



State Medicaid Policy Choices Under the Deficit Reduction Act Provisions Affecting Children and Adults with Mental Disorders

Background: The Deficit Reduction Act

The Deficit Reduction Act of 2005 (DRA), signed into law in February 2006, set the stage for some of the most significant changes to Medicaid since the program's inception in 1965. It amended a number of other federal programs and aimed to achieve savings of nearly \$100 billion for the federal government over a 10-year period, netting an estimated \$28 billion or more from adjustments to Medicaid.

Some of the DRA changes to Medicaid involve across-the-board revisions, requiring all states to comply with new federal rules. Some will affect people with mental illnesses. These include a tightening of rules on Targeted Case Management and the requirement that individuals prove their citizenship status.

However, many other provisions of the DRA create new options for states, allowing them greater flexibility in the design of their programs. These include options to:

- create different benefit packages for different groups of Medicaid beneficiaries;
- increase cost-sharing;
- institute initiatives or policies intended to encourage healthy behavior;
- create home- and community-based services for people with disabilities through a state plan amendment, and
- allow certain families of children with disabilities to buy into Medicaid.

Finally, the DRA includes authority for the federal government to promote demonstration initiatives. Important demonstrations for people with mental disorders are the Home and Community-Based Alternatives to Psychiatric Residential Treatment Facilities for Children and the Money Follows the Person Rebalancing Initiative. The first expands services for children in or at risk of placement in residential treatment facilities; the second provides incentives to states to move people out of institutions and into the community with appropriate supports and services.

This report and the accompanying tables summarize ways in which states have responded to the new flexibility provided by the DRA. It does not address the provisions of the law that give states no options. Each section of the report summarizes the law¹ and then describes how states have implemented it as of December 31, 2007. Further details on state policies are provided in the tables.

Overview of State Implementation of the DRA

Two provisions in the DRA that might limit access to mental health services for those in need are 1) the authority for states to create benchmark plans with different (and lesser) benefits than traditional Medicaid and 2) the provisions that allow increases in cost-sharing for Medicaid benefits.

Generally, states have not rushed to take up these options. Eight states have created benchmark plans, but some of these are very limited in reach. Only four states have created significant benchmark plans limiting access to traditional Medicaid services for some populations. Three states have picked up the option to increase cost-sharing requirements, primarily as part of the creation of a benchmark plan, and three others have increased cost-sharing for expansion populations.

Four states have adopted policies that are intended to encourage healthy behavior among Medicaid beneficiaries. In one state, individuals may lose access to benefits for failure to adhere to these new requirements.

States have been quite responsive to the opportunities to create new demonstration programs under Medicaid. There are now 10 state demonstrations of home- and community-based services for children at risk of placement in a psychiatric residential treatment facility and 31 Money Follows the Person demonstrations, 13 of which include people with mental illnesses.

Few states, however, have opted to expand home- and community-based services through the Family Opportunity Act, the new state plan option. Two states are using the Family Opportunity Act to cover more children with disabilities under Medicaid.

Only one state has so far received approval for a state plan amendment to offer home- and community-based services, although other states have either begun negotiations or are working on the application.

The following summary describes how the states have implemented the DRA options as of January 2008 and how this may affect people with mental health care needs.

Benchmark Medicaid Plans

Federal Law

Section 6044 of the DRA makes a radical change to how Medicaid operates, eliminating the principles of statewide coverage and identical benefit packages for all individuals covered in a state's plan.

The DRA allows states to modify the Medicaid benefit package for some beneficiaries. States may amend their state plan to shift some groups of individuals into what is called "benchmark coverage" or "benchmark-equivalent coverage." This coverage parallels the coverage authorized under the State Children's Health Insurance Program (SCHIP). There are some restrictions on which groups of Medicaid-eligible individuals can be required to enroll in these more limited benchmark plans.

The health care plans that states may use as benchmarks for the new, more limited Medicaid coverage are:

- the standard Blue Cross/Blue Shield preferred-provider plan under FEHBP, the federal employees health benefits plan;
- a state employee plan;
- the HMO plan in the state that has the largest non-Medicaid enrollment; or
- a benchmark-equivalent plan with coverage approved by the Secretary.

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 statute sets forth a standard to determine the actuarial value. For mental health services and prescription drugs (as well as vision and hearing services), the benchmark-equivalent coverage need be at least 75% of the actuarial value of the benchmark plan.

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.

States have the option to provide additional benefits as "wraparound" coverage to any of the beneficiaries who are moved into benchmark plans. They must provide wraparound coverage to children under age 19 in order to ensure that children still have access to the Early and Periodic Screening, Diagnosis and Treatment services (EPSDT) as defined in existing Medicaid law. This means these children must continue to receive any medically necessary Medicaid-covered service, whether or not that service is covered or defined in the state Medicaid plan.

The DRA leaves the EPSDT mandate intact for children who are not enrolled in benchmark plans. Although there is no specific requirement for EPSDT wraparound benefits for youngsters over age 19, the EPSDT mandate in the law is not repealed and would appear still to apply to those individuals.

States are limited as to whom they may require to enroll in these new plans. The following populations may *not* be compelled to enroll in a benchmark plan:

- pregnant women with mandatory eligibility for Medicaid;
- blind or disabled adults and children (including those on SSI or SSDI);
- medically needy individuals;
- dually eligible (Medicaid and Medicare) people;
- institutionalized individuals and those qualifying for long-term care services;
- hospice patients and people with terminal illnesses;
- medically frail people and those who have special medical needs;
- children in foster care who are receiving services under Title IV-B of the Social Security Act and children receiving foster care or adoption assistance under Title IV-E;
- TEFRA children (also known as Katie Becket option); and
- individuals who qualify for Medicaid on the basis of receiving TANF in states that link Medicaid eligibility to TANF eligibility.

Generally, this leaves low-income, relatively healthy adults and children as the groups that may be required to enroll in these alternative plans.

In addition, states cannot now create new eligibility categories and put those people into benchmark plans. Only people who meet the state's eligibility standards in place prior to enactment of the DRA may be included on a mandatory basis.

According to CMS policy, states may also offer (but not mandate) benchmark coverage to any group of Medicaid-eligibles (including those exempted from the mandatory coverage), provided they have the Secretary's approval to do this through Medicaid's waiver authority. CMS guidance on this question is contained in a letter to state Medicaid directors.² This letter emphasizes that states:

...must inform the individuals that such enrollment is voluntary and that such individuals may opt out of such alternative benefit package at any time and regain immediate eligibility for the regular Medicaid program under the State plan. The State must inform the individual of the benefits available under the alternative benefit package and provide a comparison of how they differ from the benefits available under the regular Medicaid program.

State Implementation

Prior to enactment of the DRA in October of 2005, CMS approved an 1115 waiver submitted by Florida that presaged the passage of Section 6044 of the DRA. In fact,

Florida was cited during debate on the DRA as an example of how a state might wish to change its Medicaid program. Although not resulting from enactment of the DRA, the Florida waiver is sufficiently similar to make it a useful study. This waiver allows mandatory enrollment of certain groups of Medicaid-eligible individuals (children, parents, those on Supplementary Security Income but not Medicare, and pregnant women) in a participating managed care organization (MCO). The state provides a defined contribution to each beneficiary by paying a risk-adjusted premium based on an individual risk score. Individuals use this to purchase health care from one of the participating MCOs. If they wish, beneficiaries may opt out of Medicaid altogether and use their premiums to purchase individual or employer-sponsored private coverage.

