



TECHNICAL ASSISTANCE PROJECT

**REPORTS ON**

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The Impact of State Budget  
Shortfalls on Access to  
Assistive Technology  
Through State Medicaid  
Programs

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## Contents

	Page
Assistive Technology and Medicaid	1
Changes in State Fiscal Conditions, 1998–2003	2
Changes in Medicaid Eligibility	3
Eligibility Expansions Enacted	3
Eligibility Restrictions Enacted	4
Changes in Coverage and Reimbursement for AT Devices	4
Wheeled Mobility	4
Patient Lifts	7
Augmentative and Alternative Communication	7
Hearing Aids	9
Optical	11
Changes in Medicaid Policies	12
Medicaid Managed Care	12
Home- and Community-Based Services Waivers	14
Changes in Medicaid Practices	14
Outlook	15
Five-Year Changes Limiting Access to AT for Medicaid Recipients with Disabilities	17
Acknowledgements	19

## **ASSISTIVE TECHNOLOGY AND MEDICAID**

Thousands of Americans with disabilities have been able to maintain or improve their independence through the use of assistive technology (AT). Barriers in all areas of daily life have been mitigated, thanks to the acquisition and use of hundreds of different types of AT devices.

Medicaid is the number one funding resource in the nation for providing AT devices. Medicaid is the state and federal program that funds healthcare and long-term care services for more than 50 million Americans. Typically, it is the second-largest program in state budgets behind education, and approximately three-fourths of Medicaid spending is devoted to persons with disabilities and the elderly.

State budget conditions can have a significant impact on Medicaid programs. From 1998 through 2003, state legislatures moved from a period of dealing with budget surpluses to having to make agonizing choices over major budget shortfalls. Pressures on state Medicaid spending intensified considerably over the past six years.

This policy brief examines how changes in the following 10 state budgets from 1998 through 2003 have impacted the provision of AT devices through Medicaid:

- Colorado
- Delaware
- Illinois
- Kansas
- Maine
- Maryland
- Missouri
- North Carolina
- Oklahoma
- Texas

An AT device is defined in the Assistive Technology Act of 1998 as “Any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve functional capabilities of individuals with disabilities.”

Most of the AT devices in state Medicaid plans are covered as durable medical equipment (DME) or are under a state’s optical or hearing aid programs. Services in a state Medicaid plan must be available to all categorically eligible individuals in the state. Specifically, this brief looks at these five types of cross-disability assistive technology devices that are commonly covered under state Medicaid plans:

- Wheeled mobility
- Patient lifts
- Augmentative communication devices
- Eyeglasses
- Hearing aids

## **CHANGES IN STATE FISCAL CONDITIONS, 1998–2003**

In 1998, the vast majority of states were in good to excellent fiscal condition. On the spending side, only 14 states were expecting to request supplemental appropriations for unanticipated spending requirements. A number of states even reported savings in their budgets as a result of declining caseloads in Medicaid. The favorable conditions led several of the 10 survey states to expand Medicaid eligibility to varying degrees, and even to expand some services.

A survey of legislative fiscal staffs by the National Conference of State Legislators (NCSL) in early 1998 reported that revenues were adequate in every state to offset any unanticipated spending requests. Thirty states reported that revenues exceeded initial expectations, and revenue estimates were on target in another 18 states. Each of the 10 states in this brief had to raise their midyear revenue projections far beyond the original estimates. One of the key legislative issues in Colorado and Missouri was what to do with excess revenues because, in both states, revenues were limited by state constitutions. In Texas, revenue collections were on target for the first quarter of 1998 after FY1997 had provided the state with a surplus of \$650 million.

The budget picture in 2003 provided a remarkable contrast to 1998. State budgets first began to moderate in 2000, and the national economic downturn gave states dismal budget outlooks as they planned for FY2002. State taxes on sales, personal income, and corporate income dropped dramatically. The effects of the terrorist attacks on September 11, 2001, exacerbated the budget situation.

In stark contrast to 1998, 44 states reported that revenues were below forecasted levels in the first months of FY2002. States began using budget reserve funds, tobacco settlement money, or one-time funding sources to augment their state budgets. State budget shortfalls going into FY2003 and FY2004 were severe in most states. Budget cutting in most states included restrictions in Medicaid programs.

At the same time that state revenues were shrinking, state Medicaid caseloads began to grow more rapidly. Nationwide, Medicaid enrollment increased by 7.8% in FY2003 and is expected to rise an additional 5.3% during FY2004. Also, the increased costs of providing services, especially prescription drugs, drove Medicaid expenditures to an increase of 9.3% in FY2003, after a 12.8% increase in FY2002. States took a number of Medicaid cost-containment actions, which would have been even more severe without the \$10 billion in fiscal relief passed on to states in FY2003–2004 from the federal Jobs and Growth Reconciliation Act.

