New York Battle Over Medicaid: 
Cutbacks Mirror the Nation’s Pain

In late January, New York Gov. George Pataki presented an austere budget plan aimed at closing the state’s two-year, $11.5 billion gap without resorting to raising income or corporate taxes. Among the items on his $5.6 billion “hit list”: a $1.9 billion cut in health care programs, including a $1 billion bite out of Medicaid, which, at $27 billion, represents nearly a third of the state’s overall $90.8 billion budget. Not unexpectedly, the plan has touched off a firestorm of protest among providers and advocates for the poor, causing legislators on both sides of the aisle to scour for new sources of revenues in order to avoid depriving needy residents of critical health services and adding to the ranks of the uninsured.

While the New York Medicaid numbers are large—due in part to its demographics, in part to its historical generosity in determining benefits and eligibility—the struggle to preserve the program’s integrity typifies what’s transpiring across the U.S. Faced with the worst economic downturn in 50 years, fueled by a sharp decline in revenues, a rise in unemployment and mandated spending on antiterrorism activities, states have a formidable budget-balancing act. In an update issued April 24, NCSL reported that states confront a cumulative budget gap of $25.7 billion for the remainder of FY 03, up from $17.5 billion last November, and the FY 04 picture looks even worse, with a projected aggregate shortfall of $53.5 billion.

As one of the biggest line items, Medicaid is in the hot seat. In 2001 and 2002, after five years of stable growth, program expenditures reached into double digits: 13.3 percent in FY 2002, compared to a 1.3 percent increase in overall state expenditures. For the current fiscal year, program costs top out at $280 billion ($121 billion in state funds and $159 in federal funds). Primary drivers include the rising cost of long-term care and prescription drugs, plus enrollment growth resulting from outreach in the late 90s and a jump in unemployment since 2001. All told in 2002, the program covered 47 million people, including 24 million children, or more than 1 in 4; 5 million seniors; and 8 million people with disabilities.

Viewing Medicaid as a critical piece of the safety net, most states have tried to maintain coverage by drawing on rainy day funds or surpluses from other trust funds or securitizing tobacco settlement dollars. Reducing benefits and restricting eligibility have been seen as a last resort, but a January report by the Kaiser Family Foundation indicates that is changing. According to State Fiscal Crisis and Medicaid, 49 states and the District of Columbia planned to trim Medicaid spending in FY 2003. Nearly all have tried to reign in prescription drug costs; 37 have frozen or cut provider payments; and nearly half planned to pare benefits or limit eligibility. While the main targets are optional services and populations, state legislators “are having to retrench on some things they thought were important,” said Joy Johnson Wilson, NCSL’s federal affairs counsel. Deciding which services or groups will go is “an extremely difficult call,” she said.

THE LONG VIEW: REFORM STRATEGIES

As the fiscal pressures on Medicaid intensify, states are looking to the federal government for help. For its part, the Bush Administration on Jan. 31 offered up a plan that would give states significant flexibility in determining eligibility and benefits for optional populations under both Medicaid and the Title XXI State Children’s Health Insurance Program. To maintain budget neutrality, states would receive more money from the federal government in the first seven years of the

[Medicaid, p.2]
plan but less in the last two years. While the proposal maintains the federal commitment to mandatory Medicaid populations and services, the suggestion is that states seeking to expand coverage to the uninsured through public programs will have to do that “using their own funds,” Wilson observed.

In February, the National Governors’ Association (NGA) formed a nine-state (Florida, Connecticut, Kentucky, Idaho, Indiana, Iowa, North Dakota, Missouri and New Mexico) Medicaid Reform Task Force to assess states’ changing needs since the program’s inception in 1965 and to seek additional assistance to keep it afloat. Key issues on NGAs agenda, which was unveiled in an April 10 release and will be sent to Congress in mid-May, include: a larger federal contribution for 6.2 million dual eligibles—elderly and disabled Medicare beneficiaries who also qualify for Medicaid and who account for more than two-thirds of Medicaid spending; more flexibility in administering the program without use of waivers and in determining benefits, eligibility and cost sharing; more say in the design and administration of a prescription drug program; an overhaul of long-term care to enable states to offer options other than nursing homes; and an exploration of partnerships between Medicaid and the private sector to facilitate improvements in quality and efficiency.

