State Health Watch

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THOMSON AMERICAN HEALTH CONSULTANTS

## In This Issue



# Supreme Court ruling: It's time for the states to control managed care

The national organization representing health plans is downplaying the recent Supreme Court decision on Kentucky's any willing provider (AWP) laws because plans are responding to consumer demands for broader provider choices and states no longer pass such laws.

But several attorneys see potential implications that are broader than the Kentucky law.

Francis Serbaroli, partner in the law firm Cadwalader, Wickersham & Taft of New York City, tells *State Health Watch* the decision may not have a wide-ranging impact because it was decided on narrow terms involving the Kentucky laws. Legislation from any other state would have to be looked at individually, he adds. "The court upheld the Kentucky law and said it didn't violate ERISA [Employee Retirement Income Security Act of 1974]. But it didn't give states carte blanche for wide-ranging any willing provider laws."

Susan Conway, a health attorney with Vincent and Elkins in Austin, TX, tells *State Health Watch* the decision could encourage state medical societies and other groups interested in seeing AWP laws passed,

*See* ***Cover story*** *on page 2*

# *For states with limited Medicaid resources, risk adjustment helps identify best providers*

Under severe budget pressures, many states are looking for ways to enable Medicaid managed care programs to profile managed care plans and better evaluate the impact of rate increases and better demonstrate the value that plans are providing.

The ways in which risk adjustment is being used have been studied under Centers for Medicare & Medicaid Services (CMS) contracts by the Center for Health Program Development and Management at the University of Maryland, Baltimore County.

John Kaelin, executive director for the Center for Health Program Development and Management, tells *State Health Watch* that his research first looked at nine states that have been using various risk adjustment programs and then added states that have not been using risk adjustment but would like to. He defines risk adjustment as a process by which the health status of an enrolled population is taken into consideration when determining capitation rates or other at-risk payments.

***Fiscal Fitness: How States Cope***

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State Health Watch
The Newsletter on State Health Care Reform

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## *Cover story*

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but can't gauge how much interest there still is in that approach.

According to Ms. Conway and Michael Richman, an attorney with Reed, Smith in Washington, DC, the more important impact lies in the clarification the court gave to the test to determine whether a state law is pre-empted by ERISA.

Ms. Conway and Mr. Richman say that the court's change from a three-prong test borrowed from other law to a two-prong test simplifies the issue. That means more state laws will stand on their own without being superceded by ERISA, they say.

### New test is key element

"I'm impressed that it was a unanimous decision," Mr. Richman tells *State Health Watch*. "That's not always the case with ERISA. And it's significant that it was a unanimous decision with a new test. I think the Court is hoping that with the new test it won't have to take these [ERISA] cases any more."

Also struck by the unanimous decision in an ERISA case was Diane Fuchs, an attorney with Womble Carlyle in the Washington, DC, office, who tells *State Health Watch* that while the high court addressed only one of three clauses in the ERISA law dealing with preemption, it is significant that it developed a new test for determining whether state law applies, especially since it upheld district and appeals court decisions that had relied on the former test. In essence, the high court said the lower courts reached the right conclusion, but then came up with a new way to get there.

"It's a fairly significant case with implications beyond the AWP statute because the court made a clean break from the old standard," Ms. Fuchs says. "There are implications for all types of health insurance statutes."

To her, one that sprung to mind immediately was mandated benefits laws. The new test enunciated by the Supreme Court looks at whether a statute is directed specifically at the insurance industry and also at risk pooling, two conditions that are met by mandated benefits laws.

"Why should people care about this decision?" Ms. Fuchs asks. "It's important to keep in mind that whoever is assembling a provider network guarantees the doctors money based on a guaranteed volume of patients. If they can't control the volume of patients by restricting the number of doctors, the doctors won't agree to the price structure.

"Costs will increase because if they let any provider in, they can't promise the few who are in the network a sufficient number of patients," she adds. "Some people have estimated that this decision could increase costs by 15%. I think it really will vary based on the number of doctors in an area. The biggest impact will be in the geographic areas where there are a lot of doctors."

Ms. Fuchs says that one intriguing question still to be decided is whether self-insured plans are affected. They have been covered under a clause that was not at issue in the Kentucky case. But a footnote in the Supreme Court decision has fueled some speculation that the court wants to apply its findings to noninsuring HMOs. She says it's hard to believe the court intended to make such a major change in policy through an unclear footnote, but more cases will have to be decided before it is known for sure.

"This decision was not a surprise," she says. "It's a continuation of what has happened in recent years in terms of state law being able to regulate more than insurers. It endorses state power to regulate."

The nation's highest court upheld a ruling from the Sixth Circuit Court of Appeals that allowed Kentucky to continue its open network policy designed to ensure patients' access to the physicians they wanted and to give qualified physicians a guarantee that their businesses wouldn't be jeopardized because a health plan refused to make them part of its network.