The 10 states surveyed carried out a variety of Medicaid cost-saving actions that impacted access to AT, including the following:

- Changes in eligibility for Medicaid populations that include persons with disabilities
- Changes in coverage and reimbursement rates for AT devices

- Changes in policies that can affect access to AT, such as implementation of managed care, prior authorization review, medically needy programs, and so forth

## **CHANGES IN MEDICAID ELIGIBILITY**

### ***Eligibility Expansions Enacted***

The 10 states surveyed did have some expansions in Medicaid eligibility for persons with disabilities, with most enacted before the start of state budget shortfalls. The expansions allowed thousands of persons with disabilities to gain coverage of DME in their state's Medicaid plan.

In 1999, North Carolina expanded its income eligibility level for recipients who are Aged, Blind, and Disabled from approximately 75% to 100% of the Federal Poverty Level (FPL), thus resulting in about 40,000 persons becoming eligible for Medicaid services.

Over a three-year period, Illinois also implemented a significant Medicaid expansion for its Aged, Blind, and Disabled population. Eligibility was expanded from 41% to 70% in FY2000, to 85% in FY2001, and up to 100% in FY2002. In Missouri, the 2001 legislature also enacted a 3-year, phased-in increase of Medicaid income eligibility for its Aged, Blind, and Disabled population from about 75% to 85% of FPL in FY2002, to 90% in FY2003, and to 100% in FY2004. There were considerable efforts to repeal the Missouri phase-in during the 2003 legislative session, but those efforts eventually failed.

During this period, another Medicaid eligibility expansion for persons with disabilities was the buy-in programs implemented in states through the Ticket to Work and Work Incentives Improvement Act and through the Balanced Budget Act of 1997. Medicaid buy-in programs were implemented in four of the states surveyed. According to figures released in October 2003 by the Centers for Medicare and Medicaid Services (CMS), implementation dates and enrollment totals at the end of 2002 for the four states were these:

- Illinois: enrollment began February 2002; enrollment at the end of 2002 = 323
- Kansas: enrollment began July 2002; enrollment at the end of 2002 = 513
- Maine: enrollment began August 1999; enrollment at the end of 2002 = 673
- Missouri: enrollment began July 2002; enrollment at the end of 2002 = 8,461

CMS reports that 75% of buy-in participants were already on Medicaid before enrolling in the new programs. However, some recipients had been enrolled in the "medically needy" category in some states. These are programs under which persons with incomes barely above a state's Medicaid income eligibility levels can become eligible once they incur enough medical expenses for incomes to fall below the eligibility level. The buy-in programs gave many recipients access to Medicaid services, including covered AT, on a permanent basis. The Medicaid buy-in program ended up being

especially critical in Missouri, where limits enacted in the medically needy program curtailed Medicaid eligibility for thousands of recipients with disabilities.

### ***Eligibility Restrictions Enacted***

Legislatures in 34 states enacted restrictions on Medicaid eligibility for FY2003 and FY2004. During this period, states will cut from 1.2 million to 1.6 million persons from Medicaid, the State Children's Health Insurance Programs (SCHIP), or related health insurance programs, according to the Center on Budget and Policy Priorities (CBPP). It is impossible to estimate the numbers of persons with disabilities who have been affected because many are in eligibility categories that do not reflect the disability. However, a significant number of persons with disabilities are clearly being impacted by these restrictions. Of the 10 states surveyed, only Maine and Illinois did not report new eligibility limits enacted over the past 5 years. On the other end of the spectrum, Texas appears to lead the nation in the number of overall eligibility restrictions, with the CBPP reporting anywhere from 184,000 to 334,000 residents possibly losing Medicaid coverage from the numbers who would have been covered without state legislative changes. An additional 160,000 children in Texas may also lose coverage under the state's Children's Health Insurance Program.

Of the 10 states surveyed, Oklahoma and Texas eliminated their medically needy programs in 2003. An estimated 16,000 persons lost coverage in Oklahoma, while in Texas the disabled Medicaid population was never able to participate in the medically needy program. Policy changes in Missouri's medically needy program in 2002 made it much more difficult for individuals to spend down to Medicaid eligibility by incurring medical expenses. About 25,000 persons were impacted, but many were able to regain coverage through the state's buy-in eligibility category.

North Carolina limited eligibility in 2003 for certain seniors and persons with disabilities by changing the way asset limits are computed for these individuals. No estimates have yet been made on how many persons were affected. Also in 2003, Maryland stopped enrolling families with incomes above 200% of FPL. Previously, the eligibility level was 300% of FPL.

## **CHANGES IN COVERAGE AND REIMBURSEMENT FOR AT DEVICES**

The 10 states were asked about coverage and reimbursement of AT for adults and children through the age of 20. For each type of AT, the states were asked about reimbursement rates and requirements for prior authorization. They were also asked to list any changes in the coverage policies or reimbursement for each type of AT device from 1998 to 2003.

