

Health Centers and the Deficit Reduction Act: An Overview for State Policy Makers

ANDREW SNYDER

Federally qualified health centers (FQHCs), which provided care to 5 million Medicaid enrollees in 2005, have a special relationship with Medicaid programs. The complex package of measures in the Deficit Reduction Act of 2005 (DRA) raises particular considerations for these health centers. While their role in the safety net is recognized in the DRA, important aspects of their relationship to their state Medicaid programs, especially regarding the availability of Medicaid reimbursement, may change.

Signed into law by President Bush in February 2006, the DRA made some of the most significant alterations to Medicaid in the 40-year history of the program. The DRA is a complex piece of legislation that is intended to generate

almost \$100 billion in savings from various federal programs over ten years, with \$26.3 billion of those savings coming from Medicaid.¹ It included provisions to allow states greater flexibility in benefit design and cost-sharing, including the ability to tailor benefits to groups of Medicaid enrollees. It also made changes to multiple other sections of law governing a variety of program functions, from eligibility determination to provider reimbursement methodology. The DRA is still a work in progress; Congress has passed one bill containing “technical corrections” to the law (H.R. 6408, The Tax Relief and Health Care Act of 2006), and the Centers for Medicare and Medicaid Services is still in the process of promulgating rules on various DRA provisions.

The National Academy for State Health Policy (NASHP), under a National Cooperative Agreement with the Health Resources and Services Administration (HRSA), Bureau of Primary Health Care, is working to better inform state policy makers about the DRA, as it affects the health care safety net, and particularly federally funded community health centers. This *State Health Policy Briefing*, subsequent *Briefings*, and other project activities are intended to stimulate dialogue and promote collaboration between state government and safety net providers in addressing shared missions and goals for assuring access to care for vulnerable populations.

This *Briefing* gives special attention to the “benchmark” plans authorized under the DRA. The plans allow states to enroll Medicaid recipients in alternative benefit packages that are more similar to private insurance products than to traditional Medicaid, and which can have benefits that vary between groups of enrollees. It also touches briefly on a variety of other DRA provisions that could affect health centers, including:

- New provisions related to cost-sharing,

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- More stringent federal requirements related to citizenship verification, as well as policing of Medicaid fraud,
- Alternative benefit structure through Health Opportunity Accounts,
- Important changes to reimbursement methodology for pharmacy services and to Medicaid’s relationship with other funding sources for services like targeted case management,
- New options to improve Medicaid for disabled and elderly persons, and
- Grants to states to reduce inappropriate use of emergency rooms.

The DRA introduces important changes to the policy environment for state Medicaid programs. The new options and flexibility granted in the DRA, especially as they relate to increasing the risk and responsibility of the individual program enrollee, can have effects that pose unique challenges and opportunities to health centers. As state policy makers and health centers assess this new environment, they should be aware of these effects, and engage each other in determining how best to implement changes to address the role of safety net providers in achieving shared goals.

The Role of Health Centers

Federally qualified health centers are primary health care clinics which receive special grant funding from the federal government under Section 330 of the Public Health Service Act to provide safety-net services in areas of need.

Federally qualified health centers must:

- Be located in a medically underserved area;
- Provide broadly-defined primary health services including not only physician services, but also preventive dental care, referrals to or the direct provision of mental health care, transportation, and more;
- Implement a sliding schedule of fees based on a patient’s ability to pay; and
- Be governed by a community board made up primarily of health center users.

In 2005, 952 Section 330-funded FQHCs were in operation across the United States.² Additionally, there were approximately 100 “look-alike” clinics, which meet all the requirements for federal health center designation, but which do not receive Section 330 funding.³

