State Health Watch

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States, advocates prepare for Supreme Court battle over funding for home- and community-based services

ADA requires states to expand choice to disabled and mentally retarded, say lower courts

The U.S. Supreme Court is set this spring to rule on a case that, if upheld, would force states to provide expensive home- and community-based services for the mentally disabled. Some 24 states have either filed amicus briefs or joined the appeal to stop the expansion, which they say would add astronomical costs to their Medicaid budgets.

Many state governments say letting the lower court rulings stand would devastate their Medicaid budgets. In Florida alone, officials estimate that compliance with the lower court rulings would cost as much as $1 billion annually.

The high court will hear oral arguments in the case of *L.C. v. Olmstead,* brought by two Georgia women with mental retardation and psychiatric conditions who were patients in a state psychiatric hospital. The women claim discrimination under the Americans With Disabilities Act (ADA). Doctors at the hospital agreed they were appropriate for discharge into community programs, but no state money was available for such services.

The women won their case in the U.S. District Court. The state of Georgia appealed the District Court decision to the 11th Circuit Court of Appeals, which has jurisdiction over Florida, Georgia, and Alabama. The appellate court upheld the decision.

Georgia now has asked the U.S. Supreme Court to decide whether the public services portion of the ADA "compels the state to provide treatment and habilitation for mentally disabled persons in a community placement, when appropriate treatment and habilitation can also be

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Critics blast attempt to privatize health centers in Pennsylvania

When Pennsylvania proposed two years ago to privatize 60 of its public health centers, the intent was to save taxpayers money. Instead, critics charge, what happened is a case study in what can go wrong when people who don't understand public health try to tinker with it.

At three pilot projects approved by the state legislature and at 29 other state health centers where staffing was reduced, problems include tuberculosis patients lost to follow-up, poor record keeping, and inadequate TB infection-control practices, says Steve Lopez, the lead investigator and author of a report released late last year, which lambasted the privatization efforts. Mr. Lopez, a doctoral candidate in sociology at the University of California at Berkeley, is a research analyst at Keystone Research Center, a Harrisburg, PA-based nonprofit think tank that frequently investigates issues related to public health.

"People we've interviewed say these changes may not immediately lead to an outbreak of TB, but that they weaken the infrastructure and reduce our ability to know about an outbreak and deal with it if it occurs," says Mr. Lopez.

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provided to them in a State mental institution."

The issue is becoming more pressing in the United States as those who are mentally retarded live longer and their aging parents worry about how their adult children will be cared for. The Arc, the nation's leading advocacy group for the retarded, estimates that nearly 250,000 mentally retarded people are on waiting lists for either residential or day services. Advocates say the ADA provides a legal means of forcing states to act.

At issue is interpretation of a regulation adopted by the U.S. Justice Department to enforce Title II of the ADA. It says a public entity "shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." The department has said the regulation means community placement of institutional residents is required when treating professionals in the state institutions recommend such placement.

The state is required under the ADA to make such expenditures, said the 11th Circuit Court, unless community placement is so "unreasonable given the demands of the State's mental health budget that it would fundamentally alter the service it provides."

With so many states claiming the expansion of services would bankrupt their budgets, it would seem simple to claim such placements as "unreasonable." However, the courts have set stringent tests for making such claims.

The court said the following three factors must be considered:

• the reasonableness of the expenditures in light of the entire budget for mental health;

• whether it would be unreasonable to require the state to expand its waiver program to minimize the financial burden;

• whether any difference in the cost of providing community-based services will lessen the state's burden.

Sally K. Richardson, director of the Health Care Financing Administration's Center for Medicaid and State Operations, wrote to all state Medicaid directors last July alerting them to *L.C. v. Olmstead* and two other Medicaid cases related to the ADA. Ms. Richardson pointed out that Attorney General Janet Reno has said "states have an obligation to provide services to people with disabilities in the most integrated setting appropriate to their needs." The department maintains that the "most integrated setting" standard applies to all state programs, including Medicaid programs.

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Many states, expecting the ruling to exert a significant drain on their budgets, are resisting the effort to mandate increased home- and community-based services. Twenty-two states joined with Georgia in asking the Supreme Court to review *L.C. v. Olmstead.* In their brief, they said that if applied elsewhere, the 11th Circuit's reasoning "will necessarily affect the manner in which services are provided to individuals with disabilities in any group setting. It is self-evident that if a state spends enough money, virtually any person can safely and appropriately be served in his or her home (or in the most integrated community setting). However, legitimate fiscal reality limits the ability of states to adequately fund community-based placements for all individuals with disabilities."

So far, 14 states have joined in an amicus brief to the Supreme Court on the case, making the argument that the federal government should not interfere in states' operation of mental health and developmental disability systems. Advocates for the disabled were able to persuade 12 of the original 22 states that supported the appeal to the Supreme Court to withdraw their support and not oppose the 11th Circuit decision.

The Washington, DC-based Bazelon Center for Mental Health Law, which organized an amicus brief in the 11th Circuit, says it is calling on advocacy organizations to file briefs as friends of the court. Specifically, the Bazelon Center wants disability advocates to help assure the justices that many states already are committed to providing services in the community instead of in institutions and that they can comply with the integration mandate at a reasonable cost.

