State Health Watch

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Anesthesiologists ask Bush to overturn nurse anesthetist rule

Buoyed by a presidential extension of the implementation date for a controversial rule allowing state professional practice laws and hospital bylaws to determine which licensed professionals can administer anesthesia, the Park Ridge, IL-based American Society of Anesthesiologists (ASA) is lobbying Tommy Thompson, secretary of Health and Human Services, to rescind the rule that was approved by the Clinton administration Jan. 18, just two days before leaving office.

"We are getting information to the new administration," Philip Weintraub, ASA spokesman, tells *State Health Watch*. He says Mr. Thompson has received a comprehensive outline of reasons why the rule should be rescinded.

The anesthesiologists have long opposed the proposal that would allow nurse anesthetists to administer anesthesia to Medicare and Medicaid patients without being supervised by a physician.

"States and hospitals can always exceed basic Medicare rules," says ASA president Neil Swissman, MD, "but seniors should not have to worry about their Medicare coverage based

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You say you want an evolution? Many states say they expect change with new administration

This year is a turning point for Medicaid and managed care, a time when administrations are changing places and bringing with them a chance to put a new mindset into the mix. There is an evolution to another level of government and health care.

The 5th Annual Congress on Managed Medicaid & Medicare

But evolving into what? Those gathered at the 5th Annual Congress on Managed Care and Medicaid in Washington, DC, held in January, had a chance to hear from leaders in the field, both private and public, who voiced their views and concerns while government changed hands at 1600 Pennsylvania Ave.

Many conceded that how the Bush administration deals with health care can have a ripple effect on the rest of the country.

The appointment of Gov. Tommy Thompson of Wisconsin to head Health and Human Services got many nods of approval, especially for his positive record of handling Medicaid and the federal government through BadgerCare, his home state's program for insuring low-income

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the program. Also, making sure that the program is properly staffed is key. Toss in a package for expectant moms that includes a diaper bag, baby bath towels, a thermometer, and a pre-programmed cell phone, and you have a program its administrators are proud of. A report from the Fifth Annual Congress on Managed Medicaid & Medicare in Washington, DC 5

For many states, e-health means benchwarming, not benchmarking

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Mathematica Policy Research and the federal government say states could put a wide-ranging mental health benefit for children and adolescents in place under the Children's Health Insurance Program for about $18 per month, per enrollee. They say it would be worth the cost in the long run. But not everyone is convinced it is the right thing to do 9

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on where they live or where they travel. In the name of patient safety, we are urging the secretary to conduct a thorough review of all available and verifiable data on this subject. This is a significant opportunity to overturn a grave mistake, one that was based on politics and not on science."

Meanwhile, those on the other side, represented by the American Association of Nurse Anesthetists (AANA), also in Park Ridge, IL, hailed the new rule as "smart health care policy because it will ensure access to safe, high-quality anesthesia care in medically underserved areas, especially in rural and inner-city hospitals where certified registered nurse anesthetists are often the sole anesthesia providers."

"All surgical patients can now rest assured that they will receive the highest caliber of anesthesia care, even if they live far beyond the city limits. The issue has never been about quality of care, but about access to care. AANA applauds HCFA for staying the course and ultimately carrying through with its initial plan."

Larry G. Hornsby, CRNA
President
American Association of Nurse Anesthetists
Park Ridge, IL

An association spokesman said, as a result, hospitals and ambulatory surgery centers will be able to receive reimbursement from Medicare without requiring surgeons or other physicians to supervise nurse anesthetists.

"All surgical patients can now rest assured that they will receive the highest caliber of anesthesia care, even if they live far beyond the city limits," says AANA president Larry G. Hornsby, CRNA.

"The issue has never been about quality of care but about access to care. AANA applauds HCFA [the Health Care Financing Administration] for staying the course and ultimately carrying through with its initial plan," he says.

For its part, HCFA said its decision to allow certified registered nurse anesthetists to practice without supervision where state laws permit is consistent with the agency's commitment to decrease regulatory burden by deferring to state licensing laws regulating professional health practice.

The final rule was proposed in 1997 in an effort to restructure and refocus Medicare's conditions of participation for hospitals so they focus on outcomes rather than regulating processes.

"The final rule recognizes the states' traditional domain in establishing professional licensure and scope-of-practice laws," a HCFA fact sheet says.

"It does not prohibit, limit, or restrict in any way the practice of medicine or prevent anesthesiologists from administering anesthesia or supervising another professional. The new rule allows an appropriate level of regulatory flexibility without compromising patient health or safety. Research has demonstrated that a variety of factors contribute to the unprecedented safety record for anesthesia administration that now exists in this country.

