State Health Watch

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Not yet singing the Blues — TennCare officials say plan's departure won't kill the program

When the nation's largest single Medicaid contractor wants to bail from the nation's most ambitious program to enfranchise the uninsured, one of the first questions has to be whether it's the idea or the execution that went south.

"I don't think it's the idea," says Gordon Bonnyman, director of the Tennessee Justice Center and nationally recognized consumer advocate. He and the rest of the nation are watching how state officials deal with the December announcement that BlueCross BlueShield of Tennessee will leave the TennCare program effective June 30. The Blues cover 645,000 TennCare members, about half of the program's total enrollment.

As *State Health Watch* was going to press, TennCare officials insist the program still is viable and add they are courting managed care organizations to replace the Blues, but have no engagement to announce. The Blues' position is that they are continuing to talk with state policy-makers, to help with either an orderly transition to another managed care organization or

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How long will the tobacco industry be the goose that lays the golden egg?

Santa Claus, the Easter Bunny, and full settlement payments from the tobacco industry 10 years from now — are they all myths?

Perhaps that's the view of officials in New York's Westchester County, who worry that the promise of regular and full payments under the tobacco settlement 10 years from now might turn out to be nothing more than a fairy tale. The county just outside New York City is among a small but significant number of governments successfully creating a separate entity to issue bonds backed by anticipated tobacco settlement payments.

The chief reason for those fears is an adjustment in the payout formula — one of many — that lowers payments from the tobacco companies in proportion to every percentage drop in domestic tobacco consumption, as measured by the amount manufacturers ship to retailers.

"Westchester County firmly believes that the tobacco companies will not have the funds to meet their obligations in the later years of the settlement schedule," says a Web letter to voters from Andrew Spano, Westchester County executive.

Maybe not, but bond raters seem more optimistic that the bonds will

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creation of an administrative services only (ASO) role for the company.

The Blues have been TennCare providers since the program's inception in January 1994, and the relationship has been profitable. Through October 1999, the Medicaid business has given the company a cumulative after-tax gain of $33.1 million, of which $6.9 million is from underwriting gain and $26.2 million is investment interest income.

The decision to flee is driven by relatively poor performance in 1999 and the specter of losing money in 2000. After posting net gains of $10.6 million, $11.7 million, and $24.7 million during 1996-98, the company's TennCare business posted a $350,000 net gain through October of last year. Anticipated losses for 2000, which would be its first red ink since 1995, are estimated at $51 million to $96 million.

"We are very willing to do whatever we can to help the program survive, but we just couldn't sustain the losses that our actuaries are predicting," says Blues spokeswoman Frances Haman-Prewitt.

TennCare provided its managed care contractors a $16 per-member-per-month increase last year, of which at least $12.40 had to be passed on to providers. The rate increase kept physicians at least happy enough to forestall significant defections, but not enough to keep enough hospitals in the program and meet other anticipated costs, says Ms. Haman-Prewitt.

For hospitals, whose officials point out that indigent and uninsured patients will show up "no matter what," the looming departure of the Blues is disappointing.

"They didn't pay much, but they did pay us and they paid quickly," says Craig Becker, president of Tennessee's hospital association. He doesn't fault poor utilization management for the Blues' reversal of fortune in TennCare. "This has nothing to do with utilization. Utilization has been pretty much staying the same — it has everything to do with the fact that they've been chronically underfunded. If the Blues can't do it, nobody can do it," he says. "It's symptomatic that this program is on its last legs."

Tennessee Gov. Don Sundquist in late November announced a 12-step plan to rehab TennCare. (See "Tennessee governor proposes downsizing TennCare," *State Health Watch*, January 2000, p. 11.) The plan calls for dramatic changes in TennCare: closing enrollment temporarily to all but uninsured children and the Medicaid-eligible, limiting TennCare

benefits, and increasing premiums for many of the program's participants. Most of the proposed changes would require the Health Care Financing Administration to approve a change in the program's Section 1115 Medicaid waiver.

"It seems to me that there will have to be a massive restructuring of the program to keep it afloat and likely sizable reductions in enrollment," says Robert Hurley, an associate professor of health administration at Virginia Commonwealth University in Richmond, and an observer of Medicaid programs around the country. "Since the major accomplishment of the program has been expanded enrollment, it's hard to see what is gained if that is the price of saving it."

Operational disputes also poisoned the air between TennCare and the Blues. Late last year, TennCare inflicted on its managed care organizations the nation's "most unworkable and most far-reaching" appeals process, says a statement from the Blues, in order to resolve a protracted dispute with consumer advocates. Implementing a 40-page federal court order addressing notification of denials of service and the delivery of care while the decision is being appealed will cost the Blues an estimated $86 million annually, says the company. At the same time, the order "leaves many questions unanswered" and its full impact can't be determined, the company adds.

