State Health Watch

Vol. 13 No. 9 — *The Newsletter on State Health Care Reform* — September 2006

THOMSON
AMERICAN HEALTH CONSULTANTS

In This Issue

A near-failing grade for mental health system reflects beleaguered states

The nation's mental health system has been given a near-failing grade of D by the National Alliance on Mental Illness (NAMI) in its first state-by-state evaluation of the nation's mental health system in more than 15 years.

The 230-page report, "Grading the States: A Report on America's Health Care System for Serious Mental Illnesses," includes individual state narratives and scoring tables. It calls on states to make smarter investment choices through proven, cost-effective practices, and to link taxpayer funding to performance and individual outcomes. The report also includes a section on innovative state best practices (**see article, p. 7**) that NAMI said should be replicated in other states.

"Grades are more than report cards," said NAMI executive director **Michael Fitzpatrick**. "They reflect standards that help people recover, and choices being made by governors and legislatures every day. States doing well in the report have developed a common vision and political will to move their treatment systems forward."

Grades were calculated by scoring 39 criteria, based in part on a survey of state mental health agencies

See NAMI on page 2

Prescription drugs for low-income uninsured and the elderly can be hard to find in some states

While health policy-makers have been working on extending prescription drug coverage for Medicare beneficiaries through the new Part D benefit, some researchers are reminding us that fulfilling the prescription drug needs of nonelderly, low-income uninsured people is a growing problem.

Fiscal Fitness: How States Cope

Center for Studying Health System Change (HSC) researcher **Laurie Felland** tells *State Health Watch* that while safety net providers have made acquiring free or reduced-fee prescriptions an integral part of their daily operations, access to affordable prescription drugs remains a challenge. Ms. Felland wrote an issue brief, *The Community Safety Net and Prescription Drug Access for Low-Income, Uninsured People*, with Mathematica Policy Research consulting researcher **Erin Taylor** and HSC research assistant **Annaliese Gerland**. The issue brief is based on HSC's 2005 site visits to 12 nationally representative communities — Boston; Cleveland; Greenville, SC; Indianapolis; Lansing, MI; Little Rock, AR;

See Fiscal Fitness on page 5

State Health Watch
The Newsletter on State Health Care Reform

On-line access / Index

Back issues of *State Health Watch* may be searched on-line for a fee at **www.newslettersonline.com/ahc/shw.** Issues may be searched by keyword and date of publication.

State Health Watch (ISSN# 1074-4754) is published monthly by Thomson American Health Consultants, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Application to mail at periodicals postage rates is pending at Atlanta, GA 30304. POSTMASTER: Send address changes to State Health Watch, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information:
Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30 a.m. - 6 p.m. Monday-Thursday; 8:30 a.m. - 4:30 p.m. Friday ET.
E-mail: ahc.customerservice@thomson.com.
Web site: www.ahcpub.com.

Subscription rates: $399 per year. Discounts are available for multiple subscriptions. For pricing information, call Steve Vance at (404) 262-5511. Back issues, when available, are $67 each.

Government subscription rates: Call customer service at (800) 688-2421 for current rate. For information on multiple subscription rates, call Steve Vance at (404) 262-5511.

(GST registration number R128870672.)

Vice President/Group Publisher: Brenda Mooney, (404) 262-5403, brenda.mooney@thomson.com.
Editorial Group Head: Lee Landenberger, (404) 262-5483, lee.landenberger@thomson.com.
Editor: John Hope, (717) 238-5990, johnhope17110@att.net.
Senior Production Editor: Nancy McCreary.

THOMSON
AMERICAN HEALTH CONSULTANTS

NAMI

Continued from page 1

conducted between October and December 2005. The state-by-state grade distribution was:

B: Connecticut, Ohio

B-: Maine, South Carolina, Wisconsin

C+: Maryland, Michigan, Minnesota, Oregon

C: California, District of Columbia, Hawaii, New Jersey, Rhode Island, Texas

C-: Delaware, Florida, Massachusetts, Missouri, New Mexico, Tennessee, Vermont

D+: Arizona, North Carolina, Pennsylvania

D: Alaska, Alabama, Georgia, Mississippi, Nebraska, New Hampshire, Oklahoma, Utah, Virginia, Washington, West Virginia, Wyoming

D-: Arkansas, Indiana, Louisiana, Nevada

F: Iowa, Idaho, Illinois, Kansas, Kentucky, Montana, North Dakota, South Dakota

U (unresponsive): Colorado, New York

The report confirmed earlier negative assessments of the nation's mental health system by President Bush's New Freedom Commission and the Bazelon Center for Mental Health Law.

The New Freedom Commission's July 22, 2003, final report said the nation's mental health system was beyond simple repair and recommended a wholesale transformation that involves consumers and providers, policy-makers at all levels of government, and both the public and private sectors.

"The time has long passed for yet another piecemeal approach to mental health reform," said commission chairman **Michael Hogan**, director of the Ohio Department of Mental Health. "For too many Americans with mental illnesses, mental health services and supports they need are disconnected and often inadequate. The commission has found that the time has come for a fundamental transformation of the nation's approach to mental health care."

The commission said the current system is unintentionally focused on managing the disabilities associated with mental illness rather than promoting recovery, and that this limited approach is due to fragmentation, gaps in care, and uneven quality. It called for a shift toward consumer and family-driven services.

