



# State Health Watch

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The Newsletter on State Health Care Reform

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## In This Issue

### Keeping policy simple is the Holy Grail states continue to chase

Keeping state health policy simple isn't as simple as anyone would like to think it could be. But that hasn't stopped 3½ decades of constant examination and re-examination of the system and those who run it. The most recent round of tinkering is in the exploratory stages as Tommy Thompson, Health and Human Services secretary, makes the rounds of his charges, including the Health Care Financing Administration. But a movement that nine states and the District of Columbia are spearheading has helped them streamline their programs and lower their costs in the meantime. . . . . cover

### States called upon to create mandatory reporting system

Ever since the Institute of Medicine (IOM) published its report on medical errors last year, states have been struggling to develop the best way to approach the concern. The IOM called on each state to create a mandatory reporting system, beginning with hospitals, to collect information about adverse events that cause death or serious harm. The institute suggested that state-based mandatory reporting would protect the public by assuring that errors are reported and responded to, and would encourage providers to invest in and improve patient safety . . . . . cover

## Quest for simplicity still the Holy Grail of health care policy

**W**hen it comes to health policy, whether it's delivered by states or the money and rules trickle down from the federal government, there is near consensus among conservatives, moderates, and liberals — the health care system, as directed by government, is weighted down with complexity. This revelation is being embraced, in one form or another, and the whiff of change is in the air.

Keeping it simple isn't an option; making it simple is. It's the reasoning behind the decision by Tommy Thompson, Health and Human Services secretary, who went from fighting Wisconsin's battles with

Washington to serving as a general for what was the opposition, to spend a week in Baltimore to gaze into the heart of the rulemaking beast — the Health Care Financing Administration. He knew what he would find before he arrived. The agency he says America loves to hate is freighted with "excess regulations and responsibilities without the resources to do the job effectively."

In the next few months, Mr. Thompson plans to take his philosophy on the road to the other mammoth federal health care bureaucracies — the Food and Drug Administration,

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## Following IOM report, states given help in dealing with medical errors

**E**ver since the Institute of Medicine (IOM) published its report on medical errors last year, states have been struggling to develop the best way to approach the concern.

The IOM called on each state to create a mandatory reporting system, beginning with hospitals, to collect information about adverse events that cause death or serious harm. It suggested that state-based mandatory reporting would protect the public by assuring that errors are reported and responded to, and would encourage providers to invest in and improve patient safety. In the institute's view,

mandatory reporting would be complemented by voluntary reporting systems to identify system weaknesses before serious harm occurs.

In the months since the IOM report was issued, the National Academy for State Health Policy (NASHP) in Portland, ME, has been working with states to address the Institute's recommendations.

The Academy first looked at eight states (Colorado, Florida, Kansas, Massachusetts, New York, Pennsylvania, South Carolina, and Washington), which have mandatory

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***Simplicity***

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the Centers for Disease Control and Prevention, and the National Institutes of Health. If he finds a way to cut red tape, the effects will be felt all down the line to the state houses and Main Street in many small towns. No one is predicting when change could come. But when and if it does, it will join the tide of change that has marked Medicaid and Medicare since their creation in the mid-1960s.

Welfare reform of the 1990s is only the recent, largest wave of change. "The character of Medicaid has changed dramatically. The de-linking of Medicaid and welfare was on the way before the law changed because there were so many kids on Medicaid and not on welfare," Vernon Smith, a principal with Health Management Associates in Lansing, MI, tells *State Health Watch*. "Now states have more latitude to simplify. It takes time."

Mr. Smith is one of the authors of *Eliminating the Medicaid Asset Test for Families: A Review of State Experiences*, published recently by the Kaiser Commission on Medicaid and the Uninsured in Washington, DC. Smith and company eyeballed nine states and the District of Columbia when they stopped conducting asset tests in July 2000. After talking to state officials, he found that the change streamlined the eligibility process, saved administrations money, and made enrollment more accessible for families that needed it.

Here are some blurbs from state officials gushing over the change:

• "[It] was an important part of a package of changes that resulted in saving because the process took less paper and less time." — Missouri

• "It has paid off in worker attitude and in potential applicants who view the process like enrolling in commercial insurance." — Oklahoma

The states involved were:

- Delaware;
- Massachusetts;
- Mississippi;
- Missouri;
- New Mexico;
- Ohio;
- Oklahoma;
- Pennsylvania;
- Rhode Island.

