National Conference of State Legislatures

STATE HEALTH *NOTES*

FORUM FOR STATE HEALTH POLICY LEADERSHIP

VOLUME 25, NUMBER 429

OCTOBER 4, 2004

Assisted Living for Seniors: Build It and They'll Come

"Ellen" is a 76 year-old, partially blind diabetic who wishes to live independently as long possible. Eligible for Medicaid, she cannot afford to pay for in-home care, nor can she pay for an assisted living facility at market rates. Like many seniors, Ellen takes multiple medications daily, and twice within the past month she's been hospitalized for accidental overdoses.

While Ellen is a fictional compilation, the conditions under which she "lives" are only too real for millions of Americans who are poor, elderly and slowly becoming less able to care for themselves. According to the U.S. Census Bureau, in 1990, one in 25 Americans was 65 years of age or older. A decade later, that figure had jumped to one in eight Americans, and the proportion is expected to increase even further to one in five Americans (20 percent of the population) by the year 2050.

Today's seniors are healthier and more mobile than those of generations past, but even the most stalwart may come to need assistance. Already, nearly 7 million people over the age of 65 need help with activities of daily living such as bathing, grooming, meal preparation, dressing, housekeeping and medication management. By 2020, 13 million seniors are expected to need such aid.

Those statistics raise a troubling question: who will care for low-income seniors who don't require the services of a skilled nursing facility but are too frail to live on their own?

One attractive option is assisted living. There's no uniform definition (the eligibility, reimbursement rates and service inclusion criteria vary widely among states), but in general assisted living offers elderly and disabled individuals a rental apartment with access to support services and 24-hour supervision.

The "pure" model of assisted living maximizes an individual's autonomy, privacy and dignity, said Robert Jenkens, vice president at the NCB Development Corporation (NCBDC), a Washington, D.C.-based non-profit organization that provides financial and technical assistance to projects that serve disadvantaged communities. People get their own room with kitchenette, they don't share double rooms; they have the freedom to entertain guests and family members overnight; and in many facilities, they may have a small pet.

TOO COSTLY FOR SOME

But, however attractive assisted living may be, not many Americans can take advantage of it. In part, that's because few can afford to pay private market rates, which range from $1,800 to $5,000 a month (see "Not So Rich," page 7).

Forty-one states cover some form of assisted living, cobbling together Medicaid funds for optional services, Medicaid waivers and general revenue funds. Some are combining funding for health and social support services with vouchers from the U.S. Department of Housing and Urban Development (HUD) for the bricks and mortar. Even so, coverage remains "extremely limited," said Ann McDermott, consultant on state relations to the Assisted Living Federation of America.

States have an enormous stake in finding ways to enable more Americans to afford assisted living – and not just because so many seniors want to remain independent. There's growing evidence that diverting seniors from nursing homes to assisted living facilities (and to other forms of home- and community-based services) saves states money.

An eight-state survey conducted by the NCBDC found that state Medicaid programs spent an average of 62 percent less (ranging from 31 to 75 percent) for each person who qualified for nursing home care but was appropriately cared for in assisted living.

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State Health Notes is supported in part by a grant from the Robert Wood Johnson Foundation.

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The Coming Home Program is a template of high-quality assisted living for low-income Americans. Administered by the NCBDC with funding from the Robert Wood Johnson Foundation (RWJF), the program provides assisted living to low-income seniors in rural areas. The original goal of the project was to identify and select a small number of rural communities and local organizations in which to create models of affordable assisted living.

With a $2.2 million grant from RWJF, NCBDC provided technical and financial assistance to housing and health-care organizations that developed new facilities or converted programs that were already in place. At the end of Phase I, five affordable assisted living demonstration projects were established in four states – **Colorado**, **Illinois**, **Oregon** and **Arkansas**.

Phase II of the program, which began in 1999 and will run through 2005, is building on the "lessons learned" from the first phase. The early efforts showed that unless the state provides policies and regulations that support assisted living, "establishing and maintaining affordable assisted living facilities is extremely difficult," said Robert Jenkens, vice president at the NCBDC.

