State Health Watch

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In This Issue

NGA's pandemic primer says the states have a long way to go in planning for flu

States have made progress in planning for the public health aspects of coping with a major flu pandemic, but have a long way to go in thinking through many of the other aspects. That's a conclusion drawn by the National Governors Association (NGA) Center for Best Practices in its study *Preparing for a Pandemic Influenza: A Primer for Governors and Senior State Officials*.

Center for Best Practices senior policy analyst **Chris Logan** tells *State Health Watch* that, to date, states have focused primarily on public health preparedness and medical preparedness, addressing issues such as surge capacity, alternative treatment sites, and the need for additional staff.

"Now states need to focus on the nonmedical aspects," he says, "such as continuity of operations and maintaining existing services. For instance, it's necessary to think through how to maintain essential police, fire, sanitary, and wastewater services when up to 40% of the people who normally work in those areas are unable to come to work because they are sick."

Meanwhile, the Centers for Disease Control and Prevention said the national pandemic influenza plan should be revised to provide

*See **Pandemic** on page 2*

Reasons for high emergency department use elusive and they are not tied to uninsured

Contrary to popular wisdom, communities with heavy use of hospital emergency departments (EDs) have fewer numbers of uninsured, Hispanic, and noncitizen residents.

Fiscal Fitness: How States Cope

A study of ED use by Center for Studying Health System Change senior fellow **Peter Cunningham** found that visits to EDs increased 26% between 1993 and 2003 to some 114 million visits annually. About one-third of those visits are classified as nonurgent or semi-urgent, suggesting that the care could have been provided in another setting.

"Increases in emergency department use contribute to overcrowding," Mr. Cunningham says, "which can lead to longer waiting times and more ambulance diversions to other facilities. Growing use of the emergency department for nonurgent medical problems can also increase health care costs and negatively affect quality of, continuity of, and patient satisfaction with care."

Explanations that have been offered for the increase in ED use

*See **Fiscal Fitness** on page 5*

State Health Watch
The Newsletter on State Health Care Reform

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Vice President/Group Publisher: Brenda Mooney, (404) 262-5403, brenda.mooney@ahcmedia.com.
Editorial Group Head: Lee Landenberger, (404) 262-5483, lee.landenberger@ahcmedia.com.
Editor: John Hope, (717) 238-5990, johnhope17110@att.net.
Senior Production Editor: Nancy McCreary.

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Pandemic

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states with more concrete information they could use in their planning process (**see box, p. 3**).

Mr. Logan says the NGA primer calls for comprehensive planning that involves government agencies, businesses, and individuals, each of whom will have a role to play in responding to a pandemic outbreak.

"The impact of a pandemic will be felt most acutely at the state and local levels," said NGA vice chair **Janet Napolitano**, governor of Arizona. "Strong state leadership will be crucial. This document will help governors and state officials understand their unique roles in the development of an effective response plan and the challenges they face."

Outlined in the document are four key principles to guide governors in their ongoing efforts to shape effective response plans:

- The effects of a pandemic flu will be broad, deep, and simultaneous, and states must focus resources to ensure continuation of essential services;
- Medical response capability in a pandemic will be limited, strained, and potentially depleted during a pandemic;
- Government must work closely with the private sector to ensure critical operations and services are maintained;
- A pandemic will force many key decisions to be made in a dynamic environment of shifting events and partnerships must be built now and tested to ensure appropriate and rapid action.

All social sectors will be affected

"Pandemic planning involves more than stockpiling pharmaceuticals and planning for surges of patients at hospitals," the primer says. "A severe pandemic will affect all sectors of society: high rates of worker absenteeism could affect the operations of water treatment facilities and power plants; efforts to slow or stop the spread of the disease could limit the availability of food, cause schools to be closed for significant periods of time, and cause economic hardships for state and local governments, business owners, and individuals; and government efforts to manage the public's response could be complicated by the myriad sources of information—including the Internet—on which people rely for guidance."

According to the report, state and local officials must address not just the immediate outbreak of influenza, but also the time between the pandemic waves, and the possibility that the worst effects may occur in a second or third wave. It may take more than a year to complete the likely three phases of the disease. During each time between outbreaks, it says, there will be an opportunity to recover and prepare for a future outbreak, but that opportunity will come during a time of considerable stress for the public and an exhausted responder community.

"After a pandemic wave is over, it can be expected that many people will have lost friends or relatives, suffer from fatigue, or have financial losses as a result of the interruption of business," the report explains. "State governments or other state or local authorities will need to address these concerns while also preparing to respond to the next wave of the disease. A key priority will be ensuring that government operations continue. Each agency must develop a list of service priorities and then develop plans for meeting those priorities."

Effective plans, the report says,

(Continued on page 4)

Gaps are seen in pandemic containment plans

Research reported by the Centers for Disease Control and Prevention says the lack of unified national direction for states to follow in developing pandemic flu plans is leading to disparate and confused state efforts and could result in "a patchwork of plans that will not adequately detect and control this or other respiratory disease pandemics."

