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## **Analysis of Impact of Deficit Reduction Act on Health and Social Services**

The *Deficit Reduction Act of 2005* (DRA) was signed into law as P.L. 109-171 by President Bush on February 8, 2006. There are a number of changes to entitlement programs that were made in the DRA. These changes affect LSA members and those they serve. Of particular interest are provisions that make changes to the Medicaid, child welfare and Temporary Assistance for Needy Families (TANF) programs.

### **The following are provisions included in the DRA that affect the Medicaid program:**

The DRA makes significant changes to the Medicaid program. Some low-income beneficiaries will now be required to pay more for services and those with assets will be penalized if they give away their assets in order to qualify for the program. One of the most far reaching proposals is that all Medicaid beneficiaries will be required to show proof of citizenship to remain on Medicaid.

Some provisions, such as asset transfer changes for the elderly and new citizenship requirements for all Medicaid beneficiaries, are mandatory for states. Other provisions are at the state's option. The Centers for Medicaid and Medicare Services (CMS) will issue regulations for these provisions throughout the coming year.

Cost Sharing: This is a new state option. States have always been allowed to ask Medicaid beneficiaries to contribute to the cost of their care.

However, the new provision would allow the states to require higher co-payments and premiums. This means that individuals, based upon their income level, could face higher co-payments. Also, for the first time, individuals who do not pay the fee can be denied services.

There are many concerns regarding changes in cost sharing. Individuals with low incomes below the federal poverty level would be required to pay cost sharing. This is believed to be a clerical error. Senator Charles Grassley (R-IA), Chairman of the Senate Finance Committee, and HHS Secretary Michael Leavitt, have said that the DRA does not override existing Medicaid law that disallows cost sharing for people with incomes below the federal poverty level.

Asset Transfer Changes: These provisions of the DRA are mandatory for all states. They are effective on the date of enactment, which is February 8, 2006. The look back period for transferring assets has been changed from three to five years. This means that any individual who gave a gift or made a transfer within five years of applying for Medicaid could face a penalty, as the gift or transfer may be interpreted as "spending down" to qualify for Medicaid.

There is also a change in the penalty period. Before the DRA was passed, the asset transfer penalty was based on when the transfer took place. For example, if an individual gave \$10,000 to a child, and it was determined that the transfer took place to qualify for Medicaid, the \$10,000 penalty phase would begin the date the transfer was made. The DRA changes the penalty to begin when the individual needs Medicaid. This raises concerns for providers who will have to bear the costs if someone they serve is penalized and loses

coverage. However, there is a clause that permits the facility in which the individual resides to file an undue hardship waiver application, with the consent of the individual and on behalf of the individual.

The DRA also includes a provision that excludes individuals whose home value exceeds \$750,000 from receiving long term care services funded by Medicaid. Individuals may obtain reverse mortgages on their homes to cover the cost of care. This provision is not applicable to individuals with a spouse or children with a disability living in the home. This provision is mandatory with the retroactive effective date of February 8, 2006.

#### Home and Community Based Services (HCBS)

State Option: The HCBS provision is a state option to provide HCBS without a state waiver for people with disabilities and for elderly persons. It establishes stricter eligibility criteria for institutional settings, such as an Intermediate Care Facility for Individuals with Mental Retardation (ICF-MR) and nursing homes, and broader eligibility criteria for in home supports under the state plan. States that choose to implement this plan may continue to provide services through existing waiver programs. Although the services provided under both the state plan and the waiver program are similar, the existing waiver program is broader and allows for more flexible programs.

For the first time in Medicaid history, the HCBS state option allows states to cap enrollment for this service. The cap for long term services and supports is codified. As a result, states can maintain a waiting list. This provision is effective January 1, 2007, and states can choose to implement this option at that time.

Consumer Directed Supports: This is a new state option for self-directed personal assistance services. This program is similar to “cash and counseling,” which allows an individual to take funds that are allocated to the individual by the state, based upon need, and pay family members,

neighbors, or professionals to administer the needed supports. To qualify, the individual must be eligible for personal care services under the state’s Medicaid plan or HCBS waiver. Individuals living in property owned, operated, or controlled by a service provider are not eligible for this service. This provision is effective January 1, 2007.

Family Opportunity Act: The Family Opportunity Act allows parents with incomes up to 300 percent of the federal poverty level and who have children with severe disabilities to buy into Medicaid. This provision is effective January 1, 2007. LSA supported the Family Opportunity Act.

Money Follows the Person: This rebalancing demonstration is an option for states. It provides an enhanced FMAP (Federal Medical Assistance Percentages) payment for individuals moving from a large facility to a community setting. The enhanced FMAP will be equal to the state’s regular FMAP plus half of the difference between the regular FMAP and 100 percent. The enhanced FMAP cannot exceed 90 percent and will last for one year. Funds will be awarded through competitive grants lasting two to five years. Appropriations of \$1.75 billion have been made for grants from January 1, 2007 through September 30, 2011.