The experience of those states and the nation's capital

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

has been that eliminating the asset test streamlines the eligibility determination process, allowed them to adopt automated eligibility determination systems, improves the productivity of eligibility workers, and makes enrollment a friendlier more accessible process for families.

The downside: There continues to be some concern that dropping the test would cause state budgets to increase.

In 1996, when the federal government introduced welfare reform, it allowed states freedom to change Medicaid eligibility rules. The asset test, which counts the resources of families such as savings accounts and automobiles, was a standard part of the paperwork of determining eligibility. The states generally each have a different set of similar rules, but nine took the plunge by July 2000 by saying, "This is one round of paperwork we can do without."

Two states, Pennsylvania and Massachusetts, eliminated Medicaid asset tests for all family cases before welfare reform. Ohio dropped the Medicaid asset test for adults in families. Oklahoma, Missouri, and Washington, DC, dropped the tests when they implemented the Children's Health Insurance Program, and from 1998 to 2000, the remainder dropped the tests for parents. Arizona, Connecticut, Illinois, New Jersey, and South Carolina are considering following suit.

The participating states and the district had similar experiences. The asset test for families had been difficult to administer and had only a tiny effect on limiting eligibility. Families found locating bank statements, insurance policies, and other documentation a hurdle to enrolling. Then, if all the documentation was gathered, the state had to review everything, resulting in what these states agreed was a cumbersome burden on administrative workers — a

face-to-face interview would have to be conducted, and then all paperwork would have to be confirmed with banks and insurance companies. It all cost too much money and time. Even if the process were completed, officials said there were only a small number of denials for Medicaid.

The states, in their quest to eliminate the asset test, pursued the change administratively, through public hearings and then a change in the amendment governing Medicaid. In Massachusetts, officials wanted a study showing there would be a savings to the program. In New Mexico, officials were worried that applicants who happened to own large amounts of property would become eligible; they found those applicants to be in tiny numbers. If administrative workers didn't have to review the asset test, then the states found they could install automated eligibility systems. Staff efficiency rose with the test's elimination.

According to the study, families

benefited, too. Applications became shorter. In Missouri, the application went from 22 pages to two, and in Oklahoma, from 12 to two. There was less stigma associated with applying, too, as these states focused on providing "health care" not "welfare," making signing up more enticing for those needing help.

"If you go back to the mid-'80s, the proportion of the Medicaid caseload not on welfare was around 15%," Mr. Smith says.

"Now there are more people on Medicaid not on welfare than there are on welfare. This is a dramatic change. The de-linking of Medicaid and welfare was on the way before the federal government changed the laws because there were so many kids on Medicaid and not on welfare. Now the states have more latitude to simplify," he adds.

*(For a copy of Eliminating the Medicaid Asset Test for Families: A Review of State Experiences, go to [www.kff.org/content/2001/2239/](http://www.kff.org/content/2001/2239/).)* ■

### ***Michigan upgrades its information systems***

**M**ichigan's Department of Community Health has designed a new executive information system to make accessing information easier. The new system, designed by the Medstat Group in Ann Arbor, MI, is structured to give the state the tools and information to analyze and measure the effectiveness of programs, more readily detect fraud and overlapping coverage, and improve the overall financial management of major programs such as Medicaid. The system will enable the department to provide reports to lawmakers and taxpayers explaining some of the state's largest programs, officials say. The new system will eventually allow the department to access and analyze raw data from different computer platforms and applications stored in a data warehouse and then convert them into information for upper management, state officials say.

State officials say the department will use the information to help make policy decisions. For instance, managers will be able to view summary information to identify where changes might be necessary. Policy and budget analysts will be able to analyze data to see how Michigan compares to other states. Managed care specialists also should be able to use the system to measure the performance of health plans. The system also should offer overviews of services that individuals or groups are receiving. In addition to Medicaid, the department provides services for the Women, Infants, and Children Supplemental Nutrition Program, the Michigan Childhood Immunization Registry, and the Community Mental Health Programs. ■

## Medical Errors

Continued from page 1

reporting programs that had been developed before the IOM report was written and were not designed specifically to address medical errors. The academy found that each state defined reportable events somewhat differently and there were other significant differences in how data are gathered and used.

