



STATES IN ACTION

A Quarterly Look at Innovations in Health Policy

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This *States in Action* quarterly newsletter identifies and describes innovative state health-related programs across the country. It is intended to help policymakers, administrators, and researchers as they work to stretch health care dollars and meet the needs of their residents.

States in Action is part of a new Commonwealth Fund initiative on state innovations. The initiative aims to increase understanding about state health system performance, identify and measure the effects of policies intended to improve performance, and spread information about promising practices. For more information about the program, send an e-mail to stateinnovations@cmwf.org.

We welcome those involved in state efforts to expand coverage and improve care and efficiency to let us know about their efforts at stateinnovations@cmwf.org.

Profiles: In-Depth Looks at Initiatives that Are Making a Difference

North Carolina Is Assuring Better Child Health and Development

Summary: North Carolina's Assuring Better Child Health and Development (ABCD) program aims to improve identification of potential developmental disorders in children and engage families and community stakeholders in the process. It utilizes an inexpensive, validated, and easily administered screening tool, provides opportunities for interactions with and education of family members, and involves a variety of community members. The program has had several positive outcomes. In areas using ABCD, the referral rate for early intervention services is at least double the statewide average and the screening rate has increased from less than 20% to more than 85%. In July 2004, the success of the ABCD program led to a change in state Medicaid policy. Providers are now required to screen children for developmental disorders at specific time periods with a standardized screening tool, following the ABCD model.

The Issue

Nationally, approximately 16% of all children have some form of disability, including speech and language delays, mental retardation, learning disabilities, and emotional/behavioral problems. The numbers are even higher for low-income children. Taking into account psychosocial problems, between 20% and 25% of all U.S. children may have a developmental or behavioral disorder. In pediatrics, this has been called the “new morbidity.”^[1]

For More Information: See [ABCD: Lessons from a Four-State Consortium](#), Helen Pelletier and Melinda Abrams, The Commonwealth Fund, December 2003

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Only 30% of these cases are detected prior to school entrance, meaning that there are many missed opportunities to intervene early to address problems.^[2] The federal government requires that states establish early intervention programs, and research shows that children who participate in such programs prior to kindergarten are more

likely to graduate from high school, hold jobs, and live independently, and to avoid teen pregnancy, delinquency, and violent crime.^[3] The savings for these outcomes are substantial, ranging from \$30,000 to \$100,000 per child. According to one study, for every \$1 spent on early intervention, society saves up to \$7 through avoided teen pregnancy, delinquency, violent crime, and social services.^[4]

Background

Like other states, North Carolina faces the challenge of serving an increasing number of children in Medicaid and the State Children's Health Insurance

Program (CHIP). The state also has had a large increase in referrals to their early intervention system.^[5] In the fall of 2000, North Carolina was one of four states to be awarded a grant from The Commonwealth Fund's Assuring Better Child Health and Development (ABCD) initiative, which seeks to build the capacity of state Medicaid programs to provide child development services.

Participants

The ABCD project began as a pilot initiative at three pediatric practices in Guilford Child Health, Inc. (GCH), one of Medicaid's Community Care networks in Guilford County. After six months, it had expanded to three more practices in the network. After a year, it had spread to more than six practices in two new counties, Gaston and Forsyth. In the following year, the ABCD project was in an additional seven counties and more than 100 practices. Now, the program is statewide for all Medicaid primary care physicians who provide Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services to children.

Process of Change

North Carolina's Medicaid Agency turned over leadership of the ABCD project to the Office of Rural Health in partnership with GCH, which took a two-pronged approach to improve child development services:

1. Developing a "best practices" comprehensive community model for screening, surveillance, and referral in well-child care that could be replicated. This physician-driven community model is characterized by two major components:
 - Introduction and integration of a standardized developmental screening tool at selected well-child visits; and
 - Collaboration with local and state agency staff and families in developing this system for identifying and serving children.
2. Forming a state advisory group comprising leaders from key agencies who have the capability of making policy changes.

Participating physicians chose the Ages and Stages Questionnaire (ASQ), a validated parent survey of child development. The questionnaire is written at a fourth- to sixth-grade reading level. It is inexpensive, with a one-time cost of \$199 for a kit. After purchasing the kit, practices can make unlimited copies of the questionnaire.

