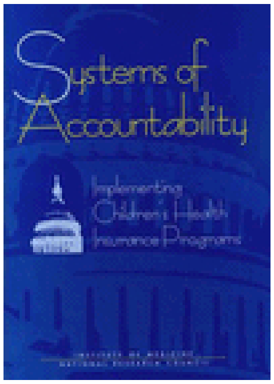

Systems of Accountability: Implementing Children's Health Insurance Programs

Margaret Edmunds and Molly Joel Coye, Editors; Committee on Children, Health Insurance, and Access to Care, National Research Council and Institute of Medicine

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THE NATIONAL ACADEMIES
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Systems of Accountability

Implementing Children's Health Insurance Programs

Margaret Edmunds and Molly Joel Coye, Editors

Committee on Children, Health Insurance, and Access to Care
Division of Health Care Services, Institute of Medicine,
and
Board on Children, Youth, and Families,
National Research Council and Institute of Medicine

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Preface and Acknowledgments

In the summer of 1996, the Robert Wood Johnson Foundation asked the National Academy of Sciences to conduct a study of the relationship between health insurance coverage and access to care for children. In response to this request, the Institute of Medicine's (IOM's) Division of Health Care Services and the Board on Children, Youth, and Families of the National Research Council and the IOM—in a joint activity—formed an expert committee to:

- examine the extent of health insurance coverage for children;
- analyze evidence on the relationship between health insurance coverage and children's access to health care;
- identify trends in the availability and size of safety net programs (e.g., community health centers, children's hospitals, and public health departments), and how these programs affect children's access to health care services; and
- consider the potential effects of significant changes in public and private insurance coverage on children's access to health care.

Between March and June 1997, the committee met three times and convened a public workshop. Members of a liaison panel (see Appendix B) made presentations at the workshop and submitted a variety of materials and statements for the committee's review.

Based on its deliberations and an extensive review of national databases, published health services research findings, policy and news analyses, and other publicly available information, the committee prepared a report entitled *America's Children: Health Insurance and Access to Care. America's Children* presents the committee's review of evidence and draws conclusions about the relationship of children's health insurance and access to care.

The committee met again in January 1998 specifically to consider the new State Children's Health Insurance Program (SCHIP) enacted as part of the Balanced Budget Act of 1997. This meeting led to the development of the current report, *Systems of Accountability: Implementing Children's Health Insurance Programs* as a companion to *America's Children.*

Systems of Accountability addresses practical concerns about the implementation and evaluation of SCHIP and presents the committee's recommendations about accountability for measuring the program's impact. The committee hopes that this report will help a variety of policy makers make more informed decisions about how to achieve their multiple—and often competing—objectives as SCHIP is implemented across the country.

The committee and its IOM staff express their deep appreciation to all those who contributed to *Systems of Accountability*. These include speakers at the committee's meeting on January 28, 1998: Ellen Bayer, American Association of Health Plans; James Crall and Burton Edelstein, American Academy of Pediatric Dentistry; Stan Dorn, Children's Defense Fund; Carrie Gavora, The Heritage Foundation; Joan Henneberry, National Governors Association; and Judith Moore, Medicaid and State Operations, Health Care Financing Administration. Gary Claxton, Denise Dougherty, Margaret Hamburg, Patricia MacTaggart, and Marina Weiss also made contributions.

This report has been reviewed by individuals chosen for their diverse perspectives and technical expertise, in accordance with procedures approved by the National Research Council's Report Review Committee. The purpose of this independent review is to provide candid and critical comments that will assist the authors and the IOM in making the published report as sound as possible and to ensure that the report meets institutional standards for objectivity, evidence, and responsiveness to the study charge. The content of the review comments and the draft manuscript remain confidential to protect the integrity of the deliberative process. We wish to thank the following individuals for their participation in the review process: Melvin Worth, Institute of Medicine; Judith Feder, Institute for Health Care Research and Policy and Georgetown University; Julius Goepp, University of Rochester School of Medicine; David Nathan, Harvard Medical School; Stuart Orkin, Children's Hospital and Harvard Medical School; and Diane Rowland, Kaiser Commission on the Future of Medicaid.

While the individuals listed above have provided many constructive comments and suggestions, responsibility for the final content of this report rests solely with the authoring committee and the IOM.

The committee expresses its deep gratitude to Study Director Margo Edmunds for her creative and energetic guidance and leadership. Her efforts were well supported by Kathleen Nolan, research assistant, and Tracy McKay, project assistant. The contributions of several other IOM and Academy staff members are gratefully acknowledged. They include Clyde Behney, Claudia Carl, Mike Edington, Karen Hein, Roger Herdman, Jim Jensen, Marion Ein Lewin, Constance Pechura, Dan Quinn, and Kenneth Shine. Sue Barron, Kay Harris, and Evelyn Simeon also contributed to the study's activities.

In developing the recommendations for *Systems of Accountability,* the committee tried to address the interests and needs of different stakeholders, including members of Congress, federal and state agencies, managed care organizations, professional provider groups, policy researchers, and parents. The committee's intention is to offer practical suggestions. Some of the recommendations describe evaluation efforts that are feasible within the limits of existing resources and easy to implement quickly. Other recommendations describe efforts that will take longer because of the need to identify funding sources to support the design and development of an evaluation infrastructure.

At this very early stage in the program, it is vitally important to design and develop systems of accountability and to anticipate information and communication needs based on experiences with other national programs. Our recommendations emphasize an open exchange of meaningful information that can be used to improve SCHIP as well as to guide future efforts to reduce the number of uninsured children, to improve their access to health care, and, ultimately, to improve their health.

Molly Joel Coye
Chair

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Summary

APPROACH TO THE STUDY

Children's health insurance became a subject of national debate early in 1997 when President Clinton and members of Congress began to develop a variety of competing proposals to expand coverage for children. After several months of active discussion and negotiation, Congress enacted the State Children's Health Insurance Program (SCHIP) as part of the Balanced Budget Act of 1997 (P.L. 105-33).

This report describes the responsibilities of Congress, the U.S. Department of Health and Human Services (DHHS), and the states in implementing and evaluating SCHIP. The report presents a framework and recommendations for designing systems of accountability for SCHIP as states take a variety of steps to reduce the number of uninsured children.

In general terms, *accountability* is the process by which an individual or organization accepts responsibility for an activity and provides information regarding progress on meeting requirements and expectations. **The committee defines *systems of accountability* as those processes and procedures that provide information for analysis and decision-making and that provide a basis for designing, implementing, evaluating, and improving programs.**

SCHIP makes $24 billion available to states over 5 years, including $20.3 billion for new initiatives based on private insurance coverage and $3.6 billion for Medicaid improvements. States may use SCHIP funds to broaden their Medicaid programs, to start up or expand state-sponsored or private insurance programs, or to support a combination of programs. The potential for flexibility in SCHIP designs appeals to most states because it gives them the opportunity to provide coverage and services in ways that reflect the state's unique circumstances and characteristics, such as the availability of insurance products and providers, the geographic distribution of uninsured children, and the potential sources of financing, among others.

This flexibility also raises some technical and practical issues. The most fundamental question is this: With so much variation possible, how will we know whether SCHIP is effective? Unless there is consistent reporting of reliable data within and across states, it will be difficult to evaluate the program's impact. At this very early stage in the program, it is vitally important to design and develop systems of accountability and to anticipate needs for information and communication based on experiences with other national and state programs, especially those that involve low-income working families.

ACCOUNTABILITY FOR SCHIP

Having enacted SCHIP and appropriated $24 billion over 5 years, Congress will oversee DHHS's administration of the program. The legislation requires states to submit written plans to DHHS describing their programs as well as their strategic objectives, performance goals, and performance measures. With these legislative requirements, Congress established a basic template for SCHIP accountability.

DHHS has created an interdepartmental steering committee to implement SCHIP. State plans are being submitted to the Health Care Financing Administration (HCFA) and are being reviewed by HCFA's national and regional offices in collaboration with the Health Resources and Services Administration, the Agency for Health Care Policy and Research, the Office of the Assistant Secretary for Planning and Evaluation, and other participants on the steering committee. To qualify for their first-year SCHIP allotments, states must have federal approval for their plans by September 30, 1999.

