

# Legislative Issues Concerning the WEOLCC

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**1. Cuts to Medicaid Hospice and other benefits:** The September revenue forecast for Washington State projected a cash deficit for the remaining 9 months of the 2009-2011 biennium. To meet the target of \$520 million in cuts to balance the budget, the Governor ordered 6.3% reductions across the board. Agencies have been asked to propose additional 10% cuts for the 2011-2013 biennial budget.

DSHS has implemented cuts effective January 11, 2011 to all "optional" Medicaid services including hospice, pharmacy coverage, adult dental coverage, maternity support services, the disability lifeline program, physical/occupational/speech therapy, podiatry, hearing, vision, Medicare Part D copays, family planning, interpreter services, and medical care for non-citizen children and adults.

Restoring benefits will be an uphill struggle, since the Legislature must cut an estimated \$3.6 - \$4.5 billion from the 2011 - 2013 budget to achieve a balance with projected revenues. Now that revenue options are closed because of Initiative 1053, there is very little chance of preserving these critical services for Washington citizens in the next biennium, even though alternative treatment or symptom management in the hospital costs far more.

**2. Passage and failure of initiatives makes the hole deeper and harder to fill:**

- **I-1053** (passed) makes it virtually impossible to raise additional revenue—by requiring a 2/3 vote or a referendum on the ballot to raise revenues or close tax loopholes.
- **I-1107** (passed) repeals the taxes on soda pop, bottled water, candy, and gum passed in the spring of 2010. Because of this initiative, legislators must cut an additional \$272 million out of state programs in the next biennium.
- **I-1098** (failed) would have generated approximately \$2 billion per year to a dedicated trust fund for education and health services from a state income tax on the wealthy.

**3. Pain management rulemaking:** The 2010 legislature passed Engrossed Substitute House Bill 2876 in response to concerns about the consequences and risks of managing chronic, long-term pain. A workgroup composed of two members from each of five health care provider licensing boards and a representative from the Attorney General has finalized a consensus draft of administrative rules. The consensus draft now goes to each licensing board for formal adoption through the rulemaking process. The rules will require doctors and other prescribers to maintain and update detailed screening, history, and treatment plan records for most pain patients. It also establishes a dose threshold

of 120 morphine equivalents as the maximum a provider may prescribe without consulting a pain management expert.

- **What does the bill require?** The bill requires five boards and commissions (the legislation specifically names the Medical Quality Assurance Commission, Nursing Care Quality Assurance Commission, Board of Osteopathic Medicine and Surgery, Dental Quality Assurance Commission and Podiatric Medical Board) to adopt rules related to pain management by June 30, 2011. These boards and commissions have separate disciplining and rulemaking authority. The legislation does not require one set of rules for all professions. It does require separate rules for each profession.
- **What professions are included in the bill?** The professions include medical physicians and medical physician assistants; advanced registered nurse practitioners; osteopathic physicians and osteopathic physician assistants; dentists; and podiatrists.
- **Will these rules apply to all types of pain management?** No. The rules required by the legislation will not apply to treatment of chronic cancer pain or acute pain caused by an injury or a surgical procedure. It also does not apply to palliative, hospice, and other end-of-life care.
- **Have concerns been raised about the potential unintended impacts on terminally ill patients?** Yes. Advocacy organizations and others have raised concerns that the dose limit may have a chilling effect on providers' willingness to prescribe appropriately higher doses for dying patients or that if physicians feel threatened by the rules, some may cease treating people for pain. The risks of underprescribing for dying patients may be able to be addressed through education and monitoring for unintended impacts.
- **How can I stay informed about this process or get involved?** The DOH has created a pain management listserv and website, <http://www.doh.wa.gov/hsqa/Professions/PainManagement/>, to keep people informed. You can join this listserv or the listserv for one of the named professions to receive regular emails about the project. If you have questions, please send them to [painmanagement@doh.wa.gov](mailto:painmanagement@doh.wa.gov).

**4. Prescription Monitoring Program reinstated:** The legislature created a prescription monitoring program back in 2007, but it was mothballed for lack of funding. The DOH recently obtained two federal grants to restart this program. A prescription monitoring program collects controlled substance prescription data from pharmacies. The data is compiled into a central data base for reporting. Practitioners and other authorized users can view the information and use in making patient treatment decisions, including tracking prescriptions written by providers and obtained by patients.

It may take more than a year to get a system up and running, since the DOH must do rulemaking and there is a significant implementation effort to connect all pharmacies, prescribers, and hospitals to the system.

**5. Medicine return legislation:** In late September, both the federal House and the Senate passed an updated version of S. 3397, the Secure and Responsible Drug Disposal Act of 2010 (remove impediments to organizations that are not part of a law enforcement agency to set up take-back programs).

In 2009 and 2010 legislation has been proposed in Washington to create a convenient, statewide secure medicine take-back program paid for by drug companies. Leftover medicines would be securely collected and safely disposed to help reduce access to drugs, decrease diversion, reduce risks of poisonings, and reduce environmental contamination. The estimated cost of the program is less than \$1 million/year.

You can learn more at [www.takebackyourmeds.org](http://www.takebackyourmeds.org). Since the bill's prime sponsor Rep. Dawn Morrell (D-Puyallup) may not survive an extraordinarily tight election, the Take Back Your Meds Coalition is exploring options for other sponsors and strategies. The primary opposition to take-back legislation is pharmaceutical companies.