State Health Watch
Vol. 14 No. 8
The Newsletter on State Health Care Reform
August 2007

AHC Media LLC

In This Issue

'Shocking' difference among states on quality, access, other indicators

Where one lives clearly matters for access to care when it is needed, the quality of care that can be received, and opportunities to lead healthier lives, according to a new state-by-state scorecard issued by the Commonwealth Fund Commission on a High Performance Health System. "The differences we found between the top and bottom states were shocking, often a two- to threefold variation or greater," according to Commonwealth Fund senior vice president for research and evaluation **Cathy Schoen**, the report's co-author.

Ms. Schoen tells *State Health Watch* that even though the data she and her colleagues examined have been in the public arena for some time, they were "struck by the incredible variations such as asthma admissions for children and the percentage of people in some states who are uninsured. And we were struck by the levels the highest-performing states have achieved."

The report ranked states on 32 indicators grouped in categories including access, quality, avoidable hospital use and costs, equity, and healthy lives *(see Exhibit 1)*. While no one state scored at the top across the board, some states far

See ***Scorecard*** *on page 2*

States' fiscal situations ease: NGA cautions adding to base budget

The June 2007 Fiscal Survey of States issued by the National Governors Association (NGA) and National Association of State Budget Officers (NASBO) reported stable state financial conditions in FY 2007 and the prospect of a steady FY 2008 for most states, but with some experiencing slower revenue growth and somewhat tighter fiscal conditions.

Fiscal Fitness: How States Cope

"Overall, state finance officers are concerned about the future due to anticipated trends toward at least somewhat slower growth, as well as continued expenditure pressures in areas such as health care (primarily Medicaid), education, corrections, employee pension systems, and infrastructure," the report said.

In FY 2007, state general fund spending grew by 8.6%, about two percentage points above the 29-year historical state spending average of 6.5%. But state expenditures are anticipated to drop to 4.2% based on the governors' recommended FY 2008 budgets. Expenditures include one-time spending from surplus funds, transfers into budget stabilization funds and other reserve

See ***Fiscal Fitness*** *on page 8*

State Health Watch
The Newsletter on State Health Care Reform

On-line access / Index

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

State Health Watch (ISSN# 1074-4754) is published monthly by AHC Media LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid 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: customerservice@ahcmedia.com.
Web site: www.ahcmedia.com.

Subscription rates: $399 per year. Add $9.95 for shipping & handling. Discounts are available for group subscriptions. For pricing information, call Tria Kreutzer at (404) 262-5482. Back issues, when available, are $67 each.

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.)

Senior Vice President/Group Publisher: Brenda Mooney, (404) 262-5403, brenda.mooney@ahcmedia.com.
Associate Publisher: Lee Landenberger, (404) 262-5483, lee.landenberger@ahcmedia.com
Managing Editor: Paula Cousins, (816) 237-1833, paula.cousins@ahcmedia.com.
Editor: John Hope, (717) 238-5990, johnhope17110@att.net.
Senior Production Editor: Nancy McCreary.

AHC Media LLC

Scorecard

Continued from page 1

surpassed others, the commission said. States in the Northeast and upper Midwest often ranked high in several dimensions, while states in the South tended to have the lowest rankings *(see Exhibit 2)*.

Thirteen states—Hawaii, Iowa, New Hampshire, Vermont, Maine, Rhode Island, Connecticut, Massachusetts, Wisconsin, South Dakota, Minnesota, Nebraska, and North Dakota—emerged in the top quartile of the overall performance rankings. The commission said these states generally ranked high on multiple indicators in each of the five dimensions assessed by the scorecard and many have been leaders in reforming and improving their health systems and have among the lowest uninsured rates in the nation.

At the other end of the spectrum, the 13 states in the bottom quartile of the overall performance ranking—California, Tennessee, Alabama, Georgia, Florida, West Virginia, Kentucky, Louisiana, Nevada, Arkansas, Texas, Mississippi, and Oklahoma—lagged well behind their peers on multiple indicators across dimensions. Uninsured rates for adults and children in these states are well above national averages, and more than double those in the quartile of states with the lowest rates. The rates for receipt of recommended preventive care are generally low, and mortality rates from conditions amenable to health care often high.

Significant progress could be made

The report estimates that if all states could do as well as the top states, 90,000 lives could be saved each year, 22 million additional adults and children would have health insurance, and millions of older adults, diabetics, and young children would receive essential preventive care. Also, the report says, Medicare could save $22 billion a year if high-cost states moved down to spending levels of the average states.

The report, *Aiming Higher: Results from a State Scorecard on Health System Performance*, compares each state to benchmarks that have already been achieved in some states.

"As policy-makers and private sector leaders look at how their states did on this scorecard, it should be clear that there is room for improvement in all states," said lead author **Joel Cantor**, director of the Rutgers University Center for State Health Policy. "In key areas, even the top states aren't doing as well as they could be."

Across the country, the scorecard found that states that score well on access to care, particularly through health insurance coverage, were also more likely to do better on quality of care. Four of the five states with the best access to care rankings (Massachusetts, Iowa, Rhode Island, and Maine) also are among the highest on quality of care. And states with low quality rankings tend to have high rates of uninsured residents.

