I. Introduction

On February 8, 2006, President George W. Bush signed the Deficit Reduction Act (DRA), which contains several new provisions offering States flexibility with regard to their Medicaid benefits. These new provisions may result in States implementing changes that affect the types of services covered and cost-sharing with respect to particular services. The DRA also redefines targeted case management services and makes significant changes in prescription drug payment policies, long-term service reforms and citizenship documentation requirements. In addition, the Act authorizes the granting of waivers to enable States to fund health opportunity accounts in place of standard Medicaid benefits packages for certain populations. These new provisions may significantly impact Medicaid benefits available to individuals with traumatic brain injury. Some States are already proposing to incorporate their TBI Medicaid Home and Community-Based Waivers into larger waivers or as a part of their overall benefit plan.

The purpose of these DRA provisions is to reduce Federal spending overall. The Congressional Budget Office (CBO) estimates that the Medicaid provisions of the DRA will reduce Federal spending by $6.9 billion over the next five years, with new spending for the State Children’s Health Insurance Program (SCHIP) and Hurricane Katrina health care relief leading to a net Medicaid spending reduction of $4.7 billion.

The DRA contains 39 sections changing a wide range of Federal Medicaid policies and procedures. As of August 1, 2006, the Centers for Medicare and Medicaid Services (CMS) had issued only one DRA-related regulation, an interim final regulation for the documentation of citizenship provisions which was released on July 6, 2006. CMS has announced its intention to implement ten sections of the DRA through notice of proposed rulemaking and two by interim final regulation. CMS has also issued letters to State Medicaid directors addressing various changes.

Some of these new provisions can be implemented through amendments to the State Medicaid Plan while other provisions require waivers from the U.S. Department of Health and Human Services. In many States, the Governor, the State Legislature, or both, will be designing the new Medicaid benefits package. Therefore, this paper is designed to highlight the major provisions that TBI advocates and State administrators should be aware of in order for proposed State Medicaid Plans and waivers accommodate the needs of individuals with traumatic brain injury. These issues may also need to be readdressed by Congress should these policies be a detriment to individuals with disabilities, including traumatic brain injury.
II. Background
Medicaid is a Federal/State entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. The 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, prior to the DRA, the law mandated that certain services (i.e. emergency room, in-patient hospital care, in-home services, nursing home services, Early and Periodic Diagnosis & Treatment – EPSDT -- for children under 21) be provided and that certain individuals be covered for services. The States have had the flexibility to provide optional services (i.e. rehabilitative services, therapies, in-home care, ICF-MR, personal care, dental services, durable medical equipment, non-emergency transportation and visual care) in addition to these mandated benefits. States offering these benefits were required to offer these services statewide.

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, etc.). In general, to change its Medicaid program a State must either amend its State Medicaid Plan or obtain a waiver of requirements set forth in Title XIX of the Social Security Act from the U.S. Secretary of the Department of the Health and Human Services (DHHS). 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 to CMS for review and approval.

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 Waivers.

Under the Home and Community-Based (HCB) 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 HCB waiver program and can restrict services to one
area or portion of the State. Waiver services do not have to meet the “statewideness”
requirement.

A number of States administer TBI HCB waivers. In Massachusetts the State is pursing an 1115
waiver to combine the ABI/TBI HCB 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.

Medicaid pays for 40% of all long-term care services that are provided and almost half of all
nursing home care. A new 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).

III. DRA Provisions

Medicaid Policy Process
The DRA contains a number of changes in the Medicaid policy process. The DRA allows States
to implement some policies that would have required a waiver from the Secretary before the
passage of the DRA, such as limiting Medicaid benefits for certain populations or expand home
and community based services through the State Plan Amendment process instead of using a
waiver. The ability for States to file State Plan Amendments for home and community-based
services will be effective in January 2007. The DRA also creates two new waiver authorities for
the Secretary 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 with or without formal or informal guidance.

Proposed Regulatory Changes – Rehabilitation Services Option
The CMS is considering 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 a number of vulnerable groups including 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 current provision allowing 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 a State also provides to non-Medicaid-eligible individuals free of charge.

