An Overview of Michigan Requirements and Options under the Affordable Care Act and its Potential Impact on People with Disabilities

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Preface

This paper focuses on several key requirements and options contained in the Affordable Care Act ["ACA"] likely to impact how people with disabilities access Medicaid and Medicaid-funded medical care, as well as options available to the state that could affect access to care for Medicaid recipients with disabilities. The paper primarily discusses provisions of Title II of the ACA, which contains changes in the Medicaid law that are designed to expand the number of individuals covered by Medicaid, and offer options for states to improve access and quality of care for Medicaid recipients.

Many of the final and proposed regulations implementing the Act were not available at the time most of the paper was written.

Abbreviations and acronyms

ACA = Affordable Care Act, a short version of the name of the health reform legislation passed by Congress and signed by President Obama in March 2010

CHIP = Children's Health Insurance Program, called MIChild in Michigan

CMS = Centers for Medicare and Medicaid Services

Dual eligible = people who are eligible for both Medicaid and Medicare

FPL = Federal Poverty Level

HHS = Health and Human Services

MAGI = Modified Adjusted Gross Income as defined under the Internal Revenue Code, see p. 3-4 for a discussion of some of the types of income included and excluded from MAGI

MIChild = Michigan's Child Health Insurance Program ["CHIP"] program that covers children up to 200% of FPL who are not eligible for Medicaid

SSI= Supplemental Security Income

Requirements of the Affordable Care Act

1. No-Wrong Door Applications and the Need to Align Health Plans and Provider Networks

Under the ACA, individuals seeking insurance coverage to pay for health care will be able to shop for coverage and apply for insurance affordability programs, as well as Medicaid, through a health insurance Exchange. Michigan has opted to have a Federally Funded Exchange (FFE), without a State Partnership. This means the federal Department of Health and Human Services (HHS) will carry out all Exchange functions, including certification of the Qualifies Health Plans that will be offered on the Exchange, determining eligibility for insurance affordability programs, and establishing programs to assist consumers and others participating in the Exchange.

HHS has announced that the following principles will guide its FFEs:

> 1) *Commitment to consumers:* Ensure that consumers in all 50 States and the District of Columbia have access to high-quality, affordable health coverage options..
>
> 2) *Market parity:* HHS will work to harmonize market requirements inside and outside of an FFE to promote the competitiveness of each FFE, minimize administrative burden for issuers, and ensure consumer protections.
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> 3) *Leveraging the traditional State role:* HHS recognizes the significant experience and the traditional role of States in many core areas of FFE operations. And will attempt to capitalize on existing State policies, capabilities, and infrastructure that can also assist in implementing some of the components of an FFE.
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> 4) *Engagement with States and other stakeholders:* HHS will seek input from a variety of stakeholders to support and inform decision-making. We will communicate our progress regularly so that affected parties understand how each FFE is developing and have adequate time to prepare for successful participation.

See General Guidance on Federally-facilitated Exchanges, issued May 16, 2012.

Under the ACA, the Exchange and existing Medicaid and CHIP eligibility systems must be fully integrated so that individuals will have seamless, "no wrong door" access to both private health insurance subsidies and public health insurance programs (Medicaid and MIChild), no matter where or how they apply. People who apply through traditional Medicaid or CHIP channels (such as by submitting a Medicaid application at a Department of Human Services ["DHS"]

office or an online Healthy Kids/MIChild application at healthcare4mi.com)[1] will not have to apply separately for health insurance premium and cost-sharing subsidies if they are ineligible for Medicaid and MIChild. Those who apply for subsidies through the Exchange will be automatically screened for Medicaid and MIChild and enrolled by the Medicaid agency without having to file a separate application. The State must use a single, simplified application for private insurance subsidies as well as basic Medicaid and MIChild eligibility. People must be able to apply for subsidies, Medicaid, and MIChild online, by phone, in person, and by mail.

Information technology systems also must be integrated so that people whose incomes change will have seamless transitions between Medicaid/MIChild and subsidized private insurance coverage, without having to complete new paperwork and without gaps in coverage. However, such transitions are likely to have a negative impact on continuity and quality of care. Unless Michigan's Exchange has the authority (and uses it) to ensure that at least some of the health plans that participate in the private health insurance Exchange also participate in Medicaid and MIChild, and/or that there is significant overlap in provider networks between plans offered in the individual insurance Exchange and the Medicaid/MIChild programs.

Under the proposed regulations issued by the Centers for Medicare and Medicaid Services ["CMS"], individuals seeking to qualify for Medicaid categories that require proof of eligibility criteria other than identity, citizenship or immigration status, and Modified Adjusted Gross Income ["MAGI"] —such as disability—may be required to complete a supplemental or alternative application to the simplified, single application. The proposed regulations would require the Medicaid agency to make a determination of eligibility for the non-MAGI eligibility categories, and to also assure enrollment in other "insurance affordability programs", including MAGI-based Medicaid, MIChild, or private insurance subsidies, while a determination of eligibility for non-MAGI categories is occurring.[2]

The ACA provides funding for a network of navigators to assist individuals in enrolling in Qualified Health Plans through the Exchange.[3] Under the FFE, HHS will determine who provides Navigator assistance in Michigan.

