



**BUILDING QUALITY INTO RITE CARE:
HOW RHODE ISLAND IS IMPROVING HEALTH CARE
FOR ITS LOW-INCOME POPULATIONS**

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FIELD REPORT

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ABOUT THE ECONOMIC AND SOCIAL RESEARCH INSTITUTE

The **Economic and Social Research Institute (ESRI)** is a nonprofit organization that conducts research and policy analysis in health care and in the reform of social services. ESRI specializes in studies aimed at enhancing the effectiveness of social programs, improving the way health care services are organized and delivered, and making quality health care accessible and affordable.

ABOUT THE AUTHOR

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EXECUTIVE SUMMARY

Against a backdrop of dwindling tax revenues and rising health-related costs, states are struggling to make ends meet. Some are trying to squeeze out new funds to cover a portion of the uninsured, while others are trying to just “hold the line” or minimize cutbacks in existing Medicaid coverage. A less prevalent, but potentially promising strategy for states involves trying to improve the *quality* of care.

Rhode Island is a leader in incorporating quality improvement into its public insurance programs. By making quality improvement a central feature of RItE Care—the state’s managed care program for Medicaid, the State Children’s Health Insurance Program (CHIP), and certain uninsured populations—Rhode Island officials believed they could achieve better health for residents as well as lower health costs in the long run. They posited that if coverage were provided within the context of improved access under a comprehensive managed care model, enrollees would be empowered to use the system more effectively and efficiently—and would achieve the kinds of health outcomes enjoyed by higher-income families.

INTERVENING EARLY AND EXPANDING THE “MEDICAL MODEL”

Improving Prenatal Care Use and Birth Outcomes

Built into RItE Care’s program for pregnant women are design features and interventions intended to improve access to prenatal care and the health of newborns. Through its streamlined application process, reimbursement policies, toll free hotlines, outreach campaigns, free pregnancy testing, and other features, the program addresses many obstacles to prenatal care—including delivery system, capacity, cultural, and organizational barriers—that have plagued Medicaid programs and have been documented in the literature. Indeed, a study that examined prenatal care among all Rhode Island Medicaid-funded births before and after implementation of RItE Care revealed significant improvement in adequacy of prenatal care over that period, and continued monitoring has revealed further improvements. For example, one study found that the portion of pregnant Medicaid beneficiaries receiving adequate prenatal care increased from 56 percent in 1993 to 73 percent in 2000.

RItE Care’s focus on prenatal care, combined with an emphasis on providing enrollees a medical home through its managed care model, has also had a positive impact on infant health outcomes and access to care. Infants are born healthier, receive care earlier, and have more doctor visits. Researchers have found that from 1993 to 1995, the incidence of low-birth-weight babies declined by half, from 10 percent to 5 percent.

Family Planning Initiative

Short intervals between births (less than 18 months between deliveries) have been related to poor perinatal outcomes, including low birth weight and prematurity. Rhode Island Medicaid officials sought to address birth-spacing issues through family planning services. The state requested and received a family planning waiver from the federal government in 1994, which allowed RIte Care to continue to provide family planning and primary care benefits to women after they deliver a baby for a period of two years—well beyond the regular 60-day postpartum coverage period. The vast majority of women in this category were later provided the full set of RIte Care benefits when the program expanded to include parents in the late 1990s.

Rhode Island's Family Planning Initiative is considered a major success, in terms of both lengthened birth intervals and cost-effectiveness for the state. In 1993 (pre-RIte Care), 41 percent of women having a Medicaid-funded birth became pregnant within 18 months of a previous delivery (considered a short interval). By 2000, that portion was cut nearly in half, to 21.3 percent. In fact, mothers on Medicaid had longer birth intervals than privately insured women for the first time in 2000. The initiative proved cost effective as well, saving the state nearly 2.5 times more than its investment. According to the state, these services reduced the number of RIte Care deliveries by an estimated 1,443, saving about \$14.3 million in program expenditures.

Providence Lead Center

Rhode Island's first lead center opened in 1998 in response to research indicating a high incidence of lead poisoning in the state and an understanding that many families with a lead-poisoned child have multiple needs that could not be met by primary care providers alone. Located in an inner-city Providence neighborhood, the lead center uses a case-management approach to provide education, screening, early detection, needs assessment, referrals, and assistance with housing and moving issues. The center also replaces lead-painted windows, conducts removal of lead surrounding the windows, and instructs families in specialized cleaning techniques. Rhode Island was the first state to receive federal Medicaid funds to cover the cost of replacing lead-painted windows in the homes of lead-poisoned children who are enrolled in RIte Care. With window casings the source of 80 percent of the lead in affected homes, the state expects to significantly reduce future incidences of lead poisoning through this program.

The lead center is financed by the state Department of Human Services (DHS) through Medicaid, both for targeted case management services and for window

replacement. To meet lead-related needs outside the Providence area, DHS is certifying additional providers and hopes to open lead centers in other parts of the state.

Lessons

RItE Care's emphasis on early interventions and expansion of the medical model underscores the following:

- Improving access to essential primary and preventive care services is likely to improve health outcomes, and in some cases, will lead to subsequent savings as babies are born healthier, chronic health conditions are brought under control, and emergency room visit rates and length of hospital stays are reduced.
- An important part of enhancing access involves increasing the pool of service providers, thereby easing the burden on community health centers and hospital clinics.
- The traditional medical model could be extended to include services that address social determinants of health, such as hazardous exposure to lead in the home, transportation and language barriers, and tobacco use.

PERFORMANCE GOAL PROGRAM

One of a handful of states to incorporate financial incentives into its Medicaid contracts with participating health plans, Rhode Island launched its RItE Care Performance Goal program in 1998 to measure and reward health plan performance related to administration, access, and clinical service. It ties performance to financial rewards separate from and in addition to the negotiated capitation payments.

A total of \$1.25 per member per month, or a little more than 1 percent of the capitation rate, is potentially available to each of three health plans participating in RItE Care if they meet 21 specified performance goals. In 2001, this maximum reward amount was equivalent to approximately \$762,000, \$555,000, and \$56,000, respectively, for the three health plans. In addition to rewards, RItE Care contracts with health plans include a provision for financial penalties; the state may assess a fine of \$2,500 per day if a plan does not comply with contractual obligations, such as timely and complete submission of data. Rhode Island has never invoked penalties, however, preferring to work out problems in a cooperative and collaborative way.

State assessment of the plans' performance is based on two parts: review of encounter data submitted by the health plans (for clinical and some access goals), and an annual on-site review by DHS personnel (for administrative and some access goals). The state recognizes progress toward achieving goals; rather than an "all or nothing" payment

rule, the state allows partial payments when health plans approach but do not actually meet specified standards. Further, financial awards are based in part on completeness, accuracy, and timeliness of data submitted as well as actual performance.

Lessons

While the impact of RItE Care's performance-based incentive program is still unclear, state officials believe that health plans are paying attention and trying to improve their scores. Their experience to date reveals the following:

- Collaboration with health plans in developing and modifying an incentives program is critical for enhancing health plan "buy in" and cooperation. Flexibility is equally important.
- An incentives program requires solid administrative support, including qualified staff to monitor and analyze the results and to spend sufficient time working with the health plans on system improvements, particularly in the clinical areas.
- Incentives should be structured to reward improvement as well as realization of goals; health plans should know that some goals are attainable in the relatively short term.
- The program should not impose excessive burden on health plans and providers; e.g., the number of goals and the work involved in collecting necessary data should be minimized.

RESEARCH AND EVALUATION

Research and evaluation (R&E) play an integral role in Rhode Island's Medicaid programs. R&E is used to: (1) determine the unmet needs of Medicaid populations through focus groups, data analysis, and surveys; (2) present results to state officials who will develop programs to meet those unmet needs; and (3) monitor and track health indicators to assess the impact of managed care and other program interventions. The R&E effort has not only documented quality improvements in Rhode Island's Medicaid program but has contributed toward quality improvement by identifying problems, assessing ways to fix problems, and providing data that has helped build support among legislators, enrollees, and private funders. R&E is financed through Medicaid administrative funds, supplemented by grants from private foundations.

Lessons

RItE Care's experience with R&E has yielded the following lessons for other states:

- Data can be used in a variety of ways: identifying service gaps that can be filled; revealing patterns of over-utilization of high-cost services; highlighting interventions

that improve outcomes and should be expanded; and demonstrating success that can build support for the program among legislators and advocates.

- R&E should be integrated into the coverage program, for example, through an “on-site” presence that improves access to information and encourages greater interactions among state program staff and researchers.
- The research and evaluation team should be interdisciplinary, with individuals selected for their interpersonal skills as well as their knowledge and expertise.
- Particularly in times of Medicaid budget constraints, it is helpful to supplement R&E funding with private grants.
- Priority should be given to obtaining and organizing data sets and records.

