PUBLIC CITIZEN HEALTH RESEARCH GROUP

Health Letter

SIDNEY M. WOLFE, M.D., EDITOR

April 2007 ◆ VOL. 23, NO.4

Unsettling Scores: A Ranking of State Medicaid Programs

The following is an excerpt from Public Citizen's 2007 report evaluating and ranking state Medicaid programs. To read the full text of this report and view data broken down by state on an interactive website, visit www.citizen.org/medicaid.

Almost 20 years ago, Public Citizen's Health Research Group published a report on Medicaid, *Poor Medicine for Poor People*, ranking state Medicaid programs. The current report seeks to update that report. Because programmatic mandates have changed and states now have considerably more latitude in how they run their programs, the indicators are different, as are the sources of data. As a result, there is greater variety among states, as well as greater differences within states.

Methods

Each state program has been evaluated in terms of four categories: eligibility, scope of services, quality of care, and reimbursement. These were in turn measured by 55 indicators, and the resulting scores were weighted according to the relative value given to each category by experts. The ranking system gives a state a score for each category as well as an overall score.

Certain principles underlie the selection of indicators, their interpretation, and the points assigned to them. Our scoring methodology is based on the following guidelines:

#1. No state gets extra points for merely following the law and doing what is federally mandated. That is taken as a "floor" from which extras are measured.

#2. States that are doing less than what is required or that deviate from a desirable norm may have points deducted. For example, states are penalized for limiting services that are considered desirable or for falling short of indexes that are considered essential to quality of care. Because these items tend to involve judgment calls, we have made our values explicit whenever this is the case.

#3. In scoring each indicator, we have taken the state-by-state distribution into account. As a result, with only one exception, even the most stringent indicators are met by at least one state. The top values are therefore not unreachable targets but rather feasible objectives for states that are committed to meeting the needs of their Medicaid beneficiaries.

#4. Because we believe that access to health care should be based on need rather than on ability to pay, we reward those states that have lowered financial barriers to care. Conversely, we penalize those that use cost-sharing and other similar means to restrict access. This is based on extensive research which shows that, while cost-sharing may promote cost-consciousness in the general population, its burdens may impose substantial financial barriers for the poor. Consequently, cost-sharing may result in the postponement of treatment of illness when it is most amenable to successful intervention.

#5. In some cases, we have used accepted benchmarks for care as the standard of choice. Only those programs that meet these benchmarks are credited with extra points.

#6. States that have expanded the usual offerings or that show innovation in their concern with the scope or quality of care are rewarded for their promising efforts.

#7. In the area of quality, we look at both systems for monitoring quality and actual outcomes. Indicators on monitoring include activities to assess services and correct any deficiencies

continued on page 2

CONTENTS

UNSETTLING SCORES, *from page 1*

found. Outcomes reflect improvements in actual health status, or actions that further desirable policy objectives.

#8. In each case, we have used the most recent information available that includes all states. We have therefore relied primarily on data from 2004 or more recent years, and have not used any data from earlier than 2000.

To determine the relative weight of each of the four categories and each indicator, the preliminary scoring protocol without the assigned points was submitted to two other recognized experts in the field of Medicaid. They were first asked to distribute 100 points among the four basic categories. They were then asked to distribute 100 points among the different indicators within each of the four categories. Because the number of indicators within a given category ranged from 36 to 3, the point distribution by category varied widely. The relative weights assigned by the two experts were then averaged, and the mean of the two values was used as the weight for a particular indicator or category.

The final weights assigned to each of the four categories were as follows, totaling 100 percent:

Eligibility	35 percent
Scope of Services	20 percent
Quality of Care	20 percent
Reimbursement	25 percent

The final score for each indicator was therefore the product of the scores (i.e., the points assigned to the item) and the two sets of relative weights recommended by the experts.

The assigned points for each of the four categories and their indicators were entered, state by state, into an Access spreadsheet and the points assigned to each indicator were totaled. These numbers were then multiplied by the relative weight, producing a final score for each state and indicator. The final state-specific scores were ranked both overall and by category.

In the case of three categories as well as the overall scores, two or more states shared a rank. If, for example, two states tied for 5th place, they received the same rank, 5th. But the rank following that was 7th rather than 6th, so that there are as many ranks as there are programs scored.

Eligibility

Consumers who want to know if they are eligible for Medicaid have to work their way through a complicated list of demographic categories to see if they qualify under any of these. Indeed, federal law describes more than 50 eligibility pathways. Many demographic variables – e.g., age, sex, marital status, family composition, income, disability, and disease – help define current eligibility criteria.

In keeping with the program's labyrinthine complexity, there are some populations that **must** be covered by all states, and there are others who **may** be covered as well. To add another layer of confusion, not everyone is covered under the same circumstances, nor for the same services.

While Medicaid is more frequently known as a "program for the poor," and the program has always targeted low-income individuals, not all the poor are eligible and not all the eligible are poor. To be covered, the poor must meet **financial requirements** (regarding income, assets, and expenses) as well as **categorical requirements** (regarding age, family circumstances, employment status, blindness, disability, and other factors). These requirements exclude many people from Medicaid. Indeed, it is estimated that approximately 60 percent of poor Americans are not covered by Medicaid.

Eligibility rules vary from one state to another, although there are guidelines that govern local options. While federal regulations require all states to cover certain groups and limit the additional groups that states may cover, each state can elect to include other groups falling somewhere between the federal "floor" and "ceiling." As a result of these differences among states, the same person may be eligible in one state but ineligible in another. Moreover, many states have taken advantage of Medicaid "waivers" which exempt them from eligibility and coverage requirements as long as they are budget-neutral and do not cost the federal government more than prior coverage.

