State & Federal Medicaid Policies Resulting from the DRA of 2005:
Impact on Individuals with Traumatic Brain Injury

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I. Introduction

On February 8, 2006, President George W. Bush signed the Deficit Reduction Act (DRA) of 2005, which is now Public Law No. 109-17; that contained several new provisions offering States flexibility with regard to their Medicaid plans and benefits. The purpose of the DRA was to reduce Federal spending overall. However, in a 2008 report published by the Kaiser Commission on Medicaid and Uninsured, State Medicaid directors believe that the initial cost savings from DRA, such as the prescription drug payment policies, have been realized, and that now those savings have leveled off.

Recently, the Centers for Medicare and Medicaid (CMS) has issued seven regulations that will impose additional savings projected at $12 billion over the next five years. These regulations limit Medicaid payment for case management services, rehabilitation services, school-based transportation and outreach services, governmental providers, provider taxes and hospital outpatient services. Many national organizations and Congress believe these policies go beyond the intent of the DRA and will shift costs to the States.

Meanwhile, States have and continue to implement changes to their Medicaid plans, which may affect the types of services covered and in some instances, imposed cost-sharing with respect to particular services. As these new DRA provisions impact Medicaid benefits available to individuals with traumatic brain injury (TBI), the NASHIA TBI Technical Assistance Center (TAC) developed an overview of the DRA in December 2006. This paper is an update on State and Federal activities since that time.

Overall, the DRA contains 39 sections changing a wide range of Federal Medicaid policies and procedures. Some of these new provisions can be implemented through amendments to the State Medicaid Plan, while other provisions require waivers from the CMS in the U.S. Department of Health and Human Services. In some States, the Governor, the State Legislature, or both, will be designing or have designed the new State Medicaid benefits package. Therefore, this paper is designed to inform TBI administrators, consumers and advocates of these Medicaid changes to ensure that proposed State Medicaid Plans and waivers accommodate the needs of individuals with traumatic brain injury and their families.

II. Background: The Medicaid Program

The Medicaid Program is a Federal/State entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. Medicaid pays 40% of all long-term care services that are provided and almost half of all nursing home care. A 2006 report reveals that the seven percent of Medicaid beneficiaries use long-term care (LTC) services, which accounts for over half (52%) of all Medicaid spending.
Medicaid’s LTC users not only use LTC services, but they also use the program’s acute care services more intensively than non-LTC users. (Kaiser Commission, November 2006).

The Medicaid Program is administered by the States with each State setting its own guidelines regarding eligibility and services in accordance with Title XIX of the Social Security Act. Within broad national guidelines established by Federal statutes, regulations and policies, each State (1) establishes its own eligibility standards; (2) determines the type, amount, duration, and scope of services; (3) sets the rate of payment for services and (4) administers its own program.

While States may tailor their Medicaid programs to meet their States’ needs, the Federal Medicaid law mandated that certain medical assistance be provided and that certain individuals be covered for benefits. These mandated services include emergency room, in-patient hospital care, physician services, home health care, nursing facility services for persons 21 or older and Early and Periodic Diagnosis & Treatment – EPSDT -- for children under 21. States have also had the flexibility to provide optional services in addition to these mandated benefits. Services or benefits considered optional services include diagnostic; rehabilitation, physical therapy and other therapies; Intermediate Care Facilities for the Mentally Retarded (ICF-MR); personal care; dental services; durable medical equipment; non-emergency transportation and visual care. States offering these benefits were required to offer these services statewide.

In addition to a State’s Medicaid program, States offer a health insurance program for children up to age 19, known as the State Children’s Health Insurance Program (SCHIP). In some States the SCHIP is part of the State’s Medicaid program, while some States offer it as a separate program, and in other States it is a combination of both types of programs. These programs are for children whose parents have too much money to be eligible for Medicaid, but not enough to buy private insurance. Most states offer this insurance coverage to children in families whose income is at or below 200% of the Federal poverty level.

State Medicaid Plan
The State Medicaid Plan is the comprehensive written statement explaining how a State operates its Medicaid program (i.e. whom it covers, what services it offers, how much it pays for those services, quality assurance). States are required to amend their State Medicaid Plans whenever they make a “material” change in State law, organization, or policy or in their “operation” of the Medicaid program. States are also required to amend their State Medicaid Plans to reflect changes in Federal law, regulations, policy interpretations or court decisions. To amend its State Medicaid Plan a State must submit a State Plan Amendment (SPA) to CMS for review and approval. In general, to change its Medicaid program a State must either submit a SPA or obtain a waiver of requirements set forth in Title XIX of the Social Security Act from US HHS, CMS.

Medicaid Waivers
Title XIX of the Social Security Act authorizes multiple waiver and demonstration authorities to allow States flexibility in operating Medicaid programs. To obtain a waiver of Federal statutory requirements, a State must apply to CMS for approval. These waivers include waivers that:
1. test policy innovations likely to further the objectives of the Medicaid program -- Section 1115;
2. allow States to implement managed care delivery systems, or otherwise limit individuals' choice of providers under Medicaid -- Section 1115(b); and
3. allow long-term care services to be delivered in community settings in lieu of institutional settings -- Section 1115 (c) or Home and Community-Based Services Waivers (HCBS).

Under the Home and Community-Based Services (HCBS) Waivers, States may offer a variety of services to eligible individuals that are above and beyond services available through the Medicaid State Plan service benefit package. These programs may provide a combination of both traditional medical services (i.e. dental services, skilled nursing services) as well as non-medical services (i.e. respite, case management, home and environmental modifications). States have the flexibility to choose who is to be served (i.e. traumatic brain injury, elderly, physical disabilities), the number of individuals to be served in a HCBS waiver program and can restrict services to one area or portion of the State. Waiver services do not have to meet the “statewideness” requirement.

Although CMS initially offered States an opportunity to submit a TBI prototype waiver to expedite approval of waivers, most TBI HCBS Waivers are 1115 (c) waivers and offer an array of services including personal care, home modifications, case management, therapies, respite and so forth. In Massachusetts the State is pursing an 1115 waiver to combine the ABI/TBI HCBS waiver with similar waivers (frail and elderly), while other States are incorporating their TBI HCB waivers in to new Medicaid plans as authorized by the DRA.

III. DRA Provisions, Rules and Regulations and Related Policies: Overview

Medicaid Policy Process
The DRA contains a number of changes in the Medicaid policy process. The DRA allows States to implement some policies through the State Plan Amendment (SPA) process that would have required a waiver from the Secretary of Department of Health and Human Services, CMS, prior to the passage of the DRA. The ability for States to file State Plan Amendments for home and community-based services became effective in January 2007. The DRA also created two new waiver authorities for the Secretary of HHS that allow States to receive more Federal Medicaid matching funds for certain costs than they otherwise would receive.

The DRA requires the use of a regulation in only four of its 39 Medicaid provisions. Other provisions are scheduled to take effect, or have since become effective, with or without formal or informal guidance.

CMS Regulatory Changes
To carry out the provisions of the DRA CMS has issued interim and final rules and regulations. Some of these are of particular concern to the disability community and Congress believing they go further than the DRA provisions. Some of these new policies are highlighted in this section of the paper. These rules and regulations are also explained further in the paper in the DRA sections governing these benefits.

Targeted Case Management/Case Management Services
CMS published an interim final rule for targeted case management and case management services (Federal Register, December 4, 2007, Vol. 72, No. 232, 68077-68093), effective March 3, 2008. The rules are to reflect changes made under Section 6052 pertaining to how Medicaid...
will fund targeted case management activities. These rules, which tighten the extent to which case management services may be billed for Federal reimbursement, may have significant impact on beneficiaries, particularly children in foster care, individuals with physical or mental disabilities or other chronic health conditions.

Medicaid allows States to target case management for particular beneficiaries based on their health care condition or where they live. Some States provide targeted case management for individuals with traumatic brain injury. The DRA specified that targeted case management under the State plan could include assessment of service needs; the development of a care plan; referral to assist beneficiaries in accessing needed services; and monitoring and follow-up activities to ensure that the care plan is effectively carried out. Targeted case management can be provided without regard to Medicaid’s statewideness and comparability requirements.

Other States may bill for administrative case management, which provides activities that help the program operate efficiently and help beneficiaries receive needed health care.

The interim rules:
- Limit case management services for beneficiaries leaving institutional care;
- May result in fragmenting services for children in foster care, due to limitations;
- Restrict case management for some children with disabilities,
- unless the services are specified in their Individualized Education Plan (IEP); and
- Limits reimbursement to only one case manager of a beneficiary.

States that cover case management as an administrative activity may not allow them to:
- Conduct a comprehensive assessment;
- Implement a complete care plan;
- Allow state staff to conduct tasks included as case management activities;
- Limit providers to State agency staff.

