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Health Watch

The Newsletter on State Health Care Reform

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State Health Watch at the 2000 NASHP Conference

Simplifying state health policy is easier said than done. Much was said at the recent National Academy for State Health Policy Conference in Bloomington, MN, as policy-makers met to discuss ways to improve the programs in their individual states. Cover

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Magellan Behavioral Health is pulling out of the NorthSTAR program in Texas and cites rising pharmaceutical costs as the reason. Company officials say those costs have more than doubled over initial projections in recent months Cover

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NASHP convention topics cover both ends of the policy spectrum

Minnesota's gift to the Hall of Unusual Governors, Jesse Ventura, did his best to try to make the jobs of more than 500 state health policy workers seem less of a burden.

"Policy should be simple and clear," Mr. Ventura told those gathered for the 13th annual National Academy for State

Health Policy (NASHP) conference in Bloomington in August. Taking in the stunned silence around the room, the governor, no stranger to stunned silences, added, "Yet health care policy

has become very complicated and confusing."

To say the least. Ventura, who does his best to boil everything down to its simplest form, even the incredibly complex and swiftly changing planet of state health policy, must have known that even he would have a hard time selling simplicity to this group of hardboiled policy wonks who daily leap through hoops of paperwork and slog through the muck of political turmoil. Ventura said he encourages personal responsibility when it comes to health care. But personal responsibility is only one

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Contractor pulls out of Texas pilot mental health program — NorthSTAR

The NorthSTAR program, a managed care approach to delivering mental health and chemical dependency services to Medicaid recipients and the indigent in seven counties around Dallas, is losing one of its two contractors because of rising pharmaceutical costs.

Using Medicaid, state general revenue and federal block grant funds, the pilot, which officially started July 1, 1999, but didn't bring in Medicaid patients until the end of that year, was intended to demonstrate a better-coordinated system of behavioral health care.

The NorthSTAR contracts were awarded to Magellan Behavioral Health in Columbia, MD, and ValueOptions in Falls Church, VA, two national behavioral health firms with extensive experience in managed mental health care. Magellan announced in early July that it would not renew its contract with the Texas Department of Mental Health and Mental Retardation (MHMR) and will leave the pilot as of Sept. 30.

Steve Niemi, senior vice president with Magellan Public Solutions Group, tells *State Health Watch* that

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NASHP convention

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of several factors when it comes to safeguarding the health of the uninsured.

"Whose responsibility is all this? The states? Individuals?" asked Christine Ferguson, director of the Rhode Island Department of Human Services, during a session of the conference. At the very least, the responsibility is shared three ways when private funding is added to the mix of state and individual funding.

Jane Beyer, senior counsel with the Democratic Caucus in Olympia, WA, sees funding as a metaphor. "I think of it as two sets of railroad tracks. There is public and employer-sponsored coverage," she said. "The tracks must start to cross instead of remaining parallel."

Ms. Beyer added that there is also a chance that plan might not work. "It's possible these two trains could crash."

Simplifying state health policy ruled at one end of the spectrum at the conference, while traditional, add-more-legislation-to-already-existing-policy theories hunkered down at the other end. And of course, everything in between was represented. That's why approximately 525 NASHP members and guests attended the three-day conference. They came to hear how other states administer their funding and enact their policies. Since all 50 states have their own methods of conducting business, those at the NASHP gathering wanted to get an earful from their fellow members, with the hope they would hear something that would help them do their jobs more effectively.

From the practical to the improbable

Recommendations from the meeting ranged from the practical to the improbable, such as when Mark Reynolds, director of TennCare in Nashville, TN, queried, "Do we need something else entirely other than insurance?"

Talking about alternatives and hearing new ideas is crucial to helping solve the state's problems. If ideas and policies aren't talked about, if they aren't kept in range of the public's hearing also, the system bogs down, NASHP members agreed. Keeping the issue public also helps build steam in local legislatures.

"It's a matter of political will," said Gordon Bonnyman, an attorney with the Tennessee Justice Center in Nashville. "We need to build a will for what we know needs to be done."

Building a political will means having a vision for the future of the state's role in health care. There is no

clear consensus on the best way to proceed, but James Tallon Jr., president of the United Hospital Fund of New York in New York City, urged NASHP members to set their sights high, such as finding a way to universal coverage where 97% to 98% of people have health insurance. He added that unless there is a federal-state framework for coverage of the uninsured, no system can work.

Mr. Tallon also said that current statistics on the uninsured are lower than the actual number. "The problem is masked by the surge in our economy," he told NASHP members.

Public vs. private

Integrating public and private money into health care coverage is the best way to universal coverage, according to many attending the meeting. Getting the two sources to meet was the problem, some members said.