This is particularly important to advocates because a number of organizations representing public officials, including the National Governors Association, the National Conference of State Legislatures, and the Conference of State Governments are marshalling their forces to challenge the lower courts' decisions. They have formed the State and Local Legal Center, which has filed an amicus brief on behalf of its members with the Supreme Court on the *Olmstead* case.

In documents posted on the Internet, the Bazelon Center says the State and Local Legal Center's brief, and the list of organizations supporting it, create the impression that every state, county, and city in the country backs the State of Georgia in its appeal. Bazelon is calling on advocates

to "make clear that the State and Local Legal Center's brief does not speak for all states, counties, and cities—especially not for states that have withdrawn from the states' amicus brief." The advocates maintain that community-based care is less expensive than institutional care, and that funding can be shifted to follow any migration from residential to home or community settings.

Observers in a number of states have said the Supreme Court may be planning to overturn the lower courts' rulings. Their reasoning is that in cases such as this, the justices usually will not hear an appeal unless there have been conflicts in lower court decisions. Because all lower court decisions to date have agreed with each other, they suspect that the Supreme Court may have agreed to hear the Olmstead case because justices believe the 11th Circuit decision should be overturned.

One of the states most interested in the Supreme Court's decision is Florida, which has been under pressure for several years to move developmentally disabled and mentally ill people from segregated state institutions to integrated community settings.

Florida Gov. Jeb Bush recently proposed increasing funding for the developmentally disabled by $210 million and restructuring how services are provided and money is spent. He has called for a system that is "consumer-driven, family-oriented, and choice-based."

Too little, too late?

Advocates say Bush's proposal is a step in the right direction but still too little, too late. A number of cases already are pending in U.S. district courts in Florida. Miami attorney Steven Weinger is litigating two class-action suits against the state. The first involves clients who entered a home- and community-based services waiver program only to find out later the state had imposed an arbitrary funding cap on individuals based on their needs when they entered the program. Clients were told that if they needed additional services, they would have to give up services they already were receiving. Thus, clients who were able to prove a need for services such as physical therapy could not receive the services because the state wouldn't fund them. In addition, Mr. Weinger says, the state put unrealistic limits on certain services, such as providing no more than a 10-month supply of diapers in a 12-month period.

In the second suit, Mr. Weinger is challenging Florida's practice of fixing its budget for home and community-based services, which entails refusing to add new recipients unless someone dies or moves elsewhere. Mr. Weinger says this creates a waiting list for such services of several thousand people.

The 11th Circuit has ruled that every individual with a developmental disability must be offered appropriate services within 90 days, a requirement Florida says would cost an estimated $750 million to $1 billion annually. Mr. Weinger says he has a motion for contempt pending against the state for refusing to implement the Circuit Court order.

Olmstead does not mean everyone must be treated in a community-based setting, Mr. Weinger says, but that residents must be allowed to choose the setting in which they believe they will be best served. Those who would rather be in an institution have that option under the Circuit Court ruling, he says.

Several other states have committed themselves to programs to reduce waiting lists and expand services. Wisconsin has a waiver to combine Medicare and Medicaid funding streams for its Wisconsin Partnership and improve outcomes by combining community long-term support with a health component. New York proposes to spend $230 million over five years to cut its waiting list of 6,500, and Maryland has a multimillion-dollar plan.

The seriousness of the problem perhaps is best seen in New Jersey. In 1994, New Jersey voters approved a $160 million bond issue, with half the funds earmarked to reduce home and community-based waiting lists. In four years, the waiting list has grown from 4,000 to 5,214 as more families taking care of adult children seek help. State officials now say $323 million will be needed to address the problem.

Contact the Judge David L. Bazelon Center for Mental Health Law at (202) 467-5730, and Mr. Weinger at (305) 444-0060. ■

High court requires school district to fund care for disabled student

Observers may wish to study a March 3, 1999, Supreme Court decision for a clue to the court's thinking regarding funding for the disabled. In that case, the court voted 7-2 to require a public school district to provide health services needed by a quadriplegic 12-year-old boy to remain in mainstream classes.

The case was brought under the Individuals with Disabilities Education Act. Officials of the National School Boards Association complained that the country's public education system "is not adequately funded to provide full medical services for approximately 17,000 students with severe disabilities." While the two dissenting justices said the decision "blindsides unwary states with fiscal obligations they could not have anticipated," the majority said the decision was intended to "help guarantee that students like Garret [the plaintiff] are integrated into the public schools." ■

Medicaid programs that adopt disease management face unique challenges of working in public sector

Florida, Virginia programs are beginning to take disease management seriously

Bringing disease management to a Medicaid program often is slowed by regulations and political considerations unique to the public sector. Nevertheless, early positive returns with disease management are giving Medicaid officials the confidence to implement such programs for their enrollees.

Virginia is kicking off a disease management initiative that addresses five common ailments: diabetes, hypertension/congestive heart failure, depression, asthma/chronic obstructive pulmonary disease, and gastroesophageal reflux disease/peptic ulcer disease. As in many states, the foray beyond claims handling into clinical management represents a huge philosophical leap for Virginia's Medicaid agency.