When first enacted, Medicaid was linked to beneficiaries of the federally-assisted income maintenance program

Editor.....*Sidney M. Wolfe, MD*
Managing Editor.....*Kate Resnevic*
Contributor.....*Annette Ramírez de Arellano, DrPH*
Sidney M. Wolfe, MD
Proofreader.....*Shiloh Stark*
Production Mgr......*Kristy I. Jackson*
President.....*Joan Claybrook*

THE PUBLIC CITIZEN HEALTH RESEARCH GROUP
Health Letter

The Health Research Group was co-founded in 1971 by Ralph Nader and Sidney Wolfe in Washington, D.C. to fight for the public's health, and to give consumers more control over decisions that affect their health.

Material in the *Health Letter* may not be re-printed without permission from the Editor. Send letters and requests to HEALTH LETTER, Editor, 1600 20th St., NW, Washington, D.C., 20009.

Annual subscription price is $18.00 (12 is-sues). Mail subscriptions and address changes to *Health Letter*, Circulation Department, 1600 20th St., NW, Washington, D.C., 20009. Our Web site address is **www.citizen.org/hrg**.

Aid to Families with Dependent Children (AFDC). After 1972, the program also included those covered by Supplemental Security Income (SSI), a program which provides cash assistance to help aged, blind, and disabled people who have little or no income. Since then, changes in Medicaid and SSI have created additional groups of beneficiaries whose financial eligibility is based solely on income and resources rather than on cash assistance. The inclusion of these "poverty-related" groups expanded Medicaid to include pregnant women and children by separating Medicaid eligibility from receipt of AFDC. At present, these groups represent a growing proportion of Medicaid beneficiaries, accounting for over one-quarter of the total.

States are addressing a Medicaid law that went into effect on July 1, 2006, restricting benefits to those who can provide proof of citizenship. This measure, which was part of the Deficit Reduction Act of 2005, requires that beneficiaries and applicants to Medicaid present a birth certificate, passport, or another form of identification in order to apply. This documentation replaces the previous requirement that applicants to Medicaid attest in writing that they are citizens, under penalty of perjury.

The legislation has both ideological and fiscal roots. Originally designed to prevent undocumented immigrants from gaining to access to care, the measure was also touted as a cost-saving device, estimated to save the federal government some $220 million over five years and $735 million over 10 years.

Given the multiple pathways into Medicaid, states exhibit much variety in how they score in the eligibility category. Of the four categories examined, eligibility is the one weighted most heavily, accounting for 350 of the total 1000 points. States that rank high in this category are therefore more likely to score high overall.

Rhode Island, the highest-ranking state in eligibility, earned a total score of 296.8, while Indiana, with a score of 90.6, had the lowest eligibility value. There is therefore a more than threefold difference between the two ends of the eligibility spectrum.

In addition to Rhode Island, the other states ranking among the "Top 10" in terms of eligibility include, in descending order of rank: Vermont, New York, Washington, California, Minnesota, District of Columbia, Massachusetts, Wisconsin, and Hawaii.

Ultimately, eligibility is the most important category. If a person is deemed ineligible for Medicaid, it matters little what services are available, how good they are, or how equitably the providers are paid.

Given the high relative weight of this category, it is not surprising that seven of these 10 states are also among the "Top 10" overall.

The 10 states with the lowest ranks in eligibility are: Indiana, Alabama, Mississippi, Arizona, South Dakota, Nevada, Texas, Idaho, Delaware, and Virginia.

As with their higher-ranked counterparts, most of these states (Indiana, Alabama, Mississippi, South Dakota, Texas, and Idaho) are also among the 10 programs with the worst scores overall.

Ultimately, eligibility is the most important category. If a person is deemed ineligible for Medicaid, it matters little what services are available, how good they are, or how equitably the providers are paid. Yet widely divergent eligibility requirements continue to plague the Medicaid program. For example, a pregnant woman in family of three needs to have an annual income of less than $22,128 in order to qualify for Medicaid in Wyoming, while her Minnesota counterpart can be covered with an income of up to $45,650. Similarly, an infant's family's income would have to be less than $22,128 in Virginia for the baby to be covered, but less than $49,800 in Missouri. These are disparities that reflect local political decisions but have a ripple effect throughout the Medicaid program, undermining the very concepts of "one nation," equal opportunity, and equal protection.

Scope of Services

Scope of services is the category exhibiting the most variety, complexity, and nuances. Over time, states have modified the optional services they provide under Medicaid in response to need, federal financial incentives, and political imperatives.

Because this category has the largest number of indicators, we have grouped them into seven major, mutually-exclusive subcategories:

- Services by type or target group
- Women's services
- Services delivered by specific providers
- Rehabilitation services
- Devices and equipment
- Drugs
- Transportation

Most of these are in turn broken down into a number of discrete services, which were scored using different point values and weights before being reaggregated into the seven categories.

In general, we are ranking states only in terms of the non-mandated services they provide. Most of the services listed above are optional. In the case of mandated services, we have taken into account only those characteristics that affect scope and that exceed or refine the mandated minimum levels. Over time, optional services have increased their share of Medicaid expenditures. In 1998, for example, Medicaid spending on optional services accounted for 65 percent of the total spent by the federal and state governments.

Rankings are based on the following criteria:

continued on page 4

UNSETTLING SCORES, *from page 3*

Coverage: States offering an optional service receive credit in their scores, regardless of how limited the scope or how restricted the eligible population. The total number of points, however, may reflect the scope of service, as indicated below.

Population covered: Some states cover only the categorically needy, while others extend services to the medically needy as well. The latter receive more points than the former in our scoring scheme.

