



## AFFORDABLE CARE ACT MASSACHUSETTS IMPLEMENTATION UPDATE

December 01, 2014

### Quick Links

[MA-ACA Website](#)



These Updates, published by the Executive Office of Health and Human Services (EOHHS) in consultation with the other state agencies involved in ACA implementation, will bring you news related to the implementation of provisions of the ACA here in Massachusetts.

### Grants and Demonstrations

The ACA provides funding opportunities to transform how health care is delivered, expand access to care and support healthcare workforce training.

## Grant Announcements

**Behavioral Risk Factor Surveillance System (BRFSS)**, §4002. Announced November 24, 2014. Funding is available to continue to provide financial and technical assistance to state and territorial health departments to maintain behavioral surveillance through the BRFSS and increase the use of BRFSS data by health departments to inform public health actions to improve health.

The BRFSS is an annual telephone survey that collects data on emerging public health issues, health conditions, risk factors and behaviors of non-institutionalized adults ages 18 years and older. The BRFSS is the principal source of state-specific surveillance information about health risk behaviors and health status among the states' resident population. BRFSS statistics have been used to support public health programs and policies that seek to improve population health.

Only state governments are eligible to apply for this opportunity. \$14,000,000 in total for 57 awards is available.

Applications are due December 30, 2014.

This announcement may be viewed at: [GRANTS.GOV](http://GRANTS.GOV)

**Pipeline to Proposal Awards Initiative**, §6301. Announced November 24, 2014. Funding is available for projects that fit into a progressive, three-tiered funding approach that aims to accelerate research proposal submission and dissemination and to develop a nationwide foundation of patients, stakeholders, and researchers equipped and eager to participate in patient-centered outcomes research (PCOR).

Eligible applicants include individuals, consumer and patient organizations, clinicians, researchers, or a combination of these applicants. \$4 million in total awards is available.

Required Letters of Intent are due December 23, 2014.

Applications are due February 16, 2015.

This announcement may be viewed at: [PCORI.ORG](http://PCORI.ORG)

The Patient Centered Outcomes Research Institute (PCORI), created under ACA §6301, is an independent nonprofit organization, tasked with conducting patient-centered outcomes research and studies.

For more information about PCORI, visit: [PCORI](http://PCORI)

## Grant Activity

For information about ACA grants awarded to and grant proposals submitted by the Commonwealth, visit the Grants page of the **Massachusetts National Health Care Reform website** at: [www.mass.gov/eohhs/gov/commissions-and-initiatives/healthcare-reform/national-health-care-reform-plan/grants-and-demonstrations.html](http://www.mass.gov/eohhs/gov/commissions-and-initiatives/healthcare-reform/national-health-care-reform-plan/grants-and-demonstrations.html)

## Guidance

### **11/21/14 IRS/Treasury issued final regulations called "Minimum Essential Coverage and Other Rules Regarding the Shared Responsibility Payment for Individuals."**

The regulations relate to the requirement to maintain [minimum essential coverage](#), or MEC, (ACA §1501). The final regulations provide individual taxpayers with guidance under section 5000A of the IRS Code on the requirement to maintain MEC and rules governing certain types of exemptions from that requirement. The final regulations guarantee that large employers (companies with at least 50 full-time workers) must offer their employees health plans that include both inpatient hospital services and physician services in order to meet the ACA's threshold for minimum value (MV) as required by Section 36B of the IRS Code and the ACA. Under Section 36B, a plan provides MV if the plan's share of the total allowed costs of benefits provided under the plan is at least 60% of the costs. §ACA 1302 provides that in determining the percentage of the total allowed costs of benefits provided by a group health plan or health insurance coverage under the IRS Code, regulations promulgated by the Secretary of HHS under section 1302(d)(2), addressing actuarial value, apply.

Beginning earlier this year, the [individual shared responsibility provision](#) requires each nonexempt individual to have basic health insurance coverage known as MEC, qualify for an exemption, or make a shared responsibility payment when filing their federal income tax return. The requirement applies to adults, children (as tax dependents), seniors (most of whom will meet the coverage requirement through Medicare), and lawfully present immigrants.

Read the final regulations (which were published in the Federal Register on November 26, 2014) at: [www.gpo.gov/fdsys/pkg/FR-2014-11-26/pdf/2014-27998.pdf](http://www.gpo.gov/fdsys/pkg/FR-2014-11-26/pdf/2014-27998.pdf)

### **11/24/2014 HHS/CMS issued a proposed rule called "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016a Notice of Benefit and Payment Parameters for 2016."**

The proposed rule sets forth payment parameters and provisions related to the risk adjustment, reinsurance, and risk corridors programs; cost sharing parameters and cost-sharing reductions; and user fees for Federally-facilitated Exchanges. It provides additional standards for the annual open enrollment period for the individual market for benefit years beginning on or after January 1, 2016, essential health benefits (EHB), qualified health plans (QHP), network adequacy, quality improvement strategies, the Small Business Health Options Program (SHOP), guaranteed availability, guaranteed renewability, minimum essential coverage, the rate review program, the medical loss ratio program, and other related topics.

Starting October 1, 2013, qualified individuals and qualified employees could purchase private health insurance coverage through competitive marketplaces called Affordable Insurance Exchanges, or "Exchanges" (also called Health Insurance Marketplaces). The ACA established Affordable Insurance Exchanges (§1311(b)) to provide individuals and small business employees with access to health insurance coverage beginning January 1, 2014, where low and moderate income Americans will be eligible for premium tax credits (§1401, §1411) to make purchasing a health plan more affordable by reducing out-of-pocket premium costs.

