

Policy Report: Issues and Opportunities Related to Access to Medicaid for People with Disabilities

Prepared by:
Jacqueline Doig, Center for Civil Justice

In conjunction with:
Michigan Disability Rights Coalition
Alliance for Michigan Medicaid Access

April 2013

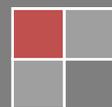


Table of Contents

Introduction.....i

Medicaid Decision-Makers..... ii

I. Improving Transportation assistance for Medicaid Recipients 1

 A. What is the Law on Medicaid Transportation?..... 1

 B. How does Michigan Ensure Medicaid Transportation..... 1

 Advocacy Opportunities..... 3

**II. Reducing Out of Pocket Costs that are a Barrier to Healthcare for
 People with Disabilities.....4**

 A. The Affordable Care Act Expansion of Medicaid to People with Income
 Below 138% of the Federal Poverty Level.....4

 Advocacy Opportunities.....5

 B. Medicaid Spend-downs or Deductibles.....6

 1. What is “Medicaid with a Deductible?”6

 2. How is the deductible amount calculated?.....6

 3. What is the law on Deductible Medicaid?7

 4. Are there other ways to reduce the Medicaid Deductible to a more
 affordable level?.....7

 5. How is Medicaid coverage activated for people who have Medicaid with
 a Deductible?.....8

 6. Will the Affordable Care Act (ACA) make Deductible Medicaid Irrelevant?.....8

 Advocacy Opportunities.....9

 C. Medicaid Co-Payments.....10

 1. What’s the Law on Medicaid Co-payments?.....10

 2. Do Medicaid co-payments apply to all Medicaid recipients and all
 Medicaid services?.....10

 3. How high can Medicaid co-payments be?.....10

 4. What if I cannot afford to pay my co-payment?.....11

 5. What about Medicaid recipients who have Medicare part D for prescription
 drugs?.....12

 6. Issues in Implementation of the Affordable Care Act.....12

 Advocacy Opportunities.....12

III.	Reducing Medicaid Paperwork and Red Tape that is Barrier to Health Care for People with Disabilities.....	14
	A. Opportunities under the ACA.....	14
	B. Information Technology Improvements for Deductible Medicaid.....	14
	Advocacy Opportunities.....	15
IV.	Reducing Barriers to Health Care for People with Disabilities for Whom English is a Second Language.....	16
	Advocacy Opportunities.....	17
V.	Reducing Barriers to healthcare for People with Multiple Disabilities.....	18
	Advocacy Opportunities.....	18

Introduction

In January 2011, the Michigan Developmental Disabilities Council (DD Council) funded a state-level project to develop an advocacy campaign to reshape the state's health care delivery system for people with developmental and other disabilities. This project identified barriers to consumer access Medicaid to services, opportunities for people with developmental disabilities to influence how funding and services are provided, building advocacy around Medicaid, and building and sharing information among community partners. This report is the first public report for the campaign and highlights the results of focus groups conducted around the state. Six focus groups were held with approximately ten participants in each. The focus groups were held in ethnic and geographically diverse locations throughout Michigan. They identified barriers experienced by people with disabilities – especially those with Medicaid - seeking to access high quality medical care. This paper provides a legal and policy background on issues that arose in the consumer focus groups, and some initial thoughts on advocacy opportunities to address the barriers identified.

Medicaid Decision-Makers

Medicaid is jointly funded and operated by the state and federal government. A federal law (statute), which passed by Congress created Medicaid. Some of the decisions about the federal Medicaid law, and federal funding for Medicaid, are made in Congressional committees before they go to the full House and Senate. Michigan's federal **Senators and Congresspersons** can be contacted when they are making decisions that affect Medicaid.

The federal law is implemented through **federal regulations**, which are written and enforced by the **Centers for Medicare and Medicaid Services (CMS)**. CMS must publish any proposed regulations that they are considering before the regulations become final, asking for public comment. Individuals who think the federal regulations need to be changed or enforced can contact CMS with their comments on proposed regulations.

Under the federal law, each state, including Michigan, can make some decisions or choices about its Medicaid program, within limits set by federal law. Some of the choices affect who is covered, what services are covered, how the payments are made, and how much is paid. Michigan's Medicaid program was created by the **Michigan legislature**, in part of the state law called the **Social Welfare Act**. Each year the Michigan legislature decides how much money will be available to pay for Medicaid in Michigan, when they pass the Appropriations Act for the Department of Community Health (DCH). Individuals who think the state law needs to be changed, or more money should be available to improve or expand Medicaid, can call or write their **State Representative** or **State Senator**. Some of the decisions about Medicaid are made by legislative committees before they are considered by the full State Senate and House. Members of those committees may be contacted when they are making decisions that affect Medicaid.

Michigan's Governor is in charge of the Executive branch, which must run the Medicaid program in compliance with the state and federal Medicaid laws. The Governor makes recommendations to the legislature each year about the amount of money that should be budgeted to run the Medicaid program. Directly or indirectly, through the Department of Community Health (discussed below), the Governor also recommends or decides which Medicaid options Michigan should adopt as permitted by federal law, and how Michigan should use its flexibility.