BUILDING QUALITY INTO RITE CARE: HOW RHODE ISLAND IS IMPROVING HEALTH CARE FOR ITS LOW-INCOME POPULATIONS

1. BACKGROUND: EARLY RITE CARE FOCUS ESTABLISHES GUIDING PRINCIPLES

RItE Care is Rhode Island’s managed care program for Medicaid, State Children’s Health Insurance Program (CHIP), and certain uninsured populations. The program began in 1994, and has expanded incrementally since then to cover pregnant women and children in families with income up to 250 percent of the federal poverty level (FPL), and previously uninsured parents with income up to 185 percent of the FPL. Using a managed care model that provides a “medical home” to each member, RItE Care offers comprehensive benefits to its nearly 117,000 members.

When RItE Care was developed in the early 1990s, the primary objectives were to improve access and health outcomes, and to curtail cost escalation. There was much concern among consumer advocates, enrollees, and some government officials that a move to managed care might have a negative impact on the populations being served. In response, a committee composed of the directors of the Department of Health (DOH) and the Department of Human Services (DHS) and research experts devised a set of five long-term goals that would reflect RItE Care’s objectives related to access and quality.¹ The committee selected indicators that were relevant to the populations RItE Care would be serving, could be measured and tracked, and would lead to long-term improvements in health outcomes. The subsequent design of RItE Care’s benefits, clinical and access guidelines, contract provisions with health plans, outreach efforts, and research and evaluation efforts reflects these goals and underlying principles related to access and quality.

The populations initially served by RItE Care were (primarily) nondisabled infants, children, and pregnant women. Thus, the goals selected were geared toward keeping children and women healthy (Table 1). As other populations have been added to RItE Care, additional indicators have been monitored.

¹ The RItE Care program was originally designed to be jointly administered by DOH and DHS; before implementation it was placed under DHS authority, although DOH continues to play an important role in research and other activities related to RItE Care.

**Table 1. Long-Term Goals
of the RItE Care Program**

- Improve Access to Prenatal Care
 - Improve Birth Outcomes
 - Increase Inter-Birth Intervals
 - Reduce Lead Poisoning
 - Increase Immunization Rates
-

This report examines initiatives implemented by Rhode Island’s Department of Human Services to achieve these long-term goals and address other aspects of access and quality. Most of these initiatives take place within the RItE Care managed care program. Some, however, have expanded to cover additional Medicaid populations in the fee-for-service program. Since the majority of health care providers serving RItE Care populations also serve commercial patients, it is likely that some quality improvements have “spilled over” to the privately insured population as well.

Section 2 of this report examines three interventions aimed at meeting RItE Care’s long-term goals: 1) reducing barriers to prenatal care; 2) the Family Planning Initiative; and 3) the Providence Lead Center. Section 3 describes the Performance Goal program, which incorporates financial rewards for improved performance into the contracts with health plans participating in RItE Care. Section 4 describes the Research and Evaluation effort, and Section 5 presents a brief conclusion.

2. EARLY INTERVENTIONS AND EXPANDING THE “MEDICAL MODEL”

This section describes three sets of initiatives within Rhode Island’s RItE Care program that are intended to improve the quality of Medicaid services and health outcomes. They include:

- Interventions aimed at improving access to prenatal care and birth outcomes;
- The Family Planning Initiative, intended to lengthen inter-birth intervals among RItE Care enrollees; and
- The Lead Center, which provides case management and an array of services to families of children with lead poisoning, including window replacement and other strategies to ensure a lead-safe home environment.

Improving Prenatal Care Utilization and Birth Outcomes

Built into RItE Care’s program for pregnant women are design features and interventions intended to improve access to prenatal care and the health of newborns. Through its

streamlined application process, reimbursement policies, toll free hotlines, outreach campaigns, free pregnancy testing, and other features (delineated in Table 2), the program addresses many obstacles to prenatal care—including delivery system, capacity, cultural, and organizational barriers—that have plagued Medicaid programs and have been documented in the literature.²

Table 2. RIte Care Interventions to Reduce Barriers to Prenatal Care

- Shorter application form, expedited eligibility, mail-in enrollment option;
- Provision of lists of open health plan obstetric providers to pregnant women at the time of Medicaid enrollment;
- Option to continue with current obstetric care provider even if he/she is not in a RIte Care health plan;
- Requirement that any provider participating in a RIte Care health plan and accepting that plan's privately insured members must also accept RIte Care members;
- Increased reimbursement to prenatal and obstetrical care providers;
- Requirements that health plans provide outreach to all members of childbearing age, including free pregnancy testing, and that providers see enrollees as early as possible in the first trimester and within three weeks of a positive pregnancy test;
- Toll-free information line whereby counselors ensure that pregnant women who call are enrolled in prenatal care;
- Provision of bus passes and cab vouchers that ensure transportation to prenatal care visits;
- Outreach campaign including advertising on billboards, newspaper, radio, and television.

Source: Jane F. Griffin, Joseph W. Hogan, Jay S. Buechner, and Tricia M. Leddy. "The Effect of a Medicaid Managed Care Program on the Adequacy of Prenatal Care Utilization in Rhode Island," *American Journal of Public Health* 89 (April 1999): 497–501.

A study that examined prenatal care among all Rhode Island Medicaid-funded births before and after implementation of RIte Care revealed significant improvement in adequacy of prenatal care over that period.³ RIte Care researchers attributed the improvement to the specific targeted interventions that helped expand the number of obstetric care providers serving Medicaid patients, in turn easing the burden on community health centers and hospital clinics.⁴

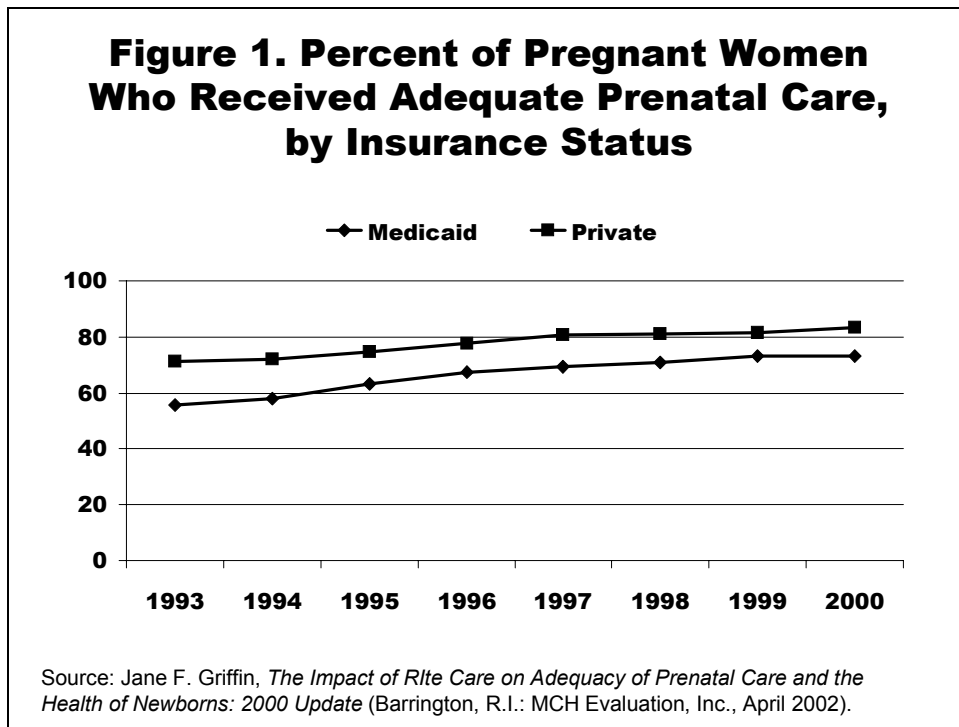
² Institute of Medicine, *Prenatal Care: Reaching Mothers, Reaching Infants* (Washington, D.C.: National Academy Press, 1988).

³ Adequacy of prenatal care utilization is measured using the Kotelchuck Index, which is based on: month prenatal care began, number of prenatal care visits, and gestational age. Care was deemed adequate if prenatal care began by the fourth month of pregnancy and 80 percent or more of recommended visits were completed.

⁴ Jane F. Griffin, Joseph W. Hogan, Jay S. Buechner, and Tricia M. Leddy, "The Effect of a Medicaid Managed Care Program on the Adequacy of Prenatal Care Utilization in Rhode Island," *American Journal of Public Health* 89 (April 1999): 497–501.

Continued monitoring reveals further improvements in prenatal care over time:⁵

- The portion of pregnant Medicaid beneficiaries receiving adequate prenatal care increased from 56 percent in 1993 to 73 percent in 2000 (Figure 1).
- The portion of women on Medicaid who began prenatal care in the first trimester increased from 77 percent in 1993 to 84 percent in 2000; the gap between privately and publicly insured women was cut nearly in half over this period.
- Prenatal care appears to have had an impact on health-related behavior: from 1993 to 2000, the portion of pregnant women in Rhode Island Medicaid who smoke declined from 32 percent to 24 percent; however, pregnant women on Medicaid are still 2.6 times more likely to smoke than those with private coverage.



