State Health Watch

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THOMSON AMERICAN HEALTH CONSULTANTS

# Survey shows opinion leaders, Bush disagree on health policy

As President Bush begins his second term with an emphasis on medical malpractice reform, a survey of health care experts and innovative thinkers conducted by the Commonwealth Fund has come up with a very different perspective on what can and should be accomplished over the next five years.

Commonwealth Fund president Karen Davis says the survey asked opinion leaders to identify the most important issues for Congress' health policy agenda over the next five years and to list their top five priority solutions for addressing the issues of rising health care costs and improving quality, next steps in Medicare reform, and how best to cover the uninsured. "The results [318 respondents from 1,155 surveyed] show broad consensus in a number of areas, a divergence of opinion in others, and a few surprises along the way," she reports.

The survey revealed widespread agreement that expanding coverage to the uninsured should be lawmakers' top priority. That response cut across all groups represented in the survey population — academic and

*See **Health policy survey** on page 2*

## *States stretch shrinking health care dollar through innovative money management*

Despite pressing budget concerns that have limited their discretion and sometimes led to cuts in existing programs, many states still have managed to implement innovative strategies, stretching health care dollars by using a portion of state money to leverage private, federal, and additional states funds, according to a state survey conducted by the Economic and Social Research Institute (ESRI) for the Commonwealth Fund.

***Fiscal Fitness: How States Cope***

"States have expanded health care access, coverage, and efficiency through sound financial management, by judiciously investing a little to get a lot," says ESRI's Sharon Silow-Carroll, who conducted the study.

The study divides state activities into four categories — building on employer-based coverage, pooled and evidence-based pharmaceutical purchasing, targeted care management to enhance cost-effectiveness, and innovative use of uncompensated care funds.

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# *Health policy survey*

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policy experts, as well as leaders in health care service delivery, health industry, business, consumer groups, and government. There also was considerable agreement on reforms needed to accomplish broader coverage, options that Ms. Davis says suggest an incremental approach rather than radical overhaul.

Improving the quality and safety of medical care, including increased use of information technology, was ranked as the second most important priority for Congress, followed by reforms aimed at ensuring Medicare's long-term solvency and addressing the issue of rising health care costs. "That costs ranked fourth on our experts' priority list is a bit surprising given all of the public, political, and media attention that the rise in health care expenses has generated over the past year," she adds. "Also surprising, malpractice reform, which the administration and Republican congressional leaders have expressly listed as a legislation priority, ranks well down the opinion leaders' list, as do actions designed to control Medicaid costs."

There was limited consensus among opinion leaders on the best way to cover the uninsured, but the top two approaches were allowing individuals and small businesses to buy into the Federal Employees Health Benefits Program and expanding Medicaid/CHIP. Those in the insurance industry appear to favor the Medicaid/CHIP expansion approach, as do consumer and advocacy group leaders.

Ms. Davis says allowing uninsured people to buy into Medicare, implementing some form of Medicare-for-all system, also had a surprising degree of support, not just in the academic/research sector, but also in the health care delivery sector, although an incremental approach to reducing the number of Americans lacking health coverage seems far more likely than a more basic system overhaul.

"Perhaps the most surprising finding, again given the amount of public and political attention the concept has received, is the lack of enthusiasm in this survey for health savings accounts or tax credits to buy individual health insurance," Ms. Davis notes.

When asked about potential solutions to the problem of rising health care costs and improving quality of care, respondents came together in large numbers on three approaches — pay for performance in which providers are rewarded for efficiency and effective disease management; increased use of information technology; and greater availability of public information on provider performance and comparative quality and costs. Much further down the list was any notion of greater patient cost sharing, again somewhat surprising given the attention being paid to consumer-directed health care. Also ranking quite low was importation of lower-cost prescription drugs, which has engendered considerable attention in Congress.

For Medicare reform, there was broad agreement on three strategies — government negotiation of prescription drug prices (not supported by drug industry opinion leaders), linking incentives in physician payment to quality performance, and increasing premiums for higher income beneficiaries.

"We consider the results of this inaugural opinion leaders' survey to be an excellent starting point for a thoughtful discussion of the difficult issues our policy-makers must address in the next few years," Ms. Davis explains. "Our findings are

especially interesting when viewed in concert with the results of some recent public opinion polls on similar issues." She notes the November/December 2004 Kaiser Family Foundation Health Poll that asked the public to choose the most important issue for the president and Congress to address among several specific health care issues. Some 29% said increasing the number of insured Americans was most important, followed closely by lowering health insurance cost (25%). In an open-ended question, nearly half of those polled said health care costs was the most important issue for government to address, followed by access to care.

