EMBASSY OF THE
UNITED STATES OF AMERICA
PRAGUE

OFFICE OF THE AMBASSADOR

December 31 1997

Melanne Verveer
Deputy Assistant to the President and
Deputy Chief of Staff to the First Lady
Fax: (202) 456 6244

Dear Melanne:

Dr. Zuzana Roithova, the Director of the hospital and orphanage Mrs. Clinton visited in July of 1996, has just been named Minister of Health in the new Czech Government. If Mrs. Clinton thinks it appropriate, Dr. Roithova would be thrilled to have a note of congratulations. I don't know when she'll move from the hospital into the ministry but I expect in the next few days (people become officially ministers as soon as they are named here, even 'tho the new govt has 30 days to win Parliamentary approval). I could forward a faxed note whenever it arrived to wherever she happened to be by then. My direct fax is: (42 02) 5732 0583.

I had just sent you, by snail-mail, a photo sent me by a couple who've adopted one of the children Mrs. Clinton met -- of Mrs. C. with their new son; they hope she'll autograph it. Hope this doesn't overload the circuits!

Best to you and Mrs. Clinton -- and, as I said in the letter with the photo, you should try to make a private trip to Prague, just for play, while I'm still here.

Sincerely,

Jenonne Walker
Ambassador

THE WHITE HOUSE
WASHINGTON

VINOHRADY Hospital

Dr Zuzana Roithova
Prague, Czech Republic

Dear Dr Roithova:

I have ~~just~~ learned ~~that~~ from U.S. Ambassador, Jeronne Walker, that you have just been named Minister of Health. I want to extend my congratulations to you ~~on your being named~~ as you assume

THE WHITE HOUSE
WASHINGTON

this important position in your country. I will always remember my visit to the hospital + orphanage and the interesting discussion we had about ~~the challenges~~ the delivery of health care services.

Best wishes to you as you embark on your new

THE WHITE HOUSE
WASHINGTON

Challenger and a
very happy new year.

THE WHITE HOUSE
WASHINGTON

January 9, 1998

Ms. Mary Regula
National First Ladies' Library
Saxton McKinley House
331 Market Avenue South
Canton, OH 44702

Dear Mary:

On behalf of the First Lady, thank you very much for your letter and invitation to the National First Ladies' Library's press conference and luncheon at the Renwick Gallery on January 27.

Regrettably the First Lady will be not be able to accept your kind invitation due to a scheduling conflict, but sends her best wishes for a successful event. We look forward to seeing you next month.

Thanks and best wishes. Happy New Year!

Sincerely,

Melanne Verveer
Chief of Staff to
the First Lady

NATIONAL FIRST LADIES' LIBRARY

December 19, 1997

Mrs. Hillary Rodham Clinton
First Lady of the United States
ATTN: Melanne Verveer
Old Executive Office Building, Rm. 100
Washington, DC 20503

Dear Mrs. Clinton :

As 1997 draws to a close, we are pleased to report that this year has been one of successful development and growth for the National First Ladies' Library. All of the latest news will be detailed in the Library's first issue of *News from the National First Ladies' Library*, which you will be receiving this week.

However, we would like to highlight an important event that is being planned for January 27, 1998. On this day the National First Ladies' Library will hold an announcement press conference and luncheon at the Renwick Gallery in Washington, DC to launch the Library at the national level. We are grateful to Elizabeth Broun, one of our board members and director of the National Museum of American Art and its Renwick Gallery, for cosponsoring the event in this historic Second Empire-style building across the street from the White House.

We are expecting board members, National Advisory Board members, Congressional spouses, Cabinet spouses, presidential descendants, corporate sponsors of the Library and others who are interested in becoming involved with the Library in the future. A formal invitation will follow this letter after the first of the year, but in the meantime we would like to invite you to:

- **mark your calendar for Tuesday, January 27, 1998 at 12:00 noon, and**

- **make plans to join us at the Renwick Gallery in Washington, DC as our guest for this historic event.**

You will be receiving more information about this event as the details are finalized. We hope you have a joyous holiday season, and we will be in touch soon.

Sincerely,

Mary A. Regula
Founding Chair and President

Debbie Dingell
President, General Motors Foundation

Ray N. Ivey
Vice President, CNG Foundation

Saxton McKinley House, 331 Market Avenue South, Canton, Ohio 44702-2107

National Board of Directors

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The Center for Political and Stragegic Studies
Mrs. Jane Gephardt
Mrs. Marianne Gingrich
Mrs. Annie Glenn
The Honorable Mark Hatfield
Dr. Bernadine Healy
Ohio State University

Ms. Wilhelmina Cole Holladay
National Museum for Women in the Arts
Mrs. Priscilla Houghton
Ms. Sandra Hull
Main Street Wooster, Inc.
Mr. Roger Kennedy
Former Director, National Park Service
Mrs. Coretta Scott King
The Martin Luther King Center
Ms. Rachel Longaberger
The Longaberger Company
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Mrs. Abigail McCarthy
Dr. John J. McGrath
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Mrs. Donna McLarty
Ms. Ann McLaughlin
The Aspen Institute
Ms. Martha Regula
Library of the Western Reserve Academy
Mrs. Nancy Suarez
Suarez Industries
Mr. Jack Valenti
National Motion Picture Association of America
Mrs. Janet Voinovich
First Lady of Ohio
Dr. Eddyth N. Worley
Education Advisor

THE WHITE HOUSE
WASHINGTON

January 23, 1998

Ms. Carolyn Robbins, Ph.D
Carolyn Robbins Jury Simulations, Inc.
18181 N.E. 31st Court
Suite #207
N. Miami Beach, FL 33160

Dear Ms. Robbins:

Thank you very much for your letter and interest in meeting with the First Lady about your work as a jury consultant.

Regrettably, the First Lady is not available to meet with you at this time. Thank you for your support.

Best wishes.

Sincerely,

Melanne Verveer
Chief of Staff to
the First Lady

CAROLYN ROBBINS JURY SIMULATIONS, INC.

Nationwide Jury Research Services

January 12, 1998

Kim Widdess
1600 Pennsylvania Avenue
Washington, D.C. 20500

Dear Ms. Widdess:

I am writing to you and sending some information about my area of expertise as a follow up to my conversation with Mrs. Clinton. I met with Mrs. Clinton in the fall at the Women's Leadership Forum for the Democratic National Party at the Sheraton in Bal Harbour, Florida. We discussed my work as a jury consultant, and she told me that she would like to discuss my work in further detail at a later time.

Per Mrs. Clinton's request, I gave my business card to an assistant, and that assistant told me to get in touch with you. Please call me when you receive this so that we may set up an appointment with myself and Mrs. Clinton.

Very truly yours,

Carolyn Robbins, Ph.D.
Carolyn Robbins Jury Simulations, Inc.

CR/za enclosure

18181 N.E. 31st Court ◆ Suite #207 ◆ N. Miami Beach, FL 33160 ◆ 1 (800) 880-JURY

Clinton Presidential Records
Digital Records Marker

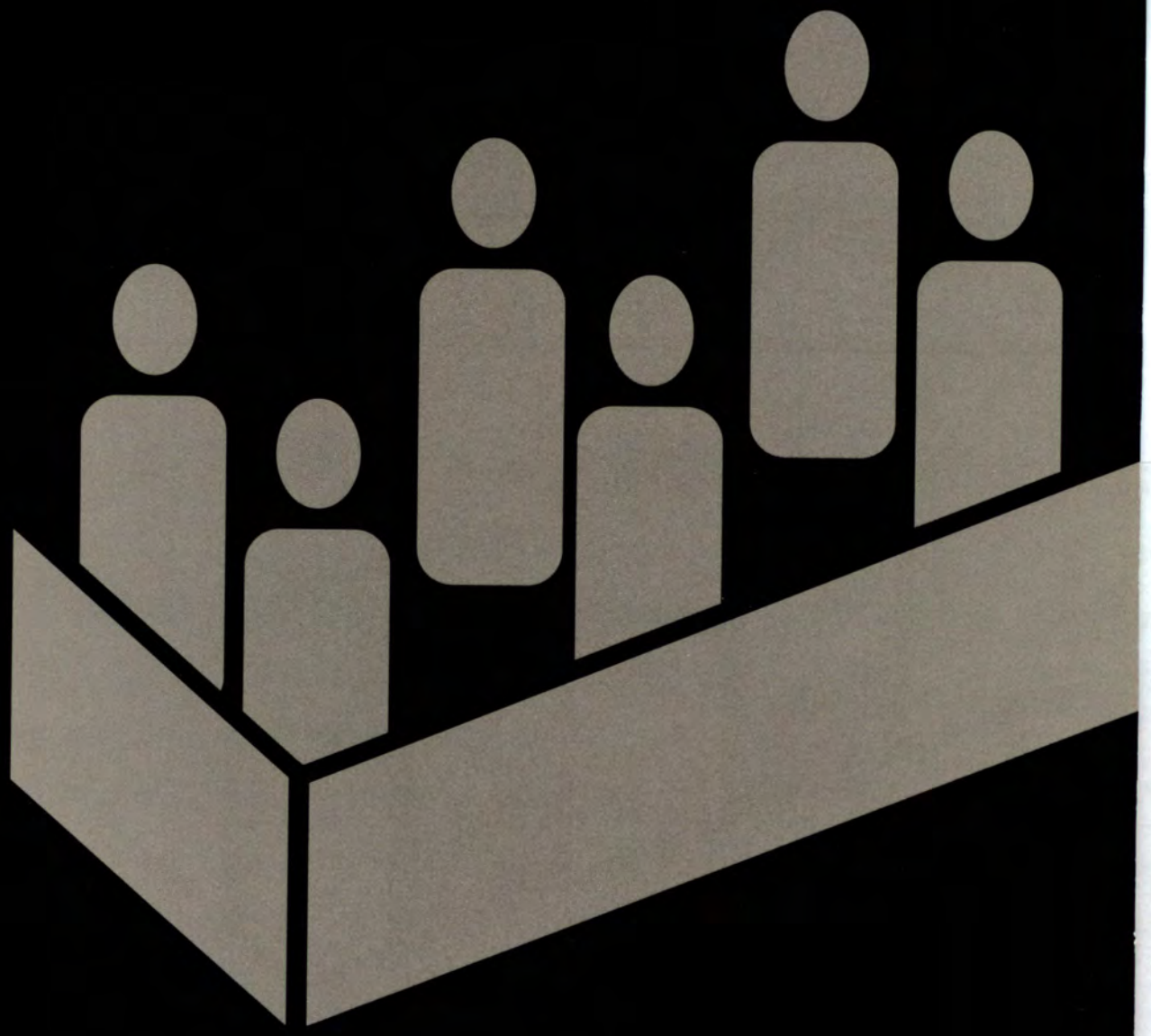
This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a publication.

Publications have not been scanned in their entirety for the purpose of digitization. To see the full publication please search online or visit the Clinton Presidential Library's Research Room.

CAROLYN ROBBINS

JURY SIMULATIONS, INC.



Nationwide Jury Research Services

CAROLYN ROBBINS
JURY SIMULATIONS, INC.

Our consultants have appeared on CNN, CNBC, CBS, NBC and FOX, and have lectured around the country on the topic of trial consulting and jury behavior.

CAROLYN ROBBINS
JURY SIMULATIONS INC.
Nationwide Jury Research Services
(800) 880-JURY

CAROLYN ROBBINS, Ph.D.
Chief Consultant

CAROLYN ROBBINS
JURY SIMULATIONS, INC.

Nationwide Jury Research Services

Phone: 305-932-9332 or 800-880-JURY
Fax: 305-932-4362 E-Mail: CAROLYN@CRJURY.COM
18181 N.E. 31st Ct. #207, N. Miami, FL 33160
Website: "http://www.CRJURY.COM"

MOCK TRIALS

CAROLYN ROBBINS
JURY SIMULATIONS, INC.

Phone: 800-880-5879
Fax: 305-932-4362
18181 N.E. 31st Court - #207
N. Miami Beach, FL 33160

Carolyn G. Robbins, Ph.D.

EDUCATION

9/87-6/94 **Nova University**, Ft.Lauderdale, FL: Ph.D in Clinical Psychology
9/87-5/89 **Nova University**, Ft.Lauderdale, FL: Masters of Science in Clinical Psychology
9/83-6/87 **Tufts University**, Medford, MA: Bachelor of Arts in Psychology (Cum Laude)

WORK EXPERIENCE

12/88 to Present **Carolyn Robbins Jury Simulations, Inc.**, Miami, FL
* Chief Consultant - Coordinator and facilitator of jury simulations and focus groups
* Analysis of group dynamics and decision-making processes to aid attorneys in the preparation and presentation of jury trials

1/88-4/88 **Trial Consultants**, Miami, FL
* Assisted in the organization and analysis of jury focus groups and simulations

9/86-5/87 **Decision Research, Inc.**, Lexington, MA
* Organization and analysis of market research surveys and focus groups
* Organization and analysis of jury focus groups * Research assistant

NETWORK CONSULTING

Has appeared numerous times on "Larry King," "Tom Snyder," CBS, NBC & FOX regarding jury behavior and trial consulting.

WORKSHOPS AND SEMINARS

6/95 **Faculty: Northwestern School of Law at Lewis & Clark College**
Topic: Voir Dire and Damages

6/94 **Faculty: University of Colorado/ATLA Specialized College**
Topic: Voir Dire

3/94 **Faculty: University of Miami Law School/ATLA Civil Litigation Seminar**
Topic: Mock Trials and Voir Dire

3/93 **Speaker at Harvard University Law School/ATLA Ultimate Advocacy Course**
Topic: Writing Understandable Jury Instructions

3/92 **Speaker at the Florida Bar Association**
Topic: Jury Psychology

3/92 **Speaker at the Ohio Academy of Trial Lawyers**
Topic: Jury Psychology and Focus Groups

9/91 **Speaker at the Dade County Trial Lawyers Association**
Topic: The Psychology of the Law and the Jury

9/90 **Speaker at the Broward County Trial Lawyers Association**
Topic: The Psychology of Jury Selection and Voir Dire

PROFESSIONAL ORGANIZATIONS

American Psychological Association, Florida Psychological Assoc., Dade County Psychological Assoc.

PUBLICATIONS

*Robbins, Carolyn (1992). "Using consultants for jury simulations and jury selection during trial preparation." Business Litigation: Annual Update, Ethics, and Strategic Uses of Trial Technology-Beyond the Yellow Pad. Florida: The Florida Bar.

*Robbins, Carolyn (1993). "Improving Jurors' Understanding of Instructions." Ultimate Trial Advocacy: Art of Persuasion. Association of Trial Lawyers of America: 1993.

*Robbins, Carolyn (1994). "Effects of rewriting the verdict form in laymen's terms on jury verdicts." Dissertation, Nova University.

Since 1988, CRJSI's *clients have included:*

Aetna Insurance
Alamo
Allstate Insurance
Amsted Industries
Amtrak
Bell South
Brunswick
Ciba Geigy
Conrail
CSX
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H&R Block
The Hartford Insurance
Honda
Interstate Insurance
Johnson & Johnson
Kemper Insurance
Kraft Foods
Lloyds of London
Matsushita
Merrill Lynch
Northbrook Insurance
Pfizer
Prudential
Reliance National Insurance
Rollins/Orkin
Ryder Systems
Sierra Club Legal Defense Fund
St. Pauls
Texaco
The Travelers
Union Carbide
University of Miami/Jackson Memorial
Value Rent-A-Car
Wausau Insurance

TheTravelers

Mark J. Welzenbach
Director
P-C Claim Department

The Travelers Companies
One Tower Square
Hartford, CT 06183

July 19, 1993

Ms. Carolyn Robbins
Jury Simulations, Inc.
4132 N. Clarendon, #3-S
Chicago, IL 60613

Dear Carolyn:

I just wanted to drop you a note and thank you for your very professional assistance with the jury simulation of the Smith case. We were all very impressed with how well orchestrated the procedure was and with the thoroughness of your preparation.

Substantively, the procedure gave us substantial assistance both in identifying those portions of our defense which will be the most effective at trial and with identifying problem areas and assessing the risks associated with trying the case. I know from discussions with defense counsel that they found the procedure to be invaluable in assisting with trial preparation.

From my own standpoint, I can no longer imagine taking a substantial case to trial without first presenting it to a simulated jury. In fact, it now occurs to me that to do so would be akin to taking a major examination without studying for it in advance.

Again, thank you for your help. I look forward to working further with you in the future.

Very truly yours,

Mark J. Welzenbach

MJW/aln

11

LAW OFFICES

COOPER, MITCH, CRAWFORD, KUYKENDALL & WHATLEY

JEROME A. COOPER
WILLIAM E. MITCH
THOMAS N. CRAWFORD, JR.
FREDERICK T. KUYKENDALL, III
JOE R. WHATLEY, JR.
JOHN D. SAXON
GLEN MARSHALL CONNOR
PATRICIA GUTHRIE FRALEY
JAY SMITH
MICHAEL K.K. CHOY*
CANDIS A. McGOWAN
ANDREW C. ALLEN*
WILLIAM Z. CULLEN
SAMUEL H. HELDMAN

*ALSO ADMITTED IN GEORGIA
*ALSO ADMITTED IN MISSISSIPPI

505 20TH STREET NORTH
1100 FINANCIAL CENTER
BIRMINGHAM, ALABAMA 35203-2605

(205) 328-9576
FAX (205) 328-9669

March 4, 1994

Carolyn Robbins, M.S.
Jury Simulations, Inc.
4132 North Clarendon
Suite #3S
Chicago, IL 60613

Dear Carolyn:

I have enclosed our check in the amount of for the remainder of our amount due under our contract.

the jury returned a verdict for approximately 3½ million dollars, which is, so far as we can determine, the largest wrongful death verdict ever in the State of Louisiana.

Yours truly,

Joe R. Whatley, Jr.

JRWjr:mae
Enclosure

WEIL, GOTSHAL & MANGES
A PARTNERSHIP INCLUDING PROFESSIONAL CORPORATIONS

767 FIFTH AVENUE
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FAX: (212) 310-8007
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ITT 423144

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TELEX: ITT 440045

700 LOUISIANA
SUITE 1600
HOUSTON, TEXAS 77002
(713) 546-5000
FAX: (713) 224-9511
TELEX: ITT 4620144

50 STRATTON STREET
LONDON W1X 5FL
4471-495-3131
FAX: 4471-629-7900

October 14, 1991

Ms. Carolyn Robbins, Inc.
1800 Northeast 114th Street
Suite 601
North Miami, Florida 33181

Dear Carolyn:

On behalf of Bruce Berman and myself, I would like to commend you for the outstanding job you did conducting our mock jury focus groups. Although our case involved numerous parties, a multitude of claims, and technical issues that appeared to be beyond the grasp of most jurors, you were able to help us develop themes that normal people could comprehend. Through the use of your service, we were able to see more clearly the strengths and weaknesses of our case. Your ability to interact with the jurors and draw out their thoughts and opinions was most insightful, and your psychological training and analysis of the jury's behavior aided us tremendously during our preparation for trial and jury selection. Furthermore, our presentations became more persuasive as a result of your improvements to our demonstrative aids.

Your extremely professional demeanor made it a pleasure to work with you. I look forward to working together in more focus groups and mock trials in the near future.

Sincerely,

Jamie A. Cole

JAC/lmc

MI...:\LI\80\99980\0001\95\LTR09171.280

Johnson & Johnson
MEDICAL INC.

September 22, 1995

Carolyn Robbins, Ph.D.
Carolyn Robbins Jury Simulations, Inc.
18181 N. E. 31st. Ct. # 207
N. Miami Beach, FL 33160

Dear Carolyn:

It was a great pleasure for me to actively participate in your jury research work sessions with our Johnson & Johnson Corporate in-house and outside legal counsel. You facilitated and directed our team in an extraordinary way in which the diversity of talent and experience of the individual team members were tapped to their fullest level of contribution.

What impressed me the most was your insightful process to obtain the quick actionable results from the high energy sessions which allowed our team to test theories and exhibits in order to translate your jury research into meaningful, targeted tactical plans. In our litigation strategy and tactical management of the complex issues, this was of key importance in clearly communicating our themes in an proven effective manner. I certainly will remember your honest and accurate assessements of our team's thought processes. As you are aware, this was confirmed throughout jury research, mediation, and judge magistrate updates.

The videoed jury simulations enhanced our ability to focus, analyze, and produce creative solutions. Your efforts were certainly significant to the successful resolution of our product liability cases.

I also want to express my thanks for your active participation during our work session toward developing the liability process management preventive model of the future to reduce our product liability risks.

Sincerely,

Robert S. Dicheck

Robert S. Dicheck
Vice President - Quality Systems

WAUSAU

CAROLYN ROBBINS
JURY SIMULATIONS INC
18181 NE 31ST CT # 207
NORTH MIAMI BEACH FL 33160

September 26, 1995

Steven Bowen - Magnetec

Ms. Robbins, regarding the above captioned product liability claim wherein Attorney Bruce Simberg and Attorney John Lurvey were successful in securing a Defense verdict, your services and expertise in a mock trial provided to us was beneficial in the outcome of this case.

This mock trial gave our attorneys and myself the opportunity to find our strong and weak points within this very interesting product liability case. It also helped our attorneys to determine what type of jury was needed to secure the winning result. This claim had the potential of a large verdict value.

You and your staff presented the simulation of the trial in a professional manner, and I would recommend your services in future cases which have large verdict potential.

Thank you for your assistance.

Denise Rather

Denise Rather
Senior Claim Adjuster
ljw

WAUSAU INSURANCE COMPANIES
POST OFFICE BOX 820698
SOUTH FLORIDA, FLORIDA 33082-0698
TELEPHONE (305) 436-1471

KEY STAFF BIOGRAPHIES

Carolyn G. Robbins, Ph.D.
President and Senior Litigation Consultant
Dr. Robbins began her career at Decision Research in Boston, Massachusetts assisting with the organization and analysis of both legal and marketing oriented focus groups. In 1987, she joined Trial Consultants in Miami, Florida as an associate litigation consultant working exclusively on jury simulations and focus groups. In 1988, Dr. Robbins formed her own litigation research company, Carolyn Robbins Jury Simulations, Inc. Since that time, Dr. Robbins has assisted lawyers in preparing for a variety of cases including: medical malpractice, copyright and patent law, product liability, real estate law, securities litigation, wrongful death, contracts, business torts, eminent domain, sexual harassment, criminal law, and environmental law. She has appeared on CNN's Larry King Live and CNBC's Tom Snyder Show to deliver opinions on prominent jury trials and the jury system. Dr. Robbins obtained her B.A. in Psychology from Tufts University, graduating with honors, and holds a Ph.D. in Clinical Psychology from Nova University in Ft. Lauderdale, Florida.

Jodi Aronson, Ph.D.
Litigation Consultant
Dr. Aronson's background consists of extensive experience in psychotherapy, and in the observation and analysis of group dynamics. During the past five years, Dr. Aronson has treated clients in various populations such as the mentally handicapped, women in correctional institutions, and family therapy. Her experience with groups enhances CRJSI's ability to analyze the deliberation process. Dr. Aronson has her BA in psychology from the University of Florida, her Masters in Education/Family Therapy from the University of Miami and her Ph.D. in Marriage and Family Therapy from Nova University.

Gina D'Errico, Ph.D.
Litigation Consultant
Dr.. D'Errico's background consists of extensive research and experience in individual psychotherapy, group dynamics, interviewing and presentation skills. She obtained her B.A. in Psychology at Duke University, graduating with honors, and obtainer her Ph.D. in Counseling Psychology at the University of North Carolina at Chapel Hill. She has run numerous focus groups, and specializes in interviewing jurors and voir dire analysis.

Jennifer Mae Hoberman, J.D.
Legal Consultant
Ms. Hoberman received her J.D. from the University of Miami School of Law. She was a member of the University of Miami Law Review. Her knowledge of the law and her experience in the courtroom contribute to CRJSI's team of consultants in a substantial manner. She is able to suggest innovative yet practical approaches to trial consulting, helping CRJSI to produce highly effective analyses and recommendations.

Don Silver
Communications Consultant
Mr. Silver has spent the last twenty years devoting himself to the study of sales through effective communication strategies. His incredible success as a sales representative for several major companies allows him to make accurate assessments and recommendations with respect to attorney's verbal as well as non-verbal communication skills.

Sal Pisani
Creative Arts Consultant
Mr. Pisani, a member of the Screen Actors Guild, brings to CRJSI the creative aspects of acting. Mr. Pisani applies numerous acting techniques in order to enhance persuasiveness. He has appeared on T.V., in film and in the theatre professionally for the last ten years.

Dina R. April
Litigation Consultant
Specializing in the fields of advertising and market research, Ms. April began her career with Video Monitoring Services of America. At VMS, she assisted the nation's largest corporations in the obtaining and compiling of audio and video market research materials. In 1988, Ms. April joined G.M. Anderson and Associates in Springfield, Illinois as senior account executive in charge of advertising and public relations. Since that time, Ms. April has acted as public affairs and market research director for a major cable operator as well as assisting with focus groups and mock trials for Carolyn Robbins Jury Simulations, Inc.. Ms. April has a BS degree in Communications and Political Science from Northwestern University in Evanston, Illinois.

THE WHITE HOUSE
WASHINGTON

January 14, 1998

Ms. Estelle B. Richman
Health Commissioner
Department of Public Health
1600 Arch Street - 7th Floor
Philadelphia, PA 19103

Dear Ms. Richman:

On behalf of the First Lady, thank you very much for your letter and invitation to the opening ceremonies of Temple Children's Medical Center later this month.

I have forwarded your letter to the First Lady's scheduling office and they will be in touch once a decision has been made.

Thanks and best wishes.

Sincerely,

Melanne Verveer
Chief of Staff to
the First Lady

CITY OF PHILADELPHIA

DEPARTMENT OF PUBLIC HEALTH
1600 Arch Street -7th Floor
Philadelphia, Pa 19103

ESTELLE B. RICHMAN
Health Commissioner

January 13, 1998

Mrs. Hillary Rodham Clinton
The White House
1600 Pennsylvania Avenue, NW
Washington, D. C. 20500

Dear Mrs. Clinton:

I am writing to request that you consider the invitation from Temple University Hospital concerning the opening ceremonies for their Temple Children's Medical Center in January 1998.

Your presence at this occasion is greatly desired. Temple University Hospital has a history of commitment to the inner-city community in Philadelphia. Temple Children's will also be devoted to improving the health of North Philadelphia's children through its primary focus on outreach and intervention programs. These efforts can only further enhance the initiatives currently underway through my office.

