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November 25, 2013

Marilyn Tavenner  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-2380-P  
P. O. Box 8016  
Baltimore, MD 21244-8016

**Re: Basic Health Program: State Administration of Basic Health Programs; Eligibility and Enrollment in Standard Health Plans; Essential Health Benefits in Standard Health Plans; Performance Standards for Basic Health Programs; Premium and Cost Sharing for Basic Health Programs; Federal Funding Process; Trust Fund and Financial Integrity**

Dear Administrator Tavenner:

On behalf of the Massachusetts Executive Office of Health and Human Services (EOHHS), we appreciate the opportunity to provide comments on the Notice of Proposed Rulemaking related to the Basic Health Program option of the Affordable Care Act as published in the Federal Register on September 25, 2013.

More than seven years ago, Massachusetts enacted landmark health reform legislation, Chapter 58 of the Acts of 2006, which has led to Massachusetts having the highest rate of insurance coverage in the nation. Chapter 58 enabled Massachusetts to expand coverage to the uninsured through MassHealth, the state's Medicaid program, and the Health Connector, an independent governmental authority that serves as a health insurance marketplace. The Health Connector has offered the Commonwealth Care subsidized health insurance program for low-income residents and the Commonwealth Choice commercial health insurance program for individuals and small employers. The Commonwealth is proud that many components of the Affordable Care Act (ACA) are based on elements of the Massachusetts model, including Medicaid expansion, the individual mandate, standards defining minimum essential coverage and affordability, and the development of an Exchange to facilitate the purchase of health insurance.

The Basic Health Program (BHP) provides states with the opportunity to establish a health benefits coverage program for low-income individuals earning at or below 200 percent of the Federal Poverty Level (FPL) who otherwise would be eligible to purchase subsidized coverage



through the Exchange, and Massachusetts is currently exploring this option in light of the recently proposed federal rule.

As an overarching comment, EOHHS appreciates the level of flexibility that CMS has provided in the proposed rule, specifically the opportunity for states to choose between Medicaid and Exchange rules for enrollment periods, eligibility determinations, verification processes, notifications, and redeterminations. Given that different states may take significantly different approaches to implementing a BHP, this flexibility is both appropriate and helpful to states that adopt this option. We also offer the following comments and seek clarification on certain provisions.

## **Subpart B – Establishment and Certification of State Basic Health Programs**

### **§600.170 Annual report content and timing**

Annual reports provide significant value when implementing any program, as they can demonstrate a program's progress, successes, and potential opportunities for improvement. However, we do have concerns with the requirement to submit an annual report 60 days before the end of each operational year. Due to the delay in enrollment reporting and claims (which typically are not reported real-time), this may lead to inaccuracies in the data reported. This problem may be especially acute in the first year when program data from a prior year will not be available. We suggest that the submission of the annual report occur after the end of the operational year to provide sufficient time for data collection and analysis; we suggest that the annual report should be due no less than 60 days after the end of the operational year.

## **Subpart D – Eligibility and Enrollment**

### **§600.320 Determination of eligibility for and enrollment in a standard health plan**

The proposed rule explains that the BHP is intended to provide an alternative coverage option for certain individuals who would, but for the existence of the BHP, otherwise be eligible to purchase a plan through the Exchange. The rule then outlines some of the specific eligibility criteria for BHP but does not specify whether all Exchange eligibility rules apply. For example, the rule specifies the age, income and immigration status requirements for BHP enrollees, as well as that BHP enrollees must not be incarcerated and must not have access to public or private Minimum Essential Coverage. However, the proposed BHP rule does not mention the Exchange eligibility rules that require an individual to indicate that he or she expects to file a tax return and if married, that the couple must file a joint tax return. We seek clarification on this requirement, particularly whether all Exchange rules apply with respect to eligibility and redeterminations for the BHP, including the requirements related to filing taxes.

## **Subpart E – Standard Health Plan**

### **§600.410 Competitive Contracting Process**

Since the competitive contracting process is a unique feature to the BHP, which involves new specific standards, it is important that states have the time necessary to comply with this

provision. We respectfully request that states have the opportunity for a grace period longer than one year to ensure coordination with other state contracting cycles. Providing a flexible grace period would also allow interested states to facilitate a transition period between current plans and the BHP and thereby ensure a better continuity of care for eligible members.

We also recommend that CMS examine a state's existing health plan contracting process and, if the state's competitive procurement for a Medicaid managed care or Exchange-based contract aligns with the requirements as proposed for the BHP, we strongly recommend that this condition be waived by CMS.

The proposed rule requires that the BHP procurement include "negotiation of premiums, cost sharing, benefits, and innovative care management models." We seek clarification on this subject, given the strict cost-sharing and premium requirements established for this program as well as the application of Essential Health Benefits (EHBs). We propose that states should have additional flexibility in designing rather than negotiating aspects of the BHP to the extent that this would better align with other state procurement procedures and coordinate with Medicaid and CHIP.

#### **§600.420 Enhanced availability of standard health plans**

The proposed rule requires that any state which implements a BHP must have at least two health plans that are available to participants in every area of the state. States may have rural or otherwise isolated areas where it may not be feasible to contract with one or more willing and qualified standard health plans, and we are concerned that this will result in a state being unable to offer a BHP in any part of the state. We suggest clarifying that states that offer to contract throughout the state with at least two health plans be allowed to implement a BHP in certain areas of the state rather than statewide if they are unable to contract with at least two qualified standard health plans in every area. Additionally, we request clarification on whether a state-operated plan that contracts directly with its provider network, such as a Primary Care Case Management (PCCM) plan operated by the state Medicaid agency, would be considered a standard health plan, assuming it met the coverage requirements at §600.405. We also request clarification on whether an accountable care organization (ACO) that holds a health care provider or providers accountable for the provision, cost and quality of health care services could be considered a standard health plan, assuming it met the coverage requirements at §600.405. As states explore new options for delivering high-quality, cost-effective care to residents, we recommend that CMS provide added flexibility to allow states to implement delivery systems for the BHP that best advance their goals for innovation and improvement in care.

### **Subpart G – Payment to States**

#### **§600.605 BHP payment methodology**

The proposed rule establishes that states will receive 95 percent of premium tax credits and 95 percent of cost-sharing reductions that enrollees would otherwise receive through the Exchange. We accordingly request reconsideration of this issue. We believe that the statute may reasonably be read, and should be read, to mean that states will receive 95 percent of premium tax credits and 100 percent of cost-sharing reduction that enrollees would otherwise receive through the Exchange.

**§600.610 Secretarial determination of BHP payment amount**

We were encouraged by CMS' methodology for BHP payment adjustments, which only allows retroactive adjustments for enrollment and calculation errors. This provides reassurance to states regarding the stability of financing for a BHP program. We look forward to further details in the forthcoming proposed rule regarding the BHP payment methodology.

**Subpart H – BHP Trust Fund**

**§600.715 Corrective action, restitution, and disallowance of questioned BHP transactions**

The proposed rule establishes a process for corrective action for improper BHP trust fund expenditures. We seek clarification on the administrative process for this provision, and suggest that appeals from CMS disallowances be made to the Departmental Appeals Board, which is consistent with 42 CFR 430.42(f) for appeals of disallowances under Title XIX. Alternatively, we recommend that the regulations make explicit that appeals from CMS disallowances be subject to judicial review without further administrative process, which is consistent with 42 CFR 430.38, which provides review of state plan denials and other CMS decisions.

We thank you for consideration of our comments and look forward to continuing to work with the federal government on successful implementation of the ACA.

Sincerely,

  
John W. Polanowicz