The survey of publicly posted plans for 49 states covered vaccination strategies, surveillance and detection, and containment strategies.

Research Triangle Institute International senior infectious disease epidemiologist **Scott Holmberg**, MD, MPH, the lead study author, said that despite the lack of clear guidance, and the fact that no one can say with any certainty when a flu pandemic will strike, what its characteristics will be, or the effectiveness and quantity of any strain-specific vaccine, still the evolving state plans are in agreement in adhering generally to Advisory Committee on Immunization Practices and Department of Health and Human Services guidelines for prioritizing vaccination.

"In general, the elderly, those with chronic diseases, and health care and infrastructure personnel will be prioritized to receive vaccination," Dr. Holmberg said, "and in approximately one-third of the states, young children will be prioritized to be vaccinated. We believe the estimate that such persons make up 15% to 20% of the population in any state is reasonable. However, the vaccination strategy is predicated on preventing deaths from influenza, not stopping or retarding an epidemic or pandemic. Given that vaccine adequate to cover the entire U.S. population will not be available for several more years, the goal of reducing transmission would require much more vaccination than is available."

Looking at surveillance and detection, the report notes, state plans are even more variable than they are about strategizing vaccinations. Systems states are planning to use have unavoidable delays built into them, it said, and thus some state are looking into the possibility of moving to a different type of program.

"However," the researchers wrote, "to our knowledge no health authority feels confident that earlier detection of influenza by one to three weeks would necessarily lead to better control or substantial retardation of an outbreak."

In terms of proposing practical containment measures in the community, there is confusion and lack of specificity in the posted state plans, the researchers found. They noted that the national Department of Health and Human Services plan has several recommendations for infection control in hospitals, but is weaker and nonspecific in other areas such as control of influenza in the community.

"For example," they wrote, "there is no agreed-upon definition of geographic clustering of cases or number of persons infected that will trigger the declaration of a pandemic. Much of the national plan suggests social distancing and respiratory (cough) etiquette and devotes much of its discussion to mask use. Accordingly, states are comparably nonspecific about community control plans."

Dr. Holmberg said several practical, nonpharmaceutical steps should be under consideration. For example, he said, only one-third of state plans are explicitly considering recommending self-isolation of adults with influenza-like symptoms and keeping children with such symptoms home from school and day care. Even in an increasingly computer-based economy, in which a considerable percentage of people can work from home most of the time, the strategy has not been addressed in most state plans. And other simple recommendations for use in the community such as avoiding mass gatherings, shopping on off-hours, and household and workplace strategies such as frequent hand washing, avoiding handshaking, and keeping towels separate, often are neglected in state plans.

The report blames the lack of uniformity and consistency in state plans on weak federal direction, but also on the fact that answers are lacking to several epidemiologic questions necessary for national planning.

Questions that need answering

Questions the report raises include:

- What is the typical intrahousehold or institutional attack rate, and would vaccination or chemoprophylaxis of contacts retard or stem outbreaks?
- How well do masks work for pandemic influenza in the community, and where and for how long should they be used?
- Does closing a school or other institution actually reduce community-level illness and death?
- Does earlier detection of influenza in a community lead to behavior changes that could stem an outbreak?

The researchers said they know of no studies designed to address those and several other issues, and several

state plans have expressed frustration about such lack of information.

They argue for revisions to the national pandemic influenza plan to provide more uniform, specific, and practical influenza protection, avoidance, and containment practices, and also call for studies and expert panels to determine if masks, school closings, social isolation, and several other nonpharmaceutical strategies would be useful in reducing the illness and death caused by pandemic influenza and its spread in the community.

The research report is available online at www.cdc.gov/ncidod/eid/vol12no09/06-0369.htm. E-mail Dr. Holmberg at sholmberg@rti.org. ■

must answer these questions:

• Is there recognition of the potential human, social, and economic impact of a pandemic within the state and region?

• Are there public and private sector commitments to prepare for such an event?

• Is there a strategy on how to involve the community in the planning process?

• Have ethical aspects of policy decisions been considered? Is there a leading ethical framework that can be used during the response to an outbreak to balance individual and population rights?

• Is a legal framework in place for the state pandemic plan? Does this framework include contingencies for health care delivery and the maintenance of essential services, and for the implementation of public health measures?

• Has the state prioritized countermeasure allocation before an outbreak? Can the state update this prioritization immediately after the outbreak begins based on the at-risk populations, available supplies, and characteristics of the virus?

• Does the state have an effective communications plan and strategy? Are all the key state personnel aware of their roles and responsibilities in the communication plan? Does the state have backup plans in the event that one or more functions fail due to infrastructure or manpower losses during the epidemic?

Plans must stress communication, intergovernmental coordination, public education, health resources, curbing economic impacts, maintaining essential services, using appropriate legal authority to stop disease spread, and training, NGA says.