The benefit rules in the waiver are similar to those in the DRA benchmark provision. Each plan must offer all of the mandatory Medicaid services, but may choose which optional services to provide. Plans also have the flexibility to determine the amount, duration and scope of the benefits. The only requirement is that the benefit package of each plan must be actuarially equivalent to Florida's current Medicaid package for the average member of the target population. Additionally, plans must cover 45 days of inpatient hospital care, EPSDT for children and all medically necessary care for pregnant women.

Florida also sets annual maximum benefit limits for adults. Once adult beneficiaries (except pregnant women) reach this limit, there is no further Medicaid coverage and individuals must cover the costs of their own care. Co-payments for adults may also be increased under this waiver, although they must remain nominal.

Florida's waiver also offers "Enhanced Benefit Accounts" for beneficiaries who participate in state-defined healthy activities. Money in these accounts may be used for cost-sharing, medical expenses not covered by the MCO and "extras" such as weight-loss programs. Individuals who lose their Medicaid eligibility but whose income remains below 200% of federal poverty can maintain their access to these accounts for three years after losing Medicaid eligibility.

Evaluations of the Florida Medicaid waiver have identified some problems. For example, the HMO benefit packages became less generous in the second year and co-payments increased as well. Beneficiaries reported problems in getting access to medications, and this was seen to be the most serious problem facing people with disabilities.³ Provider participation in Medicaid also appears to be declining.⁴ In an attempt to protect themselves from these adverse effects, people with disabilities were more likely to sign up with the provider-sponsored networks that are not permitted to limit benefits in the same way as HMOs.⁵

For these and other reasons, Florida has announced that it will not expand this program statewide, although it will continue its initial pilot projects in five counties.

States Using the DRA Option: Overview

As of December 2007, eight states had approved state plan amendments that implement this section of the DRA (see Table 2). Idaho, Kansas, Kentucky, South Carolina, Virginia, Washington, West Virginia and Wisconsin have approved benchmark plans for some (or all) groups of Medicaid beneficiaries. Texas and Missouri have announced plans to create reforms to their Medicaid program which may include benchmark plans.

Of these states, Idaho, Kentucky and West Virginia have made substantial changes to their Medicaid programs. In addition, South Carolina has created significant change for a pilot population in one county. Four of the states used the benchmark-plan option to improve coverage for specific populations: Kansas, Virginia, Washington and Wisconsin. In these states there is no reduction in basic Medicaid.

Mental health coverage in the benchmark plans of the three states with comprehensive changes is limited, emphasizing basic inpatient and outpatient services with limits for most populations, although those with disabilities generally have broader coverage.

Covered Populations

While most states are implementing their new state plan option statewide, West Virginia is phasing in the benchmark plans beginning with a pilot in three counties. Idaho, which has three benchmark plans, is operating two on a statewide basis and the other in 13 counties. Kentucky is offering benchmark-plan services statewide and phasing in a disease-management program in select counties. South Carolina's plans are limited to 1,000 people in one county. Washington is phasing in its program by large groups.

The states have taken very different approaches in terms of the target populations for their benchmark plans. Kentucky and Idaho have targeted the widest group of Medicaid beneficiaries. Kentucky has redesigned its entire Medicaid program so that now all beneficiaries fall into one of four plans: Global Choices, Family Choices, Comprehensive Choices and Optimum Choices. Global Choices is the new name of "regular" Medicaid, and the remaining three plans are all benchmarks intended for different populations. Family Choices is designed for children, while Comprehensive and Optimum Choices are for the elderly and individuals with disabilities.

Idaho has developed three benchmark plans, a basic plan for children and working adults, an enhanced plan for individuals with disabilities and a coordinated plan for dual eligibles.

West Virginia's redesigned Medicaid program, Mountain Health Services, is also broad. It covers healthy adults and children in one of four plans (a basic or enhanced benefit package for both adults and children). The two basic plans cover mandatory services while the enhanced plans also cover some optional services and provide wellness benefits. West Virginia's pilot emphasizes a medical home and uses outreach and other strategies to engage people who fail to show up for appointments.

South Carolina has created two new programs that can enroll up to 1,000 people in one county. Low-income families and children, as well as individuals with disabilities and dual eligibles, can receive coverage based on the state employees' high-deductible health plan. All Medicaid-covered individuals, except those who are dually eligible for Medicare and Medicaid and foster care children, will also be offered the option of setting up a virtual Health Savings Account to use for services in addition to those covered under the state employees' benchmark plan.

Other states have targeted narrower populations for their benchmark plans. Kansas has a benchmark plan that offers Personal Assistance Services (PAS) to individuals eligible for the state's Ticket to Work and Work Incentives Improvement Act (TWWIIA) Medicaid buy-in program. Virginia covers disease-management services for Medicaid beneficiaries with asthma, congestive heart failure, coronary artery disease and diabetes through its newly approved benchmark plan (covered individuals remain eligible for all regular Medicaid services as well). Washington is providing disease-management (on an opt-in basis and in addition to other Medicaid benefits) for categorically needy aged, blind and disabled individuals. These three states have focused on expanding services for small groups without altering the Medicaid program for other beneficiaries.

Wisconsin has also retained Medicaid benefits for all populations while creating two specific plans: a standard plan which provides full Medicaid coverage for certain low-income children and pregnant women and a new benchmark plan for children, pregnant women and families with higher incomes.

Mental Health Benefits

Most states are providing beneficiaries with "Secretary-approved coverage" instead of opting to use an existing benefit package from one of the authorized benchmark plans defined in the law (see summary above). Exceptions are Kentucky and South Carolina, which are using state employee plan coverage for some populations.

Idaho, Kentucky, South Carolina, West Virginia and Wisconsin include mental health benefits in their benchmark plans. The plans in Virginia, Kansas and Washington have not changed mental health coverage, which remains part of the traditional Medicaid program. All states with benchmark plans indicate that children will also have access to EPSDT-mandated services.

Idaho has the most restrictive mental health coverage for children and working-age adults, while providing more generous coverage for adults who are dual-eligibles. Idaho's basic and enhanced plans both cover limited inpatient hospitalization, outpatient psychotherapy, case management, psychological evaluations and clinic services (with slightly higher limits for the enhanced plan). The enhanced plan also includes limited psychiatric rehabilitation, partial hospitalization and psychiatric hospital services for

children. For dual-eligibles, Idaho covers inpatient and outpatient services to the same degree as for physical health care, along with clinic, rehabilitation and crisis support.

Kentucky's plans for low-income children and adults offer inpatient and outpatient services with no limits, but with increased co-payments. No other mental health services are included. The plans for the elderly and people with developmental disabilities who meet institutional level of care criteria provide full Medicaid coverage with the addition of home- and community-based services.

Adults in West Virginia's basic plan have access only to mandatory Medicaid services, but with no inpatient psychiatric care. Children have coverage for limited inpatient and outpatient services. In the enhanced plan, adults have limited inpatient and outpatient mental health benefits, while children have unlimited inpatient and outpatient coverage and full EPSDT services.

In South Carolina, participants in plans based on the state employees' coverage will have access only to inpatient hospital care and outpatient services, although children will have EPSDT "preventive, dental and vision services" as well.

Kansas provides traditional Medicaid state plan services in addition to personal assistance and other independent living services for the state's ticket-to-work buy-in population. There are no specific additional mental health treatment benefits.

The disease-management programs in Virginia and Washington focus on populations with chronic physical health conditions.

Benefits in Wisconsin's plan for higher income groups are similar to those offered under the state employees' HMO plan and include inpatient and outpatient mental health benefits, prescription drug coverage and early childhood development services, as well as EPSDT coverage for children.

Status of "Exempt" Populations

Most of these state plans do not affect populations listed in the law as exempt from inclusion in benchmark plans. However, Kentucky's Comprehensive and Optimum Choices plans and Idaho's Enhanced Plan all cover exempt groups. (Also, Virginia's disease-management program is an opt-out program for those who have the covered chronic illnesses.)

