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Threats of recession and terrorism cause states to reconsider priorities

The twin threats of recession and terrorism are now very real in the minds of legislators and they have arrived at nearly the same time. Both will put strains on funding public health care as states strive to protect not only the have-nots but now the haves.

States will be squeezed by lowered revenues and will be considering cutbacks in the coming months following the Sept. 11 terrorist attack on the World Trade Center in New York City and the Pentagon in Washington, DC. An entitlement such as Medicare will likely remain unchanged, but states will consider cutting back on programs and staff. States also will find themselves the facilitators of information and services between the federal government and municipalities and cities. Plans for combating bioterrorism are in place, but they must be staffed. It will all cost money, which now must flow from Washington, DC.

But both problems are new and just beginning to loom. No one is sure how extensive the problems will be or how drastic the steps to fight them will be. Public health will not be the only state expense; funding for armed marshals is one avenue many states are considering. The money must come from somewhere, and it's not clear

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What will result from Medicaid reform? Flexibility for states or loss of protections?

The National Governors Association (NGA) is trying to get the ear of former Gov. Tommy Thompson, now secretary of Health and Human Services (HHS), to push changes to Medicaid that the nation's governors say will give them more flexibility in administering the program in their states. Some think tanks and advocates, however, say that while the changes might give the states flexibility, they also would deny beneficiaries basic protections they now enjoy and could increase the disparity in state programs.

Last January, just before the Clinton administration left office, HHS promulgated final regulations on Medicaid managed care that would have had the effect, as the NGA sees it, of "mandating redundant, excessive, and expensive layers of oversight on the interaction between state Medicaid agencies and Medicaid managed care plans." Those regulations were pulled back by the Bush administration and then were scheduled to take effect first on June 18 and then on Aug. 18. Now they are being held until Aug. 16, 2002.

The NGA says that with the delay,

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Threats

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how deeply the federal government will become involved in mandating state and local requirements.

"It will be a challenging time as state revenues are likely to come in below expectations," Jocelyn Guyer, senior policy analyst with the Kaiser Commission on Medicaid and the Uninsured in Washington, DC, tells *State Health Watch*. "It's important to look at the fact that states went into this year in relatively good fiscal shape. The silver lining is they have built up reserve funds in the late 1990s, so they can draw on that through this difficult period."

A recession leaves more people on the rolls of the uninsured, Ms. Guyer adds, and it's happening at a time when there is a general resurgence in health care inflation.

"Sometimes, what happens during tough times is an effort to scapegoat programs and Medicaid is often scapegoated," Ms. Guyer adds. "When you look at different programs, all are experiencing the same problem."

Julie Hudman, Kaiser Commission associate director, tells *State Health Watch* that she doesn't foresee any Medicaid cuts. "But CHIP [Children's Health Insurance Program] is different. It's a block grant."

Rising drug costs could play a significant role in the decision of where to make cuts at the state level, and that could lead directly to decisions made about Medicaid, says Robert Hurley, associate professor of the Department of Health Administration at Virginia Commonwealth University in Richmond. Plus, he adds, any plans to fight terrorism will bring new competition for dwindling resources. He suspects the antiterrorism battle will be paid for by a combination of state and federal money.

"The feds may have to finance it, and the states will be integral players in providing and delivering services," Mr. Hurley tells *State Health Watch*. "At the state level, it's not clear there is a sea change. Soon we'll see, after the first of the year. It's easier to spend someone else's money, and in this case, there is a strong case to be argued that life and liberty is what we have the federal government for. If they can't do it, you won't get it from localities."

The roots of state government stretch deeply into the fabric of everyday life, into places most people are not aware of. In Georgia, part of the state's antiterrorism role is played by annually inspecting every X-ray machine in the state.

It has been the state's responsibility for years, but the role is now magnified by concerns at Atlanta's Hartsfield International Airport, one of the busiest in the world. For the moment, Marty Rotter, director of the office of regulatory services for the Georgia Department of Human Resources, tells *State Health Watch* that the state is not doing anything different with its inspections than it has in the past.

Getting up to speed

But many states are looking at their public health role differently in light of the events of Sept. 11. It was not unusual for a state to have a bioterrorism plan, but it was not business as usual to test its practicalities.

"Certain states looked at this prior to Sept. 11th. Now they need to get up to speed and make sure their departments of public health can handle it," Doug Farquhar, program director for environmental health at the National Council of State Legislators in Denver, tells *State Health Watch*. "The infrastructure is in place. Now they need to be prepared to address problems, able to shift priorities."

Money will be spent to make sure that previously made plans are practical, Mr. Farquhar says.

We need help making sure strategy is in place, so the state departments of health know where their place starts and ends," he adds. "States are in the middle, not the front line, and they are not the final source. They are intermediaries in many respects."

Mr. Farquhar predicts a revisitation of state laws regarding protections of populations against disease. For instance, he says, what happens if there is an outbreak of smallpox? Health departments cannot arbitrarily cordon off an area that might be infected. The state legislature has to make such decisions, he says, and carrying out those decisions will cost money that states may not have.

