

# Deficit Reduction Act (DRA) Fact Sheet: Overview of the DRA

## INTRODUCTION

The Deficit Reduction Act (DRA) of 2005, P.L. 109-171, was signed into law on February 8, 2006. It is a far-reaching piece of legislation touching many areas of Federal spending and policy, including student loan policy, farm subsidies, Medicare, Medicaid, and other areas and is expected to save \$40 billion over five years. Included in the DRA are a number of mandatory and optional changes to slow the pace of spending growth in Medicaid and Medicare. The DRA includes Medicaid provisions intended to improve access to community-based care and greater benefit flexibility for children and adults with mental illnesses and other disabilities.

This fact sheet covers the major Medicaid provisions affecting children with serious emotional disturbances and adults with mental illness and substance use disorders. 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](http://www.mentalhealth.samhsa.gov). To access the other fact sheets in this series: Medicaid Services for Children Under the DRA; Expanded Medicaid Coverage Under the DRA; and The DRA and Medicaid: State Implementation, visit the National Council's website at [www.TheNationalCouncil.org](http://www.TheNationalCouncil.org).

## OVERVIEW OF THE MAJOR PROVISIONS OF THE DRA

### 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.

### **Citizenship Documentation Requirements for Medicaid Eligibility (Section 6036)**

Under this section of the DRA, all citizens applying for Medicaid or renewing their coverage are required to produce documentation to prove both their U.S. citizenship and their identity in order to receive benefits. The new documentation requirement does not change the eligibility criteria for Medicaid for any group of beneficiaries — instead, it replaces the pre-DRA practice allowing beneficiaries to self-declare their citizenship. Individuals whose Medicaid coverage is up for recertification will continue to receive benefits as long as a good faith effort to present evidence of citizenship and identity is shown, but new applicants for Medicaid will not receive benefits until they can present the required evidence.

In the interim final regulations, issued July 6, 2006, the Centers for Medicare and Medicaid Services (CMS) described acceptable documentation of citizenship and identity in four levels or tiers. States must first seek documents from the primary list before looking to the second, third, and fourth lists. If an individual is unable to produce a document from the first or primary tier, citizenship can be documented from the second, third, or fourth levels. In rare circumstances, affidavits can be used to document citizenship. Additional types of documents are acceptable for children under age 16, such as nursery school or daycare records. A passport is the only single document that CMS has deemed acceptable for proof of both citizenship and identity. Because most Medicaid recipients are unlikely to have passports, they will need to produce two or more documents from the lists.

Under the July 6, 2006 interim final regulations, CMS also included an exemption from the documentation requirement for senior citizens and people with disabilities who receive Medicare and/or most people who receive Supplemental Security Income (SSI). The SSI exemption covers people who live in States that automatically qualify SSI recipients for Medicaid. In the States where Medicaid eligibility is not automatically linked by SSI eligibility - currently CT, HI, IL, IN, MN, MO, NH, ND, OH, OK, VA - the States may access the Social Security Administration's SDX database to confirm citizenship.

On December 20, 2006, the Tax Relief and Health Care Act of 2006 (H.R. 6111), a bill containing several technical corrections to the DRA, was signed into law. The bill clarifies Congress' original intent to exempt certain groups of citizens from the need to provide documentation of their citizenship. Under the bill, CMS' exemption of senior citizens and people with disabilities who receive Medicare and/or most people who receive SSI was made

part of the statute. Additionally, it extends new exemptions to recipients of Social Security disability benefits and to children receiving adoption or foster care services under Titles IV-B and IV-E of the Social Security Act.

This provision creates challenges for Medicaid beneficiaries with mental illnesses, who may have difficulty locating documents such as birth certificates and passports or following the procedures to obtain new copies of documents to prove their citizenship and identity. In a guidance letter issued to State Medicaid Directors on June 9, 2006, CMS declared that States must assist any applicant or recipient with a mental impairment who makes a good faith effort to locate their documents and needs assistance in doing so if that applicant or recipient does not have someone else who can act on their behalf. It is unclear exactly how individual States will respond – questions such as whether and how much the States will assist in obtaining copies of documents and whether the cost of obtaining these copies will be covered are yet to be answered.

