New inside: *Bioterrorism Watch*

State Health Watch

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In This Issue

Budget shortfalls spread as states cope with tax troubles, recession

It wasn't that long ago when states exerted lots of economic power in determining the path of their health care coverage. It didn't take long for that to change. Sept. 11 is only part of the story.

Tax cuts, dramatic price hikes in Medicaid in the cost of prescription drugs, provider payment rates have risen after years of being fairly flat, and many states' financing strategies to bring in more federal aid have combined to bring states to their knees.

The first place many are looking toward is Washington, DC. This is a large group of states, not just a handful.

"Is there a state that's not hit hard?" Michael Collins, director of consulting for the government section of Medstat in Ann Arbor, MI, tells *State Health Watch*. "I'm hard pressed to come up with one. The budget problem is a function of its success. States set out to expand coverage, Medicaid or CHIP [the Children's Health Insurance Program], and have been successful. Now they are having trouble paying. This is going to be troublesome when the legislative season starts in earnest."

This year, 35 states are predicting budget shortfalls. Cuts in services and/or tax increases are among their options and more than 30 states are

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Health insurance coverage for adults: Tax credits or public program expansion?

With public policy in place to expand the numbers of children who have health insurance coverage through Medicaid or the state Children's Health Insurance Program (CHIP), policymakers have been turning their attention to the problem of uninsured adults.

Two recent studies have looked at two approaches to providing health insurance coverage for more adults: tax credits to individuals or expansion of public programs such as enrolling parents through CHIP.

A report from the Washington, DC, Urban Institute — "Workers Without Health Insurance: Who Are They and How Can Policy Reach Them?" — gives more details about the demographic profile of the uninsured than earlier studies, and makes the case for individual tax credits. And a paper from Washington, DC-based Kaiser Commission on Medicaid and the Uninsured looks at "Covering Parents Through Medicaid and CHIP: Potential Benefits to Low-Income Parents and Children."

The Urban Institute research on uninsured adults found that some 26% work in retail, 10% work in construction, and 10% work in business and repair services. These

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Shortfalls

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thinking about one or the other in order to pay their bills. According to the Urban Institute, in Washington, DC, six states — Connecticut, Delaware, Illinois, Kansas, Kentucky, and Maine — have no reserves to meet their welfare payments.

"California is the hardest hit if not the worse because during the '90s a tremendous portion of the state's budget was funded through capital gains taxes, the technology boom. Now it's got an energy crisis, a tech bust, a recession, and a general recession nationally, all at one time. They have a multibillion-dollar deficit," Mr. Collins adds. "The government is giving orders to cut its budget by 15%."

California and Washington, DC, are having a battle royal of wills and budgets. Bush administration officials say California will have to take a $17 million hit from federal cuts in Medicaid and Medicare payments. Next fall is round one: a $400 million reduction from DC to California regarding Medicaid. Those eligible in the Golden State for Medicaid rose by 700,000 in 2002, so state health officials are saying the dollars should be going up, not coming down.

California's per-capita income is partly to blame. Federal officials saw how the state's income was going up and determined that California would need less help in the future.

There is a lot of dependence on the California state government by its residence, Mr. Collins says. "That's a structural issue," he says. "Besides Sept. 11th, I think their problem was coming anyway."

Part of that structural problem is the structure of California's population. It has 12% of the U.S. population, and 14% of the nation's poverty stricken live there, but the state only gets 11% of national Medicaid dollars because of the high incomes the rest of the state's population brings in.

According to the Kaiser Foundation on Medicaid and the Uninsured in Washington, DC, states have a long list of questions they must ask themselves. They include:

- Will states be able to find ways to contain Medicaid cost growth within what is affordable?
- Will the new fiscal realities cause states to re-think recent expansions of Medicaid and CHIP coverage, or will there be a slowdown or reversal of this policy direction?
- Will states continue to use Medicaid as a vehicle to finance health coverage for low-income uninsured workers, and to assure coverage for the low-income families and children, the elderly and disabled populations served by the program?
- How will the safety net be affected and will budget constraints at the state and federal levels force communities to face additional challenges?
- Will states take action to shore up state revenues in order to preserve Medicaid and other state programs?

There are 50 states pondering at least 50 ways to deal with these problems right now. Cuts are the focus.

"Some of the biggest items are optional services, like prescription drug services," Julie Hudman, Kaiser Commission associate director, tells *State Health Watch*. "They can put a limit on the number of drugs [someone can receive] per month. They can raise the formulary."

There are obstacles to that tactic. In Michigan, a pharmaceutical trade group has filed a suit over Medicaid changes that would make 350,000 of the state's Medicaid fee-for-service patients get the state's prior approval for certain prescriptions.

The suit, filed by the Pharmaceutical Research and Manufacturers of America, maintains that doctors would have to receive permission from the state before prescribing medicine that does not generate extra savings beyond those required by federal Medicaid law.

The cost of prescriptions has risen 98% for Medicaid fee-for-service patients in the last two years.

The National Governors Association (NGA) has a plan it has proposed to the federal government regarding Medicaid. Member governors say they have watched their revenues plunge and Medicaid costs soar, but Medicaid is set to decrease in 29 states in the current fiscal year. Toss in costly health care preparations related to Sept. 11, they say, and the result is a $15 billion shortfall.

"Texas did some really funky things with its Medicaid budget in recent years. It has a two-year budget. To save money, it opted to pay providers for 23 of the 24 months and to spill over to the next year to free up spending money. But [the state has] to pay for it."

Jocelyn Guyer
Senior Policy Analyst
Kaiser Commission on Medicaid and the Uninsured
Washington, DC

NGA recommends a temporary increase in the federal share of the Medicaid program — federal medical assistance percentage — to give what they call "an immediate boost to the economy."

NGA says it sees much higher numbers of workers entering the rolls

of the unemployed in coming months and cites a recent study by the Urban Institute, that estimates Medicaid recipients could increase by 800,000 adults, 2 million children, and 260,000 disabled persons if unemployment rises to 6.5%.

"If the economy does not turn around quickly, it is possible for unemployment to reach as high as 7% or 8% as a worst-case scenario," says Raymond C. Scheppach, executive director of the NGA. "Regardless of where the unemployment numbers bottom out, previously employed individuals will be coming back on the Medicaid rolls because they will lose their jobs and their health care benefits."

Other studies are just as bleak. Jocelyn Guyer, senior policy analyst with the Kaiser Commission on Medicaid and the Uninsured, says that a recent survey of the budgets in North Carolina, Indiana, Idaho, Missouri, and Texas show how previous decisions are now giving those states fits. Idaho, for instance, cut back on taxes and is now paying the price, she explains.

