



National Association of State Medicaid Directors

an affiliate of the American Public Human Services Association

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2007 Medicaid Federal Policy Priorities

1. Reauthorize the State Children's Health Insurance Program (SCHIP). States believe that the expiring authorization of SCHIP affords Congress an opportunity build upon states current efforts to expand coverage to more low income children and families. Specifically, additional federal funding is necessary to maintain the current levels of coverage provided in each state's SCHIP program. In addition, states will need the flexibility to utilize SCHIP funding to meet the unique needs of their respective states. Other issues that states may make a priority during reauthorization include: improving the baseline funding formula; improving the reallocation process; addressing barriers to implementing and/or expanding premium assistance programs; facilitating coverage for state employees through the SCHIP program; and minimizing the burdensome impact of the PERM initiative.
2. Address funding shortfalls in the SCHIP program. The 109th Congress took an important step in addressing expected SCHIP shortfalls in FFY 2007. However, this action did not fully resolve the shortfalls expected by states for FFY 2007. According to analysis by the Congressional Research Service, the shortfalls remaining for the rest of FFY 2007 are estimated to be \$716 million. Congress will need to act early in the new year to ensure that all states can continue to operate their programs as they currently exist. States would like Congress to resolve this issue within the following parameters: (1) shortfalls for FFY2007 should be addressed outside of the reauthorization process; (2) additional funding for SCHIP should not be sought by making cuts or otherwise changing the statute of the Medicaid program; and (3) states should not be forced to alter eligibility or make other changes to their SCHIP program as it currently exists in order to qualify for any additional funding to address the shortfall they expect.
3. Monitor CMS administrative actions. Renewed efforts to monitor and oversee administrative and regulatory actions impacting the Medicaid program are necessary. Such oversight will help to ensure that policymaking is conducted through appropriate policy channels rather than the audit and/or disallowance processes or via inflexible negotiating terms for State Plan Amendments (SPAs). Further, several administrative Medicaid related provisions under consideration are expected to have a significant adverse impact on states, including provider taxes, school based health services, limiting cost to government providers, and limiting the rehabilitation option. Congressional input is essential to ensuring that these and other Medicaid related proposals and unauthorized practices do not

change the scope and shape of Medicaid services, especially for beneficiaries with significant medical needs.

4. Retain state flexibility to pay for graduate medical education. Federal policy has provided states with the flexibility to utilize Medicaid funding to help pay for graduate medical education (GME) for the next generation of physicians who will serve Medicaid beneficiaries. GME payments have received federal and state approval because they are viewed as part of the long-term strategy for meeting the needs of Medicaid beneficiaries and the general public. In recent years, many states have examined their GME policies to strengthen the fiscal integrity of the program and the connection between accountability between distributed funds and training.
5. Preserve appropriate match rates for Medicaid functions. Expenditures necessary for the administration of the Medicaid program generally are reimbursed at 50%. Medicaid administration includes a wide variety of outreach and enrollment, care management, provider monitoring, planning and development, network development, payment, auditing and quality improvement activities. The federal government has approved an enhanced match rate for certain administrative functions that are perceived as good public policy or initiatives that should be supported, such as systems upgrades. Congress should ensure that these incentives are preserved to support and reward states in adopting good public policy.
6. Extend authorization of the Transitional Medicaid Program (TMA). In December 2006, Congress passed the “Tax Relief and Health Care Act of 2006,” (P.L. 109-432), which included a provision to extend TMA authorization through July 1, 2007. States are requesting that Congress extend authorization of this important work support program. Transitional Medicaid Assistance provides low-income working families an option to maintain health insurance coverage. States have used transitional Medicaid to provide health insurance coverage to families who have become ineligible for Medicaid because of earnings, in many cases because they have left welfare for work.
7. Simplify the DRA’s citizenship documentation provisions. Important updates to the DRA’s citizenship documentation requirements were included when Congress passed the “Tax Relief and Health Care Act of 2006,” (P.L. 109-432). However, states believe additional technical updates are necessary to further minimize the administrative burden on states’ Medicaid and SCHIP programs. Specifically, as currently implemented, states are prohibited from providing automatic coverage to newborns, even though these babies have been born in the United States and are U.S. citizens and Medicaid has covered the cost of their birth. States believe the interpretation and implementation of this provision has been counter-intuitive and goes well beyond the intent of Congress. At a time when states are focused on insuring all children, this particular piece makes the goal a lot harder to reach.

States believe that Congress can achieve the intended goal while simplifying the provision as it relates to newborns, Native Americans, and other technical issues.

8. Amend operationally and fiscally burdensome provisions of the Medicare Part D program. Specifically, states believe the methodology for the state monthly payments, referred to as the “clawback,” do not reflect the true cost that states’ incurred or would have incurred for covering prescription drugs for dually eligible enrollees. In addition, state Medicaid agencies believe the a Medicaid-Medicare office or division within the Department of Health and Human Services is necessary to address the many overlapping issues with Medicare Part D as well as on other aspects of these major health care programs.
9. Provide Medicaid agencies access to Medicare Part D data for dually eligible beneficiaries. States currently manage the medical and behavioral care for dually eligible beneficiaries. However, the Medicare Part D program now covers this population’s prescription drugs through private plans. As a result, states currently do not have access to the necessary prescription drug data collected by the Part D prescription drug plans and are unable to continue to efficiently manage dual eligibles’ medical care.
10. Clarify Targeted Case Management (TCM) provisions. States believe statutory language is necessary to clarify that the TCM provisions in the Deficit Reduction Act (DRA) do not restrict TCM for Medicaid beneficiaries and do not discourage entities (private, local, state or federal) from providing these services to people not eligible for Medicaid.
11. Include Medicaid in any health information technology (HIT) initiatives. Any effort to address health information technology, including expansion of HIT, requirements for electronic medical records, and interoperability, should include consideration of the impact on the Medicaid program. States should be consulted in terms of the feasibility of the timeline for HIT initiatives and the resources that will be required of state Medicaid agencies.
12. Conduct oversight of implementation and minimize burdensome provisions of the Payment Error Rate Measurement (PERM) initiative. In fiscal year 2007, state Medicaid agencies are required to comply with new eligibility error rate measurements in conjunction with the federal PERM program. States not only are faced with insufficient guidance and unrealistic short time frames, but also they are incurring significant new costs for which they will not receive adequate compensation. These requirements fail to adequately consider the crossover with other federal and state initiatives, and, in many instances, conflict with existing federal and state efforts. Taken together these facts mean that states must divert precious resources from enrolling eligible individuals or expanding coverage and simplifying processes, including the eligibility process.

13. Expand the “Money Follows the Person” grant program. MFP is a grant program created by the Deficit Reduction Act which has broad support from a range of Medicaid stakeholders. While states strongly support the concept envisioned through MFP, there are significant concerns that the program is not sustainable at the state level beyond the one year of funding. In addition, as currently structured, the MFP program limits state flexibility to develop appropriate eligibility criteria.

14. Support role for Medicaid in federal emergency preparedness and response legislation. The experience in the aftermath of hurricanes Katrina and Rita highlighted the pivotal role of the Medicaid program in times of emergency. Regardless of whether the emergency is caused by a natural disaster in a specific location or from an attack on our nation’s security, states support the development of “emergency Medicaid” protocols that would provide states with the flexibility to coordinate across state lines and a trigger for additional federal resources necessary to meet the needs of victims of large-scale emergencies.

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