"Most state legislatures are not in session. Their budgets are killing them. They're out of money, and they now have huge new initiatives," Mr. Farquhar says. "It's not like the feds. States can't create money."

The state of Indiana would love to create some money for its coffers. Instead, it must make do with what it has. "Indiana is broke. It has a $600 million deficit. There will be no raises. We will see programs cut back. There will be Draconian measures to balance the budget, and we are mandated to have a balanced budget," Margaret Joseph, director of Indiana's office of public affairs, tells *State Health Watch*.

But Indiana began work on its bioterrorism project before the troubles set in. Labs are set to test for outbreaks, and specimens do not have to be sent out of state for analysis. The state's e-mail network among local health departments is up and running. The funding for testing comes from the feds, she says, and the state funds the infrastructure.

Much of the funding comes through the Centers for Disease Control and Prevention in Atlanta. ■

TennCare says it plans to seek major design changes

When TennCare, Tennessee's innovative managed care program, submits a new federal waiver request in mid-December, it will seek significant changes to the program's design that will divide it into three parts and drop an estimated 180,000 people from coverage.

In a Sept. 29 speech to the state, Gov. Don Sundquist said, "TennCare in its present form costs more than we can afford. It has more enrollees than we can pay for, and it covers more benefits than we can support."

Although state officials have said that Tennessee would be spending $40 million a year more to cover fewer people for health care had it not created TennCare seven years ago, there have been calls for radical changes to the program that is suffering more and more from budget problems.

The waiver will seek permission to divide the program into three parts as of Jan. 1, 2003. TennCare Medicaid would be for the 820,000 residents who are eligible for Medicaid. TennCare Standard would be a traditional HMO for adults under the federal poverty level, children under 200% of the poverty level, and those that an independent underwriting firm designate as uninsurable. And TennCare Assist would be a subsidy program to help low-income families buy employer-sponsored health insurance.

The level of state funding for TennCare Standard and TennCare Assist would dictate benefit levels and the number of people who would be covered.

Insurance industry representatives had urged that the program be divided into two parts, one for beneficiaries who are categorically eligible under Medicaid and one for beneficiaries eligible through the state's expansion waiver.

Tom Wildsmith, a representative for Health Insurance Association of America in Washington, DC, testified at a legislative oversight committee hearing that the state should reduce benefits to uninsured and uninsurable TennCare beneficiaries to ensure that the program doesn't compete with private insurers.

During that hearing, state Rep. Gene Caldwell pointed out that waiver-eligible uninsured and uninsurable TennCare beneficiaries are required to pay premiums that bring additional federal matching funds to the program, and cautioned that the federal government might not provide matching funds for a redesigned TennCare program that has slashed benefits.

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>
> Tony Garr
> *Executive Director*
> *Tennessee Health Care Campaign*
> *Nashville*

Also at the hearing, TennCare Commissioner John Tighe said the number of uninsurable TennCare enrollees has jumped from 21,031 in 1994 to 163,040 this year, raising a concern that the innovative program has made it too easy for insurance companies to avoid writing coverage for sick individuals. "The 800% growth in uninsurables is a symbol of something going on," Mr. Tighe said. "We believe that TennCare has taken up 75% of the riskiest population, and the insurance companies have the remainder."

Following the governor's announcement, advocates warned that the state's health care safety net would be stretched thin and clients would be adversely affected. And an editorial in the *Memphis Commercial Appeal* said that any TennCare "cure should not add to misery." The paper said people, including the governor, appear to be using the program as a scapegoat rather than address the state's "obsolete and unfair tax structure."

The editorial said that for those who are dropped from TennCare, the "alternatives would be to do without health care or to seek expensive, uncompensated emergency department treatment. The latter option would place huge financial pressure on hospitals [privately insured patients] and the local governments [taxpayers] that support those hospitals. The lack of balance in the revamped program is troubling."

The suggestion that TennCare be divided does not sit well with Tony Garr, executive director of the Tennessee Health Care Campaign in Nashville, an advocacy group.

"The problem we're facing is a revenue problem," Mr. Garr tells *State Health Watch*. "Our state doesn't have an income tax and relies almost exclusively on a very high sales tax. Neighboring states have an income tax and thus lower sales taxes, and sales taxes that don't apply to food or clothing. Many of our people live near those other states

and can shop there. We were having problems even before the current economic slowdown, and now we're really in trouble."

TennCare simply needs more money to keep up with the cost of medical inflation and has "become a whipping boy for the state's economic problems," Mr. Garr says.

What's the problem?

Given that state officials say the state is paying less than it would have paid, even when covering more people, Mr. Garr says he sees no reason to divide the population and slash benefits for one group, especially when even proponents of the move say they don't expect it to save any money. "We believe that TennCare is not the problem. TennCare actually has delayed the necessary discussions of tax reform because it has been able to control risk in health care."

At public hearings on the proposed changes to TennCare recommended by a blue-ribbon panel, consumers expressed apprehension about the program being broken up, and providers said they could live with reduced payments if there were less administrative hassles with preapprovals and other elements in the program design, Mr. Garr says.

