Impact of the Deficit Reduction Act (DRA) on Maternal and Child Health (MCH) Programs and Populations

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HRSA

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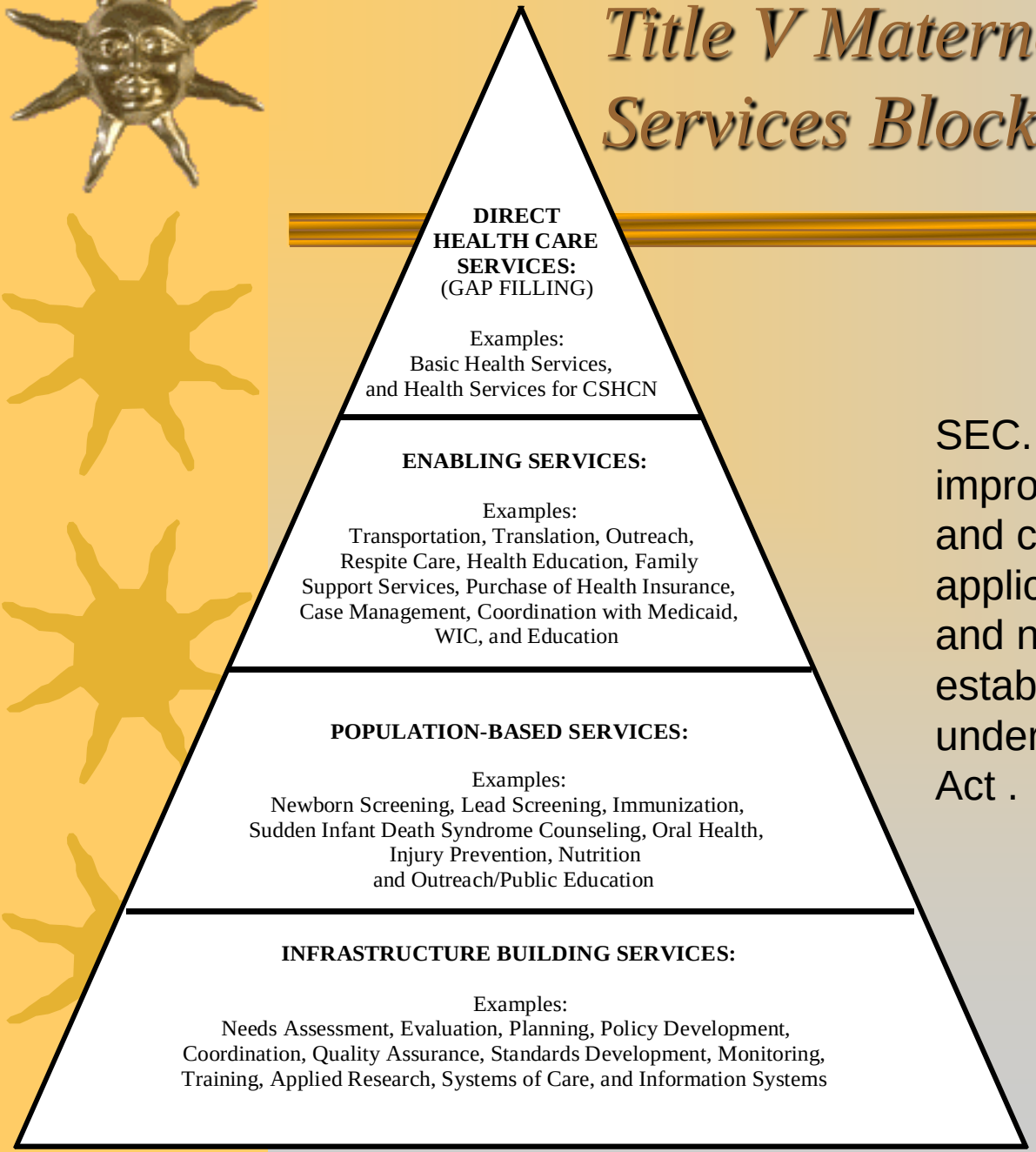
Linkages Between Public Health (MCH) and Medicaid

Title V Maternal and Child Health Services Block Grant:



SEC. 501. *[42 U.S.C. 701]* (a) To improve the health of all mothers and children consistent with the applicable health status goals and national health objectives established by the Secretary under the Public Health Service Act .

