



# State Health Watch

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The Newsletter on State Health Care Reform

July 2008



## States building high-performance health systems, but much more can be done

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States are pursuing health system improvements across the full spectrum of their authority, including health care purchasing, provider regulation, performance data reporting, integration of public health with health care approaches, and improving the availability and affordability of health insurance. But for as much as states are doing, a National Academy for State Health Policy (NASHP) study finds there is room for states to do much more. It says ongoing efforts to track, study, and diffuse information on state activities could accelerate adoption of promising policies and practices.

NASHP reported findings from

its Commonwealth Fund-supported State Health Policies Aimed at Promoting Excellent Systems (SHAPES) project. The project was aimed at identifying and spreading information about state health policies and practices for promoting high-performance health systems. NASHP senior program director Catherine Hess tells *State Health Watch* states have an opportunity to try some things and can show the way to health care reform, but can't do it all without some federal help, and especially federal money.

"It would benefit states to go

*See States on page 2*

## Eligible but not enrolled: 12 million people—half of them children—could have coverage

Some 25% of people in the United States who lack health coverage are eligible for public insurance programs but are not enrolled due to barriers that make it difficult for them to do so. That's the conclusion drawn in a National Institute for Health Care Management Foundation (NIHCM) report. The group, whose principal sponsor is Blue Cross and Blue Shield plans, says that about 12 million people (half of them children) are reachable by Medicaid and SCHIP

programs but fail to enroll because they're not aware the programs exist, they don't know how to enroll, or they fear being linked with a publicly financed program. NIHCM also found it can be difficult for those people to stay enrolled if they do enroll.

Although childless adults comprise more than half of the uninsured, NIHCM says there is little public assistance available for them. Since 2001, states have been allowed to expand coverage to childless adults and others who have been traditionally ineligible for Medicaid.

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**Fiscal Fitness:  
How States Cope**



The Newsletter on State Health Care Reform

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## States

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through this report and look at what they are doing in these areas," she says. "I think most states could find areas in which they could do more."

States, Ms. Hess says, have been doing the most in the area where historically they have been involved—improving coverage so as to improve access to care—primarily because of the federal-state Medicaid partnership. States also have been working on quality, Ms. Hess tells *State Health Watch*, but that has been a more recent and growing focus. Many of the new tools being used, she says, have been developed in the private sector and states could benefit by partnering in that arena. While states have been taking some action to leverage their buying power, Ms. Hess says they could do more, especially in terms of looking at all places where they purchase care. "Purchasing is another way to carry out the state role in access and quality," she says.

### IT interest growing

States have not been as active in the information technology area, according to Ms. Hess, although she sees that interest growing. Information technology, she says, needs strong private sector engagement and federal tie-ins at the regional level. "You need federal involvement if you want to have regional IT systems," Ms. Hess says.

Asked why it seems there is less emphasis on patient safety, when so much was said about it several years ago, Ms. Hess says while the study authors reported there was relatively less going on in late 2006 when the survey was taken, there has been a significant increase in safety activity recently.

The report points out the need for states to exchange information and experiences. Ms. Hess says such exchange does happen but it is somewhat uneven, again reflecting financial resources. "Information exchanges work better if there is an outside organization that maintains support for convening groups and organizing the sharing through political cycles," she says. "When there is such support, it often is short-lived. The problem is that the support that comes is often sporadic and topic-specific. It would be great if it could be more sustained and with a broader focus."

### Take-home points

Study authors said their analysis found significant variation in states' involvement in system improvements, including the following broad categories:

- **Health insurance coverage.**

States are said to be able to play a major role in ensuring affordable health coverage, not only by maximizing use of federal programs, but by going beyond them with state-only investments and public-private approaches. Federal financial support is most available for children, and many states are working to extend that support to cover all children. The study also found that states are working to cover adults. States are exerting their influence over insurance benefit design by defining minimum benefit packages and requiring parity in mental health coverage.

- **Quality, safety, and value.**

States reportedly are engaging in collaborative efforts to improve quality of care, both with the private sector and in cross-agency efforts. They are using a variety of levers as purchasers, including requiring reporting on quality, employing specific contractual provisions for

vulnerable populations, and having joint quality requirements in multiple-agency purchasing.

- **Health system infrastructure.** More than half of responding public health agencies and governors' offices reported that their states have a public health information system that integrates data from multiple sources. Immunization and vital statistics data were most commonly included in these systems, following by hearing screenings, laboratory data, newborn screenings, hospital discharge information, and cancer registry data. States are addressing health system provider capacity by monitoring the safety net, addressing provider shortages, and reimbursing for telehealth. A number of states cited collaborative relationships with other entities in these efforts, including primary care associations representing community health centers.

NASHP says every state reported activity to promote achievement of a high performance health system. Even though this finding was not unexpected, it underscores the fact that states are today important players with multiple roles in achieving improved health system performance.

