State Health Watch

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Power shift may mean more state money for children's health care

It's a delicate dance between state and federal governments. Somebody has to take the lead, and it's almost always the fed because it carries the biggest purse. For the state, which would like a little more time on the dance floor, the last few months have been encouraging. President Bush brought in Tommy Thompson, who seems to understand the concerns of states, to head Heath and Human Services. And the sudden change in Senate leadership now tilts it toward expansion of Medicaid and children's health coverage.

Sens. Edward Kennedy (D-MA), Jay Rockefeller (D-WV), and Olympia Snow (R-ME) have seized upon a new Commonwealth Fund report that advocates extending Medicaid and the Children's Health Insurance Program (CHIP) to low-income parents in the hopes that it will get their children covered, too. The senators say they will prepare legislation that would allow more federal tax dollars to flow to the states for this kind of coverage. The senators say they hope, as a new Commonwealth Fund study indicates, that by expanding Medicaid and CHIP, more parents will be covered and they too will want to add their children to the coverage.

The Annie E. Casey Foundation in

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Medicaid spending heading up, says report

A new report from the Center on Budget and Policy Priorities in Washington, DC, says Medicaid spending increases are rising again after a four-year lull. While state and national policy-makers are concerned, co-author Jocelyn Guyer, an analyst with the center, tells *State Health Watch* it's important to recognize that the program is not out of control, but government officials should understand the underlying causes for the increases and be prepared to ensure that adequate funding remains available.

"The message is that Medicaid spending is not out of control," Ms. Guyer says. "It is not specifically a Medicaid problem, it is reflecting the general health care situation. State and federal officials need to prepare responsibly by not enacting tax cuts that would undermine their ability to cover predictable health care costs."

The report says short- and long-term factors are contributing to the increase in Medicaid spending. In the short term, a key element is the continuing use by some states of "creative financing," allowing them to recycle federal Medicaid funds into the state's general revenue fund and use the money for any purpose, even for items unrelated to health care. Such financing arrangements push up federal spending on Medicaid because they allow states to draw down additional federal funds.

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Power shift

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Baltimore has produced evidence that the past 10 years have seen an upturn in the outlook for children living in poverty. The foundation's roundup of the conditions these children live in across the 50 states — the *2001 Kids Count Data Book* — shows that times are better when it comes to major indicators such as the infant mortality rate, the child death rate, and the number of children living with parents who do not have full-time, year-round employment. Conditions were a little worse in the last decade for families with children headed by a single parent and the percentage of low birth weight babies.

The good news is a combination of circumstances, ranging from better health care policy to better medical technology.

"Child death rates are going down, and that's partly due to medical services," William O'Hare, Annie Casey Foundation demographer, tells *State Health Watch*. "The health of children seems richer there than in any other area because of state-level measures and improvements in medical technology."

In the past 10 years, according to the foundation study, seven of 10 key measures of children's well-being have improved, including the child poverty rate dropping 16.9% in 2000 from a decade high of 22.7% seven years ago. Teen births have dropped steadily, too, from 37 per 1,000 teens in 1990 to 30 per 1,000 teens in 1998. (See chart, p. 3.)

On the negative side, there are more low birth weight births and there are more children living in single-parent families.

Sitting at the top of the study's list is New Hampshire, deemed the best when it comes to the well-being of children among states. Candice Leonard, director of policy analysis for the Children's Alliance of New Hampshire in Concord, says it's great to be No. 1, but she adds her state still has plenty of problems to overcome. Those problems, she says, cut across policy disciplines and directions.

"Our rate of increase is not that great compared to other states. We're concerned about what's gotten worse, particularly when it's related to economics and poverty," Ms. Leonard tells *SHW*. "We face an education funding crisis. New Hampshire has no income tax. It relies on property taxes to fund education. . . . Because the state needs to fund education, it is taking money away from the general fund, away from social service. Health and education are all connected, in a sense."

Mississippi fared well in the study, but it also has its problems. The study shows the state ranks at the bottom for teen birth rates, but it made the most gains across the country in states fighting child poverty, jumping from No. 50 to No. 44. From 1990 to 1998, according to the study, the proportion of Mississippi's children living in poverty dropped by 26%. As for the bad showing for low birth weight babies, Jane Boykin, president of the

Changes in Key Indicators of Child Well-being

Source: The Annie E. Casey Foundation, Baltimore.

Forum on Children and Families in Jackson, MS, says state policy should redirect itself.

