DEFICIT REDUCTION ACT (DRA) INFORMATION FOR EMPLOYEES

On February 8, 2006, the President signed the federal Deficit Reduction Act of 2005. This sweeping legislation affects many aspects of domestic entitlement programs, including both Medicare and Medicaid.

Provisions of the Deficit Reduction Act

The Deficit Reduction Act is a crucial step forward in bringing mandatory spending under control. In the long run, the biggest challenge to the budget is mandatory spending - or entitlement programs like Medicare, Medicaid, and Social Security. Together, these programs are now growing faster than the economy and the population - and nearly three times the rate of inflation. By 2030, spending for Medicare, Medicaid, and Social Security alone will be almost 60 percent of the entire Federal budget. The annual growth of entitlement programs needs to be slowed to affordable levels, but these programs do not need to be cut. Through reforms that will reduce the annual growth of mandatory spending, the Deficit Reduction Act saves taxpayers nearly $40 billion over the next five years - about $300 per taxpayer.

- **The Deficit Reduction Act is estimated to slow the pace of spending growth in both Medicare and Medicaid while maintaining our commitment to beneficiaries.** These two programs provide vital services to millions of Americans, but their costs are straining budgets at both the Federal and state levels. The Deficit Reduction Act restrains spending for entitlement programs while ensuring that Americans who rely on these programs continue to get needed care.
- **Taxpayers will save more than an estimated $6 Billion on Medicare over the next 5 years.** The Deficit Reduction Act, together with the Medicare Act of 2003, requires wealthier seniors to pay higher premiums for their Medicare coverage. The savings created by this reform and others will make it possible to increase Federal funding for important areas like kidney dialysis and rural hospitals.
- **The Deficit Reduction Act will also reduce the growth in Medicaid by nearly $5 Billion over the next 5 years.** The Deficit Reduction Act helps restrain Medicaid spending by reducing Federal overpayment for prescription drugs so that taxpayers do not have to pay inflated markups. The bill also gives governors more flexibility to design Medicaid benefits that efficiently and affordably meet their states' needs, and tightens the loopholes that allowed people to game the system by transferring assets to their children so they can qualify for Medicaid benefits.
- **The President is committed to finding additional ways to make Medicare and Medicaid more efficient.** The President's FY 2007 budget proposes another $36 billion in savings on Medicare and more than $1 billion in savings on Medicaid. The President's proposals slow the average annual growth in Medicare over the next five years from 8.1 percent a year to 7.7 percent a year. Together with the Deficit Reduction Act, the President's budget will slow Medicaid's average annual growth over the next five years from 6.9 percent a year to 6.6 percent a year.
- **In the long run, ensuring the stability of Medicare and Medicaid requires structural reform.** In his State of the Union Address, the President proposed a bipartisan

commission to examine the full impact of Baby Boomer retirements on Medicare, Medicaid, and Social Security. This commission will include members of Congress from both parties and will recommend long-term solutions.

Providing new resources for those with the greatest needs.

- The Deficit Reduction Act includes $1 billion in additional mandatory spending for the Low-Income Home Energy Assistance Program (LIHEAP) to help low-income Americans pay heating bills; $2 billion in new funding to cover health care costs for Hurricane Katrina victims; and more than $1 billion in new funding for low-income disabled children.

Health Opportunity Accounts

Effective January 1, 2007, Public Law No. 109-171 Deficit Reduction Act of 2005 Section 6082 Health Opportunity Accounts (HOAs) provides for ten States to operate Medicaid demonstrations programs to test alternative systems to deliver Medicaid benefits through an HOA in combination with a high deductible health plan (HDHP).

Additional information regarding the statute and grant application instructions is forthcoming.

Medicaid Drug Rebate Program

Created by the Omnibus Budget Reconciliation Act of 1990 (OBRA'90), the Medicaid Drug Rebate Program requires a drug manufacturer to enter into and have in effect a national rebate agreement with the Secretary of the Department of Health and Human Services (HHS) for states to receive Federal funding for outpatient drugs dispensed to Medicaid patients. The drug rebate program is administered by the Centers for Medicare & Medicaid Services' Center for Medicaid and State Operations (CMSO). The drug rebate program was amended by the Veterans Health Care Act of 1992 (VHCA). Under VHCA, drug manufacturers are required to enter a pricing agreement with HHS for the Section 340B Drug Pricing Program, which is administered by the Health Resources and Services Administration. To obtain a copy of this pricing agreement, click on the download links listed below. In addition, VHCA requires drug manufacturers to enter into various agreements with the Department of Veterans Affairs. For more information regarding Section 603 of the VHCA's requirements, please contact Carole O'Brien at (708)786-4957 or carole.obrien@med.va.gov. A drug manufacturer must sign an agreement with these two programs in order to have its drugs covered by Medicaid.

