State Health Watch
Vol. 15 No. 4
The Newsletter on State Health Care Reform
April 2008

AHC Media LLC

In This Issue

Events conspire against states striving for health care program expansion

States working to expand health coverage for low-income, uninsured individuals — especially children — are running into a proverbial perfect storm of federal barriers.

First, states were counting on a strong SCHIP reauthorization bill, but that did not happen. Instead, President George Bush vetoed two bills he said would expand the program too much and then signed a measure that essentially extended it in place, with no expansion in eligibility. The temporary extension will run until the end of March 2009.

Next, the Centers for Medicare & Medicaid Services (CMS) issued an Aug. 17, 2007, federal directive restricting states' ability to use SCHIP funds to cover children in families with gross incomes above 250% of the federal poverty line. And CMS also has issued new regulations curtailing Medicaid funding, including one eliminating administrative funding for outreach and enrollment activities conducted by school personnel.

Also, implementation of the Medicaid citizenship documentation requirement under the Deficit Reduction Act enacted in 2006 has resulted in U.S. citizens having their

*See **Expansion** on page 2*

Community health centers having trouble making specialty referrals

The nation's community health centers (CHCs) provide primary health care services to more than 15 million people, many of whom are members of racial or ethnic minorities, have low income, are uninsured, or have coverage through Medicaid. But a Commonwealth Fund study says there are concerns that CHCs don't have adequate capacity to provide a full range of services to their patients, and in particular have difficulty obtaining off-site specialty services, including referrals to medical specialists, diagnostic testing, and mental health and substance abuse treatment. The problem is especially acute for CHC patients who are covered by Medicaid or are uninsured, the study found.

Fiscal Fitness: How States Cope

The Commonwealth Fund report, "Access to Specialty Care and Medical Services in Community Health Centers," was developed by surveying 814 medical directors of federally qualified CHCs focusing on two issues—1) the relationship between access to specialty medical

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

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 $17.95 for shipping & handling. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. 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: Coles McKagen, (404) 262-5420, coles.mckagen@ahcmedia.com
Managing Editor: Gary Evans, (706) 310-1727, gary.evans@ahcmedia.com.
Editor: John Hope, (717) 238-5990, johnhope17110@att.net.
Senior Production Editor: Nancy McCreary.

AHC Media LLC

Expansion

Continued from page 1

Medicaid benefits delayed, denied, or terminated due to the requirement that new applicants and current enrollees provide original documents to prove citizenship and identity.

The above findings come from a recent report by the Kaiser Commission on Medicaid and the Uninsured. The report includes a 50-state update on eligibility rules, enrollment and renewal procedures, and cost-sharing in Medicaid and SCHIP. (**See report highlights, p. 4.**) The federal developments are impeding states' efforts to cover children made eligible through newly authorized expansions, as well as their efforts to enroll children who are already eligible for coverage but who remain uninsured, according to Kaiser Commission policy analysts **Robin Rudowitz** and **Caryn Marks.**

"States are trying to meet the problems of the uninsured," Ms. Rudowitz tells *State Health Watch*. "The problem of the uninsured is getting worse because people can't afford employer coverage or other private coverage and states are trying to meet that need, especially for children."

She says in addition to the issues described in the state survey, states are being hindered by tightening state economies. During the last economic downturn several years ago, Ms. Rudowitzsays, kids remained a priority. But state Medicaid directors are now saying there are some things they were able to do in the past, such as cutting provider payments and controlling drug spending, they no longer can pursue because there's not much maneuvering room left. Ms. Rudowitz and Ms. Marks say over the next year, children's health coverage in 23 states will be hurt by the August 2007 directive. The 23 affected states include 10 that passed eligibility expansions but had not obtained federal approval before the directive was issued and 14 states that had implemented coverage expansions above the level but will have to comply with the directive by this coming August. (Washington is counted in both categories.) In response to the directive, several states have scaled back or postponed their expansion plans or have decided to absorb the full cost of covering children from families with income above the CMS limit. As a result, they say, thousands of children already have lost the opportunity to obtain health coverage and many more may be adversely affected as states make decisions about going forward.

Asked what can be done about the CMS August 2007 directive, Ms. Rudowitz says the two SCHIP reauthorization bills the president vetoed contained provisions to overturn the directive and Congress could adopt separate legislation to do so. "There's still some legislative effort," she says, "but it's unclear where it will go without a larger SCHIP reauthorization." She notes several states have filed federal court suits challenging the directive.

"Several elements are critical if states are to realize the advances achieved in 2007," Ms. Rudowitz and Ms. Marks say. "SCHIP reauthorization that provides support from the federal government to undergird states' efforts to furnish health coverage for children is essential to continued progress in reducing the number of uninsured children. The concern that federal action will curtail longstanding federal financial support for children's health coverage and states' flexibility to design and operate their programs

has created considerable tension at the state level. In addition, emerging state budget deficits and potential pressure to cut state spending is placing the hard-won progress on children's health coverage at further risk. These conditions present new hurdles for states and will make it even more challenging to identify steps to maintain and promote coverage, especially if the economy and state revenue situation worsens."