"Advances in medical knowledge, implementation of practice guidelines, better drugs, and safer equipment all have contributed to better quality care," the fact sheet states.

HCFA says that according to the 1999 Institute of Medicine report on medical errors, the number of deaths from errors in administering anesthesia has dropped from two deaths per 10,000 patients receiving anesthesia in the 1980s to approximately one death per 200,000 to 300,000 patients today — a 40- to 60-fold improvement.

"There is no evidence that CRNA [certified registered nurse anesthetist] independent practice would cause adverse outcomes," the HCFA statement claims. "There also is no evidence that states are any less concerned with ensuring the quality of care and safety of their citizens than is the federal government, or that states have been unsuccessful in overseeing other health care professional practice."

Speaking for the anesthesiologists, Mr. Swissman says there has been a "basic but critical misconception that has clouded this issue from the beginning — that the practice of anesthesiology involves only the administration of anesthetic agents." Rather, he says, it "requires continuous medical judgment before surgery to diagnose a patient and determine the best anesthetics to use, during surgery when split-second decisions are made, and after surgery when recovery of the patient and pain treatment are critical. Nurses are not doctors and should not be expected to make those critical decisions."

"Instead of heeding the warning flags, HCFA chose to disregard the research rather than taking it to the next logical step."

Neil Swissman, MD
President
American Society of Anesthesiologists
Park Ridge, IL

Mr. Swissman also points out that there is no scientific research to support the rule change and that a study by the University of Pennsylvania in the summer of 2000 reviewed the care of 235,000 Medicare patients and determined that there were 25 needless deaths per 10,000 cases when an anesthesiologist was not involved in the care.

"Instead of heeding the warning flags, HCFA chose to disregard the research rather than taking it to the next logical step," he says.

"To make it worse, HCFA still has offered absolutely no scientific evidence of its own that this change will maintain the current level of safety," Mr. Swissman adds.

Expecting that argument from the anesthesiologists, HCFA says the University of Pennsylvania study "is not relevant to the issue involved in this rule. It did not compare CRNA practice with nonanesthesiologist physician supervision to CRNA practice without physician supervision. It does not provide sound and compelling evidence to support maintaining federal preemption of state law."

As the press release bickering over turf continues, the nurse anesthetists have tried to stake out the high ground.

"Despite the difficult and sometimes personal debate between AANA and ASA over the issue," a release issued when the rule was approved says, "AANA leaders sounded a note of confidence that the rule marks the beginning of a new era of cooperation.

"Mr. Hornsby cast his sights on the future and called on ASA to work with the nurse anesthetists and other health care practitioners to make anesthesia even safer."

Mr. Hornsby was quoted as saying, "We hope this will put an end, once and for all, to the federal supervision debate. We urge ASA to work with AANA on important health care issues confronting anesthesia providers and to work together for the common good of patient safety."

Mr. Swissman later said that despite the fact that the only new evidence supports the current involvement of a physician, "HCFA caved in to political pressures and issued this inappropriate, dangerous new rule."

[Contact the ASA at (847) 825-5586 and the AANA at (847) 692-7050, ext. 3043.] ■

Health care evolution

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families. Some conference attendees and speakers see Thompson working to shift responsibilities from the federal government to individual states.

"The new president could redesign the Medicare programs," said Judith Moore, co-director at the National Health Policy Forum in Washington, DC, a nonpartisan education program serving senior federal, state legislative, and regulatory health staff.

Thompson will not shift Medicare responsibility to the states in a sudden move, said Alan Weil, director of the Assessing the New Federalism project at the Urban Institute in Washington, DC. If there is a shift in power, he said, it will be a gradual one.

In a shift of power to states, added Vernon Smith, a principal with Health Management Associates in Lansing, MI, the federal government must look at the combination of Medicare and Medicaid to determine the proper amount of responsibility. In 1996-97, Medicaid program costs were flat, he said, adding that the Congressional Budget Office had forecast an increase of 8% to 9% for the program.

The cost increases will create trouble, Mr. Smith predicted, and states will eventually want more flexibility to solve the problems created by the high prices.

Leonard Kirschner, principal with William M Mercer, a global consulting firm, added that Mr. Thompson had looked at programs in Wisconsin that combined both Medicaid and Medicare.

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Whatever combination is considered, according to Ray Hanley, director for Medical Services, with the Arkansas Department of Human Services in Little Rock, the new presidential administration must be more flexible than the previous administration in finding ways to cover the uninsured.

The threats of recession and inflation, or a combination of the two, looming over the country could unveil a hard truth in the national health that has been hidden behind 10 years of fabulous economic growth; there are still millions of people who do not have proper health care.

