



Implementing the Affordable Care Act:

A Roadmap for People with Disabilities



National Council on Disability

January 19, 2016



National Council on Disability

An independent federal agency making recommendations to the President and Congress to enhance the quality of life for all Americans with disabilities and their families.

Letter of Transmittal

January 19, 2016

President Barack Obama
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear Mr. President:

The National Council on Disability (NCD) is pleased to submit its report, *Implementing the Affordable Care Act (ACA): A Roadmap for People with Disabilities*. In many ways, ACA could be the single most important piece of legislation for people with disabilities since the Americans with Disabilities Act. For the disability community ACA is paramount to being able to make choices that lead to successful daily living on par with nondisabled Americans.

NCD is an independent federal agency, composed of nine members appointed by the President and the U.S. Congress. The purpose of the NCD is to promote policies, programs, practices, and procedures that guarantee equal opportunity for all individuals with disabilities and empower individuals with disabilities to achieve economic self-sufficiency, independent living, and inclusion and integration into all aspects of society. Consistent with NCD's overall purpose, this first ACA report presents a map for approaching the provisions of this important federal law to support outcomes the disability community has prioritized. The first in a series of three ACA reports NCD is publishing, this report seeks to achieve the following goals:

- Provide an overview of future healthcare implementation decisions by private insurers and state and federal officials, along with an analytical supplement exploring policy options important to people with disabilities;
- Analyze key potential decision points for people with disabilities, advocates, and policymakers at the state and federal levels, and identify approaches to maximizing ACA's positive impact on people with disabilities while limiting risks to the disability community that could result from unwise implementation choices; and
- Evaluate the policy options facing states as they consider expanding Medicaid, structuring Medicaid benefits for newly eligible adults, defining essential health benefits, implementing state-based exchanges, taking up the Community First Choice State Option, integrating Medicare and Medicaid funding and services for dually eligible adults, and other critical decisions.

Planning of healthcare processes and procedures must engage ACA beneficiaries in meaningful ways. The report findings show a need for targeted and continuous raising of awareness and

1331 F Street, NW ■ Suite 850 ■ Washington, DC 20004

202-272-2004 Voice ■ 202-272-2074 TTY ■ 202-272-2022 Fax ■ www.ncd.gov

increased advocacy on behalf of people with disabilities to boost positive outcomes involving healthcare and related home- and community-based services. These outcomes include providing access to inclusive education, training, employment/workforce retention mechanisms, and community participation choices. NCD's recommendations in this first ACA report are grounded in an approach that breaks down "silos" at all levels—individual, local, state, tribal, and federal.

Finally, we urge the White House and Congress to engage stakeholders, including people with disabilities, as healthcare and related issues impacting the disability community are addressed now and in the future.

Sincerely,

A handwritten signature in black ink, appearing to read "Clyde Terry". The signature is fluid and cursive, with the first letter of each word being capitalized and prominent.

Clyde Terry
Chair

(The same letter of transmittal was sent to the President Pro Tempore of the U.S. Senate, the Speaker of the U.S. House of Representatives, and the Director of the Office of Management and Budget.)

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Acronym Glossary

ABP	Medicaid alternative benefit plan
ACA	Patient Protection and Affordable Care Act
ACL	Administration for Community Living, U.S. Department of Health and Human Services
AHRQ	Agency for Healthcare Research and Quality
CCIIO	Center for Consumer Information and Insurance Oversight
CFC	Community First Choice
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
EHB	Essential health benefit
FDA	Food and Drug Administration
FMAP	Federal medical assistance percentage
FFM	Federally Facilitated Marketplace
FFS	Fee-for-service
FPL	Federal poverty level
HCBS	Home- and community-based services
HHS	The U.S. Department of Health and Human Services
IAP	Insurance affordability program
LTSS	Long-term services and supports
MAGI	Modified adjusted gross income
MCO	Managed care organization
MMP	Medicare-Medicaid Plan
MOU	Memorandum / memoranda of understanding
NAIC	National Association of Insurance Commissioners
NBPP	Notice of Benefit and Payment Parameters
OCR	The Office for Civil Rights of the U.S. Department of Health and Human Services
QHP	Qualified health plan
SBM	State-Based Marketplace
SHOP	Small Business Health Options Programs (marketplaces for small businesses)
SNAP	Supplemental Nutrition Assistance Program
SSA	Social Security Administration
SSI	Supplemental Security Income
T-MESIS	Transformed Medical Statistical Information System

Contents

Introduction	3
Chapter 1. Foundational Decisions	5
Federal Decisions	5
<i>Health Care Coverage, Access, and Disparities</i>	5
<i>Employment</i>	11
<i>LTSS</i>	12
State and Marketplace Decisions	13
<i>Health Care Coverage, Access, and Disparities</i>	13
<i>Employment</i>	16
<i>LTSS</i>	16
Chapter 2. Recurring Decisions	21
Federal Decisions	21
<i>Rules for Individual Market Plans (Including QHPs)</i>	21
<i>Financial Integration Demonstrations for Dual Eligibles</i>	22
State Decisions	22
<i>Individual Health Insurance Plans</i>	22
<i>LTSS</i>	23
<i>State Budget Legislation</i>	23
Chapter 3. Other Future Decisions	25
Federal Decisions	25
State Decisions	26
Conclusion	27
Analytic Supplement	29
Foundational Decisions	29
<i>Federal Decisions</i>	30
<i>State and Marketplace Decisions</i>	32

Recurring Annual Decisions	42
<i>Federal Decisions</i>	42
<i>State Decisions</i>	45
Other Future Federal Decisions	45
<i>EHB Updates</i>	45
<i>Federal Enforcement</i>	47
Conclusion	47
Endnotes	49

Introduction

The Patient Protection and Affordable Care Act (ACA) is one of the most significant pieces of domestic legislation enacted in generations. Its impact has been widely debated, but people with disabilities have fallen outside much of the policy conversation. This is surprising, given the many ways that people with disabilities could benefit from or be harmed by ACA, depending on how it is implemented.

This “roadmap” to ACA implementation helps to fill that gap. It identifies key policy choices, at both the federal and state levels, that could greatly affect people with disabilities. One goal of developing this inventory is to equip the disability community with information that it can use to assess its priorities and to develop an agenda for ACA implementation.

The roadmap’s most basic organizational structure is chronological. It starts with foundational policy choices that shape basic ACA implementation, many of which have already been made (but which can typically be reexamined). The report goes on to flag key decisions slated for future time periods. Within each chronological category, the roadmap begins with federal decisions and then explores state policy choices. In some cases, the report sorts issues into three general categories:

- Health care coverage, access, and disparities, the category into which most issues fall;

Report Orientation

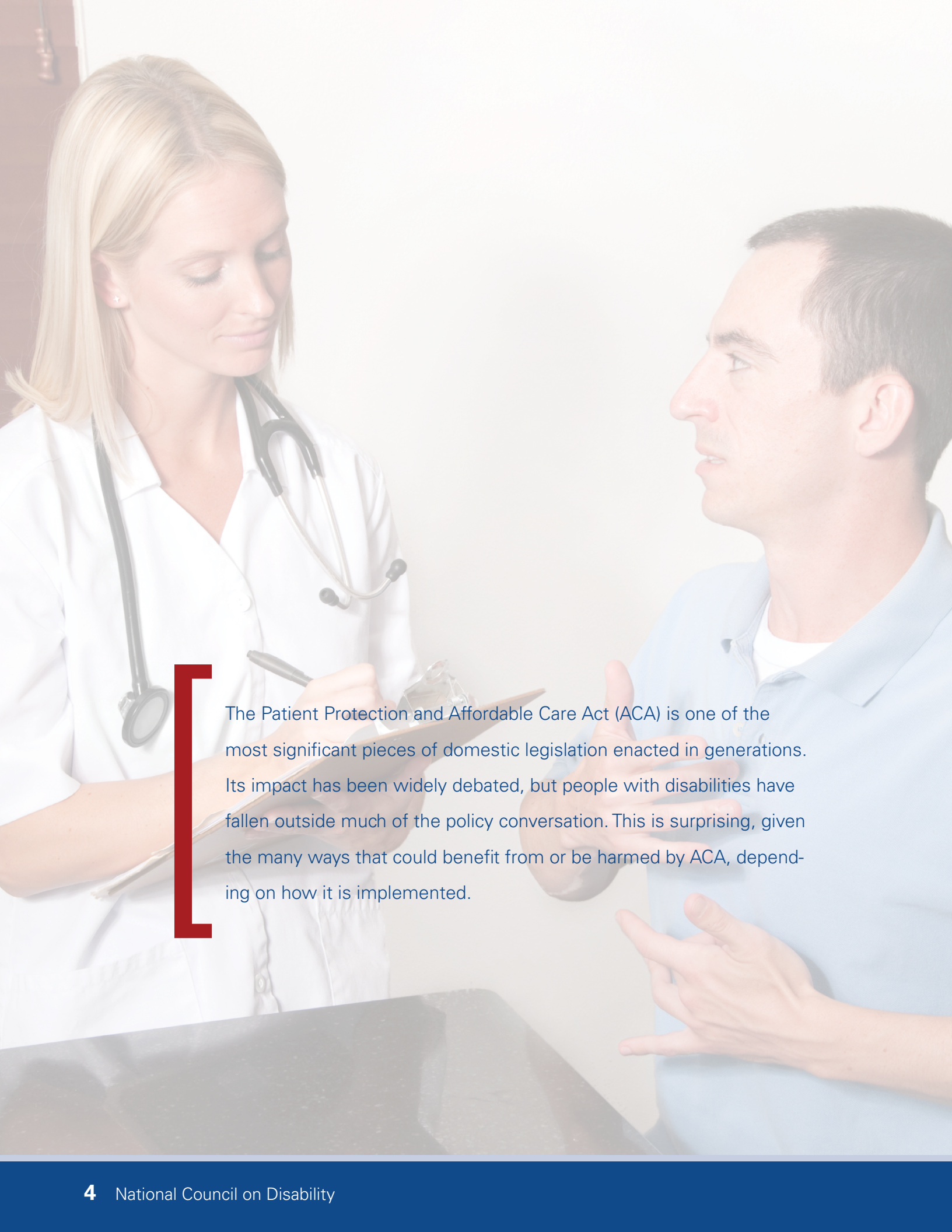
Roadmap— outlines key policy choices at state and local levels that can greatly help or harm people with disabilities

- Health care coverage, access, disparities
- Health care issues that affect employment
- Long-term services and supports

Analytic Supplement—identifies key contextual factors and explores policy options

- Health care issues that affect people with disabilities’ employment; and
- Long-term services and supports (LTSS).

For many if not most of the policy choices identified in the roadmap, the stakes for people with disabilities and the resolution that is most favorable to the disability community are self-evident. In some cases, however, further analysis is required. To address the latter, an Analytic Supplement follows the body of this roadmap, identifying key contextual factors and exploring or developing policy options to meet the needs of people with disabilities.



The Patient Protection and Affordable Care Act (ACA) is one of the most significant pieces of domestic legislation enacted in generations. Its impact has been widely debated, but people with disabilities have fallen outside much of the policy conversation. This is surprising, given the many ways that could benefit from or be harmed by ACA, depending on how it is implemented.

Chapter 1. Foundational Decisions

Policy decisions that establish the basic terms on which a particular coverage system operates are classified here as “foundational.” Many of these decisions have already been made, but they can often be reopened for discussion—indeed, some are expressly slated for future review, as is made clear later. Moreover, the federal policy choices described here provide an essential context for understanding the decisions that now face states, many of which remain open or subject to change.

Federal Decisions

Health Care Coverage, Access, and Disparities

The Federal Government has made important implementation choices in several areas that involve coverage, access to care, and disparities.

Data Gathering

Gathering and reporting data about people with disabilities’ receipt of care can be important when assessing whether policies and practices have a disparate adverse impact on people with

disabilities. Section 4302 of ACA thus required significant collection of data about possible disparities based on “race, ethnicity, sex, primary language, and disability status.”¹ This involved:

- *Data collection for “any federally conducted or supported health care or public health program, activity, or survey;”² along with required analysis of the gathered data “to detect and monitor trends in health disparities,” making both the analyses and data themselves publicly available,³ all to the extent supported by direct appropriations.⁴ These data collection provisions included a special requirement to conduct a provider survey that assesses people with disabilities’ access to care and treatment.⁵*
- *Specific application of these data collection requirements to Medicaid and the Children’s Health Insurance Program (CHIP), with required reports to Congress and the implementation of approaches found effective in such reports.⁶*

The U.S. Department of Health and Human Services (HHS) adopted guidance on October 31, 2011, governing new federal surveys and existing

Disability Questions from the U.S. Department of Health and Human Services Implementation Guidance on Data Collection Standards (2011)

1. Are you deaf or do you have serious difficulty hearing?
 - a. ___ Yes
 - b. ___ No
2. Are you blind or do you have serious difficulty seeing, even when wearing glasses?
 - a. ___ Yes
 - b. ___ No
3. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? (5 years old or older)
 - a. ___ Yes
 - b. ___ No
4. Do you have serious difficulty walking or climbing stairs? (5 years old or older)
 - a. ___ Yes
 - b. ___ No
5. Do you have difficulty dressing or bathing? (5 years old or older)
 - a. ___ Yes
 - b. ___ No
6. Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping? (15 years old or older)
 - a. ___ Yes
 - b. ___ No

surveys that undergo major revisions.⁷ They must ask, at a minimum, the questions about disability in the box found on this page.⁸

In addition to incorporating these questions into new federal surveys and revisions to existing surveys, HHS has required state Medicaid and CHIP programs to provide the Centers for Medicare and Medicaid Services (CMS) with

disability status information about each enrollee. This will be done through the Transformed Medical Statistical Information System (TMSIS), a new repository for Medicaid and CHIP data, which is being implemented on a rolling basis, by state.⁹ Concerning another data issue that affects the disability community, on July 17, 2015, the HHS Administration for Community Living

(ACL) released a draft report for public comment describing proposed quality measures for HCBS, developed by the National Quality Forum.¹⁰

Notwithstanding these important steps, HHS has not implemented ACA's above-described special requirements to survey providers nor assessed the care people with disabilities receive. Moreover, the disparities reports released thus far by the Agency for Healthcare Research and Quality (AHRQ) have focused

primarily on racial and ethnic disparities.¹¹

A recent report also discusses other "priority populations," which do not include adults with disabilities;

they do, however, include people "with special health care needs." Among the latter are "children with special health care needs" and such adult groups as the obese, smokers, people diagnosed with arthritis, and hospice patients.¹²

Marketplace Accessibility

Health insurance Marketplaces (sometimes called "Exchanges") are a central focus of ACA enrollment into all insurance affordability programs (IAP). Consumers can sign up for a qualified health plan (QHP) offered in the Marketplace, potentially qualifying for subsidies if their incomes are between 100 and 400 percent of the federal poverty level (FPL). Those who seek coverage at the Marketplace are also evaluated for potential Medicaid and CHIP eligibility and enrolled if they qualify.