The ASQ helps detect potential problems in five developmental areas: communication, gross motor, fine motor, problem solving, and personal/social. It consists of 30 questions and can be offered up to 19 times to parents of children between four and 60 months. In the ABCD pilot project, providers chose to offer the ASQ at six key stages of development: six, 12, 24, 36, 48, and 60 months. The questionnaire takes about five to 10 minutes for parents to complete and two

to three minutes for a doctor or nurse to score. After scoring the ASQ, providers discuss the results with parents and, if necessary, arrange referrals for full evaluations. Such evaluations are performed by a Children's Developmental Services Agency or Preschool Program, depending on the age of the child.

Prior to ABCD, the average developmental screening rate for children across Medicaid systems in North Carolina was approximately 15.3%. This low rate was partially attributable to the fact that the most common screening was untenable: it took too much time to administer and relied on assessments made in doctors' offices rather than parents' observations. After the new screening tool was adopted, screening rates soared to more than 70% within the model practices by 2002. As of March 2005, the screening rate was up to 85%.^[6]

In addition to raising screening rates, North Carolina wanted to improve relationships between providers and parents. The ABCD program creates opportunities for clinicians to involve parents in a dialogue about their children's health and development, even when children do not receive an "at risk" score on the ASQ. According to Marian Earls, M.D., medical director at Guilford Child Health, Inc., parent-completed questionnaires such as the ASQ are "more family-centered, engage parents as partners in care, and are more reflective of the child's true skills." Sherry Hay, ABCD project coordinator, adds that "instituting a system for developmental screening and surveillance into primary care not only helps in making the care more family-centered but can also make the well-child visit more time efficient."

The model also helps to forge relationships between providers and community partners. These relationships are facilitated by community care coordinators within Medicaid networks. The coordinators—usually social workers or nurses—oversee the program at its various sites, provide support to families, and help with referrals. In some areas, such as Guilford County, the coordinator is also certified as an early intervention specialist (EIS). As the program has expanded, networks have been creative in developing the care coordinator role. A few networks have an EIS, others use their own care coordinators, and some counties have other early childhood community agency staff members who provide support to practices.

The ABCD model has been disseminated in several ways. In some cases, Community Care Medicaid networks directly adopted the initiative after the success of the ABCD pilot. The model has also spread through physician practice trainings endorsed by the state chapters of the American Academy of Family Physicians and the American Academy of Pediatrics. Seven trainings were held in 2002 and five to six in 2004. Physicians receive continuing medical education credits for attending. In addition, program administrators have distributed educational materials to parents and a DVD to practices that explains the rationale for screening and surveillance, how to integrate the activity into office flow and billing, and how to collect process and referral (performance)

data. And in 2004, North Carolina mandated that all practices that serve Medicaid-enrolled children use a standardized screening tool.

Results

Since 2000, North Carolina's ABCD program has had success:

- The screening rate has increased from less than 20% to more than 85% in areas using ABCD.
- The referral rate (for early intervention services) is 7% among practices that initially adopted the ABCD model, compared with 2.9% statewide.[\[7\]](#)
- Many families receive counseling from the care coordinator even though their children's ASQ scores do not identify any risks. Care coordinators may help with referrals to Head Start, assist with identifying quality child care, or provide counseling regarding typical development.
- In a referral cohort followed in the evaluation process, 94.5% of all children screened and referred completed their referrals by having appointments arranged. Among those referred, 55.3% began early intervention services.
- Surveys have found widespread support for ABCD among health care providers; a 2003 survey found that 77% of providers recommended the ASQ, 74.3% thought parents were good reporters on the questionnaire, and 71% used the tool as a guide when talking to parents. Also, parents told providers that they appreciated the tool as a guide for developmental milestones for their children.[\[8\]](#)

In July 2004, the success of the ABCD program prompted a change in state Medicaid policy. Medicaid providers are now required to use a standardized screening tool, such as the ASQ, that meets specific sensitivity and specificity levels at the six, 12, 18 (or 24), 36, 48, and 60 month well-child visits.[\[9\]](#) In addition, providers must now list a specific code on their Medicaid claim form to indicate that these services have been rendered.

