

Medical Assistance Program  
Oversight Council  
November 9, 2012





# **Connecticut Medicaid and Health Care Reform:**

**Where are we now?**

**Where are we going?**

# Where are we now?

- A snapshot of the program
- Transition to medical Administrative Services Organization (ASO)
- Projects related to primary preventative care
- Projects related to integration of care
- Rebalancing

# A Snapshot of the Program: Participation

- Overall, Medicaid currently serves over **575,000** beneficiaries (**20%** of the state population)
  - **275,000** children (one out of every four kids in Connecticut and Medicaid covers one out of every four births)
  - **148,000** parents
  - **65,000** older adults and people with disabilities who are eligible for both Medicare and Medicaid
  - **45,000** older adults and people with disabilities who are eligible only for Medicaid
  - **83,827** low-income adults

# A Snapshot of the Program: Costs in Context

Connecticut has:

- the fourth highest level of health care expenditures at \$8,654 per capita, behind only the District of Columbia, Massachusetts, and Alaska
- the ninth highest level of Medicare costs at \$11,086 per enrollee
- the highest level of Medicaid costs at \$9,577 per enrollee

[Kaiser State Health Facts, 2009 data]

## A Snapshot of the Program: Costs in Context (cont.)

- Among populations in need, the cost profile for Connecticut individuals who are dually eligible for Medicare and Medicaid is of particular concern, with per capita costs exceeding the national average by 55%

# A Snapshot of the Program: Reimbursement

- Based on 2008 data, Kaiser State Health Facts indicate that Connecticut's overall Medicaid-to-Medicare fee index in 2008 was 0.99
- This is strongly influenced by favorable rates for obstetrics

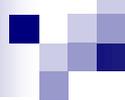
	All Services	Primary Care	Obstetric Care	Other Services
U.S.	0.72	0.66	0.93	0.72
CT	0.99	0.78	1.74	0.59

# Transition to Medical Administrative Services Organization (ASO)

- Member services
- Provider services
- Predictive modeling/Intensive Care Management (ICM)
- Administrative: Performance measures, reporting, rate melds

# Transition to Medical ASO: Member Services

- Centralization of member services with CHN-CT has enabled streamlined support with:
  - Referral to primary care physicians
  - Referral to specialists
  - Assistance with prior authorization requirements and coverage questions



# Transition to Medical ASO: Provider Services

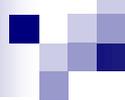
- Centralization of provider services with CHN-CT has improved support with:
  - Prior authorization requirements
  - Coverage questions
  - Referrals

# Transition to Medical ASO: Predictive Modeling/Intensive Care Management

- Predictive modeling tools and other referral means (e.g. self-report, provider referrals) enable CHN-CT to identify those beneficiaries most in need of care management support
- Through Intensive Care Management (ICM), CHN-CT nurse care managers use a specially developed care coordination tool to work with beneficiaries to set goals and address needs

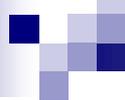
# Transition to Medical ASO: Administrative

- DSS' contract with CHN-CT includes a performance withhold that will be paid based on a range of measures related to health outcomes as well as beneficiary and provider satisfaction with CHN-CT
- CHN-CT is at an advanced stage of preparing a series of reports that will illustrate performance
- DSS is in process of completing the rate “melds” that were required in transition from Medicaid MCOs



# Projects Related to Primary Preventative Care

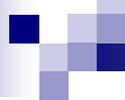
- Person-centered medical home (PCMH)
- Electronic Health Records (EHR)
- Rewards to Quit
- Health Disparities Grant



# Projects Related to Primary Preventative Care

Why are we focusing here?

Adults do not use primary care as indicated, with 1) 12% of at-risk Connecticut residents not having visited a doctor within the two years previous to the study; 2) considerably fewer people of color having done so; and 3) only half of Connecticut adults over age 50 receiving recommended care. [Commonwealth Fund, 2009]



# Projects Related to Primary Preventative Care

A report from the Connecticut Hospital Association indicated that one-third of all emergency department visits are for non-urgent health issues, and that 64% occur between 8:00 a.m. and 6:00 p.m., suggesting that there are barriers to accessing primary care even during typical work hours. [Connecticut Hospital Association, 2009]

# Person Centered Medical Home (PCMH) Defined

*A patient-centered medical home is a model of care that strengthens the physician-patient relationship by replacing episodic care with coordinated care and a long-term healing relationship. Each patient has an ongoing relationship with a personal physician who leads a team at a single location that takes collective responsibility for patient care, providing for the patient's health care needs and arranging for appropriate care with other qualified clinicians. The medical home is intended to result in more personalized, coordinated, effective and efficient care.*