In helping consumers sign up for coverage, Marketplaces must be accessible to people with disabilities in the overall furnishing of information; the operation of Web sites; the provision of consumer assistance, outreach, and education;

notices; and "the provision of auxiliary aids and services at no cost to the individual."¹³ QHPs themselves must likewise provide materials in accessible form for "all information that is critical for obtaining health insurance coverage or access to health care services through the QHP, including applications, forms, and notices."¹⁴

For Federally Facilitated Marketplaces (FFMs), which as of June 2015 served residents of 37

states,¹⁵ federal regulations are more specific in describing the accessibility requirements that Navigators and certain other consumer assistance programs

must satisfy.¹⁶ The regulations require such programs to:

Ensure that any consumer education materials, Web sites, or other tools utilized for consumer assistance purposes, are accessible to people with disabilities, including those with sensory impairments, such as visual or hearing impairments, and those with mental illness, addiction, and physical, intellectual, and developmental disabilities;

Provide auxiliary aids and services for individuals with disabilities, at no cost, when necessary or when requested by the consumer to ensure effective communication, with use of friends and family only when requested by the consumer as the preferred alternative to an offer of other auxiliary aids and services;

Provide assistance to consumers in a location and in a manner that is physically and otherwise accessible;

Notwithstanding these important steps, HHS has not implemented ACA's . . . special requirements to survey providers nor assessed the care people with disabilities receive.

Marketplaces must be accessible to people with disabilities in the:

- Overall furnishing of information
- Operation of websites
- Provision of consumer assistance, outreach, and education
- Notices
- Provision of auxiliary aids and services at no cost to the individual

Ensure that authorized representatives are permitted to assist an individual with a disability to make informed decisions;

Acquire sufficient knowledge to refer people with disabilities to local, state, and federal long-term services and supports programs when appropriate; and

Be able to work with all individuals regardless of age, disability, or culture, and seek advice or experts when needed.¹⁷

These more specific requirements do not govern State-Based Marketplaces (SBMs). However, nothing prevents an SBM from using the accessibility practices and standards that CMS approved for the FFM. SBM and FFM states could also extend some or all of these standards to certified application counselors, who do not receive Marketplace funding for their work. In all states, such counselors must provide information in a manner that is accessible to individuals with disabilities, either directly or through an appropriate referral to a Navigator, certain non-Navigator assistance personnel, or to the Marketplace call center.¹⁸

ACA regulations involving consumer information and network adequacy do not specifically address the accessibility to people with disabilities of providers in QHP networks.¹⁹ The Center for Consumer Information and Insurance Oversight (CCIIO), the agency within CMS that oversees Marketplaces, chose neither (1) to require insurers to include information about physical accessibility in the directories that identify network providers; nor (2) to establish accessibility to people with disabilities as a standard for QHP network adequacy, beyond the general requirement that networks must be “sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay.”²⁰ In a regulatory preamble, CCIIO analyzed provider directory issues as follows:

Comment: Commenters supported having issuers list detailed information in provider directories about physical accessibility for individuals with disabilities to help consumers choose plans and providers. Some sought information about exam table access, transfer assistance, and wheelchair access. One commenter urged caution in this area out of concern that including information on accessibility features for certain providers could be read to imply that other providers need not offer such features, even though they are legally obligated to do so pursuant to the Americans with Disabilities Act and section 504 of the Rehabilitation Act.

Response: We appreciate the complexity of this topic, and do not intend to issue additional regulation on this topic at this

time. We urge all issuers and providers to continue to ensure that they are providing full and equal access to all covered services to all enrollees, including those people with disabilities, and we remind them of the obligation to adhere to the requirements of the Americans with Disabilities Act and section 504 of the Rehabilitation Act. Issuers are encouraged to consult relevant Department of Justice guidance on accessibility of medical providers and effective communications at www.ada.gov. We will continue to monitor this issue.²¹

Other laws require health care *providers* to furnish services that are accessible to people with disabilities; these duties are not framed as obligations for *health plans* to assure network adequacy. Applicable statutes include pre-ACA laws, such as the Americans with Disabilities Act and Section 504 of the Rehabilitation Act. They also include new enactments in ACA, like Section 4203, which creates voluntary standards for accessible medical diagnostic equipment,²² as well as the anti-discrimination laws described next.

Discrimination

ACA and its implementing regulations incorporate a number of anti-discrimination provisions that protect people with disabilities, including:

- ACA Section 1557(b), which provides that an “individual shall not, on the ground prohibited under . . . section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity” funded or administered under ACA;²³
- ACA Sections 1302(b)(4)(B) and (C), which provide that the definition of essential health benefits (EHBs) shall “not make coverage decisions . . . or design benefits in ways that discriminate against individuals because of their . . . disability” and shall “take into account the health care needs of diverse segments of the population, including . . . people with disabilities;”
- 42 CFR 156.125(a), which forbids private insurers (including QHPs) from offering a “benefit design, or the implementation of its benefit design” that “discriminates based on an individual’s age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions;”²⁴ and
- 45 CFR 155.120, which requires states and exchanges to comply with applicable nondiscrimination statutes and which prohibits discrimination based on disability.

Anti-discrimination provisions of ACA and its implementing regulations:

- ACA Section 1557(b)—nondiscrimination in health programs or activities
- ACA Sections 1302(b)(4)(B) and (C)—nondiscrimination in coverage decisions and benefit design
- 42 CFR 156.125(a)—nondiscrimination in benefit design
- 45 CFR 155.120—nondiscrimination by states and exchanges

HHS has made important decisions interpreting these provisions:²⁵

- The Department characterized Section 1557 as effective on enactment, without any need to promulgate regulations. The HHS Office for Civil Rights (OCR) has already begun enforcing this law by accepting, investigating, and taking action on administrative complaints.²⁶ In its August 1, 2013 Request for Information to inform its rulemaking under Section 1557, OCR explained how Section 1557 changed prior law:

In developing a regulation to implement Section 1557, the Department recognizes that Section 1557 builds on a landscape of existing civil rights laws. For example, the prohibitions against discrimination on the grounds of race, color, national origin, age, and disability in Title VI, the Age Act, and Section 504, respectively, apply to all programs and activities covered by those statutes, including those related to health; however, the prohibition of sex discrimination in Title IX applies only to education programs and activities of covered entities. Section 1557 is the first Federal civil rights statute that prohibits sex discrimination in health programs and activities of covered entities. Section 1557 also applies to entities created under Title I of the Affordable Care Act, such as the Health Insurance Marketplaces. Additionally, Section 1557 is the first broad based Federal civil rights statute incorporating the grounds prohibited by four distinct civil rights statutes.²⁷

More recently, HHS issued proposed regulations that describe the requirements of Section 1557 in much more detail.²⁸

The comment period ended on November 9, 2015.

- In a regulatory preamble, CMS explained that the anti-discrimination provisions of 42 CFR 156.125 forbid “benefit designs that . . . would discourage enrollment by individuals based on age or based on health conditions.” The preamble listed several examples of such discriminatory benefit designs: “(1) Attempts to circumvent coverage of medically necessary benefits by labeling the benefit as a ‘pediatric service,’ thereby excluding adults; (2) refusal to cover a single-tablet drug regimen or extended release product that is customarily prescribed and is just as effective as a multi-tablet regimen . . . ; and (3) placing most or all drugs that treat a specific condition on the highest cost tiers.”²⁹

Essential Health Benefits: Habilitative Services

ACA lists as “essential health benefits” ten service categories; the EHB requirement governs most individual insurance, small group plans, and expanded Medicaid coverage of low-income adults.³⁰

One EHB benefit category is “rehabilitative and habilitative services and devices.”³¹ Because of major changes to federal policy in February 2015, as well as the importance of habilitative services to people with disabilities, this section focuses specifically on that set of essential health benefits.

As with other EHB categories, the amount, duration, and scope of required habilitative

services is based on the “benchmark” employer plan the state chooses from a list of federally-specified options. Such options include highly subscribed small-group plans and health maintenance organizations within the state, as well as coverage offered to state and federal employees.

Some states have benchmark plans that do not cover habilitative services. In such cases, the state itself may define the scope of covered habilitative services, provided that “the State definition complies with EHB policies, including nondiscrimination.”³² If the state does not define “habilitative services,” the following federal definition of habilitative services and devices applies: “[H]ealth care services and devices that help a person keep, learn, or improve skills and functioning for daily living (habilitative services). Examples include therapy for a child who is not 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.”³³

The federal definition also

- forbids each plan from imposing limits on habilitative services that are “less favorable than” the plan’s limits on rehabilitative services; and
- for coverage in 2017 and beyond, bars plans from imposing a single, combined limit

on habilitative and rehabilitative services. Instead, any limits must apply separately to each service category.³⁴

If the benchmark plan covers some habilitative services but falls short of the federal definition, the state must “supplement the benchmark plan,” according to CMS, since the federal definition comprises the “minimum for States to use when determining whether plans cover habilitative services.” In explaining the meaning of this federal definition, CMS described the difference between habilitative and rehabilitative services:

Habilitative services, including devices, are provided for a person to attain, maintain, or prevent deterioration of a skill or function

never learned or acquired due to a disabling condition. Rehabilitative services, including devices, on the other hand, are provided to help a person regain, maintain, or prevent deterioration of a skill or function that has been acquired but

then lost or impaired due to illness, injury, or disabling condition.³⁵

ACA did not change previous Medicaid options, such as for ‘buy-in’ coverage... [b]ut [t]he Federal Government has not released any regulations or guidance exploring how Marketplaces could help a larger proportion of the eligible population sign up for such pre-ACA coverage categories.

Employment

ACA did not change previous Medicaid options, such as for “buy-in” coverage, that facilitate people with disabilities’ employment. These options cover LTSS, often on a sliding scale, at incomes above generally applicable Medicaid thresholds. The Federal Government has not released any regulations or guidance exploring

how Marketplaces could help a larger proportion of the eligible population sign up for such pre-ACA coverage categories.

LTSS

ACA contained numerous provisions that expanded state Medicaid programs' options and incentives to cover LTSS for people with disabilities, particularly home- and community-based services (HCBS). Many of these provisions have received extensive analysis elsewhere, including in NCD's other work.³⁶ In discussing federal foundational decisions, this section of the roadmap focuses on one discrete area: integrating Medicare and Medicaid coverage for low-income people with disabilities who are "dual eligibles," simultaneously qualifying for full benefits under both programs. Later, the report discusses state implementation decisions involving both integrated coverage for dual eligibles and ACA's "Community First Choice" option for state Medicaid programs.

Section 2602 of ACA established the Federal Coordinated Health Care Office ("Medicare Medicaid Coordination Office"). The Office has authorized demonstration projects to test two models for "expanding access to seamless, integrated programs" by combining Medicare and Medicaid:

- A capitated model, through which "CMS, the State, and health plans . . . enter into a three-way contract" and "participating plans . . . receive a prospective blended payment to provide comprehensive, seamless coverage" with "actuarially developed blended rates that . . . provide a new savings opportunity for both States and the Federal Government;" and
 - A managed fee-for-service (FFS) model, under which "CMS and a State will enter into agreement whereby the State would be eligible to benefit from savings resulting from initiatives that improve quality and reduce costs for both Medicaid and Medicare."³⁷
- To participate in any version of this "financial alignment" initiative, a state must meet standards and conditions that include the following:
- The state model "ensures . . . the provision and coordination of all necessary Medicare and Medicaid covered services;"
 - The state care model includes mechanisms for "person-centered coordination of care" and "improving care transitions (e.g., between providers and settings) to maximize continuity of care;"
 - The state provides "evidence of ongoing and meaningful stakeholder engagement during the planning phase and has incorporated such input into its proposal" and "established a plan for continuing to gather and incorporate stakeholder feedback on an ongoing basis;"
 - The state establishes various beneficiary protections "to ensure beneficiary health and safety and beneficiary access to high quality health and supportive services necessary to meet the beneficiary's needs," including "meaningful beneficiary input processes," the development of accessible beneficiary education materials, ensuring physical accessibility options within provider networks, and full "grievance

and appeals rights under Medicare and/or Medicaid;”

- The state demonstrates that it has or can build the capacity needed to implement and oversee the model;
- The provider network must “ensure adequate access to medical and supportive service providers that are appropriate for and proficient in addressing the needs of the target population;”
- The state has systems in place for “oversight and monitoring to ensure continuous quality improvement,” which include measures of “experience, access to and quality of all covered services (including behavioral health and long term services and supports), utilization, etc., in order to promote beneficiaries receiving high quality care;”
- The state provides CMS with data “to inform program management, rate development and evaluation,” including beneficiary-level “expenditure data and covered benefits, . . . including available encounter data in capitated models;”
- The state identifies enrollment targets, with strategies for beneficiary education and outreach;
- Financial modeling demonstrates that the state’s model “will achieve meaningful savings while maintaining or improving quality;” and
- The state provides specified public notice and comment opportunities, including “appropriate tribal consultation.”³⁸

Under both models, CMS enters into memoranda of understanding (MOU) with

participating states that further detail state commitments. CMS also has expressed an openness to models beyond the two mentioned above. As of July 2015, such MOUs are publicly available for nine states operating capitated projects, two states using a managed FFS model, and one state taking a different approach.³⁹

In addition, each state participating in the demonstration must operate an ombudsperson program to serve beneficiaries in the demonstration.⁴⁰ The requirement to have an ombudsperson appears in each of the MOUs between states and CMS, as well as, in capitated states, the three-way contracts among CMS, the plan, and the state.

State and Marketplace Decisions

This section identifies foundational decisions that face state-level agencies. Unlike the preceding discussion of specific federal policy choices that apply nationwide, this portion of the roadmap analyzes policy choices that are being made differently in different states. It thus raises many issues in the form of questions. Such framing can help the disability community identify key implementation decisions to track in monitoring state implementation of ACA, focusing scarce resources on the most important issues. Note that many decisions involving the Marketplace are made at the state level only in states with SBMs; FFM operations are directed by CMS, rather than state officials.