"Consumers' needs and preferences, not bureaucratic requirements, must drive the services they receive," the commission declared.

A 2001 Bazelon Center report said almost everywhere "consumers and families are frustrated, providers are overwhelmed, and state mental health administrators are beleaguered. Policy-makers and taxpayers alike should be concerned because the result is both unnecessary human suffering and a waste of precious resources."

Bazelon said the situation exists "not because we lack information about what to do. It exists because, collectively, we have chosen not to do it." Its report called for elevating public mental health to a position of priority that more truly reflects the impact and the cost of mental illness.

"Failure to exercise the political will to do this will guarantee the continuing disintegration of state mental health systems, leaving more and more people with nowhere to turn," the report said.

The NAMI report indicates that little has changed in the years since the other groups called for reform.

"Treatment works, if you can get it, and if states get it right," said

NAMI medical director **Ken Duckworth**. "Unfortunately, too many states are willing to risk or tolerate premature deaths."

He said that Ds are unacceptable grades and Cs should not be considered a passing grade.

"If you need heart surgery, you don't want a surgeon who only got a C in medical school," he explained. "The same principle applies in helping people with mental illness. Too many states are behind the curve. They are not keeping pace by moving toward a recovery-oriented health care system, based on proven, cost-effective practices. They are selling taxpayers short by settling for pieces of systems that are largely obsolete."

How well can people get info?

The NAMI survey included the "Consumer and Family Test Drive." Since access to services depends on access to information, NAMI had consumers and family members navigate the web sites and telephone systems of the state mental health agency in each state and rate their accessibility according to how easily one could obtain basic information.

To some degree, NAMI said, this exercise was like a "pop quiz." More than 80% of the states scored less than 50% of the total points. And in one case, an Illinois agency employee told a consumer, "No, I will not help you."

"Getting help means getting access to information," Mr. Duckworth said. "When 40 states can't pass a pop quiz on providing basic information to the people whom they are supposed to serve, then the system is in trouble."

States that received excellent Test Drive scores were Indiana, Michigan, Ohio, South Carolina, and Tennessee. Those receiving the lowest Test Drive scores were Alabama, Arkansas, Missouri, New Mexico, and South Dakota.

NAMI said high-quality state mental health systems are characterized by 10 elements:

1. Comprehensive services and supports, including affordable and supportive housing, access to medications, Assertive Community Treatment, Integrated Dual Diagnosis Treatment, illness management and recovery, family psychoeducation, supported employment, jail diversion, peer services and supports, and crisis intervention services.

2. Integrated systems.

3. Sufficient funding.

4. Consumer- and family-driven.

5. Safe and respectful treatment environments.

6. Accessible information for consumers and family members.

7. Access to acute and long-term care treatment.

8. Cultural competence.

9. Health promotion and mortality reduction.

10. Adequate and qualified mental health work force.

Mr. Fitzpatrick said he expected the report to have policy consequences. "Consumer and family advocates will use it as a tool for change," he suggested. "Governors and legislators should use it as a check list. The goal is to raise the level of awareness, dialogue, and creative action. Iowa is a prime example. It gets an F overall. Some 89 of its 90 counties are classified as rural, but the state lacks a strategy for addressing distinctive rural needs. Tell that to presidential contenders who plan on visiting the state."

He also called attention to New Hampshire, once considered to have one of the best mental health systems in the nation but in this report was one of 19 states to receive a grade of D.

The report was particularly critical of Illinois because it was the only large, populous state to receive a failing grade and also because it ranked 46th in the Consumer and Family Test Drive.

Report attracting attention

Mr. Fitzpatrick tells *State Health Watch* NAMI has been pleased with the media attention the report has received since its March release.

"We continue to see conversations," he says. "There have been a number of states where the media have made reference to the grades. That was our intent and one reason why we used the report card and grading format."

NAMI is developing new materials for the upcoming 2007 legislative sessions in states, he says, and hopes they will get more attention because of the attention paid to the report.

He suggested that even though the NAMI report mirrors language used by the New Freedom Commission, the U.S. Surgeon General, and the Institute of Medicine, it may be getting more attention and greater traction because of its report card format.

"It's easier for advocates to use," Mr. Fitzpatrick says. "And the state recommendations are personalized, not global. We tell states the things they are doing well and the things they need to work on."

Because the report is geared to affecting policy, NAMI made several policy recommendations as a result of its findings:

1. Increase funding tied to performance and outcomes. NAMI said that in recent years most states have reduced funding for services for people with serious mental illnesses or level-funded the programs. Impacts associated with those funding decisions, the report said, include overflowing emergency rooms with no place for people to go, increased numbers of people with serious mental illnesses in jails and prisons, and large numbers of

people without access to desperately needed services. "State legislators and policy-makers must realize that cuts to vital services for people with serious mental illnesses raise rather than reduce overall costs to society," the report said. But NAMI said it recognizes and supports the importance of linking public sector mental health expenditures with positive outcomes and said states should be able to demonstrate that mental health services funded through Medicaid, the Federal Mental Health Services Block Grant, or state dollars achieve positive outcomes such as reduced symptoms, increased independence, employment, housing, and increased consumer satisfaction. And states should be able to demonstrate that their expenditures reduce negative outcomes such as hospitalizations, homelessness, criminal justice involvement, and suicides.