Lessons and Next Steps

According to Hay, implementation of the new state policy is going well because “the groundwork was done early, and the change is physician-driven. It makes a big difference to have physicians who have implemented [the ABCD practice] providing support, as opposed to the policy coming down from the state. It is not a punitive approach, but an educational approach.”

Earls believes the approach can work for populations outside of Medicaid and CHIP. “Once physicians begin this in their practices, they do it with all their patients; it's easier to do that than to have a separate flow,” she says. “Also, physicians are aware of the recommendations from the American Academy of Pediatrics and know this should be available to all children.” She adds that

involving parents is crucial; physicians must “respect and react to what parents have to say because they are often the first to spot problems.”

References

[1] Saxe, J. “Assessing and Addressing Development: A 21st Century Frontier.” *NC Family Physician*, Spring 2005.

[2] Glascoe FP, Shapiro HL. “Introduction to Developmental and Behavioral Screening.” May 27, 2004 (revised August 10, 2005). Available online: <http://www.dbpeds.org/articles/detail.cfm?TextID=5>.

[3] The states are mandated under Public Law 99-457, also known as the Individuals with Disabilities Education Act, Part C. This law amended Public Law 94-142 by offering services to three- and four-year-old children as well as creating an entitlement program of services to eligible infants, toddlers, and their families.

[4] Glascoe, 2004.

[5] According to data from the State Early Intervention Program, physician referrals into the early intervention system increased 17% over the previous year in North Carolina.

[6] From Medicaid claims data. It is suspected that the screening rate may be even higher, since the data are manually entered and human error is likely to be a factor.

[7] Statewide referral data that reflect the new state policy are not yet available.

[8] The ABCD workgroup, lead by Earls, Hay, and others, did provider surveys in 2001, 2002, and 2003. An expanded evaluation in 2004 looked at ABCD and non-ABCD providers.

[9] The Denver Developmental Assessment, which had previously been recommended by the North Carolina Division of Public Health, was not included on the new list of standardized tools. The ASQ, as well as other screening tools such as Parents’ Evaluation of Developmental Status (PEDS), are on the list.

Michigan Tackles Health Care Disparities

Summary: The state of Michigan has been aggressive and innovative in confronting health care disparities. The state’s Medicaid program has undertaken a variety of measures, including providing funds to community organizations to target health conditions within specific racial or ethnic groups, requiring managed care organizations to undertake disparities reduction initiatives, and analyzing Health Plan Employer Data and Information Set (HEDIS) data across racial

categories to help identify and confront disparities at the system, community, and individual levels.

The Issue

The March 2002 Institute of Medicine report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, cited consistent research noting significant racial and ethnic disparities for medical procedures, even when insurance status, age, income, and seriousness of illness are analogous.

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In Michigan, the state surgeon general's *Healthy Michigan 2010: Health Status Report* finds progress being made in preventing chronic disease. However, it also found that significant racial disparities exist for many chronic conditions.^[1] For example, compared with whites, Hispanics are 1.75 times more likely to have diabetes and 1.5 times more likely to die

of the condition. African Americans are 1.4 times more likely than whites to die from heart disease and are hospitalized for asthma at a rate five times greater than whites.^[2]

According to Loretta Davis-Satterla, the director of the Division of Health, Wellness, and Disease Control at the Michigan Department of Community Health, "although overall health indicators have improved for most of the Michigan population, the same improvement in health measures has not been realized for racial and ethnic minorities."

Participants

The Health Disparities Reduction Program, part of the Michigan Department of Community Health, funds highly targeted and evidence-based prevention, health promotion, and screening services to help reduce health disparities. The state also has a Health Disparities Reduction Committee, a workgroup comprising representatives from various entities across the Department of Community Health, including Medicaid, mental health, chronic disease, HIV/AIDS and STD, epidemiology, child family health, and immunization.

Process of Change

Michigan's strategies to address disparities include: 1) providing funds to community organizations to target health conditions within specific racial or ethnic groups, 2) requiring managed care organizations (MCOs) to undertake disparities reduction initiatives, and 3) analyzing Health Plan Employer Data and Information Set (HEDIS) data across racial categories to identify and confront health disparities at the system, community, and individual levels.

