STATES CONSIDER REQUIRING NEW HPV VACCINE FOR GIRLS

Anna C. Spencer

In June, the Food and Drug Administration approved a vaccine for human papillomavirus, or HPV, for use in females ages 9 to 26 to prevent cervical cancer. Following FDA approval, the Centers for Disease Control and Prevention’s Advisory Committee on Immunization Practices (ACIP)—the body responsible for analyzing and making recommendations on vaccine-preventable diseases—voted unanimously to recommend that girls and women ages 11 to 26 receive the vaccine.

In the absence of federal laws mandating the immunization of children, states are responsible for defining and implementing vaccination policy. Though the final ACIP guidelines are not due out until November, some controversy has already arisen over whether to require the HPV vaccine for school attendance.

“Vaccinating against HPV is not as straight-forward as something like measles or whooping cough,” said Curtis Allen, spokesperson for the CDC. The virus is not as contagious as many other vaccine-preventable diseases (HPV is spread by skin to skin contact only and is primarily sexually transmitted), and, at present, the vaccine is only available for females. “To require the parents of girls to pay for that vaccine but not the parents of boys poses some gender equity issues,” said Allen. Furthermore, some parents’ groups have voiced concern that immunizing their pre-teen daughters against a sexually transmitted disease sends the wrong message.
A Widespread STD

Each year, 10,000 women are diagnosed with cervical cancer in the United States, and 3,700 women die from the disease. Virtually all cervical cancer cases are linked to the human papillomavirus, the most common sexually transmitted disease in the United States. Roughly 20 million people are currently infected with HPV, and about half of all sexually active men and women will acquire HPV at some point in their lives. Most people who become infected with the virus will remain asymptomatic and the condition generally clears on its own. In some cases, however, the virus causes the cells in the cervix to change, which can lead to cancer.

Gardasil, the brand name for the vaccine, protects against four different strains of the human papillomavirus. Clinical trials have shown it to be 99 to 100 percent effective in preventing those strains of HPV, which cause about 90 percent of genital warts and can lead to cancer.

The ACIP voted to recommend that girls ages 11 to 12 routinely receive the vaccine (upon entering 6th grade). “Catch-up” vaccination is suggested for females 13 to 26 who have not been vaccinated previously. Ideally, the vaccine should be administered before potential exposure to HPV through sexual contact.

Michigan Moves

On Sept. 20, Michigan became the first state to consider legislation to require the HPV vaccine for school entry. Unanimously approved by the Senate, SB 1416 and SB 1417 would require girls who are entering the 6th grade to be vaccinated against HPV beginning in the 2007-2008 school year. Girls whose parents have medical, religious or philosophical oppositions to the vaccine would be exempt. (All 50 states allow exemptions from vaccination requirements for medical reasons; every state except Mississippi and West Virginia allow religious exemptions; and 20 states allow philosophical or personal exemptions for people who object to immunizations for personal, moral or other nonreligious beliefs).

“This vaccine prevents cancer. It really is a no-brainer,” said bill sponsor Sen. Beverly Hammerstrom. While her office has received some complaints about the proposed requirement, Hammerstrom says, “The timing fits naturally with other vaccines that are administered before 6th grade, like tetanus and diphtheria, so the requirement will not pose an extra burden for parents.” The bills go before the House when the Legislature returns in mid-November.

Mandating immunizations for school entry significantly improves vaccination rates. “It’s our hope that states will follow Michigan’s lead by requiring the HPV vaccine for school enrollment,” said Deborah Arrindell, vice president for health policy at the American Social Health Association. “It’s the most effective way to ensure that vaccines become universal.”

Who Will Pay?

Vaccinating against HPV doesn’t come cheap: the three-dose series of shots will retail for $360. Although not binding, ACIP recommendations generally become the standard of practice for health-care professionals, determining whether private insurers will reimburse for it and whether states will publicly fund it.
The ACIP also voted to add Gardasil to the CDC’s Vaccines for Children (VFC) program. Since 1994, the VFC program has funded vaccine for children younger than 19 who are Medicaid-eligible, uninsured and/or Native American. VFC also covers immunizations for children whose insurance does not cover vaccinations, provided they are vaccinated at participating federally qualified health centers and rural health clinics.

