

June 20, 2003

This is one of a series of periodic reports from NHeLP's Washington office, reporting briefly on recent and forthcoming developments relating to federal policy of interest to NHeLP advocates and friends. We always appreciate your feedback and comments, which can be sent to Mara Youdelman at youdelman@healthlaw.org.

SUBJECTS COVERED

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House Commerce Committee Action Against Waste
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ICHIA
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GOVERNORS' MEDICAID TASK FORCE

The National Governors Association's (NGA) Medicaid Task Force disbanded without making any formal recommendations (for background, see Capital Communique, April 14 and May 23). The Republican and Democratic members separately issued statements. Both Democratic and Republican Governors agreed that additional flexibility would be helpful. One point of contention focused on changing Medicaid from a federal "entitlement" program (which requires ongoing federal contributions as enrollment and costs increase) into a block grant or capped allotment for certain Medicaid expenditures. The Republican Governors supported a cap on spending for optional beneficiaries and optional services, while the Democratic Governors responded that they would "never support any proposal that could be used to divert Medicaid funding away from the low-income elderly, disabled, pregnant women and children currently provided health care coverage."

One precondition for Medicaid changes accepted by all of the Task Force members was that the federal government should assume the Medicaid costs of individuals eligible for both Medicaid and Medicare, particularly prescription drug and long-term care costs. But during the

debate over adding a prescription drug benefit to Medicare, both the Administration and Congress declined to absorb those costs. The National Governors Association meeting in August may herald further Medicaid discussions.

HOUSE COMMERCE COMMITTEE ACTION AGAINST WASTE

The House Energy and Commerce Committee has begun an investigation of waste and fraud by states in Medicaid. The Committee sent a letter to all 50 governors stating that it will hold states accountable for the Medicaid reimbursements sought from the federal government. According to the Associated Press, the letter states that some states "have created the illusion that they have made large Medicaid payments to certain providers, such as county health facilities, in order to generate federal matching payments."

The Congressional budget resolution this year requires all authorizing committees to examine their programs for evidence of waste, fraud and abuse. And in January, GAO added Medicaid to its high-risk list of government programs affected by fraud, waste, abuse or mismanagement. The results of the Commerce Committee findings will likely result in recommendations for changes to Medicaid, one of the stated aims of the Commerce Committee's Medicaid Task Force. In light of the Committee's apparent concern about the current level of waste and abuse by states, it remains to be seen whether those changes will suggest affording states even greater flexibility with even less federal oversight.

SCHIP REALLOCATIONS

Last year, \$1.2 billion in unspent SCHIP funds (appropriated for FY 1998 and 1999) expired and reverted to the U.S. Treasury. Earlier this year, the Centers for Medicare & Medicaid Services (CMS) issued an interim rule which authorized the redistribution of approximately half of the states' unexpended FY 2000 SCHIP allotments to the 14 states and territories that fully spent their FY 2000 allotments. However, under current law, those states must fully expend the redistributed funds by September 30, 2003.

The Senate Finance Committee favorably reported out of committee S. 312 to extend the time to spend these funds. The full Senate is expected to consider the bill shortly. A companion bill in the House, H.R. 531, would extend the availability of the FY 2000 and 2001 allocations by two years and would allow a fair and equal redistribution of leftover, unspent funds to a larger number of states. In addition to preventing an additional \$2 billion from reverting to the treasury later this year (when the FY 2000 funds are set to expire), these bills would also restore the \$1.2 billion in funding that reverted to the federal treasury last October. Congress included funding for this bill in the 2004 Budget Resolution.

Without Congressional action by June 30, 2003, CMS will issue a final rule governing the remaining redistribution of FY 2000 funds and limit distribution to the 14 states that have expended their SCHIP funds.

Possible Action: Advocates wishing to do so could call their members to support passage of S. 312 and H.R. 531 and extend the availability of expiring SCHIP funds for the states.