For several months, DHHS has been actively providing information and technical assistance to states as they develop and implement their SCHIP plans. With only half of the state plans submitted as of the beginning of April 1998, it is too early to tell how DHHS will handle the variety of performance measures proposed by the states or whether any uniform performance measures will be recommended or required.

RECOMMRNDATIONS

The recommendations in this report are based on an extensive review of evidence on the relationship between insurance coverage and access to care, as presented in the committee's companion report, *America's Children: Health Insurance and Access to Care* (IOM, 1998). The recommendations are also based on the following assumptions:

- **New Opportunities.** SCHIP offers new opportunities for innovation and flexibility in insurance expansion, for improving existing programs, for increasing children's access to health care, and for developing child-specific performance measures.
- **Accountability for Public Funding.** The $24 billion in federal funds allocated for SCHIP and Medicaid improvements represents a significant national commitment to insurance expansion for children. This commitment should be monitored to ensure that the legislation's goals are fulfilled.
- **Need for Sustained Efforts.** Although SCHIP will help to reduce the number of uninsured children, millions of children will remain uninsured or underinsured even assuming its full implementation. To guide future insurance expansions, careful evaluation of the multitude of state approaches used under SCHIP will be essential.

CONGRESSIONAL ACCOUNTABILITY FOR SCHIP

1. Congress should take immediate action to ensure that funding is adequate to evaluate SCHIP's impact.

a. The leadership of key committees should periodically ensure that DHHS has adequate resources to implement its responsibilities under SCHIP.
b. Key committees should designate staff members who would keep in contact on an informal basis with DHHS staff to ensure that SCHIP accountability systems have adequate resources and support.

FEDERAL GOVERNMENT ACCOUNTABILITY FOR SCHIP

Performance Monitoring for SCHIP.

2. DHHS must establish a performance monitoring system for SCHIP in collaboration with agencies from other levels of government and with private organizations.

a. DHHS should designate an interdepartmental task force to coordinate, implement, and oversee a performance monitoring system for SCHIP.
b. A well-chosen set of basic performance measures is needed to provide comparable information on all SCHIP programs.
c. The interdepartmental task force should coordinate its activities with representatives of the technical and analytical infrastructure being developed at state and federal levels to evaluate welfare reform and other recent health insurance legislation.
d. A new, rapid turnaround survey is needed to track key indicators of SCHIP performance at the state-level.

Children's Health Indicators

3. DHHS must develop systems that improve the availability of national and state-level information on children's insurance coverage, access, utilization, satisfaction, health status, and outcomes, particularly for children with special health care needs.

a. DHHS should increase the sample size of the National Health Interview Survey to permit state-level estimates and evaluations. Supplements on child health and well-being should be conducted every 3 years.
b. DHHS should continue to support and encourage efforts to develop and improve indicators of children's health status and outcomes, including indicators for children with special health care needs.

STATE ACCOUNTABILITY FOR SCHIP

Designing Accountability Systems

4. **States should begin immediately to design and implement systems to produce meaningful information on SCHIP's effects.**

Public Information

5. **Information on SCHIP should be made available by states to the public and should be meaningful in evaluating the program's performance.**

Data Collection and Performance Reporting

6. **As much as possible, states should delegate the collection and synthesis of SCHIP information to contracted health plans or provider groups, with requirements for independent auditing of these data.**

Performance Incentives and Rewards

7. **States should set conditions for participation in SCHIP, experiment with a variety of incentives to reward health plans for their performance, and develop the technical and analytical capacity to evaluate the impact of incentives on health plan performance.**

CONCLUSION

SCHIP is historic, innovative, and rapidly evolving. It offers an unprecedented opportunity to move from the traditional monitoring and compliance models of health care, which focus on financial performance, to a quality improvement model that fulfills the intent of the SCHIP legislation: to provide insurance coverage for uninsured children, to improve their access to high-quality health care services, and, ultimately, to improve their health.

Overview of the State Children's Health Insurance Program

Children's health insurance became a subject of national debate early in 1997 when President Clinton and members of Congress began to develop a variety of competing proposals to expand coverage for children. After several months of active discussion and negotiation, Congress enacted the State Children's Health Insurance Program (SCHIP) as part of the Balanced Budget Act of 1997 (P.L. 105-33).

SCHIP was designed to allow states to provide "child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children." For the purposes of SCHIP, low-income children are generally defined as those whose family incomes are higher than Medicaid eligibility but lower than 200% of poverty (about $32,000 for a family of four).

After October 1, 1997, SCHIP made $24 billion available to states over 5 years, including $20.3 billion for new initiatives based on private insurance coverage and $3.6 billion for Medicaid improvements, such as continuing eligibility for children who were formerly eligible for Supplemental Security Income, and guaranteeing 1 year of Medicaid eligibility. Some analysts suggest that SCHIP funding may be adequate to cover almost 6 million children, but that only about 3 million children will be eligible for SCHIP under current program rules (Ullman et al., 1998).

According to the latest estimates from the Census Bureau, 11 million children are uninsured—1 out of every 7—and most of these children live in low-income working families (Employee Benefits Research Institute, 1997). States may use SCHIP funds to broaden their Medicaid programs, to start up or expand state-sponsored or private insurance programs, or to support a combination of programs. Under SCHIP, states must screen all applicants for Medicaid eligibility and must enroll any eligible children in the Medicaid program. Depending on the source of these data, an estimated 1.6 million to 4.7 million children who are already eligible for Medicaid are not enrolled (Selden et al., 1998; Ullman et al., 1998; Weigers et al., 1998) Thus, coordination between SCHIP and Medicaid programs will be critically important.

The potential for flexibility in SCHIP designs appeals to most states because it gives them the opportunity to provide coverage and services in ways that reflect the state's unique circumstances and characteristics, such as the availability of insurance products and providers, geographic distribution of uninsured children, and the potential sources of financing, among others.

This flexibility also raises some technical and practical issues. The most fundamental question is this: With so much variation possible, how will we know whether SCHIP is effective?

PURPOSE OF THIS REPORT

This report describes the responsibilities of Congress, the U.S. Department of Health and Human Services (DHHS), and the states in implementing and evaluating SCHIP. The report presents a framework and recommendations for designing systems of accountability for the program as states take a variety of steps to reduce the number of uninsured children. **The committee defines *systems of accountability* as those processes and procedures that provide information for analysis and decision-making and that provide a basis for designing, implementing, evaluating, and improving programs.**

The committee strongly supports the flexibility and innovation that are built into the SCHIP legislation, provided there are ways to measure the program's impact on a national basis and to ensure that the funds spent actually improve insurance coverage and health outcomes for children. From the beginning, it will be important to learn where states are heading with their spending and services. Later on, it will be important to be able to identify which program components are effective so that “best practices” can be continued and replicated in other locations and less effective practices can be avoided. Thus, the committee's accountability framework includes steps that can be taken immediately, as well as steps that are needed to build infrastructure, capacities, and systems for a coordinated, longer-term approach.

WHO IS ACCOUNTABLE FOR SCHIP?

What Is Accountability?

In general terms, *accountability* is the process by which an individual or organization accepts responsibility for an activity and provides information regarding its progress in meeting requirements and expectations. Accountability involves the development and dissemination of information regarding the process, quality, and outcomes of work; the use of fiscal resources; the problems encountered or anticipated; and other activities undertaken to fulfill contractual, fiscal, statutory, professional, or public responsibilities. **For a children's health insurance program, accountability refers to responsible spending to expand children's access to affordable, high-quality health care.**

Systems of accountability should specify the mechanisms and formats for collecting and transmitting the expected information. These formats may be oral, written, electronic, or in some other standardized technology. The systems also should specify the ways in which feedback on the information will be exchanged, and what kinds of responses might be expected as a result.

Accountability is an interactive process. In other words, accountability should be defined specifically in the context of relationships. Figure 1 portrays the specific relationships through which the committee believes accountability for SCHIP must be established.

