



DISABILITY
LAW
CENTER

Utah's Protection and Advocacy Agency

Patient Protection & Affordable Care Act (PPACA or ACA) of 2010

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4 Goals

- Private insurance market reform
- Medicaid changes
- Long-term care expansion
- Capacity building/infrastructure development



Private Insurance Market Reform

- Required to have coverage (2014)
- Guaranteed issue (2014)
- No lifetime cap & restrictions on annual limits (2010-2014)
- No pre-existing condition exclusion (kids 2010, adults 2014)

Sliding scale subsidy up to 400% FPL



Private Insurance Market Reform (cont.)

- No co-pays or deductibles for preventive care (2010)
- Federal high-risk pool (2010 until 2014)
- State health insurance exchanges (2014)
- Essential benefit packages (2014)
- Basic health plan for new eligibles between 133-200% FPL (2014)

High-risk pool eligibility = 6 mos. w/o credible coverage

Exchanges should facilitate risk pooling, risk adjusting, comparison shopping, employer contribution aggregation, and public program enrollment

Plans must include at least the essential benefits in order to be offered on the exchange

Essential benefits are: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, **mental health and substance use disorder services, including behavioral health treatment**, prescription drugs, **rehabilitative and habilitative services and devices**, laboratory services, preventive and wellness services, and **chronic disease management** pediatric services, including oral and vision care

Platinum, gold, silver, or bronze packages = 10%, 20% 30%, or 40% cost-sharing respectively

Basic health plans (which include essential benefits) offer an alternative to full Medicaid for this population



Medicaid Eligibility

- States must maintain current or higher standards (2011)
- Increased to 133% FPL (2014)
- No asset test (2014)
- Hospitals & other providers can make presumptive eligibility determinations (2014)

Modified Adjusted Gross Income (MAGI) replaces most deductions with a flat 5% income disregard for most enrollees, **excluding elderly & disabled**, essentially increasing eligibility to 138% FPL

Currently, childless adults not eligible; adults with dependent children eligible at about 55% FPL; disabled Medicaid = 100% FPL



Medicaid Benefits

- Clarif[ies] that “[t]he term “medical assistance” means payment of part or all of the cost of the following care and services **or the care and services themselves**, or both, . . .”
- Establishes the Federal Coordinated Health Care Office (CHCO) within CMS to align Medicare and Medicaid financing, benefits, administration, oversight rules, and policies for dual eligibles



Medicaid Benefits (cont.)

- Allows eligible children to receive hospice services concurrent with other treatment (2010)
- States can establish health homes for enrollees with 2 or more chronic conditions (2011)
- New drug reimbursement rates (2011)
- Eliminates Part D cost-sharing for HCBS enrollees (2012)

\$25 million until expended (90% FMAP for two years) for health homes

Chronic conditions include, but are not limited to: a mental health condition; substance use disorder; asthma; diabetes; heart disease; or a Body Mass Index over 25

Health homes are required to provide: Comprehensive care management; care coordination and health promotion; comprehensive transitional care, including appropriate follow-up, from inpatient to other settings; patient and family support; referral to community and social support services; and, if relevant and as feasible, use health information technology to link such services

Health home state plan amendment must: Require participating hospitals to establish procedures for referring participating beneficiaries who seek or need treatment in a hospital emergency department to designated providers; coordinate with SAMSHA; include a methodology for tracking avoidable hospital readmissions and calculating savings as a result of improved management; propose a project using health information technology in providing health home services, and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider)



LTC Philosophy

Sense of the Senate stating that Congress should address long-term services and supports in a comprehensive way that guarantees elderly and disabled individuals care they need and that care should be available in the community in addition to institutions



HCBS Barrier Removal Objectives (2010)

- Ensur[es] that all states develop service systems that are responsive to the needs and choices of beneficiaries receiving state and Medicaid-funded, community-based, long-term care services
- Enable beneficiaries to receive services in a way that maximizes their independence including through the use of client-employed providers
- Provide the support and coordination needed to design a self-directed, community-supported life



HCBS Barrier Removal Objectives (cont.)