"What's so onerous about this just boggles my mind," says Michelle Johnson, a staff attorney with the plaintiffs' counsel, the Tennessee Justice Center. "A lot of this stuff we assumed, and I think the state would say they assumed, the MCOs were doing already."

The Blues also are worried about absorbing poor underwriting risks from the state's second- and third-largest TennCare contractors, Access MedPLUS and Xantus. Access MedPLUS is out of compliance with statutory reserve requirements and Xantus has been in receivership since March 1999. A Davidson County (Nashville) chancellor was scheduled in mid-January to review the state's latest plan to rehabilitate Xantus.

Contact Mr. Bonnyman at (615) 255-0331, Ms. Haman-Prewitt at (432) 755-5815, Mr. Becker at (615) 256-8240, the Bureau of TennCare (615) 741-0213, and Mr. Hurley at (804) 828-1891.

The court order was filed in the Nashville division of U.S. District Court for the Middle District of Tennessee (Civil Action No. 79-3107). ■

Growing a successful TennCare takes time, money, realistic expectations

TennCare policy-makers need patience if they want managed care to bring about the structural changes they hoped for when the program was begun six years ago, say researchers in the current issue of *Health Affairs*.

"Managed care systems do not evolve 'overnight' even if basic infrastructure and contracting arrangements are put in place," say Marsha Gold and Anna Aizer in the journal's January/February issue. Moreover, expecting managed care to produce enough savings to fund the expansion toward universal coverage is problematic, to say the least.

"Policy-makers choosing this route need to be prepared for limited savings, at least initially, and for a very long period of development," they say.

The lessons of TennCare are "exceedingly relevant" to other Medicaid programs, say the authors, pointing out that 12 states had more than 75% of their Medicaid populations in managed care as of 1997, with several others moving in that direction.

As the Blues contemplate leaving TennCare (see "Not yet singing the Blues," p. 1), state officials must first decide whether to hang on to a managed care model for Medicaid. Neither the establishment of a state-run managed care organization nor a transition of the Blues' enrollees to another plan would necessarily solve TennCare's problems, Ms. Gold tells *State Health Watch*. The experience of existing plans might scare off possible replacements, and the prospects for a successful state-run plan seem dim.

"I think that the experience of TennCare that we documented in our article would seem to make that a rather dubious proposition," says Ms. Gold, a senior fellow in the Washington, DC, office of Mathematica Policy Research. "For one thing, any managed care plan takes a long time to get set up. It's not like they can get around problems that other plans are having. They would just have to do it and you would be starting from scratch. On top of which, they haven't had a very stable state staff, so the question is who would do it."

Of course, Ms. Gold points out, the state could revert back to a conventional Medicaid strategy, in which it merely paid the bills as in a self-insured plan, and retreat from its efforts to expand eligibility.

"To me, that would be a pity. That to me is what makes TennCare different from anything else. It's certainly a feasible option and may even be an affordable option consistent with the state's financial requirement, (but) it basically would mean that TennCare failed."

Contact Ms. Gold at (202) 484-4227. See Gold M, Aizer A. Growing an industry: How managed is TennCare's managed care? Health Affairs, *1999; 19:86-101.* ■

States ready to take advantage of federal incentives to cover disabled workers through Medicaid

States already have moved to take advantage of Congress' latest offer, just a few months old, to bring disabled workers making up to 250% of the poverty limit into the Medicaid program.

Admittedly, the states that have jumped on the bandwagon have been planning to do so for months, and in some cases, years. After all, the federal Work Incentives Improvement Act (WIIA), signed Dec. 17 by President Clinton, essentially gives states incentives to do what Congress already allowed them to do in the Balanced Budget Act (BBA) of 1997. Several states that pursued extending Medicaid to the disabled under the BBA now are encouraged enough to want to take advantage of the new carrots dangled in the WIIA.

"These are unbelievably great, great steps," says Doug Stone, co-director of the Oregon Employment Initiative. Under the authority of the BBA, Oregon has raised the Medicaid income threshold for persons on Supplemental Security Income (SSI) from $20,000 to $40,000. Since February, the program has enrolled about 220 participants.

"The uptake seems to be fairly constant and consistent," Mr. Stone says. "We're anxious to look at what's come out of the WIIA."

Several other states already have or appear likely to expand Medicaid benefits for the disabled, including Alaska, Wisconsin, Maine, Iowa, Minnesota, and Vermont.

Vermont officials already had authority to extend Medicaid benefits to disabled workers when the new federal legislation was signed. Effective Jan. 1, Vermont's disabled workers on Social Security Disability Insurance (SSDI) were able to make

The Work Incentives Improvement Act H.R. 1180 — Key Features

❒ State options:

— Medicaid expansion.

States may extend Medicaid benefits to disabled workers or those with a "medically improved disability" who have incomes up to 250% of the federal poverty level.

