Katrina Puts Proposed Medicaid Cuts on Hold

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WASHINGTON — Among the many things put on hold by Hurricane Katrina is the fate of $10 billion in cuts to the Medicaid program that were proposed by a federally appointed commission.

The Medicaid Commission, which was called for by the fiscal year 2006 federal budget agreement and chartered in May by Health and Human Services Secretary Mike Leavitt, included 13 voting members and 15 nonvoting members representing a variety of interests. It was given a deadline of Sept. 1 to come up with ways to cut the money from the Medicaid budget.

After only two meetings, the commission announced its list of ways to achieve the cuts: changing the reimbursement formula for prescription drugs, tightening rules for asset transfers prior to receiving nursing home care, and allowing states to increase copayments for nonpreferred drugs. But then Hurricane Katrina left hundreds of thousands of people homeless and without a regular source of medical care, and Congress decided the need to reduce the Medicaid budget wasn't so urgent after all.

"There's no doubt that Hurricane Katrina has made it necessary to provide additional resources for the Medicaid program, and we're going to do that apart from reconciliation in the Katrina relief package that's being put together," Sen. Chuck Grassley (R-Iowa), chair of the Senate Finance Committee, said in announcing an indefinite delay. However, he added that the changes would be voted on eventually.

With regard to the recommendation to reform the long-term care program under Medicaid, Ray Sheppach, executive director of the National Governors Association said at the August meeting that there is a "fairly sophisticated group of lawyers now who are helping people move their assets or income streams to their children or other people so they can [qualify for] Medicaid."

To prevent people from taking advantage of some of the loopholes in the law, Mr. Sheppach said the NGA favored increasing the "lookback" period—the period during which any assets transferred would still be counted as assets for the beneficiary in determining Medicaid eligibility—from 3 to 5 years.

"We also think the type of asset should be expanded so we can look at most assets, including trusts and annuities. And although it will be somewhat controversial, we believe that housing—which is an increasingly valuable asset—should also be put on the table," Mr. Sheppach explained.

The "tiered copayments" proposal, which would allow states to implement higher copayments for nonpreferred drugs, also raised a lot of interest.

John Monahan, president of state-sponsored business at WellPoint, the for-profit California Blue Shield plan, said that he favored increased use of generic drugs. "Getting [people to increase] utilization of generic up by even 5% would be an incredible savings."

John Rugge, M.D., CEO of the Hudson Headwaters Health Network, in Glens Falls, N.Y., added that "with the psychotropic medications, there's a huge danger in [substituting] one antidepressant for another, one atypical antipsychotic for another; they clearly have to be tailored to the individual. And these are people in most need of service."

Commission vice-chair Angus King, former governor of Maine (I), said he thought the issue could be dealt with because of the ability of the physician to override any preferred drug if it was clinically necessary to do so. He noted that in Maine, such override requests are usually filled within 72 hours.

Commission member Carol Berkowitz, M.D., president of the American Academy of Pediatrics, said she was concerned about how well such an override system would work.

Dr. Berkowitz, who practices in Los Angeles, said that "in my experience it's 30-45 days before it gets approved."

At its next meeting, which was scheduled for late October, the commission was expected to begin the second phase of its work: making recommendations for long-term restructuring of Medicaid. ■

Information about the Medicaid Commission is available online at www.cms.hhs.gov/faca/mc/details.asp.