State Health Watch

Vol. 8 No. 1 *The Newsletter on State Health Care Reform* January 2001

In This Issue

Special Report: Insuring America's Children

When it comes to insuring kids, Oklahoma's newest figures are OK

Oklahoma must be doing something right. The state has managed to find a way to look after a large percentage of its uninsured children and pregnant women. While the average state averaged a 2% increase to its insured rolls between June 1997 and December 1999, Oklahoma powered to the head of the class with a 39.1% tally.

It's a big accomplishment, one that others obviously find difficult to match.

So what has Oklahoma done that everyone else can only envy? Analysts and officials say Oklahoma had the advantage of many variables falling into place at one time, a feat nearly impossible to plan in advance and one in which the way the chips randomly fall plays a large role.

What could cause aged and disabled enrollment to shoot up 3.4% or enrollment in families, children, and pregnant women categories to swell by 61.5%?

Success, it's often said, occurs when preparedness and opportunity meet. Preparedness is the variable that is most controllable in this equation for success. Oklahoma had it nailed down.

"They did a bunch of the right

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Marketing of children's health insurance comes close but is still missing the mark

The first nationwide analysis of state advertising campaigns for children's health insurance programs (CHIPs) finds that the ads are attractive and appealing and convey basic information, but lack details that participants in parent focus groups have said they want before they consider enrolling.

The study was sponsored by the Kaiser Commission on Medicaid and the Uninsured to create a baseline of information about states' marketing efforts for children's health coverage programs and to identify common approaches and messages states are using as well as innovative approaches and ideas. Kaiser Commission policy analyst Christina Chang tells *State Health Watch* that the effort is unique in combining interviews with state officials with an analysis of ads from many states by public opinion research firm professionals under contract to the commission.

Interviews with state agency officials revealed that most states are giving their CHIP program an appealing name so that it doesn't sound like a government program. "There's definitely a movement for states to shape a new identity for CHIP and even for

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Oklahoma

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things at the same time. They were ahead, for example, of everyone on eligibility," Julie Hudman, associate director of the Kaiser Commission on Medicaid and the Uninsured tells *State Health Watch*. "They had a bill ready to go before CHIP [the Children's Health Insurance Program] passed. Other states were much slower."

During the early 1990s, leading up to CHIP's coronation in 1997, policy changes paved the way for a change in Medicaid. During that ramp-up period, Oklahoma outpaced its 49 competitors, edging out its nearest competitor, the commonwealth of Massachusetts, which posted an increase of 32.5% in its enrollment. The bottom dweller, in a ranking by the Kaiser Foundation, was West Virginia, whose enrollment dropped by 12.1%. (See the total Medicaid enrollment list, p. 3.)

For the most part, the past three years have been successful for increasing enrollments, but there have been down periods, too.

"In 1999, the total number of uninsured individuals in America decreased for the first time after steadily increasing over the past decade. Both the booming economy and expansions of public programs contributed to this decline," the Kaiser Foundation notes in its report *Medicaid Enrollment in 50 States*. "From December 1998 to December 1999, national Medicaid enrollment increased by 1.1 million individuals, or 3.6%, with 43 states and the District of Columbia experiencing growth."

Streamlining the program

Oklahoma's legislators and policy-makers saw the big picture of the process and did lots of streamlining in its drive to the top.

"We were way ahead on CHIP. The state legislature in 1997 passed Title 19 expansion prior to creation of the federal CHIP program," Nico Gomez, of the Oklahoma Health Care Authority in Oklahoma City, OK, tells *State Health Watch*. "The legislature also raised the [for enrollment] to 185% of the poverty level, including children under age 18."

Another key element of Oklahoma's success, according to Mr. Gomez: the state's decision to expand its Medicaid program, creating SoonerCare, instead of starting its own separate CHIP division.

"That helped our total number of children enrolled,"