The Administration had proposed very similar changes changes to Medicaid coverage for Targeted Case Management Services (TCM), however Congress adopted a significantly revised set of changes to TCM in the DRA as described in this paper.

DHHS has also proposed a new policy regarding Medicaid reimbursement to school systems for related services provided to special education students who are Medicaid eligible. CMS is trying to eliminate school-based administrative and transportation claiming through the issue of regulations.

**DRA Benefit, Eligibility and Program Changes**

**Section 6011 -- Extending Look-Back Period for Transferring Assets**
The new provisions extend the “look-back” period from three years (previous law) to five years and change 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.

The new 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 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 will be 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 is 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 would establish a Medicaid Integrity Program in which the U.S. Secretary of the DHHS contracts 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 is 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. Section 6037 became effective for eligibility determinations made on or after July 1, 2006. It requires the HHS Secretary to develop an outreach plan to educate individuals who are likely to be affected by these provisions.

Three States (California, Ohio, and the District of Columbia) initially refused to implement the DRA’s citizenship documentation requirements on the Federally mandated date of July 1. The reasons included that the implementation date provided inadequate time to develop plans for
counties, print new guidelines, train workers and warn beneficiaries of the new requirement, especially since the CMS did not release any guidelines on the requirement until June 9.

In September 2006, Federal Judge Ronald Guzman issued an interim ruling in regards to Plaintiffs’ motion for a preliminary injunction in the nationwide class action lawsuit, Bell v. Leavitt, filed June 28th against Mike Leavitt, Secretary of the U.S. DHHS. Guzman ruled that he would likely order an injunction exempting 500,000 kids in foster care from the new Medicaid regulation requiring recipients to show proof of citizenship.

As the result of a study on the State of New York’s experience, the Kaiser Commission found that Congress should:

1. Execute a technical amendment to Section 6037(a)(2) of the DRA exempting citizens who are beneficiaries of Medicare and SSI from documenting citizenship in Medicaid.

2. The final regulations implementing the Medicaid citizenship documentation requirement should incorporate the following recommendations:

   • Provide States with discretion to broaden the list of public benefit programs whose beneficiaries are exempt from the DRA’s citizenship verification requirements to include at least TANF and Title IV-E beneficiaries.

   • Exempt newborn infants born to women who are Medicaid beneficiaries from documenting citizenship in Medicaid.

   • Expand the list of acceptable citizenship documents to include additional documents accepted in New York and other States that require citizenship documentation.

   • Give States flexibility and discretion in implementing the DRA requirements by eliminating or simplifying the “tiered” approach to citizenship documentation.

   • Eliminate the requirement that States accept only original documents or copies certified by the issuing agency as satisfactory forms of citizenship documentation and allow states to conduct data matches to verify citizenship.

   • Clarify that States are obligated to provide Medicaid applicants and beneficiaries with assistance in obtaining the documents necessary to prove citizenship.

   • Allocate targeted funds to States for outreach, education and application assistance activities related to DRA implementation.

   • Delay implementation of the DRA citizenship documentation requirement.

   • Provide States with adequate time for implementation of the DRA to ensure seamless transition to the new citizenship documentation rules with minimal disruption of program administration or access to Medicaid coverage for eligible citizens.
Section 6041 -- State Option for Alternative Medicaid Premiums and Cost Sharing

Section 6041 creates 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 U.S. Secretary of the DHHS 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 is March 31, 2006.

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 drugs 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.

The effective date for this provision is March 31, 2006.

Section 6043 -- Emergency Room Co-payments for Non-Emergency Care
This section creates 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 becomes effective on January 1, 2007.

This section conflicts with the Emergency Medical Treatment and Active Labor Act (EMTALA), which is a non-discrimination statute that requires each Medicare participating hospital with an emergency room 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.

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. States can obtain an amendment to their State Plan to shift people into what is called “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 “bench-mark 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 or other specialized services to other groups of beneficiaries on a voluntary basis.

This provision is effective March 31, 2006.

As of August 1, 2006, CMS has approved “benchmark” benefits State Plan Amendments submitted by Idaho, Kentucky, and West Virginia. Kentucky’s new plan, “KyHealth Choices,” 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 will be included in KyHealth Choices. The plan also includes 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.

