State Health Watch
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The Newsletter on State Health Care Reform
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In This Issue

States struggle to balance budgets, look for creative ways to survive

States are in a tough spot. Coffers are running low, administrations are slashing spending, and they are talking about raising taxes.

It's a confluence of events and agendas that elected officials would rather avoid, but to help maintain health care for those who need it and to protect the rest of the population from the terrors of bioterrorism, states are having to do some quick thinking and fancy dancing.

In August, according to the National Association of State Budget Officers, more than half of the states were in the throes of recession or were close enough to be worried.

Since Sept. 11, it's gotten worse. On average, 15% of state spending goes to Medicaid, and at least 20 states are looking at next year fearfully, according to a recent survey by the Kaiser Commission on Medicaid and the Uninsured in Washington, DC.

The study, conducted in 20 states in October, shows the economic damage is accumulating in the past few months, with revenue growth dropping and the cost reductions mounting.

"Some states have Medicaid eligibility on the table, some are lowering their eligibilities, some have quit

See States struggle on page 2

Special-needs patients require broad care coordination, according to new study

Enrollment of increasing numbers of beneficiaries with special needs in Medicaid managed care programs is leading some states to develop broad care coordination programs to deliver both medical and psychosocial services as efficiently as possible.

In a policy brief summarizing a study conducted for the Center for Health Care Strategies, Margo Rosenbach, vice president for Mathematica Policy Research in Cambridge, MA, says comprehensive care coordination "enables people with special health care needs, especially those with chronic conditions, to navigate through complex Medicaid managed care systems. A relatively new trend, care coordination can include brokering for social support and medical services, breaking down boundaries between systems of care, assisting families with transportation and telephones — in short, whatever it takes to keep patients at home and healthy."

Ms. Rosenbach tells *State Health Watch* that some states are pursuing "overlays" in Medicaid managed care to put more emphasis on a broad coordination of care.

"Some states have broken down the boundaries between what is

*See **Special-needs patients** on page 4*

States struggle

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doing outreach," Julie Hudman, Kaiser Commission associate director, tells *State Health Watch*. "States have to balance their budgets and if Medicaid is part of that, they must look at it. States are rightfully trying to decide which way to turn."

The Kaiser Commission study points out a feature of Medicaid that state public health directors have always known and regarded warily — the federal grants are meaningless when the state cannot afford its share. The downward spiral becomes more powerful when states make their cuts because newly unemployed workers will find it harder to find coverage.

"On average for each $1 that states cut from their Medicaid general fund budgets, the total amount of spending on the program drops by $2.33 because of the even greater loss of federal Medicaid matching funds," the report states.

"In states with higher than average federal matching rates, however, the economic consequences of cutting Medicaid can be even more severe since each $1 cut in state funds causes a total of more than $3 to $4 to be withdrawn from the state's economy," the report adds.

The National Conference of State Legislatures offers a similarly grim view of the immediate future in its report on the fiscal outlook for 2002.

"The news is not good," the report states, "with only a few exceptions, state fiscal conditions have taken a dramatic downturn. Moreover, as legislative fiscal analysts look ahead, the outlook is bleak."

Highlights of the report include these findings:

- Fourteen states have implemented belt-tightening measures that include hiring freezes, cancellations of capital projects, and

Note: National Conference of State Legislatures, revenue projections provided based on information provided by 46 states and spending projections based on data by 40 states. Data gathered in Summer 2001.

Source: Kaiser Commission on Medicaid and the Uninsured, Washington, DC.

Source: National Association of State Budget Officers. Fiscal Survey of State, June 2001. Kaiser Commission on Medicaid and the Uninsured, Washington, DC.

travel restrictions.

- Seven states will convene or have convened special sessions to address budget problems. Several others are considering special sessions.
- The budget outlook for the rest of FY 2002 is worrisome for most states because fiscal conditions are expected to get worse before they get better.
- Much of the information currently available does not yet include the economic effects of the Sept. 11 terrorist attacks.