"We must take advantage of employers helping pick up the tab," Ms. Beyer said. "Small businesses often can only pick up a small bit of it."

Mr. Reynolds shared his theory of what created the logjam: "What's holding back universal coverage? The private sector."

Ms. Ferguson also saw the combination of public and private funding as the future of health care, but she reminded the gathering that insurance is only a tool for health care. "Is it leading to better outcomes?" she asked. "Are kids entering school in better health than in the past?"

Colliding with funding is the cost of health care, which continues to spiral upwards. That's a situation that is unlikely to change, Mr. Reynolds said.

"People are now paying more for health care than they ever did," he said, adding that no matter what policy choices are made, the costs of keeping people healthy in America will continue to rise. ■

IOM report on medical errors: A wake-up call?

A recent Institute of Medicine (IOM) report on the high number of deaths caused by medical errors seems to have been not only a wake-up call to health care professionals but to those involved in formulating state policy.

"States are important levers of change," Trish Riley, executive director of the National Academy for State Health Policy (NASHP) in Portland, ME, said at the group's 13th annual conference in Bloomington, MN, in August. "It's tough to keep public attention on this. . . . The public doesn't fully understand this issue."

But to solve the problem, that's exactly what states must do, she added. Keeping the issue public brings more awareness to the problem, Ms. Riley said, because until the public understands the deadly reach of medical errors into their own lives, the problem will persist.

The IOM report stated that medical errors lead to between 44,000 and 98,000 patient deaths annually, making it the eighth leading cause of

death in the United States. The annual costs of those errors is estimated to be as much as \$29 billion. Even using the 44,000 figure, that is more deaths from medical mistakes annually than from highway accidents, breast cancer, or AIDS, the report said.

Ms. Riley said oversight for hospitals must increase in order for medical errors to decline. Fifteen states, she said, have introduced 45 bills since December regarding oversight, and that's a step in the right direction.

"Fifteen states have mandatory reporting of adverse events," she said. "But there is no common definition of adverse events or medical errors."

Because of the lack of definition for

adverse events or medical errors, it is hard to craft legislation to fight them, Ms. Riley explained. The IOM report defined "error" as the "failure to complete a planned action as intended or the use of a wrong plan to achieve an aim. Not all errors result in harm, and the report recommended that a nationwide, mandatory public reporting system be instituted.

"Hospitals first, and eventually other places where patients get care, would be responsible for reporting such events to state governments," the IOM recommended.

Joyce Greenleaf, assistant regional inspector general, Office of the Inspector General, in Boston, told conference attendees that states must make sure that minimum standards are met to prevent errors. Accreditation is important, she said, but states should be able to respond more from the front lines of hospital health care and make hospitals more publicly accountable.

"The downside for states is that they lack a routine presence in hospitals because they lack resources and tend to be more reactive than preventive," she said. "It is in the best interest of states to take advantage of their own strengths and of the Joint Commission [on Accreditation of Healthcare Organizations]. There should be state initiatives and public disclosure on the Internet, using surveys and performance measures. States can complement other systems of oversight, so states should play to their strengths."

Nancy Foster, coordinator of policy initiatives for the Agency for Healthcare Research and Quality in Rockville, MD, suggested to NASHP members that a plan should be created for reducing medical errors by 50% in the next five years. Parts of her plan include conducting research into reducing medical errors, converting

findings into improved practices, and educating the public about safety issues. Reporting systems are also part of her vision. She recommended that mandatory reporting systems be put in place in all states in three years, with no identification of patients or health care professionals. The voluntary systems she recommended include public and private systems that also keep tabs of errors that cause minimal harm and close calls, and that all data be kept confidential.

Ms. Foster also recommended integrating all data from federal, state, and private systems to develop a response system and common approaches to privacy and peer review protections, and that all participate in a national quality forum. Reporting all errors, from minor to major, is one of her goals. "Only some events end up with adverse consequences," she said. "If a nurse takes the wrong bottle off a shelf, realizes the error, but the patient doesn't get the medicine, an error has still been made," she said. "We need to establish a sense of urgency that change needs to be made."

That sentiment was echoed at the meeting by Janet Corrigan, director of the Quality of Care in America Project from the IOM. "States must keep the pressure on and the issue visible. Because once the issue passes from the media and we move on to the next issue du jour, medical errors are easy for the public to forget."

Seven bills have been enacted recently in five states regarding medical errors. In Florida, the Florida Commission on Excellence in Health Care was created to improve health care through better reporting standards, data collection and review, and quality measurements. And in Washington, the Department of Public Health must now publicly disclose information received through filed reports and inspections, and hospitals must have quality assurance programs with access to records by the state. ■

Finding good help in health care continues to be a tough chore

It may not be the states' responsibility to educate and produce workers, but it ultimately does fall into their laps. A continually booming economy has increasingly taken potential health care workers out of the market place, leaving a vacuum that seems, and often is, larger every month.