Kentucky and Idaho automatically enroll these individuals, while allowing them to opt out if they believe it is in their best interest. Kentucky sent a letter to its Medicaid members who are eligible for the Comprehensive and Optimum Choices plans, informing them that they had been enrolled in one of the two new benefit packages. The letter went on to say that they could opt out of the plan and enroll in Global Choices but would have to pay higher co-payments. The "Frequently Asked Questions for Participants" section of Idaho's Medicaid website states that applicants will be enrolled

in one of the two plans, depending on their needs, and that current beneficiaries will also be enrolled in one of the new plans at their renewal date and that they “don’t have to do anything.”⁶ However, the participant section of the website only lists the two benchmark plans, so it’s not clear to beneficiaries that regular Medicaid is still an option. To confuse matters more, Idaho recently changed its regular Medicaid plan to mandatory services only.⁷

These two states may be violating the law by not providing full information about their options as required by CMS. Kentucky’s approach penalizes those who choose to opt out by charging them higher co-payments and Idaho’s exempt groups may not even know they can opt out. Furthermore, Kentucky and Idaho appear to have provided insufficient information regarding the differences between regular Medicaid and the benchmark packages to their beneficiaries. By doing so, the states have failed to fulfill a second requirement in the CMS guidance letter for enrolling exempt groups in benchmarks.

EPSDT

States with benchmark plans that include children have to address how EPSDT benefits will be administered, since the law requires that children continue to have access to these services. Most states included only statements of assurance on their state plan applications, without providing details of how they will do this. For example, Kentucky said that “EPSDT services will be provided by the State to insure that the full EPSDT benefit is available when medically necessary.” Some states are more specific. Idaho allows children in the basic plan who develop needs beyond their covered benefits to opt into the enhanced plan. However, any Medicaid-covered service not covered even under the enhanced plan will require pre-authorization and be subject to amount, scope and duration limits set by the state.

West Virginia’s benchmark plans have generated the most questions regarding EPSDT. The principal concern is that there are two different benefit packages for children, distinguished only by the level of services they provide. How can the basic plan, which does not cover certain services, claim to provide all medically necessary benefits? Children in the enhanced plan have a wider range of benefits, but in order to stay in this plan they have to comply with the member agreement. For many of the items on this agreement, such as “I will show up on time when I have appointments,” compliance is out of a child’s control. Despite the obvious complexities of the system, West Virginia has provided assurances that children will have access to EPSDT through their medical home.

Encouraging Healthy Behavior

Florida’s waiver led the way in encouraging certain behavior on the part of Medicaid beneficiaries. Low-income parents, children, the elderly and people with disabilities can earn enhanced benefits for complying with a list of healthy behaviors. Benefits are in the

form of resources (up to \$125 a year) that can be used to purchase health-related products and supplies.

Following Florida's lead, some states have added provisions to some of their benchmark plans that focus on consumer responsibility and preventive services. Only West Virginia requires members to meet behavioral expectations set forth in the member agreement. Individuals who fail to make and keep these agreements lose their access to the enhanced-benefit plan. Beneficiaries who do not adhere to the agreement will be put back in the basic plan, although they can appeal that decision. After 12 months on the basic plan, they can re-sign the member agreement and re-gain the enhanced-benefit package.

The West Virginia member agreement includes 12 requirements such as, "I will do my best to stay healthy," "I will take the medicines my health care provider prescribes for me," and "I will use the hospital emergency room only for emergencies." The medical home established through the West Virginia benchmark plans will, among other things, monitor beneficiaries' compliance with the member agreement.

On a smaller scale, Idaho and Kentucky are also using the new benchmark packages to encourage healthy behavior among Medicaid beneficiaries. Idaho is offering two Preventive Health Assistance (PHA) programs: one focusing on behavior and the other on wellness. The former addresses tobacco cessation and weight management while the latter aims to help keep children up to date with wellness exams and immunizations. Beneficiaries who fulfill their obligations can receive vouchers or coverage for delinquent premiums.

Kentucky rewards participants in one of its new disease-management programs with access to additional benefits—such as \$50 of dental services, \$50 of vision hardware, five nutritionist's visits and smoking-cessation services—if they fulfill screening requirements and maintain participation for a year.

Further Applications Pending

Texas has submitted a proposal for the Texas Health Care Reform program that comprises pilot projects for promoting healthy lifestyles, Health Savings Accounts and a Health Opportunity Trust Fund. Many of the provisions in the Texas proposal will require a waiver (Section 1115), but Texas may also rely on the DRA for some changes. For example, Texas is planning to develop new optional-benefit packages for children with special health care needs and may expand the concept to other Medicaid eligibility groups. The state also plans a program to encourage Medicaid recipients to lead healthy lifestyles, with value-added services and individual health rewards accounts. The DRA authority for higher co-payments for non-emergency use of emergency rooms is one of the changes contemplated.

Missouri is revamping its Medicaid program and is considering a premium offset program, Health Improvement Plans (with a required medical home) and a health assurance program for Ticket to Work recipients.

Impact on People with Mental Health Care Needs

These changes alter the way Medicaid has operated in the past, in that for the first time different groups of eligible beneficiaries in a state can have different service coverage without the state's having to apply for a special waiver. Moreover, the coverage for groups in the benchmark plans can not only be limited in scope (such as limiting mental health coverage to inpatient care and outpatient therapy/medications) but also in duration, with limits imposed on certain services—for example, 20 outpatient mental health visits per year. The DRA cites the need for states to include full access to all Medicaid services for children under age 19, whether or not the service is included in the state plan or the benchmark plan. However, it is silent on those ages 19-22, who are also protected by the EPSDT mandate.

Expanded Access to Home- and Community-Based Services for the Elderly and Disabled

Federal Law

Section 6086 of the DRA creates a new Section 1915(i) in Medicaid law giving states the option to provide home- and community-based services (HCBS) to elderly individuals and people with disabilities as a state plan service. Previously, states had to apply for a waiver and demonstrate cost neutrality before they could include this option under Medicaid.

An important aspect of the state plan option compared with a home- and community-based waiver is that states do not have to demonstrate budget neutrality. It has been nearly impossible for states to secure HCBS waivers for adults age 22-64 with mental illnesses due to the Medicaid rule that prohibits federal financial participation for services provided in Institutions for Mental Diseases (IMDs). States could not show that community care would be budget neutral since IMD expenditures were disallowed.

Unlike a HCBS waiver, this state plan option is also not limited to individuals who are in or at risk of placement in a Medicaid-covered institution. Instead, eligibility will be determined based on need. However, states must apply stricter level-of-care eligibility criteria for admission to an institution than are applied to those seeking home- and community-based services. States can modify these criteria without federal approval if enrollment exceeds projected capacity. States also have the option to have stricter income and resource eligibility rules for home- and community-based services than for institutional services.

States have more flexibility under this option than they do for other state plan services. The DRA allows states to limit the number of people to be served and to maintain

waiting lists for participants. States electing this new option may also chose to provide the services in limited areas of the state without having to meet Medicaid's usual requirement that benefits be available statewide.

The law's financial eligibility criteria for home- and community-based services are more stringent than those that apply to HCBS waivers. Participation is restricted to individuals with incomes at or below 150% of poverty. States that cover medically needy individuals in their state plans, however, may elect to waive rules relating to this group's financial eligibility and instead use institutional eligibility criteria. This means states can cover children in families with incomes over 150% of poverty by disregarding their parents' income.