RItE Care's focus on prenatal care, combined with an emphasis on providing enrollees a medical home through its managed care model, had a positive impact on infant health outcomes and access to care. Infants are born healthier, and receive care earlier and have more visits. Comparing the pre-RItE Care period (1993) with post-RItE Care (1995) in a study of Providence inner-city births, the following improvements were documented:⁶

⁵ Jane F. Griffin, *The Impact of RItE Care on Adequacy of Prenatal Care and the Health of Newborns: 2000 Update* (Barrington, R.I.: MCH Evaluation, Inc., April 2002).

⁶ Jane F. Griffin, *Changes in Access and Quality of Pediatric Health Care in Inner City Providence from 1993 to 1995: Results of the RItE Care Infant Health Survey* (Barrington, R.I.: MCH Evaluation, Inc., April 1998).

- Decline in incidence of low-birth-weight babies by half, from 10 percent to 5 percent;
- Increase in percentage of infants who had their first physician visit within the first two weeks, from 54 percent to 70 percent;
- Increase in percentage of one-year-olds with up-to-date immunizations, from 88 percent to 95 percent;
- Increase in portion of infants who waited less than two weeks for specialty care, from 44 percent to 71 percent;
- No change in percentage of infants treated in the emergency department or admitted to the hospital, but there were declines in both emergency department visit rate per infant and inpatient length of stay.

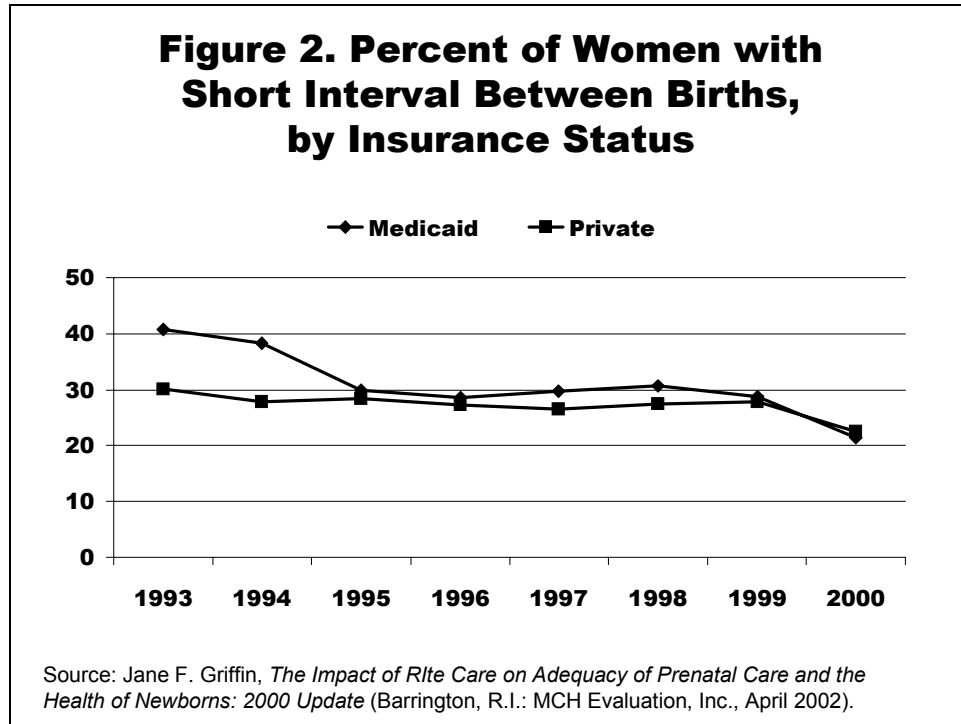
Family Planning Initiative

Short intervals between births (less than 18 months between deliveries) have been related to poor perinatal outcomes including low birth weight and prematurity.⁷ This prompted Rhode Island Medicaid officials to address birth spacing issues through family planning services. The state requested and received a Family Planning waiver from the Health Care Financing Administration (now Centers for Medicare and Medicaid Services [CMS]) in 1994, which allowed RItE Care to continue to provide family planning benefits to women (in the Medicaid “expansion” population) after they deliver a baby for a period of two years—well beyond the regular 60-day postpartum coverage period. These women would receive a limited set of benefits that includes primary care and family planning. The vast majority of women in this category were later provided the full set of RItE Care benefits when the program expanded to include parents in the late 1990s. The waiver, however, continues to provide family planning benefits for women with income between 185 percent and 250 percent of the FPL.

This Family Planning Initiative is considered a major success, in terms of both lengthened birth intervals and cost-effectiveness for the state. In 1993 (pre-RItE Care), 41 percent of women having a Medicaid-funded birth became pregnant within 18 months of a previous delivery (considered a “short interval”). By 2000, that portion was cut nearly in half to 21.3 percent. In fact, mothers on Medicaid had longer birth intervals than privately insured women for the first time in 2000 (Figure 2).

⁷ See B. P. Zhu, R. T. Rolf, B. E. Nangle, and J. M. Horan, “Effect of the Interval Between Pregnancies on Perinatal Outcomes,” *New England Journal of Medicine* 340 (February 25, 1999): 589–94; J. S. Rawlings, V. B. Rawlings, and J. A. Read, “Prevalence of Low Birth Weight and Preterm Delivery in Relation to the Interval Between Pregnancies Among Black and White Women,” *New England Journal of Medicine* 332 (January 12, 1995): 69–74; and E. Lieberman, J. M. Lang, K. J. Ryan, R. R. Monson, and S. C. Schoenbaum, “The Association of Inter Pregnancy Interval with Small for Gestational Age Births,” *Obstetrics and Gynecology* 74 (July 1989): 1–5.

The initiative proved cost effective as well, saving the state nearly 2.5 times more than its investment. RItE Care spent \$5.7 million on family planning services from 1994 to 1997. According to the state, these services reduced the number of RItE Care deliveries by an estimated 1,443, saving about \$14.3 million in program expenditures.⁸



The Providence Lead Center

Rhode Island’s first Lead Center opened in 1998 in response to research indicating a high incidence of lead poisoning in the state and an understanding that many families with a lead-poisoned child have multiple needs that could not be met by primary care providers alone. Repeat cases of lead poisoning within families indicated that the state needed to go beyond treating the child alone, to pay attention to environmental hazards, and to help families get into lead-safe homes.

The Lead Center, located in an inner-city Providence neighborhood, uses a case management approach to provide education, screening, early detection, needs assessment, referrals, and assistance with housing and moving issues. The Center also replaces lead-painted windows, conducts removal of lead surrounding the windows, and instructs families in specialized cleaning techniques.⁹ Rhode Island was the first state to receive

⁸ “State Efforts to Expand Medicaid-Funded Family Planning Show Promise,” *The Guttmacher Report on Public Policy*, Special Analysis, April 1999.

⁹ More extensive lead abatement work is conducted through Rhode Island Housing Resources Commission.

federal Medicaid funds to cover the cost of replacing lead-painted windows in the homes of lead-poisoned children who are enrolled in RItE Care. The window replacement effort is part of Governor Almond's comprehensive, inter-departmental lead prevention program, Lead Free Rhode Island, initiated in 1998. With window casings the source of 80 percent of the lead in affected homes, the state expects to significantly reduce future incidences of lead poisoning through this program.

When window replacement is deemed necessary (if recommended by a licensed inspector and approved by DHS) to create a lead-safe environment, the state pays for the work, and a lien is placed on the property. As of October 2002, 145 windows have been replaced in 10 housing units.¹⁰ When the property is sold, the cost of the window replacement must be returned to the state, though this has not yet occurred in the relatively new program.

The Lead Center staff includes a nurse and administrator, and two to three bilingual case managers. It is financed by DHS through Medicaid, both for targeted case management services (an "optional" service covered under Medicaid), and for window replacement (approved under an amendment to the original RItE Care Medicaid waiver). Approximately 200 children are assisted through this program per year, somewhat fewer than anticipated. In response, the DHS has reduced the lead blood level threshold for services and eased other restrictions.¹¹ To meet lead-related needs outside the Providence area, DHS is certifying additional providers and hopes to open Lead Centers in other parts of the state.

3. PERFORMANCE GOAL PROGRAM

The RItE Care Performance Goal program began on July 1, 1998. One of a handful of states to incorporate financial incentives into its Medicaid contracts with participating health plans, Rhode Island designed this program to measure and reward health plan performance related to administration, access, and clinical service.¹² It ties performance to financial rewards separate from and in addition to the negotiated capitation payments. As

¹⁰ Actual window replacements began in late 1999; after a slow start, the state is encouraging greater utilization of this service through the existing Lead Center and is certifying additional providers.

¹¹ The state is allowing partnerships between a case management agency and an environmental abatement company in which each agency may bill the state separately; the prior model required the primary agency to conduct or subcontract for all services.

