State Health Watch
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The Newsletter on State Health Care Reform
September 2002

In This Issue

■ **States looking for fiscal help from the feds:** With no end in sight for state budget woes, governors and legislatures are looking to Washington for help. The Bush administration says there's a limit to the spending . . . . . cover

■ **Managed care for special needs saves money:** An Oklahoma experiment posts a 15% cut in claims costs by putting aged, blind, and disabled Medicaid patients in a managed care program . . . . . cover

■ **Preventive care best practices shown:** Bringing preventive care to children makes good sense, but it's easier said than done. Here are some methods that work 3

■ **Local outreach works best:** While states have made strides in improving application forms and removing enrollment barriers for Medicaid and SCHIP, what works best to build enrollment is local outreach. 7

■ **SCHIP and Medicaid enrollees like on-line applications:** States find that enrollees appreciate the flexibility in time demands and prompt response available to them through on-line applications . . . 9

Clip Files/Local News From the States 11

DC, can you spare a dime? States turn to Washington for fiscal help

The nation's governors and legislatures used summer 2002 to sound the alarm about the worsening fiscal condition in most states, brought on by increasing costs for Medicaid, and to plead for more federal help. The pleas were met with mixed signals. After the Bush administration indicated help was not likely to come from Washington, DC, the U.S. Senate adopted a measure to send more money to the states.

A report released at the annual meeting of the National Conference of State Legislatures (NCSL) demonstrated the widespread fiscal problems confronting states:

- Twelve states reported FY 2002 budget gaps of more than 10% of their general funds.
- State ending balances fell nearly 42% from FY 2001 to FY 2002.
- Aggregate "rainy-day fund" balances have fallen from $16.5 billion in FY 2001 to $10.8 billion at the end of FY 2002.
- Twenty-six states collected less revenue in FY 2002 than they did in the previous year.
- Twenty-nine states have implemented targeted or across-the-board cuts.

*See **Fiscal help** on page 2*

In Oklahoma, a managed care pilot program saves big money on special needs patients

Can states save money by treating special needs patients in a managed care setting rather than a traditional fee-for-service program?

The answer is a resounding yes, according to results of a project undertaken in Oklahoma that showed claims savings of about 15%.

The Lawrenceville, NJ-based Center for Health Care Strategies (CHCS) provided a grant to Schaller Anderson Inc. of Phoenix to enable the health care management firm to work with the Oklahoma Health Care Authority and Heartland Health Plan of Oklahoma in assessing services provided to aged, blind, and disabled (ABD) patients before and after enrollment in Heartland Health Plan.

Fiscal Fitness: How States Cope

In July 1999, the Oklahoma Health Care Authority began to enroll ABD members in managed care through several organizations, including Heartland, which is owned by the University of Oklahoma and serves more than 110,000 Medicaid-only members in Oklahoma City and Tulsa. The study followed slightly

*See **Pilot program** on page 5*

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Fiscal help

Continued from page 1

- Nineteen states drew on rainy-day funds to compensate for higher expenses and reduced tax income.

"Fiscal 2003 is shaping up to be even more of a challenge than 2002," says NCSL executive director William Pound.

"Though many legislatures have already addressed their fiscal 2003 budget gaps, budget cuts, tax increases, and rainy-day funds are not out of the question," he says.

Estimates for FY 2003 show that the aggregate budget gap will continue to widen to $57.9 billion.

Attendees at the recent National Governors Association (NGA) meeting said that state spending on Medicaid increased 13% last year and now accounts for about 20% of total state spending. The governors said the increase in Medicaid costs was primarily due to the growing number of senior citizens who are dually eligible for Medicare and Medicaid. States are now responsible for a portion of dually eligible seniors' health expenses, which had been completely covered by the federal government. It is estimated that the 7 million dually eligible seniors are responsible for 35% of the cost of Medicaid.

"We've reached deep into our reservoir of options," says Michigan Republican Gov. John Engler. "We set aside a lot of money in rainy-day funds. Now we are drawing that reserve down. Well, in many cases, that was enough to get maybe a couple of fiscal years. The rainy-day funds were never designed to go for five budget cycles."

A glimmer of hope for the states came on the floor of the U.S. Senate when a measure that would send nearly $9 billion in fiscal relief to states for Medicaid and social services programs was approved on a 75-24 vote. The measure would temporarily increase the federal share of Medicaid by $6 billion through a hold-harmless provision for states that experience a drop in their Federal Medical Assistance Percentage (FMAP) and a 1.35% across-the-board increase for each state, with a 2.7% FMAP increase for each territory. The amendment also would provide an additional $3 billion in temporary social service block grants to be administered through Title XX.

"We set aside a lot money in rainy-day funds. Now we are drawing that reserve down. Well, in many cases, that was enough to get maybe a couple of fiscal years. The rainy-day funds were never designed to go for five budget cycles."

John Engler
Governor
State of Michigan

"Many states continue to face budget shortfalls and face the prospect of instituting significant cuts in health care and social services to curb expenditures," NGA chairman and Kentucky Gov. Paul Patton said after the Senate vote. "Adoption of this amendment is an important first step in helping states maintain service levels during the continuing fiscal crisis."

