

To: Health Advocates [\[1\]](#)

From: Jane Perkins and Steve Hitov

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Question: Our office has seen reports that Missouri plans to make significant cuts to its Medicaid program. What cutbacks have been approved, and are they legal?

Brief answer: Missouri has enacted a range of Medicaid cuts that affect both eligibility and service coverage. While the Medicaid Act allows the State tremendous flexibility in the operation of its Medicaid program, some of the cuts appear to run afoul of federal laws, including the Medicaid Act and the Americans with Disabilities Act.

Discussion:

Missouri recently initiated a number of dramatic changes to its Medicaid program. Most of the changes were enacted as part of a substantive Medicaid bill, Senate Bill 359, which the legislature passed and the Governor has signed. Other changes are included in the appropriations legislation for the state Department of Social Services (HB 11), which awaits the Governor's signature. The revisions will begin to be implemented as early as July 1, 2005, with all changes to occur by the end of the year. A Medicaid reform commission has been established to plan the termination of the Missouri Medicaid program by June 30, 2008.

The Missouri Medicaid cutbacks

Among other things, the legislation reduces or eliminates coverage of a number of eligibility groups and services, imposes premiums on SCHIP coverage for families with incomes over 150% of the federal poverty level (FPL) (approximately \$24,180 for a family of three), expands the use of copayments, requires extensive annual reinvestigation and documentation to maintain Medicaid eligibility, and revises eligibility rules for long term care recipients. The revisions include the following:

- **Reductions in covered groups**

The Missouri legislation eliminates health insurance coverage entirely for several groups of low-income Missourians. New annual “reinvestigation” requirements will also cause a number of additional individuals to lose coverage, regardless of whether they remain eligible for assistance. Based on data provided by the state Medicaid agency during the legislative debate, Legal Services of Eastern Missouri provides the following breakdown of the eligibility changes and their effects on health insurance coverage in Missouri: [\[2\]](#)

Eligibility Change

Number losing coverage

Reduction of family coverage to Temporary Assistance eligibility levels, which range from 17% to 22% of

68,219 low-income parents

Elimination of Extended One Year Transitional Medical Assistance

1,150 low-income workers

Elimination of Medical Assistance for Workers with Disabilities (MAWD)

9,529 working disabled individuals

Reduction of income eligibility of poverty level aged and disabled from 100% of the FPL to 85% of the FPL

NOTE: 100% FPL eligibility is	<i>retained</i>	for persons eligible base
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8,660 elderly and disabled individuals

Extensive annual reinvestigations and related paperwork requirements

13,609 individuals (including 8,998 children)

Elimination of state-funded health coverage for

General Relief recipients

3,046 people with temporary disabilities

Total: 104,213 individuals

In addition to these cuts, SB 539 makes continued coverage of other optional eligibility groups “subject to appropriations” each year.

- **Reductions in services**

The legislation has eliminated the requirement that the state Medicaid program cover the following services, unless the recipient is blind, pregnant, or a child under age 21: dental services; dentures; podiatry; optometric services (budget for 2006 allows one exam every two years); orthopedic devices; prosthetics (covered in 2006 budget); hearing aids; hospice (covered in 2006 budget); wheel chairs (covered in 2006 budget, except for batteries and accessories); eyeglasses; and comprehensive day rehabilitation services. The budget legislation also eliminates most durable medical equipment, including: augmentative communication devices, decubitus care equipment, hydraulic patient lifts, orthotics, hospital beds, special mattresses, bed side rails, commodes, and bed pans. Oxygen and respiratory care equipment and diabetic supplies and equipment, which had been eliminated in the Senate bill, were restored through the budget process. [\[3\]](#)

- **New copayment requirements**

The legislation generally allows copayments to be imposed on *all* Medicaid-covered services and recipients to the extent allowed under federal law. See 42 U.S.C. § 1396o, 42 C.F.R. § 447.50 et seq. This policy change affects hospital and physician visits, laboratory testing, non-emergency transportation, clinic services, and prescription drugs. Payments to providers will be reduced by the amount of the copayments. Subject to approval by the federal government, the law allows providers to deny “future services” to a Medicaid recipient who has an unpaid debt resulting from unpaid copayments, as long as it is the “routine business practice” of the provider to terminate services in these circumstances.

