



What New CMS Guidance on DRA Means to Children's Dental Care

The Centers for Medicare and Medicaid Services (CMS), the agency responsible for implementing the Deficit Reduction Act (DRA), has released guidance on the new Medicaid provisions. Three Medicaid changes of particular interest to the dental community are citizenship verification requirements, alternative benefit packages, and cost sharing options. This brief provides details on recently released CMS guidance on these three issues to assist children's oral health advocates in working with their states.

Citizenship Verification

Medicaid rules require beneficiaries to be a citizen or a qualified alien in the U.S. Although that law has not changed, prior to DRA Medicaid applicants could self-declare their citizenship status under penalty of law (in all but four states). Effective July 1, 2006 DRA now requires a one-time determination of citizenship for Medicaid beneficiaries, new and existing.

CMS guidance released on June 9, 2006 through a "Dear State Medicaid Directors Letter" details how states are to implement this citizenship-identification provision of the law. CMS established a "hierarchy of reliability" of documents that can be used to validate citizenship. A U.S. passport, Certificate of Naturalization and a Certificate of Citizenship are at the top of the list. If these documents are not available within a specified period of time then a combination of other documents providing proof of citizenship and identity must be provided, including but not limited to a birth certificate, American Indian card, final adoption decree, school record, or daycare/nursery school record. Regardless of the form of identification, originals or certified duplicates must always be presented – copies are not a valid proof of citizenship. Under certain circumstances Medicaid agencies may conduct data matches with other government agencies to verify citizenship and identity.

The new guidance clearly states that Medicaid applicants are not eligible for benefits until proper identification is provided. For existing beneficiaries, a "reasonable opportunity period" must be provided for beneficiaries to prove citizenship before eligibility is terminated. This "reasonable opportunity period" is determined by each state. Outreach efforts to educate those affected by the new regulations will also be implemented as part of DRA.

Alternative Benefit Packages

Until DRA, State Medicaid programs were required to provide a comprehensive set of EPSDT benefits to all "mandatory" and "optional" children. Under DRA, states have new authority to offer children one of four "benchmark packages" as an alternative to EPSDT – none of which include dental benefits. Guidance released by CMS on March 31, 2006 (and effective the same day) included details about state options for alternative benefit packages.

According to the "Dear State Medicaid Director Letter," states now have the option to offer Medicaid beneficiaries coverage equivalent to one of the following healthcare plan's benefits package: 1) Federal Employees Health Benefit Plan, 2) State Employee coverage, 3) the health maintenance organization with the largest insured commercial, non-Medicaid enrollment in the State, 4) Secretary approved coverage.

DRA further requires that children who receive the benchmark package also receive an EPSDT "wrap-around" benefit. This letter begins to define the term "EPSDT wrap-around." The guidance states that the wrap-around must "...be sufficient so that, in combination with the benchmark or benchmark-equivalent benefits package, these individuals receive the full EPSDT benefit." No further details are provided.

Some groups of Medicaid beneficiaries may not be offered an alternative benefit plan under DRA. These groups include the "medically frail" and children with special health care needs, children in foster care, and

other special needs populations. Additionally, states cannot require that an individual enroll in an alternate benefit package but are required to inform individuals of the alternate package in comparison to regular Medicaid benefits.

Cost Sharing Options

Prior to DRA, services for children were exempt from cost sharing (premiums or co-payments) within Medicaid. In the new CMS guidance released on June 16, 2006, for the new state options effective March 31, 2006, "mandatory" children remain exempt from cost sharing. However, states may impose cost sharing for children in the "optional" category for non-preventive services.

Two categories of cost sharing specifically addressed in the guidance are premiums and co-payments (co-pays). Children exempt from premiums include mandatory children under age 18, children under 100 percent of the federal poverty level (FPL), and foster care children. Exemptions regarding co-pays include mandatory children under age 18, children in foster care, preventive services for children, and emergency services. Separate guidance is available for non-emergency use of the emergency room and prescription drugs.

A cap of five percent of a family's income* has been established as the limit for total payments for premiums and co-pays, including prescription drugs. The cap may include the optional premium for "optional" children from families with incomes above 150 percent of FPL. Additionally, the cap may include co-pays. Co-pays may be established for up to 20 percent of the cost of non-preventive services for families above 150 percent of FPL or up to 10 percent for families between 100-150 percent of FPL. State flexibility extends to the application of cost sharing by allowing states to apply them differently to groups of individuals or services, within specified limits.

DRA also provides states the option to terminate Medicaid coverage if premiums are not paid and to grant health care providers the right to deny care if Medicaid patients fail to pay co-pays.

Additional CMS Guidance

In addition to the above, CMS has also released guidance on Medicaid DRA provisions including but not limited to non-emergency medical transport (March 31, 2006), SCHIP waivers (March 31, 2006), and State High Risk Health Insurance Pool Funding (March 31, 2006).

Implications for New Medicaid Provisions

Recent changes made by Congress through DRA have provided states tremendous opportunities for changing their programs with the promise of cost savings. Although the legislation intends for eligible children to continue to receive comprehensive EPSDT benefits, including dental services, the potential impact of these provisions may have unanticipated consequences that have yet to be measured. Maintaining an understanding of the national trends in Medicaid empowers dental advocates to improve state policy decisions that shape access to dental care for vulnerable children.

Mandatory Eligible Children

- Children under the age of 6 from families with incomes less than 133% Federal Poverty Level (FPL).
- Children age 6 to 19 with family incomes less than 100% FPL.
- Children in foster care.

Optional Eligible Children

- Children above minimum income requirements (*determined by the state*)

For more information on current Medicaid coverage for children's dental care, go to www.cdhp.org or call (202) 833-8288.

* States can elect whether to determine the aggregated cap on a quarterly or monthly basis.

Sources

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