¹² Rhode Island, Utah, and Wisconsin built performance-based incentives into their Medicaid contracts with HMOs; Iowa and Massachusetts have incorporated financial incentives into Medicaid contracts with behavioral health plans. (Mary Beth Dyer, Michael Bailit, and Christine Kokenyesi, "Are Incentives Effective in Improving the Performance of Managed Care Plans?" Working paper, Center for Health Care Strategies, Inc., March 2002).

of summer 2002, the state is completing its fourth year of experience with the Performance Goal program.

In May 2001, the Rhode Island DHS received an award recognizing its efforts in improving quality care for its RItE Care members from the National Health Care Purchasing Institute (NHCPI).¹³ Specifically, Rhode Island was selected for its work in “buying higher quality health care plans and rewarding performance through financial incentives.”

Performance Incentives

A total of \$1.25 per member per month, or a little more than 1 percent of the capitation rate, is potentially available to each of three health plans participating in RItE Care if they meet 21 specified performance goals. In 2001, this maximum reward amount was equivalent to approximately \$762,000, \$555,000, and \$56,000, respectively, for the three health plans. In addition to rewards, RItE Care contracts with health plans include a provision for financial penalties; the state may assess a fine of \$2,500 per day if a plan does not comply with contractual obligations, such as timely and complete submission of data. Rhode Island has never invoked penalties, however, preferring to work out problems in a cooperative and collaborative way.

RItE Care’s performance goals are allocated to three categories:

- Administration/management 20% of reward = 25 cents per member per month
- Access 30% of reward = 37.5 cents per member per month
- Clinical Care 50% of reward = 62.5 cents per member per month

Each category contains specific goals, each of which is assigned a point value displayed in Table 3. That is, each goal is weighted differently within that category. Compliance is measured using performance assessment criteria provided to each of the health plans and scored according to a point system. Attaining all the points for a specific goal qualifies the health plan for the full amount of the reward designated for that particular goal. The state recognizes progress toward achieving goals; rather than an “all or nothing” payment rule, the state allows partial payments when health plans approach but do not actually meet specified standards. Further, financial awards are based in part on completeness, accuracy, and timeliness of data submitted as well as actual performance.

¹³ NHCPI is sponsored by the Robert Wood Johnson Foundation through a grant to AcademyHealth. It was founded to improve health care quality by advancing the purchasing practices of major corporations and governmental agencies.

State assessment of the plans' performance is based on two parts: review of encounter data submitted by the health plans (for clinical and some access goals), and an annual on-site review by DHS personnel (for administrative and some access goals). A health systems analyst at DHS leads a team that analyzes and reports on the data.

Results are presented to each health plan in a detailed report each year. In addition, the plans meet with DHS staff to discuss concerns, suggestions for modifications, and ways to improve scores. The three health plans see each other's results and pay-outs, which may drive some healthy competition. Additionally, the state sends the results to CMS, the federal oversight agency for Medicaid. Neither the state nor the health plans, however, have yet made the results widely available to the public or to enrollees.

The performance measures included in RItE Care's financial incentive program comprise only a small subset of the data that DHS collects from the health plans and monitors for quality assurance. DHS is in frequent contact with the health plans concerning a wide range of indicators, such as member satisfaction, service utilization, and others that are important but separate from the incentives program.

Table 3. RIte Care Performance Goals and Point Values, 2002 Program¹⁴

Performance Goal	Standard	Point Value
Administration/Management		
1. Permanent ID cards within 10 days	98%	
Member handbook within 10 days	98%	5
2. PCPs assigned within 20 days	95%	10
3. Average speed to answer calls 30 seconds or less	100%	20
4. Grievance and appeals in time frames	97%	20
5. Pay “clean” claims within 30 days	95%	20
6. Pay claims to ER for medical screening	100%	10
7. Notify DHS of potential third-party liability within 15 days	90%	15
Total		100
Access		
1. Members seeking ER receive services immediately	100%	5
2. Members seeking urgent care receive within 24 hours	95%	15
3. Members seeking non-ER, non-urgent Behavioral Health care within 5 days	75%	10
4. New adult members receive first PCP visit within 6 weeks	50%	35
5. New pediatric members receive first PCP visit within 90 days	65%	35
Total		100
Clinical		
1. Members less than 2 years immunized	85%	22
2. Members between 6 and 21 years age-appropriate screenings	85%	22
3. Pregnant women adequate prenatal care using Kotelchuk Index	85%	22
4. Lead screening for age 18 mos. received in preceding 9 mos.	85%	22
5. Pap rates age 16 to 64 years:		12
Age 16 to 20, at least one test during past year	40%	
Age 21 to 64, at least one test within past 3 years	80%	
Total		100

Source: Center for Child and Family Health, Rhode Island Department of Human Services.

Establishing and Modifying the Program

The Performance Goal program was born out of a transition DHS made in the mid-1990s toward a “value purchasing” philosophy. Under the leadership of a Medicaid director with a background in value purchasing, RIte Care altered its approach to contracting with health plans. First, it shifted in 1996 from a somewhat passive Request for Proposal (RFP) process in which health plans submitted bids based largely on their own standards, to a “bidding specification” process in which the state specified in detail what it expected from

¹⁴ Data is drawn from previous calendar year.

a health plan. The state built on the general language of earlier contracts, but developed specific standards and criteria.

The second step of the transition was to attach monetary consequences to performance. The plan was to implement a five-year “experiment,” using financial incentives, and then to reassess the program. DHS hoped to see improvement in areas most directly under the plans’ control (e.g., administrative measures) within three years and in areas indirectly under the plans’ control (e.g., measures related to individual provider performance) within five years. Program planners strove to develop goals that would motivate the plans to improve but that were attainable in the near future.

After careful study and deliberations, DHS developed a model with defined goals and standards and presented it to the health plans in the spring of 1998. With input and comments by the plans, contracts including the new performance measures were signed in July 1998. Over the following year, DHS and the health plans held a series of meetings to develop measurement and other implementation strategies. The state developed and studied utilization tables and devised definitions for numerators and denominators of performance measures. Some of the goals were based on HEDIS measures, though they were generally more restrictive.¹⁵ Other goals were specific to RIte Care, such as the lead screening measure, which had become an important component of RIte Care’s prevention strategy.

Two years later, in 2000, the state adopted an additional five performance goals and standards as pilot measures, presented in Table 4. RIte Care administrators intend to collect and review three years of data on these goals before deciding whether or not to add them to the permanent list and assign monetary awards. At the same time, however, the state and health plans are interested in reducing the number of goals (particularly clinical goals), and aligning them more closely with HEDIS measures. The intent is to simplify the process for both the state as well as for the plans, which are already collecting HEDIS data for the purpose of accreditation, and to use measures that are generally accepted and can be compared with health plans nationally.

A number of modifications were made along the way, including one related to full versus partial rewards.¹⁶ Initially, the state planned to base its rewards on whether or not

¹⁵ The Health Plan Employer Data and Information Set (HEDIS) is a set of standardized health plan performance measures that is sponsored and maintained by the National Committee for Quality Assurance.

¹⁶ After the first year, DHS eliminated a behavioral health readmission performance goal due to low frequency of events and fairly volatile rates that raised doubts about the meaningfulness of the data. In 2001, the state eliminated the lead screening goal due to insufficient data, although the state continues other quality initiatives related to lead screening and treatment (such as the Lead Center described earlier), and the goal was brought back for the 2002 program.

each standard was fully met—an “all or nothing” approach. But administrators realized during the first year of implementation that there are many possible reasons for not meeting standards, some of which are out of a health plan’s control. DHS made some adjustments to the standards to account for certain unknowns in the environment. Also, state administrators decided it was important to look for progress, not just success or failure. The state’s intent was to help plans identify problems and encourage them to improve. As a result, it modified its scoring to use weighted averages, providing reduced pay-outs for evidence of progress even when falling short of the specified standard.

Table 4. Pilot Performance Goals and Standards

Performance Goal	Standard
Postpartum visit within 21 days to 56 days after delivery	80%
First outpatient pediatric visit for infants within two to four weeks	90%
Emergency room visits for people with asthma, using HEDIS measures for 4- to 9-year-olds, and 10- to 17-year-olds	To be determined
Outpatient visit after discharge for a mental health diagnosis within two weeks	80%
Translation assistance offered by members’ doctor or health plan for members to better understand their health care	70%

Results and Impact

Although the amount of the incentive payment is very small compared with the capitation payment (\$1.25 versus about \$120 per member per month), administrators believe that the health plans are taking the program seriously because the reward money “drops to the bottom line.” That is, this amount over and above the normal reimbursement rate can be viewed as profit, and therefore the plans have come to pay attention to it, particularly in the last year or two. Also, since the clinical standards are weighted most heavily in the calculations, health plans are motivated to take encounter data seriously. Still, program administrators would like to see more evidence that the health plans are tracking standards on a monthly basis and reviewing the results with teams of clinical and administrative staff.