Neither of those proposals, however, is advanced enough to offer any immediate help to struggling states. As the following snapshot of the New York debate suggests, reaching consensus on difficult choices isn’t an easy task.

**Reasonable Balance...**

The size of New York’s Medicaid program—it covers nearly 3.5 million children and adults at a cost of $27 billion per year, and spending per enrollee is nearly double the national average ($7,180 vs $3,822)—is due in large part to the state’s unique demographics. In an April report, for instance, the Healthcare Association of New York State (HANYS) noted that compared to the U.S. as a whole, the state has more low-income residents (17 percent vs. 14 percent), more low-income children (25 percent vs. 21 percent) and more low-income seniors (17 percent vs. 13 percent). In addition, it has a higher-than-average rate of children and adults under the age of 65 who are living with disabilities and the largest number of residents with AIDS (20 percent more cases than California), all of whom have much more-intensive health care needs than healthy residents.

In the face of the $11.5 billion budget shortfall, however, cuts were clearly on the table and in Pataki’s budget, health care for low-income families was one of them. At the heart of his plan are raising fees for the Elderly Pharmaceutical Insurance Coverage program by 10 percent ($15 million in savings); shifting 234,000 from Medicaid to Child Health Plus, the state’s Title XXI program ($42 million), in order to draw down the more-generous federal match; and cutting the number of beneficiaries in Family Health Plus by 47,000 by stiffening income eligibility requirements ($20 million). In addition, the budget would reduce funds for family planning, rural health, Alzheimer’s and HIV/AIDS services; reinstate a 0.7 percent tax on hospitals; and impose a 0.6 percent tax on other health care providers, including home health agencies.

Supporters of the proposed budget maintain that it’s a reasonable balance between reducing spending and raising what the governor called “job-killing” taxes. In hard fiscal times, “something has to give,” said a Republican Assemblywoman who asked not to be quoted by name. Over the years, the Assemblywoman noted, New York has extended Medicaid coverage to a broad range of optional services and populations, well beyond what federal law mandates and what most other states offer. In addition to covering larger numbers of low-income children and pregnant women, the state also offers insurance to families with incomes up to 150 percent of poverty and to single adults and childless couples up to 100 percent of poverty, plus the elderly prescription drug benefit and comprehensive home health and hospice care.

During “tough economic times, we have no choice but to scale back on some of these extras,” she argued. Moreover, she said, those vulnerable residents receive more than just health care from the state. “There are a whole host of [social and human] services that need to be weighed. It’s not easy.”

**... or Bitter Pill**

While agreeing that New York faces tough choices, Assemblyman Richard Gottfried, a Democrat who chairs the Health Committee, argues that by cutting health care, the Republican governor has made “the wrong choice.” One of the more “outrageous” proposals in the budget in Gottfried’s view is the transition of nearly a quarter million youngsters currently enrolled in Medicaid into Child Health Plus. It’s “unconscionable” to ask poor working families to spend their disposable income in order to qualify for state-sponsored care, he said in an interview. In addition, he claimed that the state has opted to delay implementation of streamlined enrollment procedures, which had been slated to take effect April 1. “It’s appalling that the Medicaid administration is willfully trying to keep people off the rolls” in order to save money, he asserted.

Cuts in Medicaid will have an impact on more than the just the elderly, disabled and low-income individuals who rely on the program, Gottfried argued. “When you take money from a hospital, nursing home or home health agency, personnel are cut and services are stretched to their limit. Everyone is affected, and people will die,” he said.