He adds that he'd rather see those changes pursued, instead of following the call of the insurers. "There's a bias that the private sector can take care of this better than government, but that's just not true. The state of Tennessee is our largest purchaser of health care services. We need to be the Wal-Mart of health care, insisting on the lowest possible prices. If the program is divided, the state will lose some of that bargaining power.

"Another concern is that we got a really good deal in the terms in our federal waiver, but the agency might not be as willing to give those good terms if we change the program that way. I don't know what the motives are of those who say to divide the program since they don't expect it to save any money," Mr. Garr says.

The financial analysis showing the benefit of TennCare was developed by comptroller assistant director Doug Wright, who compared Medicaid spending in 1993, the year before TennCare, with current TennCare spending.

He inflated the 1993 figure by the medical consumer price index of 33%, resulting in $921 million, and compared that figure to the state's 2001 TennCare spending, taking into account inflation and other factors, resulting in $881 million. He made the same comparison between FY 1995 spending, the first full year of TennCare, and current spending. That analysis showed current spending is about $20 million more than 1995 spending when inflated by the medical consumer price index.

Mr. Wright's analysis also indicated that in 1999, the average Medicaid spending in other southern states was $3,218 per enrollee, while Tennessee spent on average $2,611 per Medicaid enrollee on TennCare. Had the state had a traditional Medicaid program like other southern states, it would have spent $485 million more for its 800,000 enrollees, Mr. Wright claims.

Meanwhile, some hospitals, particularly in rural areas, have said that unless they receive additional funding from TennCare, they are in danger of closing and sending patients longer distances for care at larger safety-net hospitals. In 2000, the state provided $90 million to hospitals with a disproportionately high number of TennCare and charity patients, but this current state budget allocates $14 million in state funds ($40 million with the federal match). The Tennessee Hospital Association has said that many hospitals, most of them rural and psychiatric facilities, won't get the funds they need to balance their budgets. In response, TennCare spokeswoman Lola Potter says the fate of rural hospitals is not decided by the program. "TennCare may help, but we can funnel only so much money to them. Cuts in Medicare reimbursement — not inadequate TennCare funding — are responsible" for the hospitals' financial problems.

And as if there weren't enough problems, at the end of September, TennCare officials notified Access MedPlus, the largest managed care organization in TennCare, that it would be dropped from the program unless it demonstrated that its finances were in order. The threat came after Access failed to file a number of mandated financial documents. Although this would be the first time that TennCare has dropped a plan, there have been years of tension between Access and TennCare.

The best solution

Company officials have said they were underpaid $20 million last year and also had been given a disproportionate number of costly and severely ill patients. They said Access had given state officials an independent analysis showing the level of underpayments and had been in lengthy negotiations over the plan's financial status.

Mr. Garr says he thinks the best solution would be for Access to pull back from its statewide coverage and consolidate its offerings in the western part of the state, where it has its greatest strength.

He also suggested that if Access were to consolidate in the western region, that area's Methodist Hospital might be willing to develop some sort of partnership that could help save Access.

[Contact Mr. Garr at (800) 280-8682 and TennCare at (615) 532-7542.] ■

Medicaid reform

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it is interested in working with the administration on necessary changes. In its policy document, it calls on the HHS Centers for Medicare and Medicaid Services (formerly HCFA) to "acknowledge the unique role of states as funders and administrators of the Medicaid program, rather than treating states as merely one of many stakeholders."

That means, the governors say, that states need more options in running their programs, and the agency has to be more timely and responsive in working with states.

The governors say that state Medicaid director letters and "regulations that undermine state flexibility" should be reviewed to see if they are necessary and serve a constructive purpose. They also caution against continually raising the bar higher for managed care programs than for fee-for-service programs, lest states risk the loss of commercial managed care entities willing to participate in the program.

One of the most significant recommendations calls for a restructuring of the "all-or-nothing" approach to Medicaid so governors will have more flexibility in designing benefit packages for optional populations. They recommend going to three categories of coverage:

1. Core vulnerable populations (mandatory). For all populations covered under federal minimum standards, states would guarantee eligibility and the federal minimum requirements with respect to benefits. There would be no cost-sharing responsibility on mandatory benefits, although states could impose reasonable cost sharing on a sliding scale basis for optional benefits.

2. Additional core populations (state option). Many states want to go beyond the minimum guarantee established in Category 1 to guarantee eligibility and benefits for additional populations. The NGA says that states should have the option to expand these guarantees to all individuals, regardless of category, up to a certain percentage of the poverty level. For everyone in this category, states must provide a benefit package that is actuarially equivalent to the Children's Health Insurance Program (CHIP) statutory model. NGA calls for an "enhanced federal match," equivalent to the CHIP match, for all services provided to any individual in this category, anticipating that would give states an incentive to expand a guaranteed entitlement to a full benefit package. Cost sharing would be permitted consistent with the CHIP model.

