State Health Watch

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New York, Tennessee score big in HCFA turnabout on DSH

Hospitals that serve a disproportionate number of poor and elderly appear likely to receive a five-year, $2.14 billion boost from the federal government.

Interim final rules published by the Health Care Financing Administration (HCFA) in January would allow hospitals in Delaware, Hawaii, Massachusetts, Missouri, New York, Oregon, Tennessee, and Vermont to use days provided under so-called Medicaid expansion programs in its calculation of Medicare disproportionate share payments. Medicare disproportionate share hospitals (DSHs) receive funding tied to the level of care provided to Medicaid patients and low-income elderly.

FOLLOW-UP
Medicare DSH

"We're thrilled about it," says Lynne Fagnani, vice president for finance and reimbursement at the National Association of Public Hospitals and Health Systems in Washington, DC.

Effective for discharges from Jan. 20 onward, the interim final rule allows hospitals to count as Medicaid

See Medicare DSH on page 2

Teaching hospitals turn to legislators for help in coping with funding cuts

It helps that 'there are surpluses everywhere'

For safety-net hospitals, now is the best of times and the worst of times.

It's the best of times, for example, for hospitals in one of the eight states that can expect a financial boost from the federal government's recent redefinition of a Medicaid day. (See DSH story, above.)

Others, however, are taking their stories of Balanced Budget Act (BBA) hardships to their state legislatures. Bolstered by tobacco revenues and a strong economy, state legislators appear ready to listen.

"Clearly, there are surpluses everywhere, at the federal and state level," points out Lynne Fagnani, vice president for finance and reimbursement of the National Association of Public Hospitals and Health Systems in Washington, DC.

It's not that teaching hospitals are losing money. For the year ending in 1998, Baltimore-based HCIA reported a 3.24% median operating profit margin for teaching hospitals with 250 or more beds.

And hospitals still are doing better than the health plans with which they

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Medicare DSH

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the care provided to people who are eligible for the program through a section 1115 waiver. The rule tweaks earlier policy that says care to people in a Medicaid section 1115 research and demonstration project could be included in the definition, but only if such people could have enrolled in Medicaid without a waiver anyway.

"We believe allowing hospitals to include the section 1115 expanded waiver population in the Medicare DSH calculation is fully consistent with the congressional goals of the Medicare DSH adjustment to recognize the higher costs to hospitals of treating low-income individuals covered under Medicaid," states the narrative in the interim final rule published in the *Federal Register* Jan. 20. Comments will be received on the rule through the close of business on March 20.

In New York, hospitals have been drawing down the higher reimbursement all along, and the policy keeps intact a critically important source of revenue, says Jeannie Cross, vice president for communications for the Healthcare Association of New York State. About 130 New York hospitals are affected, 20 of which would have fallen below the Medicare DSH threshold altogether under a restricted definition, she says.

What's in a name?

Arriving at a definition of what constitutes a Medicaid day for the purposes of the Medicare DSH payment has been a tortured, multi-year process for federal officials and hospital representatives alike.

In order to satisfy hospitals and eliminate variation in the practices of third-party intermediaries, in early January, HCFA allowed the payment for certain disputed days, but restricted hospitals' ability to go back and request the higher reimbursement if they had not been doing so all along. (See "Hospitals can keep disputed DSH payments," *State Health Watch*, February 2000, p. 8.) Another point of contention is that the two DSH guidelines issued in recent weeks still don't recognize programs, such as those without section 1115 waivers, that states may administer through the Medicaid program but fund completely with state funds.

"I think a lot of these problems are a product of the fact that Medicaid isn't Medicaid anymore," says Ms. Fagnani. "There are all these other categories of individuals. The purpose of the adjustment was to reflect

low-income individuals, not to reflect fine distinctions on who is or isn't in one of those categories."

The HCFA interim final rule notes the Medicare DSH program predates the ability of states to experiment with their Medicaid programs and didn't anticipate how that flexibility might complicate the legal definition of a Medicaid day.

FOLLOW-UP
Medicare DSH

The impact of the latest policy change varies dramatically among the eight states. Two states with close ties to the administration in this election year, New York and Tennessee, account for almost three-fourths of the total disputed DSH payments, with New York expecting about $850 million over five years and Tennessee about $700 million over the same time period.

Barely a ripple

On the other hand, the change is barely making a ripple in other expansion program states. When the interim final rule was published, for example, Hawaii Medicaid officials weren't even sure how many of its 123,000 Medicaid managed care enrollees were part of its section 1115 expansion population. The head of the association representing the state's acute and long-term facilities didn't know the financial impact of the rule and doubted it would be significant.

"It's not going to affect a great number of facilities here," says Richard Meiers, president and chief executive officer of the Healthcare Association of Hawaii. "It will have an impact here, but certainly not the impact we would like to have seen."

