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Budget Brief

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MassHealth and Health Reform Provisions in the June FY 2012 Supplemental Budget (Chapter 118)

The Legislature recently enacted, and the Governor signed, an FY 2012 supplemental budget (Chapter 118 of the Acts of 2012) that includes a number of provisions affecting MassHealth and health reform programs. The supplemental budget creates a new Delivery System Transformation Initiatives (DSTI) Trust Fund and authorizes a transfer of $186.9 million—the bulk of the approximately $213 million contained in the budget—into this new fund. The legislation also includes legislative changes that are related to implementation of federal health reform in Massachusetts under the Patient Protection and Affordable Care Act (ACA). While adoption of further legislation to implement components of the ACA will be necessary in 2013, the legislature approved the provisions included in Chapter 118 because these need to be in place in order for the state to comply with certain federal deadlines for implementation activities, and to provide insurers with suitable time to develop new products. The remainder of this budget brief outlines both the MassHealth and ACA-related provisions in Chapter 118.

MassHealth and Health Reform Provisions in Chapter 118 of the Acts of 2012	
MassHealth (Medicaid) and Health Reform	
Delivery System Transformation Initiatives Trust Fund	• **Section 7** creates a **Delivery System Transformation Initiatives (DSTI) Trust Fund** that will be used to pay for activities designed to promote changes in the health delivery system at seven safety net hospitals. • Payments for these activities are authorized in the state's 1115 Medicaid waiver. Hospitals must submit, and receive approval for, specific plans for the use of funds. Initiatives can include investments in information technology to support medical home models, development of care models to manage chronic conditions or other illnesses, creation of the infrastructure to support new payment methods, and other efforts to support the triple aims of better care, better population health, and lower costs. • Line item **1599-1067 appropriates $186.9 million** for an operating transfer to the DSTI Trust Fund in FY 2012 (because of contributions from public hospital Cambridge Health Alliance, which count towards the state's share of payments, as well as federal matching funds, the actual cost to the state is about $82.0 million). The FY 2013 budget includes a second transfer of $186.9 million to the Fund, and a third transfer is expected in FY 2014. The FY 2013 budget also includes $26.0 million for similar **Infrastructure and Capacity Building** grants to community hospitals and community health centers that are not eligible for grants from the DSTI Fund.
Money Follows the Person Rebalancing Demonstration Grant Trust Fund	• **Section 7** creates a **Money Follows the Person (MFP) Rebalancing Demonstration Grant Trust Fund**. • In 2011 the federal government awarded Massachusetts a five-year **MFP** grant to help transition Medicaid-eligible elders and disabled adults from institutions back to homes in the community. Under the program the state provides a wide variety of services, such as assistive technology and housing support, to enable enrollees to remain in community-based settings. • The **MFP Rebalancing Demonstration Grant Trust Fund** will receive enhanced federal reimbursement revenue related to services provided under the program, and these funds will be used to support slots for participants in **two new MFP programs**.