The bill also makes Medicaid available for such persons beyond the 250% threshold, though certain cost-sharing rules apply. A demonstration project allows states to provide Medicaid to workers with a "potentially severe disability." A potentially severe disability is an impairment that, but for Medicaid services, "is reasonably expected" to render a person blind or disabled.

— Grants.

Annual grants between $50,000 and $300,000 are available to states for planning and implementation activities related to the Work Incentives Improvement Act (WIIA). A total of $23 million is available nationally. In addition, the bill authorizes annual grants of $100,000 to about $250,000 for outreach to beneficiaries to notify them about the new benefits under the WIIA. Infrastructure grants of at least $50,000 annually are available to states to support structural changes to encourage the employment of disabled workers, provided the state offers personal attendant services under its Medicaid program.

The total amount available for infrastructure grants nationally is $20 million in fiscal year 2001, increasing each year to 2011.

❒ Social Security Disability Insurance (SSDI) extension.

Current rules allow SSDI recipients to receive free Medicare hospital benefits and the option to purchase Medicare physician benefits for about four years. The WIIA extends the provision to eight years.

❒ Expedited reinstatement.

If a recipient gives up SSDI benefits, reinstatement currently requires reconsideration of a new application, a process that may last several months. The WIIA provides for "expedited reinstatement" that restores SSDI benefits within one month.

❒ Continuing disability reviews.

Returning to work now triggers a "continuing disability review" for an SSDI recipient, in addition to regularly scheduled reviews of eligibility. Under the WIIA, resumption of work will not trigger an automatic continuing disability review, for a period of three to five years.

❒ Vocational rehabilitation.

The WIIA allows private-sector competition to conventional state-run vocational rehabilitation agencies.

up to 250% of the federal poverty level (in 1999, $20,600) and maintain Medicaid benefits. Under conventional SSDI rules, Medicare and cash benefits end abruptly when a recipient's income reaches $700 per month.

About 300 people are expected to take advantage of Vermont's new program. Many disabled workers maintain their incomes at just under SSDI's $700 threshold to hang on to Medicare benefits, Mr. Baird notes, and many others drop their income even lower to be eligible for Medicaid and its all-important prescription drug benefit. The benefit is particularly crucial for HIV and psychiatric patients on long-term drug therapy.

"For some psychiatric patients, the drug costs can run $500 to $1,000 a month. I can't afford that; you can't afford that; nobody can afford that," he says.

Long may it wave

Wisconsin will initiate a Medicaid buy-in program for the disabled on March 15, and state officials in the Wisconsin Pathways to Independence hope to have about 1,100 residents enrolled by the middle of 2001.

The state has extended income eligibility up to the full 250% of poverty allowed by the BBA and eliminated premiums for anyone making less than 150% of poverty.

Most of the Wisconsin residents likely to take advantage of the new program already are receiving Medicaid through other routes, says program coordinator Karen Tritz, such as Medicaid provided to the medically indigent.

The attraction of the Pathways program is that participants are allowed a much higher asset limit than conventional Medicaid, $15,000 compared to $2,000, and they are allowed to set aside assets in a retirement or similar cash account.

A seemingly obscure but significant provision of the WIIA restores the ability of the Social Security Administration to grant certain programmatic waivers.

Wisconsin is interested in seeking a waiver under which the Social Security Administration would reduce SSDI benefits when workers reached their $700 monthly cap by $1 for every extra $2 earned, says program director John Reiser. Such a change would recast the SSDI's strategy to resemble the approach taken under SSI.

Where's the savings?

Currently, SSDI cash benefits are discontinued entirely when a worker's earnings reach $700, a milestone so threatening and abrupt that it is called a "cash cliff."

Oregon, Wisconsin, and Vermont are participating in a Robert Wood Johnson Foundation program to promote health insurance coverage among the disabled. (See "Model programs aim to get disabled people to work by maintaining Medicaid health benefits." *State Health Watch*, January 1999, p. 1.) Part of the funding is for analyses of the cost and savings associated with getting the disabled to work.

"The problem with that sort of analysis is that we think most of the costs are at the state level and most of the savings are at the federal level," says Mr. Baird.

"At that point, you go to the feds and say, 'Look, we saved you this much money by doing this; now it's time for us to find a way to share this savings. We don't have any specific plans for that. Once we have the research, we'll take a look at it," he says.

Contact Mr. Stone at (503) 945-5836, Mr. Baird at (802) 241-2127, and Mr. Reiser at (608) 206-3063. ■

Tobacco industry

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be repaid. Moody's Investors Service in late December assigned ratings of A1 and A2 to bonds with maturity dates of July 2029 and July 2039, respectively. Amortization of the bonds is weighted toward the later years of the anticipated payout.

"We're taking the future revenue stream and turning it into an asset today," says county attorney Alan Scheinkman. "On a net present value basis, we think we actually came out ahead on the deal."