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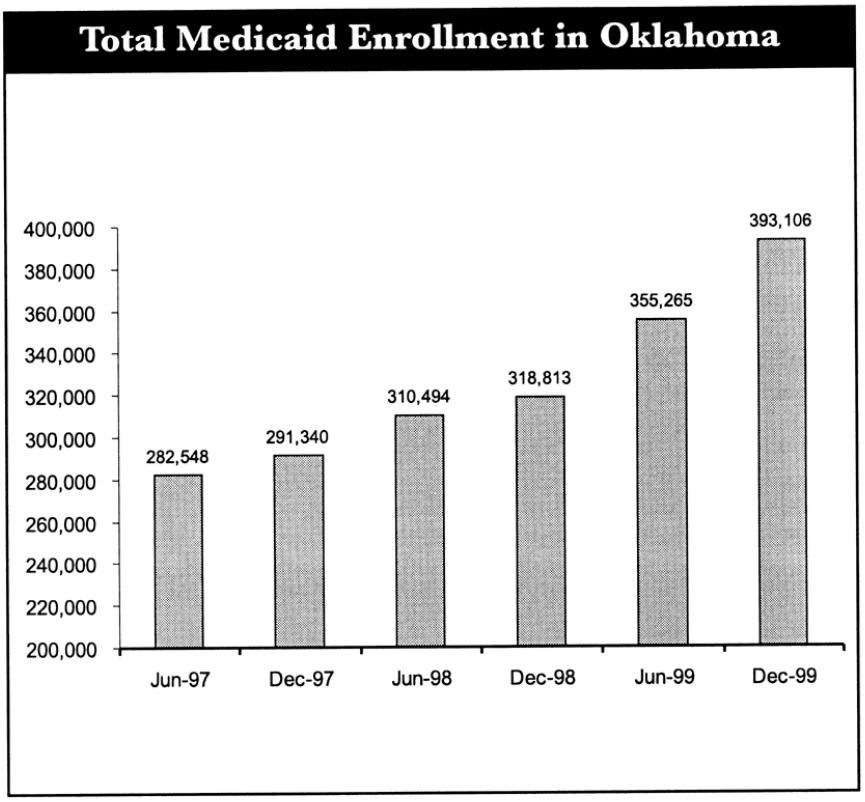
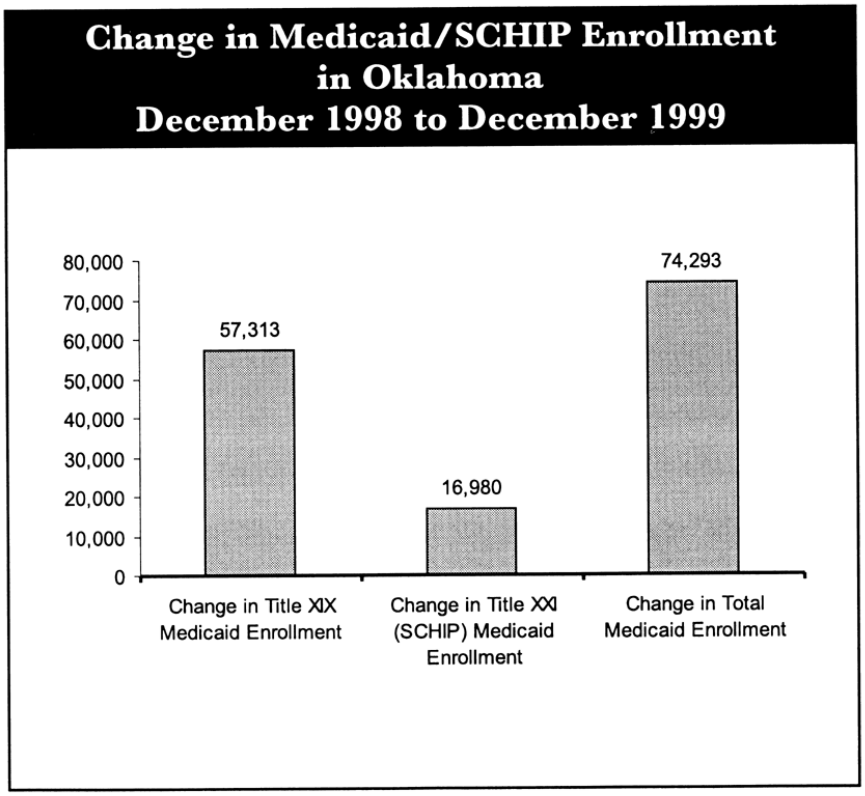
Total Medicaid Enrollment in 50 States and the District of Columbia

