Topical Session: The Deficit Reduction Act (DRA) Emphasis on Medicaid, Potential Implications for Part C of IDEA

Developed by SOLUTIONS Consulting Group, LLC for the NECTAC Finance Leadership Symposium

The Deficit Reduction Act (DRA)

- This is a tremendous time of "flux" for state Medicaid programs, given the many changes at the Federal level, and budget pressures local, state and Federal levels.
- The Deficit Reduction Act (DRA) which was signed into law on February 8, 2006, contains ten sections addressing cost savings requirements for a variety of federal programs including Medicaid/ Medicare.
  - Most specifically, the DRA establishes new requirements and provides potential options for states to implement which would provide "relief" from selected federal requirements.

Opportunities under the DRA

- Enroll and cover more parents of low-income children to create family coverage
- Extend coverage to more children with disabilities and CSHCN
- Ensure the full range of EPSDT services to children
- Structure effective case management services for children with social and medical risks and conditions, including using other sources of funding where necessary.
- Create more opportunities for family support and information about Medicaid coverage through the creation of Family-Family Health Information Centers in all states by 2009.

Ten Provisions of the DRA

- Title I – Agriculture
- Title II – Housing and Deposit Insurance
- Title III – Digital Television Transition and Public Safety
- Title IV – Transportation
- Title V - Medicare
- Title VI – Medicaid and SCHIP
- Title VII – Human Resources and "Other"
- Title VIII – Education and Pension Benefits
- Title IX – LIHEAP
- Title X – Judiciary-Related

Deficit Reduction Act: Public Law 109-171

Key Changes:

- Targeted Case Management
- Funds from Other Sources
- S-CHIP-like Plan Option
- Co-payments and Premiums
- Waivers
- Family Opportunity Act: Buy-In
- U.S. Citizenship Requirement