Underreporting was found to be a problem in all states, and no reliable method was identified for determining an anticipated number of reports. Neither was there consensus among states on what information is disclosed and when and how to protect information from disclosure.

Most states surveyed said they use the data collected to trigger on-site investigations and plans for correction. Some states aggregated information; three sent out alerts to hospitals when trends are seen; others publish newsletters, made web-based reports, report to advisory groups, and share information with other state agencies.

As a result of that initial work, the academy turned its attention to what other things states could be doing and how they could organize their work. "We've been looking into the roles states play and what's happening between states and the federal government that could provide models other states could follow," Jill Rosenthal, NASHP policy analyst, tells *State Health Watch*. "Our latest publication looks at possible state roles and raises a series of questions for states to consider in addressing the issue."

The issue for states to consider is how to estimate the size of the problem in their states. NASHP's report, *Patient Safety and Medical Errors: A Road Map for State Action*, points out that state data agencies and purchasers have hospital discharges, claims, and other sources of data that can be used

to help estimate how many reported deaths in a state are likely to be due to medical errors. By working with the state data agencies, hospitals and their associations, and researchers, states can identify means of estimating the number of medical errors.

"States say the information needs to be made public so they can hold facilities accountable. But providers say that if information is made public, it could lead to less reporting of errors and thus less information on which to base a realistic assessment of the nature and magnitude of the problem and develop sound new policies and procedures."

Jill Rosenthal

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Assigning responsibility for patient safety in state government can be an issue because many governmental agencies typically have a role to play. For instance, health departments protect public health; licensing and certification agencies have an oversight responsibility; a number of state and private parties purchase health care and are concerned about outcomes and quality; data agencies collect information; and insurance departments oversee health insurance and health plans.

"In general," the report states, "there is no vehicle around which to organize state activities on patient

safety, although at least one state has created a Center on Patient Safety to coordinate fragmented state activities. Other states have created task forces and commissions to craft coordinated strategies."

As states search for ways to organize their efforts, Ms. Rosenthal says, privacy has become one of the most controversial issues to be dealt with. Should the information obtained through reporting systems be made available to the public or should it be kept confidential?

There are strong arguments made on either side. "Consumers want to have information available," Ms. Rosenthal tells *SHW*.

"States say the information needs to be made public so they can hold facilities accountable. But providers say that if information is made public, it could lead to less reporting of errors and thus less information on which to base a realistic assessment of the nature and magnitude of the problem and develop sound new policies and procedures," she says.

Ms. Rosenthal says one thing that has been found in visits to states is that underreporting is a problem both when the data are made public and when they are kept confidential. So it may be that provider fears that public reporting of data could lead to more underreporting are not valid.

"Deciding whether and how to protect system data from public disclosure and legal discovery involves balancing the public's need and uses for the information with provider concerns about the legal consequences of making information public," the NASHP report says.

"Several strategies for protecting mandatory reporting system data are available, should policy-makers decide that such protections are needed. System design features, such as de-identifying data and receiving reports anonymously, may reduce the need for legal protections by

making it difficult to link specific incidents to individuals or institutions. This approach may make it more difficult for state officials to conduct important follow-up activities to ensure compliance with reporting requirements," according to the report.

The academy says that exempting mandatory reporting system data from public disclosure laws provides limited protection, while combining public disclosure exemptions with other statutory protections is a useful strategy for strengthening their effectiveness for protecting data.

### Strong protections needed

"Special confidentiality statutes and statutory peer review protections may provide the strongest protections from disclosure for mandatory reporting system data if their statutory language is explicit, expressing a clear legislative intent that the information not be disclosed," according to the report.

The academy report adds that while each strategy has strengths and weaknesses, they all are helped when their language explicitly references reporting system data, they are used in combination, and each references the other, making it clear that reporting system data are protected by each of them.

Ms. Rosenthal says that while some federal guidance in terms of definitions could be helpful, this issue needs a state-by-state resolution because states vary in terms of peer review and licensing.

"States are looking for federal leadership, but want the ability to adapt what comes out," Ms. Rosenthal adds. Meanwhile, NASHP will continue helping states share information on specifics and developing best-practices models.