The Michigan **Department of Community Health (DCH)** is the state agency with primary responsibility for Michigan's Medicaid program. The **Medical Services Administration (MSA)** is the part of DCH that actually administers Michigan Medicaid. However, DCH has an agreement with the **Department of Human Services (DHS)** for DHS to decide eligibility and enroll people in the Michigan Medicaid program. MSA and DHS develop and issue policies

and procedures to implement the state law. They also sometimes issue formal state rules. Medicaid eligibility policies and procedures are included in the DHS Bridges Eligibility Manual, Bridges Administrative Manual (BAM), and Tables issued as part of the DHS Reference Manuals. DHS Policies are available online at www.mfia.state.mi.us/olmweb/ex/html/. DCH issues policies and procedures about what services are covered and what procedures must be followed to obtain payment for services, most of which are included in the Medicaid Provider Manual. The Provider Manual is available online at www.michigan.gov/mdch/0,1607,7-132--87572--,00.html . Michigan Medicaid policies are published 30 days before they become effective, for public comment. Individuals can call or write DCH and DHS if they think state policies should be changed, or if they believe the state is not following or enforcing the state or federal Medicaid laws.

Local DHS offices have some flexibility in establishing procedures for processing Medicaid applications and in deciding how to assure transportation for Medicaid recipients to and from Medicaid-covered services. Individuals can call or write **their County DHS Director or DHS District Manager**, or their **local DHS Board**.

Federal Medicaid Law Decision-Maker: *Congress*

(Michigan's United States Senators and Representatives)

Write, call or meet regarding changes to Medicaid law or federal budget decisions affecting Medicaid

Federal Medicaid Regulations

Decision-Maker: *Centers for Medicare and Medicaid Services*

Comment on Proposed regulations

State Medicaid law (Social Welfare Act)

Decision-Maker: *Michigan Legislature* (Governor signs or vetoes)

(Michigan State Senator and State Representative)

Write, call or meet regarding changes to Medicaid law or state appropriations decisions affecting Medicaid

State Medicaid or DHS Procedural Rules

Decision-Maker: *DCH or DHS*

Written comments or attend and comment at public hearing on proposed rules (rare)

State Medicaid Policy

Decision-Maker: *DCH/MSA and DHS*

(State Directors and Deputy Directors for DHS and DCH/MSA)

Changes to statewide policies or procedures are not consistent with state or federal law, or could be improved

Local DHS policies and practices (usually unwritten)

Decision-Maker: *Local DHS Director, DHS Board*

County Director, Board Members, Supervisors/Managers

I. Improving Transportation Assistance for Medicaid Recipients

Focus group participants spoke about difficulties getting transportation help. They also spoke about postponing necessary health care because of inability to pay transportation costs.

This part of the report discusses some of the key laws and policies regarding Medicaid transportation assistance.

A. What is the Law on Medicaid Transportation?

Federal law requires states to ensure that recipients have transportation to and from providers.¹ The state must specifically offer transportation assistance to children and young adults who receive Medicaid, and provide such services upon request, under the Early Periodic Screening, Diagnosis and Treatment (EPSDT) requirements of Medicaid.² Federal law allows the state to contract with “brokers” to ensure transportation for Medicaid recipients who have no other means of transportation and specifically exempts transportation broker contracts from the usual requirement that services be statewide.³

A federal court determined that the Michigan Medicaid agency must provide information to Medicaid recipients about the availability of transportation assistance and must provide written notice of denial and hearing rights to recipients who are denied Medicaid transportation assistance.⁴ Nursing homes must provide transportation to off-site medical services for Medicaid recipients.⁵

B. How Does Michigan Ensure Medicaid Transportation?

Most Medicaid recipients are required to enroll in managed care health plans, which provide most of their care for physical health care problems, as well as some mental health visits. All Medicaid Health Plans that contract with the state are required to provide transportation for their enrollees, for all contracted services. However, for non-emergency transportation, the Health Plans “must also utilize DHS guidelines for the evaluation of a member’s request for medical transportation to maximize use of existing community resources.” See Sample Health Plan Contract at p. 29, available online at www.michigan.gov/documents/contract_7696_7.pdf. As discussed below, the DHS policy can lead to mixed results. The Health Plans are required to address transportation needs in case management for people with chronic health conditions. *Id.* at p. 30. Health Plans are required to include information about transportation help in their

¹ 42 USC 1396a(a)(4)(A); 42 CFR 431.53.

² 42 CFR 441.62.

³ 42 USC 1396a(a)(7)) and 412 CFR 440.170.

⁴ *Boatman v Hammons*, 164 F3d 286 (6th Cir 1998).

⁵ 42 CFR. 483.55(a)(3)(ii), (b)(2)(ii) (dental services), 483.75(j)(2)(iii) (lab services), (k)(2)(iii) (radiology services).