In order to ensure that health centers’ Section 330

funds are used for the purpose of providing free or low-cost care to the uninsured, and not subsidizing care to Medicaid beneficiaries, state Medicaid programs are required to make payments to FQHCs that meet the health center’s reasonable costs of providing care. Since 2001, in most states this has taken the form of the Prospective Payment System (PPS), which is an all-inclusive rate per visit that approximates the health center’s average costs of providing care.^{4,5} Under PPS, services are not billed individually to state Medicaid programs; rather, one standard payment is made for each visit to an FQHC where an allowable service is provided. Allowable FQHC services under Medicaid are defined as services provided by physicians, physician assistants, nurse practitioners, clinical psychologists, and clinical social workers, as well as any other ambulatory services included in the Medicaid State Plan.⁶ (Services provided by the listed provider types must be reimbursed, even if they are not in the Medicaid state plan.) Note that states and health centers are allowed to negotiate alternative payment methodologies that pay an amount at least equal to what the FQHC would have received under PPS. These mechanisms are important to keep in mind in the context of benefit changes that are allowed under the DRA.

Over the last 20 years, Medicaid has become the critical funding source for health centers, and health centers have emerged as an important part of the safety net for Medicaid enrollees. In 2005, Medicaid was the largest funding source for health centers, accounting for \$2.7 billion (37 percent) of a total \$7.3 billion in revenues, and 5 million (36 percent) of the health centers’ 14.1 million patients were Medicaid-enrolled. Section 330 grant funds supported an additional 5.6 million health center users (40 percent) who were uninsured, and who contributed to the cost of their health services with out-of-pocket payments according to a sliding fee schedule based on ability to pay.⁷

In 2004, 91 percent of the 13.1 million health center patients had family incomes below 200 percent of the federal

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Portland, Maine Office:
50 Monument Square, Suite 502, Portland ME 04101
Phone: (207) 874-6524

Washington, D.C. Office:
1233 20th St., NW, Suite 303, Washington, DC 20036
Phone: (202) 903-0101

How the DRA Will Affect Health Centers

States have the option to design benchmark plans that may change Medicaid coverage for services provided by federally qualified health centers.

- These plans may result in Medicaid benefit packages that do not align with services that health centers are mandated to provide.
- States have new flexibility to provide varying benefits to different groups of enrollees; this may complicate the relationship between patients and health centers, as well as other providers.
- A new focus on disease management and wellness may present an opportunity for health centers to expand their education and case management functions.

DRA provisions, as well as other state health care reform efforts, may have large effects on how patients use health centers.

- Ongoing state efforts to redesign health coverage may result in changes to the benefit packages available even to Medicaid enrollees who aren't in benchmark plans.
- Increases in co-payments, and states' new ability to allow private providers to refuse services to enrollees for failure to pay co-payments, may mean that patients turned away by other providers may seek out health centers as a no-cost source of care.
- Citizenship and identity verification requirements

may affect the ability of patients to access Medicaid coverage, and of health centers to access Medicaid reimbursement. If patients experience disruptions in Medicaid coverage due to the new requirements, they may go to health centers if they cannot access other community providers.

The DRA recognizes the important role of health centers, and offers opportunities for states to work collaboratively with the safety net.

- States pursuing benchmark plans must assure that enrollees have access to health center services. It is unclear, however, how these assurances will be implemented.
- \$50 million in grants will be made to states to encourage the use of more appropriate care settings, such as health centers, instead of hospital emergency rooms. This presents an opportunity for health centers and state government to work together to build stronger "medical homes."
- New emphasis on community placement of elderly and disabled Medicaid enrollees, as well as the new option to expand coverage of disabled children under the Family Opportunity Act provides a way for health centers to support state efforts to provide care in the community.
- Effective dialogue between states, health centers, and primary care associations is essential to avoid unintended consequences that strain the safety net.

poverty level, and over 70 percent had incomes of less than 100 percent of the federal poverty level.⁸ Changes in law affecting low-income Medicaid enrollees have the potential to have very large impacts on health center operations, and therefore on their ability to serve uninsured as well as publicly insured patients.