CMS directive very restrictive

Looking in depth at the new CMS directive, Ms. Rudowitz and Ms. Marks say it restricts states from using SCHIP funds to cover children in families with gross incomes above 250% of the federal poverty line. To obtain approval for such an expansion, states would have to demonstrate they have already enrolled 95% of children under 200% of poverty who are eligible for SCHIP or Medicaid and that private employer-based coverage for lower-income children has not declined by more than two percentage points over the past five years. States that meet those requirements still would have to impose specific cost-sharing policies and would have to require children to be uninsured for at least 12 months before being allowed to enroll.

"Having to meet the Aug. 17 conditions impedes the ability of states to proceed with new expansions and hinders the viability of previously approved expansions," they say. "Indiana, Louisiana, and Oklahoma have decided to expand to only 250% of the federal poverty line and New York and Wisconsin have decided to use state funds to pay the full cost of covering children above the CMS limit. Other states with new expansions, and states that expanded prior to the directive, have not yet determined how they will proceed. As a result of the directive, thousands of children already have lost the opportunity to obtain health coverage and many more may be adversely affected as states make decisions about going forward."

Many of the states would have to make significant adjustments to be able to comply with the new directive. Of the 23 affected states, all but the District of Columbia and Hawaii now impose cost-sharing for children under their expansion or plan to do so if their expansions are allowed to proceed. But it appears to the analysts that none of the states plan to charge amounts as high as those required by the directive.

Also, while all of the affected states except the District of Columbia, Hawaii, and Rhode Island require or plan to require children to be uninsured for a period of time before enrolling for SCHIP, they would not be mandating that children be uninsured for a full year, as the directive requires. And while Illinois, Louisiana, and West Virginia would impose 12-month waiting periods, they also would allow some exceptions, such as when the cost-sharing for the private plan exceeds a certain percentage of family income, and these exceptions may not comply with the directive.

Simplifying enrollment, renewal

Nine states took steps to simplify enrollment and renewal procedures for children. While some states adopted basic simplified strategies such as disregarding assets in determining eligibility, allowing enrollment and renewal without an in-person interview, and limiting renewal to once a year, simplification advancements mainly focused on other strategies. Thus, Tennessee and Texas adopted 12-month continuous eligibility for children in their separate SCHIP programs and New York, Tennessee, and Wisconsin no longer require families to present documentation of their income when they are enrolling or renewing Medicaid or SCHIP coverage for their child. Under such administrative verification and renewal procedures, states generally consult state databases or available case records to verify income.

Five states—Colorado, Kansas, Louisiana, New York, and Wisconsin—adopted the presumptive eligibility option, which allows "qualified entities" such as clinics, hospitals, schools, WIC agencies, Head Start programs, and the agencies that determine eligibility for some public benefits to temporarily enroll children who appear eligible while the family completes the process for ongoing eligibility.

Although Georgia retracted its administrative verification and now requires families to provide proof of income when applying for SCHIP, state officials say the program's integrity was not compromised when they did use the simplification procedure.

Enrollment sensitive to changes

Ms. Rudowitz and Ms. Marks say when states impose restrictive procedures, enrollment declines in the same way it would if states tightened eligibility. While a cut in income limits would make some potential applicants ineligible, procedural barriers often result in individuals being denied or losing coverage even though they are eligible.

The experience in a number of states shows that enrollment is sensitive to changes in procedures. In Washington, the children's health coverage program saw a sharp drop in enrollment when the state replaced 12-month continuous eligibility with a requirement that children renew coverage every six months. And enrollment went back up when the state returned to its original policy.

Enrollment in Connecticut's program fluctuated when the state removed and then reinstated several simplification procedures, including administrative verification of income.

In Mississippi, the state in 2005 dropped its mail-in application process and required families to report and renew their coverage in person. In 2006, 62,000 fewer children and adults were enrolled in Medicaid and SCHIP as compared with 2004. A report from the Mississippi Center for Justice and Mississippi Health Advocates says Medicaid offices are inaccessible and some 80% of Medicaid outstations are open one day a week or less, with some open only one day a month, sometimes for only a few hours, making it quite difficult for working families and those without transportation. Data show that nearly 60% of individuals due for renewal do not appear for their face-to-face meeting and nearly 90% of "new" approved applications are for children or adults whose coverage has lapsed.

Citizenship requirement problems

The survey of states found the Medicaid citizenship documentation requirement continues to impede state efforts to simplify their enrollment procedures. Adverse effects have persisted even when states have tried to employ strategies to minimize loss of coverage, the investigators found. At least 39 states say they now conduct data matching with their vital records agencies to obtain birth records.

While many states have found such data matching helpful, others report that database constraints and technological challenges limit its effectiveness. And an overriding problem reported by many states is that securing birth records for individuals born in other states is difficult, if not impossible. When individuals attempt to secure out-of-state records of their own, they find it requires considerable time and expense.