With that in mind, RWJF awarded grants of up to $300,000 over three years to nine states (**Alaska**, Arkansas, Colorado, **Florida**, Illinois, **Iowa**, **Massachusetts**, **Maine**, Oregon, **Vermont**, **Washington** and **Wisconsin**) to create and/or improve their regulatory, Medicaid, and housing finance policies and programs in order to make assisted living as widely available as nursing home care. The goal of Coming Home is to help grantee states "create, reform and integrate the subsidies (Medicaid and housing) and oversight programs necessary to support quality assisted living," explained Jenkens.

To date, 22 facilities have opened in the nine states, and 73 facilities are in some stage of feasibility analysis. With an original goal of establishing two affordable assisted living facilities per state, "we're very happy with the response and results," Jenkins said.

BRICKS AND MORTAR

Below are two examples that show how states can create affordable assisted living facilities by combining Medicaid waiver expansions, tax credits and assistance from HUD.

With the seventh highest percentage of persons aged 65 and older in the U.S., many of whom are poor, Arkansas has a great need for affordable assisted living.

The Division of Aging and Adult Services and the Office of Long-term Care (both within the Arkansas Department of Human Services) joined with the state Development Finance Authority to participate in the Coming Home Program. At the outset of the grant application, Arkansas did not have regulations defining assisted living, a permit approval process for assisted living facilities or a Medicaid waiver covering assisted living services.

NCBDC provided technical assistance to the state Department of Human services and to the Community Development Corporation of Bentonville/Bella Vista Inc. to create the Gardens at Osage Terrace, a 45-unit affordable assisted living project. The service and rent charges for each unit is within reach of individuals who have incomes as low as $564 per month.

Five programs were used to finance the Gardens, including a loan from the Coming Home Program, low-income housing tax credits and grants from federal agencies and community foundations. The low-income tax credit, which paid for 57 percent of the development cost, provides equity by giving tax credits to a non-profit organization, which can then sell them to investors to offset the investors' tax liability.

In 2002, the Arkansas Legislature authorized the state to apply for a Medicaid waiver. Approved in 2003, the waiver not only allowed nursing home-eligible beneficiaries to transfer to an assisted living facility, but set up a reimbursement stream for assisted living services. (The new state rules require that all Medicaid and private-pay assisted living facilities have a private room and a bathroom, as well as a kitchenette.)

The real estate subsidy programs used by the Gardens enable them to accept individuals at or below 60 percent of the area median income ($1,760 per month), and Medicaid services subsidies are available to individuals with incomes of 300 percent or less of the federal Social Security Income (SSI) benefit ($1,692 per month). All units at the Gardens are designated as Medicaid-eligible, although residents with assets that exceed income eligibility requirements may pay privately for services until they spend down their assets.

One of the challenges in setting up affordable assisted living is "getting people together who are knowledgeable about the financing aspect as well as the delivery of services," said Herb Sanderson, director of the Arkansas Division of Adult and Aging Services. "It's horribly complex and people generally know one or the other, but not both." The technical assistance provided by NCBDC has been "invaluable," he added.

To date, only one third of the 1,000 slots approved by the Legislature have been filled, due in large part to the lack of physical facilities, although several buildings are in various stages of development and construction. "As far as we're concerned, assisted living is cost saving, or at least cost-neutral," Sanderson stated. "It's also a much more attractive option to many people."

FILLING A NEED

In 2002, the Vermont HUD office released a report indicating that 2,000 units of affordable housing were required to meet the needs of the state's elderly population. Nationwide, Vermont has the highest percentage of people over 65 residing in rural communities, and 13 percent of those individuals live at or below the federal poverty level.

The Vermonters Coming Home Program joined together the Cathedral Square Corporation (a non-profit developer and manager of affordable senior housing), the state Department of Social Welfare, the Vermont Housing Finance Authority, the Agency of Human Services and the Department of Aging and Disabilities.

Among the challenges that the Vermonters faced were the lack of state regulations for high-service assisted living programs; lack of an adequate reimbursement program for individuals below a nursing home level of need; and the absence of a model for small-scale assisted living facilities (four- to ten-bed facilities). "There just aren't the economies of scale to attract developers to create facilities with fewer than 20 units," said Karin Hammer-Williams, project director for the Vermonters Coming Home Program.

Together, stakeholders reworked the state's assisted living regulations, including requiring private accommodations, and increasing reimbursement levels for residential care and assisted living. In addition, the regulations stipulate a "mandatory scope of aging in place," said Hammer-Williams.

