

Deficit Reduction Act

Excerpts from
An Overview of Key Medicaid Provisions of the Deficit Reduction Act of 2005

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Plus

**Additional Provisions of the Deficit Reduction Act of 2005 Identified by NACHC
for Potential Impact on Health Centers**

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INTRODUCTION

On February 8, 2006, President Bush signed the Deficit Reduction Act of 2005 (DRA) into law.¹ The most significant set of changes to Medicaid since its 1965 enactment, the DRA refashions some of the program's most basic rules in ways that have long term implications for beneficiaries, health care providers, and states. This overview focuses on four provisions contained in the legislation: proof of citizenship; flexibility to redefine the meaning of "medical assistance" for certain populations and the relationship of this flexibility to the special coverage rules applicable to children; cost-sharing and premium flexibility; and changes to the rules under which federal financial participation is available for targeted case management services, a feature of the program used heavily by states to manage high-need and complex care beneficiaries who are served by and across multiple public health and health-related programs. A future separate analysis will focus principally on changes affecting persons in need of long term institutional and community-based services.

In brief, the Act imposes new citizenship verification restrictions on applicants and beneficiaries, gives states new flexibility to impose premium and cost sharing requirements, and accords states important new flexibility, in the case of certain beneficiary populations, in particular children, to revise the structure of "medical assistance," the legal term of art that defines the covered benefits and services to which Medicaid-enrolled persons are entitled. States that opt to use this new coverage flexibility must adhere to certain minimum standards, including continuation of EPSDT services. At the same time, the flexibility created by the law marks a new chapter in the life of Medicaid, permitting states to begin to align program coverage principles for certain beneficiaries more closely with the concept of "premium support," which has been a dominant feature of national health policy reform proposals since the early 1990s.

This Issue Brief begins with a brief overview of Medicaid coverage principles prior to enactment of the DRA. It then describes the policy landscape surrounding the legislation's passage, an important consideration given the Act's relatively limited legislative history, the speed with which passage occurred, and a number of ambiguities that appear in the legislative text. The Brief then summarizes the key elements of the legislation through a series of tables summarizing changes in eligibility, medical assistance coverage, premiums and cost sharing, and federal financial support for targeted case management.

¹ P.L. 109-362.

As with any major health insurance legislation, the text of the DRA is dense and contains a number of important textual ambiguities that remain unclarified by the law's legislative history. In some cases, these legislative ambiguities appear to be the result of a deliberate policy choice on the part of Congress to move the program in certain basic directions, while simultaneously giving the Secretary of the United States Department of Health and Human Services considerable latitude to interpret and implement the law. In other cases, the ambiguities appear to be a product of the vagaries of legislative drafting, a not-uncommon event when, as here, a major legislative enactment occurs within a compressed time frame. The task of clarifying the DRA is expected to continue for some time; as a result, the analysis offered in this Issue Brief should be considered preliminary.

OVERVIEW OF PRE-DRA MEDICAID STANDARDS

It is important to briefly review pre-DRA Medicaid policy in the areas of eligibility, benefits and coverage, premiums and cost sharing, and case management in order to understand the reforms.

Eligibility

Medicaid eligibility is a complex combination of factors related to financial eligibility, coverage categories describing certain defined populations (e.g., children, parents and caretaker relatives, pregnant women, elderly persons, and persons with disabilities), state residence, U.S. citizenship or legal status, and other matters.² Certain populations are considered “categorically needy” because they fall into certain classification categories and meet certain financial rules described in the statute. Categorically needy persons can be both mandatory and optional. For example, children under age 6 with countable family incomes at or below 133% of the federal poverty level are classified as mandatory categorically needy, while children with countable family incomes above this standard are considered optional categorically needy. Ninety-four (94) percent of all Medicaid children fall into a categorically needy eligibility grouping.³

² Andy Schneider et. al., 2003. *The Medicaid Resource Book* (Kaiser Commission on Medicaid and the Uninsured, Washington D.C.) Available at <http://www.kff.org/medicaid/2236-index.cfm> (Accessed February 18, 2006).

³ Sommers A, Ghosh A, & Rousseau D. Medicaid Enrollment and Spending by “Mandatory” and “Optional” Eligibility and Benefit Categories. KFF. June 2005.

Proof of Citizenship. Medicaid law requires citizenship or legal status of a minimum duration for all but emergency care.⁴ Prior to the DRA, federal law required no written proof of citizenship at the time of application or redetermination, although legal residents were required to submit written proof of legal status.⁵ Citizenship was dealt with on the basis of oral affirmation.

Disabled Children in Families with Low to Moderate Income. Medicaid law mandates Medicaid coverage of all children who receive Supplemental Security Income (SSI). In addition, with the exception of those states that use eligibility standards for children and adults with disability that differ from SSI, as well as states that use separate enrollment procedures) coverage is automatically conferred on any child found eligible for SSI by the Social Security Administration.

In the case of children with disabilities whose family incomes and assets exceed levels permitted under a state Medicaid plan, federal law accorded states several options, including coverage as medically needy “spend-down” beneficiaries, coverage of certain institutionalized children as well as children at risk of institutionalization,⁶ and the use of certain financial flexibility options to adjust family income in the case of children with disabilities whose families incur higher than normal medical costs.⁷

Benefits and Coverage Rules

Prior to the DRA, a detailed series of standards governed Medicaid coverage principles. These standards defined not only the *classes* of benefits and services that either must or could be covered, but also the *amount, duration, and scope* of coverage within each covered benefit and service class. Some of these rules of coverage applied to both “categorically needy”⁸ and “medically needy” beneficiaries,⁹ while others applied only to categorically needy persons.¹⁰

⁴ Undocumented persons and recent legal residents are eligible for emergency coverage only.

⁵ Leighton Ku. 2006. *Survey Indicates Budget Reconciliation Bill Jeopardizes Medicaid Coverage for 3 to 5 Million U.S. Citizens* (CBPP, Washington D.C.) Available at <http://www.cbpp.org/1-26-06health.pdf> (Accessed February 12, 2006)

⁶ 42 U.S.C. §1396a(e)

⁷ Section 1902(r)(2) grants states flexibility to recognize income deductions and disregards that extend beyond those normally applicable under federal cash welfare programs.

⁸ The principal categorically needy eligibility groups involving children are as follows: (1) children who meet welfare requirements in effect in the state at the time of TANF’s effective date; (2) poverty level children under age 18 who meet applicable financial tests (incomes or below 133% FPL in the case of children under 6 and 100% of poverty for children ages 6-18); (3) children receiving SSI

Benefit Classes. In the case of categorically needy persons, Medicaid covers a set of required and optional benefit and service classes. **(Figure 1)** These coverage classifications have been expanded many times over Medicaid’s 40-year existence and result in a Medicaid coverage structure that can best be defined as a “defined benefit” entitlement. That is, persons enrolled in the program are entitled to coverage for certain classes of benefits that are defined with relative precision (e.g., inpatient hospital care, family planning services, and supplies, outpatient hospital care, federally qualified health center services, and the like).

Figure 1. Medicaid Benefits

<u>“Mandatory” Benefits</u>	<u>“Optional” Benefits</u>
<ul style="list-style-type: none"> • Physician services • Hospital services • Rural and federally-qualified health center services • Family planning • Certified pediatric and family nurse practitioners • Nurse mid-wives • Laboratory and x-ray services • Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under 21 • Pregnancy-related services • Medical and surgical services by a dentist • Nursing facility services for individuals 21 or over 	<ul style="list-style-type: none"> • Prescription drugs • Home health care • PT/ST/OT • Dental services & dentures • Optometrist & eyeglasses • Other prosthetic devices • Mental health services • Intermediate care facility for mental retardation • Nursing facility for < age 21 • Private duty nursing • Personal care services • Case management, including targeted case management and primary care case management • Hospice care • Medical transportation

Source: CMS, Medicaid at-a-glance: 2005.

Amount, Duration, and Scope, and Concepts of Reasonableness in Coverage. The “amount, duration and scope” principles that govern the program date back to the law’s 1965 enactment. These principles were designed to ensure that coverage would be reasonable and

benefits; (4) children receiving federally assisted adoption or foster care assistance under Title IV of the Social Security Act; (5) children in families receiving transitional medical assistance because they return to work and increase their earnings and as a result lose their cash assistance, or because their Social Security benefits increase; and (6) certain institutionalized children.

