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Building Blocks for Promising Practice Models

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Deficit Reduction Family Style: Understanding the DRA, the FOA and the $$$ for Families

JAMES RESNICK: Thank you very much, Linda. It's really actually a pleasure to be introduced by Linda, because when I first started in the bureau, actually when I first started in the agency, I really looked to people like Linda as a mentor and really Linda has taught me a lot and I've really learned a lot from her experiences, her worldly advice and I really appreciated my working relationship with Linda. So thank you, Linda.

LINDA HONBERG: Always remember to bring your glasses.

JAMES RESNICK: Yes. There's been a lot in the news in the last year about the Deficit Reduction Act. The message I want to bring home today is that there are challenges and there are barriers and there are opportunities as well, and that's what I want to discuss today.

I think the main thing that I want to also get across is have you called your Medicaid director or have you called your Medicaid counterpart, because the main thing in the law is that it allows states opportunities to do things to change the program in ways that they would have needed a Medicaid waiver, and now they only need to use a state plan.

And why is that so important to know? Well, in the old days, when you had a waiver and came to central office at CMS, it was reviewed by a large committee and included partners from across the department. There was an extensive review. They had to meet budget neutrality requirements, and guess what, they also needed to be renewed.

It was a 1915-B waiver every two years, and for the 11-15 waivers every five years. Guess what, the state plans are handled in the regional office. They're not done in central office.

No public reporting requirements. So you will not know if something has been changed in your Medicaid program until after you see it where we all see it and that's on the Kaiser family website or in the news or something.

So the main thing is that you need to find out, call your Medicaid counterpart and ask them what are you thinking, are there any changes that you're suggesting or proposing.

So I hope I can make that point strongly. Of course, what would be an MCHB meeting without the pyramid. The main thing I want to say is I'll be looking at certain sections of the DRA. I'm looking on its impact to MCH programs and populations and I'm going to try and connect it to different levels of the pyramid. We know, and I've said this time and time again, we know that there are requirements in both federal law, federal regulation, federal policy that require Medicaid and Title V to work collaboratively on multiple issues, including EPSDT, identification.

What's interesting is you look at the data, we know that 32 million people are served somehow on one level or another of the pyramid by Title V. And we know that a lot of those people that are served by Title V are also enrolled in Medicaid covered by Medicaid.

So while we have all these laws and rules that require collaboration on the state level between the two agencies, we know that on the ground that Medicaid clients are served

by Title V programs. So there is collaboration and there is definitely cross-over between those two programs.

As I said before, the impact of DRA in some cases it's very clear. It's cut and dry, black and white, and other times it's fuzzy, and it's very hard to analyze.

I'm going to cover in the presentation eligibility. I'm going to talk a little bit about premiums and cost sharing, benchmark coverage's. Targeted case management and citizen requirements. I'm really going to target those areas, can't hit every piece of the law because those are the areas that have the largest impact on MCH programs.

I think I'll be throwing out tons of federal poverty level, 100%, 150%. Let's get it in context. What are we actually talking about when I say 100% federal poverty level.

We're talking for a family of four, around $20,000. Just for a family of four. So I think that's important. We're thinking when we're thinking what kind of money are we talking about for families.

I have created this slide because I wanted to make a point. Because this summarizes premiums, cost sharing and benefit flexibility. The yellow shows very clearly where there's not flexibility. Where states cannot change parts of the program.

We know for pregnant women it's very limited. For mandatory population. So where the states have the most opportunity to change the program are with the optional children. And so there is a lot of flexibility as far as cost sharing and benefit flexibility. So I think it's an important point. For the pregnant women they've really made it much more difficult for states to change the program.

I think it's also important to note that some of the exempted cost sharing services, emergency, family planning, services to mandatory Medicaid women, but also on the benchmark plans, they must include well baby and well child care including age-appropriate immunizations and EPSDT wrap-around. What's important about the EPSDT wrap-around, yes it's supposed to wrap around but there's a ton of coordination issues that need to be worked out. So while it's protected in the law, how that wrap-around actually works on the ground is very important.

So this is a very quick graphic to show that we know -- these are the Medicaid eligibility for children. We know that the SCHIP is supposed to go around 200%. We also know that under the law there's a new eligibility category which is going to be talked about more extensively with the Family Opportunity Act for states to cover certain children with special healthcare needs who would otherwise not be eligible for Medicaid.