Respond to changing conditions

Because a pandemic will not present a single event or catastrophe, but rather a series of events to address over time, states' decision-making processes must be agile and responsive, the report stresses.

"For this reason," it says, "states, together with localities, the private sector, and neighboring states, must spend considerable time in testing plans and simulating events. Only through such exercises will there be an opportunity to explore contingencies and build relationships among those tasked with responding."

Mr. Logan tells *State Health Watch* that much of the planning has to look at interdependencies among various systems and activities. Thus, he says, planners have to consider what happens if the schools must close to ensure that children don't end up going to the mall to hang out. And they must consider the possible need for additional law enforcement resources if students are not in school.

"Once you start looking at it, it can become overwhelming," he says. "Everyone needs to be present to discuss and decide."

Mr. Logan says governments must realize the situation will change rapidly and they will need to be able to react quickly in response to changing situations.

He says it is not NGA's role to produce a template that all states could follow. The primer was written, he says, to raise questions and help state officials think through the many issues that are involved.

"What will be needed in California and Washington is very different from what will be needed in Wyoming and New Mexico," he says. "Everyone needs to think about the same kinds of things, and especially about how to preserve resilience."

States have an advantage, according to Mr. Logan, because they have done planning for other kinds of catastrophes and some of the issues are the same.

"One of the things we learned from Hurricane Katrina is that the things you rely on can disappear quickly," he says. "If you can ride out a pandemic, you're in pretty good shape for a number of other things. States probably have been thinking about many of the issues already in other contexts."

Long way to go in planning

American Public Health Association executive director **Georges Benjamin**, MD, FACP, who had been Secretary of Health and Mental Hygiene in Maryland, tells *State Health Watch* states' ability to respond to a pandemic is improving, but "we still have a long way to go."

He says there is a broad awareness

in government about the issue today. Major companies are aware of some of the potential ramifications for them, he says, but smaller employers have not yet gotten their hands around the issues. The average person has heard something about flu pandemics on TV but that's all, and the low-income and disabled populations don't have it on their radar screens.

"States have made some plans," according to Dr. Benjamin, "but they're in varying degrees of completeness. And even the best plans have not been fully integrated into broader preparedness plans. They have not stood the test of real time. You have to drill and test plans to identify problems that need to be fixed."

He also is concerned that states have not engaged the public yet.

"It's clear the public won't do what we want them to do," he says, "and that leads to a mismatch between plans and what people actually do."

Dr. Benjamin agrees with Mr. Logan that the task can seem overwhelming, but says it can be managed if state officials take it one step at a time. Strategies states should consider, he says, include 1) building to the extent possible on the existing infrastructure; and 2) building a logistical system that works. He gives just one example of the kinds of logistical issues that need to be addressed—schools provide many functions in addition to educating children, such as providing one or more meals a day to children. If the schools close, some way must be found to continue mass feedings. Dr. Benjamin says there have been suggestions that school buses be used to follow their normal routes and deliver meals.

"But school bus drivers don't know anything about mass feeding and delivery routes," he says. "It might make more sense to involve those who are used to delivering in a community, such as FedEx and UPS, and team them up with people who are used to cooking for large numbers such as fast-food restaurants and other eating establishments."

Dr. Benjamin also believes states need to build their public health capacity holistically.

"Surge capacity comes from people who are already there but are doing other things," he says. "You need to be sure people know it's their responsibility to come to work and pick up a different task."

Download the NGA primer from www.nga.org/Files/pdf/0607PANDEMICPRIMER.PDF. Contact Mr. Logan at (202) 624-5379. American Public Health Association pandemic materials are available at www.apha.org. Contact Dr. Benjamin at (202) 777-2742. ■

Fiscal Fitness

Continued from cover

include changes in the population that have increased demand for ED services and health system changes that have constrained capacity of other outpatient care. Increases in the number of uninsured people who lack access to other types of outpatient care also are often cited.

Mr. Cunningham used data from the 2003 Community Tracking Study (CTS) household survey to look at the extent of variation in ED use across communities and how that variation is related to many population and health system characteristics. His study focused specifically on the extent to which high levels of ED use in some communities are related to high levels of uninsurance and Medicaid coverage, as well as high numbers of noncitizen and racial/ethnic minorities, who are known to have reduced access to medical care. He also looked at evidence that greater convenience of ED and outpatient capacity constraints contribute to high levels of ED use in some communities.

Survey respondents were asked to report the number of visits to hospital EDs in the previous 12 months. They also were asked to distinguish between visits that resulted in an inpatient admission and those that did not. (The data analysis excluded visits resulting in an inpatient stay because they are likely to be the least discretionary type of visit and less affected by patients' preferences and health system factors.)