### ***Wheeled Mobility***

In all states surveyed, Medicaid programs cover wheeled mobility for both adults and children. The state with the most restrictive coverage policies among the 10 appears to be Kansas, where power wheelchairs are not covered except under special circumstances.

Kansas recipients cannot obtain a power chair unless it is needed for school or for work. Moreover, Medicaid in Kansas does not cover specialized seating systems. Each of the other states surveyed cover standard, power, and custom chairs. One provider that operates in 5 of the 10 states reported some difficulties in providing wheeled mobility to Illinois recipients because of extreme delays in receiving payment from the state Medicaid agency, although the agency reports that the pay cycle as of February 2004 is only 36 days.

Of the states reporting Medicaid reimbursement for standard wheelchairs, the rates ranged from \$350 (Missouri) to \$571.73 (Colorado). All states require prior authorization, but some do not require it until the cost of DME exceeds a certain amount (\$150 in Colorado, \$499.99 in Maine, and \$500 in Oklahoma). All states reported that batteries for power wheelchairs are covered.

State rates for power and custom chairs are difficult to compare because of differences in reimbursement methodologies and in how items are grouped under each rate. Reported reimbursement methodologies range from paying based on various fee schedules to paying a percentage under the manufacturer's suggested retail price (MSRP), to paying a percentage over a vendor's acquisition cost. Various discounts can also be applied to acquisition costs. Samples of reported rates include the following:

- Colorado pays an acquisition cost plus 20% for custom chairs and most power chairs (however, there can also be another 20% secondary discount, which would raise reimbursement to acquisition cost plus 40%, as in Maine)
- Illinois covers custom and power wheelchairs at rates typically ranging from 85% to 90% of MSRP, and sometimes 80% depending on the item
- Maine pays an adjusted acquisition cost plus 40% not to exceed \$2,000, or the maximum MaineCare amount, whichever is lowest
- Missouri covers custom wheelchairs at 85% of MSRP, and powered wheelchairs at 90% of MSRP
- Texas reimburses at about 82% of MSRP (however, there is an extra payment for labor and the evaluation)

One rehab technology vendor reported that the Medicaid reimbursement from state to state generally is similar, with some differences in specific items.

*Changes in Coverage of Wheeled Mobility, 1998–2003.* During most of the 5-year period, wheeled mobility access in the 10 states was improved somewhat by policy changes, with the exception of 2003. Changes in the states' wheeled mobility coverage policy include the following:

- 1998

Maine, before this year, did not provide any reimbursement to providers of powered wheelchairs for persons who were eligible for both Medicaid and

Medicare—the provider received only the Medicare amount. After years of advocacy by providers and consumers, the policy was changed so that the provider could receive payment up to the established MaineCare allowance for power wheelchairs.

Texas began coverage of powered wheelchairs for adults.

- 2000

Kansas began coverage for purchase of wheelchairs. Before this change, coverage of wheeled mobility was for rental only.

- 2001

North Carolina began coverage for bariatric wheelchairs.

Oklahoma began coverage for purchase of wheelchairs for adults. Before this change, coverage of all DME was limited to a 30-day rental per year. Eliminated was the policy stating that coverage was limited to the categorically needy only in their own home.

- 2002

Maine began coverage for power operated vehicles (scooters).

Maine added criteria for power wheelchairs, but the state reserved the right to request a second opinion concerning medical necessity.

- 2003

Maine added the following criteria for standard wheelchairs: “Without the use of the wheelchair, the member would otherwise be confined to bed or a chair; the primary purpose is not to allow the member to perform leisure or recreational activities; payment is made for only one wheelchair at a time; a member’s residence must be accessible to meet the needs of the equipment being requested.”

Maine added the requirement that power wheelchairs must be prior authorized, even if the member is dually eligible.

Maine added the requirement for special-sized wheelchairs: all of the criteria of a standard wheelchair must also be met.

Texas implemented a new methodology for cost-saving reimbursements of DME. Wheelchairs fall into one of three levels: a standard chair level and two levels of custom chairs. Custom chairs require an evaluation by a physical therapist and review by a Medicaid nurse to make sure a lesser code is not applicable. Advocates are concerned that the policy can be limiting for a recipient if a provider does not recognize a special need or if the consumer does not have help getting special circumstances considered for his or her wheelchair.

## ***Patient Lifts***

Nine of the 10 states reported that that hydraulic lifts are covered for both children and adults. The exception was Colorado, where neither hydraulic nor electric lifts were reportedly covered for adults or for children.

For electric lifts, Illinois and Maryland were the only two states reporting coverage for both children and adults. The Delaware Assistive Technology Initiative reported that the program is aware of electric lifts being covered by Medicaid on a case-by-case basis for adults and for children even though the Delaware Medicaid agency states that electric lifts are not covered.

