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In This Issue

Political waters are chilly as policy is decided upon one issue at a time

Health care policy-makers who take a look into the heart and soul of the American electorate may get a frightening reminder of how fickle voters are.

Voters are nervous about new approaches to solving health care's problems, its funding, and its delivery to the public.

They want to ensure Medicare stays viable, medical errors barely register on their radar screen, and they are wary of government's ability to get the job done.

SHW at the 2001 NASHP Conference

However, the electorate is no longer keen on waiting for the federal government to find solutions to health care's challenges.

It will eagerly respond to state and local politicians who will talk about finding creative solutions and partnerships that might resolve health care's seemingly intractable problems.

This is the political climate those who attended the recent National Academy for State Health Policy annual conference find themselves in.

The vast array of challenges policy-makers find themselves faced with are sometimes solved with the

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Florida makes a PACT for the mentally ill

Florida is the latest state to implement a community-based treatment program for the mentally ill that is noteworthy for its success over more than 20 years.

While part of the reason for a broadening interest in Programs of Assertive Community Treatment (PACT) is the 1999 U.S. Supreme Court decision in the *Olmstead* case, which ruled it is discrimination to confine a person in a nursing home or mental hospital if he or she could live in the community with appropriate support, another important reason is simply that it works.

It has been proven to decrease the time that people with severe and persistent mental illness spend in hospitals and to facilitate the community living and psychosocial rehabilitation of those individuals.

Chris Gosen, Tallahassee, FL-based Apalachee Center for Human Services chief operating officer, tells *State Health Watch* that 10 PACT sites were implemented by various vendors in Florida in 2000, with another 13 request for proposals issued this year.

Project began in Wisconsin

"This is a well-researched model that began in Wisconsin and has been heavily promoted by the National Alliance for the Mentally Ill [NAMI]. It's one of the well-funded new programs and is targeted to a

*See **Florida PACT** on page 6*

Policy-makers

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help of voters, and sometimes they are solved while voters look in the other direction.

"The public is concerned about health care issues, but it's very hard to get the public to move forward," political analyst and pollster Celinda Lake, of Lake Snell Perry and Associates, told attendees on the first night of the conference in Charlotte, NC.

Important to women

Ms. Lake charted the waters according to recent poll data, saying health care policy is ranked as being important mostly by women, lower income voters, and Democrats.

Voters have lots of concerns to keep themselves occupied, she added, and they are not necessarily looking for new health care issues to confront. One issue at a time is the way the electorate thinks and beyond that, progress will be slow, she said.

Voters have one health care issue per cycle," Ms. Lake said. "In 1998 it was the patients' bill of rights cycle, in 2000, it was the prescription drugs cycle."

Hot-button issue

Looking ahead to November, there is a slight shift of concerns, Ms. Lake said. Prescription drugs will still be a hot-button issue, but nursing home reform is gaining momentum, she said, calling it a sleeper issue that will cause voters to demand more of state government when it comes to rules and policy. And if the states don't grab the horns, then voters will turn to the cities, to any place that will give direction, she pointed out.

"For a while, national solutions were seen as the solution. Then we saw voters move back their concerns to the state," Ms. Lake continued. "Now it's all over the map. People say they don't give a damn who does it as long as someone does. People are even interested in cities offering insurance."

A two-tiered society is emerging, Ms. Lake said, in which voters have health insurance, are concerned about money and health care issues, and

More are in nursing than ever, yet states still can't lure enough to practice

There is a structural problem with the job of nursing across the country, and states are trying a number of ways to address and stem the shortage.

"In 1998 and 1999 there was an increase in those asking for licenses, and a reduction in people going into nursing programs," said Georges Benjamin, secretary of the Maryland Department of Health and Mental Hygiene. "But people are not finishing the programs. Where did they go? They have left nursing."

Maryland created a commission on the crisis in nursing, with 46 members that meet four to six times per year. The state may not have the answers to the problem, but it has outlined why the nursing situation has become what it is.

SHW at the 2001 NASHP Conference

Among the reasons cited in a recent Maryland study:

- Nursing schools are expensive and that scares off potential students.
- Curriculum at the schools do not keep up current practices.
- There is a lack of qualified faculty.
- There are no incentives or reimbursement for continuing education.
- There is a lack of mentoring.
- There is insufficient clinical experience for students.
- There is a poor image of nursing among the public.

What to do? The state has introduced bills among the legislature for nursing scholarships, increased Medicaid funding by $20 million per year, and discussed workplace concerns with hospital CEOs.

But there is still going to be trouble. "Until we fundamentally change the workplace, you've got nothing going for you," Mr. Benjamin says. "We need more federal action."

Edward Salsberg, director of the Center for Workforce Studies at the State University of New York, says his state also has taken steps to get more people back into nursing. New York has expanded grants; capitation funding and/or mandates for educational programs; state funding for training and training initiatives; scholarships; and marketing for health careers, he says.

