NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

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Deficit Reduction Act (DRA) Fact Sheet: Expanded Medicaid Coverage

INTRODUCTION

The Deficit Reduction Act (DRA) of 2005, P.L 109-171, signed into law on February 8, 2006, authorizes a number of mandatory and optional changes to Medicaid. Included in the DRA are provisions that expand on States' ability to offer Medicaid coverage for children and adults with mental illnesses and other disabilities.

Under the DRA, children and adults with mental health problems have increased access to Medicaid and new opportunities to receive home- and community-based services through the following provisions: Benchmark Equivalent Coverage, the Optional Choice of Self-Directed Personal Assistance Services, Money Follows the Person Rebalancing Demonstration, and Expanded Access to Home and Community-Based Services for People with Disabilities and the Elderly.

This fact sheet covers the major Medicaid provisions expanding coverage to children and adults with mental illnesses. Final details on some provisions were announced after the completion of the fact sheet. For the most up-to-date information, see the Resources section at the end of this document.

For more information on the DRA and mental health, please visit www.mentalhealth.samhsa.gov. To access the other fact sheets in this series: Overview of the DRA; Medicaid Services for Children Under the DRA; and The DRA and Medicaid: State Implementation, visit the National Council's website at www.TheNationalCouncil.org.

MEDICAID COVERAGE FOR PEOPLE WITH MENTAL ILLNESSES PRE-DRA

Prior to the enactment of the DRA, people with mental illnesses faced challenges in securing needed coverage and care despite the many services available through Medicaid. Some did not have access to Medicaid because they were not financially eligible. Others, who were Medicaid-eligible, did not have access to home- and community-based services, which allow people to receive care in their communities rather than in an institutional setting. The DRA attempts to address some of these obstacles.

EXPANDED MEDICAID COVERAGE POST-DRA: NEW PROVISIONS

Benchmark-Equivalent Coverage (Section 6044)

The DRA contains a provision (Section 6044) that allows States to change their policies governing Medicaid benefits, granting States greater flexibility to tailor the benefits they offer to certain Medicaid beneficiaries. If States can better match benefits with beneficiaries' health care needs, then States may generate savings that can be used to expand Medicaid eligibility for other populations. The Congressional Budget Office (CBO) estimates that these provisions will result in a $1.3 billion reduction in Medicaid expenditures over five years and a $1.6 billion reduction over 10 years.

Prior to the DRA, the Federal government established two sets of Medicaid services: a limited set of mandatory services that States were required to offer all Medicaid beneficiaries, and a list of optional services that States

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were permitted to provide. If a State chose to offer a benefit from the optional list, it generally had to offer the benefit to all Medicaid-eligible individuals in the State. States were permitted to determine the scope, duration, and amount of the services they chose to cover. Children were guaranteed Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) through Medicaid, ensuring that they received all "medically necessary" services even if a particular service would not have otherwise been covered by their State's Medicaid plan. While the Medicaid Act does not define the term "medically necessary," it does require State agencies to provide for "necessary health care, diagnostic services, treatment, and other measures...to correct or ameliorate defects and physical and mental illnesses and conditions covered by the screening services."[i]

Under the DRA, States now have the option to tailor their Medicaid benefits package to mirror one of the following programs: the Federal Employees Health Benefits Program (FEHBP) or its equivalent; the State Employees Health Benefits Package or its equivalent; the benefits package of the HMO in the State with the largest non-Medicaid enrollment; the actuarial equivalent of any of the three previous plans; or "Secretary-approved" coverage. This final category provides the Secretary of the Department of Health and Human Services (HHS) with the authority to approve a plan that may not meet the other criteria. According to the CBO, services that may be affected by these new scaled-back benefit packages include all optional services, such as dental care, vision care, mental health services, and certain therapies. Depending on the benchmark plan selected by a State, other services may also be restricted in amount, duration, and scope.

The DRA does not require that States offer the same Medicaid benefits statewide, meaning States could design different benefit packages for rural and urban areas, for example. States may also tailor packages for different populations, although certain groups are exempt from mandatory changes to their Medicaid benefits package.

Exempt populations include the following: dual eligibles (individuals eligible for both Medicare and Medicaid), hospice patients, people living in institutions, pregnant women, medically frail and special needs populations, people eligible for long-term care, the blind, people with disabilities, foster children, women in the breast or cervical cancer eligibility category, and parents eligible for cash assistance under State rules as of July 16, 1996. People who are part of these populations may be assigned to a new benefit package but must be given the opportunity to opt out. Kentucky and Idaho are examples of States that have chosen to assign people in these populations to a new benefit package.