2. Invest in evidence-based and emerging best practices. NAMI said that while it has identified the elements of high-quality services for people with serious mental illness, its research for the report revealed that those services are in short supply or even nonexistent in many parts of the country. "If services with an established research base of demonstrated effectiveness are not translated into practice, the cynicism of policy-makers may be justified," the report said.

3. Improve data collection, reporting, and transparency of information. NAMI said it found very little data that would give advocates and consumers information about state mental health systems and how well they are performing. The data that exist are not designed to allow easy state comparisons and are not linked to consumer outcomes.

4. Involve consumers and families in all aspects of the system. NAMI said that although "lip service is given to the importance of consumer- and family-driven systems, we found very few examples where this important principle actually is being translated into practice. The examples we did find are exemplary and should be replicated in all states . . . . Unfortunately, on an overall basis, involvement of consumers and families in various aspects of the mental health system (planning, implementation, and evaluation) is token at best. Some states and systems apparently find it difficult to break away from outdated, paternalistic attitudes toward the people they are charged with serving."

5. Eliminate discrimination. NAMI said people with serious mental illnesses continue to encounter stigma and discrimination in all aspects of their lives. Overcoming such discrimination, it said, requires not only community education, but also the change of certain federal policies that reinforce the discrimination.

For example, it said, Congress continues to sanction discrimination against people with serious mental illness by failing to enact a federal law requiring that mental illness be covered on a par with all other medical disorders in health insurance policies.

And the Medicaid program contains a provision that encourages discrimination toward people with serious mental illness by prohibiting use of federal Medicaid dollars to pay for services in an "institution for mental disease." NAMI said the provision is a barrier to care in psychiatric hospitals but also to implementing Medicaid-reimbursable home- and community-based waivers of the kind that have been helpful in facilitating recovery among people with developmental disabilities and other Medicaid populations.

Finally, the Medicare program also discriminates against those with mental illness by covering 80% of the costs of outpatient treatment for traditional medical disorders but only 50% of the costs of outpatient psychiatric treatment.

Bazelon Center policy director **Chris Koyanagi** tells *State Health Watch* little has happened since she wrote the center's 2001 report and the New Freedom Commission issued its 2003 report.

"The biggest issue is getting mental health to be a higher priority so it can get the resources needed to do what needs to be done," she says.

Ms. Koyanagi says there has been some "intellectual progress" in terms of a consensus coming together on what to do.

"There's lots of rhetoric," she says, "but there is a widening gap between an appreciation for what works and its implementation. We either need to redirect existing money, which is very difficult to do, or get new money, which also is very difficult to do in this environment. Sitting here in Washington watching the federal government, it seems like we're going backwards."

A significant problem, according to Ms. Koyanagi, is that not all of the wasted money is in the mental health system. Rather it's in the courts and prisons and a number of different budgets and it's hard to get people to be able to cross organizational. Lines so they can access the money.

"Local people understand the situation best," she says. "But they often have state and federal regulations preventing them from doing what needs to be done to bring the money together."

Ohio Department of Mental Health director **Michael Hogan**, who chaired the New Freedom Commission, tells *State Health Watch* there have been mixed results in the three years between the commission's report and the

NAMI report card. Mr. Hogan praises the federal effort to bring together many agencies that have some part to play with the mentally ill, but notes there haven't been sufficient resources for that collaboration to move into program improvements.

At the state and county level, he says, many people understand and support the notion of treatment for the severely mentally ill. But a lack of resources has again worked against programming improvements.

"So it's been a mixed bag at both the federal and local levels," he says.

Download the NAMI state-by-state report from www.nami.org. The New Freedom report is available online at www.mentalhealthcommission.gov. The Bazelon report is on-line at www.bazelon.org. Contact Mr. Fitzpatrick at (703) 516-7977, Ms. Koyanagi at (202) 467-5730, ext. 118, and Mr. Hogan at (614) 466-2337. ■

Fiscal Fitness

Continued from cover

Miami; northern New Jersey; Orange County, CA; Phoenix; Seattle; and Syracuse, NY.

Not surprisingly, the authors say, low-income, uninsured people report more problems obtaining prescription drugs because of costs than do people with insurance.

Communities play a key role in providing prescription drugs for low-income, uninsured people, who often seek medications from the same safety net providers who offer medical services and prescribe the medications, according to the site visits.

"Safety net hospitals and community health centers typically have on-site pharmacies or contract with outside pharmacies to offer a full range of medications, usually charging patients a copayment," the report says. "Free clinics and other small providers often can dispense only limited quantities or types of medication. . . . As the number of uninsured Americans rises, community safety net providers are treating more uninsured patients without proportionate funding increases."

Old and new strategies

Ms. Felland says that to help subsidize and reduce the cost of prescription drugs for low-income uninsured people, safety-net providers, sometimes in collaboration with community-level programs, have built on existing strategies and developed new ones. Many safety net hospitals and community health centers have access to a federal prescription drug discount program. And while all types of safety net providers have long dispensed manufacturer drug samples to patients, they have developed more structured ways of obtaining ongoing supplies of the most commonly prescribed medications. These strategies include, in general order of prominence, increased use of federal discounts, obtaining donated prescription drugs from manufacturers, use of public and private funding to subsidize drugs, and establishing discounts for uninsured people at local retail pharmacies.