### **Promoting more equal access**

All states are playing a role in promoting more equal access to the health care system. More than 80% of states cover children at income levels that meet or exceed federal program minimums. And some states are blazing trails in promising coverage for all children. Some states also are moving to ensure that everyone, including adults, has affordable coverage. States are simplifying administrative processes and beginning to make greater use of technology for application, enrollment, renewal, and coordination of coverage, as well as for other services.

Some states also are trying to exert influence with the private insurance market, leverage their purchasing power, and collaborate more with the private sector. While historically these have been areas of concern to the federal government or private sector, states now are taking a much more active role. Thus, more than half the responding states said they require minimum benefit packages for the individual or small group market. Most states have programs to reduce the cost of coverage for small employers and their workers. And states are taking advantage of their relatively new role as purchasers of health care coverage for a substantial share of the population to influence the content and quality of care.

Most states report considering quality when making contracting decisions and requiring reporting on quality measures. States are maintaining their focus on the needs of racially and ethnically diverse populations, as well as vulnerable populations such as children and those with disabilities, increasingly through contractual obligations. And in addition to serving as regulators and purchasers in the private sector, states also are partnering and collaborating in areas relevant to system performance.

Interestingly, fewer states are actively pursuing system performance in areas such as efficiency and patient safety. NASHP says those findings may reflect the lack of a clear federal framework for action, the recent emergence of these issues relative to topics such as insurance coverage, or a belief that federal action will supersede state roles.

### **Much remains to be done**

While NASHP found considerable state activity under way geared toward creating a high-performance

health system, there still is much more that can be done. Although there are very real fiscal constraints regarding coverage in the absence of strong federal action, the report says, many states could work to bring coverage levels to that of their peers in other states by increasing federally matched program eligibility levels and by simplifying and automating enrollment and renewal processes. The analysts say more states could use regulatory levers to influence the private marketplace to provide affordable products with adequate benefit packages. And many states and agencies could increase their attention to contract quality provisions, especially those addressing the specific needs of children, diverse racial and ethnic groups, and individuals with special health care needs.

The report found that state employee health plans generally lag behind Medicaid and SCHIP agencies in using purchasing levers to affect content and quality of care. And it said more states could monitor and address the strength of the health care safety net.

The level of state activity could be improved through ongoing mechanisms to monitor, study, and report state activities. While some of the policies and practices reported by states, particularly those related to public coverage, are monitored and reported regularly by national organizations including NASHP, many are not. So as states look to other states for advice and ideas, it will be important to have a source of current information on activities and outcomes to facilitate learning and adoption of proven and promising policies and practices. The analysts said their survey "laid important groundwork in identifying relevant state policies and practices. In the future, a mechanism that obtains similar, updated information from

surveillance of state activity could help states move toward better performance.”

### **In-depth analysis would help**

There is more analysis that can be done as well. The SHAPES survey only touched the surface of a broad range of state policies and practices, the analysts say. More in-depth exploration is likely to yield additional information that might prove

useful to understanding impact and to accelerating diffusion. Areas that appeared particularly ripe for further exploration, according to the report, included assisting small employers with affordable coverage, developing minimum benefit packages for the private market or public programs, and developing and maintaining interagency and public-private collaboration and forums. Other areas to pursue include using purchasing

levers to address patient safety, revising policies and providing incentives for health information exchange and technology, and integrating population-based and health care system strategies to achieve improved health outcomes.

*Download the report at [www.commonwealthfund.org/publications/publications\\_show.htm?doc\\_id=67649](http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=67649)*  
6. Contact Ms. Hess at (202) 903-2783. ■

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## ***Fiscal Fitness***

*Continued from cover*

But only seven states (Arizona, Idaho, Indiana, Michigan, New Mexico, Oregon, and Utah) currently have such coverage, and the programs often have low enrollment caps, cost-sharing requirements, or other eligibility limitations.

“The paucity of public coverage for low-income childless adults is really troubling,” says NIHCM CEO **Nancy Chockley**. “This is a population that really can only be helped by an expansion of public programs or some form of subsidy, yet we don’t see a lot of that out there across the states.”

The 12 million people who are eligible for public coverage but are not enrolled are primarily low-income children and parents. This includes 6.1 million uninsured children, 64% of all uninsured children. Ms. Chockley says the vast majority of these children are in families with incomes below 200% of the federal poverty level. Since public program eligibility is more restrictive for adults, only 29% of uninsured parents (3.6 million people) and 10% of uninsured childless adults (2.4 million people) are reachable through public programs, according to the report.

The researchers found that administrative hassles can inhibit

both program enrollment and retention. New enrollees often can feel daunted by the paperwork required to enroll in a program, while existing enrollees can be involuntarily disenrolled if they don’t complete renewal forms. In Florida, for example, multiple administrative barriers reportedly led to a 39% drop in Florida’s SCHIP rolls (a loss of 128,000 children). This was the largest decline reported in the United States. Ms. Chockley says the state has since made efforts to reverse the decline and early reports were that 16,000 children had been added to the rolls.