Four of the 10 states reported that electric lifts are not covered by Medicaid for adults: North Carolina, Missouri, Kansas, and Oklahoma. Kansas reported that electric lifts have sometimes been provided for children, but not without difficulty. Maine reported coverage of electric hooyer lifts for adults and children, but not ceiling lifts.

As with other DME, comparisons of reimbursement rates are difficult; however, the reported rates for patient lifts ranged from \$650 (Missouri) to \$2,000 (Maine).

*Changes in Coverage of Patient Lifts, 1998–2003.* States reported only two changes in coverage of patient lifts over the 5-year period:

- 2001  
Oklahoma began coverage of lifts for adults.
- 2003  
Maine began coverage of seat lift mechanisms (for chair lifts).

## ***Augmentative and Alternative Communication (AAC)***

The 10 states were asked about coverage of AAC for adults and for children in three areas:

- Coverage for devices
- Coverage of AAC evaluations
- Coverage of training on how to use devices

*Reimbursement for AAC Devices.* Seven of 10 states reported that AAC devices are covered for adults: Colorado, Illinois, Kansas, Maine, Maryland, Missouri, and Texas. The Delaware Medicaid agency has stated that AAC devices are covered for adults by “individual consideration.”

Oklahoma and North Carolina have reported that AAC devices are not covered for adults. Even though North Carolina Medicaid does not cover AAC devices for adults, it

does cover AAC evaluations and training. Oklahoma ABLE Tech, the state assistive technology program, was not aware of any adult in Oklahoma requesting Medicaid coverage of an AAC device to date, let alone appealing a denial.

Nine of the 10 states reported coverage of AAC devices for children. North Carolina's Medicaid agency reported that AAC devices are not covered by Medicaid because they are covered by the state Children's Special Health Services program. The program is for children who are Medicaid eligible and who have chronic health conditions. The state Medicaid agency has reported that it is evaluating future Medicaid coverage of AAC devices for children. One North Carolina Medicaid waiver program, CAP-MR/DD, covers AAC devices for both children and adults who are eligible CAP-MR/DD clients. The cost of the device must be covered in the individual budget. Colorado has reported that although AAC devices are a covered service for both children and adults, actually getting devices approved is difficult.

Kansas reimburses AAC devices at 80% of manufacturer's suggested retail price, and Missouri reimburses at 85% of MSRP. Delaware uses the Region A Medicare Durable Medical Equipment Regional Carrier (DMERC) fee schedule. Maine uses its MaineCare schedule or adjusted acquisition rate. Colorado reimburses at invoice plus 10%. Texas uses a fee schedule that reimburses by device category (the maximum Texas reimbursement for the most costly device category is \$6,475.12).

*Reimbursement for AAC Evaluations.* Rates for AAC evaluations were also reported using differing methodologies. Providers in Delaware are not reimbursed separately for AAC evaluations or training. Rather, those services are considered to be part of the AAC device reimbursement. Providers in Texas are reimbursed in limited instances. States that reimburse evaluations on a time segment basis include the following:

- Kansas reimburses \$20 to \$25 per 30 minutes through home health, home- and community-based service (HCBS) waivers, and AT case management. Many Speech and Language Pathologists (SLPs) cannot get reimbursed for AAC evaluations.
- Maine reimburses \$11.75 per quarter hour.
- Missouri reimburses \$12.50 per 15 minutes.
- Oklahoma (for children only) reimburses \$67.53 per first hour and \$13.05 per each additional hour.

*Reimbursement for AAC Training.* The following states reported coverage:

- Colorado considers training to be already reimbursed as part of device purchase.
- Delaware considers training to be already reimbursed as part of device purchase.
- Kansas reimburses \$20 to \$25 per 30 minute through home health, HCBS waivers, and AT case management. Many SLP providers cannot get reimbursement for AAC evaluations.

- Maine reimburses \$11.75 per quarter hour.
- Missouri reimburses \$12.50 per 15 minutes.
- North Carolina reimburses \$62.80 per hour.
- Oklahoma (for children only) reimburses \$36.52 per hour.
- Texas considers training to be already reimbursed as part of device purchase.

*Changes in Coverage of AAC, 1998–2003.* AAC coverage for adults began in three of the states in 1998 and 1999. Establishing coverage policies that work well for recipients has been a problem in some states, such as Texas.

- 1998

Kansas began coverage of AAC for adults.

Maine added codes for AAC evaluations and therapy to SLP services policies.

- 1999

Missouri began coverage of AAC for adults. The Missouri Assistive Technology Project, the state's Assistive Technology Act program, worked with the governor and legislators to add AAC coverage for adults to the state Medicaid budget.