As States explore the option of adopting benchmark plans, policymakers and other stakeholders should assess how mental health services are currently being utilized in their State and how the benchmark package options could affect coverage and services. A State that already has behavioral health managed care, for example, may not have a need for benchmark plans because a mechanism already exists to ensure that Medicaid beneficiaries are receiving only the care they actually need.

For more information and up to date information on alternative benefit packages being implemented in the states, see
http://www.cms.hhs.gov/DeficitReductionAct/21_Benefits.asp#TopOfPage

Targeted Case Management (Section 6052)

In Section 6052, the DRA narrows the definition of Medicaid reimbursable case management services. Prior to the DRA, "targeted case management" was defined broadly as services that assist eligible individuals in accessing needed medical, social, education, and other services. Under the pre-DRA definition, a broad range of case management activities, such as determinations of Medicaid eligibility, scheduling and transportation related to EPSDT, and intake processing, could be billed as administrative services.

Under the DRA's new definition, "case management" has four main components: 1. assessment to determine service needs; 2. development of a specific plan of care; 3. referral and related activities to help an individual obtain needed services; and 4. monitoring—i.e., follow-up activities to ensure the plan of care is implemented effectively. The DRA clarifies that direct delivery of medical, education, social, or other services are not included

as part of case management. Under the DRA, case management services must first be billed to any other relevant entities before they can be submitted to Medicaid for reimbursement due to concerns of duplication of effort.

Certain case management services for foster children, such as assessing adoption placements, may no longer be billed to Medicaid as an administrative service. At the time of the DRA's passage, 38 States used targeted case management to help meet the unique needs of children in foster care. An Urban Institute study shows that foster children who receive targeted case management received far more Medicaid services than those who did not receive case management.[ii]

"Targeted case management" refers to case management services provided to targeted populations within a State without regard to requirements of statewideness and comparability. Under the DRA, targeted case management services may only be covered for individuals who are eligible for Medicaid and part of the target population for targeted case management listed in their State's Medicaid plan.

These changes to the definition of case management present challenges for providers of community mental health services and for the individuals they serve. Case management services are key to community mental health services, helping consumers gain access to needed medical, social, educational, and other services. States and providers must carefully consider how they will adapt to this new definition as they work to expand mental health services under the DRA.

In December 2007, Centers for Medicare and Medicaid Services (CMS) issued an interim final rule (CMS 2237-IFC) regarding Medicaid case management and targeted case management services. Subsequently, a one year moratorium on the full enactment of the Rule was included in the Supplemental Appropriations Act, 2008 (Pub. L. 110-252), which was signed into law on June 30, 2008.

The final impact has been complicated by the fact that the moratorium retroactively bars implementation of only certain parts of the interim final rule (IFR) through March 31, 2009. Specifically, Section 7001((a)(3) of Pub. L. 110-252 precludes CMS from taking any action that would be more restrictive than applied on December 3, 2007, and thus allows CMS to enforce the part of the rule that implements the statutory definition of case management (as amended by the DRA) as long as it is no more restrictive than the policies contained in following issuances to states:

- A July 25, 2000 State Medicaid Director letter(SMDL) summarizing CMS policy clarifications designed to support state efforts to transition individuals from institutions and expand availability of home and community-based services; and
- A January 19, 200l letter to State Child Welfare and State Medicaid Directors clarifying TCM requirements in a foster care context. However, this letter has also been cited as applicable to other TCM arrangements, and thus is referenced when clarifying policy on targeted case management services under the Medicaid program as it relates to an individual's participation in other social, educational, or other programs.

What Does This Mean for Case Management and Targeted Case Management (combined "CM")?

The moratorium prevents CMS from implementing CM polices that are more restrictive than those in place on December 3, 2007. In addition, even though the interim final rule (IFR) was in effect from March until the supplemental appropriations bill was signed at the end of June, the moratorium prevents CMS from forcing states to comply with the rule during this brief time period and CMS cannot deny claims for noncompliance with sections of the rule now subject to the moratorium during the months that the rule was effective. In particular, CMS will not enforce the following interim rule provisions in light of the moratorium:

1. The requirement that case management services be comprehensive, as specified in Section 441.18(a)(5).
2. The requirement for the development of a specific care plan meeting certain requirements, as specified in Section 440.169(d)(2).
3. The requirement that case-management services be provided by a single case manager as specified in Section 441.18(a)(5) of CMS 2237-IFC.
4. The case record documentation requirements as specified in Section 441.18(a)(7) of the IFC.