With regard to transition services, Medicaid policy allows States to provide TCM to assist an individual in transitioning from an institution to the community. Prior to the interim rule, Federal reimbursement was available for case management for up to the last 180 days of the stay in the institution. The interim final rules only allow case management to be provided during the last 60 days of a stay in an institution that lasts 180 days or more and for only the last 14 days of a stay that lasts less than 180 days. The rules would prohibit payment until an individual is actually living in the community. This means that some providers would be unable to deliver transition services, because they lack the financial capacity to wait for payment and they cannot take the risk that they will not be paid at all if the individual is unable to complete the transition to the community.
Individuals with traumatic brain injury who are Medicaid eligible often have more than one case manager that is involved in the planning and delivery of care. These case managers may have expertise in a specific service area, resulting in each one bringing together resources that may be needed to support the individual in the community. Limiting the reimbursement for services to only one person means that that one case manager must be knowledgeable and able to coordinate all services, whether they reside within that person’s agency or across agencies. It is unclear as to whether this refers to one person or one provider agency or one Full Time Equivalent (FTE).

Rehabilitation Services Option
CMS has also issued regulatory changes to the Medicaid Rehabilitative Services option to narrow the scope of services that may be reimbursed through this optional services category. In its FY 2007 budget proposal, the Administration stated that it plans to "clarify allowable services that can be claimed as rehabilitation services" and assigned almost $2.3 billion in savings over five years to these changes.

The rehabilitative services option covers "other diagnostic, screening, preventive and rehabilitative services, including any medication or remedial services (provided in a facility, home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level." (Social Security Act, Sec. 1905(a)(13)).

States use the rehabilitative services option to reduce institutionalization and finance an array of community-based services for individuals with traumatic brain injury, children with developmental disabilities, seniors with disabilities due to aging, as well as individuals with mental illnesses. Rehabilitative services covered through this option include community/independent living skills training, medication management, crisis services, day programs and employment-related services. The Administration proposes savings by:

- prohibiting payment for services through the rehabilitation option if such services could be funded through other Federal, State or local programs;
- eliminating the provision that allowed rehabilitation services to be provided in any setting (the flexibility to go where the client is -- a critical component of rehabilitation); and
- prohibiting Medicaid payment for services that a State also provides to non-Medicaid-eligible individuals free of charge.

The comment period ended February 4, 2008, and these regulations are effective March 3, 2008.

School-Related Health
CMS has also issued a new policy regarding Medicaid reimbursement to school systems for related services provided to special education students who are Medicaid eligible. The final rule, published in the December 28, 2007, Federal Register, was issued after the proposed rule underwent a 60-day public comment period which closed on November 6, 2007.

CMS’s final rule prohibits Federal Medicaid reimbursement for administrative activities performed by school employees or contractors, and for transportation of students from home to school. However, Congress intervened and passed legislation to extend a six-month delay in implementing these changes so school budgets in the 2007-2008 school year will not be
affected. The final rule does not affect Federal Medicaid reimbursement for direct medical services provided by schools for children on Medicaid such as physical therapy, speech therapy or transportation to medical services during the school day.

As a result of these proposed rules and regulations, the 110th Congress has proposed a moratorium on the regulations addressing case management, rehabilitation options and school-related administration and transportation costs through various legislative remedies.

Cost-Sharing
On February 22, 2008, CMS published final rules to implement and interpret the provisions of Sections 6041, 6042, and 6043 and Section 405(a)(1) of the Tax Relief and Health Care Act of 2006 (TRHCA), which included several technical correction to the DRA. These sections amend the Social Security Act (the Act) by adding a new Section 1916A to provide State Medicaid agencies with increased flexibility to impose premium and cost sharing requirements on certain Medicaid recipients.

The final rules will allow States to deny Medicaid coverage to anyone who cannot pay a premium or enrollment fee, and it gives States the right to allow providers to turn people away.

Provider Tax Rates
The February 22, 2008 final rule also reduces to 5.5 percent the maximum allowable health care-related tax States can impose on providers (73 Fed. Reg. 9685), which implements a provision of the Tax Relief and Health Care Act of 2006. The rule also clarifies standards used to determine the existence of hold harmless arrangements that return State-collected taxes to providers. In addition, CMS finalized a provision that expands the provider tax rule to apply to all managed care organizations in a State, not just those participating in the Medicaid program.

Provisions of the rule take effect on April 22, 2008. However, in the final rule, CMS indicated it will not consider a State to be out of compliance with the revision to the definition of permissible classes until October 1, 2009.

States have raised some of their share (State match) of Medicaid expenditures by using revenue from taxes on hospitals, nursing homes, managed care organizations and other health care providers.

IV. DRA Sections and Policies

Section 6011 -- Extending Look-Back Period for Transferring Assets
The DRA extended the “look-back” period from three years (previous law) to five years and changed the beginning date for the period of Medicaid ineligibility to the date on which the individual would otherwise be eligible for Medicaid. Section 6011 also makes significant changes to the rules affecting transfers of assets for less than fair market value for people applying for Medicaid coverage of long-term services and supports. Transfers of money or property for “less than fair market value” often include transfers or cash gifts to other family members, payment for education of grandchildren and donations to charitable organizations.

These provisions require States to establish a hardship waiver process with an appeals process. Undue hardship is defined as when the transfer of assets provisions would deprive the individual of medical care so that health or life would be endangered or would deprive the individual of food, clothing, shelter, or other necessities of life.
These provisions were effective on February 8, 2006.

**Section 6012 -- Annuities**
Section 6012 addresses the use of annuities as a method of sheltering assets. Individuals at times invest large sums of money in annuities which are expected to pay out an amount that is not commensurate with the investment, or which will pay out beyond the individual’s anticipated life span. Upon death of the beneficiary, the remainder of the investment passes to designated heirs. To discourage the use of annuities to shelter funds for heirs while qualifying for Medicaid, this provision requires the following:

- Applicants must disclose to the State any interest the applicant or spouse has in any annuity;
- The State must be named as the remainder beneficiary, or as the second remainder beneficiary after a community spouse or minor or disabled child, for an amount at least equal to the amount of Medicaid benefits provided; and
- Annuities purchased by or on behalf of the applicant must be part of a bona-fide retirement plan or must be irrevocable, non-assignable, actuarially sound, and provide for equal monthly payments.

An annuity purchased after February 7, 2006 that does not meet the requirements above will be treated as a transfer of assets subject to penalty. (CMS, Transfer of Assets Document, 7/24/06.)

**Section 6013 -- The “Income First Rule”**
Section 6013 of the DRA addresses the methodology for calculating the amount of resources that may be preserved for a community spouse. Section 1924 of the Social Security Act provides that the amount of resources to be preserved for a community spouse may increased beyond the statutory maximum if the community spouse’s income is less than a minimum amount, also set forth in statute. The same section 1924 of the Act provides that income from the institutionalized spouse may be made available to the community spouse to bring that spouse’s income up to minimum level. The “income first rule” requires that the amount of the institutionalized spouse’s income that would be made available to the community spouse be considered to be available to the community spouse before computing the amount of additional resources that would be required to bring the community spouse’s income up to the standard. Some States applied the income first rule prior to enactment of the DRA, however the DRA now requires that all States use this methodology. (CMS, Transfer of Assets Document, 7/24/06.)

**Section 6014 – Home Equity and Eligibility for Long Term Care Assistance**
Section 6014 establishes an upper limit for the excluded value of a home when determining the value of an individual’s assets for purposes of Medicaid eligibility. An individual will not be eligible for Medicaid nursing or other long-term care services if the equity interest in his or her home exceeds $500,000. States may increase the equity limit, but may not exceed $750,000. Beginning in 2011, the dollar limits will be increased yearly consistent with increases in the consumer price index. The equity limits will not apply if the individual’s spouse, child under 21, or adult child with a disability lives in the home. The provision does not prevent individuals from using reverse mortgages or home equity loans to reduce equity value. The U.S. Secretary of the Department of Health and Human Services (DHHS) will establish a hardship waiver process.
The provision applies to individuals who are determined eligible for nursing or other long-term care services based on an application filed on or after January 1, 2006.

**Section 6021 -- Expansion of State Long Term Care Partnership Program**
This provision allows all States to develop Long Term Care Partnership programs, beyond the original four States, for individuals who have exhausted benefits of their private long-term care insurance to access Medicaid without the same means-testing requirements as other applicants. The four States that had implemented this program previously are California, Connecticut, Indiana and New York. To qualify, States and the insurance plans must meet extensive Federal requirements outlined in the provisions.

