State Health Watch

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California expands HMO liability, external review coverage mandates

New laws are pushing envelope for national reforms in liability, access

Unprecedented managed care reforms in California are raising the bar for state and federal lawmakers considering expansions of rights of health care consumers.

"The work we've done here is driving the train in Washington. I don't think there's any question about it," says Marjorie Swartz, a legislative advocate with the Western Center on Law and Poverty in Sacramento.

Gov. Gray Davis in late September signed bills that expand access to independent review of HMO coverage denials, as well as expand and reorganize the regulation of managed care plans. New legislation also makes California the third state in the country, behind Texas and Georgia, to allow enrollees to bring a suit against their health plans for negligence.

California's expansion of liability doesn't become effective until Jan. 1, 2001. In the meantime, the HMO industry is steadfast in maintaining that increased plan liability poses a threat to both the quality and

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NYC Medicaid mandatory managed care rollout hits a few speed bumps in enrollment

The first rollout of Medicaid managed care in New York City has had its problems — enrollment materials not available in the many languages needed, exempt people receiving enrollment packets, providers telling people they must enroll to continue receiving services — but the issue dividing government agencies and consumer advocates is whether the problems are temporary bumps in the road or a warning of bigger problems to come.

"Things have gone quite well," says Sandra Mullen, a spokeswoman for the city's Department of Health, which shares responsibility with the state Health Department for the program. "Obviously, there are kinks involved in any kind of start-up. But we're very pleased that from Aug. 9 to Oct. 1, there were 12,000 enrollments processed. We're moving at a very good pace."

That assessment is shared by the state Health Department's spokesman Rob Kenney, who says the rollout is "going well" with benefits education and enrollment contractor Maximus "meeting all the contract requirements for enrollment and processing."

But consumer advocates are less sanguine, fearing that the "kinks" seen

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■ States get federal grants to help rural hospitals to make transition to cost-based reimbursement: *Will cost-based reimbursement be enough to save rural hospitals? Texas thinks not, and is using the federal government's critical access hospital program to do more than just boost hospital Medicare payments. A first-year evaluation suggests how the program should be tweaked*. 8

■ This issue of *SHW* contains a survey asking for comments on our revised layout: *Please fill out and fax back* . . . . . Insert

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

California

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affordability of care. "Twenty-eight state legislatures considered liability, and all but two others rejected it," noted Susan Pisano, spokeswoman for the American Association of Health Plans in Washington, DC. If anything, what this does is to intensify our resolve to talk about what is at stake here."

A host of benefit mandates also became California law with the governor's signature. Effective July 1, 2000, health plans will have to provide coverage and terms for mental health conditions comparable to those for physical conditions.

The coverage extends to children with "severe emotional disturbances" and adults with "severe mental illness," the latter defined as schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, or bulimia nervosa. The mandate for children covers all conditions except substance abuse and developmental disorders.

Effective Jan. 1, plans also will have to provide coverage for "a variety of Food and Drug Administration [FDA] approved prescription contraceptive methods." The coverage is very broad, as the plan can be required to approve an alternative FDA-sanctioned method if a physician determines that none of the plan's original choices are medically appropriate for a given patient.

Religious employers are eligible for an exemption to the contraceptive coverage mandate.

Medi-Cal gets invited

Consumer advocates pushed back attempts to exclude Medicaid beneficiaries from access to the external review process, in which medical experts examine instances in which care is "delayed, denied, or modified" based on a determination of medical necessity. The argument in favor of excluding enrollees in Medi-Cal, California's Medicaid program, was that existing appeals in Medicaid processes were adequate.

"We don't think there will be that much redundancy, but if it is a medical necessity issue, a Medicaid beneficiary ought to have the benefit of this new expert panel," says Ms. Swartz.

Significantly, both California and Texas allow enrollees to sue for punitive as well as actual damages. Georgia legislation passed in the most recent session mandates the right to external review and gives enrollees the right to sue their health plans for damages for lack of "ordinary diligence," but blocks any rights to punitive damages.

In approving the expansion of liability, California legislators appeared savvy about federal law and case law interpreting it would allow state intervention, says Patricia Butler, JD, DrPH. Ms. Butler, a health care analyst in Boulder, CO, says the Employee Retirement Income Security Act of 1974 and subsequent case law draw the distinction between disputes about "whether or not to pay" — where state intervention is limited or blocked — and disputes about the "care delivery process" — where states have more latitude. "That's a fuzzy line, obviously," she says.

California advocates were disappointed in — and hope to reverse — their failure to secure funding for an external ombudsman, specifically one empowered to act as a legislative advocate and represent clients in disputes with health plans.

"It doesn't matter what rights you give people; if they don't know about them and they don't have help asserting them, forget it," says Ms. Swartz.

Lack of agreement

At press time, the U.S. Senate and House of Representatives were wrangling over their respective versions of managed care reforms. Debate on the right to sue, a key feature of the House version but not the Senate's, threatened passage of any managed care reforms at all.

