



# The Deficit Reduction Act: Important Facts for State & Local Government Officials

**T**he 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](http://www.cms.hhs.gov/deficitreductionact).



## ALTERNATIVE BENEFIT PACKAGES

Under Section 6044, the DRA provides States with the flexibility to change their Medicaid benefit packages to mirror certain commercial insurance packages (alternative benefit or benchmark packages). States may use this authority to leverage employer-sponsored coverage of Medicaid beneficiaries. While only certain groups of beneficiaries may be mandated into a benchmark benefit plan, States may also use alternative benefit packages for providing disease management services or other specialized services to other groups of beneficiaries on a voluntary basis. Within these packages, States have the option to amend their State plan to provide alternative benefit packages without regard to traditional requirements such as statewideness, comparability, freedom of choice, or certain other traditional Medicaid requirements.

### Alternative 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.
- 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.
- Build public-private partnerships through premium assistance with employer coverage options.
- If a State has an active section 1115 demonstration or other waiver program such as a 1915(b) or 1915(c) waiver, determine if a new amendment to the State Medicaid Plan may be beneficial or necessary in order to align with benchmark plans.

## ALTERNATE PREMIUM & COST-SHARING

Sections 6041 and 6042 of the DRA allow States to vary the premiums and cost sharing that they charge to certain Medicaid recipients. For families with income between 100 percent and 150 percent of poverty, no premiums are permitted, but cost sharing up to 10 percent of the cost of services is permitted within this group. 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.

In addition, States have the option to require payment of alternative premiums as a condition of eligibility and alternative cost sharing as a condition of receipt of the service or drug, or cost sharing for non-emergency services in the ER. The DRA provides that the aggregate premium and/or cost-sharing amounts must not exceed 5 percent of the family's income for all family members for the month or quarter period. As part of the ER provision, the DRA sets up a grant program that provides \$50 million in funding over 4 years for states to establish non-emergency alternate providers.

## **Alternate Premium & Cost-Sharing Checklist**

- Should the State impose alternative premiums and cost sharing upon certain Medicaid recipients.
- 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.
- Apply for a grant to establish an alternate non-emergency services provider—application due October 15, 2006.

## **MONEY FOLLOWS THE PERSON**

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Under this DRA provision, States will be able to make targeted reforms in their State to fortify the community-based infrastructure so that individuals have a choice of where they live and receive services. These grants also encourage States to adopt a strategic approach to improving quality in both home and community-based services and institutional settings as the State designs and implements its rebalancing initiative. The Centers for Medicare & Medicaid Services (CMS) is soliciting proposals from States to participate in the Money Follows the Person Rebalancing Demonstration (MFP Demo). This demonstration, created by section 6071 of the Deficit Reduction Act, supports State efforts to “rebalance” their long-term support systems by offering \$1.75 billion over 5 years in competitive grants to States.

### **MFP Checklist**

- Apply for grant by November 1, 2006
- Determine whether legislative changes to encourage the provision of LTC services in the home and community setting are necessary

## **LONG TERM CARE PARTNERSHIP**

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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 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) are permitted to 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 submit a SPA 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 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 SPA "pre-prints" that a State may use.
- Submit a SPA if the State wishes to apply a home equity cap that exceeds \$500,000 but does not exceed \$750,000.
- 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.

## TRANSFORMATION GRANTS

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Section 6081 of the DRA authorizes new grant funds to States for the adoption of innovative methods to improve effectiveness and efficiency in providing medical assistance under Medicaid. Through the use of the Transformation Grants, States can work with CMS to create programs that are more aligned with today's Medicaid populations and the health care environment. We strongly encourage States to develop these grant proposals that enhance the Medicaid program. CMS will issue one grant solicitation for the 2-year grant period of FYs 2007 and 2008. A total of \$75,000,000 is available for FY 2007 and \$75,000,000 for FY 2008. No State matching funds are required for these special grants.

### Transformation Grants Checklist

- Assess if your State's Medicaid program has an innovative proposal that will improve the effectiveness and efficiency of the Medicaid program which meets the grant criteria.
- Apply for grant by September 15, 2006.

## DOCUMENTATION OF CITIZENSHIP

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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. It also gives States guidance on the processes that may be used to minimize the administrative burden on States, applicants, and recipients.

### 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, public assistance, law enforcement, or corrections agencies.

## HEALTH OPPORTUNITY ACCOUNTS

Section 6082 of the DRA provides for ten States to operate Medicaid demonstrations 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. Beneficiaries 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 beneficiaries, to ensure that the HOA program works well both for healthier beneficiaries and those with chronic illnesses.

### Health Opportunity Accounts Checklist

- Assess whether your State's implementing an HOA in the Medicaid program requires an 1115 waiver or can be achieved through the submission of an HOA State Plan Amendments.
- Determine whether legislative changes to the Medicaid program are necessary to implement an HOA.



# Special Needs Plans

## Important Facts for State & Local Government Officials

**T**he 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.
- Issue a Request for Information to prospective SNPs.
- 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.