State	Monthly Enrollment in Thousands						Percent Change			
	Jun-97	Dec-97	Jun-98	Dec-98	Jun-99	Dec-99	Jun 97 to Dec 99	Dec 97 to Dec 98	Dec 98 to Dec 99	Jun 97 to Dec 99
Alabama	497.4	491.5	504.5	511.5	526.4	530.0	32.6	4.1%	3.6%	6.6%
Alaska	62.2	60.0	65.9	63.9	72.9	76.4	14.2	6.4%	19.6%	22.8%
Arizona	397.3	385.1	373.1	372.9	381.4	407.4	10.1	-3.2%	9.3%	2.5%
Arkansas	297.9	321.2	353.1	370.5	383.9	355.6	57.7	15.4%	-4.0%	19.4%
California	5,178.5	4,968.7	4,980.4	4,987.9	5,067.4	5,033.0	(145.4)	0.4%	0.9%	-2.8%
Colorado	259.5	253.1	250.3	246.1	244.1	258.8	(0.7)	-2.8%	5.2%	-0.3%
Connecticut	310.4	307.0	311.0	315.3	324.7	324.8	14.4	2.7%	3.0%	4.6%
DC	133.1	131.7	128.2	131.3	138.2	142.0	8.9	-0.3%	8.1%	6.7%
Delaware	75.9	76.4	76.0	82.2	88.5	89.5	13.6	7.6%	8.8%	18.0%
Florida	1,454.9	1,460.0	1,417.9	1,465.0	1,521.2	1,597.6	142.7	0.3%	9.1%	9.8%
Georgia	946.6	941.4	926.0	942.5	927.4	904.4	(42.2)	0.1%	-4.0%	-4.5%
Hawaii	161.0	160.7	159.2	151.6	155.3	152.5	(8.6)	-5.6%	0.6%	-5.3%
Idaho	86.8	86.7	88.7	86.1	87.5	93.0	6.2	-0.7%	8.0%	7.1%
Illinois	1,305.0	1,290.3	1,243.7	1,233.9	1,246.3	1,292.3	(12.7)	-4.4%	4.7%	-1.0%
Indiana	490.8	495.1	448.2	520.3	549.8	582.7	91.9	5.1%	12.0%	18.7%
Iowa	213.7	210.7	206.0	201.1	200.3	201.0	(12.7)	-4.6%	-0.02%	-5.9%
Kansas	183.1	175.7	168.6	167.6	178.5	188.9	5.7	-4.6%	12.7%	3.1%
Kentucky	526.8	519.0	518.4	511.0	520.6	525.4	(1.3)	-1.5%	2.8%	-0.2%
Louisiana	541.7	537.8	531.7	536.3	561.2	621.4	79.8	-0.3%	15.9%	14.7%
Maine	155.3	151.0	154.0	159.9	163.8	166.5	11.3	5.9%	4.1%	7.2%
Maryland	461.7	446.7	445.2	465.3	491.8	574.1	112.4	4.2%	23.4%	24.3%
Massachusetts	687.0	747.5	823.4	856.8	891.4	910.5	223.5	14.6%	6.3%	32.5%
Michigan	1,103.1	1,081.9	1,087.8	1,052.9	1,063.3	1,061.9	(41.3)	-2.7%	0.9%	-3.7%
Minnesota	458.2	436.1	430.5	420.9	448.2	439.7	(18.5)	-3.5%	4.5%	-4.0%
Mississippi	409.3	392.9	382.5	396.1	409.2	427.1	17.8	0.8%	7.8%	4.3%
Missouri	569.7	572.9	564.6	600.6	676.2	721.9	152.2	4.8%	20.2%	26.7%
Montana	74.0	72.8	71.7	72.7	72.5	71.3	(2.7)	0.0%	-2.0%	-3.7%
Nebraska	148.9	151.2	156.2	168.1	173.7	180.6	31.7	11.2%	7.4%	21.3%
Nevada	92.9	97.5	97.5	99.5	99.4	101.1	8.2	2.0%	1.7%	8.8%
New Hampshire	80.3	78.4	77.6	78.0	83.3	82.1	1.8	-0.5%	5.3%	2.3%
New Jersey	665.2	658.7	667.5	674.6	678.3	690.7	25.5	2.4%	2.4%	3.8%
New Mexico	255.6	249.7	259.7	275.0	289.3	298.2	42.6	10.1%	8.4%	16.7%
New York	2,918.7	2,858.7	2,806.3	2,746.5	2,727.5	2,719.9	(198.7)	-3.9%	-1.0%	-6.8%
North Carolina	828.5	822.0	815.4	814.7	828.5	848.0	19.5	-0.9%	4.1%	2.4%
North Dakota	45.3	42.7	42.5	42.4	43.4	42.9	(2.4)	-0.7%	1.1%	-5.3%
Ohio	1,107.8	1,060.8	1,066.9	1,062.8	1,045.6	1,071.6	(36.2)	0.2%	0.8%	-3.3%
Oklahoma	282.5	291.3	310.5	318.8	355.3	393.1	110.6	9.4%	23.3%	39.1%
Oregon	379.7	373.6	381.0	379.7	399.0	385.7	6.0	1.6%	1.6%	1.6%
Pennsylvania	1,475.2	1,449.4	1,430.2	1,406.1	1,409.0	1,396.8	(78.4)	-3.0%	-0.7%	-5.3%
Rhode Island	124.0	125.0	125.0	127.0	136.0	146.0	22.0	1.6%	15.0%	17.7%
South Carolina	393.6	414.9	443.0	471.8	498.1	517.4	123.8	13.7%	9.7%	31.5%
South Dakota	60.3	60.3	61.2	65.3	68.2	70.0	9.7	8.3%	7.3%	16.1%
Tennessee	1,188.6	1,231.1	1,262.5	1,288.8	1,306.7	1,315.9	127.2	4.7%	2.1%	10.7%
Texas	1,944.1	1,892.7	1,803.5	1,825.0	1,776.9	1,796.6	(147.5)	-3.6%	-1.6%	-7.6%
Utah	133.9	133.2	135.7	133.5	135.5	133.6	(0.4)	0.2%	0.1%	-0.3%
Vermont	85.1	85.4	85.0	85.1	88.0	89.8	4.7	-0.4%	5.5%	5.5%
Virginia	522.1	505.5	498.6	492.4	491.7	492.5	(29.5)	-2.6%	0.0%	-5.7%
Washington	732.0	724.3	720.0	710.6	716.5	727.7	(4.3)	-1.9%	2.4%	-0.6%
West Virginia	300.3	303.2	308.9	270.4	256.9	263.8	(36.5)	-10.8%	-2.5%	-12.1%
Wisconsin	435.5	412.8	397.3	394.3	395.3	437.9	2.5	-4.5%	11.1%	0.6%
Wyoming	32.8	33.1	33.4	33.0	32.7	33.2	0.5	-0.5%	0.7%	1.4%
Total	**31,273.7**	**30,829.3**	**30,695.7**	**30,885.6**	**31,426.9**	**31,985.1**	**711.4**	**0.2%**	**3.6%**	**2.3%**

SOURCE: Compiled by Health Management Associates from State Medicaid enrollment reports

Source: Kaiser Commission on Medicaid and the Uninsured, Washington, DC.





Source: Kaiser Commission on Medicaid and the Uninsured, Washington, DC.

he says. "After Medicaid expansion, our number was then 275,685 children. We then began an aggressive outreach program. We had legislation in place that gave us the opportunity to do things the state needed in order to address pregnant women. That increased access and lowered barriers."

The majority of states have expanded their Medicaid programs and CHIP, on top of that, making enrollment easier.

Other states followed Oklahoma's lead but with less success, not because there weren't enough people to fill the rolls of the uninsured but because fewer people came in through the door to sign up for help.

So how specifically did Oklahoma get the attention of those qualified for the program?

