



AFFORDABLE CARE ACT MASSACHUSETTS IMPLEMENTATION UPDATE

April 27, 2015

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 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

Guidance

4/17/15 HHS/CMS issued a notice under the Paperwork Reduction Act of 1995 (PRA) seeking comments on four information collection activities.

Comments are due May 20, 2015 on all items.

Read the notice (which was published in the Federal Register on April 20, 2015) at: www.gpo.gov/fdsys/pkg/FR-

In [item #2](#), HHS/CMS is seeking comments on the extension of a currently approved information collection activity related to Application to Be a Qualified Entity to Receive Medicare Data for Performance Measurement. Under ACA §10332, the HHS Secretary is required to make standardized extracts of Medicare claims data under parts A, B, and D available to “qualified entities” for the evaluation of the performance of providers of services and suppliers. The statute provides the Secretary with discretion to establish criteria to determine whether an entity is qualified to use claims data to evaluate the performance of providers of services and suppliers. HHS is proposing to evaluate an organization’s eligibility across several areas to determine whether they will be approved as a qualified entity.

In [item #3](#), HHS/CMS is seeking comments on the revision of a currently approved information collection activity related to Cooperative Agreements to Support Establishment of State-Operated Health Insurance Exchanges.

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 individuals would be eligible for premium tax credits (§1401, §1411) to make purchasing a qualified health plan (QHP) more affordable by reducing out-of-pocket premium costs. If states choose not to run either a State-Based Exchange or a State-Federal Partnership Exchange, HHS will operate a Federally-facilitated Exchange (§1321). Note that Massachusetts runs a State-Based Exchange.

As the State-Based Marketplaces and Small Business Health Options Program (SHOP) have matured and moved from the developmental phases to full-operation, the reporting requirements for the states have been modified and streamlined to insure only information necessary to provide effective oversight of their operations by CMS is collected. Given the innovative nature of Exchanges and the statutorily prescribed relationship between the HHS Secretary and the states in their development and operation, according to HHS, it is critical that the HHS Secretary work closely with states to provide necessary guidance and technical assistance to ensure that states can meet the prescribed timelines, federal requirements, and goals of the statute and the grants awarded to them.

In [item #4](#), HHS/CMS is seeking comments on the revision of a previously approved information collection activity related to Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel.

Pursuant to ACA §1311, HHS [regulations](#) require Navigators, as well as those non-Navigator personnel, to inform consumers of the functions and responsibilities of Navigators and non-Navigator assistance personnel and obtain authorization for the disclosure of consumer information to the Navigator or non-Navigator assistance personnel prior to obtaining the consumer’s personally identifiable information. Under the ACA, navigators and non-Navigator assistance personnel are also required to maintain a record of the authorization provided in a form and manner as determined by the Exchange.

In [item #5](#), HHS/CMS is seeking comments on the revision of a previously approved information collection activity related to Patient Protection and Affordable Care Act; Consumer Assistance Tools and Programs of an Exchange and Certified Application Counselors; Exchange and Insurance Market Standards for 2015.

ACA §1311(d) and §1311(i) direct all Exchanges to award grants to Navigators and establish certified application counselor programs that will provide unbiased information to consumers about health insurance, the Exchange, QHPs, and insurance affordability programs including premium tax credits, Medicaid and the Children’s Health Insurance Program (CHIP). These consumer assistance tools will provide outreach and education efforts and assistance applying for health insurance coverage. Non-Navigator assistance personnel (also known as in-person assistance personnel)

perform generally the same functions as Navigators, but aren't funded through Navigator grants. For example, certified application counselors (who perform many of the same functions as Navigators and non-Navigator assistance personnel) are funded by the Exchange in which they operate through other sources. If states choose not to run either a State-Based Exchange or a State-Federal Partnership Exchange, HHS will operate a Federally-facilitated Exchange (§1321). Massachusetts runs a State-Based Exchange.

Under the ACA, enrollment assistance can be provided by: Navigators, in-person assistance personnel, or certified application counselors. In addition, agents and brokers can also help consumers enroll in new insurance options. Furthermore, under the ACA, Exchanges are required to have a certified application counselor program.

