Inside: *Bioterrorism Watch*

State Health Watch

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Are they frustrated? Overwhelmed? No. They just don't need coverage

As the State Children's Health Insurance Program (CHIP) matures, many states are turning their attention from recruitment to retention, looking for ways to ease the paperwork burden for consumers and remove barriers to enrollment and renewal.

Then along comes the National Academy for State Health Policy (NASHP) in Portland, ME, with news that many people who don't re-enroll in CHIP drop out because they no longer need the coverage, not because they are frustrated or overwhelmed.

Using data from a telephone survey of 3,780 parents in Alabama, Arizona, California, Georgia, Iowa, New Jersey, and Utah, NASHP found that more than two-thirds of parents interviewed had discontinued their families' participation in CHIP because they no longer were eligible for the coverage. Most of those parents said they had found private insurance coverage or thought their children no longer were eligible.

NASHP executive director Trish Riley tells *State Health Watch* the finding contradicts state records indicating the majority of children with

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OIG: States could have saved $470 million if they had done more to control costs of drugs

According to the Department of Health and Human Services Office of the Inspector General (OIG), there's a critical need for states to better control the cost of their Medicaid drug programs, and the OIG also suggests that a different type of payment methodology could have saved Medicaid $470 million in 1999.

Centers for Medicare & Medicaid Services (CMS) officials say they agree with the OIG's conclusions and will urge states to act.

In a March 2 report, *Medicaid Pharmacy — Actual Acquisition Cost of Generic Prescription Drug Products*, Inspector General Janet Rehnquist said most states use an average wholesale price (AWP), minus a percentage discount that varies state by state, as a basis for reimbursing pharmacies for drug prescriptions. This recent review, she says, is intended to help develop an estimate of the discount below AWP at which pharmacies purchase generic drugs.

The OIG obtained pricing information from 217 pharmacies in eight states — Colorado, Florida, Indiana, Montana, Texas, Washington, West Virginia, and Wisconsin — leading to an analysis of 8,728 invoice prices for generic drug products. Each

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CHIP coverage

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lapsed coverage are the result of failure to complete renewal forms or pay premiums.

An overwhelming majority of the parents surveyed rated CHIP as an excellent or very good program that they valued because it is affordable, comprehensive, and provides high quality. More than 80% of lapsed families said they would want their children back in the program.

"CHIP is a program that works," Ms. Riley says. "Children who would otherwise be uninsured are receiving needed health care services, and parents appreciate the security that CHIP provides for their families."

Ms. Riley says the study is the first and most comprehensive look at disenrollment factors and the conventional wisdom about where people go and why.

"What we're seeing is that CHIP is a transition program, a bridge to private coverage, and that's a good thing," she says. "It's not something people will stay on for years and years. Most of those who leave the program are doing so for appropriate reasons — because they have obtained private coverage, because the child has gotten too old for coverage, or because they have moved to a new location."

Focusing resources

Using this information, Ms. Riley says, states will be able to focus their resources on the small subset of parents who leave for reasons that are not appropriate from a public policy standpoint, the ones who fail to pay their premiums or fail to complete necessary paperwork.

"People don't tell the states why they leave the program," she says.

Half of noncitizen CalKids children are not re-enrolled

A study by the California HealthCare Foundation has found that about half of the enrollees in L.A.CalKids, a health insurance program for low-income, noncitizen children, do not re-enroll before their coverage lapses, despite the fact that members don't have to pay premiums.

Analysts found the program was "highly successful" in recruitment efforts, enrolling 6,000 children within two years, 2,000 more than the target enrollment.

Although enrollees reported high satisfaction with the program, about half did not re-enroll, the study found.

Researchers found that 30% of enrollees had changed telephone numbers after enrollment, and concluded that family stability was an important factor in re-enrollment. They said that more frequent contact with enrollees could improve re-enrollment.

Meanwhile, a Kaiser Commission on Medicaid and the Uninsured study of State Children's Health Insurance Program outreach efforts in Los Angeles County, CA, yielded several lessons:

1. Coordinated outreach and enrollment efforts can increase coverage in publicly-funded programs among low-income children. Although in focus groups and surveys, low-income parents of uninsured children said that they would not consider enrolling their children in MediCal because of the "welfare stigma" and "administrative hassles," more than 110,000 children have been enrolled in Los Angeles County and more research is needed on the parents of newly-enrolled beneficiaries to better understand why they chose to enroll their children.

2. Although progress has been made, the program's administrative complexity still inhibits greater participation. There are bills pending in the California legislature to address some of the issues that county officials say are creating barriers to enrollment.

3. Accurate data can provide important baseline information about target populations. Profiles that were developed provided valuable information to county officials on health insurance coverage, access to health care services, and health status of the population.

