NASUAD
National Association of States United for Aging and Disabilities

PROVISIONS IN THE ACA THAT IMPACT LTSS, OLDER ADULTS, AND INDIVIDUALS WITH DISABILITIES

With the January 20th inauguration of Donald Trump, Republicans have control over the White House and both branches of Congress. Party leadership is currently working to fulfill their campaign promises of repealing the Affordable Care Act (ACA) and implementing a replacement that lowers the cost of care, maintains some level of coverage expansion, and reduces the regulatory requirements on insurance plans, patients, and providers.

Much of the attention regarding the ACA repeal has focused on the major coverage provisions, including the establishment of the Exchanges, the tax credits to support the purchase of health plans on the exchange, and the Medicaid expansion to 138 percent of the federal poverty level. Yet in addition to these expansions, there were a number of provisions that impacted a wide range of health and human services programs in the United States.

As a bipartisan organization that represents states with Democratic and Republican administrations, NASUAD does not take a stance on the repeal efforts underway; however, we believe that our members should be aware of some of the potential impacts of repeal legislation. Below, we have summarized major components of the ACA that impact the provision of long-term services and supports (LTSS) to older adults and people with disabilities. These provisions may not be impacted by a repeal of the ACA, but some proposals include restriction or elimination of programs that provide these services and supports.

NASUAD will continue to work with Congress and the Administration to support bipartisan efforts to promote deinstitutionalization, balance the LTSS system, improve the health and wellbeing of program participants, and increase the autonomy of seniors and people with disabilities. To that end, we request that Congress adhere to the following principles in any "repeal and replace" package:

- Retain programs that support state rebalancing and health promotion activities, such as the Community First Choice Option and Medicaid Health Homes;
- Reauthorize and extend expired programs that supported state LTSS initiatives, such as the Money Follows the Person demonstration and funding for the Aging and Disability Resource Centers; and
- Promote state flexibility and innovation regarding Medicaid, Medicare, and LTSS.

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Provisions in the ACA that Impact LTSS, Older Adults, and Individuals with Disabilities

Provision	Implications for LTSS	Current Status and Other Information
The Medicaid Community First Choice (CFC) Option. Also known as the 1915(k) state plan benefit	1915(k) allows states to provide HCBS through the Medicaid state plan to individuals who meet the state's institutional level of care requirements. Services include attendant care supports and related services, which includes purchase of items that could be substituted for human assistance. Participating states receive a 6 percent FMAP increase for CFC services.	Eight States currently participate (CA, CT, MD, MT, NY, OR, TX, WA). In 2015, Congress passed a reconciliation bill to repeal portions of the ACA that was vetoed by President Obama. Repeal of CFC was included in this legislation. For more information: *https://www.medicaid.gov/medicaid/hcbs/authorities/1915-k/index.html*
Medicaid Spousal Impoverishment Protections	The ACA extended "spousal impoverishment" protections to individuals receiving LTSS in the community for a five-year period. Spousal impoverishment policies allow participants with a spouse to retain a certain amount of income and assets while receiving Medicaid LTSS in order to prevent the community spouse from becoming impoverished. Spousal impoverishment is mandatory in institutions, and was optional in HCBS programs prior to the ACA.	The spousal impoverishment rule is in place for a five-year period beginning January 1, 2014. Absent congressional action, the protections will become a state option after that time for HCBS participants but will remain mandatory for institutional LTSS. For more information: *https://www.medicaid.gov/medicaid/eligibility/spousal-impoverishment/index.html*
Medicaid Health Homes	Medicaid Health Homes are a care coordination program available to individuals with two or more chronic conditions or with a serious and persistent mental health issue. Health homes provide care management, care coordination, health promotion, and other supports to participants. States receive 90 percent federal funding of the health home services for the first eight calendar quarters after a program is established.	As of 2016, 20 states operated one or more health home programs. For more information: *https://www.medicaid.gov/medicaid/ltss/health-homes/index.html*
Medicaid Expansion	One of the most prominent parts of the ACA was the Medicaid expansion, which originally required states to expand Medicaid to individuals under 65 who are not eligible for Medicare and who have incomes below 138 percent FPL. While this expansion was largely targeted to adults without disabilities, some states have explicitly allowed individuals who access Medicaid through this group to receive LTSS if they meet clinical eligibility criteria (see California for example: *http://www.disabilityrightsca.org/pubs/555101.pdf*). The Medicaid expansion excludes people on Medicare, but individuals receiving SSDI, who are in the 24-month waiting period for Medicare, could be included in this group.	The Supreme Court made the expansion optional for states in a 2012 ruling. The Federal government financed 100 percent of the costs for the first three years. The matching rate gradually lowers to 90 percent, where it stays indefinitely. Thirty-one states and DC have adopted the expansion. Several different repeal proposals have included provisions for the Medicaid expansion. These have included: keeping the expansion as a state option; lowering the eligibility threshold to 100 percent FPL; removing the increased Federal match for expansion population; or repealing the expansion completely. The 2015 reconciliation bill would have ended the expansion after a two-year transition period, effective 12/31/2017. For more information: *http://www.ncsl.org/research/health/affordable-care-act-expansion.aspx*