Since 1992, federally qualified community health centers and safety net hospitals receiving federal disproportionate share payments have been eligible for brand name and generic prescription drug discounts through the federal 340B drug pricing program. That program requires drug manufacturers to give eligible providers discounts equal to or greater than those received by Medicaid. Providers distribute the drugs obtained that way to patients through their own pharmacies or through contracted retail pharmacies, charging patients a sliding-scale fee based on income.

Ms. Felland says the 340B program has grown in recent years. All 12 visited sites have at least one safety net provider participating in the program but some communities, including Boston, Cleveland, Indianapolis, Miami, and Seattle, have a broad network of participating hospitals and health centers.

Many safety net providers, including those participating in 340B, rely on drug company assistance programs to obtain free or reduced cost prescription drugs for patients. According to the report, manufacturers as a group have significantly increased the amount of drugs donated through the assistance programs, with the number of free prescription medicines distributed growing from some 3 million in 1998 to 22 million in 2004, according to Pharmaceutical Research and Manufacturers of America, an industry advocacy organization.

The authors say manufacturer assistance programs vary but are typically available to uninsured people, generally with household incomes below 200% of the federal poverty level. Applicants also must demonstrate citizenship or legal immigrant status.

Getting more donated drugs

Many providers, the report says, have hired staff and devoted other resources to bringing in more donated drugs. Thus, a Lansing, MI, health center found that dedicating one full-time staff member to this effort generated more than $300,000 in free medications in one year. And in Cleveland, the county hospital assists physicians in obtaining donated drugs for their patients through automated prompts in the hospital's electronic

medical record system.

In addition, some safety net hospitals and community health centers have arranged for what is known as bulk replacement, a process by which drug manufacturers stock providers' pharmacies with medications that providers dispense to patients determined to be eligible for the manufacturers' assistance programs but who have not applied individually. The process allows pharmacies to offer medications immediately to patients, rather than having to pursue each individual application.

Another way communities fund prescription drugs for low-income uninsured people is through programs providing primary and preventive care through safety net providers, coordinating access to specialty care, and encouraging appropriate use of other services such as emergency care. Ms. Felland and her colleagues say prescription drugs are included as a vital part of managing patients' conditions. In addition to accessing available 340B discounts through participating hospitals and health centers, the programs use a portion of state and federal disproportionate share payments, state charity care pools, or local property taxes to offer medications to enrollees, usually for a small copayment.

The site visits found that some providers have pursued funding from private, usually local, charities to subsidize drug costs. While free clinics are particularly reliant on private funding, some community health centers and hospitals also have turned to foundations for help when existing programs and funding could not meet the need.

Impact on providers and patients

The report lists a number of impacts the various strategies have had on safety net providers and their patients:

• **Provider Costs**. Although the 340B program allows many safety-net providers to purchase discounted Rx drugs, the providers still must subsidize patient drug costs. And while many safety net providers and communities have streamlined how they participate in manufacturer assistance programs, the time and resources required to tap into them is prohibitive for small providers and free clinics with more limited budgets. Also, many safety-net providers are experiencing financial problems as they try to cope with a rising number of uninsured patients and they find it harder to keep pace with the rising cost of drugs, even with significant discounts.

• **Patient Costs**. Although generally a small percentage of the total medication cost, copayments, or other cost sharing required by safety net providers and prescription programs can pose barriers for low-income people. Some providers have increased their pharmacy copayments over the last few years. Also, recent discount card initiatives typically require significant out-of-pocket spending.

Although many providers offer a short-term supply of medication to patients unable to contribute to the cost, such patients may struggle to comply with a longer-term drug regimen.

• **Eligibility Restrictions**. Many people in the 12-site visit communities noted that individuals with incomes just above the thresholds of manufacturer assistance and other programs face particular barriers in accessing prescription drugs. Also, most manufacturer program requirements limit their impact in communities with many undocumented immigrants who do not qualify.

Ms. Felland tells *State Health Watch* most providers use a combination of the cited strategies to stretch their resources as much as possible. "The 340B program is important for those that qualify," she says. "They are layering on other strategies because of the lack of resources."

She says she doesn't see much relief on the horizon, and that's why providers are struggling to keep up. "They're doing the best they can without a broader solution," she says.

In Indianapolis, the Health Advantage program is operated by the Health and Hospital Corporation of Marion County, which has the Marion County Health Department, Wishard Hospital, and Wishard Community Health Centers. In 1997, the corporation established Health Advantage as a managed care program for the indigent modeled after the Indiana Medicaid program.

The county has found that while Medicaid still plays a critical role in addressing the needs of the uninsured, stringent eligibility criteria often exclude needy individuals. Many children are entitled to health benefits through Medicaid expansion, but the needs of their family members remain unmet.

Individuals without insurance face significant difficulty in accessing care and thus avoid or delay care, which results in unnecessary hospitalization for preventable illness, increased cost, and adverse communitywide health outcomes.