The Medicaid reimbursements would help to increase wages and improve benefits, such as health insurance for workers, and portability of benefits within the industry, Mr. Salsberg explains.

Lack of diversity among nurses is also a common concern. In California, Hispanics, African-Americans, and Asians comprise only 21% of the total nursing population. "As a policy analyst, I think we must look at broad issues," Mr. Salzburg adds.

"More RNs are employed than ever. But there are underrepresented minorities in the nursing work force. We must look at the issue of job design and re-engineering, and we must bring nurses into the process," he says. ■

believe that they are paying more money for their health care. The other tier is the one without money and may not even vote.

What do the voters want?

Where does the voting public's sympathy lay? With themselves, according to Ms. Lake, especially with the seniors who vote. But the public seems to care deeply about the welfare of children and about helping the working poor, those who are employed but are without health insurance.

"Medicare is a big issue on the agenda," she told policy-makers at the conference.

"Democrats will run on the tax cut as being irresponsible. Voters are not eager for tradeoffs. They say Medicare is sincerely in trouble. They would decrease spending on other programs to save it. When they were asked about commonly discussed reforms to make Medicare solvent, none of them are popular. The No. 1 reform for Medicare is to offer a prescription drug benefit," she explained.

Caution is required

Knowing that she spoke to policy-makers who believe government-sponsored health care should be more widely spread than it is, Ms. Lake offered caution.

"The public thinks welfare reform has been successful. Arguing that they are wrong is not good strategy," she said. "So what can we do to help the working poor? The area of welfare reform may be a chance to bring working families front and center. In a time of declining budgets, this won't be easy."

As for medical errors as a motivating issue for voters, forget it, Lake advised, saying there is a more concrete issue to focus upon. "The shortage of nurses, that's wildly popular with the public." ■

Medical error statistics: How to staunch the flow of bad numbers

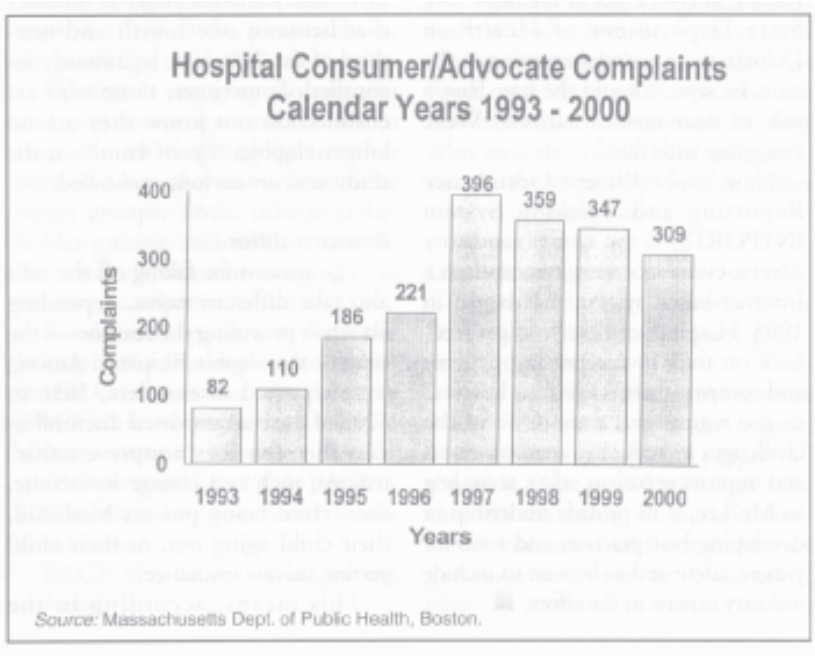
The Institute of Medicine report on the toll medical errors take stands like a monolith in front of every provider, payer, patient, and state. The figures are by now familiar: An estimated 2.9% to 3.7% of hospital admissions end up with an adverse event, with as many as 98,000 deaths per year. The cost is estimated to be a whopping $17 billion to $29 billion.

To Jan Malcolm, commissioner of health with the Minnesota Department of Health in St. Paul, the debate over the accuracy or inaccuracy of these numbers is a sideshow. One of the very real problems is that there is such a heated debate over the numbers instead of more debate about system changes by states, she says. Many states have stepped into the breach to staunch the flow of bad numbers. Coordinators among the states realize they are not working alone, that other states are constructing systems of their own to help, as is the federal government. She says her state created the Minnesota Alliance for Patient Safety, joined the National Quality Forum, and commissioned a study on the factors influencing patient safety and patient care. States are responsible for holding providers accountable for safety, should provide clear performance standards, and should educate everyone about medical errors and safety, she contends.