### **DRA continues to pose problems**

Another barrier is the 2005 Deficit Reduction Act provision requiring those who want to enroll to show proof of U.S. citizenship. The law was intended to restrict enrollment among undocumented immigrants, but NIHCM cites concerns that it has led to inappropriate enrollment denials and/or delays for large numbers of citizens.

Ms. Chockley says children have the most to gain from solutions aimed at increasing enrollment in Medicaid and SCHIP, but since those programs already reach 79% of targeted children, more aggressive strategies are needed to reach remaining children. Ideas states could consider include automatic enrollment methods, removing

binding enrollment caps, and simplifying the renewal process.

The report says improving program take-up among eligible people will not significantly reduce the ranks of uninsured parents and childless adults. There are 9.1 million uninsured childless adults and 4.8 million parents with incomes below 200% of the federal poverty level. One-third of each group has income below 100% of the federal poverty level. “These adults could be helped by extending current public programs or providing public subsidies,” Ms. Chockley says. “With only seven states now providing public assistance to low-income childless adults and half of all states denying access to traditional Medicaid benefits for working parents in families above 63% of the federal poverty level, there is ample room for expansion just to reach the poorest adults. Covering more parents also would be expected to increase Medicaid and SCHIP enrollment among eligible children since there is evidence that children are more likely to be enrolled in these programs if their parents also are eligible.”

Another challenge to be faced is that more than 40% of the uninsured have moderate to higher incomes. And since the vast majority of those with incomes above 200% of the federal poverty level have insurance, it is difficult to find

affordable solutions without disrupting those who are insured. Policy options include mandates, tax credits, tax system changes, high-risk pools, and reinsurance. Ms. Chockley also notes that the private sector is beginning to develop insurance products tailored to previously uninsured people.

### **'Complicated proposition'**

"What this report shows us is that reaching universal coverage is a very complicated proposition, but that we can get a quarter of the way there by getting more people who are eligible for public programs enrolled and we can make a lot of headway, too, by looking for subsidies for low-income childless adults and parents," she says.

Ms. Chockley acknowledges that current state budget problems make it less likely that states will be able to increase enrollment among people who are currently eligible and also dampen the outlook for expanding eligibility to others.

The report says strategies and solutions to increase enrollment and retention among those eligible for public programs include increasing outreach and education activities, simplifying eligibility determination, and facilitating enrollment and reenrollment processes.

One possible avenue for improving program uptake, it says, would be for Medicaid and SCHIP to adopt automatic enrollment methods that dispense with the need for individuals to complete applications. Such automatic enrollment relies on data sharing with other means-tested programs to determine categorical eligibility after eligibility in a more restrictive public program is verified. Removing binding eligibility caps would be another way to increase enrollment among eligible people.

Most strategies for reducing

program dropout, according to the report, revolve around simplifying the renewal process. Options would include changing from biannual to annual re-enrollment, providing enrollees with renewal forms that have already been filled out with their prior-year information, and using passive enrollment for SCHIP programs so that families must update their eligibility information only when there have been significant changes in their situations. NIHCM says there also is evidence that programs covering parents and children together result in higher retention of eligible children.

"It is worth noting that improving outreach and facilitating program enrollment and retention among currently eligible persons will have limited appeal to states if their budgets and federal matching funds are not sufficient to support higher enrollment levels," the report cautions. "Faced with budget constraints, states may be fearful of making enrollment too easy for current eligibles and being overwhelmed by enrollment and burgeoning program costs."

Solutions for reaching the 34.5 million uninsured nonelderly people who are not eligible for current public programs may include expansions of these public programs, strengthening private market options, or some combination of those two approaches. NIHCM says the cost and political feasibility of those options will be linked in some fashion to the income level and characteristics of the groups being targeted.

### **Comprehensive reform choices**

Choices also must be made about how comprehensive reforms should and can be. While some favor a comprehensive approach using a mix of public- and private-sector solutions in a coordinated manner

in an effort to achieve universal coverage, others believe that incremental reforms designed to address priority subpopulations of the uninsured may be more pragmatic.

Efforts to increase coverage through expanded public programs or improvements in the private market need to be coupled with initiatives to control health care spending, NIHCM says. Since increased spending on health care translates into higher health insurance premiums, failing to control spending will exacerbate insurance affordability issues for both public and private payers and can cause coverage rates to decline.

Policy options to address uninsured young adults include increasing age cutoffs for eligibility, mandating coverage in college, and creating more affordable insurance options. The report says young adults could benefit from extending dependents' eligibility on private family coverage. As of November 2007, 17 states had increased the age of dependency on private insurance, with upper age limits ranging from 24 to 30 years old.

Low-income uninsured young adults also could be helped by expanding eligibility for children's public programs beyond age 18 or by expansions of public programs for adults. Ensuring that colleges require students to have health insurance and offer coverage also would help to reduce the number of uninsured in that age group.