"This is a long-term issue," says David Shepherd, RPh, a pharmacy consultant with Virginia's Division of Medical Assistance Services.

Virginia's program is an outgrowth of a successful pilot program carried out in the mid-1990s. A federal mandate to implement some type of prior authorization program for the state's fee-for-service pharmacy program seemed to promise a fiscal disaster. The strategy chosen by most states—contracting with an outside pharmacy benefits manager—would cost millions the state doesn't have while simultaneously jeopardizing generous manufacturers' rebates Virginia receives through the Medicaid program.

Get creative

The Health Care Financing Administration encouraged Virginia officials to be creative in incorporating prior authorization into their state Medicaid plan, says Chuck Shasky, BSciPharm, MBA, director of the $706,000 disease management pilot that brought Virginia into compliance with the requirement.

State officials persuaded the National Pharmaceutical Council to fund a voluntary three-phase program to teach physicians, pharmacists, nurses, and other health care professionals how to manage asthma patients.

While drug costs went up for the patients in the asthma disease management intervention, emergency department visits declined 47%. Researchers estimated that each dollar invested in training saved Medicaid $3 to $17 in asthma expenditures. Eventually, Virginia's Medicaid officials embraced a "major thinking shift" to accept the notion that spending more on pharmacy could help their budget.

"They became very cognizant that the old way Medicaid managed their operations, which was quashing one pile that was specific for a budget code, was causing untoward effects in other budget code areas. It was like squeezing Jello," says Mr. Shasky.

The five-disease expansion to be carried out by Heritage Information Systems emphasizes the role of pharmacists—who at this point will not be paid for their educational services—more than did the pilot project. It's a variation that concerns Mr. Shepherd, but he says the concept of disease management is crucial and long overdue.

"I think things have turned out differently than I would have wanted them to, but at least there's emphasis being put on the demographics and what's going on with these people," he says.

Florida Medicaid officials cribbed from Virginia's playbook when they went looking for a disease management strategy, and, like Virginia, will target asthma first. In March, Integrated Therapeutics Group (ITG), a subsidiary of Schering-Plough Corp., began enrolling Medicaid members into a three-year project that will provide education and support to asthmatics and their health care providers. At the same time, ITG is continuing to sponsor a series of community outreach programs, called "Asthma Adventures," to raise asthma's profile among the general public.

The whole nine yards

The state does not compensate ITG financially for its disease management activities, but does give ITG access to confidential Medicaid data for research purposes. Schering-Plough, ITG's parent company, manufactures the widely prescribed allergy drug Claritin. According to Schering-Plough's Web site, the company received about 56% of its $2.7 billion in 1997 pharmaceutical revenue from allergy and respiratory drugs.

Florida's asthma project is only one of nine conditions targeted in a highly ambitious disease management initiative among state Medicaid programs. In Florida's disease management bullpen are projects addressing diabetes, HIV/AIDS, hemophilia, congestive heart failure, end-stage renal disease, sickle cell anemia, hypertension, and cancer.

And there are more projects on the horizon. Florida Agency for Health Care Administration director Ruben J. King-Shaw wants to implement disease management projects that focus more specifically on elderly, disabled, and mentally ill

patients. He credits his experiences as a Medicaid HMO director with establishing his confidence in disease management.

"This is the beginning of a process, not the end of one," he says.

Florida's dive into disease management comes at the same time as the state's highly controversial attempt to establish a Medicaid formulary. The state's pharmacy expenditures rose from $400 million in 1993 to $1.1 billion in 1998, and grew from 8.3% to 12% of the Medicaid budget during that same time.

Mr. King-Shaw acknowledges that a disease management program probably will increase pharmaceutical costs, but he says he hopes combining disease management with implementation of a formulary will allow the state to contain overall Medicaid costs. He sees no conflict in these strategies and says, in fact, that disease management demands a tighter rein on the use of pharmaceuticals.

"In many—not all—disease management programs, your utilization of therapeutic drugs will increase," he says. "And when you know you're going to use more of a substance, and you know those substances are costly, it drives you to the need to better manage the purchase and the use of those substances. That's what takes you into a formulary."

The rate of increase in Florida's pharmacy costs has hovered between 15% to 20% in the last three years, while annual increases in the overall Medicaid budget range from 3% to 5%. Mr. King-Shaw credits the spike in pharmaceutical spending with holding overall Medicaid cost increases to a more modest rate than they would be otherwise.

"You can do things, in an overall sense, more cost-effectively with drug therapies," he says.

Contact Mr. King-Shaw at (850) 922-5871, Mr. Shepherd at (804) 225-2773, and Mr. Shasky at (804) 828-0172. ■

Critics blast privatization of TB clinics

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Other critics are more candid and say the pilot projects—which were to have been stopped and evaluated by the end of the first year—need to be scuttled altogether. "They should stop the pilots, just shut them down," says Ed Powers, who recently retired from his post as manager of the state health department's division of sexually transmitted diseases and who also is a former state health advisor for the Centers for Disease Control and Prevention.

As an advocate of privatization, Mr. Powers takes pains to emphasize he's not opposed to the principle of privatization in public health; he simply disapproves of the way the state has implemented the change.

Also, the staff cutbacks at many of the health centers were never sanctioned by the legislature, which had instead directed that services should be kept at current levels in all but the pilot programs, Mr. Lopez adds.

