The Deficit Reduction Act:
Important Facts for State Government Officials

The Deficit Reduction Act (DRA) provides States with much of the flexibility they have been seeking over the years to make significant reforms to their Medicaid Programs. States may use these new opportunities in combination with other options under the Medicaid Program, State Children's Health Insurance Program (SCHIP) and other programs as a strategy to align the Medicaid Program with today's health care environment. States can expand access to affordable mainstream coverage, promote personal responsibility for health and accessing health care, and improve quality and coordination of care. The DRA provides flexibilities that States can use to pursue innovative ideas in health care—like consumer-directed healthcare and rebalancing long-term care.

This publication contains brief descriptions and a checklist for many of the provisions contained in the DRA. The publication will help State government officials in implementing the DRA. For more information, see **www.cms.hhs.gov/deficitreductionact** on the web.

NEW OPTIONS FOR BENEFIT PACKAGES

Under section 6044, the DRA provides States with the flexibility to change their Medicaid benefit packages to mirror certain commercial insurance packages through the use of benchmark plans. States may use this authority to leverage employer-sponsored coverage of Medicaid beneficiaries. While only certain groups of beneficiaries may be mandated into a benchmark benefit plan, States may also use this flexibility to provide tailored benefits to meet the special health needs of other groups of beneficiaries on a voluntary basis. Within these packages, States have the option to amend their State Medicaid Plan to provide State flexibility in benefit packages without regard to traditional requirements such as statewideness, comparability, freedom of choice, or certain other traditional Medicaid requirements.

NEW OPTIONS FOR PREMIUM & COST SHARING

Sections 6041 and 6042 of the DRA allow States to vary the premiums and cost-sharing that they charge to certain Medicaid recipients. No premiums are permitted for families with income above 100 percent and at/or below 150 percent of the Federal Poverty Limit (FPL). Cost-sharing up to 10 percent of the cost of services is permitted within this group. Above 150 percent of the FPL, premiums are permitted and cost-sharing up to 20 percent of the cost of services is allowed. No premiums or cost-sharing are permitted for families with incomes below 100 percent of the FPL. The DRA contains special rules on cost-sharing for prescription drugs and non-emergency care provided in emergency rooms (ER).

In addition, States have the option to require payment of alternative premiums as a condition of eligibility and alternative cost-sharing as a condition of receipt of the service or drug, or cost-sharing for non-emergency services in the ER. The DRA provides that the aggregate premium and/or cost-sharing amounts must not exceed 5 percent of the family's income for all family members for the month or quarter period. As part of the ER provision, the DRA sets up a grant program that provides $50 million in funding over four years for States to establish non-emergency alternate providers.

REBALANCING LONG TERM CARE

Money Follows the Person (MFP)

This demonstration, established by section 6071 of the DRA, supports State efforts to "rebalance" their long-term care (LTC) support systems by offering $1.75 billion over five years in competitive grants to States. Under this DRA provision, States are able to make targeted reforms to strengthen the community-based infrastructure so that individuals have a choice of where they live and receive services. These grants encourage States to adopt a strategic approach to improving quality in both home and community-based services and institutional settings as the State designs and implement its rebalancing initiative. In July 2006, CMS solicited proposals from States to participate in the Money Follows the Person Rebalancing Demonstration (MFP Demo). The grant proposals were due November 1, 2006, and are currently being evaluated by CMS. Monitor the CMS website at **www.cms.hhs.gov/newfreedominitiative** for updates on the grant awards.

Long Term Care (LTC) Partnership

The LTC partnership is a unique program combining private LTC insurance and special access to Medicaid. The partnership helps individuals financially prepare for the possibility of needing nursing home care, home-based care or assisted living services sometime in the future. The program allows individuals to protect some or all of their assets and still qualify for Medicaid if their LTC needs extend beyond the period covered by their private insurance policy. Section 6021 of the DRA allows for Qualified State Long-Term Care Partnerships. States with approved State Plan Amendments (SPAs) also exclude from estate recovery the amount of LTC benefits paid under a qualified LTC insurance policy.

Transfer of Assets

The cost of LTC continues to increase, making such services difficult to afford for most individuals, and inaccessible for many. The Medicaid Program provides coverage of LTC services for individuals who are unable to afford this care. Some individuals, with assistance from financial planners and attorneys, have developed methods of arranging assets in such a way that they are not countable when Medicaid eligibility is determined, and are thus preserved for the individual and/or family members. Various techniques are used to artificially impoverish Medicaid applicants, including gifting of assets to family members, investing assets in financial instruments that are inaccessible, and executing financial transactions for which fair market value are not actually received to get LTC coverage through Medicaid. Sections 6011 through 6016 of the DRA include several provisions designed to discourage the use of such "Medicaid planning" techniques and to impose penalties on transactions which are intended to protect wealth while enabling access to public benefits.

