The Deficit Reduction Act:
Important Facts for State & Local 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 options under the Medicaid, 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. This package contains brief descriptions and checklists for many of the provisions contained in the DRA. The package is the first in a series that will help State and local government officials in implementing the DRA. For more information, see **www.cms.hhs.gov/deficitreductionact**.

STATE FLEXIBILITY IN 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 benefits plan, State 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 plan to provide State flexibility in benefit packages without regard to traditional requirements such as statewideness, comparability, freedom of choice.

State Flexibility in Benefit Packages Checklist

- ❑ Assess how your state could use alternative benefit packages to update its Medicaid program.
- ❑ Determine whether legislative changes to the Medicaid program are necessary to implement the new benefit packages—changes to eligibility, benefits, services, or delivery systems.
- ❑ Build public-private partnerships through premium assistance with employer coverage options.
- ❑ Work with CMS to determine whether your state's new vision of the Medicaid program requires an 1115 waiver or can be achieved through the submission of a series of State Plan Amendments.
- ❑ If a State has an active section 1115 demonstration or other waiver program such as a 1915(b) waiver, determine if a new amendment to the State Medicaid Plan may be beneficial or necessary in order to align with benchmark plans.

ALTERNATIVE PREMIUMS & COST SHARING

Sections 6041, 6042, and 6043 of the DRA allow States to vary the premiums and cost sharing that they charge to certain Medicaid beneficiaries. No premiums are permitted for families with incomes above 100 percent and at/or below 150 percent of poverty. Cost sharing up to 10 percent of the cost of services is permitted within this group. 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. Above 150 percent, premiums are permitted and cost sharing up to 20 percent of the cost of services is allowed. The DRA contains special rules on cost sharing for prescription drugs and non-emergency care provided in emergency rooms. The cost sharing provision for non-emergency care provided in an emergency room is effective January 1, 2007. 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.

As part of the ER provision, the DRA sets up a grant program that provides $50 million in funding over 4 years for states to establish non-emergency alternate providers. the Grant Announcement will be posted at http://www.cms.hhs.gov/GrantsAlternaNonEmergServ/.

Alternative Premium & Cost-Sharing Checklist

- ❑ Consider if the State should impose alternative premiums and cost sharing upon certain Medicaid beneficiaries.
- ❑ Assess whether the implementation of alternative premiums and/or cost sharing would require legislative changes.
- ❑ Determine if your State could benefit from implementing non-emergency alternative providers and if such a program would meet the grant criteria.

LONG TERM CARE PARTNERSHIP

The long-term care partnership is a unique program combining private long-term care insurance and special access to Medicaid. The partnership helps individuals financially prepare for the possibility of needing nursing home care, home care or assisted living services someday. The program allows individuals to protect some or all of their assets and still qualify for Medicaid if their long-term care 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.

Long-Term Care Partnership Checklist

- ❑ Work with your Medicaid agency to evaluate the benefit of submitting a SPA using the draft pre-print template developed by CMS that specifies that benefits paid under a qualified long-term care insurance policy will be disregarded in both the eligibility determination and in the estate recovery process. The SPA must also stipulate that the policies that serve as the basis for these disregards meet all of the requirements for a qualified long-term care policy as specified in the DRA, and that, where appropriate, the State Insurance Commissioner will attest that the policies meet those requirements. CMS has provided draft SPA "pre-prints" to make the SPA submission easier.
- ❑ Work closely with the State Insurance Commissioner, State Medicaid Director, and others to establish efficient lines of communication regarding the Partnership.
- ❑ Assist the Commissioner in developing the training program that is required for individuals who will be permitted to sell qualified policies in the State.
- ❑ Consider a dialogue with State health policy officials, insurers, advocates, consumers and other interest groups to establish procedural and policy guidelines consistent with the DRA, State law and NAIC rules.

TRANSFER OF ASSETS

The cost of long-term care continues to increase, making such services difficult to afford for most individuals, and inaccessible for many. The Medicaid program provides coverage for long-term care 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 preserved for the individual and/or family members, but are not countable when Medicaid eligibility is determined. 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 is not actually received to get long-term care 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.

Transfer of Assets Checklist

- ❑ Work with Medicaid agency to submit a State Plan Amendment (SPA) that applies the new transfer of assets rules to transfers that take place on or after February 8, 2006. To simplify the SPA submission process, CMS has designed "draft SPA pre-prints templates" that a State may use.
- ❑ "Submit a SPA using the draft pre-print template developed by CMS to indicate that the State is applying a home equity cap at the required minimum level of $500,000, or that the State is electing to increase the cap to a maximum of $750,000." Submitted a SPA is not optional. Every state needs to do it.
- ❑ Alter the application for Medicaid coverage of long-term care expenses to include a disclosure of annuities and language which names the State as a remainder beneficiary.
- ❑ Review existing State policy and procedure to determine other changes that may be necessary to implement the provisions of the DRA, such as the treatment of loans, promissory notes, mortgages, life estates, annuities, and continuing care retirement community entrance fees, or the calculation of penalty periods or the community spouse resource allowance, or the implementation of undue hardship provisions.

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. Effective July 1, 2006, individuals must provide satisfactory documentary evidence of citizenship when initially applying for Medicaid or upon a recipient's first Medicaid re-determination. The statute and regulation provide States with guidance on acceptable documentary evidence, including alternative forms not explicitly named in statute. These documents 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.

Documentation of Citizenship Checklist

- ❑ Determine whether State legislative changes to Medicaid eligibility laws are necessary to implement the new documentation of citizenship requirements.
- ❑ Provide Medicaid eligibility workers with training.
- ❑ Distribute educational materials to beneficiaries.
- ❑ Determine whether your State has the capacity to begin using automated data matching systems to verify citizenship, such as those with Federal or State governments, or public assistance agencies.

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.

Health Opportunity Accounts Checklist

- ❑ Assess whether your State is interested in implementing an HOA in the Medicaid program. The program may be part of your regular Medicaid program or existing 1115 demonstration and can be achieved through the submission of an HOA State Plan Amendment.
- ❑ Determine whether legislative changes to the Medicaid program are necessary to implement an HOA.

Special Needs Plans

Important Facts for State & Local Government Officials

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 introduced a new type of Medicare coordinated care health plan, the Special Needs Plan (SNP). SNPs can restrict enrollment to a group of "special needs" individuals. Special needs individuals were identified as:

- institutionalized beneficiaries,
- beneficiaries who are dually eligible for Medicare and Medicaid (i.e. "dual eligibles"), and/or
- beneficiaries with severe or disabling chronic conditions.

SNPs provide an opportunity to better integrate care and provide additional benefits to these populations. For example, dual-eligible SNPs can offer the full array of Medicare and Medicaid benefits, plus supplemental coverage, in a single plan, through a single set of providers.

The States and CMS can partner to ensure that coverage offered to beneficiaries by Medicare, Medicaid, and Medicare Advantage plans is seamless. Many States already have business relationships with Medicare Advantage organizations, which include providing a smooth transition to a plan such as a SNP for individuals eligible for both Medicare and Medicaid.

Special Needs Plans Checklist

- ❑ Examine the CMS State Guide to Integrated Medicare & Medicaid Models on CMS website at http://www.cms.hhs.gov/DualEligible/04_IntegratedMedicareandMedicaidModels.asp#TopOfPage .
- ❑ Issue a Request for Information to prospective SNPs.
- ❑ Begin dialogue with SNPs to pursue potential integrated arrangements.
- ❑ Determine whether to pursue a demonstration waiver—1115, 1915(b) and/or 1915(c)—or to develop its program within the confines of the flexibility afforded to it under its State plan.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES