



AFFORDABLE CARE ACT MASSACHUSETTS IMPLEMENTATION UPDATE

January 22, 2013

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These Updates, published by the Executive Office of Health and Human Services (EOHHS) in consultation with the other state agencies involved in ACA implementation, will bring you news related to the implementation of provisions of the ACA here in Massachusetts.

Grants and Demonstrations

The ACA provides funding opportunities to transform how health care is delivered, expand access to care and support healthcare workforce training.

Grant Announcements

Affordable Care Act New Access Point Grants, §10503. Announced January 16, 2013. Funding is available to organizations that will establish a new single access point or multiple access points that will increase access to culturally competent primary health care services and improve the health status of underserved and vulnerable populations. Public or nonprofit entities, including tribal, faith-based, and community-based organizations are eligible to apply. States are not eligible to apply. Applicants must demonstrate a need in the community for an access point site and demonstrate that they are ready to meet this need. Access points will also address the unique and significant barriers to affordable primary care services for target populations. \$19M in 25 awards is available. Applications are due February 27, 2013. The announcement can be viewed at: [HRSA](#)

Grant Activity

January 17, 2013 HHS awarded a \$80,225,650 Level 2 Exchange Establishment Grant under ACA §1311 to the Health Connector. This grant will assist the Health Connector and support state agencies in successfully transitioning the Health Connector to an ACA-compliant, State-based Exchange while maintaining a commitment to the seamless coverage transition of existing members. In particular, funding from this grant will support the

multi-agency project dedicated to building a fully integrated "real-time" eligibility system designed to determine eligibility for enrollment in state and federally-subsidized health insurance coverage. This project will enhance the shopping experience for individuals and small businesses shopping for health insurance through the Health Connector. In addition, this opportunity will support the development and operation of a state-based risk adjustment program that will support stabilization of the merged small and non-group market in the Commonwealth and will provide funding to develop and execute a robust outreach and education campaign designed to inform Massachusetts residents of the benefits available to them through the ACA and the Health Connector.

The grant abstract can be viewed on our website under the Grants section at:

<http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/grants/121114-sec-1311-project-abstract.pdf>

December 21, 2012 HHS awarded a two-year \$1,982,666 Medicaid Adult Quality Grant under ACA §2701 to the Executive Office of Health and Human Services. The grant award will assist MassHealth in implementing up to 15 metrics from the Medicaid Adult Core Measure Set and in initiating quality improvement projects related to the core measure set. The initial quality improvement topics include post-partum visits and the initiation and engagement of treatment for substance and alcohol abuse. The grant award will also assist MassHealth in developing capacity to effectively use data for decision-making. Among other things, funding from this grant supports the development of training modules on measurement techniques, applying software tools and indentifying actionable opportunities for improvement from data. The project involves collaboration between MassHealth, the University of Massachusetts Medical School, the Center for Health Information and Analysis and the Department of Public Health.

The grant abstract can be viewed on our website under the Grants section at:

<http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/grants/120831-medicaid-quality-narrative.pdf>

Guidance

1/16/13 In conjunction with President Obama's announcement about protecting children and the reduction of gun violence, CMS released a State Health Official (SHO) letter on the application of the Mental Health Parity and Addiction Equity Act (MHPAEA) to Medicaid managed care organizations, the Children's Health Insurance Program, and benchmark-equivalent plans (also known as Alternative Benefit Plans).

ACA §2001 expanded the application of MHPAEA to benefits in Medicaid non-managed care benchmark and benchmark-equivalent (also known as Alternative Benefit Plans) state plan benefits pursuant to section 1937 of the Act. The application of MHPAEA to Medicaid non-managed care Alternative Benefit plan benefits was effective on March 23, 2010. Also effective as of that date, Medicaid Alternative Benefit plans that are benchmark-equivalent plans must include mental health and substance abuse services as a basic service.

Read the MHPAEA at: <https://www.cms.gov/Regulations-and-Guidance/Health-Insurance-Reform/HealthInsReformforConsume/downloads/MHPAEA.pdf>

Read President Obama's plan at:

http://www.whitehouse.gov/sites/default/files/docs/wh_now_is_the_time_full.pdf

Read the State Health Official Letter at: <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf>

1/14/13 HHS/CMS issued a proposed rule called, "Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing." The proposed rule codifies statutory eligibility provisions and outlines a structure and options for coordinating Medicaid, the Children's Health Insurance Program (CHIP), and Exchange eligibility notices and appeals. The rule also proposes to modify existing benchmark benefits regulations for low-income adults, and codify several of the eligibility-related provisions included in the Children's Health Insurance Program Reauthorization Act (CHIPRA). The proposed rule is intended to complement the Medicaid Eligibility [Final Rule](#) published on March 23, 2012.

Beginning January 1, 2014, ACA §2001 requires states to expand their Medicaid programs to individuals under 65 years of age with incomes at or below 133% FPL. (However, on June 28, 2012 the Supreme Court ruled that the **Medicaid expansion** was optional for states and that the HHS Secretary could not withdraw federal funding from non-expanding states' pre-existing Medicaid programs). The ACA established Affordable Insurance Exchanges (§1311(b)) to provide individuals and small business employees with access to health insurance coverage beginning January 1, 2014, where low and moderate income Americans will be eligible for **premium tax credits** (§1401, §1411) to make purchasing a health plan more affordable by reducing out-of-pocket premium costs. According to CMS, the proposed rule will help develop systems that will make it easy for consumers to determine if they are eligible for Medicaid or premium tax credits.

The proposed rule also affects a wide range of other Medicaid provisions including: the streamlining of eligibility rules; the role of counselors in assisting people with their coverage applications; procedures to verify eligibility for qualifying coverage in an eligible employer-sponsored plan for Affordable Insurance Exchanges; and the use of updated Medicaid eligibility categories. The proposed rule revises the rules relating to the substitution of coverage to improve the coordination of CHIP coverage with other coverage and implements other CHIPRA eligibility-related provisions, including eligibility for newborns whose mothers were eligible for and receiving Medicaid or CHIP coverage at the time of birth.

The proposed rule also includes provisions related to **Medicaid Essential Health Benefits** (EHB) that will allow states to offer benefit packages to the new adult eligibility group (§2001) for citizen and qualified alien low-income adults under age 65 that would differ from what is currently allowed for Medicaid patients under the traditional Medicaid program. Effective January 1, 2014, all non-grandfathered health insurance coverage in the individual and small group markets, Medicaid benchmark and benchmark-equivalent plans (also known as Alternative Benefit Plans), and Basic Health Programs (§1331) will cover essential health benefits (EHBs). As required under ACA §1302(b), EHBs are a package of medical services and treatments which includes ambulatory and emergency care, maternity care, prescription drugs and other comprehensive health care services in 10 statutory benefit categories, and are equal in scope to a typical employer health plan. The proposed rule modifies existing "benchmark" regulations applicable to Medicaid programs to implement the benefit options available to the new eligibility group. The proposed rule provides guidance on the use of section 1937 benchmark and benchmark-equivalent plans (Alternative Benefit Plans) for the new eligibility group; the relationship between benchmark-equivalent plans (Alternative Benefit Plans) and Essential Health Benefits; and the relationship between section 1937 and other Title XIX provisions. States that implement the new eligibility group under ACA §2001 are required to provide medical assistance for that group through a benchmark-equivalent plan (Alternative Benefit Plan) subject to the requirements of section 1937 of the Social Security Act. Learn more about Essential Health Benefits in the Medicaid Program at:

<http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-003.pdf>

Comments on the proposed rule are due February 13, 2013.

Read the CMS fact sheet at: [fact sheet](#)

Read the HHS press release at: <http://www.hhs.gov/news/press/2013pres/01/20130114a.html>

Read the proposed rule (which was published in the Federal Register on January 22, 2013) at:

<http://www.gpo.gov/fdsys/pkg/FR-2013-01-22/pdf/2013-00659.pdf>

1/15/14 CMS issued a State Medicaid Director Letter that provides guidance related to health homes, authorized by ACA §2703. Health homes provide an opportunity to build a person-centered care delivery model that focuses on improving outcomes and disease management for beneficiaries with chronic conditions and obtaining better value for state Medicaid programs.

The guidance shares with states CMS' recommended core set of health care quality measures for assessing the health home service delivery model that the agency intends to promulgate in the rulemaking process. While CMS is not requiring states to use the measures until the regulations are formally promulgated, the agency is sharing the core set to help states as they consider the design and implementation of their health home programs, as well as provide time for states to share information with their health care providers.

According to CMS, the recommended health home core quality measures are a key component of larger payment and care delivery reform that focuses on quality outcomes for beneficiaries. Furthermore, the recommended core set of health home measures were chosen because they reflect key priority areas such as behavioral health and preventive care, and they align with [the initial core set](#) of health care quality measures for Medicaid-eligible adults and quality initiatives such as HHS' [National Strategy for Quality Improvement in Health Care](#).

