State Health Watch

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THOMSON AMERICAN HEALTH CONSULTANTS

Feds: Medicaid is a partnership, not an exercise in gamesmanship

The debate over Medicaid funding apparently will continue through this volatile election year. In his FY 2005 budget, President George Bush said the secretary of Health and Human Services (HHS) will work with Congress to pass an option for states to receive Medicaid and State Children's Health Insurance Program (SCHIP) funds in the form of flexible allotments, presumably a reference to an idea floated last year that Medicaid become a block grant program.

HHS secretary Tommy Thompson also served notice at the National Governors Association winter meeting that he intends to propose "tough new rules [to] curb creative bookkeeping" used by many states to obtain additional federal funds for Medicaid. Federal officials say state efforts to shift the cost of the joint federal-state program to the federal government have resulted in rising federal Medicaid expenditures.

Bush said in his budget message that the federal government could save $1.5 billion in the next fiscal year and $23.6 billion over the next

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In This Issue

Pennsylvania's AmeriHealth Mercy decides to look inward and cuts its Medicaid drug costs

Because drug costs are a major concern for Medicaid HMOs and state Medicaid programs, AmeriHealth Mercy created PerformRx to assist other plans to develop the capability to manage drug utilization and product and service costs.

Fiscal Fitness: How States Cope

Tom Lyman, AmeriHealth Mercy senior vice president for marketing, tells *State Health Watch* that for 13 years, Mercy Health Plan served a population that was 95% Temporary Assistance for Needy Families (TANF) beneficiaries and, with the help of traditional pharmacy benefit managers (PBMs), was able to hold drug costs to below $10 per member per month.

In 1997, however, Keystone Mercy took on Pennsylvania's mandatory Medicaid managed care business, receiving disabled and dual eligible members, and drug use skyrocketed because of patients with hemophilia, sickle cell anemia, and comorbidities.

"Our mission is to serve the

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State Health Watch
The Newsletter on State Health Care Reform

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Partnership

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10 years through efforts to restore the fiscal integrity of the Medicaid program.

The administration contends that in many instances, states have paid for their share of Medicaid costs with phantom dollars rather than state or local tax revenues. State officials admit to working to maximize what they contend are legitimate federal financing opportunities, especially important to them in hard financial times.

Earlier this year, the General Accounting Office (GAO), Congress' investigative arm, dubbed Medicaid a high-risk program, saying states have "used various financing schemes to generate excessive federal Medicaid matching funds, while their own share of expenditures has remained unchanged or decreased."

In some instances, according to the GAO, states have created the illusion that they have made large Medicaid payments to county hospitals and nursing homes and then claimed federal Medicaid money to help defray the costs, even as they required the counties to return most of the funds to the states.

"State financing schemes have driven up federal Medicaid costs," says GAO health care specialist Kathryn Allen.

"Congress has repeatedly tried to curtail such arrangements, but states have consistently developed new variations," she says.

In a notice in the *Federal Register*, states were advised that the federal government plans to require them to provide detailed descriptions of each source of revenue used to pay their share of Medicaid costs. The federal government wants to approve state Medicaid budgets, and states would not be able to receive federal funds for additional costs unless and until federal officials approve the expenditures.

The governors have said this would be a very expensive and time-consuming administrative burden. Faced with opposition from governors of both parties, Mr. Thompson said the federal government would consult with governors and state officials on the proposed changes and would provide a formal 60-day period for public comment before implementing any new rule on the subject.

Trying to end gamesmanship

"The Medicaid program must be a federal-state partnership, not an exercise in federal gamesmanship," says Dennis Smith, the top federal official for Medicaid since Tom Scully resigned from the Centers for Medicare & Medicaid Services at the end of 2003. (President Bush has nominated FDA administrator Mark McClellan to head the Medicare and Medicaid programs.)

Meanwhile, at Academy Health's State Coverage Initiatives National Meeting early in 2004, State Coverage Initiatives director Alice Burton reviewed the state of the states in 2004 in a presentation — Cultivating Hope in Rough Terrain.

She joined other analysts in saying that states may have hit bottom in their fiscal crises, although improvement still will take quite a while. There are 21 states reporting revenues above forecast, she said, and 24 states report a stable revenue outlook. But states still need to address massive shortfalls — for FY 2004, states collectively face a shortfall of $40 million to $50 million, and for FY 2005, at least 21 states project budget gaps.

States addressed their FY 2003 budget gaps in a variety of ways,

Ms. Burton said, including across-the-board cuts (32 states), raiding rainy-day funds (25 states), raising sales taxes (17 states), layoffs and early retirement of state workers (13 states), program reorganization (13 states), and temporary income tax increases (10 states).

Medicaid cost-control strategies employed by states in FY 2002 through FY 2004 include controlling drug costs, reducing or freezing provider payments, reducing or restricting eligibility, reducing benefits, and increasing copayments.