MCH Block Grant Expenditures

Federal-State Title V Block Grant Partnership Expenditures FY 2004

Total	Federal Allocation	Unobligated Balance	Total State Funds (Match and Overmatch)	Local MCH Funds	Other Funds	Program Income	Total
National	$531,441,553	$34,978,436	$2,323,729,126	$302,428,710	$400,337,740	$1,343,465,611	$4,936,381,176
% of Total	10.8%	0.7%	47.1%	6.1%	8.1%	27.2%	--

Federal-State Title V Expenditures by Category of Service

Total	Direct Health Care Services	Enabling Services	Population Based Services	Infrastructure	Total
National	$2,919,498,609	$1,105,234,680	$539,994,945	$456,731,739	$5,021,459,973
% of Total	$58.1%	$22.0%	$10.8%	$9.1%	--

As reported by States in their Title V Block Grant FY 2004 Annual Report and FY 2006 Application

Populations Served By MCH Block Grant

Number of Individuals Served by Title V, by Class of Individuals

Total	Pregnant Women	Infants Less Than 1 Year	Children 1 to 22 Years	CSHCN	Other	Total
National	2,327,892	3,822,746	22,050,122	963,634	2,957,008	32,121,402

Federal-State Title V Block Grant Partnership Expenditures, by Class of Individuals Served, FY 2004

Total	Pregnant Women	Infants Less Than 1 Year	Children 1 to 22 Years	CSHCN	All Others	Administration	Total
National	$385,914,829	$559,772,929	$966,557,955	$2,711,857,337	$199,156,127	$113,121,999	$4,936,381,176
% of Total	$7.8%	$11.3%	$19.6%	$54.9%	$4.0%	$2.3%	--

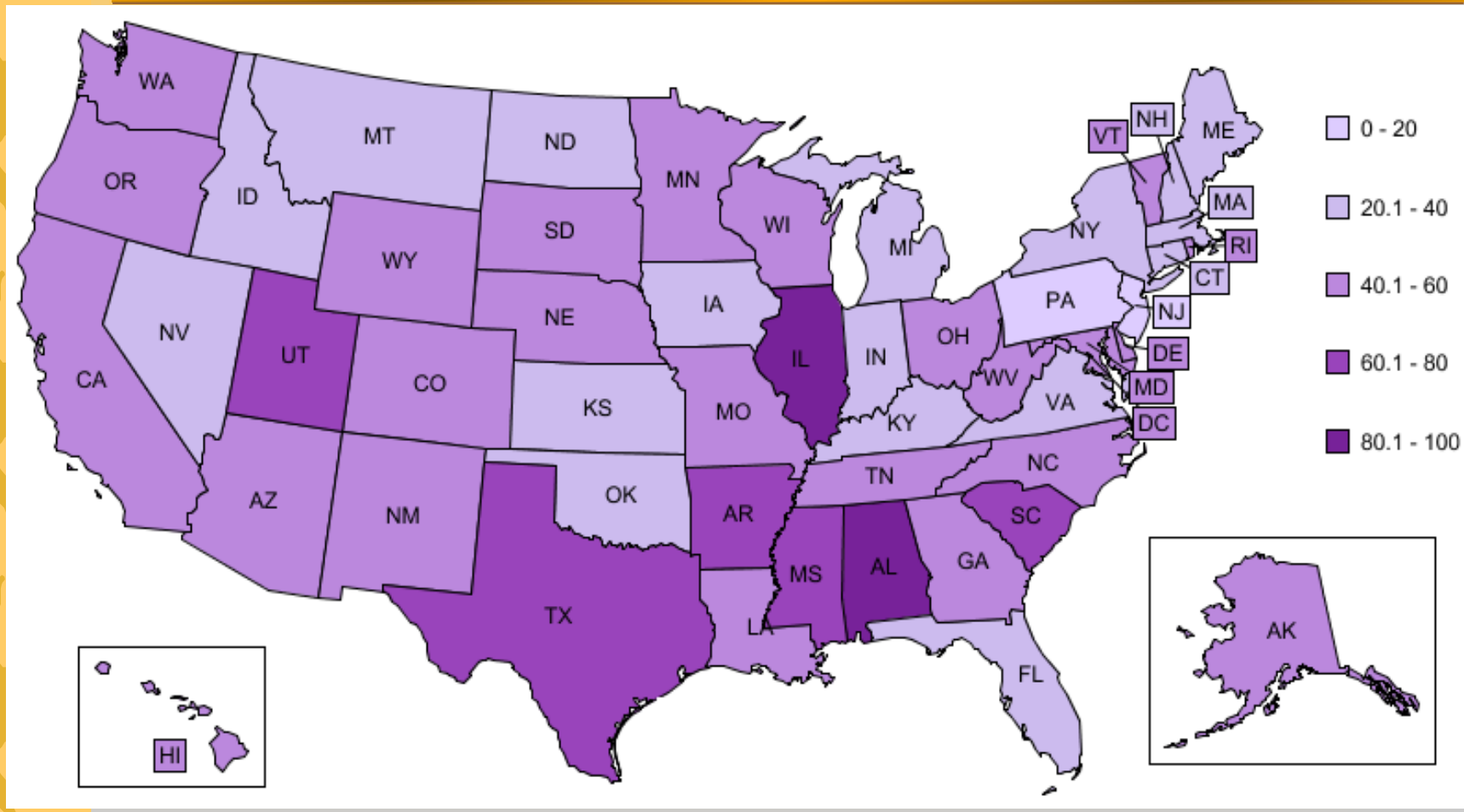
As reported by States in their Title V Block Grant FY 2004 Annual Report and FY 2006 Application