The report likens the current downturn to the rough economic waters of the early 1990s and concludes that most states are probably going to wait until their legislatures convene in 2002 to begin addressing the imbalances in their respective budgets.

GAO is watching VA's methods

Virginia has taken a controversial accounting tack by trying to funnel almost $260 million from the Medicaid program to the state coffers to offset revenues.

The federal General Accounting Office has cocked an eye at the state, saying the attempt to use waivers given by the Bush administration runs counter to what Congress wants. Virginia officials say other states have used the tactic for years, that the money is there to be taken, and the federal government has given its approval.

The National Governors Association in Washington, DC, which is very aware that many states face shortfalls of more than $1 billion, says the House economic stimulus bill would, if it is enacted, reduce state revenues by at least $5 billion annually and create in its wake huge budget cuts.

Instead it recommends that temporary increases be made in Medicaid's federal medical assistance percentage (FMAP) by 10 percentage points, the introduction of a "hold harmless" provision for states that were set to have their FMAPs held for 2002, and the approval of a one-year extension of supplement grants for the Temporary Assistance to Needy Families program.

Beefing up protection against bioterrorist attacks requires a delicate dance between the states and the federal government. Amy Smithson, director of the Chemical and Biological Nonproliferation Project at the Henry L. Stimson Center in Washington, DC, recently wrote in *The New York Times* that the federal government must realize that "all emergencies are local . . . Instead of having federal contractors hopscotch all over the country to train local people, training should be turned over to professional schools like police and fire academies and medical and nursing programs, with federal guidance, in order to ensure that preparedness remains constant."

The National Association of County and City Health Officials (NACCHO) agrees that communication between states and Washington, DC, is crucial for proper preparedness.

In its recent report on bioterrorism, *Local Centers for Public Health Preparedness: Models for Strengthening Public Health Capacity*, NACCHO looked at the public health programs in DeKalb County, GA; Denver; and Rochester, NY.

Using these departments as models, NACCHO's study concluded that strong "partnerships and communications with agencies involved in bioterrorism preparedness and emergency response efforts are important," including surveillance activities, response planning, training, tabletop exercise planning, and implementation.

A vital note

"Local, state, and federal partners each play a vital role in planning and response, and therefore linkages with these partners are essential to successful planning and response," the report states.

States have found themselves unequal in the abilities to pay for such planning and responses. Secretary of Health and Human Services Tommy Thompson told Congress on Oct. 3 that there are 42 Epidemic Intelligence Service graduates from the Centers for Disease Control and Prevention in Atlanta among the 50 states.

Mr. Thompson said he wants to make sure there is at least one per state to fight potential epidemiological episodes. ■

Maryland's losses in Medicaid and other health care funding could total $521 million

The Maryland General Assembly in Annapolis could be facing more than a half billion dollars in deficits in Medicaid and other health care programs when it begins its session in January, legislative analysts say.

The Department of Legislative Services told the House Appropriations Committee that the combined deficit from the current fiscal year and the budget that the General Assembly will vote on next year could total $521 million. The figure combines a previously announced projection of a $184 million shortfall this year with a forecast of $337 million in additional shortfalls next year. ■

Special-needs patients

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health care and what isn't. For example, having a phone installed that can be used in an emergency may mean the difference between a person being institutionalized or being able to stay at home."

If individuals are able to function better as a result of a broad concept of care coordination, Ms. Rosenbach says, that will lead to a long-term reduction in health care costs.

Care coordination programs work best with a stable patient population, she says.

Several states involved

The Mathematica report was based on interviews with officials and advocates in Colorado, Delaware, New Mexico, Oregon, and Washington. At the time of the interviews in 1999, there was no standard definition of care coordination and thus those interviewed were asked to define the term and indicate how care coordination differs from care management in their program or experience.

Ms. Rosenbach says that although the differences are presented as a dichotomy, they really exist along a continuum, with some features more or less dominant depending on program structure.