MEDICARE PRESCRIPTION DRUGS

Congress is currently debating bills to add a prescription drug benefit to Medicare. The two House committees with jurisdiction — Ways and Means and Energy and Commerce — are expected to finish work on their respective bills this week. After reconciling the two committee bills, a final bill could proceed to a vote on the House floor next Wednesday or Thursday. The Senate Finance Committee has passed a bill and debate has begun on the Senate floor. It is expected to finish work on that bill late next week. It is possible that a joint House-Senate conference committee will begin working out the differences between the bills in July, with a final vote possible late in July. The Administration released a statement generally supporting the Senate bill. Currently, all Medicare enrollees, regardless of their income, are eligible for all of the benefits that the program offers. This has been the case since Medicare's creation in 1965. Under the bills currently being debated, both the Senate and House would alter this characteristic of the program. For example, the Senate bill precludes beneficiaries who are eligible for both Medicare and Medicaid from participating in the Medicare drug benefit — states will, to the extent they cover prescription drugs in Medicaid (prescription drugs are an optional service), continue to pay for these individuals. Senator Rockefeller (D-WV) is proposing an amendment to ensure that all Medicare beneficiaries remain eligible for all benefits.

The drug coverage that would be available to low-income beneficiaries differs in the House and Senate, particularly regarding copays. For individuals under 100 percent FPL, the Senate bill requires 2.5 percent cost-sharing up to \$4500 in drug costs; after reaching that amount, the bill would require a 5 percent copay until an individual spends \$3700 out-of-pocket. The House bill would require up to a \$5 copay per prescription up to \$2000 of drug costs and then no assistance until \$3500 is spent. After meeting these catastrophic coverage amounts, the Senate would require a 2.5 percent copay while the House would provide 100 percent coverage. For individuals between 100-160 percent FPL, the Senate bill provides limited assistance while the House significantly scales back assistance to those over 135 percent FPL.

The House bill would also require the traditional Medicare fee-for-service program to enter into competitive bidding with private insurance plans. To potentially save money, seniors and people with disabilities likely will leave traditional fee-for-service Medicare and join HMOs and private for-profit managed care plans. This provision is not in the Senate bill and it is likely that the Administration will not support the provision.

ICHIA

The Immigrant Children's Health Improvement Act (ICHIA) was included in the Medicare prescription drug bill reported out of the Senate Finance Committee. Under ICHIA, states would have the option to cover lawfully present immigrant children and pregnant women in Medicaid and SCHIP for FY 2004-7. Senators Grassley (R-IA), Chair of the Finance Committee, and Baucus (D-MT), Ranking Member, agreed to include both ICHIA and a bill advanced by Senator Kyl (R-AZ) to provide additional funding to hospitals along the US-Mexico border that provide care to undocumented immigrants.

Currently, about 20 states and D.C. use their own money to cover costs for pregnant women and/or children who are lawfully present immigrants. A statement from the Administration released Thursday reiterated its opposition to ICHIA. Last year, the Administration initially supported ICHIA but withdrew its support after finalizing the SCHIP "fetus eligibility" regulations (which allow states to provide coverage from conception to age 19).

Possible Action: Advocates wishing to do so could talk to their members while they are in their home districts for the July 4th recess regarding the importance of ICHIA and the need to it as included in the Senate Finance Committee bill without amendments.

RESOURCES:

NEW LANGUAGE ACCESS PUBLICATION:The National Health Law Program and The Access Project are releasing the "Language Services Action Kit." This action kit will aid advocates and health care providers working to ensure that people with limited English proficiency in their states get appropriate language assistance services in medical settings. The Language Services Action Kit costs \$25.00. To place an order, please email your mailing and billing information to lepactionkit@accessproject.org . The kit will be mailed in late July.

NEW MEDICAID EPSDT PUBLICATION:The National Health Law Program has recently released "Toward a Healthy Future: Medicaid Early and Periodic Screening, Diagnostic and Treatment Services For Poor Children and Youth." http://www.healthlaw.org/pubs/200305.toward_ah_healthy_future.html

This 97-page manual provides comprehensive information about EPSDT and offers practical suggestions for working with and improving the EPSDT program. It includes background information on the needs of children and youth, a basic overview of the Medicaid program, legal requirements for EPSDT, common barriers encountered and examples of how these problems can be addressed. "Toward a Healthy Future" is available for \$55.00 from NHeLP's Los Angeles office. To order, call NHeLP at 310- 204-6010 or send an e-mail request to nhelp@healthlaw.org

FEDERAL FACTOID: In 2002, health care spending rose at a rate of 9.6 percent, while the Gross Domestic Product increased 2.6 percent. According to the Center for Studying Health Systems Change, the health care spending growth rate slowed for the first time in five years and evidenced slowing trends in the four primary categories of spending " inpatient (rising 6.8 percent) and outpatient (14.6 percent) hospital care, prescription drugs (13.2 percent), and physician services (6.5 percent).