Benchmark Plans and Benefit Redesign

Under the DRA, states may use state plan amendments to provide "tailored" benefit packages, called benchmark or benchmark-equivalent plans, to certain groups of Medic-

aid enrollees. These are alternative plans that are generally considered to be more like commercial insurance products, and less expensive than the traditional Medicaid benefit set. Thus far, three states – Idaho, Kentucky, and West Virginia – have received approval of state plan amendments that use benchmark plans to deliver tiered benefits to differing groups of Medicaid enrollees, involving a "basic" package of benefits, with access to more generous health benefits conditioned on health status or compliance with personal responsibility agreements. Two other states have received approval under DRA authority for plans that maintain the state's standard Medicaid package for most enrollees, but extend additional benefits to specific groups of enrollees: the working disabled in Kansas, and people with certain chronic diseases in Virginia.

BENCHMARK AND BENCHMARK-EQUIVALENT PLANS DEFINED

States may opt to provide one or more of these *benchmark plans* to Medicaid enrollees:

- The federal employees' health plan,
- The health plan offered to state employees,
- The largest commercial managed care plan in the state, and
- A "Secretary-approved" plan – that is, any plan deemed by the Secretary of the Department of Health and Human Services to provide "appropriate coverage" to the designated groups. (All five of the approved state plan amendments to date have been "Secretary-approved" plans.)

Benchmark-equivalent plans are state-designed plans that have an aggregate actuarial value at least equivalent to one of the benchmarks. They are required to provide the full actuarial value of these services:

- Inpatient and outpatient hospital services,
- Physician, surgical, and medical services,
- Laboratory and x-ray services,
- Well-baby and well-child care, including age-appropriate immunizations, and
- Other appropriate preventive services, as designated by the Secretary.

And if the benchmark plan includes any of the following services, states are required to provide them at a level of no less than 75 percent of their actuarial value in the comparison benchmark plan:

- Pharmacy services,
- Mental health services,
- Vision services,
- Hearing services.

For children and adolescents up to age 19 enrolled in a benchmark or benchmark-equivalent plan, states are required to provide wrap-around coverage that ensures access to the full range of medically necessary medical, vision, hearing, and dental services that Medicaid-enrolled children are entitled to through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit.

EFFECT OF BENCHMARK PLANS ON REQUIRED FQHC SERVICES

By law, FQHCs are required to provide the following services:

- Health services related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology that are furnished by physicians and where appropriate,

physician assistants, nurse practitioners, and nurse midwives;

- Diagnostic laboratory and radiology services;
- Preventive health services, including prenatal and perinatal services; cancer screening; well-child services; immunizations; screenings for elevated blood lead levels, communicable diseases, and cholesterol; pediatric eye, ear, and dental screenings to determine the need for vision and hearing correction and dental care; voluntary family planning services; and preventive dental services;
- Emergency medical services;
- Pharmaceutical services;
- Referrals to providers of medical services, including specialty referral, substance abuse, and mental health services;
- Patient case management services;
- Services that enable individuals to use the services of the health center, including outreach, transportation, and translation services; and
- Patient education.

Thus, the benefit packages allowed by the DRA may not be exactly contiguous with the services that FQHCs are required to provide.

It is important to note that the DRA requires that states electing to enroll recipients in a benchmark plan must provide assurances that these enrollees will have access to services provided by Federally Qualified Health Centers, and that the Prospective Payment System to FQHCs remain intact.¹¹ Guidance from the Centers for Medicare and Medicaid Services, however, is unclear about exactly what these assurances mean for health centers, and it remains to be seen how states will implement these provisions – for example, whether managed care organizations administering benchmark plans will be required to contract with all (or any) health centers in their service areas, or whether health center services will be made available outside of the regular benchmark plan.¹²

Additionally, an assurance of access to FQHCs does not necessarily mean that the benchmark plan must contain all health center services. If the health center is required to provide a service, such as dental services for adults, and a benchmark plan removes that service from a state's benefit plan for Medicaid enrollees, it does not remove the health center's obligation to provide those services. However, it brings into question the availability of Medicaid reimbursement for that service. It may mean that the health center would need to charge the patient based on its sliding fee schedule, or that the health center's PPS payment might

be calculated on the basis of only the ambulatory services included in the benchmark package.¹³

State limitations on coverage of optional services like adult dental services are not a new occurrence, but the DRA allows states to pursue benefit plans that vary in the amount, scope, and duration of services offered to different groups of enrollees based on health status, compliance with personal responsibility standards, or location in the state. This is a significant change that can affect a health center's ability to provide care, as well as a patient's decisions about seeking care. It complicates a provider's relationship with the Medicaid program, and it requires greater awareness of a particular patient's enrollment status at the time of care.