"We'll see a big return on any investment in prenatal care," Ms. Boykin tells *SHW*. "Our first step should be to extend coverage for pregnant women under the Mississippi Health Benefits Plan."

The plan covers pregnant women with incomes at or below 185% of the federal poverty level. Ms. Boykin recommends removing all income limits and implementing a sliding scale copayment requirement at upper income levels. The cost of prenatal care is tiny compared to what the state, meaning taxpayers, ends up paying for the care for low weight, pre-term births. Better to pay the lower bill now than to be socked with a huge one later on, as has been the practice, Ms. Boykin adds.

The state's public health and welfare chairman, Bunky Huggins, says legislators passed a bill in 2000 so that HMOs could offer care to low-income, expectant mothers. The state wants more federal dollars, he says, but the big problem is that the state needs to match the federal ante, and that is the biggest hurdle.

So despite gains in medical technology, which have contributed to the increased well-being of children in America, policy should be at the base of more improvements, according to Douglas Nelson, president of the Annie E. Casey Foundation,

"Based on the nation's experience with the baby boom of the 1950s, it's clear that this recent rise in American's under-18 population will put heavy demands on our already struggling public education, child care and family-support systems," Mr. Nelson says. "If we are going to sustain the recent progress we've seen in conditions affecting kids in the U.S., we will have to do far more to keep pace with the needs of this larger and more diverse generation of American children. . . . The first decade of this millennium will be pivotal. Our policy and investment decisions for families in the next few years will determine whether we'll build on the progress of the '90s or see important gains eroded. "

(For more detailed information on the Annie Casey Foundation study, go to www.aecf.org/kidscount/kc2001.) ■

Nurse anesthetist regulation scrapped

The Bush administration has cancelled — for at least six months — implementation of a last-minute Clinton administration approval of a regulation that would have allowed nurse anesthetists to administer anesthesia to Medicare and Medicaid patients without physician involvement. The Department of Health and Human Services (HHS) says it will introduce a proposal to:

1. allow state governors to apply for a waiver of the supervision rule provided it is consistent with state law and following consultation with the state's medical and nursing boards;
2. consider a prospective patient outcomes study to compare different anesthesia practices by state.

As has been the case throughout the lengthy debate over this proposal, anesthesiologists and nurse anesthetists argued publicly about the HHS decision and its impact on patients and health care providers.

Neil Swissman, MD, president of the American Society of Anesthesiologists in Park Ridge, IL, says physicians are "absolutely confident that when the new rule from the Bush administration takes effect, and when the scientific facts are known to the individual governors, they will do what is best for the people of their states — retain the supervision requirement for their senior citizens."

But the American Association of Nurse Anesthetists (AANA), also in Park Ridge, IL, says the department's proposals for the future support the principle of state regulation of anesthesia providers that the association has backed. Larry Hornsby, AANA president, points out that while his group has always said individual states should be allowed to decide whether to require physician supervision of certified registered nurse anesthetists based on each state's particular needs, "it should be completely unacceptable to the American public that another delay has occurred thanks to the nurse-bashing tactics of physician anesthesiologists."

On the issue of a prospective study, Mr. Hornsby says the AANA "has never been opposed to a post-supervision rule study of anesthesia care. We feel our safety record speaks for itself."

Mr. Hornsby says that 29 states currently do not require physician supervision of nurse anesthetists in their medical or nurse practice acts or board of medicine or nursing rules and regulations. If the issue becomes a matter for governors to decide, he says, "people simply will have to be on the lookout for the nurse-bashing tactics of physician groups, and dismiss them as nothing more than hurtful rhetoric. Poll after poll has shown that nurses are the most trusted health care providers. We believe governors will wisely recognize nurse anesthesia is safe anesthesia, and that removing a bureaucratic federal supervision requirement for nurse anesthetists does not mean removing the surgeon, OB/GYN, podiatrist, or dentist from the patient's care." ■

State CHIP programs vary in reproductive health services offered for adolescents

A survey conducted by the Alan Guttmacher Institute in New York City found that despite nearly comprehensive coverage of reproductive health services, state Children's Health Insurance (CHIP) programs were inconsistent in guaranteeing the information, confidentiality, and flexibility in choosing providers that the organization thinks is critical to adolescents' ability to access care.

Adam Sonfield, public policy associate at the institute, tells *State Health Watch* that when the federal government developed the CHIP program, it gave state governments flexibility to do what they wanted to do and address needs that were most important in their states.

While many states have better programs than they had before, in terms of reproductive health services for adolescents, Mr. Sonfield says, the survey found some deficiencies in the range of covered services and problems that could impede adolescents' access to covered services.