Wide variation across cities

Mr. Cunningham says he found considerable variation in ED use across the 12 CTS case study sites. The average for 2003 was some 32 visits per 100 people for both the United States and large metropolitan areas. This varied from a high of almost 40 visits per 100 in Cleveland to about 21 visits in Orange County, CA.

"Despite popular perceptions, communities with the highest levels of emergency department use did not necessarily have the highest numbers of uninsured, low-income, racial/ethnic minority, or immigrant residents," Mr. Cunningham says. "For example, Cleveland and Boston had the highest emergency department use levels among the 12 CTS sites and some of the lowest uninsurance rates, while Phoenix and Orange County had both low emergency department use and higher-than-average uninsurance rates in 2003. In addition, communities with the lowest emergency department use also tended to have a higher percentage of Hispanics and noncitizens than communities with high emergency department use."

In 2003, according to Mr. Cunningham's analysis, communities with the highest levels of ED use did not typically have population characteristics that are commonly associated with high levels of use. In fact, he says, there was little variation across the four groups of communities on measures of poverty or health insurance coverage. In terms of race/ethnicity, communities with high ED use had a higher percentage of African Americans than low-ED use communities had, although low-use communities had much higher levels of Latinos and noncitizens compared to high-use communities. More consistent with expectations was that communities with low ED use tended to have somewhat higher numbers of children (who use less health care generally) and fewer people with multiple chronic conditions.

Constraints

The analysis also found a correlation between some health system characteristics and levels of ED use. Thus, in 2003, communities with high ED use tended to have greater outpatient capacity constraints than communities with lower use, as indicated by significantly longer average appointment waiting times. While high-use communities also contained more hospital EDs relative to the population than low-use communities had, there were no statistically significant differences in the average distance to the ED between high- and low-use communities. Contrary to expectations, communities with high ED use had greater community health center capacity in 2003 compared to low-use communities, which Mr. Cunningham says could reflect in part the smaller population and lower population density of high-use areas compared to low-use areas.

More consistent with expectations was that low-use communities tended to have a higher percentage of their insured populations enrolled in HMOs in 2003 compared to other communities.

Results dispute popular notions

While insurance, demographic, socioeconomic, and health factors are strongly related to individuals' emergency department use, Mr. Cunningham says, some of the results run contrary to popular perceptions. For example, in 2003 the uninsured had about 16 fewer visits per 100 people on average than Medicaid enrollees, about 20 fewer visits than Medicare enrollees, and roughly similar levels of use compared to privately insured people. Noncitizens had much lower levels of ED use than citizens did (17 fewer visits per 100 people on average) and the difference between poor citizens and noncitizens was almost twice as large.

In terms of racial/ethnic differences, blacks had higher ED use levels than whites and Hispanics did in 2003. More in line with expectations was the higher ED use by poor people compared to other income groups, and higher use by people in fair or poor health and with chronic medical conditions.

Mr. Cunningham says that for communities whose populations have high rates of ED use, it is unclear how much the rates could be reduced by emulating the health care systems in communities with low use rates.

"For example," he says, "efforts to increase insurance coverage in high-use communities may be a viable strategy for increasing access and reducing the amount of uncompensated care in a community, but it will not decrease overall emergency department use both because coverage rates are already slightly higher in high-use communities and because insured people have as much emergency department use as uninsured people have, or even more."

Increasing outpatient capacity may result in some modest reductions in ED visits for high-use communities, and expansions of HMOs and community health centers might help reduce ED use among poor and low-income people, although Mr. Cunningham found that differences in these two factors are not large enough to account for much of the variation in ED use, even among the poor.

Looking at implications of his research for the future, Mr. Cunningham says population increases will contribute to increases in the overall number of ED visits nationally, although projected changes in the population's composition (such as an increase in the number of people of Hispanic origin) are likely to have mixed effects on ED visit levels.

Immigration

"There is much concern that some of the increase will be driven by illegal immigration," Mr. Cunningham says, "which is cited as straining emergency department capacity in some hospitals, especially along the U.S./Mexico border. However, given the very low levels of emergency department use among poor noncitizens in general (many of whom are likely to be undocumented immigrants), it is very unlikely that these highly localized problems with emergency department crowding will affect the nation more generally as the Latino population increases and migrates to other parts of the country."

One potential source of increases in ED visit rates in the future, according to Mr. Cunningham, is high levels of ED use among Medicare beneficiaries and Medicaid enrollees.

"The aging of the population and retirement of the baby-boom generation will greatly increase Medicare

enrollment and the proportion of the population who are elderly, who tend to have higher levels of emergency department use compared to other age groups," he says. "Also, continued increases in private insurance costs could result in increases in both Medicaid and other public coverage of nonelderly people, as well as increases in the number of uninsured people. High use of emergency departments in Medicaid likely reflects in part little or no cost-sharing for health services use, and perhaps lack of access to office-based physicians (because of low physician reimbursement rates under Medicaid). Thus, higher levels of emergency department use associated with increased enrollment in public coverage could be offset to some extent by increasing access to office-based physicians, providing inducements to use nonemergency department settings for nonurgent care, and perhaps greater utilization as evidenced by lower emergency department use among poor people enrolled in HMOs."

