The federal health care reform law, the Affordable Care Act (ACA), institutes an array of new rules and programs that have significant implications for Massachusetts' health care system. Many of these changes require state legislative or administrative action to comply with the federal law. Other changes will not require such action, but will prompt important policy decisions regarding how state leaders, stakeholders, and the public want Massachusetts health care reform to function within the new federal system. The ACA Tracking Tool identifies state policy decisions related to ACA provisions that may affect health coverage for Massachusetts residents. It is designed for policymakers, advocates and other stakeholders who wish to track when and how state leaders may address policy issues. The tool does not include ACA issues that are purely federal, such as Medicare changes, or topics involving health quality or payment and delivery system reforms. The goal is to provide a basic roadmap and timeline of ACA-related coverage decisions being considered by state leaders.

Governor Patrick has designated the Secretary of the Executive Office of Health and Human Services to coordinate all activities relating to ACA implementation in the Commonwealth. The Secretary conducts quarterly public meetings to share findings and gather feedback about the state's policy directions. Information about the meetings is posted at mass.gov/nationalhealthreform.

This tracking tool is a living document and will be updated regularly. If you have any suggested additions or corrections, please email Elisabeth Rodman at Elisabeth.Rodman@bcbsma.com.

Columns in the ACA Tracking Tool

ACA Topic: Areas of the ACA that require or prompt state action.
State Decisions: List of policy decisions that state leaders are considering.
Background: Information about the new federal rules and programs pertaining to each issue and their relationship to Massachusetts' current state system, laws, and programs.
Considerations and Data Sources: Issues that state leaders must consider when making policy decisions in each area, and data that may inform these decisions.
State Players: State bodies that may be involved with each policy decision, depending on state's approach (i.e. policy changes through administrative rule making, through legislation, or a hybrid approach).
Timing: Key dates in the process of making the decision.

Glossary of Federal Agencies

Health and Human Services (HHS)
Centers for Medicare and Medicaid Services (CMS)
Center for Consumer Information and Insurance Oversight (CCIIO)

Glossary of State Agencies

Executive Office for Administration and Finance (ANF)
Executive Office of Health and Human Services (EOHHS)
Division of Health Care Finance and Policy (DHCFP) – effective until 11/04/2012
Division of Unemployment Assistance (DUA)
Children's Health Insurance Program (CHIP)
Health Safety Net (HSN)
Department of Revenue (DOR)
Division of Insurance (DOI)
Center for Health Information and Analysis (CHIA) – replaces DHCFP as of 11/05/2012