Westchester County used about $65 million of the bond proceeds to pay off a recurring obligation to the Westchester County Health Care Corp. for future health care services. The hospital corporation, in turn, is using the infusion to restructure the debt of Westchester Medical Center and attract investors to its own bond issue for a new children's hospital.

"By having this infusion, they will be able to more successfully market their bonds for that long-term capital project and we will be guaranteeing a good number of those bonds," says Mr. Scheinkman.

California is the only state other than New York in which local governments explicitly share in the tobacco settlement payments. In December, Tulare County, an agricultural community of about 355,000 residents in the geographic center of the state, became California's first government to borrow against anticipated tobacco payments. With the proceeds from the sale of about $45 million in bonds, the county has established an indentured endowment called the "Millennium Fund" to bankroll capital improvement projects.

Tulare's bonds are rated A+ by Fitch IBCA, a rating agency with U.S. headquarters in New York City. In addition to using conservative

assumptions in its structuring of the bond issue, Tulare County has pleased bond analysts by promising to dip into general revenues if tobacco revenues are insufficient to meet its debt service obligations. Because California law prohibits municipalities from securitizing tobacco proceeds, a public finance authority is transferring the funds to the county through an asset lease arrangement.

Good economic times

New York City and New York's Nassau County have securitized their tobacco settlement payments, and several other California communities are looking at borrowing against their anticipated revenue. State governments seem less interested, though Oregon and several other states have analyzed the idea.

"States have been slow to act on securitization because their economies are so good," suggests Don DeSimone, a policy analyst with the National Association of State Treasurers in Washington, DC. "Now that the funds are being disbursed, they're going to be looking at it again when their legislatures are back in session."

On Dec. 14, states that had reached so-call "state-specific finality" on their tobacco settlements (i.e., resolution of all pending legal complications) began receiving their first regular payments under the Master Settlement Agreement, with additional payments scheduled for January and April 2000.

Payments are due each succeeding April with an anticipated $206 billion payout through the year 2025.

Contact Mr. Scheinkman at (914) 285-2660 and Mr. DeSimone at (202) 624-8595. An analysis of securitization prepared by the National Governors Association is available at www.nga.org/Pubs/IssueBriefs/1999/Sum990908Tobacco.asp. ■

Colorado will tinker with success in RFP for managed mental health

How do you improve upon a mental health managed care program that consumers, providers, and advocates support? Very carefully, according to Colorado officials who are seeking proposals for services to take effect Jan. 1, 2001.

"I think our program has been largely successful," says Bill Bush, director of mental health services in the Colorado Department of Human Services in Denver. "But we have lots more ground to cover. Still, we see the new request for proposals (RFP) as fine-tuning, and not a major overhaul."

The scope of Colorado's effort to contract for Medicaid mental health services is ambitious. The Colorado Medicaid Mental Health Capitation and Managed Care Program was implemented in 1995 in 51 counties, with the remaining 12 counties added in 1998. Approximately 225,000 Medicaid individuals are enrolled, and about 30,000 receive mental health services per year.

Services are provided through Mental Health Assessment and Services Agencies (MHASAs) that hold contracts with the state to manage delivery of mental health services to Medicaid-eligibles.

Eight managed care contractors, one in each region, provide services through 17 community mental health centers, a number of hospitals, some specialty clinics, and several hundred private practitioners. The annual program budget is approximately $125 million.

State officials like to tick off improvements in the programs' first years, including:

1. new services such as crisis beds, respite care, self-help groups, and home-based services;

2. expansion of community-based services;

3. a shift from hospital inpatient to less restrictive community-based services;

4. increased involvement and empowerment of consumers and their families;

5. steps toward development and use of a recovery model of care;

6. improved coordination of mental health services;

7. creation of an independent ombudsman program;

8. cost savings and increased control over future cost increases.

The new RFP will emphasize a recovery model for adults that assumes they can and do recover from mental illness, says Mr. Bush. It calls for MHASAs to provide innovative supportive services such as clubhouses, drop-in centers, vocational services, self-help groups, housing, and education.

Gaining consumer confidence

While the state emphasizes consumer involvement and empowerment, it has taken time to win consumer confidence. As the program began, consumers were worried that they would not have sufficient choice of providers. "Their worst fears have not come to pass," Mr. Bush says. "We have not had great problems. There has been some choice but not enough yet, and we need to do better."

One problem is that many of the MHASA contractors are community mental health centers and there are consumers who don't want to receive services from a center because of a perceived stigma.

Mr. Bush says that consumers and advocates have changed their views since reports of their concerns in a 1997 pilot project study.

"From the point of view of a Medicaid patient, managed care has

not been a bad thing. They are getting adequate care," says Carol Jean Foos-Garner, volunteer director of MidWest Mental Health Association in Paonia, CO.

Mr. Bush acknowledges consumer concerns over managed care's capitation strategy and the possibility of incentives to withhold care.