Approximately 550 pharmaceutical companies currently participate in this program. Forty-nine states, (Arizona is excluded), and the District of Columbia cover drugs under the Medicaid Drug Rebate Program.

By signing into law the Deficit Reduction Act of 2005, which among other provisions places severe new restrictions on the ability of the elderly to transfer assets before qualifying for Medicaid coverage of nursing home care.

In addition, the law incorporates provisions in the original budget bill passed by the Senate closing certain asset transfer "loopholes," among them:

- The purchase of a life estate will be included in the definition of "assets" unless the purchaser resides in the home for at least one year after the date of purchase.
- Funds to purchase a promissory note, loan or mortgage will be included among assets unless the repayment terms are actuarially sound, provide for equal payments and prohibit the cancellation of the balance upon the death of the lender.
- States will be barred for "rounding down" fractional periods of ineligibility when determining ineligibility periods resulting from asset transfers.
- States will be permitted to treat multiple transfers of assets as a single transfer and begin any penalty period on the earliest date that would apply to such transfers.

Medicaid

Many of the changes to the Medicaid program are established as options for the states. Regardless of the effective dates indicated in the Act, those provisions that create new state options for Medicaid will no be come effective until the state has fulfilled the requirements under state law for changes to its Medicaid state plan. Where possible, some states will likely prepare their state plan amendments in advance, so that new options are in effect on the first possible date under federal law. As we learn details of the Administration's plans regarding implementation, including rulemaking and issuance of policy guidance, we will update the information below with relevant information.

Eliminating Waste, Fraud, and Abuse in Medicaid

Of interest to people with disabilities, their families, and their service providers are a number of provisions that were added to the Medicaid program to help prevent or detect waste, fraud, and abuse, including:

Section 6032: Encouraging the Enactment of State False Claims Acts

- Section 6032 provides financial encouragement to states to have in effect a law dealing with false of fraudulent claims that meets certain federal requirements. If state have such a law in place, when recoveries are made for Medicaid funds improperly paid, the share owed to the federal government will be decreased by 10 percentage points. (effective January1, 2007)

Section 6033: Employee Education About False Claims Recovery

- Section 6033 requires states to ensure that any entity receiving Medicaid payments of at least $5 million per year must establish written policies with information about the federal False Claims Act; state laws regarding civil or criminal penalties for false claims and statements; and whistleblower protections with respect to preventing and detecting fraud, waste, and abuse in federal health care programs. (effective January 1, 2007)

Section 6035: Medicaid Integrity Program

- Section 6035 would establish a Medicaid Integrity Program in which the Secretary of the Department of Health and Human Services contracts with eligible entities to: review actions of individuals or organizations providing items and services reimbursed by Medicaid; audit payment claims; identify Medicaid overpayments to individuals or organizations; and educate service providers, managed care organizations, beneficiaries, and other individuals regarding payment integrity and benefit quality assurance issues.

Eligible entities must:

- Have demonstrated capability to carry out the activities
- Agree to cooperate with the Inspector General of HHS, the Attorney General, and other law enforcement agencies in investigation and deterrence of fraud and abuse
- Comply with federal acquisition and procurement conflict of interest standards
- Meet other requirements specified by the Secretary.

Funds are appropriated as follows:

- $5 million for fiscal year 2006;
- $50 million each for fiscal years 2007 and 2008; and
- $75 million for each fiscal year thereafter.

Amounts are available until expended.

The Secretary of HHS must increase by 100 the number of full-time equivalent employees whose duties consist solely of protecting the integrity of the Medicaid program by providing support and assistance to states.

The HHS Office of Inspector General is to receive an additional $25 million for each of fiscal years 2006 through 2010 for Medicaid integrity work and such amounts remain available until expended.

In addition, the Secretary shall ensure that, beginning in 2006, the Medicare-Medicaid Data Match Program (commonly known as the Medi-Medi Program) is conducted to identify program vulnerabilities, coordinate activities to protect the federal and state share of expenditures; and increase the effectiveness and efficiency of both programs through cost avoidance, savings, and recoupments of fraudulent, wasteful, or abusive expenditures. Funds are appropriated for expansion of the Medi-Medi Program as follows:

- $12 million for fiscal year 2006;
- $24 million for fiscal year 2007;
- $36 million for fiscal year 2008;
- $48 million for fiscal year 2009; and
- $60 million for fiscal year 2010 and each fiscal year thereafter.

Where the Secretary determines that a state requires legislative action to comply with requirements of the new fraud and abuse provisions, the state will not be found non-compliant before the first quarter after the next regular session of the state legislature that begins after enactment. (Where a state has a two-year legislative session, each year will be considered a separate regular session of the state legislature.)