The five top-ranked states overall (Hawaii, Iowa, New Hampshire, Vermont, and Maine) all have high rates of insurance coverage, with nearly 90% of working-age adults insured. In contrast, the share of adults insured ranges between 70% and 78% in the five states with the lowest ranking (Nevada, Arkansas, Texas, Mississippi, and Oklahoma).

"The findings point to improving access to care and health insurance coverage as important first steps

(Continued on page 4)

EXHIBIT 1

List of 32 Indicators in State Scorecard on Health System Performance

	Year	All States Median	Range of State Performance (Bottom – Top)	Top State
Access				
1. Adults under age 65 insured	2004–2005	81.5	69.6 – 89.0	MN
2. Children insured	2004–2005	91.1	79.8 – 94.9	VT
3. Adults visited a doctor in past two years	2000	83.4	73.9 – 91.5	DC
4. Adults without a time when they needed to see a doctor but could not because of cost	2004	87.2	80.1 – 96.6	HI
Quality				
5. Adults age 50 and older received recommended screening and preventive care	2004	39.7	32.6 – 50.1	MN
6. Adult diabetics received recommended preventive care	2004	42.4	28.7 – 65.4	HI
7. Children ages 19–35 months received all recommended doses of five key vaccines	2005	81.6	66.7 – 93.5	MA
8. Children with both medical and dental preventive care visits	2003	59.2	45.7 – 74.9	MA
9. Children with emotional, behavioral, or developmental problems received mental health care	2003	61.9	43.4 – 77.2	WY
10. Hospitalized patients received recommended care for acute myocardial infarction, congestive heart failure, and pneumonia	2004	83.4	79.0 – 88.4	RI
11. Surgical patients received appropriate timing of antibiotics to prevent infections	2004–2005	69.5	50.0 – 90.0	CT
12. Adults with a usual source of care	2004	81.1	66.3 – 89.4	DE
13. Children with a medical home	2003	47.6	33.8 – 61.0	NH
14. Heart failure patients given written instructions at discharge	2004–2005	49	14 – 67	NJ
15. Medicare patients whose health care provider always listens, explains, shows respect, and spends enough time with them	2003	68.7	63.1 – 74.9	VT
16. Medicare patients giving a best rating for health care received	2003	70.2	61.2 – 74.4	MT
17. High-risk nursing home residents with pressure sores	2004	13.2	19.3 – 7.6	ND
18. Nursing home residents who were physically restrained	2004	6.2	15.9 – 1.9	NE
Potentially Avoidable Use of Hospitals & Costs of Care				
19. Hospital admissions for pediatric asthma per 100,000 children	2002	176.7	314.2 – 54.9	VT
20. Asthmatics with an emergency room or urgent care visit	2001–2004	15.5	29.4 – 9.1	IA
21. Medicare hospital admissions for ambulatory care sensitive conditions per 100,000 beneficiaries	2003	7,278	11,537 – 4,069	HI
22. Medicare 30-day hospital readmission rates	2003	17.6	23.8 – 13.2	ID
23. Long-stay nursing home residents with a hospital admission	2000	16.1	24.9 – 8.3	UT
24. Nursing home residents with a hospital readmission within three months	2000	11.7	17.5 – 6.7	OR
25. Home health patients with a hospital admission	2004	26.9	46.4 – 18.3	UT
26. Total single premium per enrolled employee at private-sector establishments that offer health insurance	2004	$3,706	$4,379 – 3,034	UT
27. Total Medicare (Parts A & B) reimbursements per enrollee	2003	$6,070	$8,076 – 4,530	HI
Healthy Lives				
28. Mortality amenable to health care, deaths per 100,000 population	2002	96.9	160.0 – 70.2	MN
29. Infant mortality, deaths per 1,000 live births	2002	7.1	11.0 – 4.3	ME
30. Breast cancer deaths per 100,000 female population	2002	25.3	34.1 – 16.2	HI
31. Colorectal cancer deaths per 100,000 population	2002	20.0	24.6 – 15.3	UT
32. Adults under age 65 limited in any activities because of physical, mental, or emotional problems	2004	15.3	22.8 – 10.8	DC