NCQA

# DSS PCMH Initiative: Overview

- implemented January 1, 2012
- an investment of financial and technical resources to help primary care practices obtain PCMH recognition from the National Committee for Quality Assurance (NCQA)

# DSS PCMH Initiative: Financial Model

- financial assistance to NCQA-recognized practices includes advance payments, enhanced fee-for-service payments and retrospective payments for meeting benchmarks on quality measures

# DSS PCMH Initiative: Key Features

- key features of transformation include helping practices to:
  - enhance their medical care coordination functions
  - Increase capacity for non face-to-face and after hours support for patients
  - work towards meaningful use of interoperable electronic health records

# DSS PCMH Initiative: Participation

Approved PCMH Practices = 14

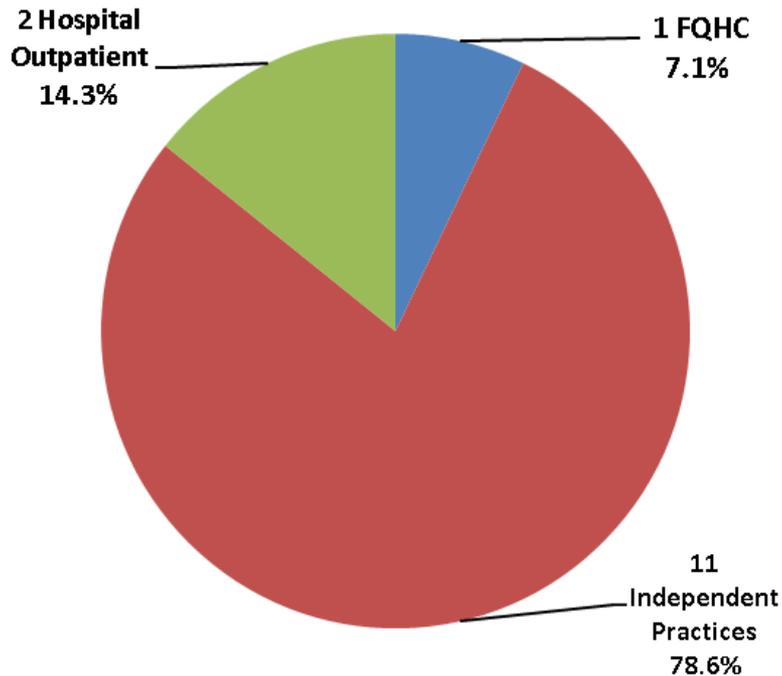
Total # of PCMH Sites = 109

Total # of PCMH Providers = 411

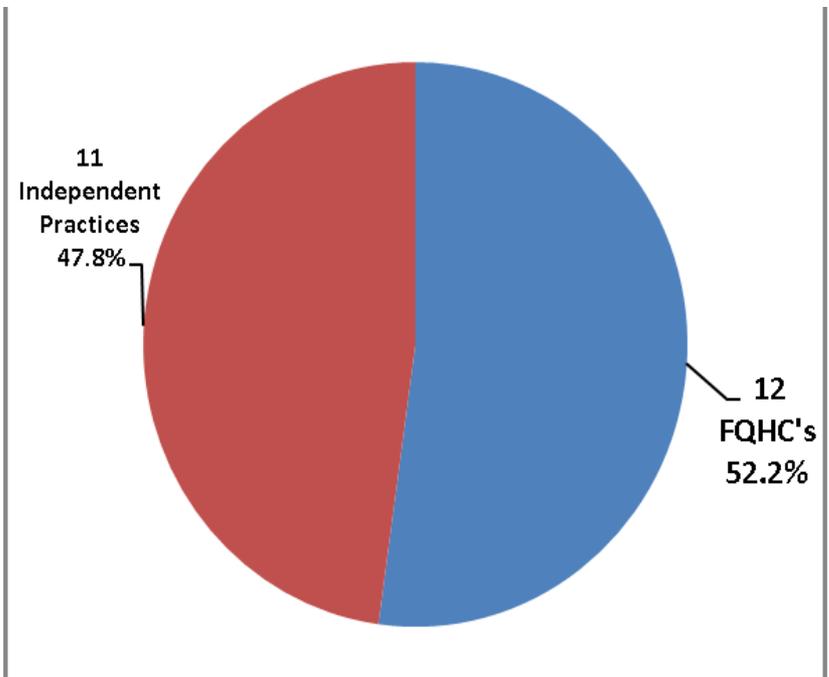
According to past claim history, these 109 PCMH sites served over 100,000 Medicaid members.