Provisions in the ACA that Impact LTSS, Older Adults, and Individuals with Disabilities *Continued.*

Provision	Implications for LTSS	Current Status and Other Information
Mandatory Inclusion of Essential Health Benefits in Medicaid Alternative Benefit Plans	The ACA required Alternative Benefits Plans (formerly known as benchmark benefit plans) include the Essential Health Benefit package. EHBs are provided to all individuals who are eligible for Medicaid through the ACA expansion, and states can elect to establish EHBs for other populations.	The EHB includes benefit requirements such as rehabilitative and habilitative services, in addition to other health care benefits. Such supports can be beneficial to individuals with disabilities and/or chronic conditions. The 2015 reconciliation package removed the requirement that Medicaid ABPs include the EHB package. For more information: *https://www.medicaid.gov/medicaid/benefits/abp/index.html*
Medicare Independence at Home Demonstration	The program allows primary care practices to provide home-based primary care to targeted chronically ill Medicare beneficiaries. The statute limits participation in the demonstration to no more than 10,000 beneficiaries.	The program was originally authorized for three years; it was extended for two additional years (through the end of FY2017). For more information: *https://innovation.cms.gov/initiatives/independence-at-home/*
Medicaid Eligibility Maintenance of Effort for Children	States must not enact Medicaid or eligibility requirements that are more restrictive than those the state had in place at the date of enactment through October 1, 2019. Since eligibility for LTSS can convey Medicaid eligibility, CMS has interpreted this to restrict changes to level-of-care requirements. See: *https://www.medicaid.gov/federal-policy-guidance/downloads/smd11-009.pdf*	A similar MOE existed for adults, but expired when the ACA exchanges and Medicaid expansions became operational (see below). The 2015 reconciliation legislation, vetoed by President Obama, ended this requirement effective October 1, 2017.
Federal Coordinated Health Care Office for Dual Eligible Beneficiaries	The FCHCO, "Duals Office" at CMS was established and has been a central component of policy for these populations. Among other activities, FCHCO has partnered with CMMI (see below) for the Financial Alignment Demonstration, and has also provided states with data on Medicare.	For more information, see: *https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/index.html*
The Center for Medicare and Medicaid Innovation	CMMI has been a driver for Medicaid and Medicare payment modification since its inception. Section 1115A of the Social Security Act, added by the ACA, created the Center and provided CMMI with waiver authority to test demonstrations, including the Accountable Health Communities model, the Medicaid Innovation Accelerator Program, and the Financial Alignment Demonstration. Other initiatives have focused on hospital and nursing home quality, payment reform, and improving care transitions.	CMMI's use of waiver authority has been subject to Congressional scrutiny; however, Congressional discussions about health policy have indicated a desire for increased flexibility to the states. CMMI could be a conduit for providing states with increased flexibility around Medicaid and Medicare policy moving forward. For more information, visit: *https://innovation.cms.gov/*