Health Care Coverage, Access, and Disparities

State policymakers face questions that include but also go beyond the issue categories used earlier to organize federal foundational issues:

- Data
 - *Plan-level data.* How (if at all) are Medicaid managed care organizations (MCOs) and Marketplace QHPs required to collect and report data about the disability status of enrollees? How do the state and the Marketplace use those data to spot potential gains and challenges for people with disabilities (including possible disability-based disparities)? Are those data made publicly available in de-identified form so that patient and advocacy groups can conduct their own independent analyses? Are reports describing plan access and quality tabulated in terms of members' disabilities?
 - *Agency-level data.* How (if at all) do the Medicaid program and the Marketplace gather data about the disability status of applicants and enrollees? How do the state and the Marketplace use those and other data to spot potential gains and challenges for people with disabilities (including possible disability-based disparities)? Are those data made publicly available in de-identified form so that patient and advocacy groups can conduct their own independent analyses? Are reports describing quality and access tabulated in terms of peoples' disabilities?
- Marketplace accessibility
 - *Enrollment systems.* When consumers seek health coverage through the Marketplace, to what extent are information and enrollment services fully accessible to people with disabilities, including through the Marketplace Web site, call center, forms, notices, public education materials, and consumer assistance programs?
 - *QHP information.* When consumers are choosing QHPs, does the Marketplace provide information about QHP provider networks and prescription drug formularies (including applicable cost-sharing levels) that is important to people with disabilities? Such information could include, for example, general accessibility of services, accessibility of medical equipment, prior receipt of disability competency training, and network inclusion of specialists needed by people with disabilities.
- Discrimination
 - *Monitoring QHPs.* How (if at all) are the state insurance regulator and Marketplace monitoring and enforcing the prohibition against marketing practices and benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs? How are other ACA nondiscrimination requirements being monitored and enforced? How and where is this information being made publicly available?
- EHBs
 - *The state's chosen benchmark plan.* How does this plan cover services that are particularly important to many people with disabilities, including rehabilitative and habilitative services and devices, durable medical equipment, prescription drugs, and behavioral health care? (Exploration of this question needs to include limits, exclusions,

and exceptions.) Are aspects of the benchmark plan inconsistent with federal law? CMS has posted information about the benchmark plans that are effective starting in 2017.⁴¹

- *Modifications to benchmark benefits.* In defining the scope of each EHB service category, how (if at all) has the state modified and supplemented the benchmark plan's benefits when required to meet ACA's requirements, including for nondiscrimination and mental health parity? Has the state limited QHPs' ability to substitute benefits for the particular services covered by the benchmark plan?⁴²
- *Habilitative services.* Has the state defined "habilitative services and devices," for EHB purposes?
 - If so, is the state definition narrower than the federal regulatory definition? Is it missing protections in the federal definition (e.g., separate limits for habilitative and for rehabilitative services, starting in 2017)?
 - If the state has not promulgated its own definition, and the benchmark plan covers habilitative services, does that benchmark coverage meet the federal definition? If not, how (if at all) has the state modified that coverage to fit the federal definition? And how is the state monitoring QHPs to ensure that their coverage of this EHB category fits the federal definition?
- QHPs
 - *Network adequacy.* Do the state's adequacy standards that govern QHP provider networks⁴³ ensure the sufficient availability of health care providers who are fully accessible and who meet the health diagnosis and treatment needs of people with disabilities? If people with disabilities must go outside QHP networks to obtain essential care, what mechanisms ensure that they can obtain this care with the same limitations on cost-sharing amounts that apply within the provider network? (Such limitations include maximum, annual out-of-pocket costs and income-based cost-sharing reductions.)
- Expanded Medicaid eligibility for low-income adults
 - If the state has implemented the ACA option to expand Medicaid eligibility and cover all non-elderly adults up to 138 percent FPL, additional questions arise:
 - *Covered benefits.* Has the state aligned its alternative benefit plan (ABP) for newly eligible, low-income adults with benefits that other adult Medicaid beneficiaries receive? If not, how do ABP-covered services differ from benefits offered to other Medicaid adults, including those who need LTSS?
 - *Exemptions from benefit limitations.* If ABP-covered services are different from those provided to other adults, what system has the state created through which low-income adults can qualify for standard adult Medicaid benefits, including by showing "medical frailty"? How does the state define this term? What process has the state put in place to identify medically frail adults and assure that

they can receive standard benefits, rather than ABP benefits? How does the state notify consumers who could potentially qualify for an exemption from ABP benefit limitations? What steps must consumers take to receive the exemption?

- *Additional benefits for targeted groups.* Whether or not the state has aligned benefits for newly eligible adults with those covered for other adults, has the state implemented the option provided by ACA to furnish enhanced services to high-need subpopulations among adults who qualify because of income at or below 138 percent FPL?⁴⁴
- *Renewal.* How is the state approaching Medicaid administrative renewal for people with disabilities whose income comes largely or entirely from highly stable sources, such as Supplemental Security Income (SSI) and accompanying state supplements or from other disability-based payments?
- *Premium assistance.* How is the state using available options under ACA to give Medicaid beneficiaries with disabilities access to Marketplace QHPs, with supplemental Medicaid coverage that provides additional benefits and cost-sharing protections?

Employment

State Medicaid programs face key issues that affect people with disabilities' capacity to progress in the workplace:

- *Maintaining buy-in coverage.* Has the state retained Medicaid buy-in coverage and other pre-ACA options to help people with disabilities progress up the economic ladder? Such options permit people with disabilities, even as income rises, to retain the LTSSs that are needed for employment. Often, these Medicaid services are available on a sliding scale, with payments proportioned to beneficiary income.
- *Improving the effectiveness of buy-in coverage.* Now that the Marketplace is serving as a portal to health coverage for state residents of all income levels, is the state pursuing any innovative strategies for using the Marketplace to increase the number of eligible people with disabilities who participate in buy-in or similar Medicaid programs?

LTSS

The LTSS topics discussed here involve two sets of issues: demonstration projects that align Medicaid and Medicare for dual eligibles, as discussed earlier; and the Community First Choice (CFC) Medicaid option, created by ACA, for covering HCBS.

Financial Alignment Initiatives for Medicare-Medicaid Eligibles

Is the state pursuing a demonstration program to align financing and service delivery for dual eligibles that involves managed FFS care? If so:

- What monitoring and reporting requirements are in place?
- What quality measures are being used? How are they being applied? How does the state collect, track, and report data on key

quality metrics, encompassing outcome and process measures? These include beneficiary utilization of, experience with, access to, and quality of all covered services (including LTSS and behavioral health). How well adapted are the state's metrics to the unique needs of people with disabilities and the goal of prioritizing receipt of LTSS in home- and community-based settings, rather than institutions?

- For what functional and operational areas has the state delegated content development to providers? What is the state's oversight approach?
- How will the federally-sponsored evaluation be used to guide midcourse corrections and improvements? To what extent will information from the evaluation be made publicly available?
- Will data the state provides to CMS be made available to independent researchers and community groups, in de-identified form, for analysis? If any such data are currently available, what do they show?
- How was the disability community involved (if at all) in developing the Demonstration Agreement between the state and CMS? In other aspects of designing the Demonstration? How did the state incorporate community input?
- Does the demonstration provide additional services or cost-sharing protections to beneficiaries, beyond what they would receive under the standard configuration of Medicare and Medicaid? Are otherwise applicable Part D cost-sharing amounts

waived? What about other Medicare cost-sharing amounts?

Is the state pursuing a demonstration program to align financing and service delivery for dual eligibles that includes capitation of LTSS? If so, the above questions should be supplemented with the following:

- What specific mechanisms does the care model include for person-centered coordination of services and for improving care transitions to maximize continuity of care?
- Are meaningful input processes in place through which, on an ongoing basis, the disability community can participate in the demonstration program's development and oversight? For example, are beneficiary representatives involved in plan governing bodies, and has the state established a beneficiary advisory board for the overall demonstration? Are beneficiary representatives included in multi-stakeholder boards that help shape the demonstration?
- How does the state keep beneficiaries (including people with disabilities) informed of changes to policy and practice involving the demonstration?
- What protections (such as enrollment and disenrollment procedures, procedures for ensuring access to and continuity of care, etc.) has the state established to ensure people with disabilities' health, safety, and access to high-quality, necessary, culturally competent services and supports? What internal and external ombudsperson, grievance, and appeals mechanisms are in place? Do uniform requirements govern

- plan complaints and internal appeals? Are “ombuds” programs and other consumer assistance entities adequately staffed to handle inquiries from consumers, including those regarding LTSS? Are such organizations limited in their independence and authority to act on behalf of aggrieved consumers?
- Are all enrollment and marketing materials accessible and understandable to the target beneficiary population, including people with disabilities? Are they communicated in alternate formats as needed? Do disability-rights advocates review such materials before their approval and use?
 - Are measures in place ensuring the privacy of beneficiary health records and providing beneficiaries with access to their records?
 - What measures ensure that beneficiaries receive full and timely information about their care options?
 - What specific network adequacy requirements are being applied, including for LTSS and behavioral care services? How is the state ensuring that those requirements are met by plans seeking state contracts?
 - What systems does the state have in place for oversight and monitoring to ensure continuous quality improvement?
 - Under what circumstances will substandard plan performance trigger loss of quality “contract withholds,” suspension or termination of passive enrollment, or stronger state responses (such as terminating the plan’s participation in the demonstration)?
- Have the state and CMS ensured that all services otherwise covered by Medicare and Medicaid are covered by the plan?
 - How does the state ensure that past poor performers do not serve as capitated plans? How does the state ensure that capitated plans have a track record of positive service to people with disabilities, including the provision of high-quality LTSS in home- and community-based settings?
 - What passive enrollment policies are being applied? How are plan readiness and quality of care tested and assured before passive enrollment begins? How are operational and beneficiary access issues monitored? How are beneficiary opt-out rights secured?
 - What procedures (including beneficiary notice) are in place for nonpassive enrollment and for voluntary disenrollment? For ensuring that beneficiaries can make decisions about disenrollment free from undue influence? For tracking and reporting plan disenrollment rates?
 - What incentives encourage plans to provide LTSS in home- and community-based settings?

CFC Option

If the state is implementing CFC coverage:

- How does CFC interact with the state’s other HCBS systems of care?
- How does the state ensure that the plan of services and supports is person-centered and that the furnishing of services is controlled, to the maximum extent possible, by the individual beneficiary?

- Which individuals qualify?
- What services are covered? What models of care delivery are used?
- How do individuals appoint representatives? What safeguards apply?
- In what settings will services be provided? How is the state meeting the statutory requirement that services must be furnished in the most integrated setting appropriate to the individual's needs?
- How is input from the disability community incorporated into the development and implementation of the state's CFC initiative? How is the community represented on the CFC's Development and Implementation Council? What other steps has the state taken to assure ongoing input?
- What quality assurance system has the state established? What system of appeals is used for individual plans? How is feedback from consumers, their representatives, their families, and disability-rights organizations obtained? How is the health and well-being of beneficiaries monitored? What process is used for mandatory reporting, investigation, and resolution of allegations of neglect, abuse, or exploitation? How is quality assurance information made public?

Chapter 2. Recurring Decisions

Federal Decisions

Each year, CMS publishes new rules governing (1) the individual market and (2) demonstration projects that integrate Medicare and Medicaid services for dual eligibles.

Rules for Individual Market Plans (Including QHPs)

HHS regulations require the Federal Government to publish, each year, a Notice of Benefit and Payment Parameters (NBPP) that sets out ground rules for the coming year's Premium Stabilization Programs—programs that make payments to and from individual health plans to prevent instability and to share risk throughout each state's individual market.⁴⁵ Thus far, the annual publication of NBPPs has provided a vehicle for CMS to make additional decisions as well, revising policies affecting the individual market, including QHPs. The NBPP for 2016, for example, promulgated regulatory changes to EHBs (including the above-described federal definition of habilitative services), rules for consumer assistance programs, an exceptions process for prescription drugs not covered on formularies, new standards for Marketplaces to provide information about QHPs, and many other requirements governing the individual

and small-group markets.⁴⁶ These NBPPs are published, first as proposed, and then as final regulations, subject to standard regulatory notice and comment procedures.

CMS also updates annually the rules and procedures that apply to the FFM, which serves the residents of 37 states, as of June 2015.⁴⁷ These policies are embodied in both the NBPP and a letter to health insurance issuers that sets the terms on which the FFM will oversee coverage during the specified year. Such "issuer letters" are published in draft and then final form, providing an opportunity for public input, even though they do not involve regulations that trigger formal notice and comment procedures. Illustrating the range of topics they cover, such letter for 2016 explains how CMS will monitor QHP compliance with anti-discrimination requirements:

- The agency will "continue to assess compliance through issuer monitoring and compliance reviews, including analysis of appeals and complaints."
- While reviewing QHP certification, "CMS will perform an outlier analysis on QHP cost sharing (e.g., co-payments and co-insurance)" to "compare benefit packages with comparable cost-sharing structures to

identify cost-sharing outliers with respect to specific benefits.”

- CMS will analyze QHPs’ “Plans and Benefits Template,” looking for “discriminatory features or wording.” Such features typically raise cost-sharing or otherwise reduce benefit generosity with some but not all enrollees for “reasons not clearly based on common medical management practices.”
- In addition, “CMS is considering conducting a review of each QHP to identify outliers based upon estimated out-of-pocket costs associated with standard treatment protocols for specific medical conditions using nationally-recognized clinical guidelines. The conditions under consideration include: bipolar disorder, diabetes, HIV, rheumatoid arthritis, and schizophrenia.”⁴⁸

Financial Integration Demonstrations for Dual Eligibles

CMS releases several annual policy and operational documents that affect financial integration demonstrations that use capitated, Medicare-Medicaid plans (MMPs):

- Annual MMP contract requirements. They include requirements for MMPs to furnish information about provider networks (including for LTSS), models of care, prescription drug formularies, medication therapy management programs, and an integrated package of covered Medicare, Medicaid, and other benefits. In the February 2015 version of this annual document, CMS also provided guidance on other MMP issues, including the circumstances under

which prior performance problems either (1) completely bar a plan from participation or (2) disqualify a plan from receiving so-called “passive enrollees.”⁴⁹

- Medicare annual guidance concerning the Medication Therapy Management Program under Medicare Part D. This guidance applies to MMPs.⁵⁰
- Medicare’s annual “call letter” for Medicare Advantage and Part D plans.⁵¹ A separate CMS analysis explains how the call letter applies to MMPs.⁵²
- Annually updated reporting requirements for MMPs.⁵³

State Decisions

This section discusses recurring state decisions in several areas: individual health insurance, including QHPs; LTSS; and state budget legislation.

Individual Health Insurance Plans

Like the Federal Government, states periodically update the rules that apply in the individual market:

- A state that uses its own approach to risk adjustment, rather than the federal formula, must publish annual NBPPs that update risk-adjustment rules.⁵⁴
- Many state insurance departments release annual issuer letters that update standards for the individual market as a whole, including QHPs.
- Some SBMs release annually updated requirements and procedures for QHP certification.

- For a plan to be offered in the Marketplace in the coming year, it must first be approved both by (a) the state insurance regulator, which oversees the individual market as a whole; and (b) the Marketplace, which recertifies QHPs each year as authorized to participate in the Marketplace.