Regardless of what happens in Congress, at least one health policy veteran expects the action to be at the state level. "What the states are doing is not paying attention to Congress," says Ms. Butler. "Most of them are doing what they feel they need to do."

Contact Ms. Swartz at (916) 552-5830, Ms. Butler at (303) 440-0586, and Ms. Pisano at (202) 778-3200. ■

NYC Medicaid

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by Ms. Mullen are only the tip of the iceberg of massive problems caused by lack of adequate planning and preparation for the Aug. 9 launch.

Mandatory managed care ultimately will cover 1.5 million people in New York City. Phase I mandatory enrollment started Aug. 9 for 382,000 Medicaid recipients in Manhattan, Brooklyn, and Staten Island. They are given 60 days to choose from among 18 health plans that have a total of 6,576 participating primary care physicians and 20,152 specialists. Those who do not choose a plan within 60 days are automatically assigned to a plan. Participants have 90 days from the date of their initial enrollment to change plans without cause; after that they are locked in until 12 months after enrollment.

Mandatory managed care excludes Medicaid recipients in institutions or foster care and exempts those with HIV/AIDS, serious mental illness, developmental disabilities, or language barriers. Individuals who are exempted still may enroll voluntarily if they wish.

One of the major problems advocates see is that outreach educational materials were not available in the many languages needed when the first mailings went out. They also complain that community groups and even providers have not had sufficient information and understanding to be able to help Medicaid beneficiaries decide what is best for them.

"There were a number of problems that we felt should have been addressed in planning that are now appearing in implementation," says Susan Dooha, director of health care access for Gay Men's Health Crisis. "For one thing, the state's data system doesn't recognize that some Medicaid beneficiaries are exempt from managed care. The state had said that no one with HIV or AIDS would be asked to enroll or be mandatorily assigned. But many in this group are receiving enrollment packets.

"We also had asked for adequate resources to educate AIDS provider agencies so they could help their clients. But there were no presentations and no materials, and the agency people don't know the basics of enrollment, exemption, or how health care may change for those who choose to enroll," she adds.

"We see problems now with kids with AIDS being enrolled in mandatory managed care even though they are exempt. Their families want to disenroll them, but it's difficult to accomplish and they are at risk of having their care disrupted. These kids are medically fragile and may need urgent care at any time. While the incidence hasn't been great yet, we've only just gotten started, and I'm concerned about what we may see as we go on," Dooha says.

Another major area of concern is the lack of printed materials in many different languages. Ms. Mullen acknowledges that only English-language materials were ready Aug. 9, with the Spanish version coming several weeks later. She says materials in Haitian-Creole, Russian, Chinese, and Arabic are being rushed into production.

State spokesman Mr. Kenney notes that the Health Care Financing Administration (HCFA) requires only English and Spanish materials, based on the percentage of population in the target area, but the state and city are taking extra steps in producing materials in other languages as well.

The city tried to overcome the lack of brochures in various languages with a notice in 18 languages on the back of the envelope holding the enrollment mailing, says Judy Wessler, policy coordinator for the Commission on the Public Health System. The notice gives a telephone

number for a translation service operated by Maximus.

"But they're not getting many calls for help," she concedes. "The language on the envelope may not have been strong enough so people understand there can be major changes in the way they receive health care and they need to know what is happening." Ms. Dooha reports that providers say they are seeing Russian, Chinese, and other patients who are very confused about the enrollment materials they received.

"Those are the fortunate ones," she says, "because they're well-enough connected to come in and ask for help. What about all the others who are confused but are not asking anyone?"

She also said that those who do not speak English can have difficulty with the telephone help line because they listen to a series of baffling voice mail messages in English until the system finally hangs up on them.

The program is "moving too quickly without adequate plans in place for a major disruption" in health care services, says Chris Molnar, director of the Medicaid Managed Care Education Project of the Community Services Society. Because the city and state have refused to adequately involve community agencies in the outreach work, Ms. Molnar says, "people have been clueless. They are very vulnerable to misleading marketing pitches. People are enrolling without understanding what it means to enroll, without understanding that they have choices, without understanding that they may not have to enroll at all."

The first auto-assignment figures — due before the end of October — will suggest to advocates how well enrollees understand their options. A high level of auto-assignment into managed care plans indicates to advocates that outreach and counseling efforts need to be stepped up.

Some of the concerns are driven by the experience of 12 upstate counties where mandatory Medicaid managed care already is under way. "We've heard from upstate that auto-assignment can be high," Ms. Dooha says, "and that there can be disparities among communities or populations. We understand, for instance, that the black auto-assignment rate is significantly higher than for whites. That suggests that outreach plans were not developed in an effective way and that the government agencies don't have good connections with community leaders and groups. It alarms me that this could be happening in upstate communities.

"There's a question of who's watching the shop as everyone tries to gain market share. It's important that the city and state put the monitoring forces on the street that they said they would."

