State Health Watch
Vol. 15 No. 1
The Newsletter on State Health Care Reform
January 2008

AHC Media LLC

In This Issue

Grass-roots community health initiatives meet local needs

While politicians, analysts, and policy-makers discuss and debate big-picture solutions to the nation's health care problems, locally crafted community health initiatives have been steadfast in their efforts to connect uninsured and medically indigent people to health care services and health insurance.

A Commonwealth Fund report by **Karen Minyard**, executive director of Georgia State University's Georgia Health Policy Center in Atlanta, says the community programs assist in outreach, coordinate and integrate care, and help clients use resources efficiently.

In her report she presents case studies from five local community health initiatives that seek to improve access and coverage for low-income, nonelderly adults. Included are Community Health Works, Forsyth, GA; General Assistance Medical Program, Milwaukee; Choice Regional Health Network, Olympia, WA; Community HealthLink's Health Care Access Program, Ratcliff, AR; and Project Access, Wichita, KS (**see related story, p. 3**).

Ms. Minyard says it is clear that merely referring people with complex medical and social needs to care is

*See **Initiatives** on page 2*

Happy days here again? States looking to make program gains under improving fiscal conditions

Buoyed by an improving fiscal environment, coupled with modest Medicaid spending and enrollment growth, states are looking at making program restorations, improvements, and expansions for acute and long-term care that were not possible in the tough economic times of the last several years.

Fiscal Fitness: How States Cope

A new report, "As Tough Times Wane, States Act to Improve Medicaid Coverage and Quality: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2007 and 2008," prepared by Health Management Associates' **Vernon Smith** for the Kaiser Commission on Medicaid and the Uninsured, says states are placing a high priority on measuring and improving quality of Medicaid-financed health care, often through enhancements in managed care or disease management. And almost all states in the 50-state survey of Medicaid directors reported moving forward with initiatives to address the increasing number of

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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 $12.95 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.)

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Initiatives

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often insufficient. Thus, these successful initiatives assist in outreach, coordinate and integrate care, and help clients use limited resources efficiently.

Study findings fall into three areas—1) the critical importance of state context; 2) the need for community health initiatives and the difficulty of sustaining them; and 3) the challenges of replication.

Across the five case studies, Ms. Minyard says, it is apparent that state political, economic, and social context matters. Local programs can support or complement state public and private insurance programs, but they are unlikely to thrive independently. The researchers found that community initiatives that don't capitalize on state policies and resources struggle against greater barriers.

Several measures of state context, she says, seem especially useful in differentiating whether a community initiative can survive and succeed, including supportive public programs or a strong private insurance base, state-level vision and supportive programs and policies, and community and provider culture.

Despite their value to individuals and the community as a whole, local initiatives are difficult to sustain. Community leaders interviewed for the research identified several organizational attributes as necessary for sustainability, including dedicated leadership; funding sources, including provider volunteerism, Medicaid partnerships, and federal grants; and data to evaluate and demonstrate initiatives' successes. Strong leaders were able to create programs that were solidly grounded in the needs of the target population. They flexibly adapted to the changing environment and engaged in a continuous blending of programs to shape a complete portfolio connecting their clients to care.

Face-to-face communication

Diffusion of innovation among community health initiatives is more likely, Ms. Minyard says, when there is extensive face-to-face communication between individuals in the original and replication sites, and when there are contextual and organizational factors common to both sites. She says research indicates that important contextual factors include strong leadership, high levels of knowledge among interconnected parties, and a state environment with opinion leaders and change agents who value local innovation.

Even though the initiatives are local, Ms. Minyard says, they have state and federal policy implications because they ultimately are derived from state and federal policies, and changes in policy would cause the initiatives to adapt and change.

She says policy change in the current environment would not eliminate local initiatives' goal of serving low-income residents at the edges of both public programs and private coverage. "Some proposals at the national level—in particular, block grants to finance Medicaid—could greatly increase the need for community initiative if states were forced to respond by narrowing program eligibility," she says. "Without greater resources for community initiatives, however, the volunteerism they rely on would be strained and could fray."

Other national proposals offering new opportunities for financing coverage could help support local initiatives if care were taken to define qualified coverage to include programs offered through community initiatives. Ms. Minyard says the initiatives then could leverage and

amplify the funds' value. Thus, refundable tax credits could be used to buy coverage offered through the networks and their providers. Community initiatives might also be allowed to qualify as association health plans that could enroll any small group that includes a threshold proportion of low-wage workers. Small employers might offer the programs as an option available to low-wage workers or to their entire group.

Researchers spent 18 months visiting each of the five study groups that were selected to represent a range of geographic areas and operational models. All five groups want to improve access and coverage for those most likely to be uninsured—low-income, nonelderly adults. The programs that offer coverage typically provide comprehensive benefits for a limited time, often for individuals who seek care after contracting an illness. Other programs manage care for clients with complex needs, chaperoning them through systems they characteristically have trouble navigating.