Indeed, provider groups are worried as well. Monica Mahaffey, spokeswoman for HANYS, which represents 550 nonprofit and public facilities, from hospitals and nursing homes to home health agencies and hospice, said there’s a sense among some lawmakers that Medicaid has “grown out of control.” But, she added, expanding coverage to optional populations has been a “conscious decision… to maximize federal contributions to the program.” (Of the total annual Medicaid budget, she estimates that $6.8 billion is attributable to state policies that seek to enhance the federal match, not to overspending.) The notion that the program has grown to unwieldy proportions, is “not accurate” she asserted.

According to Mahaffey, the proposed taxes on hospitals, nursing homes and home health care agencies, which are expected to generate $172 million in revenue for the state, will translate into cuts in services and 40,000 lost jobs. Imposing a “sick tax” in a market that is already starved for nurses and other allied health professionals “just doesn’t make sense,” she maintained. (On April 1, some 25,000 health care workers rallied in Albany to protest “job-killing cuts.”) As for the Assemblywoman’s observation on optional services, Mahaffey counters that

**[Medicaid, p.7]**
Thinking Outside “the Silo”: States Seek Ways to Integrate Health, Human Services

With states facing chilling deficits—the aggregate projected total for FY 2004 is $53.5 billion, by NCSL’s count last month—legislators and program administrators are scrambling to find funds to continue providing essential services, from health care to child care to education and employment assistance, to their most-vulnerable constituents. To do so in the current budget climate, however, they may have to find a new way of thinking about the structure of the health and human services system and how it’s financed—even if that means trampling on toes protecting individual program turf.

Traditionally, states, the federal government and philanthropic and other private organizations have targeted funds to specific programs that provide specific services to specific populations. In most communities, that categorical mindset has resulted in services that “are fragmented, inequitable and too often of poor quality,” according to a March 2002 report by the Washington, D.C.-based Finance Project, a nonprofit group whose mission is “to support decision making that produces and sustains good results for children, families and communities.” The economic downturn, the authors said, “heightens the sense of urgency” for developing better financing strategies. (See page 5 for the text of its full recommendation.)

To stretch resources and, at the same time, improve the service delivery system, policymakers may need to move away from what NCSL’s president, Oklahoma Sen. Angela Monson, calls “the silo mentality” of categorical funding and think about how best to meet the totality of people’s needs. One thing “that doesn’t cost any money and doesn’t take a whole lot of time,” she said, “is to create new channels of communication and information sharing. “I don’t mean the bosses,” Monson added. “I’m talking about the frontline employees who are in the trenches, working with families every day.” (See page 4 for the text of the full interview.)

Well before the current slump began, a number of states had set about to reform and integrate the delivery and financing health care, education and social services. Among the strategies they’re using to improve systems integration are joint administration of funds; cross-training of workers; multidisciplinary teams; comprehensive state and local planning; and defined policy goals and outcomes.

MEETING MULTIPLE NEEDS

As most policymakers recognize, children and families don’t fit neatly into one category. Rather, they face a multitude of problems that require a variety of responses, often from many agencies. Take, for example, a child who’s been placed out of the home into the child welfare or juvenile justice system. At a minimum, the child will have interactions with two other massive bureaucracies—Medicaid and the school system—and it’s not uncommon for one child to be involved with four or more separate agencies, each with a different legal mandate, funding source, organizational culture, training and values.

In Texas, the Integrated Funding Consortium—a statewide effort to restructure and enhance financing of youth services at the local level—is working to address just that issue by improving collaboration between child protective services and other key agencies. Created in 1999 as part of a broader law requiring coordinated state and local planning and delivery of federally funded health and human services including Medicaid, the Title XXI State Children’s Health Insurance Program and Head Start as well as foster care, child care, child abuse, juvenile justice and welfare systems, the consortium funds comprehensive, cross-program efforts to help youngsters with severe emotional and behavioral problems. (In that year, according to the state Heath and Human Services Commission, two-thirds of children with such problems failed to receive the help they need, often because services were fragmented among so many different agencies.)