The $9 billion would flow directly into Medicaid budgets and the flexible Social Services Block Grants that provide critical services such as long-term care for the elderly and assistance for the disabled. Fiscal relief also would allow states to reduce proposed cuts in state budgets to other programs, including education.

"As it stands, states can no longer afford Medicaid," said NGA vice chairman and Idaho Gov. Dirk

Kempthorne. "With the program's growth rate approaching 25% over the past two years and representing more than 20% of state budgets, it was imperative for the Senate to recognize that states needed significant assistance. Passage of this amendment ensures that many low-income families will be protected from drastic cuts in the programs that provide for their health care and social service needs."

But the ultimate fate of the assistance is far from certain, given that a key Bush administration executive traveled to the NGA meeting to tell the governors that the administration does not support the Senate action.

"We can't always give you more money," said Centers for Medicare & Medicaid Services administrator Tom Scully. "I know that's frustrating. But we are trying to help you make the money go as far as you can."

Mr. Scully said that rather than look to Congress for help, given that the federal government is running a $165 billion deficit, governors should instead focus their efforts on proposals to create a prescription-drug program for the elderly. "It's probably the single biggest thing we could do in the federal budget that would take pressure off the states. This is bigger than almost anything else you're talking about."

But Christopher Jennings, a health care consultant who was a health police advisor to former president Bill Clinton, told the governors they should continue to push for Medicaid relief because there is no guarantee that a prescription drug plan would pass. "If you rely solely on a drug benefit for the financial relief you hope to get, you may be putting too many eggs in one basket."

[Contact the NGA at (202) 624-5300 and NCSL at (202) 624-8667. Download the NCSL's 2002 State Budget and Tax Actions from www.ncsl.org/programs/press/2002/pr020724a.htm.] ■

Initiative finds ways to improve preventive care for kids

Although children covered by Medicaid and State Children's Health Insurance Programs (SCHIP) often are at higher risk for many illnesses, increased infant mortality, and developmental delays, they can become lost in the health care system and not even the most devoted health care providers can find the time and resources to identify and find every child in need of health care services.

To address this problem, the Lawrenceville, NJ-based Center for Health Care Strategies (CHCS) started a five-year initiative to identify and pilot best practices to improve the delivery of preventive care services for children within their own health plans.

Literature on clinical preventive practice supports the idea that every visit to a doctor should be a preventive visit. According to the report, most health plan leaders agree that it is important to develop programs supporting preventive practices because: (1) children represent 50% of Medicaid beneficiaries, making them the largest demographic Medicaid group; (2) nearly all SCHIP enrollees are children; (3) only about 50% of 2-year-olds on Medicaid receive the full regimen of immunizations; (4) while preventive care service delivery is a problem in both private and public settings, poor children tend to receive less preventive care; (5) state and federal Medicaid officials often target preventive care services for children as a quality improvement project; (6) child prevention measures often are used as performance measures in report cards and other consumer materials; and (7) it is seen as the right thing to do.

Margaret Oehlmann, a program officer who directed the initiative for CHCS, tells *State Health Watch* the best practices toolbox is needed because it often is difficult to do even basic things under Medicaid. "Outreach is particularly challenging," she says. "People on Medicaid move frequently, and typical outreach activities such as outbound phone calls and mail don't work."

Best practices vary

Ms. Oehlmann says it's not possible to identify preventive care techniques that will work in every circumstance.

"As in much of Medicaid, if you've seen one successful program, you've seen one successful program," she says. "What works for one health plan doesn't necessarily work for others. We looked at the barriers to care and brainstormed a number of approaches that work. It's hard to give a blanket statement that something will always work."

The typology used by the workgroup includes strategies for identifying children in need of preventive care services, stratifying their risks, conducting outreach, and finally making appropriate health interventions. Strategies employed by health plans in the workgroup included analyzing missed opportunities to deliver immunizations and well-child services and developing methods to reverse those situations; designing automatic reminder systems to patients and providers, based on variables such as member age or immunization status; developing regional, cross-company, or corporatewide registries to track immunizations; and redesigning and supporting health plan operations to

make every visit a preventive visit.

The workgroup report includes a process improvement strategy that covers a Plan-Do-Study-Act cycle that provides a systematic analysis to the improvement process. **(See cycle, below right.)**

For example, Hawaii's AlohaCare has implemented a unique approach to building a foundation for well-child care even before a baby is born. An analysis of the plan's data showed that although 1,200 births had taken place among its 30,000 members in 2000, only 40% of those babies had received the full range of well-child care. Plan officials contended that affiliation with a provider was the most important predictor of well-child care. To foster development of a relationship before delivery, they created a program to engage prenatal providers as advocates of well-baby care. Thus, during prenatal visits, doctors encourage mothers to select pediatricians and meet them even before their baby is born. The plan tracks the information and follows up with providers if a pediatrician is not selected.

While the idea made sense, tracking the information was more complicated than originally thought. AlohaCare ended up modifying its information system to better capture newborn information and developed an outreach initiative with prenatal mothers to identify high-risk mothers and promote well-baby care.

As part of the new program, the prenatal authorization form was expanded to identify maternal risk factors such as substance abuse and teen pregnancy, expected delivery date, and the pediatrician selected by the mother. A major objective of the revised form was to identify pregnant women and assign a temporary identification number to their unborn babies. That information went into the database, allowing an early screening detection and treatment coordinator to monitor babies after birth and provide outreach to families whose babies are not receiving well-baby care.