Appropriate care is cost-effective

Local leaders in each of the communities studied said that providing more appropriate care is cost-effective for both providers and the community. The initiatives reportedly use various strategies to control cost, including cost-sharing in the form of modest copayments, administrative fees, or membership dues, and health care providers bearing significant risk through discounted rates or capitated reimbursement.

Community initiatives generally can't or don't make the necessary investment to develop strong evidence of cost-effectiveness, but some in the case studies were able to demonstrate cost-effectiveness on selected measures or a positive return on investment. Thus, Community Health Works estimates its clients use 40% less hospital care and 18% less emergency department care than a synthetic control group developed from national data. And the longer a client remains in the program, the less likely it is that he or she will have an inpatient stay.

Choice Regional Health Network has claimed success in enrolling and retaining eligible adults in the Washington Basic Health Plan. And GAMP says it has raised an additional dollar for every local dollar used to pay for the care of individuals enrolled in the program, offering a 100% rate of return to local funds, without even considering potential gains from improvements in population health and efficient use of care.

Ms. Minyard tells *State Health Watch* that local initiatives often have difficulty demonstrating their

Five community initiatives profiled

A Commonwealth Fund research team headed by Georgia State University professor **Karen Minyard** developed case studies of five community health initiatives that seek to improve access and coverage for low-income, nonelderly adults. Highlights from the five case studies include:

• **Community Health Works, Forsyth, GA.** This organization has served nearly 4,000 uninsured residents with incomes at or below 200% of the federal poverty level since 2001. The program emphasizes appropriate use of services and a rigorous case management element across the continuum of care. It only enrolls residents with any of four specific chronic diseases—hypertension, diabetes, heart disease, or depression. It estimates that its clients use 40% less hospital care and 18% less emergency department care than a synthetic national control group.

• **General Assistance Medical Program, Milwaukee.** This organization served some 26,000 county residents in 2004 with incomes less than $902 per month. The program makes services available at 17 clinics in 23 sites and 10 local hospitals and leverages millions of national, state, and local dollars to serve the county's uninsured.

• **Choice Regional Health Network, Olympia, WA.** The program helps people enroll in Medicaid, SCHIP, and the Washington Basic Health Program. It has enrolled as many as 17,000 local residents since 1996. Some 98% of its applications result in enrollment (compared with 4% of individuals who enroll on their own) and 96% remain enrolled three years later (compared with 40% who enroll on their own).

• **Community HealthLink's Health Care Access Program, Ratcliff, AR.** This network health insurance plan serves 120 working uninsured residents with incomes below 300% of the poverty level. Employers and employees support two-thirds of the cost of coverage, and HealthLink has developed a subsidy fund to cover the final one-third.

• **Project Access, Wichita, KS.** This program serves uninsured residents with incomes below 200% of the poverty level. The program enrolls eligible residents when they seek care for a health problem and links them to a medical home for ongoing primary care. It covers primary care for three months and specialty care for six months. ■

successes because there is a lot they are trying to do with limited resources and it is in their nature to just get into the work and do it, rather than thinking about long-term sustainability. "It's not usually in their area of expertise to do cost-effectiveness analysis and evaluation," she says.

The original Commonwealth Fund proposal had been to develop an evaluation template that communities could plug into, she says, and there still is a need for such a template that could look at evaluation with common measures.

Such evaluation is important, she says, because it can help lead to long-term sustainability and that can be important because community initiatives are an important component of how the nation deals with access to care and health status improvement. She says community initiatives can be sustainable if they focus not only on what they are doing but also on the issue of sustainability past the initial funding.

"There are a lot of local resources on the table," she says. "Some people think of national solutions without bringing those local resources into the mix. State and national leaders must recognize that there are important resources left on the table if they don't work with local communities to build return on investment."

Download the report at www.commonwealthfund.org/publications/publications_show.htm?doc_id=515749. Contact Ms. Minyard at (404) 413-0301. ■

Fiscal Fitness

Continued from cover

uninsured and said Medicaid is a key building block and critical component of financing for these strategies. Despite a more positive fiscal environment, states reported ongoing pressure to control Medicaid spending growth.

This seventh Kaiser Commission survey of state Medicaid officials found that Medicaid spending continued to grow slowly in state fiscal year 2007, after reaching an all-time low in 2006, and state revenues remained strong in most states. Total Medicaid spending growth was 2.9% in FY 2007, up from the record low of 1.3% the previous fiscal year. Lower Medicaid spending growth occurred at the same time revenue growth in most states was strong in 2006 and remained strong, although somewhat lower, into 2007.

"This picture is dramatically different from the depth of the economic downturn in 2002 when Medicaid spending growth hit a high of 12.7% at the same time state revenues plummeted, hitting a low of –10.6%," Mr. Smith said. "Moving into FY 2008, state legislatures authorized total Medicaid spending growth that averaged 6.3% as state revenue growth was projected to be still relatively strong but somewhat less robust than it was in 2007."