State strategies for sustaining coverage in hard times, according to Ms. Burton, include bolstering the safety net, partnering with the private sector, prioritizing populations most in need, and limiting or redesigning benefit packages.

She reviewed expansion plans being considered in five states: Maine, California, Idaho, New York, and Utah.

Maine's Dirigo Health Insurance, a voluntary program addressing cost, quality, and access, is being offered to small businesses with fewer than 50 workers, self-employers, workers without offered coverage, and low-income workers in large firms. The state also is working on a MaineCare (Medicaid) expansion to 200% of the federal poverty level for parents, 125% for childless adults, and sliding-scale subsidies to 300% of the poverty level. Innovative financing and cost-containment mechanisms would be included.

Under California's Pay or Play mandate, companies would pay into a state health purchasing fund for each worker and receive credit for providing what the state calls "acceptable" coverage. The program would be phased in over several years, starting with firms with more than 200 employees in 2006. Many challenges to the plan are expected.

Idaho's Health Insurance Access Card legislation would expand SCHIP from 150% of the federal poverty level to 185%. In a pilot program covering 1,000 adults, participants would receive a $100 per month subsidy to buy private health insurance for those under 185% of the federal poverty level who work for businesses with two to 50 employees.

New York is working on changes to its Healthy New York small group market product intended to boost enrollment in the program. The stop-loss corridors are lowered from 90% of claims between $30,000 and $100,000 to between $5,000 and $75,000, and there are increased eligibility provisions.

Utah's Primary Care Network has a benefit package focused on primary and preventive care. It hit an enrollment cap of 19,000 for the traditional primary care network and is focusing on enrolling 6,000 in its Covered at Work program using a voucher to buy employer-sponsored insurance. There is a $50 enrollment fee and a $1,000 cap. Specialty physician and hospital coverage comes through community donated care alliances.

Ms. Burton said that in terms of Medicaid reform, the questions for policy-makers include:

1. What is the appropriate financing system for Medicaid?
2. What roles should states and the federal government assume?
3. Is there a reform strategy in the near future that will receive bipartisan support?

In a separate study, the Kaiser Commission on Medicaid and the Uninsured cautioned that when one-time federal Medicaid financial aid ends in June 2004, few states will have resources available to fill the gap.

"The issue is not out-of-control Medicaid spending, but the economic downturn and sluggish state revenue growth that are pushing states to cut Medicaid," said commission executive director Diane Rowland. "Federal fiscal relief has clearly helped to stave off deeper cuts this year, but the June end of fiscal relief is likely to bring more aggressive cost containment next year."

Kaiser released a survey of all 50 states plus two reports on state budget conditions. The first report indicates that while economic conditions are improving, state revenue growth is too weak to pull states out of their slump. The second study looks at responses in 10 states to budget pressures in FY 2004, showing that health spending cuts in Medicaid and SCHIP were more severe than in earlier years of the fiscal crisis, as states generally remained reluctant to increase income or sales taxes and already have exhausted one-time budget fixes and revenue measures such as raising alcohol and cigarette taxes. ■

Fiscal Fitness

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poor," Mr. Lyman says, "and our networks are built to serve all our members. But we couldn't get the data [on drug use] so we could meet the needs of our new members."

He says the plan went through several PBMs at that point, trying to get access to data so they could identify high utilizers, but kept running into roadblocks. Also, the PBMs had restricted pharmacy lists, weren't providing good service to prescribers, didn't share drug rebate information, and had differential pricing arrangements that weren't transparent to plan executives.

Pharmacy management

"We decided to look inward and take it on ourselves," Mr. Lyman says. "And in the first couple of years, we saved about $22 million in Pennsylvania."

He reports Keystone Mercy took its drug expenditure trend rate from 22% to less than 9% and down to 4% to 5% in the current year.

"All of our issues [that Keystone Mercy had with the PBMs] have been reversed," according to Mr. Lyman. "We negotiate directly with the drug manufacturers. We subcontract with Argus, a best-in-class company, for claims management. And we have the information tools to get at the data we need."

The result, says Mr. Lyman, is that payments to pharmacists and physician networks have increased, while costs to the plan have been dropping overall.

To give a sense of what Keystone Mercy has been able to accomplish once it got access to data on its members, Mr. Lyman reports that in its first year of mandatory managed care, the plan had 50 members with hemophilia, more than half of the states in the United States each have in their total Medicaid program. The cost of those 50 members to Keystone Mercy was $10 million a year.

Once the plan had identified the patients, it assigned case managers to each family and made connections with advocates and providers. Mr. Lyman says that although the number of hemophiliac members has increased, the total cost has dropped to $8 million, a 20% decrease.

"A major reason why we're so successful," Mr. Lyman tells *State Health Watch*, "is that we think like a health plan, not like a PBM. We take data to the providers so they can put together a program for their patients. Once the data are available, case management and disease management programs become very important to our success."