At issue were two AWP laws. The first prohibited health insurers from discriminating against any provider in the geographic coverage area of the health benefit plan who is willing to meet the terms and conditions for participation established by the health insurer. The second provided that any health plan with chiropractic benefits must permit any licensed chiropractor who agreed to provide by the terms, conditions, reimbursement rates, and standards of quality of the health benefit plan to serve as a participating primary chiropractor to anyone covered by the plan.

The Kentucky Association of Health Plans had brought the suit, claiming the state's AWP law was preempted by ERISA because it did not specifically regulate insurance, a prerequisite for exemption from ERISA control. Writing for a unanimous court, Justice Antonin Scalia said the plans believe that the AWP laws frustrate their efforts at cost and quality control, and ultimately will deny consumers the benefits of their cost-reducing arrangements with selected providers.

The plans, he said, claimed that the state AWP laws were not specifically directed toward insurers because they regulated not only the insurance industry but also doctors seeking to form and maintain limited provider networks with HMOs.

"That is to say," Mr. Scalia wrote, "the AWP laws equally prevent providers from entering into limited network contracts with insurers, just as they prevent insurers from creating exclusive networks in the first place. We do not think it follows that Kentucky has failed to specifically direct its AWP laws at the insurance industry. Neither of Kentucky's AWP statutes, by its terms, imposes any prohibitions or requirements on health care providers. . . . And Kentucky health care providers are still capable of entering exclusive networks with insurers who conduct business outside the Commonwealth of Kentucky or who are otherwise not covered" by the statutes.

> "While they were well intentioned, any willing provider laws hurt the effort to run managed care properly."
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> Francis Serbaroli
> Partner
> Cadwalader, Wickersham & Taft
> New York City

Mr. Scalia said regulations directed toward certain entities almost always would disable other entities from doing, with the regulated entities, what the regulations forbid. "[But] this does not suffice to place such regulation outside the scope of ERISA's savings clause," he said.

The health plans also argued that the AWP laws did not regulate insurers regarding an insurance practice because they did not control the actual terms of insurance policies. Rather, the laws focused on the relationship between an insurer and third-party providers, which, according to the plans, does not constitute an "insurance practice."

"Those who wish to provide health insurance to Kentucky [any health insurer] may not discriminate against any willing provider," Mr. Scalia wrote. "This 'regulates' insurance by imposing conditions on the right to engage in the business of insurance; whether or not an HMO's contracts with providers constitute 'the business of insurance' is beside the point. We emphasize that conditions on the right to engage in the business of insurance must also substantially affect the risk pooling arrangements between the insurer and the insured to be covered by ERISA's savings clause."

Donald J. Palmisano, president-elect of the American Medical Association (AMA), hailed the decision as a victory that "adds clarity to patient projections established by state lawmakers against the abuses of managed care." The AMA had joined the Kentucky Medical Association and several other medical societies in a "friend of the court" brief that had argued that health plans should have to abide by state laws that regulate insurance, as the AWP law did.

Observers trace the shift in Supreme Court thinking on state control over health plans to a 2000 decision in which it said that situations in which benefit decisions were intertwined with medical judgment could be subject to state laws that traditionally govern insurance and medicine. Then last year, the Supreme Court ruled that a health plan was subject to an Illinois independent review law that plans had said should be pre-empted by ERISA.

But Mr. Serbaroli said he believes there will be very little carry-over effect from the Kentucky decision in

terms of ERISA and state control.

"The rest of ERISA has been upheld so often that I don't think there will be real impact, although with health care, you never can be positive," he says.

Kentucky Association of Health Plans executive director Melody Shrader expressed disappointment at the decision, saying that when plans are forced to include all doctors and other health professionals in a network, costs increase and have to be passed on to employers and consumers.

"The unintended consequences of this decision will be that fewer employers will be able to afford health insurance for their employees in the future," she says.

Also disappointed was Health Insurance Association of America president Donald Young, who says that AWP laws "are one more instance of government unnecessarily interfering in private relationships between doctors and health plans. The requirement for health plans to open their provider networks will result in higher health insurance premiums and the real possibility of diminished quality of care. It is another step for those who believe the government can best determine how health care should be financed and delivered, further limiting choices for health care consumers. Ultimately, it is the American worker who will bear the brunt of this decision."

But American Association of Health Plans executive director Karen Ignani says the ruling changed little in terms of current practice.

"In the nine years since Kentucky's any willing provider legislation was passed, insurers responded to consumer demands, offered more product choices, and built a higher quality health care system. Innovation is the hallmark of this industry, and we will continue to adapt to the interests of consumers and the demands of regulators. In a time of rising health care costs, today's ruling underscores the critical need for state legislators to carefully evaluate the consequences of legislation of affordability and quality. Polls consistently show that consumers' top health care priorities are enhanced access to affordable coverage and quality."

Mr. Serbaroli says he agrees with Ms. Ignani's analysis, adding that AWP laws effectively gutted the whole purpose of managed care in terms of the desire to put together a network of doctors that would be cost-effective in delivering high-quality care.