# DSS PCMH Initiative: Practice Types

## PCMH Practices by Type



## Glide Path Practices by Type



# DSS PCMH Initiative: First Steps Toward Multi-Payer Approach

- PCMH is a meaningful example of efforts in support of a multi-payer approach
- DSS PCMH uses the same core measures of success and similar payment strategies to those being used by the Office of the State Comptroller State Employee Health Plan PCMH
- This helps providers engage with private payers

# Electronic Health Record (EHR)

- another important aspect of enhancing the capacity of primary care is financial support for adoption of EHR
- DSS is also collaborating with UConn Health Center to administer the Medicaid EHR Incentive Program and to improve outreach and education to providers

# Electronic Health Record (EHR)

- incentive payments disbursed to date (September, 2011 to October, 2012):
  - \$17,056,679 to 780 eligible professionals
    - “Eligible professionals” include physicians, physician assistants, nurse practitioners, certified nurse-midwives, dentists
  - \$15,780,928.04 to 22 eligible hospitals

## Rewards to Quit (R2Q)

- five-year federal grant of up to \$10 million
- tobacco cessation program
- smokers and their providers will engage in counseling and training sessions, peer coaching and other smoking-cessation techniques
- participants will receive financial incentives for achieving various milestones toward quitting



# Health Disparities

- Through generous funding from the Connecticut Health Foundation, DSS and its partner CHN-CT have the opportunity to examine access barriers related to gender, race and ethnicity faced by Medicaid beneficiaries
- This project is focusing on identifying disparities and equipping primary care practices with tools and strategies to reduce these barriers



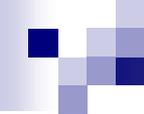
# Health Disparities

- DSS is also continuing to partner with the Office of Minority Health (OMH) on various efforts to improve the health of racial and ethnic populations through the development of policy and programming designed to eliminate disparities



# Projects Related to Integration of Care

- Demonstration to Integrate Care for Dually Eligible Individuals
  
- Health Home



# Projects Related to Integration of Care

Why are we focusing here?

Many Medicaid beneficiaries, especially those who are dually eligible for Medicare, have complex health profiles.

A high incidence of beneficiaries have co-morbid physical and behavioral health conditions, and need support in developing goal-oriented, person-centered plans of care that are realistic and incorporate chronic disease self-management strategies.

# Duals Demonstration: Overview

Through the Demonstration, stakeholders and the Department seek to create and reward innovative local systems of care and supports that provide better value over time by:

- integrating medical, behavioral and non-medical services and supports
- providing financial incentives to achieve identified health and client satisfaction outcomes

# Duals Demonstration: Key Structural Features

- Enhanced Administrative Services Organization (ASO) Model
  - Under the Demonstration, the ASO will address the need for more coordination in providing services and supports, through such means as:
    - integration of Medicaid and Medicare data
    - predictive modeling
    - Intensive Care Management (ICM)
    - electronic tools to enable communication and use of data

# Duals Demonstration: Key Structural Features (cont.)

- Expansion of Person-Centered Medical Homes (PCMH) pilot to serve dual eligible individuals (“MMEs”)
  - Under the Demonstration, the Department will extend the enhanced reimbursement and performance payments to primary care practices that serve MMEs

# Duals Demonstration: Key Structural Features

- Procurement of 3-5 “Health Neighborhoods” (HNs)
  - HNs will reflect local systems of care and support and will be rewarded for providing better value over time
  - HNs will be comprised of a broad array of providers, including primary care and physician specialty practices, behavioral health providers, long-term services and supports providers, hospitals, nursing facilities, home health providers, and pharmacists

# Duals Demonstration: Recent Activities

- The Department submitted the final application to CMMI on May 31, 2012
- Final submission reflected revisions related to feedback received during the thirty-day public comment period
- Application is posted on Department's web site:

<http://www.ct.gov/dss/lib/dss/pdfs/mmedemo.pdf>

# Duals Demonstration: Recent Activities (cont.)

- The Department has mapped best practices associated with other integrated care initiatives and produced white papers on:
  - care coordination
  - structure of provider networks
  - performance measures

# Duals Demonstration: Recent Activities (cont.)

- Further, the Complex Care Committee has heard presentations from Connecticut stakeholders on existing models of care coordination (medical and behavioral health ASOs, Access Agencies, behavioral health partnerships), as well as coordination of providers across disciplines

# Duals Demonstration: Recent Activities (cont.)

- The Department is now drafting an operations plan for the proposed “health neighborhoods”, three to five of which are expected to be procured by RFP in 2013

# Duals Demonstration: Issues Pending Resolution

- CMS has not yet established minimum standards for performance (quality and care experience) that must be met to share in savings
  
- CMS has not yet issued its methodology for:
  - establishing cost targets or benchmarks against which performance will be measured
  - computing savings (e.g. minimum savings threshold, first dollar requirements)