States must conduct an evaluation to determine eligibility, including an individualized, independent needs assessment. This assessment must be conducted in consultation with the individual, their providers and, if appropriate, the individual's family. Eligibility must be re-determined, at minimum, on an annual basis. Individuals are assessed as to whether they are able to perform activities of daily living (ADLs) and about their needs for significant support in order to perform two or more ADLs. The law, however, does not limit participation to those who cannot perform ADLs.

An individualized written plan of care must be developed, again in consultation with the individual, providers and, if appropriate, the individual's family. States may provide to participants the option of self-directing their services, including the option to have an individual budget. The plan will identify necessary services or, if the individual elects to self-direct, the services that may be purchased. The plan of care must be reviewed at least annually.

Services that may be covered under the state plan option are less extensive than the service array permitted for home- and community-based waivers. Covered services are those specifically authorized in Medicaid law for waivers. (Additional services can be authorized by the Secretary for a HCBS waiver, but not for the state plan option.) This means that states can provide under the state plan option:

- case management;
- home maker/home health aide services;
- personal care services;
- psychosocial rehabilitation;
- home health, private duty nursing;
- adult day care;
- habilitation;
- respite care; and
- day treatment.

Any state waiver under Sections 1915 or 1115 that will cover services for individuals who are going to be covered by the new state plan option must have expired prior to

adoption of the option. States, however, may continue to provide home- and community-based services through existing Medicaid 1915(c) and 1115 waivers. If, in the future, the state elects the state plan option and establishes new eligibility criteria, beneficiaries who now receive services but do not meet the new criteria would be grandfathered into the program.

State Implementation

Overview

To date, only Iowa has an approved state plan amendment under Section 1915(i), approved in April 2007. Iowa sets an important precedent by using this option specifically for individuals with serious mental illnesses.

Eligibility Criteria

Iowa has chosen not to limit service availability geographically and services will be available statewide. However, it has set enrollment caps, which could result in a waiting list for HCBS. The state plans to serve 3,700 people in the first year, with the number of participants increasing to nearly 4,500 in the fifth year.

Financial eligibility is connected to existing Iowa Medicaid eligibility rules. Individuals who qualify for Medicaid because they are medically needy will be eligible to participate.

The needs-based criteria are restrictive so as to limit services to those with histories of serious mental illness. In addition, the functional eligibility criteria are more restrictive than the criteria states generally use for rehabilitation or clinic services. Specifically, the individual must have at least one of two risk factors:

- have undergone more than once (or be currently undergoing) psychiatric treatment more intensive than outpatient care (e.g., emergency services, alternative home care, partial hospitalization or inpatient hospitalization). Individuals currently receiving inpatient hospital services demonstrate this risk factor, but cannot receive 1915(i) HCBS State Plan Services while in the institution. Or
- have a history of psychiatric illness resulting in at least one episode of continuous, professional supportive care other than hospitalization.

Furthermore, the individual must have ongoing needs related to his or her disability. The person must meet at least two of the following five criteria on a “continuing or intermittent basis” for at least two years:

- be unemployed, or employed in a sheltered setting, or have markedly limited skills and a poor work history;
- require financial assistance for out-of-hospital maintenance and be unable to procure this assistance without help;

- show severe inability to establish or maintain a personal social support system;
- require help in basic living skills such as self-care, money management, housekeeping, cooking or medication management, or
- exhibit inappropriate social behavior that results in demand for intervention.

Person-Centered Planning

Although consumer-direction is permitted under the HCBS option of the DRA, Iowa has chosen a provider-managed service delivery method. The service plan will be person-centered. It will be developed by the participant and his/her interdisciplinary team. This team consists of the participant, a legal representative if applicable, the case manager and anyone else, including providers and others the participant would like to have involved. The interdisciplinary team then develops a service plan based on the participant's strengths, needs and goals.

Services Covered

Iowa has elected to offer case management and habilitation as its HCBS state plan services. Habilitation services are divided in four components:

- home-based habilitation, which assists with skills related to living in the community;
- day habilitation, offering support with socialization and adaptive skills in a nonresidential setting;
- pre-vocational habilitation, which helps prepare individuals for employment and supported employment; and
- supported employment habilitation that provides assistance in work settings to help individuals maintain their jobs.

All services must be provided by a specified provider who meets certain qualifications. No payment may be made for any services provided by relatives, legal guardians or legally responsible persons.

Iowa has placed limits on habilitation services for both the categorically and medically needy. Supported employment habilitation services are limited to 40 units of "supports to maintain employment" per week (one unit being equal to one hour).

The state pays for the service components based on units of service. Except for supported employment habilitation services, a unit of service is hourly, half-day or a day. There is an upper limit for these services per hour, per half-day or per day.

Impact on People with Mental Health Care Needs

This new option has great potential to expand the range of services available to adults and children with serious mental disorders under Medicaid. However, the population that could benefit does not include all individuals who may be eligible for Medicaid in a

particular state, due to the tighter income requirements and the provisions that allow states to limit access to a certain geographic area and to cap eligibility based on creation of a certain number of slots.

This service cannot be limited by diagnostic group, however, and states may only have one Section 1915(i) benefit. States that choose to limit the covered services to mental health interventions, as Iowa has done, can control their costs and address the specific needs of individuals who have mental illnesses. Other states may choose to limit services to those benefiting another population group (meaning that people who have mental illnesses will not have access) or to cover all people with disabilities, in which case the state, to control its costs, may limit the covered services or impose a strict cap on the number of people who may participate.

It is too early to know exactly how Section 1915(i) may benefit people with mental illnesses across the country, although a number of states are reportedly considering this option specifically for people with serious mental illnesses.

Opportunity for Families of Children with Disabilities to Purchase Medicaid Coverage for Their Children

Federal Law

Section 6062 of the DRA creates a new state plan eligibility option. It allows states to permit certain families of children with disabilities to buy into their state Medicaid program by paying a premium and meeting cost-sharing requirements.

Section 6062 is entitled the Family Opportunity Act because many of its provisions were first introduced through a separate bill with that title. It is designed to address problems faced by families with incomes above the Medicaid-eligibility level who have children with disabilities for whom they are unable to afford needed health care. Because Medicaid covers a broad array of treatment and rehabilitation services, its coverage is generally more appropriate for children with disabilities than private plans.

States may offer this buy-in option to parents with incomes up to 300% of the federal poverty level (\$61,950 or a family of four). States may then charge these families on a sliding-fee scale. To be eligible, the child must be under age 19 and meet all the eligibility criteria for disability in the SSI program, other than requirements regarding income and resources. This would include children with serious mental disorders if they meet the SSI standard.

States can phase in the program over four years:

- Children 0 to 6 years old can be eligible in 2008.
- Children 7 to 13 years old can be eligible in 2009.
- Children 14 to 18 years old can be eligible in 2010.

States may charge a premium up to the full cost of the coverage, so long as it does not exceed 5% of family income for those with incomes up to 200% of the federal poverty level, or 7.5% of family income for those between 200% and 300% of the poverty level. In cases of undue hardship, states may waive the premium. Also, states are forbidden to terminate a child's Medicaid eligibility based on failure to pay the premium until the failure continues for at least 60 days from the premium's due date.

States may elect to cover children at a faster pace and to cover families with higher incomes. But they must do so only with state funds, with no federal financial participation.

Parents who are offered employer group health insurance (where the employer pays 50% of the total cost of the annual premium) must elect such coverage if they want to participate under this provision. Medicaid then would pay for services that are not covered by the private health plan but are covered under Medicaid. In these cases, a state must reduce its premium by an amount that reasonably reflects the contribution the family has paid for the private coverage. If parents do not have access to employer group health insurance that meets this criterion, then Medicaid would be the primary payer.