Mandatory Proof of Citizenship: This provision is mandatory for all states. It is intended to enforce current law, which provides that only U.S. citizens access Medicaid benefits. This provision will require that all Medicaid applicants must provide either a passport or a birth certificate in order to receive, or to continue to receive, Medicaid benefits. There is concern that some elderly beneficiaries and beneficiaries that are incapacitated might not be able to provide needed documentation. This provision is effective on July 1, 2006.

Emergency Room Co-payments for Non-Emergency Care: A new state option permits states to allow hospitals to impose cost sharing for non-emergency services. After providing an appropriate medical screening examination and after a determination has been made that the individual does not have an

emergency medical condition, the hospital will be required to inform the patient that a co-payment may be required, and provide an alternative non-emergency provider.

Use of Benchmark Benefit Packages: This new state option allows states to enroll certain Medicaid beneficiaries in benchmark packages. The benchmark packages are the standard Blue Cross/Blue Shield preferred provider option service benefit plan, an equivalent to the state employee coverage, coverage offered through an HMO, or any other package that the HHS Secretary approves.

This option may provide wrap around benefits for children or provide full coverage for certain Medicaid beneficiaries. The state may not require the following populations to participate in the benefits package: pregnant women; individuals with disabilities; dual-eligibles; terminally ill hospice patients; individuals residing in an ICF-MR or a nursing facility; individuals who qualify for long term care services; children in foster care; TANF and section 1931 parents; or women with breast or cervical cancer. CMS has released a letter to the state Medicaid directors with implementation instructions.

Targeted Case Management: The DRA clarifies how Targeted Case Management (TCM) services can be accessed. Case management for abused and neglected children and elderly adults, medically fragile children, and people with HIV/AIDS receiving Medicaid who are assessed in a program other than Medicaid, will need to access case management through the program conducting the assessment. Medicaid will only be able to be billed for TCM where “there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, education or other program.” HHS is required to issue formal regulations on this provision.

**The following are provisions included in the DRA that affect child welfare programs:**

Title IV-E Foster Care Administrative Costs: The DRA reverses an HHS clarification in 2001 on reimbursements for administrative costs. The HHS rule changes were pending for several months prior to passage of the DRA. The DRA changes restrict states’ ability to receive federal reimbursement for certain foster care administrative costs. These costs include kinship placements in non-licensed relatives’ homes, children considered candidates for foster care, and children leaving non Title IV-E eligible facilities (e.g. psychiatric facilities, detention centers and crisis centers) and moving into foster care.

Title IV-E administrative matching funds will no longer be able to be drawn down by states for foster and adoptive children placed with relatives who are not licensed by the state within 12 months of the placement or the average time its take to license foster parents in that state, whichever is less.

Prior to the changes made in the DRA, federal funds were used to pay for time spent by workers to find and make a placement and other case management services. Title IV-E administrative funds are now limited to a one-month period after a child is transferred from an institution outside of the child welfare system. Child welfare agencies may use Title IV-E administrative funds for case management and planning services during this limited time.

Title IV-E Foster Care Maintenance Payments: The DRA overturns a Ninth Circuit Court decision in 2003 in *Rosales v. Thompson*. Financial eligibility for Title IV-E is still linked to the 1996 AFDC income criteria. In the *Rosales* decision the court said that income eligibility could be determined from the home in which the child resided in over the previous six months or the home of removal. Due to this decision, many more children were eligible for Title IV-E foster care assistance because many children live with grandparents or other relatives on a temporary basis while determinations are made about what is in the best interest of the child.

The DRA says that income eligibility must be determined by looking at the home from which the

child was legally removed due to allegations of abuse and neglect. This is usually the parents' home.

Funding Increases: The DRA does include some increases in funding for the child welfare system.

The Promoting Safe and Stable Families Program (Title IV-B funding) received a \$40 million increase in mandatory funding for FY 2006. The discretionary funding for the program was decreased by \$9.4 million. The DRA provides no specificity as to how the \$40 million should be spent. Congress might include instructions on spending in the Promoting Safe and Stable Families reauthorization bill, which is likely to pass in 2006.

Mandatory funding in the amount of \$100 million over five years was added to the Promoting Safe and Stable Families for new court improvement projects. The recommendations of the Pew Commission's on Children in Foster Care include improving the dependency courts by building capacity to track and analyze caseloads, cross-training court personnel and child welfare agency staff, and expanding the Court Appointed Special Advocates (CASA) program.