Funding Community Efforts

Michigan's Medicaid administrators believe that building relationships on the ground level—that is, with and among community-based organizations (CBOs)—will lead to reductions in health disparities. Michigan's Department of Community Health funded 12 CBOs to target health conditions within particular groups. Among these are Tomorrow's Child, targeting infant mortality among African Americans in Detroit; the Arab-American & Chaldean Council, targeting cancers (breast, cervical, prostate, and colorectal) among Arabs in Dearborn and Detroit; St. Joseph Mercy Health Care, targeting asthma among African Americans in Ypsilanti; and St. John Community Health, focusing on diabetes and obesity among African Americans in Northwest and Northeast Detroit. The funding is a combination of state dollars and money from federal preventive health block grants. Davis-Satterla points out that "the funding of new, innovative, and targeted programs, especially at the community level, to reduce health disparities is critical, not only for the sake of the clients served, but also so successful programs can be duplicated in other venues."

Managed Care Initiatives

Every year, the Medicaid program brings together all the contracted Medicaid health plans in the state for a health disparities workshop, run by the Institute for Health Care Studies at Michigan State University. Health plans report on projects they are undertaking to help reduce health disparities and exchange ideas about effective strategies.

In FY 2005, the state required Medicaid managed care organizations to identify and implement a health disparities initiative. For example, the Physician's Health Plan of Southwest Michigan is hosting a cultural competency workshop for high-volume providers in Kalamazoo. M-Caid, the Medicaid health plan from M-Care, the University of Michigan's health plan, is revising its member Web site in an effort to make health information easier to understand. For the initial round, none of the initiatives was scored and measurable data were not required. According to Moran, "the next step is to review the projects, share the list with all plans, and encourage plans to take their initiative to the next step, which is a formalized performance improvement project. From the Medicaid agency perspective, the next step would be a requirement, beyond encouragement, that all plans analyze their population's racial and ethnic characteristics using HEDIS data, and initiate improvement actions accordingly."

Analyzing Data

The state has begun to analyze HEDIS data from Medicaid managed care plans in Wayne County, which includes Detroit, focusing specifically on access to care measures across racial and ethnic categories. The state, researchers from the University of Michigan and Michigan State University, and the managed care plans will evaluate the findings and develop policy recommendations to address major health disparities. Annual HEDIS data will then be collected over time to determine whether particular measures have changed.

Lessons

Moran says that obtaining data on disparities has been a challenge since “a regular and standardized method for collection of data by race and ethnicity does not exist.” Also, reporting data on quality of care for racial and ethnic groups within health plans can result in relatively small sample sizes, making it difficult to draw conclusions. In addition to such issues, the state faces staffing and budgeting constraints. Even with these challenges, Moran maintains that “state Medicaid agencies are in a unique position to focus attention on health care disparities, specifically through Medicaid managed care organizations.”

Anne Beal, M.D., senior program officer for the Program on Quality of Care for Underserved Populations at The Commonwealth Fund, describes Michigan’s multifaceted approach as particularly noteworthy. “It appears to be a coordinated, multi-pronged effort to address disparities,” Beal says. “Most work is done by individual entities, such as hospitals, health plans, and providers, but this seems to involve several players in the health care system in Michigan. That is innovative.”

References

[1] Available online:

http://www.michigan.gov/documents/Healthy_Michigan_2010_1_88117_7.pdf.

[2] Hispanic/Latino American and African American Fact Sheets, Michigan Department of Community Health. Available online:

http://www.michigan.gov/mdch/0,1607,7-132-2940_2955_2985---,00.html.

Snapshots: Short Takes on Promising Programs

Minnesota: Discounted Care to Uninsured

In an arrangement negotiated by State Attorney General Mike Hatch, the majority of Minnesota’s hospitals agreed to provide discounted care to uninsured patients and to be less aggressive in their debt collecting for the next two years.

This agreement comes on the heels of numerous studies and reports finding that uninsured patients are often charged more than insured patients. A recent Commonwealth Fund [study](#) found that an estimated 77 million Americans ages 19 and older—nearly two of five (37%) adults—have difficulty paying medical bills, accrued medical debt, or both.