At the other end of the age range, there are a number of potential policy solutions for the near-elderly. One that directly targets that age group would allow near-elderly adults to buy insurance through Medicare. Other possible solutions are more general and attempt to make private coverage more accessible and affordable, especially for people with higher risks. Such options

include approaches as supporting state high-risk pools by federal grants and funding state-based reinsurance for private coverage.

### Reference with benchmarks

Ms. Chockley tells *State Health Watch* that although the NIHCM report came out at the height of the 2008 presidential primary campaign, the group is not political and was not trying to create a political health care agenda for the next

president. “We’re trying to produce an important reference document with some very important benchmarks,” Ms. Chockley says. “We don’t make policy recommendations and we don’t say how to make any changes. We’ve tried to address all the different issues that people are talking about.”

She notes that the United States is, in many ways, a very generous country and its people want to do the right thing. But those in Europe’s

industrialized countries look at us and can’t understand why we have so many uninsured, she says. “There’s a lot of political rhetoric about covering the uninsured,” she says, “but not much political will. And yet covering the uninsured should be a priority. The rhetoric and the reality are very far apart right now.”

*Download the report at <http://www.nihcm.org>. Contact Ms. Chockley at (202) 296-4426. ■*

## Federal SCHIP changes ‘have no basis in law’

A “friend-of-the-court” brief filed with a federal district court on behalf of more than 25 prominent health policy and child health experts says Department of Health and Human Services changes to the State Children’s Health Insurance Program (SCHIP) “have no basis in evidence or the law.”

The brief, filed by the national law and consulting firm of Manatt, Phelps, says the changes in the Centers for Medicare & Medicaid Services (CMS) August 2007 policy directive were announced as intending to prevent crowd-out, but are poorly designed for that goal.

With no advance notice or opportunity for public comment, the directive prohibits states from providing health coverage to uninsured children in families earning more than 250% of the federal poverty level unless states can prove they have enrolled 95% of children at or below 200% of the poverty level. States also would have to demonstrate that private health insurance enrollment had not declined more than two percentage points among SCHIP-eligible children in the last five years. And the directive specifies that even if states can meet these requirements, they must force children who previously

had private health coverage to be uninsured for 12 months before enrolling in SCHIP.

The scholars say the “harsh strategies mandated in the directive, which are utterly disconnected from research and experience relating to crowd-out, and which are poorly designed to actually reduce crowd-out, would at the same time significantly increase the number of children who lack health coverage. In short, the specific strategies imposed by the directive threaten the primary statutory objective of SCHIP—to provide coverage to low-income uninsured children and thereby increase children’s access to health care—without any evidence that they would effectively advance the policy goals stated in the directive.”

The brief argues that the 95% standard is unattainable and will thus act as a de facto bar to coverage; that references to private insurance coverage levels, which are largely beyond state control, are arbitrary when viewed against the directive’s stated purpose; and that the 12-month waiting period mandated by the directive will have substantial adverse health effects on the nation’s youth.

“These new requirements represent a fundamental threat to the

health of children,” said George Washington University School of Public Health and Health Services Hirsh Professor of Health Law and Policy **Sara Rosenbaum**, one of those who signed the brief. “This brief underscores how irrational the standards would have been shown to be, had the directive been published as a proposed rule, as required by law,” she adds.

### Supporting New Jersey’s lawsuit

The brief supports a lawsuit filed by the State of New Jersey Oct. 1, 2007, to challenge the directive’s validity on procedural and substantive grounds. The state claims, among other things, that the federal government’s failure to provide a public notice and comment period before issuing such significant policy changes violated the law. The brief is intended to document the extensive research on public health insurance programs that would have been presented during a notice and comment period.

“These prescribed policies reflect a fundamental shift in federal SCHIP policy and would have the effect of elevating the prevention of health insurance crowd-out over the provision of health coverage to uninsured low-income children,”

the brief asserts. “More important...is that the harsh strategies mandated in the directive, which are utterly disconnected from research and experience relating to crowd-out, and which are poorly designed actually to reduce crowd-out, would significantly increase the number of children who lack health coverage.

“In short, the specific strategies imposed by the directive threaten the primary statutory objective of SCHIP—to provide coverage to low-income children and thereby increase children’s access to health care—without any evidence that they would effectively advance the policy goals stated in the directive.”

The experts complain that CMS issued the requirements by means of a 2½-page directive without an opportunity for comment from experts, affected stakeholders, or the public.

According to the experts, the 95% requirement would do nothing to ensure any greater coverage of the lowest-income children. They say a review of research on enrollment into means-tested public health insurance programs and other voluntary enrollment arrangements shows such a standard has never been met and is virtually unachievable in the absence of an automatic enrollment process, which federal law prohibits Medicaid and SCHIP from using.

They say the mandated 12-month waiting period has no basis in the extensive literature analyzing the impact of waiting periods on crowd-out, nor in the real-life experience of states that have been moving in recent years to reduce their waiting periods, with federal approval.