[Assisted Living, p.7]

PUBLIC HEALTH *NEWS*

Health Care in Rural America: A Potentially Powerful Economic Engine

The list of challenges facing rural America is daunting. Studies show that rural populations tend to be older, poorer, are more likely to be uninsured and have lower levels of education than their urban and suburban counterparts – all of which can contribute to a lower health status and a greater need for health-care services.

But there's another reason that health care is crucial to rural areas: jobs. Managers who are looking for new locations often look for access to high-quality health care. For these and other reasons, one of the best industries that rural areas can attract is health care itself.

"There are three major roles for health care in rural economic development: as a contributor to the local economy; as an economic base industry attracting external dollars; and as a factor to recruit businesses, workers and retirees to the community," said Eric Scorsone, assistant professor at the Department of Agricultural Economics, University of Kentucky.

Providing health-care services is labor-intensive. At last count, a national average of 10 to 15 percent of rural workers were directly employed by the health-care industry, Scorsone said.

"Hospitals are often the second or third largest employer in rural areas," said Brad Gibbens, associate director of the University of North Dakota's Center for Rural Health. A single rural physician can generate more than five jobs and over $232,000 in additional income each year in a rural community.

And there's a multiplier effect – each health-care dollar rolls over in a rural community approximately 1.5 times. If a rural hospital employs 80 people directly, another 40 jobs are created in the community as the physicians, nurses, pharmacists and aides build houses, eat at restaurants, purchase groceries and enroll their children in the local child-care centers.

Also contributing to local prosperity, hospitals and other health-care providers "sell" services to third-party payers like private health insurance, Medicare and Medicaid. These external sources of income would not filter into the community without the health service provider.

NOT AN EASY TASK

But attracting or sustaining a hospital, or even a physician's office or clinic, can be a daunting challenge.

Rural areas have 20 percent of the U.S. population and less than 9 percent of practicing physicians. Why? Rural physician practices are often solo, with nearly endless "on-call" shifts, little support from other health professionals and reduced earnings compared to most urban practices.

Rural Americans are more likely to be uninsured than urban dwellers, largely because they are less likely to have employer-sponsored coverage, according to a March 2004 policy brief from the National Rural Health Association (NRHA). Rural Americans have an uninsured rate that is 6 percent higher than that of urban Americans because their employer-sponsored coverage rate is 11.5 percent lower than their urban counterparts', the NRHA said.

"With the aging rural population and the disproportionate share of low-income folks in our rural areas, providers depend on Medicare and Medicaid reimbursements, but it is hard to earn a living that way," said Rep. Lynn Kessler, House majority leader in Washington.

Historically, Medicare has paid rural providers less than it pays their urban counterparts – for the same exact service. And Medicaid rates tend to be lowest of all.

Gibbens agreed that this is a problem but pointed out that there is movement by the federal government to "equalize" the payments – at least for Medicare. "In time, it shouldn't matter if you are providing the service in rural America or urban America, the Medicare payment will be the same," he said. He also noted that "any dollar coming into a rural economy is a positive."

"GROW YOUR OWN"

"Recruitment and retention of health care professionals is a major issue for our rural communities," said North Dakota Rep. Ken Svedgen. But states are taking steps to fill in the gaps. In an effort to get health providers out to its rural areas, North Dakota, like many other states, passed laws creating loan repayment programs for physicians, nurse practitioners and dentists.

Svedgen is a big fan of the "grow-your-own" concept because students who are trained in North Dakota are more likely to stay. "The focus of the medical school here is to train family practice physicians largely because that is what the rural communities need," he said.

Idaho "did a great deal to assist rural communities in recruiting health professionals," said Idaho Rep. Sharon Block. "We tried to help providers economically by passing tort reform legislation to help lower liability insurance premiums as well as providing for loan repayment." Because Idaho does not have a medical school, the legislature also has an agreement with two out-of-state schools in an effort to import practitioners.

Block would like to see smaller communities use mid-level practitioners, such as physician assistants and nurse practitioners, to extend the services of the rare rural doctor. As a matter of fact, North Dakota is doing just that. "We have expanded the scope-of-practice for nurse practitioners, which could be an important component to the access issue in rural areas," said Svedgen.

