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Deficit Reduction Act (DRA) Fact Sheet: State Implementation

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 projected to save $40 billion over five years. Included in the DRA are a number of mandatory and optional changes to Medicaid intended to slow the pace of spending growth. The DRA includes provisions that could enable States to improve access to community-based care and provides States with greater flexibility to tailor benefit packages for Medicaid recipients.

This fact sheet covers the major provisions and approaches that a variety of stakeholders - consumers, families, providers, advocates, and policymakers - may wish to consider when working with States to utilize and implement the DRA. 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; Expanded Medicaid Coverage Under the DRA; and Medicaid Services for Children Under the DRA, visit the National Council's website at www.TheNationalCouncil.org.

COMMON THEMES FOR ALL STAKEHOLDERS

Though each group of stakeholders has its own set of issues to consider under the DRA, there are a number of themes common to all stakeholders, such as the importance of a transparent and inclusive process in which to propose and consider potential Medicaid changes. Each group must understand the significance of Medicaid to other stakeholders, i.e., people with serious mental health needs, States, and providers. To ensure meaningful participation in State-level Medicaid reform efforts, self-education and outreach are crucial for all stakeholders, as is an understanding of who the decision makers are for each particular issue. Finally, each group must understand how to make contact with the relevant decision makers and build relationships with them. The State Medicaid agency plays a particularly important role in the implementation of the DRA. To find contact information for your State's Medicaid Director, visit the National Association of State Medicaid Directors (NASMD) online at www.nasmd.org.

Citizenship Documentation Requirements for Medicaid Eligibility (Section 6036)

Under Section 6036 of the DRA, all citizens applying for Medicaid or being recertified as Medicaid-eligible 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. Current Medicaid beneficiaries must be given a reasonable opportunity to gather their documents. Individuals who are already enrolled in Medicaid will continue to receive benefits during the recertification process as long as they demonstrate a good faith effort to present evidence of citizenship and identity. 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 section took effect July 1, 2006.

Consumers and Family

This provision creates challenges for Medicaid beneficiaries with mental illnesses and their families, who may have difficulty locating documents such as birth certificates and other documents or following the procedures to obtain new copies of documents to prove their citizenship and identity, particularly if these documents must be generated by another State. Consumers and families may also have difficulty paying any required fees to obtain these documents. It is critical that consumers and family members understand that this requirement is not optional and that, with the exception of the SSI exemption outlined here, all Medicaid beneficiaries and applicants must be able to document their citizenship and identity in order to receive benefits.

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 US 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."[i]

Providers

The citizenship documentation 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. CMS announced that States can receive a 50 percent Federal administrative match for any expenses they incur from

the documentation requirements. Providers should encourage States to use the match to reduce the financial burden on providers and recipients for obtaining documents.

Case management and other staff need to ascertain if their Medicaid-eligible clients have the necessary documentation, and in the event that they do not, help them obtain these essential documents. Staff should educate themselves on the types of documents necessary to meet this requirement and work with the State to streamline the process for obtaining copies of relevant documents.

Advocates

Mental health advocates must educate policymakers on the challenges the new citizenship and identity documentation requirement presents for consumers and their families. Advocates need to help policymakers understand that the exemption of senior citizens and people with disabilities who receive Medicare and/or most people who receive SSI from the documentation requirement does not cover all people with mental illnesses who may face difficulty under the provision and encourage policymakers to remove as many obstacles as possible.

Advocates can also ensure that policymakers understand the advantages of utilizing the SDX database in States where Medicaid eligibility is not automatically linked by SSI eligibility (CT, HI, IL, IN, MN, MO, NH, ND, OH, OK, VA). By accessing a person's record in the SDX database, records of documents proving citizenship and identity that are no longer in the person's possession, such as birth certificates, can be used to meet the documentation requirement.

Policymakers

Policymakers should educate themselves on their role in applying the citizenship and identity documentation requirement in their State. Policymakers must understand the exemptions that CMS has outlined for the citizenship and identity documentation provision and ensure that they are applied in their State. In States where Medicaid enrollment is not automatic with SSI eligibility, policymakers should ensure their State is using the SDX database to relieve consumers, families, and providers of the burden of supplying birth certificates and other relevant documents. Use of the SDX database to access documents such as birth certificates rather than obtaining a new copy of the document could help to reduce the cost of implementing this requirement. Policy makers should use the 50 percent Federal administrative match to reduce the financial burden on Medicaid recipients, applicants and providers in obtaining documents. In addition, policymakers should consider waiving fees for obtaining copies of documents, streamlining the process of requesting official documents, and assisting people with obtaining necessary documents from other States and/or the Federal government.