Consumers "still want to see all the problems with the mental health system addressed, and so do we. But we've made a shift in people's thinking, and most consumers would now say we've made a big step in the right direction," he says.

Providers also have changed their opinions. Donald Rohner, vice president for managed care at Jefferson Center for Mental Health in Arada, CO, says the program has made "enormous accomplishments in the last five years."

'Competition is good!'

"The big advantage at the service delivery end is the type of flexibility we get from this type of funding. We're not confined to strict CPT codes. We're not concerned with production of units of service, but with what's happening with each individual and family we see. The program is working as the theory says it should," he says.

Many providers still are learning how best to incorporate the input of consumers and their family into treatment and decision making and he expects the new RFP to improve consumer direction and service and further expand freedom of choice, Mr. Rohner says. "The community mental health centers think they will be completely cut out if there is total freedom of choice, but I think it's more likely that they'll be 'cut-in' because of the varied services they can provide in their regions."

One concern that providers and consumers share is whether the new RFP will result in national providers eyeing Colorado as a good place to operate and elbowing out the local contractors.

The existing regional approach was planned carefully to give the community mental health centers an opportunity to be competitive and succeed in winning contracts, Mr. Bush says, but the state is opposed to any sole source contracting to favor the centers.

"Competition is good!" Mr. Bush declares. "Our legislature tends to like and expect competition, and the federal government expects to see it. It's simply not an option for us to hand the new contract to our current contractors."

The Jefferson community mental health center is not afraid of competition, but Mr. Rohner says he understands the anxiety that some center administrators have about the outcome of the bidding process.

"The state tried to be scrupulous in the design of the new RFP to create a level playing field. It's the only reasonable and fair thing they could do."

Jefferson does feels somewhat vulnerable, he says, because it is a major provider and a community safety net for indigent non-Medicaid patients who have benefited from the Medicaid managed care programs. "Outside organizations can focus 100% of their resources on the Medicaid population and could beat us on that contract. The non-Medicaid population would suffer because we would not be able to serve the number of medically indigent that we do now.

"We would have to turn people away. We currently try to operate with one standard of care for everyone. But it is possible that we could end up with two very different standards of care — one for Medicaid and one for the non-Medicaid indigent," adds Mr. Rohner.

Contact Mr. Bush at (303) 866-7411, Ms. Foos-Gardner at (970) 527-4388, and Mr. Rohner at (303) 432-5000. ■

Require CHIP reporting by race and income, say 130 consumer advocacy organizations

States should be required to describe health coverage by income level, race, and ethnicity — primary language spoken in their Children's Health Insurance Program (CHIP) plans, said the National Health Law Program and some 130 other organizations in an early January letter to Department of Health and Human Service Secretary Donna Shalala.

"It is now well-established in the research that minority children are more likely than non-minority children to lack health insurance," said the National Health Lawyers Program (NHeLP) advocates in separate comments to proposed rules implementing CHIP legislation. "To understand and eliminate this disparity, health policy-makers, analysts, providers, and government authorities need access to information about how the . . . program is meeting the needs of eligible minority children."

Requiring such data will help ensure that CHIP initiatives are in compliance with federal civil rights laws, including Title VI of the Civil Rights Act of 1964, and will assist the department in meeting its its goal of eradicating racial and ethnic disparities in health care by the year 2010, says NHeLP. In addition, such information will help build a comprehensive minority health database recently recommended by the U.S. Commission on Civil Rights. ■

HCFA won't recoup contested DSH payments, but says it will tighten funding going forward

Hospitals leave open the possibility of challenging HCFA's policy

Effective Jan. 1, state-funded programs or even certain Medicaid programs will not factor into the equation when Medicare calculates how much extra to give hospitals that treat a disproportionate share of indigent patients, stated a Dec. 29, 1999, memo to state Medicaid directors from Timothy Westmoreland, director for the Health Care Financing Administration (HCFA).

Hospitals will, though, be allowed to keep payments based on provision of such services through Dec. 31, 1999.

"This is consistent with HCFA's determination that hospitals and intermediaries relied, for the most part, on Medicaid days data obtained from state Medicaid agencies to compute Medicare DSH payments and that some of those agencies commingled the types of otherwise ineligible days listed above with Medicaid Title XIX days in the data transmitted to hospitals and/or intermediaries," said a December program memorandum.

The impact of HCFA's decision not to recoup payments already paid out is enormous, meaning as much as $160 million to hospitals in New York state alone.

In New Jersey, the state hospital association estimates that the decision will secure between $250 million and $370 million for about 60 hospitals.

"That certainly is positive news for New Jersey hospitals," says Sean Hopkins, New Jersey Hospital Association vice president of health economics. At the same time, the association isn't sure it is willing to let the issue rest.

"We feel these days . . . should continue to be allowed moving forward, and it appears HCFA may have a different opinion on that. We would be looking to investigate why they feel the [days] should be included retroactively, but not included prospectively," Mr. Hopkins says.