Texas began coverage of AAC for adults. The coverage was the result of the *Fred C. v. Texas* lawsuit in the Fifth Circuit Court, although the state delayed in publishing formal coverage policies after the decision. Advocates opposed draft rules because the state had not agreed to comprehensive reimbursement to adequately cover accessories and mounting systems. Manufacturers indicate that devices are now being purchased by the Texas Medicaid program, although advocates question the quality and adequacy of devices provided, given the state's poor reimbursement. Coverage rules have been published recently.

### ***Hearing Aids***

Only 3 of the 10 states said that they currently cover hearing aids for adults: Kansas, Illinois, and Missouri. One state, Maine, said that hearing aids are covered for adults only when they are living in nursing facilities.

Colorado, Delaware, Maryland, North Carolina, Oklahoma, and Texas reported that hearing aids are not currently covered for adult recipients. Texas eliminated coverage in 2003. In Delaware, the State Medicaid agency stated that hearing aids are not covered for adults, yet one Medicaid managed care organization was routinely covering hearing aids for adult enrollees.

Hearing aids for adults range from \$360 (Missouri) to \$485 (Kansas). Maine reported that all hearing aids are reimbursed at a flat rate of \$400. Rates can include a variety of related services such as fitting and dispensing fees, ear molds, and others.

All 10 states reported that hearing aids are covered for children through age 20. At least two states, Missouri and North Carolina, cover digital hearing aids on a regular basis. The Kansas Medicaid agency reportedly views digital hearing aids as experimental and will not cover them, but will cover cochlear implants.

A variety of reimbursements were reported for hearing aids for children, including the following:

- Colorado reimburses invoice cost plus 10 percent.
- Kansas reimburses \$485.
- Maine reimburses \$400.
- Missouri reimburses wholesale cost plus 20 percent.
- Oklahoma has reimbursements allowable under the Healthcare Common Procedures Coding System (HCPCS).
- Texas reimburses \$300 acquisition cost after deductions, plus approximately \$80 for fitting and dispensing fee and ear molds.

*Changes in Coverage of Hearing Aids, 1998–2003.* States reported the following changes:

- 2000

Missouri increased the hearing aid reimbursement rate for adults from \$187 to \$360.

- 2002

Illinois decreased the hearing aid reimbursement rate by 6%.

- 2003

Delaware, as recently as 2002, had its Medicaid agency reportedly consider requests for hearing aids for adults on a case-by-case basis. Now such requests are considered to be excluded from coverage.

Maine began coverage of cochlear implants for adults over the age of 18.

Missouri has a reimbursement rate for adults that remained the same, but the rate for children decreased from wholesale cost plus 25% to wholesale cost plus 20%.

Kansas eliminated hearing aid coverage for adults and parents for a 6-month period from January to June 2003. Thousands lost coverage during the period. The services were restored for FY2004.

Texas eliminated coverage for hearing aids.

## **Optical**

Four of the 10 states reported covering eyeglasses for adults: Illinois, Maine, Missouri, and North Carolina. Kansas Medicaid policy is to cover eyeglasses if the person is employed or in cases of medical hardship, although providers have not indicated any difficulty in getting glasses covered. Colorado will cover glasses only following eye surgery.

Three states reported that Medicaid will not cover eyeglasses for adults: Delaware, Oklahoma, and Texas. No coverage information was provided for Maryland. All of the states reported that eyeglasses for children are covered.

Reimbursement rates again are difficult to compare. Kansas appears to pay the highest rate at \$21.50 for frames and \$39 for single vision lenses. North Carolina's reimbursement is among the lowest at \$8 for frames and \$16 for single vision lenses. Only Colorado, North Carolina, and Texas reported that prior authorization is required for eyeglasses.

*Changes in Coverage of Optical (Eyeglasses), 1998–2003.* The only change in coverage for eyeglasses was reported by Texas, which eliminated coverage in 2003.

**Overall Changes in AT Coverage and Rate Reductions.** In terms of elimination of AT from Medicaid coverage, Texas adult recipients lost both hearing aid and eyeglass coverage for adults as of September 1, 2003. Coverage of hearing aids in Kansas was stopped in January 2003 but was restored 6 months later, in June 2003. In Missouri, eyeglass coverage for adults was eliminated for a short period before a court injunction restored it.

As for decreased reimbursement rates, Illinois appears to have the deepest cuts, with a 6% rate reduction in 2002 for all DME. Colorado's Medicaid also implemented a 5% rate reduction in 2002 for most DME, with the exception of customized wheelchairs, ~~or~~ orthotics and prosthetics. DME providers in Colorado said they were slated to receive a 1% increase but were instead cut by 5%. Representatives of the Colorado Association of Medical Equipment Services (CAMES) said that the cut has the potential to again decrease the number of suppliers who can afford to be Medicaid providers.

Oklahoma's ABLE Tech also reported that low reimbursement rates for some DME are limiting the number of vendors that will contract with the state to be a Medicaid provider, which, in turn, makes it difficult to access AT in some areas of the state. Likewise, some providers in Maine have chosen to no longer participate in the MaineCare program, citing poor reimbursement rates. Other Maine providers have limited their caseloads to a designated number of MaineCare recipients.