However, he says, increases in uninsurance rates are not likely to result in net increases in ED visit rates because although the uninsured rely on emergency departments to a greater extent than insured people do, because they lack access to other outpatient care, their actual use of hospital EDs is no greater than that of the privately insured, probably because fear of incurring the entire cost of an ED visit acts as a constraint on how frequently they visit them.

Why is it broken?

American College of Emergency Physicians (ACEP) president **Frederick Blum**, MD, FACEP, tells *State Health Watch* it's important to those on the front lines that the true reasons for increases in ED use are known.

"You can't fix something if you don't know why it's broken," he says. "There have been lots of fallacies about the problem, such as that there are a lot of people in emergency departments who don't need to be there. People who use the emergency department inappropriately are not the source of overcrowding."

According to Dr. Blum, because EDs operate with a triage system, those who seek to use the facility inappropriately are likely to have to wait a long time, backing up in waiting rooms but not causing overcrowding in the ED itself.

The principal problem, according to Dr. Blum, is that the primary care system has failed many people, especially those with chronic conditions who don't have access to appropriate medical care.

"There is a mismatch between resources and demand," he says.

While the number of ED visits has increased significantly over the last decade or more, the number of EDs has dropped in the same period, putting even more pressure on the facilities that remain open, Dr. Blum says. The problem is exacerbated, he says, by the nursing shortage and by declining reimbursement rates.

"There aren't many businesses that could succeed with this business model," he says. "It's not a sustainable business model because of the poor reimbursement."

Mr. Blum says there are no simple fixes for the problem and that what has to be done is to chip away at all the varying causes. "It's potentially going to get worse before it gets better," he cautions. "We need to figure out how to fix the physician payment formula. It's hard to see the way out of the wilderness."

ACEP is supporting the Access to Emergency Medical Services Act that would:

- recognize hospital EDs as the backbone of the nation's health care safety net and help offset the costs of uncompensated care;
- provide hospitals with incentives to end boarding of admitting patients in EDs, to help end gridlock and save lives during natural disasters and acts of terrorism;
- extend liability protection to emergency physicians and on-call specialists who provide critical services to uninsured patients.

"Our emergency departments are struggling with the day-to-day demands put on them," Mr. Blum said. "If something isn't done soon to fortify our emergency services, there is a real question about how hospitals would handle another terrorist attack or major public health crisis."

Increased demand

Mr. Cunningham's analysis indicates that continued increases in ED use nationally are more likely to be driven by increased demand for health care in general than by changes in the population, as was the case with the increase in ED use over the past decade. If increases in the number of physicians aren't able to meet the increased demand, ED visit levels among the population could also increase, he says, as they absorb the overflow of patients who can't get timely appointments with their regular physicians.

Reducing use of hospital EDs for nonurgent medical problems is desirable, according to Mr. Cunningham, because it could help lower overall health care costs and improve patients' experiences with the health care system. However, he cautions, reducing ED use defies simple solutions such as expanding insurance coverage or restricting access for undocumented immigrants.

"Increasing nonemergency department capacity in the health care system, as well as expanding the

availability of community health centers and HMOs for low-income people, might lead to some marginal reductions in emergency department use," he says. "Nevertheless, while reducing emergency department use might be desirable from a health system perspective, emergency departments are likely to remain highly popular and convenient sources of medical care for many people and communities, including the majority of emergency department users who have private insurance coverage."

Download an abstract of Mr. Cunningham's analysis from www.healthaffairs.org. E-mail Mr. Cunningham at pcunningham @hschange.org or telephone him at (202) 484-4242. Information on ACEP's position on demand for emergency department services and the legislation it supports is at www.acep.org. Contact Dr. Blum at (202) 728-0610. ■

Study: Cutting Medicaid family planning won't save money

The Guttmacher Institute says the experiences of states that have expanded Medicaid family planning programs during times of budget strain prove that cuts to family planning would end up costing money in the long run.

With the Deficit Reduction Act of 2005 giving states significant new latitude to change their Medicaid programs, including excluding family planning from the benefits offered to some groups of enrollees, the institute is pushing the notion that such actions would be penny-wise but pound-foolish.

"Medicaid cuts would have significant implications for women's access to contraceptives and their ability to prevent unwanted pregnancies," the institute said in a statement, "because Medicaid is now the largest single source of public funding for family planning. Nearly 12% of all women of reproductive age rely on Medicaid for their health care, and the program provides more than six in 10 public dollars spent on family planning in the United States. Cuts to Medicaid funding for family planning would increase the difficulties that poor women already face in accessing the contraceptive services and supplies they need to avoid unplanned pregnancies."