Health Advantage beneficiaries are its more than 30,000 active members. Potential beneficiaries include the remaining low-income, uninsured residents of Marion County. The program directly benefits the group described as the "working poor," people who fall within the gap that exists between government-assisted health coverage such as Medicaid and employer-sponsored insurance. It is open to county residents who fall at or below 200% of

the federal poverty level and don't qualify for any other assistance program. Advantage provides health care coverage for the parents of Medicaid and CHIP recipients, as well as other low-income and uninsured populations.

The program contracts with a primary care physician group, the Indiana University Medical Group, and pays them a capitated rate. Officials believe having the primary care physicians at risk for all primary care needs provides an incentive for the physicians to build relationships with their patients, encourage appropriate use of the delivery system, and improve provision of primary and preventive services.

Wishard Health Services manager of inventory control **Petra Fippen** tells *State Health Watch* Health Advantage members pay a $5 per prescription copay. She says each of the primary care clinics in the county that see Health Advantage members has a pharmacy that is operated as a closed pharmacy system. The Health and Hospitals Corp. hospitals and clinics share the same closed formulary.

"By managing the formulary and patients' health, we're working to save the county and the program money," she says. Strategies Ms. Fippen employs include trying to enroll those who are eligible in Medicare Part D or the state's Hoosier Rx, using generic drugs as much as possible, drug ceiling pricing, and enrolling members in drug company patient assistance programs. She says these activities produced an estimated $4 million last year to help offset the county's costs.

The program dispenses some 1 million prescriptions a year. Ms. Fippen candidly says she's not sure if patients are healthier as a result of the program's efforts or if they often see sicker patients. "We're doing a lot of work," she says, "and I'd like to think we're doing something to help people."

The HSC issue brief is available at www.hschange.org. Contact Ms. Felland at (202) 484-4833 and Ms. Fippen at (317) 630-8939. ■

State innovations and best practices should be replicated

While many states received low grades from the National Alliance on Mental Illness for their state mental health systems, they often had some outstanding examples of innovation and commitment to providing high-quality services to people living with mental illness. NAMI said these examples "demonstrate the pioneering approach that is necessary to fundamentally change America's mental health system. There is an urgent call for our nation to take steps to make these new programs the norm, not the exception," NAMI said.

• Financing

— California's Proposition 63 in which voters recognized a need to creatively fund services

— Combining multiple funding sources as in New Mexico to streamline care and decision making

— Local municipalities taking the lead to address mental health concerns in their communities through special tax districts or unique bond proposals (Arizona and California)

• Housing

— Tennessee is cited for tremendous progress in developing housing from almost none in NAMI's 1990 report to among the best today.

— Illinois is using real estate transaction fees to promote rental housing assistance.

— Passage of legislation dedicating $200 million to create 10,000 units of new supported housing in the next 10 years occurred in New Jersey.

— New York State has an initiative to develop more than 36,000 supportive housing units.

— Minnesota has a cooperative program between the state mental health agency and the housing finance agency to provide $650,000 in housing subsidies for people with serious mental illness.

• Restraint and seclusion reduction

— The leadership of the National Association of State Mental Health Program Directors drives a national culture change.

— There have been significant reductions in use of restraint and seclusion in a forensic setting at North Texas Hospital in Texas and Taylor Hardin Secure Medical Facility in Alabama.

— Regulations were enacted this year in Massachusetts to codify a preventive approach and discourage using restraint and seclusion in all acute and state-run facilities.

• Jail diversion

— Ohio has a culture of jail diversion that permeates almost the entire state.

— Legislation has been proposed in Kentucky to mandate a telephone triage system to screen jail inmates for mental illness and provide links to treatment.

— Connecticut has extensive post-booking jail diversion programs in arraignment courts.

— Maryland has the TAMAR (Trauma, Addictions, Mental Health, and Recovery) program for treating female consumers in

detention centers.

— NAMI Indiana runs a prison education program supported by state agencies to educate prison guards and staff about serious mental illness.

— Texas has mandatory jail diversion for every county.

— Georgia and Texas are implementing statewide police crisis intervention training.

• Employment/Vocational success

— Five states — Connecticut, Maine, Missouri, New Mexico, and Vermont — received excellent scores in the NAMI survey for their work in employment.

— South Dakota is dedicated to employment opportunities, despite being a rural state, and has a 41% employment rate for consumers.

• Disaster Response

— Mississippi, Louisiana, Alabama, and Texas are credited for quick response and triage to continue service provision and ensure safety of consumers during and after Hurricane Katrina.

— Mutual aid support from many states across the country.

• Academic/State collaboration

— Ohio, Hawaii, and Indiana are partnering with SMHAs and universities to establish centers promoting implementation of evidence-based practices.

— Connecticut is collaborating with Yale University to promote the mental health care work force.

• Creative use of public land

— There is a public/private collaboration to rebuild a community mental health center in Massachusetts.

— Oregon is reinvesting funds from sale of a state hospital to create increased housing options for individuals with mental illnesses through the Community Mental Health Housing Fund.

— Alaska has established a Mental Health Trust Authority to generate revenue for the state's mental health services.

• Mortality studies

— Medical directors from the National Association of State Mental Health Program Directors are investing in mortality studies as a priority.

