The ACA's Impact on Medicaid: Changes and Opportunities for MassHealth

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About the Massachusetts Medicaid Policy Institute

The Massachusetts Medicaid Policy Institute (MMPI)—a program of the Blue Cross Blue Shield of Massachusetts Foundation—is an independent and nonpartisan source of information and analysis about the Massachusetts Medicaid program, "MassHealth." MMPI's mission is to promote the development of effective Medicaid policy solutions through research and policy analysis.

About Bailit Health Purchasing

Bailit Health Purchasing, LLC is a health care consulting firm dedicated to working with public agencies and private purchasers to expand coverage and improve health care system performance for consumers, purchasers and taxpayers.

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Executive Summary

The Patient Protection and Affordable Care Act (ACA) requires states to make a number of changes to their Medicaid programs that will impact the administration of MassHealth. The ACA also presents Massachusetts with opportunities to make optional changes meant to improve quality while containing costs. Both the mandatory and many of the optional changes are accompanied by significant increases in federal funding. The key ACA provisions follow.

Mandatory Coverage of Adults to 133 percent of the Federal Poverty Level (FPL)

The ACA expands mandatory coverage under the Medicaid program to all individuals up to 133 percent FPL, beginning in January 2014. Massachusetts currently provides coverage for much of this population under a combination of MassHealth and Commonwealth Care. Benefits must meet the essential health benefits standard required under the ACA, but can be less generous than those a state provides to other mandatory Medicaid populations. Premiums are not allowed, but cost sharing may be required up to 5 percent of family income.

Beginning in 2014, the federal government will pay for most of the expansion population's benefits as long as states maintain the eligibility standards they had in place for other populations as of July 2008. Massachusetts will receive an increasing level of federal matching funds toward coverage of childless adults with incomes up to 133 percent FPL, reaching 90 percent federal match in 2020.

Simplified Eligibility Determinations

The ACA requires that Medicaid and the Children's Health Insurance Program (CHIP) coordinate their eligibility with the state's Exchange, allowing individuals to access coverage through a "no wrong door" approach and using a single application for Medicaid, CHIP, or subsidies through the Exchange. MassHealth currently operates a combined eligibility determination process for Medicaid, CHIP, and Commonwealth Care consistent with the ACA and plans to modernize its eligibility system, including through the provision of online eligibility and redeterminations as required by the ACA beginning in 2014.

Massachusetts, in partnership with a consortium of New England states, received a $35 million Innovator Grant from the U.S. Department of Health and Human Services to support the early development of system changes focused on Exchange-related enrollment

processes. Among other things, this funding will allow Massachusetts to develop systems to adopt the ACA's Modified Adjusted Gross Income (MAGI) standard to be used in determining an individual or family's income beginning in 2014. Under MAGI, all eligibility determinations will be standard across all state Medicaid programs for the non-aged, non-blind, and non-disabled population, will include a gross income test with an automatic 5 percent income disregard and will not consider assets. While Massachusetts currently uses gross income and does not count assets in determining eligibility for MassHealth and Commonwealth Care, the state does not currently provide any income disregard.

Enhanced Benefits

The ACA provides a number of opportunities for states to receive enhanced federal match for providing certain benefits. Massachusetts should carefully review these opportunities to determine whether they will improve the quality of care for MassHealth members while helping the state contain costs. Opportunities include:

- An incentive to eliminate cost sharing for preventive services with a 1 percentage point increase in federal match for those services starting in 2013.
- A new state plan option to provide health home services to individuals with certain chronic conditions, including mental health, substance abuse, diabetes, heart disease or obesity.
  - Health home services include comprehensive care management, care coordination, health promotion services, comprehensive transitional care, patient and family support, and utilization of health information technology (HIT) to link to services.
  - CMS will support state health home planning efforts by matching planning-related expenditures at a state's regular match rate. Upon implementation, health home services will receive 90 percent federal matching funds for the first two years.

Impact on the MassHealth Waiver

The ACA dramatically shifts the federal funding for both MassHealth and Commonwealth Care and allows full federal funding for subsidies towards the purchase of Exchange coverage for individuals and families up to 400 percent FPL. Currently Commonwealth Care is only available to those with incomes up to 300 percent FPL. It also allows legal immigrants who have been in the country for less than five years to obtain federal subsidies towards coverage purchased through the Exchange. Beginning in 2014, Massachusetts will receive increasing levels of enhanced federal match for coverage of adults without dependent children with incomes up to 133 percent FPL. Then, beginning in 2015, Massachusetts will receive a 23 percentage point enhanced match for

CHIP. Availability of this federal funding without the need for a Section 1115 Medicaid demonstration waiver significantly changes the financial landscape and has implications for the need for and use of the state's current MassHealth 1115 waiver. At the same time, the ACA reduces funding for disproportionate share hospitals (DSH) starting in 2014.

The Executive Office of Health and Human Services (EOHHS) and the Office of Medicaid should undertake a comprehensive analysis of current spending under its 1115 waiver, the funding that will be available upon full implementation of the ACA, and consider how best to propose using such funding going forward. As part of their efforts, EOHHS and the Office of Medicaid must continue to be transparent and meet the new public notice requirements for waiver proposals required under the ACA.

Rethinking Coverage across MassHealth, Commonwealth Care, and MSP

The ACA provides Massachusetts with an opportunity to reconsider many aspects of its own health reform. In Massachusetts, coverage through the Connector was specifically differentiated from coverage through MassHealth in eligibility start date, premium payment requirements, and benefit packages. This differentiation, as well as differences between the Connector and the Medical Security Program (MSP), leads to some potentially avoidable gaps in coverage, splits families across programs, and may make transitions across programs difficult for individuals to navigate and understand. The ACA provides an opportunity for the state to examine its public coverage programs through a new lens, to look comparatively across programs to understand if and where these programs treat similarly situated individuals differently, and to consider making changes to make programs more equitable.