Under the law, the consortium, which is supported by contributions from the participating agencies—$30,000 each in FY 2000 and $70,000 in FY 2001—awards funds to community-based projects to provide children’s mental health services. As a result of the consortium’s work, a recent evaluation reported that services are easier for families to access and more responsive to their needs; that there are fewer gaps in services and a better understanding among service providers of the resources available in their communities; and that officials have been able to identify services that overlap or are not readily available in a particular community.

“The government that works best is the government closest to the people,” said Sen. Jane Nelson, who chairs the Committee on Health and Human Services. “I feel strongly that our local mental health agencies could stretch their dollars better than our large state agencies,” which is the rationale behind the consortium effort. “Given that the cost of health and human services is such a major driver of state budgets and given that so many state legislatures are battling budget shortfalls, Texas included, we really owe it to the people who need our services and who pay the bills to look for ways to integrate services,” Nelson declared.

On a smaller scale, the Kids in Different Systems project in Franklin County, Ohio provides services for youngsters who are involved in two or more systems and who are at risk of out-of-home placement. Since 1986, the county has pooled funds from five agencies (child welfare, education, juvenile justice, the board of mental retardation and developmental disabilities and the alcohol, drug addiction and mental health board) for family support services that aren’t covered by any [Integration, p.6]
For vulnerable families in need of an array of services—health care, social supports, education and the like—the structure of government itself can stand as a formidable barrier. In an interview, Oklahoma Sen. Angela Monson, who is also president of NCSL, offered her ideas for making the system more user-friendly. Among her committee assignments, Monson—who was in the state House of Representatives from 1990 to 1993 before being elected to the Senate—sits on both the Human Resources Committee and the Appropriations Subcommittee on Health and Social Services and is an assistant majority floor leader. An edited text follows.

Q: Government typically is organized around categorical programs and funding streams. What problems does that pose for people in need of services?
A: Categorization by issue area or funding stream creates a clear separation among state agencies and interferes with our chance to meet individual family needs, resulting in a kind of silo mentality. Generally, families fit into more than one category, particularly low-income families or those with special needs. They need access to health care, social services supports, education and training. They don’t know where to go for services, or they end up going to more than one location looking for help, so the process is very stressful. If there’s more than one case manager or an [employee] who is unaware of the rules, procedures or programs provided through another agency or even another division within the same agency, [the family] can get contradicting information and conflicting recommendations from the advice given by another agency worker.

Q: Can you give an example of a problem that illustrates that lack of coordination?
A: I can. Medicaid in Oklahoma is administered by the Health Care Authority, which sets rules for eligibility and benefits, everything any state Medicaid agency would do. The eligibility determination process, whereby you apply and [talk to] a social worker, is through our Department of Human Services (DHS), and more than once a case worker has given the wrong information about Medicaid eligibility and services, so the family leaves the office believing that certain of its members are covered or that certain benefits are available when they are not. Because I knew the program fairly well, I intervened in a situation [in which] a family had been given erroneous information.

**HEALTH TALK**

**MONSON: CREATING A FAMILY-FRIENDLY SYSTEM**

Q: How can government be restructured to improve overall well being and achieve positive outcomes for children and families?
A: First, it’s critical to create new channels of communication and information sharing among frontline staff who are in the trenches working with families every day. That doesn’t take a lot of time or money. We might even devise ways to share some responsibilities.

As lawmakers, we can create the mechanisms to require cooperation among agencies, put in place a structure in statute or program funding that not only will require the level of dialogue I’ve just described but also identify the kinds of services that should be delivered jointly or that at least could be better coordinated. We have an example in Oklahoma for children with special health needs. Those aren’t dying children but a very small group, probably no more than a couple of hundred, with extraordinarily intensive health needs on an ongoing basis, plus other needs such as mental health and education.

What we did is bring together all of the relevant state agencies—Medicaid, DHS, our mental health agency—to look at this very small population. Their families basically were showing up in all of these systems and were assigned to multiple case managers. Solving the problem required funding to create linkages between computerized databases.