NO OUT-SHOPPING

Another difficulty rural areas face is "out-shopping" – when residents bypass local providers to purchase health-care services in urban areas. This not only deprives the local area of needed dollars, but may contribute to that area's eventual loss of its provider.

[Rural, p.4]

PUBLIC HEALTH *NEWS*
is produced by staff from the Environment, Energy and Transportation Programs and the Health Care and Prevention Projects Programs, located at the National Conference of State Legislatures headquarters in Denver.

For more information about the programs, visit: http://www.ncsl.org or call (303) 364-7700.

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This insert is supported in part by grants from the Centers for Disease Control and Prevention and the Health Resources and Services Administration, U.S. Department of Health and Human Services

HEALTH*TALK*

DOEKSEN: HOW CAN RURAL AREAS PROVIDE HEALTH-CARE SERVICES?

How do health-care services affect rural areas? And what can communities do to ensure that services are available? In an interview, Gerald Doeksen, regents professor and extension economist for the Department of Agricultural Economics at Oklahoma State University, answers these and other questions. An edited transcript follows:

Q) What components of the health-care sector most affect a rural economy?

A) If you look at the aspects of a rural economy and all health services, one of the most critical is a hospital. Research has indicated that a hospital will attract and retain physicians in a rural community.

Q) What percentage of people do health-care facilities usually employ in the rural area?

A) Generally 10 to 15 percent of the people in a rural area work directly in the health sector. As the health-care industry and the health-care employees spend their money locally, it eventually contributes up to 25 percent of the employment base.

Q) How important is this to the community?

A) It's extremely important to a community, especially if they want to attract business. The two most critical factors that a business looks at to determine a location (after they look at profitability) are the health system and the education system. Towns that lack those are at a pretty big disadvantage to other communities.

Q) What are some of the predictors for people who are choosing a retirement location?

A) Many rural areas have environments that enable them to be in a good position to attract retirees. Retirees' spending and purchasing can be an important source of local jobs. If the people in a rural community have an economic development strategy of attracting retirees, they need to look at their health-care facilities. Research shows that two of the best predictors for retirement location are health care and safety. Retirees want to feel safe, and they want to know they have health services when they look for a place to retire.

Q) As demographics in the U.S. continue to change, and more people become ready for retirement, what do you see as the long-term effect on rural communities?

A) If you look at the aging population in rural communities right now, it is really a challenge for providers to be successful. For instance, rural hospitals treat many patients on Medicare and Medicaid. In fact, 60 to 80 percent of their customers or patients are in either Medicare or Medicaid, with Medicare being 60 to 70 percent, and Medicaid being about 10 percent. The combination of payments makes it extremely difficult for providers to profit, let alone break even.

Q) As reimbursement rates decrease, what is the impact on communities when health-care facilities are forced to change into something else, or close?

A) The community would quickly deteriorate as employees such as doctors, pharmacists, nurses, etc., are forced to leave the community. It is devastating for a community to lose any component of its health sector.

Q) Can you provide examples of communities that have creatively addressed providing health care in rural areas?

A) Some small communities, such as Drumright, Oklahoma, focused on strategic health planning, which is a process that helps local communities identify their health-care needs. Strategic health planning involves cooperation among people and organizations to pursue common goals. The process is designed to answer 1) Where is the community now? 2) Where does the community want to go? 3) How will the community get there? The people of Drumright are building a new critical access hospital, and physicians are showing an interest in moving to the area.

Other creative ways to provide health care in rural areas include telemedicine.

Telemedicine, or telehealth as it is also called, connects patients with health-care providers in sometimes-distant locations. Telemedicine includes interactive video (enabling "face-to-face" contact between patient and provider), store-and-forward imaging, remote monitoring and sharing of medical records. For example, teleradiology improves the quality of services in a rural area by providing immediate results; it connects a patient to a radiologist in a larger city.

Q) What can rural communities do to position themselves to benefit from health care in their area?

