Report to Congress
On Extending The
P.L. 102-585 Drug Pricing Program
To Selected PHS Block Grant Recipients

Submitted by the
Department of Health and Human Services

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Federal liaisons from the Office of Drug Pricing Program, Maternal and Child Health Bureau, Center for Mental Health Services, and Center for Substance Abuse Treatment reviewed the material and provided valuable suggestions.

Information for the Secretary of Health and Human Services'
Report to Congress on Extending P.L. 102-585 Drug Pricing Agreements
To Selected Public Health Service Block Grant Recipients

EXECUTIVE SUMMARY

Title VI of the Veterans Health Care Act of 1992 (P.L. 102-585) directed the Secretary of Health and Human Services to prepare a report on the potential impact of extending the Public Health Service (PHS) drug pricing discounts to health care entities receiving PHS Act funds through the following block grants: Community Mental Health Services (CMHS) Block Grant, Substance Abuse Prevention and Treatment (SAPT) Block Grant, and the Maternal and Child Health Services (MCH) Block Grant.[1]

Between May and July 1993, the Public Health Foundation gathered information for the Office of the Assistant Secretary for Health (OASH) about the potential impact of extending the drug pricing discounts to these entities. The findings indicate that many entities already participating in the PHS drug discount program have had positive experiences with it. The savings conferred by the program have been used to improve the quality of health care services provided to patients. Discussions with the directors of entities that would become eligible if the PHS drug discount program is extended to recipients of the MCH, mental health, and substance abuse block grants revealed eagerness to participate in a program that will enable them to pay lower prices for pharmaceuticals. However, whether savings from the discounts would enable block grant-funded entities to better serve their patients will be determined by: (1) the amount of savings realized by participating in the PHS drug discount program; (2) whether the entities are able to retain the savings for program purposes; (3) the cost of administering the program; and (4) manufacturers' behavior, especially with regard to cost-

[1] In Title VI, Congress referred to the Alcohol, Drug Abuse, and Mental Health Services (ADMS) Block Grant. This block grant formerly served the program areas of mental health and substance abuse. However, in 1992, the ADMS Block Grant was replaced by the Community Mental Health Services Block Grant and the Substance Abuse Prevention and Treatment Block Grant. The names of the newly formed block grants are used in the narrative section of the report. The former name, ADMS Block Grant, is used in the tables at appendices C and D.

shifting.

The estimated national expenditures for outpatient drugs for the MCH, CSHCN, and mental health program areas in fiscal year 1992 were $179 million. This includes $37.0 million for MCH programs, $48.3 million for CSHCN programs, and $93.7 million for mental health programs. Data from the states were insufficient to calculate a national estimate of outpatient drug expenditures for the substance abuse program area.

The estimated national expenditures are based on a small number of reporting states that are not necessarily representative of all states. In addition, the range of expenditures in each program area is extremely large, thus the "true" national expenditures could be different than those reported here. Still, the large expenditures reported by several states make it clear that some states and entities in each of the four program areas could realize significant savings if Congress extends the PHS drug discount program to the block grants.

The state program directors and others suggested a number of ways in which both the current and an expanded PHS drug discount program could be improved:

- Extend the PHS drug discount program to state and local governments so that all programs that receive public funds are able to participate in the program, regardless of the source of funding (i.e., local, state, or federal tax dollars);

- Operationalize a rebate structure as well as a discount; and

- Provide states with definitive guidelines for implementing the program and on-site technical assistance.

The policy implications of the recommendations are discussed in the report. Additional factors that the federal government may want to consider include: (1) ways to encourage state programs to dedicate the savings conferred by the PHS drug discount program to program purposes; and (2) incentives for states to administer the PHS drug discount program centrally, minimizing the cost of administration and maximizing the savings available for program purposes.

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I. INTRODUCTION

To address concerns about rising Medicaid prescription drug costs, Congress included in the Omnibus Budget Reconciliation Act of 1990 (OBRA) a requirement that pharmaceutical companies give rebates to state Medicaid programs. The goal of this provision was to provide Medicaid programs with the "best price," or lowest price available, on outpatient prescription drugs.[1]

One of the OBRA requirement's unintended results was that drug costs for other federal purchasers, including the Department of Veterans Affairs (VA), increased substantially over the next year. In response, Title VI of the Veterans Health Care Act of 1992 (P.L. 102-585) included provisions requiring pharmaceutical manufacturers to enter into drug pricing agreements whereby they would offer discounts on outpatient drugs to the VA and to certain Public Health Service (PHS) grantees and disproportionate-share hospitals.

Title VI also directed the Secretary of Health and Human Services to prepare a report on the potential impact of extending these drug pricing discounts to health care entities receiving PHS Act funds through the following block grants: the Community Mental Health Services (CMHS) Block Grant, the Substance Abuse Prevention and Treatment (SAPT) Block Grant, and the Maternal and Child Health Services (MCH) Block Grant.[2]

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[1] U.S. General Accounting Office, *Medicaid: Change in Drug Prices Paid by VA and DOD Since Enactment of Rebate Provisions*, Report to Congress. September 1991, GAO/HRD-91-139.

[2] In Title VI, Congress referred to the Alcohol, Drug Abuse, and Mental Health Services (ADMS) Block Grant. This block grant formerly served the program areas of mental health and substance abuse. However, in 1992, the ADMS Block Grant was replaced by the Community Mental Health Services Block Grant and the Substance Abuse Prevention and Treatment Block Grant. The names of the newly formed block grants are used in the narrative section of the report. The former name, ADMS Block Grant, is used in the tables accompanying this report.

The purpose of the report is to provide the Office of the Assistant Secretary for Health (OASH) with information about the potential impact of extending the drug pricing discounts to health care entities receiving funds through the CMHS, SAPT, and MCH block grants. This information was gathered between May and July 1993 by the Public Health Foundation (PHF).

II. OBJECTIVES AND METHODOLOGY

This report has three objectives. The first objective is to provide background information about the types of entities that receive funds through the MCH Block Grant, the CMHS Block Grant, and the SAPT Block Grant in terms of:

- The types and number of entities that receive funds from each block grant (e.g., community mental health centers, hospitals, local health departments);
- The populations that are served; and
- The types of services that are commonly provided by these entities.[3]

The second objective is to estimate the extent to which the entities are involved in the procurement of outpatient prescription drugs, including:[4]

- The proportion of block grant-funded entities that procure drugs;
- The entities' predominant methods of procuring drugs; and

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[3] For this report, *entity* is defined as an organization or individual that receives funds directly from the state for the purpose of providing block grant services (i.e., *entity* does not include subgrantees, subcontractors, or satellite clinics of an entity). This definition is based on the language used by Congress in section 602 of P.L. 102-585, which defines an *entity* as: "(A) receiving funds from a State for the provision of mental health or substance abuse treatment services under subparts I or II of part B of title XIX of the Public Health Service Act or under Title V of such Act; or (B) receiving funds from a State under Title V of the Social Security Act for the provision of maternal and child health services that are furnished on an outpatient basis (other than an entity described in section 340B(a)(4)(G) of the Public Health Service Act)."

[4] "Procurement" means that block grant-funded entities either purchase drugs themselves or use drugs purchased by the state agency. Prescriptions are not included in the definition of procurement unless the entity subsidizes prescription costs for the patients.

- The entities' total expenditures on outpatient drugs for fiscal year 1992.

The third objective is to describe the potential impact of extending the PHS drug discount program to the block grants on the quality of care and the health status of patients.[5] The description includes:

- Ways in which drug discounts might affect the quality of care offered by entities;[6]

- Ways in which drug discounts might affect patient health status;[7]

- Factors that are critical to the entities' ability to fully benefit from drug discounts, such as their willingness to change the ways in which they procure drugs in order to take advantage of drug discounts; and

- Other relevant factors as identified by entities that are already participating in the federal drug discount program.

To describe the entities (objective one), PHF staff used secondary sources of information such as relevant documents and discussions with experts in the field. To evaluate the extent of drug procurement under the block grants (objective two), PHF canvassed 232 state and territorial directors of mental health services, substance abuse treatment, and MCH programs about their procurement practices.[8] To evaluate the potential impact of extending the PHS drug discount

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[5] P.L. 102-585, the Veterans Health Care Act of 1992.

[6] Quality of care includes staffing, facilities, diagnostic and therapeutic procedures, and outcomes of care. (Based on the International Epidemiological Association's *Dictionary of Epidemiology*.)

[7] Health status is defined as physical function, emotional well-being, activities of daily living, feelings, etc. (Based on the International Epidemiological Association's *Dictionary of Epidemiology*.)

[8] PHF worked in collaboration with the Association of Maternal and Child Health Programs (AMCHP), the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol and Drug Abuse Directors

to the block grants on quality of care and patient health status (objective three), PHF conducted a series of interviews with representatives of entities already participating in the PHS drug discount program; entities that may become eligible to participate; state MCH, CSHCN, mental health, and substance abuse programs; and pharmaceutical companies. Additional details about the methodology are provided in appendix A.

(NASADAD), and federal liaisons to identify *state program directors*. For the purposes of this report, *state program directors* were identified in 50 states, the District of Columbia, and the territories in which a contact person was known to AMCHP, NASMHPD, and/or NASADAD. In all, 232 state program directors were identified. This group includes 57 state MCH program directors, 57 state CSHCN program directors, 59 state mental health program directors, and 59 state substance abuse program directors. See table 1 for a list of the jurisdictions included in the report.

III. DESCRIPTION OF THE ENTITIES

This section provides a brief overview of the types of entities that receive funds from the Maternal and Child Health Services (MCH) Block Grant, the Community Mental Health Services (CMHS) Block Grant, and the Substance Abuse Prevention and Treatment (SAPT) Block Grant. A detailed description of both the program areas funded by the block grants and the entities that provide services in these program areas appears at appendix B.

According to data reported by 111 state program directors, the MCH, CMHS, and SAPT block grants supported services at over 7,500 entities in fiscal year 1992. This number is based on PHF's assessment of procurement practices among state block grant-funded programs. However, not all state program directors were able to respond to the assessment (i.e., 165 of 232 state program directors responded for a response rate of 71 percent), not all state program directors who did respond were able to provide numbers (i.e., only 111 provided numbers), and the total number of entities may include some duplicates. See table 2 at appendix C for a state-by-state display of the number of entities receiving block grant funds.

To understand why some states were unable to provide specific information about entities receiving block grant funds, one needs to examine the nature of the block grants. In establishing the block grants, the federal government encouraged states to spend federal dollars on their priority health problems. The availability of information about entities receiving block grant funds is limited by two factors: (1) the block grants do not require reporting of drug procurement activities as a condition of receiving funding; and (2) states had inadequate lead time (i.e., 3 weeks) to pass on requests for information about procurement activities to subgrantees that receive funds from the block grant (e.g., local health departments, community health centers, etc.).

Maternal and Child Health Services Block Grant-Funded Entities

The MCH Block Grant provides funding to two separate program areas: MCH programs and children with special health care needs (CSHCN) programs. MCH programs provide

comprehensive preventive and primary health care services. CSHCN programs provide more specialized health care services to children with chronic conditions. Both programs are discussed in the following sections.

MCH Block Grant - MCH Entities

Under the MCH Block Grant, MCH programs provide a broad spectrum of general health care services to mothers and children through a large number of community-based entities. **Local health departments (LHDs)** are the most commonly utilized provider of MCH services; research conducted by AMCHP has shown that state MCH programs most often used LHDs to provide prenatal care and primary care services.[9]

In some local jurisdictions, LHDs are the lead agency for assuring and providing MCH services. In other local jurisdictions, **community and migrant health centers,** which provide primary care services to underserved and migrant populations, are the lead agency. In states where no local health department structure exists or where local health departments are not used to provide medical services to mothers and children, state MCH programs often administer **state clinics** and may enter into contracts for service delivery with appropriate local providers.

States may develop contractual agreements with **hospital outpatient clinics** to provide primary care services to low-income women and children. A variety of other types of entities also provide MCH block grant-funded program services, including **private physicians** (e.g., pediatricians, family physicians, and obstetricians/gynecologists), **school-based clinics, youth correctional facilities, Community Action Programs**, and other local projects.

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[9] Association of Maternal and Child Health Programs, *Selected Preventive and Primary Care Services for Children and Adolescents Supported Through State Title V Programs in FY 1991*, 1993; Association of Maternal and Child Health Programs, *Caring for Mothers and Children: A Report of a Survey of FY 1987 State MCH Program Activities*, March 1989; and Maternal and Child Health Bureau, HRSA, *Understanding Title V of the Social Security Act: A Guide to the Provisions of Federal Maternal and Child Health Services Legislation After the Enactment of the Omnibus Reconciliation Act (OBRA) of 1989 (PL 101-239)*, 1992.

MCH entities commonly procure drugs for preventive purposes and for treating acute illnesses. The most frequently used drugs include multivitamins and iron supplements for pregnant women, contraceptives, fluoride treatment for children, prophylactic penicillin for infants and children with sickle cell disease, and antibiotics for acute care.

MCH Block Grant - CSHCN Entities

CSHCN entities, which are also funded through the MCH Block Grant, provide specialized health care services to children with chronic and disabling conditions through a large number of community-based and regional service sites. According to data collected by AMCHP, **tertiary care centers**, which include training hospitals, genetics centers, hemophilia centers, and pediatric pulmonary centers, are the most frequently used providers of care to children with special health care needs.[10]

These centers frequently work with **local health departments** to provide care, especially in rural areas. For example, an LHD may provide the facility and administrative support for periodic clinics staffed by a team of tertiary care specialists. LHDs are less widely used to provide CSHCN services than to provide general MCH services. In states where no local health department structure exists or where local health departments are not used to provide specialty medical services to children with special health care needs, the state CSHCN program often operates **state clinics**.