Mr. Lopez and Mr. Powers agree that politicians and health department officials lacked a clear understanding of how the system worked when they tried to restructure it.

Understanding the TB universe

"There's very little understanding of what public-health nurses do," says Mr. Powers. "And there's very little understanding of TB patients and of that whole universe around them—tests, medications, follow-up, DOT [directly observed therapy.]"

The two say trouble began when the state's former secretary of health, acting at the behest of the governor, declared that the state-controlled public health system was wasteful and that he intended to replace it with private providers.

At first glance, says Mr. Powers, the idea looked pretty good. After all, many of the state's large urban areas, where the majority of TB cases are concentrated, are served by their own county-based public-health clinics. That leaves a mix of mostly rural and urban counties, with relatively few TB cases each year, served by one of the 60 state clinics. By privatizing those 60 state clinics, the health secretary said, it would be possible to save $1 million the first year and $8 million each subsequent year.

According to Mr. Powers, however, the secretary's announcement of the privatization plans had the effect of swiftly and thoroughly alienating the entire public-health infrastructure at the state level. "No matter what the guy said after that, he didn't have any of them on his side," he says.

In any case, the state legislature put aside wholesale abolition, opting instead to phase into privatization slowly by establishing three pilot projects in three counties. The pilots were to perform screening and administer treatment for TB, along with certain other duties—screening and treatment for sexually transmitted diseases, HIV testing and counseling, and childhood immunizations.

Nonclinical duties were relegated to district-level offices, where public-health nurses were supposed to perform follow-up, including DOT, and keep track of epidemiology.

What happened next was a combination of bad luck and shortsightedness, says Mr. Lopez. The three pilots were contracted out to three agencies — two visiting nurse associations and a private hospital. The VNAs, in turn, subcontracted their duties out to two branches of Planned Parenthood.

But the local Planned Parenthood organization suffered a money crunch that forced it to cut back hours, and the private hospital was gobbled up in a merger. Without a public health clinic to fall back on, the result was chaos, say Mr. Lopez and Mr. Powers.

For example, even though clients were comfortable with Planned

Parenthood staff and knew the clinic locations, the five other locations where patients were directed to go during the Planned Parenthood cutback were less accessible and much less familiar to patients than were previous sites, says Mr. Powers.

The private hospital, now swallowed up in the black hole of a merger, in the process had lost a Latino physician whom patients in the city had liked and trusted, Mr. Lopez says. To make things worse, adds Mr. Powers, "nobody [at the hospital] knew any longer who was in charge of anything; there was nothing solid to go back and touch, no one to say they'd made this [subcontracted] commitment."

In time, a physician on staff was appointed to take care of state health center patients, Mr. Powers adds. But again, a lack of understanding of public health posed a stumbling block. "What [private-sector] doctors understand is that when their patients make an appointment, they keep it," Mr. Powers says. "What they don't understand is that a patient who's got three kids and no income, and whose boyfriend is giving her a hard time, probably isn't going to keep that appointment she's made, now that she's feeling better."

The same lack of understanding resulted in occasional bungling of TB infection-control practices, Mr. Powers and Mr. Lopez say. In some situations, "they didn't have the right air exchange," says Powers. "They were going to have their TB clinics next door to the well-baby clinics and the HIV clinics. And why not? That's not the kind of thing that's written down somewhere."

At the same time, the state began shifting nurses at approximately half the other state health clinics up to district-office levels, even though those health centers weren't involved in pilot programs, Mr. Lopez says. That left nurses at the local level short-handed. Those bumped up to district level felt out of sorts for a other reasons, says Mr. Lopez. For one thing, nurses in district offices now found they were spending a lot more time driving. In addition, now that they were charged with performing follow-up and DOT on all TB patients in the district, patients began complaining that they disliked being asked the same set of questions by two people in succession, and in some cases were lost to follow-up, Mr. Lopez says.

> "They were going to have their TB clinics next door to the well-baby clinics and the HIV clinics."
>
> Ed Powers

Meanwhile, pilot projects also had trouble relaying data to the University of Pittsburgh, where the state had charged researchers to do the officially sanctioned investigation of the pilot projects, Mr. Lopez says. Citing a lack of usable data, the university asked for and received two substantial extensions for the deadline by which the assessment was to have been completed.

Gary Marsh, PhD, a professor of biostatistics at the graduate school of public health at the university, flatly denies the school has felt pressure to produce a favorable report of the project, as some critics have charged.

"I have no vested interest at all in this," he says. The problem with information flow is one the state ought to have anticipated, he adds. "A lot of these people [at the pilot projects] simply weren't trained to provide the information we need in a format we could use," he says. "That's not uncommon in such situations. But we've provided some assistance, and I think we're over that hump." Mr. Marsh also is critical of Mr. Lopez's report. "I wouldn't place much weight in it," he says. "It's based on a lot of anecdotal information."

Mr. Lopez denies the charge of subjectivity. "To understand how the network is working, you have to talk to people," he says. "We also used Department of Health internal audits. We have hard data on how the number of patients has plummeted by as much as half. There's nothing biased about that."