"The new president and Congress might throw more money at the problem. There will be a scramble, and states will then begin to change programs to cover parents."

Alan Weil
Director
Assessing the New Federalism
Urban Institute
Washington, DC

A recent Commonwealth Fund Task Force on the Future of Health Insurance reports that roughly 30% of Americans ages 19 to 29 lack health insurance.

The task force added that the number of older adults and children without health insurance is about half of the total number of young adults reported without insurance. The Children's Health Insurance Program (CHIP), available through state programs, is working to cover entire families, not just children. Will the trend to cover parents through the efforts of the states continue?

Patricia MacTaggart, senior advisor, for the Center for Health Plan and Providers at the Health Care Financing Administration in Baltimore, sees the programs continuing to make children's health care their priority.

"The new president and Congress might throw more money at the problem," Mr. Weil added. "There will be a scramble, and states will then begin to change programs to cover parents."

Bruce Vladeck, senior vice president for policy at Mount Sinai New York University Health and director of the Institute for Medicare Practice, sees a recession as inevitable.

Either this year or next, since no one has repealed modern economic principles, a recession will come along, bringing with it a change in the country's health care priorities, he predicted.

A recession will show the limits of states' abilities, and there will be lots of action in state legislatures to handle increasing number of uninsured, Vladeck added.

He also said to expect the expanded use of Medicaid waiver authority.

More must be done with waivers, Mr. Hanley said, because it will give more flexibility to states.

Two keys to covering more of the uninsured, according to Mr. Weil, were:

• The new administration needs to be more flexible in finding ways to cover those without insurance.

• The administration must find ways to help employers make CHIP more successful.

Flexibility was a word often used by speakers and attendees when discussing new ways to handle old business. Prescription drugs got the same treatment. "When it comes to prescription drugs, states must have more flexibility in dealing with costs," Mr. Hanley said.

The Blue Cross and Blue Shield Association annual "State of the States" report showed that drug formulary legislation is near the top of

the list of priorities. Last year, according to the study, 23 states tried to control prescription drug costs by creating or expanding public subsidy programs.

"Inflation never went away in drug costs," Mr. Hanley said. A prescription drug benefit for managed care is on the table in Washington, DC, and it is up to President Bush to turn it into law, he pointed out. "It is up to the president. Without presidential leadership, nothing will get done on this issue."

The complexity of rules governing health care providers and state authorities has not gone away, either. Increasingly rules and regulations are added to the books across the country, sometimes clarifying health care procedure but oftentimes complicating them.

Margaret E. O'Kane, president of the National Committee for Quality Assurance talked about attending a conference on MediCal in California recently. She said she was struck by the number of people who came to her complaining of the labyrinth of rules and regulations they must negotiate every day in order to do their jobs.

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"We are wasting a lot of money and driving a lot of people nuts," Ms. O'Kane added.

The call for more legislation continues. Mr. Hanley said states must continue to resolve conflicts that are created by the legislative branch of government. "Are there too many regulations?" he asked. "We need to question this."

[Contact Mr. Hanley at (501) 682-1197, Mr. Kirschner at (602) 522-6539, Ms. Moore at (202) 872-1390, Mr. Smith at (517) 482-9236, and Mr. Weil at (202) 261-5709.] ■

Keeping expectant moms happy is key to a happy GEMS program

For Horizon Mercy, proper staffing is the first step toward a successful health care management program.

If you have the wrong people, it won't work. If you don't give them the proper resources, it won't work," Robert Robison, MD, Horizon Mercy's chief medical director, told those attending the Fifth Annual Congress on Managed Medicaid and Medicare.

Horizon Mercy, part of Horizon Healthcare of New Jersey Inc. in Trenton has 95 hospitals in its network that offer Get Early Maternity Services (GEMS), which ushers through 90% of Horizon Mercy's deliveries for New Jersey Medicaid recipients.

Providing a program that works for the public is only part of the battle. GEMS also must make money.

"Our chief financial officer has to see if there is a return on investment before he will approve anything for the program," Mr. Robison said. A major step to accomplishing that: "Get clinical outcomes. Then you get the savings."

Mr. Robison said Horizon Mercy makes money by being in contact with the Medicaid recipients and their families. "We had 30,000 touches last year, that includes telephone calls and home visits." In all there are 185,000 members in Horizon Mercy's plan.

Staying in touch with those members can be tremendously difficult. Many in the Medicaid population who need GEMS, through Horizon Mercy or another provider, become disenfranchised because they have poor access to transportation or the provider is not properly trained in cultural competencies.

"Plans must understand that different cultural groups seek pregnancy attention at different times," said Martha Fountain, who is responsible for the Utilization Management Department at Horizon Mercy. "For example, expectant Puerto Rican mothers seek treatment at a different time during the pregnancy than expectant African-American mothers."