• Multicultural outreach

— State leadership in California is encouraging and monitoring county-based efforts to ensure culturally competent care.

— Arizona is working to ensure the mental health work force has appropriate linguistic skills, and that materials are properly transmitted.

— Washington is establishing subcommittees — specifically on ethnic/cultural minorities and sexual minorities — to focus on the impact that legislation, public policies, and practices have on treating multicultural and/or minority groups in institutional, residential, and community

• Co-occurring systems change

— Oklahoma is developing a consumer- and family-driven process to evaluate every level of the system to integrate services for co-occurring disorders.

— Leadership to integrate treatment for substance abuse and mental illness, resulting in statewide adoption of integrated dual disorder treatments in Delaware.

— State-funded programs in Georgia to incorporate mental health treatment principles into a traditional 12-step model.

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

• Capacity response

— Arkansas is using its authority to generate new inpatient beds to address a profound population need.

• Parity Laws

— Connecticut, Maryland, Minnesota, and Vermont have a model parity law that includes substance abuse.

— Maine is including mental health parity in a statewide program to expand health insurance to uninsured populations.

• Clinical approaches to Medication access

— Missouri has a program to provide clinical feedback to doctors on prescribing patterns that save money and improve outcomes.

• Peer support/peer-run programs

— Vermont has a culture infused with recovery principles.

— Connecticut has policies to promote recovery and ensure it is a part of the state's mission and treatment planning.

— Georgia provides Medicaid reimbursement of certified peer counselors.

• Health Promotion

— New Hampshire is developing a program that provides identification and intervention for diabetes, hypertension, and other cardiac risk factors among individuals with serious mental illnesses.

• Community system of care

— Comprehensive systems of care with demonstrated linkage between service providers and integrated services and approaches (Vermont and Wisconsin).

• Engaging Rural Constituents

— Use of audiovisual technology to eliminate long-haul vehicle transport for Oklahomans in needs of emergency detention orders.

— Nebraska is taking a deliberate and deliberative approach to system redesign to improve local service capacity and access within specific budgetary restraints. ■

Utah waiver gives caution for Medicaid changes wrung from coverage reductions

Utah's experience with a Section 1115 waiver allowing expansion of primary care to adults not previously eligible for Medicaid using savings from coverage reductions for previously eligible parents provides a cautionary note on such strategies, according to a Kaiser Commission on Medicaid and the Uninsured survey.

"Officials need to be realistic about the potential for achieving Medicaid cost savings without harming enrollees, who are poorer and sicker than the privately insured population and often need broad benefits and cost protections," says Kaiser Commission senior policy analyst **Samantha Artiga**. "Recent analysis indicates that Medicaid is already an efficient program when compared with private coverage. Efforts to stretch the Medicaid dollar should guard against the unintended consequences of passing the buck to beneficiaries, who are among society's most vulnerable citizens."

Utah got its waiver approval in 2002 and the Kaiser survey was conducted in 2004. The recently enacted Deficit Reduction Act of 2005 gives states new authority to limit benefits and impose cost on beneficiaries, expanding the administration's efforts to give states increased discretion over program changes. Ms. Artiga tells *State Health Watch* that while there may have been some small program adjustments since the survey, there have been no major changes that would affect the validity of the survey report.

Reportedly a major impetus for the Utah redesign was the desire of then-governor Mike Leavitt (now Secretary of Health and Human Services in the Bush administration's second term) to expand coverage for low-income working adults, with the goal of providing preventive and primary care and eventually preventing and reducing illness and reducing uncompensated care in the state's health care system.

The federal government's active encouragement of waivers was seen as an opportunity to pursue the coverage initiative, Ms. Artiga says, and a second factor was that costs in the Utah Medical Assistance Program, which provided care for acute and life-threatening conditions to very poor adults not eligible for Medicaid, had exceeded expectations for several years, and there was increasing legislative pressure to reduce those costs.

Ms. Artiga notes that, because of a desire to move quickly, the waiver was designed primarily by the state with little input from other stakeholders. Some state officials told Kaiser they were faced with the trade-off of covering fewer people with full benefits vs. covering more people with limited benefits, and that they chose the route of providing less to more.

Advocates expressed concerns about increased demands on primary care providers and the waiver's absence of a formalized system for providing Primary Care Network (the new coverage entity) enrollees inpatient hospital and specialty care. Because the Primary Care Network coverage package did not include hospital and specialty care, the state made an informal agreement with the state's hospitals to provide a set amount of charity care to enrollees and made Department of Health case managers available to help enrollees obtain donated specialty care. However, enrollees were to be

held responsible for care they obtained that was not covered through donations.

Advocates and providers told the commission that while the notion was well intentioned, it did not guarantee enrollees access to necessary and timely specialty care and did not provide good continuity of care, particularly for beneficiaries outside of Salt Lake City. It also was noted that some primary care providers stretched the scope of their services by providing care they would usually refer to a specialist so the care would be covered by the Primary Care Network.

Eligiblity rules

Survey respondents said enrollees appeared able to obtain hospital care, but expressed concern about the sustainability of the donated hospital care system since hospitals reported providing care in excess of the agreed-upon amount and an inequitable distribution of the donated care across all the state's hospitals.