- Improve coordination, consistency, and regulation of federally and state-funded services, including development of effective eligibility determination and assessments, complaint management and monitoring systems
- Assure an adequate number of qualified direct-care workers to provide self-directed personal assistance services.



HCBS State Plan Option (2010)

- Cover individuals with incomes up to 300% of the maximum SSI payment and a higher level of need
- Permits states to extend full Medicaid benefits to individuals receiving HCBS under a state plan
- No enrollment caps, but can target specific needs
- States may, with permission from CMS, offer other services not specifically listed



Money Follows the Person (2010)

- Extended through 2016
- Individuals must reside in a nursing home for not less than 90 consecutive days (excluding rehab stays)
- 90% FMAP for first year
- Focused on system redesign

Down from 180 days

DOH did not apply



State Balancing Incentive Program (2011-2015)

- Provide enhanced federal matching payments to states (that furnish over half of their LTC in facilities) to increase the proportion of community-based long-term care services
- States can use a waiver or SPA; expand eligibility to 300% SSI under SPA
- Required structural changes

Required structural changes include no wrong door, conflict-free case management, standardized assessment instrument, service data collection, core quality data, and outcome measures

Utah may qualify depending on how ratio is calculated



CLASS (2011)

- Establishes a national, voluntary insurance program for purchasing HCBS
- All working adults will be automatically enrolled in the program, unless they choose to opt-out
- Financed through payroll deduction or direct contribution
- Individuals below FPL and employed students will pay nominal premium (starting at \$5/month)
- 5-year vesting period, must be employed for 3 of those



CLASS (cont.)

- Provides individuals with functional (at least 2 ADLs) and/or cognitive limitations a cash benefit of not less than an average of \$50 per day to purchase non-medical services and supports necessary to maintain community residence
- Cash deposited in a debit account, can be rolled over month-to-month but not year-to-year
- Benefit continues as long as functional criteria are met
- For Medicaid enrollees, 50% could be used to supplement/offset costs

“(d) Advocacy Services- An agreement entered into under subsection (a)(2)(A)(ii) shall require the **Protection and Advocacy System** for the State to-

“(1) assign, as needed, an advocacy counselor to each eligible beneficiary that is covered by such agreement and who shall provide an eligible beneficiary with--

“(A) information regarding how to access the appeals process established for the program;

“(B) assistance with respect to the annual recertification and notification required under subsection (c)(6); and

“(C) such other assistance with obtaining services as the Secretary, by regulation, shall require; and

“(2) ensure that the System and such counselors comply with the requirements of subsection (h).



Community First Choice Option (2011)

- Allows states to provide community-based attendant supports and services to individuals with incomes up to 150% FPL with disabilities who require an institutional level of care
- Provide states with an additional 6% FMAP for reimbursable expenses in the program (including transition)



Health Professions Workforce Demonstration (2010-2014)

- Provide low-income individuals with education and training for occupations in the health care field
- 6 states, \$85million
- Develop core training competencies and certification programs for **personal or home care aides**

Core training competencies for personal or home care aides include: The role of the personal or home care aide, consumer rights, ethics, and confidentiality, communication, cultural and linguistic competence and sensitivity, problem solving, behavior management, and relationship skills, personal care skills, health care support, nutritional support, infection control, safety and emergency training, training specific to an individual consumer's needs, and self-care



Direct Care Worker Training (2011-2013)

- Grantee must be an institution of higher education & associated with an LTC provider
- Targets employees of HCBS providers & LTC facilities
- \$10 million



Cultural Competency, Prevention, Public Health, and Individuals with Disabilities (2010-2015)

- Include development, evaluation and dissemination of research, demonstration projects, and model curricula for cultural competency, prevention, public health proficiency, reducing health disparities, and **aptitude for working with individuals with disabilities** training for use in health professional schools and continuing education programs
- Appropriations as necessary