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5. A 60 and 14-day limit on the number of days states may claim for the provision of case-management to institutionalized persons to facilitate transition as specified in Section 441.18(A)(8)
6. A prohibition on claims submitted for residents that do not successfully transition from institutions to community settings as specified in Section 441.18(A)(8).
7. A prohibition on the use of workers of other programs to provide Medicaid case-management.

CMS will continue to review state plan amendments and financial documentation to ensure claims do not represent direct delivery of non-Medicaid services. The IFR prohibited federal matching funds for case management provided to children in foster care and a number of other programs, and limited state flexibility in structuring the case management benefit. This is clearly *more restrictive than* the SMDL, and therefore the moratorium prevents CMS from prohibiting payment for case management for activities that may be considered "integral to the administration of another non-medical program" including programs such as foster care, child welfare and protective services, and juvenile justice programs as set forth in Section 441.18(c)(4).

8. Requirement for billing in 15 minute increments. Although CMS will not require states to bill for TCM in 15 minute units, the provisions of Section 1902(a)(30)(A) of the Act mandate that they continue to review rates to ensure that they are economic and efficient. Therefore, CMS will continue to require states, for any rate and billing unit proposed, to demonstrate that the rate does not reimburse for non-Medicaid costs or services and the rate accurately reflects the cost of services that beneficiaries actually receive. (For more information on Case Management Rate Setting, see article in this issue entitled, Case Rates, Bundled Rates, and Other Alternatives to Fee for Service—Be Careful What You Contract For.)

WHICH PARTS OF THE TCM REGULATIONS CAN BE IMPLEMENTED?

CMS will uphold the case management and targeted case management (TCM) benefit defined in the previously mentioned SMDLs, which specifically state that the components of case management are assessment, development of a care plan, referral and referral related activities, monitoring and follow-up. The 2001 SMDL further states that Medicaid is only liable for case management if there are no other liable third parties, and excludes reimbursement for direct services to which the individual has been referred.

Although the third party provision in the DRA focused on the potential overlap between case management activities in foster care and Title IV-E services (such as home investigations and providing transportation), providers should be aware that CMS is clearly evaluating how this statutory language could be extended to other types of activities that are excluded from the definition of case management, rather than as isolated exclusions. The list of foster care activities outlined in the SMDL and subsequently incorporated in the DRA provide instances where there could be cost shifting from the foster care program to Medicaid. CMS has interpreted this language to apply to similar activities where there could be cost shifting from other programs to Medicaid. While the moratorium prevents CMS from implementing this broader interpretation, states and providers should be actively investigating allocation of case management costs across state agencies.

For foster care services specifically, the 2001 SMDL did not prohibit case management for children in foster care. Rather it only clarified that case management does not include the direct delivery of foster care services and that for children who are entitled to foster care assistance under Title IV-E (about one-half of children in foster care), the state cannot bill Medicaid for referrals to medical providers. Title IV-E is clearly not responsible for all of the activities that are defined as case management, however, it is not clear that at the federal or the state levels that there is a clear bright line between the two. We do know however that activities relating directly to the provision of foster care services such as assessing adoption placements and interviewing prospective foster parents are not allowable case management activities under Medicaid. The costs of case management activities for which Title IV-E programs are responsible are not billable to Medicaid.

In most cases, States already have a methodology through its cost allocation plan that allocates case management costs between the different programs according to what is covered and not covered by Medicaid. If the state does not have a plan, CMS or the Division of Cost Allocation may require one. The moratorium prevents

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CMS from enforcing the flat prohibition on targeted case management provided by child welfare or child protective services workers or contractors of child welfare agencies.

The SMDL also states that contact with individuals who are not eligible for Medicaid or not in the target group are covered Medicaid services as long as the purpose of the contact is related to case management for the eligible individual. This is in keeping with other guidance provided by CMS which is concerned with the expansion of services to non-eligible family members.

Optional Choice of Self-Directed Personal Assistance Services (Section 6087)

Section 6087 of the DRA gives States a new option for self-directed personal assistance services for beneficiaries, similar to the "cash and counseling" demonstration projects already available under Medicaid and designed to allow beneficiaries more control over what services they receive and who provides them.

Prior to the DRA, self-directed personal care services were provided to beneficiaries through home- and community-based waivers (HCBWs) and other Medicaid demonstration projects. In three States (Arkansas, Florida, and New Jersey), beneficiaries have been given monthly budgets from which to purchase their care and services through demonstration projects.