I know how honored Temple would be if you could recognize their commitment to improving the health of our children in Philadelphia. As the Nation's advocate for child health care, I could only hope that you would consider this to be a meaningful event. It would be a great honor to both Temple Children's and Philadelphia to join us on this historic occasion.

Sincerely,

Estelle B. Richman

Estelle B. Richman
Health Commissioner

EBR/kd

THE WHITE HOUSE
WASHINGTON

March 4, 1998

Ms. Kim Regan
President of the Board
Children's Council of San Francisco
One Second Street, 4th Floor
San Francisco, CA 94105

Dear Kim:

Thank you very much for your letter and invitation to the First Lady to deliver the keynote address to Children's Council's 25th Anniversary in October.

It is much to early to determine whether the First Lady will be able to attend. Our scheduling office will contact you once a decision has been made.

Best wishes.

Sincerely,

Melanne Verveer
Chief of Staff to
the First Lady

CHILDREN'S COUNCIL
OF SAN FRANCISCO

To Patti

February 24, 1998

Ms. Melanne Verveer
Chief of Staff
Office of the First Lady
The White House
Washington DC 20500

Dear Melanne,

Since moving to San Francisco I have become involved in a number of volunteer activities. One of them prompts me to call upon our friendship and ask for your assistance.

I am the President of the Board of Directors of the Children's Council of San Francisco, a nationally recognized private, non-profit, child care services agency. This is our 25th anniversary and we are planning a major event, probably a luncheon, to focus greater public awareness on our services. We would like to invite Mrs. Clinton to be our guest of honor and keynote speaker. It can be scheduled anytime in October of 1998 that it would be convenient for her to come.

Her work on behalf of children is aligned so closely to our mission, that we hope she will see this opportunity to appear as a way to assist in making programs such as ours known to a wider audience. Our programs have supported nearly 100,000 children and their families, but there are so many more who need our help.

We want to use this occasion to generate increased interest and recognition for the crucial role child care plays in enabling families to become economically independent. The Children's Council of San Francisco was the first resource and referral organization in the nation, and it continues in that role. However, today our programs also include child care subsidies for low income parents, families at risk, and parents moving from welfare to work; technical assistance and training for child care providers; research for child care policy development; and legislative advocacy. I have included a brief fact sheet to give you some idea of our history and the scope of our programs.

Invitations will be sent to everyone in the Bay Area with an interest in child care. More than 75% of our budget is child care subsidy funding from federal, state, and local government programs, therefore we would expect a number of California office holders to attend. There are many private sector corporate users of our services, and they too, will be invited.

This event will also honor our founder, Patty Siegel. She was recently in Washington as an invited panelist at the White House Conference on Child Care, and met President and Mrs. Clinton. She is the founder and Director of the California Child Care Resource and Referral Network, an umbrella organization with over 60 agency members. Ms. Siegel's wide circle of friends will also be invited.

You must feel the weight of the world on your shoulders, but there is lots of support out here. Thanks for staying in the trenches! My best to Phil.

I appreciate your help with this. I will call you soon to follow up.

Warm regards,

Kim Regan
President of the Board
[415] 771-7798 (home and work)

Main Office: *One Second St., 4th Floor San Francisco, CA 94105-3407 415-243-0700 FAX: 243-4414*
Mission Office: *1398 Valencia St. San Francisco, CA 94110 415-920-7272 FAX: 550-6839*
Bayview/Hunter's Point Office: *3450 3rd St. Suite 200 San Francisco, CA 94124 415-920-7280*

The Children's Council of San Francisco

Achievements

- In our 25 years of service to the San Francisco community, CCSF has provided services to over 100,000 families and child care providers.
- We expect to double our child care subsidies in 1998, providing funds to over 2,000 families to support parents' work or training schedules, or respite care for families in stress. This significant increase is a result of our expansion to meet the needs of welfare reform.
- CCSF provides most of the government-supported child care subsidies in the City of San Francisco. As new funding becomes available this year for parents moving from welfare to work, we expect to provide nearly $14 million to families with children.
- Our Resource and Referral department provides information to over 5,000 clients per year.
- CCSF training programs reach almost 500 child care providers offering topics such as nutrition, program administration, child development, CPR, First Aid, and activities for children.
- CCSF annually provides licensing orientations to approximately 500 providers; 150 site visits and evaluations for providers; and technical assistance to 2,000 providers, parents and members of the community.

Brief History

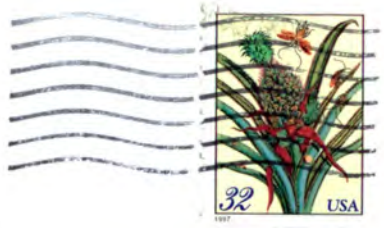
- CCSF was the nation's first child care resource and referral agency, starting as the "Child Care Switchboard" in 1973. Resource and referral agencies now exist all over the country.
- For many years CCSF has been a resource for parents looking for safe and convenient child care. Ten years ago we pioneered a collaboration with the local County Welfare Department to provide child care referral and subsidy services to families on welfare who were in training and job-seeking activities. In 1994, we were the first to develop a similar partnership for child care referral and subsidy services for teenage parents on assistance, to enable them to continue their high school education through Cal-Learn, a state supported program.
- Today, CCSF is the lead agency in an innovative program providing mental health and child development consultation to child care providers, assisting them to serve children with special emotional and developmental needs.

Our Clientele

- Teen parents of infants and young children
- Parents at risk of becoming welfare dependent
- Parents who are working, seeking employment, attending or graduating from a job-training program
- Families referred by social service agencies
- Homeless families
- Single heads of household
- Parents of children with special needs
- Parents of "latchkey" children
- Businesses seeking child care referral services for their employees
- Organizations in need of information for planning and policy development

The Children's Council of San Francisco
One Second Street
San Francisco, CA 94105-3407

SAN FRANCISCO CA 941
24 FEB
1998



Ms. Melanne Verveer
Chief of Staff
Office of the First Lady
The White House
Washington DC 20500

THE WHITE HOUSE
WASHINGTON

March 9, 1998

Ms. Mary Regula
National First Ladies' Library
Saxton McKinley House
331 Market Avenue South
Canton, OH 44702

Dear Mary:

Thank you very much for your very thoughtful letter and for the beautiful ornament which I shall treasure. It has been such a pleasure to work with you and the First Lady and I are so pleased that she was able to welcome the friends of the Library to the White House for your historic announcement.

Thanks and best wishes.

Sincerely,

Melanne Verveer
Chief of Staff to
the First Lady

Saved on a.2

NATIONAL FIRST LADIES' LIBRARY

P

Penelope for the ornament -

March 1, 1998

Dear Melanne

How can I ever adequately express my appreciation to you for your kindness, your patience and your dedication to making February 23rd an historic wonderful event.

What a glorious perfect day! The rain could not dampen our joy. I wish you could have heard the many comments and seen the tears as they said this was an experience they would never forget.

I'm sure you must have days when the rush and hazzle of your busy life must be very frustrating.

Please remember then, that we bless you and think you are <u>wonderful</u>!

Sincerely,

Mary Regula

Saxton McKinley House, 331 Market Avenue South, Canton, Ohio 44702-2107

Honoring the visit to Washington, D.C., by
H.E. Andrei Gabriel Plesu, Minister of Foreign Affairs of Romania

called to dept w/ message

Request

The Ambassador of Romania
to the United States of America
and Mrs. Mircea Dan Geoana
request the pleasure of the company of
Mrs. Melane Verveer & Chr.
at a Dinner
on Wednesday, April 22 *at* 7:00 p.m. *o'clock*

R.S.V.P.
(202) 387-6901
(202) 332-4829

2500, 30th St., NW
(Off Massachusetts Ave)
Washington, DC 20008

THE EMBASSY OF ROMANIA
1607 23-rd Street, N.W.
Washington, D.C. 20008

APR 2 '08 DC
0 32
U.S. POSTAGE

Mrs. Melane Verveer
Chief of Staff
Office of the First Lady White House
1600 Pennsylvania Avenue
Washington, DC 20050

THE WHITE HOUSE

WASHINGTON

April 30, 1998

Dr. John Reiss
Director of Policy and Program Affairs
Institute for Child Health Policy
5700 S.W. 34th Street, Suite 323
Gainesville, FL 32608-5367

Dear Dr. Reiss:

Thank you for your letter and information concerning children's health insurance and child care services for familes with children with special health care needs.

The President has proposed an ambitious initiative to make child care better, safer and more affordable for America's working families. The initiative includes two proposals specifically designed to help children with special needs. First, the President will invest $3 billion to improve early learning, parent education, and the quality of child care for infants and toddlers, including providing specialized training for child care providers about the needs of children with disabilities. In addition, the President's budget provides $5 million in fiscal year 1999 for the Families of Children with Disabilities Support Act, which funds grants to improve child care and other services for children with disabilities.

With regards to health insurance, states are encouraged to target part of their Child Health Insurance Program (CHIP) block grant money towards children with disabilities. In a recent Congressional conference committee report, language was included that encouraged states to provide insurance to assure access to quality specialty care for children with special needs.

The First Lady is dedicated to providing affordable child care and health insurance for our nation's children, particularly those with special needs. We look forward to continuing to work with you.

Sincerely,

Melanne Verveer
Chief of Staff to the First Lady

Institute for Child Health Policy
Creative Vision in Research & Service

March 16, 1998

Jen / Neera –
Cried up 15
reply & answer

Melanee Verveer
Chief of Staff to the First Lady
Attn: Katy Button
Old Executive Office Building, Room 100
17th and Pennsylvania Ave., NW
Washington, DC 20503
(202)-456-1660

Dear Ms. Verveer,

I would like to express my thanks to the First Lady for her inspiring and informative speech on children's health insurance and child care at the Annual Meeting of the Association of Maternal and Child Health Programs (AMCHP) on Monday, March 9. The First Lady continues to provide critical leadership to the Clinton Administration's efforts to improve access to and quality of child health insurance, child health services and child care.

In April, in anticipation of Ms. Clinton's speech at AMCHP, I provided to your office background information on the importance of quality child care services for families with CSHCN. It was a disappointment that the First Lady did not address the issue of children with special health care needs and their families within the context of child care, child health insurance or child health care services.

As a member of the Board of Directors of Family Voices I am aware of the support that the White House and the First Lady have provided to Family Voices, as a national grassroots organizations speaking on behalf of CSHCN and their families. It was wonderful to learn that Ms. Clinton personally expressed her appreciation of the work Family Voices to several FV state coordinators who spoke with her immediately following her speech. However, I feel that the First Lady failed to take advantage of the opportunity to publicly acknowledge and support the work of Family Voices; or to address the place of CSHCN within the Administration's child health initiatives, as part of her luncheon remarks. AMCHP has, at long last, taken steps to include family leaders in their Annual Conference and the association's policy making activities. However, the role of families, as vital partners, is in its early stages, and must be acknowledged and supported at every opportunity. I hope that Ms. Clinton will choose to communicate support of the work of FV and other parent leader organizations, and the importance of services for CSHCN in a more public manner, to professional audiences, as opportunities present themselves in the future

5700 S.W. 34TH STREET, SUITE 323 • GAINESVILLE, FL 32608-5367
TELEPHONE: 352-392-5904 • TELEFAX: 352-392-8822
E-MAIL: INFO@ICHP.EDU • WORLD WIDE WEB: HTTP://WWW.ICHP.EDU

On a related note, I would like to take this opportunity to provide the First Lady with the enclosed additional information on health insurance and CSHCN. As was addressed in the December, 1997 issues of SmartMoney in an article (enclosed) entitled "Is Your HMO Failing Your Kids?", pediatrics is the least scrutinized and perhaps most suspect element of managed care. Because "any child at any time could develop a chronic condition or disability...It is...critical for all families to have the security of knowing that coverage will be available in the event of a serious health problem (Nora Wells, family Voices).

In order to better inform families, professionals, policy makers and those with responsibility for bargaining for health benefits about managed care issues related to children, I would like to bring to your attention, a new information resource, that is available both online and as a hard copy document. This resource is a document entitled "Evaluating Managed Care Plans for Children with Special Health Needs: A Purchaser's Tool." (Ten copies of this document are enclosed.) This tool is designed to help corporate benefits managers, government officials, professionals and families select health insurance and health plans (HMO's, etc.) that are good for children, especially children who have special health needs. This tool is specifically designed to support informed decision making in selecting health plans that provide access to quality child health care while balancing cost and value.

As part of our dissemination efforts, the Purchasers Tool is being mailed to a broad range of individuals and organizations involved in determining what health care coverage options are available for children. This includes leadership of public-based programs, such as Medicaid, state Children with Special Health Care Needs (CSHCN) Programs, state Maternal and Child Health (MCH) Programs, and the new Child Health Insurance Program (CHIP); corporate and government employee benefits managers; union representatives; and executives of health care purchasing groups.

The Purchasers Tool is also being sent to child health provider organizations and associations, including managed care organizations and membership of the American Academy of Pediatrics and the National Association of Children's Hospitals and Related Institutions. Further, this document is being made available to parents of children with special health care needs through Family Voices and other family leadership organizations.

In addition, the Purchasers Tool is being made available to the public, through the Institute for Child Health Policy's WWW site: http://www.ichp.edu/mchb/center/policy/ In support of this dissemination effort through the Internet, I ask that you consider making information about the tool available to your readers and through your WWW site.