LTSS

Demonstration projects that use capitated arrangements to integrate Medicare and Medicaid coverage for dual eligibles feature three-way contracts among CMS, the state Medicaid program, and each participating health plan. Such contracts are renewed annually unless one of the parties provides a notice of nonrenewal. They have specified end dates, after which new contracts must be negotiated. For example, the contracts in California and South Carolina end

after December 2017.⁵⁵ State-administered FFS demonstration projects proceed on the basis of MOUs between CMS and the state, which last for approximately three years.⁵⁶

State Budget Legislation

Circumstances vary among states, but state budget deliberations often comprise the context in which Medicaid policy is revised. Decisions made during legislative budget debates can affect Medicaid buy-in programs, Medicaid LTSS coverage, and other Medicaid eligibility and service categories that serve people with disabilities. Depending on the state, budgets cover annual or two-year periods. The widest-ranging state budget debates typically occur before the enactment of such annual or biennial budgets, although budget discussions often take place at other times as well.⁵⁷

Chapter 3. Other Future Decisions

Federal Decisions

Several future federal decisions are important for people with disabilities and their representatives to track:

- EHB rules must be updated, according to ACA § 1302(b)(4)(G)(i), (ii) and § (b)(2)(A).⁵⁸ Periodically, HHS must provide a report to Congress and the public that assesses:
 - “Whether enrollees are facing any difficulty accessing needed services for reasons of coverage or cost;”⁵⁹
 - Whether EHBs need to be “modified or updated to account for changes in medical evidence or scientific advancement;”⁶⁰ and
 - The potential impact of added or expanded benefits on costs. The cost analysis should explore how, if some benefits expand or are added, others would need to be reduced to prevent EHBs as a whole from exceeding the actuarial “scope of benefits provided under a typical employer plan.”⁶¹

After releasing this report, HHS must update EHBs “to address any gaps in access to coverage or changes in the evidence base” that are identified in the report.

Such updating must provide public notice and comment opportunities.

- The Federal Government can decide, at any time, to assume enforcement responsibilities in a particular state’s individual or small-group market. CMS assumes this role if either (1) a state informs CMS that it will not be enforcing federal laws or (2) CMS determines that a state “is failing to substantially enforce these requirements.”⁶² As of January 1, 2014, five states (Alabama, Missouri, Oklahoma, Texas, and Wyoming) had provided the former notice, triggering CMS assumption of enforcement duties.⁶³
- ACA Section 4203 required the Architectural and Transportation Barriers Compliance Board (Access Board) to promulgate standards regarding accessibility of medical diagnostic equipment. In 2012, the Access Board released proposed standards, which were voluntary in nature.⁶⁴ However, the standards authorize the U.S. Department of Justice and the Food and Drug Administration (FDA) to take future action that would have the effect of making the standards mandatory. Over time, it will be important to track how these voluntary standards are implemented;

Future federal decisions important to people with disabilities:

- Essential health benefits rules must be updated to address any gaps in access to coverage or changes in the evidence base
- Federal Government enforcement of federal laws in states in which decline enforcement or in which CMS determines a failure to enforce
- DOJ or FDA future action to make mandatory existing voluntary standards regarding accessibility of medical diagnostic equipment
- Terms on which CMS is willing to grant states Medicaid expansion waivers to modify the terms on which consumers receive coverage

and, if the current voluntary approach proves insufficient, whether the Justice Department or FDA takes further action.

- Several states have expressed a willingness to expand Medicaid only if CMS agrees to grant waivers, under Social Security Act §1115, permitting the states to modify the terms on which consumers receive

coverage. Such waivers granted to date have authorized the increased use of private health plans, new premium and out-of-pocket cost-sharing charges, incentives for beneficiaries to participate in wellness promotion, health savings accounts, and other measures.⁶⁵ It will be important for the disability community to track the terms on which CMS is willing to approve such waiver proposals, to ensure that safeguards important to people with disabilities remain in place.

State Decisions

One additional set of future state decisions, beyond those identified above, involves renewal of Medicaid 1115 waivers. Such waivers are granted for finite periods, typically three or fewer years. Waiver renewals often become the subject of negotiation between federal and state officials. This can provide an opportunity for disability rights groups and other stakeholders to share their perspectives with both state policymakers and CMS. Such opportunities include but also go beyond building formal public comment procedures. The disability community's involvement could seek to remedy problems or secure additional improvements for people with disabilities by modifying an existing waiver's terms and conditions.

Conclusion

ACA's implications for people with disabilities are considerable and wide-ranging. During the coming months and years, some key implementation decisions that could affect people with disabilities are federal, but many more choices will be made at the state level. To ensure that policy decisions take the

needs of people with disabilities into account, it will be important for the disability community to actively monitor discussions around the issues identified here and, before key policy choices are made, to educate federal and state officials about the potential impact of those choices on people with disabilities.

Analytic Supplement

With many issues identified in the body of this report, even the casually informed reader can discern options that would best meet the needs of people with disabilities. Other policy questions are not so clear-cut, however. The latter questions are the focus of this analytic supplement.

The main audience for this report is the disability rights community, which is skilled in making its voice heard at the federal and state levels and well informed about longstanding challenges facing people with disabilities, but may not have the luxury of closely tracking the broad range of ACA implementation issues. In some cases, this analytic supplement simply fills in ACA's policy or legal background to provide important context for a particular policy choice. In other cases, the document explores a range of implementation options. On a handful of issues, the analytic supplement develops new policy approaches to help people with disabilities, approaches that reflect this project's collaboration between the Urban Institute's ACA experts and NCD's thought leaders on issues of disability policy.

In its basic structure, the supplement follows the body of the report. It begins with foundational policy choices that shape basic ACA systems. It then moves to issues that arise at other stages of ACA implementation. All issues are categorized

in terms of federal and state arenas for policy resolution, and some are further grouped into three general substantive categories:

- Health care coverage, access, and disparities;
- Health care issues that affect people with disabilities' employment; and
- Long-term services and supports (LTSS).

One final point bears emphasis. In deciding whether to include an issue from the body of the report in this analytic supplement, the issue's importance to people with disabilities was a secondary consideration. The main factor was the need for further explanation. Some vital federal and state policy choices are not mentioned here because the earlier discussion was viewed as sufficient. Conversely, some second-order issues are included, as further analysis could significantly increase the reader's understanding.

Foundational Decisions

As noted earlier, foundational policy decisions establish the basic terms on which a particular coverage system operates. Although many of these decisions have been made, some could be reopened for potential revision, at both the federal and state levels.

Federal Decisions

Several federal decisions described in the roadmap warrant further discussion.

First, the Federal Government has not implemented ACA's requirement for provider surveys that specifically focus on people with disabilities' access to care. ACA §4302(a) created Public Health Service Act §3101 [42 USC 300k], subsection (a)(1)(D) of which requires the U.S. Department of Health and Human Services (HHS) to:

survey health care providers and establish other procedures in order to assess access to care and treatment for individuals with disabilities and to identify—

- (i) locations where individuals with disabilities access primary, acute (including intensive), and long term care;
- (ii) the number of providers with accessible facilities and equipment to meet the needs of the individuals with disabilities, including medical diagnostic equipment that meets the minimum technical criteria set forth in section 510 of the Rehabilitation Act of 1973; and
- (iii) the number of employees of health care providers trained in disability awareness and patient care of individuals with disabilities.⁶⁶

However, this requirement is contained within a section—Public Health Service Act §3101—that is subject to an important limitation: “data may not be collected under this section unless funds are directly appropriated for such purpose

in an appropriations Act.”⁶⁷ The absence of appropriations may have prevented HHS from carrying out this provider survey.

Nevertheless, such a survey could move forward for providers who participate in Medicaid and CHIP. Without language that limits federal duties based on available appropriations, ACA §4302(b)(1) requires that “any data collected” by Medicaid must “meet . . . the requirements of section 3101 of the Public Health Service Act;” and that CHIP programs must have “data

collected and reported in accordance with section 3101 of the Public Health Service Act.”⁶⁸ In a recent report to Congress, HHS noted that, under ACA §4302(b), “Collection

and reporting of [disparities] data in Medicaid and CHIP must adhere to the standards developed under section 3101 of the PHS Act.”⁶⁹ Since PHS Act Section 3101 applies to Medicaid and CHIP, notwithstanding the absence of appropriations, HHS can (and arguably must) move forward with a survey of people with disabilities' access to care in Medicaid and CHIP.

Other than such specific assessments of disability-based disparities, important data-gathering initiatives are under way that could benefit the disability community. A prime example is the work being done by the National Quality Forum to develop quality measures for HCBS.⁷⁰

Second, as noted in the body of the report, CMS has required state Medicaid programs to include information about disability in the Transformed Medical Statistical Information System (T-MSIS), a comprehensive new system for tracking Medicaid coverage. This is

an important, positive step that promises to enable many analyses of people with disabilities' enrollment, receipt of services, and access to care in Medicaid.

However, the disability community may need to carefully monitor this aspect of T-MSIS implementation. ACA has placed tremendous administrative burdens on state Medicaid agencies. Many Medicaid programs are not yet done modernizing "legacy" computer systems that have housed eligibility data for decades. These other priorities may prevent T-MSIS implementation from proceeding quickly and smoothly. Aspects of T-MSIS that are seen as less urgent could be left for future years. The disability community's active involvement could be needed to help federal policymakers understand the importance of including information about disability as part of T-MSIS early implementation.⁷¹ (Because states are phasing in their implementation of T-MSIS, this issue could be raised at the state level as well.)

Finally, several federal policy questions already resolved as described in the body of the report could be reopened for further discussion:

- For purposes of determining essential health benefits (EHBs), should states be allowed to use a definition of "habilitative services and devices" that is narrower than the federal definition?
- Should State-based Marketplaces (SBMs) be required to meet the accessibility

requirements for Navigators and certain other consumer assistance programs that CMS has promulgated for Federally-facilitated Marketplaces (FFMs)?

- Should information about each network provider's accessibility to people with disabilities be required in public directories maintained by qualified health plans (QHPs) that offer coverage in a Marketplace? Should that information be consolidated at Marketplace Web sites, so consumers can compare networks without visiting multiple insurers' Web sites? If so, should this consolidated information describe each QHP network using comparable metrics so enrollees can make "apples-to-apples" comparisons?
- Should federal standards for network adequacy include specific requirements for insurers to meet people with disabilities' needs for accessible services, specialty care, and prescription drugs?
- Do people with disabilities receive sufficient protection under minimum federal standards for financial alignment demonstrations that integrate Medicare and Medicaid coverage for beneficiaries who are dually eligible? Do those standards require strengthening?

These issues are discussed below in connection with future federal decisions.

The disability community's active involvement could be needed to help federal policymakers understand the importance of including information about disability as part of T-MSIS early implementation.

State and Marketplace Decisions Health Care Coverage, Access, and Disparities

Several state policy issues involving coverage, access, and disparities require a discussion that goes beyond the body of this report.

Applying FFM approaches to SBMs: Marketplace accessibility and monitoring health plan discrimination

The roadmap notes several areas where federal standards for FFMs exceed minimum requirements for SBMs: namely, accessibility of Marketplace enrollment systems (including consumer assistance programs) and monitoring methods to detect potential discrimination by health plans. In SBM states, the disability community could explore the possibility of adopting FFM approaches.

In future years, disability advocates could monitor other emerging practices where the FFM exceeds minimum regulatory requirements. In such cases, FFM policies and practices could become a spur to SBM progress. As explained below, such tracking will involve reviewing draft and final versions of FFM issuer plan letters and Notice of Benefit and Payment Parameters promulgated by the Center for Consumer Information and Insurance Oversight (CCIIO), the portion of CMS that oversees Marketplaces and helps regulate private insurance.

To be clear, this part of the analytic supplement explains opportunities for contrasting federal with state policies in ways that may yield gains for

people with disabilities. It is not meant to suggest that federal standards, on these and other issues, cannot be improved or that states should not be encouraged to go beyond federal approaches in ways that benefit people with disabilities.

Network adequacy

A state can supplement federal standards for network adequacy, which, as explained in the body of the report, do not include specific requirements that address people with disabilities' needs for accessible care and for specialty services. A voluntary approach is probably unlikely to see most insurers meet

these needs. If some but not all plans furnish accessible care with broad participation by the specialists on whom people with disabilities rely, the plans that do so are likely to attract more than their share of people with

disabilities and other chronically ill consumers. Insurers may be hesitant to take such steps, since premium payments, under ACA, do not increase for enrollees with health problems. ACA's risk-adjustment and reinsurance payments are structured to pay for costs not covered by these "community-rated" premiums. However, insurers may worry that such payments will not fully finance the increased costs of people with disabilities and consumers with chronic illness. If so, they could be tempted to avoid offering coverage that attracts such high-cost groups.

These adverse incentives could be prevented by requiring all individual plans to operate provider networks that meet the needs of people

[A]dverse incentives could be prevented by requiring all individual plans to operate provider networks that meet the needs of people with disabilities, thus spreading out high-cost enrollees among all participating insurers.

with disabilities, thus spreading out high-cost enrollees among all participating insurers. Such requirements are typically within the jurisdiction of state insurance regulators, which oversee all individual coverage, including both QHPs and plans offered outside the Marketplace. In theory, a Marketplace could apply stricter network adequacy standards for QHP certification than insurance regulators apply to other individual plans. In practice, however, SBM officials may hesitate to take that step, since it may increase QHP premiums, causing some consumers to choose plans outside the Marketplace.⁷² QHP enrollment levels are critically important to

Marketplaces because the bulk of their administrative funding comes from health plan assessments that reflect the number of Marketplace participants.

Even if network adequacy standards that address the needs of people with disabilities apply throughout the individual and small-group markets (including QHPs and SHOP plans), policymakers may fear that tighter standards will increase premiums. People with disabilities could address that fear through the careful design of network adequacy rules. Not every Marketplace consumer needs the specialty care required by people with disabilities. Insurers could be directed to establish procedures through which enrollees whose medical needs are not met by standard plan networks can obtain access to non-network care for in-network cost-sharing amounts, subject to the same out-of-pocket limits and cost-sharing reductions that apply to network services. Such a provision is part of California's

network adequacy requirements: "Plans shall arrange for the provision of specialty services from specialists outside the plan's contracted network if unavailable within the network, when medically necessary for the enrollee's condition. Enrollee costs for medically necessary referrals to non-network providers shall not exceed applicable co-payments, co-insurance and deductibles."⁷³

Medicaid Alternative Benefit Plans (ABPs)

When a state expands Medicaid eligibility to non-elderly adults with incomes up to 138 percent

of the federal poverty line (FPL), adults who newly qualify based on income are enrolled in a Medicaid ABP, which must meet all EHB requirements. The state can (1) base its ABP on a commercial insurance

plan chosen from a menu of options or (2) align the ABP with benefits that other Medicaid adults receive. If the state offers different benefits to newly eligible adults and to other adults, the state must create procedures through which "medically frail" adults can qualify for standard Medicaid adult benefits. The latter benefits typically include LTSS, which may not be within the ABP.