Percentage of Individuals Served by Title V, by Source of Coverage

National Summary	Title V Total Served: 32,121,402	Primary Source of Coverage				
		Title XIX%	Title XXI%	Private/Other %	None%	Unknown%
Pregnant Women	2,327,892	42.4%	0.1%	22.4%	7.5%	11.9%
Infants < 1 year old	3,822,746	37.6%	0.5%	28.6%	12.4%	9.5%
Children 1 to 22 years old	22,050,122	34.4%	1.1%	21.9%	9.9%	7.5%
CSHCN	963,634	54.5%	5.2%	21.7%	6.8%	11.8%
Others	2,957,008	26.5%	0.4%	22.9%	24.4%	11.1%

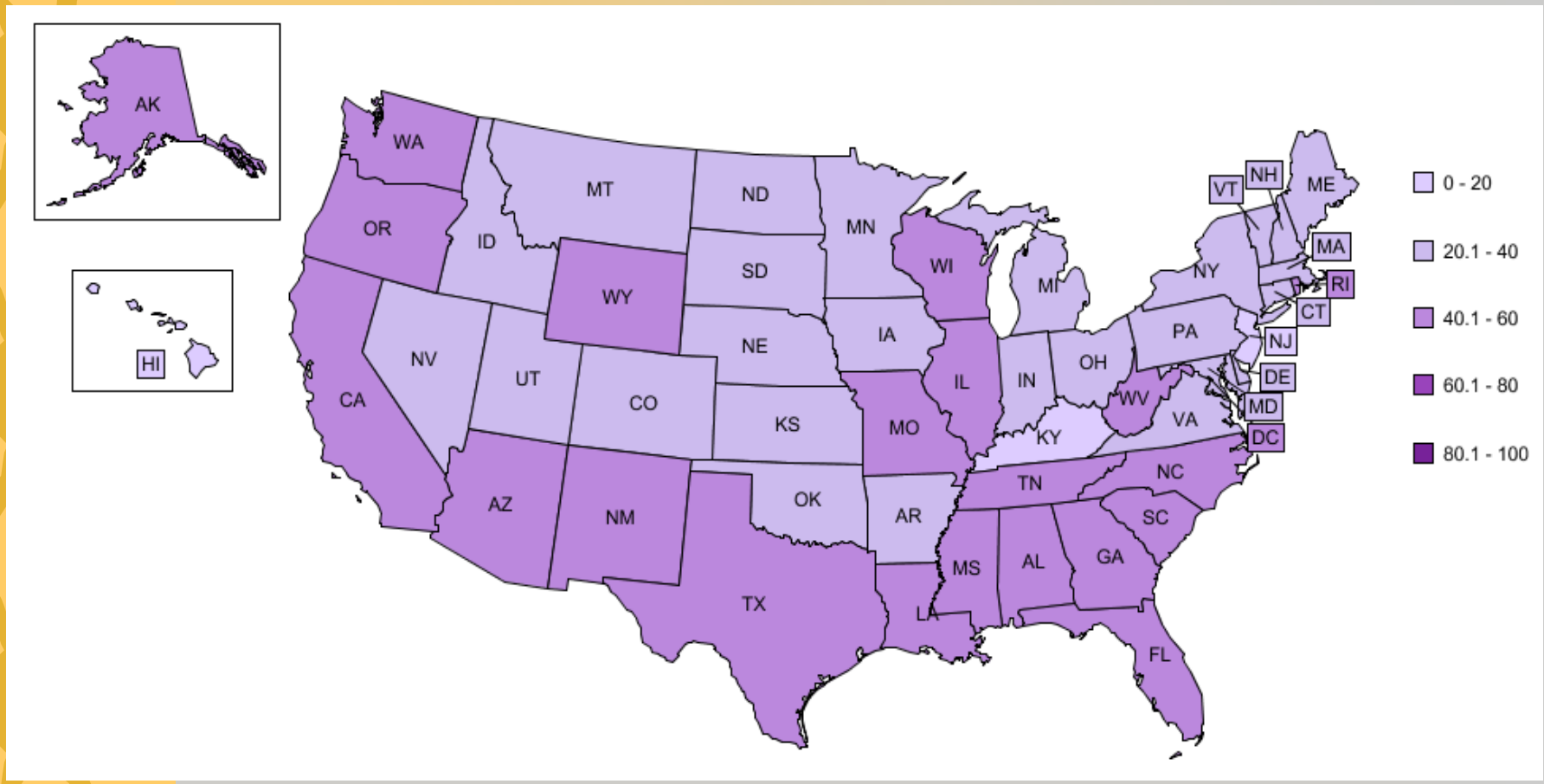
As reported by States in their Title V Block Grant FY 2004 Annual Report and FY 2006 Application