Comprehensiveness: In general, the wider the scope of services, the higher the score. Limitations in terms of amount, frequency, or duration will be taken into account in applying this criterion.

Lack of a financial barrier: Services that do not depend on cost-sharing on the part of the consumer are rewarded in our rankings. When co-pays are required, a distinction may be made between a nominal fee that is unlikely to deter access to services, and a more significant amount that may constitute a barrier to prompt care.

The range in scores runs from top-ranked New York (with 168.3 points or 84.2 percent of the total score) to Mississippi (with 66.8 points or 33.4 percent): a more than 2.5-fold difference. The average score is 117.7, or 58.9 percent of the total points.

The "Top 10" Medicaid programs in terms of scope of services are as follows: New York, Minnesota, Oregon, Washington, Illinois, North Dakota, Maine, Arizona, Tennessee , and California.

Because this was by far the category with the most indicators, the states' overall scores tend to be evenly distributed throughout the spectrum, with only one tie among states (between North Dakota and Illinois, who share the 5th rank). Although the two top-ranked states in scope of services – New York and Minnesota – rank among the top 10 overall, only one other state (Washington) also falls within both the overall and the category-specific top 10 ranks.

The following 10 states place at the bottom in scope of services, ranking from 51st to 42nd: Mississippi, Oklahoma, Alabama, Georgia, Wyoming, South Carolina, Delaware, Idaho, Arkansas, and Connecticut.

Although this category is not weighted as heavily as eligibility in our adjusted scores, it nevertheless reflects overall program performance, and half of the states ranking in the bottom 10 in scope of services also rank at the bottom in the overall score. These states are Mississippi, Oklahoma, Alabama, South Carolina, and Idaho.

Of all the categories, scope of services presents the most options for the states. Services cover the lifespan (from prenatal care to hospice), involve a broad range of facilities and providers, and can expand or contract as a function of need and budgetary possibilities. Even when two states offer the same package of services, they can do so under very different conditions. States can impose cost-sharing, or limit the frequency, duration, or amount of service provided to a given beneficiary. For this reason, this is the category with the most indicators and the most finely-calibrated scores.

Quality of Care

Given the large number of beneficiaries and the expenses involved in the program, Medicaid is under pressure to prove that it can deliver quality care. Up to now, however, the focus on quality has been primarily on avoiding fraud. Some states appeal to consumers to be careful about divulging their Medicaid card number, and urge their beneficiaries to avoid seeking medical care they do not need. For their part, Medicaid providers are told to watch for "upcoding" of procedures (billing for a more complex and costly procedure than what was actually delivered); to monitor attempts to "unbundle" a single medical event into its component parts in order to increase the fees; to be cautious of cost reports that do not reflect hours worked; and to be suspicious of anyone getting excess prescriptions that they may be reselling.

While these measures may be necessary to protect the fiscal integrity of the program, they are not directly related to the quality of care. In fact, because Medicaid comprises more than 50 different programs, there are no overall indicators of quality that all states maintain. Our comparisons are therefore based on measures that serve as markers of quality.

The data on quality vary a great deal and are a lot more complete for some services, such as nursing home care. Because this type of care was notoriously and dangerously neglected for many years, it has been subjected to greater oversight and more complete data collection. Since 1987, the Centers for Medicare and Medicaid Services (CMS) has defined the protocol that all states must use to survey their nursing care facilities and report their findings.

In cases such as nursing home care or services for children, where a significant proportion of a given service or target population is covered by Medicaid, we have used the quality indicators available for each state for all patient populations as a proxy for quality of care for the service covered by Medicaid. While these data have the limitation of not being specific enough, they provide a close approximation of the quality available to Medicaid recipients.

In the case of nursing home care, the rationale for using statewide data, even when not Medicaid-specific, includes the following:

- The overwhelming majority of nursing homes (93.9 percent) accept Medicaid patients.
- In 2003, the most recent year for which data are available, Medicaid paid for 46 percent of all nursing home expenditures, and this proportion is likely to have increased since then. An additional 12 percent was paid for by Medicare.
- Because nursing home care is so expensive, 56 percent of nursing home residents eventually "spend down" their resources and qualify for help from Medicaid.

In the case of services for children, the rationale is that Medicaid covers a significant portion of their medical care: the program covers more than one in four children in this country. Moreover,

what is adopted as the standard of care under Medicaid is often reflective of what providers do for the pediatric population as a whole, regardless of payer. Additionally, this is one of the few populations for which data on results are available.

The indicators used under the quality of care category cover structure, process, and outcomes. Indicators of structure include those ingredients or elements that facilitate or promote quality of care. Process measures include whether proper procedures were used in delivering care. Outcome measures include both improvements in health status and the avoidance of adverse results.

In part because states have not been held accountable for the quality of their Medicaid programs, they earn the lowest scores in this category. The median score for this category is a meager 28.2 percent of 200 points.

Because states have so many deficiencies in this area, even those ranking at the top have low scores, boosted only by the fact that many others do even worse in this category.

The following states score in the "Top 10" in this category: Massachusetts (143.0 points), Rhode Island (109.0 points), Ohio (106.7 points), Florida (106.4 points), Nebraska (105.4 points), Kentucky (105.1 points), Alabama (97.1 points), Alaska (95.5 points), Virginia (94.0 points), and Maine (92.7 points).

The 10 states with the lowest scores all earn less than 12 percent of the maximum points in this category. They are as follows, ranking between #51 and #42: Idaho (-4.4 points), Oklahoma (-3.8 points), Nevada (8.4 points), Louisiana (10.2 points), Kansas (18.0 points), Maryland (18.8 points), Arkansas (19.5 points), South Carolina (20.1 points), Georgia (22.4 points), and Colorado (22.4 points).

