



## AFFORDABLE CARE ACT MASSACHUSETTS IMPLEMENTATION UPDATE

February 26, 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 Activity

**2/21/13 The Center for Medicare and Medicaid Innovation awarded the Patrick-Murray Administration a 42-month \$44,011,924 grant under the Affordable Care Act's State Innovation Model Initiative.** The award will further the Commonwealth's efforts to transform its health care delivery system by moving the market away from fee-for-service payments and towards a system capable of delivering better health care and better value for all residents of the Commonwealth. The grant award will be used to support public and private payers in transitioning to integrated care systems; enhance data infrastructure for care coordination and accountability; advance a statewide quality strategy; integrate primary care with public health and other services; and create measures and processes for evaluating and disseminating best practices. Many major payers and state agencies in Massachusetts have recently developed or are creating initiatives aligned with this model including MassHealth, the Department of Public Health, the Group Insurance Commission (GIC), the Center for Health Information and Analysis, private payers and Medicare.

The grant abstract can be viewed on our website under the Grant section at: [Mass.Gov](#)

#### Guidance

**2/21/13 CCIIO issued a Frequently Asked Questions (FAQ) document describing**

**some additional flexibility for states in the area of health plan management**, particularly in regard to qualified health plan (QHP) certification.

QHPs are health plans that have been certified by an Exchange, provide essential health benefits (§1301) and follow established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts). A QHP will have a certification by each Exchange in which it is sold. ACA §1311(c)(1)(D) specifies that, to be a certified QHP and operate in the Exchange, a health plan must be accredited by a recognized accrediting entity on a uniform timeline established by the applicable Exchange.

Read the FAQ document at: <http://cciio.cms.gov/resources/files/plan-management-faq-2-20-2013.pdf>

**2/21/13 CMS issued an informational bulletin regarding verification plans required for Medicaid and the Children's Health Insurance Program (CHIP) eligibility, the Modified Adjusted Gross Income (MAGI)-based Eligibility template and a review of the verification regulations.** The informational bulletin includes clarification on areas where states must confirm compliance and areas where states have flexibility in the verification plan. CMS provides additional information on the following areas: self-attestation, federal data services hub, use of electronic data sources, reasonable compatibility standard, documentation, citizenship and immigration status, social security number, social security number for non-applicants and post-enrollment verification.

Effective January 1, 2014, a methodology for determining income based on **MAGI** will apply to both Medicaid and CHIP eligibility for most enrollees, including pregnant women, children, parents and other caretaker relatives, and the newly eligible adult group (as applicable in a state that chooses to cover this group). This will standardize the income calculation nationally. In addition to a 5% FPL across-the-board income disregard for all MAGI populations, there will no longer be any additional disregards applied, unless an individual falls into one of the populations exempted from MAGI rules (such as the elderly or the disabled). This new methodology is aligned with the one that will be used to determine eligibility for the premium tax credits (§1401, §1411) and cost sharing reductions (§1402, §1411) available to certain individuals purchasing coverage on the Exchange.

According to CMS, as stated in the informational bulletin, Medicaid and CHIP agencies will develop a plan for verification policies and procedures used within the agency. The development of the verification plan will occur in two phases. In the first phase, states must submit their verification plans for populations whose eligibility is based on MAGI to CMS by March 20, 2013. In the second phase, CMS will develop a separate verification plan for states that describe policies and procedures for MAGI-excepted populations. CMS will review verification plans and provide comments to states.

More information on MAGI can be found at: [MEDICAID.Gov](http://MEDICAID.Gov)

The informational bulletin can be accessed here: [Content.Govdelivery](http://Content.Govdelivery)

**2/20/13 HHS/CMS issued a final rule called "Patient Protection and Affordable Care Act: Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation."** The provisions that are included in this rule are necessary to implement the requirements of Title I of the ACA. According to HHS, the final rule will help consumers shop for and compare health insurance options in the individual and small group markets by promoting regularity across plans, protecting consumers by ensuring that health plans cover a core package of medical benefits that are equal in scope to benefits offered by a typical employer plan, and limiting their out of pocket costs.

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. The final rule outlines health insurance issuer standards for **essential health benefits (EHB)**, a core package of benefits that health insurance issuers must cover both inside and outside the Health Insurance Exchanges as required by ACA §1302. According to HHS, through its EHB standards, the final rule also expands coverage of mental health and substance use disorder services, including behavioral health treatment, for millions of Americans. Effective January 1, 2014, all plans sold in the exchanges and through the small group and individual markets must be equal in scope to the benefits covered by a typical employer plan and offer an EHB package of medical services and treatments in ten categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; 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.

The final rule finalizes a **benchmark-based approach** that allows states to select a benchmark plan from options offered in the market (which are equal in scope to a typical employer plan) and provides states with flexibility to define EHB in a way that best meets the needs of their residents. Twenty-six states (including Massachusetts) have already selected a benchmark plan for their state, and the largest small business plan in each state will be the benchmark for the rest.

For more information on the Massachusetts selection visit the Division of Insurance website at: [Mass.Gov](http://Mass.Gov)

Under the final rule and as required by §1302, the EHB package must also include cost-sharing limits and adhere to **actuarial value (AV) requirements**. Beginning in 2014, plans that cover EHB must cover a certain percentage of costs, known as AV or "metal levels." AV is calculated as the percentage of total average costs for covered benefits that a plan will cover and helps consumers distinguish the level of coverage offered by different health plans. Specifically, the final rule outlines health insurance issuer standards related to the determination of actuarial value (AV). To streamline and standardize the calculation of AV for health insurance issuers, HHS provided a publicly available [AV calculator](#), which issuers would use to determine health plan AVs based on a national, standard population, as required by law. The tool allows users to measure the AV of health plans and compliance with AV standards established under ACA §1302(d).

The final rule also finalizes policies and timelines related to accreditation standards for **qualified health plans (QHPs)** that will be offered through the Health Insurance Exchanges. QHPs are health plans that have been certified by an Exchange, provide essential health benefits (§1301) and follow established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts.)

A February 2013 HHS [report](#) details how provisions in the final rule will expand **mental health and substance use disorder benefits** and federal parity protections for 62 million Americans. The report shows that approximately 20% of individuals purchasing insurance in the individual market don't have access to mental health services and almost one-third had no coverage for substance use disorder services. The final rule expands coverage of these benefits in three ways: 1) By including mental health and substance use disorder benefits in the EHB package, 2) By applying federal parity protections to mental health and substance use disorder benefits in the individual and small group markets and 3) By providing more Americans with access to quality health care that includes coverage for mental health and substance use disorder services.

Read the proposed rule (which was published in the Federal Register on November 26, 2012) at: <http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28362.pdf>

Read the final rule (which was published in the Federal Register on February 25, 2013) at: <http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf>

**2/15/13 HHS/CMS issued a proposed rule "Medicare Program: Medical Loss Ratio Requirements for Medicare Advantage and Medicare Prescription Drug Benefit Programs."** The rule implements the ACA's medical loss ratio (MLR) requirements (§10101) for Medicare Advantage (MA) and Medicare Part D prescription drug plans. The proposed rule limits how much plans can spend on marketing, overhead, and profit. Similar MLR requirements have been in place in the private health insurance market since 2011. Under this MLR rule, MA and Part D prescription drug plans must spend at least 85% of revenue on clinical services, prescription drugs, quality improvements, or direct benefits to beneficiaries in the form of reduced Medicare premiums.

CMS also announced other proposed payment changes for MA and Medicare prescription drug plans for 2014. According to CMS, the changes in the Advance Notice and Call Letter to the plans will continue the trend of lower premiums and stable or improved benefits for beneficiaries. CMS will also use its ACA-granted authority to limit increases in costs to enrollees in MA plans to \$30 per member per month (a decrease from \$36 per member per month in previous years). CMS also stated that deductibles and cost-sharing for Part D Medicare prescription drug plans will decrease next year (the first time since the Part D drug benefit began in 2006). The standard Part D deductible will be \$310, a decrease from \$325 in 2013.

Read the press release: [CMS.Gov](http://www.cms.gov)

The Advance Notice and draft Call Letter are available at: [CMS.Gov](http://www.cms.gov)

Read the proposed rule (which was published in the Federal Register on February 22, 2013) at: <http://www.gpo.gov/fdsys/pkg/FR-2013-02-22/pdf/2013-03921.pdf>

Prior guidance can be viewed at [www.healthcare.gov](http://www.healthcare.gov)

## News

**2/21/13 HHS issued a report called "Medicaid Moving Forward"** which describes initiatives to support states that are undertaking activities to improve care and lower costs in both Medicaid and Children's Health Insurance Program (CHIP). The report outlines future opportunities that states can utilize in achieving these goals.

