



# Health Watch

Vol. 13 No. 8

The Newsletter on State Health Care Reform

August 2006



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## Could Massachusetts take the lead on the path to health care reform?

“We’ve got a whole new dialog about how health care should be delivered and financed,” says Kaiser Commission on Medicaid and the Uninsured executive director **Diane Rowland**. And nowhere is that more true than in Massachusetts. While West Virginia has changed its Medicaid plan to try to encourage people to take better care of themselves and Utah has tried to cover more people by reducing benefits for others (see **related story, below**), Massachusetts has undertaken a radical attempt to reform the health care system to cover everyone, leading to the natural question of whether they

have found a system that could work in many other states.

Academy Health says the Massachusetts legislation aims to cover 95% of the state’s uninsured within the next three years. The bill signed by Republican governor **Mitt Romney** April 12 ended more than a year of negotiations and compromise between the governor and legislature and includes provisions to increase access to health insurance, contain health care costs and improve quality.

Key elements of the plan include:

*See Massachusetts on page 2*

## West Virginia undergoes changes throughout its Medicaid program in a 4-year overhaul

West Virginia was one of the first states to take advantage of increased Medicaid flexibility offered through the Deficit Reduction Act of 2005 that was signed into law earlier this year. Some

**Fiscal Fitness:  
How States Cope**

observers, particularly Center on Budget and Policy Priorities senior fellow **Judith Solomon**, tell *State Health Watch* the state’s changes probably are illegal, while West Virginia Department of Health and Human Resources assistant secretary **John Law** tells *SHW* Solomon is “scaring

people” with her comments on a program that has been approved by federal officials.

Law says the West Virginia Medicaid program costs about \$2.3 billion a year in state and federal dollars, with the total cost increasing with the natural growth of the program.

“Even with moves to control utilization and paying our providers less than they would make in other states, the system is unsustainable,” he says.

The state’s May 2005 waiver

*See Fiscal Fitness on page 5*



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

**Subscriber Information:**  
**Customer Service:** (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30 a.m. - 6 p.m. Monday-Thursday; 8:30 a.m. - 4:30 p.m. Friday ET.  
**E-mail:** [ahc.customerservice@thomson.com](mailto:ahc.customerservice@thomson.com).  
**Web site:** [www.ahcpub.com](http://www.ahcpub.com).

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**Government subscription rates:** Call customer service at (800) 688-2421 for current rate. For information on multiple subscription rates, call Steve Vance at (404) 262-5511.

(GST registration number R128870672.)

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**THOMSON**  
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## Massachusetts

Continued from page 1

• **Health Insurance Connector.** To improve the availability and affordability of coverage, the Health Insurance Connector will help individuals and small businesses find affordable health coverage. It allows individuals to purchase health insurance using pre-tax dollars, which is estimated to reduce premium cost by up to 25%. A unique feature is that individuals can keep their policy even if they change jobs.

• **Insurance Market Reforms.** Starting in July 2007, the non- and small-group markets will be merged, although a study of the merger must be completed before then to assist insurers in planning for the transition. Policy-makers estimated the change will reduce premiums for people currently purchasing in the individual market by nearly a quarter of their current cost.

• **Individual Mandate.** All individuals are required to obtain health insurance by July 1, 2007. Those who cannot afford insurance, as determined by the Connector, are not penalized. For tax year 2007, penalties for not having health insurance will include loss of the personal exemption for income tax purposes. In subsequent tax years, the penalty will be a fine equal to 50% of the monthly cost of health insurance for each month without insurance.

• **Employer Requirements.** State employers with 11 or more employees that don't make a "fair and reasonable" contribution toward their employees' health insurance coverage would be required to make a per-worker contribution estimated at \$295 per full-time employee. (The governor line-item vetoed the \$295 per employee fee.) Also, employers with 11 or more employees must adopt by Jan. 1, 2007, a Section 125

cafeteria plan permitting workers to purchase health care with pre-tax dollars. And employers with 11 or more employees who don't offer to contribute toward, or arrange for the purchase of health insurance, may be assessed a surcharge if their employees access free care a total of five times per year in the aggregate or one employee accesses free care more than three times.

• **Subsidies.** The reform addresses uninsured low-income populations by establishing the Commonwealth Care Health Insurance Program to provide sliding-scale subsidies to individuals with incomes below 300% of the federal poverty level. No premiums are to be imposed on individuals with incomes below 100% of poverty. The existing Insurance Partnership premium assistance program will raise eligibility for employee participation from 200% of poverty to 300%.

• **Uncompensated Care Pool.** By Oct. 1, 2007, the current Uncompensated Care Pool is to be replaced by a new Safety Net Care Fund that will develop a new standard fee schedule for hospital reimbursements for uncompensated care. The intent is that as free care declines with implementation of the new coverage programs, the fund will be able to transfer money to subsidize the Commonwealth Care program.

• **Medicaid.** The state's MassHealth Medicaid program will be expanded, with eligibility for children increased from 200% of poverty to 300% and enrollment caps on several programs raised in hopes of enrolling more adults who are eligible for the programs.

• **Funding.** The new plan is to be funded through several revenue sources, including currently available surplus state general funds, federal matching dollars, required individual premiums, employer assessments, and pre-existing Uncompensated

Care Pool funds.

