



AFFORDABLE CARE ACT MASSACHUSETTS IMPLEMENTATION UPDATE

September 14, 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:

<http://www.mass.gov/eohhs/gov/commissions-and-initiatives/healthcare-reform/national-health-care-reform-plan/grants-and-demonstrations.html>

Guidance

9/4/15 CMS/HHS issued a notice of Information Collection related to Generic Clearance for the Health Care Payment Learning and Action Network

The Centers for Medicare and Medicaid Services (CMS), through the Center for Medicare and Medicaid Innovation, develops and tests innovative new payment and service delivery models in accordance with the requirements of section 1115A, as added by ACA §3021. To date, CMS has built a portfolio of 26 models (in operation or already announced) that have attracted participation from a broad array of health care providers, states, payers, and other stakeholders. During the development of models, CMS builds on ideas received from stakeholders—consulting with clinical and analytical experts, as well as with representatives of relevant federal and state agencies.

On January 26, 2015, Secretary Burwell announced the goal to have 30% of Medicare Fee-For-Service payments tied to alternative payment models (such as Pioneer ACOs or bundled payment arrangements) by the end of 2016, and 50% of payments by the end of 2018. To reach this goal CMS will continue to partner with stakeholders across the health care system to catalyze transformation through the use of alternative payment models. To this end, CMS launched the Health Care Payment Learning and Action Network (LAN), an effort to accelerate the transition to alternative payment models, identify best practices in their implementation, collaborate with payers, providers, consumers, purchasers, and other stakeholders, and monitor the adoption of value-based alternative payment models across the health care system. The information collected from LAN participants will be used by the CMS Innovation Center to potentially inform the design, selection, testing, modification, and expansion of innovative payment and service delivery models, while monitoring progress towards the Secretary's goal to increase the percentage of payments tied to alternative payment models across the U.S. health care system. In addition, the requested information will be made publically available so that LAN participants (payers, providers, consumers, employers, state agencies, and patients) can use the information to inform decision making and better understand market dynamics in relation to alternative payment models.

Comments are due October 5, 2015.

Read the notice at:

<http://www.gpo.gov/fdsys/pkg/FR-2015-09-04/pdf/2015-22020.pdf>

9/3/15 The Office for Civil Rights (OCR)/ Office of the Secretary, HHS issued a notice of proposed rulemaking called "Nondiscrimination in Health Programs and Activities."

According to HHS, the proposed rule on ACA §1557 prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities. ACA §1557(c) authorizes the HHS Secretary to promulgate regulations to implement nondiscrimination requirements. In addition, the HHS Secretary is authorized to prescribe regulations for the Department's governance, conduct, and performance of its business, including how HHS will apply the standards of ACA § 1557 to HHS-administered health programs and activities.

ACA §1557 extended civil rights protections banning sex discrimination to health programs and activities. Previously, civil rights laws enforced by OCR barred discrimination based only on race, color, national origin, disability, or age. The proposed rule also extends all civil rights obligations to the Health Insurance Marketplaces and HHS health programs and activities, and clarifies the standards HHS applies in implementing ACA §1557 across all bases of discrimination.

The proposed rule establishes that the prohibition on sex discrimination includes discrimination based on gender identity. It also includes requirements for effective communication for individuals with disabilities and enhanced language assistance for people with limited English proficiency.

Comments are due November 9, 2015.

Read the proposed rule (which was published in the Federal Register on September 8, 2015) at:

<http://www.gpo.gov/fdsys/pkg/FR-2015-09-08/pdf/2015-22043.pdf>

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

News

9/9/2015 The CMS Innovation/Seamless Care Models Group will issue three Single Source Cooperative Agreement Awards authorized through ACA §3021.

Under ACA §3021 CMS is authorized to test innovative payment and service delivery models to reduce program expenditures under Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) while preserving or enhancing the quality of care given to individuals under these programs.

In October 2012, CMS launched the Comprehensive Primary Care (CPC) initiative as a multi-payer demonstration to test a model that fosters collaboration between public and private health insurance companies to strengthen primary care. One of the stated goals of the initiative is improving the flow of cost and utilization data to CPC primary care practices. This single-source cooperative agreement award will allow the inclusion of Medicare data into the CPC multi-payer data model. The awardees will combine Medicare Fee-for-Service (FFS) data with utilization data from participating payers resulting in the creation of uniform and actionable reports to support physician care coordination and quality improvement efforts.

The three single-source cooperative agreements will be awarded in the initial amount of \$200,000–\$450,000 per award for the first budget period. An award for a non-competing continuation at \$200,000–\$450,000 may be awarded for a period of 12 months. CMS has solicited applications from Rise Health – Illinois, The Health Collaborative – Ohio, and My Health – Oklahoma and confirmed that they are the only entities capable of providing the data aggregation described above.

