

To: All PCA Directors & Staff  
From: Roger Schwartz & Dawn McKinney  
Re: Urgent Alert re: DRA Implementation

On Friday, March 31, 2006, CMS issued a series of documents regarding its policies relating to states' options coming out of the Deficit Reduction Act of 2005. Dawn emailed these documents to you on Monday and we have begun to take a close look at these policies, how they match up with the new law, possible impact on health centers, etc. While this will be an evolving (and maybe never-ending) process, we thought it important to give you a "heads-up" on several important aspects of two of these documents, specifically: (1) CMS' Dear State Medicaid Director (DSMD) letter dated March 31, 2006, informing the States of the new option afforded them under the DRA of '05 to adopt an alternative benefits package (benchmark or benchmark equivalent service package) by amending its State plan and the (2) State Plan Amendment(SPA) preprint that a state would complete should it decide to make use of this option.

I will not go step-by-step through these documents but will merely highlight several points that we believe **require your immediate attention**. [Note: As an aid in focusing on these points you may want to reference pages 16--26 of a paper we handed out at PCA day during the P&I and included in an email on March 30<sup>th</sup> entitled "An Overview of Key Medicaid Provisions of the Deficit Reduction Act of 2005--- Plus Additional Provisions of the Deficit Reduction Act of 2005 Identified by NACHC for Potential Impact on Health Centers" (March, 2006). You can also find it on NACHC's website at <http://www.nachc.com/advocacy/Files/state-policy/DRAof05analysisFINAL.pdf>.]

**1. The alternative benefits package option**—The DRA of 2005 (P.L. 109-362) provides a state with the option of limiting certain groups of Medicaid eligibles to a benchmark or benchmark equivalent package of services. [Section 6044 of DRA adding new Section 1937 to the Social Security Act]. The statute is clear in listing specific groups of eligibles that **cannot** be required to participate in these limited packages, that is, those who are "exempt" and remain entitled to Medicaid's broad list of services. The DSMD letter does not directly contradict this provision of the law, however it stretches it by allowing states to **offer** the alternative benefit package to these exempted groups. Specifically, the DSMD letter states:

"There may be instances in which an exempted individual may benefit from enrolling in an alternative benefit package. States are permitted to offer them such a package but may not require them to enroll in one.

\* \* \* \*

\* \* \*

In any case in which a State offers an individual the option to enroll in an alternative benefit package, the State must inform the individual that such enrollment is voluntary and that such individual may opt out of such

alternative benefit package at any time and regain immediate eligibility for the regular Medicaid program under the State plan”

Similarly, CMS’s SPA preprint provides a place for a State to indicate what populations /individuals will be **offered** opt-in alternative coverage; it also states that such individuals “may opt out of the alternative benefit package at any time and regain immediate eligibility for the regular Medicaid program under the State plan.”

In short, **PCAs and health centers must realize that if their state decides to make use of the alternative benefits option, it may include a much broader group (and possibly all groups) of Medicaid eligibles.** There is even some concern that CMS’s DSMD letter and preprint could be read to allow states to automatically put all groups of its choosing into its alternative benefits package making it incumbent on exempted individuals **to actively opt- out** of the alternative package.

**2. The FQHC service and payment protection**—Due to the efforts and support of health centers and PCAs, NACHC was successful in getting a provision in the alternative benefit package section of the DRA that requires that recipients receiving the alternative benefit package continue to have access to FQHC services either as part of the alternative benefit package or outside of it, and that centers continue to be reimbursed for such services under PPS. The DSMD letter specifically acknowledges this protection by providing that if a state provides benchmark or benchmark equivalent coverage to individuals “it must assure that the individual has access, through such coverage or otherwise, to ...FQHC services” and that payment for these services must be made in accordance with the [PPS] payment provisions of the Medicaid statute. Particularly important, the SPA preprint requires the State to assure that individuals “will have access” to FQHCs services either within or outside of the alternative benefits package and to assure that payment will be made in accordance with the PPS requirements of the Medicaid statute.

**3. Effective date of alternative benefits package SPA.** In its DSMD letter, CMS states that the alternative benefits package provision of the DRA is effective March 31, 2006 and that state plans **submitted by June 30, 2006, may be approved retroactively to the first day of the quarter ( i.e. April 1, 2006)....”**

**So here are some obvious concerns:**

--States have been seeking flexibility in Medicaid service packages for years and they now have it in this section of the DRA. We know--based on our state- by- state legislative study (which we passed out at the P&I and included in the March 30<sup>th</sup> email)--that there is little or no state legislative protection in most states to slow down state agencies from making these changes on their own, without legislative oversight or approval.

--CMS's DSMD letter and SPA preprint allows states to **require** certain groups to accept these alternative packages, and to **offer** these packages to a much broader group of eligibles. We have no idea how states will "inform" optional groups of these choices, of the pros and cons, etc.

--Access to FQHC services and payments are protected in the law, the DSMD letter and the CMS SPA preprint, **but** we have no idea how the states will implement these protections or how CMS will monitor and/or enforce these "assurances." We know from past experience with managed care implementation, 1115 waiver implementation and PPS implementation that these are not easy issues and that centers and their patients can be hurt bad when the state is left to its own devices in dealing with health centers during times of transition. For example:

---If a state institutes an alternative benefit package through a so-called "benchmark plan" such as the State employee benefit plan, will that plan have to contract with some or all FQHCs in the plan's service area, i.e. what does FQHC "access" mean to that state?

---Will there be a wrap-around from the state?

---What if the state does not require the plan to contract with FQHCs but acknowledges that the patient can go out of plan to the FQHC—will recipients be adequately informed of this option?

---How much will the health center be reimbursed from the plan or the state—its full PPS rate or will the state insist that the center establish a separate PPS rate for the narrower list of services that these patients will be receiving. Do we have to revisit all the PPS issues that we faced in 2001?

These are just some of the issues that require thought, strategies, negotiations—all of which take time if they are to be done right. The problem is you/we may not have the time if your state is moving on this option right now!

**So what's to be done?** First, it is critical to find out where your state is going on this option. Is it preparing a SPA now for implementation retroactive to April 1 or moving more slowly or not at all interested in taking up this option? Is state legislation required to make these changes in your state (see the state by state research we've provided)? Can the state amend its regulations to make these changes with necessary notice and comment, etc, or can it do an emergency rule promulgation? Depending on the answers to these questions, it may be necessary to act quickly to impact the state's direction as it relates to health centers and their Medicaid patients.

**NACHC will continue to get out information as it comes along. We're hoping to see further CMS guidance regarding cost-sharing and citizenship verification and will schedule a conference call with the PCAs as soon as those become available, the purpose of which will be to further update these issues and to brainstorm as a group on possible strategies and approaches that might be tried**

**in the states. Please feel free to call us if you have questions, comments, suggestions, etc.**