State Health Watch

Vol. 10 No. 11 — *The Newsletter on State Health Care Reform* — November 2003

THOMSON
AMERICAN HEALTH CONSULTANTS

# Squeezed: States reduce Medicaid, though it's not to blame for woes

Despite new data that show Medicaid plays a small role in states' fiscal problems, Medicaid programs in all states remain a significant target for budget cutting, according to another study.

The Kaiser Commission on Medicaid and the Uninsured released Rockefeller Institute and Health Management Associates reports in September, plus one from the Urban Institute, which looked at the principal drivers of rapid Medicaid spending growth.

The Urban Institute report points especially to enrollment increases due to loss of income and private insurance coverage during the current economic downturn. It also eyed increases in hospital and prescription drug costs.

Together, the three reports constitute the Commission's third annual survey of the 50 states and the District of Columbia.

"The duration of the state fiscal crisis is impacting Medicaid coverage broadly and deeply," commission executive director Diane Rowland said when the reports were released.

*See **Medicaid** on page 2*

## In This Issue



## *Oklahoma claims system could save millions as CMS picks up another 25% of the costs*

Oklahoma officials like the numbers they've heard about: The state could save more than $20 million through 2007.

The state's new Medicaid claims processing system, which recently won Centers for Medicare & Medicaid Services (CMS) certification and entitles Oklahoma to enhanced funding, is the savior.

**Fiscal Fitness: How States Cope**

The savings estimate came from CMS when Andrew Fredrickson, associate regional administrator for Medicaid and Children's Health, said the state "has a right to be proud of this accomplishment. The state's Medicaid program has created a state-of-the-art Medicaid payment system." Certification by CMS means that the agency will pay 75% of the system's operational costs instead of the typical 50%.

More than 90% of the state's 1.8 million monthly Medicaid claims are being processed through the new system created by Electronic Data Systems (EDS), the vendor the Oklahoma Health Care Authority

*See **Fiscal Fitness** on page 6*

State Health Watch
The Newsletter on State Health Care Reform

**On-line access / Index**

Back issues of *State Health Watch* may be searched on-line for a fee at **www.newslettersonline.com/ahc/shw.** Issues may be searched by keyword and date of publication.

State Health Watch (ISSN# 1074-4754) is published monthly by Thomson American Health Consultants, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Application to mail at periodicals postage rates is pending at Atlanta, GA 30304. POSTMASTER: Send address changes to State Health Watch, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information
Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30 a.m. - 6 p.m. Monday-Thursday; 8:30 a.m. - 4:30 p.m. Friday EST. E-mail: customer service@ahcpub.com. World Wide Web: www.ahcpub.com.

Subscription rates: $349 per year. Two to nine additional copies, $279 per year; 10 to 20 copies, $209 per year; for more than 20, call (800) 688-2421. Back issues, when available, are $58 each.
Government subscription rates: $297 per year. Two to nine additional copies, $238 per year; 10 to 20 copies, $178 per year; for more than 20, call (800) 688-2421. (GST registration number R128870672.)



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

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

Editor: John Hope, (717) 238-5990, johnhope17110@att.net.

Senior Production Editor: Ann Duncan.



THOMSON
AMERICAN HEALTH CONSULTANTS

# *Medicaid*

*Continued from page 1*

"With 34 states reducing eligibility and even more restricting health care benefits over the last three years, the state fiscal crisis is putting health care for low-income families and the elderly and disabled at risk. Many will get less care and others will lose it altogether," she explained.

Commission associate director Victoria Wachino points out two salient facts that demonstrate the problem Medicaid faces include:

- In many states, Medicaid is the second-largest area of general fund spending, trailing only elementary and secondary education.
- State revenue collections have made a dramatic downward shift after 10 years of strong revenue growth to a 5.6% decline in 2002.

"With such large shortfalls ($26 billion in 2003 and an estimated $69 billion in 2004) it is difficult to adequately fund this program," Ms. Wachino declares.

## Health care spending is up

Health Management Associates principal Vern Smith based his Medicaid budget survey on responses from all 50 states plus the District of Columbia.

"It's not new news that this is a period of a high rate of growth in health care spending," Mr. Smith says, citing a 13.9% increase in health insurance premiums in 2003, the highest growth rate since 1990, and a much higher rate than workers' earnings (3.1%) and overall inflation (2.2%).

After three years of efforts to curb Medicaid spending growth, states reported that the average spending growth for Medicaid in 2003 was 9.3%, down from 12.8% in 2002. It was the first time since 1996 the growth rate declined.

Mr. Smith points out that the reduced growth rate was striking for several reasons — it is a significant drop, while other rates remained steady or even increased; and it's difficult for any program to grow by as much as 9.3% when revenues are down.

When state Medicaid directors were asked about the factors that are driving the spending growth, Mr. Smith reports, they pointed to prescription drug costs, the overall inflation in the cost of health care services, and Medicaid enrollment increases.

Increasingly, he says, states are identifying enrollment increases as the primary factor in Medicaid growth.