Under the new option, all States may elect to provide self-directed personal assistance services for people who would otherwise be eligible for these services under the State's Medicaid plan or under HCBW services. Consumers using this new provision may hire, fire, supervise, and manage the people providing services to them, and if the State allows, may hire family members to provide services. In addition, consumers may use these funds to buy items to increase their independence or serve as a substitute for human assistance, such as an accessibility ramp. States must provide a support system to ensure that participants in the program have been adequately assessed, educated, and are able to self-direct their service needs and budget, and the Secretary of HHS is charged with ensuring that all State proposals include basic consumer protections.

Self-directed personal assistance may not be used by consumers who live in homes or property owned, operated, or controlled by a service provider. States may choose to define the eligible population and may also choose to limit the total number of people who can participate under the option.

This new option is more flexible than the HCBW, as States wishing to adopt Self-Directed Personal Assistance Services need only amend their State Medicaid plans rather than apply for a waiver.

CMS issued the final rule on September 29, 2008. It will be effective November 3, 2008. If a state adopts a self-directed personal assistance services state plan option, beneficiaries could receive a cash allowance to hire their own workers to help with such activities as bathing, preparing meals, household chores and other related services that help a person to live independently. Allotments could also be used to purchase items that help foster independence such as a wheelchair ramp or microwave oven. The beneficiaries also have the option to have their cash benefit allotment managed for them. Before a state could request this change to its state plan, it must have an existing personal care services benefit, or be operating a home or community-based services waiver program.

Enrollment in this new state plan option is voluntary and the state must also provide traditional agency-delivered services if the beneficiary wishes to discontinue self-directed care.States choosing this option must have necessary quality assurances and other safeguards in place to assure the health and welfare of participants. States must also furnish sufficient information, training, counseling and assistance to participants in order to help them effectively manage their budgets and their personal assistance services.

Money Follows the Person Rebalancing Demonstration (Section 6071)

Under Section 6071 of the DRA, Money Follows the Person (MFP) Rebalancing Demonstration grants will be awarded to States to increase the use of home and community-based services under the State's waiver or regular

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Medicaid programs. The MFP grants target people with mental illnesses and other disabilities who are currently receiving care in nursing homes and other institutions, such as intermediate care facilities for people with mental retardation. The program enables these individuals to have choices about where they live and receive care. The MFP Rebalancing Demonstration grants will allow people to move from institutions and nursing facilities into community care settings. Prior to the DRA, this typically had to be accomplished by waivers or limited grants.

States must involve consumers, their families, and providers in developing the MFP projects, and States must provide education to consumers allowing them to make informed choices. States must also provide assurances that participating consumers will receive adequate care in the community. Under the demonstration grant, States will receive enhanced Federal matching funds for the first year of community-based care and regular Federal matching payment for all years thereafter. The enhanced match enables States to cover some of the "start-up" costs of such an undertaking. States must propose an MFP project between two and five years in length.

The challenge for people with severe mental illnesses is to ensure that those who want to live in the community, including those who may choose to live in the community if they received education about their options, are identified and informed about this option. States must conduct regular, ongoing outreach and assessments that identify who prefer and are able to live in the community with the right supports.

This provision went into effect on January 1, 2007. The deadline for applications for MFP Rebalancing Demonstration grants was November 1, 2006. There is no limit to how many States may receive MFP Rebalancing Demonstration grants. Funding is appropriated for grants for the period January 1, 2007 through September 30, 2011 as follows: $250 million is allocated for use January 1, 2007 – September 20, 2007; $300 million is allocated for use in fiscal year (FY) 2008; $350 million is allocated for use in FY 2009, $400 million is allocated for use in FY 2010, and $450 million is allocated for use in FY 2011.

On January 11, 2007, CMS awarded MFP Rebalancing Demonstration grants to 17 States to help Medicaid build long-term care programs to keep people in the community and out of institutions. Arkansas, California, Connecticut, Indiana, Iowa, Maryland, Michigan, Missouri, Nebraska, New Hampshire, New York, Ohio, Oklahoma, South Carolina, Texas, Washington and Wisconsin will receive more than $23 million in grants for FY 2007 and up to $900 million over 5 years.

Updated information out the MFP demonstration program can be found at:
http://www.cms.hhs.gov/DeficitReductionAct/20_MFP.asp#TopOfPage

Expanded Access to Home and Community-Based Services for the Elderly and Disabled (Section 6086)

Under Section 6086, the DRA allows States to offer home- and community-based services to certain individuals whose incomes do not exceed 150 percent of the Federal poverty level (FPL) and whose medical needs do not currently allow them to qualify for services under home- and community-based services waivers. No waiver is required if a State decides to take advantage of this option; instead, it must amend its State Medicaid plan to indicate which services currently covered under home- and community-based services waivers it wishes to include under the new option. The DRA allows States the flexibility to tailor this option to specific areas of their State and to maintain waiting lists for these services.

