



# The Commonwealth Fund Quarterly

A DIGEST OF CURRENT WORK IN HEALTH POLICY AND PRACTICE

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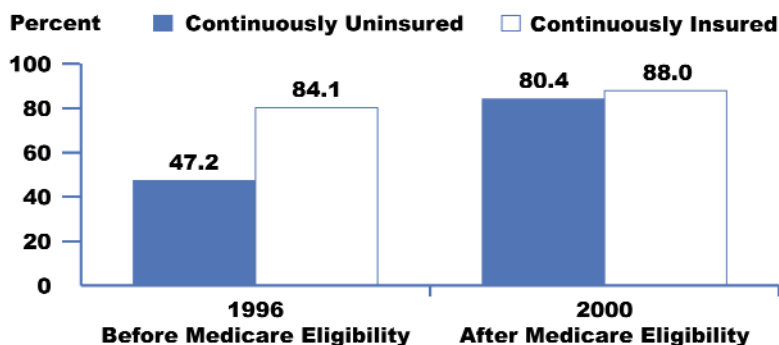
## JAMA Study: Medicare Coverage Boosts Use of Clinical Services

**G**aining access to Medicare coverage dramatically improves previously uninsured older adults' use of a range of preventive services, including cholesterol testing, mammography, and prostate exams, according to a recent study in the *Journal of the American Medical Association*. The findings suggest that if there were affordable options through which uninsured adults approaching age 65 could purchase Medicare coverage, they would likely take advantage of more potentially life-saving tests.

Researchers at Harvard Medical School and Brigham and Women's Hospital found that prior to Medicare eligibility, only 47 percent of uninsured adults ages 55 to 64 with hypertension or diabetes received cholesterol testing, compared with 84 percent of a comparable group of insured adults. But once uninsured adults gained Medicare coverage, the gap was dramatically reduced, from 37 percentage points to 8 percentage points. The study, "Impact of Medicare Coverage on Basic Clinical Services for Previously Uninsured Adults" (*JAMA*, Aug. 13), by J. Michael McWilliams, M.D., Alan M. Zaslavsky, Ellen Meara, and

*Continued on page 3*

**Rates of Cholesterol Testing Before and After Medicare Eligibility for Near-Elderly Adults with Hypertension or Diabetes**



Source: J. M. McWilliams, A. M. Zaslavsky, E. Meara, and J. Z. Ayanian, "Impact of Medicare Coverage on Basic Clinical Services for Previously Uninsured Adults," *Journal of the American Medical Association* 290 (August 13, 2003): 757-64.

## Grantee Spotlight

# Marian Earls, M.D.

In 2000, North Carolina was one of four states selected to participate in The Commonwealth Fund's [Assuring Better Child Health and Development \(ABCD\)](#) program to strengthen child development services for low-income children. At the time, North Carolina referred only 2 to 4 percent of children to early intervention services, even though 12 to 16 percent of young children nationally have some type of developmental or behavioral disorder. Marian Earls, M.D., medical director of Guilford Child Health in Greensboro, led a [demonstration project](#) that integrated developmental screening and case management into three Guilford clinics that serve low-income children. Today, this model of care has spread to 49 pediatric and family practices in North Carolina—and raised average referral rates for early intervention services to 7 or 8 percent. We asked Dr. Earls what she learned from the project, and about its potential for further replication.

*When you first started looking at how Guilford clinics were handling child development services, what did you find?*

**Marian Earls:** Clinics were supposed to be using the Denver Developmental Screening Test, which takes a nurse 20 to 30 minutes to administer. We found that the test was being given at only 3 to 5 percent of well-child visits, mostly because of staffing and time shortages.

*You eventually chose the parent-completed Ages & Stages Questionnaire as part of the new model of delivering care. Why?*

**Earls:** I always tell people that it wasn't rocket science: we looked at the different screening tools that were available, how specific the questions were, how long they took to complete, who had to complete it, and what language and reading level they were in. Ages & Stages met our needs. Parents are excellent reporters of their child's activities. Plus, it's a good way to involve them in a conversation about their child's care.



Under the direction of Marian Earls, M.D., several North Carolina clinics have raised screening rates and strengthened child development services.

*How did you get pediatricians interested in changing the way they approach child development?*

**Earls:** With this project, physicians were involved from the beginning, and they had a say in how the new model would be integrated into their practice. We've found that using the screening tool can actually improve doctor-patient communication. If a doctor asks, "Your child is talking already, isn't he?," a parent might be put on the defensive. But the screening process formalizes these conversations and builds trust. One physician even told us that using Ages & Stages questions as a template for discussion has sped up his office visits. The questionnaire can also help pediatricians talk with parents about the bread-and-butter issues—kids who don't sleep well, or don't behave in public places—that might not come up during a visit but can cause a lot of stress.

*What kind of feedback have you gotten?*

**Earls:** Many parents tell us they appreciate being asked about their child's development. Even for the 93 percent whose kids don't have problems, the screening can still provide useful information. The early intervention specialist we hired to oversee the screening process and coordinate referrals makes personal contact with parents of kids who are referred to the Head Start program as well as to speech pathologists and other services. She also lends support to families who are concerned about their child's development.

*The Commonwealth Fund's ABCD initiative relies on change at the practice and community levels. How do you translate this to broader change throughout the state?*

**Earls:** Getting physicians on board from the beginning was very important. If you want to change physician behavior, you really have to work on the ground. By next summer, Health Check [part of the state's Medicaid program], plans to make a recommendation to all pediatricians and family practitioners to employ a formal screening tool and start billing for it. Right now, the model is being used in practices that primarily have large numbers of Medicaid patients, but smaller practices with patients from all different parts of the community are starting to get interested. ❖

John Z. Ayanian, M.D., was supported by The Commonwealth Fund.