The ACA provides the state with an option to implement a Basic Health Plan for individuals with incomes between 133 percent and 200 percent FPL and for legal immigrants with incomes up to 200 percent FPL who are not eligible for Medicaid. Under the Basic Health Plan, the federal government will provide the state with 95 percent of the funds that would have been available to individuals at this income through premium tax credits and cost-sharing subsidies; however, the state must be able to demonstrate that it can contract with entities to offer a higher level of benefits at a lower premium price. Massachusetts should consider whether it should use the Basic Health Plan as a transition program between MassHealth and the options available through the Connector. To answer this question, the state must analyze whether it would be able to offer the higher level of benefits at a lower premium price with the funding it will receive in lieu of the premium tax credits for those enrolled. It should also consider the administrative issues associated with having a package for only a certain set of individuals

within the Connector if it were to decide to have the Connector rather than MassHealth administer the Basic Health Plan, and the impact on the merged market risk pool of continuing to separate these individuals from it.

Further, the state should consider how it will treat individuals with incomes above 200 percent FPL who are currently in Commonwealth Care. Under the ACA those individuals will receive a federal premium subsidy for coverage purchased in the individual or small group market through the Exchange, and it is likely that the benefits available through the Exchange will be less generous than Commonwealth Care.

Opportunities to Enhance Community Based Long-Term Care

The ACA provides enhanced federal matching funds to support expanded community long-term care services. For example, through the Community First Choice Option, beginning in October 2011 for five years the state will have the option to receive a six percentage point higher matching rate for personal care attendant services. In addition, starting in October 2011, states can start applying for enhanced federal matching funds to shift spending from institutional to community based long-term care under the State Balancing Incentive Program. Also, the state has been awarded $110 million over five years under the "Money Follows the Person" demonstration to assist in moving individuals from institutional care to the community.

Additional ACA Opportunities

The ACA provides MassHealth with significant additional opportunities to improve quality and experiment with payment reform models. The ACA created the Center for Medicare and Medicaid Innovation, which will test innovative payment and service delivery models, as well as the Federal Coordinated Health Care Office, which focuses on simplifying access to health care services and improving quality for individuals dually eligible for Medicare and Medicaid. MassHealth was recently awarded a $1 million design contract from the Innovation Center to support development of a proposal that describes how the state would structure, implement, and evaluate an intervention aimed at improving the quality, coordination, and cost-effectiveness of care for dual eligible adults ages 21-64. The ACA also includes several provisions aimed at improving the integrity of the Medicaid program and reducing fraud, waste, and abuse.

Conclusion and Next Steps

The ACA is already beginning to have a significant impact on the Massachusetts Medicaid program. The national health reform law provides a number of opportunities to advance initiatives the state has long pursued, such as integrated care for the dual eligible populations, while adding a number of mandated administrative responsibilities, such as implementation of standard program integrity programs. A number of changes have already taken effect and EOHHS, working closely with the Commonwealth Health Insurance Connector Authority, is conducting or planning to conduct a thorough analysis of each of the remaining provisions of the ACA, as it considers the programmatic and financial impact of mandatory changes, the pros and cons of implementing optional changes and opportunities, and the timing of those efforts. Implementation of ACA provisions will require ongoing resources and commitment from EOHHS over the next several years.

Opportunities for Enhanced Federal Matching Funds

ACA Provision	Enhanced Funding Available
Development and implementation of health home services for individuals with certain chronic conditions	Began January 2011; 90% federal funding available for two years after implementation
Enhanced match of 6 additional percentage points for provision of personal care attendant services	Begins October 2011; for five years
Enhanced match of 2 additional percentage points, based on current split of spending, to shift spending from institutional to community-based long-term care	Begins October 2011; for four years
Enhanced match of 1 additional percentage point for elimination of cost-sharing for preventive services	Begins January 1, 2013
Increasing federal match for coverage of adults without dependent children (up to high of 90%)	Begins January 1, 2014; reaches 90% in January 2020
Increased CHIP federal match by 23 percentage points	January 1, 2015 through December 31, 2019

The ACA's Impact on Medicaid: Changes and Opportunities for MassHealth

The federal Patient Protection and Affordable Care Act (ACA) requires states to make a number of mandatory changes to their Medicaid programs. It also provides opportunities for improvement within Medicaid. This brief describes the major changes to and opportunities for the Medicaid program through the ACA, and their impact on MassHealth, the Massachusetts Medicaid program.

A. Eligibility Changes Under the ACA

Mandatory Eligibility Changes

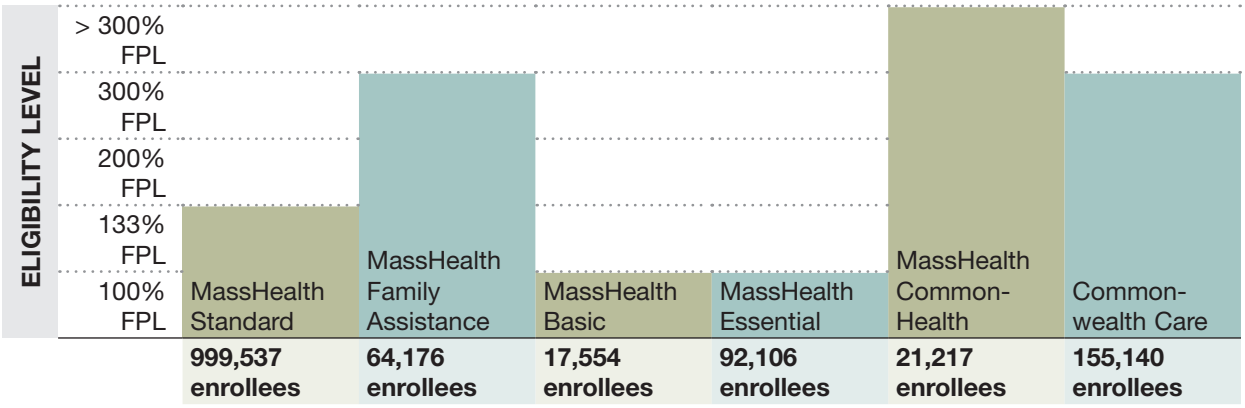
The ACA requires states to expand Medicaid eligibility. Even in Massachusetts, which already has an expansive Medicaid program, the ACA will have important effects.

Today, Massachusetts provides access to health coverage to all individuals under age 65 with incomes at or below 300% of the federal poverty level (FPL) with access to health coverage through MassHealth or Commonwealth Care, *except* undocumented immigrants and, in Commonwealth Care, those who have access to employer sponsored insurance (ESI). Certain legal immigrants are eligible to receive coverage through the Commonwealth Care Bridge program. If an individual applicant, his/her spouse, or his/her parent has access to ESI and is eligible for MassHealth, he/she is typically provided premium assistance for the purchase of ESI. In such cases, MassHealth coverage "wraps around" to pay for any benefits not covered under the ESI. Having access to ESI disqualifies an individual from Commonwealth Care, regardless of income.