Other publications address ABP issues affecting individual people with disabilities, including medical frailty procedures as well as the potential advantages for people with disabilities of an ABP that meets ACA's EHB requirements.⁷⁴ However, one additional point is important. In some states, officials may not realize that

In [some] cases, premium assistance could promote continuity of care by preserving access to the same providers who served the consumer in the previous coverage system.

significant state fiscal gains could result from state policies that help people with disabilities. Newly eligible, low-income adults receive a very high level of federal Medicaid funding—100 percent of all costs through the end of 2016, after which the federal medical assistance percentage (FMAP) gradually declines to 90 percent in 2020 and thereafter. By contrast, the FMAP for most other Medicaid categories and services—including disability-based coverage that preceded ACA—ranges between 50 percent and 74 percent, depending on the state, averaging 57 percent nationally.⁷⁵

Some consumers have the option to qualify for Medicaid either as (1) a low-income adult or (2) someone who receives pre-ACA disability-grounded coverage. If they choose the former, the state receives a substantially greater FMAP. State fiscal interests are thus served by ABP arrangements that encourage people with disabilities to qualify based on income, rather than disability.⁷⁶

Suppose a state's ABP plan lacks Medicaid benefits important to people with disabilities, and state procedures make it hard to obtain a medical frailty exemption. People with disabilities who could be eligible for Medicaid based on low income alone may instead seek disability determinations to receive full Medicaid benefits through pre-ACA pathways. To avoid that fiscally counterproductive result, a state could either (1) align ABPs with Medicaid benefits (including LTSS) offered to other adults or (2) develop streamlined procedures that make it easy for

people with disabilities to qualify for the medical frailty exemption.

Medicaid administrative renewal

ACA changed Medicaid in ways that go beyond eligibility expansion. Among those changes is a requirement for administrative renewal of Medicaid eligibility whenever "reliable information"⁷⁷ demonstrates that a beneficiary continues to qualify. The beneficiary is sent a notice that (1) describes the basis of the decision and (2) explains that the beneficiary is legally required to correct any errors. Unless the beneficiary makes a correction that

shows ineligibility, Medicaid coverage continues, without any action required from the beneficiary. Administrative renewal can make an important contribution to people with disabilities' receipt of necessary care

because it prevents eligible beneficiaries from losing coverage by failing to complete and return required forms.⁷⁸

An income determination made by another government agency can provide reliable information that triggers administrative renewal of Medicaid coverage. CMS has made clear that data from the Supplemental Nutrition Assistance Program (SNAP), for example, can lead to administrative renewal if it shows that a Medicaid beneficiary continues to be financially eligible. Even before ACA, states as diverse as Texas and Washington were using SNAP records to automatically renew children's coverage.⁷⁹ The case records of other benefit programs that

The choice of EHB-benchmark plan can be essential to defining the details of covered benefits. In each state, available options need to be compared to determine which package comes closest to meeting the needs of people with disabilities.

assist people with disabilities, including types of Supplemental Security Income (SSI) that do not automatically qualify recipients for Medicaid,⁸⁰ can likewise lead to administrative renewal when beneficiaries are already known to retain eligibility.

Beneficiaries with highly stable financial circumstances—including many people with disabilities—can likewise be administratively renewed. For example, Wisconsin’s Medicaid program extends administrative renewal to members of the following groups:⁸¹

- Medicaid beneficiaries whose eligibility is related to their receipt of SSI;
- Participants in Medicaid waiver programs covering home- and community-based LTSS;
- Enrollees in managed long-term care arrangements; and
- Participants in Medicare Savings Programs.

Within each category, Wisconsin beneficiaries must meet additional requirements for administrative renewal to take place. For example, Medicare Savings Program participants must have incomes at or below 120 percent FPL and assets no more than 50 percent of maximum permitted levels. As explained by the Wisconsin Medicaid program, “cases selected for administrative renewal are cases that are highly unlikely to lose eligibility at renewal due to increases in income or assets.” Similar examples from other states include New York’s administrative renewals for SSI-related cases with resources that, when last evaluated, did not exceed 85 percent of the applicable limit;⁸² and Louisiana’s administrative renewal for children when (1) all household income consists of Social

Security payments, (2) the children receive LTSS, or (3) monthly income does not exceed \$500 in a family whose eligibility has not changed for three years.⁸³

Medicaid premium assistance

A state Medicaid program could give Medicaid-eligible people with disabilities the option to take their Medicaid in the form of (1) Marketplace plans and (2) supplemental coverage that provides Medicaid benefits and cost-sharing protections going beyond what the Marketplace plan would otherwise provide. This option could help people with disabilities for a variety of reasons. In some states and with some people with disabilities, provider networks are broader in Marketplace plans than in Medicaid. Also, some people with disabilities may be transitioning into Medicaid from another system of coverage. In such cases, premium assistance could promote continuity of care by preserving access to the same providers who served the consumer in the previous coverage system.

Premium assistance can be offered as an option through which, if the beneficiary so chooses, standard Medicaid is converted into payments for private, individual coverage, without any need for the state to obtain a federal waiver. Requirements for a state to make this option available include (1) cost-effectiveness for the state and (2) preserving Medicaid benefits and cost-sharing protections for the beneficiary by providing “wrap-around” coverage that supplements the private plan.⁸⁴ Some states have obtained waivers under Social Security Act §1115 that change premium assistance from an option for beneficiaries into the sole available method through which beneficiaries receive coverage. In effect, such waivers let states force beneficiaries

into premium assistance arrangements. CMS has made clear that premium assistance waivers cannot apply to the medically frail.⁸⁵ Accordingly, states can offer premium assistance only as an option for people with disabilities, not as the sole form of available Medicaid.

Using premium assistance to permit people with disabilities to enroll in Marketplace coverage would likely prove cost-effective for Medicaid programs. QHP premiums charged for EHBs are based on age and geography, not health status, as noted earlier. They thus would not reflect the higher health care costs that result from disability. Instead, those costs would be shared throughout the individual market, as plans with healthier members transfer resources, through risk adjustment, to plans with less healthy members.⁸⁶

For people with disabilities to benefit, this approach would need to carefully address the structure of wrap-around assistance. Such assistance may be more likely to translate into coverage if it is provided by the same insurer that furnishes the underlying QHP coverage. As CMS explained, having the same plan deliver all services and provide all cost-sharing protections, including those within the Medicaid wrap-around package, “ensures that coverage is seamless, that cost sharing reductions are effectively delivered, and that

there is accountability for the payments made.”⁸⁷ This seamlessness can be facilitated if the same carrier sponsors both a QHP and a Medicaid-managed care plan. As of January 2015, carriers in 33 states sponsored plans in both markets.⁸⁸

One approach to the premium assistance option discussed here would make a single Medicaid payment to a carrier that offered plans in both markets. Consumers would receive EHB services from the QHP, and the carrier could make additional services available through its Medicaid plan. In states where QHP networks

are broader than Medicaid networks because providers are paid more for Marketplace members than for Medicaid patients, this approach would give people with disabilities access to QHP networks for EHBs. At the same time, it would avoid having the Medicaid agency pay commercial rates for additional, wrap-around services, thus increasing this approach’s appeal to states.

Insurance companies and Marketplaces would likely

resist such a policy because it would raise overall risk levels and premiums in the individual market. Federal QHP subsidy costs would rise, and unsubsidized consumers in the individual market—generally those with incomes above 400 percent FPL—would be charged higher premiums. However, current federal regulations require QHPs to accept consumers whose premiums are paid by “State and Federal Government programs.”⁸⁹ This regulation, on its face, requires QHPs to accept Medicaid premium

Once an EHB-benchmark plan and supplementary benchmark plans are selected, the state may need to adjust the details of benchmark coverage to meet ACA’s requirements, including nondiscrimination, mental health parity, and rules governing habilitative services and prescription drugs. Some states will probably not take this step, unless urged to do so...

payments. That said, aggressive use of the premium payment strategy discussed here could potentially prompt CMS to amend this regulation.

Two final comments are important. First, the Medicaid wrap-around discussed here cannot accompany QHP subsidies because people who qualify for Medicaid are generally ineligible for QHP subsidies. Instead, Medicaid would pay all QHP premiums while providing wrap-around coverage. Arkansas took this approach to its premium assistance waiver, for example.⁹⁰

Second, the approach to risk-spreading assumed in the above discussion is consistent with how CMS structures waivers that use Medicaid funds to purchase QHP coverage. Medicaid enrollees in QHPs are included in the risk pool that determines the standard QHP premium. As explained by the Medicaid and CHIP Payment and Access Commission, “premiums for exchange plans and other private market plans are determined using the rating rules that apply to that market, and their prices reflect the cost of the entire population—both Medicaid and non-Medicaid—in that market.”⁹¹ That said, the precise issue discussed here—namely, the impact on QHP risk pools when, without waivers, Medicaid gives beneficiaries the option to enroll into QHP coverage—has not been addressed, since no state has yet tried this precise approach.

EHB choices

Before analyzing state options for defining EHBs, it is important to explain how ACA and CMS approach EHBs. As noted in the roadmap, EHBs must be covered by all nongrandfathered individual insurance, small-group plans, and Medicaid ABPs. ACA directs HHS to “ensure that the scope of the essential health benefits . . . is

equal to the scope of benefits provided under a typical employer plan.”

ACA lists 10 EHB service categories—namely, ambulatory patient services, emergency services, hospitalization, maternity and newborn services, 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, and pediatric services (including oral and vision care).⁹² To fill out the details of these broad categories, a state can choose any of the following benchmark plans:⁹³

- The three largest plans by enrollment in the state’s small-group market;
- The three largest plans by enrollment that are offered and generally available to state employees;
- The three largest plans, by enrollment, that are offered to all federal employees; and
- The Health Maintenance Organization with the state’s largest enrollment of commercial, non-Medicaid members.

If a state does not select an EHB-benchmark plan, the small-group plan with the state’s largest enrollment is selected, by default.⁹⁴ If the EHB-benchmark plan does not cover a particular EHB service category, the state picks a different benchmark plan from the above list. In a state that fails to select supplemental benchmarks, federal regulations specify the benchmarks that are chosen by default.⁹⁵

Once the benchmark plan for a particular EHB service category is chosen, insurers subject to EHB

requirements must provide benefits within the applicable category that are “substantially equal” to the benchmark plan’s benefits, taking into account amount, duration, and scope limits.⁹⁶ Unless a state decides otherwise, a health plan can, with any EHB category other than prescription drugs, provide substitute benefits in place of benchmark coverage. Substitute benefits must be certified as the actuarial equivalent of benchmark benefits. This means that, for a standardized population, projected claim costs (without consumers’ cost-sharing payments) are equivalent.⁹⁷ Special rules apply to habilitative services, as explained in the roadmap, and prescription drugs.⁹⁸ If, after December 31, 2011, the state imposes new mandates for coverage of services beyond EHBs, the state must pay the resulting increase in QHP premium costs for all enrollees in both individual and small-group markets.⁹⁹

For people with disabilities, several different state-level EHB decisions are critically important:

- The choice of EHB-benchmark plan can be essential to defining the details of covered benefits. In each state, available options need to be compared to determine which package comes closest to meeting the needs of people with disabilities. If the EHB-benchmark plan misses an EHB category, the selection of a supplemental benchmark plan to cover that category of services is important, for the same reason. Because of the requirement that states pay the QHP premium costs that result from new state-mandated benefits, the choice of benchmark plans is one of the few state-level policy choices that is realistically available to increase the generosity of coverage in markets governed by EHB standards. Before

consumers undertake an effort to revise a state’s benchmark plan, it is important to understand that a more generous package of benefits, with resulting premium increases, could be opposed by small firms subject to EHB requirements as well as Marketplace officials seeking to increase enrollment by limiting QHP costs.

- Once an EHB-benchmark plan and supplementary benchmark plans are selected, the state may need to adjust the details of benchmark coverage to meet ACA’s requirements, including nondiscrimination, mental health parity, and rules governing habilitative services and prescription drugs.¹⁰⁰ Some states will probably not take this step, unless urged to do so, particularly if the choice of benchmark plan operates by default.
- For any EHB category, the state can forbid the substitution of actuarially equivalent benefits. Depending on the specific details of the applicable benchmark, such a prohibition may or may not help people with disabilities. In general, actuarial equivalence gives consumers additional choices and lets plans innovate, incorporating new treatments that reflect medical advances. On the other hand, if insurers are allowed to vary the details of covered benefits, such variation can become a method through which plans discourage enrollment of high-cost populations.¹⁰¹ ACA’s risk-adjustment and reinsurance mechanisms reduce plans’ incentives to avoid high-cost populations, but those mechanisms may not be fully effective.¹⁰² Plan designs that deter costly consumers from enrolling violate ACA’s

anti-discrimination rules, but if state policy permits differences in covered benefits, illegal discrimination may become more likely. Moreover, a substituted set of benefits that is actuarially equivalent to the benchmark plan—generating similar costs for a standardized population—may not provide the same generosity as benchmark coverage when it comes to meeting the needs of a nonstandardized population, such as people with disabilities.

Employment

Medicaid buy-in programs are a Medicaid option that serves workers with disabilities whose earnings exceed traditional Medicaid limits. They can provide critical support that helps people with disabilities progress in the workplace by covering LTSS that are needed for employment, as income rises about standard Medicaid levels. Such programs could be weakened or strengthened by ACA, depending on state implementation.

ACA created a system of federal subsidies for certain consumers who purchase Marketplace coverage. To qualify, people must have income between 100 and 400 percent FPL and they may not be offered minimum essential coverage, including that provided by Medicare, Medicaid, and employer-sponsored insurance that ACA classifies as affordable.

Some state officials have characterized these new subsidies as eliminating the need

for Medicaid to continue providing coverage to adults who are financially eligible for subsidies. For example, Arkansas and Louisiana eliminated buy-in coverage for workers with disabilities.¹⁰³ Such actions ignore that buy-in programs provide LTSS that many people with disabilities need to live successfully in the community and work. These services and supports go far beyond what is offered by the commercial EHBs that are available in Marketplace plans, which are modeled on employer-sponsored insurance.

On the other hand, if states maintain buy-in programs, Marketplaces, which serve consumers of all income levels, could provide an opportunity for those programs to reach more people with disabilities at higher income levels than the traditional Medicaid range. The current IAP application form asks whether the applicant has a physical, mental, or emotional health condition that limits activities like bathing, dressing, or daily chores. At a minimum, those who answer

Some state officials have characterized these new subsidies as eliminating the need for Medicaid to continue providing coverage to adults who are financially eligible for subsidies... Such actions ignore that buy-in programs provide LTSS that many people with disabilities need to live successfully in the community and work.

in the affirmative and qualify for QHP subsidies could automatically be informed about buy-in options, Medically Needy eligibility, and similar Medicaid options. In addition, those who qualify for Medicaid coverage as adults with incomes at or below 138 percent FPL could be targeted for outreach in connection with medical

fragility exceptions to alternative benefit limits.

A Marketplace could do more than provide a notice that explains how consumers can apply for assistance, however. In other contexts,

interventions that provide such information have sometimes failed to yield significant participation gains. Going beyond information to furnish hands-on assistance has often been required to “move the needle” on enrollment.¹⁰⁴ In this case, one possible approach would have the Marketplace generate an automatic notice indicating that, unless a consumer whose application indicates potential disability opts out (perhaps by calling a toll-free number or going to a specified Web site), the Marketplace, Medicaid program, or community-based group working with one of those agencies will reach out to the consumer to explore available options for extra assistance through Medicaid. Such an opt-out procedure would (1) let consumers protect their privacy; (2) permit those who dislike Medicaid to remain outside the program; while (3) increasing the likelihood that consumers who have difficulty with basic daily activities and need services that go beyond Marketplace coverage learn about, apply for, and receive Medicaid assistance with additional services.