Unlike the previous two categories, quality of care shows a very broad spread in scores, with a more than 17-fold difference between the states with the highest and lowest positive scores (Massachusetts, with 143.0 points; Nevada, with 8.4 points).

To a large extent, much of the difference can be accounted for by differences in the quality of their nursing home facilities. Because some of the indicators used rely on evidence-based benchmarks for adequacy in nursing home care, states that fall short of the acceptable minimum standards earn negative points. As a result, quality of care is the only category in which two states (Oklahoma and Idaho) have negative scores.

The distribution of scores has two "tails" representing statistical outliers on either side of the spectrum: one state that scores considerably higher than the rest, and the two that are at the very bottom, with negative scores. When these three states are omitted, the differences in scores are significantly reduced, although they still vary by a very large factor of 13.0.

Despite its top rank, Massachusetts earns only 71.5 percent of the total points in this category. It is followed at a distance by Rhode Island, with only 54.5 percent of the total points.

These findings suggest that "quality control" needs to be drastically redefined within the Medicaid program. At present, the term is used to refer to the CMS' statutory responsibility to monitor state and local Medicaid eligibility determinations. However, the sifting and sorting of people to see if they are indeed eligible for services is more of an accounting procedure than a quality assessment process. Accountability therefore needs to supplement the current emphasis on accounting. Only then will the public be served and the government be assured that it is getting value for the monies invested in the program.

Reimbursement

Medicaid is financed by the states and the federal government. Federal funding for the program comes from general revenues. As an entitlement program, Medicaid's federal spending levels are pegged to the number of people participating in the program and the services provided; spending is therefore open-ended and subject to fluctuations that are difficult to budget. As costs have risen over time, the program has become an important arena in which issues related to resource allocation have played out.

Even when states may be reluctant to commit an increasing share of their revenues to the program, the political and economic reality is that they need to leverage their share of the costs to maximize what they get from the federal government. The stakes for all participants are high. At present, Medicaid:

- covers over 55 million Americans;
- is a major budget item for the states, averaging 16 percent of all state spending;
- represents the largest source of federal grant support to states;
- accounts for eight percent of all federal spending and one of every five health care dollars spent in the U.S.;
- is the nation's main source of coverage for long-term care;
- supports tens of thousands of health care providers throughout the country; and
- has a significant multiplier effect on the U.S. economy as a whole.

It is therefore not surprising that the financing of Medicaid is a topic that is often debated, defused, reframed, or circumvented, depending on who is affected and who is doing the debating.

The federal government contributes between 50 percent and 76 percent of the payments for services provided under each state Medicaid program. This contribution, known as the Federal Matching Assistance Percentage (FMAP), varies from state to state and from year to year because it is based on the average per capita income in each state. States with lower per capita incomes receive a higher federal matching rate. The federal matching rate for administrative costs is uniform for all states and is generally 50 percent.

Although the sliding FMAP was intended to have a redistributive effect and therefore sought to reduce disparities between states, it does this only partially because of the constraints imposed by the statutory minimum FMAP. The funding formula is also problematic for additional reasons. First, the cost of coverage is substantial for both federal and state governments, and is difficult to predict. In

continued on page 7

Scores and ranks for state Medicaid programs in each category and overall, sorted alphabetically by state