And a December 2004 survey by GOP pollster Linda DiVall found that, in terms of importance, the public ranked expanding Medicaid to cover the uninsured and allowing importation of drugs from Canada well ahead of issues such as malpractice reform and tax credits to buy health insurance.

Commenting on the survey results, respondent Christopher Jennings, president of Jennings Policy Strategies, who was a senior health advisor to President Clinton, said political progressives should push their belief that all Americans should have access to affordable and reliable health insurance and that all patients should receive health care that is accountable and safe.

"First, we should aggressively promote the common-ground agenda of modernizing the nation's health system to include a technologically coherent infrastructure that enhances efficiency, improves safety, and encourages accountability," he wrote. ". . . If private and public players wish to ensure greater value for their investment, they must be more willing to use their purchasing leverage to achieve this end. Second, as we work to improve our health care system, we must expand access to it. We cannot be satisfied with making the system more responsive to the fewer number of Americans who can afford it. It must be an economic and moral imperative that we increase access to affordable, reliable insurance. We should start by finishing up unfinished business — ensuring that all of our nation's children have coverage."

Jennings said federal policy-makers should give financial incentives to states to expand Medicaid and SCHIP coverage and enroll all eligible kids. They also, he said, should provide tax credits for those up to 400% of poverty to purchase qualified insurance, perhaps in a separate insurance pool with the Federal Employees Health Benefits Program. In return, parents can and should be required to purchase health care coverage for their kids. Third, progressives must be aggressive and effective at fighting policies that will in all likelihood make things worse, particularly for those Americans who need insurance the most. He cited policies that political progressives should fight as a Medicaid block grant or cap, health savings accounts, and association health plans.

Another respondent, Project HOPE senior fellow Gail Wilensky, said that while Republicans have expressed a number of helpful health care reforms, a dose of realism is needed as leaders look ahead. First, there likely will be little new federal, or state, money for major expansions in health care coverage. Tax cuts are unlikely to be rolled back, she said, and President Bush has announced second term plans to pursue tax simplification and Social Security reform, both of which will keep busy the congressional committees that would take on any new health legislation. "The most important first step is to implement the Medicare Modernization Act," she said. "Implementing this measure right and on time will not be easy. Doing so will primarily involve the administration, but ultimately Congress will need to provide legislation to correct the inevitable problems that become apparent during implementation."

### *Improve patient safety*

Ms. Wilensky's second recommendation is to pursue the widespread agreement that the United States needs to improve patient safety and reduce medical errors. These are issues that have been embraced by both parties, she said, and by the Congress and the president, and taking effective action need not require substantial new federal funds. Her third goal is to follow up on substantial agreement that the information side of the health care system needs to be made as sophisticated as medicine's procedure and device side. Less clear, she wrote, is how to accomplish this, but new legislation undoubtedly will be needed and could lead to movement forward. Her fourth priority is medical liability reform because the president has spoken out on it and it increasingly has been raised as an issue affecting access to health care, while her fifth topic is to find ways to improve and expand access to care while staying within likely budget constraints.

"Finally, a word of caution to the uninitiated about survey reporting: The Commonwealth Fund survey had a response rate of 28%. This is not a bad response rate for an online survey. But it means that 72% of those sampled did not respond, and it is not clear whether those that did respond are representative of the entire sample," Ms. Wilensky added.

*(To see the survey instrument, results, and other materials, go to www.cmwf.org.)* ■

# Florida Medicaid reform could become the national template

Florida Gov. Jeb Bush has unveiled a Medicaid privatization program that some observers say could become a template for Republican members of Congress who want to make substantive changes to the health insurance program.

Mr. Bush said his Empowered Care program will ensure that Florida's most vulnerable families continue to receive the quality health care they need while directing their own health care. The reforms also would bring predictability to state spending on Florida's $14 billion Medicaid program, he said.

"To fulfill our commitment to Florida's Medicaid program, we must transform it completely so that the No. 1 priority is patient well-being and the last consideration is government control," the governor said.

"Our proposals put the focus back on the patient by encouraging strong patient-doctor relationships and allowing competition in the market to drive access and quality of care up from current levels in the Medicaid system. Florida's Medicaid system will collapse under its own weight if we do not fundamentally transform the way it operates. The changes we're proposing will help create more predictable and sustainable growth in Medicaid costs and ensure the program meets the needs of Floridians who rely on it for health care," he added.