The long-term care insurance partnership program was developed in the 1980s to encourage people to purchase long-term care insurance rather than turn to Medicaid for long-term care assistance. Those who purchase qualifying policies may then retain a specified amount of assets and still qualify for Medicaid should they deplete their insurance benefits.

The DRA provisions become effective in a State no earlier than the first day of the calendar quarter in which the State plan amendment was submitted to the Secretary of DHHS.

**Section 6032 -- Enactment of State False Claims Acts**
Section 6032 provides financial encouragement to States to have in effect a law dealing with false or fraudulent claims that meets certain Federal requirements. If States have such a law in place, when recoveries are made for Medicaid funds improperly paid, the share owed to the Federal government will be decreased by 10 percentage points.

This provision became effective on January 1, 2007.

**Section 6033 -- Employee Education on False Claims Recovery**
Section 6033 requires States to ensure that any entity receiving Medicaid payments of at least $5 million per year must establish written policies with information about the Federal False Claims Act; State laws regarding civil or criminal penalties for false claims and Statements; and whistleblower protections with respect to preventing and detecting fraud, waste and abuse in Federal health care programs.

This provision was effective on January 1, 2007. The exception is for States requiring State legislation to comply with this provision. These States will not be found non-compliant before the first quarter after the next regular session of the State legislature after enactment.

**Section 6035 -- Medicaid Integrity Program**
Section 6035 established a Medicaid Integrity Program for the U.S. Secretary of the HHS to contract with eligible entities to review actions of individuals or organizations providing items and services reimbursed by Medicaid; audit payment claims; identify Medicaid overpayments to individuals or organizations; and educate service providers, managed care organizations, beneficiaries and other individuals regarding payment integrity and benefit quality assurance issues.

Eligible entities must: have demonstrated capability to carry out the activities; agree to cooperate with the Inspector General of HHS, the Attorney General and other law enforcement agencies in investigation and deterrence of fraud and abuse; comply with Federal acquisition and procurement conflict of interest standards and meet other requirements specified by the Secretary.
The Secretary of HHS must increase by 100 the number of full-time equivalent employees whose duties consist solely of protecting the integrity of the Medicaid program by providing support and assistance to States. The HHS Office of Inspector General is to receive an additional $25 million for each of fiscal years 2006 through 2010 for Medicaid integrity work and such amounts remain available until expended.

In addition, the Secretary shall ensure that, beginning in 2006, the Medicare-Medicaid Data Match Program (commonly known as the Medi-Medi Program) is conducted to identify program vulnerabilities, coordinate activities to protect the Federal and State share of expenditures; and increase the effectiveness and efficiency of both programs through cost avoidance, savings and recoupment of fraudulent, wasteful, or abusive expenditures. Funds are appropriated for expansion of the Medi-Medi Program.

If the Secretary determines that a State requires legislative action to comply with requirements of the new fraud and abuse provisions, the State will not be found non-compliant before the first quarter after the next regular session of the State legislature that begins after enactment. (For those States that have a two-year legislative session, each year will be considered a separate regular session of the State legislature.)

Section 6036 -- Enhancing Third Party Identification and Payment
Section 6036 requires States to determine if third party liability exists (in order to avoid the use of Medicaid funds) for additional entities: self-insured health plans; pharmacy benefit managers; and other parties legally liable by statute, contract or agreement for payment of a health care claim or services. These organizations are prohibited from taking an individual’s Medicaid status into account in enrollment or making payments.

This provision became effective on January 1, 2007. The exception is for States requiring State legislation to comply with this provision. These States will not be found non-compliant before the first quarter after the next regular session of the State legislature after enactment.

Section 6037 -- Improved Enforcement of Citizenship Documentation Requirements
This section requires individuals to present documentation of citizenship or nationality when they apply for Medicaid benefits. Failure to present such documentation will make them ineligible for Medicaid services. Documentation includes a U.S. passport, Certificate of Naturalization (or other document specified in Immigration and Nationality Act), a birth certificate, valid driver’s license or other documentation which the U.S. Secretary of DHHS specifies is proof of U.S. citizenship or naturalization.

Although the requirement went into effect on July 1, 2006, CMS did not issue interim final regulations on how States were required to implement the new law until July 12, 2006. Final regulations were issued one year later, on July 13, 2007. Since then, there have been several statutory changes made to this requirement.

Before the interim final regulations were issued in July 2006, CMS exempted Medicare recipients and individuals receiving Supplemental Security Income (SSI) benefits in most States. In issuing the interim final regulations, CMS made it more difficult for newborns to get health coverage through Medicaid by drawing a distinction between children born in the U.S. to immigrants and children born in the U.S. to citizens. Before the DRA, children born to women who were enrolled in Medicaid on the date of the child’s birth were automatically deemed eligible for Medicaid for one year. This “deemed eligibility” also applied to U.S. citizen children.
born to non-citizen women who qualified for emergency Medicaid, which allowed non-citizens to receive Medicaid coverage in certain emergency situations, such as labor and delivery. (Children born in the United States are automatically U.S. citizens, even if their parents are not.) In the interim final regulations, CMS excluded children born to women receiving emergency Medicaid from being deemed eligible for Medicaid, instead requiring that families provide proof of a child’s citizenship at birth before receiving Medicaid services. However, children born to citizen mothers who qualify for Medicaid were considered automatically eligible for Medicaid and did not need to apply for benefits. This caused concern that some newborns would not receive important services necessary in the first year of life, including immunizations.

In March 2007, after the State of Washington filed a lawsuit against the US HHS, CMS reversed its decision. Children born in the U.S. to women receiving emergency Medicaid could receive Medicaid benefits at birth. However, after one year, at renewal, these children would have to provide proof of citizenship and identity. This clarification in policy was also included in the final rule.

The final rules allow States to verify citizenship of a naturalized citizen through the SAVE program (Department of Homeland Security computer database). A State may accept an identity affidavit signed under penalty of perjury by a residential care facility director or administrator on behalf of an individual living in the facility. For children under age 16, clinic, doctor, hospital, or school records (including report cards) may be accepted for identity purposes. Affidavits are allowed for children under age 18 if neither a school identity document nor a driver’s license is available. Affidavits for children may be signed by a caretaker relative.

A combination of three or more of the following documents may be used to prove identity: employer ID cards, high school and college diplomas from accredited schools (including GED certificates), marriage certificates, divorce decrees and property deeds/titles.

The citizenship documentation requirement can be extremely difficult for applicants and recipients to meet. Applicants who are otherwise eligible for coverage cannot obtain Medicaid services until they have produced these documents. This may cause delays in medical treatment for many individuals or individuals not having medical care.

More than 14,880 children in Louisiana lost Medicaid coverage between July 1 and December 31, 2006. Enrollment in Virginia’s Medicaid program declined by 13,279 children between July 1, 2006, and March 1, 2007. The State also reported a substantial backlog in applications at its central processing site, with 3,500 cases pending approval for Medicaid at the end of February 2007 (compared to no more than 50 pending cases at the end of a typical month). New Hampshire reported that between June 2006 and September 2006, enrollment of children in Medicaid dropped by 1,275. (Medicaid Alert. The Medicaid Citizenship Documentation Requirement One Year Later. Families USA, September 2007.)

As the result of a 2008 study on Medicaid issues by the Kaiser Commission, State Medicaid directors believed that documentation of identify and citizenship continues to contribute to lower Medicaid caseloads in 2008 as it did in 2007.

Section 6041 -- State Option for Alternative Medicaid Premiums and Cost Sharing
Section 6041 created a new State option allowing States to increase cost sharing for any group of Medicaid beneficiaries subject to certain limitations. States must submit State Plan
Amendments to the US Secretary of the HHS, CMS seeking approval of such cost sharing increases. Cost sharing can be imposed and/or increased for any item (e.g. prescription drug, durable medical equipment) or service (e.g. hospital stay, doctor’s visit, occupational, physical, or speech therapy session).

Under this option, States can require a premium (defined as “any enrollment fee”) and/or cost sharing (defined as a “deduction, co payment or similar charge”), subject to certain/beneficiary income limitations:

- The law is not explicit for beneficiaries with incomes below 100% of the Federal Poverty Level (FPL) ($9,800 – individual/$13,200-couple). The HHS Secretary has indicated that no State plan amendment that requires these beneficiaries to pay more than nominal (currently up to $3.00) co-pays will be approved.
- For those with incomes between 100 – 150% of the FPL ($9,800 – $14,700/individual; $13,200 – $19,800/couple):
  - No premium; and
  - Cost sharing cannot be more than 10% of an item or service overall (including prescription drug cost sharing).
- For those with incomes over 150 percent FPL:
  - No premiums for those in hospitals, ICF/MR residents, nursing homes, (i.e. anyone on a personal needs allowance (PNA)); and
  - Cost sharing cannot be more than 20% of cost of item or service.