	Eligibility		Scope of Services		Quality of Care		Reimbursement		Overall	
	Score	Rank	Score	Rank	Score	Rank	Score	Rank*	Score	Rank*
Alabama	91.6	50	71.9	49	97.1	7	115.7	25	376.3	42
Alaska	159.3	33	105.1	33	95.5	8	250.0	1	609.9	4
Arizona	95.5	48	142.5	8	52.5	30	184.2	4	474.5	24
Arkansas	190.0	23	94.4	43	19.5	45	111.7	26	415.7	38
California	258.9	5	141.0	10	50.4	33	75.4	42	525.7	14
Colorado	131.8	41	100.6	40	22.4	42	120.9	21	375.7	43
Connecticut	218.7	14	98.9	42	43.7	36	144.6	10	505.8	19
Delaware	127.1	43	86.2	45	63.1	23	200.4	2	476.8	22
District of Columbia	248.5	7	116.3	27	29.4	41	68.8	45	462.9	27
Florida	182.4	27	103.5	35	106.4	4	75.4	42	467.7	26
Georgia	190.9	22	76.3	48	22.4	42	136.5	15	426.1	36
Hawaii	245.0	10	135.1	16	66.7	22	100.2	30	547.1	11
Idaho	117.1	44	91.6	44	-4.4	51	120.9	21	325.2	49
Illinois	143.6	36	145.1	5	71.4	16	79.5	39	439.6	32
Indiana	90.6	51	111.6	31	71.4	16	83.5	37	357.2	45
Iowa	186.0	25	120.7	25	43.4	37	160.1	6	510.2	17
Kansas	183.0	26	131.2	19	18.0	47	100.2	30	432.4	35
Kentucky	162.8	30	104.8	34	105.1	6	123.9	20	496.6	20
Louisiana	228.7	11	118.2	26	10.2	48	100.2	30	457.3	28
Maine	210.0	18	142.6	7	92.7	10	83.1	38	528.4	13
Maryland	226.4	12	125.4	23	18.8	46	152.7	8	523.3	15
Massachusetts	247.6	8	138.5	12	143.0	1	116.9	23	645.9	1
Michigan	217.0	15	124.3	24	55.1	27	79.5	39	475.8	23
Minnesota	254.5	6	158.1	2	50.7	32	127.9	19	591.2	7
Mississippi	92.6	49	66.8	51	58.2	25	100.2	30	317.8	50
Missouri	141.8	37	102.1	39	68.3	20	66.9	47	379.1	41
Montana	159.7	32	135.8	15	72.4	15	144.6	10	512.5	16
Nebraska	220.1	13	138.8	11	105.4	5	161.3	5	625.5	2
Nevada	108.5	46	102.8	36	8.4	49	185.3	3	405.0	40
New Hampshire	211.3	17	136.8	13	84.4	12	116.5	24	548.9	10
New Jersey	216.8	16	126.6	22	55.1	27	12.2	50	410.7	39
New Mexico	160.1	31	113.6	29	32.8	39	140.5	12	447.0	30
New York	264.8	3	168.3	1	83.1	13	44.0	49	560.2	8
North Carolina	188.9	24	108.2	32	69.1	19	140.5	12	506.6	18
North Dakota	139.8	38	145.1	5	53.9	29	104.3	29	443.2	31
Ohio	144.9	35	112.5	30	106.7	3	87.6	36	451.7	29
Oklahoma	193.3	21	71.7	50	-3.8	50	75.4	42	336.7	47
Oregon	204.9	19	155.0	3	51.7	31	132.4	17	544.0	12
Pennsylvania	198.3	20	115.1	28	56.4	26	68.0	46	437.8	33
Rhode Island	296.8	1	134.7	17	109.0	2	59.5	48	600.0	6
South Carolina	132.7	40	82.9	46	20.1	44	128.3	18	364.0	44
South Dakota	101.1	47	102.5	37	37.7	38	111.3	28	352.6	46
Tennessee	175.2	28	141.6	9	85.7	11	NA*	NA*	NA*	NA*
Texas	110.3	45	100.3	41	45.5	35	79.5	39	335.5	48
Utah	167.4	29	132.8	18	80.5	14	100.2	30	480.9	21
Vermont	283.7	2	128.2	21	67.8	21	136.5	15	616.1	3
Virginia	131.0	42	102.4	38	94.0	9	96.1	35	423.5	37
Washington	260.9	4	145.8	4	31.7	40	111.7	26	550.0	9
West Virginia	157.5	34	128.4	20	48.1	34	140.5	12	474.4	25
Wisconsin	246.6	9	136.7	14	71.4	16	152.0	9	606.8	5
Wyoming	133.7	39	81.9	47	62.1	24	160.1	6	437.8	33
Total Possible	**350.0**		**200.0**		**200.0**		**250.0**		**1000.0**	

* TennCare does not pay its providers by fee-for-service, so Tennessee does not have reimbursement indicators that are comparable to the rest of the nation. The state thus lacks a reimbursement score and an overall score. Therefore, the reimbursement and overall categories are ranked one through 50 instead of one through 51.

UNSETTLING SCORES, *from page 5*

addition, Medicaid's matching payments do not automatically adjust to changing economic conditions. The program's scope may therefore be forced to contract during an economic downturn, thus having a negative effect on both the beneficiaries and those who are newly uninsured.

Furthermore, states have used "Medicaid maximization" or "revenue enhancement" strategies to increase federal spending in the program; in some cases, these payments may constitute up to one-sixth of a state's Medicaid expenditures. Because the monies obtained through such strategies enter the states' coffers without earmarking, they are often used for purposes unrelated to the population and services for which Medicaid was created. As a result, these strategies have been the target of measures to insure greater accountability. These measures have included legislation, regulation, greater federal oversight, and moral suasion. Changes in intergovernmental transfer rules would reduce federal payments to states by almost $24 billion over 10 years. States are therefore poised to adjust to a significant shortfall in federal revenues, and many are restructuring their services in anticipation of lost funds.

Few indicators relate directly to reimbursement. We have therefore relied on those that cover three aspects of Medicaid finances: payments per enrollee, by demographic group; physician fees; and Medicaid fees compared to Medicare fees. Because the data on fees are restricted to payments made under fee-for-service and do not reflect payments made to managed care organizations, they capture a decreasing proportion of Medicaid enrollees, particularly in some states where a vast majority of program beneficiaries are in managed care. Nevertheless, fee-for-service reimbursement rates also have an impact on what managed care organization rates pay physicians, as many states peg their capitation rates to what they pay under fee-for-service. Because TennCare, Tennessee's Medicaid program, does not use fee-for-service, that program has not been included in our calculations under reimbursement.

Of the four categories examined, reimbursement is the one with the fewest indicators. It is therefore subject to much fluctuation between and among states. At the same time, it is the "lumpiest" category, with several states sharing the same rank in some cases.

States have wide discretionary authority concerning the methods and amounts of fees. Medicaid fees have lagged in comparison with other physician fees, including those paid under Medicare, and many states face physicians who are reluctant to see Medicaid patients or who place limits on the number or proportion of Medicaid patients in their practices, thus closing off options for new entrants. Physician reimbursement is therefore a proxy for access to care, as research has shown that acceptance of new Medicaid patients is higher in states that have higher Medicaid fees relative to Medicare than in states with lower Medicaid fees.

Unlike the fairly even distribution of scores that characterizes some of the other categories assessed in this report, reimbursement has states with very high and very low scores. At the high end is Alaska, which pays Medicaid providers much more than the national average in order to attract and retain them. As a result, Alaska earns the maximum number of points allotted to this category, 250 points, the only case in which a state does so.

The other states within the top 10 ranks are the following: Delaware, Nevada, Arizona, Nebraska, Wyoming, Iowa, Maryland, Wisconsin, Montana, and Connecticut.