Other types of entities that provide CSHCN services include **private physicians** (usually a sub-specialist such as an orthopedist specially trained in pediatrics), **rehabilitation centers, perinatal centers, physical, speech/language therapists** who are reimbursed on a fee-for-service basis, **private nonprofits** such as local chapters of the Epilepsy Foundation and March of Dimes, and **school clinics**.

The types of drugs procured by CSHCN programs include anti-convulsants, medications for

[10] Association of Maternal and Child Health Programs, *Caring for Mothers and Children: A Report of a Survey of FY 1987 State MCH Program Activities*, March 1989.

metabolic disorders (e.g., thyroid disorders), special formulae for metabolic disorders, and medications for cardiac disorders.

Community Mental Health Services Block Grant-Funded Entities

Under the Community Mental Health Services Block Grant, mental health programs provide specialized mental health care services to adults with serious mental illness and children suffering from serious emotional disturbance.

The CMHS Block Grant requires that services be offered through appropriate, qualified community programs, which most commonly include **community mental health centers (CMHCs)**, providing mental health services to a defined geographic region or service area. At the discretion of the state mental health authority, CMHCs can be administered by the **state**, by **counties**, or by **community agencies.** In some states, CMHCs are managed exclusively by the state mental health authority, whereas in states such as California, all CMHCS are administered by county governments.

The drugs procured by these entities are used to treat depression, psychoses, and other serious mental illnesses and serious emotional disturbances (e.g., antipsychotic drugs).

Substance Abuse Treatment and Prevention Block Grant-Funded Entities

Substance Abuse Treatment and Prevention Block Grant funds are used to provide specialized services through a large number of community-based service sites. According to data reported by state program directors, **outpatient drug and alcohol treatment programs** are the most common SAPT Block Grant-funded entity. Although these programs are sometimes managed by **state and local governments** or **private for-profits**, they are most frequently run by **private nonprofit organizations.**[11] In addition, some **CMHCs** offer outpatient services in the area of substance abuse.

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[11] Substance Abuse and Mental Health Administration, National Drug and Alcoholism Treatment Unit Survey (NDATUS), 1991.

Outpatient or **ambulatory detoxification programs** are commonly offered in nonhospital settings. These programs offer immediate, short-term withdrawal services. **Methadone maintenance programs**, which provide methadone at stable dosages in addition to social and medical services, are most frequently located in nonresidential settings such as **local health departments**. They can also be located in **hospitals**, **CMHCs**, and **halfway houses**.[12]

The types of drugs currently procured by substance abuse treatment programs include antabuse and methadone. However, on July 9, 1993, the FDA approved LAAM (levo-alpha-acetylmethodol hydrochloride) for treating addictions to narcotics. LAAM is as effective as methadone and has the added benefit of extended duration, allowing patients to be treated on an every-other-day rather than daily schedule.

[12] Ibid.

IV. EXTENT OF DRUG PROCUREMENT AMONG ENTITIES THAT RECEIVE BLOCK GRANT FUNDS

The extent of drug procurement is a critical factor in determining the impact that extending the PHS discount program to block grant recipients will have on the quality of care and health status of patients. The greater the expenditures for drug procurement, the greater the potential savings from participating in the PHS drug discount program. In general, the potential savings equal the gross amount of savings less the cost of administering the program. In addition, unless states are encouraged or required to use the savings to improve the quality of care, the savings may be used for any number of purposes.

In requiring the Secretary of Health and Human Services to document the extent to which block grant-funded entities procure drugs, Congress did not define the term "extent." Extent can include, among other things, the proportion of entities that procure drugs, the volume of drugs, types of drugs, or cost of drugs. In conversations with both federal and state officials, PHF and OASH determined that obtaining extensive procurement information was impractical in the time allowed to prepare this report. Even with more time allotted, collecting this information would be onerous or even impossible for many state programs.[13] For the purpose of this report, "extent" is defined as the estimated expenditures for drugs and the proportion of block grant-funded entities that procure drugs. Appendix D, table 1 displays estimated expenditures for block grant-funded entities.

PHF gathered data from 49 state block grant program directors about expenditures for procurement of covered outpatient drugs (appendix D, table 1).[14] These data provided a basis

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[13] This level of information is not generally provided to state program directors by service providers, and it is therefore not available in files kept by program directors. A similar lack of expenditure information was documented in a U.S. General Accounting Office report, *Medicaid: Changes in Drug Prices Paid by VA and DOD Since Enactment of Rebate Provisions*, September 1991, (GAO/HRD-91-139).

[14] Of 232 state block grant program directors, a total of 49 directors provided information about expenditures for drug procurement. Thirty-eight state program directors reported information about expenditures in response to an assessment that PHF sent to 232 state

for calculating a national estimate of outpatient drug expenditures for MCH programs, CSHCN programs, and mental health programs. The data from substance abuse programs were not sufficient to calculate a national estimate.

Overall, the estimated national expenditures for outpatient drug procurement for MCH, CSHCN, and mental health programs in fiscal year 1992 were $179 million. This includes $37.0 million for MCH, $48.3 million for CSHCN, and $93.7 million for mental health. (See appendix D, tables 2-4.)

The national estimate for each program area was derived using a linear regression model. The model utilizes the relationship between known state expenditures for outpatient drugs and states' block grant allocations for fiscal year 1992. Linear regression produces a least squares or "best fit" line. The least squares line is the line that best fits the observed values (i.e., the relationship between the block grant allocations and the known outpatient drug expenditures), minimizing the sum of the distances of the values from the line. Using each state's block grant allocation as a starting point, PHF applied the linear regression model to estimate expenditures for outpatient drugs in states that were unable to report their expenditures. The estimate of national expenditures for drug procurement represents the 50 states and the District of Columbia.

Standard deviations and 95% confidence intervals were derived from the regression models. The standard deviation is a measure of dispersion or spread of observed values with respect to the least squares line. The 95% confidence interval means that it can be stated with 95% confidence that, for each state unable to report, that state's actual expenditures for outpatient drugs lies within a range that is the estimated value plus or minus the confidence interval

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program directors. Since these data were insufficient to develop a national estimate of expenditures for outpatient drugs, PHF conducted intensive follow-up by telephone with seven states which received the largest block grant allocations (i.e., California, Florida, Illinois, New York, Ohio, Pennsylvania, and Texas). In each of the four program areas, seven state program directors were contacted by telephone and were asked to provide an estimate of expenditures for outpatient drugs in fiscal year 1992. Eleven additional state program directors were able to provide estimates (appendix D).

value. The standard deviations and 95% confidence intervals demonstrate that the estimated expenditures could vary significantly from what was actually spent. This is because the regression model was dependent on a small number of states (17) that were able to report their actual expenditures, meaning each large deviation from the norm had a much greater impact on the distribution than would be the case with a larger sample. Although the estimated expenditures should be treated with caution, they represent the best estimates available.

State block grant program directors also reported that 3,711 of the 7,532 entities that received funding from the block grants (49 percent) procured drugs in fiscal year 1992 (appendix C, tables 3-10). The number of entities that procured drugs varied by program area (i.e., 1,914 MCH entities, 459 CSHCN entities, 724 mental health entities, and 614 substance abuse entities.) The number of entities that would participate in the PHS drug discount program if it is extended to the block grants will depend, in part, on the administrative costs associated with the program.

Data related to the cost of administering the PHS drug discount program were not available from state block grant program directors. However, information about procurement practices of the entities was available and can be used as an indicator of the potential administrative burden on states and entities participating in the PHS drug discount program (appendix C, tables 3-10). In its assessment of drug procurement practices of entities that receive block grant funds, PHF identified the following types of procurement practices:

- Centralized drug procurement, in which the state buys drugs and distributes them to entities;

- On-site direct procurement, in which an entity purchases drugs directly from a pharmaceutical company or wholesaler;

- Contract pharmacy, in which an entity has a contractual agreement with one or more pharmacies; and

- Group purchasing, in which an entity participates in a buying group through which several entities or organizations procure drugs jointly.

When entities use centralized drug procurement or group purchasing, much of the administrative burden is either absorbed by the state agency or is spread across entities that participate in the group purchasing organization. However, when entities use on-site procurement, the administrative burden must be absorbed by the individual entity. On-site procurement is assumed to be more burdensome for an entity than procurement made through a contract pharmacy, centralized procurement, or group purchasing arrangement. Entities that use on-site procurement have the additional burden of negotiating with each manufacturer from whom they purchase drugs.

According to the state block grant program directors, the most common procurement practices were centralized and on-site procurement. Among MCH entities and mental health entities, centralized drug procurement was the predominant method. Among CSHCN entities, on-site procurement was the predominant method. Among substance abuse entities, on-site procurement was common, but many program directors reported that the procurement method was unknown. (See appendix C, tables 2-10.) The policy implications of procurement practices are more fully addressed in Section V.

The following sections discuss drug procurement practices and estimated national expenditures for the block grant-funded entities in four program areas: maternal and child health, children with special health care needs, mental health, and substance abuse. The tables at appendices C and D, following the narrative portion of this report, display relevant data from the states.

Maternal and Child Health Program Area

Forty-four state MCH program directors (77 percent) responded to PHF's assessment of drug procurement practices (appendix C, table 1). Of these, 31 were able to provide information on procurement practices. Among the 2,451 entities that received MCH Block Grant funds, 1,914 (78 percent) procured drugs in 1992 (appendix C, table 3). The majority of these entities were

local health departments. The most common procurement methods among MCH entities were centralized procurement (39 percent) and on-site procurement (29 percent).
States reported expenditures for drug procurement ranging from $24,000 to $2.75 million (appendix D, table 1). According to the linear regression model, the estimated national expenditures for outpatient drugs in fiscal year 1992 were $37.0 million (appendix D, table 2).

The PHS drug discount program would have a different impact in states where the predominant procurement method is centralized procurement (i.e., a state agency procures drugs for the entities) compared to states where the predominant method is on-site procurement. In states with centralized procurement, it is possible that a larger proportion of the savings will be available to the entities for improving patient care. The relationship between savings and improved quality of care is discussed in Section V.

In addition, the magnitude of drug procurement expenditures will likely influence states' interest in participating in a drug discount program. As shown in table 3, MCH programs in Pennsylvania and Texas spend significant amounts on outpatient drugs and thus could realize significant savings. MCH programs in states such as Iowa may not find participating in the program cost-effective due to their smaller expenditures for drug procurement.

Children with Special Health Care Needs Program Area

Forty-two of the 57 state CSHCN program directors (74 percent) responded to PHF's assessment of drug procurement practices. Twenty-six of these program directors reported that they provided MCH Block Grant funds to 2,266 entities to support CSHCN services in 1992. Yet, only 459 of the entities were reported to have procured drugs (appendix C, table 4). The majority of these entities did not fall into the standard categories (i.e., local health department, community health center, and hospital outpatient clinic), but were described as "other entities" (i.e., private physician, tertiary care center, etc.).

The estimated expenditures for drug procurement for the 15 states able to report information

ranged from $35,000 to $6 million per state.[15] The estimated national expenditures were $48.3 million in fiscal year 1992 (appendix D, tables 1 and 3).

Since many CSHCN entities use centralized procurement, the administrative burden should not be excessive, theoretically leaving a larger proportion of the savings available to the entities for improving patient care. As shown in table 3, states such as Alabama and Michigan, reporting estimated expenditures for covered drugs as $2,645,111 and $6 million, respectively, could significantly benefit from participating in the PHS drug discount program. States such as Hawaii and Montana, estimating expenditures of $42,000 and $35,000, respectively, may not find participating in the program cost effective if additional administrative costs would be incurred. The relationship between savings and improved quality of care is more fully discussed in Section V.

Community Mental Health Program Area

Forty-one of the 59 state mental health programs (69 percent) responded to PHF's assessment of drug procurement practices and 30 of these were able to report the number of entities that received block grant funds (appendix C, table 5). As shown in table 2, 884 entities received funds from the CMHS Block Grant in fiscal year 1992. Table 5 shows that 724 of these (82 percent) procured drugs. The majority of the entities were community mental health centers (nonstate owned and operated). Many of the entities procured drugs using a centralized procurement method.

States reported expenditures for drug procurement ranging from $50,000 to $16 million per state in fiscal year 1992. Estimated national expenditures for outpatient drugs were $93.7 million in fiscal year 1992 (appendix D, tables 1 and 4).

Given that procurement tends to be centralized and that the number of entities procuring drugs

[15] In Michigan, the CSHCN program offers a broad scope of services to over 20,000 patients. About half of the estimated expenditures (i.e., $3 million) were used to procure medications for patients with hemophilia who receive care through the CSHCN program.

is small (only 724 nationwide), states' savings from the PHS drug discount program would have the potential to significantly improve the quality of patient care. Since entities tend to use centralized procurement, the administrative burden should not be excessive, theoretically leaving a large proportion of the savings available to the entities for improving patient care.

As shown in table 3, a state such as Florida, reporting an estimated expenditure for covered drugs as $4,630,850, could significantly benefit from participating in the PHS drug discount program. A state such as Alaska, estimating an expenditure of $50,000, may not find participating in the program cost effective if additional administrative costs would be incurred. The relationship between savings and improved quality of care is more fully discussed in Section V.

Substance Abuse Prevention and Treatment Program Area

Thirty-eight of the 59 state substance abuse programs (64 percent) responded to PHF's assessment of drug procurement practices and 24 of these provided information about the number of entities that received block grant funds. As indicated in appendix C, table 6, only 32 percent of the entities (614/1,931) that received funding from the SAPT Block Grant procured drugs in 1992. Appendix C, table 10 shows that the majority of these entities were outpatient drug or alcohol treatment programs (excluding methadone maintenance). On-site and centralized procurement were the most common procurement methods. However, many states were unable to provide information about procurement methods.