Finally, some states have consolidated family services under one agency. Doing that means resolving turf battles—and that isn’t easy. We haven’t done such a consolidation in Oklahoma, but it does work for some states.

Q: How does the budget crisis affect this?
A: The shortfalls create difficulty for cross-agency collaboration for two reasons. First is a turf issue. ‘I have to protect my turf, my resources are limited, so I can’t do anything new or expanded.’ And second, ‘If I show you all my cards, you may take them and use them against me in the budget process.’ Just like apple pie, collaboration is a good idea. In reality, however, agencies sometimes have conflicting goals that interfere with working together. Another problem is lack of revenue to try new things, such as restructuring a database across agencies in order to share certain information. New ideas often require research, evaluation and comparative analysis. So you’ll see some slowdown in collaborative efforts that are in place. I hope we can facilitate things that don’t cost anything and focus on communication across agencies.

Q: Wouldn’t some turf problems be diffused if agencies came together to achieve the same goal?
A: In tight budget times, everybody’s afraid of coming up a loser. Many workers have been entrenched in certain positions forever, and change is hard because you’re changing a mindset, not just behavior. I don’t know how you get through that. Even so, I’m optimistic that state agency staff [will] forget about the little barriers and come together for the good of families.

Q: What’s the role of health agencies in improving families’ overall well being?
A: Families cannot help themselves unless they are healthy. Healthy kids are more successful in school, and healthy parents do much better maintaining a job. Traditionally, [what we] don’t do is to teach people how to stay healthy and make smart choices about their health, so education is the other thing we can do to [offer] common-sense options. If my 8-year-old has a stomach ache and I don’t want give an over-the-counter medication, I may just stir up a little [baking] soda in a glass of warm water. It works wonders for my 8-year-old.

Q: What advice do you have for freshman legislators trying to learn about the multiple systems?
A: Take one agency at a time. That’s the only way to learn about a fairly massive system. If you drew a grid linking agencies, it would look wild. But if you piece bits of it together to build a foundation, [legislators] would come away with a clearer understanding of how services and programs operate and how, in some cases, we don’t get the biggest bang for our buck because there’s no coordination or communication. There are ways to slice it into components, by the individual receiving services or by agencies and the services they provide. Another idea is to follow a constituent through “the system,” play a game to figure out how to get health care and food stamps and pay the electric bill in one day on a limited income. ♦ Mary Fairchild, program director, NCSL/Annie E. Casey Partnership on Strengthening Families and Communities
FIVE KEY STRATEGIES FOR FINANCING COMPREHENSIVE CHILD/FAMILY INITIATIVES
(for state/local governments**)

STRATEGY 1
Making Better Use of Existing Resources
Redeploy—shift $ from higher-to-lower-cost programs/services
Improve efficiency—cut costs, reinvest in expanding services
Reinvest—allocate $ that can be ‘saved’ through redeployment, refinancing or cuts in spending to new/alternative services

STRATEGY 2
Maximizing State & Federal Revenue
Leverage—maximize federal revenue by taking advantage of programs that provide $ contingent on state, local and private funds
Refinance—use other sources of $ to pay for existing activities, freeing your own money for a new use
Administrative claiming—use available child welfare/Medicaid $ to cover array of administrative costs, based on the local match

STRATEGY 3
Creating More Flexibility
Pool—combine portion of $ from several agencies/programs into one unified funding stream
Coordinate—align categorical $ from a number of agencies/funding streams to support community and program-level initiatives
Devolve—delegate authority for allocation of funds from higher-to-lower levels of authority
Decategorize—remove narrow eligibility requirements governing allocations from existing $ streams

STRATEGY 4
Building Public-Private Partnerships in Existing Categories
Leverage—create partnerships that expand fiscal base for family/children’s services
Lead—build new, shared public-private leadership for investments in children/families
Technical assistance—create opportunities to share knowledge, skills, technical resources needed to create/sustain support and services systems