Chris Molnar
Director,
Medicaid Managed Care
Education Project,
Community Services Society

"Despite us raising this issue with HCFA and begging for their scrutiny of the city's outreach plans, now we're learning of problems here after enrollment has begun."

Another area of concern being voiced deals with questionable marketing practices by some HMOs and providers. "Many providers are disseminating inaccurate information to their client base," Ms. Molnar says, telling clients they will not be able to receive service unless they sign up with a particular HMO. "There's a question of who's watching the shop as everyone tries to gain market share. It's important that the city and state put the monitoring forces on the street that they said they would."

Some enrollees receiving mental health services are being told they must sign up with a particular HMO to continue to receive care, says Ms. Wessler with the Commission on the Public Health System. Government agencies take action in response to advocates' marketing concerns, she says, but usually on a case-by-case basis rather than systemically. "I think they need to make an example of an organization that's been doing things incorrectly and hand out some punishment to send a message that this shouldn't be happening," she says.

Problems also have been reported with special populations such as the hearing-impaired (a hearing person must call Maximus and ask to have the special telephone connected for the hearing-impaired person), the blind (no Braille materials available), and the homeless. The case of the homeless could prove particularly interesting because although they are supposed to be exempt, they are not coded that way in the computer system and so have been sent enrollment mailings. There is the potential for a significant auto-assignment of people who were specifically supposed to be protected from the mandatory managed care program, says David Wunch, a policy analyst with Care for the Homeless.

To complicate the task, he says, homeless people who want to opt out of managed care must telephone and ask that an exemption form be mailed to them — city and state policy doesn't allow community groups to distribute such exemption forms. But because the homeless often move among the city's homeless shelters, the mailed form may never reach them.

The system puts the homeless at risk for a break in the continuity of care, says Care for the Homeless assistant executive director Bobby Watts.

A homeless person who has been unwittingly auto-enrolled in an HMO may turn up ineligible for coverage at his or her conventional Medicaid provider, he says.

Governmental agencies may be willing to wait for problems to cause harm rather than proactively thinking of what problems there can be and working to prevent them, says Ms. Dooha.

"We should extend the managed care concept to the way change is handled as well as to the actual medical care," she declares. "I don't know how bad the problems have to get before action is taken to slow down and review what's happening. I don't want to see children with AIDS in a medical crisis because their families haven't gotten good information. I don't want to see people enrolled in managed care and then clueless about how to get the care they need.

"What level of civil rights violations is needed before things slow down and are reviewed or federal money is withdrawn? We haven't gotten an answer for how bad it has to get and how HCFA sees its role." (HCFA officials declined an interview for this article.)

"I'll grant that some progress has been made, but I'm still very disturbed. I think these early problems should be a wake-up call. I think the advocacy groups have been constructive. We've been raising issues and making suggestions to avoid problems, but we haven't been heeded. It's difficult to keep faith with so many obstacles in the way, but we're still amenable to continuing to work things out. We haven't yet given up on the idea that we can make a difference in this process."

Contact Sandra Mullen at (212) 788-5290, Susan Dooha at (212) 367-1228, Rob Kenney at (518) 474-7354, Judy Wessler at (212) 749-1227, Chris Molnar at (212) 614-5401, and David Wunch and Bobby Watts at (212) 366-4459. ■

Pennsylvania enacts huge increase in behavioral health Medicaid rates

State challenged on requirement to monitor adequacy of rates

Behavioral health providers in Pennsylvania are enjoying an unprecedented increase in Medicaid reimbursement, won by suing the state under federal law similar to the repealed Boren Amendment.

A settlement in June brought new rates for the entire range of behavioral health services, effective with the start of the state's fiscal year on July 1. The state's share of the increased Medicaid reimbursement is expected to be $23 million to $28 million, in a total Medicaid behavioral health budget of about $1 billion. Pennsylvania spends another $550 million annually for residential and outpatient services outside the Medicaid budget.

The suit brought by the Pennsylvania Community Providers Association (PCPA) was settled before going to trial and thus provides weak admissible precedent for similar efforts. But the law on which the association hung its hat, found in the requirements for the contents of a Medicaid state plan, is the basis of a growing number of efforts by providers to boost stagnant outpatient Medicaid rates (For the section of U.S. code that PCPA used, see "Medicaid plan must assure economy, access," below.)

"If I were still a Medicaid director, I'd say it's a real live liability for state Medicaid agencies in the federal law," says Gary Clarke, director of Florida's Medicaid program from 1988 to 1993 and now a partner in the Tallahassee law firm of Sternstein, Rainer, & Clarke.

Like the Boren Amendment, passed in 1980 and repealed in the Balanced Budget Act of 1997, the provision invoked by the Pennsylvania providers requires Medicaid programs to pay enough to ensure access to providers, and — significantly — have a way to monitor their progress in doing so.

"Just paying the same as the general population without having a method isn't good enough," says Mr. Clarke.

In fact, the process argument, not the access argument, is where Pennsylvania's case was stronger, says Raymond Webb, PCPA executive director. The association could document waiting lists for services, but says provider agencies were likely to

Medicaid plan must assure economy, access

A state plan for medical assistance must provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

Source: 42 USC 1396a

cost-shift and make other concessions before reducing access.