ACA Topic	State Decisions	Background	Considerations and Data Sources	State Players	Timing	Status Update
Medicaid expansion up to 133% of the Federal Poverty Level (FPL)	Determine timeline for transition of current Commonwealth Care (CommCare) enrollees who become eligible for MassHealth (those earning <133% of the federal poverty level (FPL)) • Before 2014 or in 2014 Consider how to address other newly eligible populations earning <133% FPL, including: • People now ineligible for CommCare because they have an offer of employer-sponsored insurance (ESI) • Enrollees in MassHealth Essential, Basic, HIV Family Assistance, and CommonHealth • Insurance Partnership beneficiaries • Un-enrolled people eligible for CommCare • Medical Security Program (MSP) beneficiaries • College and graduate students – parental income counted towards 133% limit if student reported as a dependent on parents' tax returns	• ACA opens Medicaid eligibility to all non-elderly adults earning less than 133% FPL • Enhanced federal reimbursement (Federal Medical Assistance Percentage (FMAP)) for these new populations becomes available in 2014 • ACA allows state to shift this population to Medicaid at any time prior to 2014 • MA already covers some of this population in CommCare; others are in other programs or are uninsured	• State budget • Scope of medical benefits for members • Opportunity to streamline programs for members earning <133% • Impact on managed care organizations (MCOs) • Funding for Health Connector given fewer members • Enhanced FMAP does not occur until 2014 • 1115 MassHealth waiver • Ability to operationalize these transitions	• MassHealth • Health Connector • ANF • DHCFP/CHIA • DUA • Legislature	• Before 2014 • Waiver negotiation in 2013 for period beginning 1/1/2014	• EOHHS decided not to implement the Medicaid expansion until 2014 • The Governor's House 1 budget proposes funding for extending MassHealth coverage terminations to the end of the month to facilitate transitions to Exchange coverage
CHIP and Medicaid Program Changes	Determine whether to transition Medicaid 1115 waiver populations (>133% FPL) into the Exchange • Timeline for transition (prior to, or in, 2014) • Process for transition • Consider whether the state should reduce eligibility for Medicaid State Plan to federal lower limits and transition people into the Exchange	• Massachusetts currently covers some populations under its 1115 waiver who would otherwise be eligible for federal insurance tax credits in 2014 • State pays 50% of costs in the Medicaid program, whereas the federal government will pay the full cost of tax credits available in the Exchange (unless the state decides to supplement this coverage) • EOHHS submitted comments to HHS/CMS on the Medicaid Eligibility proposed rule (10/31/11)	• State budget • Medicaid savings to state vs. cost to individuals • ACA maintenance of effort (MOE)requirement would need to be waived if coverage reduced prior to 2014 • Coverage and benefits for these populations • Continuity and adequacy of coverage • Medicaid MOE requirement expires when Exchange is certified as operational • The final Medicaid Eligibility rule, in which some sections were interim final (3/23/12)	• EOHHS and MassHealth, in consultation with federal HHS • ANF • Health Connector • MassHealth Workgroup • Exchange Planning Workgroup	• Before 2014	• EOHHS is planning to keep children <300% FPL in MassHealth and provide a state supplement to federal tax credits for people between 133-300% FPL
	• Move to a modified adjusted gross income standard for program eligibility	• Massachusetts currently uses a gross income standard to determine eligibility • ACA requires all state eligibility systems for	• Impact on current eligibility system • Changes to Medical Benefits	• MassHealth with EOHHS • MassHealth	• Implement by Oct 1, 2013	EOHHS and Connector working on developing a new

ACA Topic	State Decisions	Background	Considerations and Data Sources	State Players	Timing	Status Update
		Medicaid, CHIP, and new insurance tax credits to transition to a modified adjusted gross income standard • See the Massachusetts Law Reform Institute report for a more detailed explanation of how MassHealth will use MAGI	Request application form (MBR) • Potential for passive enrollment using IRS/DOR data	Workgroup		eligibility system to create streamlined/"no wrong door" entry
	• Consider applying for hardship exemption from maintenance of effort (MOE) requirement	• ACA requires states to maintain current eligibility levels for children in Medicaid and CHIP until 2019, and maintain eligibility levels for adults until an exchange is fully operational in 2014 • A state can waive out of this requirement in 2011-2013—only for non-disabled adults with incomes above 133% FPL—if it experiences a budget deficit or will do so in the following year	• Financial cost of maintaining current eligibility levels • State budget shortfall • Coverage, access, and eligibility for enrollees	• ANF • EOHHS with MassHealth • MassHealth Workgroup	• Anytime 2011-2013	• MA did not apply for hardship exemption from MOE requirement
	• Consider whether to remove cost-sharing for preventive services in Medicaid to receive 1% FMAP increase	• ACA incentivizes states to remove cost-sharing for preventive services in Medicaid by offering a 1% FMAP increase in payment for these services	• Impact on access to preventive services • Outcomes for population health • Cost to the state vs. incentives	• EOHHS • MassHealth • ANF • MassHealth Workgroup	• Before 2014	
Essential Health Benefits (EHB)	• MA must define an EHB package by selecting an EHB benchmark plan	• ACA outlines 10 service categories that EHB must include • States are required to select a benchmark plan to help define the actual services that will be covered in the EHB package • Beginning in 2014, plans offered through the Connector, non-grandfathered individual and small group plans sold outside of the Connector, plans offered through BHP (if implemented), and plans for newly eligible Medicaid enrollees must cover the EHB package	• Supplementing the benchmark plan if it does not include all 10 benefit categories required under the ACA (e.g., pediatric dental and vision) • IOM released a report (10/2011) guiding HHS on defining the EHB package • CCIIO released a bulletin (12/16/11) and an FAQ (2/17/12) on EHB, providing more guidance to states • On 11/20/12, CMS released proposed regulations on EHB and a state Medicaid director letter pertaining to EHB in Medicaid	• DOI • EOHHS • MassHealth • Health Connector	• By October 2012	• DOI selected the state's EHB benchmark plan: the BCBSMA HMO Blue plan (the largest small group plan by enrollment) supplemented with the MassHealth pediatric dental benefit
Basic Health Plan (BHP)	Consider whether to develop BHP for eligible state residents 133-200% FPL and legal immigrants <200% FPL • Determine what agency would administer the BHP and how BHP would interact with or replace	• States have the option to establish a Basic Health Plan for individuals earning 133%-200% FPL who will be eligible to receive federal premium subsidies in the Exchange	• Continuity of coverage for families • Potential state savings • Connection with/impact on	• Legislature • ANF • EOHHS must get federal HHS	• BHP would launch by 2014 • Decision by end of 2011-2012	• June FY2012 Supplemental Budget authorizes HHS

