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The DRA Benefit Provisions and EPSDT

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This summary is excerpted from NHeLP's full analysis of the Deficit Reduction Act of 2005.

Pre-DRA law

The Medicaid Act has required states to cover certain services and allowed states the option to cover others. Examples of mandatory Medicaid services for categorically needy recipients are: inpatient hospital services, physician services, nursing facility services, rural health clinic and federal qualified health center services, and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for children and youth under age 21. *See* 42 U.S.C. §§ 1396a(a)(10), 1396d(a). Optional Medicaid services for adults include prescription drugs, dental services, private duty nursing services, personal care services, and physical therapy. *Id.* States can offer a smaller set of services to individuals eligible through a medically needy program, but must include prenatal care and delivery, ambulatory services for children under age 18 and individuals entitled to institutional services, and home health services for those entitled to nursing facility care. *See Id.* § 1396a(a)(10)(C).

EPSDT requires states to cover periodic and as-needed medical, vision, hearing and dental screening. EPSDT also requires states to cover any Medicaid service, whether mandatory or optional (*see* § 1396d(a) listing), if the service is needed to "correct or ameliorate" a child's physical or mental condition. *See Id.* §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r).

Benefit Packages under the DRA

The DRA gives states the option to provide Medicaid to state-specified groups through enrollment in pre-existing health insurance plans. DRA, § 6044. In so doing, the state can ignore Medicaid's traditional rules requiring coverage of mandatory and optional services, statewideness, freedom of choice, and comparability. The provision is effective March 31, 2006. According to CMS, state plan amendments submitted by June 30, 2006, may be approved retroactive to the first day of the quarter (April 1, 2006). *See* CMS, *Dear State Medicaid Director* (Mar. 31, 2006) (SMDL #06-008) (on file with NHeLP).

States are prohibited from requiring individuals to obtain benefits through this option if they are eligible for Medicaid because they are:

- pregnant women with incomes at or below 133 percent of the FPL,
- individuals who qualify under the state plan because they are blind or disabled without regard to whether the individual is eligible for SSI,

- dually eligible Medicare/Medicaid beneficiaries,
- terminally ill hospice patients,
- individuals eligible on the basis of institutionalization and receiving only a personal needs allowance,
- medically frail and special medical needs individuals, to be defined by the Secretary of HHS in regulations. In a March 31st letter, the Secretary designated these individuals as those groups defined in the managed care regulation, 42 C.F.R. §§ 438.50(d)(1) (dual eligibles) and (d)(3) (children under age 19 who are eligible for SSI, TEFRA children, or receiving care through a family-centered, community care system under title V), *id.*,
- beneficiaries qualifying for long term care services,
- children in foster care and receiving foster or adoption assistance,
- TANF and section 1931 parents,[1]
- women receiving treatment for breast and cervical cancer,
- individuals who qualify due to TB-infection,
- non-qualified aliens receiving care for an emergency medical condition,
- medically needy.

See DRA, § 6044(a); CMS, *Dear State Medicaid Director* (Mar. 31, 2006) (SMDL #06-008). In addition, states can only exercise the option for an individual eligible under an eligibility category that had been established under the state plan on or before February 8, 2006 (the date of enactment of the provision)

Thus, mandatory enrollment will affect mostly children, working parents, and pregnant women with incomes over 133 percent of the FPL. These populations must have "access" to services provided by rural health and federally qualified health centers. It is not clear whether states will be required to maintain access to all such clinics or whether they can assure access by contracting with one or only a few clinics.

Section 6044 allows states to provide coverage to state-selected population groups through one or more "benchmark" or "benchmark equivalent" plans. The benchmark plans are: (1) the standard Blue Cross Blue Shield preferred provider option under the Federal Employee Health Benefit Plan, (2) the HMO plan with the largest commercial, non-Medicaid enrollment in the state; (3) any generally-available state employee plan (regardless of whether any state employees select the plan); and (3) any plan that the Secretary of HHS determines to be appropriate. To be considered benchmark-equivalent, the coverage must include inpatient and outpatient hospital services, physician services, laboratory and x-ray services, well baby and child care (including immunizations), and "other appropriate preventive services" designated by the Secretary of HHS. *See* DRA, § 6044. Thus, it is possible for services such as prescription drugs, dental, mental health, vision and hearing services to be excluded.