The data from substance abuse programs were insufficient to estimate national expenditures, since only 7 states were able to report expenditures. Appendix D, table 1 shows that the seven substance abuse programs' estimated expenditures for drug procurement ranged from $0 to $8.1 million per state. In a state such as California, which spent over $4 million on drug expenditures, the benefits of participating in the PHS drug discount program may be great. However, in Alaska, where only $6,800 was spent on drug expenditures, the additional administrative costs may outweigh the benefits of the discount.

Discussion

Overall, 71 percent (165/232) of the state program directors responded to PHF's assessment of drug procurement practices. According to the findings, over 7,532 entities received funds from the block grants in 1992 (see appendix C, table 2).[16] States reported that 3,710 (49 percent) of the entities procured drugs in fiscal year 1992 (i.e., 1,914 MCH entities, 459 CSHCN entities, 724 community mental health entities, and 614 substance abuse entities). It is likely that some of these entities are already eligible to participate in the PHS drug discount program (e.g., health departments and disproportionate-share hospitals). However, many more could benefit from the PHS drug discount program if it is extended to the block grants.

The analysis of the extent of procurement is limited since many states were unable to provide information about expenditures for outpatient drugs. The national estimated expenditures are based on a small number of reporting states and are not necessarily representative of all states. In addition, the range of expenditures in each program area is extremely large, thus the "true" national expenditures could be different than those reported here. Still, some states and some entities in each of the four program areas could realize significant savings if Congress extends the PHS drug discount program to the block grants.

The relationship between savings and improved quality of patient care is discussed in Section V. However, it is likely that the gross savings under the PHS drug discount program will be offset to varying degrees by administrative costs.

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[16] Some of these entities are likely to be duplicates (i.e., some entities may receive funds from more than one block grant). PHF was unable to eliminate duplicates since the identity of entities is not known. State program directors were asked to provide only numeric totals.

V. POTENTIAL IMPACT THAT EXTENDING DRUG PRICING AGREEMENTS TO BLOCK GRANT-FUNDED ENTITIES WOULD HAVE ON THE QUALITY OF CARE AND HEALTH STATUS OF PATIENTS

This section addresses two issues: (1) the potential impact of the PHS drug discount program on the quality of care and health status of patients; and (2) factors that are critical to the entities' ability to fully benefit from the drug discount program. Information in this section was gathered during interviews with state program directors, pharmacists, industry experts, and with representatives from entities, associations, and manufacturers. See Section II for a description of the methods used to collect information.

The Potential Impact of the PHS Drug Discount Program on Quality of Care and Health Status

Entities already participating in the federal drug discount program reported that the discounts were associated with improvements in the quality of patient care they provide.[17] Most notably, the entities associated cost savings from the federal discount program with:

- An increased ability to provide medications to patients, as opposed to giving them a prescription. This ensures access to medications, especially for those patients without the ability to pay for them;
- An ability to afford newer, more highly effective pharmaceuticals; and
- An ability to stretch dollars further, thereby serving more patients.

For example, a public corporation that operates eleven disproportionate-share hospitals in a

[17] To gather information for this section of the report, PHF conducted a series of interviews with representatives of entities already participating in the PHS drug discount program; entities that may become eligible to participate; state MCH, CSHCN, mental health, and substance abuse programs; and pharmaceutical companies. Additional details about the interviews are provided in Section II and appendix A.

large urban center ran short of medications in its outpatient pharmacy before it began participating in the PHS drug discount program, and it was unable to provide medications to patients. No such shortages are anticipated this year, provided the discounts are received. By averting shortages, the outpatient pharmacy can ensure that patients have access to medications.

The outpatient pharmacies at the public disproportionate-share hospitals mentioned above play an important role in the health care of indigent patients. According to the pharmacy administrator, all of the city's private hospitals have discontinued their outpatient pharmacy services. Indigent patients rely exclusively on the eleven disproportionate-share hospitals for needed outpatient pharmaceuticals. When the public outpatient pharmacies are unable to provide drugs at no cost, patients will often be unable to fill their prescriptions.

Family planning directors in the South and Southwest indicated that the drug discounts have helped to make newer and more highly effective pharmaceuticals available to more patients. During the past two decades, family planning clinics have been able to procure oral contraceptives at nominal prices (i.e., ten percent or less of the average manufacturer's price (AMP)). This is well below the PHS discount price. As a result, the clinics do not procure oral contraceptives through the PHS drug discount program. However, new family planning drugs like Norplant and Depo-Provera are not available at nominal prices. By participating in the PHS drug discount program, the clinics receive a discount of about 15.7 percent off the AMP of Norplant and Depo-Provera.[18]

Norplant and Depo-Provera provide long-term protection from pregnancy. They are more effective than oral contraceptives because there is less chance of human error (i.e., women need not remember to take a pill every day). Norplant, which costs approximately $365, protects a woman from pregnancy for a five-year period after implantation. Depo-Provera, which

[18] The formula used to calculate the PHS drug discount varies according to whether a drug is classified as a "single source or innovator multiple source" or as a "non-innovator multiple source or over-the-counter" drug. The discount for newer single source drugs like Norplant and Depo-Provera which do not have large differences between AMP and Best Price or which have not significantly increased in price since coming on the market, is about 15.7 percent. Larger and smaller discounts are possible.

currently costs about $32 for each injection, protects a woman for a three-month period. Both drugs are significantly more expensive than oral contraceptives. Clinic directors indicate that the discount allows them to make Norplant and Depo-Provera available to more women, improving the quality of care for these women. However, even with the PHS discount, family planning clinics do not have the financial resources to make these drugs as widely available as they would like.

Two state program directors who receive funds from the Community Mental Health Services Block Grant indicated that extension of the PHS discount program to the block grant would enable them to improve the quality of care for some patients. Greater availability of clozapine, a new antipsychotic medication that is highly effective for some patients, would improve the quality of patient care. Many state mental health programs, including a large state in the Southwest, are struggling to find ways to provide clozapine to their patients. The cost of clozapine is six to eight times that of older, alternative medications. Clozapine results in fewer readmissions to the hospital, but in many states there is a waiting list to receive the medication.

The state mental health program directors indicated that by using the savings from the PHS discount program for procuring clozapine, the quality of care for some patients with mental illness would be greatly improved. A small state in the Southeast agreed that earmarking the savings for newer and more effective drugs would help to avoid rehospitalization for some patients, improving the quality of care provided by community mental health centers.

According to a substance abuse entity director on the West Coast, savings from the drug discount program would enable him to serve additional patients, increase staffing, and provide an enriched environment for patients. His program currently spends about $300,000 on drugs annually. An MCH program director in the Midwest and one in a Central state indicated that the savings from the PHS discount program could have a positive affect on the quality of care provided to patients if the money is reinvested in program services.

The director of a CSHCN program in the central U.S. indicated a willingness to keep savings from the discount program in a separate account, which could be used to expand the number

of children served by the program. The program spends over $1 million on drug procurement annually. The MCH and CSHCN program directors in a large midwestern state agreed that savings from the drug discounts would be earmarked for providing more services to more patients.

Entities already participating in the PHS drug discount program are just beginning to receive discounts and have not yet conducted any studies of the association between the discounts and changes in patient health status (e.g., changes in disease rates). However, improvements in the quality of care may have led to improved health status for some patients. The entities which receive funds from the MCH, CMHS, and SAPT block grants may be able to reduce the incidence of disease, discomfort, and disability if savings from the drug discounts were used to provide medications for patients. However, improvements in health status may not be widespread. The program directors who provided information for this report indicated that it would take very large investments in program services to demonstrate widespread changes in the health status of the populations they serve.

Factors that are Critical to the Entities' Ability to Fully Benefit from the PHS Drug Discount Program

A number of factors were viewed by entities as critical to their ability to fully benefit from the drug discount program. The most often mentioned factor was the amount of savings that would be realized for improving patient care. Entities which are already participating in the program have been receiving discounts for up to seven months. They have begun to conduct cost comparisons and to evaluate the amount of savings available for improving patient services. However, when information was collected for this report, no cost comparisons were available.

Among the entities not yet eligible for the discounts, many procure drugs at a negotiated contract price. They were generally enthusiastic about having a discount applied to their current drug prices.

Critical factors in determining the amount of savings, if any, that would be available for improving the quality of care include:

- The requirement to demonstrate that drugs are not diverted to ineligible patients;
- The entity's administrative capacity;
- The entity's ability to retain all or some of the savings for program purposes;
- Unique characteristics of the programs; and
- The behavior of the pharmaceutical industry.

These factors are discussed below.

Requirement to demonstrate that drugs are not diverted to ineligible patients

The most frequently mentioned obstacle to participating in the PHS drug discount program was the requirement that entities be able to demonstrate that no diversion of pharmaceuticals occurs. Some entities viewed the requirement as an insurmountable barrier to participating in the program. Many other entities voiced uncertainty as to whether their method of demonstrating that diversion does not occur meets PHS requirements.

According to OASH, an eligible entity must be able to demonstrate that drugs being purchased at the PHS discount price will indeed be used by an "eligible patient." The operational issues involved in meeting this requirement are complex, as illustrated in the example that follows.

A large city in the Midwest indicated that the requirement to demonstrate that diversion does not occur was an insurmountable barrier to participating in the PHS drug discount program. The city procures pharmaceuticals for 39 public facilities under a hybrid system consisting of a warehouse and a contract pharmacy. The city warehouse procures about $2 million in pharmaceuticals each year and the contract pharmacy procures an additional $6 million. The warehouse and the contract pharmacy procure drugs based on "anticipated need" rather than on actual orders from the facilities. Although all 39 facilities are public, only some of them are eligible to participate in the PHS drug discount program. As a result, the warehouse and

contract pharmacy do not know at the time of purchase whether the drug will be used by an eligible entity or an ineligible entity (i.e., they cannot demonstrate that the drugs will not be diverted for use by an ineligible patient). The discount program does not offer sufficient flexibility for entities that procure drugs using a warehouse or contract pharmacy. These systems can only participate in a "reduced price program" if the discount is offered in the form of a rebate.

However, even though the city cannot formally participate in the discount program, it is benefitting from the program. The pharmacy director convinced the pharmaceutical companies to provide voluntary rebates. His program provides the manufacturers with quarterly reports that indicate the type and amount of drugs used by entities that are eligible for the "discount." Manufacturers provide a rebate for these drugs. According to the pharmacy director, the voluntary rebates are extended by manufacturers as a good business practice. Rebates are allowed under the Veterans Health Care Act of 1992 (P.L. 102-585), but have not been operationalized by the Federal Office of Drug Pricing Program.

The requirement to demonstrate that drugs are not diverted is a cause of great concern among the entities already participating in the PHS drug discount program. Entities identified four problems associated with this issue: (1) vagueness about what is required under the law to demonstrate that no diversion occurs; (2) confusion about who is responsible for enforcing this requirement (e.g., entities have been required by manufacturers to demonstrate that no diversion occurs as a precondition to receiving discounts); (3) time, effort, and cost involved in record keeping; and (4) difficulties associated with maintaining two separate inventories.

A West Coast substance abuse program director indicated the importance of receiving clear guidelines from the federal government about how to demonstrate that drugs are not diverted. He explained that without guidelines, entities feel compelled to take a conservative approach, maintaining two physically separate inventories for discounted and nondiscounted drugs. This is a costly approach, requiring storage space and additional staff. He identified less costly approaches as:

- Maintaining two bins on a shelf in the same area (i.e., a bin for discounted drugs and a bin for nondiscounted drugs). This is a less costly approach, requiring some additional storage space but no additional staff; and

- Maintaining a record that reconciles the procurement and use of discounted drugs. For entities with the computer capacity, this is the least costly approach.

If the less costly approaches are permissible (e.g., separate bins on the shelf or a paper record), entities would be more likely to participate. This perception was echoed by many respondents. According to the Federal Office of Drug Pricing Program, maintaining a record that reconciles the procurement and use of discounted drugs is permissible. Entities need not maintain two separate inventories. However, this information had not been received by the state program directors and entity managers who participated in interviews.

Entities that participate in the PHS drug discount program must maintain records that demonstrate the eligibility of patients who received discounted drugs. The additional cost associated with administering the program will vary, depending upon each entity's current capacity for record keeping. Larger entities will be better able to absorb the additional burden. For small entities, the administrative burden may outweigh the savings from the program unless drugs are procured centrally.

In addition, audits related to the issue of diversion can be very expensive and time consuming. Entities are likely to shy away from the program (for fear of unanticipated costs) unless clearer guidance is offered regarding a process for demonstrating that drugs are not diverted. Communicating this information to relevant state programs and entities may increase their willingness to participate in the PHS drug discount program.

The entity's administrative capacity

Among the disproportionate-share hospitals that provided information, the additional administrative tasks required under the PHS drug discount program are viewed as

burdensome. Because only outpatient drugs are eligible for a discount, the disproportionate-share hospitals must set up separate accounts with each vendor/manufacturer for discounted (outpatient drugs) and nondiscounted (inpatient drugs) procurement, which as much as doubles the number of invoices handled by the administrative staff. One entity in the Northeast has been attempting to reprogram a computer to process a two-tier pricing system for seven months. The entity is currently unable to keep the discounted records on computer, and has been forced to maintain a paper record system for discounted drug purchases.

Most of the block grant-funded program directors and entities raised concerns about the administrative burden of the PHS drug discount program, although they were eager to receive the discounts offered to participants. Entities have differing levels of administrative capacity. For instance, when procurement is centralized at the state level, the state generally negotiates a contract price with manufacturers and may process orders and bills for the local entities. The state generally has a larger administrative staff than an entity and it may be able to perform these administrative tasks at a lower cost.