Similar results were found for use of mammograms to detect breast cancer. Prior to Medicare coverage, 46 percent of uninsured women examined received mammograms, versus 76 percent of insured women—a 30-percentage-point difference. After gaining Medicare, however, the gap between the previously uninsured and insured patients was cut in half, to 15 percentage points. Differences in prostate cancer screening rates between uninsured and insured men, meanwhile, fell from 45 percentage points before Medicare eligibility to 20 percentage points after.

“The marked increases in the use of mammography and cholesterol testing show distinct benefits for previously uninsured adults who gain Medicare coverage,” said Dr. Ayanian. “The results show that extending Medicare coverage to these adults before age 65 has the potential to save many lives through prevention or earlier detection and treatment of major medical conditions.”

The full article is available for free download on *JAMA*'s website at <http://jama.ama-assn.org>. ❖

## Uninsured Not Reaping Benefits of Medical Technology, Study Finds

**A**dvances in medical technology have dramatically improved the lives of millions of people in the United States. But are all Americans benefiting equally? A study of three common conditions treated in both hospital and outpatient settings has found that patients without health insurance are not getting the latest treatment as often as those with coverage. What's more, the access gap is costing society an estimated \$1.1 billion yearly due to higher morbidity and mortality.

For their study, “[The Uninsured and the Benefits of Medical Progress](#)” (*Health Affairs*, July/August 2003), Columbia University analysts Sherry Glied and Sarah E. Little, working under a grant from The Commonwealth Fund, compared technology use rates among the insured and uninsured for heart attack, cataracts, and depression. Focusing on the 55-to-64 age group, Glied and Little found that in every case, the group with health coverage had received the high-tech treatment at lower rates compared with the group without coverage.

**Heart attack.** According to the analysis, uninsured people who suffered a heart attack were about 7 percent less likely than insured people to receive an invasive cardiac procedure. If the uninsured patients had received the appropriate treatment, anywhere from \$6 million to \$28 million could have been saved annually in medical and death-related costs.

**Cataracts.** The prevalence of cataracts ranges from 4.5 percent to 10 percent for people ages 55 to 64. Many in this age group who lack insurance go without expensive cataract surgery, which costs up to \$3,000. The authors estimate that 9 percent to 20 percent of the privately insured were treated for their cataracts, compared with 2 to 5 percent of the uninsured. They conclude that this gap in treatment costs society nearly \$900 million a year in morbidity-related expenses.

**Depression.** Even though mental health problems are more common among the uninsured, this group is less likely to be treated for mental illness: among individuals with general anxiety disorder, major depression, or panic disorder, those with mental health coverage are more than twice as likely to receive treatment as those without. The authors estimate that to reach the privately

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### Net Benefits Lost Because of Lower Access to Technology Among Uninsured Adults Ages 55–64

	Number of Uninsured Who Could Benefit from Increased Access	Net Benefits Forgone
Increased acute myocardial infarction (heart attack) treatment	464	\$6 million to \$28 million
Increased cataract treatment	22,000	\$894 million
Increased depression treatment	43,000	\$213 million
Total net benefit	—	\$1.1 billion
Net benefit per person <sup>a</sup>	—	\$343–\$349

<sup>a</sup> Using the Current Population Survey estimate of the total number of uninsured people ages 55–64. Source: S. Glied and S. E. Little, “The Uninsured and the Benefits of Medical Progress,” *Health Affairs* 22 (July/August 2003): 210–19.

insured rate, an additional 43,000 uninsured patients would need to have received outpatient care for depression in 2000. The gap in care resulted in a \$213 million loss.

As medical technology continues to improve, these losses will only grow if barriers to insurance are not addressed, the authors report. “More research is needed not only on the benefits new technologies provide,” Glied says, “but on the extent to which insurance plays a role in accessing these treatments.”❖

## Medicare Waiting Period Puts Disabled Adults in Limbo

**M**edicare provides coverage for adults with severe disabilities, in addition to the elderly. But disabled Americans suffering from multiple sclerosis, mental illness, or other serious impairments must wait two years after qualifying for disability insurance before receiving their Medicare benefits.

In fact, nearly 1.3 million disabled Americans under age 65, including as many as 400,000 without any health

insurance, are currently in the two-year wait for Medicare coverage, according to a Commonwealth Fund brief. Before they can be considered for Medicare coverage, disabled adults under 65 must first qualify for Social Security Disability Insurance (SSDI) by satisfying work history requirements and proving that they are too disabled to work. After waiting five months for disability benefits, they begin the two-year wait for Medicare.

Stacy Berg Dale and James M. Verdier, analysts at Mathematic Policy Research and the authors of *Elimination of Medicare’s Waiting Period for Seriously Disabled Adults: Impact on Coverage and Costs*, say that eliminating the requirement would not only provide immediate coverage to those who cannot work because of their severe chronic condition, it would offer significant fiscal relief to cash-strapped states. Forty percent of disabled adults in the waiting period qualify for state Medicaid programs, and these individuals account for a substantial share of total Medicaid spending.

“At a time when states are considering steep cuts in essential services, eliminating this hurdle to Medicare

Nearly 1.3 million disabled Americans, including as many as 400,000 without any health insurance, are currently in the two-year wait for Medicare.

could make a real difference in states' ability to maintain insurance coverage," Verdier said. "Our analysis illustrates that savings could help states keep Medicaid coverage for children and families, or the elderly and disabled's safety net for services not covered by Medicare. If Medicare included prescription drugs, state Medicaid savings could potentially be even greater."