The flexibility of this provision gives States another means to extend benefits to more people with mental illnesses – all States can choose to offer home and community-based services through their State plans under Section 6086 through the simpler process of amending their State Medicaid plan. States also have the option to continue providing services through their existing waiver programs.

This provision is effective January 1, 2007 Iowa is the first state to implement the 1915(i) State Plan Amendment. Three additional states - Colorado, Nevada, and Georgia - have requests pending under CMS review. To access CMS's State Medical Director letter on 1915(i), see http://www.cms.hhs.gov/SMDL/downloads/SMD040408.pdf.

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Iowa's State plan HCBS benefit offers statewide case management services and habilitation services (which include home-based Habilitation, day habilitation, prevocational habilitation and supported employment). To receive these services, individuals must have a need for assistance on a continuing or intermittent basis for at least two years in at least two of the following criteria:

- be unemployed, or employed in a sheltered setting, or have markedly limited skills and a poor work history;
- require financial assistance for out-of-hospital maintenance and may be unable to procure this assistance without help;
- show severe inability to establish or maintain a personal social support system;
- require help in basic living skills such as self-care, money management, housekeeping, cooking, or medication management; and/or
- exhibit inappropriate social behavior that results in demand for intervention.

In addition, individuals must meet the risk factor of needing psychiatric treatment more intensive than outpatient care, and/or have a history of psychiatric illness resulting in at least one episode of continuous, professional supportive care other than hospitalization.

WHAT DO THESE CHANGES MEAN FOR:

Consumers and Families

The DRA contains many provisions with the potential to allow people with mental illnesses to receive care in their communities rather than in an institution or nursing facility. Consumers may also have the opportunity to direct their own care, making choices about the services and providers that best meet their needs. States may begin offering Medicaid beneficiaries a choice between traditional Medicaid and benchmark plans. In order to fully take advantage of these changes, consumers and families must be more actively engaged in their own health care and have access to information that will allow them to make informed choices and effectively advocate for their State to take advantage of applicable provisions of the DRA.

Providers

Providers should be aware of demonstration grants and other opportunities available in their States and be actively engaged in helping their States decide which reforms would ensure the greatest opportunities for their clients. In addition, providers should educate themselves on options their State chooses to adopt and understand how these changes will affect the people they serve and the way they deliver services. Providers will need to be able to adapt to the changing environment post-DRA and should be prepared to increase capacity to provide home- and community-based services.

Policymakers

Policymakers are encouraged to work with consumers and their families, providers, and advocates to learn how these stakeholders believe mental health service delivery could be improved to better the lives of people with mental health problems. Working with stakeholders, policymakers should seek out information from other States and others with expertise on how provisions of the DRA could expand access to home- and community-based care in their district or State from stakeholders and make decisions on which provisions their district or State should implement based on their input. If policymakers decide to include exempt populations in benchmark plans, opt-out provisions must be clear, and consumers and families must have access to timely and reliable information about their choices. When designing benchmark plans, policymakers should not assume that people who don't meet the SSI definition of disability are healthy and don't need mental health and addiction services; all Medicaid beneficiaries need access to some mental health and addiction services.

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RESOURCES

For more information on the DRA, visit CMS' website:
http://www.cms.hhs.gov/MedicaidGenInfo/08_DRASection.asp

Money Follows the Person (Section 6071) Program Announcement
http://www.cms.hhs.gov/NewFreedomInitiative/downloads/MFP_2007_Announcement.pdf

Money Follows the Person Demonstration Program Maintenance of Effort Instructions:
http://www.cms.hhs.gov/NewFreedomInitiative/02_WhatsNew.asp

Money Follows the Person Evaluation Report:
http://www.cms.hhs.gov/RealChoice/downloads/MFP.pdf

March 31, 2006 Letter to State Medicaid Directors on Benchmark-Equivalent Coverage (Section 6044):
http://www.cms.hhs.gov/smdl/downloads/SMD06008.pdf

To find contact information for your state's Medicaid Director, visit the National Association of State Medicaid Directors (NASMD) online at www.nasmd.org.

Substance Abuse and Mental Health Services Administration (SAMHSA) National Mental Health Information Center:
www.mentalhealth.samhsa.gov or: (800) 789-2647

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[i] 42 USC §1396a(a)(43); 42 USC §1396d(r)
[ii] Geen, Rob, Anna Sommers, and Mindy Cohen. "Medicaid Spending on Foster Children." The Urban Institute Child Welfare Research Program, Brief No. 2, page 6. August 2005. http://www.urban.org/UploadedPDF/311221_medicaid_spending.pdf