An essential adjunct to this policy would let beneficiaries demonstrate disability, under SSI standards, to state-contracting medical examiners. This is already occurring in some states with disability-based eligibility categories that do not require action by the Social Security Administration (SSA). Such alternatives to SSA’s disability-determination system can produce much faster results, shortening the interim period during which Medicaid-eligible people with disabilities receive QHP coverage. An independent system could also yield more accurate disability findings in ways that benefit people with disabilities.¹⁰⁵

Another policy component would combine the above enrollment strategies with the use of ACA

§1332 to increase the range of buy-in programs. This section authorizes “state innovation” waivers through which states can rearrange ACA’s federally-funded marketplace subsidies and requirements for employer contributions. To obtain a waiver, a state must show that federal budget deficits will not increase, aggregate coverage will not decline, and consumers will not lose benefits or cost-sharing protections. CMS has made clear that such waivers can be combined with Medicaid and CHIP waivers under Social Security Act §1115.

State innovation waivers under §1332 cannot be implemented until 2017. To date, CMS has promulgated regulations describing the procedural requirements for obtaining such waivers, but substantive rules have not been proposed. One key topic that the latter rules would address involves the standards for assessing federal budget neutrality.

Depending on how substantive regulations under §1332 are structured, state innovation waivers could modify the current prohibition against using Medicaid buy-in programs to supplement federally-subsidized QHP coverage. Because ACA denies tax credits to people who receive minimum essential coverage through Medicaid, those who qualify for buy-in programs must choose between Medicaid and subsidized QHP coverage. However, Section 1332 directly authorizes waivers of those tax credit restrictions.¹⁰⁶

Some policymakers may prefer mainstreaming people with disabilities’ receipt of care, improving their ability to progress up the economic ladder, and retaining their access to QHP provider networks. These priorities would be advanced if buy-in eligibles could (1) purchase the Medicaid LTSS package of services, (2) on a sliding scale based on income that (3) supplements coverage

of EHBs provided by federally-subsidized QHPs. Wrap-around buy-in coverage would remain available to supplement employer-sponsored insurance, as is currently the case.

One challenge to this approach involves Section 1332's requirement of federal budget neutrality. Some Medicaid savings would result from using QHPs, which cannot adjust premiums to reflect enrollee risk, as explained earlier. The case for federal budget neutrality would be strengthened to the extent that people with disabilities, given this new coverage opportunity, could progress farther and faster up the employment ladder. Their increased earnings would yield several favorable federal budget outcomes:

- Higher income-based health insurance payments from beneficiaries, which would reduce the need for federally-funded support, whether provided through Medicaid or QHP subsidies;
- Increased federal income tax and payroll tax revenues; and
- Reduced use of other federally-funded benefits, including SSI and Social Security Disability Insurance.

Under this approach, the Federal Government's share of full-scope Medicaid buy-in coverage would be replaced by a combination of (1) federal QHP subsidies; and (2) federal Medicaid funding of supplemental LTSS coverage. Whether these federal costs increase or fall, on net, would likely vary with the state and enrollee. Two factors are likely to prove fundamental to this cost calculus: beneficiary income, which determines the generosity of federal QHP subsidies; and the underlying cost of QHP coverage of EHBs,

compared to Medicaid coverage of those services.

On the other hand, this approach could increase other federal expenses. Placing costly consumers into the Marketplace would raise premiums in the individual market as a whole, which would increase QHP subsidies for other Marketplace participants. (Insurance costs would also rise for consumers who purchase individual coverage without subsidies, as noted earlier.¹⁰⁷) That said, per capita premium increases could be quite modest, since the added risks will be spread throughout the entire individual market, and competition between insurers holds down QHP premiums. One variant to consider would combine this approach with reinsurance payments that limit (or entirely prevent) increased individual market premiums that would otherwise result. However, any federal funding for such payments would presumably factor into the budget neutrality calculation.

LTSS

Financial alignment demonstrations for dual eligibles

The body of the report includes a long list of LTSS issues to monitor when a state implements a demonstration project that aligns Medicaid and Medicare for dual eligibles. If that monitoring suggests that people with disabilities are being harmed or are not receiving the promised benefits of such a demonstration, both federal and state policy responses are possible. Those responses are described below, in the context of future federal and state policy choices.

Community First Choice

ACA's "Community First Choice" (CFC) Medicaid option for expanded coverage of home- and

community-based services (HCBS) has received considerable analysis elsewhere,¹⁰⁸ but one issue is important to address here. Unlike HCBS provided under pre-ACA waivers, the CFC option includes neither caps nor waiting lists. All consumers who qualify must receive covered services.

ACA provides an enhanced FMAP for CFC coverage. Five states had taken up this option by July 2015, despite the absence of caseload controls that many state officials see as an important to containing costs.¹⁰⁹ Like other HCBS, the CFC option is governed by new federal regulations that seek to ensure that services are provided in true home- and community-based settings.¹¹⁰

The absence of enrollment caps or waiting lists and the opportunity for enhanced FMAP create the possibility that the CFC option could replace services furnished under previous HCBS waivers. Careful monitoring may be required to prevent people with disabilities from inadvertently suffering harm. For example, if CFC services are provided in community settings that are more institutional than those in which pre-ACA waiver services were provided, CFC implementation could have the unintended effect of increasing rather than reducing the institutional character of a state's coverage of HCBS.

Recurring Annual Decisions Federal Decisions

As explained in the body of the report, CMS publishes annual rules governing (1) the individual market and (2) demonstration projects that integrate Medicare and Medicaid services

for dual eligibles. These proceedings provide vehicles to address emerging problems that may undermine people with disabilities' receipt of essential services. The most promising such vehicles, all of which are described above, are likely to be

- Annual Notices of Benefit and Payment Parameters (NBPP), which have already been used to revise EHBs and other policies governing the individual market (including QHPs);
- Annual letters to health insurance issuer that set out policies for the FFM; and
- For dual eligible demonstrations, annual revisions to "Medicare-Medicaid Plan" (MMP) contract requirements and reporting requirements. These revisions affect capitated, private insurers' provision of Medicare and Medicaid services, including LTSS. They do not, however, directly govern the small number of states (three, as of June 2015) that use other integration methods, such as state-organized, fee-for-service systems.

The disability community's use of these annual, federal venues will depend on the issues that emerge nationally over time and the resulting evidence that can be put forward to show the need for change. However, even at this early juncture, several issues appear worth considering:

- It is not clear why, for EHB purposes, states should be able to use a narrower definition of "habilitative services and devices" than

Unlike HCBS provided under pre-ACA waivers, the CFC option includes neither caps nor waiting lists.

the definition set out in federal regulations—namely, “health care services and devices that help a person keep, learn, or improve skills and functioning for daily living.”¹¹¹ It is likewise unclear why a state should be able, by constraining its definition, to let plans (1) cover fewer habilitative than rehabilitative services and (2) apply a common limit to all habilitative and rehabilitative services, rather than separate limits for each of these two service categories. The health care needs that led to the federal definition of habilitative services and devices are not affected by the state in which a person with disabilities happens to reside.

In analyzing whether EHBs in all states should meet the federal definition, it will be important to document how states have used their authority to depart from this definition. Before CMS promulgated regulations defining “habilitative services and devices,” several states crafted their own definitions that were similar but not identical to the definition later selected by CMS.¹¹² Other states simply required insurers to offer habilitative services in parity with rehabilitative services.¹¹³ With data-gathering ongoing, it remains to be seen how states will modify their definitions in response to the federal definition announced in February 2015.

- As noted earlier, the FFM is implementing accessibility standards for consumer

assistance programs that go beyond the minimum requirements that apply to SBMs. If problems emerge in SBMs’ approach to consumer assistance, it may become important to raise minimum federal standards, perhaps incorporating promising FFM practices as a starting point.

- CMS decided, in the NBPP for 2016, not to require QHP provider directories to include information about particular providers’ accessibility to people with disabilities.¹¹⁴ Without that information, it will be difficult if not impossible for many people with disabilities to decide which QHP best meets their needs.

As observed in the body of the report, CMS received a comment that provider directory requirements could be interpreted in a fashion that is not helpful to people with disabilities. Those requirements, according to the comment, could be viewed as implying that providers can serve federally subsidized consumers without making services accessible to people with disabilities, as required by the Americans with Disabilities Act and section 504 of the Rehabilitation Act.

However, nothing prevents CMS from accompanying a requirement for provider directories with a regulatory preamble noting that compliance with directory requirements does not relieve a provider from accessibility obligations under other statutes and regulations. CMS has already used similar language to accompany EHB

[I]t remains to be seen how states will modify their definitions in response to the federal definition [of “habilitative services and devices”] announced in February 2015.

regulations forbidding discriminatory health plan designs.¹¹⁵ Moreover, provider directories could be required to include information about where each provider falls on a spectrum of accessibility levels, each of which meets applicable requirements under the ADA and Section 504. Such a standard would not implicitly endorse provider accessibility below listed levels.

- In a similar vein, regulations promulgated in February 2015 do not make special provisions for reporting about prescription drug formularies’ covered drugs and cost-sharing tiers; instead, CMS relied on general requirements for providing information about health plan coverage.¹¹⁶ If experience shows that such general requirements leave too much “wobble room” for underreporting formulary information, disability-rights advocates could urge CMS to promulgate more specific rules that govern formularies.

- Federal network adequacy standards include no requirements that are specifically directed to people with disabilities’ need for accessible services and specialty care, as noted earlier. CMS has indicated that, once the National Association of Insurance Commissioners (NAIC) releases a forthcoming revision of

the NAIC model law on network adequacy, CMS would reexamine its regulations on this subject. Now that the NAIC has released its model law,¹¹⁷ the NBPP could be used to add safeguards for people with disabilities, along the lines discussed above in connection with states’ network adequacy standards.

- Monitoring of beneficiary experiences with Medicare/Medicaid financial alignment demonstrations could indicate a need to tighten federal safeguards. Already,

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beneficiary focus groups and presentations from consumer assistance programs suggest that, in some cases, efforts to educate consumers may be falling far short of their goals, with beneficiaries experiencing significant confusion and sometimes being unable to obtain care despite repeated

attempts;¹¹⁸ some managed care plans are frequently unable to reach enrollees to conduct assessments and develop care plans; and overall enrollment levels in some states appear to be falling short of projections.¹¹⁹ Demonstration evaluations should be carefully tracked, as they could provide other useful information about these initiatives’ effects on beneficiaries. In addition to a national evaluation commissioned by CMS, individual states are obtaining separate evaluations. Some results of state-commissioned evaluations are likely to become available before the national evaluation is released.¹²⁰

State Decisions

Two recurring procedures mentioned in the body of the report could be important to consider, depending on emerging problems experienced by people with disabilities in the individual market or financial alignment demonstrations.

First, in most states insurers need the Department of Insurance to approve annual plan designs, and QHPs must be certified by the Marketplace each year in order to participate. States vary enormously in the scrutiny they apply to health plan offerings. Regardless of the state's general practice, if a particular insurer has been problematic in its approach to people with disabilities, annual proceedings before an insurance regulator and/or Marketplace may furnish a useful opportunity to raise concerns about the insurer's performance. Even if such interventions do not result in an insurer losing the right to offer coverage, they can lead to tighter state requirements or monitoring that improve the insurer's future service to people with disabilities.

Second, as explained in the body of the report, when private insurers cover Medicare and Medicaid services under financial alignment demonstrations, three-way contracts among CMS, the state, and the MMP set the terms on which services are provided. These contracts are passively renewed each year, unless one of the parties raises concerns. Such annual renewals may present an opportunity for people with disabilities and their representatives to raise concerns about any emerging problems. They

[I]f a particular insurer has been problematic in its approach to people with disabilities, annual proceedings before an insurance regulator and/or Marketplace may furnish a useful opportunity to raise concerns about the insurer's performance.

could also be used to suggest steps to ensure that beneficiaries realize promised gains from service integration, including care coordination, coverage of additional benefits, and additional cost-sharing protections. Such issues can be raised with the plan, the state, federal officials, or some combination of the three. A positive outcome from such efforts can involve changing the conditions of the contract to benefit people with disabilities or, with particularly serious problems of plan performance, contract termination.

Note: As a related, ongoing strategy, people with disabilities and their advocates can join advisory groups or implementation councils for Financial Alignment demonstrations. Such participation can offer both information about and opportunities to influence these evolving mechanisms for integrated financing and service delivery.¹²¹

Other Future Federal Decisions

Several other future federal decisions noted in the body of the report would benefit from further analysis.

EHB Updates

Federal EHB rules are slated for periodic future updating. No fixed, statutory schedule governs the updates, which must take into account whether "enrollees are facing any difficulty accessing needed services for reasons of coverage or cost" and "changes in medical evidence or scientific advancement."¹²²

ACA proscribes a two-step process for updating benefits: publication of an HHS report, followed by EHB changes that reflect the report's findings. Notice and comment procedures provide an important, though sub-optimal, forum in which to share the experiences of people with disabilities with federal policymakers. To have greater impact in shaping federal EHB changes, it may be important to communicate the experiences of people with disabilities on an ongoing basis, well before HHS issues its EHB report.

It is not obvious precisely how HHS will implement the statutory requirement for updating EHBs. ACA appears to contemplate the promulgation and revision of detailed federal standards that specify the amount, duration, and scope of services within each of 10 EHB categories. However, CMS has eschewed such a role, instead deferring to state choices of EHB-benchmark plans, as explained earlier.

When it first described how EHBs would be defined by letting states choose from among benchmark plans, CMS explained that it intended "to propose a process to evaluate the benchmark approach."¹²³ No process has yet been announced, but this comment flags one possible change to EHBs—namely, increasing the federal role in specifying benefit details. At least in theory, this could involve a wholesale abandonment of the benchmark plan approach, instead shifting to a federally-specified set of amount, duration, and scope rules for each EHB category.

Such a significant change of approach could meet with resistance from policymakers who wish to avoid the reality or appearance of a very strong federal role in specifying the details of covered benefits throughout the country's diverse individual and small-group markets. However, once the above-described option for

§1332 waivers becomes available in 2017, a state could obtain such a waiver to depart from any newly detailed federal EHB standards. This ability of states to escape federal requirements could lessen, to some degree, concerns about a federal role some may see as overly intrusive.

Alternatively, if people with disabilities experience emerging problems with particular benefits—for example, durable medical equipment, which is included within the broader EHB category of "rehabilitative and habilitative services and devices"—HHS could create, for those particular benefits, minimum federal standards that go beyond benchmark coverage. Current regulations have already taken that step with habilitative services and prescription drugs, so there is a precedent to take similar future steps if needed to address new problems.