⁹ In general, medically needy beneficiaries “spend down” to Medicaid eligibility levels, although there are limited spend-down provisions applicable to categorically needy persons at risk for institutional care. 42 U.S.C. §1396a(a)(10)(A) and (C)

¹⁰ Only 6% of all Medicaid children are medically needy. Rules applicable to medically needy beneficiaries are not reviewed here. See Sommers *et al.*, above.

adequate, comparable among sub-populations, non-discriminatory in terms of the types of conditions covered, and available on a statewide basis.¹¹

This combination of Medicaid's extensive classes of covered benefits and the amount, duration and scope rules, along with the program's rules that permit enrollment during times of great medical need,¹² set the program apart from commercial insurance. The commercial insurance market is governed by principles aimed at avoiding risk (for example, limiting enrollment to certain enrollment periods in order to avoid entry "at the point of service") as well as by concepts of "moral hazard" and "fair discrimination" that together result in coverage and benefit design that excludes many types of chronic and high cost conditions. These concepts also allow insurers to vary coverage by both condition and by population sub-group, in order to reflect perceived differences in actuarial risk and anticipated rates health care utilization.¹³ Because Medicaid is a program that rests on principles of social insurance rather than actuarial risk, its historic structure is that of a financing entitlement rather than a risk insurer. Indeed, the hallmark of Medicaid is coverage of populations, services, and benefits that lie well outside actuarial coverage norms.¹⁴

Medicaid's amount, duration and scope rules reflect this tradition. Under pre-DRA of amount, duration and scope principles, Medicaid coverage of categorically needy persons was governed by concepts of reasonableness, statewideness, comparability, and non-discrimination. These concepts have been extensively interpreted over the years in both federal regulations as well as through judicial policy. These concepts can be summarized as follows:

- Statewideness: Medical assistance had to be available on a statewide basis;¹⁵ that is, medical assistance could not be in effect in one part of the state and not in another.
- Comparability: Medical assistance had to be comparable in "amount, duration and scope" among categorically needy groups.¹⁶ Under this rule of "comparability," states could not vary the range of benefits for sub-groups of categorically needy persons. For example, a state could not provide psychiatric coverage only to disabled adult enrollees

¹¹ The *Handbook of Public Administration, Supplement D*, a 1966 HEW-issued document interpreting the 1965 legislation, contains an extensive discussion of Medicaid's original coverage standards. The interpretation of coverage rules found in *Supplement D* was codified as original program regulations.

¹² Sara Rosenbaum, 2002. "Health Policy Report: Medicaid" *NEJM* 346: 8, p. 635-640

¹³ Rand Rosenblatt, Sylvia Law and Sara Rosenbaum, 1997. *Law and the American Health Care System* (Foundation Press, NY)

¹⁴ "Health Policy Report: Medicaid," *op. cit.*

¹⁵ 42 U.S.C. §1396a(a)(3)

¹⁶ 42 U.S.C. §1396a(a)(10)

and not to children. (Of course, because Medicaid, like health insurance, covers only medically necessary care, an adult with a serious mental disability would make extensive use of his or her psychiatric coverage, while a caretaker relative might use few or no mental health services in any year).

- Reasonableness: Coverage levels for any benefit or service – required or optional – had to be reasonable.¹⁷ This reasonableness test has been subject to longstanding agency interpretation requiring that coverage be “sufficient in amount, duration and scope to reasonably achieve its purpose.”¹⁸ In applying this rule to specific cases, judicial policy has further refined the standard. For example, one court has held that a state cannot limit physician visits to three visits per month unless it also provided an emergency exception.¹⁹
- Non-discrimination: States could not “arbitrarily discriminate” on the basis of a patient’s condition in the provision of required benefits and were instead limited to reasonable standards linked to medical necessity.²⁰ On the other hand, condition-based discrimination is common in commercial insurance, which frequently varies coverage levels based on specific diagnoses. Examples of this type of condition-based coverage distinction within the private health insurance market can be found in the areas of mental illness,²¹ coverage for HIV/AIDS treatment,²² and rehabilitative therapies for children with developmental disabilities²³ and adults with chronic and degenerative diseases,²⁴ who are judged to be incapable of making a recovery, even if the treatment prevents further deterioration or maintains or improves functioning.
- Medical necessity: States were required to ensure that both across-the-board coverage limits as well as coverage decision-making standards in individual cases would be governed by concepts of medical necessity. While the definition of medical necessity was left to states, it was understood that, as with other coverage rules, the definition of what is necessary would have to be consistent with the purpose of the benefit, reasonable, comparable, and non-discriminatory.²⁵

¹⁷ 42 U.S.C. §1396a(a)(17)

¹⁸ Handbook of Public Administration, Supp. D; 42 C.F.R. §440.230

¹⁹ Curtis v Taylor 648 F. 2d 946 (5th Cir., 1980)

²⁰ Beal v Doe 432 U.S. 438 (1977)

²¹ The Mental Health Parity Act, P.L. 107-147, is designed to alleviate at least some forms of discriminatory coverage in the case of persons with mental illness.

²² Doe v Mutual of Omaha 179 F. 3d 557 (7th Cir., 1999); cert. den. 528 U.S. 1106

²³ Bedrick v Travelers Health Insurance 93 F. 3d 149 (4th Cir., 1996)

²⁴ McGraw v Prudential Ins. Co. 137 F. 3d 1253 (10th Cir., 1998)

²⁵ Beal v Doe, *supra*

EPSDT and Standards of Reasonableness. Since 1967 states have been required to furnish children with early and periodic screening diagnostic and treatment (EPSDT) services for individuals under age 21.²⁶ EPSDT's history underscore's Congress's intent to go beyond the already strong Medicaid coverage standards for adults that were enacted in 1965, in order to ensure even broader and deeper coverage for children and adolescents, guided by principles of prevention, growth, and development.²⁷

EPSDT's broad preventive purposes grew out of a strong evidentiary base: the results of evaluations of the health status of young children enrolled in early Head Start demonstrations;²⁸ and a pre-Medicaid study of rejection rates of young military draftees, who were found to suffer extensively from chronic conditions and disabilities that might have been either prevented or ameliorated in early childhood.²⁹ Since its inception, EPSDT has provided for comprehensive health exams aimed at identifying physical or mental health conditions, vision, dental and hearing care, and provision of treatment needed to correct or ameliorate physical and mental health conditions. In 1989 the treatment rules were amended to require all medically necessary treatments (consistent with the program's preventive purpose) that fall within *any* covered service or benefit class, even if the service class is optional for persons ages 21 and older (e.g., speech and physical therapy, medical equipment).³⁰

Figure 2 sets forth the scope of the EPSDT coverage requirements, which encompass a wide range of preventive health services as well as coverage of all medically necessary services and treatments falling within any of Medicaid's service and benefit classifications. And because federal EPSDT guidelines as well as extensive judicial rulings have concluded that EPSDT's purpose is fundamentally preventive in nature, the program effectively is governed by a medical necessity test that, unlike the medical necessity standard for adults,

²⁶ Rosenbaum S, Markus AR, and Sonosky C (2004). "Public Health Insurance Design for Children: The Evolution from Medicaid to SCHIP." *Suffolk Journal of Health & Biomedical Law*, 1 (2004): 1-47

²⁷ Rosenbaum S, Mauery DR, Shin P, and Hidalgo J. (2005) *National Security and U.S. Child Health Policy: The Origins and Continuing Role of Medicaid and EPSDT* Washington, DC: The George Washington University School of Public Health and Health Services, Department of Health Policy, Washington D.C.

http://www.gwumc.edu/sphhs/healthpolicy/new_publications.html

²⁸ Children's Defense Fund, 1977. *EPSDT: Does it Spell Health Care for Poor Children* (Washington D.C.)

²⁹ Rosenbaum, Mauery *et al*, *op.cit*.

³⁰ Rosenbaum, Markus and Sonosky, *op.cit*.

require coverage of preventive and developmental treatments, not merely treatments that restore “normal” functioning following illness or injury.³¹

Figure 2. Core EPSDT Elements

- **Benefits and services:**
 - Periodic and “as needed” screening services
 - Vision, hearing, and dental care
 - All medically necessary “medical assistance,” diagnosis and treatment needed to “ameliorate” conditions, including covered treatments identified in IEPs and IFSPs under the IDEA and child welfare case plans
 - A “preventive” standard of medical necessity
- **Administrative services:**
 - Informing families
 - Transportation, scheduling and other assistance
 - Linkages to other agencies (special education, Title V, WIC, child welfare, other agencies)
 - Reporting

Premiums and Cost Sharing

Pre DRA, premium and cost sharing flexibility in Medicaid was constrained. The law prohibited any form of cost sharing in the case of children under 18, family planning services and supplies, pregnant women, institutional residents and hospice recipients.³² For adults, cost sharing was permissible if nominal, although copayments of twice the nominal amount could be imposed in the case of certain demonstrations involving efforts to curb unnecessary hospital outpatient department service utilization.³³ Prior Medicaid law permitted the use of premiums and enrollment fees under very limited circumstances.³⁴

Targeted Case Management

Since 1986 federal Medicaid law has recognized case management services both as an administrative activity aimed at managing service utilization and as a form of medical assistance. The statute defines medical assistance case management as services that “assist

³¹ Rosenbaum, Mauery et al., op. cit.; Rosie D v Romney (January 26, 2005)
<http://www.masslegalservices.org/docs/RosieD.pdf>

³² Section 1916 of the Social Security Act

³³ Id.

³⁴ Id.

individuals eligible under the plan in gaining access to needed medical, social, educational, and other services.”³⁵ Many public programs that fund health related services for children and adults with special needs, such as child welfare programs, school health clinical programs, special education programs, and programs for children with special health care needs administered by Title V agencies, provide case management services. Public clinics and agencies, and private institutions and health professionals participating in both Medicaid and these special needs programs typically have billed Medicaid for case management services, both administrative and medical assistance. Case management is also a basic service offered by the nation’s health centers, 40 percent of whose patients are children, and whose participation in Medicaid is required in order to conserve grant funds to subsidize care for uninsured persons.

