National Policy Matters

The Affordable Care Act:
What Disability Advocates Need to Know

The Arc

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Introduction

Now that the U.S. Supreme Court has affirmed the constitutionality of the Affordable Care Act (ACA), the disability community must work to better understand the law and the many benefits it can provide to people with disabilities. This will be critical to the community's role in helping to move states forward with implementation.

Numerous ACA provisions related to both acute care and long term services and supports hold great promise for improving the health and wellbeing of people with disabilities. This issue of *National Policy Matters* provides information about the major provisions and the status of their implementation.

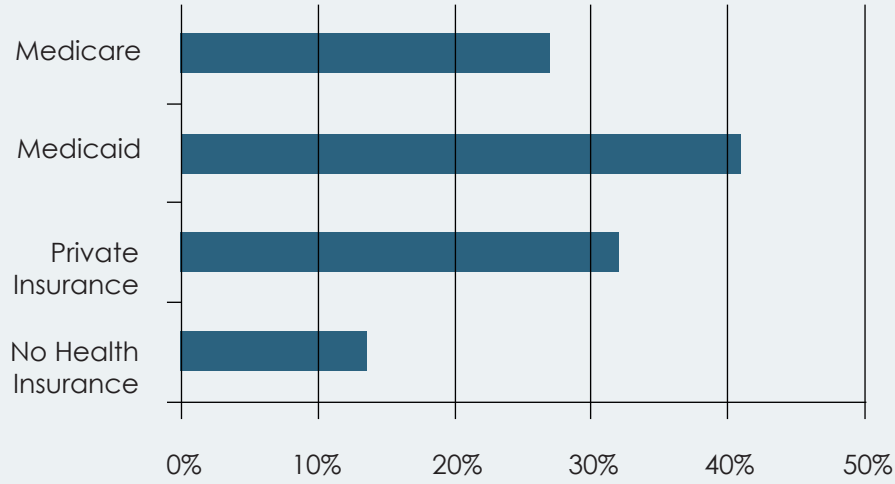
Why does The Arc support implementation of the Affordable Care Act?

The Arc has long supported expanding Medicaid to cover more low income individuals and expanding private health insurance options to achieve universal coverage. The law contains significant nondiscrimination provisions and improvements to the Medicaid long term services and support system that are critical to meeting the needs of people with I/DD. For too long, insurance companies have been able to charge people higher rates because of their health conditions, deny insurance coverage of people with I/DD, and limit coverage of needed health care treatments, services and supports.

How many people with I/DD are uninsured or underinsured?

While exact numbers are not available for persons with I/DD specifically, a recent study[1] found that of adults age 18-64 with cognitive difficulty, 13.6 % had no insurance, 32.1% private insurance, 41.0% Medicaid, and 27.0% Medicare. *(Table below)*

Health Insurance Status of Persons with Cognitive Difficulty*



** People with intellectual disability would be a subset of people with cognitive difficulty which also includes people with Alzheimer's, dementia, and other conditions.*

Many people with I/DD are not in the labor force and lack access to employer sponsored insurance. Even when people have employer sponsored health insurance, they may not have access to the services and supports they need because many private insurance plans do not cover many disability related therapies and services.

How does this impact the health of people with I/DD?

People who have access to comprehensive and affordable health insurance are more likely to receive the prescription drugs, therapies, and medical treatment they need to be healthy and maintain the ability to function in the community. People with I/DD often have multiple health conditions and are at risk of developing secondary disabilities without quality health care. Studies have documented a higher prevalence of adverse conditions, inadequate attention to health care needs, inadequate focus on health promotion, and inadequate access to quality health care services.

How will the ACA reduce costs for states?

The ACA will help ensure that individuals have access to health care to prevent costly hospitalizations and institutionalizations that occur when individuals forego treatment. For example, expanding home and community based long term services and supports (LTSS) will reduce the need for nursing home and other institutional settings. In the long run, these investments in health care and home and community based services (HCBS) will improve health and reduce dependence on costly institutions. Investments in improving public health and coverage of prevention services will also save money by reducing the cost of treating health conditions that could have been prevented.

How will the ACA reduce costs for individuals?