The authors estimate that by abolishing the wait, states would save an estimated \$1.8 billion per year in health care costs that would now be covered by Medicare—savings that could help avert cutbacks in Medicaid benefits and tightening of eligibility standards. Federal Medicaid expenditures for the disabled would also be reduced, by \$2.5 billion, offsetting some of the \$8.7 billion increase in federal Medicare expenses that would result from the change.

When it was enacted in 1972, the waiting period for SSDI beneficiaries was intended in part to avoid the displacement of private coverage. But as

the authors note, even if some displacement does occur, employers' costs of providing COBRA and other coverage to SSDI beneficiaries are in most cases substantially higher than the premiums those beneficiaries pay. Medicare coverage could provide some relief to employers for these costs, while stabilizing private coverage for employees without disabilities. ❖

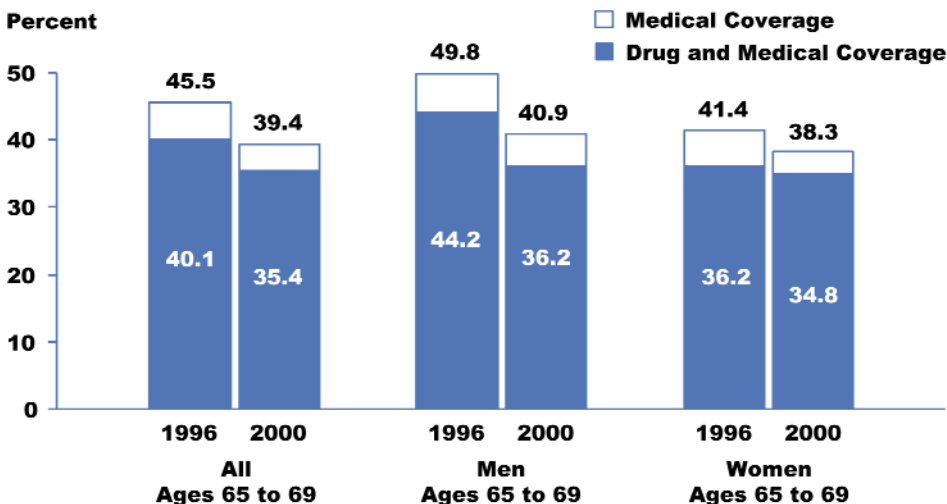
## Dramatic Decline in Employer Drug Coverage for New Retirees

**D**espite its reputation as the most reliable private source of prescription drug coverage for Medicare beneficiaries, employer-sponsored health insurance is becoming increasingly less dependable for new retirees.

A recent *Health Affairs* Web Exclusive study supported by The Commonwealth Fund has found a sharp decline in the proportion of retirees ages

From 1996 to 2000, the percentage of Medicare beneficiaries ages 65 to 69 with employer-sponsored health insurance fell from 46 percent to 39 percent.

**Percentage of 65-to-69-Year-Old Medicare Beneficiaries with Employer-Sponsored Medical and Drug Coverage, 1996 and 2000**



Source: B. Stuart, P. K. Singhal, C. Fahlman, J. Doshi, and B. Briesacher, "Employer-Sponsored Health Insurance and Prescription Drug Coverage for New Retirees: Dramatic Declines in Five Years," *Health Affairs* Web Exclusive (July 23, 2003): W3-334-W3-341.

65 to 69 with medical coverage, including prescription benefits, from an employer. Moreover, all indications point to further erosion as employers continue to cut back on coverage for new retirees.

Results from the study, “[Employer-Sponsored Health Insurance and Prescription Drug Coverage for New Retirees: Dramatic Declines in Five Years,](#)” show that from 1996 to 2000, the percentage of Medicare beneficiaries in the 65-to-69 age group who had employer-sponsored health insurance fell from 46 percent to 39 percent. There was a similar decline in the proportion of this group with drug benefits, from 40 percent to 35 percent. Health coverage for older retirees (age 70 and older) has remained relatively stable.

According to authors Bruce Stuart and colleagues at the University of Maryland School of Pharmacy, men have accounted for most of the loss in retirement benefits in this age group. In fact, the share of men who were receiving benefits from their own retirement policies fell 26 percent from 1996 to 2000. The erosion would have been more severe had men not increasingly received coverage under their spouses’ policies.

Worse still, there is nothing to suggest that the pullback in employer offers of retiree health benefits has reached bottom, say the authors. A [2001 employer survey](#) found that firms are likely to reduce their level of retiree coverage in the future. In addition, the historical increase in labor-force participation by women has nearly reached its peak; future increases will likely be too small to counteract declining employer coverage offer rates.

Most new retirees have so far managed to cope with declining offers

of health coverage from their former employers, relying on Medicare+Choice managed care plans, Medicaid, Veterans Affairs, and other public programs, individually purchased private insurance (Medigap plans), or a combination of plans. But as the study points out, only a small proportion of new retirees are eligible for public programs. Meanwhile, none of the standardized Medigap policies and only a handful of Medicare+Choice plans currently available are as generous in their drug coverage as the typical employer-sponsored policy.