Among participating Minnesota hospitals, lower prices will be charged to uninsured patients with incomes below \$125,000 a year. For a given service,

these patients will be charged no more than the amount the hospital would receive for the same service from the insurance company that was its largest payer the previous year. In most cases, the discount will result in a 40% to 60% reduction in prices. “I congratulate these hospitals for stepping forward and addressing this issue, which is in the forefront of almost every state,” says Attorney General Hatch. “By exercising this leadership, these hospitals honor their communities and their patients.”^[1]

Hospitals and clinics will change their debt collection practices as well. Before filing lawsuits against patients for medical debt, administrators will thoroughly examine their records to ensure that the patient actually has a debt; all insurance companies that may be accountable for the claim have been billed; the patient, if

For More Information, Contact:
Minnesota Attorney General’s Office,
800-657-3787

unable to pay the entire bill, was offered a payment plan; and the patient was offered any free or discounted hospital charity care for which they were eligible. Hospitals and clinics cannot take money from a patient’s

bank account or wages without a legal judgment authorizing them to do so. If patients have limited income and assets, hospitals will take that into account as well. There will be a “zero tolerance” policy in place for abusive debt collection agencies and attorneys, and these entities will be reviewed periodically by the hospital boards. There also will be no default judgment against patients until they are given a fair chance to respond. Finally, there will be a streamlined process for patients to question or dispute bills from hospitals or clinics.

By August 2005, over 50 hospitals and systems from across the state had joined the initiative, representing more than 75% of all hospital admissions in Minnesota.

Reference

^[1] Email correspondence to authors.

New Jersey: Cultural Competency Training

New Jersey has recently enacted legislation, signed into law by Governor Codey in March 2005, mandating that physicians in the state receive cultural competency training.^[1] It is the first state to attempt such an initiative. State policymakers hope that this training will:

- enable physicians to better treat and diagnose conditions more prevalent in minority communities (e.g., HIV/AIDS, asthma); and
- improve physicians’ abilities to respond to cultural and language barriers and thereby improve communication and interaction with patients.

Arizona, Illinois, and New York are considering similar bills. California, which passed legislation in 2003 to set up voluntary linguistic and cultural competency

programs for physicians, is considering two bills that propose mandating such training. Robert Like, M.D., M.S., associate professor and director of the Center for Healthy Families and Cultural Diversity at the University of Medicine and Dentistry of New Jersey, argues that “the fact that the legislation has taken off in New Jersey and now is being looked at in other states is testimony to the idea that current education is viewed as not doing the trick.”

The New Jersey bill cites a recent *New England Journal of Medicine* study that found that physicians were less likely to refer African Americans and women than

white males with identical complaints of chest pains to heart specialists for cardiac catheterization.^[2] This report is among a growing body of medical research that finds racial and gender-related disparities in health care, with cardiovascular disease being one of the main conditions for which such disparities exist.

For More Information, Contact:

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New Jersey has more than 1 million Hispanics and African Americans and

more than 500,000 Asians. According to the 2000 Census, 129 languages are spoken in the state.

The cultural training for New Jersey physicians will be developed in consultation with the state’s Commission on Higher Education and the Association of American Medical Colleges. Currently, the New Jersey State Board of Medical Examiners is drafting the law’s regulatory details, including setting the number of credits and educational formats and determining who should develop the training.

Cultural competency training will be integrated into the curriculum in all of New Jersey’s medical schools and diplomas will not be issued unless students have taken the training. For physicians already licensed in New Jersey, the training will be a mandatory condition for renewing their licenses.

Like believes cultural competency training can succeed, but will not be attained through a “cookbook approach to care. We have to see this as different from other types of CME courses,” he says. “It has to be a process of how we continue to learn about the diverse populations we’re caring for as well as our own personal and professional biases, values, beliefs, and behaviors—I don’t think taking a one- or two-hour course is going to be effective.” He also argues that cultural competency training should extend to all health care workers, including nurses, dentists, physical therapists, pharmacists, psychologists, social workers, and other allied health professionals.