STRATEGY 5
Creating New Dedicated Revenue Streams
> Charge for services—charge user fees to help cover program costs
> Special taxing districts—create independent units of government with taxing authority dedicated to specific purpose
> Special tax levies—add on to existing taxes, with additional revenues earmarked for specific programs/services
> Guaranteed expenditure minimums—set floor below which spending for specified programs/services cannot fall
> Children’s trusts—establish separate, designated account in the public treasury with special rules for managing $ allocated to it
> Fees/narrowly based taxes—generate revenue from fees/taxes on specific segments of economic activity, usually use of a service or good
> Lotteries/gaming—use lottery/gaming proceeds to support programs and initiatives for children/families
> Income tax check-offs—let taxpayers designate portion of their tax liability or donate part of their refund to specific services/programs

** also includes strategies for community-based programs/coalitions
other funding source. Services include in-home parent training on behavior modification and purchase of home alarms to help with supervision of an autistic child. In addition to the $1.5 million in pooled funds, each agency assigns a staffer to work full time on the multisystem project at a shared location.

**SYSTEM OVERHAULS**

A few states, including Missouri and Washington, have established broad-based plans to improve family and community well-being at both the state and local level. Based on the public health prevention model, the laws seek to establish a legislative framework for assessing and addressing community risk factors. Brief descriptions follow:

+ Missouri's Caring Communities Initiative—a statewide effort to improve the accountability of state agencies and communities in improving the lot of children and families—Involves eight state agencies, as well as nine partners from the private sector. The agencies encompass social services, mental health; public safety, labor and industrial relations; economic development; corrections; and elementary and secondary education. The overarching goal is to redeploy dollars from the various agencies in an effort to integrate services for children and families.

As part of the initiative, the law created a state-level interagency, private-public Family Investment Trust (it’s since been renamed Family and Community Trust, or FACT) to support community partnerships—there are now 21—with oversight of 84 sites. Because the sites are neighborhood-based, they involve parents, business and community leaders, government agencies and nonprofit providers in planning and executing services. In an effort to measure results, leaders of the initiative in November 2001 announced development of a reporting system to ensure "a public health approach to controlling and preventing violent acts and instructed local communities to take a larger role in planning and implementing prevention activities. Specifically, seven "problem behaviors" are targeted: child abuse and neglect; youth violence; domestic violence; youth substance abuse; teen pregnancy; dropping out of school; and teen suicide.

While use of community networks to reduce problem behaviors represents a major departure in the way state policymakers address juvenile crime and associated risk behaviors, the strategy seems to be working. Evaluations show that a number of networks have reduced juvenile crime rates and other problem behaviors, including alcohol and substance abuse, child abuse and neglect and teen pregnancy, and mitigated costs associated with serving high-risk families. “We have entered into a state-community enterprise that results in systemic improvements over time,” Laura Porter, director of the Washington State Family Policy Council, observed.

+ The Los Angeles Unified School District has become a certified Medicaid provider by qualifying for contractor status under the LA County Department of Mental Health. As a result, it can now claim Medicaid reimbursement as the match for services previously paid for out of the state general fund and can use the money to provide services to non-Medicaid eligible students. In 2001, its certification status allowed the district to leverage an additional $850,000 in Medicaid payments for early and periodic screening, treatment and diagnosis services.

+ In Vermont, schools receive Medicaid reimbursement for conducting outreach to encourage families to receive regular checkups. Schools with on-site medical services are also reimbursed for providing preventive services to Medicaid-enrolled students. Mary Fairchild, program director, NCSL/Annie E. Casey Partnership on Strengthening Families and Communities

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HIGHLIGHTS

MEDICAID

Immigrant Benefits

A U.S. District Court judge has cleared the way for Colorado to terminate Medicaid benefits to an estimated 3,500 legal immigrants. The cutoffs, which had been challenged by the American Civil Liberties Union, were mandated under a law (SB 03-176) signed by Gov. Bill Owens on May 3; they were to have taken effect on April 1 but were stayed in response to an emergency motion filed by the ACLU Foundation of Colorado. In the wake of an April 11 hearing on ACLU’s request for a preliminary injunction, however, Judge Robert Blackburn ruled that the state may proceed with the cuts. While he agreed that “even a temporary suspension of coverage would result in irreparable injury to many of the plaintiffs,” he said that the public interest and the constitutional provision requiring the state to balance the budget outweigh any harm. ACLU attorneys said they’ll appeal the April 16 ruling.