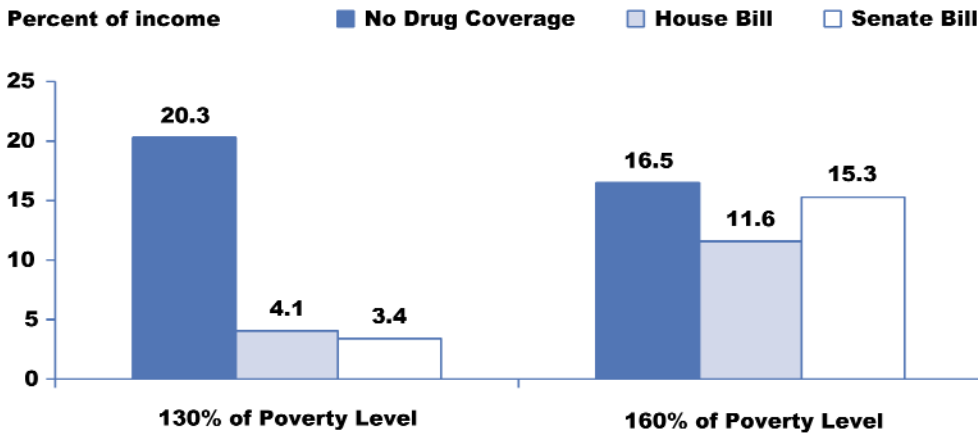
The erosion in retiree coverage, coupled with a lack of adequate alternatives, adds particular urgency to the Medicare drug debate. “The future of employer-sponsored health insurance looks bleak,” said Stuart, the study’s lead author. “In the face of continued rising prescription drug costs, employers may choose to abandon providing any coverage at all. At least a properly structured Medicare drug benefit would provide employers with an incentive to maintain coverage for critical medical benefits.” ❖

## Proposed Medicare Drug Bills Offer Limited Relief to ‘Near-Poor’

**M**any elderly and disabled Medicare beneficiaries with very modest incomes would see limited benefit from prescription drug legislation pending in Congress, according to an analysis released by The Commonwealth Fund at an August 15 news briefing held by the Alliance for Health Reform in Washington, D.C. As reported in [Caught in Between: Prescription Drug Coverage of Medicare Beneficiaries Near Poverty](#), a couple living at only 160 percent of the poverty level in 2006 (\$20,944) could still pay a sub-

Medicare beneficiaries with very modest incomes would see little benefit from prescription drug legislation pending in Congress.

### Impact of House and Senate Bills on Out-of-Pocket Spending of Near-Poor Elderly Couples, 2006



Note: To derive spending for a couple, the average spending for a married man was combined with the average spending for a married woman.

Source: D. Shea, B. Stuart, and B. Briesacher, *Caught in Between: Prescription Drug Coverage of Medicare Beneficiaries Near Poverty*, The Commonwealth Fund, August 2003.

stantial part of their income on prescription medications—11.6 percent, or \$2,437—under the current House bill. Under the Senate bill, this couple could spend 15.3 percent of their income, or \$3,208.

The authors, Dennis G. Shea of Pennsylvania State University and Bruce C. Stuart and Becky Briesacher of the University of Maryland, say that while both bills would provide significant relief for beneficiaries at lower income levels, premium and cost-sharing subsidies would be phased out for those with only slightly higher incomes. Near-poor Medicare beneficiaries are less likely than those with higher or lower incomes to have prescription drug coverage and more likely to spend a high percentage of their income on prescriptions.

Commenting on the report's findings, Karen Davis, president of The Commonwealth Fund, said that both the House and Senate bills fall short in the help they provide to needy beneficiaries. "Most of the analyses today have

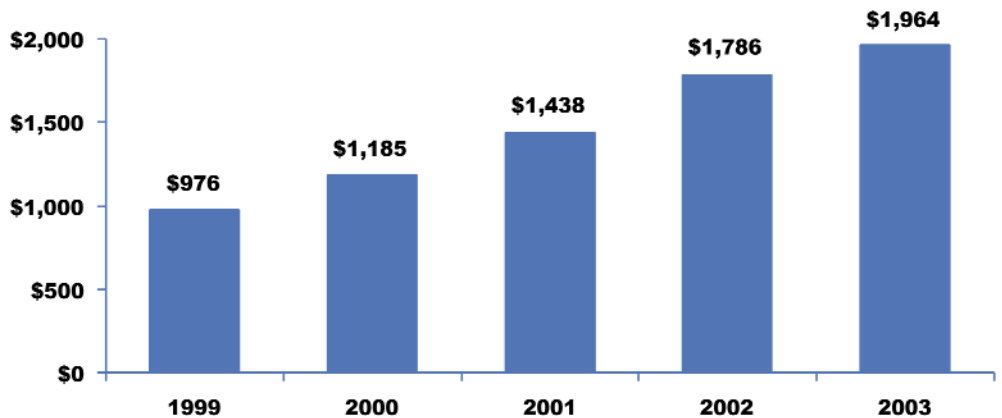
focused on an individual beneficiary, but for an elderly couple trying to get along on a very modest income, high drug costs can be devastating. The bills now being debated in Congress will still burden many of these couples, with large shares of their incomes devoted to paying for drugs."❖

## Medicare+Choice Costs for Enrollees Doubled in Four Years

Over the last four years, average plan premiums and other out-of-pocket costs have more than doubled for enrollees in Medicare+Choice, the Medicare program's managed care component. Mathematica Policy Research analysts Marsha Gold and Lori Achman, authors of a Commonwealth Fund issue brief that details cost trends in the program, also report that enrollees in poor health spend three times more out-of-pocket than those in good health.

*Medicare+Choice enrollees in poor health spend three times more out-of-pocket than those in good health.*

### Average Annual Out-of-Pocket Cost-Sharing Expenses for Medicare+Choice Enrollees, 1999–2003



Note: Results are weighted by plan enrollment. Out-of-pocket cost estimates include the Medicare Part B premium, the Medicare+Choice premium, spending for physician and hospital copayments, and outpatient prescription drugs not covered by the M+C package.

Source: M. Gold and L. Achman, *Average Out-of-Pocket Health Care Costs for Medicare+Choice Enrollees Increase Ten Percent in 2003*, The Commonwealth Fund, August 2003.