State Implementation

Overview

Despite the potential positive impact of the Family Opportunity Act option, to date only two states have submitted state plan amendments to implement this section of the DRA: North Dakota and Louisiana.

North Dakota

In North Dakota, families of children age 18 and under with disabilities whose net income is not over 200% of poverty will be eligible to buy into Medicaid. Their premiums will be set at 5% of the family's net income. The state estimates that premiums will average around \$117 a month. To calculate net income, the state will take into account not only taxes but other relevant expenses such as child care costs. There is no additional cost-sharing (beyond normal Medicaid cost-sharing) for these families. North Dakota does not have any current plan for phasing in additional children in later years.

Louisiana

Louisiana has set a higher income cutoff. Children in families whose net income does not exceed 300% of poverty will be eligible. Their premiums will be \$35 a month if they have no other insurance and \$15 a month if they have some insurance. Louisiana also does not have a specific plan to phase in additional groups of children.

Impact on Families Whose Children Have Mental Health Care Needs

A significant problem in providing services for some children with serious mental disorders has been the family and child's uninsured status or lack of coverage in their private insurance policy for the intensive community services needed. As a result, many parents have found themselves in the tragic situation of choosing between giving up custody of their child to the state (a way to get Medicaid coverage for children when family income exceeds eligibility level) and having the child go without necessary care.

The services these children need are covered under Medicaid and can be offered to children with disabilities through the Family Opportunity Act. This section of the DRA could, therefore, be of enormous importance to families with incomes too high for Medicaid but who have a child with a very serious mental disorder for whom private insurance coverage is woefully inadequate.

However, the option will not have a significant effect across the country until more states choose to implement it. It is hoped that, as time goes by and some states gain experience with the Family Opportunity Act, more states may elect to provide this option.

Demonstration Projects on Home- and Community-Based Alternatives to Psychiatric Residential Treatment Facilities for Children

Federal Law

Section 6063 of the DRA creates a five-year competitive demonstration grant program, starting in FY2007, to allow up to 10 states to test the cost-effectiveness of providing home- and community-based alternatives to psychiatric residential treatment facilities (PRTFs).

The objectives of the demonstration are to:

- test the effectiveness of home- and community-based services in improving or maintaining a child's functional level in the community;
- test the cost-effectiveness of providing coverage of home- and community-based services for children and youth enrolled in the Medicaid program compared to the costs of providing services in a residential program; and
- maintain budget neutrality so that aggregate payments under the demonstration do not exceed the costs estimated to have been incurred had the demonstration not been in place.

The demonstration has been funded, and states will receive a total of \$218 million spread over the five years (\$21 million in 2007; \$37 million in 2008; \$49 million in 2009; \$53 million in 2010, and \$57 million in 2011). Funds will be awarded in two phases: a pre-implementation planning stage and a full implementation stage based on submission of a Section 1915(c) waiver application. Implementation funds will be used

as federal Medicaid matching funds for the approved home- and community-based services.

All demonstration projects funded are subject to the same requirements as existing 1915(c) waivers. That is, they must be budget-neutral, states may limit participation to a specified number of children, services furnished must be those authorized under Section 1915(c), and the regulations and income limits of 1915(c) waivers apply.

To participate, children must require the level of care provided in a PRTF and be under the age of 21. At the end of the demonstration period, a state may continue to receive federal financial participation to continue the home- and community-based services for children already enrolled.

The Secretary will conduct an interim and final evaluation of the demonstration projects and report to Congress and the President. Applicant states must provide evaluations of the project as required by the Secretary.

State Implementation

Overview

The DRA authorized CMS to make 10 awards under this demonstration program. In early 2007, 10 states were selected, based on an initial application. These states were then required to develop and submit a full Section 1915(c) Home and Community-Based Services Waiver application, using the same template as CMS uses for all other such waivers. All but two of these waiver applications (Florida and Georgia) were approved before the end of 2007.

As a result of this design, the demonstration is a full test of the impact (and the costs) of authorizing home- and community-based services in place of psychiatric residential treatment facility services.

The 10 successful states are: Alaska, Florida, Georgia, Indiana, Kansas, Maryland, Mississippi, Montana, South Carolina and Virginia.

Use of PRTFs by States

In their applications, states were asked to provide information about their use of PRTFs including the number of children in PRTFs, the number of children in out-of-state facilities, the number of PRTFs under contract to the state (meeting the demonstration definition of a PRTF), the number of beds in these facilities and the average length of stay. Taken together, the data present a picture of PRTF utilization in the demonstration states.

Five states reported on the number of children in PRTFs prior to the demonstration, ranging from a low of 253 to a high of 2,400. Nine states provided data on the use of

out-of-state facilities, with three having no children placed out-of-state; two having only a very few children out-of-state; three with between 100 and 200 in that situation; and one having an extremely high number of children (749) placed out-of-state.

Generally, states contract with a number of PRTFs. Two states contract with only a small number (three and six respectively), while the rest contract with between 12 and 36. The number of beds per state ranges from a high of 891 to a low of 25, with one outlier state reporting 1,361 beds. Average lengths of stay range from 166 to 365 days, with an average of 264 days or over eight months.

Eligibility

States generally plan to provide home- and community-based services to a significant number of children over the next five years as an alternative to PRTFs, with four states planning to serve over 1,000 children. The state projected to serve the fewest children will provide services to 256. Kansas plans to serve the greatest number of children, with projected enrollment of 3,281. Kansas had previously received a federal home- and community-based waiver to divert children from psychiatric hospital placements and thus was well-positioned to take advantage of a PRTF demonstration.

To be eligible for the demonstration, children in most states need only have a serious emotional disorder and meet criteria for placement in a PRTF. Additional criteria are that the child also have Fetal Alcohol Spectrum Disorder (one state) or have received PRTF services for at least 90 days (one state).

Services

The most frequently cited community services to be furnished under the demonstration include respite care (all states), family services (seven states), wraparound (six states), customized goods and services (five states) and employment related services (six states). Four states include consultative clinical and therapeutic services, skills training (such as for independent living) and transition services.

Three states will offer non-medical transportation, case management, crisis services and mentoring. Habilitation, peer support and personal care services will be offered in very few states.

In addition to direct services, three states included aspects of wraparound (facilitation, child and family teams and flexible funding).

Costs

States reported on their projected spending over five years, which ranged from a high of over \$60 million to a low of less than \$5 million. On average, states planned to spend about \$30 million over the five-year demonstration. Average projected costs per child vary considerably, although five states cluster at average costs close to \$20,000 per

child. On the high end are Alaska and Maryland, spending about \$50,000 per child, while Kansas will spend the least per child at \$8,000.

Financial Eligibility

Although these demonstrations cannot solve that problem for all families, they can be used to expand eligibility for Medicaid home- and community-based services for some children. States have the option (as they do under a home- and community-based waiver) of setting income and resource limits for participating families.

Six states set the financial requirements at a level that is 300 percent of the federal SSI benefit level. One set income requirements below that level and one included medically needy children without a requirement for the family to spend down income in order to qualify. All but three states include in the demonstration children who would be eligible for Medicaid if they were institutionalized (and their parents' income was therefore not considered).

Outcomes Measured

States generally are measuring similar outcomes in terms of the impact of the demonstration upon children and their families. Heading the list are improvements in school-related functioning and avoidance of juvenile justice contacts. Also to be measured in most states are improvements in community living/integration, substance use, mental health clinical status and functioning, as well as satisfaction with the services. Residential placements and family issues will also be tracked.

Less frequently mentioned as specific outcomes being measured are abuse/neglect rates, environmental variables, social support/relationships and access to health and mental health services, although these items have some overlap with the outcomes described above.

One state tracks improved participation in vocational activities; two monitor abuse/neglect and custody rates; and two measure fidelity to the wraparound model.