A NOTE ABOUT COST-SHARING

The DRA also allows states greater flexibility to increase cost-sharing – premiums and co-payments – for certain groups of enrollees and certain types of services. Prior to the DRA, co-payments were limited to “nominal” charges, defined as being between \$.50 and \$3 per service.¹⁴ Medicaid providers could not refuse a person service for failure to pay a co-payment. Now, states can set co-payment levels at 10 percent of the cost of the service for some Medicaid enrollees with income between 100 and 150 percent of the federal poverty level. For those with incomes over 150 percent of poverty, co-payments can be set as high as 20 percent of the cost of the service.¹⁵ Additionally, states have the option of making co-payments “enforceable,” meaning that providers can be allowed to refuse services for failure to pay a co-payment prior to delivery of a service.

Health centers are not permitted to refuse services to anyone based on ability to pay; however, in states exercising the “enforceable co-payments” option, health centers may find that patients turned away by other providers may seek them out as a source of care.

BENCHMARK PLAN ENROLLMENT, AND BENEFITS FOR NON-BENCHMARK ENROLLEES

The DRA lists 11 groups of Medicaid enrollees that a state cannot require to be enrolled in a benchmark plan, including pregnant women, the blind and disabled, and foster children, among others.¹⁶ However, this does not mean that, in a state opting to have a benchmark plan, the benefits provided to all members of these 11 groups will be exactly the same as they were prior to passage of the DRA.

First, states can offer these beneficiaries the option of enrolling in the benchmark plan, so long as they are allowed to return to the “standard” Medicaid plan at any time.

Some states appear to be interpreting this requirement to mean that beneficiaries can be automatically enrolled in benchmark plans, so long as they have the opportunity to opt out.¹⁷ Second, DRA changes are happening in the context of larger state reform efforts, and a state may take the opportunity, through other mechanisms, to change the benefits available in the standard Medicaid plan. Changes to Idaho's program were made through roughly a dozen state plan amendments, some adding DRA flexibility, and others relating only to the standard Medicaid and SCHIP programs. Idaho also has received approval to remove optional covered services, including pharmacy, therapies, dental, and vision from the standard Medicaid package. This is intended to encourage enrollees to take up coverage under the benchmark plans, but it also means that enrollees remaining in standard Medicaid have a smaller benefit package.¹⁸ As detailed above, this could impact a health center's ability to obtain PPS reimbursement for all the services it provides.

The benchmark benefit redesigns can serve to expand benefits, as well. States are taking the opportunity offered by the DRA to redesign their programs around the ideas of wellness, anticipatory guidance, and disease management for persons who have chronic conditions like asthma or diabetes. Such services fall into the purview of the health centers' patient education function, and health centers may find that these new sorts of benefits allow them to expand these functions, or capture funds for services that they are already providing.

Other Facets of the DRA

The DRA contains a variety of other measures relating to Medicaid and which impact health centers.¹⁹ The sections below do not represent an exhaustive list, but highlight several of particular note.

CITIZENSHIP AND IDENTITY VERIFICATION

Medicaid is a program that is largely available only to United States citizens. (Exceptions to this rule include legal immigrants who have been in the country more than five years, and “non-qualifying aliens” who are seeking emergency services.) Prior to the passage of the DRA, states were required to collect information about applicants' citizenship; however, they were able to do so through a self-declaration on the application or other means. Now, most Medicaid applicants are required to present original, non-photocopied documentation such as a passport, birth certificate, and/or driver's license, proving their identity and citizenship before

they can be enrolled in the program.²⁰ Current enrollees are being required to provide proof of citizenship and identity when their eligibility is re-determined. (States also have the option of matching applicants against existing vital records databases to determine citizenship.) The intent of the measure was to prevent non-eligible immigrants from receiving Medicaid benefits; however, at least one study has estimated that citizenship documentation may serve as a barrier to enrollment for 1.6 to 2.3 million low-income citizens who are entitled to coverage.²¹