The institute said there are several compelling reasons to expand Medicaid family planning rather than cut it:

• **Family planning funding prevents unintended pregnancy and reduces the need for abortion**. The Institute estimates that publicly supported family planning each year helps women prevent an estimated 1.3 million unintended pregnancies and 632,000 abortions.

• **Family planning funding saves money**. A study funded by the federal government found that states that expanded eligibility for family planning under Medicaid saved money, even as they served more women. And the Guttmacher Institute estimates that every dollar spent on contraceptive services saves $3 in Medicaid costs for pregnancy-related and newborn care alone.

Guttmacher Institute Medicaid expert **Rachel Benson Gold** tells *State Health Watch* 23 states have expanded Medicaid family planning with positive results.

Required service

"Since 1972," she says, "family planning has been one of a handful of services the federal government has required all state Medicaid programs to cover, and it is one of the very few services for which patient cost-sharing is prohibited."

Under the Deficit Reduction Act, Ms. Gold says, scaled-back benefits packages can be offered to two groups of enrollees for whom access to family planning is critical — parents enrolled in the program and some women who have recently had a Medicaid-funded delivery and who, up to now, have been entitled to obtain family planning as part of postpartum care.

"In addition to allowing states to scale back enrollees' benefits packages, the Deficit Reduction Act gives states the option to impose 'nominal' cost-sharing for some drugs prescribed as part of a family planning visit," Ms. Gold says.

The legislation also removed a long-standing statutory protection that barred providers from denying care to enrollees unable to afford the required cost-sharing. Ms. Gold says these two provisions mean, for the first time in more than 30 years, enrollees seeking family planning services may be charged for some of the care they receive and may be denied care if they are unable to pay.

Ms. Gold says the experience of states that have opted for expanded family planning shows that reducing family planning coverage runs directly counter to three major goals articulated by Deficit Reduction Act supporters. First, she says, the major goal of the law's Medicaid provisions is to cut Medicaid costs. But the way to reduce Medicaid costs (**see chart, p. 9**) is to expand coverage of family planning, not cut it, she adds.

An evaluation of state experiences found that by helping thousands of women each year prevent unplanned pregnancies that would have resulted

Medicaid Family Planning Waivers

Extending Eligibility to Individuals...

Losing coverage...	Based solely on income
Postpartum	Alabama (113% of poverty)
Arizona (2 years)	Arkansas (200%)
Florida (2 years)	California (200%)
Maryland (5 years)	Mississippi (185%)
Missouri (1 year)	New Mexico (185%)
Rhode Island (2 years)	New York (200%)
Virginia (2 years)	Oregon (185%)
For any reason	South Carolina (185%)
Delaware (2 years)	Washington (200%)
Illinois (5 years)	Wisconsin (185%)

Source: Guttmacher Report on Public Policy, March 2004, Vol. 7, No. 1.

in Medicaid-funded births, the family planning expansions resulted in millions of dollars in savings to both the federal and state governments.

A second Deficit Reduction Act goal, Ms. Gold says, is to promote program enrollees' personal responsibility.

"The notion is that if enrollees are required to shoulder a part of the cost of their care, they will cut back on unnecessary care, which, in turn, will lower Medicaid costs," she explains. "This argument, however, is counterproductive when it comes to family planning, because enrollees are acting responsibly when they utilize contraceptives, not when they forego them. Any cost-sharing that would discourage use would, therefore, be counter to the goal of personal responsibility. Moreover, any cost-sharing imposed on a prescription medication that would discourage enrollees from treating a sexually transmitted disease would likewise be counterproductive, resulting not only in a more serious medical situation for the enrollees, but possibly in the transmission of new disease to someone else."

Seeking health care improvement

A third major goal of the legislation is to allow states to improve enrollees' health care and, by extension, their health. This would be accomplished by offering coverage that better meets each patient's needs. Clearly, reducing coverage for family planning runs counter to achieving that goal, according to Ms. Gold. The Centers for Disease Control and Prevention (CDC), Ms. Gold says, identified family planning as one of the top 10 public health achievements of the 20th century and, in 2000, the federal government set a goal to reduce unintended pregnancies by 40% over 10 years, and recognized family planning as the key to achieving that national objective.

A 2004 evaluation of states that have expanded family planning services commissioned by the Centers for Medicare & Medicaid Services (CMS) found that every one of the expansion programs studied not only met a federal requirement for budget neutrality, but actually saved money.

The CMS evaluation looked at state waiver programs in Alabama, Arkansas, California, New Mexico, Oregon, and South Carolina to determine whether they met the federal requirement for budget neutrality (federal spending under the waiver can't exceed what federal spending would have been without the waiver).