"Plans must understand that different cultural groups seek pregnancy attention at different times."

Martha Fountain
Utilization Management Department
Horizon Mercy
Trenton, NJ

Not getting early maternal care can end up costing the state big bucks, not to mention being bad for the health of mother and child. The cost of care from pre-term birth at 30 weeks, according to Ms. Fountain, can easily be $500,000, not including post-discharge care and long term follow-up.

One of the most important steps Horizon Mercy takes, according to Ms. Fountain, is risk stratification, dividing expectant mothers into these categories:

• High risk: A member with a past history of pre-term labor or pre-term delivery or complications with the current pregnancy.

• Moderate risk: A member with a past or current medical history that requires surveillance and appropriate interventions if and when conditions change. Members are monitored

through regular telephonic outreach each trimester, which provides an opportunity for health teaching as well as early identification of changes toward high-risk status.

• Social risk: A member with psychosocial risk factors without significant medical history that could negatively impact pregnancy outcomes. Members are managed by social workers for evaluation, support, and referrals.

• Low risk: A member with no significant medical or social indicators that would put her at risk for complications of pregnancy.

Key to Horizon Mercy's GEMS program is intense involvement by case managers to develop early positive and supportive relationships with the moms to be. Some of Horizon Mercy's case managers call on the expectant mothers daily.

Horizon Mercy also has a gift incentive program to enhance GEMS, which includes regularly scheduled visits to participants' obstetricians throughout their pregnancies. The office completes and signs a GEMS postcard that shows the member has completed a scheduled visit.

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In addition, every trimester, the expectant mom receives a package that includes a diaper bag, baby bath towels, a bath thermometer, and educational brochures regarding a healthy pregnancy.

For the past four years, Ms. Fountain said, Horizon Mercy has operated its cellular phone loaner program. The telephones are pre-programmed to connect the program participants with Horizon Mercy in case of emergency. The phone is returned after the pregnancy.

"I haven't come across another health plan that does this," Ms. Fountain added. ■

For many states, e-health means being a benchwarmer, not a benchmarker

Governments go through plenty of convolutions when deciding their place in the electronic world.

No government wants its computer system to be obsolete overnight. Or to spend hundreds of thousands of dollars on new technology only to find the system inadequate for the state's needs. But on the limited budgets that state governments have to work with, it is easy for any of those scary scenarios to become reality.

"States don't have the knowledge and wherewithal to address these problems," explains Tina Nye, chief operating officer for Schaller Anderson, a medical consulting firm in Phoenix. "For example, [requests for proposal] often are obsolete when the time comes for implementation."

There is no alternative but to take a stand. States must get in the electronic pool with everyone else, make the best decisions they can with their limited resources, then live with the consequences. Ms. Nye told members of the Fifth Annual Congress on Managed Medicaid and Medicare that the Internet, intranet, and wireless communications have forced the medical community and governments to adapt to the new technologies.

"Eight years ago, there were 50 Web sites," she said. "Now there are 170 new Web sites every hour."

In 2000, Ms. Nye said, 52 million people in the United States went to the Internet for medical information. But millions of others who could be well-served by the Internet have no access to it.

As with any technology, she said, there are many economic barriers and they must be overcome. There is a large imbalance now, she added, saying that 100% of payers are doing business on the Internet, but the rest of the U.S. population, the Medicare population, the Medicaid population, and providers are nowhere near that figure. Those with the least amount of computer knowledge, including the Medicaid population, will be expected to learn to use and access information through the Internet in order to function in society, Ms. Nye said. Slightly higher use of computers and the Internet, she added, comes from the Medicare population, though that figure is now only 18% to 20%. "It is not that significant."

Companies and governments "must adapt core, basic business processes to the Internet," Ms. Nye said.

"States should buy their own systems, then distribute them to providers so that all platforms can communicate. If not, you'll end up with a tower of Babel. Medicaid should be the driving force to get all [proposed] systems to committee, and everything should be HIPAA-compliant."

Steven Lutzky
Chief
Office on Disabilities and Aging
District of Columbia Department of Health

"We must educate ourselves and who we work with." Providers must adapt to electronic enrollment information, eligibility information, economic information, and how to collect and receive payments electronically.

She said consumers must learn to check and change their eligibility information in order to function well within the system.

Simplification is key, whether it is governments or businesses choosing the best system for their needs or whether it is consumers using the electronic system to their advantage. One e-health guru looked into the future for consumers and pondered about what it is and what it should be.

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"Why can't [the system] work like an ATM?" wondered Clive Riddle, president and creator of Managed Care On-Line, which offers managed care information over the Internet. "You have a card, you put it in and make your choices. We're in the Stone Age."