MassHealth and Commonwealth Care are funded through a combination of Social Security Act Title XIX (Medicaid), Title XXI (Children's Health Insurance Program, CHIP) and a Section 1115 Medicaid demonstration waiver.[1] Table 1 details how individuals are covered by public health coverage programs today in the Commonwealth.

1 For more detailed information, see Seifert, Robert and Anthony, Stephanie, *The Basics of MassHealth,* Massachusetts Medicaid Policy Institute Fact Sheet, Updated February 2011.

Table 1. Public Health Coverage By Enrollment[2]



The ACA expands mandatory coverage under the Medicaid program to individuals up to 133% FPL plus a 5% income disregard. Benefits provided to this newly eligible population do not need to equal full Medicaid benefits required by a state for other mandatory populations. But they do need to meet benchmark or benchmark equivlent coverage.[3] At a minimum, the benefits must include all federal Medicaid mandatory benefits plus prescription drugs and mental health services. A state is not allowed to charge premiums for this population, but cost-sharing (co-payments and deductibles) is permitted up to 5% of family income. States can provide this coverage now on an optional basis, and will be required to do so beginning in January 2014.

In Massachusetts, adults without dependent children are the only non-elderly group not currently eligible for MassHealth with incomes up to 133% FPL. This presents the Commonwealth with several key policy decisions: 1) when to expand coverage for this group, 2) what benefits to provide through that coverage, 3) through what kind(s) of delivery systems to provide such benefits (i.e., the Primary Care Clinician [PCC] Plan and/or Managed Care Organizations), and 4) what cost sharing to impose. The state will also have to decide what to name the program.

Today, Massachusetts provides access to coverage for much of this population, through a combination of MassHealth Basic and MassHealth Essential (both of which cover adults

2 Enrollment numbers are based on the MassHealth November Enrollment Snapshot Report and Commonwealth Care numbers as included in the CMS December Report. MassHealth Standard covers those traditionally eligible for Medicaid — low-income children and parents, pregnant women and the aged, blind, and disabled population. Family Assistance covers children to 300% and parents to 150% FPL. Basic and Essential cover adults without dependent children who are long-term unemployed and have incomes below 100% FPL. CommonHealth provides coverage to both working and non-working disabled adults and children at any income level. As an individual's income increases, the premium increases. Commonwealth Care covers individuals to 300% FPL who are ineligible for MassHealth.

3 Benchmark coverage allows a state to provide health benefits at a level equal to one of a number of commercially available plans, including Federal Employees Health Benefit Plan Equivalent Coverage, State employee coverage, the Health Maintenance Organization plan with the largest insured commercial population, or through a Secretary-approved coverage. Benchmark coverage must meet the essential health benefits standard required under the ACA.

without dependent children up to 100% FPL who have been unemployed for longer than 12 months) and Commonwealth Care.[4,5] Participating individuals receive services through managed care (either a Medicaid managed care organization, the state administered PCC Plan, or a Commonwealth Care managed care organization). Because each of these programs is funded through the Commonwealth's Section 1115 Demonstration Waiver, Massachusetts has not been required to show how the benefits would compare to benchmark or benchmark equivalent coverage. However, given the comprehensive level of benefits offered and the minimal cost-sharing, it seems likely that these coverage types would meet the benchmark equivalent required by the ACA or be eligible for a Secretary-approved coverage. As part of its benefits package, the Commonwealth will also need to determine the level of cost-sharing to be included in the plan. For those below 100% FPL, only nominal cost-sharing is allowed; but states have flexibility to include cost-sharing up to 10% of family income for those between 100%-133% FPL.

The ACA also requires that, beginning in 2014, states provide Medicaid coverage to former foster children up to age 26. These young adults must receive the full Medicaid benefit package (MassHealth Standard), including Early Periodic Screening Diagnosis and Treatment (EPSDT). Today, the state covers these individuals up to age 21 in MassHealth Standard. In addition, the state already covers many former foster children ages 22-26 through a combination of MassHealth Basic, MassHealth Essential, and Commonwealth Care. While MassHealth has not yet conducted an analysis of the impact of this provision, extending MassHealth Standard to former foster children is likely to have minimal financial impact on the state.

Optional Eligibility Changes

In addition to new Medicaid requirements, the ACA gives states the option to adopt other eligibility changes. Under the ACA, for example, states may choose to use presumptive eligibility for all Medicaid populations.[6] Currently Massachusetts provides for presumptive eligibility as allowed by federal law for children, pregnant women, and women with breast or cervical cancer. As implemented in Massachusetts, presumptive eligibility allows individuals to become eligible for MassHealth based on a declaration

4 While the focus of this brief is on the impact of the ACA on MassHealth, it is important to recognize that the ACA will likely result in changes to the current Commonwealth Care program as well.

5 Availability of coverage under MassHealth to 133% FPL will expand eligibility to include individuals currently excluded from Commonwealth Care based on availability of ESI. Under MassHealth, the state can take advantage of ESI and provide premium assistance towards that coverage. This ACA expansion also may provide coverage for certain full- and part-time students who are residents of Massachusetts and currently purchasing health coverage through the Qualified Student Health Insurance Program (QSHIP). There also remains an eligible but unenrolled population that may apply for coverage when the state places a renewed focus on the availability of coverage.

6 Presumptive eligibility allows an individual to declare income and other information and receive benefits immediately, but for a limited amount of time (while submitting the required verifications).

of income for which verification is required within a 60-day time frame. While the ACA expands who can make presumptive eligibility determinations to hospitals designated as qualified entities, MassHealth is unlikely to use that expansion; hospitals in the state already can assist individuals in immediately applying for MassHealth, through the Virtual Gateway.