SHW at the 2001 NASHP Conference

Nancy Ridley, assistant commissioner of the Massachusetts Department of Public Health, wants to eliminate regulatory overlap and end up with a single system to prevent medical errors. One of her main concerns is that national legislation could overwrite state rules.

The Massachusetts Medical Error Coalition has taken several steps to eliminate errors. It has developed a consumer pamphlet regarding medical errors, held leadership forums, spawned coalition member initiatives, extended its media outreach, and



Source: Massachusetts Dept. of Public Health, Boston.

hired an executive director. The state has set up reporting and investigation systems: one for hospitals and one for nursing homes. In hospitals, the most serious errors must be immediately reported by telephone; all others must be reported in writing within seven days. Reports become public after the investigation is completed.

Richard Lee, deputy secretary of quality assurance with the Pennsylvania Department of Health in Harrisburg, says reducing errors requires better communication between the board of health and other health care departments. Helping determine the number of medical errors and how they occur can be done by checking hospital records and looking at the discharge codes. "ICD-9 cards will give a guide to finding errors in your state," Mr. Lee advises.

Pennsylvania would like to have a separate reporting system for near-misses, he added. "There seem to be a tremendous number of hospitals that are underreporting. I can't believe they are not having problems."

While New York state has a mandatory reporting system, according to Robert Barnett, director of the Patient Safety Center at the New York State Department of Health in Delmar, there is underreporting to the state, he says. "Should the state have a role in near-miss situations? We're struggling with this."

New York's Patient Occurrence Reporting and Tracking System (NYPORTS) is the state's mandatory adverse-event reporting system. It is a Internet-based system that began in 1995. Hospitals can use it to get feedback on their own reporting patterns and compare them with other hospitals in the region and state. One of the challenges to reducing medical errors and improving patient safety, according to Mr. Lee, is to provide leadership in developing best practices and tools for patient safety and to be sure to include industry experts in the effort. ■

Falling off the CHIP rolls: Two sides do not always agree

There are many reasons why children who are eligible for the state Children's Health Insurance Program (CHIP) fall off the rolls, but the reasons given by their parents and the reasons given by the state do not always match. That's the finding of a National Academy for State Health Policy team study conducted in seven states.

"What states believed happened and what parents believed happened are often very different," said Susan Kannel, senior analyst with Lake Snell Perry and Associates in Washington, DC, which conducted the polling in the study.

For instance, states and parents often do not agree whether a child actually is enrolled in CHIP. About 20% of state-reported disenrollees, according to the study, believe their children are currently enrolled. Preliminary analysis suggests however that between one-fourth and one-third of the 20% have legitimately re-enrolled. Sometimes, those who are enrolled do not know they are no longer eligible; 8% of enrollees, the study says, are no longer enrolled.

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Reasons differ

The reasons for falling off the rolls also take different twists, depending on who's providing the reasons — the state or the eligible recipient. Among state-reported disenrollees, 30% to 50% of the state-reported disenrollees said they left for "nonpreventable" reasons, such as a change in income, their child being put on Medicaid, their child aging out, or their child getting private insurance.

This means, according to the study's preliminary findings, that 50% to 70% of this state-reported disenrollee sample actually say they disenrolled for "possible preventable reasons."

Whatever the reasons, says Chad Westover, CHIP administrator for the Utah Department of Health in Salt Lake City, "it's incumbent upon states to figure out ways to get people to re-enroll."

Feeling like a number

Reasons range far and wide as to why parents often do not re-enroll their eligible children, he adds. "A lot of people didn't want to be on the program because their kid is healthy and they say they are making room for others to be enrolled," he said. "Some of them loved their case-worker, and others said they felt like a number."

Tracking down those who are eligible but have fallen off the rolls is not easy.

"These are hard-to-find people," said Michael Perry, vice president of Lake Snell Perry and Associates.

"We found current and disenrolled families like the program; the health care part works for them. The disenrolled want back in. Families fall off the rolls because of communication problems. The renewal process is a hassle, and the premium payment is not high on their list of bills priorities," he says.

The only consistent complaint about CHIP, the study uncovered, referred to dental coverage.

Paying premiums was a costly but acceptable way to maintain coverage, the study found. Of those who pay a premium, 88% said they felt the premium amount "is about right" and 97% said paying the premium is

"well worth it for the care you get in return." Disenrollees are more than twice as likely (39% vs. 16%) as current enrollees to say the premium is sometimes a problem.

More than half of self-reported nonpayment disenrollees said the reason they did not or could not pay was because of financial difficulties. Twenty-five percent said they either forgot or "did not get around to it," according to the study.

"We found current and disenrolled families like the program; the health care part works for them. The disenrolled want back in."