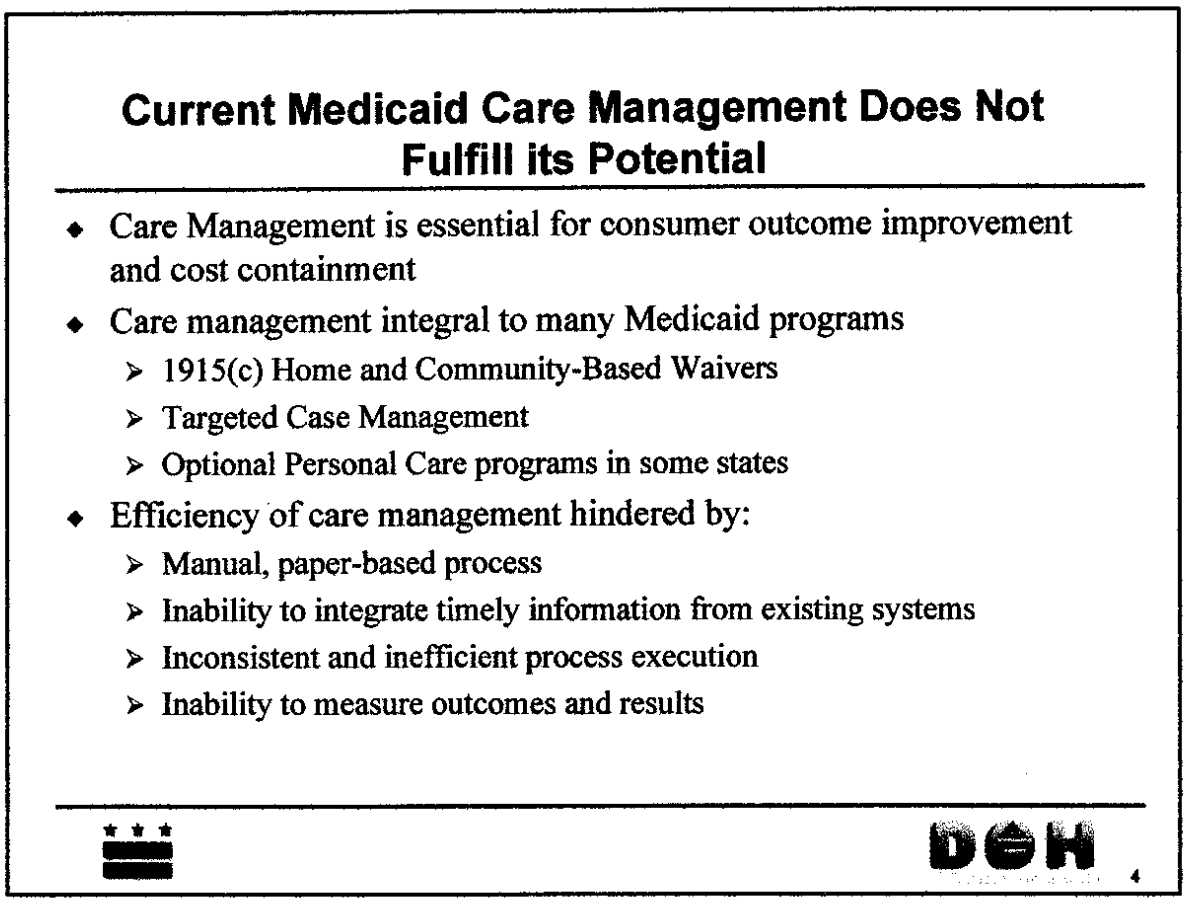
With the number of seniors in the United States getting higher every day, Mr. Riddle said providers should be more forward-looking than they are. "CEOs say, 'Those [consumers] are not plugged in.' But that is only partially true. The perception is that seniors do not use the Internet, but they are the fastest-growing group of users."

Government is often way behind the electronic pace, according to Steven Lutzky, chief of the Office on Disabilities and Aging for the District of Columbia Department of Health. "Are we innovators? Benchmarkers? In the states, we're benchwarmers."

But as the future unwinds, Mr. Lutzky foresaw e-health as "supercharging case managers, helping them to do their jobs much better.

"PalmPilots especially will be helpful to case managers as they make their rounds, shrugging off the excess heft and worries about theft that go with visits to high-crime areas." He also advised state health workers to not develop their own software for e-health.

"States should buy their own systems, then distribute them to providers so that all platforms can communicate. If not, you'll end up with a tower of Babel," he said. "Medicaid should be the driving force to get all [proposed] systems to committee and everything should be HIPAA-compliant." ■



Source: Steven Lutzky, PhD, Chief, Office on Disabilities and Aging, Medical Assistance Administration, District of Columbia Department of Health.