The requirement that insurance not cover those above 250% of the poverty line unless the state can demonstrate that the number of children insured through private

employers has not decreased by more than 2% over the prior five years “fails to take into account extensive research on the principal causes and extent of the nationwide decline in employer-sponsored insurance and fails to recognize that state programs have negligible effects on this decline, thereby linking SCHIP coverage to unrelated events,” the brief says.

Meanwhile, at the same time the brief was being filed, the Congressional Budget Office (CBO) was testifying before a Senate subcommittee on the value of SCHIP. “SCHIP has significantly reduced the number of low-income children who lack health insurance,” said CBO director **Peter Orszag**. “According to CBO estimates, the portion of children in families with income between 100% and 200% of the poverty level who were uninsured fell by about 25% between 1996 [the year before SCHIP was enacted] and 2006. In contrast, the uninsurance rate among higher-income children remained relatively stable during that period. The difference probably reflects the impact of the SCHIP program.”

Mr. Orszag said state outreach efforts and simplified enrollment processes for SCHIP appear to have increased the share of eligible children who participate in Medicaid and contributed to a decline in the percentage of children below the poverty level who are uninsured.

### **Crowd-out documented**

CBO recognizes that crowd-out does occur as a result of SCHIP, he said. On the basis of a literature review, CBO concluded that for every 100 children who gained coverage as a result of SCHIP, there is a corresponding reduction in private coverage of between 25 and 50 children.

Looking at the CMS directive intended to prevent crowd-out, Mr.

Orszag said CBO’s analysis suggests the directive’s impact on enrollment is likely to be modest under current law, given the way the administration appears to implement it and, more importantly, given the funding levels assumed in the baseline. “The directive could have a substantially larger impact on enrollment in SCHIP if the Congress expanded the program significantly,” he said.

According to program and survey data, Mr. Orszag said, about 80% of enrollment in SCHIP in all states is by families with income below 200% of the federal poverty line, about 15% of enrollment between 200% and 250% of poverty, and less than 5% over 250% of poverty. Consistent with those overall findings, he said, administrative data suggest that fewer than 20 states provide SCHIP coverage for families with income above 250% of the poverty level. Even in those states, the majority of those covered children are from families with income below 200% of the poverty level. (CBO acknowledges, however, that some states had planned to expand their coverage to families with income above 250% of poverty but dropped such plans after the directive came out.)

“Given the way that the administration appears to be implementing the directive, the provision most likely to affect enrollment is the requirement that states impose at least a one-year waiting period between private coverage and enrollment in SCHIP for children in families with income above 250% of the poverty level,” Mr. Orszag testified. “Only two states currently have a waiting period as long as one year; many require no waiting period, and the majority of states with waiting periods set them at only three or six months. The requirement for a one-year waiting period would

therefore mean that a number of children who currently could obtain coverage either immediately or three to six months after leaving private coverage would have their enrollment delayed or might never enroll in SCHIP, if they obtained private coverage during the waiting period.

On the basis of an analysis of current waiting periods, CBO estimates that, under current law, enrollment in SCHIP would be reduced by 0.1% as a result of the administration's action."

However, he noted, if Congress substantially increased SCHIP

funding, as it has been trying to do, additional states would probably wish to expand their programs to children in families with income above 250% of the poverty level. In that case, Mr. Orszag added, the directive would be a more significant constraint on enrollment. ■

## Medicaid cuts spike ED use, uninsured hospitalizations

Medicaid cuts in Oregon were followed by increases in both hospital emergency department (ED) use and hospitalization of the uninsured. A study published online April 17, 2008, in the *Annals of Emergency Medicine* says federal legislation facilitating similar Medicaid changes in other states may lead to higher ED use and hospitalizations elsewhere.

Faced with a budget crisis due to an economic recession, Oregon introduced substantial changes to the Oregon Health Plan benefit package that were implemented in February and March 2003. Some 300,000 residents who met federally mandated Medicaid eligibility criteria were not affected. But residents in the Oregon Health Plan expansion program (generally childless adults with incomes below the federal poverty level) were affected by stricter enforcement of premiums of \$6 to \$12 per person per month, with forced disenrollment if premiums were not paid monthly. The researchers say the immediate effect of the stricter payment policy was that expansion program enrollment dropped from 103,000 in 2002 to some 51,000 by late 2003.

In addition, copayments were implemented for most services, including \$5 for a primary care visit, \$50 for an ED visit, and \$250 for a hospitalization. While primary care providers were authorized to refuse care to patients who could not afford the copayments, EDs are required by federal law to provide a medical

screening examination and thus did not have the option to refuse service.

Oregon Health Plan expansion enrollees also faced a reduction in the scope of covered services, including elimination of outpatient mental health and chemical dependency coverage.