More information about health homes is available at:

<http://www.medicaid.gov/AffordableCareAct/Provisions/Quality-of-Care-and-Delivery-Systems.html>

Read the Health Home Core Quality Measures State Medicaid Director Letter at:

<http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-13-001.pdf>

Prior guidance can be viewed at: www.healthcare.gov

News

1/17/13 HHS announced the awarding of \$1.5 billion in Affordable Insurance Exchange grants to 11 states (including Massachusetts) and the District of Columbia to help them create exchanges under ACA §1311. The announcement of Level One and Two Establishment Grant funding will give states more resources to build exchanges and implement the ACA. States receiving these one-year awards are: Delaware, Iowa, Michigan, Minnesota, North Carolina, and Vermont. California, Kentucky, Massachusetts, New York, and Oregon received Level Two Exchange Establishment Grants, multi-year grants awarded to states further along in building their ACA Exchanges. Please see the grant activity section above for more information on the Massachusetts award.

With this announcement, a total of 49 states, the District of Columbia, and four territories have received grants to begin planning their Exchanges, and 34 states and the District of Columbia have received grants to begin building their Exchanges.

These grants are part of a series of ACA grants to help states develop exchanges.

The Health Connector was previously awarded two Level 1 Exchange Establishment Grants under ACA §1311. On September 27, 2012, the Health Connector received \$41,679,505 and on February 22, 2012 the Health Connector received \$11,644,938.

Massachusetts also received a \$1 million planning grant in September 2010 and is the leading partner in a consortium of the six New England states that received a \$35.6 million Early Innovator grant in February 2011.

The ACA allows each state the opportunity to establish an Affordable Insurance Exchange to help individuals and small employers purchase affordable health insurance coverage that begins on January 1, 2014. HHS will continue to award grants through 2014 and states may use funds through the initial start-up year.

For a detailed breakdown of Exchange grant awards made to states visit:

<http://www.healthcare.gov/news/factsheets/2011/05/exchanges05232011a.html>.

For more information on Exchanges, visit: <http://www.healthcare.gov/marketplace>.

1/15/13 CMS announced the fourth round of site selections under the Community-based Care Transition Program (CCTP), authorized by ACA §3026, which provides funding from the Innovation Center to community-based organizations partnering with eligible hospitals to test models for improving care transitions. The announcement of 35 new sites brings the current total to 82 sites working with CMS and local hospitals to provide support for high-risk Medicare patients following a hospital discharge as they move to new settings, including skilled nursing facilities and home. Community organizations help patients stay in contact with their doctors to ensure their questions are answered and they are taking medications they need to help them stay healthy. The program uses community groups to help provide home and community-based care to seniors who are especially likely to be readmitted after a hospital stay. With the addition of 35 new sites, approximately 500,000 seniors in over 30 states are now supported by CCTP.

CMS awarded program agreements to recipients that can demonstrate an overall reduction in Medicare expenditures over the program period. CMS did not provide savings estimates from the agreements. CCTP is part of the Partnership for Patients which is charged with reducing hospital-acquired conditions by 40% and hospital readmissions by 20% by 2013. Under the ACA, the CCTP program may spend up to \$500 million over five years and with the second round of site selections, CMS announced that the agency has committed half of the \$500 million allocated to CCTP. As part of their two-year agreement with the CMS Innovation Center, each organization will be paid a flat fee for helping to coordinate patient care after a hospital stay for each Medicare beneficiary who is at high risk for readmission to the hospital.

The fourth round of site participants are located in Alabama, California, Colorado, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Maryland, Michigan, Mississippi, Missouri, Kansas, Montana, New York, North Carolina, Ohio, Oregon, South Carolina, Tennessee, Texas, Virginia and Washington. None of the newly funded sites are located in Massachusetts.

The third round of site participants are located in California, Connecticut, Florida, Illinois, Massachusetts, Minnesota, New York, North Carolina, Pennsylvania, Texas and Washington. In Massachusetts, Somerville-Cambridge Elder Services, a Massachusetts-designated Aging Services Access Point (ASAP) and an Area Agency on Aging (AAA), will partner with Mystic Valley Elder Services, Cambridge Health Alliance, Hallmark Health System and dozens of community-based health and social service providers to provide care transitions services in Middlesex County.