However, when an entity procures drugs on-site, it must perform these administrative tasks and develop an infrastructure to support procurement. Entities which use on-site procurement indicated an unwillingness to participate in the PHS drug discount program if the cost savings conferred by the discounts did not outweigh the costs of administering the program. Centralized procurement was the predominantly identified procurement method for all of the four program areas.

A small TB program, located in a jurisdiction that participates in a multi-state drug procurement system, decided that the administrative burden of participating in the PHS drug discount program outweighed the cost savings. The multi-state procurement group (an 18-state coalition) was formed under the leadership of a rural midwestern state. Under the multi-state procurement system, the lead state provides administrative support for drugs procured through the coalition's contract. The manager of the multi-state drug procurement system indicated that participation by its entities in the PHS drug discount program would undermine the coalition's bargaining power by reducing the volume of drugs it purchases through its

contract. Entities eligible to participate in the federal drug discount program must decide whether to continue purchasing their drugs through the multi-state coalition or to begin procuring them through the federal drug discount program. For many coalition members, the administrative support provided by the coalition is reason to remain in the group. These entities appear unwilling to change their procurement method. For many small entities, the savings under the PHS drug discount program would not be significant enough to cover the cost of administering the program.

The entity's ability to retain all or some of the savings for program purposes

Several state program directors questioned whether the cost savings would be used for patient services. The legislatures in some states may decrease state funding for the program by the same amount as the savings conferred by the discounts, or the savings might be otherwise reprogrammed. In a large state in the Southwest, the program director for mental health indicated that the legislature had recently enacted a provision that allows an agency to benefit from its cost-saving measures. As a result, any savings realized by participating in the PHS drug discount program would remain in the program rather than being returned to the state's general fund. In the program director's opinion, this would ensure that the savings would be dedicated to improving patient services. However, not every state legislature has taken a similar approach.

In states that have decentralized administration for the block grant-funded programs, the program directors were uncertain about how the savings would be used. The program director of MCH in a large midwestern state indicated that this may pose a problem, since the state does not currently specify how savings should be spent at the local level.

Unique program and state characteristics

The CSHCN program encourages the delivery of services within a patient's community. The local pharmacy is viewed as essential in providing high quality services to patients. In two states (a southern state and a central state), the CSHCN program authorizes payment to

pharmacies located in the patient's community for procuring and dispensing medications. Both programs were unwilling to participate in the PHS drug discount program if it would jeopardize patients' access to medications at their local pharmacies. However, they were interested in participating if a rebate program was operationalized by the Federal Office of Drug Pricing Program.

A West Coast pharmaceutical purchasing group that procures drugs for about 80 public facilities, primarily disproportionate-share hospitals, identified a critical factors that has steered eligible entities away from participating. The PHS Act requires that disproportionate-share hospitals do not "obtain covered drugs through a group purchasing organization or other group purchasing arrangement" (i.e., the law prohibits disproportionate-share hospitals that procure drugs through a group purchasing organization from participating in the PHS drug discount program).[19] Disproportionate-share hospitals currently procuring drugs through a group purchasing organization must change their procurement practices in order to participate in the PHS drug discount program.

The manager of the West Coast purchasing group conducts cost comparisons between the group contract price and the PHS price. If PHS receives a significantly lower price, the manager tries to negotiate a better deal with the company. So far, most disproportionate-share hospitals have remained in the purchasing group.

The industry's behavior

The pharmaceutical industry's behavior is another critical factor in determining whether entities will benefit fully from the PHS discount program. State program directors and entity directors perceive that pharmaceutical costs have shifted from eligible entities to ineligible entities as a result of federal legislation. Enactment of OBRA '90, which extended a rebate for pharmaceuticals to state Medicaid programs, was perceived by many pharmacists as having disrupted their local contract prices. Some prices increased significantly. The PHS drug

[19] See Section 340B(4)(L)(iii), PHS Act.

discount program is perceived by some pharmacists as a counterbalance to the price increases that resulted from OBRA. For example, one program director in the Midwest reported that he is still making up the losses due to the cost-shifting that occurred after OBRA. His cost for nitroglycerine patches increased from $4.50 to over $20 after OBRA. According to the program director, his program's overall savings from the PHS drug discount program only amounts to an additional four percent over his nondiscounted contract price. For entities that procure discounted and nondiscounted drugs, cost-shifting can mean a net result of no savings.

Similar findings of cost-shifting were reported by GAO. According to a study of HMOs and group purchasing organizations (that do not participate in the PHS drug discount program), HMOs experienced more large price increases for outpatient drugs the year after OBRA was enacted than the year before.[20] These findings may indicate that the savings realized by entities that participate in the PHS drug discount program are passed on to ineligible entities.

A pharmacist at a disproportionate-share hospital in the Southwest indicated that pharmaceutical companies are reluctant to enter into long-term contracts that could lock them into a price. GAO has published similar findings.[21] Pharmaceutical purchasers at HMOs and group purchasing organizations reported that manufacturers were no longer willing to enter into long-term contracts (one to five years), preferring a contract period of one year or less. In addition, manufacturers refused to provide a fixed price for the contract period. The price was often based on a percentage discount off the average wholesale price.[22] These industry practices make it difficult for entities to forecast their budgetary needs for a given fiscal year.

The entities indicated that some manufacturers have imposed additional conditions on entities before discounts will be provided. According to several entities, manufacturers had required them to complete forms and other paper work prior to extending discounts to them. Some

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[20] U.S. General Accounting Office. Report to Congressional Committees. *Medicaid: Changes in Drug Prices Paid by HMOs and Hospitals Since Enactment of Rebate Provisions*, January 1993, (GAO/HRD-93-43).

[21] Ibid.

[22] Ibid.

manufacturers have required proof of non-diversion prior to extending the discounts to entities. In one case, a manufacturer asked for copies of an entity's grants as a condition to extending the discount. According to the Federal Office of Drug Pricing Program, this is not an appropriate role for drug manufacturers to assume.

Recommendations from the State Programs and Entities

During the interviews conducted by PHF, a number of recommendations were made. Many entities and program directors recommended that the PHS drug discount program be extended to state and local governments so that all programs that receive public funds would be able to participate in the program, regardless of the source of funding (i.e., local, state, or federal tax dollars). The justification for this proposal is based on two arguments. The first argument is one of fairness and equity. Public health care providers serve the same indigent populations, regardless of the source of funding, and therefore should pay the same price. The second argument is one of reducing needless bureaucracy for local health care providers, state administrators, and the federal government. At the local level, one consequence of having a categorical drug discount program, like the current PHS drug discount program, is that health care providers must develop two procurement systems—one for services that are eligible for the PHS drug discount and one for services that are not eligible. Federal administrators must monitor numerous individual entities to ensure proper use of the discount program. Extending the PHS drug discount program to state and local governments would reduce the administrative burden of procuring drugs for health care providers by allowing them to maintain one procurement and inventory system. In addition, having only one procurement system would substantially diminish the complexity of monitoring compliance with the requirements of the PHS drug discount program.

Three pharmaceutical manufacturers and industry experts who participated in interviews questioned the soundness of this recommendation. The industry representatives raised a concern about which entities are considered "public" health care providers. They view clinics with mixed populations of paying and nonpaying clients as problematic. One manufacturer indicated that continued extension of discounts to every entity which receives public dollars

threatens the industry's ability to charge a price necessary to earn adequate return on its investment. It would be unreasonable to expect the industry to take a loss on sales of its product. Industry experts are concerned about the impact of placing government mandated discounts into a highly competitive free-market system.

A second recommendation from the states and entities was that the Federal Office of Drug Pricing Program should operationalize the rebate provision of the Veterans Health Care Act of 1992, so that entities could participate in either a rebate or a discount program. This would greatly increase participation, especially among entities that procure drugs through contract pharmacies or through a statewide network of local pharmacies, as do some CSHCN programs. If a rebate is not available, many of these entities will be unable to participate.

The pharmaceutical companies and industry experts who participated in interviews indicated a need to consider the potential effect of such a hybrid system on the industry. One manufacturer suggested that the federal government could obviate the need for a PHS drug discount program by encouraging federal grantees to participate in group purchasing organizations. Another manufacturer did not view rebates as overly burdensome.

A third recommendation related to improving communication between the entities, states, the federal government, and manufacturers. State program directors suggested that guidelines and technical assistance from PHS would greatly increase the number of entities that participate. There will be a need for assistance in developing record keeping systems, especially among small and medium-sized entities.

Discussion of the Feasibility of Extending the PHS Drug Discount Program to the Block Grants

In its current form, the PHS drug discount program has a number of benefits and drawbacks. The most notable benefit of the program is the ability to procure drugs at a significant savings. However, the federal government must also consider a weighty drawback of the program, namely, the administrative burden created by the program's categorical nature (i.e., only

patients served by federally funded programs would eligible for discounted drugs).

The categorical focus of the PHS drug discount program is critical to a discussion of the feasibility of extending the program to the block grants. At the local level, the categorical nature of the program means that only some of the patients and services provided by local entities are eligible for discounts. The administrative burden of establishing two inventory systems was identified by state program directors and entity directors as the major obstacle to participating in the PHS drug discount program.

The categorical focus of the PHS drug discount program is also burdensome to state and federal administrators who must carefully monitor the entities to ensure that diversion of the discounted drugs does not occur. Extending the program to additional federal grantees would markedly increase the number of entities that must be monitored by the federal government.

By extending the PHS drug discount program to all entities providing publicly funded services the benefits of the program would be retained while a major drawback would be minimized. The PHS drug discount program could be extended to state and local governments and thus, health care providers could continue to receive significant savings while reducing administrative burden of procuring drugs. In addition, the complexity of monitoring compliance with the requirements of the PHS drug discount program would be diminished for the federal government, since it will do business with 50 states, the District of Columbia, and the territories instead of with thousands of selected entities.

VI. CONCLUSIONS

Overall, the experiences of the entities already participating in the PHS drug discount program appear to be positive. The savings conferred by the program are considered to have improved the quality of services provided to patients. In discussions with entities that would become eligible if the PHS drug discount program is extended to recipients of the MCH, mental health, and substance abuse block grants, the program directors are eager to participate in a program that will enable them to provide more services. However, the critical determinants of whether

the savings from the discounts would enable block grant-funded entities to better serve their patients are: (1) the amount of savings realized by participating in the PHS drug discount program; (2) whether they are able to retain the savings for program purposes; (3) the cost of administering the program; and (4) manufacturers' behavior, especially with regard to cost-shifting.

The estimated national expenditures for outpatient drugs for MCH, CSHCN, and mental health programs in fiscal year 1992 were $179 million. This includes $37.0 million for MCH programs, $48.3 million for CSHCN programs, and $93.7 million for mental health programs. The data were insufficient to calculate a national estimate of outpatient drug expenditures for substance abuse programs.

The analysis of the extent of procurement is limited, since many states were unable to provide information about expenditures for outpatient drugs. The estimated national expenditures are based on a small number of reporting states that are not necessarily representative of all states. In addition, the range of expenditures in each program area is extremely large, thus the "true" national expenditures could be different than those reported here. Still, the large expenditures reported by some states make it clear that some states and entities in each of the program areas could realize significant savings if Congress extends the PHS drug discount program to the block grants.

The state program directors and others suggested a number of ways in which the current and an expanded PHS drug discount program could be improved:

- Extend the PHS drug discount program to state and local governments so that all programs that receive public funds are able to participate in the program, regardless of the source of funding (i.e., local, state, or federal tax dollars);

- Operationalize a rebate mechanism as well as a discount; and

- Provide states with definitive guidelines for implementing the program and on-site

technical assistance.

The policy implications of the recommendations have been discussed in the preceding sections of the report. Extending the PHS drug discount program to the block grants may not be feasible without first eliminating the categorical nature of the program. Additional factors that the federal government may want to consider include: (1) ways to encourage state programs to dedicate the savings conferred by the discount to program purposes; and (2) incentives for states to administer the PHS drug discount program centrally, minimizing the cost of administration and maximizing the savings available for program purposes.

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APPENDIX A

OBJECTIVES AND METHODOLOGY

APPENDIX A

Objectives and Methodology

The first objective of the report is to provide background information about the types of entities that receive funds through the CMHS Block Grant, the SAPT Block Grant, and the MCH Block Grant in terms of:

- The types and number of entities that receive funds from each block grant (e.g., community mental health centers, hospitals, local health departments);
- The populations that are served; and
- The types of services that are commonly provided by these entities.[1]

The second objective is to estimate the extent to which the entities procure prescription drugs, including:

- The proportion of block grant-funded entities that procure drugs;
- The entities' predominant methods of procuring drugs;
- The entities' predominant methods of distributing drugs to their clients; and
- The entities' total expenditures on outpatient drugs for fiscal year 1992.[2]

The third objective is to describe the potential impact of including these entities under Section 340(a) of the Public Health Service Act on the quality of care provided to and the health status of the patients of such entities.[3] The description includes:

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[1] For the purposes of the Secretary of Health and Human Services' report to Congress, section 602 of Public Law 102-585 defines an *entity* as: "(A) receiving funds from a State for the provision of mental health or substance abuse treatment services under subparts I or II of part B of title XIX of the Public Health Service Act or under Title V of such Act; or (B) receiving funds from a State under Title V of the Social Security Act for the provision of maternal and child health services that are furnished on an outpatient basis (other than an entity described in section 340B(a)(4)(G) of the Public Health Service Act)." OASH interprets this definition to mean that an *entity* receives funds directly from the state (i.e., *entity* does not include subgrantees, subcontractors, or satellite clinics of an entity).

[2] "Procurement" means that block grant-funded entities either purchase drugs themselves or use drugs purchased by the state agency. Prescriptions are not included in the definition of procurement unless the entity subsidizes prescription costs for the patients.

[3] P.L. 102-585, the Veterans Health Care Act of 1992.