References

[1] P.L. 2005, c. 53 (N.J.S.A. 45:9-7.2 et seq.)

[2] Schulman KA et al. "The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization." *New England Journal of Medicine* 1999; 340 (8): 618–626.

New Mexico Implements State Coverage Insurance Program

New Mexico recently created a public–private partnership that uses unspent CHIP funds to subsidize premiums for low-income uninsured adults. Through the New Mexico State Coverage Insurance (NMSCI) program, three commercial managed care organizations are offering a low-cost product that provides

coverage for adults ages 19 to 64. The health plans are available to uninsured people with family income up to 200% of the federal poverty level who have not voluntarily dropped insurance within the last six months and to employers who have not voluntarily dropped insurance within the last 12 months.

For More Information: See [New Mexico State Coverage Insurance Web site](#)

[Stretching State Health Care Dollars: Building on Employer-Based Coverage](#), Sharon Silow-Carroll and Tanya Alteras, The Commonwealth Fund, October 2004

Contact: Mari Spaulding-Bynon, J.D., State Coverage Insurance Project Coordinator, Human Services Department Medical Assistance Division, 505-827-7788, Mari.Spaulding-Bynon@state.nm.us

Implementation of NMSCI began July 1, 2005. The program offers premium assistance, with the employer and employee each paying a share of the premium and state and federal funds

paying the remainder. Employers pay \$75 per employee member per month and the employee pays \$0 to \$35 per month, depending on income level. Individuals applying without their employer's participation pay the employer share of \$75 per month as well as the employee share.[1] Medical services require copayments on a sliding scale based on family income.[2]

The program required a \$4 million appropriation from the state legislature for state FY06, which will be matched by approximately \$16 million in federal CHIP dollars. In addition, a few counties are planning to contribute a portion of their uncompensated care funds toward the premiums of qualifying residents. The state expects that about 10,000 state residents will obtain insurance through the plan during the first year, eventually covering 40,000 state residents over five years. The arrangement was approved as a five-year demonstration, through a Health Insurance Flexibility and Accountability Demonstration waiver from the Centers for Medicare and Medicaid Services in 2002.

References

[1] An employer may include employee spouses in the group; also, the employer may choose to contribute toward the spouse's premium. To avoid adverse

selection, there are group participation requirements: for groups of up to nine employees, at least 75% of those eligible must join; for groups with 10 to 50 employees, at least 50% of those eligible must participate.

[2] For example, an individual with a household net income of \$29,000 per year and a family of four has premiums of \$20 per month and copayments of \$5 per doctor visit and \$25 per admission for inpatient hospital service.

West Virginia Implements Small Business Plan

In early 2005, West Virginia rolled out the Small Business Plan, a public–private partnership between the state’s Public Employees Insurance Agency (PEIA) and a private insurance carrier, Mountain State Blue Cross Blue Shield (BCBS).

Under the Small Business Plan, Mountain State BCBS offers a comprehensive, affordable health plan to uninsured businesses with two to 50 employees. The insurer discounts one of its commercial, high-deductible preferred provider organization (PPO) plans (with \$1,000, \$3,000, and \$5,000 deductibles). It then uses the reimbursement rates to providers and prescription drug prices negotiated through PEIA’s multi-state purchasing plan. These provisions, combined with smaller administrative fees to the

For More Information: See [West Virginia Small Business Plan Web site](#)

[Stretching State Health Care Dollars: Building on Employer-Based Coverage](#), Sharon Silow-Carroll and Tanya Alteras, The Commonwealth Fund, October 2004

Contact: Sonia Chambers, Chairperson, West Virginia Health Care Authority, 304-558-7000, schambers@hcawv.org

insurer, result in premiums averaging between 17% to 22% lower than the standard rates. So while West Virginia does not subsidize the plan, qualified small businesses and their workers still benefit from the state’s purchasing power.

A statewide marketing campaign began at the end of June 2005. As of early August, approximately 437 people were covered through 289 contracts.[1] A wide variety of small businesses are participating, including car dealerships, accountants, plumbers, high-tech firms, truckers, dentists, and even some Blue Cross Blue Shield agents.