"Texas did some really funky things with its Medicaid budget in recent years," Ms. Guyer says. "It has a two-year budget. To save money, it opted to pay providers for 23 of the 24 months and to spill over to the next year to free up spending money. But [the state has] to pay for it. It's just delaying payments to providers."

North Carolina also cut taxes and is struggling, Ms. Guyer says, while at the same time it is trying to not cut back on Medicaid eligibility.

"The Sept. 11th outcomes vary by states," she adds. "State budget officials say it has accelerated the downturn, but they are saying it's not the reason for budget problems. They have concrete spending for bioterrorism; for instance, in New York, the budget officer said they will have a surplus of CHIP funding, but they have gone from being healthy to not having enough to maintain." ■

Nontraditional community organizations help states increase CHIP enrollment

As the state Children's Health Insurance Program (CHIP) matures, outreach to the eligible uninsured encouraging them to enroll is increasingly important as states turn to local communities for help.

In its latest site visits to 12 nationally representative communities, the Center for Studying Health System Change in Washington, DC, found many organizations not traditionally involved in public health insurance activities, such as schools, employers, and religious and community groups, taking an important outreach role.

"[Local outreach] is a good way to identify those who are eligible and encourage and help them to apply. It's interesting to see the wide array of organizations and groups that put a high value on enrolling kids in the program."

Laurie Felland
Lead Author
Center for Studying Health System Change
Washington, DC

Center health research analyst Laurie Felland, lead author on the Center's CHIP outreach report, tells *State Health Watch* that local outreach "is a good way to identify those who are eligible and encourage and help them to apply. It's interesting to see the wide array of organizations and groups that put a high value on enrolling kids in the program."

Although there were approximately 2.7 million children enrolled in CHIP in December 2000, there are indications that more than 2 million more children are eligible but are not enrolled.

Urban Institute studies have reported that lack of information, confusion about eligibility requirements, and administrative hassles create significant barriers to CHIP enrollment. And a recent Center for Studying Health System Change study found that improved outreach, rather than still more expansions of eligibility, is the key to extending coverage to low-income children.

Ms. Felland says that during the past two years states have increasingly turned to communities to help identify and enroll eligible individuals in CHIP. Despite many positive features of the program designed to appeal to low-income families and reduce the stigma associated with government health care, many states initially struggled to enroll children.

As a result, many states have streamlined application processes and provided funding and training to local organizations to generate awareness about the program, identify eligible children, and help them apply. Preliminary observations of state and local leaders working with CHIP suggest that local organizations can play an important role in boosting enrollment in public programs.

There are a number of reasons for the success of local outreach, Ms. Felland says. First, because local efforts can be customized to meet the needs of a specific community, they identify and target key populations more effectively. Second, the involvement of organizations that low-income families trust and have frequent contact with has helped increase participation in public health programs.

To educate hard-to-reach populations, organizations translate CHIP program materials into native languages and hire outreach workers of the same racial, ethnic, or cultural background as target groups. Many organizations focus on minority groups and people with relatively higher incomes, reasoning that the stigma associated with government programs might deter them from applying on their own.

Also targeted are eligible immigrants who might be unable to apply because of language barriers or the fear that participation could threaten their immigration status.

Although targeted outreach can be successful, it often is costly, and the cost often exceeds the funding from state and federal CHIP and Medicaid funds that organizations receive. As a result, many organizations involved in outreach use their own resources or funds from other private resources such as foundations.

The most significant local players involved in outreach to date have been health care organizations and schools. Community and religious groups increasingly are involved, and employers are beginning to participate in some communities.

Although local health departments, providers, and health plans have conducted Medicaid outreach in the past, many have intensified efforts under CHIP. Hospitals and community health centers have particularly committed extensive resources to identify uninsured children when they seek services and then help their parents apply.

Local health departments and social service agencies often assist other providers with CHIP outreach in addition to conducting their own outreach activities. In some communities, health plans promote general awareness of CHIP through broad public information campaigns and materials. However, plans in many states are restricted from promoting their CHIP products because of concerns about potentially inappropriate influence on beneficiary plan selection.

School nurses often coordinate the effort in schools and screen students for health insurance at annual school registrations, send letters home, and discuss the program with parents at meetings. Many schools coordinate CHIP outreach with federally sponsored free and reduced school lunch programs.

Although there are successful outreach programs that can be seen in the center study, enrollment problems persist and there is a need for still more efforts to reduce the administrative hassle and stigma. However, lack of funding may present the greatest challenge to local CHIP outreach efforts. Many states are experiencing budget shortfalls along with higher-than-anticipated Medicaid and CHIP enrollment and costs per enrollee.

To locate some of the most difficult to reach children, particularly those outside the school system, community groups play important roles in CHIP outreach. Common types of involved organizations include child-care centers, food banks, homeless shelters, children's groups, and Volunteers In Service To America volunteers. Local organizations also distribute CHIP applications through small businesses, such as neighborhood grocery stores and beauty salons.

More religious organizations are becoming active in CHIP outreach, in part because of a change in federal rules that allows states to contract with faith-based groups if the individuals they target are not required to participate in religious activities.

Some communities target outreach to business groups or employers with low-wage workers that don't offer health insurance to the workers or their dependents. A significant concern about employer involvement is that it will cause crowd-out, leading employers to substitute CHIP for employer-sponsored coverage. States are required to have provisions to prevent crowd-out, such as checking to make sure that a child has not had private health insurance for a certain period before receiving public coverage.

Ms. Felland says that while schools have had the most prominent outreach role and been the most successful, it is interesting to see the increase in religious group involvement in the last couple of years.

"It's a good way to reach people outside the health care system. It reduces the stigma when neighbors are talking to neighbors," she says.

Although there are successful outreach programs that can be seen in the center's study, enrollment problems persist, and there is a need for still more efforts to reduce the administrative hassle and stigma. However, lack of funding may present the greatest challenge to local CHIP outreach efforts. Many states are experiencing budget shortfalls along with higher-than-anticipated Medicaid and CHIP enrollment and costs per enrollee. Federal funding for CHIP is set to drop 25% in fiscal 2002 and reduced funding will continue through fiscal 2004.

A program that has achieved considerable success in CHIP enrollment is Cuyahoga Health and Nutrition in

the Cuyahoga County (Ohio) Department of Jobs and Family Services. Robert Staib, marketing and communications manager tells *State Health Watch* the agency has contracted with a number of enrollment brokers — community agencies of various sizes — paying a flat rate per child enrolled by the broker.

In the first year of the effort, 3,200 applications were received enrolling 5,200 children. "We think those are good numbers," Mr. Staib says. They've also invested in a decorated van — the Kids Healthmobile — that visits community festivals and other activities, supplying health-related giveaways and program applications. And there have been TV and radio commercials and printed brochures and other literature. All the promotion contains a unified call to action — a request that people call a telephone hotline where they can speak with someone who can help them complete their application over the telephone.