For your information, development of the Tool was supported by a grant from the federal Maternal and Child Health Bureau (MCHB) to the Children with Special Health Care Needs (CSHCN) Institute at the Ohio State University; and distribution is supported by a grant from MCHB to the Institute for Child Health Policy at the University of Florida. Development of the tool was carried out in consultation with a broad range of stakeholders, and the Tool has been reviewed and is supported by the American Academy of Pediatrics, Family Voices, and the National Association of Children's Hospitals and Related Institutions

To further support informed decision making in selecting managed care plans for children, we are developing a database of information gathered through the application of the Purchasers Tool. This information resource will be available through the Internet.

In addition, I have enclosed a document entitled "Evaluating Managed Care Plans for CSHCN: A Purchaser's Tool - Potential Applications" which described ways in which the Purchaser's Tool can be used to support improved systems of care for all children, including those whose parents are federal employees. Finally, I have enclosed a document entitled "Does Your State's Title XXI SCHIP Plan Promote the Development and Maintenance of Quality Systems of Care for Children with Special Health Needs?" which identified issues and criteria for SCHIP plan review and analysis from the perspective of CSHCN and their families.

My thanks, again, to the First Lady for speak at the Association of Maternal and Child Health Programs meeting and for inspiring ongoing efforts to assure that children receive the health care that they need and deserve. I hope that you find the enclosed materials to be of value, and I look forward to the opportunity to support the Administrations ongoing efforts to improve the health of the nation's children.

Sincerely,

John Reiss, Ph.D.
Director, Policy and Program Affairs

Is Your HMO Failing Your Kids?

Why is pediatrics the least scrutinized and perhaps the most suspect element of managed care?

BY WALECIA KONRAD

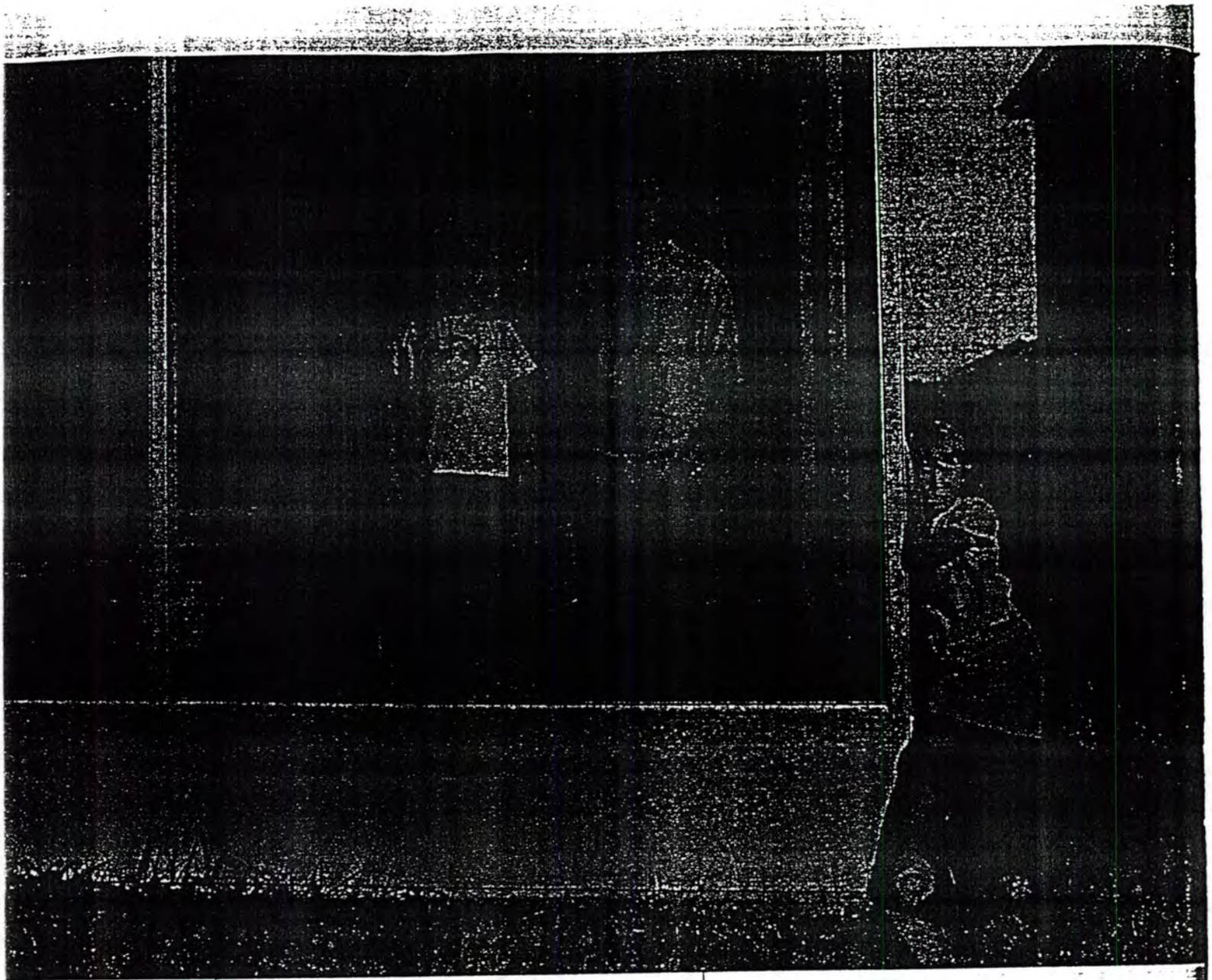
Additional reporting by Eric R. Tinson

It was a tense time. In November 1992 Katherine and Harry Christie's nine-year-old daughter, Carley, was experiencing severe stomach pains, fevers and vomiting. After a battery of tests—including a CAT scan and a biopsy—the Christies' doctor delivered the bad news: Carley had Wilms' tumor, a potentially fatal disease in which cancer cells are found in certain parts of the kidney.

Several months later, on a Friday in late January, surgery was performed. After four hours in the operating room, Dr. Stephen Shochat, a pediatric surgeon and well-known expert in Wilms' tumor, removed Carley's tumor. That weekend the Christies camped out with Carley in the intensive-care unit, helping their daughter recover from the surgery and trying to keep each other's spirits up.

On Sunday afternoon the telephone in the hospital room rang. Was it the doctor calling to check in? Was it perhaps the lab calling with the results of another

Photographs by ROBERT LEWIS



When the Tyrivers went back over their HMO contract, they learned that the vision therapy needed by Megan (right) was considered "not medically necessary."

series of tests? No. On the other end of the line was a man identifying himself as a "utilization review nurse" from the medical group contracted by TakeCare Health Plan in Concord, Calif., the Christies' health maintenance organization.

Coverage for Carley's surgery was denied. Because Dr. Shochat was not on the HMO's approved list of surgeons and the Christies had not gotten written preapproval to use an out-of-network doctor, TakeCare was no longer responsible for payment. The Christies would have to foot the $40,000 bill themselves.

Shock at getting the call turned to anger over its message. Relief over Carley's surgery was replaced by a stunning disbelief that the HMO, which had earlier thwarted the Christies in their attempt to get the care they felt they needed for Carley, was now saying it was not going to pay for surgery that might have saved their daughter's life.

This is the kind of thing that isn't supposed to happen. Yes, HMOs have gotten a bad rap for supposedly squeezing the bottom line at the expense of patient care, for putting patients through hoops before approving their medical procedures, for turning health care into an unfeeling, strictly commercial enterprise.

But most of the criticisms are generally aimed at the way HMOs treat adults, particularly adults with chronic illnesses or life-threatening ailments—heart disease, breast cancer, prostate cancer—that require special care and expensive, long-term treatments. Children are supposed to be the one group that is being well served by the HMO revolution; families, the natural constituents for these health organizations. Join an HMO and the endless routine visits to the pediatrician's office, late-night emergency-room visits for the inevitable fevers and falls and, just in case you need it, access to highly trained doctors if anything goes seriously wrong are all taken care of with low premiums and even lower copayments. After all, HMOs were designed on the premise of *preventative* care. Exact-

ly the kind of care children, with their routine vaccinations and checkups, need.

It hasn't quite worked out that way.

A close look at the evaluation data available to the public and interviews with dozens of parents, pediatricians, consumer advocates and HMO administrators show that, conceptually sound as this theory may be, in practice, children's health is the least scrutinized and perhaps most suspect aspect of this country's dramatic transition to managed health care. This phenomenon becomes even more pronounced with chronically ill children—a small percentage of the population at large and a population often overlooked by HMOs and other managed-care plans. "Children's health is the poor stepchild in the HMO business," says David Lansky, president of the nonprofit Foundation for Accountability, which independently develops tools for evaluating HMOs.

How can that be? Consider the following:

Adult health issues in managed care have been the subject of countless studies, including such tomes as *A Consumer Guide to Coronary Artery Bypass Graft Surgery,* put out by the Pennsylvania Health Care Cost Containment Council, or the *New England Journal of Medicine's Health Policy Report: Managed Care and Mental Health.* But ask about studies on children and HMOs, and most researchers draw a blank. After giving it some thought, they'll point to a 1989, 12-year, $80 million RAND Corp. experiment. HMO proponents like to highlight the part of the study that says children enrolled in an HMO received preventative care at a 40 percent higher rate than their counterparts who received fee-for-service care. But a closer look indicates that the extensive study is anything but conclusive. "The results of this experiment neither strongly support nor indict fee-for-service or prepaid care [HMOs] for children," says the first page of the report.

More recent research efforts are just as lacking. The National Committee for Quality Assurance, the independent organization that accredits HMOs, collects information on 71 data points to analyze and evaluate HMO performance. But only 12 of those points—just 16 percent—have anything to do with children. And of those, three deal with prenatal or obstetrical care and two deal with adolescents. By comparison, no such dearth of information exists on adult treatments. Looking for the latest numbers on beta blockers? The NCQA will tell you that an average of 62 percent of heart-attack victims receive this drug from their HMO to ward off a second attack. Interested in similar data on treatments for chicken pox or ear infections? Sorry. Not available.

More frustrating is the reluctance on the part of participating plans to disclose information on what few childhood measures exist. (Making data public is not a requirement for accreditation.) Only 99 plans out of the 329 in NCQA's database, for instance, release information on how many children have a yearly checkup during years three through six. Moreover, only 88 plans provide data on how many infants come in for three or more checkups during their first 15 months. Contrast that with the wealth of routine data these plans provide you on their adult care. More than 200 plans reported on breast cancer screening, for example, while 322 disclosed their cervical-cancer screening rates.

Even among plans that disclose everything in the NCQA survey, the information is far from reliable, a reflection of the fact that only 50 plans agreed to have their data audited. In addition, the NCQA measures change from year to year, making it hard to draw long-range conclusions.

'Kids who are low income, who are qualified for state are receiving bett care than those in HMOs,' says a California researc

Even consumer groups and government agencies come up short when the subject turns to HMO pediatric care. Organizations such as the Center for the Study of Services, Families USA and the Agency for Health Care Policy and Research have never looked specifically at pediatrics. And various coalitions have sprung up throughout the country to evaluate HMOs, including the Pacific Business Group on Health and the Massachusetts Health Care Purchaser Group, but they have yet to address the topic beyond routine immunizations and the number of office visits kids receive. "There has been a lot done on children and a lot done on managed care," says Amy Taylor, an economist with the Agency for Health Care Policy and Research. "But to my knowledge there just hasn't been a more comprehensive combined look."

HMO industry officials acknowledge that more data could certainly be collected but deny that the lack of information indicates that children don't get the treatment they need. "There is by far more research on managed care's track record with respect to adults," says Karen Ignagni, president of the American Association of Health Plans, an industry group representing more than 1,000 managed-care plans. "But that doesn't mean we don't get the same good outcomes with children. It just means we have to do more research on kids."

Meanwhile, a cottage industry of consultants, from big firms such as Towers Perrin to specialists such as Scheur Management Group, outside Boston, have jumped into the field by putting together HMO "report cards" for their corporate clients. To get a passing grade, however, plans don't have to do much for children except give them their shots. These surveys rarely ask such basics as how many kids are enrolled in a plan, how many pediatric specialists are on board and whether or not it's affiliated with a children's hospital. Instead, they seek to find out how many adults between the ages of 20 and 44 have seen a health care provider in the past three years, or how many adult diabetics are receiving regular eye exams. The con-

sultants themselves apparently see no problem in this lack of focus on children. "Kids don't always need someone who specializes in pediatrics," says Arlen Collins, senior medical consultant at Scheur Management and himself a pediatrician. "Parents just think they do." (Not all experts agree: "A tracheotomy on a two-year-old is a completely different procedure than a tracheotomy on an adult, I can assure you," says Dr. Vincent Riccardi, a pediatrician and head of American Medical Consumers, a for-profit group that helps patients deal with managed-care plans.)

"Kids are ignored for simple economic reasons," explains David Lansky. Children younger than 18 make up only about 20 to 25 percent of the general population. And the majority of them are basically healthy. Unlike heart-attack patients or the elderly, who account for huge chunks of national spending on health care, only 5 percent of all children account for about 90 percent of all pediatric health care expenditures. Those that do fall ill tend to do so with rare and difficult-to-treat conditions such as cystic fibrosis, congenital heart problems or spina bifida. These are the kinds of illnesses that require a battery of expensive specialists administering continuing care throughout a child's life—in other words, the kind of cases that are anathema to managed care's cost-conscious mandate.

