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method used to categorize and rank benefits was based on several assumptions as well as information from a document with a few incomplete entries. Further, the ranking assumes equal weight for all service categories.

Reviewing Column 5a of Table 1 in conjunction with a state's ranking will reveal a program's focus. For example, compare Michigan's General Assistance-Medical (GA-M) Program with Missouri's GR-M Program. According to Table 1, both programs offer five "Basic" services. However, Michigan's GA-M Program has three times as many "Optional" services as Missouri's GR-M Program, and thus ranks higher than Missouri. Column 5a indicates that Michigan's program provides "Ambulatory" services whereas Missouri's provides "Basic Coverage."

The type of benefits provided by state indigent care programs range from those that are the same as a state's Medicaid program to those that provide ambulatory services only. Table 3 lists all benefit types in ascending order of services as well as their distribution among the states. Alaska's GR-M Program, which is similar to Medicaid, is situated in the upper one-third of all state indigent care programs.

Table 3: The Distribution of State Indigent Care Programs by Benefit Type

Benefit Type[2]	Number of Programs
Varies by County	10
Ambulatory	5
Inpatient Hospital	5
Hospital (Inpatient and Outpatient)	8
Hospital and Physician	1
Hospital and Ambulatory	1
Basic Coverage	6
Similar to Medicaid	11
Same as Medicaid	9
TOTAL[3]	56

The "Scope of Eligibles" category in Table 1 reveals that only one program, California's County Medical Services Program, allows substantially more income and assets than Alaska's GR-M. To qualify for California's County Medical Services Program, an adult must earn less than $484 a month and have liquid assets under $1,500, excluding the home and automobile. To qualify for Alaska's GR-M Program, income must be less than $300 a month and liquid assets less than $500, excluding the home and vehicle. Fourteen other programs have income and asset criteria similar to those of the GR-M Program, while 21 progams have more restrictive criteria.

Table 4: The Distribution of "Scope of Eligibles Compared to Alaska" by Category

Category	Number of Programs
More	1
Equal	14
Less	21
Unknown	22
TOTAL	58

The "Scope of Eligibles" analysis does not consider variation in state-by-state cost-of-living or median incomes. The above comparison also ignores expenditures and numbers served for each program.

Table 5 summarizes the results from Column 4 of Table 1, "Financing," which shows that the majority of programs have some state funding. Twenty-six programs, including Alaska's GR-M Program, are funded solely by state government, and 26 programs are jointly funded by state and local governments. Only six programs depend completely on local funding.

Table 5: The Distribution of "Financing" by Category

Category	Number of Programs
Local	6
State	26
Both	26
TOTAL	58

According to the source document, 20 states have limited indigent care programs. Described in Table 2, Appendix C, these frequently target select populations, such as Missouri's High Risk Maternity and Child Care Program, or supplement existing ones. The State of Alaska does not currently administer any limited state indigent care programs.

NOTES:

[1]Desonia, R.A. and K.M. King. State Programs of Assistance for the Medically Indigent, Washington, D.C.: Intergovernmental Health Policy Project, 1985.

[2]Table 1's Key (in Appendix B) explains the services provided by each benefit type.

[3]Two programs, Maine's GA-M Program (medically necessary) and South Dakota's Catastrophic County Poor Relief Fund, were excluded as the source document's definition of these benefits types are dissimilar to those in Table 3. The total exceeds 50 because six states have more than one indigent care program: Virginia has four; California, Illinois, Michigan, New Jersey and Washington have two.

APPENDICES

Appendix A: Medicaid Services State by State

Appendix B: Tabulation Assumptions

Figure 1: State Indigent Care Services Ranking Explanation

Table 1: Ranking of States by State Indigent Care Program Benefits

Appendix C: Table 3: Limited State Indigent Programs

MEDICAID SERVICES STATE BY STATE

Basic Required Medicaid Services

October 1, 1983

Medicaid recipients receiving federally supported financial assistance must receive at least these services
- Inpatient hospital services
- Outpatient hospital services
- Rural health clinic services
- Other laboratory and X-ray services
- Skilled nursing facility services and home health services for individuals 21 and older
- Early and periodic screening, diagnosis and treatment for individuals under 21
- Family planning
- Physician services

Federal financial participation is also available to States electing to expand their Medicaid Programs by covering additional services and/or by including people eligible for medical but not for financial assistance For the latter group States may offer the services required for financial assistance recipients or may substitute a combination of seven services

Definitions and limitations on eligibility and services vary from State to State Details are available from local welfare offices and State Medicaid agencies

Services provided only under the Medicare buy-in or the screening and treatment program for individuals under 21 are not shown on this chart

Optional Services in States' Medicaid Programs

FMAP*	BASIC REQUIRED MEDICAID SERVICES SEE ABOVE		Podiatrists Services	Optometrists Services	Chiropractors Services	Other Practitioners Services	Private Duty Nursing	Clinic Services	Dental Services	Physical Therapy	Occupational Therapy	Speech, Hearing and Language Disorder	Prescribed Drugs	Dentures	Prosthetic Devices	Eyeglasses	Diagnostic Services	Screening Services	Preventive Services	Rehabilitative Services	Services for Age 65 or Older in IB Institutions: A Inpatient Hospital Services	B SNF Services	C ICF Services	Services for Age 65 or Older in Mental Inst: A Inpatient Hospital Services	B SNF Services	C ICF Services	Intermediate Care Facility Services	ICF for Mentally Retarded	Inpatient Psychiatric Services for Under Age 22	Christian Science Nurses	Christian Science Sanitoria	SNF for Under Age 21	Emergency Hospital Services	Personal Care Services	Total Additional Services	
71	•	Alabama		•											•																				12	AL
50	•	Alaska		•				•				•	•		•	•								•												10	AK
61		Arizona*																																			AZ
74	•	Arkansas	•	•		•		•	•	•		•	•		•	•					•			•	•		•					•			21	AR
50	•	California	•	•		•		•	•	•	•	•	•		•	•					•			•	•		•			•		•			20	CA
50	•	Colorado	•	•		•		•	•	•		•	•		•	•								•	•		•					•			14	CO
50	•	Connecticut	•	•		•	•	•	•	•		•	•		•	•								•			•					•			24	CT
50	•	Delaware	•			•		•	•	•		•	•		•	•								•			•					•			17	DE
50	•	D.C.	•	•		•		•	•	•		•	•		•	•								•			•					•		•	19	DC
56	•	Florida		•					•			•	•		•	•								•			•					•			14	FL
67	•	Georgia	•			•		•				•	•		•	•					•		•	•	•		•					•			13	GA
50		Guam	•	•									•		•	•																			6	GU
50	•	Hawaii	•	•		•		•	•	•		•	•		•	•																			20	HI
67	•	Idaho	•	•	•	•		•		•		•	•		•	•								•			•					•			12	ID
50	•	Illinois	•	•		•	•	•	•	•		•	•		•	•					•			•	•		•	•				•			29	IL
60	•	Indiana	•	•		•	•	•	•	•		•	•		•	•								•			•	•		•		•			24	IN
55	•	Iowa	•	•	•	•		•	•	•		•	•		•	•								•			•					•			19	IA
51	•	Kansas	•	•		•	•	•	•	•		•	•		•	•									•		•					•			23	KS
71	•	Kentucky	•	•		•		•	•	•		•	•		•	•		•	•	•	•			•	•		•					•			22	KY
64	•	Louisiana	•	•		•		•	•	•		•	•		•	•					•			•	•		•	•				•			17	LA
71	•	Maine	•	•		•	•	•	•	•		•	•		•	•					•			•	•		•			•		•			25	ME
50	•	Maryland	•	•		•		•	•	•		•	•		•	•								•			•					•			18	MD
50	•	Massachusetts	•	•		•	•	•	•	•		•	•		•	•								•			•			•		•			28	MA
50	•	Michigan	•	•		•		•	•	•		•	•		•	•								•			•					•			24	MI
53	•	Minnesota	•	•		•	•	•	•	•		•	•		•	•								•			•					•			31	MN
78	•	Mississippi	•	•				•	•	•		•	•		•	•		•			•			•			•					•			1	MS
61	•	Missouri	•	•	•			•	•	•	•	•	•		•	•					•			•			•								16	MO
64	•	Montana	•	•		•	•	•	•	•		•	•		•	•								•			•									MT
57	•	Nebraska	•	•		•	•	•	•	•		•	•		•	•								•			•								2	NB
50	•	Nevada	•	•	•	•	•	•	•	•	•	•	•		•	•								•	•		•					•			2	NV
59	•	New Hampshire	•	•	•	•		•	•	•		•	•		•	•								•			•			•		•			26	NH
50	•	New Jersey	•	•	•	•		•	•	•		•	•		•	•								•	•		•					•			26	NJ
69	•	New Mexico	•	•		•		•	•	•		•	•		•	•								•			•					•			15	NM
50		New York	•	•		•	•	•	•	•		•	•		•	•					•			•			•					•			28	NY
68		North Carolina	•	•		•		•	•	•		•	•		•	•								•			•								19	NC
51		North Dakota	•	•		•		•	•	•		•	•		•	•								•			•					•			23	ND
50		Northern Islands																																	8	NMI
55	•	Ohio	•	•	•	•	•	•	•	•	•	•	•		•	•								•	•		•	•				•			24	OH
58		Oklahoma	•	•		•		•	•	•		•	•		•	•								•			•								11	OK
57	•	Oregon	•	•	•	•	•	•	•	•	•	•	•		•	•		•						•			•			•		•			25	OR
66		Pennsylvania	•	•		•		•	•	•		•	•		•	•								•			•								17	PA
50		Puerto Rico	•	•		•		•	•	•		•	•		•	•								•			•								12	PR
58	•	Rhode Island	•										•		•	•								•			•								11	RI
71	•	South Carolina	•		•			•				•	•		•	•								•			•								12	SC
69	•	South Dakota			•			•		•		•	•		•	•								•			•								14	SD
71		Tennessee						•				•	•		•	•								•			•								17	TN
54	•	Texas	•	•	•	•		•				•	•		•	•					•			•			•								14	TX
68		Utah	•	•		•	•	•	•	•		•	•		•	•								•			•								20	UT
65		Vermont	•	•		•		•	•	•		•	•		•	•								•			•								14	VT
50		Virgin Islands																																	9	VI
52		Virginia	•	•		•		•	•	•		•	•		•	•					•			•	•		•					•			27	VA
50		Washington	•	•	•	•	•	•	•	•		•	•		•	•								•			•								28	WA
71		West Virginia	•	•		•		•	•	•		•	•		•	•								•			•								16	WV
57		Wisconsin	•	•		•		•	•	•		•	•		•	•								•			•								24	WI
50	•	Wyoming		•						•			•		•																				2	WY
•	20	•	16	12	14	12	4	17	16	12	7	11	15	12	19	18	6	3	4	10	8	1	1	15	9	13	24	23	13	1	8	20	18	5		
•	34	•	24	29	15	21	14	22	24	24	20	22	23	24	29	24	17	14	16	19	13	7	7	24	18	12	26	26	20	5	10	26	24	14		
	54		40	46	29	33	18	39	42	36	27	33	38	36	48	42	23	17	20	29	21	8	8	39	27	25	50	49	33	6	18	46	42	19		

*Federal Medicaid Assistance Percentage (FMAP) Rate of Federal financial participation in a State's Medical Assistance Program under Title XIX of the Social Security Act Percentages are rounded and effective as of October 1, 1983
†Categorically Needy People receiving federally supported financial assistance
‡Medically Needy People who are eligible for medical but not for financial assistance
**Indicates operation of a medically needy program under a Section 1115 Demonstration project

Reference: The data shown were reported by individual states and compiled by the Office of Intergovernmental Affairs.

Department of Health & Human Services
Health Care Financing Administration
Office of Intergovernmental Affairs

HCFA Pub. No. 03155-84

A-1

APPENDIX A

APPENDIX B

Tabulation Assumptions

The source document contains many services that do not match service categories in the modified Medicaid format. To adopt these to the Medicaid format, several assumptions were made; these are listed below. Services from the source document are in double quotations; Medicaid categories and the three additional categories are in single quotations.

"Home Health" designated as a partial 'Skilled Nursing Facility and Home Health Services.'

"Emergency Oral Surgery," "Emergency Dental Services," or "Inpatient Hospital Dental Care" designated as a partial 'Dental Services.'

"Outpatient Heroin Detoxification" or "Substance Abuse" designated as a partial 'Rehabilitative Services.'

"Outpatient Mental Health Services" designated as a partial 'Clinic Services.'

"Nonemergency Transportation" or "Emergency Transportation" designated as a partial 'Transportation.'

A single "Other Practitioner Services" equivalent to a partial 'Other Practitioners Services.'

"Physician Office Visits" designated as a partial 'Physician Services.'

"Outpatient Surgery" designated as a partial 'Clinic Services' and a partial 'Outpatient Hospital Services.'

"Hospital Services" or "Inpatient and Outpatient Hospital Services" equivalent to 'Inpatient Hospital Services,' 'Outpatient Hospital Services,' 'Emergency Hospital Services' and a partial 'Physician Services.'

"Medical Supplies and Appliances Essential to Health and Personal Functioning" include 'Dentures,' 'Eyeglasses,' 'Prosthetic Devices' and 'Medical Equipment and Supplies.'

"Outpatient Clinic," "Community Services," or "Health Center Services" equivalent to 'Clinic Services' and 'Rural Health Clinic Services.'

"Blood Products," "Insulin Supplies," "Orthopedic Appliances," and "Hearing Aids" included as 'Medical Equipment and Supplies.' When one item listed, designated as a partial.

Figure 1: STATE

Key and Notes X: Complete Service O: Partial Service *: States with unspecified services †: States without programs	Basic Services									Podiatrists' Services	Optometrists' Services	Chiropractors' Services	Other Practitioners' Services	Private Duty Nursing	Clinic Services	Dental Services	Physical Therapy	Occupational Therapy	Speech, Hearing, and Language Disorder	Prescribed Drugs
	Inpatient Hospital Services	Outpatient Hospital Services	Rural Health Clinic Services	Other Lab and X-Ray Services	Skilled Nursing Facilities and Home Health Services	EPSDT (21 and under)	Family Planning	Physician Services	Total Basic Services											
Alabama	X	X						O	3(1)											
Alaska	X	X	X	X	X		X	X	7		X				X	O	X	X	X	X
Arizona*																				
Arkansas	X	X	X	X				X	5						X					
California	X/X	X/	X/	X/	O/		/X	X/X	6(1)/X		/X				X/X	O/X		/X	/X	/O X/X
Colorado	X	X		X	O			X	5(1)											X
Connecticut	X	X	X	X				X	5		X		O		X	O				X
Delaware†																				
Florida	X							O	2(1)											
Georgia†																				
Hawaii	X	X	X	X	X	X	X	X	8	X	X		X		X	X	X	X	X	X
Idaho†																				
Illinois	X/X	O/O		X/X				X/X	4(1)/4(1)							O/O				O/
Indiana	O	O						O	3(3)											
Iowa*																				
Kansas	X	X	X	X	X		X	X	7	X		X			X	O				X
Kentucky†																				
Louisiana	X	X						O	3(1)											
Maine*																				
Maryland	X	X	X	X	X	X	X	X	8	X	X				X	X	X		X	X
Massachusetts			X	X			X	O	4(1)	X	X		O	X	X	X	X	X	X	X
Michigan	X/	/X		/X	/O		/X	O/O	2(1)/5(2)	/X	/X	/X	/O		/X	O/X		/X		/X /X
Minnesota	X	X		X				X	4								X			X
Mississippi	X							O	2(1)											
Missouri	O	X		X	O			X	5(2)						O					X
Montana	X	X	X	X	X	X	X	X	8	X	X		X	X	X	X	X	X	X	X
Nebraska†																				
Nevada	X							O	2(1)											
New Hampshire†																				
New Jersey	X/X	X/X	X/X	X/X	X/X	X/X	X/X	X/X	8/8	X/X	X/X	X/X	X/X		X/X	X/X	X/X	X/X	X/X	X/X
New Mexico	X							O	2(1)											
New York	X	X	X	X	X	X	X	X	8	X	X		X	X	X	X	X	X	X	X
North Carolina†																				
North Dakota†																				
Ohio	X	X						X	4											X
Oklahoma	X	X						O	3(1)											
Oregon	O	X	X	X	X	X	X	X	8(1)	X	X	X	X	X	X	X	X	X	X	X
Pennsylvania	X	X	X	X	X	X	X	X	8	X	X	X	X		X	O				O
Rhode Island	X	X	X	X	X	X	X	X	8	X	X					X				X
South Carolina	X	X						O	3(1)											
South Dakota*																				
Tennessee†																				
Texas	X	X	X	X	X		X	X	7	X	X	X	X							X
Utah	X	O						X	3(1)											X
Vermont								O	1(1)		O					O				O
Virginia	O/ / /O	O/ / /O		/X/X/	/ /O/			/O/O/	2(2)/2(1)/1(2)/2(2)				/X/X/		O/ / /	/X/X/				/O/O/
Washington	X/X	X/X	X/	X/X	X/O		X/	X/X	7/5(1)	X/	X/	X/	X/	X/	X/		X/		X	O/O
West Virginia†																				
Wisconsin	X	X	X	X	X	X	X	X	8			X		X	X		X	X	X	
Wyoming	X	X	X	X	X	X	X	X	8		X				X		X			X