Similarly, the Missouri Hospital Association has no idea what the impact of the policy change will be on members, says spokeswoman Barbara Long. Association members are working with state officials to establish a tracking system to monitor the effect of the change, she says.

HCFA officials told Massachusetts hospitals the policy would mean about $200 million over five years for hospitals in the state, says Joe Kirkpatrick, vice president for health care finance and managed care for the Burlington-based Massachusetts Hospital Association. The hospitals' own calculations suggest the number is closer to $100 million, he says.

"I think a lot of these problems are a product of the fact that Medicaid isn't Medicaid anymore. There are all these other categories of individuals. The purpose of the adjustment was to reflect low-income individuals, not to reflect fine distinctions on who is or isn't in one of those categories."

Lynne Fagnani
Vice President for
Finance and Reimbursement
National Assoc. of Public
Hospitals and Health Systems
Washington, DC

While "grateful" for HCFA's decision, the National Association of Public Hospitals and Health Systems would like to see the DSH formula go even further, says Ms. Fagnani. The association supports recommendations by the Medicare Payment Advisory Commission (MedPAC) for statutory changes that would, for the purposes of DSH, define low-income "broadly, to include all care to the poor."

MedPAC would include in the definition care to patients in indigent care programs other than Medicaid as well as uncompensated care, including both charity care and bad debt.

"All of these variations of who and who isn't Medicaid would be resolved if the formula was as broadly all-encompassing as possible and included anyone who is considered low-income," says Ms. Fagnani.

Even with the $700 million bonus provided courtesy of the latest policy change, Tennessee hospitals are chafing under a previous HCFA stance. That policy allows contested days to be recognized retrospectively, but only in hospitals that had been asking for them all along or that had met an Oct. 15 HCFA deadline to ask for reconsideration of the affected Medicare cost reports.

Hospitals that used a more conservative definition of Medicaid and have not already asked for a second look have no further recourse to do so, under current policy.

"Groups that have reported things correctly are being penalized, because they're not getting paid," says Tennessee Hospital Association vice president David McClure.

Contact Ms. Fagnani at (202) 585-0100, Mr. McClure at (615) 401-7465, Ms. Cross at (518) 431-7600, Ms. Long at (573) 893-3700, and Mr. Kirkpatrick at (781) 272-8000, ext. 173.

The MedPAC recommendations are found in "Report to the Congress: Medicare Payment Policy," March 1999, Medicare Payment Advisory Commission. Contact MedPAC at (202) 653-7220, or visit its Web site: www.med pac.gov. ■

Missouri Blue Cross health care foundation is held out as national model for conversions

Missouri Foundation for Health will administer $200 million for state's health care needs

A "fortuitous combination of law, public officials, and advocates" in Missouri has led to creation of a community foundation that all sides are holding up as a national model.

The Missouri Foundation for Health used more than $200 million from the conversion of Blue Cross Blue Shield of Missouri to a for-profit company to meet the health needs of Missourians not eligible for other health coverage or services.

Returning the public good

The foundation "embodies the way the people of Missouri who supported Blue Cross and Blue Shield's nonprofit public benefit get back what they put into that organization that no longer exists because it is now for-profit," says Jaemin Kim, a staff attorney with Consumers Union (CU) in San Francisco. CU has been actively monitoring and participating in conversion cases around the country and was instrumental in creating the "fortuitous combination" that Ms. Kim says drove the Missouri deliberations.

The foundation was created as part of a settlement negotiated by Blue Cross and Blue Shield of Missouri and the state government to end litigation over a 1994 reorganization of the Blues plans. The reorganization, state officials said, resulted in illegal profits for the nonprofit plans when they transferred much of their health insurance business to their newly created, for-profit RightCHOICE Managed Care Inc. subsidiary.

In May 1996, Blue Cross filed suit to block any state enforcement action, and the state countersued. In December 1996, a county court ruled in favor of state Attorney General Jay Nixon and the Missouri Department of Insurance, saying that Blue Cross had exceeded or abused its authority.

After initial settlement negotiations ignored local health care advocates, they complained to a special master who had been appointed by the court to review the settlement agreement, saying the proposal didn't adequately protect the public interest.

> "The settlement is a breakthrough because usually people in need don't get very much. The foundation will provide health care services for the uninsured, the underinsured, and the working poor who can't access Medicaid. This will be a permanent break for them."
>
> Peter De Simone
> Missouri Association for Social Welfare
> Jefferson City, MO

The master held hearings on the flaws in the settlement agreement, giving CU and local advocates an opportunity to lay out what they wanted to see in a settlement and a foundation. Ultimately, officials from Blue Cross, the state attorney general, and the state insurance department decided to work with the advocates to draft a better settlement, ending up with the agreement that is to be finalized this year.

Under terms of the settlement, the Missouri Foundation for Health will assume ownership of Blue Cross' assets, receiving $12.8 million in cash and 15 million shares (80%) of RightCHOICE Managed Care Inc. of St. Louis. With a market value for the shares at about $200 million, the new foundation will begin operations as the largest charitable health foundation in the state. It will be charged with several tasks:

1. identifying and filling the gaps in the public and private health care services already available to the uninsured and underinsured in 85 southern and eastern Missouri counties that constituted the plan's market;
2. identifying and addressing unmet needs in the underserved populations of that area where the foundation can have a significant impact;
3. identifying and funding programs in the service area that can maximize the impact of the corporation's resources on the communities served.

What makes this foundation a national model is its total independence from Blue Cross, its reliance on citizen advocates and representatives to play key roles, and its mandate to provide health care services not already provided by others, say advocates.

The legal services attorney, credited by many with articulating the role and structure desired in a foundation in the settlement hearings, holds the final product out as a "model settlement for foundations."

"The board members and the advisory committee that will nominate

them all represent the community, and the foundation cannot be used to supplant the activities of government," points out Joel Ferber, who represented Reform Organization of Welfare in the hearings. Initial provisions giving Blue Cross some input in the foundation were deleted in the final settlement, he says.

"The settlement is a breakthrough because usually people in need don't get very much," says Peter De Simone of the Missouri Association for Social Welfare in Jefferson City. "The foundation will provide health care services for the uninsured, the underinsured, and the working poor who can't access Medicaid. This will be a permanent break for them."

Mizzou-Rah!

CU's monitoring of the national scene indicates that many foundations being created from Blue Cross conversions don't have the "best practices" that ended up in the Missouri settlement, says Ms. Kim. In some states, for instance, where the Blue Cross plan has become part of the for-profit Anthem Insurance Company, the foundation is known as The Anthem Foundation and is controlled by the company, she says.

In other instances, there is no requirement that the foundation devote itself strictly to health care services. "I also like that the foundation got the full valuation of the Blue Cross assets," Ms. Kim says.

Because of legal restraints from the Blue Cross and Blue Shield Association over use of the trademarked names, the foundation is not totally free to dispose of the assets as it wants. But the foundation does have veto power over any merger with another Blue Cross plan or acquisition of the Missouri unit by another Blue. RightCHOICE is required to advise the foundation if it receives offers or is considering an acquisition.

Company and government officials are pleased to point out that the settlement "culminates almost five years of insurance department efforts to make sure [that] the assets of Blue Cross and Blue Shield, accumulated tax free, continue to work for the benefit of the public in eastern and southern Missouri," says Insurance Director Keith Wenzel.

Blue Cross and Blue Shield of Missouri president and CEO John O'Rourke says the "independence of the Missouri Foundation for Health and RightCHOICE is fundamental to delivering value through this settlement because it protects the Blue Cross and Blue Shield trademarks and provides the foundation with the opportunity to achieve up to $70 million in savings through a tax-free transaction."

Consumer groups agree that while the negotiated agreement looks very promising, it will take continued oversight to ensure that the foundation functions as it is supposed to.

"It's up to the public to monitor them," says Mr. Ferber. "The board is going to be the key. If we get a good first board, it will be a big step toward ensuring that the money will be spent the right way."

For Rachel Farr Fitch, representative of Missouri Consumer Health Care WATCH, a coalition of more than 90 organizations focused on the interest of health care consumers, the "guiding light was for the foundation to be independent and to address health care for the poor. And it's better than I thought it would turn out."

Contact Jaemin Kim at (415) 431-6747, Joel Ferber at (314) 534-4200, Peter De Simone at (573) 634-2901, Keith Wenzel at (573) 751-4126, John O'Rourke at (888) 877-9125, and Rachel Farr Fitch at (314) 361-4752. ■

Teaching hospitals

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contract, which had an operating profit margin that year of -3.5%, says the St. Paul, MN, research and consulting firm Interstudy.

Still, teaching hospitals aren't doing as well as nonteaching hospitals of the same size, which had an operating margin of 5.22% in 1998, says HCIA. Such hospitals are having differing degrees of success in making their case to the state officials:

"We've got facilities in the worst shape they've ever been in. We're the second largest industry in the state, and if they go too far, they're going to start destroying this industry."

Richard Meiers
President and CEO
Healthcare Assoc. of Hawaii
Honolulu

• Virginia Gov. Jim Gilmore has proposed, in the fiscal year ending in 2001, boosting the state's contribution to Medicaid by about $11 million and targeting these funds to the Medical College of Virginia Health System. With the state's federal Medicaid participation rate of 51.7%, the proposal would mean a boost of just over $22 million for the Medical College of Virginia Hospital and its associated physicians.

