



## AFFORDABLE CARE ACT MASSACHUSETTS IMPLEMENTATION UPDATE

March 7, 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

**National Early Child Care Collaboratives - Early Care and Education (ECE) Statewide Collaboratives to Improve Nutrition, Breastfeeding Support, Physical Activity and Screen Time Practices for Obesity Prevention in Young Children, \$4002.** Announced February 29, 2016.

Continued funding is available to previously funded grantees to improve the quality of obesity prevention practices in ECE facilities by providing opportunities to ensure equitable access to ECE services. Funded services must be related to nutrition, breastfeeding support, physical activity, and reducing a children's screen time (as defined by the amount of time spent in front of a television, computer, telephone or another device that has a screen), all of which are key areas for obesity prevention.

Eligible applicants are limited to grantees previously awarded funding under this opportunity, which includes the Massachusetts Department of Public Health.

To learn more about this program, visit: [CDC.GOV](http://CDC.GOV)

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

**Public Health Approaches for Ensuring Quitline Capacity, \$4002.** Announced February 29, 2016.

Continued funding is available to previously funded state and territorial health departments to sustain and expand the capacity of a national smoking cessation helpline, known as the Quitline. Funding will also allow callers who contact the Quitline during a federal media campaign to receive at least one smoking cessation coaching call, either immediately upon calling or by being re-contacted within two to three days. The secondary purpose of the grant is to build the capacity of state tobacco control programs to implement evidence-based smoking cessation interventions in all 50 states.

Created through the CDC's first national tobacco education campaign (Tips From Smokers), the Quitline is a free telephone helpline (1-800-QUIT-NOW) which routes callers to their state Quitlines, offering assistance and treatment for tobacco-related addiction and behavior issues.

Eligible applicants are limited to state and territorial public health agencies 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, visit: [CDC.GOV](http://CDC.GOV)

View the announcement 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-and-initiatives/healthcare-reform/national-health-care-reform-plan/grants-and-demonstrations.html](http://www.mass.gov/eohhs/gov/commissions-and-initiatives/healthcare-reform/national-health-care-reform-plan/grants-and-demonstrations.html)

## Guidance

**3/3/16 HHS issued a notice under the Privacy Act of 1974 that announces the establishment of a "Computer Matching Agreement between HHS, CMS, and the State-Based Administering Entities for Determining Eligibility for Enrollment in Applicable State Health Subsidy Programs under the Patient Protection and Affordable Care Act."**

ACA §1411 and §1413 require the HHS Secretary to establish a program for applying for and determining eligibility for enrollment in applicable state health subsidy programs and authorizes the use of secure, electronic interfaces and an on-line system for the verification of eligibility.

The purpose of the Computer Matching Agreement is to establish the terms, conditions, safeguards, and procedures under which CMS will disclose certain information to State-based Administering Entities in accordance with the ACA. The Administering Entities will use the data, accessed through the federal Hub, to make eligibility determinations for enrollment in an applicable state health subsidy program. The Computer Matching Agreement also establishes the terms, conditions, safeguards, and procedures under which state Medicaid/CHIP agencies provide data to CMS (as the Federally-facilitated Marketplace (FFM)), State-based Marketplaces (SBMs) and Basic Health Plan Programs (ACA §1331) to verify whether an applicant or enrollee who has submitted an application to the FFM or a SBM has current eligibility or enrollment in a Medicaid/CHIP program.

Comments are due April 1, 2016.

Read the notice at: <https://www.gpo.gov/fdsys/pkg/FR-2016-03-03/pdf/2016-04732.pdf>

**3/3/16 HHS issued a notice under the Privacy Act of 1974 that announces the establishment of a "Computer Matching Agreement between HHS, CMS, and the Department of Defense (DoD), Defense Manpower Data Center (DMDC), for Verification of Eligibility For Minimum Essential Coverage (MEC) Under The Patient Protection And Affordable Care Act Through a Department of Defense Health Benefits Plan."**

ACA §1411 and §1413 require the HHS Secretary to establish a program for applying for and determining eligibility for enrollment in applicable state health subsidy programs and authorizes the use of secure, electronic interfaces and an on-line system for the verification of eligibility.

The purpose of the Computer Matching Agreement is to establish the terms, conditions, safeguards, and procedures under which the DoD will provide records, information, or data to CMS for verifying eligibility for [minimum essential coverage](#) (MEC) through a TRICARE Health Care Program. A TRICARE Health Care Program constitutes MEC as defined in the Internal Revenue Code, as amended by ACA §1501. The DoD data will be used by 1) CMS in its capacity as a Federally-facilitated Exchange and the federal eligibility and enrollment platform, and 2) agencies administering applicable state health subsidy programs. Such entities will receive the results of verifications using

information received by CMS through the CMS Federal Data Services Hub from applicants and enrollees that will be matched with the DoD data.

Comments are due April 1, 2016.