Simplified Eligibility Determinations

In order to simplify eligibility determinations, the ACA requires that state Medicaid and CHIP programs coordinate their eligibility with the state's Exchange, allowing individuals to access health coverage through a "no wrong door" approach and a single application for determination of health coverage through Medicaid, CHIP, or the Exchange. To foster this approach, states must develop a secure interface between all public health coverage programs to allow for the free exchange of data and determinations of program eligibility. Today the Commonwealth Health Insurance Connector Authority uses the MassHealth eligibility system to determine eligibility for Commonwealth Care, and is therefore likely in compliance with the ACA requirements. As MassHealth modernizes its eligibility system, the state will continue to enhance the eligibility process, including introduction of online eligibility determinations and redeterminations as required by the ACA beginning in 2014. The ACA also provides outreach assistance focused on enrolling vulnerable and underserved populations, which will allow MassHealth and Commonwealth Care to continue their joint outreach efforts. Further, the ACA provides opportunities for additional collaboration, such as development of a joint website for coverage options and other operational tasks. Implementing these enhancements with an eye towards ensuring continuity of coverage will be critical as eligibility for public subsidies extends to persons with even higher incomes where income fluctuations are more common and, without coordinated eligibility determination and re-determination processes, eligibility churn could become more prevalent.

Through joint efforts of MassHealth and the Connector, Massachusetts joined with the other New England states to apply for a federal Innovator Grant to allow for early development of system changes focused on Exchange-related enrollment processes to support the ACA.[7] This collaborative effort was awarded $35 million in February 2011. The University of Massachusetts Medical School will serve as the principal investigator and project manager for this two-year project. Among other things, the funding will allow Massachusetts to develop appropriate systems to adopt the ACA's Modified Adjusted Gross Income (MAGI) standard to be used in determining an individual's or family's

7 For more information on the Innovator Grant application submitted by the New England states, see http://www.mass.gov/Eeohhs2/docs/eohhs/healthcare_reform/sec_1311_101222.pdf.

eligibility beginning in 2014. Under MAGI, all applications for the non-aged, non-blind, and non-disabled population will automatically have 5% of their income disregarded.[8] No other disregards are allowed and there is no asset test.[9]

Benefit Provisions

The ACA requires that state Medicaid programs add a number of benefits, including smoking cessation benefits, hospice coverage for children even if still being treated for a terminal illness, and family planning services.[10] MassHealth already provided both smoking cessation benefits and family planning services to its members prior to the ACA. Effective November 2010, the Commonwealth also implemented mandatory hospice coverage for children receiving treatment for a terminal illness. Additionally, beginning January 1, 2013, the ACA incentivizes states to eliminate cost sharing for preventive services by offering a 1 percentage point increase in the federal match (FMAP) for those services. Guidance has not yet been released on this provision, but MassHealth is likely to be eligible and apply for this enhanced match; the actual dollar amount is likely to be minimal, however.

Beginning in 2011, states may use a new state plan option to provide health home services to individuals with certain chronic conditions, including mental health, substance abuse, asthma, diabetes, heart disease, or obesity.[11] In November 2010, CMS released guidance on this new option, which will allow states to pay designated health homes to provide comprehensive care management, care coordination and health promotion services, comprehensive transitional care, patient and family support, and utilization of health information technology (HIT) to link services. MassHealth is currently considering potential options for pursuing this opportunity. CMS will provide planning grants at a state's regular match rate for these services. Upon implementation the services will receive 90% FMAP for the first two years.

8 Practically, this results in an increase of the allowable FPL for coverage under the Medicaid program from 133% to 138% of gross income.

9 For currently eligible individuals who would not continue to be eligible based on new MAGI rules, states are required to continue coverage through March 31, 2014, or until their next redetermination after this rule takes effect. Although few, if any, individuals are likely to be impacted by this provision in Massachusetts, EOHHS must allow for the possibility as it develops its new eligibility system, to ensure their protection.

10 While providing a family planning option for individuals not otherwise eligible for Medicaid is a state option under the ACA, providing family planning services to those eligible for Medicaid benefits is required.

11 To participate, individuals must have two or more eligible chronic conditions, or one chronic condition with the risk for a second, or a serious and persistent mental health condition. The Secretary has the authority to expand coverage to include additional conditions outside what is listed in the ACA.

B. Federal Funding

Beginning in 2014, the federal government will pay for virtually all the expansion populations, including an enhanced match for states like Massachusetts that already covered much of this population through a Medicaid waiver. Specifically, Massachusetts is considered a transition state and, as such, will receive an increasing federal match toward coverage of childless adults up to 133% FPL, reaching 90% match in 2020.

In addition, the federal government will provide 100% federal funding for subsidies towards health coverage purchased through the Exchange for eligible individuals with incomes at or below 400% FPL.[12] While the ACA does not lift the five-year bar for coverage under the Medicaid program for legal immigrants, it does include legal immigrants as individuals eligible to receive subsidies through the Exchange. This means that federal funding could be made available to fund enrollees of Commonwealth Care Bridge *if* they were to purchase subsidized Exchange coverage instead.

Maintenance of Effort Requirement

To receive enhanced federal match for the Medicaid program, states are required to maintain the eligibility standards they had in place in July 2008, though a hardship waiver is available for states that can show budget deficits. The waiver would allow for a state to reduce coverage to optional populations (e.g., childless adults, parents at higher income levels), but such reduction in coverage may increase the number of uninsured people and shift costs to other payers. States may continue to meet state budget constraints through reductions in optional benefits and payment rates.

The increased federal funding for health coverage through Medicaid, and the addition of new federal monies for subsidies through the Exchange, significantly changes the financial landscape, which may have implications for the state's current MassHealth Section 1115 Demonstration Waiver. Currently, the MassHealth Waiver is used to fund MassHealth coverage for individuals with incomes up to 100% FPL who are long-term unemployed, as well as for the government-subsidized portion of the Commonwealth Care premium for individuals with incomes up to 300% FPL. Going forward, covering these individuals will no longer require a Waiver, and federal matching funds will no longer be subject

12 Technically, the federal subsidies provided under the ACA are advanceable tax credits based on an individual's estimated annual income. In practice, these tax credits will function much like the subsidies provided in Commonwealth Care today. That is, individuals will be eligible for health insurance coverage with a reduced out of pocket payment based on an eligibility determination. The difference is that the actual tax credit to which an individual is entitled may differ from what is received, introducing the potential for reconciliation with federal income tax filing. The IRS has not yet issued regulations describing how this process would work.

to the budget neutrality constraints a Waiver imposes. The Executive Office of Health and Human Services (EOHHS) and the Office of Medicaid should undertake a comprehensive analysis of current spending under the Waiver now, to assess how best to propose using such funding going forward. Public comment is now required on Waivers prior to CMS review and approval, and must include feedback on demonstration goals, budget neutrality, coverage, and compliance. As they move forward, EOHHS and the Office of Medicaid must continue their efforts to be transparent, and to fully meet the new public notice requirements for waiver proposals required under the ACA.

