



AFFORDABLE CARE ACT MASSACHUSETTS IMPLEMENTATION UPDATE

February 29, 2016

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

Empowering Older Adults and Adults with Disabilities in Tribal Communities through Chronic Disease Self-Managed Education Programs, \$4002. Announced February 24, 2016.

Funding is available to increase the number of American Indian, Alaskan Native, and Native Hawaiian older adults and adults with disabilities who participate in evidence-based self-management education programs. This award will also help increase the sustainability of these programs through innovative financing arrangements.

Eligible applicants are limited to all Native American tribal organizations. \$400,000 is available for four awards.

Applications are due April 25, 2016

View the announcement at: [GRANTS.GOV](#)

Evidence-Based Falls Prevention Programs in Tribal Communities, \$4002. Announced February 24, 2016.

Funding is available to increase the number of American Indian, Alaskan Native, and Native Hawaiian adults who participate in evidence-based community programs to reduce falls and the risk of falls. Grant fund will also help increase the sustainability of these programs through innovative financing arrangements.

Eligible applicants are limited to all Native American tribal organizations. \$400,000 is available for four awards.

Required Letters of Intent are due March 16, 2016.

Applications are due May 9, 2016.

View the announcement at: [GRANTS.GOV](#)

Health Systems PCORnet Demonstration Project, \$4002. Announced February 23, 2016.

Funding is available for Clinical Data Research Networks (CDRNs) to engage with their health systems leaders to identify and prioritize a set of data-driven research activities of high interest to both health systems and clinicians.

Eligible applicants are limited to CDRNs that are currently funded by PCORI as part of Phase II of the PCORnet initiative. \$4 million is available for up to five awards.

Created under ACA §6301, PCORI is an independent nonprofit organization, tasked with conducting patient-centered outcomes and studies.

Applications are due April 19, 2016.

To learn more about this award, visit: PCORI.ORG

State and Local Public Health Actions to Prevent Obesity, Diabetes, Heart Disease and Stroke financed solely by Prevention and Public Health Funds, \$4002. Announced February 22, 2016.

Continued funding is available to support implementation of population-wide and priority population approaches to prevent obesity, diabetes, heart disease and stroke and reduce health disparities in these areas among adults.

Eligible applicants are limited to organizations previously awarded funding under this opportunity, which includes the Massachusetts Department of Public Health. There are fifty awards available.

To learn more about this program, including a list of current awardees, visit: CDC.GOV

Applications are due April 29, 2016.

View the announcements at: 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-and-initiatives/healthcare-reform/national-health-care-reform-plan/grants-and-demonstrations.html

Guidance

2/24/16 HHS/CMS issued a notice under the Paperwork Reduction Act of 1995 (PRA) seeking comments on the revision of a currently approved information collection activity related to the Medicare Current Beneficiary Survey (MCBS).

The MCBS is an in-person, nationally-representative, longitudinal survey of Medicare beneficiaries that is directed by the Office of Enterprise Data and Analytics in partnership with the Center for Medicare and Medicaid Innovation (CMMI, established by ACA §3021). The survey captures information about beneficiaries whether they are aged or disabled, living in the community or a facility, or serviced by managed care or fee-for-service. The MCBS has been continuously fielded for more than 20 years, and consists of three annual interviews per survey participant. According to CMS, the MCBS provides insight into the Medicare program and helps the agency and external stakeholders better understand and evaluate the impact of existing programs and significant new policy initiatives.

The survey is being revised in order to streamline some questionnaire sections, add a few new measures, and update the wording of questions and response categories. According to the agency, most of the revised questions reflect an effort to make the MCBS questionnaire consistent with other national surveys that have more current wording of questions and response categories with well-established measures.

Comments are due April 25, 2016.

Read the notice at: <https://www.gpo.gov/fdsys/pkg/FR-2016-02-24/pdf/2016-03908.pdf>

2/19/16 HHS/CMS issued a notice under the Paperwork Reduction Act of 1995 (PRA) seeking comments on two information collection activities.

Comments are due March 21, 2016.

Read the notice at: <https://www.gpo.gov/fdsys/pkg/FR-2016-02-19/pdf/2016-03473.pdf>

In item #1, HHS/CMS is seeking comments on the revision of a currently approved information collection activity related to Enrollment Opportunity Notice Relating to Lifetime Limits; Required Notice of Rescission of Coverage; and Disclosure Requirements for Patient Protection under the Affordable Care Act.

ACA §1251 requires that certain health plans in existence as of March 23, 2010, known as grandfathered health plans, are not required to comply with certain statutory provisions in the ACA. The [final regulations](#) called "Final Rules under the Affordable Care Act for Grandfathered Plans, Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, Dependent Coverage, Appeals, and Patient Protections" require that, to maintain its status as a grandfathered health plan, a plan must maintain records documenting the terms of the plan in effect on March 23, 2010, and any other documents that are necessary to verify its status as a grandfathered health plan. A grandfathered health plan is also required to include a statement in any summary of benefits under that plan, that the plan considers it to be a grandfathered health plan meeting the criteria established by ACA §1251, and to provide contact information for participants to direct questions and complaints.

In addition, a grandfathered group health plan that is changing health insurance issuers is required to provide the succeeding health insurance issuer (and the succeeding health insurance issuer must provide) documentation of certain plan terms (including benefits, cost sharing, employer contributions, and annual limits) as indicated by HHS. Certain insured group health plans (that are grandfathered plans) are required to notify the issuer if the contribution rate changes at any point during the plan year.

In item #2, HHS/CMS is seeking comments on the revision of a currently approved information collection activity related to Enrollment Opportunity Notice Relating to Lifetime Limits; Required Notice of Rescission of Coverage; and Disclosure Requirements for Patient Protection under the Affordable Care Act.