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.[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.
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.

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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.

Consumers and Family

It is important that consumers and family members understand that case management may not look the same under the DRA's new definition as it did prior to the DRA. They should document any problems and raise concerns about implementation of the new provision with providers, advocates, and policymakers in their State. The effects of the new definition on foster care case management are of particular concern, and families and consumers must ensure policymakers know the importance of case management to foster children.

Providers

Providers must understand how to meet the new requirements for case management services and work to eliminate any duplication of effort. It is important that providers track services that may no longer be billable under Medicaid and work with advocates and policymakers to address ways to provide these needed services. By documenting services that are no longer being provided, providers are able to come to the table with details on what services are no longer billable and how the loss of these services affects their clients.

Advocates

Advocates should work closely with other stakeholders, particularly providers, to determine if the application of the new case management definition is resulting in unmet mental health needs. Advocates should also work with policymakers to identify other ways to fund these services.

Policymakers

Policymakers should work with other stakeholders to understand the important services provided by case management. Policymakers must provide clear guidance to providers on the new rules to ensure that policies are making full use of Medicaid for case management services. In addition, policymakers should work with advocates, consumers, and their families to identify and address unmet mental health needs no longer being covered by Medicaid, using other Federal, State, and local funds.

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.

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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.

Consumers

While the flexibility of this option has the potential to give consumers new opportunities to take control of their care and to allow more consumers to live in their own homes and communities, there is also a risk that consumers who do not receive adequate education and information about the options available to them under this provision may not receive the care and services they need. Consumers are being asked to be more active and informed health care consumers and should be prepared to ask policymakers questions about self-directed care to ensure that the mental health services and supports they need will be adequately available. Questions to ask include:

- How much money is available to me to direct my own care?
- Is it in my best interest to take advantage of this option if I am part of the eligible population in my State?
- What training or education is available to me and/or to my family to help me understand my options if I decide to take advantage of self-directed care?
- If I reach my allotted funds for self-directed care, how do I continue to receive a medically necessary service?

Families

Families must be active participants in a consumer's decision to self-direct their services. Families in States that adopt this provision should seek information on program details to see if their family member qualifies as part of the eligible population. It is important that family members understand what services and service providers may be used under this option. Family members should work with advocates, providers, and policymakers to ensure that the necessary educational tools and programs will allow consumers and their family members to make the best decisions about how to spend and manage their self-directed care funds.

Advocates and providers

In States that adopt this provision, advocates and providers should work with policymakers to ensure that the required support system to ensure that participants adequately understand and are able to self-direct their service needs and budget. Advocates and providers should work with consumers, family members, and policymakers to develop the necessary educational tools and programs to ensure that consumers and their families will be able to make the best decisions about how to spend and manage their self-directed care funds.

Policymakers

Policymakers should seek input from consumers, families, advocates, and providers to better understand Medicaid recipients' mental health needs and the types of services and items that may enable individuals to receive care in their homes and communities rather than in an institutional setting. While self-directed care presents many

opportunities to consumers and their families, it is crucial that the required support system give consumers and their families the information they need to make informed decisions about how to spend their self-directed funds. Policymakers should work with consumers, family members, advocates, and providers to develop the assessment and education programs that will be used in their State.

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

Effective March 31, 2006, the DRA grants new authority to States to impose premiums and cost-sharing on Medicaid beneficiaries. Section 1916A contains the Federal standards that govern premiums and cost-sharing for: individuals between 100 and 150 percent of the Federal poverty limit (FPL); individuals above 150 percent of the FPL; and for special groups and services, such as children and pregnant women.

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.

Studies indicate that cost-sharing may be inappropriate for certain populations. Research has shown that the introduction or increase of cost-sharing for people with mental illnesses discourages them from seeking or continuing treatment, resulting in poor health outcomes, increased emergency room visits, hospital care, and institutionalization. A large study looking at the situation before and after coinsurance was introduced found that emergency room use increased by 88 percent and poor outcomes such as hospitalization, institutionalization and death increased by 78 percent.[iii]

<u>Consumers, families, and advocates</u>
Much has been written about the difficulty that people with serious mental illnesses have staying engaged in their treatment. For this population, co-pays and premiums would serve as an additional barrier to staying actively engaged. For this reason, consumers, their families, and advocates must work to ensure that cost-sharing is not imposed on people with serious mental health needs. If cost-sharing is imposed, advocates should track its impact on this population to ensure that any negative effects are captured and this information is disseminated to

policymakers.