Expanding Medicaid and private health insurance options: Individuals who are currently uninsured and become insured will spend less of their income paying for needed health care services. The health insurance reforms mean that insurance will cover more of the services that people with pre-existing conditions need, thereby reducing costs to the individual. The inclusion of essential benefits in health insurance plans means that a core set of health care services that people with I/DD need will be covered by many health plans. Subsidies and cost sharing for low and middle income people with make health insurance coverage more affordable for people purchasing insurance in the exchanges. (These issues are described in more detail later in this update).

Expanding the risk pool: Since the law requires most individuals to purchase insurance or face penalties, it is expected that more people will purchase health insurance. This will allow for the law's private insurance reforms to work without sky-high premiums. For example, requiring insurance companies to insure people with pre-existing conditions can only be affordable if healthy people also share the risk before they need medical care due to illness or injury.

Covering preventive services: Eliminating cost-sharing for preventive services saves money for individuals and families immediately and reduces medical costs over the long term.

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[1]Altman, B. and Bernstein, A. Disability and Health in the United States, 2001-2005. Hyattsville, MD National Center for Health Statistics 2008

How does the ACA...
reform private health insurance?

Eliminates pre-existing condition exclusions: Health insurance companies are not allowed to deny enrollment or specific benefits based on pre-existing conditions for individuals under the age of 19. Effective in 2014, the ban will also apply to adults. A pre-existing condition is one that existed before the date of enrollment for health insurance coverage and can include common conditions such as diabetes, seizures, asthma, and others.

Bans annual and lifetime limits: The use of lifetime limits in health plans and insurance policies is prohibited. A lifetime limit is the total amount of money that a health insurance company will pay for health care over the lifetime of a policy. An annual limit is the total amount of money that a health insurance company will cover in one calendar year. Annual limits are being phased out and will end in 2014.

Ends the practice of rescissions: A rescission is when insurance coverage is retroactively cancelled when a person develops an expensive health condition. Now insurance companies will only be able to drop coverage if there is fraud or intentional misrepresentation.

Requires private health insurance reforms in 2014: The law implements strong reforms that prohibit insurance companies from refusing to sell coverage or renew policies because of an individual's pre-existing conditions. Also, in the individual and small group market, it eliminates the ability of insurance companies to charge higher rates due to gender or health status. The Department of Health and Human Services (HHS) has yet to develop regulations implementing these critical protections.

Improves appeals process including independent reviews: The law requires greater consistency of consumer protections and adds standards that insurance companies must meet. Plans must also provide for an external appeal to an independent decision maker.

Requires that 80% of health insurance premium dollars are paying for health care and if the goals are not met, consumers receive a rebate: Prior to the ACA, many insurance companies spent a substantial portion of consumers' premium dollars on administrative costs and profits, including executive salaries, overhead, and marketing. One goal of the ACA is to bring overhead of the insurance companies down to under 20% for individual and small group coverage and under 15% for large group insurance. Insurers will be required to make the first round of rebates to consumers by August 1, 2012. Enrollees owed a rebate will see a reduction in their premiums, receive a rebate check, or, if the enrollee paid by credit card or debit card, a lump-sum reimbursement to the same account that the enrollee used to pay the premium. In some cases, the rebate may go to the employer that paid the premium on the enrollee's behalf. Regardless of whether the rebate is provided to enrollees directly or indirectly through their employer, each enrollee must receive a rebate that is proportional to the premium amount paid by that enrollee.

Enhances state capacity to regulate unfair increases in insurance rates: The ACA seeks to curb premium increases by requiring vigorous reviews that assure cost estimates use verifiable medical trend data and realistic administrative cost projections. Starting

September 1, 2011, insurers seeking rate increases of 10 percent or more for non-grandfathered plans in the individual and small group markets must publicly disclose the proposed increases and the justification for them. In future years, the threshold for review of increases will be set on a state-by-state basis using data that reflect insurance and health cost trends in each state. States were provided grants to strengthen their capacity to review rates.

How does the ACA... *expand coverage?*

Establishes temporary high risk pools to cover those who are currently uninsured: These pre-existing conditions plans were established in every state for people who have pre-existing conditions and could not obtain health insurance. They will expire in 2014 when the health insurance exchanges become available and pre-existing condition exclusions are prohibited. In many states, the federal government is running the plan.