At least 12 states allow use of affidavits in which parents attest to the identity of their children younger than age 16, but that doesn't cover everyone affected by the requirement and the analysts say identity documentation remains a significant barrier. Wisconsin reports it has birth records but not identity documentation for the majority of people who have been denied coverage, showing they are citizens but have been unable to comply with the requirement. Under the federal requirement, states are not allowed to provide Medicaid benefits to applicants who otherwise appear eligible until they provide the required documents. The only mechanism under which states can do this is presumptive eligibility, and some states have adopted that approach as a way to ease the negative consequences of the citizenship documentation requirement.

Download the report at http://www.kff.org/medicaid/7740.cfm. Contact Ms. Rudowitz and Ms. Marks at (202) 347-5270. ■

Major findings of Kaiser report reveal progress, pitfalls

Major findings of a recent report by the Kaiser Commission on Medicaid and the Uninsured include the following:

1. Some 32 states, including Washington, DC, took actions to increase access to health coverage for low-income children, pregnant women, and parents. Of the 32, 26 states authorized or adopted income eligibility expansions, 11 states reduced procedural barriers, and seven states reduced financial barriers to Medicaid and SCHIP. While most activity was focused on children, there also were modest improvements for pregnant women and parents.

2. Some 26 states improved access to children's health coverage. Of the 26 states, 12 raised or authorized raising SCHIP income limits to 300% of the poverty line or higher, more than doubling the number of states setting eligibility at that level. Plus, nine states simplified enrollment procedures and seven states reduced coverage financial barriers.

3. Some 14 states enacted moderate children's coverage expansions focused on particularly vulnerable populations such as infants or children discharged from foster care at age 18. The changes included modest income eligibility expansions, increasing the SCHIP asset limit, and allowing children who are discharged from foster care at age 18 to retain Medicaid through age 21.

4. No state cut back income eligibility for children, but a few states restricted eligibility. Thus, three states froze children's enrollment and two states imposed or lengthened waiting periods. The analysts say experience from states that have had enrollment freezes indicates that most children who are closed out of coverage have no alternatives and remain uninsured, missing out on needed health care including prompt medical treatment, medication, preventive exams, and immunizations.

5. States claim progress in adopting simplified enrollment and renewal procedures in children's Medicaid and SCHIP, particularly emphasizing strategies reducing

paperwork and jump-starting enrollment. Nine states took steps to simplify enrollment and renewal procedures for children Several basic simplified strategies such as disregarding assets in determining eligibility, allowing enrollment and renewal without an in-person interview, and limiting renewal frequency to once a year, have been adopted for children almost universally. Only Georgia retracted a simplified procedure in its children's health coverage program during the survey period.

6. The Medicaid citizenship documentation requirement continues to impede state simplification efforts by complicating enrollment, especially for children.

7. Seven states reduced or eliminated premiums for children's health coverage, but another seven states either imposed new premiums or increased the amount of existing premiums.

8. Twelve states and the District of Columbia enacted modest coverage expansions for pregnant women and parents and no state retracted eligibility for these adults. Nine states increased eligibility for pregnant women, either by expanding income eligibility or by adopting the option to cover unborn children in SCHIP. Six states took steps to expand health coverage for parents.

9. Income eligibility for parents still lags behind eligibility for children, although the disparity was reduced a bit in 2007.

10. Efforts to simplify enrollment and renewal procedures for parents continued, but the report says it remains harder for an eligible parent than for an eligible child to obtain and keep coverage. Research indicates that efforts to cover low-income parents in programs like Medicaid and SCHIP increase the enrollment of eligible children. Also, when their parents are insured, children gain better access to health care and improve use of preventive health services. The analysts say efforts to expand parent coverage will help advance enrollment of children as well, while limits on parent coverage could pose a barrier to enrolling more children. ■

Fiscal Fitness

Continued from cover

and mental health services and patient insurance status; and 2) other factors associated with access to off-site specialty services for uninsured and Medicaid patients.

Lead author **Nakela Cook** of Massachusetts General Hospital and Harvard Medical School says CHC medical directors told her some 25% of CHC visits result in medically necessary referrals for services not provided by the centers, regardless of patient insurance category.

She found that getting specialty medical care outside the CHC usually posed little problem for patients with Medicare or private insurance. But access to off-site specialty services was difficult for patients who were uninsured or were covered through Medicaid and was even more challenging for patients needing off-site mental health or substance abuse services. Such access was difficult for uninsured patients, she says, even if the CHC was affiliated with a medical school or a hospital. Access to off-site mental health services was found to be somewhat easier if the CHC had on-site mental health services.

The medical directors said the most common barriers to care were providers who are unwilling to take patients with specific types of insurance, patients who could not pay up front as required, and patients lacking full coverage for needed services. "The effect of these barriers varied significantly by insurance status," Ms. Cook says.