### Major components

State information describes the major components of the proposal this way:

- Empower Medicaid participants to make choices about their own care. Health care providers will create benefit packages in combinations of three components — basic care, catastrophic care, and flexible spending. Participants will be helped by counselors to choose the program that best meets their needs.
- Medicaid participants can build a "bridge to independence" by opting out of Medicaid plans and using their state-paid premium to purchase private market insurance.
- Participants will be able to use a new feature of the benefit structure that encourages healthy practices and responsible lifestyle choices by giving them the ability to earn enhanced benefits through flexible spending accounts. The enhanced benefits will provide extra funds to buy increased coverage or services through their care plan.
- Providers will have greater flexibility in designing service plans. In addition to basic, catastrophic care, and flexible spending services, providers will be free to compete for participant membership by offering innovative care, convenient networks, and optional services. Participants will not be limited to HMOs and insurance plans. Options like provider service networks and innovative community-based systems will be available to meet the unique needs of participants.
- Basic or catastrophic plan participants will have access to all types of mandatory health services, including professional care, hospitalizations, and diagnostic services.
- Instead of the state setting the amount or scope of services, competing vendors will be allowed to offer different packages that may appeal to different customers. The state will continue to allocate the premium to each of the three categories based on historic spending patterns.

### Questions, not criticism

Florida observers report the governor's proposal was greeted more with questions than with outright criticism. Democratic lawmakers and advocates for Medicaid recipients expressed concern that benefits for the poor not become more limited than they already are.

"While market forces can be a positive force for good, we are concerned about how the proposals we have seen can, or will, harness those forces to protect the people who have previously been shut out of the health and long-term care market," said Kathy Marma of Florida's AARP chapter.

"Will service packages offered under the new system be meaningful and cover the needs of persons with chronic conditions and special needs that the private market has chosen not to cover?" she asked.

And ARC of Florida executive director John Hall told local media state paid premium rates could be too low to cover people with disabilities adequately since premiums would be based on historic funding as well as an individual's level of health risk.

"It's unrealistic that somehow he's going to be able to put together a package for persons with disabilities based on current funding levels that are inadequate, and it will result in better outcomes," Mr. Hall cautioned.

*(For state information on the proposal, go to www.empoweredcare.com.)* ■

## *Fiscal Fitness*

*Continued from page 1*

Ms. Silow-Carroll tells *State Health Watch* no single category is the one answer for all states.

"None of these actions is going to fix a state's fiscal problems and make things easy," she cautions. "But each one helps a little. They don't necessarily save money, but they can stretch the available money further."

### States face a challenge

Ms. Silow-Carroll notes that providing health insurance coverage for vulnerable populations such as low-income, high-risk individuals with limited access to health care is a challenge for states even in good economic times, and has been especially arduous in the last few years.

But despite significant financial concerns, she explains, many states have managed to implement innovative strategies in the four areas:

1. **Building on employer-based coverage.**

Whether subsidizing an existing employer plan or creating a new and affordable program for uninsured workers, Ms. Silow-Carroll notes, states are using their dollars, regulatory/legislative powers, and purchasing clout to leverage employer and employee contributions to cover more people.

The effort can involve these approaches:

- premium assistance for existing employer plans;
- state reinsurance to cover a portion of private insurers' claims to help reduce the price of premiums and provide a more affordable option for uninsured workers;
- direct subsidization of a new public-private plan;
- state negotiated health plans;
- a pay-or-play approach in which states require businesses to either provide coverage to their workers or pay into a fund that purchases coverage, on a larger scale, for those and other workers.

2. **Pooled and evidence-based pharmaceutical purchasing.**

In recent years, the report says, drug costs have been a major contributor to the overall growth in health care costs generally and for Medicaid in particular.

As a result, many states are implementing drug cost-containment mechanisms that don't merely pass state expenditures on to consumers in the form of higher copayments and deductibles, but instead put innovative approaches in place that reduce state costs to expand or maintain access.

Strategies described in the report include:

- multistate purchasing and collaboration;
- pooling across several state agencies;
- state-negotiated discounts and drug-only benefits;
- substitutions, evidence-based preferred drug lists, and supplemental rebates.

3. **Care management to enhance cost-effectiveness.**

With more than 75% of Medicaid spending on people with chronic conditions and the number of Americans with at least one chronic condition expected to increase at least 25% by 2020, states are pursuing efficiencies through a number of care management strategies for high-cost individuals. Services can be provided directly, Ms. Silow-Carroll continues, or contracted out to specialized vendors.

Care management programs may be characterized as medical vs. long-term care oriented; targeted diagnosis such as asthma, diabetes, or congestive heart failure; high service use or cost; and key interventions that focus on a specific issue such as patient education, drug management, or advanced care interventions by nurses or other health professionals.

4. **Innovative use of uncompensated care funds.**

Ms. Silow-Carroll points out that hospitals are a significant element in the health care safety net because they serve the uninsured and other vulnerable people who can't pay for service themselves.

