The Deficit Reduction Act of 2005:
Provisions affecting providers working to reduce infant mortality

Secretary's Advisory Committee on Infant Mortality

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HRSA
Health Resources and Services Administration

- The Deficit Reduction Act (DRA) of 2005 became law February 8, 2006
- Purpose:
  - To increase flexibility for State Medicaid Programs
  - To reduce the rate of growth in spending

Relevant Sections of DRA

- 6001 Pharmaceutical Pricing
- 6004 Children's Hospitals
- 6101 SCHIP Allotments
- 6102 SCHIP Prohibitions
- 6037 Documentation Requirements

Relevant Sections of DRA cont.

- 6041 Cost Sharing – Services
- 6042 Cost Sharing – Medication
- 6043 Cost Sharing - Emergency
- 6044 Benchmark Benefit Packages
- 6052 Case Management
- 6064 Family Health Information Centers
- 6082 Health Opportunity Accounts

Section 6001: Pharmaceutical Provisions

- Average Manufacturers Price (AMP) & Best Price: Modified federal rebate definitions relating to authorized generics, wholesaler prompt pay discounts, & nominal price sales
- Mandated monthly disclosure of AMPs to states & quarterly postings to internet

Section 6001: Pharmaceutical Provisions

- Greater AMP transparency (due to monthly disclosure)
- Could result in Medicaid cost containment strategies which initially target high-cost drugs and later apply to all Medicaid reimbursed drugs
- Potentially decreased operating margins for small, independent pharmacies

Section 6004: Children's Hospitals

- Allows children's hospitals to participate in the 340B drug pricing program so they can purchase outpatient drugs at significantly discounted rate
- Implementation pending resolution of legislative and policy issues

Section 6101: Additional SCHIP Allotments to Eliminate Funding Shortfalls

- Appropriates $283 million for FY 2006
- Distributed based on projected SCHIP shortfalls
- Covers health care assistance for targeted low-income children
- Available through September 30, 2006

Section 6102: SCHIP Prohibition Against Covering Non-Pregnant Childless Adults

- Prohibits use of funds for non-pregnant childless adults
- CMS can’t approve Medicaid waivers or demos to cover them
- Caretaker relatives are not considered childless adults
- Effective as if enacted October 1, 2005

Section 6037: Documenting Proof of Citizenship

- Beneficiaries must provide documentation or lose Medicaid eligibility
  - Documentation requirements are known to affect enrollment and application rates
  - Impact is sure to be a reduction in enrollment
- Some providers will likely
  - Lose paying Medicaid patients and serve more uninsured
  - Be asked to assist patients in securing needed documentation
- States will likely
  - Encounter administrative and financial burdens
  - Change simplified enrollment and application processes (passive, mail-in, drop-off, or electronic applications)
- ***Effective July 1, 2006***

Section 6041: Cost-Sharing – Services

- States have new options to impose premiums and cost-sharing for many new groups and types of services
  - **Premiums** permitted over 150% FPL and
  - **Increased cost-sharing** permitted over 100% FPL
- The premium and cost-sharing provisions will come into play primarily when a state expands coverage
- Guidance on cost-sharing from CMS

Section 6041: Cost-Sharing – Services cont.

- Limits and exemptions
  - Cost-sharing: limited to **10%** of service cost under 150% FPL and **20%** over 150% FPL
  - Cap on premiums and cost-sharing: In aggregate, family payments cannot exceed **5%** of family income
  - Exempted populations: mandatory kids, pregnant women, institutionalized persons, persons receiving hospice care and women with coverage due to Breast and Cervical Cancer
  - Exempted services: preventive services to kids, pregnancy services, hospice or institutional services, emergency services and family planning services

Section 6041: Cost-Sharing – Services cont.

- Greatest impact on non-pregnant adults, optional children and expansion populations
- More children than adults are at risk
  - 17 states cover adults over 100% FPL
  - 28 states currently impose premiums on children in separate SCHIP programs

Section 6041: Cost-Sharing – Enforceability

- States have the option to allow providers to deny services if cost-sharing is not paid
  - This is a significant reversal of long-standing Medicaid policy
    - Beneficiaries denied services due to financial barriers may seek care from safety net providers.
    - Effective tracking of cost-sharing related to family cap is critical
- ***Effective: March 31, 2006***

Section 6042: Cost-Sharing – Prescription Drugs

- States have option to impose higher co-pays on non-preferred drugs (& to waive co-pays for preferred drugs).
- Co-pays for "exempt" populations must be nominal
- Rx co-pays are subject to a "Medical Necessity" override, which would then apply the co-pay for preferred drugs
- ***Effective March 31, 2006***

Section 6043: Co-Payments for Non-Emergency Care in ERs

- States have option to impose higher co-pays on non-emergency ER services
- Higher co-pay applies only if alternate source of non-emergency care is available and notice is provided
- ***Effective Jan 1, 2007***

Section 6044: Benchmark Coverage

- States can select from four types of actuarially equivalent coverage:
  - BCBS Standard Federal Employee Health Benefits Program
  - State employee coverage
  - Coverage offered by the largest commercial HMO in the state;
  - Secretary approved coverage;
- States must assure access to FQHC and RHC services either through a plan or directly, and they must be paid via PPS
- EPSDT benefit is protected in full per *Dear State Medicaid Letter* issued March 31, 2006

Section 6044: Benchmark Coverage cont.

- May permit states to combine non-exempt Medicaid and SCHIP children and their parents and caretakers in a larger purchasing pool under benchmark plans
- Benchmark coverage is generally applicable to
  - categorically needy children (including expansion groups)
  - parents who receive Medicaid but not TANF, and
  - optional pregnant women.
- "Medically frail" and special needs beneficiaries – as identified by the Secretary in forthcoming regulation – are exempt.
- ***Effective March 31, 2006***

Section 6052: Case Management and Targeted Case Management

- Specific definition of medical case management:
  - Assessment to determine service needs,
  - Development of a care plan,
  - Referral and related activities,
  - Monitoring and follow up.
- Restricts FMAP to services for which no other third party is liable, including reimbursement under a medical, social, educational or other program;
- Third party liability rules under HIV Health Care Services and Indian Health Services are not affected.
- ***Effective January 1, 2006***

Section 6064: Family-to-Family Health Information Centers

- Assists families of children with special health care needs (CHSHCN) to access and coordinate resources typically available through separate and difficult to navigate systems
- Identifies successful health delivery models
- Conducts outreach activities to families, health professionals, schools, and other appropriate entities
- $3 million in 2007 for no less than 25 states
- $4 million in 2008 for no less than 40 states
- $5 million in 2009 for all states and the District of Columbia
- ***Effective upon appropriation of funds***

Looking Forward

- DRA provides significant new options for states
- State responses will vary:
  - Expect greater use of State Plan Amendments (SPAs)
  - Flexibility will be limited for many states based on existing Medicaid eligibility
  - Some states will still choose Section 1115 demonstrations
  - Gubernatorial elections in 2006 may be a factor
- States are awaiting further CMS guidance

Potential Impacts

- Medicaid enrollment may decrease as a result of new documentation, premium and cost-sharing requirements
- Number of persons who are uninsured may increase
- Safety-net providers may see increase in utilization
- Providers may see reduced reimbursement due to more restrictive benefit plans and lower pharmacy payments
- More people may delay or forego prenatal care which may increase acuity

Potential Impacts cont.

- More people could be covered with streamlined benefit packages
- State Medicaid Programs may be better able to reduce the rate of spending increase

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