TennCare gets high marks for access and care, but financial and provider problems remain

Researchers from the University of Tennessee Center for Health Services Research in Knoxville say that members of TennCare, Tennessee's often-maligned managed care program for 1.3 million people who are Medicaid-eligible, uninsured, or uninsurable, are experiencing better health and better health care than under the previous Medicaid program.

"TennCare has improved access to insurance for Tennesseans, particularly for those with chronic illnesses who often are refused insurance through private insurance companies," says James E. Bailey, MD, an associate professor in the university's departments of medicine and preventive medicine. Mr. Bailey says, however, that little change has been made in the overall number of Tennesseans who are uninsured, because:

1. Fewer people are being offered employer-sponsored insurance.

2. Private insurers are becoming less likely to insure people with preexisting conditions.

3. Many people added to the program as uninsured or uninsurable were actually previously insured but changed to TennCare because of its generous benefits package.

Mr. Bailey tells *State Health Watch* that he had taken on the research project "with a strong bias that TennCare has done bad things for quality." But evidence from 10 other studies he reviewed "is overwhelming that TennCare has not made things worse," he says.

Statewide research using administrative data and a regional study based on chart review data have demonstrated substantial improvements in mammography rates for women served by TennCare. Statewide research using administrative data also has demonstrated marked improvements in well-child visit rates. Two studies have demonstrated no significant changes in exposure and timeliness of prenatal care. A study in Tennessee and North Carolina demonstrated markedly improved coronary revascularization rates for patients under TennCare after a heart attack. Studies also have shown improvements in diabetes care and outcomes for diabetics, improvements in processes and outcomes for HIV and AIDS, decreases in emergency care and hospitalizations for asthma, and either no change or slight improvement in infant mortality and the occurrence of low birth weight in the state.

Familiarity with PCPs helpful

While Bailey and his colleague, David Mirvis, MD, director of the research center, did not pinpoint reasons for improvements in health care, they hypothesize that much of it is due to patients having greater exposure to primary care providers. They say that when patients know who their primary care providers are, there is an increase in visits to the providers and a decrease in emergency room visits. "Paying someone upfront to assume responsibility as a primary care provider yields the greatest share of improvement," Mr. Bailey says. "There are a lot of bad things one can say about TennCare, but when you ask what has happened to patients, you mostly see improvement."

Mr. Mirvis tells *SHW* that legitimate concerns about the program deal with financing and organizational problems that "threaten the viability of essential safety-net providers and could adversely affect quality of care and public health throughout the state. It's harder to maintain quality of care as resources fall. If the financing falls apart, the gains we've seen are going to be lost."

TennCare has had problems with its effect on providers, according to Mr. Bailey. Particularly affected have been managed care organizations, academic medical centers, and safety-net hospitals. "There still are advantages for providers who don't care for sick people. The academic medical centers are taking care of the sickest of the sick but are not paid any more. Lots of uninsured patients are going to safety-net hospitals. But all Medicaid disproportionate share payments have disappeared, and it's been devastating to the array of services that safety-net providers are now able to offer. Per person flat payments under TennCare punish nonprofit and academic medical centers that provide more care for the more severely ill people that go to them."

State looking for solutions

Bailey says an access problem could develop because TennCare accepts people that private insurance will not cover and also offers a more generous benefits package than many private policies. "With the generous benefits, people come out of the private sector and into the public sector, and businesses are off the hook. Unless TennCare directly competes with private industry or private industry is forced to insure the same types of patients, the problem will continue to grow." Mr. Bailey and Mr. Mirvis say a governor's commission is looking at the TennCare policy, and they contend the state legislature is looking for help in solving the dilemma.

[Contact Mr. Bailey at (901) 545-7196 and Mr. Mirvis at (901) 448-5826.] ■

Should states broaden CHIP mental health benefits?

Researchers at Mathematica Policy Research Inc. in Washington, DC, and the federal government's Substance Abuse and Mental Health Services Administration say states could put a wide-ranging mental health benefit for children and adolescents in place under the state Children's Health Insurance Program (SCHIP) program for about $18 per month per enrollee, and they suggest that it would be worth the cost in the long run.

In an article in the November/December 2000 issue of *Health Affairs*, they note that SCHIP plans are still evolving and states are experimenting with the structure of their mental health and substance abuse benefits.

The importance of good state mental health benefits was underscored earlier this year when U.S. Surgeon General David Satcher, MD, released a National Action Agenda for Children's Mental Health, which outlines goals and strategies to improve services for children and adolescents with mental health problems, as well as their families.