To learn more about this announcement, visit: GPO.GOV

9/9/15 CMS released an Effectuated Enrollment Snapshot stating that 9.9 million consumers had received health insurance coverage a through Health Insurance Marketplace by June 30, 2015. These individuals have paid their premiums and have had an active policy since the end of June 2015.

Of the 9.9 million consumers who were enrolled at the end of June 2015, nearly 84 percent were receiving an advanced premium tax credit (APTC) to make their premiums more affordable throughout the year. 7.2 million of these consumers were enrolled through the 37 Federally-Facilitated Marketplaces and supported State-based Marketplaces. 2.7 million of the consumers were enrolled through the remaining State-based Marketplaces. In Massachusetts, 156,448 consumers had enrolled through the Health Connector Insurance Marketplace, with an average APTC of \$188.

The first Marketplace enrollment snapshot for 2015 was released on June 2 and covered effectuated enrollment through March 31, showing that 10.2 million consumers had effectuated coverage. Today's announcement provides an update through June 30 on the number of individuals with citizenship, immigration status, or household income data matching issues.

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. These Marketplace effectuated enrollment snapshot provides point-in-time estimates and are released on a quarterly basis, detailing how many consumers have an effectuated enrollment, how many are benefiting from APTC and/or cost-sharing reductions (CSR), and the distribution of effectuated enrollment by qualified health plan metal level.

For more information about this snapshot, visit: CMS.GOV

9/9/15 The U.S. Preventive Services Task Force (USPSTF) issued two final recommendation statements on screening for iron deficiency anemia (IDA) in pregnant women and children ages 6 to 24 months. The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for iron deficiency anemia in pregnant women and children ages 6 to 24 months.

In the final recommendation on screening for IDA in asymptomatic pregnant women, the USPSTF found that there is insufficient evidence on the benefits and harms of routine screening for IDA or the use of iron supplements during pregnancy to improve maternal health and birth outcomes, and it cannot recommend for or against either service. As a result, the Task Force assigned an "I" rating to the recommendation.

In the final recommendation on screening for IDA in young children, the Task Force found that there is not enough evidence to make a recommendation for or against screening for IDA in children ages 6 to 24 months who have no signs or symptoms of the condition. As a result, the Task Force assigned an "I" rating to the recommendation.

According to the USPSTF, although iron deficiency is a well-known cause of anemia in the United States, since most people get enough iron by eating a well-balanced diet, it's unclear whether iron supplementation or screening for IDA can improve health. The Task Force stated that additional research is needed to evaluate whether screening for IDA can improve the health outcomes for mothers and young children.

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. Since the IDA screening recommendations were finalized with "I" ratings, the services will not be required to be provided without cost sharing.

The final recommendation statement for iron deficiency anemia in pregnant women can be read at:

<http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/iron-deficiency-anemia-in-pregnant-women-screening-and-supplementation>

The final recommendation statement for iron deficiency anemia in young children can be read at:

<http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/iron-deficiency-anemia-in-young-children-screening>

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

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

9/9/15 The U.S. Preventive Services Task Force (USPSTF) issued draft recommendation statements about screening for depression in adolescents ages 12 to 18 years and children age 11 and younger.

The Task Force recommends screening for major depressive disorder (MDD) in adolescents ages 12 to 18 years when adequate systems are in place for diagnosis, treatment, and monitoring. The Task Force recommends such screening and assigned a "B" grade to the recommendation. For children age 11 years and younger, the Task Force concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for MDD in this age group and assigned an "I" grade to the recommendation.

According to the USPSTF, Depression is a leading cause of disability in the United States. Children and adolescents with MDD typically have functional impairments in their performance at school or work, as well as in their

interactions with their families and peers. Depression can also negatively affect the developmental trajectories of affected youth. MDD in children and adolescents is strongly associated with recurrent depression in adulthood; other mental disorders; and increased risk for suicidal ideation, suicide attempts, and suicide completion.

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 recommendation on screen for depression in adolescents is finalized with a "B" rating, then this service must be provided without cost-sharing. If the recommendation on screening for depression in children is finalized with an "I" rating, then such screening will not be required to be provided without cost sharing.

Comments are due October 5, 2015 and can be submitted at:

<http://www.uspreventiveservicestaskforce.org/Comment/Collect/Index/draft-recommendation-statement116/depression-in-children-and-adolescents-screening1>

Read the draft recommendation statement at:

<http://www.uspreventiveservicestaskforce.org/Page/Document/draft-recommendation-statement116/depression-in-children-and-adolescents-screening1>

Upcoming Events

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

Wednesday, September 23, 2015
10:00 AM – 12:00 PM
Worcester Public Library
3 Salem Square
Saxe Room
Worcester, MA

We welcome attendance at all meetings from all stakeholders and members of the public with an interest in One Care. Reasonable accommodations will be made for participants who need assistance. Please send your request for accommodations to Donna Kymalainen at Donna.Kymalainen@state.ma.us.

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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