In a rare look at how HMOs treat seriously ill children, Elizabeth Jameson, a senior analyst at the Institute for Health Policy Studies at the University of California at San Francisco School of Medicine, a leading health-policy group, extensively surveyed 59 pediatricians, social workers and nurses who treat large numbers of children with three serious childhood disorders: sickle-cell anemia, spina bifida and craniofacial abnormalities. Jameson looked exclusively at HMOs that hold outside contracts with doctors, as opposed to "closed end" plans, which require all doctors to be on staff.

The forthcoming study, says Jameson, points to one overwhelming conclusion: Children in these managed-care plans are far less likely to gain access to care consistent with recognized clinical guidelines than are children insured by Medi-Cal and California Children's Service, two state public health plans for low-income families. "The results of my study are incredibly dramatic," says Jameson. "Kids who are low-income, who are qualified for state aid, are receiving better care than those in HMOs."

Kids with sickle-cell anemia, for instance, often avoid problems related to chronic lung disease by undergoing a series of pulmonary tests. But these tests are routinely denied by managed-care plans, according to Jameson's survey results, despite their preventative nature and the fact that these procedures fall under accepted medical guidelines for treating sickle-cell-anemia patients. Meanwhile, children with public insurance in California routinely receive these tests.

While Jameson's study deals exclusively with treatment of chronically ill children, in general there are three specific ways in which HMOs work that tend to undermine their potential to give even healthy children the level of pediatric care your family expects.

First is the HMOs' constant restraint in allowing primary-care physicians to conduct costly tests and recommend specialists. This, of course, is a problem with adults too. But the situation is more acute with kids, because their ailments are often a mystery to doctors untrained in pediatrics or family care. "What sets children apart as patients," says Jameson, "is that they must be diagnosed and treated in the context of their rapid and continuous growth and development."

'Of course you want the most qualified doctors when it comes to your loved ones. But the *most* qualified isn't alway what you'll get. That what goes along with lower costs.'

Consider 16-year-old Paige Lancaster from Stafford, Va. She started having severe headaches back when she was 11 years old. Paige was covered by her father's insurance with Kaiser Permanente of the Mid-Atlantic States. For more than a year Paige's mother, Barbara Lancaster, would take her daughter every few months to her Kaiser pediatrician, Dr. Corder Campbell, pleading with him to help find out what was causing Paige's headaches, nausea and bloodshot eyes. But the doctor insisted that this was normal for some preteen girls and prescribed adult dosages of migraine medicine. Lancaster, concerned with her daughter's complaints of pain, short-term memory loss and dramatically slipping grades, continued to lobby her doctor. "Should she see someone else? Have some tests?" she asked him. Each time, Lancaster says, he dismissed the problem as migraines.

The Christies' HMO was fined $500,000 because of the way it handled Carley's treatment.

By the time Paige was a freshman in high school, she was routinely vomiting from the headaches. Her learning problems were so extreme Paige was placed in a special program at school. Her teachers, wanting to rule out any physical reasons for Paige's difficulties, kept asking Paige's mom what tests had been done.The school psychologist even wrote a letter to Campbell requesting an MRI and an EEG. According to Lancaster, Campbell's response was less than enthusiastic. "I'd like to report them for practicing medicine without a license," Lancaster remembers him saying. When he did finally order the tests, the MRI showed Paige had a cyst that emanated from a tumor covering 40 percent of her brain. It took two surgeries and severe radiation to get rid of most of it. And although she is recovering, Paige and her mom are still not sure to what extent Paige may be suffering permanent damage. "It just keeps hitting me in the face that Paige didn't have to

"Children's health is the poor stepchild in the HMO business," says David Lansky.

go through the pain, the surgeries, the frustration with school, the humiliation and the fact that the rest of her life may not be the quality it could have been," says Barbara Lancaster, who has filed a lawsuit against Kaiser.

Lancaster sought the advice of Michael Miller, a local attorney. As he looked closer at the case, Miller consulted with Dr. Bruce Bertoff, an ear, nose and throat surgeon who is also an attorney in Miller's office. "Based on conversations I've had with other doctors," says Bertoff, "Kaiser will traditionally hold back five to 10 percent of the physicians' income and put it in a pool and pay it at the end of the year, depending on how close the physicians come to certain economic targets." One of the best ways primary-care physicians can keep costs down, argues Bertoff, is to avoid expensive tests and specialist referrals. This incentive program, Miller and Bertoff charge, is what kept Paige's primary physician from administering an MRI and referring her to a pediatric neurologist.

Neither Campbell nor his lawyer, Anthony Tringa, would comment on the Lancaster incident, and referred all calls to the HMO, which disputes the charges. "I'm very confident that our compensation system will not be an issue in the Lancaster case," says Dr. Larry Oates, Kaiser's associate medical director. He says that incentives are only a small part of a Kaiser physician's salary-based compensation, and that for the past four years the HMO has tied incentive programs for all physicians to broad goals such as quality of care and member satisfaction. Financial goals that deal with issues such as hospital stays or specialist referrals are applied to Kaiser's physician group as a whole. "We haven't driven that down to the individual physician level," says Oates, "because we are concerned about the impact on patient care."

Even when an ailment is finally diagnosed, chances are kids may be less likely than adults to get proper treatment. Why? Because most HMOs can recommend only plan-based specialists. And as Katherine and Harry Christie learned with their daughter, Carley, that's no guarantee that the doctor is the best, or even well regarded, in his field.

The parents had learned, for example, that the National Cancer Institute recommends that pediatric surgeons with direct experience in Wilms' tumor perform the operation. But when the Christies met that week with the HMO oncologist who would be treating Carley, they found out her surgeon was neither a pediatric specialist nor an expert in Wilms' tumor. It was even more disconcerting when the Christies found out that Dr. Stephen Shochat, a pediatric surgeon with plenty of experience treating this rare cancer, practiced in the children's branch of the same hospital as their assigned doctor and was even

The Best HMOs for Kids

To find the HMOs with the best track records in treating children, we searched the database of the National Committee on Quality Assurance, the organization that accredits HMOs, for plans that voluntarily reported data in all of the following five areas of pediatric care. Out of that small pool (only 17) we chose seven plans that scored in the top half in each category.

	PERCENTAGE OF CHILDREN IN THE PLAN WHO RECEIVE THE FOLLOWING CARE				
PLAN	CHILDHOOD IMMUNIZATIONS	3 OR MORE WELL-CHILD VISITS IN THE FIRST 15 MOS.	1 OR MORE WELL-CHILD VISITS IN YEARS 3–6	ADOLESCENT WELL-CHILD VISITS	ADOLESCENT IMMUNIZATION
COLUMBIA MEDICAL PLAN (MD.)	91.0	98.0	79.0	42.3	87.6
FALLON COMMUNITY HEALTH (MASS.)	92.5	95.5	78.3	46.7	84.7
HEALTH CARE PLAN (N.Y.)	90.0	98.3	74.7	37.7	64.7
HEALTH NEW ENGLAND (MASS.)	75.5	97.9	72.4	35.6	83.0
HEALTHGUARD OF LANCASTER (PA.)	61.3	100.0	67.4	44.5	60.6
NYLCARE HEALTH PLANS (MD.)	82.2	95.1	88.1	48.4	59.9
WELBORN HEALTH PLANS (IND.)	76.3	99.4	71.6	40.0	85.6

DATA: NCQA; SMARTMONEY

contracted with the same HMO. Unfortunately for the Christies, however, Shochat was a member of a different independent practice association, or IPA, than the one the Christies had signed up with when they joined TakeCare.

"What's going on?" Harry Christie asked Carley's primary-care doctor. He says her only response was to defend the adult urologist assigned to the case. He's one of the specialists in the medical group they chose under contract with their HMO, he says she explained. Dr. Shochat simply wasn't on that list.

Don't expect to get services you're not paying for, says one HMO official: 'It's like going to McDonald's and ordering a cheeseburger. If you want lettuce and tomato, order the Big Mac.'

No way, thought Christie. "I can't risk my daughter's life by placing her in the care of someone not qualified." So Christie told the primary-care physician he was going to make an appointment with Dr. Shochat. "You have to get us a referral," he told Carley's doctor.

When the HMO refused to pay, the Christies appealed several times, then ultimately took the case to arbitration. The committee ruled that TakeCare had to pay the bill. The Christies also filed a complaint with the California Department of Corporations, the state agency that oversees HMOs. The department fined TakeCare $500,000 three years after Carley's surgery, the largest fine ever imposed on a California managed-care organization.

TakeCare, after a series of HMO mergers, is now part of PacifiCare, which won't comment on the case. But Mark Reagan, an attorney with Foley Lardner Weissburg & Aronson, who represented TakeCare in the case, stands by the plan's initial endorsement of the adult urologist. "There is evidence out there that you don't have to know Wilms' tumor to treat it," says Reagan, "but you do need experience in removing kidneys. The TakeCare doctor assigned to the case was an expert in these surgeries." But was he the most qualified? "Of course you want the most qualified doctors when it comes to your loved ones," says Reagan. "But the *most* qualified isn't always what you'll get. That's what goes along with lower costs."

Another factor that leads HMOs to falter in their treatment of children is this: Most of their policies are based largely on adult care, which may not be appropriate for children. In Jameson's study, for example, one of the pediatricians surveyed referred a lupus patient to an adult urologist within his plan for a kidney biopsy. The adult urologist performed an open-back biopsy on the child. But this type of biopsy is inappropriate for children—a pediatric urologist would have performed a less invasive procedure. The open-back wound resulted in serious complications from the anesthetic required for the procedure. Jameson also found numerous examples of spina bifida patients who were denied a wheelchair or set of braces. HMO policies often provide for these devices only once or twice during a patient's lifetime. That may be fine for adults, but it doesn't take into account children's constant need for new devices as they grow.

Denise Tyriver knows what it's like to deal with plans that don't pay enough attention to child development. The Orlando mother of two switched her family to an HMO just this past June, when her husband's employer started offering the option. Tyriver's seven-year-old daughter, Megan, has an autism-related disorder, and her constant care has meant plenty of medical bills. The HMO looked like the perfect, less expensive option.

Like a lot of children with this condition, Megan has trouble focusing her eyes. An optometrist using special exercises may be able to help train her vision. But the doctor group affiliated with the Tyrivers' HMO, Florida Hospital Healthcare System, turned down the request. Why? The HMO, American Medical Healthcare, will not cover what are called "developmental treatments."

Stunned by the refusal, Denise Tyriver pulled out her plan's certificate of group coverage and studied it carefully. She found out her health plan did not, indeed, cover treatments such as "learning-disabled testing . . . speech therapy for other than acute traumatic injury or physical functional defect incurred while covered under this certificate; vision therapy, including eye exercises . . ." Says Tyriver: "There it was in black and white. I couldn't believe I hadn't paid attention before."

"Most plans don't cover developmental programs," explains Dr. Edward Cabrera, chief executive of American Medical Healthcare, "because it falls in the vague category of 'not medically necessary.' It may help the individual, but

RATE

	Atlanta, Ga.	Boise, Idaho	Boston, Mass.	Denver, Colo.	San Diego, Calif.
Well-baby pediatric visit	$54.00	$85.00	$70.00	$72.00	$45.00
Initial eye exam	44.00	64.00	50.00	60.00	75.00
Dental checkup	91.00	84.00	103.00	92.00	100.00
Sealants for the first four molars	100.00	109.00	180.00	80.00	112.00
Set of braces	2,700.00	3,500.00	3,250.00	4,100.00	2,700.00
Inoculations and physical required before start of kindergarten	129.00	91.00	125.00	132.00	115.00
Asthma inhaler	10.99	13.07	14.00	13.29	12.39
Dermatologist visit for acne treatment	65.00	76.00	85.00	98.00	65.00
Nose job (for deviated septum, of course)	6,200.00	3,000.00	4,500.00	3,900.00	5,000.00
At-home drug test	59.95	39.99	59.95	59.99	60.00
Tattoo removal for your wayward teenager	650.00	500.00	484.00	500.00	350.00
Weekly visit to shrink (for kid)	85.00	70.00	90.00	100.00	100.00
Weekly visit to shrink (for parent)	85.00	85.00	100.00	100.00	100.00
Weekly visit to family therapy (for the whole gang)	85.00	70.00	90.00	100.00	100.00

it may not solve a medical problem. It's just not in her plan, so it's not something she bought. It's kind of like going to McDonald's and ordering a cheeseburger. If you want lettuce and tomato, you have to order the Big Mac." ("Plans constantly use this reasoning to deny care, saying a procedure or treatment isn't medically necessary," says Carol O'Brien, an attorney at the American Medical Association. Worse, she adds, some plans have been gravitating toward even more ambiguous language, stating that they will cover "only what the plan deems medically reimbursable.")

Fortunately, cases like the Tyrivers' are starting to put a long-overdue spotlight on the problems with pediatrics and managed care. The industry itself has come up with several encouraging initiatives, such as the pediatric Asthma Patient Management Program of U.S. Healthcare (now part of Aetna), under which kids with asthma—one of the most common pediatric ailments—experienced a 25 percent decrease in hospital admissions and a 60 percent decrease in emergency-room visits. Meanwhile, a subsidiary of United Healthcare has just announced its nationwide pediatric transplant network, which includes access to specialists from all over the country in pediatric heart, lung, liver, kidney and bone-marrow transplants.

The American Association of Health Plans has stepped up its efforts to track medical outcomes in pediatric care, says President Karen Ignagni. The association recently launched a research institute that will, among other things, look at children's special needs.