4. County agencies can provide a strong foundation to launch and sustain outreach and enrollment efforts, but they must build trusting relationships with community-based organizations to achieve success.

5. An evaluation of county actions is important to determine which are effective and which are not.

6. Because of high turnover rates among outreach and enrollment staff, training efforts need to be ongoing.

[Contact the California HealthCare Foundation at (510) 238-1040 and the Kaiser Commission on Medicaid and the Uninsured at (202) 347-5270.] ■

"But now that subset that is having problems can be identified."

The survey results indicate that 84% of current enrollees and 68% of lapsed families perceive the CHIP annual renewal process to be about "as easy as possible." Only 15% of current enrollees said the process was much more or somewhat more difficult than it needed to be. However, about twice as many lapsed families (31%) rated the renewal process as much more or somewhat more difficult than necessary.

For example, most parents said renewal forms were fairly simple, but a few found them problematic. A common concern about renewal was that the required background information could be difficult to obtain. The study's focus groups suggested that parents in atypical work situations have more trouble with CHIP's income-verification requirements. Income verification is especially challenging for people who change jobs frequently or are self-employed. Farmers and seasonal workers in the focus groups said they had a hard time providing income information because they do not receive a regular paycheck and their income varies widely from month to month.

Another problem: Some parents say they were not told they needed to renew their coverage. About 70% of current enrollees were more likely to say that they were told about renewal, while only 50% of lapsed parents said they were told. NASHP says that while information about renewal often is in the program materials parents receive when their children are enrolled, it is unclear if parents pay attention to the requirement at that time.

A strong majority of both current enrollees (90%) and lapsed families (83%) said they felt the CHIP premium amounts were reasonable. Even among lapsed families with premiums higher than $20 per month, 75% felt their premium payment was reasonable. A majority of current enrollees and lapsed families said that paying the premium was worth it for the peace of mind they received by having coverage. There also was widespread agreement that the premium amount was justified by the care and coverage available through CHIP.

But some focus group parents said that while paying the monthly premium usually was not a problem, it could become overwhelming if they had unexpected expenses. This was particularly true of lapsed families. In the survey results, 17% had trouble paying their children's premium at least every couple of months, and 38% experienced some problems paying premiums. Lapsed families that paid more than $20 per month in premium were more likely to have trouble than those who paid $20 or less.

"CHIP is a program that works. Children who would otherwise be uninsured are receiving needed health care services, and parents appreciate the security that CHIP provides for their families."

Trish Riley
Executive Director
National Academy for State Health Policy
Portland, ME

One issue that states will have to continue to address is helping parents understand the value of insurance and the value of purchasing it when it doesn't appear to be needed. A few parents in the focus groups questioned whether it was worthwhile to be enrolled in CHIP since their children are healthy. That feeling also was expressed in the survey, with 10% saying they sometimes feel that paying the premium is a waste of money. Lapsed families were more likely to feel that way (21%), which could help explain why they allowed CHIP enrollment to lapse.

Forgetting to renew

In another finding, families that lapsed because they did not complete the renewal process are most likely to say they forgot or did not get around to it. Some parents also identified communications problems with CHIP as reasons why they did not renew. The survey gives evidence of problems and frustrations experienced by some parents, particularly in lapsed families, when interacting with CHIP. Some 18% of current enrollees said they had to wait weeks or months to hear back from CHIP about enrollment or some other issue. That number jumps to 32% in lapsed families. Similarly, 12% of current enrollees had trouble getting questions answered, but 22% of lapsed families reported this problem. Lapsed families also are likely to perceive that they have been given incorrect information about CHIP or to have had their children removed from the program without being told why.

NASHP says the survey findings offer insights for all states that want to improve retention in CHIP and reduce the number of lapsed families. Recommendations include:

- Follow up with lapsed families by giving parents a convenient way such as a postage-paid postcard to report changes in status. Another way is to follow up with telephone calls to discover why people have left the program and to determine if they are still eligible for CHIP or other programs.
- Educate families about the renewal process. Families either are not being told about the process or are ignoring what they are told. Better and more strategic kinds of information to explain the renewal process would likely

help retain eligible families.

- Enhance communication pathways between CHIP and enrolled families. Parents, particularly in lapsed families, point out a number of communication problems with CHIP, and the findings suggest that quicker and clearer responses from CHIP and fuller explanations to families about why they are experiencing problems could help families stay enrolled.
- Make allowances for families' fluid economic and personal lives. The researchers say that in most cases, CHIP already is flexible enough to accommodate many shifts in families' personal and financial lives, such as adjusting premiums to reflect a lower income, but families aren't aware of their options. In other cases, they say, there may not be enough program flexibility to allow families to miss a couple of premium payments but remain enrolled.
- Provide additional training and support for CHIP staff. Additional training could help the staff's ability to troubleshoot and keep eligible families who are enrolled in the program.

