



State Health Watch

Vol. 8 No. 8

The Newsletter on State Health Care Reform

August 2001

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In the struggle to survive, rural hospitals are battling the odds

While times are tough for hospitals no matter where they are located, rural hospitals fight more of an uphill battle than their urban counterparts.

Two skirmishes are highly visible and reflect the flaws hospitals face every day. Outside the city, the scramble for reimbursement dollars yields less than inside the municipal limits. And the work force has made it obvious it would rather be in the city.

Supporters of the Rural Health Care Improvement Act, which was introduced to Congress in June, have high hopes that the federal legislation can help even the playing field.

"Traditionally, rural hospitals have been reimbursed at a lower rate for Medicare. The thinking is that they have different costs than urban hospitals," Alan Morgan, vice president of government affairs and policy for the National Rural Health Association in Kansas City, MO, tells *State Health Watch*. "People can drive 30 to 50 miles into the city to work for higher wages. If you look at individual rural hospitals, no two are alike, though some are doing OK, but by and large, that's not the case."

The Improvement Act's highlights include:

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Most states still in the planning phase for Olmstead implementation, ADA compliance

It's been two years since the U.S. Supreme Court decision in the landmark *Olmstead* case, and 11 years since the passage of the Americans with Disabilities Act (ADA). Most states are in the midst of planning how to implement the court's order that they provide community-based services for people with disabilities in the following scenarios:

- Treatment professionals determine that such placement is appropriate.
- The affected individuals do not object to such placement.
- The state has the available resources to provide community-based services.

While expressing appreciation for the manner in which states are conducting their planning process, including involving those who are disabled, advocates are concerned about the slow pace of progress but seem inclined to give a bit more time before mounting full-scale legal or public policy objections.

The National Conference of State Legislatures (NCSL) in Washington, DC, recently conducted a 50-state survey to determine initial state responses to the June 1999 *Olmstead* decision. NCSL's Wendy Fox-Grage,

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Rural hospitals

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- removing the cap for rural hospitals that receive disproportionate share hospital payments, which would funnel more money to the countryside and bring more parity with city hospitals;

- closing the gap between urban and rural standardized inpatient payment levels;

- streamlining wage index reclassification for all hospital services, not just inpatient and outpatient;

- providing loans and grants to help rural facilities with capital improvements and high-tech acquisitions.

"You have a situation where, nationally, rurals are losing money or just getting by," Mr. Morgan says. "But at the same time, you have medical safety concerns. Hospitals must update their technology. There are also new regulations on privacy; there's HIPAA [the Health Insurance Portability and Accountability Act of 1996]. Hospitals across the country must revamp how they do things to address these regulations. Plus, many were built 20 to 30 years ago and must improve their infrastructure."

The balancing act also must include not just federal action, but cooperation from the states too, Mr. Morgan says, mostly in the search for capital.

James Lewis was involved in starting HomeTown Health in Cumming, GA, a coalition of 20 rural Georgia hospitals, in 1997, and he says he doesn't see much cooperation coming from his state or the federal government. Appealing to the state for money is a constant process for him and his organization, which has seen its membership dwindle by eight hospitals in the past few years.

"I believe there is a consensus at a high level of the federal government that goes back to the states that says,

'We don't need these rural hospitals and we're going to let many of them close,'" Mr. Lewis tells *State Health Watch*. "There may be in the state of Georgia, in the next two or three years, as many as 15-plus hospitals that will close."

HomeTown Health has gotten the state to come through with some money, but Mr. Lewis says that it is not enough.

"Personnel stress is a common problem and fixing it is not just a money issue. Some places have a hard time keeping open. Reimbursement levels will slowly erode a place over time."

Thomas Ricketts

Researcher
Rural Policy Research Institute
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"In terms of big bucks coming back to the rurals, it has not occurred," he says. "[Government] listens real good, gins a nice song, but [it's] distracted by the patient's bill of rights and prescription drugs for the elderly."

Money is a hot button with Mr. Lewis and every hospital he deals with; reimbursement is the shiny red paint on that button. He says there are a handful of good state legislators in Georgia's capitol building that understand the needs of rural people and the hospitals that serve them. But there aren't enough of them to have the impact that needs to be made, he says.

The business offices of rural hospitals are incapable of handling the complex reimbursement issues they face, Mr. Lewis says, and that is a

guaranteed loss of revenue.

"There are tremendous denials," he says. "They have jerked the reimbursement problem around so drastically that coders are probably the poorest trained people in the hospital. So the business office and the coders — the gatekeepers — get it wrong going in."