Case management programs typically rely on a medical model that focuses on a patient's health care, while care coordination programs tend to use a broader social service model to consider a patient's psychosocial context such as housing needs, income, and social supports. Case management programs tend to coordinate services internally, focusing only on covered services, while care coordination programs may coordinate a full range of medical and social support services offered within and outside a managed care plan.

Source: Mathematica Policy Research, Princeton, NJ.

As a result, care coordination programs typically arrange covered and uncovered services for patients.

For managed care organizations, coordination of noncovered services may be the most important factor differentiating care coordination from case management.

Ms. Rosenbach says that from her interviews, two particular lessons stand out for those interested in implementing a care coordination

effort. First, care coordination programs take time to develop. States need to allow enough time to work with managed care organizations, providers, and advocates before implementing Medicaid managed care for people with special health care needs.

She says it is unrealistic to expect managed care organizations to develop care coordination services at the same time they are enrolling new members.

The second important lesson learned is that care coordination can be implemented even after a state has implemented Medicaid managed care.

In Delaware, she says, the Medicaid agency introduced care coordination for children with special health care needs about four months after they were enrolled in managed care, after advocates and families had raised concerns about discontinuities in care.

While managed care organizations vary widely in their approaches to designing care coordination models, Ms. Rosenbach says she was able to identify three generic models:

1. a centralized team model, generally involving nurses and social workers, in which all care coordination staff are located at a managed care organization's central office;
2. a regionalized model in which staff are assigned to specific geographic areas;
3. a provider-based model in which staff are assigned to support specific provider groups.

Even within the three models, she says, managed care organizations have been very flexible in designing hybrid models and defining staff responsibilities.

Some managed care organizations make use of outside resources to help support their care coordination programs. **(For a checklist of items states need to consider in implementing a care coordination program, see box, p. 4.)**

Source: Mathematica Policy Research, Princeton, NJ.

Ms. Rosenbach's report says that anecdotal evidence suggests that the care coordination concept is well received within Medicaid managed care programs.

Six challenges that must be addressed are:

1. bridging confidentiality barriers experienced by managed care organizations;
2. addressing boundary issues between managed care organizations and other agencies;
3. increasing knowledge about the availability of care coordination services;
4. developing standardized tools for assessment and care planning;
5. setting appropriate rates to cover the cost of care coordination services;
6. evaluating the effectiveness of care coordination services.

Oregon's program has been very successful, according to Joan Katowich, program and policy manager in the state's Office of Medical Assistance Programs. Contracts with managed care organizations call for them to have someone on staff to handle care coordination in a combined medical and social model.

Ms. Katowich says the program developed with broad goals but without the state agency prescribing how the goals were to be met.

"We have a framework through which managed care members can be placed in the community in ways that the organizations thinks will work best," she tells *State Health Watch*. The care coordinators meet with the state agency staff several times a year to share problems and best practices.

The program was not set up to meet a specific cost-benefit goal, Ms. Katowich says, and it's not an easy

thing to define.

"We didn't want people to spend a lot of time justifying their existence." In later years of the program they have obtained a lot of anecdotal information from members indicating the success of the program, even to the point that a dying patient asked that his care coordinator be with him in the final days. There also is a lot of informal coordination that sometimes takes place for patients who are not eligible, she says.

Oregon gets creative

Managed care organizations in Oregon have taken varying approaches to the problem, with some using nurses and others using social workers.

"It's an intimate program. The coordinators are involved in solving both small and big problems. They sometimes arrange for transportation and sometimes help patients divide medications by color. They've arranged for developmentally disabled members to live at home with hospice care, Ms. Katowich says. "Their job and ours is to keep the support going."

Delaware's program for children from birth to 3 years old has been around for many years, according to Nancy Colley, manager for the Early Intervention Program.

"Integration of services depends on the need," she tells *State Health Watch.*

The program uses the services of case managers, developmental health specialists, public health case managers, developmental specialists, and the state Department of Public Instruction. Children were identified for the program based on the ICD-9 codes that qualified them for developmental services.