Keystone Mercy is able to customize programs for various discrete populations because it integrates pharmacy with physical health, Mr. Lyman says. He also points out that PBMs generally don't do much with utilization review, while Keystone Mercy looks closely at potential overuse of drugs and develops protocols for use of specific drugs. He says the three priorities the plan follows in drug protocols are safety, efficacy, and cost, in that order.

"We've found that we usually can get to a win-win-win situation," he says.

While providers initially were cautious about how Keystone Mercy would be in managing drug utilization and costs, Mr. Lyman says they have been won over through the plan's physician education efforts and strong dependence on local physicians in plan areas serving on pharmacy and therapeutics committees.

"We know the drug companies lobby physicians," he says, "and we have to lay out our case as well. There's never been a time when the industry has made a better case than us."

Sell product to other plans

With the success that Keystone Mercy achieved, two years ago, it decided to expand beyond the affiliate health plans that are part of the parent company, AmeriHealth Mercy. They have targeted all Medicaid managed care plans and also are approaching states agencies for their fee-for-service and other programs.

According to Mr. Lyman, AmeriHealth Mercy has succeeded with PerformRx because it runs an open, transparent system.

"We think like our clients because we think like a health plan," he explains. "We are totally open with our provider networks." He says it also is important that they can use the data they have to create special programs such as specialty injectables.

PerformRx's approach has resonated with Mike Jernigan, CEO of Select Health, an AmeriHealth Mercy Medicaid-only health plan in South Carolina.

Before going with PerformRx, he tells *State Health Watch*, Select Health used a third-party vendor that provided PBM services to some Medicaid programs but was decreasing that part of the company's business.

"They didn't seem to have the long-term commitment to the type of program we wanted," he says. "We're getting into more complex case management."

Mr. Jernigan says that Select Health went with PerformRx in December 2001, and they have seen a significant improvement in utilization of generic drugs.

"We couldn't get generic utilization up to 50% before," he says,

"and with PerformRx we're pushing 60%. That's been a real plus for us."

They also see a lower trend in their overall drug cost for Medicaid patients than other plans in the industry, although they recognize that it continues to be a significant challenge to manage pharmacy benefits in such a way that members get the drugs they need at a reasonable cost and with high value.

PerformRx has helped Select Health identify cases that are suitable for enhanced case management and then the plan handles the actual case management responsibility.

AmeriHealth Mercy says that PerformRx can provide knowledge and experience; administrative and clinical tools; access to drug product purchasing consortiums; point-of-service claims systems and sophisticated reporting; turnkey clinical programs and administrative processes that can be purchased as a packaged or customized to meet a plan's needs; start-up staff to help a plan design and manage its program while recruiting and training employees; and transition to self-management or an ongoing administrative contract.

Specific services provided include contracting and rebate management through drug product consortiums, prospective and retrospective drug utilization management, extensive management reporting and profiling, retail pharmacy network contracting and oversight, point-of-service claims processing, specialty-drug contracting, mail order service, telephone call center, and member and provider outreach and education.

[For more information, go on-line to: www.amerihealthmercy.com. Contact AmeriHealth Mercy through its corporate communications director, Rick Buck, at (215) 863-5102.] ■

Health care system is failing adolescents

Research comes out every month identifying groups having difficulty obtaining needed services in our country's health care system. A group often not discussed, perhaps because it is generally healthy, is adolescents. But a recent study by the Maternal & Child Health Policy Research Center (MCH) makes clear that when it comes to caring for adolescents, the health care system is not doing a very good job.

MCH co-director Margaret McManus tells *State Health Watch* the group previously had studied adolescents in the State Children's Health Insurance Program (SCHIP) in selected states and had identified issues around provider availability, reproductive health care, and behavioral health care. The next step, she says, was to take a broader perspective and look at how the overall health care system is responding to the needs of adolescents.

What MCH found, she says, is that our health care system is not geared to meeting the needs of adolescents, especially in terms of preventive care, reproductive health care, and behavioral health care — both mental health and substance abuse.

Although most adolescents are reported to be healthy, Ms. McManus' report says, the preponderance of evidence reveals that they confront significant health risks: physical and mental health problems; early experimentation with sex and drugs; physical inactivity; overweight and obesity; and substantial stress from school, family, and peer pressures. Adolescents who are low-income, minority, and living in inner cities appear to be at highest risk.

Nationally, according to the report, the annual costs of preventable adolescent health problems were estimated in 2002 to be $51.5 billion, or $1,152 per adolescent. When associated medical, legal, and lost productivity costs are included, the annual cost of preventable adolescent morbidity increases to $830.8 billion.

Despite the fact that adolescents face several health risks, their use of health services also can be a problem. Ms. McManus and her two co-authors, Kandi Shejavali and Harriette Fox, write that no other age group, except for young adults, is as likely to be without a usual source of care and have lower ambulatory visit rates.