States use Medicaid disproportionate share funds and state-based revenue streams to reimburse hospitals for this otherwise uncompensated care.

Experts say hospitals' ability to continue to provide uncompensated care in the future can be strained because of their rising costs and lower operating margins, limited state revenues, cuts in Medicaid disproportionate share payments, and a growing uninsured population.

These trends have led states to look at strategies for reducing the need for expensive uncompensated services over the long term, including using a portion of uncompensated care funds proactively to finance primary and preventive care programs that ultimately could reduce emergency and inpatient hospital costs and divert a percentage of disproportionate share or uncompensated care pool funds and combine the money with state/county/local funds and employer contributions to support community safety net providers.

The study does not compare approaches because of the dynamic political and economic environment in states as well as the fact that initiatives typifying the four basic categories are at different

stages in different states.

However, Ms. Silow-Carroll explains, the study is most useful because it presents leading examples of state and collaborative efforts that can inform policy-makers and administrators who are interested in the latest innovation for stretching their limited health care dollars.

That these programs are worthy of emulation, she says, can be seen in these examples from the cases documented in the reports:

- By accessing unused federal SCHIP funds for new FamilyCare program and a previously state-only KidCare Rebate program, Illinois stretched dollars and expanded eligibility without making cutbacks in other coverage programs.
- New York's Healthy New York reinsurance program offers businesses a lower-cost private insurance alternative, with recent modifications resulting in an average premium reduction of some 17%.
- By paying a Medicaid-eligible worker's share of his or her employer-sponsored coverage, Pennsylvania's Health Insurance Premium Assistance Program relieves the state of having to offer direct Medicaid coverage for any of the individuals, saving $76.3 million in FY 2003.
- West Virginia's participation in the RXIS Multi-State Pharmaceutical Purchasing Pool saved the state $7 million in its first year, and $25 million in savings is expected over the three-year contract with the pharmacy benefits management firm that serves the five participating states.
- Michigan's preferred drug list, representing about 70% of the drugs used in the state's Medicaid outpatient pharmacy benefit, saved an estimated $60.5 million its first year.
- Colorado estimates its advanced care management initiative that integrates disease management and care management interventions for high-risk pool enrollees, generated $2.3 million in direct savings to the state from May 2002 to September 2003.
- The General Assistance Medical Program, supported in large part by uncompensated care funds, saved Milwaukee County, WI, $4.2 million in calendar year 2000.

Ms. Silow-Carroll points out that since no one solution fits all states, the first step for state officials to follow in deciding which strategies to pursue is to conduct a needs assessment covering different populations, values, priorities, and politics.

"States have to decide which population to target first, the resources that are available, what policies are politically acceptable, and who the stakeholders are that can be brought in," she explains. Out of that needs assessment can come specific policy reform.

Most states already have been involved in such assessments, she says, with federal funds coming through the state planning grant process. Looking to the future, she says that although the economy has been improving slightly and slowly, many states still are facing shortfalls and an escalation of Medicaid costs.

"We still have a few years to go before there is significant improvement," Ms. Silow-Carroll adds. "Until health care costs are under better control, they will continue to rise faster than state revenues and general inflation."

*[The reports and case studies prepared by Ms. Silow-Carroll are available at www.cmwf.org/publications/publications_show.htm?doc_id=243623. Contact Ms. Silow-Carroll at (201) 836-7136 or e-mail her at silow@optonline.net.]* ■

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

# Women benefit from expanded Medicaid family planning coverage, new study shows

A new study published by The Alan Guttmacher Institute indicates states that have expanded Medicaid coverage of family planning services to more low-income women are better able to meet women's need for these services than states that have not.

Researcher Jennifer Frost said the states also have seen a 27% increase in the proportion of women whose need for publicly funded family planning service has been met, while states without any Medicaid expansion for family planning have not seen any improvement.

Each year, she wrote, more than 20 million American women obtain contraceptive services from a medical provider, and one-quarter of these women received care from a publicly funded family planning clinic.

In 2001, a total of 6.7 million women, including 1.9 million teens, received contraceptive services from the 7,683 publicly funded U.S. family planning clinics.

Medicaid is a major source of funding for family planning services. Between 1994 and 2001, seven states — Alabama, Arkansas, California, New Mexico, Oregon, South Carolina, and Washington — obtained federal waivers to provide Medicaid coverage of family planning services to some low-income women earning more than the standard Medicaid cutoff in their states.

### *Publicly funded clinics needed*

On average in 2000, these states served half of women in need of publicly funded services, while states that had not expanded Medicaid coverage served only 40% of women in need.