*[Contact Ms. Rosenthal at (207) 874-6524.] ■*

## Using the school lunch program to enroll children in health care

States concerned about improving outreach efforts to enroll eligible children in health insurance programs are looking at the National School Lunch Program as a possible source of leads, if not outright enrollments. Since the income eligibility guidelines to obtain free or reduced-price meals through the program are similar to or more restrictive than the income eligibility guidelines for children's health coverage in most states, a child who is eligible for school lunch benefits is likely to be eligible for health coverage through the Medicaid or Children's Health Insurance Program (CHIP).

The Agricultural Risk Protection Act of 2000 included provisions to make it easier to disclose information from a school lunch application. States and school food authorities were given an option to disclose children's free and reduced-price meal eligibility data to Medicaid and CHIP agencies without first obtaining parental consent.

### Opting out

To protect confidentiality, school food authorities are required to tell families that the information will be shared and give them an opportunity to opt out of the disclosure.

The Center on Budget and Policy Priorities in Washington, DC, conducted a survey to determine how state child nutrition agencies and local school districts responded to the call to explore using the school lunch program for effective health care outreach.

It also looked at the extent to which the U.S. Department of Agriculture's (USDA) multiuse school lunch application and waiver forms were used during the 1999-2000

school year. To assist with health insurance outreach for children, the USDA developed and distributed several prototype forms that could be used to obtain parental consent to disclose children's free and reduced-price meal eligibility information for the purpose of identifying and enrolling children in Medicaid and CHIP.

The prototypes are available either as a check-box on a multiuse school lunch application or as a separate waiver form that could be attached to an application.

### Availability publicized

The survey found that most state school lunch agencies issued either the USDA prototype multiuse school lunch application or waiver form to local school districts in the 1999-2000 school year. Most states that did not use either the form or the waiver used other means to tell families about availability of free and low-cost children's health care coverage, including enclosing flyers or other promotional materials with school lunch applications.

More than half the states that used the prototype forms included a cover letter encouraging school districts to use the materials or providing instructions on how to use them, or both.

Strategies for sorting out school lunch applications or waivers on which families had checked the consent box appeared to vary from state to state and even school district to school district.

Many state child nutrition directors did not know how applications with boxes checked off were being sorted. State child nutrition directors also were not familiar with how the information was being communicated to

health insurance agencies or how those agencies responded.

The directors had mixed opinions of the prototype application and waiver forms, and said the key factors for successful implementation of a multiuse application or waiver were a strong partnership between relevant state agencies and the availability of Medicaid or CHIP staff to help implement transfer and follow-up procedures.

The greatest obstacles to successful implementation of the multiuse school application or waiver appeared to include inadequate availability of school staff to implement procedures and a lack of clear procedures for handling the multiuse application or waivers. Cost of implementation was not mentioned as a significant concern.

Donna Cohen-Ross, center analyst, tells *State Health Watch* the survey revealed a significant amount of interest in exploring the best way to link the school lunch application with children's health care.

While forms were moved around and used, in many instances, what was needed was something more — promotion of planning and coordination so a system and procedures could be in place to make use of the information from the application form, she says. "In those instances when something productive happened, it was because there had been some coordination at the state or local level between people working in nutrition and health care."

A major issue was what schools did with an application once it was returned by a family. "Is there a system in place to make use of the information to make a health care eligibility determination? In a lot of places, that just didn't happen," Ms. Cohen-Ross says.

"Families may have checked the box on the form, but because there was no system in place, they didn't hear back and thought they weren't

eligible, and so they passed up other outreach. There needs to be better collaboration and a plan in place."

She suggests that states could follow up on applications that are sent to school districts to offer assistance and could authorize sharing of income information and not just a family's name and address.

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Donna Cohen-Ross

*Analyst  
Center on Budget  
and Policy Priorities  
Washington, DC*

Reportedly, a USDA interim rule will require a written agreement between state agencies so a system will have to be in place to make use of the information. Such a requirement, Ms. Cohen-Ross says, would be a great help in acknowledging what has to happen in both the school and the health care agency.

Rachelle Wagner, who has worked on the program in Cincinnati for Automated Health Systems, tells *SHW* that in the first pilot year, they used the modified application to obtain a parental release for information and an indication of interest in learning more about health insurance for their children.

Her company sent the application

to about 20 school districts and met with the public and parochial schools that used it to set up a protocol for gathering the information.