A) Communities need to take a very proactive approach and plan their health system and provide the services they can economically and feasibly provide. For example, I recently worked with a community that was looking to establish a kidney dialysis unit in their hospital. After analyzing its market, the community found that the dialysis unit would be economically feasible as well as beneficial to local people. One thing providers can do is to convey to residents the quality of care available locally. There exists a myth out there that bigger is better when it comes to delivering services, and that is not true. Primary-care services provided at the rural centers have been shown to be just as good as those at the urban centers. ✦ *JR*

Rural, from p. 3

According to Tess Ford, director of the Center for Rural Health and Social Service Development at Southern Illinois University, "Bigger is better in many health consumers' eyes."

"Only about 30 percent of the people in my state's rural communities use their local hospitals," added North Dakota's Svedgen. The remainder travel to the more urban areas for services.

The same is true in Washington Rep. Lynn Kessler's district. "Health-care dollars escape from my counties all of the time," she said. "Local communities need to let people know about the health-care services available."

To address those escaping dollars, communities and providers are working together to market their health-care services and improve their quality. "When communities contribute to the design of local health-care services, they are more apt to spend their health-care dollars locally," Ford said.

Marketing high-quality health services and creating a link between business groups, the community and the health-care sector are important steps to keeping health-care dollars at home and improving the quality of local health care, agreed Scorsone.

But he cited two major hurdles: that local economic development committees rarely communicate with health-service providers, and, again, that recruiting and retaining high-quality health staff in rural areas remains an ongoing and complicated issue.

"When we go into the local communi-

[Rural, p. 6]

VITALSIGNS

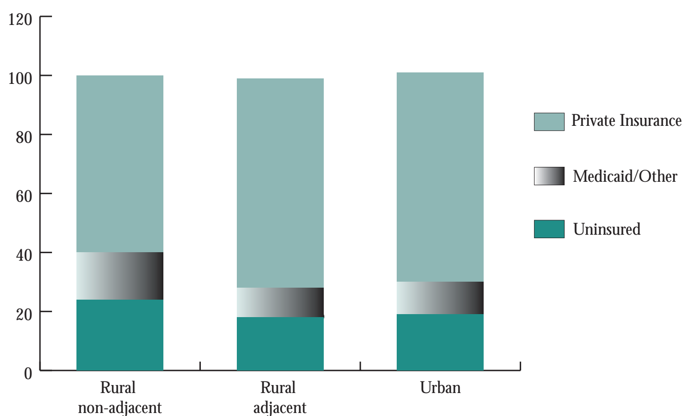
Health Care in Rural America

A National Rural Health Snapshot

	Rural	Urban
Percentage of USA Population**	25%	75%
Percentage of USA Physicians**	10%	90%
Num. of Specialists per 100,000 population**	40.1	134.1
Population aged 65 and older	18%	15%
Population below the poverty level	14%	11%
Average per capita income	$19K	$26K
Population who are non-Hispanic Whites	83%	69%
Adults who describe health status as fair/poor	28%	21%
Adolescents (Aged 12-17) who smoke	19%	11%
Male death rate per 100,000 (Ages 1-24)	80	60
Female death rate per 100,000 (Ages 1-24)	40	30
Population covered by private insurance	64%	69%
Population who are Medicare beneficiaries	23%	20%
Medicare beneficiaries without drug coverage	45%	31%
Medicare spends per capita compared to USA average	85%	106%
Medicare hospital payment-to-cost ratio	90%	100%
Percentage of poor covered by Medicaid	45%	49%

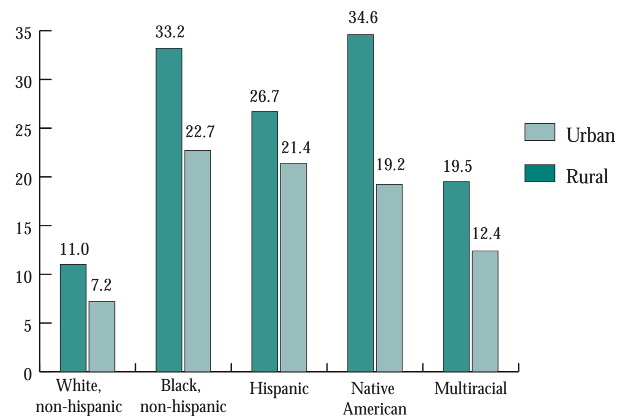
Reprinted with permission from the National Rural Health Association, statistics from "Eye on Health" by the Rural Wisconsin Health Cooperative, from an article entitled "Rural Health Can Lead the Way," by former NRHA President, Tim Size.
http://www.nrharural.org/pagefile/different.html

Sources of Health Insurance Coverage Among the Nonelderly (Ages 0-64) by Residence, 1998



Source: Kaiser Commission on Medicaid and the Uninsured

Poverty Rates by Race and Ethnicity, 2002



Source: United States Department of Agriculture Economic Research Service

Rural, from p. 4

ties to help, we almost always recommend a task force led by the Chamber of Commerce, which includes the health sector," Scorsone said.