Total cost sharing amounts are capped for all of the above groups at five percent of total family income for a month or quarter (time period to be determined by the State). This means that total cost sharing amounts (for all items, including prescription drugs and services) cannot be more than five percent of the individual or family’s income per month or quarter. The HHS Secretary must increase nominal cost sharing amounts every year by the annual percentage increase in the medical care component of the consumer price index, beginning in 2006.

States cannot impose premiums on:

- Children in mandatory coverage categories under age 18, including children in foster care/adoption assistance
- Persons in institutions who have only a personal needs allowance
- Women in treatment for breast or cervical cancer
- Pregnant women
- Terminally ill individuals receiving hospice care

States cannot impose cost sharing on:

- Services for children in mandatory coverage categories under age 18, including children in foster care/adoption assistance
- Preventive services provided to children under age 18, regardless of family income
- Persons in institutions who have only a personal needs allowance
- Women in treatment for breast or cervical cancer
- Pregnancy-related services for pregnant women
- Services for terminally ill individuals receiving hospice care
- Emergency services
- Family planning services
The effective date of this provision was March 31, 2006. In February 2008, CMS released proposed regulations on cost sharing structures. These new provisions are similar to what is allowed under SCHIP and will not change existing cost sharing rules for Medicaid beneficiaries with family income below 100 percent of the federal poverty level (FPL).

Individuals with family incomes between 100 and 150 percent of the FPL may see some cost sharing while monthly premiums can be charged to individuals with incomes above 150 percent of the FPL. As in SCHIP, all cost sharing must be limited to no more than 5 percent of the family’s income. (The 2008 FPL for a family of four is $21,200.)

Section 6042 -- Special Rules for Cost Sharing for Prescription Drugs
This section allows States to impose higher cost sharing to non-preferred (typically brand name) medications to encourage the use of preferred (typically generic) drugs, subject to the following limitations. States have the authority to decide which drugs are preferred versus non-preferred. For non-preferred medications, beneficiaries who income is below 150% FPL cannot be charged more than nominal cost sharing (currently up to $3 per medication).

States can reduce or waive co-pays for preferred drugs. For beneficiaries whose income is 150% or above FPL, co-pays for non-preferred rugs cannot exceed 20 percent of the drug’s cost.

Section 6042 includes a provision allowing a State to waive these rules if a physician determines that a preferred drug is not effective or causes adverse health affects, the State can charge the preferred (generic) co-pay amount for a non-preferred (brand name) drug. Unlike other services, no groups of beneficiaries are exempt from cost sharing for non-preferred prescription drugs.

Families with incomes below 150 percent of the FPL (Federal Poverty Level) could be subject to nominal cost sharing for non-preferred drugs and families with incomes over 150 percent of the FPL could face co-payments up to 20 percent of the cost of non-preferred drugs. Nominal cost sharing amounts are currently $3 and States could increase that amount by the medical component of the consumer price index.

This provision became effective March 31, 2006.

Section 6043 -- Emergency Room Co-payments for Non-Emergency Care
This section created another State option permitting States to submit a State Plan Amendment allowing hospitals to impose cost sharing for non-emergency services provided in hospital emergency rooms, if they follow strict notice requirements. Non-emergency services are defined as “any care or services furnished in the emergency department of a hospital that the physician determines do not constitute an appropriate medical screening examination or stabilizing examination and treatment required to be provided by the hospital”. This provision requires that the beneficiary receive a medical screening (as defined in Medicare law) and a
determination by the emergency room that the beneficiary does not have an emergency medical condition. Before non-emergency care is provided, the beneficiary must be told that:

- the hospital can require a co-pay before the non-emergency service is provided;
- the name and location of an alternate non-emergency provider (that is available and accessible) that may charge a lower co-pay;
- the alternate non-emergency provider can provide the services with a lower or no co-pay;
- the hospital will provide a referral to coordinate scheduling of the treatment.

Alternate non-emergency providers include physicians’ offices, health care clinics, community health centers, and hospital outpatient departments. Such providers must be able to diagnose or treat a condition “contemporaneously” (i.e. within the same amount of time as a hospital emergency room would have taken to provide the non-emergency services).

Co-pays for non-emergency services in an emergency room for beneficiaries under 100% FPL (Federal Poverty Level) cannot be more than twice the nominal amount (i.e. currently $6.00 – twice the nominal $3.00 limit). As part of this provision, grant funding is authorized to establish alternate non-emergency services. The grant funding amount is $50,000,000 over four years. Section 6043 became effective January 1, 2007.

On February 22, 2008, CMS published rules and proposed under Sec. 447.71(b)(2) that cost sharing for non-emergency services furnished in a hospital emergency department for those individuals not exceed the nominal cost sharing amount and be imposed only so long as no cost sharing is imposed on those individuals to receive such care through an outpatient department or other alternative non-emergency services provider in the geographic area of the hospital emergency department involved.

**Section 6044 -- Use of Benchmark Benefit Packages**

Section 6044 of the DRA allows States to modify the Medicaid benefit package for some beneficiaries. This provision gives States the option to provide “benchmark” or “benchmark-equivalent” health care benefits to mirror certain commercial insurance packages to certain beneficiary groups which may be more limiting. This provision became effective March 31, 2006.

On February 22, 2008, CMS published regulations to give States more flexibility in designing their Medicaid programs, including tailoring benefit packages to better meet beneficiaries’ needs as well as requiring increased cost sharing (73 Fed. Reg. 9714, 9727). The goal seems to be to implement the Administration’s goals of aligning Medicaid more closely with private market insurance and giving States more control over their Medicaid benefits packages. The proposed rules have a 30-day public comment period. The rules allow States to target benefits to different populations, such as designing packages for patients with diabetes. That means all Medicaid beneficiaries may not receive the same benefits. CMS noted that in some cases, benchmark coverage may be more generous than the State Medicaid plan.

States can obtain an amendment to their State Plan to shift people into “benchmark coverage” or “benchmark-equivalent coverage.” The benchmarks are the Federal Employee Health Benefits Plan standard Blue Cross/Blue Shield preferred provider option, any State employee plan generally available in a State, the HMO plan that has the largest, commercial non-Medicaid enrollment in the State, or any plan which the Secretary of the U.S. Department of Health and
Human Services deems appropriate. The benchmark options are the same as those provided to States for their State Children’s Insurance Programs (SCHIPs).

Benchmark-equivalent coverage is defined as a benefit that has an aggregate actuarial value at least equivalent to one of the above benchmark plans. The DRA sets forth a standard to determine the actuarial value. Services covered under any of these plans need only include:

- inpatient and outpatient hospital services;
- physicians’ surgical and medical services;
- laboratory and x-ray services;
- well-baby and well-child care, including age-appropriate immunizations; and
- other appropriate preventive services, as designated by the Secretary of DHHS.

Under this option, children must continue to receive Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefits – either directly or through a “benchmark” or “benchmark equivalent” plan. This coverage is the same as that in the State Children’s Health Insurance Program (SCHIP).

States that use benchmark plans must nonetheless make available to all children under age 19 an additional “wrap around” benefit, consisting EPSDT services as defined in current Medicaid law. This means children under age 19 must continue to receive any medically necessary Medicaid-covered service, whether or not that service is covered or defined in the Medicaid State Plan. However, the DRA is unclear as to whether children between 19 and 22 have lost their EPSDT protection. Current EPSDT protections could still apply to these youth. For children entitled to the “wrap around” benefit, the law creates dual benefit packages (the “benchmark benefit” and the additional wraparound benefit). No specificity is given or standard used to determine what would be considered “wrap around.”

States are limited in whom they may switch into these benchmark plans. They may not shift the following categories of people:

- pregnant women with mandatory eligibility for Medicaid;
- blind or disabled individuals (including those on SSI or SSDI);
- dually eligible (Medicaid and Medicare) people;
- institutionalized individuals and beneficiaries qualifying for long-term care services;
- people with terminal illnesses or hospice patients; medically frail people and those who have special medical needs;
- children in foster care who are receiving services under Title IV-B; and
- children receiving foster care or adoption assistance under Title IV-E.

States may also choose to exempt other categories of Medicaid beneficiaries from being moved into benchmark plans if they pick up this option. States may also use alternative benefit packages for providing disease management services, such as persons with diabetes, or other specialized services to other groups of beneficiaries on a voluntary basis.