[Contact Ms. Rosenbach at (617) 491-8044, Ms. Katowich at (503) 945-6500, and Ms. Colley at (302) 995-8576.] ■

Recent events may slow move for new mental health emphasis

Policy advocates who had been buoyed by introduction of legislation that would put new emphasis on mental health policy are concerned that the recent terrorist attacks in the United States may distract lawmakers and others from that effort.

"There were bills sponsored by Sen. Kennedy and others that gave us hope," Henri Treadwell, program director for health and science education at the Kellogg Foundation in Battle Creek, MI, tells *State Health Watch.* "It looked as though this was an issue whose time had come and that people recognized that there were unmet needs with the uninsured and underinsured.

"We're concerned that events may overtake us and lead to ignoring the needs of those who have regular old-fashioned mental health problems in their desire to help those who have problems arising from the events of Sept. 11," he says.

Earlier this year, the Kellogg Foundation funded a study, "Forgotten Policy: An Examination of Mental Health in the U.S.," that pointed out significant gaps in mental health policy and suggested strategies for improving the current system.

Marguerite Ro, who is a professor at Columbia University in New York City, wrote the report and expresses concern with the study's conclusion.

"In an era of technological and scientific advances, most Americans who suffer from mental health and/or substance abuse disorders go untreated," she says.

"Approximately 20% of the population is affected by mental health or substance abuse disorders during any given year. Less than one-third of those affected will receive any type of treatment. Barriers to treatment include the lack of health insurance coverage, high cost of pharmaceuticals, and stigma surrounding mental illness," Ms. Ro says.

For vulnerable populations — those with low income, the uninsured, and rural and minority populations — the barriers to care are compounded by problems with transportation and childcare and a lack of culturally competent and geographically accessible care.

Ms. Ro says the strategies and recommendations arising from the study offer ways to start improving the current system so it better addresses the mental health needs of vulnerable Americans. Highlights of the strategies and recommendations include:

- Reduce stigma as a barrier to access by providing stigma awareness training for health care providers, disseminating stigma awareness literature for consumers and providers in Medicaid contracting, increasing awareness at community-based points of entry through professional associations and institutions and employers, and training culturally competent and diverse health and social service providers.
- Eliminate financial barriers to access by expanding the federal mental health parity act to require that all limitations on coverage for mental illness equal those for medical and surgical benefits and advocating for state legislation that achieves full and comprehensive parity with protections for treatment for alcohol and substance abuse.
- Address prescription drug coverage issues by requiring drug companies to base direct-to-consumer drug costs on an average of costs negotiated with insurance companies, requiring prescription drug coverage in plans regulated by state insurance commissioners, requiring

insurance companies to review and revise drug formularies routinely to ensure that newer, more effective drugs are included, and supporting prescription drug coverage for all Medicare recipients.
- Integrate services for co-occurring mental health and substance dependence disorders by coordinating funding streams to allow mental health and substance abuse treatment into integrated plans, requiring that inpatient and emergency treatment for either condition involve screening of the other along with discharge and follow-up for both conditions, and rolling out requirements and incentives for integrated mental health, general medical, and social services systems.
- Support the mental health work force by maintaining flexible use of nonphysician providers, requiring or increasing reimbursement rates for mental health services provided by mental health and primary care practitioners, standardizing mental health quality indicators across provider types, and supporting continuing education programs for primary care professionals in delivery of mental health care.
- Target the needs of vulnerable populations by requiring cultural competence for Medicaid participation, requiring managed care entities to contract with primary care physicians to provide mental health services in rural areas, supporting research into alternative delivery options in rural areas, expanding use of telemedicine and e-health, and convening a broad-based task force to study the needs of those with serious mental disabilities.
- Enhance school-based health and mental health services by training teachers to identify and respond to individuals with mental illness, maximizing use of available Medicaid funds for outreach, enrollment, and preventive services, and finding better ways for case management and reduction of administrative inefficiencies.
- Support school-based violence prevention programs by increasing availability of mental health services in schools and developing standards and mechanisms for schools to integrate violence prevention interventions into the curriculum.
- Address the needs of foster children by convening a task force to examine the special needs of those in foster care and developing state guidelines on the process and regulations for providing children in foster care with adequate general and mental health care.
- Expand insurance coverage for adults with mental disabilities through expanding Medicaid coverage.
- Address housing needs of adults with mental illness by supporting independent living arrangements and providing incentives for neighborhoods to accept supervised living arrangements.
- Tackle employment needs of adults with mental disabilities by providing incentives for vocational rehabilitation programs to address needs of adults with severe mental illness and providing supported employment, transitional employment, and psychosocial rehabilitation programs for people with mental illnesses.
- Address issues involving criminalization of adults with mental illness through supporting applied violence risk assessment research for use in law enforcement and community settings, enhancing referral and follow-up mechanisms from the criminal justice system to the mental health and substance abuse systems, and using diversion programs to channel individuals with mental illness into treatment, rather than jail.
- Promote mental health among the elderly by encouraging screening for depression in primary care, monitoring referrals and outcomes as a quality assurance process and requiring training in primary care clinician curriculums and continuing education for the recognition, diagnosis, and treatment of mental disorders in the elderly.
- Address deficiencies in nursing homes by providing incentives for development of innovative programs that increase coordination of care and geographic access to services and minimize cost, training nursing home providers to identify symptoms of mental disorders and make referrals to mental health providers, and developing quality assurance guidelines on mental health for nursing home facilities.