Frequent need for specialized care

Despite the frequent need for specialized medical and mental health services, CHC medical directors reported major problems obtaining them for uninsured and publicly insured patients. "Given that federal policies expanding the number of CHC sites have not led to a substantial increase in the availability of many on-site specialty services, the problem of difficult access for services may increase if additional resources and planning are not devoted to assuring access to outside specialty services or bringing a greater array of services into CHCs," Ms. Cook says.

One potential solution she sees is for some federal funds to be earmarked for providing such services and requiring off-site facilities to deliver a defined amount of specialty care to patients referred from CHCs. Recognizing that centers affiliated with medical schools or hospitals, and those with on-site mental health services, reported greater access to specialty services, Ms. Cook and her colleagues also suggest that policy-makers encourage CHCs to seek such affiliations. Additional research is needed to explore other aspects of CHCs associated with referral success, they say.

"If policy-makers plan to extend access to primary care for the uninsured by increasing the number of CHCs, they must also address the problem of access to secondary and tertiary levels of care," Ms. Cook says. "Because CHC patients are disproportionately minority and low income, these improvements could go a long way in correcting disparities in health outcomes across racial and socioeconomic groups."

Ms. Cook tells *State Health Watch* there are differences among CHCs across the country in terms of the numbers and types of services they have available on-site. "There are a lot of community health centers that don't have in-house services and have to refer out to specialists, labs, etc.," she says. "Many do have mental health services. We found that if they have some services available on-site, they are more likely to be able to get referrals."

According to Ms. Cook, the report from CHC medical directors that, on average, 25% of their patients need specialist care was higher than the researchers had expected. "We found that a lot of people need services but couldn't get them," she says. "A lot of providers won't accept patients who don't have insurance or who are covered through Medicaid."

Ms. Cook says the solution to the program is through a broader effort to persuade more doctors to accept other payments or people with no insurance or even require that physicians provide some level of service to the uninsured and Medicaid patients. "It's difficult to promote that idea among providers," she adds.

It may ultimately be better, Ms. Cook says, if more effort goes into enhancing services that are offered through existing CHCs rather than increasing the number of CHCs. It also would be important, she says, to find ways to put more specialists on-site at CHCs and to set up referral networks. But she also says she recognizes that some areas of the country, especially rural areas, need CHCs, although the focus still should be on providing full service.

Ms. Cook tells *SHW* additional research could help clarify the issues facing CHCs. She would like to see research into CHCs that have referral networks that work well and what the factors are that make them work for uninsured patients. She also would like to see researchers look at the role CHC organizational structure plays in being able to obtain referrals and what role any affiliation with an academic medical center or hospital plays in obtaining referrals.

Contact Ms. Cook by e-mail at ncook1@partners.org. Access the study from Health Affairs at http://healthaffairs.org. ■

No lack of health care challenges for next president

Guaranteeing affordable health insurance for all, changing the way doctors and other health care providers are paid, and better organizing and coordinating care delivery are among the top action items that await the next president, according to a report by the Commonwealth Fund Commission on a High Performance Health System.

Other health care priorities for the man or woman who ascends to the highest office include implementing an electronic information system in a reasonable period (e.g., five years), the report says. Members of the commission are a diverse group of leading health policy experts from government, private industry, health care delivery organizations, academia, and professional associations.

"This report outlines how essential it is that we pursue improvements in health care quality and efficiency at the same time as we pursue universal coverage," said commission chair **James Mongan**, the CEO of Partners HealthCare System. "We cannot and should not hold either of these facets of reform hostage while we wait for the other to happen."

Specific strategies

The report, "A High Performance Health System for the United States: An Ambitious Agenda for the Next President," outlines specific strategies to contain costs and organize the U.S. health care delivery system to address how the system falls short by failing to provide health insurance to everyone, by delivering care that is highly variable in quality, and by promoting inefficient health care spending.

Among the changes called for are:

1. Affordable coverage for all by extending health insurance to all in a way that will allow people to seamlessly get coverage and not risk losing coverage when they change jobs, become widowed, or become ill;

2. Aligned incentives and effective cost control by rewarding doctors and hospitals for providing high-quality, cost-effective care; moving away from a fee-for-service model to one where providers share accountability for the total care of their patients; and addressing the payment disparity between primary and specialty care doctors;

3. Accountable, coordinated care in an organizing health system where doctors, hospitals, and other health care services are linked together, virtually or literally, and it is easy for patients to navigate between their primary care doctor, specialist, and hospital;

4. Aiming higher for quality and efficiency by investing in ways to help all doctors and health care systems practice evidence-based medicine and provide the highest-quality care possible, and ultimately report their quality data to the public, including investing in

health information technology such as electronic medical records;

5. Accountable leadership possibly through a national entity that would develop goals for the health care system, set national health care priorities, develop measurements for health system performance, and recommend policies and practices for achieving them.

"There is no question that health care is at the top of the nation's agenda in the presidential election and will be a key issue for the next president," says Commonwealth Fund president **Karen Davis**. "These recommendations lay out how, in the next five years, we can move closer to a health system that gives all Americans the chance to lead longer, healthier, and more productive lives."