Medicaid enrollment grew 7.8% in fiscal year 2003, nearly as much as the 8.3% in 2001 and 9.2% in 2002, and much more than the 2.1% in 1999 and 3.7% in 2000. An enrollment increase of 5.3% is forecast for FY 2004.

"Most of the enrollment increase has been in the low-cost categories like kids and moms," Mr. Smith adds, "while most of the spending growth is in the high-cost categories of the elderly and disabled."

## Trying to control costs

He reports that half the states restricted eligibility in FY 2003 and a third are expected to do so in FY 2004.

Although most represented minor reductions in eligibility, several states started out with significant reductions but ended up rolling them back after they were challenged politically or legally. And for FY 2004, as many states are planning eligibility expansions as are looking at reductions.

On the payment side, most Medicaid programs will freeze or cut some provider rates in 2004, although 37 states have set increases for one or more provider groups. Physicians typically are the provider group being cut, while hospitals and nursing homes are those most likely to see an increase.

Mr. Smith says that when asked whether they expected a Medicaid budget shortfall in FY 2004, three state Medicaid directors declined to respond, 16 said they did not expect a shortfall, and 32 said they did expect a shortfall.

He points out that the enhanced federal Medicaid matching rate that was part of the Jobs and Growth Tax Relief Reconciliation Act of 2003 softened or prevented cuts that would have been made for FY 2004 and may prevent midyear cuts, but also said there is a strong concern for FY 2005 when the fiscal relief will expire but it is anticipated that state revenues will remain depressed while Medicaid costs continue to go up.

Overall, he reports that, for fiscal years 2002-2004, 50 states have implemented controls on drug costs and reduced or froze some provider payments, 35 have reduced benefits, 34 have reduced or restricted eligibility, and 32 have increased copayments.

"The outlook is for continuing budget pressure on Medicaid," Mr. Smith concludes. "State officials expect Medicaid enrollment and costs to continue to grow faster than state revenues, and the task of controlling Medicaid cost growth will be more difficult."

### Spending drivers examined

Urban Institute researcher John Holahan's report addressed factors contributing to Medicaid spending growth between 2000 and 2002.

Total growth in that period was 6.6 million people, including 3.7 million children (56%), 2.3 million adults (35%), 400,000 blind and disabled (6%), and 200,000 aged (3%).

The growth in enrollment of families and children was attributable to recession, rising health care costs, and state expansion of Medicaid eligibility in the late 1990s, Mr. Holahan says.

### Increases for aged, disabled

For the aged and disabled, there was increased participation due to rising health care costs, especially for prescription drugs; the aging of the population, which affects disability rates; medical technology; and increased participation in home- and community-based waiver programs.

While the aged and disabled were only 9% of the enrollment growth combined, they accounted for 59% of the Medicaid expenditure growth in the same time period.

"It's hard to see how states will deal with this situation given their budget problems," Mr. Holahan says. "But it's also hard to see how the federal government can give them any more relief."

### State revenue drops a problem

Rockefeller Institute director of fiscal studies Donald Boyd demonstrated that state tax revenues have fallen far more sharply relative to the economy than happened in previous recessions.

The current fiscal crisis is so bad, he says, because of the "bursting of our fiscal bubble."

Indicators he pointed to included a drop in capital gains of nearly 50% in 2001 after quadrupling in the late 1990s; manufacturing weakness followed by a recession and war uncertainty; consumption growth (important to sales taxes) slowed; and other positive trends of the 1990s ended (stock options gone, welfare windfall used up, Medicaid spending going up).

"At this point, the economy may be recovering," Mr. Boyd adds, "but the employment decline has been steep and prolonged relative to the last recession."

He says that for the FY 2002 state budget gap, the growth in Medicaid spending contributed $6.9 billion, while drops in revenue collections accounted for $61.8 billion.

"The near- and middle-term outlook is not good," Mr. Boyd states. "Employment remains weak. It will take states several years to work out of the current crisis, since one-shot solutions and other nonrecurring actions spread the problem out. Capital gains are likely to be weak. There will be downward pressure on sales taxes, and there will be continued spending pressure."

### In the thick of the fight

Ohio Department of Jobs and Family Services deputy director for health plans Barbara Edwards says that as her agency planned its biennial budget for fiscal years 2004 and 2005, the governor said he could no longer protect Medicaid and an anticipated 14% increase in spending.

Significant benefit cuts and a rollback in eligibility were planned, along with aggressive drug cost controls.

Ms. Edwards says that even after avoiding $1 billion in costs, the state projects a 9% increase for 2004 and 6% for 2005.

At that point, she adds, advocacy groups entered the picture and sent very clear messages about the program's value, to the point that the state Legislature added a temporary sales tax increase to restore most of the projected cuts.

The enhanced federal match helped offset the problem.

"We now have an appropriation for an 11% increase in 2004 and 7% in 2005," Ms. Edwards reports. "But Medicaid is going to stay in the bull's-eye because its growth in spending remains twice the rate of revenue projections."

Robert Day, Kansas director of Medicaid policy views Medicaid as two programs:

1. a program that provides health insurance to help poverty-level children and their mothers;
2. a program that purchases health care services for the aged and disabled.