- Ways in which drug discounts might affect the quality of care offered by entities;[4]
- Ways in which drug discounts might affect patient health status[5];
- Factors that are critical to the entities' ability to fully benefit from drug discounts, such as their willingness to change the ways in which they procure drugs in order to take advantage of drug discounts; and
- Other relevant factors as identified by entities that are already participating in the federal drug discount program.

To describe the entities (objective one), PHF staff conducted a literature review and collected relevant documents from experts in the field, including federal officials and the associations that represent state directors of programs for mental health services, substance abuse, maternal and child health (MCH), and children with special health care needs (CSHCN). These documents provided background information about the types of entities, the populations served, and the services provided. In addition, PHF held discussions regarding entity characteristics with federal officials and with staff at the National Association of State Alcohol and Drug Abuse Directors (NASADAD); the National Association of State Mental Health Program Directors (NASMHPD); and the Association of Maternal and Child Health Programs (AMCHP).

To evaluate the extent of drug procurement under the block grants (objective two), PHF canvassed 232 state and territorial program directors for MCH, CSHCN, mental health services, and substance abuse treatment.[6] The assessment provides detailed information from state health and mental health agencies about the number of entities that receive funds from the MCH, CMHS, and SAPT block grants, the proportion of entities that procure outpatient pharmaceuticals, the procurement practices of entities, the ways in which entities distribute

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[4] Quality of care includes staffing, facilities, diagnostic and therapeutic procedures, and outcomes of care. (Based on the International Epidemiological Association's *Dictionary of Epidemiology*.)

[5] Health status is defined as physical function, emotional well-being, activities of daily living, feelings, etc. (Based on the International Epidemiological Association's *Dictionary of Epidemiology*.)

[6] PHF worked in collaboration with AMCHP, NASMHPD, NASADAD and federal liaisons to identify *state program directors*. For the purposes of this report, *state program directors* were identified in 50 states, the District of Columbia, and the territories in which a contact person was known to AMCHP, NASMHPD, and NASADAD. In all, 232 state program directors were identified. This group includes 57 state MCH program directors, 57 state CSHCN program directors, 59 state mental health program directors, and 59 state substance abuse treatment program directors. See table 1 for a list of the jurisdictions included in the report.

drugs to their patients, and the estimated expenditures for outpatient pharmaceuticals.

PHF worked in collaboration with federal officials, NASADAD, NASMHPD, and AMCHP to design the assessment and to gather the information from the state program directors.

To evaluate the potential impact of extending the PHS discount to the block grants (objective three), PHF conducted a series of interviews. PHF interviewed staff members at entities that are currently participating in the PHS drug discount programs as a result of the Veterans Health Care Act of 1992 to identify ways in which rebates or discounts have affected their procurement practices and services. Three types of entities were selected for interviews: disproportionate-share hospitals, health department pharmacies, and family planning programs. Selection of the entities was based on region of the country, urban/rural location, and type of procurement practices. The seven entities that participated in interviews were located in a large city in the northeast, a large city in the midwest, a southern state, a southwestern state, a West Coast state, a Rocky Mountain state, and a large northern state.

PHF also interviewed state directors of block grant-funded programs that could become eligible to participate in the PHS drug discount program (i.e., MCH programs, CSHCN programs, mental health programs, and substance abuse programs). The state directors were asked about the potential impact of extending the federal drug discount program to entities that receive funds from the block grants. Selection of the entities and state program directors was based on region of the country, urban/rural location, and type of procurement practices. The eleven program directors who participated in interviews were located in a central state, a West Coast state, a southern state, a southeastern state, and a southwestern state.

PHF also interviewed association staff to inquire about the policy implications of the federal discount program for the states. PHF interviewed the following associations: National Family Planning and Reproductive Health Association, NASMHPD, and AMCHP. NASADAD was not able to participate in an interview.

Manufacturers and industry experts also participated in interviews. The representatives provided information about how the PHS drug discount program has affected the industry and the policy implications of the program.

There are a number of limitations associated with the information included in this report. It should be pointed out that state program directors provided estimates when exact figures were not available to complete PHF's assessment of procurement practices. The data represent the best estimates available, but should not be regarded as actual numbers.

In addition, when PHF conducted interviews with selected state program directors, a statistical sampling frame was not used. The purpose of the interviews was to gather very detailed information about the experiences of a few states. The information is qualitative in nature. The findings are not necessarily representative of the experience of all states and entities that have been, or might become, involved in the PHS drug discount program.

APPENDIX B

DESCRIPTION OF ENTITIES

APPENDIX B

Description of the Entities

The purpose of this section is to provide background information about the types of entities that receive funds under the MCH, CMHS, and SAPT block grants. The description includes information about the most common types of entities that provide services, the populations that are served, and the level of services provided.

Summary of the Four Program Areas

The block grants support program services at over 7,500 entities in the areas of MCH, CSHCN, mental health, and substance abuse.[1] Under the MCH Block Grant, MCH programs provide a broad spectrum of general health care through a large number of community-based entities. In addition, the CSHCN programs provide specialized health care services to children through a large number of community-based and regional service sites. The drugs procured by these two programs are very different. The MCH program procures a wide variety of general use drugs for primary and preventive care (e.g., contraceptives, antibiotics, multivitamins). The drugs procured by CSHCN are used to treat chronic conditions such as asthma, heart conditions, and metabolic disorders (e.g., anti-convulsants, special formulae, cardiac medications).

Under the Community Mental Health Services Block Grant, mental health programs provide specialized health care services to a population of seriously mentally ill patients through a limited number of service sites. The drugs procured by these entities are used to treat depression, psychoses, and other serious mental illnesses (e.g., antipsychotic drugs).

The Substance Abuse Treatment and Prevention Block Grant funds are used to provide specialized services through a large number of community-based service sites. The drugs procured by these entities tend to be restricted to medications that control addiction, such as antabuse and methadone.

More detailed information about each block grant is provided in the following sections.

MATERNAL AND CHILD HEALTH SERVICES (MCH) BLOCK GRANT ENTITIES

Title V of the Social Security Act (SSA), the Maternal and Child Health Services (MCH) Block Grant, provides funds to states for the following purposes:

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[1] This number is based on PHF's assessment of procurement practices among state block grant-funded programs. The reader should note that: (1) not all states responded to the survey; (2) not all states who did respond were able to provide numbers; and (3) the total number of entities may include duplicates, if an entity is providing more than one type of service (i.e., MCH, CSHCN, mental health, and substance abuse). See table 2.

- To enable them to ensure access to maternal and child health services for all mothers and children, particularly those who are medically underserved or have low incomes;

- To assist states in their efforts to "reduce infant mortality and the incidence of preventable diseases and handicapping conditions among children; to reduce the need for inpatient and long-term services, to increase the number of children appropriately immunized against disease and the number of low income children receiving health assessments and follow-up diagnostic and treatment services, and otherwise to promote the health of mothers and infants by providing prenatal, delivery, and postpartum care for low income, at-risk pregnant women, and to promote the health of children by providing preventive and primary care services for low income children";

- To foster the development of comprehensive, community-based, family-centered services for children with special health care needs (CSHCN); and

- To provide rehabilitative services for blind and disabled children up to the age of 16.[2]

In fiscal year 1992, over $547 million in MCH Services Block Grant funds were distributed to the states.[3]

A list of the types of entities that provide MCH and CSHCN services was developed by PHF in collaboration with AMCHP and federal officials. The types of entities that most commonly provide MCH services include:

- Local health departments;
- Hospital outpatient clinics;
- Community/migrant health centers; and
- Other types of entities.

It is difficult to compile a representative list of the types of entities that provide MCH services for two reasons. The first is that the MCH Block Grant gives states jurisdiction over the actual organization and administration of their MCH programs. Thus, every state selects the types of entities that will provide MCH services, and even the types of conditions that will be covered in their state. Because maternal and child health priorities and resources vary from state to state, no two state MCH programs are exactly alike.

The second reason little information regarding MCH clinical service delivery systems is available has to do with MCH Block Grant reporting requirements. Most readily available information on MCH programs involves service volume (e.g., counts of patients, number of

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[2] Maternal and Child Health Bureau, HRSA, *Understanding Title V of the Social Security Act: A Guide to the Provisions of Federal Maternal and Child Health Services Legislation After the Enactment of the Omnibus Reconciliation Act (OBRA) of 1989 (PL 101-239)*, 1992.

[3] Ibid.

client encounters), rather than service providers.

However, the Association of Maternal and Child Health Programs (AMCHP) has collected extensive information on state MCH program activities. Information from AMCHP's surveys of MCH program activities was extensively used in this section of the report.[4]

A description of the entities that receive funds for MCH and CSHCN programs follows.

MCH Program Entities

MCH services are provided through a variety of community-based health care entities. These entities commonly procure drugs for preventive purposes. The most frequently used drugs include multivitamins and iron supplements for pregnant women, contraceptives, fluoride treatment for children, prophylactic penicillin for infants and children with sickle cell disease, and antibiotics for acute care.

Local health departments

The Public Health Foundation has defined a local health department to be "an official (governmental) public health agency which is, in whole or part, responsible to a substate governmental entity or entities. An entity may be a city, county, city-county, federation of counties, borough, township, or any other type of substate governmental entity."[5] Although most local health departments are answerable to their local governmental entity, they must also comply with appropriate sections of the state health code, and are thus also accountable to the state health agency. According to the National Association of County Health Officials, there are 3,020 local health departments in the U.S.[6]

Local health departments (LHDs) are widely used to provide MCH services. Preliminary results from a recent AMCHP survey showed 88 percent of state MCH programs utilized LHDs to provide prenatal care and primary care services for children and adolescents.[7] LHDs are the predominant provider of state-sponsored MCH services in the mid-Atlantic, Southern, and

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[4] Association of Maternal and Child Health Programs, *Caring for Mothers and Children: A Report of a Survey of FY 1987 State MCH Program Activities*, March 1989; and Maternal and Child Health Bureau, HRSA, *Understanding Title V of the Social Security Act: A Guide to the Provisions of Federal Maternal and Child Health Services Legislation After the Enactment of the Omnibus Reconciliation Act (OBRA) of 1989 (PL 101-239)*, 1992.

[5] Public Health Foundation, Public Health Agencies 1991: An Inventory of Programs and Block Grant Expenditures, December 1991.

[6] National Association of County Health Officials, *Primary Care Assessment: Local Health Departments' Role in Service Delivery*, October 1992.

[7] Association of Maternal and Child Health Programs, *Selected Preventive and Primary Care Services for Children and Adolescents Supported Through State Title V Programs in FY 1991*, 1993.

Southwestern states, as well as in California, Hawaii, and the U.S. territories.

In states where no local health department structure exists or where local health departments are not used to provide medical services to mothers and children, the state itself often operates clinics.

The types of MCH services that may be provided by LHDs include gynecologic care, family planning, prenatal care, well child clinics, immunization services, in addition to other primary and preventive care for children.

Hospital outpatient clinics

States without LHDs or with limited resources for health departments often find it more effective to have contractual agreements with hospital clinics to provide primary care services to low-income women and children. States also use hospital outpatient clinics to provide prenatal services to women with high-risk pregnancies. Use of hospitals as service delivery sites is particularly common in urban areas. Hospital outpatient clinics play an important role in providing prenatal care to indigent and underserved populations. According to AMCHP's most recent data, 24 percent of state Title V programs support some hospital outpatient clinics.

Community/migrant health centers

The Public Health Service (PHS) Act defines a community health center (CHC) as "an entity which either through its staff and supporting resources or through contracts or cooperative arrangements with other public or private entities provides" primary care services, supplemental health services as appropriate (e.g., hospital services, home health services, dental services, rehabilitative services), environmental health services, and case management and outreach services.[8] One of their most important mandates is to provide primary care services to medically underserved populations, which are urban and rural areas and populations designated by the U.S. Department of Health and Human Services as suffering from a shortage of such services. Migrant health centers (MHCs), which are also authorized through the PHS Act, provide primary care services to seasonal farm workers and their families.

There are approximately 550 C/MHCs in the United States, the majority of which are private nonprofits governed by boards of directors. Although in some jurisdictions the CHC is the lead agency for assuring and providing MCH services, often LHDs are the lead agency and contract specific services out to CHCs. AMCHP's recent survey found that 30 out of 45 state Title V programs reported funding C/MHCs to provide maternal and child health services in FY 1991.

Other types of entities

Other types of entities that provide MCH program services include private physicians, school-

[8] Association of Maternal and Child Health Programs, *MCH Related Federal Programs: Legal Handbooks for Program Planners, Community and Migrant Health Centers*, 1991.

based clinics, youth correctional facilities, Community Action Programs, and other local projects.

Private physicians (e.g., pediatricians, family physicians, and obstetricians/gynecologists) commonly provide MCH program services. LHDs sometimes have contractual agreements with private physicians, who may either see clients in their offices or use health department facilities to provide MCH services.

School-based clinics provide services in a broad spectrum of areas, including treatment of acute illness and injury, mental health, physical examinations, immunizations, reproductive health, chronic disease management, and counseling about healthful behaviors.[9] AMCHP has estimated that two-thirds of state Title V programs supported school-based and/or linked services in FY 1991.

Children with Special Health Care Needs (CSHCN) Program Entities

The MCH Block Grant provides about 30 percent of the total funding for state Children with Special Health Care Needs (CSHCN) programs. CSHCN programs serve children with chronic and disabling conditions. CSHCN and MCH programs are often separately administered, and although CSHCN programs are usually housed within the state health agency, in 10 states the programs are located in another agency or a university.

Although each state has discretion over which conditions will be the focus of their CSHCN programs, these conditions primarily include chronic medical disorders, physical disabilities, and sensory impairments (e.g., speech, language, and hearing impairments) but may also include mental retardation, learning disorders, emotional disturbance, and in some states child abuse and prenatal drug exposure.