The Cincinnati public schools arranged for telephone calls to families to try to encourage them to complete the application. Wagner estimates they reached 25% of the families. Problems with lists not having telephone numbers and other logistic difficulties cut the response. They received the names of 3,400 children in Hamilton County and sent out 1,500 applications.

The rest of the state, Ms. Wagner says, used a mail center to mail applications for health insurance in response to the information they received. Parent involvement coordinators from the schools also conducted outreach to encourage parents to apply.

Ms. Wagner says an initial lesson learned is not to do so much upfront telephoning and instead concentrate on coaching people in submitting an application. She also says it would help if schools shared telephone numbers and even Social Security numbers.

The Center on Budget and Policy Priorities says that technical challenges related to sharing information from school lunch applications with Medicaid and CHIP, such as waiver language, methods for matching records, and strategies for electronic information transfers, should be reviewed and stumbling blocks removed. "While using the school lunch application to identify children who are likely to qualify for health coverage is a crucial first step, greater emphasis should be placed on aggressively facilitating enrollment of those children in health coverage programs," the report says.

*[Contact Ms. Cohen-Ross at (202) 408-1080 and Ms. Wagner at (513) 731-2345.] ■*

# Children in foster care need continuity of health care services, coverage of special needs, study shows

**A** groundbreaking study of health care services provided under Medicaid for children in foster care indicates there is a major need to ensure continuity of coverage and thus continuity of care. "Making sure these children have access to continuity of coverage, rather than being covered off and on, is a top priority," says Margo Rosenbach, vice president of Mathematica Policy Research Inc. in the Cambridge, MA, office.

"We also want to be sure that the nation's health care system recognizes the special needs of foster children," she adds. "They are a very vulnerable population and have big needs." Many of the children studied have physical, emotional, or developmental problems, sometimes resulting from abuse or neglect.

Ms. Rosenbach studied services provided to children in foster care for 1994 and 1995 in California and Florida and for 1993 and 1994 in Pennsylvania. Three comparison groups were children under age 19 who received either adoption assistance, Aid to Families with Dependent Children (AFDC), or Supplemental Security Income (SSI) benefits because of disability.

The study captured only health care utilization and expenditures that were paid by Medicaid; foster care children may have received health care that was not billed to Medicaid or that was paid by other sources. As a result, Rosenbach says, the study underestimates the total amount and cost of health care services provided to children in foster care.

Ms. Rosenbach tells *State Health Watch* there was a need for this study because foster care children have very high health needs and little has been known broadly about the care and

treatment they receive. She says there are pros and cons in using data from the early 1990s, but they were the latest available at the time of the survey. "There have been some state initiatives since then, and so care may have improved. On the other hand, since states are moving toward managed care, there could be less care. We'd like to think that things have gotten better, but we need a more recent study to be sure."

Ms. Rosenbach's key findings were:

- Children in foster care represented between 1% and 3% of Medicaid children, but between 4% and 8% of Medicaid expenditures.

- Most children were enrolled in Medicaid before they entered foster care, but between one-third and one-half lost their Medicaid coverage when they left foster care.

- Children in foster care were more likely than other groups of Medicaid children to have a mental health or substance abuse condition.

- Health care utilization varied considerably across the three states studied.

## Too many lose Medicaid

Research has shown that continuous, year-round health insurance coverage is related to improved access to care," Rosenbach's report says. "Children in foster care had less continuous Medicaid coverage than children receiving SSI benefits and children in families receiving adoption assistance. And in all three states studied, significant numbers of children lost Medicaid in the month they left foster care."

Children in foster care were more likely than other groups of Medicaid children to have a mental health or substance abuse condition, either

alone or in combination with a physical condition. They also had a higher likelihood of comorbidities than AFDC and adoption-assistance children, but they were less likely than SSI children to have multiple diagnoses.

Generalizing on the variation in health care services, Rosenbach says that foster care children in California were less likely to receive health care services than were children in Pennsylvania and Florida. More than 80% of foster care children in Florida and Pennsylvania had at least one provider visit in 1994, compared with 65% in California.

The likelihood that foster care children received a preventive checkup during 1994 ranged from 28% in Florida to 41% in California. Many foster care children did not receive routine checkups, despite recommendations for an annual physical and mental health assessment each year. Very few foster care children received an assessment during the first two months of a foster care placement. Children with no prior Medicaid coverage received early assessments more often, suggesting that providers were more likely to perform assessments on those who were newly enrolled in Medicare.