### A very different program

"States are picking up a publicly-funded health insurance program that is no longer tied to a welfare model," Mr. Day says. "Medicaid today looks very different than it did five or six years ago."

Though Kansas is a socially and fiscally conservative state, he says it still hasn't controlled Medicaid growth. The state agency often finds itself "up against advocacy communities who are not always in tune with what we see as our priorities," Mr. Day adds.

He predicts efforts to provide a better care management model for the chronically ill, who are responsible for 60% to 70% of the state's Medicaid budget.

*[To see the three Kaiser Commission reports, go to: www.kff.org/content/2003/20030922. For a webcast of the briefing, go to: www.kaisernetwork.org/healthcast/kff/22sep03. Contact Ms. Rowland and Ms. Wachino at (202) 347-5270; Mr. Smith at (517) 482-9236; Mr. Holahan at (202) 833-7200; Mr. Boyd at (518) 443-5284; Ms. Edwards at (614) 466-4443; and Mr. Day at (785) 296-3981.]* ■

# Report assesses physician access

While Medicaid and the State Children's Health Insurance Program (SCHIP) have done much to bring health care services to people who need them, those efforts can be in vain if there aren't enough physicians available and willing to participate in the programs.

Many states have reported difficulty in generating sufficient access to physician services for their Medicaid and SCHIP enrollees, at least in some geographic areas and for some specialties. Until now, there hasn't been a systematic way to examine this problem. But a new report from Mathematica Policy Research Inc. in Washington, DC, provides a framework through which states can assess factors that promote or hinder physician access and also identify actions that can be taken to improve access.

The framework report is one of several commissioned by the California HealthCare Foundation's Medi-Cal Policy Institute. Institute program officer Lucy Streett tells *State Health Watch* that anecdotal information has outlined a problem with physician access in California for some time, and the Institute wanted to quantify the situation. (Although much of the Institute's work is California-specific, the Mathematica framework report is applicable to all states interested in systematically looking at the problem of physician access.)

Physician surveys in California have found that about 50% of all physicians are willing to accept Medi-Cal patients, and that there has been minimal increase in that percentage despite an increase in Medi-Cal payment rates.

In addition to low rates, doctors have complained about bureaucratic issues in dealing with Medi-Cal, Ms. Streett says.

The Mathematic framework report offers a way to assess the problem and then develop action steps (**see chart, p. 5**), according to Mathematica senior fellow Marsha Gold, lead author of the report. "When any state looks at this issue," she says, "it's useful to have a sense of all the factors that influence access. Priorities in terms of access issues may vary state by state or even market by market. The data suggest that while states often focus on one or two priorities, they occur in a context. For example, in California there has been an issue around payment rates but also around the attitudes of physicians, and it's important to work on both issues."

The framework is intended to help states identify: 1) the sources of problems with physician access; 2) the interventions that may be effective for different types of problems; and 3) the major parties to be involved in implementing these interventions.

Ms. Gold says that the goal of equitable access to physician services in public insurance programs is more likely to be achieved if all critical parties share and commit themselves to this goal, each doing its part to advance it.

According to Ms. Gold, previous research has identified six key factors that influence access to physician services in Medicaid:

**1. Provider supply.**

The number, mix, and location of physicians determine the geographic accessibility of care. Data typically are expressed in geographically based physician-to-population ratios. Potential options for enhancing supply include bonus payments

or less geographically dependent ways of delivering care.

**2. Provider participation in public programs.**

The extent to which available providers participate in public programs will determine the actual (vs. theoretical) availability of care. In theory, Ms. Gold says, several types of policy levers are potentially available to states to influence participation, including payment policy and various other incentives or disincentives for participation such as bonuses and clinical or data requirements.

**3. Financial accessibility.**

Financial accessibility of care depends on the cost of care and the insurance coverage and/or income and other financial resources at an individual's disposal to pay those costs. Medicaid and SCHIP provide insurance coverage and thus make care more financially accessible. But, Ms. Gold cautions, "the growing flexibility provided to states in structuring benefits and cost-sharing under SCHIP and for those Medicaid beneficiaries who are not categorically eligible could mean that financial accessibility may become a more important barrier now than in the past."

**4. System accessibility.**

The ways in which health care systems are designed and operated will influence the degree of accessibility of the available care. Important variables include: design of office hours; availability and ease of making appointments for urgent, routine, or preventive conditions; availability of transportation; and rules and processes that determine access to specialty services.

**5. Patient knowledge, including subgroup accessibility.**

Regardless of how system entry and flow work, according to Ms. Gold, accessibility depends on how well those covered by the program understand it. Patient knowledge is an issue, particularly when systems undergo change such as through introduction of managed care.

In some subgroups, knowledge may be especially important when individuals have characteristics, such as those who are sick or frail, that may make access more difficult and motivation to learn about the system higher. Racial or other ethnic subgroups, particularly those influenced by the customs of other locales or countries, may have expectations about how to access care that differ from systems in place in their communities.