The types of drugs procured by CSHCN programs include anticonvulsants, medications for metabolic disorders (e.g., thyroid disorders), special formulae for metabolic disorders, and medication for cardiac disorders.

Local health departments

Local health departments are described under MCH program entities, above. In providing CSHCN services local health departments sometimes work in collaboration with tertiary care centers, performing outreach, case management, and administrative functions. LHDs are less widely used to provide CSHCN services than to provide MCH services; AMCHP's 1988 survey showed that only half of state CSHCN programs used local health departments to provide

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[9] The School-Based Adolescent Health Care Program, *Bringing Health Care to Our Students.* The School-Based Adolescent Health Care Program: Washington, D.C. (202) 466-3396. May 1993.

services to this population.[10]

In states where no local health department structure exists or where local health departments are not used to provide specialty medical services to children with special health care needs, the state itself often operates clinics. According to AMCHP's 1988 survey, 79 percent of CSHCN programs operated state administered clinics. These clinics are sometimes offered on a regional or mobile basis.[11]

Other types of entities

The "other" category includes all community-based organizations and private physicians that provide CSHCN services. Examples include rehabilitation centers, tertiary care centers, perinatal centers, physical, speech/language therapists who are reimbursed on a fee-for-service basis, private nonprofits such as local chapters of the Epilepsy Foundation and March of Dimes, and school clinics.

Partly in response to OBRA '89's call for CSHCN programs to provide more family-centered, community-based care, recent years have seen increased use of home health agencies and community-based organizations. AMCHP's 1988 survey results indicated that home health services were the most common types of community services funded by state CSHCN programs.[12]

According to a survey conducted by AMCHP for its 1989 publication, tertiary care centers were the most frequently used providers of care to children with special health care needs. Tertiary care centers include training hospitals and such entities as pediatric pulmonary centers, hemophilia centers, genetics centers, and university affiliated programs (UAPs are training and research programs affiliated with, but not necessarily located in universities, and provide services to mentally retarded and developmentally disabled children. The Maternal and Child Health Bureau/HRSA currently funds 24 such programs).[13]

Tertiary care centers are usually funded through grants or contracts from the state CSHCN program, and provide both outpatient and inpatient services. These centers frequently work with local health departments to provide care, especially in rural areas. For example, a local

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[10] Association of Maternal and Child Health Programs, *Caring for Mothers and Children: A Report of a Survey of FY 1987 State MCH Program Activities*, March 1989.

[11] Ibid.

[12] Ibid.

[13] Association of Maternal and Child Health Programs, *Caring for Mothers and Children: A Report of a Survey of FY 1987 State MCH Program Activities*, March 1989; and Maternal and Child Health Bureau, HRSA, *Understanding Title V of the Social Security Act: A Guide to the Provisions of Federal Maternal and Child Health Services Legislation After the Enactment of the Omnibus Reconciliation Act (OBRA) of 1989 (PL 101-239)*, 1992.

health department may provide the facility and administrative support for periodic clinics staffed by a team of tertiary care specialists.

In 1987, 83 percent of state CSHCN programs said that they provided some services through private physicians in offices, clinics, or under contract in hospitals. Most of these physicians are sub-specialists (e.g., an orthopedist specially trained in pediatrics). Private physicians are often the first point of contact for a child with special health care needs. Where state and local clinics are held only on a periodic basis, private doctors also provide supplementary care.

COMMUNITY MENTAL HEALTH SERVICES (CMHS) BLOCK GRANT ENTITIES

Under the CMHS Block Grant, the Substance Abuse and Mental Health Services Administration (SAMHSA) allocates funds to states for the provision of community mental health services to adults with a serious mental illness (SMI) and children suffering from serious emotional disturbance (SED).

Adults age 18 and over are defined as having SMI if they currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet specific diagnostic criteria.[14] This disorder must have resulted in functional impairment which substantially interferes with or limits one or more major life activities. Children up to age 18 are defined as having a serious emotional disturbance if they currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-III-R. This disorder must have resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities. The types of drugs procured by CMHS Block Grant-funded entities include antidepressants, antianxiety medications, antimanic medications, and other psychotropic drugs.

According to the National Association of State Mental Health Program Directors (NASMHPD), CMHS Block Grant funds make up approximately two percent of total State Mental Health Agency (SMHA) spending ($278 million out of a total of approximately $12 billion). Award of these funds is contingent on the creation of state mental health planning councils, whose purpose is to create networks of families, providers, and consumers to direct federal resources to local needs. States are also required to submit plans as part of the annual block grant application. The CMHS Block Grant requires that services be offered through appropriate, qualified community programs, which most commonly include the following entities.

Community mental health centers (CMHCs)

CMHCs provide mental health services to a defined geographic region, or service area. By law, they must offer outpatient services for children, elderly, people with serious mental illnesses,

[14] Joseph R. Leone, Acting Deputy Administrator, SAMHSA, published the final definitions for children with serious emotional disturbance and adults with serious mental illness in the *Federal Rigister* on May 20, 1993.

and residents of the service area who have been discharged from inpatient treatment at a mental health facility. CMHCs must also offer 24-hour service, day treatment or partial hospitalization services, psychosocial rehabilitation services, health and dental services, and screening for patients to determine the appropriateness of admission to a state mental hospital. CMHCs also often provide outpatient drug treatment services in their service area.

At the discretion of the state mental health authority, CMHCs can be administered by the state, by counties, or by community agencies. In some states, CMHCs are managed exclusively by the state mental health authority, whereas in states such as California all CMHCS are administered by county governments.

Other types of entities

Other "appropriate, qualified community programs," as defined by the law, might include child mental health programs, psychosocial rehabilitation programs, mental health peer support programs, and mental health primary consumer-directed programs.

SUBSTANCE ABUSE PREVENTION AND TREATMENT (SAPT) BLOCK GRANT ENTITIES

In 1992, the Alcohol, Drug, and Mental Health Services (ADMS) Block Grant was reorganized into two separate block grants, the Community Mental Health Services (CMHS) Block Grant and the Substance Abuse Prevention and Treatment (SAPT) Block Grant. In FY 1993, close to $1.1 billion will be distributed to the states for the purpose of planning, establishment, and evaluation of programs to administer substance abuse prevention, treatment, and rehabilitation services.[15]

To be eligible to receive SAPT Block Grant funds, states must agree to dedicate at least 35 percent of the funds to alcohol and drug services and at least 20 percent to primary prevention services. The newly created SAPT Block Grant also places an emphasis on services for pregnant women and women with dependent children, requiring that states increase their block grant spending in this area by 5 percent in FY 1993 and an additional 5 percent in FY 1994.

SAPT Block Grant funds are funneled through the governor of the state to the state substance abuse program, which is sometimes housed in a stand-alone agency, but can also be located in the state health department or in the state mental health agency. Subsequently, the state program distributes funds to counties and cities based on need. The types of drugs procured by substance abuse treatment programs include antabuse and methadone.

Not all substance abuse treatment sites provide outpatient care. The most common types of entities that provide outpatient treatment fall into the following categories:

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[15] Substance Abuse and Mental Health Services Administration, PHS, *Center for Substance Abuse Treatment: Mission, Goals, and Programs*, 1993.

Community mental health centers (CMHCs)

In addition to services described in the CMHS Block Grant Section, some CMHCs offer outpatient services in the area of substance abuse prevention and treatment.

Outpatient drug/alcohol detoxification programs

Outpatient or ambulatory detoxification programs are commonly offered in nonhospital settings. These programs offer immediate, short-term withdrawal services. After detoxification has been completed, a patient may be referred to other providers for longterm outpatient treatment.

Outpatient drug/alcohol treatment programs

Unlike detoxification programs, substance abuse treatment programs provide long-term physical, mental, and social support for drug and alcohol abusers. Although these programs are sometimes managed by state or local governments or by private for-profits, they are most frequently run by private nonprofit organizations.[16]

Methadone maintenance programs

Methadone is a non-physically addictive substitute for opiates such as heroin. Methadone maintenance programs provide methadone at stable dosages in addition to social and medical services. Methadone units are most frequently located in nonresidential settings such as local health departments or storefront facilities. They can also be located in hospitals, community mental health centers, and halfway houses.[17]

Other types of entities

These include entities such as recovery homes and halfway houses, which often provide transitional services for patients who are moving back to the community from an inpatient setting.

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[16] Substance Abuse and Mental Health Administration, National Drug and Alcoholism Treatment Survey (NDATUS), 1991.

[17] Ibid.

APPENDIX C

ASSESSMENT OF PROCUREMENT PRACTICES

DATA REPORTED BY STATE BLOCK GRANT PROGRAM DIRECTORS

Table 1. States Responding to an Assessment of Drug Procurement Practices of Block Grant-Funded Entities, By Program Area and PHS Region, FY 1992

PHS Region	States and Territories	Program Area			
		MCH	CSHCN	Mental Health	Substance Abuse
1	Connecticut		✓	✓	✓
	Maine	✓			
	Massachusetts				✓
	New Hampshire	✓	✓	✓	
	Rhode Island	✓		✓	✓
	Vermont	✓	✓	✓	✓
2	New Jersey	✓	✓		✓
	New York	✓		✓	✓
	Puerto Rico		✓		✓
	Virgin Islands			✓	
3	Delaware	✓			
	District of Columbia	✓	✓	✓	
	Maryland	✓	✓	✓	
	Pennsylvania			✓	
	Virginia	✓			✓
	West Virginia	✓	✓	✓	
4	Alabama	✓	✓	✓	
	Florida		✓	✓	✓
	Georgia	✓		✓	
	Kentucky	✓	✓	✓	
	Mississippi	✓			✓
	North Carolina	✓		✓	✓
	South Carolina	✓	✓	✓	✓
	Tennessee	✓		✓	✓
5	Illinois	✓	✓	✓	✓
	Indiana	✓	✓	✓	✓
	Michigan	✓	✓	✓	✓
	Minnesota	✓	✓		
	Ohio	✓	✓	✓	
	Wisconsin	✓	✓	✓	✓
6	Arkansas	✓	✓		✓
	Louisiana	✓	✓	✓	✓
	New Mexico	✓	✓		
	Oklahoma	✓	✓		✓
	Texas	✓	✓	✓	✓
7	Iowa	✓	✓	✓	✓
	Kansas	✓	✓	✓	✓
	Missouri	✓	✓	✓	✓
	Nebraska	✓	✓		✓
8	Colorado	✓	✓		✓
	Montana	✓	✓		✓
	North Dakota	✓	✓	✓	
	South Dakota	✓	✓	✓	
	Utah	✓	✓	✓	
	Wyoming	✓	✓	✓	✓
9	Arizona	✓	✓	✓	✓
	California	✓		✓	✓
	Hawaii		✓	✓	✓
	Nevada		✓	✓	✓
	American Samoa		✓	✓	
	Guam			✓	
	Northern Mariana Is.		✓	✓	
	Marshall Islands	–	–		
	Fed. States Micronesia		✓		✓
	Palau	–	–	✓	✓
10	Alaska		✓	✓	✓
	Idaho	✓	✓		✓
	Oregon	✓	✓	✓	✓
	Washington	✓			✓
ALL	RESPONSE RATES	44/57 (77%)	42/57 (74%)	41/59 (69%)	38/59 (64%)

– = No MCH and CSHCN contacts were available in the Marshall Islands and Palau; therefore, these programs were not included.

Source: Public Health Foundation

Table 2. Estimated Number of Entities Receiving Block Grant Funds in FY 1992, by Type of Program and State

States and Territories	MCH Program	CSHCN Program	Mental Health Program	Substance Abuse Program
Total Number of Entities	2,451	2,266	884	1,931
Alabama	81	1	27	NR
Alaska	NR	U	2	5
Arizona	22	4	7	U
Arkansas	U	544	NR	U
California	U	NR	55	86
Colorado	U	U	NR	54
Connecticut	NR	U	14	76
Delaware	22	NR	NR	NR
District of Columbia	12	12	1	NR
Florida	NR	1	79	U
Georgia	U	NR	27	NR
Hawaii	NR	1	2	U
Idaho	7	7	NR	U
Illinois	202	1	66	28
Indiana	69	961	21	U
Iowa	23	U	U	U
Kansas	113	U	U	U
Kentucky	122	168	15	NR
Louisiana	192	8	7	38
Maine	U	NR	NR	NR
Maryland	27	997	U	NR
Massachusetts	NR	NR	NR	79
Michigan	U	126	4	11
Minnesota	U	U	NR	NR
Mississippi	82	NR	NR	U
Missouri	114	23	25	59
Montana	71	1	NR	22
Nebraska	2	U	NR	U
Nevada	NR	U	3	4
New Hampshire	U	1	10	NR
New Jersey	52	U	NR	136
New Mexico	46	U	NR	NR
New York	167	NR	U	347
North Carolina	91	NR	41	51
North Dakota	24	U	8	NR
Ohio	114	1	304	NR
Oklahoma	84	U	NR	42
Oregon	35	1	U	U
Pennsylvania	NR	NR	45	NR
Rhode Island	U	NR	11	40
South Carolina	46	13	17	U
South Dakota	U	U	U	NR
Tennessee	95	NR	21	35
Texas	110	1	35	U
Utah	U	U	11	NR
Vermont	U	1	U	U
Virginia	21	NR	NR	55
Washington	35	NR	NR	122
West Virginia	235	U	3	NR
Wisconsin	125	1	U	492
Wyoming	U	U	U	150
American Samoa	NR	1	U	NR
Guam	NR	NR	1	NR
Puerto Rico	NR	78	NR	1
Virgin Islands	NR	NR	1	NR
Northern Mariana Is.	NR	1	1	NR
Marshall Islands	--	--	NR	NR
Fed. States Micronesia	NR	1	NR	9
Palau	--	--	1	1