Over the first three years of the program (1998–2000), there was no clear evidence that it had led to improved performance. Not only had the three plans come up short on meeting most clinical goals, but also the direction of the scores over the first few years of the program was variable, and in fact the majority of indicators worsened from 1999 to 2000. State administrators explain that measuring performance is a dynamic process, with “confounding” factors, or circumstances out of the health plans’ direct control, that can adversely affect scores. One health plan experienced a sudden, rapid enrollment increase from 1998 to 1999 (when other health plans stopped enrolling applicants) that put a strain on administration. Another health plan changed vendors for enrollment materials and

converted its information system, and needed to “work out the kinks.” One plan cited a strike that resulted in the exclusion of some claims from its data submission. The implementation of the RItE Share premium assistance program diverted staff time and resources temporarily, possibly diverting attention from the quality improvement process. In another case, a health plan that is part of a multistate corporation had its administrative functions centralized out of state, where attention was not paid to how the data was collected for the Performance Goal program. It took some time to educate the new administrators and make proper adjustments.

Other declines (or lack of clear improvement) are not easily explained, and DHS continues to work with the health plans to better understand and improve scores. While the state and outside reviewers find it difficult to gauge the overall effectiveness of the program at this time, state administrators perceive the program to be helpful and moving in the right direction.¹⁷

Results for FY2002 seem to bear out this perception. The three plans have been allocated 77.3 percent, 66.4 percent, and 72.4 percent, respectively, of their total incentive funds. This compares with 62.5 percent, 56.8 percent, and 71.3 percent, respectively, for FY2001, indicating that all of the plans showed overall improvement, although some scores for specific indicators declined while others improved. Although the program is still relatively young, and one can not attribute the changes to the financial incentives alone, the health plans report to DHS that they have been working hard to improve scores.

After the incentives program’s fifth year, DHS will carefully assess its impact and decide its future direction. Meanwhile, the state and the health plans continue to consider streamlining the goals and shifting the measures toward a HEDIS model.

One of the three health plans, Neighborhood Health Plan of Rhode Island (NHPRI), began to pass a portion of the financial reward to the 13 health centers that serve as Primary Care Providers (PCPs) for nearly half of NHPRI’s RItE Care enrollees. Specifically, it shares the payment for the access indicator related to new patients receiving their first PCP visit within a designated period. An NHP official reports that this incentive has resulted in marginally improved performance, and has served to help align the health centers with NHP toward common goals. Also, it is perceived as fair to give the reward to those responsible for improved scores.

¹⁷ An analysis by the Center for Health Care Strategies, Inc. of the program’s experience in 1998 and 1999 was inconclusive regarding the overall effectiveness of the financial incentives (Dyer et al.).

Lessons for Other States

RIte Care's experience with financial performance incentives reveals some important lessons for other states considering this approach:

Use a Collaborative Process: The strong emphasis on collaboration between DHS and the health plans is related in part to the insurance market in Rhode Island. With only three health plans operating in the state, it is deemed important to maintain their participation in the RIte Care program. Other states less concerned with losing health plans can afford to take a more autocratic approach. Yet, there are other advantages to collaboration: it enhances buy-in and cooperation by the health plans, which are critical to making an incentive program work. It minimizes the extent to which health plans need to be on the defensive; the state can involve plan representatives in the development of the standards and data requirements, and listen to their concerns. Once operational, the state should provide feedback to the plans on where the results are sub-par, and where the process is breaking down. For example, on the yearly site visit, experienced DHS evaluators track the business processes behind a performance indicator and provide guidance to health plan personnel, who may be new and inexperienced, in developing strategies to improve performance.

Provide Adequate Administrative Support: One health plan representative stressed the need for adequate resources toward administrative support of the program. To encourage real system improvements, qualified staff must be able to monitor and analyze the results, and spend sufficient time working with the health plans on system improvements, particularly in the clinical areas.

Structure Incentives to Reward Improvement: RIte Care's performance incentives were structured to reward improvement as well as realization of goals. State officials recommend that health plans be given some milestones that can be reached in the relatively short term (within one to two years). Health plans should know that goals are attainable.

Be Flexible: Rhode Island's experience underscores the fact that establishing performance incentives is a fluid process. State officials should be aware that there is a learning curve and be willing to make changes along the way. For example, many external and internal reasons may explain why a plan does not meet standards, and states should be willing to adjust the guidelines accordingly. Similarly, if eligibility criteria change, so will the population; it may be important to look at different measures.

Minimize Burden on Plans, Providers, and States: States would be well served to choose a focused set of goals, and to be attentive to the work involved in measuring the goals for the state, health plans, and providers. To maximize cooperation, they should try to minimize the complexity and administrative burden on the plans. This may involve using existing data (e.g., HEDIS measures) when possible. States should also recognize that health plans have more control over direct administration than information that must come from various providers around the state. The latter data takes longer to assemble and it is more difficult to ensure its comparability and completeness.

4. RESEARCH AND EVALUATION

Research and evaluation (R&E) play an integral role in Rhode Island's Medicaid programs, including the interventions described earlier in this report. Originally designed to monitor the RItE Care managed care demonstration, R&E has expanded to other Medicaid programs and populations as well. Their efforts are overseen by an Evaluation Studies Workgroup whose primary goals are to:

- Determine the unmet needs of Medicaid populations through focus groups, data analysis, and surveys;
- Present results to state officials who will develop programs to meet those unmet needs; and
- Monitor and track health indicators over time to assess the impact of managed care and other program interventions.

The R&E effort has not only *documented* quality improvements in Rhode Island's Medicaid program, but has *contributed* toward quality improvement by identifying problems, assessing ways to fix problems, and providing data that has helped build support among legislators, enrollees, and private funders. R&E is financed through Medicaid administrative funds, supplemented by grants from private foundations.

Formation of the Evaluation Studies Workgroup

Rhode Island Medicaid's R&E effort grew out of the state's establishment of RItE Care in 1994. Concerned about the possible negative effects of moving pregnant women and children into managed care, the state included in its 1115 demonstration waiver application a set of research objectives focused on monitoring the impact of the program (delineated in Section 1). The DOH and DHS put out an RFP seeking qualified researchers. They selected MCH Evaluation, Inc., a private health program evaluation firm, to lead the R&E efforts. The state also collaborated with researchers at Brown University who specialize in pediatric health care and adults with disabilities. In addition,

DHS hired Birch & Davis/ACS to perform RIte Care administrative functions, including conducting member satisfaction surveys and monitoring health plan quality. More recently, fellowships have been planned for two Brown University public health graduate students, who will work on thesis topics and state data sets relevant to the state's R&E needs. In addition to expanding the R&E capabilities, this fellowship program promises to train people who may work in other states in the future.

Two MCH Evaluation researchers, the two Brown University faculty, the director of health statistics from Rhode Island's Department of Health, the administrators of DHS' Center for Child and Family Health and Center for Adult Health (CCFH/CAH), and senior staff from Birch & Davis/ACS comprise the core of Rhode Island's Evaluation Studies Workgroup. Established in 1996, the Workgroup meets monthly to discuss areas in need of study, methodology, results, implications, and follow-up actions. Additional Medicaid staff attend Workgroup meetings when the issues being discussed relate to their program area (e.g., prenatal care, adults with disabilities, the uninsured). The interdisciplinary nature and the particular interests of the people involved result in a collegial atmosphere with an active interchange of ideas.

Originally, the researchers used public health data sets (e.g., birth certificates, Centers for Disease Control surveys, hospital discharge records), and conducted some surveys to monitor access to care for RIte Care enrollees. In 1998–1999, the R&E efforts expanded beyond RIte Care populations (primarily healthy children and women) to other Medicaid programs and populations, including adults and children with disabilities. Also, with the expansion of RIte Care to children receiving Supplemental Security Income and those in foster care, the R&E effort has begun to monitor the impact of the program change on these populations.

Rhode Island's Health Indicator System and Medicaid Data Archive

The Evaluation Studies Workgroup designed and implemented a Health Indicator System to ensure access to information for monitoring and evaluating Medicaid programs, collecting baseline information on the health status of the population served, and tracking health outcomes of Medicaid beneficiaries compared with privately insured populations. The Workgroup developed the Health Indicator System through a four-step process:¹⁸

1. A review of existing research literature, policy reports, and performance measure projects to come up with a list of recommended measures;

¹⁸ *Design of a Health Indicator System: A "How-To" Manual for State Medicaid Programs*. Developed by Evaluation Studies Workgroup, Division of Health Care Quality, Financing and Purchasing, Rhode Island Department of Human Services, March 2000.

2. Determination whether available data sets collect the recommended measures;
3. Input from Medicaid program staff regarding indicators that would be most useful to monitor and evaluate new program initiatives;
4. Establishment of a Medicaid Data Archive to ensure that data sets to measure selected indicators were documented and available for program and policy staff.