Perhaps most promising, the Foundation for Accountability, David Lansky's organization, is about a year into a two-year project that will pinpoint a group of consistent pediatric measurements that companies can use to evaluate how well managed care treats children. And he'll be working with the NCQA to implement these measures. Meanwhile, the NCQA is planning to release data on treatment of ear infections—a ubiquitous pediatric problem—next year. Also, federal and state governments have stepped up efforts to regulate managed-care companies. States have passed more than 200 laws on managed care this year, covering everything from grievance procedures to who can sue.

Recognizing that more regulation is probably unavoidable, Kaiser Permanente, HIP Health Insurance Plans and Group Health Cooperative of Puget Sound—three large nonprofit HMOs—have banded together with consumer organizations to come up with 18 enforceable guidelines for managed care, among them a full disclosure of how a health plan's compensation system is structured.

So what to do if your HMO denies payment for a treatment you think your child needs or the services of a doctor who's not covered in your plan? Should you just go ahead and do it anyway, and live with the fact that the money will come out of your own pocket?

That, apparently, is what many HMOs may well be counting on. Keep in mind that in order to keep costs down, medical directors of HMOs may sometimes automatically deny a certain number of procedures each month, says Linda Peeno, a former medical reviewer at Humana who is now a full-time advocate for health care reform. "They don't really pay attention to the specifics of each case," says Peeno. "And they figure most people won't fight."

But all HMOs are required to have a grievance or appeals process that allows customers to question the plan's denial of coverage. The appeals process is actually a plus of managed care. There's nothing like it at traditional fee-for-service insurers. And it can often work. HMOs have become more generous with appeals as a way to avoid malpractice suits. Some plans have reversal rates as high as 76 percent on denials.

"A lot of patients think that once a decision is made, it's in stone," says Cabrera at American Medical Healthcare, "but you can always appeal. With an appeal, we get a lot of new information about a case that we otherwise wouldn't know. I would encourage anyone who's been turned down to appeal." SM

Karen Ignagni denies that the lack of data on children implies that HMOs are lacking when it comes to pediatric care.

One Family's Frustrations

If ever there were a poster family for the drawbacks of the HMO system, then the Phillipses of Matthews, N.C., would surely qualify. No catastrophic illnesses here. No debilitating diseases. Just the daily, numbing, unrelenting frustration of trying to get simple questions answered and routine medical treatments approved.

How long does Pam Phillips say she typically had to wait on the phone before being able set up an appointment for her 12-year-old daughter, Megan, or her seven-year-old son, Parker? Thirty minutes or more. "You cut a part out of your day just to make an appointment," recalls Phillips.

The problems with the Phillipses' HMO, Cigna HealthCare, really began to emerge in 1994, when Parker was diagnosed with asthma, an ailment shared by 4.7 million children. Common though it may be, it was still a new experience for Phillips, and she found herself peppering her HMO pediatrician with questions. When should she give Parker his cromolyn (a nasal medication) or his Prelone (a steroid)? What is a peak-flow meter, and what should she do if it indicates Parker's nearing a crisis?

After repeated problems with their HMO, the Phillipses finally decided that they had had enough.

According to Phillips, it felt as if she were talking to a brick wall. "[The doctor] would say, 'This wasn't mentioned. You didn't bring him in for this. I have approximately two minutes per patient, and I have been in here long enough.'" Phillips says she tried to explain that she felt overwhelmed by Parker's treatment. But the doctor merely replied that perhaps Pam should pick another doctor in the group who wasn't so booked up, and then, she says, he reiterated that point in a letter that he sent some weeks later.

Bumped by one doctor but still with Cigna, Phillips then began to run into more problems, this time with Megan, who was experiencing a series of increasingly sharp headaches and bouts of vomiting in late 1994 and early 1995. Phillips suspected a link with the chronic stomach problems her daughter had experienced since infancy. However, her requests for a referral to a gastroenterologist were initially brushed off. Instead, Megan was put through a gauntlet of eye and head examinations to rule out the possibility of a brain tumor before her doctor agreed to the GE referral. Once he saw her, Megan's gastroenterologist diagnosed the problem as a severely impacted colon. Megan was easily treated, and everyone was relieved that the examinations had turned up nothing. But Phillips walked away frustrated that her first request, one that would have caught the problem earlier, went unheeded.

Things got so bad that, in April 1995, when Parker fell from a tree house, Phillips found her first reaction—to get her son to an emergency room immediately—was quickly eclipsed by a concern that Cigna would refuse payment unless she got prior approval. So she found herself hustling a groggy Parker into the car, then frantically dialing her cell phone with one hand, steering the car with the other, before finally getting through to a Cigna administrator who gave the okay. An extreme reaction? Perhaps. But Phillips says she felt so beaten down by the system at that point that even a visit to the ER filled her with dread about a possible fight over the medical bill.

The family has since switched plans.

Dr. William Popik, the national medical director for Cigna HealthCare, acknowledges that the Phillipses had a legitimate complaint with the delays they experienced, explaining that the waiting time for appointments was a problem when he took over two years ago. But, he adds, many of those problems have since been addressed. Says Popik: "Within the last year we've begun rolling out a 24-hour health care information line. Members have an 800 number and can call 24 hours a day, seven days a week, anywhere in the country, and get medical advice."

Popik says he cannot directly address Phillips's concerns about her first doctor (the family has declined to disclose the physician's name) but adds that he would not have condoned someone's suggesting that they had patients on a time clock. He does, however, say that he sympathizes, in part, with doctors, who must field all kinds of demands. "You think that you can do something in 15 minutes," says Popik. "And that's what you're planning on doing, and then at the end of 15 minutes somebody asks you something that, if done well, would take another 15 or 30 minutes—you can't do it." —*Eric R. Tinson*

sultants themselves apparently see no problem in this lack of focus on children. "Kids don't always need someone who specializes in pediatrics," says Arlen Collins, senior medical consultant at Scheur Management and himself a pediatrician. "Parents just think they do." (Not all experts agree: "A tracheotomy on a two-year-old is a completely different procedure than a tracheotomy on an adult, I can assure you," says Dr. Vincent Riccardi, a pediatrician and head of American Medical Consumers, a for-profit group that helps patients deal with managed-care plans.)

"Kids are ignored for simple economic reasons," explains David Lansky. Children younger than 18 make up only about 20 to 25 percent of the general population. And the majority of them are basically healthy. Unlike heart-attack patients or the elderly, who account for huge chunks of national spending on health care, only 5 percent of all children account for about 90 percent of all pediatric health care expenditures. Those that do fall ill tend to do so with rare and difficult-to-treat conditions such as cystic fibrosis, congenital heart problems or spina bifida. These are the kinds of illnesses that require a battery of expensive specialists administering continuing care throughout a child's life—in other words, the kind of cases that are anathema to managed care's cost-conscious mandate.

In a rare look at how HMOs treat seriously ill children, Elizabeth Jameson, a senior analyst at the Institute for Health Policy Studies at the University of California at San Francisco School of Medicine, a leading health-policy group, extensively surveyed 59 pediatricians, social workers and nurses who treat large numbers of children with three serious childhood disorders: sickle-cell anemia, spina bifida and craniofacial abnormalities. Jameson looked exclusively at HMOs that hold outside contracts with doctors, as opposed to "closed end" plans, which require all doctors to be on staff.

The forthcoming study, says Jameson, points to one overwhelming conclusion: Children in these managed-care plans are far less likely to gain access to care consistent with recognized clinical guidelines than are children insured by Medi-Cal and California Children's Service, two state public health plans for low-income families. "The results of my study are incredibly dramatic," says Jameson. "Kids who are low-income, who are qualified for state aid, are receiving better care than those in HMOs."

Kids with sickle-cell anemia, for instance, often avoid problems related to chronic lung disease by undergoing a series of pulmonary tests. But these tests are routinely denied by managed-care plans, according to Jameson's survey results, despite their preventative nature and the fact that these procedures fall under accepted medical guidelines for treating sickle-cell-anemia patients. Meanwhile, children with public insurance in California routinely receive these tests.

While Jameson's study deals exclusively with treatment of chronically ill children, in general there are three specific ways in which HMOs work that tend to undermine their potential to give even healthy children the level of pediatric care your family expects.

First is the HMOs' constant restraint in allowing primary-care physicians to conduct costly tests and recommend specialists. This, of course, is a problem with adults too. But the situation is more acute with kids, because their ailments are often a mystery to doctors untrained in pediatrics or family care. "What sets children apart as patients," says Jameson, "is that they must be diagnosed and treated in the context of their rapid and continuous growth and development."

'Of course you want the most qualified doctors when it comes to your loved ones. But the *most* qualified isn't always what you'll get. That's what goes along with lower costs.'

Consider 16-year-old Paige Lancaster from Stafford, Va. She started having severe headaches back when she was 11 years old. Paige was covered by her father's insurance with Kaiser Permanente of the Mid-Atlantic States. For more than a year Paige's mother, Barbara Lancaster, would take her daughter every few months to her Kaiser pediatrician, Dr. Corder Campbell, pleading with him to help find out what was causing Paige's headaches, nausea and bloodshot eyes. But the doctor insisted that this was normal for some preteen girls and prescribed adult dosages of migraine medicine. Lancaster, concerned with her daughter's complaints of pain, short-term memory loss and dramatically slipping grades, continued to lobby her doctor. "Should she see someone else? Have some tests?" she asked him. Each time, Lancaster says, he dismissed the problem as migraines.

By the time Paige was a freshman in high school, she was routinely vomiting from the headaches. Her learning problems were so extreme Paige was placed in a special program at school. Her teachers, wanting to rule out any physical reasons for Paige's difficulties, kept asking Paige's mom what tests had been done. The school psychologist even wrote a letter to Campbell requesting an MRI and an EEG. According to Lancaster, Campbell's response was less than enthusiastic. "I'd like to report them for practicing medicine without a license," Lancaster remembers him saying. When he did finally order the tests, the MRI showed Paige had a cyst that emanated from a tumor covering 40 percent of her brain. It took two surgeries and severe radiation to get rid of most of it. And although she is recovering, Paige and her mom are still not sure to what extent Paige may be suffering permanent damage. "It just keeps hitting me in the face that Paige didn't have to

The Christies' HMO was fined $500,000 because of the way it handled Carley's treatment.

Institute for Child Health Policy
Creative Vision in Research & Service

March, 1998

Dear Colleague:

In keeping with the mission of our MCHB funded Center for Policy and Program Coordination to promote collaboration on CSHCN related activities, we are assisting the Children with Special Health Care Needs (CSHCN) Institute to disseminate the enclosed document "Evaluating Managed Care Plans for Children with Special Health Needs: A Purchaser's Tool." This tool is specifically designed to support informed decision making in selecting health plans that provide access to quality child health care while balancing cost and value.

As part of our dissemination efforts, the Purchaser's Tool is being mailed to a broad range of individuals and organizations involved in determining what health care coverage options are available for children. This includes leadership of public-based programs, such as Medicaid, state Children with Special Health Care Needs (CSHCN) Programs, state Maternal and Child Health (MCH) Programs, and the new Child Health Insurance Program (CHIP); corporate and government employee benefits managers; union representatives; and executives of health care purchasing groups.

The Purchaser's Tool is also being sent to child health provider organizations and associations, including managed care organizations and membership of the American Academy of Pediatrics and the National Association of Children's Hospitals and Related Institutions. Further, this document is being made available to parents of children with special health care needs through Family Voices and other family leadership organizations.

In addition, the Purchaser's Tool is being made available to the public, through the ICHP WWW site: http://www.ichp.edu/mchb/center/policy/

To further support informed decision making in selecting managed care plans for children, we are developing a database of information gathered through the application of the Purchaser's Tool. This information resource will be available through the Internet. For updates on the development of the Purchaser's Tool database and information on health care for CSHCN and their families, please return the enclosed postcard.

Thank you for your interest in working with the Institute, the Maternal and Child Health Bureau and others to provide children with access to the health care that they need and deserve.

Sincerely,

John Reiss, Ph.D.
Director, Policy and Program Affairs

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March, 1998

Dear Colleague:

I am pleased to share with you the enclosed copy of "Evaluating Managed Care Plans for Children with Special Health Needs: A Purchaser's Tool."

Because of rapid changes in the health care industry, selecting a health care plan that is responsive to the needs of children, especially those with chronic or disabling conditions, is a challenging responsibility. The "Purchaser's Tool" is specifically designed to support informed decisions as you select plans that provide access to quality child health services, facilities, and professionals while balancing cost and value.

"Evaluating Managed Care Plans for Children with Special Health Care Needs: A Purchaser's Tool" is a product of the Children with Special Health Care Needs Continuing Education Institute at Children's Hospital, Columbus, Ohio. Distribution of the Purchaser's Tool is supported by grant "MCJ-39R006" from the Maternal and Child Health Bureau, Health Resources and Services Administration, Department of Health and Human Services.

This tool was developed by Margaret McManus, Co-Director of the Maternal and Child Health Policy Research Center, Chevy Chase, MD; with consultation and support from members of the Purchaser's Tool Advisory Committee. Additional support, including background research, graphic design, production and distribution was provided by the Institute for Child Health Policy at the University of Florida, Gainesville, FL; David Brasgalla, Graphic Designer; John Reiss, PhD, Director of Program and Policy Affairs.