The disability community could also seek to change the menu of benchmark options. An option that has been problematic in the coverage it offers to people with disabilities could be removed from the approved list. CMS could also make new benchmark options available to states. A precedent for the latter is provided by current regulations that go beyond commercial coverage to give states the option to use CHIP benefits as the benchmark for EHB that involves children's dental and vision care.^{124,125}

Another issue that could warrant reexamination is the option for plans to provide substitute benefits, based on actuarial equivalence. It is hard to envision CMS entirely abandoning such actuarial equivalence. CMS's first EHB bulletin explained, "Permitting flexibility would provide greater choice to consumers, promoting plan innovation through coverage and design options, while ensuring that plans providing EHBs offer a certain level of benefits."¹²⁶

On the other hand, that same bulletin showed that CMS understood the potential need to limit substitution:

The Affordable Care Act also directs the Secretary to consider balance in defining benefits and to ensure that health insurance issuers do not discriminate against enrollees or applicants with health conditions. Providing guidelines for substitution will ensure that health insurance issuers meet these standards.¹²⁷

If the current regulatory approach to substitute benefits results in problems for people with disabilities, targeted limitations on particular, problematic kinds of substitution and actuarial equivalence is likely to prove more acceptable to CMS than a wholesale repeal of all benefit substitution options.

Federal Enforcement

States are generally responsible for enforcing ACA's requirements that govern the private market, including QHPs. However, as explained in the body of the report, the Federal Government assumes enforcement responsibility if either (1) a state provides notice that it is not enforcing federal laws or (2) CMS determines that a state is failing to substantially enforce applicable requirements.

In a number of states, the disability community may view state insurance regulators and Marketplaces as unduly sympathetic to the insurance industry. Some may thus advocate for CMS to assume enforcement responsibilities.

However, many observers also view CCIIO as highly receptive to insurance industry concerns; and the past history of federal enforcement of private health insurance laws does not provide grounds for optimism, given capacity constraints facing federal agencies. When state enforcement gaps appear, the Department of Labor is responsible for enforcing insurance market safeguards, under several pre-ACA federal statutes, and very little federal enforcement activity has taken place. Experience overseeing the private insurance industry is substantially deeper at the state than the federal level, and federal health agencies are not staffed to take on labor-intensive enforcement duties overseeing the individual market.

Conclusion

Federal and state policymakers implementing ACA face a broad range of disparate choices that could have a significant impact on people with disabilities. A well-informed disability community has the potential to influence those decisions. Given the large number of choices in play, it will be important for people with disabilities and their representatives to make careful judgments about prioritization. By combining wise choices about issue focus, solid evidence of effects on people with disabilities, and policy remedies that are carefully crafted to take into account the full range of policymakers' likely concerns, the disability community can help people with disabilities avoid the major risks posed by ACA while achieving many of the gains promised by this landmark legislation.

Endnotes

- 1 42 USC 300k(a)(1)(A), enacted in ACA §4302(a).
- 2 42 USC 300k(a)(1).
- 3 42 USC 300k(b), (c).
- 4 42 USC 300k(h).
- 5 42 USC 300k(a)(2)(D).
- 6 See 42 USC §§ 1396a(a)(76) [Social Security Act §1902a], 1397hh(e)(7) [Social Security Act §2108], 1396w-5 [Social Security Act §1946], enacted by ACA §4302(b).
- 7 Covered surveys collect data from self-reports or respondents who serve as household representatives.
- 8 U.S. Department of Health and Human Services (HHS), Oct. 2011, "Implementation Guidance On Data Collection Standards For Race, Ethnicity, Sex, Primary Language, And Disability Status," <http://aspe.hhs.gov/datacncl/standards/ACA/4302/index.shtml>, cited in Rashida Dorsey and Garth Graham, "New HHS Data Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status," *JAMA* December 7, 2011, 306 (21): 2378-79. See also Virginia S. Cain, National Center for Health Statistics, "HHS Data Standards for Race, Ethnicity, Sex, Primary Language and Disability Status," http://www.cdc.gov/nchs/data/bsc/CAIN_Data_standards.pdf (undated).
- 9 HHS, Nov. 2014, "Report to Congress Improving the Identification of Health Care Disparities in Medicaid and CHIP," <http://www.medicare.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/4302b-rtc-2014.pdf>. For the T-MSIS data elements corresponding to the questions about disability in the text, see Center for Medicare and Medicaid Services (CMCS), Nov. 2013, "T-MSIS Data Dictionary Appendices, Version Nov13v1.1," <http://www.medicare.gov/medicaid-chip-program-information/by-topics/data-and-systems/downloads/t-msis-data-dictionary.zip>. For more information about T-MSIS, see CMS, Aug. 23, 2013, "Transformed Medicaid Statistical Information System (T-MSIS) Data," SMD 13-004, <http://www.medicare.gov/Federal-Policy-Guidance/Downloads/SMD-13-004.pdf>.
- 10 National Quality Forum is conducting a project to develop a conceptual framework and perform an environmental scan to address gaps in performance measures for HCBS. This project seeks to enhance the quality of community living.
- 11 The most recent versions include AHRQ, March 2014, "Health Care Coverage Analyses of the National Health-care Quality and Disparities Reports: 2000-2008 Trends," <http://www.medicare.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/health-coverage-analyses-of-nhqr-2000-2008-trends.pdf>; and AHRQ, May 2014, "National Healthcare Disparities Report, 2013," <http://www.ahrq.gov/research/findings/nhqrdr/nhdr13/index.html>.
- 12 AHRQ, 2013 National Healthcare Disparities Report, "Priority Populations Appendix," October 2014 www.ahrq.gov/research/findings/nhqrdr/nhqrdr13/prioritypopsapp.html. The report discusses functional limitations in the context of patients receiving home health care, nursing home services and inpatient care. "Chapter 3 Effectiveness of Care Across the Lifespan," www.ahrq.gov/research/findings/nhqrdr/nhqr13/chap3a.html#fig316.
- 13 45 CFR §§ 155.205(c)(1), (c), (d) (e), 155.230(b).
- 14 45 CFR 156.250.
- 15 This count includes so-called "partnership" Marketplaces and "federally supported" Marketplaces, both of which are governed by FFM rules. Kaiser Family Foundation, 2015, "State Health Insurance Marketplace Types, 2015," State Health Facts, <http://kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/>. Information as of June 2015.
- 16 45 CFR 155.215(d).

- 17 Ibid.
- 18 45 CFR 156.225(d)(5).
- 19 On December 2, 2015, CMS published proposed regulations modifying consumer information and network adequacy standards. This roadmap does not address that draft rule. See HHS, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017; Proposed Rule," 80 Federal Register 75488 (December 2, 2015), <http://www.gpo.gov/fdsys/pkg/FR-2015-12-02/pdf/2015-29884.pdf>.
- 20 45 CFR 156.230(a)(2).
- 21 HHS, Feb. 27, 2015, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016; Final Rule," 80 FR 10750, 10833.
- 22 Draft Standards are available online at <http://www.Access-Board.gov>. Final standards have not been released as of October 2015.
- 23 On its face, this provision appears to cover Marketplaces; QHPs that receive tax credits or subsidies; insurers that enter into contracts that provide federal funding through Medicaid, Medicare, CHIP, or the Federal Employee Health Benefit Program; and perhaps health care providers who receive payments from such QHPs or contracting insurers. Depending on how the statute is interpreted in the coming years, this prohibition may also apply to state agencies, including insurance regulators.
- 24 Notwithstanding that prohibition, 42 CFR 156.125(e) protects an insurer's ability to "appropriately utilize[e] reasonable medical management techniques."
- 25 On September 8, 2015, HHS issued proposed regulations interpreting Section 1557. This roadmap does not address that draft rule. See HHS, "Nondiscrimination in Health Programs and Activities; Proposed Rule," 80 Federal Register 54172 (September 8, 2015), <http://www.gpo.gov/fdsys/pkg/FR-2015-09-08/pdf/2015-22043.pdf>.
- 26 OCR (undated). "Section 1557 of the Patient Protection and Affordable Care Act," <http://www.hhs.gov/ocr/civilrights/understanding/section1557/>.
- 27 Request for Information Regarding Nondiscrimination in Certain Health Programs or Activities published in the Federal Register on August 1, 2013; <https://www.federalregister.gov/articles/2013/08/01/2013-18707/request-for-information-regarding-nondiscrimination-in-certain-health-programs-or-activities>. This request for information specifically asked for information about experiences with, and examples of, disability-based discrimination in health programs and activities.
- 28 HHS, Sept. 8, 2015, Nondiscrimination in Health Programs and Activities; Proposed Rule, 80 FR 54172-54220, <http://www.gpo.gov/fdsys/pkg/FR-2015-09-08/pdf/2015-22043.pdf>.
- 29 HHS, Notice of Benefit and Payment Parameters for 2016, at 10822.
- 30 45 CFR 147.150(a). EHB requirements do not govern "grandfathered" plans that have not changed their terms substantially since before the application of ACA's insurance market reforms.
- 31 ACA Section 1302(b)(1)(G).
- 32 HHS, Notice of Benefit and Payment Parameters for 2016, at 10811. See 45 CFR 156.110(f).
- 33 45 CFR 156.115(a)(5)(i), added by HHS, Notice of Benefit and Payment Parameters for 2016.
- 34 45 CFR 156.115(a)(5)(ii) and (iii).
- 35 HHS, Notice of Benefit and Payment Parameters for 2016, at 10811.
- 36 One area that may warrant additional analysis involves ACA §2402(a), which directs HHS to issue regulations that remove various barriers to the receipt of HCBS.
- 37 CMS, July 8, 2011, "Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees," SMDL 11-008, ACA 18, http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf.
- 38 CMS, July 8, 2011, "Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees," SMDL 11-008, ACA 18, http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf.

- CMS, Oct. 2011, "Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees: Standards and Conditions," <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FADemonstrations-StandardsandConditionswithCoverPage.pdf>.
- 39 CMS, Page last Modified: 02/25/2015, "Approved Demonstrations - Signed MOUs," <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/ApprovedDemonstrationsSignedMOUs.html>.
- 40 <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FundingtoSupportOmbudsmanPrograms.html>.
- 41 CCIIO, undated, "Information on Essential Health Benefits (EHB) Benchmark Plans," <https://www.cms.gov/ccio/resources/data-resources/ehb.html>.
- 42 Unless prohibited by a state, health plans can substitute actuarially equivalent services, within an EHB category, for the coverage offered by the state's benchmark plan. This substitution is prohibited, however, for EHB prescription drugs, to which other regulatory standards apply. 45 CFR §156.115(b). For prescription drug standards, see the amended provisions of 45 CFR 156.122 contained in HHS, Notice of Benefit and Payment Parameters for 2016, at 10871.
- 43 In most states, these standards are promulgated by the Department of Insurance (or another insurance regulatory agency) and apply to all plans sold in the individual or "nongroup" market, including QHPs. In some states, Marketplaces supplement these standards and apply additional certification requirements to QHPs.
- 44 CMS, July 15, 2013, "Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment; Final Rule." 78 Federal Register 42160, 42191.
- 45 See, e.g., 45 CFR 153.320(a).
- 46 HHS, Notice of Benefit and Payment Parameters for 2016.
- 47 As noted earlier, this count includes all states with Marketplaces that are subject to FFM rules; such states use the federal healthcare.gov platform to offer QHPs.
- 48 See, e.g., CCIIO, Feb. 20, 2015, "FINAL 2016 Letter to Issuers in the Federally-facilitated Marketplaces," <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016-Letter-to-Issuers-2-20-2015-R.pdf>.
- 49 CMS, Feb. 23, 2015, "Medicare-Medicaid Plan Annual Requirements and Timeline for CY 2016," <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/2016MMPAnnualRequirements.pdf>.
- 50 CMS, April 7, 2015, "Medication Therapy Management Program Guidance and Submission Instructions," http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/2016_MTMAAnnualRequirements.pdf.
- 51 See, e.g., CMS, April 6, 2015, "Announcement of Calendar Year (CY) 2016 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter," <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2016.pdf>.
- 52 See CMS, April 7, 2015, "Applicability of Final Call Letter Provisions to Medicare-Medicaid Plans," <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/2016MMPFinalCallLetter040715.pdf>.
- 53 CMS, March 6, 2015, "Update to Contract Year 2015 Medicare-Medicaid Plan Reporting Requirements," <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FinalCY2015CoreReportingMemo030615.pdf>.
- 54 45 CFR 153.100.
- 55 CMS, "Three Way Contract" for South Carolina, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/SouthCarolinaContract.pdf>; "Three Way Contract" for California, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CACContractwithoutSub.pdf>.

- 56 In Colorado, Minnesota, and Washington, the MOUs cover the periods from, respectively, July 1, 2014 through December 31, 2017; September 13, 2013, through December 31, 2016; and April 1, 2013 through December 31, 2016. CMS, Feb. 28, 2014, “MOU Between CMS And The State of Colorado,” <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/COMOU.pdf>; CMS, Sept. 12, 2013, “MOU Between CMS And The State of Minnesota,” <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MNMOU.pdf>; CMS, Oct. 24, 2012, “MOU Between CMS And The State of Washington,” <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/WAMFFSMOU.pdf>.
- 57 Many important state budget decisions are made between the enactment of standard annual or biennial budgets—for example, when a previously adopted budget is revised. Special legislative sessions and legislative attempts to override gubernatorial vetoes can provide further budget-related opportunities to change state Medicaid policy.
- 58 Public Law -148 – March 23, 2010 www.gpo/fdsys/pkg/PLAW-111publ148.pdf.
- 59 *Ibid.*, p.768.
- 60 *Ibid.*
- 61 *Ibid.*, p.46.
- 62 45 CFR 150.203.
- 63 CCIIO, undated, “Compliance,” <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/compliance.html>.
- 64 Architectural and Transportation Barriers Compliance Board, Feb. 8, 2012, “Proposed Accessibility Standards for Medical Diagnostic Equipment,” <http://www.access-board.gov/attachments/article/664/nprm.pdf>.
- 65 For a discussion of waivers proposed and granted to date, see Robin Rudowitz, Samantha Artiga, and MaryBeth Musumeci, Feb. 2015, “The ACA and Medicaid Expansion Waivers,” Washington, DC: Kaiser Commission on Medicaid and the Uninsured, <http://files.kff.org/attachment/issue-brief-the-aca-and-medicaid-expansion-waivers>.
- 66 Public Health Service Act §3101(h) [42 USC 300k(h)].
- 67 Public Health Service Act §3101(h) [42 USC 300k(h)].
- 68 These provisions are codified in Social Security Act §§ 1902(a)(76) and 2108(e)(7) [42 USC §§1396a(a)(76), 1397hh(e)(7)].
- 69 HHS, Nov. 2014, “Report to Congress Improving the Identification of Health Care Disparities in Medicaid and CHIP,” <http://www.medicare.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/4302b-rtc-2014.pdf>.
- 70 See, e.g., National Quality Forum, Addressing Performance Measure Gaps in Home and Community-Based Services to Support Community Living: Initial Components of the Conceptual Framework: Interim Report, July 15, 2015, <http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=79920>.
- 71 In monitoring TMSIS implementation, it is important to distinguish between information about (1) Medicaid eligibility categories that are based on the Supplemental Security Income (SSI) definition of disability, which is extremely restrictive; and (2) the six questions about potential disability status that were adopted in 2011, pursuant to ACA §4302, and that are set out in the body of the report. Only if answers to the latter questions are incorporated into TMSIS data will policymakers and the public learn how well Medicaid serves a broad range of people with disabilities, many of whom do not receive Medicaid based on SSI disability. The latter group will be particularly large in states that expand Medicaid eligibility to include all non-elderly adults with incomes up to 138 percent of the FPL because numerous people with disabilities will be able to qualify in those states based on income alone.
- 72 Such competition will primarily involve consumers who are ineligible for federal subsidies. Most who qualify for subsidies are likely to favor QHPs over other individual plans, since subsidies can be used only with QHPs.
- 73 28 CCR 1300.67.2.2 (c)(7)(B).