"While they were well intentioned, any willing provider laws hurt the effort to run managed care properly," he says.

An analysis of the decision prepared by attorneys Gregory Pimstone of the Los Angeles firm of Manatt Phelps & Phillips and Michael Shpiece of Shpiece and Tischler in Southfield, MI, who represented the Kentucky Association of Health Plans, and distributed to members of the American Health Lawyers Association, says the decisions is the court's 20th on ERISA since 1981.

Before the Kentucky case was brought, they say, AWP laws had been considered by at least five circuit courts of appeals, with three ruling that the laws were saved from pre-emption by ERISA and two favoring ERISA preemption.

"After *Kentucky Association*, it appears that the bar for concluding that a state law is directed at the insurance industry has been set low," Mr. Pimstone and Mr. Shpiece write.

"Apparently the state law need only be aimed at insurers, even if it also impacts noninsurance entities to some degree," they point out.

The two attorneys say that while most state AWP laws only apply to providers willing to accept all of the terms and conditions set by the carrier, an AWP law conceivably does not need to do so.

"A state could adopt a law requiring the carrier to accept all providers who, for example, were willing to accept the carrier's payment terms," they write, "thus potentially eliminating the ability of the carrier to enforce credentialing or other requirements. Similarly, laws like that enacted in Washington that requires carriers to provide coverage for alternative providers or treatments should also survive challenge. . . . *Kentucky Association* could result in an increase in the number and scope of AWP laws in some states. In states where open networks are already prevalent, however, the opinion may have little if any direct impact." ■

**This issue of *State Health Watch* brings you news from these states:**

# Medicaid reform: Politically doable or wasted effort?

Washington observers are questioning the degree to which Congress will be willing and able to address thorny health care issues such as Medicaid reform, especially as funds go to war and rebuilding in Iraq.

At a March 28 roundtable discussion sponsored by the Washington, DC-based Kaiser Family Foundation — which was titled Déjà Vu All Over Again?? The Great Health Debates of 2003 — *Washington Post* columnist David Broder said that he sees forces mobilizing to prevent the Medicaid situation from becoming worse, but not to improve the program and its funding.

"My sense is that from now until 2004, we're going to be in a holding pattern where the victories will come in avoiding the things that would make this situation even worse," he said. Mr. Broder predicted that health care once again will be high on the country's agenda in the 2004 election campaign.

### *Facing enormous fiscal pressures*

Former Secretary of Health and Human Services (HHS) Donna Shalala, now president of the University of Miami, told the roundtable that governors facing enormous fiscal pressures from Medicaid have "come to Washington, hat in hand, assuming that with a Republican president who had been a governor and a number of governors in the administration and in Congress, they would get a response, but they haven't yet gotten a serious response."

While current HHS Secretary Tommy Thompson, one of those former governors in the administration, has proposed a block grant approach to Medicaid reform, and has said that as a governor he would have jumped at such an opportunity, Ms. Shalala said governors "are smart enough to realize that's a very short-term approach and they won't have the kind of money they need until at least the next cycle of elections."

> "I would argue that if you're going to take a major step in health care, you have to both describe the problem and have a solution on which there's a consensus, a bipartisan consensus, and we don't have that now."
>
> Donna Shalala
> President
> University of Miami

She also referred to the large number of uninsured and said that while there seems to be consensus on describing the problem accurately, "in politics that's not enough. We may get consensus on what the problem is, but we still don't have consensus any more than we did in 1993 on the solution to the problem.

"This is not a situation in which large groups of people are convinced that there's a government role here and a government solution. I would argue that if you're going to take a major step in health care, you have to both describe the problem and have a solution on which there's a consensus, a bipartisan consensus, and we don't have that now," Ms. Shalala said.

American Enterprise Institute resident scholar Norm Ornstein said that to understand the administration's block grant approach to Medicaid reform, people need to regard President Bush as "President Reagan's son," a very politically conservative person who wants to get the federal government out of the Medicaid business by "giving an inducement to the states in the short run and then taking it down and leaving it to them."

Mr. Ornstein said that what states would prefer is that the federal government take on Medicaid and relieve states of the burden.

Given those very different approaches, he predicted a highly politicized confrontation that will divide the governors. "I don't see much of it happening," he said. "I also have to say that I don't see much appetite either in the White House or for many in Congress for the generous aid that the states want."

### *A key solution*

He said that one key to a solution could be the effectiveness of Sen. Olympia Snowe (R-ME), a member of the Senate Finance Committee who would like to see states get more money.

Mr. Ornstein said that if Sen. Snowe "keeps her resolve, . . . she might be able to work out a bargain in which we simply provide more money to the states along with some flexibility for Medicaid, but without the other changes."

Ms. Shalala predicted a higher federal match for Medicaid but without any other program restructuring.

Against that political backdrop, the National Governors Association (NGA) has appointed a Medicaid Reform Task Force and charged it with developing a reform package

for the association to push.