The ACA also shifts additional funding responsibilities to the federal government for CHIP from 2015 through 2019, by enhancing its current federal match by 23 percentage points. This provision increases Massachusetts' CHIP match from 65% to 88% for the 2015-2019 period. In addition to providing enhanced funding for CHIP, the ACA reauthorizes the CHIP program through 2019, although it only appropriates funding for the program through 2015.[13]

In addition, the ACA reforms the Medicaid Disproportionate Share Hospital (DSH) program and reduces DSH payments beginning in 2014. The Secretary of HHS is charged with developing the specific methodology to reduce DSH payments; however, the statute contemplates that states with the lowest levels of uninsured and those that do not target their DSH allotments to hospitals with high Medicaid or uncompensated care will see the largest reductions. The impact on Massachusetts' allotment is unclear. While the state has low levels of uninsured, which may lead to a reduced DSH payment, it certainly targets DSH payments to hospitals with high Medicaid or uncompensated care through the Health Safety Net, which may protect the state from large DSH reductions.

Finally, the ACA makes changes to Massachusetts' ability to collect Medicaid Drug Rebates. This section of the ACA, retroactive to January 1, 2010, increases the minimum rebates a pharmaceutical company must provide to a Medicaid program, but provides that any *additional* savings from this change accrue to the federal government.[14] While the drug rebate provision, as interpreted by HHS, will not reduce the amount of drug rebates MassHealth currently collects, it does take rebates away as a mechanism to create future savings to the MassHealth budget, since all rebate funds collected above current levels, as noted, will accrue to the federal government. The ACA also reduces the pharmacy upper

13 Unlike Medicaid, federal CHIP spending is limited by allotments. In FY2010 the Massachusetts CHIP allotment from the federal government totaled a $422 million. The ACA includes a formula for CHIP allotments through 2015. Beginning in 2016, Congress will be required to either appropriate additional CHIP allotment to account for the increase in federal share or, if no further CHIP allotment is forthcoming, states will likely stop providing a separate program for children and include them within their parents' coverage through the Exchange. See Dorn, Stan and Buettgens, Matthew, *Net Effects of the Affordable Care Act on State Budgets*, The Urban Institute, December 2010.

14 The provision also extends the availability of rebates to Medicaid managed care plans. No savings accrue to the state from this provision.

payment limit to no less than 175% of the weighted average of the reported average manufacturer price (down from 250%). This change may reduce ingredient costs in MassHealth and lead to slight savings in the pharmacy program.

C. Opportunities to Coordinate Coverage through MassHealth and the Connector

The ACA provides Massachusetts an opportunity to reconsider many aspects of its own health reform. In particular, the ACA provides an opportunity to examine the state's public health coverage programs through a new lens — to look comparatively across programs to understand if and where these programs treat similarly situated individuals differently.

In Massachusetts, for example, coverage through the Connector was specifically differentiated from coverage through MassHealth, with the two programs differing in eligibility start date, premium payment requirements, and benefit packages. This differentiation, as well as differences between the Connector and the Medical Security Program (MSP) leads to potentially avoidable gaps in coverage, splits families across programs, and may make transition across programs difficult for individuals to understand.

The Basic Health Plan

As described above, the ACA requires that, beginning in 2014, states provide coverage to adults without dependent children to 133% FPL. This change will result in a significant transition of individuals from Commonwealth Care to MassHealth. The ACA also provides for an optional Basic Health Plan for individuals with incomes between 133% and 200% FPL,[15] who today may be served through MassHealth or Commonwealth Care. Further, it allows for legal immigrants with incomes up to 133% FPL to receive coverage through the Basic Health Plan with federal funding — an important change for Massachusetts, which today provides limited coverage to some of these individuals *at full state cost* through the Commonwealth Care Bridge program.

Similar to Commonwealth Care, the Basic Health Plan in the ACA is conceived as a separate health plan offered outside the Medicaid program, as a step towards commercial coverage. The ACA does not specify a particular entity to administer the Basic Health Plan; so such a plan could potentially be administered through either the Connector or

15 See Section 1331 of the ACA.

MassHealth. If a state elects to implement a Basic Health Plan, the federal government will provide 95% of the funds that would have been available (through premium tax credits and cost-sharing subsidies for participating individuals) toward the cost of coverage through the Exchange. The Basic Health Plan is to be offered through one or more health insurers chosen through a competitive procurement. If the program were to be administered by MassHealth, this procurement could be combined with MassHealth's larger managed care organization reprocurement to ensure a consistent offering of health plans as member incomes fluctuate over time. Alternatively, if the program were administered by the Connector, the state would need to consider the administrative issues associated with their overseeing a benefit plan for only a certain set of individuals within the Connector.

Coverage under the Basic Health Plan must include at least the ACA-required essential health benefits[16] and meet the 85% medical loss ratio requirement that applies to large groups. Further, while premiums may be no higher than those tied to the second lowest priced Silver plan provided through the Exchange, benefits must meet the Platinum level for individuals with incomes up to 150% FPL, and the Gold level for those with incomes between 151% and 200% FPL.[17] This could present a challenge to offering such a plan in Massachusetts, as it may be difficult to provide a higher level of benefits for a lower cost. In addition to the benefit standards, the ACA directs states to consider innovative features such as care coordination, incentives for preventive care use, and appropriate service utilization when offering a Basic Health Plan.