New funding will be needed

Ms. Ro says that many of the strategies would require new funds. "Yet it is clear that ignoring mental health problems is costly to individuals and to society. Many of these recommendations require the acknowledgment of mental health and a system of accountability toward insuring quality mental health services. Mental health impacts more than biological health; it is a component to social functioning and productivity. As such, the impact of mental health on education, employment, and well-being cannot be ignored."

Mr. Treadwell tells *State Health Watch* the question of linkage between mental health and substance abuse is a key issue. "We need to figure out how to give counseling that gives hope and doesn't get people into a self-destructive cycle."

Despite the terrorist attacks, he says, "We are reaffirmed in our direction and committed to pushing the needs of everyday Americans."

[Contact Mr. Treadwell at (616) 968-1611 and Ms. Ro at (212) 305-7185.] ■

Transportation gaps affect health care access

While governments and advocates work on eliminating health care access barriers such as complicated forms and lack of outreach, a study by the Children's Health Fund in Washington, DC, indicates that a major barrier still has not been addressed — transportation gaps.

"In spite of the significant progress made in enrollment, millions of children face substantial barriers to health care that defy broad-based insurance approaches," says a Children's Health Fund report.

"Specifically, insufficient transportation infrastructure and inadequate public transportation services have emerged as critical factors and determinants of child health access in medically underserved communities. Transportation, as a barrier to child health access, is a critical item of unfinished business in the Children Health Fund's campaign to secure affordable, comprehensive pediatric care for all children."

Dennis Johnson, vice president for external affairs at the Children's Health Fund, tells *State Health Watch* that a 1998 National Child Health Caravan from New York to Mississippi and Arkansas found that in all sites visited along the way, lack of adequate transportation resources was given as the single greatest reason why children were not getting the pediatric care they needed on a timely basis.

Unreliable transportation

In poor urban areas, the organization's report says, public transportation often is unreliable, inconvenient, and underfunded. And in many rural areas, public transportation is nonexistent or severely limited in scope. "For millions of children, health insurance does not automatically mean access to health care. Barriers such as inadequate or nonexistent transportation prohibit these children from receiving the health care they desperately need."

Mr. Johnson says that a March 2001 national survey on children's health access and transportation conducted by Zogby International for the Children's Health Fund confirmed the findings from the caravan and reinforced the necessity of developing a national strategy to address transportation as a hidden barrier to health care.