The provision also creates new administrative burdens and costs for case management staff within community mental health centers and for the State and local agencies that operate Medicaid. Case management and other staff need to ascertain if clients who are Medicaid beneficiaries have birth certificates or passports, and in the event that they do not, help them obtain these essential documents. The DRA does not allocate any additional Federal funds for State costs associated with administering this new requirement beyond the current 50 percent match for administrative costs.

While the technical corrections in the Tax Relief and Health Care Act of 2006 do exempt children receiving adoption or foster care benefits from the documentation requirements, children in foster care continue to face difficulties under this new requirement. For many children, Medicaid eligibility is linked to their entry into the foster care system, which often occurs during an emergency and under circumstances that make it difficult to locate documents. Foster children have greater health and mental health care needs than children in general, and delays in determining their Medicaid eligibility can delay access to important services.

On June 28, 2006, a class-action lawsuit (*Bell v. Leavitt*) was filed in U.S. District Court in Chicago on behalf of nine plaintiffs who said they could not document their citizenship and risked losing their Medicaid benefits if the law was implemented. The lawsuit was aimed at eliminating the requirement on grounds that it violates the Fifth Amendment right to due process.

On September 19, 2006, U.S. District Judge Ronald Guzman ruled that the plaintiffs in the case did not have standing to challenge the regulation, writing in his decision, "Absent a showing that their injuries can be traced to the regulations, which they have not made, plaintiffs do not have standing to pursue these claims."<sup>i</sup>

This section took effect July 1, 2006.

### **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 Early Periodic Screening, Diagnosis, and Treatment (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.<sup>ii</sup>

"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, the 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, 2001 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 policies 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.
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 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.

### **New Medicaid Premiums and Cost-Sharing Requirements (Section 1916A(a))**

The DRA establishes Section 1916A(a), which gives States new authority to impose premiums and cost-sharing on Medicaid beneficiaries effective March 31, 2006.

Prior to the DRA, the Medicaid statute prohibited premiums for categorically needy recipients, such as recipients of SSI. States also had the option to impose nominal co-payments, ranging from \$0.50 to \$3.00 depending on the cost of the service, with exemptions for certain services and groups, such as services for children under 19. Providers were not required to collect a co-payment nor could they deny care because of an individual's inability to pay the co-payment. Individuals at or below 100 percent of the Federal Poverty Level (FPL) and individuals between 100 to 150 percent of the FPL paid no premiums for services they received, and could be charged co-payments of up to \$3 per service.

The DRA adds a new section to the Medicaid statute that allows States to increase cost-sharing and creates separate options for cost-sharing on prescription drugs and non-emergency use of the emergency room. Under Section 1916A(a), States will be allowed to vary the premiums and cost-sharing that they charge by and within groups, by geographic area, and by type of service. Individuals between 100 to 150 percent of the FPL may face cost-sharing up to 10 percent of the cost of most services. This group may also be charged up to \$6 for non-emergency use of the emergency room. Individuals above 150 percent of the FPL face premiums not to exceed 5 percent of the individual or family's monthly or quarterly income. In addition, States may implement cost-sharing of up to 20 percent of the cost of most services for this group.

In the Tax Relief and Health Care Act of 2006 (H.R. 6111), Congress clarified that Medicaid recipients below 100 percent of the FPL are not subject to the new cost-sharing requirements. Premiums and co-payments for individuals at or below 100 percent of the FPL are allowed, in line with the nominal co-payments of \$0.50 to \$3.00 allowed prior to the DRA. This point was clarified in a June 16, 2006 guidance letter from CMS, as cost sharing for this group was not addressed initially.

People who live in an institution, are receiving hospice care, children in mandatory coverage categories under age 18, and people who qualify for Medicaid under the breast and cervical cancer eligibility category are exempt from premiums and cost-sharing under the DRA, but they do face a charge of up to \$3 for a non-preferred drug or for non-emergency use of an emergency room.

This section became effective on March 31, 2006, except for the emergency room provisions, which become effective January 1, 2007.

### **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' healthcare 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 States 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 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.”<sup>iii</sup>

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](http://www.cms.hhs.gov/DeficitReductionAct/21_Benefits.asp#TopOfPage)

## **Home and Community-Based Care Provisions**

The DRA creates two demonstration grant programs and one new option intended to expand access to Medicaid coverage for some people with disabilities.