Based on the numbers of children enrolled, Mr. Staib says there has been "quite incredible" success. In September 2000 there were 94,000 children in the CHIP Healthy Start program and as of August 2001 that was up to 115,000, believed to be an historical high. (The 115,000 far exceeded the goal of 104,000 that had been set.)

Mr. Staib says they can't tell how much of the increased enrollment is specifically due to the outreach efforts since in July 2000 there was an eligibility increase to 200% of poverty and a simplified application form was introduced. He rates the various forms of outreach with the telephone hotline first, followed by the broadcast spots, print literature, and the contracted brokers last.

[Contact Ms. Felland at (202) 261-5667 and Mr. Staib at (216) 987-8433.] ■

Adult health coverage

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industries have lower-than-average coverage rates. **(See pie chart, below.)** A substantial share of uninsured workers — 16% — is in the professional services industry. While the rate of uninsurance is relatively low for such workers, they are a large fraction of the work force.

In terms of company size, 25% of the uninsured work in firms with fewer than 10 employees, but 43% are in companies with 100 or more employees. **(See pie graph, p. 6.)** Seventy-one percent of uninsured workers are employed full-time.

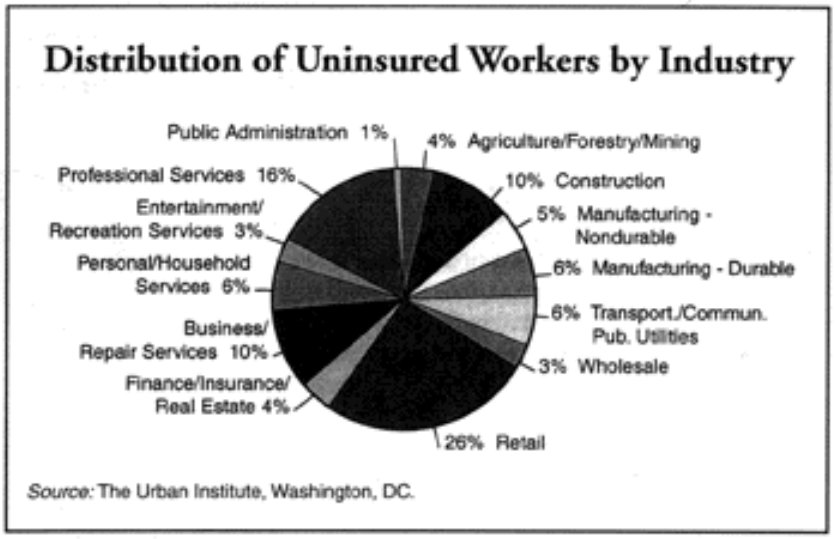
The researchers say that workers may lack employer-sponsored insurance for one of three main reasons:

1. The employer does not sponsor a plan.
2. The employee is not eligible for the employer's plan.
3. The employee is offered coverage but turns it down.

They found that 59% of uninsured workers have employers that do not sponsor a health insurance plan. Many have tried unsuccessfully to find employment with a company that does offer a coverage plan. Some 21% of uninsured workers were not eligible for their company's plan, and 20% declined the coverage that was available to them.

The Urban Institute report says the key findings on the working uninsured are that firm size is more important than industry in explaining sponsorship, eligibility, and take-up rates; income is more important than family type; high income and high wages are associated with higher rates of sponsorship, eligibility, and coverage; income and wages are correlated, but not perfectly, since many low-wage workers are married to someone with higher income; lower coverage rates for Hispanics are mostly due to working in jobs with much lower offer rates than whites obtain; lower coverage rates for blacks are mostly due to lower spousal coverage rates than those for whites; and given an offer, all races are equally likely to accept employer-sponsored insurance.

Bowen Garrett, a researcher with the Urban Institute, says that if targeting of efforts to increase health insurance coverage is to be effective, it must hit a meaningful share of uninsured workers. And for targeting to be efficient, eligibility must extend to a



large number of the uninsured relative to the already insured. On the whole, Garrett says, both effectiveness and efficiency are accomplished by targeting workers who are disproportionately likely to be uninsured such as low-wage workers, low-income workers, and workers in small firms.

Len Nichols, another Urban Institute researcher who worked on the report, says that firms offer health insurance if their workers demand it, but the evidence makes clear that many low-income workers can't afford to demand health insurance today.

"Increasing their purchasing power through targeted subsidies is the surest way to expand coverage. If such subsidies are structured properly, the share of firms that offer health insurance and the share of workers who enroll would both increase," he explains.

Policies designed to expand health insurance coverage tend to focus on workers in low-income households, low-wage workers, and small firms. But many low-wage workers are secondary earners in higher-income households and are already insured.

"Targeting subsidy dollars to low-income workers would extend eligibility to a large share of uninsured workers, and would be less likely than targeting low-wage workers to subsidize workers who already have coverage," Mr. Garrett says. Targeting workers in small firms is the least likely way to reach a high share of uninsured workers.

Mr. Garrett and Mr. Nichols say that public program expansion would work better than individual tax credits to reduce the rate of worker uninsurance for low-income workers, unless a tax-credit subsidy were nearly equal to the price of an insurance policy. But public program expansions would require a more elaborate eligibility determination system.

One possible approach to changes in public programs would be for states to cover parents under Medicaid and CHIP. In a study for the Kaiser Commission on Medicaid and the Uninsured, Lisa Dubay and Genevieve Kenney, also researchers for the Urban Institute, say that if states were to cover parents to the same extent as they currently cover children, 7.4 million parents (70% of all uninsured parents) would gain coverage. A side benefit would be that coverage of children also could be expected to increase.

Focus going beyond children

Ms. Kenney tells *State Health Watch* that until the 1980s, public policy focused on increasing coverage for children and pregnant women. In the early 1990s, there were some small-scale 1115 waivers to expand coverage to parents with state funds. Additional federal money came into the picture through welfare reform and some changes in eligibility.

Today, she says, most states can cover parents up to 100% of poverty without a waiver and get federal matching funds.

Ms. Dubay says this approach can be easier to implement because states know where children are and thus can find their parents and offer them coverage. While such an effort has the potential to significantly increase coverage, there are challenges in trying to make it happen.