THE POLICY LANDSCAPE FOR MEDICAID REFORM

For many years, state officials have raised concerns about Medicaid’s broad coverage standards, not only with respect to the classes of required benefits but equally as importantly, with respect to the program’s amount, duration and scope standards and tests of reasonableness. Beginning with the Clinton Administration’s approval of Oregon’s §1115 health care rationing demonstration program in 1993,³⁶ HHS began to permit changes in Medicaid’s historic coverage standards for both demonstration and traditional beneficiary populations; changes have been particularly notable in the case of demonstration populations, whose coverage increasingly reflects private insurance norms rather than the rules that govern Medicaid.³⁷ As states’ use of Medicaid managed care arrangements grew, the pressure to move toward coverage standards viewed as more compatible with commercial insurance principles also grew, particularly since, given Medicaid’s entitlement nature, states remained legally obligated to adhere to Medicaid coverage standards and principles, even if

³⁵ 42 U.S.C. §1396a(a)(19)

³⁶ Rosenbaum S (1993) “Mothers and Children Last: The Oregon Cost Sharing Experiment” *Am. J. Law and Medicine*

³⁷ Alker J. (2005) *Premium Assistance Programs: How Are They Financed and Do States Save Money?* Washington, DC: Kaiser Family Foundation, <http://www.kff.org/medicaid/upload/Premium-Assistance-Programs-How-are-they-Financed-and-do-States-Save-Money-Issue-Brief.pdf>; Artiga S and Mann C (2005) *New Directions for Medicaid Section 1115 Waivers: Policy Implications of Recent Waiver Activity* Washington, DC: Kaiser Family Foundation, <http://www.kff.org/medicaid/upload/New-Directions-for-Medicaid-Section-1115-Waivers-Policy-Implications-of-Recent-Waiver-Activity-Policy-Brief.pdf>

their contracts with managed care entities were limited to the scope of benefits found in a more standard insurance policy.³⁸

The SCHIP program, enacted in 1997, represented the first federal legislative attempt to more closely align public health insurance coverage standards for low income children with private health insurance principles. SCHIP is not a legal entitlement for children; furthermore, SCHIP coverage rules are expressed as an insurance premium “benchmark” bounded by actuarial value rather than by defined benefits. Although SCHIP permits coverage of services and benefits that are virtually as broad as those found in Medicaid, its minimum coverage requirements are quite limited; coverage standards are expressed as broad categories rather than defined benefits. Furthermore, coverage adequacy is tied to the value of a premium rather than to specific coverage rules. In this regard, SCHIP moved public financing for low income families closer to the concept of “premium support,” under which a group health insurance sponsor offers competing insurers a defined contribution toward the cost of enrollee coverage, with the concept of coverage itself broadly defined.³⁹

The theoretical underpinnings of premium support date back to the writings of Alain Enthoven,⁴⁰ and the concept has been a prominent one in federal health policy since the early 1990's. The theoretical basis of premium support is that the use of a defined contribution approach to the cost of health care, coupled with broadly delegated powers to insurers to hold down costs, will foster competition among insurers while holding down spending. Although the fixed contribution tends to receive more attention than the delegation of benefit design powers, premium support in fact turns on both principles. Key to the premium support model is not only the use of a “defined contribution” toward enrollee premium costs, but also, considerable delegation of powers from sponsor to insurers to “fill in” the specifics of benefit design, within a very broadly defined coverage outline set out by the sponsor. As a result, in a premium support environment, insurers gain power to cut benefits and thus potentially slow the growth of sponsors' premium costs, not merely through the introduction of purchasing efficiencies, but also by shrinking what they will cover and pay for in the event that funding falls short.

³⁸ Wadley v Daniels, 1997 DRA Medicaid managed care rules

³⁹ See, e.g., Moon M. (1999) *Restructuring Medicare: Impact on Beneficiaries*. New York, NY: The Commonwealth Fund; Moon M. (2000) *Competition with Constraints: Challenges Facing Medicare Reform*. Washington, DC: The Urban Institute

⁴⁰ See, e.g., Enthoven A (1993) “The History and Principles of Managed Competition.” *Health Affairs* 12 Suppl: 24-48; Enthoven A and Kronick R (1989) “A Consumer-Choice Health Plan for the 1990s. Universal Health Insurance in a System Designed to Promote Quality and Economy.” *N Engl J Med* 320(1):29-37; Enthoven A (1988) “Managed Competition: An Agenda for Action.” *Health Affairs* Summer; 7(3):25-47

The SCHIP statute parallels premium support concepts because the law requires only that states administering separate SCHIP programs offer coverage possessing a minimum actuarial value. Very few classes of services are enumerated, and the legislation eliminates all of the underlying tests of coverage reasonableness and non-discrimination that are the hallmark of Medicaid coverage requirements. Thus, for example, SCHIP requires coverage of “well baby” care, not detailed screening requirements. SCHIP requires “physician” services and “hospital” services but contains no minimum standards governing how much care or the medical necessity standards by which the adequacy of care is to be measured. In other words, because SCHIP contains no EPSDT coverage mandate, the statute eliminates EPSDT’s rules of coverage and medical necessity requirements. Although some states with separately administered SCHIP programs have elected to maintain an EPSDT coverage standard, many others have not. Research indicates that numerous state SCHIP plans offer a narrower benefit range and use a narrower definition of medical necessity.⁴¹

By 2005, state pressures for expanded Medicaid coverage flexibility and higher cost sharing responsibilities for beneficiaries had grown; although 30 percent of Medicaid expenditures are attributable to optional benefits,⁴² and the top 10 percent of Medicaid enrollees who are high cost patients with serious disabilities or in poor health account for 72 percent of all Medicaid expenditures,⁴³ intense state interest in “flexible benefit design” and higher cost sharing coincided with a broader interest on the part of the Administration and Congressional leadership in reducing the extent of public and private insurance coverage by limiting benefits and increasing direct patient responsibility for financing health care. (This interest can be seen in the President’s FY 2007 budget proposal to expand the use of Health Savings Accounts coupled with high deductible health plans).⁴⁴ Indeed, the Medicare Part D prescription drug program offers such a model, entitling Medicare beneficiaries to premium subsidization rather than a defined set of pharmaceutical benefits, with control over the details coverage design delegated to Part D plans operating under broad standards.

In the case of the citizenship and targeted case management reforms included in the DRA, both provisions also reflect a broader policy context. The 109th Congress has witnessed an ever-more-intense focus on curbing what some policy makers consider to be a

⁴¹ Rosenbaum, Markus and Sonosky, *op.cit.*

⁴² Sommers *et al.*, *op.cit.*

⁴³ Schneider A, Lambrew J, and Shanouda Y (2005) *Medicaid Cost-Containment: The Reality of High-Cost Cases*. Washington, DC: Center for American Progress

⁴⁴ Office of Management and Budget (2007) *Budget of the United States Government Fiscal Year 2007* Washington, DC, <http://www.whitehouse.gov/omb/budget/fy2007/>

serious problem of service use by individuals who are not citizens. With respect to case management, a series of investigations undertaken in recent years by Congress as well as both the Clinton and Bush Administrations suggested several problems:⁴⁵ (i) the use of Medicaid case management funds to pay for public activities falling outside of the service definition for case management; (ii) the use of Medicaid funds to pay for case management services furnished to ineligible children and adults; and (iii) and failure on the part of a number of public agencies to adhere to Medicaid claims payment and administrative cost rules and documentation requirements.

In addition, the coverage expansion option for low and moderate income children with severe disabilities, known as the Family Opportunity Act, was the result of ongoing concerns on the part of a number of lawmakers over the serious health care barriers faced by low and moderate income families whose children experienced high health care costs.

KEY PROVISIONS OF THE DEFICIT REDUCTION ACT IN A CHILD DEVELOPMENT CONTEXT

Tables 1 through 7 set forth the key elements of the Act pertaining to changes in law relating to eligibility, benefits, premiums and cost-sharing, and targeted case management. **Figure 3** summarizes the cost estimates prepared by the Congressional Budget Office (CBO) for each set of reforms. CBO projects that the reductions in Medicaid spending will yield \$4.8 billion in net savings over the 2006-2010 time period.⁴⁶

⁴⁵ Office of Inspector General (2005) *Audit Review of the Oklahoma Department of Human Service's Medicaid Administrative Costs* (A-06-03-00046) Washington, DC: Department of Health and Human Services; Government Accountability Office (2005) *Medicaid Financing: States' Use of Contingency-Fee to Maximize Federal Reimbursement Highlights Need for Improved Federal Oversight* (GAO-06-748) Washington, DC; Government Accountability Office (2005)

⁴⁶ Congressional Budget Office. Cost Estimate-S.1932 Budget Deficit Reduction Act of 2005. January 27, 2005. Available at <http://www.cbo.gov/ftpdocs/70xx/doc7028/s1932conf.pdf>

Figure 3. Net Costs and Savings from Medicaid Changes in DRA 2005 (millions)

	2006	2006-2010
<u>Savings</u>		
Evidence of citizenship	-5	-220
Alternative benefit packages	-30	-1,250
Increase premiums & cost-sharing	-10	-960
Additional cost-sharing for drugs	-20	-960
Targeted case management	-30	-760
<u>Costs</u>		
Coverage of certain disabled children	0	1,380
Cost-sharing non-emergency care provisions	5	10

Source: CBO, Cost Estimate--S. 1932 Deficit Reduction Act of 2005, January 27, 2005.

1. Verification of Citizenship

The DRA modifies current law by requiring individuals seeking Medicaid coverage to furnish written proof of citizenship. This modification is expected to have a significant effect on enrollment, because of the practical and financial difficulties families will face in obtaining necessary documentation, including birth certificates in the case of children. Effective the financial quarters beginning July 1, 2006, all federal financial participation in Medicaid will be ended for individuals whose eligibility determinations and redeterminations do not include written proof of citizenship (**Table 1**).⁴⁷

⁴⁷ Sec. 6036 of the Deficit Reduction Act of 2005, which amends Sec. 1903 of the Social Security Act; 42 U.S.C. 1396(b)(i)

**Table 1. Eligibility: Documentation of Citizenship
(Effective July 1, 2006)**

	Pre-DRA	DEFICIT REDUCTION ACT
U.S. Citizens	No written proof of citizenship at time of application (i.e., oral affirmation of citizenship status sufficient)	Written proof of citizenship at application or redetermination (i.e., no self-declaration of citizenship): (1) U.S. passport, certificate of naturalization, certificate of U.S. citizenship, valid driver’s license, or other ID document deemed valid, or (2) birth certificate or other ID document deemed appropriate Certain groups exempt (SSI recipients, dual enrollees) as a result of alternative verification pathways through the Social Security Administration
Legal Residents	Written proof of legal status for legal residents at time of application	No change

Source: GW Analysis of Deficit Reduction Act of 2005, February 2006.