"We do feel the Keystone report was anecdotal, but that doesn't mean we're ignoring it," says Megan Neuhart, a spokeswoman for Gary Gurian, the acting secretary of health. "We're waiting for the University of Pittsburgh to do a complete and nonbiased study, and we're going to await judgment until we see that report."

Mr. Powers, the former state health department manager, argues that the time has passed for collecting more data. "The state could have done a much better job of looking down its own throat," he says. "We know as much as we need to know that it's time to shut these pilots down."

Though Mr. Powers agrees with Mr. Marsh that the Keystone report is heavily critical, he adds that he made the decision to cooperate with Keystone investigators because he feared the consequences to public health that might otherwise result. "There's no mothers' marches against TB," he says. "It's not like fluoride in the water — it doesn't affect you and me."

Mr. Powers still supports privatization. "We've learned a lot from these pilots. Now we need to take the [idea] back and fix it."

For his part, Mr. Lopez concurs with Mr. Powers that the pilot projects should be shut down. In addition, his report says the state should conduct an assessment of its public health system. He also recommended that the department of health restore staffing in state health centers; initiate a best-practice study in public-health delivery; and sponsor an audit of the true costs of the pilot projects.

Contact Mr. Lopez at the Keystone Research Center at (717) 255-7181; by fax at (717) 255-7193; or by e-mail at KeystoneRC@aol.com. ■

L.A. County Medi-Cal tests strategy to lower costs by authorizing all requests for emergency room care

ER visits will be used to educate patients on how to use services effectively

Horror stories about delays in getting authorization for emergency care have health plan officials in Los Angeles County ready to try something dramatic: authorizing everybody.

"It probably costs more money to deny an emergency room service than to just approve it," explains Ed Benjamins, RN. Mr. Benjamins is director of utilization management and case management activities for L.A. Care Health Plan, which serves about 587,000 enrollees—more than half the county's managed care Medi-Cal population—through about seven health plan subcontractors.

A six-month pilot project under development at selected emergency departments in the county will eliminate the need for prior authorization for emergency services while educating plan members on appropriate use of emergency services. The pilot is slated to begin in May at St. Francis Medical Center, a central Los Angeles county hospital that sees about 150 L.A. Care patients each month.

If the pilot suggests that "auto-authorization" lowers costs, the strategy will be promoted to all of the enrollees in L.A. Care, says L.A. Care Health Plan spokesman Keith Malone.

Denials are too expensive

In the current system, denials account for an estimated 13% of the requests for ER authorization in the L.A. Care network. A survey last year showed that 67% of emergency department authorizations for "post-stabilization care" were fully approved; another 11% were partially approved. The study did not examine figures for medical screening exams, which are mandated under California law and the federal Emergency Medical Treatment and Active Labor Act.

Nuggets gleaned from brainstorming sessions among HMO representatives, hospital administrators, and ER staffs helped suggest the "auto-authorization" strategy for unclogging emergency departments:

• Rarely do physicians send Medicaid HMO enrollees to emergency departments for care; patients self-refer. A high rate of walk-in demand for emergency care—an average of 86% for L.A. Care and another large Medi-Cal plan in the 1998 survey—suggested that physician or EMS education would not be enough to fully address the problem.

• About 80% of the authorizations were secured within 20 minutes or less. This suggested to L.A. Care officials and others that they concentrate on the remaining 20% that were consuming an extended period of time.

All visits paid global rate

The heart of the experiment is implementation of a global capitated fee for hospital and physician services. Except for cases in which a patient is admitted to the hospital, all emergency room services for L.A. Care-managed Medi-Cal enrollees will be reimbursed at a global rate still being hammered out between L.A. Care and its payers.

While calculating the physician component of the reimbursement rate has been relatively straightforward, developing an average hospital reimbursement rate has been a challenge.

Even identifying the direct medical costs is difficult, as many hospitals do not code to indicate where a particular service is provided in the facility. On top of that, researchers are trying to isolate the cost of clerical staff required for phone calls and copying records, as well as the clinical staff required to perform medical reviews.

ED project targets satisfaction and care as well as lower costs

While lower emergency department costs are the main goal of L.A. Health Care Plan's auto-authorization pilot project, researchers also will be measuring several other outcomes:

• Unacceptable clinical outcomes

• Unacceptable clinical outcomes attributable to the model

• Utilization trends, including overall levels of utilization

• Global costs (little or no impact on costs would be quite acceptable, if other outcomes are favorable)

• Member, emergency department, primary care physician, and plan satisfaction, based on specific survey tools

• Reductions in repeat visits for members and their families

• An increased number of preventive services for the member and the member's family

• An increased percentage of completed post-ED follow-up visits with the member's PCP

• A reduced rate of PCP/Plan transfers

• Over time, reduced ED use by L.A. Care members at the

Early attempts to identify the total facility costs for emergency room care produced estimates among network hospitals that ranged from $400 down to an astonishing $25.

"It's not because that's their actual costs," says Mr. Benjamins. "It's because the data they're using to produce that average is inconsistent and inaccurate. I'm struggling with that," he says.

The reimbursement rates will be set to maintain expenditures at existing levels. To develop the rates, researchers are using paid claims data from Medi-Cal fee-for-service and Los Angeles Medi-Cal managed care provider claims.

