

This issue is part of a series of periodic reports from the National Health Law Program's Washington office, reporting briefly on recent and forthcoming developments in federal policy of interest to NHeLP advocates and friends. We always appreciate your feedback and comments. Please send them to Deborah Reid at [reid@healthlaw.org](mailto:reid@healthlaw.org). For updates and information on NHeLP publications, go to <http://www.healthlaw.org>.

## **SUBJECTS COVERED**

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Economic Stimulus Act of 2008  
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## **THE ECONOMY**

### *Economic Stimulus Act of 2008*

On February 13, President Bush signed the \$168 billion "Economic Stimulus Act of 2008" (H.R. 5140) into law. The objective of the law is to avoid a national economic recession by providing tax rebates and incentives for certain individuals and businesses. The legislation largely excluded Senate leadership's recommendations that would assist low-income populations, such as extensions of unemployment benefits, additional food stamp benefits, increased federal Medicaid matching rates, energy tax credits, and more tax rebates to low-income senior citizens. However, the new law does qualify those individuals for a tax rebate who can prove they have \$3,000 in earned income credit in 2007.

## **FY 2009 BUDGET**

President Bush released his proposed budget for FY 2009 on February 4. Several provisions in the budget proposal would impact Medicaid and SCHIP beneficiaries. For example, the budget proposal supports the development of legislation to require states to implement Medicaid Pay-for-Performance measures, with reporting requirements to begin in FY 2009. By 2012, if states had not met the performance standards, they would risk a reduction in their Federal medical assistance percentage (FMAP) until they achieved the threshold measures.

The budget proposal also calls for a reduction in the FMAP for Medicaid functions that are claimed as optional services for federal reimbursement purposes, such as targeted case management (TCM). TCM provides specific services to individuals with illnesses such as developmental disabilities, AIDS, tuberculosis, or chronic physical or mental illness. Currently,

the federal reimbursement rate for TCM is the same as a state's FMAP, which is often higher than 50 percent, and averages about 57 percent. Under the Bush budget proposal, the reimbursement rate for all case management activities would be held to a maximum of 50 percent.

The FY 2009 budget proposal would also impact federal reimbursement for some women's health services under Medicaid. Typically, FMAP rates of 90 percent or more are provided for family planning services and services for women with breast or cervical cancer. In contrast, the budget proposal limits the FMAP for family planning services to a state's standard reimbursement rate.

The budget proposal would also expand the reach of the Centers on Medicare & Medicaid Services' August 17 directive to state health officials. The proposal focuses on applying the special (and most likely illegal) conditions contained in that directive to states attempting to expand their SCHIP programs to children with incomes above 200 percent FPL, rather than the current limit of 250 percent FPL. Although no state has been able to do so, the budget proposal requires states to comply with another provision in the August 17 directive to enroll 95 percent of eligible children with incomes below 200 percent of the FPL. Before states could expand SCHIP eligibility, the budget proposal would first require states with SCHIP income eligible levels greater than 250 percent FPL to achieve 95 percent enrollment of the eligible uninsured population with annual incomes less than 200 percent FPL. States that did not reach the 95 percent SCHIP enrollment goal would receive a reduction in their FMAP rate. The proposal does not include any performance-based assistance to those states that might be able to enroll uninsured children with the lowest incomes in their jurisdictions.

## **BILLS OF INTEREST**

### *Temporary Increase of the Federal Medical Assistance Percentage*

On February 7, in an effort to assist states in meeting what is expected to be an increased demand for Medicaid because of the economic downturn, Representatives John Dingell (D-MI), Frank Pallone (D-NJ), Peter King (R-NJ), and Thomas Reynolds (R-NY) introduced legislation to temporarily increase the FMAP under the Medicaid Program (H.R. 5268) in order to reimburse states for a slightly higher percentage of their Medicaid costs. Among other provisions, the bill would authorize a temporary increase of the Medicaid FMAP by 2.95 percent for the last two quarters of FY 2008 and the first three quarters of FY 2009. Similarly, U.S. territories would receive a temporary FMAP increase of 5.9 percent for five quarters from April 1, 2008 through June 30, 2009. The House Committee on Energy and Commerce is currently considering the legislation.

*Possible action:* In light of the predictable cutbacks to state Medicaid programs because of the sagging economy, those wishing to do so could encourage their elected officials to support this effective form of increased federal participation in Medicaid, especially since the federal government, unlike all but one state, does not have to balance its budget each fiscal year.

