

AFFORDABLE CARE ACT MASSACHUSETTS IMPLEMENTATION UPDATE

December 7, 2015

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

Pipeline to Proposal Awards Initiative Tier I - Pre-Engagement/Community Projects, \$6301.

Announced December 1, 2015. Funding is available to build and strengthen the community engagement and capacity necessary to develop a patient-centered comparative effectiveness research (CER) project addressing an issue of interest to the awardee. This opportunity is intended to support individuals and groups who may not have other opportunities for research funding.

Eligible applicants include individuals, consumer and patient organizations, clinicians, researchers, or a combination of these applicants. \$15,000 for individual awards is available.

Required Letters of Intent are due January 18, 2016.

Applications are due April 18, 2016.

This announcement may be viewed at: 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

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

12/3/15 HHS/CMS issued a final rule called "Medicaid Program; Mechanized Claims Processing and Information Retrieval Systems (90/10)." The proposed rule implements portions of ACA §1104, §1413 and §1561.

The final rule will extend enhanced funding for Medicaid eligibility systems as part of a state's mechanized claims processing system, and will update conditions and standards for such systems, including adding to and updating

current Medicaid Management Information Systems (MMIS) conditions and standards. According to CMS, the changes will allow states to improve customer service and support the dynamic nature of Medicaid eligibility, enrollment, and delivery systems.

Read the rule (which was published in the Federal Register on December 4, 2015) at:

<http://www.gpo.gov/fdsys/pkg/FR-2015-12-04/pdf/2015-30591.pdf>

12/2/15 HHS/CMS issued a notice called " Medicare, Medicaid, and Children's Health Insurance Programs; Provider Enrollment Application Fee Amount for Calendar Year 2016."

As required by ACA §6401, the notice announces the 2016 calendar year application fee of \$554.00 for institutional providers that are initially enrolling in the Medicare or Medicaid program or the Children's Health Insurance Program (CHIP); revalidating their Medicare, Medicaid, or CHIP enrollment; or adding a new Medicare practice location.

Read the notice (which was published in the Federal Register on December 3, 2015) at:

<http://www.gpo.gov/fdsys/pkg/FR-2015-12-03/pdf/2015-30686.pdf>

12/2/15 HHS/CMS issued a notice under the Paperwork Reduction Act of 1995 (PRA) seeking comments on four information collection activities.

Comments are due February 1, 2016.

Read the notice at: <http://www.gpo.gov/fdsys/pkg/FR-2015-12-02/pdf/2015-30534.pdf>

In item #1, HHS/CMS is seeking comments on the revision of a currently approved information collection activity related to Information Collection Requirements for Compliance with Individual and Group Market Reforms under Title XXVII of the Public Health Service Act (PHS Act). According to HHS, sections of the PHS Act and its implementing regulations direct CMS to enforce a requirement when a state has notified CMS that it has not enacted legislation to enforce (or that it is not otherwise enforcing) a provision of the group and individual market reforms with respect to health insurance issuers, or when CMS has determined that a state is not substantially enforcing one or more of those provisions. HHS stated that this collection of information includes requirements that are necessary for CMS to conduct compliance review activities.

In item #2, HHS/CMS is seeking comments on a new information collection activity related to the Establishment of an Exchange by a State and Qualified Health Plans. 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).

In item #3, HHS/CMS is seeking comments on a new information collection activity related to the Establishment of Exchanges and Qualified Health Plans (QHPs); Exchange Standards for Employers. ACA §1321(a) requires HHS to issue regulations setting standards for meeting the requirements under Title I of the ACA including the offering of QHPs through the Exchanges. The [final Exchange rule](#) (which was published in the Federal Register on March 27, 2012) contains provisions that mandate reporting and data collections necessary to ensure that health insurance issuers are meeting the requirements of the ACA. According to HHS, the data collected by health insurance issuers will help to inform HHS, Exchanges, and health insurance issuers as to the participation of individuals, employers, and employees in the individual Exchange and assist HHS in creating a seamless and coordinated system of eligibility and enrollment.

In item #4, HHS/CMS is seeking comments on the extension of a currently approved information collection activity related to the Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Health Benefits Exchanges, Medicaid and Children's Health Insurance Program (CHIP) Agencies. ACA §1413 directs the HHS Secretary to develop and provide to each state a single, streamlined form that may be used to apply for coverage through the Exchange and Insurance Affordability Programs, including Medicaid, CHIP, and the Basic Health Program, if applicable. A state may also develop and use its own single streamlined application if approved by the HHS Secretary in accordance with ACA §1413 and if it meets the standards established by the HHS Secretary.

The [final Exchange rule](#) (which was published in the Federal Register on March 27, 2012) provides more detail about the application that must be used by the Exchange to determine eligibility and to collect information necessary for enrollment. According to HHS, the application is being designed to solicit sufficient information from applicants so that in most cases no further inquiry will be needed. Individuals will be able to submit an application electronically, through the mail, over the phone through a call center, or in person. The application may be submitted to an Exchange, Medicaid or CHIP agency. The electronic application process will vary depending on each applicant's circumstances, their experience with health insurance applications and online capabilities.