Figure 1

Medicaid's Role in the Health Care System

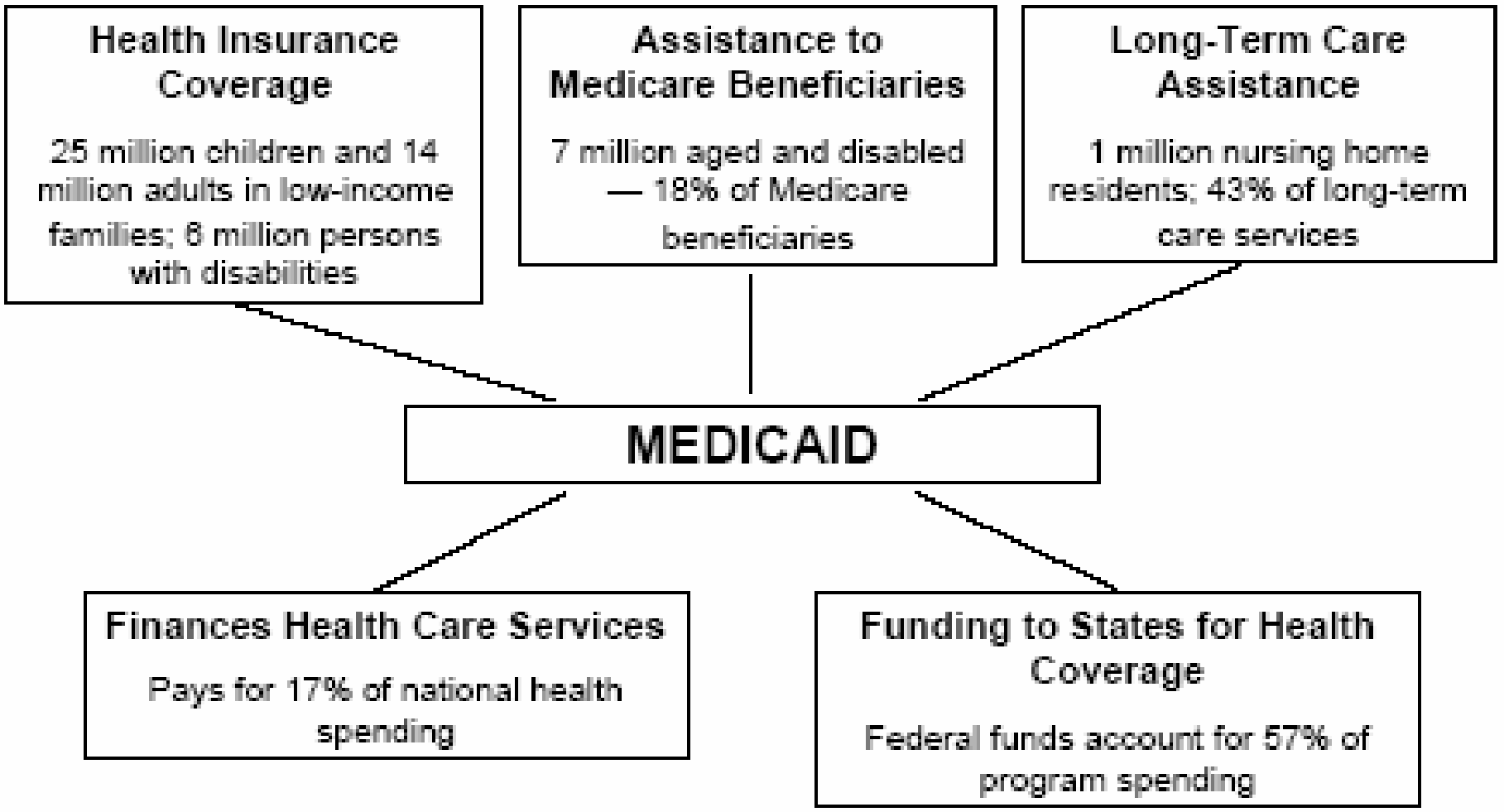

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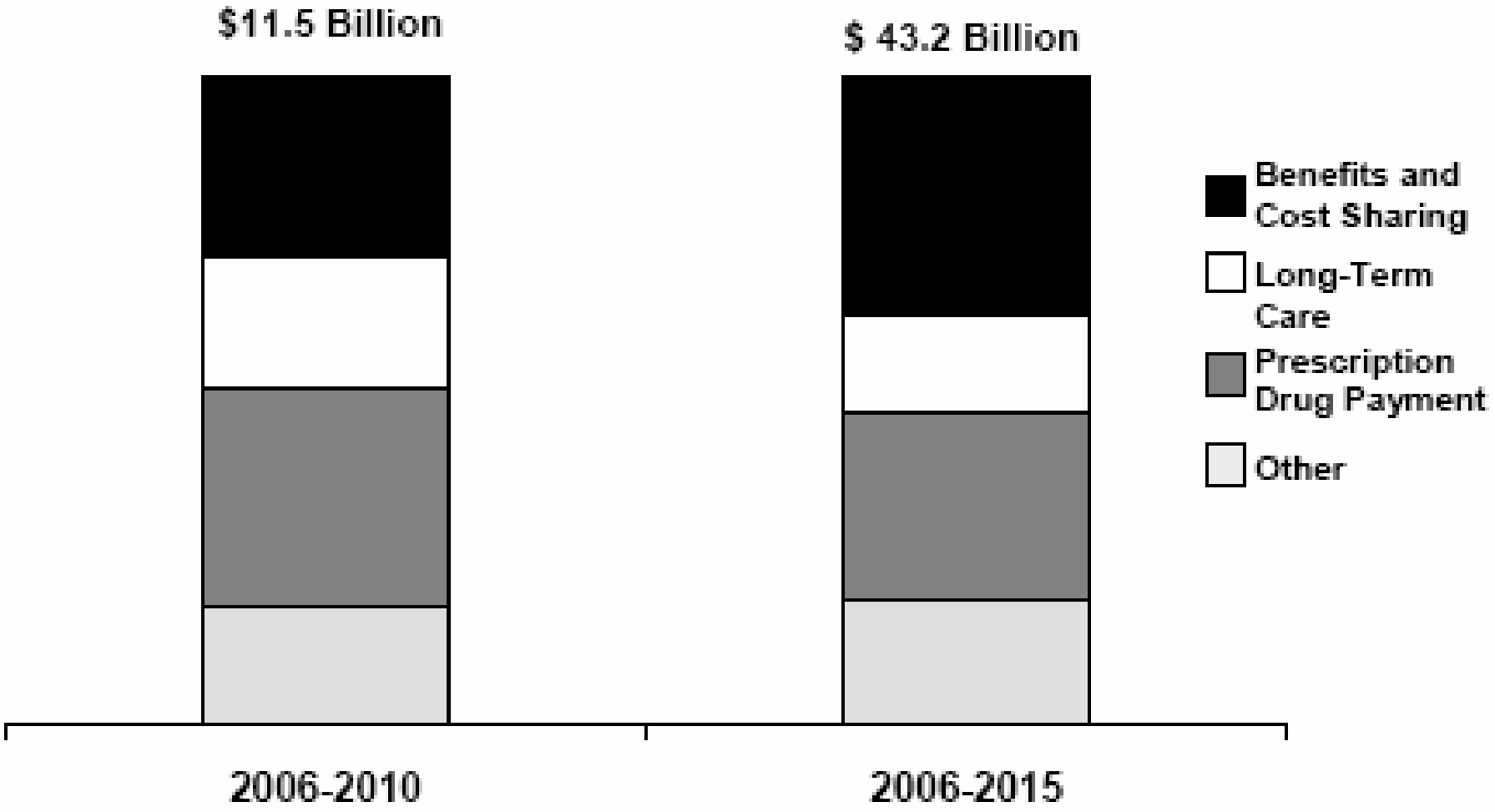
Figure 2

Medicaid Spending Reductions in the Deficit Reduction Act by Category



Note: "Other" provisions in the conference report include targeted case management, third-party recovery, provider taxes, and requiring evidence of citizenship
SOURCE: CBO, January 27, 2006