# Health Home: Overview

- ACA built upon existing efforts to **integrate medical, behavioral and social services and supports for individuals with behavioral health and chronic conditions** by permitting states to seek approval of state plan amendments to implement such coverage
- ACA “health home” amendments qualify states to receive eight quarters of **enhanced Federal Medical Assistance Payment (FMAP)** in support of this work
- By contrast to the typical Connecticut FMAP of 50% FMAP for health homes is at **90%**

# Health Home: Eligibility

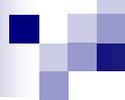
- To be eligible for the health home option, beneficiaries must have:
  - two or more chronic conditions
  - one chronic condition and risk of developing a second or
  - a serious and persistent mental health condition
  
- Chronic conditions are defined as including behavioral health conditions, substance use disorders, asthma, diabetes and heart disease

# Health Home: Design Considerations

- States have the option to elect health home funding for all beneficiaries with these conditions, or to limit the set of conditions that are included
- States may define the level of severity that is required to qualify
- CMS has stated that electing health home funding in support of one population tolls the eight quarters only for that group, and does not foreclose electing successive 90% FMAP periods for other populations

# Health Home: Connecticut Activity

- DMHAS has been partnering with a work group of the CT Behavioral Health Partnership Oversight Council (BHP) since enactment of the ACA health home option to assess how this model could be implemented in support of the needs of individuals with Serious and Persistent Mental Illness (SPMI)

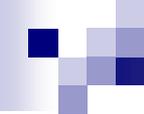


# Health Home: Proposed Connecticut Approach

Elect health home funding outside the context of the duals demonstration and implement a number of condition-specific health homes for both dually-eligible and single-eligible individuals with Serious and Persistent Mental Illness (SPMI)

# Comparison of Health Neighborhood and Health Home Models:

Feature	Health Neighborhood (3-5 to be procured)	Health Home (number to be determined)
Provider composition	Broad range of medical, behavioral health, and long-term services and supports	Care team selected from among three options identified in State Medicaid Director letter
Population served	Minimum of 5,000 dually-eligible individuals	Smaller scale, targeted for individuals with SPMI, both dually-eligible and single-eligible individuals
Care Coordination	Multi-disciplinary care team, PMPM to support costs of care coordination and supplemental services	Care team defined as selected, PMPM to support costs of care coordination



# Rebalancing

- Money Follows the Person (MFP)
- Nursing Home Transformation/Workforce Initiative
- “My Place” campaign
- State Balancing Incentive Payments Program (BIPP)

# Projects Related to Rebalancing

## Why are we focusing here?

- Consumers overwhelmingly wish to have meaningful choice in how they receive needed long-term services and supports
- Connecticut's Medicaid spending remains weighted towards institutional settings, but re-balancing is shifting this. In 2011:
  - 54% of long-term care clients received care in the community
  - 40% of spending supported home and community-based care

# Projects Related to Rebalancing

Why are we focusing here (cont.)?

- Further, only 7% of the Medicaid population receives long-term services and supports (LTSS) but 61% (\$2.863 billion) of the SFY'12 Medicaid expenditures (\$4.714 billion) were made on the behalf of these beneficiaries



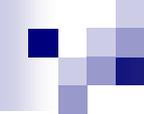
# Money Follows the Person: Overview

- a partnership with the federal government under which federal grant funds are used to assist individuals in transitioning from institutional settings back to community-based living
- implemented in December, 2008 and significantly expanded over time



## Money Follows the Person: Overview (cont.)

- intended to increase use of home and community-based services, eliminate barriers to flexible use of Medicaid dollars, and assure continued access to services once transition is complete
- enhanced federal support to assist individuals with costs of transition (e.g. security deposits, assistive technology)



## Money Follows the Person: Overview (cont.)

- not intended to be a long-term source of payment
- after one year of transition support, participants must be served, ongoing, through the Medicaid LTSS system
- over 1,200 individuals have been successfully transitioned to date

# Nursing Home Transformation/Workforce Development

- strategic rebalancing plan
- \$21 million in grants over a five-year period to nursing facilities in support of diversifying their services to include home and community-based services
- must be based on local needs and must be done in collaboration with local governments

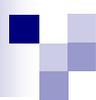


# “My Place” Campaign

- My home
- My role in person-centered care planning
- My role as a caregiver

# State Balancing Incentive Payments Program (BIPP): Overview

- effective October 1, 2011 through September 30, 2015, CMS will offer enhanced Federal Medical Assistance Payments (FMAP) to states that agree to increase the proportion of Medicaid spending on home and community-based services (HCBS)