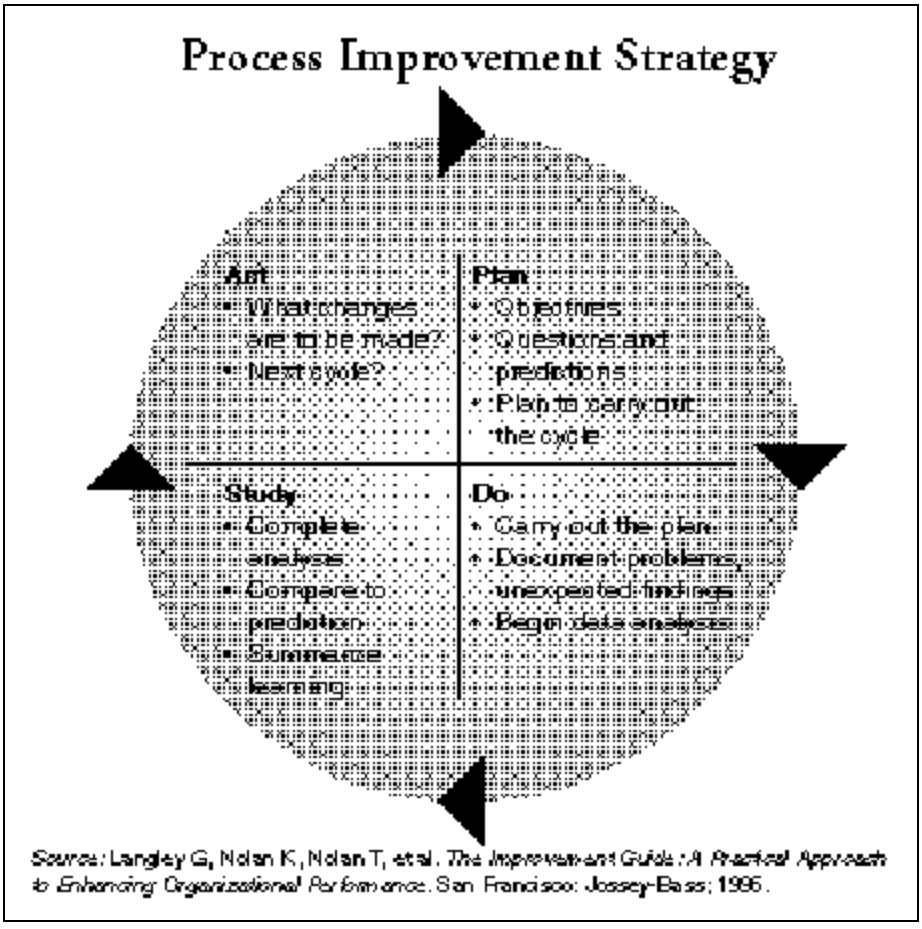
Before the program's implementation, 10% of mothers had named a pediatrician prior to delivery, and approximately 18% named a pediatrician within one month following delivery. Six months into the project, those numbers had increased to 14% and 21%. To further increase the number of new mothers who choose a pediatrician prior to delivering their newborns, the plan will send study results to prenatal providers to reinforce the link between what they do and the program outcomes.

With new babies being identified and tracked, outreach coordinators can work to reach babies who are not receiving necessary care, often partnering with community health centers to identify families in need of services. The plan's goal is to reduce the number of infants who are not receiving well-child care by 50% or more. The plan also wants to provide two Early Periodic Screening, Diagnosis, and Treatment visits to 100% of infants by the fifth month of life.

Reaching out to teens

Targeting another specific demographic group, Neighborhood Health Plan of Rhode Island worked with a community health partner to improve adolescent health. Their goal was to increase the number of students who complete physical examinations at school-based health centers in the town's middle schools and high schools from 19% to 50%.

Reneé Rulin, MD, the plan's medical director, tells *State Health Watch* that children typically are not a focus of health plans because they are not those on whom much money is spent. The intention of the program, she says, is to provide incentives to teens to make use of



Source: Langley G, Nolan K, Nolan T, et al. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*. San Francisco: Jossey-Bass; 1996.

preventive services at the school-based centers. The incentive was $10 gift coupons for a music store, Blockbuster, and Pizza Hut.

The plan began by initiating a letter campaign to students who were not enrolled in the school-based health centers but were patients of Thundermist Health Associates. The letter advised of the availability of the incentives to those who enrolled in the school-based centers and completed a physical exam. A separate mailing and incentive offer went to students who were enrolled in the centers but were overdue for a complete physical exam. The plan also encouraged students to promote the program to their peers to take advantage of the incentive gifts.

In the project's first year, the number of plan members who enrolled in school-based health centers increased by 22%. Among the new members, 37% completed a physical examination during the project period. Of members who were enrolled in the school centers but had not received a physical, 74% had a complete physical exam during the project period. Overall, the number of eligible students who received a physical during the project increased from 19% to 50%. "To us, that's pretty successful," Ms. Rulin says. The program, which started in Woonsocket, is being expanded to the rest of the school-based health centers next year.