An annual turnover rate of between 40% and 100% dogs the health care industry. Facilities have had to close due to the inability to meet the need for labor. According to the School of Public Health in Albany, NY, shortages exist for registered nurses, home health aides, nursing home aides, information system specialists, pharmacists, dentists, and mental health workers.

That's not breaking news to health care administrators who have to fill these positions. But what is news are the ways states have positioned themselves in finding, training, and retaining these workers.

SHW at the 2000 NASHP Conference

At the recent National Academy for State Health Policy conference in Bloomington, MN, several groups gathered to hash out the problem and trade ideas that could alleviate the burden.

"The supply of RNs will continue to drop," said Edward Salsberg, director of the Center for Health Workforce Studies, School of Public Health, State University of New York in Rensselaer. "In New York, nursing school applications have dropped rapidly in the past few years. Is this a short-term phenomenon due to a healthy economy? Structure is the problem, and no, it's not a temporary shortage."

For Mr. Salsberg, the picture comes into focus with basic economic

theory: Demand for the workers is increasing faster than the supply. And he added that the supply is decreasing.

In many of the states, the universities are usually the major producers of RNs, Mr. Salsberg said, and it is difficult for the states to do anything about the structure of the jobs, such as working conditions, without being accused of meddling in the workplace. At least one-half of the states have commissions and task forces looking at those issues, he said.

"If you don't restructure your jobs, you're not addressing the core problem," Mr. Salsberg added, referring mainly to pay issues.

Recent immigrants to the United States could temporarily fill the lower level health care jobs, he said, but that is not a good source of labor for the long term.

Improvements states should make on the supply side, according to Mr. Salsberg, include changing education strategies by increasing mandates, funding, and directives for state universities and colleges; increasing grants to private and public institutions; and increasing scholarships. Also, increasing wages supported by Medicaid reimbursement policies is crucial, he said, plus the targeted increases must be tied to wages and required pass-throughs. He also suggested permitting or increasing Medicaid fees for service, and permitting or mandating private insurance coverage for workers.

According to Karen Hicks, director of the Office of the Commissioner at the New Hampshire Department of Health and Human Services in Concord, "I used to think this is nothing a good recession won't cure. But I don't think that anymore."

Improving upon the quality of care patients receive cannot come to pass until the quality of the work force is improved. Ms. Hicks said there is 75% to 85% annual turnover in the home health sector and 80% to 90% annual turnover for nursing homes. She said the workers that leave those jobs are the least trained, lowest paid employees in the health care system, and there is inadequate training, a lack of benefits, a high risk of injury, and poor management and supervision.

"We also need to develop a career lattice, not a ladder. We need to figure out a way to not top out pay at \$10 per hour."

Karen Hicks

*Director
Office of the Commissioner
New Hampshire Department of
Health and Human Services
Concord*

"It is stressful to provide the type of care they provide," Ms. Hicks said, noting that the work done by those workers is very intimate and takes an emotional toll. The policy responses in New Hampshire to this crisis have been to focus on making those jobs better jobs. "The most common state response is to raise wages, about \$1 an hour. People who do this kind of work want to do it. It's more satisfying than working at Target or McDonald's," she said.

"We need to let workers know what assistance they are eligible for, such as health care and child care for single moms and travel expenses. We also need to develop a career lattice, not a ladder," she added. "We need to figure out a way to not top out pay at \$10 per hour, and establish a credentialing system. We must change the overall image of those jobs and show appreciation and recognition by the states." ■

States search for ways to keep children in CHIP programs

It's been two years since the Children's Health Insurance Program (CHIP) started its work in the states. That's long enough for many children to have dropped off the enrollment list and for states to search for the best ways to re-enroll those who are eligible.

Forty-four percent of eligible families did not renew their CHIP memberships in Alabama in the first year of the program's existence. Looking into the numbers, Alabama officials found that 21% of them, 4,677 children, simply did not return their re-enrollment forms.

"We discovered we needed to educate people about the ways to re-enroll," Cathy Caldwell, CHIP data manager for the Alabama Department of Health in Montgomery, told those attending the National Academy for State Health Policy convention in Bloomington, MN, in August.

Alabama officials investigated and found that most children and families learned

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through

the public schools, so an effort was made to distribute forms and follow through on re-enrollment there. Public service announcements on radio and in newspapers were also phenomenally successful, said Gayle Lees Sandlin, CHIP director for Alabama's Department of Health.

Further research in Alabama yielded some in-depth background on why children did not have health insurance:

- Costs too much: 44%.
- No longer eligible for Medicaid: 25%.
- Lost/changed jobs: 18%.

• Employer dropped health coverage: 2%.

• Child had a pre-existing condition: 1%.

• Other: 10%.

Alabama state research also showed that the two main reasons for ineligibility for CHIP were that families were either over the required income limit or below it (qualifying the family for Medicaid). Other reasons included requested cancellations, nonpayment of premiums, other insurance, on Medicaid, over required age limit, and no response to correspondence.

In its first year, Wisconsin's CHIP program, BadgerCare, enrolled more than 77% of the state's eligible children. Enrolling and re-enrolling children and families presented their own unique challenges, said Susan Wood, director of Wisconsin's Department of Health and Family Services. The first step was to focus the state's approach.

"We found there was a welfare stigma, so marketing is important. We focus on 'health insurance for working families,'" Ms. Wood said. "And the public approval of the state's governor helped dispel the stigma, too."

Other lessons that Wisconsin officials have learned to improve CHIP include:

• Seamless, family-based coverage results in high enrollment for both Medicaid and CHIP.

• Integrating programs and data collection presents opportunities to understand the target population and their health status and to improve participation in other entitlements.

• Select and package administrative and policy options to reach families who have never applied and to address barriers that cause eligible

SHW at the 2000 NASHP Conference

families to drop out.

Simplifying the program as much as possible is also a goal for BadgerCare. Automating support for new mail and phone options for applications and reviews has helped. The program now does its review annually instead of semi-annually, participants have an option to do program reviews and file applications by mail, and there are reduced verification requirements.

Overall enrollment for BadgerCare is 70,651. About 77% of the targeted group of uninsured children under 200% of poverty in the state have been enrolled in Medicaid or BadgerCare in the first 12 months of the program's operation, according to state officials. ■

HCFA guide on printed materials available

Jeanne McGee, president of McGee & Evers Consulting Inc. in Vancouver, WA, has prepared a writing and designing guide for the Health Care Financing Administration. "Writing and Designing Print Materials for Beneficiaries: A Guide for State Medicaid Agencies," is available from HCFA's Center for Medicaid and State Operations. Request the guide, by mail, by writing to:

Health Care Financing Administration
Office of Internal Customer Support
Administrative Services
Group SLL-B-15
7500 Security Blvd.
Baltimore, MD 21244-1850

Or fax a request to (410) 786-1905. Ask for HCFA publication No. 10145. ■

When designing materials, go to the source

Choosing a long-distance carrier and making health care choices have many similarities. Both are complex and require the ability to take in information and make an informed choice. But making the right choice about long-distance calling and health care have very different and far-reaching consequences, too.

That was the point Robert Friedland, director of the National Academy on an Aging Society of Washington, DC, made at the National Academy for State Health Policy

conference in Bloomington, MN, in August. Similar skills are used for making both decisions, he said, but with about 40% of the population suffering a lack of literacy skills problems, and 21% functionally illiterate, the cost of health care soars.

There are expenses, he explained, as simple as having health care workers spend time making sure patients understand instructions for taking their medication properly. The cost, overall, he said, goes into the billions annually.

Reaching this population is tough. Some experts in the field contend that it is hard to tell when people have trouble reading or retaining information because they have developed skills over the years to mask their deficiencies. Functional illiteracy, Mr. Friedland said, is not necessarily tied to education. It also can result from aging, when reading and retention skills of an educated person can drop, for instance, following retirement. Locating the enemy can often be as tough as combating it.

The best way for health care workers to fight the problem is to go

directly to the source, the patients, said Jeanne McGee, president of McGee & Evers Consulting Inc. in Vancouver, WA. Her company prepared a writing and designing guide for the Health Care Financing Administration (HCFA) last year so that workers could design materials to reach those with literacy problems. (To order guide, see box, at left.)

"There are a combination of ways to communicate," Ms. McGee said. "We rely heavily on feedback from readers."

Ms. McGee created a six-step model for helping health care workers develop and test their print materials:

- 1. Identify goal and intended audience.**
- 2. Research to learn about audiences and issues.**
- 3. Develop and test materials.**
- 4. Distribute materials.**
- 5. Assess effectiveness.**
- 6. Use feedback to make further improvements.**

She cautioned about using formulas when creating printed materials, especially formulas for determining the grade level of the intended reader.

"Be cautious because it's hazardous to take it too seriously," she said. "They are based on words and sentences, short words vs. long words and sentences. It's mechanical and the assumption is the reader is mechanical, a robot. [Formulas] don't take into account what they bring to the material. Short sentences are not always the best."

It is humbling to find out that people do not understand your materials, no matter how simple and readable you thought they were, Ms. McGee added.

Ms. McGee suggested that the best way to approach judging the readability of materials was to be patient and invest in staff education, training, and development.

Use audience research by learning about the various cultures of potential readers, and take the time to use the proper graphics. Find graphics, she said, that will attract and hold readers' attention and allow them to focus on the main points. Next, make a mock-up of the document and test it by interviewing potential readers.

The interviews should identify whether the material is appealing, culturally acceptable, easy to understand, well-organized, and if readers can actually put the information to use. Several rounds of testing are important, Ms. McGee added.

Her tips for successful testing include:

- Explain the purpose and process to participants to encourage candor.
- Ask questions in a way that allows and encourages people to say what they think without feeling pressured or inhibited.
- Suspend your assumptions; be sure to ask about reasons why.
- Be nondefensive; it's a rewarding if humbling experience.

Daniel Rubin, health policy coordinator, of the Office of Policy, Legislative, and Constituent Relations of Olympia, WA, said using emotional material is another way to get a point across to readers. His example was a comic book showing the hazards of smoking that was created for young readers. He said drawings and characters are often more accessible and understandable to readers instead of straight text.

Mr. Rubin also suggested that creators of health care materials keep in mind that their potential audience is not always future patients, but also health care management and policy-makers. ■

See NorthSTAR

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pharmaceutical costs have more than doubled over initial projections in the months the program has been operational. "We had projected pharmacy costs of \$300,000 per month based on the area's experience before NorthSTAR, but the costs have been averaging more than \$700,000 a month. We worked with the state to explore ways we could address the problem, perhaps through sharing the risk, but couldn't agree on terms to do that, and the department couldn't see a way to drop pharmacy from the benefit design."

Mr. Niemi says the problem was not only caused by inflation in pharmacy costs but by the program having more people taking prescription drugs than were doing so before the pilot started.

One of the advantages seen in the program by state officials is that more people are receiving care. They report that in the first six months of NorthSTAR, 15,360 low-income people in the seven counties received mental health care, an increase of 21% over the same time period the previous year. An additional 3,731 people received treatment for drug or alcohol abuse during the first six months of the new system, also an increase.

An executive with the other contractor, ValueOptions, says the "whole industry has problems with pharmaceutical costs, and all of us are looking at it." But Howard Glassroth, vice president for ValueOptions, tells *State Health Watch*, "There is no reason at this point for us to change our current contract."

He declined to comment on reports that the state agency is seeking to have ValueOptions take over Magellan's clients until the contract is re-bid in 2001. "There would be a lot of issues for us to weigh and look at. We intend to discuss all kinds of things with the state."

Consumer and provider reactions to NorthSTAR haven't been solicited yet, although state officials say they've heard few complaints; they add that if people were getting out of care and were really upset about the system, they would be complaining.

Underfunding may be the Achilles' heel for the innovative program that was intended to increase access to care, improve quality of care, improve member and provider satisfaction, improve cost effectiveness, integrate mental health and chemical dependency service delivery systems, and use managed care to improve quality of services and cost efficiency through competition.

"Agencies will need to explore how extensively programs are funded now and what will happen when they go into managed care."

Steve Niemi

*Senior Vice President
Magellan Public Solutions Group
Columbia, MD*

Mr. Niemi says having two contractors was a key to giving patients a choice, and he says that even if ValueOptions handles all patients for an interim period, when the program is re-bid, the goal will be to have more than one contractor. Previously, Medicaid recipients and other low-income people could get mental health care only from MHMR centers in each of the seven-member counties. NorthSTAR brought private providers into the mix, although recipients sometimes complain that Magellan and ValueOptions favor short-term treatments over more intensive long-term care.

Texas reportedly has been near the bottom of the list historically in terms of state funding for mental health care. The executive director of the Mental Health Association of Greater Dallas told news media there that the "amount of money put in [for NorthSTAR] was ridiculous. Any time for-profit entities come into a system . . . and still cannot turn it around, it speaks very loudly to the fact that this system is terribly underfunded." And state Sen. John Carona said that managed care "can never be a substitute for adequate funding. If the base funding continues to be as meager per capita as it has been, I don't think NorthSTAR or any system like it can work."

Mr. Niemi says that as a result of its experience with NorthSTAR, Magellan will be much more selective in contracting for public-sector programs in which it assumes risk, especially for pharmacy costs. "I think we're going to be reluctant to take a contract that has pharmacy on a risk basis."

Mr. Niemi says public agencies are going to have to become much more concerned with how adequately a program is funded. "Agencies will need to explore how extensively programs are funded now and what will happen when they go into managed care. Success in new programs usually is measured by how much money is saved and how much of an increase there is in people accessing services. [Public agencies] need to look at the service continuum before and after managed care funding and ask themselves if there is pent-up demand" that is going to explode once a contractor is in place.