What this means for people with disabilities in Michigan

People with disabilities and their allies will have to be vigilant to ensure that the evolving web-based, and telephone-based enrollment tools are designed to be accessible to persons with various kinds of disabilities, and that accessibility for persons with disabilities is taken into consideration when navigators are chosen. Increased reliance on web-based information and

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[1] DHS expects to have online an online Medicaid application for all eligibility categories available through its mibridges website in January 2012., at www.mibridges.michigan.gov/access/.

[2] Proposed 42 CFR 155.345(b) & (c), 76 Fed Reg 51236, and 42 CFR 435.1200(g)(2), 76 Fed Reg 51195.

[3] ACA Section 1311(i).

applications may make it more difficult for people with disabilities to get personalized assistance. However, some new requirements, like the requirement that people must be allowed to apply by telephone, hold significant promise for people with certain kinds of disabilities. Simplifying and streamlining eligibility processes and allowing people to access the Medicaid and MIChild programs through entities other than the DHS office may be very helpful to people with disabilities. High caseloads, caseworker turnover, and ongoing difficulties with the new Bridges computer system frequently have resulted in poor customer service at DHS, particularly for people with disabilities who need extra help with applications, reviews, and verifications.

2. Michigan must use Modified Adjusted Gross Income (MAGI)[4] when calculating income eligibility for most Medicaid eligibility categories

Beginning in 2014, the ACA requires income eligibility for most Medicaid eligibility categories, MIChild, and private insurance subsidies to be based on MAGI instead of on the complicated methodologies currently in use. States must set an income limit, based on a percentage of the Federal Poverty Level (FPL), that will not result in disqualification of individuals who currently are eligible.

Groups for which the state will not use MAGI (unless a waiver is obtained) are:

- Individuals eligible without a calculation of income by the state (such as SSI recipients)
- Seniors age 65 or older
- Individuals who qualify for disability- or blindness-based Medicaid
- Medically needy recipients (generally recipients with deductibles or spend-downs)[5]
- Individuals eligible for Medicare cost-sharing
- Individuals qualifying for Medicaid for long term care, including home and community based services under a waiver

These groups are also known as non-MAGI eligibility categories.

What this means for people with disabilities:

People with disabilities can pursue eligibility under a non-MAGI eligibility category regardless of whether they qualify under a MAGI-based category. As discussed in the "Options" section, below, this will be particularly important if the state chooses to provide benefits to the new low-income expansion category for people with MAGI below 133% FPL that are less generous than the full Medicaid benefits package. Some people may wish to pursue a non-MAGI category so they can receive the more comprehensive Medicaid package.

[4] MAGI Definition: Modified Adjusted Gross Income is a measure used by the IRS to determine if a taxpayer is eligible to use certain deductions, credits, or retirement plans

[5] Medically needy categories are also known as "Group 2" categories in Michigan.

Depending on the amounts and sources of income that a particular person has, the methodology or formula for calculating MAGI may be more or less advantageous than the SSI-based methodology for calculating income eligibility for disability-based Medicaid categories. For example, all or most of a person's Social Security benefits are excluded from MAGI, but not from SSI-related income budgeting. But on the other hand, SSI-related methodology provides a large ($65 plus ½ of the remainder) deduction from earned income, which can help some people qualify for Medicaid when they have earnings.

In addition, some categories of disability-based Medicaid have rules that disregard certain sources of income. These include the Disabled Adult Child Medicaid category for some former SSI recipients, which does not count Social Security Disabled Adult Child benefits, or Freedom to Work Medicaid, which excludes earned income for some working people with disabilities. The income budgeting methodology and limits for these categories may be more advantageous than the MAGI rules and limits for some people.

It will be important for people with disabilities to have access to knowledgeable, well-trained "navigators" to help them understand their options and make decisions about which categories of Medicaid eligibility (or other affordability programs) will best meet their needs.

3. The State must expand Medicaid to cover young adults up to age 26, with no income or asset test, if they were in foster care and receiving Medicaid on their eighteenth birthday[6] (Effective January 1, 2014)

This expansion group is entitled to the full Medicaid benefits package.

4. Adult Health Quality Measures

The ACA requires HHS to develop health quality measures for Medicaid covered adults and a system for state reporting on the measures. At the same time, the ACA includes a prohibition against denial of coverage for services based solely on the grounds that they do not reflect "evidence based" medicine.

Under the ACA, Michigan will have to report on quality measures for its fee-for-service Medicaid component, instead of just its Medicaid managed care plans. However, this may become less important depending on the outcome of the state's planning to integrate care for individuals dually eligible for Medicaid and Medicare (see below), which may result in many fewer individuals receiving fee-for-service care.