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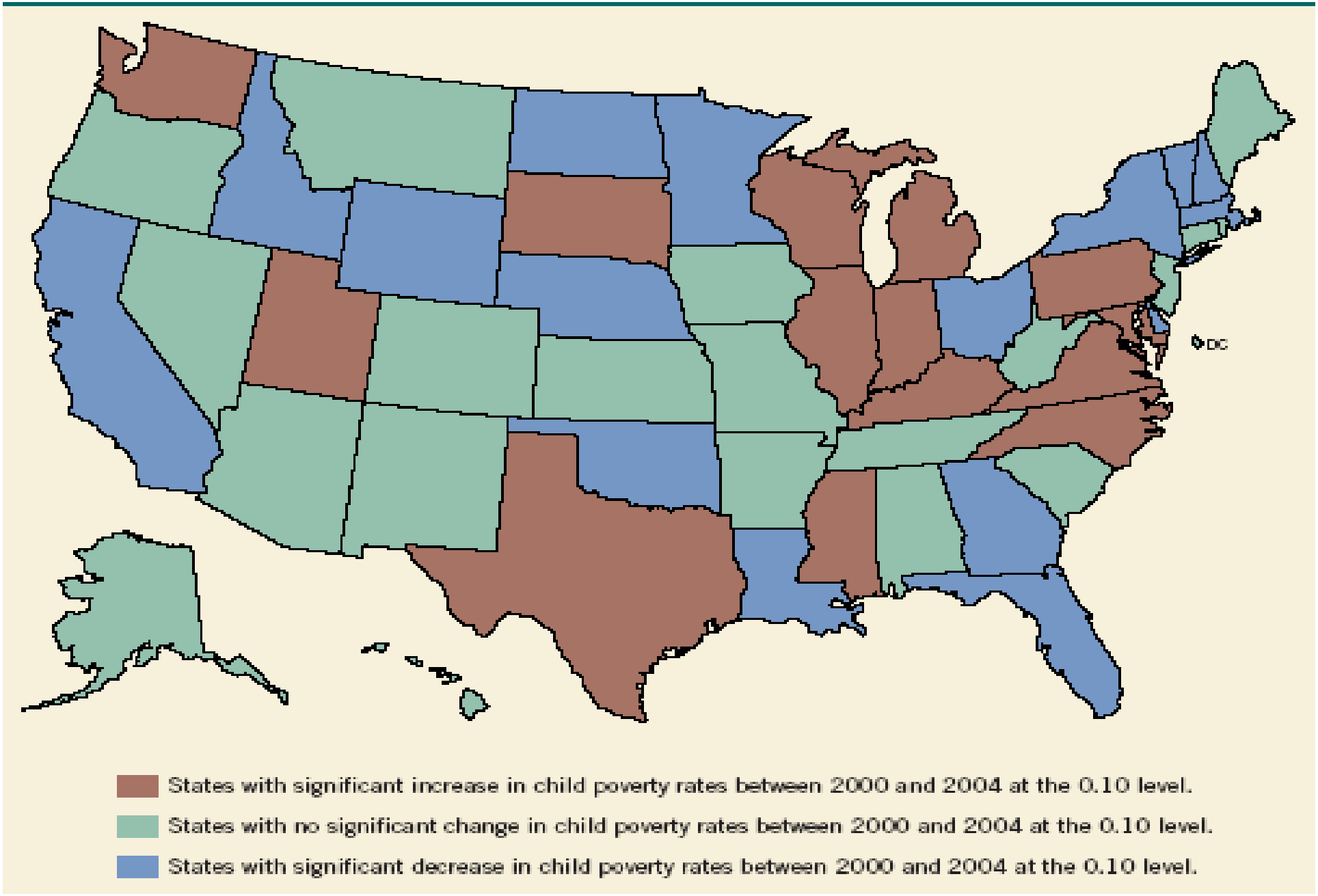