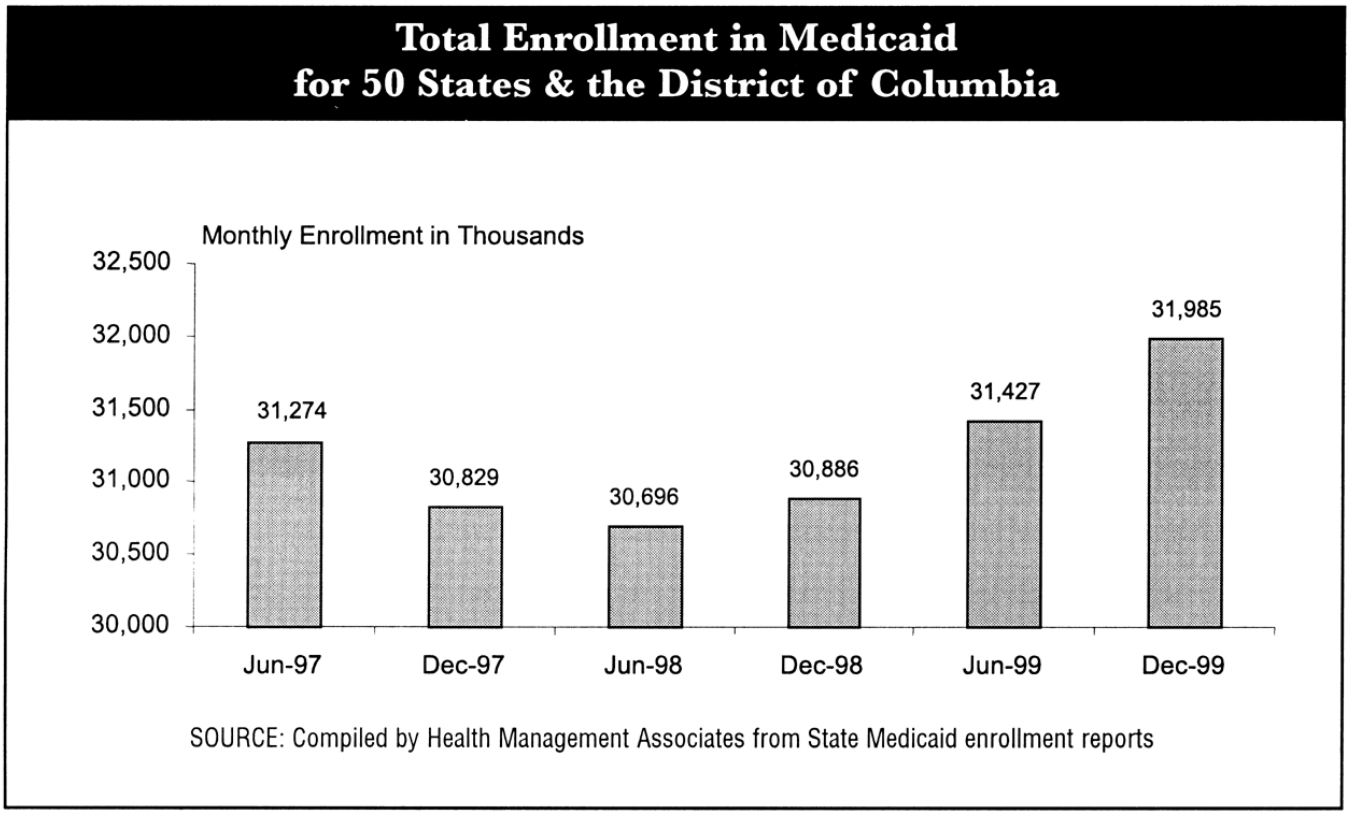
"Oklahoma made some key simplifications. They changed the application from 17 to two pages and got rid of the asset test. By dropping the asset test, that makes the process easier to enroll in, it saves time," says Ms. Hudman.

Forms and functions

Mr. Gomez likes to point out a key phrase for the asset test: It is not a two-page form, he says, it is one page, front and back. Processing time for paperwork also was slashed to 20 days from 45.

One of the most important changes Oklahoma officials made, Ms. Hudman adds, was the creation of the self-declaration-of-income form.

"That's where you say how much you make per month or year, then the state goes and checks it," Ms. Hudman says. "That took the place of the face-to-face interview. Now you can enroll in Medicaid through the mail or over the telephone. Before, the burden was on the family, and that has changed."



Source: Kaiser Commission on Medicaid and the Uninsured, Washington, DC.

Another step in the right direction from SoonerCare: Simplifying the methods used to keep the uninsured from falling off the rolls.

"We've reduced the application days. A case does not automatically terminate in six months," Mr. Gomez says. "Now it is proactive. We do a redetermination and make contact with the participants and redetermine their eligibility. Before that, to stay on the rolls, they came to us."

From December 1998 to December 1999, nine states saw double-digit growth in their total enrollment in Medicaid, according to the Kaiser Foundation.

Those states are, alphabetically:

- Alaska: 19.6%
- Indiana: 12%
- Kansas: 12.7%
- Louisiana: 15.9%
- Maryland: 23.4%
- Missouri: 20.2%
- Oklahoma: 23.3%
- Rhode Island: 15%
- Wisconsin: 11.1%

Total Medicaid enrollment rose 3.6% during the same period, hitting 31.99 million from 30.89 million. The states showing decreases in their rolls were, alphabetically:

- Arkansas: -4%
- Georgia: -4%
- Iowa: -.02%
- Montana: -2%
- New York: -1%
- Pennsylvania: -.7%
- Texas: -1.6%
- West Virginia: -2.5%

There is still plenty more work to be done. Nationally, there are about 2.5 million children who are eligible for the CHIP program who are not included on its rolls. In Oklahoma, Mr. Gomez says statistics show that more children are steadily being added to the ranks of the insured.

"I don't think it has leveled off yet," he says. "Oklahoma still, as the national trend will tell you, has a large number of children who have not been enrolled."

Nearly 379,000 low-income residents of Oklahoma are uninsured. In the next two years, Oklahoma officials will be studying eligibility requirements to see if further adjustments are needed.

"There may be an increase in provider rates," Mr. Gomez says. "We will see what is effective for other states, especially in outreach." One of the largest hurdles to overcome, in Oklahoma and nationally, is overcoming the negative stigma of being on Medicaid rolls, he adds.

[For more information, contact Julie Hudman at (202) 347-5270, fax: (202) 347-5274; and Nico Gomez at (405) 522-7484.] ■

Chips ads

Continued from page 1

Medicaid," Ms. Chang commented. States use a combination of television, radio, and print ads to promote the program, and generally promote CHIP and Medicaid jointly. The survey found that nearly two-thirds of states make efforts to target specific geographic areas or populations and all states work with diverse community-based organizations in their outreach efforts.

Ms. Chang says states are trying to make clear to the public, and even to state agency personnel, that these are not welfare insurance programs. "They're choosing new names that appeal to parents, and they're working hard with community-based organizations to supplement the advertising and develop support in the community to link families to the system."