[6] 42 USC 1396a(a)(10)(A)(i)(VIII) and (IX).

What this means for people with disabilities in Michigan

Depending on the measures and the design, this initiative could provide useful information about the quality of care received by people with disabilities. The protection against denial of payment for services because they are not "evidence based" may help ensure access to treatment for individuals whose particular health conditions or treatments have not been the subject of extensive research.

Options and Opportunities Under the Affordable Care Act

5. Michigan has the option to expand Medicaid to cover individuals with income under 133% of the (FPL), with no asset limit[7] (Effective January 1, 2014)

The Affordable Care Act ["ACA"] provides an option to the states to expand eligibility for Medicaid to most individuals with Modified Adjusted Gross Income ["MAGI"] below 133% of the Federal Poverty Level ["FPL"], after a standard deduction from their MAGI. The standard deduction from MAGI required under the ACA raises the effective income limit for this category to 138% FPL.

Estimates of the number of adults in Michigan who will be eligible for Medicaid coverage under this expansion range from about 400,000 to about 800,000. Most (between 2/3 and 3/4) of the newly-eligible individuals will be adults who are not raising children in their home at the time of their application.

If the state adopts the ACA Medicaid expansion, the people in Michigan who would be covered fall into three groups: groups:

1. Childless adults, including
   a. Young adults age 19-20, with incomes above the current Medicaid income limit of about 45% FPL,[8]
   b. Childless adults age 21-64 who are not disabled, and who currently are not covered by Medicaid regardless of income;[9]
2. Adults with disabilities with incomes above the current Medicaid income limit of 100% FPL;
3. Parents and other relatives raising dependent children with incomes above the current Medicaid income limit of about 45% FPL.[10]

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[7] 42 USC 1396a(a)(10)(A)(i)(VIII).

[8] The effective income limit is somewhat higher for individuals with earned income or child support expenses.

[9] Under the Adult Benefits Waiver (ABW) Adult Medical Program (AMP), Michigan currently provides a limited, outpatient benefit to about 62,000 childless adults with income under 35% FPL. Enrollment in the program is allowed only a couple months every couple of years. The estimated number of persons who will be covered is an early estimate by the Michigan Department of Community Health.

People who **cannot** be covered under this category include:

1. Seniors (age 65 or older),
2. People entitled to or enrolled in Medicare Part A,
3. People enrolled in Medicare Part B,
4. Pregnant women,
5. People who are eligible under certain mandatory Medicaid eligibility categories (e.g. SSI recipients).

People with disabilities who are not enrolled in Medicare Parts A or B, and are not entitled to Medicare Part A, may become eligible for Medicaid as a result of this new, mandatory Medicaid eligibility category.

Because this new category does not require proof of assets or of status (*e.g.* disability), enrollment in this category will be streamlined, thus offering more timely access to covered services for those who qualify under this category.

A. Michigan can opt to provide full Medicaid coverage to people in the expansion group, rather than more limited "benchmark" or "benchmark equivalent" coverage

If Michigan chooses to accept federal funds to expand Medicaid under the ACA, it will also have to decide what services it will cover for individuals who qualify for Medicaid as a result of the expansion. The state will have the option of providing individuals eligible under the expansion (a) benchmark coverage,[11] (b) benchmark-equivalent coverage,[12] or (c) Secretary-approved coverage, unless the individuals are in one of the groups that are exempt from benchmark coverage and are entitled to receive full Medicaid coverage. The Centers for

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[10] The effective income limit is somewhat higher for families with earned income, child support income, or out-of-pocket child care or child support expenses. Individuals with income below the current income limit but with cash assets above $3,000 would also be covered by the expansion. The estimated number of persons who will be covered is an early estimate from the Michigan Department of Community Health.

[11] Benchmark coverage must be equivalent to (1) Blue Cross/Blue Shield preferred provider option for federal employees in Michigan; (2) State plan employee coverage; (3) coverage provided by the largest, generally-available, non-Medicaid HMO plan.

[12] Benchmark equivalent coverage must offer basic service (such as hospital, physician, and preventive services) with an actuarial value equivalent to one of the benchmark plans listed in note 10, above, and other services with actuarial value equivalent to 75% of the actuarial value of those services under the benchmark plan.