Percent of Infants Served by State Title V Programs Eligible for Medicaid Coverage – FY 2004



As reported by States in their Title V Block Grant FY 2004 Annual Report and FY 2006 Application

Percent of Deliveries Served by State Title V Programs Eligible for Medicaid Coverage FY 2004



As reported by States in their Title V Block Grant FY 2004 Annual Report and FY 2006 Application

Additional Information

- **DRA appropriates funds to support Family-to-Family Health Information Centers**
- **Family-Opportunity Act**
- **DRA changes SCHIP adult coverage requirements**

DRA Impact on Maternal and Child Health Programs and Populations

(Clear) ←→ (Not-So-Clear)

Deficit Reduction Act of 2005

- **Eligibility**
- **Premiums and cost-sharing**
- **“Benchmark” coverage**
- **Targeted case management**

A Quick Analysis: Premiums, Cost Sharing and Flexibility

- DRA Provides Protections for Pregnant Women and Low-Income Children

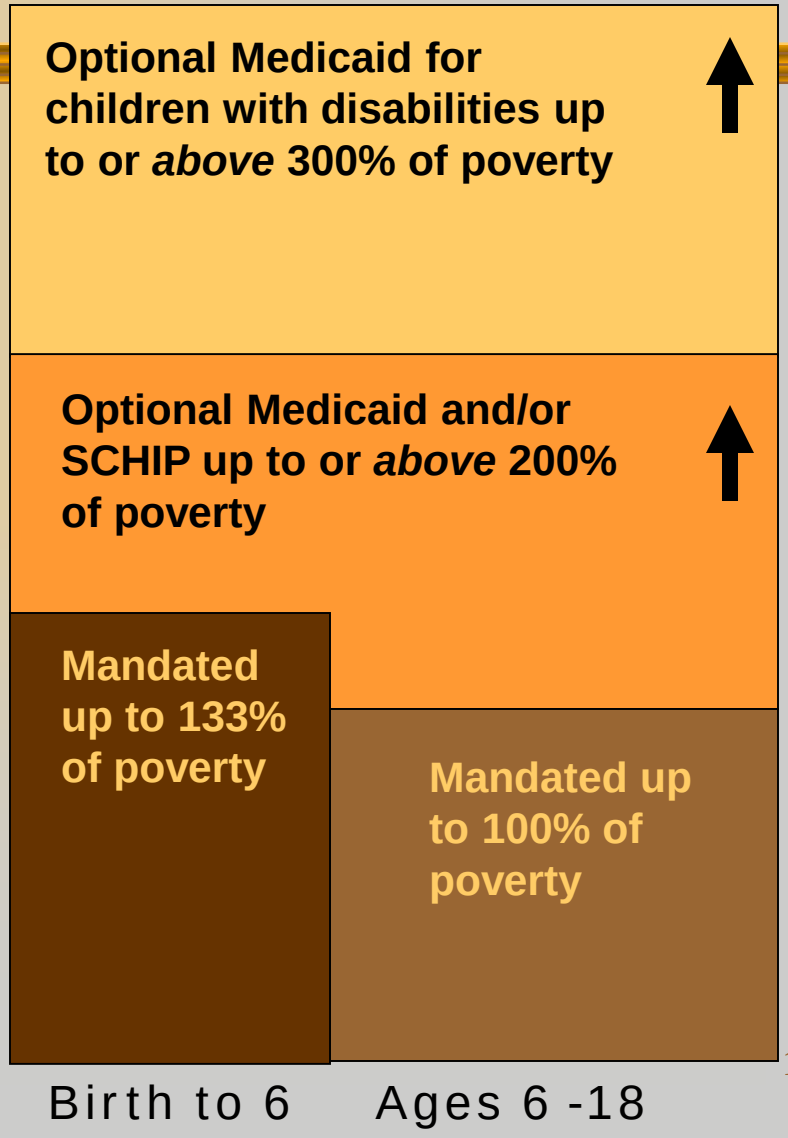
	Pregnant Women	Mandatory Populations	Children 100-150% FPL	Children Above 150%
Premiums	None allowed	None allowed	None allowed	Not to exceed 5% of family income
Cost sharing	None allowed	None allowed	Individual Services limited to 10% Total not to exceed 5% of family income	Individual Services limited to 20% Total not to exceed 5% of family income
Benefits Flexibility	Excluded	Allowed	Allowed	Allowed