2. Coverage of Low and Moderate Income Children with Disabilities

Effective January 1, 2007, states will have an explicit option to extend Medicaid coverage under certain circumstances to low and moderate children with disabilities who are under age 19, whose families meet the financial eligibility standards of the Act.⁴⁸ **Table 2** provides the minimum statutory requirements for this new expansion option.

⁴⁸ Sec. 6061 of the Deficit Reduction Act of 2005

Table 2. Family Opportunity Act: Eligibility Expansion Options for Children with Disabilities (Effective July 1, 2007)

	Pre-DRA	DEFICIT REDUCTION ACT
Disabled Children with Low and Moderate Family Incomes	Coverage options for children with low and moderate incomes exceeding SSI payment levels included special rules for children in need of institutional care, medically needy coverage, and the use of general program flexibility to vary financial eligibility rules in order to recognize extraordinary costs associated with children with disabilities.	<p>New and explicit option targeted on children with family incomes up to 300% FPL, with federal financial participation phased in by age of children</p> <p><i>Age:</i> Under age 19; state option to phase in coverage beginning with children born on or after January 1, 2001.</p> <p><i>Family income:</i> Up to 300% FPL (federal assistance only)</p> <p><i>Income-related premiums:</i> At state option, 5% cap <200% FPL, 7.5% cap 200-300% FPL; state’s right to terminate coverage for failure to pay >60 days and waive payment if “undue hardship”</p> <p><i>Employer-sponsored family coverage:</i> Must enroll if eligible and if 50% of premium paid by employer. State must pay remainder of premium and treat employer coverage as TPL.</p>

Source: GW Analysis of Deficit Reduction Act of 2005, February 2006.

3. “Benchmark” Coverage

Section 6044 of the DRA adds a new Sec. 1937 to the Medicaid law, which permits states to revise and restructure the medical assistance as a state plan option and without special waivers. This section is complex and applies only to certain population groups, including all categorically needy children. States that elect this option must meet certain minimum standards, including the provision of EPSDT benefits. Section 1937 becomes effective March 31, 2006.

Section 1937(a), which sets forth the state option, provides as follows:

“Sec. 1937. (a) STATE OPTION OF PROVIDING BENCHMARK BENEFITS.—

(1) AUTHORITY.—

(A) IN GENERAL.— *Notwithstanding any other provision of this title* [emphasis added], a State, at its option as a State plan amendment, may provide for medical assistance under this title to individuals specified by the State through enrollment in coverage that provides—

- (i) benchmark coverage ... or benchmark equivalent coverage ...; and
- (ii) for any child under 19 years of age who is covered under the State plan ..., wrap-around benefits to the benchmark coverage or benchmark equivalent coverage consisting of early and periodic screening, diagnostic, and treatment services defined in section 1905(r)”⁴⁹

The language of the amendment is not clear (the use of the term “may provide” leaves open the possibility that the terms of benchmark coverage are themselves optional, and the sweeping introductory language, “Notwithstanding any other provision of this title” raises many questions about the amendment’s full impact). But the legislative history, the CBO cost estimates, a letter to Members of Congress from Dr. Mark McClellan (CMS Administrator) and a Congressional Record Statement from Congressman Joe Barton, Chair of the House Commerce Committee, all suggest important flexibility limitations where application of the benchmark standard to children is concerned.

What is the benchmark standard?

As with SCHIP, the benchmark is expressed in terms of commercial insurance norms and actuarial equivalence. The language of equivalence resembles SCHIP, permitting states to fashion their “benchmark benefit packages” in relation to the Federal Employee Health Benefit Plan, state employee coverage, coverage offered by the state’s largest federally qualified HMO, or any other benchmark approved by the Secretary. A state also may offer “benchmark equivalent” coverage, which is coverage that includes certain basic services as well as “substantial actuarial value” for certain additional services offered at state option.

Although a state can choose a benchmark, as a practical matter, benchmark equivalency operates as the minimum standard of coverage. The minimum services for

⁴⁹ Sec. 6044 of the Deficit Reduction Act of 2005

benchmark equivalency, as well as the “additional services” for which a “substantial actuarial value” must be shown through a formal actuarial determination, are shown in **Figure 4** below:

Figure 4. Benchmarks and Benchmark Equivalency

<p><u>Benchmarks</u></p> <ul style="list-style-type: none">• FEDERAL EMPLOYEE HEALTH BENEFITS PLAN• STATE EMPLOYEE PLAN• LARGEST SELLING FEDERALLY QUALIFIED HMO <p><u>benchmark equivalency</u></p> <p><i>required (full actuarial value)</i></p> <ul style="list-style-type: none">• INPATIENT AND OUTPATIENT HOSPITAL SERVICES• PHYSICIAN SURGICAL AND MEDICAL SERVICES• LABORATORY AND X-RAY SERVICES• WELL-BABY AND WELL-CHILD CARE, INCLUDING AGE APPROPRIATE IMMUNIZATIONS• OTHER APPROPRIATE PREVENTIVE SERVICES, AS DESIGNATED BY THE SECRETARY <p><i>optional (75% of actuarial value)</i></p> <ul style="list-style-type: none">• PRESCRIPTION DRUGS• MENTAL HEALTH SERVICES• VISION SERVICES• HEARING SERVICES

Table 3 compares EPSDT benefits with “benchmark” coverage and illustrates important differences in terms of preventive services, diagnostic and treatment care, and the standard of coverage that governs the amount, duration, and scope of services.

Table 3. A Comparison of EPSDT and Benchmark Benefits

EPSDT	Benchmark Equivalent Coverage
<p>Periodic and “as needed” screening services that include:</p> <ul style="list-style-type: none"> • Unclothed physical examination • Comprehensive health and developmental history (including assessment of both physical and mental health development) • Immunizations recommended by the CDC advisory committee on immunization practices (ACIP) • Laboratory tests including assessment of blood lead levels • Health education and anticipatory guidance 	<p>Well-baby and well-child care, including age-appropriate immunizations</p> <ul style="list-style-type: none"> • Required at full actuarial equivalence • Undefined in content • Undefined in frequency
<p>Vision services (periodic and as needed)</p> <ul style="list-style-type: none"> • Assessment • Diagnosis • Treatment, including eyeglasses 	<p>Vision services</p> <ul style="list-style-type: none"> • Not required • Undefined in content • If furnished, 75% of actuarial value
<p>Hearing services (periodic and as needed)</p> <ul style="list-style-type: none"> • Assessment • Diagnosis • Treatment, including hearing aids and speech therapy 	<p>Hearing Services</p> <ul style="list-style-type: none"> • Not required • Undefined in content • If furnished, 75% of actuarial value
<p>Dental services (periodic and as needed)</p> <ul style="list-style-type: none"> • Preventative beginning not later than age 3 or earlier if medically indicated • Restorative beginning not later than age 3 or earlier if medically indicated • Emergency care beginning not later than age 3 or earlier if medically indicated 	<p>Other appropriate preventive services as designated by HHS</p> <ul style="list-style-type: none"> • Required but only at Secretarial discretion • Undefined in frequency or content • If required by secretary, full actuarial value

EPSDT	Benchmark Equivalent Coverage
<p>Diagnostic and treatment services that are medically necessary and the need for which is disclosed by a periodic or interperiodic screen</p> <ul style="list-style-type: none"> • Standard of coverage: early, to correct or ameliorate defects and physical and mental health conditions discovered by screening services, whether or not such services are covered under the state medical assistance plan. These services include: • Physician services • Hospital Services (outpatient and inpatient) • Federal qualified health center services • Rural health clinic services • Family planning services and supplies • Medical care or any other type of remedial care recognized under state law or furnished by licensed practitioners within the scope of their practice; as defined by state law • Home based care • Private duty nursing services • Dental services • Clinic services • Physical therapy and related services • Prescribed drugs • Dentures • Prosthetic devices • Other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial service (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level. Services in an intermediate care facility for the mentally retarded and inpatient psychiatric services for individuals under age 21 • Nurse midwife and certified pediatric nurse practitioner services to the extent that such services are authorized under state law • Case management • Respiratory care • Personal care services • Any other medical or remedial care 	<p>Hospital, physician, and laboratory services</p> <ul style="list-style-type: none"> • Required • Undefined in frequency and standard of coverage • Full actuarial value <p>Prescription drugs</p> <ul style="list-style-type: none"> • Optional • Undefined • 75% actuarial value <p>Laboratory and x-ray services</p> <ul style="list-style-type: none"> • Required • Undefined • Full actuarial value <p>Mental health services</p> <ul style="list-style-type: none"> • Optional • Undefined • 75% actuarial value <p>Vision services</p> <ul style="list-style-type: none"> • Optional • Undefined • 75% of actuarial value

EPSDT	Benchmark Equivalent Coverage
recognized by the Secretary of Health and Human Services	

Source: GW Department of Health Policy, 2005

Table 4 assesses EPSDT in relation to the FEHBP, to provide a further sense of the differences between EPSDT and what a state might consider a “benchmark” plan.