More than two-thirds of the states say they have conducted some form of evaluation of their ads' success. "Most states did this by tracking the volume of calls or applications coming in and asking callers to an 800 number where or how they learned of the program," the study says. "Others have a question on their application asking people how they heard about the program. A handful of states surveyed program enrollees for their feedback. Some states are now also asking callers what they think could be changed about the ads or applications that would make the ads more effective and the application process easier."

Analysis of many ads from various states found four common themes: "It is affordable;" "This is working for parents like you;" "Children need health coverage;" and "You will have peace of mind." Kaiser researchers say that secondary messages emphasize concepts such as the importance of health coverage to children's development; the high cost of health coverage today; the availability of a new alternative; differences from the Medicaid program; the ease of enrollment; and the many benefits of coverage for children.

While there are subtle differences among state advertising efforts, states generally use many of the same approaches to encourage enrollment. First, ads for children's health coverage have the look and feel of ads for commercial products, with a child-friendly, optimistic feel, showing visuals of diverse happy and healthy-looking children. It is not readily apparent that the ads are for a government health program. Most of the ads provide only limited information about the program itself, rarely talking about how the program works, who qualifies, how to enroll, how much it costs, and what services are covered.

The ads target working families. There are no scenes of poverty and urban settings are less prevalent than rural locations. Affordability of the program is stressed as often as the assertion that enrollment is simple and easy. Most states emphasize that the coverage is just for children and some ads feature the services that CHIP and Medicaid cover, especially checkups, medication, hospitalization, and dental care.

"Age limits, telephone numbers, catchy slogans, and the program's name and logo are staples of most children's health coverage ads," the survey authors say. "The main message that most states use is that CHIP/Medicaid is affordable health coverage for uninsured children in working families. Previous focus group research with parents suggests this message has much appeal."

The professionals who reviewed the ads were struck with how "polished" they were, Ms.Chang says, looking more like ads for commercial products than the traditional state-produced public service announcement.

The researchers say, however, that the ad campaigns face two important challenges — a lack of detail and a need to target broader audiences, especially those at the lower end of income eligibility. "Focus group research shows that some parents feel that the current wave of ads is missing key information. They want to know specific facts about the program, such as what services are covered, whether they qualify, and how much they would have to pay, before they call a toll-free number. [And] although most studies are targeting working families at the highest end of the income eligibility scale, some families, particularly those without experience with government health programs, may not believe that they now qualify for assistance. At the same time, few states seem to be reaching out to former welfare beneficiaries with their ads, despite the fact that many children in these families still qualify for coverage."

Kaiser says the next phase of CHIP advertising will have to reach parents who have not responded to the current ads and perhaps will need to incorporate new messages while reinforcing some of the original messages. They suggest states should continue to:

• use appealing images of diverse children and teens, while adding images of children with disabilities to show that the programs are also for those with special needs;

• address "peace-of-mind" themes, while avoiding frightening images such as children getting injured or a very ill child, because studies show such images may turn parents off to the message;

• emphasize that CHIP and Medicaid provide free or low-cost health coverage;

• identify health services covered by CHIP or Medicaid;

• make phone numbers and Web site addresses even more prominent;

• stay focused on workers, perhaps mixing in images of less-affluent families and neighborhoods so that families in the lower eligibility levels can see that the programs are for them as well;

• emphasize that health coverage is important for children to flourish and

that providing coverage is part of being a good parent, avoiding any language that implies blame for parents who have uninsured children;

• give an example of how much a family can earn and have children who qualify;

• keep saying that enrolling in CHIP and Medicaid is easy, but make sure that the enrollment process is, in reality, easy for parents to access and complete.

Ms. Chang says the two most important factors seem to be including some type of income guideline and listing covered services. She says that calling attention to covered dental and vision services can be a hook to get people to look into the program further since they often have the hardest time obtaining those services.

The researchers say that parents also want to hear that CHIP covers all family members who are uninsured. If that is not the case, they want to hear suggestions on how to obtain coverage for uninsured family members not covered under CHIP or Medicaid. "A recurring theme in a number of studies with low-income parents is the desire for whole-family health coverage," the study says. "Many parents dislike the notion of insuring some family members while other family members remain uninsured. In recent focus groups, some parents objected to CHIP only covering children, and they recommended that the program cover other uninsured family members as well. They assert that parents need health coverage, too, and that sick parents cannot care for their children nor can they hold down a regular job. The whole family suffers when even one member is uninsured. While some states have expanded coverage to families, most have lower eligibility levels for parents, making the parent unlikely to qualify for assistance." Expanding coverage to parents may actually help reach more uninsured children, Kaiser says, as research shows that eligible children are more likely to be enrolled if their parents also qualify for coverage.

Cindy Stamper, manager of eligibility and outreach for Indiana's Medicaid and Hoosier Health programs, tells *State Health Watch* that her agency's most effective broadcast ad ran last spring and "produced calls by the

New ads look great, but enrollment barriers still dominate CHIP

The Kaiser Commission on Medicaid and the Uninsured study of advertising for state Children's Health Insurance Programs (CHIP) points out that in addition to effective advertising, states must work to eliminate barriers that may keep parents from enrolling their children. While marketing strategies focus on portraying coverage in an appealing manner, studies have shown that negative stereotypes of Medicaid are not reported by parents to be the most serious barrier to enrolling children. Rather, in focus groups and surveys, parents repeatedly report that enrollment problems are the primary barriers to enrolling their children in Medicaid or CHIP. "States must continue to simplify the enrollment process and develop additional strategies to broaden coverage if efforts to increase [CHIP] enrollment are going to be successful," the report states. Four barriers that parents have identified are:

1. They don't believe the program is for them. Some parents say they do not think their children will qualify and thus have not tried to enroll them. They assume that they earn too much because they are workers and believe that the program is for poorer families.