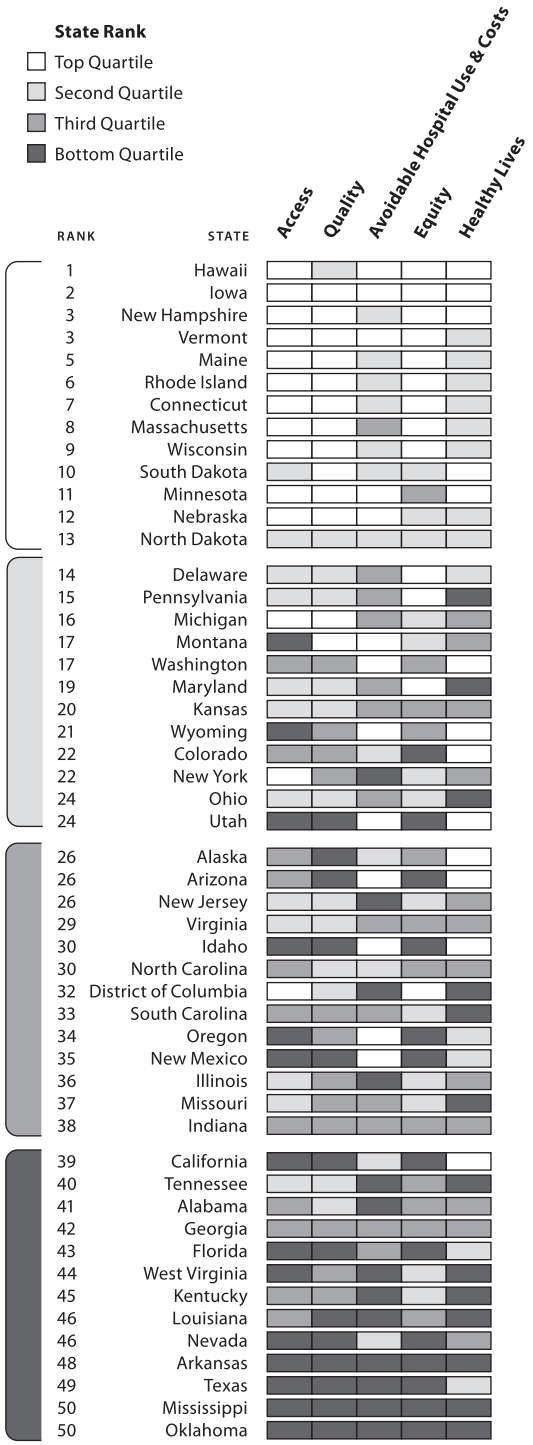
Note: All values are expressed as percentages unless labeled otherwise.

SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

(Continued from page 2)

EXHIBIT 2

State Scorecard Summary of Health System Performance Across Dimensions



SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

toward ensuring that all patients get recommended care that is patient-centered, well coordinated, and efficient," the report says. "In states with low rates of uninsured, adults and children are more likely to receive essential preventive and chronic care and to have an ongoing connection to care."

No connection between spending and quality

Interestingly, the researchers found no systematic connection between high spending and high quality health care. They report that some states achieve high quality at relatively low cost. The states with the highest levels of spending tended to have higher rates of preventable hospital use including readmissions and admissions for diabetes, asthma, and other chronic illnesses that should be effectively treated outside the hospital. "The scorecard documents stark variability across states in potentially preventable use of hospitals," the commission said. "For example, the rate of children admitted to the hospital for asthma ranges from 55 per 100,000 in Vermont to 300 per 100,000 in South Carolina.

The commission said its scorecard "points to the substantial gains for the nation if all states could reach levels achieved by the top-performing states on key indicators." Among the items cited:

- Nearly 90,000 fewer deaths before the age of 75 would occur annually from conditions amenable to health care if all states achieved the level of the lowest rate state.
- The uninsured population would be cut in half if insurance rates nationwide reached insurance rates in the top states.
- Nearly 4 million more diabetics across the nation would receive basic recommended care, helping to avoid renal failure and lost limbs, and 9 million adults age 50 or older would receive essential preventive care.
- If all states reached the lowest levels of potentially preventable admissions and readmissions, these hospitalizations could be reduced by 30% to 47% and save Medicare $2 billion to $5 billion yearly.

"The report points to the need for action in four key areas," the commission said, "expanding health insurance to all; having better information to assess performance to guide and drive change; analyses to determine the key factors that contribute to state variations; and national leadership and collaboration across public and private sectors. In addition, the report underscores opportunities for states to look to each other as well as models of excellence within their own borders to inform efforts to improve."

Action needed at all levels

"The scorecard tells us where we are," said Commonwealth Fund president **Karen Davis**. "States need healthy and productive citizens. Doing better is possible,

but it will take commitment and action on all levels to achieve real change. The state scorecard documents that we have much to gain as a nation with coherent national and state policies that respond to the urgent need for action."

According to the commission, universal health care coverage is critical *(see related story)* for improving quality and delivering cost-effective care, as well as ensuring access. Federal action as well as state initiatives will be essential for progress nationwide.

Also needed, it said, is more information to assess performance and identify benchmarks. "It takes information to guide and drive change," the report said. "We need more sophisticated information systems and better information on practices and policies that contribute to high or varying performance.

The commission said there is a need for analyses to determine key factors that contribute to variations, noting states can use such information to develop evidence-based strategies for improvement.

Finally, it said, national leadership and collaboration across public and private sectors is essential for coherent, strategic, and ultimately effective improvement efforts.

Ms. Schoen tells *State Health Watch* the researchers were struck by the association between rankings on access to health care and those on quality. She said there was a fairly consistent correlation with hospital process quality indicators that the researchers would not have intuitively expected to be present.

Asked whether the problem is too big to be resolved by states on their own, Ms. Schoen says there are things states can do in terms of state policy and health system practices such as benchmarking. There are some aspects, she said, however, where it will be necessary to look at federal solutions or federal support for state solutions. She noted that in recent years, states have expanded insurance coverage when the federal government helped with Medicaid and SCHIP expansions.

"If the federal government acted," she said, "it would support states in moving forward. Many states are waiting in the wings to develop a comprehensive plan."

Focus on improvement

Ms. Schoen says the commission hoped the scorecard would draw attention to the opportunity to improve and stimulate action and so far it has received positive attention. State officials who have contacted her, she says, have asked for statewide leadership forums where ideas could be exchanged. Officials, she said, have identified the scorecard dimensions where they are doing well but could do better and the areas where they are not doing well and could improve.