3. Full flexibility expansions (state option). Either in addition to whatever expansions a state opted for in Category 2 or instead of a Category 2 expansion, states would be allowed to expand health insurance coverage to any population.

They would be allowed to expand coverage to all recipients up to a certain level of income, or target services to at-risk individuals, as defined by the state. States would have maximum flexibility in determining the level of benefits and amount of cost sharing provided to beneficiaries in this category. Because of the high degree of flexibility, states would only receive their regular federal match for all services provided.

An assessment of the implications of the NGA proposal performed by the Urban Institute's John Holahan for the Kaiser Commission on Medicaid and the Uninsured in Washington, DC, indicates that the plan "would shift a substantial share of the cost of Medicaid to the federal government, primarily due to enhanced match. States could also expand coverage substantially because of the enhanced match and spend less than they do currently. The increased flexibility sought under the proposal is unlikely to result in substantial savings."

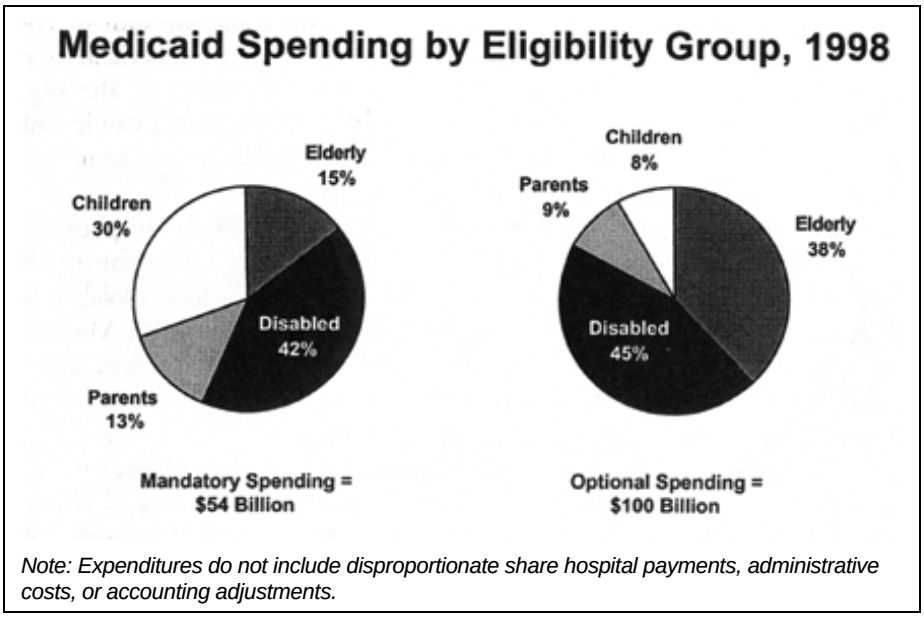
Mr. Holahan questions whether there is any justification for shifting so much spending to the federal government in the absence of any other changes in state policies, such as expanding coverage.

He says that one of the reasons that Medicaid spending grows faster than state tax revenues is the tendency of many states to rely on sales and property taxes, revenue sources that tend to grow more slowly than

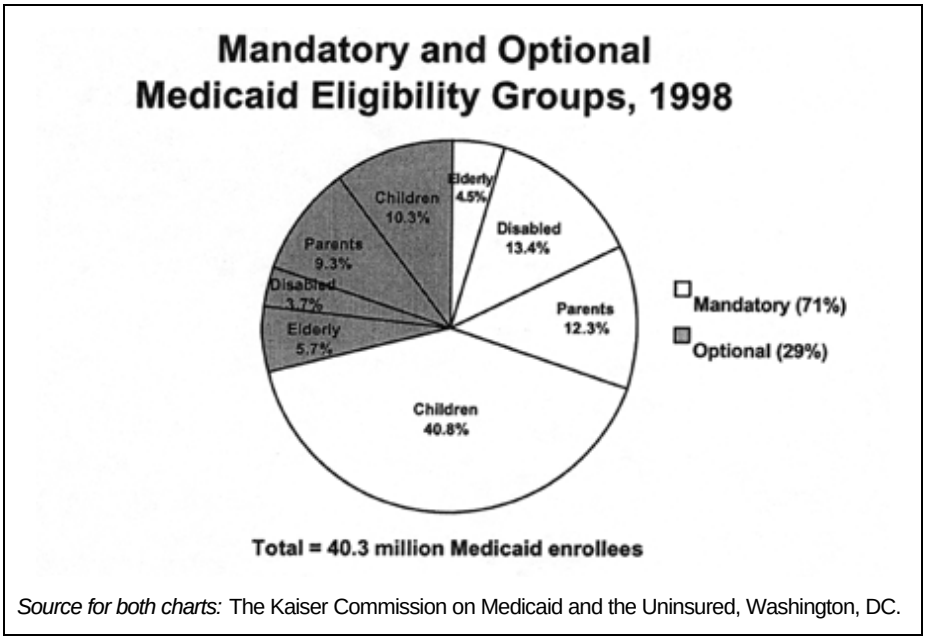
Disaster yields expedited health coverage

One of the by-products of the Sept. 11 terrorist attacks in New York City was a decision by the U.S. Department of Health and Human Services (HHS) to provide expedited health coverage for low-income New York children and adults in the Medicaid, Child Health Plus, and Family Health Plus programs.