**The following are provisions included in the DRA regarding the Temporary Assistance to Needy Families (TANF) program:**

The DRA reauthorizes the TANF program, something Congress has been trying to do for many years. The DRA provisions related to TANF include a requirement that all states increase the percentage of a state's TANF caseload that must participate in certain work activities. States can no longer adjust the work participation requirement downward by a caseload reduction credit. States must have 50 percent of all adults that receive TANF participating in defined worked activities and at least 90 percent of two-parent families that receive TANF assistance participating in defined work activities. If a state reduces its TANF caseload below the

2005 level, the work requirements are lower. However, some estimates project that at least 42 states will not meet the new caseload requirements because TANF caseloads are at historic lows.

There are reports that some states have indicated they will have no choice but to restrict families' access to TANF and focus solely on meeting the work participation rates. Currently, most state budgets will not accommodate funding state-only programs that improve families' employment outcomes without a federal match. The DRA requires states to include households participating in state-only programs in the TANF caseload numbers. However, the DRA eliminates the provision in existing law that allows states to include state-only programs as part of the state's maintenance of effort (MOE) fund. Some states will no longer be able to afford the state-only programs if they cannot draw down federal funds against the state-only program by including the state program in the MOE calculation.

There are nine core work activities defined in the DRA: 1) unsubsidized employment; 2) subsidized private-sector employment; 3) subsidized public-sector employment; 4) work experience; 5) on the job training; 6) job search and job readiness assistance, for up to six weeks per year; 7) community service programs; 8) vocational educational training, for up to 12 months; and, 9) vocational educational training, for up to 12 months (42 U.S.C. Sec. 607(c)(1)(A) and (d); 45 C.F.R. Sec. 261.31).

The effective date for implementation of the new caseload reduction credit and MOE calculation is October 1, 2006.

The DRA also instructs HHS to adopt regulations no later than July 1, 2006 specifying uniform methods for reporting hours of work. The regulations will also specify the type of documentation needed to verify reported hours of work, whether an activity can be treated as one of the federally listed work activities for purposes of participation rates, and the circumstances under which a parent who resides with a child receiving assistance should be included in the work participation rates (Deficit Reduction Act, Sec. 7102(a)(b)(c)). If a

state fails to implement procedures and controls consistent with the new regulations, HHS can assess a penalty of up to five percent of a state's TANF block grant (42 U.S.C. Secs. 07(a),(b)(3)).

In early May 2006, HHS sent draft regulations to the Office of Management and Budget for review. It is unclear when OMB will complete the review of the draft regulations.

## **Update on FY 2007 Federal Budget**

On March 16, the Senate adopted a budget resolution (S. Con. Res. 83) by a vote of 51-49. The vote was mostly along party lines. The Senate's budget resolution would allow discretionary spending levels up to \$878 billion for FY 2007.

On May 18 at 1:00 a.m. in the morning, the House passed their budget resolution (H. Con. Res. 376) by a vote of 218-210. The vote was mostly along party lines with twelve Republicans voting "no." The total discretionary spending cap is \$873 billion, which is the same as the President's and \$4.2 billion less than the Senate's discretionary spending cap. The moderate Republicans accepted a written promise that an additional \$3.1 billion could be added to the Labor-HHS-Education spending bill if an acceptable offset is found. Appropriators had already shifted \$4.1 billion from defense and foreign programs to education and health care programs. However, a total of \$7.2 billion is needed for programs in the Labor-HHS-Education spending bill to maintain level funding from FY 2006.

The next step in the budget process is for the House and Senate to meet in a conference committee and work out the differences in their bills. However, it is unlikely that the House and Senate will reach a compromise. Therefore, the Appropriations process will likely proceed in each chamber with the numbers agreed upon in the individual chamber's budget resolution. The final

spending limits will be decided in a conference committee for the appropriations bills.

While House leadership and the moderates were negotiating the budget resolution, the subcommittees of the House Appropriations Committee began marking up or voting on appropriations bills. The first appropriations bills are expected to come to the House floor on May 18 or soon thereafter.

The appropriation subcommittees in the Senate have yet to begin marking up or voting on their spending bills.

**Call to Action!** State and local organizations are being asked to sign onto a letter to the House and Senate leadership urging Congress to balance concerns over the nation's long-term budget deficit with the need to preserve vital programs. A copy of the letter is posted on the LSA Public Policy Advocacy website at [www.lutheranservices.org](http://www.lutheranservices.org). Organizations interested in signing on to the state and local letter should email the organization's name, city and state along with contact information to Jenn Novesky at [jenn.novesky@uwa.unitedway.org](mailto:jenn.novesky@uwa.unitedway.org). The deadline for signatures is open as the letter will be sent to Congress on a periodic basis.

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