Despite the Magellan decision, Tom Turnage, MD, executive director of the Dallas Area NorthSTAR Authority says, "I think for the most part it's been a good year. Any time you have a project of this size . . . you're going to run into some issues."

[Contact Mr. Niemi at (800) 458-2740 and Mr. Glassroth at (800) 236-4648.] ■

NYC Medicaid managed care contractor gets extension despite advocate concern

Maximus, the contractor that operates the New York City Medicaid CHOICE managed care program, has been given a 24-month, \$40.8 million contract extension by the state of New York, despite concerns expressed by state officials, complaints filed by the Legal Aid Society, and a request from consumer advocates that contract extensions be given one month at a time until issues are resolved.

Under the contract renewal, Maximus will continue to operate the New York Medicaid CHOICE program as it continues its rollout and will provide managed care education and enrollment services to 1.2 million Medicaid recipients in New York City. It also will handle education and enrollment services for Nassau and Suffolk counties.

"I think they need to make an example of an organization that's been doing things incorrectly and hand out some punishment to send a message that this shouldn't be happening."

Judy Wessler
Policy Coordinator
Commission on the
Public Health System
New York City

Judy Wessler, policy coordinator for the Commission on the Public Health System in New York City, tells *State Health Watch* that advocates have been concerned about Maximus' performance for a number of reasons, some of which have been made public.

She says her organization and others eagerly await a forthcoming Health Care Financing Administration review of the company's work. Ms. Wessler had urged monthly contract reviews and extensions because "we have a company with major responsibilities that has a cloud hanging over its ability to do what it needs to do."

Looking for a stronger response

State Health Watch reported in November 1999 that there were some problems with the initial rollout of the CHOICE program, including enrollment materials not available in the many languages needed, exempt individuals receiving enrollment packets, and providers telling consumers they must enroll to be able to continue receiving services. At that time, state and city officials said they thought the rollout was going well, given its magnitude, while advocates painted a less optimistic picture.

Ms. Wessler told *State Health Watch* that government agencies needed to make a stronger response to the problem of enrollees being told they must choose a particular HMO to continue receiving mental health services.

"I think they need to make an example of an organization that's been doing things incorrectly and hand out some punishment to send a message that this shouldn't be happening." Now she says problems have continued and Maximus shouldn't be receiving a contract extension.

For its part, Maximus is claiming considerable success. It says its telephone helpline is available in five languages, and its counselors can communicate in 12 languages. In the past two years, it says, it has sent more than 600,000 educational and

enrollment packets to individuals with Medicaid and has held more than 400 presentations per month in the five boroughs that make up New York City. It subcontracted with more than 50 community-based organizations to help reach Medicaid consumers in their own neighborhoods and conduct educational workshops in their native language. As a result of these accomplishments, said Maximus CEO David V. Mastrian, MD, the contract extension and expansion "is a validation of the quality work Maximus provides to its clients. We are proud of the excellent work we have performed for citizens of New York. Maximus looks forward to continuing to increase the understanding by the Medicaid population of the health care options available to them, and improving their access to quality health care."

State officials say that of the 79,326 Medicaid recipients enrolled through May in areas of the city where Medicaid managed care is mandatory, 81% picked their health plan voluntarily, significantly more than the 60% contract target.

Susan Dooha, director of health policy at the Gay Men's Health Crisis and co-chair of the New York City Task Force on Medicaid Managed Care, who had raised concerns with *State Health Watch* in 1999, told *The New York Times* that "the state and city are paying good taxpayers' dollars for an effort that is falling far short and hurting the health care of low-income New Yorkers."

But Maximus official Daniel Walsky said the company has a grasp on what needs to be done. "We're not in a process of total denial," he told *The Times*. "Any issue that comes up, whether we think it is supported or not, we will go back and train our staff."

[Contact Ms. Wessler at (212) 749-1227.] ■

Anesthesiologists say states oppose Medicare nurse anesthetist proposal

The American Society of Anesthesiologists in Park Ridge, IL, says that every state medical society in the United States and most major medical specialties are opposing a Health Care Financing Administration (HCFA) proposal to no longer require that nurse anesthetists with advanced training be supervised by a physician when administering anesthesia in a hospital setting.

The doctors say the medical community's show of support challenges the agency's stated reason for the change — to give states control over health care matters.

"I think that if you walk down a hospital corridor six months after this takes effect, you won't see any difference. This is not a change in practice, just in billing. I think the opposition has blown it all out of proportion. Doctors may believe there is some control slipping away from them, but they never really had it."