Ms. Gold said the evaluators used what they deemed to be the most appropriate method for calculating budget neutrality and found that all six programs resulted in often substantial net savings (**see chart, above**). "Interestingly," Ms. Gold said, "corroboration for the CMS cost-savings finding came recently from Wisconsin, but for an unlikely reason. Since 2002, Wisconsin has had a waiver to provide family planning services to all women in the state with incomes up to 185% of poverty. A bill is pending in the state legislature to limit coverage under the waiver to individuals ages 18 and older. A cost estimate for the provision developed by the Wisconsin Department of Administration indicated that denying care to individuals 15 to 17 would result in more than 3,300 additional births to teens in the state, at an additional cost of $12.7 million in public funds over a five-year period."

Save money, increase access

The CMS evaluation also found that even as they saved money, the waivers increased access to services. Thus, in four of the six states, the number of clients served in clinics receiving funds through the Title X program who met the eligibility requirements for the waiver grew after the program was implemented. And Ms. Gold says the study found evidence in two states of a measurable reduction in unintended pregnancy among the total population of women eligible for the waiver, a very high bar for the program to clear, according to the researchers.

Ms. Gold said the evaluation findings "have significant relevance for policy-makers at the state level as well. In harsh economic times, when the states are feeling compelled to make difficult choices about their Medicaid programs, an effort that can reduce costs while actually improving access to care for enrollees may be particularly attractive. 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. According to the CMS study, 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.

"Accordingly, the eight states that have tailored their waiver programs more narrowly to women losing Medicaid coverage may want to reassess the scope of their efforts. Similarly, in light of the study results from Wisconsin, those states that are considering barring teenagers from eligibility under their programs may want to think twice before doing so."

At a 2005 Kaiser Family Foundation briefing on women and Medicaid, foundation vice president and director of women's health policy **Alina Salganicoff** said the vast majority of women on Medicaid are in their reproductive years, although they're not the most expensive population to treat.

"The elderly and disabled account for two-thirds of the spending because of [their] greater health needs and more costly medical and long-term care," Ms. Salganicoff said.

On average, a low-income adult on Medicaid, typically a mother, costs about $2,000 a year to treat, whereas a disabled elderly beneficiary costs about $12,000 a year.

Women comprise more than 70% of the adult Medicaid population and are more likely than men to qualify because of their lower incomes and status as single, low-income parents of children, she said.

"Forty percent of poor women are still uninsured," Ms. Salganicoff asserted. "Women on Medicaid are more than four times as likely to report their health as fair or poor," because low-income people tend to have more health issues."

Medicaid covers half of the women in the United States with a permanent physical or mental impairment who live in a community setting. This percentage is even higher among institutionalized women—Medicaid pays for the care of nearly three-fourths of the residents in nursing homes.

Relatively new to Medicaid assistance are uninsured women with breast and cervical cancer, Ms. Salganicoff said. In 2000, treatment was extended as an optional Medicaid benefit for women screened under a program established by the CDC in 1990, she reported. "In California alone, 10,000 women got treatment under this program."

Study materials from the Guttmacher Policy Review and Guttmacher Report on Public Policy *are available on-line at www.guttmacher.org. Contact Ms. Gold at (202) 296-4012, ext. 4228. Contact Ms. Salganicoff at (202) 347-5270.* ■

North Carolina program improves well-child screenings

Changing doctor office processes as part of the North Carolina Assuring Better Child Health and Development (ABCD) Project has resulted in a significant increase in screening rates to more than 70% of the designated well-child visits. Data from the project prompted a change in Medicaid policy and screening now are statewide in primary practices that perform Early Periodic Screening, Diagnosis, and Treatment (EPSDT) examinations.

Dr. **Marian Earls**, of Guilford Child Health, Greensboro, NC, and the University of North Carolina School of Medicine Department of Pediatrics, says while some features of the program are specific to North Carolina, there are elements that could be used by any practice or state interested in integrating child development services into the medical home.

Dr. Earls tells *State Health Watch* the initial work was done under a Commonwealth Fund grant for a quality improvement project in one county that then took off.

Developmental screening and surveillance are recommended at well-child physicians visits, according to Ms. Earls, as a key component of preventive care for children. With primary care providers the best-informed professionals with whom families have regular contact over a child's first five years of life, screening is important as a way to facilitate early identification and referral for infants and children who need early intervention services.

The problem, Dr. Earls says, is that only 30% of children needing services are identified by school age because too often primary care physicians don't identify their needs in the course of well-child care, demonstrating the need for systems to integrate the use of formal, validated screening tools.

And the benefits of screening and surveillance aren't limited to children with developmental and behavioral delays. For typically developing children, families still benefit by increased awareness of appropriate developmental and behavioral expectations.

The ABCD project was started in North Carolina in August 2000 to pilot test formal developmental screening and surveillance for children receiving EPSDT services in pediatric and family practices. The project's goals were to assist physician practices in implementing an office process for screening that would be efficient and practical, to promote early identification and referral, and to facilitate practice

ability to link to early intervention and other community services. The intent was to establish a sustainable system for the entire state. The project started in one county, was replicated to nine additional counties, and then became a statewide Medicaid policy in 2004.