To help win provider support for the project, researchers have promised payment within 30 days of the date of service. For their part, providers are responsible for faxing encounter data to the plan at financial risk and the enrollee's primary care physician no later than the working day after service.

The educational component of the pilot project includes the development of a scripted patient education protocol, to be delivered by emergency department staff after services have been provided. The script is intended to help members identify their primary care physician and establish a relationship.

"We think once they've established that relationship, their inappropriate utilization of the emergency department will decrease," says Mr. Benjamins.

The logistics of an expansion would be daunting. Los Angeles County's square mileage is greater than that of Delaware and Rhode Island combined. Its 9.3 million residents make it more populous than 42 states. L.A. Care alone has in its network 87 emergency departments in 109 hospitals.

Contact Mr. Benjamins at (213) 637-2403. ■

Legal challenges threaten quick approval of tobacco settlement

New York, Arizona are among states where counties want a bigger share

While states have been defending their tobacco settlement against federal encroachment, some also have been guarding their flanks. In New York and Arizona, for example, suits by local governments have sought a larger share of the $206 billion awarded to 46 states and six other governments.

County and city governments are basing their claims to a larger share of the settlement pie on local contributions to state Medicaid coffers. Generally, states have used Medicaid expenditures to justify their suit against the tobacco industry and allocate the settlement amount among the states and territories.

Local suits could slow down the disbursement of tobacco settlement funds to all states, not just those in which the court cases have arisen. States in which all judicial hurdles to the agreement have been cleared will receive their funds no later than June 30, 2000, but that date could be earlier if enough of their colleagues get on the bandwagon. Tobacco funds will be available to states that have approved the agreement when the settlement is cleared in 80% of the states and other areas that also represent at least 80% of the tobacco payments.

Courts in virtually all jurisdictions covering the suit have approved the agreement, but that's only the first step. States also must ride out all possible legal challenges to the approval before reaching what the agreement calls "state-specific finality."

New York state alone represents 12% of the tobacco settlement payments. New York City wants a larger share of the state's annual payments—about 36%—than the 26.7% offered in the most recent proposal submitted for court approval.

Another dispute in New York state involves how the state is distributing the settlement's "strategic contribution fund," $8.6 billion set aside to reimburse the states that bore the costs of bringing the tobacco suit to resolution.

Westchester County attorney Alan Scheinkman argues that when local governments in New York complied with state requests to suspend their own suits against the tobacco industry, New York state was able to draw down a larger share of the tobacco settlement than it would have otherwise. For that reason, local governments deserve to be compensated for their contribution to bringing the case to trial.

"Our argument is, the counties should have shared in the special fund all along," he says.

For Westchester County, a New York City bedroom community of about 900,000, the strategic contribution funds could mean $20 million to $40 million in addition to the hundreds of millions not at issue, says Mr. Scheinkman.

New York state officials have, to varying degrees, supported local governments' claim to a share of the larger "annual contributions," reflecting local contributions to the state Medicaid budget, but have balked at dividing up the strategic contribution funds the same way.

New York City likewise wants a larger piece of the strategic contribution fund and also is challenging the way the state is carving up the annual payments.

All of Arizona's counties except one have filed a motion in Superior Court to reopen and set aside the judgement in the state's suit against tobacco companies. Counties are seeking assurances they will be reimbursed for

bearing about 37% of the costs of Arizona's Medicaid waiver program, the Arizona Health Care Cost Containment System, since the program was implemented in 1982.

The counties, including holdout Pima County, are at the same time trying to get the legislature to route some of the settlement money back to the counties. But they're not putting their faith in such efforts.

"The governor has suggested that we all share," says Maricopa County spokesman Al Bravo, "but nothing's written in stone."

There are some bright spots for the settlement. California, which represents about 13% of the settlement proceeds, reached what it considers state-specific finality, says Al Sheldon, supervising deputy attorney general.

Contact Mr. Scheinkman at (916) 285-2660, Mr. Bravo at (602) 506-7063, and Mr. Sheldon at (619) 645-2089. ■

Washington state finds illegal ER coverage denials

More than half the denials for emergency room coverage in Washington state were found to be unlawful in a recent review of coverage patterns.

State investigators looked at more than 700 emergency room denials by four major carriers during the first four months of last year.

State Insurance Commissioner Deborah Senn said insurers most frequently claimed that the emergency room situation was not a true emergency, that the consumer did not get a referral from his or her primary care provider, and that the patient was out of the service area at the time of the

California providers set to receive millions in price-fixing settlement

Clinics and hospitals serving poor residents in California are slated to receive $148 million in brand-name drugs under a proposed settlement in a pharmaceutical price-fixing case.

The 19 pharmacy firms involved do not concede wrongdoing in the settlement. The class-action suit alleges that the companies' two-tier pricing system unfairly overcharges consumers who use neighborhood pharmacies and some drug-store chains. Those presumably more affluent residents who have access to drugs through high-volume purchasers such as HMOs and insurance mail-order plans receive an unfair discount, the suit maintains.

The settlement provides for $27 million for attorneys' fees and $1.6 million to administer the three-year program in addition to the drug distribution.