Jan Stewart
President
American Association of Nurse Anesthetists
Park Ridge, IL

"There is a distinct difference between medicine and politics," says Ronald A. Mackenzie, DO, president of the American Society of Anesthesiologists. "We in medicine

do not implement a change without knowing that we first will 'do no harm' to the patient. Many politicians, however, are willing to implement changes, knowing they can reassess their decisions and, if necessary, change them back. Doctors practicing medicine cannot do that."

The doctors say HCFA should keep the current level of physician involvement unless science shows that patients will not be harmed by the proposed change. They say a Pennsylvania study due to be published this summer showed a significantly higher patient death rate when a nurse is not supervised by an anesthesiologist.

But officials of the American Association of Nurse Anesthetists (AANA) in Park Ridge, IL, representing certified registered nurse anesthetists, say, "senior citizens will be just as safe as they've always been."

A Wirthlin Worldwide study of seniors conducted last year showed that two-thirds of the Medicare patients questioned said it was not necessary for nurse anesthetists to be supervised by their surgeon as long as the two work collaboratively during the operation.

AANA president Jan Stewart, CRNA, tells *State Health Watch* that when HCFA introduced its proposal, "this decision removes the supervision requirement for a hospital to be paid by Medicare. It doesn't affect providers. I think that if you walk down a hospital corridor six months after this takes effect, you won't see any difference. This is not a change in practice, just in billing. I think the opposition has blown it all out of proportion. Doctors may believe there is some control slipping away from them, but they never really had it." ■

Home health agencies want in on self-directed care

Home health agencies in Washington state that opposed legislation allowing the physically disabled to self-direct their own health care are now signaling an interest in amending the law to include their staffs as covered providers.

As the law is now written, only independent contractors may provide services under the direction of a disabled person, and the services may be provided only in the disabled person's home.

The Washington Aging and Adult Services Administration says that those who are disabled, live at home, are age 18 or older, and want to direct their own care must:

- tell the health care professional who has ordered the treatment that they want to direct an individual provider to perform the tasks;
- have the necessary knowledge and ability to train someone to perform the tasks;
- train the personal aide or individual provider to perform the tasks;
- supervise the performance of the personal aide or individual provider.

Ignoring patients

The bill, which passed last summer, arose out of changes to the state's nurse practice act. Hearings on nurse delegation legislation that was approved in 1995 raised awareness among members of the state's disabled community that they were left out of the equation.

Toby Olson, executive director of the Governor's Committee on Disability Issues and Employment, says disabled people listened to discussions about conditions under which a nurse could delegate authority to perform personal tasks to personal assistant providers and realized that the debate was ignoring the

patients for whom the tasks were performed.

Public forums on self-directed care followed the nurse delegation debate, aided by a health department study of self-directed care initiatives in other states. Mr. Olson said the graduate nursing student who did the study for the department had been skeptical of the concept but ended up a believer based on what she found in other states, a conversion that helped convince people to support the concept.

Patty McDonald, program manager with the Aging and Adult Services Administration, tells *State Health Watch* that case managers continue to be concerned about liability, especially since the legislation does not include a specific list of tasks that can be self-directed.

"Who may be held liable if a bad outcome occurs depends on a variety of issues. For example, if the physician prescribes an inappropriate treatment, the physician is liable," she points out. "If the disabled person gives the care provider the wrong instructions, the disabled person is liable. If the care attendant performs the task incorrectly or refuses to follow directions, then the care attendant is liable."

Ms. McDonald sympathizes with the challenge facing case managers. "Case management is one of the most difficult jobs a person can undertake. The case manager is responsible for supporting the client and that includes support in implementing the plan of care. If self-directed care tasks are not performed as outlined in the plan of care, the case manager may offer assistance and training, or help the client obtain an alternative. People with a disability do not have to self-direct. They also do not have to self-direct all of their needed care. For example, they could choose to

self-direct their medications, but not their wound care. This is part of the service plan development process that the case manager and the client must work out."

Mr. Olson says participation in the law remains low as the program gets started. "It's still very early in implementation, and it's hard to say anything about it yet," he tells *State Health Watch*. "We haven't seen any particular problems."

The Washington law appears to have been one of the most liberal at the time it was adopted. According to Mr. Olson, many states still do not support self-directed care even for activities of daily living, such as dressing, that are not covered by professional licensure.

Ms. McDonald says a study of the self-directed care law is due to the state legislature in 2001. Researchers from the University of Washington School of Nursing in Seattle are looking into the impact of the bill in terms of consumer satisfaction with self-directed care including these points:

- perceptions of degree of autonomy, self-direction, and choice allowed by the bill;
- service quality and consumer safety as determined both by consumers and by quantifiable outcomes;
- number of reports that personal aides abused or neglected a consumer;
- number of cases of consumer neglect or abuse that directly caused medical or social emergencies;
- whether consumers were coerced into accepting self-directed care or caregivers were coerced into performing tasks that they were not trained to do.