The researchers say the effect of the cuts on ED use had been uncertain. "One might expect decreased ED use by patients losing Medicaid coverage because ED utilization rates by the uninsured are lower than rates for Medicaid enrollees and because poor patients respond to the risk of increased out-of-pocket costs by reducing ED use," they say. "On the other hand, patients with worse access to primary care are more likely to use EDs for primary care-treatable conditions and for emergencies caused by exacerbation of inadequately treated chronic diseases." Thus, the study's purpose was to evaluate the effect of the Oregon Health Plan changes on ED use in a representative sample of Oregon EDs before vs. after the Oregon Health Plan cutbacks to determine the change in payer mix.

Participating EDs provided data on 2,680,954 ED visits by Oregon residents. Individual ED patient volumes during the last 12 months ranged from 6,435 to 70,850 per year. There was a slight decrease in patient volumes throughout the study period.

Immediately after the date of the Oregon Health Plan cutbacks, there was an abrupt and sustained increase in ED visits by the uninsured, from

6,682 per month in 2002 (12.5% of visits) to 9,058 visits per month (17.3% of visits) in 2004, the report says. ED visits per month by Oregon Health Plan enrollees decreased beginning around the March 2003 date of the Oregon Health Plan policy changes (most likely attributable to Oregon's increasing unemployment rate during the period and the resultant loss in employer-sponsored insurance.

The report says the abrupt 20% adjusted increase in uninsured ED visits immediately after the Oregon Health Plan cutbacks is clearly seen and strongly suggests that much of the increase in uninsured ED visits is attributable to the Oregon Health Plan cutbacks.

"A 15% cutback in the Oregon Health Plan enrollment led to a 20% increase in the number of uninsured patients visiting the emergency department, which is a disturbing increase," said study author **Robert Lowe**, MD, director of the Oregon Health and Science University Center for Policy and Research in Emergency Medicine. "Equally disturbing is the enormous increase in emergency department visits related to alcohol, drug dependencies, and psychiatric illnesses, which are likely due to the concurrent cutbacks in mental health and drug treatment services by the Oregon Health Plan. And emergency hospitalizations rose by 50% for uninsured patients, while emergency hospitalization rates for the

other groups remained about the same, suggesting that after the cutbacks uninsured patients were sicker overall when they came to the emergency department.”

The effect’s magnitude was even larger for behavioral health conditions, with an 82% adjusted increase in alcohol-related visits by uninsured persons and more than doubling of the adjusted number of drug-related and other psychiatric visits. “That the increase in uninsured visits was observed in all 26 emergency departments argues against artifactual causes such as a change in data systems in one hospital,” the researchers say.

The researchers caution the study cannot distinguish between two possible explanations for the increase in uninsured ED visits: 1) whether the rate of ED use by uninsured patients changed; or 2) whether there was merely an increase in the number of uninsured Oregonians. However, they say, each possibility has important implications.

If the rate of ED use by Oregon’s uninsured increased, it would suggest worsened access to medical care outside the ED because population groups with impaired access to traditional sources of primary care use EDs more frequently. If the rate of ED use by the uninsured remained constant as the number of uninsured increased, the increased number of uninsured ED patients affects the medical care delivery system as an increasing burden of uncompensated care for hospitals.

The analysis found that Oregon hospitals experienced an increase in charges for uncompensated care from \$256 million in 2002 to \$509 million in 2004, suggesting that the changes in Oregon’s EDs mirrored the effect of the Oregon Health Plan cutbacks on inpatient care.

The researchers say the large uncompensated care burdens may have important consequences for

hospitals’ financial solvency, nurse staffing decisions, support for the safety net, and patient outcomes. And commercially insured populations may ultimately pay the bill for the increased utilization as hospitals attempt to raise their rates to commercial health plans in response to increased uncompensated care.

### **Relying on ED for primary care**

The data also address the question of whether the increased ED use by the uninsured represents use of the ED for primary care that was previously provided in a traditional primary care setting, vs. care for more acute problems.

“After the Oregon Health Plan policy changes, the odds that an uninsured ED visit led to hospital admission increased by 50%,” the researchers say. “Therefore, a disproportionate amount of the increase in ED use by uninsured patients than for other payer groups suggests that uninsured patients are forced to rely on EDs for primary care that insured patients are able to obtain in traditional primary care settings or that other factors such as nonfinancial barriers or patient preference lead uninsured patients to use EDs. At the same time, the observation that the proportion of ED visits requiring hospitalization was lower for uninsured patients than for other payer groups suggests that uninsured patients are forced to rely on EDs for primary care that insured patients are able to obtain in

traditional primary care settings or that other factors such as nonfinancial barriers or patient preference lead uninsured patients to use EDs.”

A disproportionate increase in drug- and alcohol-related ED visits and in other psychiatric visits among uninsured patients is consistent with other data about deteriorating access to outpatient care for these conditions. Although the study does not provide definitive evidence about the cause of the increase, the researchers say that Oregon Health Plan enrollees with behavioral health conditions may have stopped paying Oregon Health Plan premiums when services such as methadone maintenance and outpatient counseling were no longer covered, using EDs instead.