Reference: State Programs of Assistance for the Medically Indigent

INDIGENT CARE SERVICES

Optional Services																					Other Services			
							Srvcs for Age 65 or Older in TB Inst.			Srvcs for Age 65 or Older in Mental Inst.														
Dentures	Prosthetic Devices	Eyeglasses	Diagnostic Services	Screening Services	Preventive Services	Rehabilitative Services	A. Inpatient Hosp. Srvcs.	B. SNF Services	C. ICF Services	A. Inpatient Hosp. Srvcs.	B. SNF Services	C. ICF Services	Intermediate Care Facility Services	ICF for Mentally Retards	Inpatient Psychiatric Service for Under Age 22	Christian Science Nurses	Christian Science Sanitoria	SNF for Under Age 21	Emergency Hospital Services	Personal Care Services	Total Additional Services	Transportation	Medical Equipment and Supplies	Kidney Dialysis	Total Other Services
																			X		1				0
	X	X											X	X					X		12	X	X		2
																			X		?				0
	X/X	/X				0/X													/X		5(2)/11(1)	X/X	X/X	X/X	3/3
																			X		?				0
X	X	X				0													X		10(3)	0	X		2(1
																			0		1(1)				0
X	X	X	X	X	X	X							X	X				X	X	X	21				0
	0/0																		X/X		4(3)/4(3)	X/X	0/0		2(1)/2(
																			X		1	0			1(1
						X													X		7(1)	0			1(1
																			X		1				0
X	X	X					X			X			X	X				X	X	X	17				0
		X				X															12(1)	0	X		2(1)
/0		/X																	/0		1(1)/12(3)		/X		0/1
	X																		X		4	X	0		2(1)
																			0		1(1)				0
	X																		X		4(1)	0	X		2(1)
X	X	X	X	X	X	X				X	X	X	X	X	X			X	X	X	26				0
																			0		1(1)				0
X/X	X/X	X/X	X/X	X/X	X/X	X/X				X/X	X/X	X/X	X/X	X/X	X/X		X/X	X/X	X/X	X/X	27/27				0
																			0		1(1)	X			1
X	X	X	X	X	X	X				X			X	X	X			X	X	X	24				0
																			X		?				0
																			X		1				0
X	X	X			X	X				X			X	X	X		X	X	X	X	24				0
X	X									X	X	X	X	X	X			X	X		17(?)				0
X	X	X								X			X	X				X			11				0
																			X		1				0
	X	X				X	X						X	X			X	X	X	X	15				0
																			X		?	0			1(1)
																					3(3)	X	0		2(1)
/X/X/	/X/X/	/X/X/																	0/ / /0		2(2)/6(1)/6(1)/11(1)	/X/X/	/X/X/		0/2/2
X/	X/	X/	X/		X/	X/	X/	X/	X/	X/	X/	X/	X/	X/	X/			X/	X/		26(1)/1(1)	/X			0/1
	X		X	X	X	X	X	X	X		X	X	X	X	X			X	X	X	22				0
	X					X							X					X			8				0

Ranking Explanation

Ranking is based on the most services in a single program. That is, for states with more than one program, the program with the most benefits was used for ranking and the other was disregarded except in the case of a tie. States with several programs do not advance in ranking because an indigent generally cannot qualify for two programs.

No distinction was made between optional and mandatory programs as states usually provide some sort of assistance--administrative, financial or both--that induces cities, counties or municipalities to participate. States without state indigent care programs (none) and states who have programs that the source document does not list benefits for, are not ranked. These are listed at the end of Table 1.

When a tie occurred, two methods were used as tie breakers. If one state had two programs and the other had one, the state with the additional program received the higher ranking. For states with one program only, the program with partial benefits or the most partial benefits was assigned the lower ranking. (Partial services are included in the total services and shown in parentheses as well.) If a tie could not be resolved with these methods, the states were assigned the same ranking.

Table 1: Ranking of States by State Indigent Care Program Benefits

COLUMN: 1	2	3			4			5a	5b	5c	5d	6
		SCOPE OF ELIGIBLES COMPARED TO ALASKA			FINANCING			BENEFITS				
									Medicaid Services			
STATE	PROGRAM	MORE	EQUAL	LESS	LOCAL	STATE	BOTH	Type	Number of Basics	Number of Optionals	Number of Other Services	Total Services	RANKING
New Jersey	AFDC Non-Federal Medical			X		X		Same as Medicaid	8	27	0	35	
	General Assistance State Match Medical*			X			X	Similar to Medicaid	8	27	0	35	1
Montana	General Relief*		X				X	Same as Medicaid	8	26	0	34	2
Washington	General Assistance Unemployable	unavailable				X		Same as Medicaid	7	26(1)	0	33(1)	
	Limited Casualty-Medically Indigent			X		X		Basic coverage	5(1)	1(1)	1	7(2)	3
New York	State-Only Medicaid		X				X	Same as Medicaid'	8	24	0	32	4
Oregon	General Assistance -Medical		X			X		Same as Medicaid	8(1)	24	0	32(1)	5
Wisconsin	General Relief-Medical	unavailable					X	Similar to Medicaid (varies by county)	8	22	0	30	6
Hawaii	State-Only Medicaid		X			X		Same as Medicaid	8	21	0	29	7
Maryland	State-Only Medicaid		X			X		Same as Medicaid	8	17	0	25	8
Pennsylvania	General Assistance -Medical		X			X		Same as Medicaid	8	17(2)	0	25(2)	9
Texas	Indigent Health Care Treatment			X		X		Similar to Medicaid	7	15	0	22	10

TABLE READS: In New Jersey the AFDC Non-Federal Medicaid Program has less eligibles than Alaska's GR-M program. The program is financed with state funds. The benefits are the same as those of New Jersey's Medicaid program and include eight basic services and 27 optional services. There are no other services. New Jersey ranks first with 35 total services (none of these are partial).

See the KEY at the end of the table for notes and an explanation of column contents.

COLUMN: 1 2 3 4 5a 5b 5c 5d 6

STATE	PROGRAM	SCOPE OF ELIGIBLES COMPARED TO ALASKA			FINANCING			BENEFITS					RANKING
		MORE	EQUAL	LESS	LOCAL	STATE	BOTH	Type	Medicaid Services: Number of Basics	Medicaid Services: Number of Optionals	Number of Other Services	Total Services	
Alaska	General Relief-Medical		X			X		Similar to Medicaid	7	12	2	21	11
Rhode Island	General Assistance-Medical		X			X		Same as Medicaid	8	11	0	19	12
Massachusetts	General Relief		X			X		Ambulatory	4(1)	12(1)	2(1)	18(3)	13
Michigan	General Assistance-Medical		X			X		Ambulatory	5(2)	12(3)	1	18(5)	
	Residential County Hospitalization*	unavailable					X	Inpatient hospital	2(1)	1(1)	0	2(2)	14
California	Medically Indigent Services	unavailable					X	Similar to Medicaid	3	11(1)	3	17(1)	
	County Medical Services	X				X		Similar to Medicaid	6(1)	5(2)	3	14(3)	15
Connecticut	General Assistance Medical Aid			X			X	Similar to Medicaid	5	10(3)	2(1)	17(4)	16
Wyoming	Minimum Medical			X		X		Similar to Medicaid (varies by county)	8	8	0	16	17
Kansas	MEDIKAN		X			X		Similar to Medicaid	7	7(1)	1(1)	15(2)	18
Virginia	General Relief-Emergency Medical Assistance*	unavailable					X	Ambulatory (varies by county)	3(2)	6(1)	2	11(3)	
	General Relief-On going Medical Assistance*		X				X	Ambulatory (varies by county)	2(1)	6(1)	2	10(2)	
	State and Local Hospitalization*			X			X	Hospital (varies by county)	2(2)	2(2)	0	4(4)	
	State Teaching Hospitals			X		X		Hospital	2(2)	1(1)	0	3(3)	19

COLUMN: 1 2 3 4 5a 5b 5c 5d 6

STATE	PROGRAM	SCOPE OF ELIGIBLES COMPARED TO ALASKA			FINANCING			BENEFITS					RANKING
									Medicaid Services				
		MORE	EQUAL	LESS	LOCAL	STATE	BOTH	Type	Number of Basics	Number of Optionals	Number of Other Services	Total Services	
Missouri	General Relief-Medical			X		X		Similar to Medicaid	5(2)	4(1)	2(1)	11(4)	20
Minnesota	General Assistance -Medical Care			X			X	Basic coverage	4	4	2(1)	10(1)	21
Illinois	General Assistance -Medical			X			X	Basic coverage	4(1)	4(3)	2(1)	10(5)	
	Aid to the Medically Indigent			X		X		Basic coverage	4(1)	4(3)	2(1)	10(5)	22
Arkansas	Indigent Health Care	unavailable				X		Hospital & ambulatory	5	2	0	7	23
Colorado	Statewide Medically Indigent			X		X		Basic coverage	5(1)	2	0	7(1)	24
Utah	Indigent Medical Assistance*			X			X	Basic coverage	3(1)	2	1(1)	6(2)	25
Vermont	General Assistance -Medical			X		X		Ambulatory (limited)	1(1)	3(3)	2(1)	6(5)	26
Ohio	General Relief-Medical			X			X	Hospital & physician	3	2	0	5	27
Indiana	Health Care For the Indigent†			X	X			Hospital (emergency only)	3(3)	1	1(1)	5(4)	28
Louisiana	State Charity Hospital System			X		X		Hospital (at 9 Charity Hospitals)	3(1)	1	0	4(1)	
Oklahoma	Indigent Health Care*			X			X	Hospital	3(1)	1	0	4(1)	
Alabama	Health Care Responsibility Act†			X	X			Hospital	3(1)	1	0	4(1)	29
S. Carolina	Medically Indigent Assistance Fund	unavailable			X			Hospital	3(1)	1	0	4(1)	
New Mexico	Indigent Hospital Claims Act†		X		X			Inpatient hospital	2(1)	1(1)	1	4(2)	33

COLUMN: 1 2 3 4 5a 5b 5c 5d 6

STATE	PROGRAM	SCOPE OF ELIGIBLES COMPARED TO ALASKA: MORE	EQUAL	LESS	FINANCING: LOCAL	STATE	BOTH	BENEFITS: Type	Medicaid Services: Number of Basics	Number of Optionals	Number Of Other Services	Total Services	RANKING
Florida	Health Care Responsibility Act†	unavailable			X			Inpatient hospital	2(1)	1(1)	0	3(2)	
Mississippi	State Hospital Commission	unavailable				X		Inpatient hospital	2(1)	1(1)	0	3(2)	
Nevada	Supplemental Fund For Medical Assistance to the Indigent†	unavailable			X			Inpatient hospital	2(1)	1(1)	0	3(2)	34
XXXXXXXXXXXXXXXXXXXX													
Delaware	none	unavailable			X			Varies by county	u n a v a i l a b l e				
Georgia	none	unavailable			X			Varies by county	u n a v a i l a b l e				
Idaho	none	unavailable			X			Varies by county	u n a v a i l a b l e				
Kentucky	none	unavailable			X			Varies by county	u n a v a i l a b l e				
Nebraska	none	unavailable			X			Varies by county	u n a v a i l a b l e				
New Hampshire	none	unavailable			X			Varies by county	u n a v a i l a b l e				
N. Carolina	none	unavailable			X			Varies by county	u n a v a i l a b l e				
North Dakota	none	unavailable			X			Varies by county	u n a v a i l a b l e				
Tennessee	none	unavailable			X			Varies by county	u n a v a i l a b l e				
West Virginia	none	unavailable			X			Varies by county	u n a v a i l a b l e				

COLUMN: 1	2	3			4			5a	5b		5c	5d	6
		SCOPE OF ELIGIBLES COMPARED TO ALASKA			FINANCING			BENEFITS					
									Medicaid Services				
STATE	PROGRAM	MORE	EQUAL	LESS	LOCAL	STATE	BOTH	Type	Number of Basics	Number of Optionals	Number of Other Services	Total Services	RANKING
Arizona	Arizona Health Care Cost Containment			X			X	Similar to Medicaid	unavailable				
Iowa	State Papers	unavailable				X		Hospital services from the University of Iowa Hospital and clinics					
Maine	General Assistance -Medical		X				X	Medically necessary as determined by physician					
South Dakota	Catastrophic County Poor Relief Fund	unavailable			X			County catastrophic medical expenses (in excess of $20,000)					

TABLE KEY AND NOTES

EXPLANATION

Column 1, STATE.

Column 2, PROGRAM, designates the state indigent care program.

* The symbol * in Column 2 indicates that the program is optional; that is, the local entity responsible for providing care to resident indigents has the option of participating. The inducement for cities, counties or municipalites to participate is usually some form of state assistance--administrative, financial or both.

† The symbol † in Column 2 indicates that the program or statute summarized deliniates county responsibilities for care.

Column 3, SCOPE OF ELIGIBLES COMPARED TO ALASKA, indicates the eligibility criteria of other state programs relative to Alaska's GR-M Program. More indicates those states with less restrictive eligibility requirements, such as allowing more assets and higher income, than GR-M's criteria. Equal indicates those states with eligibility criteria the same as or similar to GR-M's criteria. Less indicates those states with more restrictive eligibility requirements, such as allowing fewer assets and lower income, than GR-M's criteria.

Column 4, FINANCING, indicates which governmental entity funds the program: Local (county or town), State or Both (local and state). South Carolina's program is funded by assessments on counties and hospital revenues.

Columns 5a thru 5d, BENEFITS, summarize the type and quantity of services covered under the state indigent care program.

Column 5a, Type, provides a categorical description of benefits. The categories are listed here in ascending order; that is, the benefit coverage increases with each category, as explained below.

Varies by County indicates each county sets the benefit coverage; therefore, coverage varies within the state.

Physician indicates the program provides primary care physician services only.

Ambulatory indicates the program covers physician and other noninstitutional settings for primary care.

Inpatient hospital indicates the program provides inpatient hospital services only.

Hospital indicates the program covers inpatient and outpatient services, including emergency services, provided at the hospital.

Basic Coverage indicates the program covers most of the mandatory services under Medicaid. These services include: inpatient and outpatient hospital, physician, labs and x-rays, skilled nursing facility and home health, rural health clinic, family planning and EPSDT.

Similar to Medicaid indicates the state indigent care program covers virtually the same services as the state's Medicaid program. (See Appendix A for state benefits under Medicaid.) The difference is the indigent care program usually has more restrictive limitations, does not cover nursing home services or covers slightly fewer services.

Same as Medicaid indicates the state indigent care program benefits are identical to the state's Medicaid program. However, since each state's program is different, the benefits covered under this designation vary with the state.

Column 5b Medicaid Services shows the number of services provided by the state indigent care program. Under Medicaid, there are eight mandatory services (inpatient hospital, outpatient hospital, physician, labs and x-rays, skilled nursing facility and home health, rural health clinic, family planning and EPSDT). Number of Basics indicates the number of mandatory Medicaid services that the state indigent care program provides. Some states elect to expand their Medicaid program by covering additional services. These optional services consist of 32 categories. (See Appendix A for a listing of optional services in state Medicaid programs.) Number of Optionals indicates the number of elective services that the state indigent care program provides. (See Figure 1 in Appendix B for the program's profile of basic and optional services.) Partial services are included in the number of services and shown in parentheses as well.

Column 5c, Number of Other Services, indicates the number of services beyond Medicaid that the indigent care program provides. These other services consist of three categories: transportation, medical equipment and supplies, and kidney dialysis. (See Figure 1 in Appendix B for the program's profile of other services.) Partial services are included in the number of services and shown in parentheses as well.

Column 5d, Total Services, shows the number of basic, optional and other services provided by the state indigent care program. Partial services are counted in the total services and shown in parentheses as well.

Column 6, Ranking, lists the states by the number of benefits in the state indigent care program. The value in Column 5d was used to assign ranking. The state with the most benefits was listed first, the state with the next highest total follows, etc. (See Appendix B for a more detailed explanation of ranking.)