**6. Concordance between system design and patient preferences.**

Ms. Gold maintains that even with sound health care systems in place, access to physician services could be a problem if the available care does not match beneficiaries' preferences. An example she cites is of a situation in which appointments are timely, but patients want to be seen on an unscheduled basis and are willing to trade a wait in the office for the flexibility to seek care when it best fits with other demands on their time.

Ms. Gold discusses why each of the six factors is important and reviews some of the research that has been done on each factor.

With the six factors that influence access to physician services in Medicaid, she also has identified six tools potentially available to encourage effective collaboration among all parties in responding to diverse types of barriers to access.

They are contracting mechanisms, payment mechanisms, delivery system mechanisms, monitoring mechanisms, provider education

## Framework for Assessment and Action

| Assess Barriers | | Act: Potential Interventions | |
|---|---|---|---|
| Provider supply: | Adequate? | Plan and provider contracting: | Requirements |
| Provider program participation: | High? | | |
| Financial accessibility: | Good coverage? | Payment: | Adequate, predictable |
| System accessibility: | Easy to access? | Delivery system: | Features to ease access |
| | | Monitoring: | Identify emerging problems |
| Patient knowledge: | Good? Problems for particular vulnerable subgroups? | Provider education: | Patient needs and program policies |
| | | Consumer education: | How to seek care effectively |
| Patient preferences: | Reflected in system? | | |

*Source:* Mathematica Policy Research Inc., Washington, DC.

mechanisms, and consumer education mechanisms.

Potential interventions to bolster participation in public programs include increasing payment rates, monitoring plan networks coupled with incentives for improvement, limiting administrative burden, prompt payment, and state mandates on participation. "Within the traditional Medicaid program," Ms. Gold writes, "the most common strategy for increasing participation has been to raise physician fees, either across the board or selectively in areas of perceived care shortage. Unfortunately, little research has specifically evaluated the effectiveness of these incentive payments."

Use of the framework allows a broader look at potential barriers and ways to address them. Specifically, according to Ms. Gold, states looking to address the issues will need to: 1) identify concrete measures of key barriers to physician access; 2) monitor performance against these measures regularly; and 3) when problems are identified, take action that is appropriate to the specific problem. "States that are proactive in anticipating problems may be able to avoid them or limit their scope," she declares.

Based on the analysis presented in the framework, Ms. Gold says that collaboration for success will be more likely if each party takes on responsibilities appropriate to its role. She identifies likely commitments as:

- **Government.** Responsible for equitable payment and good business practices to encourage stable and broad-based provider participation organized in ways that create access to beneficiaries. It means that payment levels are set by adopting appropriate standards that, to the extent feasible, result in predictable levels of payment over the years, regardless of budget pressures, and timely reimbursement of claims. It also means that government works to establish effective means of communication and two-way interchange among all parties.
- **Providers.** Responsible and willing to treat patients on a nondiscriminatory basis. They should be willing to provide effective feedback to plans and providers on what they need to make participation feasible, to take their fair share of publicly insured patients as long as reasonable conditions are met, and to educate themselves sufficiently to understand accurately the needs of their patients.
- **Health plans.** As agents of the state, plans are responsible for structuring payments and practices in an equitable way to encourage stable and broad-based provider participation and access. They assume many of the same responsibilities as states by serving as a substitute for the state or complementing state actions.
- **Consumers.** Responsible for being informed, assuming an appropriate system and infrastructure to support education and access. Consumers need to be willing to learn how to use systems, particularly when the systems aim to accommodate their needs and preferences and when appropriate education is provided.

Ms. Gold tells *State Health Watch* that she hopes that states will put monitoring systems in place to look at the barriers and potential solutions. "With state budget crises, the potential for the situation to get worse is growing," she says, "and it will be important to find resources to deal with these issues."

*[Contact Ms. Streett at (570) 286-8976 and Ms. Gold at (202) 484-4227.]* ■

## *Fiscal Fitness*

*Continued from page 1*

chose when it decided to build a new claims processing system from the ground up.

Since Jan. 1, one of the key features of the system has allowed Medicaid providers to use a secure web site to submit claims over the Internet and also check patient eligibility, covered services, and service pricing.

Charles Brodt, Oklahoma Health Care Authority director of federal-state health policy, tells *State Health Watch* the state had been using a system that was first built in the early 1970s but found it increasingly difficult to make changes to fit with a move to Medicaid managed care and other efforts to improve health care delivery in the state. When the decision was made to create a new system rather than try to continue to modify the old one, the agency had two goals, Mr. Brodt says. First, it wanted to develop a state-of-the-art system that would process payments in a timely and efficient manner. Second, it wanted a system with querying and report management features that would allow staff to better manage their business.

Two factors that affected the drive to create the new system were the state's response to the Y2K concerns and the realization that Health Insurance Portability and Accountability Act (HIPAA) requirements included being able to handle uniform transactions by Oct. 16, 2001. Although that compliance date later was pushed back to 2003, Oklahoma moved forward in expectation of meeting the 2001 deadline.

Mr. Brodt said that two vendors bid on the request for proposal the authority issued, and EDS was chosen. The firm brought in a base

system that had been in use in Indiana but then modified it considerably to meet the requirements set forth by the Oklahoma Authority.