Michael Perry

Vice President
Lake Snell Perry and Associates
Washington, DC

A majority of those surveyed (82%) said the renewal process was easy, but some found it problematic; 34% of current enrollees and 38% of disenrollees agree that "too much background paperwork is required" for renewal.

Other findings from the study:

• 28% said CHIP told them they had not paid their premium even though they had.

• 20% say they have "had to wait weeks or months to hear back from CHIP about enrollment or some other issue."

• 14% say they have "had trouble getting answers about eligibility or coverage."

• 7% said their child was terminated from coverage at some point without being told why.

The seven states in the study were Alabama, Arizona, California, Georgia, Iowa, New Jersey, and Utah. ■

State pharmacy programs: Are they too political to work?

Beware, those who enter the gates of the state pharmacy program, warns Thomas Snedden of the Pennsylvania Department of Aging. Awaiting those brave enough to walk through is a tangle of politics and dollar signs, he says.

"These programs are steeped in politics," Mr. Snedden asserts, "with the pharmaceutical industry, pharmacists, older people, the states, all of them lobbying. You've got to have money to do this. Many states do not have it."

To begin, money is a top priority; there should be plenty in the coffers at the beginning, he says. States should then identify their nonfinancial resources and expertise. Then define their target groups and choose their cost-containment strategies.

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"It's very political," Snedden says. "It's a zero-sum game. The loser is the manufacturer or the pharmacist or the people."

Up next is engaging procurement and contracting agencies. It's best to find out what's going on in other states and how they serve their similar target groups. Then, inform stakeholder groups, such as pharmacists, the state's department of aging, and insurance companies.

Snedden's program is the Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE). He admits he had a leg up when it comes to funding PACE, which was started in 1983: PACE is 100% funded by the Pennsylvania state lottery.

PACE eligibility requirements included:

• Recipients must be age 65 or older.

• Recipients must be Pennsylvania residents for at least 90 days prior to application.

• Their income must be no more than $14,000 for a single person or $17,200 for a married couple.

• Participants must not be enrolled in a Medicaid prescription program.

• Re-enrollment is required annually or biannually.

Among PACE's cost-containment features are the fixed-income limits ("The biggest cost-containment limit we have," Mr. Snedden says), mandatory generic substitution, manufacturer rebates, mandatory drug utilization edits, and aggressive provider compliance.

Across the country, pharmacy programs vary from state to state. According to Kimberly Fox, policy analyst for Rutgers University's Center for State Health Policy in New Brunswick, NJ, funding comes from general funds; categorical funds such as casino revenue, lotteries, and cigarette taxes; tobacco settlement funds; and Medicaid waivers. She also says states have a tough time deciding who exactly needs help and ultimately the eligibility determination revolves around politics.

Lessons to learn

She offers these lessons from states who have undertaken pharmacy programs:

• For start-up, investment outreach is key. "Program cost is the biggest issue for states with this program," she adds. "Also, provide enough lead time for designing the benefit, consumer education and outreach, and getting the rebate agreements in place."

• Be conservative; start small. Low enrollment and underspending is not necessarily bad at the outset, Ms. Fox says.

• Keep it simple. A complicated program design limits participation and can result in negative publicity. Recent expansions with complicated cost sharing have had lower than expected enrollment, according to Ms. Fox.

"We didn't want pharmacies, in the first year, badmouthing the program, so we gave in and are paying the Medicaid rate."

Rob Tester

Assistant Director
South Carolina Office of Insurance Services
Columbia

In South Carolina, the pharmaceutical program is run with $20 million in funds from the state's share of the general tobacco settlement, according to Rob Tester, assistant director of South Carolina's Office of Insurance Services in Columbia.

To enroll, participants must be age 65 and older, be ineligible for Medicaid, must use no other prescription insurance coverage, and their annual income must not be above 175% of poverty.

The pharmacy reimbursement rates are held at the state Medicaid level, which Mr. Tester says is "a rich rate. We didn't want pharmacies, in the first year, badmouthing the program, so we gave in and are paying the Medicaid rate."

To keep the program running as smoothly as possible, Tester said the state has created an advisory council of advocates from pharmacies, senior centers, and state social agencies to give their input on program issues. ■

Florida PACT

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small number of persons in which we can make a difference," he says.

Program participants often are those who are noncompliant in traditional institutional or outpatient settings or who routinely cycle through the mental health and justice systems.

"The treatment is very intensive," Mr. Gosen says. "The difference is that we take intensive services to people in the community rather than providing them in an institution."

At the heart of the PACT concept is a treatment team that for Apalachee includes a full-time equivalent (FTE) program psychiatrist, one FTE team leader, one FTE peer specialist, three FTE RNs, two FTE licensed mental health professionals, two FTE licensed or nonlicensed master's level professionals, one FTE bachelor's level mental health worker, and 1.5 FTE program assistant.