Table 2: Limited State Indigent Care Programs By State*

STATE	PROGRAM	S P E C I F I C S
Alabama	Cancer Screening & Treatment for Indigents	Screening program (pap smears and breast exams) for indigent women in 53 of the state's 67 counties. Services to 15,000 - 20,000 annually. $375,000 funded for FY '85.
Arkansas	High-Risk Maternity Patients	Agreement with Regional Medical Center to reimburse maternity services to certain high-risk residents of a nine-county area in eastern Arkansas. Specific income standards.
Connecticut	Soldiers, Sailors, and Marines Fund	Provides short-term cash assistance and health care services to needy veterans. Interest from a $32 million fund provides operating expenses. Cash payments made to indigent veterans for 16 weeks, except in cases of illness or disability when benefits given from 26 to 28 weeks. Funding for clothing, shelter, health care and burial expenses. $3,100,000 funded for FY '84 of which $1 million provided health care for 100 to 200.
Florida	Primary Care Networks	Authorizes use of $10 million from the Public Assistance Medical Trust Fund to establish primary care programs for indigents through county public health units. RFPs issued to solicit contractors. Intended to provide services for indigents not receiving care. Free care provided to those under federal poverty level; those with incomes ranging from 100 to 200 percent of poverty level receive graduated discounts. Some programs operational by 1985.
	Regional Perinatal Intensive Care	Eligible participants must meet a low-income standard. Medicaid-eligible persons covered after Medicaid Funds exhausted. For those ineligible due to income, a "spend-down" of $250 for medical expenditures permitted. Services provided by contracted hospitals and physicians include prenatal care for women, inpatient hospital services for babies and annual screening for children. $25.9 million projected for FY '84.

*This table lists only those programs that state health policymakers identified as alternatives or supplements to other indigent care programs. Thus, the list is illustrative rather than exhaustive.

STATE	PROGRAM	S P E C I F I C S
Illinois	Pharmaceutical Assistance for Aged and Disabled	Tied to state's tax "circuit breaker" program that provides for low-income people who pay property taxes. Participants must be eligible under the "circuit breaker" program and meet age, income, need and property tax requirements. Eligibles pay an annual fee; no copayment required. Implemented summer 1985.
Kentucky	Quality Charity Care Trust	State, University of Louisville (UL), Jefferson County, City of Louisville and Humana reached a four-year agreement in 1983 whereby Humana leased the UL Hospital in return for providing charity care. Agreement creates the "Quality Charity Care Trust" to reimburse Humana for care; state provides 75 percent of funding, county 15 percent and the city 10 percent. Annual appropriations to trust increases by recent CPI or rate of increase in tax revenues. Humana must provide care for all indigents of Jefferson County and admit all emergency patients (definition of indigent excludes Medicare or Medicaid recipients). Hospital paid-for-care based on normal charges minus five percent. Agreement automatically renewable for nine subsequent four-year periods unless Humana opts out.
Maine	Medical Eye Care	Residents who meet income and medical criteria (significant eye disorder that may progress to blindness if left untreated and a visual acuity of 20/70 after correction in better eye) eligible. Coverage provides eye exams, medication, hospitalization, surgery, transport, laser therapy and eyeglasses. Provider reimbursement based on Medicaid fee schedules. Served 4,000 (75 percent over age 50) in FY '83 for $274,000.
	Pharmaceutical Assistance for Aged Persons	Copayment program to provide drugs used to treat heart conditions, high blood pressure and diabetes. Applicant must meet residency, age and income requirements. $2 copayment levied for each prescription filled. Served 23,000 in FY '81, FY '83; FY '83 expenditures $1,405,000.

STATE	PROGRAM	S P E C I F I C S
Maryland	Pharmacy Assistance	Copayment program to provide assistance in paying for prescriptions. Eligibles for Medicaid are not allowed to participate; other criteria include income and assets (by household size). $1 copayment levied for each prescription filled. FY '84 enrollment 11,000; expenditures $3,500,000.
Minnesota	University Hospital Papers	Intended to provide care for those ineligible for other programs. University of Minnesota Hospital (UMH) receives appropriation from legislature to provide care for indigents referred by county welfare departments. UMH authorized to spend $2 million annually. Eligibility criteria set by counties. Counties pay 40 percent of costs under $11,000 for eligibles and UMH picks up 60 percent. UMH pays all of charges in excess of $11,000. Some counties have strict eligibility criteria while others are more lenient.
Missouri	Blind Pension	Provides medical services to residents who meet age, vision, need for support and asset criteria. Services same as those provided categorically eligible Medicaid recipients; reimbursement follows Medicaid also. Served 1,300 in FY '84. FY '83 expenditures $504,000.
	High-Risk Maternity and Child Care	Income eligibility based on sliding scale adjusted for family size and cost of conditions treated. Services include: transportation for women and infants, care for high-risk pregnant women, care to infants for respiratory distress syndrome, and ultrasound screenings. Services covered by Medicaid not covered, but services not covered by Medicaid provided. A $40,000 reimbursal limit placed on services provided for premature infants. $3 million appropriated for FY '85; expect to serve 1,350.
	Sickle Cell Anemia	Provides screening for 18,000 and treatment for 30. $90,000 appropriated for FY '85.

STATE	PROGRAM	S P E C I F I C S
Missouri (Continued)	Cystic Fibrosis	Expects to serve 200 in FY '85 for $90,000.
	Tuberculosis	Expects to provide 50 inpatient days and 34,000 weeks of outpatient TB services for $245,000 in FY '85.
	State Chest Hospital	FY '85 funding $2,700,000.
	Ellis Fishel Cancer Hospital	FY '85 funding $3,390,000.
	Public Hospital Subsidy	Available to public hospitals; provides a subsidy (not specifically targeted for indigent care) of up to 10 percent of the difference between costs and revenue. FY '85 funding $250,000.
Nebraska	State Disability -Medical	Provides aid to needy persons who have a disability expected to last at least six months but less than the 12 required to qualify for Supplemental Security Income (SSI). Eligibility criteria same as SSI program and services provided same as those under the categorically needy component of Medicaid. Served 1,000 in FY '83 for $1 million.
New Jersey	Pharmaceutical Assistance for Aged and Disabled	Copayment program. Participants must meet income eligibility criteria. $2 copayment levied for each prescription filled. 271,000 served in FY '84 for $70 million.
New Mexico	Special Medical Need Program for The Seriously Ill	For individuals over age 65, blind or disabled and ineligible for Medicaid. Applicant must meet seriously ill and income criteria. Services provide same as those under Medicaid with exception of nursing facilities or intermediate care facilities which are not provided. Inpatient hospital coverage limited to five days per admission. Served 113 in FY '84 for $340,000.

STATE	PROGRAM	S P E C I F I C S
North Dakota	Remedial Blind	Provides services for persons suffering from eye conditions that may cause blindness but do not meet Medicaid definition of blindness. Serves six people a year; FY '85 budget $10,000.
Ohio	Adult Emergency Assistance	For persons meeting eligibility criteria and who have an emergent need. Service provided if delay in treatment results in a threat to or loss of life. In FY '82, $11.6 million spent before eligibility standards tightened. FY '83 expenditure was $1.2 million; FY '84 funding negligible.
Pennsylvania	Pharmaceutical Assistance for the Aged	Copayment program funded from state lottery proceeds. Residents must meet eligibility criteria for age and income and be ineligible for public assistance. Legend drugs, and insulin and supplies provided. $4 copayment levied for each prescription filled. Implemented July 1984. 310,000 participants served to date; $115,600,000 appropriated for FY '85.
South Carolina	Midlands Hospital Indigent Care Partnership	"A short-term solution so that hospitals can remain financially viable until a long-term solution is found." Partnership formed (in 1984) by four general acute-care hospitals in the Greater Columbia area in response to insufficient government funds for indigents. Partnership coordinates one fund and creates another. The first fund (a county-financed medically indigent fund) provides the hospitals payments at 80 percent charges to cover inpatient services delivered. A second fund, the Midlands Hospitals Indigent Care Partnership Fund, was created to cover additional indigent care costs. Hospitals agreed on an amount to be deposited, and each hospital's contribution was derived by multiplying its ratio of inpatient costs to total inpatient costs for the four hospitals with the partnership fund total. Before drawing from partnership fund, hospital must attain its "threshold" of charity care; total "threshold" amount equal to anticipated funding shortfall.

STATE	PROGRAM	S P E C I F I C S
South Carolina (Continued)	Sickle Cell Anemia	Adults with disease are eligible to participate if income does not exceed 200 percent of federal poverty level. Reimburses for clinic services and occasionally hospital services. $180,000 appropriated for FY '85. Served 186 as of June 1984.
South Dakota	Kidney Disease	Copayment program for persons with chronic kidney disease who require dialysis or transplant. Recipients must be eligible for Medicare's End-Stage Renal Dialysis program and meet eligibility criteria. Income eligibility criteria structured in disregards (i.e. two-person family may disregard $12,000 in computing program deductibles). Copayments must equal 20 percent of income above the disregard. Maximum expended on an individual is $5,000. Transplants excluded from program. $374,000 appropriate in FY '85; expected to serve 119 people.
Tennessee	Speech and Hearing	Provides hearing tests and aids to children under the age of 21. 4,252 served in 1983.
	Hemophilia	Provides blood supplies and treatment to hemophiliacs unable to afford care. Services include blood, blood products, hospitalization, and dental services. Limitations include $10,000 per year for antihemophiliac factor and seven days per year for inpatient hospitalization. 317 served for $447,000 in FY '84.
	Chronic Renal Disease	Assist persons suffering from chronic renal disease who are unable to pay for lifesaving care or treatment. Reimbursement provided to hospitals, dialysis clinics, physicians, laboratories and pharmacies. Eligibility criteria include annual income and assets. 1,100 served for $704,000 in FY '84.
Wisconsin	Chronic Renal Disease	Deductibles and copayments program for residents suffering from chronic renal disease and in need of dialysis or a transplant; covers pharmacy, physician, hospital and home dialysis supply costs. Reimbursement for Medicare and Medicaid covered services are at those program's respective rates.

STATE	PROGRAM	S P E C I F I C S
Wisconsin (Continued)	Hemophilia	Covers home blood products and supplies for hemophiliacs. Recipients must meet income and residency criteria and are liable for 0 to 15 percent of care. 101 served in FY '84 for $140,000.
	Needy Indians	Provides cash assistance and medical care for needy Native Americans who meet residency and income criteria. Program administration contracted to ten Indian tribes. FY '83 expenditures for medical care $1.8 million.

THE ANALYST'S CORNER

Primary Care Case Management for Medicaid Clients: Michigan's Response

Vernon K. Smith and Sally Hetrick

In "The Analyst's Corner" in Volume VI, Issue 4, Bruce Spitz of the Health Policy Center at Brandeis University presented an overview of Michigan's Physician Primary Sponsor Plan (PPSP). In the PPSP program, Medicaid clients who select PPSP from among several options select a primary care physician. This physician is obligated to provide case management (the review, control, and coordination of the client's health care needs, including the approval of all referrals), guarantee a twenty-four hour a day point of access for medical care for the client, adhere to a number of client's rights (including second opinions), and operate within cost and utilization limits set by the state.

A DIFFERENT PERSPECTIVE

Spitz described a study that compared the changes in cost and utilization of a control group and a matched population of "case-managed" PPSP enrollees from 1983 to 1984. Spitz stated that the study found substantial savings among recipients who had been classified as high users prior to their PPSP enrollment. He also said the study found that costs and utilization increased for previous nonusers and that only modest savings were experienced for those defined as medium users.

Spitz looked at the savings generated by the high users and concluded that states might want to consider a high-user-only program, thus capitalizing on the large amount of savings generated by a small percentage of the total Medicaid population. This approach would have the additional advantage of allowing states to set up a high-user program without going through the time-consuming waiver process.

In this article, we present a different perspective on the data from the same PPSP study. We first present an analysis of the data that show that PPSP has substantial benefits beyond the high-user population. Second, we describe what constitutes case management to counter Spitz's conclusion that Michigan does not clearly understand the case management process.

THE EXTENT OF PPSP BENEFITS

As mentioned above, Spitz's article concluded that states should consider a program targeted at high users only since the study showed annual savings of $757 per capita compared with small savings for medium users. But a closer look at the data leads to the conclusion that PPSP has benefits for a wide spectrum of the PPSP population. First, for the entire AFDC population, costs and utilization showed significant reductions for the case-managed PPSP group. Net annual savings for the PPSP group relative to the control group were $108, yielding a "PPSP effect" of 13 percent.

Within the AFDC population, there are substantial differences among age groupings. For AFDC adults age 22 and over, the net savings were $463 per person per year. This represents a reduction in costs of 29 percent relative to the control group. This age group also had a higher proportion of high users. Over 21 percent of the adult AFDC eligibles were considered high users of physicians' services.

For AFDC recipients age 15-21, the net annual savings were $241 per person. This represents a reduction in costs of 27 percent relative to the control group. Of special note is that this age group did not have a substantial number of high users. The savings, which are substantial, were from those defined as medium users.

Equally interesting is the impact upon children age 14 and under. When they were enrolled with a physician sponsor, their cost and utilization rose. The net increase in costs (before adding in the case management fees and administrative costs) was $63 per child per year. This represents an increase in costs of 18 percent relative to the control group.

Finally, the analysis shows very little PPSP impact on the high-use disabled SSI population. For this group, there was a small increase in expenditures attributable to PPSP, which was primarily the result of case management fees and administrative costs. Evidently, a case management program has little effect upon cost and utilization of a population that is known to be disabled and in need of more medical care than one that is not disabled.

In contrast to a conclusion that PPSP is only worthwhile for high users, we conclude that PPSP increases the likelihood of children receiving medical care, decreases utilization and costs for AFDC adults, and has little or no impact upon the disabled population. The decrease in

costs in the AFDC adult population is a positive result of PPSP as is the increase in services provided to children. Presumably, case management results in more preventive care and early treatment for children. Increasing appropriate medical care was a goal of PPSP, in addition to reducing overuse by some adults. While PPSP had little cost effect for the disabled population, the disabled may still have benefited from case-managed services.

DEFINING CASE MANAGEMENT

Another of Spitz's significant conclusions was that case management, the cornerstone of PPSP, cannot be operationally defined, and therefore its benefits cannot be fully understood or duplicated. Critics of the case management approach also contend that programs like PPSP rely on restricting access, not case management, to lower costs. This approach does not explain the variation between children and adults and between AFDC and SSI eligibles. Case management does more than restrict access; in fact, for some, particularly children, it appears to increase access.

Case management can be defined, although it is not a simple subject. The definition of case management is found in the Department of Social Services' contract with physician sponsors, which spells out the department's expectations of the sponsor, for example, twenty-four hour availability for care, authorization of nonemergency primary care, and rendering not less than 50 percent of primary care services. The contract also spells out the sponsor's expectations of the department, for example, enrollment lists, utilization reports for high users, and case management fee payments.

The case management expectations are also found in the bulletins that are issued periodically and that provide elaboration of the contract items. Case management is discussed to some degree in every issue of the *Sponsor News*, a publication created to keep physician sponsors informed about the program—one issue was devoted entirely to case management. The medical societies also contribute to the physician's knowledge of case management expectations through their publications.

To ensure that case management is properly applied, case management standards can be identified and verified by comparing actual with anticipated outcomes. For example, authorization of referrals is part of the program. Sponsors are instructed regarding how to make referrals, including what information referral physicians should provide the sponsor. Comparing the medical record to the claims-paid report can verify case management activity.

Similarly, health care standards can also be established and measured to verify that good case management takes place. Protocols for treatment of diseases such as high blood pressure, diabetes, and asthma lend themselves to the establishment of minimal treatment protocols. The management information system can be used to track ongoing treatment and can be augmented with periodic medical record reviews. Michigan is now doing an equivalency-of-care study using an experimental and a control group. After the results of this study are available, ongoing protocols will be developed.

An effective case management program is much more than a concept developed on paper. It is much more than a program to control utilization of the high users in the population. It must be more than a means to increase doctor fees. To ensure that case management is appropriately applied, contract compliance protocols can and should be used at two levels. First, cost effectiveness of the sponsor doctor can be measured through data from the computer system. Claim-detail experience will yield a cost per patient and can be adjusted for age, sex, and welfare category. This approach assures that in a comparison of peers, the physician's cost results will be adjusted for case mix and the attendant differences in cost expectations. For example, a general practitioner with a preponderance of elderly patients will have a very different cost profile than a general practitioner or pediatrician who deals mostly with children.

The second level of the use of contract compliance protocols requires a review of medical records and an interview with the physician. Case management as defined through the contract can be discerned through an examination of the medical records and a review of the physician's stated procedures through use of contract compliance protocols (using a claim detail to verify services rendered both by the physician sponsor and referral physicians).

It takes time to build these components into a PPSP program. In Michigan, it has taken several years. And case management is still evolving in Michigan. The state is looking at several program changes, intended to be enhancements, as a result of findings from both the PPSP monitoring project and the evaluation. In particular:

- Increased enrollment efforts with a special focus on enrolling high users in the separate recipient monitoring control program.
- Enhanced benefits for recipients as a way of sharing the savings with them. This is planned to be done through the elimination of most copayments for enrollees, an additional health care benefit for enrollees, and the establishment of a Medicaid telephone hotline for all eligibles.
- Establishment and use of precontract and contract renewal screening standards for providers.
- Investigation of a financial incentive factor for participating sponsors. This would provide a mechanism for physicians to be rewarded for cost-effective care for their patients.