Overview: Protected Services for Women and Children

- Exempted Cost-Sharing Services
  - Emergency
  - Family Planning
  - Services to Mandatory Medicaid Women
- Benchmark Plans Must Include:
  - Well-baby and well-child care, including age appropriate immunizations
  - Secretary approved preventative services
  - EPSDT Wrap-around

Eligibility

- **Federal law mandates**:
  - Infants and children to age 6 up to 133% of poverty
  - Children ages 6-18 up to 100% of poverty
- **State options to cover:**
  - Children in Medicaid at any income level
  - SCHIP ≥ 200% of poverty
  - Children with disabilities and special needs ≥ 300% of poverty



Family Opportunity Act

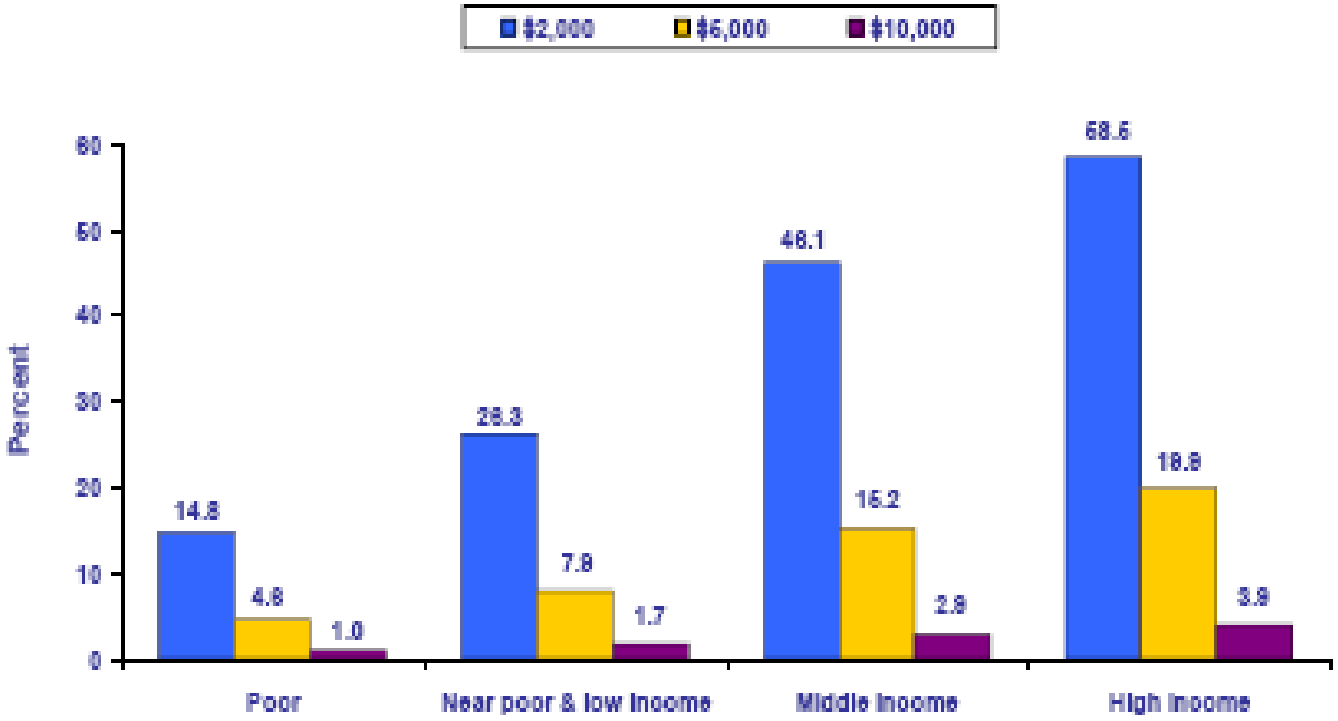
Provides an option to States to allow families of disabled children to buy into Medicaid