Ms. Frost said publicly funded family planning clinics continue to play a critical role in delivery of contraceptive services and supplies to millions of American women.

Two broad types of change have occurred in the network of publicly funded family planning clinics:

- First are structural changes, such as changes in the distribution of clinics and clients according to provider type.
- Second are capacity changes revealed in the absolute gains and losses in clinics and clients served and in changes in the proportion of needs met by clinics.

According to Ms. Frost, structural changes in the clinic network have resulted in part because family planning focused providers have consolidated their operations and are now serving more clients at fewer sites, while primary care focused providers have dispersed and have a greater number of sites, each serving fewer contraceptive clients.

"From the point of view of women seeking services," she said, "the implications of these structural changes are likely to be considerable. High turnover in facilities means that many women will not have a stable source of ongoing care. Some women may lose access to a site they know well or like and may not know of an alternative source. Others may need to travel further to access care when sites close or merge."

The study found regional and state trends in the numbers of clinics and clients served reveal evidence of change in the capacity of the family planning clinic network. Clinic closures, according to Ms. Frost, have not always been compensated for by clinic openings in the same area.

When the researchers looked at the expansion of Medicaid covered family planning care under state-initiated waiver programs, they found that seven states initiated such programs between 1994 and 2001, expanding eligibility for Medicaid-covered contraceptive care to low-income women.

In those states, 25% more clients were served by clinics in 2001 than in 1994, and the proportion of met need increased by 27%, so that 50% of all women who needed publicly funded contraceptive care received such care in clinics.

By contrast, the study pointed out, states with less expansive or no waivers served fewer cases in 2001 than in 1994, and the proportion of need met by clinics remained at or below 40%.

Ms. Frost explained that her findings demonstrate the implementation of income-based Medicaid family planning waivers raises the capacity of local clinic networks and improves access to contraceptive care for more women who need such care.

And the impact of waivers on clinic capacity may help explain the striking regional variation observed, she added.

### *Waivers in 19 states*

An October 2004 Guttmacher Institute Policy Brief said 19 states have obtained federal approval to extend Medicaid eligibility for family-planning services to individuals who otherwise would not be eligible. Thus, six states have extended

eligibility for family planning services to women losing Medicaid postpartum, with eligibility generally lasting for two years.

Also, two states provide family planning benefits for women losing Medicaid for any reason, and 11 states provide family planning benefits to individuals based on income, with most states setting the income ceiling at or near 200% of poverty. Some five states provide family planning benefits to men and women, and three states limit their programs to women at least 19 years old.

The value of state-initiated programs expanding eligibility for Medicaid-covered family planning services was demonstrated in a Centers for Medicare & Medicaid Services (CMS)-funded evaluation conducted earlier in 2004.

The evaluation found that all of the expansion programs studied not only met a federal requirement that they not result in additional costs to the federal government, but actually saved money.

### Good time to save money

"Although saving public funds while expanding government services is laudable at any time, finding a way to do so is particularly significant at a time when states are otherwise feeling the need to make painful Medicaid cuts," wrote researcher Rachel Benson Gold.

The CMS evaluation first looked at waiver programs in Alabama, Arkansas, California, New Mexico, Oregon, and South Carolina to determine whether they met the federal requirement for budget neutrality — holding federal spending under the waiver to no more than it would have been without the waiver.

Using what they deemed to be the most appropriate method for calculating budget neutrality, evaluators from CAN Corp., Emory University, and the University of Alabama at Birmingham found that all six programs resulted in substantial net savings. (**See chart, below.**)

For example, Ms. Gold said, the South Carolina program realized total savings of $56 million over a three-year period starting in 1994, while Oregon's program, saved nearly $20 million in one year. Savings were split between the federal and state governments based on a formula established by CMS for calculating the federal share of Medicaid costs.

The evaluation also found that even as they saved money, the waivers increased access to services.

In four of the six states studied, the number of clients served in clinics receiving funds through the

## Impact of Medicaid Family Planning Waivers

| State | Year | Births Averted | Net Savings (in 000s) | | |
|---|---|---|---|---|---|
| | | | Total | State Share | Federal Share |
| Alabama | 2000-2001 | 3,612 | $19,029 | $6,982 | $12,047 |
| Arkansas | 1997-1998 | 2,748 | 15,524 | 5,199 | 10,325 |
| | 1998-1999 | 4,486 | 29,748 | 9,412 | 20,336 |
| California | 1999-2000 | 21,335 | 76,183 | 64,314 | 11,868 |
| New Mexico | 1998-1999 | 507 | 1,334 | 653 | 682 |
| | 1999-2000 | 1,358 | 5,009 | 2,038 | 2,972 |
| | 2000-2001 | 1,528 | 6,511 | 2,650 | 3,860 |
| Oregon | 2000 | 5,414 | 19,756 | 11,078 | 8,679 |
| South Carolina | 1994-1995 | 2,228 | 13,634 | 4,135 | 9,499 |
| | 1995-1996 | 3,151 | 19,616 | 6,202 | 13,414 |
| | 1996-1997 | 3,769 | 23,067 | 7,403 | 15,663 |

*Source:* Alan Guttmacher Institute, Washington, DC.