"Foregone care is common among teens," they say, "especially among those who are older, low-income, uninsured, from minority backgrounds, or involved in high-risk behavior. . . . Despite high levels of preventable morbidity and potential cost savings, investment in adolescent health care has been limited. Moreover, few significant reforms have moved beyond the demonstration phase to wide-scale implementation, despite numerous national and state policy recommendations calling for improvements in adolescent health care."

The three researchers developed their report by interviewing more than 200 health care providers in four cities — Boston, Denver, Houston, and San Francisco — in a range of settings, including community health centers, school-based health centers, office-based practices, hospital-based clinics, family planning clinics, community mental health centers, and substance-abuse programs. The four cities were chosen based on their innovative adolescent health care leadership and program initiatives.

Providers who were interviewed

painted what the researchers say is a "disturbing picture of the lives of many adolescents in their cities." They say the most common adolescent health conditions are indicators of the turbulent world in which they live, rather than signs of inherent medical problems. Moreover, they say, a significant proportion of teens experience a considerable lack of parental involvement in many aspects of their lives, including health care.

In all four cities, behavioral health conditions were cited as serious issues in the adolescent population, more so than reproductive health or physical health conditions.

"Providers described the most pervasive behavioral health conditions experienced by teens as depression, anxiety, and post-traumatic stress syndrome [typically resulting from family or interpersonal violence]," the report states.

"Substance abuse, most often alcohol, marijuana, and tobacco, was also reportedly widespread. The use of club drugs, for example, Ecstasy, was commonly mentioned, mostly among middle- and high-income teens. Providers told us repeatedly about the lack of hope and low self-esteem that characterizes many adolescents they care for, causing them not to feel good about themselves and prone to making risky decisions," it continues.

Reproductive health conditions were described as the second most important category of health problem by the providers, specifically sexually transmitted diseases and teen pregnancy. Physical health conditions mentioned most include obesity and asthma. Poor nutrition, lack of exercise, and even lack of sleep were said to be typical among teens.

When the providers were asked about subgroups with a disproportionate burden of health problems, their answers cited differences by income, age, sex, race, and ethnicity.

The interrelatedness of behavioral, reproductive health, and physical health conditions were commonly stressed among providers serving adolescents, the report says. The providers noted that adolescent health problems often occur in concert with other problems and with common risk factors. Thus, while adolescents often present themselves to health care providers with physical symptoms, the problem may actually be behavioral or gynecological. This is how the providers view the three areas of concern:

- **Preventive and primary health care.**

According to the providers, preventive and primary health care don't generally meet the needs of adolescents because there are too few teen-friendly sites of care.

The authors say that whenever they heard of preventive and primary care services that were adequately meeting the needs of adolescents, it was because services were easily accessible and at least some physical, behavioral, and reproductive services were coordinated. Through site visits in the four cities, the researchers learned that such arrangements are available in many school-based health centers, community health centers, and hospital outpatient departments with special teen clinics and multidisciplinary staff arrangements, a few group model HMOs with special teen programs, and even some mobile services.

According to the providers, what makes preventive and primary care services work for adolescents are delivery arrangements that allow walk-ins, extended office hours (late afternoons and evenings), anticipating no-shows, having separate office space for teens, eliminating cost-sharing, assuring confidentiality, emphasizing parent participation, and most important, having providers who truly care about treating adolescents and have the training to do so.

Roadblocks identified as standing in the way of providing comprehensive preventive and primary care to adolescents include provider availability and organization, insurance and managed care, and parental consent and communication.

- **Reproductive health care.**

Providers said organization and delivery of reproductive care does not meet the needs of adolescents. Prevention and education don't receive enough attention, confidentiality protections are not well understood or consistently implemented, and reproductive health care often is disconnected from preventive and primary care.

Reproductive health care appears to adequately meet the needs of adolescents where a broad array of reproductive services are available on a free and confidential basis and reproductive and primary care are linked in teen-friendly settings. Such arrangements were found in many family planning programs, community health centers, and hospital outpatient departments with special teen clinics, and a few group-model HMOs with special teen programs.

As with preventive and primary care services, reproductive health services that work are those that offer confidential protections, no cost-sharing, a teen-friendly atmosphere, easily accessible sites of care, public transportation, and evening hours.

Barriers to effective reproductive health care are lack of confidentiality protections, insurance coverage limits, insufficient financing for confidential care, inadequate information for adolescents, and limited provider availability.

- **Behavioral health care.**

Providers in all four cities expressed the greatest concern that mental health and substance abuse treatment services are grossly inadequate to meet the needs of adolescents. The authors say a shortage of psychiatrists, psychologists, social workers, and substance abuse counselors trained to serve adolescents is widespread and has been at a crisis stage for some time.

Relatively few adolescents who need mental health services receive treatment, and even fewer receive substance-abuse treatment services, according to providers in all four cities. Those who do receive care generally have a serious emotional disturbance, are experiencing a crisis, or have been required by schools or courts to participate in counseling. Comprehensive, continuous treatment consistently is unavailable.

