



## AFFORDABLE CARE ACT MASSACHUSETTS IMPLEMENTATION UPDATE

November 30, 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 Announcements

**Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program, \$2951.** Announced November 18, 2015.

Funding is available to support the delivery of coordinated and comprehensive high-quality voluntary early childhood home visiting services to eligible families. The MIECHV program provides an opportunity for significant collaboration and partnership at the federal, state, tribal, and community levels to improve health and development outcomes for children through evidence-based home visiting programs.

Eligible applicants are limited to the following entities currently funded in FY 2015 under the MIECHV programs: 47 participating states, including Massachusetts; three nonprofit organizations serving Florida, North Dakota, and Wyoming; and six territories and jurisdictions serving the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, the Commonwealth of the Northern Mariana Islands, and American Samoa. \$345,000,000 is available for 56 awards.

Applications are due January 19, 2016.

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

### 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-](http://www.mass.gov/eohhs/gov/commissions-)

[and-initiatives/healthcare-reform/national-health-care-reform-plan/grants-and-demonstrations.html](http://www.hhs.gov/and-initiatives/healthcare-reform/national-health-care-reform-plan/grants-and-demonstrations.html)

## Guidance

### **11/24/15 HHS issued a notice called “Federal Financial Participation in State Assistance Expenditures: Matching Shares for Medicaid, the Children’s Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2016 through September 30, 2017.”**

According to HHS, the Federal Medical Assistance Percentages (FMAP), Enhanced Federal Medical Assistance Percentages (eFMAP), and disaster-recovery FMAP adjustments for Fiscal Year 2017 provided for in the notice have been calculated pursuant to the Social Security Act.

The notice announces the calculated FMAP rates (which will be effective from October 1, 2016 through September 30, 2017), in accordance with the Social Security Act that the U.S. Department of Health and Human Services will use in determining the amount of federal matching for state Medicaid programs, Temporary Assistance for Needy Families (TANF) Contingency Funds, Child Support Enforcement collections, Child Care Mandatory and Matching Funds of the Child Care and Development Fund, Foster Care Title IV-E Maintenance payments, and Adoption Assistance payments, and the eFMAP rates for the Children’s Health Insurance Program (CHIP) expenditures as authorized under the ACA for fiscal years 2016 through 2019.

ACA § 2001 provides for a significant increase in the FMAP for medical assistance expenditures for individuals determined eligible under the new adult group in the state and who will be considered to be “newly eligible” in 2014. The newly eligible FMAP is 100% for calendar years 2014, 2015, and 2016, gradually declining to 90% in 2020 where it remains indefinitely. In addition, ACA §10201 provides that states, including Massachusetts, that had expanded substantial coverage to low-income parents and nonpregnant adults without children prior to the enactment of the ACA, referred to as “expansion states,” shall receive an enhanced FMAP that begins in 2014 for medical assistance expenditures for nonpregnant childless adults who may be required to enroll in benchmark coverage. The FMAP for Massachusetts for members considered newly eligible under the ACA was 75% in 2014, is 80% in 2015, will gradually increase to 93% in 2019, decreasing to 90% in 2020 where it remains indefinitely. The eFMAP rate for CHIP in Massachusetts is 88%.

Read the notice (which was published in the Federal Register on November 25, 2015) at:

[www.federalregister.gov/articles/2015/11/25/2015-30050/federal-financial-participation-in-state-assistance-expenditures-federal-matching-shares-for](http://www.federalregister.gov/articles/2015/11/25/2015-30050/federal-financial-participation-in-state-assistance-expenditures-federal-matching-shares-for)

**11/23/15 HHS/CMS issued a notice under the Paperwork Reduction Act of 1995 (PRA) seeking comments on the revision of a currently approved collection related to the Establishment of Qualified Health Plans (QHPs) and American Health Benefit Exchanges.** The ACA expanded access to health insurance for individuals and employees of small businesses through the establishment of new Affordable Insurance Exchanges, including the Small Business Health Options Program (SHOP).