Immunizations pushed

An emphasis on immunizations was the focus of efforts by The Wellness Plan, a nonprofit health plan in Michigan with 110,000 Medicaid members who wanted to increase the immunization rate for 2-year-olds from 43% in 2000 to 80% by 2004.

To achieve the increase, the plan modified existing data systems to identify 100% of the members ages 12 months to 18 months and stratify them by immunization status. A cross-referencing system was developed to determine the accuracy of health plan data by verifying immunization status with parents and providers.

The new cross-referencing system evaluates whether a child has been assigned to more than one primary care provider while enrolled in the health plan, has more than one member identification number, and has duplicate insurance and no encounters with The Wellness Plan. The system also is able to determine whether the member's assigned pediatrician has more than one practice location and/or more than one medical record documenting the child's medical history.

Once members were cross-referenced, letters were sent to providers with lists of their members and their immunization status. Providers were asked to submit revised documentation if the immunization status listed was incorrect. Letters also were sent to members asking parents to review their child's immunization records and contact the child's provider for an appointment if immunizations were missing.

The cross-referencing system allowed the plan to increase the number of 2-year-olds with complete immunization records captured by the health plan's administrative database from 0.44% to 17%. The plan then identified remaining children with incomplete immunizations and contacted the child's parent and/or primary care provider. A significant response was received from providers and parents, who submitted updated immunization information and/or scheduled well-child visits. Overall, the plan achieved a 9% increase in its Health Plan Employer Data and Information Set immunization rates between 2000 and 2001, from 43% to 52%.

[Contact Ms. Oehlmann at (609) 895-8101 and Ms. Rulin at (401) 459-6130.] ■

Pilot program

Continued from page 1

more than 500 people who selected Heartland to be their managed care plan.

Heartland CEO Sally Venator tells *State Health Watch* that enrollment of the ABD program in the plan accounted for claims savings of approximately 15% over what was spent caring for them in the traditional Medicaid fee-for-service program during the 12 months before their Heartland enrollment. And when the 10 individuals with the highest medical claims costs were removed from the analysis, the managed care savings increased to 31%.

Perhaps the greatest proof of the success of the experiment, Ms. Venator says, is that advocacy groups for ABD patients now would be the first to loudly protest attempts to remove them from managed care.

"They are believers," Ms. Venator says. "We are doing what we said we would do with case management. The bottom line is that helping people coordinate their care is the best thing we can bring to the program. Otherwise, they are on their own. It's nice to know that we can save money, but what's most exciting is that the members perceive that their overall health status has improved."

The Schaller Anderson fiscal analysis shows the 10 most costly individuals in the study group represented less than 2% of the individuals in the group, yet accounted for 25% of all the fee-for-service group's medical claims. While most in the ABD population had lower medical claims costs under managed care, total medical claims costs for the 10 most costly individuals were actually higher under managed care.

Why? Because of their complex medical needs and the fact that payment for their care in the managed care environment was not restricted

to certain established limits, such as payment for only two physician visits per month, as it had been under fee-for-service. The overall savings in the pilot were realized even though the paid benefits available in managed care were more comprehensive than under fee-for-service.

Results of focus-group sessions with advocacy organizations representing the patients indicated that access to care and continuity of care were greatly with Heartland. Prior to enrollment in managed care, the advocates said, "creativity" was required to access some fee-for-service services. They said that while patients encountered many knowledgeable, caring providers, they often had to pursue alternative avenues to obtain necessary services. Under fee-for-service, advocates maintain, patients waited longer for appointments, traveled further, and sought care from any provider rather than from specialists. After enrolling with Heartland, advocates expressed relief that the plan provided a full spectrum of services and sought to ensure access and continuity of care through its enhanced provider network development efforts.

The focus groups also highlighted areas they say still need to be worked on, including additional education for providers and their office personnel, lack of sufficient dental providers, and payment rate issues.

The CHCS report concluded: "Results of this study confirm that with appropriate levels of care and management, the special needs/aged, blind, disabled populations can be effectively, efficiently, and economically served in a managed care environment. . . . Members felt their health status had improved since enrollment in Heartland and provider satisfaction also showed improvement."

Ms. Venator says Heartland's effort started relatively smoothly because of focused attempts to eliminate patient and advocacy group anxiety about the change.

"We had a lot of meetings in which we were there to listen to their concerns," she says. "The concept that choice will be limited and patients may have to change providers can always be a concern. But we had a good level of success in a 120-day transition period."

One significant improvement, she says, was the involvement of primary care providers into the service mix. Often, ABD patients are tied closely to specialists and don't have anyone looking out for their general health care. Bringing in primary care providers meant a new access to services. For the doctors, it opened up a market segment they had never seen and added new patients to their panel rosters. Ms. Venator says the ABD patients were encouraged to obtain primary care physician evaluations and most did, so many unmet medical needs were identified.

"It's been interesting to see and hear the comments from network providers seeing complex cases for primary care for the first time," she says.

The Heartland care coordinators took a broad view of their role, dealing with issues such as transportation, social services, and follow-up in addition to more traditional medical care services. According to Ms. Venator, when Heartland hits needs not within its area of responsibility, the health plan has resources it can refer patients to and remains involved to be sure that the needs are met.