The survey found:

1. Between 3 million and 4 million children in American families with income up to $50,000 are unable to access routine medical care because of a lack of transportation resources.
2. For children in families with income at or below the poverty level, 21% miss routine doctor visits because of transportation problems.
3. Sixteen percent of Medicaid families miss at least one pediatric appointment because of a lack of transportation.
4. Nearly half of the families responding to the survey did not have any transportation available to access medical facilities, with the percentage increasing to 75% in rural areas.
5. Sixty percent of families with children enrolled in Medicaid were unaware that federal guidelines requires states to ensure necessary transportation for recipients to and from health care providers.
6. Nearly one-third of families lived more than 10 miles from their physician, neighborhood clinic, or hospital, with more than 7% living between 25 miles and 50 miles from their nearest health care provider.
7. One-fifth of respondents did not believe there was an adequate supply of physicians in their area.

Fund officials say there is a need for federal designation of areas that lack an adequate transportation infrastructure and thus are unable to support access to health services.

They say the designation, similar to that for health professional shortage areas, should be created for areas that lack transportation resources and are unable to support access to health services.

Congressional hearings needed

A General Accounting Office (GAO) study could determine the scope and causes of transportation inadequacies and recommend strategies to overcome the barriers. The officials say there should be congressional hearings following the GAO study.

Clearly, funding will be a major issue in resolving the problem. The Children's Health Fund says resources must be made available to support development of health care transportation infrastructure in areas where a lack of transportation presents a barrier to health care access for children.

Resources also should be made available, the report says, to designated medical transportation shortage areas to develop transportation strategies and coordinate available transportation resources.

Also, public/private partnerships should be encouraged to pilot and support innovative child health programs that are designed to meet the challenge of transportation barriers.

The report calls for greater efforts to educate and inform Medicaid-eligible families and their health care providers about the availability of nonemergency medical transportation assistance.

Best practices in contracting for transportation assistance services should be followed to maximize transportation resources and efficiency. For example, the report says, transportation needs should be coordinated with TANF Workfare transportation initiatives. In addition, all states should be strongly encouraged to include transportation services as part of their State Children's Health Insurance Program (SCHIP) benefits package.

The Children's Health Fund says that initiatives and incentives must be expanded to ensure that pediatric and primary care resources are appropriately distributed, and that physicians and other health care providers are sufficiently available to provide care in underserved rural and urban areas.

The maldistribution of health care resources disproportionately affects rural communities and the urban poor, who also are more likely to have inadequate access to transportation. Efforts should be made to ensure that adequate support is given to community health centers and other local providers of health care.

Follow-up appointments missed

The Zogby study found that as a result of transportation problems, children with manageable, chronic medical conditions get sick more often and children who need critical follow-up care after surgery or a major illness can't get it. Asthma was the most frequently cited chronic child health condition, according to the survey. Fund officials say they also have seen instances in which obtaining chemotherapy has been a problem for children without access to transportation.

"While enormous state resources have been channeled into state-based initiatives to successfully enroll children in SCHIP and Medicaid, millions of children face other barriers — like transportation access — that compromise the value of being insured," explains Irwin Redlener, MD, founder and president of the Children's Health Fund.

"For as many as 4 million children, health insurance does not mean access to health care because they literally can't get to the doctor. This is not about health insurance. It's about the hard-core realities for families who want to do the right thing for their children, but are stymied by the lack of affordable, reliable transportation."

Mr. Johnson tells *State Health Watch* the Children's Health Fund has been very active in advocating for transportation reform. Transportation is a cornerstone of the Fund's Kids First/Kids Now campaign.

"There are a number of areas for remedies," he says. "We believe the federal government certainly has a role to play. We need to get more resources to communities that need support. We'd like to see a federal-state-private partnership whenever possible."

Mr. Johnson says transportation will be one of the important issues discussed at child health summits the Fund is planning at which policymakers, legislative staff, and advocates will discuss how best to proceed on key child health issues.

He says interest in the problem has been expressed by other groups such as the Community Transportation Association of America and the American Academy of Pediatrics.

"It's hard to deal with the nonfiscal barriers to care," Mr. Johnson explains. "Everyone recognizes the importance of insurance. We need to pay as much attention to the nonfiscal barriers."

