits—which often define eligibility for Medicaid—because of improvements in their medical conditions.

To overcome the objections of Sen. Phil Gramm (R-TX), Democrats agreed that additional costs associated with the bill would be funded from elsewhere in the federal budget, not a tax increase. Advocates long have argued that the tax revenues generated by newly employed disabled workers would offset if not replace expenditures associated with the expanded benefits.

—*New York Times*, June 17

Rhode Island expected to give regulators, public more oversight in health plan mergers

PROVIDENCE, RI—Regulators and the public would get more of a say in proposed health plan mergers under bills expected to pass both houses of the Rhode Island legislature.

Regarded as the most important health legislation of the year, the bills were submitted in response to Blue Cross & Blue Shield of Rhode Island's courtship with potential buyers. The plan has nearly 470,000 subscribers in Rhode Island and Massachusetts.

One of the two known suitors for Blue Cross, for-profit Anthem Insurance Companies of Indianapolis, had unsuccessfully sought an amendment that it said would

clarify how regulators would decide appropriate profit levels after a sale. The other company expressing interest in Blue Cross is the Blue Cross system in Massachusetts. Like the Rhode Island affiliate, Blue Cross of Massachusetts is nonprofit.

Under the bill, a prospective buyer would have to disclose substantial public information about its current business, as well as its plans for the company it's buying. The Department of Business Regulation would have veto power over the acquisition, with advice from the attorney general's office.

The Senate version of the measure passed on a 42-1 vote; a similar bill passed in the House by a vote of 86-0.

—*Providence Journal*, June 25

Merger with Columbia/HCA turns around strapped Oklahoma teaching hospitals

TULSA, OK— The first 11 months of a controversial joint operating agreement with Columbia/HCA has given the state-owned University Hospitals a $10.3 million profit, reversing a flood of red ink that helped spur the February 1998 agreement.

University and Children's Hospital of Oklahoma lost $15 million in the seven months before the agreement, Oklahoma University College of Medicine Dean Jerry Vanatta told university regents in late June. He attributed the turnaround to $10 million in cuts in benefits packages and "significant" reductions in middle management staffing.

—*Tulsa World*, June 23

Report: HIV patient care 'inferior' for blacks, Latinos, uninsured

CHICAGO—Quality of care among HIV patients in the United States is improving but remains "inferior" for large segments of the population, says an analysis in the June 23-30 issue of the *Journal of the American Medical Association*.

Three interviews with more than 2,000 HIV-infected individuals between January 1996 and January 1998 suggested that "inferior patterns of care" were seen for blacks and Latinos compared with whites, the uninsured and Medicaid-insured compared with the privately insured, women compared with men, and other risk and/or exposure groups compared with men who had sex with men. The disparity persisted even after adjustments for variations in CD4 cell count.

Outcome measures were patterns of ambulatory and emergency room visits and receipt of antiretroviral therapy and prophylaxis against *Pneumocystis carinii* pneumonia.

—*JAMA* 1999; 281:2,305-2,315.

This issue of *State Health Watch* brings you news from these states:

OIG encourages states, HCFA to boost efforts to combat Medicaid managed care fraud

WASHINGTON, DC—"Confusion and disagreement" mark states' efforts to handle fraud and abuse among their Medicaid managed care programs, says a recent report from the Department of Health and Human Services Office of the Inspector General (OIG).

The study of 10 states with Section 1115 waivers found there is "limited" activity in developing or actively pursing and referring fraud and abuse cases in the Medicaid managed care program. While eight of the 10 states had systems to detect and refer fraud cases, two states, Arizona and Tennessee, accounted for 97% of all the managed care referrals during the time period studied.

The Inspector General recommends that the Health Care Financing Administration take the following steps, with coordination with the OIG:

• establish guidelines for states and managed care organizations to follow in developing and carrying out proactive fraud and abuse detection and referral activities;

• ensure that states monitor managed care organizations' fraud and abuse programs for compliance with its guidelines;

• continue to develop, sponsor, and emphasize detection and referral training for states and Medicaid managed care organizations.

The OIG report is available at www.dhhs.gov/progorg/oei/whatsnew.html.

—Staff report

Trauma care access problems in Florida generate care guidelines but no more money

Florida legislators have taken the first step toward reviving the state's moribund trauma system.

Representatives from four state agencies are meeting to create guidelines on how the state can develop a "necessary continuum" of care for the trauma victim from injury to final hospital discharge under legislative mandate approved in the 1999 session. Agencies involved are the Department of Health, the Agency for Health Care Administration, the Board of Medicine, and the Board of Nursing.

State Health Watch

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The legislation is spurred by a high-profile death in 1997 in which a two-year-old sexual assault victim never was transferred to a trauma center. The case caught the attention of State Sen. William "Doc" Myers (R-Stuart) and convinced legislators to fund a study about the problem.

"There has been a lack of timely access to trauma care due to the state's fragmented system," legislators conceded in the 1999 legislation. While policymakers long have complained that trauma system development is hampered by the lack of a stable revenue source, the 1999 legislation addresses the issue by merely directing the Department of Health to implement a statewide trauma system "as funding is available."

—Staff report

Pennsylvania restores Medicaid to 32,000 residents inadvertently dropped in move from welfare to work

PHILADELPHIA—Some 24,000 children are among the 32,000 Pennsylvania residents coming back on the Medicaid rolls after state officials mistakenly kicked them off.

The children lost Medicaid coverage as their parents moved off welfare and into paying jobs. The state in early July planned to mail to the dropped enrollees insurance cards pre-programmed with two months of coverage. After that, residents will have to fill out necessary application forms to continue coverage.

Pennsylvania's efforts to find and enroll Medicaid members represent "meaningful, broad reform," said Claudia Schlosberg, a Washington, DC-based staff attorney for the National Health Law Program. "Pennsylvania has done something that all states should be doing."

Another 34,000 Pennsylvania residents had been incorrectly dropped from the Medicaid rolls since 1997, but have since found their way back to the program.

—*The Inquirer*, July 1