In March 2012 CMS announced the **second site selections** under this program. This included:

1) Elder Services of Berkshire County, a Massachusetts-designated Aging Services Access Point (ASAP) and federally-designated AAA in rural western Massachusetts, that will partner with Berkshire Medical Center and the Berkshire Visiting Nurse Association to improve care transition services for Medicare beneficiaries; and 2) Elder Services of Worcester, Massachusetts, a Massachusetts-designated ASAP and federally-designated AAA, that will partner with Bay Path Elder Services. They will provide care transitions services in partnership with seven hospitals, including: MetroWest Medical Center; St. Vincent Hospital; UMass Memorial Medical Center; Wing Memorial Hospital; Marlborough Hospital; Clinton Hospital, and HealthAlliance Hospital.

In November 2011 CMS announced the **first site selections** under this program. This included: 1) Elder Services of the Merrimack Valley, Inc., in partnership with Anna Jacques Hospital, Saints Medical Center, Holy Family Hospital, Lawrence General Hospital, and Merrimack Valley Hospital, and serving 23 cities/towns in the Merrimack Valley of Massachusetts and ten bordering cities/towns in southern New Hampshire where patients using these hospitals also reside.

The CMS Innovation Center will continue to accept applications and approve participants on a rolling basis as long as funds remain available. For more information on how to apply visit: CMS.Gov

For more information about the Community Based Care Transitions Program, including a complete list of all site selections announced, visit: <http://go.cms.gov/caretransitions>

EOHHS News

1/18/13 EOHHS held a Quarterly Affordable Care Act Implementation Stakeholder Meeting and the agenda included recent ACA implementation activities as well as a question and answer session.

The Health Connector gave an overview of the recent proposal regarding Employer Responsibility in Massachusetts. The presentation reviewed the Massachusetts' employer responsibility provisions including: Fair Share Contribution, Free Rider Surcharge, Section 125 Requirement, and the Employer/Employee Health Insurance Responsibility Disclosure. In addition, Massachusetts employers also pay Unemployment Health Insurance (UHI) assessments that are used to finance the Medical Security Program (MSP). The MSP provides insurance coverage for unemployed, low-income residents. However, in 2014, because of the ACA, residents covered by the MSP will become eligible for coverage via the Health Connector and MassHealth. On January 8, 2013 Governor Patrick filed legislation to 1) Freeze the UI rate, 2) Eliminate the Fair Share Contribution program, 3) Eliminate the Medical Security Program and the Unemployment Health Insurance employer assessment that funds it, and 4) Create a new health insurance responsibility contribution that will provide funds to the Health Connector and MassHealth for subsidized care for low-income Massachusetts residents. Since its members will move to MassHealth and Health Connector, the MSP is no longer needed. The employer assessment amount is retained and lowered (not to fund the MSP) but to set up new "employer responsibility trust fund" for these assessments, and use funds to help support subsidized coverage for low-income individuals enrolled in MassHealth and Health Connector. Also, effective June 30, 2013, the legislation will eliminate the Fair Share Contribution Program (FSC). The ACA has a similar policy for employers with over 50 employees, effective in 2014, that could result in double-penalties if the two policies were to coexist.

Stakeholders also heard an update from EOHHS and the Health Connector about options for subsidized coverage under the ACA. MassHealth had been planning to develop a Basic Health Plan (\$1331) for adults 134-200% FPL and AWSS 0-200% FPL but, in the absence of federal guidance, is unable to do so at this time. As provided by the ACA, the alternative for these

individuals is to purchase qualified health plans (QHP) through the Exchange. The ACA established Affordable Insurance Exchanges (§1311(b)) to provide individuals and small business employees with access to health insurance coverage beginning January 1, 2014, where low and moderate income Americans will be eligible for premium tax credits (§1401, §1411) and cost sharing reductions (where applicable) to make purchasing a QHP more affordable. The state is also proposing several strategies to make buying a QHP easier and more affordable including a state subsidy or "wrap" to reduce premiums and cost-sharing for QHP enrollees up to 300% FPL to be closer to current Commonwealth Care levels.

View the Employer Responsibility in Massachusetts Recent Proposal Overview at:

<http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/prev-meetings/130118-employer-responsibility-proposal-overview.ppt>

View the Update on ACA Subsidized Coverage Configuration Presentation at:

<http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/prev-meetings/130118-update-aca-subsidized-coverage.ppt>

All presentations from past Quarterly Stakeholder Meetings are available at:

[Presentations](#) under Materials from Previous Quarterly Stakeholder Meetings.

Bookmark the **Massachusetts National Health Care Reform website**

at: http://mass.gov/national_health_reform to read updates on ACA implementation in Massachusetts.

Remember to check <http://mass.gov/masshealth/duals> for information on the

"Integrating Medicare and Medicaid for Dual Eligible Individuals" initiative.