FMAP matters

Mr. Smith noted that for state policy-makers, a state's general fund cost for Medicaid is a key factor. For the last few years, he said, the state share of Medicaid spending has increased more rapidly than total Medicaid spending as the federal matching rate (Federal Medical Assistance Percentage or FMAP) declined for more than half the states (**see sidebar, p. 5**). Declines in the FMAP place pressure on states to allocate additional state general revenues to maintain current program levels. State general fund spending for Medicaid increased on average by 3% in 2006 and 3.2% in 2007. State legislatures appropriated an increase in state general fund spending for Medicaid that averaged 7.8% for 2008. Mr. Smith reported that for each of those years, the growth in state funding was greater than for total Medicaid spending.

According to Mr. Smith's analysis of state responses, the primary factors contributing to lower Medicaid spending growth were slow enrollment growth and the transition of prescription drug costs for dual-eligibles from Medicaid to Medicare Part D.

Medicaid enrollment growth was low in 2006 and actually decreased in 2007, he said. While the drop in enrollment was relatively small at one-half of one percent, it still was the first drop since 1998. Many states reported the new citizenship and identity requirements in the Deficit Reduction Act (DRA) contributed to the decline. Also a factor was the improving economy since Medicaid enrollment growth is higher in economic downturns when more people are likely to be unemployed, move into poverty, lose employer-sponsored health coverage, and subsequently become eligible for the program.

More states than in any of the last seven years removed restrictions or adopted policies to improve or expand their Medicaid programs in FY 2007 and FY 2008. Mr. Smith says every state implemented some type of provider rate increase in 2007 and 49 states planned to increase rates for at least one provider group in FY 2008. He noted that during the economic downturn, cutting or freezing provider rates was a primary mechanism states used to control Medicaid spending growth. States told Mr. Smith that improving provider rates

is necessary to maintain access to services and is important for state strategies using Medicaid to expand coverage to more of the uninsured.

More than half of all states in 2007 and 2008 made positive eligibility changes such as increasing the eligibility income limit, expanding eligibility for a new group, or streamlining and simplifying the application or renewal process. A few states restored or added benefits, he said. Compared to previous years, fewer states restricted provider payments, limited eligibility, or cut benefits.

Nearly 75% of states reported the new citizenship and identity

Got a match? You might with projected FMAP changes

With personal income in the U.S. increasing 6.6% in 2006, the strongest growth in this decade, some states are likely to see a higher Federal Medical Assistance Percentage (FMAP) in FY 2009, according to data being prepared by Federal Funds Information for States, a joint project of the National Governors Association and the National Conference of State Legislatures.

The federal match percentage is important to state Medicaid officials because a lower FMAP often means the state general fund will be asked to increase its support of Medicaid.

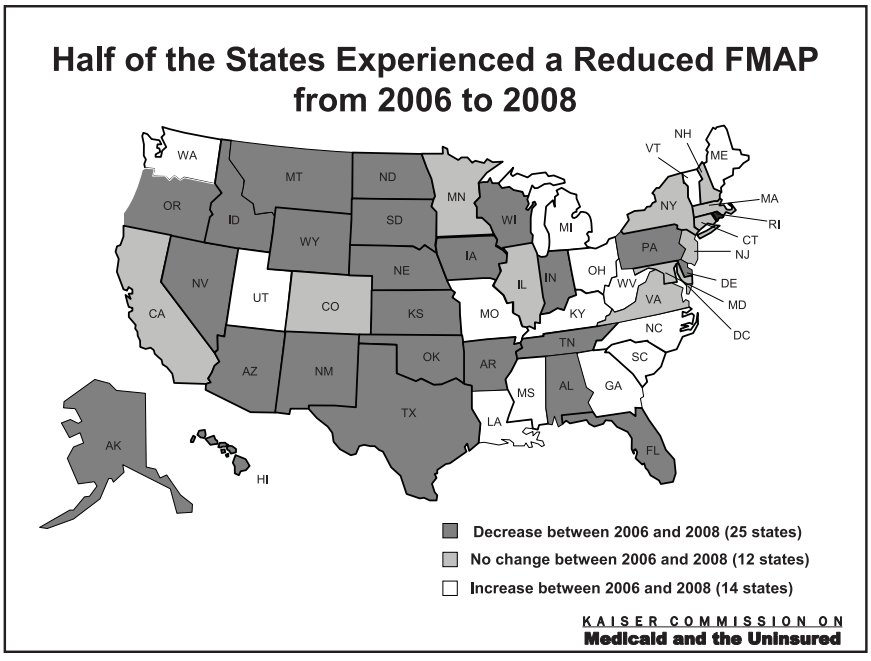
The FMAP calculation is based on a three-year average of state per capita personal income compared to the national average. A state with average per capita income receives an FMAP of 55%, and no state receives less than 50%.

FMAPs for FY 2009 are based on per capita incomes for calendar years 2004 to 2006. In the 6.6% growth in 2006, the western and southern regions continued to grow the fastest, led by the southwest (8.5%) and Rocky Mountains (7.7%). The slowest growth continued to be in the Great Lakes (4.8%) and the Plains (5.3%).