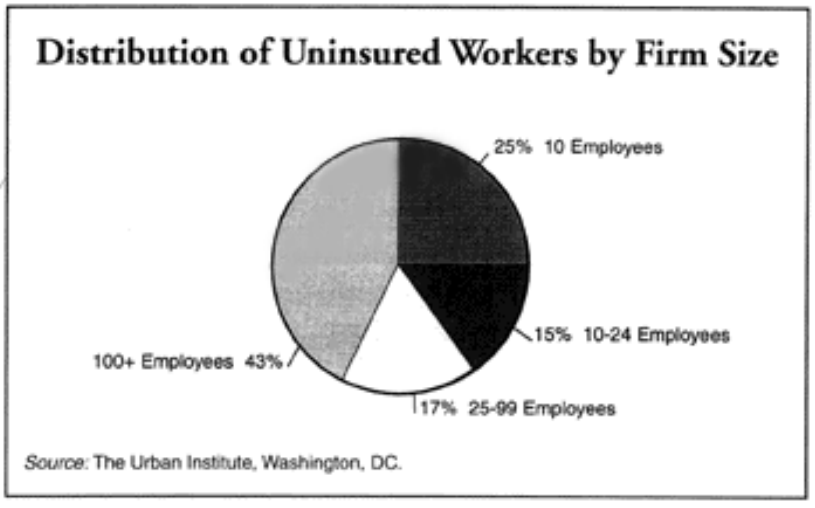
For the roughly 3 million parents who have children enrolled in Medicaid or CHIP, the policy problem is the relatively straightforward one of expanding coverage to include the parents of children already covered. But more than half of uninsured parents who meet Medicaid or CHIP income thresholds have children who are uninsured despite meeting the thresholds.

Increasing Medicaid/CHIP participation by eligible children, Ms. Dubay and Ms. Kenney say, hinges on raising awareness and understanding of the programs and their benefits, improving enrollment systems, and addressing barriers related to other program dimensions.

Another concern is that expanding coverage will draw some parents who were not in fact uninsured but were paying for private coverage.

"Policy-makers need to come to terms with the inevitable fact that covering whole families may lead to some substitution of public for what was previously privately financed coverage," the authors say.

"Results from Massachusetts suggest that the extent of substitution will be small, about the magnitude observed under the Medicaid expansions for



children, with most of the increased coverage coming from real reductions in the number of uninsured children. Coverage expansions to parents with higher incomes can be expected to increase the amount of substitution, while coverage expansion directed at lower-income parents should result in lower levels of substitution," they explain.

An overriding potential problem will be the availability of funds for coverage expansion, especially during an economic downturn.

"States that have the political will will find the resources to cover parents," Ms. Dubay says, "but it may be harder when there are shrinking budgets. We can't underestimate the importance of political will in being able to cover more children in the last few years."

Some states may cut benefits

Because of the economy, some states are talking about cutting benefits to avoid having to tighten eligibility. One way to address the concern may be to drop coverage of children from 300% of the poverty level to 200% and use the money saved to add some parents.

While earlier this year there were some signals that policy-makers were ready to consider sending more federal money to the states to be used to help cover parents, that all changed after the Sept. 11 terrorist attacks. Congressional hearings that had been planned were dropped, and Ms. Dubay and Ms. Kenney don't expect to see any additional federal money available this year.

That means, however, that states have more flexibility and guidance from the Centers for Medicare & Medicaid Services, which indicates a willingness to accept more trade-offs between benefit levels and eligibility.

[Contact Mr. Garrett, Mr. Nichols, Ms. Dubay, and Ms. Kenney at the Urban Institute at (202) 833-7200.] ■

States get more flexibility in Medicaid/CHIP program design with coverage for adults

The Centers for Medicare & Medicaid Services (CMS) is implementing the newly minted Health Insurance Flexibility and Accountability Initiative so that states will find it easier to expand access to health care coverage for low-income individuals through Medicaid and the state Children's Health Insurance Program (CHIP).

The initiative is based in part on recommendations from the National Governors Association, which supports the changes.

Governors have an ally

Secretary of Health and Human Services Tommy Thompson, the former governor of Wisconsin, said the agency's goal is to "give governors the flexibility they need to expand insurance coverage to more Americans through innovative approaches, including the kind of health insurance options available in the private sector.

"Through this initiative, we are creating a new, simpler process for states to propose and implement creative ideas to help uninsured residents," he explained.

Some of the elements in the initiative include:

- States will have more flexibility to design benefit packages that will promote expanded access to health care coverage and meet the need of residents.
- Special emphasis will be placed on coordinating Medicaid and CHIP with private-sector insurance programs to achieve seamless coverage for low-income individuals.
- In exchange for upfront flexibility, states will be required to set goals for reducing the number of residents without health care coverage and then document their progress toward reaching that goal.
- A new electronic application will make it quicker and easier for states to propose and implement new approaches to promote access to health care coverage.

Agency officials say the new approach will encourage states to design benefit packages that will best meet the needs of their residents. Thus, different benefits could be made available for different populations, expanding coverage to more individuals and families who might not be eligible for Medicaid or CHIP under current law.

States should find it easier to operate demonstration projects that are designed to extend health care coverage to their uninsured residents. As in the past, such projects must be budget neutral, meaning states would have access to the same amount of federal funding under the demonstration as they would have received under current law.

Speeding up the process

States wanting to take advantage of the opportunities in the initiative and seek an expedited review of a waiver request will be able to use an on-line application.

"We intend to use today's technology to speed up and simplify the process and cut down on the bureaucratic red tape and paperwork that stifles new approaches to expanding health coverage," Mr. Thompson said.

"By increasing flexibility, promoting innovation, and demanding accountability, we are giving states more options to increase the number of individuals with access to affordable health insurance," he explained. ■

New anesthesia rule mixes politics, science, and states rights — and continues the controversy

Whether you are an anesthesiologist, nurse anesthetist, or member of the Bush administration, the Centers for Medicare & Medicaid Services' (CMS) final rule on anesthesia services represents an obvious attempt at good science, power politics, or additional support for state self-determination.

But patients are unlikely to be able to tell which factor was at work and how the changes in Medicare conditions of participation regarding anesthesia services will affect them.

The final rule, published Nov. 13, is markedly different from that published just two days before the Clinton administration left office last January. After years of debate between physician anesthesiologists and nurse anesthetists over the need for physician supervision of nurses providing anesthesia services, the Clinton administration decided to side with the nurses and issued a proposal eliminating the physician supervision rule in states where it was not required by state law.

Predictably, the nurse anesthetists cheered, and the physicians cried foul. Implementation of the Clinton proposal was delayed as part of the incoming Bush administration's review of all last-minute regulations issued by the prior administration.

CMS said that as it reviewed the Clinton proposal and alternatives for implementation, it uncovered two questions that had not been raised and addressed:

- whether states relied on Medicare physician supervision requirements in establishing state scope-of-practice laws and monitoring practices so that eliminating the Medicare requirement could change supervision practices in some states without allowing states to consider their individual situations;
- whether a prospective study or monitoring should be undertaken to assess the impact in those states where certified registered nurse anesthetists (CRNA) practice without physician supervision.