Idaho became the first State with an approved benchmark plan followed by Kentucky, and West Virginia. Since August 2006, other States that have submitted SPAs for benchmark requests, include Kansas, Virginia, South Carolina, Washington, Wisconsin, Maine and Missouri.
Kentucky was approved for a benchmark plan called “KyHealth Choices”, which consists of several benefit plans tailored towards different groups including the State’s general Medicaid population, children, the elderly and disabled and beneficiaries with mental disabilities. **Current waivers for acquired/traumatic brain injury, supports for community living and home and community based services are to be included in KyHealth Choices, under the Comprehensive Choices Plan.** The Comprehensive Choices plan covers individuals who need a nursing facility (NF) level of care, are at risk of institutionalization and/or have been previously covered under the HCB Waiver, Model II or the ABI waiver. The plan also include disease management services for individuals with chronic illnesses. The level of coverage a plan provides depends on the beneficiaries’ medical needs, intending to provide individuals with the most complex needs the largest array of benefits. KyHealth Choices will provide health care coverage for Medicaid members throughout the State, except those currently being served by the State's Passport health plan, which operates under an existing managed care waiver.

Idaho’s new plan similarly provides varying benefit packages for different subpopulations. The Basic plan covers healthy children and adults and includes most traditional Medicaid services, but excludes intensive mental health treatment, organ transplants, and long-term care. Beneficiaries with more complex health care needs, such as those with disabilities, are to receive coverage through the Enhanced Plan, including long-term care. The Coordinated Plan includes all services covered by traditional Medicaid. Idaho’s plan also allows the working individuals with disabilities to buy into the most basic of the new benefit packages.

**Idaho’s Traumatic Brain Injury Medicaid Waiver was collapsed under the existing Aged/Disabled Waiver and will maintain the cost neutrality provision via special rates.** A separate nursing home level of care waiver is planned for that will accommodate those individuals who are at 300% of the Federal SSI benefit rate. There are plans to move the TBI waiver under the State plan where individuals could be eligible for either basic or expanded State Plan services. Idaho is waiting for clarification from CMS as to how the DRA provisions impact Idaho’s current benchmark basic and enhanced plans before moving ahead with any changes.

West Virginia’s Medicaid coverage under this provision consists of two tiers of services. The basic level includes fewer benefits than the State’s Medicaid program previously provided. The enhanced level provides coverage for services limited or eliminated in the basic level plan.. West Virginia offered this plan initially in three counties before expanding statewide.

The Kansas Health Policy Authority (KHPA) submitted a benchmark SPA request, approved September 7, 2006, to offer Personal Assistance Services (PAS) and related services to beneficiaries eligible for Working Healthy, the State’s Medicaid buy-in program. This is designed to be beneficial for individuals with disabilities for these reasons:

- The State will aid in the improvement of the health of persons with disabilities by providing person-centered care to meet their unique needs.
• The flexibility of this option permits Kansas to design a benefit package that meets the needs of a working population requiring PAS to live and work in the community.
• Individuals with developmental disabilities, physical disabilities, and traumatic brain injuries will be able to self-direct their PAS and related services and to receive these services at home, at work, and in the community, thereby facilitating their ability to become employed.

Eligible for the program include individuals categorically eligible in the State’s Ticket to Work and Work Incentives Improvement Act (TWWIIA) Basic Medicaid buy-in program with developmental disabilities, physical disabilities and traumatic brain injuries, who require PAS and related services. This optional Medicaid buy-in eligibility group is comprised of working individuals between the ages of 15 and 65 years old who, except for their income and resource levels, are eligible to receive SSI.

This new DRA State Plan option places groups of children, seniors and parents at risk to being switched into less adequate plans. Adults with traumatic brain injury may be at risk in terms of being eligible for services if they are not defined as a “person with a disability,” but rather are eligible for Medicaid based on income.

Children may face obstacles in part because these private plans do not have Medicaid’s Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirement. The law does allow States to provide scaled-back benefit packages for children similar to EPSDT, as long as wrap-around coverage is also provided to substitute for EPSDT. However, the DRA only extends this wraparound protection to children up to 19 years old (the current EPSDT requirement applies to individuals up to age 21). Some children could fall through the cracks. Some families will not know they can obtain the wraparound benefit; others may find their child inappropriately denied the additional benefit and still others may receive the wraparound benefit, but encounter discontinuity in providers and treatment plans.

Another drawback for people with traumatic brain injury is that they often find their private insurance does not provide coverage for comprehensive rehabilitation, therapies, community support and long-term services. By basing Medicaid benefits on those benefits generally available under private plans, it will lead to restrictions on comprehensive rehabilitation and other needed community and long-term services in Medicaid programs.

Section 6052 – Redefines Targeted Case Management
Section 6052 tightens the definition of the Medicaid’s targeted case management option and places limits on use of targeted case management and administrative case management. CMS has issued final rules that tighten the requirements further. The DRA clarifies that to be eligible for targeted case management an individual must be eligible for Medicaid and be a part of the target population for targeted case management specified in the State Plan. It also requires States to bill other funding sources that are “legally obligated” to pay for targeted case management services first, before charging Medicaid.

Under Medicaid law, case management services are services that will assist individuals in gaining access to needed medical, social, educational or other services. This includes
assessment; development of a specific plan of care; referral and related activities to help obtain needed services; and monitoring and follow-up activities.

The DRA clarifies that case management does not include:

- direct delivery of an underlying medical, educational, social or other service to which the individual has been referred; or
- direct delivery of foster care services.

The DRA lists examples of foster care services that may not be billed to Medicaid targeted case management, specifically:

- research gathering and completion of documentation required by the foster care program
- assessing adoption placements
- recruiting or interviewing potential foster care parents
- serving legal papers
- home investigations
- providing transportation
- administering foster care subsidies
- making placement arrangements

Case management is often billed under other State services, such as EPSDT, Clinic or Rehabilitation services, as well as under the Medicaid option of Targeted Case Management or Administrative Case Management. The new definition applies in all cases.

Of particular concern with regard to the CMS issued rule:

- Transition case management may be ineffective helping consumers relocate from institutions if the transition cannot be completed within 60 days.

- States with single entry point system and states that use case managers to perform all case management functions for 1915 (c) waivers may have to unbundle the process for accessing services by allowing community case management agencies to complete the assessment and care plan and designate state staff to determine eligibility, approve the care plan and authorize services.

- States that provide administrative case management may not allow case managers to:
  - Conduct a comprehensive assessment;
  - Implement a complete care plan;
  - Conduct tasks included as case management activities;
  - Limit providers to state agency staff.

Medicaid recipients must be given a choice of case management providers who meet the State’s qualifications. The State may limit the providers of case management to target groups that consist entirely of persons with traumatic brain injury or developmental disabilities, for
example, to ensure that case managers are capable of ensuring that needed services are actually delivered.

The DRA could significantly reduce Medicaid coverage of Targeted Case Management (TCM) services that assist targeted populations in gaining access to necessary medical, social, educational and other services. The law allows for reduced Federal Medicaid funding for TCM by $760 million over five years and more than $2 billion over 10 years. The most troubling provision states that “[f]ederal 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, including as reimbursement under a medical, social, educational or other program.” In effect, the provision could be interpreted in a way that discourages other entities (private, local, State or Federal) from providing these services to people not eligible for Medicaid. On past occasions, CMS has attempted to disallow Federal funding for case management on the basis that a State makes such services available without charge to non-Medicaid-eligible individuals.

Recent CMS rules have further restricted case management functions eligible for Federal financial participation.

Section 6071 -- Money Follows the Person Rebalancing Demonstration
Section 6071 authorizes the U.S. Secretary of the HHS to grant competitive awards to States to increase the use of community in lieu of institutional services. This section provides for an enhanced Federal medical assistance percentage (FMAP) for twelve months for each person transitioned from an institution to the community during the demonstration period. The enhanced FMAP will be equal to the State’s regular FMAP plus half of the difference between the regular FMAP and 100 percent. No State may receive more than 90 percent Federal match.

Eligible participants must have resided in an institution for a period from 6 months to 2 years, as a minimum stay requirement (States set the requirement); and States must continue to provide community services after the demonstration period for as long as the individual remains on Medicaid and in need of community services.

CMS has defined MFP as “a system of flexible financing for long-term services and supports that enables available funds to move with the individual to the most appropriate and preferred setting as the individual’s needs and preferences change." This approach has two major components. One component is a financial system that allows Medicaid funds budgeted for institutional services to be spent on home and community services when individuals move to the community. The second component is a nursing facility transition (NFT) program that identifies consumers in institutions who wish to transition to the community and helps them do so.

Some States, especially those without large institutional populations, have defined MFP broadly such as the improvement of community-based services (ME), community integration (ID), or the elimination of barriers in programs, procedures and policies so that financing, services and supports move with the person to the most appropriate and preferred setting (NV). Some States (ID, MI and NV) have also included diversion from admission to an institution in their definition of MFP. California is still working to develop a definition of MFP.
CMS awarded (MFP demonstration grants to 31 States in 2007, to support individuals in institutions to move to the community.

**Section 6063 -- HCB Alternative to Psychiatric Residential Treatment Facilities for Children**

This section authorizes a five-year demonstration program to provide community-based alternatives to psychiatric residential treatment facilities for individuals under the age of 21. The Secretary of the HHS is authorized during the period from FY 2007 through FY 2011 to conduct demonstration projects in up to ten States. This proposal would appropriate $218 million for the project period, and, of that amount, $1 million is made available for required interim and final evaluations and reports.

The waivers funded through this demonstration are subject to the same requirements as existing 1915(c) waivers, including budget-neutrality rules. At the end of the demonstration period a State may continue the home- and community-based services for children already enrolled in the program.

**Section 6062 -- Family Opportunity Act**

The DRA included the Family Opportunity Act (FOA) as a State option to offer parents of children with severe disabilities the ability to buy into Medicaid. The provision is for parents whose income is at or below 300 percent of the FPL (approximately $60,000 for a family of four). Under this provision, States can require cost-sharing (premiums and co-pays), but cannot exceed five percent of family income up to 200 percent of the Federal poverty level, and 7.5 percent of family income from 200-300 percent of Federal poverty.

In order for a family to participate in the Medicaid buy-in for their child with a disability, a State must require a parent to take employer-offered insurance within the following guidelines: (1) the employer offers family coverage under a group health plan, and (2) the employer contributes at least 50% of the total cost of the annual premium for the coverage.

If such coverage is attained by the family, the State is required to reduce the premium charged for the buy-in, in an amount that reasonably reflects the parent’s premium contribution for private coverage for their child with a disability. Participating States may charge premiums up to the full cost of the premium as long as that premium does not exceed 5% of family incomes up to 200% of the poverty level and 7.5% of family incomes between 200-300% of the poverty. The State may waive payment of a premium in any case where the State determines that requiring a payment would create an undue hardship.

This section became effective for items and services provided on or after January 1, 2007.

The Medicaid rules on cost-sharing were clarified in the Tax Relief and Health Care Act of 2006 (TRHCA), which was signed into law on December 20, 2006.

**Section 6064 -- Family-to-Family Health Information Centers**

As part of the Family Opportunity Act provisions, Section 6064 establishes Family-to-Family Health Information Centers to provide information to parents of children with disabilities and special health needs so that they can make informed decisions about health care (e.g. treatment decisions, cost effectiveness, and improved health care for their children including available resources, identify successful health care delivery models, develop a model for collaboration between health care professionals and these families, and provide outreach and training to health care professionals and other appropriate entities). The U.S. Department of
HHS Secretary is to develop these centers, through grants, contracts, or otherwise, in at least 25 States in FY 2007, 40 States in FY 2008, and all States, including the District of Columbia, in FY 2009.

**Section 6065 -- Restoration of Medicaid Eligibility for Certain SSI Beneficiaries**

Section 6065 establishes that Medicaid eligibility for children (under age 21) will occur on the latter of the date of application or the date SSI eligibility is granted. This eliminates requirements that the child wait until the beginning of the following month. This section became effective on February 8, 2007.

**Section 6081 -- Medicaid Transformation Grants**

The DRA provided new opportunities for States to work with the Federal Government to build on the effective reforms to slow spending growth, while providing needed coverage. Through the use of the Transformation Grants, States can work with Centers for Medicare and Medicaid Services (CMS) to create programs that are more aligned with today's Medicaid populations and the health care environment.

Examples of the permissible uses of funds include, but are not limited to, the following:

- Methods for reducing patient error rates through the implementation and use of electronic health records, electronic clinical decision support tools, or e-prescribing programs;
- Methods for improving rates of collection from States of amounts owed under Medicaid;
- Methods for reducing waste, fraud, and abuse under Medicaid, such as reducing improper payment rates, as measured by annual error rate measurement (PERM) projects;
- Implementation of a medication risk-management program as part of a drug use review program under section 1927(g) of the Act (See enclosure A for a description of what a medication risk-management program means for purposes of this grant program);
- Methods in reducing, in clinically appropriate ways, Medicaid expenditures for covered outpatient drugs, particularly in the categories of greatest drug utilization, by increasing the utilization of generic drugs through the use of education programs and other incentives to promote greater use of generic drugs;
- Methods for improving access to primary and specialty physician care for the uninsured using integrated university based hospital and clinic systems.

**Section 6082 – New Waiver Authority for Alternative Benefits Package**

This section established new waiver authority for demonstration of an alternative benefits package with a high deductible combined with a “Health Opportunity Account” established for individual Medicaid beneficiaries. This new demonstration authority overrides the “statewideness” and comparability requirements of the Medicaid statute.

The demonstration is limited to low-income children and parents in no more than 10 States; participation by the target population must be voluntary. These waivers and the HOA demonstrations move away from a defined Medicaid benefit to a defined contribution model and represent a fundamental policy change. States would set up accounts for individuals to pay for medical services. After the money in the account is

On June 12, 2007, CMS approved the South Carolina’s State Plan Amendment (SPA), the first in the nation to offer beneficiaries the option of enrolling in a High Deductible Health plan.
exhausted, beneficiaries could face additional cost sharing requirements to meet a deductible before they had access to full Medicaid benefits. This section became effective January 1, 2007.

On June 12, 2007, CMS approved the South Carolina’s State Plan Amendment (SPA) the first Demonstration SPA in the nation to offer beneficiaries the option of enrolling in a High Deductible Health plan. The demonstration program provides annual coverage for medical expenses for items and services which would otherwise be provided under Medicaid, after an annual deductible has been met and contributions into a HOA account as defined.

This plan is to be beneficial for Medicaid beneficiaries for the following reasons:

• Enrollment will create patient awareness of the high cost of medical care;
• Provides incentives to seek preventives to seek preventive care services;
• Reduces inappropriate use of health care service;
• Engages in a more proactive role in their health care;
• Provides enrollment counselors and ongoing education activities;
• Provides transactions involving HOAs to be conducted electronically and without cash;
• Allows for continued use of account balance after loss of eligibility; and
• Provides access to negotiated provider payment rates

Enrollment is voluntary and limited generally to Medicaid children and parents. Eligible individuals will be given the opportunity to voluntarily out of traditional Medicaid coverage and into the HOA plan.

The State will deposit $2500 per eligible adult and $1000 per eligible child into the HOA. The maximum yearly deposit amount is $2500 per person. Beneficiaries are subject to a 10% cost sharing obligations while using the HOA. Initial implementation was targeted to 1000 beneficiaries within a certain county.

Section 6086 -- State Option to Provide HCB Waiver Services

The DRA creates a new State option to provide all Home and Community Based (HCB) waiver services without the State needing to apply for a waiver. The HCB waiver services would apply to individuals who need medical assistance and whose income does not exceed 150% of poverty level. This provision does not establish a new eligibility group. The 150% income limit is an eligibility requirement which must be met in addition to meeting the requirements of some eligibility groups covered under the State Plan.

If the State decides to establish new eligibility criteria in the future, HCBS waiver beneficiaries who do not meet the new criteria would have grandfathering protection, but for as little as one year from the date the beneficiary first received the service.

The DRA requires States to capture enrollment, maintain waiting lists and offer the option without providing services statewide. Since the services will be State Plan option services, rather than waiver services, the Federal government will no longer have a role in periodically approving these services. States do have to submit quarterly reports every three years, similar to annual 1915(c) waiver report.

The SPA option removes the requirement that an individual must meet the institutional level of need criteria to receive HCB services. Instead, States are required to set needs based criteria for home and community-based State Plan Amendment services. They are also required to set more stringent criteria for institutional services (hospital, ICF-MR and nursing home) than for the
SPA services. This requirement may be met by raising the institutional level of need criteria and retaining (or lowering) the community level of need; or by keeping the current institutional level of care and lowering the community level of need criteria. The criteria for institutional and HCB services requires an assessment of the individual’s support needs, and may take into account the individual’s inability to perform two or more activities of daily living (ADLs) (i.e. bathing, dressing, eating, transferring, toileting and continence), or the need for significant assistance to perform ADLs and other risk factors as the State may determine. Another section of the DRA says that States shall use the two ADLs criteria.

While the new State Plan Amendment option does not replace the section 1915(c) waiver authority, which remains available to States, it does differ from the waiver authority in a number of ways, such as not requiring budget neutrality. There is no requirement that eligible beneficiaries require an institutional level of care. It is unclear whether the States’ new authority to establish cost-sharing for services will also apply to these non-institutional long term services and supports. States can only cover statutory 1915(c) waiver services in this option, which does include some traditional waiver services such as adaptive equipment or home modifications.