ACA Topic	State Decisions	Background	Considerations and Data Sources	State Players	Timing	Status Update
	CommCare	• In Massachusetts, this population currently receives insurance subsidies through CommCare • BHP must provide coverage through one or more standardized plans that provide the EHB package and cannot have premiums or cost-sharing exceeding what people would have received through a subsidized plan on the Exchange • States that establish a BHP will receive 95% of the federal subsidies that would have been paid to eligible individuals through premium and cost-sharing tax credits	CommCare • Role of MCOs • Interaction of BHP with Exchange • How BHP benefit package compares with CommCare regarding coverage and cost-sharing for enrollees	approval • Health Connector • MassHealth Workgroup • Exchange Planning Workgroup	legislative session or early in 2013	to "design, establish, and administer a basic health program" no earlier than January 1, 2014 • MassHealth chose not implement BHP in 2014 due to a lack of federal guidance • In Feb. 2013, CMS released an FAQ indicating that BHP will be delayed until 2015
Subsidized Federal Coverage	Consider whether to supplement federal premium tax credits • Populations who qualify for supplemental assistance (by FPL level, 133-400%) • Amount of premium subsidies Consider whether to supplement federal cost-sharing tax credits • Populations who qualify for supplemental assistance (by FPL level, 133-400%) • Amount of cost-sharing subsidies Consider whether to alter benefits under MA's subsidized health plans • Preserve, align, or change covered benefits at state level given federal EHB requirement Determine flow of tax credits and insurance subsidies through the Exchange Determine how to integrate tax credit calculation into eligibility process	• In 2014, federal premium tax credits will replace state subsidies for Commonwealth Care members earning between 133% FPL and 300% FPL • Federal tax credits will be less than current state subsidies for Commonwealth Care • If MA does not wrap federal tax credits, CommCare recipients will face higher premiums and out-of-pocket costs in subsidized plans than they currently do • CommCare subsidies currently flow through the Connector, which also determines the premium amount owed by the beneficiary; federal law gives the IRS responsibility for the tax credits • Tax credits will be determined based on the individual's household income during the most recent taxable year for which information is available; if a person's circumstances changed since then, the HHS Secretary will determine procedures of how to decide eligibility on the basis of household income for a later period or by the individual's estimate of such income for the taxable year	• Eligibility for insurance subsidies is different in state and federal laws • State budget • Gap between federal subsidies and premiums under CommCare • Relationship between state subsidies and affordability • Relationship between subsidy levels and take-up rates • Impact on CommCare recipients • Effect on Health Connector's finances • If there are savings to the state, there will be competing demands for these funds • Costs for people earning 300-400%FPL • Waiting for federal guidance about how tax credits will be determined in cases where	• EOHHS • ANF • Legislature • Health Connector • MassHealth Workgroup	• Decision by early 2013	• June FY2012 supplemental budget authorizes the Connector to provide supplemental subsidies for 200-300% FPL • The Connector is proposing to implement a QHP wrap benefit to provide additional state subsidies for consumers between 133 – 300% FPL receiving coverage through