### *Making full use of the web*

One of the most significant changes, Mr. Brodt says, was the decision to use the Internet and web-based technology for many of the system's operations. One reason for that decision was the assumption that while large billing companies would be willing to spend the money needed to upgrade their own technological capabilities to interact with the new system, smaller providers who were used to putting their claims on a floppy disk and sending it in wouldn't be able to afford the technological upgrade and would want to revert to paper. The health care authority was determined to operate in a paperless environment as much as possible. The solution was the secure password-protected web site that providers can access with a PIN number.

Information available on the web site includes eligibility, procedures covered, pricing, and a billing manual. Claims can be submitted through the web site and the provider can watch the claims go into production and determine whether they are accepted, rejected, or suspended. If claims are suspended, the provider is given the reasons through the web site. If they are being paid, information on the check run is available there. Mr. Brodt says he's not aware of any other state Medicaid system that makes as full use of the web as does Oklahoma's system.

Mr. Brodt says a major key to the success of the system development and cutover was the presence on his staff of people with a lot of experience in Medicaid and a culture that promotes hands-on involvement in a major project like this one. He says it took approximately two years from the time the contract was awarded to EDS to when the new system was operational, and much of that time was spent in the state staff defining what they expected from the system and how it should be designed and giving that information to the EDS people.

"We're very hands-on," Mr. Brodt says, "and we monitored EDS very closely. Over time, the result was a mutual respect between the contractor and the state. It was a very successful team approach."

Another key success factor was the amount of time and effort spent in outreach to providers, billing agents, pharmacists, and other stakeholders to be sure they knew what was going on and that they would be prepared to participate.

"We did a lot of testing in the final six months before taking the system live so that everything would come together," Mr. Brodt says. "We phased the new system in during December 2002 because our heaviest times are at the beginning and end of each month. There was a 24-hour period in which no claims were accepted and then we began processing with the new system. Electronic transfers were accepted as of Dec. 26, and the first payment run was Dec. 27. I've been through new system implementations before, and this was the smoothest cutover I've ever seen."

Gov. Brad Henry also was impressed with the results. "It is difficult for people to understand what the Oklahoma Health Care Authority accomplished in developing this new payment system. To put it in perspective, it is considered a greater undertaking than preparing for the Y2K conversion. I commend the health care authority staff and contractor for their commitment to this onerous project, the result of which streamlines services with the medical community and reduces red tape."

One concern during development had been the state's nursing homes, which were used to submitting claims in an "old-style paper turnaround document" in which the nursing home sent in information on paper and the agency added its information and returned the paper to the nursing home. "We woke them up to a new day," Mr. Brodt says, by converting the nursing homes to use of the UB-92 form for any paper claims. But the web site also was made available to the nursing homes, and they are finding that 50% of nursing home claims are coming through the Internet.

According to Mr. Brodt, providers expressed some anxiety when CMS extended the deadline for uniform transactions but Oklahoma stuck with its commitment to go live with the new system Jan. 1, 2003, despite the lack of a federal mandate. "There were concerns that we wouldn't be ready. But everyone got into compliance. Things tested well; and when we got to Jan. 1 of this year, we were receiving successful transactions."

What advice does Mr. Brodt have for other states that want to do a new Medicaid payment system? First, take the time and resources to clearly define what you want to do. Then manage the project yourself. "What made this successful for us is that while we worked diligently with the contractor, we also managed the effort ourselves."

The third important step is to take time to inform people about what's coming. Oklahoma's outreach efforts to stakeholders started a year in advance of implementation. "Don't be in a hurry," Mr. Brodt counsels.

*[Contact Charles Brodt at (405) 522-7300.]* ■

# States don't mandate adequate newborn screening

The March of Dimes in White Plains, NY, says that while every baby born in the United States undergoes some level of newborn screening, many parents don't realize that states determine the disorders to screen for, and most do not meet the recommendations made by the March of Dimes' medical specialists.

In 2000, the agency recommended that all babies receive a screening for nine metabolic disorders (**see related story, p. 9**) and also receive a hearing test.

"These screenings can sometimes mean the difference between a healthy start in life and disability or even death for a baby," March of Dimes spokeswoman Michele Kring tells *State Health Watch*. "The tests recommended by the March of Dimes lead to reliable diagnosis of conditions for which there is a proven treatment for a newborn's metabolic or hearing deficiency."

While nearly all babies born in the United States undergo some newborn screening, the number of screened disorders varies greatly by state, says March of Dimes president Jennifer Howse.

"While a few states may screen for even more than these nine metabolic disorders, only 11 states now provide all nine tests recommended by the March of Dimes. Expansion of newborn screening has been a March of Dimes priority for three years, and our chapters have worked closely with governors, state legislatures, and health departments to increase access to these important tests. States spend an average of $24.99 per baby on these tests, according to a recent report from the U.S. General Accounting Office. The tragic cost of a child disabled by a genetic disorder is inestimable to families and to society," she adds.