Ms. Schoen says that in many ways expansion of insurance coverage is the key to success on this issue. "It's not sufficient to aim higher across cost and quality," she said. "We often think of health care in a fragmented way without total coverage. According to Ms. Schoen, churning and fragmentation of the insurance market make it hard to benchmark and give health plans an incentive to put systems in place for the long haul. Insurance, she says, is a foundation to address quality and benchmarks in a new light.

Having now issued a national scorecard and a state scorecard, the commission will move over the next several years from descriptive reports to modeling and options to be considered.

Commenting on the scorecard, Ms. Davis discussed the experiences of Hawaii and Maine in extending health insurance to all. She says Hawaii's ranking in first place overall may be due in part to its early efforts to cover its residents. In 1974, the state's Prepaid Health Care Act mandated that employers, with a few exceptions such as seasonal employers and government services, provide insurance to all employees working more than 20 hours a week. Employers must pay 50% of premiums, but can require employees to contribute up to 1.5% of their wages. Other residents, including employees working fewer than 20 hours per week, the self-employed, and Medicaid beneficiaries receive coverage under a public program called the State Health Insurance Plan. The legislation also mandates that insurance plans offer certain benefits, including hospital and surgical benefits, maternity benefits, and laboratory services.

Ms. Davis says Maine's Medicaid program has been expanded to cover all adults below 100% of the federal poverty level and parents below 200% of the federal poverty level. In addition, Maine's reform legislation created a new insurance product, DirigoChoice, with a maximum deductible of $1,250 and lower sliding-scale deductibles and premiums available to residents with incomes below 300% of the federal poverty level. Employers who don't cover workers may voluntarily pay a fee covering 60% of the workers' premiums for DirigoChoice.

Ms. Davis also gave examples of New York and Rhode Island promoting effective cost control strategies; Iowa and Connecticut organizing the health care system; North Carolina and South Carolina pursuing and raising benchmark levels of high-quality, safe, effective, and efficient care and enhancing system capacity to innovate and improve; and Wisconsin and Kansas sharing a coherent set of health policies

through national leadership and public-private collaboration.

At a news conference at which the scorecard was released, University of North Dakota School of Medicine and Health Sciences associate dean **Mary Wakefield** cautioned that policies and strategies directed to just one of the scorecard areas such as efficiency or high quality and safety are not going to get the nation to a high-performing health care system. "So when we think about policy changes and strategies and approaches," she said, "it is a set of strategies that addresses all four of those areas. That is a big menu, a big portfolio of activity to put in front of state policymakers, clinicians, researchers, federal policy-makers, and so on, but it is that complement of activities in areas of focus that the commission thinks are necessitated or is necessitated for us to create a high-performance health system in this country. So we need efforts in each of those areas to support moving the set of scorecard measures north on the metrics instead of south on the scale."

The report is available on-line from www.cmwf.org. Contact Ms. Schoen and Ms. Davis at (212) 606-3864. Contact Ms. Wakefield at (701) 777-3848 and Mr. Cantor at (732) 932-4653. ■

Report documents importance of parents to children's health coverage

As members of Congress considered whether to expand the SCHIP program when it is reauthorized, the George Washington University Medical Center School of Public Health and Health Services and First Focus, a bipartisan advocacy organization for children, released a report demonstrating that children benefit greatly when their parents have health care coverage.

According to report authors **Sara Rosenbaum** and **Ramona Perez Treviño Whittington**, the enrollment of parents in public insurance programs such as SCHIP results in greater participation by their children, as well as improvements in the continuity of the child's health coverage. The report also says parental coverage appears to be associated with a more effective use of the child's health care coverage.

"Offering coverage for parents, especially low-income parents who are extensively uninsured and who may have significant unmet health needs, appears to operate as an incentive for families to both seek and use coverage," the authors said. "Low-income parents who are uninsured have significantly reduced rates of health care use and coverage of parents appears to offer an important strategy for increasing access to and use of appropriate health care. Like other parents, low-income parents who enroll in coverage also seek benefits for their children."

The report analyzed research published since 2000 that explored the relationship between public health insurance coverage of parents and the rate and effectiveness of coverage among children.

The authors said that the 10.9 million parents who were uninsured in 2005 comprised nearly 25% of the more than 46 million uninsured persons that year. Among 20.4 million low-income parents, 37% lacked coverage, 36% had employer-sponsored coverage, and 27% had coverage through Medicaid or another source of public financing.

"There is broad agreement that diminished health insurance coverage among nonelderly adults is a cause for concern," they wrote, "in view of the individual and communitywide effects of high uninsurance rates."

Distinctions blurred

The report says the line between direct coverage and coverage subsidies has become increasingly blurred, and what remains is a clear desire across the political spectrum to improve coverage of adults. Given that desire, the authors said, the fundamental policy question appears to be not whether to publicly subsidize coverage for low-income parents but instead how to finance and structure the subsidy, whether through tax expenditures or direct financing. Another policy question is how high up the family income range public subsidies in whatever form should reach.