Medicare and Medicaid (CMS) has indicated full Medicaid coverage may be Secretary-approved.[13]

Even if they are enrolled in benchmark or benchmark-equivalent coverage, recipients under age 21 are entitled to receive Early Periodic Screening Diagnosis and Treatment (EPSDT) services. Benchmark or benchmark equivalent coverage must include prescription and mental health benefits, as well as family planning services. States must assure emergency and non-emergency transportation to medical care for individuals enrolled in benchmark or benchmark-equivalent coverage to the same extent as they assure it for recipients who receive full Medicaid benefits.[14]

Most people with disabilities are exempt from having to accept benchmark or benchmark-equivalent coverage instead of the full, comprehensive coverage available to current Medicaid recipients in Michigan. The full range of mandatory, Medicaid-covered services must be provided to people eligible for Medicaid based on blindness or disability; people who are in an institution, terminally ill, or eligible for long term care services (including home and community based services provided under a waiver). In addition, it must cover people who are medically frail or have special medical needs (including people who have physical or mental disabilities that significantly impair their ability to perform one or more activities of daily living). However, the state may offer these exempt groups the option of enrolling in benchmark or benchmark-equivalent coverage, with the right to switch to full Medicaid coverage at any time.

These exemptions from benchmark or benchmark-equivalent coverage require proof of medical need, need for assistance with ADLs, or eligibility for disability-based categories. If Michigan chooses to provide less than the full Medicaid benefits package to this new eligibility category, people with disabilities may not be able to take full advantage of the streamlined eligibility process available to individuals who qualify for Medicaid based on MAGI.

B. Michigan can opt to keep the same co-payments and cost-sharing for people covered by the expansion, to ensure access to care, streamline procedures, and reduce administrative costs

Under pre-ACA Medicaid law, states have the option of imposing higher co-payments or co-insurance on Medicaid recipients with income over 100% FPL than may be required for people with lower incomes. However, such cost sharing is limited to 10% of the cost of an item or

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[13] 42 CFR 440.330(d) (published at 75 Fed. Reg. 23102-3 (Apr. 30. 2010) indicates the Secretary will approve health coverage that "provides appropriate coverage to meet the needs of the population provided that coverage" and further states Secretary-approved coverage "will be limited to the scope of the categories available under a benchmark coverage package or the standard full Medicaid package."

[14] 42 CFR 440.390.

service and the monthly or quarterly cost-sharing imposed on a family cannot exceed 5% of family income.[15]

Michigan currently imposes only nominal co-payments for most adult recipients under its fee-for-service Medicaid program.[16] Michigan also allows Medicaid managed care plans to impose only nominal co-payments. Michigan does not impose higher cost sharing on people with incomes above 100% FPL.

C. The federal government pays most of the cost of providing Medicaid to the expansion population.

The federal government pays 100% of the cost of Medicaid for the expansion population in 2014 and 2015, gradually declining to 90% of the cost in 2020. The Michigan Senate Fiscal Agency and House Fiscal Agency both have determined that the state will save significant state dollars (about $275 – 285 million per year in the first 3 years) if Michigan chooses to accept the federal money to expand Medicaid, because federal Medicaid dollars would pay for mental health and Department of Correction health services currently paid with state dollars.

What this means for people with disabilities in Michigan

This new, low-income expansion category holds the promise of streamlining and expanding access to Medicaid for some people with disabilities, as discussed in more detail below. However, because of the exclusion of "dual eligible" (people eligible for, or enrolled, in Medicare Part A and people enrolled in Part B), some people with disabilities will not be able to benefit from the expansion. In addition, if Michigan opts to provide a benchmark or benchmark-equivalent plan rather than a plan with the full range of Medicaid-covered services, and if Michigan opts to require higher cost-sharing for people with income above 100% FPL, the coverage available under this expansion category may not meet the full needs of low-income people with disabilities.

a. Less paperwork

People who currently receive Medicaid under disability-based Medicaid categories have to submit paperwork at least annually to verify the value of their assets and, in some cases, medical proof of their disability, as well as proof of income. Under the new low-income category, no proof of assets or disability is required. Thus, people with disabilities with MAGI below 133% FPL after the standard deduction may choose to enroll in Medicaid under the new, low-income expansion category because of the streamlined eligibility process.

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[15] 42 USC 1396o-1.

[16] Nominal co-payments include $1 (generic) or $3 (name brand) co-pays for prescriptions, $3 co-pays for office visits, and $50 co-pays for inpatient hospitalizations. Co-payments are not charged for certain populations and services, including pregnancy-related services, services for people under age 21, and services for people in nursing homes.

However, if the state chooses to provide benchmark or benchmark-equivalent coverage instead of the full package of Medicaid services to individuals who qualify under the new, low-income expansion category, people with disabilities may have to continue providing proof of their medical needs -- or, in some cases, proof of assets and disability to show they qualify under other Medicaid categories -- so they can be exempted from benchmark coverage and continue receiving important services such as long term care supports and services that may not be available under benchmark or benchmark-equivalent coverage.

b. More Medicaid, less paperwork

People with disabilities who currently are ineligible for Medicaid because of assets will become eligible for Medicaid if they have MAGI below 133% FPL after the standard deduction. People with countable assets worth more than $2,000 for an individual or $3,000 for a couple cannot receive Medicaid under Michigan's current disability-based Medicaid categories.[17] **Some people with disabilities may be able to qualify for Medicaid without having to submit proof of their assets at each annual review of eligibility.** As noted above, however, the package of services available under the low-income expansion category may not be as robust as the Medicaid package available to some other Medicaid recipients.