Table 4. A Comparison of EPSDT and the FEHBP Standard PPO

benefit	MEDICAID EPSDT PROGRAM	FEHBP standard PPO option blue cross/blue shield PLAN
Comprehensive assessment of physical and mental growth and development (developmental assessments)	Covered	Limited to “healthy newborn visits,” “routine screening,” “routine physical examinations,” “neurological testing,” and initial examination of a newborn needing “definitive treatment,” when the infant is covered under a family enrollment.
Anticipatory guidance	Covered	Silent [Not covered]
Physical, speech, and related therapies	Covered without limitations other than medical necessity; no “recovery” requirements; therapy covered for conditions identified through early intervention and child care programs.	Limited to inpatient coverage. “Maintenance therapy” expressly excluded. Also excluded are “recreational and educational” therapy and “any related diagnostic testing except as provided by a hospital as part of a covered inpatient basis.” All services billed by schools or a member of school staffs are excluded.
Hearing services	Covered without limitations, including tests, treatment, hearing aids, and speech therapy related to hearing loss and speech development.	Testing covered only when “related to illness or injury.” Routine hearing tests excluded other than as standard part of “routine” screening for children; hearing aids excluded along with testing and examinations for the prescribing or fitting of hearing aids.
Eye examinations and eyeglasses	Covered without limitations, as medically necessary.	One pair of eyeglass replacement lenses or contact lenses to “correct an impairment directly caused by a single instance of accidental ocular injury or intraocular injury;” eye examinations for specific medical conditions; nonsurgical treatment for amblyopia and strabismus from birth through age

benefit	MEDICAID EPSDT PROGRAM	FEHBP standard PPO option blue cross/blue shield PLAN
		12. Eyeglasses and routine eye examinations specifically excluded, as are eye exercises, visual training and orthoptics except in connection with the specific diagnosis of amblyopia or strabismus.
Durable medical equipment (DME)	Covered without limitations, as medically necessary.	Certain DME covered but only if prescribed for the treatment of “illness or injury.”
Home nursing	Covered without limitations, as medically necessary; home visits can cover health educators, therapists, health aides, and others.	Covered for 2 hours per day, 25 visits per year, when furnished by a nurse or licensed practical nurse and under a physician’s orders.
Other medically necessary care	Covered (and covered in greater amount, duration, and scope) if recognized under §1905a of the social security act	No supplemental coverage
Medical necessity standard	Early care to correct or ameliorate conditions	<p>BCBS determines “whether services, drugs, supplies, or equipment provided by a hospital or other covered provider are:</p> <ol style="list-style-type: none"> 1. Appropriate to prevent, diagnose, or treat your condition, illness, or injury; 2. Consistent with standards of good medical practice in the United States; 3. Not primarily for the personal comfort or convenience of the patient, the family, or the provider; 4. Not part of or associated with scholastic education or vocational training of the patient; and 5. In the case of inpatient care, cannot be provided safely on an outpatient basis. <p>The fact that one of our covered providers has prescribed, recommended, or approved a service or supply does not, in itself, make it medically necessary or covered under this Plan.”</p>

Sources: S. 1905(r) of the Social Security Act, 42 U.S.C. 1396d(r); Part 5, Section 5122 of the State Medicaid Manual; OPM, FEHBP Blue Cross and Blue Shield Service Benefit Plan, 2005. Comparisons by GW.

An additional way of thinking about coverage differences related to EPSDT and the benchmark standard is to examine coverage in relation to enrollment in a managed care

arrangement. Most state Medicaid programs use managed care arrangements for children. Regardless of how the contractual coverage rules of managed care enrollment are specified, the actual standard of coverage would be the full EPSDT benefit, which, in the vernacular, would “wrap around” the contractual plan. In a benchmark arrangement, such as those used in many separately administered SCHIP states, the benchmark coverage offered by the plan represents full coverage. This difference is illustrated in **Table 5**.

Table 5. EPSDT and Benchmark Coverage in a Managed Care Context

BENEFIT	EPSDT/Current Law Managed Care Standards	DEFICIT REDUCTION ACT OF 2005
Contractual benefits	Benefits defined in Section 1905(r) of the Social Security Act Managed care performance standards described in Section 1932 of the Social Security Act or under terms of a waiver	Defined contribution to a benchmark-equivalent set of basic benefits at an actuarial rate that does not have to be reasonably sound Applicability of Section 1932 is unclear
Supplemental or Extra-contractual benefits	Benefits defined in Section 1905(r) of the Social Security Act Managed care standards described in Section 1932 of the Social Security Act or under terms of a waiver	At state option

Source: GW Department of Health Policy, 2005

How does EPSDT relate to the benchmark standard?

Section 1937(a) as added by the DRA, provides that in the case of children under 19, the state must provide for:

“enrollment in coverage that provides * * * wrap around benefits to the benchmark coverage or benchmark equivalent coverage consisting of early and periodic screening, diagnostic, and treatment services described in section 1905(r).”

This sub-section suggests that, as is the case with many state Medicaid managed care plans today, the conferees envisioned that EPSDT benefits, to a greater or lesser degree, would supplement the benchmark, effectively giving children a dual level of coverage. Because EPSDT is so extensive, few, if any, states attempt to purchase the entire benefit from managed care entities and instead leave certain services (or certain services in amount, duration and scope) as a supplement to the benchmark directly furnished by the state itself. Other states may use specialized managed care entities (e.g., behavioral health organizations, other special purpose contractors) to furnish the more extensive level of EPSDT coverage not found in the MCO contract.

Treatment of federally qualified health center and rural health clinic services

In addition to the special EPSDT wrap-around rule, Section 1937 also provides for coverage of FQHC and rural health clinic services, as follows:

“Notwithstanding the previous provisions of this section, a state may not provide for medical assistance through enrollment of an individual with benchmark coverage or benchmark equivalent coverage under this section unless (A) the individual has access through such coverage or otherwise to [FQHC and rural health clinic services]; and (B) payment for such services is made in accordance with [the prospective payment system]”

This provision appears to require continued coverage of FQHC and RHC services at the statutory payment rate specified under the PPS prospective payment.

Beneficiary groups subject to and exempt from the benchmark

Section 1937, while extending appearing to extend the benchmark option to all categorically needy children, also contains numerous exemptions, shown in **Figure 5**.

Figure 5. Benchmark-Exempt Medicaid Beneficiaries

- PERSONS WHO QUALIFY FOR MEDICAID UNDER THE STATE PLAN “ON THE BASIS OF BEING BLIND OR DISABLED (OR BEING TREATED AS BLIND OR DISABLED) WITHOUT REGARD TO WHETHER THE INDIVIDUAL IS ELIGIBLE FOR SSI, INCLUDING AN INDIVIDUAL WHO IS ELIGIBLE AS AN INSTITUTIONALIZED PERSON
- MANDATORY PREGNANT WOMEN
- PERSONS WHO ARE DUALY ELIGIBLE FOR MEDICARE AND MEDICAID
- HOSPICE PATIENTS
- RESIDENTS OF MEDICAL FACILITIES
- MEDICAL FRAIL OR SPECIAL NEEDS INDIVIDUALS (TO BE DEFINED BY THE SECRETARY)
- BENEFICIARIES QUALIFYING FOR LONG TERM CARE SERVICES
- CHILDREN RECEIVING FOSTER CARE AND ADOPTION SERVICES UNDER TITLE IV-B OR TITLE IV-E
- INDIVIDUALS WHOSE COVERAGE IS BASED ON THEIR ELIGIBILITY FOR ASSISTANCE UNDER TITLE IV-A (TANF RECIPIENTS)
- WOMEN WHOSE COVERAGE IS BASED ON ELIGIBILITY UNDER THE BREAST AND CERVICAL CANCER PROGRAM
- CERTAIN OTHER LIMITED SERVICES BENEFICIARIES

Given these exemptions, it appears that the benchmark option applies to categorically needy children other than children who receive TANF or SSI (or who are SSI related), are in foster care or adoption placements, are residents of institutions, or fall into a special need status recognized by the Secretary. In the case of parents and caretakers, similar exemptions apply; that is, persons who receive TANF are exempt.

In essence, the Medicaid beneficiary groups subject to the new benchmark option appear to be non-exempt poverty level children and parents and caretakers who receive Medicaid but not TANF. A number of states had expressed interest in waivers that would permit them to substitute SCHIP’s general approach for Medicaid coverage standards. Section 1937 appears to permit states to respond to this expression of interest by permitting states at their option to establish benchmark plans that would combine SCHIP children and non-exempt poverty level Medicaid-enrolled children and their non-exempt parents and caretakers into larger purchasing pools. In the case of Medicaid-enrolled poverty level

children, EPSDT would continue as a required “wrap-around” while in the case of both children and their poverty-level parents and caretakers, coverage for FQHC and RHC benefits would continue.

It is important to note that although Section 1937 permits adjustment of medical assistance coverage, it does not alter beneficiaries’ entitlement to medical assistance. Thus, although children eligible for separately administered SCHIP plans are not entitled to coverage, children covered by the Section 1937 benchmark provisions remain entitled to assistance, even if the nature of the assistance changes. At the same time, however, until the Secretary interprets the breathtaking “Notwithstanding” language that introduces Section 1937, it is not fully possible to know with certainty precisely how Medicaid coverage is altered, if at all.