IDing those at risk

The model built on Community Care of North Carolina, the state's physician-driven enhanced primary care case management program. The community networks are designed to better manage services for the Medicaid population. Many of them also have expanded services to other populations such as those in the SCHIP program and the uninsured.

Dr. Earls says the heart of the program is community providers taking a population-based approach to managing enrollee care by systematically identifying patients at risk and then bringing in the processes and supports needed to manage the care.

A key project characteristic, Dr. Earls reports, is that it is physician-/practice-driven. The process began with physicians exploring options for a screening process that would be compatible with a busy office schedule, be satisfying to parents, optimize early identification of infants and toddlers who are at risk, and facilitate anticipatory guidance in promoting successful developmental outcomes.

In choosing a screening tool, factors that were considered included the type of screen, staff required, time required, and cost. Parent-completed tools required little staff time, were not costly, and fit well into the office flow. Also, they engaged the parents as experts of their own children and acknowledged the partnership between parents and providers in caring for children.

Dr. Earls says based on the experience of the initial pilot and other practices that later joined the project, key steps identified for the office process include:

- assessing current office protocols;
- identifying a physician champion to maintain the initiative as a priority;
- selecting a screening tool;
- mapping the workflow;
- identifying system supports to facilitate networking with community partners;
- conducting staff orientations, being sure to include nursing and office staff who will be instrumental in the office flow;
- sharing process and outcome data at regular intervals with staff.

Expanding the program

Information that has been shared with other states that have inquired about following North Carolina's lead include the need to identify a physician champion to lead project activity, directing activity from a local level rather than at the state level, piloting activity before trying to replicate it, replicating activities after data are collected and shared, developing policies for best practices in well-child care on the basis of local activity experience, aligning goals with collaborating partners to help ensure active participation from partners, and identifying care management resources in local communities to support the practice and family rather than hiring additional staff.

Dr. Earls tells *SHW* it's important to recognize that doctors typically are not the people who best know how a practice is run, and it's important to work with the office staff on practical issues, such as who hands out the parent-screening tools and who puts them in the patient charts.

Physicians have positively reacted to the program, she says, because using the screening tool makes well-child visits more efficient and the responses from parents can be used to provide guidance to them. And, she says, parents understand their own child's development better than the professionals do and love being asked to talk about it. Because of the screening tool, she says, doctors and parents can spend time talking about those things the parents are actually concerned about.

A key to project success outside of the well-child visits, Dr. Earls says, is for physician practices to make full use of other community services and

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

resources that are available.

"We encourage practices to network, to go out and talk with people and not just build phone lists," she explains. "It's been hugely effective in forging relationships that become very helpful to families who need something. It can be particularly useful if there are already truly collaborative activities under way."

Commonwealth Fund is continuing to promote project spread, Dr. Earls says, recognizing there will be variations from state to state. She says an important key to long-term success in North Carolina was that the project started with physicians, meaning there was more doctor buy-in that if it had been mandated by Medicaid.

"You need a physician champion," Dr. Earls says, "someone who can go to new practices and tell them of people they know who are already participating."

To help promote the program, ABCD has produced a training DVD for physician practices that includes interviews with doctors who have been participating in the effort.

Download Dr. Earls' report on the project from the journal Pediatrics *at www.pediatrics.org/cgi/content/full/118/1/e183. Contact her at (336) 272-1050, ext. 2231, or e-mail: mearls@gchinc.com.* ■

Clip files / Local news from the states

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

Hospitals must use translators

ALBANY—New York will require all hospitals to provide skilled translators amid fears that family members can be unreliable translators for non-English-speaking patients.

The reliance on friends and family to translate for patients — a common practice in exam rooms — can interfere with medical care, advocates say. A well-intentioned niece may hesitate to share upsetting news, or a patient might not disclose symptoms for fear of alarming their child. In other cases, information may just get garbled.

"It impedes the ability for information to flow freely and violates patient confidentiality laws," said **Adam Gurvitch**, director of health advocacy at the New York Immigration Coalition, which pushed for the new regulations that recently took effect.

Most hospitals are likely to rely on volunteers, bilingual staff, and telephone translation agencies to meet the new rules, he said.

There are no state or federal standards for what qualifies as a "skilled" medical interpreter.

Jeffrey Hammond, spokesman for the state Health Department, said the regulations will be enforced through the state's regular on-site visits and by investigating patient complaints to the department's hotline.

Previously, hospitals were required to provide interpreters for all patients, but the broad wording allowed them to count children and relatives as translators, Mr. Gurvitch said. The new regulations clarify those terms and require hospitals to appoint language coordinators and identify a patient's primary language on medical records.

Patients still could choose to use friends or relatives as interpreters, but only after they refused translators provided by the hospital.

Children younger than 16 may not be used, except in emergencies.

— The Associated Press, Sept. 15, 2006 ■