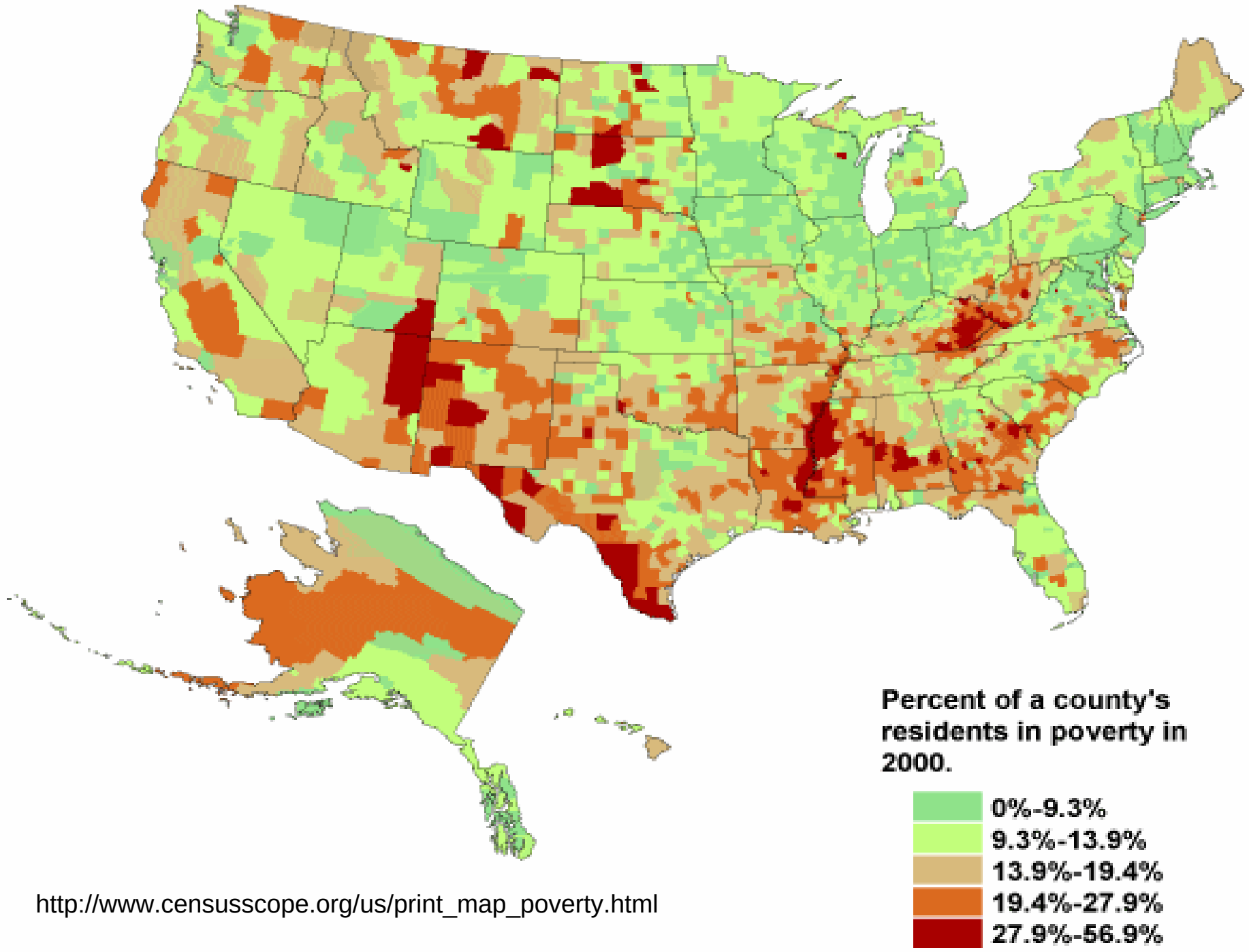
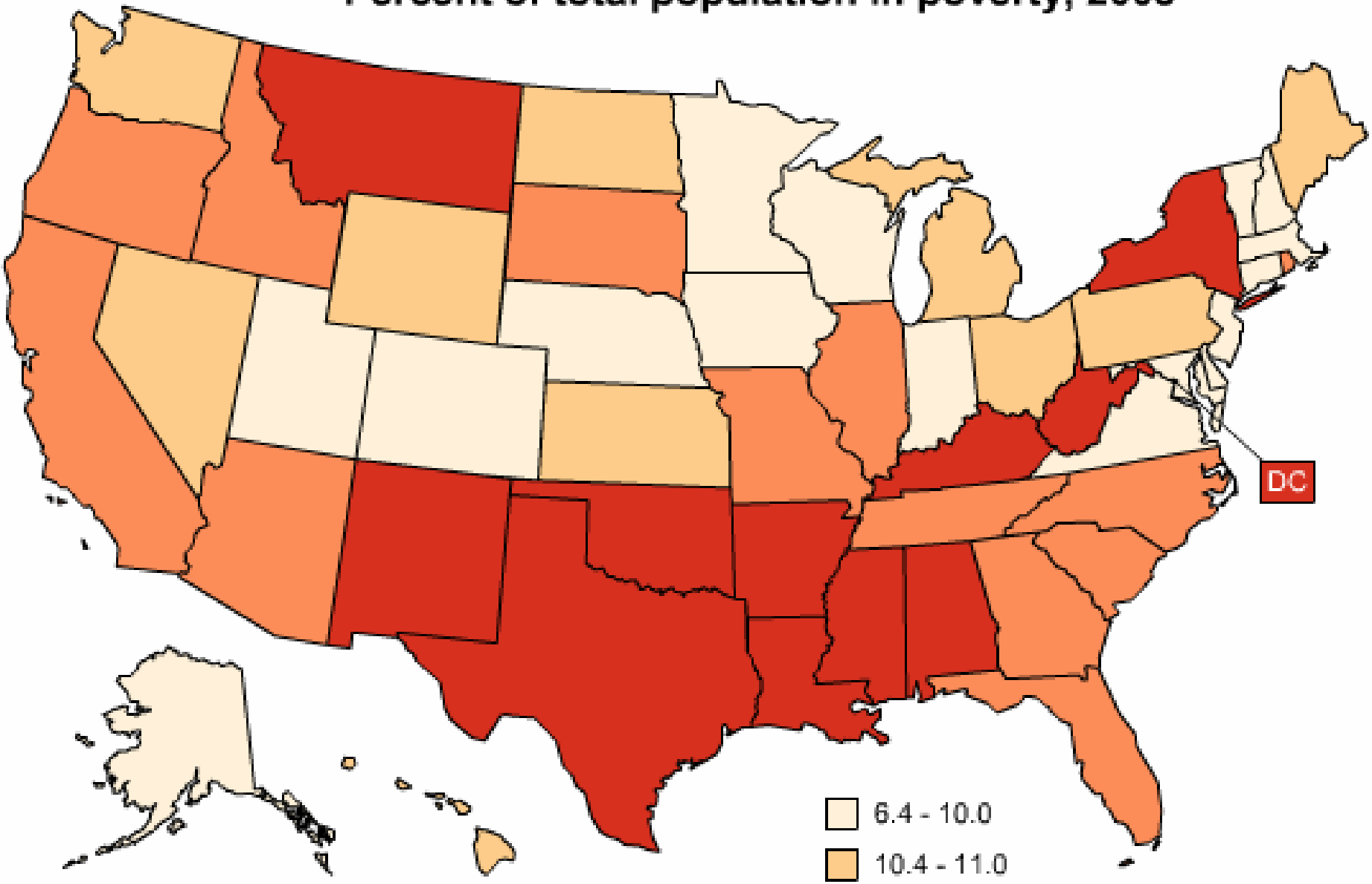