[Contact Mr. Johnson and Mr. Redlener at (212) 535-9400.] ■

States paid too much for prescriptions

According to a new report from the Department of Health and Human Services (HHS) Office of Inspector General (OIG), under their Medicaid programs, states paid more than $1 billion more than they should have for prescription drugs in 1999 alone.

How did this happen? According to the report, states receive a discount of 10% off the average wholesale price on prescription medications; pharmacies, however, regularly receive discounts of up to 20%. The report notes that in 1999, states received an average discount of 10.13%, which compared with a nationwide discount of 21.84% paid by pharmacies. (Pricing information was gathered from 216 pharmacies in eight states.) The disparity, the report says, adds up to as much as $1.08 billion in lost savings on the 200 brand name drugs with the greatest amount of Medicaid reimbursement in 1999.

In its review, the OIG did not examine ingredient acquisition costs nor did it look at other areas such as medication dispensing because states generally pay retail pharmacies for these services separately than they do for the medications.

The report also calls on the Centers for Medicare and Medicaid Services (CMS) to require states to "bring pharmacy drug reimbursement more in line with the actual acquisition cost of brand name drugs."

CMS "agreed that an accurate acquisition cost should be used to determine drug reimbursement and will encourage states to review their estimates of acquisition costs in light of our findings." ■

Clip files / Local news from the states

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

Maine officials take steps to retain nursing force

AUGUSTA, ME—Maine's shortage of nurses, technicians, and other health care workers is approaching crisis proportions, according to a new study that recommends spending $4 million a year on education to ease the problem.

The report calls for expanding health care training at Maine colleges and universities and free tuition for graduates who agree to stay and work in Maine.

"This issue represents a great risk to Maine people and the economy" unless the state takes bold steps to beef up health care education, said Senate President Michael Michaud (D-East Millinocket), who co-chaired the Committee to Address the Health Care Skilled Worker Shortage.

The panel found that working conditions, including long hours, have made it hard to attract and retain workers.

—*Portland* (ME) *Press Herald*, Oct. 18

In a multistate buying program, a drug-purchasing group thrives

CHARLESTON, WV—Six states have signed on with West Virginia to create a multistate drug purchasing pool, says Tom Susman, director of Public Employees Insurance Agency (PEIA).

With 1.4 million insurees and $852 million in pharmaceutical claims in the 2001 budget year, the multistate drug purchasing program will have eight times the buying power of PEIA, he said.

"We will move our market share," he said.

By pooling the buying power of 10 public employee health insurance plans in the six states, the program should be able to get lower prices by buying from drug manufacturers in bulk, Susman said.

He also hopes that the multistate program will attract a pharmacy benefits manager that will be reimbursed at a fixed rate, not on a percentage of the drug costs.

"Currently, as we get sicker, they get wealthier," he said of percentage reimbursements for pharmaceutical claims processors.

PEIA will issue a request for proposals today for a pharmacy benefits manager for the new program, with a Dec. 10 deadline for firms to submit bids.

The goal is to award the contract in March and to initiate the purchasing pool July 1.

—*Charleston* (WV) *Gazette*, Oct. 18

New leader: Changes made in Kentucky's Medicaid program

FRANKFORT, KY—State Medicaid officials are moving ahead with changes expected to significantly reduce spending on prescription drugs in Medicaid, and they plan to bring on a new leader for the $3 billion program that serves the poor.

Health Services Cabinet Secretary Marcia Morgan told a legislative committee that Mike Robinson, director of administrative services in the Governor's Office for Technology, will become Kentucky's new Medicaid commissioner. Morgan said Gov. Paul Patton is expected to make an official announcement before Nov. 1, when Robinson takes over.

This issue of *State Health Watch* brings you news from these states:

Robinson, 54, who has 18 years of state government experience in areas including finance, replaces Dennis Boyd, who was booted from the job after holding it for three years. Boyd was asked to resign in March in a move spurred by multimillion-dollar deficits in Medicaid and an intensified effort to overhaul the program.