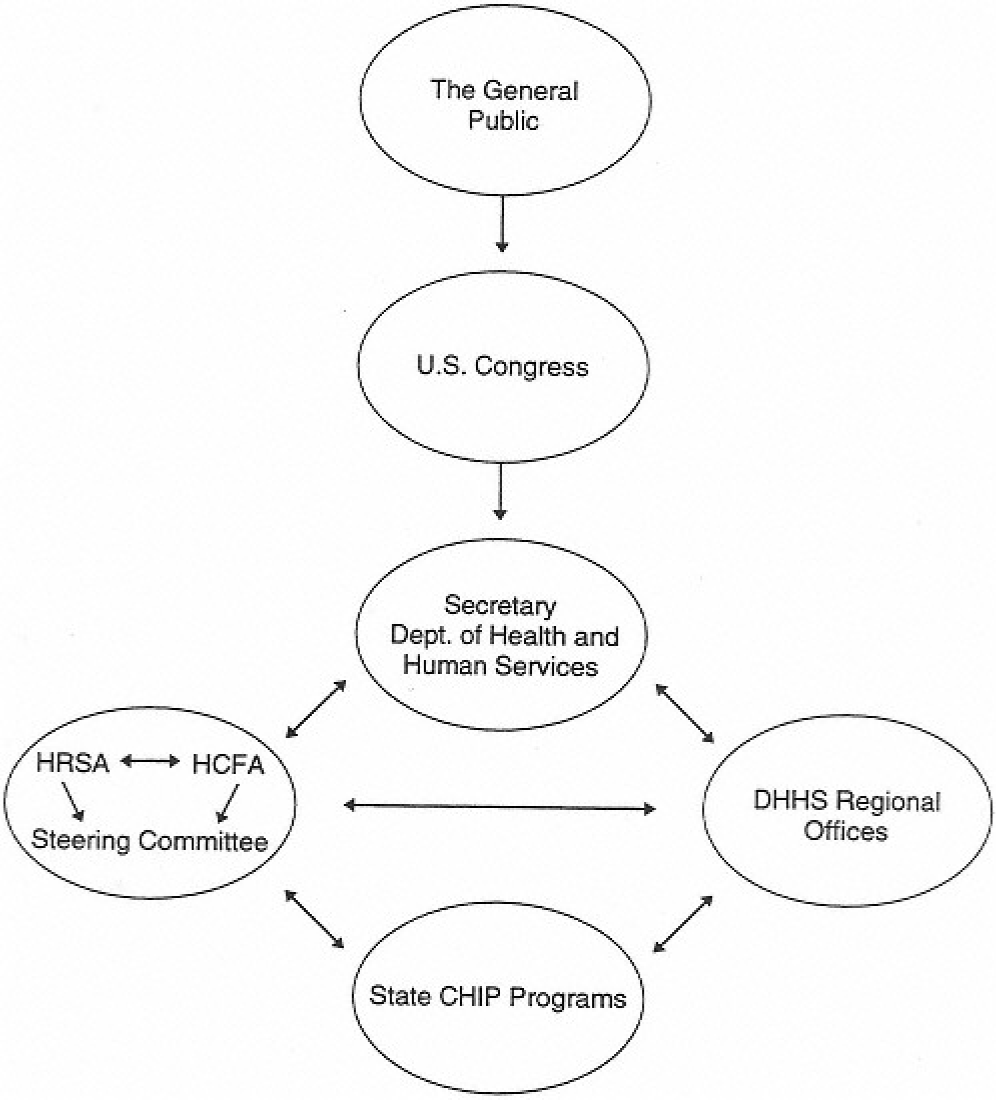

FIGURE 1 Accountability for SCHIP programs. One-way arrows indicate public accountability specified in The Balanced Budget Act of 1997 (P.L. 105-33). Two-way arrows indicate collaborative exchanges of information to ensure accountability for the SCHIP programs.

Congress

Having enacted SCHIP and appropriated $24 billion over 5 years, Congress will oversee DHHS's administration of the program. The legislation requires states to submit written plans to DHHS describing their programs as well as their strategic objectives, performance goals, and performance measures (see Box 1). The legislation also requires the secretary of DHHS to report to Congress on the effectiveness of the state plans by December 31, 2001.

BOX 1 STRATEGIC OBJECTIVES AND PERFORMANCE GOALS DESCRIBED IN THE BALANCED BUDGET ACT OF 1997

States must do the following:

- Submit a written SCHIP plan for approval.
- Describe the process used to involve the public in the design and implementation of the plan, as well as the process for ongoing public involvement.
- Set strategic objectives related to measuring the extent of “creditable” health coverage among targeted low-income children and other low-income children.
- Set one or more performance goals for each strategic objective.
- Indicate how performance will be measured through objective, independently verifiable means.
- Conduct an annual assessment and submit an annual report of results to the secretary of Health and Human Services.
- Provide assurance that the state will collect the data, maintain the records, and furnish the reports to the secretary, to enable the secretary to monitor state program administration and compliance, and to evaluate and compare the effectiveness of state plans.
- Allow access to any records or information for purposes of review or audit.
- By March 31, 2000, submit a report to the secretary based on an assessment of the effectiveness of the state SCHIP plan including:

a. An assessment of the effectiveness of the program in increasing the number of children with “creditable” health coverage, including the following information:

1. child and family characteristics, including age of children, family income, and the child's access to or coverage by other health insurance prior to participation in the state program;
2. quality of health coverage including types of benefits provided;
3. amount and level of financial assistance, including payment of premiums by the state; and
4. scope of services provided.

b. An assessment of the effectiveness of other state and private programs in the state in increasing the availability of affordable, quality medical and family health insurance for children.
c. A review and assessment of state activities to coordinate the SCHIP program and other public and private programs in providing health care financing, including Medicaid and maternal and child health services.
d. An analysis of changes and trends in the state that affect the provision of accessible, affordable, quality health insurance and health care to children.
e. A description of any state plans for improving the availability of health insurance and health care for children.
f. Recommendations for improving the SCHIP program.

By December 31, 2001, the secretary shall submit a report to the Congress and will make it available to the public. The report will be based on information submitted by the states. The Balanced Budget Act does not further specify the information to be collected, analyzed, or evaluated by the secretary.

SOURCE: Based on The Balanced Budget Act of 1997 (P.L. 105-33, Subtitle J, *Summary of Provisions,* at http://www.house.gov/budget/papers/mainsumm.htm.

With these legislative requirements, Congress established a basic template for SCHIP accountability. However, the authorizing legislation leaves a great deal of room for interpretation by DHHS and by the states. **At this very early stage in the program, it is vitally important to design and develop systems of accountability and to anticipate information and communication needs based on experiences with other programs.**

If Congress chooses to gather additional information on SCHIP, it has several of its usual oversight options. For example, it may hold hearings or it may request a study by the U.S. General Accounting Office. After SCHIP has been fully implemented, if it is not developing in the way Congress intended, Congress could amend the statute to change the program or to include additional requirements.

U.S. Department of Health and Human Services

Within DHHS, the Health Care Financing Administration (HCFA) and the Health Resources and Services Administration (HRSA) are leading an interdepartmental steering committee to implement SCHIP. State plans are being submitted to HCFA and are being reviewed by HCFA's national and regional offices in collaboration with HRSA, the Agency for Health Care Policy and Research, the office of the Assistant Secretary for Planning and Evaluation, and other participants on the steering committee.

For several months, DHHS has been actively providing information and technical assistance to states as they develop and implement their SCHIP plans. Activities have included

- a series of regional conferences in January and February 1998 for state and federal officials, state legislators, providers, and community leaders;
- written guidance in the form of “dear state” letters on the state plan approval process, financial reporting, outreach and enrollment, cost-sharing, substitution of coverage, public involvement, and other issues;
- a web site (www.hcfa.gov) containing the “dear state” letters, press releases, names and contact information for agency assistance, and other information; and
- collaboration with the American Public Human Services Association, the National Governors' Association, the National Conference of State Legislatures, the Association of State and Territorial Health Officials, the National Association of Insurance Commissioners, and other groups.

By late September 1998, 50 plans have been submitted and 41 plans have been approved. Of the 50 plans, 13 are for programs created by states, 27 are for Medicaid expansions, and 10 are combinations of Medicaid and state programs. DHHS has created a standard format to help states provide information that is required by the statute, but the current focus is on start up and enrollment activities. Further decisions and guidance on data and on federal and state accountability systems are still pending.

Several child health performance measurement and managed care quality improvement activities have implications for SCHIP, including Bright Futures encounter forms and the National Committee on Quality Assurance's expansion of HEDIS child health measures. In addition, HCFA's Quality Improvement System for Managed Care standards and guidelines are in interim final form as of late September 1998. The challenge for DHHS will be to continue to collaborate with the variety of efforts underway in states and the private sector while also moving forward on defining standardized reporting information for SCHIP.