Not all states cover ECs

The report says that only 43 of 58 Medicaid-based and state-designed CHIP programs reported coverage of emergency contraception. "This is a disappointing but unsurprising finding," the survey report says in the March/April 2001 issue of *Family Planning Perspectives*:

"Despite recent publicity campaigns, emergency contraception — high-dose regimens of oral contraceptives that can prevent pregnancy if taken within 72 hours of unprotected intercourse or known or suspected contraceptive failure — is still a relatively unknown method. Some policy-makers [and even providers] confuse it with the medical abortion drug mifepristone, and others insist that it is an abortifacient because it, like other hormonal contraceptive methods, may prevent implantation of a fertilized egg in the uterus."

The report also notes that medically necessary abortion is rarely covered, but this is as expected because the federal government will not help to pay for abortion in cases other than life endangerment, rape, or incest. States choosing to pay for medically necessary abortions must do so entirely with their own funds, and few states choose to do so even under their basic Medicaid programs, let alone for adolescents under CHIP, the report adds.

> "The CHIP program was primarily designed for younger children. States could give some conscious thought to the issues that are pertinent to adolescents and adjust their programs accordingly."
>
> Adam Sonfield
>
> *Public Policy Associate*
> *Alan Guttmacher Institute*
> *New York City*

In addition to coverage gaps, Mr. Sonfield says, there are three serious problems that could adversely affect adolescents' access to covered reproductive health services:

1. Only about half the programs provided information to adolescents, even about whether contraceptive services were covered, and only 18 of the 58 programs offered information about coverage and accessing care for the full range of reproductive health services.

"Particularly because of the sensitive nature of contraceptive, STD [sexually transmitted diseases], and similar services, adolescents need to be made fully aware of the extent of their coverage and need to be given such information directly," the report says.

2. According to the study, there is a lack of protections for adolescents' confidentiality. Only 17 programs reported the maximum level of confidentiality both before and after the provision of care.

A larger number of programs required only a limited degree of confidentiality. That lack creates the potential for even accidental notification of a teenager's parents — for example, through routine insurance billing practices of sending an explanation of benefits to the home — and can delay or dissuade a teen from seeking critical, sensitive care, and put a female at risk for unintended pregnancy, STDs, and future infertility.

3. Only a small number of programs allowed access to out-of-network providers, even for contraceptive services and supplies, and much less for other reproductive health services.

"In fact, six Medicaid components did not provide enrollees the freedom to choose to obtain contraceptive services and supplies from a provider not affiliated with their managed care plan, despite a clear federal mandate that enrollees be able to do so.

"Freedom of choice was even less available under state-designated

components, as would be expected because there is no comparable federal requirement," according to the report.

"While Medicaid managed care enrollees overwhelmingly seek contraceptive services from providers within their own managed care plans, the freedom-of-choice provisions in the overall Medicaid program have been important for providing access over the years to women who, for a variety of reasons, need to obtain care elsewhere. Because of the heightened importance of confidentiality to teenagers, this option is particularly critical for enrollees in all CHIP efforts," the report says.

Results valid three years later

Mr. Sonfield says that while data collection for this study is from 1999, he believes the results remain valid because states have been focusing on solving enrollment and outreach problems rather than on the services available for adolescents.

When information isn't readily available, he says, it's hard for adolescents to know where to go for care, especially when some insurers and some providers don't cover or provide some services for various reasons.

"No one is looking to reopen CHIP, especially not just to address these concerns," he says, "and that may be a good thing because it could become very controversial. We think that states should look at what other states are doing and implement models they find that are working. Often they may be able to implement something that they just hadn't thought of. The CHIP program was primarily designed for younger children. States could give some conscious thought to the issues that are pertinent to adolescents and adjust their programs accordingly."

[Contact Mr. Sonfield at (202) 296-4012, ext. 4223.] ■

Medicaid spending

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Ms. Guyer says that although the federal government has taken steps to cap such payments, states still are coming in with plans that would make use of them. "The Clinton administration cut back on such payments but did not eliminate them. Creative financing still will be a driver for the next couple of years." The key factors influencing Medicaid spending increases are those that affect health care in general in this country — increased utilization of health services and health care inflation, including increases in the cost of prescription drugs. Ms. Guyer stresses that some factors typically blamed for spending increases, such as increased enrollment of children and parents, in reality are not a significant factor.

"Specifically, the new estimates anticipate that 6% of the increase in federal Medicaid expenditures during the current year will be attributable to the enrollment of more children [and an additional 2% due to increases in the number of adults enrolled]," the report says.