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Provision	Implications for LTSS	Current Status and Other Information
Public Health and Prevention Fund	The Affordable Care Act established the Prevention and Public Health Fund to provide expanded and sustained national investments in prevention and public health, to improve health outcomes, and to enhance health care quality. The fund was initially provided with $15 billion over a 10-year period; however, legislation following the ACA reduced the funding allocations.	The Administration for Community Living (ACL) has received resources from this Fund to support several of its activities, including chronic disease self-management, falls prevention, and Alzheimer's education and outreach. Other CDC programs have focused on diabetes and stroke prevention, which are significant for older adults. The Fund has been subject to reductions from Congress in prior years. Most ACA repeal proposals include an elimination of the Prevention Fund, which has been derided as a "slush fund" for HHS. *https://www.hhs.gov/open/prevention/*

Expired or Closed ACA Provisions that Impacted LTSS, Older Adults, and Individuals with Disabilities

Provision	Implications for LTSS	Notes and Other Information
Additional funding for Aging and Disability Resource Centers	ADRCs are core components of LTSS systems and provide crucial supports that can include, but are not limited to, information & referral services, choice counseling, and case management.	The ACA included an additional $10 million for a five-year period from FY2010 through FY2014. The funding expired in September, 2015. ADRCs have seen a significant reduction of Federal support since that expiration.
Community-Based Care Transitions Program	Creates linkages between community-based organizations (CBOs) and hospitals to improve discharge management. CBOs use care transition services to effectively manage Medicare patients' transitions and improve their quality of care.	$300 million of grant funding was distributed between 2012–2015. 101 CBOs were participating as of 2015, with preference given to ACL/AoA grantees. The five-year program began in February 2012.
Medicaid Money Follows the Person Rebalancing Demonstration (MFP)	MFP provides significant funding and flexibility to state LTSS agencies in order to promote deinstutionalization and increase HCBS.	The MFP program was first created by the Deficit Reduction Act in 2005. ACA extended the program, added additional funding, and implemented some policy changes. The ACA extension of MFP expired September 30, 2016. The Senate Finance Committee developed a bipartisan draft to further extend the program, but the bill has not been formally introduced.

Expired or Closed ACA Provisions that Impacted LTSS, Older Adults, and Individuals with Disabilities *Continued.*

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Medicaid State Balancing Incentive Payments Program	BIPP was created as a program that would provide states with additional funding using increased Federal Medicaid matching funds to assist states with rebalancing their LTSS programs. States were eligible based upon their previous LTSS expenditure balances, and were required to establish structural changes to their HCBS/LTSS system as part of the grant.	BIPP was authorized from October 1, 2011 to September 30, 2015. The program has expired and no substantial discussions regarding reauthorization have occurred in Congress.
The CLASS Act	The CLASS act was a national LTSS insurance program that would have enabled individuals to voluntarily enroll. The insurance plan was funded by a payroll deduction for those who chose to participate.	CLASS was repealed after actuaries determined that there would not be a way to keep the program solvent.
Medicaid Adult Eligibility Maintenance of Effort	Medicaid programs were prohibited from reducing eligibility for adults through January 1, 2014, or at the implementation of the exchanges.	This provision included both the financial eligibility, as well as level of care for LTSS, since the level of care criteria can impact Medicaid eligibility for certain individuals.
Temporary High Risk Pool	$5 billion was provided to subsidize existing state-run high risk pools for individuals with pre-existing medical conditions who have been uninsured for at least six months. This provision was a temporary bridge between the ACA's passage in 2010 and the full-scale implementation in 2014.	The high risk pools covered approximately 110,000 individuals in 2012. Some proposals to replace the ACA include a reinstatement of high risk pools as a component of insurance expansion. Critics of the risk pools cite high costs and limited benefits as limitations to this approach.