Program criteria

The maximum number of patients the team can work with is 100. Apalachee expected its team to admit 30 patients within the first six months and add up to 70 more over the next 18 months. Those admitted to the program must meet one of three admission criteria:

1. individuals with severe and persistent mental illness such as schizophrenia, bipolar disorder, or other psychotic disorders;

2. individuals with significant functional impairments;

3. individuals with problems such as high use of psychiatric hospitals/jails, substance use disorder, inability to meet basic survival needs, or severe major symptoms.

The goal is to place each patient in an independent living setting and deliver at least 75% of all services in the community.

In its materials on the PACT model, NAMI says the program differs from traditional care in that most individuals with severe mental illnesses who are in treatment are involved in a "linkage or brokerage case management program that connects them to services provided by multiple mental health, housing, or rehabilitation agencies or programs in the community." Under that traditional model, a person with a mental illness is treated by a group of individual case managers who operate in the context of a case management program and have primary responsibility only for their own caseloads.

Working within a team concept

In contrast, the PACT multidisciplinary staff works collaboratively as a team to deliver the majority of treatment, rehabilitation, and support services required by each client to live in the community. A psychiatrist is a member of the team, not a consultant to it; patients are clients of the team, not of individual staff members.

Elizabeth Edgar, director of state health care with NAMI's National PACT Center, says assertive community treatment is one option that should be a part of every state's *Olmstead* plan because PACT programs exist specifically to give consumers the choice of living in a community or an institution. "A PACT program can overcome the barriers to living in communities faced by people leaving, or being diverted from, admission to institutions."

Despite their proven success and cost-effectiveness (Florida expects to spend $10,000 per year per PACT patient, compared to an average annual cost of $107,553 per bed at Florida State Hospital), PACT programs are only operating in a few states.

NAMI reports that full statewide

PACT programs are available only in Delaware, Idaho, Michigan, Rhode Island, and Texas, with one or more pilot programs under way in 19 states. "In the United States, adults with severe and persistent mental illness constitute 0.5% to 1% of the adult population. It is estimated that 20% to 40% of this group could be helped by the PACT model if it were available."

Ms. Edgar tells *State Health Watch* there are several reasons why so few states currently have PACT programs. "First, financing of a comprehensive approach such as this may not match the traditional fragmented funding sources. Often funding comes from different pots for substance abuse, psychiatric treatment, housing, etc." Ms. Edgar says Rep. Jim Greenwood (R-PA) has introduced legislation that would allow states to establish a new Medicaid option for intensive community services that could be used by PACT programs.

Another potential acceptance problem, she says, is that PACT is designed for the 10% to 15% of mental health patients who are not well-served by traditional programs. Thus, it may target people not now being seen, such as those who are in jail or are homeless. "The system may be reluctant to pick up the care for more people with complicated, severe disorders when they aren't seeking the system out."

Some don't see the need

A third problem may be that local providers and policy-makers believe the systems they have in place are working well and there is no need to import something from another state.

Ms. Edgar says she sees an increased interest in PACT, however, as a result of the *Olmstead* decision by the U.S. Supreme Court and the need for states to look into the types of assistance people need when they are released from an institution. There also is concern being expressed about people who are ending up in jail. Ms. Edgar says there are some specialized PACT teams who are working specifically with people discharged from county jails. And continued efforts by the federal government to spread the gospel of evidence-based treatment should help PACT programs because of the clear evidence of its success.

"The team's direct, integrated provision of services brings medical/psychiatric treatment, rehabilitation, and community support services to severely ill consumers who otherwise would receive little or no care unless they were in a crisis that the community could not disregard."

William Knoedler, MD

Staff Psychiatrist
Program of Assertive Community Treatment
Madison, WI

In a NAMI-published interview with William Knoedler, MD, a psychiatrist who helped create the initial program in Madison, WI, and continues to serve it and a rural Wisconsin program today, the point is made that one of PACT's strengths is its "one-stop shopping" approach to providing services. (For the complete interview, go to NAMI's web site: www.nami.org.)

"The team's direct, integrated provision of services brings medical/psychiatric treatment, rehabilitation, and community support services to severely ill consumers who otherwise would receive little or no care unless they were in a crisis that the community could not disregard. The team also deals with legal issues. When a consumer is arrested for minor offenses, the team intervenes. When a consumer is in jail, the team continues to see him or her, which often facilitates an earlier release. The one-stop approach is especially effective in three areas: vocational skills, alcohol and drug treatment, and helping consumers, usually women, develop skills as parents."

Mr. Knoedler says PACT teams also do a good job of working with a consumer's family. The psychiatrist and other team members meet with the family to teach them about the consumer's mental illness and its treatment, he says, and they offer practical suggestions for interacting with the mentally ill family member.