2. They are not aware of the program. Parents are not part of any system where they would naturally learn about CHIP and Medicaid. Another group in this category involves those who do not speak English. Since broadcast and print ads still are primarily in English, such parents may have less opportunity to learn about the programs.

3. There is not enough information readily available. Some parents say that all they know about CHIP or Medicaid is the name of the program. They say that ads don't provide details they want such as what it covers, income eligibility, and costs. Without knowing more details, some parents are reluctant to call a toll-free number or contact the program.

4. The enrollment process is burdensome. Parents say they must complete too much paperwork, miss time from work, go to the welfare office, fill out a complicated application, answer intrusive questions, and wait for many hours to enroll their children.

The commission suggests that states consider improving the enrollment process to live up to its advertising that it is quick and simple. Ideas include having mail-in enrollment forms or taking enrollments over the telephone; immediate enrollment with forms to be completed later; enrollment offices open after working hours or on weekends; automatic enrollment for children entering a school lunch program; enrolling at a doctor's office or clinics; and providing help from someone who speaks the parent's language.

"One specific suggestion made by states is to have trained assistants to help parents complete the application at all enrollment sites," the report says. "State officials claim that this is a successful way to help parents accurately complete the application, thereby reducing the number of applicants turned down because of incomplete forms." ■

thousands." Ms. Stamper says it was a general ad without income or coverage specifics that tried to reach those who had just become eligible due to a state expansion of income guidelines to 200% of the poverty level.

Ms. Stamper says she has mixed feelings about the commission's recommendation to include income information because "you can screen people in but also screen them out." She says it is true that people who call in to get more information often say they were responding to a "catchy, cute commercial," but didn't think they would qualify and are surprised to learn that they do.

In New York State, according to Health Department spokesman John Signor, Gov. George Pataki has made enrolling every eligible child in the state's Child Health Plus program a priority, even to appearing in commercials himself. Ms. Chang praised the governor's involvement, saying it sends a clear message to the community and to agency staff about the importance he attaches to the program.

Mr. Signor says the result is that enrollment has gone from 90,000 when Mr. Pataki took office to more than 550,000 previously uninsured children in the program now. "No other state can match that enrollment," he says. "Much of it was due to an aggressive media campaign that includes benefits information." The state also has allocated $10 million to use community-based organizations as "facilitated enrollers," working evenings and weekends to be available to parents who work and can't enroll their children during normal business hours. The community groups are also going out into neighborhoods to find unenrolled families and bring them in. And the state has started a Family Health Plus program so entire families can obtain coverage.

[Contact Ms. Chang at (202) 347-5270, Ms. Stamper at (317) 232-4906, and Mr. Signor at (518) 474-7354.] ■

Illinois negotiating pharmacy for reimbursement changes

Faced with protests, the Illinois Department of Public Aid has backed away from its plan to implement an emergency rule in November that would change the Medicaid reimbursement formula for pharmacy and reduce dispensing fees.

The protest came from the American Society of Consultant Pharmacists (ASCP), which said cuts would be devastating to seniors seeking medication and that the new rule was created with no input from the state's pharmacists. The rule was to go into effect Nov. 27.

"We're talking with the industry to discuss what was proposed, working toward a compromise plan. We can't talk about what the final result is likely to be and can only say that we hope to resolve it as soon as possible," Matt Powers, agency administrator for medical programs, tells *State Health Watch*.

According to an ASCP action alert to its members, the proposed changes included:

• reimbursing brand name drugs at wholesale acquisition cost plus 8% plus a $3 dispensing fee;

• reimbursing generic drugs with a $3.58 dispensing fee and the lowest of either federal upper limit, state maximum allowable cost, average wholesale price minus 12%, or wholesale acquisition cost plus 12%;

• reimbursing over-the-counter items at 125% of average wholesale price.

Mr. Powers says the agency is talking with industry officials about using something other than the average wholesale price. It also is discussing instituting a dispensing fee from the current flat and floating fee that is correlated to the cost of drugs and is seen as inconsistent in its application.

While the agency's goal, according to Mr. Powers, is to "see the prescription drug appropriation line behave

Medicaid drug costs are cut in Illinois by lowering payouts to pharmacists

State officials are carving millions of dollars out of Illinois' Medicaid drug costs. The savings stem from reducing the amount the state pays pharmacists for buying and dispensing drugs and by cutting what it pays for certain kinds of prescription drugs.

Officials of the Bureau of the Budget in Springfield also have introduced new rules requiring doctors and pharmacists to use the cheapest prescription drugs available, when possible, to treat Medicaid patients, according to George Hovanec, deputy budget director.

Double-digit growth in Medicaid drug bills during the past three fiscal years prompted the proposal, he said.

"At the end of fiscal year 2000 [June 30], Medicaid costs, including drug, doctor, and hospital costs, had escalated by $60 million over projections," Mr. Hovanec said.

State planners project 20% per year growth in Medicaid costs, driven by increases in the cost of prescriptions. ■

not as aggressively as it has been," the agency also wants to achieve consistency with other major payers in Illinois, including state government and with commercial contracts.

ASCP officials say the department expected to save $15 million in the remaining six months of fiscal year 2001 under the changes, plus $30 million in fiscal year 2002 with the change in dispensing fee. During that same period, the association told its members, the agency expected to save another $40 million with the change in reimbursement formula.

"Public Aid hinges [its] argument to implement these changes on the fact that drug expenditures continue to escalate. However, this is contrary to recent studies showing that this is not due to dispensing fees to pharmacists, but because of increased utilization of medications, greater numbers of covered individuals, and increases in drug product prices," according to the alert.