HHS issued [regulations](#) in July 2013 that finalize the requirement that certified application counselors in all Exchanges are required to be recertified on at least an annual basis and successfully complete Exchange-required recertification training. The final regulations create conflict-of-interest, training and certification, and meaningful access standards applicable to Navigators and non-Navigator assistance personnel in Federally-facilitated Exchanges, including State Partnership Exchanges, and to non-Navigator assistance personnel in State-based Exchanges that are funded through federal Exchange Establishment grants.

Additional information about the various consumer assistance personnel can be found at: www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/AssistanceRoles_06-10-14-508.pdf

4/16/15 The Equal Employment Opportunity Commission (EEOC) issued a proposed rule called "Amendments to Regulations under the Americans with Disabilities Act."

The proposed rule would amend the regulations and interpretive guidance implementing Title I of the Americans with Disabilities Act (ADA) as they relate to employer wellness programs. The proposed rule amends the ADA regulations to provide guidance on the extent to which employers may use incentives to encourage employees to participate in wellness programs that include disability-related inquiries and/or medical examinations.

Employee health programs offered by employers must comply with laws enforced by the EEOC, including Title I of the ADA which restricts the medical information employers may obtain from applicants and employees and makes it illegal to discriminate against individuals based on disability. Employers also must comply with other laws EEOC enforces that prohibit discrimination based on race, color, sex, national origin, religion, compensation, age, or genetic information. Additionally, wellness programs that are part of group health plans must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by ACA §1201.

Comments are due June 19, 2015.

Read the proposed rule (which was published in the Federal Register on April 20, 2015) at: www.gpo.gov/fdsys/pkg/FR-2015-04-20/pdf/2015-08827.pdf

4/16/15 HHS/DOL/Treasury issued FAQ Part XXV regarding the implementation of the ACA, specifically wellness programs. Group health plans and health insurance issuers in the group and individual market are generally prohibited from discriminating against participants, beneficiaries, and individuals in eligibility, benefits, or premiums based on a health factor. An exception to this general prohibition allows premium discounts, rebates, or modification of otherwise applicable cost sharing (including copayments, deductibles, or coinsurance) in return for adherence to certain programs of health promotion and disease prevention, commonly referred to as wellness programs. The wellness program exception applies to group health coverage, but not individual market coverage.

On June 3, 2013, the Departments issued [final regulations](#) that address the requirements for wellness programs

provided in connection with group health coverage. According to the agencies, the final rule implements and expands employment-based wellness programs to promote health and help control health care spending, while ensuring that individuals are protected from unfair health plan underwriting practices that could otherwise reduce benefits based on health status. The rule implements nondiscriminatory wellness programs in group health coverage, consistent with ACA §1201 and §1251. Specifically, the regulations increase the maximum permissible reward under a health-contingent wellness program offered in connection with a group health plan (and any related health insurance coverage) from 20% to 30% of the cost of coverage. The final regulations further increase the maximum permissible reward to 50% for wellness programs designed to prevent or reduce tobacco use. These regulations also include other proposed clarifications regarding the reasonable design of health-contingent wellness programs and the reasonable alternatives they must offer in order to avoid prohibited discrimination.

In the preamble to the wellness program regulations, the Departments stated that they anticipated issuing future subregulatory guidance as necessary; FAQ Part 25 addresses several issues that have been raised since the publication of the regulations.

Read FAQ Part 25 at: www.dol.gov/ebsa/faqs/faq-aca25.html

4/15/15 HHS/CMS issued a proposed rule called “Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNFs) for FY 2016, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, and Staffing Data Collection.” The rule implements portions of ACA §3006, 3401 and 6106.

The proposed rule updates the payment rates used under the prospective payment system (PPS) for skilled nursing facilities (SNFs) for fiscal year (FY) 2016. In addition, the rule includes a proposal to specify a SNF all-cause all-condition hospital readmission measure, as well as a proposal to adopt that measure for a new SNF Value-Based Purchasing (VBP) Program and a discussion of SNF VBP Program policies that CMS is considering for future rulemaking to promote higher quality and more efficient health care for Medicare beneficiaries.

Additionally, this proposed rule proposes to implement a new quality reporting program for SNFs and would amend the requirements that a long-term care facility must meet to qualify to participate as a SNF in the Medicare program, or a nursing facility (NF) in the Medicaid program. The requirements implement ACA §6016 regarding the submission of staffing information based on payroll data.