Impact on Children with Mental Health Care Needs

While states have had authority to create home- and community-based services waivers for children with mental disorders who would otherwise be in a hospital setting, most children with mental health care needs who are in a residential setting are not in a hospital. PRTFs are widely used by state Medicaid programs to provide institutional care to these children. The failure of Medicaid law to recognize PRTFs as institutions for purposes of budget-neutrality calculations under HCBS waivers has been a major impediment to providing access to these services for children.

The demonstration project will test the feasibility and the cost-neutrality of HCBS waivers for children who would otherwise be in a Medicaid-covered PRTF. Congress

enacted the demonstration in order to assess whether or not a permanent change should be made to Medicaid law to permit such waivers. The fact that the demonstration will be evaluated yearly, and the results made available to the public and Congress, may encourage Congress to address this issue earlier than 2013, when the demonstration officially ends. This would greatly benefit children with mental health care needs.

Money Follows the Person Rebalancing Demonstrations

Federal Law

Section 6071 of the DRA authorizes CMS to award competitive grants to states, totaling \$1.5 billion over five years, to help them develop Money Follows the Person programs. These programs enable Medicaid recipients who are elderly or who have disabilities to transfer from institutions to home- and community-based long-term care. States can target these initiatives to certain groups and limit the number of participants.

The goal of the program is to eliminate barriers (in state law, state Medicaid plans, state budgets or otherwise) that prevent or restrict the flexible use of Medicaid funds so as to enable individuals to receive appropriate long-term care services in the setting of their choice. The demonstration project has four objectives:

- Rebalancing—to increase the utilization of home- and community-based services in place of institutional care;
- Money Follows the Person—to eliminate barriers that prevent Medicaid recipients from using Medicaid funds for long-term care services in the setting of their choice;
- Continuity of Service—to ensure that individuals who are moving from an institution to a HCBS system have needed services; and
- Quality assurance and quality improvement—to see that procedures are in place to assess quality and promote quality improvement in home- and community-based services.

To participate, individuals must be residing in a qualified institution and continue to need the level of care provided in the institution. Qualified institutions include hospitals, nursing homes and ICF-MRs. Institutions for mental diseases can also be qualified institutions, but only if services in the institution are covered under the state Medicaid plan. This allows participation by individuals who are over age 64 and are in psychiatric hospitals where the state has covered these institutions in its state Medicaid plan.

Individuals participating in the demonstration program must do so voluntarily. Individual assessments of need and personal preference are conducted, and individualized service plans are developed through a person-centered planning process. Service plans may include self-directed services and an individualized budget under the control of the individual.

Participants are able to choose a qualified residence in the community. The state must continue to furnish home- and community-based services to any individual who participates in the demonstration program for as long as the person qualifies under the state's rules for home- and community-based services.

To apply for funds, states must:

- Assure a public development process.
- Operate the project in conjunction with a qualified home- and community-based care program.
- Assure continuity of the individual's Medicaid coverage for home- and community-based care;
- Specify the period for running the program, with a minimum requirement of two consecutive fiscal years.
- Describe the method for calculating individual budgets.
- Demonstrate how it will rebalance its spending so as to increase the percentage of long-term care expenditures used for home- and community-based services.
- Demonstrate how it will eliminate barriers, including costs of transition to the community, so that money can follow the person.

Priority in the award of these grants will be given to states that cover multiple target groups and that give individuals the opportunity to self-direct services.

States will receive an enhanced Medicaid match for one year for certain services provided to individuals in the program who move from institutional to community care. After the first year, the match returns to its normal level.

HHS must report to the President and Congress on its findings and conclusions regarding the effectiveness of the program.

State Implementation

Overview

There are two phases to MFP demonstration applications: application for a pre-implementation stage of one-year and submission of an operational protocol, which must be approved before states can fully implement their programs.

A total of 30 states and the District of Columbia have received awards from CMS for a pre-implementation stage of Money Follows the Person (MFP). The first round of grants, awarded in January 2007, went to 17 states,⁸ and the second round to another 13 states and the District of Columbia.⁹ The awards totaled \$14.4 million and were to assist 37,731 people making the transition to community living. Thirteen of the states are specifically including people with mental illnesses in their demonstrations (See Table 5).

Some states are already approved for their operational protocols. Wisconsin and New Hampshire were approved in October. Other states with pre-implementation awards are expected to receive approval for their operational protocols soon.

Eligibility

In the program announcement issued by CMS, states were given flexibility to determine the length of time a participant would need to have resided in an institutional setting prior to the demonstration. The minimum requirements for eligibility could be set between six months and two years. The states serving people with mental illnesses have almost uniformly set their minimum residency requirement at six months, thus broadening the eligible population. The exception to this is DC, where eligibility factors do not include a residency requirement.

The other elements of eligibility (namely, being eligible and receiving Medicaid benefits and requiring an inpatient level of care) were specified in the program announcement and therefore do not vary between states.

There is a very wide range in the size of the group of people with mental illnesses that states are planning to include in these demonstrations, from seven (Arkansas) to 735 (Illinois). The overall average group size for the population of people with mental illnesses is 205.

Services

States generally include services previously covered under their 1915(c) home- and community-based waivers for the MFP demonstration participants. These services include housing, employment, and benefits-coordination assistance, as well as a range of supports for independent community living. In a number of states, respite care, peer support, habilitation and specific mental health services (see below) are also covered. For example, North Carolina includes assistance with housing, medical equipment, adaptive aids and technology, consumer-managed personal care, independent-living training, case management, counseling, transportation, caregiver supports, assistance with one-time transition costs, crisis services, disability self-management, residential supports, peer counseling and peer advocacy, respite, supported employment, and independent-living assessment and training.

Sixteen states have not added any supplemental services to their MFP programs.¹⁰ Instead, the services offered to their demonstration populations will be only those offered under their home- and community-based waiver program or state plan services.¹¹

Mental Health Services

Although a substantial number of states (13) are including people with mental illnesses in their target populations, few include mental health services beyond their regular

Medicaid program benefits and/or home- and community-based waiver services. However, many of the services covered by the state plans or waivers are relevant for people with mental illnesses.

Those that add specific additional mental health services as part of the MFP demonstration are Delaware, Georgia, North Carolina, Ohio, Pennsylvania and Texas.

Delaware will provide pre-vocational training, community transition, day treatment and other mental health services to demonstration participants. Georgia will include mental health services, such as specialized geriatric mental health, dual diagnosis crisis management, sustaining behavioral supports and training for family caregivers. Ohio will provide social work and counseling to each of its targeted populations. Pennsylvania offers “one-to-one behavioral health supports” for participants with mental illnesses. These supports include symptom management, skill development and assistance in accessing resources. Texas offers cognitive-adaptive training, motivational interviewing and outpatient substance abuse treatment. North Carolina focuses on children’s services, such as therapeutic foster care and wraparound services.

Two states have, or will, include mental health services in new waivers. New York will offer Positive Behavioral Interventions and Supports (PBIS) as part of a new Nursing Home Transition and Diversion Waiver. Through two 1915(c) waivers (Community Integration Program and Community Options Program Waiver), Wisconsin already offers counseling and therapeutic resources. This service is also offered as part of a managed long-term care program. Furthermore, both the managed long-term care program and the state plan include mental health crisis stabilization, outpatient mental health services, mental health day treatment and in-home psychotherapy.

There is an advantage for consumers when states offer the mental health services through a waiver or as part of their regular Medicaid state plan program. These services will endure. The special services offered as part of the MFP demonstration are only guaranteed to be provided for 12 months.