“As policy-makers contemplate fundamental changes to Medicaid nationwide, these events in Oregon should provide a warning about a potential large increase in emergency department use by the uninsured in the United States,” Dr. Lowe said. “Cost-cutting measures may have substantial and lasting impacts on the health care system, and more importantly on its most vulnerable patients.”

*Access the report, Lowe RA, McConnell KJ, Vogt ME. Impact of Medicaid Cutbacks on Emergency Department Use: The Oregon Experience. Ann Emerg Med April 17, 2008, at: [www.annemergmed.com/article/S0196-0644\(08\)00426-5/abstract](http://www.annemergmed.com/article/S0196-0644(08)00426-5/abstract). ■*

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# Survey of states finds boom in e-health strategies

**A**lmost all states are actively engaged in e-health strategies to facilitate use of information technology to make the health care system more efficient and provide greater value and higher quality. That's the principal finding of a 2007 survey of states conducted by the National Governors Association and Health Management Associates. The survey and report were supported by the Commonwealth Fund.

The researchers found that while states see e-health initiatives as a high priority, they and their private sector partners face significant challenges accompanying such initiatives, including issues of time and cost needed for implementation and for a return-on-investment.

The paper defines e-health as any health care practice supported by electronic processes and communication, including health information technology (HIT) and health information exchanges (HIE). Across the United States, the researchers found, states have taken on the challenge of promoting e-health policies and initiatives, encouraging a wide variety of public and private sector efforts.

States are said to be motivated by their interest in improving performance, assuring quality, and obtaining greater value in their role as health care purchasers, providers, and regulators, and as protectors of public health and catalysts for private sector action.

There reportedly is broad agreement that HIT can significantly improve health care delivery and quality and reduce its costs. "Indeed," the researchers said, "HIT has the potential to transform health care delivery and produce great improvements in efficiency and effectiveness for all the programs in which states have a role and an interest."

But states face many constraints on what they are able to do, due to limits on available state funds and the presence of many competing demands for those resources. As a result, the report says, important goals, including those that might lead to a nationwide health information network, remain on the horizon as states pursue a variety of strategies and approaches toward their attainment.

Survey responses were received from 41 states and the District of Columbia. Among the key findings:

- **All states place a high priority on e-health activities.** No state said its e-health activities were not significant and nearly 70% said their activities were "very significant." Among the initiatives states listed as their most significant were electronic HIE activities, adoption of HIT components, quality and transparency initiatives, registries, and efforts to resolve privacy and security issues.

- **State governors' two highest e-health priorities for the next two years are developing electronic HIEs and developing policies fostering local or state-level electronic HIEs to assure interconnectivity among health care providers.** More than 75% of responding states said electronic HIE activities were among their highest priorities, with 11 states forming a statewide committee, commission, or board to study electronic HIE issues, 17 states reporting other HIE planning and monitoring activities, and seven states describing either developing or implementing electronic HIEs. Also, four states said their significant activity involved providing grants, loans, or pro bono technical support to spur both HIT and electronic HIE development.

- **State HIT initiatives span a**

**broad range of activities.** Many states identified HIT components such as telehealth, e-prescribing, replacing their Medicaid Management Information System, electronic medical records, electronic health records, patient health records, decision-support tools, chronic disease management, case management, and web-based tools as their most significant e-health activities. The report says such activities not only help states operate more efficiently, but also help them improve health care quality and give them opportunities to participate in e-health partnerships with private payers.

- **E-health applications enable states to implement quality and transparency initiatives.** Five states reported significant e-health activities focusing on quality and transparency, including efforts to collect and distribute data on health outcomes, costs, utilization, and pricing, thus increasing accountability in public and private health care delivery systems.

- **Privacy and security are key state concerns and a focus for state action.** Some 31 of the 42 respondents said they have state privacy laws and other protections in place, and 28 reported establishing policies and procedures to address data privacy and security breaches. Five states said their privacy and security activities were their most significant e-health activities.

- **Different consent requirements is the greatest barrier to release of health information within an electronic HIE, especially for services related to substance abuse, mental health, and HIV/AIDS.** Respondents said the second-greatest barrier was federal privacy requirements. In particular, 24 of 38 responding states said federal laws related to substance abuse

services create a barrier when implementing an electronic HIE. And 13 states said that state and federal confidentiality and consent laws create obstacles for e-health activities, while nine states reported HIPAA pre-emption standards as a barrier. Other barriers cited included the technological challenges of securing data and authentication.

- **States are interested in knowing and improving availability of medical data to health care providers and Medicaid enrollees.** One barrier found for consumers is lack of computer access. One-third of responding states had recently assessed the extent to which the Medicaid population has access to computers and the Internet. One-third of the respondents also said they had started education efforts about e-health specifically intended to inform consumers from culturally and linguistically diverse communities. And two-thirds of the states had assessed provider connectivity. Barriers cited for electronic medical records included initial and ongoing costs associated with the implementation process, lack of quantifiable return-on-investment, and difficulty finding an interoperable electronic medical record application.

