State Health Watch

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THOMSON AMERICAN HEALTH CONSULTANTS

This growth not necessarily good: Medicaid set to trump education

State spending on Medicaid is poised to surpass the percentage spent on elementary and secondary education, according to a new report from the National Association of State Budget Officers (NASBO) and the National Governors Association (NGA).

Between FY 2002 and FY 2003, Medicaid increased by 8%, the NASBO report said, while total state spending, including mandated federal programs, increased by only 4.5% and discretionary state spending grew by just 1.4%.

When NASBO first started doing its state expenditure surveys in 1987, Medicaid accounted for barely 10% of state budgets, while education spending held steady at 23%. In FY 2003, Medicaid accounted for 21.4% of all state spending, nearly as much as the 21.7% devoted to elementary and secondary education.

"Since Medicaid is a federal entitlement and education is discretionary, Medicaid will trump education going forward," said NGA executive director Raymond Scheppach.

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Managed care results in improvements in access and preventive care, as well as savings

Fiscal Fitness: How States Cope

A synthesis of 14 research studies by the Lewin Group for America's Health Insurance Plans (AHIP) indicates that Medicaid managed care provides significant cost savings and high-quality medical care.

"Since the early 1990s, many state Medicaid programs have turned increasingly to managed care to improve the quality of and access to care and to contain costs," noted AHIP president Karen Ignani. "This report demonstrates how our members are fulfilling these expectations. The report provides tangible evidence that Medicaid managed care is getting results for states and the beneficiaries they serve. It also shows there is a tremendous opportunity for future growth in this important public-private partnership as more states look to Medicaid managed care plans to meet more of their health care needs."

The report said the studies "present compelling evidence that Medicaid managed care programs

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Medicaid

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NASBO reported that Medicaid continued to grow robustly. "Medicaid is crowding out other parts of state budgets," said NASBO executive director Scott Pattison. "Medicaid's unsustainable pace of growth means that over both the short and long terms, states must find some source of relief. Other state functions are certainly being impacted."

Even with extensive cost containment efforts and last year's temporary federal fiscal relief, states' Medicaid expenditures have exceeded the amounts originally budgeted, with 23 states experiencing Medicaid shortfalls in FY 2003 and 18 states projected to experience shortfalls in 2004. The combined amount of the shortfalls is projected to be $7 billion.

For actual FY 2003, the pieces of the total budget pie were K-12 education, 21.7%; Medicaid, 21.4%; higher education, 10.8%; transportation, 8.2%; corrections, 3.5%; and public assistance, 2.2%. Spending on all other state functions — including information technology, parks and recreation, state police, and aid to local governments — totaled 32.2% of total state expenditures.

Meanwhile, the Kaiser Commission on Medicaid and the Uninsured's fourth consecutive survey of state Medicaid officials about their Medicaid spending growth and cost containment plans indicated a mix of good and bad news for states as they completed FY 2004 and entered FY 2005.

Although the revenue situation in many states has started to improve, the report said, states continue under severe pressure from Medicaid. Key findings in the survey included:

- Despite severe fiscal stress, Medicaid enrollment grew by nearly one-third since the beginning of 2001 as the program maintained its role as a critical safety net for low-income populations.
- Medicaid spending in FY 2003 and FY 2004 grew faster than other state programs, but slower than growth in private health insurance premiums.
- Responding to pressure to control Medicaid costs, all 50 states and the District of Columbia implemented actions designed to control Medicaid spending growth in FY 2004, and all states planned to implement cost-containment measures in FY 2005.
- Federal fiscal relief helped states meet Medicaid shortfalls in FY 2004 and helped to maintain Medicaid eligibility levels; however, states are expecting sharp increases in the state share of Medicaid costs in FY 2005 as they replace the loss of the enhanced federal support.
- Implementation of the Medicare prescription drug benefit will generate significant fiscal and administrative challenges for state Medicaid programs, and only three states reported they have allocated resources to FY 2005 to meet these challenges.
- States are approaching FY 2005 with caution. While revenues are improving overall, many states still face budget shortfalls, and pressure to control Medicaid spending growth will continue.

In a public policy briefing on the Kaiser survey, commission executive director Diane Rowland said that what happens to Medicaid has a direct relationship with the national debate over the uninsured (**see box, p. 4**) and the release of census data indicating that the

number of uninsured has climbed to nearly 45 million people on any given day in 2003, an increase of about 5.1 million uninsured since 2000.

"If we look at what's been changing in health insurance coverage, we see a steady erosion of the percent of the population who gets their coverage through employer-sponsored coverage and a growth in those who are now dependent on Medicaid and its companion program, the State Children's Health Insurance Program [SCHIP], for coverage," she said. "The percent of people with employer-based coverage has dropped to 64%, while the number with Medicaid and SCHIP has risen to 11% in the period from 2000 to 2003."