Requires coverage for dependents until age 26: Effective for health plan years beginning on or after September 23, 2010, dependents are able to continue to be covered under their parents' health insurance plans until age 26. Employers are not obligated to provide dependent coverage, but if they do, the coverage must be provided through the age of 26.

Creates health insurance exchanges (or marketplaces) for individuals and small employers to purchase insurance: In 2014, each state will have health insurance exchanges which are a marketplace to sell private insurance that meets certain criteria to individuals and small businesses. In states that choose not to create an exchange, the federal government will create and run the exchange. Forty nine states and DC have taken the exchange planning grants, the first in a series of grants available to states to build the exchanges.

The exchanges are required to:

- Implement insurance market reforms;
- Ensure non-discrimination;
- Establish consumer education campaigns and consumer assistance programs;
- Expand technical capabilities and create accessible electronic information systems; and
- Create a seamless eligibility and enrollment systems.

Numerous specific features of the exchange are particularly important to people with disabilities, including:

- Significant subsidies to assist low income individuals to afford coverage;
- All plans sold in the exchange must include 10 essential benefits which includes coverage of pediatric, dental and vision care for children, mental health services, rehabilitative and habilitative services and devices, and other critical disability services;

- Plans must offer varying levels of coverage between 60% of the cost of covered benefits to 90% of covered benefits.
- Exchanges must operate a risk adjustment system and implement the requirement that issuers calculate risk across all of their health plans inside and outside an exchange.

To date, 11 states have enacted state exchange laws and 3 states have used executive orders. For more information, see: http://www.cbpp.org/files/CBPP-Analysis-on-the-Status-of-State-Exchange-Implementation.pdf

Requires certain individuals to purchase insurance or pay a penalty: The law requires U.S. citizens and legal residents to have qualifying health coverage. Those without coverage pay a tax penalty of the greater of $695 for individuals, per year up to a maximum of three times that amount ($2,085) per family, or 2.5% of household income. The penalty will be phased-in according to the following schedule:

- 2014: the greater of $95 or 1.0% of taxable income
- 2015: the greater of $325 or 2.0% of taxable income
- 2016: the greater of $695 or 2.5% of taxable income
- 2017 and after: the greater of $695 or 2.5%, as adjusted for inflation each year

Exemptions will be granted to individuals for financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost plan option exceeds 8% of an individual's income, and those with incomes below the tax filing threshold (in 2009 the threshold for taxpayers under age 65 was $9,350 for singles and $18,700 for couples).

Requires cost-sharing and premium credits: The law will provide cost-sharing subsidies to eligible low and middle income individuals and families. The lower the income, the less individuals and families will pay in out-of-pocket costs (out-of-pockets costs include such things as deductibles, co-pays, and/or co-insurance). The ACA will provide refundable and advanceable premium credits to eligible individuals and families with incomes between 100-400% of the federal poverty level to purchase insurance through the exchanges starting on January 1, 2014. The premium credits will be tied to the second lowest cost plan in the area. It will be set on a sliding scale such that the premium contributions are limited

Income as percent of poverty	Annual income for a family of four	Premium contribution as a percent of income	Monthly dollar amount for family of four
133%	$29,326	3%	$73
150%	$33,075	4%	$110
200%	$44,100	6.3%	$232
250%	$55,125	8.05%	$372
300%	$66,150	9.5%	$524
350%	$77,175	9.5%	$610
400%	$88,200	9.5%	$608

to the following percentages of income for specified income levels, meaning that the people with the lowest income will receive the most help: *(see table on previous page)*

Requires certain employers to provide health insurance or pay a penalty: The law builds upon our current system of employer sponsored health insurance and provides a disincentive to large employers to drop coverage or not provide coverage at all.

It requires employers with 50 or more full-time employees that do not offer coverage to pay a fee if at least one full-time employee enters the exchange and receives a premium tax credit. Employers with up to 50 full-time employees are exempt from any penalties (Effective January 1, 2014). Employers are not required to provide insurance to part-time employees. Click here to read The Arc's National Policy Matters issue on the ACA's employer provisions.

How does the ACA... *expand essential benefits?*

What are essential benefits?