Task Force co-chairman Dick Kempthorne, governor of Iowa, said the governors have made Medicaid their highest priority because "the program is crushing our budgets, and we believe that restructuring it to meet the demands of the 21st century is one of the most effective actions we can take to bring state budgets under control."

In a working session, the task force identified six key issues for states:

1. **Dual Eligibles.** The task force is reviewing prescription drug benefits, long-term care, and premiums, copays, and deductibles currently financed by states for Medicare beneficiaries who also qualify for Medicaid. The NGA said states have long advocated for the federal government to finance all of the health care needs of Medicare beneficiaries who also qualify for Medicaid, the so-called dual eligibles. There are some 6.2 million elderly and disabled individuals who qualify for both programs. About one-third of states' Medicaid spending is on the dual eligibles.
2. **Flexibility.** The NGA said there now are more than 2,500 approved Medicaid waivers, many of them in operation in multiple states for many years. States have advocated for more flexibility in administering the Medicaid program without having to resort to waivers. Such flexibility would relate to every part of the program, including benefit packages, cost sharing, and eligibility determination.
3. **Prescription Drugs.** With costs associated with prescription drugs increasing significantly, states have sought more flexibility in determining benefit design, copays, and eligibility.
4. **Long-Term Care.** The NGA said that governors recognize that the entire long-term care system needs broad restructuring. In the past, governors have pursued waivers to allow Medicaid beneficiaries to be able to choose from an array of long-term care options, and not only be faced with selecting a nursing home as the only alternative.
5. **Private Sector Coordination.** Current statutes and regulations deter states from partnering effectively with the private sector to deliver cost-effective services, the NGA reported. Effective partnerships between Medicaid and the private sector would facilitate improvements in quality and efficiency.
6. **Financing.** The governors pledged to review and evaluate the current structure and various alternative proposals.

Meanwhile, the American Hospital Association (AHA) testified before a U.S. House subcommittee on its concerns about the administration's Medicaid reform proposal.

"The administration proposal seeks fundamental change to the Medicaid program and ties any fiscal relief for states to the acceptance of such proposed changes," the AHA statement said.

"It weakens the guarantee of coverage for vulnerable populations and dismantles the Disproportionate Share Hospital [DSH] Payment program [which is] our nation's primary source of support for safety-net hospitals that serve the most vulnerable Americans — Medicaid beneficiaries and the uninsured and underinsured. The proposal loosens federal oversight and state accountability, and it is the poor, disabled, and elderly that would be affected."

The AHA called for immediate fiscal relief for states through higher federal match payments or other relief under which states could use the funds to help their Medicaid programs.

"States should not be forced to radically transform their programs to receive such relief," the association said, "nor should they be compelled to reduce future spending to repay the federal support given now."

The AHA also called for maintaining a federally enforced entitlement to a set of meaningful benefits for the nation's most needy people and argued against giving states absolute flexibility in deciding which non-mandatory populations and health care services will be covered in the future.

On the question of financing and financial integrity, the AHA said that both federal and state governments have a responsibility to maintain their financial commitment to the Medicaid program.

"The administration proposes to sever the federal and state financial partnership and replace it with a fixed federal commitment and a state maintenance of effort, which begins to unravel the financial foundation of the Medicaid program," the hospital groups' testimony said. "At the heart of the proposal is the absorption of the Medicaid disproportionate share payment funds into the acute care

allotment. The current Medicaid DSH program is the reason that many hospitals have been able to continue serving our most vulnerable people. The elimination of this discrete payment program would be a devastating blow to these hospitals, and to the poor and uninsured patients they serve. Many of these hospitals are in financial jeopardy; many are the sole source of care in their communities. Their failure would put communities at risk because without them, medical services, social services, and important jobs would disappear."

The hospital group also argued against the administration proposal to cap federal spending using FY 2002 spending as the base year, updated annually by a nonspecified trend factor. The administration also would tie required state maintenance of effort to the FY 2002 base year amounts, with annual updates. "What this translates into is a capped program that over time will struggle to meet the needs of the mandatory population by putting pressure on states to reduce coverage to the nonmandatory populations and to reduce payments to providers."

Opposition to any federal cap on funding or elimination of the federal-state partnership in Medicaid also has been voiced by the National Health Law Program, which urged advocates and providers to identify the financial and public health consequences that a cap could have in terms of limiting the flexibility and staff needed to respond to newly developing diseases such as severe acute respiratory syndrome or other currently unforeseen events.

*[Contact NGA public affairs specialist Jason Feuchtwanger at (202) 624-5333; Norm Ornstein at (202) 862-5800; and the American Hospital Association at (202) 638-1100.]* ■

## *Fiscal Fitness*

*Continued from page 1*

The method also can be used in managed care to evaluate patterns or outcomes of practice.

In a presentation earlier this year to the Seventh Annual Congress on Medicaid and Medicare, Mr. Kaelin said a method of risk adjustment is needed to deal with the fact that a small percentage of the population is responsible for a disproportionate share of health care expenditures.