According to Ms. Guyer, it's only a coincidence that the resurgence in Medicaid spending is occurring when many states are adding additional clients. "When you look at the situation, you see that's responsible for just a tiny fraction of the overall cost." In addition, she says, there is little overall increase that is attributable to coping with mandates imposed by the federal government.

The report says that one reason for the resurgence of health care inflation in both Medicaid and the private sector is that cost-containment measures that began to be instituted in the mid-1990s are now largely in place. "Turning to managed care programs may yield savings for employers and publicly financed programs initially, but does not necessarily slow the long-term rate of expenditure growth. In addition, payment rates to health care providers and managed care firms could be held down for a certain period, but now providers and health plans are demanding higher payments to catch up after years of low payment and some financial losses."

Increases in prescription drug expenditures are cited as a major reason that Medicaid costs will continue to increase significantly, along with higher costs into the future for treating the elderly and disabled. Despite the use of creative financing in some states, which continues to artificially hold down state Medicaid spending, the center says a large number of states are now facing Medicaid budget shortfalls, with current spending higher than the amount appropriated. Many states in that position are considering implementing one or more of three responses:

1. containing costs, especially on prescription drugs or reimbursement rates for select types of service as well as efforts to reduce caseloads by scaling back eligibility or reducing outreach efforts;

2. obtaining more federal dollars by shifting some Medicaid expenditures to the state Children Health Insurance Program (SCHIP);

3. using tobacco settlement funds or other state resources.

Ms. Guyer says she is concerned about the continuing availability of sufficient funds for Medicaid "especially since much of the surplus is likely to disappear with the tax cut."

She says steps the federal government could have taken to help states enroll more children and families in the program may not be available. "It's difficult to make predictions, but we're concerned that enormous tax cuts will make things much harder."

The Center on Budget and Policy Priorities says states that were not able to spend all their initial SCHIP funds can use a little-known provision in the law to put additional funds into outreach efforts in hopes of enrolling more children. Ms. Guyer tells *SHW* that

only 12 states were able to meet the Sept. 30, 2000, deadline for using fiscal year 1998 SCHIP funds. Many of the other states said they needed considerably more time than Congress had anticipated to design and initiate their SCHIP programs and conduct outreach campaigns.

Last December, Congress passed the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) with a compromise that allowed the 12 states that met the deadline to get some reallocated funds, while the remaining 39 were allowed to keep a portion of their unspent money. Officials in many of the states that didn't spend all their money said they could have spent more if they had been allowed to use more of their SCHIP funds for outreach. As a result, BIPA created a new 10% outreach option for unspent first-year SCHIP funds, Ms. Guyer says. That option allows the 39 states allowed to retain some of their unspent funds to spend up to 10% of those funds on outreach activities and not have it count toward the 10% limit on spending for non-coverage activities.

"Thus, states need not be concerned that if they invest more of their retained funds in outreach, they will have less money for administration," the report says. "Furthermore, these states may use up to 10% of their retained funds for outreach activities even if they do not spend any other retained funds to cover children."

One concern is that states are effectively required to use up all of their retained funds before spending regular SCHIP allotments. As a result, states with substantial SCHIP costs and states with only a small amount of retained funds will likely exhaust their fiscal year 1998 retained funds quickly and have no retained funds remaining with which to take advantage of the 10% outreach option.

[Contact Ms. Guyer at (202) 408-1080.] ■

Case management strategies faltering in New York state Medicaid programs

While the private sector has embraced case management and disease management as ways to promote better health while holding down costs, New York State's Medicaid managed care plans are experiencing difficulties, according to a study by the United Hospital Fund, and the problems may affect other states' Medicaid programs.

Timothy Prinz, United Health Fund senior health policy analyst, tells *State Health Watch* that enrollment difficulties play a major role in making it difficult for plans to implement case management programs.

Making it work

"Plans have difficulty keeping patients for an extended period, and that's really what's needed for case management to work. The classic example is pregnancy," he says. "You really want to have the woman in a case management program for the entire time, but often there are gaps in coverage. It's not that plans don't want to do case management. It's that it's more difficult for them to accomplish it."

United Hospital Fund's Medicaid Managed Care Plan Survey 2000, with data from 1999, collected information on five types of case management programs:

- asthma;
- diabetes;
- HIV;
- hypertension;
- pregnancy.

Mr. Prinz says many plans also reported operating other types of programs, such as mental health, obesity, pediatrics, and preventive care.