Newborn screening is done by testing a few drops of blood, usually from the newborn's heel, before hospital discharge. If a result is positive, the infant will usually be retested and then given treatment as soon as possible, before becoming seriously ill from the disease.

Currently, parents seeking screening for disorders not covered by their state must arrange for a private lab to do the testing, often with additional out-of-pocket expense. Ms. Howse says parents are encouraged to check with their state's health department to determine which newborn screening tests are offered.

In some states, approval and funding of expanded screening may be in development. In other states, she says, legislators may need encouragement to give attention and resources to these programs. Ms. Howse says the March of Dimes is urging Congress to appropriate funds to Title XXVI of the Children's Health Act to provide states with funds for newborn screening equipment, training, and public/professional education.

Ms. Kring says the agency believes the time when all 50 states will test for all nine disorders is a "long way off" even though the states currently are doing "a grave injustice to babies." She says she believes parents would be shocked to learn how little some states are doing.

### Population trends are changing

"The differences among states are often historical," Ms. Kring tells *State Health Watch*.

"Legislators and health officials look at the population and see only certain diseases and think that's all they need to be concerned about. They don't realize how mobile the population has become in the last 50 years. And they don't realize that metabolic disorders cross all population boundaries."

She says the tests being promoted by the March of Dimes have been accepted as important by almost all pediatric authorities and associations. And the organization also advocates for testing only for disorders for which there is an immediate treatment available.

She reports that the issue with hearing tests is more complicated because states allow some hospitals to opt out of the testing.

The March of Dimes contends that at least 90% of all newborns in every state should have a hearing test.

Eleven states now screen for the nine metabolic disorders:

- Illinois;
- Indiana;
- Iowa;
- Maine;
- Massachusetts;
- Mississippi;
- Nevada;
- New York;
- Oregon;
- Rhode Island;
- Wisconsin.

Eighteen states offer five or fewer tests: Alabama, Arkansas, California, Florida, Kansas, Kentucky, Louisiana, Missouri, Montana, New Hampshire, Oklahoma, South Dakota, Tennessee, Texas, Utah, Washington, West Virginia, Wyoming. The District of Columbia and Puerto Rico also offer fewer than five tests.

*[For more information, contact Michele Kring at (914) 997-4613 or go to www.marchofdimes.com.]* ■

# *CORE group of recommended newborn screening (with metabolic tests)*

Listed here are the nine metabolic screening tests for newborns (**see related story, p. 8**) that are recommended by the March of Dimes in White Plains, NY:

1. **Medium-chain ACYL-COA dehydrogenase (MCAD) deficiency.** Incidence: One baby in 15,000. An inherited disorder of fatty-acid metabolism caused by the lack of an enzyme required to convert fat to energy. Seemingly well infants or children suddenly can develop seizures, respiratory failure, cardiac arrest, coma, and death. Identifying affected children before they become ill is vital to preventing a crisis and averting these consequences. Treatment includes steady food or glucose intake and avoidance of fasting.

2. **Phenylketonuria (PKU).** Incidence: One baby in 12,000. An inability to properly process the essential amino acid phenylalanine, which then accumulates and damages the brain. PKU can result in severe mental retardation unless detected soon after birth and treated with a special formula. Affected individuals must be kept on a low phenylalanine diet at least throughout childhood, adolescence, and for females, during pregnancy.

3. **Congenital hypothyroidism.** Incidence: One baby in 4,000. A thyroid hormone deficiency that severely retards both growth and brain development. If detected soon after birth, the condition can be treated with oral doses of thyroid hormone to permit normal development.

4. **Congenital adrenal hyperplasia (CAH).** Incidence: One baby in 5,000. CAH refers to a set of inherited disorders resulting from defects in the synthesis of hormones produced by the adrenal gland. Certain severe forms of CAH cause life-threatening salt loss from the body if undetected and untreated. Treatment includes salt replacement and hormone replacement.

5. **Biotinidase deficiency.** Incidence: One baby in 70,000. Biotinidase is the enzyme that recycles biotin, a crucial B vitamin. Biotinidase deficiency may cause serious complications, including frequent infections, uncoordinated movement, hearing loss, seizures, and mental retardation. Undiagnosed and untreated, the deficiency can lead to coma and death. If the condition is detected soon after birth, these problems can be prevented simply by giving the baby extra biotin.

6. **Maple syrup urine disease.** Incidence: One baby in 250,000. A rare inborn error of metabolism that is lethal if unrecognized and untreated. There is a wide spectrum of this condition from mild to severe. Affected babies appear normal at birth but soon begin to have neurological symptoms. It is unusual for severely affected babies to survive the first month, and those who do usually have irreversible mental retardation. Rapid diagnosis and treatment are major factors in survival and mental development. Therapy consists of a special diet that requires frequent monitoring and must be continued indefinitely.

7. **Galactosemia.** Incidence: One baby in 50,000. Affected babies are missing the liver enzyme needed to convert galactose, a major sugar found in milk, into glucose, another simple sugar that the body can use. Galactose then accumulates in and damages the vital organs, leading to blindness, severe mental retardation, infection, and death. Milk and other dairy products must be eliminated from the baby's diet.