The national advocacy group Community Catalyst says while the legislation represents a major coverage expansion, many questions remain unanswered. Uncertainty surrounding the individual mandate is perhaps the biggest, but not the only issue to be resolved. Key questions also remain about the plan's financial viability, the group says, since the ongoing commitment of state and federal funds is critical, as is the projected \$200 million to come in over three years from employer contributions.

In assessing the plan's policy lessons, Community Catalyst says some features of the Massachusetts plan are not easily replicable elsewhere. Foremost among them is the availability of federal matching money, because special circumstances arising from the Massachusetts waiver made money available and led the Centers for Medicare & Medicaid Services to insist it be used for coverage.

What could be exported, according to the group, is the provision to allow purchase of health insurance with pre-tax dollars. Also, the principle of an employer contribution has been established, even though the contribution level is low, and it is clear that is growing political interest across the country in addressing the role of employers in solving the problem of the uninsured.

"Even where support for coverage is broad, it is all too easy for reform efforts to get bottled up in the legislative process," Community Catalyst said. "The necessity of passing legislation to address the waiver coupled with the ballot proposal created the political environment where something had to happen. Creating similar 'must-do' scenarios will be important in other states pursuing reform."

Commonwealth Fund president

**Karen Davis** said that since it doesn't appear there will be any federal solution to the problem of the uninsured any time soon, what Massachusetts has done potentially holds lessons for every state. "One particularly cogent lesson," she said, "is the manner in which the measure was crafted — via a civil process that successfully brought together numerous players from across the political, business, health care delivery, and policy sectors."

She expressed the hope that other states would follow Massachusetts' lead, "particularly if some of the other states that have traditionally served as economic and social policy models for the nation, New York, California, and Maryland among them, can work toward similar solutions. It won't be easy, and it likely will take time. But never before have there been so many good reasons to take such action."

Not everyone is as optimistic that the Massachusetts plan can be a national model. Even Mr. Romney told members of the U.S. Chamber of Commerce that the plan was custom-made for his state's situation and unique circumstances, although other states could borrow some ideas. Because of high private insurance rates and an expansive Medicaid program, Massachusetts estimates only 7% of residents are uninsured, compared to a national average of 15%. Also, Massachusetts can subsidize premiums with funds other states don't have. It already spends \$680 million in state and federal money to support hospitals serving the poor and that money will be redirected to buy insurance for lower-income residents.

"It's obvious in some respects that, if we could do it there, we could do it in other states," Mr. Romney said. "I believe that's true. I'm not sure it would be done in exactly the same way. Some of the

principles we found to work in Massachusetts may well be applied in other states, others perhaps not."

He said the Commonwealth Connector is one element that other states could adopt, and State Coverage Initiatives director **Alice Burton** agreed, although she noted the concept depends on merging the individual and small group health markets, which would be a giant leap for most states.

### **Destined to fail**

A note of caution was sounded by Harvard Medical School professors **Steffie Woolhandler** and **David Himmelstein**, co-founders of Physicians for a National Health Program. They said the plan is likely to fail because politicians underestimated the true number of uninsured in the state, because it's not true that uninsured people will be able to find affordable health plans, and because the legislation does nothing to contain the skyrocketing costs of care in the state, already the highest in the world. "Predictably, rising costs will force more and more employers to drop coverage," the two said, "while state coffers will be drained by the continuing cost increases in Medicaid. Moreover, when the next recession hits, tax revenues will fall just as a flood of newly unemployed people join the Medicaid program or apply for the insurance subsidies promised in the reform legislation. The program is simply not sustainable over the long, or even medium, term."

Ms. Woolhandler and Mr. Himmelstein said a better solution would be a single-payer, universal coverage plan that cuts costs by streamlining health care paperwork, making health care affordable.

A study by the California HealthCare Foundation found that providing health insurance coverage for nearly all Californians would

cost significantly more than the Massachusetts price tag. That analysis found that a Massachusetts-style program would require as much as \$9.4 billion in additional funding (\$1,450 per uninsured Californian) because of socioeconomic and insurance coverage differences between the two states.

### **California is not Massachusetts**

The foundation report said some experts have criticized the Massachusetts plan as based on unrealistic cost estimates. The study noted several key differences between California and Massachusetts that could contribute to the higher California cost estimates, including:

- The percentage of the population without health insurance is much higher in California (20.7%) than in Massachusetts (13.1%).

- The nonelderly population with employer health coverage in California is 13.8% lower than Massachusetts, in part because more Californians are employed in firms with a majority of low-wage workers. Coverage rates among such firms are much lower than in other firms.

- In California, 42.8% of the population has low or modest incomes, compared to 28.7% in Massachusetts.

- Massachusetts already spends considerably more public money than California does on uncompensated care for the uninsured, between four and six times more per uninsured person. Massachusetts expects that redirecting these funds will pay for most of the coverage subsidies.

At a Cato Institute forum on the replicability of the Massachusetts plan, Families USA executive director **Ron Pollack** said he was “cautiously enthusiastic.” He said he’s enthusiastic because the proposal has the potential for significantly expanding health coverage to people who are now uninsured and because

the process that led to adoption of the program represents a political breakthrough. His caution comes because of the outstanding issues remaining to be resolved, including the level of subsidies for people between 100% and 300% of poverty, the standard for coverage affordability under the individual mandate, and whether the Commonwealth Connector can come up with insurance policies that are both adequate and affordable.