Member Handbooks that are distributed to enrollees. *Id.* at 33. Transportation includes meals and lodging when necessary.

Anecdotal evidence suggests that Health Plans are willing and able to provide transportation to recipients as long as the recipient provides advance notice of the transportation need.

Local Department of Human Services (DHS) Offices are required to provide transportation assistance to fee-for-service Medicaid recipients (those not enrolled in Medicaid Health Plans) and also must “assure” transportation to Medicaid-covered services, such as mental health, dental, and vision services, that are not covered by the Medicaid Health Plan contracts. In Wayne, Oakland, and Macomb counties, DHS has contracted with transportation brokers to provide services. Anecdotal reports suggest transportation is more reliably available and accessible to Medicaid recipients in counties served by the transportation broker than in some other counties.

In non-brokered counties, DHS practices vary widely, at least in part because of the somewhat contradictory policy published by DHS, and in part because of variations in other, local transportation resources and caseworker availability.

DHS policy excludes reimbursement for Medicaid transportation

- Not approved in advance for “episodic” medical care and pharmacy visits
- For routine care from a provider outside the community when “comparable care” is available locally and the recipient was not referred to out-of-community care by a physician
- If provided by family, neighbors, or friend that have provided transportation at no cost in the past, “except in extreme circumstances or hardship”

DHS policy specifically instructs local offices, “Do not routinely authorize payment for medical transportation. Explore why transportation is needed and all alternatives to payment.” Policy encourages DHS offices to be the payer of last resort and to identify the lowest cost option for providing transportation. Bridges Administrative Manual (BAM) 825 p. 3-4.

At the same time, however, DHS policy required local offices to administer transportation assistance “in an equitable and consistent manner” and to “have procedures to assure medical transportation eligibility and that [sic] payments reflect policy.” Policy recommends that local offices have a transportation coordinator. *Id.* It also recommends that local offices have a supply of tickets, tokens or passes for bus service for clients who wish to use public transportation for medical transportation.

DHS requires verification of transportation expenses, which must be on specific DHS forms. Payment may be made to the recipient or the provider.⁶

DCH (not DHS) must give prior authorization (which can be for up to 6 months for prolonged treatments) for

- Out of state services, except services from borderland providers
- Overnight stays within 50 miles of the recipient's home.
- Overnight stays of more than 5 days (14 days for U of M Mott Children's Hospital)
- Overnight stays for more than one family member of the recipient
- Meals for non-overnight trips
- More than one attendant
- Mileage and food costs for daily trips
- Methadone treatment for more than 18 months.⁷

Consistent with the Court decision in Boatman v Hammons, DHS policy provides for notice and an opportunity for a hearing when transportation is denied. *Id.* at p. 13-14. However, because there is no mandatory, written application process for Medicaid transportation services, and no reporting regarding transportation requests and approvals/denials by local DHS offices, it is unclear whether all requests for transportation are formally denied in writing.

Advocacy Opportunities

1. Increase funding for Medicaid transportation, and enter into broker contracts in more counties. Encourage the legislature to fund more transportation services in counties that do not have broker contracts.

2. Improve Bridges Administrative Manual (BAM) 825/Statewide DHS policy (simplify, eliminate contradictions, set criteria for hardship). Encourage DCH and DHS to set up a work group to develop better policies and to publicize the availability of transportation.

3. Improve local DHS office policies and practices. Advocate for a single, accessible Transportation Coordinator; monitoring and reporting on transportation requests; and publicizing transportation policies.

⁶ DHS Bridges Administrative Manual (BAM) 825 p. 12- 13. Available online at <http://www.mfia.state.mi.us/olmweb/ex/bam/825.pdf>.

⁷ BAM 825 p. 7-9.

II. Reducing Out of Pocket Costs that are a Barrier to Healthcare for People with Disabilities

Focus group participants spoke about postponing non-emergency health visits because of the costs associated with such visits. They also spoke about scheduling visits based on payment or coverage rules, rather than based on medical need or health provider recommendations. Focus groups also discussed problems getting prescription medications, which may in part be due to inability to pay co-payment debts.

This part of the report discusses some of the key laws and policies that result in out-of-pocket costs for some Medicaid recipients, and possible advocacy opportunities related to lowering out-of-pocket costs. The first section talks about the Medicaid expansion funded under the Affordable Care Act (ACA). The second section talks about Medicaid with a Deductible (also known as spend-down Medicaid), which is available to people who have too much income to qualify for full-coverage Medicaid. The third section talks about Medicaid Co-payments.