QHPs are health plans that have been certified by an Exchange, provide essential health benefits (§1301) and follow established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts). A QHP must have a certification by each Exchange in which it is sold. ACA §1311 and subsequent regulations provide that, in order to be certified as a QHP and operate in the Exchanges that will be operational in 2014, a health plan must be accredited on the basis of local performance by an accrediting entity recognized by HHS.

The premium tax credit is designed to make purchasing a health plan on the Exchange affordable for low and moderate income Americans by reducing a taxpayer's out-of-pocket premium cost. To be eligible to receive the premium tax credit, individuals and families must have incomes between 100%- 400 % FPL (or between 0% - 400% FPL if lawfully present and ineligible for Medicaid) and be enrolled in a qualified health plan (QHP) through an exchange. The individual must also be ineligible for government sponsored insurance and not have access to employer sponsored insurance that meets definitions of affordability and minimum essential coverage as established by ACA §1401. Advance payments are made monthly under ACA §1412 to the issuer of the QHP in which the

individual enrolls. ACA §1402 provides for the reduction of cost sharing for certain individuals enrolled in QHPs offered through the Exchanges and §1412 provides for the advance payment of these reductions to issuers.

The ACA established three risk-mitigation programs to stabilize premiums in the individual insurance market and minimize the effects of adverse selection that may occur as insurance reforms and the Exchanges launch in 2014. These programs include transitional reinsurance (§1341), temporary risk corridors programs (§1342), and a permanent risk adjustment program (§1343) to provide payments to health insurance issuers that cover higher-risk populations and to more evenly spread the financial risk borne by issuers. The transitional reinsurance program and the temporary risk corridors program, which begin in 2014, are designed to provide issuers with greater payment stability as insurance market reforms are implemented. The reinsurance program will reduce the uncertainty of insurance risk in the individual market by partially offsetting risk of high-cost enrollees. The risk corridors program, which is a federally administered program, will protect against uncertainty in rates for qualified health plans by limiting the extent of issuer losses and gains.

Comments are due December 22, 2014.

Read the proposed rule (which was published in the Federal Register on November 26, 2014) at:  
[www.gpo.gov/fdsys/pkg/FR-2014-11-26/pdf/2014-27858.pdf](http://www.gpo.gov/fdsys/pkg/FR-2014-11-26/pdf/2014-27858.pdf)

**11/24/14 The US Office of Personnel Management (OPM) published a proposed rule called "Patient Protection and Affordable Care Act; Establishment of the Multi-State Plan Program for the Affordable Insurance Exchanges."**

The proposed rule will implement modifications to the Multi-State Plan (MSP) Program based on the experience of the Program to date. OPM established the MSP Program pursuant to ACA §1334. The proposed rule clarifies the approach used to enforce the applicable requirements of the ACA with respect to health insurance issuers that contract with OPM to offer MSP options. The proposed rule amends MSP standards related to coverage area, benefits, and certain contracting provisions under §1334 and also makes non-substantive technical changes.

Comments are due December 24, 2014.

Read the proposed rule at: [www.gpo.gov/fdsys/pkg/FR-2014-11-24/pdf/2014-27793.pdf](http://www.gpo.gov/fdsys/pkg/FR-2014-11-24/pdf/2014-27793.pdf)

Prior guidance can be found at: [www.hhs.gov/healthcare/index.html](http://www.hhs.gov/healthcare/index.html)

## News

**11/25/14 The USPSTF issued a final recommendation statement on screening for vitamin D deficiency.**

The USPSTF does not recommend screening for vitamin D deficiency in asymptomatic adults. The Task Force assigned a "I" rating to the recommendation, indicating that the Task Force concluded that the current evidence is insufficient to determine the effectiveness of screening for Vitamin D deficiency.

The USPSTF's evidence review found that although some studies have demonstrated that low levels of vitamin D are associated with increased risk for fractures, functional limitations, cancer, diabetes, cardiovascular disease, depression, and mortality, there is no consensus about what constitutes a vitamin D deficiency. Furthermore, according to the USPSTF, there are many testing methods available to detect a deficiency but the accuracy of these tests is difficult to determine due to the lack of studies using an internationally recognized reference standard and the lack of consensus on the values used to define vitamin D deficiency.

The USPSTF is an independent panel of non-federal government experts that conduct reviews of scientific evidence of preventive health care services. The USPSTF then develops and publishes recommendations for primary care clinicians and health systems in the form of recommendation statements. As part of their recommendations process, the USPSTF will assign definitions to the services they review based on the certainty that a patient will receive a substantial benefit from receiving the benefit. Services that are graded "A" and "B" are highly recommended and the USPSTF believes there is a high certainty that patient will receive a substantial or moderate benefit.

Under ACA §1001, all of the recommended services receiving grades of "A" or "B" must be provided without cost-sharing when delivered by an in-network health insurance provider. Because the recommendation was finalized with an "I" rating, screening for vitamin D deficiency will not be required to be covered without cost-sharing under the ACA.

Read the final recommendation statement at:

[www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/vitamin-d-deficiency-screening](http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/vitamin-d-deficiency-screening)

Learn more about preventive services covered under the ACA at: [HHS.Gov](http://HHS.Gov)

Learn more about the USPSTF at: [www.uspreventiveservicestaskforce.org/](http://www.uspreventiveservicestaskforce.org/)

## Upcoming Events

### Money Follows the Person (MFP) Semi-Annual Informational Meeting

Wednesday, December 17, 2014

2:00 PM– 3:30 PM

Worcester Public Library

3 Salem Street

Worcester, MA 01608

Directions can be found at: <http://goo.gl/maps/xqEPO>

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

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

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