c. More Medicaid, less paperwork, more money to spend on non-medical expenses

Some people with disabilities whom currently must meet a Medicaid deductible because their budgeted income is above 100% FPL will gain full Medicaid eligibility -- without a deductible – if they have MAGI below 133% FPL after the standard deduction. They will not have to submit monthly paperwork to establish their eligibility and will not be liable for a deductible amount. For some people, this will mean having hundreds of dollars more to spend on household expenses instead of on medical care. As noted above, however, the package of services available under the low-income expansion category may not be as robust as the Medicaid package available to some other Medicaid recipients.

d. More opportunity to save

People who qualify under the expansion category will be able to accumulate savings or other assets without losing Medicaid eligibility as long as they are income eligible. As noted above, however, the package of services available under the low-income expansion category may not be as robust as the Medicaid package available to some other Medicaid recipients.

[17] See Michigan Bridges Eligibility Manual (BEM) 400, available online at http://www.mfia.state.mi.us/olmweb/ex/bem/400.pdf for information on which assets are countable.

6. The State has more options for providing presumptive eligibility to low-income individuals

Under the ACA, states, like Michigan, that provide presumptive eligibility for Medicaid to low-income pregnant women and children will have the option to provide presumptive eligibility to the new, low-income and former foster care expansion populations.[18] In addition, all states will have the option of allowing hospitals to make presumptive eligibility determinations for all Medicaid eligibility categories.[19]

Under federal law, certain agencies and providers automatically may be considered "qualified entities" for purposes of determining presumptive eligibility,[20] but the state also has the ability to include any other entity recognized by the state as being capable of making presumptive eligibility determinations. 42 USC §1396r-1a(c)(3)(A)(i) and (ii).[21] Qualified entities can help individuals who appear to be eligible receive immediate access to necessary health care by providing proof of temporary Medicaid eligibility. The temporary eligibility ensures that the individual can access care while the state agency or the insurance exchange is processing the person's formal application and determining longer-term eligibility.

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[18] 42 USC 1396r-1(e)(i)(VIII) and (IX).

[19] 42 USC 1396a(47)(B).

[20] For children, qualified entities include:

- Head Start agencies (paragraph II),
- Health Departments, even if they are not providers -- because they determine WIC eligibility (paragraph II),
- DHS – because they determine MA, CDC and TANF eligibility, and enforce child support (paragraph II & III),
- Maximus – because they determine eligibility for CHIP/MIChild (paragraph II),
- Elementary and secondary schools (paragraph II),
- State or tribal child support enforcement agencies (paragraph III),
- Organizations that provide assistance under Stewart B. McKinney Homeless Assistance Act (paragraph III),
- State or tribal agencies involved in Medicaid or CHIP enrollment (paragraph III),
- MSHDA, local Public Housing Agencies Organizations, and others that determine eligibility for certain housing programs (paragraph III).

42 USC §1396r-1a(c)(3)(A)(i). The state retains the ability to exclude listed entities as needed to prevent fraudulent or inaccurate Presumptive Eligibility decisions. *Id.* at (C).
For pregnant women, certain clinics and other providers, as well as the "qualified entities" listed above for children, are recognized by statute as being authorized to determine Presumptive Eligibility. 42 USC §1396r-1(b)(1).

[21] Federal regulations suggest that CMS approval is required for entities not specifically listed in the statute but recognized by the state as capable. 42 CFR 435.1101(10)

Michigan's Current Presumptive Eligibility System for Children and Pregnant Women

Currently, presumptive eligibility is only available for children and pregnant women who qualify for Healthy Kids Medicaid or MIChild, and pregnant women who qualify for MOMS. When a "qualified entity" assists a pregnant woman or child with the online, MIChild/Healthy Kids application and the applicant appears eligible based on computer screening of the application information, the qualified entity immediately can give the applicant a Guarantee of Payment letter (for pregnant women) or an eligibility letter (for children) that the applicant can use as proof of coverage, thus expediting access to care. At this time, Michigan has not taken advantage of the option to certify entities that are not Medicaid-enrolled providers, thus limiting opportunities for low-income children and pregnant women to obtain presumptive eligibility.[22]

Presumptive eligibility prevents delays in access to healthcare that can result in serious harm, inappropriate use of expensive emergency room care, and/or the need for much more costly interventions in the future. Although not all providers accept guarantee of payment letters or presumptive eligibility letters, children or pregnant women who obtain presumptive eligibility generally do not have to wait the standard 14 days (for pregnancy-related Medicaid) or 45 days (for Healthy Kids) to be approved for coverage. Presumptive eligibility lasts for up to 45 days, or until the state agency makes an eligibility determination.