NR = State did not respond to the assessment.
U = Information unavailable because: (a) none of the entities procured drugs in 1992; or (b) the state program director did not know if block grant dollars were used to procure drugs in 1992.
-- = No MCH and CSHCN contacts were available in the Marshall Islands and Palau; therefore, these programs were not included.
Source: Public Health Foundation

Table 3. Drug Procurement Practices and Expenditures of MCH Block Grant-Funded Entities - MCH Program Area, FY 1992

States and Territories	Reported No. of Entities that Received Funds	Entities that Procure Drugs, Reported No. and (%)	Predominant Procurement Method	Reported Expenditures for Drugs in FY 1992
	Total: 2,451	Total: 1,914 (78)		Median: $126,900
Alabama	91	91 (100)	Centralized	U
Alaska	NR	NR	NR	NR
Arizona	22	13 (59)	On-site	$125,000
Arkansas	U	U	U	U
California	U	U	U	U
Colorado	U	U	U	U
Connecticut	NR	NR	NR	NR
Delaware	22	21 (95)	Contract Pharmacy	U
District of Columbia	12	2 (17)	Centralized	U
Florida	NR	NR	NR	NR
Georgia	U	U	U	U
Hawaii	NR	NR	NR	NR
Idaho	7	7 (100)	Centralized	U
Illinois	202	195 (97)	Contract Pharmacy	U
Indiana	69	48 (70)	Other	U
Iowa	23	23(100)	Centralized	$24,000
Kansas	113	105 (93)	On-site	U
Kentucky	122	122 (100)	On-site	$1,200,000
Louisiana	132	131 (99)	Centralized	U
Maine	U	U	U	U
Maryland	27	10 (37)	U	U
Massachusetts	NR	NR	NR	NR
Michigan	U	U	U	U
Minnesota	U	U	U	U
Mississippi	82	81 (99)	Centralized	$727,945
Missouri	114	72 (63)	Other	U
Montana	71	14 (20)	On-site	U
Nebraska	2	2 (100)	Contract Pharmacy	$100,000
Nevada	NR	NR	NR	NR
New Hampshire	U	U	U	U
New Jersey	52	25 (48)	On-site	U
New Mexico	46	46 (100)	Centralized	U
New York	157	76 (48)	On-site	U
North Carolina	91	91 (100)	On-site	U
North Dakota	24	1 (4)	Centralized	$199,574
Ohio	114	108 (95)	Contract Pharmacy	U
Oklahoma	84	84 (100)	Centralized	$545,000
Oregon	35	30 (86)	Centralized	U
Pennsylvania	NR	NR	NR	NR
Rhode Island	U	U	U	U
South Carolina	46	46 (100)	Group Purchasing	U
South Dakota	U	U	U	U
Tennessee	95	95 (100)	On-site	U
Texas	110	110 (100)	Other	U
Utah	U	U	U	U
Vermont	U	U	U	U
Virginia	21	21 (100)	Centralized	U
Washington	35	7 (20)	U	U
West Virginia	335	248 (74)	Centralized	U
Wisconsin	125	29 (23)	On-site	U
Wyoming	U	U	U	U
American Samoa	NR	NR	NR	NR
Guam	NR	NR	NR	NR
Puerto Rico	NR	NR	NR	NR
Virgin Islands	NR	NR	NR	NR
Northern Mariana Is.	NR	NR	NR	NR
Marshall Islands	--	--	--	--
Fed. States Micronesia	NR	NR	NR	NR
Palau	--	--	--	--

U = State completed the assessment, but was unable to provide information on the program in this area.
NR = State did not respond to the assessment.
-- = No MCH and CSHCN contacts were available in the Marshall Islands and Palau; therefore, these programs were not included.
Source: Public Health Foundation

Table 4. Drug Procurement Practices and Expenditures of MCH Block Grant-Funded Entities - CSHCN Program Area, FY 1992

States and Territories	Reported No. of Entities that Received Funds	Entities that Procure Drugs, Reported No. and (%)	Predominant Procurement Method	Reported Expenditures for Drugs in FY 1992
	Total: 2,266	459 (20)		Median: $187,900
Alabama	1	1 (100)	Contract Pharmacy	$2,645,111
Alaska	U	U	U	U
Arizona	4	4 (100)	U	U
Arkansas	544	260 (48)	On-site	$187,527
California	NR	NR	NR	NR
Colorado	U	U	U	U
Connecticut	U	U	U	$66,526
Delaware	NR	NR	NR	NR
District of Columbia	12	2 (17)	Centralized	U
Florida	1	1 (100)	Other	$195,000
Georgia	NR	NR	NR	NR
Hawaii	1	1 (100)	Other	$42,000
Idaho	7	1 (14)	U	U
Illinois	1	1 (100)	Other	$1,055,032
Indiana	961	1 (< 1%)	Other	U
Iowa	U	U	U	U
Kansas	U	U	U	U
Kentucky	166	52 (31)	Contract Pharmacy	$209,235
Louisiana	9	9 (100)	Centralized	U
Maine	NR	NR	NR	NR
Maryland	357	1 (< 1%)	Other	U
Massachusetts	NR	NR	NR	NR
Michigan	126	1 (1)	Other	$6,000,000
Minnesota	U	U	U	U
Mississippi	NR	NR	NR	NR
Missouri	23	23 (100)	U	U
Montana	1	1 (100)	Other	$35,000
Nebraska	U	U	U	U
Nevada	U	U	U	U
New Hampshire	1	1 (100)	Other	$127,899
New Jersey	U	U	U	U
New Mexico	U	U	U	U
New York	NR	NR	NR	NR
North Carolina	NR	NR	NR	NR
North Dakota	U	U	U	U
Ohio	1	1 (100)	Contract Pharmacy	$1,100,000
Oklahoma	U	U	U	U
Oregon	1	1 (100)	On-site	$84,122
Pennsylvania	NR	NR	NR	NR
Rhode Island	NR	NR	NR	NR
South Carolina	13	13 (100)	Centralized	U
South Dakota	U	U	U	U
Tennessee	NR	NR	NR	NR
Texas	1	1 (100)	Other	$1,417,817
Utah	U	U	U	U
Vermont	1	1 (100)	Other	$140,048
Virginia	NR	NR	NR	NR
Washington	NR	NR	NR	NR
West Virginia	U	U	U	U
Wisconsin	1	1 (100)	Other	$140,000
Wyoming	U	U	U	U
American Samoa	1	1 (100)	Centralized	U
Guam	NR	NR	NR	NR
Puerto Rico	78	78 (100)	Centralized	U
Virgin Islands	NR	NR	NR	NR
Northern Mariana Is.	1	1 (100)	Centralized	U
Marshall Islands	--	--	--	--
Fed. States Micronesia	1	1 (100)	Centralized	U
Palau	--	--	--	--

U = State completed the assessment, but was unable to provide information on the program in this area.
NR = State did not respond to the assessment.
-- = No MCH and CSHCN contacts were available in the Marshall Islands and Palau; therefore, these programs were not included.
Source: Public Health Foundation

Table 5. Drug Procurement Practices and Expenditures of ADMS Block Grant-Funded Entities - Mental Health Program Area, FY 1992

States and Territories	Reported No. of Entities that Received Funds	Entities that Procure Drugs, Reported No. and (%)	Predominant Procurement Method	Reported Expenditures for Drugs in FY 1992
	Total: 884	Total: 724 (82)		Median: $1,600,000
Alabama	27	24 (89)	Centralized	$2,100,000
Alaska	2	2 (100)	Contract Pharmacy	$50,000
Arizona	7	7 (100)	Contract Pharmacy	U
Arkansas	NR	NR	NR	NR
California	55	55 (100)	U	U
Colorado	NR	NR	NR	NR
Connecticut	14	7 (50)	U	$248,000
Delaware	NR	NR	NR	NR
District of Columbia	1	1 (100)	Centralized	U
Florida	79	63 (80)	Centralized	$4,630,850
Georgia	27	27 (100)	Centralized	$2,000,000
Hawaii	2	1 (50)	Other	U
Idaho	NR	NR	NR	NR
Illinois	68	43 (63)	Contract Pharmacy	U
Indiana	31	19 (61)	Contract Pharmacy	U
Iowa	U	U	U	U
Kansas	U	U	U	U
Kentucky	15	15 (100)	Centralized	$1,251,000
Louisiana	7	2 (29)	Centralized	$576,000
Maine	NR	NR	NR	NR
Maryland	U	U	U	U
Massachusetts	NR	NR	NR	NR
Michigan	4	4 (100)	Group Purchasing	U
Minnesota	NR	NR	NR	NR
Mississippi	NR	NR	NR	NR
Missouri	25	25 (100)	Other	U
Montana	NR	NR	NR	NR
Nebraska	NR	NR	NR	NR
Nevada	3	3 (100)	Group Purchasing	U
New Hampshire	10	4 (40)	Contract Pharmacy	U
New Jersey	NR	NR	NR	NR
New Mexico	NR	NR	NR	NR
New York	U	U	U	U
North Carolina	41	41 (100)	Centralized	$1,000,000
North Dakota	8	8 (100)	Other	U
Ohio	304	254 (84)	Centralized	$3,569,184
Oklahoma	NR	NR	NR	NR
Oregon	U	U	U	U
Pennsylvania	45	34 (76)	Other	$3,573,375
Rhode Island	11	9 (82)	Centralized	$1,591,370
South Carolina	17	17 (100)	Centralized	U
South Dakota	U	U	U	U
Tennessee	31	12 (39)	On-site	U
Texas	35	35 (100)	Contract Pharmacy	U
Utah	11	8 (73)	Contract Pharmacy	U
Vermont	U	U	U	U
Virginia	NR	NR	NR	NR
Washington	NR	NR	NR	NR
West Virginia	U	U	U	U
Wisconsin	U	U	U	U
Wyoming	U	U	U	U
American Samoa	U	U	U	U
Guam	1	1 (100)	Contract Pharmacy	U
Puerto Rico	NR	NR	NR	NR
Virgin Islands	1	1 (100)	Other	U
Northern Mariana Is.	1	1 (100)	Centralized	U
Marshall Islands	NR	NR	NR	NR
Fed. States Micronesia	NR	NR	NR	NR
Palau	1	1 (100)	Centralized	U

U = State completed the assessment, but was unable to provide information on the program in this area.
NR = State did not respond to the assessment.
Source: Public Health Foundation

Table 6. Drug Procurement Practices and Expenditures of ADMS Block Grant-Funded Entities - Substance Abuse Program Area, FY 1992

States and Territories	Reported No. of Entities that Received Funds	Entities that Procure Drugs, Reported No. and (%)	Predominant Procurement Method	Reported Expenditures for Drugs in FY 1992
	Total: 1,931	**Total:** 614 (32)		**Median:** $140,800
Alabama	NR	NR	NR	NR
Alaska	5	2 (40)	Other	$6,800
Arizona	U	U	U	U
Arkansas	U	U	U	U
California	90	90 (100)	On-site	$4,415,040
Colorado	54	54 (100)	On-site	U
Connecticut	70	14 (20)	On-site	U
Delaware	NR	NR	NR	NR
District of Columbia	NR	NR	NR	NR
Florida	U	U	U	U
Georgia	NR	NR	NR	NR
Hawaii	U	U	U	U
Idaho	U	U	U	U
Illinois	28	28 (100)	On-site	U
Indiana	U	U	U	U
Iowa	U	U	U	U
Kansas	U	U	U	U
Kentucky	NR	NR	NR	NR
Louisiana	38	38 (100)	Centralized	$129,682
Maine	NR	NR	NR	NR
Maryland	NR	NR	NR	NR
Massachusetts	79	10 (13)	On-site	U
Michigan	11	11 (100)	Contract Pharmacy	U
Minnesota	NR	NR	NR	NR
Mississippi	U	U	U	U
Missouri	59	5 (8)	On-site	U
Montana	22	3 (14)	Contract Pharmacy	U
Nebraska	U	U	U	U
Nevada	4	2 (50)	U	U
New Hampshire	NR	NR	NR	NR
New Jersey	136	10 (7)	Contract Pharmacy	U
New Mexico	NR	NR	NR	NR
New York	347	188 (54)	Centralized	U
North Carolina	51	51 (100)	Centralized	$1,000,000
North Dakota	NR	NR	NR	NR
Ohio	NR	NR	NR	NR
Oklahoma	42	7 (17)	On-site	U
Oregon	U	U	U	U
Pennsylvania	NR	NR	NR	NR
Rhode Island	40	3 (7)	On-site	U
South Carolina	U	U	U	U
South Dakota	NR	NR	NR	NR
Tennessee	35	35 (100)	U	U
Texas	U	U	U	U
Utah	NR	NR	NR	NR
Vermont	U	U	U	0
Virginia	55	10 (18)	On-site	$152,000
Washington	122	8 (7)	On-site	U
West Virginia	NR	NR	NR	NR
Wisconsin	492	46 (9)	U	U
Wyoming	150	1 (1)	Centralized	U
American Samoa	NR	NR	NR	NR
Guam	NR	NR	NR	NR
Puerto Rico	1	1 (100)	Centralized	U
Virgin Islands	NR	NR	NR	NR
Northern Mariana Is.	NR	NR	NR	NR
Marshall Islands	NR	NR	NR	NR
Fed. States Micronesia	9	6 (67)	On-site	U
Palau	1	1 (100)	Centralized	U

U = State completed the assessment, but was unable to provide information on the program in this area.
NR = State did not respond to the assessment.
Source: Public Health Foundation

Table 7. Predominant Procurement Methods Used by MCH Block Grant-Funded Entities - MCH Program Area, As Identified by Responding States, FY 1992*