A. The Affordable Care Act expansion of Medicaid to People with Income below 138% of the Federal Poverty Level

In general,⁸ Michigan provides Medicaid for people with disabilities only if they have budgeted income below 100% of the federal poverty level (\$931 a month for a single person, \$1,261 per month for a couple) and countable assets below \$2,000 for a single person or \$3,000 for a couple.⁹ If your countable assets are over \$2,000/\$3,000 asset limit, you will not be eligible for Medicaid. If your income is over 100% of the poverty level you will have to meet a monthly deductible before your Medicaid eligibility can begin.¹⁰

Under the Affordable Care Act (ACA), states have the option to expand their Medicaid program in January 2014, to cover anyone who has Modified Adjusted Gross Income below 138% of the federal poverty level (\$1,285 per month for a single person, \$1,740 for a couple). There is no asset test for this Medicaid eligibility group. People do not have to prove they are disabled in order to get Medicaid under this category. However, people will not be able to get Medicaid under this group if they are eligible for Medicare or are age 65 or older.

⁸ Some people with disabilities who have income below \$2,094 per month (3 times the SSI federal benefit rate) also qualify for Medicaid if they are in a nursing home or qualify for the MIChoice waiver.) In addition, some people with disabilities who have unearned income below 100% of the federal poverty level but also have earned income may qualify for Freedom to Work Medicaid. There also are special Medicaid categories for former SSI recipients who lost their SSI eligibility for certain specific reasons.

⁹ Some people with disabilities qualify for Medicaid under different Medicaid rules that apply to children and pregnant women. This paper does not discuss those Medicaid groups.

¹⁰ Deductible Medicaid is discussed in section II.B., below.

Many people with disabilities who currently have Deductible Medicaid would be able to get Medicaid coverage under this expansion, without meeting a deductible each month, if Michigan accepts the federal money to implement the expansion. However, the ACA gives states the option of providing a somewhat different benefit package to people who qualify for Medicaid under the expansion. If Michigan chooses to expand eligibility for Medicaid but provides a smaller benefit package for the expansion group, then some people with disabilities may have to choose between having Medicaid with a deductible and having “full” Medicaid with fewer covered services.

In addition, as explained in section II.C., below, the state has the option of requiring more cost-sharing (premiums or co-payments) for some people with higher incomes who would qualify for Medicaid under the expansion group.

And, most importantly, the Supreme Court decision holding that CMS cannot eliminate all federal Medicaid funding for states that do not expand Medicaid to this group has been interpreted as creating an option not to expand Medicaid to this group of people. Some Michigan lawmakers are trying to stop the Medicaid expansion in Michigan by refusing to accept and spend the federal Medicaid dollars available to pay for the expansion.

Advocacy Opportunities

4. Implement the ACA Medicaid Expansion for people with income below 138% of the Federal Poverty Level – Advocate for the Legislature to adopt the Executive Budget which includes the recommendation of the Governor and the Department of Community Health to accept federal funding to implement this expansion.

5. Don’t set a different benefit package for the Medicaid expansion group – Advocate for the Governor and the Department of Community Health to provide the same coverage for all Medicaid recipients, including those who qualify under the Medicaid expansion.

6. Don’t set higher co-payments for recipients in the ACA expansion category - Recipients and advocates will have to be alert to any indications that Michigan intends to impose higher copayments on the expansion group and advocate that, as a minimum, co-payments should not be higher for the expansion group than they are for current Medicaid recipients.

B. MEDICAID SPEND-DOWNS OR DEDUCTIBLES

1. What is “Medicaid with a Deductible”?

Medicaid with a deductible is Medicaid for individuals whose income is too high to qualify for other Medicaid categories, but who meet the non-financial requirements for one of the Medicaid Deductible eligibility groups (also called “medically needy” groups), as well as the asset limit, if any.¹¹

Medicaid with a deductible allows some individuals to receive Medicaid by showing their medical expenses are very high in comparison with their income. Each person is allowed a minimal amount of “protected” income each month. DHS expects that if you have income above this protected amount, you will use this “excess” income to pay your medical expenses. This amount of excess income is called your “deductible.” You can meet your “deductible” obligation by showing that you have medical expenses (either paid or unpaid) that are equal to or more than the deductible amount. Once you show that you have met the deductible for a particular month, Medicaid will pay for all your Medicaid-covered medical expenses during the rest of the month.

Your ability to obtain payment for medical care under Medicaid deductible categories will depend on the amount of your medical expenses in any given month. This makes Medicaid with a Deductible different from other categories of Medicaid where DHS focuses on the amount of income you have, and does not consider the amount of your medical expenses.

2. How is the deductible amount calculated?

Medicaid deductibles are calculated on a monthly basis. They are calculated by subtracting the Medicaid Protected Income Level (PIL) from monthly net countable income. The rules about whose income counts, and how much of it is counted, deducted, or disregarded, will vary depending on which category of Medicaid is being considered by DHS.¹²

¹¹ Income limits for full Medicaid without a deductible vary depending on the Medicaid category or group the person is in. For example, the income limit for seniors (age 65+) and people who are disabled is 100% of the federal poverty level (less than \$15,000 a year for a married couple); the income limit for children age 1- 18 is 150% of the poverty level (about \$33,000 a year for a family of 4); and the income limit for parents is well below the federal poverty level. All recipients except children and pregnant women must meet an asset test.