The Workgroup established the Medicaid Data Archive under a planning grant from the Center for Health Care Strategies.¹⁹ Selection of data sets for the archive was based on reliability, accuracy, and ability to track indicators over time. They include public health data sets (available in most states), including Hospital Discharge, Vital Statistics Birth File, Minimum Data Set for Nursing Home Residents, and the Behavioral Risk Factor Surveillance System. The Workgroup also developed age categories/ population groups, with different indicators for such groups as adolescents, healthy adults, children with disabilities, adults with disabilities, and the elderly.

Under the same planning grant, the Evaluation Studies Workgroup used its own experiences to produce a “How-To” Manual for other state Medicaid programs interested in designing a Health Indicator System.²⁰ This manual provides detailed instructions on how to set up a Health Indicator System that would enable states to design new program initiatives and evaluate them.

Research Methods

Research and evaluation studies are divided by age group: children (up to age 21); working age population (ages 21 to 64); and elderly (age 65+). Populations are also divided into “healthy” populations for which statewide data sets provide much information, and populations with “disabilities” for which MMIS and Medicaid program data sets contain much relevant information.

The Evaluation Studies Workgroup employs three principal methods for study:

- Focus Groups—to learn how a program is working from consumers’ perspectives;
- Analysis of Existing Data Sets—to obtain baseline data and assess trends; and
- Health Surveys—to identify unmet needs and/or evaluate specific interventions “pre-test” and “post-test.”

¹⁹ The Center for Health Care Strategies is funded through a separate grant from the Robert Wood Johnson Foundation.

²⁰ Available at <http://www.dhs.state.ri.us/dhs/reports/dhcrep.htm>.

The surveys are given statewide using random samples and are conducted by telephone. They have been conducted for: 1) children with disabilities; 2) adults with disabilities; 3) higher-income RItE Care families newly faced with premiums (to assess the impact of the cost-sharing). Looking ahead, the Workgroup intends to follow up on children who have disenrolled from Medicaid, focusing on reasons for gaps and disruptions in coverage. It also plans to survey persons enrolled in RItE Share, the premium subsidy program. In addition to the surveys conducted by the Workgroup, Birch & Davis/ACS conducts periodic member satisfaction surveys.

Dissemination of Research Findings

There are many venues for the documentation and dissemination of Rhode Island's R&E findings. They include:

- Internal reports submitted by Evaluation Studies Workgroup members to DHS;
- Scholarly articles in journals such as the *Journal of Pediatrics* and *American Journal of Public Health*;
- *RItE Stats*, a publication series that presents analyses of RItE Care utilization data;
- One-page Issue Briefs that summarize R&E findings;
- Presentations by state officials and Workgroup members at interstate policy conferences, consumer advisory group meetings, and provider meetings (e.g., a Workgroup member presented findings of a needs assessment study related to teen pregnancy programs to community-based case managers).²¹

Using Data to Identify Problems and Improve Quality

One key to the R&E program's success is that the directors of DHS and CCFH/CAH have had a clear understanding of the importance of research and its many potential uses. As noted above, R&E is used to assess and document the impact of moving populations into managed care (RItE Care), to determine interventions that work and should be continued or expanded, and to provide data that helps "sell" RItE Care to the public, policymakers, and potential funders. Most important, DHS uses the data to identify gaps and to improve the quality of its Medicaid programs. Examples of R&E efforts that have effected change include the following:

²¹ Researchers admit that the state should increase dissemination of results to health care providers in the community. A grant was recently obtained to help DHS package and present material to community groups.

- A statewide survey among families of children with disabilities on Medicaid revealed significant unmet needs related to support and ancillary services to caregivers.²² The work prompted a series of meetings on Children with Special Needs, and resulted in the establishment of the CEDARR initiative.²³ Two CEDARR Family Centers constitute “one-stop” service sites providing professional assessment, specialty clinical evaluation, intensive case management, information and education for parents, coordination of services, and ongoing referral assistance and support for families of children with disabilities.
- Focus groups with adults with disabilities in Medicaid’s fee-for-service program revealed misunderstandings by members about program benefits and confusing information (including incorrect telephone numbers) on Medicaid identification cards. The state responded by producing and distributing a brochure that clearly explains the program’s benefits and designing and issuing new identification cards (with correct telephone numbers).
- A study examining lead screening in Rhode Island revealed much higher screening rates, but also higher lead poisoning rates compared with national rates. These findings underscored the need to focus intervention on creating a lead-free environment. Along with an assessment that lead-affected families have a complex set of needs, the research findings contributed toward the opening of a special Lead Center (described in Section 2), which provides education and assistance to families of lead-poisoned children on how to achieve and maintain a lead-safe environment for their children.
- A study to determine the impact of managed care on prenatal care utilization revealed significant variation in adequacy of prenatal care among the different health plans providing RItE Care coverage. As a result, the state incorporated an index of prenatal care as a performance indicator in the financial incentive program (Section 3).
- A member satisfaction survey showed that only 55 percent of RItE Care applicants needing translation services were offered them. This data confirmed concerns voiced by consumer advocates, and DHS added a new standard related to offering translation services as a pilot performance measure in its financial incentive program. Also, the three health plans worked together in a broad effort to educate provider offices about offering translation services.

²² Jane F. Griffin, *Health Care Needs of Children with Disabilities on Medicaid: Results of Caregiver Survey*, June 8, 1998.

²³ Comprehensive Evaluation, Diagnosis, Assessment, Referral, and Reevaluation services and supports.

- After data indicated very high neonatal intensive care unit (NICU) utilization, the state investigated and found higher than average rates in both admissions to the NICU and length of stay. DHS responded by carving this benefit out of those covered by the participating health plans, and changing the reimbursement structure. It chose to manage this benefit by placing a staff person directly in the primary NICU in the state, as a consultant contractor. While NICU admission rates have remained fairly constant, the length of stay has declined since these changes were made.

Lessons for Other States

A number of factors have helped make Rhode Island's R&E program successful, and should be considered by other states launching or expanding their own evaluation efforts.

- *Start Early to Establish Baseline:* It is advantageous to begin an R&E effort at the start of the new program, allowing researchers to get baseline data. This enables the researchers to assess the impact of various interventions over time.
- *Use the Data in a Variety of Ways:* Rhode Island's R&E effort has been productive in large part because state officials appreciate the value of data, and know how to use the information to improve programs as well as to gain support. For example, R&E has proved that the investment in managed care has improved health, and this information has been critical for maintaining support for RItE Care and its expansion among legislators and consumer advocates. Also, R&E identifies problems and gaps that administrators can act upon, and highlights interventions that improve outcomes that can be expanded to further improve their programs. It also reveals patterns of over-utilization of high-cost services, which could prompt institutional changes to shift care to more appropriate, lower-cost settings, or elimination of care that is simply unnecessary.
- *Integrate Research into Medical Program:* Unlike other states in which the primary R&E functions are "farmed out" to firms and universities physically removed from state offices, Rhode Island's R&E infrastructure is on-site at DHS. The Evaluation Studies Workgroup leader, a contracted consultant, is at DHS offices two to three days per week. In addition to improving access to information, this arrangement encourages greater interactions among state program staff and researchers, and reinforces a mindset that R&E is an integral and integrated part of the Medicaid program.
- *Use Interdisciplinary Team:* The interdisciplinary nature of the R&E Workgroup (including individuals with expertise in medical sociology, pediatrics, demography,

statistics, and epidemiology), and the particular personalities of the members have contributed toward a collegial, productive, and high-quality team. Other states should select the participants carefully, seeking variety in expertise and considering interpersonal skills including ability to be a “team player.”

- *Ensure Access to Data:* State officials should not take it for granted that their researchers can gain access to all state data. In Rhode Island, DHS obtained a “Memorandum of Understanding” early on that spells out the sharing of information among state agencies. This, along with the active participation of a Health Department official in the Evaluation Studies Workgroup and the establishment of a Medicaid Data Archive, help to ensure access to public health data sets and records.
- *Acknowledge Trade-Offs Under HIFA:* A DHS official acknowledges that as states attain new flexibility to subsidize private health coverage under the Health Insurance Flexibility Act (HIFA), access to certain data will decline. While the benefits of leveraging employer contributions and supporting private coverage are clear, one “downside” to these efforts is that it will be more difficult to gather and track claims and utilization data and monitor/improve quality for the population with private coverage.
- *Supplement Research and Evaluation with Outside Funding:* Particularly in times of budget constraints in Medicaid programs, it is helpful to supplement R&E funding from state administrative budgets with private grants. While the core budget for Rhode Island’s R&E is derived from RIte Care funds, the Evaluation Studies Workgroup has also sought and attained grants for particular research studies from the Center for Health Care Strategies, and the State Coverage Initiatives program, with funding from the Robert Wood Johnson Foundation.
- *Monitor Long Term Goal:* In addition to tracking costs and utilization, it is important to keep in mind the long-term goal of improved health. This requires developing outcome indicators and tracking this information as early as possible, even when significant results would not emerge in the short term. In Rhode Island’s experience, legislators would rather see improvements in health status rather than increases in enrollment.