In the United States, according to Satcher's report, 10% of children and adolescents suffer from mental illness severe enough to cause some level of impairment. But it is estimated that in any given year, fewer than 20% of those children receive needed treatment. "The burden of suffering by children with mental health needs and their families has created a health crisis in this country," Mr. Satcher says. "Growing numbers of children are suffering needlessly because their emotional, behavioral, and developmental needs are not being met by the very institutions and systems that were created to take care of them."

Embry Howell, vice president at Mathematica, tells *State Health Watch* that rather than undertake original research, she and her government colleagues looked at past empirical studies on the mental health needs of children and adolescents and the types of services they receive when they are offered. They then developed a cost model based on a number of criteria and estimated the cost of offering a broad package of services under a number of assumptions.

States can provide coverage by expanding Medicaid, designing a separate insurance program, or combining the two approaches. States expanding Medicaid coverage must offer the full Medicaid benefit package, and states designing new programs must offer a benefit package that is comparable to one of three private benchmark insurance plans:

- the Federal Employees Health Benefits Program Blue Cross standard option plan;
- the state's employee health benefit plan;
- the HMO with the largest number of commercially insured members in the state.

Of particular importance for mental health services, a SCHIP plan must include coverage that is equivalent to 75% of the actuarial value of the benchmark plan for four services: prescription drugs, mental health, vision, and hearing.

The survey of other studies indicated that mental health coverage differs greatly between Medicaid expansion and benchmark plans. "While both types of plans cover traditional inpatient and outpatient care," the article states, "Medicaid expansion plans are much more likely to cover residential, partial hospitalization, case management, and school health services."

States with benchmark SCHIP plans are allowed to charge copayments for services, which generally are not allowed for Medicaid expansion plans. Although day and visit limits are allowed under both options, most states do not use such limits extensively in their Medicaid expansion plans, meaning they are more common under benchmark plans.

Ms. Howell says the review of the literature supports Mr. Satcher's concerns about prevalence, with estimates ranging from one-tenth to one-third of children and adolescents with a diagnosable mental health problem.

Poor children more at-risk

Poverty is associated with mental health problems, with prevalence rates somewhat higher for the poorest children then for higher-income children. The research also shows that at least 5% of children and adolescents in the United States use some mental health services each year. Generally, the Medicaid population has the highest rate of mental health service use, while privately insured children have the lowest rate.

Studies indicate that outpatient treatment shows the strongest evidence of effectiveness, and reasonable evidence also exists that partial hospitalization improves child behavior and family functioning. Evidence for the effectiveness of residential treatment centers and inpatient care is limited, Ms. Howell says, and community-based care generally is considered to be more cost-effective.

SCHIP plans with significant copayment requirements may disproportionately affect children and adolescents with mental disorders. Further, a recent study found the most common provider of care to be schools, which treated approximately 70% of children receiving mental health services. Ms. Howell's article

says that turnover in the SCHIP population creates issues of consistency in benefit coverage and source of care.

The article reports that studies suggest several features that are likely to be important in designing effective mental health benefits under SCHIP:

- broader coverage than found in typical private insurance plans;
- case management services;
- school-based care;
- limited copayments;
- Medicaid expansion programs for children with serious mental health problems since they are more likely to return to Medicaid.

Ms. Howell says the research and cost modeling "show that a broad range of mental health services can be supported under SCHIP for about $18 per month in 1998 constant dollars, or less if lower prevalence and utilization is assumed." She tells *SHW* the estimates were based on Medicaid and CHAMPUS utilization rates, which are likely to be much higher than SCHIP rates, meaning that the cost estimates might be too high.

Although a recent study of Medicaid capitation rates suggest that the $18 per month estimate could be lowered, Ms. Howell says there are "several reasons to be cautious in using capitation rates to make such judgments. Medicaid capitation rates often do not include the full scope of services that we have used in our estimates. It may be best to consider our estimate an upper bound for what could be expected under SCHIP should a broader range of services be covered."

[Contact Ms. Howell at (202) 484-5277.] ■

Clip files / Local news from the states

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

State offers to offset cost of eye exams

FRANKFORT—A new state law that requires small children to get an eye examination is aimed at preparing youngsters for school.

But for some uninsured Kentucky parents, paying for that exam isn't easy.

The exams, which sometimes can cost around $75, are covered by most family health insurance plans.

Now the state is willing to help families who don't have insurance. The Cabinet for Health Services announced that $150,000 is available to pay for the eye examinations, which became mandatory in July for children entering Kentucky public schools for the first time.

Families are eligible for assistance if they don't qualify for Medicaid or the Kentucky Children's Health Insurance Program, and if their income is between 200% and 250% of the federal poverty level. For a family of three, that would be an annual income between $28,300 and $35,375.