Key survey findings

Vern Smith, whose Health Management Associates conducted the state survey for Kaiser, said three key survey findings were:

1. Medicaid enrollment continued to increase fairly dramatically over the last few years, responding to the economic downturn, increase in the number of people in poverty, and the increased number of people without health insurance.
2. States have used broad-based strategies to respond to the cost pressure increases.
3. The pressure on Medicaid continues to be unrelenting.

Medicaid directors told Mr. Smith that last year Medicaid spending increased in total in terms of payments to providers and dollars spent by 9.5%, almost exactly the same growth rate as in 2003. "This is a very high rate of growth in any spending category in state budgets, especially over the last couple of years," he said. "It is somewhat less than the rate of growth that occurred in the previous two or three years, but still a very significant rate."

According to the Medicaid officials interviewed, the most significant drivers of Medicaid cost growth are increases in the number of beneficiaries, increases in the cost of prescription drugs, and increases in the cost of medical services in general.

From 2001 through 2004, overall Medicaid enrollment increased by one-third, described by Mr. Smith as a very large rate of growth. The rate of enrollment growth projected for FY 2005 was 4.7%, and the expectation was expressed that the number of people served by the program will continue to grow.

States are most concerned about their own program costs when they make decisions about Medicaid, Mr. Smith says, and those numbers can be misleading this year. Thus, in 2004, the state cost of Medicaid spending increased by 4.8%, much less than the 9.5% in overall Medicaid spending increases that occurred that year. The reason, of course, is that in 2004, states benefited from a temporary enhanced federal matching rate provided by Congress in May 2003 as part of the fiscal relief package.

That state increase of 4.8% seems reasonable in the context of all that was happening until people realize that total state spending for all programs, including Medicaid, increased just 2.8%. "So Medicaid grew even with the enhanced federal matching about two-thirds faster than other programs in state government," Mr. Smith said. Because the enhanced federal match ended June 30, 2004, states entered FY 2005 without that extra boost and are seeing dramatically large increases in state share of Medicaid spending for 2005. "Based on initial appropriations, state legislatures authorized increases in states' share of Medicaid growth of 11.7%, against overall state program growth of 2.8%, so Medicaid is authorized to grow about four times faster than other state programs," Mr. Smith declared.

Officials in 30 states told Mr. Smith there was at least a 50-50 chance their state would experience a Medicaid shortfall in FY 2005, he said. A glimmer of hope, he said, is that last year 34 states said they expected a shortfall. "But the bottom line is that even with all of the actions that states have taken over the last several years, Medicaid spending growth far exceeded the growth in state revenues," Mr. Smith concluded. He also found that even with some of the positive things that are happening in states, directors in 39 states said the pressures on their programs were actually increasing, while directors in 12 states said the pressures would remain about the same.

"Not one state in the country said that the pressures on the program were subsiding," he said. "State officials cited a number of reasons why the pressure was increasing. Foremost was a continuing pressure coming from legislators and state budget directors to control the rate of growth in Medicaid spending. As one Medicaid director said, 'There are no rabbits left in our hat and they're still looking for new ways to control the rate of growth in spending.' Secondly, states have become very much aware of their responsibilities associated with the new Medicare prescription drug benefit. . . . Third, states mentioned increasing pressure from the Centers for Medicare & Medicaid Services involving increased fiscal scrutiny. Fourth, there is concern about the increasing number of people in poverty and the increasing number of people without health coverage. . . . And finally, people are beginning to talk about demographics and its impact on

Medicaid. A number of states said that they're already seeing increases in elderly and disabled enrollment in their program, and that's having an impact on their spending."

Center on Budget and Policy Priorities analyst Donna Cohen-Ross gave results from a survey covering April 2003 to July 2004, when nearly half the states made it harder for eligible children and families to secure and retain coverage through imposition of financial barriers such as premiums and procedural barriers as well as enrollment freezes. Ms. Cohen-Ross said most of the changes occurred in the SCHIP program rather than in Medicaid because states have more flexibility to modify SCHIP.

She reported that 33 states now have premiums or enrollment fees in children's health coverage programs, with 16 states imposing or increasing premiums or targeting them to families at lower income levels during the survey period, making it harder for families to afford health coverage, particularly lower income families.

Also, eight states froze enrollment for children's health coverage for some portion of the survey period. At the time of the briefing, only Florida, Idaho, and Utah still had a freeze in effect. To compound the problem, she said, states that implemented freezes also dropped waiting lists, making it impossible to determine the potential demand for the program and how many children are eligible but can't get into the program.

While some states adopted new administrative simplification procedures, others retracted some procedures that had been found to be very effective. Thus, Ms. Cohen-Ross said there has been a decline in use of 12-month continuous eligibility and reduced verification.

She cited examples from Ohio, in which administrative simplification coincided with a marked increase in enrollment, and Washington, where simplification, including 12-month continuous eligibility, self-declaration of income, and other things was retracted and there has been a drop of more than 40,000 children in the caseload.

Also surveyed was parent coverage, and Ms. Cohen-Ross reported that expanding eligibility for parents still lags behind work that's been done to expand coverage for children in about half the states.