- **States have formed public/private consortia to develop standardized measures of utilization and**

**performance.** Some 18 states reported working with private payers to develop statewide measures of utilization and performance.

- **States have adopted HIT activities in a wide variety of programs.** States reported a range of e-health activities in five health care programs—Medicaid, employee health benefit plans, state-operated mental health hospitals, state prison systems, and public health. The greatest number of state e-health activities was in public health, with the second-highest number in Medicaid. Registries were reported as the most prevalent e-health activity, followed by telehealth and decision support tools.

- **Public health has extensive experience operating registries, which will be foundational to other e-health activities.** Public health agencies in many states have spent decades operating registries related to immunization, surveillance, disease, newborn screening, and early and periodic screening, diagnosis, and treatment. States said their experiences with these registries will support their efforts to develop other HIT and electronic HIE activities.

- **Almost all states reported Medicaid e-health initiatives.** Some 37 of the 42 responding states said they had Medicaid e-health initiatives. More than half reported

implementing web-based Medicaid Management Information Systems, telehealth, and decision-support tools. Web-based provider enrollment and certification and immunization registries were reported in about one-third of the responding states.

- **The most significant barrier reported to the widespread adoption of interoperable HIT and a nationwide network of electronic HIEs was obtaining funding for implementation and long-term operations.** More than half of responding states identified lack of funding as the greatest barrier. Other impediments cited included stakeholder engagement, lack of standards, privacy and security concerns, terminology, and legal constraints for e-prescribing.

- **States say their most important lesson learned is the need for collaboration and stakeholder engagement.** Other lessons learned include the need for sufficient time and careful planning, clear and effective communication, dedicated resources and start-up funding, and using a versatile electronic HIE model that does not lock out prospective participants because of its dependence on a particular vendor or service.

*Download the report at [www.commonwealthfund.org/publications/publications\\_show.htm?doc\\_id=669309](http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=669309). ■*

## *Clip files / Local news from the states*

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

### **PA first state to use Medicaid for autism**

HARRISBURG—Pennsylvania has become the first state in the nation to receive the federal government's permission to spend federal Medicaid dollars on services that enable autistic adults to live more independently. Gov. Ed Rendell said the state received

approval for a waiver from existing Medicaid rules to spend \$20 million a year on home and community-based services for autistic adults. Federal special-education law requires public schools to provide services for children with autism and other disabilities through age 21, but no similar entitlement has been available in

Pennsylvania for adults with the disorder.

The federal Centers for Medicare & Medicaid Services have previously allowed states to spend Medicaid money on programs targeting autistic children, but not adults, spokeswoman **Mary Kahn** said. Autism is a complex developmental disability usually not diagnosed in children until after age 3. It is characterized by repetitive behaviors and poor social

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Pennsylvania's waiver program is expected to serve up to 200 autistic adults who meet certain eligibility requirements based on income and on the severity of their disability. The Department of Public Welfare, which oversees programs for the disabled, has no statistics on how many adult Pennsylvanians have the disorder, spokeswoman **Anne Bale** said.

The federal money will help pay for a wide range of services, such as respite aid for relatives who care for autistic adults and crisis intervention, Ms. Bale said.

— *Associated Press, 5/23/08*

### **Advocates fear vulnerable group will lose benefits**

NASHVILLE—Health care advocates fear that 140,000 TennCare enrollees will lose their benefits in the coming year, and they are urging legislators to create

a safety net now. The Tennessee Health Care Campaign calls for using up to \$125 million of existing TennCare budget money to treat the sickest of these enrollees, who have been exempt from annual eligibility checks and are expected to face re-evaluation. The funds would be used to treat about 20,000 people with severe mental illness and life-threatening conditions, such as transplant patients needing anti-rejection drugs and cancer patients undergoing radiation treatment. We are not asking to take care of all those who could be cut, just the 20,000 whose medical conditions are so serious that it could jeopardize their lives or the lives of others," said **Tony Garr**, executive director of the Tennessee Health Care Campaign, a health care advocacy group. "As a caring, civilized group of people, we need to make sure we don't place people's lives at risk."

However, **Marilyn Wilson**, TennCare's spokeswoman, said providing medical care for these enrollees and not others, who have been found to be ineligible, wouldn't be fair. She said in an average month, 20,000 people lose TennCare, the state's insurance program for the poor and disabled, because they are no longer eligible, and another 22,000 new enrollees are added. "Every dollar you use to serve someone who isn't eligible, you take away from someone who is eligible," Ms. Wilson said. "Those taxpayer dollars are meant to provide care for people who are eligible for the program." Furthermore, she added that it is premature to speculate on how many people will lose coverage before a re-evaluation process takes place.

— *Nashville Tennessean, 5/11/08*

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