5. CONCLUSION

In light of budget pressures that may prevent major health reforms in the short term, Rhode Island’s experience illustrates that much can be done to improve quality as well as efficiency through relatively modest quality improvement initiatives. Rhode Island’s

success may be attributed to the deliberateness of the process, early planning, creativity, and leadership.²⁴

At RItE Care's inception, program administrators established specific goals and principals related to improving access and health outcomes that continue to shape and define the program. An emphasis on preventive, primary, and prenatal care has resulted in concrete improvements in health and financial savings. Creative use of Medicaid funds (e.g., for replacement of windows with lead-based paint) has expanded the traditional medical model to address social determinants of health. RItE Care has been experimenting with contractual arrangements that provide financial incentives to health plans as an additional way to improve quality of care. Finally, program leaders understood the value and many uses of data, and built a research component that plays an integral role in improving quality and securing program support. These experiences provide valuable lessons for other states.

²⁴ For a broader analysis of the factors behind Rhode Island's successful coverage initiatives, see the full case study at http://www.cmwf.org/programs/insurance/silow-carroll_rhodeisland_565.pdf.

APPENDIX. METHODOLOGY

In gathering information presented in this report, we interviewed RItE Care administrators, consultants to the state who are integrally involved in the quality initiatives described, and the CEO of a health plan participating in the RItE Care incentive program. In addition, we reviewed reports, articles, newsletters, and other relevant material about the quality-related initiatives in Rhode Island.

RELATED PUBLICATIONS

In the list below, items that begin with a publication number are available from The Commonwealth Fund by calling its toll-free publications line at **1-888-777-2744** and ordering by number. These items can also be found on the Fund's website at **www.cmwf.org**. Other items are available from the authors and/or publishers.

#597 *Assessing State Strategies for Health Coverage Expansion: Profiles of Arkansas, Michigan, New Mexico, New York, Utah, and Vermont* (December 2002, Web publication). Sharon Silow-Carroll, Emily K. Waldman, Heather Sacks, and Jack A. Meyer, Economic and Social Research Institute. The authors discuss, in detail, initiatives undertaken to maximize health insurance coverage in Arkansas, Michigan, New Mexico, New York, Utah, and Vermont.

#596 *Expanding Health Insurance Coverage: Creative State Solutions for Challenging Times* (December 2002). Sharon Silow-Carroll, Emily K. Waldman, Heather Sacks, and Jack A. Meyer, Economic and Social Research Institute. The authors summarize lessons from 10 states that have innovative strategies in place for health insurance expansion or have a history of successful coverage expansion. The report concludes with recommendations for federal action that could help states maintain any gains in coverage made and possibly extend coverage to currently uninsured populations.

#587 *Assessing State Strategies for Health Coverage Expansion: Summary of Case Studies of Oregon, Rhode Island, New Jersey, and Georgia* (November 2002). Sharon Silow-Carroll, Emily K. Waldman, Jack A. Meyer, Claudia Williams, Kimberley Fox, and Joel C. Cantor. These summaries of case studies look at four states' unique as well as shared experiences and draw lessons for other states. (See pub. **#565** for the full case studies.)

#577 *Toward Comprehensive Health Coverage for All: Summaries of 20 State Planning Grants from the U.S. Health Resources and Services Administration* (November 2002, Web publication). Heather Sacks, Todd Kutyla, and Sharon Silow-Carroll, Economic and Social Research Institute. In 2000, the DHHS' Health Resources and Services Administration awarded grants to 20 states to create comprehensive coverage plans for all citizens. These summaries report on the progress of states' coverage expansion efforts, detailing the history of reform, data on uninsured populations, actions taken, and goals for future efforts. Available at www.cmwf.org.

#565 *Assessing State Strategies for Health Coverage Expansion: Case Studies of Oregon, Rhode Island, New Jersey, and Georgia* (November 2002). Sharon Silow-Carroll, Emily K. Waldman, Jack A. Meyer, Claudia Williams, Kimberley Fox, and Joel C. Cantor. These case studies provide an in-depth account of four states' efforts to expand health coverage, detailing their relative strengths and weaknesses and highlighting what appear to be the key factors for success.

#574 *Employer Health Coverage in the Empire State: An Uncertain Future* (August 2002). According to this report, the combination of a weak economy, higher unemployment, and rising health care costs is placing pressure on New York State employers to eliminate or scale back health benefits for workers, their dependents, and retirees.

#559 *The Erosion of Employer-Based Health Coverage and the Threat to Workers' Health Care* (August 2002). Based on a Commonwealth Fund survey of health insurance in the workplace, this report finds that two of five workers experienced increases in their premiums or cost-sharing, or both,

during 2001. Although public support for job-based health insurance remains strong, many workers are not confident that employers will continue to offer coverage to them down the road. Workers are even more uncertain about their ability to get good health care in the future.

#509 *Family Out-of-Pocket Spending for Health Services: A Continuing Source of Financial Insecurity* (June 2002). Mark Merlis. This report examines trends in out-of-pocket spending, the components of that spending, and the characteristics of families with high out-of-pocket costs.

#557 *Eliminating Racial/Ethnic Disparities in Health Care: Can Health Plans Generate Reports?* (May/June 2002). David R. Nerenz, Vence L. Bonham, Robbya Green-Weir, Christine Joseph, and Margaret Gunter. *Health Affairs*, vol. 21, no. 3. The absence of data on race and ethnicity in health plan and provider databases is a significant barrier in the creation and use of quality-of-care reports for patients of minority groups. In this article, however, the authors show that health plans are able to collect and analyze quality of care data by race/ethnicity.

#556 *Do Enrollees in 'Look-Alike' Medicaid and SCHIP Programs Really Look Alike?* (May/June 2002). Jennifer N. Edwards, Janet Bronstein, and David B. Rein. *Health Affairs*, vol. 21, no. 3. In their analysis of Georgia's similar-looking Medicaid and SCHIP programs, the authors present three possible explanations for the differences in access to care between the two populations: Medicaid families are less familiar with and supportive of systems requiring use of an assigned primary care physician, the families face more nonprogram barriers to using care, and physicians have different responses to the two programs.

#527 *Are Tax Credits Alone the Solution to Affordable Health Insurance? Comparing Individual and Group Insurance Costs in 17 U.S. Markets* (May 2002). Jon R. Gabel, Kelley Dhont, and Jeremy Pickreign, Health Research and Educational Trust. This report identifies solutions that might make tax credits and the individual insurance market work, including raising the amount of the tax credits; adjusting the credit according to age, sex, and health status; and combining tax credits with new access to health coverage through existing public or private group insurance programs.

#518 *Bare-Bones Health Plans: Are They Worth the Money?* (May 2002). Sherry Glied, Cathi Callahan, James Mays, and Jennifer N. Edwards. This issue brief finds that a less-expensive health insurance product would leave low-income adults at risk for high out-of-pocket costs that could exceed their annual income.

#507 *Lessons from a Small Business Health Insurance Demonstration Project* (February 2002). Stephen N. Rosenberg, PricewaterhouseCoopers LLP. This report finds that the recently concluded pilot project, the Small Business Health Insurance Demonstration, launched by the New York City in 1997, was successful in providing a comprehensive, low-cost insurance option for firms with two to 50 workers. But poor implementation and marketing, plus flaws in product design, prevented the program from catching on among small businesses.

#528 *The APHSA Medicaid HEDIS Database Project* (December 2001). Lee Partridge, American Public Human Services Association. This study (available on the Fund's website only) assesses how well managed care plans serve Medicaid beneficiaries, and finds that while these plans often provide good care to young children, their quality scores on most other measures lag behind plans serving the commercially insured.

#512 *Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk* (December 2001). Lisa Duchon, Cathy Schoen, Michelle M. Doty, Karen Davis, Erin Strumpf, and Stephanie Bruegman. This report, based on The Commonwealth Fund 2001 Health Insurance Survey, finds that in the past year one of four Americans ages 19 to 64, some 38 million adults, was uninsured

for all or part of the time. Lapses in coverage often restrict people's access to medical care, cause problems in paying medical bills, and even make it difficult to afford basic living costs such as food and rent.

#513 *Maintaining Health Insurance During a Recession: Likely COBRA Eligibility* (December 2001). Michelle M. Doty and Cathy Schoen. This issue brief, based on The Commonwealth Fund 2001 Health Insurance Survey, examines the potential as well as limits of COBRA eligibility as a strategy for protecting workforce access to affordable health care benefits.

#514 *Experiences of Working-Age Adults in the Individual Insurance Market* (December 2001). Lisa Duchon and Cathy Schoen. This issue brief, based on The Commonwealth Fund 2001 Health Insurance Survey, describes the difficulties faced by those without access to group health coverage in obtaining adequate, affordable individual health insurance.

#478 *Universal Coverage in the United States: Lessons from Experience of the 20th Century* (December 2001). Karen Davis. This issue brief, adapted from an article in the March 2001 *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, traces how the current U.S. health care system came to be, how various proposals for universal health coverage gained and lost political support, and what the pros and cons are of existing alternatives for expanding coverage.