"The literature we reviewed indicated that the anesthesia-related death rate is extremely low, and that the administration of anesthesia in the United States is safe relative to surgical risk. However, in the absence of clear research evidence, it is impossible to definitively document outcomes related to independent CRNA practice," CMS said in its *Federal Register* notice.

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>
> Deborah Chambers
> *President*
> *American Association of Nurse Anesthetists*
> *Park Ridge, IL*

The final rule retains the physician supervision provision, while allowing state governors to submit a written request to opt out of that requirement after consulting with the state boards of medicine and nursing in the affected state on issues related to access and the quality of anesthesia services. In addition, the Agency for Healthcare Research and Quality will design and conduct a prospective study or monitoring effort to assess outcomes-of-care issues relating to CRNA practice and involvement.

Many commentaries on the proposal questioned how consultation with state boards would work if a governor wanted to pursue the opt-out provision and suggested the process might allow one profession to make judgments about the scope of practice of another profession. However, CMS said its intent is to allow governors to make local decisions without being told by a federal agency how to do so. "We purposefully were not prescriptive in detailing processes or steps that should be undertaken," the agency said. "In addition, the particular factors that are pertinent in reaching a sound policy decision will invariably vary from state to state."

Publication of the final rule did not stop the sniping that has gone on for years between nurse anesthetists and anesthesiologists — but increased it.

Deborah Chambers, president of the American Association of Nurse Anesthetists in Park Ridge, IL, says Medicare "got it right the first time [in the Clinton administration rule]. After three years of careful consideration, last January, Medicare proposed removing the federal physician supervision requirement for nurse anesthetists. This was largely due to the fact that anesthesia care is nearly 50 times safer today than 20 years ago, with nurse anesthetists being the primary hands-on providers of anesthesia in this country."

She says one positive element in the Bush administration proposal is that for the first time, states have the opportunity to opt out of the supervision requirement. "While the new rule clearly is not as good for patients as the January proposed rule would have been, nurse anesthetists will work with the new rule to continue

ensuring the safest, highest quality anesthetics for our patients, particularly those in rural and medically underserved areas where CRNAs have long been the lifeline between those communities having and not having access to surgical, emergency, and obstetrical care."

Ms. Chambers also said the CMS decision proves there is no safety issue involved because states would not have been given an opt-out opportunity if it would jeopardize patient safety. "The public should not be buffaloed into thinking that what happened here is anything other than a transparent attempt by the White House to keep the medical lobby happy."

However, Barry Glazer, MD, president of the American Society of Anesthesiologists, also in Park Ridge, praised the administration for preserving "an important patient safety measure that has been protecting patients for more than 35 years before it was discarded by the Clinton administration." He expressed concern about the opt-out provision, saying it could be "exploited and abused by those opposed to having a physician involved in every anesthetic." He cautioned that the "opt-out criteria fails to adequately define what specific procedures and protocols a state governor would have to follow to opt out of, or back into, the supervision rule. We expect that any governor considering this option will want to do what is best for the citizens of the state and will base such a decision on sound science, and not political pressure."

While the issue may now be finally resolved at the federal level, the battleground will shift to those states in which CRNAs can practice independently. Governors in those states (and the two sides can't even agree on how many there are) will certainly come under pressure from nurse anesthetists to exercise the opt-out provision and from physicians to retain a supervision requirement. ■

Sentinel events to reportable ones

Now that you've gotten used to the idea of sentinel events, get ready for the state equivalent: the list of "serious reportable events" recently adopted by the National Quality Forum (NQF) in Washington, DC.

The list is similar to, but entirely separate from, the sentinel events list used by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The NQF, which developed the serious reportable events list, changed the name from "never events" because that sounded too harsh and allowed no flexibility in identifying the incidents. The NQF board recently approved the list of serious reportable events and will pass it on to other health care organizations for implementation.

Individual states will determine how and when to use the serious reportable events list, says John Colmers, a program officer at the Milbank Memorial Fund, an endowed national foundation in New York City that works with decision makers in the public and private sectors on issues of policy for health care and public health. Mr. Colmers worked with the NQF to develop the serious reportable events list and says the project was an outgrowth of the Institute of Medicine's (IOM) report on medical errors, *To Err is Human*. That report called for a state-based system for reporting serious medical errors.

"The IOM study anticipated a two-tiered system for reporting medical errors," Mr. Colmers says. "One would be a mandatory system for reporting the most serious and egregious events at a state level. The second, and considered by IOM the most important, is a system of voluntary reporting."

The serious reportable errors list can be used for developing both mandatory reporting requirements and encouraging voluntary reporting. The Centers for Medicare & Medicaid Services (CMS), and the Agency for Health Care Policy and Research (AHCPR) funded the research. Colmers says the NQF's job was to develop the list and then hand it over to CMS and the AHCPR for implementation.

The list looks like another version of the Joint Commission's sentinel events but drawn up by a different committee. Critics are suggesting that the NQF's new list duplicates the sentinel event system and will only create a dual track of reporting with unnecessary and redundant work. ■

Temporary Medicaid program to be offered in New York City

The United Hospital Fund and a coalition of health and community service organizations will conduct a campaign to increase public awareness in New York about a temporary new Medicaid program created by city, state, and federal officials in the wake of the Sept. 11 terrorist attacks, according to the American Hospital Association in Chicago. Disaster Relief Medicaid provides four months of free health benefits to qualifying, low-income New York City residents. Eligibility is based on income, and applicants do not have to be direct victims of the World Trade Center attacks. The program also features faster approval, less paperwork, and higher income than regular Medicaid. ■

Clip files / Local news from the states

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

Michigan hospitals criticize state Medicaid funding cuts

LANSING, MI—The Michigan Health & Hospital Association (MHA) says plans to cut state Medicaid funding would result in a loss of $14 million to nonprofit community hospitals. Michigan's House and Senate appropriations committees has approved an executive order by Gov. John Engler that calls for the Medicaid cuts.

"The latest round of Medicaid cuts is clearly inappropriate. At a time when Michigan residents expect and deserve a strong and responsive health care system, the state is sending the wrong message, that health care doesn't count," said MHA President Spencer Johnson. He noted that Michigan faces the continued loss of programs and services because of government cuts to health care, and hospitals now face costs estimated at $100 million to prepare for public and employee safety and potential disaster protocols.

—American Hospital Association, Nov. 8, 2001

Bush administration says it may help unemployed with coverage

WASHINGTON, DC—Health and Human Services Secretary Tommy Thompson indicated that President Bush would likely agree to a Democratic provision in an economic stimulus plan that would assist unemployed workers pay for health insurance coverage.

Thompson said if the measure meets the overall parameters the president set for the stimulus package, the president would sign it. Such a provision is absent in Bush's original $60 billion to $75 billion stimulus plan, as well as the House $100 billion plan.