8. **Homocystinuria.** Incidence: One baby in 275,000. A rare deficiency in the enzyme responsible for converting the amino acid homocysteine into cystathionine, which is needed by the brain for normal development. If undetected and untreated, homocystinuria leads to mental retardation, eye problems, skeletal abnormalities, and stroke. Treatment consists of a special diet, which for many patients includes high doses of vitamin $B_6$ or $B_{12}$, although treatment is not completely effective.

9. **Sickle cell anemia.** Incidence: One baby in 400 among African-Americans; One baby in 1,000 to 30,000 among Hispanics (depending on the region of the United States); less common among babies with other ethnic backgrounds. This is a blood disease that can cause severe pain, damage to the vital organs, stroke, and sometimes death in childhood. Young children with sickle cell anemia are

prone especially to dangerous bacterial infections such as pneumonia and meningitis. Vigilant medical care and treatment with penicillin, beginning in infancy, can dramatically reduce the risk of these adverse effects and the deaths that result from them.

### Hearing impairment

Incidence: One to three babies per 1,000 in well-baby nursery; two to four per 100 in neonatal intensive care.

Significant hearing impairment is one of the most common developmental abnormalities present at birth.

Undetected, the condition will impede speech, language, and cognitive development.

The March of Dimes supports newborn hearing screening for every baby in every state because of the potential benefits, but is concerned about the current level of technology and intervention.

### Screening, follow-up

Implementation of universal newborn hearing screening should occur only where adequate provisions are made to avoid oversight, ensure quality, and provide the necessary follow-up.

Even so, parents need to be alert throughout childhood for hearing impairment.

*(For more information about the screening tests or the organization, go to the March of Dimes web site at: www.marchofdimes.com.)* ■

## *Should MCOs get the Medicaid drug rebate?*

A report of the pros and cons of extending the federal Medicaid drug rebate to managed care plans shows the potential for savings of up to $700 million over 10 years, but also recognizes that there could be some downside risk to plans and each one would have to evaluate the advantages and disadvantages of having access to the rebate if the rules were changed.

Prepared by the Lewin Group for the Association of Health Center Affiliated Health Plans and the National Association of Urban-Based HMOs, the report concludes that while significant savings are possible if the current Medicaid rebate given to fee-for-service state programs is extended to Medicaid managed care plans, "there are a number of factors that could limit the level of savings that occurs, chief among them the almost certain reaction of the pharmaceutical industry. At best, the industry's crusade would delay the implementation of any policy change and consume state and Medicaid MCO time and resources and, at worst, succeed in preventing such a policy shift altogether."

The report also says that while the trade-offs may not be as significant as once thought, Medicaid MCOs stand to jeopardize some of their successes in managing the pharmacy benefit — for example, they may have to give up effective relationships with their pharmacy benefits managers for their Medicaid lines of business, wait longer to receive rebates, or incur new administrative costs.

"For some MCOs," the report candidly says, "the potential benefit may outweigh the potential cost."

Other MCOs, however, may conclude that rebates are a low priority in their efforts to control drug costs and may find that resources could be better spent in areas other than extension of the federal rebate.

### Environment has changed

"When the drug rebate program was instituted in 1990," says Association for Health Center Affiliated Health Plans executive director Margaret Murray, "less than 10% of all Medicaid beneficiaries received their drugs through Medicaid managed care. Today the situation is very different. [More than] a third of all Medicaid beneficiaries receive their drugs through Medicaid managed care, yet the government does not get to benefit from the higher rebates."

Included in the Omnibus Budget Reconciliation Act of 1990, the Medicaid drug rebate program is intended to tap Medicaid's purchasing power by giving the program the same types of volume discounts generally afforded to other large purchasers of health care services. Under the program, drug manufacturers must have a signed agreement with the Secretary of Health and Human Services for payment to be made for Medicaid-covered outpatient drugs.

In exchange for getting the Medicaid "best price," state Medicaid fee-for-service programs must maintain a relatively open drug list. With the exception of a few drugs or classes of drugs that can be excluded from coverage altogether (such as



barbiturates, agents used for anorexia, weight loss, or weight gain), states that include outpatient drugs in their Medicaid benefit package (and all states plus the District of Columbia do include them) must provide coverage of all Food and Drug Administration-approved drugs made by companies that have signed a rebate agreement.

The Omnibus Budget Reconciliation Act of 1993 amended the law to allow states to create a formulary if: 1) it was developed by a committee of physicians, pharmacists, and other appropriate individuals; 2) it limits coverage of an outpatient drug only if it does not have a significant clinically meaningful therapeutic advantage in terms of safety, effectiveness, or clinical outcome over other drugs in the formulary; and 3) the state permits coverage of an excluded drug pursuant to a prior authorization program.

Although states cannot take the "closed formulary" approach usually followed by private insurers, they can take other steps to pharmacy benefit management, including prior authorization requirements, often in conjunction with preferred drug lists, mandatory generic substitution, step therapy, or as a standalone utilization control mechanism; quantity limits; generic substitution; step therapy; and patient cost-sharing.