#511 *How the Slowing U.S. Economy Threatens Employer-Based Health Insurance* (November 2001). Jeanne M. Lambrew, George Washington University. This report documents the link between loss of health insurance and unemployment, estimating that 37 percent of unemployed people are uninsured—nearly three times as high as the uninsured rate for all Americans (14%). The jobless uninsured are at great financial risk should they become ill or injured.

#485 *Implementing New York's Family Health Plus Program: Lessons from Other States* (November 2001). Rima Cohen and Taida Wolfe, Greater New York Hospital Association. Gleaned from research into the ways 13 other states with public health insurance systems similar to New York's have addressed these matters, this report examines key design and implementation issues in the Family Health Plus (FHP) program and how Medicaid and the Child Health Plus program could affect or be affected by FHP.

#484 *Healthy New York: Making Insurance More Affordable for Low-Income Workers* (November 2001). Katherine Swartz, Harvard School of Public Health. According to the author, Healthy New York—a new health insurance program for workers in small firms and low-income adults who lack access to group health coverage—has so far been able to offer premiums that are substantially less than those charged in the private individual insurance market.

#475 *Business Initiatives to Expand Health Coverage for Workers in Small Firms* (October 2001). Jack A. Meyer and Lise S. Rybowski. This report weighs the problems and prospects of purchasing coalitions formed by larger businesses to help small firms expand access to health insurance. The authors say that private sector solutions alone are unlikely to solve the long-term problem, and the public sector will need to step in to make health insurance more affordable to small businesses.

#502 *Gaps in Health Coverage Among Working-Age Americans and the Consequences* (August 2001). Catherine Hoffman, Cathy Schoen, Diane Rowland, and Karen Davis. *Journal of Health Care for the Poor and Underserved*, vol. 12, no. 3. In this article, the authors examine health coverage and access to care among working-age adults using the Kaiser/Commonwealth 1997 National Survey of Health Insurance, and report that having even a temporary gap in health coverage made a significant difference in access to care for working-age adults.

#493 *Diagnosing Disparities in Health Insurance for Women: A Prescription for Change* (August 2001). Jeanne M. Lambrew, George Washington University. In this report, the author concludes that

building on insurance options that currently exist—such as employer-sponsored insurance, the Children’s Health Insurance Program (CHIP), and Medicaid—represents the most targeted and potentially effective approach for increasing access to affordable coverage for the nation’s 15 million uninsured women.

#472 *Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools* (August 2001). Lori Achman and Deborah Chollet, Mathematica Policy Research, Inc. The authors argue that high premiums, deductibles, and copayments make high-risk pools unaffordable for people with serious medical conditions, and suggest that by lifting the tax exemption granted to self-insured plans, states could provide their high-risk pools with some much-needed financing.

#464 *Health Insurance: A Family Affair—A National Profile and State-by-State Analysis of Uninsured Parents and Their Children* (May 2001). Jeanne M. Lambrew, George Washington University. This report suggests that expanding Medicaid and State Children’s Health Insurance Program (CHIP) coverage to parents as well as children may not only decrease the number of uninsured Americans but may be the best way to cover more uninsured children.

#445 *Expanding Employment-Based Health Coverage: Lessons from Six State and Local Programs* (February 2001). Sharon Silow-Carroll, Emily K. Waldman, and Jack A. Meyer, Economic and Social Research Institute. As with publication **#424** (see below), this report describes the various ways states and local communities are making coverage more affordable and accessible to the working uninsured, but looks more closely at programs in six of the states discussed in the earlier report.

#439 *Patterns of Insurance Coverage Within Families with Children* (January/February 2001). Karla L. Hanson. *Health Affairs*, vol. 20, no. 1. Using the 1996 Medical Expenditure Panel Survey, this article examines patterns of health insurance within families with children, determining that 3.2 million families are uninsured and another 4.5 million families are only partially insured.

#415 *Challenges and Options for Increasing the Number of Americans with Health Insurance* (January 2001). Sherry A. Glied, Joseph A. Mailman School of Public Health, Columbia University. This overview paper summarizes the 10 option papers written as part of the series *Strategies to Expand Health Insurance for Working Americans*.

#476 “*Second-Generation” Medicaid Managed Care: Can It Deliver?* (Winter 2000). Marsha Gold and Jessica Mittler, Mathematica Policy Research, Inc. *Health Care Financing Review*, vol. 22, no. 2. This study of Medicaid managed care programs in seven states finds that the programs require state policymakers to make difficult tradeoffs among the competing goals of improving Medicaid access, providing care for the uninsured, and serving those with special needs who are dependent on state-funded programs. Available online only at www.cmwf.org.

#422 *Buying into Public Coverage: Expanding Access by Permitting Families to Use Tax Credits to Buy into Medicaid or CHIP Programs* (December 2000). Alan Weil, The Urban Institute. Medicaid and CHIP offer administrative structures and plan arrangements with the capacity to enroll individuals and families. This paper, part of the series *Strategies to Expand Health Insurance for Working Americans*, proposes permitting, but not requiring, tax-credit recipients to use their credits to buy into Medicaid or CHIP. Available online only at www.cmwf.org.

#419 *Allowing Small Businesses and the Self-Employed to Buy Health Care Coverage Through Public Programs* (December 2000). Sara Rosenbaum, Phyllis C. Borzi, and Vernon Smith. Public programs such as CHIP and Medicaid offer the possibility of economies of scale for group coverage for small employers as well as individuals. This paper, part of the series *Strategies to Expand Health Insurance for Working Americans*, proposes allowing the self-employed and those in small businesses to buy coverage through these public plans, and providing premium assistance to make it easier for them to do so. Available online only at www.cmwf.org.

#424 *State and Local Initiatives to Enhance Health Coverage for the Working Uninsured* (November 2000). Sharon Silow-Carroll, Stephanie E. Anthony, and Jack A. Meyer, Economic and Social Research Institute. This report describes the various ways states and local communities are making coverage more affordable and accessible to the working uninsured, with a primary focus on programs that target employers and employees directly, but also on a sample of programs targeting a broader population.

#411 *ERISA and State Health Care Access Initiatives: Opportunities and Obstacles* (October 2000). Patricia A. Butler. This study examines the potential of states to expand health coverage incrementally should the federal government decide to reform the Employee Retirement Income Security Act (ERISA) of 1974, which regulates employee benefit programs such as job-based health plans and contains a broad preemption clause that supercedes state laws that relate to private-sector, employer-sponsored plans.

#392 *Disparities in Health Insurance and Access to Care for Residents Across U.S. Cities* (August 2000). E. Richard Brown, Roberta Wyn, and Stephanie Teleki. A new study of health insurance coverage in 85 U.S. metropolitan areas reveals that uninsured rates vary widely, from a low of 7 percent in Akron, Ohio, and Harrisburg, Pennsylvania, to a high of 37 percent in El Paso, Texas. High proportions of immigrants and low rates of employer-based health coverage correlate strongly with high uninsured rates in urban populations.

#385 *State Experiences with Cost-Sharing Mechanisms in Children's Health Insurance Expansions* (May 2000). Mary Jo O'Brien et al. This report examines the effect of cost-sharing on participation in the State Child Health Insurance Program (CHIP).

#384 *State Experiences with Access Issues Under Children's Health Insurance Expansions* (May 2000). Mary Jo O'Brien et al. This report explores how the design and administration of state incremental insurance expansions affect access to health insurance coverage and, ultimately, access to all health care services.

#380 *Educating Medicaid Beneficiaries About Managed Care: Approaches in 13 Cities* (May 2000). Sue A. Kaplan, Jessica Green, Chris Molnar, Abby Bernstein, and Susan Ghanbarpour. In this report, the authors document the approaches used and challenges faced in Medicaid managed care educational efforts in 13 cities across the country.

#366 *National Medicaid HEDIS Database/Benchmark Project: Pilot-Year Experience and Benchmark Results* (February 2000). Lee Partridge and Carrie Ingalls Szlyk, American Public Human Services Association. This report summarizes the first year of a project to create national summaries of state Medicaid HEDIS data and national Medicaid quality benchmarks against which each state can measure its program's performance.

#368 *Managed Care in Three States: Experiences of Low-Income African Americans and Hispanics* (Fall 1999). Wilhelmina A. Leigh, Marsha Lillie-Blanton, Rose Marie Martinez, and Karen Scott Collins. *Inquiry*, vol. 36, no. 3. This article examines the experiences of low-income Hispanics, African Americans, and whites enrolled in managed care plans in Florida, Tennessee, and Texas and compares them to their racial/ethnic counterparts enrolled in fee-for-service plans.

#260 *State-Subsidized Health Insurance Programs for Low Income Residents: Program Structure, Administration, and Costs* (April 1998) Laura Summer, Alpha Center. In an effort to determine states' success in covering uninsured populations, the author interviewed public insurance officials in 12 states and reviewed their programs' administrative structures, use of managed care, eligibility rules, and application and enrollment processes.