[Interim final regulations](#) called "Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections" contain enrollment opportunity, rescission notice, and patient protection disclosure requirements. The one-time enrollment opportunity notice required health plans to notify certain individuals of their right to re-enroll in their plan. The rescission notice will be used by health plans to provide advance notice to certain individuals that their coverage may be rescinded as a result of fraud or intentional misrepresentation of material fact. The patient protection notification will be used by health plans to inform certain individuals of their right to choose a primary care provider or pediatrician and to use obstetrical/gynecological services without prior authorization. The related provisions are finalized in the [final regulations](#) called "Final Rules under the Affordable Care Act for Grandfathered Plans, Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, Dependent Coverage, Appeals, and Patient Protections." The final regulations also include additional requirements related to balance billing designed to protect enrollees.

2/19/16 HHS/CMS issued a notice under the Paperwork Reduction Act of 1995 (PRA) seeking comments on two information collection activities.

Comments are due April 19, 2016.

Read the notice at: <https://www.gpo.gov/fdsys/pkg/FR-2016-02-19/pdf/2016-03474.pdf>

In item #3, HHS/CMS is seeking comments on the revision of a currently approved information collection activity related to Rate Increase Disclosure and Review Reporting Requirements.

The [rate review program](#) under §1003 requires that insurers seeking rate increases of 10% or more for non-grandfathered plans in the individual and small group markets publicly and clearly disclose the proposed increases and the justification for them. Such increases are reviewed by either state experts (or by federal experts in states that do not have a rate review program deemed effective by HHS) to determine whether they are unreasonable. The statute provides that health insurance issuers must submit to the HHS Secretary and the applicable state justifications for unreasonable premium increases prior to the implementation of the increases. Beginning with plan years beginning in 2014, the HHS Secretary, in conjunction with the states, shall monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange.

In order to obtain the information necessary to monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange, health insurance issuers are required to submit specific documentation based on increases at the plan level that would justify any rate increases. The required documentation is outlined in the notice.

In item #4, HHS/CMS is seeking comments on the extension of a currently approved information collection activity related to Medical Loss Ratio (MLR) Annual Reports, MLR Notices, and Recordkeeping Requirements.

As required by ACA §2718, the [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 notice and rebates to their consumers.

Health insurance issuers offering group or individual health insurance coverage must submit a related report to the HHS Secretary concerning the amount the issuer spends each year on claims, quality improvement expenses, non-claims costs, federal and state taxes and licensing and regulatory fees, the amount of earned premium, and beginning with the 2014 reporting year, the amounts related to the transitional reinsurance, risk adjustment, and risk corridors. Each issuer is required to submit annually MLR data, including information about any rebates it must provide, on a form prescribed by CMS, for each state in which the issuer conducts business.

Additionally, each issuer is required to maintain for a period of seven years all documents, records and other evidence that support the data included in each issuer's annual report to the HHS Secretary. Under ACA §1342, issuers of qualified health plans (QHPs) must participate in a risk corridors program. A QHP issuer is required to pay charges to or receive payments from CMS based on the ratio of the issuer's allowable costs to the target amount. Each QHP issuer is required to submit an annual report to CMS concerning the issuer's allowable costs, allowable administrative costs, and the amount of premium. The 2015 MLR Reporting Form and Instructions reflect changes for the 2015 reporting / benefit year and beyond. 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).

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

News

2/23/16 The Patient-Centered Outcomes Research Institute (PCORI) approved \$31.6 million in grant funding to be appropriated over three years to support PCORnet's Coordinating Center's next stage of operation. PCORnet is a large national network used to conduct clinical outcomes research.

Funding will continue to support PCORnet program management, data refinements, coordination among networks, and sustainability planning during the second phase of development for the program. The goal of PCORnet is to

harness the power of data and partnerships to make health research faster and less expensive.

Created under ACA §6301, PCORI is an independent nonprofit organization, tasked with conducting patient-centered outcomes and studies.

To learn more about the PCORnet program, visit: PCORI.ORG

2/19/16 CMS has proposed payment and policy updates for Medicare Health and Drug plans in 2017, as directed by ACA §3201. These updates are proposed through the 2017 Advance Notice and Draft Call Letter.

CMS released proposed changes for the Medicare Advantage (MA) and Part D Prescription Drug Programs that would be implemented in 2017. According to CMS, if finalized, these changes would provide updates that are designed to improve the accuracy of payments to plans serving MA program beneficiaries who are dually eligible for Medicare and Medicaid.

These program adjustments are designed to improve the precision of payments to plans serving vulnerable populations such as dually eligible or low income beneficiaries. Specifically, CMS is proposing updates to the Risk Adjustment Model used to calculate payments to Medicare Advantage plans and to the Star Rating system used to evaluate plan performance. These changes are intended to improve payment precision and encourage quality, while continuing to protect beneficiaries from significant increases in premiums and out of pocket costs.

Comments on the proposed Advance Notice and Draft Call Letter must be submitted by March 4, 2016. The final 2017 Rate Announcement and Call Letter, including the final Medicare Advantage and FFS growth percentage and final benchmarks will be published by Monday, April 4, 2016.

To learn more about this Advance Notice and Draft Call Letter, visit: CMS.GOV

The Advance Notice and Draft Call Letter may be viewed at: CMS.GOV

Upcoming Events

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

March 18, 2016

1:00 PM - 3:00 PM

Health Policy Commission, 50 Milk Street, 8th Floor Public Meeting Room
Boston, MA

MBTA and driving directions to 50 Milk Street are available here: www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/directions-to-50-milk-st.pdf

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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