The ACA requires all qualified health benefit plans including those offered through the exchanges, those offered in the individual and small group markets outside the exchanges (except grandfathered plans), and Medicaid benchmark plans, to offer at least the essential health benefits package.

The 10 categories of essential health benefits are:

- Hospitalization;
- Emergency services;
- Ambulatory (i.e. outpatient) services;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Mental health and substance abuse disorder services including behavioral health treatment;
- Preventative and wellness services and chronic disease management;
- Pediatric services including dental and vision care;
- Laboratory services; and
- Maternity and newborn care.

Why is this important to people with I/DD?

Many people with I/DD will benefit from the inclusion of habilitative and rehabilitative services and devices, mental health and behavioral services, chronic disease management and pediatric services including dental and vision care. Currently, private health insurance may limit the availability of some of these services.

What are the major principles to guide the development of the essential benefits package to meet the needs of people with disabilities?

The law also requires:

- An "appropriate balance" among the ten categories of essential care. The Arc views this, in part, as a prohibition of unreasonable restrictions and exclusions in one benefit category (e.g., rehabilita

tion) if similar restrictions are not placed on other categories;
- Benefit design that does not discriminate against, and takes into account the health care needs of, persons with disabilities. As part of this, health plans may be required to disclose severity-adjusted quality indicators of access, outcomes, consumer satisfaction and disenrollment rates; and
- Essential benefits are not subject to denial to individuals against their wishes on the basis of the individual's present or predicted disability, degree of medical dependency, or quality of life. This is intended to ensure that negative judgments about the quality of life of a person with a disability are not used against people with disabilities when establishing the essential benefits package.

In advance of regulating the essential health benefits package, HHS has released non-binding guidance instructing states to choose an existing plan as a benchmark for their essential health benefits package. It also instructs states to enhance that plan in areas where it does not cover all 10 of the required essential health benefit categories. States are provided significant flexibility to pick from several different types of health plans to be their benchmark.

What is covered by habilitative and rehabilitative services and devices?

This is intended to broadly cover a number of important services, including durable medical equipment, prosthetics, orthotics, and habilitative and rehabilitative services.

What is habilitation?

The Medicaid program defines habilitation services as "services designed to assist participants in acquiring, retaining and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings." Many different services, therapies and supports are considered to be habilitation. For example, habilitation may include teaching someone with a developmental disability:

- basic social skills;
- how to administer his/her own medication safely;
- about his/her rights to privacy;
- how to use a phone;
- how to ask a healthcare professionals questions and expect to get answers;
- how to reliably report how they are feeling.

Are there other definitions of habilitation?

There has been considerable debate about what habilitation means and how it should be covered. Insurers and others do not want a broad definition such as the Medicaid definition and have pushed for a more narrow interpretation. The HHS proposed rules on how plans should describe the key benefits defined habilitation as:

> *"Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings."*

While more narrow than the Medicaid definition, it does address many of the habilitation services. Ensuring that habilitation includes learning a new skill or function is a critical aspect of the definition.

What is rehabilitation?

In proposed rules, HHS defines rehabilitation as follows: "Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings."

What did Congress intend regarding the definition of rehabilitation and habilitation?

States will likely decide how these terms will be defined. As states debate different definitions, it is important to consider what Congress intended. Congress is familiar with the definition of habilitation used by the Medicaid program. It has been in the statute for many years. During the House debate, then-Chairman George Miller, House Committee on Education and Labor, explained that the term rehabilitative and habilitative services "includes items and services used to restore functional capacity, minimize limitations on physical and cognitive functions, and maintain or prevent deterioration of functioning. Such services also include training of individuals with mental and physical disabilities to enhance functional development." [Congressional Record, H1882 (March 21, 2010)]

How is habilitation different from rehabilitation?