States

To qualify for their first-year SCHIP allotments, states must submit written plans to HCFA before September 30, 1999. (The original deadline of June 30, 1998, was extended on May 1, 1998, by H.R. 3579). After HCFA approves the plans, they become the states' contracts and serve as the basis for each state's accountability framework for SCHIP.

As of March 17, 1998, 22 states had submitted plans to HCFA for approval, and four plans had been approved—those for Alabama, Colorado, Florida, and South Carolina. HCFA has also encouraged states to submit “mini-plans” that would secure their allotment for up to 3 years, but would also allow them to submit revised plans later on (National Economic Council/Domestic Policy Council, 1998).

In addition to information on eligibility, enrollment, and program coordination, state plans must include information on the scope of services and on methods to ensure the quality and appropriateness of care (see Box 2 and Figure 2).

States vary widely in technical and analytical capacities as well as in their willingness to collect and analyze performance data (Landon et al., 1998; Rosenbaum et al., 1997). Technical problems in the exchange of health care information arise from the variety of software systems used by states, health plans, and other providers, as well as from the cost of new management information systems—which can range from $250,000 to $1 million for a basic administrative system and much higher for a full managed care system (Ciotti and Zodda, 1996).

For example, even though HCFA requires states to collect encounter-level data for Medicaid managed care 1115 waiver demonstrations, some states' information systems will not allow them to merge and analyze eligibility and claims files, which could enable them to analyze access and patterns of care (Epstein, 1997). As large-scale purchasers of private health care coverage for SCHIP enrollees, states must be able to develop specific contract language, define a scope of services within existing resources, and establish performance measures that ensure access and quality of care.

BOX 2 INFORMATION TO BE INCLUDED IN STATE SCHIP PLANS

States must submit a written SCHIP plan to DHHS for approval in order to receive the federal match. The plan must include the following information:

- steps to increase enrollment and identify eligible children,
- steps to coordinate with other health insurance programs in the state,
- scope of services and methods of delivery,
- eligibility standards for enrollment,
- outreach activities,
- methods to ensure quality and appropriateness of services provided,
- methods to ensure access of enrollees to care, and
- strategic objectives, performance goals, and performance measures for the SCHIP program and related programs to provide insurance coverage for children.

SOURCES: Based on The Balanced Budget Act of 1997 (P.L. 105-33, Subtitle J, *Summary of Provisions,* at http://www.house.gov/budget/papers/mainsumm.htm and *Title XXI Summary from The Balanced Budget Act of 1997, Children's Health Insurance Program* by the Health Care Financing Administration at http://www.hcfa.gov/init/kidssum.htm.

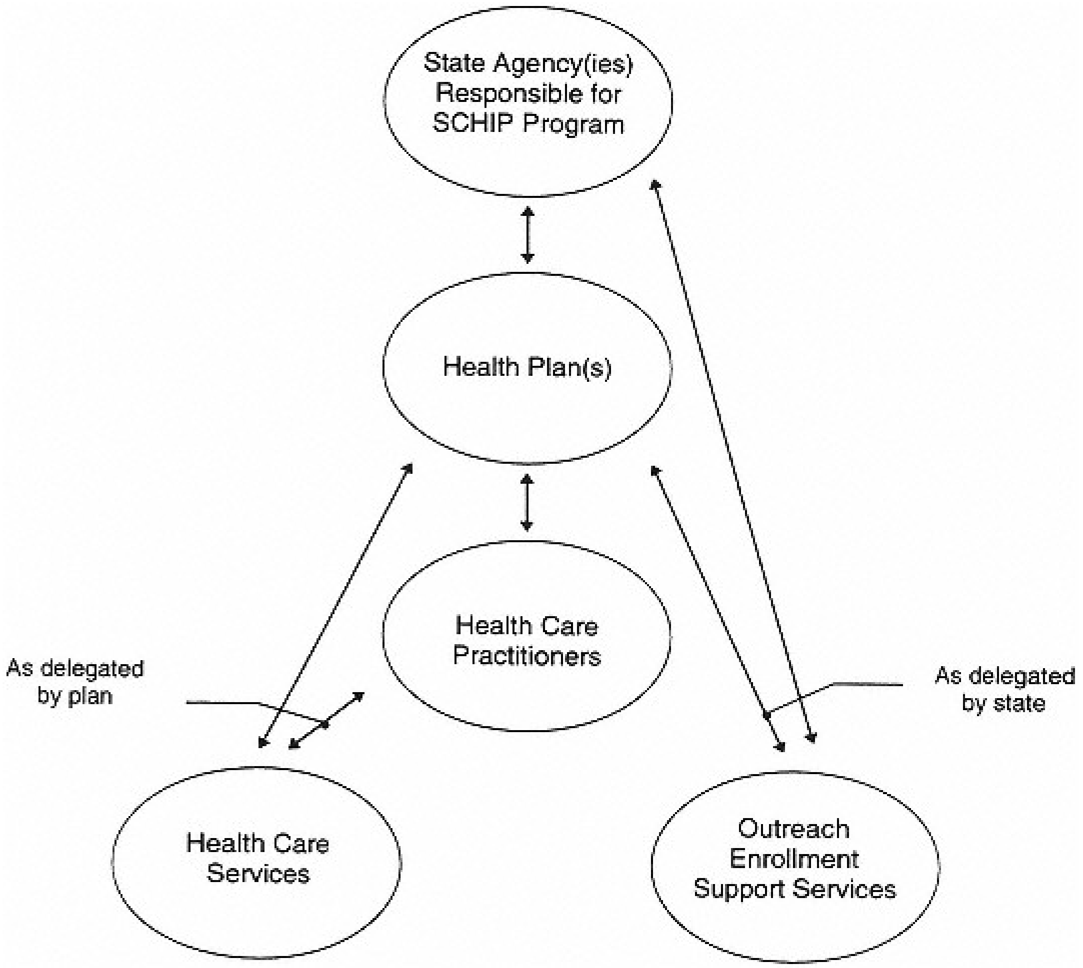

FIGURE 2 Information flows to support accountability relationships within states for SCHIP programs. Arrows indicate information flows and accountability relationship, as specified in state laws, public policies, and contractual agreements.

RECOMMENDATIONS

The recommendations in this report are based on an extensive review of evidence on the relationship between insurance coverage and access to care, as presented in the committee's companion report, *America's Children: Health Insurance and Access to Care* (IOM, 1998). The recommendations are also based on the following assumptions:

- **New Opportunities.** SCHIP offers new opportunities for innovation and flexibility in insurance expansion, for improving existing programs, for increasing children's access to health care, and for developing child-specific performance measures.
- **Accountability for Public Funding.** The $24 billion in federal funds allocated for SCHIP and Medicaid improvements represents a significant national commitment to insurance expansion for children. This commitment should be monitored to ensure that the legislation's goals are fulfilled.

- **Need for Sustained Efforts.** Although SCHIP will help to reduce the number of uninsured children, millions of children will remain uninsured or underinsured even assuming its full implementation. To guide future insurance expansions, careful evaluation of the multitude of state approaches used under SCHIP will be essential.

CONGRESSIONAL ACCOUNTABILITY FOR SCHIP

1. Congress should take immediate action to ensure that funding is adequate to evaluate SCHIP's impact.

Congress provided a basic template for SCHIP accountability systems by requiring states to set strategic objectives and performance goals and to collect performance data as part of their SCHIP plans, and by requiring the Secretary of DHHS to report to Congress by December 2001 on the effectiveness of the state plans (see Box 1). The commitment to using performance data is a critical component of any long-term accountability system (Congressional Budget Office, 1993).

The committee is concerned that existing federal and state information systems, data sources, and analytical capacities may not be adequate to accomplish the ongoing evaluation and monitoring of child health insurance coverage, access, utilization, and outcomes that are required by the SCHIP legislation. For example, recent experience with welfare reform shows that new programs need adequate resources to be able to make initial procedural and programmatic adjustments (GAO, 1998a,b).

To protect the national investment in SCHIP, the committee urges Congress to take the necessary steps to ensure that the resources and strategies needed to evaluate the impact of SCHIP are adequate at the state and federal levels.

a. **The leadership of key committees should periodically ensure that DHHS has adequate resources to implement its responsibilities under SCHIP.**
b. **Key committees should designate staff members who would keep in contact on an informal basis with DHHS staff to ensure that SCHIP accountability systems have adequate resources and support.**

FEDERAL GOVERNMENT ACCOUNTABILITY FOR SCHIP

Performance Monitoring for SCHIP

2. DHHS must establish a performance monitoring system for SCHIP in collaboration with agencies from other levels of government and with private organizations.