11/27/15 HHS/CMS issued a notice under the Paperwork Reduction Act of 1995 (PRA) seeking comments on a new information collection activity related to the Reapplication Submission Requirement for Qualified Entities under ACA §10332.

ACA §10332 requires the HHS Secretary to make standardized extracts of Medicare claims data under Parts A, B, and D available to "qualified entities" (QEs) for the evaluation of the performance of providers of services and suppliers. The statute provides the HHS 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. According to CMS, the agency issued the [final rule](#) (which was published in the Federal Register on December 7, 2011) called "Medicare Program; Availability of Medicare Data for Performance Measurement" after consideration of comments from a wide variety of stakeholders. CMS established the Qualified Entity Certification Program (QECP) to implement the Final Rule. One of the requirements in the Final Rule is that QEs must reapply for certification

six months prior to the end of their 3-year certification period to remain in good standing. This information collection is related to the official reapplication that Qualified Entities must complete to reapply to the QECP.

Comments are due January 26, 2016.

Read the notice at: <http://www.gpo.gov/fdsys/pkg/FR-2015-11-27/pdf/2015-30070.pdf> (see item #2)

11/20/15 HHS/CMS issued a proposed rule called "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017."

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. The rule also provides additional standards for the annual open enrollment period for the individual market for the 2017 benefit year; essential health benefits (EHB, §1301); cost-sharing requirements; qualified health plans (QHP); updated standards for Exchange consumer assistance programs; network adequacy; patient safety standards; the Small Business Health Options Program (SHOP, §1311(b)(1)(B)); stand-alone dental plans; acceptance of third-party payments by qualified health plans; the definitions of large employer and small employer; fair health insurance premiums; guaranteed availability; student health insurance coverage; the [rate review program](#) (§1003); the [medical loss ratio program](#) (MLR, §10101); eligibility and enrollment; exemptions and appeals; 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 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 21, 2015.

Read the rule (which was published in the Federal Register on December 2, 2015) at:
<http://www.gpo.gov/fdsys/pkg/FR-2015-12-02/pdf/2015-29884.pdf>

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

News

12/1/15 The U.S. Preventive Services Task Force (USPSTF) issued a draft recommendation statement on visual skin cancer screening exams by doctors in adults. Based on its review, the Task Force found that the current evidence is insufficient to assess the balance of benefits and harms of a full-body visual skin exam performed by a doctor to find melanoma skin cancer in adults. As a result, the USPSTF assigned an "I" grade to the recommendation. The "I" rating indicates that the Task Force does not recommend the service.

According to the Task Force, skin cancer is the most common cancer in the United States, although most forms of skin cancer do not result in death. Melanoma is a type of skin cancer that is much less common (representing less than 2% of all skin cancers) but has a higher death rate. The USPSTF reviewed the current research on the effectiveness of a full-body visual skin cancer screening by a doctor and determined that there is not enough evidence to confirm whether such screening prevents death from melanoma. Additionally, the Task Force found that there are potential harms that go along with skin cancer screening, including unnecessary biopsies. The USPSTF encouraged more research in this area and reminded Americans that the best way to avoid skin cancer is to minimize exposure to ultraviolet rays.

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 visual skin cancer screening exams by doctors in adults is finalized, then such screening for adults will not be required to be provided by health plans without cost sharing.

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

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

Comments are due December 28, 2015 and can be submitted at:
<http://www.uspreventiveservicestaskforce.org/Comment/Collect/Index/draft-recommendation-statement168/skin-cancer-screening2>

Read the draft recommendation statement at:
<http://www.uspreventiveservicestaskforce.org/Page/Document/draft-recommendation-statement168/skin-cancer-screening2>

12/1/15 HHS released a report indicating that from 2010 to 2014 an estimated 87,000 fewer patients died in hospitals, creating \$20 billion in health care costs saving for hospitals. According to the report, prevention efforts created by ACA §3008 have lowered hospital-acquired conditions (HACs) by 17% over the four-year period.

The report illustrates that hospital patients experienced 2.1 million fewer HACs from 2010 to 2014 due to HAC Reduction Program. This announcement builds on results previously achieved and reported by HHS in December 2014, which showed 50,000 fewer patients died in hospitals resulting in \$12 billion in health care costs saved by hospitals between 2010 and 2013.

HAC can include conditions such as adverse drug events, catheter-associated urinary tract infections, central line associated bloodstream infections, pressure ulcers, and surgical site infections.

The ACA established the HAC Reduction Program, creating incentives for hospitals that reduce HACs. The program adjusts payments to hospitals that rank in the worst-performing 25% of hospitals with respect to HAC quality measures. These hospitals may have their payments reduced to 99% of what would otherwise have been paid for such discharges.

To read the report, visit: AHRO.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, 2016
1:00 PM - 3:00 PM
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

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 to RSVP and to request reasonable accommodations. Although RSVPs are greatly appreciated, they are not required.

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](#) for information on the "**Integrating Medicare and Medicaid for Dual Eligible Individuals**" initiative.

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