The evolving concept of case management means different things depending on the recipient population and the provider of care. Michigan is developing one model for primary care medical case management for Medicaid recipients. Another state could develop a different model for the same population. However, certain components are necessary if the program is to control costs successfully while maintaining access and enhancing the doctor-patient relationship. We have identified and discussed some of the key elements while corroborating our belief that case management is a desirable goal for *all* connected with the Medicaid program—the patient, the provider, the taxpayer, and the state administration. ■

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I WANT TO THANK THIS COMMITTEE FOR THE OPPORTUNITY TO SPEAK THIS MORNING ON AN ISSUE OF GREAT CONCERN TO MANY.....MANDATED BENEFITS.

HOWEVER, BEFORE I BEGIN TO DISCUSS THE ISSUE OF MANDATES I FEEL THAT IT IS IMPORTANT TO FIRST SPEAK TO YOU BRIEFLY ON THE CHANGING ROLE OF HEALTH INSURANCE IN OUR SOCIETY.

HISTORICALLY, HEALTH INSURANCE HAS BEEN CENTERED ON WHO WAS PROVIDING THE SERVICES AND THE LOCATION OF THAT SERVICE, BASICALLY A "PROVIDER ORIENTED" APPROACH. IT USED TO BE IF YOU WENT TO A HOSPITAL ALL SERVICES WOULD BE PAID AND IF YOU RECEIVED SERVICES OUTSIDE THE HOSPITAL VERY LITTLE WAS PAID.

AS YOU KNOW, THAT SYSTEM OF HEALTH INSURANCE IS CHANGING. WE ARE NOW BECOMING MORE "PATIENT CENTERED". WE ARE TAKING A CUSTOMER AND FOLLOWING THAT INDIVIDUAL THROUGH THE HEALTH CARE SYSTEM. THIS IS TO ASSURE THAT THE CUSTOMER IS RECEIVING SERVICES THEY NEED AND ARE NOT CHARGED FOR SERVICES THEY DON'T NEED. IN SHORT, WE ARE PROTECTING OUR CUSTOMER IN A BEWILDERING SYSTEM - WE ARE HELPING THE CONSUMER.

THE "TRIPLE OPTION" APPROACH IS A PERFECT EXAMPLE OF THIS CHANGING SYSTEM.

IN THE PAST THERE WAS ONLY ONE PRODUCT AN EMPLOYER COULD PURCHASE. THIS WAS CALLED TRADITIONAL FEE FOR SERVICE HEALTH INSURANCE. NOW, AN EMPLOYER CAN OFFER EMPLOYEES 3 PROGRAMS TO CHOOSE FROM - THIS IS THE "TRIPLE OPTION".

AN EMPLOYEE CAN CHOOSE FROM AN: HMO, PPO AND MANAGED CARE.

BRIEFLY, AN HMO IS A CAPITATED SYSTEM WHERE EACH PROVIDER IS PAID A FLAT AMOUNT PER PATIENT ANNUALLY.

PPOS ARE FEE FOR SERVICE BUT THE PATIENT BASE IS DIRECTED TO A SELECT NUMBER OF PROVIDERS. THIS SYSTEM ALLOWS FOR DISCOUNTS IN PRICE AND UTILIZATION CONTROLS.

MANAGED CARE HAS THE TRADITIONAL FEE FOR SERVICE COMPONENT BUT ALSO PROVIDES FOR PROGRAMS SUCH AS: HOSPITAL PRE-ADMISSION CERTIFICATION AND SECOND SURGICAL OPINION. THIS MANAGES THE PATIENT CARE RECEIVED.

PART OF WHAT WE AT BLUE CROSS AND BLUE SHIELD ARE DOING IS MONITORING LEGISLATIVE ACTIVITY THAT WOULD POTENTIALLY IMPEDE THIS INNOVATIVE APPROACH TO PROVIDING HEALTH INSURANCE.

ONE ISSUE OF GREAT CONCERN IS MANDATED BENEFITS.

BRIEFLY STATED, MANDATES REQUIRE INSURERS TO INCLUDE CERTAIN SERVICES AS COVERED BENEFITS IN ALL POLICIES.

LET'S TAKE A TYPICAL STATE'S LIST OF MANDATES:

NURSE MIDWIVES
PSYCHOLOGISTS
DENTISTS
CHIROPRACTORS
ALCOHOLISM
DRUG ABUSE
MENTAL HEALTH
BREAST RECONSTRUCTION
HOME HEALTH
AMBULATORY SURGERY

....AND THERE ARE NINE MORE FOR THAT STATE ALONE.

I THINK YOU GET MY POINT THAT THERE ARE A LOT OF THEM.

THE CHART IN FRONT OF YOU WILL TELL YOU HOW MANY MANDATES ARE IN YOUR STATE. IF YOU DON'T HAVE THEM NOW IT IS LIKELY THAT YOU WILL SEE THEM.

WHEN A MANDATE IS INTRODUCED LEGISLATIVELY, SEVERAL INTEREST GROUPS VOICE CONCERNS.

EMPLOYERS ASK: AREN'T WE THE BUYERS? ISN'T IT THE BUYER'S RIGHT TO SAY WHAT BENEFITS WE ARE WILLING TO PAY FOR?

UNIONS ASK: ISN'T AN EXPANSION OF BENEFITS SOMETHING FOR THE BARGAINING TABLE? WHAT IF OUR MEMBERS WOULD RATHER HAVE AN EQUIVALENT PAY RAISE, OR SOME OTHER HEALTH BENEFIT, LIKE DENTAL?

INSURERS SHOW CONCERN: IS MANDATING NEW BENEFITS FOR EMPLOYERS COUNTER-PRODUCTIVE WHEN THEY ARE ASKING US TO DO WHAT WE CAN TO REDUCE THEIR EXPENSE? AND WHEN EVERYONE IS URGING US TO COMPETE MORE VIGOROUSLY?

STATE INSURANCE SUPERINTENDENTS CONCUR: BENEFIT DESIGN SHOULD BE BETWEEN THE PAYOR AND THE INSURER, WITH OUR OFFICES MAKING SURE THE BENEFIT IS PROPERLY RATED. HOW ELSE CAN REAL COMPETITION TAKE PLACE?

BUT, YOU AS STATE LEGISLATORS ASK: HOW CAN WE TURN OUR BACKS ON THE REAL WORLD OUT THERE.....PROVIDERS WHO ARE CONVINCED THEY CAN PROVIDE COMPARABLE CARE LESS EXPENSIVELY? WE HAVE BOTH THE RESPONSIBILITY AND RIGHT TO RESPOND TO SUCH POLITICAL PRESSURES.

IS THERE AN ANSWER? WILL THIS TUG OF WAR OVER MANDATES EVER END?

THESE QUESTIONS ARE DIFFICULT TO ANSWER FOR ALL CONCERNED. IN ORDER TO BETTER UNDERSTAND THE ISSUE I WILL FIRST GIVE YOU AN OVERVIEW OF THE TYPES OF MANDATES WHICH EXIST, SECOND, THE EVOLUTION OF MANDATES AND THIRD, SEVERAL OF THE ISSUES INVOLVED WITH MANDATES WHICH IMPACT THE HEALTH SYSTEM.

MANDATED COVERAGE LAWS FALL INTO FOUR CATEGORIES WHICH ARE ROUGHLY EQUIVALENT TO THE: WHO, WHAT, WHEN AND WHERE.

#1) MANDATED BENEFITS - "THE WHAT" - THESE MANDATES EXPAND THE KIND OF SERVICES COVERED SUCH AS ALCOHOLISM TREATMENT OR INVITRO FERTILIZATION.

#2) PROVIDER BENEFITS - "THE WHERE" - THESE MANDATES EXPAND THE NUMBERS AND TYPES OF PROVIDERS ELIGIBLE TO PERFORM AND BE REIMBURSED FOR THE COVERED SERVICES. BIRTHING CENTERS AND AMBULATORY SURGERY CENTERS ARE EXAMPLES.

#3) DEPENDANT BENEFITS - "THE WHO" - THESE MANDATES EXPAND THE NUMBER OF PEOPLE TO BE COVERED UNDER A CONTRACT SUCH AS NEWBORNS AND ADOPTED CHILDREN.

#4) CONTINUATION/CONVERSION BENEFITS - "THE WHEN" - THESE MANDATES EXPAND THE LENGTH OF TIME A PERSON IS COVERED. THESE REQUIRE THAT A WORKER MAY CONTINUE PARTICIPATING IN THE GROUP CONTRACT FOR A CERTAIN PERIOD AFTER EMPLOYMENT TERMINATION.

TOGETHER, THESE MANDATES CREATE A BALLOONING EFFECT. IN FRONT OF YOU ARE TWO CHARTS. AS I NOTED EARLIER, THE FIRST CHART LISTS THOSE MANDATES ENACTED BY EACH STATE AND THE YEAR OF PASSAGE. THE SECOND CHART INDICATES THE GROWTH OF MANDATES ENACTED BY 50 STATES EACH YEAR SINCE THE FIRST MANDATE PASSED IN MASSACHUSETTS IN 1956. THE TOTAL NUMBER OF MANDATES HAS CLIMBED FROM TWO PRIOR TO 1956 TO 645 AT THE END OF 1986.

AS YOU CAN SEE, THE CHART IS REMARKABLY SIMILAR TO THE TRADITIONAL PRODUCT LIFE CYCLE AS TAUGHT IN BASIC MARKETING COURSES. FIRST, THEY ARE INTRODUCED, SECOND THEY TAKE OFF INTO A RAPID GROWTH STAGE, THIRD, THEY MATURE AND LEVEL OFF AND FINALLY DECLINE. THIS TYPE OF CYCLE APPLIES TO EVERYTHING FROM HULA HOOPS TO COMPACT DISCS. UNFORTUNATELY, WHEN CUSTOMERS BECOME BORED WITH STATE MANDATES THEY CANNOT TOSS THEM BACK INTO THE CLOSET. AS YOU KNOW, MANDATES ARE LAWS AND IT IS VERY DIFFICULT TO REPEAL ANYTHING. ASK ANY LEGISLATOR WHO HAS TRIED TO ABOLISH EVEN A SMALL STATE BUREAU.

ALTHOUGH THE NUMBER OF MANDATES PASSED HAS SLOWED IT IS A CONTINUING TREND.

SEVERAL ISSUES EMERGE WHEN DISCUSSING THE ISSUE OF WHETHER OR NOT TO MANDATE COVERAGE.

FIRST, IS COST. THE ACTUAL INCREASE IN CLAIMS COST IS OFTEN THE SUBJECT OF DEBATE.

INSURERS AND EMPLOYER GROUPS MAINTAIN THAT THE COST OF MANDATES ~~KEEP~~ IS ESCALATING.

PROVIDERS AND ADVOCATES FOR CERTAIN DISEASE VICTIMS ARGUE THAT THE COSTS ARE NOT HIGH. THEY STATE THAT THE MONEY SPENT ON ONE SERVICE IS OFFSET BY EVENTUAL SAVINGS IN THE COST OF TRADITIONAL SERVICES.

HOWEVER, WHATEVER THE ACTUAL COST IN TERMS OF CLAIMS SUBMITTED THERE CAN BE LITTLE DOUBT THAT IF ONE EXPANDS THE SERVICES COVERED, AND THE NUMBER OF PEOPLE PROVIDING THE SERVICES, AND THE NUMBER OF PEOPLE RECEIVING THE SERVICES, AND THE LENGTH OF TIME IN WHICH THEY ARE ELIGIBLE TO RECEIVE THEM, THE EXPOSURE TO COST INCREASES MUST BE LARGE. AS STATED PREVIOUSLY, A BALLOONING EFFECT.

THE ARGUMENT THEN BECOMES A QUESTION OF WHETHER THE SOCIAL NEED JUSTIFIES THE POTENTIAL COST. AN INCREASING NUMBER OF LEGISLATORS ARE ASKING THAT QUESTION BY PASSING LEGISLATION WHICH ASSESSES THE SOCIAL AND ECONOMIC IMPACT OF MANDATED BENEFITS.

IN 1984, WASHINGTON BECAME THE FIRST STATE TO ORDER A STUDY OF THE COSTS AND BENEFITS OF MANDATED BENEFIT LAWS. OREGON AND ARIZONA FOLLOWED SUIT IN 1985 AND PENNSYLVANIA IN 1986. SO FAR THIS YEAR FIVE MORE STATES FLORIDA, HAWAII, LOUISIANA, MARYLAND, AND MONTANA HAVE UNDERTAKEN SIMILAR LEGISLATION.

THIS IS A GOOD APPROACH WHEN QUESTIONING THE EFFECTIVENESS OF MANDATED BENEFITS BECAUSE IT DOES NOT PREJUDGE THE MERITS OF ANY MANDATED BENEFIT PROPOSAL, BUT MERELY REQUESTS AN ASSESSMENT OF THE PROS AND CONS OF SUCH A PROPOSAL.

A SECOND MAJOR PROBLEM WITH MANDATES IS THAT IF AN EMPLOYER WANTS TO MAKE AN INSURANCE PACKAGE AVAILABLE TO ITS EMPLOYEES

THEY MUST INCLUDE ALL MANDATES AS PART OF THE PACKAGE. IN OTHERWORDS, IF YOU OFFER ANYTHING YOU HAVE TO OFFER IT ALL. THIS MAKES OFFERING INSURANCE UNAFFORDABLE TO MANY SMALL EMPLOYERS.

THIS LEADS TO THE THIRD MAJOR ISSUE WHICH HAS EMERGED IN THE AREA OF MANDATES...SELF FUNDED HEALTH INSURERS. SELF FUNDING IS LIKE RUNNING YOUR OWN INSURANCE COMPANY. THIS HAS OCCURRED BECAUSE UNDER ERISA, THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, PREEMPTS ANY STATE REGULATION OF SELF FUNDED PLANS. MANDATES DO NOT APPLY. FOR THIS REASON MANY LARGER EMPLOYERS ARE BECOMING SELF FUNDED. THEY CAN THEN AFFORD HEALTH INSURANCE FOR THEIR EMPLOYEES. SMALLER EMPLOYERS OF SAY 200 EMPLOYEES JUST CAN'T TAKE THE RISK.

AN ADDITIONAL POINT WITH RESPECT TO SELF FUNDING. ONCE AN EMPLOYER SELF FUNDS, THE STATE LOSES CONTROL OF THEM. THIS INCLUDES LOSS OF THEIR PARTICIPATION IN GUARANTY FUNDS, STATE RISK POOLS, CONFIDENTIALITY LAWS, PREMIUM TAXES, RESERVE REQUIREMENTS AND OTHER CONSUMER PROTECTION LAWS.

TODAY, APPROXIMATELY 40-50% OF THE GROUP BENEFIT MARKET IS SELF FUNDED AND IT CONTINUES TO GROW AS THE NUMBER OF MANDATES INCREASE.

MY FINAL POINT IS THAT SPECIAL INTEREST GROUPS COME TO LEGISLATORS TO DO FOR THEM WHAT BUSINESS AND LABOR HAS NOT DECIDED TO PURCHASE OR NEGOTIATE. TODAYS PURCHASERS HAVE

BECOME SOPHISTICATED BUYERS OF HEALTH INSURANCE. THEY ARE THE PEOPLE WHO SHOULD DETERMINE WHAT EMPLOYEE BENEFITS SHOULD LOOK LIKE.

INSURERS WILL DESIGN A BENEFIT PACKAGE TO MEET THE NEEDS OF AN EMPLOYER AND ARE CONTINUALLY ATTEMPTING TO FIND COST EFFECTIVE WAYS TO DELIVER SERVICES TO ITS CUSTOMERS.

THE PRESSURES THAT YOU AS LEGISLATORS FACE BACK HOME ARE TREMENDOUS ESPECIALLY WHEN YOU HEAR TESTIMONY FROM TRAUMATIZED INDIVIDUALS.

HOWEVER, KEEP IN MIND WHEN CONSIDERING A MANDATE THAT IT ONLY AFFECTS THOSE INDIVIDUALS WHO ARE INSURED. ROUGHLY 10% OF THE POPULATION IS COVERED UNDER PUBLIC PROGRAMS SUCH AS MEDICARE AND MEDICAID, 15% ARE UNINSURED AND ~~5%~~ 40% ARE SELF FUNDED. THE REMAINING ~~25%~~ 35% OF THE POPULATION IS INSURED. SO, ONLY THOSE ~~25%~~ 35% ARE ACTUALLY AFFECTED BY MANDATES.