The key difference is that habilitation usually refers to acquiring or learning skills whereas rehabilitation is usually involves regaining skills that have been lost or improving or preventing deterioration of skills. There are many anecdotal examples of the unfair practice of a service being approved for rehabilitation purposes but not for habilitation: *(table below)*

Habilitation	Rehabilitation
An occupational therapist teaching adults with developmental disabilities the fine motor coordination required to dress themselves.	An occupational therapist teaching adults who have had a stroke the fine motor skills required to re-learn how to dress themselves.
A speech therapist providing speech therapy to a 3-year old with autism who has never had speech.	A speech therapist providing speech therapy to a 3-year old to regain speech after a traumatic brain injury.
A physical therapist providing a strength training program for an individual with a congenital spine condition to prevent osteoporosis and decline in function as he ages.	A physical therapist providing a strength training program for an individual who recently acquired a spinal cord injury.
A physical therapist making a splint for an adult with a chronic condition, such as arthritis, to prevent hand deformities.	A physical therapist making a splint for an adult who has had hand surgery for a torn tendon.

Does private insurance cover habilitation?

A few states have mandates that require habilitation services for children. For instance, many of the states with autism mandates use the term habilitation to cover the broad range of services and supports required in that state. However, some insurance plans may refuse services such as those described in the chart above that they view as habilitation.

What if a state picks a benchmark plan that does not include habilitation services?

HHS has said that states have a lot of flexibility in how they add benefits, but they must make sure habilitation is added. In its study of essential benefits, the Institute of Medicine (IOM) recommended that the states look toward Medicaid:

"The committee is guided by the unambiguous direction of Section 1302 to start with a commercial health insurance benefit; however, it suggests that the Secretary compare, in particular, how Medicaid plan benefits for habilitation and mental health and substance abuse services compare with commercial plans that currently include such services. For example, Maryland has requirements to cover habilitation services in children under age 19 in its small business standards for health insurance (Maryland Insurance Administration, 2009). On the basis of this review, the Secretary would add selected services to the preliminary list to fulfill the 10-category requirement." IOM Report: Essential Benefits: Balancing Coverage and Cost *(2011), p. 5-3*

How does the ACA... *impact Medicaid?*

Expands Medicaid eligibility to 138% of the federal poverty level: The ACA requires states to expand Medicaid eligibility to 138% of the federal poverty level and to childless adults, a group that few states cover in their Medicaid program. The ACA established a new method of determining income and eliminated the asset test for the new beneficiaries. The newly eligible individuals will have access to Medicaid benchmark plans designed by the state.

The government estimated that 16 million new beneficiaries would receive Medicaid by 2019. While not a perfect measure of how many people with disabilities are uninsured, the Urban Institute estimates that 12% of uninsured adults with incomes below 138% of the federal poverty level report limited ability to work or unable to work. The new eligibility level for a family of four equals approximately $30,000 per year.

How does the Supreme Court ruling affect the Medicaid expansion?

The Supreme Court ruling that the federal government cannot withhold existing Medicaid funding if the state does not expand its Medicaid program as called for by the ACA has the effect of making the Medicaid expansion **optional** for the states. It appears that the states that do go forward will need to follow the provisions of the law and will receive the very generous Medicaid match. (The federal government will pay 100% of the costs of the newly eligible individuals through 2016 with a phase down to 90% by 2020).

The ACA also has a maintenance of effort

(MOE) provision that does not allow states to reduce eligibility in advance of the expansion but that will expire in 2014. This provision has been opposed by states but is a logical provision to prevent states from trying to game the system by dropping people from Medicaid and enrolling them after 2014 when the federal government will pay the cost. The numerous other changes to the Medicaid program are not impacted by the Supreme Court decision.

According to the Kaiser Commission on Medicaid and the Uninsured, since April 2010 when the option became available, eight states (CA, CT, CO, DC, MN, MO, NJ, and WA) have received approval to expand Medicaid to adults early through the new option and/or a Section 1115 waiver. For an interactive map of states and the Medicaid expansion, see: http://www.americanprogress.org/issues/2012/07/medicaid_expansion_map.html

Creates an option to provide health homes for Medicaid enrollees with chronic conditions: The ACA provides states with a new option to reform the delivery system for beneficiaries with chronic conditions by providing "health home" services and authorizes a temporary 90% federal match rate for these services to allow states to build person-centered systems of care to improve outcomes for Medicaid beneficiaries. The health home model for service delivery integrates primary, acute, behavioral health and long term services and supports for persons with chronic illness.

As of April 2012, the Centers for Medicare and Medicaid Services (CMS) has approved six state plan amendments (SPA) in four states to provide health home services: two in MO; two in RI, one in NY, and one in OR. There are two additional health home SPAs under review in NC and WA, and CMS is reviewing draft proposals in five states (AL, IA, IL, OH, and OK). In addition, CMS has approved funding requests from 15 states for planning activities to develop a health home SPA.