Some 21 states are expected to receive increased FMAPs in FY 2009 and 17 decreases. There should be 13 states receiving the minimum 50%. The most substantial increases were expected to be received by South Dakota (2.52), Michigan (2.17), Wisconsin (1.76), Oregon (1.59), Indiana (1.57), Nebraska (1.52), Georgia (1.39), Ohio (1.35), and Maine (1.10). The most substantial declines are expected to be felt by Nevada (-2.64), Alaska (-1.95), Florida (1.43), Hawaii (-1.39), Oklahoma (-1.20), Louisiana (-1.16), and Texas (-1.12).

Officials with Federal Funds Information for States said the relatively balanced set of increases and decreases appear to end a series of years in which precipitous declines occurred for many states. They said 12 states experienced declines of one percentage point or more between fiscal years 2004 and 2006, and 11 had such declines between fiscal years 2006 and 2008. By comparison, only Georgia and Ohio had sustained and substantial FMAP increases over the time period.

The impact of FY 2009 FMAPs will be a function of states' Medicaid and SCHIP spending in that fiscal year. On net, officials said, FY 2009 Medicaid grants to states are estimated to grow $389 million, with increases totaling $1.2 billion for 21 states partially offset by decreases of $816 million for 17 states. The largest increases are expected to come to Michigan, Ohio, Indiana, Georgia, Wisconsin, Pennsylvania, and North Carolina. The largest declines will affect Texas, Florida, Louisiana, Oklahoma, and Nevada. ■



Source: Kaiser Commission on Medicaid and the Uninsured, Washington, DC.

documentation requirements contributed to slowing enrollment growth, and 45 states said the requirements increased their administrative costs. Before the DRA changes, 47 states allowed applicants to self-declare their citizenship status. Some 37 states specifically identified the new citizenship and identity documentation requirements as contributing to slower enrollment growth or actual drops in the number enrolled, and several states said it was one of the most significant factors affecting Medicaid enrollment.

Administratively, states have had to train eligibility workers, make changes to their enrollment processes, set up systems for data matching of vital records, or rollback eligibility simplifications that had been in place, such as reinstating a requirement for face-to-face interviews. States said the new requirements have caused delays in processing new applications and renewals, and that in most cases the delays were for individuals who were otherwise eligible for Medicaid.

While most states have been troubled by the DRA citizenship and identity requirements, few have taken advantage of its other provisions to change benefits or impose new cost sharing requirements. So far, Mr. Smith found, eight states have used or reported plans to use the new options related to benefits.

Kentucky, West Virginia, and Idaho moved quickly to do a comprehensive redesign of their Medicaid benefits. And five other states are using the flexibility in a much more targeted way. Thus, in FY 2007, Virginia converted its existing disease management program from a voluntary opt-in program to a voluntary opt-out benchmark program and Washington implemented a chronic care management pilot program. In FY 2008, Kansas is adding personal assistance services for participants in the state's Ticket-to-Work Medicaid buy-in program and South Carolina will implement a voluntary one-county pilot Health Savings Account plan using its State Employee High Deductible health plan as the benchmark. Wisconsin is planning to offer a modified benefit package adapted from the state's largest commercial, low-cost health care plan to the BadgerCare Plus expansion population. Kentucky was the only state to use DRA authority to impose higher-than-nominal cost-sharing amounts and to make copayments enforceable.

States expand services

The survey found that states are continuing to expand their home- and community-based care services to balance their long-term care delivery systems and some states are using new long-term care options provided under the DRA. In FY 2007, 35 states expanded LTC services, while in FY 2008 a total of 46 states planned to do so. The LTC expansion most commonly reported was expanding existing waivers or adopting new ones. States also continued to add Programs for All-Inclusive Care for the Elderly.

The DRA gave states a number of options for increased flexibility to deliver LTC services and supports, Mr. Smith said. Thus, 31 states are using the DRA "Money Follows the Person" initiative that encourages states to reduce reliance on institutional care by transitioning individuals from institutions to the community to support home- and community-based service efforts. Nearly half the states had plans to implement a Long-Term Care Partnership Program in 2008 to help increase the role of private long-term care insurance. But there have been only limited attempts to use new DRA state plan options around cash and counseling or home- and community-based service options.

Mr. Smith found states are increasingly focusing on Medicaid quality improvement and initiatives to get better value from Medicaid expenditures. In 2008, some 44 states will be using HEDIS and/or CAHPS performance data from managed care organizations to measure and provide incentives for improved performance. The survey found an increasing number of states are also requiring their health plans to be accredited by a national organization such as the National Committee on Quality Assurance or implementing Medicaid pay-for-performance policies to reward and encourage quality care. By 2008, 27 states should have managed care pay-for-performance programs. And a few states have reimbursement systems that reward performance for hospitals, physicians, and nursing homes.

While states say they are committed to program integrity, many also reported they are frustrated and concerned about the administrative burdens imposed by federal oversight activities. State officials also expressed concern over new federal interpretations of long-standing, previously approved Medicaid policies that in some cases had the effect of shifting federal Medicaid costs to the states.