The report said Medicaid and SCHIP offer parallel pathways to expand public insurance coverage of low- and moderate-income children. In the context of SCHIP reauthorization, it said, the question is whether to carry the parallelism where children are concerned into the parental coverage arena. "The answer to this question," the authors said, "lies at least part in a decision as to whether covering parents actually represents sound child health policy. Some have argued that coverage of parents is not only good for parents, but furthermore that extending coverage to parents promotes not only coverage of children but also the more effective use of coverage in terms of increased access to care and a greater use of appropriate care. It is because of this assertion regarding the beneficial pediatric effects of family coverage that the case for creating parallel coverage flexibility under both Medicaid and SCHIP has arisen."

The authors report that all studies they examined showed positive coverage effects on children from parental coverage. There were no studies suggesting that covering

parents diminishes coverage for children. Because the proportion of eligible but unenrolled low-income children is so high, the authors contended, the issue is the significance of the coverage gains for children, not whether states that cover parents do so by diminishing coverage for children.

The authors said one approach under SCHIP might be to allow states that meet child coverage milestones to apply their remaining SCHIP allotment funds toward parental coverage. In that way, children would remain the principal beneficiaries of reform, while states that wish to do so could apply the balance of their allotments toward expanded coverage of parents at a preferred federal rate. Another possible approach would be to permit use of SCHIP allotments for parental coverage by states that achieve national children's coverage benchmarks through Medicaid expansions at the regular federal matching rate.

Universal participation essential

Meanwhile, Commonwealth Fund assistant vice president **Sara Collins** testified at a June Senate Budget Committee hearing on the need for universal health insurance.

"The U.S. health care system performs poorly relative to other industrialized nations and relative to achievable benchmarks for health outcomes, quality, access, efficiency, and equity," Ms. Collins said. "In addition, where you live in the United States matters greatly in terms of access to care when it is needed, the quality of that care, and the opportunity to lead a healthy life. A major culprit in the inconsistent performance of the nation's health system is that we fail to provide health insurance to nearly 45 million people and inadequately insure an additional 16 million more. Universal coverage is essential to placing the system on a path to high performance."

Referring to the Commonwealth Fund's National Scorecard on U.S. Health System Performance, that preceded the just-released state scorecard *(see related story)*, Ms. Collins reported that out of a possible 100 points based on benchmarks that have been achieved here or in other countries, the United States received a score of 66, a full one-third below benchmark levels of performance. The United States scored particularly poorly, she said, on indicators of efficiency, with wide variation in cost and quality across the country and with much higher spending levels than other countries.

Thus, the United States ranks 15th out of 19 countries on mortality from conditions "amenable to health care" and ranks last on infant mortality.

"Universal participation is essential for dramatic improvement in health care outcomes as well as overall performance of the U.S. health system," she said.

According to the testimony, universal coverage is essential to achieving a high performance health system. It is critical, Ms. Collins said, that the entire population be brought into the health care system in a way that ensures timely access to care across the full length of people's lives. Uninsured and underinsured patients and the doctors who care for them are far from able to obtain the right care at the right time in the right setting, she declared. Uninsured patients are more likely to receive wasteful and duplicative care because of a lack of care coordination. Quality and effectiveness measurements will not be meaningful, she cautioned, unless those measures reflect the experience of a fully and continuously insured population and the work of providers who care for them. And it will be impossible to realize efficiency in the operation of provider institutions and financing arrangements in the presence of billions of dollars in uncompensated care now paid for through pools of federal, state, and local government revenues and a highly uncertain amount of cost-shifting to other payers.

Evaluating reform proposals

Ms. Collins told the senators that key questions to consider in evaluating health reform proposals include:

- Does the proposal improve access to care?
- Does the proposal have the potential to lower cost growth and improve efficiency in the health care system?
- Does the proposal improve equity in the health system?
- Does the proposal have the potential to improve the quality of care in the health system?

"The majority of recent proposals at both the federal and state levels build on the current system by connecting public and private insurance to ensure more coherent and continuous coverage over a person's lifespan," Ms. Collins testified. "A framework for such an approach would create a new group insurance option similar to the Federal Employees Health Benefits Program, with income-related subsidies for the purchase of coverage; expand Medicaid and SCHIP for lower-income families; and expand the Medicare program for older adults. It would require employers to offer coverage or pay into a fund and require individuals to obtain coverage."

An alternate framework, she said, might include a more substantial role for Medicare. All uninsured people, people with private individual coverage, and most Medicaid beneficiaries would enroll in Medicare. Employers would pay 80% of their employees' premium,

and workers would pay 20% of the premium. Employers could opt out if they elected to provide an actuarially equivalent benefit. Individuals could not opt out. The program would subsidize both premiums and cost-sharing for families living below 500% of the federal poverty level.

"Ultimately what is needed to move the health care system to high performance is a coherent set of policies with goals and properly aligned incentives that move all participants in the system in the same direction—toward improving access, quality, equity, and efficiency for everyone," Ms. Collins concluded. "It is critical that all adults and children are able to fully participate in a health care system that is well organized and is based on incentives that ensure that everyone receives the right care, at the right time, and in the right setting over their lifespan. It will not be productive in the long run if we focus overly on the impact of reform policies on the federal budget, or on the budgets of major corporations, or even the impact on our families' budgets. Instead, we can only move forward when we keep our eye on the number that really matters: the $2 trillion that we spend as a nation on health care each year. This ultimately determines the size and growth of all participants' budgets and should be the focal point of our collective energies as we develop coherent, consistent, and equitable health care policy."