Treasury Secretary Paul O'Neill echoed the sentiments, saying the administration may accept elements of a compromise $75 billion plan offered by Senate moderates, which includes assistance to the unemployed for health coverage, business and individual tax cuts, and an extension of unemployment benefits by 13 weeks. Thompson additionally remarked that the public health system would need at least $300 million a year for five years to combat bioterrorism.

—American Hospital Association, Nov. 21, 2001

Iowa says nursing home had improper supervision

DES MOINES, IA—According to the Iowa Department of Inspections and Appeals, Georgian Court of Oskaloosa failed to supervise seven residents, resulting in three residents falling and one resident eloping twice without being noticed by the staff.

The home also was cited for numerous deficiencies related to residents' rights, quality of care, dietary services, pharmacy services, and cleanliness. During a state inspection, the staff allegedly failed to clean feces from a couch near the nurses' station for more than six hours.

The administrator and director of nursing allegedly told the inspector that they did not know what sort of in-service training they needed to provide for the staff.

Earlier this year, when the home was operating as Siesta Manor, it was fined $250 for allegedly failing to provide kind and considerate care. The state alleged that a worker had become angry after observing a resident feed ice cream to a fellow resident with cerebral palsy.

—*Des Moines Register*, Dec. 1, 2001

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

Some say Tennessee's plan to rewrite TennCare is too much

NASHVILLE, TN—Gov. Don Sundquist's proposal to rewrite the TennCare program is so far-reaching that TennCare advocates and medical provider groups want lawmakers to delay the plan, perhaps until a new governor is elected. Sundquist has proposed replacing TennCare with a managed-care Medicaid program for Medicaid-eligible Tennesseans and creating a separate HMO-style program for the state's chronically ill "uninsurables" — adults under the poverty level and poor children without access to health care — if there's money to fund it. Under Sundquist's plan, an estimated 180,000 TennCare enrollees would not be eligible for either of the replacement programs. The restructured program would go into effect Jan. 1, 2003, only days before Sundquist leaves office.

Given Tennessee's financial straits, lawmakers, TennCare advocates, and medical industry officials fear the state won't have the money to fund the HMO-style "TennCare Standard" program for those who aren't Medicaid-eligible.

As a result, they fear, Sundquist's plan could push as many as 500,000 Tennesseans off TennCare with no access to health coverage. The loss of those patients also would cost the state's health care system $1 billion in federal Medicaid matching funds, they say.

—*Memphis Commercial Appeal*, Dec. 3, 2001

TennCare's recipients says care they receive is fine with them

NASHVILLE, TN—TennCare recipients remain satisfied with the care they receive under the 7-year-old program for poor and otherwise uninsured Tennesseans, according to a new survey. They're also seeing doctors without excessive travel or waiting time, and visiting emergency rooms less frequently, according to the survey by the University of Tennessee-Knoxville.

The survey of about 3,000 TennCare recipients found that 79% of respondents are satisfied with TennCare, a figure that has remained stable since 1996.

"TennCare continues to achieve its mission — effective health care within a predictable budget for Tennesseans who are Medicaid eligible or who lack access to health insurance," said TennCare Director Mark Reynolds in a statement detailing the survey's findings. "It's also important that members are satisfied with the quality of care they're getting."

Three-quarters of the TennCare recipients rated the quality of medical care for their children as either "excellent" or "good," according to the TennCare bureau. That was a slight improvement over last year.

—*The Tennessean*, Dec. 2, 2001

California groups ask if parents can join children's' health plan

SACRAMENTO, CA—A statewide coalition of community groups and three state lawmakers, have joined to ask for federal approval to let parents enroll in a government insurance program for poor children.

California officials requested a waiver in December 2000 from the U.S. Department of Health and Human Services to allow low-income parents to enroll in the Healthy Families program. But since then, Gov. Gray Davis has proposed delaying the expansion as part of cuts to this year's budget, which would save $53 million. Members of the Pacific Institute for Community Organization, which advocates for the working poor, said Monday they want the state funds protected and for Health and Human Services Secretary

Tommy Thompson to approve the long-sought waiver.

Rob Sweezy, director of public affairs for the federal Centers for Medicare & Medicaid Services, said California's application was still under review.

Thompson approved applications by Minnesota, Wisconsin, Rhode Island and New Jersey earlier this year.

—*Associated Press*, Dec. 3, 2001

Georgia officials to evaluate care for 3,600 in group home

ATLANTA—Georgia health officials are dispatching 150 state employees to check on the welfare of 3,600 people with mental retardation in group homes and other private residences, says Human Resources Commissioner Jim Martin. The move came as an immediate response to news stories about 163 residents of the homes who died under the state's watch during the last four years. The deaths included people who were scalded, malnourished, severely bruised, and dehydrated; at least 13 died as a result of choking.

"If there is a person in crisis, we will identify that," Mr. Martin said. "Based on that information, we will move to our next step — how we go about improving the system for all of our people."

—*Atlanta Journal-Constitution*, Dec. 4, 2001

Minnesota task force to study options to lower health costs

ST. PAUL, MN—Gov. Jesse Ventura and top legislators say they will delay consideration of proposals to lower health care costs for at least a year while a task force examines the issue.

Ventura, joined by top officials and legislators, announced plans to form a task force made up of senators and representatives that will receive advice from a community group. The group will include former U.S. Sen. David Durenberger, health providers, consumers, and labor and business leaders. Mr. Ventura said the group should try to tackle rising premiums, suggest ways to engage consumers in decisions about their care, and propose ways to stabilize the market through new insurance risk pools.

Still, as the governor acknowledged, the move all but guarantees that no significant changes will be undertaken during the governor's first term in office. He has not said whether he will seek reelection. "It's a problem that is monumental, so it's going to take awhile," Mr. Ventura said. "It's going to go long through the legislative session and past the election of next year."

—*Associated Press*, Dec. 4, 2001

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BIOTERRORISM WATCH

Preparing for and responding to biological, chemical and nuclear disasters

Flu or anthrax? First inhalational cases yield clues for clinicians to make the critical call

Use case history, blood work, X-rays, rapid tests

There is a postal worker in your emergency department (ED) with flulike symptoms.

That once insignificant observation about occupation and illness now triggers a detailed algorithm created by the Centers for Disease Control and Prevention (CDC) in Atlanta. **(See algorithm, p. 2.)** Is it flu or inhalational anthrax? Whether a realistic question or not, it is what many of your incoming patients may be asking — particularly if another wave of anthrax scares coincides with a nasty influenza season. Many of the initial symptoms are similar, but investigators dealing with the first inhalational anthrax cases have gleaned out key indicators that will help clinicians make the call.

"It is important to take a careful history from the [patients] when they present," says **Julie Gerberding**, MD, acting deputy director of CDC's National Center for Infectious Diseases. "If the [patients are] mail handlers in a professional environment — where they're dealing with large amounts of mail that is not their own — then the index of suspicion should be raised and more testing should be done to be sure there aren't additional clues to suggest that it is not a common viral infection."