Coping with uninsured

To try to cope with the growing number of uninsured people, 42 states are advancing or developing plans to expand health insurance coverage, with almost all relying extensively on Medicaid to support and finance these plans.

"Despite a year dominated by program enhancement," Mr. Smith said, "Medicaid directors said that increasing program costs remains a top concern, although the singular urgency of this issue has significantly

abated as state revenues rebounded in recent years."

Strategies for reducing the number of uninsured include Medicaid or SCHIP expansions and promoting private health insurance coverage. Mr. Smith said the outlook for state revenue growth and the outcome of SCHIP reauthorization and federal support for the expansions will determine how far states feel able to go in expanding coverage. As state efforts continue, he said, Medicaid is likely to stay at the forefront of the policy debate as the larger discussions around health care reform including issues of coverage, costs, quality, and long-term care continue to play out at both the state and national level into the 2008 election cycle.

Asked whether there is a concern that states could expand too much and run into problems during the next fiscal downturn, Mr. Smith tells *State Health Watch* that most coverage expansions have been modest and often represented a decision not to take the kinds of restrictive actions states took in the previous five years.

"For the first time since we started this survey, there were no benefit cuts reported," he says. "And the cuts to provider payments were much less."

With regard to the potential flexibility in the DRA, he reports that many states weren't interested in pursuing the DRA options because they were involved in expanding coverage rather than restricting it. He says researchers identified some states that found ways to use the options that had not been envisioned, by enhancing benefits rather than restricting them. "The real test of those provisions is likely to come with the next economic downturn," he says.

Questioned about whether states were making decisions based on their expectations about the outcome in the 2008 presidential election, Mr. Smith said he had no sense that as states made decisions about FY 2008 they were looking forward to a time after the election in which there would be a different political environment. "Right now they're looking at what they can do with their programs in fiscal year 2008," he says. "The election is likely to be something of a factor in the FY 2009 state budgets."

Download the report at www.kff.org/medicaid/7699.cfm. Contact Mr. Smith at (517) 318-4819 or e-mail Vsmith@healthmanagement.com. ■

P4P cuts health care costs in CMS Medicare pilot

Coordinating care and reducing hospitalizations can lower Medicare costs, according to early results of a Centers for Medicare & Medicaid Services (CMS) study. The study began April 2005 and will run through April 2008 and is intended to examine how Medicare reimburses physicians for care with a focus on quality rather than on the number of tests and procedures performed.

In the study, CMS analyzed hospital and physician bills for 224,000 patients treated by 10 selected physician groups and compared them with bills from other doctors and patients in the same geographic areas.

Doctors in the experiment were required to meet certain quality criteria, such as adhering to 10 clinical measures for diabetes care. Clinical measures for heart disease care are being added to the experiment, as are measures for hypertension and basic preventive care.

Two groups qualify for bonuses

The results indicated that all 10 participating physician groups improved patient care during the first year. But only two of the 10—the University of Michigan Faculty Practice and the Marshfield Clinic in Wisconsin—met the threshold to qualify for bonus payments. The two groups were paid a total of $7.3 million, in addition to standard Medicare payments for services, for saving the program $9.5 million.

For each physician group practice, Medicare demonstration savings were calculated by comparing actual spending to the group's own base year per capita expenditures trended forward by a comparison group's expenditure growth rate. Case-mix adjustments were made to account for changes over time in the types of patients treated by the physician group and changes in the types of patients included in the comparison group. Cost and quality performance payments for the group are calculated if it achieves a Medicare savings of more than 2%. To determine quality performance payments, the demonstration includes 32 quality measures drawn from CMS' Doctor Office Quality project. Groups become eligible for payments by meeting threshold or improvement targets.

The demonstration includes 10 physician groups that cover all four Census regions. Each group has at least 200 doctors and together they represent more than 5,000 physicians. The groups include freestanding group practices, components of integrated delivery systems, faculty group practices, and a physician network organization made up of small and individual physician practices.

Together they provide the largest portion of primary care services for more than 220,000 Medicare fee-for-service beneficiaries.

In addition to the Michigan and Wisconsin sites that received bonus money, the other participating groups are Billings Clinic, Montana; Dartmouth-Hitchcock Clinic, New Hampshire; Everett Clinic, Washington; Forsyth Medical Group, North Carolina; Geisinger Health System, Pennsylvania; Middlesex Health System, Connecticut; Park Nicollet Health Services, Minnesota; and St. John's Health System, Missouri.

Four themes emerged at a site conference sponsored by CMS and the Commonwealth Fund in April 2006, the end of the first study year:

1. Improving care management and coordination of care. Approaches include chronic disease management, high-cost/high-risk patient management, and transition management. Most of the participating physician groups have implemented chronic disease management programs for diabetes and heart failure. Those diseases are emphasized, conference participants said, because they have relatively high prevalence among Medicare beneficiaries, usually have room for improvement on quality measures, and also have potential to reduce costs. High-cost/high-risk patient management programs usually are more broadly defined than disease management programs, in that they usually target patients who have multiple chronic diseases, while disease management programs tend to focus on single diseases. Transitional care interventions include enhanced hospital and emergency department discharge planning to ensure that appropriate follow-up care is received and readmissions are avoided.