"Access was not an easy issue for us to deal with. Agencies had not gone out of business. Had it gone to court, we would have struggled with that issue," he says.

The law technically applies to all Medicaid services, but lawsuits using it as a cause of action tend to be from outpatient providers. Repeal of the Boren Amendment, which applied to nursing homes, hospitals, and intermediate care facilities, suggested Congress' intent to remove "all Boren-like" protections from federal law for these facilities, says Ruth E. Granfors, an associate in the Harrisburg, PA, firm of Kirkpatrick & Lockhart, which brought the suit against the Department of Public Welfare for PCPA.

Ripple effect

Legal actions to increase fees under the law, usually referred to by the shortened citation "30(A)," generally have been on behalf of fee-for-service providers. Pending suits in the district courts of New Hampshire and northern New York use 30(A), among other statutory provisions, to argue for increased dental fees for Medicaid services.

"Where are lawyers looking to construct an argument now that Boren is gone? That's [30(A)] probably the best place," says Mr. Clarke.

When Medicaid managed care plans cross paths with 30(A), often it is because certain provisions have been interpreted to give the Medicaid program the right to set upper payment limits. Medicaid plans often will ask for a waiver of the law to allow managed care organizations to pay providers above the calculated upper payment limit, typically in geographically limited areas or to respond to unique market conditions. Pennsylvania itself has such a wavier, says Charles Curie, deputy secretary for mental health within the Department of Public Welfare.

"It becomes almost a moot point if they pay more than the state rate, because if they overspend their capitation, it's on them," he says.

Mr. Curie cites instances in which Philadelphia MCOs already were paying more than the fee-for-service rate, so the settlement will not necessarily boost rates statewide. Still, providers report that the settlement is pushing up managed care rates, even in the five southeastern and 10 southwestern counties where the state is rolling out mandatory Medicaid managed care. Where provider payments have been lower than Medicaid, the behavioral managed care companies "are increasing the rates, have increased them, or are thinking about doing it," says Mr. Webb.

Pennsylvania counties, which are prohibited under state law from reimbursing for county-funded services at rates higher than Medicaid, have similarly started to boost their rates, he says.

"It's had some interesting spinoffs, which frankly we didn't anticipate." Mr. Webb says.

Crucial to the settlement was a California Supreme Court decision holding that an association such as PCPA had the legal standing to represent its members in federal court, Mr. Webb says.

"I've been here 10 years, and on a number of occasions I've tried to get members to agree to act as a plaintiff in a lawsuit. Not one of them would ever do it," he says. "This California Supreme Court decision gave us the right in federal court to represent our members; we had standing before the courts. We would not have sued if we had not had that."

Contact Mr. Clarke at (850) 577-6557, Mr. Webb at (717) 657-7078, Ms. Granfors at (717) 231-5835, and Mr. Curie at (717) 787-6443. ■

Selected Reimbursement Rates — Pennsylvania Medicaid

Service	Code	New Rate
Outpatient Psychiatric Individual Psychotherapy	W9801	$26.00 per ½ hour
Outpatient Psychiatric Family Psychotherapy	W0983	$26.00 per ½ hour
Outpatient Psychiatric Collateral Family Psychotherapy	W0984	$26.00 per ½ hour
Outpatient Psychiatric Group Psychotherapy	W0981	$7 per person per ½ hour (1 hour min.)
Outpatient Psychiatric Evaluation	W0987	$75
Psychiatric Clinic Medication Visit for Drug Administration and Evaluation	W1855	$15 (¼ hour min.)
Licensed Adult Psychiatric Partial Hospitalization Program	W0860	$14 per adult per hour

States draw the line on on-line Internet dispensing, bring suit against out-of-state doctors, pharmacies

At least three states are cracking down on what they say are illegal uses of the Internet to prescribe and sell prescription drugs. The states are targeting pharmacists and physicians using the Internet to practice where they are unlicensed, but regulators seem wary of Internet medicine, period.

"It's wrong and dangerous to dispense prescription drugs on the basis of a prescription issued by a doctor who has never spoken with the patient, and who issues the prescription for a potentially lethal drug solely on the basis of an e-mail," Missouri Attorney General Jay Nixon said in a prepared statement. He has obtained temporary restraining orders to prevent several Texas pharmacies and pharmacists from doing business with Missourians. (See specifics on Missouri and Kansas at the end of this article.)

Michigan Attorney General Jennifer Granholm has created a high-tech unit whose charge includes investigating Internet dispensing, but has not yet brought any formal action in the area, says the office's director of communications Christopher DeWitt.

Kansas is pursuing its cases on two fronts. All six of the state's active cases involve allegations that out-of-state pharmacies or physicians have used the Internet to cross state lines and practice illegally in Kansas. The other tack relies on claims of deceptive advertising — the promise that every prescription order is reviewed by a physician, for example — or of substandard levels of care.

