



Changes in the Medicaid Program: The Deficit Reduction Act (DRA) of 2005

April 2006

The Deficit Reduction Act (DRA) was signed into law in early February of 2006. The Act includes a number of key provisions that will result in significant changes to the Medicaid program including the following:

- There is a new requirement to verify citizenship for those accessing services. Certain populations such as tribal nations, Katrina survivors and others will have a difficult time meeting the new criteria.
- For those who apply for nursing home coverage under Medicaid, the “look-back period” for any transfer of assets has been lengthened from three to five years from the date of the application.

Optional Provisions for States

Under the DRA, states now have considerable latitude for making changes to their Medicaid programs. However, if they choose to use these new options, the DRA provides rules for how the changes must be made. This is particularly true in the area of cost-sharing and premiums. In addition, there are new programs states can choose to add to their existing Medicaid program.

New state authority to impose co-payments and premiums

- States can vary cost-sharing for different groups of beneficiaries. In addition, states can allow providers to refuse services to anyone who cannot afford to pay any required co-pay.
- Co-pays on drugs take effect March 31, 2006. Inappropriate ER visit co-pays begin January 1, 2007. States must amend their state plans to change these cost sharing requirements.

Other cost-sharing allowances

- The act provides no limits on co-pays for those below the poverty line. Prior to the DRA, “nominal cost-shares” were allowed. It is thought that the authors of this legislation meant to allow states to only increase the “nominal charge” based on medical inflation, but that is not specified and therefore states are left free to do as they wish. Another drafting error does not even protect lower income beneficiaries from spending more than

5% of their total family income on out-of-pocket health expenditures. This limit on out-of-pocket expenses applies to other populations that actually have higher incomes.

- For those between 100%-150% of the federal poverty level (FPL), the DRA allows states to impose a 10% or less co-pay on the cost of the each service used by a beneficiary. Beneficiaries that fall above 150% FPL can be charged premiums and co-pays up to 20% of the cost of each service. The only other limit imposed by DRA is that families above 100% of FPL may not be required to pay above 5% of a family's income over a three-month period of time.

Populations Protected from Premiums and Co-pays

States are not allowed to charge premiums to:

- Children in mandatory eligibility groups (these include children under 6 with incomes below 133% of the FPL or those 6 to 18 at 100% of the FPL);
- SSI recipients;
- Most children in foster care and adoption assistance programs;
- Pregnant women;
- Women being treated for breast or cervical cancer; and,
- Institutionalized beneficiaries.

States cannot allow providers to charge co-pays to:

- Children under 18 in mandatory coverage groups (see above);
- SSI recipients;
- Children in foster care and adoption assistance ;
- For all preventive services to children under 18 regardless of family income;
- Pregnancy related services;
- Family planning services;
- Emergency services;
- Institutionalized beneficiaries; and,
- Women who are being treated for breast or cervical cancer.

Co-payments for prescription drugs

- States can create categories of preferred and non-preferred drugs based primarily on the cost of the drugs.
- Beneficiaries with incomes below 150% of FPL (even those exempt from cost-sharing) can be charged “nominal” co-pays for non-preferred drugs.
- Beneficiaries with incomes above 150% of FPL can be charged up to 20% of the cost for non-preferred drugs.
- The existing “nominal” co-pay of \$3 can be increased to match inflation based on the Consumer Price Index.

Co-pays for non-emergency use of the emergency room

States can allow hospitals to charge beneficiaries for use of the ER for non-emergency room care. Hospitals will still be required to screen patients but they then may be able to require a co-pay before further treatment is continued. Again, there are no limits on out-of-pocket expenses set on those below 100% of FPL. Those with incomes between 100%-150% FPL can be charged up to twice the “nominal” co-pay required for other services. This applies to those who are exempted from other cost-sharing requirements.

Scaled-back benefit packages for some groups of beneficiaries

States are allowed to amend their state plans to establish new Medicaid benefit packages modeled on commercial plans for certain beneficiary groups. This model can be applied to all children regardless of income except those eligible for Medicaid because of foster care or adoption assistance and those who are blind or disabled.

EPSDT

States are still required to provide EPSDT services as a wrap-around regardless of new benchmark plans, but the plans may not be responsible for these wrap-around services. Rather, state Medicaid programs would be required to cover those additional services.

These benchmark plans may apply to working parents and pregnant women above 133% of FPL. Effective date is March 31, 2006.

New Programs and Demonstrations

Demonstration grants for up to 10 states to provide Health Opportunity Accounts

States under this demonstration can require Medicaid beneficiaries to meet a deductible before receiving regular Medicaid benefits. Beneficiaries may be responsible for up to 10% of the size of the deductible and higher co-pays as result of these demonstrations. Seniors and people with disabilities are exempt from these demonstrations.