“As Congress debates the role of private plans in the future of the Medicare program, it should consider the eroding financial protection experienced under Medicare+Choice,” said Gold, the lead author of *Average Out-of-Pocket Health Care Costs for Medicare+Choice Enrollees Increase Ten Percent in 2003*. Costs for enrollees in Medicare+Choice have steadily risen since 1999, the first year Gold and Achman analyzed beneficiary spending in the Medicare+Choice program. In 2003, enrollees will pay an average of \$1,964 in out-of-pocket expenses for health care, compared with \$976 in 1999.

The report also reveals that out-of-pocket spending for enrollees in Medicare PPO (preferred provider organization) demonstration plans is nearly 50 percent higher, on average, than costs for those in Medicare+Choice plans. Gold and Achman estimate that enrollees in the PPO plans, which the federal government implemented in 2003 to give Medicare+Choice enrollees more plan options, will spend

\$2,884 out-of-pocket in 2003. That is substantially higher than the \$1,964 in average annual costs for those in Medicare+Choice plans.

Sicker Medicare+Choice enrollees face even higher cost burdens. Those in poor health will spend about three times more out-of-pocket than those in good health. Costs for sicker plan enrollees also increased at a faster rate over the four-year period than did costs for healthy enrollees. From 1999 to 2003, average out-of-pocket costs for beneficiaries in poor health climbed from \$2,211 to \$5,305. Annual costs for those in good health rose from \$836 to \$1,564. ❖

## Medicare+Choice: A Cautionary Tale for Medicare Reformers

**B**efore Congress adopts any proposal to shift more Medicare beneficiaries into private insurance plans, it may first want to review the often tumultuous history of the six-

The nation's experience with Medicare+Choice highlights just how difficult it is for private plans to reduce their total health care costs while offering beneficiaries additional benefits.

year-old Medicare+Choice program, the managed care alternative to traditional fee-for-service Medicare. According to an analysis from The Commonwealth Fund, the nation's experience with Medicare+Choice highlights just how difficult it is for private plans not only to reduce their total health care costs from the level of fee-for-service Medicare, but to offer beneficiaries additional benefits and more coverage choices while still turning a profit.

"Policy experts projected that Medicare+Choice plans would expand to all parts of the country, that educated beneficiaries would be making informed choices based on costs and quality, and that plan competition would reduce overall costs to the Medicare program and beneficiaries alike," says Geraldine Dallek, the lead author of *Lessons from Medicare+Choice for Medicare Reform*. "None of these predictions has come to pass."

Enrollment in Medicare+Choice plans, originally projected to reach 34 percent of Medicare beneficiaries by 2005, currently stands at 11 percent, after declining from 16 percent in 1998.

### **Rural Regions Not Well Served**

Dallek, an independent health policy consultant, along with coauthors Brian Biles and Lauren Hersch Nicholas of George Washington University, says that some parts of the country have never been attractive to Medicare HMOs and other managed care plans. This has especially been the case in rural areas, where only 13 percent of Medicare beneficiaries even have the option of joining a managed care plan. In 19 states, many of them rural, less than 1 percent of Medicare beneficiaries are enrolled in private plans. Although payment rates for plans in rural locales exceed fee-for-service costs, only a small number of hospitals and physicians are available—

and many are reluctant to contract with managed care plans.

No significant inroads have been achieved by other types of private plans, either. The two private fee-for-service plans that participate in Medicare+Choice, Sterling and Humana, have a combined enrollment of less than 23,000. Meanwhile, the 31 preferred provider organizations (PPOs) established under a federal demonstration have failed to expand beneficiaries' choice in areas where there are no Medicare HMOs.

### **Instability in Plan and Provider Participation**

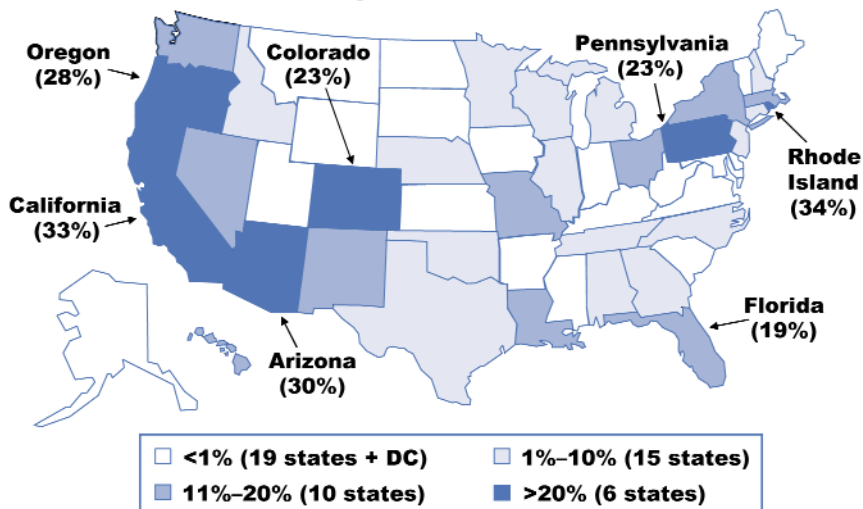
A large number of Medicare+Choice plans that had managed to attract significant enrollment have since withdrawn from local markets or cut back on their service areas. From 1999 to 2003, more than 2.4 million beneficiaries had their health care disrupted as a result of plan withdrawals or service cutbacks. Plans' motivating factors have been varied, from soaring prescription drug costs to hospitals' and physicians' refusal to accept risk contracts. Physician and hospital participation in plans has been unstable as well: nine of 36 states had Medicare+Choice primary care turnover rates of 20 percent or more.