Significantly, the increase is for only the first year of a biennial budget cycle. The governor is waiting to see more aggressive and market-oriented strategies from the not-for-profit authority that governs the

hospital before deciding how to proceed next year, says Rob Lockridge, associate director for education in the Virginia Department of Planning and Budget.

"I think we'll be back looking at it in the second year," he says. "The dollar amount wasn't in question. We want them to act a little more along the line their competition acts."

The teaching hospital already is on board with the governor's strategy, notes Mr. Lockridge, and the significant unknown is how that strategy will be implemented.

• Hawaii leaders are petitioning both federal and state officials for help in dealing with BBA cuts in a state not quite feeling the economic boom gracing the rest of the country.

"What we're working with them on is no further cuts," says Richard Meiers, president and CEO of the Healthcare Association of Hawaii, a Honolulu-based organization representing both acute and long-term care providers.

"We've got facilities in the worst shape they've ever been in. We're the second-largest industry in the state, and if they go too far, they're going to start destroying this industry," he explains.

Changes in Medicare from the BBA and state changes to the Medicaid program will cut about $39.2 million annually from Hawaii's hospitals and nursing homes between 2000 and 2002, estimates a report done for the Healthcare Association of Hawaii by Ernst & Young, LLP. The cuts affect 16 hospitals, including their hospital-based nursing facilities and five long-term care facilities.

• In Florida, BBA cuts estimated at $1.07 billion over five years have put the ability of hospitals to educate residents in "grave danger," says a report from the legislature's Graduate Medical Education Study Committee.

In his proposed 2001 budget, Gov. Jeb Bush accepts the Florida Board of Regents' suggestion to move $14.5 million from other parts of state government into the state's Medicaid agency and, it's hoped, snag the federal match without a Medicaid waiver.

On the other hand, a board recommendation to pump $24 million into a newly created graduate medical education trust fund is "much iffier," says Linda Rackleff, a health affairs specialist with the board.

In a related issue, the regents also are watching the outcome of Mr. Bush's budget support for the development of a medical school at Florida State University in Tallahassee. In unanimously voting against the idea last spring, the board noted the "high cost of actually operating a medical school," which ranges from $208 million to $500 million annually at Florida's three allopathic institutions even before the costs of the affiliated teaching hospitals are included. Florida State University System Chancellor Adam Herbert also noted in remarks at that time that shrinking practice plan revenues and shortfalls in state and federal appropriations to public medical schools inflicted "serious constraints" on the growth of medical school activities in Florida and throughout the county.

Contact Ms. Fagnani at (202) 585-0100, Mr. Meiers at (808) 521-8961, Mr. Lockridge at (804) 786-6321, and Ms. Rackleff at (850) 201-7120. ■

Georgia legislator tries noncash methods to help struggling rural hospitals

Jack Hill says the real answer is money, but the Georgia state senator will work any angle he can to boost the health of failing rural hospitals in his district.

The Democrat from the southeast part of the state got his fellow lawmakers last year to approve a hospital modernization grant program, but they didn't free up the money to fund it. He says he plans to propose a one-time $10 million bailout for rural hospitals this year, but isn't very optimistic about his chances.

So in addition to asking for the one-time lifeline, Mr. Hill says he will champion a bill to simplify the process by which a rural hospital can be sold. A separate proposal will toughen the requirements for HMOs to negotiate with rural facilities for inclusion in provider networks.

"We're doing everything we can," he says. "Beating out the brush fires might not put out the main fire, but we're doing what we can do."

Along with the Georgia hospital association, Mr. Hill is championing a bill (HB 1212) that would exempt hospitals with fewer than 100 beds from some of the analysis and reporting requirements imposed in the transfer of ownership of a facility run by a hospital authority. Mr. Hill acknowledges that the requirements are motivated by previous "abuses" in which hospital ownership changed hands without adequate oversight of local government. In the case of rural hospitals, however, he says the mandates unnecessarily burden a corporation that might be willing to infuse capital into a rural hospital.

"I don't know if we need to study it too hard," he says.

Contact Mr. Hill at (404) 656-5038. ■

The feds' new Olmstead guidelines are looking like much ado about something, say advocates

Disability advocates not only like what the federal government is saying about how states should implement the U.S. Supreme Court's Olmstead decision, they like that the federal government is stating it so clearly.

"The letter is a good start," says Mark Murphy, deputy director of the Disabilities Law Project, referring to Jan. 14 correspondence from the Health Care Financing Administration (HFCA) to state Medicaid directors on how to comply with the access and other requirements of *L.C. v. Olmstead*.