She gave credit to Illinois, which moved forward despite fiscal worries, expanding eligibility in the SCHIP program, increasing coverage to 200% of the federal poverty level in children, and increasing parent coverage in a two-stage process so parents are covered if their income is at or below 133% of the federal poverty line. This year, she said, Illinois adopted new simplifications, reduced some income verification requirements, adopted presumptive eligibility for children, and continued to conduct outreach to support and recruit new community-based application assistance agents.

"We did everything that we were asked to do. We expanded coverage, and we conducted outreach. We're still committed to that, but the bottom line for us is we need the resources to continue to pay the cost of coverage for the kids currently on our program and any new kids that may come in. It's very difficult to invest in outreach when you're so constrained in terms of what you have to cover the cost of the coverage itself," Ms. Cohen-Ross added.

[To see the NASBO report, go to www.nasbo.org. For the Kaiser Commission report, go to http://kff.org. Contact Mr. Scheppach at (202) 624-5300; Mr. Pattison at (202) 624-5382; Ms. Rowland at (202) 347-5270; Mr. Smith at (517) 482-0920; and Ms. Cohen-Ross at (202) 408-1080.] ■

The number of uninsured is up, and employment-based coverage is down

Analyzing data from the U.S. Census Bureau's March 2004 Current Population Survey, the Employee Benefit Research Institute (EBRI) said in a report that among all Americans, 60.4% (174 million people) were covered by employment-based health benefits during 2003, down from 2000 when 63.6% of the population was covered by employment-based benefits. EBRI says this continues a trend that started between 2000 and 2001, before which the percentage of Americans covered by employment-based health benefits had been increasing since 1994.

"The decline in employment-based health benefits can be attributed to a decline in the percentage of both workers and nonworkers with health insurance coverage," EBRI explained. The decline was coupled with an increase in the number and percentage of Americans without any health insurance coverage. EBRI said these trends are the result of a weak labor market and rising health benefit costs. Children, working family heads, other workers, and nonworkers were all more likely to have employment-based health coverage than any other type of coverage, either public or private. Individuals whose family head did not work were more likely to be covered by public programs, or to be uninsured, than to have employment-based health insurance. EBRI said these trends can be expected to continue as long as the labor market remains weak and the cost of providing health benefits continues to increase.

(To see the EBRI report, go to www.ebri.org.) ■

Fiscal Fitness

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can yield savings. The studies also suggest that certain populations or services are especially likely to generate savings in a managed care delivery system."

Specific findings presented by the Lewin Group include:

- Studies strongly suggest that Medicaid managed care typically yields cost savings ranging from 2% to 19%.
- Studies provide some evidence that Medicaid managed care savings could be significant for the Supplemental Security Income (SSI) and SSI-related population.
- Studies demonstrate that states' Medicaid managed care cost savings largely are attributable to cuts in inpatient utilization.
- Studies indicate pharmacy is an area where Medicaid managed care programs yield noteworthy savings.

According to Lewin Group analysts, there still is substantial opportunity for states to expand Medicaid enrollment in managed care plans. They note that according to the Centers for Medicare & Medicaid Services, 59% of the Medicaid population is enrolled in managed care. Of the Medicaid managed care population, 66% are in comprehensive, prepaid managed care plans. Thus, the report said, approximately 39% of all Medicaid enrollees are in prepaid managed care plans.

"A number of states, though, have carved out some of the highest-cost services from their managed care programs," the report explained, "and most states have excluded some entire eligibility categories — generally the high-cost disabled populations — from their managed care initiatives. As a result, while prepaid managed care plans provide health care services to almost half of Medicaid beneficiaries nationwide, 88% of national Medicaid spending remains in the fee-for-service system where coordination of care is the exception rather than the rule."

With states continuing to face budget pressures, the analysts said, there is interest in assessing whether Medicaid managed care expansion might ease the fiscal pressures less painfully than alternatives such as cutting eligibility, eliminating benefits, or reducing already low provider payments.

Structural means to save money

According to the Lewin Group study, savings opportunities in Medicaid managed care largely are created by the inherent structural challenges of coordinating care and containing costs in the fee-for-service setting. "The fee-for-service model is an unstructured system of care that creates incentives to provide as many services as possible, while doing little to encourage providers to manage the mix and volume of services effectively," the report noted. "Managed care organizations, on the other hand, combine within one entity the responsibility for both the financing and delivery of health care and thus have strong incentives and means to coordinate care and, in turn, reduce the costs of inpatient and other expensive categories of health care services, where Medicaid spending is concentrated."

While states often have turned to provider payment cuts for savings in fee for service, the Lewin Group explained such a strategy risks driving mainstream physicians out of the Medicaid program, impeding Medicaid beneficiaries' access to primary and preventive care services, and funneling Medicaid care toward more expensive institutional-based services.