- Eligibility
  - Child is defined as disabled
  - Income does not exceed 300% FPL
  - Incomes above 300% FPL must only use State funds
- Premiums and Cost Sharing
  - (<200% FPL) – Not to exceed 5% of family income
  - (200% - 300% FPL) – Not to exceed 7.5% of family income

Effective Date: January 1, 2007

Out-Of-Pocket Health Expenditures

Figure 3. Percentage of nonelderly individuals living in families with out-of-pocket expenditures on health care and insurance premiums exceeding $2,000, $5,000, and $10,000, by poverty status, 2003



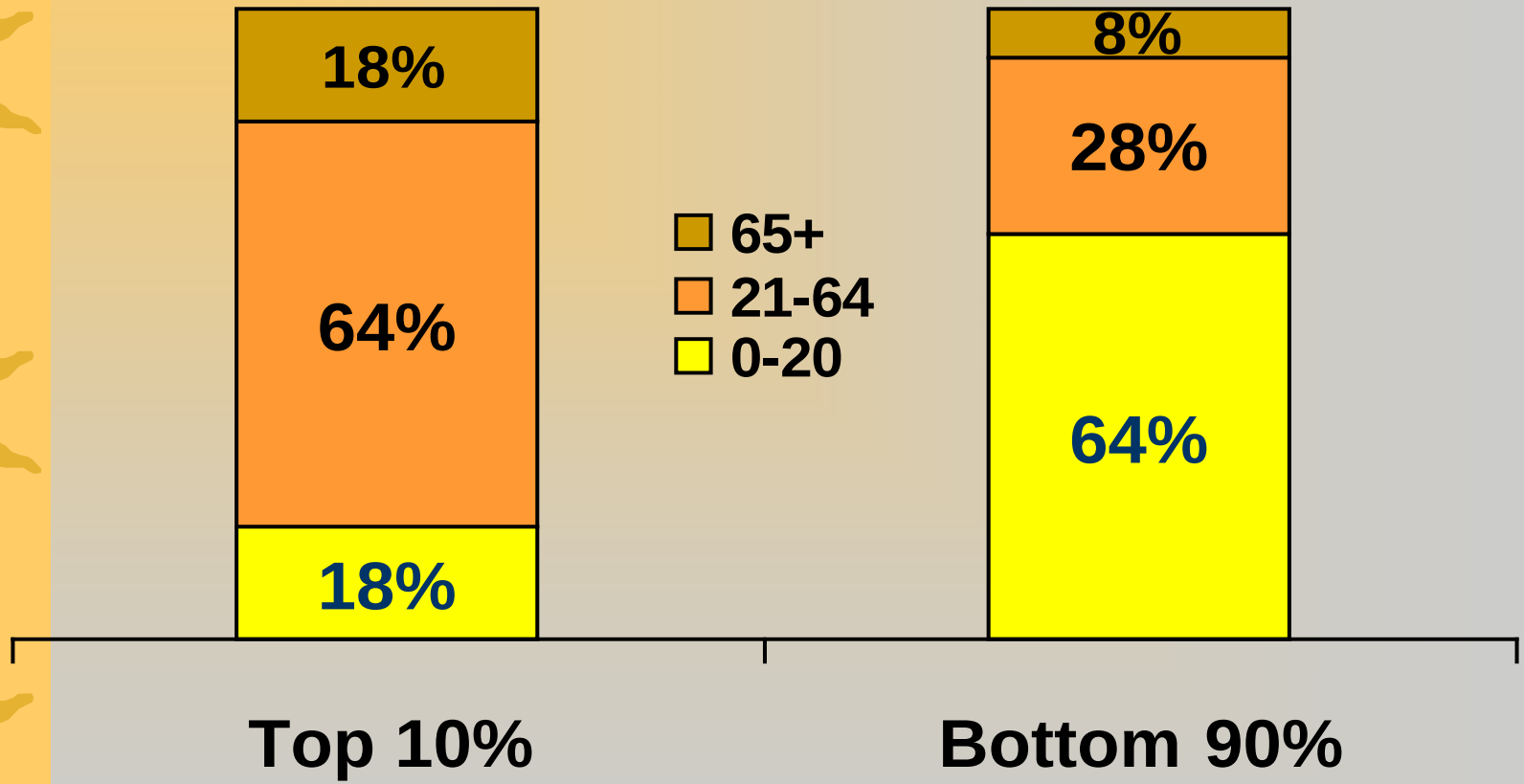
Source: Center for Financing, Access, and Cost Trends, AHRQ, Household Component of the Medical Expenditure Panel Survey, 2003