Policymakers

Policymakers must understand that the DRA does not require cost-sharing. If policymakers decide to impose cost-sharing in their State, they should ensure that it is imposed only on generally healthy people and not on those with serious mental health needs. It is important that policymakers understand that Medicaid recipients who are not eligible for SSI may still have serious mental health needs. Policymakers should ensure that State policies encourage early intervention and prevention for mental health needs. Cost-sharing is intended to deter Medicaid recipients from seeking unnecessary care, not to impede access for those with serious and chronic health and mental health care needs.

Benchmark-Equivalent Coverage (Section 6044)

The DRA contains a provision (Section 6044) that allows States to change their policies governing the benefits States must offer to certain Medicaid beneficiaries, in effect allowing States greater flexibility to reduce the benefits they offer to Medicaid beneficiaries. 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 ten 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 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 it to all people covered by Medicaid 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 of the "medically necessary" services they needed even if a particular service would not have otherwise been covered by their State. 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."[iv]

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 can be anything that the Secretary of the Department of Health and Human Services (HHS) approves. 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 that one part of the State could receive a more comprehensive package than another part of the State. States are also permitted to define new groups of people who will receive the new DRA benefit package, though certain groups are exempt from changes to their Medicaid benefits package. Coverage for dual eligibles, 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 are voluntary under these changes. People who are part of these populations cab 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.

Because States that choose to adopt the benefit flexibility provision may be offering a variety of benefit packages among different groups of people and different parts of the State, it is crucial that States provide clear information on benefit plans so that consumers and families can make informed decisions. It is also important

that voluntary decisions be made voluntarily – particularly in the case of individuals who fall into populations that can be assigned to a new benefit package with an opportunity to opt out of the new package. Consumers must be educated and involved in their health care decisions so that they can select a benefit package that is appropriate for their needs.

Consumers

People with serious mental illnesses are being asked to be more active and informed health care consumers. Consumers must be active participants in Medicaid redesign consideration and planning. Consumers should be prepared to question their providers and policymakers about benchmark plans to ensure that mental health services are adequately available to the populations targeted. Questions to ask include:

- What plan has been selected as the benchmark plan in my State?
- How do benefit packages differ from my current Medicaid coverage?
- Am I eligible to opt out of the new package? Is it in my best interest to do so?
- If I reach my limit on a particular benefit, how do I continue to receive a medically necessary service?

Families

Families must be active participants in any Medicaid redesign consideration and planning. The preservation of EPSDT services, such as developmental assessments, is of critical importance to families of children with mental health problems. In States that choose to adopt the benefit flexibility provision, families should ask questions about what EPSDT services are part of the benchmark plans and which EPSDT services will be provided as wraparound care.

Families should be prepared to question providers and policymakers about benchmark plans to ensure that mental health services are adequately available to the populations targeted. Questions to ask include:

- What plan has been selected as the benchmark plan in my State?
- How do benefit packages differ from my family member's current Medicaid coverage?
- Is my family member eligible to opt out of the new package? Is it in his or her best interest to do so?
- How will families access EPSDT services under the new Medicaid benefit packages?

Advocates and providers

Advocates and providers should educate policymakers in their State on the importance of including mental health benefits in all health care benefit packages. In States that adopt the benefit flexibility provision, advocates and providers should ensure that the State provides adequate information and assistance so that consumers and families can select the most appropriate benefit package for their needs. Advocates and providers should also ensure EPSDT services are still available and that families know how to access them.

Policymakers

Benefit flexibility is a complicated area, and policymakers should take time to consider the necessity of benefit changes in their State. Prior State reforms, such as managed care, may make benchmarks plans unnecessary. Policymakers should seek out input from consumers, families, advocates, and providers to better understand Medicaid recipients' mental health care needs and include them in Medicaid redesign consideration and planning. Mental health benefits should be made available in every benefit package to be offered. If changes are implemented, policymakers should create a mechanism for tracking health outcomes to ensure benefit packages are providing necessary coverage.

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 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 is being phased in by age: those six or under in 2007; seven to 13 in 2008, 14 to 19 in 2009.

Families and advocates

The Family Opportunity Act creates new opportunities for families to buy into Medicaid, which allows families to receive alternatives to psychiatric residential treatment facilities. Because the Family Opportunity Act is optional, families and advocates should work to educate policymakers about the importance of these opportunities and encourage their State to take advantage. Families and advocates can point to experiences in States like New York, Kansas, Vermont and Indiana to illustrate the cost-effectiveness of providing home- and community-based care to children who would otherwise be place in psychiatric residential treatment facilities. In addition, families can share their experiences of trying to obtain or maintain Medicaid eligibility and the devastating effects custody relinquishment on families who cannot secure the services they need.