Robinson, who did not want to comment until the announcement becomes official, steps in as the state prepares to have new restrictions — by Dec. 1 — on prescription drugs in Medicaid, the federal-state health program that serves 600,000 poor and disabled Kentuckians.

—*Lexington Herald-Leader*, Oct. 18

Thirty-two states are now signed up for cancer Medicaid extensions

WASHINGTON, DC—HHS Secretary Tommy Thompson has approved 13 new state requests to extend Medicaid benefits to uninsured women who are diagnosed with breast or cervical cancer through a federal screening program.

Alaska, Arizona, Arkansas, California, Connecticut, Florida, Kansas, Hawaii, Nebraska, Maine, Michigan, Vermont, and Wyoming are the latest of 32 states to take advantage of the 2000 Breast and Cervical Cancer Prevention and Treatment Act. The federal law allowed states to expand Medicaid benefits to women who are diagnosed with breast or cervical cancer through the National Breast and Cervical Cancer Early Detection Program run by the federal Centers for Disease Control and Prevention.

—American Hospital Association, Oct. 22

Mississippi cautious about confusing flu symptoms with anthrax attacks

JACKSON, MS—Mississippi health officials expect heightened public interest in receiving flu shots this season because of the similarity in early symptoms between flu and anthrax.

"It's not expected to be any more virulent or severe than in previous years," William Bell, MD, a physician at the Barnes Crossing Medical Clinic Urgent Care Center, said of this year's expected flu strains.

"But people are going to be a lot more concerned with the early symptoms," Mr. Bell said. "Recently, with the West Nile virus, we had several calls about that."

The early symptoms of anthrax infection are similar to those of the flu, including fever, fatigue, and respiratory problems.

"All viral infections start out with symptoms similar to the flu," said Mary Currier, MD, state epidemiologist with the Mississippi State Department of Health in Jackson.

"This really is going to be difficult," Currier said, if the public starts associating those early symptoms with possible anthrax exposure. "We always have an increase in flulike symptoms this time of the year."

The state has ordered 110,000 doses of flu vaccine and began offering the shots last week at all of its county health offices. The cost of the vaccine is $10.

—*The Associated Press*, Oct. 22

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Doctors on the lookout in Nevada for clusters of new, strange diseases

LAS VEGAS—Nevada doctors are on alert to spot and immediately report unexplainable symptoms of disease, such as the sudden onset of severe pneumonia, coughing up blood, turning blue, and fluid-filled lungs.

Alerted to the potential for a biological attack in the United States, doctors nationwide are quickly learning how to detect symptoms of six diseases in particular. These are botulism, plague, smallpox, tularemia, anthrax, and viral hemorrhagic fevers, primarily Ebola.

These six diseases are the most feared by both doctors and government officials because of their high fatality rates.

The Centers for Disease Control and Prevention warned doctors nationwide to be on the lookout for unusual illnesses that may be caused by the release of a biological weapon designed to spread any of the six diseases.

Nevada doctors are looking for clusters of disease, strange disease patterns, or the sudden onset of disease in otherwise healthy people, said Dr. Dale Carrison, director of University Medical Center's emergency department.

—*Las Vegas Review Journal*, Oct. 19

Shortfalls in Maryland may mean cutbacks in Medicaid services

ANNAPOLIS, MD—As tax revenue continues to decline, fiscal analysts say Maryland is facing more than a $500 million shortfall in paying for Medicaid and other health care costs.

When lawmakers return to Annapolis in January, they will face the daunting task of trying to cover increasing health care costs not only in the next budget they prepare but also in the current year's budget — work they supposedly completed during the last General Assembly session. The shortfalls could mean cuts in services for recipients of Medicaid, the health care program for the poor.

The shortfalls come only a week after Gov. Parris N. Glendening (D) announced $205 million in cuts to the $21 billion state budget because of weakening tax revenue. He instituted a state hiring freeze, canceled capital budget programs, and ordered state agencies to cut spending by 1.5%.

—*Washington Post*, Oct. 24

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