Sincerely yours,

Toni

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BUILDING SYSTEMS TO ADDRESS THE NEEDS OF CHILDREN

Does Your State's Title XXI SCHIP Plan Promote the Development and Maintenance of Quality Systems of Care for Children with Special Health Needs?

Issues and Criteria for SCHIP Plan Review and Analysis

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Introduction

For the purposes of planning and systems development, the Maternal and Child Health Bureau (MCHB) has defined children with special health care needs (CSHCN) as those children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally. Based on this definition, an estimated 15% of the general population of children have a special health care need.

In regard to health care costs, the 10% of children who have the most intensive health care needs, account for about 70% of all child health expenditures. The majority of these children have one or more severe chronic illnesses or disabilities. Another 20% of children, those who have minor chronic health conditions such as allergy disorders and asthma, utilize about 20% of child health care resources. The remaining 70% of children, who are healthy are require only regular preventive medical check-ups and treatment of minor acute illnesses, incur about 10% of the medical expenditures used to care for children.[1] Thus, while CSHCN constitute a relatively small proportion of the childhood population, they account for the majority of health care expenditures.

CSHCN have increased and often unique the health care services needs. In addition, these children and their families often must confront unique barriers to obtaining and maintaining adequate health insurance to meet their needs. Therefore, it is critical that the health plans developed under Title XXI (Children's Health Insurance Program) include elements and features that are specifically designed to address common issues for CSHCN.

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[1] Neff & Anderson. Protecting Children with Chronic Illness in a Competitive marketplace. JAMA. 1995;274,23:1866-1869.

In 1982, Surgeon General Koop began his efforts to reshape the organization, financing and delivery of health care services to CSHCN and their families. The initial focus of this child health reform was on children who were dependent on technology, and the development of programs to ensure that these children could be successfully cared for at home rather than undergoing long-term hospitalization. Based on the lessons learned from this initial effort, Surgeon General Koop initiated Campaign '87, which, over the last decade, has focused on moving our nations child health care system from a categorical to a non-categorical paradigm of service delivery; from medical to more functional definitions of disability; from deficit perspectives to strengths perspectives; from clinical to family-centered philosophies; and from isolated to integrated models of providing services. In 1989 the principles and goals of Campaign '87 were translated into legislation, through the OBRA '89 amendments to Title V of the Social Security Act. OBRA '89, in part, requires that states provide and promote family-centered, community-based coordinated care (including care coordination services) and to facilitate the development of community-based system of services for CSHCN and their families. Further, in 1991, a goal was included in the National Healthy People 2000 Objectives, to establish family-centered, community-based systems of services in 50 states by the year 2000.[2]

Currently, our Nations "medical care marketplace" is changing rapidly. New systems are emerging and existing systems are being redesigned in response to reform in both the public and the private sectors. Increasingly, managed care arrangements are being used to provide health and medical services for all adults and children, including CSHCN. Because these "financing and delivery system" reforms are primarily a result of forces and factors at work in the adult health care system, the effects that these changes are having on children is of mounting concern to those who are most knowledgeable about child health. For example, one unintended by product of marketplace changes has been the increase in the proportion of children who are uninsured or under-insured. Currently, an estimated 14% of American children under the age of 18 have no health insurance coverage.

In an effort to counteract this trend, and to expand access to health insurance to children in low and moderate income families, the State Child Health Insurance Program legislation was passed, as Title XXI of the Social Security Act. Over the next ten years, this program is designed to infuse as much as $48 billion into the child health system; the vast majority of this in the form of health insurance. This infusion of additional, relatively flexible funds has great potential to improve children's access to needed preventative, primary, and chronic health care services. Under Title XXI, states are afforded a significant level of flexibility in defining the target groups of children for coverage under the new program. SCHIP is designed make Medicaid or other health insurance coverage available to children, up to age 19, from families with incomes up to 200% of the Federal Poverty Level (FPL) However, states that have already raised the income eligibility to above 150% FPL can extend coverage to children with family incomes up to 50 percentage points

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2 Maternal and Child Health Bureau. National Agenda for CSHCN: Achieving the Goals 2000. Rockville, MD. MCHB, HRSA, DHHS; 1995. (Contact Dr. Merle McPherson, Director, DSCHSN, MCHB, HRSA. 301-443-2350; FAX 443-1728; email: MMcPherson@hrsa.dhhs.gov)

above the state's current income eligibility level. In addition, states have broad discretion as to how to calculate income (gross, net, or countable income). More significantly, states have flexibility in establishing non-financial eligibility criteria. For example, SCHIP can use criteria such as age, residency, geographic area, access to other coverage, and disability status (provided that disability standards are not used to restrict eligibility to those with disabilities).

It is important to note, however, that this program could also stimulate the development of duplicative systems for healthy children, further fragment child health financing and delivery for children with special needs, ignore existing gaps in the service system, and fail to effectively support the ongoing development and maintenance of family-centered, community-based, coordinated and culturally competent systems of care for CSHCN and their families.

In order to help assure appropriate linkages among programs supported through Title XXI (SCHIP), Title XIX (Medicaid), Title XVI (SSI), and Title V (MCH) of the Social Security Act and to help promote the development and maintenance of appropriate systems of care for CSHCN, State Child Health Insurance Plans should specifically address CSHCN, as a special targeted population. Systems that are appropriate for CSHCN are those that are in keeping with the principles and models articulated in Surgeon General Koop's Campaign '87, mandated through OBRA '89, and defined in MCHB's National Agenda for CSHCN.

CSHCN-Related Issues and Criteria for SCHIP Plan Review and Analysis

Children with chronic and disabling conditions have increased and often unique the health care services needs, and confront unique barriers in obtaining and maintaining adequate health insurance coverage to address their needs. Further, children with the most intensive health care needs, who comprise approximately 10% of the childhood population, account for about 70% of all child health care expenditures. Thus it is critical that the Title XXI (State Children's Health Insurance Program) Plans specifically address CSHCN as an distinct subpopulation, include elements and features that are specifically designed to address common issues for CSHCN and are in keeping with the principles and approaches articulated in Campaign '87. Following are CSHCN-related issues and criteria which can be used when reviewing and analyzing SCHIP plans. Specific questions, issues and criteria are provided for major sections of the Plan document.

Section 2: Description of State Approach to Child Health Coverage

In Section 2.1, the Plan is to include a description of the "the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children....currently have creditable health coverage...(and to) make a distinction between creditable coverage under public health insurance programs and public-private partnerships".

- Does the Plan include information on current health care coverage for CSHCN (as a distinct "class" of children)?
- How does the Plan define CSHCN (as a distinct "class" of children)

(See "Defining and Identifying Children with Special Health Care Needs: A Review and Analysis"[3] for a discussion of methods and materials for defining and identifying CSHCN.)

- Does the Plan make reference to health care coverage and/or health insurance provided to CSHCN through the state Title V CSHCN Program?

In Section 2.2, the Plan is to include a description of the "current state efforts to provide or obtain creditable health coverage for uncovered children".

- See Questions under Section 2.1, above
- Does the Plan include a description of strategies and mechanisms used to provide or obtain appropriate health coverage for uncovered CSHCN?
- Does the Plan address the issue of adequacy of available health coverage, in reference to the needs of CSHCN?
- Does the Plan make reference to activities of the state Title V CSHCN Program?

Section 4: Eligibility Standards and Methodology

In Section 4.1, the Plan specifies the standards to be used to determine eligibility of targeted low-income children for child health assistance under the Plan.

- Does the Plan include a "Disability Status" standard (standard 4.1.6)?
- If the Plan includes a "Disability Status" standard, what "disability" criteria are used and what is the relationship between these criteria and:
    - eligibility criteria of the state Title V CSHCN Program?
    - Definition of CSHCN adopted by MCHB?
    - Supplemental Security Income (SSI) Program definition/criteria?
    - other definitions?
    - (Also see Questions under Section 2.1, above)

In Sections 4.2.1 and 4.2.2, the Plan describes methods used to screen out children eligible for other forms of health insurance, and to assure that "children found through the screening to be eligible for...Medicaid... are enrolled"

- Does the Plan include, in this screening and referral process, methods to identify, count, and refer CSHCN to appropriate programs and services (including services and supports from the state Title V CSHCN Program)? Note: Data gathered through this screening process may be of value to state Title V CSHCN and MCH Programs, in carrying out the state Needs Assessment, as required by the MCH Block Grant Program.
- Does the Plan include, in this screening process, methods to identify children potentially eligible for the Supplemental Security Income (SSI) Program? Such screening methods must include both financial and disability criteria. In most states, SSI child beneficiaries are categorically eligible for Medicaid. Since the financial eligibility criteria for SSI are, in most states, more liberal than the financial criteria for Medicaid, children

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3 McManus (with revisions and additions by Reiss). Defining and Identifying Children with Special Health Care Needs: A Review and Analysis. Gainesville, FL. Institute for Child Health Policy, 1997. (Contact John Reiss, ICHP, 352-392-5904, ext. 224; FAX 352-392-8822; email: jgr@ichp.edu)

with disabilities, not otherwise eligible for Medicaid, may qualify as an SSI recipient.

In Section 4.4.5. the Plan describes coordination with other public and private programs providing creditable coverage for low-income children.

- Does the Plan describe coordination with the state Title V CSHCN Program, the Social Security Administration (as the administrator of the SSI Program), and other programs that provide supports to CSHCN. (See Section 4.2.1 and 4.2.2 above for a discussion of coordination around the SSI Program.)
- Does the Plan describe coordination with the state Title XIX Medicaid Program in regard to the follow-up and referral of children who lost SSI benefits as a result of the 1996 changes to SSI, but retained eligibility for Medicaid, through the SCHIP legislation. The state Medicaid Program is responsible to conduct periodic Medicaid eligibility redeterminations of such children (based on SSI income and disability criteria). If such children are redetermined to be not eligible (because of a change in income or disability status), referral should be made to the Title XXI Program.

Section 5. Outreach and Coordination

In Section 5.1. the Plan describes outreach to families.

- Does the Plan include a description of outreach strategies and mechanisms specifically designed for families with CSHCN?
- If the Plan does not include outreach specifically targeted to families with CSHCN, does the Plan include strategies and mechanisms likely to reach families with CSHCN? For example, do outreach efforts include coordination with health, education, and social service programs serving CSHCN and their families and other public and private organizations with a interest in CSHCN and their families. Such programs and organizations include parent leadership organizations (e.g. Family Voices); Parent Training and Information Centers (funded through the Department of Education); voluntary and charitable health organizations (such as United Cerebral Palsy and Shrines' Hospitals); children's hospitals and pediatric specialty clinics; Healthy Start; Head Start; health foundations and their funded projects (e.g. Robert Wood Johnson Foundation, Annie E. Casey Foundation); the American Academy of Pediatrics, including its Medical Home Project and state AAP Chapters; labor unions (such as AFL-CIO).

In Section 5.2. The Plan describes coordination of the administration of this program with other public and private health insurance programs: (Section 2102(c)(2))

- Does the Plan include a description of coordination with public and private health insurance programs that have a focus on CSHCN? Such programs includes the state Title V CSHCN Program, children's hospitals and pediatric specialty clinics, education (especially special education and early intervention), voluntary and charitable health organizations (such as United Cerebral Palsy and Shrines' Hospitals), etc.

Section 6. Coverage Requirements

In Section 6.1 the Plan describes the scope of coverage and benefits offered under the Plan including the categories under which that coverage is offered; amount, scope, and duration of each offered service as well as any corresponding limitations or exclusions.

- Does the scope of coverage and benefits include a definition of medical necessity that is appropriate for children, including children with special health care needs.
- Does the definition of medical necessity make reference to the EPSDT Program, even if the Plan does not involve an expansion of Medicaid. "The EPSDT program rests on an assumption that a service is medically necessary if needed for the 'early' diagnosis and treatment of a condition...The preventive purpose of the program necessitates that...states use a medical necessity standard that takes into account such issues as whether an intervention will prevent the onset of a condition or ameliorate a condition, not merely cure it or restore the patient's health.....(The) Massachusetts (Medicaid Program) expressly incorporates the purpose of EPSDT into its (Medicaid managed care contract) coverage rules and reserves to the agency the discretion to make medical necessity determinations. The Massachusetts contract also establishes the preventative purposes for which services must be furnished: '...comprehensive and continuous health care designed to prevent illness and disability;...early detection and prompt treatment of health problems before they become chronic or cause irreversible damage."[4]
- Family Voices endorses a definition of medical necessity that has been adopted by the state of Texas (and modified somewhat by Family Voices)[5]:
  - Medically necessary services shall be defined as services which are:
    - reasonable and necessary to prevent illness or medical conditions and provide early screening, intervention and treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity, or endanger life;
    - provided at appropriate facilities (which may include the home) and at the appropriate level of care for the treatment of a medical conditions;
    - consistent with the health care practice guidelines and standards that are issued by professionally recognized health care organizations or governmental agencies;
    - consistent with the diagnoses of the conditions; and
    - no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency.

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4 Rosenbaum, Shin, Smith et al. Negotiating the New health System: A Nationwide Study of Medicaid managed Care Contracts. Volume 2. Washington, DC: Center for health policy Research, The George Washington University. 1997.

5 Family Voices. What Should a Children's Health Insurance Program Look Like?. Algodones, NM: Family Voices, 1997. (Contact Jullie Beckett 319-356-4294; FAX 319-356-3715)

- Does the scope of coverage and benefits include services and supports that are appropriate to children with special health care needs?
  (See "Evaluating Managed Care Plans for Children with Special Health Needs: A Purchaser's Tool"[6] for detailed listing of appropriate supports and services; also see "What Should a Children's Health Insurance Program Look Like?".)