In Iowa, according to Anita Smith, chief of the Bureau of Insurance in the Department of Human Services in Des Moines, a change in program contractors led to data problems that hampered analysis.

"We were pleased to find that a higher percentage of families than we thought were leaving for good reasons and not because of administrative problems," Ms. Smith tells *State Health Watch*. "We see that we need to rethink the nature of CHIP. It may be that families are not going to be on it long term."

Ms. Smith says the agency is addressing preventable reasons that were identified for families lapsing in coverage. "We're trying to remind people in several different ways that if their income decreases, they may no longer have to pay a premium. That information is being included in correspondence and on the premium payment coupons." In addition, Iowa puts a message on the Month 10 payment coupon to remind the family to submit a renewal form.

She says they are redesigning their notices to make them more attractive and readable for families and are stressing the availability of a customer service center that can respond to telephoned questions.

Chad Westover, Utah's director of CHIP in Salt Lake City, tells *SHW* that during the study period, Utah did not charge a premium. But now that the state has had to institute a premium because of financial pressures, it is learning from experiences of other states in the study and trying to avoid their problems.

Get more information

"We realize that as people drop from the program for nonpayment of premium it is not sufficient to assume that they either don't have the money or don't want to pay," he says. "We've started surveying disenrollees to find out why, to get underneath the initial layer of data. The study also is helping us understand why people sometimes don't want to pay their premium. We're trying to be more accurate in our data because it's the data that drive policy decisions."

Mr. Westover says the agency is sending additional notices for payments, past-due payments, and warnings that coverage is about to end. There also are telephone follow-ups. "Making the contacts takes time and effort and resources," he says, "but the study demonstrates the value of doing the work."

[Contact Ms. Riley at (207) 874-6524, Ms. Smith at (515) 281-8791, and Mr. Westover at (801) 538-6982.] ■

OIG report

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invoice drug price was compared to AWP for the drug, and any discount percentage was calculated.

"We estimated that the actual drug-acquisition cost was a national average of 65.93% below AWP," Ms. Rehnquist wrote in a cover letter with the report to CMS Administrator Thomas Scully.

"Our previous estimate, based on calendar year 1994 pricing data, showed a discount of 42.45% below AWP for generic drugs. As a result, this review showed an increase of 55.31% in the average discount below AWP for generic drugs from 1994 to 1999," she wrote.

The analysis included four types of pharmacies: rural-chain, rural-independent, urban-chain, and urban independent, and excluded results from nontraditional pharmacies. **(See chart, p. 5.)**

Unlike brand-name drugs for which reimbursement is based predominantly on a discounted AWP, reimbursement for generic drugs can be limited by federal upper-limit amounts.

The OIG says that while the estimate of the discount below AWP of invoice price for generic drugs was significant, the difference was mitigated by federal upper-limit amounts. The upper limits are based on 150% of AWP for the lowest-priced generic equivalent. For generic drugs that do not have an upper limit assigned, reimbursement of the ingredient cost is the same as for brand name drugs.

"The difference between what Medicaid reimbursed for ingredient cost and our estimate of the amount pharmacies actually paid could be as much as $470 million for [calendar year] 1999," Ms. Rehnquist said.

"The majority, $364 million, of the difference was attributable to the

104 drugs without upper limits established. Reimbursement for 72 of the 96 drugs with upper limits was $115 million more than the estimated cost, while reimbursement for the remaining 24 drugs was $9 million less than the estimated cost," she added

Even while claiming large possible savings, she pointed out that the calculations do not incorporate all the complexities of pharmacy reimbursement and that acquisition cost is just one factor in pharmacy reimbursement policy.

Mr. Scully says CMS agrees that an accurate estimate of the acquisition cost should be used to determine drug reimbursement. He says the agency will strongly encourage states to reevaluate their reimbursement methodology for drugs and that he will continue to encourage states to look for an alternate basis for reimbursement.

Meanwhile, the state of Nevada has filed suit against 12 major drug companies, charging them with fraudulently inflating the price of Medicaid- and Medicare-covered drugs. The suit says the manufacturers illegally manipulated the AWP on a wide range of drugs.

Observers say litigation is gaining steam as the newest technique states use to control drug costs as many states are preparing or considering such suits.

Robert Reid, administrator for the Department of Job and Family Services pharmacy program in Columbus, OH, tells *State Health Watch* that his state recently lowered its reimbursement level to pharmacies. Effective May 1, Ohio will reimburse at wholesale acquisition cost (WAC) plus 9% and a dispensing fee, rather than the previous formula of WAC plus 11% and a dispensing fee.