DHHS should involve states, local governments, health plans, national organizations, and private foundations active in health care in a national effort to evaluate the impact of SCHIP. This effort should be coordinated with ongoing performance monitoring activities concerned with public health, mental health and substance abuse treatment and preven tion, education, disabilities, and other programs and activities involving children and families, especially low-income working families.

The collaboration should involve the design and support of measurement methods and strategies and the development of technical and analytical capacities in the states, including financial and technical support for designing and implementing new information systems. State governments and state and local private foundations should assist the national effort by supporting statewide and local evaluations and by helping to develop systems to disseminate information and stimulate action in the states and in local communities.

a. DHHS should designate an interdepartmental task force to coordinate, implement, and oversee a performance monitoring system for SCHIP.

The task force should develop a strategic plan that sets clear, realistic priorities for SCHIP in the short term (1998–2000) and for the mid-phase (2001–2003). The plan should identify what can be learned from different SCHIP approaches over the long-term, including the net increase in the number of insured children under different SCHIP program approaches; effective strategies for coordination of SCHIP with Medicaid and other state and community-based programs; and likely effects on SCHIP children's health status. This strategic plan should be made available to the public.

The task force could include the key staff who were involved with the DHHS Steering Committee for SCHIP during its design phase. The task force should continue to develop relationships with stakeholder groups in state and local governments, as well as with foundations.

b. A well-chosen set of basic performance measures is needed to provide comparable information for all SCHIP programs.

Currently, states vary widely in their use of information systems, analytical and technical capacities, and measurement approaches. Without a minimum set of comparable data, it will be difficult to establish baseline information and to track changes in the number of uninsured children; to evaluate disparities in health status; to compare the scope of services in different programs, utilization data for different groups, and the quality of care in different health plans; and to collect other information essential for evaluating the success of SCHIP across states.

The field of performance measurement is continually improving and is moving toward more outcome-oriented, population-specific, and evidence-based measures. In addition to the technical difficulty and expense of developing and implementing new accountability systems, a major challenge and tension in this evolving field is how to strike a balance between the desire for comparable information and the resistance to public comparisons and judgments. For example, states are accustomed to financial reporting for federal programs but may be less willing to collect programmatic data that can be used for monitoring or for purposes of cross-state comparisons.

The set of SCHIP performance measures should anticipate and incorporate future developments in the science and technology of performance measurement. Unless the existing resources are increased, the set of measures should be relatively small, should not be too burdensome or expensive to implement, and should be based on existing systems wherever possible. In addition to this minimum data set, states also should be encouraged to collect more extensive information as described in their state plans.

c. The interdepartmental task force should coordinate its activities with representatives of the technical and analytical infrastructure being developed at state and federal levels to evaluate welfare reform and other recent health insurance legislation.

When DHHS became responsible for SCHIP, it was already in the process of implementing two other major pieces of recent legislation: the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (welfare reform), and the administrative simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA). Due to technical difficulties, competing agency demands within the existing staffing levels, and the need for public involvement and commentary, DHHS missed its statutory deadline for implementing a high-performance bonus program under welfare reform (GAO, 1998a) and is behind schedule in issuing its national data standards for HIPAA.

These challenges in implementing the requirements of welfare reform and HIPAA may be important lessons for SCHIP. The last decade of experience on the implementation and oversight of Medicaid managed care, including the issues associated with state contracting with managed care plans under Medicaid, also may be instructive for SCHIP. The committee encourages DHHS to continue to strengthen its interdepartmental communications, to make the most efficient use of existing resources, and to learn from recent experience in other areas.

d. A new, rapid turnaround survey is needed to track key indicators of SCHIP performance at the state level.

An initial survey should be implemented quickly to provide a baseline for measuring changes in children's insurance coverage, enrollment, and utilization. A more comprehensive survey should be repeated on an ongoing basis to monitor changes in children's health status and well-being after states implement their SCHIP programs.

Children's Health Indicators

3. DHHS must develop systems that improve the availability of national and state-level information on children's insurance coverage, access, utilization, satisfaction, health status, and outcomes, particularly for children with special health care needs.

The major national health surveys, including the National Health Interview Survey (NHIS) and the Medical Expenditure Panel Survey, can provide national and regional data on insurance coverage, utilization, and health status. However, these surveys do not provide state-level data for most states, and the data they do provide are not always current. For example, the last child health supplement to the NHIS was conducted in 1988. Additional resources may be necessary to develop and improve these data collection systems.

a. DHHS should increase the sample size of the NHIS to permit state-level estimates and evaluations. Supplements on child health and well-being should be conducted every 3 years.

b. DHHS should continue to support and encourage efforts to develop and improve indicators of children's health status and outcomes, including indicators for children with special health care needs.

DHHS has undertaken several exemplary activities in quality measurement. These include department-wide collaborative efforts with the National Committee for Quality Assurance; HCFA's testing of outcome measures developed by the Foundation for Accountability and development of the Quality Improvement System for Managed Care; and the Agency for Health Care Policy and Research's support of the Consumer Assessment of Health Plans Survey.

However, most measures being tested are not child-specific, and current children's health and functional status indicators are inadequate, especially for children with special health care needs. For the most part, existing measures lack the sensitivity and specificity needed to track changes in children's health status and treatment outcomes over time. The committee urges the sponsoring and participating organizations to increase their commitment to developing child-specific and age-appropriate measures.

STATE ACCOUNTABILITY FOR SCHIP

Designing Accountability Systems

4. States should begin immediately to design and implement systems to produce meaningful information on SCHIP's effects.

Information should be collected to provide evaluative data on the impact of SCHIP on children's insurance coverage, access, utilization, satisfaction, health status, and outcomes, particularly for children with special health care needs.

To the maximum extent possible, information systems to track SCHIP should be developed at the same time the programs are being designed and implemented. Without coordinated guidance and planning for state-level accountability systems, opportunities may inadvertently be missed. For example, a state with streamlined enrollment forms may choose not to ask about prior insurance status, race/ethnicity, or other information that could be extremely useful to the state later on in determining overall program impact as well as SCHIP penetration with particular subgroups.

Regardless of which state agency takes the lead during the planning process, each state will need to identify the responsible parties and strategies for SCHIP implementation and for technical assistance in developing statewide accountability systems. At a minimum, states will need to specify the agencies and individuals responsible for providing public information about SCHIP; for developing tools and incentives for provider and health plan participation; for evaluating program impact; and for making timely adjustments and modifications to the enrollment process, information and tracking systems, and other administrative components of the program.

Public Information

5. Information on SCHIP should be made available by states to the public and should be meaningful in evaluating the program's performance.

The committee recognizes the technical and procedural difficulties inherent in developing systems that can produce useful, comparable information and that can track developments and changes in performance over time. However, the demand for better information on the delivery and outcomes of health care is increasing among policymakers, providers, and consumers (IOM, 1997; Roper and Cutler, 1998). Many states are already beginning to benchmark the performance of a variety of public programs (National Academy of Public Administration, 1998; Southern Growth Policies Board, 1995), and are disseminating “best practices” models so they can learn from each other's experiences (National Governor's Association, 1998). However, few existing programs that serve children are being systematically evaluated.

SCHIP can stimulate the development of new sources of useful information on the quality and types of care provided to children. Because SCHIP is a public program, information about the program should be made available to the public to hold policymakers accountable and to ensure that the funds are spent appropriately. Information also should be made available to practitioners for quality improvement purposes and to researchers for analysis. A coordinated effort should be made to collect and analyze these SCHIP data nationally to provide an ongoing, comprehensive tracking of efforts to insure children and improve their health.

Data Collection and Performance Reporting

6. As much as possible, states should delegate the collection and synthesis of SCHIP information to contracted health plans or provider groups, with requirements for independent auditing of these data.

States often lack the financial resources, trained administrative and technical staff, and information systems required to monitor the quality of care purchased from managed care organizations (GAO, 1997; Howell, 1996; IOM, 1988; Landon et al., 1998; Zuckerman et al., 1997). In contrast, many managed care organizations are experienced in reporting information on performance to employers, other large-scale purchasers, and accreditation organizations.