A CASE IN POINT

Grays Harbor County is located on the Olympic Peninsula in Washington about 75 miles from Seattle. This rural county – there are about 35 people per square mile – offers rolling tree-covered hills and beautiful ocean beaches, giving way to rugged mountains in the northernmost area. In the middle of the major population base, on the top of a hill overlooking the bay, lies Grays Harbor Community Hospital. County residents look to the hospital not only for high-quality health-care services but for jobs and a boost to the local economy.

"The hospital employs about 600 people, which makes it the third largest employer in the county," said Michael Tracy, executive director of the Grays Harbor Economic Development Council. In Grays Harbor, "the hospital and the local economic development council have a very close relationship." In fact, the president of the Council works for the hospital.

The people in the community also support the hospital. "This community shows its heart when it comes to assisting the hospital," said Kim Woodford, director of guest relations and administrator of volunteer services at the hospital. Not only does the community do a "fantastic job" of volunteering their time but they also support the fundraisers – book, art and jewelry sales to name a few.

"Over the years, the volunteer auxiliary purchased many needed items for the hospital, with the most recent being an ultrasound machine that helps place IV equipment and dental x-ray equipment for a new pediatric dentist," Woodford said.

In another example of a town pulling together to bolster its health-care providers, a community organization joined with the local hospital to market new health-care services – chemotherapy and oncology – to area residents.

"These were services that the locals were traveling great distances to receive on a regular basis," Kessler said. The result was satisfied customers who, through word of mouth and letters to the editor, helped to increase patronage for the local health-care providers. "Word of mouth is a tremendous force" in rural areas, Kessler said.

A variety of federal and state programs exist to help maintain and increase the health-care workforce in rural areas. The National Health Service Corps provides scholarships and loan repayment to physicians and other health professionals who agree to serve in rural and urban underserved areas. In addition, they administer the State Loan Repayment program, which provides funds to the states for their own loan repayment programs.

Sometimes it is the local government or hospital that provides incentive for recruiting providers. Kessler noted that one rural hospital in her district subsidizes the wages of its physicians in an effort to recruit them. The hospital guarantees them a certain level of income and makes up any gap between what they take in and the guaranteed level.

"Health-care providers – doctors, nurses, pharmacists – look at the same things in a community that businesses do when making a decision to relocate," Tracy said.

The economic development council helps build the infrastructure that aids the hospital in recruitment of workers. And the hospital, with its high-quality services, makes attraction of other industries possible. "The assistance goes both ways," Tracy said. *LT*

THE DELTA PROJECT

One innovative federal program for rural regions is the Delta Rural Hospital Performance Improvement Project. Funded by the federal Office of Rural Health Policy of the Health Resources and Services Administration, the project brings needed consultation and information to small rural hospitals in the Mississippi Delta region. The goal is to improve the hospitals' financial, clinical and operational performance, while collecting information and business tools that the hospitals can use to help themselves.

In March of this year, West Feliciana Parish Hospital in Louisiana received training and consultation from national experts funded by the Delta Rural Hospital Project. According to Mark Chustz, administrator for the hospital, the federal dollars were used to conduct an economic impact study of the local health-care industry on the community as well as a health needs survey of the community.

The hospital — the third largest employer in the county – hoped to improve its services and to collect information that would educate people about the hospital's economic contribution to the community.

The study revealed that the hospital's 90 or so full-time employees and $3.7 million dollar payroll enriched the local economy to the tune of about $4.4 million. In total, the parish's health-care providers boosted the local economy by $21.3 million.

Chustz reports that he took the results of the study to a well-attended Rotary club meeting and asked, "What would you do to attract a $21 million industry to this community?" Being a group interested in economic development, the Rotarians answered, "a lot." Chustz then made the point that just such an industry already existed in the community and that it needed support to survive and grow.