WOMEN’S HEALTH

Waiting Period

After nine years of debate, the Minnesota Legislature has approved a law establishing a 24-hour waiting period for women seeking an abortion. The measure (SF 187), which was signed by Gov. Tim Pawlenty on April 13, requires doctors to give women who are considering abortion information on such things as the probable gestational age of the fetus at the time the procedure is to be performed and estimates of how much pain it might feel as well as the medical risks of carrying the fetus to term and the psychological impact of abortion. In addition, women must be told about availability of state benefits for prenatal, childbirth and neonatal care and the state must create a website on which to display the information. Finally, the measure defines an “unborn child” to begin from the moment of fertilization until birth. Pawlenty’s predecessor, Jesse Ventura, had vetoed similar legislation on two separate occasions. The signing makes Minnesota the 19th state to enact a “right-to-know,” or informed consent law.

Prenatal Care

Michigan and Rhode Island are the first two states to take advantage of a new federal rule that allows them to provide prenatal care services as a state plan option under the Title XXI State Children’s Health Insurance Program, rather than going through the often-lengthy process of applying for an SCHIP waiver. Under its plan, Michigan expects to reach more than 5,000 pregnant women in families with income to 185 percent of the federal poverty line, or $34,040 a year for a family of four. In Rhode Island enrollment for the benefit is expected to total 675, with an income cutoff of 250 percent of poverty, or $36,800 for a family of four. In both cases, the women will receive a standard SCHIP benefit that includes prenatal care.

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Sometime over the summer, State Health Notes will make the transition to an electronic version and will discontinue production of printed copies. In the coming weeks, we’ll be asking for your e-mail address. Once we have a complete list from all our readers and the e-version is set to go, you’ll receive notice every other Monday that the newsletter is online. Notes will look much the same and will continue to offer the same timely, accurate reporting. But instead of waiting for ‘snail mail,’ you can print a copy instantly and, just as you do now, put it in your files or a binder.

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many of them “are far from optional if the goal of the program is to protect the health of the state’s most-vulnerable residents.”

Also on the chopping block is the Medicaid “crossover” payment for dual eligible enrollees, which the governor’s office estimates will save the state $38 million. To the Medical Society of the State of New York, the modest state savings translates into $152 million in lost Medicaid payments to physicians and other providers. (Medicaid payments are split 50:25:25 among the federal government, the state and counties). New York physicians, who are already reimbursed by Medicaid at the lowest rate in the country, aren’t going to be able to absorb the difference, said society spokeswoman Molly Williams, and “patients who need care the most won’t get it.”

AN ACCOMMODATION?

At a mid-March rally sponsored by HANYS to protest the Pataki plan, Assembly Speaker Sheldon Silver, a Democrat, and Senate Majority Leader Joseph Bruno, a Republican, vowed to find the revenue to restore at least some of the proposed health care cuts. But as the April 1 deadline for finalizing the budget came and went—this is the 19th year in a row the budget has been late—no obvious solutions for doing so had yet emerged.

Republican Kemp Hannon, who chairs the Senate Health Committee, continues to look for an accommodation. “In times of limited fiscal resources and growing budget demands,” Hannon said, the legislature “needs to become creative and look for opportunities” to maintain core services. The goal, he insisted, must be to “balance the needs of New Yorkers” against “the fiscal concerns of local governments... struggling with increasing Medicaid costs and the burden placed on property taxes.”