### Home and Community-based Alternatives to Psychiatric Residential Treatment for Children (Section 6063)

Section 6063 of the DRA addresses the obstacles States face in attempting to obtain a 1915(c) home- and community-based services waiver (HCBW). Since 1981, States have been able to apply for a HCBW for children under 21 who need the level of care provided by a hospital, nursing facility, or intermediate care facility for people with mental retardation. Because pre-DRA cost neutrality provisions (which required the average per-

beneficiary cost for those receiving services through a waiver program not be any higher than it would have been if they were receiving services through a non-waiver program) excluded costs for psychiatric residential treatment facilities, States had difficulty obtaining the waiver or, in those five States which obtained waivers, could serve only a very limited number of children.

Under Section 6063 of the DRA, competitive grants have been awarded to 10 States to conduct five-year demonstration projects. These projects are intended to test the effectiveness of providing home- and community-based services to children who would otherwise be placed in psychiatric residential treatment facilities. Effectiveness will be measured in two ways--cost-effectiveness and whether the services improve or maintain the child's functioning. In the States that have obtained 1915(c) waivers, the cost of providing home- and community-based care has averaged about half of the cost of psychiatric residential treatment facilities. The deadline for applications for these grants was October 18, 2006.

On December 19, 2006, CMS awarded 10 States grants to develop care delivery systems to help move children with emotional disturbances from institutional settings to community-based treatment. Alaska, Florida, Georgia, Indiana, Kansas, Maryland, Mississippi, Montana, South Carolina and Virginia will receive \$218 million in grants over five years to State Medicaid programs to develop care delivery systems under the Community Alternatives to Psychiatric Residential Treatment Facilities (PRTF) demonstrations. These 10 States will receive a total of \$21 million in the first year of the program, which will continue through 2011.

### **Money Follows the Person (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 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 serious 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 those who prefer and are able to live in the community with the right supports.

This provision goes 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 30, 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.

This provision went into effect on January 1, 2007. The deadline for applications for MFP Rebalancing Demonstration grants was November 1, 2006.

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](http://www.cms.hhs.gov/DeficitReductionAct/20_MFP.asp#TopOfPage)

### Expanded Access to Home and Community-Based Services for People with Disabilities and the Elderly (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 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>.

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.

### **Family Opportunity Act Provisions (Section 6062)**

The DRA contains a provision (Section 6062) that allows States to adopt the Family Opportunity Act, which permits parents of children with disabilities who would otherwise not qualify for Medicaid to buy into the Medicaid program. To participate, family income must be below 300 percent of the Federal poverty level (FPL)

(approximately \$60,000 for a family of four). States may charge premiums on a sliding scale—i.e., no more than 5 percent of family income if under 200 percent of the FPL; no more than 7.5 percent income if between 200 and 300 percent of the FPL. The Congressional Budget Office estimates this provision would increase Federal Medicaid spending by \$1.4 billion over the next five years, extending Medicaid coverage to an additional 115,000 children.

The Family Opportunity Act option is intended to end the financial devastation that families too often encounter in attempting to access quality treatment for their children who have serious mental health needs. Without this Medicaid buy-in option, many families must stay impoverished, turn down promotions, place their children in out of home placements or relinquish custody in order to obtain Medicaid coverage to secure the health care services their children need.

This provision will be phased in by age, beginning January 1, 2007: those six or under in 2007; seven to 13 in 2008, 14 to 19 in 2009.

### **Other Children's Services Provisions**

#### Family-to-Family Information Centers (Section 6064)

Section 6064 of the DRA requires the funding of family-to-family health information centers to provide information to parents of children with disabilities and special health needs so that they can make informed decisions about health care. These centers are similar to the Parent Training and Information Centers funded through the Individuals with Disabilities Education Act (IDEA).

The Family to Family centers are to be staffed by health professionals and family members who have expertise in Federal and State public and private health care systems and who can provide information on treatment options, offer training on caring for children with disabilities, and other resources. The centers will also make outreach efforts to health professionals, schools, and other relevant entities.