Title X program who met the eligibility requirements for the waivers grew after the program was implemented.

Ms. Gold reported that geographic availability of services increased in all states and two states demonstrated significant use of private-sector as well as family planning clinic-based services.

Also, the study found evidence in two states of a measurable reduction in unintended pregnancy among the total population of women eligible for the waiver.

Ms. Gold said the evaluation results have important implications for federal and state policymakers and for reproductive health advocates.

The first lesson learned, she said, is that states need to be allowed to decide how to structure their programs. Waivers are time-limited research, and demonstration initiatives that test innovative strategies for providing cost-effective care to Medicaid enrollees and the evaluation provided what Ms. Gold said is convincing evidence that the waivers demonstrated what they were intended to test.

### *Legislation introduced*

The Family Planning State Empowerment Act, sponsored by Sens. Lincoln Chafee (R-RI) and Diane Feinstein (D-CA) would give states the authority to expand Medicaid family planning eligibility on their own, without having to obtain a federal waiver.

A similar provision also is in the Improving Women's Health Act sponsored by Sen. Blanche Lincoln (D-AR) and in the Prevent Prematurity and Improve Child Health Act sponsored by sens. Lincoln, Richard Lugar (R-IN), and Jeff Bingaman (D-NM).

At a minimum, Ms. Gold said, the CMS evaluation provides a road map for CMS to streamline the waiver process by giving states a uniform formula for asserting budget neutrality that is agreed upon in advance. That could reduce the length of time significantly between an application's submission and its approval.

The second lesson learned is that bigger is better. She said the evaluation findings have relevance for state policy-makers who, in harsh economic times when difficult choices must be made on the Medicaid program, can reduce costs while improving access to care.

"Because family planning services are cost-effective, the more people eligible to receive services, the greater the savings to the federal government and to the states," Ms. Gold explained.

The evaluators wrote that "programs that cover all low-income women, for example, will likely reach more of the expansion-eligible women in a given year than those that cover only postpartum women. Given the eligibility structure of the demonstration, a higher enrollment of uninsured eligible women and a greater use of effective contraceptive services will lead to a greater likelihood that the state will see an effect on unwanted pregnancies," they added.

The value of streamlined enrollment was seen in the California Family PACT program.

Clients are enrolled at the family planning clinic rather than having to apply in person at a welfare office.

Such point-of-service eligibility eliminates the need for clients to make multiple visits and avoids the stigma associated with welfare. Also, clients are able to access services immediately.

The study found that in California, 48% of eligible individuals used services, more than twice the level reported in other states.

While the study does not assert a causal relationship between provider-determined eligibility in California and utilization levels, Ms. Gold noted that it gives policy-makers something to think about.

Finally, the evaluation provided important corroborative evidence for a long-standing assertion of reproductive health advocates that providing additional resources for high-quality family planning services is a wise policy choice, especially in difficult economic times, because it expands access to a service people want and need to improve their own health and well-being while still saving taxpayers money, Ms. Gold pointed out.

*(Download the study materials from www.guttmacher.org.)* ■

# Do 'vulnerable adults' understand LTC options?

With the number of Americans needing long-term care (LTC) slated to reach unprecedented levels over the next several decades, it is important to know how easily they will be able to secure the care they need.

That will depend on their ability to navigate what has been described as the complex mosaic of services, providers, coverage types, and benefit and payment options that are today's LTC system.

Recognizing these issues, the Robert Wood Johnson Foundation's Community Partnerships for Older Adults Program is helping 13 communities develop strategies to improve awareness about LTC issues and to increase access to related services. To identify older adults at risk of needing LTC in the next few years and assess gaps in their knowledge about their options, Mathematica Policy Research Inc. conducted a telephone survey in mid-2002 of adults age 50 and older in the 13 communities and used the results to describe their demographic characteristics, education, and health status; knowledge of LTC coverage and service availability; and sources of information used to address their LTC questions.

Mathematica's William Black and Randall Brown said the process of obtaining LTC, which is confusing, is further complicated by two overriding factors:

1. Most Americans do not begin to explore LTC choices until their need is urgent.
2. There is no single, authoritative source of information on the care.