“I am left with a sense of optimism about this,” Pollack declared. “And that is because I believe that the policy-makers in the state of Massachusetts are truly committed to expanding coverage for everyone. And as these problems crop up, as they undoubtedly will, I believe that there are key members who are leading the drive in the legislature who are prepared to make modifications in this proposal, to make sure that it truly works.”

### **Wrong on all counts**

Taking a totally different perspective, Cato Institute director of health and welfare studies **Mike Tanner** said that while the plan may be well intentioned, “in almost every case the state’s gotten it wrong.” He described the individual mandate as an unprecedented level of interference with individual decision making in the health care marketplace. “Never has any state or the federal government mandated that simply because you live in a particular place, a particular state, you must therefore buy a particular government-prescribed product,” he declared. Beyond that, he said, the mandate is an enormous infringement on individual liberty that sets in place a series of dominoes that he said will cascade down to ever more government control over the health care system, because once you set up a situation in which individual consumers can’t discipline the

marketplace by refusing to buy a product, when you create a captive audience or a captive buying populace, it will lead to every special interest group, every provider group, every disease constituency demanding that they be included in the product that now has to be bought, driving up the product’s cost.

He also criticized the plan’s increase in government imposition on businesses through the business mandate, no matter how modest it is, and the creation of 10 new government entities, vastly expanding the health care bureaucracy.

“Essentially, health care reform in this country needs to move in the direction of greater consumer control and more freedom,” Mr. Tanner declared. “The Massachusetts plan moves in exactly the opposite direction. It moves in favor of greater government control, less consumer choice, more subsidies, and more regulation.”

### **Bipartisan agreement best feature**

New American Foundation health policy program director **Len Nichols** told the forum the best thing about the Massachusetts experiment is that it is a bipartisan agreement. “You’ve got a Republican governor, expressly declared to be running for president, shaking hands with a legislature that I think we would agree is among the bluest of the blue in the country as we know it,” he said. “So the fact that you had a Republican presidential candidate willing to use the word ‘all’ and a Democratic liberal legislature willing to accept the word ‘limits’ is news. This is progress. This is indeed advancing the ball down the court and why I think it can be a model for all of us.”

He also stressed the importance of the combination of individual responsibility and shared community responsibility.

Economist **Arnold Kling** said the Massachusetts plan doesn't address any of the three major problems he sees in health care policy today — Medicare's unfunded liability; the cost-effectiveness gap in American health care, marked by spending more than any other country but not having the best health outcomes; and the issue of affordable health care for all. What it has the potential to solve, he said, is the problem of affordable health insurance for people who need health care least.

“Actually, I do like the idea of state-level experiments,” he said. “But I would like to see interesting experiments. I would like to see some states experiment with radical deregulation and more consumer-oriented health care. And I would like to see some states experiment with a single-payer system because I believe that in the context of premium medicine, Americans are making extravagant use of procedures that have high cost and low benefit. But in that context, a single payer system would be a disaster. I

would much rather see that disaster unfold in one or two states before we try it out at a national level.”

*Contact Ms. Rowland at (202) 347-5270; Ms. Davis at (212) 606-3800; Ms. Burton at (202) 292-6700; Ms. Woolhandler and Mr. Himmelstein at (617) 665-1032; Mr. Pollack at (202) 628-3030; Mr. Tanner at (202) 842-0200; Mr. Nichols at (202) 986-2700; and Mr. Kling through [www.econlib.org](http://www.econlib.org). The Cato Institute forum is available through [www.kaisernetwork.org](http://www.kaisernetwork.org). ■*

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## ***Fiscal Fitness***

*Continued from cover*

proposal said its goals were to 1) streamline administration; 2) tailor services to meet the needs of enrolled populations; 3) coordinate care, especially for those with chronic conditions; and 4) provide members with the opportunity and incentives to maintain and improve their health.

Under the Deficit Reduction Act, states have an opportunity to scale back health care benefits for children and parents enrolled in Medicaid. CMS approved West Virginia's plan in May, allowing the state to provide a scaled-back basic benefit package for most children and parents in Medicaid, while providing access to an “enhanced” benefit package if they sign and follow an agreement with the state.

In a Center on Budget and Policy Priorities issue brief on the changes, Ms. Solomon says West Virginia's state plan amendment was submitted without any opportunity for public comment and was approved by CMS less than two weeks after it was submitted for review. However, Mr. Law said before the state plan amendment was submitted, inter-

ested individuals and groups developed a concept paper for state officials to follow in preparing the redesign. He also pointed out that unlike other states such as Tennessee, no groups were eliminated from Medicaid coverage.

West Virginia had 191,316 children in Medicaid as of June, slightly more than half the total number of beneficiaries but accounting for only 27% of program costs. There were 60,233 adults in its programs, about 24% of the beneficiaries covered and accounting for 44% of the cost of the program. Other eligibility groups comprise the remainder of the program.