Impact on People with Mental Health Care Needs

This demonstration will clearly affect individuals with mental illnesses who are transitioning out of institutions because 13 out of 31 demonstration states are specifically targeting this group. However, the demonstration does not provide a significant incentive beyond the first year of community placement because the enhanced federal match only applies for a year. While the demonstration states clearly have a significant interest in money following people from institutions to community (as indicated by their applying for these funds), it is not certain that other states will similarly consider such policies should the law be amended to make the rules of this demonstration permanent. One year of enhanced match may be a weak incentive, unless the demonstration clearly shows the community services to be less expensive than the institutional care they replace.

DRA Cost-Sharing Changes

Federal Law

Three sections of the DRA (Section 6041: State Option for Alternative Medicaid Premiums and Cost-Sharing, Section 6042: Special Rules for Cost-Sharing for Prescription Drugs and Section 6043: Emergency Room Co-Payments for Non-Emergency Care), as well as Section 405(a)(1) of the Tax Relief and Health Care Act of 2006, give states new authority to impose new cost-sharing requirements. These sections of law amend Section 1916A of the Medicaid statute with respect to premium and cost-sharing requirements.

Section 6041 gives states authority to impose premiums (including an enrollment fee or similar charge), deductibles and co-payments for services to groups of Medicaid-eligible individuals. Moreover, for the first time, Medicaid beneficiaries can be denied coverage for failure to pay their premiums within 60 days and denied services if they fail to make co-payments, including being unable to fill a prescription if they do not meet the cost-sharing requirements.

Section 6042 authorizes states to impose higher cost-sharing for some Medicaid-covered non-preferred drugs. States can waive these higher cost-sharing requirements when a physician determines that the preferred drug is not effective for the individual or causes adverse effects.

Section 6043 authorizes states to permit hospitals to charge individuals for non-emergency use of emergency rooms. However, before these charges can be levied, the following conditions must be met:

- An alternate non-emergency services provider must be available and accessible to the individual, and
- After a medical screening examination and determination that the individual does not have an emergency medical condition, the hospital must:
 - a) inform the person that a payment may be required;
 - b) supply the name and location of an alternate accessible and available non-emergency services provider;
 - c) inform the person that the alternate provider can offer services with a lower co-payment or none; and
 - d) provide a referral to coordinate scheduling of the treatment.

For states taking this option, the above information must be provided by the hospital before it can provide non-emergency services to an individual in the Emergency Room.

These provisions are in addition to the cost-sharing provisions in the prior Medicaid statute. These allowed adults to be charged a nominal co-payment for services (between \$0.50 and \$3.20 depending on the cost of the service), or up to 5% of the cost

of a service (co-insurance). Children were exempt from any cost-sharing.

The new DRA cost-sharing provisions are complex, and there are some protections for some groups of Medicaid beneficiaries. In addition, the DRA does not permit these new charges to be imposed on any beneficiary for certain services, including preventive services, inpatient care and emergency services.

Certain groups of eligible individuals are exempt from premiums and other cost-sharing authorized by the DRA (although they may still be charged nominal cost-sharing, as authorized under prior Medicaid law). These groups include:

- children under 18 years of age who are required to be covered due to low family income;
- children in foster care or receiving adoption assistance;
- terminally ill individuals;
- institutionalized individuals receiving only a personal-needs allowance; and
- children eligible for Medicaid through the state option for the Family Opportunity Act buy-in. Cost-sharing for this group is defined under Section 6061.

Total cost-sharing for any individual may not exceed 5% of family income. In addition, allowable state-imposed charges are further limited by law, based on family income:

- Individuals with family incomes at or below 100% of the federal poverty level are exempt from having to pay premiums and from most of the new cost-sharing provisions. These individuals:
 - may not be charged more than the allowable nominal amount (\$3.20) for non-preferred drugs and the new cost-sharing for non-emergency use of hospital emergency departments.
- Individuals in families with incomes between 100% and 150% of the federal poverty level are exempt from having to pay premiums and have some other protections. These individuals:
 - may be charged up to 10% of the cost of most services;
 - may be charged up to twice the allowable nominal amount for non-emergency services in a hospital emergency department;
 - may be charged the allowable nominal amount for preferred and/or non-preferred drugs.
- Individuals in families with incomes over 150% of poverty have the fewest protections. These individuals:
 - may be charged premiums, and
 - may be charged up to 20% of the cost of most services, including non-preferred drugs;

States may set different rules on cost-sharing for different Medicaid beneficiaries. The DRA allows states to vary these charges within a group (as defined by the state), by geographic area or by type of service. Under prior law, these distinctions could not be

made and all cost-sharing had to be applied program-wide.

These federal limits on the amount states can increase their cost-sharing requirements each year will increase over time, as they are to be indexed to the medical consumer price index.

State Implementation

Overview

States have not taken significant advantage of the DRA provisions that allow them to charge premiums, institute higher co-payments and charge individuals more for the non-emergency use of hospital emergency rooms. States have had the authority to impose higher fees for some populations under waivers and a number of states have already used waivers to raise cost-sharing amounts beyond the nominal Medicaid amounts for certain populations. These generally are populations that would not be eligible for Medicaid under standard eligibility rules.

The DRA authority has been used explicitly only by Kentucky, Idaho and South Carolina—states that have also adopted benchmark plans under Section 6044 of the DRA. Several states have recently written waivers to cover expansion populations under Medicaid and these waivers also include some of the concepts in the DRA, but the DRA authority is not needed to charge additional fees to expansion populations. (Some data on new waivers is also included in Table 7 and in the summary below.)

Emergency Room Use

All three of the states using the new DRA authority have picked up the option to charge for non-emergency use of hospital emergency rooms. Three new waivers in states apply a similar policy to an expansion population that would not otherwise be eligible for Medicaid.

Idaho, Kentucky and South Carolina apply this rule to certain populations for whom they have created benchmark plans, including SCHIP children and certain groups of Medicaid beneficiaries, primarily low-income children and adults. Kentucky also applies it to foster care children and the elderly in benchmark plans, while South Carolina applies it to people with disabilities (although South Carolina's plan is only being implemented as a pilot).

For example, Kentucky beneficiaries now must pay 5% co-insurance for emergency room visits that are deemed non-emergency. Idaho has also authorized a \$3 co-payment for inappropriate emergency room and inappropriate ambulance service use. However, beyond the federal standards regulating emergency room co-payments, an individual in Idaho is not responsible for a co-payment if “the physician determines that a prudent layperson would have sought emergency treatment in the same circumstances, even if the care rendered is for a non-emergent condition.”¹²

Additionally, the hospitals and ambulance providers have discretion both to impose the co-payment and to require payment before the participant can receive services.

Arkansas, Indiana and Minnesota have policies for expansion populations to pay for non-emergency use of hospital ERs.

Premiums

Idaho and Kentucky are using DRA authority to institute premiums for some Medicaid populations. Using waivers, some other states are charging premiums to children in certain income groups (including SCHIP children) and expansion populations. In three states, some individuals will lose Medicaid eligibility if they do not pay their premium. In Idaho and Kentucky, this penalty kicks in if individuals are 60 days or more late with their premium payments. In South Carolina fees must be paid up front. Penalties apply only to certain Medicaid populations in each of these states.

These fees are being charged only to families with incomes over the federal poverty level, but some states have set these family income levels quite low. For example, Kentucky will charge premiums to children in Family Choices with family incomes over 150% of poverty, and to the transitional Medicaid population with incomes over 100% of poverty. Premiums are set at \$20 to \$30 a month.

In the case of families with transitional Medicaid, good cause could prevent loss of coverage. For KCHIP families, coverage is re-established once the payment is made and the overdue payment is not required if the child has been without coverage for 12 months.