"The most common case management programs focus on asthma treatment and pregnancy," according to the study report.

Most New York Medicaid managed care plans said they had few enrollees in their case management programs. For instance, the number of beneficiaries enrolled in asthma programs ranged from four to 1,700; for diabetes from four to 5,035.

Pregnancy and HIV program enrollment was more uniform, ranging from two to 210 and from one to 258, respectively. The report says that case management programs "are still in the early stages of program implementation, and it may take some time for them to systematically identify, enroll, and retain eligible members."

Mr. Prinz's analysis found modest variations in program frequency between New York City and the rest of the state. Results from the survey indicated that plans serving the rest of New York State generally have more extensive and diverse case management programs in place.

Patterns and needs

Some 66% of plans serving the rest of the state had diabetic programs, for example, compared with only 37% of plans in the city. Notably, the portion of plans that have implemented asthma programs for Medicaid beneficiaries in both the city and the rest of the state is high — 100% and 84%, respectively. The proportion of city-based plans with HIV programs significantly exceeds that of plans serving the rest of the state (90% to 33%), a trend that fits with disease patterns and medical needs in the state, Mr. Prinz explains.

The survey indicated that all plans except one rely on some combination of plan staff and providers to administer case management programs. Mr. Prinz says such shared responsibility

underscores the importance of facilitating a free exchange of information among patients, plans, and providers for the successful operation of case management.

He says the problem is not only getting people enrolled with managed care plans, but also keeping them enrolled with their plan.

"Patients need to stay with a plan if we're going to expect that plan to manage their care. Continuous enrollment is important, and it's not unrealistic to expect patients to stay in one plan, Mr. Prinz says. "There are problems but no insurmountable barriers. We've heard of success stories when patients have found a medical home and have gained benefit from that. But both outcomes and cost savings are difficult to see at the outset."

Who is responsible?

Mr. Prinz says there have been debates over whether the state, the city, or the plans should bear major responsibility for who should be resolving the problems that are slowing enrollment in case management.

"In some respects, part of the problem is that these are government programs that try to mimic the private sector, and in such a situation, the question of responsibility can fall through the cracks," he says. "There should be more patient education about the need to stick with one plan. The question is whether the state or the plans should be doing that education. It can be resource-intensive to fix.

"Everyone knows the value of patient education, but it's hard to know who should do it and who should finance it. Plans might be willing to do more patient education if the state realized and acknowledged that it is resource intensive and the plans need money," Mr. Prinz explains.

[Contact Mr. Prinz at (212) 494-0746.] ■

Research group ranks state medical board disciplines

North Dakota seems to discipline a lot of its doctors. Based on data obtained from the Federation of State Medical Boards (FSMB) on the number of disciplinary actions taken in 2000 against doctors, Public Citizen's Health Research Group in Washington, DC, has calculated the rate of serious disciplinary actions (revocations, surrenders, suspensions, and probation/restrictions) per 1,000 doctors in each state and compiled a national report ranking state boards by number of serious disciplinary actions taken against them.

How are they compiled

The calculation of rates of serious disciplinary actions per 1,000 doctors by state is created by taking the number of such actions and dividing it by the American Medical Association data on nonfederal physicians as of December 1999, then multiplying the result by 1,000 to get state disciplinary rates per 1,000 physicians.

Nationally, there were 2,746 serious disciplinary actions taken by state medical boards in 2000, up slightly from the 2,696 serious actions taken in 1999. However, there were more physicians practicing in 2000, and the rate per 1,000 physicians was essentially the same in the two years: 3.50 serious actions per 1,000 physicians in 1999 and 3.49 in 2000.

State rates ranged from 12.43 serious actions per 1,000 doctors (North Dakota) to 0.85 per 1,000 physicians (Idaho), a 14.6-fold difference between the best and worst states.

Public Citizen points out that if all the boards did as good a job as the lowest of the top five boards, the lowest rate for #5, Oklahoma being 6.68 serious disciplinary actions per 1,000 physicians or 0.668%, this would amount to a total of 5,255 (0.668% of 786,685 nonfederal doctors) serious actions a year. This is 1.9 times as many (2,509 more serious actions)

Grants available for people with disabilities

By September, the Department of Health and Human Services (HHS) will grant nearly $70 million to states to increase services and support to people of all ages with disabilities. The funds will help states enable people with disabilities to remain in their own homes and participate in normal community life.

The grants include $50 million in "Real Choice Systems Change Grants" to help states improve their health and long-term service delivery systems. The funds may be directed toward improvements in quality assurance mechanisms, long-term service system reform, and demonstration projects. Up to $15 million in grants and 400 Section 8 housing vouchers also will help states transition people with disabilities from institutional to community-integrated living.