ACA Topic	State Decisions	Background	Considerations and Data Sources	State Players	Timing	Status Update
		• ACA aims to promote seamless eligibility across public and private coverage, which can be challenging in Massachusetts where multiple programs have varying eligibility criteria	income reported in the last available taxable year does not reflect current circumstances			the Connector • The Governor's House 1 budget proposes to fund a wrap to the QHP benefit to keep benefits consistent with current levels under CommCare
	Determine how subsidized plans through the exchange will integrate newly eligible populations that currently have coverage under a state program (people earning 133-400%FPL): • Medical Security Program (MSP) • HSN • People with unaffordable or inadequate ESI • Insurance Partnership	• Currently several populations cannot access CommCare due to crowd out restrictions under state law • Under the ACA, federal tax credits will be available to those with an offer of ESI if it is deemed "unaffordable" (defined as >9.5% household income spent on employee-only premium costs)	• State budget • Relative cost of coverage (to state and to enrollees) under each state program versus cost of subsidized coverage in the Exchange • State cost of wrapping federal tax credits • Coverage benefits of exchange plans versus other state programs	• EOHHS • DUA • DHCFP/CHIA • ANF • Health Connector • Legislature (if laws need to be changed) • Exchange Planning workgroups • MassHealth Workgroup	• Before 2014	• In Jan. 2013 Governor Patrick filed legislation to eliminate MSP by the end of calendar year 2013 • Those currently enrolled in MSP will get subsidized coverage through the Connector
Health Insurance Exchange	Determine contours of CommCare and CommChoice programs under new federal rules • Determine plans that federal tax credits can subsidize on the Exchange • Consider how to integrate CommCare and CommChoice programs • Adapt methodology for determining subsidy levels • Connector's role in negotiating premiums and benefits given new federal rules	• ACA requires states to set up health insurance exchanges with minimum requirements • Health Connector deemed in compliance by federal law, but may want to change in some significant ways • CommCare and CommChoice now operate separately, with a different set of insurers offering coverage; ACA may not allow this to continue • Connector submitted comments to HHS on the Exchange Establishment and Qualified Health Plans (QHPs) proposed rule; comments to HHS on the Reinsurance and Risk Mitigation proposed rule; and comments to HHS/Treasury on the Health Insurance Premium Tax Credit rule (10/31/11)	• Future of CommCare and CommChoice programs • Coverage, plan designs, and Health Connector's operating procedures • Sustainability of Health Connector's funding • Impact on beneficiaries • Impact on MCOs • Final rule for exchange establishment and eligibility standards, in which some sections were interim final (03/27/12)	• EOHHS and the Health Connector, in consultation with federal HHS • Exchange Planning workgroups	• Before 2014	• CommCare will be eliminated, and current beneficiaries will enroll in MassHealth or subsidized coverage through the Connector • Connector awarded $1M CCIIO grant for research and planning; (10/10 – 11/11); contracting with Manatt/Mercer