*Moratorium on Changes to Targeted Case Management Payments*

Senators Barbara Mikulski (D-MD), Norm Coleman (R-MN), and Amy Klobuchar (D-MN) offered an amendment (S. Amdt. 4023) to the Indian Health Care Improvement Act (S. 1200) that temporarily delays implementation of an interim final targeted case management (TCM) rule that CMS initially proposed to have take effect on March 3, 2008. Among other provisions, the TCM rule would deny federal matching funds for certain Medicaid services that are “integral components of another covered Medicaid service.” For example, the TCM rule would exclude federal matching payments for transportation and day care assistance that are used to access health services, activities relating to the administration of foster care and other non-medical programs (guardianship, legal services, and special education), and TCM services for individuals under age 65 who live in mental institutions. By voice vote, the Senate approved S. Admt. 4023 on February 14, which would impose a moratorium on implementing the TCM rule until April 1, 2009.

In addition, some expect the House to consider legislation that would impose a moratorium on the TCM regulations and other CMS proposals that many in Congress consider to be overreaching on the part of that agency. This anticipated bill might or might not supercede a bill introduced on January 29 by Representative Keith Ellison (D-MN) to temporarily delay application of proposed Medicaid payment rules for case management and targeted case management services (H.R. 5173). The Ellison bill calls for delaying implementation of changes in payment for case management and TCM until after April 1, 2009. The bill further would prohibit the Secretary of the Department of Health and Human Services from issuing or using more restrictive regulatory action to impact coverage or payment for case management or TCM services until after March 31, 2009. H.R. 5173 is currently under consideration in the House Committee on Energy and Commerce.

*Technologies for Restoring Users' Security and Trust in Health Information Act*

Representatives Edward Markey (D- MA) and Rahm Emanuel (D-IL) introduced the “Technologies for Restoring Users' Security and Trust (TRUST) in Health Information Act” (H.R. 5442) on February 14. The bill focuses on protecting patients' medical records through security and privacy measures, while supporting the development of health information technology (HIT) networks by establishing HIT standards and providing grants. H.R. 5442 requires that patients be notified of any breach of security concerning their records. A public-private partnership would be established to recommend HIT standards. The bill would also require specific consent from patients to include their personal medical information in HIT networks.

*Essential Oral Health Care Act of 2007*

The “Essential Oral Health Care Act of 2007” (H.R. 2472) would provide a maximum of six grants to create mid-level dental professionals (Community Dental Health Coordinators) supervised by licensed dentists, to serve patients in underserved areas. These allied health staff would work in federally qualified health centers, Indian Health Service facilities, or local public health clinics. The bill would also award grants for portable dental equipment as part of the overall effort to provide dental care in underserved communities. In addition, the legislation allows for an increase in the FMAP for dental and oral health services for children insured

through the Medicaid or SCHIP programs. Although Representative Albert Wynn (D-MD) originally introduced H.R. 2472 in May 2007, the bill remains pending before the House Ways and Means Committee and the Subcommittee on Health.

### **FEDERAL FACTOID**

In "Relief, Restoration and Reform: Economic Upturn Yields Modest and Uneven Health Returns," the Center for Studying Health System Change recently determined that in periods of national economic uncertainty, state officials often cut funding for safety-net health providers in order to balance their state budgets, despite the resulting loss of federal reimbursement for Medicaid and SCHIP expenditures and the increased demand for public insurance enrollment due to lost private coverage. Although most states tend to try to repair the damage caused by budgetary cuts to safety-net providers and programs when the economy improves, the Center observed that the future of safety-net systems remains vulnerable to economic uncertainty. For further details on the Center's report, see: <http://www.hschange.com/CONTENT/964>.

### **RESOURCES**

The National Health Law Program joined with several organizations in drafting a Shadow Report in response to the State Department's report on the United States' compliance with the Convention on the Elimination of all Forms of Racial Discrimination (CERD). The report notes the many ways in which the United States has failed to live up to its obligations under CERD, and the severe negative consequences for people of color as a result of those failures. CERD is important for health advocates, as it prohibits not only intentional discrimination (in health care and other arenas) but also practices that result in disparate outcomes. It is also one of the few human rights treaties that the United States has actually ratified, thereby making it binding federal law. For more information on CERD and the Shadow Report, go to: [http://www.state.gov/g/drl/rls/cerd\\_report](http://www.state.gov/g/drl/rls/cerd_report)

and

<http://www.healthlaw.org/library/item.128018>

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