Points to press

The ASCP encourages pharmacists to contact the state and press these points:

- Decisions were made without input from the pharmacy community or forewarning that there were any problems with current Medicaid payment.
- Cuts will reduce access to medications for patients served by pharmacies.
- Cuts threaten quality of care for frail elderly seniors receiving Medicaid benefits.
- Cuts are severe to pharmacies, most of which already operate with very thin margins.
- The cuts to dispensing fees are approximately 30%.
- Dispensing fee reductions were chosen arbitrarily and without any cost studies.
- Increases in Medicaid drug expenditures are not a result of increased profitability of pharmacies. ■

Maryland HealthChoice program attacked by advocates for children and youth

A Baltimore-based advocacy organization for children and youth says a qualitative study of parents and pediatric offices shows that a significant number of children are having trouble accessing the health care services they are entitled to under Maryland's HealthChoice Medicaid managed care program.

In particular, says Advocates for Children and Youth (ACY), Maryland is not following federal law in the way it covers newborns. Children face long delays before they can see pediatric specialists, and thousands of children risk losing their traditional doctors because of the way managed care organizations auto-assign children to specific doctors.

Carol Fanconi, health policy director for ACY, tells *State Health Watch* that the organization used three focus groups made up of parents and interviewed pediatric office managers at 34 practices with a combined staff of 121 doctors to obtain the data presented in its qualitative report. Because of the nature of the research, she says, the organization cannot estimate the extent of the concerns raised.

However, every concern included in the report had been voiced enough times to convince researchers that it was a systemic problem and not isolated to a particular patient, physician practice, or managed care organization. Ms. Fanconi says a research advisory group approved the nature and methodology of the work.

Debbie Chang, deputy secretary for health care financing with the Maryland State Department of Health and Mental Hygiene, tells *State Health Watch* that the report's backers interviewed "a select group of providers and families who were solicited to talk about their problems."

She says the researchers who prepared the report talked with six providers, 31 office managers, and 42 parents from Baltimore; the program has approximately 400,000 members and more than 54,000 providers.

"The information in the report is not representative of the program as a whole and shouldn't be generalized to the program as a whole," Ms. Chang says.

Although state officials say those surveyed only were asked to discuss problems and never asked about any positive aspects of the program, Ms. Fanconi says the questionnaire used with the pediatric office managers specifically asked participants to first list improvements that had taken place during the three-year history of the program. "

The office managers had a difficult time identifying things that had improved. The start-up year was chaotic, and they think it's still pretty much chaotic," she says.

Parents voiced concerns

The report's findings look at general concerns voiced by parents and office managers and then at specific problems relating to these issues:

- auto-assignment and continuity of care;
- eligibility verification;
- provider directories;
- interruption of care;
- newborn eligibility;
- appointment scheduling;
- testing and lab work;
- dental and vision care;
- access to specialists;
- equipment and supplies;
- restrictions on medication choices;
- children with special health needs;
- foster children;
- consumer complaint resolution;
- billing, payment, and reimbursement issues.

Many of the concerns are illustrated by descriptions of real situations with the names of the clients disguised. Ms. Chang says the department has asked for information on the real-life cases so they could be reviewed and help could be provided, but ACY has refused to release the information.

"We think that's unfortunate because we could be much more help," she says.

A key concern of both parents and providers was that children frequently are auto-assigned by managed care organizations to practices that are inconveniently located and have no prior history with the children or their families. Parents reported that sometimes children in the same family were assigned to different managed care organizations and primary care providers.

Office managers complained about cumbersome eligibility verification processes that need to be followed every time a child comes to the office. They also said managed care plan directories showing pediatric specialists often are not accurate, listing doctors who are not participating with the plan or not taking new HealthChoice patients.

Continuing interruptions in coverage and service were reported, which often did not come up until the time a patient was in the physician's office or trying to fill a prescription.

ACY officials complain that while managed care organizations may be following a state policy in denying services for newborns who do not have their own HealthChoice ID number, their actions are contrary to federal law, which requires plans to reimburse under a mother's name for up to one year.

"Many practices said they feared that parents were not bringing their newborns in for services because they believed babies were not insured until they had their own numbers and that the families would have to pay for such services," the report states. "In addition, office managers said that they have great difficulty securing services from third parties, including pharmacists, specialists, and medical equipment suppliers, who were not willing to provide free services."

There were complaints from parents about long waits for appointments and being sent for lab work to facilities that were difficult to travel to. Parents also said there were not enough dental providers or pediatric specialists. Office managers complained about overly restrictive and rapidly changing pharmacy formularies and requirements that parents obtain all equipment and supplies from managed care organization subcontractors rather than from doctors or nearby providers.

"The bottom line is that we believe Medicaid is a good program with good benefits."

Carol Fanconi

Health Policy Director
Advocates for Children and Youth
Baltimore

Practices said that too few children qualified for the Rare and Expensive Case Management program, a fee-for-service system for children with severe, complex, or unusual medical conditions. They also said that primary care providers were not being included in development or implementation of case management plans for the children with special needs who remain in HealthChoice.

Ms. Chang says the department already is implementing many of the changes that ACY called for. Providers directories are being revised and will be put on-line, she says, and hospitals are being required to submit newborn eligibility forms within 24 hours. She says they want to implement a single form for specialists to use in communicating with primary care providers and want to have more regular involvement with the foster care system.

Regarding concerns about the assignment of newborns, Ms. Chang says the state is following a procedure that is acceptable under federal law. She says ACY wants newborns auto-assigned to the managed care organization that cares for their siblings instead of the mother's plan. Usually, parents and children are in the same plan, Ms. Chang says. But if they are different, assignment is made to the mother's plan because that is the one responsible for the birth outcome of the newborn and thus has an interest in providing high-quality care.

Ms. Fanconi says ACY recognizes that because of the complicated nature of implementing Medicaid managed care, no single one-time correction can solve all the problems. So its key recommendation is that Maryland initiate a continuous improvement process modeled after the Massachusetts Health Access Networks.

"The Massachusetts concept is built on a no-fault philosophy that recognizes that all players want to do a good job of delivering health care, but each is isolated from important information held by other stakeholders. Such a process could promote ongoing communication between providers, MCOs, and local health agencies, as well as advocates and consumers," Ms. Fanconi says.