"The difference between what Medicaid reimbursed for ingredient cost and our estimate of the amount pharmacies actually paid could be as much as $470 million for [calendar year] 1999."

Janet Rehnquist
Inspector General
Department of Health and Human Services
Washington, DC

And in Texas, drug utilization review director Curtis Branch tells *SHW* that the Texas Health and Human Services Commission Vendor Drug Program in Austin is reviewing drug acquisition costs through a process of pharmacy invoice audits. That analysis should be completed by late June, he says. In addition, a consultant is doing a statewide study of pharmacy dispensing costs to determine the appropriate pharmacy fee level in the state.

"It is important to adjust both sides of the equation, product cost and dispensing costs," Mr. Branch says, "to ensure that the prudent pharmacy operation is appropriately reimbursed to ensure access to prescription drug services for Medicaid/CHIP recipients. Preliminary review of the data indicates there may be some decrease in product cost reimbursement. Both of these studies should be completed by mid- to late summer, and the final results will be used to determine adjusted reimbursement rates for both product cost and fee."

Both Mr. Reid and Mr. Branch are members of a technical advisory group on pharmacy issues established by the National Association of State Medicaid Directors.

[The OIG report is available at http://oig.hhs.gov/oas/reports/region6/60100053.pdf. Contact Mr. Reid at (614) 466-6420 and Mr. Branch at (512) 338-6922.] ■

Drug-Acquisition Costs of Generic Drugs

Category	Percent Below AWP (Point Estimate 1999)	Sample Pharmacies	Prices Compared
Rural-Chain	64.39%	52	2,073
Rural-Independent	66.64%	55	1,142
Urban-Chain	66.97%	56	4,492
Urban-Independent	63.79%	54	1,022
Nontraditional	67.07%	58	1,185
Overall (Exc. Nontrad)	65.93%	217	8,728

Source: Department of Health and Human Services, Office of the Inspector General, Washington, DC.

NJ sees 250% increase in its malpractice premiums

New Jersey hospitals' medical malpractice insurance premiums jumped an average of 250% in the past three years, and 65% of facilities said skyrocketing insurance rates are driving some physicians out of the practice of medicine.

Those findings were among the results of a new survey by the New Jersey Hospital Association (NJHA) to gauge the effects of rising medical malpractice insurance rates on the state's health care industry.

Survey is a 'wake-up call'

More than half of NJHA's 106 member hospitals responded to the survey, and their responses provided a sobering study of escalating costs, reduced availability of insurance, and ultimately, worries that patients may experience difficulty accessing certain health care services," says Gary Carter, NJHA's president and CEO.

"We should consider this information a wake-up call," Mr. Carter says. "The fact that malpractice insurance is becoming more expensive is no great surprise. But we should be alarmed that these skyrocketing prices are driving many physicians out of medicine and threaten to have far-reaching effects on our state's health care system."

According to the survey, seven out of 10 New Jersey hospitals experienced increases in their professional liability insurance premiums last year. The average hospital saw its premium jump from $373,328 in 1999 to $942,539 this year, which is an increase of 252%.

In other findings, the survey showed:

- 78.2% of hospitals said their physicians had experienced sizeable increases in their medical malpractice insurance premiums.
- 74.5% of hospitals said they have had one or more physicians dropped from coverage entirely.
- 64.8% of hospitals said they have had physicians cease the practice of medicine or plan to leave practice because they were dropped from coverage or could not afford the premium increases.

Respondents said OB/GYNs and surgeons were the types of physicians who most often reported dramatic malpractice insurance price hikes. In this survey, only hospital executives were surveyed.

Their responses included reports on malpractice insurance premiums for physicians within their facilities. Respondents were asked about the impact rising rates have had on their hospitals. Many cited the overall fiscal impact on hospital budgets.

Taking a 'hit to the bottom line'

One hospital administrator called the impact a "direct hit to the bottom line, which means less money for salaries, equipment, supplies, building maintenance, etc."

The survey also asked respondents' opinions on the potential future impact of skyrocketing medical malpractice insurance rates. The most common response? A loss of ability

Report calls for errors reporting system

The National Quality Forum (NQF) recently announced the availability of a report that it says could be used to form the basis for a national, state-based adverse event reporting system.

Titled *Serious Reportable Events in Healthcare: A National Quality Forum Consensus Report,* the report and accompanying list of serious medical errors could form the framework of a system that allow health care providers to report medical errors in a consistent way, says Kenneth W. Kizer, MD, president and CEO of the NQF.

"Events, such as wrong-site surgery, medication errors, and infant discharges to the wrong person, occur more frequently than the public would like to believe," Mr. Kizer says.