When the access information is miscoded, Mr. Lewis adds, there is little chance of getting the revenue the hospital should have collected. Even under the best of circumstances, this is a hospital's Achilles' Heel, and for rural hospitals, it's probably worse than it is for urban hospitals, he adds.

"Nursing is a huge problem. Personnel stress is a common problem and fixing it is not just a money issue," Thomas Ricketts, a researcher with of the Rural Policy Research Institute's Hospital Flexibility Program Tracking Project for Region B in Chapel Hill, NC, tells *SHW*. "Some places have a hard time keeping open. Reimbursement levels will slowly erode a place over time."

He says states have a strong role to play in keeping rural hospitals and health care alive and vital. The Tracking Project keeps tabs on rural hospitals that are designated as critical access hospitals (CAH). The CAH program, according to the Rural Policy Research Institute, requires participating states to support and implement community-level outreach and technical assistance. Very small rural hospitals, those with only 15 beds, often are involved in this program that includes participation from the feds, the state, the local community, and the hospital administration. The combination of heads at the table is one of the program's strengths, Mr. Ricketts says.

"Some states see this as a federal program, and it has a federal stamp,

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Medicare Rural Hospital Flexibility Program

Source: North Carolina Rural Health Research Policy Analysis Center, Chapel Hill.

but it is meant to develop state resources," he says. "Here is money from the federal government to allow states to do what they want to do in rural health care. It's an opportunity for states to take money from the feds and handle it as they feel is appropriate. It takes a political commitment on the part of states to help these rural hospitals."

With 50 states to consider, Mr. Ricketts adds, there are 50 levels of strength and sophistication when it comes to managing and funding CAHs, with the best states serving as brokers to ease the way in overcoming deficits. The fed has committed \$25 million annually to support the CAH flex program, with \$775,000 as the upper-level grant. Some hospitals use the money for recruitment and retention, others for their emergency medical services, and others for upgrading data and tracking for modern quality assurance. The amount issued varies to the degree that the individual state can spend.

"Nebraska is a strong state," Mr. Ricketts asserts. "They basically have agencies within state government that are not antagonistic about turf and who is responsible for what. The licensing agency can do its job, keep the Medicaid agency involved, keep support mechanisms involved."

"The state removes barriers to bureaucratic programs. It can bring people together to make hospitals work better. A sharing, caring environment makes things work. . . . We are aware of places where there is conflict between agencies, that Medicaid takes a hands-off view, the licensing agencies take a strict view. I don't know any magic formula for it, but political considerations can keep programs in limbo as conflict between government offices increases," Mr. Ricketts says.

Dave Palm, administrator for the state of Nebraska's Office of Public Health in Lincoln, has seen three rural

hospital closings since 1998, and one has since reopened as a CAH. He says 53 of the state's 58 rural hospitals are likely to convert to rural access, meaning they cannot have more than 15 acute care patients at any one time.

"That's made a big difference for us in terms of financial viability," Mr. Palm tells *SHW*. "We will see some closures because of low volume. This is not a panacea and will not prop up rural hospitals, but it has made a big difference."

He acknowledges the same concerns that vex rural hospitals across the country — personnel retention and reimbursement. The Nebraska

Hospital Association does its best to train rural staff about the labyrinthine complexities of coding, but it's not always enough.

"With corporate compliance and HIPAA, things are getting more and more complex rather than moving in the other direction," Mr. Palm says.

What's needed, he explains, is more capital for expansion and updating of hospital facilities. "A lot of facilities were built in the 1940s and '50s and are getting old. There isn't money to upgrade them," he says. "We have to be concerned about that. It's not like we're pumping millions of dollars out for this." ■

Adverse-events data shared in Minnesota

A new law in Minnesota will allow hospitals, doctors, and health care professionals from across the state to share patient safety information in ways that previously were impossible.

The law changes the Minnesota Peer Review Statute, which previously inhibited the exchange of information from one hospital to the next for fear of litigation. In essence, Minnesota hospitals could learn from adverse events within their own organizations, but not others.

Senate File 560 was championed by the Minnesota Hospital and Health care Partnership (MHHP) in Minneapolis, an association representing Minnesota's 142 hospitals and 20 health systems. Signed into law recently by Gov. Jesse Ventura, the new measure allows hospitals, doctors, and medical staff to report medical errors anonymously in a web-based registry that can be aggregated and accessed by other health care professionals and the public.