Download the GWU report at www.gwumc.edu/sphhs/healthpolicy/chsrp/downloads/Parental_Health_Insurance_Report.pdf. Download the testimony at http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=494551. ■

Fiscal Fitness

(Continued from cover)

funds, and payments to local governments to reduce property taxes.

NGA said Medicaid continues to be the dominant force in state spending and to constrict state budgets as it has for many years. Medicaid currently represents 22% of total state spending. Also, according to the report, over the past year, health insurance issues have become increasingly significant at the state level. Thus, 34 governors introduced plans to reduce the number of uninsured residents in their states in FY 2008. Their proposals rely on a variety of methods, including expanding SCHIP, expanding Medicaid, using flexibilities provided in the Deficit Reduction Act, waivers, and various state programs. Proposed FY 2008 funding for these programs totals nearly $18.4 billion, the NGA added.

While Medicaid spending rates have moderated somewhat in recent years, it continues to be a major state budget issue. Medicaid spending is estimated to increase by 5.8% in governors' recommended budgets for FY 2008, with state funds increasing by 7% and federal funds increasing by 4.9%. In FY 2007, total Medicaid spending is estimated to increase by 6.6%, with state funds increasing by 8% and federal funds by 6.1%. Since Medicaid makes up such a major portion of state budgets, these large growth rates have a major impact on states, NGA said.

Drug coverage change

In FY 2006, the Medicaid spending growth rate of 2.5% was significantly lower than in previous years due partly to passage and implementation of the Medicare Part D prescription drug legislation. Beginning in January 2006, prescription drug costs for dual-eligibles were no longer part of the Medicaid program but became part of Medicare Part D. States finance these benefits through a payment to the Medicare trust fund. The amount paid by states to the federal government for the Part D coverage represents about 5% of state Medicaid expenditures. At the federal level, lower Medicaid spending will be offset by an increase in Medicare spending on dual-eligibles. Other costs for dual-eligibles, such as long-term care, remain with Medicaid.

NGA says states have been aggressive over the past five years in pursuing cost containment measures to help moderate spending increases. The Kaiser Commission on Medicaid and the Uninsured reported that every state started cost containment measures during the time period, with the majority involving freezing or reducing provider payments and managing prescription drug costs.

According to the fiscal survey, one of the leading health care issues states have been dealing with is the number of people without health insurance. To address that concern, two-thirds of governors included plans to expand health care coverage in proposed FY 2008 budgets. Key characteristics of the governors' proposals vary widely from proposals to cover all of the uninsured in the state to targeted expansions for specific groups such as uninsured children.

The number of additional people who would be covered, ranging from 268 people to 4.8 million people, depends very much of the individual proposal's scope, the state's population, and the percentage of the state's population that is uninsured. While the national uninsured rate is about 16%, individual state rates range from about 9% to 25% of the state's population.

In 22 states, the expansion target is children, a situation that mirrors

discussion at the federal level about ways to expand the SCHIP program when it is reauthorized in FY 2008. In addition to seeking greater coverage for children, some governors also are targeting childless adults, parents, and the aged and disabled. Thus, 11 states want to expand coverage for childless adults and in seven states, health care expansions are intended to cover all of the uninsured. Expansion often includes an increase in the income allowed to meet program eligibility requirements, typically defined as a percentage of the federal poverty level.

Many funding sources used

States are planning to use Medicaid, SCHIP, Medicaid waivers, Deficit Reduction Act program flexibilities, and market-based approaches for their health care expansion efforts. They often plan to use a combination of funding sources and also may include employer and individual contributions, tobacco funding, and provider taxes and fees. Expansion features include employer mandates in five states, individual mandates in five states, personal responsibility requirements in 12 states such as requiring healthy behaviors and health screenings, Deficit Reduction Act flexibilities in seven states to allow changes in benefit packages and cost-sharing, market-based components in 12 states such as use of Health Savings Accounts or purchasing pools, and capping enrollment in seven states to provide greater funding certainty. The report includes tables showing plans in individual states.

It says about one-third of the states have plans to conduct outreach and streamline eligibility in Medicaid and SCHIP to attain greater program participation, addressing concerns about those who are currently eligible but have not enrolled in Medicaid and SCHIP. It could lead to a significant reduction in the numbers of uninsured children.

"The number of health care proposals at the state level to expand coverage and the federal interest in expansion of SCHIP continue to place health care access in the limelight," NGA said. "While many proposals may not be enacted this year or may be scaled down considerably, it is clear that covering the uninsured is a high priority across many state governments. Due to the high cost of health care proposals, changes to expand health care may take more than one budget cycle to achieve and proposals to address the uninsured are expected to surface for the next several years."

The report acknowledges that states face a number of challenges in funding and providing health care within Medicaid and throughout state government. Among the issues of greatest concern for states are expanding access to health care for the uninsured, health care cost increases and greater utilization of services, the aging population and the impact on long-term care financing, reductions at the federal level for health care programs including public health programs, inmate health care, work force shortages *(see story in this newsletter)*, pressure to raise physician rates to maintain participation in Medicaid, SCHIP funding, mental health funding and access, federal changes affecting Medicaid such as proposed regulations affecting government health care providers, and generally the pressure to maintain health care spending that on average consumes a greater share of state budgets over time.