Using the first 10 cases of inhalational anthrax as a baseline patient profile, the CDC reports that the median age of the patients was 56 years (range: 43-73 years), and seven were men.[1]

The incubation period from the time of exposure to onset of symptoms when known (seven cases) was seven days (range: five to 11 days).

The initial illness in the patients included fever (nine) and / or sweats / chills (six). Severe fatigue or malaise was present in eight, and minimal or nonproductive cough in nine. One had blood-tinged sputum. Eight patients reported chest discomfort or pleuritic pain. Abdominal pain or nausea or vomiting occurred in five, and five reported chest heaviness. Other symptoms included shortness of breath (seven), headache (five), myalgias (four), and sore throat (two). The mortality rate was 40% for the 10 patients, much lower than historical data indicated. Indeed, one of the critical reasons to recognize inhalational anthrax early is that it is far more treatable than originally thought.

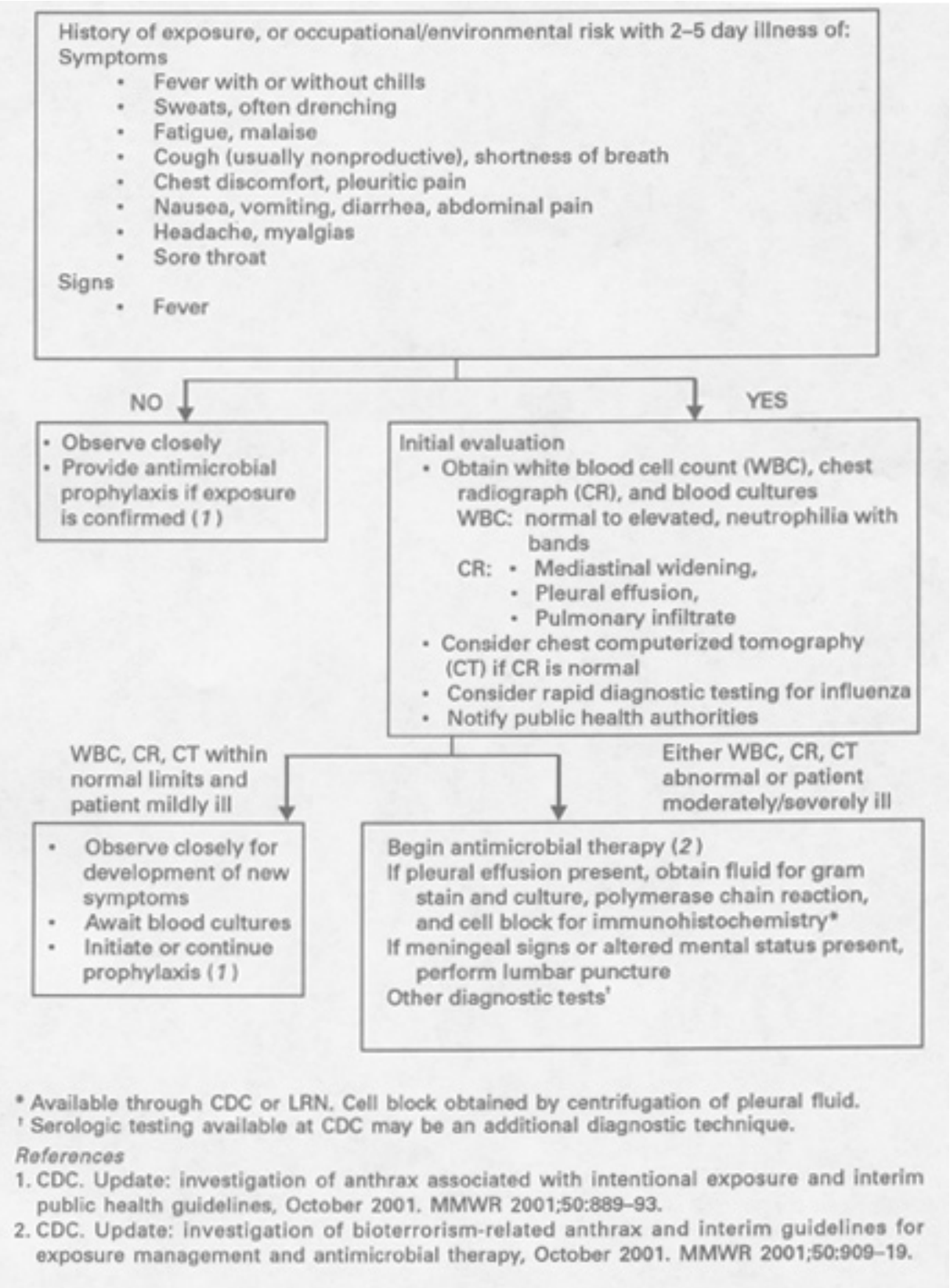
The CDC gathered comparative data on the symptoms and signs of anthrax and influenza, finding, for example, that only 20% of the anthrax patients reported sore throat.[2] Flu sufferers report a sore throat in 64% to 84% of cases. Likewise, 80% of the anthrax cases reported symptoms of nausea and vomiting. That symptom is reported in only 12% of flu cases. Shortness of breath appears to be another key distinguishing symptom, affecting 80% of the anthrax patients but seen in only 6% of flu patients.

"One of the other clues that we are noticing is that the patients with inhalation anthrax actually do not have nasal congestion or a runny nose,"

(Continued on page 3)

This supplement was prepared by Gary Evans, editor of *Hospital Infection Control*. Telephone: (706) 742-2515. E-mail: gary.evans@ahcpub.com.

Clinical Evaluation of People with Possible Inhalational Anthrax



Source: Centers for Disease Control and Prevention. Update: Investigation of bioterrorism-related anthrax and interim guidelines for clinical evaluation of persons with possible anthrax. *MMWR* 2001; 50:945.

Gerberding says. "They don't have the symptoms of an upper-respiratory tract infection. They have a more systemic chest presentation, and that may be another distinguishing characteristic."

Another finding on initial blood work is that none of the inhalational anthrax patients had a low white blood cell count (WBC) or lymphocytosis when initially evaluated. Given that, CDC officials note that future suspect cases with low WBC counts may have viral infections such as influenza. Chest X-rays were abnormal in all patients, but in two an initial reading was interpreted as within normal limits. Mediastinal changes including mediastinal widening were noted in all eight patients who had CT scans. Mediastinal widening may be subtle, and careful review of the chest radiograph by a radiologist may be necessary, the CDC advises.

Complementing the CDC's effort, are the observations of the few clinicians who have actually seen inhalational anthrax cases come into their hospital systems. Two inhalational anthrax cases, both of which survived, were admitted to the Inova Healthcare System in Fairfax, VA (near Washington, DC).