In contrast, Medicaid managed care can achieve savings through a number of mechanisms including improving access to preventive and primary health care by requiring participating doctors and hospitals to meet standards for hours of operation, availability of services, and acceptance of new patients; investing in enrollee outreach and education incentives to promote utilization of preventive services and healthy behaviors; providing a medical home for individuals and using a physician's expertise to refer patients to the appropriate place in the system rather than relying on patients' ability to self-refer; providing individualized case management services and disease management services; channeling care to providers who practice cost-effectively; using lower-cost services and products where available and clinically appropriate; and conducting provider profiling and enhancing provider accountability for quality and cost-effectiveness.

But the Lewin Group compilation also identified some factors that work against the ability to achieve Medicaid savings, including:

- **Transitory enrollment.** The Lewin Group said there is volatile eligibility in the Transitional Assistance to Needy Families (TANF) population. Most Medicaid managed care enrollees are TANF recipients and, by definition, have short-term enrollment duration. The Lewin Group said this poses a substantial administrative burden in continually processing a large volume of enrollments and disenrollments.
- **Poverty-related enrollee characteristics.** Barriers to health care related to Medicaid recipients' impoverished status include low educational attainment, language and literacy barriers, homelessness, lack of reliable transportation, and inadequate child-care options. Such barriers can challenge the efforts of managed care

organizations to manage and coordinate enrollee care and often require them to make additional investments to accomplish their goals.

- **Prescription drug rebates.** Drug manufacturers participating in the Medicaid Drug Rebate Program provide quarterly rebates to states for drugs dispensed to Medicaid recipients. These rebates result in best price to Medicaid. But as private purchasers, Medicaid managed care plans aren't entitled to the rebates and must enter into separate negotiations with drug manufacturers either directly or through their contracting pharmacy benefits manager.
- **Rural barriers.** Rural settings can pose daunting challenges to managed care in Medicaid and other payers, the report explained. The limited number of providers can make it difficult to assemble a network, and the market may be unable to provide the economies of scale achievable in more metropolitan areas.
- **Limited price discount strategies.** While managed care organizations outside of Medicaid are able to negotiate price discounts, they generally are not available to Medicaid plans. The Lewin Group report said that given the low levels of Medicaid participation among physicians, it is not realistic or appropriate from a network development perspective to drive down Medicaid prices. Savings thus have to come from truly managing care rather than managing price.
- **Capitation rate setting.** An overarching issue that determines the level of Medicaid savings that can be achieved through a capitation model is the capitation rates themselves, the report noted. It is not an automatic process for states to pay a capitation rate that builds in savings and also is sufficient to cover managed care organizations' medical costs, administrative costs, and profit/operating margin needs. Capitation rates set unnecessarily high can result in states having greater expenditures under their managed care program than in fee-for-service, while rates set too low will make it difficult to attract or retain health plans and could violate federal requirements for actuarially sound rates.

The report said the 14 studies provided some evidence that Medicaid managed care savings could be significant for the SSI and SSI-related population because they typically are high users of services and are the most costly group to cover. In some states, most of overall Medicaid managed care savings achieved is attributable to this population.

Thus, in Arizona, 60% of the $102.8 million saved from 1983 to 1991 was from the SSI population, while in a Kentucky region, the SSI population made up 25% to 34% of total enrollment and accounted for 53% to 61% of savings from 1999 to 2003.

States also demonstrated that cost savings largely are attributable to decreases in inpatient utilization. A study of preventable hospitalizations in California found that the TANF and TANF-related population had 38% lower rates of preventable hospitalizations, saving the state an estimated $66 million between 1994 and 1999. The SSI and SSI-related population had 25% lower rates of preventable hospitalizations.

Pharmacy also was an area in which noteworthy savings were seen. A Center for Health Care Strategies comparison of fee-for-service and Medicaid managed care drug costs in 2001 found that the per-person-per-month cost of drugs in a capitated setting was 10% to 15% lower than in a fee-for-service setting, even after considering the larger rebates state agencies receive under fee for service.

Access improved generally

While access to care and quality under Medicaid managed care were not the main focal points of the Lewin Group review of research, the studies yielded some information on access and quality data. In most cases, the report said, Medicaid managed care programs have improved Medicaid beneficiaries' access to services, and both the programs and individual managed care organizations have earned high satisfaction ratings from enrollees.

In Wisconsin, for example, HMO members are more likely to have at least one primary care physician visit than those in fee for service.

Policy implications the Lewin Group gleaned from the studies include recommendations that states consider including the SSI and SSI-related population in a managed care program and states with managed care programs that have carved out prescription drugs consider revisiting that decision, since capitating the pharmacy benefit may reduce costs more than are offset by rebates available to carved out programs.

The Lewin Group report concluded that there have been instances where states have not achieved savings from their Medicaid managed care program in a given year, and other instances where health plans have left the program. "There is obviously always going to be a point below which the state's managed care payment rates are no longer viable for managed care organizations," the authors said.

"However, the preponderance of the research evidence is that prepaid managed care partnerships between state Medicaid agencies and managed care organizations can produce a substantial program cost savings without forcing the health plans to operate at a financial loss.