Long-term strain

"Even with the more moderate growth rates in health care spending from the height of the most recent fiscal downturn," NGA says, "projections over the next decade remain at an average annual rate of about 8% from FY 2008 through FY 2017, according to the most recent estimates by the Congressional Budget Office. With Medicaid comprising 22% of state budgets, these long-term growth rates will continue to strain state budgets."

NGA executive director **Ray Scheppach** tells *State Health Watch* states need to be aware that there may be a downturn in revenues in coming years and cautions they should probably not make expenditures that will add to their base budgets.

Asked about a *New York Times* report on the fiscal survey that pictured state officials as having "coffers unexpectedly full of cash" and acting "like teenagers who went without allowance…working off pent-up demand," Mr. Scheppach says the story was "more optimistic" than he would have liked.

He says NGA recommends that states that want to spend surplus funds do it for one-time items such as deferred maintenance and infrastructure that won't add to their base budget.

"The last budget dip in 2002 was so bad that states put off that type of thing," he explains. "There is a little more money now because revenues have been growing and some Medicaid costs have gone down. But we still sense a move back to the long-term trend. States do have more flexibility in benefit packages that will help."

Mr. Scheppach says he is afraid that as revenues again slow, states that are trying to do things that add to their base may have to back off. "Basically, we need the federal government to provide vouchers or tax credits for low-income people," he says. "That plus an expansion of SCHIP could mean comprehensive

health care reform for 15-20 states. How states will do depends somewhat on what happens to the economy. Our sense is that revenue growth is going to slow and Medicaid expenditures are going to come back up."

National Association of State Medicaid Directors executive **Martha Roherty** tells *SHW* states are "well aware of the ebb and flow of revenues and are doing a good job containing Medicaid costs." She says rather than looking at Medicaid as simply a payer of claims, many states are looking at it as the cornerstone for health care reform.

States know to be careful

Right now, Ms. Roherty says, with the economy as strong as it seems to be, there are not as many people who need Medicaid services, and that is helping make some surplus money available in the states. "States know they have to be careful," she says. "They are keenly aware that funds go up and down. They are not being extravagant, not thinking they can cover the world because they have a little more money. For example, some states are now trying to cover dental care in a more efficient manner by paying for preventive services. There are a number of 'expansions' like that in which states are providing a better quality of service to save money in the long run."

Download the fiscal survey from www.nga.org/portal/site/nga. Contact Mr. Scheppach at (202) 624-5300 and Ms. Roherty at (202) 682-0100. ■

Study: Better work force planning needed

The Association of Academic Health Centers (AAHC) says that work force planning is rapidly becoming one of the most critically important functions that states need to address.

A new AAHC report found that states lack comprehensive and coordinated long-term planning for the health work force and thus are not prepared to address an emerging national health work force crisis.

AAHC assistant vice president for policy and program **Denise Holmes** tells *State Health Watch* that by 2014, there will be a need for 6 million new health care workers, with fully half of them needed to replace workers who will be retiring. "The current shortage in nursing gets all the attention," she says, "but shortages really are across the board."

And AAHC program associate **Michal Cohen Moskowitz** says some states operate from crisis to crisis, without a comprehensive long-term plan. "They are very reactive," she says, "and not very coordinated."

The report notes that states leverage much influence over development and practice of the health work force through education, financing, and regulation of health professionals. Thus, it says, state action is critical not only in resolving current shortages but also in producing and sustaining a work force for the future.

The AAHC study sought to determine the outcomes of state task forces established to address work force issues, explore current state activities, and examine the extent to which states are engaged in planning for the future. Ms. Holmes and Ms. Moskowitz studied eight representative states—California, Georgia, Maryland, Massachusetts, Montana, Nebraska, New York, and Texas. They selected the states to reflect diversity in geographic distribution, population size, and urban/rural distribution.

The analysts say their research was hampered by an initial difficulty in determining which, if any, agency in each state has responsibility for the health work force and which functions are delegated to various agencies and offices. "As these states generally lack a central coordinating mechanism to monitor and plan for the health work force, state decision-making for health work force issues is often splintered between several bodies," they explain.

Of the eight study states, only in Texas has the state health department developed comprehensive coordinated mechanisms for analyzing and addressing statewide, cross-professions work force issues. Montana has recently formed a group to perform similar functions.

Vital role for colleges, universities

The report says institutions of higher education play an indispensable role in nearly all aspects of health work force development, including outreach to elementary and secondary school students, education of health professionals, and work force data analysis. Historically, it says, states have been dedicated to educating and retaining residents to work within the state after graduation. Accordingly, state higher education authorities are leading health work force projects in seven profiled states. But only in California and Georgia have higher education systems or authorities produced comprehensive analyses of the state's health work force and developed strategic plans to align health professions education with the state's work force needs.

State labor and work force offices aggregate data and perform analyses on industry trends in employment,

vacancies, and wages; producing short-term and long-term labor projections; disseminating career information to job seekers; and conducting job training programs.

A consistent report from state officials was that work force initiative success depends on direct support from their governor's office, but they said that activity and involvement from that office varies and it is often difficult to determine what priority the health work force has on a governor's agenda.