"The situation is especially critical for vulnerable adults — those at significant risk of needed long-term care services in the near future," the two wrote in a Mathematica Issue Brief. "Absent an understanding of what services are available and how to access and finance them, these individuals might make less than optimal long-term care decisions, especially if they do so at a time of crisis, when there is little opportunity to investigate alternatives. Doing so could lead to reduced quality of life, unnecessary health problems, and greater caregiver burden."

The data compiled by the researchers defined "vulnerable adults" as all those older than 75, and those ages 60 to 74 who meet at least one of these criteria — say they are in fair or poor health or have one or more chronic illnesses such as congestive heart failure, coronary artery disease, diabetes, stroke, or lung disease.

On average across the 13 study communities, 40% of the target population met these criteria. More than half of the vulnerable adults were at least 75. And 40% described their health as fair or poor, compared to 24% of all older adults in the communities. Vulnerable adults in the sample also had lower education and income levels.

Some 28% of vulnerable adults in the sample either receive assistance or expect to need it within five years to continue living independently. About 13% have problems or need help with at least one personal care activity of daily living such as bathing or dressing; 26% reported having problems or needing help with at least one instrumental activity of daily living such as preparing meals or doing light housework. Generally, unpaid family members and friends provided the personal assistance received by those adults.

"In the 13 communities we studied, vulnerable adults typically do not know much about coverage for long-term care costs," Mr. Black and Mr. Brown wrote. "Only 8% have private long-term care insurance, and 71% of the remainder do not know how much coverage would cost for someone their age. In fact, 31% of vulnerable adults have never even heard of long-term care insurance. More than half do not know that Medicare does not cover personal assistance or that Medicaid does cover it."

The report indicated that financial constraints put LTC beyond the reach of many people. Nearly 60% of vulnerable adults said they would be unable to afford $100 per week for help with personal care, and many probably could not afford any assistance as 30% have a yearly income under $20,000 and are not on Medicaid. Also, 25% reported being unable to afford some basic need such as food or prescription drugs at some time during the previous 12 months.

In addition to their financial problems, a sizeable minority of vulnerable adults lack information about LTC services available in their communities. Between 15% and 25% of vulnerable adults reported not knowing that nursing homes, visiting nurse services, home-delivered meals, and senior centers are available to them, despite the fact that these are well-established programs that generally are quite visible in communities.

About one-third reported they did not know that personal assistance services and door-to-door transportation — two key factors that could help them remain in the community — were available. Likewise, nearly 40% are unaware that adult day-care programs are available, and 30% don't know of assisted-living facilities in their area.

"It is noteworthy that, despite their greater need for information about long-term care, vulnerable adults who either receive personal assistance or expect to need it within five years are no more likely to be aware of the availability of long-term care services than are vulnerable adults generally," the researchers said.

The study showed that many adults who are likely to need LTC information in the next few years have substantial gaps in their knowledge.

There is a wide range of knowledge levels among communities and a wide range of sources people said they would turn to for information.

Mr. Black and Mr. Brown reported that communities seeking to bridge people's information gaps are likely to face challenges in improving vulnerable adults' awareness of LTC issues, particularly since that population uses a wide range of sources for information.

Some strategies that individual partnerships are implementing include:

- developing and promoting use of a telephone helpline seniors can use to access information about LTC services;
- conducting a media campaign to promote awareness of LTC issues;
- conducting a door-to-door outreach campaign to reach isolated older adults;
- improving communication and collaboration among LTC service providers and senior services organizations to promote a "no wrong door" approach that facilitates access to LTC services and information by allowing seniors to enter the LTC system through multiple community channels.

*(More information is available at www.mathematica-mpr.com.)* ■

# GAO report shows Medicaid program integrity efforts could use more funding

The General Accounting Office (GAO), said the federal resources committed to overseeing state Medicaid program integrity activities "may be disproportionately small relative to the risk of serious financial loss." The Centers for Medicare & Medicaid Services (CMS) disagreed with that assessment, saying program integrity work should be viewed as part of its broader financial management of state Medicaid programs.

CMS officials noted that 65 agency financial management staff in regional offices review Medicaid expenditures, conduct financial management reviews, provide technical assistance to states on financial policy issues, and analyze state cost allocation and administrative claiming plans. They also said the agency experts to hire 100 new Medicaid financial management staff this fiscal year and has contracted with the Office of Inspector General to perform additional auditing.