# State Balancing Incentive Payments Program (BIPP): Overview

- Connecticut submitted application October 31, 2012
- Connecticut's award will be \$68.5 million

# State Balancing Incentive Payments Program (BIPP): Requirements

- BIPP requires that states:
  - in which 25% or greater of Medicaid spending is on HCBS (as opposed to institutionally-based long-term care) commit to increase that percentage to a target of 50% by September 14, 2015; and

# State Balancing Incentive Payments Program (BIPP): Requirements (cont.)

- within six month of applying, have implemented the following:
  - a “no-wrong door single entry point system” to facilitate consumer access to information on LTC services and to assess their financial and functional eligibility for available programs

# State Balancing Incentive Payments Program (BIPP): Requirements (cont.)

- "conflict-free" case management (e.g. of the kind provided by the Access Agencies for the Connecticut Home Care Program for Elders; neutral in relationship to providers)
- a core, statewide, standardized assessment instrument

# Where are we going, 2013?

- 2013 Affordable Care Act (ACA) mandatory provisions:
  - Primary care rate increases
  - Reduction in Disproportionate Share Payments (DSH)
  
- 2013 ACA optional provisions:
  - Medicaid preventative services

# 2013 ACA Mandatory Provisions: Primary Care Rate Increases

- Effective January 1, 2013, ACA requires states to increase Medicaid payments for primary care services provided by primary care doctors to 100% of the Medicare payment rate for 2013 and 2014 (financed with 100% federal funding)
- Final federal rule issued November 2, 2012

## 2013 ACA Mandatory Provisions: Primary Care Rate Increases (cont.)

- services must be delivered by a physician who specializes in family medicine, general internal medicine, or pediatric medicine
- certain physician subspecialists who are board certified in those specialties or provide primary care within the overall scope of those categories also qualify for the enhanced payment

## 2013 ACA Mandatory Provisions: Primary Care Rate Increases (cont.)

- higher payment will be made for primary care services rendered by practitioners (e.g. Advance Practice Registered Nurses, APRNs) working under the personal supervision of any qualifying physician

# 2013 ACA Mandatory Provisions: Reduction in DSH Payments

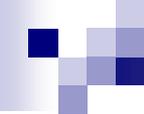
- Effective October 1, 2013, ACA reduces states' Medicaid Disproportionate Share Hospital (DSH) allotments and requires CMS to develop a methodology for distributing the DSH reductions

# 2013 ACA Optional Provisions: Medicaid Preventative Services

- Effective January 1, 2013, ACA provides a one percentage point increase in federal matching payments for preventive services in Medicaid for states that offer Medicaid coverage with no patient cost sharing for services recommended (rated A or B) by the U.S. Preventive Services Task Force and recommended immunizations

# Where are we going, 2014?

- 2014 ACA mandatory provisions:
  - Coverage
  - Plan requirements
  - Health exchange related activities: web site, Navigator program, integrated eligibility determination
  
- 2014 ACA optional provisions:
  - Eligibility expansion



# 2014 ACA Mandatory Provisions: Coverage

- Effective January 1, 2014, ACA:
  - Requires U.S. citizens and legal residents to have qualifying health coverage (there is a phased-in tax penalty for those without coverage, with certain exemptions)

# 2014 ACA Mandatory Provisions: Coverage

- Effective January 1, 2014, ACA (cont.):
  - Provides refundable and advanceable tax credits and cost sharing subsidies to eligible individuals
    - Premium subsidies are available to families with incomes between 133-400% of the federal poverty level to purchase insurance through the Exchanges
    - Cost sharing subsidies are available to those with incomes up to 250% of the poverty level

# 2014 ACA Mandatory Provisions: Plan Requirements

- Effective January 1, 2014, ACA :
  - Requires guarantee issue and renewability of health insurance regardless of health status and allows rating variation based only on age (limited to a 3 to 1 ratio), geographic area, family composition, and tobacco use (limited to 1.5 to 1 ratio) in the individual and the small group market and the Exchanges
  - Prohibits annual limits on the dollar value of coverage

# 2014 ACA Mandatory Provisions: Exchange-related activities

- Effective January 1, 2014, ACA :
  - Requires states to operate an Internet website that links the Exchange, Medicaid, and Childrens Health Insurance Plan (CHIP) and permits individuals to compare available health subsidy programs and apply for or renew such coverage

## 2014 ACA Mandatory Provisions: Exchange-related activities (cont.)

- Requires CMS to develop a single, streamlined form that states can use for all those applying on the basis of income to applicable State health subsidy programs (e.g. premium tax credits and cost-sharing reductions in the Exchange, Medicaid, CHIP, and state qualified basic health plans)