Of concern to some disability advocates is that Kentucky’s plan could put many individuals at
risk of losing coverage for needed services, as some of the benefit packages cover fewer
services than traditional Medicaid benefits.

Idaho’s new plan similarly provides varying benefit packages for different subpopulations. The
Basic plan covers healthy children and adults. It 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, will receive coverage
through the Enhanced Plan. This plan covers all traditional Medicaid services, including long-
term care. Elderly Medicaid beneficiaries who are also enrolled in Medicare (dual eligibles) will
receive Medicaid coverage through the Coordinated Plan. The Coordinated Plan includes all
services covered by traditional Medicaid. Enrollment in the Basic, Enhanced and Coordinated
Plans is voluntary. Individuals may choose to opt out of the new plans and return to traditional
Medicaid coverage at any time. Idaho’s plan also includes a program allowing the working
individuals with disabilities to buy into the most basic of the new benefit packages. Other
changes include streamlining enrollment for Medicaid and State Children’s Health Insurance
Program (SCHIP), as well as using SCHIP dollars to help schools provide preventive health
services to low-income children.

The purpose of this proposal is to modernize the Medicaid program to foster a greater focus on
program quality. Idaho proposes to achieve improved Medicaid quality by identifying and sorting
Medicaid populations according to their identified needs. Accordingly, Idaho Medicaid also
proposes to restructure the program by creating Medicaid eligibility categories based on health
needs. Using needs rather than complex Federal requirements as the basis for eligibility will
have multiple positive effects on Medicaid operations. In the near term, Idaho Medicaid
proposes to form three distinct populations of eligible individuals: 1) Low-Income Children and
Working-Age Adults, 2) Individuals with Disabilities or Special Health Needs, and 3) Elders via
three separate State plans.

**Idaho’s Traumatic Brain Injury Medicaid Waiver** was due for renewal September 30, 2006,
and the decision was made to collapse this waiver under the existing Aged/Disabled
Waiver and still 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. Idaho’s
Traumatic Brain Injury Advisory Council provided written comments concerning these proposed
changes.

West Virginia’s new Medicaid coverage consists of two tiers of services. The basic level
includes fewer benefits than the State’s Medicaid program currently provides. The basic level
limits children to four prescription drugs per month and places new limits on dental, hearing and
vision services. In addition, the basic plan eliminates coverage for skilled nursing care, orthotics,
prosthetics, tobacco cessation programs, nutrition education, diabetes care and essential
mental health and substance abuse services for children.
The enhanced level provides coverage for services limited or eliminated in the basic level plan. However, children are only eligible for enhanced level coverage if their parents sign a “Medicaid Member Agreement.” This agreement requires beneficiaries to promise not to miss medical appointments, to always follow doctors’ advice, and to only use the emergency room for emergencies. The plan returns children whose parents do not follow their member agreements to the basic level of services. Families may re-apply for enhanced coverage after 12 months or when renewing Medicaid coverage.

West Virginia’s new plan was approved with no public comment in only eight days by CMS. The legality of the West Virginia plan is also questionable. Federal law requires that all States provide Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services to children in their Medicaid programs. Although the West Virginia plan claims to include EPSDT, the State changed its definition of the services to exclude follow-up diagnostic and treatment services. West Virginia offered this plan initially in three counties before expanding statewide.

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. 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. The new definition applies in all cases.

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.

Of particular concern is whether this language would be interpreted to supersede the section of current Medicaid law (Section 1903c of the Social Security Act) that authorizes payment for services in a child’s individualized education program (IEP) under the Individuals with Disabilities Education Act (IDEA). If Medicaid does not pay for such services when a child is Medicaid-eligible, it is highly unlikely that schools will include the services in the child’s IEP. Specific language exempts some other Federal programs (e.g. for HIV) from this third-party liability. However, no explicit exemption is included for IDEA students. (taken from the Brazelton Law Center for Mental Illness website)
Section 6071 -- Money Follows the Person Rebalancing Demonstration

Section 6071 authorizes the U.S. Secretary of the DHHS 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 12 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.