Figure A: Changes in child poverty by state, 2000-04



http://www.censusscope.org/us/print_map_poverty.html

Percent of total population in poverty, 2003



http://www.ers.usda.gov/Data/PovertyRates/

Source: Prepared by ERS using Census data.

ERS

Citizenship Documentation

Citizenship Documentation

Effective July 1, 2006, new federal requirements included in the DRA requires all U.S. citizens and nationals applying for or renewing their Medicaid coverage to provide documentation of their citizenship status.

- Range of acceptable documents, according to a "hierarchy of reliability" established by CMS.
- Presumptive eligibility still extended to pregnant women and children; documentation still required when Medicaid application is completed.

Potential Impact(s)

- Consumers:
  - Potential delays in accessing care because appropriate documentation not available
  - Cost and delays in obtaining documentation – e.g., passports, birth certificates
- Providers:
  - Difficulty in timely notice/access to information re: consumer enrollment status
- States:
  - Reduction in many of the streamlining and simplification efforts that have been implemented
  - Increase in state administrative costs (50% match)
  - Risk in covering individuals who then cannot be certified as eligible; all service costs will be the state's obligation

Specific Impact of P.L. 109-171 Upon Part C/IDEA

http://www.cms.hhs.gov/MedicaidEligibility/Downloads/dra6036.pdf
Download the law through this website

http://www.cms.hhs.gov/MedicaidEligibility/05_ProofofCitizenship.asp
CMS Information

http://www.kff.org/medicaid/upload/7533.pdf
Kaiser Summary

- Data as of 2000 from the U.S. Census Bureau indicates a range of growth across the country from 273.7% (NC) to 1.1% (ME).

- Many states report informally, however, that there are increasing “pockets” of Latino families within their state. In addition to Medicaid enrollment challenges related to citizenship, this new reality also carries with it challenges of language and cultural competency to the early intervention/early childhood systems of care and services in terms of Medicaid recruitment, service planning and service delivery.

Table 1: Percentage Change in Foreign Born Population 1990-2000 (U.S. Bureau of the Census, 2000)

North Carolina	273.7%	South Carolina	132.1%	Mississippi	95.8%	Wisconsin	59.4%	Vermont	32.5%
Georgia	233.4%	Minnesota	130.4%	Washington	90.7%	New Jersey	52.7%	Connecticut	32.4%
Nevada	202.0%	Idaho	121.7%	Texas	90.2%	Alaska	49.8%	New Hampshire	31.5%
Arkansas	196.3%	Kansas	114.4%	New Mexico	85.8%	Michigan	47.3%	Ohio	30.7%
Utah	170.8%	Iowa	110.3%	Virginia	82.9%	Wyoming	46.5%	Hawaii	30.4%
Tennessee	169.0%	Oregon	108.0%	Missouri	80.8%	Pennsylvania	37.6%	North Dakota	29.0%
Nebraska	164.7%	Alabama	101.6%	South Dakota	74.6%	California	37.2%	Rhode Island	25.4%
Colorado	159.7%	Delaware	101.6%	Maryland	65.3%	New York	35.6%	West Virginia	23.4%
Arizona	135.9%	Oklahoma	101.2%	Florida	60.6%	Massachusetts	34.7%	Montana	19.0%
Kentucky	135.3%	Indiana	97.9%	Illinois	60.6%	Louisiana	32.6%	Maine	1.1%

Fear of Deportation

Undocumented residents may feel threatened to "come forward" even if their child was born in the United States, for fear of being reported to the Immigration and Naturalization Services (I.N.S.) for arrest and potential deportation. It is likely that some states will experience a reduction in Medicaid enrollment for this population. The health of all residents is of concern to state planners as these expenses are borne, at public cost, at some juncture – usually the emergency room, rather than through prevention or early intervention.

Consequently ...

The U.S. Department of Education/Office of Special Education requires that families and children be "residents" and not necessarily "citizens" in order to be served through the state's Part C system.

This may mean that increasing costs are shifted to state and/or federal Part C funds while the availability of Medicaid and other federal resources that potentially exist for this population declines.

New Medicaid Coverage Options / Opportunities

Family Opportunity Act

- States may extend eligibility to children in families with incomes up to 300% FPL - $58,500 for a family of 4.
- Also may extend coverage to families above 300% FPL without federal matching funds.
- Phased in, starting January 1, 2007, with children <6 first; 13 or under in 2008; under 19 in 2009.
- States can charge sliding scale premium – no more than 5% of income if <200% FPL; 7.5% of income is 200-300% FPL.

- The DRA gives states the option to restructure Medicaid under a state plan amendment – under a complicated and fairly intricate set of criteria. A benchmark benefit is defined in comparison to a typical commercial insurance. These requirements are the same for SCHIP.

Effective March 2006, These new options
– **at state discretion** –
may be applied to most children enrolled in
Medicaid and to some parents and pregnant women.

The minimum standards required under EPSDT
include
prevention through periodic well-child,
age-appropriate check-ups,
and the mandatory coverage of
any identified service that is needed
whether or not it is a covered service
under the state's Medicaid plan (i.e., wrap-around").

- This is essentially a private insurance model.
- States must provide “wrap-around” EPSDT benefits to children under age 19.
- States may extend eligibility to children in families with incomes up to 300% FPL - $58,500 for a family of 4.
- Also may extend coverage to families above 300% FPL without federal matching funds.
- Phased in, starting January 1, 2007, with children <6 first.

States under this DRA option may create different groups of families, multiple plan options, and/or different plans for different parts of the state. Termed "benchmark" benefit packages, applicable only to eligibility groups established after February 8, 2006, this option means meeting or being "equivalent" to one of four options:

- The standard Blue Cross/Blue Shield preferred provider option plan under the Federal Employee Health Benefits Plan (FEHBP);
- Any state employee plan generally available in the state, regardless of enrollment;
- The HMO plan that has the largest commercial, non-Medicaid enrollment in the state; or
- Any plan determined by appropriate, as submitted by the state for consideration, by the Secretary of Health and Human Services (DHHS).

- The EPSDT service requirements must be provided to children in any of these options through what the Centers for Medicare and Medicaid are terming a “wrap-around benefit,” meant to ensure that children receive EPSDT services that they need regardless of the option that they are enrolled in.
- These options could provide coverage to currently uncovered individuals, and could also limit benefits to those covered under the “benchmark” as compared to current benefits under the state’s Medicaid program.