To be eligible for the Primary Care Network, adults had to have income below 150% of poverty, be uninsured, and not have access to employer-sponsored insurance. Eligible individuals were required to pay an enrollment fee initially set at $50, and there were copayments ranging from $5 to $30 depending on the service, and up to 10% coinsurance for some services.

Utah offset costs for the Primary Care Network expansion by reducing benefits and increasing cost-sharing for previously eligible parents, including very poor parents with income below 54% of poverty, parents who recently left TANF because of employment, and parents with high medical expenses who spent-down to qualify for Medicaid. The state referred to this program as nontraditional Medicaid.

The Kaiser survey found that Primary Care Network adults were primarily poor (67%), and nearly 60% were parents with dependent children. Enrollees represented a broad mix of ages, with more than half being older than 40. More than a third reported being in fair to poor health, and almost two-thirds said they suffered from chronic or ongoing health conditions, and nearly one-third reported a disability or condition that regularly prevented them from engaging in normal activities.

More than half the enrollees reported they were employed at least part time, but the overwhelming majority said they were not offered health insurance through an employer.

Nearly 20% of the enrollees said the enrollment fee was somewhat or very unaffordable, and a quarter received help paying the fee. Almost half said that paying the fee disrupted their monthly budget.

Consistent with the high prevalence of health conditions reported on the survey, respondents from both the Primary Care Network and nontraditional Medicaid reported using a wide range of health care services. Nearly all Primary Care Network enrollees reported having had a physician visit in the past year, more than half reported a dental visit, nearly one-third reported an emergency department visit, and more than a quarter reported an eye exam — all services covered at least in part. Respondents also reported using uncovered services such as mental health care and inpatient hospital care.

More than 90% of nontraditional Medicaid patients said they had visited a doctor in the past year, and almost half reported an emergency department visit. Some 40% said they had visited a dentist, nearly one-third reported an eye exam, and 20% said they were admitted to the hospital.

"It appears that most of the surveyed enrollees in both groups — 76% of Primary Care Network enrollees and 67% of nontraditional Medicaid enrollees — used or needed services beyond the scope of their coverage," Ms. Artiga said.

Among Primary Care Network enrollees, 40% said medical expenses had had a major impact on their family, and a similar number reported medical expenses of more than $250 during the past 12 months. Nearly one-third had been contacted by a collection agency in the past year for unpaid medical bills. Many also reported problems paying for basic needs, especially those who had difficulty paying for medical expenses.

Fewer nontraditional Medicaid parents reported that medical bills had a major impact on their family or medical expenses exceeding $250 in the previous 12 months. Many of those enrollees reported difficulty paying for basic needs, however. And many also reported difficult financial experiences in the previous 12 months.

Ms. Artiga says Utah's experience shows strong demand and a high level of need for health insurance among low-income uninsured adults. Although many enrollees were working at least part time, the vast majority did not have access to employer coverage and the Primary Care Network filled an important void for them. However, the need for coverage exceeded what the program's funding could support. The limited financing available from the nontraditional Medicaid reductions for parents resulted in an enrollment cap that constrained the Primary Care Network's expansion reach. She notes that in the past, other states have funded broader Medicaid expansions by drawing on larger

sources of funds such as managed care savings or unspent disproportionate share hospital funds, and tells *SHW* that such large financing sources appear necessary for larger expansions with broader coverage.

Possible renewal changes

State officials announced in the spring they were planning to request the Department of Health and Human Services extend the Primary Care Network past 2007 and planned to request some program changes based on discussions with doctors, hospitals, clinics, and advocates for low-income individuals.

Among the proposed changes are development of a preferred drug list, addition of urgent care coverage with a $20 copayment, possible elimination of emergency department coverage to free funding for other services such as specialty care, an increase in emergency department copayments if the coverage is retained, and an increase in the out-of-pocket maximum from $1,000 to $1,500.

Changes proposed for nontraditional Medicaid include increasing the pharmacy copayment from $2 to $3 and seeking a federal match for physician fees that now are paid only from state funds.

Ms. Artiga's survey report is in the March/April Health Affairs. *Other reports on the Utah experience are available from the Kaiser Commission on Medicaid and the Uninsured online at www.kff.org. E-mail Ms. Artiga at sartiga@kff.org or telephone (202) 347-5270.* ■

Clip files / Local news from the states

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

Hospitals' revenue to start being taxed

JACKSON, MS — All hospitals' revenue in Mississippi will be taxed to shore up a $360 million budget shortfall in the Medicaid program. Medical directors warn that staff and services will be cut as a result. "It will diminish the health care available to our citizens," said **Gerald Wages**, executive vice president of North Mississippi Medical Center in Tupelo. "A sizable number of hospitals are operating at a deficit."

The tax will cost the northeast Mississippi system's five hospitals $9.5 million out of about $18 million profit margin last year, said Mr. Wages, chairman of the state hospital association. In June 2005, the federal government told the state to stop a previously approved accounting tactic that pulled in more federal money for the program. The result is a $360 million gap in funding that lawmakers did not address in this year's legislative session because they were not told.

Medicaid will charge about 1.5% assessment on all hospitals' gross revenues. Currently, only public hospitals pay the assessment, which is about 0.35%. "We believe this action must be taken to ensure Mississippi hospitals do not lose $360 million worth of net revenue in the future," Medicaid executive director **Robert Robinson** wrote to hospitals in June. The plan is to shift some burden from public facilities to all hospitals, said **Pete Smith**, Gov. Haley Barbour's spokesman.