A few weeks earlier, the commission issued a report saying that health insurance reform plans that build on a mix of private and public health insurance, where costs are shared among government, employers, and enrollees, would have the best chance to move the system to high performance and would be the most practical to implement.

The report's authors said affordable, comprehensive health insurance coverage for all Americans is essential to achieving a high-performance health system because coverage helps to ensure access to essential preventive services; improve overall health; cut down on inefficiencies such as duplicate medical tests; reduce administrative costs; and eliminate costly uncompensated care for uninsured and underinsured families.

"If we do health reform right, we can get all Americans covered, improve quality and efficiency, and control skyrocketing health care costs," said report author **Sara Collins**, Commonwealth Fund assistant vice president.

The report says health reform should:

- provide equitable and comprehensive health insurance to all Americans, regardless of income or health status, in a way that ensure full and equal participation;
- provide a minimum standard benefit floor;
- have premiums, deductibles, and out-of-pocket costs that are affordable relative to family income;
- offer automatic and seamless enrollment;
- provide a choice of health plans or care system so people can keep their current insurance if they so choose;
- reduce administrative costs and keep plans simple to administer, with health risks pooled across broad groups;
- adequate financing with costs shared among federal and state governments, employers, individual households, and other stakeholders.

In the commission's view, both the mixed private-public group insurance with a shared responsibility for financing, and the public insurance reform proposals have the greatest potential to provide everyone with comprehensive and affordable health insurance, achieve greater equity in access to care, realize efficiencies and cost-savings in providing coverage and delivering care, and redirect incentives to improve quality. However, it said, the mixed public-private approach is the more pragmatic one because it allows those who now have employer-based health coverage to retain it, causing far less dislocation initially than asking people to enroll in a new program and minimizing federal budget outlays.

Reasons for universal coverage

"The most important takeaway of this report is that universal coverage is essential to improve access, quality, equity, and efficiency in the U.S. health care system," said **Dallas Salisbury**, CEO of the Employee Benefit Research Institute and chairman of the commission's coverage workgroup. "However, the design of any health care reform plan will determine whether we are able to achieve the goal of a truly high-performing health system."

Meanwhile, the National Federation of Independent Business (NFIB), an advocate for small business interests, released its "Small Business Principles for Healthcare Reform." NFIB said it supports policy reforms to balance the competing goals of access to quality care, affordability, and predictability and consumer choice. The resulting health system would be:

- **Universal.** All Americans should have access to quality care and protection against catastrophic costs. A government safety net should enable the neediest to obtain coverage.
- **Private.** To the greatest extent possible, Americans should receive their health insurance and care through the private sector. Care must be taken to minimize the extent to which governmental safety nets crowd out private insurance and care.
- **Affordable.** Health care costs to individuals, providers, governments, and businesses must be reasonable, predictable, and controllable.
- **Unbiased.** Health care and tax laws should not push Americans into employer-provided or government-provided insurance programs and hobble the market for individually purchased policies. Small employers should be treated the same as large employers, who can already pool across state lines. A health care system built on employer mandates or play-or-pay taxes is unacceptable.
- **Competitive.** Consumers should have many choices among insurers and providers. Policy-makers should

work to alleviate the limitations that state boundaries and treatment mandates place on competitiveness.

• **Portable.** Americans should be able to move throughout the U.S. and change jobs without losing their health insurance.

• **Transparent.** Information technology should enable all parties to access accurate, user-friendly information on costs, quality, and outcomes. Providers must be able to obtain relatively complete medical histories of patients. At the same time, patients' privacy must be guarded zealously. The private sector must play a vital role in developing the new technologies.

• **Efficient.** Health care policy should encourage an appropriate level of spending on health care. Laws, regulations, and insurance arrangements should direct health care spending to those goods and services that will maximize health. Adequate risk pools throughout the health care system are vital.

• **Evidence-based.** The health care system must encourage consumers and providers to accumulate evidence and to use that evidence to improve health. Appropriate treatment choices and better wellness and preventive care should be key outcomes.

• **Realistic.** Health care reform should proceed as rapidly as possible, but not so quickly that firms and individuals cannot adjust prudently.

"Reform is a delicate balancing act," NFIB said. "Moving too slowly will allow costs to rise too far and too fast. In the process, the health of Americans will suffer, and the financial security of some will be disastrously impacted. But excessive speed is also risky. Thus, we must assure that reform does not allow some Americans to slip through the cracks—to lose coverage or see their costs rise too rapidly. Somewhere in between is a seamless transition from the status quo to a more efficient and equitable system."

Download the Commonwealth Fund documents at http://www.commonwealthfund.org. Download the NFIB principles at www.nfib.com. ■

Medicaid a lightweight when it comes to low-birth weight kids

Medicaid is falling short in providing services for children with very low birth weight, according to a study by Boston University researchers, who say their findings reinforce the Institute of Medicine's concerns regarding inadequate outcome data and health care services for pre-term infants. The data also support the importance of enrollment in the Early Intervention Program (EIP) for children with low birth weight.