In FY 2003, CMS awarded $6.5 million in grants to nine States to improve their long-term care systems by implementing Money Follows the Person (MFP) initiatives. Receiving grants were California, Idaho, Maine, Michigan, Nevada, Pennsylvania, Texas, Washington and Wisconsin. The nine MFP Grantees’ initiatives included a wide range of activities (i.e. identifying barriers, developing legislation, developing reimbursement methodologies, and so forth).

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.

Maine, as a part of its grant, proposed to develop assessment instruments to identify individuals with traumatic brain injury in facilities who might be able to live independently. The State also had as its goal to create a trust fund for persons with traumatic brain injury.

Six MFP grantees have passed legislation to develop MFP mechanisms for the transfer of funds between institutional and HCBS budgets -- MD, NM, ND, TX, UT and WI. As of May 2006, only two of the nine MFP Grantees – TX and WI – had enacted legislation authorizing the transfer of funds across State budget categories. Of the States that did not receive MFP grants, West Virginia considered legislation in the 2006 legislative session, but the bill did not pass.

(Real Choice Systems Change Grant Program: Money Follows the Person Initiatives of the Systems Change, US DDHS, CMS, July 2006.)
injury to fund the provision of information and referral to light case management services.

The State also worked to redirect resources for persons with brain injury toward more person-centered and consumer-driven services. The State awarded pilot grants to two nonprofit organizations. One organization is developing new less-restrictive housing options, such as supported housing for individuals with brain injury, who are currently living in residential facilities. The other organization is developing assessment instruments and tools to identify individuals with traumatic brain injury who live in a facility who might be able to live independently. The State is piloting the assessment instrument in one facility with 30 residents. The State plans to transition six to eight individuals to pilot housing programs.

Under the DRA, appropriations are made for grants beginning on January 1, 2007 through September 30, 2011, as follows:

- $250 million for January 1 through September 30, 2007 of fiscal year 2007;
- $300 million for fiscal year 2008;
- $350 million for fiscal year 2009;
- $400 million for fiscal year 2010; and
- $450 million for fiscal year 2011.

Amounts unspent remain available for awarding of grants to States not later than September 30, 2011.

In the report to CMS on the MFP Grants authors noted several problems for States to implement MFP to expand home and community-based services. (Real Choice Systems Change Grant Program: Money Follows the Person Initiatives of the Systems Change, US DHHS, CMS, July 2006). These problems noted are:

- The use of separate line-item budgets to pay for institutional services and home and community services.
- The longstanding policy of tying funding to providers and service settings rather than to consumers.
- The excess demand for nursing home care and the resulting high occupancy rates.

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 DHHS is authorized during the period from FY 2007 through FY 2011 to conduct demonstration projects in up to 10 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 becomes effective for items and services provided on or after January 1, 2007. The section applies to children under age 19 and is to be phased in, beginning with the youngest children, as follows:

- Beginning on January 1, 2007, through September 30, 2007 (the last three quarters of fiscal year 2007) – children born on or after January 1, 2001;
- Fiscal year 2008 – children born on or after October 1, 1995; and

The State may choose to phase in coverage more quickly in Fiscal Years 2007 and 2008.

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.

Funds available for the Centers are as follows:
- $3 million for fiscal year 2007;
• $4 million for fiscal year 2008; and
• $5 million for fiscal year 2009.

The funds remain available until expended.

**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 becomes effective on February 8, 2007.

**Section 6081 -- Medicaid Transformation Grants**

The DRA provides new opportunities for States to work with the Federal Government to build on the effective reforms to slow spending growth, while providing needed coverage, and doing more to help people get the kind of care they prefer. 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.

States will receive $150 million over 2007 and 2008 to fund research and design of ways to transform their Medicaid systems and to increase the quality and efficiency of care. There is no requirement for State matching funds for a State to receive payments under this subsection.

South Carolina submitted for Federal review a concept paper entitled “South Carolina Healthy Connections Medicaid Transformation Plan.” The State has been in discussion with the CMS for some time about the possibility of making changes to its Medicaid program -- originally through a Section 1115 waiver and, more recently, through a State Plan Amendment change authorized

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As part of a mandate initiative by Congress to reduce inappropriate payments, CMS has published its final rule on Medicaid/SCHIP payment error rate measurement. It represents a significant expansion of Federal oversight of day-to-day State Medicaid operations, Medicaid providers and Medicaid managed care organizations.