### **Four-year phase-in**

Implementation began in three rural counties July 1 and the program is to be phased-in statewide over four years. According to Ms. Solomon, some 75% of affected beneficiaries are children. Because of the state's Medicaid eligibility requirements, the two groups affected by the changes are low-income children and very low-income parents.

West Virginia Gov. **Joe Manchin III** said the changes “will help bring down program costs while helping to prevent disease.” But Ms.

Solomon counters that the plan is unlikely to lower the amount the state spends on Medicaid, largely because the affected groups account for less than one-quarter of the state's Medicaid costs, and also is unlikely to improve beneficiaries' health.

Under the new plan, she says, the basic benefit package for parents and children who enroll in Medicaid will have fewer benefits than the Medicaid program used to offer. For children, for example, the new basic benefit package limits them to four prescription drugs a month and imposes new limits on dental, hearing, and vision services. It also eliminates coverage for skilled nursing care, orthotics, prosthetics, tobacco cessation programs, nutrition education, diabetes care, and chemical dependency and mental health services.

The West Virginia plan includes Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for children in the basic benefits but excludes certain services that EPSDT covers and limits other such services.

“There is a basic inconsistency here,” Ms. Solomon says, “since under EPSDT, children who need them are supposed to be entitled to

the very services that are contained in West Virginia's current benefit package but are being eliminated or scaled back under the state's new plan."

She says the state has redefined EPSDT to include only the screening exams and some dental, vision, and hearing services that are part of the EPSDT benefit.

"The definition the state has adopted fails to include the follow-up diagnostic and treatment services that a health care provider prescribes for a child, on the basis of the child's screening examination," she says. "Under West Virginia's definition of EPSDT, services such as diabetes care and mental health services thus would not be covered for children under the basic benefit package. This definition of EPSDT is contrary to federal law."

### **No negative impact seen**

Law disagreed on the impact, saying children still will be screened for diabetes and will receive treatment regardless of the reduced benefits for those who don't sign contracts with the state.

"Kids are still going to get that screening," he says. "Whatever they need as a result of that screening they are still going to get."

For parents as well, according to Solomon, the revised basic benefit package will cover fewer health care services than the current Medicaid program. Thus, parents will no longer have coverage under the basic benefit package for emergency dental services, diabetes care, physical or occupational therapy, or mental health services. And the basic benefit package will cut the number of prescription drugs for parents from 10 per month to four, and will impose a limit of five on transportation for nonemergency trips a year.

The carrot that goes with the revised plan is an enhanced benefit

package made available to parents who, for themselves or their children, sign a Medicaid Member Agreement with the state committing to "do my best to stay healthy," to "go to health improvement programs as directed by my medical home (health care provider," and to "go to my medical home when I am sick."

The state plan amendment says if people sign the agreement and then fail to live up to it, their coverage will revert to the basic benefit package. Health care providers will be expected to monitor and report on patients' compliance with the member agreements. In the first year of implementation, providers will be asked to monitor whether beneficiaries receive health screening exams, follow health improvement programs, show up for scheduled appointments, and take medication as directed. The state plan amendment suggests that beneficiaries who are sent back to the basic benefit program for noncompliance with their member agreement can reapply for enhanced benefits after 12 months or when their Medicaid coverage is renewed.

For children, Ms. Solomon says, the enhanced benefit package does not limit dental, hearing, or vision services, prescription drugs, or medically necessary transportation. And it includes a number of services not in the basic package, such as diabetes care, tobacco cessation programs, nutrition education, and chemical dependency and mental health services.

For parents, the enhanced benefit package does not limit the number of medically necessary prescription drugs or use of medically necessary transportation. It also includes several services not in the basic package such as cardiac rehabilitation, diabetes care, and chemical dependency and mental health services.

"Because children and parents will not be covered for the services in the enhanced plan until they can see a health care provider to sign a member agreement, they could be left without a way to pay for critical services until an agreement is signed," Ms. Solomon says. "Moreover, children and parents could lose access to the services provided under the enhanced package if a decision is made that they did not comply with their member agreement." She says the state's underlying assumption that the requirement to sign a member agreement to receive enhanced benefits will lead beneficiaries to use preventive care more and use the emergency department and other costly services less is unproven and untested and the state has not provided any information to show that substantial numbers of Medicaid beneficiaries are not already following provider's instructions or not taking their children for checkups. Nor, she says, has the state presented data to show that large numbers of beneficiaries are using the emergency department inappropriately.

"West Virginia's plan actually could lead to poorer health for some beneficiaries," Ms. Solomon contends. "Those receiving the basic benefit package would not have access to critical health care services such as diabetes care and mental health services and might not be able to get all the prescriptions they need. Faced with these limits, some of these beneficiaries may end up using more costly services such as inpatient hospital care, which would be an unfortunate outcome both for beneficiaries and for the state."

She says an additional risk is that having health care providers monitor and report on compliance with member agreements could lead to uneven enforcement.

Department of Health and

Human Resources spokeswoman **Shannon Riley** has countered that the new system will encourage many parents to make it to their child's medical appointments and follow the doctor's advice.

"And a parent who fails to take their child to an immunization, who fails to pick up the prescriptions, that child is already suffering," she told West Virginia news media. "Even though the services are available, the child isn't getting them because the parent isn't responsible."

