

**FOLLOW-UP QUESTIONS AND ANSWERS
WEBINAR
FUNDING HEALTH-RELATED VR SERVICES: THE POTENTIAL IMPACT OF THE
ACA ON THE USE OF PRIVATE HEALTH INSURANCE AND MEDICAID TO PAY
FOR HEALTH-RELATED VR SERVICES**

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Prepared by

Bobby Silverstein

Bobby.silverstein@ppsv.com

1. WHICH STATES ARE PARTICIPATING IN THE MEDICAID EXPANSION?

See the following website for an up-to-date review of the status of state participation in the Medicaid Expansion:

<http://www.cbpp.org/files/status-of-the-ACA-medicaid-expansion-after-supreme-court-ruling.pdf>

2. WHICH STATES HAVE ESTABLISHED STATE-BASED EXCHANGES OR STATE-PARTNERSHIP EXCHANGES?

See the following hyperlink to the official CMS website for the status of CMS approved State-Based Exchanges and State Partnership Exchanges:

<http://cciio.cms.gov/resources/factsheets/state-marketplaces.html>

3. WHAT IS THE TIMELINE FOR STATES TO DETERMINE THE SCOPE OF THE ESSENTIAL BENEFIT PACKAGE?

The Secretary of Health and Human Services has proposed in a Notice of Proposed Rulemaking regarding Standards Related to Essential Health Benefits [[Notice of Proposed Rulemaking](#) at page 70649] that the State's benchmark plan selected in December 2012 would be applicable for the 2014 and 2015 benefit years. HHS explains that it chose this approach for establishing a consistent set of benefits for two years in order to directly reflect current market offerings and limit market disruption in the first years of the Exchanges. HHS intends to revisit this policy for subsequent years. CMS plans on proposing that Medicaid adopt this same approach for initial implementation of the new adult group and all other populations that may be provided benefits under the Medicaid Expansion provisions.

Once a state selects a base-benchmark plan, HHS and states will evaluate the plans in 2013 to determine if any changes are necessary to meet the standards for an EHB-benchmark plan. Recall that all EHB-benchmark plans must cover the 10 mandated categories of benefits listed in the ACA. As noted in the proposed rule, the ACA also requires the Secretary to define EHB in a manner that (1) reflects appropriate balance among the 10 categories; (2) is not designed in such a way as to discriminate based on age, disability, or expected length of life; (3) takes into account the health care needs of diverse segments of the population; and (4) does not allow denials of EHB based on age, life expectancy, or disability.

In other words, the next few months may be critical. VR agencies and other disability advocates should continue to work with State policymakers to ensure that the initial essential health benefits package for the 2014 benefit year meets the needs of persons with disabilities and chronic conditions, particularly focusing on the details of specific items and services covered under each of the ten categories and the definitions of key terms such as rehabilitation services and rehabilitation devices and medical necessity.

4. ESSENTIAL BENEFITS COVERAGE—IS THIS SOMETHING EACH STATE DETERMINES, BASED ON FEDERAL GUIDELINES OR IS THERE A FEDERAL DEFINITION?

As explained above, the ACA and implementing regulations provide for the establishment of a health-benefits package that includes coverage of “essential” health benefits. The Secretary of HHS is responsible for defining general standards and the states (the State-Based Exchanges) are responsible for selecting the actual essential health benefit package, consistent with certain specified options and the standards described above (Q&A #3). In those states that decide not to establish a State-Based Exchange, the actual essential health benefit package will be determined by the Secretary of HHS (Federally-Facilitated Exchange), again consistent with specified options and standards. Under either the State-Based Exchange or the Federally-Facilitated Exchange, Stakeholders will have an opportunity to provide input.

5. CAN YOU PROVIDE MORE DETAIL ABOUT THE COMMUNITY FIRST CHOICE OPTION AND THE AVAILABILITY OF PERSONAL ATTENDANT CARE.

In accordance with proposed regulations issued by CMS, States must make available attendant services and supports in a home or community setting which do not include certain institutional settings e.g., a nursing facility. States must conduct a face-to-face assessment of the individual’s needs, strengths, and preferences, including employment and provide services in accordance with a person centered plan. FYI, the Community First Choice Option may not include VR services

provided under the Rehabilitation Act. [See [Proposed Rule Medicaid Program: Community First Choice Option, 76 FR 10736](#) (February 25, 2011)]

6. WHAT ABOUT ASSISTIVE TECHNOLOGY THAT HAD PREVIOUSLY BEEN DENIED BECAUSE IT IS NOT REQUIRED IN THE HOME BUT RATHER IN THE WORKPLACE?

First off, durable medical equipment (DME) is denied coverage by the Medicare program if it is not medically necessary for use in the home. This is a major restriction in the DME benefit that some other insurers have adopted. After much advocacy from the disability community, the definition of “durable medical equipment” that was adopted by the federal regulations with regard to ACA implementation does not include the in-the-home restriction but these definitions are non-binding on the states. Therefore, this issue will be fought out at the state level as states define their own EHB packages. Even if a state has officially determined what constitutes its EHB package, advocates should still continue to advocate for a rejection of the in-the-home DME standard because it violates important provisions of the ACA that mandate an appropriate balance and nondiscrimination in benefit design.