C. Jason Wang and colleagues report some 60,000 infants with very low birth weight (less than 3.3 pounds) are born each year in the U.S. Almost all are premature (less than 37 weeks' gestation) and are at greater risk than term infants for health and developmental problems and premature death. Half of the infants are extremely low birth weight (less than 2.2 pounds) and are said to be at the greatest risk for disability. No data are available about the quality of care the infants receive once they are discharged from the hospital.

Mr. Wang says improving quality of care for important medical problems such as vision and hearing loss that disproportionately affect children with very low birth weight "can greatly improve their health and long-term developmental trajectory."

Timely diagnosis and treatment for eye disease and hearing loss can ameliorate or even eliminate their negative consequences. But if left untreated, they can lead to speech and language problems, behavioral problems, and learning disabilities, all of which can harm school performance.

Need for follow-up

In the United States, most neonatal intensive care units offer high-risk follow-up clinics, but few of the clinics follow children past 1 year of age. Also, Mr. Wang says, it isn't known what proportion of extremely low birth weight children return to a high-risk follow-up clinic after discharge.

Although preschool vision screening is recommended for all children, the rate of such screening is low in the primary care setting due to the difficulty of screening young children, lack of experience with screening tests, and high numbers of false-positives associated with vision screening. Likewise, although universal newborn hearing screening now is recommended in the United States, studies have documented that the proportion of returns to follow-up for infants with risk factors for hearing loss or who failed a hearing screen is less than desired.

The researchers say they constructed a data set linking all health services files relevant to caring for children with very low birth weight receiving Medicaid in South Carolina and used previously developed quality of care indicators to determine the proportion of children with very low birth weight with nonconductive hearing loss who received hearing rehabilitation by 6 months of age and the proportion of all the children with very low birth weight

who received a routine ophthalmologic examination between ages 1 and 2 years. The researchers also examined factors associated with receiving timely vision follow-up care.

Many have hearing loss

The study used data from 1996 through 1998 and found a total of 1,461 children with very low birth weight who were enrolled in Medicaid for all 12 months in the first year of their lives. Among them, 16% (241) had a diagnosis of nonconductive hearing loss and were eligible for the indicator on hearing rehabilitation. A total of 1,052 children with very low birth weight were continuously enrolled in Medicaid between ages 1 and 2 years and all were eligible for the ophthalmologic examination during the second year of life.

Among those eligible for the hearing quality indicator, 20% (48 of 241) received the service by 6 months of age. The researchers say that allowing a one-month grace period (rehabilitation by 7 months of age) raised adherence to 24%.

Expanding adherence benefits

Among very low-birth weight children eligible for the vision examination, 23% (241 or 1,052) received a recommended ophthalmologic examination. If the adherence period was expanded to start at 11 months and go to 25 months, the researchers say, the percentage receiving the service among those continuously enrolled in Medicaid increased to 27%. Similarly, if the adherence period was further expanded from 11 months to 36 months, the percentage receiving the service increased to 37%.

When the analysis was restricted to just infants with extremely low birth weight, 29% received hearing rehabilitation during the first six months and 29% received an ophthalmologic examination between 1 and 2 years of age.

With less than one-fourth of children with very low birth weight receiving recommended hearing rehabilitation or ophthalmologic examination through South Carolina Medicaid, the researchers say such gaps in critical services support the Institute of Medicine's call for improving the quality of care for preterm infants.

"...overall findings indicate that children from all backgrounds may need better screening for disabilities."

Early identification key

While hearing loss in children affects cognition, educational level, social-emotional development, and family-child interaction, early identification of hearing loss and appropriate intervention within the first six months of life have been demonstrated to prevent many of the adverse consequences and facilitate language acquisition.

Also, the lifetime cost to society of pre-lingual onset of profound deafness has been estimated at $1 million per individual, largely because of special education and reduced work productivity.

The researchers say since interventions such as cochlear implants in profoundly deaf children have a positive effect on quality of life at reasonable costs and seem to result in a net savings to society, timely assessment and treatment for hearing loss are particularly important for children with very low birth weight in view of their increased risk of hearing loss and availability of effective treatments.

The researchers say they found variations in receipt of ophthalmologic services. Thus, enrollment in Medicaid programs by the time of hospital discharge for children with very low birth weight and extremely low birth weight and enrollment of children with extremely low birth weight in the early intervention program were strongly associated with receipt of needed ophthalmologic examinations. Also, children with very low birth weight with black mothers, higher birth weight, and higher Apgar scores (a standardized assessment of the health of newborns) were less likely to receive ophthalmologic examinations, whereas those born in Level 3 hospitals were more likely to receive them.

Better screening needed

The negative correlation between receipt of vision services and higher birth weight and Apgar scores may reflect a lower prevalence of vision impairment in these populations, the researchers say. And the positive association between receipt of vision services and birth in a Level 3 hospital, enrollment in Medicaid by the time of hospital discharge, and enrollment in the early intervention program may highlight the importance of enrolling eligible infants in Medicaid and EIP services.