Ms. Riley, Mr. Law, and other state officials also argue the plan is legal because it has been approved by CMS.

### **When parents are dysfunctional**

West Virginia pediatrician **Joan Phillips** told *The Washington Post* she worries that because of the member agreements, children could be denied medical services if "the parent is not motivated or is

dysfunctional." And she said doctors who report to the state that a patient is not following the rules will face an ethical bind knowing that the patient will lose benefits as a result.

Ms. Solomon tells *State Health Watch* she doesn't disagree with the goal of promoting parental responsibility and accountability, but believes there are better ways than the path chosen by West Virginia, including through managed care contract requirements.

"You first should have a good diagnosis of the problem," she says. "You can't make changes just because you think they might work."

Ms. Solomon says she had positive conversations with the state's Ms. Riley about the issues, but the program was already in place and moving forward. She hopes to be able to work with local groups to monitor implementation and evaluate the impact of the changes.

Officials from many other states

also will be monitoring what happens in West Virginia and in Kentucky, which also received early approval for significant changes to its Medicaid program. Kentucky is dividing Medicaid beneficiaries into four categories, depending on their health and age, and establishing different benefits for each group. Most adults there will face higher copayments for medical services and new limits on prescription drugs. Beneficiaries who sign up for a disease management program eventually will be able to earn credits toward extra "get healthy" benefits such as eyeglasses or classes to quit smoking.

*Ms. Solomon's analysis is available on-line at [www.cbpp.org/5-31-06health.htm](http://www.cbpp.org/5-31-06health.htm). Contact her at (202) 408-1080. Contact Mr. Law at (304) 558-7899 or e-mail [johnlaw@wvdhhr.org](mailto:johnlaw@wvdhhr.org). E-mail Ms. Riley at [shannonriley@wvdhhr.org](mailto:shannonriley@wvdhhr.org). ■*

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## **Trying to achieve a culture of safety without blueprints**

For years, experts have said improving patient safety will depend as much on significant shifts in the culture of health care as on specific changes in the process of providing care. But there have been no blueprints for laying the foundation for a culture of safety.

The Commonwealth Fund supported research that resulted in "Stories from the Sharp End: Case Studies in Safety Improvement" in the March *Milbank Quarterly*. The research gives a snapshot of promising techniques for stimulating cultural change in health care organizations through case studies demonstrating that patient injuries are not an inevitable side effect of care.

The Fund notes that much safety culture theory originated in other

industries such as nuclear power and aviation that are viewed as safety pioneers. Regardless of the industry, according to researchers **Douglas McCarthy** and **David Blumenthal**, the same interrelated attributes are present in work environments committed to improving patient safety: they are informed, just, and flexible; inspire individuals to report errors and near misses; and use safety data to learn and reform.

Mr. McCarthy tells *State Health Watch* the organizations studied followed one of two approaches — either 1) a concerted organization-wide effort to study safety throughout the organization and develop organizationwide strategies to be adopted by each unit; or 2) focused activities addressing specific organizations units with methods specific

to each unit, which can yield learnings that are applied more broadly.

Safety improvement efforts in health care often run up against traditional aspects of medicine's culture, including steep hierarchies, tenuous teamwork, reluctance to acknowledge human fallibility, and a punitive approach to errors. Many of the initiatives launched by the case study organizations sought to overcome one or more of those potential barriers and adopt key safety attributes.

Mr. McCarthy says the six case studies used in the report were chosen by contacting recognized leaders in the patient safety field and asking them which institutions were, in their view, doing the most exciting work in patient safety. More than 20 potential cases were identified and

10 were chosen for study. The report covers six unique initiatives; the other four had similar interventions.

“All the programs we examined cited cultural change — creation of a ‘patient safety culture’ — within their organizations as critical to making patients safer,” Mr. McCarthy says. “Thus the organizations seemed to differ chiefly in the methods they were using to create this safety culture. Some were trying to change culture directly. Others were using less direct methods by relying on particular reforms in the structure or process of care, such as promoting teamwork to improve safety vigilance or introducing methods to reduce variability in the processes of care, and hoping that attitudes would change as behavior changed. Some were using both direct and indirect approaches. But regardless of means they chose, our study organizations shared the goal of cultural reform.”

Cultural changes are hard to study, he says, because culture is difficult to measure reliably and changes seem to occur incrementally and unpredictably in organizations. The lack of a clear road map for cultural change and the very elusiveness of safety culture as a destination make it a daunting goal for leadership to set. And yet, leadership commitment is essential to success.

Mr. McCarthy suggests that one function of the case studies included in the report “may be to assure leaders who are taking personal and organizational risks to create a safety culture that they are in good company and to offer ideas and examples that they can take back to their own institutions.”

The report suggests a definition of safety culture from the nuclear power industry can be helpful: Safety culture is the product of individual and group values, attitudes, competencies, and patterns of

behavior that determine the commitment to, and the style and proficiency of an organization’s health and safety programs. Organizations with a positive safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventive measures.

“As far as we know,” Mr. McCarthy and Mr. Blumenthal wrote, “no health care organization a yet can offer a model of what other health care institutions should strive to achieve in their safety culture. Accordingly, health care leaders must determine their own objectives. In our view, this makes it all the more important that institutions share their aspirations, efforts, progress, and disappointments in as close to real time as possible.”