HHS secretary Tommy Thompson said that for four months, low-income New York applicants for the programs only would have to complete a simple, one-page application attesting to their financial and other relevant circumstances. The temporary procedure replaced the normal application requirements that call for more detailed information that is also confirmed by the state. A fuller application will be taken and approved after the four-month period. In addition, under the temporary change, current beneficiaries who were due to be recertified for the programs during the four-month period will continue to receive coverage for another year without recertification. ■



Note: Expenditures do not include disproportionate share hospital payments, administrative costs, or accounting adjustments.



Source for both charts: The Kaiser Commission on Medicaid and the Uninsured, Washington, DC.

income. "Use of these revenue sources makes Medicaid a constant budget issue and contributes to chronic funding problems as well as efforts to shift spending to the federal government. Further complicating state decision making are expenditure caps in states like Colorado and Washington. While states are themselves to blame for their tax and expenditure constraints, it is health care for low-income populations that is affected."

A second implication seen in the analysis is that because state-matching requirements would be reduced by 30%, the cost of any expansion of coverage would be reduced. States could, Mr. Holahan says, substantially increase coverage with little or no new money. Under some scenarios, federal government costs could increase by nearly $40 billion.

At the same time, incentives facing states considering cutting back on benefits also would be reduced, and the possibility of cuts in coverage and benefits is a great concern to many observers about the NGA proposal, he adds.

He also raises questions about these issues:

• the poor incentives created by differential matching rates for mandatory vs. optional populations;

• the increased disparity in coverage among states;

• a benefits package such as CHIP that seems to ignore the fact that the bulk of Medicaid spending is on the disabled and individuals who are heavy users of long-term care services.

Although these are serious concerns, the analysis concludes, the proposal has raised issues that merit full consideration. It raises legitimate issues about the appropriate roles of federal and state governments in financing health care for low-income families, the disabled, and the elderly. "An argument clearly can be made supporting a greater federal financial role. The proposal would also fundamentally alter the financial incentives facing states. The changes in matching rates that states seek could also usefully increase incentives for states to expand their programs to cover more of the uninsured as well as reduce the incentives to contract coverage, benefits, and provider payments when under financial stress.

"Thus, while it is hard to envision enactment of the NGA proposal as written, it may well contribute to the debate over how to both support and extend public insurance coverage for low-income populations," Mr. Holahan says.

Significant changes

The Kaiser Commission says the NGA approach turns to Medicaid as a vehicle to potentially expand coverage to the low-income uninsured population and give states greater flexibility and enhanced federal spending for their programs. The approach also increases the ability of fiscally pressed states to reduce the scope of the benefits they offer and increase the cost-sharing requirements they impose on low-income beneficiaries.

"Thus, the NGA proposal could result in significant changes to the

current program structure, particularly with regard to services for the disabled and elderly. The proposal would eliminate many of the current protections under Medicaid and invite greater state variation in the coverage and scope of benefits available under Medicaid. While the NGA reform agenda also calls for enhanced federal matching dollars to provide incentives to maintain or improve coverage, it is unclear whether federal fiscal relief would be forthcoming, or in the way proposed by the NGA," the Kaiser Commission says.

Laurie Rubiner, vice president for program and public policy for the National Partnership for Women and Children in Washington, DC, tells *State Health Watch* that what the Bush administration sees as "cumbersome restrictions that prevent states from expanding coverage" the Partnership views as basic federal protections that should be preserved. There would be no additional money provided and no requirement that any savings that states can achieve be used for health insurance.

She raises a concern about the request to change cost-sharing provisions, nothing that Medicaid does not allow cost sharing to be more than beneficiaries can afford, but NGA would eliminate this restraint. While that change would only apply to optional categories, 66% of Medicaid spending is on optional categories or optional benefits.

An uphill battle

Ms. Rubiner says the Partnership has been talking with members of Congress about the NGA proposal but recognizes they face an "uphill battle" to try to derail it.

[Contact NGA at (202) 624-5300, Mr. Holahan at (202) 833-7200, the Kaiser Commission at (202) 347-5270, and Ms. Rubiner at (202) 986-2600.] ■

Pain management experts fear 'giant step backward' due to OxyContin controversy

Pain management specialists and advocates for chronic-pain patients say they are worried by recent attempts at the state level to restrict availability of the tablet form of the popular painkiller, oxycodone, better know by its trade name, OxyContin.

Efforts by state law enforcement officials have made it difficult for pain patients to get the needed drug, and medical professionals need to be more active in protecting legitimate access to the medication, experts warn.

"There have been reports that, even when appropriately prescribed by a licensed physician, patients are having difficulty in obtaining the medication," says Michael Ashburn, MD, MPH, president of the American Pain Society and a professor of anesthesiology at the University of Utah in Salt Lake City.