And not -- I'm only providing a very one slide because I know that my other colleagues are going to talk about the Family Opportunity Act but we're talking about for families to buy into Medicaid, it's important to note that the law clearly states that the child has to meet the SSI definition for severity of disability.

But as far as income goes, this allows families to buy into Medicaid. There are some cost sharing requirements within it, and I'm sure that my colleagues will speak about this more specifically. But also within the law there were, there's funding now to support the family-to-family health information centers.

One thing that I wanted to talk about, too, is that I actually, with the national children with special healthcare needs survey, I kind of -- I wanted to look at when we're talking with children with special healthcare needs I wanted to look at raw numbers as far as impact

goes. And I actually worked with them to break up by eligibility group to look at how many children with special healthcare needs are estimated how many children with special healthcare needs actually get public assistance whether through Medicaid, SCHIP or Title V.

I just wanted you to see especially look at the income categories in the 100 to 150% and the 150 to 299. And think about the raw numbers in the end when you're dealing with cost sharing and premiums, et cetera. So very important to think about.

We know that there have been many studies that have been done on cost sharing. And we know that cost sharing can impact people's ability to maintain and obtain insurance. We know that when states impose an SCHIP has been used, I know in this Kaiser study they did a major study on SCHIP enrollees, we know when you impose cost sharing that's too high, it can lead to disenrollment. And often it really discourages people to seek out services. And that's something that was mentioned in the Kaiser study. And I thought it was important to analyze.

Benchmark. Like I said previously, this is a real tough one, because you don't need a waiver, and now the state plan amendment is all that is needed. And this is similar, you're

going to see in a second, the standard benchmark plans. The federal employee health benefits program, state employee coverage. Coverage offered through the largest insured commercial nonMedicaid plan in the state. So this is cut and pasted directly from the SCHIP law. Why this becomes a challenge is that with that flexibility, and if you look at some of the state plans, like if you go onto the CMS website, because again this is something I went onto the CMS website. I downloaded them, and you look at for instance the Kentucky state plan. There are limits on rehabilitation services for children in there, if you look at it. And there's a number. I have them in my notebook. I meant to open it up.

But when there's opportunities within that to limit services, and it's not always clear, and so that's a strong point that I wanted to make that you really have to read into these state plans and you really need to make the case why there has to be some thought on part of the state on when you put limitations on certain services what is the impact.

It doesn't mean that people stop getting the services. They need the services and where are they going to go to get the services if they can afford it or are they going to look toward public health programs like Title V to do the gap filling.

Also in the law for other services like prescription drugs, vision and hearing, it's 75% of the actual coverage. So it's at a reduced level for those types of services.

So as I said before, the impact of benefits flexibility is very unclear. We don't know how it's going to impact family planning. When you look at duration and scope of services, we think about hearing, vision, mental, behavioral health services.

When you're looking at children with special healthcare needs I talked before about Kentucky physical therapy, occupational therapy, durable medical equipment, supplies, these are things to think about and it's not -- you don't really -- unless you're the person that's receiving the services you may not even realize especially if you're removed, you might not even think about these types of services.

But they're real and for the families that need these services, if they're limited, it can have an impact. And EPSDT. How are we going to coordinate, if the services are being provided by a health plan and it's being wrapped around and provided by the state how is that coordination going to work? How do families know that they have a right to that EPSDT benefit, even know to advocate for it and ensure if their child is screened for a

service and there is something is found in that screen under the law they are supposed to be able to get treatment. Even if it's not covered under the Medicaid state plan.

So it's important that these are things that when working with families we have to ensure that people don't forget EPSDT is critical in the Medicaid program. For those who attended the workshop yesterday, Kay Johnson made it clear that the EPSDT services are Medicaid for children. The EPSDT benefits are children services under Medicaid.

Citizen requirements. This has been probably what -- if you read -- if there's one piece of the DRA that I've seen most written about, it's probably about the citizen requirements, because it has been a huge administrative challenge for states and you know what amazed me is I actually downloaded, there was a state, Dear State Medicaid letter and it was five or six pages. If you look there was level one, level two. Went down to six levels.