Citizenship verification requirements can affect health centers in two ways. First, current patients who fail to provide citizenship and identity verification are at risk of losing their Medicaid coverage. From the health center's perspective, this means that, rather than being able to capture Medicaid funds for services provided to these patients, they must instead charge them on their sliding fee schedule, or entirely subsidize their care using their Section 330 grant funding or other sources. Second, patients who had been seen by other community providers and who lose their Medicaid eligibility (or who were unable to complete an application for benefits) may flow to health centers as a point of access when they cannot afford care at their current providers.²² A recent report and survey of health centers indicates that they are already experiencing disruptions in coverage for Medicaid enrollees, and that documentation requirements may jeopardize Medicaid coverage for up to 300,000 health center patients.²³

HEALTH OPPORTUNITY ACCOUNTS

The DRA gives the Secretary of Health and Human Services the ability to authorize up to 10 states to enroll certain recipients in another alternative benefit design called a Health Opportunity Account (HOA).²⁴ An HOA is a high-deductible plan coupled with an individual health spending account. The state makes a contribution of up to \$2,500 for an adult, or \$1,000 for a child (to a maximum of \$4,000 for a family), and the enrollee is then responsible for using these funds to purchase necessary care until the deductible has been met. The deductible can be set no higher than 110 percent of the premium, or at most \$2,750 for an adult. After that point, the person may receive regular Medicaid benefits. This means that, in the course of a year, there may be a "gap" period when an HOA enrollee has exhausted the funds contributed to his or her health savings account and must pay for medical services out-of-pocket. It may be that patients in this situation will seek out health centers and other safety net providers as a source for subsidized care.

PROGRAM INTEGRITY

The DRA gave the federal Centers for Medicare and Medicaid Services (CMS) several tools to enhance the government's ability to police Medicaid fraud and abuse. Included in this set of measures was a requirement that entities receiving more than \$5 million in Medicaid reimbursement per year must provide their employees with education about state and federal false claims acts, as well as whistleblower protections under those laws. These providers, which include many health centers, also must establish and document their own internal procedures for detecting and preventing fraud by January 1, 2007.²⁵

PHARMACY REIMBURSEMENT

Health centers that operate pharmacies are eligible to participate in the 340B drug reimbursement program, through which they receive access to discounted prices on pharmaceuticals. Under the DRA, a change was made to Medicaid reimbursement for pharmaceuticals. The basis for setting drug payment prices was changed from the Average Wholesale Price, the price at which a retail pharmacy purchases a drug, to the Average Manufacturer's Price (AMP), or the cost to the manufacturer of producing the drug. The maximum that a Medicaid program can reimburse a pharmacy for a drug (i.e., the Federal Upper Limit) was set at 250 percent of AMP. The upshot for health centers is that the payment they receive from Medicaid programs for dispensing of generic drugs will likely decrease, since AMP is lower than Average Wholesale Price. A proposed CMS rule to implement the AMP provision is currently the topic of controversy due to disagreements about the method for calculating AMP.²⁶

TARGETED CASE MANAGEMENT AND THE DEFINITION OF "THIRD PARTY PAYORS"

Targeted case management (TCM) is an optional benefit that allows Medicaid to reimburse qualified providers who assist patients in gaining access to needed medical, social, educational, and other services. It does not include the actual provision of needed medical services, but can include assistance such as development of a care plan, or advocating for services on a patient's behalf. This benefit can be "targeted" to program enrollees who fall into certain geographic areas or classes, for example children in foster care or children with special health care needs. In some states, health centers can be recognized by Medicaid programs as TCM providers and reimbursed separately for those services. The DRA made important changes to targeted case management, including clarifications of the activities which can be considered targeted case management and a redefinition of

the relationship between TCM and other funding for other coordinating services.