AS A LEGISLATOR YOU ARE RESPONSIBLE FOR PURCHASING HEALTH CARE COVERAGE FOR THE STATE EMPLOYEE PROGRAM. WHEN YOU PUT ON YOUR APPROPRIATIONS HAT ASK YOURSELF IF A REQUIRED BENEFIT WILL SAVE THE STATE BUDGET MONEY OR COST THE STATE MONEY. THIS MAY BE A GOOD TEST WHEN CONSIDERING A MANDATE.

TO CONCLUDE, IF THE PURCHASERS AREN'T WILLING TO BUY THE SPECIAL ARGUMENTS OF SO-CALLED BETTER CARE AND LOWER COSTS, [redacted] SHOULD LEGISLATORS DO THEIR MARKETING FOR THEM BY MANDATING EVERYBODY BUY THEIR PRODUCT? [redacted]

THANK YOU.

Blue Cross
and
Blue Shield
Association

Brenda J. Larsen
State Services Representative

1709 New York Ave., N.W.
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STATE MANDATED HEALTH CARE COVERAGE LAWS

(ENACTED THROUGH JUNE, 1987)

PREPARED BY THE OFFICE OF
GOVERNMENT RELATIONS,
STATE SERVICES DEPARTMENT,
BLUE CROSS AND BLUE SHIELD
ASSOCIATION

CONTACT PERSONS:
GREG SCANDLEN
BRENDA LARSEN
AUGUST, 1987

MANDATED COVERAGES

	AL	AK	AZ	AR	CA	CO	CT	DE	FL	GA
ALL LICENSED HEALTH PROFESSIONALS				75						
NURSES						87				
NURSE MIDWIVES		83	85				84		83	
NURSE PRACTITIONERS			85				84			
NURSE ANESTHETISTS			85				84			
PHYSICAL THERAPISTS		87					75			
OCCUPATIONAL THERAPISTS		87			78		82			
SPEECH/HEARING THERAPISTS				85	78					
PROFESSIONAL COUNSELORS					80/81					
PSYCHOLOGISTS	82		83/87	75	80	79	75			80
PSYCHIATRIC NURSES					82		84			
SOCIAL WORKER					76		79			
DENTISTS	75	83	77		76		75			
ORAL SURGEONS										
OPTOMETRISTS	67	83			80		75	X*	74	
PODIATRISTS	76			75	76			X*	74	
CHIROPRACTORS	75	83	83/87		76		71	X*	76/86	80
OSTEOPATHS		83								
NATUROPATHS		87					75			
ALCOHOLISM	79		79	87	78	76	74/77		79	
DRUG ABUSE			79				76		79	
MENTAL HEALTH			79	83	73	76	75/82		76/83	81/84
BREAST RECONSTRUCTION			81	78	78					
MATERNITY				76	76	75	76			78
PRESCRIPTION DRUGS							75			
ORTHOTIC AND/OR PROSTHETIC DEVICES					85					
CLEFT PALATE						87				
DIABETIC EDUCATION					81					
DIABETIC OUTPATIENT										
SECOND OPINION										
HOME HEALTH			82		78	84	75/76			
HOSPICE						84	76			
LONG TERM CARE										
INVITRO FERTILIZATION				87						
AMBULATORY SURGERY			71						77	
ANTI-ABORTION						85	82			
PUBLIC INSTITUTIONS										
AMBULANCE/TRANSPORT FOR NEWBORNS										
PREVENTIVE CARE FOR CHILDREN/INFANTS					74				86	
OTHER HEALTH CENTERS										
DEPENDENT STUDENTS							82			79
ADOPTED CHILDREN			85						85	
NEWBORNS	75	75	74	75/83	71	75	74	74	80/84	74
MENTALLY/PHYSICALLY HANDICAPPED			77	69	71		71		70	72
NON-CUSTODIAL CHILDREN							84			
CONVERSION PRIVILEGE			85	79/85	83		75			
CONTINUATION FOR DEPENDENTS			85	85	76		75/76			80/81
CONTINUATION FOR EMPLOYEES				85	77/84	86			75	86
CATASTROPHIC COVERAGE										
MANDATE EVALUATION			85						87	

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MANDATED COVERAGES

	HI	ID	IL	IN	IA	KS	KY	LA	ME	MD
ALL LICENSED HEALTH PROFESSIONALS			82							83
NURSES										
NURSE MIDWIVES								84		78
NURSE PRACTITIONERS										79
NURSE ANESTHETISTS										84
PHYSICAL THERAPISTS										
OCCUPATIONAL THERAPISTS										
SPEECH/HEARING THERAPISTS										
PROFESSIONAL COUNSELORS										
PSYCHOLOGISTS	84			85		74		75	75	73
PSYCHIATRIC NURSES									83	83
SOCIAL WORKER						**82**			83	77
DENTISTS	74			74		73		74	75	
ORAL SURGEONS										
OPTOMETRISTS			80	74	**83**	73			82	73
PODIATRISTS			81	74		73				73
CHIROPRACTORS				74	86	73	**80/86**	75	86	73
OSTEOPATHS										73
NATUROPATHS										
ALCOHOLISM				76		86	**78**	**80**	**74**	82 80
DRUG ABUSE						**78/86**		**80**	83	78
MENTAL HEALTH			**74/77**			78/86	**86**	75	79/83	73/86
BREAST RECONSTRUCTION			80							
MATERNITY	74								75	75
PRESCRIPTION DRUGS									83	
ORTHOTIC AND/OR PROSTHETIC DEVICES										78
CLEFT PALATE		85		85						82
DIABETIC EDUCATION					**84**					
DIABETIC OUTPATIENT										
SECOND OPINION										85
HOME HEALTH							**82**		77	79
HOSPICE										82
LONG TERM CARE							86			
INVITRO FERTILIZATION	87									85
AMBULATORY SURGERY	74						78			
ANTI-ABORTION							78			
PUBLIC INSTITUTIONS										67
AMBULANCE/TRANSPORT FOR NEWBORNS								80		
PREVENTIVE CARE FOR CHILDREN/INFANTS										
OTHER HEALTH CENTERS				85					79	76
DEPENDENT STUDENTS								78		79
ADOPTED CHILDREN			81							79
NEWBORNS	74	74	75	76	74	74	**76**	73	76	77
MENTALLY/PHYSICALLY HANDICAPPED	68	72	67	69/86				72		X
NON-CUSTODIAL CHILDREN										
CONVERSION PRIVILEGE			83		86	78/80	74		82	79
CONTINUATION FOR DEPENDENTS			76/85		86	78/84	80			77
CONTINUATION FOR EMPLOYEES	74	75	84		86	84	80	83	83/86	79
CATASTROPHIC COVERAGE										78
MANDATE EVALUATION	87									

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MANDATED COVERAGES

	MA	MI	MN	MS	MO	MT	NE	NV	NH	NJ
ALL LICENSED HEALTH PROFESSIONALS										
NURSES								85		84
NURSE MIDWIVES			83	80		87	84			82
NURSE PRACTITIONERS				80		87			85	
NURSE ANESTHETISTS			83	80						
PHYSICAL THERAPISTS										75
OCCUPATIONAL THERAPISTS										
SPEECH/HEARING THERAPISTS					84					
PROFESSIONAL COUNSELORS						85/87			83	
PSYCHOLOGISTS	75	68*	75	74	83	81	74	80	75	73
PSYCHIATRIC NURSES	86									
SOCIAL WORKER	82					85			83	
DENTISTS	75		73	74	78	83	75	75		79
ORAL SURGEONS		85							75	
OPTOMETRISTS			73	66	78		69	75		67
PODIATRISTS			73		78		69	75		
CHIROPRACTORS		79	73	80	78		67	82		80
OSTEOPATHS							67	75		
NATUROPATHS										
ALCOHOLISM	73	74/82	73/82	74	77/85	79	80	83		77
DRUG ABUSE		74/82	73/82		80	81		83		
MENTAL HEALTH	73/82		75		80	81			75/83	
BREAST RECONSTRUCTION		85	80					83		83
MATERNITY			73		73			77		
PRESCRIPTION DRUGS										
ORTHOTIC AND/OR PROSTHETIC DEVICES		85								
CLEFT PALATE										
DIABETIC EDUCATION										
DIABETIC OUTPATIENT										
SECOND OPINION										80
HOME HEALTH	86					81		75		
HOSPICE		84						83		
LONG TERM CARE										
INVITRO FERTILIZATION										
AMBULATORY SURGERY		84/85	76		75/81					
ANTI-ABORTION					83					
PUBLIC INSTITUTIONS			73			73	84			
AMBULANCE/TRANSPORT FOR NEWBORNS				79						
PREVENTIVE CARE FOR CHILDREN/INFANTS										
OTHER HEALTH CENTERS										
DEPENDENT STUDENTS							76			
ADOPTED CHILDREN	75		83							
NEWBORNS	74		73	74	74	73	75	76	75	75
MENTALLY/PHYSICALLY HANDICAPPED	56	66	69	72		71		76	69	66
NON-CUSTODIAL CHILDREN										
CONVERSION PRIVILEGE	76		77		81	81	78	80		
CONTINUATION FOR DEPENDENTS			73/77		69		80	80	81	76/80
CONTINUATION FOR EMPLOYEES			73		85	81	79			82
CATASTROPHIC COVERAGE			76							
MANDATE EVALUATION							86			

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MANDATED COVERAGES

	NH	NY	NC	ND	OH	OK	OR	PA	RI	SC
ALL LICENSED HEALTH PROFESSIONALS										
NURSES		**84**						86		
NURSE MIDWIVES	85	82			84	71		82		
NURSE PRACTITIONERS				84			80	86		
NURSE ANESTHETISTS								86		
PHYSICAL THERAPISTS		73								
OCCUPATIONAL THERAPISTS										
SPEECH/HEARING THERAPISTS										
PROFESSIONAL COUNSELORS										
PSYCHOLOGISTS	77	71	77	87	74	71	76	78		
PSYCHIATRIC NURSES										
SOCIAL WORKER		85								
DENTISTS	77	75			73	71	71			
ORAL SURGEONS										
OPTOMETRISTS	77	X			80	71	76	78		85
PODIATRISTS	77	X			80	71				72
CHIROPRACTORS	84	X	73	79	80	71		**81**	87	**80**
OSTEOPATHS	77				80					
NATUROPATHS										
ALCOHOLISM	**83**	82/83	**84**	75/87	78		75/81	86	80	
DRUG ABUSE			**84**	75/87					87	
MENTAL HEALTH		77		75/87	83		73			
BREAST RECONSTRUCTION		75								
MATERNITY		76			79		73			
PRESCRIPTION DRUGS										
ORTHOTIC AND/OR PROSTHETIC DEVICES										
CLEFT PALATE			82							
DIABETIC EDUCATION										
DIABETIC OUTPATIENT										
SECOND OPINION		76							83*	
HOME HEALTH	77	72/75							84*	
HOSPICE		**85**								
LONG TERM CARE										
INVITRO FERTILIZATION										
AMBULATORY SURGERY		**X**				76				
ANTI-ABORTION				79				82		
PUBLIC INSTITUTIONS			75		76					
AMBULANCE/TRANSPORT FOR NEWBORNS	75									
PREVENTIVE CARE FOR CHILDREN/INFANTS		82								
OTHER HEALTH CENTERS		**X**								
DEPENDENT STUDENTS										
ADOPTED CHILDREN										
NEWBORNS	75	77	73	79	74	**84**	75	76		74
MENTALLY/PHYSICALLY HANDICAPPED	69	65	69/73	**82**	71			68		70
NON-CUSTODIAL CHILDREN										
CONVERSION PRIVILEGE	83	71/81	82	83	75/84		77		78	78
CONTINUATION FOR DEPENDENTS	83	81	83	87					83	78
CONTINUATION FOR EMPLOYEES				80						
CATASTROPHIC COVERAGE									74	
MANDATE EVALUATION							85	86		

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MANDATED COVERAGES

	SD	TN	TX	UT	VT	VA	WA	WV	WI	WY
ALL LICENSED HEALTH PROFESSIONALS	80									71
NURSES							81			
NURSE MIDWIVES	80			79			81	83		
NURSE PRACTITIONERS	80						81			
NURSE ANESTHETISTS										
PHYSICAL THERAPISTS						87				
OCCUPATIONAL THERAPISTS										
SPEECH/HEARING THERAPISTS			83							
PROFESSIONAL COUNSELORS						87				
PSYCHOLOGISTS	86	74	77	75		77				85
PSYCHIATRIC NURSES								77		
SOCIAL WORKER		**85**	87	75		**79/87**				
DENTISTS		74	83						75	
ORAL SURGEONS										
OPTOMETRISTS		65	79	75		77			75	
PODIATRISTS		65	77	75		79	83		75	
CHIROPRACTORS		81	79	75		79*	**83**		**76**	
OSTEOPATHS			**58**			77				71
NATUROPATHS										
ALCOHOLISM	79	**79**	81	81	82/85	77/80	74/87	82	74/85	
DRUG ABUSE			81			77/80			74/85	
MENTAL HEALTH		**79/80**	81		76	76/77	83	77*	74/86	
BREAST RECONSTRUCTION							83/85			
MATERNITY		84	77			78			82	
PRESCRIPTION DRUGS										
ORTHOTIC AND/OR PROSTHETIC DEVICES										
CLEFT PALATE										
DIABETIC EDUCATION									84	
DIABETIC OUTPATIENT				84					82	
SECOND OPINION										
HOME HEALTH			**87**		76		**83**		78	
HOSPICE							**83**			
LONG TERM CARE								86		
INVITRO FERTILIZATION			**87**							
AMBULATORY SURGERY				76						
ANTI-ABORTION										
PUBLIC INSTITUTIONS									80	75
AMBULANCE/TRANSPORT FOR NEWBORNS										
PREVENTIVE CARE FOR CHILDREN/INFANTS										
OTHER HEALTH CENTERS			83						75	
DEPENDENT STUDENTS										
ADOPTED CHILDREN	83			85						
NEWBORNS	76	74	73	77	76	76	74/84	75	76	75
MENTALLY/PHYSICALLY HANDICAPPED		69	81	75		74	69		75	71
NON-CUSTODIAL CHILDREN										
CONVERSION PRIVILEGE	79	80	77	79		82	84		80	83
CONTINUATION FOR DEPENDENTS	80	86	79		84		80	83	80	
CONTINUATION FOR EMPLOYEES							73	82	73/80	
CATASTROPHIC COVERAGE										
MANDATE EVALUATION							84			

X = Year unknown

* = Commercials only

Bold Print = Mandated offerings

08/87

MANDATED COVERAGES

Miscellaneous

AZ - Maternity benefits for natural mother of an adopted child on adopted parents policy (86)

CA - Sterilization (70); Prenatal Care (76,79); Acupuncture (84); Psychiatric Health Facility (84)

CT - Notice of Termination (82); most passed under comprehensive health care act of 1975; HMO Rehabilitation Facilities (82); Emergency Ambulance Services (83); Home Health Aides; (84) Home Health Aides under Medicare supplement policies (86)

CO - Anti abortion mandate for state group only (85)

HI - Prepaid Health Care Plans (74)

ID - Complications of Pregnancy (76)

IL - Raped or Sexual Assault (75,82); Psychologists Mandated Through Regulation (76); Liver Transplants (84);

KY - Newborn Nursery Care (80); Nursing Home (86)

LA - Non-group to age 65 (74)

MA - Cardiac rehabilitation (86)

MD - Partial Psychiatric Hospitalization (76); Blood Products (75); Orthopedic Braces (78); OP benefits resulting from UR programs (85)

MI - Non-group Medicare Complimentary Coverage (85); Mental Hospitals (83)

MS - Pre-existing Conditions (82)

MO - Pharmacists (78)

MT - Denturists (85)

NV - Chinese Medicine (75)

NJ - Diagnostic X-rays by Chiropractors (76)

NY - Pre-admission Testing (76); Ambulance Cancer Treatment (82); Nursing Home Option (X)

ND - Continued Coverage after HMO Selections (83)

NH - Practitioner Mandates of 1977 do not apply to Plan; Lay Midwives (85)

OH - OP Dialysis (72)

OR - Denturists (80)

TN - School Psychologists (82)

TX - OP Psychiatric Centers (83); Dietician (87)

VA - Opticians (77); Termination Notice (82); Mandated Benefit Option (82)

WA - Removal of a rider (87)

WI - Tuberculosis; Skilled Nursing Homes (75); Kidney Disease (74) Insulin Infusion Pumps (81)

ALASKA HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

TO: Lisa DATE: 10/12

FROM: Mary Jennings

We didn't do overlays of prenatal service to Ak. area populations because: (1) community populations don't correspond to the area pop. actually served by a provider; (we also couldn't get females of child bearing by community – only by census area); (2) Census Areas don't really work because a provider's work area doesn't really correspond to the census areas. I feel the issue of prenatal care delivery in Alaska can be researched from another angle but I'm not sure ~~dire~~ which direction you would like to take. Please contact me if you would like to discuss this.