In one instance, for example, a 16-year-old boy was able to secure Viagra on-line even after he correctly supplied his age. "We're alleging that it's unconscionable within the meaning of our consumer protection statute for any entity, whether it's a pharmacy or a clearinghouse or the prescribing physician, to put prescription drugs in the hands of a consumer who has never had an in-person examination or consultation with the examining physician," says Kansas assistant Attorney General Derek Schmidt.

Confimed LLC is one of the five companies under a temporary restraining order from doing business in Kansas. Its Web site is active, but requires customers to attest that they are not from Kansas "or any other jurisdiction that limits access to medication over the Internet."

In response to "public concern" regarding the safety of pharmacy practices on the Internet, the National Association of Boards of Pharmacy in Park Ridge, IL, is promoting a policy of self-policing. The association has developed a 17-point certification program for on-line pharmacies, the Verified Internet Pharmacy Practice Sites (VIPPS). The certification is voluntary, and the official position of the association is that existing laws and regulation applied to "bricks and mortar" pharmacies should be used for the on-line variety. VIPPS addresses areas "where existing laws do not specifically mention the distinctions of on-line pharmacies," according to the NABP's description of the program.

The association estimates the number of on-line pharmacies at 400. In mid-September, the group certified its first three VIPPS pharmacies: RxAmerica LLC (www.drugstore.com), Merck-Medco Services of Nevada, Inc.(www.merck-medco.com), and planetRx (www.planetRx.com).

Telemedicine advocates are watching the regulation of on-line pharmacies "very closely," but so far feel that their activities look nothing like the on-line prescribing that's the target of state regulators.

"Right now, it seems like apples and oranges," says Glenn Wachter, head of advocacy and government affairs for the Association of Telemedicine Service Providers in Portland, OR. "Telemedicine technology is a lot more sophisticated that going on-line and filling out a form.

• Missouri

— Temporary restraining order against S&H Drug Mart and pharmacist William Stallknecht from selling and shipping prescriptions

— Agreement with James Reed Williams, MD, of Texas to stop treating Missouri residents or using on-line consultations to write prescriptions for Missouri residents

— Temporary restraining order against Houston's Procare Clinic for Men, owner Kenneth N. Miles, Piney Point Pharmacy, and Danny Ray Johnson, MD, from accepting or processing orders from Missourians, or in Mr. Johnson's case, from treating or prescribing drugs for Missourians.

• Kansas

— Suit against DVM Enterprises Inc.; Home Prescription Services Inc.; Confimed LLC; Focus Medical Group Inc.; Senior Care Pharmacy Inc., formerly LTC Pharmacy Inc.; and Viapro Inc.

— Also named are two individuals doing business as Male Clinic, one individual doing business as Community Drug of Pittsburgh, and one individual doing business as Stivercorp and On-line Physicians.

— The state also is pursing out-of-state doctors who prescribed the medications.

Contact Mr. Schmidt at (785) 296-2215, Mr. Wachter at (503) 222-2406, and the National Association of Boards of Pharmacy at (847) 698-6227. ■

States get federal grants to help rural hospitals make transition to cost-based reimbursement

The federal program creating "critical access" hospitals in rural areas has made "substantial progress" toward full implementation, says a recent report from the Health Resources and Services Administration (HRSA).

As of Sept. 1, 35 states had won approval from the Health Care Financing Administration for their plans to convert conventional hospitals into those eligible for cost-based reimbursement under the Medicare program. HRSA in mid-September awarded more than $13 million to 43 states for the planning and analysis needed to evaluate participation in the program (see chart, p. 9). The funds also will be used to develop rural health networks that include the enhancement of emergency medical services.

Of the 35 states with approved plans, the report lists 12 with certified critical access hospitals: Colorado, Georgia, Idaho, Kansas, Maine, Minnesota, Nebraska, New York, North Carolina, Oklahoma, South Dakota, and West Virginia. It was completed for HRSA by the Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill.

The report noted several problems in the existing legislation and suggested modifications:

• Hospitals do not have sufficient clinical flexibility to work within the 96-hour maximum for every hospital stay. Hospital representatives could work more easily with an annual average cap of 96 hours. Even lowering the cap to an annual average 72-hour cap would provide more flexibility than the existing fixed 96-hour maximum.

• Some hospitals in rural communities are in metropolitan counties and are thus ineligible for the program. Respondents suggested that the definition of "rural" be modified to accommodate such situations.

• There is confusion over the degree of necessary involvement of emergency medical service providers. With a shortage of volunteers and other factors putting pressure on the delivery of emergency medical services in rural areas, hospitals are uncertain how to incorporate EMS into their plans, says Tom Ricketts III, PhD, MPH, director of the North Carolina Rural Health Research Program at the Sheps Center.

• Other recommendations dealt with the credentialing of critical access hospitals and the creation of a central clearinghouse for information on the program.