Massachusetts should also consider whether to conform the Commonwealth Care program for those with incomes between 133% and 200% FPL to the Basic Health Plan to serve as a bridge between MassHealth and, as envisioned in the ACA, the commercial options available through the Connector come 2014. To answer this question, the state must analyze: 1) whether it would be able to offer the higher level of benefits at a lower premium price with the funding it will receive in lieu of the premium tax credits for those

16 The ACA requires that, in order to meet the health insurance coverage requirement, plans must include essential health benefits, similar to Massachusetts' requirement for minimum mandatory coverage requirements. The ACA provides a general list of benefits that must be included (inpatient, outpatient, emergency and maternity care; mental health and substance abuse treatment; oral and vision care; prescription drugs and lab tests; and preventive and rehabilitative care) but provides the federal Secretary of Health and Human Services with the authority to define essential health benefits. As a first step, the Secretary has asked the Institute of Medicine to study how essential health benefits should be determined and updated. The study, which is scheduled for completion in September 2011, is only expected to provide a framework for decision making, leaving to HHS the task of developing specific standards. The federal Department of Labor conducted a separate study, released in April 2011 that details what benefits health insurers are offering today. Trapp, Doug, *IOM takes first step in defining essential health benefits*, American Medical News, November 29, 2010.

17 The ACA creates four benefit categories of health insurance plans which must provide the minimum essential health benefits (to be defined by HHS). These plans are defined by actuarial value, which is a summary measure of the amount of medical claims that would be paid by the health plan as a percentage of the total medical claims incurred for a standard population. The four categories of plans are: Platinum (90% of the benefit costs must be covered by the plan); Gold (80%); Silver (70%) and Bronze (60%).

enrolled; and 2) the impact on the merged market risk pool of continuing to separate these individuals from it.[18]

In addition, depending on where such a program were to be administered, the state should consider the impact on the Connector's purchasing power were these additional members included within its purchasing purview or not. Further, the state should consider how it will treat individuals with incomes above 200% FPL who are currently in Commonwealth Care, because under the ACA those individuals would receive a federal premium subsidy for coverage purchased in the individual or small group market through the Exchange. The state's options will depend in part on whether the federal government allows MassHealth to continue to operate its Waiver using current categories and funding. Given the likelihood that the federal government will try to conform state programs to the ACA, the state will need to consider whether to allow current Commonwealth Care plans to operate within Commonwealth Choice, or whether to enroll the current Commonwealth Care population in Commonwealth Choice with either federal subsidies or a combination of state and federal subsidies.

D. Quality and Payment Reform Opportunities Focused on Medicaid

Quality Opportunities

The ACA creates two new offices within HHS focused on improving quality, which in turn can potentially reduce health care costs. The federal Coordinated Health Care Office is focused on simplifying access to health care services and improving quality for individuals dually eligible for Medicare and Medicaid. A key responsibility of the Office is to eliminate regulatory conflicts between the Medicare and Medicaid programs. The Center for Medicare and Medicaid Innovation will test innovative payment and service delivery models, including initiatives focused on integrating care for dual eligibles, as discussed below.

The ACA also vests additional responsibility in the previously created Medicaid and CHIP Payment and Access Commission (MACPAC). MACPAC, created in 2009 as part

18 The calculus in Massachusetts will differ from that in other states. Today, the financial risks associated with the small group and individual markets are pooled into a "merged market", but the Commonwealth Care program is not included in that risk pool. Going forward, individuals in Commonwealth Care with incomes above 200% FPL are likely to move into Commonwealth Choice, continue receiving subsidies as provided for in the ACA up to 400% FPL and be included in the merged market risk pool. The analysis of the impact here should look at the difference between adding all individuals with incomes between 133% and 300% FPL currently in Commonwealth Care into the merged market risk pool, compared to splitting out those with incomes between 133% and 200% FPL from that risk pool.

of the CHIP reauthorization legislation, is charged with reviewing policies and advising Congress on a range of issues, including the impact of payment policies on quality and access. The ACA increases the scope of MACPAC's oversight review to include eligibility policies, enrollment and retention processes, coverage policies, quality of care, interactions between Medicare and Medicaid, and medical malpractice.

In addition to creating these new organizations and increasing oversight through MACPAC, the ACA builds off the existing efforts to create standard quality measures for children participating in Medicaid and CHIP that began with the CHIP reauthorization, and charges HHS with developing standard quality measures for adults. HHS released proposed measures for public comments in January 2011 and is scheduled to publish an initial set of core measures in January 2012, after obtaining public input, and to develop a standard reporting format by January 2013. Reporting on these measures to Congress will begin in 2014 and occur every three years thereafter. Massachusetts will be required to report on these adopted quality measures and will be allowed to continue to include state-specific information in its external quality review organization (EQRO) reports.

Payment Reform Opportunities

The ACA provides a number of opportunities for payment reform demonstrations, focused on moving from the current fee-for-service system to payments that reward quality and outcomes rather than utilization. These opportunities extend to the Medicaid program and include demonstrations for:

- Pediatric Accountable Care Organizations (ACOs);[19]
- Bundled payments for integrated care around a hospitalization;[20]
- Global capitated payment models for safety net hospitals;
- Center for Medicare and Medicaid Innovation grants to improve delivery system and payment models for dually eligible individuals; and,
- Payment, through a demonstration, to an Institute for Mental Disease (IMD) for stabilization of an emergency medical condition for a psychiatric patient.[21]

19 The ACA authorized the Pediatric ACO program, but did not include an appropriation. If funded, the Pediatric ACO would require a three-year commitment from a Pediatric ACO. In addition, Massachusetts and HHS would have to establish quality guidelines and agree on minimal savings levels. Any savings that exceeded the baseline level would entitle the ACO to an incentive payment.

20 Through this ACA provision, Massachusetts could make bundled payments for integrated care around hospitalization based on predetermined episodes of care to be addressed and services to be included. Participating hospitals must have robust discharge planning. The ACA does not provide additional funding for a bundled payment pilot. Payment methodologies to providers using a bundled payment must be approved by CMS and will receive Massachusetts' regular FMAP of 50%.

21 The ACA provides for this demonstration project to begin in 2011 and continue through 2015. Participating states will receive regular FMAP and will be required to establish a mechanism to determine whether an individual is stabilized.

Massachusetts will review all ACA payment reform opportunities as guidance is released, and has shown particular interest in pursuing the global capitated payment model for safety net hospitals. Under the ACA, HHS has the authority, though no additional funds, to implement this model in up to five states. Massachusetts has proposed to conduct a global payment pilot with one or more providers as part of its MassHealth Waiver Amendment, submitted in June 2010.