Presumptive eligibility likely reduces state costs for care, given the high preventive value of timely prenatal and well-child care. The state receives the full federal matching rate for coverage during the presumptive eligibility period, even if ongoing eligibility is not approved,[23] and very few individuals who receive presumptive eligibility are later denied ongoing eligibility.[24]

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[22] This unnecessarily hampers or delays access to care for children and pregnant women. It also results in anomalous and irrational situations including:

- Only some County Health Plans are able to provide Presumptive Eligibility to plan enrollees who become pregnant and need to switch to Medicaid or to children of Health Plan members. Plans associate with Public Health Departments award presumptive eligibility; those not associated with a provider do not.
- Only one of the two Child Outreach and Enrollment programs funded by CMS under the CHIPRA grant is able to award Presumptive Eligibility to the children enrolled, because the outreach and enrollment program sponsored by the Grand Rapids YMCA is not affiliated with a medical provider/FQHC.

[23] See 42 CFR 435.1102(c) and 457.355.

[24] Presumptive eligibility decisions are very accurate for three reasons. First, qualified entities do not calculate eligibility on their own. Presumptive eligibility is awarded by qualified entities based on an automated, preliminary eligibility decision made by state-approved computer systems. Second, eligibility for Healthy Kids Medicaid and CHIP-funded programs is

A wide variety of organizations currently assist children and pregnant women with Healthy Kids/MIChild online applications,[25] and it is likely even more would help if they also had the ability to provide Presumptive Eligibility to individuals who meet the necessary qualifications, especially in urgent situations where immediate, but non-emergency, medical attention is needed. By allowing more agencies to provide Presumptive Eligibility/proof of coverage, to a child or pregnant woman who needs diagnosis and treatment but does not need emergency room care, the state could ensure more individuals receive care in the most appropriate, least expensive setting, thus reducing Medicaid expenditures and preserving emergency room care for true emergencies. Earlier prenatal care leads to healthier babies and reduces Medicaid expenditures during the baby's first year of life.

What this means for people with disabilities in Michigan

If Michigan opts to expand presumptive eligibility by certifying more agencies and organizations as "qualified entities" and by allowing hospitals to determine presumptive eligibility for all Medicaid categories, many more people with disabilities will be able to receive timely access to healthcare. Even if Michigan does not provide the full Medicaid package of services to the low-income expansion group, people with disabilities could have access to at least benchmark or benchmark-equivalent health coverage under presumptive eligibility while they wait for a determination of eligibility under disability-based categories.

CMS has indicated that it expects information technology systems developed under the ACA to provide "real time" determinations of eligibility for Medicaid, CHIP (known as MIChild in Michigan) and insurance affordability subsidies for private coverage. However, neither the ACA nor the proposed implementing regulations issued by CMS thus far include a standard of promptness for enrolling eligible individuals into Medicaid, or indicate whether there will be any differences for different types of Medicaid. In addition, the proposed regulations issued by CMS on August 17, 2011 provide that even after the ACA is fully implemented in 2014, Medicaid eligibility decisions will continue to be made exclusively by public employees. Therefore, even if community-based organizations or other non-public entities are helping low-income individuals apply for Medicaid, and even if the electronic eligibility and verification systems required under the ACA confirm that the individual is eligible for Medicaid, the individual may have to wait for a public employee to certify the eligibility decision. Therefore, it appears presumptive eligibility will continue to be an important tool for low-income

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streamlined (based on self-certification of income, without an asset test, and using the SSA computer cross-match to verify identity and citizenship). Thus, it is unlikely that individuals who appear to be eligible on their application will later be determined ineligible. Third, all entities that are authorized by the state to award presumptively eligibility must complete training sponsored by MDCH/MSA.

[25] In addition to Outreach and Enrollment projects and County Health Plans, enrollment assistance is provided by many schools, community action agencies, legal services offices, community-based and faith-based organizations, etc.

individuals seeking timely access to healthcare – including people with disabilities whose health may be particularly at risk if timely care is not provided.

7. Michigan has the option, beginning in 2014, of providing a "Basic Health Program" to people with incomes between 133% and 200% FPL, as well as legal immigrants, with incomes below 133% FPL, with federal funding equal to 95% of the premium tax credits and cost sharing subsidies that would have been paid Basic Health enrollees if they had been enrolled in qualified health plans through the Exchange

To be covered under a Basic Health Program, individuals have to be under age 65 and not eligible for affordable employer-sponsored insurance, Medicare Part A or other "minimum essential coverage", or Medicaid, including lawfully present immigrants with income below 133% FPL.

The Basic Health Program has to provide the essential benefits required of qualified health plans offered in the Exchange, and participating plans must have a medical loss ratio of at least 85%. In addition, there are limits on the monthly premiums and cost sharing required for Basic Health Program participants.