"The federal requirement for actuarially sound rates is a critical building block for a successful program. As states consider expanding their Medicaid managed care programs and as other states implement new Medicaid managed care programs, they may wish to include certain populations and services that have often been excluded from Medicaid managed care due to quality and access to care concerns."

Plans for difficult populations

Two plans that have succeeded in serving difficult populations are AmeriHealth Mercy Health Plan and Amerigroup. The Lewin Group cited units of both organizations as models of how plans can cover the SSI and SSI-related populations.

Medicaid managed care for AmeriHealth Mercy's Passport Health Plan SSI population made up 25% to 34% of total enrollment and accounted for 53% to 61% of savings achieved from 1999 to 2003. Other studies have shown that since its inception, Passport has demonstrated more than $10 million in cost savings for the Commonwealth of Kentucky.

"The results from the AHIP report clearly support what we have always believed — that managed care works in Medicaid," says AmeriHealth Mercy president Daniel Hilferty.

"Like the numerous success stories of the plans in the report, AmeriHealth Mercy and its family of companies have demonstrated their value for more than 20 years by giving Medicaid recipients access to the health care system, providing preventive care, offering case management and disease management programs, supporting community health initiatives, and saving taxpayer money at the same time."

Mr. Hilferty tells *State Health Watch* that his organization has been a Medicaid-only managed care plan since its founding by a group of inner-city hospitals. "We've developed expertise in managing the care of this population," he says.

What AmeriHealth Mercy has learned, according to Mr. Hilferty, is to use capitated payments to develop a structure for a modest margin financially and then at the same time improve quality and access to care.

"We're able to help states that are in a fiscal crunch with their fee-for-service program going out of control," he adds.

AmeriHealth Mercy plans in Kentucky and Pennsylvania provide managed care services to the SSI population and Mr. Hilferty says it has enabled them to put very sick individuals into a system of care with access to a primary care physician, specialists, and everything else that is needed for their care so that care is managed for the highest quality with the lowest cost.

Asked how patient advocates have responded, Mr. Hilferty says that traditionally advocates have resisted managed care models. "We've learned that in dealing with advocates, parents, and others, we need to help them realize that the system in place provides a higher quality of care and access to better care," he says.

AmeriHealth Mercy makes good use of community outreach efforts and meetings with advocacy groups and parents and guardians to listen to their concerns and explain how the plan addresses them.

"This is not the traditional Medicaid population that is largely poor and has other cultural and social issues," Mr. Hilferty explains.

"These often are children of people who have access to commercial health insurance care. They've been thrown into a system that is bureaucratic and run by the government, but they expect it to be the same as what they have," he noted. "Their comfort level with us develops over time through dialog, but there certainly are still issues. However, we don't see the large level of concern any more."

Mr. Hilferty says there continues to be an undercurrent of anti-managed care sentiment, often because people's sense is that too often care is managed by denying care.

"We've found that just doesn't work," he says. "We need to coordinate care and collaborate with providers. We have to be better promoters of our success stories so people understand that this is the right way to manage care for those in need."

In Texas, the report said, Amerigroup's Star+Plus program is targeted to the urban SSI population of Harris County. Assessments of the program reviewed by the Lewin Group indicate that the enrollment of the population into Medicaid managed care has yielded savings and that the level of savings has grown over time. Savings during the first waiver period (February 1998 to January 2000) was $6.05 million or $4.11 per member per month, while in the second waiver period (September 1999 to August 2002) it was $123 million or $91.67 per member per month.

Star+Plus president Aileen McCormick tells *State Health Watch* that care coordination for the SSI population is very different from that used with traditional

Medicaid populations, and the nuances in care require different types of plan associates and not solely RN case managers.

New care model needed

"We need social workers and long-term care coordinators," Ms. McCormick notes. "We're working with psychosocial needs that go well beyond the traditional medical needs. In fact, we have to address the psychosocial issues before we can address the clinical issues. This a real psychosocial model rather than a medical model and we have to truly understand the nature of the people we are working with."

It's not always easy for the plan to find the resources it needs, Ms. McCormick says. They need to reach out to home health agencies and other sources of professionals who are used to going into homes and providing hands-on work.

But while serving the SSI population requires intensified resource utilization, she says they have found that if they can ensure that patients have the basics and comply with the other elements of the care plan, they will have more of a chance of remaining ambulatory and staying out of the hospital, meaning that overall costs will be lower.

"It takes a lot of money up front and a lot of outreach to really make a difference so that patients remain ambulatory," Ms. McCormick says.

She says Star+Plus patient satisfaction scores are high, sometimes driven by how satisfied long-term care providers are.

"We have made great strides [to bring long-term care providers in as partners], but we can still do more," she says, noting that sometimes when aides voice problems, it will affect member satisfaction. "There's been a learning curve, even for us, but we've now got it."