In settings where the behavioral health needs of adolescents are being met, the providers said, risks are identified early on, families are involved in treatment, mental health and substance abuse counseling are integrated, and a continuum of services is delivered in a timely manner by well-trained providers. In reality, however, such optimal arrangements rarely are found.

Providers offered many insights into what makes behavioral health services work well for adolescents, citing single point of access or one phone-in line but multiple sites of care, same-day services, evening and weekend hours, flexible scheduling, longer appointments, after-school programs, and outreach with particular attention to immigrants and others with little or no experience using behavioral health services.

Perhaps even more than with primary and reproductive services, having the right type of provider — skilled and interested in caring for teens — is key. All providers reportedly commented on the importance of providing mental health and substance-abuse treatment at much earlier ages. They also noted the value of having adequate numbers of male therapists and more therapists from diverse racial, ethnic, and linguistic backgrounds who understand the cultural and social context in which adolescents experience problems.

The most critical roadblocks to effective behavioral health and substance-abuse services are provider shortages and inadequate reimbursement rates. Other problems cited include restrictive managed care policies and arrangements, health insurance benefit limits and cost-sharing, inadequate funding and fragmentation of public programs, weaknesses in special education, stigma, parental consent requirements, lack of defined roles for primary care providers, and an overall lack of accountability. Unlike preventive and primary care and, to a lesser extent, reproductive care, providers concluded that there is an overall lack of accountability with respect to mental health and substance-abuse treatment services for youth.

"Not only are there enormous provider shortages," the report concludes, "there is no continuum of clinical services, no recognition of the unique needs of youth and opportunities for prevention and treatment, no widespread use of effective medications and other therapeutic interventions, no internal mechanisms for coordination among inpatient and outpatient providers or between physical and mental health services, and no data to track receipt of care or health outcomes."

Collaborative action needed

Ms. McManus and her colleagues call for creation of community-level adolescent health collaboratives with public and private representatives who would plan and implement more effective ways to deliver health services to adolescents.

Activities that collaborative members might undertake, according to the report, include:

1. examining the range of potential opportunities to integrate and expand preventive, reproductive, behavior health services, and youth development activities;
2. developing a work force plan to increase availability of mental health and substance-abuse treatment providers trained to serve adolescents, the number of male reproductive and behavioral health providers, and the number of providers from culturally diverse backgrounds;
3. expanding the number and financial viability of school-based or school-linked programs as well as teen programs in community health centers, office-based practices, hospital outpatient departments, managed care clinics, family planning programs, community mental health centers, and substance-abuse programs;
4. developing uniform approaches for assuring adolescents' confidentiality, strategies for sharing records, and ways for obtaining parental consent in a timely and efficient manner;
5. promoting improvements in care coordination focused on assuring adolescents' adherence to treatment recommendations; maintaining communication among primary, specialty reproductive, and behavioral health services; and linking health, education, and community support services;
6. developing an outreach strategy, with peer educators and others, to encourage adolescents to use health care services and become

active participants in health care decision making;
7. creating new models of parent outreach and education to support families in dealing with predictable adolescent challenges as well as addressing the needs of adolescents who are experiencing health problems;
8. expanding availability of school health education programs aimed at promoting self-esteem, healthy relationships, conflict resolution, sex education, physical fitness, and nutrition by involving community health programs.

System flaws are shocking

Ms. McManus tells *State Health Watch* that she and the other researchers were "shocked at how fundamentally flawed the delivery and financing health care system for adolescents is."

And yet it's not surprising, she says, because no action was taken on a federal study of adolescent health care from the early 1990s and there has been no concerted national attention paid to adolescents as a whole.

The sites they found that are working effectively are "wonderful, but few and far between," according to Ms. McManus.

"They happen because there are a few strong personalities in the area, not because the system is set up for it," she adds.

The solution that Ms. McManus sees is for action in Congress and the executive level of the Department of Health and Human Services to put more dollars into adolescent health.

"Unless payment levels go up," she says, "we're not going to get the provider availability we need."

[To see the report, go to: www.mchpolicy.org. Contact Margaret McManus at (202) 785-7425.] ■

Public health system still is not ready for terrorist attacks

More than two years after the terrorist attacks in New York City and Washington, DC, and despite $1.8 appropriated by Congress to revitalize the country's public health system, some progress has been made, but not nearly enough, according to a report prepared by Trust for America's Health (TFAH). The question the organization asked was simple and direct: Two years and almost $2 billion later, are we better prepared to respond to public health emergencies?

Despite a perception that the federal investment in public health preparedness over the last two years has brought rapid and substantial improvements to a long-neglected public health system, TFAH says it found "a more complicated and, at times, unsettling picture."

To assess the current level of emergency preparedness, TFAH worked with an advisory committee of state and local officials and public health experts to define 10 key indicators that express the fundamental capabilities every state should have.