A Basic Health Program could be another method for the state to assure continuity and quality of care for people whose income results in periods of enrollment and disenrollment from Medicaid or MIChild, if the same health plans that offer Medicaid and MIChild coverage offer he Basic health Plan coverage. A Basic Health Program also could make it easier for parents and children to be in the same health plans when children qualify for Medicaid, which has an income limit of up to 185% for children under age 1 and 150% FPL for children ages 1-18, or MIChild, which has an income limit of 200% FPL (higher than the mandatory 133% FPL limit for covering adults under Medicaid).

The Basic Health Plan coverage for citizens and legal immigrants who have been in the U.S. for 5 years or more would begin at the income level (133% FPL) at which individuals are over-income for the Medicaid low income expansion coverage. However, the Basic Health Plan might not cover as many services as Medicaid and could have higher cost sharing (deductibles or co-pays).

What this means for people with disabilities in Michigan

It is not clear whether a Basic Health Program would be able to offer better access to quality care for people with disabilities than coverage under Medicaid with a deductible or the private insurance plans available through the Exchange with a subsidy.

If the federal facilitated Exchange that operates in Michigan fails to take an active role in setting standards for plans that are offered on the Exchange, a Basic Health Program may be necessary or desirable to assure continuity of care for people with fluctuating income who transition between subsidized private insurance and Medicaid or CHIP. However, unless the essential benefits package includes comprehensive benefits that may be particularly important to people with disabilities, such as durable medical equipment, attendant services, and other long term supports and services, a Basic Health Program may be less desirable than Medicaid with a deductible.

Basic Health Programs cannot be offered to individuals who are ineligible for enrollment in qualified health plans under the individual Exchange. This would exclude anyone who is eligible for Medicare Part A from participating in a Basic Health Program.

8. Opportunities to Offer More Long Term Care Services and Supports at Home and in the Community

The ACA offers a number of options that could help Michigan build on its existing investments in providing attendant care and other support services to people with disabilities in home and community settings, instead of in nursing homes or institutions. Below is a quick overview of the options.

A. Option to Improve Access to Home and Community Based Services ["HCBS"] without a Waiver, and to Provide Access to Full Medicaid for People Eligible for HCBS

The ACA has changed the criteria for offering optional HCBS without a waiver to people who do not need nursing home level of care. The ACA allows states to set eligibility at 300% of the SSI benefit ($2022 per month) – significantly higher than the 100% FPL limit generally applied to Medicaid recipients in Michigan.[26] Under the ACA changes, states can no longer restrict the availability of these state plan HCBS geographically, but can target the services to particular populations based on clinical needs-based criteria. In the event that the state modifies its clinical need criteria for home and community based services, persons currently receiving such services must remain eligible for such services under a grandfather clause. Coverage for the entire covered population may be phased in but must be achieved in full by the end of a 5-year phase-in period. This option has been available since March 23, 2010. The ACA also expands the services that can be approved as HCBS under this option.

The ACA also provides an option for states to offer full Medicaid coverage to people who meet the criteria for home and community based services.

[26] 42 USC 1396n(i).

Enhanced federal match is not provided under these options, but the state can apply for an enhanced match for the HCBS provided under this option, under the State Balancing Initiative Payments Program discussed below.

B. Community First Choice Option for Home and Community Based Attendant Services and Support Services with Increased Federal Match

The ACA creates a new state option to provide Home and Community Based Services ["HCBS"] and supports to people with income up to limit for the MIChoice waiver or Extended Care Medicaid (300% of the SSI benefit level or $2022 per month), who would require the level of care provided in an institutional setting if they did not receive attendant services or supports in the community. The state can receive increased federal match (6 percentage points above the usual matching rate for Medicaid-covered services) for services covered under this option.[27] Services covered under this option do not include the full comprehensive Medicaid benefits package.

Mandatory services under the option:
In addition to attendant care assistance with Activities of Daily Living ["ADLs"], Instrumental Activities of Daily Living ["IADLs"], and Health-related tasks, states that choose to provide care under this option must also assist recipients with (1) acquiring, maintaining, or enhancing skills necessary to perform ADLs, IADLs, or Health related tasks themselves; (2)back up systems or mechanisms, such as beepers or other electronic devices; and (3) voluntary training on selecting, managing, and dismissing attendants.

Optional services:
States that choose this option also can cover (1) transitions costs such as deposits and first month's rent or utilities; bedding, kitchen supplies and other necessities and (2) items that will increase independence or substitute for human assistance .

Prohibited services:
The state cannot cover (1) other room and board costs, (2) special education services, (3) other assistive technology, (3) medical supplies or equipment, and (4) home modifications.