Medicaid managed care for the SSI population will be expanding into other Texas communities and Ms. McCormick says Star+Plus is developing networks outside of Harris County to be ready for the expansion.

"It's easier for us to deal with expansion," she says. "We've gotten over the learning curve, and we don't have to make the same mistakes again."

Pharmacy is politically sensitive

With the Lewin Group report recommending that plans consider not carving out pharmacy, Ms. McCormick says there have been preliminary discussions with Texas officials on what is a politically sensitive issue. "We have pharmacy risk in our other models, and we think it would be in the state's best interests to put that risk with us," she explains.

Mr. Hilferty says AmeriHealth Mercy's PerformRx pharmacy management program serves nearly 900,000 members in five states and has demonstrated the kinds of savings the report suggested are possible by maintaining an average pharmacy cost trend of 8%, contrasted with a national trend of 15% in the Medicaid sector.

For other plans considering moving on the Lewin Group report's recommendation to expand managed care to SSI recipients, Ms. McCormick offers the following suggestions:

1. Don't have stars in your eyes, and understand how sick SSI patients are so you realize you will spend a lot of money on medical care.
2. Staffing ratios are much higher with SSI patients than with other populations.
3. SSI patients require a different care management system rather than the typical case management on-line tool.
4. Recognize that you will feel more like a social and outreach agency than a medical management department and accept the positive aspects of that difference — that you are touching patients and improving their lives.
5. Don't underestimate the need to work with advocates, building trust so they accept that your plan is in this business for the right reasons.

[The Lewin Group report is available on-line at www.ahip.org. Contact Mr. Hilferty through www.amerihealthmercy.com. Contact Ms. McCormick at (713) 218-5101.] ■

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

States play a role in eliminating health disparities

While federal efforts are under way to reduce racial and ethnic health disparities, states also have a significant role to play, governors, legislatures, and agencies may not know where or how to start. Researchers from Harvard University, under contract to the Commonwealth Fund, have produced a state policy agenda that gives policy-makers a menu of interventions that have been implemented in various states to address disparities in minority health and health care.

Harvard School of Public Health professor Brian Gibbs, who directs the Program to Eliminate Health Disparities in the Division of Public Health Practice there, tells *State Health Watch* that health disparities have not been at the forefront of policy-maker concern, and it is important to understand the significant differences in which groups fare better in terms of reduction in death rates for some diseases and improvement in quality of life. He says a recent report from the Institute of Medicine looked at a deeper level to help appreciate the disparities in health care, and says there has been more scrutiny at the federal level than at the state level.

"The agenda we produced is one small effort to probe the gap in health care for states," Mr. Gibbs says. "It's not necessarily a blueprint, but some suggestions on how policy-makers can frame an agenda for their state."

Janet Scott-Harris, one of the researchers who is a W.K. Kellogg Fellow in Health Policy Research at the Heller Graduate School of Brandeis University, says the authors want to give policy-makers different avenues with which to serve their constituents. "They can target disease-specific areas if they want, work force development, capacity, or infrastructure," she says.

The report noted that a national strategy to achieve a public health goal most often requires state involvement. While many states now sponsor specific health programs to help members of racial and ethnic minorities (**see story, p. 10**), health disparities as such have not been a high-level issue. Key programs cited in two areas of concern include:

- **State infrastructure and capacity.** Efforts can include standards tailored to community needs for cultural and linguistic competency; data collection and analysis; support of home- and community-based services for the elderly; insurance coverage for the more than 50% of U.S. uninsured who belong to racial and ethnic minorities; primary care access through community health centers and other means; use of state purchasing power to require data collection and reporting; influencing professionals, institutions, and health plans through licensure and regulatory requirements; development of state infrastructure and resources; and work force development to increase the number of minority health care professionals.
- **Health conditions.** Comprehensive state programs can address issues in asthma, cancer, cardiovascular disease, diabetes, HIV/AIDS, immunizations, infant mortality, injury prevention, mental health, obesity, physical activity, tobacco use, and oral health.

The authors say eight key needs arise for state policy-makers, and those who seek to develop omnibus or multifaceted legislation to address disparities would do well to ensure that any proposal addresses these needs:

1. Better and more consistent data collection. The report says major inadequacies in data collection hamper efforts within individual states and hinder efforts to understand differences among states. At the extreme, it says, some state surveillance systems still categorize all racial and ethnic groups as black or white only, rather than following the accepted national standard from the Office of Management and Budget for American Indian or Alaska Native; Asian; black or African American; Native Hawaiian or other Pacific Islander; white; and Hispanic or Latino. States should also collect and report health data on the racial and ethnic subgroups that reside there, and they should initiate strategies to identify gaps in available data for small population groups.
2. Effective program evaluation. While the researchers initially intended to collect best practices among state efforts, they say they abandoned that term for the more ambiguous "promising practices." Practices are identified as promising based on case studies and other reports, as well as recommendations by researchers, policy experts, and state officials. The authors say their inability to find best practices prompts the recommendation that researchers and public officials work together to evaluate effectiveness of disparities interventions and document and publicize those

programs and policies that yield positive results.