The Medicaid Payment Error Rate Measurement (PERM) initiative means that every State will undergoing a detailed examination of paid claims, capitation payments, reimbursement and premium policies, coding and so forth. States must turn over vast amounts of data every quarter, including information on rates, policies, and claims processing edits and audits.

CMS will hire a series of new contractors to examine all this, run samples, and identify errors. CMS will then set maximum acceptable error rates (based on what it or its contractors determine is an "error") and, then, a State must take corrective action. These corrective actions could include recovering payments, changing reimbursement policies and revising claims processing requirements.

States will rotate, with each State going through the entire process every three years. The States selected for the first round (FY 2006) are Pennsylvania, Ohio, Illinois, Michigan, Missouri, Minnesota, Arkansas, Connecticut, New Mexico, Virginia, Wisconsin, Oklahoma, North Dakota, Wyoming, Kansas, Idaho and Delaware.


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Section 6082 – New Waiver Authority for Alternative Benefits Package

This section establishes 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 exhausted, beneficiaries could face additional cost sharing requirements to meet a deductible before they had access to full Medicaid benefits.

A demonstration State would contribute funds (up to $2,500 per adult, $1,000 per child) to a beneficiary’s HOA that the beneficiary could use to meet the high deductible (which could not exceed 110% of the amount contributed by the State) and other health care costs specified by the State. Under the demonstration, Federal Medicaid matching funds would be available for the
State contribution to the HOAs as well as for the costs of the high-deductible alternative benefits package. Participating States are not required to demonstrate budget neutrality.

The Medicaid benefits could be limited from current law or face additional cost sharing as permitted by other sections of DRA. These accounts are similar to Health Savings Accounts (HSAs) and proposals that several States have included in their 1115 Waiver plans.

**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 quality 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) (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 not include some traditional waiver services such as adaptive equipment or home modifications.

Since the level of need criteria for institutional services must be more restrictive, the DRA allows individuals in institutions or individuals who receive waiver services and no longer meet the new institutional criteria to continue to receive services until they leave the institution or the waiver or they no longer require the level of care prior to the change. The more stringent institutional level of need criteria apply to individuals entering an institution or enrolling in a waiver program after the effective date of the State Plan Amendment.

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 limit. 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 is effective January 1, 2007.

| 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. |

Section 6087 -- Self-Directed Personal Assistance Services (Cash and Counseling)
Section 6087 establishes a new State option for self-directed personal assistance services, also known as “cash and counseling.” This provision requires that self-directed personal assistance services 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 home- and
community-based waiver services. 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 quality reports every three years, similar to the annual 1915(c) waiver report.

Nearly half of the States (22) have or are actively planning programs for the frail elderly using this model. Ten states have active programs or pilot programs. Thirteen States have active programs or are planning programs that incorporate some degree of participant direction, but do not include the frail elderly. Some of these States have programs that allow individual budgets for other populations, most often only for personal care services. Two States, Connecticut and Louisiana, expressed the intent to extend existing individual budget programs for their MR/DD (mental retardation/developmental disabilities) population to include the elderly.

Arkansas, Florida, New Jersey and New York initially received Cash and Counseling Demonstration Grants supported by the Robert Wood Johnson Foundation, the U.S. Department of Health and Human Services and the Administration on Aging (AoA). The Cash and Counseling Demonstration was designed to compare outcomes of traditional agency-directed care with care that is directed by the recipient -- especially to determine whether satisfaction increased and health and safety were maintained. In all four states, both older (aged 65 and above) and younger adults (aged 18 to 64) with disabilities were targeted to participate. In addition, in Florida targeted children with disabilities and their parents.

Alabama, Iowa, Kentucky, Michigan, Minnesota, New Mexico, Pennsylvania, Rhode Island, Vermont, Washington, and West Virginia have more recently been awarded three-year grants to implement the Cash & Counseling model. Additionally, Illinois has been funded by the Retirement Research Foundation to implement its own C&C program.

Both Minnesota and New Mexico created ambitious plans using innovative practices to expand significantly beyond the basic Cash & Counseling model. These two states were awarded an additional $100,000 to implement these innovations.