The ACA provisions to improve the coordination of care for individuals dually eligible for Medicare and Medicaid offer additional opportunities for the state. Through the Center for Medicare and Medicaid Innovation, for example, MassHealth was recently awarded a $1 million design contract to support development of a proposal that describes how the state would structure, implement, and evaluate an intervention aimed at improving the quality, coordination, and cost-effectiveness of care for dual eligible adults ages 21-64. Since 2003, Massachusetts has administered the Senior Care Options (SCO) program, a voluntary managed care program available to seniors participating in MassHealth, including those who are dually eligible for Medicare and Medicaid. The state's proposed model of integrated care and financing for the under 65 dual eligibles will draw upon lessons learned from the SCO program. EOHHS recently solicited input through a Request for Information (RFI) to obtain stakeholder feedback on the details of the proposed model. A key feature is the integration of Medicare, Medicaid, and Home and Community-Based waiver services and funding to allow for comprehensive person-focused care. As envisioned by EOHHS, Massachusetts and the federal government would share any aggregate savings across the Medicaid and Medicare programs.

In addition, the ACA includes the availability of up to $100 million between 2011 and 2016 in grant funds to state Medicaid programs to develop incentives for Medicaid members to participate in programs aimed at prevention of chronic diseases. EOHHS submitted a grant proposal on April 29, 2011 aimed at increasing participation in existing programs for chronic disease self-management, tobacco cessation, diabetes self-management education and medical nutrition therapy for diabetes care.

In an effort to improve access to primary care in the Medicaid program, the ACA provides for increased Medicaid payments for primary care services provided by general medicine, family medicine, and pediatric practices in 2013 and 2014. The enhanced payments will be equal to the Medicare rate in a given geographic area; and the difference between the state's rate and the Medicare rate will be fully funded with federal dollars. MassHealth should anticipate pressure to continue these enhanced payment rates at its regular FMAP beginning in 2015.

E. Long-Term Care

While much of the attention to the ACA focuses on changes in insurance, coverage, and capacity regarding acute medical care delivery, a significant portion of the law addresses the long-term care system.

A number of ACA provisions deal with long-term care. Some present options for states in their Medicaid programs; others are changes in federal policy with which states must comply. There are also grant and demonstration opportunities for states to consider. Below we discuss two categories of long-term care provisions in the ACA: 1) provisions to rebalance the delivery of long-term care services between community and institutional settings, and 2) provisions to broaden their financing.

Provisions to Rebalance Long-Term Care Delivery

Medicaid's eligibility rules and benefits design have historically favored institutional care, such as nursing homes. The criteria for elders to qualify for nursing home care are less restrictive than the eligibility criteria for community-based services, and many home- and

Long-Term Care

Long-term care — often referred to as long-term services and supports (LTSS) — accounts for a substantial part of spending in MassHealth. Given the amount of spending by MassHealth on long-term care and the aging of the Massachusetts population, it is particularly important to consider opportunities in the ACA to improve access to community-based services and, thus, reduce overall long-term care spending.

Long-term care encompasses the medical and non-medical services, equipment, and other supports that help people meet their daily needs and improve the quality of their lives over an extended period. Such care may be provided in people's homes, elsewhere in the community, or in residential facilities.

Massachusetts residents of all ages use long-term care, but the chance of needing services increases with age. This is important for MassHealth, which has an older than average population that is becoming even older. Medicaid is the predominant payer for long-term care, both nationally and in Massachusetts. Nationally, Medicaid accounts for about half of all spending on long-term care. The proportion is similar in Massachusetts, where MassHealth is the most common financing source. Not surprisingly, long-term care accounts for a large portion of the MassHealth budget; MassHealth spends hundreds of millions of dollars per year for both facility-based and community-based services.

community-based services (HCBS) are offered through Medicaid only under program waivers and available to a limited number of individuals with specific conditions or levels of need. Massachusetts has long been committed to a vision of community first and for the past several years has worked to serve more residents in the community rather than in institutional settings. A number of ACA provisions are explicit efforts to shift policy toward greater reliance on HCBS and less on facility-based care.

Community First Choice option

This provision of the ACA reiterates a state's option of covering personal attendant services, which enable many people with disabilities to live at home rather than in an institution, as part of the regular Medicaid program rather than under a special waiver. The ACA provides for a 6 percentage point enhancement to a state's Medicaid federal matching rate, beginning in October 2011, for provision of this service, even in states such as Massachusetts, which currently provide personal care attendant services as an optional benefit. This provision is set to sunset after five years, however. CMS released proposed regulations governing this section in February 2011.

Removal of barriers to providing HCBS

This provision updates Section 1915(i) of the Social Security Act, which governs HCBS in the Medicaid program. Under the ACA, a state is now allowed to provide a broader range of HCBS under its Medicaid state plan to a broader range of members. Previously, states could offer HCBS under 1915(i), which were more limited in scope than could be authorized by an HCBS waiver and could exclude members up to the income level that waivers allow. The ACA broadens the scope of services states can offer without a waiver, and allows a state to serve members who meet the same financial and functional criteria as under its current HCBS waivers. A potential problem is that amending a state plan in these ways exposes a state to a level of financial risk it might not be able to support in the current economic climate, because a state cannot limit the number of people eligible to receive benefits that are part of its state plan. In the long run, these provisions give states much more flexibility to align services with needs in appropriate settings. It seems unlikely that Massachusetts will take advantage of the state plan option, as the state is currently contemplating developing two additional HCBS Waivers as part of its Money Follows the Person demonstration project, discussed below.

Expansion of "Money Follows the Person" rebalancing demonstration

This program, begun in 2006, provides federal grants to help states transition individuals from facilities to services in the community. Massachusetts did not participate in the

original demonstration, but used a planning grant provided through the ACA to develop a proposal for the extension period. The state was awarded $110 million over five years and will use the funds to assist in moving individuals from institutional care to the community.

The proposal, filed with CMS on January 7, 2011, focuses on transitioning about 2,500 individuals from institutions and nursing facilities to the community over a five-year period. As part of this initiative, the Commonwealth is planning to expand its existing institution-to-community transition capacity, and build appropriate administrative structures to support the needed expansions of community services. In addition, the plan includes the two new HCBS Waivers noted above, which include provision of residential support.