Contracts are the basis for defining the business and accountability relationship between purchasers and providers. States vary in the degree to which they specify performance standards in contracts and establish and apply sanctions in contracts for Medicaid managed care providers (Rosenbaum et al., 1997). Recent experience with Medicaid managed care suggests that state-level expertise and technical capacity are necessary components in monitoring the quality and effectiveness of managed care. Similar challenges may arise with SCHIP, particularly in states with less managed care experience.

Therefore, the committee believes that state contracts with health plans or provider groups should clearly specify their responsibilities for analyzing, synthesizing, and reporting SCHIP data to states. Contracts should also specify the measures, format, timeline, and incentives or penalties associated with reporting, as well as requirements for independent audits. Once states have received data and information, they should exercise their oversight responsibilities through technical and analytical procedures to ensure the quality and completeness of the information. Ultimately, states are accountable and responsible for fulfilling their public obligations through analyzing and evaluating the data produced by the participants in publicly supported programs.

Performance Incentives and Rewards

7. States should set conditions of participation in SCHIP, experiment with a variety of incentives to reward health plans for their performance, and develop the technical and analytical capacity to evaluate the impact of incentives on health plan performance.

Performance reporting using standardized measures is critical—necessary although not sufficient alone—to the implementation of systems of accountability. Many private purchasers and purchaser coalitions have seen costs, satisfaction and utilization patterns, or both improve as a result of using performance reporting and related tools and incentives (Hanchak et al., 1996). In contrast, few state agencies now require standardized reporting or link performance to conditions of participation or compensation, and performance-based incentives can be difficult to implement (GAO, 1998a; IOM, 1997).

Performance reporting must be accompanied by one or more of the following reinforcements: (a) dissemination of information on performance to providers, consumers, state agencies, or others who are in a position to influence the reporting entity; (b) the application of conditions of participation (i.e., thresholds of contracting); or (c) the provision of variable compensation (i.e., linking reimbursement to performance). For example, states may choose to provide additional compensation for every child who receives age-appropriate immunizations on a recommended schedule.

States may benefit from developing collaborative relationships with purchaser coalitions to identify and test incentives tied to health plan performance. These partnerships and incentives may help to address inherent problems in SCHIP, such as limitations on the amount that can be spent on information systems and other administrative expenses.

CONCLUSION

SCHIP is historic, innovative, and rapidly evolving. It offers an unprecedented opportunity to move from the traditional monitoring and compliance models of health care, which focus on financial performance, to a quality improvement model that fulfills the intent of the SCHIP legislation: to provide insurance coverage for uninsured children, to improve their access to high-quality health care services, and, ultimately, to improve their health.

REFERENCES

Congressional Budget Office (CBO). 1993. *Using Performance Measures in the Federal Budget Process.* Washington, DC: CBO.
Ciotti V, Zodda F. 1996. Selecting Managed Care Information Systems. *Healthcare Financial Management* June, 35–40.

Employee Benefits Research Institute (EBRI). 1997. Special tabulations from the Bureau of the Census, Current Population Survey, prepared for the Institute of Medicine Committee on Children, Health Insurance, and Access to Care. Washington, DC: EBRI.

Epstein AM. 1997. Medicaid Managed Care and High-Quality: Can We Have Both? *Journal of the American Medical Association* 278 (19):1617–1621.

GAO (U.S. General Accounting Office). 1997. *Medicaid Managed Care Accountability* (Pub. No. GAO/HEHS-97-86). Washington, DC: GAO.

GAO. 1998a. *Medicaid: Early Implications of Welfare Reform for Beneficiaries and States* (Pub. No. GAO/HEHS-98-62). Washington, DC: GAO.

GAO. 1998b. *Welfare Reform: HHS's Progress in Implementing Its Responsibilities* (Pub. No. GAO/HEHS-98-44). Washington, DC: GAO.

Hanchak NA, Schlackman N, Harmon-Weiss S. 1996. U.S. Healthcare's Quality-Based Compensation Model. *Health Care Financing Review* 17(3):143–159.

Howell EM. 1996. Medicaid Managed Care Encounter Data: What, Why, and Where Next? *Health Care Financing Review* 17(4):87–95.

Institute of Medicine (IOM). 1988. *The Future of Public Health.* Washington, DC: National Academy Press.

IOM. 1997. *Managing Managed Care: Quality Improvement in Behavioral Health.* Washington, DC: National Academy Press.

IOM. 1998. *America's Children: Health Insurance and Access to Care.* Washington, DC: National Academy Press.

Landon BE, Tobias C, Epstein AE. 1998. Quality Management by State Medicaid Agencies Converting to Managed Care: Plans and Current Practice. *Journal of the American Medical Association* 279(3):211–216.

Lefton R. 1997. Aligning Incentives Using Risk-Sharing Arrangements. *Healthcare Financial Management.* February, 50–57.

National Academy of Public Administration. 1998. *Alliance for Redesigning Government* [WWW document]. URL http://www.alliance.napawash.org (accessed April 13, 1998).

National Economic Council/Domestic Policy Council. *Implementation of the Children's Health Insurance Program* [WWW Document]. Washington, DC: The White House. URL http://www.hcfa.gov/init/wh-chip5.htm (accessed May 22 1998).

National Governors Association. 1998. *Promising Practices to Improve Results for Young Children* [WWW document]. URL http://www.nga.org/Promising Practices/default.htm (accessed April 28, 1998).

Roper WL, Cutler CM. 1998. Health Plan Accountability and Reporting: Issues and Challenges. *Health Affairs* 17(2):152–155.

Rosenbaum S, Shin P, Smith BM, Wehr E, Borzi PC, et al. KA Johnson, Ed. 1997. *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts.* Washington, DC: The George Washington University Center for Health Policy Research.

Selden TM, Banthin JS, Cohen JW. 1998. Medicaid's Problem Children: Eligible but Not Enrolled. *Health Affairs* 17(3):192–200.

Southern Growth Policies Board. 1995. *Measure by Measure: Benchmarking and Performance Measurement in the South* [WWW document]. URL http://alliance.napawash.org (accessed March 9, 1998).

Ullman F, Bruen B, Holahan J. 1998. *The State Children's Health Insurance Program: A Look at the Numbers. Occasional Paper Number 4.* Washington, DC: Urban Institute.

Weigers ME, Weinick RM, Cohen JW. 1998. *Children's Health, 1996. MEPS Chartbook No. 1.* (AHCPR Pub. No. 98-0008). Rockville, MD: Agency for Health Care Policy and Research.

Zuckerman S, Evans A, Holahan J. 1997. *Questions for States as They Turn to Medicaid Managed Care* [WWW document]. URL http://newfederalism.urban.org/html/anf_all.htm (accessed April 24, 1998).

APPENDIX A

Committee and Staff Biographies

COMMITTEE BIOGRAPHIES

MOLLY JOEL COYE, MD, MPH (*Chair,*) is Senior Vice President and Director of the West Coast Office of The Lewin Group, in San Francisco, California. Previously, she was Executive Vice President for Strategic Development of HealthDesk Corporation in Berkeley, California and Senior Vice President of Clinical Operations for the Good Samaritan Health System in San Jose, California. From 1991 to 1993, Dr. Coye was Director of the California Department of Health Services, where she oversaw Medical's transition to managed care. She has also been the Commissioner of Health in New Jersey and served on the Board of Directors of the Association of State and Territorial Health Officials and the Board of Directors for The Medical Quality Commission, which certifies managed care providers. Currently, Dr. Coye is a member of the Board of Directors of the California Endowment. Her past academic appointments include Head of the Division of Public Health at the Johns Hopkins University of School of Hygiene and Public Health, Professor on the clinical faculty in the Department of Medicine at the University of California at San Francisco and the Department of Community Health at the University of California at Davis, and visiting professor at the School of Public Health at the University of California at Los Angeles. Dr. Coye is a member of the Institute of Medicine (IOM) and has served on several IOM committees.

IRENE AGUILAR, MD, is a primary care physician at the Westside Family Health Center in Denver Colorado, and an assistant professor at the University of Colorado Health Sciences Center. Dr. Aguilar is a member and Secretary of the Colorado Board of Medical Examiners and has served on the Health Benefits Advisory Board of the Colorado Division of Insurance. She is also the parent of three children, one of whom has special health care needs.