The experience has yielded information about some potential downsides to balance the great success. Ms. Venator says the program can be hard for primary care physicians (PCPs) because they are not given an option of whether to participate. She says some doctors managed to opt out of serving the ABD population by controlling their panel size, and the rest needed to make significant adjustments because members of this population are not usually seen in PCP offices.

"It's more than doorways and accessible bathrooms," she explains. "These patients generally need two to three times more time in the office than other patients. To help alleviate that situation, the doctors get a higher capitation fee for this group."

Specialists gained more time through use of PCPs by the patients. And if patients needed to stay with a specialist who was not part of Heartland, the plan gave the specialist a single patient contract to facilitate continuity of care.

Ms. Venator says the ABD patients also have a lot of behavioral health issues, often as their primary diagnosis. They can be disruptive in physician offices. "We tried to be sure none of our physicians and office staffs were caught off-guard. We gave them some strategies they could use."

Heartland experienced problems, she says, because the program has been underfunded and the university had to absorb losses. "Working with this population was a challenge for commercial plans because they were pushed beyond what they were willing to accept as losses. It's still a problem. There's also a problem as new, very expensive drugs for this population come on the market."

Spell out contract terms

Jennifer Goodman, manager of Medicare and Medicaid business development for Schaller Anderson, tells *State Health Watch* that planning is the key to success. Also important is a carefully and clearly worded contract.

"By putting details in the contract, we could ensure that our network was appropriate," she says.

There also is an obvious need for dedicated care management. The state mandated that an exceptional-needs coordinator be identified for each enrolled patient and be in touch

with the patient at least monthly.

For other plans wanting to take on the ABD population, Ms. Venator says it's important to take the time to assess member needs, something that's not easy to do, and realize that a lot of unmet needs will be uncovered as a result of the fee-for-service benefit design. "The first six-month expense will be huge," she counsels. "We've seen some people go directly from the PCP office to the hospital."

It's also important, she says, to have people with the right skills do outreach and care management. Heartland uses registered nurses with experience with the disabled, along with a corps of specialized social workers. They also have behavioral health care managers to coordinate between behavioral and medical needs.

Realize that things that work with other populations won't work with this one, Ms. Venator says, and be candid in providing information to providers. "It takes creative thinking to succeed in this arena. There's a certain element of the population that is totally noncompliant and won't address the very serious health issues that they have."

Ms. Goldman talks about the need to take general concepts and apply them to local situations. Rural areas have a harder time matching clients to providers than do urban areas, she says. "You can't take a cookbook approach. But any plan can be successful if they understand Medicaid and this population and have knowledgeable people involved. I can't speak highly enough about this program. We didn't cut anything. We actually increased services. We're not underutilizing. We're trying to tell all the states that this is a way that they can save money."

[The CHCS report is available for download through http://www.chcs.org. Contact Ms. Venator at (405) 552-6500 and Ms. Goldman at (602) 659-2096.] ■

Local outreach is the key to increased SCHIP enrollment

While significant efforts have been made to enroll people in State Children's Health Insurance Programs (SCHIPs), millions of children and adults are eligible for public coverage programs but not enrolled. Local outreach is thought to be the key to bringing them into the fold.

A catalog of successful outreach efforts has been created by Community Voice, a program of the W.K. Kellogg Foundation of Battle Creek, MI, in which 13 community organizations across the country have been given grants to help increase access to health care, promote quality and cost-effective care, and strengthen the safety net.

Barriers to enrollment include a lack of information, cumbersome application and recertification procedures, and premiums or enrollment fees.

In addition, Community Voices has found that some populations are particularly difficult to reach — immigrant families, people with language or cultural differences, people who have had negative past experiences with government agencies, people who perceive a stigma associated with publicly funded programs, low-wage workers in small businesses, and individuals facing geographic or logistical barriers.

To make the best use of steps that states have taken to streamline application procedures, outreach is needed in community health centers and clinics, county health departments, community-based organizations of all types, churches, bodegas, and beauty parlors, a Community Voices report says. "Particularly in a time of budget shortfalls and fiscal constraints, communities must focus on effective strategies for connecting individuals and families to critical health care programs."

Examples cited

The Community Voices "cookbook" gives examples of outreach efforts including developing innovative outstationing and technical tools; addressing language and cultural differences; enlisting neighborhood residents, community health workers, or promoters; ensuring a user-friendly atmosphere and process; building relationships with community organizations; forming outreach collaboratives; participating in community events; using local media and marketing; and providing funding to help with application fees in states where they are imposed.

Community workers say there are some things states do that help them in their outreach and enrollment efforts and should be expanded. Those state policies that help community efforts include visits from or placements of Medicaid/SCHIP workers with community workers in community-based organizations; active high-profile support and involvement of the governor or other high-ranking state officials; a reduced waiting period between the end of private coverage and eligibility for public coverage; medical care or vouchers for low-income pregnant women who have not completed the application process or who do not otherwise receive Medicaid services; and retrospective Medicaid and SCHIP payments for emergency department services that motivate hospital staffs to facilitate enrollment in public coverage.