2. Expanding palliative and hospice care. Several of the participating physician groups have developed or explored programs for expanding access to palliative, hospice, or end-of-life care. Though currently underutilized for Medicare beneficiaries and other U.S. health care system patients, these initiatives are seen as having promise for reducing utilization of high-cost hospital care and improving patients' quality of life.

3. Modifying physician practice patterns and behavior. Physician behavior is central to reducing costs and improving quality of care, conference attendees said, given that physicians have the largest influence on patient treatment and resource utilization. All of the participating physician groups have considered ways to influence or modify physicians' practice patterns. They include modifying physicians' work processes, encouraging physicians to consider the health of a panel of patients rather than individual patients, and feedback reports to improve coordination and quality of care. The Commonwealth Fund conference report says a key challenge "is in identifying the optimal ways to modify clinical work processes, such as when physicians can delegate routine care to nurses or medical assistants."

4. Enhancing information technology. Most of the participating physician groups highlighted information technology innovations as critical for their success under the demonstration. Included are applications that identify and track high-risk patients, develop chronic disease patient registries, provide doctors with detailed reports on individual patients, prepare broader feedback reports, and give automated reminders to physicians or support staff on needed care. Some groups enhanced electronic medical records, while others focused on more limited and less expensive patient registries.

CMS has concluded that to date the demonstration has shown that it is possible for large multispecialty group practices to respond to a hybrid set of quality improvement and cost-containment incentives layered on top of a fee-for-service payment system. The physician groups have used the demonstration as a vehicle for expanding data systems, care management programs, coordination of care efforts, and other interventions that are not directly reimbursed in fee-for-service payments.

As Medicare's first pay-for-performance initiative for physicians, the demonstration enables doctors to provide the high-quality and appropriate services they would like to give their patients but frequently feel they are penalized for under the current health care financing system. CMS and Commonwealth Fund say the focus among participating physician groups is less on direct financial rewards for individual providers and more on getting the reimbursement system out of the way so doctors can provide services they know patients need.

Can it work in other formats?

CMS says a goal for the future is to develop ways to expand the demonstration approach to other practice formats. The physician group demonstration model is a provider-based approach to Medicare reform. Incentives are given directly to providers, they are put in charge of managing patient care, and they share the rewards of improving quality and efficiency. Participating provider groups may contract with external organizations such as care management, disease management, and patient monitoring companies to assist in patient care management activities, but that is at the discretion of the providers.

No private insurance companies are involved to act as intermediaries between Medicare and the provider groups. And Medicare beneficiaries' insurance arrangements are not affected in any way.

The Commonwealth Fund conference report says a barrier to previous private sector attempts to establish direct financial incentives for quality and efficiency for providers has been the inability of many provider organizations to accept financial risk for patient care. The current demonstration addresses that concern by not having a downside penalty for underperformance. Rather, it tests whether a provider-based approach emphasizing incentives rather than punishment will prove effective in enhancing the quality and efficiency of care Medicare beneficiaries receive.

CMS acting deputy administrator **Herb Kuhn** said the agency wanted to "reward providers for the right care at the right time" and said he was "very, very pleased with the first year results." Kuhn said while the available results are only from the first of three years, they are "trending in a very positive way."

Estimated savings of $21 million

While Medicare has not calculated the experiment's overall savings, the physician groups said the 10 groups together saved the program some $21 million.

But even the groups able to achieve savings say the program's complexity and the time elapsed since the first-year test period ended makes it difficult to respond to the potential financial incentives. "The financial model for this program may not be viable," said **Caroline Blaum**, the physician leading the effort at the University of Michigan Faculty Practice. Blaum added that the doctors in her practice are uncertain about what exactly they did to generate savings.

Questions remain about how to motivate individual physicians because the experiment rewards organizations and not individual doctors who must actually ensure that a patient gets a flu shot or goes to the right specialist.

Download the Commonwealth Fund report at www.commonwealthfund.org/publications/publications_show.htm?doc_id=428880. ■

Opinion leaders: U.S. health system in crisis

Opinion leaders from academia and research organizations; health care delivery; business, insurance and other health industry; and government and advocacy groups surveyed by the Commonwealth Fund say the U.S. health care system isn't designed to provide high-quality health care and changes must be made at the highest levels.

The 214 individuals taking part in the midyear 2007 survey gave responses that were closely aligned with principles laid out by the Commonwealth Funds' Commission on a High Performance Health System and with the views of the general public. Commonwealth Fund officials said the survey responses "indicate a growing recognition that access to care, quality of care, and the costs of care are interrelated, and that it is difficult, if not impossible, to fix one area without addressing the others. There is strong support for change both in payment and in organization of care, as well as a surprising level of support for government intervention in critical areas."

Looking ahead to the 2008 elections, health care opinion leaders say there is an opportunity to achieve significant change within our health care system. "Hopefully, our nation's leaders will seize the opportunity to give all Americans the high-performing health care system they deserve," they say.