Federal laws don’t stipulate immunization coverage for adults under Medicaid. It remains to be seen whether states will cover the “catch-up vaccine” for Medicaid-eligible women ages 19 to 26. “This will have a financial impact on state Medicaid budgets,” admitted Sen. Hammerstrom. But, she said, “It will be a lot cheaper than the human and economic toll of cervical cancer.”

STATE NEWS

MONTANA LAW PAVES WAY FOR COLLABORATION BETWEEN INDIAN TRIBES AND STATE

Christina Kent

A recent Montana law (HB 452) could serve as a model for states that are wrestling with one of the thorniest issues in health care: how to bring American Indians and Alaska Natives together with state officials to protect and improve tribal access to Medicaid financing.

As part of its trust obligations to Indian Nations, the federal government provides a 100 percent match for Medicaid for services provided in certain settings to American Indians and Alaska Natives. But, beyond federal regulations, states decide a number of issues such as eligibility rules, benefit packages, cost-sharing requirements or provider payment rates.

One impetus for the Montana law was a concern that the state might adopt certain Medicaid policies that would not produce savings for the state in Indian Country (since the feds provide a 100 percent match), but would harm American Indians and Alaska Natives.

Among other things, HB 452 requires the state to seek a federal waiver so that any reductions in Medicaid funds do not shift costs to tribal or Indian Health Service (IHS) facilities; directs the state to work with tribal governments to leverage federal funds for SCHIP; and mandates that the state work with tribes to review Indian eligibility issues.

“This is going to break through a lot of the bureaucracy (that hinders progress on health care in Indian country),” bill sponsor Rep. Jonathan Windy Boy said during a Robert Wood Johnson Foundation-sponsored NCSL web-assisted audioconference on the law. He added, “This is just the beginning of a huge process. We are thinking outside the box.”

There are more than 562 federally recognized tribes within the United States. Although a significant number reside in Alaska (227), the remaining tribes are located within the boundaries of 36 states.
The obstacles to improving care are enormous. The health status of American Indians and Alaska Natives is, on average, far worse than the health status of other Americans. Indians and Alaska Natives have rates of diabetes that are 291 percent higher than all U.S. races, suicide rates that are 91 percent greater, and pneumonia/influenza rates that are 67 percent higher.

Then there’s the fact that the complexities of blending Medicaid with other programs that serve Native Americans and Alaska Natives are “mind-boggling,” in the words of Kris Locke, consultant for the Northwest Portland Area Indian Health Board.

In addition to the IHS, many tribal members could qualify for Medicaid, so increasing enrollment in Medicaid would seem to be a win-win proposition. However, a history of IHS underfunding, and differing perspectives on treaty obligations and tribal autonomy can stall collaboration. Conflicting programs and values require negotiations to build trust, and coordination is needed to align Medicaid and IHS requirements.

At a recent roundtable on the IHS and Medicaid reform, sponsored by the Urban Institute, speakers noted that a distinct disadvantage of Medicaid, from the Indian perspective, is that it is a state program. As states do not share in the federal government’s special trust responsibility to Indian tribes, communication has often been difficult.

“HB 452 recognizes and acknowledges the unique situation of the tribes in Montana,” said Garfield Little Light, associate area director for the IHS. “It’s slow, but we’re kind of pioneers. I’m happy we’re starting the journey.”

For more, go to: http:www.ncsl.org/programs/statetribe/tribes.htm

For more on the continuing web-assisted conference series on cultural competency, http://www.ncsl.org/programs/health/webcast2.htm or contact kala.ladenheim@ncsl.org.

STATE NEWS

CALIFORNIA EXPANDS ACCESS TO DENTAL CARE

Matthew Gever

The medically underserved in California may soon have greater access to dental care.