State Balancing Incentive Program

This ACA provision gives states financial incentives, in the form of enhanced federal match, to shift more of their long-term care from facility- to community-based care. States that currently devote less than 50% of their Medicaid long-term care spending on non-institutional services would qualify for the incentive payments. For states with less than 25% of their long-term care spending on non-institutional services, the enhanced match will equal 5 percentage points; states with 25%-50% of such spending on non-institutional services are eligible for a 2 percentage point match enhancement, for which Massachusetts is likely to be eligible. According to MassHealth data, MassHealth spending on nursing facility care totaled 60% of all long-term care spending in FY2008.[22] States can apply for this balancing incentive beginning October 1, 2011. The enhanced funds are available for a four-year period.

Medicare Part D

The ACA includes elimination of cost sharing in the Medicare Part D prescription drug program for Medicare/Medicaid dual eligible members enrolled in an HCBS waiver program who would otherwise require facility-based care. This will lead to savings in the MassHealth program, as the state will no longer need to provide assistance with cost-sharing under Part D for these members.

Provisions to Broaden the Financing of Long-Term Care

The ACA includes one major provision intended to shift financing of long-term care away from stressed state Medicaid programs toward private sources. The Community

22 *Long-Term Care in Massachusetts: Facts at a Glance*; accessed at www.massmedicaid.org on January 11, 2011.

Living Assistance Services and Supports (CLASS) program, originally scheduled to begin in 2011 but likely to be significantly delayed, will help individuals plan and save for future potential long-term care needs. As envisioned, working individuals will be able to contribute, through payroll deduction, to a fund that will pay a cash benefit to individuals who have been enrolled for at least five years and who meet a specified level of need. The CLASS benefit will be available for community- or facility-based services, will require no health screen, and will not exclude people with pre-existing conditions. The program is voluntary, however, so its long-term financial sustainability depends on the participation of a broad range of people — including young as well as old, and those less likely to need long-term care, at least in the short-term.[23] It is possible that CLASS will be repealed; if not, it is certain to go under major revision prior to implementation. If successfully implemented, CLASS could reduce future MassHealth expenditures by reducing the number of people who spend down their own resources and then must turn to MassHealth to finance their long-term care.[24]

F. Program Integrity Provisions Impacting Medicaid

In an effort to reduce wasteful spending within the Medicaid program and other health coverage programs nationally, the ACA includes several provisions aimed at improving the integrity of the Medicaid program and reducing fraud, waste, and abuse. As a first step, HHS established new procedures for screening providers for fraud, waste, and abuse across the Medicare, Medicaid, and CHIP programs.

In addition, the ACA includes the following provisions:

- Medicaid providers are required to disclose current or previous affiliation with any provider or supplier with uncollected debt, subject to payment suspension or exclusion;
- States may implement a new provider enrollment freeze;
- All prescribing or referring providers must also be Medicaid providers;
- Automatic termination from Medicaid will follow termination from Medicare;
- Exclusion from Medicaid is mandatory for any provider that owns, controls,

23 The National Commission on Fiscal Responsibility and Reform — the Commission charged by President Obama to make recommendations for reducing the federal budget deficit — cited in its final report the view of "many experts" that the financing of CLASS is financially unsound and recommended that it be reformed or repealed.

24 For more details on long-term care financing in Massachusetts and the potential benefit of CLASS, see *Securing the Future, Report of the Massachusetts Long-Term Care Financing Advisory Committee* accessible at http://www.mass.gov/Eeohhs2/docs/eohhs/ltc/ma_ltcf_full.pdf.

manages or is affiliated with an entity that has an unpaid overpayment, suspension from participation, exclusion, or termination; and,

- No Medicaid payments may be made to entities located outside the United States.

Further, providers must report and return overpayments within 60 days of identification. Massachusetts is required to return to the federal government its overpayment share either when it receives payment from the provider or within one year of the identification date, whichever is sooner. The ACA also increases associated state reporting requirements. To meet these requirements, Massachusetts may need to require additional data elements on claims for program integrity, program oversight, and administration. Massachusetts may, at its option, extend this requirement to its Medicaid managed care organizations.

The ACA also requires states to have a state recovery audit contractor. In October 2010, CMS issued a State Medicaid Director (SMD) letter requiring states to establish one or more contractors to identify underpayments or overpayments and to recoup overpayments. While Massachusetts has an ongoing program to identify and recover overpayments, it is important for the state to review this against the SMD letter and final federal regulation, once published, to ensure that the current Massachusetts contract meets ACA requirements, including that payments are on a contingency fee basis for collecting overpayments, with a maximum fee of 12.5%.

In addition, the ACA includes a number of new requirements focused on claims processing and adjudication. Like the program integrity provisions, these requirements are focused on ensuring proper payment and reducing opportunities for fraud and abuse. First, the ACA requires that National Provider Identifier (NPI) numbers be included on all claims effective July 2010. Second, it requires that states report encounter data to CMS on a timely basis or risk the withholding of federal match. Third, it requires that all claims billed using HCPCS/CPT codes processed on or after April 1, 2011 for dates of service on or after October 1, 2010, utilize methodologies that are compatible with the National Correct Coding Initiative, as identified in a September 2010 SMD letter. MassHealth has made updates to its NewMMIS system to comply with this initiative.

Finally, the ACA adds new reporting requirements to the Medicaid program to allow for comprehensive reporting of individuals meeting the ACA's health coverage requirements (i.e., the individual mandate). Specifically, Massachusetts will be required, beginning in 2014, to provide the U.S. Treasury with the name, address, and identification number of all enrollees. Further, MassHealth will be required to report annually to CMS on Medicaid enrollment by eligibility category and population, and on outreach and

enrollment processes, beginning in 2015. Much of this information is already reported to CMS through MassHealth's annual waiver report and CHIP annual report.

G. Conclusion and Next Steps

As described above, the ACA is already beginning to have a significant impact on the Massachusetts Medicaid program. This national health reform law provides a number of opportunities to advance initiatives the state has long pursued, such as integrated care for the dual eligible populations, while adding a number of mandated administrative responsibilities, such as implementation of standard program integrity programs. A number of changes have already taken effect in Massachusetts; and the Executive Office of Health and Human Services, working closely with the Commonwealth Health Insurance Connector Authority, is conducting or planning to conduct a thorough analysis of each of the remaining provisions of the ACA, as it considers 1) the programmatic and financial impact of mandatory changes, 2) the pros and cons of implementing optional changes and opportunities, and 3) the timing of such efforts. The ACA implementation will require ongoing resources and commitment from EOHHS over the next several years.

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