### **Plan Design an Obstacle**

The report also finds that Medicare+Choice plan design can also discourage enrollment by high-risk beneficiaries. Across the nation, plans have increased costs on specific services most likely to be used by enrollees with costly chronic conditions, such as hospital care, dialysis and radiation therapy. Plan options, the authors say, are also too complicated for many elderly beneficiaries, a substantial number of whom are cognitively impaired. Although choice of health plans is the cornerstone of competition

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### Medicare+Choice Enrollees as a Percent of Medicare Beneficiaries, by State, 2003



Source: G. Dallek, B. Biles, and L. H. Nicholas, *Lessons from Medicare+Choice for Medicare Reform*, The Commonwealth Fund, June 2003, from Henry J. Kaiser Family Foundation, *Medicare+Choice Fact Sheet*, April 2003. Data from Centers for Medicare and Medicaid Services, *Medicare Managed Care Contract Plans Monthly Summary Report*, March 2003.

in the private marketplace, the complex range of choices in Medicare+Choice benefits and cost-sharing make it difficult for anyone to make an informed choice.

But perhaps the finding most immediately relevant for policymakers looking to control Medicare spending is that private plans do not cost less than traditional Medicare. In fact, private plans can actually *increase* program costs: Medicare, to attract private plans in more rural areas, increases payments above the level it pays in these areas for traditional Medicare. Moreover, private plans have higher administrative costs than Medicare, including costs associated with marketing and, in the case of for-profit plans, a return for investors. ❖

## Medicaid Managed Care Plans Share Ideas for Improving Kid Care

**C**hildren can learn to share. Apparently, so too can managed care plans that serve children.

*Children can learn to share. Apparently, so too can managed care plans that serve children.*

With guidance from the Center for Health Care Strategies (CHCS) and support from The Commonwealth Fund, a working group of 12 Medicaid managed care plans is sharing ideas, setting common goals, and identifying “best practices” to improve the developmental services provided to the plans’ youngest patients. The group is following a four-step framework that so far is working well: identifying children under age 6 in need of a developmental service, classifying their developmental needs, reaching out to the targeted families, and designing specific interventions. Common developmental problems in young children include learning disabilities, visual or hearing impairments, and behavioral disorders.

Medicaid is the single most important source of health insurance coverage for low-income children under age 6, and well over half of Medicaid-covered children are enrolled in a managed care plan. As part of their emphasis on prevention, these plans often support

developmental screening for children, parent counseling, and other services that promote healthy development. But they also face challenges in engaging health care providers in the provision of developmental care and in measuring the effectiveness of services provided.

The 12 plans are developing customized strategies based on their members' needs. Virginia Premier Health Plan aims to have three-quarters of its providers perform developmental screening on high-risk children up to age 3. Boston Medical Center Health Plan, meanwhile, hopes to enlist parents' help in tracking their children's developmental milestones through collaboration with an established child literacy program.

Attempting to treat developmental problems at the earliest possible stages, Massachusetts-based Network Health will create a user-friendly yet rigorous screening regimen to identify developmental problems in infants from 6 to 18 months old. The plan is working with one large practice to implement use of the parent-completed Ages & Stages Questionnaire, both in pediatric offices and in home visits. During home visits, trained family service workers from a local visiting nurse association will help parents perform the developmental evaluation and assess the family's social environment. According to Albert Yee, M.D., chief medical officer of Network Health, physicians really liked this aspect of the project.

"Parents are usually more relaxed at home, and visitors can see things in homes that pediatricians can't see in the office," Yee said. Family service workers submit reports to the pediatricians, helping to close the communication loop.

"My advice to other plans: start big and then get real," added Peggy

Waters, maternal child health program manager at Network Health. "We had really grandiose ideas in the beginning. Now what we're doing feels solid."

By next year, Network Health and the other members of the collaborative will have finalized a "toolkit" of lessons learned and proven clinical and administrative practices. CHCS plans to disseminate the toolkit to Medicaid agencies and State Children's Health Insurance Programs around the country. ❖

## Tools Created to Improve Developmental Services

**Y**oung children with developmental problems often miss out on the care they need because their health insurance will not cover it, their pediatrician does not provide it, or their community lacks the resources to offer it. Without these essential health services, many of these children begin school without the physical, social, emotional, or cognitive skills they need to succeed.

Poor children are particularly vulnerable: research shows they are less likely than their more affluent peers to be ready for kindergarten, more likely to fall behind as grade-schoolers, and more likely to drop out of school. But the good news is that early intervention can help.

Through the Commonwealth Fund's [Assuring Better Child Health and Development \(ABCD\)](#) initiative, four states—North Carolina, Utah, Vermont, and Washington—developed strategies to enhance the financing and delivery of early child development services for low-income children. After three years, the states have screened

*"States can do much to strengthen, sustain, and expand early child development services—even in the current fiscal environment."*

greater numbers of children for developmental problems, created targeted case management programs for children at risk, built alliances between pediatricians and parents, and standardized the delivery of developmental services. The fruits of this labor have been harvested for the [ABCD Toolbox \(www.nashp.org\)](http://www.nashp.org), a rich compendium of information and resources for state Medicaid officials, State Children's Health Insurance Program administrators, legislators, pediatricians, case workers, researchers, and parents.

"For states seeking to strengthen the early childhood development services they offer low-income children, the toolbox offers a tremendous amount of helpful information," said Helen Pelletier, director of communications at the National Academy for State Health Policy, which administers the ABCD program. "States can do much to strengthen, sustain, and expand early child development services—even in the current fiscal environment. And the toolbox helps prove the point by showcasing the resources and strategies developed by states committed to the goal in good times and bad."

For states, the toolbox includes technical assistance materials to help with coordination of services and funding among local, state, and federal entities. Financing and policy recommendations are also provided, plus the latest research findings on the effectiveness of developmental services. For pediatricians, the toolbox has developmental screening instruments and information about what parents want and need from their child's physician. Parents, meanwhile, can benefit from the child health guidelines and practical child-rearing advice that are included.