"Let's think about what this distribution in costs means for health care financing at the health plan or provider level," he said. "Is it likely that each plan or provider group would have a proportional distribution of each category of cost groups?"

While risk adjustment wouldn't be necessary if populations were randomly distributed among plans and providers; in the real world, according to Mr. Kaelin, health plan membership and membership in a particular physician's panel are not randomly distributed. As a result, he says, risk adjustment is necessary:

- to protect plans and providers that enroll a costlier-than-average group of enrollees;
- to minimize incentives for plans and providers from selecting or marketing to healthier enrollees;
- to provide accurate financing for plans and providers that treat individuals with higher-than-average health care needs and costs.

In general, he says, risk adjustment affects the distribution of funds among health plans and should not increase or decrease payments in the aggregate to all plans. Risk adjustment should not determine the "size of the [payment] pie," but may affect the size of each managed care organization's slice of the pie.

Under its first CMS contract, Mr. Kaelin's center held two forums with representatives of nine states that are making risk-adjusted payments to collect information on their approaches and experiences. They developed a training manual on how to implement a risk-adjusted payment system and produced what he describes as the most complete documentation of state experiences in making risk-adjusted payments.

Under the second research grant, the center is responsible for preparing a checklist to be used by CMS regional offices to review risk-adjusted rate packages; developing a training manual and conducting a training session for regional staff, and holding a three-day forum for officials from states that want to learn how to use risk adjustment for payment methods, plan profiling, and program evaluation.

### Survey findings

In January 2001, the center released the first comprehensive survey of states using health-based risk adjustment. Among its major findings:

- Eight states used the Chronic Illness and Disability Payment System (CDPS/DPS), with 65 health plans affected.
- Two states used Adjusted Clinical Groups (ACG), affecting 16 health plans.
- Significant numbers of enrollees are covered by risk adjustment.
- Three states risk adjust the Temporary Assistance for Needy Families population of women and children.
- Four states risk adjust the disabled Social Security Income population.
- Three states risk adjust both populations.

Mr. Kaelin says that the most common applications of risk adjustment are in financing (either determining capitation payments or establishing financial targets) or in profiling (comparing health plans and providers and assessing relative efficiency of plans and providers).

Implementation of a risk adjustment system involves a number of steps, starting with choosing the system that will be used.

There are two basic types of systems — categorical systems classify members into mutually exclusive groups based on their diagnostic history, while additive systems assign a risk score to each member based on his or her unique diagnostic history. Mr. Kaelin tells *State Health Watch* that for the states, the actual system selected is not as important as the implementation and data issues that arise following selection of a system.

Once a system has been selected, it is necessary to develop a database of diagnostic history for a plan's members that will be used to measure their health status.

Questions to be posed and answered include the categories of service to be included, treatment of noncovered services, length of risk assignment period, risk assignment lag, and number of diagnoses.

Most risk assignment systems specify an annual risk assignment period, although some users believe that six or even three months is long enough to get an accurate measure of health status. Mr. Kaelin says there is a need to use a consistent number of diagnoses when health status is measured for payment purposes. There also is a need to define the lag between the payment period and the risk assignment period.

"With a two-year lag, the data for the risk assignment period should be complete," he says, "but many of the observed medical conditions may have been resolved. A one-year lag will be more reflective of current medical conditions, but the diagnostic data may be incomplete."

Based on choice of risk adjustment system, payments will either be based on risk groups or risk scores. With risk groups, Mr. Kaelin says, officials should consider combining the risk groups into a smaller number of actuarially stable groups.

"You need to carefully evaluate your encounter data to ensure that they are complete and measure health status accurately."

John Kaelin
Executive Director
Center for Health Program Development and Management
University of Maryland
Baltimore

A decision has to be made whether to make individual level payments or managed care organization level payments. Risk groups or scores can be used to determine payment for each individual. The groups and scores also can be used to determine the average health status for enrollees in each managed care organization.

While fee-for-service data can be used in new managed care programs, as programs mature they need to switch to encounter data to measure health status.

"You need to carefully evaluate your encounter data to ensure that they are complete and measure health status accurately," Mr. Kaelin says.

His survey of states using risk adjustment found that most phased in their programs using a variety of mechanisms, including implementing risk adjustment for one eligibility group and gradually expanding it to their entire population, blending risk adjustment and demographic payments, and placing corridors on changes in managed care organization revenue.

Although risk adjustment is generally budget-neutral, it can be an important tool in difficult budgetary times, Mr. Kaelin says.

Risk adjustment can help agencies understand relative differences in cost and utilization among plans. It can help evaluate the merit of individual health plan financial issues and rate adequacy concerns. And by paying plans based on health status, it can improve the equity and efficiency of the overall payment system.

The lessons learned from the research, he says, are that achieving the benefit of risk adjustment requires careful implementation, assessing the completeness and validity of the diagnostic data are essential, and involving health plans early in the process is important.