Chustz hopes that the information gathered will help the hospital fine tune its services to meet the needs of the community, as well as develop trust and patronage from the local taxpayers who support the hospital by giving it $1.5 million in tax revenue each year. "Strategically growing the local health-care industry serves the community (both) medically and economically," said Chustz.

For more information on this initiative, visit http://deltarhpi.ruralhealth.hrsa.gov/index.shtml

HIGHLIGHTS

PRESCRIPTION DRUGS

Some States Pay More

State Medicaid programs paid enormously varying prices for prescription drugs in FY 2001, according to a new report from the Office of Inspector General, at the U.S. Department of Health and Human Services. The OIG sampled 28 brand-name and generic medications purchased by 42 states. It found that the highest-paying state paid anywhere from 12 to 4,073 percent more per drug than the lowest paying state for the 28 drugs in the sample. Michigan and Texas consistently paid low prices relative to other states, while New Jersey and New York consistently paid high. Other states, such as Ohio and Nebraska, tended to vary in price rank depending on the type of drug. Medicaid could have saved $86.7 million in FY 2001 if all states had paid the same price as the lowest paying state for each of the 28 drugs, the OIG said. To help states more accurately calculate their costs, the OIG recommended that the Centers for Medicare & Medicaid Services give states access to average manufacturer price data (which are used by federal Medicaid officials to calculate state rebates). That data is not released to states because of manufacturer confidentiality issues. Instead, states have access to the average wholesale prices, which are published by drug manufacturers. The OG said it plans to send specific results to each state of their analysis so that the state can review its Medicaid payments. CMS officials said they planned to follow up with states, especially with those that paid the highest prices. In FY 2001, Medicaid spent $20 billion on prescription drugs, or 9 percent of the total federal Medicaid budget. For more, go to: www.oig.hhs.gov/oei/reports/oei-05-02-00681.pdf

MALPRACTICE

Mixed Reviews in Texas

Last June, Texas Gov. Rick Perry signed into law a bill that caps noneconomic damages in malpractice lawsuits. The effects of that law have been mixed, according to a recent series of articles in the *Dallas Morning News.* The paper found that the law – which caps noneconomic damages at $250,000 for physicians, hospitals, nursing homes and other health-care facilities – has not decreased malpractice insurance premiums for most of the physicians in the state. However, in a possible harbinger of things to come, the rate of malpractice lawsuits filed in most large Texas counties has dropped by at least 80 percent. And a survey by the Texas Hospital Association found that many hospitals in the state have experienced reductions in their premiums, as have physician groups that self-insure for most of their initial risk. Consumer advocates complain that the law has prevented some injured state residents from being able to find attorneys to represent them in malpractice lawsuits. Attorneys told the *Morning News* that they're caught between potential clients and the reality of the caps, which often leave "little for the plaintiff after the expenses and contingency fee." ✦

Assisted Living, from p. 2

"That consumers have the option to remain in one facility, though the intensity of their care may change, was complex language to negotiate, but important to guarantee," she said.

In July 2003, an affordable assisted living facility opened in Burlington. The development, which was incorporated into an existing HUD project, consists of 80 units of independent living and 28 units of assisted living, 21 of which are considered affordable. A HUD conversion grant provided the funds necessary to make accessible the bottom two floors of the complex, add a community recreational and dining areas, and provide private rooms and bathrooms. Cathedral Square Corp. owns the building and provides direct-care assistance to tenants, including full-time personal and health-care services. A second facility is set to open in January 2005.

"I think it's been a surprise to people that we can create an assisted living facility that is as nice or nicer than a market-rate facility by combining affordable housing subsidies and Medicaid programs," said Jenkens.

While state officials fear that individuals will come "out of the woodwork" if more assisted living facilities become available, Jenkins said he's seen no evidence to suggest that's occuring. "There's no reliable evidence either way," he said.

But an analysis of whether the "woodwork effect" exists is an important next step, Jenkens added. "Before we can move forward, it's the single biggest policy issue to resolve."