[Contact Ms. McDonald at (800) 422-3263 and Mr. Olson at (360) 438-3168.] ■

Special project funds California community groups to help neighbors receive needed health care

Funded by an \$8.5 million grant from The California Endowment in Los Angeles, seven consumer groups are attempting to demonstrate that independent, community-based organizations can help people navigate an increasingly complex health care system to obtain the services they need.

The three-year grant went to six Health Consumer Alliance assistance centers in six California counties and the Sacramento-based Health Rights Hotline. Together they serve areas that include more than 60% of California's poor.

Health Consumer Alliance project director Stan Dorn says the organization's ombudsprogram has three elements:

1. help consumers to get the health care services they need;
2. provide education and information to consumers;
3. perform a systemic analysis of health access barriers and attempts to overcome them.

The alliance started work in 1998 with a two-year, \$5 million grant from The California Endowment. Mr. Dorn says it has helped more than 25,000 people with health access problems. The consumer assistance programs are operated by community-based legal service organizations.

According to a report issued by the group, 9,000 cases were resolved by:

- counsel and advice to consumers (39%);
- referral to other agencies (22%);
- other brief services (17%);
- negotiation without formal proceedings (4%);

- administrative appeals decisions (0.4%);
- negotiated settlements of litigation, primarily collection actions against indigent consumers (0.2%);
- court decisions, primarily collection actions against indigent consumers (0.09%);
- other outcomes, including client withdrawal, client ineligible for service, and claims found to be without merit (18%).

"These programs have the expertise to clarify and resolve problems at an early stage, before they endanger consumers' health."

Gwen Walden

*Senior Program Officer
The California Endowment
Los Angeles*

Mr. Dorn tells *State Health Watch* that while the organization's main goal is to help the more than 1,000 consumers who come to it each month, its work provides a "great opportunity to see what the systemic access problems are." It is also working on a database of uniform, comprehensive information about the problems consumers bring and their resolutions.

The alliance can analyze results by gender, income, age, race, ethnicity, language, immigration status, area of residence, source of health coverage, health plan, medical group, self-identified disability status, health care need, and other factors.

The Health Consumer Alliance says it is in a position to provide "not

just compelling anecdotes, but also the objective data needed to discern the extent to which problems are truly systemic. We then work collaboratively with other stakeholders to seek effective solutions to the problems our consumers' experience."

The endowment's support for the project follows announcement of studies indicating that millions of uninsured California children and their parents qualify for public programs but are not enrolled. Recent studies show that Californians are far more likely to be uninsured than are other Americans.

Mr. Dorn says the alliance's programs offer a "very innovative approach to address the growing complexity of the health care system." In addition to navigational assistance and direct advocacy, the alliance offers educational programs on topics such as where to obtain health care coverage, health care for immigrants, the Children's Health Insurance Program, MediCal (California's Medicaid program), and how to use an HMO properly.

In the first two months of this year, 10,000 low-income consumers and staffs of organizations serving low-income communities attended education and outreach events sponsored by a variety of groups including:

- 20 children's organizations;
- 20 local government agencies
- 18 community health centers and other health care providers;
- 12 Asian community groups;
- 12 organizations focused on mental health and substance abuse issues;
- 10 health care or consumer coalitions;
- nine Latino community groups;



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- nine faith-based organizations;
- nine social service agencies;
- nine disability rights groups or organizations serving people with disabilities;
- 30 other groups.

Consumer education materials in 11 languages are available on the alliance Web site.

In recent years, federal and state lawmakers have considered public funding for independent consumer assistance. To help the public and policy-makers assess the potential benefits and drawbacks of such assistance, the grant will also fund University of Southern California researchers to evaluate the alliance and its hotline.

Under California's new Department of Managed Care, which opened July 1, consumer assistance programs are expected to work closely with the state agency as stipulated in an HMO reform package signed into law last year. Independent assistance programs will supplement the department's work by providing local expertise in solving consumer problems and furnishing intensive assistance to individual consumers when necessary.

"These programs have the expertise to clarify and resolve problems at an early stage, before they endanger consumers' health," says Gwen Walden, senior program officer, for The California Endowment. "Independent consumer assistance programs help make the voices of the most vulnerable Californian consumers heard in the health care debate."

At the end of the five years of alliance work, Mr. Dorn hopes the evaluation will find that there is a need for independent, community-based, local assistance to help consumers with the health care system and that the work of the alliance will be able to continue through government funding and then be replicated in other communities.

"If a community-based agency can develop a real track record," he asserts, "local trust in it can develop, and it's that kind of trust that is missing in today's health care system."

[Contact Mr. Dorn at (510) 302-0445.] ■

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