4. Premiums and Cost Sharing

Sections 6041 through 6043 of the DRA modify pre-enactment rules on premiums and cost sharing, by amending the statute to provide states with additional flexibility with respect to certain populations and services. Of great importance is the fact that the amendments fail to expressly address treatment of persons with incomes below the federal poverty level (as determined by a state). The legislative history of the Act as well as statements from Congressman Barton, suggest that pre-DRA rules related to premiums and cost sharing remain applicable. At the same time, the precise interaction between pre-DRA and post-DRA standards (both the amount of cost sharing permitted, covered and exempt services, and provider flexibility to deny care in the case of persons who cannot pay) is sufficiently unclear so that this section must be considered preliminary only. At the same time, however, it should be stressed that the provisions are relatively clear with respect to poverty level children.

The DRA adds a new section 1916A, which becomes effective March 31, 2006; special rules on the use of cost-sharing for emergency room services become effective on January 1, 2007. In effect, the law creates a series of options where cost sharing and premiums for children are concerned, which did not exist prior to the DRA. In the case of children whose coverage is mandatory (e.g., TANF children, poverty-level children, children in federally assisted foster care or adoption placements, certain institutionalized children, and children receiving SSI) prior protections continue to apply. In the case of optional children, both premium and cost sharing options are considerably expanded. States may continue to exempt all children or take advantage of these new options, either in part or in whole.

Table 6 summarizes the premium and cost sharing changes as they apply to children.

Table 6. State Options for Premiums and Cost-Sharing in the Case of Children

Pre-DRA	DEFICIT REDUCTION ACT
<p><i>Premiums:</i> No premiums for categorically needy children; premiums permitted for other children</p> <p><i>Cost sharing:</i> Cost sharing prohibited</p>	<p><u>Mandatory Children</u></p> <p><i>Premiums:</i> No premiums allowed in the case of children whose coverage is mandatory (including children in foster care and adoption placements under Titles IV B and E)</p> <p><i>Cost sharing:</i> No cost sharing for children whose coverage is mandatory, including children in foster care and adoption placements</p> <p><u>Optional Children</u></p> <p><i>Premiums:</i> Families with incomes at or below 150% of poverty cannot be charged premiums. Families with state-defined countable incomes over 150% may be charged premiums.</p> <p><i>Cost sharing:</i> No cost sharing (in the case of children whose coverage is optional, at any income level) for preventive services and family planning, or services furnished to terminally ill or institutionalized persons, and emergent use of the emergency room. Cost-sharing allowed for non-preferred prescriptions and non-emergent use of emergency room</p> <p>Provider enforceability permitted</p> <p>States permitted to define family income for purposes of applicable copayment and coinsurance levels and aggregate permissible exposure to premiums and coinsurance</p> <p>Certain variations in permissible coinsurance (10%/20%) and permissible aggregate limits apply depending on state-defined income family income levels. Families below 150% of poverty have a 5% aggregate limit on cost sharing and families above 150% of poverty have a 5% aggregate limit on premiums and cost sharing combined.</p>

Source: GW Analysis of the Deficit Reduction Act of 2005.

Types of payments recognized

Section 1916A recognizes explicitly the use of premiums, copayments, and co-insurance. Allowable coinsurance can be up to 10% of cost for services in the case of

families with incomes between 100% and 150% of the federal poverty level, and up to 20% in the case of families with incomes over 150% of the federal poverty level.

Valuation of family income

Section 1916A permits states to set standards for the post eligibility valuation of family income, permitting recognition (or disallowance) of deductions and disregards that determine whether a family's *gross* income falls below or above the *countable* income levels that in turn trigger cost sharing responsibilities or exemptions under the state plan. For example, in determining eligibility for Medicaid, states are required to disregard work-related expenses. Post eligibility however, Section 1916A appears to permit states to eliminate this disregard, thereby potentially raising family income from below-poverty to above-poverty levels.

Enforceability of payment rules

In addition to giving states new flexibility over premiums and cost sharing, the DRA gives states the option to permit providers to make premiums and cost-sharing requirements "enforceable." Prior to the DRA, participating physicians and hospitals were obligated to furnish care to patients regardless of their ability to satisfy applicable cost sharing rules. The DRA permits states to allow participating providers to require payment of any allowable cost sharing before providing care, including payments for services sought in emergency departments, while also authorizing providers to waive advance payment on a case-by-case basis.⁵⁰

Reconciling the new options with EMTALA

Although the Act appears to maintain applicable EMTALA standards,⁵¹ the law also gives states flexibility to permit cost sharing in hospital emergency department situations. With respect to the conduct of emergency department personnel, the law appears to permit hospital personnel to make *a priori* determinations that services sought by patients are not in fact those which they are obligated to furnish under EMTALA (appropriate screening to determine the existence of an emergency medical conditions, and stabilization or medically appropriate transfers in cases in which an emergency medical condition is identified) and to impose cost sharing. How this new authority to impose cost sharing based on the judgment of

⁵⁰ Sec. 1916A(d)(2) of the Social Security Act

⁵¹ Section 1916A(e) as added by §6043.

ED personnel is to be reconciled with their duty to furnish care without prior discussion of the cost of care under the EMTALA statute remains unclear.

Section 1916A gives states the option to terminate coverage for a patient's failure to pay premiums in cases in which the failure to pay is more than 60 days since the last payment was made.⁵² States may also, however, waive this penalty in cases of "undue hardship."⁵³

Adjustments to "nominal" cost sharing

The DRA requires the Secretary of HHS to adjust "nominal" cost-sharing levels allowed for non-preferred prescriptions and non-emergent use of the emergency room for the rate of medical inflation on an annual basis.⁵⁴

Minimum aggregate exposure protections where premiums and cost sharing are permitted

Section 1916A establishes certain aggregate upper limits on the amount of permissible premiums and cost sharing in relation to family income. Families with countable incomes between 100% of the federal poverty level but not in excess of 150% of the federal poverty level cannot be charged premiums but can be charged cost sharing up to 5% of aggregate family income on a quarterly or monthly basis. Families with countable incomes over 150% of poverty can be charged premiums and cost sharing, but the combined aggregate of premiums and cost sharing may not exceed 5% of family income. Ironically, this means that while lower income families are exempt from premiums, they can face higher point of service cost sharing given the use of the same aggregation standard applicable to higher income families.

As with individual liability for cost sharing, this aggregate limitation rule allows states to define the meaning of income, thereby resulting in aggregate limits, for example, that are aggregate in relation to gross income rather than income adjusted to take certain housing and work expenses into account. As previously noted, in the case of families with state-defined poverty level income, the permissible limitations with respect to both payment liabilities and the enforcement rules are unclear.

⁵² Sec. 1916A(d)(1) of the Social Security Act

⁵³ Sec. 1916A(d)(1) of the Social Security Act

⁵⁴ Sec. 1916A(d)(2)(b) of the Social Security Act

5. Targeted Case Management

The DRA appears to limit the scope of permissible targeted case management services as the term is used in a medical assistance context. How these changes affect the capacity of states to bill for case management services as an administrative activity is unclear.

In addition, the DRA amends the definition of third party liability (TPL) under federal law by providing that certain public programs may be considered “first dollar” (i.e., the primary payer) in situations involving the provision of covered case management services to children and adults who are simultaneously enrolled in Medicaid and receiving services under other programs. Again, however, the TPL amendments contain important ambiguities (especially with respect to the extent to which other programs will be considered TPL under federal and state law, as well as whether these TPL limitations, as with other forms of third party liability under Medicaid, should be applied in the context of both medical assistance and administrative payments for case management). Thus, this analysis should be viewed as preliminary only.

The targeted case management changes are summarized in **Table 7**.

Table 7. Targeted Case Management

pre-dra	deficit reduction act (§6052)
Case management defined	
<p>Medical assistance case management: Medical assistance case management: services that assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services (42 U.S.C. §1396n(g) (2)). All federal rules applicable to medical assistance access, coverage, claims and payment would apply.</p> <p>Case management billed as an administrative service: no single definition, but federal guidelines recognize the following activities as costs directly related to state plan administration the following: EPSDT administrative services linked to outreach, scheduling, transportation, service coordination and care arrangement; Medicaid eligibility determinations and redeterminations; Medicaid intake processing; Medicaid preadmission screening for inpatient care; Prior authorization for Medicaid services and utilization review; and Medicaid outreach</p>	<p>Expands on the definition by amplifying its meaning: Amends §1396n(g)(2) to retain the existing definition but also to provide the following clarification of what is meant by case management in the context of the medical assistance definition.</p> <p>May or may not carry over to the definition of case management in the context of administrative services.</p> <p>(I). assessment of an eligible individual to determine service needs, including activities that focus on needs identification, to determine the need for any medical, educational, social, or other services. Such assessment activities include the following: taking client history; identifying the needs of the individual and completing related documentation; gathering information from other sources such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the eligible individual.</p> <p>(II) development of a specific care plan based on the information collected through an assessment, that specifies the goals and actions to address the medical, social, educational,</p>