#### **Flatten hierarchies**

As part of their safety interventions, Kaiser Permanente of California and Baltimore’s Johns Hopkins Hospital launched initiatives to train surgical and critical care personnel to speak up about safety concerns and to cross-check each other’s work. By doing so, they aimed to increase staff members’ ability to make changes and to flatten hierarchies that traditionally exist among physicians and other clinical care staff.

Kaiser Permanente adopted strategies from aviation, including crew resource management training, pre-flight checklists, and crisis simulation, to improve teamwork and communication among their surgical and labor/delivery teams. Within six months, the organization reported, operating room staff became more willing to share their safety concerns and discuss mistakes.

At Missouri Baptist Medical Center in St. Louis, multidisciplinary rapid response teams helped

to improve the flow of critical information across traditional boundaries to reduce communication breakdowns. Within two months, floor nurses recognized the teams’ value as a safety resource and began to call for them any time a patient exhibited early warning signs of a problem. As a result, the hospital reported decreases in acute medical crises of as much as 60%.

Error report systems — a strategy explored by many of the case study organizations — can present opportunities for future learning. By focusing on change rather than blame, they also can help increase an organization’s level of trust. OSF St. Joseph Medical Center in Bloomington, IL, enabled informal reporting of errors and near-misses among nursing staff by holding safety briefings at shift changes and through “walk rounds” — routine visits on nursing units — by the hospital’s executives. To reduce medication errors, the hospital also instituted a telephone hotline to simplify adverse drug event reporting and allow pharmacists to analyze potential problems each day.

Within 10 months of enhancing its patient safety reporting system, the Veterans Health Administration saw a 30-fold increase in reporting of events, emphasizing the importance of a confidential, nonpunitive system. By training frontline staff to use structured analytic tools and techniques when investigating safety incidents, staff began to see more errors are preventable.

Frustrated by the slow pace of organizational improvement at Sentara Norfolk General Hospital in Norfolk, VA, officials changed direction and worked to make specific safe behaviors, such as clear communication, a regular practice. Their strategies involved repeating back instructions or asking clarifying questions, and establishing high-priority “red rules” — such as

verification of surgical sites — to emphasize the critical nature of certain safety steps. Adherence to the behavioral standards became part of staff performance reviews and overall organizational performance monitoring.

Mr. McCarthy says the cases illustrate how health care organizations are working to instill five characteristics of high-reliability safety culture. First, they are seeking to become informed about system vulnerabilities that threaten patients' safety so they can plan and prioritize system improvements. Thus, Sentara Norfolk General Hospital and OSF St. Joseph Medical Center have integrated performance indicator systems that track progress in meeting safety goals by measuring safety-related attitudes, behaviors, events, risks, and outcomes using multiple data sources such as surveys, assessments, incident reports, direct observation, medical records, and malpractice claims.

Next, case study organizations encourage reporting safety incidents and concerns, including near misses or close calls, through internal and external reporting systems, safety briefings, and executive walk rounds. Mr. McCarthy says they appear to have "moved beyond a superficial preoccupation with the volume of reports as a barometer of safety culture to a more mature outlook that values reports for the learning that they enable when accompanied by effective analytic tools." To encourage participation and build trust in the efficacy of reporting, the case study organizations have established feedback loops to discuss with both management and frontline staff what they are learning and doing as a result.

Third, the organizations recognize the necessity of providing a psychologically safe environment for reporting medical errors so mistakes can be identified, learned from, and

prevented rather than hidden out of fear of punishment. While some have characterized this as a "blame-free" environment for patient safety, others have more carefully defined it as a nonpunitive or just culture that protects the reporting of honest errors while recognizing that misconduct, in which an individual intentionally endangers patients, is not an error.

A flexible culture, the fourth attribute, encourages greater teamwork and collaboration across disciplines to help maintain and improve patients' safety under the often complex and demanding delivery of health care.

Finally, study organizations seem to be promoting a learning culture by undertaking system reforms based on data and knowledge gleaned from both inside and outside their local environment.

#### **Lessons learned**

Mr. McCarthy says the lessons learned from the case study organizations include:

1. Dramatic safety improvements, such as elimination of documented catheter-related bloodstream infections in the ICU and a tenfold reduction in detected adverse drug events, seem to challenge the assumption that adverse events must be tolerated as an inevitable side effect of health care.

2. Safety principles and techniques developed in other industries may be applicable to health care for similar human factor issues. Simple human factor engineering approaches such as standardization and simplification of processes and independent checks to catch errors often seemed to be effective. But knowledge and tools must be adapted to fit the culture of medicine and the particular organizational context and safety threat.

3. Safety awareness and vigilance that can be taught by training and

coaching staff to use practical skills, tools, and behaviors so they gain the ability and confidence to identify safety threats and mitigate their causes, in both real-time work and later analysis.

4. An organization's leadership that can motivate and support a "bottom-up" approach to safety improvement among physician leaders and other frontline clinical staff. Some improvements require direct financial investment, and all require dedicated staff time to plan and implement. Several organizations noted the importance of repeatedly telling stories about successful improvements to introduce and reinforce desired cultural values and behaviors and to build momentum for change.