Section 6036: Enhancing Third Party Identification and Payment

- Section 6036 would require states to determine if third party liability exists (in order to avoid the use of Medicaid funds) for additional entities: self-insured health plans; pharmacy benefit managers; and other parties legally liable by statute, contract, or agreement for payment of a health care claim or services. These organizations would be prohibited from taking an individual's Medicaid status into account in enrollment or making payments.

Section 6037: Improved Enforcement of Documentation Requirements

- This section requires individuals to present documentation of citizenship or nationality when they apply for Medicaid benefits. Failure to present such documentation will make them ineligible for Medicaid services. Documentation includes: a U.S. passport, Certificate of Naturalization (or other document specified in Immigration and Nationality Act), a birth certificate, valid driver's license, or other documentation which the U.S. Secretary of Health and Human Services specifies is proof of U.S. citizenship or naturalization.

Section 6037 becomes effective for eligibility determinations made on or after July 1, 2006. It requires the HHS Secretary to develop an outreach plan to educate individuals who are likely to be affected by these provisions.

Long Term Services and Supports

The Deficit Reduction Act includes a number of provisions affecting long term services and supports. The provisions of most interest to people with disabilities include the following:

Section 6086: Expanded Access to Home & Community-Based Services for the Elderly & Disabled

- Section 6086 contains the provisions from Title II of S. 1602, the Improving Long-Term Care Choices Act, introduced by Senators Charles Grassley (R-IA), Evan Bayh (D-IN), and Hillary Clinton (D-NY) with the support of the disability community. These provisions of Section 6086 will: establish a new option for states to provide home- and community-based services (HCBS) without states needing to use a waiver process; allow states to provide any of the services now covered under HCBS waivers; and require states to establish stricter eligibility (level of care) criteria for institutional services than for community-based services. In addition, states may continue to provide services through their existing waiver programs.

However, this section is overshadowed by new state flexibility provisions. Section 6086 allows states to cap the number of people to be served under the new home and community services Medicaid option. It allows states to provide these services in limited areas of the state and explicitly allows states to maintain waiting lists for these services. If the state decides to establish new eligibility criteria in the future, HCBS beneficiaries who do not meet new criteria would have grandfathering protection, but for as little as one year from the date the beneficiary first received the service.

Essentially, this combination of new state flexibility provisions maintains the states' entitlement for federal reimbursement for allowed expenditures while it eliminates the individual's entitlement to these services. Since the services will be state-plan option services, rather than waiver services, the federal government will no longer have a role in periodically approving these services.

It is unclear whether the states' new authority to establish cost-sharing for services will also apply to these non-institutional long term services and supports.

Section 6087: Optional Choice of Self-Directed Personal Assistance Services (Cash and Counseling)

- Section 6087 establishes a new state option for self-directed personal assistance services, also known as "cash and counseling." This provision requires that self-directed personal assistance services be provided based on a written plan of care and budget for people who would otherwise be eligible for personal care services under the State's Medicaid plan or home- and community-based waiver services. The section prohibits use of self-directed personal services for beneficiaries who live in homes or property owned, operated, or controlled by a service provider. Individuals using this new option are allowed to hire, fire, supervise, and manage the people providing the services and, if the state allows, may use family members to provide the services.

False Claims Act

Under the False Claims Act, 31 U.S.C. $$3729-3733, those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for three times the government's damages plus civil penalties of $5,500 to $11,000 per false claim.

The False Claims Act contains *qui tam*, or whistleblower, provisions. *Qui tam* is a unique mechanism in the law that allows citizens with evidence of fraud against government contracts and programs to sue, on behalf of the government, in order to recover the stolen funds. In compensation for the risk and effort of filing a qui tam case, the citizen whistleblower or "relator" may be awarded a portion of the funds recovered, typically between 15 and 25 percent. A *qui tam* suit initially remains under seal for at least 60 days during which the Department of Justice can investigate and decide whether to join the action.

The False Claims Act provides protection to employees who are retaliated against by an employer because of the employee's participation in a qui tam action. The protection is available to any employee who is fired, demoted, threatened, harassed or otherwise discriminated against by his of her employer because the employee investigates files or participates in a qui tam action.

This "whistleblower" protection includes reinstatement and damages of double the amount of lost wages if the employee is fired, and any other damages sustained if the employee is otherwise discriminated against.

The following are the more common types of fraud:

- Upcoding/unbundling
- Kickbacks
- Submitting false cost reports
- Billing for services not rendered

Overall, the DRA provides states with much of the flexibility states have been seeking over the years to make significant reforms to their Medicaid programs. Combined with other options in Medicaid, states will be able to reconnect their healthy populations to the larger health insurance system, transform long-term care from an institutionally-based, provide-driven system to a person-centered and consumer-controlled model. There are great opportunities for covering more people at a lower cost, and with greater continuity of coverage.