For about a year, Texas officials have been studying how to use the program to restructure the local health systems of designated hospitals, not just change their Medicare reimbursement strategy. Since the program was rolled out July 1, the state has received two applications, from Palmer Memorial Hospital in Friona and Linden Memorial Hospital in Linden.

"Some people expected there to be

Florida goes on-line with data on the state's health care industries

How healthy are health care providers? In Florida, regulators have just made it a bit easier to find out.

An index describing the financial health of the state's investor-owned health care economy is newly available on the web at http://www.fdhc.state.fl.us/stocks/. It tracks, both separately and collectively, the market value of HMOs, nursing homes, and hospital stocks. The index has no formal regulatory role but does give state officials a heads-up about crucial health care developments. When Vencor Inc. filed in early September to restructure its debt, Agency for Health Care Administration (AHCA) officials had been tracking the health of nursing homes industry and had been in close contact with Vencor officials.

"Part of the problem has been, in the past, the agency has been sort of behind the eight ball when these things happen; we get caught with our pants down. This is sort of a way to be in front of problems," says John P. Noble Jr., developer of the index and AHCA's director of corporate affairs. Both the index and Mr. Noble's position are new with the administration of Republican Gov. Jeb Bush and both reflect an increased emphasis on private sector-developments in the state's health care economy. Because the index is limited to companies that are significant in Florida and are regulated by state officials; pharmaceutical firms are not included.

The existence of the index is logical enough, given the size of the for-profit sector within Florida health care. Of the 200 short-term, acute care hospitals described in the state's *1999 Guide to Hospitals in Florida*, 93 are for-profit. As of January 31, 1999, the capitalization of the stocks tracked ranged from $20.3 million to $14.2 billion.

Contact Mr. Noble at (850) 922-5876. ■

"Simply going to critical access hospital designation is not going to change the demographics of the community or the county. It's not going to change the utilization of the hospitals; it's not going to change the long-term survivability of that hospital unless some other things change."

Sam Tessen
Executive Director, Texas Center for Rural Health Initiatives

a deluge," says Sam Tessen, executive director of the state's Center for Rural Health Initiatives. "But I think because we took a conservative approach and expect hospitals to go through an intense process of self-evaluation, the decision on the part of the local hospitals is far more soul-searching." The count of likely candidates for designation is 43 and another six interested hospitals are located in rural outposts of metropolitan counties.

Any Texas hospital applying for critical access designation must provide a detailed pro forma on the impact of cost-based Medicare reimbursement on its facility. In addition, it must make a "concerted" effort to educate the community about what the designation would mean for residents and the hospital, Mr. Tessen says.

Texas, like many other states, is using its HRSA money to help hospitals ascertain whether the switch to cost-based Medicare reimbursement makes sense. For example, part of the

See States get grants on page 10

HRSA Rural Hospital Flexibility Program

Grantee	Grant Award
Alabama Department of Public Health	$162,650
Alaska Department of Health & Social Services	$382,705
The University of Arizona	$124,379
Arkansas Department of Health	$478,381
California Department of Health Services	$220,055
Colorado Department of Public Health and Environment	$382,705
Florida Department of Health	$191,352
Georgia Department of Human Resources	$411,408
Hawaii Department of Health	$162,650
Idaho Department of Health and Welfare	$334,867
Illinois Department of Public Health	$478,381
Indiana Department of Health	$287,029
Iowa Department of Public Health	$231,378
Kansas Department of Health and Environment	$550,138
Kentucky Department for Public Health	$191,352
Louisiana Department of Health and Hospitals	$220,055
Maine Department of Human Services	$124,379
Maryland Department of Health and Mental Hygiene	$ 83,717
Massachusetts Department of Public Health	$ 81,325
Michigan Department of Community Health	$224,839
Minnesota Department of Health	$550,138
Mississippi Department of Health	$171,403
Missouri Department of Health	$ 81,325
Montana Department of Public Health & Human Services	$574,057
Nebraska Health and Human Services System	$550,138
University of Nevada School of Medicine	$220,055
New Hampshire Department of Health and Human Services	$ 95,676
New Mexico Department of Health	$153,082
New York Department of Health	$550,138
North Carolina Department of Health and Human Services	$287,029
University of North Dakota School of Medicine and Health Sciences	$541,712
Ohio Department of Health	$ 95,676
Oklahoma Department of Health	$478,381
South Carolina Depart. of Health and Environmental Control	$263,110
South Dakota Department of Health	$287,029
Tennessee Department of Health	$399,448
Texas Department of Health	$478,381
Vermont Department of Health	$167,433
Virginia Department of Health	$167,433
Washington Department of Health	$550,138
West Virginia Department of Health and Human Resources	$358,786
Wisconsin Department of Health & Family Services	$550,138
Wyoming Department of Health	$220,055
Total	**$13,114,506**

States get grants

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state's $478,381 award was given to a hospital association to construct a model for a "mini" pro forma. By plugging in local data concerning utilization, finances, and demographics, a hospital can gauge whether it makes sense to proceed to the next step of a detailed analysis.