- 74 See, e.g., National Disability Navigator Resource Collaborative, 2014, "Fact Sheet #8: Medically Frail Status as an Exemption to Receiving Medicaid Alternative Benefit Plan with Essential Health Benefits," Washington, DC: American Association on Health and Disability, <http://www.nationaldisabilitynavigator.org/wp-content/uploads/Materials/Fact-Sheet-8-medically-frail-ABP.pdf>.
- 75 Kaiser Commission on Medicaid and the Uninsured, Sept. 2012, "Medicaid Financing: An Overview of the Federal Medicaid Matching Rate (FMAP)," <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8352.pdf>. ACA established some elevated FMAP rates for various categories of care, such as for HCBS coverage under Social Security Act Section 1915(k) and the first eight quarters of health home services.
- 76 CMS has made clear that: (1) given more than one basis for Medicaid eligibility, the consumer can select his or her eligibility category; and (2) as long as a low-income adult has not received a formal determination of disability, under the same standards that apply to SSI, the state can claim the highly enhanced FMAP that applies to low-income adults. CMS, March 23, 2012, "Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010. Final Regulations." Federal Register. Vol. 77, No. 57. 17144; CMS, May 22, 2012. "Medicaid/CHIP Affordable Care Act Implementation. Answers to Frequently Asked Questions: Eligibility Policy." <http://www.medicaid.gov/state-resource-center/FAQ-medicaid-and-chip-affordable-care-act-implementation/downloads/Eligibility-Policy-FAQs.pdf>.
- 77 42 CFR 435.916(a)(2).
- 78 Even before ACA, Medicaid regulations required states to make "ex parte" redeterminations of eligibility, whenever possible. Put differently, renewal was required, without asking anything from the enrollee, whenever information available to the state demonstrated continuing eligibility. See, e.g., Health Care Financing Administration. April 7, 2000, and April 22, 1997, Dear State Medicaid Director letters, <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd040700.pdf>, <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD042297.pdf>. These requirements were not always followed, however.
- 79 These policies did not involve Express Lane Eligibility, an option through which children who receive other public benefits are deemed eligible for Medicaid. Southern Institute on Children and Families, March 2009, "Medicaid and CHIP Retention: A Key Strategy to Reducing the Uninsured," <http://www.thesoutherninstitute.org/docs/publications/MedicaidCHIPRetention.pdf>.
- 80 In a small number of so-called "209(b) states," SSI recipients do not automatically qualify for Medicaid. Some states also make recipients of SSI state supplemental payments ineligible for Medicaid.
- 81 Wisconsin Department of Health Services, July 27, 2011, "3.1.5 Administrative Renewals," Medicaid Eligibility Handbook Release 11-02, <https://www.dhs.wisconsin.gov/medicaid/meh-coversheet-11-02.pdf>.
- 82 David Goldfarb and Joseph Rosenberg, 2012, "9.09 Recertification, Reauthorization and Tape Matches," New York Elder Law, Danvers, MA: Mathew Bender and Company.
- 83 Tricia Brooks, Feb. 2009, "The Louisiana Experience: Successful Steps to Improve Retention in Medicaid and SCHIP," Washington, DC: Georgetown University Health Policy Institute Center for Children and Families, <http://ccf.georgetown.edu/wp-content/uploads/2012/04/The-Louisiana-Experience.pdf>.
- 84 See 42 CFR 435.1015; CMS, March 2013, "Medicaid and the Affordable Care Act: Premium Assistance," <http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf>.
- 85 CMS, Medicaid and the Affordable Care Act: Premium Assistance.
- 86 Plans with healthier-than-average members pay into the risk-adjustment system, and those with sicker-than-average members are reimbursed by the risk-adjustment system. This has the effect of shifting premium dollars from the former to the latter plans. This system seeks to pool all risk within the individual market, so that premiums reflect that market's average risk, rather than the risk level among the members of a particular plan.
- 87 CMS, Medicaid and the Affordable Care Act: Premium Assistance.
- 88 Nearly two in five (39 percent) QHP-sponsoring issuers offered Medicaid managed care plans as well. Association for Community-Affiliated Plans, updated January 2015, "Overlap Between Medicaid Health Plans and QHPs in the Marketplaces: An Examination," <http://www.communityplans.net/Portals/0/2015%20ACAP%20QHP%20Analysis%20Brief.pdf>.

- 89 45 CFR 156.1250(c).
- 90 Letter from Marilyn Tavenner, CMS Administrator, to John Selig, Director, Arkansas Department of Human Services, December 31, 2014, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-ca.pdf>.
- 91 Medicaid and CHIP Payment and Access Commission, March 2015, "CHAPTER 5: Premium Assistance: Medicaid's Expanding Role in the Private Insurance Market," Report to Congress on Medicaid and CHIP, <https://www.macpac.gov/wp-content/uploads/2015/03/March-2015-Report-to-Congress-on-Medicaid-and-CHIP.pdf>.
- 92 ACA §1302(b)(1).
- 93 45 CFR 156.100(a).
- 94 45 CFR 156.100(c).
- 95 They are, in order, the second-largest small-group plan, the third-largest small-group plan, and the largest national plan that serves federal employees (with size, in each case, determined by enrollment). For supplementing the general benchmark plan to provide pediatric oral and dental benefits, the state can choose between the most highly-subscribed plan for federal employees and CHIP benefits. If the state does not make a decision, the former plan becomes the benchmark for oral and dental pediatric coverage. 45 CFR 156.100 (b)(2) and (c).
- 96 45 CFR 156.115(a).
- 97 45 CFR 156.115(b). For the certification that a plan's actuary must complete to offer substitute benefits, see CCIIO, "EHB-Substituted Benefit (Actuarial Equivalent) Supporting Documentation and Justification," <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Chapter10cEHBSubstitutedBenefitJustification-Ver1-021315.pdf> (undated).
- 98 For prescription drug standards, see 45 CFR 156.122, as revised in HHS, Feb. 27, 2015, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016; Final Rule," 80 Federal Register 10750, 10871.
- 99 ACA's language apparently requires states to pay the cost of benefit mandates that exceed EHB, regardless of when those mandates went into effect. ACA § 1311(d)(3)(B). However, state benefit mandates in effect during calendar year 2012 were met by all benchmark plans except those offered to federal employees. As a result, CMS relieved states of the need to pay for benefit mandates in effect during 2012. This decision was characterized as a "transition" policy, in effect for 2014 and 2015 and subject to reexamination for 2016 and beyond. CCIIO, December 16, 2011, "Essential Health Benefits Bulletin," http://www.cms.gov/CCIIO/Resources/Files/Downloads/essential_health_benefits_bulletin.pdf. However, EHB standards enacted for 2016 did not revisit the issue. HHS, Notice of Benefit and Payment Parameters for 2016.
- 100 45 CFR 156.110(d), 156.115(a)(5), 156.125. See also HHS, Notice of Benefit and Payment Parameters for 2016, 80 Federal Register at 10811.
- 101 See generally Justin Giovannelli, Kevin W. Lucia, and Sabrina Corlette, Oct. 2014, "Implementing the Affordable Care Act: Revisiting the ACA's Essential Health Benefits Requirements, prepared by the Georgetown University Center on Health Insurance Reforms for the Commonwealth Fund," http://www.commonwealthfund.org/~media/files/publications/issue-brief/2014/oct/1783_giovannelli_implementing_aca_essential_hlt_benefits_rb.pdf.
- 102 ACA forbids premiums from varying based on health risk factors. Accordingly, plans are likely to compare (1) the increased costs expected to result from enrolling high-cost populations to (2) the anticipated risk-adjustment and reinsurance payments that would accompany those populations. Plans have an incentive to avoid high-cost populations whose anticipated costs exceed premiums plus projected risk-adjustment and reinsurance payments.
- 103 Vernon K Smith, Ph.D., Kathleen Gifford, Eileen Ellis, Robin Rudowitz, and Laura Snyder, Oct. 2014, "Medicaid in an Era of Health & Delivery System Reform: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2014 and 2015," Health Management Associates and Kaiser Family Foundation, <http://files.kff.org/attachment/medicaid-in-an-era-of-health-delivery-system-reform-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2014-and-2015-report>.

- 104 See, e.g., Diane Schanzenbach, 2009, "Experiment Estimates of the Barriers to Food Stamp Enrollment," Madison, WI: Institute for Research on Poverty, University of Wisconsin- Madison; Eric P. Bettinger, Bridget Terry Long, Philip Oreopoulos, and Lisa Sanbonmatsu, Sept. 2009, "The Role Of Simplification And Information In College Decisions: Results From The H&R Block FAFSA Experiment," National Bureau of Economic Research Working Paper 15361; Glenn Flores, Milagros Abreu, Christine E. Chaisson, Alan Meyers, Ramesh C. Sachdeva, Harriet Fernandez, Patricia Francisco, Beatriz Diaz, Ana Milena Diaz, and Iris Santos-Guerrero, 2005, "A randomized, controlled trial of the effectiveness of community-based case management in insuring uninsured Latino children." *Pediatrics*. 116:1433–41. <http://pediatrics.aappublications.org/content/116/6/1433.full.pdf>.
- 105 Ari Ne'eman, 2015, Autistic Self Advocacy Network and National Council on Disability, personal communication.
- 106 Those limits are contained in Internal Revenue Code §§36B(2)(B) and 5000A(f)(1)(A)(ii). ACA §1332(a)(2)(D) expressly authorizes waiving both §§ 36B and 5000A.
- 107 This may result in consumer cost and coverage effects that CMS would need to consider in deciding whether to grant the proposed waiver.
- 108 See, e.g., the Arc, undated, "The Community First Choice (CFC) Option," <http://www.thearc.org/page.aspx?pid=3045>; Elizabeth Dickey, "Understanding Medicaid's Community First Choice Program," Nolo, <http://www.nolo.com/legal-encyclopedia/community-first-choice.html> (undated).
- 109 Kaiser Family Foundation, "Section 1915(k) Community First Choice State Plan Option as of July 2015," State Health Facts, <http://kff.org/medicaid/state-indicator/section-1915k-community-first-choice-state-plan-option/>, See also CMS, "Community First Choice 1915 (k)," <http://www.medicare.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/community-first-choice-1915-k.html>.
- 110 CMS, Jan. 16, 2014, "Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers; Final Rule," 79 Federal Register 2948.
- 111 45 CFR 156.115(a)(5)(i).
- 112 For example, Arkansas defined habilitative services as "Services provided in order for a person to attain and maintain a skill or function that was never learned or acquired and is due to a disabling condition." CCIIIO, undated, "Arkansas EHB Benchmark Plan," <http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/arkansas-ehb-benchmark-plan.pdf>; and California defined them as "medically necessary health care services and health care devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual's environment." CCIIIO, undated, "California EHB Benchmark Plan," <http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/california-ehb-benchmark-plan.pdf>.
- 113 Examples include Delaware and Kansas. See CCIIIO, undated, "Delaware EHB Benchmark Plan," <http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/delaware-ehb-benchmark-plan.pdf>; CCIIIO, undated, "Kansas EHB Benchmark Plan," <http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/kansas-ehb-benchmark-plan.pdf>.
- 114 HHS, Notice of Benefit and Payment Parameters for 2016.
- 115 "We note that other nondiscrimination and civil rights laws may apply, including the Americans with Disabilities Act, section 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, section 504 of the Rehabilitation Act of 1973 and State law. Compliance with § 156.125 is not determinative of compliance with any other applicable requirements." HHS, Notice of Benefit and Payment Parameters for 2016, 80 Federal Register at 10823.
- 116 HHS, Notice of Benefit and Payment Parameters for 2016.
- 117 NAIC, "Health Benefit Plan Network Access and Adequacy Model Act," October 2015, <http://www.naic.org/store/free/MDL74.pdf>.

- 118 Cal MediConnect Ombudsman for LA County, Jan. 21, 2015, “Engaging Consumers in Care,” <http://www.calduals.org/wp-content/uploads/2015/01/January-21-2015-Providers-Summit-Session-3A.pdf>; Gerald Craver, Meredith Lee, and Sarah Broughton, March 23, 2015, “Review of Commonwealth Coordinated Care Beneficiary Focus Groups (CY 2014),” http://www.dmas.virginia.gov/Content_atchs/altc/2014%20Focus%20Group%20Summary%2003.23.15.pdf.
- 119 Cal MediConnect, Engaging Consumers in Care; Virgil Dickson, April 21, 2015, “Future of dual eligible demonstrations questioned due to low enrollment,” Modern Healthcare, <http://www.modernhealthcare.com/article/20150421/NEWS/150429978/future-of-dual-eligible-demonstrations-questioned-due-to-low>.
- 120 Indeed, some of the above findings about problems experienced by waiver programs come from state-commissioned evaluations’ early reports.
- 121 See, e.g., Community Catalyst, Consumer Advisory Committees, <http://www.communitycatalyst.org/resources/tools/meaningful-consumer-engagement/consumer-advisory-committees>.
- 122 ACA § 1302(b)(4)(G) and (H).
- 123 CCIO, Dec. 16, 2011, “Essential Health Benefits Bulletin,” http://www.cms.gov/CCIO/Resources/Files/Downloads/essential_health_benefits_bulletin.pdf.
- 124 45 CFR 156.110(b)(2)(ii), (c)(2)(ii).
- 125 Some of these precedents in current regulations were developed to fill gaps in group coverage, which, before ACA’s enactment, often did not cover habilitative services or pediatric dental and vision care. CCIO, Essential Health Benefits Bulletin. However, prescription drugs were covered by nearly all small group plans, and CMS has recently promulgated prescription drug standards that go well beyond the specifics of EHB-benchmark coverage. HHS, Notice of Benefit and Payment Parameters for 2016.
- 126 CCIO, Essential Health Benefits Bulletin.
- 127 Ibid., p.15, https://www.cms.gov/CCIO/Resources/Files/Downloads/essential_health_benefits_bulletin.pdf.