- Exceptions to this option include:
  - SSI recipients
  - Children with disabilities under age 19 who meet the SSI program rules for disability but not the income rules
  - Child welfare participants
  - Medicaid enrollees with spend-down requirements
  - TEFRA eligible/enrolled children
  - TANF recipients

Other FOA Initiatives

- Creates the opportunity for alternative residential treatment programs for up to 10 demo sites
- Creates Family-Family Health Information Centers, to expand to 50 states by the third year of implementation.

Targeted Case Management (TCM)

Targeted Case Management

- In the past, states have employed a number of different kinds of case management or service coordination programs.
- The DRA retains the definition of medical case management services as those services which assist the Medicaid-eligible individual to gain access to “medical, social, education, and other services needed by the eligible individual.”
- Case management service is now in the law, so regs will follow.

- Case management contacts must directly relate to the management of a child's care:
  - Assessment of an individual to identify needs
  - Development of a plan of care based upon this information
  - Assistance in referrals and related activities which help access the services
  - Monitoring the plan to ensure that it is being implemented and the services are meeting the individual's needs.

- Case management services which are not reimbursable include the direct delivery of any medical, educational, social or other services that the child or individual is referred for.
  - This may include prenatal care coordination, home visiting, care coordination for children with special needs, and mental health wraparound services.

- TCM must be to specific class of individuals (for example, children with serious emotional disturbances/SED)
- No Medicaid coverage for foster care services (current rules)
- No Medicaid reimbursement is any other third party is liable to pay for case management including a medical, social or educational or “other” program.

Federal Cost Sharing Rules

Perhaps the most significant changes as a result of the DRA that could affect families with young children are those changes related to federal cost sharing rules. These changes give states significant new authority to impose charges to families and children including those living in poverty. Research has informed us that even modest fees or reduced premiums can, particularly for the low income population, reduce utilization of services, particularly primary and preventive care.[1]

A GAO Study[2] of four states documented that up to 10 percent of children with SCHIP[3] lost coverage due to their parents' failure to pay the premiums.

Similar findings by Rosenbach et al, 2001, in North Carolina found that, among other things, the failure to pay an enrollment fee in North Carolina was the leading cause of denied applications ($50 per child with a $100 maximum). A RAND Study[4] (1986) documented a 56% likelihood of receiving highly effective outpatient care for acute conditions for low-income children in cost-sharing plans relative to low-income children with no cost-sharing, in contrast to 85% likelihood for higher income children.

[1] Wong et al, 2001; Blais et al, 2001; Solanki et al, 2000; Solanki and Schauffler, 1999; Blustein, 1995; Anderson et al, 1991; Leibowitz et al, 1985.

[2] Government Accountability Office

[3] State Children's Health Insurance Program

[4] Lohr, K. et al, September 1986, "Effect of Cost-Sharing on Use of Medically Effective and Less Effective Care

New federal premium and cost sharing standard became effective March 31, 2006 with the exception of new rules governing cost sharing for non-emergency use of an emergency room, effective January 1, 2007. Under the DRA, fairly complex federal cost sharing standards for children may be implemented depending upon two variables – the type of service being provided or the FPL* of the family.

- These regulations pertain to children ages 17 and below: for children at 133% who are <age 6 and for children at 100% age 6 to 17. For children and families with incomes above 150% FPL, the DRA permits states to impose premiums. This translates to $24,900 for a family of 3 in 2006.

*Federal Poverty Level

State Options for Premiums & Copays—General Rules

- No cost sharing for those in poverty -- *maybe*
- 100-150% FPL no premium; 10% copays, capped at 5% family income
- Over 150% FPL premiums, 20% copays; total capped at 5% family income
- All indexed to medical inflation

Some Groups Protected

- For children:
  - No premiums or cost sharing for children under 18 in mandatory eligibility groups (including IV-E & IV-B kids regardless of age)
  - No cost sharing for emergency services
- For drugs:
  - can use PDLs with higher co-pays for non-PDL drugs
  - Up to 20% of cost of drug for families 150% FPL or above, nominal amounts for others

- If the cost sharing obligation is not met, the DRA permits providers to deny care. Other arrangements are offered including prepayment requirements for insurance premiums, before individuals enroll with termination of coverage if the parent or individual doesn't pay within 60 days.

- A significant change in the DRA that needs to be considered is the new ability for states to vary premiums and cost sharing by or within individual groups or regions, which are defined by the state, or by type of service. This particularly pertains to those states where local "match" arrangements exist, or where the costs of services vary by county.
  - Depending upon the variation in concentrations of poverty WITHIN a state (as particularly related to population) could create a significant negative impact if variations of cost were permitted.

Inability to Pay

While families in early intervention may be "protected" by federal Part C/IDEA regulations under the "inability to pay" requirements, decisions as to what constitutes inability to pay and the inclusion of ancillary costs such as co-payments and deductibles of other third party resources are at the discretion of the state lead agency level.

Penalities for non payment

- State may terminate Medicaid if some or all premium is unpaid
- State may permit providers to deny services if co-payments not met
  - Providers may waive this requirement on a case by case basis