"Utilizing the list can be a valuable tool for making health care safer for all patients. Focusing on these serious adverse events should lead to improvements in systems and processes that will minimize their future occurrence," he adds.

The report identifies 27 adverse events in six major categories:

1. Surgical Events
2. Product or Device Events
3. Patient Protection Events
4. Care Management Events
5. Environmental Events
6. Criminal Events

Also identified are standardized definitions of key terms that are necessary if the list is to be used in a uniform manner across the country.

For more information on ordering the report, go to www.qualityforum.org. ■

for hospitals to provide specialty services to their communities.

Betsy Ryan, NJHA general counsel, says the survey results send a loud warning that increasing malpractice premiums will hurt patient care.

Too many physicians will leave

"These survey responses make it clear that what's at stake is much more than hospitals' bottom lines and physicians' earnings," Ms. Ryan says.

"Without relief from these rapidly escalating premiums, more and more physicians will be driven out of health care, and hospitals will face difficult decisions about what services they will — and will not — be able to provide. It's the patient who will feel the ultimate impact," she explains. ■

CMS urges states to continue HIPAA implementation despite fiscal problems

States facing fiscal problems still should make every effort to comply with electronic transaction requirements on time and not seek the one-year extension available under the Administrative Simplification Compliance Act signed by President Bush Dec. 27. That's the advice from Dennis Smith, federal Medicaid director, in a March 7 letter to state Medicaid directors.

"We recognize that all states are facing severe fiscal constraints for the coming year and possibly beyond," Mr. Smith wrote. "It is critically important that you maintain your level of effort to achieve Health Information Portability and Accountability Act (HIPAA) compliance."

Mr. Smith said that while it is possible to get a one-year extension to the compliance date by filing a compliance plan with the secretary of Health and Human Services by Oct. 16, 2002, any delay in implementation activities could jeopardize success and also increase the cost of achieving compliance. "The Administrative Simplification Compliance Act requires that your compliance plan include a timeframe for testing that begins not later than April 16, 2003," he wrote. "If your HIPAA activities are stopped or severely curtailed, your agency may not even be able to meet these new compliance deadlines." He also pointed out that the act does not delay the April 14, 2003, compliance date for the HIPAA privacy rule and said that delays by Medicaid agencies in implementing the transactions rule may lead to delays in meeting requirements of the privacy rule.

There are several reasons why state efforts should move forward, Mr. Smith said:

- The Centers for Medicare & Medicaid Services (CMS) has approved enhanced funding at the 90% federal financial participation level for many Medicaid Management Information System-related HIPAA gap analysis and remediation activities.
- Using HIPAA standards to process crossover and third-party liability claims will accelerate reimbursement and facilitate use of electronic data interchange. Any delay could prevent state agencies from realizing the significant cost savings that are anticipated from use of a standard coordination of benefit and third-party liability process and may worsen state fiscal pressures.
- Standardization of health care transaction information is expected to greatly facilitate fraud detection, which has been estimated to cost payers as much as 11 cents of every health care dollar spent.
- It is essential to maintain state leadership in HIPAA work groups and standard-setting organizations. Lack of state representation reduces state agency ability to get modifications adopted by national standard-setting organizations, modifications that are critically needed to meet Medicaid business needs within the mandated HIPAA standards.
- HIPAA implementation does not lend itself to being stopped and then restarted later without serious project compromises, inefficiencies, and cost increases.

Mr. Smith said state Medicaid directors should keep in mind that HIPAA administrative simplification requirements are expected ultimately to result in substantial savings to health providers and payers, including state agencies.

(Access the letter at www.hcfa.gov/medicaid/letters/smd30702.htm.) ■

Birth defects information lacking, survey finds

If states did a better job of tracking and preventing birth defects, they could make significant strides in beating the cause of nearly 20% of all infant deaths each year. That's the conclusion drawn by the Trust for America's Health (TFAH), a Washington, DC-based advocacy group, that surveyed the 50 states, District of Columbia, plus Puerto Rico and gave each a letter grade based on efforts to monitor and research birth defects. More than half the states received a C, D, or F on their report card.

Paul Locke, TFAH's principal investigator on the report, tells *State Health Watch* that society is not investing enough in tools for prevention of illness. "We're disinvesting where we should be investing," he says. "TFAH focuses on prevention, on what the public health system can do to become more active in prevention. You need to understand the biology, study causes, and risk factors, and have tracking data on where and when birth defects occur." Mr. Locke says the group's report tries to shed light on an area where investment could be made. "We know how to do what needs to be done," he says. "We're alerting the public and policymakers to the need."

Birth defects are the leading cause of infant deaths in the United States, Mr. Locke says, affecting approximately 150,000 babies each year. There is a serious impact on families when a baby has a birth defect, with the possibility of frequent surgeries, emotional and social burdens, and costs that can range from $150,000 to more than $700,000 over a child's lifetime.