Other requirements:
To exercise this option, the state must maintain all services and all coverage for elderly and disabled Medicaid populations for a full year. Services to individuals eligible for Community First Choices must be provided in the home or community according to a person-centered plan based on an assessment of the individual's needs, by a qualified provider, controlled by the individual, under an agency-provider or other model (including vouchers., direct cash payment, and use of a fiscal agent). The state must develop the state plan amendment for exercising this option in consultation and collaboration with a council that includes members

[27] 42 USC 1396k(n).

with disabilities, the elderly, and their representatives; must have a system for continuous quality assurance for community based attendant care and support services; and must collect and report certain data to CMS.

C. Option to Extend and Expand Money Follow the Person Rebalancing Act

Under the ACA, Michigan has the option of continuing and expanding its demonstration program for transitioning people with disabilities from nursing homes to the community for an additional 5 years. Under the Money Follows the Person demonstration grants, Michigan receives a higher federal match rate for people transitioning under the program during their first year in the community.

Under the ACA, the state can qualify for a higher federal match for long term care services and supports in the community, for people who have been in a nursing home for a minimum of 90 consecutive days instead of a minimum of 6 months, excluding days the person was in an institution solely for short-term rehabilitation.[28]

D. State Balancing Incentive Payments Program

Under this ACA option, Michigan could receive a 5 percentage point increase in the federal match for long term care and supports provided in non-institutional settings if it (a) sets, and by October 2015 meets, a target of spending at least 25% of its long term care dollars on home and community based services either under a waiver or under state plan amendments such as the Community First Choice option or the options to expand home and community based services under 42 USC 1396n(i); (b) Implements 6 structural changes within 6 months of setting its 25% target. The structural changes are (1) No wrong door/single point of entry system; (2) conflict-free case management services; (3) a core standardized assessment tool to determine eligibility for HCBS; (4) collection of services data for each beneficiary from all providers of HCBS; (5) collection of quality data on population-specific outcome measures; (6) development of population-specific outcome measures, including beneficiary and family caregiver experiences, satisfaction, and desired outcomes in specific cases.

What these options mean for people with disabilities in Michigan

These options could significantly expand long term services and supports for people with disabilities seeking to transition from nursing homes to the community, as well as people with disabilities who meet clinical criteria for long term services and supports and want to receive those services at home or in the community. These options may be more viable given the increased federal match available for the Money Follows the Person and Community First Choice options, as well as the other, state plan expansions if Michigan were to commit to achieving 25% state spending on long term care for services in the community, under the State Balancing Incentive Payments Program.

[28] ACA Section 2403.

Michigan could expand its nursing home transition program to serve more people with disabilities who want to receive services at home and in the community under the Money Follows the Person extension and expansion. Michigan also could expand the availability of home and community based long term services and supports well beyond the limited population served by the current MIChoice Waiver.

9. Options to Pay for Health Homes for People with Chronic Conditions

The ACA includes an option to provide health homes for enrollees with chronic conditions to be specified by regulation, including a mental health condition, asthma, diabetes, heart disease, and being overweight with a Body Mass Index of 25 or greater. To be eligible for a health home, Medicaid recipients must have a level of severity to be prescribed by regulation, which will be at least the following severity: people with two specified chronic conditions, people with one specified chronic conditions and the risk of developing a second, and people with a serious and persistent mental health condition.

Services that could be provided under the health home option include: comprehensive care management, care coordination and health promotion, transitional care from in-patient hospitalization to other settings; patient and family support; referrals to community and social support services, and use of health technology to link services.

What this means for people with disabilities in Michigan

Some people with disabilities who do not already receive these types of comprehensive supports and services under one of Michigan's Medicaid waiver programs, and who have chronic health conditions, could benefit if Michigan opted to pursue this model.

10. Demonstration Programs for Provider Payment Models

The ACA authorizes several types of demonstration projects for states to test various models for providing payment that may improve quality and outcomes of care, including demonstrations for: bundled payments for hospitalizations for particular types of conditions, global payments for safety net hospital systems or networks, Pediatric Accountable Care Organizations, and emergency psychiatric hospitalizations.

What this means for people with disabilities in Michigan

If Michigan pursues any of these demonstration projects, people with disabilities and their advocates will want to ensure that any payment rates take into account the higher health care needs and costs of people with disabilities, to ensure that people with disabilities do not experience greater difficulty in accessing providers who will accept them as patients and that they receive an appropriate amount, duration and scope of care.

11. Option to Integrate Services for Persons Dually Eligible for Medicaid and Medicare

Michigan has received a grant from CMS under the ACA and is in the process of planning for a demonstration project for integration of Medicaid and Medicare under a managed care system. People with disabilities and their advocates have already identified concerns regarding the state's initial framework for the project and the detailed evaluation of the project is beyond the scope of this paper.

What this means for people with disabilities in Michigan

Integration holds considerable promise for people with disabilities if it is done in a consumer-directed manner with a focus on quality and on improving the individual's ability to navigate the system and obtain timely resolution of problems that arise in accessing care. However, it is clear that a "one-size fits all" model will not be appropriate given the diverse populations potentially covered by an integrated model.

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