The landmark June 22, 1999, decision expanded the right to community-based care for Medicaid beneficiaries who otherwise are entitled to institutional care under the program.

Lest anyone miss the point, a separate letter from Dept. of Health and Human Services (HHS) Secretary Donna Shalala on the same day encouraged governors to "place substantial emphasis on developing programs and services for individuals with disabilities" as they developed funding priorities for their states.

"The letter sends a pretty powerful message," says Jennifer Mathis, a staff attorney with the Bazelon Center for Mental Health Law in Washington, DC. "We believe some state attorneys general looked at the decision as not changing anything. But it says that states potentially will have to do more than they are now doing.

"The letter doesn't say explicitly that states must expand their Medicaid program, but it acknowledges that Medicaid is a critical source of funds for states to expand community-based programs and comply with Olmstead," she says.

The court's decision in the suit, brought under the Americans with Disabilities Act (ADA), identified circumstances under which Medicaid beneficiaries who would be eligible for institutional care should be afforded access to community-based care:

- The state's treatment professionals reasonably determine that such placement is appropriate.
- The affected persons do not oppose such treatment.
- The placement can be reasonably accommodated, taking into account the resources available to the states and the needs of others who are receiving state-supported disability services.

"The thing to look for down the road is how much time the states will take. Letters from the government help, but they don't necessarily push state officials into taking action."

Mark Murphy
Deputy Director
Disabilities Law Project
Pittsburgh

The Supreme Court also said that a State may be able to meet its obligation under the ADA by having a plan to ensure that individuals with disabilities receive services in the most integrated setting appropriate. The court also spelled out its expectation that the state keep its waiting list moving at a reasonable pace — a pace not controlled by a state's objective of keeping its institutions fully populated.

"We're offering assistance to states for the development of comprehensive, effectively working plans that will show they are in compliance with the court order," says Sheila Foran, a representative of the HHS Office of Civil Rights (OCR), whose agency helped develop the Olmstead guidance with HCFA.

"It's important that the government is including persons with disabilities in the process and important that it recognizes that states must address not only those who are institutionalized but also those who are at risk for institutionalization," says Ms. Foran.

Advocates should be at the table when states are determining if they have a comprehensive, effectively working plan, concurs Elizabeth Priaulx, an attorney who is a community integration specialist with the National Association of Protection and Advocacy Systems (NAPAS) in Washington, DC.

"We're pleased that OCR stayed in touch with advocates and said in the letter that states should work with advocates," she says.

NAPAS developed a template of principles that should be in a state comprehensive plan and much of that material is reflected in the technical assistance included in the HCFA/OCR letter to state Medicaid directors, Ms. Priaulx says.

In their letter, HCFA and OCR call on states to take these actions:

- Develop a comprehensive, effectively working plan (or plans) to strengthen community service systems and serve people with disabilities in the most integrated setting

appropriate to their needs.

• Actively involve people with disabilities and, where appropriate, their family members or representatives, in design, development, and implementation.

• Use the department's technical assistance materials as one of the guides in the planning process.

• Raise questions that need to be resolved and share ideas regarding technical assistance that would be helpful.

While HCFA, OCR, and advocates for the disabled say they recognize that no one model plan will be appropriate for all states and situations, there are some key principles that probably should be recognized in any plan. Those principles include:

• Recognize the need for a comprehensive, effectively working plan or plans for providing services to eligible individuals with disabilities in more integrated, community-based settings.

• Provide an opportunity for interested persons, including individuals with disabilities and their representatives, to be integral participants in plan development and follow-up.

• Take steps to prevent or correct current and future unjustified institutionalization of individuals with disabilities.

• Ensure the availability of community-integrated services.

• Afford individuals with disabilities and their families the opportunity to make informed choices regarding how their needs can best be met in community or institutional settings.

• Take steps to ensure that quality assurance, quality improvement, and

Florida clash over Medicaid cost-shifting leads to rate increase

Community mental health providers in Florida have parlayed an investigation into their Medicaid accounting practices into a midyear $3.3 million rate increase effective April 1. Rates for the eight behavioral health codes involved had been largely untouched since Medicaid started paying for the services about 20 years ago. While the new rates don't necessarily cover the complete costs of the services, they are "getting better," says a representative for Florida's community mental health centers.

"Everyone recognized that maintaining a system of care could not be done on 1980 rates," says Randy Wilcox, director of governmental relations for the Florida Association for Community Mental Health.

The revision in the rates stems from an investigation last year into the centers' practice of cost-shifting funds between Medicaid, which is administered by the Agency for Health Care Administration (AHCA), and programs funded by the state's Department of Children and Families (DCF). DCF objected to the way in which providers were using state funds to supplement underfunded Medicaid services.