—*Herald-Leader*, Lexington, KY, Jan. 25

Iowa looks to regain millions that accidentally went to hospitals

DES MOINES, IA—State officials say they are trying to negotiate a deal with Iowa's hospitals to recover millions of tax dollars paid to the hospitals in error.

The Iowa Department of Human Services recently notified the Iowa Hospital Association that the state inadvertently exceeded federal spending limits on Medicaid payments to hospitals for inpatient services.

According to the association, the state estimates the potential overpayment for last year alone is $10 million to $11 million.

That's just the beginning. The state has concluded that overpayments of an undetermined size were made annually from 1996 through 1999, and that payments for outpatient services at University Hospitals in Iowa City exceeded federal limits in 1996, 1997, and 2000.

State officials are working with the Health Care Financing Administration, which oversees Medicaid spending, to resolve the matter. So far, no one at the Department of Human Services is willing to say how much taxpayer money may have been misspent through the overpayments.

Jessie Rasmussen, director for the Department of Human Services, said that's because the state and the hospitals are trying to agree on how much is owed and how the money can be repaid.

"We've got some numbers, but we're trying to be careful because we want to work with the hospital association," she said.

"We're not out to set up problems for the hospitals. They serve our people, and we don't want to damage that. So we're going to want to negotiate with the hospitals about reasonable payback periods for them, and then we'll want to take that into our negotiations with the association," adds Ms. Rasmussen.

—*Des Moines Register*, Jan. 25

States spend plenty in treating drug abuse, but prevention dollars go by the wayside

WASHINGTON, DC—State governments are spending billions of dollars to pay for the consequences of drug and alcohol abuse while giving scant attention to prevention and treatment efforts, a private research center reported.

The group called for a "revolution" in spending priorities, showing that states spend an average of 96 cents of every dollar in their substance-abuse budgets to cover cost increases that drug and alcohol abusers bring to law enforcement, social services, and health care. Meanwhile, just 4 cents in each dollar go to drug abuse prevention, treatment or research.

Altogether, states spent $81.3 billion — more than 13% of their combined total operating budgets of $620 billion — covering the damage wrought by drug addiction on public programs in 1998. Alcohol was the biggest drain, accounting for $9.2 billion in state spending.

"It's an incredibly lopsided way to deal with the problem of substance abuse. We need a revolution in the way governors and state legislators look at this problem," said Joseph A. Califano Jr., president of the National Center on Addiction and Substance Abuse at Columbia University in New York City.

The center spent three years analyzing spending in 45 states plus the District of Columbia and Puerto Rico to generate the report.

Figures were even more lopsided for the cost of substance abuse among children. There, the report found that only $1 out of every $113 spent on juvenile justice, child welfare, and other areas goes to prevention and treatment.

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Vice President/Group Publisher: ***Brenda Mooney****, (404) 262-5403, brenda.mooney@ahcpub.com.*
Editorial Group Head: ***Coles McKagen****, (404) 262-5420, coles.mckagen@ahcpub.com.*
Managing Editor: ***Lee Landenberger****, (404) 262-5483, lee.landenberger@ahcpub.com.*
Production Editor: ***Ann Duncan****.*

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The center used studies linking substance abuse to public spending in order to estimate the impact of drug use on government budgets in each state.

The numbers do not include the federal share of education, welfare programs, or Medicaid. They also do not account for the effect of substance abuse on private insurance costs and lost workplace productivity.

—*Reuters Health*, Jan. 29

Rhode Island has plenty of confusion on exactly how much the tab costs

PROVIDENCE, RI—Christine Ferguson, state human services director — a candidate for a top health care post in the new Bush administration — recently went before one of Rhode Island's legislative panels to explain why her agency is overspending its budget for this year by $19.5 million in state and federal dollars.

At Ms. Ferguson's request, U.S. Sen. Lincoln Chafee (R-RI) has written to Vice President Richard Cheney recommending Ferguson for the top position in the Health Care Financing Administration (HCFA).

"Christy offers the new administration a wealth of experience in health care and human services," Mr. Chafee wrote of Ms. Ferguson, who was a key staff member to his father, the late Sen. John H. Chafee, during his unsuccessful efforts to forge a compromise on health care reform in the early years of the Clinton administration.

Her prospects for a job in the Bush administration remain uncertain.

Ferguson was casting blame at the Clinton-era HCFA for her state agency's inability to impose some of the cost-controls that lawmakers here approved last year in an effort to rein in the exploding costs of RIte Care, the state's much-heralded health insurance program for low- to middle -income families with children.

—*Providence Journal*, Jan. 26