Medicare disproportionate share hospital (DSH) payments are based on the care provided to low-income elderly and Medicaid-eligible.

The justification for HCFA's narrow definition of Medicaid is generally that the disputed days are not part of care under an approved Medicaid state plan.

> "That certainly is positive news for New Jersey hospitals. . . . We would be looking to investigate why they feel the [days] should be included retroactively, but not included prospectively."
>
> Sean Hopkins
> Vice President of Health Economics
> New Jersey Hospital Association

December's policy guidance was published to eliminate variations in interpretation of allowable DSH payments among Medicare fiscal intermediaries. (See *State Health Watch*, January 2000, p. 9.)

"The term 'Medicaid days' does not refer to all days that have some relation to the Medicaid program, through a matching payment or otherwise.

"If a patient is not eligible for medical assistance benefits under an approved Title XIX State plan, the patient day cannot become a Medicaid day simply by virtue of some other association with the Medicaid program," stated the memo.

The disputed days in New Jersey, for example, are provided under a Medicaid disproportionate share program to persons who exceed the conventional Medicaid asset limits. The charity care program uses both state and federal funds.

If a fiscal intermediary re-opened a Medicare cost report before HCFA's December memorandum in order to take back payments using the expanded definition of Medicaid, the hospital will receive that money back with interest.

Fiscal intermediaries can respond to a hospital's request to re-open a cost report on this issue, but only if the request was made before Oct. 15, 1999.

HCFA recognizes that, in some state medical assistance programs, a hospital may have difficulty determining the specific source of a payment and thus whether it can be used to justify disproportionate share payments.

"If a hospital is unable to distinguish between Medicaid beneficiaries and other medical assistance beneficiaries, then it must contact the state for assistance in doing so," said the memorandum.

The HCFA memorandum is found at www.hcfa.gov/medicaid/smd12299.htm. ■

Managed care liability, uninsured, and tobacco top list of priorities in 2000 state legislative sessions

While perennial issues such as Medicaid, the Children's Health Insurance Program, and caring for the uninsured will appear in most state houses in upcoming legislative sessions, lawmakers also plan to tackle problems that were largely unknown five years ago, says a survey by the National Conference of State Legislatures (NCSL) in Washington, DC.

Regulation of Internet dispensing of drugs is likely to come up in 19 states, and confidentiality concerns surrounding digital signatures or electronic records is an issue in about one-quarter.

'A lightning rod'

Though the 1990s was the "decade of managed care reform," there's still some work to be done," says NCSL. Of the 48 states responding to the survey, 44 expect to address in the next session some aspect of managed care, most notably insurer liability or quality.

Georgia, Texas, and California are the only states with laws holding health plans accountable for the care provided to their members, but the issue remains the "lightning rod" for concerns about access and quality in managed care, says Lee Dixon, director of the NCSL Health Policy Tracking Service. States unwilling to assign liability to health plans still may consider measures such as stronger grievance procedures, he says.

Tobacco settlement funds — now flowing freely to the states — promise to make budget negotiations even more high profile than usual.

"Certainly, tobacco is going to be a leading issue, just as it was in 1999," he says. Their coffers are full, but "states are not really going overboard on spending," says Mr. Dixon. "I still think they're taking a cautious approach and thinking, 'These are flush days, but it might not always be this way.'"

The growing interest in tobacco securitization, a method of borrowing against future settlement payments, reflects this wariness.

"Many state legislators are concerned about what's going to happen to the industry — how stable are these dollars? Many states are thinking about securitization [to] transfer the risk to somebody else and have the state get its money upfront," he says. (See related story, p. 1.)

While recognizing that the number of violent incidents involving youth has decreased in recent years, the NCSL notes that the degree of violence in such acts has risen. In the upcoming sessions, 25 states are expected to consider measures to toughen penalties for violence on school grounds, increase funding for mental health programs, increase safety on school grounds, and increase coordination among relevant government agencies.

On the heels of a successful push in California, laws that would mandate minimum nursing staff ratios have caught the imagination of legislators around the country. Some 21 states expect to consider such mandates in the upcoming session, compared to the five that took up the issue last year. California, the only state which enacted a minimum staffing ratio, is expected to extend the effective date of the legislation from Jan. 1, 2001 to Jan. 1, 2002 to allow time for the regulatory and technical tasks involved in implementation. (See *State Health Watch*, December 1999, p. 5.)

The full survey is available for $35 plus $2 shipping and handling from the National Conference of State Legislatures at (202) 624-5400. ■

Health costs take growing share of budgets

Education spending continues to dominate state budgets, but rising health care costs now represent more that 25% of most state budgets, says a recent survey released by the National Governors Association (NGA). Since 1993, Medicaid alone has been the second largest component of state spending. In fiscal 1999, Medicaid spending increased by almost 5% (as opposed to increases between 3% and 4% in 1996 and 1998) and the Congressional Budget Office (CBO) estimates an increase of 7.5% for fiscal 2000.