Money Follows the Person

States can apply for demonstration money that allows them to expand their home and community-based services structure. The state match normally required for HCBS waiver applicants can be applied by the state to expand HCBS services when an applicant is being de-institutionalized. These must be new services in a new area and cannot be applied to those currently being served under an HCBS waiver. The demonstration runs for five years, but the state match allowance is only available for the first year.

Family Opportunity Act Medicaid Buy-In

States have the options to adopt a Medicaid buy-in program for families of children with severe disabilities up to 300% of FPL.

Families will be required to continue their health insurance coverage under this buy-in and the premium required cannot exceed 7.5% of the families' adjusted gross income. However, there are no restrictions placed on the list of out-of-pocket costs incurred by the family that may be applied to the family's responsibility toward this premium. The limit of 5% of a families' premium does apply to this population. Thus, while the 7.5% was included, the limit on family obligation is only 5%. This Medicaid buy-in is for those who are underinsured. Those who are uninsured would still need to apply for the SCHIP program.

HCBS waivers for children with severe psychiatric disorders

Included in the FOA are new demonstration waivers that states must apply for to grant children with severe psychiatric disorders the possibility to be served outside of Psychiatric Medical Institutions for Children and in their homes and communities.

Restoration of SSI benefits to certain previously eligible families of children and youth with special health care needs

There is a new provision passed as part of the Family Opportunity Act that provides for a restoration of benefits to families previously eligible for SSI who were subsequently dropped from SSI due to slight increases in family income.

Family-to-Family Health Information Centers (F2FHICs)

Each state will be eligible to apply for a F2FHIC through a family-run, statewide organization. These F2Fs will provide information and guidance on making good choices for their children with special health care needs. They will be responsible for monitoring the state system of services, identifying gaps in the health service and financing systems and working with state agencies to improve health care access for all children. F2Fs will be part of a national system that can do the following: a) provide input into policymaking decisions for children with special health care needs and their families by collecting data from the families they serve; b) identify needs of families of children with special needs that exist in states and regions; c) provide input based on their expertise and knowledge of programs and service systems regarding existing gaps in systems and how proposed changes to both the public and private health care financing systems will impact families and children.

Here is the actual language in the DRA about the F2FHICs:

SEC. 6064. DEVELOPMENT AND SUPPORT OF FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS.

Section 501 of the Social Security Act (42 U.S.C. 701) is amended by adding at the end the following new subsection:

“(c)(1)(A) For the purpose of enabling the Secretary (through grants, contracts, or otherwise) to provide for special projects of regional and national significance for the development and support of family-to-family health information centers described in paragraph (2), there is appropriated

to the Secretary, out of any money in the Treasury not otherwise appropriated--

- ` (i) \$3,000,000 for fiscal year 2007;
 - ` (ii) \$4,000,000 for fiscal year 2008; and
 - ` (iii) \$5,000,000 for fiscal year 2009.
- ` (B) Funds appropriated or authorized to be appropriated under subparagraph (A) shall--
- ` (i) be in addition to amounts appropriated under subsection (a) and retained under section 502(a)(1) for the purpose of carrying out activities described in subsection (a)(2); and
 - ` (ii) remain available until expended.
- ` (2) The family-to-family health information centers described in this paragraph are centers that--
- ` (A) assist families of children with disabilities or special health care needs to make informed choices about health care in order to promote good treatment decisions, cost-effectiveness, and improved health outcomes for such children;
 - ` (B) provide information regarding the health care needs of, and resources available for, such children;
 - ` (C) identify successful health delivery models for such children;
 - ` (D) develop with representatives of health care providers, managed care organizations, health care purchasers, and appropriate State agencies, a model for collaboration between families of such children and health professionals;
 - ` (E) provide training and guidance regarding caring for such children;
 - ` (F) conduct outreach activities to the families of such children, health professionals, schools, and other appropriate entities and individuals; and
 - ` (G) are staffed--
 - ` (i) by such families who have expertise in Federal and State public and private health care systems; and
 - ` (ii) by health professionals.
- ` (3) The Secretary shall develop family-to-family health information centers described in paragraph (2) in accordance with the following:
- ` (A) With respect to fiscal year 2007, such centers shall be developed in not less than 25 States.
 - ` (B) With respect to fiscal year 2008, such centers shall be developed in not less than 40 States.
 - ` (C) With respect to fiscal year 2009 and each fiscal year thereafter, such centers shall be developed in all States.
- ` (4) The provisions of this title that are applicable to the funds made available to the Secretary under section 502(a)(1) apply in the same manner to funds made available to the Secretary under paragraph (1)(A).
- ` (5) For purposes of this subsection, the term `State' means each of the 50 States and the District of Columbia.'.

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