"Texas Gov. Rick Perry appears to be only one of the eight whose office houses a standing council dedicated to strategic health work force planning and monitoring," the report said. "The council, whose members include representatives from state agencies as well as higher education, identified nursing education as a major work force priority, and successfully influenced inclusion of $47 million in new funding for nursing education in the governor's 2008-2009 budget."

The report said other governors have authorized and supported significant health work force-related initiatives, mostly related to nursing and allied health professions.

Funding influences work force

Most state work force action can be traced in some way to state funding and legislative decision making. Higher education institutions receive major financial support from state budgets. Also, in many states, Medicaid provides significant financial support for graduate medical education programs. Because more states successfully retain physicians who completed their graduate medical education, rather than medical school education, in the state, support for graduate medical education may be critical for filling a state's physician work force needs. States also promote health profession education through their investment in elementary and secondary education, financing of scholarships, distribution of worker training funds, and public and rural health initiatives.

The analysts said budget crises and subsequent decreases in higher education funding hurt appropriations to colleges and universities at the beginning of this century. State budgets have been showing signs of recovery *(see Fiscal Fitness, cover page)* and state higher education appropriations have grown at faster rates in the 2005-2006 and 2006-2007 fiscal years. But even though state funding for medical education has more than doubled since the early 1980s, state appropriations have declined proportionally as a source of allopathic medical school revenue. While in the 1980s and 1990s many states were promoting an increase in the supply of physicians, many legislatures now appear to be focused on nursing, the report said.

State attention appears to be focused on the most visible issue of public or current concern. Thus, in the eight study states, nursing receives the greatest share of state action and analysis. All eight study states have implemented initiatives to address the nursing crisis. Significant attention also has been paid to the long-term care work force.

Specific state actions on nursing have included commissioning task forces and reports, establishing state nursing work force centers as central places to gather data and make policy recommendations, enacting legislation such as mandatory overtime protection and minimum hospital staffing ratios, funding faculty loan repayment, expanding educational capacity, and developing partnerships between schools and health care providers to educate more nurses and place them in jobs.

While other health care professions tend to be addressed piecemeal, there are indications that some state are seeing the need to develop a cross-professions perspective on work force capacity, particularly as shortages in pharmacy, allied health, and veterinary medicine attract increasing media coverage. Thus, Texas and Montana now have standing bodies dedicated to studying and advising the state on its entire health work force.

The report identifies five strategies and tactics states can employ to boost the health work force:

1. Data collection and analysis. Experts have emphasized the need for current, comprehensive data about the work force to address worker shortages. States vary tremendously in their health professions information systems. Examples of centers for work force data collection and analysis include state nursing centers, centers for health work force studies, and university centers.

2. Pipeline development. Pipeline development efforts can include marketing campaigns, elementary and secondary school outreach initiatives, and scholarships for students entering high-need professions. State recruitment tactics include health career web sites, K-12 outreach programs, and scholarships.

3. Retention. Efforts to improve health worker retention are considered essential to ensure continuity of the health work force. The vast majority of state-sponsored programs geared toward improving retention dealt with nurses, with some being created for allied health. Examples included career ladders, mandatory overtime, and minimum staffing ratios.

4. Licensure and credentialing. States have enacted regulatory changes that affect the supply and practice of health professionals. They include scope of practice changes and changes in licensure requirements.

5. Educational capacity building.

Health professions require years of advanced education, meaning the health work force depends on a strong educational system capable of producing a sufficient supply of future professionals. Limited educational capacity can pose a major obstacle across the health professions. Strategies to increase supply through education and training include faculty scholarships and loan repayment, increasing educational capacity, and innovation in educational delivery.

Multiple complexities to address

The analysts conclude that states are facing current or looming shortages in health care workers stemming from multiple complex factors such as the aging population, changing educational and practice environments, and a limited pipeline of people entering health professions. AAHC says that several themes have emerged in states' activities over the last five years.

First, there is a lack of comprehensive planning. The report says that calls for cohesive, thorough health work force planning are evident in task force reports across all states. But despite these calls, many states still lack long-term planning.

Second, responsibility for the health work force often is divided between several bodies within states. While growing collaboration between state agencies in addressing work force problems is a positive sign and a signal of changing practices, many gaps still remain, the report says.

Next, the absence of leadership poses a major challenge to sustained work force initiatives and planning. Most of the eight study states lack a central leading body to set the state's health work force agenda. And many state work force initiatives have faced challenges in sustaining funding and have struggled to maintain visibility and prioritization of health work force issues among governors and legislatures.

Fourth, state activities have focused heavily on immediate crises, most recently nursing. Many states also have looked at developing and investing in the long-term care work force. It appears, the analysts said, that new cross-profession approaches to the health work force are emerging, which will enable states to look beyond current crises and addressed broader emerging trends and concerns.

Fifth, communication and collaboration among state health, education, and labor agencies is essential for developing cohesive policy and programs and in preventing duplication of efforts. The analysts said that while state officials usually noted collaboration and communication with other offices, it appears that much activity is still conducted in silos.

Finally, the eight profiled states have developed similar strategies and tactics to address health work force needs, including data collection, pipeline development, retention, licensure and credentialing, and educational capacity building.

More information is available online at www.aahcdc.org. Contact Ms. Moskowitz at (202) 265-9600 or e-mail mcohen@aahcdc.org. ■