The researchers say it also may suggest that stronger efforts may be needed to screen children for disabilities if they were born in non-Level 3 hospitals or had black mothers. "However," they add, "the overall findings indicate that children from all backgrounds may need better screening for disabilities."

Download the report from http://www.pediatrics.org. ■

Quick economic downturn surprises states

It seems only yesterday that many states were enthusiastically embracing an improving fiscal situation and making plans to restore many of the Medicaid cuts and restrictions that had been adopted during economic downturn. Now they are surprised to see that after just a few months of FY 2008, signs are emerging that the economic climate is changing.

In a November 2007 discussion with state Medicaid directors who serve on the executive committee of the National Association of State Medicaid Directors, the Kaiser Commission on Medicaid and the Uninsured asked the directors to identify the most important issues facing Medicaid in their states and how the issues may have changed since the beginning of the fiscal year.

At the top of the list of key issues, concerns, and priorities in mid-FY 2008 were the effects of an increase in fiscal stress across states, a number of federal-state issues, including those affecting Medicaid enrollment and access, and the directors' efforts to address the uninsured.

State Medicaid directors described an economic situation that in many states had leveled off unexpectedly, or even deteriorated, between July and December 2007. As a result, for a number of states, revenues early in the current fiscal year came in below projections and below levels on which state policymakers had based their state budgets. So, outlook for the immediate future was less optimistic than it had been at the beginning of the year.

At the beginning of this fiscal year, Medicaid directors had described in the Kaiser Commission budget survey a strong sense that state economies were rebounding compared to recent years, based on recent rates of growth in state revenues. They said state budget decisions had been based on expectations of continued growth in revenues. Medicaid planning had been based on expected relatively slow growth or even a decline in enrollment and there was interest in improving Medicaid.

But by the middle of the fiscal year, Medicaid directors described a less optimistic picture of the economic conditions in several states. While some directors continued to see positive economic news, most reported that recent revenue projections indicated a likelihood that actual state revenues would be below previous estimates for the current fiscal year.

Housing market major problem

The state Medicaid directors said that housing market difficulties were being cited as a primary contributor to the less optimistic state revenue outlook. Also, some states face an "unresolved structural deficit," in which even a relatively healthy economic climate in the state doesn't translate into comparable revenue strength.

The report says the slower growth rate in state revenues brought out a concern that the gap between the revenue growth rate and Medicaid expenditures might widen, and that it could be more difficult for states to finance their share of Medicaid program costs in the future.

Some officials said there already were discussions under way on the possibility of targeted or even across-the-board Medicaid program cuts before the end of calendar 2008 and the possibility of state work force reductions that could affect Medicaid staff.

The Medicaid directors also expressed concern over the way state budgets are affected by the annual changes in each state's federal Medicaid matching rate, the Federal Medical Assistance Percentage (FMAP). Although the FMAP formula is intended to be countercyclical, providing states with increased federal funding during times of fiscal stress, because of lags in the data the matching rate changes usually are not responsive to changes in states' economic situations. Directors also expressed concern that the FMAP calculation doesn't account for the relative ability of states to finance Medicaid or for the differences in the cost of living across states. They indicated that a more responsive formula would improve Medicaid program stability at the state level.

The Medicaid directors told Kaiser Commission interviewers it will be more difficult to achieve significant Medicaid cost savings now than it was during the last economic downturn. That's because many policy options that typically would be considered now were just used during the recession a few years ago and are no longer available. Thus, in 2003 and 2004 virtually every state adopted prescription drug controls. This time around, any savings that could accrue from additional prescription drug controls would be much lower.

"Even with the less optimistic economic outlook," the Kaiser Commission says, "the directors expressed their strong commitment and a commitment of their state administrations to maintain current levels of coverage and the restorations of the payment rates and benefits that occurred in the last two years. Most states continue to look for ways to expand coverage for low-income uninsured individuals if at all possible, even while recognizing the need to restrain the growth in Medicaid spending in a time of state fiscal constraint. One director suggested the issue of expanding coverage is such an imperative in states that all governors have had to look at it." ■

Improved malpractice environment bringing doctors to Texas

Four years after Texas voters approved a state constitutional amendment limiting medical malpractice lawsuit awards, doctors from all around the country are moving there to add to the ranks of specialists at Texas hospitals and bring health care to some underserved rural areas.

The influx, which has significantly improved the state's ranking in physicians per capita, has made considerable work for the Texas Medical Board, which can take up to six months to process the many hundreds of applications that have come in.

Neurosurgeon and lawyer **Donald Patrick**, the board executive secretary, told *The New York Times* the increased workload was hard to believe at first. But he said the trend has held, with licenses up 18% overall since 2003, when the caps were enacted. In fact, in the last fiscal year there were 30% more license applications than in the year before. "Doctors are coming to Texas because they sense a friendlier malpractice climate," Dr. Patrick declared.