pre-dra	deficit reduction act (§6052)
<p>(methods to inform or persuade recipients or potential recipients to enter into care through the Medicaid system). Separate FFP rates and claims payment and billing procedures apply.</p>	<p>and other services needed by the eligible individual, including activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual’s authorized health care decision maker) and others to develop such goals and identify a course of action to respond to the assessed needs of the eligible individual.</p> <p>(III) referral and related activities to help an individual obtain needed services, including activities that help link eligible individuals with medical, social, educational providers, or other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.</p> <p>(IV) monitoring and followup activities including activities and contacts that are necessary to ensure the care plan is effectively implemented and adequately addressing the needs of the eligible individual, and which may be with the individual, family members, providers, or other entities and conducted as frequently as necessary to help determine such matters as whether services are being furnished in accordance with an individual’s care plan; whether the services in the care plan are adequate; whether there are changes in the needs or status of the eligible individual and if so, making necessary adjustments in the care plan and service arrangements with providers.</p> <p>Specifically excludes from the definition: “the direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred, including with respect to the direct delivery of foster care services, services such as (but not limited to) the following: (I) research gathering and completion of documentation required by the foster care program. (II) assessing adoption placements. (III) recruiting or interviewing potential foster care parents. (IV) serving legal papers. (V) home investigations. (VI) administering foster care subsidies. (VII) making placement arrangements.</p> <p>Clarifies that case management services need not comply with comparability or statewideness requirements.</p>
<p>Types of Case Management and Conditions for FFP</p>	
<p>Medical assistance case management services (payable at the state medical assistance rate) may be targeted to particular subgroups as a state plan matter (no freedom of choice waiver required). Case management services must be billed as medical assistance and must comply with conditions of payment for medical assistance (e.g., free choice of providers, furnished by a</p>	<p>Specifies when case management will and will not be recognized with respect to certain individuals. With respect to contacts with “individuals who are not eligible for medical assistance under the state plan” or who, if eligible “are not part of the target population specified in the state plan,” such contacts are considered allowable case management “when the purpose of the contact is directly related to the management of the eligible individual’s care.” Contacts are NOT considered</p>

pre-dra	deficit reduction act (§6052)
<p>qualified provider, be considered medically necessary, and be billed in accordance with Medicaid claims principles) (SMM §4302)</p> <p>Case management also may be furnished as an integral part of another billable service, in which case it is not separately reimbursable (SMM §4302)</p> <p>Case management may be furnished as an administrative service (paid at the federal matching rate for administrative services). Case management services must be directly related to state plan administration. When case management is furnished as an administrative service, federal requirements regarding administration costs must be followed (use of time studies, allocation of costs among programs, related to administration of state Medicaid plan). (SMM §4302)</p> <p>Case management may be furnished as an integral part of EPSDT medical assistance services or as an EPSDT administrative service.</p>	<p>allowable case management activity if such contacts relate “directly to the identification and management of the noneligible or nontargeted individual’s needs and care.”</p> <p>In the case of case management services that are reimbursable under another federally funded program as third party liability, state cost allocation systems must adhere to OMB Circular 87 or successor circulars</p>
<p>Third party liability recovery for case management services</p>	
<p>General third party liability recovery principles apply to “care and services available under the plan” 42 U.S.C. §1396a(a)(25)(A). Where [third party] legal liability is found to exist, states must make recovery efforts “after medical assistance has been made available” 42 U.S.C. §1396a(a)(25)(B). States must have in place subrogation laws that apply “to the extent that payment has been made under the state plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance.” 42 U.S.C. §1396a(a)(25)(H).</p>	<p>Specifies that “in accordance with 42 U.S.C. §1396a(a)(25), federal financial participation only is available under this title for case management services or targeted case management services if there are no other third parties liable to pay for such services, <i>including as reimbursement under a medical, social, educational, or other program.</i>”</p> <p>Exempts activities carried out under the Indian Health Service and the Ryan White Care Act from the meaning of federal programs.</p>

Source: GW Analysis of the Deficit Reduction Act of 2005.

DISCUSSION AND IMPLICATIONS

The DRA makes highly significant changes in federal Medicaid policy in the areas of eligibility benefits and services, and federal contributions to state programs. A number of critical issues bear close watching, particularly the impact of the citizenship verification changes on enrollment, the implementation of “benchmark” coverage and its impact on the involvement of private health plans in the program, how states articulate the relationship between benchmark coverage and EPSDT in the case of children, the expanded use of cost sharing and premium arrangements, and the cumulative impact of these changes on health care providers and health systems treating large numbers of low income patients.

Many provisions within the DRA raise enormous uncertainty, and extensive federal guidance clearly is warranted. The Act adds a new layer of complexity to state program design and many unknowns remain. Federal guidance is expected to lift much of this uncertainty. As for the remaining unresolved questions, they will be answered only as implementation begins.



The National Association of Community Health Centers, Inc.

State Policy Report #10: Additional Provisions of the Deficit Reduction Act of 2005 Identified for Potential Impact on Health Centers

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Health Opportunity Accounts

Section 6082 of the DRA establishes authority in Section 1938 of the Social Security Act (SSA), for the Secretary of HHS to approve demonstration programs in which states can implement “Health Opportunity Accounts” (“HOA”) in their Medicaid programs. During the first five years of this program—beginning in January, 2007-- the Secretary can only approve up to 10 state demonstration programs with each state’s demonstration covering one or more of its geographic areas. After the initial five year period, if the Secretary concludes that a specific state demonstration has been successful, that demonstration may be extended or made permanent in the state. In addition, unless the Secretary concludes that “all state demonstration programs previously implemented were unsuccessful, ” other states will be allowed to implement similar HOA demonstration programs. Section 1938(a)(2)(A)(ii).

Participation in a HOA demonstration project is voluntary to the Medicaid recipient and certain groups of recipients are not eligible to participate, including those over the age of 65, disabled, those eligible for Medicaid solely due to their being pregnant, and those who have only been eligible for Medicaid for 3 months or less. The statute also puts some limitations on the number of managed care recipients who can be enrolled in the program.

Put simply, the HOA demonstration program would operate as follows: the participant will be provided with an HOA to which the State can contribute an amount (for which there would be federal matching funds) not to exceed \$2500 for adults and \$1000 for children. However, the state must impose a deductible on these same recipients that would be no less than 100% and no more than 110% of its annualized HOA contribution. Thus, if the state contributes \$2500/\$1000 to the HOA for adults and for children, respectively, it could impose a \$2750/\$1100 deductible for these two groups respectively. In effect, after the patient exhausts his HOA, he will have to spend \$250/ \$100 (adult/child) out-of-pocket before Medicaid will resume paying for medical services. If an individual loses Medicaid eligibility and has not exhausted his health savings account, he can use 75% the account balance toward certain specified medical expenses for up to three years after loss of eligibility.

Impact on FQHCs: Determining the impact of the HOA demonstration programs on FQHCs is speculative, at best-- particularly since recipient participation is voluntary. Nonetheless, it appears possible that in states where such programs become operational, health centers may be hurt financially since some of their patients would enroll in their state’s HOA program and choose to see other Medicaid providers whose charges are less than the health centers (assuming the center would charge the recipient its FQHC per visit rate). Once the recipient has exhausted his HOA, however, and has to meet a sizable

deductible before Medicaid coverage kicks in again, he is likely to go back to the health center for free or sliding-scale services.

FMAP for Alaska

Federal matching funds to the states for Medicaid services are determined by a formula that provides for higher federal match percentages for those states with lower per capita income, that is, the poorer states. The federal match for states is determined annually : those states that have an increase in per capita income will see a reduction in their Federal Matching Assistance Percentage (FMAP) while those suffering a decrease will have their FMAP increased. Alaska was due to see a notable decrease in its FMAP under the federal match formula.. However, in Section 6053 of the DRA, Congress essentially holds that State harmless by providing that its FMAP in FY 2006 and FY 2007 will be no less than what it received in FY 2005.

FMAP for the Territories

In the U.S. Territories, Medicaid is not an entitlement program. Instead, the federal statute provides an over-all maximum federal matching payment for each territory. In Section 6055 of the DRA, Congress raised these federal payment limits by \$12 million for Puerto Rico in FY 2006 and \$12 million in FY 2007; by \$2.5 million for the Virgin Islands for FY 2006 and 5 million for FY 2007; by \$ 2.5 million for Guam in FY 2006 and \$5 million in FY 2007; by \$1 million for the Northern Mariana Islands for FY 2006 and \$2 million for FY 2007; and by \$2 million for America Samoa in FY 2006 and \$4 million in FY 2007.

Emergency Room Demonstration Program

In Section 6043 of the DRA, Congress legislated an amendment to the Medicaid statute providing states with an option to permit hospitals to impose cost-sharing on a Medicaid recipient for non-emergency services furnished to the recipient in the hospital emergency room. The amendment includes a number of provisions such as limiting the amount of cost-sharing that can be imposed, defining “non-emergency services,” etc. In addition, the amendment requires the Secretary of HHS to provide for payment to States for the establishment of “alternate non-emergency service providers...or networks of such providers” and includes a “health care clinic” and a “community health center” among the

various providers that meet the definition of an “alternate non-emergency service provider.” Sections 1916A(e)(5)(B) and 1903(y) of the SSA, as amended by Section 6043 of the DRA.

To fund this effort, Congress provided for up to \$50 million in grant funds for a 4 year period beginning in 2006, and specified that HHS must provide preference to States that establish or provide for alternate non-emergency services providers that (1) serve rural or underserved areas in which recipients may not have regular access to providers of primary care services or (2) to providers that are in partnership with local community hospitals. Clearly, community health centers and other safety net providers are offered an opportunity in this legislation to be recipients of these grant funds in this federally-funded effort to minimize the use of emergency room services for non-emergency care.

Expansion of the PACE (Program for All-Inclusive Care for the Elderly) Provider Grant Program

PACE is a program providing comprehensive Medicare and Medicaid services under a managed care arrangement to individuals over age 55 who are eligible for a nursing home level of care. PACE organizations, which are public or private non-profit entities, receive a fixed monthly Medicare and Medicaid payment to cover a comprehensive set of services for PACE participants. The PACE service package must include all Medicare and Medicaid covered services, and other services determined necessary by the multidisciplinary team for the care of the PACE participant. Currently, health center patients represent approximately 15% of the 10,000 patients nationwide enrolled in the PACE program.