## 2014 ACA Mandatory Provisions: Exchange-related activities (cont.)

- Requires state Exchanges to establish “Navigator” programs to provide fair and impartial, culturally and linguistically appropriate information concerning enrollment in qualified health plans and available subsidies through the Exchange, facilitate enrollment in qualified health plans, and provide referrals for complaints

# 2014 ACA Mandatory Provisions: Eligibility Determination

- Effective January 1, 2014, ACA requires states to remove asset tests and to use modified adjusted gross income (MAGI) for purposes of Medicaid eligibility determination for parents and other non-elderly adults as well as children

# 2014 ACA Mandatory Provisions: Connecticut Plans

- A “no wrong door” approach to the citizen web portal that will provide access to Health Insurance Exchange services and data as well as to non-MAGI Medicaid, SNAP, and Temporary Assistance to Needy Families (TANF)-related services and data

## 2014 ACA Mandatory Provisions: Connecticut Plans (cont.)

- A single shared eligibility service that will be used by both the Exchange and DSS to determine eligibility for Medicaid, CHIP, Advance Premium Tax Credits & Cost Sharing Reductions (APTC/CSR), as well as non-health public assistance programs such as SNAP and TANF

# Overview

Series of projects has been broken into 4 Tiers



*Tier*

*Scope*

**Tier I**

CT HIX, MAGI Medicaid & CHIP

**Tier II**

Non MAGI Medicaid & CHIP and back office

**Tier III**

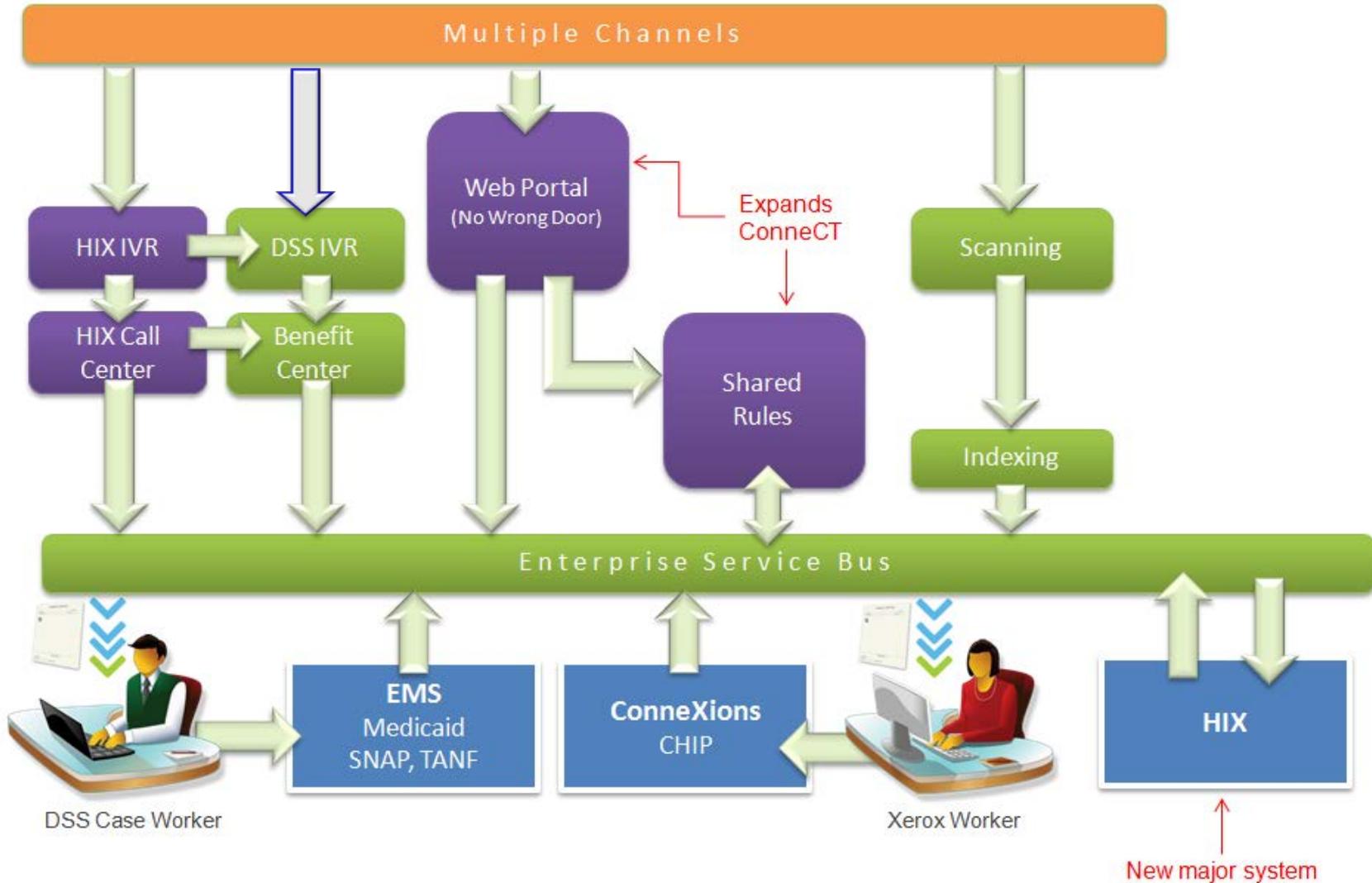
SNAP, TANF, RCA, RMA, SAGA, CADAP, (IE, back office)