MJ

Pouch Y, State Capitol
Juneau, Alaska 99811
(907) 465-3991

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

P.O. Box Y, State Capitol
Juneau, Alaska 99811-3100
Mail Stop 3100
(907) 465-3991

October 12, 1987

MEMORANDUM

TO: Representatives Niilo Koponen and Johnny Ellis

ATTN: Lisa McLaren

FROM: Mary Jennings
Legislative Analyst

RE: **Location of Prenatal Care Providers in Alaska**
Research Request 88.032

You requested that we determine the number of prenatal care providers in Alaska by community and by provider type (i.e., private practice, State of Alaska public health nurse, U.S. Public Health Service, military and lay midwife).[1] Additionally, you requested information concerning the patient eligibility requirements applicable to the State public health nurse service and the U.S. Public Health Service.

Private Practice

There are approximately 129 private physicians providing prenatal care throughout Alaska. The physicians specialize in either obstetrics/gynecology or family practice medicine. In addition to the physicians, there are 10 certified nurse midwifes. These prenatal care providers are associated with the 17 hospitals located in the state.[2]

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[1]After discussions with various health professionals, it was decided that a prenatal care provider is best defined as a physician, certified nurse midwife, or lay midwife who is the primary care provider of a pregnant woman and has delivery privileges at a hospital or birthing center. Although State health nurses are not primary care providers, these data are significant because for those rural women who are unable to regularly visit a physician, the public health nurse, with urban physician oversight, is the provider of prenatal care.

[2]Of the 20 hospitals in the state, 17 provide primary health care services and three are psychiatric facilities.

Public Health Nurses

Public health nurses are employed by the State of Alaska Department of Health and Social Services (DHSS) to provide professional nursing services in urban health centers and rural communities. There are 68 public health nurses in the state.[3] Public Health Nurses are employed at health centers and also serve on an itinerant basis. Itinerant nurses are based in one community but do the majority of their work in outlying rural areas. In addition to providing education and counseling considered essential to ongoing prenatal care, public health nurses may provide pregnancy testing and initial screening for referral to primary care. Anyone may visit a public health nurse. Persons with financial resources may volunteer payment for services rendered.

According to DHSS, all communities in Alaska are provided with some level of health service, including prenatal care. The department states that remote rural areas, to which transportation is costly, receive the lowest level of health care service. Some communities may receive only a few visits per year from an itinerant nurse. The department specifically mentioned the Prince of Wales area as receiving minimal service. Although a public health nurse is employed at the Craig Health Center, the surrounding communities are served by only one itinerant nurse. The Prince of Wales-Outer Ketchikan area has a population of over 5,000 people.

U.S. Public Health Service

The U.S. Public Health Service provides health care to Native persons in Alaska. The Health Service has a large medical center in Anchorage and nine smaller facilities throughout the state.[4] To obtain health care, persons must have identification showing that they are registered as Native Americans with the Bureau of Indian Affairs. A non-Native spouse of a

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[3]Ten nurses serve on a contract basis with DHSS. These contractors are based in Kotzebue, Barrow, Nome and Anchorage.

[4]Aside from the medical facility in Anchorage, the U.S. Public Health Service has clinics in Barrow, Dillingham, Fairbanks, Juneau, Ketchikan, Kotzebue, Metlakatla (Annette Island), Sitka and Bethel.

Native may receive prenatal care. (Health care to the mother is curtailed after the birth of the baby.) Fifty-three physicians and 13 certified nurse midwives employed by the U.S. Public Health Service provide prenatal care. Physicians or nurse midwives visit all villages at least twice a year to provide health services.

Each village has a health aid employed by the U.S. Public Health Service. The health aid is a lay person who has received several weeks of medical training with emphasis on prenatal care. The health aid acts as a liaison between the urban physician and the pregnant women of his or her village. According to Jackie Greenman, Director of the U.S. Public Health Service prenatal care program, this system of care delivery provides adequate service. Ms. Greenman stated that many village women see a physician only once during their pregnancy. She felt that if additional funding existing for transportation, women would be encouraged to visit a primary care provider during their first and third trimesters of pregnancy.

Military

The United States Military has five facilities in the state that provide military employees and their dependents with prenatal care. A total of 20 physicians provide this service.

Lay Midwives

There are 11 lay midwives registered with the Alaska Lay Midwife Association. All 11 midwives have private practices and are located in urban areas in the state. Registration with the Association is voluntary. According to Sherry Holly, director of the Association, there are several more practicing midwives in the state, but it would be difficult to estimate their numbers--especially those in rural areas.

Location of Providers

Table 1 provides a list of Alaska communities and the location and type of prenatal care providers. The table indicates that there are 37 communities in which one or more prenatal care providers are based. (There are 295 communities/villages in the state.) The table does not provide an accurate indication of the level of prenatal care service received throughout the state. Some service is provided to all areas because, as mentioned

earlier, many of the public health nurses are based in urban areas but actually work in rural areas. Also, U.S. Public Health Service prenatal care providers visit all villages.[5]

Discussions with the Department of Health and Social Services and the U.S. Public Health Service indicated that there are areas in the state that receive relatively low levels of prenatal care service. The majority of officials agreed that many rural areas could be better served by additional funding that would allow more frequent visits by primary care providers and/or more visits by rural women to urban areas.

I hope you find this information useful. Please contact me if you have any questions.

Attachment

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[5]Public health nurses and the U.S. Public Health Service coordinate services when possible. For example, if a public health nurse is going to a rural community where there are pregnant women under Public Health Service care, the nurse will consult with the village health aid as to the health of these women.

TABLE 1
PRENATAL CARE PROVIDERS BY COMMUNITY

COMMUNITY	TOTAL	PRIVATE PRACTICE		PUBLIC HEALTH NURSE	U.S. PUBLIC HEALTH SERVICE		MILITARY		LAY MIDWIFE
		Physician	Nurse		Physician	Nurse	Physician	Nurse	
Adak	2						2	0	
Aleution Chain	1			1					
Anchorage	94	60	4	2	6	7	8		7
Annette Island	2				1	1			
Barrow	7			3	4	0			
Bethel	24			10	13	1			
Bristol Bay	5				4	1			
Cordova	3	3	0						
Craig	1			1					
Dillingham	1			1					
Fairbanks	38	13	0	10	4	1	8	0	2
Fort Greely	2						2	0	
Fort Yukon	1			1					
Galena	1			1					
Glenallen	3	2	0	1					
Haines	1			1					
Homer	8	4	2	2					
Juneau	18	8		5	4	0			1
Kenai	2			2					
Ketchikan	16	5	1	5	4	1			
Kodiak	9	6	0	2					1
Kotzebue	6			2	4	0			
McGrath	1			1					
Naknek	1			1					
Nome	10	6	0	4					
Palmer	5	3		2					
Petersberg	3	2	0	1					
Prince of Wales	1			1					
Seward	5	3	1	1					
Sitka	15	3	0	2	9	1			
Soldotna	8	6	2						
Tanana Valley	1			1					
Valdez	3	3	0						
Valdez-Cordova	1			1					
Wasilla	2			2					
Wrangell	3	2	0	1					
TOTAL	304	129	10	98	53	13	20		11

Prepared by the House Research Agency, October 1987 (88.032; 080387-03).

CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

TABLE 1
PRENATAL CARE PROVIDERS BY COMMUNITY

COMMUNITY		PRIVATE PRACTICE		PUBLIC HEALTH NURSE	U.S. PUBLIC HEALTH SERVICE		MILITARY		LAY MIDWIFE
	TOTAL	Physician	Nurse		Physician	Nurse	Physician	Nurse	
Adak	2						2	0	
Aleution Chain	1			1					
Anchorage	94	60	4	2	6	7	8		7
Annette Island	2				1	1			
Barrow	7			3	4	0			
Bethel	24			10	13	1			
Bristol Bay	5				4	1			
Cordova	3	3	0						
Craig	1			1					
Dillingham	1			1					
Fairbanks	38	13	0	10	4	1	8	0	2
Fort Greely	2						2	0	
Fort Yukon	1			1					
Galena	1			1					
Glenallen	3	2	0	1					
Haines	1			1					
Homer	8	4	2	2					
Juneau	18	8		5	4	0			1
Kenai	2			2					
Ketchikan	16	5	1	5	4	1			
Kodiak	9	6	0	2					1
Kotzebue	6			2	4	0			
McGrath	1			1					
Naknek	1			1					
Nome	10	6	0	4					
Palmer	5	3		2					
Petersberg	3	2	0	1					
Prince of Wales	1			1					
Seward	5	3	1	1					
Sitka	15	3	0	2	9	1			
Soldotna	8	6	2						
Tanana Valley	1			1					
Valdez	3	3	0						
Valdez-Cordova	1			1					
Wasilla	2			2					
Wrangell	3	2	0	1					
TOTAL	304	129	10	68	53	13	20		11

Prepared by the House Research Agency, October 1987 (88.032; 080387-03).

POLICY STATEMENT

THE ROLE OF THE PUBLIC HEALTH NURSE IN PRENATAL CARE

Public health nurses provide professional nursing services in urban health centers, rural communities and remote villages Statewide. Many public health nurses work in isolated areas of the State that have limited medical resources. Pregnant women in these areas may not have ready access to "a primary care provider."[1] In medically underserved areas, the public health nurse is often the only accessible licensed health care provider. In these areas, the degree and variety of public health nursing services provided may vary in relation to medical resources.

In urban areas, in addition to providing education and counseling considered essential to ongoing prenatal care, the public health nurse may provide pregnancy testing and initial screening, and referral to a primary care provider.

In medically underserved areas, the public health nurse may initiate prenatal monitoring. Copies of the client's Prenatal History (06-1371) and Prenatal Flow Record (06-1372) shall be provided to the client's primary care provider. Upon receipt of the client's Prenatal Flow Record (06-1372), on which the primary care provider has identified risk factor, problems and plans, the public health nurse may continue to provide services to the client on an ongoing basis. In addition to education and counseling, these services may include gathering and monitoring selective prenatal data and evaluating the normalcy of the data through the process of guided assessment. The record of each client encounter is forwarded to the primary care physician following each visit.

In situations where the client makes no contact with a primary care provider, and/or the public health nurse receives no response to the record of her assessment, the public health nurse may continue to provide education and counseling.

[1]A primary care provider (attending physician or certified nurse midwife) is one who is trained and licensed to provide the medical management of pregnant women, and is held legally responsible for the consequences of their medical care and accountable for the outcome of the patient and her pregnancy.

Approved by:

Elizabeth Ward, M.N.
Director
Division of Public Health

March 13, 1987
Date

STATE of Alaska, Division of Public Health.

PUBLIC HEALTH NURSES	PCN	TELEPHONE	LOCATION
Abel, Betty	1502	543-2110	Bethel Itinerant, Dist V
Andrew, Jo	1115	543-2110	Bethel Itinerant, Dist II
Bayer, Nancy	1489	452-1593	Fairbanks Itinerant
Berger, Jeanne	1323	276-5363	Anchorage Itinerant
Blaschka, Rae Jean	1102	486-3319	Kodiak Itinerant
Bliesath, Lissa	1147	662-2460	Fort Yukon Itinerant
Brunner, Joanne	1545	452-6406	Fairbanks Home Health
Cameron, Linda	1103	543-2456	Bethel Health Center
Campbell, Marjorie	1259	376-2437	Wasilla Health Center
Chamberlin, Mary	1424	835-4612	Valdez/Cordova Itinerant
Cushing, Marlene	1218	772-4611	Petersburg Health Center
DeBerge, Mary	1520	543-2456	Bethel Health Center
Daubney, Lois	1141	224-5567	Seward Health Center
Delaney, Dorothy	1148	452-1776	Fairbanks Health Center
Demoski, Diane	1123	524-3868	McGrath Itinerant
Dohner, Sheree	1148	452-1776	Fairbanks Health Center
Elston, Katharine	1500	225-4350	Ketchikan Health Center
Fenske, Donna	1124	235-8857	Homer Itinerant
Finn, Kathy	1100	543-2110	Bethel Itinerant, Dist VII
Fisch, Mary	1544	586-3736	Juneau Home Health
Ford, Pamela	1371	874-3615	Wrangell Health Center
Golden, Debra	1425	452-1776	Fairbanks Health Center
Henley, Shirley	1236	283-4871	Kenai Health Center
Hopson, Barbara	1460	586-3736	Juneau Health Center
Housman, Janis	1302	842-5981	Dillingham Itinerant, Dist II
Jacobsen, Elinore	1220	225-4350	Ketchikan Health Center
Jepsen, Deborah	1408	452-1776	Fairbanks Health Center
Johnson, Bonnie	1383	452-6406	Fairbanks Home Health
Krygier, Barbara	1382	586-3736	Juneau Health Center
Lefever, Dolly	1136	246-4250	Naknek Itinerant
Lehmann, Patricia	1225	747-3255	Sitka Itinerant
Lokken, Janet	1146	452-1593	Tanana Valley Itin., Fbks.

PUBLIC HEALTH NURSES	PCN	TELEPHONE	LOCATION
Manual, Wilma	1122	543-2110	Bethel Itinerant, Dist VI
Martin, Susan	1399	543-2456	Bethel Health Center
Martinek, Karen	1109	822-3209	Glennallen Itinerant
McKelvey, Margaret	1409	452-1776	Fairbanks Health Center
McMonagle, Nancy	1224	747-3255	Sitka Health Center
Merkel, Kari	1216	586-3736	Juneau Health Center
Mills, Carol	1153	656-1200	Galena Itinerant
Monsen, Norma	1333	745-4258	Palmer Health Center
Morral, Colleen	1411	452-1776	Fairbanks Health Center
Mosher, Judith	1217	766-2125	Haines Health Center
Muth, Pamela	1149	452-1776	Fairbanks Health Center
Nantez, Carmen	1459	826-3433	Craig Health Center
Nault, Diane	1531	452-1776	Fairbanks Health Center
O'Bryan, Mary	1142	452-1776	Fairbanks Health Center
Ott, Susan	1501	376-2437	Wasilla Health Center
Parks, Johnnie	1490	235-8857	Homer Health Center
Paterson, Marylou	1119	543-2110	Bethel Itinerant, Dist III
Pfeffer, Penelope	1314	543-2456	Bethel Health Center
Pontti, Jeanne	1408	452-1776	Fairbanks Health Center
Reed, Darlene	1139	745-4258	Palmer Health Center
Robson, Ann	1543	225-4350	Ketchikan Health Center
Russell, Susan	1252	225-4350	Ketchikan Health Center
Sackinger, Patricia	1547	452-6406	Fairbanks Home Health
Sawyer, Cynthia	1112	283-4871	Kenai Health Center
Skelton, Barbara	1522	586-3736	Juneau Health Center
Smaha, Elizabeth	1279	276-5363	Aleutian Chain Itinerant
Staska, Lauren	1533	225-4350	Ketchikan Health Center
Strebeck, Hazel	1214	225-9431	Prince of Wales Itinerant
Sugita, Mildred	1281	486-3319	Kodiak Health Center
Sullivan, Catherine	1520	543-2456	Bethel Itinerant, Dist I
Trollan, Connie	1215	586-3736	Juneau Health Center
Via, Suzanne	1096	543-2110	Bethel Itinerant, Dist IV

PUBLIC HEALTH NURSING SERVICES CONTRACTED TO:

MANIILAQ ASSOCIATION

Kotzebue Public Health Nursing, Box 170, Kotzebue 99752
Telephone: 442-3313

903 X Marian Mann, Program Manager 902
901 ✓ Reggie Kuhnley

Ambler	Kivalina	Noorvik
Buckland	Kobuk	Point Hope
Deering	Kotzebue	Selawik
Kiana	Noatak	Shungnak

NORTH SLOPE BOROUGH HEALTH & SOCIAL SERVICES AGENCY

Public Health Nursing, P.O. Box 69, Barrow 99723 Telephone: 852-5600

954 X LEEANNE MERCIER, Program Manager
952 X Bobbie McCumber
953 X Joan Kovil, Maternity Services

Atqasuk	Barter Island	Nuiqsut
Barrow	(Kaktovik)	Point Lay
		Wainwright

NORTON SOUND HEALTH CORPORATION

Nome Health Center, P.O. Box 1710, Nome 99762 Telephone: 443-3221

971 X DORENE VALLEE, PHN Director
970 ✓ Eleanor Oakes
972 . Katherine Becher
975 . Vickie-Marie Colacicco

Brevig Mission	Golovin	Shishmaref
Council	Little Diomede	Teller
Elim	Nome	Wales
Gambell	Savoonga	White Mountain
Koyuk	Shaktoolik	Stebbins
St. Michael	Unalakleet	

MUNICIPALITY OF ANCHORAGE HEALTH DEPARTMENT*
DEPARTMENT OF HEALTH & ENVIRONMENTAL PROTECTION, P.O. Box 196650
Anchorage 99519-6650

Jeanne Wolf
Manager
Community Health Services

Telephone: 264-4607

Jan Wills
Coordinator of Nursing Services
and Nursing Staff

Telephone: 264-4800

*Note: This information is included for your convenience; Anchorage Health Department is not operated by the State of Alaska.