Eliminates Medicare Part D (drug coverage) co-pays for Dual eligibles receiving waiver services: Effective January 1, 2012, full benefit Dual eligibles (people receiving Medicare and Medicaid benefits) receiving home and community based waiver services will have no cost sharing for Part D covered drugs. This creates parity with how Dual eligibles in nursing homes and institutional settings are treated.

Improves Medicare Part D access to key anti-seizure, anti-anxiety and anti-spasm medications:

- Starting in 2013, Part D will cover benzodiazepines and will cover barbiturates used in the treatment of epilepsy, cancer, or a chronic mental disorder.
- Starting in 2014, Medicaid programs will no longer be able to exclude smoking cessation agents, barbiturates, and benzodiazepines from coverage under Medicaid. Because Part D covered drugs are defined generally as those drugs that are covered under Medicaid, this new provision will result in a small expansion of Part D coverage of barbiturates.

The current six protected classes of drugs (which includes critical anti-seizure, anti-depressant and other drugs used to treat mental illness) remain protected until the Secretary decides to change it.

How does the ACA...
expand long term services and supports?

Several provisions of the ACA are designed to assist states to balance their long term care systems and help people move from institutions to the community. They reflect a broad consensus that people who need long term supports want to receive them in their homes and communities and not in institutional settings.

Community First Choice Option (CFC)

Through the CFC Option, states may choose to provide participant-directed or agency-provider home and community-based attendant services and supports as part of their state Medicaid plan. States that choose the option will receive a 6% increase in their Federal Medical Assistance Percentages (FMAP) (the portion of state Medicaid costs the federal government covers) for the CFC services.

CFC services are for people of any age with any type of disability who would have to go to an institution if they did not receive the services. Institutions include:

- hospitals;
- nursing facilities;
- intermediate care facilities for people with intellectual/developmental disabilities;
- institutions providing psychiatric services for individuals under age 21; and
- institutions for mental diseases for individuals age 65 or over.

If a state takes up the CFC Option, the state must provide home and community-based attendant services and supports to anyone who qualifies. Since this is not a "waiver" program, the state cannot set limits on the number of people served. Attendant services and supports are:

- assistance with activities of daily living (ADLs, such as dressing and bathing);
- instrumental activities of daily living (IADLs, such as money management or shopping for food); and
- health-related tasks (such as taking medications).

Attendant services and supports are pro vided through hands-on assistance, supervision, and/or cueing and include helping an individual learn the skills to complete ADLs, IADLs, and health-related tasks more independently. States may choose to provide additional services such as transition services, including rent and utility deposits, bedding, basic kitchen supplies and other necessities that someone who is moving out of an institution into the community might need.

The rules for the Community First Choice Option program became final in April 2012.

State Plan Home and Community-Based Services Option (also known as Sec. 1915(i) option)

States have had the option to include home and community based services (HCBS) in their state Medicaid plans without a waiver since 2005. The ACA made improvements to the option by making it easier for individuals to qualify for services and to allow states to target specific populations (such as persons with I/DD).

If a state chooses to add HCBS to its state plan, the state:

- must use needs-based criteria for the home and community-based benefit that are less stringent than institutional level of care criteria;
- must provide these services to all Medicaid recipients who meet eligibility criteria for the services;
- is not allowed to have waiting lists;
- may make self-direction of services available; and
- must offer independent assessments (professionals who evaluate a person for eligibility for the services cannot be provider of the home and community-based services and supports).

Money Follows the Person

The Money Follows the Person Rebalancing Demonstration (MFP) program was originally authorized by Congress in 2005 at $1.75 billion. The ACA extended the program to September 30, 2016 and authorized an additional $2.25 billion.

States may choose to participate in the MFP demonstration and receive an enhanced FMAP (portion of state Medicaid costs the federal government covers) for 12 months to help transition people who are elderly or have disabilities from institutions to home and community-based services and supports. States may use grants to pay for things such as housing coordinators and relocation expenses. As of March 2012, 43 states and the District of Columbia had MFP grants and 22,500 individuals had transitioned to the community. States participating in MFP as of June 2012: AR, CA, CO, CT, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, TN, TX, VA, VT, WA, WI, WV, and the District of Columbia.