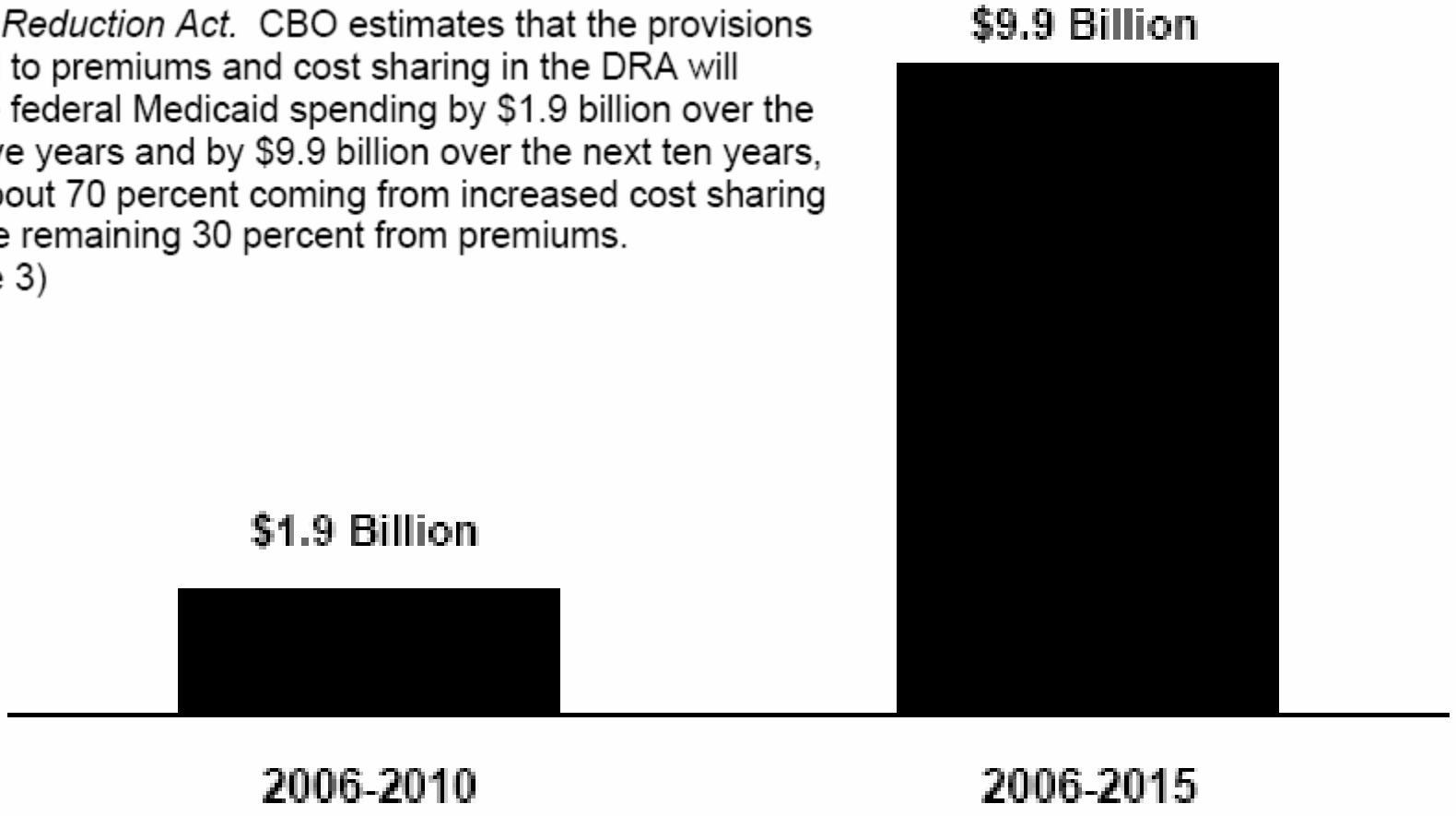
Emergency Room Use

- State option to charge for non-emergency use of Emergency Rooms:
  - as long as alternative exists, is “accessible” and the responsible person informed
  - Those exempt from other premiums/ co-pays pay only “nominal” amount
  - 100-150% FPL-- pay twice nominal amount
  - Aggregate caps (as in co-pay rules) apply

Figure 3

Medicaid Spending Reductions Attributable to Premium and Cost Sharing Provisions

Deficit Reduction Act. CBO estimates that the provisions related to premiums and cost sharing in the DRA will reduce federal Medicaid spending by $1.9 billion over the next five years and by $9.9 billion over the next ten years, with about 70 percent coming from increased cost sharing and the remaining 30 percent from premiums. (Figure 3)