In Idaho, premiums of \$10 are charged for a child in the basic plan whose family income is between 133% and 150% of the poverty level. Children in families whose income is between 150% and 185% of poverty must pay \$15 per child per month.

Cost-Sharing

States are adding deductibles, higher co-payments and additional co-payments for certain drugs, as well as out-of-pocket maximums that protect individuals somewhat from cumulative cost-sharing requirements. Two states have new deductibles (Indiana and South Carolina). Co-payments have been created by Kentucky.

Co-payment amounts vary by income level and sometimes also by service (see table). For example, in the Kentucky Family Choices plan, the amount of the co-payment and the services that require it differ from plan to plan. Co-payments are generally small (\$1-\$3). Co-payments are more burdensome for inpatient services. In the Global Choices plan, members not exempt from cost-sharing must pay \$50 on admission for acute inpatient hospital services. In the Comprehensive and Optimum Choices plans, a \$10 co-payment is required for inpatient hospital services. The Global Choices plan requires co-payments for a larger number of services.

The DRA authority to deny services for those who do not pay their co-payments has been adopted in Kentucky, while South Carolina requires payment up front. In Kentucky, the various co-payment provisions are enforceable so that providers may not waive a member's liability for a payment. However, only pharmacy providers can deny services for failure to pay.

Expansion populations in Arkansas, Indiana and Minnesota will also have deductibles and/or co-payments that are more than nominal.

Combinations of Charges

In Kentucky in particular, Medicaid beneficiaries could find themselves paying out-of-pocket on many occasions, so that even when one cost-sharing policy looks reasonable, the combined effect has a significant impact on the individual or family.

In Kentucky, beneficiaries now must pay 5% co-insurance for emergency room visits that are deemed non-emergency. Additionally, many groups of beneficiaries must pay co-payments for some services. In all groups the maximum for medical out-of-pocket payments is \$225 per year, as is the maximum for pharmacy out-of-pocket payments. However, total cost-sharing cannot exceed 5% of a family's quarterly income.

Idaho has imposed a premium and charges for non-emergency use of emergency rooms, but has not added other cost-sharing requirements. South Carolina's plan requires payment for all services, with a high deductible and charges for non-emergency use of the emergency room.

Expansion populations may also have significant cost-sharing, but these populations would not otherwise have coverage, and all have higher incomes than traditional Medicaid.

Impact on People with Mental Health Care Needs

Like the section authorizing benchmark plans, the sections making changes to Medicaid cost-sharing rules represent a major departure from prior Medicaid policy. Under previous law, children could not be charged co-payments and charges for other populations were strictly limited to nominal amounts unless the state obtained a federal waiver.

This new expansion of state authority to increase cost-sharing is likely to have a significant impact on the Medicaid population. Low-income individuals are not in a position to contribute very much toward the cost of their health services, and such cost-sharing can be a disincentive to seek care. Particularly burdensome may be the imposition of cost-sharing for using the emergency room of a hospital for a non-emergency visit. In some communities, the hospital emergency room offers the only

access to care. Concern about meeting co-payment requirements may keep some individuals with genuine mental health emergencies from visiting the emergency room.

States that have enacted benchmark plans, most of which severely limit mental health coverage, have been the most enthusiastic about increasing cost-sharing. Premiums, higher co-payments, emergency room charges and limited benefits may seriously disadvantage low-income people who need mental health care.

Conclusion

This study has found that few states have acted on the DRA options, other than the states that responded to the two demonstration programs for which CMS had more than sufficient applications. However, the study covers only the first two years since passage of the DRA, and there are signs that some other states still intend to make use of some of these options.

The impact of some of the DRA changes on people with mental health care needs could be severe. Unfortunately, the options that would expand access have been taken up by fewer states than the options that will limit access, although overall most states have not acted on any of the state plan options.

The perception in Washington that states were anxious to alter Medicaid appears erroneous—that they wanted to create new benefit packages modeled on private insurance plans, to raise cost-sharing requirements significantly or to require Medicaid beneficiaries to engage in “healthy behaviors.” Over time, more flexibility may creep into Medicaid state programs, but apparently most states are relatively comfortable with the high degree of flexibility they already have to design their own program. In particular, states seem anxious to protect people with disabilities from cuts in service or access, perhaps because these individuals would have nowhere to turn but the state if their needs were unmet.

The longer term impact of the demonstration projects might be the more significant outcome of these new state choices. The Family Opportunity Act could greatly aid children and families with incomes too high for Medicaid who are unable to access needed services or pay for them out-of-pocket. The home- and community-based services demonstration for children in PRTFs, should it show that these community services are cost-effective, could result in a permanent change to federal law that would benefit many children in many states, opening up access to the community services they need.

The Deficit Reduction Act represents a dramatic shift in Medicaid policy as it eliminates much of the uniformity in the program and potentially weakens the entitlement to services for many populations. Yet it remains to be seen how much these changes will actually alter the program over the next several years.

Notes

¹ The Deficit Reduction Act of 2005 and the Tax Relief and Health Care Act of 2006, which made technical corrections to the DRA, are the relevant statutes.

² Centers for Medicare & Medicaid Services. (March 31, 2006). State Medicaid Director Letter #06-008. Retrieved November 28, 2007 from www.cms.hhs.gov/smdl/downloads/SMD06008.pdf.)

³ Jessie Ball DuPont Fund (July, 2007) *Uncertain Access to Needed Drugs: Florida's Medicaid Reform Creates Challenges for Patients*. Briefing #3. Retrieved December 10, 2007 from <http://www.dupontfund.org>.

⁴ Jessie Ball DuPont Fund (July, 2007) *Waving Cautionary Flags: Initial Reactions from Doctors and Patients to Florida's Medicaid Changes*. Briefing #2. Retrieved December 10, 2007 from <http://www.dupontfund.org>.

⁵ Jessie Ball DuPont Fund (December, 2007) *Medicaid Pilots at One Year: How is the new Medicaid Marketplace Faring*, Briefing #4. Retrieved December 10, 2007 from <http://www.dupontfund.org>.

⁶ Solomon, J. (September 14, 2006). *The Illusion of Choice: Vulnerable Medicaid Beneficiaries Being Placed in Scaled-Back "Benchmark" Benefit Packages*. Retrieved November 28, 2007 from www.cbpp.org/9-14-06health.pdf.)

⁷ Families USA. (June, 2007). *Idaho Medicaid Under the DRA: Changing Benefit Packages for Participants*. Retrieved November 28, 2007 from <http://www.familiesusa.org/assets/pdfs/state-medicaid-waivers/id-state%20plan-amendment.pdf>.)

⁸ Arkansas, California, Connecticut, Indiana, Iowa, Maryland, Michigan, Missouri, Nebraska, New Hampshire, New York, Ohio, Oklahoma, South Carolina, Texas, Washington and Wisconsin.

⁹ Delaware, District of Columbia, Georgia, Hawaii, Illinois, Kansas, Kentucky, Louisiana, New Jersey, North Carolina, North Dakota, Oregon, Pennsylvania and Virginia.

¹⁰ Connecticut, DC, Iowa, Louisiana, Nebraska, New York, North Carolina, Pennsylvania and Virginia.

¹¹ Lipsom, D, Gruman, C., Schimmel, J., Colby, M., Denny-Brown, N., Peterson, S., & Williams, S. (August 31, 2007) *Money Follows the Person Demonstration Grants: Summary of State MFP Program Applications*. page 32. Retrieved November 30, 2007, from <http://www.cms.hhs.gov/DeficitReductionAct/downloads/StateMFPGrantSummaries-All.pdf>.

¹² Idaho Department of Health & Welfare, Medicaid Information Release #07-03, January 5, 2007