"Some pharmacies are no longer carrying the medication — due to fears of robbery — and there have been efforts by policy-makers to restrict the availability of the drug," he said.

Released by Purdue Pharma in 1996, OxyContin has become a popular pain-relief medication for cancer patients and other chronic-pain sufferers because it delivers a higher dose of oxycodone than Tylox and Percocet, and its controlled-released mechanism allows patients to take fewer tablets per day. But in recent years, law enforcement officials at the state and federal level have documented dramatic increases in the illegal diversion and abuse of the drug.[1]

Several cities nationwide have reported armed robberies targeting pharmacies that stocked the medication. Additionally, more than 120 overdose deaths have been linked to OxyContin in the United States.[2]

Across the country, different cities and states are taking drastic actions to halt the spread of OxyContin abuse. In August, Vermont Gov. Howard Dean announced that physicians would have to get state approval in order to prescribe OxyContin to patients enrolled in Medicaid and other state-funded health programs. Previously, the governor asked that physicians find alternatives to prescribing the drug and asked pharmacies to stop stocking the medication.

Other states have also removed OxyContin from their Medicaid formularies. And police in the small town of Pulaski, VA, recently announced that people who want to buy OxyContin at the town's six pharmacies will have to be fingerprinted to receive the drug.[3]

The result of these efforts is that patients who desperately need the medication are prevented from obtaining it, says Mr. Ashburn. Policy-makers need to be encouraged to reasonably regulate access to opioids like OxyContin, but efforts to essentially make the medication "illegal" need to be strongly resisted.

"Asking Medicaid not to cover the medication, and asking pharmacies not to stock it, is a particularly egregious action, I feel," he says. "It denies access to a legitimate drug for an appropriate medical use."

Physicians reluctant to prescribe

In addition to state restrictions on coverage of OxyContin and pharmacies refusing to carry the medication, some physicians are becoming very reluctant to prescribe it. Furthermore, patients are afraid to take the drug due to the increased scrutiny, says Russell K. Portenoy, MD, chairman of the department of pain medicine

and palliative care at St. Luke-Roosevelt Hospital Center in New York City.

"Although we can't really quantify this, we sense that the country has taken a step back in being able to provide effective long-term opioid therapy to appropriately selected patients with chronic pain," Mr. Portenoy says. "The intense media attention on OxyContin appears to have re-ignited a climate of fear about the prescribing, dispensing, and taking of opioid drugs."

In 1996, the American Pain Society (APS) and the American Academy of Pain Medicine (AAPM) issued a consensus statement on the appropriate use of opioids to treat chronic pain. These guidelines were endorsed at the time by the U.S. Federation of Medical Boards, which then released guidelines similar to the consensus statement, Mr. Ashburn explains.

Health policy-makers recognized that opioids had a legitimate medical use and established practice guidelines for clinicians to use, he adds. Now, although there has been no report of medical boards changing their policies, Mr. Ashburn says he's concerned that the medical community is not advocating more strongly for continued access.

Pain specialists, in particular, need to be sure that misinformation and misconceptions about OxyContin are corrected, and to ask policy makers to develop regulations that protect pain patients' access to opioids.

As an example, Mr. Ashburn cites the Vermont governor's request that physicians try to prescribe medications other than OxyContin.

"There have been patients who have fairly good pain relief with OxyContin that have not experienced relief using other opioid compounds," he says. "There are patients who report better pain relief with one compound vs. another. As a pain physician, I want access to as many options as possible to allow me a better chance to meet the patient's needs. I need more options, not less."

Who should be responsible?

Both society and health care providers have a responsibility to make sure that drugs with addictive potential are not used inappropriately, both Mr. Portenoy and Mr. Ashburn say.

"There may be an increase in vigilance to make sure that physicians are appropriately prescribing these medications, and that is not all bad," Mr. Ashburn says. "But there is a fundamental difference between appropriate vigilance and inappropriate vigilance."

The U.S. Food and Drug Administration (FDA) has formed an advisory panel to recommend what actions, if any, need to be taken to further regulate OxyContin, and Purdue Pharma, the manufacturer of OxyContin, is responding to requests to develop a new formulation of the drug that will make it more difficult for the medication to be misused.

Mr. Portenoy, a member of the FDA panel, says it is likely the panel will examine possible enhancements to the labeling of OxyContin and increasing physician education about pain management and issues of chemical dependency.

At the same time, it is still essential that the drug continue to be available to patients who need it now, says Mr. Ashburn.

"Clearly, Purdue Pharma feels that they can move forward with research to make the product less likely to be diverted — clearly, that is something I support," he says. "But such development is very expensive and takes lots of time. Even if they had a product right now that they were ready to enter into clinical trials — and I don't think they do — it is likely to still be five to seven years before that product will be available. While they are developing a new product to roll out, we still must have access to the old one."