Grants up to $8 million will support state efforts to improve community-based personal assistance services, programs that, for example, will provide education and training to people disabilities in managing workers, assist people with disabilities in hiring workers, and help people with disabilities establish their own businesses. ■

than the 2,746 that actually occurred in 2000.

The bottom 15 states, those with the lowest serious disciplinary rates in 2000, starting with the lowest are:

- Idaho (0.85 per 1,000 physicians);
- South Dakota (1.24);
- Hawaii (1.33);
- Delaware (1.39);
- Minnesota (1.53);
- Massachusetts (1.58);
- Illinois (1.67);
- Washington (1.78);
- Montana (1.91);
- New Mexico (2.13);
- Maryland (2.21);
- Nebraska (2.39);
- Texas (2.42);
- Kansas (2.53);
- West Virginia (2.54).

Of the 15 states with the worst disciplinary records, eight of the states, Massachusetts, Illinois, Maryland, Washington, Minnesota, Kansas, Hawaii, and Delaware also were in the bottom 15 states in 1999 and 1998. In 2000, the bottom 24 states all had rates of serious disciplinary action that were one-half or less than the rates of the top five states.

Public Citizen says these data raise serious questions about the extent to which patients in many states with poorer records of serious doctor discipline are being protected from physicians who might well be barred from practice in states with boards that are doing a better job of disciplining physicians. "It is likely that patients are being injured or killed more often in states with poor doctor disciplinary records than in states with consistent top performances," the group says.

The top 10 states, or those with the highest rate of serious disciplinary actions per 1,000 physicians are:

- North Dakota (12.43 per 1,000 physicians);
- Alaska (11.47);
- Kentucky (8.51);
- Wyoming (8.10);
- Oklahoma (6.68);
- Utah (6.27);
- Arizona (6.18);
- Ohio (5.89);
- Georgia (5.35);
- New York (5.08).

Four of these 10 states (Alaska, Oklahoma, Wyoming, and Ohio) also were in the top 10 in 1998 and 1999, and one state, Alaska, has been in the top 10 for 10 straight years. Oklahoma, 5th this year, has been in the top 10 states for nine of the last 10 years. Wyoming, 4th this year, has been in the top 10 for eight of the last 10 years, and Ohio, 8th this year, has been in the top 10 for six of the last 10 years.

Only two of the nation's 15 largest states, Ohio, and New York, are represented among those 10 states with the highest disciplinary rates. Other large states such as Michigan and California (14th and 19th respectively in 2000) have shown improvement from 40th and 37th in 1991. But other large states such as Texas, Illinois, and Massachusetts (38th, 44th, and 45th in 2000) have not disciplined much of the last 10 years. ■

Clip files / Local news from the states

This column features selected short items about state health care policy.

Deal between Florida legislature and Pfizer becomes public and then fizzles

TALLAHASSEE, FL—After secret negotiations with the nation's largest drug maker became public, state health officials backed off key provisions of a deal assuring the company of millions in future sales to Florida's Medicaid program.

Instead, Pfizer Inc. will have to abide by the same review process required of other drug companies competing to have their drugs included on a list of Medicaid-approved medications.

The negotiations evolved as the state attempts to cut Medicaid drugs costs. A bill expected to become law July 1 is intended to save the state more than $200 million by requiring drug companies to provide discounts in the form of cash rebates or other services.

The *Sun-Sentinel* of Fort Lauderdale recently revealed terms of a confidential proposed agreement with the Agency for Health Care Administration (AHCA) in which Pfizer agreed to provide certain health services instead of paying cash rebates. In return, AHCA would have assured that 23 of Pfizer's drugs were automatically on the list, called a formulary, without going through a review by a committee of medical experts.

—*Sun-Sentinel*, Fort Lauderdale, May 17

In an attempt to save money, Louisiana officials seek to limit Medicaid prescriptions

BATON ROUGE, LA—A bill that would limit the types of medications available to 736,000 of Louisiana's poor, and in turn save the state millions of dollars, passed the Senate after more than a decade of debate in the legislature.

Fueled by support from the state Medical Society and overcoming fierce opposition from a phalanx of pharmaceutical industry lobbyists from across the country, the Medicaid pharmacy measure passed 22-15 in the Senate. It now moves to the House.

Senate Bill 502 by Sen. Tom Schedler (R-Slidell) seeks to limit rapidly rising costs in the state's Medicaid pharmacy program by implementing a system used by most of

the nation's private health insurers.

Medicaid patients are currently entitled to a virtually unlimited list of medications for up to $3 per prescription.

A list devised largely by doctors and pharmacologists would dictate which types of drugs, generic and brand-name alike, would be readily available to Medicaid recipients, unless their physicians obtain prior approval from the state to use another drug.

—*Times-Picayune*, New Orleans, May 18

New life granted to Tennessee agency that controls clinics and hospitals

NASHVILLE, TN—Senators have compromised and agreed to extend for two years the life of a state agency that controls health clinics and hospitals.

Gov. Don Sundquist has wanted to put the Health Facilities Commission in a one-year wind-down, while many senators wanted to give the commission the typical four-year renewal.

''We tried to find good common ground to help improve the commission," said Sen. Bill Clabough (R-Maryville), who offered the compromise amendment. The legislation also creates an eight-member study committee. The Senate vote was 27-2 with one member abstaining.

The Health Facilities Commission was created to keep the costs of health care down by limiting excess clinic and hospital construction, as well as services and equipment purchases.

Sundquist has been dismayed by some commission decisions favorable to facilities that do not take TennCare patients. Sen. Curtis Person (R-Memphis) opposed the bill, saying Sundquist wants to reform the commission and does not think incentive will be there without more time pressure.

—*The Tennessean*, May 18

Feds say North Carolina filed claims before eligibility was determined

WASHINGTON, DC—An audit by the U.S. Department of Health and Human Services says North Carolina misused $48 million in child care payments and is recommending that the state return the money.

The audit involved federal foster care and child care grants made to the state from 1993 until 1997. Federal auditors found that state officials failed to determine whether programs were eligible to receive reimbursements before submitting claims, according to audit documents.

"Our review indicated that the state was reimbursed over $48 million for unallowable child care payments," said a letter from Michael Mangano, an acting inspector general for the federal agency.

The letter, sent to state Health and Human Services official Diann Dawson, recommended both repayment of the money and that state officials better monitor consultants who submit claims.

The audit documents also indicate that a federal review into child care reimbursements after October 1997 is continuing.

State officials called the audit process "critically flawed" and are fighting efforts to force the return of the money.

Debbie Crane, a spokeswoman for the state Department of Health and Human Services, said the dispute is largely over the interpretation of federal rules.

—*Associated Press*, May 18

Vermont considers hiking cigarette prices to help lower costs for prescription drugs

MONTPELIER, VT—A Senate committee is expected to examine whether to hike the tax on cigarettes as much as 67 cents a pack to help pay for health care programs.

Sen. Cheryl Rivers (D-Windsor), the chairwoman of the Senate Finance Committee, rolled out a proposal to amend a bill aimed at lowering high prescription drug prices with a cigarette tax.

The House had passed a bill that relied on a list restricting the drugs available to Vermonters on state-run health programs and using the savings to aid those with extremely high drug bills. But the Senate Health and Welfare Committee scaled back that plan, tossing out the cost containment and catastrophic pharmacy assistance provisions.

Rivers' tentative plan would use some of the money generated by the cigarette tax hike — about $25 million a year by some estimates — to pay for the catastrophic pharmacy plan, which would get $2 million.

—*Rutland* (VT) *Herald*, May 21

Maine officials may ask drug makers to disclose more about promo costs

AUGUSTA, ME—Hoping to put more pressure on prescription drug companies to make their prices more affordable, the Maine House has endorsed a bill requiring drug firms to disclose more about their promotional costs.

A bill that received preliminary approval by a 76-57 vote would oblige companies that manufacture or label drugs sold in Maine to submit annual reports on how much they spend marketing, advertising, and promoting their products.

Much of the information would be available to the public as a way to control costs that are said to inflate the cost of prescription medicines.

Rep. Nancy Sullivan said she and other politicians must disclose where they get campaign money and how they spend it, and "I think the pharmaceutical companies need to be held to the same standard."

"We're asking here for companies [to] put out your information, disclose it, and let public perception decide if you're spending your money wisely," the Biddeford Democrat said during a lengthy debate.

Supporters also contended that consumers who are targeted by ads ask their doctors for certain medicines even though less-expensive alternatives are available.

—*Associated Press*, May 21

Rates for health care along Mexican border take front stage for Texas state legislature

AUSTIN, TX—Lawmakers continue overhauling the state's Medicaid program with bills ranging from making it easier for children to enroll to studying rate disparities on the border.