Prior to the DRA, public programs such as child welfare agencies might seek Medicaid reimbursement for case management services, reserving limited federal or state discretionary funds for services not covered by Medicaid.²⁷ As a result of changes made in the DRA, this behavior may no longer be allowable.

Medicaid has legal status as “payor of last resort,” meaning that, in most cases, an enrollee’s other sources of health care coverage must be exhausted before Medicaid will pay for a service. These other sources of coverage, usually private insurance, are known as “third-party payors.” The DRA made a clarification to the definition of third-party payors, to state that *any* parties that are legally responsible for payment for a health care item or service must be charged prior to Medicaid. CMS rules are in development that should provide further clarification on whether this definitional change means that child welfare agencies must spend their other funds prior to billing Medicaid for case management; it should also clarify the areas other than TCM that are affected by the change. Rules are also in development regarding other details of the case management provisions, as well as a related provision regarding rehabilitation services. Their effect on funders of case management services, and by extension, health centers that provide TCM services, remains to be seen.

OPTIONS FOR ELDERLY AND DISABLED POPULATIONS

The DRA seeks to allow states to increase the number of opportunities for elderly and disabled enrollees to receive care in their communities, rather than in nursing facilities, by expanding the PACE partnership program, by opening a new pathway to Medicaid enrollment for disabled children in higher-income families through the Family Opportunity Act, and by giving states the flexibility to implement Home and Community-Based Services programs for certain enrollees without a federal waiver. Prior to the DRA, if a state wished to divert Medicaid recipients with extensive needs from a nursing home care setting, it would need to pursue a Home and Community-Based Services (HCBS) waiver from the Department of Health and Human Services (under section 1915 (b) of the Social Security Act). HCBS waivers allowed states to provide case management, personal care, rehabilitation services, and a variety of medical care in the person’s home, rather than in an institution. With the new flexibility provided by the DRA, more states can opt to provide this type of alternative-setting care. The Family Opportunity Act is a new option through which states can elect to allow disabled

children in families with incomes below 300 percent of the poverty level to enroll in Medicaid and receive medical services in community settings. This presents an opportunity for health centers with experience in serving disabled clients to support their states in such coverage expansions.

Decision makers must be knowledgeable about the specific services and community resources these enrollees need. This population can be fragile, or have special physical needs, such as a need to be transitioned in and out of a wheelchair for examination. Health centers seeking to provide services to this population may need to ensure that their facilities are compatible with the special needs of this population, and that they have adequate numbers of providers and staff with the training and expertise necessary to deliver appropriate care. This is particularly an issue regarding services like dental care, where very few dental professionals have training in caring for geriatric or special-needs patients.

GRANTS TO STATES TO REDUCE INAPPROPRIATE EMERGENCY ROOM USE

The DRA makes \$50 million in competitive grant funding available over four years to states for efforts to divert people seeking care in hospital emergency rooms for non-emergency situations to more appropriate care delivery settings. Community health centers are specifically noted in a list of Medicaid-participating “alternate non-emergency services providers” that states should encourage enrollees to utilize instead of emergency rooms.²⁸ This presents an opportunity for health centers and state primary care associations to work with their state Medicaid agency to develop grant applications and innovative approaches to encourage the use of appropriate care settings and “medical homes.”

Conclusion

The Deficit Reduction Act of 2005 made a large number of changes to the Medicaid program, and the implications of those changes are still being sorted out by federal and state governments. As a safety-net system that disproportionately provides care to low-income persons and families, including a high percentage of Medicaid enrollees, and that relies on Medicaid reimbursements for one-third of its revenue, health centers are particularly sensitive to changes in that program.

The emergence of new benefit options presents both challenges and opportunities for health centers. Benchmark and benchmark-equivalent plans can significantly change the package of services that Medicaid enrollees are eligible for.

Health centers are required to provide a certain spectrum of services, and benchmark plans are not guaranteed to include all of them. However, they may also include disease management and an improved focus on prevention that comports well with the mission of health centers. While states are required to maintain enrollees' access to FQHCs, there are still unresolved questions about the form that this access might take.

