Effects of Deficit Reduction Act on Maternal and Child Health Services

SACIM Subcommittee on Funding and Finance

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Background

In order to preserve the safety net for women and children that has had a positive impact on healthy birth outcomes, infant mortality rates, quality health care, and the integrity of the family, key elements of maternal and child health related programs must be maintained and/or expanded with adequate public funding. Over the past several years, public funding for maternal and child health services has been on the decline. It is imperative that funding for these critical and necessary services be preserved and/or expanded for women, children, and their families to decrease infant mortality, improve birth outcomes, and overall, improve the health and well-being of families and their children.

Public Funding/Deficit Reduction Act of 2006

The Deficit Reduction Act (DRA) (P.L. 109-171) was signed into law in February 2006. In relation to funding of maternal and child health services, there are two primary areas within the DRA that will potentially have an impact on the delivery of services. These two areas include the Medicaid Program and the Title V Maternal and Child Health Block Grant Program.

Medicaid Program

The Medicaid program currently serves an estimated 52 million individuals – 39 million people in low-income families and 13 million elderly and people with disabilities. In regards to low-income families covered by the Medicaid program, 25 million are children and 14 million are adults. Of the 14 million adults covered under Medicaid, 70% or 9.8 million are women. The combined state and federal cost for Medicaid services in FY 2005 was $320 billion, which translates to 17% of national health spending.

The Medicaid program is a critical source of health care for many women and children. As an example, Medicaid provides coverage for 50% of all births to low-income families.
As the primary health insurer of low-income individuals, each state must provide a mandatory set of services as part of their state plan.

Mandatory State Plan Services

Mandatory State Plan Services for eligibility groups classified as categorically needy, unless these services are waived under section 1115 of the Medicaid Law:

- Inpatient hospital (excluding inpatient services in institutions for mental disease)
- Outpatient hospital including Federally Qualified Health Centers and if permitted under state law, rural health clinic and other ambulatory services provided by a rural health clinic which are otherwise included under states' plans
- Laboratory and x-ray
- Certified pediatric and family nurse practitioners (when licensed to practice under state law)
- Nursing facility services for beneficiaries age 21 and older
- Early and periodic screening, diagnosis, and treatment (EPSDT) for children under 21
- Medical and surgical services of a dentist

- Home health services for beneficiaries who are entitled to nursing facility services under the state's Medicaid plan – also includes intermittent or part-time nursing services provided by home health agency or by a registered nurse; home health aides; medical supplies and appliances for use in the home
- Nurse-midwife services
- Pregnancy related services and service for other conditions that might complicate pregnancy
- 60 days postpartum pregnancy related services
- Family planning services and supplies

Medically Needy Services

Services for Medically Needy eligibility groups if the state covers this group of beneficiaries (35 states have medically needy programs):

- Prenatal and delivery services
- Postpartum pregnancy related services for beneficiaries under age 18 and who are entitled to institutional and ambulatory services as defined in a state's plan
- Home health services to beneficiaries who are entitled to receive nursing facility services

Changes in Medicaid Program due to DRA

According to the Congressional Budget Office, the DRA is expected to reduce federal Medicaid spending by $11 billion over the 2006-2010 period. Many of these reductions will be generated by new flexibility that will enable states to design more limited benefit packages and to require higher levels of cost sharing and premiums for certain beneficiaries. The DRA contains broad new flexibility for States, enabling them to make extensive changes in their Medicaid benefits packages in order to reduce state spending. Some of these changes include:

- States will be allowed to increase cost-sharing requirements for certain beneficiaries;
- States will be allowed to design alternate Medicaid benefit packages for targeted populations under 'benchmark' options; and
- States will be allowed to make fundamental changes in the way Medicaid services are delivered and financed through 1115 waivers.

Potential Impact on Maternal and Child Health Services

A study by the Congressional Budget Office outlines some of the possible Medicaid changes that can have an impact on maternal and child health services:

Premiums and Cost-Sharing

- States are permitted to increase co-payments substantially for many recipients and can impose premiums on many beneficiaries, including children. For families with incomes over 150 percent of the federal poverty level (FPL), states may charge unlimited premiums and may charge co-payments up to 20 percent of the cost of medical services. Co-payment limits are set at 10 percent of the service for recipients with incomes between 100 percent and 150 percent of the FPL.

- 13 million Medicaid beneficiaries (20 percent of all Medicaid beneficiaries) will face higher co-payments for medical services other than prescription drugs by fiscal year 2015. 9 million of these beneficiaries, about 4.5 million of whom are children, will face co-payment charges for the first time.
- Some 20 million Medicaid beneficiaries will face higher co-payments for prescription drugs by 2015. Children who currently are exempt from co-payments will account for about one-third of these 20 million affected beneficiaries. Almost half of the 20 million beneficiaries – nearly 10 million – will be individuals with incomes below the poverty line.
- Some 80 percent of the savings that result from the increases in co-payments will come from decreased use of medical services, rather than from collection of increased co-payments. Low-income beneficiaries will most likely forgo needed health care services and medications because of the co-payment costs.
- States can allow providers to deny needed services to beneficiaries who cannot make the higher co-payments.
- States can charge premiums to about 1.3 million Medicaid beneficiaries by fiscal year 2015; most will be adults and children. Currently, states generally cannot impose premiums for Medicaid coverage. Unable to afford these premiums, 65,000 individuals will lose Medicaid coverage entirely – children will account for 60% of the individuals who are unable to pay their premiums.