While the respondents acknowledge that many activities are taking place to measure and improve quality of care, the U.S. is unlike many other countries in not having a single national entity charged with coordinating all the efforts and setting a quality improvement agenda for the nation. Some 56% of the experts who were surveyed supported or strongly supported creation of a new public-private agency to coordinate efforts around quality and set a national quality agenda, while only 16% said they oppose creation of such an entity.

Surveyed experts said they thought a number of strategies would be effective or very effective in improving health care quality and safety, including accelerating adoption of health information technology (66%); public reporting of provider performance on quality measures (59%); financial incentives for improved quality of care, such as pay-for-performance (51%); and stronger regulatory oversight of providers (50%).

Fee-for-service rewards quantity

One of the problems the experts noted was that the predominant method of paying for health care services remains fee-for-service, which rewards providers for the quantity of services they provide, without regard

to the appropriateness, quality, or efficiency of the care. The respondents noted that pay-for-performance programs are an attempt to align payment with the quality and efficiency of care delivered and 44% of them said they support or strongly support expansion of pay-for-performance programs, with support higher among business leaders (62%) than among academic experts (41%). The Commonwealth Fund report suggests that since most pay-for-performance programs are based on a fee-for-service structure, they are relatively ineffective in promoting care coordination and efficiency, leading some policy experts to say that more fundamental payment reform is needed. One idea would be to move away from payments based solely on discrete face-to-face clinical encounters and instead to move toward bundled payment mechanisms, such as payment for episodes of care.

Some 95% of those surveyed said fundamental payment reform is needed, and only 1% said it was not necessary. Close to half of respondents (47%) said that while fundamental payment reform is needed, the pay-for-performance programs now in place represent an important transitional step, while 25% believe that current pay-for-performance programs are an unnecessary distraction to reform efforts.

Health care opinion leaders surveyed agree with the Commission on a High Performance Health System that a much greater degree of provider organization is critical to achieving improvements in quality and efficiency. Some 73% said they support efforts to foster integration of individual providers, with half indicating they strongly support such efforts.

Potential barriers to integrating providers cited included the culture of physician autonomy (79%), a lack of financial incentives for integration (69%), and current laws and regulations (35%). Only 14% thought consumer resistance would be a major barrier.

Medical homes supported

The commission strongly supports development of medical homes for people and the opinion leaders agree. Some 66% said they support or strongly support giving Medicare beneficiaries a financial incentive, such as a reduction in Part B premiums, to register with a medical home. And 73% of respondents support reforming Medicare payment policy to encourage medical homes (currently, Medicare does not pay for providing patient-centered services such as care coordination).

The health care opinion leaders said expansion of health information technology is the most promising tool for improving quality and safety. Advanced health information systems that provide clinicians with decision-support tools and enable them to assess and monitor care can improve patient outcomes and foster more innovative, efficient use of resources, they said. But at present, only 19% of U.S. primary care doctors have advanced information capacity in their practice, compared with more than 80% of primary care doctors in the UK and the Netherlands.

Feds should take lead

Because the price tag for a significant expansion of health information technology is so high, 70% of opinion leaders surveyed said the federal government should play a leading role in assisting providers in financing health information technology, while 59% said pay-for-performance bonuses should be linked to using health information technology. Nearly 90% said that Medicare should require use of electronic medical records for all Medicare participating providers in either the next five or 10 years.

Although many health information exchange networks are emerging throughout the country, almost none have established a business model for sustained operations. Some 42% of respondents said the government should help finance development and ongoing operations of the networks, while 52% said that private insurers and payers should help finance network development and maintenance. Only 7% of respondents said government should not help finance health information exchange networks at all, and only 8% think private insurers and payers should not help finance them.

Safety bill not strong enough

Health care opinion leaders are skeptical that the Patient Safety and Quality Improvement Act of 2005 will be effective. The act calls for voluntary and confidential reporting of actions that adversely affect patients to patient safety organizations that would analyze the data and help providers implement measures to improve patient safety. Only 7% of respondents said the act is sufficient as written to improve patient safety. Some 75% believe that reporting to patient safety organizations should not be voluntary, and 60% believe that information about patient safety events should not be confidential. Interestingly, respondents who are engaged in health care delivery were least likely to be comfortable with mandatory participation in patient safety organizations (55%) and public reporting of patient safety events (31%).

Download the issue brief reporting survey results at www.commonwealthfund.org/publications/publications_show.htm?doc_id=511967. ■

Boy's death spurs dental home bill in Congress

The House Energy and Commerce Committee is considering HR 2371, Deamonte's Law, which its sponsor says would establish a dental home for every American child by increasing dental services in community health centers and training more people in pediatric dentistry.