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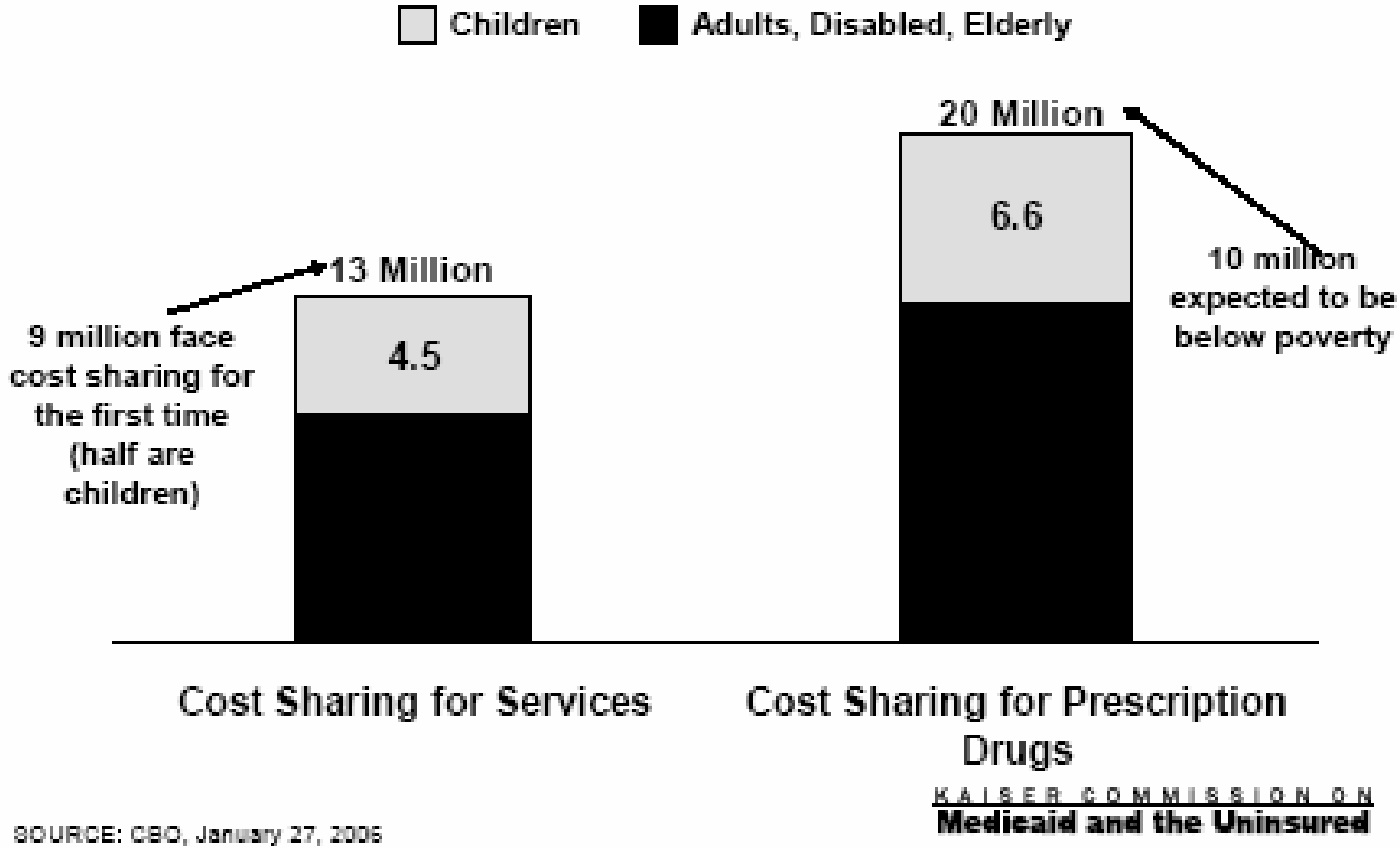
SOURCE: CBO, January 27, 2006

Figure 4

Impact of Cost Sharing Changes on Medicaid Enrollees by 2015



SOURCE: CBO, January 27, 2006

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Health Opportunity Account Demonstration Opportunity

Health Opportunity Account Demonstration

Another DRA option is for up to ten (10) states to establish Health Opportunity Account Demonstration programs, providing for high deductible plans and personal accounts. Due to the very nature of this option, it is not likely to be considered by states for low-income individuals.

Implementation Considerations

- Rules are critical – carefully written rules can expand options and activities for kids and families
  - Rules must meet the federal standards, including service descriptors
  - State must clarify what isn't covered
  - There must be a "plan" that articulates what is being provided, and linked to the individual goals for the child/family
  - Services must be recommended, provided or supervised by appropriately qualified personnel

- TCM
  - Carefully define the “target” group
  - Make sure TCM meets the federal definition
  - Check for other funding/service sources first
  - Consider community partners as providers (helps to avoid duplication)
  - ?Include case management as a component of another service

- Involving Families in the IFSP/IEP implementation
  - Include education to the family on the child's disability as a covered service
  - Assist families through training and support to manage the child's disability – beyond general parent ed
  - Services should be defined to support child in the home environment

- Respite Care
  - May include respite care – for the child
  - Focus would be to prevent disruption of the child's placement (at home)
  - Is short-term, and supervised
  - May be out of the child's home
  - A crisis must be documented
  - Build in some flexibility

Avoid at ALL Cost

- Medicaid Audit/Recoupment
  - In writing state rules, be specific and detailed as to:
    - Evaluations
    - Treatment plans
    - Service documentation
  - Remember: who, what, when, where, why and how!
- Consistently clarify that services are to promote:
  - The restoration of best possible functional level
  - Maximum reduction of the disability or delay

Documentation Issues

- Have a chart that is readily available, easy to sort through
  - Train providers and administrators on documentation, key terms and state rules
  - Give examples, required forms, whatever it takes
- Document active treatment; monitoring is case management!

Also ...

- Make sure that all providers are appropriately qualified according to state standards and federal licensure requirements
- Transportation is, by itself, not a covered service.

The BIG Picture

Opportunities/Challenges

Added to the changing Medicaid environment prompted by the DRA is the current political climate in any state including, but not limited to:

- Gubernatorial elections in November
  - a change of leadership in January 2007?
- On-going state budget/economic challenges
  - Competing demands and needs
- Status of the states Part C system as related to the OSEP monitoring

Quick Summary: Opportunities under the DRA

- Enroll and cover more parents of low-income children to create family coverage
- Extend coverage to more children with disabilities and CSHCN
- Ensure the full range of EPSDT services to children
- Structure effective case management services for children with social and medical risks and conditions, including using other sources of funding where necessary
- Create more opportunities for family support and information about Medicaid coverage available within each state

What Can I Do?

- Be at the table … every table, to hear what is being discussed for all relevant programs affected by the DRA.
- Have data to demonstrate the impact upon Part C families and children – and the state in general
  - Positive
  - Negative
  - E.g. – using state funds in lieu of federal match
- Understand competing demands and pressures that are coming to bear on state finances, the Medicaid agency, others
- Think about options and creative solutions as you partner with state resources

More Things to Do

- Read the Deficit Reduction Act and become familiar with its impact upon many federally sponsored and funded programs – some of which have been eliminated due to poor performance in the PART.

http://www.cbo.gov/showdoc.cfm?index=7028&sequence=0