3. Emphasis on stronger cultural and linguistic competence in all disparities reduction activities.
4. Work force development programs and improvement to the cultural competence of all health care professionals.
5. Health screening and access.
6. Establishment of designated office, commission, council, or advisory panel on minority health.
7. Involvement of all health system stakeholders.
8. Creation of a national coordinating body to promote continuing state-based activities to eliminate racial and ethnic health disparities.

Listing the eight key needs makes sense, they say, because policy-makers have so much disparity information coming to them that they trouble identifying a place to start.

According to Amanda Navarro, a doctor of public health student at the University of Texas, there has been a lot of talk about health disparities, but people often don't know the statistics describing the magnitude of the problem. "Policy-makers are aware of public health problems in their communities," she tells *State Health Watch*. "This is a toolkit so they can look at specifics relating to the problems they see."

Mr. Gibbs says the researchers recognize that some readers might think there is too much information, while others might say it still is not specific enough. "We had to balance how to present a lot of information as cogently as possible and then give references for further research."

Providing resources for communities that are having dialogs on health disparities and don't know where to start allow them to focus on promising practices through which they can accomplish measurable outcomes, Ms. Scott-Harris adds.

The authors recognize there are necessary limitations to their work. she says they didn't bring in any social, economic, or political issues and don't want states to lose that context. They also don't want states to think that if they put a specific program in place it will solve their disparity problems, Ms. Scott-Harris says.

And there is concern because they were not able to devote much time in the report to historical aspects of how health disparities have persisted and the context of what has been done to date to try to overcome disparities. "The context is underlying as well as overarching," Mr. Gibbs says. "It extends to limited life chances that affect all groups, just in a different way."

Those who worked on the report are heartened that more than 30,000 copies have been downloaded, putting it among the top five documents in Commonwealth Fund publishing history. Discussions are under way on steps that could be taken to build on the report, recognizing that states often are looking for technical assistance as a follow-up. Interest has been expressed by the Centers for Disease Control and Prevention Reach 2010 program.

"The next steps will vary by state and where states find themselves," Mr. Gibbs says.

(To see the report, go to www.cmwf.org.) ■

Researchers say social and ethnic health disparities can be cut

"Research on racial and ethnic health disparities has greatly expanded in recent years, and the existence of disparities in health and health care cannot be denied." That's the view of a researcher who conducted a literature review in the *Archives of Pediatrics and Adolescent Medicine* and is quoted by Commonwealth Fund senior program officer Anne Beal in her September/October 2004 *Health Affairs* article on policies to reduce racial and ethnic disparities in child health and health care.

While there are many initiatives to address various aspects of health and health care disparities, Ms. Beal said, they are fragmented and would benefit from an oversight body based at the U.S. Department of Health and Human Services (HHS) that would monitor progress and coordinate efforts for eliminating disparities.

She cited problems with health care coverage, child health care, and health care providers in making her case for additional research and for federal oversight and monitoring.

Ms. Beal said that lack of health insurance is a major hindrance to accessing care, and racial differences in uninsurance are the first step in producing health care disparities by limiting access, regardless of the quality of care. Children without health coverage are less likely to have a regular doctor or to receive preventive care and are more likely to have unmet medical needs, she noted.

Given that in the current fiscal environment states can't provide coverage to all eligible children, Ms. Beal said providing coverage through Medicaid and SCHIP is the most feasible alternative to universal health care coverage. "If every child who was eligible for either

Medicaid or SCHIP was enrolled, coverage would be provided to 6.7 million children, 75% of those who are uninsured," she declared. "This would have a greater impact on health care for children of color because they are more likely than white children to be uninsured and to have had no regular source of care prior to SCHIP enrollment."

She said that although SCHIP expansions would raise that program's costs, further analyses are needed to determine the best methods for increasing enrollment and the degree to which increased costs attributable to higher enrollment would be offset by savings in uncompensated and emergency care.

Even when children of color have access to care, according to Ms. Beal, they may experience poor quality care, caused by bias and poor care delivered by individual providers, but also by poor quality in the health systems that serve children of color. Programs such as Medicaid typically reimburse providers at below-market rates, and most safety net health systems suffer from chronic underfunding and shortages in resources, making them less able than better funded health systems to provide high-quality care.

Ms. Beal suggested that quality improvement efforts within health systems serving children of color would reduce disparities to health care, which essentially are disparities in quality. Framing the issue in terms of quality has advantages, she said, in keeping focus on an issue that often is seen as separate from health care quality in general. "If the health care system is allowed to provide poor quality care to any segment of the pediatric population, then all children are at risk for receipt of such care," Ms. Beal wrote. "The child health care quality movement needs to identify and address threats to health care quality pertinent to children of color, to meet its goal of improving care for all children. Also, efforts to reduce disparities can use the language, tools, and methods developed to improve health care in general, applying them to care for children of color."