Mr. Kaelin says that those states that had the most cooperation from their plans accomplished that cooperation by talking a lot with the plans in advance of implementing risk adjustment so that the plans were able to identify potential data issues. There have been no reports of plans actually pulling out of Medicaid managed care because of problems with risk adjustment.

"Risk adjustment sits within the overall payment system and can maximize the efficiency of the payment system so that it is more fair and equitable," he tells *State Health Watch*. "But if there isn't enough money in the system, risk adjustment isn't likely to help."

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# Innovative state and local programs could cut inappropriate adolescent mental health placements

The investigative agency of Congress said that in 2001, more than 12,700 children were placed in the child welfare or juvenile justice systems by their parents just to receive needed mental health services. The General Accounting Office (GAO) said systems were not designed to serve children who have not been abused or neglected, or who have not committed a delinquent act.

The agency recommended that innovative programs at the local and state level that show promise for reducing the need for such placements be evaluated and encouraged.

Representatives of two leading mental health advocacy organizations praised the report, which was prepared for Sen. Susan Collins (R-ME) and U.S. Reps. Pete Stark (D-CA) and Patrick Kennedy (D-RI). Both groups have published studies about parents who find that surrendering custody of their children is often the price they must pay for mental health care.

"The problem is a national tragedy," says Darcy Gruttadaro, national director for the Arlington, VA-based National Alliance for the Mentally Ill's (NAMI) Child & Adolescent Action Center. "It is a moral, economic, and political scandal."

She says the GAO findings support a NAMI study published in 1999 in which 20% of families surveyed reported having to give up custody of children to states in exchange for adequate treatment.

Laurel Stine, federal relations director for the Bazelon Center for Mental Health Law in Washington, DC, says custody relinquishment "is absolutely devastating to families. Children with mental health needs face the added stress of being displaced and feeling abandoned. Meanwhile, parents have to give up their say about key aspects of their children's lives, like where or whether they go to church and how late they can stay up at night."

Ms. Stine says the GAO's figures "may be the tip of a much larger iceberg" because many states did not provide data to GAO investigators, but indicated that such placements do occur.

The GAO report identified a number of factors (**see box, p. 10**) that influence parents' decisions to relinquish custody:

- **Gaps in and limits on mental health coverage.** Some mental illnesses are not covered, and families often face limits on the intensity or duration of care that private insurers will pay for. Medicaid covers a limited number of children who could benefit from mental health services. Both public systems and private insurers often fail to cover the intensive community-based services that could reduce the need for more expensive residential treatment.
- **Limited child mental health resources.** The GAO said that parents may be encouraged to take drastic measures to make their children a priority for scarce mental health resources.
- **Lack of coordination.** Eligibility requirements for services often differ between agencies, making it difficult for children to obtain coordinated care. Also, the agency said, some services providers and officials have "misunderstood the role of their own and other agencies," and have given parents incomplete or inaccurate information, creating service gaps for children with mental health needs, the agency said.

According to the survey of state child welfare directors, placed children are more likely to be boys than girls and are more likely to be adolescents. "Child welfare directors in 19 states reported that in fiscal year 2001, 65% of placed children were male, and 67% were between the ages of 13 and 18," the report said. "While juvenile justice officials could not provide information about the gender and ages of children placed in their system, most children in the juvenile justice population are male and range in age from 13 to 18."

Children who were placed were described as having severe mental illnesses, sometimes in combination with other disorders. Parents of the children believed that they needed intense treatment that could not be provided in their homes. Many of the children were described as violent, having tried to hurt themselves, their parents, or their siblings, and often preventing their parents from meeting the needs of other children in the family.

Children who are placed or at risk of placement come from families that span a variety of economic levels.

The GAO reported that although few strategies have been developed specifically to prevent mental health-related child welfare and juvenile justice placements, state and local officials identified a range of practices that they say may prevent such placements by addressing key issues that have limited access to child mental health

services in their state. Although some programs were modeled on practices that had been evaluated in other settings, the effectiveness of the practices is unknown because many of them were implemented on a small scale in one location or with a small target group or were too new to be rigorously evaluated.

Officials in six states that were visited by GAO staff (Arkansas, California, Kansas, Maryland, Minnesota, and New Jersey) said that one way to reduce the cost of services is to better match children's needs to the appropriate level of service. The report said that one goal of some of the programs reviewed was to ensure that children with lower-level needs were appropriately served with lower-level and less expensive services, reserving more expensive services for children with more severe mental illnesses.

The report highlighted New Jersey's Systems of Care Initiative through which the state contracted with a private, nonprofit organization for a variety of services such as mental health screenings and assessments to determine the level of care needed, authorization of service, insurance determination, billing, and care coordination across all agencies involved with children. When the initiative is expanded statewide from its current five out of 21 counties, the contractor in each county will use standardized tools to assess children's mental health and uniform protocols to determine appropriate levels of care. Children requiring lower levels of care will be referred to community-based providers, while children requiring a higher level of care will be approved to receive services from local care management organizations specifically created to serve them.