Individual patient and caregiver information is not provided, only the data needed to learn from the event, says Bruce Rueben, president of MHHP.

"This law will improve patient safety," Mr. Rueben says. "Minnesota hospitals fought hard to create this web-based registry. By capturing and sharing information on medical accidents regardless of whether or not a patient is harmed, hospitals can provide safer care and prevent mistakes before they happen."

Scott Anderson, vice president of information services with MHHP, says a key aspect of the system is that it is voluntary. "Hospitals understand the importance of learning from each other," Mr. Anderson says. "This system will help facilitate that process because it is designed to capture both adverse events and near misses."

MHHP launched a pilot program with a few hospitals in June, with plans for a statewide rollout later in 2001. The new law was scheduled to take effect Aug. 1. ■

Olmstead implementation

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one of the survey report's authors, tells *State Health Watch* that there were a number of reasons why states are moving slowly. "A major reason is that 37 of the states have formed a task force or commission to handle the planning process. Usually, they are very open and have included all the major players. That inclusiveness has affected the pace of the process. We expect a lot to happen over the summer and will be analyzing all the state plans later this year."

Ms. Fox-Grage says four states — Missouri, North Carolina, Ohio, and Texas — have issued final comprehensive plans that appear to meet recommendations that were laid out by the Health Care Financing Administration, which is now the Centers for Medicare and Medicaid Services (CMS). None of the plans have been implemented yet, she says, because they were published only recently and full implementation is contingent upon new state appropriations. In addition, six states have issued "significant papers, many of which contain thoughtful recommendations that are not intended to be comprehensive."

Governors and legislatures have been significantly involved in the process in many states. Governors in 17 states created the planning commissions, and several appointed commission members. In 10 states, governors actually issued executive orders to create a planning commission. Because of this involvement, the commissions will issue their reports to the governors and, in many cases, to the legislatures as well. In California, Hawaii, Illinois, and Kentucky, legislation was adopted to form their commissions. Legislators and legislative staff sit on the commissions in Missouri, Utah, and Wisconsin.

NCSL says legislatures will play their most significant role in their next legislative session when most of the commissions will have developed their plans, and agencies will be submitting budget requests to implement those plans.

"States have been on notice for a while, although *Olmstead* was the first case through the Supreme Court. The fact that 11 years after the law was passed, we're just beginning to plan to plan is surprising."

Jennifer Mathis

*Staff Attorney
Bazelon Center
for Mental Health Law
Washington, DC*

Although *Olmstead* specifically involved two women with mental illness and developmental disabilities, NCSL says the federal government has made it clear that the Supreme Court decision applies to all disabled people, regardless of their age. Thus, it says, "most states are assessing their systems of care for people with developmental disabilities, people with physical disabilities, people with mental illness as well as older people with disabilities. In addition, plans include many subgroups, including (1) institutional residents whose needs can be appropriately met in the community; (2) residents in community-based settings who require institutional care, and/or (3) people who reside in the community and are

at risk for institutionalization because of the absence of care."

Complexities identified by many of the commissions include how to:

- assess people who are at risk for institutionalization;
- define institutionalization and review and measure placement activities in institutions;
- develop the service infrastructure within the constraints of the personal care attendant and nursing aide shortage;
- find accessible, affordable community-based housing;
- access transportation;
- identify sources of funding within state budgets.

Jennifer Mathis, staff attorney with the Bazelon Center for Mental Health Law in Washington, DC, tells *State Health Watch* that advocates wonder why states are taking so long, when the ADA has been in effect since 1990 and there is a very clear integration mandate in Title II and a number of court decisions favoring those with disabilities since the early '90s. "States have been on notice for a while, although *Olmstead* was the first case through the Supreme Court. The fact that 11 years after the law was passed, we're just beginning to plan to plan is surprising."

While advocates recognize that implementing integration of disabled people into community-based services is a complex process, Ms. Mathis says, they think there's no good reason why it shouldn't have been started before now. "It's heartening to see that the states are beginning the process, but the slowness of the pace is disappointing."

Although some lawsuits are under way, Ms. Mathis says the general consensus in the disability community is to try to work through policy channels before resorting to wholesale litigation. One thing that has slowed advocacy efforts has been the need to defend the constitutionality of the ADA. "In one

sense, we've been backtracking because advocates have been forced to defend the constitutional underpinnings of the law, and that has taken energy away from implementation."