Policymakers

Policymakers should work with families and advocates to understand the benefits of adopting the Family Opportunity Act option. If the State selects this option, it must ensure effective outreach and education to families that might be eligible. As with cost-sharing provisions, families and advocates should educate the State about the possible impact of premiums and advocate for a sliding scale that will encourage families to use this option. This option provides States not only the opportunity to keep costs down but presents an opportunity to keep families together.

Home and Community-Based Care Provisions

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 were 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.
On December 19, 2006, CMS awarded 10 States grants to develop care delivery systems to help move children with mental illness 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.

Families

Families in States that have been awarded demonstration grants under this section should seek information on program details to see if they qualify for services under the grant. At the time this fact sheet was written, it was unclear if additional grant cycles would be offered. If additional grant cycles are offered, families should work to encourage policymakers in their State to consider applying for a grant.

Money Follows the Person (Section 6071)

Under Section 6071 of the DRA, Money Follows the Person (MFP) Rebalancing Demonstration grants have been 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 the mentally retarded. 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 those who prefer and are able to live in the community with the right supports.

This provision went into effect on January 1, 2007. 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.

Consumers

In States that have been awarded demonstration grants under this section, consumers should seek information on program details to see if they qualify for services under the grant. At the time this fact sheet was written, it was unclear if additional grant cycles would be offered. If additional grant cycles are offered, consumers should work to encourage policymakers in their State to consider applying for a grant.

Advocates and Providers

Advocates and providers should advocate for effective and timely plans to use the MFP Rebalancing Demonstration grant funds. Because the enhanced funds are only good for a year, advocates and providers must build capacity in their communities and ensure funds are used for that purpose.

Policymakers

Policymakers must reach out to consumers and family members, identifying people with mental illnesses in nursing homes and other institutional settings who want to live in the community and moving quickly to maximize their use of the enhanced match.

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 took effect on January 1, 2007.

Consumers, families, and advocates

Consumers, families, and advocates should urge policymakers in their State to take advantage of this opportunity to move adults and children out of institutions and back into their communities. Advocates should provide outreach and education to consumers and families.

Providers

Providers should educate policymakers and other stakeholders about the ability of adults and children with serious mental health problems to live in the community with the appropriate services. Providers must also build the capacity to serve people moving into community-based care.

Policymakers

Policymakers should assess the number of children and adults in their State who are unnecessarily institutionalized but for access to home- and community-based services. By weighing the potential cost savings and social benefits of this option, policymakers can make the best choice for those they serve.

WHAT MORE YOU CAN DO IN YOUR STATE

For consumers, families, providers, and advocates

Medicaid has always been complicated, and the DRA has made it even more difficult for many people to understand the program. It is important for consumers, families, providers, and advocates to work together in coalition to educate one another. Together, these stakeholders can collectively promote the use of the DRA to improve the lives of people with mental health problems in your State.

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For policymakers

Every State Medicaid plan is different, but all States can benefit from one or more of the DRA provisions to expand access to Medicaid and/or return adults and children from institutional settings to the community. Policymakers are encouraged to work with consumers and their families, providers, and advocates to learn what mental health services are currently being provided in your State and how these stakeholders believe they could be improved to better the lives of people with mental health problems. Seek out information on how provisions of the DRA could impact mental health care in your district or State from stakeholders and make decisions on which provisions your district or State should implement based on their input.

RESOURCES

For more information on the DRA, visit CMS' website:
http://www.cms.hhs.gov/DeficitReductionAct/01_Overview.asp#TopOfPage

For more information on the Citizenship Documentation Requirements for Medicaid Eligibility (Section 6036):
http://www.cms.hhs.gov/DeficitReductionAct/12_Citizenship.asp#TopOfPage

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) Resources:
http://www.cms.hhs.gov/DeficitReductionAct/20_PRTF.asp#TopOfPage
Money Follows the Person (Section 6071) Evaluation Report:
http://www.cms.hhs.gov/RealChoice/downloads/MFP.pdf

Money Follows the Person Resources
http://www.cms.hhs.gov/DeficitReductionAct/20_MFP.asp#TopOfPage
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] 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

[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

[iii] Tamblyn, R. et al., "Adverse Events Associated with Prescription Drug Cost-Sharing among Poor and Elderly Persons," Journal of the American Medical Association, 285(4):421-429, January 2001.

[iv] 42 USC §1396a(a)(43); 42 USC §1396d(r)