Foster care children were far more likely to receive dental care than were other groups of Medicaid children, and foster care children were more likely than other groups of Medicaid children to receive mental health or substance abuse services.

Average monthly Medicaid expenses for foster care children ranged from \$154 in California to \$375 in Washington. Medicaid spending for foster care children was two or more times higher than expenditures for all Medicaid children. By

contrast, Medicaid expenditures for AFDC children were well below the average for all Medicaid children.

Ms. Rosenbach says the study provides four main policy implications:

**1. Continuity of coverage is important.** Discontinuities in health care coverage can have an adverse effect on access to care. Policy-makers should focus on ways to improve continuity of health insurance coverage for children in foster care.

**2. Medicaid may be underutilized as a funding source.** States have considerable flexibility in how they use Medicaid to pay for services for foster care children. Medicaid can fund a comprehensive continuum of care, ranging from screening and assessment to follow-up treatment and ongoing therapies.

**3. A broad-based concept of care coordination is needed.**

**4. The structure of managed care systems should recognize foster children's needs.**

Ms. Rosenbach says efforts to ensure continuity of coverage are important because foster care children often are involved in many different health and juvenile justice systems, but still can fall through the cracks.

She says that while her study documents the differences that existed in the three states surveyed, there is a need to find out why the variations occur.

"Possible factors include health care services for children in foster care, the role of the courts in mandating health care for children in foster care, characteristics of state programs [such as the use of health passports, level of staff caseload, and availability of transportation services], variations in the Medicaid benefit package, availability of providers to serve the population, provider knowledge concerning services needed by the population, generosity of reimbursement rates, differences in case mix, and level of stigma about accessing services," Rosenbach explains.

Another question raised by the study is the extent to which needs are unmet.

"Without external benchmarks against which to evaluate patterns of care, coupled with more detailed clinical assessments, we cannot tell whether lower rates of utilization are indicative of access barriers or simply lower health care needs," she adds.

"To gain a better understanding of unmet needs in the foster care population, policy-makers and researchers could perform a medical records review or conduct a survey of foster care families and caseworkers," Ms. Rosenbach says.

*[Contact Ms. Rosenbach at (617) 491-7900.] ■*



**The ninth annual Medicaid Managed Care Congress** is scheduled for June 25-27 in Alexandria, VA. Educational tracks are designed for marketing, education, member services, contracting, compliance, and network development. Workshops and seminars will include:

- Diversify your beneficiary population by leveraging state child health insurance programs
- Initiatives, trends, and prospects in Medicaid managed care: An informed perspective from the Health Care Financing Administration
- Understanding Medicaid risk-adjustment strategies for health services to special needs populations
- Transition planning when states carve benefits out of existing Medicaid managed care programs
- Educational competence in marketing for Medicaid managed care
- Developing and using new technologies to streamline Medicaid processes:
- A case study of the Arkansas program

A panel session will be held in which former Medicaid directors will gather to discuss their experiences. Panelists will include Larry Ford, the former Medicaid director of New Hampshire; Kevin Piper, former Medicaid director of Wisconsin; Charles Milligan Jr., former Medicaid director of New Mexico; Jim Verdier, former Medicaid director of Indiana; and Alan Weil, director of the Urban Institute in Washington, DC.

To register, call (888) 670-8200 or go to [www.iir.ny.com](http://www.iir.ny.com).

The conference is presented by the Institute for International Research, Healthcare Division. ▼

**The National Academy for State Health Policy** in Portland, ME, holds its 14th annual conference Aug. 12-14 in Charlotte, NC. The conference is designed by and for state policy-makers. Sessions will be held on health care costs and cost containment, prescription drug programs, long-term care, the future of Medicaid and managed care, children's health, and serving the chronically ill and people with disabilities.

For more information, call the academy at (207) 874-6524. ■

# Clip files / Local news from the states

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

## Federal laws, a state's concerns about arsenic meet in Michigan

LANSING, MI—Michigan lawmakers are pushing to lower federal arsenic limits in drinking water by 80%, although 450 public water systems statewide would likely fail the new standard.

In all, uncounted private wells and about 15% of Michigan's 3,000 municipal water systems would exceed the arsenic standard proposed by Democratic U.S. Reps. Dingell, Stupak, Conyers, and Bonior in a House bill.