More importantly, says Mr. Tessen, the state is making the point that Medicare cost-based reimbursement can't be equated with a "hospital survival program." Texas wants to give at-risk rural hospitals the marketing, financial, and other tools they need to survive even beyond those offered by critical access designation.

"Simply going to critical access hospital designation is not going to change the demographics of the community or the county. It's not going to change the utilization of the hospitals; it's not going to change the long-term survivability of that hospital unless some other things change," he says.

The legislature is helping in the effort. Two endowments established with the proceeds of Texas' share of the tobacco settlement are targeted toward rural health concerns. Interest from a $100 million endowment will go to emergency medical services and trauma care, with 60% of the proceeds earmarked for rural areas. In addition, interest from a $50 million endowment will be available for grants or loan guarantees for capital improvements in rural hospitals. The first funds from the capital improvement endowment will be available Nov. 30. (See related story, *State Health Watch*, June 1999, p. 9.)

Contact Mr. Tessen at (512) 479-8891 and Mr. Ricketts at (919) 966-7361. More information about the program is available on the Internet at www.hrsa.dhhs.gov/Newsroom/releases/HHSrhfp.htm. ■

Clip files / Local news from the states

Increase in uninsured keeps pace with population growth, reaching all-time high of 44.3 million, says Census Bureau

WASHINGTON, DC—Health insurance coverage throughout the states during the last three years has been most prevalent among residents of Hawaii, Minnesota, and Wisconsin, while Arizona and Texas are near the bottom in a recent Census Bureau ranking.

State-level averages for 1996 to 1998, as well as recent individual years, are found in the bureau's *Health Insurance: 1998*. The number of uninsured Americans is at an all-time high — 44.3 million — but the proportion of uninsured — 16.3% — is not statistically different from 1997, states the report. It found that the status of children's health care coverage did not change significantly from 1997 to 1998, with 11.1 million, or 15.4%, of all children under age 18 uninsured.

Data in the report are from the March 1999 Current Population Survey.

A copy of the report is available on the Web at www.census.gov/hhes/www/hlthin98.html.

Tennessee, Louisiana win approval for CHIP proposals

WASHINGTON, DC—Louisiana and Tennessee will expand their Medicaid program under Children's Health Insurance Program (CHIP) proposals recently approved by the Health Care Financing Administration.

In an expansion of its existing CHIP coverage, Louisiana will extend Medicaid to an estimated 10,000 children between birth and age 19 who are in families with incomes between 133% and 150% of the federal poverty level.

In total, the state expects to enroll over 38,000 children by September 2000. LaCHIP currently covers children between the ages of 6 and 19 in families with incomes at or below 133% of the federal poverty level. The federal poverty level is $16,700 per family of four.

Tennessee's CHIP implementation will expand Medicaid to cover children born before Oct. 1, 1983, who are under age 19, in families with incomes at or below 100% of the federal poverty level, and who could not have been enrolled under the operating rules for the state's Medicaid demonstration program before April 1, 1997. The federal poverty level is $16,700 for a family of four. The state expects to cover nearly 10,000 children under its CHIP program. The full Medicaid package of benefits will be offered and there will be no family cost-sharing.

—HCFA releases, Aug. 23, Sept. 3

Four states, District of Columbia snag $20 million each for reducing rate of out-of-wedlock births and abortions

Alabama, California, the District of Columbia, Massachusetts, and Michigan each will receive $20 million for reducing the rate of out-of-wedlock births between 1994 to 1995 and 1996 to 1997. The awardees reported the following reductions: California, 5.7%; the District of Columbia, 3.7%; Michigan, 3.4%; Alabama, 2.0%; and Massachusetts, 1.5%.

The awards, established by the 1996 welfare reform legislation, require that recipients also reduce the rate of abortions, defined as the number of abortions

divided by the number of births.

Health Care Financing Administration (HCFA) officials recognized that three of the four years covered by the bonus program predated the welfare reform initiatives to reduce the rate of out-of-wedlock births, and that Medicaid waiver programs likely contributed to the reported declines.

—HCFA release, Sept. 13

Academic medical center MCOs tend to get sicker patients, concludes JAMA analysis

Managed care organizations run by academic medical centers bear the brunt of the sickest patients in Tennessee's Medicaid managed care program, says an analysis in the *Journal of the America Medical Association*. Such adverse selection may pose "serious financial risks" for the academic medical centers that participate in managed care, the authors conclude.

The state's three academic managed care organizations were more likely than statewide organizations to care for TennCare patients in five of six high-cost chronic conditions, by factors that ranged from 2.4 to 14.1. Only in prematurity was the prevalence comparable. Academic medical centers also saw sicker patients, compared to statewide MCOs, in 22 of 27 additional conditions. Comparisons between academic medical center and regional MCOs yielded similar results.

Development of risk-adjustment payments and other public policy measures are needed to ensure academic medical centers' expertise in "providing highly complex care, service to the poor, medical research, and physician training."