The group recommends that the Department of Health and Mental Hygiene hold regular meetings that include all stakeholders, perhaps 10 such meetings a year in each of five regions.

Ms. Chang counters that her agency has a number of advisory groups already functioning, makes use of representative focus groups, and has

other means to hear about problems and obtain recommendations. There also is a complaint-and-grievance process, she says, that federal authorities have said is a model for the nation. In addition, there will be a comprehensive evaluation of the three-year-old program in preparation for the application to renew its waiver. With all of that, she says, they are studying the Massachusetts system to see if there is anything they want to import to Maryland.

ACY provided 16 key recommendations and additional supporting recommendations for specific changes in program design and practice, including:

• a new auto-assignment algorithm that assigns to a child's historic doctor and managed care organization;

• reimbursement for services to newborns under their mother's ID for up to one year;

• corrections to provider directories to ensure they reflect what physicians are in the network and are accepting new patients;

• a requirement for all MCOs to have a 24-hour automated eligibility verification hotline;

• a guarantee of eligibility for HealthChoice for 12 months at a time to reduce interruptions in care;

• enforcement of the requirement that well-child visits be scheduled within 30 days of a parent's request;

• a requirement for MCOs to reimburse clinics, hospitals, and physician offices for tests and lab work as long as the facilities are certified.

"The bottom line," Ms. Fanconi tells *State Health Watch*, "is that we believe Medicaid is a good program with good benefits. We just want to be sure that people can access the program and its benefits and that we are able to improve outcomes."

[Contact Ms. Fanconi at (410) 547-9200 and Ms. Chang at (410) 767-4664.] ■

Clip files / Local news from the states

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

New plans for treatment of asthma given a breath of fresh air in New Hampshire

CONCORD, NH—Nearly 65,000 children and adults in New Hampshire have asthma. For the first time in the state, managed care companies have developed a common set of guidelines for the treatment of asthma. The guidelines, printed on a bright, 11-inch by 17-inch poster, will help physicians assess, classify, treat, educate, and equip asthma patients. The Foundation for Healthy Communities in Concord will send two copies of the poster to every licensed internist, family physician, pediatrician, allergist, pulmonologist, emergency room physician, and nurse practitioner in the state.

Asthma management specialists from Aetna U.S. Healthcare, Anthem Blue Cross Blue Shield of New Hampshire, Cigna HealthCare, Harvard Pilgrim Health Care, and the American Lung Association worked with the foundation to produce the guidelines.

—The Foundation for Healthy Communities, Concord, NH

Many children in South Dakota going without insurance because they don't know of opportunities

SIOUX FALLS, SD—Some 24,000 eligible South Dakota children are not enrolled in the Children's Health Insurance Program, a publicly funded plan for kids whose parents cannot afford coverage. The South Dakota Department of Social Services attributes the shortfall to a lack of awareness about changes made to the program last July. "Families don't even realize they qualify," said Mina Hall, a registered nurse who chairs the South Dakota Covering Kids Coalition.

When the program began in 1998 as an extension of the existing Medicaid program, it covered uninsured children, ages 6 to 18, who were not eligible for Medicaid and whose family income was no more than 133% of the federal poverty line. A year later, the income eligibility level was raised to 140% and applied to all children 18 and younger. In July, the program expanded once again, this time lifting the family income ceiling to 200% of the poverty guideline. A family of four living in South Dakota, for instance, would now qualify if it made no more than $34,000 after the costs of child care.

—*Argus Leader*, Sioux Falls, SD

More calls to NJ FamilyCare means adding new phones, staff

TRENTON, NJ—Due to the overwhelming response to the new NJ FamilyCare health insurance program, the state is adding more phone lines and staff at eligibility processing centers. It also is placing newspaper ads asking the public to be patient with the enrollment process of the program providing health insurance for low- and moderate-income adults and children.

The steps were announced by Michele K. Guhl, commissioner of the New Jersey Department of Human Services. Ms. Guhl said the department has been receiving almost 30,000 calls a week and sending out 1,100 applications a day since ads featuring Gov. Christie Whitman promoting the program were aired in November.

"Until we can get extra staff and phone lines in place, we may not be able to

State Health Watch

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respond to these calls as quickly as we would like," she said. "We don't want people to be frustrated if they experience some delays in enrolling in the program. We encourage uninsured families to continue to apply."

Since the program began accepting applications for adults in November, 36,800 adults have been enrolled, the department reported. More than 74,000 children have enrolled since the program began as NJ KidCare in 1998. Applications are being processed for another 31,000 adults, the department said. It is estimated that 125,000 and 157,000 children are eligible for the program.

—Associated Press, Nov. 29, 2000

Public sector picking up large share of the tab for mental health/substance abuse

ANN ARBOR, MI—Fifty-six percent of the funding for mental health and substance abuse treatment in 1997 was paid by the public sector, up from 53% in 1987, according to a study conducted by the Medstat Group for the Substance Abuse and Mental Health Services Administration (SAMHSA) in Rockville, MD. The fastest growing public-sector payers were Medicare and Medicaid for which the average annual growth rate for mental health and substance abuse spending were 11.7% and 9.9% respectively.

Spending for mental health and substance abuse treatment nationwide reached $85.3 billion in 1997. Its growth rate, adjusted for general price inflation, averaged 3.7% per year between 1987 and 1997, significantly below the comparable rate of 5% for total health expenditures.

"Because so many Americans are affected by mental illness and substance abuse, it's critical that we understand our nation's investment in this area," said Joan Dilonardo with the project office for the Center for Substance Abuse Treatment (CSAT).

"Particularly troubling is a decline of 0.6% in private insurers' real spending for substance abuse services between 1987 and 1997, which highlights our need to monitor how these trends are affecting patients' health, said H. Westley Clark, director of CSAT.

—The Medstat Group