Wading into a war of statistics and clouded science, the lawmakers want to reinstate a 10 parts-per-billion (ppb) arsenic maximum that appeared in the waning days of the Clinton administration.

U.S. Environmental Protection Agency (EPA) officials, directed by the Bush administration, recently moved for a nine-month delay in adopting a lower threshold for arsenic. The current standard of 50 ppb dates to 1942.

"Arsenic is a deadly poison, and this matter has been studied for 17 years. How much more do we need to study?" said Rep. John Dingell. "I'm inquiring about the legality of the EPA's action."

A metal that occurs naturally, arsenic's danger concerns the threat of cancers of the lung, bladder, kidney, and skin that scientists have linked to tainted water sources. In Michigan, arsenic is commonly found in underground layers of rock, where it can join groundwater tapped by unsuspecting residents' wells.

But citing high costs of removing arsenic, Christine Whitman, EPA director, has proposed a delay until 2002 to consider a range of standards from 3 ppb to 20 ppb.

The House bill would effectively prevent any delay and provide \$2 billion in loans for rapidly revamping water systems.

"This [delay] gives us a chance to take a narrower focus," said Robin Woods, EPA arsenic specialist in Washington, DC. "We just want time to review the costs and take another look at the science behind the standards."

—*Detroit News*, May 3

## Arizona lawmakers try to make sense of who gets prescription drug dollars

PHOENIX—Low-income rural seniors got some help to pay for their prescription drugs recently in Arizona, but it wasn't the widespread bailout many were expecting.

State lawmakers struggled during their recent session to create a plan to help older Arizonans, especially those in rural counties where health maintenance organizations pulled out last year, cope with the rising cost of prescription drugs.

What survived is the so-called "catastrophic" plan, backed by Rep. Deb Gullett (R-Phoenix). Seniors who are 150% to 250% above the federal poverty level (\$8,590 for one person or \$11,610 per couple) would have to spend from \$500 to \$1,000 of their own money on drugs before qualifying for a 50% discount.

"This is not a global fix; it's a modest fix," Ms. Gullett said. "But this plan sends relief to the people with the biggest need."

The Senate approved the bill, 16-13, and sent it to Gov. Jane Hull. Ms. Gullett said the plan is a two-year stopgap until Congress can add a prescription benefit to Medicare. On Monday, the House killed a more expansive prescription drug bill that included a federally negotiated discount on prescription drugs throughout the state.

## Facing opposition

Opposed by pharmaceutical companies and budget-conscious House Republicans, the program was championed by the late Sen. Andy Nichols (D-Tucson). A similar program in Vermont is under litigation, and President Bush is unlikely to permit any new programs until the lawsuit is settled, Ms. Gullett said.

Sen. Chris Cummiskey (D-Phoenix) said he was incensed that House members killed a compromise bill containing aspects of his, Gullett's, and Nichols' ideas in favor of a bill with only Gullett's "catastrophic" discount.

—*The Arizona Republic*, May 2

## Florida mulls change in policy to generic for four brand-name drugs

TALLAHASSEE, FL—In what would mean a savings for thousands of Floridians, pharmacists could substitute less-expensive generics for four brand-name drugs under a bill sent to the governor.

The list of affected drugs includes the popular brand-name blood thinner Coumadin. If the bill becomes law, pharmacists automatically would substitute the generic warfarin for Coumadin, unless doctors write "medically necessary" on a prescription for Coumadin.

The Senate approved the bill. Gov. Jeb Bush has not taken a position on the issue, a spokeswoman said.

Pharmacists already are required by Florida law to fill prescriptions for nearly all brand-name drugs with generic equivalents. They must use the brand-name drugs only if doctors write “medically necessary” on the prescription.

But Coumadin was among a handful of brand-name drugs on the state’s “negative formulary” list. Any brand name on that list could not be substituted.

Under the bill, Coumadin and three other drugs would be removed from the list and treated just like any other name brand drugs. Doctors who wanted their patients to receive Coumadin still could write “medically necessary” on the prescriptions.

“Two words can be placed on the prescription pad that make it crystal clear if the doctor does not want a substitution,” said Sen. Ron Klein (D-Delray Beach).