As another cost-saving method, the GAO said, some programs substituted expensive traditional mental health providers with nontraditional and less expensive providers. Officials in New Jersey, Kansas, and Minnesota reported that they had started using less expensive providers, such as using nurses to distribute medications rather than psychiatrists and bachelor's-level workers for case management instead of master's-level social workers.

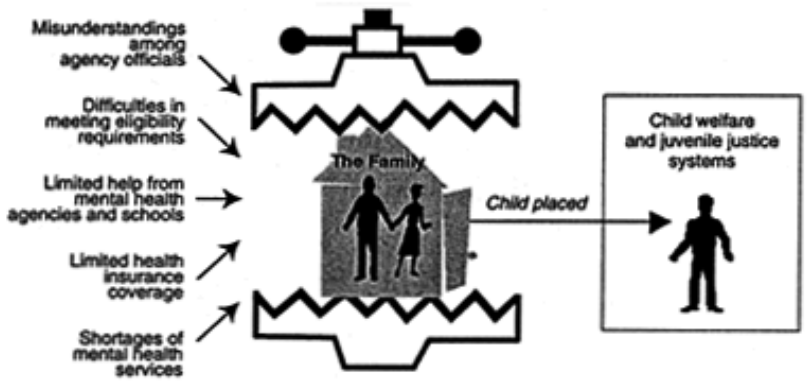
Officials in five states also recommended increasing use of volunteer and charitable organizations to reduce the cost of services because these organizations can provide inexpensive or free supportive services to children with a mental illness and their families. While the services were not therapeutic, they helped families cope with problems associated with mental illness and kept some mental health problems from escalating.

An example cited in the report is the Four County Mental Health Center in Kansas that used volunteers from churches, community agencies, and charities such as the Salvation Army to provide services such as mentoring and tutoring for children with a mental illness.

In addition to reducing the cost of services, state officials in all six states visited identified the blending of funds from multiple sources as another way to pay for services, thus working around agencies' limitations on the types of mental health services and placement settings each can fund. The report discussed a Maryland county with a coordinating council headed by a local judge that blends funds from multiple agencies to provide community-based services to children with a mental illness involved with the judicial, child welfare, and mental health systems and with district special education programs. The council leveraged funding by inviting decision makers who could commit resources from a variety of child-serving agencies and organizations to serve on the council.

Officials in four of the six states also pointed to use of flexible funds, with few restrictions, to pay for nontraditional services that generally are not allowable under state guidelines. For example, Arkansas' Together We Can program used flexible funds from a federal social services block grant, state general revenue, and the Title IV-B program to provide a wide range of nontraditional supportive services and items to children with a mental

## Factors Influencing Placement




*Source:* U.S. General Accounting Office, Washington, DC.

illness and their families. The program provided services and items such as in-home counseling, community activities, respite care, mentoring, tutoring, clothing, and furniture that helped the family care for the child at home and supported the child in the community.

To improve access to mental health services and bring clarity to a confusing system, three of the states developed a facility to be a single point of entry into the mental health system. Typically, several agencies are represented at the facility and children are assessed with a common instrument and eligible for the same services regardless of which agency has primary responsibility. One example of this effort is Kansas' Shawnee County Child and Family Resource Center, a one-stop facility that houses workers from 11 social service agencies, including mental health, child welfare, juvenile justice, and education. All children with mental health needs, regardless of which agency first encountered them, are referred to the center. Center case managers assess each child's psychological, educational, and functional needs, determine appropriate services and placements, make referrals, provide some direct counseling services, and determine how to pay for services. The facility even has four bedrooms for children who need to be removed from their home for a short period and a secure juvenile justice intake suite staffed 24 hours a day. County officials told GAO investigators that the center ends service fragmentation and prevents duplication of services for children with a mental illness and their family by implementing one intake procedure for all county social services.

State officials in all six of the visited states cited the value to improved access of colocating services in public facilities such as schools and community center. Los Angeles County officials in California have found that integrating mental health services into the school system has been a very effective way of reaching poor families without transportation and working families, helping to ensure regular participation in mental health services.

In Maryland's Hartford County, mental health services are colocated at an elementary school specifically to improve access to care for students with mental illness. The school used county health and mental health funds to provide mental health services through a bachelor's-level social worker, a nurse practitioner, and consulting services from a physician and psychiatrist. The school also has internal support staff available to children with mental illness, including a guidance counselor, behavioral specialist, home visitor who supports families and assesses the home situation, and a pupil personnel worker who visits homes and helps with transportation issues.

The report says that officials in all six of the visited states identified expansion of the number and range of community-based services to provide an entire continuum of care as a way to improve treatment for children with a mental illness.

Meanwhile, the president's New Freedom Commission on Mental Health released an outline of its report scheduled to be presented to President Bush at the end of April, ending the commission's one-year lifespan. The commission's vision statement said it is committed "to a future where recovered is the expected outcome and when mental illness can be prevented or cured. We envision a nation where everyone with a mental illness will have access to early detection and the effective treatment and supports essential to live, work, learn, and participate fully in their community."