If you didn't have this service -- and it was really incredible. I mean it's very extensive. And I think there's been a lot of public outcry about this and there actually was some recent legislation that there are some now some exempted groups from citizen requirements, citizens receiving SSDI, children in foster care and also there was a March 20th news release. I've been looking for where it's actually in the reg, but there

was a news release. It's on the CMS website that all babies born in the United States whose deliveries are covered by Medicaid may remain eligible under certain circumstances for Medicaid for up to a year after their birth.

Case management. If you ever talk to me for more than ten minutes I'm going to talk about case management and targeted case management. Because this is one of the areas that falls in that category of unclear, and it's like way over there. It's very unclear.

We know the old laws were very complicated on what was reimbursed for case management. We know for certain services they were matched at different rates and it was somewhat confusing. The one thing I noticed, and I took this directly from the law, is case management versus targeted case management, we're talking about case management for a second, services which will assist individuals under the plan in gaining access to needed medical, social, educational and other services.

The law really does a good job at really identifying what is assessment, what is the development of the specific care plan? It's very clear, which I think is an improvement over the previous law. What concerns me is targeted case management. And I didn't know exactly the best way how to describe targeted case management. And I actually

quoted Kay Johnson when she once said it out loud. She said for a specific category of beneficiaries, specific geographic areas or a specific set of services. And so DRA allows direct, directly related to the management of eligible individual's care. What I'm very concerned about is that the DRA says that if there are no -- basically what it says under the law, and I think I have a typo in there, is that if there are other third-parties liable to pay for the services, like the services that Title V provides, possibly, that it's unclear but it could possibly impact who the payor of last resort is. And the way the law is written it could be interpreted possibly that things that Title V covers that Medicaid could now claim that Title V is the payor of first resort which is very problematic. Nothing has come out in reg. I'm not advocating that obviously. I think if you read the law they were targeting foster care. And I think it was poorly worded in the law. But, again, one of the things that I hear is that each of the -- there's been nothing in -- nothing that I have seen yet, dear state Medicaid letter or anything that is directly targeted this issue. It has been infused in some regulations. But it's still unclear. And it still needs to be worked out. And what concerns me is we know -- what we know that these changes we talk about outreach, what is targeted case management, outreach for pregnant women home visiting for children with special healthcare needs prenatal education services medical coordination for individuals with severe medical conditions.

So it's very unclear in the future if CMS could change some of the methodologies for reimbursement for targeted case management.

One of the things I love to do is to go to the TBIS system and do narrative searches. I'm not going to read everything here. But let's talk what are states saying as targeted case management? I'm going to take the first one. Targeted case management, protocol will be developed for use with home health nurses that identify infants who missed or failed initial newborn hearing screening.

I'll go to my next thing, made reimbursement for targeted case management for Medicaid patients including children in custody who are at risk of being in custody of a state, adults in need of protective services and for rehab services for Medicaid eligible children in custody who are at risk of being in custody of the state.

So I really have gone and looked at the TBI system to look for real life examples of exactly what are states, from the Title V perspective thinking of case management services as.

So in conclusion, states have multiple options to change their Medicaid programs. We don't know -- it's very hard to know what those changes are until they go to CMS, put in a state plan amendment and the change just kind of happens overnight. We need to look at both the Medicaid regulation as updates come out. We need to look at the Medicaid manual and we need to look at the state plans as they're put up on the CMS website and also we need to look at the Dear State Medicaid letters.

Some things to think about, does the number of individuals requesting services and assistance from MCH public health programs increase. So we need to look at the data in the future and see, are our Title V programs being asked to provide services at the top of the pyramid?

Are we pushing up the pyramid instead of pushing down the pyramid. That's one of the big concerns they have. Again when you talk about things that are clear and unclear, that's one of the issues that's unclear. And that's something to explore in the future in looking at the data.

We also need to see if in states where they impose cost, you know co-payments and premiums, are they now going to safety net providers instead like community health centers? And as I said before, we need to continue looking at the TBIS data.

And we also need to provide information to families so they can advocate for services like EPSDT and we constantly need to work with our partners, other partners within the state like Medicaid and other public health agencies to really make the case when they're thinking about state reform efforts, to protect the services that are near and dear at MCH. So that concludes my comments right now. And I'm sure later I'll be able to take questions.

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