ACA Topic	State Decisions	Background	Considerations and Data Sources	State Players	Timing	Status Update
						• Connector awarded $11.6M Exchange Establishment Level 1 Grant in Feb. 2012 (Projected completion date of project: 2/13) • Connector awarded $41.7M Exchange Establishment Level 1 Grant in Sept. 2012 (Projected completion date of project: 10/13) • Connector awarded $81.3M Exchange Establishment Level 2 Grant (01/2013)
	• Determine how health insurance offered through the Connector will change given new federal rules and programs • Create and implement new plan designs (include platinum level, different actuarial values, new cost sharing and benefits requirements) • Transition Young Adult Plans to federally defined Catastrophic plans • Role of risk-adjustment, risk-sharing, and reinsurance for products offered through the Connector • Offer stand-alone dental plans • Offer child-only plans • Create an enrollment system for all subsidized coverage programs, with Connector serving as a point of entry					• New England States Collaborative Insurance Exchange Systems, led by UMass Medical, awarded $35.6M two-year Early Innovator Grant by CCIIO (2/11); See project narrative • June FY2012 supplemental budget authorized

ACA Topic	State Decisions	Background	Considerations and Data Sources	State Players	Timing	Status Update
						• Connector to sell stand-alone dental, child-only, and catastrophic plans • The state received Exchange Establishment Grant funding to develop the Massachusetts Risk-Adjustment and Reinsurance Program • The Connector will administer the risk adjustment program; MA will use a federally-certified alternative risk adjustment methodology, currently under development by a multi-agency workgroup co-chaired by DOI and the Connector
	Align Connector's quality rating and reporting procedures with federal standards					
Individual Mandate	Consider whether to change state individual mandate given new federal rules and programs: • Maintain, alter, or eliminate state penalties for uninsured • Change population affected by the state mandate	• ACA requires individuals to have insurance coverage, if affordable, beginning 2014 • Federal individual mandate does not pre-empt the MA individual mandate; thus, uninsured people in MA may face two penalties	• Differences between state and federal rules regarding what qualifies as coverage under the mandate • Differences between state and	• Legislature • Health Connector re: affordability and MCC • ANF	• Before 2014 • If state pursues legislative change, then decide by early	• Connector and Department of Revenue (DOR) convened an Individual

ACA Topic	State Decisions	Background	Considerations and Data Sources	State Players	Timing	Status Update
	• Maintain or alter state Minimum Creditable Coverage (MCC) standards • Maintain or change state insurance affordability rules	• Key difference between state and federal mandates is definitions of "affordability," which differs significantly, as do the amount of penalties for remaining uninsured, and minimum coverage standards • Federal affordability standard will exempt more higher-income people from the mandate than the state standard, but federal standard requires more low-income people to have coverage than current state standard • In 2016 and beyond, federal penalties for remaining uninsured will be greater than state penalties for people earning <250%FPL, and less than state penalties for some moderate income people	federal rules about who the mandate applies to. Desirability of consistent, coordinated policies • Penalties for individuals and families • Connector/DOR estimates of numbers of people affected by change • Impact of federal EHB requirement on state-defined MCC • Impact of federal affordability level on MA affordability, especially for people with low-to-moderate incomes • Impact of changes in state mandate on state revenue • See Foundation report for more detail on the individual mandate options	• DOR re: penalties • EOHHS re: child mandate • Insurance Reform Workgroup	2013	Mandate Advisory Committee to discuss options – general consensus was to keep the state mandate • Connector Board tasked with approving details of any changes that need to be made to state mandate. • Connector Board voted to keep the state mandate at its board meeting on December 13, 2012
Employer responsibility requirements	Consider whether to adapt state employer responsibility provisions given new federal rules and programs • Adapt, preserve, or eliminate the Fair Share Contribution • Adapt, preserve, or eliminate the Free Rider Surcharge • Determine whether to change which employers state rules affect (i.e. number of employees/FTEs) • Address different state and federal definitions for full-time, FTE, waiting periods, etc • Consider whether to alter HIRD (Health Insurance Responsibility Disclosure) reporting	• Federal employer rules do not pre-empt MA requirements • ACA requires businesses with >50 employees to offer affordable and adequate coverage; employers owe a penalty if they do not offer coverage or if employees access federal tax credits • Federal penalties for employers are significantly higher than those in MA • MA currently requires businesses with 11 or more full-time employees (FTEs) to offer "fair and reasonable" (defined by regulation) coverage or pay a penalty; note: the number of FTEs will change to from 11 to 21 on July 1, 2013	• Desirability of consistent, coordinated policies • Impact of two penalties on some businesses • Reporting requirements for businesses • Impact of changing state employer rules on state revenues • Employer penalties help fund CommCare subsidies, the need for which will shrink • Impact on coverage offered by employers with 11-50 FTEs • See Foundation report for more detail on the employer responsibility options	• Legislature with DOR • DHCFP/CHIA • Employer Workgroup	• By 2014 • If state pursues legislative change, then decide by end of 2011-2012 legislative session or early in 2013	• In Jan. 2013 Governor Patrick filed legislation to repeal the Fair Share Contribution and adopt federal employer responsibility provisions