Section 7. Quality and Appropriateness of Care

In Section 7.1, the Plan describes the methods to be used to assure the quality and appropriateness of care and the qualifications of entities that will provide coverage.

- Does the SCHIP Plan specifically address the issue of the adequacy of provider network(s)?
  Provider networks differ with regard to the mix of child health professionals used. Many use a combination of pediatricians, family physicians, and nurse practitioners to deliver primary care services to children. Provider networks also vary with regard to the availability of adult versus pediatric subspecialists and the availability of general hospitals versus hospitals specializing in the care of children.
  (See "Evaluating Managed Care Plans for Children with Special Health Needs: A Purchaser's Tool" for questions to be used in gathering information about the capacity of provider networks to appropriately address the needs of CSHCN and their families.)

- Does the SCHIP Plan specifically address the issue of the appropriateness and quality of care coordination for CSHCN?
  The Plan should include, in its monitoring and quality assurance plan, strategies and mechanisms to assure that children with special health needs are identified and are provided with a level of service coordination that is in keeping with the strengths and needs of the child and family.

- Does the SCHIP Plan address the issue of monitoring the appropriateness and quality of service integration carried out by participating health plans?
  The SCHIP Plan should include, in its monitoring and quality assurance plan, strategies and mechanisms to assure that services provided through Title XXI funding are appropriately integrated with the broader array of public and private programs serving CSHCN. This include defining the extent to which the administration of the Title XXI program is coordinated with other health, education and social programs serving this population of children.

- Does the SCHIP Plan address the issue of monitoring the appropriateness of reimbursement and capitation, and mechanisms to address the issue of adverse selection?

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6 McManus et al. Evaluating Managed Care Plans for Children with Special Health Needs: A Purchaser's Tool. Columbus, OH: CSHCN Institute, The Ohio State University. (Contact John Reiss, ICHP, 352-392-5904, ext. 224; FAX 352-392-8822; email: jgr@ichp.edu or see the ICHP WWW site: http://www.ichp.edu/mchb/center/policy/index.htm)

In order to assure the long-term financial viability of the child health infrastructure, within the competitive health care market place, pediatric professionals, programs and facilities must receive an appropriate level of reimbursement. Therefore, the SCHIP Plan should include specific strategies and mechanisms to assure that various components of the CSHCN provider infrastructure receive a level of reimbursement appropriate to the level of time and effort expended, when caring for CSHCN; including strategies to address issues of adverse selection (i.e. providing appropriate supports to providers serving a disproportionate number of CSHCN)

- Does the SCHIP Plan include the issue of "family-centered care" in its monitoring and quality assurance plan?
  The SCHIP Plan should include strategies and mechanisms to assure that services provided through Title XXI funding are in keeping with the principles of family-centered care, as articulated by MCHB, family leadership organizations, and others. (For additional information on family centered care and CSHCN, contact Dr. Merle McPherson, Director, DSCHSN, MCHB, HRSA. 301-443-2350; FAX 443-1728; email: MMcPherson@hrsa.dhhs.gov. Also see the MCHB WWW site: www.os.dhhs.gov/hrsa.mchb/)

- Does the SCHIP Plan include the issue of "cultural competence" in its monitoring and quality assurance plan?
  The SCHIP Plan should include strategies and mechanisms to assure that services provided through Title XXI funding provided in a culturally appropriate fashion as articulated by MCHB, family leadership organizations, and others. (For additional information on family centered care and CSHCN, contact Dr. Merle McPherson, Director, DSCHSN, MCHB, HRSA. 301-443-2350; FAX 443-1728; email: MMcPherson@hrsa.dhhs.gov. Also see the MCHB WWW site: www.os.dhhs.gov/hrsa.mchb/))

Section 8. Cost Sharing and Payment

In Section 8.2 of the Plan describes cost-sharing requirements. Cost-sharing includes the amount (if any) of premiums, deductibles, coinsurance and other cost-sharing imposed.

- Does the benefits package include co-payment, deductible and premium provisions that take into account the special circumstances of families with children with special health care needs?
  (See "Evaluating Managed Care Plans for Children with Special Health Needs: A Purchaser's Tool" for a framework for describing and comparing cost sharing provisions; also see "What Should a Children's Health Insurance Program Look Like?" for recommended cost sharing amounts and policies.)

Section 9. Strategic Objectives and Performance Goals

In Sections 9.1 and 9.2, the Plan addresses the strategic objectives, performance goals, and performance measures the state has established for providing child health assistance to targeted low-income children under the Plan for maximizing health benefits coverage for other low-income children and children generally in the state.

- Does the SCHIP Plan reference, in its strategic objectives and goals, the provisions of the Omnibus Budget Reconciliation Act (OBRA) of 1989 (Public Law [PL] 99-272), related to the responsibilities of MCHB and state Title V Children with Special Health Care Needs (CSHCN) Programs, to:
  - provide and promote family-centered, community-based, coordinated care (including care coordination services, i.e. services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services) for children with special health care needs [CSHCN] and
  - facilitate the development of community-based systems of services for such children and their families?

- Does the SCHIP Plan reference Healthy People 2000 Goal 17.20, to:
  - increase to 50 the number of states that have service systems for children with or at risk of chronic and disabling conditions, as required by PL 101-239.

- Does the SCHIP Plan reference the performance goals and objectives of the state Title V CSHCN Program, as specified in the state's Maternal and Child Health Block Grant Program Application. MCH Block Grant Program performance goals relevant to CSHCN.
  (See attached "Title V MCH Block Grant Program CSHCN Specific Performance Measures". For additional information about the Title V MCH Block Grant Program and CSHCN-related performance measures contact Dr. Peter van Dyck, Director, Office of State and Community Health, MCHB, HRSA. 301-443-2204; FAX 480-2694; email: PvanDyck@hrsa.dhhs.gov)

Evaluating Managed Care Plans for CSHCN: A Purchaser's Tool Potential Applications

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If this document is distributed to a group of more than twenty-five individuals or organizations, please send a note describing this group to John Reiss < jgr@ichp.edu > of ICHP.__

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Introduction

"Evaluating Managed Care Plans for CSHCN: A Purchaser's Tool" is an efficient and effective mechanism for describing the capacity of health plans to serve children, with or without chronic conditions. The Purchaser's Tool is a consensus document that has been reviewed and is supported by the three most expert organizations in the area of children's health: the American Academy of Pediatrics, National Association of Children's Hospitals and Related Institutions, and Family Voices. Further, the Purchaser's Tool was developed with funding from and active participation of HHS/HRSA/Maternal and Child Health Bureau/Division of Services for Children with Special Health Needs (DSCHSN).

In my view, advancements in child health services research has been limited by the lack of a common framework for adequately describing the characteristics of health plans/health systems that are most salient to children's health. The Purchaser's Tool provides such a framework. Thus, we now have the opportunity to take a critical step in the advancement of child health services research and systems development, by assuring the implementation of the Purchaser's Tool, as a common descriptive framework.

Potential Applications of the Purchaser's Tool

In order to assure that the Purchasers Tool is used to gather and make information available on a "critical number" of health plans/health systems, I propose that:

1. All state Title XXI/Child Health Insurance Program (CHIP) plans include, as part of their application and/or periodic reports, a completed "Purchaser's Tool", describing the health plan(s) made available to children covered through CHIP. Such action could be required or requested by HHS's Health Services and Resources Administration (HRSA) and the Health Care Financing Administration (HCFA), and supported by stakeholders at the state level.

2. State Medicaid Programs submit to HCFA a completed "Purchaser's Tool" on all Medicaid managed care plans as well as on the Medicaid fee for service (FFS) system. Such action could required or requested by HHS's Health Services and

Resources Administration (HRSA) and the Health Care Financing Administration (HCFA), and supported by stakeholders at the state level.

3. Health plans participating in the Federal Employees Health Benefits Program (FEHBP) submit a completed "Purchaser's Tool" and that this detailed information be provided to federal employees. This information will enhance the capacity of federal employees to make informed decisions about the health coverage and health services that they are purchasing for their children. Such action could be required or requested by the federal Office of Personnel Management (OPM); supported by the Congressional Committees with oversight responsibility for the OPM, and supported by unions representing federal employees.

4. Health plans providing health insurance to public employees at the state, county, and municipal levels, submit a completed "Purchaser's Tool" and that this detailed information be provided to covered public employees. This information will enhance the capacity of employees to make informed decisions about the health coverage and health services that they are purchasing for their children. Such action could be required or requested by the state Office of Personnel or Insurance; and supported by legislative bodies, state Title V CSHCN Programs, unions representing public employees, family leadership organizations, and other stakeholders at the state, county, and municipal levels

5. Contractors providing care through DoD's TRICARE Program, include, as part of their application and/or periodic reports, a completed "Purchaser's Tool", describing the health plan provided to children covered under TRICARE, and that this detailed information be provided to military families. This information will enhance the capacity of military families to make informed decisions about the health coverage and health services that they are purchasing for their children. Such action would need to be required by Department of Defense (DoD), as part of its contract specifications; supported by the Congressional Committees with oversight responsibility for DoD health affairs, and supported by military families.

6. State Title V CSHCN Programs use the Purchaser's Tool as a mechanism to: 1) describe and monitor the strengths and needs of the overall system(s) of care for CSHCN in the state; and 2) provide information about the state Title V CSHCN Programs' system of care for CSHCN in form that allows comparison to other systems available to children not served through the state Title V CSHCN Program. State Title V Programs could also use of the Purchaser's Tool, as a viable framework for the upcoming Needs Assessment, which must be completed as part of the Title V MCH Block Grant Program. Such actions could be promoted by HRSA/MCHB, as part of their organizational efforts to promote the development of family-centered, community-based systems of services for all CSHCN and supported by stakeholders at the state and local levels.

7. Corporate purchasers, require that health plans, as part of the bid process, describe/define their child health benefits, provider network and quality assurance mechanisms in terms of the framework provided by the Purchaser's Tool. In this way, corporations, and parents employed in the private sector can make health insurance purchasing decision based, in part, on information provided in terms of the Purchaser's Tool framework. Because the Purchaser's Tool is descriptive, rather than proscriptive (i.e. does not mandate specific benefits or network capacity), corporations that provide health insurance under ERISA, as well as through the purchasing of health insurance, should be open to using the tool. . Such actions could be promoted by HRSA, as part of its public-private partnerships efforts, as well as by employee unions, stock holders, and other stakeholders at the state and community levels.

8. DHHS and/or other responsible federal agencies, in keeping with their responsibility to respond to President Clinton's Executive Memorandum of February 20 on the Patient's Bill of Rights, identify the Purchaser's Tool as an effective mechanism for documenting that federally supported health plans, including CHIP, FEHBP, DoD TRICARE and Medicaid, are in keeping with the recommendations of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, as these recommendations relate to children. As described below, the Purchaser's Tool specifically addresses many of Commission recommendations:

   The Purchaser's Tool addresses the issue of "information disclosure", by documenting, in an easily understood format, children's covered benefits; cost-sharing; provider network composition; procedures that govern access to specialists and emergency services; and care management information. It also gathers information regarding procedures for resolving complaints; licensure, certification, and accreditation status; and addresses the importance of comparable measures of quality and consumer satisfaction that specifically focus on children with special health needs.

   The Purchaser's Tool provides a mechanism for health plans to describe the adequacy of their pediatric provider network, by documenting the degree to which plans provide access to the comprehensive array of providers that comprise a quality pediatric network. The Tool also addresses the issue of direct access to specialists providing ongoing care.

   The Tool solicits information about issues related to the involvement of families and children in the decision making process, access to medical records, quality management, treatment effectiveness, and health education.

9. State Title V CSHCN and MCH Programs use the Purchaser's Tool as the basis for: a) self assessment of the state Program's benefits, network capacity and quality assurance mechanisms; b) communicating to state legislatures, policy makers, families and other partners about the Title V program; and c) assisting

major employers (both in the public and private sectors) to implement a self-assessment and plan to improve the child health care benefits and services available to employees.

10. Private health insurance and managed care organizations, and corporations offering ERISA plans carry out a self-assessment and describe/define their child health benefits, provider network and quality assurance mechanisms in terms of the framework provided by the Purchaser's Tool.

11. Employee union representatives use the Purchaser's Tool to gather information on the characteristics of health plans offered under union contracts; negotiate for adequate pediatric benefits, and inform bargaining unit members about the strengths and weaknesses of alternative coverage available for their children.

12. Families request that information on the capacity of health plans to provide quality care to children is provided to them in terms of the framework provided by the Purchaser's Tool.

13. Advocacy organizations and foundations with an interest in health care services and systems for children, including CSHCN, promote the use of the Purchaser's Tool as framework for child health systems research and service. Such organizations could also use the Purchaser's Tool to carry out a self-assessment and describe/define the health plan offered to their own employees in terms of the child health benefits, provider network and quality assurance mechanisms.

In my view, the Purchaser's Tool, which was developed under a grant from HRSA/MCHB/DSCSHN to the CSHCN Institute at the Ohio State University, is a valuable tool that can be used by the federal government, state Title V CSHCN Programs, family leaders, and other public and private organizations to help assure that all children, including those with special health care needs, have access to the health care that they need and deserve.

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A PURCHASER'S TOOL

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