5. Focusing on patient needs, which can be a powerful motivator for change.

6. Seeking and measuring improvement in both systems and outcomes seems to enhance sustainability by validating clinical success factors while helping make a valid and meaningful case for patient safety.

According to Mr. McCarthy, interviews with staff at the case study organizations suggest that the organizations are internally motivated to perform well. Reputational rewards appear paramount, he says, typically to fulfill high public expectations but in some cases as part of a wider effort to shore up reputation.

Several organizations also cited the financial and operational benefits of safety improvement, such as reductions in hospital length of stay and nursing staff turnover as motivators for change. And accreditation requirements are viewed by the case study leaders as a floor on which to build. In contrast, he says, accreditation requirements appear to be the primary driver of safety efforts in most hospitals.

Mr. McCarthy tells *State Health Watch* that it is difficult to generalize from the case studies. "Organizations have shown that it is possible to make the kinds of changes that put safety at the top of the agenda and show very positive outcomes that appear to be replicable," he asserted.

In a Commonwealth Fund commentary on the study, Joint Commission on Accreditation of Healthcare Organizations senior vice president **Paul Schyve** said there is no dispute that patients suffer too much preventable harm. He said while the science, patient safety tools, and knowledge of safe practices have advanced rapidly since the 1999 Institute of Medicine report on errors in health care, that has been the easy phase of change. "It turns out that developing and maintaining a safe culture is the hard phase and the real, underlying challenge to successfully applying safety science and safe practices throughout health care," he said.

Mr. Schyve said changing culture is hard work because of the nature of culture in general, and of a safety culture in particular. With culture defined as the customary beliefs, values, and behaviors shared by members of a group, he said, it is difficult to change one element, such as behaviors, without making corresponding changes to the other elements.

"No wonder changing the existing culture is hard," he said. "We are asking health care professionals to change not only their traditional ways of thinking and doing, but their image of themselves. That is why many health care organizations, after translating some of the science and tools into safe practices and implementing them, have begun to feel they have 'hit the wall' of culture change. Further changes to advance patient safety seem increasingly difficult to make and sustain."

According to Mr. Schyve, in the new safety culture, health care professionals are obligated to be committed and competent, recognizing that they still will make mistakes; be active participants in reporting and studying errors and in redesigning systems to prevent them; commit to improve the safety of all patients, not just their own; train, through practice, to make better judgments at the sharp end of patient care; and be vigilant.

Vigilance is a key, he said, because safety must be a continuous, conscious focus in a safety culture and can't be assumed. Also, risks from latent system failures often are difficult to recognize until the failures align and a patient accident occurs. And third, whenever systems are changed, there will be unexpected consequences.

"The more complex the system [and health care systems are very complex], and the more multiple systems interact [and health care systems are open systems], the less we are able to predict all the consequences of planned change — both in the system we are changing and in the systems within which it interacts," he said. "Unfortunately, vigilance is neither easy nor pleasant, and itself creates fatigue."

Meanwhile, the Institute for Healthcare Improvement's "100,000 Lives Campaign" claimed midyear that its efforts to reduce lethal errors

and unnecessary deaths in U.S. hospitals have saved an estimated 122,300 lives in the last 18 months.

"I think this campaign signals no less than a new standard of health care in America," said Harvard professor **Donald Berwick**, who is the institute's president.

Berwick announced his 100,000 Lives Campaign in December 2004 and set a June 14, 2006, deadline for signing up at least 2,000 U.S. hospitals in the effort and to implement six types of change. Perhaps the best known of the six changes is to deploy rapid response teams for emergency care of patients whose vital signs suddenly deteriorate. Another urged checks and rechecks of patient medications to protect against drug errors, while a third focused on preventing surgical site infections by following certain guidelines, including giving patients antibiotics before operations. The other three changes are to deliver reliable, evidence-based care to heart attack patients, prevent central line infections, and prevent ventilator-associated pneumonia.

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# CMS issues citizenship guidelines to state Medicaid directors

On June 9, CMS issued the long-awaited guidelines for states to administer the provision in the Deficit Reduction Act of 2005 requiring individuals claiming U.S. citizenship when they apply for Medicaid to provide satisfactory documentary evidence of citizenship or nationality when initially applying for Medicaid or upon a recipient's first Medicaid redetermination on or after July 1, 2006.

The CMS letter to state Medicaid directors provides four charts with documents of varying levels of acceptability for establishing citizenship and one chart for documents establishing identity.

The law requires that for new Medicaid applicants or currently enrolled individuals, states must obtain evidence of citizenship at the time of application or the first redetermination on or after July 1, 2006. Recipients will need to provide documentation only once unless doubt is cast on the situation because once citizenship is established, it is a

circumstance not likely to change, CMS said.

Thus, beginning July 1, self-attestation of citizenship by applicants or recipients was not acceptable. At the time of application or redetermination, states must give applicants or recipients who signed a declaration claiming to be a citizen, a "reasonable opportunity" to present documents establishing U.S. citizenship or nationality and identity.

Individuals who already are Medicaid recipients remain eligible until determined ineligible. CMS said a determination terminating eligibility may be made only after a recipient has been given a reasonable opportunity to present evidence of citizenship or the state determines the individual has not made a good-faith effort to present satisfactory documentary evidence of citizenship.