"All Medicaid providers do, everywhere, because historically in most states, Medicaid doesn't pay everybody's costs up to 100%," says Mr. Wilcox. "If [Medicaid] is not covering costs, either directly or indirectly, some other payer stream is offsetting that, either by making a profit in some other area of the agency or some other mechanism."

But DCF stuck to its guns against the cross-subsidization of funds, says Mr. Wilcox, implementing contract language more restrictive on the practice than even state and federal statutes. "That immediately raised the question relative to the adequacy of the rates," says Mr. Wilcox. "That's an issue that's been lying around and periodically gets raised, but has not gotten an awful lot of attention from AHCA. When the two funding streams had to be separated at the hip, then it became a major issue."

After about six months of wrangling, providers were able to get an unusual midyear budget amendment giving them a rate increase through the end of the fiscal year on June 30. On an annual basis, the increase would cost the state about $8.4 million and represent, with the federal Medicaid match, about $19.3 million in increased payments. Medicaid rates will come before legislators again during budget negotiations in the current legislative session.

To fund the increased Medicaid payments this year, state officials went back to the Department of Children and Families and agreed to transfer funds to Medicaid as needed. "In certain agencies, that did not do a lot of Medicaid business, that was problematic," says Mr. Wilcox.

"In one regard, it's an advantageous shift for the state as a whole, because it allows the state to earn more federal participation in paying the cost of care. On the other hand, the services that those general revenue dollars support . . . supported things Medicaid doesn't pay for, such as residential care and care to indigents who are not Medicaid eligible," he says.

State officials have discontinued the disputed language in DCF contracts in favor of references to existing federal and state statutes on the co-existence of Medicaid and non-Medicaid funding, says Mr. Wilcox. In addition, the agreement among state officials and mental providers calls for ongoing monitoring of the adequacy of Medicaid rates.

Contact Mr. Wilcox at (850) 224-6048. See related story, "Pennsylvania enacts huge increase in behavioral health Medicaid rates," State Health Watch, *November 1999, p. 10.* ■

sound management support implementation of the plan.

The technical assistance document provides guidance on how to carry out each of the six principles.

Although advocates for the disabled are supportive of the government's initial steps, they recognize that what really matters is how quickly states move to implement Olmstead. Some advocates are saying that a good way to celebrate the July 26 10th anniversary of ADA would be for states to have their plans in place and functioning by then.

Ms. Foran says she's heard that suggestion but believes it's hard to say if that will be enough time. "It really depends on the state, its existing infrastructure, and its ability to quickly shift resources to meet the needs of a new infrastructure. We'd certainly like to have as much done by then as possible."

"Most states say they favor the concept but then don't take prompt steps to implement it," says Mr. Murphy, who serves the Pittsburgh office of the Pennsylvania-based Disability Law Project.

"The thing to look for down the road is how much time the states will take. Letters from the government help, but they don't necessarily push state officials into taking action," he says.

"The fact that states have to have a comprehensive, effectively working plan will help move things forward. Having a plan in place will be an effective defense for states, but it also will mean that people are actually living and working in communities," Mr. Murphy adds.

Contact Ms. Foran at (202) 619-1002, Ms. Priaulx at (202) 408-9514, Ms. Mathis at (202) 467-5730, ext. 22, and Mr. Murphy at (412) 391-5225. ■

New York tries to cover 1 million residents in ambitious public and private initiatives

What one national observer describes as "a stealth piece of legislation," quietly adopted by the New York legislature and signed by Gov. George Pataki just before the end of 1999, outlines a bold and ambitious plan to bring health insurance to an estimated 1 million people currently uninsured.

"This is going to be a difficult program to implement, especially with the new populations. It's hard to know how to find the families you're looking for and get them eligible."

James Fossett
Associate Professor of public administration and policy
State University of New York
Albany

The price tag for three new programs is $1.2 billion in county, state, and federal funds over the next 3½ years and $900 million per year when fully implemented.

"The fact that they think they can cover 1 million uninsured is very interesting," says Trish Riley, executive director of the National Academy for State Health Policy. "And there are some features like the stop-loss for direct pay consumers that we haven't seen tried before. As with any new program, the devil will be in the details."

In many respects, details of the new initiatives still are to be worked out this year in anticipation of a Jan. 1, 2001, launch. But broad outlines are available.

The biggest of three new programs will be Family Health Plus (FHP), a Medicaid expansion modeled after the current Child Health Plus (CHP). The program is designed to provide comprehensive health insurance at no cost to low-income uninsured adults, according to an analysis by Rima Cohen, vice president for insurance options development of the Greater New York Hospital Association in New York City.

The program is targeted at the working poor whose jobs don't provide health insurance but provide too high an income to meet conventional Medicaid eligibility.