"Clinically, I think the history of the people who presented here is useful," says **Allan J. Morrison Jr.**, MD, MSc, FACP, health care epidemiologist for the Inova system. "They stutter-stepped toward their pulmonary symptoms. That had some mild symptoms and then they were sort of 'meta-stable.' They were not relentlessly progressing. Then they progressed with symptoms more aggressively. Whereas with influenza — in our experience — once you start to get sick, it just keeps on progressing with very high fevers, chills, muscle aches, and pains. As a consequence, we feel there should be a good way to differentiate the two."

Since anthrax is a realistic concern in the Washington, DC, area, what about the aforementioned scenario of symptomatic postal workers in the ED?

"We would take a very aggressive history, not only of occupation but physically where they have been," Morrison says. "If they are symptomatic and have been in or work around a 'hot zone' — a location from which anthrax has either been cultured environmentally or patients have come from there — we will err on the side of being very aggressive about working up anthrax. By that I mean chest X-rays, chemistry profile, [etc.]"

In addition, the hospital system pushed early flu vaccination programs for staff and the surrounding community. "We want to move toward herd immunity," he says. "We are also working with our local hospitals to make sure that they have access to the rapid influenza tests. So for diagnosis — for obvious reasons — it is very helpful to make that distinction early."

One such rapid test is ZstatFlu (ZymeTX Inc., Oklahoma City), which the company claims can yield a diagnosis of influenza A or B some 20 minutes after a throat swab. The test detects neuraminidase, an influenza viral enzyme. However, Gerberding cautions clinicians not to rely solely on such tests. Rather, they should use the results of tests in combination with the patient history and clinical presentation, she says.

"So it is a constellation of history, clinical findings, and laboratory tests," she says. "Hopefully, when we get these all together, we'll be able to at least reduce the anxiety among some people and help clinicians diagnose those patients who really do require the antibiotic treatment. What we don't want to have happen is for everybody coming in with the flu to get an antibiotic because that undermines a whole other set of public health issues relating to antimicrobial resistance and proper management of influenza."

Even the vaccinated can still have flu

Complicating the issue is the fact that the flu vaccine efficacy can vary annually, but is usually 70% to 90% protective, says **Keiji Fukuda**, MD, a medical epidemiologist in the CDC influenza branch. Thus, depending on how well the vaccine matches the circulating strain, a certain portion of flu patients will tell clinicians they have been immunized. But in addition to vaccine breakthrough infections, there is a plethora of other viral and respiratory pathogens that will be creating similar symptoms, he says. In a somewhat sobering reminder — given that at this writing, the total anthrax cases remained in the double digits — Fukuda notes that a typical flu season will send 114,000 people to the hospital and 20,000 to their graves.

"There has been an awful lot of attention on the [anthrax] cases, but the bottom line is that there have been few cases, and these cases generally have occurred in a limited number of communities within a limited number of groups," he says. "And so the epidemiologic message is that anthrax really has not been diagnosed in most parts of the country, whereas we expect to see millions and millions of flu cases all over the place."

If facilities are faced with an onslaught of patients with respiratory illness there are several measures they can take, he notes. Those include:

- Reduce or eliminate elective surgery.
- Relax staff-to-patient ratios within the limits of your licensing agency.
- Emphasize immunizing staff so more staff are available.
- Identify ways to bring in extra staff to help out with the patients.
- Set up walk-in flu clinics to triage the patients.

Reference

1. Centers for Disease Control and Prevention. Update: Investigation of bioterrorism-related anthrax and interim guidelines for clinical evaluation of persons with possible anthrax. *MMWR* 2001; 50:941-948.

2. Centers for Disease Control and Prevention. Consideration for distinguishing influenza-like illness from inhalational anthrax. *MMWR* 2001; 50:984-986. ■

CDC moving quickly on smallpox front

Immunizations, training, vaccine dilution studied

Though officially stating it has no knowledge of any impending use of smallpox as a bioweapon, the Centers for Disease Control and Prevention (CDC) is scrambling with conspicuous speed to be ready for just such an event.

CDC workers from a variety of specialties are not only receiving smallpox vaccinations, they are being trained to give them to others using the old bifurcated needle scarification technique. And, even as creation of a new vaccine is fast-tracked, researchers are trying to determine if the current stockpile of 15.4 million doses can be expanded fivefold by simply diluting the vaccine.

Based on such actions, it is fair to say the agency is at least highly suspicious that the known stocks of smallpox virus are not safely ensconced in their official repositories in Russia and the United States.

"CDC is putting together a number of teams, which will probably total [more than] 100 employees, that could be quickly dispatched in a moment's notice to assist state and local health departments and frontline clinicians investigate suspect cases of smallpox," **Tom Skinner**, a spokesman for the CDC, tells *Bioterrorism Watch.*

"They are Epidemic Intelligence Service (EIS) officers, laboratorians, and others. Part of this includes vaccinating them against smallpox," he explains.

But while confirming that the CDC teams are being trained to administer the vaccine, Skinner would not specify who would be vaccinated following a smallpox bioterror event. "We have a smallpox readiness plan," he says. "Issues around vaccination are covered in that plan. That plan is being finalized. It is considered an operational plan. If we have a case tomorrow, it could be implemented. It covers who should be vaccinated and when."

The general consensus among bioterrorism experts is that those exposed would be vaccinated because the vaccine can prevent infection and possibly death even if given several days out. Likewise, health care workers and their family members would want vaccine if they were expected to care for the infected. Some aspect of quarantine would no doubt come into play because, unlike anthrax, it will be critical to separate the first smallpox cases and their contacts from the susceptible population.

Another aspect of CDC preparations includes the smallpox vaccine dilution study, which is being headed up by **Sharon E. Frey**, MD, associate professor of infectious diseases and immunology at Saint Louis University School of Medicine.

The vaccine, known as Dryvax, is no longer produced, but there are 15.4 million doses left. Frey and colleagues are looking at dilution studies that could maintain vaccine efficacy while increasing the available stock by millions of doses. In a study last year, Frey tried a one to 10 vaccine dilution, which would create a stockpile of more than 150 million doses. However, the resulting vaccine had only a 70% effective rate.

"The undiluted vaccine has about a 95% take rate," she tells *BW*. "It is not perfect, but we would like to be as close to that as we could be."

The new study will include a one to five dilution, which should show greater efficacy while increasing the stockpile to more than 75 million doses.

"We are looking at a 'take' rate for the vaccine, in other words how many people actually develop a typical lesion and whether they have a strong neutralizing antibody response to the vaccine," Frey says. "We know that the vaccine is still good. We actually titered the vaccine and it is very similar to its original titer," she adds. ■