"They encourage and try to help consumers live in their own housing, if possible. The level of independence may take some time to accomplish, but having housing separate from parents, while remaining well supported by the PACT team, can make it easier for the consumer to relate to his or her family as an adult. Whatever happens, the team will be there supporting the consumer and the family," he adds.

Mr. Gosen says he expects the new Apalachee program to be as successful as others that have been operating, but recognizes that no program can be successful if patients don't cooperate. Even though team members sometimes visit participants twice a day, "We're not going to involuntarily medicate someone," he says. "If someone absolutely refuses to take [his or her] medicine, you come back in the afternoon and try again."

[Contact Mr. Gosen at (800) 226-2931, ext. 2203, and Ms. Edgar at (703) 516-7973.] ■

What do health care companies want for Americans? More affordable health insurance available for all

America's leading health care firms are funding an advertising and lobbying campaign to reduce the number of uninsured. Under the leadership of the Healthcare Leadership Council's Health Access America effort, the group started with a full-page newspaper ad in June and visits to members of Congress to push use of tax incentives to make private health insurance more affordable through the workplace.

Mary Grealy, executive director of the Healthcare Leadership Council in Washington, DC, says preliminary data from a new study show the value of existing tax benefits for employer-provided health insurance is worth about $610 for individuals with an income up to $25,770, or three times the poverty level. That falls far short of proposed tax credits before Congress, which range from $1,000 to $1,500 for individuals and $2,000 to $3,500 for families, she says.

"We can make a lot of progress addressing the problem of the uninsured right out of the box by making coverage more affordable for working families and Main Street business owners," Ms. Grealy adds.

Besides urging policy-makers to use tax incentives to make private health insurance more affordable through the workplace, campaign leaders say they also will seek improvements in current federal programs such as Medicaid and Children's Health Insurance Programs (CHIP) to increase participation by eligible families.

"This is a solvable problem," Ms. Grealy says. "We know that three of every four uninsured Americans live in a household in which there is at least one wage-earning family member. There are millions of people who receive an offer of insurance from an employer, but can't afford it for themselves or their dependents. There are millions more who work, but who do not received an offer of employer insurance coverage.

"One concern raised by the survey is the fact that a significant number of small employers will likely drop their coverage if their health insurance premiums rise by 10% in the near future."

Mary Grealy

Executive Director
Healthcare Leadership Council
Washington, DC

"A survey by the National Association of Health Underwriters shows that there are many employers who want to offer health coverage to their employees and will do so if a change in public policies make that coverage economically feasible," she explains. "Likewise, many working Americans who are now declining insurance will, with a helping hand in the form of tax incentives, begin to purchase coverage for themselves and their families. We can reach the vast majority of the uninsured through the existing employer-based coverage system."

Several months before the campaign broke, Ms. Grealy testified before the Senate Finance Committee that more than 70% of the uninsured are in families with at least one worker. More than one-third of the uninsured, nearly 17 million people, are in families in which at least one family member has been offered employer coverage but has turned it down.

"According to our research, the decliners of employer health insurance predominantly decline coverage for their families, not themselves. This is most likely because many employers charge higher premiums and cost sharing for dependents than for the actual employees," she says.

Another large group of the uninsured is in families in which there is at least one worker but the employer does not offer coverage. The survey found that many companies that do not now offer health coverage would begin to do so if premiums were reduced or subsidized by as little as 10%, although many would require as much as a 25% subsidy, Ms. Grealy says.

"However, two of three employers surveyed who do not offer insurance said that they will continue that practice if no public policy changes are made to reduce the cost of insurance. One concern raised by the survey is the fact that a significant number of small employers will likely drop their coverage if their health insurance premiums rise by 10% in the near future," she points out.

Also testifying at the March 13 Finance Committee hearing was Diane Rowland, executive director for the Kaiser Commission on Medicaid and the Uninsured in Washington, DC, who said that for the low-income uninsured, the most immediate and potentially most effective means of broadening coverage will be to build on current public programs: Medicaid and CHIP.

"Building on coverage available today through Medicaid and CHIP would help close the gaps that currently

exist when some family members are eligible and others are ineligible for coverage and low-income childless adults are excluded from coverage," she told the committee. "This approach also has the advantage of building on an existing administrative and financing structure in operation in all 50 states."

Ms. Rowland tells *State Health Watch* there is concern that as the income level for those who are covered is raised, there can be an incentive for employers to cut coverage and for employees to move from private to public coverage. Another concern is funding for the public programs.

"States vary in their ability to take on additional funding burdens," she says. "Most people need insurance in bad economic times, when state money is least likely to be available."

A strategy that relies on state action without a federal mandate can result in variations around the country, Ms. Rowland says. "But if we have 42 million uninsured and we can get the states where many of them live [such as California, Texas, Florida, and New York] to act, that will help address the problem. The federal government needs to demonstrate a willingness to put more money on the table."