At the other end of the scoring scale, the states occupying the bottom 10 ranks in reimbursement are the following: New Jersey, New York, Rhode Island, Missouri, Pennsylvania, District of Columbia, Florida, California, Oklahoma, Texas, Illinois, Michigan, Maine, and Indiana.

Because New Jersey ranks so low, the scores between the highest- and the lowest-ranking states vary 20.5-fold. But even when the two states representing the extreme values are omitted, the difference in scores between the second-highest state (Delaware) and the next-to-last state is still approximately 4.5-fold.

These are differences that make a difference. States have understandably attempted to keep their Medicaid costs low by paying providers lower fees, and this has had an impact on access to care. Low payment rates deter physician participation in the program, or lead providers to cap their Medicaid clientele. This is especially the case among physicians in solo practice or working in small groups. As a result, an increasing proportion of Medicaid patients are relying on physicians who practice in larger groups, hospitals, or community health centers.

Results

Almost all state Medicaid programs are doing poorly in meeting all of their basic objectives.

The best overall score is only 645.9 (64.6 percent) and the average score is 472.3 out of 1000 points. The median overall score of 471.1 means that half of all states have scores lower than this. Further, 31 states have scores of less than 500 (50 percent of possible points). Highlighting the problem of very widespread and uneven performance is the fact that a total of 30 states (over one-half of states) were in the bottom 10 in one or more of the four categories. These 30 states include: Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Kansas, Louisiana, Maryland, Michigan, Mississippi, Missouri, Nevada, New Jersey, New York, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Virginia, and Wyoming.

The 10 highest-scoring states earn between 645.9 and 548.9 points of the maximum 1000.

The following states occupy the first 10 ranks, in descending order: Massachusetts (645.9), Nebraska (625.5), Vermont (616.1), Alaska (609.9), Wisconsin (606.8), Rhode Island (600.0), Minnesota (591.2), New York (560.2), Washington (550.0), and New Hampshire (548.9).

The 10 most deficient state programs have overall scores ranging from 317.8 to 379.1 of the

continued on page 8

UNSETTLING SCORES, *from page 7*

total 1000 points.

The worst programs, in order from 50th to 41st, are in Mississippi (317.8), Idaho (325.2), Texas (335.5), Oklahoma (336.7), South Dakota (352.6), Indiana (357.2), South Carolina (364.0), Colorado (375.7), Alabama (376.3), and Missouri (379.1).

Even the top-ranking programs fall short in some categories and have ample room for improvement.

When the data are broken down by category, there are gaps between the scores of even those at the top and the maximum scores. For example, in eligibility, Rhode Island, the highest-ranking state in that category, earns only 84.8 percent of the maximum points in that category. Similarly, in scope of services, the state ranked first, New York, gets 84.2 percent of the total points in that category. In quality of care, even the best-scoring state, Massachusetts, receives a modest 71.5 percent of the total. Reimbursement is the only area in which one state, Alaska, gets the maximum number of points. This can be attributed to the fact that the state pays its Medicaid providers much more than the rest of the country in order to attract and retain practitioners. This is a clear anomaly, as suggested by the fact that the second-ranking state in this category earns only 80.2 percent of the total points and the average for the other 48 states was only 44.3 percent of the total.

Emphasizing the spotty performance of some of the top-ranking states is the fact that two states in the "Top 10" overall, New York and Rhode Island, were in the bottom 10 in one of the four categories; both states had poor reimbursement policies. This poor showing confirms that even the states with the most resources, best intentions, and higher overall scores are failing in one or more of the categories we examined: eligibility, scope of services, quality, and reimbursement.

In Short

In summary, this evaluation of Medicaid demonstrates a bleak picture for millions of people in many states.

The first barrier, eligibility, is difficult to get past for millions of uninsured people. The wide variation in eligibility scores, more than threefold between the best and worst states, reflects this, as does the fact that 23 states had eligibility scores less than 50 percent of the total possible (350 points), thus keeping people out who would be eligible were they to live in certain other states.

But even for those eligible for Medicaid, the scope of services is extremely uneven. In addition to the 2.5-fold difference between the best and worst states, 10 states had scope of services scores of less than 50 percent of the possible 200 points.

Similarly, even if people are eligible for Medicaid in their state and the program provides those services needed by particular patients, the miserly reimbursement policies in many states make it less likely that they will be able to find a physician who can provide these services. There was a 20.5-fold difference between the best and the worst scores on reimbursement; in this important category, 31 states had scores that were less than 50 percent of the total possible 250 points.

We have titled our report *Unsettling Scores* because it is indeed disturbing that, after more than four decades, the Medicaid program has clearly failed to achieve its objectives and to therefore fully meet the needs of those it serves or is supposed to serve.

Our findings make it clear that there are large numbers of people who need to be, but are not, eligible; need to have access to a wider scope of services; need to benefit from better quality health care; or need to have access to more providers than are available because state reimbursement policies make their participation difficult if not impossible. Yet these critically needed additions are "voluntary" on the part of states rather than mandated nationally. The fact that many states have chosen to go beyond the federal legal requirements suggests that they are responding to constituent needs and public pressures, and that the "floor" of mandated Medicaid coverage is clearly inadequate. Because the federal requirements are so lacking, if someone happens to live in the "wrong" state – one that does not provide optimally in all four of these categories – they will be denied needed care.