Among the recommendations to be included in the report:

- Advance and implement national strategies for suicide prevention and a national campaign to reduce the stigma of seeking care.
- Strengthen early childhood mental health interventions by implementing a national effort to focus on mental health needs of young children and their families that includes screening, assessment, intervention, training, and financing of services.
- Screening, assessment, and treatment for co-occurring disorders should be the expectation in mental health, substance abuse, child welfare, criminal and juvenile justice, and primary care settings.
- Screen for mental disorders in primary care settings across the lifespan.
- States should ensure that each adult with serious mental illness and each child with serious emotional disturbance and his or her family have a single, individualized plan of care.
- Create an integrated state plan for treatment and support.
- Expand the recovery orientation of the system of care by increasing the opportunities and capacities of consumers to share their inspiration, knowledge, and skills.
- Strengthen and expand supported employment.
- Protect and enhance rights.
- Expand criminal justice and juvenile justice diversion and re-entry programs.
- Reform financing for Medicaid and Medicare.
- Improve access to housing and end chronic homelessness.
- Accelerate research to cure or prevent mental illness.
- Expand knowledge base to inform policy designed to reduce mental health disparities, long-term

effects of medications, and develop process to study crisis interventions and acute care.
- Test evidence-based practice interventions in demonstration projects.
- Increase and improve a diverse mental health work force.
- Use information technology to improve care.
- Establish funding incentives for recruitment and retention of mental health professionals in rural settings.
- Through a public and private partnership develop and implement comprehensive public health policies that reduce barriers to access, improve community outreach and engagement, and ensure development of culturally competent care to racial and ethnic minorities.

*[For the GAO report, go to: www.gao.gov. Contact NAMI at (703) 524-7600 and the Bazelon Center at (202) 467-5730. For information from the New Freedom Commission, go to: www.mentalhealthcommission.gov.]* ■



# *Clip files / Local news from the states*

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

### Illinois may borrow $1.5 billion for overdue Medicaid bills

SPRINGFIELD, IL—Gov. Rod Blagojevich's administration has reached a tentative agreement with state comptroller Dan Hynes and state treasurer Judy Baar Topinka to borrow hundreds of millions of dollars to help pay overdue bills to hospitals, pharmacies, nursing homes, and other Medicaid providers. But the three have yet to agree on the amount they want to borrow, with Gov. Blagojevich and Mr. Hynes, both Democrats, pushing for up to $1.5 billion to avert a slowdown in paying income tax refunds and sending state aid payments to schools. Ms. Topinka, a Republican, so far has agreed to borrow only $750 million to cover Medicaid reimbursements, an amount sufficient to capture an additional $740 million in federal Medicaid matching funds. Ms. Topinka agreed with the governor and comptroller to notify lawmakers of the plan to borrow $1.5 billion. The governor contends Ms. Topinka is "on board in concept," said Tom Schafer, a Blagojevich spokesman. Last year, refunds to many Illinois taxpayers were months late, going out only after the state borrowed money. That earlier loan still is being repaid.

Medical care providers greeted the short-term borrowing plan with cautious optimism. "I think it's wonderful if we start to get paid," said Warren Winston, a pharmacist at Sherrick Drug & Medical in Carthage, IL. "This money could literally keep pharmacies afloat. I guess we will know more within the next 30 days when the next billing cycle begins." The state owes Sherrick Drug more than $130,000 in unpaid Medicaid bills dating to last fall. On average, the state has acknowledged falling behind 90 days in paying all kinds of providers. That has prompted hospitals, pharmacies, physicians and others to turn away Medicaid patients for drugs and outpatient services. Providers still are treating emergencies.

—*Chicago Tribune*, April 18, 2003

### Judge OKs Medicaid cutoff

DENVER—Colorado can legally shut out thousands of sick, poor, and elderly legal immigrants from the program that buys their medicine and pays for medical treatment and nursing home care, a judge ruled. U.S. District Judge Robert Blackburn denied a request, filed by the American Civil Liberties Union (ACLU) on behalf of eight immigrants, to stop the state from implementing a new law ending Medicaid payments for legal immigrants. ACLU spokesman Mark Silverstein said the group would appeal. The legislature, seeking nearly $1 billion in spending cuts to balance the state's budget, passed the measure — signed into law March 5 by Gov. Bill Owens. It was to have taken effect April 1, resulting in about $1.3 million in savings this year and nearly $6 million next year. In challenging the law, ACLU attorneys argued that Medicaid "may actually make the difference between life and death." In his decision, Judge Blackburn agreed that the state legislature's move will harm the immigrants. "Even a temporary suspension of coverage would result in irreparable injury to many of the plaintiffs," he wrote. Nevertheless, he concluded that the public interest, including the constitutional requirement of a balanced state budget, outweighs that harm.

—*Denver Post*, April 17, 2003