Building on the success of the first ABCD program, The Commonwealth

Fund and NASHP recently launched ABCD II. The new initiative is focused on building the capacity of state Medicaid agencies to provide preventive mental health services for children in low-income families—particularly services that address social and emotional problems, which can affect behavior and learning ability. ❖

## Quality Improvement Must Be 'Lifetime Obsession'

**S**peaking at the annual U.S.–U.K. meeting on quality improvement sponsored by The Commonwealth Fund, Matthew Chin invoked a concept not usually mentioned in health care circles—Newton's second law of thermodynamics. Chin, who directs the health care team at New York City's Primary Care Development Corporation (PCDC), cautioned the assemblage of experts that, just as energy disperses in nature, systems tend to fall apart. He was referring in this case to improved systems of care, which he said require constant maintenance and vigilance against backsliding.

"We have learned that quality improvement is not a project," Chin told the gathering. "It is a lifetime obsession that requires continual organizational focus, resources, and course corrections."

Chin's talk was [based on a paper he prepared](#) for the Fund's July conference, which was held in Pennyhill Park, England, and cosponsored by the London-based Nuffield Trust. Among the 40 senior policymakers and experts participating were Carolyn Clancy, M.D., director of the U.S. Agency for Healthcare Research and Quality, and Sir Liam Donaldson, chief medical

*"Quality improvement is a lifetime obsession that requires continual organizational focus, resources, and course corrections."*



At a U.S.–U.K. conference, Matthew Chin warned that constant vigilance is needed to ensure that quality improvements in health care stand the test of time.

interruptions to work or school days, and clinics are able to see more patients.

Yet, even though PCDC interventions have been able to produce consistent results across different clinics, they have inevitably run up against the force of entropy—something with which every system must contend. To better sustain its improvements over time, PCDC plans to introduce new elements into its learning collaboratives. Leaders from each organization will be encouraged to implement systems for defining, measuring, and sharing results, and PCDC staff will provide coaching and periodic follow-up.

“No process can ever be 100 percent foolproof, and no process can stay in place unless we work to keep it in place,” Chin said. “We need to work together to stay on the scale and maintain our wait loss.”

Chin’s talk was certainly a highlight of the three-day conference. Participants also were updated on the NHS plan to begin rolling out an electronic medical record system for hospitals and doctors’ offices across the U.K. in 2004. A briefing on the recently launched “Premier Hospitals” demonstration, meanwhile, explained how the Centers for Medicare and Medicaid Services plans to reward U.S. hospitals that provide superior care. ❖

## Wait Is Getting Shorter at NYC Medicaid Offices

**N**ew York’s Medicaid offices sure aren’t what they used to be. Thanks to new technology and more efficient work processes, the seemingly endless waits long endured by enrollees and applicants seeking help have been replaced by much shorter lines and more targeted, friendlier service.

officer for the U.K.’s Department of Health. Health policy leaders from Australia and New Zealand were also in attendance.

Chin’s organization, PCDC, works with health care clinics that primarily serve the poor and the uninsured, for whom delays in securing appointments and hours-long waits to see doctors are typical. Through its “Wait Loss” series of learning collaboratives, PCDC helps clinics reengineer appointment scheduling and office procedures to build a patient-centered model of care. Chin said the goal is to achieve visits that last no more than an hour, including time spent waiting to see a doctor, and to allow patients to make an appointment with their own provider within 24 hours.

These learning collaboratives have dramatically improved patient satisfaction and continuity of care. Eighteen participating teams reduced average office visit from 99 minutes to 50 minutes, and five teams reduced delays for appointments from an average of 29 days to just four days—an 85 percent reduction. As a result, patients endure fewer

.....  
*While Medicaid applications once took well over two hours, average enrollment time in the 10 model offices is 47 minutes.*  
 .....

The remarkable transformation is a result of the Medicaid Model Office Project, an initiative developed by the Human Resources Administration and the Mayor's Office of Health Insurance Access with support from the Commonwealth Fund, United Hospital Fund, and New York Community Trust. The project's goal: to dismantle barriers to health insurance coverage.

"We know that about half of the uninsured in the city are eligible for public health programs but not enrolled," said Jennifer Edwards, director of The Commonwealth Fund's Health Care in New York City program. "Simplifying the process of enrollment could go a long way toward reducing the number of uninsured."

Although New York's Medicaid program is one of the most generous in the country in terms of eligibility criteria and benefits offered, enrollment had long been a daunting process. Applicants were required to provide substantial documentation and make at least two visits to community offices, where staff were frequently overwhelmed. For working families, the process often threw up too many logistical hurdles.

Beginning in June 2002, consultants from Coleman Associates with expertise in improving health service settings began work in pilot Medicaid offices in Coney Island and Jacobi Medical Center in the Bronx. Staff teams put themselves in the shoes of new applicants, tracing the steps of enrollment and noting the roadblocks along the way.

In the past, all visitors to Medicaid offices waited in a single line, no matter what the purpose of their visit. Today, as part of the redesigned system, a greeter "triages" visitors into lines for quick services, such as address changes or card replacements, and other

lines for full enrollment. Applicants used to be screened at an initial visit and then had to return to complete the process; today enrollment requires only a single visit. Moreover, new technology means that applicants have less paper documentation to provide. Office staff can now access a central database, which enables them to verify eligibility through electronic records.

Such simple changes—and modest investments—have produced dramatic results. While Medicaid applications once took well over two hours, average enrollment time in the 10 model offices is 47 minutes. All of the city's 19 Medicaid offices will be redesigned by the spring of 2004.