She discussed gaps in public settings, current policies and practices in Medicaid and SCHIP, current practices and policies in the safety net, gaps in private settings, and current practices and policies in private settings before recommending collecting data on patients' race and ethnicity combined with stratified reporting of quality measures by race and ethnicity. Ms. Beal said that if all currently accepted measures of quality were reported stratified by race and ethnicity, it would greatly expand the ability to monitor disparities in care and also would address the so-called disparity in disparities issue by linking improved ability to identify child health disparities with the growing ability to monitor quality of care for all children.

While many of those concerned about health care disparities focus on the need to improve the technical components of care, there also is a need to improve interpersonal aspects of care, improve cross-cultural interactions and communication, and increase patients' involvement, Ms. Beal said. "All providers must be trained to improve their cross-cultural interpersonal interactions to engage parents from all racial and ethnic backgrounds equally," she asserted. "At the same time, the racial and ethnic diversity of health care providers needs to be increased."

To help address these aspects, she suggested that one of the requirements for state medical license renewal could be participation in cultural competency training. And to improve the diversity of the health care work force, she suggested that communities with documented health disparities and poor school performance be designated "Health and Education Empowerment Zones" and receive additional federal support from the No Child Left Behind Act for improved education and expansion and enrichment of science and health curricula.

"The elimination of child health care disparities will require multiple interventions from various sectors in the health care system," Ms. Beal concluded. "The next step for adopting any of these recommendations is to analyze the costs and feasibility of their implementation and the benefits they would provide. Such analyses will inform debates about the costs and benefits of promoting policies to reduce disparities."

Further research is very important, Ms. Beal tells *State Health*

Watch, noting she has been impressed by how much policy has been informed by anecdote rather than hard data.

"We need a body of research to inform and create thoughtful policies," she points out.

Asked if there is a way to prioritize her recommendations, Ms. Beal says it isn't possible because multifactorial problems require multifactorial solutions from many disciplines.

"Addressing disparities shouldn't be an afterthought," she says. "All segments of the system need to take ownership of the problem."

One of her key recommendations is that overall coordination and monitoring of efforts to reduce disparities be managed within HHS.

"A mandate for HHS to address disparities will promote research, public health, and health promotion efforts," Ms. Beal continues.

"Such a mandate can be coupled with an advisory council of minority health experts who would oversee the process, promote coordination of efforts across various federal agencies, and receive reports of local efforts to reduce disparities.

"Monitoring progress can be done by an annual review and report to Congress, with an evaluation of changes in outcomes as reported by the National Center for Health Statistics and changes in care as reported by the National Healthcare Disparities Report. Several federal efforts to reduce disparities are under way, and an advisory council would facilitate coordination to promote synergy and reduce replication of these activities," she adds.

[To read the article, go to http://healthaffairs.org. Contact Ms. Beal at (212) 606-3854 or e-mail acb@cmwf.org.] ■

Clip files / Local news from the states

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

Insuring controversy: Malpractice surcharges

WASHINGTON, DC—Kenneth M. Greene wasn't sure how his 1,500 patients would react when he asked them for a $10 contribution to help pay his $11,000 malpractice insurance bill. "The medical malpractice insurance crisis has come full force to Maryland," the 47-year-old Towson internist declared in a letter he sent last December. A "small donation . . . is necessary if we are to continue to keep our doors open." Nine hundred miles away in North Palm Beach, Fla., family physician Ira G. Warshaw launched a similar plan. Warshaw asked his 3,000 patients to send him a check for $125 ($25 if they were younger than 25) to help defray his $30,000 insurance bill, which has quadrupled since 2002. If patients didn't help, Warshaw warned in an earlier letter, he might be forced to stop participating in Medicare and some health plans. "I felt like I was drowning, really," said Warshaw, a solo practitioner who said he felt some guilt about his request but was grappling with a $100,000 debt from a failed venture in group practice.

Greene and Warshaw are among the pioneers of a new, controversial tactic that is being viewed with keen interest by medical groups around the country: the malpractice surcharge. Both doctors say their letters were so successful, they plan to send another appeal before next year's insurance bills are due. Rising expenses and static reimbursements have led a growing number of physicians, most of them in the less lucrative primary care specialties of pediatrics, family practice, and internal medicine, to begin charging so-called access fees for services they once provided for free. These include filling out camp and disability forms, taking after-hours phone calls, and answering e-mail questions. Some also are dunning patients for canceled appointments. A malpractice surcharge, some doctors say, is simply one more access fee, although it usually is presented as voluntary to avoid running afoul of Medicare rules that prohibit such mandatory charges.

Its appeal is enhanced by the anger many doctors feel about rising insurance rates, which has touched off a fierce political battle in Maryland and other states. "Physicians are getting crushed by the combination of malpractice cost shocks and declining reimbursement," said T. Michael Preston, executive director of MedChi, the Maryland state medical society. "As a result, there is great interest in surcharges or access fees."

—*Washington Post*, Sept. 24, 2004

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