At present, many states are taking measures to recast their Medicaid programs. Some are attempting to make a dent in the number of uninsured by loosening eligibility requirements and allowing a greater proportion of the population or their employers to buy into the program by paying a sliding-fee premium. Others are changing the way care is organized, requiring all beneficiaries to have a "medical home" through which services are orchestrated. Many states are focusing on cost-containment through different approaches. One is experimenting with a "fixed contribution" that caps the amount available for each covered person. Several are focusing on the four percent of "high users" that account for approximately 50 percent of all Medicaid expenses. This in turn requires adopting disease-management strategies, diverting those in nursing homes to less expensive modalities, and promoting behaviors to insure greater compliance with preventive practices and treatment regimes. Yet these approaches can only exacerbate the differences in state programs and thwart any attempt to create a universal program in which coverage is equitable, comprehensive, and portable across state lines.

Given the current concern with health disparities, it is surprising that so little attention has been paid to the fact that, for many Medicaid beneficiaries, the care they get is largely a function of where they live. Geography is therefore one of the determinants of who gets what, when, where, how, and at what cost. The differences in state Medicaid program scores represent inequities in health care rather than desirable diversity. Programs need to be made more standard, more uniform, and more accountable if the many state programs that are now failing are to realistically aspire to the achievements of a select few. ■

Product Recalls

February 28, 2007 — March 15, 2007

This chart includes recalls from the Food and Drug Administration (FDA) Enforcement Report for drugs and dietary supplements, and Consumer Product Safety Commission (CPSC) recalls of consumer products.

DRUGS AND DIETARY SUPPLEMENTS

The recalls noted here reflect actions taken by a firm to remove a product from the market. Recalls may be conducted on a firm's own initiative, by FDA request or by FDA order under statutory authority. If you have any of the drugs noted here, label them "Do Not Use" and put them in a secure place until you can return them to the place of purchase for a full refund. You can also contact the manufacturer. If you want to report an adverse drug reaction to the FDA, call (800) FDA-1088. The FDA Web site is *www.fda.gov.* Visit *www.recalls.gov* for information about FDA recalls and recalls issued by other government agencies.

Recalls and Field Corrections: Drugs — CLASS II

Indicates a problem that may cause temporary or reversible health effects; unlikely to cause serious injury or death

Name of Drug or Supplement; Problem; Recall Information

Levothroid (levothyroxine sodium tablets, USP), 25 mcg, packaged in 100- and 1,000-count bottles, Rx only; Subpotent (6-month stability). Lot # 050604 (100 ct.) and Lot # 050605 (1,000-ct.), exp. date 04/2007, Lloyd Inc.

Levothyroxine Sodium Tablets USP, 25 mcg (0.025 mg), 50 mcg (0.050mg), 75 mcg (0.075mg), 88 mcg (0.088mg), 100 mcg (0.1mg), 112 mcg (0.112mg), 125 mcg (0.125mg), 137 mcg (0.137mg), 150 mcg (0.150mg), 175 mcg (0.175mg), 200 mcg (0.200mg), 300 mcg (0.300mg), 100 and 1000 tablet bottles; Subpotent. Multiple lots, Mova Pharmaceutical Corp.

Thyro-Tab, 0.025 mg, packaged in 150,000-tablet bulk drums intended for repackaging; Subpotent (6-month stability). Lot #HA08306, exp. date 04/2007, Lloyd Inc.

Tizanidine HCl Tablets, 2 mg, packaged in 150 tablet plastic bottles, Rx only; Failed dissolution test requirements. Lot # 9694, exp. date 09/2007, Alphapharm Pty, Ltd.

CONSUMER PRODUCTS

Contact the Consumer Product Safety Commission (CPSC) for specific instructions or return the item to the place of purchase for a refund. For additional information from the Consumer Product Safety Commission, call their hotline at (800) 638-2772. The CPSC web site is *www.cpsc.gov.* Visit *www.recalls.gov* for information about FDA recalls and recalls issued by other government agencies.

Name of Product; Problem; Manufacturer and Contact Information

Children's Easels. The paint on the chalkboard side of Elite 5-in-1 Easels contains high levels of lead. Lead is toxic if ingested by young children and can cause adverse health effects. Discount School Supply, (800) 293-9314 or easelrecall@discountschoolsupply.com.

Children's Jackets. The attached compass on Boy's Jackets with an attached compass can break, posing a choking hazard for young children. Additionally, the liquid mineral oil, inside the compass can be harmful if swallowed. H&M, (877) 439-6261 or www.hm.com.

Children's Lounge Pants. N-Kids Brand Girl's Drawstring Flannel Pants and Pine Peak Blues Brand Boy's Drawstring Flannel Pants are 100 percent cotton and fail to meet the children's sleepwear flammability standards, posing a risk of burn injury to children. These garments were not labeled or marketed as sleepwear, but because they are children's loungewear, they must meet the children's sleepwear flammability standards. Nordstrom Inc., (888) 282-6060 or www.nordstrom.com.

continued on page 10

CONSUMER PRODUCTS *cont.*

Name of Product; Problem; Manufacturer and Contact Information

Children's Mood Necklaces. The recalled children's mood necklaces contain high levels of lead. Lead is toxic if ingested by young children and can cause adverse health effects. Rhode Island Novelty, (800) 528-5599 or www.rinovelty.com.

Children's Necklaces Sold at Claire's. The recalled children's necklaces contain high levels of lead. Lead is toxic if ingested by young children and can cause adverse health effects. Claire's Boutiques Inc., (866) 859-9281 or www.claires.com.

Children's Necklaces. Children's Mood Necklaces contains high levels of lead. Lead is toxic if ingested by young children and can cause adverse health effects. United Imports Inc., (800) 457-3545 or www.unitedimports.com.

Children's Stationary Sets. The children's stationery set contains a razor blade cutter with a sharp edge, posing a laceration hazard to young children. Tri-Star International Inc., (800) 638-2772.