Changes in Medicaid Benefits:

- States are required to provide mandatory services to certain mandatory populations (refer to page 2 for mandatory services). However, states do have the flexibility to determine the amount, duration and scope of services that they provide. The DRA would allow states to replace existing Medicaid benefits for children and certain other beneficiaries with "benchmark" services. These benchmark services would include the typically offered health benefits as seen by major health benefits plans (i.e., federal employee health benefits, state employee health benefits, or health coverage offered by the largest commercial HMO in the state). By 2015, the Congressional Budget Office estimates that this change in benefits package would affect 1.6 million enrollees, primarily adults. Such services could include family planning and many rehabilitative services.
- The DRA includes a provision to tighten the definition of what qualifies as Medicaid targeted case management. States will only be allowed a 50 percent Federal matching rate for these services. It is anticipated that this restriction will reduce Medicaid cost by $208 million in FY 2007. This restriction will have an impact on services provided to children in higher risk categories of care.

Maternal and Child Health (MCH) Services Block Grant Program

The MCH Services Block Grant is a safety-net program to states devoted to improving the health of all women and children, including those who are low-income, at-risk, uninsured and underinsured and remains the only Federal program that focuses solely on improving the health of all mothers and children. It is a partnership between state and federal authorities offering

many health related services and initiatives to women and children through building community capacity and complementing the State Medicaid Program. States use the block grant to provide an array of services and benefits to women and children such as pregnancy care, newborn screening, lead poisoning, injury prevention, and services for children with disabilities and chronic illnesses. For many states, these block grant funds are used to fill gaps in services not included under Medicaid.

States match the MCH Services Block Grant Program with over $2.5 billion, leveraging the federal investment to create health care for many pregnant women, infants and children. Currently, the states serve over 28 million people including over 95 percent of all newborns, 50 percent of all pregnant women, and 20 percent of children in the United States. Federal support for this program and these services has decreased substantially over the past 5 years, even though this program has been recognized as an effective program by Administration budget rating tools.

Changes in MCH Services Block Grant Program due to DRA

The Deficit Reduction Act of 2006 cut funding for the MCH Services Block Grant from $724 million to $700 million. In addition, a 1 percent across-the-board cut of all federal programs was also included. This leaves the MCH Services Block Grant at a funding level of $693 million in FY 2006 – the lowest amount of funding for these services since 1999. The MCH Services Block Grant has been cut a total of $47 million in 2006, or 6.4 percent, compared to the 2005 funding level adjusted for inflation.

Potential Impact on Maternal and Child Health Services

Congress is authorized to provide up to $850 million for the MCH Services Block Grant Program, however, with only $693 million available in FY 2006 many services for women and children are being eliminated or reduced. This reduction in funding is troubling when we know that from the recent Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics report of 2004 statistics that:

- There were no improvements in timely receipt of prenatal care from 2003 to 2004 – 84.1 percent of all mothers in 2003 and 83.9 percent of all mothers in 2004;
- More than a half-million infants were born preterm (less than 37 weeks gestation) in 2004, the highest number reported since comparable national data on gestational age have been available in 1981. In 2003, 12.3 percent of infants were born preterm in comparison to 12.5 percent in 2004; and
- Infants were also more likely to be born low birthweight (LBW) (less than 2,500 grams) in 2004 – LBW rate rose from 7.9 to 8.1 percent between 2003 and 2004.

As an effect of this reduction in funding, states are already eliminating many maternal and child health programs – Missouri ended a primary health care program for over 30,000 low-income women, while Iowa and Ohio have closed specialty clinics for children with special health care needs.

Fully funding the MCH Block Grant to the FY 2005 level of $724 million will allow states to preserve and maintain needed maternal and child health services for positive birth outcomes and healthy lifestyles. Restoring this level of funding to the MCH Block Grant needs to be

complementary and in addition to the already existing community-based initiatives administered by the Maternal and Child Health Bureau, such as Healthy Start, Early Hearing and Screening Programs, and Emergency Medical Services for Children. It is critical that all of the programs within the MCH Block Grant and overall with the MCH budget be restored to the FY 2005 levels to offset any elimination of much needed maternal and child health programs.

Strategies/Recommendations from HHS Advisory Committee on Infant Mortality (ACIM)

In order to improve the health and well-being of women and children and to reach the Healthy People 2010 goals for maternal and child health services, the HHS Advisory Committee on Infant Mortality makes the following recommendations:

1. We strongly recommend that the Centers for Medicare and Medicaid Services (CMS) develop consistent policies for approval of State Medicaid Plan Services. It is critical that all states have similar benefit packages to meet the needs of women and children.
2. We strongly recommend that safe-guards be put into place on 'benchmark' plans approved by CMS for State Medicaid Services to ensure that adequate and quality health care services are provided to women and children. Services impacting on the health and well-being of women and children, reducing infant mortality, having a positive impact on healthy birth outcomes, and providing necessary services for children to thrive must be protected in any approved benchmark plan.
3. We strongly recommend that the match for targeted case management services within Medicaid not be reduced for maternal and child health services and that consumer input be sought on developing program variables and definitions of targeted case management.
4. We strongly recommend that the FY 2005 level of funding - $724 million – be restored to the MCH Block Grant Program so that states can continue to provide complementary services not covered under Medicaid to women and children for positive birth outcomes and healthy lifestyles.
5. We strongly recommend that CMS work more closely with programs within the Maternal and Child Health Bureau and other federal agencies to improve public health, eliminate health disparities, and coordinate maternal and child health services to reach the Healthy People 2010 goals.
6. We strongly recommend that HHS focuses its priorities, funding and services on evidence-based practices and proven strategies to improve birth outcomes and reduce infant mortality. These practices should be the standards set for clinical practice and public health care.