Section 6201-6203: Katrina Relief
Sections 6201-6203 provide $2.9 billion in funds for Hurricane Katrina-related Medicaid waivers for use by the Secretary of Health and Human Services. These funds are to pay eligible States for the non-Federal share of expenditures for health care for Katrina evacuees. Funding is also provided for high-risk pools that States operate for Katrina evacuees who cannot otherwise obtain health insurance.

Eligible States are defined as those that have provided care to affected individuals or evacuees under a Section 1115 waiver. Funds are designated to cover the non-Federal share of expenditures for health care provided to affected individuals (those who reside in a major disaster area declared as a result of Hurricane Katrina and continue to reside in the same State) and evacuees (affected individuals who have been displaced to another State) under approved multi-State Section 1115 demonstration projects. Funds may also be used for administrative costs related to such projects, as well as the non-Federal share of expenditures for medical care provided to individuals under existing Medicaid and SCHIP State plans. They may be used for other purposes, if approved by the Secretary, to restore access to health care in affected communities. The non-Federal share paid to eligible States will not be considered Federal funds for purposes of Medicaid matching requirements.
No payment obligations may be incurred under these provisions for regular health care provided as Medicaid or SCHIP medical assistance after June 30, 2006, or for uncompensated care after January 31, 2006.

The Katrina demonstration programs build upon existing Medicaid/State Children’s Health Insurance Program (SCHIP) eligibility and other program rules. Approved waivers allow for Host States to provide the Medicaid/SCHIP benefit package within their own State and provide comprehensive State Plan services to evacuees.

CMS has approved Hurricane Katrina Multi-State Section 1115 Demonstrations for Alabama, Arkansas, District of Columbia, Florida, Georgia, Idaho, Mississippi, Puerto Rico, Tennessee, Texas, Indiana, South Carolina, Louisiana, Maryland, Nevada, Ohio, and California.

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. The bill also authorizes appropriations of $75 million for each year FY 2007 through 2010.

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.

While a large number of families have moved from welfare to work, the Government Accountability Office (GAO) has determined that approximately 44 percent of TANF recipients' still receiving benefits have a disability or are caring for a child or adult relative with a disability. Thus, a large proportion of TANF recipients with disabilities have major barriers to employment and are struggling to obtain employment before their TANF benefits run out.

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 Act established June 30, 2006, as the deadline for the Secretary of DHHS to release regulations.

The TANF provisions jeopardize progress some States have made in ensuring these families are accessing the services and supports they require to achieve greater self-sufficiency. These provisions include increased work participation rates, subjecting State maintenance of effort dollars to Federal TANF work requirements, and developing a standardized set of approved work activities, without ensuring States have the flexibility to meet the needs of families that include a person with a disability.

Unless HHS regulations allow States to continue to have the much-needed flexibility and will receive credit for their efforts to assist parents with disabilities and parents caring for a child with a disability, many people with disabilities will be unable to meet the required number of work hours nor will they benefit from a standardized set of work participation activities. In all likelihood, as happened in the past, these families will face sanctions for failing to comply with requirements they cannot meet.

IV. Trends

States are continuing to look at ways to increase cost savings and slowing the growth in Medicaid spending. The DRA provides opportunities for States to redesign their Medicaid programs with less oversight. Three 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 (ID, KY, WV). Sixteen other States are under discussion to revamp their benefit programs similarly. Three States are looking to revamp their waiver programs: Florida, Massachusetts and Vermont.

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.

Several States had health-related ballot initiatives in November. In Missouri, Constitutional Amendment 3 was placed on the ballot to raise the State cigarette tax for additional annual revenue to increase reimbursement rates for health care providers who treat Medicaid beneficiaries and uninsured residents. The measure failed. In Oregon, a ballot initiative passed to expand the State’s prescription drug discount program to cover all State residents who do not currently have drug coverage.

V. 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 others with disabilities, other organizations and advisory councils will also be monitoring and advocating for proposals to not diminish resources, but rather 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.

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 oversite 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).

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This DRA Policy Update was prepared for NASHIA members by Susan L. Vaughn, Director of Public Policy, on behalf of the NASHIA Public Policy Committee, chaired by Debra S. Kamen.