The Texas House gave preliminary approval, 88-45, to a proposal by Rep. Norma Chavez (D-El Paso) to study whether the state pays too little for Medicaid services along the Texas-Mexico border.

"What we're trying to deal with, members, is the disparity issue," Ms. Chavez said.

Doctors practicing in the region have said they are insufficiently reimbursed when compared with physicians in other parts of the state.

Supporters say increasing reimbursement rates will encourage physicians to practice along the border, where a high number of uninsured patients are treated by few providers. Opponents say raising border rates would create a subsidy at the expense of other areas.

—*Associated Press*, May 22

Alabama told it owes millions from improper payments from the feds

WASHINGTON, DC—The Alabama Medicaid Agency should refund the federal government at least $168 million for improperly collected payments over the last four years, according to a review by the inspector general for the Health Care Financing Administration (HCFA).

Auditors concluded that state officials sidestepped their own regulations in seeking to shake loose more matching money from Washington. Between fiscal 1997 and 2000, the report states, Alabama Medicaid drew down $168.3 million in federal funds to which it was not entitled. The inspector general recommends that the state return the entire amount to HCFA.

It is not certain, however, that federal officials will adopt the recommendation. Under a best-case scenario, such a move would be likely to trigger years of legal wrangling. At worst, it could wreck the state's already wobbly finances and imperil health care for tens of thousands of Alabamians.

A HCFA spokesman said the agency was reviewing the inspector general's report and hoped to make a decision later this year. At Alabama Medicaid, which disputes owing any money, spokeswoman Mary Finch said the agency is preparing a response to the findings.

"Once we know what action, if any, HCFA is going to take, then we'll work with our state and congressional representatives," Ms. Finch said.

— *Mobile* (AL) *Register*, May 22

DOA: Tennessee legislature puts aside patients' bill of rights, for now

NASHVILLE, TN—The push to bring a patients' bill of rights to Tennessee may be dead for the year under pressure from the insurance industry.

The House Budget subcommittee voted to delay consideration until after the state budget is passed, an unusual move since the legislation does not have any costs attached and would not affect the budget.

''It probably is dead, but I'm not sure,'' said Rep. Randy Rinks (D-Savannah), House Democratic Caucus chairman and a member of the subcommittee. ''The trouble was trying to get agreement across the board with all the parties . . . the insurance industry and business groups."

The bill would allow Tennesseans who think they have been denied necessary medical care by their health insurance plans to appeal under a streamlined review process and then have the option to sue.

''It's not good news for any bill that does good for people of Tennessee to be put behind the budget," said Rep. Kim McMillan (D-Clarksville), the House sponsor.

— *The Tennessean*, May 24

Wisconsin, fighting to close gap in child care funding, passes new compromises

MADISON, WI—The Legislature's budget committee unanimously approved a measure to fund a projected $95.1 million child care subsidy shortfall in the state's welfare program, helping to close the budget gap in the process.

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The $95.1 million was part of a $761 million gap in the budget the Joint Finance Committee is trying to eliminate. By funding the shortfall through a combination of new state money, federal dollars and cuts — along with other provisions — the committee has reduced the budget gap to about $650 million.

"It probably, at least for a while, could be the largest single reduction in the bottom line that we'll see," said Rep. John Gard (R-Peshtigo). "This is a very significant step for this committee to actually balancing the budget."

Gard worked out a compromise to fund child care in the state's welfare-to-work program, W-2, with Democratic Sens. Gwendolynne Moore of Milwaukee and Kimberly Plache of Racine.

The provision includes $10 million in new state funding, about $36 million in federal funds, and almost $50 million in cuts. Mr. Gard said $8 million of the reductions come through savings in administrative costs.

—*Associated Press*, May 23

Church and state clash in Oregon over insurers and contraceptives

SALEM, OR—A House committee has made little progress on a bill that would require insurers to cover contraceptives.

At least 19 amendments to the bill have been proposed to exempt religious organizations that oppose birth control.

Debate has centered on how broad that exemption should be. Oregon Catholic Charities, which asked for the "conscience clause," wants the exemption to apply to any employer, public, or private, citing a religious objection.

Gayle Atteberry, executive director of Oregon Right to Life, said she does not want to be required to provide birth control to her employees.

Ms. Atteberry said she believes birth control methods that work by preventing implantation are equivalent to abortion because life begins at conception, not implantation.

Backers want the exemption to apply only to nonprofit organizations whose core service is religious. "Anyone could declare that they have religious tenets," said Rep. Cherryl Walker (R-Murphy).

—*Statesman Journal*, May 25