To offer insurance through an Exchange, a health insurance issuer must have its health plans certified as QHPs by the Exchange. Each Exchange is responsible for collecting data and validating that QHPs meet minimum requirements as described in the [Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers Final Rule](#). In addition to data collection for the certification of QHPs, Exchanges must ensure that a QHP meets certain other requirements such as network adequacy, inclusion of Essential Community Providers, and nondiscrimination.

According to HHS/CMS, the information collection and related reporting requirements and data collection in the Exchange rule address Federal requirements that various entities must meet with respect to the establishment and operation of an Exchange; minimum requirements that health insurance issuers must meet with respect to participation in a State based or Federally-facilitated Exchange; and requirements that employers must meet with respect to participation in the SHOP and compliance with other provisions of the ACA.

Beginning October 1, 2013, qualified individuals and qualified employees could purchase private health insurance coverage through Exchanges (Marketplaces) for January 1, 2014 effective dates. 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. Furthermore, an Exchange makes an advance determination of tax credit eligibility for individuals who enroll in a QHP through the Exchange and pursue financial assistance (§1401, 1411, and 1412). QHPs are health plans that have been certified by an Exchange, provide essential health benefits (EHB, §1301) and follow established limits on cost-sharing (such as reduced deductibles, copayments, and out-of-pocket maximum amounts).

§1311(b)(1)(B) also requires that the SHOP assist qualified small employers in facilitating the enrollment of their employees in QHPs offered in the small group market. QHPs are health plans that have been certified by an Exchange, provide EHB, and follow established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts).

Comments are due January 22, 2016.

Read the notice at: [www.gpo.gov/fdsys/pkg/FR-2015-11-23/pdf/2015-29725.pdf](http://www.gpo.gov/fdsys/pkg/FR-2015-11-23/pdf/2015-29725.pdf)

**11/20/15 HHS/CMS issued a request for information called “Medicare Program; Request for Information to Aid in the Design and Development of a Survey Regarding Patient and Family Member Experiences with Care Received in Inpatient Rehabilitation Facilities.”**

According to CMS, the request for information will aid in the design and development of a survey regarding patient and family member experiences with the care received in inpatient rehabilitation facilities (IRF).

As required by ACA Section 3011, HHS developed the National Quality Strategy (NQS), which is led by the Agency for Healthcare Research and Quality, to create national aims and priorities to guide local, state, and national efforts to improve the quality of health care. The NQS established three aims (better care, healthy people/health communities and affordable care) supported by six priorities. The six priorities are: (1) making care safer by reducing harm caused by the delivery of care; (2) ensuring that each person and family are engaged as partners in their care; (3) promoting effective communication and coordination of care; (4) promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease; (5) working with communities to promote wide use of best practices to enable healthy living; and (6) making quality care more affordable for individuals, families, employers, and governments by developing new health care delivery models.

HHS is developing the “IRF Patient and Family Member Experience of Care (PEC) Survey” in order to support the collection of data that can be used to pursue the agency’s progress on these priorities in the IRF setting.

Comments are due January 19, 2016.

More information about the NQS is available at: [www.ahrq.gov/workingforquality/](http://www.ahrq.gov/workingforquality/)

Read the request for information at: [www.gpo.gov/fdsys/pkg/FR-2015-11-20/pdf/2015-29623.pdf](http://www.gpo.gov/fdsys/pkg/FR-2015-11-20/pdf/2015-29623.pdf)

**11/20/15 HHS/CMS issued a request for information called “Medicare Program; Request for Information to Aid in the Design and Development of a Survey Regarding Patient and Family Member Experiences with Care Received in Long-Term Care Hospitals.”**

According to CMS, the request for information will aid in the design and development of a survey regarding patient and family member experiences with the care received in long-term care hospitals (LTCHs).