DOCUMENTATION OF CITIZENSHIP

Section 6036 of the DRA requires States to obtain satisfactory documentary evidence of an applicant's or recipient's citizenship and identity in order to receive Federal Financial Participation (FFP). Effective July 1, 2006, individuals must provide satisfactory documentary evidence of citizenship and identity when initially applying for Medicaid or upon a recipient's first Medicaid re-determination. The statute and interim final regulation provide States with guidance on acceptable documentary evidence, including alternative forms not explicitly named in statute. The statute and regulation also give States guidance on the processes that may be used to minimize the administrative burden on States, applicants, and recipients. CMS encourages States to utilize automated matching systems to verify citizenship and identity in order to satisfy these requirements.

CONSUMER DIRECTED HEALTHCARE

Health Opportunity Accounts

Section 6082 of the DRA allows for ten States to operate Medicaid demonstration programs to test alternative systems to deliver Medicaid benefits through a Health Opportunity Account (HOA) in combination with a high deductible health plan (HDHP). The demonstrations will provide States with the option of allowing individuals to assume greater responsibility for their own care by enrolling in flexible consumer-based accounts. Recipients are given the tools to take a greater role and responsibility in their health care. States can adjust contributions to the accounts based on the expected health needs of recipients, to ensure that the HOA program works well both for healthier recipients and those with chronic illnesses.

PURSUING PAYMENTS FROM THIRD PARTIES

Federal law generally requires health insurers and other third parties with payment liability for health care services received by Medicaid recipients to pay for such services primary to Medicaid. However, Medicaid agencies often pay claims for which a third party may be liable because they lack information about the existence of other coverage. Section 6035 of the DRA made several changes to the third party liability provisions of the Medicaid statute which are designed to enhance States' ability to identify, and to recover payment from, third parties that are legally required to pay primary to Medicaid. Specifically, section 6035 of the DRA (1) clarified the specific entities that are considered "third parties" and "health insurers" that may be liable for payment and cannot discriminate against individuals on the basis of Medicaid eligibility; and (2) required that States pass laws requiring health insurers (a) to provide the state with eligibility and coverage information needed by the State to identify potentially liable third parties; (b) to honor the assignment to the state of the Medicaid recipient's right to payment by such insurers for health care items or services; and (c) not to deny such assignment or refuse to pay claims by Medicaid based on procedural reasons. The third party liability provisions of the DRA were effective January 1, 2006, except where States are required to pass laws in order to comply with the DRA. Some States may already have the requisite laws. As a practical matter, legislatures in States without the necessary laws should pass legislation during the current or next legislative session.

FIGHTING MEDICAID FRAUD AND ABUSE

Fraud and abuse in the Medicaid Program divert dollars that could otherwise be spent to safeguard the health and welfare of beneficiaries. The DRA included three provisions that target Medicaid program integrity and fraud and abuse.

Section 6032 requires any entity that receives or makes payments to the State Medicaid Program of at least $5,000,000 annually, to provide Federal False Claims Act education to their employees. The CMS Medicaid Integrity Program (MIP) was established by section 6034 of the Deficit Reduction Act and provides more resources for CMS to fight Medicaid fraud, waste, and abuse. Funding levels for the MIP will rise from $5 million in start-up funding in fiscal year (FY) 2006, to $50 million in each of FY 2007 and 2008 and $75 million in FY 2009 and each year thereafter.

Section 6031 of the DRA creates cash incentives for State fraud and abuse laws. If a State enacts a False Claims Act that is closely modeled on the federal version of the law, the Federal Government will increase the state share of amounts recovered under that False Claims Act by 10 percentage points.

HOME & COMMUNITY BASED SERVICES

The Home and Community-Based Services (HCBS) waiver program in particular is a viable option for States to use to provide integrated community-based long-term care services and supports to qualified Medicaid eligible recipients. States can provide individualized, person-centered care through this model of care. As a result of the passage of the DRA, States can now amend their State plans to offer HCBS as a State plan optional benefit. This benefit allows States to provide most of the services now covered under HCBS waivers, with the exception of the services categorized as "other services." States have advocated for the ability to provide HCBS services without needing to go through the waiver process for years. Now, the new DRA option breaks the "eligibility link" between HCBS and institutional care.