**Under this option, the DRA does not allow States to target groups of beneficiaries such as aged or disabled or individuals with traumatic brain injury.** All Medicaid beneficiaries who meet the level of need criteria for the SPA option must be served within limits. States may be able to indirectly target a specific group of individuals by carefully designing the benefits that are covered. If a State wanted to serve individuals with traumatic brain injury, they might limit the SPA option benefit to rehabilitation or cognitive therapies and define the services in such a way that only someone with a traumatic brain injury would use it. However, if a State tried to limit who will be served in this way, it may affect eligibility for others who receive HCB waiver services. That is, if the State would implement more stringent level of need criteria for the waiver, even if it limits the service(s) covered under the State plan, it would appear that the more stringent criteria would have to apply to all waiver beneficiaries.

It has been noted that his State flexibility provision establishes a new precedent in the basic Medicaid program. It maintains the States’ entitlement for Federal reimbursement for allowed expenditures, while, at the same time, it eliminates the individual’s entitlement to services. This provision was effective January 1, 2007.

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**Beneficiaries receiving services under Section 6086 will not have an entitlement to services because the law will allow the States to cap the number of people receiving services, maintain waiting lists and offer services in limited areas of the State. Advocates are concerned that the State flexibility provisions of Section 6086 might undermine grassroots advocacy efforts to move people out of institutions in compliance with the U.S. Supreme Court’s decision in *Olmstead*, which required that waiting lists at least move at a reasonable pace. Advocates are also concerned that States might move to cap the number of beneficiaries and maintain waiting lists for services now covered under the state Medicaid plan, such as personal care services and rehabilitation services, by moving them into the new home- and community-based services option.**

In addition, as a result of the States’ new authority to establish cost-sharing for services, cost sharing may also apply to non-institutional long term services and supports.

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**Section 6087 -- Self-Directed Personal Assistance Services (Cash and Counseling)**
Section 6087 establishes a new State option for self-directed personal assistance services (PAS), also known as “cash and counseling.” This provision requires that self-directed PAS be provided based on a written plan of care and budget for people who would otherwise be eligible for personal care services under the State’s Medicaid plan or HCBS waiver. The section prohibits use of self-directed personal services for beneficiaries who live in homes or property owned, operated or controlled by a service provider. Individuals using this new option are allowed to hire, fire, supervise, and manage the people providing the services and, if the State allows, may use family members to provide the services. The provision does not require comparability or “statewideness”. States are required to submit quarterly reports every three years, similar to the annual 1915(c) waiver report.

On September 13, 2007, CMS sent a letter to State Medicaid Directors to provide guidance on the implementation of Section 6087 of the DRA. In its letter CMS requires States to assure that necessary safeguards have been taken to protect the health and welfare of Medicaid beneficiaries served under this State plan option and to assure the financial accountability for funds expended for self-directed services. Minimally, CMS requires that participants have sufficient supports available to them to manage their workers and budgets and an individualized backup plan to address critical contingencies or incidents that would pose a risk of harm to the participant’s health or welfare.

CMS also requires that States perform an evaluation of the need for personal care under the State plan or a section 1915(c) Home and Community-Based Services waiver. Individuals who are interested in the self-directed State plan option must be appropriately counseled and informed of the option and feasible alternatives to the self-directed PAS State plan option, prior to enrollment.

The CMS further requires that States provide a support system to individuals prior to enrollment, and, as requested, throughout the period of an individual’s enrollment, or when the State has determined that the individual is not effectively managing their services identified in their service plans or budgets. The support system is intended to inform, counsel, train, and assist participants with their employer-related responsibilities, including managing their workers and budgets and performing their fiscal and tax responsibilities. Individuals have discretion whether and to what extent they will avail themselves of these supports, although individuals not participating in the cash option will be utilizing financial management services.

States must submit an annual report to CMS reflecting the number of individuals served under the State plan option and total expenditures on their behalf. States also are required to conduct an evaluation every three years of the overall impact of the self-directed State plan option on participants’ health and welfare as compared to non-participants. CMS has not yet defined the requirements of the evaluation, but will issue further guidance and offer technical assistance on a case-by-case basis to States that submit a State plan amendment for this option.

Previously, States could provide self-directed personal assistance through:

1. a SPA to add some limited self-direction under the traditional personal care services optional benefit,
2. a Section 1915 (c) HCBS waiver, or
3. a Section 1115 Demonstration Program.

On May 24, 2007, CMS announced that Alabama is the first
State to receive Federal approval to allow self-directed personal assistance services (PAS) as a feature of its Medicaid plan, eliminating the need for repeated requests for time-limited section 1115 demonstration programs or section 1915(c) waiver programs.

Other DRA Provisions

Extension of Funding for Operations of State High Risk Health Insurance Pool Funding (Public Law No: 109-172)
The DRA extends the funding and authorizes Public Law No: 109-172 to help fund existing qualified State high risk pools and grants to assist States to create and initially fund qualified high risk pools.

Public Law No: 109-172 -- Section 2745
This section establishes: (1) seed grants to States for the creation and initial operation of a qualified high-risk pool for those States that do not have one, (2) grants to States to reimburse them for a percentage of losses incurred based on a methodology that allocates funding by 40% among all States, 30% to States based on their number of uninsured residents and 30% based on the number of people in State risk pools operating as an existing qualified high-risk pools during specified years and (3) bonus grants for supplemental consumer benefits.

Thirty-five States operate high risk pools. These programs target individuals who can not otherwise obtain or afford health insurance in the private market primarily due to pre-existing health conditions and are at risk for being uninsured. In general, high risk pools are operated through State established non-profit organizations, many who contract with private insurance companies to collect premiums and administer benefits and pay claims. As of September 30, 2005, and as part of the original appropriation, 26 States have received more than $80 million in Federal funding for seed grants and to offset High Risk Pool losses.

Supplemental Security Income (SSI)

Section 7501 -- Review of State Agency Blindness and Disability Determinations
Section 7501 requires the Social Security Administration (SSA), before payments begin, to review eligibility decisions for people age 18 or older made by the State disability determination agencies in order to ensure that the individuals are, in fact, eligible for SSI benefits. Known as “pre-effectuation reviews,” these reviews are already conducted for people in the Old Age, Survivors, and Disability Insurance Program (OASDI) and for SSI beneficiaries who also receive OASDI benefits.

The provision establishes that the SSA Commissioner will review 20 percent of all disability decisions in Fiscal Year 2006, 40 percent of decisions in fiscal year 2007 and at least 50 percent of all decisions in Fiscal Year 2008 or later.

Section 7502 -- Payment of Certain Lump Sum Benefits in Installments Under the SSI Program
Section 7502 changes the law regarding payment of retroactive benefits owed to SSI beneficiaries by the Social Security Administration. The provision requires that, when more than three months of benefits (formerly 12 months of benefits) are due, the payment must be made in installments. The first payment will be for no more than three months of the maximum Federal SSI benefit. Six months later, the second payment will be for no more than three months of the
maximum Federal SSI benefit. Six months after the second payment, the final payment would include all remaining amounts due.

This section became effective May 8, 2006.

**Temporary Assistance For Needy Families (TANF)**

Reauthorization of the TANF program was included in the Deficit Reduction Act of 2005. TANF was originally enacted in 1996 to provide low-income families with assistance to move from welfare to work. TANF recipients are required, with few exceptions, to find employment or lose their TANF benefits and generally may receive benefits for only five years.

TANF reauthorization provisions included in the Act make the following changes to current law:

- Extends the block grant through 2010.
- Provides $200 million in new child care funding, subject to a State match, which is far less than the estimated need or what was proposed in previous TANF legislation. No new TANF funding is provided.
- Revises the caseload reduction credit so that the credit is applied to caseload decline after 2005. In 2007, a State will have to have 50 percent of all families participating in prescribed work activities. According to the Congressional Research Service, 47 States fall short of meeting a 50 percent participation rate, and 16 of those States have rates below 25 percent. (The current credit has been helpful in providing States flexibility in assisting people with disabilities – this will disappear.)
- Work participation rates would apply to separate State programs. Separate State programs are often used to assist two-parent families, some families with disabilities, and some families in which the parent is in college.
- While the provisions in the budget reconciliation act do not change the work hours requirements and other key aspects of current law, they direct the Secretary of HHS to issue regulations (for the first time) that address the following:
  - When an activity can count as one of the Federally listed work activities;
  - Uniform methods for reporting participation hours;
  - Documentation needed to verify reported hours; and
  - Circumstances under which a parent who resides with a child receiving assistance should be included in the work participation rates.
- HHS can impose significant penalties on States that do not develop State procedures to ensure consistency with the new regulations.