Pregnant women, children, and people with visual impairments are exempted from the copayments, as are mental health and personal care services. The budget legislation also exempts home and community based services. [\[4\]](#)

- **Increasing the level of disability**

Individuals will have to make a greater showing to qualify for nursing home and home and community-based care services. The state Medicaid agency has been directed to increase the scoring required to be considered disabled (from 18 to 21 points). Preliminary estimates from the state Department of Social Services found that about 11,000 residents would lose Medicaid coverage as a result of this change. [5]

Examples of the legal questions presented by the changes

The proposed cutbacks will consign over 100,000 Missouri citizens to the ranks of the uninsured. In doing so, the State will voluntarily give up at least \$379 million in federal matching payments. While the vast majority of the cutbacks reflect policy choices that are likely to prove shortsighted, many of them, including those discussed above, may run afoul of the Medicaid Act and the Americans with Disabilities Act (ADA). Some potential legal pitfalls are discussed below.

- Elimination of durable medical equipment

The legislation has eliminated coverage of most durable medical equipment (DME). Whatever the wisdom of eliminating this coverage, doing so implicates the Medicaid Act and in some circumstances the ADA.

Durable medical equipment is treated by the Medicaid program as a component of home health services. See 42 C.F.R. § 440.70(b)(3) (listing as “required services” under home health “[m]edical supplies, equipment, and appliances suitable for use in the home”). The Medicaid Act requires that the state provide “home health services for any individual who under the State [Medicaid] plan is entitled to nursing facility services.” 42 U.S.C. § 1396a(a)(10)(D). Thus, for this population group, home health, including durable medical equipment, is a mandatory Medicaid service. See also CMS, Dear State Medicaid Director (Sept. 4, 1998),

www.cms.hhs.gov/states/letters/smd90498.asp

(“As you know, the mandatory home health services benefit under the Medicaid program includes coverage of medical supplies, equipment, and appliances suitable for use in the home

(42 C.F.R. § 440.70(b)(3)").

Consequently, Missouri should not be allowed to move forward with the planned elimination of DME coverage. Moreover, the categorical elimination of coverage of specific types of DME, such as augmentative communication devices, may violate Medicaid Act rules which require each service to be covered in sufficient in amount, duration and scope to reasonably achieve its purpose. See 42 U.S.C. § 1396a(a)(10)(B); 42 C.F.R. § 440.230(b). These same provisions could also come into play to prohibit the State's plan to deny coverage, not for a wheelchair itself, but of the *battery necessary to operate the chair*. As the federal law indicates, the touchstone in any amount, duration and scope analysis is the need to achieve the purpose of the service. An electric wheelchair without electricity would not appear to meet that standard.

In light of the above, Missouri should not be able to categorically refuse to cover the list of DME items that it has proposed to eliminate, ranging from augmentative communication devices and hospital beds to bed pans. Indeed, it may well be the case that denying an individual with a disability with cost effective medical equipment in a community setting will also violate the Americans with Disabilities Act. The ADA, 42 U.S.C. § 12101 et seq., is designed "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities." 42 U.S.C. § 12101(b)(1). Congress identified isolation, segregation and unnecessary institutionalization of individuals with disabilities as forms of discrimination that must be eliminated. 42 U.S.C. §§ 12101(a)(2), (3) and (5). The ADA specifically recognizes that discrimination persists in the provision of "health services," 42 U.S.C. §12101(a)(3), and establishes a national goal "to assure. . . independent living . . . for such individuals." 42 U.S.C. § 12101(a)(8).

Congress delegated to the Attorney General responsibility for issuing regulations implementing the broad anti-discrimination mandate included in the Act at 42 U.S.C. § 12132. Those regulations, as relevant here, are found at 28 C.F.R. § 35.101 et seq. Section 35.130 provides that:

(b)(3) A public entity may not, directly or through contractual or other arrangements, utilize criteria or methods of administration:

(i) That have the effect of subjecting qualified individuals with disabilities to discrimination on the basis of disability; [or]

(ii) That have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the public entities program with respect to individuals with disabilities; . . .

(d) A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

Bearing in mind that Congress declared, and the Supreme Court in *Olmstead v. L.C.*, 527 U.S. 581, 597 (1999)

affirmed, that unnecessary segregation and institutionalization of people with disabilities are forms of discrimination prohibited by the ADA, the refusal to provide medical equipment to a person in the community may run afoul of this regulation. Without the equipment, people with disabilities who now function perfectly well in the community will be forced into nursing homes and other institutions. Once there, they will get the equipment they need. This discrimination, *i.e.*

unnecessary segregation and institutionalization in order to receive necessary services, whether or not an intended result of Missouri's elimination of the DME, is exactly what is prohibited by § 35.130(b)(3) and (d). Such an approach to operating the Medicaid program certainly is not one designed to provide services to those with disabilities in "the most integrated setting appropriate to the needs of" those individuals, as required by § 35.130(d).