Conversely, there are some state actions that are seen as frustrating

local outreach and enrollment activities. Some of the barriers are political or philosophical such as noneligibility of documented individuals and families who arrived in this country within the last five years and undocumented immigrants; state requirements for information about noncustodial fathers when mothers apply for Medicaid and other programs, and the failure of many states to recognize school-based clinics, which are accessible to children and teens and already are providing important primary and preventive care.

Most of the state barriers cited by local Community Voices programs are related to fiscal constraints. They include state imposition of enrollment freezes, stringent Medicaid eligibility criteria, limited state outreach payments to community-based organizations, and very low payments to health plans and providers.

In times of fiscal distress, states are going to be challenged to sustain current outreach, enrollment, and benefit levels. Options they face include using unspent federal SCHIP funds; obtaining federal grants for outreach; expanding Medicaid and SCHIP eligibility to populations such as childless adults; focusing policy debates toward the need to invest in health programs as a long-term strategy toward building a healthier and more productive society; providing financial and technical support for innovative, community-based coverage programs; and concentrating on developing affordable coverage options for small businesses and low-income workers.

Influencing state policy

Community Voices West Virginia has achieved significant success by outstationing enrollment workers in primary care centers and family resource centers. These workers also have been successful by visiting nursing homes to engage and educate staff and elderly residents about public coverage. West Virginia also uses parent educators who go to homes to teach child development and basic parenting skills, along with assistance with health plan enrollment.

Community Voices West Virginia director Nancy Tolliver tells *State Health Watch* that her organization has worked successfully on the community level as well as influencing state policy.

"The focus of both those efforts is to increase access to health care for the uninsured and underserved," she says.

"The reason we're effective in meeting with state officials is that we actually have people from the grass roots speaking directly to policymakers to resolve problems and come up with new ways of doing things."

Nancy Tolliver
Project Director
West Virginia Community Voices
Charleston

A committee from the local level has influenced state benefit design decisions and under the state's Healthy Kids Coalition, outreach workers from around the state have an opportunity to meet with state agency officials to describe their successes and problems, meetings that Ms. Tolliver says have been extremely effective.

"The reason we're effective in meeting with state officials is that we actually have people from the grass roots speaking directly to policymakers to resolve problems and come up with new ways of doing things," Ms. Tolliver says.

Working with the Center for Civic Life, Community Voices designed a process for community forums held to discuss access and utilization issues. This year, the forums were part of a public broadcasting radio series on health care problems. "If we can get community groups talking about issues, they often can come up with good solutions," she says.

Moving into an area where much work needs to be done, Community Voices funded a task force to work on legislation for creation of an Office of Oral Health in an effort to have more dental care made available. Ms. Tolliver says they are now trying to secure grant funds for other elements, including a media campaign to help people understand that West Virginia ranks poorly in oral health and that good oral health begins at birth.

Local promoters achieve success

In New York City, Sandra Harris, executive director of the Northern Manhattan Community Voices Coalition, says they have had their greatest success through use of community health promoters. Community-based organizations engage individuals who have been through the enrollment process to share their experience with others in their communities in terms of the importance of maintaining health and how the process works.

"Word-of-mouth efforts work in taking out the myths about the enrollment process," Ms. Harris tells *State Health Watch*.

An evaluation of the success of the program found that 43% of families referred to the state agency came through the community promoters, Ms. Harris says.

"The promoters also are important because they help us maintain contact after an initial encounter," she adds. "Too often, we have tended to lose families as they start through the process."

The coalition has links with workers outstationed in hospital emergency departments to help identify the uninsured who are using the emergency department as a primary care physician.

Although Community Voices can demonstrate that progress is being made, the organization says the challenges go beyond filling out applications and submitting forms.

"Enrolling eligible people is only the beginning of the process toward ensuring access to appropriate quality health care," the report says.

"Once people are enrolled in public [or private] health coverage, ongoing challenges include helping enrollees navigate and appropriately use the complex health care system; encouraging healthy lifestyles, prevention, and early intervention; reducing nonfinancial obstacles to care related to language and culture, lack of transportation, and lack of childcare; keeping people enrolled in coverage; and ensuring adequate provider capacity to serve enrolled populations," the report continues.

"And of course, a broader societal challenge involves expanding access to coverage and services to people who are not currently eligible for public programs and who cannot afford private insurance."

[Download the report from http://www.communityvoices.org. Contact Ms. Tolliver at (304) 558-0530 and Ms. Harris at (212) 304-7032.] ■

States experiment with electronic Medicaid and SCHIP apps

While conventional wisdom suggests that not many people who receive health care through Medicaid or State Children's Health Insurance Programs (SCHIPs) are computer literate or have access to computers, states are reporting good results in experiments with on-line applications for the health care programs.

Legislation has been introduced that would give states grants to develop web-based enrollment systems. Brendan Krause, a policy analyst for the Washington, DC-based National Governors Association, tells *State Health Watch* that development of the electronic applications is consistent with state movement toward a more technological culture in which state web sites are used to provide information about and access to a number of services.

"The greatest benefits of the system are now just being realized. Administrative efficiency increases could be substantial if fewer applications have to be processed by the mail center, few require data entry and paper filing, and if tracking applications is made easier."

Brendan Krause
Policy Analyst
National Governors Association
Washington, DC

While there may be questions about computer access and literacy, Mr. Krause says, some states are surprised at the number of applications received electronically.