"Collectively," the report says, "these indicators provide a snapshot of improvements that have been made and ways in which the public health system is still vulnerable. The indicators do not present a full measure of preparedness, but they do represent a first step toward providing the level of accountability and transparency that should be expected of publicly funded programs, particularly those that allow communities to understand what has been done and what remains to be done to improve homeland security.

"The study demonstrates that while states have made important advances in certain critical preparedness functions, many essential improvements have not yet been achieved. The indicators, while pointing out progress, also reveal that state public health agencies are facing fundamental, structural problems that threaten the nation's ability to respond to a large-scale public health emergency."

TFAH put together a state-by-state assessment on the 10 indicators to provide a picture of each state's preparedness to handle a public health emergency. States received one point if they had achieved an indicator and zero points if they did not achieve the indicator.

California, Florida, Maryland, and Tennessee received the highest scores, achieving seven out of the possible 10 indicators. With two out of a possible 10 points, Arkansas, Kentucky, Mississippi, New Mexico, and Wisconsin had the lowest scores. More than 70% of the states received scores of three, four, or five.

The report's authors say the fact that a majority of states have scores in the lower range depicts a trend: While states have achieved piecemeal progress, the full-scale effort to comprehensively fix the nation's public health system is falling short.

TFAH concludes that despite a surge in federal funds, states are only modestly more prepared to respond to health emergencies than they were before Sept. 11.

"Overall," it says, "the preparedness effort has been severely compromised by the impact of state budget crises, the lack of priority placed on addressing underlying systemic problems, and the failure to eliminate bureaucratic obstacles."

In response to what it found,

TFAH recommends these actions:

1. Public health agencies must be battle-ready for all hazards and not just bioterrorism. The Centers for Disease Control and Prevention (CDC) must authorize states to use federal preparedness funds for an all-hazards approach to preparedness that simultaneously addresses the potential for biological, chemical, radiological, and natural disease outbreaks. In consultation with state and local health officials and outside experts, the CDC should define measurement standards for comprehensive preparedness that all states and major local health departments should meet. And Congress should provide long-term commitment and oversight to ensure the nation achieves adequate and sustainable public health security.
2. Establishment of health security requirements in terms of mandates and accountability will ensure that all citizens are adequately protected. The CDC should be required to track state and local funding and expenditures on critical public health functions, especially those involving federal support, and should independently verify that health emergency performance standards are being met at the federal, state, and local levels. The CDC also should establish rules for ongoing federal funding by requiring that state or local governments maintain core public health funding levels.
3. Staging a summit on the future of public health will develop a cohesive, national approach to public health protection. Such a summit, TFAH says, should develop a vision for the future of the American public health system and the resources needed to make the vision a reality. The summit would consider how the country can best build a robust, integrated, 21st century infrastructure.

In a similar effort, the General Accounting Office (GAO) was asked to examine improvements in state and local preparedness for responding to major public health threats and federal and state efforts to prepare for an influenza pandemic. In testimony earlier this year before the House of Representatives Committee on Government Reform, the GAO said that although states have further developed many important aspects of public health preparedness since April 2003 (when the GAO last briefed the Congress on this issue), no state is fully prepared to respond to a major public health threat.

"States have improved their disease surveillance systems, laboratory capacity, communication capacity, and work force needed to respond to public health threats," a GAO report said, "but gaps in each remain. Moreover, regional planning between states is lacking, and many states lack surge capacity — the capacity to evaluate, diagnose, and treat the large numbers of people that would present during a public health emergency."

The GAO concluded that while states have taken many actions to improve their ability to respond to a major public health threat, no state has reported being fully prepared, and state efforts to develop their plans have been complicated because federal plans for the purchase, distribution, and administration of vaccines and drugs in response to an influenza pandemic still have not been finalized. "States are more prepared now, but much remains to be accomplished," the GAO added.

Responding to the studies, American Public Health Association executive director Dr. Georges Benjamin tells *State Health Watch* that TFAH wanted to be sure people knew that while some progress has been made, it has been uneven among the states.

"While there have been improvements in some important areas, the basic infrastructure has been eroded because of state fiscal problems," Mr.

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

Benjamin says. He notes that when the anthrax scare broke, Maryland was able to pull people from other programs to work on that issue. But state budget cuts have reduced the capacity for such response and have made the overall system weaker.

According to Mr. Benjamin, it's important that the federal and state governments understand and accept the need to continue to invest in public health. "We need to have some kind of rational plan," he tells *State Health Watch*. "We need to decide what we want our protection systems to be like and then adequately fund them."

Officials must recognize that their plans will always need to be updated in response to changing conditions, Mr. Benjamin says. For instance, some states are planning to use their National Guard troops to move stockpiled supplies to where they are needed. But if those troops have been called to active duty and are serving outside the country, the plan calling for them to be involved may need to be revised.