The December 1999 edition of "The Fiscal Survey of States" reveals that states are in sound fiscal health, although some state economies are expected to witness slower economic growth next year. The governors estimate they will increase spending by 5.5% in fiscal 2000 over the previous year, compared to increases of 7.7% and 5.7% in fiscal years 1999 and 1998, respectively.

A copy of the full report is available from the NGA Office of Public Affairs at (202) 624-5300. ■

Clip files / Local news from the states

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

Missouri Blues, state officials agree on plan to create health care foundation

ST. LOUIS—Missouri's largest charitable health care foundation will be created from an agreement reached in early January between Blue Cross and Blue Shield of Missouri. The agreement, which has the support of some 100 consumer groups but the opposition of a Jefferson City judge, transfers all the assets of the insurer into a newly created Missouri Foundation for Health. Terms of the agreement call for the foundation to receive $12.8 million in cash and 15 million shares of Blue Cross' for-profit subsidiary, RightChoice Managed Care Inc. of St. Louis. Those shares, which represent an 80% stake in RightChoice, were worth about $200 million based on the stock's price at the time the agreement was announced.

The foundation will be led by a 15-member board, with members yet to be chosen.

Crucial to the settlement was an agreement by Blue Cross and state officials to withdraw suits pending against each other in Cole County Circuit Court. The judge in these suits twice has rejected settlement agreements, arguing that the foundation should receive more money in the deal.

The agreement is contingent on shareholder and regulatory approvals, as well as resolution of a separate suit filed by policyholders. Missouri Attorney General Jay Nixon said he hoped the foundation would be operational in six months and anticipated that it intends to award grants equal to about 5% of its assets each year.

—*St. Louis Post-Dispatch*, Jan. 7

Wisconsin legislators consider expansion of external review mandates

MADISON—Wisconsin legislators are considering expanding the state's external review mandates beyond managed care organizations to include all health benefit plans.

To be eligible for review under AB 518, the decision must relate to the plan's denial of treatment or payment for treatment that the plan determined was experimental, or be predicated on the determination that a service did not meet the plan's requirements for medical necessity or appropriateness, health care setting, or level of care or effectiveness.

The measure was approved by the Assembly 94-3 and sent to the Senate for consideration.

—Wisconsin Legislative Web site: http://www.legis.state.wi.us/1999/data/AB518hst.html; Dec. 7

Washington state rules speed up review of health plan denials

OLYMPIA, WA—Consumers in Washington state can speed up the process when health plans reconsider denials of care, thanks to a new rule scheduled to go into effect Dec. 30, 1999.

The rule adopted by State Insurance Commissioner Deborah Senn does not replace other built-in appeals for the consumer, but does allow a treating doctor to identify a situation as an emergency, requiring the insurer to complete the review within 72 hours. Under the rule, the reviewer would have to be someone not involved in the first denial, knowledgeable about the condition and with the training, and have experience and expertise to render a competent decision.

In addition the rule requires the carrier to cite the actual clinical reason for the denial and prevents the carrier from penalizing any doctor who advocates for his or her patient in the review.

—Business Wire/NewsEdge Corp., Dec. 1

California Medi-Cal fraud estimated at $1 billion annually

LOS ANGELES—Simplicity and lax oversight of California's Medicaid program cost taxpayers an estimated $1 billion annually, say investigators in FBI's Sacramento office. "What we have here is a system that was designed to pay out money fast so that nobody's health care would suffer," says James Wedick Jr., supervisor of the corruption and health care fraud unit in the FBI's Sacramento office. "When you do that, it leaves itself open to abuse and misuse and fraud."

The crackdown has led to the arrest of 73 persons. The majority of those charged are of Armenian or Middle Eastern descent, leading community leaders to seek assurances that ethnic communities are not being targeted.

—Associated Press/NewsEdge Corp., Dec. 2

Georgia to re-examine community-based care for mentally ill and mentally retarded

ATHENS, GA—Reported abuses by local agencies caring for Georgia's mentally retarded and mentally ill residents don't necessarily invalidate the move to decentralize such services, says a legislator involved in the effort and subsequent investigations into its aftermath.

"We've decided that it wasn't a system failure because of [decentralization]; it was a system failure that existed before the community service boards came into existence," said Rep. James Martin (D-Atlanta).

Georgia legislators have been examining whether a 1994 law that decentralized the funding system for services and gave people choice about who provides those services contributed to abuses by the Northeast Georgia Community Service Board in Elberton. Several employees have left or been fired, many facing criminal charges.

A panel studying the problem is expected to provide a report suggesting action during the spring legislative session.