Some observers have expressed doubts about the role played by the malpractice caps, noting that malpractice lawsuit awards showed little increase in the 12 years before the law changed. And liability lawyers said the changes may have left patients more vulnerable. They said doctors often have cut back on their insurance in response to the reduced malpractice exposure, making it harder for plaintiffs to collect damages.

Noneconomic damages for pain and suffering are generally held to $250,000. Plaintiffs still can recover economic losses, like the cost of continuing medical care or lost income, but the amount they can win was capped at $1.6 million in death cases.

The National Conference on State Legislatures says all but 15 states have adopted some limits on medical damage awards, but those in Texas go further than in many states, where the limits are often twice as high as in Texas. An average 21.3% drop in malpractice insurance premiums has helped send the message about the Texas environment.

In some medical specialties, the gains have been particularly impressive, according to the Texas Alliance for Patient Access. There have been 186 new obstetricians, 156 orthopedic surgeons, and 26 neurosurgeons.

Not everyone is satisfied, however. "We've lost our system of legal accountability," Texas Watch executive director **N. Alex Winslow** told the *Times*. "Just having more doctors doesn't make patients safer. It remains to be seen who is coming to our state."

Texas Watch also questioned the decline in malpractice insurance rates, saying they must be evaluated in light of increases of nearly 150% before the 2003 constitutional amendment. ■

Clip files / Local news from the states

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

Massachusetts' subsidized care plan's cost to double

BOSTON—The subsidized insurance program at the heart of Massachusetts' healthcare initiative is expected to roughly double in size and expense over the next three years, an unexpected level of growth that could cost state taxpayers hundreds of millions of dollars or force the state to scale back its ambitions.

State projections obtained by the *Boston Globe* show the program reaching 342,000 people and $1.35 billion in annual expenses by June 2011. Those figures would far outstrip the original plans for the Commonwealth Care program, largely because state officials underestimated the number of uninsured residents. The state has asked the federal government to shoulder roughly half of the program's cost from 2009 through 2011, but there is no guarantee of that funding.

Commonwealth Care provides free or subsidized insurance for low- and moderate-income residents. "The state alone cannot support that kind of spending increase," said **Michael Widmer**, president of the Massachusetts Taxpayers Foundation, a business-funded budget watchdog group. Even with federal backing, the state may not be able to afford the insurance initiative as designed, because the law did not make any attempt to trim wasteful health spending, said **Alan Sager**, a Boston University professor who specializes in healthcare costs.

Currently, 169,000 people have enrolled in the program, which is expected to cost $618 million in the fiscal year ending June 30. When it authorized the program in 2006, the legislature estimated that about 215,000 people would eventually be enrolled at a cost of $725 million. State officials in late 2006 reduced that estimate to between 140,000 and 160,000, a number that was surpassed last year.

"We're paying the price of our own success," said Mr. Widmer. From the beginning, many health policy specialists said the initiative would cost the state more than expected. Now, some say, the benefits

of reaching near-universal insurance coverage may counterbalance the financial pain.

"I wouldn't say there's an imminent danger that the whole thing is going to collapse," said **Robert Seifert,** senior associate at the Center for Health Law and Economics at the University of Massachusetts Medical School. "It's challenging, but if it's a priority for the administration, then I think it's doable. There are benefits that don't appear in the budget numbers," including healthier residents, who are less of a financial drain in the long run. Government-funded costs of another part of the insurance initiative—expansion of the state's Medicaid program, called MassHealth—are also projected to grow significantly. The also state is seeking federal reimbursement for half of those expenses.

— *Boston Globe,* 2/3/08

Colorado health care panel pitches plan

DENVER — A state commission on health care has recommended that everyone in Colorado be required to have medical insurance and that the state put more money into child health care and Medicaid. The commission also recommended subsidies for low-income workers to purchase private insurance. The commission was appointed by lawmakers and Gov. Bill Ritter to find away to get health care to nearly 800,000 Coloradans who don't have insurance. Members have acknowledged their initiatives could cost millions of dollars, but they left it to lawmakers to figure how to pay for them.

"These recommendations represent a bold, yet realistic, approach to providing high-quality, affordable health care to all Coloradans, a roadmap to reform," commission chairman **William Lindsay III** said. "This is not merely a laundry list of suggestions. This is a comprehensive, integrated, interdependent package that can be implemented in stages." He said one key recommendation is requiring insurance companies to provide coverage to any applicant who doesn't have a pre-existing medical condition. People who have severe health problems but earn too much money to qualify for welfare or other low-income health programs would be eligible for CoverColorado, an existing state program for people who are denied coverage by insurance companies because of their medical conditions.

The panel said employers that don't offer health insurance should provide plans to help their workers buy coverage. The panel said administrative costs for physicians, hospitals and insurers could be reduced by streamlining processes and combining functions. Wellness programs could be encouraged by allowing health plans to discount premiums for people who have healthy behavior and eliminating copays for preventive care.

— Associated Press, 1/31/08 ■