Elizabeth Priaulx, an attorney with the National Association of Protection and Advocacy Systems (NAPAS), also in Washington, DC, says advocates she works with are concerned because states are only in the planning process. "Individuals who have already been found appropriate for community services may not be moving into those services as quickly as possible. We want to be sure that states don't use the planning process as a delay to moving people, claiming that their plan must be done first."

Ms. Priaulx says she is pleased that states are involving consumers and the disabled in the planning process. She expresses hope that once the plans are done the states will consider them a "living document" to be referred to, funded, and evaluated each year, rather than being put on a shelf and ignored. NAPAS member organizations will be involved in quality assurance and monitoring to ensure the plans are used, she adds.

While the principles being enunciated in state plans seem good, Ms. Priaulx says, they lack specific time frames to move people to community-based services, and that can be a problem. "There's a serious lack of numbers in many of the plans. They have recommendations that aren't tied to funding streams or deadlines."

Another concern, Ms. Priaulx says, is that in some states, there are several agencies maintaining independent planning tracks with no apparent plan to integrate them. "*Olmstead* calls for a comprehensive plan to overcome the bureaucratic hurdles."

[Contact Ms. Fox-Grage at (202) 624-3572, Ms. Mathis at (202) 467-5730, ext. 22, and Ms. Priaulx at (202) 408-9514.] ■

Can disease management work in Medicaid managed care?

With many commercial managed care companies using disease management programs to help contain costs, Florida's experience in trying to use disease management in a Medicaid managed care context could help other states considering such a move.

In 1996, the Florida legislature and the state's Agency for Health Care Administration began planning for the design and implementation of a chronic disease management program to overlay MediPass, the state's primary care case management program. Florida's chronic disease management program has been operational since May 1999, using contracts with seven vendors for five specific chronic illnesses:

- HIV/AIDS;
- diabetes;
- hemophilia;
- congestive heart failure;
- end stage renal disease.

Plans are under way to contract with vendors to provide services for cancer, hypertension, and sickle cell anemia.

While there is not enough experience with the program to evaluate its impact on health outcomes, the Center for Health Care Strategies (CHCS) in Lawrenceville, NJ, decided to examine the program in terms of key operational and policy issues that Florida dealt with in its planning and early implementation. Nikki Highsmith, an analyst with CHCS, tells *State Health Watch* there are some lessons to be learned from Florida's experience.

One problem in Florida was there were not enough linkages built between the vendor disease management organizations (DMO) and provider organizations. "[Administrators] essentially built two separate programs even though they were with the same people," Ms.

Highsmith says. "People had to learn to navigate through the two programs, and that made it hard for both beneficiaries and providers. Some vendors did well in connecting with physicians, but some did not."

Because physician participation is voluntary, the DMOs are required to contact a member's primary care physician (PCP) to secure his or her participation and to discuss these issues:

1. the role of the DMO regarding education and information about the relevant clinical guidelines and standards of care;

2. availability of case management services to members and providers;

3. requirement of the PCP to provide the DMO with access to encounter-level data/medical records in an effort to monitor and evaluate service delivery and program effectiveness. The DMO is neither contractually authorized nor responsible for physician credentialing, compliance monitoring, or utilization management.

Another potential problem observed by CHCS is that the Florida disease management program was structured to be voluntary for both beneficiaries and providers. "States should consider mandatory enrollment in chronic disease management programs," Ms. Highsmith's research report says. "Florida's program is voluntary. Many other states' Medicaid managed care programs, however, have shown that mandatory enrollment achieves higher enrollment volume [needed to achieve economies of scale] and controls for selection bias."

Florida's legislature mandated establishment of the nation's first and only statewide Medicaid chronic disease management program after receiving reports that it could reduce

the higher cost services such patients often require, while improving their quality of life. In anticipation of cost savings to be reaped from the program, the legislature reduced the Medicaid budget for FY 1997-98 by \$4.17 million, with an additional \$39.4 million decrease in FY 1998-99, and a decrease of \$20 million in FY 1999-2000. The pressure for early cost savings to offset the reduced appropriations undoubtedly has had an impact on the program.

As operated in Florida, the program has five elements:

- outreach and stratification;
- reimbursement and payment methodology;
- quality assurance and outcomes;
- provider roles and participation;
- care management.

Identifying participants

Recipients with target diagnoses are identified monthly through the state agency's retrospective claims analysis and are automatically assigned to a DMO. The vendor must contact the beneficiary to confirm eligibility for the program, complete a new member assessment, and solicit participation of the patient's PCP. The patient has 30 days in which to opt out of the disease management effort. CHCS says that while the assign in/opt out process has produced more enrollees than would have been expected in a purely voluntary program, it requires the vendors to contact individual members, and that can be a problem because many beneficiary telephone numbers are missing or incorrect. Recipients also can self-refer to the program.