The bill's primary sponsor is Rep. **Elijah Cummings** (D-MD), who drafted it after the death of Deamonte Driver, a 12-year-old Maryland boy who died in 2007 when a tooth infection spread to his brain. "A routine dental checkup might have saved his life," Mr. Cummings says, "but Deamonte was poor and homeless and he did not have access to a dentist. When I learned of this senseless tragedy, I was deeply shaken. I simply cannot comprehend how, in this country where we have sent a man to the moon, we let a little boy's teeth rot so badly that his infection became fatal. To be clear, Deamonte's case was rare and extreme. However, even the most casual investigation reveals that children across the country are living with painful untreated tooth decay, many of them dangerously close to acquiring life-threatening infections."

The congressman says the Centers for Disease Control and Prevention has found that tooth decay is the single most common childhood chronic disease and that it disproportionately affects poor and minority children.

The bill, he says, would ensure that children have access to dental services in the communities where they live, through the community health centers that provide a health care safety net to underserved areas such as rural and urban communities. The bill would establish a five-year, $5 million pilot program to provide funds for dentists, equipment, and construction for dental services at community health centers. It also would provide support for contracts between health centers and private practice dentists.

A second part of the bill would address the dentist shortage in the United States by establishing a five-year, $5 million pilot program to enhance training and academic programs in pediatric dentistry, recruit and train dentists to study pediatrics, and provide continuing education for practicing dentists. ■

Clip files / Local news from the states

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

Wisconsin moves on health insurance for kids

MILWAUKEE—Every child in Wisconsin will have access to affordable health insurance starting Feb. 1, 2008 through a sweeping restructuring of state health programs put in place by Gov. **Jim Doyle**. The governor said the plan, known as BadgerCare Plus, will streamline the state's existing health programs and allow parents to buy affordable health insurance for their children.

"We have a moral obligation to provide every child in Wisconsin with affordable, quality health care," Mr. Doyle said in a statement. "With BadgerCare Plus, we will reach out to every family across this state to ensure their children get the care they need at a price they can afford." Under BadgerCare Plus, families whose children are not eligible for existing state programs would be able to buy health insurance for a child for $10 to $68.53 a month, or $120 to $822.36 a year, depending on the families' income.

The state expects to pay for the expansion primarily from streamlining state programs; expanding the use of health maintenance organizations; and the premiums and co-pays paid by families.

Wisconsin has one of the lowest rates of uninsured children in the country, according to U.S. census data. Nonetheless, an estimated 71,000 children in Wisconsin were uninsured at a given time in 2006, up from an estimated 63,000 in 2005, according to the state's 2006 Family Health Survey. The study found that an estimated 48,000 children were uninsured for all of last year.

— *Milwaukee Journal-Sentinel,* 11/7/07

Now what? Oregon child health plan up in smoke

PORTLAND—Voters' snub of a tobacco tax increase has sent legislative leaders and Oregon Gov. Ted Kulongoski back to square one in their quest to make health care affordable for all Oregonians. Cigarette tax money from Measure 50 would have gone to insure many of the estimated 116,000 children in Oregon without health insurance, as well as a sliver of the roughly 460,000 uninsured adults.

Leaders in Salem have no backup

plan, but a seven-member panel is charged with drafting legislation for 2009 to expand health coverage for the uninsured. "That's what's so frightening. This was an attempt to deal with the crisis for kids, and now that that's gone, we're all looking at each other," said Senate president **Peter Courtney**, D-Salem.

"There's an undercurrent that someone else will solve this problem for us, and that's not good." Even Measure 50 supporters acknowledge that the tax would have provided a short-term fix for a problem that requires a top-to-bottom overhaul of a system that's inefficient and expensive.

Tax would have raised millions

Measure 50 would have raised an estimated $147 million in 2008-09 and $208 million in 2009-11 to provide health insurance for more than 90,000 low- and middle-income children. Money also would have gone to enroll 10,000 poor adults in the Oregon Health Plan.

Kulongoski ran for re-election last year promising health care for Oregon's uninsured children, paying for it by raising cigarette taxes. There was widespread agreement that providing coverage for children was a good start, **Chip Terhune**, Mr. Kulongoski's chief of staff, said. "You have the business community really struggling with rising health care costs and the impact on their bottom line. You have employees, labor, and a host of consumers out there, generally, that are facing the exact same pressure on their own pocketbooks," he said. "And that dynamic creates this incredible pressure in the middle to do something."

— *Portland Oregonian*, 11/8/07

Arkansas unveils health program for workers

NORTH LITTLE ROCK— Arkansas state employees can earn days off for quitting smoking, eating more fruits and vegetables and other healthy changes under a new incentive program, Gov. Mike Beebe and health officials announced. Mr. Beebe announced the expansion of a pilot program started under former Gov. Mike Huckabee, his predecessor. Under the Arkansas Healthy Lifestyle program, state employees can earn up to three days per year for participating in a voluntary program that focuses on increasing physical activity, increasing consumption of fruits and vegetables, and decreasing or eliminating the use of tobacco products.

Expands lifestyle program

The announcement expands the Healthy Employee Lifestyle Program, a pilot project started in 2004 targeting 10,000 employees in the Department of Health and Department of Human Services. So far, more than 2,500 people have registered in the program and 947 have earned time off work through points earned by improving their eating habits and health.

— *Associated Press,* 11/10/07