¹² Rules on calculating net countable income are complicated and vary depending on the Medicaid category and the individual’s household family composition. Details on calculation of countable income are beyond the scope of this summary.

The PIL that is used in calculating an individual's deductible amount will vary depending on the number of persons included in the individual's Medicaid group¹³ and the part of Michigan in which the individual lives (the "shelter area"). Current PILs are in the Program Reference Manual – Tables and Charts, PRT Item 240 available online at www.mfia.state.mi.us/olmweb/ex/html/. The shelter areas are listed in PRT 200.

3. What is the law on Deductible Medicaid?

Deductible Medicaid coverage for individuals who cannot qualify for full Medicaid coverage under other, "categorically needy" categories is **optional** under federal law.¹⁴ Michigan's state law – the Social Welfare Act -- **requires** Deductible Medicaid coverage.¹⁵ Federal and state law set the upper and lower limits for states to use in setting the Protected Income Level (PIL) used to determine Medicaid deductibles in Michigan. Under the state and federal law, the PIL cannot be greater than 133 1/3% of the amount that Michigan paid to families on the Aid to Families with Dependent Children (ADC) welfare program on July 16, 1996, with limited cost of living adjustments.¹⁶ As a result, the PILs in Michigan are less than half of the federal poverty level.

Because the PILs are extremely low, deductibles are often quite high. Even individuals who are struggling to pay for medical care, or who are finding that they cannot afford to pay for the medical care and treatment they need, may be unable to meet their deductible and thus unable to qualify for Medicaid.

4. Are there other ways to reduce the Medicaid deductibles to a more affordable level?

Federal Medicaid law¹⁷ allows states to change the way that they count income in calculating a person's Medicaid eligibility and deductible amount. States can lower deductible amounts by reducing the amount of income that is taken into account when calculating a person's deductible. States can do this for some Medicaid eligibility groups but not others, but it has to use the same method for counting income for all people in the same eligibility group (such as the group of people who qualify for Medicaid based on disability). Unfortunately, because of the state's fiscal problems, Michigan has not used this option to increase health care coverage for persons who currently have very high deductibles.

¹³ Rules on determining who is included in the Medicaid group vary according to the Medicaid category being considered, and are beyond the scope of this discussion.

¹⁴ 42 USC 1396a(a)(10)(C) and 1396d(a).

¹⁵ MCLA 400.106(1)(b).

¹⁶ 42 USC 1396b(f)(1)(B) and 1396u-1(f)(3).

¹⁷ 42 CFR 435.1007(f), implementing 42 USC 1396a(r)(2).

5. How is Medicaid coverage activated for people who have Medicaid with a Deductible?

Getting a Medicaid case activated when one has a deductible can be a slow and paper-intensive process. **Under current DHS policies and procedures, individuals who have an active Medicaid deductible case must submit documentary verification of medical expenses (e.g. medical billing statements) to their DHS caseworker.** The DHS caseworker must enter information about each bill into the DHS computer system (Bridges) and certify an eligibility determination. If more than three months go by and the caseworker does not enter bills into the Bridges computer system showing that the deductible was met, Bridges automatically closes the “active” Medicaid deductible case and should send a case closure notice to the individual.¹⁸ If the Medicaid case has closed, the individual will have to re-apply for Medicaid when she or he wants to submit bills showing she or he is eligible. Each time the caseworker redetermines eligibility for Medicaid because the individual has submitted medical bills, the individual will be asked to provide verification of factors that might have changed, such as income and assets.

Delays in entering Medicaid expenses into the computer system result in delays in activating Medicaid coverage, which can make it impossible for people to take advantage of the coverage they are entitled to. Many providers will not provide treatment or services until the Medicaid eligibility is verified in the computer system, which may not occur until **after** the eligibility has ended, under the current, cumbersome eligibility process.

Bills submitted by providers through the DCH Medicaid billing payment system (Champs) are not automatically entered into the Medicaid eligibility system as incurred expenses. In addition, providers have no way of verifying the individual’s deductible amount or the amount of the deductible that is unmet at a particular point in time. Inquiries about eligibility show the individual is ineligible until the DHS caseworker enters enough bills into the Bridges system to meet the deductible and then certifies the individual’s eligibility.

Some states have systems that automate at least part of the Medicaid eligibility process for “medically needy” individuals by having providers input the amount of the bills the person owes, and using computer systems to add up the individual’s bills and activate Medicaid coverage when the total amount of the bills equals the person’s Medicaid deductible. This makes things easier for people seeking Medicaid, providers, and DHS caseworkers.

6. Will the Affordable Care Act make Deductible Medicaid irrelevant?

As explained in section A, Medicaid under the expansion is not available to people age 65 or older, and people who are eligible for Medicare. In addition, the state could make decisions about cost sharing or covered services for the expansion group that would make it important

¹⁸ Other, non-deductible Medicaid cases remain open for 12 months unless circumstances make the individual ineligible.

for some people to have disability-based Deductible Medicaid instead of Medicaid under the expansion.