A new law (AB 1334) expands the ability of dental hygienists to practice in free-standing settings. Hygienists in so-called “alternative practice” who have undergone special training are authorized to provide specified services, such as teeth cleaning and preventive care, in selected settings, such as underserved communities. The new law eliminates a 1997 requirement that patients obtain a prescription from a dentist or physician before being treated by a hygienist outside a dentist’s office.
Some advocates had complained that the prescription requirement was a barrier to care because too few low-income persons had access to a dentist or physician. Also, they said, few dentists were willing to write prescriptions. Dentists said prescriptions were needed to ensure that the hygienists provided appropriate high-quality care, and succeeded in amending the legislation to require a prescription for patients after they have been treated by a hygienist for 18 months.

The legislation will expand access to oral health services by increasing the pool of people available to serve, said Assemblyman Simon Salinas, sponsor of AB 1334. “A lot of underserved communities don’t have a dentist,” he explained.

In California, as elsewhere, few dentists see Medicaid patients because reimbursement rates do not cover dentists’ overhead costs, and the paperwork is burdensome. Most dentists operate as independent businesses, meaning they do not have the same access to capital as a physician working in a hospital.

Support for AB 1334 was boosted by a recent report from the Dental Health Foundation—a research organization focused on California oral health issues—on the state of children’s oral health in the state. The survey found that two-thirds of children have significant tooth decay by 3rd grade, and three-fourths of low-income elementary school children have had a cavity, compared to about half of kids who are not low-income. The report ranked the Golden State 24th out of 25 states surveyed.

Nationwide, poor oral health is an “epidemic,” according to a landmark report by former Surgeon General David Satcher. Tooth decay is the most prevalent childhood disease, affecting 59 percent of children. By comparison, 11 percent of children have asthma.

**Expanding Access**

A large number of states have increased access to dental hygienists in an effort to improve oral health. Currently, 49 states allow dental hygienists to perform certain authorized services without a dentist being physically present on the premises. The settings and levels of supervision required vary from state to state. In 20 states, the dental hygienist can initiate treatment and provide hygiene services based on his or her assessment of patient need. (For more on state actions, go to [www.adha.org](http://www.adha.org).)

California’s dental hygienists in alternative practice may provide care in dental health professional shortage areas, as well as in residential facilities and schools, and for homebound clients. Their allowable duties include preventive and prophylactic services, such as cleanings and sealants.

California first tested the concept of “alternative practice” ten years ago. Under the pilot program, 20,000 patients were seen by the hygienists without a single problem, according to Assemblyman Salinas. “There was no indication this would jeopardize the safety of patients.”

The [California Dental Association](http://www.cadent.org) (CDA) expressed concern about AB 1334, saying that the number of hygienists currently practicing in alternative settings (about 150) is too few to assess the impact of the prescription requirements. “Until data indicates otherwise, CDA believes that requiring a level of involvement by a dentist is not unreasonable for [the hygienists], who can provide a limited scope of services to patients,” said a CDA policy statement.
CDA persuaded legislators to amend the bill by allowing patients to be treated by a hygienist in alternative practice without a prescription; however, 18 months from the initial date of seeing the patient, a prescription for services must be obtained from a dentist or physician. That prescription is valid for 24 months, after which a new prescription must be obtained. Failure to follow the new provision would be considered unprofessional conduct and subject the hygienist to penalties.

"The intent is not to have hygienists be dentists," said Assemblyman Salinas.

HIGHLIGHTS

PRESCRIPTION DRUGS

Border Seizures to End

As of Oct. 9, U.S. Customs and Border Protection officials will no longer seize prescription drugs sent by mail to U.S. residents from Canadian pharmacies. Since Nov. 17, 2000, Customs officials have seized thousands of packages of drugs that were sent by Canadian pharmacies to U.S. residents. Federal laws prohibit the importation of medications from abroad, although Customs and FDA officials had previously generally allowed the practice. Patient advocates and lawmakers criticized the seizures, saying they deprived American seniors of access to drugs and protection from the high prices charged by U.S. drug companies. Customs officials said that they will end the seizures and will instead begin to test random packages for counterfeit and/or ineffective drugs. "We are still very committed to protecting the American public from these medications. We just decided to focus our resources differently," Lynn Hollinger, a Customs official told the South Florida Sun-Sentinel.