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FL Medicaid law angers drug companies

A new Florida law that would limit Medicaid patients' access to a number of costly prescription drugs has pharmaceutical producers angry. So irate, in fact, that the Pharmaceutical Research and Manufacturers of America (PRMA) has filed suit in a U.S. District Court in Tallahassee, FL, claiming that the new law violates federal Medicaid rules and asking for a preliminary injunction against the law until a full challenge can be made. The law in question, which establishes a formulary for Medicaid drugs in an attempt to save the state $214 million in Medicaid spending, requires that physicians seek prior state authorization before prescribing more than 1,000 drugs. PRMA's attorneys say that Florida failed to appoint a committee to review and implement changes to Medicaid formularies as mandated by federal Medicaid rules. ■

Washington state negotiating settlement with Arc for disabled services in 1999 class action suit

The Arc (formerly the Association for Retarded Citizens) of Washington State in Olympia has concluded successful negotiations with Washington state officials over ways to spend $14 million for additional services for the disabled in 2003 and now is working with state officials to develop the next biennial budget request.

The negotiations arise out of the settlement of a 1999 class action suit filed by the Arc claiming that some 7,000 qualified people with developmental disabilities are entitled to Medicaid services funded by the state and federal governments. The lawsuit said the state was not providing its share of the funding. Settlement was announced over the summer.

"The Phase I negotiations to allocate the $14 million went very well," Sue Elliott, Arc executive director, tells *State Health Watch*.

She says a supplemental budget request must go to the state legislature by Dec. 1 and is hopeful that work on the biennial budget request can be finished early so that legislators will have plenty of time to consider and react to it before being asked to approve it next year.

The agreement will change the definition of covered class to all Division of Developmental Disabilities clients who are eligible for waiver services and are not receiving all the services they need with reasonable promptness, as well as those persons who may become similarly situated in the future prior to Dec. 31, 2006.

In Phase I of the settlement, the state Department of Social and Health recommended to the governor that an additional $14 million in state and federal dollars be added to the 2002 supplemental budget for FY 2003. The state is to maintain the increased services funded by the $14 million, which will be carried forward to the 2003-2005 biennium with an estimated $24 million per year.

The Arc says the emphasis in the new spending will be on implementing a choice-driven and self-directed system. Some of the funds will go to increasing the available out-of-parental-home residential options.

Although so far the Arc and the state administration have been in agreement on the terms of the settlement and uses for the funds, the legislature still will have to decide whether to fund the requests. If at any time the governor, state agency, or legislature don't support the request, the Arc can ask the court to lift a stay that has been imposed and order a prompt trial.

As part of the settlement, the state of Washington will be paying the Arc attorneys' fees of $275,440.25 and costs of $28,000.79, for a total of $303,441.04. The state also will pay additional reasonable attorney fees incurred by the Arc while the settlement agreement is pending, up to $50,000. That limit will not apply if the case has to go to trial.

Two advocacy groups have filed motions to intervene in the case, expressing concern that the class that is being certified is too large, Ms. Elliott says. "Our goal has always been to get as much money as possible for as many people as possible."

The Arc lawsuit was filed on behalf of four women who had waited several years for services. One of the four was born with significant developmental disabilities and now, according to court filings, is age 21, weighs 200 pounds, and becomes assaultive when stressed. She reportedly spends most of each day in her pajamas. For three years, the woman's parents asked the Department of Social and Health Services to place their daughter in a group home. When the suit was filed in 1999, they were still waiting for a placement.

Washington state media have reported that the settlement followed damning revelations in a state audit of how the Division of Developmental Disabilities spent $200 million annually serving disabled people who choose to live in the community rather than in a state-run institution.

The audit found that the state's oversight of services for the disabled was "so limited as to pose high risk for the individuals being served" and that the disabled were getting only 45% of the mandated services they needed.

Auditors said they found a 49-year-old mentally disabled woman living in a room in a private residential facility with rats and human feces. She had been given just two baths in four months, and although she had vomited and soiled herself, facility staff were not doing anything to help her. Agency officials said they were not surprised by the audit's findings

Correction

In the article on plan exits in the September 2001 issue of *State Health Watch*, we inadvertently misidentified the research organization that had looked into the issue. The report mentioned in the article is available from the Center for Health Care Strategies in Lawrenceville, NJ. Telephone (609) 895-8101. ■

because the department has been so underfunded that case managers have had to handle as many as 141 clients each.

The Arc's attorneys said the audit gave them additional ammunition backing their claim that people living in adult family homes need much more intensive service than they have been able to get.

The suit also promised relief to aging parents concerned that they could no longer care for their disabled adult children and unsure what will become of them. Elliott has said that increasing numbers of parents who are reaching their 60s and 70s find they no longer have the stamina to bathe, dress, feed, and entertain their adult disabled children. But the state budget has been so limited that they have been offered little relief. That can now change as a result of the settlement.

Linda Rolfe, the acting director of the Division of Developmental Disabilities, says there is a good chance the legislature will support the settlement because of the potential risks if the case went to trial. "We agree there are people out there who need support. The advantage of the settlement is that it allows us to plan for and develop these services over time," she adds.