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MassHealth and Health Reform Provisions in Chapter 118 of the Acts of 2012	
MassHealth (Medicaid) and Health Reform (continued)	
Dual Eligibles Demonstration Program	• **Section 25** adds a new section to the state Medicaid statute directing the Secretary of Health and Human Services to establish a **Medicaid demonstration program** to integrate care for people aged 21-64 at the time of enrollment who are **dually eligible for Medicaid and Medicare**, and it includes provisions governing the integrated care organizations (ICOs) that will provide care for this population under contracts with the state and federal governments. The program will allow ICOs to receive a blended payment that combines Medicaid and Medicare reimbursements. The state received a $1 million planning grant in 2011, submitted its proposal to the Centers for Medicare/Medicaid Services (CMS) in early spring 2012, and recently published the Request for Responses (RFR) for coverage to begin April 2013. A website dedicated to the demonstration is available at mass.gov/masshealth/duals. • Related legislation requiring ICOs to include independent long term services and support coordinators is included in Section 117 of the cost containment legislation recently passed by the legislature.
MassHealth Line Item Transfers	• **Section 65** contains language, similar to that approved in previous years, that allows transfers among various MassHealth line items to cover costs due to shifts in enrollment and expenses across MassHealth programs. Section 63 carries over funds in two MassHealth accounts into the beginning of FY 2013 for payments for services that were provided in FY 2012.
Transition to Affordable Care Act Health Coverage	
Basic Health Plan and Subsidized Coverage	Under the ACA, adults with incomes under 133% FPL will be eligible for Medicaid (MassHealth), and people with incomes above that level but below 400% FPL will be eligible for health insurance tax credits and cost-sharing subsidies. However, states also have the option to create a **Basic Health Plan (BHP)** that would provide directly subsidized coverage for state residents with incomes between 133% and 200% FPL and for residents who are lawfully present immigrants with incomes between 0% and 200% FPL, including those with incomes below 133% FPL who are not eligible for Medicaid; because of federal restrictions. States choosing this option will receive federal funds equal to 95% of the tax credits, plus the cost-sharing subsidies, for which these individuals would have otherwise been eligible had they chosen the second lowest cost "silver" plan available in the Exchanges, which in Massachusetts will be the Connector. In Massachusetts, people in this category typically receive coverage under the Commonwealth Care program. Adopting the BHP would help to ensure affordability and continuity of care and coverage for those under 200% FPL who are now enrolled in Commonwealth Care. • **Section 24** authorizes HHS to "design, establish, and administer a basic health program" to provide health coverage to residents, including legally present aliens, with incomes under 200% FPL. • **Sections 38, 42 and 43** amend the Health Connector's enabling statute to authorize **premium assistance payments** and **cost-sharing subsidies** for eligible individuals under 300% FPL. These provisions not only permit a program like Commonwealth Care to continue but would, subject to available funding, enable the Health Connector to ensure affordability and continuity of care and coverage for individuals now typically enrolled in Commonwealth Care with incomes between 200% and 300% FPL who will be eligible to receive federal tax credits and cost-sharing subsidies after 2014 but would not be financially eligible for the BHP. • **Section 68** specifies that if the state establishes a BHP, it will begin on Jan 1, 2014, in accordance with the ACA's requirements. The state would also need to receive federal approval for the BHP design.
Massachusetts Health Connector and Commonwealth Care Trust Fund	The ACA requires states to set up **Health Insurance Exchanges** that meet certain requirements (or use a federally facilitated exchange), and although this provision is modeled on Massachusetts' Health Connector, technical changes are necessary to bring the **Health Connector** into compliance with ACA requirements. Language included in another supplemental budget (Chapter 96) authorizes the Health Connector to perform the functions required of an Exchange under federal law, and Chapter 118 adds further provisions that affect the Health Connector (in addition to those described in the section above). • **Section 8** makes technical changes to the **Commonwealth Care Trust Fund** statute, such as specifying that funds are to be used for programs administered by the Health Connector (such as those described above) that are designed to increase health coverage under its enabling statute. • **Sections 35, 39-41, and 45-49** add definitions and other language allowing the Health Connector to offer **stand-alone dental and vision plans**, as well as catastrophic and child-only plans. **Section 44** authorizes the Health Connector to administer a **risk adjustment program** for the entire small and non-group merged market sold both inside and outside of the Exchange in order to spread the financial risk among insurance carriers in the merged market (a similar program already exists for Commonwealth Care health plans).

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MassHealth and Health Reform Provisions in Chapter 118 of the Acts of 2012	
Changes to Align State Law with Affordable Care Act Provisions	
Non-Payment for Health Care-Associated Infections and Serious Reportable Events	• **Sections 17-18** amend the existing state statute that prevents health facilities from charging for services related to health care-associated infections or the occurrence of a serious reportable health event. The new language specifies that ACA provisions concerning Medicaid reimbursement for such conditions prevail in the case of payments for services to MassHealth members (the ACA provisions are similar to the state rules, which were enacted as part of health cost control legislation in 2008).
Ordering and Referring Providers in Medicaid	The ACA prohibits Medicaid payments for services that are the result of an order or referral by a provider who does not participate in Medicaid. This can happen, for instance, in cases where a patient has both private insurance and Medicaid. • **Sections 19-23** require various types of providers (physicians, podiatrists, etc.) to enroll as providers in Medicaid "for the limited purposes of ordering and referring services covered under such program," and Section 34 directs insurance companies to require the same of providers in their networks. For example, in cases where a patient has both private insurance and Medicaid, Medicaid could continue to subsidize the drug copayment to a Medicaid participating pharmacy for a prescription written by a clinician who does not otherwise participate in Medicaid. Ordering and referring providers would not be required to participate as direct providers under the Medicaid program.
Child-only and Catastrophic Plans	**Sections 27-30 and 32** amend statutes governing the small group insurance market to include **catastrophic and child-only health plans**, in accordance with the ACA. Section 26 makes a technical change that aligns the state statute with the federal statute governing high-deductible plans that would allow HMOs to offer catastrophic plans with high deductibles.
Reinsurance	**Section 31 and 33** amend the state insurance statute to authorize the Commissioner of Insurance to study and establish a **transitional three-year reinsurance program**, as required under the ACA or, if the Commissioner believes such a program is not appropriate for Massachusetts, to apply for a federal waiver from the requirement to implement it. If established, the program would provide reinsurance for individual plans sold between 2014 and 2016, and would be funded by payments from insurance carriers and self-insured plans.

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