But **Dan Harrison,** executive vice president of Rush Health Systems in Meridian, said the tax is unfair because it charges hospitals for revenue that was never in the bank.

Indigent care, Medicaid, and Medicare rarely pay for the actual cost of services, so hospitals lose almost 50% of gross revenue, he said. Facilities usually write this loss off at tax time. The planned tax would charge hospitals for the full cost of services, no matter if the client paid or not, he said.

— Jackson *Clarion/Ledger*, 6/27/06

New law orders coverage for 4,000 more WV children

CHARLESTON, WV — Although West Virginia Gov. Joe Manchin signed a bill to expand health insurance to an estimated 4,000 West Virginia children, he wanted to delay making a decision about expansion until Congress reauthorized the Children's Health Insurance Program (CHIP) — something that is not expected to happen until next year. Manchin aide **Brian Kastick** asked for the delay during a meeting of CHIP's board of directors. Gov. Manchin believes it is unwise to expand the program until state officials know how much Congress will commit to it, Mr. Kastick said. "He's not against expanding the program," Mr. Kastick said. "He just doesn't want to spend money we don't have."

CHIP board members voted to put off a decision and to seek legal advice. They have to decide whether the law requires them to expand coverage or whether they can delay indefinitely. Gov. Manchin believes the board legally can wait until next year or longer, said spokeswoman **Lara Ramsburg**.

House Speaker **Bob Kiss**, D-Raleigh, disagreed. He said a delay of more than a couple of months could cause legal problems for the governor. "They just can't sit on their hands and not expand it for several months or a year," Mr. Kiss said.

The state's CHIP insures about

26,000 low-income children whose parents make too much money to qualify for the Medicaid program. The federal government pays about 80% of the cost and state taxpayers pay the rest. Earlier this year, the Legislature passed a bill (HB 4021) to expand coverage to children whose families earn 300% of the poverty level, up from 200% today. The families of new CHIP recipients would be required to pay premiums and might not receive the same level of services as poorer children, the bill said. At the bill signing in April, Gov. Manchin touted the CHIP expansion as part of his effort to cover the uninsured.

"If you're a child now in West Virginia, since we've raised the bar to 300% of the poverty level, and that's 95% of the children in West Virginia, you have some form of health care called the CHIP program," Gov. Manchin said.

—Charleston *Gazette*, 6/30/06

San Francisco's supervisors expand health coverage

SAN FRANCISCO — The San Francisco Board of Supervisors gave initial approval to a plan to extend health care coverage to the uninsured by opening up and expanding the city's system of physicians and clinics now serving poor city residents. The plan, a merger of proposals put forth by supervisor **Tom Ammiano** and Mayor Gavin Newsom, would go into effect next year, provided it passes a second board vote and is signed into law by Newsom — both considered virtual certainties. "We want to put health care on the front burner," Mr. Ammiano said, just before the unanimous 11-0 board vote in favor. "We are well on our way to that admirable goal."

The key political compromise that led to passage was an agreement between the mayor and the more liberal Board of Supervisors majority that city businesses be required to contribute to health care coverage for their employees. It would require businesses and other employers to pay $1.06 or $1.60 per hour per worker, depending on the size of the company. The balance of the estimated $200 million annual cost of the program would be covered by consumer premiums and copayments and by the $104 million a year San Francisco already spends on providing care to uninsured patients at city clinics and hospitals.

City Health Director Dr. **Mitch Katz** has said he foresees a system that emphasizes preventive medicine in which uninsured residents join or are enrolled by their employers, are assigned a primary care physician and have access to a network of specialists and hospitals.

— *San Francisco Chronicle*, 7/19/06

3 Arrested in Katrina Hospital Deaths

NEW ORLEANS — A doctor and two nurses have been arrested on suspicion of second-degree murder for allegedly administering lethal drugs to patients at a hospital while it was marooned in Hurricane Katrina's floodwaters without electricity or running water. The hospital, Memorial Medical Center, was emblematic of the near-total breakdown of New Orleans' emergency and health care systems after rising water breached the levee system Aug. 29, 2005. Scores of employees stayed at the hospital and struggled to care for hundreds of stranded patients as the electric generator died, rescue efforts stalled and temperatures soared above 100 degrees. When substantial help arrived six days later, 41 patients were dead.

The circumstances may have been dire, but Louisiana Atty. Gen. Charles C. Foti Jr. — whose office made the arrests — suggested that the suspects deliberately crossed an ethical barrier. The documents released by Foti's office included dramatic accounts by purported eyewitnesses to the alleged fatal injections.

"We're talking about people who pretended that maybe they were God," Foti said at a news conference in Baton Rouge. "And they made that decision. This is not euthanasia. It's homicide."

The suspects, Dr. Anna Pou, 50, and nurses Lori L. Budo, 43, and Cheri A. Landry, 49, were arrested Monday and released on bail. Each is charged with injecting four patients with a deadly cocktail of morphine and the drug midazolam, also known as Versed.

— *Los Angeles Times*, 7/19/06 ■