Deductible Medicaid will continue to be important for a variety of people, including some seniors, some people who have Medicare, and some people who are “underinsured” or need services not covered by their private insurance, such as long term care/nursing home care.

Advocacy Opportunities

7. Implement the ACA Medicaid Expansion for people with income below 138% of the Federal Poverty Level – As discussed in section A, above, the ACA Medicaid expansion would allow many more low-income people, including some people with disabilities, to qualify for full Medicaid without meeting a spend-down or deductible.

8. Improve computer systems to automate eligibility – Encourage DCH and DHS to update their computer systems to track incurred medical expenses and automate eligibility based on spend-down/deductible. This would reduce or eliminate a lot of the paperwork and “red tape” involved in getting Medicaid coverage activate for Deductible Medicaid recipients.

9. Use income disregards to eliminate or reduce the “cliff” that people with disabilities face when their income rises above the income limit for full Medicaid coverage – **Encourage** the Governor, DCH, and the legislature to ensure that people with disabilities and seniors who are Medicare-eligible receive the same coverage as (a) people with disabilities and seniors who are not Medicare eligible and (b) non-disabled, non-senior individuals. (Even when the ACA is fully implemented, people who are eligible for Medicare will not be eligible for full-coverage Medicaid under the ACA Expansion category. Thus, many low income people with disabilities and seniors will continue to face large deductibles/spenddowns if they have budgeted income above 100% of the federal poverty level. Michigan could use income disregards to, in effect, raise the protected income level so that people in this group who have income below 138% of the federal poverty level will have the same full-coverage Medicaid as non-elderly, non-Medicare-eligible individuals.) Applying those new disregards also would reduce the Deductible amounts for people with income above 138% of the federal poverty level who seek Medicaid because private insurance is unaffordable for them (even with subsidies) or leaves them underinsured because the benefit package does not include all Medicaid-covered services.

C. MEDICAID CO-PAYMENTS

1. What's the Law on Medicaid Co-payments?

Federal law allows state Medicaid programs to require co-payments for some (but not all) Medicaid recipients for some (but not all) services. Federal law limits on how high the co-payments can be. And federal law has rules on when services can be denied if co-payments are not paid. States do not **have** to charge **any** co-payments for Medicaid-covered services.

The Michigan legislature has chosen to impose co-payments, through a provision in the annual Appropriations Act.

2. Do Medicaid co-payments apply to all Medicaid recipients and all Medicaid services?

No. The following Medicaid recipients are exempt co-payments:

- Children (under age 21 in Michigan) or
- Living in a nursing home.

In addition, **no** Medicaid copayments can be charged for:

- Pregnancy related services
- Family planning services and supplies
- Emergency services, and
- Hospice services
- Tobacco cessation drugs
- Indian health program services.¹⁹

In addition, as explained above, recipients in some managed care plans will not be charged co-payments, or may have lower co-payments than those listed for fee-for-service Medicaid.

3. How high can Medicaid co-payments be?

Federal law limits the amounts that can be charged as co-payments to Medicaid recipients with income below 100% of the federal poverty level.²⁰ In general, co-payments must be “nominal.”

¹⁹ 42 U.S.C. 1396o(a)(2), (b)(2), and (j)(1).

²⁰ For recipients in groups with income between 100 and 150% of the federal poverty level, States can impose higher co-payments of up to 10% of the cost of a service, but total co-pays (and premiums) for all family members cannot be more than 5% of the recipient group's quarterly or monthly income. States can impose co-payments of up to 20% of the cost of services for recipients with income over 150% of the federal poverty level, but the total quarterly or monthly co-payments and premiums still cannot be more than 5% of recipient's family income. 42 U.S.C. 1396o-1(b)(1) and (2). There are some groups that cannot be charged these higher co-payments under federal law, such as foster care children.

States also can impose higher cost-sharing on non-preferred prescription medications for recipients with income over 150%, but the co-pays cannot be over 20% of the cost of the drug and is included in when determining whether the total co-pays and premiums exceed 5% of the recipient's family income.

These amounts are **maximums**. States do not have to charge **any** co-payments for Medicaid services.

In the annual Appropriations Act, the Michigan legislature has directed the Medicaid agency to impose co-payments on fee-for service Medicaid recipients (recipients who do not have a managed care plan). The amounts set are within the “nominal” co-payment limits set by federal law. Under state law, 2011 P.A. 63 Sec. 1620 and 1631, the co-payments are:

- \$1 for an outpatient hospital visit
- \$1 for a generic drug
- \$3 for a brand-name drug
- \$2 for a physician, podiatrist, or eye doctor office visit.
- \$3 for a hospital emergency room
- \$3 for a dentist office visit
- \$5 for the first day of an inpatient hospital stay

The Medical Services Administration allows, but does not require Medicaid Managed Care Plans to impose co-payments for services, up to the amounts listed above.