Despite an overall drop in infant mortality, birth defects persist, the TFAH report says.

In fact, the percentage of infant deaths from birth defects has been rising, and the causes of as many as 80% of birth defects are unknown.

Information, Mr. Locke says, is the first step that must be taken toward prevention. Birth defects registries can be used to provide basic data about the frequency and location of specific birth defects, and the data can be cross-referenced to identify anomalies, trends, and possible causes.

Even though the need for good information is obvious, TFAH says, most states don't make the grade. Many states don't track birth defects statewide, the thoroughness of data collection and quality assurance is insufficient, and two-thirds of states with registries don't explore links with environmental factors.

The TFAH report graded states on several criteria:

- tracking capacity;
- data use, prevention, and research capacity;
- data-sharing capacity;
- legislation and resources.

Only eight states received a grade of A: Arkansas, California, Georgia, Hawaii, Iowa, Massachusetts, Oklahoma, and Texas.

Mr. Locke says that states with a grade of B or C have gaps in their programs. Perhaps, the reasons for these gaps are systems are not statewide, they might track limited birth defects, or information may not be reported in a timely fashion.

The B states were Alabama, Alaska, Arizona, Colorado, Florida, Illinois, Kentucky, Missouri, Nebraska, New Jersey, New Mexico, New York, South Carolina, and Virginia. The C states and territories were Connecticut, Delaware, Maryland, Michigan, Nevada, North Carolina, Puerto Rico, Tennessee, Utah, and West Virginia.

D states — Indiana, Louisiana, Maine, Minnesota, Mississippi, Montana, New Hampshire, Pennsylvania, Rhode Island, Washington, and Wisconsin — have less than fully active programs or are just beginning to establish programs.

And the nine F states — District of Columbia, Idaho, Kansas, North Dakota, Ohio, Oregon, South Dakota, Vermont, and Wyoming — have what TFAH describes as marginal birth defects monitoring registries or no program at all.

The group recommends creation or improvement of state monitoring programs, creating programs where they don't now exist, and improving methods in existing programs to ensure statewide coverage, cover all birth defects, and report information in a timely fashion.

TFAH also calls for more state and federal funding, saying that the Centers for Disease Control and Prevention in Atlanta should help fund birth defects programs in every state and state legislatures should provide at least 25% of needed funding.

In order for measurable progress to be made, TFAH calls for national minimum standards so that data are comparable across states and possible links between birth defects and environmental exposures can be studied.

In the long term, the group is calling for creation of a nationwide health tracking network, noting that the United States has no network for tracking where and when chronic diseases such as birth defects, cancer, and asthma occur, or for examining potential links to factors in the environment. Such a network is important given that chronic diseases account for 70% of all deaths in this country.

The new nationwide tracking network would build on birth defects registries and other efforts to track chronic and infectious diseases, Mr. Locke says. "The information provided would be a key first step toward prevention," he says. "The public

health infrastructure needed for nationwide health tracking would also help strengthen our ability to detect and respond to incidents of biological or chemical terrorism."

He tells *SHW* that leadership to bring about the changes the group seeks has to come from all three levels of government — federal, state, and local. One problem right now, Mr. Locke says, is the four vacancies in key federal health positions that have gone unfilled throughout the Bush administration. "There's a tremendous public health leadership gap at the federal level."

States that earned an A ranking have taken some leadership, he says, but the others have not. Local governments may want to be more active, but they rely on resources passed on to them from the state and federal governments. "People at the local level do emergency response, but we haven't equipped them to do their job."

The first step to be taken, he says, is to fill the four vacant federal public health positions with qualified public health practitioners. "What would the country say if the top leadership positions of any other essential service were vacant?"

Mr. Locke sees some good signs for the future because Congress has made it clear that it wants health tracking on a national level. "We need to be sure the program we make is sustainable."

[Contact Mr. Locke at (202) 589-0940.] ■

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

Personal assistance boosts SCHIP enrollment

No matter how good a health care system is, if people aren't enrolled for coverage, it won't be able to do its job. The Virginia Health Care Foundation in Richmond, whose main mission is to increase access to primary and preventive health care for Virginia's uninsured and medically underserved, also is funding an initiative to help the state government enroll eligible children in its Medicaid and State Children's Health Insurance Program (SCHIP).

Two years ago, the foundation, which is a public/private partnership initiated by the state legislature and its Joint Commission on Health Care, issued $1 million in grants to 12 community-based organizations in the state to fund efforts to enroll kids. That effort, Project Connect, targeted 47 localities and enrolled 6,500 children.