The report highlights key changes to the Medicaid program that occurred in 2012 as well as reviews important guidance released by CMS on implementing various provisions of the ACA. Key CMS developments include: issuing guidance on a state option to implement integrated care organization models without a waiver (§2703), issuing rules under §1202 to pay at least Medicare rates to eligible physicians for primary care services in 2013 and 2014, and building stronger program integrity activities with states (Title VI of the ACA).

In addition, the report lists current opportunities for states to improve care and lower costs. The report also highlights opportunities through the Medicare-Medicaid Coordination Office, authorized under §2602 and designed to improve beneficiary care and coordination of services for Medicare-Medicaid enrollees (also known as "dual eligibles").

Read the HHS report at:

[http://www.medicaid.gov/State-Resource-Center/Events-and-Announcements/Downloads/MMF\\_Jan-Dec-2012\\_FINAL.PDF](http://www.medicaid.gov/State-Resource-Center/Events-and-Announcements/Downloads/MMF_Jan-Dec-2012_FINAL.PDF)

**2/21/13 HHS announced that almost \$300 million in funding has been awarded to 25 states (including Massachusetts) in State Innovation Model Initiative grants** for the development and implementation of state-based models of improvement in their health care delivery systems under ACA §3021. This initiative provides funding for two different funding opportunities, Model Design Awards and Model Testing Awards.

Approximately \$35 million will be distributed to 19 states for Model Design Awards. Model Design Awards provide financial and technical support in order to engage stakeholders and create a State Health Care Innovation Plan. The plan will serve as a guide for health care transformation.

Over \$250 million of the funding will support Model Testing Awards. These awards fund the implementation, testing and evaluation of the State Health Care Innovation Plan. These grants will help transform the health care delivery systems of six states: Arkansas, Maine, Massachusetts, Minnesota, Oregon and Vermont. Please see the grant activity section above for more information on the Massachusetts award.

For a detailed breakdown of State Innovation Model grants awarded to states visit:

<http://innovation.cms.gov/initiatives/State-Innovations/>

**2/21/13 The HHS Inspector General released a report showing that most states will be ready to implement the ACA's requirements** to streamline procedures for determining eligibility and enrolling applicants in Medicaid, the Children's Health Insurance Program (CHIP), and state health insurance Exchanges by the January 1, 2014 deadline. Of the 45 states that responded to a 2012 survey, 35 reported that they anticipate implementing streamlined eligibility and enrollment systems, streamlined application forms, and data sharing and matching on time.

In March and April 2012 the HHS Inspector General surveyed the 50 states and the District of Columbia and asked questions about the requirements under ACA §1413, including: 1) eligibility and enrollment systems, 2) application forms, and 3) eligibility data sharing. Forty states reported that they would have application forms that meet the ACA's requirements ready on time. Eleven states said their healthcare eligibility and enrollment systems are so outdated that they need complete renovations.

The survey also asked states about guidance they had received from the Obama administration on how to achieve streamlined eligibility and enrollment requirements, and about how helpful it was. Many states reported challenges, such as implementing the requirements by the target date and upgrading outdated eligibility and enrollment systems. States also described various funding issues related to implementing needed changes and called for additional guidance from CMS on a variety of topics such as application requirements.

Read the report at: <https://oig.hhs.gov/oei/reports/oei-07-10-00530.pdf>

## **EOHHS News**

**1/21/13 Massachusetts submitted comments to HHS/CMS on a [proposed rule](#) "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 processes, 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.

ACA §2001 required states to expand their Medicaid programs to individuals under 65 years of age with incomes at or below 133% FPL, beginning January 1, 2014. (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, CHIP or premium tax credits.

The proposed rule also affects a wide range of other Medicaid and Exchange 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 alternative benefit packages to the new adult eligibility group (§2001) for citizen and qualified alien adults under age 65 with income up to 133% FPL that would differ from what is currently allowed for Medicaid members under the traditional Medicaid program. 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. 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>

The comment period has closed but a link to the January 14, 2013 Federal Register notice containing the proposed rule can be read at: <http://www.gpo.gov/fdsys/pkg/FR-2013-01-22/pdf/2013-00659.pdf>

The Massachusetts comment letter can be read online at the Massachusetts national health reform website under the State and Federal Communications section at:  
<http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/state-fed-comm/130221-comment-letter.pdf>

Bookmark the **Massachusetts National Health Care Reform website** at:  
[National Health Care Reform](#) to read updates on ACA implementation in Massachusetts.

Remember to check the Mass.Gov website at: [Dual Eligibles](#) for information on the **"Integrating Medicare and Medicaid for Dual Eligible Individuals"** initiative.