Type of Entity	Predominant Procurement Method					
	Centralized	On-site	Contract	Group	Other	Unknown
All Entities (**Total: 1914**)	707	523	282	66	230	106
Community/Migrant Health Centers	135	12	3	0	6	26
Hospital Outpatient Clinics	12	23	14	0	13	14
Local Health Departments	465	413	199	46	151	13
Other Type of Entity	95	75	66	20	60	53

* Of 44 responding states, 29 were able to identify the predominant procurement methods used by MCH entities.
Source: Public Health Foundation

Table 8. Predominant Procurement Methods Used by MCH Block Grant-Funded Entities - CSHCN Program Area, As Identified by Responding States, FY 1992*

Type of Entity	Predominant Procurement Method					
	Centralized	On-site	Contract	Group	Other	Unknown
All Entities (**Total: 459**)	104	261	55	1	10	28
Community/Migrant Health Centers	0	0	0	0	0	0
Hospital Outpatient Clinics	0	10	1	0	0	26
Local Health Departments	17	0	0	0	0	1
Other Type of Entity	87	251	54	1	10	1

* Of 42 responding states, 23 were able to identify the predominant procurement methods used by CSHCN entities.
Source: Public Health Foundation

Table 9. Predominant Procurement Methods Used by ADMS Block Grant-Funded Entities - Mental Health Program Area, As Identified by Responding States, FY 1992*

Type of Entity	Predominant Procurement Method					
	Centralized	On-site	Contract	Group	Other	Unknown
All Entities (**Total: 724**)	455	37	77	8	39	108
State-operated Community Mental Health Centers	23	2	2	0	11	0
Other Community Mental Health Centers	308	31	68	6	26	15
State Mental Health Authority	4	1	0	0	1	0
Regional Mental Health Authority	0	0	7	2	1	0
County Mental Health Programs	65	3	0	0	0	89
Other Type of Entity	55	0	0	0	0	4

* Of 41 responding states, 28 were able to identify the predominant procurement methods used by mental health entities.
Source: Public Health Foundation

Table 10. Predominant Procurement Methods Used by ADMS Block Grant-Funded Entities - Substance Abuse Program Area, As Identified by Responding States, FY 1992*

Type of Entity	Predominant Procurement Method					
	Centralized	On-site	Contract	Group	Other	Unknown
All Entities (**Total: 614**)	104	195	32	4	2	277
Community Mental Health Centers	2	22	0	0	0	31
Community/Migrant Health Centers	0	1	0	0	0	0
State Mental Health Authority	0	1	0	0	0	1
State Substance Abuse Authority	2	1	1	0	0	1
Local Health Departments	1	11	0	0	0	0
Outpatient Drug or Alcohol Detoxification Programs	10	31	6	0	0	4
Outpatient Drug or Alcohol Treatment Programs, Excluding Methadone Maintenance	73	27	1	0	0	184
Methadone Maintenance Programs	15	96	11	4	2	41
Other Type of Entity	1	5	13	0	0	15

* Of 38 responding states, 21 were able to identify the predominant procurement methods used by substance abuse entities.
Source: Public Health Foundation

APPENDIX D

ESTIMATED NATIONAL EXPENDITURES FOR OUTPATIENT DRUGS IN FISCAL YEAR 1992

Table 1. Reported Expenditures for Covered Outpatient Drugs in FY 1992 for Entities That Received MCH and ADMS Block Grant Funds, by Type of Program and State

States and Territories	MCH Program	CSHCN Program	Mental Health Program	Substance Abuse Program
Total Expenditures	$10,640,457	$22,993,217	$48,857,779	$13,954,533
Alabama	U	2,645,111	2,100,000	U
Alaska	U	U	50,000	6,800
Arizona	126,900	U	U	U
Arkansas	U	187,927	U	U
California	U	4,600,000*	16,170,000*	4,215,040
Colorado	U	U	U	U
Connecticut	U	66,526	248,000	U
Delaware	U	U	U	U
District of Columbia	U	U	U	U
Florida	1,245,988*	195,000	4,630,850	U
Georgia	U	U	2,000,000	U
Hawaii	U	42,000	U	U
Idaho	U	U	4,300,000	U
Illinois	U	1,055,032	U	U
Indiana	U	U	U	U
Iowa	24,000	U	U	U
Kansas	U	U	U	U
Kentucky	1,200,000	209,235	1,251,000	U
Louisiana	U	U	576,000	129,682
Maine	U	U	U	U
Maryland	U	U	U	U
Massachusetts	U	U	U	U
Michigan	U	5,000,000	U	U
Minnesota	U	U	U	U
Mississippi	727,545	U	U	U
Missouri	U	U	U	U
Montana	U	35,000	U	U
Nebraska	100,000	U	U	U
Nevada	U	U	U	U
New Hampshire	U	127,899	U	U
New Jersey	U	U	U	U
New Mexico	U	U	U	U
New York	U	U	U	U
North Carolina	U	U	1,000,000	1,000,000
North Dakota	109,574	U	U	U
Ohio	1,500,000*	1,100,000	3,569,184	151,011*
Oklahoma	545,000	U	U	U
Oregon	U	84,122	U	U
Pennsylvania	2,911,150*	5,047,500*	3,573,375	8,100,000*
Rhode Island	U	U	1,591,370	U
South Carolina	U	U	U	U
South Dakota	U	U	U	U
Tennessee	U	U	U	U
Texas	2,750,000	1,417,817	7,400,000	U
Utah	U	U	U	U
Vermont	U	140,048	U	0
Virginia	U	U	U	152,000
Washington	U	U	U	U
West Virginia	U	U	U	U
Wisconsin	U	140,000	U	U
Wyoming	U	U	U	U

U = State was unable to provide information on outpatient drug expenditures for this program.
* = States that reported estimated expenditures after intensive follow-up.
Source: Public Health Foundation

Table 2. Estimated National Expenditures in Fiscal Year 1992 for Outpatient Pharmaceuticals by Entities That Received Block Grant Funds – MCH Programs

State	Block Grant Appropriation	Reported Expenditures[1]	Estimated Expenditures[2]
Total	$527,118,252	$10,640,457	$37,017,057
Alabama	12,339,452		808,300
Alaska	1,064,591		0
Arizona	5,646,911	126,900	126,900
Arkansas	7,371,414		426,300
California	35,792,571		3,111,200
Colorado	7,032,699		394,300
Connecticut	4,927,855		135,500
Delaware	2,020,719		0
District of Columbia	7,143,054		404,700
Florida	17,530,573	1,245,985	1,245,985
Georgia	16,435,476		1,282,600
Hawaii	2,256,764		0
Idaho	3,193,813		31,600
Illinois	22,463,200		1,852,000
Indiana	12,515,366		865,000
Iowa	6,793,917	24,000	24,000
Kansas	4,684,511		372,500
Kentucky	11,916,616	1,200,000	1,200,000
Louisiana	13,599,089		1,014,600
Maine	3,566,947		66,900
Maryland	12,144,324		577,200
Massachusetts	11,839,884		646,400
Michigan	19,382,371		1,550,300
Minnesota	9,169,174		595,100
Mississippi	10,427,828	727,845	727,845
Missouri	12,351,726		896,800
Montana	2,349,246		0
Nebraska	4,075,177	100,000	100,000
Nevada	1,293,537		0
New Hampshire	2,034,003		0
New Jersey	12,537,695		914,300
New Mexico	4,096,444		116,900
New York	41,660,599		3,685,500
North Carolina	16,836,319		1,320,400
North Dakota	1,901,324	109,574	109,574
Ohio	22,525,555	1,500,000	1,500,000
Oklahoma	7,017,154	545,000	545,000
Oregon	5,937,852		290,900
Pennsylvania	24,960,489	2,211,150	2,211,150
Rhode Island	1,715,556		0
South Carolina	11,719,268		837,600
South Dakota	2,376,273		0
Tennessee	12,183,327		880,900
Texas	31,087,417	2,750,000	2,750,000
Utah	5,220,699		289,200
Vermont	1,753,589		0
Virginia	12,719,879		931,600
Washington	8,376,794		521,300
West Virginia	6,616,558		355,000
Wisconsin	10,969,184		756,700
Wyoming	1,191,862		0
Standard Deviation		933,500	
95% Confidence Interval		551,800	

[1] Expenditures reported to PHF by state block grant program directors.

[2] Includes reported expenditures and estimated expenditures (using linear regression model).

Source: Public Health Foundation.

Table 3. Estimated National Expenditures in Fiscal Year 1992 for Outpatient Pharmaceuticals by Entities That Received Block Grant Funds – CSHCN Programs

State	Block Grant Appropriation	Reported Expenditures[1]	Estimated Expenditures[2]
Total	$527,118,252	$22,993,217	$48,252,800
Alabama	12,889,752	2,645,111	2,645,111
Alaska	1,064,591		0
Arizona	5,846,911		936,900
Arkansas	7,371,414	187,927	187,927
California	55,792,571	4,500,000	4,500,000
Colorado	7,032,599		538,400
Connecticut	4,927,866	66,526	66,526
Delaware	2,020,719		0
District of Columbia	7,143,054		551,500
Florida	17,530,576	195,000	195,000
Georgia	16,435,470		1,668,300
Hawaii	2,256,764	42,000	42,000
Idaho	3,193,813		80,300
Illinois	22,463,200	1,055,032	1,055,032
Indiana	12,015,366		1,132,900
Iowa	6,793,917		509,900
Kansas	4,684,511		258,200
Kentucky	11,916,616	209,235	209,235
Louisiana	13,599,389		1,321,900
Maine	3,566,947		124,900
Maryland	12,144,324		1,149,300
Massachusetts	11,539,884		1,112,000
Michigan	19,382,371	6,000,000	6,000,000
Minnesota	9,169,174		793,300
Mississippi	10,427,828		943,500
Missouri	12,351,726		1,173,000
Montana	2,349,246	35,000	35,000
Nebraska	4,075,177		195,500
Nevada	1,293,637		0
New Hampshire	2,034,003	127,899	127,899
New Jersey	12,537,895		1,195,200
New Mexico	4,095,444		188,000
New York	41,560,599		4,570,300
North Carolina	16,836,319		1,708,200
North Dakota	1,901,324		0
Ohio	22,525,555	1,100,000	1,100,000
Oklahoma	7,017,154		536,500
Oregon	5,937,852	84,122	84,122
Pennsylvania	24,960,488	5,047,500	5,047,500
Rhode Island	1,715,556		0
South Carolina	11,719,268		1,097,600
South Dakota	2,376,273		0
Tennessee	12,188,327		1,153,000
Texas	31,057,417	1,417,617	1,417,617
Utah	5,920,599		405,700
Vermont	1,753,686	140,048	140,048
Virginia	12,719,579		1,217,800
Washington	8,376,794		696,600
West Virginia	6,516,552		488,700
Wisconsin	10,869,184	140,000	140,000
Wyoming	1,191,662		0
Standard Deviation		1,970,800	
95% Confidence Interval		936,800	

[1] Expenditures reported to PHF by state block grant program directors.
[2] Includes reported expenditures and estimated expenditures (using linear regression model).
Source: Public Health Foundation.

Table 4. Estimated National Expenditures in Fiscal Year 1992 for Outpatient Pharmaceuticals by Entities That Received Block Grant Funds – Mental Health Programs

State	Block Grant Appropriation	Reported Expenditures[1]	Estimated Expenditures[2]
Total	$260,062,441	$48,859,779	$93,712,400
Alabama	3,831,936	2,100,000	2,100,000
Alaska	558,698	50,000	50,000
Arizona	3,954,790		1,360,200
Arkansas	1,824,264		479,400
California	98,059,721	16,170,000	16,170,000
Colorado	3,652,403		1,295,200
Connecticut	3,387,339	243,000	243,000
Delaware	680,422		0
District of Columbia	1,000,507		138,800
Florida	12,893,181	4,630,850	4,630,850
Georgia	5,600,164		2,123,200
Hawaii	1,283,237	2,000,000	2,000,000
Idaho	599,421		14,300
Illinois	12,799,962	4,300,000	4,300,000
Indiana	5,336,986		2,135,400
Iowa	2,047,187		571,600
Kansas	1,824,722		479,600
Kentucky	3,002,229	1,251,000	1,251,000
Louisiana	4,010,597	576,000	576,000
Maine	1,117,095		157,000
Maryland	5,087,733		1,828,600
Massachusetts	7,356,511		2,767,500
Michigan	9,302,457		3,773,000
Minnesota	3,895,209		1,335,600
Mississippi	2,087,558		558,200
Missouri	4,690,383		1,664,400
Montana	719,553		22,500
Nebraska	1,230,153		233,700
Nevada	1,425,556		314,500
New Hampshire	1,081,166		172,100
New Jersey	9,539,284		3,710,300
New Mexico	1,446,684		323,300
New York	21,179,654		8,481,800
North Carolina	5,566,127	1,000,000	1,000,000
North Dakota	502,878		0
Ohio	11,575,928	3,569,184	3,569,184
Oklahoma	2,920,340		891,200
Oregon	2,824,955		893,100
Pennsylvania	12,528,749	3,973,375	3,973,375
Rhode Island	1,499,126	1,591,370	1,591,370
South Carolina	3,147,668		1,026,500
South Dakota	768,159		42,127
Tennessee	4,187,338		1,456,400
Texas	16,367,908	7,400,000	7,400,000
Utah	2,187,717		629,600
Vermont	800,651		56,200
Virginia	5,697,959		2,081,800
Washington	5,575,583		2,030,300
West Virginia	1,527,599		356,700
Wisconsin	4,132,594		1,433,700
Wyoming	323,876		0
Standard Deviation		4,186,600	
95% Confidence Interval		2,194,000	

[1] Expenditures reported to PHF by state block grant program directors.

[2] Includes reported expenditures and estimated expenditures (using linear regression model).

Source: Public Health Foundation.