Additionally, there are a set of other changes included in the DRA, from sweeping changes in citizenship verification to more technical requirements for increased education on preventing fraudulent billing, that all affect safety net providers. It falls to states to make decisions about implementation of these provisions, and it is incumbent upon state policy makers to keep the potential effects on the federally qualified health center safety net and the mission it embodies in mind as they craft their response to this new policy environment.

Notes

- 1 Congressional Budget Office cost estimate. (January 26, 2006) Internet; available at <http://cbo.gov/ftpdocs/70xx/doc7028/s1932conf.pdf>. Accessed April 6, 2007.
- 2 Health Resources and Services Administration, Bureau of Primary Health Care, Uniform Data System National Aggregate Data for Years 1996-2005. Internet; available at <http://www.bphc.hrsa.gov/uds/nationaldata.htm>. Accessed April 3, 2007.
- 3 Sara Rosenbaum and Peter Shin, *Health Centers Reauthorization: An Overview of Achievements and Challenges* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2006), pp. 4-5.
- 4 Statement by Dennis Smith, Director, Center for Medicaid and State Operations to House Energy and Commerce Subcommittee on Oversight and Investigations, May 25, 2005. Available at <http://www.hhs.gov/asl/testify/to50525a.html>. Accessed February 12, 2007.
- 5 P.L. 106-554, Section 702.
- 6 These provider types are enumerated in the Medicare definition of Rural Health Clinic "core services" (see Section 1861(aa) of the Social Security Act), which is incorporated into the definition of FQHC services. This policy is explained in a 2003 letter from CMS to HRSA, available at <ftp://ftp.hrsa.gov/bphc/docs/2004pins/2004-05.doc>.
- 7 HRSA, Uniform Data System.
- 8 Sara Rosenbaum and Peter Shin. *Health Centers Reauthorization: An Overview of Achievements and Challenges*. (Washington, DC: Kaiser Family Foundation, March 2006), 7.
- 9 P.L. 109-171, Section 6044. Note that if these services are not offered in the comparison benchmark plan, then they do not need to be offered in the benchmark-equivalent plan.
- 10 42 U.S.C. §254b(b)(1)
- 11 P.L. 109-171, Section 6044.
- 12 In a "Dear State Medicaid Director" letter of March 31, 2006, guidance from CMS states: "If a State provides benchmark or benchmark-equivalent coverage to individuals, it must assure that the individual has access, through such coverage or otherwise, to rural health clinic services and FQHC services[...]" (emphasis added). SMDL #06-008; Internet; available at <http://www.cms.hhs.gov/smdl/downloads/SMD06008.pdf>, accessed April 10, 2007.
- 13 As previously noted, children under 19 enrolled in benchmark plans are required to have coverage of medically necessary services through an EPSDT wraparound. Thus, even if these services were "noncovered" for children, they would likely be available through an EPSDT wrap-around. Likewise, physician, physician assistant, nurse practitioner, clinical psychologist and clinical social worker services must be reimbursed, even if they are not in the Medicaid State Plan.
- 14 Note that the DRA also requires "nominal" co-payment amounts to be indexed to the medical Consumer Price Index, beginning in 2006.
- 15 P.L. 109-171, Section 6041 (a). Groups exempted from co-payment requirements include "mandatory" populations of children – children under 6 with incomes under 133 percent of the FPL, and children ages 6-18 with incomes under 100 percent of the FPL – as well as hospice patients, institutionalized patients, and women whose Medicaid eligibility is tied to a diagnosis of breast or cervical cancer. Also exempt are preventive services for children, pregnancy-related services, emergency services, and family planning services. The level of allowable co-payment was also raised for brand-name prescription drugs that are not on a state's formulary of "preferred" pharmaceuticals, and for use of an emergency room for non-emergency services.
- 16 See Congressional Research Service, *Side-by-Side Comparison of Medicare, Medicaid, and SCHIP Provisions in the Deficit Reduction Act of 2005*. (Washington, DC: Library of Congress, January 27, 2006) 71-72. The enumerated groups also include some nursing home residents, disabled children eligible for Medicaid under the Katie Beckett/TEFRA pathway, Medicare/Medicaid dual eligibles, women in the breast and cervical cancer eligibility group, and limited benefit eligibles, including certain people enrolled in a tuberculosis-only benefit.
- 17 See, for example, the "Comprehensive Choices" and "Optimum Choices" recipient enrollment letters available on the Kentucky Choices webpage, <http://chfs.ky.gov/dms/kyhealthchoices.htm>
- 18 Idaho Department of Health and Welfare, *Issue Brief: Federal Approval of Idaho Medicaid Reform*, February 23, 2007 and *Enrollment Process*, November 17, 2006. Internet; available at <http://www.medicaid.idaho.gov>. Accessed April 3, 2007. Note that this state plan amendment is not included in the set of DRA-related state plan amendments which are accessible through the CMS website, http://www.cms.hhs.gov/DeficitReductionAct/03_SPA.asp#TopOfPage.
- 19 Some Medicare provisions in the DRA also specifically relate to health centers. Diabetes self-management training and medical nutrition therapy services provided by health centers were added as Medicare-covered services; Medicare is now allowed to make payments directly to health centers for services provided by health care professionals who contract with the center; and health centers who receive Section 330 grant money for care to the homeless are now eligible for Medicare reimbursement.
- 20 Since the passage of DRA, certain groups have since been exempted from these requirements, including foster children funded under Titles IV-B and IV-E of the Social Security Act, and elderly and disabled persons whose eligibility is tied to Medicare, SSI, and SSDI are exempt from this requirement. Newborns whose delivery was paid for by Medicaid are exempt for one year post-delivery. See Kaiser Commission on Medicaid and the Uninsured, "Citizenship Documentation Requirements in Medicaid," (March 2007); Internet; available at <http://www.kff.org/medicaid/upload/7533-02.pdf>. Accessed April 10, 2007. Also note that certain other documentation of citizenship and identity may be accepted under limited conditions.