To qualify for FHP, people will have to be 19 to 65 and ineligible for Medicaid. Those with dependent children may earn up to 150% of the poverty level; those with no dependent children may earn up to 100% of the poverty level. In addition, eligibility is extended to those who meet Medicaid's definition of a "qualified immigrant," covering most legal immigrants who arrived in the United States before 1996. Immigrants who arrived after 1996 and have lived in this country for at least five years will be eligible.

Federal, state, county funding

Implementation will be in stages. At full implementation in Oct. 1, 2002, the program will cover an estimated 600,000 adults. The anticipated income caps will be $8,300 for an individual and $25,500 for a family of four.

FHP will provide a comprehensive benefits package, established in the law, through managed care plans that contract with the state to offer the program.

Benefits are similar to those offered by CHP, and include inpatient and outpatient hospital care, physician services, lab tests, X-rays, prescription drugs, durable medical equipment, radiation therapy, ambulance and emergency department care, and routine, preventive, and emergency dental, vision, and hearing services.

Funding to pay for FHP is supposed to be divided, with counties and the state each paying 25% and the federal government paying 50% in matching funds. Initially, there had not been much public outcry from the counties, says Ms. Cohen. "The counties know they have a lot of uninsured, but they'd always prefer if someone else pays the bill."

Who picks up the check?

Toward the end of January, however, the counties' discontent boiled over as Republican members of the General Assembly joined Democrats in saying the state should cover all of local governments' costs as well as its own.

Senate Majority Leader Joseph L. Bruno said the state could afford to pay the entire share because of a projected budget surplus this year of at least $1 billion. When the Pataki administration reacted coolly to the proposal, even suggesting that the governor would call for cuts in programs important to the legislature to pay for the plan, the stage seemed to be set for the first fight over the new health care package.

Ms. Cohen says enrollment details are still to be developed for the 2001 launch — assuming timely federal approval of the matching

New York businesses skeptical of state plan to boost health coverage

New York officials are ready to roll out their health insurance program for small businesses and a new stop-loss fund for the direct pay market.

In 2001, Healthy New York is to start offering small businesses subsidized health insurance with limited benefits. Healthy New York policies will cover most basic health care services, but the law waives many of the mandated benefits included in other coverage. In addition, there will be much higher copayments than in current small group policies.

To participate, businesses must have no more than 50 employees, no employer-based insurance for the previous 12 months (to prevent companies from dropping an insurance plan to qualify), and one-third of their employees making less than $30,000 per year. In addition, the business must pay at least 50% of the employee premiums. The state will reimburse plans for 90% of the claims paid per Healthy New York member per calendar year between $30,000 and $100,000.

FOLLOW-UP
Insurance partnership

Healthy New York also will provide $56 million over three years to subsidize insurance for individuals making under 208% [flag this number] of poverty who work for firms that do not provide coverage. Health plans will be required to offer a reduced set of benefits and high claims will be subsidized from a stop-loss fund that will reimburse direct pay policies for claims between $20,000 and $100,000 per member per year.

Funding of the state share of the programs will come primarily from some of the tobacco settlement money as well as a doubling of the state tax on cigarettes to $1.11 per pack. Such funding sources may help the program succeed because other states have found that they are better able to sustain a program when it's not drawing on the state's general fund, says Trish Riley, executive director of the National Academy for State Health Policy.

Although many interest groups came together to support passage of the programs, they did not meet with the approval of business leaders. Elliot Shaw, director of government affairs for the Business Council of New York State, says his members would have structured health insurance for the uninsured very differently.

"We would not have expanded Medicaid and created a two-tiered approach for small businesses. We would have tried to make insurance more affordable for all by making changes that would have helped the private sector provide coverage rather than relying on government," he says.

Mr. Shaw says his group will now assist with implementation, however, working to help small businesses become eligible for Healthy New York. "We'll try the best we can to make the system work. Perhaps we can re-tool it a bit, too, as it gets implemented. We certainly would not want to re-open the whole debate, but we might be able to make some changes."

Contact Mr. Shaw at (518) 465-7511. See related story, "New York City, Texas, roll out purchasing alliances to broaden health coverage among small businesses," State Health Watch, *May 1999, p. 10.* ■

funds request. But the state made a commitment to a simple enrollment process that focuses on community-based enrollment, attempting to avoid some of the criticisms that have been voiced over the enrollment problems in the Medicaid managed care rollout in New York City.

Communities get involved

Individuals will be able to sign up through providers, many community-based organizations, and district social service agencies.

Recertification will be conducted annually. Unlike Medicaid, there will be no resources test, and the community-based organizations and providers will be able to conduct enrollment interviews. Funds were identified in the law for an extensive outreach, marketing, and enrollment assistance campaign.