One problem Mr. Benjamin sees is a lack of recognition generally of the importance of the broad protective role of the nation's public health system. "Studies indicate that citizens don't believe they have been affected by the public health system," he says. "They don't see it operating in their daily lives. We need a federal-state partnership in an educational effort so that public health and what it does will become a household word. It's good to see increased leadership at the federal level to push for a better understanding by the public of what public health is."

[For more information, go to: www.healthyamericans.org. To see the GAO report, go to: www.gao.gov/cgi-bin/getrpt?GAO-04-458T. Contact Georges Benjamin at (202) 777-2742.] ■

Medicaid-only plans show increasing strength

With commercial health plans exiting from the Medicaid market in the last few years, state Medicaid programs are becoming more dependent on Medicaid-only plans. But are Medicaid-only plans able to provide high-quality cost-effective care and remain in business for the long-term?

The Center for Health Care Strategies (CHCS) in Princeton, NJ, set out to find the answers to those questions by examining financial data from 183 plans and nonfinancial data from 59 plans, and interviewing officials in 13 states and 26 plans.

Results of the study, conducted by Robert Hurley and Michael McCue, both of Virginia Commonwealth University in Richmond show:

- The shift to further reliance on Medicaid-focused plans appears inevitable.
- Most Medicaid participating health plans are profitable, although margins are narrow.
- Member satisfaction and clinical quality ratings are similar between Medicaid-focused and other plans as states require them to comply with identical contractual requirements.
- Strong collaborative relationships between states and surviving Medicaid-focused plans are growing as both parties have become more experienced and reliant upon each other.

Mr. Hurley tells *State Health Watch* that a Darwinian-type evolution has occurred among health plans, with the fittest ones surviving, and the less-capable plans falling by the side.

"The surviving plans have grown because of the shrinkage in participating plans," he says. "The upside of plans exiting the Medicaid market is that the remaining plans are redistributing the members of the departed plans and thus are becoming larger and more sophisticated."

In his report, Mr. Hurley says that concerns about financial and nonfinancial performance among Medicaid-focused plans have not become a reality.

"The current roster of Medicaid-focused plans is financially robust," he says. "States generally have not needed to relax contract requirements or arrange special financial accommodations, although there were some extraordinary interventions in a few instances.

"While member satisfaction levels for some Medicaid-focused plans appear to be slightly lower than other plans, beneficiaries have not shunned Medicaid-focused plans as inferior or gravitated toward mainstream commercial plans when provided with the opportunity to do so," Mr. Hurley explains.

Through his interviews, he says, he determined that plans that specialize in Medicaid often develop more intensive outreach, are more frequently engaged in community-related initiatives, and employ more aggressive hands-on management approaches for their members. He attributes such increased sophistication to both the increasingly demanding contract requirements imposed by states and recognition of the added efforts that health plans need to succeed in the Medicaid product line.

According to Mr. Hurley, this latest study validates a prediction made in earlier studies — that state agencies and health plans remaining in Medicaid managed care have moved to a higher level of interdependence or mutual reliance. Medicaid payment rates are critical

for the continued viability of plans, he says, and the plans exert a major impact on sustainability of the state Medicaid program.

This is particularly true in states such as Ohio, Rhode Island, and Washington, where more than half of all beneficiaries are enrolled in one or two plans that are Medicaid-focused, and in urban markets in many other states.

Mr. Hurley points out that both sides are acutely aware of the high degree of mutual dependence, but so far that has motivated them to function as partners rather than adversaries, something he had suggested in the earlier studies.

However, he says, "without question, the current financial crises in the states are severely testing the sustainability of relationships and increased brinkmanship appears inevitable. Next year will be a truer test of the lasting nature of these relationships as contract renewals become due and as plans reconsider their tolerance for the rate increases proferred."

Mr. Hurley tells *State Health Watch* that the future of many plans probably hangs in the balance of how the fiscal crises in states play out.

In California, he says, many plans are vulnerable; and in Oklahoma, a pre-paid program is being dropped because of an inability to get agreement on rates.

"We don't know how well states will maneuver through this," he says. "The issues are very much in play right now, and we really won't know until the end of state legislative sessions and we can see the rates."

According to the report, the prominence of investor-owned Medicaid-focused firms bolsters the market while raising challenging issues for state agencies. A small number of companies is collectively involved in more than 25 Medicaid-focused plans, and they can affect Medicaid agencies directly by expanding or sustaining the number of contractors when they enter new markets, acquire available plans, or merge existing plans into larger ones.

The companies, Mr. Hurley says, also are openly and strongly committed to promoting political and financial support for Medicaid, perhaps more forcefully than previously done by other program advocates. Because these publicly traded firms must report financial performance quarterly, their growing involvement in Medicaid raises a new set of concerns that states may find increasingly challenging.

"Touting profitability to shareholders every 90 days will inevitably invoke concerns from some state policy-makers and ire from many Medicaid providers, irrespective of the ability of these firms to support their claims of delivering real value," he says.