She says the most effective strategy at this point may be to reach out to uninsured families, going where the kids are today, and building on that success.

How likely is it that changes will be made? Ms. Rowland says she thinks that members of Congress are generally proud of what has been accomplished with CHIP, although they wish it would be bigger and grow faster. "It's generally well-received by most states. There's a real sense of wanting to build on Medicaid and CHIP, but they also want to look at the president's proposal for tax credits and other changes."

Meanwhile, legislation introduced in Congress over the summer would allow parents as well as children to get coverage through CHIP. The Family Care Act of 2001 would use $28 billion set aside in the FY 2002 congressional budget resolution to expand a variety of coverage options for low-income people. The prime sponsor of the bill, Sen. Edward M. Kennedy (D-MA), said, "If you can cover the parents, you can ensure that you can cover the remaining children."

Sen. Olympia Snowe (R-ME) also sponsors the measure.

States that expand eligibility for CHIP to children in families with incomes up to twice the federal poverty level ($29,260 for a family of three) would be eligible for an enhanced match that would allow parents to sign up for coverage as well. States also would be given incentives to extend coverage for children up to age 20, childless pregnant women, legal immigrant children and pregnant women, and parents through the Medicaid program.

A report from Families USA says that while many people, including policy-makers, believe that Medicaid offers a health care safety net for all low-income people, this is a myth, as shown by the readily apparent holes in the safety net. Because states have the freedom to design their own programs, Families USA says, there are 56 different programs, all of which treat children, parents of dependent children, and nonparent adults differently.

As a result of incremental improvements to Medicaid over the last 15 years and introduction of CHIP, most states now cover children in families with income below 200% of the federal poverty level. However, most states have established eligibility standards for parents that are very low. For example, in more than half of the states, a parent in a three-person family working at minimum wage is considered to have too much income to qualify for Medicaid if the parent works full time.

In 40 states, nonparent adults are ineligible for Medicaid, even if they have no income at all, unless they are severely disabled. Ten states provide some coverage for adults, either through Medicaid or through Medicaid-like coverage without any federal funds. But even in those states, income eligibility standards are very low.

[Contact Ms. Grealy at (202) 452-8700, Ms. Rowland at (202) 347-5270, and Families USA at (202) 628-3030.] ■

Vermont residents look north for answers

Vermont Gov. Howard Dean urged his state's residents to look to Canada for cheaper prescription medication following the rejection by a federal appeals court of a state plan to lower the cost of prescriptions for some 70,000 state Medicaid recipients. The federal court ruled against Vermont's plan because it found many state residents who were counted as Medicaid beneficiaries and deemed eligible under the state program did not, in fact, qualify for the full range of Medicaid benefits and thus were ineligible to participate in the state's proposed prescription plan. Rather than drive across the border, Gov. Dean urged those affected to take advantage of United Health Alliance, a physician mail-order program that offers medications at Canadian prices.

The program requires that a physician fill out a form, which details the patient's prescription needs. That form is then faxed to a Canadian pharmacy that in turn sends a three-month supply to the patient's doctor's office where they can pick up their medications. ■

Do foster children receive adequate health care?

Although children in foster care represent only 1% to 3% of Medicare children, they account for between 4% and 8% of Medicaid expenditures, according to a study conducted by Mathematica Policy Research for the Department of Health and Human Services.

Policy-makers are interested in foster children because they are a particularly vulnerable population. Many have physical, emotional, or developmental problems, sometimes resulting from abuse or neglect. But there have been ongoing concerns about the adequacy of the health care services those children have received. The concerns have grown as managed care has become a more dominant form of health care delivery for this group.

The study looked at health care utilization and expenditures paid by Medicaid for foster care children in California, Florida, and Pennsylvania. Health care not billed to Medicaid or paid by other sources was not considered, so the study understates the total amount and cost of health care services provided to children in foster care.

The Mathematica report said that 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. Researchers also found that children in foster care were more likely than other groups of Medicaid children to have a mental health or substance abuse condition, and health care utilization varied considerably across the three study states.

Margo Rosenbach, Mathematica vice president in Cambridge, MA, and the author of the study, tells *State Health Watch* that one problem with coverage is that children in foster care are a very mobile population, often being moved from foster home to foster home, or between foster home and parental home.

"With that mobility comes changes in eligibility and coverage," she says. "One way to address this problem would be to institute 12-month continuous coverage for the population or at least less frequent redetermination of eligibility."

There also are issues of continuity of care when children move across state lines, and problems if a child is moved back to his or her family and the family is not covered. Although many foster children are eligible for coverage under the Temporary Assistance for Needy Families program, Ms. Rosenbach says, there can be lags in the eligibility that could be prevented by having presumptive eligibility as soon as a child is placed in foster care.