[1] The provision apparently intends to exclude TANF and section 1931 parents from mandatory enrollment. However, it refers to individuals "who qualify for medical assistance on the basis of eligibility to receive assistance under a State plan funded under part A of title IV (as in effect *on or after* the welfare reform effective date … [July 16, 1996]." DRA. § 6044 (Emphasis added). After July 16, 1996, AFDC was replaced by TANF in title IV-A, and no-one automatically qualifies for Medicaid on the basis of title IV-A eligibility. *Cf.* 42 U.S.C. § 1396u-1 (treating individuals as automatically eligible for Medicaid if they meet the IV-A requirements in effect *as of* July 16, 1996). The CMS letter of March 31st exempts parents who qualify for Medicaid "solely on the basis of qualification under the State's TANF rules (e.g., the State links Medicaid eligibility to TANF eligibility)." However, parents cannot qualify for Medicaid solely on the basis of TANF. Thus, in practice, no one will qualify for the exemption from mandatory enrollment.

Implications for EPSDT

There has been some confusion about how the provision affects EPSDT. No doubt, the provision could have been more artfully drafted. However, regardless of the benchmark selected, the DRA clearly provides that a state will provide "for any child under 19 years of age who is covered under section 1396a(a)(10)(A) [categorically needy coverage], *wrap-around benefits* to the benchmark coverage or benchmark equivalent coverage *consisting of early and periodic screening, diagnostic, and treatment services* defined in section 1905r [42 U.S.C. § 1396d(r)]." DRA, § 6044(a) (emphasis added). While another, later provision of § 6044(a) does give states the option of providing wrap-around benefits, this more general provision will not control EPSDT. According to the rules of statutory construction, this provision would apply to groups other than children under age 19, and the under 19 group is protected by the more specifically worded EPSDT language. The Secretary of HHS has recently confirmed this reading:

> Individuals under age 19 who are covered under the State plan under section 1902(a)(10)(A) of the Act must receive wrap-around benefits to the benchmark, or benchmark-equivalent plan, consisting of early and periodic screening, diagnosis, and treatment (EPSDT) services defined in section 1905r. Wrap-around benefits must be sufficient so that, in combination with the benchmark … package, these individuals receive the full EPSDT benefit.

CMS, *Dear State Medicaid Director* (Mar. 31, 2006) (SMDL #06-008).[2] *See also* Letter from Charles Grassley, Chairman, Senate Committee on Finance, and Joe Barton, Chairman, House Committee on Energy and Commerce, to Hon. Michael O. Leavitt, Secretary, DHHS (Mar. 29, 2006) (on file with author) ("We insist that CMS reject any state plan amendment involving benchmark … coverage that does not also provide for wraparound EPSDT services and benefits to individuals under age 19…. Congress intended to make no change to EPSDT coverage."). *See also* Dep't of Health & Human Services, *Statement by Mark B. McClellan, M.D., Ph.D., Administrator, Centers for Medicare & Medicaid Services* (undated) (on file with author) ("Children under age 19 will receive EPSDT benefits."); 109 Cong. Rec. H46 (Feb. 1, 2006) (Statement of Rep. Joe Barton, R-TX, Chairman of the Committee on Energy and Commerce) (section 6044 "language reflects the clear legislative intent by both the House and Senate that all children should continue to receive access to coverage of early and periodic screening, diagnostic, and treatment services ("EPSDT") services…. Congress clearly intended for all children under Medicaid to continue to receive EPSDT services and we will work with Administrator McClellan to ensure that all children continue to have access to these important services.").

Nevertheless, there is cause for concern. Youth aged 19-21 can be enrolled in the benchmark coverage and, for them, the wrap-around benefit appears to be optional. The March 29, 2006 letter from the congressional leaders to the Secretary of HHS inaccurately states, "Consistent with section 1902(a)(43)(A) of the Social Security Act [42 U.S.C. § 1396a(a)(43)(A)] EPSDT remains a required benefit to all individual under the age of 19 who have been determined eligible for Medicaid and, if the state elects to provide coverage, up to the age of 21." Letter from Charles Grassley, Chairman, Senate Committee on Finance, and Joe Barton, Chairman, House Committee on Energy and

[2] A State Plan Amendment pre-print that accompanied the letter required the state to assure, and describe how, EPSDT will be maintained. This pre-print has since been removed from the CMS website, and its status is unclear.

Commerce, to Hon. Michael O. Leavitt, Secretary, DHHS (Mar. 29, 2006). Section (a)(43)(A) explicitly extends EPSDT to all Medicaid-eligible persons in the state who are under age 21.

In addition, there is a great risk that services and administration between benchmark and wrap around EPSDT benefits could be uncoordinated, and advocates should work to assure clear guidelines and education regarding them. One place to look for a track record (good or bad) is how your state has coordinated the provision of services when contracting with managed care plans that do not provide the full scope of Medicaid benefits, for example carving out mental health, dental, or long term care services. Lessons learned from this past experience may inform the new debate.

Moreover, the benchmark options contained in section 6044 are the same as those provided to states for their SCHIPs. So, your state's experiences with SCHIP contracting will be relevant. Moreover, these types of benchmark options may be applied to additional Medicaid populations in the future.