In his report, Mr. Hurley says the durability of the Medicaid managed care market remains uncertain, but he points out he generally is optimistic about the future of Medicaid-focused plans.

He notes that skeptics continue to raise concerns about the commitment of investor-owned Medicaid-focused plans, suggesting they could flee the market if profitability proves difficult to sustain, much like what happened in the Medicare market and among commercially focused plans in Medicaid. Mr. Hurley says the Medicaid-focused plans currently appear to be trading successfully on the upside growth potential of market aggregators or consolidators who can grow substantially and avail themselves of cross-market economies and synergies.

To date, he says, capital markets and investors have rewarded them for their strategic positioning and performance.

Nowhere else to go

Perhaps equally important, according to Mr. Hurley, Medicaid-focused plans have nowhere else to go and so have a powerful incentive to make Medicaid managed care a successful enterprise for themselves, the states, and their beneficiaries.

"Provider-sponsored plans, as the other substantial segment of the Medicaid-focused plans, also have a strong interest in ensuring that Medicaid is adequately funded, at least in terms of provider payments," Mr. Hurley says.

"Although their long-term commitment to the Medicaid market is unclear, plan sponsorship allows providers to protect their market share ad to avoid becoming overly dependent on the investor-owned Medicaid-focused plans that represent their principal competitors. The competitive tension between these segments of the Medicaid focused market could prove valuable in enabling states committed to Medicaid managed care to maintain a viable set of contracting alternatives," he says.

CHCS vice president for programs Nikki Highsmith tells *State*

Health Watch that she thinks it is a positive situation that there are fewer Medicaid-focused plans and that those plans are more committed to the successful long-term continuation of the Medicaid program. "The trend among the plans that are left is to look at how to raise the bar for everyone in delivering care to Medicaid patients," she says.

One policy concern that has been raised, Ms. Highsmith says, is whether Medicaid-dominated health plans can maintain a high level of quality. But so far, she says, member satisfaction scores and clinical scores show that Medicaid-focused plans can be competitive on quality measures.

She says the partnership between states and plans on the Medicaid line of business is particularly important, as shown in states such as Virginia and Wisconsin where there are good partnerships. "There's always a fine line," she says. "The dance is always interesting. States are glad there are plans that want to stay in the Medicaid business. I do think states will have to rethink their negotiating strategies with fewer plans and leverage the marketplace in different ways. They could tie rate increases to quality improvements and demand value from their contractors.

Sentara Health Management director of Medicaid Megan Padden tells *State Health Watch* that Virginia's payment rates to Sentara's Optima Health Plan provide a sufficient return. One advantage Sentara has, she says, is that it is organized as a not-for-profit corporation and thus serving Medicaid fits well with its mission. Because it is not investor-owned, its margins are different as well, and the plan is not looking for huge profits, Ms. Padden explains.

A collegial relationship for now

"The partnership we have developed with the state agency makes it easy for us to stay in the program," she says. "Our relationship is more collegial than that in some states."

According to Ms. Padden, Optima's revamped obstetrics program is a good example of changes that have been made to better serve the Medicaid population. She says the health plan began to focus on high-risk obstetrics patients for obvious reasons, and its revamped program also has helped Sentara's commercial business. The same type of thing has happened for asthma treatment.

Currently, she says, the federal balanced budget amendments and the Health Insurance Portability and Accountability Act are raising administrative hurdles that Sentara and the state agency are working to resolve. "The state is open to feedback from plans on these issues," Ms. Padden says.

"We don't want things to be so administratively burdensome that they don't make sense. We'd like to see the state become a better purchaser of health care services and build that into their rate structure," she notes.

Virginia Medicaid director Cheryl Roberts tells *State Health Watch* that her agency works with seven plans, including one that is Medicaid-only (Virginia Premiere) and one that is partially Medicaid (Sentara).

"Working relationships with those plans are easier than with plans on the commercial side," she says. "It's easier to focus on the product line when it is Medicaid only. There's more hands-on activities such as disease management, outreach, and marketing. And even though the commercial plans put a lot of energy into their product, it can be difficult for them to make changes."

According to Ms. Roberts, Virginia Premiere and Sentara are more willing to expand to new geographic areas of the state than are the commercial plans.

However, she is concerned that if the state's budget crisis continues, the two plans may cut back to their home areas, although she doesn't think they will drop the business.

Ms. Roberts warns that if Virginia Premiere and Sentara start to lose money, "it's over because they have no other place to get revenue."

Is the working relationship between the state and the plans likely to change? "Money changes every discussion," she says.

"The people we work with now are happy. Those who are likely to come in [from the corporate executive level] when they are losing money are not going to be happy," she adds.

(The report is available at www.chcs.org. Mr. Hurley and Ms. Highsmith can be contacted by e-mail: mppadden@sentara.com and croberts@dmas.state.va.us.) ■