The DRA required States to implement certain work requirements effective October 1, 2006, among which were including families with an adult receiving assistance in a separate State program funded with qualified State maintenance-of-effort expenditures (SSP-MOE) in the work participation rates and revising the base year of the caseload reduction credit from FY 1995 to FY 2005.

On February 5, 2008, the Administration for Children and Families (ACF) published final rules for implementing these provisions. On June 29, 2006, the ACF published an interim final rule implementing the required statutory changes with a 60-day comment period that ended on August 28, 2006.

The final rule includes a number of important changes. These include:
• Allowing time spent in a bachelor's degree program to count as vocational educational training;
• Allowing up to an hour of unsupervised homework time for each hour of class time in all educational activities;
• Expanding State flexibility by converting the six-week limit on job search and job readiness assistance to an hourly equivalent;
• Adding the flexibility for a State to exclude a parent who is a recipient of Social Security Disability Insurance (SSDI) benefits from the definition of a work-eligible individual, as is the case with a recipient of Supplemental Security Income (SSI);
• Clarifying that excused holidays are limited to 10 days in a year; and
• Enhancing State flexibility by allowing a State to account for "excused hours" rather than an "excused day."

V. Trends

States are continuing to look at ways to increase cost savings and slowing the growth in Medicaid spending. The DRA provides, and subsequent rules and regulations, opportunities for States to redesign their Medicaid programs with less oversight. Several States have already submitted State Plan Amendments to create “benchmark plans” that allow them to shape Medicaid into a program that looks more like private insurance.

In general, States are looking to cover more children, cover more uninsured, using employee sponsored insurance (partnership between employer sponsored insurance and the State), improving quality, promoting health and focusing on prevention, disease prevention and management (obesity, diabetes, asthma, heart disease). Other trends and initiatives relate to increased care coordination, integration of services, universal health care coverage, health assessments and improved behavioral health services.

VI. Summary: Pointers for Advocates

In general TBI Advisory Councils, lead agencies and advocates need to be informed of any proposed changes in their States’ Medicaid programs that will affect health, medical, rehabilitation, long-term care and community supports and services for individuals with traumatic brain injury. As these proposals will affect individuals with other disabilities, other disability organizations and advisory councils will also be monitoring and advocating for proposals to not diminish resources, but rather to improve and expand benefits. TBI Advisory Councils and advocates may find it beneficial to work with these other coalitions or groups, such as the Developmental Disabilities Councils, Governors Council on Disabilities, Assistive Technology Advisory Councils/Projects, State Association on Mental Illness, UCP, ARC, State Protection & Advocacy Systems, and so forth.

If your State is considering health reform, or other innovations in Medicaid, what should you think about? (CMS Website)

Populations Covered
Which populations will be offered the benchmark plan benefit package by the State?

• Can the State require mandatory enrollment for these populations, or must it be a voluntary opt-in due to their eligibility category?
• How will the State inform voluntary opt-in populations of their options, including a comparison to the benefits under the traditional State plan?

Benefits
• What benefits will the State offer under the new benefit packages?
• Which benchmark or benchmark equivalent plan will the State provide?
• Will the State provide wrap-around benefits in addition to the benchmark or benchmark equivalent plan?
• Will State legislative changes to the Medicaid program be necessary to implement the new benefit packages?

The following are tips that have been “borrowed” or modified, from Advocacy Tips for Responding to the Deficit Reduction Act of 2005, prepared by the National Health Law Program for the Training and Advocacy Support Center of the National Disability Rights Network:

✓ Monitor State Plan Amendments. Most of the DRA changes can be implemented through State Plan Amendments, which do not require consumer input.

✓ Provide information to policy makers on the available research that shows that cost-sharing deters low income people from obtaining necessary health care. The cost-sharing provision is targeted at beneficiaries, rather than to the managed care companies and/or physicians who follow procedures to control prescribing practices. Research has demonstrated that low-income individuals who are required to pay for health care generally do not seek health care.

✓ Monitor how your State defines “family income” for cost-sharing/premium purposes, including disregards. States may select its own definition of “family income” for these purposes. Advocate for maximization of what can be disregarded.

✓ Monitor how the State implements the provision that allows health care providers to deny care, items and services to individual Medicaid beneficiaries, especially with regard to pharmacy services. A State can decide to cut beneficiaries off of Medicaid for failing to pay a premium (if it has been unpaid for at least 60 days) and may waive the premium in a case of “undue hardship,” a phrase not defined in the statute. Advocate for States not to take advantage of this; but if they choose to do so, to use a low threshold for “undue hardship.”

✓ Advocates should ask the State to clarify in its State Plan Amendment that “equally effective” be the standard used for special prescription drugs and that the State will not require prior authorization. The special prescription drug provisions do not require the drug to be the “least costly, equally effective” drug.

✓ Advocates should encourage States to clearly incorporate existing Emergency Medical Treatment and Active Labor Act (EMTALA) screening requirements into any State Plan Amendment relating to emergency room (ER) co-payments. EMTALA requires each Medicare participating hospital with an ER to provide an appropriate medical screening examination for any individual who comes to the ER and requests treatment or examination for a medical condition. EMTALA prohibits hospitals from delaying the screening to inquire about the individual’s method of payment or insurance status – which conflicts with the DRA.
Advocates should make sure that the distribution of benefits using cost sharing does not become attached to the perceived worthiness of the beneficiary involved. By eliminating the comparability requirement, the DRA allows States to carve up Medicaid populations into segments and either impose or exempt these segments from cost sharing.

Advocates should pay close attention to any plan a State has for offering and implementing the “benchmark” options in Section 6044. Although many currently eligible Medicaid recipients with disabilities are exempt from mandatory participation, many individuals with disabilities are eligible for Medicaid under more than one category (i.e. disability, age, income).

Advocates should make sure that States exercising DRA benefit flexibility use systems that do not confuse or disrupt patient care. Information explaining options to individuals must be clearly stated.

Advocates should monitor the limits placed on benefits, including scope of benefits and the delivery system being considered (e.g. managed care, fee-for-service, vouchers).

Monitor how the citizenship documentation requirements impact citizens with disabilities losing Medicaid eligibility or not seeking it in the first place. Advocates should also inform individuals of these requirements and assist them when possible. In instances of emergency or critical medical services the immediate lack of documentation does not prohibit a person from being eligible for the Medicaid program, but the lack of paperwork results in the State being ineligible for Federal financial participation.

With regard to the Family Opportunity Act (FOA) provisions children already may be eligible for Medicaid under other Medicaid categories. For children qualifying for FOA coordination will be essential and may also be complicated (i.e. FOA, private employer’s health care plan, benchmark plan and wrap around benefits). Make sure that these potential gaps or problems in service coordination are addressed.

With regard to Home and Community Based Services (HCBS) Options advocates should monitor and be prepared to respond to Centers for Medicare and Medicaid Services (CMS) draft regulations when they are published.

If States are undertaking the HCBS options (e.g. Money Follows the Person, Waivers), advocates should recommend that there be legislative or other consumer oversight with regard to eligibility criteria, statewideness and benefit services including optional services, such as rehabilitative services. Eligibility criteria should be broad enough to include individuals with cognitive, neurological and mental disabilities.

Work to ensure that the State does not terminate important optional Medicaid services, such as rehabilitation services, or offer them only to persons qualifying under the HCBS option where the number of individuals receiving services may be capped.

Monitor and track any adverse effect of changes on benefits for individuals with traumatic brain injury. These situations should be shared with policy makers (i.e. Medicaid agency, Governor and State legislatures).

References

“A View from the States”, A PowerPoint Presentation by Nancy Atkins and Martha Roherty, National Association of State Medicaid Directors, during the NASMD Fall 2006 Meeting, November 14, 2006.


R. Mollica, Budget Deficit Reduction Act: Home and Community-Based Services State Plan Option, Fact Sheet, National Academy for State Health Policy for the Community Living Exchange, Rutgers Center for State Health Policy, April 2006.

National Council for Community Behavioral Healthcare Website: http://www.nccbh.org/.


R. Rudowitz and A. Schneider, The Nuts and Bolts of Making Medicaid Policy Changes: An Overview and a Look at the Deficit Reduction Act. This brief was prepared by the Kaiser Commission on Medicaid and the Uninsured and Andy Schneider of Medicaid Policy, LLC. August 2006.

J. Solomon, New Medicaid Rules Would Limit Care for Children in Foster Care and People with Disabilities in Ways Congress Did Not Intend, Center on Budget and Policy Priorities.

A. Sommers and M. Cohen (Urban Institute) and M. O’Malley (Kaiser Commission on Medicaid and Uninsured), Medicaid’s Long-Term Care Beneficiaries: An Analysis of Spending Patterns,


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