A second phase of the program, funded by the state Department of Medical Assistance Services, has made additional grants available to 11 organizations targeting 33 localities with a new goal of enrolling an additional 5,056 children by the end of 2002.

Grantees are using a variety of outreach and enrollment techniques including school-based insurance screening, pediatric clinic enrollment sites, work-site enrollment events, and special initiatives targeting existing client groups who are most likely in need of health insurance such as churches, day care centers, and legal aid offices. The foundation-sponsored efforts support a state marketing campaign to inform people about the new FAMIS (Family Access to Medical Insurance Security) program that uses posters, brochures, bus placards, and print and broadcast ads.

Need for the outreach was seen in a 2001 Health Access Survey conducted by the foundation, which estimated that 1.05 million people were uninsured in the state, more than 230,000 of them children.

Foundation officials say that FAMIS has signed up about 39,000 children to date, just over half of the state's goal of 63,200, the number state officials believe are eligible for low-cost coverage. Some estimates have said the number of eligible enrollees is even higher. And nearly 70,000 more children are thought to be eligible for free coverage under Medicaid.

Federal funds lost

The state has been paying a steep price for the low number of FAMIS enrollees. An article in the *Virginian-Pilot* says the state forfeited $16 million in federal dollars the first year, according to a Joint Legislative Audit and Review Commission report, and ranks 40th in the nation in the percentage of federal funds spent for the program. The newspaper says an additional $40 million in federal funds has been lost since that report.

Foundation executive director Debbie Oswalt tells *State Health Watch* that when Project Connect started, the decision was made to undertake a bold and sweeping strategy rather than approach the issue piecemeal with small individual grants. "We said we'd take all the money we would put into children and some extra and use it to get kids enrolled," she recalls. "Enrollment numbers haven't been high, and there were a lot of enrollment barriers. It became clear that one-to-one assistance was needed."

The initial $1 million in grants to 12 organizations was made for 18 months, Ms. Oswalt says, to allow times for the agencies receiving the funds to organize and experience success. "That was different for us because we were used to 12-month granting cycles. But we realized we weren't likely to be able to repeat this program and we wanted to be sure there was enough time for it to succeed."

Because trying to resolve enrollment problems can be very frustrating for outreach workers, Ms. Oswalt says they wanted to develop the various community-based organizations into a cohesive unit whose members could support each other through what they saw as a dysfunctional project. To meet that goal, the foundation brought the groups together periodically for training and sharing of successes and problems.

"In addition to bringing the groups together four times during the 18-month period, we developed a database for each group to use to track where each person they were working with stood in the system," Ms. Oswalt says. "The database also let the workers see who had fallen out of the system, and when and why. That way they were able to document the problems and barriers their clients experienced."

Ms. Oswalt says that in the 18 months of the first phase of the program, they enrolled 75,000 children, about 60% in Medicaid and 40% in the Title XXI program. The results of the effort provided data the foundation took to the legislature to argue for changes in the Title XXI rules.

While there was a learning curve, she says, the organizations that have been working at this for a while and are now in Phase 2 "are now going gangbusters." Although the state has made some changes in FAMIS, problems still persist, demonstrating the continuing need for personal assistance. "We find that people can move quickly into the system if they have someone running interference for them," Ms. Oswalt says. If goals that have been set are met, there eventually will be 5,000 kids

enrolled in the programs.

Ms. Oswalt says it remains difficult to give a hard number on the impact of the outreach effort because data have not been collected consistently. "Our new governor made full child health coverage enrollment a campaign theme last year," she says, "and already we're seeing some wonderful changes coming from the executive offices. A lot of improvements are being made. I'm feeling very optimistic about where we're headed."

The system remains very difficult to navigate, according to Ms. Oswalt, and thus the need for personal one-on-one assistance remains. The foundation's goal is to get to a user-friendly system in which clients don't need an advocate working with them. "We'll probably need the one-to-one help for another 12 to 18 months," she estimates.

Ms. Oswalt says it is difficult to give other states advice on how to do what Virginia has done because the situation in each state is so different. "We wanted to be like North and South Carolina, where enrollment has been over the top." It's important, she says, that the outreach program be supported by the executive branch of state government and that the governor gives the program substantive and public relations support. "Every time we're faced with a decision about the child health insurance program, the people involved should always be asking themselves if what they're working on will make it easier for people to enroll. If not, they shouldn't be making any changes unless they're absolutely necessary. The problem is to create that kind of culture within state government and local agencies. The federal government is giving a lot of flexibility, and our job is to find a way to make it simple and user-friendly. Any differences between FAMIS and Medicaid shouldn't be visible to those who sign up for either program."