The Arc has estimated that 9,000 of the 89,000 developmentally disabled people in the state are awaiting service and that 1,800 would initially have access to new or expanded services.

[Contact Ms. Elliott at (360) 357-5596.] ■

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Clip files / Local news from the states

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

Arizona board says state does not investigate complaints into improprieties quickly enough

PHOENIX—The state board that licenses nurses is not doing enough to investigate complaints quickly, according to a new audit.

One complaint reviewed by the Arizona Office of the Auditor General involved the death of a 17-year-old patient with a history of suicide attempts.

The audit found that the Arizona Board of Nursing took four years to hear the case against a psychiatric nurse who allegedly sent the patient back to his cell without calling a psychiatrist or taking proper precautions, resulting in the patient's death.

"Based on our audit, they are doing some things very well, but other things they need to do a better job with," said Dale Chapman, manager of the audit.

Auditors found:

- Most investigations took longer than 360 days.
- 23 complaints took more than 1,000 days.
- One investigation took 1,938 days.

"The board is working very hard at this time to shorten those investigation times," Mr. Chapman said. "We believe 180 days should be an appropriate amount of time. They have a challenge ahead of them, and they know that."

—*Arizona Republic*, Sept. 18

Washington bucks national trend as its uninsured rate is on the rise

OLYMPIA—The number of people without health insurance in Washington is on the rise while the number of uninsured nationally is declining, according to a survey by the U.S. Census Bureau.

When two-year averages were compared, the uninsured rate in Washington rose from 12.3% in 1998 and 1999 to 13.8% in 1999 and 2000. Washington was one of only eight states with growing gaps, the survey said.

Nationally, the two-year average fell from 14.7% to 14.%. Overall, the Census Bureau said, 39.3 million Americans were uninsured in 2000, down 600,000 from 1999.

The census survey of 623 Washington households contradicts the brighter findings of a much larger state survey of 6,700 households, which found that the rate of uninsured in Washington actually is declining. The survey by the state Office of Financial Management found that 8.4% of Washington residents were uninsured in 2000, compared with 9.5% in 1998.

But regardless of the apparent discrepancy, health advocates and analysts said uninsured rates could rise with the economy worsening and The Boeing Co. planning to lay off up to 30,000 workers.

—*Seattle Post-Intelligencer*, Sept. 28

Investigation into Allina and Medica comes to a dead end in Minnesota

ST. PAUL—Minnesota Attorney General Mike Hatch released his voluminous audit of Allina and Medica by saying that while he found footprints of wrongdoing, his office wouldn't be prosecuting any of it.

"We're not taking any more regulatory action on this," Hatch said after releasing his review of nearly every dime the $2.5 billion former Allina Health System — Minnesota's largest health care provider — spent over the past few years.

In releasing the report, Hatch also announced that Allina had agreed to pay the federal government $16 million. The offer, if accepted by the U.S. Justice Department, closes an investigation by the U.S. Attorney's office into alleged Medicare and Medicaid fraud. The money covers nearly $13 million in "billing errors" that Allina made, as well as fees and penalties.

—*Pioneer Press*, Sept. 25

Prices increases for flu vaccine mean fewer Ohioans will be protected in the coming year

COLUMBUS—The Ohio Department of Health (ODH) will buy fewer flu vaccines this year and tighten restrictions on who can get flu shots at local health departments because of a sharp increase in price, officials said.

The cost of one dose of vaccine has jumped from $1.85 in 1999 to $4.49 this year, said department spokesman Jay Carey. Only one vaccine manufacturer bid for the Ohio contract this year, compared with two in 2000.

"What we have is a dramatic increase in price," Mr. Carey said. "Because of this increase in cost, ODH is not able to purchase as many doses as it has in the past and as many as it would like to."

The department will restrict flu shots given by local health departments to people 65 years and older or those

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who have chronic diseases or compromised immune systems.

"There's not enough to hit younger people or people who are not ill," Mr. Carey said.

However, he said flu shots may be available to those people at doctor's offices, hospitals, and pharmacies that have their own supplies of the vaccine.

—*The Associated Press*, Sept. 28

Due to lower unemployment, more families insured last year, but that trend is coming to an end says Families USA

WASHINGTON, DC—Fewer Americans lacked health insurance last year, as a then-robust economy and government programs helped more children and poor people get coverage.

About 14% of Americans, or 38.7 million people, were without coverage during the entire year of 2000, down from 14.3 percent, or 39.3 million, in 1999, the Census Bureau reported.

With unemployment low during that period, more people were able to get insurance through their employers. And analysts said more lower-income families and kids picked up coverage through programs such as Medicaid and the Children's Health Insurance Program.

But the overall downward trend is likely to reverse this year as the economy struggles, said Ron Pollock, executive director of the consumer group Families USA.

"As the worsening economy and the repercussions of Sept. 11 result in many people losing jobs, health coverage relief becomes increasingly urgent," Mr. Pollock said.

Since the terrorist attacks, more than 100,000 layoffs have been announced in the airlines and related industries.

—*The Associated Press*, Sept. 28