—*Atlanta Journal-Constitution*, Nov. 15

Indiana creates separate program to expand children's insurance coverage

WASHINGTON, DC—Indiana officials hope to insure 12,000 children with the creation of a separate Children's Health Insurance Program (CHIP) initiative recently approved by the Department of Health and Human Services.

The plan amendment brings to 48,000 the number of children Indiana hopes to cover by September 2000. It creates a separate program for children below age 19 in families with income levels between 150% and 200% of the federal poverty level (FPL).

The current FPL for a family of four is $16,700. The benefit package will be equivalent to the standard Blue Cross/Blue Shield preferred provider option offered under the Federal Employees Health Benefits Program.

Families' copayments for the separate SCHIP program will be computed on a sliding scale based on income levels, with cost-sharing not exceeding 5% of the families' income. There are no cost-sharing requirements for American Indian/Alaskan Native children.

—HCFA release, Dec. 22

Healthy hospital industry in NJ demands closure of some facilities, says panel

NEWARK, NJ—Overcapacity in New Jersey's hospital industry could cost as much as $1 billion annual and puts state facilities "at a staggering competitive disadvantage in today's health care marketplace," stated a 52-page report from the Advisory Commission on Hospitals.

As many as half of the 30,000 beds in the state's 82 acute care hospitals are empty on any given day, according to the report, a function of changing patterns of utilization and other pressures common to the industry nationwide.

Trimming the number of beds in existing hospitals will be inadequate to address the problem, added the report.

"Closing entire hospitals, as opposed to across-the-board downsizing, offers much more potential for improving the financial condition of the state's hospitals as a whole.

"Remaining hospitals will gain additional patients and will likely be able to treat them without significantly increasing their fixed costs," the report said.

—*Star-Ledger*, Nov. 10

HCFA extends comment period on proposed privacy regulations

WASHINGTON, DC—Public comments on proposed privacy regulations implementing provisions of the Health Insurance Portability and Accountability Act will be accepted through 5 p.m. February 17. The deadline previously had been set for Jan. 3. (See "Proposed privacy regs would allow 'trolling' through patient records," *State Health Watch*, Dec. 1999, p. 1).

NASHP offers guidance for improving health services for children in foster care

PORTLAND, ME—The National Academy of State Health Policy has published case studies of nine states' efforts to improve the delivery of health services of children in foster care.

Also available is a summary of resources for states to use for addressing the issue.

States profiled are Alaska, California, Colorado, Iowa, Maine, Massachusetts, New York, Texas, and Utah. A copy of the case studies is available to government and nonprofit entities for $20, and available to other entities for $35. The description of resources available to states is $30 for governments and nonprofits, $50 for other entities.

The academy can be reached at (207) 874-6524.

—NASHP release, Dec. 27

Mann to oversee family and children's services at HCFA

WASHINGTON, DC—Cindy Mann is the new director of the family and children's health program group within the Health Care Financing Administration. Her responsibilities will include oversight of Medicaid and CHIP policy and operations for children and families. Ms. Mann formerly was in the national policy staff of the Center for Budget and Policy Priorities.

—Center for Budget and Policy Priorities release, Dec. 6

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Florida Medicaid overpaid Humana, other HMOs almost $16 million, says Inspector General

WASHINGTON, DC—Florida Medicaid overpaid Humana HMO approximately $4.7 million and other HMOs another $11.2 million in calendar year 1996, according to a report recently released by the Office of the Inspector General (OIG). Approximately $8.8 million of the overpayments represents the federal contribution to Medicaid.

The OIG recommends that the Florida Agency for Health Care Administration recover the overpayments made to Humana and, after further investigation of the other overpayments, recover those as well. The amounts of the estimated overpayments are based on statistical samples of payments made to Humana and other HMOs.

The Medicaid overpayments were made on behalf of beneficiaries who were enrolled in both a Medicare HMO and Medicaid, so-called "dual-eligibles." The payments were made for services that should have been covered in Medicare HMO but were billed for separately in the Florida Medicaid fee-for-service system. The overpayments were made because Florida officials did not use Medicare's Group Health Plan database to identify Medicaid beneficiaries who also were enrolled in a Medicare HMO, Inspector General June Brown Gibbs said in a Dec. 16 letter to Health Care Financing Administration (HCFA) Administrator Nancy-Ann DeParle.

The OIG rejected the contention of officials from the Florida Agency for Health Care Administration that the state's data sharing agreement with HCFA prohibits Florida from sharing data to recover duplicate payments.

"If there is any doubt . . . in using the data for recovery of duplicative payments, the agreement allows the State the latitude to work with HCFA officials to initiate an appropriate data sharing agreement to recover any overpayments identified," she said.

A copy of the full report, "Medicaid Fee-for-Service Payments for Services on Behalf of Beneficiaries enrolled in Medicare Health Maintenance Organizations," is available at http://www.hhs.gov/progorg/oas/reports/region4/49701168.pdf or by contacting the OIG Office of Public Affairs at (202) 619-1343.