2006 HHS Poverty Guidelines

Persons in Family or Household	48 Contiguous States and D.C.	Alaska	Hawaii
1	$ 9,800	$12,250	$11,270
2	13,200	16,500	15,180
3	16,600	20,750	19,090
4	20,000	25,000	23,000
5	23,400	29,250	26,910
6	26,800	33,500	30,820
7	30,200	37,750	34,730
8	33,600	42,000	38,640
For each additional person, add:	3,400	4,250	3,910

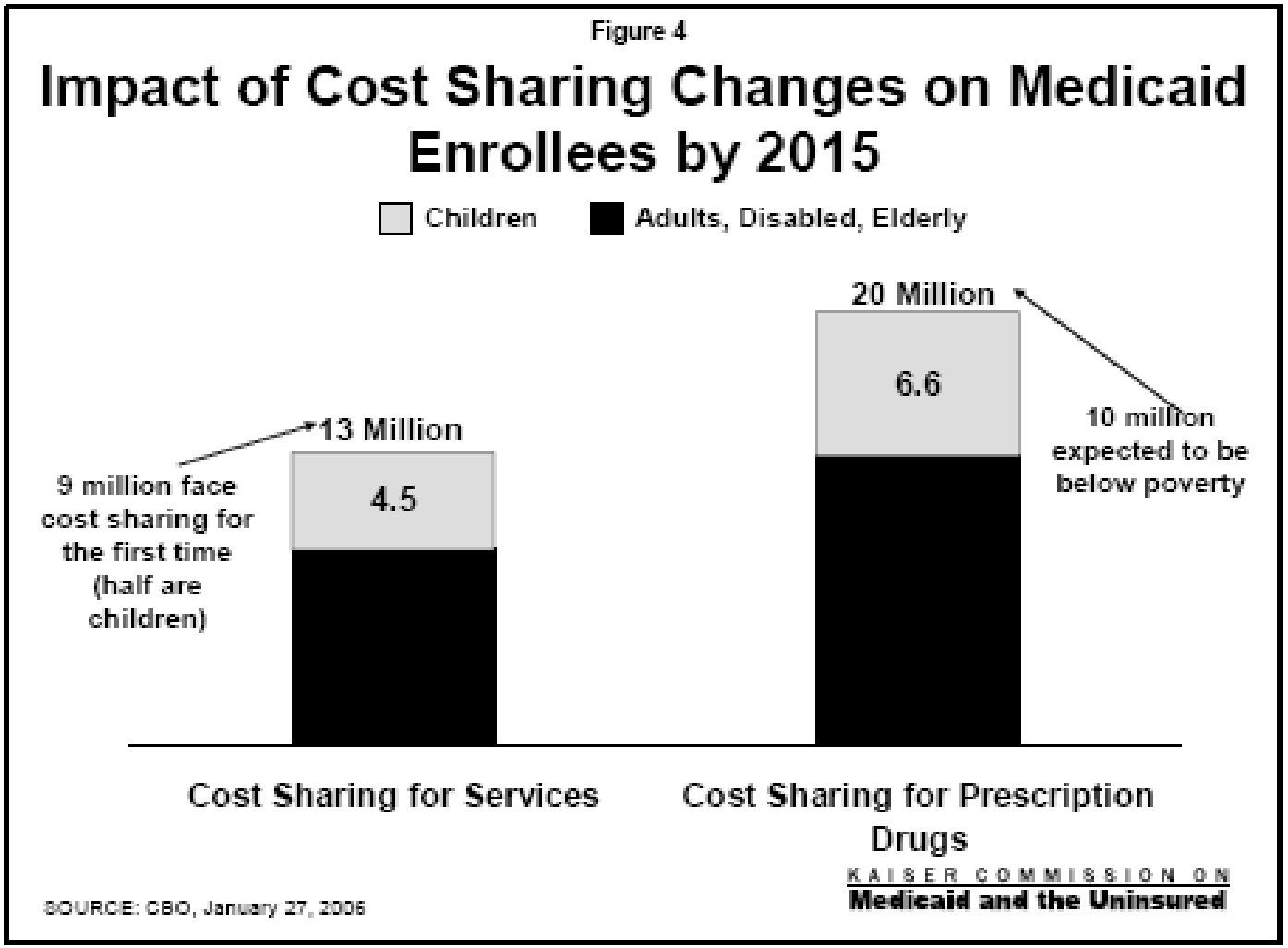
SOURCE: *Federal Register*, Vol. 71, No. 15, January 24, 2006, pp. 3848-3849

Costs for Children are Relatively Low



Source: Schneider A, Lambrew J, & Shanouda Y. Medicaid Cost-Containment: The Reality of High-Cost Cases. Center for American Progress. 2005. (Slide courtesy of Sara Rosenbaum).