Timely and accurate access to both clinical and utilization data by disease management organizations and physician leaders is critical to success of any disease management program, and that has been an issue in Florida, according to the CHCS study. "In Florida, the DMO is not responsible

for authorizing services, nor is it responsible for medical or pharmacy claims payment. This eliminates a rich [though not complete] data source from which to measure utilization variations and identify opportunities for intervention.

"The second and probably more complex side of the data equation relates to the accessibility of patient-specific clinical data contained in the patient medical record. The patient medical record is the 'data warehouse' — the one central data source containing physician orders, ancillary and diagnostic testing results, specialist consultation findings, and other medical history. DMOs must be able to access these data to truly manage patient care. For example, the DMO needs to identify, track, and evaluate the combination drug therapy regimens for HIV patients, measure the effectiveness and patient compliance with the results of viral load testing CD4 counts, and at the same time, promote and track other prophylactic services and treatments. . . . The DMOs are challenged to create accurate and efficient systems for collecting these patient data, whether through on-site medical record audits, clinical encounter level data reports, or a combination thereof. Absent highly technical and sophisticated systems for data exchange, integration of clinical data remains a manual, labor-intensive process, and one that is nonreimbursable."

Ms. Highsmith says that because many patients have multiple chronic conditions, they can be in more than one disease management program with more than one DMO. Having different vendors for each diagnostic category can make coordination of care difficult, she reports.

One state that has integrated a disease management program with its primary care case management program is North Carolina, whose Access program has been working successfully

in rural areas. Michael Keogh, a program consultant, tells *State Health Watch* that the state has been involved with PCP case management since 1991, and that effort has evolved into the Access 2 and Access 3 programs in select communities and counties.

The programs are an effort to improve access and quality and control costs through a collaborative joint governance process that allows all factions to be at the table. Disease management components focus on asthma, diabetes, otitis media, and other chronic needs, Mr. Keogh says. The community-based case management program uses registered nurses to work with high-risk patients who have been identified through an assessment form. State funds are used to support the local-level disease management activities. Under the theory that "local people know local needs best," the state pays \$2.50 per member per month for disease management and case management efforts, allowing the local organizations to hire local people to do the disease management work using protocols provided by national organizations.

Reducing ED visits

Mr. Keogh says quarterly chart reviews and analysis of emergency department (ED) visits have indicated the program has been successful in increasing the use of asthma drugs, for instance, and reducing unnecessary ED visits.

Mr. Keogh's advice to other states interested in emulating North Carolina's success is to recognize that "a community development model works." Rural residents don't want to lose control over the health care system in their communities, and the Access program helps them maintain control, he adds.

[Contact Ms. Highsmith at (609) 895-8101 and Mr. Keogh at (919) 733-2040.] ■

L.A. Care tries to identify and serve abused or neglected children in its membership

LA. Care, an independent entity created by the state of California to provide managed health care services to Los Angeles County residents, has started L.A. Cares for Kids in an attempt to identify abused or neglected children within its membership who are under the supervision of the Department of Children and Family Services and who live with their families under that department's Family Maintenance program. The intent is to ensure that the children's health care needs are assessed and met.

David Hollinger, manger for community benefits and program innovation at L.A. Care, tells *State Health Watch* that L.A. Cares for Kids came out of work the staff did several years ago with foster children who are carved out of the state's Medicaid program. They realized that another subset of children who likely could benefit from special attention was those who are part of the Family Maintenance program in which they still live with their family but are under county child protection agency supervision for abuse or neglect.

Children have multiple needs

"Research shows that abused children have many health issues: mental and physical health and developmental issues," Mr. Hollinger says. State workers soon realized they had no way to identify which of the children on their membership rolls were in the Family Maintenance program. "We assumed we had some, but they were invisible. There was no system in place for care coordination, provider training, etc. We saw several holes to be filled."

One key to getting the program off the ground, he says, was early collaboration with the Department of

Children and Family Services. A willingness to participate in and dedicate resources to solving health and related policy issues at the community level is part of L.A. Care's vision for itself and something the plan says distinguishes it from most other health plans.

"Providing community benefit requires cooperation and partnership with other entities striving to improve conditions for the least advantaged in our county. L.A. Care's approach to developing, implementing, and sustaining L.A. Cares for Kids is defined by our ambition and commitment to be accountable for the health and well-being of the members we serve and the communities where they live," Mr. Hollinger says.

The program summary says project goals are to:

- demonstrate an effective model of managed care delivery, utilizing provider training, care coordination, and patient tracking to promote the health and safety of vulnerable children;

- collect data regarding the unique health care needs of children in the Family Maintenance program, creating a baseline health profile to drive future policy development.

The goals are to be met by:

- establishing a means to identify eligible children;

- conducting provider training to improve assessments, services received, communication with families, and identification of risk factors for abuse and neglect;

- developing protocols for communication and coordination between health care providers and the child protection agency;

- designing a replicable care coordination process to ensure that each child receives prescribed health and

related services and to assist parents in gaining skills to manage their children's health needs;

- creating a data collection and evaluation system to gather baseline health data on the children and perform process and outcome based analyses of L.A. Cares for Kids.

Identifying those eligible

Mr. Hollinger says identification of eligible children on the L.A. Care membership rolls was accomplished by close contact with the county's Dependency Court, which issued an order allowing the child protection agency to release information on its clients to the health plan.

At any given time, he says, the county has 50,000 to 60,000 foster children, 10,000 children in the Family Maintenance program, and 2,300 to 3,300 of those children who are members of L.A. Care.

One of the initial hurdles in the project, which has been funded for three years, was the reluctance of families to be identified as participants in the Family Maintenance program. Mr. Hollinger says that during the planning process, L.A. Care conducted focus groups with families and found them to be generally very supportive, but concerned that the physicians would treat them differently if they knew about their family situation.

Concern was expressed by those whose physicians didn't know that the family had an open case with the county child protection agency, he says. Families whose physicians did know about the situation were very supportive, he adds.

Karen Goodyear, project manager, tells *SHW* that she is optimistic the program can work if the recruitment

barriers can be overcome. Since the children who are being identified already are L.A. Care members, their medical services continue as is, with the addition of services under the new program.

Involving the entire family

L.A. Care works with the entire family, so other family members receive benefits from participation in the program. "We have to work with the parents. That's what's going to make or break this program," she points out.

Ms. Goodyear says part of the case coordination work is to develop a transition plan for when families leave the Family Maintenance program. They also are working to identify needed resources such as transportation.

"We don't want to replace any existing services," she says. "We want to coordinate and augment them."

Working with physicians

In addition to working with families, the staff also work with physicians to be sure they have a systematic way to do rough screening on developmental issues and behavioral problems in the children who are in the program.

Goodyear says her criteria for success of the program include:

- gathering needed health data;
- increasing screening at the front end for developmental and mental health issues;
- training physicians and improving their ability to screen;
- increasing services accessed through care coordinators.

"We hope we can document coming up with a system that identifies the elements of what it took to make this work so it can be replicated elsewhere," Goodyear says.

[Contact Mr. Hollinger and Ms. Goodyear at (213) 694-1250.] ■

HHS plans single state contact for Medicaid/SCHIP by creating CMS

The Department of Health and Human Services (HHS) says one aspect of the morphing of the Health Care Financing Administration into the Centers for Medicare and Medicaid Services (CMS) will be naming a single Medicaid/State Children's Health Insurance Program (SCHIP) contact person to work with each state at the regional and central office levels. HHS documents announcing the agency name change and new initiatives directed at consumers said the contact persons will "troubleshoot, resolve disputes, and generally break through bureaucratic bottlenecks within CMS.

"We need to make sure that the people who are covered by Medicare know exactly what choices they have for their health care coverage."

Thomas Scully

*Administrator
Centers for Medicare
and Medicaid Services
Baltimore*

"They will also be directly accountable to the CMS administrator [Thomas Scully] and the director of the Center for Medicaid and State Operations as they respond to state issues," the documents stated.

Reforms announced by HHS Secretary Tommy Thompson are intended to make the agency more responsive to consumers, providers, and state officials, and make it a source of readily available help and information.

The new name was chosen after

focus group sessions with beneficiaries and interviews with other stakeholders. It is intended to increase consumers' understanding of the government's role in health care, while making sure that they know where to get the information and assistance they need about the Medicare and Medicaid programs, Mr. Thompson said.