As required by ACA Section 3011, HHS developed the National Quality Strategy (NQS), which is led by the Agency for Healthcare Research and Quality, to create national aims and priorities to guide local, state, and national efforts to improve the quality of health care. The NQS established three aims (better care, healthy people/health communities and affordable care) supported by six priorities. The six priorities are: The six priorities are: (1) making care safer by

reducing harm caused by the delivery of care; (2) ensuring that each person and family are engaged as partners in their care; (3) promoting effective communication and coordination of care; (4) promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease; (5) working with communities to promote wide use of best practices to enable healthy living; and (6) making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

HHS is developing the "LTCH Patient and Family Member Experience of Care (PEC) Survey" in order to support the collection of data that can be used to pursue the agency's progress on these priorities in the LTCH setting.

Comments are due January 19, 2016.

More information about the NOS is available at: [www.ahrq.gov/workingforquality/](http://www.ahrq.gov/workingforquality/)

Read the request for information at: [www.gpo.gov/fdsys/pkg/FR-2015-11-20/pdf/2015-29622.pdf](http://www.gpo.gov/fdsys/pkg/FR-2015-11-20/pdf/2015-29622.pdf)

**11/16/15 HHS/CMS announced the final rule for the Comprehensive Care for Joint Replacement Model (CJR).** According to CMS, the CJR model will support better and more efficient care for Medicare beneficiaries undergoing hip and knee replacements.

This model will test a bundled payment and quality measurement for hip and knee replacements to encourage hospitals, physicians, and post-acute care providers to work together to improve quality and coordination of care. CJR aims to improve the care experience for Medicare beneficiaries who receive joint replacements, making the patient's successful surgery and recovery a top priority for our health care system.

The CJR Model was designed by the CMS Innovation Center, which was established under §3021 of the ACA. The CMS Innovation Center tests innovative payment and service delivery models to reduce CMS program expenditures and improve quality for CMS beneficiaries. There are currently 67 participants; none of the participants are from Massachusetts.

For more information on the CJR model, including a list of participants, visit: <https://innovation.cms.gov/initiatives/cjr>

Read the final rule (which was published in the Federal Register on November 24, 2015) at: [www.gpo.gov/fdsys/pkg/FR-2015-11-24/pdf/2015-29438.pdf](http://www.gpo.gov/fdsys/pkg/FR-2015-11-24/pdf/2015-29438.pdf)

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

## News

**11/19/15 HHS announced that consumers and small employers have received more than \$2.4 billion in consumer rebates on premiums since 2011 as a result of the implementation of the medical loss ratio (MLR) requirements under ACA §10101.**

The ACA's MLR rules establish the minimum dollar percentage that health insurance companies must spend of consumers' health insurance premiums on medical care and quality improvement activities, not on income, overhead or marketing. The ACA requires insurance companies in the individual and small group markets to spend at least 80% of collected premium dollars on medical care and quality improvement activities; insurance companies in the large group market are required to spend at least 85% on such activities. Insurance companies must report their MLR data to HHS on an annual basis so that residents of every state will have information on the value of the health plans offered by insurance companies in their state. Under the MLR rules, insurance companies that do not meet the MLR standard are required to provide rebates to their consumers.

Through this provision, in 2014 5.5 million consumers received nearly \$470 million in rebates, for an average of \$129

per family. Massachusetts consumers received a total of \$12,617,420 in total rebates, averaging a total savings of \$235 per family.

To learn more about this report please visit, [CMS.GOV](http://CMS.GOV)

## Upcoming Events

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

Friday, December 11, 2015

12:00 PM - 2:00 PM

1 Ashburton Place, 21st Floor  
Boston, MA 02108

Friday January 15, 2015, 1:00-3:00PM

1 Ashburton Place, 21st Floor  
Boston, MA 02108

We welcome attendance 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](mailto:Donna.Kymalainen@state.ma.us)

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

Wednesday, December 16, 2015

2:00 PM– 3:30 PM

Worcester Public Library  
3 Salem Street  
Worcester, MA 01608

The Massachusetts MFP Project Office holds this meeting semi-annually to provide stakeholders and other interested parties the opportunity to stay current on MFP Demonstration activities and topics related to program success. Please contact [MFP@state.ma.us](mailto:MFP@state.ma.us) to RSVP and to request reasonable accommodations. Although RSVPs are greatly appreciated, they are not required.

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

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



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