The guidance advises: 1) an individual who is already enrolled in Medicaid will remain eligible if he/she continuously shows a good-faith effort to present satisfactory evidence of citizenship and identity; 2) applicants for Medicaid should not be made eligible until they have presented the required evidence; 3) if an applicant or recipient tries in good faith to present satisfactory documentation, but is unable because the documents are not available, the state should assist the individual in securing these documents; and 4) if an applicant or recipient cannot obtain the necessary documents and needs assistance (i.e., is homeless, mentally impaired, or physically incapacitated), and lacks someone who can act on his or her behalf, then the state should assist the applicant or recipient to document U.S. citizenship and identity.

The letter also provides several state processes and best practices:

1. All documents must be either originals or copies certified by the issuing agency. Copies or notarized copies may not be accepted.

2. States must maintain copies in the case record or database and make them available for compliance audits.

3. States may permit applicants and recipients to submit such documentary evidence without appearing in person at a Medicaid office.

4. If documents are found to be inconsistent with pre-existing information, are counterfeit, or altered, states should investigate for potential fraud and abuse, including referral to the appropriate state and federal law enforcement agencies and/or the agency that issued the document.

5. Presentation of documentary evidence of citizenship is a one-time activity. Once a person's citizenship is documented and recorded in a state database, later eligibility changes should not require repeating the documentation of citizenship unless later evidence raises a question about citizenship.

6. A number of states — New York, New Hampshire, and Montana — have required documentation of citizenship for many years. New York and New Hampshire have published guidelines for documenting U.S. citizenship that generally mirror the list of acceptable documents in the letter. States with such a process currently in place to document citizenship should review the letter and modify their process as appropriate, CMS said.

CMS warns that federal matching funds will not be available if states don't require appellants and recipients to provide satisfactory documentary evidence of citizenship.

Before CMS issued its guidelines, states had been asking for more

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

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flexibility in implementing the requirement. While the law is intended to prevent undocumented immigrants from claiming to be citizens in order to receive benefits provided only to legal residents, states have said they worry that eligible Medicaid enrollees who cannot provide the necessary documentation also stand to lose coverage. State officials also fear the law will create a large administrative burden and confuse beneficiaries.

California Medicaid director **Stan Rosenstein** said he wants to use signed personal affidavits for young children and some adults on

Medicaid who can't produce the required documents.

"We want to use as many alternative sources as possible," he said. But CMS administrator **Mark McClellan** said the agency wanted "to provide an effective way to document citizenship without placing excessive burdens on states or beneficiaries." We know that for some people it's going to take a little time, and we want to be able to account for that."

*Download the CMS materials at [www.cms.hhs.gov/MedicaidEligibility/05\\_ProofofCitizenship.asp](http://www.cms.hhs.gov/MedicaidEligibility/05_ProofofCitizenship.asp). ■*

## Clip files / Local news from the states

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

### Health care plan in works to offer up big changes

BATON ROUGE — Louisiana will have a detailed health care plan to present to federal officials by mid-October, outlining major changes in the way such care is delivered and paid for in the New Orleans area, Louisiana Health and Hospitals Secretary **Fred Cerise** says. The goal of the plan, which will be crafted in cooperation with U.S. Health and Human Services Secretary **Michael Leavitt**, is to create a "medical home" for the poor by revising the rigid rules that govern the Medicaid program. Cerise said the redesigned system could lead to the program being expanded to cover more people, but also might require poor people to pay for a portion of their care in exchange for having greater flexibility and access to more primary and preventive care.

— *New Orleans Times-Picayune*, 6/13/06

### Bredesen Signs Health Care Legislation

NASHVILLE — Tennessee Gov. **Phil Bredesen** has signed health care

legislation designed to help cover Tennessee's more than 600,000 uninsured workers. Bredesen made the program, Cover Tennessee, his top priority this session, and the General Assembly passed the legislation shortly before adjourning. "These uninsured are an issue we can no longer ignore," Bredesen said. The plan is optional and offers low-income workers a chance to buy basic subsidized health insurance, giving employers an option to help pay part of the premium. Employers would have an incentive to opt in because the state's insurance plan will cost less than others. The average monthly premium will be \$150 for basic insurance under the plan. The state will pay \$50, employers will have the option to contribute another \$50, and employees pay the rest. Cover Tennessee also includes a plan to cover children and a program for adults who can't get insurance because of a pre-existing medical condition. There's also a state-sponsored pharmacy assistance program and an effort to reduce obesity and diabetes. The state

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estimates that 100,000 adults, 75,000 children and 15,000 chronically ill residents will enroll in the plan within three years. The entire program is expected to cost the state \$350 million over that time.

People who make less than 2½ times the federal poverty level — \$24,500 for an individual or \$50,000 for a family of four — would be eligible for most of the Cover Tennessee proposal. Bredesen said he expects the plan's coverage to begin in early 2007, although several details have yet to be ironed out, including which insurance companies will participate. The legislation calls for at least two companies to offer coverage. Bredesen has described Cover Tennessee as an alternative to the mandatory universal health program passed by Massachusetts.

— *Newsday/AP*, 6/12/06