The pioneer state for on-line application process was California, which first made its Health-e-App available for the state's Medicaid and SCHIP programs in San Diego County.

That on-line application was created by Deloitte Consulting under contract to the California Health Care Foundation. It allows enrollees to apply on-line with the assistance of Certified Application Assistants who work primarily at community-based agencies and help some 60% of Medi-Cal and Healthy Families applicants to enroll.

A statewide rollout of Health-e-App should be completed by the end of the year.

Health-e-App is available in both English and Spanish and takes 20-30 minutes to complete. It has a read-aloud version for use by those with limited vision and uses an electronic signature pad for application authorization.

The system generates a fax cover sheet with a bar code that is used to match faxed income and birth certificate documents with the rest of the application. Those paper documents are turned into digital images so the entire application file is electronic. An initial eligibility determination is made in real time.

Consumers like on-line format

State officials say that Health-e-App is linked to an updated database of participating providers so enrollees can select health plans and primary care providers more efficiently.

"The greatest benefits of the system are just now being realized," Mr. Krause says of Health-e-App. "Administrative efficiency increases could be substantial if fewer applications have to be processed by the

mail center, fewer require data entry and paper filing, and if tracking applications is made easier. Based on feedback surveys, consumers prefer the Health-e-App process because they get immediate information on their likely eligibility and confirmation that their application has been received."

The Health-e-App model also is being tested in Pima County, AZ. Deloitte Consulting again worked with Arizona's Health Care Cost Containment System, the state Department of Economic Security, and Community Health Centers Collaborative Ventures to modify the California version to meet Arizona's unique requirements.

California Health Care Foundation program officer Claudia Page says she was "pleased that our investment is being leveraged by another state to make its enrollment process more efficient for both administrators and consumers."

And Phoenix El Rio Health Center executive director Robert Gomez says that licensing Health-e-App from the foundation "allowed for rapid implementation of an application that will fundamentally change the way we provide services in our communities."

In its first year of operation, the on-line enrollment system for PeachCare for Kids, Georgia's SCHIP program, processed more than 29,000 applications and won positive feedback from consumers.

The on-line process provides parents with a more convenient mechanism for applying, eliminates mail delays, and gives instant feedback about likely eligibility. Its launch in April 2001 followed funding increases by the governor and legislature to cover children the first day in the month that they apply.

The web-based system coordinates with the program's eligibility system and was developed in less than four months by PeachCare staff and staff with the program's third-party administrator. The on-line application is available in English and Spanish and takes 22 minutes to complete. Parents can log in and out, allowing them to work on the application over a period of time.

Mr. Krause reports that parents can use the web site to update their addresses at any time. "Smart" software stops incomplete applications from advancing past key prompts and stops categorically ineligible applicants from submitting an application. The server updates eligibility every two minutes at a minimum, providing application processing in almost real time.

Data submitted through the web site are protected with firewalls and encryption. The server that collects the applications does not retain any income or account information, and confidential information is moved continually to a secured internal server.

Reducing enrollment delays

PeachCare for Kids program director Jana Key tells *State Health Watch* that the state wanted to reduce the time delay in enrollment, wanted to increase access to health care services, and wanted a system with edit checks to be sure that all applications are complete.

A one-page paper application PeachCare was using was designed to meet literacy standards and the on-line application tracks that form, she says.

About half of the 29,000 on-line applicants completed a feedback survey that praised the new system's convenience and accessible information. Parents working night shifts or long hours said they appreciated the way the system let them fit applying for benefits into their schedule.

State officials said they were surprised to find that half of the on-line applicants who qualified for benefits were Medicaid eligible, compared to 25% using paper applications who are Medicaid eligible.

Twenty-three percent of parents said they would not have applied for PeachCare that day, if at all, if it were not for the on-line application.

Most on-line applicants were referred to the web site by PeachCare staff, with friends and family providing the second highest number of referrals, and most submitted their applications from a home computer.

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

Arizona	p. 10	Michigan	pp. 2, 5
California	p. 9	New York	p. 8
Georgia	p. 9	Oklahoma	p. 1
Hawaii	p. 4	Pennsylvania	p. 11
Idaho	p. 2	Rhode Island	p. 4
Indiana	p. 12	Texas	p. 11
Kentucky	p. 2	West Virginia	p. 8
Louisiana	pp. 11, 12		

Pennsylvania has created its Commonwealth of Pennsylvania Application for Social Services (COMPASS) as part of an initiative to make government services more accessible electronically.

Ultimately, COMPASS will provide on-line applications for most services covered by the state's Department of Public Welfare, including health insurance, food stamps, cash assistance, day care, Low-Income Energy Assistance Program, long-term care, work supports, and mental health/mental retardation services.

The first element — an on-line application for use with children applying for Medicaid and PaCHIP — was developed and released in fall 2001. The application was developed for the state by Deloitte Consulting.

Department of Public Welfare spokesman Jay Pagni tells *State Health Watch* that the impetus was primarily to improve customer service by providing an alternative for individuals to use to apply for services for themselves or for others with whom they are working through community-based organizations.

As is typical, the application takes about 30 minutes to complete and families have up to 30 days to complete it, being able to log in and out of the system and not have to finish it in one sitting.