4. What if I cannot afford to pay my co-payment?

Medical providers **cannot refuse services** because of a Medicaid recipient’s inability to pay a co-payment. 42 U.S.C. 1396o(e) and 42 C.F.R. 447.15 and 447.53(e). Under Michigan’s Medicaid State Plan, a provider must accept a client’s statement that he or she is unable to pay the co-payment. However, under federal law, the provider does not have to forgive the co-payment (the recipient still owed it as a debt).

Under state policy in the Medicaid Provider Manual, the Medical Services Administration allows providers to deny services to Medicaid recipients if they have failed, after a reasonable period of time, to pay a debt owed for a co-payment charged for a previous service.

Providers that refuse service based on non-payment of co-payment debt must follow special procedures, including:

- Give the recipient a written statement of the debt (can be a cash register receipt, as long as it is in writing)
- Allow a reasonable time to pay
- Refer the recipient to the Medicaid Beneficiary Helpline or the managed care plan customer service number if the recipient has questions or concerns
- Transfer the recipient’s health record to a subsequent provider at no cost to the recipient

Providers other than physicians and dentists (DO, MD, or DDS) must also follow specific procedures for adopting policies and giving notice to recipients before denying services.²¹

5. What about Medicaid recipients who have Medicare Part D for prescription drugs?

When a Medicaid recipient also has Medicare (is “dually eligible”), almost all of that person’s prescription medications will be paid for by Medicare instead of Medicaid. The recipient must pay

- \$2.60 for generics and preferred multi-source drugs
- \$6.50 for non-preferred brands

Under Medicare, providers can refuse to provide services to recipients who are not able to pay the Medicare co-payment.

6. Issues in Implementation of the Affordable Care Act

As discussed in section A, above, under the ACA, Michigan has the opportunity to expand Medicaid to individuals with Modified Adjusted Gross Income (MAGI) up to 138% of the federal poverty level. If Michigan adopts this option, this “expansion group” will enable more people with disabilities to become eligible for Medicaid. However, because recipients in the expansion group will have income above 100% of the federal poverty level, the state will have the option of imposing higher co-payments on these newly eligible recipients.

Advocacy Opportunities

10. Eliminate or reduce Medicaid co-pays- The Michigan legislature could stop requiring Medicaid co-payments, or reduce co-payment amounts, for some or all Medicaid services when it passes the Appropriations Act for 2014 or future years.

11. Prohibit denial of services for recipients who cannot afford co-payments - MSA could stop allowing providers to deny services based on unpaid co-payment debts.

12. Advocacy with non-physician/non-dentist providers- Encourage providers to adopt policies that do not deny services when recipients are unable to pay their co-payment debts. (Could include monitoring compliance with the Provider Manual requirements and enforcing compliance with the Provider Manual notice/policy/posting requirements).

13. Eliminate or reduce prescription medication co-payments in the Pilot Project for Integration of Medicaid and Medicare - Encourage MSA to require co-payments no higher than the **Medicaid** level and allow managed care plans to eliminate prescription co-payments altogether

²¹ Michigan Medicaid Provider Manual Section 11.2.B.

14. Do not set higher co-payments for recipients in the ACA expansion category -

Recipients and advocates will have to be alert to any indications that Michigan intends to impose higher copayments on the expansion group and advocate that, as a minimum, copayments should not be higher for the expansion group than they are for current Medicaid recipients.

III. Reducing Medicaid Paperwork and Red Tape that is a Barrier to Healthcare for People with Disabilities

Focus group participants spoke about the difficulty of providing necessary paperwork and meeting deadlines for paperwork. Medicaid eligibility is an incredibly paper-intensive process, especially for people who access Medicaid through the Deductible Medicaid process.

A. Opportunities Under the ACA

Some of the changes under the ACA that are discussed in earlier section also create opportunities to eliminate red tape and streamline Medicaid eligibility. For example, the Medicaid expansion group does not have to meet an asset test, which eliminates requests for verification of bank accounts, life insurance policies, vehicles, etc. In addition, income eligibility for the expansion group uses Modified Adjusted Gross Income to determine income eligibility, and the federal government will be creating computer interfaces that will allow the states to access IRS information to verify income, which will potentially eliminate income verification requirements for the expansion group. In addition, states will be allowed to set standards for “reasonable compatibility” so that Medicaid can be provided immediately if the person’s own statement of their income is “reasonably compatible” (as defined by the state) with information available from the IRS or other data sources the state already uses to verify or identify income. Advocacy will be important to ensure Michigan adopts reasonable compatibility standards for Medicaid that eliminates as much red tape as possible.

Furthermore, to ensure the streamlined eligibility processes for the expansion group will benefit as many people with disabilities as possible, it will be important to advocate for a uniform Medicaid benefit package for all Medicaid eligibility groups. If the expansion groups get skimpier coverage, people with disabilities may have to resort to the more cumbersome, paper-intensive eligibility process for disability-based Medicaid categories. The same thing may be true if Michigan chooses to impose higher cost sharing (copayments or premiums) on some people in the expansion group.