The DRA included provisions targeted to providers in rural communities, such as community health centers, which will assist them in developing and operating PACE programs. In particular the DRA language provides for site development grants, required that technical assistance be established for rural PACE providers, and created a fund to reimburse rural PACE providers for certain outlier costs. HHS will establish a process and criteria to award site development grants to qualified PACE providers that have been approved to serve a rural area. A rural area would be a county that is not part of a Metropolitan Statistical Areas (as defined by the Office of Management and Budget) as established for Medicare IPPS payments to acute care hospitals. The technical assistance program will provide (1) outreach and education to specified entities interested in starting rural PACE programs, and (2) technical assistance necessary to support rural PACE pilot sites.

The DRA allocated \$7.5 million for FY2006 for the rural site development grants and these funds will be available for expenditure through FY2008. Up to 15 qualified PACE

providers that serve a rural area, in whole or in part can receive a grant not to exceed \$750,000. The DRA also includes \$10 million for FY2006 for the outlier funds. These appropriated funds would remain available for expenditure through FY2010. Rural PACE pilot sites must apply to receive outlier funds and document their incurred costs for the outlier participant. NACHC will work with the Center for Medicare and Medicaid Services to ensure that health centers can fully participate in this PACE opportunity.

Medicaid provisions affecting pharmacy services

The DRA makes a number of changes in the pharmacy reimbursement and delivery aspect of the Medicaid program. Of these provisions, NACHC believes the following may have a direct impact on FQHCs:

- Replacement of Average Wholesale Price (AWP) in basic formula for covered prescription drug reimbursement with Average Manufacturers Price (AMP), effective Jan. 1, 2007.
- Revision of the Federal Upper Limit (FUL) for payments to states at 250% of AMP (omitting customary prompt pay discounts extended to wholesalers).
- Absence of any establishment of a minimum/adequate dispensing fee for pharmacists.
- Requirement for public monthly updates of manufacturers' pricing of both branded and generic drugs.
- Lowered requirements for drugs to be considered 'multi-source' for the purpose of determining an FUL (i.e., two rather than three bioequivalent generics must be market-available);

At this time, FQHCs are expected to see minimal if any impact on "branded" prescriptions dispensed to state Medicaid patients since the cost to a 340B eligible entity is currently passed on to the state. However generic dispensing to Medicaid programs will be impacted because of the new FUL rules (250% of AMP), the revised definition of "multi-source" and the inadequate generic purchase discounting available to CHC's under 340B. NACHC urges all FQHCs to monitor this to ensure that they are buying at or below this benchmark.

The introduction of AMP as the benchmark is also likely to have a significant impact on pharmacy practices within health centers. FQHCs with in-house pharmacies and those with contracted pharmacies could see a dramatic reduction in profit on generic dispenses and may need to make adjustments to mitigate the impact of the proposed changes. In light of these changes, FQHCs may wish to review and amend contracts with respect to dispensing

fees and review generic purchase practices. The full impact of the DRA pharmacy provisions will not be known until the Centers for Medicare & Medicaid Services (CMS) publishes program guidance documents or regulations interpreting and implementing the law.

Medicare Provisions Impacting Federally Qualified Community Health Centers

The Deficit Reduction Act of 2005 (DRA) made several important changes in the Medicare program specific to federally qualified health centers.

1. Updates to the Medicare Service Package

Health centers are currently allowed to bill for services delivered by five providers: physicians, licensed clinical social workers, licensed mid-wives, physician assistants, and nurse practitioners. In the past few years, Congress has added services that are reimbursable under Medicare without updating the list of providers at health centers which can be considered a billable visit.

Included in the DRA is a provision that adds diabetes self-management education and nutrition therapy for diabetic patients, as covered under Medicare, as additional services that may be covered under the all-inclusive per visit payment rate for FQHCs. Health centers may count the visit to these specific providers as a “billable visit” under Medicare. NACHC is in contact with the Centers Medicare and Medicaid Services (CMS) as the agency develops its definition of these services. Previously, FQHCs were not permitted to bill separately for these services and were required to bundle these Medicare covered services into their FQHC Medicare rate, that is, they qualified as allowable costs but not billable visits.

2. Homeless Grantees Included in the Medicare FQHC Program

The DRA also makes a technical correction to the Medicare statute to recognize Public Health Service Act Section 330 homeless grantees as eligible for Medicare FQHC status and reimbursement. Previously homeless grantees were eligible under the Medicaid FQHC program but were inadvertently excluded from the Medicare FQHC program.

3. FQHC Contract

Finally the DRA would allow FQHCs to receive payments for services provided through a health care professional who contracts with the center. NACHC is currently working with CMS to ensure that the agency’s guidance reflects what we believe to be the intent of the statute: to allow FQHC physicians or appropriate practitioners to be reimbursed

at the FQHC Medicare rate for outpatient services provided to a FQHC patient when that individual is a hospital inpatient. CMS's position and policy on this provision, however, has not yet been announced.

Expanded Access to Home and Community-based Services for the Elderly and Disabled

Prior to the DRA, Medicaid home and community-based service (HCBS) waivers, commonly known as Medicaid 1915(c) waivers, allowed states to provide home and community-based services to Medicaid beneficiaries who would otherwise need the level of care provided in a nursing facility, intermediate care facility for persons with mental retardation (ICF-MR) or hospital. HCBS waiver services included case management, homemaker/home health aide services, personal care, psychosocial rehabilitation, home health, private duty nursing, adult day care, habilitation, respite care, day treatment, and any other service requested by the state. As part of the waiver, states could define the services to be offered, target a specific population or a specific geographic region, and limit the number of waiver participants.

The DRA establishes home and community-based services as an optional Medicaid benefit that would not require a waiver and that meets certain other requirements for individuals whose income does not exceed 150 percent of the federal poverty level. The scope of services may include any services permitted under Section 1915(c)(4)(B) of the Social Security Act and would not include an individual's room and board. The state may provide this option to individuals without determining that but for the provision of such services, the person would require the level of care provided in a hospital, nursing home, or ICF-MR. The state must meet certain conditions in order to be allowed to add this benefit to its State Plan Amendment: (1) Any state waiver or demonstration under Sections 1915 or 1115 of the Social Security Act with respect to such services for individuals described in this provision must have expired; and (2) the state must monitor and report to the U.S. Department of Health and Human Services the enrollment and expenditures for services provided.

States will be required to establish several criteria and guidelines including: needs-based criteria for determining an individual's eligibility for the HCBS option, the specific HCBS the individual will receive, needs-based criteria for determining whether an individual requires the level of care provided in a hospital, nursing home, ICF-MR, or under a waiver of the state plan, that is more stringent than the needs-based criteria for the HCBS option established by this provision. The state may limit the number of individuals who are eligible

for these services. A state is allowed to modify the needs-based criteria described above if enrollment for the HCBS option is greater than expected.

This new option may be of interest to FQHCs that are already providing many of the eligible HCBS services and/or in states with existing 1915(c) waivers. CMS is expected to issue additional guidance on this provision in early Spring 2006.

SCHIP Allotments

As part of the DRA, Congress appropriated \$283 million for FY 2006 for “shortfall” states. Shortfall states are those whose 2006 SCHIP expenditures are expected to exceed: any unspent 2004 and 2005 funds, any amounts to be redistributed, and the state’s 2006 allotment. Shortfall states will receive additional allotments that the Secretary determines will eliminate the estimated shortfalls. These additional funds can only be used for low-income children as approved under state plans. These funds will only be available through September 2006 and any unspent funds will not be redistributed. NACHC is trying to find out which and how much states are expected to receive. Section 6101.

Prohibition Against Covering Non-pregnant Childless Adults with SCHIP Funds

Section 6102 of the DRA prohibits the Secretary of HHS from approving any waiver that would allow SCHIP funds to be used to provide health coverage to non-pregnant childless adults. This prohibition does not apply to caretaker relatives and is effective as of October 1, 2005. This statutory provision means that states wishing to extend coverage to childless adults will have to use Medicaid or state dollars going forward. For example, Arkansas recently received approval for an expansion and will use SCHIP funds to cover the parents of Medicaid and SCHIP kids and use Medicaid funds to cover childless adults. The federal matching rates for each will apply. Health centers must keep in mind that FQHC is not a mandatory service under SCHIP, so in situations in which SCHIP funds are being expended, a state can opt not to cover FQHC or reimburse at the FQHC’s PPS rate without seeking a federal waiver.

Katrina Relief

Congress appropriated \$2 billion for Hurricane Katrina relief as part of the DRA (Section 6201). The two main purposes of this funding will be to cover the non-federal (i.e. state) portion of Medicaid and SCHIP costs and uncompensated care for evacuees and affected individuals. Seventeen states (**AL, AR, CA, DC, FL, GA, ID, IN, LA, MD, MS,**

NV, OH, PR, **SC, TN, TX**) received approval for emergency Section 1115 demonstration projects and will be eligible for Medicaid and SCHIP costs, and of those 8 (in bold) secured uncompensated care pools and will be eligible for those costs. Health centers in these states had to negotiate with their Medicaid directors to secure PPS for the Medicaid/SCHIP eligibles. Each state had to submit a plan outlining the details of their uncompensated care pools which CMS is currently reviewing. CMS has indicated that health centers will be eligible entities for these pools.