Missouri experienced a 2002 rate reduction of 5% in reimbursements for power and custom wheelchairs, augmentative communication devices, and hearing aids for children. In North Carolina, reimbursement rates for wheelchairs also decreased 2%.

## CHANGES IN MEDICAID POLICIES

### *Medicaid Managed Care*

Without formal comparisons or evaluations of managed care's impact on access to AT, any assessments can be only anecdotal. The Texas Technology Access Project (TTAP) has heard of instances of managed care hindering access to AT, but also has heard occasional reports of Medicaid health maintenance organizations (HMOs) providing "value added" AT items that are not covered by state plan Medicaid, such as a prosthetic limb for an adult. TTAP reported that Medicaid managed care in Texas has been extremely difficult to evaluate because of poor data collection and reporting systems. Advocates are concerned about the lack of state oversight of its contractors and the lack of accountability among contractors for the quality of services they deliver. Gaining access to information concerning HMO subcontractors is even more difficult, such as adequacy of networks; provider reimbursement rates; and timeliness, accessibility, and responsiveness. The HMO model has raised concerns about adequate assessments, especially access to out-of-network providers. Choice and quality may be limited: some HMOs own and use their own DME companies or contract with a single DME contractor exclusively.

It is estimated that 15% of Social Security Income (SSI) recipients in Texas are in Medicaid managed care arrangements, but many of these are in primary care case management (PCCM) rather than capitated HMOs. As in other states, a large number of cases are children who have special health care needs but do not receive SSI. Those children must enroll in PCCM or in a capitated HMO. There have been ongoing concerns about under-identification of such children who have special health care needs and who are in managed care that has inadequate services to meet their needs. Texas also has a demonstration project in the Houston area that integrates primary and acute care with long-term care and that enrolls Medicaid and Medicare dual eligibles. Enrollment is mandatory for SSI recipients, with some exceptions. Approximately 21,000 blind and disabled SSI recipients are enrolled. A recent actuarial study of the feasibility of expanding Medicaid managed care in Texas recommends that the state greatly expand HMO enrollment of blind and disabled recipients to achieve maximum savings. The study envisions that HMOs can lower the use of medical services and "in some cases, such as DME, shift usage toward lower cost items."

Maryland began mandatory Medicaid managed care across the state in 1997 for most recipients, including most persons with disabilities. About 75% of all recipients are now in managed care. The state has set standards for Maryland's seven current HMOs for various special needs populations. Among the standards listed for "Individuals with a Physical Disability" are that all HMOs must document that their providers are clinically qualified to provide DME and AT services.

Maryland's Medicaid program makes payments to the HMOs at fixed capitation rates that are based partially on an enrollee's past claims history or on whether the person is in a "Disabled" eligibility group. The higher capitation rate aims at serving more enrollees who need a more expensive range of services. Persons who are dually

eligible for Medicaid and Medicare are exempted from managed care, as are those who are 65 years or older and certain institutionalized individuals.

Oklahoma's Aged, Blind, and Disabled (ABD) Medicaid population was added to the state's mandatory managed care program in July 1999. With approximately 50% of the ABD population in managed care, ABD has been implemented only in Oklahoma's three metropolitan areas around Oklahoma City, Tulsa, and Lawton.

In Kansas, Medicaid managed care has been implemented in the metropolitan areas of Kansas City, Lawrence, Topeka, and Wichita. No estimate was provided of the number of persons with disabilities in managed care. Recipients have the choice of primary care case management or capitated HMOs.

In Maine, the state has repealed its Medicaid managed care initiative. It now has a PCCM program under which an enrollee's primary care physician is paid a monthly fee for managing MaineCare members. In general, persons with disabilities are excluded from the program.

In Delaware, Medicaid managed care has been implemented for recipients with disabilities, but no estimate was available as to the percentage in managed care. The Delaware Assistive Technology Initiative (DATI) reported that the introduction of managed care organizations in the Medicaid structure initially resulted in a steep increase in denials for services, but service has improved. This typical experience has occurred in some states as capitated HMOs are brought into the Medicaid picture.

Interestingly, one of Delaware's managed care HMOs was routinely covering hearing aids for adult enrollees, a service that is not covered by the state Medicaid agency. After DATI reported on this fact in its newsletter, the state Medicaid agency issued a formal reply saying that Medicaid HMOs are bound to the same exclusions found in the state plan. It is doubtful that such is the case, so the HMO coverage is still in question.