**Tier IV**

TBD (LIHEAP, Child care, Employment, WIC, or DDS)

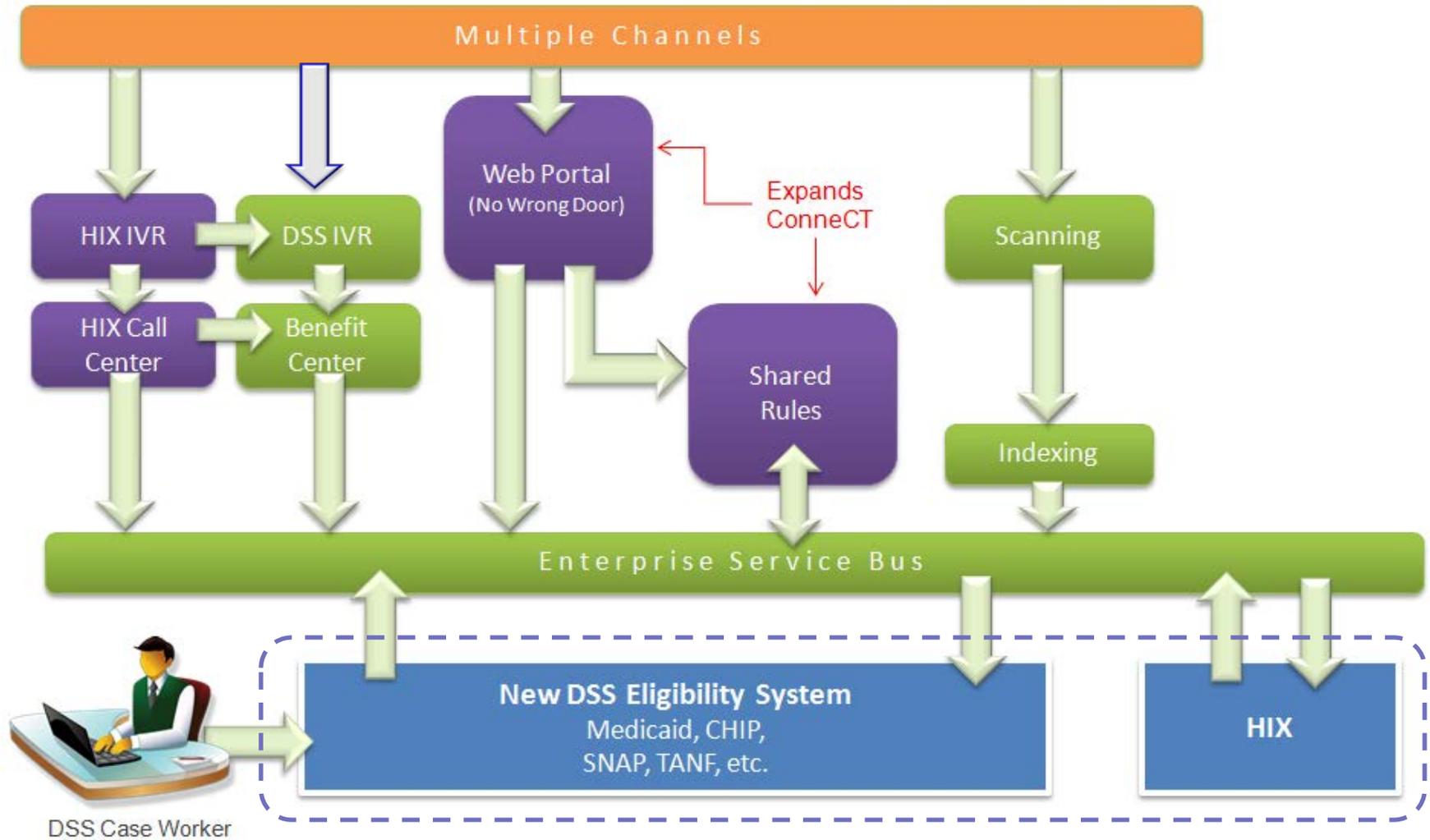
# Planned system

Planned October 2013



# Planned System

Planned – No later than end 2015



# 2014 ACA Optional Provisions: Medicaid Expansion

- Effective January 1, 2014, ACA as enacted required states to expand Medicaid to all individuals not eligible for Medicare under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL

# 2014 ACA Optional Provisions: Medicaid Expansion

- Note that Connecticut currently meets or exceeds this requirement for all of these groups with the exception of childless adults
- Childless adults age 19-64 are currently covered under the Medicaid for Low-Income Adults (MLIA) program up to an income limit of 55% of FPL\*
- 83,827 beneficiaries are currently being served by MLIA
  - \* for regions B & C; 67% of FPL for region A

## 2014 ACA Optional Provisions: Medicaid Expansion (cont.)

- This expansion in coverage will be associated with enhanced federal match funds:
  - 100% match for calendar years 2014 through 2016
  - 95% match for calendar year 2017
  - 94% match for calendar year 2018
  - 93% match for calendar year 2019
  - 90% match for calendar years 2020 and ongoing

## 2014 ACA Optional Provisions: Medicaid Expansion (cont.)

On June 28, 2012, the Supreme Court issued a decision in a challenge to the constitutionality of the ACA: National Federation of Independent Business, *et al* v. Sebelius, Secretary of Health and Human Services, *et al*

# 2014 ACA Optional Provisions: Medicaid Expansion (cont.)

## The Court:

- generally upheld the constitutionality of the law
- with respect to the mandate that States expand Medicaid coverage as described above held:

## 2014 ACA Optional Provisions: Medicaid Expansion (cont.)

- that while Congress acted constitutionally in offering federal match funds to states to expand coverage
- the provision that requires states to either expand coverage or forego all federal match funds for their Medicaid programs exceeded Congress' scope of authority under the Spending Clause of the Constitution

# 2014 ACA Optional Provisions: Medicaid Expansion (cont.)

- but, that this can be corrected by narrowly tailoring the expansion requirement to give states two options:
  - to accept federal match funds for expansion in compliance with the conditions associated with those funds; or
  - to refuse federal match funds for expansion and continue to operate their Medicaid programs as they do currently

## 2014 ACA Optional Provisions: Medicaid Expansion (cont.)

How many individuals are likely to be eligible under the expansion?

- approximately 129,786 uninsured Connecticut residents have incomes of less than 139% FPL (note that the 83,827 MLIA beneficiaries are a subset of this figure)

[Kaiser Commission on Key Facts: How Will the Medicaid Expansion for Adults Impact Eligibility and Coverage, July 2012]

# Planning Ahead: Connecticut State Innovation Model (SIM) Application

- Under the leadership of the Office of Health Care Reform and Innovation (OHRI), DSS joined a broad range of state agency partners and other stakeholders in mutually drafting an application seeking funding from CMS for formal health care reform planning efforts
- This application was submitted in September, 2012

# Planning Ahead: Connecticut State Innovation Model (SIM) Application

- The application acknowledges the many examples of state agency health care reform work that are already in evidence
  
- In support of enhancement of primary, preventative care:
  - DSS and Office of the State Comptroller PCMH initiatives
  - EHR funding

# Planning Ahead: Connecticut State Innovation Model (SIM) Application (cont.)

- In support of integration of care across disciplines:
  - Co-location of Medicaid medical Administrative Services Organization (CHN-CT) with the behavioral health ASO (Value Options)
  - Substance Abuse and Mental Health Services Administration (SAMHSA)/Department of Mental Health and Addiction Services (DMHAS) funded primary care/behavioral health integration pilots
  - Duals demonstration

# Planning Ahead: Connecticut State Innovation Model (SIM) Application (cont.)

- In support of efforts toward multi-payer approaches:
  - use of shared performance metrics and payment strategies in the DSS and OSC PCMH initiatives
  
- In support of engagement of consumers in informed decision-making:
  - Office of the Healthcare Advocate
  - CHOICES/Aging & Disability Resource Centers

# Planning Ahead: Connecticut State Innovation Model (SIM) Application (cont.)

- In support of efforts to positively influence health care consumer behavior:
  - OSC Health Enhancement Program
  - DSS Rewards to Quit and ASO chronic disease self-management education
  - DPH Community Transformation Grant and promotion of Healthy People 2020



## In conclusion . . .

- Connecticut Medicaid is already utilizing diverse strategies to support use of primary preventative care, integration of care, and rebalancing of long-term services and supports
- In collaboration with a broad range of state agency partners, DSS is partnering to plan for both mandatory and optional aspects of ACA implementation



**Questions or comments?**