BRIAN K. ATCHINSON, JD, is currently Second Vice President for government relations, for UNUM in Portland, Maine. He was Superintendent of Insurance for the State of Maine from June 1992 through August 1997. Previously, he was Legal Counsel for the Maine Department of Professional and Financial Regulation. Mr. Atchinson also served as a member of the Governor's Cabinet Council on Health Care Policy. He is a former president of the National Association of Insurance Commissioners.

STEPHEN M. BOROWITZ, MD, is Associate Professor of Pediatrics and Health Evaluation Sciences at the University of Virginia. Dr. Borowitz has a special interest in the use of technology to increase access to care and improve exchange of information. Currently, he is developing a computer-based medical record for pediatric patients, a comprehensive on-line children's immunization database, and a regional medical information system based on the Internet to provide practitioners and consumers with information and electronic consultations. Dr. Borowitz is a Fellow of the American Academy of Pediatrics.

RICHARD BUCCIARELLI, MD, is a professor at the Institute for Child Health Policy and Associate Chair, Department of Pediatrics, at the University of Florida College of Medicine. Dr. Bucciarelli is a former Robert Wood Johnson Health Policy Fellow and has expertise in neonatology and pediatric cardiology. He is currently a Fellow of the American Academy of Pediatrics and the American College of Cardiology.

PETER BUDETTI, MD, JD, is a professor of Law, Preventive Medicine, and Health Services Management and Founder and Director of the Institute for Health Services Research and Policy Studies at Northwestern University. Dr. Budetti founded the Center for Health Policy Research at George Washington University in 1990 and served as its director until 1996. From 1984 to 1990, he served as counsel to the Subcommittee on Health and the Environment in the U.S. House of Representatives. Dr. Budetti is a former associate professor of Social Medicine in Pediatrics and at the Institute for Health Policy Studies, University of California at San Francisco.

THOMAS W. CHAPMAN, MPH, is Senior Associate Vice President for Network Development and Professor, Health Services, Management and Policy at the George Washington University Medical Center. Mr. Chapman is former President of Greater Southeast Healthcare System and has a particular interest in urban health initiatives, community outreach, and community-based medicine. He has received several awards for community service, leadership, and innovation.

MARGARET HEAGARTY, MD, is Director of Pediatrics at Harlem Hospital Center and Professor of Pediatrics in the College of Physicians and Surgeons of Columbia University. Dr. Heagarty is a Fellow of the American Academy of Pediatric, past president of the Ambulatory Pediatric Association, and a former member of the Board of Trustees of the New York Academy of Medicine. She is a member of the IOM and a former member of the IOM Council and has participated on several committees, including the Steering Group of the National Forum on the Future of Children and Their Families, the Committee to Study Outreach for Prenatal Care, and the Committee for the Study of U.S. Health Goals for the Year 2000.

ROBERT HELMS, PhD, is a Resident Scholar and director of health policy studies at the American Enterprise Institute in Washington, D.C. Dr. Helms currently participates in the Consensus Group, an informal task force that is developing market-oriented health reform concepts. An economist, he served as Assistant Secretary for Planning and Evaluation and Deputy Assistant Secretary for Health Policy in the U.S. Department of Health and Hu man Services from 1981 to 1989. He also served on the IOM Committee on Implementation of a Graduate Medical Education Trust Fund in 1997.

VELVET MILLER, PhD, is Deputy Commissioner of the New Jersey Department of Human Services. She is responsible for policy, program, and fiscal oversight of the state's Medicaid and welfare programs, including the state's children's health program, KidCare. Her previous positions include Assistant Commissioner, Bureau of Public Health and Hospitals, and Associate Commissioner, Division of Health Systems Management in the Commonwealth of Massachusetts, and Assistant Commissioner for the Division of Medical Assistance in New York State. Dr. Miller is a member of the board of Families, USA, and has published on ethnic health issues and health care conflict resolution.

ARNOLD MILSTEIN, MD, directs the national clinical consulting practice at William M. Mercer, Inc. and is Medical Director of the Pacific Business Group on Health, located in San Francisco. His work focuses on evaluating and strengthening managed care programs for providers, large purchasers, insurers, and government. Dr. Milstein is board certified by the American Board of Psychiatry and Neurology and the American Board of Utilization Review and Quality Assurance. He held several positions in the Health Care Financing Administration from 1977 to 1994 and was a member of the IOM Committee on Utilization Management from 1988 to 1990.

PAUL NEWACHECK, DrPH, is a professor of Health Policy at the Institute for Health Policy Studies and a professor in the Department of Pediatrics at the University of California at San Francisco. He is also Codirector of the Maternal and Child Health Policy Research Center, which is based in Washington, D.C., and San Francisco. Dr. Newacheck conducts health services research in the areas of utilization and access, Medicaid, and chronic illness in children. He has published widely on the role of insurance as a determinant of access to and use of health services by children. Dr. Newacheck is a member of the Board on Children, Youth, and Families of the National Research Council and Institute of Medicine. He is also a member of the National Committee on Vital and Health Statistics.

DAVID S. WEINER, MPH, is President and Chief Executive Officer of Children's Hospital in Boston, where he has held several positions since 1967. Mr. Weiner is a lecturer at the Department of Social Medicine and Health Policy at Harvard Medical School and has received awards from the Massachusetts Health Council and the NAACP Legal Defense Fund. He is a Fellow of the American College of Healthcare Executives and a former trustee and chair of the National Association of Children's Hospitals and Related Institutions (NACHRI).

STEVEN H. WOOLF, MD, MPH, is a family physician with the Fairfax Family Practice Center and professor of Family Medicine at the Medical College of Virginia—Virginia Commonwealth University. From 1987 to 1995, Dr. Woolf served as Science Advisor to the U.S. Preventive Services Task Force in the U.S. Department of Health and Human Services. He provides independent consulting to government agencies and specialty societies regarding practice guideline development and is an associate editor of the *American Journal of Preventive Medicine.*

STAFF BIOGRAPHIES

MARGARET EDMUNDS, PhD, Study Director and Senior Program Officer, joined the Institute of Medicine in October 1995 to direct a study of quality assurance in managed behavioral health care. From 1992 to 1995, she directed a multisite clinical evaluation of integrated delivery systems at the Institute for Health Policy Studies, University of California at San Francisco. Previously, she directed studies relating to national standards for information technology and day care. Dr. Edmunds was a member of the affiliate staff of the Johns Hopkins Hospital from 1986 to 1992 and was a member of the faculty at the Johns Hopkins Medical School from 1989 to 1992. She was a research and clinical fellow at the Johns Hopkins School of Medicine from 1986 to 1989 and a postdoctoral fellow at the Johns Hopkins School of Public Health from 1985 to 1986. Dr. Edmunds received her doctoral degree in Human Development from Pennsylvania State University. She is a member of the Board of Directors and a Fellow of the Society of Behavioral Medicine.

KATHLEEN NOLAN, Research Assistant, came to the Institute of Medicine in 1996. She has worked with the National Roundtable on Health Care Quality, on a study on implementing a national graduate medical education trust fund, and on a study on non-heart-beating organ donors. Previously, she worked on regulations and legislation in the Colorado Department of Public Health and Environment. She is enrolled in the Master's of Public Health program at the George Washington University and received her bachelor's degree in psychology from Carleton College in Minnesota.

TRACY McKAY, Project Assistant, joined the Institute's Division of Health Care Services in January 1997. She also serves as project assistant for the National Roundtable on Health Care Quality. Ms. McKay received her Bachelor of Arts degree in sociology from Vassar College.