MEMORANDUM State of Alaska

TO: Lisa McLaren
Professional Assistant
Health Hess Committee

DATE: September 18, 1987

FILE NO:

TELEPHONE NO: (907) 274-7626

SUBJECT: Prenatal Care

FROM: Rita Schmidt, Chief
Section of Family Health

This memo is in response to a request for information regarding Prenatal Care in the State of Alaska. I have attempted to answer the specific questions you have asked, and am adding additional information that is relevant to this topic.

1) How many women of child bearing age are in Alaska?

1984 Alaska Vital Statistics Annual Report

Women by Age and Race

Age	White	Native	Other	Total Females
15-19	13,605	4,051	1,684	19,340
20-24	14,455	3,980	2,139	20,574
25-29	23,497	3,338	3,902	30,737
30-34	24,205	2,939	1,785	21,248
35-39	17,192	2,271	1,083	14,459
	104,604	18,305	13,873	136,782

This table shows that for Alaska Native women, the numbers of women in the lower age groups are double the numbers for the older age groups. This is markedly different than for the "White" and "Other" category. It is currently estimated that the teen Alaska Native pregnancy rate is 70% higher than for teens nationally. Because there are greater numbers of Alaskan Natives who will be coming into the prime childbearing years, it is critical to plan services around this increase in number of women in the childbearing years.

The following table shows that out of the number of women of childbearing age in 1984, the following births occurred. What is not stated in this table is the number of pregnancies that end in miscarriages, stillbirths, fetal deaths in utero, and abortions that would also occur to these women.

Births by Age and Race of Mother

Age	White	Native	Black	Other	Unknown	Total
<15	4	4	0	0	0	8
15-17	158	136	17	3	0	314
18-19	531	294	41	11	6	883
20-24	2,929	848	160	82	30	4,049
25-29	3,163	628	126	119	25	4,061
30-34	1,911	328	51	77	23	2,390
35-39	567	117	5	39	0	733
40-44	55	22	0	4	0	81
45+	1	1	0	1	0	3
	1	2	0	0	0	3
	9,320	2,380	400	336	89	12,525

Alaska has the highest birthrate (24.1) of any state in the Nation. Within Alaska, Natives experience a higher birthrate (35.0), than is true for Whites (22.6). The birthrate for other races (including Asians, Blacks, and Pacific Islanders) is 18.5. Alaska's crude birthrate in 1984 was 23.9 births per thousand residents, compared to 15.7 for the United States.

Alaska also has the highest fertility rate for any state. Alaska's fertility rate in 1984 was 40% higher than the U.S. rate. Alaskan "White" fertility rate exceeded the rate for U.S." White" by 38%. National rates for Natives are not available, but the Alaska Native fertility rate was 119 percent higher than the national rate for all races.

2) Where Do They Live?

The most recent information concerning place of residence for women of childbearing age is the Alaska Population Overview-1985, from the State Demographers Office, Greg Williams, state demographer. This document includes a table for each census area in the State of Alaska, by age and race.

3) How Many Of Them Are Likely To Be High Risk?

In 1980, the State of Alaska received an Improved Pregnancy Outcome Grant from the Federal Government. The activities of this grant included the development of a prenatal care risking form that could be used to identify high risk pregnancy patients. This form has been implemented throughout the Alaska Native Health Services and is in use with the State Public Health Nurses. The Indian Health Service has developed a system to deliver perinatal care that includes assessment of all pregnant women using this form. The health aide fills out the form and sends it to the Regional Maternal Child Health Coordinators, employed by Health Corporations, who assess each patient for complications during pregnancy. A written plan is then developed for each high risk patient and is communicated to the health aide. The plan of care is then implemented by the health aide.

In 1986, there was a total of 1948 Native births. Using this system described above, the Indian Health Service identified 728 high risk pregnancies, or approximately 38%. It is generally accepted that in any normal population, at least 15% of the population will experience a high risk pregnancy. How these numbers would compare to the total Alaska population is unknown at this time, as there is no system for identifying high risk pregnancies in the state for non-Native women.

4) How Many Women Have Guaranteed Access To Care Through Indian Health Services Or Other Providers?

The Batell Study of 1982 did an extensive analysis of the health insurance coverage of residents of the State of Alaska. At that time, 17.2% of the employed, non-Native labor force were not eligible for Medicare, job related insurance, Medicaid, VA or Champus. Small employers tend to offer limited or no health benefits. There are a large number of small employers in Anchorage and Alaska. In Anchorage, from 1977 through 1984, 86% of the small businesses have less than 20 people. The economics of scale, as well as high administrative costs, make the purchasing of health plans more expensive relative to larger employers. Small employers are often disqualified from group plans.

As you are aware, the Medicaid program provides payment of medical bills for those people who are at 97% of poverty level. There are currently discussions to enhance the Medicaid coverage to include women up to 100% of the Alaskan poverty income. This would mean allowing women who are in the following family sizes and incomes to be incorporated into the Medicaid program.

Family Size	Income
1	$ 6,860.00
2	9,240.00
3	11,620.00
4	14,000.00
5	16,380.00

There is no doubt that expanding Medicaid to include higher income levels would greatly expand the number of women who would be eligible for prenatal care in the state of Alaska, however, there are many women who would still be left without any resource to prenatal care.

The state demographer estimates that 11% of the Alaska population have incomes above the Alaska poverty scale, but below $18,000.00 per year. A recent study done by a private firm has shown that the disposable income per capita, for Alaska citizens, is the same as it was in the period 1969 through 1973, prior to the Alaska pipeline construction.

THE COSTS OF PRENATAL CARE and HOSPITAL CHARGES

Hospital Costs (Providence)

Providence Hospital Labor and Delivery Charges

"Package rate" for normal uncomplicated NSVD (Normal Spontaneous Vaginal Delivery)	$1,950
Approximate cost of an "uncomplicated" C-Section with a 3 day hospital stay	$3,000
Costs for the surgical delivery (C-section) increase if the patient had a complicated labor, required additional laboratory and pathology services, and as the number of days in the hospital increase.	An average of $5,000

Alaska Women's Health Service - Prenatal Care

1st Prenatal Visit	$ 200
Each Subsequent Visit @ $45.00 x 13 visits	$ 585

Since the recommended prenatal visit schedule for prenatal care totals 14 visits for a low risk full term gestation, I multiplied the $45 per visit rate by 13 visits.

Delivery Fees

Vaginal delivery	$ 700
Cesarean Section	$1,400

Cost of a Vaginal Delivery

Prenatal Care	$ 785
Delivery-Physician Chge.	700
Total Fees	$1,485
Providence Hospital Charges	$1,950
Grand Total	$3,435

Cost of a C-Section Delivery

Prenatal Care	$ 785
C-Section Delivery	$1,400
Total Fees	$2,185
Providence Hospital Charges	$3,000 to $5,000
Grand Total	$5,185 to $7,185

Neighborhood Health Center

Fee includes all prenatal visits plus delivery charges

0 Fee	25% Fee	50% Fee	75% Fee	Full Fee
Medicaid Eligible	125% Poverty	150% Poverty	175% Poverty	200% Poverty
$0.00	$300	$600	$900	$1,200

The minimum monthly income which a single pregnant woman can earn and be qualified for MEDICAID is $572 per month. The following calculations below compare a single woman's yearly income, at various poverty levels, with the cost of a normal vaginal delivery and a C-Section.

125% of Poverty

Monthly Income	$ 573 - $ 761
Yearly Income	$ 6,876 -$ 9,132

	NSVD	C-Section
Percent of Income Needed for Prenatal and Hospital Care	37%-50%	57%-75%

150% of Poverty

Monthly Income	$ 762 - $ 955
Yearly Income	$ 9,144 - $11,460

	NSVD	C-Section
Percent of Income Needed for Prenatal and Hospital Care	30%-37%	45%-57%

175% of Poverty

Monthly Income	$ 956 - $ 1,144
Yearly Income	$11,472 - $13,728

	NSVD	C-Section
Percent of Income Needed for Prenatal and Hospital Care	25%-30%	38%-45%

200% of Poverty

Monthly Income	$ 1,145
Yearly Income	$13,740

	NSVD	C-Section
Percent of Income Needed for Prenatal and Hospital Care	25%	38%

Women earning just over 200% of poverty are not considered low income and must pay the full fee for prenatal care. A woman at this income level who has a low risk, uncomplicated pregnancy and birth must spend at least 25% of her income for prenatal fees and hospital charges. If she has a low risk pregnancy, but must have a surgical delivery (C-Section), the expenses equal a minimum of 38%. If her pregnancy is complicated by threat of pre-term labor, her expenses mount up at the rate of about $350-$500 per day in the hospital for management and control of this complication.

The Medicaid Statute requires states to determine eligibility, but since applications are generally initiated by pregnant women after the pregnancy is verified, this always results in a delay, which can result in poor women foregoing prenatal care during a critical period. Many women are not eligible for Medicaid because of seasonal employment or low paying jobs that keep them just above the income guidelines. These women are of particular concern. Among this group are women with multiple medical, social and personal risks. Because they are underemployed, they do not have health insurance and do not have the cash-out-of-pocket to purchase care.

In addition, the Alaska Medicaid application is intimidating in its length (35 pg.) and is quite complicated. Many Alaskan women who qualify for Medicaid have great difficulty reading, understanding, or filling out the application. The application is a particular barrier for Native women. The illiterate or non-English speaking woman also has the difficulty with the monthly reporting requirements. Competeting survival needs in the sometimes crisis filled lives of these women often make the monthly reporting inconsistent. It is not uncommon for a woman to become eligible one month, fail to send in her form, and, therefore, be ineligible the next month.

The Fairbanks Health Center public health nurses are currently following pregnant teenagers and other low income women identified through the family planning clinic, or who come in for pregnancy testing. Out of a total of 90 pregnant women seen during the past year, seventy-eight were teenagers. Of the teenagers, three had not received prenatal care until the third trimester, and nine had not initiated care by the beginning of the second trimester. Sixteen patients were smokers, seven had a history of drug and alcohol abuse, three had a history of premature labor, one had active herpes, two were diabetic, two were losing weight during their pregnancies, several had poor weight gain, and one had a history of kidney problems.

The program coordinator reports that 68 of the women are not eligible for Medicaid. The teens are not eligible before their third trimester of pregnancy because they live at home and the combined assets and income of their parents is above the poverty guidelines. The older women, who are living independently, are minimally employed, but earn just enough to be over the Medicaid guidelines.

The 1984 Vital Statistics documents that 25% or 605 Native women had inadequate prenatal care (initial visit in the third trimester, or fewer than five prenatal visits). This compares with 13% of white Alaskan women who received inadequate care. The Chief of Maternal Child Health Services for IHS has indicated that while IHS has elements of a system in place, many of the women are not Medicaid eligible. Native women could receive additional IHS services, if travel dollars could be made available. For example, in some cases, women who require special tests such as ultrasound to determine the maturity of the fetus, or a glucose tolerance test to screen for diabetes, must pay for their own transportation to the hospital themselves, or go without care. Because of the eligibility criteria of Handicapped Children's Program, any child who is handicapped as a result of poor prenatal care would become the responsibility of the state, therefore, prenatal care services to improve their outcome could reduce expenditures to the Handicapped Children's Program, and improve the birth outcomes for Native women. The state must include Native women as part of the target population who need improved service.

The Anchorage Neighborhood Health Center is currently funded to provide prenatal care to low income women. Each physician can accept 5 or 6 prenatal patients per month only. When these slots are filled up, women are referred to the Alaska Women's Health Clinic in Anchorage. This agency reports that 27% of the women they are seeing are not eligible for any third party reimbursement or Medicaid, and they currently have a growing number of women who have agreed to pay for their care on a payment plan. The accounts receivable ledger for this care is $40,000.00, and the agency may soon stop providing this care unless a mechanism to help these women financially can be provided.

The Alaska Women's Health Clinic reports that physician's from their clinic are called to the emergency rooms in Anchorage 4 to 5 times per month to deliver babies. This is a result of the women having no physician providing prenatal care who can be called for the delivery. The Anchorage Neighborhood Health Center and the Alaska Women's Health Clinic are the only two providers who have agreed to make their OB-GYN's available for emergency room deliveries. In all instances, the physician has no information on the woman's reproductive or current prenatal status.

Providence Hospital reports that in 1986 there were 2,480 births at Providence Hospital. Of this total, 390 were Medicaid eligible and 667 were women who had no third party reimbursement for their birth. 555 of these women have established some sort of payment plan for their birth. 112 of these women were thought to be Medicaid eligible at the time of the birth, but did not qualify for Medicaid subsequently, and have not been able to establish a payment plan for their charges.

The prenatal care in Alaska, as it now stands, leaves many gaps, including underemployed poor women who aren't eligible for Medicaid; teenagers less than 18 who live at home; women who have medical insurance, but cannot afford the cost of transportation to access care; and Native women who need special care or tests, but cannot afford the travel expenses. The prenatal care program we are proposing would compliment private insurance, Medicaid, and the Alaska Native Health Service by filling these gaps by providing pregnant women with the care or transportation necessary to enhance their health and the health of their baby. It would create the final piece of a system that would make prenatal care accessible to every woman.

5) How many of them are Medicaid eligible?

This information was covered in the memo you received from Nancy Bennett and in the answers to question #4. I have no other information to add, other than the information that we have that there are many people who are falling between the cracks as not being Medicaid eligible and not being eligible for third party reimbursement.

6) Where and by whom is prenatal care being delivered now, and how does it link with delivery/neonatal care?

The Indian Health Service has their own system for Native women and I have attempted to explain some of the gaps in that system. For non-Native women, the availability of prenatal care is dependent on the geographic area in which they live. Urban communities, such as Anchorage, Fairbanks, and Juneau have private providers and the Anchorage community has two clinics, the Anchorage Neighborhood Health Center and Women's Health Care Clinic, both of which attempts to provide prenatal services to low income women and deliver babies at both Providence and Humana. The Anchorage Neighborhood Health Center has one OB-GYN on staff, the rest of the physicians are general practitioners or family practice physicians. The Women's Health Care Clinic has four OB-GYN's on staff. Some communities, such as Prince of Wales Island, other communities of the Southeast and outlying areas in the Fairbanks area have no access to prenatal care. All of the physicians in those areas have stopped accepting prenatal care patients, or there are no longer any physicians providing services to that area.

7) What is it we want to impact?

The National Institute of Health estimates that for every dollar spent on prenatal care, two dollars can be saved in the first year of an infant's life because of the reduced need for hospital care. Researchers estimate that the incidence of low birth weight can be reduced by as much as 33%-61% when

literature suggests that prenatal care plays an important role in preventing poor pregnancy outcomes, especially among minorities, low income, and adolescent women who are regarded as high risk groups. Complications of pregnancy are more likely to occur among women who received no prenatal care until the third trimester, or who received no prenatal care at all.

Babies born to women who received no prenatal care are at least three times as likely to be low birth weight, as are babies born to women who received early care. In 1984, there were a total of 608 low birth weight births in Alaska. Sixty-two percent of these low weight births occurred to women who reside outside the city of Anchorage. The highest rates of low weight births occur in the North Slope, Bristol Bay, Yukon-Koyukuk, and Prince of Wales census districts, and the Native and black population of the city of Anchorage.

The American College of Obstetrics and Gynecology (ACOG) recommends a comprehensive program of prenatal care beginning as early in the first trimester as possible. For uncomplicated pregnancies, the prenatal visits should occur every four weeks for the first 28 weeks of pregnancy, one visit every two weeks for the next eight weeks, and one week thereafter until delivery, or a total of 14-15 visits for prenatal care per birth. In 1980, the median number of visits per mother, nationally, was 11.2, up from 10.4 in 1972. The 1984 Alaska Vital Statistics reports that 16% of the Alaska births, or 2,004, had fewer than 5 prenatal care visits. Anecdotal information from public health nurses indicate that many women in the rural areas of Alaska have only one prenatal visit.

Furthermore, the ACOG standards assume that the prenatal care provider is prepared as, either, an Obstetrician/Gynecologist, a Certified Nurse Midwife, or an Advanced Nurse Practioner. It is suspected that many of the prenatal visits in Alaska are delivered by providers who do not have these qualifications.

What is Adequate Prenatal Care?

The number of visits and the content of care is dependent on previous reproductive history, current medical status, and exposure to such risks as previous cesarean delivery, use of alcohol, drugs, or tobacco, and genetic disorders. Many women need services besides medical care, such as nutrition counseling, social services and parent training.

1) Prenatal care should begin in the first trimester of the pregnancy.

2) The number of visits should include one visit every 4 weeks for the first 28 weeks of pregnancy. One visit every 2 weeks for the next eight weeks, and one visit thereafter until delivery. Complicated pregnancies should include more visits.