Distribution of the settlement is being organized by the Public Health Trust, a Berkeley, CA-based organization that manages settlements of public health litigation. The trust convened an ad hoc panel of experts to develop criteria for choosing drugs to secure as part of the settlement.

The panel favored drugs with a preventive or curative effect as opposed to hospital-based drugs such as anesthesia, says Marice Ashe, director of the trust. In addition, formulary drugs had to be those that the public health system could not already get inexpensively, eliminating such drugs as oral contraceptives. Representatives from the pharmaceuticals and the San Francisco firm handling the case are in the last stages of negotiating the final list.

"We didn't get everything we wanted, but it's very good," says Ms. Ashe.

While the benefits of the suit are being distributed to indigent residents, the case actually is brought on behalf of California consumers generally. The benefits to taxpayers are calculated in terms of lower medical costs for indigent care, says an associate of the firm bringing the class-action suit. Because the drugs chosen also were picked for their potential to save medical costs, the tax benefit is greater than it might have been if the benefits were funneled to tax coffers directly, says Josh Davis, with the San Francisco firm of Lieff, Cabraser, Heinmann & Bernstein.

The drugs will be distributed through 300 public hospitals, public health clinics, and community health centers throughout the state. As with other pharmacy price-fixing cases, the benefits of the settlement must not replace existing pharmacy programs.

Although the settlement is large, it is dwarfed by what California's public health system already pays in pharmacy costs. The value of drugs to be distributed over three years is roughly equivalent to what the Los Angeles County public health system spends on pharmaceuticals in nine months.

The drugs provided by the pharmaceutical firms will be valued at their wholesale acquisition cost—the price the retail pharmacy pays the wholesaler.

While the proposed settlement does not appear to affect the structure of pharmacy pricing for poor people, Ms. Ashe says the case would not be the place to do that.

"If the allegations are true, it really calls for a policy solution," she says.

Final approval of the settlement is pending the outcome of a Superior Court hearing scheduled for April.

Contact Ms. Ashe at (510) 548-1468 and Mr. Davis at (415) 956-1000. For information on a similar settlement of a pharmacy price-fixing case, see State Health Watch, *January 1999, p. 7.* ■

Montana managed care officials bust deadlines to replace troubled behavioral health care vendor

Regional nonprofit plans likely to succeed statewide commercial MCO

Contingency planning: That's how Montana officials are coping with the turmoil swirling around the state's behavioral health managed care program.

The only certainty is that the current contractor, Magellan Health Services, is exiting early from its five-year, $400 million contract to provide behavioral health services to Montana Medicaid residents. But state officials and Magellan officials can't even come to agreement on the exact date for terminating their rocky two-year relationship.

"It's under negotiation," says Erin Somers, a Magellan spokeswoman in the company's Columbia, MD, behavioral health subsidiary. At issue is when the clock did (or will) start ticking for the contract's 180-day notification clause for termination. Parties to the dispute have claimed exit dates that range from April to late fall. Montana officials say even the best-case possibility is not good enough.

"Nov. 1 will be difficult, to say the least," says Randy Poulson, head of the state's bureau of managed care.

Despite Montana's disastrous experience with Magellan and its two corporate predecessors, the state remains committed to providing Medicaid behavioral health services through a managed care model, says Mr. Poulson. To ensure that services and provider payments flow smoothly, state officials have crafted a transition strategy that involves the following:

• Increased reliance on outside consultants. Lansing, MI-based Health Management Associates (HMA) and other consultants are helping to assess the current status of the plan and develop projections for future contractors. In addition to a two-year evaluation slated to be completed in April of this year, HMA is analyzing how program services should be regionalized and what software the state should use under various service delivery scenarios, and helping the state secure the necessary HCFA waivers.

• Abbreviated public input into the plan. The request for proposals that brought behavioral managed care into the state two years ago is the product of extended public discussion, "but we're not going to have the luxury of that this time," says Mr. Poulson. On the bright side, state officials are confident that the skeleton of the existing RFP is sound.

> "We want [new vendors] to demonstrate the ability to go live *before* they go live."
>
> Randy Poulson

• Close communication with Magellan.

• Close communication with regional and national officials in the Health Care Financing Administration (HCFA). The program's 1915b waiver expires April 1, and the state is negotiating one or more temporary extensions until new contractors are found.

The experience with Magellan has suggested to Mr. Poulson an additional task for potential applicants: successful completion of a rigorous dress rehearsal. In retrospect, he wishes he had imposed the requirement on Magellan's predecessor, CMG.

"There was a hurry to bring them on, and they were not ready to be implemented," says Mr. Poulson. "We want [new vendors] to demonstrate the ability to go live *before* they go live. If we've learned anything, that's one of the most important things."

In the meantime, state officials have a daunting to-do list:

• Maintain the current level of services and claims adjudication.

• Prepare an RFP that meets the legislature's apparent goals of regionalizing behavioral managed care. The challenge is that specific legislative direction may change while administrators are developing the RFP.

"It's terribly difficult," says Lou Thompson, a program analyst within the state's addictive and mental disorders division. "We hope to have the RFP on the street by April 16. Realistically, our legislature probably won't even have adjourned by that time."

For example, one of the unresolved variables is the licensure requirement for the new vendor or vendors. A bill being considered by the legislature would require Magellan's successor to be licensed as an HMO, which is not currently mandated.