APPENDIX B

Members of the Liaison Panel

National Organizations and Associations	**Contact Person**
American Academy of Family Physicians	Robert Graham
American Academy of Pediatrics	Steve Edwards Samuel S. Flint Graham Newson Jacqueline Noyes
American Association of Health Plans	Ellen Bayer
American College of Nurse Midwives	Trish Woollcott
American College of Obstetricians and Gynecologists	Ralph W. Hale
American College of Preventive Medicine	Hazel Keimowitz
American Hospital Association	James Bentley Bonnie Connors Jellen
American Public Health Association	Mohammad Akhter
American Public Welfare Association	A. Sidney Johnson
Association for Health Services Research	Michael Stafford
Association for the Care of Children's Health	Heather Bennett McCave
Association of Asian-Pacific Islander Community Health Organizations	Stephen Jiang

Association of Maternal and Child Health Programs	Amy Fine Catherine A. Hess
Association of State and Territorial Health Officials	Cheryl A. Beversdorf
Association of Women's Health, Obstetric, and Neonatal Nurses	Joy Grohar
Children's Defense Fund	Stan Dorn
Families USA	Geraldine Dallek
Federation of Families for Children's Mental Health	Barbara Huff
National Association of Children's Hospitals and Related Institutions	Shirley Girouard Lawrence A. McAndrews
National Association of City and County Health Officials	Donna Grossman
National Association of Community Health Centers	Dan Hawkins
National Association of Health Data Organizations	Mark Epstein
National Association of Insurance Commissioners	Elizabeth Hadley
National Association of Psychiatric Treatment Centers for Children	Joy Midman
National Association of Public Hospitals	Dennis Andrulis
National Coalition of Hispanic Health and Human Services Organizations	Jane L. Delgado
National Conference of State Legislatures	Shelly Gehshan William T. Pound Marjorie Shofer
National Governors Association	Joan Henneberry Raymond C. Scheppach
National Health Lawyers Association	Marilou M. King
National Medical Association	Yvonne Fuller
National Perinatal Association	Gail J.H. Wilson
Society of Pediatric Nurses	Sheila Q. Rucki

Foundations and Charitable Organizations

Annie E. Casey Foundation	Patrick Chaulk
Caring Program for Children/BlueCHIP of Pennsylvania	Charles P. LaVallee
The Children's Health Fund	Dennis Johnson Irwin Redlener
Kaiser Commission on the Future of Medicaid	Diane Rowland Patricia Seliger
March of Dimes Birth Defects Foundation	Marina Weiss
Robert Wood Johnson Foundation	Robert Hughes Judith Whang
Women's Health Foundation	Teri G. Fontenot

Policy Research Organizations

Alliance for Health Reform	Ed Howard
Alpha Center	Ann Gauthier
Brookings Institution	Robert Reischauer
Center for Health Policy Research, George Washington University Medical Center	Kay A. Johnson Sara Rosenbaum
Center for Studying Health System Change	Cara Lesser
Center on Budget and Policy Priorities	Wendell Primus
Children Now	Mike Bergmyer Lois Salisbury Maryann O'Sullivan
CityMatch, University of Nebraska	Magda Peck
Employee Benefits Research Institute	Paul Fronstin
The Heritage Foundation	Carrie Gavora
Hudson Institute	William Styring
Making the Grade	Jane Koppelman

National Academy for State Health Policy	Jane Horvath
National Academy of Social Insurance	Jill Bernstein Pamela Larson
National Center for Education in Maternal and Child Health	Gail Perry
National Center for Policy Analysis	John Goodman
National Health Policy Forum	Judy Miller Jones
National Institute for Healthcare Management	Ed Neuschler
National Perinatal Information Center	David Gagnon
Urban Institute	C. Eugene Steuerle
Health Care Industry Groups	
American Association of Health Plans	Liza Greenberg
Blue Cross-Blue Shield Association	Kris Haltmeyer
Foley & Lardner	Ann Langley
Gibbons and Company	Sam Gibbons
Greenspring Advisors, Inc.	Carl J. Schramm
Health Care Leadership Council	Kathleen Means
Health Futures Group	Diane Albrecht
Hewitt Associates L.L.C., Washington, D.C., Research Office	Frank B. McArdle
Human Affairs International	David Nace
The McGeein Group	The Hon. Marty McGeein
National Account Consortium, Inc.	Alex Rodriguez
Pfizer Inc., Corporate Strategies	Alison Keith

Washington Business Group on Health	Constance Dellmuth Mary Jane England Kim Monk
Academic Health Centers	
Columbia University School of Nursing	Judy Honig
Georgetown University, Child Development Center	Sybil Goldman
Georgetown University, Institute for Health Care, Public Policy and Research	Judith Feder
Georgia State University Department of Risk Management and Insurance	William Custer
Harvard School of Medicine, Department of Pediatrics	Judith Palfrey James Perrin
Harvard School of Public Health, Department of Maternal and Child Health	Marie C. McCormick Mary Parke
Johns Hopkins School of Hygiene and Public Health, Department of Maternal and Child Health	Bernard Guyer
Johns Hopkins School of Medicine, Department of Pediatrics	Julius Goepp
Northeastern University School of Business	Charles Baker, Sr.
Stanford University	Annika Olsen
UCONN Health Center, University of Connecticut	Jonelle C. Rowe
University of California at Los Angeles, National Center for Infancy and Early Childhood Health Policy	Miles Hochstein
University of California at Los Angeles, School of Public Health	Janet Currie
University of California at San Francisco, Department of Pediatrics	Elena Fuentes-Afflick
University of North Texas-Health Sciences Center	Fernando Trevino
University of Pittsburgh Schools of Medicine and Public Health	Kelly Kelleher
University of Rochester School of Medicine	Charles Phelps

University of Washington School of Medicine	Gina Sucato
Wake Forest University School of Law and Bowman Gray School of Medicine	Mark A. Hall
Health Care Providers	
Boston Children's Hospital	Laura Camisa
California Children's Services	Diana Obrinsky
California Pacific Medical Center	George F. Lee
Center for the Vulnerable Child, Children's Hospital Oakland	Laurie Soman
The Children's Hospital of Alabama	Crayton A. Fargason
Children's Hospital of New Mexico-University of New Mexico Hospital	Robert T. Maruca
Church Health Center	G. Scott Morris
Columbia Hospital for Women	Amy R. Niles
Corporate and Community Services, Office of Community Health, Johns Hopkins Hospital	Adrian Mosley
CURE	Melvin B. Tuggle II
DMC/Hutzel Hospital	Susan A. Erickson
Howard University Hospital	Sherman P. McCoy
Jeannette District Memorial Hospital	Maureen Ceidro
Kaiser Permanente	Jane Andrews
Magee-Womens Hospital	Irma E. Goertzen
Mary's Center for Maternal and Child Care	Maria Socorro Gomez
Memorial Hospital Southwest	Vicki A. Lukas
Merit Health Care System	Joan Justesen
Northside Hospital	Janis Dubow

Phoenix Children's Hospital	Leland Clabots
Presbyterian Intercommunity Hospital	Margo J. Kaatz
Saint Barnabas Health Care System	Mark D. Pilla
Saint Luke's Hospitals of Kansas City	Ann L. Ropp
Shriners' Hospital for Children	David Wood
Sibley Memorial Hospital	Dietra L. Ford
Sixteenth Street Community Health Centers	John Bartkowski
University of Kansas Community Health Center	Martin Gerry
The University of Rochester/Strong Memorial Hospital	James Woods
U.S. Government Agencies	
U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation	Cheryl Austein-Casnoff Gary Claxton Margaret Hamburg
Agency for Health Care Policy and Research	Denise Dougherty Wendy Parker
Center for Mental Health Services, Substance Abuse and Mental Health Services Administration	Judith Katz-Leavy
Health Care Financing Administration	Debbie Chang Richard Strauss
Maternal and Child Health Bureau, Health Resources and Services Administration	Woodie Kessel
U.S. Department of Treasury	James E. Duggan Jonathan Gruber
U.S. General Accounting Office	Sheila Avruch Sally Jaggar
U.S. Congress	
House Democratic Policy Committee	Melissa Narinf
Office of Congressman Pete Stark	Bill Vaughn

Office of Representative Kay Granger	Stephen Garrison
Office of Senator Edward Kennedy/Senate Labor Committee	Susan Hammersten Arthur Safran Barbara Skydell
Office of Senator James Jeffords/Senate Labor Committee	Karen Guice Patricia Stroup
Office of Senator Tom Daschle	Burton Edelstein
Senate Finance Committee	Faye Drummond
State and Local Government	
California Department of Health Services	Robert Isman
California State Senate Insurance Committee	Richard Figueroa
Florida Agency for Health Care Administration	Martin Markovich
Jackson County Health Department	Ross Marine
Massachusetts Department of Public Health	Deborah Kline Walker
Massachusetts Division of Medical Assistance	Annette Hanson
Massachusetts State Legislature	John McDonough
Philadelphia Health Department	Susan Lieberman
Virginia Department of Medical Assistance	William J. Lessard, Jr.
Parents	
Barbara Lamb	San Mateo, CA
Karen LaPlante	Dublin, VA