3) Care should include pregnancy testing, clinical assessment, laboratory testing, including amniocentesis and ultrasonograph as indicated, identification of high risk patients through risk rating, and referral for appropriate care, health education, counseling, social services, labor and delivery services and post partum care (including family planning).

4) Qualifications of Providers - National standards assume that the health care provider will be a physician or nurse practitioner. This will need to be modified for Alaska, as sufficient providers do not exist.

Proposed Program:

1) Eligibility - Low income women of childbearing age, who had been denied eligibilty through the Medicaid program and who were experiencing a high risk pregnancy, either as a result of a medical condition or because of lack of access to prenatal care. High risk medical conditions include: fetuses, currently pregnant and hypertensive, distended uterus from amniotic fluid (polyhydramnios), history of pre-term birth or low birth weight infants, or DES exposure, history of drug and alcohol abuse, history of education less than grade 12, all teenagers, or because of absence of available medical prenatal care. Each woman would be assessed financially for most recent IRS statement, availability of other insurance resources, and documentation of financial assets. Each woman would have a participation amount that would be dependent on her income and family size (see proposed sliding participation amounts, and financial eligibility form). The woman would be eligible for the program once she had documented her participation amount in receipts or bills.

2) Application Process - Each woman would complete an application packet in conjunction with her public health nurse, who would complete the prenatal history assessment form (attached) that would be part of the packet that would be sent to the Family Health Section Office.

3) Services to be Provided - Payment of travel for treatment, ongoing prenatal care visits, nutrition counseling , amniocentesis, ultrasound, prenatal medications, other laboratory testing, pregnancy testing, health education, and parenting and social services counseling.

4) Case Management - The Section of Family Health would hire a case manager, who would work with the public health nurse in establishing a plan for care for each pregnant woman. Specific treatments would be authorized for payment under the prenatal care program, the case manager would be in contact with all other providers and get the pregnant woman to other needed services. Travel arrangements would be made either by the woman herself, the public health nurse, or in some instances, the Section of Family Health case manager.

Under COBRA, the states may now cover case management services to all Medicaid recipients as an optional Medicaid service. State legislation is required to include this service for Alaskan women. Case management services are defined as "services which aid individuals eligible under the plan gaining access to needed medical, social, educational, and other services."

Case management services include outreach, patient referral and coordination of services, and can improve access to care and insure better utilization.

5) Contract Services - The Section of Family Health would document geographic areas of the state where adequate prenatal service is not available, and contract with nurse practioners and physicians, to provide the prenatal care in these areas. This would be done on an as needed basis, and attempts would be made to negotiate contracts to provide prenatal care. Arrangements and agreements would be made with local hospitals, and local private providers to continue to deliver the babies of these women. This would require negotiation by the case manager, the public health nurses, and

staff of the Section of Family Health, with hospitals in the vicinity of each patient. Facilities such as the Anchorage Neighborhood Health Center, would continue with their current efforts, however, women they identify as meeting these eligibility criteria would now have a payment source other than a once a year grant, or their charity slots.

Inherent Problems with the Program:

1) It will be very difficult to meet the standards of care established by the American College of Obstetrics and Gynecology stated above. A more realistic goal for our state, would be an average number of 8 visits per pregnancy.

2) We have estimated that the number of women who would use this program during a first year would be 120 women. However, this is a best guess estimate, and in reality may turn out to be many more women than this.

3) Once the need for this service is well documented through a one year trial, it may increase the needed budget for this program, for it very likely will increase the acceptability of the clients with private providers, and may result in increased services in the state. This will, in turn, also increase the budget, however, it will also increase the access to prenatal care. As with the Handicapped Children's Program, the payment of these services increase the use of the services, but it should decrease the cost of care in the newborn intensive care unit.

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

P.O. Box Y, State Capitol
Juneau, Alaska 99811-3100
Mail Stop 3100
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September 28, 1987

MEMORANDUM

TO: Representatives Johnny Ellis and Niilo Koponen

ATTN: Lisa McClaren

FROM: Jay Livey
Legislative Analyst

RE: Maternal and Child Health Statistics for Alaska
Research Request 88.033

You asked that we provide statistics on the number of infants in Alaska who are born with birth defects or handicapping conditions. You also asked that we research the extent to which these conditions could be mitigated through prenatal programs. In addition to this information, we include health statistics related to infant mortality and its causes.

PREVALENCE OF HANDICAPPING CONDITIONS AND INFANT DEATH

The current state plan for the Alaska Governors Council for the Handicapped and Gifted (AGCHG) defines an individual who is substantially handicapped as "a person who has a severe, chronic disability which:

1. Usually originated in childhood or before age 22;

2. Is attributable to mental or physical impairments or a combination of mental and physical impairments

3. Is likely to continue indefinitely;

4. Results in substantial functional limitations in three or more of the following areas of major life activities:

   -- self-care
   -- receptive and expressive language
   -- learning

-- mobility
-- self-direction
-- capacity for independent living
-- economic self sufficiency

5. Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

Table 1 indicates the number of Alaskans who are defined as substantially handicapped for 1980 and 1984. As the table indicates, the number of handicapped children under age 5 increased from 1,375 in 1980 to 1,792 in 1984. However, as a percentage of the total population within the 0 to 5 years old age group, the number of children with handicaps remained constant at approximately three percent.

TABLE 1

NUMBER OF ALASKAN CHILDREN AGE 0 TO 5 WITH SUBSTANTIALLY HANDICAPPING CONDITIONS; 1980 AND 1984

AGE RANGE	1980	1984
Birth - 2 years	732	955
3 - 5 years	643	837
Total	1,375	1,792

Source: Alaska Governors Council for the Handicapped and Gifted, Three Year State Plan 1987-1989, page 14.

Although Table 1 provides the number of handicapped children in Alaska, it does not provide information regarding the cause of the handicap or when the handicap first occurred. The Department of Health and Social Services maintains a system which monitors birth certificates to record congenital anomalies (any abnormalities encountered by babies at birth). Although the information from some birth certificates is not usable, we can use data from this system to generally indicate the health status of Alaska infants at birth.

Table 2 contains the number of babies born in Alaska with congenital anomalies during the period 1982 through 1985. As the table indicates, a total of 1,230 babies, or approximately 2.5 percent of all babies born during the period, were born with anomalies. The table also indicates that the percentage of babies born with anomalies increased from 1.69 percent in 1982 to 3.40 percent in 1985. The reader is cautioned, however, that because a relatively low number of infants are born with anomalies in each

TABLE 2
CONGENITAL ANOMALIES OF ALASKA INFANTS
1982-1985

YEAR	NUMBER OF INFANTS BORN WITH CONGENITAL ANOMALIES	TOTAL NUMBER OF BIRTHS	% OF INFANTS BORN WITH CONGENITAL ANOMALIES
1982	192	11,355	1.691%
1983	295	12,093	2.439%
1984	304	12,533	2.426%
1985	439	12,896	3.404%
TOTAL	1,230	48,877	2.517%

SOURCE: ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES, DIVISION OF PUBLIC HEALTH

Prepared by the House Research Agency, September 1987 (88-033B;080387-03)

year, annual percentages can be greatly influenced by minor changes in occurrences.

Two factors that are considered by Maternal and Child Health experts to be significant indicators of healthy babies are: 1) the weight of the infant at birth, and 2) when the mother began prenatal care. Table 3 compares the birthweights of babies with congenital anomalies to the birthweights of all babies for the years 1982 through 1985. As the table indicates, between 1982 and 1985, 4.826 percent of all babies born weighed less than 2,500 grams, the weight normally considered to be low. However, during this same period, 14.027 percent of the babies born with anomalies weighed less than 2,500 grams at birth. This result indicates that a higher percentage of babies with anomalies have a low birthweight than do the total number of babies born. Although this does not mean that low birthweight causes birth anomalies, it does suggest that they are related.

Table 4 examines the relationship between the initiation of prenatal care and the number of babies born with congenital anomalies. The table indicates that, by the end of the second trimester of pregnancy, 95.640 percent of all pregnant women during the period 1982 through 1985 had begun prenatal care. During this same period, 95.120 percent of the women whose babies were born with anomalies had entered prenatal care by the end of the second trimester. The same percentage of women whose babies had anomalies entered prenatal care by the end of the second trimester as women whose babies had no anomalies. It should be noted that we have examined only the initiation of prenatal care and not the quality or frequency of prenatal visits.

INFANT MORTALITY

Additional information regarding maternal and child health can be gathered by looking at infant mortality--deaths which occur within one year of birth. Maternal and child health professionals generally agree that eliminating the conditions which are highly correlated with infant death would also decrease the prevalence of preventable handicaps. Additionally, infant mortality rates are a more standard measure of the success of maternal and child health programs.

TABLE 3
BABIES WITH CONGENITAL ANOMALIES BY BIRTHWEIGHT CATEGORIES
1982-1985

YEAR	BIRTHWEIGHT IN GRAMS: < 1,000		1,000 - 1,499		1,500 - 1,999		2,000 - 2,499		2,500 - 3,999		4000 +		TOTAL
	WITH ANOMALY	NO ANOMALY	WITH ANOMALY	NO ANOMALY	WITH ANOMALY	NO ANOMALY	WITH ANOMALY	NO ANOMALY	WITH ANOMALY	NO ANOMALY	WITH ANOMALY	NO ANOMALY	
1982	3	52	2	48	7	87	19	334	133	8,922	24	1,640	11,271
1983	2	43	7	49	10	126	12	313	211	9,485	50	1,709	12,017
1984	2	54	4	48	5	104	26	362	195	9,771	69	1,825	12,465
1985	6	37	6	46	20	99	40	373	308	9,939	58	1,919	12,851
TOTAL	13	186	19	191	42	416	97	1,382	847	38,117	201	7,093	48,604
% OF TOTAL BIRTHS BY WEIGHT		0.409%		0.432%		0.942%		3.043%		80.166%		15.007%	
% OF BIRTHS WITH ANOMALIES BY WEIGHT		1.066%		1.559%		3.445%		7.957%		69.483%		16.489%	

NOTES: TABLE 2 DOES NOT INCLUDE ALL BIRTHS FROM 1982 - 1985 AS SOME BIRTH DATA WAS EXCLUDED BECAUSE IT WAS NOT CODED FOR BIRTH WEIGHT.
SOURCE: ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES, DIVISION OF PUBLIC HEALTH

Prepared by the House Research Agency, September 1987 (88-0338;080387-03)

TABLE 4
CONGENITAL ANOMALIES OF ALASKA INFANTS BY TRIMESTER PRENATAL CARE BEGAN
1982-1985

YEAR	PRENATAL CARE - 1ST TRIMESTER		PRENATAL CARE - 2ND TRIMESTER		PRENATAL CARE - 3RD TRIMESTER		NO PRENATAL CARE		TOTAL
	WITH ANOMALY	NO ANOMALY	WITH ANOMALY	NO ANOMALY	WITH ANOMALY	NO ANOMALY	WITH ANOMALY	NO ANOMALY	
1982	111	8,142	52	1,973	4	389	1	30	10,702
1983	206	8,278	66	2,226	12	417	3	71	11,279
1984	213	8,751	64	2,243	13	467	3	73	11,827
1985	306	8,958	97	2,403	18	423	4	82	12,291
TOTAL	836	34,129	279	8,845	47	1,696	11	256	46,099
% OF TOTAL BIRTHS BY WHEN PRENATAL CARE BEGUN		75.848%		19.792%		3.781%		0.579%	
% OF BIRTHS WITH ANOMALIES BY WHEN PRENATAL CARE BEGUN		71.270%		23.785%		4.007%		0.938%	

NOTE: DOES NOT INCLUDE ALL BIRTHS FROM 1982-1985 AS SOME WERE NOT CODED FOR INITIATION OF PRENATAL CARE.
SOURCE: ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES, DIVISION OF PUBLIC HEALTH

Prepared by the House Research Agency, September 1987 (88-033;080387-03).

Table 5 provides the number of infant deaths in Alaska for the period 1980 through 1984 and compares these rates to the United States rates for the same time periods.

TABLE 5

INFANT DEATH RATE FOR ALASKA AND THE UNITED STATES
1981-1984

1980	ALASKA	UNITED STATES
BIRTHS	9,609	
INFANT DEATHS	117	
RATE	13.6%	12.5%
1981		
BIRTHS	10,203	
INFANT DEATHS	130	
RATE	11.9%	11.9%
1982		
BIRTHS	11,358	
INFANT DEATHS	123	
RATE	11.9%	11.5%
1983		
BIRTHS	12,089	
INFANT DEATHS	148	
RATE	11.5%	11.2%
1984		
BIRTHS	12,525	
INFANT DEATHS	141	
RATE	11.7%	10.8%

NOTES: Infant death rates are calculated as a three year moving average except for 1984 which is a two year average (1983 and 1984).

SOURCE: Alaska data from Vital Statistics, 1984 published by the Department of Health and Social Services. United States data from Vital Statistics, 1984 and Statistical Abstract of the United States, 1986.

As Table 5 indicates, the infant death rate for Alaska is consistently higher than the rate for the United States for the period 1980 through 1984. However, during this period, the Alaska rate has decreased from 13.6 percent to 11.7 percent.

Infant deaths are categorized as neonatal (occurring within 28 days of birth) and postneonatal (occurring between 23 days and the end of the first 11 months of life). The Department of Health and Social Services Vital Statistics report for 1984 (hereinafter referred to as Vital Statistics) notes that of Alaska's 141 infant deaths in 1984, 72 (51.43 percent) were neonatal while 69 (48.57 percent) were postneonatal. Vital Statistics reports that during 1984, congenital anomalies was the primary cause of neonatal mortality while sudden infant death syndrome was the primary cause of postneonatal death, accounting for 53 percent of these deaths.

Low Birthweights and Infant Mortality

As noted above, it is generally accepted by Maternal and Child Health professionals that the weight of a baby at birth is a significant indicator of the health of the baby. The Alaska State Plan for Maternal and Child Health notes that:

> "Infants born weighing less than 2500 grams (5 pounds 8 ounces) are considered low birthweight babies and are at high risk for serious health problems. Low birthweight infants have a high mortality rate and a greater incidence of disease, mental retardation, and other developmental problems..."

Table 6 reports low birthweight rates and percent of total births for Alaska and the United States in 1984.

TABLE 6
LOW BIRTHWEIGHT RATE AND PERCENT OF TOTAL BIRTHS
BY RACE FOR ALASKA AND THE UNITED STATES
1984

RACE OF CHILD	ALASKA L.B.W. RATE	ALASKA % OF BIRTHS	U.S. % OF BIRTHS
WHITE	43.6	4.4	5.6
NATIVE	56.6	5.9	NA
BLACK	69.7	7.0	12.4
OTHER RACES	60.0	6.3	11.1
TOTAL	47.8	4.9	6.7

NOTES: "OTHER RACES" IN THE UNITED STATES DATA INCLUDES NATIVES. LOW BIRTH WEIGHT (LBW) RATES ARE: LBW BIRTHS/ALL BIRTHS * 1000.

SOURCE: VITAL STATISTICS 1984, PAGE 13.

Table 6 suggests that, overall, a lower percentage of Alaska babies are low birthweight than are all babies born in the United States. Within Alaska, a smaller percentage of white babies are low birthweight than are babies of other races. Low birthweights would appear to be a significant problem among black babies in Alaska. It should also be noted that in 42 percent of all the infant deaths in Alaska, the baby was low birthweight.

I hope you find this information useful. If you require additional research, please contact the agency.

Medicaid Eligibility for Pregnant Women: Reforms Contained in the Sixth Omnibus Budget Reconciliation Act (SOBRA)

Prepared by
Sara Rosenbaum

April, 1987

Introduction

In October, 1986, as part of the Sixth Omnibus Budget Reconciliation Act (SOBRA, Pub. L. 99-509), Congress broadened states' ability to provide Medicaid coverage to indigent pregnant women and young children and enabled them to establish a program of presumptive eligibility (PE) for pregnant women. These reforms potentially can revolutionize the manner in which low-income pregnant women and children are covered by, and gain access to, Medicaid. They should also strongly encourage the provision of early and continuous prenatal and pediatric care.

The purposes of this memorandum are to: describe the reforms and their review background and need; describe the elements of a successful presumptive eligibility program; and identify key elements in negotiating effectively for a PE contract.

I. Background and Need for the SOBRA Reforms

There is overwhelming evidence of the need to improve the Medicaid coverage of pregnant women and children.

A. The Health Status of Low Income Infants

Infants born to low-income women are at significantly greater risk of death and disability. Poor children are 1.5 to 2 times more likely to die before reaching their first birthday,[1] 1.5 times more likely to be born at low birthweight (weighing less than 5.5 pounds),[2] and are at significantly greater risk (because of their lower birthweight) of suffering from such permanent disabilities as retardation, cerebral palsy, epilepsy, vision and learning disabilities, and other serious lifelong