Mountain State BCBS reports that they have not been experiencing adverse selection, whereby only high-risk people seek out the coverage. So far, the risk levels for the Small Business Plan pool are lower than for their regular small business book of business. As one BCBS official stated, “These people are not uninsurable, they are just uninsured.”

Reference

[1] The majority of the contracts (about 200) were for individuals; 26 were child and employee contracts, 29 were employee and spouse contracts, and 32 were family contracts.

Updates:

New Developments in Ongoing Programs

Rhode Island: Performance Incentives to Improve Quality

Over six years of implementing performance goals, Rhode Island has found steady, significant improvements in administration and access measures among its Rlte Care (Medicaid/CHIP) health plans. The three health plans that cover Rlte Care members receive additional payments, above the negotiated capitation rates, if they meet specified targets. The program now covers six areas:

- member services;
- medical home/preventive care;
- women's health;
- chronic care;
- behavioral health; and
- cost management.

A total of \$1.25 per member per month, or a little less than 1% of the capitation rate, is potentially available to each of the health plans if they meet performance goals. An additional reward is given to the health plan with the highest score in member services, which includes timely provision of identification cards,

distribution of handbooks, welcome calls to new members, and grievance procedures. Though this supplemental reward is modest, it is a way to emphasize the need for improvement in a particular area.

For More Information: See [Rlte Care Research and Evaluation Web site](#)

[Building Quality into Rlte Care: How Rhode Island Is Improving Health Care for Its Low-Income Populations](#), Sharon Silow-Carroll, The Commonwealth Fund, January 2003

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The targets are based on the Health Plan Employer Data and Information Set (HEDIS), Consumer Assessment of Health Plans Study (CAHPS), and other measures.^[1] In

2004, the three plans were awarded from 82% to 85% (a total of about \$1.4 million) of their potential maximum reward amounts. Though a direct causal relationship is hard to document, administrator Murray Brown believes that the financial incentives “have been an important factor in quality improvements over recent years.” For example, there have been continuous improvements in the proportion of children, adults, and pregnant women receiving timely preventive and primary care.^[2] The performance incentives “have a high profile among the health plans; the program is a way of emphasizing important quality issues,” Brown says.

References

[1] HEDIS is a set of standardized performance measures intended to help purchasers and patients compare health plans in terms of quality. CAHPS is a survey that attempts to assess enrollees' satisfaction with their health care services.

[2] The program measures the portion of children and adults receiving their first primary care visit within 90 days of entering a RItE Care managed care plan.

Multi-State I-SaveRx Program Expands

The I-SaveRx multi-state program, which facilitates the purchase of lower-cost pharmaceuticals from other countries, is expanding its network to include Australia and New Zealand. Previously, the program's network included more than 60 approved pharmacies and prescription drug wholesalers in Canada, the United Kingdom, and Ireland. The announcement of the expansion was made on

For More Information: See [I-SaveRx Web site](#)

Read the original "Snapshot" at [States in Action](#), Sharon Silow-Carroll, The Commonwealth Fund, Spring 2005

July 18, and the new countries should be integrated into the program within six to eight weeks. The expansion came after a study by the Illinois Prescription Drug Advocates highlighting the safety and cost

savings of prescription drugs in the two countries. These savings could be substantial; the study noted that prices for the 78 most-used drugs in I-SaveRx cost 51% less in Australia than in the U.S.—making them even cheaper than in Canada, where they cost 31% less.

I-SaveRx was launched in October 2004, with Illinois, Kansas, Missouri, Vermont, and Wisconsin participating. The program has various quality and safety protections and includes oversight of network pharmacies. It is available to all state residents, irrespective of income or age. Thus far, more than 10,000 orders have been filled and average savings have ranged between 25% and 50%.

Related Publications

Brodsky KL.

[Best Practices in Specialty Provider Recruitment and Retention: Challenges and Solutions.](#)

The Commonwealth Fund, 2005 Aug.

Catalano RA, Coffman JM, Bloom JR et al.

[The Impact of Capitated Financing on Psychiatric Emergency Services.](#)

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Upcoming Meetings

National Conference of State Legislatures (NCSL), Fall Forum.

December 6–9, 2005. Chicago.

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