ACA Topic	State Decisions	Background	Considerations and Data Sources	State Players	Timing	Status Update
	Clarify how new federal rules may alter Section 125 plans that allow pre-tax purchase of non-group plans through the Health Connector	• ACA does not allow employees to buy individual health insurance through an exchange on a pre-tax basis using a Section 125 plan • This appears at odds with current state law requiring employers with 11 or more FTEs to establish Section 125 plans • *Businesses that offer coverage with a premium contribution that costs between 8% and 9.8% of an employee's income are required to offer the employee a Free Choice Voucher to purchase coverage through the Exchange -- §10108 REPEALED 4/15/11*	• Clarify federal rules • Loss of implicit discount (through tax subsidy) of premiums for people purchasing individual coverage • Impact on businesses currently offering Section 125 plans to employees • Impact of Free Choice Voucher program on Exchange's and employers' risk pools	• EOHHS, in consultation with federal HHS • Legislature • DHCFP/CHIA • Health Connector • Employer Workgroup • Exchange planning workgroup	• Before 2014	
Small businesses	Consider how to adapt state rules and programs for small businesses given new federal rules and programs • Size and number of small businesses eligible to shop through the Connector • Adapt or eliminate Insurance Partnership program given new insurance tax credits for small businesses • Consider how to alter Connector's small business insurance options given new rules for Exchanges and small business insurance tax credits	• ACA institutes new rules and coverage opportunities for small businesses that are different from what is currently available in MA • MA provides subsidies to small businesses through the Insurance Partnership program and offers coverage through several programs in the Health Connector • Sec. 1312 allows small businesses to offer employees coverage through the Exchange	• People covered by small business programs in MA • Insurance Partnership • Health Connector • Benefits and coverage options available through the Exchange • Forthcoming federal guidance • Implications of having merged individual and small group markets on health insurance options for small businesses	• EOHHS • DHCFP/CHIA • Health Connector • Employer Workgroup • Exchange planning workgroup	• Before 2014	• DOI hired consultants to evaluate the market impact of expanding the definition of small employer to those with <100 employees before 2016; new definition (1-100 employees) likely to be implemented Jan. 2016
	Develop "employee choice" model for businesses that offer health insurance for employees through the Exchange	• Employers will choose a "level" of coverage and employees will have a choice of available plans within that level • States can open this option to large businesses beginning in 2017	• Effect on businesses participating in Contributory Plan pilot through Connector • Access to insurance for small businesses • Affordability and adequacy of insurance choices for employees • Forthcoming federal guidance	• Health Connector • DHCFP/CHIA • Employer Workgroup • Exchange planning workgroup	• Before 2014	
Insurance reforms and consumer protections	Consider how to adapt state insurance rules to align with new federal rules and protections • Phase out annual dollar caps for young adult plans and student health insurance plans • medical loss ratio standards	• ACA includes new consumer protections and rules for health insurance, many of which were previously implemented in MA • MA's community rating rules are more protective for older people and smokers than the new federal	• Potential state cost • Possibility of adverse selection • Impact on MA community rating standards • Authority of DOI re: federal rules	• EOHHS in consultation with federal HHS • DOI • DHCFP/CHIA	• Community rating: Before 2014 • Annual caps: Before 2012	• DOI awarded HHS grant to support rate review expansion and other work