- 21 Leighton Ku, "Revised Medicaid Documentation Requirement Jeopardizes Coverage for One to Two Million Citizens," (Washington, DC: Center on Budget and Policy Priorities, July 13, 2006) Internet; available at <http://www.cbpp.org/7-13-06health2.htm>. Accessed April 10, 2007.
- 22 This concern is further detailed in an August 7, 2006 letter from National Association of Community Health Centers Vice President Dan Hawkins to CMS, available at <http://www.nachc.com/advocacy/Files/state-policy/NACHC%20Comments%2000n%20Citizenship%20Rule%20FINAL-Signed%208%207%2006.pdf>. Accessed April 10, 2007.
- 23 Peter Shin, et. al. "An Initial Assessment of the Effects of Medicaid Documentation Requirements on Health Centers and Their Patients," (Washington, DC: George Washington University, May 7, 2007).
- 24 P.L. 109-171, Section 6082, and Dear State Medicaid Director Letter #07-001, available at <http://www.cms.hhs.gov/smdl/downloads/SMD011007.pdf>. Accessed April 10, 2007.
- 25 P.L. 109-171, Section 6032. See also Melinda Murray, "More Compliance Sticks and Carrots: The Deficit Reduction Act of 2005." National Association of Community Health Centers Issue Brief #87 (July 2006).
- 26 See for example a February 15, 2007 press release from Senate Finance Committee chairman Max Baucus, available at <http://finance.senate.gov/press/Bpress/2007press/prbo201507.pdf>. Accessed April 10, 2007.
- 27 See Sara Rosenbaum and Anne Markus, *The Deficit Reduction Act of 2005: An Overview of Key Provisions and Their Implications for Early Childhood Development*. (New York: The Commonwealth Fund, October 2006). Internet; available at http://www.cmf.org/publications/publications_show.htm?doc_id=409144.
- 28 P.L. 109-171, Section 6043. The term 'alternative non-emergency services provider' is defined to include "a physician's office, health care clinic, community health center, hospital outpatient department, or similar health care provider."

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