Impact of Cost Sharing



Impact of Cost Sharing

Research Report Conducted by: Kaiser Commission on Medicaid and the Uninsured, May 2005

- New or increased premiums served as a barrier to obtaining and/or maintaining public coverage
- Premiums disproportionately impacted those with lower incomes, but also led disenrollment among those with incomes about 150% of poverty
- While some disenrollees obtained other coverage, many became uninsured
- Cost sharing led to unmet medical need and financial stress, even when amounts were nominal or modest
- Coverage losses and affordability problems stemming from increased out-of-pocket costs let to increased pressures on providers and the health are safety-net
- Increases in beneficiary costs may have created savings for States, but they may accrue more from reduced coverage and utilization rather than increased revenue.

Post-DRA: Coverage Rules
(Effective 3/31/2006)

- States have the option to use a "benchmark" benefit package and require enrollment for certain groups.
  - No need for waiver; State Plan Amendment suffices
  - This is similar to what is used for State (non-Medicaid) SCHIP programs
  - EPSDT wraparound required

Impact of Benefits Flexibility-Unclear

- Family Planning
- Duration and scope of services
  - Hearing, Vision, Mental/Behavioral Services
  - Services for Children with Special Health Care Needs (CSHCN)
- EPSDT
  - Coordination of wrap-around services

Case Management: PRIOR DRA

TYPE	SAMPLE ACTIVITIES	MATCH RATE
EPSDT case management	• Outreach & informing • Assisting with transportation	50/50
Administrative case management	• Assisting with applications • Assisting providers	50/50
Targeted case management	• Help in identifying services • Care coordination	Medical Services FFP Rate
Case management requiring expertise of skilled medical personnel	• Reviewing care plans • Approving provider payments • Certain referrals	75/25

Source: Johnson K. Prepared for HRSA Managed Care TA Project. May 2005.

Case Management

DRA Defined: "…Services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational and other services."

Assessment	**Referral and related activities including Linkages to:**
Taking client history Identifying the needs of indiviudals and documentation Gathering information	Medical Social Educational
Development of a specific care plan that addresses:	**Monitoring and follow-up activites**
Medical Social Education	Ensuring that care plan is implemented and addresses needs of individual

Targeted Case Management

DRA Defined: "Furnished without regard to the requirements of section 1902(a)(1) and section 1902(a)(10)(B) to specific classes of individuals or to individuals who reside in specific areas."

K Johnson Defined: "For specific categories of beneficiaries, specific geographic areas, or specific sets of services."

Allowable

- DRA: "…directly related to the management of the eligible individual's care"

Not Allowable

- DRA: "…relate directly to the identification and management of the noneligible or nontargeted individual's needs and care"
- DRA Defined: FMAP is Not Available "…if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program."

Impact of Medicaid Case Management Changes

- Examples of Title V MCH case management services
  - Outreach for pregnant women
  - Home visiting programs for CSHCN
  - Prenatal education services
  - Medical coordination for individuals with severe medical conditions
  - Care coordination to support the medical home
- It is unclear if changes to Medicaid law will impact reimbursement of services performed by MCH programs

Conclusion: Increased flexibility

- States have multiple options to change Medicaid programs.
  - Impact will only be known once changes are implemented by States
  - Many policy decisions affecting MCH populations and programs will be made in the near future
    - Update of Medicaid regulation
    - Revision of Medicaid manual
    - Review of CMS approved Medicaid State Plan Amendments

Conclusion: Title V Monitoring Role

- Monitoring the impact of these changes on public health/ MCH programs at the national, state and local levels
  - Does the number of individuals requesting services and assistance from MCH public health programs increase?
  - Do higher co-payments/premiums cause individuals to seek care from safety-net providers?
  - Will costs shift to public health programs?
  - Analysis of TVIS data to determine if States have shifted funds from Infrastructure, Enabling and Population services to Direct health services

Conclusion: Title V Coordination

- Title V MCH programs lead in coordination, infrastructure, and enabling services
  - How can state and local MCH programs provide information to families when benefit, cost-sharing, and case management rules change?
    - Toll-free hotline updates
    - Outreach & informational materials
  - Engage families, providers, and other agency partners in designing approaches to continue care coordination for children with special health care needs (CSHCN).
  - Study impact on systems of care (perinatal, early childhood, CSHCN, genetics, mental health, etc.)

For More Information

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