Funding for centers will be phased in as follows: \$3 million is appropriated for 25 States in FY 2007, \$4 million for 40 States in FY 2008, and \$5 million for all States (including the District of Columbia) in FY 2009. Funds are to remain available until they have been spent. The DRA gives HHS the authority to determine how the funds will be distributed—e.g., by grant, contract, or some other means.

For more information about this program, overseen jointly the U.S. Department of Health and Human Services, through the Health Resources and Services Administration (HRSA)/Maternal and Child Health Bureau (MCHB) and the Centers for Medicare & Medicaid Services (CMS), see [http://www.cms.hhs.gov/RealChoice/06\\_FamilytoFamily.asp](http://www.cms.hhs.gov/RealChoice/06_FamilytoFamily.asp)

#### Medicaid Eligibility for Children (Section 6065)

Section 6065 establishes that Medicaid eligibility for children (under age 21) will occur on the later of: the date of application or the date SSI eligibility is granted. This eliminates the requirement that the child wait until the beginning of the following month to be eligible.

This section takes effect February 8, 2007.

### **WHAT THE DRA MEANS FOR CONSUMERS OF MENTAL HEALTH SERVICES & THEIR FAMILIES**

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 take advantage of the provisions of the DRA that stand to benefit them and to deal with those provisions that place new or increased financial responsibilities on them.

**1. New requirements:** All consumers and/or their families must be able to document their citizenship and identity to qualify for Medicaid coverage.

**2. May have to contribute more money to one's own care:** Some consumers and families may see new or increased cost-sharing and premiums under the new benefit flexibility and cost-sharing provisions of the DRA.

**3. Benefit changes and opportunities:** Under the DRA, children and adults with mental illnesses have increased access and new opportunities to receive home and community-based services and care under the Family Opportunity Act, Expanded Access to Home and Community-Based Services for People with Disabilities and the Elderly, and Money Follows the Person provisions.

**4. A Work in progress:** Much is still unknown about the implementation and effects of the DRA, and consumers and families will need to work with their providers, States, policymakers, and other stakeholders as the process unfolds.

## RESOURCES

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

For more information on the Citizenship Documentation Requirements for Medicaid Eligibility (Section 6036): [http://www.cms.hhs.gov/MedicaidEligibility/05\\_ProofofCitizenship.asp](http://www.cms.hhs.gov/MedicaidEligibility/05_ProofofCitizenship.asp)

June 16, 2006 Letter to State Medicaid Directors on New Medicaid Premiums and Cost-Sharing Requirements (Section 1916A(a)):  
<http://www.cms.hhs.gov/smdl/downloads/SMD061606.pdf>

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

Home and Community-based Alternatives to Psychiatric Residential Treatment for Children (Section 6063) Application and Announcement:  
<http://www.cms.hhs.gov/NewFreedomInitiative/Downloads/PRTF%20Solicitation.pdf>

Money Follows the Person (Section 6071) Evaluation Report:  
<http://www.cms.hhs.gov/RealChoice/downloads/MFP.pdf>

Money Follows the Person Program Announcement:  
[http://www.cms.hhs.gov/NewFreedomInitiative/downloads/MFP\\_2007\\_Announcement.pdf](http://www.cms.hhs.gov/NewFreedomInitiative/downloads/MFP_2007_Announcement.pdf)

For more information on Family to Family Information Centers (Section 6064):  
[http://www.cms.hhs.gov/PromisingPractices/Downloads/F2F\\_PromPrac.pdf](http://www.cms.hhs.gov/PromisingPractices/Downloads/F2F_PromPrac.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](http://www.nasmd.org).

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

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<sup>i</sup> Bell v. Leavitt, No. 1:06-cv-03520 (N.D.Ill. filed June 28, 2006).  
[https://ecf.ilnd.uscourts.gov/cgi-bin/show\\_case\\_doc?70,199658,,,,,303,1](https://ecf.ilnd.uscourts.gov/cgi-bin/show_case_doc?70,199658,,,,,303,1)

<sup>ii</sup> 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](http://www.urban.org/UploadedPDF/311221_medicaid_spending.pdf)

<sup>iii</sup> 42 USC §1396a(a)(43); 42 USC §1396d(r)