Providing continuous coverage

Being able to maintain coverage is important, the report said, because research has shown that continuous, year-round health insurance coverage is related to improved access to care. But, "children in foster care had less continuous Medicaid coverage than children receiving SSI benefits and children in families receiving adoption assistance. . . . In all three states, significant numbers of children lost Medicaid in the month they left foster care."

One reason policy-makers are taking more interest in this population is that they tend to be high users of health care services with a disproportionately high amount of behavioral health and mental health concerns. The research found that children in foster care were more likely than other groups of Medicaid children to have a mental health or substance abuse condition. They also had a higher likelihood of comorbidities than Aid to Families with Dependent Children (AFDC) recipients and adoption-assistance children, but were less likely than Supplemental Security Income (SSI) children to have multiple diagnoses.

Ms. Rosenbach explains that health care utilization patterns varied considerably across the states, often as a function of different benefits and variation in practice patterns. In general, foster care children in California were less likely to receive health care services than children in the other two states. More than 80% of foster care children in Florida and Pennsylvania had at least one provider visit in 1994 (the latest data available for the analysis), compared to 65% in California. In California, foster children also were less likely than AFDC and SSI children to see a provider during the year. In the other two states, foster children were more likely than AFDC children to see a provider. In Florida they were also more likely than SSI children to see a provider during the year.

The likelihood that foster care children received a preventive checkup during 1994 ranged from 28% in Florida to 41% in Pennsylvania. In California and Pennsylvania, foster care children were more likely than other Medicaid children to have a preventive checkup during the year. Nevertheless, many foster care children did not receive routine checkups, despite recommendations for an annual physical and mental health assessment each year. In addition, very few received assessments during the first two months of a foster care placement. The report says it was interesting to find that children with no prior Medicaid coverage received early assessments more often, perhaps suggesting that providers were more likely to perform assessments on those who were newly enrolled in Medicaid.

One anomaly, at a time when

other research indicates that dental care is a problem for Medicaid children and too often is delivered in the emergency department, is that foster care children were far more likely to receive dental care than other groups of Medicaid children — 60% of foster care children in Pennsylvania and 45% in California and Florida had at least one dental visit in 1994, compared with 28% to 38% of the AFDC population and 31% to 35% of the SSI population. Ms. Rosenbach says she is unable to explain the dental care finding, although says it may relate to the comprehensive assessments that some foster care children receive.

The report said there are four main policy implications:

1. Continuity of coverage is important since discontinuity of coverage can have an adverse effect on access to care.

2. Medicaid may be underutilized as a funding source.

3. A broad-based concept of care coordination involving systems such as public health, child welfare, mental health, schools, and juvenile justice, is needed.

4. The structure of managed care systems should recognize the needs of foster care children.

Although the data analyzed for the study were from the mid-1990s, the problems identified still are salient, and the situation actually may have been made worse by the increased use of Medicaid managed care that has occurred, Ms. Rosenbach says. While studying three states is an improvement over studies that looked at just one state, the results cannot be generalized to all states or to the nation as a whole, she point out. But using multiple states demonstrates the extent of variation and can provide useful comparisons with other states.

One group of foster children, those who age out of foster care, got some additional help in the Foster Care Independence Act of 1999. A Dec. 14, 1999, state Medicaid director letter from federal officials urges states to take advantage of a new optional Medicaid eligibility group for children who are in foster care under the responsibility of the state on their 18th birthday.

The law gave states the options to:

1. provide eligibility for the children until they reach age 21, or to 20 or 19;

2. not apply an income or resource test for the children;

3. only make those children eligible who were furnished foster care maintenance payments or independent living services under a program funded under Title IV-E of the Social Security Act.

In the letter, Timothy Westmoreland, Medicaid director, called on states to "elect this new option to ensure that children aging out of foster care have the health care that they need."

In her research report, Ms. Rosenbach wrote, "As the health care needs of children in foster care have garnered increasing attention, interest has grown in developing performance measures to track the effectiveness of child welfare services."

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On-line access / Index

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Clip files / Local news from the states

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

GAO says Medicaid doesn't adequately serve those under 21

WASHINGTON, DC—A General Accounting Office (GAO) report released says Medicaid is failing to provide certain preventative health services for beneficiaries under age 21. The report found, for instance, that those enrolled in Medicaid do not receive lead screening and dental services. It said a comprehensive review is impossible due to annual state EPSDT (Early and Periodic Screening, Diagnostic and Treatment) delivery reports to the Centers for Medicare & Medicaid Services (CMS) being unreliable and incomplete. GAO said contributing factors behind this problem include inadequate state oversight and parents being unaware of the need for, or the availability of, covered services. The GAO recommends that CMS work with states to develop criteria and a timetable for assessing and improving the reporting and provision of EPSDT services.

—American Hospital Association, Aug. 13

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