• Prepare for a temporary transition to fee-for-service, if necessary. State and Magellan officials are discussing the possibility of having Magellan provide administrative services during that time.

• Ensure that Magellan meets its obligations for a smooth transition.

As it has throughout its relationship with the state, Magellan maintains the program simply is not funded adequately to provide the level of service demanded. In newspaper ads throughout the state,

Magellan officials describe a $17 million shortfall in the program that they whittled down to $10 million through "significant efficiencies" in their operations.

"We can't continue to subsidize the program," Ms. Somers says.

Contact Ms. Somers at (410) 953-2405 and Mr. Poulson at (406) 444-2706. ■

Senate considers stronger coverage for emergency department care

Legislation that would mandate coverage for "reasonably sought" emergency room care has won bipartisan support in the U.S. Congress.

The measure, sought by Sens. Bob Graham (D-FL) and John Chafee (R-RI), also would prevent insurance plans from requiring patients to obtain insurer preapproval before seeking emergency treatment.

Some 32 states have legislated some version of emergency-room access, said Mr. Chafee, but many of the state laws are not as comprehensive as the proposed federal legislation. In addition, state laws often conflict with HMO regulations, causing confusion, he said.

Karen Ignagi, president of the American Association of Health Plans, said many HMOs already follow payment guidelines in accordance with so-called "prudent layperson" directives, and called the measure unnecessary. "Every provider group and specialty society has its particular mandate, but the sum total of all these would be higher premiums,"

Clip files / Local news from the states

This column features selected short items about state health care policy digested from publications from around the country.

New Jersey insurers cover non-drug costs for cancer trials

TRENTON—An agreement among New Jersey's largest health insurers has opened access to clinical trials for as many as 20,000 state residents with cancer who now can't afford such care.

The voluntary agreement, the first of its kind in the nation, calls for the health insurers to provide care to cancer patients in Phase III clinical trials, those that compare experimental drugs with standard treatments, said William Hait, MD, PhD, director of the Cancer Institute of New Jersey in New Brunswick.

About 400 to 1,000 cancer patients in New Jersey currently are involved in such trials, Mr. Hait said. Normally, the cost of the medicine used in the trial is paid for by the pharmaceutical company developing the drug. But the costs of routine care, including hospitalization, lab tests, outpatient visits, and treatment of other illnesses associated with the clinical trial, often are not covered by insurance.

—*The Star-Ledger*, Feb. 25.

Pennsylvania Medicaid HMOs limit optional benefits

PHILADELPHIA—Two of four Medicaid HMOs in southeastern Pennsylvania are dropping popular but discretionary benefits in their adult vision and dental plans.

Then cutbacks went into effect Jan. 1 at Keystone Mercy Health Plan, whose 225,000 members make it the largest Pennsylvania Medicaid managed care plan. Similar changes are being implemented at 71,000-member Healthcare Management Alternatives (HMA) Medicaid plan.

The only nonprofit plan among Pennsylvania's Medicaid managed care roster, 104,000-member Health Partners, will continue to cover eyeglasses and dental care, spokeswoman Deborah Tortu said. The fourth plan, HRM Health Plans (formerly Oxford), also plans no cutbacks, though it does not cover glasses or contacts for adult members except for those who have particular conditions.

—*The Inquirer*, Feb. 18. For more information on problems among Pennsylvania Medicaid managed care plans, see *State Health Watch*, October 1998, p. 7.

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State commission cuts Maryland hospital rates by 1%

BALTIMORE—Despite warnings that the move could lead to program cuts and a loss of 3,000 jobs, officials in Maryland have cut hospital reimbursement rates by 1%.

The Health Services Cost Review Commission, concerned that Maryland's hospital costs were outstripping those in other states, initially proposed a 2% rate rollback. The commission's move essentially splits the difference between the industry and state positions.

Hospital costs in Maryland were 25% above the national average when the commission began setting rates in 1976. By 1992, costs had dropped to 13% below average. Since then, however, Maryland costs have grown faster than the national rate for six straight years, and the cost of an average hospital stay in Maryland now is once again above the national average.

—*The Sun*, March 4. See story in *State Health Watch*, March 1999, p. 7.

San Francisco officials face deficit, bursting ER conditions

SAN FRANCISCO—Health officials want to limit ambulance admissions at San Francisco General Hospital as a way to cope with an overcrowded emergency room and a $24 million deficit.

The hospital's 36-bed emergency room is using gurneys in the hallways to juggle as many as 54 patients at a time.

A recommendation to scale back emergency room admissions is under consideration by the Health Commission and must ultimately be approved by the Board of Supervisors, which has final say over hospital policy.

The new policy would suspend rules allowing private hospitals to divert ambulances headed toward San Francisco General. Instead, patients suffering from broken bones, illness, and heart attacks would have to be treated by the nearest hospital. Only severe trauma cases, such as gunshot wounds, car accidents, and burn victims, would be guaranteed a ride to the county emergency room.

Administrators say an increased number of poor patients and inadequate government compensation are generating a record amount of red ink. Even with added money, the county hospital does not have the space to handle the current level of patients in need of emergency care, officials say.

—*San Francisco Chronicle*, March 2.