Ohio Begins Prescription Monitoring Program

On Oct. 2, the Ohio State Board of Pharmacy launched the Ohio Automated Rx Reporting System, a computer database that tracks sales of controlled substances. The goal is to prevent "doctor shopping," where patients visit multiple doctors in order to get multiple prescriptions of a drug. The board will require bi-monthly reports on prescription sales from retail and mail-order pharmacies that sell to Ohio patients. Doctors and pharmacists will then have access to Internet reports that show if a patient has been doctor shopping. The general public will not have access. Ohio becomes the 25th state with a monitoring program. "A doctor can look at the report and see that you've been going to one doctor and one pharmacy and you're a legitimate patient. But if he sees you going to 15 different doctors and 15 different pharmacies and you've been going the next day and then the next day and the next day, they see you might not be a legitimate patient and might not want to write a prescription for you," William Winsley, executive director of the pharmacy board, told the Cleveland Plain Dealer.
Prescription Drug Abuse Up, Other Abuse Down in California Students

A survey of California students shows that more kids are abusing prescription drugs, even as use of other substances is decreasing. The survey found that 15 percent of 11th graders and 9 percent of 9th graders use pharmaceuticals without a prescription. Prescription drugs are now the third most popular substance among young Californians, trailing alcohol and marijuana. On the upside, the survey found a significant decrease in underage drinking and use of marijuana and inhalants. In the decade since the last survey, drinking among 9th graders dropped from 60 percent to 40 percent, while drinking among 11th graders fell from 70 percent to less than 50 percent. However, binge drinking—defined as having 5 or more drink in a row—among those groups did not change.

A Preference for Phones or “Snail Mail”

Physicians are slow to adopt e-mail to communicate with their patients, according to an Oct. 3 study from the Center for Studying Health Systems Change (HSC). Only about one in four physicians (24 percent) reported using e-mail to discuss clinical issues with patients in 2004-05, up from one in five physicians in 2000-01. Physicians in staff/group-model health maintenance organizations and medical school faculty practices had the highest rates of adoption, followed by physicians in group practices of more than 50 physicians. Only about 20 percent of physicians in practices with nine or fewer physicians communicate with patients via e-mail. Rural, low-income, elderly and African-American consumers are among those least likely to have Internet access and to use e-mail. The American Health Information Community, a recently formed federal commission, has identified secure online communication between physicians and patients—especially those with chronic conditions—as a technology that should be rapidly developed. Moreover, 80 percent of online Americans would like to communicate with their doctors via e-mail.

GRAPHICALLY SPEAKING

MEDICAID INCREASE SLOWS, BUT STORM CLOUDS REMAIN

Christina Kent

Thanks to an improved economy and the new Medicare prescription drug benefit, the growth in Medicaid spending has slowed to 2.8 percent—the lowest rate of growth in a decade, according to a new 50-state survey from the Kaiser Family Foundation’s Commission on Medicaid and the Uninsured.

The survey found that the number of persons in Medicaid increased by just 1.6 percent in FY 2006, the lowest rate of growth since 1999 (see chart). However, officials in six states said their new beneficiaries are primarily elderly and disabled, and the growth in enrollment of those individuals is expected to have a disproportionate effect on program costs.

The fact that state revenues increased faster than Medicaid spending for the first time since 1998 helped states to expand their Medicaid policy initiatives beyond measures aimed
strictly at cost containment, to ones aimed at improving care and restraining costs, such as disease management (see chart). Nearly three-quarters of states plan to expand their community-based long-term care services in FY 2007, and more than two-thirds of all states will have quality initiatives in place, with most classified as “pay for performance.”

Few states are planning to use the new flexibility allowed under the 2005 Deficit Reduction Act (DRA) to change benefits or impose cost sharing in FY 2007, but some are considering those options. Three states—Kentucky, West Virginia and Idaho—had plans approved to change benefits.

On the downside, many state officials said that the new citizen documentation requirements in the DRA will increase administrative costs and harm enrollment. And states may be facing additional financing strains as formula-driven changes continue to decrease federal matching rates and as the Center for Medicare & Medicaid Services continues to scrutinize state financing practices. Many states expressed frustration that the “rules of the road” around these fiscal issues are “murky, changing, and inconsistently applied,” which makes budgeting for Medicaid extremely difficult.