"We commend CMS for the actions it has begun to take to address its Medicaid financial management challenges," GAO said in its summer 2004 report. "As we have reported in recent years, CMS had fallen short in providing the level of oversight required to ensure states' Medicaid financial responsibility. When fully implemented, CMS' effort to increase the number of staff dedicated to reviewing the states' financial management reports should help it strengthen the fiscal integrity of Medicaid's state and federal partnership. However, financial management and program integrity, while related functions, are not interchangeable," it noted. "Financial management focuses on the propriety of states' claims for federal reimbursement, such as the matching, administrative, and disproportionate share funds that CMS provides the states. In contrast, program integrity — the focus of this report — addresses federal and state efforts to ensure the propriety of payments made to providers. Unlike the commitment to expand resources for Medicaid financial management activities, CMS has not indicated a similar commitment to enhancing its support and oversight of states' program integrity efforts."

According to GAO, various forms of Medicaid fraud and abuse have resulted in substantial financial losses to states and the federal government. Fraudulent and abusive billing practices committed by providers include billing for services, drugs, equipment, or supplies not provided or not needed. Providers also have been found to bill for more expensive procedures than were provided. In recent cases, it found, 15 clinical laboratories in one state billed Medicaid $20 million for services that had not been ordered, an optical store falsely claimed $3 million for eyeglass replacements, and a medical supply company agreed to repay states nearly $50 million because of fraudulent marketing practices.

State officials told GAO auditors their Medicaid program integrity activities generated cost savings by applying certain measures to providers considered to be at high risk for inappropriate billing and by generally strengthening their program controls for all providers. Some 34 of the 47 states that completed a GAO inventory reported using one or more measures to control enrollment of high-risk providers. Controls cited included on-site inspections of applicants' facilities

prior to enrollment, criminal background checks, requirements to obtain surety bonds that protect the state against certain financial losses, and policies to enroll providers on a probationary or time-limited basis.

States also reported making use of information technology to integrate databases containing provider, beneficiary, and claims information and conduct more efficient utilization reviews. Targeted claims reviews are conducted by 34 states to identify unusual patterns that might indicate provider abuse. States also cited legislation to direct use of certain preventive or detection controls or authorized enhanced enforcement powers as lending support to their Medicaid program integrity efforts. The report briefly summarizes some state activities in each of these areas.

At the federal level, GAO said, CMS has initiatives designed to support states' program integrity efforts. Those initiatives include two pilots: one that seeks to develop a methodology for measuring the accuracy of each state's Medicaid claims payments, and the other to identify aberrant provider billing by linking Medicaid and Medicare claims information.

The most recent results of the first pilot showed Medicaid fee-for-service accuracy rates for 11 states ranged from 81% to nearly 100%. The second pilot resulted in a reported $58 million in savings and more than 80 cases against suspected fraudulent providers after the first year of testing in California.

GAO said CMS also provides technical assistance to states by sponsoring monthly teleconferences at which states can discuss emerging issues and propose policy changes.

The congressional oversight agency said varied and substantial cases of Medicaid fraud or abuse uncovered around the country reaffirm the need for Medicaid agencies to safeguard program dollars. Such losses have prompted program integrity units and legislatures in many states to take active roles in prevention and detection efforts. In their attempts to limit improper payments, states have pursued a broad range of methods, such as tightened provider enrollment and advanced claims review techniques, it added. "As some states report identifying substantial cost savings, further enhancements in program integrity activities are likely to generate positive returns on such investments."

As noted, GAO expressed concern that there may be disparity between the level of CMS resources devoted to Medicaid program integrity and the program's vulnerability to financial losses. On its current schedule for conducting state program integrity compliance reviews, the watchdog said, CMS will not obtain a programwide picture of states' prevention and detection activities more than once every six years. Moreover, because these reviews are limited in scope, CMS does not evaluate states' effectiveness in addressing improper payments. In addition, findings from the CMS payment accuracy pilot indicate a need for CMS to further enhance state efforts to prevent and detect payment errors.

*(To see the report, go to www.gao.gov/cgi-bin/getrpt?GAO-04-707.)* ■



# *Clip files / Local news from the states*

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

## Tennessee's retreat on Medicaid points to struggle

NASHVILLE, TN—Gov. Phil Bredesen, a Democrat elected in 2002 on a promise to rescue TennCare, announced he is cutting 323,000 low-income adults from the program and limiting services for 400,000 others. The governor said the expanded Medicaid program is devouring the state budget and he cannot afford what had been hailed as one of the most generous government health plans in the nation. The announcement sent shivers through health care advocates nationwide who see the start of a bleak trend to scale back government paid care. Even with the severe cutbacks, Mr. Bredesen said TennCare will remain among the most generous Medicaid plans in the nation in terms of the percentage of residents covered and percentage of the state budget. But for much of the past decade, Tennessee neglected other public health investments, such as community clinics, health departments, and specialty programs for immunizations and AIDS.

—*Washington Post*, Jan. 18, 2005