CMS will conduct business through three subcenters:

- the Center for Medicare Management, which will deal with the traditional fee-for-service Medicare program;
- the Center for Beneficiary Choices, focusing on providing beneficiaries with information on Medicare, Medicare Select, Medicare+Choice, and Medigap options;
- the Center for Medicaid and State Operations, which will handle state-administered programs, including Medicaid, SCHIP, insurance regulation functions, survey and certification, and the Clinical Laboratory Improvements Act.

Based on comments by Mr. Thompson and others, it appears the initial push will be to position CMS as a consumer-friendly agency that can be counted on especially to help Medicare beneficiaries navigate their way through a very complex system.

"Few beneficiaries understand Medicare and the coverage options and costs associated with Medicare, such as Medigap and Medicare+Choice," HHS staff say.

"Results from the 1999 Medicare Current Beneficiary study found that nearly half of Medicare beneficiaries do not know they can select among different health plan choices within Medicare, and about one-fourth do not know that Medicare does not pay

for all of their health care expenses. More than half say they know little or nothing about the availability and benefits of Medicare+Choice plans. Only about one-fourth say they know everything or most of what they need to know," they explain.

The initial Medicare consumer push will include these actions:

1. expansion of a toll-free telephone call center to 24-hour service;
2. development, by Oct. 1, of a web-based decision-support tool to help users narrow down health plan choices available in their geographic area based on what's important to them and to allow a direct comparison of out-of-pocket costs;
3. a \$35 million national advertising campaign corresponding with the 2002 Open Enrollment period this fall to inform beneficiaries about the expanded services and sources of information available to them.

"We need to make sure that the people who are covered by Medicare know exactly what choices they have for their health care coverage," says Mr. Scully.

"Too many consumers just don't understand Medicare coverage options and the costs associated with them, from their Medigap options to Medicare+Choice to the cost of prescription drugs," he says. "We need to get that information to them and their family members, while working closely with the doctors and other health care providers who give them medical care."

Still to be seen is the degree to which these reforms can and will be applied to beneficiary outreach efforts to Medicaid and SCHIP. Studies of these programs often have indicated a need for more outreach to consumers and efforts to make the programs more understandable.

(For more information, see documents on the change in the news media section at <http://www.hhs.gov>.) ■

Clip files / Local news from the states

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

Appeals court rules that Vermont cannot offer certain deals for prescription drugs

MONTPELIER, VT—An appeals court has barred Vermont from offering reduced drug prices under a state program, saying a federal agency acted improperly when it approved the program.

Under the program, the state offered enrollees discounts of up to 30%, then required pharmaceutical companies to make up the difference. The Vermont plan had been approved by the U.S. Health and Human Services department.

The program, which has been copied by several other states, was challenged in federal court by a trade group representing the pharmaceutical industry.

A three-judge panel of the United States Court of Appeals for the District of Columbia Circuit ruled that Vermont lacked the authority to offer the same prescription rebates and discounts offered under federal Medicaid insurance.

Congress imposed those rebate requirements to reduce the cost of Medicaid, the court said, but because Vermont's program resulted in no Medicaid savings, the federal health agency acted improperly in approving it, the judges said.

—*Associated Press*, June 9

In New York, Medicaid expenses keep going up and are capped by regional lawmakers

ALBANY, NY—Capital region lawmakers called for the state to cap the local share of Medicaid expenses, which Albany County officials say have tripled in the past decade.

If Medicaid costs continue to escalate, the county will be forced to raise property taxes, said Albany County Executive Michael Breslin. The county's Medicaid bill has gone from \$34.7 million in 1996 to an estimated \$45.2 million this year to provide health care to 28,677 people.

"It's a wonderful idea to take care of people who otherwise would not be taken care of," Breslin said. "However, the cost of Medicaid and the way it has been forced on localities is not fair."

According to the state Association of Counties, New York is one of two states that make county governments pick up a substantial portion of Medicaid costs. The federal government pays for about half of program for the poor and elderly, while state and local governments split the rest.

—*Albany Times Union*, June 8

South Dakota legislators propose a rule limiting financial assistance for mental health treatment

SIOUX FALLS, SD—A new rule that would deny financial assistance to some people with mental health problems has a children's advocate worried.

The state of South Dakota has proposed a rule that would limit financial assistance to families making more than \$32,656 a year.

But Susan Randall, director of the South Dakota Coalition for Children, said the rule will deny aid to families that don't have enough money to pay for expensive treatments.

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“I just think this action, if approved by the Legislative Rules Review Committee, is shortsighted,” she said. “It’s a question of paying now or paying later. If some of these kids don’t get treatment now and later their behavior becomes more and more difficult, they could end up in trouble with the criminal justice system.”