Comments are due June 15, 2015.

Read the proposed rule (which was published in the Federal Register on April 20, 2015) at: www.gpo.gov/fdsys/pkg/FR-2015-04-20/pdf/2015-08944.pdf

Prior guidance can be found at: www.hhs.gov/healthcare/index.html

News

4/21/15 The Patient-Centered Outcomes Research Institute (PCORI) approved \$120 million for 34 new Patient Centered Research Projects. Created under ACA §6301, PCORI is an independent nonprofit organization, tasked with conducting patient-centered outcomes and studies.

Out of the total awards, \$58.5 million in funding will be used for five pragmatic clinical studies that seek to answer important questions about radiation therapy for breast cancer, fractures in older adults, and treatments for children with bipolar disorder or Crohn's disease. The 29 other awards totaling \$61.6 million will compare different options for improving outcomes for conditions such as opioid addiction, arthritis, stroke, Parkinson's disease, leukemia, chronic kidney disease, and child abuse.

With these new awards, PCORI has approved \$854.6 million in funding for 399 patient-centered outcomes research projects since it began funding research in 2012.

To learn more about these awards, visit: PCORI.ORG

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4/21/15 The U.S. Preventive Services Task Force (USPSTF) issued draft recommendation statements on screening for breast cancer in asymptomatic women age 40 and older who have not been previously diagnosed with breast cancer and who are not at high-risk for breast cancer (meaning they do not have a known genetic mutation or a history of chest radiation at a young age). According to the Task Force, women at high-risk of breast cancer should consult their doctors for individualized recommendations regarding screening.

The draft recommendation statement is made up of several recommendations, addressing different age groups and screening methods.

For women in their 40s, the Task Force found that mammography screening every two years can be effective and recommends that the decision to start screening should be an individual one, assigning a "C" rating to this recommendation. According to the USPSTF, science shows that some women in their 40s will benefit from mammography, most will not, while others will be harmed. Of the potential harms, the most serious is unneeded diagnosis and treatment for a type of breast cancer that would not have become a threat to a woman's health during her lifetime. The most common harm is a false-positive test result, which often leads to additional tests and procedures. Among women in their 40s, women who have a mother, sister, or daughter with breast cancer may benefit more than average-risk women by beginning screening before age 50. The Task Force noted that mammography for women in their 40s is effective in reducing deaths from breast cancer, but that the benefits are less than for older women and the harms potentially greater.

Based on the evidence, the Task Force found that the benefit of mammography screening increases with age, with women ages 50 to 74 benefiting most, and assigned a "B" rating to this recommendation.

For women age 75 and older, the USPSTF determined that the current evidence is insufficient to make a recommendation for or against mammography screening. As a result, the Task Force assigned an "I" rating to this recommendation and stated that additional research on screening in this age group is needed.

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 in the plan years (or, in the individual market, policy years) that began on or after September 23, 2010. If the screening recommendations are finalized, then only the service with a "B" grade will be required to be provided without cost sharing.

Comments can be submitted at:

www.uspreventiveservicestaskforce.org/Comment/Collect/Index/RecommendationStatementDraft/breast-cancer-screening1

Comments are due May 18, 2015.

Read the draft recommendation statement at:

www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementDraft/breast-cancer-screening1

Learn more about preventive services covered under the ACA at: HHS.Gov

Learn more about the USPSTF at: www.uspreventiveservicestaskforce.org/

Upcoming Events

Integrating Medicare and Medicaid for Dual Eligible Individuals (also known as One Care) Implementation Council Meeting

Friday, May 29, 2015
1:00 PM - 3:00 PM
1 Ashburton Place, 21st Floor
Boston, MA

MBTA and driving directions to the Transportation Building are available here:
www.mhd.state.ma.us/default.asp?pgid=dist/HQ_directions&sid=about.

MBTA and driving directions to 1 Ashburton Place are located here: www.sec.state.ma.us/secdir.htm.

A meeting agenda and any meeting material will be distributed prior to the meeting. Reasonable accommodations are available upon request. Please contact Donna Kymalainen at Donna.Kymalainen@umassmed.edu to request accommodations.

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

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



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