—Bailey JE, Van Brunt DL, Mirvis DM, et al. Academic managed care organizations and adverse selection under Medicaid managed care in Tennessee. *JAMA* 1999; 282:1,067-1,072.

Patient-level inpatient data now available through centralized database at AHCPR

All payer, patient-level data from hospitals in 11 states are now available from a centralized repository at the Agency for Health Care Policy and Research (AHCPR) in Rockville, MD.

Database records contain more than 100 clinical, financial, and administrative variables describing an inpatient stay. The databases contain the universe of each state's inpatient discharge abstracts translated into a uniform format that allows multistate analyses. In some instances, a record may contain information, such as a patient's race, not uniformly available from all states.

The 11 states, California, Colorado, Iowa, Maryland, Massachusetts, New Jersey, New York, Oregon, South Carolina, Washington, and Wisconsin, are among the 22 who participate in the agency's Healthcare Cost and Utilization Project (HCUP).

The other 11 states in HCUP initiative — Arizona, Connecticut, Florida, Georgia, Hawaii, Illinois, Kansas, Missouri, Pennsylvania, Tennessee, and Utah — are considering joining the centralized database, said AHCPR spokeswoman Karen Migdail.

Information about the project is available at (805) 681-5876 or by e-mail at hcupsid@medstat.com.

—AHCPR release, Sept. 27

Drive-through deliveries don't increase risk of rehospitalization for newborn — JAMA study

Decreasing the length of stay for full-term newborns doesn't seem to increase their risk of being re-hospitalized, according to a *JAMA* study of almost 103,000 neonates born to Ohio women receiving Medicaid from 1991 to 1995.

While the mean length of stay decreased 27%, from 2.2 (1.0) to 1.6 (0.9) days over the course of the study, rehospitalization rates within seven and 14 days of discharge decreased by 23%, from 1.3% to 1.0% (P=.01), and by 19%, from 2.1% to 1.7%, respectively. Primary care visits increased within 14 days of birth increased 117%.

—Kotagal UR, Atherton HD, Eshett R, et al. Safety of early discharge for Medicaid newborns. *JAMA* 1999; 282:1,150-1,156.

Judge backs Atlanta's domestic-partner insurance plan, scolds foot-dragging

ATLANTA—The state insurance commissioner's refusal to approve the city of Atlanta's domestic-partner benefits was "outside the scope of his statutory authority and . . . abuse of his discretion," a Fulton County Superior Court judge declared in late September.

Judge Wendy Shoob ordered Georgia Insurance Commissioner John Oxendine to approve the city's plan to let employees cover straight or gay dependent, domestic partners.

The city's domestic partner benefits were first proposed in 1993. Subsequent legal challenges brought the issue to state Supreme Court, which upheld the benefits in 1997. Mr. Oxendine, however, has refused to approve the change.

Attorneys for the city and a gay rights group suggest that the ruling clears the way for other employers to grant domestic partner benefits.

—*Atlanta Journal-Constitution*, Sept. 23

State Health Watch

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Group Publisher: ***Brenda Mooney****, (404) 262-5403, brenda.mooney@medec.com.*

Executive Editor: ***Susan Hasty****, (404) 262-5456, susan.hasty@medec.com.*

Senior Editor: ***Elizabeth Connor****, (404) 262-5457, elizabeth.connor@medec.com.*

Production Editor: ***Ann Duncan****.*

AIDS expert to replace Richardson as head of Medicaid

WASHINGTON, DC—AIDS policy expert Timothy Westmoreland was selected in late September to replace Sally K. Richardson as director of the Center for Medicaid and State Operations. Mr. Westmoreland, 45, is a lawyer and has worked on the House Energy and Commerce Committee's subcommittee on health under Rep. Henry Waxman, D-CA.

TennCare's director of eight months resigns amid praise from hospital and doctor groups

NASHVILLE, TN—Brian Lapps, the high-profile TennCare director who acknowledged having "foot-in-mouth" disease, resigned unexpectedly in late September, just eight months into the job.

John Tighe, recently named the state's deputy finance commissioner with oversight responsibilities for TennCare, will temporarily assume his duties.

"I think it is appropriate that I step down as director at this time so that John Tighe can build his team from the ground up," Mr. Lapps said in a prepared statement.

Lapps was the sixth director at TennCare in five years.

—*Nashville Tennessean*, Sept. 28

New York hospital agrees to pay $45 million in response to claims of Medicaid overbilling

In the largest recovery by one state in the history of Medicaid, Staten Island University Hospital in New York has agreed to pay $45 million to settle allegations that it overbilled the program for outpatient services for nearly five years.

The 635-bed hospital also will have an outside monitor for five years, a measure that no State Medicaid Fraud Unit has before imposed, said assistant deputy attorney general Thomas Staffa.

The settlement calls for a $4.5 million cash payment and the remaining $40.5 million to be withheld in Medicaid payments through 2019. In addition, the hospital is required to provide $39 million in uncompensated care during the next 20 years.

—*Compliance Hotline*, Oct. 4