—*Yankton Press and Dakotan*, June 11

Uncertainty about new technology and training causes Rhode Island to reassess guidelines

PROVIDENCE, RI—The state Health Department has turned away three companies that hoped to offer Rhode Islanders a new technology for diagnosing cancer and other illnesses, saying there are too many uncertainties about the best way to provide it. Instead, within the next few months, the department will develop a set of guidelines for the technology, and then ask for applications that meet those guidelines.

At issue is positron emission tomography, or PET, a sophisticated imaging tool that reveals the functioning of tissues. PET has been used in research for many years, but it has also been shown to aid diagnoses of cancer, heart disease, and neurological problems. “We need to go through a standard-setting process,” said Patricia A. Nolan, MD, director of the state Department of Health. “One of the major questions about new technology is [whether] there’s adequate training and preparation for the people who use it.”

In the case of PET, this is especially important because it uses radioactive materials. In addition to safety, the department wants to make sure that people are trained well enough to accurately read the scans.

—*Providence Journal*, June 12

Wisconsin Democrats offer a plan on use of money from anti-tobacco funding

MADISON, WI—A \$103 million-a-year prescription drug benefit for seniors was included by Senate Democrats in their version of the state budget, but questions remained over how the plan would be funded.

Then Democrats, meeting in caucus, pushed through a plan to set up a \$313 million endowment with proceeds from the sale of the tobacco settlement payment to provide long-term funding for anti-tobacco efforts. That would boost anti-tobacco funding from a proposed \$10.5 million a year to a maximum of \$31 million a year.

Approval of the prescription drug benefit sets the stage for a battle between Democrats who control the Senate and the Assembly’s majority Republicans, who favor a more modest benefit. The Joint Finance Committee approved a budget that included \$44 million for a drug plan, but did not specify details of the program.

—*Milwaukee Journal Sentinel*, June 11

Increase in health care funding saves Medicaid programs in Oklahoma

OKLAHOMA CITY—A 9% budget increase for the Oklahoma Health Care Authority probably will save the Medicaid agency from seeking another Legislative bailout next year, the authority’s board chairman said.



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State Health Watch (ISSN 1074-4754) is published monthly by American Health Consultants®, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. First-class postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **State Health Watch**, P.O. Box 740059, Atlanta, GA 30374.

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Subscription rates: \$327 per year. Two to nine additional copies, \$262 per year; 10 to 20 copies, \$196 per year; for more than 20, call (800) 688-2421. Back issues, when available, are \$55 each. **Government subscription rates:** \$297 per year. Two to nine additional copies, \$238 per year; 10 to 20 copies, \$178 per year; for more than 20, call (800) 688-2421.

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Funding approved recently by the Legislature is enough to allow all Medicaid programs to be fully functional during the 2002 fiscal year, said Ed McFall, chairman of the authority's board of directors.

"I've been on this commission since day one, and this is the first time I've been able to make that statement," Mr. McFall said during the board's monthly meeting. The board approved the agency's \$2.25 billion budget for the fiscal year which began July 1. The agency provides services to more than 400,000 Oklahomans.

Facing a \$20 million budget deficit, board members voted earlier this year to cut some Medicaid services. A \$19 million supplement from lawmakers saved the programs. Similar situations occurred in 1995, 1996, 1999, and 2000. During negotiations for the agency's 2002-2003 appropriations, legislators were concerned that the pattern would continue.

— *The Oklahoman*, June 15

Mandatory advanced approval for expensive prescription drugs is hailed as a cost-saver

OKLAHOMA CITY—Oklahoma's health care system for the poor and disabled saved \$3.3 million by requiring pre-authorization for the use of popular prescription drugs to treat arthritis and ulcers, a recent report indicates.

"We always strive to match the appropriate medications with our recipients in the most cost-efficient manner," said Lynn V. Mitchell, state Medicaid director.

About 100,000 Medicaid recipients in Oklahoma use either anti-inflammatory drugs with brand names that include Celebrex, Relafen, Indocin, Vioxx, Daypro, and Naproxen, or anti-ulcer drugs such as Axid, Pepcid, Prevacid, Prilosec, or Aciphex.

A study last year commissioned by the Oklahoma Health Care Authority outlined the effects of prior authorization — or mandatory advance approval for the use of expensive medications. The study showed sizable across-the-board savings on all classifications of drugs commonly used to address arthritic conditions and gastrointestinal disorders.

— *The Oklahoman*, June 27

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