Early analysis indicates that most applications are being submitted by individuals rather than by outreach organizations submitting applications for individual applicants. Administrative cost savings were not a goal and have not been measured. Staff did not expect a significant increase in enrollments and none has occurred.

On-line vs. off

Mr. Krause says an initial evaluation of Texas' on-line application found a higher number of complete applications submitted using the on-line form, 90% compared to 60% using paper applications. State officials say they are happy with usage of the system, particularly by higher-income SCHIP-eligible applicants, but are hoping to increase system utilization among applicants who are between 100% and 150% of the federal poverty level.

According to Mr. Krause, states interested in pursuing on-line applications should take these steps:

• Form development groups across agencies that have program authority or that must approve information technology projects to determine and address organizational differences.

• If permitted by law, consider an application that either requires no signature or accepts an electronic signature.

• Choose pilot site test populations that represent people who will actually use the system.

• Recognize that people using on-line systems expect a quick response and create a system that can communicate with the state's eligibility system on an ongoing basis, rather than overnight or with a batch of applications.

• Create a secure system to protect applicants' privacy.

Meanwhile, U.S. Rep. Adam Schiff (D-CA) introduced legislation that would provide $50 million to help states develop web-based enrollment systems for Medicaid and SCHIP. States also could receive information and technical assistance, including information on Health-e-App. Grants would be paid across five years, starting in 2003.

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Clip files / Local news from the states

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

Louisiana SCHIP to cover pregnant women

BATON ROUGE, LA—Louisiana has made a big push to get more of its children covered by government-funded health insurance.

Now it's pregnant women's turn as the state expands its effort to produce healthier children and save money by treating fewer sick children. Later this year, pregnant women in working-poor families will be able to apply for free health insurance benefits previously available only to the poorest people.

The benefits start Jan. 1. Women in families with incomes up to double the federal poverty level will be eligible. "It's logical," said David Hood, secretary of the State Department of Health and Hospitals.

"The child, in order to be totally healthy, needs care from conception, not just birth," Mr. Hood said.

Today all children in families with incomes up to twice the federal poverty level are eligible for the Louisiana Children's Health Insurance Program (LaCHIP). Since LaCHIP started in fall 1998, 74,407 children have been enrolled, and another 144,385 children have been added to traditional Medicaid, which offers free health care to poor people.

There are 534,063 children covered by the two

programs. LaCHIP already provides health insurance for teens under age 19 who get pregnant.

The new program will expand the coverage to women of all ages who meet the requirements.

"It's been a 'policy disconnect' to have the babies eligible for Medicaid at birth and have the mother with no prenatal care," said Sandra Adams, director of the Louisiana Coalition for Maternal and Child Health. Ms. Adams said the new program helps "a small population, but it's a population that absolutely cannot get care other than through public facilities."

—*Baton Rouge Advocate,* July 21

Medicaid expands to pay psychologists

BATON ROUGE—Louisiana's failure to meet a federal court deadline to get psychological services to developmentally disabled children is leading to a costly expansion of Medicaid, the government's health insurance program for the poor.

The state is expanding the Medicaid provider list to include psychologists, and the services they offer won't be limited to the special class of 3,400 mentally retarded and developmentally disabled children in a federal lawsuit.

Under federal law, some 400,000 Medicaid-eligible recipients younger than 21 also could benefit from the services if needed.

State health officials estimate the Medicaid expansion could cost up to $30 million annually in state and federal funds.

The provision of behavioral and psychological services for children with autism and other developmental disorders is one component of a 1997 federal lawsuit, known as the *Chisholm* case.

The case sought help for Medicaid-eligible children who were on a waiting list for specialized services for the mentally retarded and developmentally disabled.

David Hood, secretary of the State Department of Health and Hospitals (DHH), said his agency didn't intentionally miss the deadline U.S. District Judge Carl Barbier set for compliance.

It's just that DHH's initial service delivery plan didn't work, he said.

—*Baton Rouge Advocate,* July 31

Medicaid costs under budget

INDIANAPOLIS—A lawsuit increasing the number of people who get taxpayer-paid health care didn't turn out to be the budget-buster Indiana state officials had feared.

Final figures aren't in, but officials say they expect the landmark *Patricia Day* case to cost Indiana Medicaid about $130 million — not $850 million, as had been projected.

The lawsuit helped expand Medicaid from a program that covers just permanent, untreatable disabilities to one that covers disabilities expected to last at least four years if left untreated.

That opened the door for thousands of Hoosiers turned down for Medicaid during a nearly eight-year period to get publicly funded health care. The state lost the legal battle in June 2001 when the Indiana Supreme Court upheld a lower-court ruling.

Records compiled so far show just 3,665 of 17,559 people state officials tried to contact afterward signed up, said Melanie Bella, the state's Medicaid director.

State officials caution that the lower-than-projected response won't mean a windfall.

"It's not going to give us extra money to go shopping with," State Budget Director Marilyn Schultz said.

It also won't ease Indiana Medicaid's funding deficit, which has resulted in nearly $660 million in cuts in payments to nursing homes, hospitals, pharmacies, and other caregivers.

—*Indianapolis Star,* Aug. 1