In Missouri, mandatory Medicaid capitated managed care began more than 5 years ago in three metropolitan areas, with enrollees having the choice of at least two different HMOs. Eligibility categories for persons with disabilities are excluded, although some children with disabling conditions in other categories are enrolled. In the fall of 2003, an interim legislative committee on Medicaid cost-containment discussed mandatory enrollment for persons with disabilities and the elderly. The Medicaid budget introduced in the Missouri House in February 2004 assumed cost savings from enrolling into Medicaid HMOs those recipients who are blind, disabled, and elderly.

Colorado had mandatory Medicaid managed care programs before 1995, but mandatory enrollment was lifted for persons with disabilities. Anecdotal reports are that some types of AT are more difficult to obtain through some managed care organizations. CAMES reported that Colorado currently has only two Medicaid HMOs, and that HMO rates there are usually 5% below fee-for-service Medicaid rates.

Illinois has a voluntary Medicaid managed care program with a very small enrollment compared to other states. Only a small percentage of persons with disabilities are enrolled.

### ***Home- and Community-Based Services Waivers***

The 10 states reported few changes in HCBS waivers related to AT over the past 5 years. All states surveyed reported a number of HCBS waivers that covered a wide range of AT, such as aids for daily living, AAC devices, hearing aids, low-vision devices, eyeglasses, adaptive computer hardware and software, environmental controls, home modifications, vehicle modifications, adapted toys and games, and other devices.

Few changes were reported in policy related to HCBS waivers that impacted AT. Oklahoma and Delaware reported two changes in practice. The most frequently mentioned limitation of HCBS waivers was significant waiting lists resulting from state revenue shortfalls.

## **CHANGES IN MEDICAID PRACTICES**

The participants who contributed to this report were asked whether they were aware of any changes in Medicaid practices in their states that might impact access to AT for recipients with disabilities. The survey defined *practices* as changes that are noticed by consumers, providers, and advocates and have made it harder or easier to obtain some type of assistive technology. The changes referred to are not part of any formal or announced policy changes by the state Medicaid agency.

Oklahoma ABLE Tech reported that although many types of AT are technically covered under Oklahoma HCBS waivers, some types are not always available for certain waiver participants. Reportedly, the Oklahoma agencies that administer the waivers have limited their payments to the Medicare copay amount for persons who have both Medicaid and Medicare. This situation is particularly problematic with Oklahoma's Advantage waiver, for which almost all recipients are dually eligible. If Medicare does not cover a device, recipients are told by a caseworker that the Medicaid waiver cannot pay for it either, which is not accurate under the waiver policy. The exception to this practice is for bath and toilet devices.

In Kansas, it appears to be taking longer for prior authorization for DME than in past years when the state budget was not as tight. Some more expensive equipment had not been approved for a period. For example, no AAC devices were approved for at least 6 months starting in May 2003, but a few have been approved in 2004. Also, Kansas Medicaid staff members indicated that leasing devices for trial use will no longer be approved, even though no formal policy has been issued. Also, the number of denials for powered mobility appears to have increased during the summer of 2003. Advocates are concerned that some vendors may become hesitant to submit a Medicaid claim for some devices or to appeal denials of service.

Assistive Technology for Kansans (ATK), the state's Assistive Technology Act project, experienced some discrepancies in reported reimbursement rates for some DME across the state. It was unclear whether the discrepancies were due to changes in how providers code the prior authorization request or whether some other variable might be involved. ATK plans to follow up on the reported rate discrepancies.

In Delaware, there is anecdotal evidence among some DME providers that the state is now requiring prior authorization for low-cost accessories that previously did not require it. Delaware reportedly has also seen a trend toward eliminating access to environmental modifications in HCBS waivers. An application for a new brain injury waiver was approved by CMS, but before implementation, the state decided to eliminate the coverage for environmental modifications. Some provisions of the waiver are now being rewritten, but advocates do not know yet what the new provisions will include.

Finally, DATI reported inconsistencies in the treatment of claims from one reviewer to another. Some reviewers seem to approach the claim with "denial presumption" while others try to facilitate a positive outcome for the beneficiary. This issue was reported by several states for which the approval decision for equipment may depend on which reviewer deals with the claim.

In Missouri, some providers have recently reported that prior authorization is taking longer for some types of AT, such as AAC devices. As reported in Delaware, the outcome of claims appears to differ from reviewer to reviewer. One reviewer told a provider that she believed her job was to save Medicaid for future generations. Clearly, this viewpoint can influence whether a device will be determined to be medically necessary for a recipient.

The Texas Technology Access Project (TTAP) reported that the coverage authorization process has long been a barrier because of subjective claims review by "qualified medical personnel," allowing treating physicians to be freely overruled. TTAP also commented that at the most basic level, some recipients do not have information, or they get bad information and do not question it or appeal denials. They are told something is not covered when it is, and their doctors do not say the right things in prescriptions or justifications. A dearth of experienced assessment providers in many parts of the state makes obtaining good justifications more difficult.