Strength in designing program

New York historically has been better at designing programs than at getting people to enroll in them, says James Fossett, associate professor of public administration and policy at the State University of New York in Albany.

"This is going to be a difficult program to implement," he says, "especially with the new populations. It's hard to know how to find the families you're looking for and get them eligible. Another problem is just the scale of the thing.

"Some other states have tried to bring families in, but New York has three times as many people eligible. And they just don't have a sparkling track record. The logistical problems should not be underestimated," says Mr. Fossett.

Contact Ms. Riley at (207) 874-6524, Mr. Brecher at (212) 998-7449, Mr. Fossett at (518) 443-5846, and Ms. Cohen at (212) 246-7100. ■

Clip files / Local news from the states

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

Oregon's governor considers voluntary, all-payer formulary

PORTLAND, OR—Faced with 10% to 20% increases in health insurance costs in his state, Oregon Gov. John Kitzhaber has proposed the state develop a voluntary statewide formulary. From its bully pulpit, the state would exhort not only the Oregon Health Plan, the state's Medicaid program, but also state employees, medical groups, health maintenance organizations, and other health insurance companies to help control costs by adhering to the formulary.

"If you're going to make a difference, you need to look at all 3 million of us, vs. 350,000 in the Oregon Health Plan," said Lynn Read, deputy director of the Office of Medical Assistance. "To date, states have not had success controlling costs. We're hopeful this process will yield results."

The state overall saw a 4% to 5% increase in prescription drug costs last year, a representative from the governor's office said. The Oregon Health Plan, however, spent $116 million on prescription drugs last year, a 33% leap from 1997, according to a report by the Office of Medical Assistance Programs. A combination of factors contributed to the increase, from volume increases to new medications coming on line.

—*Business Journal of Portland*, Jan. 31

NASHP takes retrospective look at impact of state-level initiatives

PORTLAND, ME—Without a quarter century of state initiatives, the current level of uninsured in the country would be greater by several millions of people, says a report from the National Academy for State Health Policy.

The report, "Access for the Uninsured: Lessons from 25 Years of State Initiatives," describes how state actions have not only insured millions of Americans, but provided a testing ground for large-scale federal efforts. For more information on the report or to order a copy, contact the National Academy for State Health Policy, 50 Monument Square, Suite 502, Portland, ME 04101. Telephone: (207) 874-6524. The report costs $30 for government and nonprofit agencies and $50 for all others.

Welfare reform is given a 'major role' in declining health coverage for women

WASHINGTON, DC—Welfare reform is likely to have played a "major role" in the drop in health insurance coverage among women of reproductive age during the 1990s, says a special analysis from the Alan Guttmacher Institute. The proportion of American women of reproductive age enrolled in Medicaid fell by 21% between 1994 and 1998, and nearly one in five American women of reproductive age lacked insurance of any kind by 1998, says the report in the December 1999 issue of *The Guttmacher Report on Public Policy*. Author Rachel Benson Gold describes the variety of responses to this "spillover effect" of welfare reform, particularly those involving transitional Medicaid, outreach, and special initiatives for immigrant women. The full report is available at www.agi-usa.org/pubs/journals/ gr020606.html.

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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.*

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

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

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Decline in tobacco consumption will lower tobacco settlement payments

HOUSTON—Declining consumption will cut tobacco settlement payments to states by 11%, says Philip Morris attorney Meyer Koplow. His remarks came as Texas hospital districts learned that they will receive $60 million less than expected this year as a result of a drop in the domestic shipment of tobacco products. Payments are tied to both the level of tobacco shipped and to inflation. A 14% overall decline in shipments was offset by a 3% inflation adjustment.

—*Houston Chronicle*, Jan. 31

Health plans in New York kick off anti-fraud campaign

NEW YORK—Hospitals in New York are enlisting the help of consumers in a campaign to fight health insurance fraud and abuse.

"It is estimated that fraud and abuse are costing all of us as much as $100 billion each year," said a statement from William Mahon, executive director of the National Health Care Anti-Fraud Association. The association has joined with the New York Health Plan Association in developing a print and Internet campaign to raise awareness about health care fraud and how to combat it.

—New York Health Plan Association release, Jan. 21

Kaiser Commission suggests ways to get kids enrolled in Medicaid

WASHINGTON, DC—The reasons parents don't enroll their eligible children in Medicaid are not inherent in the program but rather are "problems with practical, feasible solutions all states can implement," says a new report from the Kaiser Commission on Medicaid and the Uninsured. "Medicaid and Children: Overcoming Barriers to Enrollment," is a summary of a national survey of parents and an analysis of ways to boost participation in Medicaid.

A copy of the report is available through the Kaiser Web site, www.kff.org/content/2000/2174/ or by calling (800) 656-4533.

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