"We've been buoyed by the success of this work," said Marjorie Cadogan, director of the Mayor's Office of Health Insurance Access. "This concept of looking at government services from the consumer's point of view is one that we'd like to apply to many other city services." ❖

## **New Policies Needed to Alleviate Medical Debt, Report Says**

**A**mbiguity in the law is indirectly responsible for the crushing medical debt facing a number of U.S. families, according to researchers at Brandeis University. Carol Pryor and her colleagues with The Access Project say that federal health care fraud and abuse laws, as well as Medicare rules designed to prevent overbilling, may have the unintended effect of discouraging health care providers from offering reduced-cost or free care to indigent patients.

Their findings are reported in *Unintended Consequences: How Federal Regulations and Hospital Policies Can*

*Ambiguity in the law is indirectly responsible for the crushing medical debt facing a number of U.S. families.*

*Leave Patients in Debt*, published by The Commonwealth Fund.

Partly because of these rules, many hospitals have not established procedures for identifying and offering discounts to uninsured patients who lack the means to pay large medical bills. In other words, uninsured patients are sometimes asked to pay more than insured patients for the same service.

The report's authors recommend several policy changes to alleviate the medical bill problems that burden uninsured patients. They call upon the federal government to establish clearer guidelines on how laws and regulations on billing and debt collection should be applied to the uninsured and underinsured. States or hospitals, meanwhile, should establish standard eligibility criteria for free or discounted care and simplify application procedures.

Hospitals should also be discouraged, the authors say, from aggressive bill collection practices toward patients with limited financial means.

"Medical debt is surprisingly widespread and has devastating consequences for patients and their families," says Pryor. "Clarifying government rules would enable providers to be more accommodating to their patients' financial circumstances." ❖

## Web Publishing Pro Hired to Lead Fund's Communications Unit

**B**ill Silberg, a pioneer in electronic publishing who helped establish quality standards for use of the Web as a health and medical information tool, has joined The Commonwealth Fund, the foundation reported in July. As vice president for communications and publishing, he will lead the Fund in its new emphasis on

electronic publishing, information, and outreach services.

Prior to joining the Fund, Silberg was senior vice president and executive editor at Medscape for WebMD, the online portal for health and medical professionals worldwide.

"We are very fortunate to have someone with Bill's experience join our staff at this critical juncture," said Fund President Karen Davis. "Electronic communication is presenting so many opportunities for getting new information quickly into the hands of those who can bring about improvements in health policy and the quality of care."

Silberg joined Medscape in March 1999 and worked with then-editor-in-chief George D. Lundberg, M.D., former editor of the *Journal of the American Medical Association*, to build the site's editorial staff. During Silberg's tenure, Medscape became one of the most widely visited professional medical websites in the world, as well as a leader in online continuing medical education. He joined Medscape after 13 years in publishing at the American Medical Association, the last four as *JAMA's* editorial director for medical news and new media. ❖



Bill Silberg, the Fund's new Vice President for Communications and Publishing

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## Recent and Forthcoming Commonwealth Fund Publications, Summer 2003

### Fund Reports

- M. Chin, *Sustainability and the Second Law of Thermodynamics*, September 2003
- S. R. Collins, K. Davis, and J. M. Lambrew, *Health Insurance Coverage Returns to the National Agenda: The Health Insurance Expansion Proposals of the 2004 Presidential Candidates*, forthcoming
- S. Crystal, T. Trail, K. Fox, and J. Cantor, *Enrolling Eligible Persons in Pharmacy Assistance Programs: How States Do It*, forthcoming
- S. B. Dale and J. M. Verdier, *Elimination of Medicare's Waiting Period for Seriously Disabled Adults: Impact on Coverage and Costs*, July 2003
- G. Dallek, B. Biles, and L. H. Nicholas, *Lessons from Medicare+Choice for Medicare Reform*, June 2003
- K. Davis, *American Health Care: Why So Costly*, June 2003
- M. H. Davis, *Strengthening New York's EPIC Program: Options for Improving Pharmaceutical Coverage for Medicare Beneficiaries*, forthcoming
- M. Gold and L. Achman, *Average Out-of-Pocket Health Care Costs for Medicare+Choice Enrollees Increase Ten Percent in 2003*, August 2003
- M. Kofman, K. Lucia, and E. Bangit, *Health Insurance Scams: How Government Is Responding and What Further Steps Are Needed*, August 2003
- K. Lipson, E. Fishman, P. Boozang, and D. Bachrach, *Rethinking Recertification: Keeping Eligible Individuals Enrolled in New York's Public Health Insurance Programs*, August 2003
- C. Pryor, R. Seifert, D. Gurewich, L. Oblak, B. Rosman, and J. Prottas, *Unintended Consequences: How Federal Regulations and Hospital Policies Can Leave Patients in Debt*, June 2003
- S. N. Rosenberg, *New York's HealthPass Purchasing Alliance: Making Coverage Easier for Small Businesses*, forthcoming
- C. Schoen and B. S. Cooper, *Medicare's Future: Current Picture, Trends, and Prescription Drug Policy Debate*, August 2003
- D. Shea, B. Stuart, and B. Briesacher, *Caught in Between: Prescription Drug Coverage of Medicare Beneficiaries Near Poverty*, August 2003

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- S. Glied and S. E. Little, "The Uninsured and the Benefits of Medical Progress," *Health Affairs* 22 (July/August 2003): 210–19
- J. Goldsmith, D. Blumenthal, and W. Rishel, "Federal Health Information Policy: A Case of Arrested Development," *Health Affairs* 22 (July/August 2003): 44–55
- J. M. McWilliams, A. M. Zaslavsky, E. Meara, and J. Z. Ayanian, "Impact of Medicare Coverage on Basic Clinical Services for Previously Uninsured Adults," *Journal of the American Medical Association* 290 (August 13, 2003): 757–64
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