## **OUTLOOK**

Most policy actions in the early part of the 5-year period increased access to AT devices and services in the 10 states. However, measures enacted especially during the past 2 fiscal years have resulted in restricted AT access. The outlook for the near future is still cloudy, even with recent improvements in the nation's economic outlook.

In Kansas, legislators are still discussing Medicaid cost containment. Estate recovery for Medicaid recipients has generated considerable discussion and caused

considerable concern among families with Medicaid recipients, particularly farm families.

In Missouri, a legislative interim committee on Medicaid cost containment met several times in late 2003. Among the topics receiving the most discussion was the possible mandatory enrollment of the elderly, blind, and disabled Medicaid population into capitated managed care organizations. During the 2003 legislative session, the Missouri legislature cut funds for coverage of eyeglasses for adults, as well as implementing several other cost-containment measures. However, the legislators failed to pass the required legislation to enact the measures, so the Missouri Medicaid program requested supplemental appropriations during the 2004 session to cover FY2003 expenditures. Limitations on Medicaid populations and on services are both being seriously pushed during the 2004 session.

In Texas, the 2003 legislature mandated that Medicaid managed care be expanded beyond its current service areas "if cost-effective." A feasibility study has just been completed and recommends expansion of Medicaid managed care.

On the positive side in Texas, disability advocates and legislators alike are expressing interest in "consumer directed" services. Medicaid waivers now offer this option for attendant services. Assistive technology and home modifications may be added to the option in the coming year, after a workgroup and agency staff members figure out how to implement it. TTAP will be part of the effort. The approach has the potential to overcome some barriers as long as people are allotted budgets that cover AT along with other needed supports.

On a national level, the Fiscal Survey of States released in December 2003 by the National Association of State Budget Officers estimates that 32 states assumed they will have a shortfall in their FY2004 Medicaid budgets. Over the current decade, Medicaid spending is expected to increase at an average annual rate of 8.5% (Congressional Budget Office estimate), a rate that will far outpace state revenue growth even after a full economic recovery is under way.

From FY2002 to FY2004, 34 states reduced or restricted Medicaid eligibility. A total of 35 states reduced Medicaid benefits. All 50 states froze or reduced payments to providers. Similar cuts may be on the horizon during the coming year, many of which could directly or indirectly impact access to AT for persons with disabilities.

The reductions in DME reimbursement rates may not have as obvious an impact for persons with disabilities as would eliminating a service or an eligibility category. However, additional rate reductions will make it difficult or impossible for some providers to furnish devices and equipment needed by recipients with disabilities to maintain or improve their independence. As an industry, the pretax profit margins of DME providers are historically in the range of only 3 to 7%, according to a Texas DME provider coalition. In the rehabilitation technology area, the new Medicare limitations imposed on power wheelchairs, combined with any further Medicaid rate reductions, will put some suppliers at risk for survival.

Clearly, disability advocates will have to be active participants along with providers in their state legislatures and Medicaid agencies to ensure that access to AT in state Medicaid programs is not further eroded. A useful effort would be collecting information for each state, as related to changes that impact Medicaid provision of AT. This information could assist advocates and consumers keep up with the impact of changes in other states that may be repeated in their own state. Certainly, access to AT will remain a critical issue for individuals with disabilities as states prepare their FY2005 budgets and over the next several years.

### Five-Year Changes Limiting Access to AT for Medicaid Recipients with Disabilities

	<b>Eligibility Limitations</b>	<b>Service Limitations</b>	<b>Reimbursement Changes</b>	<b>Other Limiting Restrictions</b>
Colorado	Tightened medical criteria to get nursing home and home- and community-based care.		2002—Reimbursement decrease of 5% for most DME	
Delaware				Elimination of access to environmental modifications in home-and-community-based waivers
Illinois			2002—Reimbursement decrease of 6% for most DME	
Kansas		2003—Lost adult coverage for hearing aids for 6 months—Now restored		2003—Ended payment for leasing of AAC devices for trial periods
Maine		Power wheelchairs must have prior authorization		
Maryland	2003—Stopped enrolling families with incomes greater than 200% (from previous 300%) of federal poverty level			
Missouri			2002—Reimbursement decrease of 5% for most DME	2002—New policies restrict medically needy program

	<b>Eligibility Limitations</b>	<b>Service Limitations</b>	<b>Reimbursement Changes</b>	<b>Other Limiting Restrictions</b>
North Carolina			2002—Reimbursement decrease of 2% for wheeled mobility	2003—More restrictive asset limits for seniors and persons with disabilities
Oklahoma	2002—Cut aged and disabled eligibility from 100% to 80% of federal poverty level  2003—Lost medically needy program			
Texas	2003–04—Up to 334,000 persons may lose Medicaid coverage; estimate for number of recipients with disabilities is unknown	2003—Lost coverage for hearing aids and eyeglasses	2003—New reimbursement structure for DME to save costs	

DME = Durable Medical Equipment

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