[Contact Ms. Oswalt at (804) 828-5804.] ■

Clip files / Local news from the states

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

Audit assails state Medicaid oversight

SEATTLE—The state fails to verify adequately the eligibility of some of its Medicaid clients, as well as the license records of almost one-fourth of the health professionals the government pays to care for them, according to a draft state audit obtained by the *Seattle Post-Intelligencer*. Those two conclusions — based on samplings of the state's $4 billion-a-year Medicaid program — are the most substantial findings in the state auditor's broad annual review of Washington's use of federal funds, which is expected to be released in about a week, state auditor Brian Sonntag said. The report, required by the federal government, contends that the state is not complying with Medicaid requirements of the federal government, which pays for half of Washington's Medicaid program. It's up to federal officials to decide whether any noncompliance jeopardizes funding, Sonntag said. "This is a very substantial amount of public funds. It's a very significant report, and it's one that the state has to respond to," he said. "If this doesn't get cleaned up, then I think it puts the future of these kinds of federal funds at potential risk."

Officials at the state Department of Social and Health Services (DSHS), which runs Medicaid, acknowledged concern over the findings. But DSHS argues that the Auditor's Office overstated the seriousness of the problem. Many of the findings can be explained, the agency said, and steps are being taken to improve the monitoring of client eligibility and provider licensure.

—*Seattle Post-Intelligencer*, March 13

State could get help with Medicaid shortfall

WASHINGTON, DC—West Virginia could receive $114 million from the federal government over the next three years to plug financial holes in Medicaid, even as the state program for the poor and disabled faces a $187 million deficit next year alone. Sen. Jay Rockefeller (D-WV) has proposed legislation to reimburse states for losses caused by a business tax break recently approved by Congress. The tax incentive, which allows businesses to write off part of the cost of capital investment, could cost West Virginia's bottom line between $70 million and $86 million over the next three years. At the same time, most states, including West Virginia, are facing shortfalls in their Medicaid programs.

Rising unemployment, growing enrollment, and increases in health care costs have put strains on the program. While West Virginia should be able to cover its Medicaid costs this year, Commissioner Nancy Atkins says the program faces a $187.3 million shortfall in the new fiscal year, beginning July 1. Since last July 1, enrollment in the program has climbed sharply, adding 14,730 new participants, most of them children. "We continue to go up every month," she said. Ms. Atkins and other administration officials have been discussing solutions to Medicaid's looming fiscal problem. None of them are pretty: cutting services, tightening eligibility requirements, or slashing reimbursements to health care providers. The Rockefeller proposal would give every state a 1.5 percentage point increase in reimbursement rates through September 2004. States with high unemployment, including West Virginia, also would be eligible for an additional rate increase for the same three year period.

—*Charleston Daily Mail*, March 20

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Vice President/Group Publisher: Brenda Mooney, (404) 262-5403, brenda.mooney@ahcpub.com.

Editorial Group Head: Lee Landenberger, (404) 262-5483, lee.landenberger@ahcpub.com.

Editor: John Hope, (717) 238-5990, jghope@worldnet.att.net.

Senior Production Editor: Ann Duncan.

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State taps Medicaid for Internet service

CHICAGO—Illinois Public Aid officials are paying a Massachusetts company $2,000 for each Medicaid family signed up to an Internet service designed to monitor the condition of sick children and to educate parents, even though three-quarters of the families don't own a computer. The no-bid deal makes Illinois the first state to dip into overburdened Medicaid funds to pay for the fledgling Baby CareLink program, which was touted here by a key Republican Party official and lobbyist.

Illinois Public Aid officials have earmarked $400,000 for Baby CareLink at Cook County Hospital and Mount Sinai Medical Center, Chicago hospitals that record the state's highest number of Medicaid births. If the pilot program is expanded statewide, Clinician Support Technology of Framingham, MA, a for-profit company, could earn as much as $12 million a year.

Baby CareLink is aimed at parents of premature infants who need weeks of hospitalization in intensive care. Parents can access information about their child's condition and read dozens of educational articles on how to provide better care at home. They also can view photos of their child.

"We hook these parents when their baby is at death's door — the moment of truth, maternal instinct," said Dennis Farrell, executive vice president of the company. "We get them using Baby CareLink, and it answers their informational and emotional questions." He acknowledged that most parents don't have home access to the Internet but said parents without computers can use those at the hospital installed by his company or computers owned by friends or relatives.

With the state slashing basic Medicaid services for doctors and nursing homes, not every state official is embracing the CareLink program. "If the goal is to provide lower-income parents with greater access to their infant children in hospitals, then it would be far less expensive to pay for cab fare every day than to throw this money into a relative luxury, such as viewing your children over the Internet," said state Rep. Jeff Schoenberg (D-Evanston), chairman of a House appropriations committee.

—*Chicago Tribune*, March 24