Balancing Incentive Payments Program (BIPP)

BIPP is a $3 billion grant program that encourages states to rebalance their Medicaid long term services spending away from institutional care and toward home and community-based services and supports. This program addresses all disability and aging long term services spending.

States that spent less than 50% of their total Medicaid long term services dollars on non-institutional services in Fiscal Year 2009 may participate in the program. It provides different levels of incentives depending on the state's spending on HCBS:

- States that spent between 25% and 50% of their Medicaid long term care budget on home and community-based services are eligible for a 2% FMAP increase (2% increase in the portion of state Medicaid costs the federal government covers) for new or expanded home and community-based services.
- States that spent less than 25% of their total Medicaid long term services budget on home and community-based services (Mississippi) are eligible for a 5% FMAP increase (5% increase in the portion of state Medicaid costs the federal government covers) for new or expanded home and community-based services.

In exchange for the increase in federal dollars, states must:

- provide conflict-free case management services (the case manager may not be the provider of community-based services);
- use a standard assessment instrument for individuals across the state who may be eligible for leaving an institution and receiving home and community-based services; and

- create a system that has "no wrong door" (people can obtain all necessary information and apply for the services in one place).

The program began in October 2011 and runs through October 1, 2015. As of June 2012, six states had received BIPP grants (New Hampshire, Maryland, Iowa, Mississippi, Missouri, and Georgia).

Medicare-Medicaid Coordination Office

The ACA created the Medicare-Medicaid Coordination Office (MMCO) within CMS to coordinate policy for individuals who are eligible for both Medicare and Medicaid. These individuals, who sometimes are referred to as Duals, have multiple chronic conditions (diabetes, hypertension, Alzheimer's, serious mental illness, developmental disabilities, physical disabilities) and very low incomes. Two-thirds of the Duals are over the age of 65 and one-third are between 18 and 64. Because of their complex health needs, Duals tend to represent a disproportionate share of Medicare and Medicaid costs. MMCO has awarded 15 states $1 million grants to design plans to improve health care for Duals and reduce costs.

Centers for Medicare and Medicaid Services Innovation Center

The ACA created the Innovation Center within CMS to find new ways to pay for and deliver health care in better, less costly ways. The Innovation Center tests innovative payment and service delivery models that enhance the quality of health care services while lowering costs.

How does the ACA... *emphasize prevention?*

Eliminates cost-sharing for critical prevention services:

The ACA provides states with a 1% increase in their FMAP for offering Medicaid coverage of and removal of cost-sharing for preventive services. Preventive services are those that are highly rated by the U. S. Preventive Services Task Force. Examples of these services include:

- immunizations;
- screenings for diabetes and depression;
- autism screening for children at 18 and 24 months;
- developmental screenings for children under age 3;
- behavioral assessments throughout childhood; and
- well visits with assessments and individualized prevention plan for Medicare beneficiaries.

Creates the Prevention and Public Health Fund (PPHF):

This program provides new funding for transformational investments in promoting wellness, preventing disease, and other public health priorities. The ACA also creates a grant program to support the delivery of evidence-based and community-based prevention and wellness services. The grants have primarily gone to state departments of health which in turn are partnering with local community based organizations, schools, and other agencies.

Are there other provisions important to people with I/DD?

Improves accessibility of medical diagnostic equipment:

The Access Board is developing standards for accessible medical equipment. The standards address access for people with disabilities to examination tables and chairs, weight scales, mammography equipment, and other equipment used for diagnostic purposes. The draft standards were published for public comment on February 9, 2012.

Improves data collection about people with disabilities:

The ACA requires the collection of data on "disability status for applicants, recipients, or participants" by "any federally conducted or supported health care or public health program, activity or survey." This is a very broad requirement and will take some time to include disability status in all these activities. Once implemented it will expand the information that researchers, policy makers and advocates will have about the health care status of people with disabilities.

The ACA is a very comprehensive law and includes numerous other provisions that will expand the health care workforce, make changes to existing programs, test new ways to pay for health care services and other provisions affecting people with disabilities not discussed in this update.

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