—*St. Petersburg Times*, May 3

### **Tax credits for the uninsured could be part of more government spending**

WASHINGTON, DC—Moving to help the 43 million Americans who lack health coverage, House and Senate budget negotiators have accepted a plan that could lead to the biggest expansion in decades in government funding and tax credits for the uninsured.

The provision, included in the compromise budget resolution the negotiators have been working on and which now is headed for congressional approval, reflects bipartisan enthusiasm for trying to significantly reduce the ranks of people without health coverage. Extending coverage has proved a stubbornly persistent problem despite the recent years of strong economic growth.

The House and Senate are expected to approve the budget resolution. House leaders had planned to pass the measure May 3, but postponed action because of a clerical error, they said. The delay came after GOP leaders made last-minute changes in another crucial area of the budget.

### **Some emergency funds will be cut**

Although President Bush and congressional negotiators had agreed to a 5% spending increase for government discretionary programs, sources said GOP leaders decided to scale back the spending hike to the 4% the White House initially sought. The change would trim back \$6 billion that had been included for natural disasters and other emergencies.

The health insurance initiative, which was accepted by House and Senate negotiators and was unaffected by the

squabble concerning discretionary programs, would make available an additional \$28 billion over the next decade in federal money to cover the uninsured.

Proponents advocate using it to extend health insurance to parents of children already covered by a federal program for low- and moderate-income households.

—*Los Angeles Times*, May 4

### **Aetna U.S. Healthcare sells its New Jersey Medicaid and NJ FamilyCare to AmeriChoice**

PHILADELPHIA—Aetna U.S. Healthcare has agreed to sell its New Jersey Medicaid and NJ FamilyCare businesses to AmeriChoice Corp. Terms were not disclosed.

The agreement affects about 118,000 low-income families including New Jersey Medicaid beneficiaries and members of the state’s FamilyCare program for uninsured children and adults, the company said.

Subject to approval by the New Jersey departments of Human Services, Health and Senior Services, and Banking and Insurance, the transaction is expected to be completed by the end of the year, Aetna U.S. Healthcare spokeswoman Jennifer King said.

Participants whose coverage is being switched will be notified in writing and be given an opportunity to switch to another health care provider if they wish, the companies said.

Aetna U.S. Healthcare’s and AmeriChoice’s networks of participating providers overlap and the companies said most members would continue to have access to their current physicians.

—*Associated Press*, May 4

### **Arizona’s KidsCare and the schools agree to not mix in the classroom**

PHOENIX—A signature from Gov. Jane Hull is all that’s needed to allow schools to help promote Arizona’s health care program for low-income children as long as they keep those efforts out of classrooms.

The Senate voted, 25-3, for a bill (Senate Bill 1087) recently that would permit districts to perform “out-reach and information activities.” It also states that the activities “shall not reduce or interfere with classroom instruction time and shall not be performed by teachers or in classrooms during regularly scheduled classroom hours.”

While conservatives have contended that the KidsCare program is government taking on an unnecessary role,



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★  
**THOMSON HEALTHCARE**

supporters say school involvement is needed to inform families about the program and the health care it provides.

Hull's State of the State speech in January urged legislators to use schools to promote KidsCare, and she has said she looks forward to signing the bill.

The bill also cuts in half the current six-month "bare period" during which new enrollees must not have dropped private insurance before becoming eligible for KidsCare.

—*Arizona Republic*, May 3

### North Carolina will receive less for Medicaid funding in the coming year

RALEIGH, NC—A change in federal Medicaid reimbursements will cost North Carolina \$29 million next year, putting additional pressure on lawmakers to find ways to curb costs in the program.

The change will essentially shift the federal government's share of Medicaid from 62.47% to 61.46%, state officials said.

Although the change is made every year, the amount was larger than expected.

"The federal share goes down every year because North Carolina is becoming wealthier every year," said Dick Perruzzi, head of the state's Division of Medical Assistance.

The formula change is based on states' per capita income.

Medicaid is a \$5.5 billion program in North Carolina. It serves about 1.2 million people in the state.

Most of the people served are at or below the federal poverty level — \$17,050 for a family of four.

North Carolina will spend about \$1.6 billion on the program this year, or about 10% of the state's operating budget. Those costs will grow by roughly \$500 million next year unless changes are made in the program.

—*Raleigh (NC) News & Observer*, May 4

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