✦ *ACS*

For more information, visit www.ncbdc.org

NOT SO RICH

The myth that most seniors are rich is just that. Forty-seven percent of Americans aged 65 and older have annual incomes of less than $25,000; of the 10.2 million households of people 75 and older, two-thirds have incomes below $25,000. Seniors who live in rural areas have an especially difficult time. In rural areas, the elderly make up 15 percent of the population, compared with 12 percent in urban areas. Moreover, the elderly living in rural communities are more likely to be poor. On average, per capita income is $7,147 lower than in urban areas, and rural Americans are more likely to live below the poverty level. — ACS

STATE HEALTH *NOTES*
Forum for State Health Policy Leadership

Published biweekly (24 issues/yr.) by the FORUM FOR STATE HEALTH POLICY LEADERSHIP, an information and research center at the National Conference of State Legislatures in Washington, D.C.

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FOR YOUR *INFORMATION*

Finding Homes for the Mentally Ill in High-Cost San Francisco

A program in San Francisco for people with serious mental illnesses demonstrates the healing power of home.

Launched some 35 years ago, the Progress Foundation offers voluntary, community-based residential treatment as an alternative to hospitalization to about 1,400 clients each year. Most patients are thought to be extremely disabled due to emotional regulation or psychotic thought disorders, and at least 60 to 70 percent have or have had a substance abuse problem.

The foundation places clients in large family homes in San Francisco neighborhoods. The treatment philosophy is "social rehabilitation" – clients are taught that their illnesses do not prevent them from engaging in normal, daily activities. By combining clinical therapies with social interactions and responsibility for household operations, the program tries to dispel the sense of isolation that many clients feel from believing that they cannot function in a world that does not understand their mental illness.

"One problem with institutionalization is that patients are expected to act 'normally' in a strange, unfamiliar and potentially threatening environment," said Foundation Executive Director Steve Fields. "Our homes provide the most normal and comfortable environment possible, with everyday activities such as socializing with roommates and cooking dinner." As clients step out of the role of being "psychotic" and bring daily activities into their treatment, "they see they can live in a 'normal' setting and respond with motivation for recovery."

MOVING ON UP

Clients help develop a care plan that may include medication, therapy, neither or both, and they must adhere to that plan. The program has four levels of care, and clients are encouraged to reach the highest level of independence in the least restrictive setting possible.

The most intensive level of care – the five "acute diversion" houses – offer frontline services, usually to clients in crisis who may come directly from hospital emergency rooms or the streets. There are five acute diversion houses that serve about 50 clients altogether. The next, less intensive level of care are "transitional" homes, for those who are stable but still need 24-hour care. Fields said many acute diversion clients would like to enter transitional housing, but the eight transitional houses have 75 beds, and those are rarely enough to fill the need. Clients may stay in a house for up to four months, although residents of Ashbury House, which serves mothers and children, may stay for up to one year.

In the third level of care – cooperative apartments – clients must accept individualized case management services on the foundation's terms, which vary from 24x7 care to loosely structured services. In the least restrictive setting – permanent supported housing – clients are not required to go to treatment. Some clients have regular volunteer commitments, and a few are employed.

The houses are beautiful old family houses in pleasant neighborhoods. As Fields explains, "Securing houses in nice neighborhoods reaffirms clients' positive behavior because it raises their own expectations for how they must act to receive positive community feedback. I don't think you would see the same interplay in a bad neighborhood, where they would be subjected to a self-fulfilling prophecy as behavioral expectations were lowered." Although each house opening has encountered varying degrees of public opposition, there have not been any reported problems after program implementation, Fields said. In some cases, he added, neighbors who were initially opposed to homes have served as references for other residences.

Foundation officials don't doubt that they save the state money: a bed in a psychiatric hospital costs about $1,200 a day, while a bed in acute diversion costs $350 a day, and in the transitional program, $250 a day.

Funding for the program comes from the rehabilitation option available under Medi-Cal, California's Medicaid program, and from other state and county funds. In addition, the foundation gets 8-11 grants from the U.S. Department of Housing and Urban Development, to help pay the facility costs for the last two tiers of care.

The Progress Foundation is on the crest of a new wave of treatment options geared at re-establishing a sense of normalcy in clients' lives. Foundation staff say the essence of their accomplishments lies in the question they ask themselves when choosing new houses and developing new programs: "Would you put *your* own family member there?" ✦ *MH*

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