The Lewin researchers say that while these techniques theoretically have been available to states for many years, they only have recently begun to implement them in large scale and/or groundbreaking ways. The drug companies have challenged some, with the final outcome not yet known.

An earlier Lewin Group study analyzed differences among pharmacy costs, drug mix, and utilization in the capitated Medicaid MCO setting vs. fee-for-service Medicaid. That study demonstrated that the approaches taken by the Medicaid managed care companies in the drug cost area have been highly effective in containing costs when contrasted with the fee-for-service environment.

"Even though the Medicaid MCOs are at an ingredient price disadvantage of approximately 15 percentage points as a result of the larger rebates available to [fee-for-services] FFS Medicaid," the researchers said, "they generally are managing the mix and usage of prescription medications such that overall TANF [Temporary Assistance for Needy Families] per member per month costs of the pharmacy benefit are 10% to 15% lower in the capitated [Medicaid MCO] setting than in FFS Medicaid."

### How useful would rebate be?

The latest report looks at the fundamental question of whether Medicaid MCO participation in the federal rebate program would create cost advantages that would be entirely additive, or whether there would be trade-offs and/or mitigating factors associated with such participation, and identifies five key factors likely to affect the impact of a change in federal rebate policy: potential restrictions on Medicaid MCO utilization and cost-management approaches; timing of rebates (Would they come more slowly with a rebate program?); MCOs' relationships with their pharmacy benefits managers that could change and lead to increased costs; pharmaceutical industry reaction; and dynamics of capitation rate development and its potential impact on sharing of savings between MCOs and states.

The Lewin Group sees two scenarios that are most likely in terms of drug company reaction. First, the industry could argue that companies agreed to a certain level of rebates based on the size of the population for whom the rebates would apply and would likely push for a lower rebate percentage if the law was changed to broaden the size of the rebate population. The researchers say counterarguments can be made that the number of capitated

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

enrollees has grown substantially and that changes in welfare rules have reduced the number of persons to whom rebates apply.

"If the pharmaceutical industry is unsuccessful in recouping its additional rebates through the above approach, the industry could raise prices more sharply for all payers than would otherwise be the case. In effect, this would create a 'cost-shift' to the private sector. Such an approach would reduce or eliminate any systemwide savings, but would still create sizeable savings for the Medicaid program," researchers say.

### Savings vary by scenario

Applying a number of different scenarios for calculating savings, the Lewin report says that even under the most conservative assumptions regarding capitated pharmacy penetration, annual savings start at approximately $50 million in the first year and grow to almost $150 million in year 10, for a cumulative savings of more than $900 million over the 10 years. The most aggressive assumptions result in cumulative savings of almost $2 billion over 10 years.

"While it is impossible to know which of these scenarios will play out, the 'mid' scenario represents Lewin's best estimate of the degree to which Medicaid pharmacy costs will be capitated," the report says.

"This scenario is based on a growth in capitated pharmacy penetration over the next 10 years from approximately 32% to 55% for TANF, and from 13% to 25% for Social Security Income. The annual savings generated in this scenario grow to $267 billion by year 10, with cumulative savings of $1.4 billion."

Ms. Murray tells *State Health Watch* that while there are pros and cons to extending the rebate, as outlined in the Lewin report, her association is in favor of making it available on a voluntary basis so plans could decide if it would be beneficial for them.

"Our support was announced at our recent meeting, and we're now trying to find someone in Congress who will champion it for us and will introduce legislation for a voluntary rebate program," she adds.

*[Contact Lewin Group at (703) 269-5500 and Margaret Murray at (202) 331-4600.]* ■



# *Clip files / Local news from the states*

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

### Health aid for poor is facing cuts

ATLANTA—Faced with a deficit of nearly $1.5 billion over the next two years and calls for $180 million in state budget cuts, Georgia health officials are having to consider the once unthinkable: slashing enrollment and optional services the poor have long counted on.

Tim Burgess, commissioner of the Department of Community Health, told his governing board that he has been given an extra month to figure out how to make spending cuts in a program already facing a massive deficit.

Mr. Burgess said officials must decide what kind of health care the state can afford to provide to the 1.3 million Georgians covered by state medical programs. "Nothing should be off the table for consideration," he said. "We're not just nibbling at the edges right now." Talk of limiting enrollment and cutting services worries advocates for the poor, who have been fighting political battles against such proposals for years.

The Department of Community Health started FY 2004, which began July 1, in the hole, because lawmakers took almost $150 million out of its budget at the last minute to balance the state spending plan. The latest estimate is that Medicaid and PeachCare, a health insurance program for poor and middle-income children, will run a $493 million deficit this year, including $190 million in state funds.

The programs run on state and federal money. In FY 2005, which begins July 1, 2004, the deficit is projected to be $1 billion, including $405 million in state funds. In addition, the department, like other agencies, must meet Gov. Sonny Perdue's call to cut 2.5% this year and 5% next year. That amounts to $100 million, including $40 million in state funds, for FY 2004, and $354 million, with $144 million of it in state funds, next year.

—*Atlanta Journal & Constitution*, Sept. 12, 2003