Clamp Meters. Amprobe Digital Clamp Meters used for electrical testing can fail to give an appropriate voltage reading, resulting in the operator believing the electrical power is off, which can pose a risk of shock, electrocution, or thermal burn hazard. Amprobe Test Tools, (800) 350-8661 or www.amprobe.com/recall.

Coffeemakers. The heating element of the Gevalia Kaffe Combo Coffeemaker can melt the plastic outer shell, posing a burn hazard to consumers. Global Marketing Corp., (800) GEVALIA (438-2542) or www.gevalia.com.

Extension Cords. 15-Foot Extension Cords have undersized wiring, and fail to connect properly at the plug and receptacle ends. This poses fire, shock and electrocution hazards to consumers. Dollar Stop Plus, (773) 539-6036.

Gas Grills. The gas hose attached to the side burner of Weber® Genesis(r) 320(tm) Series Gas Grills can crack or break off during shipping, causing it to leak gas when in use, which poses a fire hazard to consumers. Weber-Stephen Products Co., (866) 249-3237 or http://www.weberrecall.com.

Laptop Computer Batteries. If the lithium-ion extended-life batteries used in ThinkPad notebook computers is struck forcefully on the corner, such as from a direct fall to the ground, the battery pack can overheat and pose a fire hazard to users. This is not an internal battery cell defect. Lenovo Inc., (800) 426-7378 or www.lenovo.com/batteryprogram.

Toy Sets. "Elite Operations" Toy Sets contain high levels of lead in the paint, which is toxic if ingested by young children and can cause adverse health effects. Also, the toys have sharp points, posing a laceration hazard. Toys "R" Us Inc., (800) TOYSRUS (869-7787) or www.toysrus.com.

Youth Jackets with Drawstring. The recalled jackets have drawstrings in the hood and waist, or only at the waist. Children can get entangled and strangle in drawstrings that can catch on playground equipment, fences or tree branches. In February 1996, the CPSC issued guidelines to help prevent children from strangling or getting entangled on the neck and waist by drawstrings in upper garments, such as jackets and sweatshirts. Cobmex Inc., (877) 926-2639 or www.cobmex.com.

OUTRAGE, *from page 12*

4. Blacks in the South who were denied access to maternity wards during segregation are also unable to easily obtain a birth certificate.

5. Many who have uprooted themselves may find it difficult to obtain proof of citizenship. This group includes those in nursing homes, many with mental and physical disabilities, and victims of natural disasters.

Taken as whole, these groups constitute a sizeable fraction of Medicaid beneficiaries. Although the federal government felt that 35,000 persons were at risk of losing benefits because of the proof-of-citizenship legislation, the data from the states indicate that many more are indeed vulnerable. In Virginia, for example, the total number of children enrolled in the state Medicaid program declined by 12,000 between July and November 2006. In Florida, the number of children on Medicaid declined by 63,000 from July 2006 to January 2007. In Iowa, the number of Medicaid recipients dropped by 5,700 in the second half of 2006. Declining enrollments in Medicaid combined with mounting protests against the rule resulted in the Centers for Medicaid and Medicare services reversing the policy for infants born in US hospitals to undocumented immigrants. These will be automatically covered by Medicaid for a year, after which their families must submit proof of citizenship.

While this takes care of one of the populations affected by the rule, it does not address the plight of the rest. At present, it is not at all clear if the current difficulties are all unintended consequences of the legislation, or if its sponsors actually felt that that was a just price to pay to keep undocumented immigrants from seeking Medicaid. The fact is that the provision creates procedural barriers for many citizens, thwarts prompt care for those in need, and hinders preventive care for all. ■

Walling off Medicaid Beneficiaries

A year ago, two U.S. representatives from Georgia decided that a major problem with Medicaid was that the program was being swamped by undocumented immigrants who were lying about their entitlement or circumventing eligibility requirements. In an attempt to curtail the enrollment of these "interlopers," these two legislators incorporated a proof-of-citizenship rule into the Deficit Reduction Act of 2006. Prior to that, state Medicaid programs could determine citizenship by allowing applicants to attest to their citizenship in writing, under penalty of perjury. The new provision stipulates that persons seeking Medicaid enrollment must provide "satisfactory documentary evidence of citizenship" such as a passport or the combination of a birth certificate and driver's license. Applicants are required to submit original documents or official copies so certified by the issuing agency.

Both the goal of the stipulation and its implementation seemed clear. The aim of the legislation was to keep illegal immigrants from receiving Medicaid. Program applicants who could not show proof of citizenship were thus excluded. Whatever the merits of this (and a strong argument can be made against any measure that restricts access to care for anyone), the legislation has had a much wider effect that that originally envisioned. In fact, what seemed like a very targeted measure focused on undocumented immigrants has had a blunderbuss effect, affecting many others who are citizens but have difficulty proving it.

Who are these? They are a very mixed lot. The new requirements have had a direct effect on the following:

1. Infants born to low-income undocumented immigrants. While these are US citizens, their parents must apply on their behalf. Health coverage may be withheld while citizenship is processed and approved, which can take several weeks. Parents who feel that their child needs immediate care may therefore opt for the emergency department of their nearest hospital, a costly alternative that is not designed for continuity of care.

2. Persons who have moved (e.g., foster children) and who are unable to locate their birth certificates or other documents to prove their citizenship.

3. Persons born in counties that did not routinely issue birth certificates. For example, a woman born in 1911 in Arkansas in a county that did not start keeping birth certificates until 1914 is therefore "undocumented" and not eligible for Medicaid.

continued on page 10