ACA Topic	State Decisions	Background	Considerations and Data Sources	State Players	Timing	Status Update
	• Develop capacity to offer consumer assistance with health insurance • Implement prohibition on cost-sharing for preventive services in private plans • Implement ACA-compliant rating rules • Role of risk adjustment, reinsurance, and risk-sharing, as required under the ACA	standards • Some plans in MA are currently permitted to have annual caps • CMS released final rate review rule (9/6/11), clarifying that coverage sold to individuals or small groups sold through an association is subject to rate review • HHS issued an interim rule (8/1/11) requiring private health plans starting on or after 8/1/12 to cover women's preventive services without charge; see IOM guidelines and HHS news release; HHS issued the final rule in February 2012	• Impact on premiums for consumers • State coverage mandates	• Legislature • Insurance Reform Workgroup		• Ch 224 enacts a new MLR standard of 89 for April 2014 – April 2015, and 88 beginning April 2015, which will be used in lieu of federal standard • In FY 2014, the Connector plans to give up to $1M in grants for the Navigator program • DOI will administer the state's reinsurance program
Care Coordination for Dual Eligibles	Decide whether to apply for the funding opportunity provided by CMMI and the Medicare/Medicaid Coordination Office, "State Demonstrations to Integrate Care for Dual Eligible Individuals," in order to reduce costs and improve care for the population that is dually eligible for Medicare and Medicaid	ACA creates two new federal entities to examine and improve care for dual eligibles: • The Federal Coordinated Health Care Office (or the Medicare/Medicaid Coordination Office), which is focused on finding ways to improve Medicare-Medicaid integration; and • The Center for Medicare and Medicaid Innovation (CMMI), which is charged with testing innovative payment and delivery models to reduce costs and improve quality for dual eligibles	• EOHHS/MassHealth resources necessary to implement an alternative payment and delivery system for dual eligibles • Potential costs/savings	• EOHHS (MassHealth) in consultation with CMS	• February 2011	• MA was one of 26 states to submit a proposal to integrate care for dual eligibles, and was awarded a $1M planning grant • In Aug. 2012, MA signed an MOU with CMS to begin to implement the duals demonstration • It is anticipated that voluntary enrollment into

ACA Topic	State Decisions	Background	Considerations and Data Sources	State Players	Timing	Status Update
						Integrated Care Organizations will begin July 2013
Long Term Care	Develop coordinated strategy to promote community-based long term care services • Consider adopting coverage for home and community-based services under the State Plan • Consider adopting state balancing incentives payment program (BIPP) to shift people from institutions to home-based settings • Consider implementing spousal impoverishment protection for people receiving home and community-based services • Evaluate Community First Choice Option (CFCO) • Pursue Money Follows the Person rebalancing demonstration	• ACA provides incentives and options for long-term care programs • MA has adopted a "Community First" long-term care policy and has been moving to develop a coordinated approach to long term care financing and care delivery, so the state is well-positioned to benefit from the ACA provisions	• Federal rules for determining which states qualify for incentives • Impact on existing care patterns • Cost to the state • Out-of-pocket costs for consumers and their families	• EOHHS • Executive Office of Elder Affairs (EOA) • Department of Children and Families (DCF) • Long Term Care/Behavioral Health Workgroup	• Apply for grants, where applicable, by deadlines • Begin BIPP and CFCO by end of 2011	• MA was awarded $110M for Money Follows the Person rebalancing demonstration (02/12); See project abstract
	Consider implementing elder assistance programs • Determine whether to develop and implement elder justice provisions, including adult protective services and long term care ombudsman program					