As April wound down, budget negotiations were still underway. Gottfried predicted that some restorations will be made, but at this point, he said, “it’s not clear what the final picture will look like.”

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State Health Notes - May 5, 2002
Florida Medicaid Workers Go the Extra Mile as Mentors

For the staff of Florida’s Area Six Medicaid office, commitment to the Tampa community goes beyond the nine-to-five work day within agency walls. Currently, 28 of the office’s 42 employees are volunteering as mentors at a total of 9 local schools, taking part in programs that are designed to help children learn and offering friendship to kids whose self-esteem may need a boost.

The effort is in response to Gov. Jeb Bush’s statewide Mentoring Initiative. Unveiled in August 1999, eight months after Bush took office, the initiative seeks to recruit 200,000 volunteers to meet weekly with youngsters who are performing poorly at school and who may be at risk of dropping out. According to the initiative’s website, statistics show that a youngster who meets with a mentor is 46 percent less likely to use illegal drugs, 27 percent less likely to begin drinking alcohol and 52 percent less likely to skip school. State agencies, businesses and nonprofit organizations are all encouraged to take part.

To build state agency enthusiasm, Bush followed up in late November with a rule granting state employees up to an hour of administrative leave per week, not to exceed five hours per calendar month, to take part in the initiative. The overall goal: achieve 10 percent participation in every state agency, including the Agency for Health Care Administration (AHCA), which runs Florida’s $11 billion Medicaid program.

Across its 11 district, or area, offices, AHCA reported on April 1, 100 of its employees are active mentors or school-based volunteers in 15 schools across the state; of the 29 in the Area Six contingent, 14 are signed up at Egypt Lake Elementary School, three blocks from the office. According to Harold Daniels, the office’s Medicaid liaison to the five-county school system who’s been tapped as the mentoring coordinator, the strong participation makes AHCA one of only five state agencies so far to meet the 10 percent target. (The largest of the five counties is Hillsborough, in which Tampa is located.)

The Area Six program, which is now in its third full year and is run under the auspices of the Big Brother–Big Sister organization, started with an orientation session, followed by one-on-one talks by Daniels to sell the mentoring concept to his colleagues. To make it work, “I had to have the support of office management,” which, he noted, was readily forthcoming. Over the three years, participants have come from the ranks of clerks and administrative assistants to the field office manager, and in the current quarter, they’ve put in close to 200 hours outside the one-hour weekly allotment for administrative leave.

Unlike tutors, who are assigned to help a child with a specific class, like reading, mentors are more of a “buddy” helping to build the child’s self image. On his last mentoring visit, for instance, Daniels said he and “his child” took a walk around campus to talk, did some homework, tossed around a football and then talked some more. Not only is that good for the child, it helps break down the barrier that often exists between desk-bound bureaucrat and beneficiary.

If a mentor detects a domestic problem (or the child confides one), the preferred course of action is to report it to a guidance counselor or another school authority. In one case, a volunteer reported an incident “that cost her the relationship” with the child, “so you have to be careful,” Daniels warned.

In addition to individual sessions with the kids, AHCA mentors are involved in what spokesman Pat Glynn calls “health literacy,” including making a bilingual presentation on Child Health Check-Up, which is the Early and Periodic Screening, Diagnosis and Treatment component of Medicaid, and handing out applications. AHCA has “a very active outreach program” that provides Medicaid families with information on a range of health issues, from diabetes and nutrition to “aging in place,” and there is “crossover” between it and the mentoring initiative, Glynn noted.

Other health-related activities, according to Daniels, are health fairs, a class for third graders on dental health and an upcoming class on bullying. “We’ve had so many success stories with children, it’s unbelievable,” he enthused. Thanks to the dedication of the mentors and the support of AHCA, “this is a program that really works.” The community seems to think so as well: It’s chosen the Area Six program as a finalist for a 2003 “Eddie Award,” to be handed out on May 8 by the Hillsborough Education Foundation in recognition of the volunteer spirit. + LD

(See http://www.flamentoring.org for more info.)