



## Deficit Reduction Act (DRA): Impact and Implications for State Medicaid Programs

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The recently passed Deficit Reduction Act (DRA) contains a host of provisions with which states likely are to deal in the coming year. Notably, the bill included a number of the Medicaid reforms that the National Governors Association and other state-oriented organizations sought. Following is a summary of DRA provisions that states likely will address soon.

### ***Asset Transfers***

The methodology by which states determine eligibility for Medicaid long-term care changes significantly with implementation of the DRA. The DRA makes it more difficult to access services through state Medicaid programs. For example, the bill counts the value of a house with an assessed value of \$500,000 or more (with an option available to states to raise that number to \$750,000, though) as a resource for establishing eligibility. For many senior patients who have lived in their current homes for decades, who have long since paid off mortgages, their home—now considerably more valuable than at purchase or mortgage sunset—becomes a barrier to medical security.

### ***Home and Community-Based Services***

The DRA grants or expands states' options and programs designed to keep seniors, disabled persons and others requiring long-term care out of an institutional setting. Among these is the reinstatement of the Long-Term Care Partnership. Under this program, individuals purchasing approved long-term care insurance policies do not have some personal assets counted against them when the state determines eligibility for Medicaid. Another DRA provision allows states to expand the use of home and community-based care without first obtaining a waiver. Finally, the DRA expands the options for states to use "Cash and Counseling" programs, among the more popular models of consumer-directed care, that keep disabled persons active and productive at home and in the community through direct grants that the recipient may determine how to spend (e.g., home health aides, home modifications).

### ***Benefits***

A key item requested by governors is a greater flexibility in the structure of their benefit packages. The DRA grants this request, to a degree. States will now have some additional leeway in benefit package design, but it comes with a number of exemptions, restrictions, caveats and necessities for approval.

### ***Cost-Sharing***

Another of the key items governors requested was the option to implement cost-sharing for Medicaid services and prescriptions. The DRA indexes cost-sharing to medical inflation, which could run the risk of accelerating the cost of care to enrollees more quickly than their income may accommodate, particularly during an economic downturn when more pressure is placed on Medicaid.

The end-result likely would be an avoidance of care or nonconformity to a physician's recommended prescription regimen. If they implement this option, states likely will model Medicaid cost-sharing on private insurance co-pays.

### ***Prescription Drugs***

In addition to prescription drug co-pays, the DRA changes the methodology determining states' reimbursements for pharmaceuticals. While states might pay less for prescription drugs, pharmacies will be affected negatively. This is especially true for smaller pharmacies. As a result, higher dispensing fees may follow, providing an additional cost for patients.

### ***Fraud, Waste and Abuse***

In response to recent reports estimating the level of fraud, waste and abuse in Medicaid, the DRA attempts to clamp down on the problem. One provision encourages states to adopt their own False Claims Acts, based upon the federal act signed into law by President Lincoln during the Civil War. This provision also increases a state's share in recovered funds if the state has passed a false claims act. On the potentially negative side, as suits may be brought by any witness to a false claim under the act, there exists a strong potential for an increase in frivolous lawsuits. Additionally, the DRA establishes a new Medicaid Integrity Program which essentially will increase the number of federal auditors in the states. There also is a provision requiring providers to be more helpful to states in identifying responsible third parties and other payors, with the goal of making Medicaid the payor of last resort. Finally, perhaps most controversially, is the provision requiring certification of citizenship.

### ***Money: Limiting***

Two DRA provisions affect Medicaid financing, with the first limiting provider taxes on Medicaid managed care entities, the second on targeted case management. In the latter, state child welfare and human services agencies, among others, were riding on Medicaid's richer payment and federal draw-down for coordination of the spectrum of social services for children.

### ***Money: Expanding***

Two provisions offer states an opportunity to draw down additional federal dollars. The first, Medicaid Transformation Grants, places \$150 million on the table for states to

- expand use of EHR's, electronic clinical decision support tools, or e-prescribing programs;
- establish new methods to recover funds from estates of individuals who owe money to Medicaid;
- establish new methods to combat fraud, waste and abuse;
- implement medication risk management as a part of drug use review programs;
- establish methods to reduce outpatient drug utilization, particularly through expanded use of generics and education programs; and
- use university-based hospital clinic systems to expand access to primary and specialty care services for the uninsured.

The second grant program—Medicaid Health Opportunity Accounts (HOA)—provides funds for grants to up to ten states to establish a pilot program that relies heavily on the health savings account model.

Under the HOA program, Medicaid patients would self-direct care from a pre-funded account. Balances, if there are any, will roll over to the following year. Additionally, a portion of any balance may be retained for use on qualifying expenses—medical care, health insurance, job training and tuition, for example—after an individual leaves Medicaid. For the HOA program, the DRA provides \$56 million over five years, with \$261 million budgeted over 10 years.

***Money: New Options and Demonstrations***

A new option for states under the DRA is the option to establish non-emergency transportation broker programs. Essentially, states will be allowed to select non-emergency transportation providers through competitive bidding. The state is not required to provide comparable services for all enrollees in all parts of a state or offer freedom of choice among transportation providers to enrollees.

Additionally, Congress added the Family Opportunity Act, for which Senator Charles E. Grassley (R-IA) had fought for some time, to the DRA. The measure includes several provisions of interest to states:

- A state option to allow families of disabled children to purchase Medicaid coverage that largely follows an earlier option allowing working disabled individuals to buy into Medicaid;
- A demonstration program for home and community-based psychiatric residential treatment for children, for which the federal government is providing \$36 million over five years and \$110 million over 10; and
- A “money follows the person” demonstration, which will have the federal government supplying 90 percent of the costs of home and community-based long-term care services for 12 months following a participant’s transition from an institution into the community (estimated to cost upwards of \$2 billion over 10 years).