That the ADA may impose limits on the manner in which a state operates its Medicaid program with regard to people with disabilities, even for optional benefits, has already been recognized by the courts. In *Fisher v. Oklahoma Health Care Auth.*, 335 F.3d 1175, 1182 (10th Cir. 2003), for example, the court found that plaintiffs' claim that a five-prescription-per-month limit in Oklahoma's Medicaid program would force them into nursing homes would, if proven, constitute a violation of 28 C.F.R. § 35.130(d), unless the state could demonstrate that not allowing it to impose such a limit would force it to make a fundamental alteration of its Medicaid program. The court was skeptical of the state's ability to show the latter, as it had previously operated the program without that limit.

- Imposition of new copayment policies

As noted, another change enacted by Missouri will allow a provider to deny services to a program beneficiary who owes the provider money because the beneficiary was unable to afford an earlier copayment. Under the law, while a provider will have to provide service at the time the Medicaid beneficiary fails to pay the copayment, it can deny all future services to that person for as long as the copayment debt remains outstanding.

The Medicaid Act specifically forbids providers from denying services to a beneficiary who is unable to meet a permissible copayment amount. 42 U.S.C. § 1396o(e). Section 1396o(e) not only requires the provision of services when a beneficiary cannot afford a required copayment, it also provides that the amount of the unmet copayment remains a liability of the beneficiary. This second provision anticipates the situation in which desperately poor beneficiaries would be unable to pay even nominal copayments and would carry any unmet copayments as an ongoing liability. Having foreseen this situation, Congress did not say that providers could deny service to a beneficiary with a financial liability for an unmet copayment, as Missouri now permits. Rather, the approach devised by Congress was more balanced, taking into account the need of the beneficiary for care and the expectation of the provider for payment. By declaring the unmet copayment to be an ongoing liability of the beneficiary, Congress allowed the provider to sue to recover any amounts owed. Providers are also free to garnish wages or take other available legal steps, except that they may not, under the terms of the statute, deny needed medical care in order to force payment.

Conclusion

In addition to the problems discussed above, the Missouri law raises a number of other legal questions. For example, the State has redefined Medicaid eligibility based on disability by increasing the point scores that applicants must meet in order to be considered disabled. At least one court has found such a process to violate the Medicaid Act. *See Kerr v. Holsinger*, No. 03-68-JHM, 2004 U.S. Dist. LEXIS 7804 (E.D. Ky. Mar. 25, 2004) (preliminary injunction) (finding that 42 U.S.C. §§ 1396a(a)(10) and 1396d(a) require coverage of mandatory services that cannot be ignored simply because the state does not want to pay for the services, and § 1396a(a)(3) requires specific due process when services are reduced or terminated). Indeed, any cutbacks in eligibility groups and services, to the extent they are legal, must adhere federal due process protections. These include proper notice of the termination or reduction in eligibility or services and, if there are any facts in dispute (for example, whether the individual may continue to qualify for Medicaid under another eligibility category), the individual must have the opportunity for a fair hearing before an impartial hearing officer.

See

42 U.S.C. § 1396a(a)(3); 42 U.S.C. § 431.200 et seq.;

see also, e.g.,

Appellee's Brief in *Rosen v. Comm'r*, No. 05-5633 (filed with Sixth Circuit Court of Appeals, May 17, 2005) (on file with NHeLP) (arguing that TennCare Medicaid reforms violate Constitutional and Medicaid Act due process requirements and a binding consent order).

In short, more than a few of the Missouri cuts appear to be unlawful under the terms of the Medicaid Act or the Americans with Disabilities Act. And even if some of the cuts can be implemented without a legal challenge, they may not achieve the hoped for savings. Rather, it is

more likely that the cost of care for many of the affected beneficiaries will be shifted from the federal government to the state and its safety net providers. In those situations in which the federal government will continue to pay its share, the costs to the state may nonetheless rise, as more elderly and disabled people enter nursing homes in order to receive the services they need.

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[2] See Joel Ferber, Legal Services of Eastern Missouri, *Summary of Medicaid Cuts Adopted in the 2005 Legislative Session* (May 23, 2005) (on file with NHeLP).

[3] *Id.*

[4] *Id.*

[5] *Id.*