B. Information Technology Improvements for Deductible Medicaid

As discussed in section II.B., above, other states have improved their computer systems to streamline eligibility for medically needy Medicaid recipients (individuals with Deductible Medicaid). Michigan could improve the connections between its Champs system that monitors provider billings and the Bridges eligibility system that is used to determine Medicaid eligibility, to automate and streamline Deductible Medicaid eligibility.

Advocacy Opportunities

15. Advocate for “reasonable compatibility” standards that minimize paper verification requirements, maximize the use of self-attestation, and do not delay eligibility.

Encourage DCH/MSA to include advocates and consumers in the discussion on this issue, and to eliminate red tape whenever possible.

16. Do not set a different benefit package for the Medicaid expansion group - Advocate for the Governor and the Department of Community Health to provide the same coverage for all Medicaid recipients, including those who qualify under the Medicaid expansion.

17. Do not set higher co-payments for recipients in the ACA expansion category - Recipients and advocates will have to be alert to any indications that Michigan intends to impose higher copayments on the expansion group and advocate that, as a minimum, co-payments should not be higher for the expansion group than they are for current Medicaid recipients.

IV. Reducing Barriers to Healthcare for People with Disabilities for Whom English is a Second Language

Focus group participants for whom English was a second language (ESL) reported problems getting appropriate diagnosis and treatment from providers who did not speak their language, failure to provide interpreters, delays in appointments and access to providers (apparently due to the logistics of arranging interpreters), and failure to provide translations of written directions.

Under the ACA, Title VI of the Civil Rights Act, and federal regulations, medical providers who are paid with Medicaid funds are required to ensure language access for the patients they treat. In addition, many hospitals have community service obligations because they were constructed in whole or in part with Hill Burton Act funding.

The DCH Medicaid Provider Manual informs providers that they cannot discriminate in violation of federal anti-discrimination laws, but does not specifically address the need for interpreters and translations, except in the context of prohibiting billing for interpreter services and requiring language assistance for informed consent to sterilization.

The DCH contract with managed care Medicaid Health Plans requires the Plans to include information about how to get interpreter services in their member handbooks. It also requires that the member handbook be translated into any language spoken by 5% or more of the Plan's enrollees, but it does not explicitly require interpreters and translations in the provision of healthcare services to Medicaid recipients.

Under federal Medicaid law and guidance, states can choose to provide Medicaid payment for interpreters or other language services as an administrative cost or as a covered service under the State Medicaid Plan. The federal government covers half of administrative costs. The federal government pays 2/3 of the cost of Medicaid-covered services for people currently eligible for Medicaid in Michigan and will pay 100% of the cost of Medicaid-covered services for those who become eligible under the ACA Medicaid expansion. 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.

Providing Medicaid payment for interpreter services arranged by providers or managed care organizations could help improve language access for LEP Medicaid recipients. Many providers are reluctant to treat Medicaid recipients because of low payment rates and the lack of reimbursement or payment for the additional expense of interpreter services is a disincentive to providing those services and to providing equal access to patients who need such services. More than a dozen states provide Medicaid payments for reimbursement for interpreter and translator services.

Advocacy Opportunities

18. Advocate for explicit requirements in Michigan Medicaid policies and contracts that all providers provide interpreters and translators for Medicaid recipients who have limited English proficiency. Qualified interpreters cost money and Medicaid providers, who already receive low reimbursement rates, are likely to rely on staff with some foreign language abilities or on patients' family members or friends to provide interpreter services if reimbursement is not available. This can lead to poor medical outcomes, which may be more costly in the end. Non-discrimination is often seen as a requirement that everyone be treated the same. However, nondiscrimination based on national origin may mean taking affirmative steps to provide interpreters or translation services. Medicaid policies and contracts should be explicit on this point.

V. Reducing Barriers to Healthcare for People with Multiple Disabilities

Focus group participants with multiple disabilities identified the time required to arrange transportation and schedule appointments for medical care, as well as difficulty finding specialists to work in coordinated ways as significant barriers.

Under the ACA, funding is available to develop health homes for people with chronic health conditions. It is unclear whether any efforts are being undertaken in Michigan to develop health homes for people with multiple disabilities, who may not have the chronic diseases specifically listed in the ACA (such as asthma, diabetes, or heart disease). Michigan also has received a CMS innovation grant to use Community Health Workers in Saginaw, Muskegon, and Ingham County to improve health outcomes for at risk populations. It is not clear what services are available through this project for people with multiple disabilities.

Advocacy Opportunities

- # 19. Advocate to develop health homes for people with multiple disabilities.



Production of this product was supported by Grant # 2013070 from the Michigan Developmental Disabilities Council, awarded pursuant to P.L. 106-402, as amended, the Developmental Disabilities Assistance and Bill of Rights Act, through the Michigan Department of Community Health, the Council's designated state administering agency.