Read the notice at: <https://www.gpo.gov/fdsys/pkg/FR-2016-03-03/pdf/2016-04734.pdf>

**3/3/16 HHS issued a notice under the Privacy Act of 1974 that announces the establishment of a "Computer Matching Agreement between HHS, CMS, and the Department of Veterans Affairs, Veterans Health Administration (VHA) for the Verification of Eligibility for Minimum Essential Coverage (MEC) under the Patient Protection and Affordable Care Act through a VHA Health Benefits Plan."**

ACA §1411 and §1413 require the HHS Secretary to establish a program for applying for and determining eligibility for enrollment in applicable state health subsidy programs and authorizes the use of secure, electronic interfaces and an on-line system for the verification of eligibility.

The purpose of the Computer Matching Agreement is to establish the terms, conditions, safeguards, and procedures under which the VHA will provide records, information, or data to CMS for verifying eligibility for [minimum essential coverage](#) (MEC) through a Veterans Health Care Program. A Veterans Health Care Program constitutes MEC as defined in the Internal Revenue Code, as amended by ACA §1501. The VHA data will be used by 1) CMS in its capacity as a Federally-facilitated Exchange and the federal eligibility and enrollment platform, and 2) agencies administering applicable state health subsidy programs. Such entities will receive the results of verifications using information received by CMS through the CMS Federal Data Services Hub from applicants and enrollees that will be matched with the VHA data.

Comments are due April 1, 2016.

Read the notice at: <https://www.gpo.gov/fdsys/pkg/FR-2016-03-03/pdf/2016-04735.pdf>

**2/29/16 CMS issued a set of Frequently Asked Questions (FAQs), "Moratorium on the 2017 Health Insurance Provider Fee."**

ACA §9010 charges a fee to each covered entity engaged in the business of providing health insurance. The Consolidated Appropriations Act of 2016 suspends collection of the Health Insurance Provider Fee for the 2016 calendar year. As a result, health insurance issuers are not required to pay the fee in 2017.

According to HHS, the FAQs have been prepared by the agency to provide guidance on how the one-year moratorium is expected to affect 2017 rate filings for single risk pool plans in the individual and small group market.

The ACA created the annual fee on certain health insurance providers which began in 2014. The Health Insurance Providers Fee [final rule](#) (which was published in the Federal Register on November 29, 2013) provides guidance on the annual fee imposed on covered health insurance plans engaged in the business of providing insurance for United States health risks under ACA §9010. The ACA defines a United States health risk to include the health risk of a U.S. citizen or a resident non-citizen.

Additional information about the Health Insurance Providers Fee can be found at: <https://www.irs.gov/Businesses/Corporations/Affordable-Care-Act-Provision-9010>

Read the FAQ's at: [https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FINAL\\_9010\\_FAQ\\_2-29-16.pdf](https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FINAL_9010_FAQ_2-29-16.pdf)

**2/25/16 HHS/CMS issued a final notice establishing the methodology for determining federal funding for the Basic Health Program (BHP) in program years 2017 and 2018.** According to CMS, this final notice is substantially the same as the final notice for program year 2016.

The rule provides the methodology and data sources necessary to determine federal payment amounts made in program years 2017 and 2018 to states that elect to establish a Basic Health Plan (BHP) under the ACA to offer health benefits coverage to low-income individuals otherwise eligible to purchase coverage through Affordable Insurance Exchanges (Marketplaces).

The BHP program, as authorized by §1331 and subsequent guidance, provides states the option to establish a health benefits coverage program for low-income individuals who would otherwise be eligible to purchase coverage through the Health Insurance Exchange. Under the BHP rules, citizens or lawfully present non-citizens who do not qualify for Medicaid, the Children's Health Insurance Program (CHIP) or other minimum essential coverage and have incomes between 133% FPL and 200% FPL are eligible for the BHP.

The BHP is federally funded by determining the amount of payments that the federal government would have made through the premium tax credit and cost sharing reductions (CSR) for individuals enrolled in BHP had they instead been enrolled in an Exchange. To calculate the amounts for each state, HHS/CMS is asking states for "reference premiums" for the second lowest cost silver plans in each geographic area in a state, as those amounts are a basic unit in the calculation of tax credits and CSRs under the Exchanges. Furthermore, reference premiums are critical components of the BHP payment methodology. According to HHS/CMS, the agency has the required data to establish reference premiums for states with Exchanges that are operated by the Federally Facilitated Exchange (FFE) or are operated in partnership with the FFE, although the agency is seeking such information from the 17 states that are operating State Based 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. 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).

Beginning January 1, 2015, states have an option to establish a BHP for certain individuals who meet the income criteria and would otherwise be eligible to obtain coverage through the Exchange. BHP benefits are required to include at least the ten essential health benefits specified in §1301. BHP monthly premiums and cost sharing cannot exceed what an eligible individual would have paid if the eligible individual were to receive coverage from a QHP through the Exchange. A state that operates a BHP will receive federal funding equal to 95% of the amount of the premium tax credits and the cost sharing reductions that would have otherwise been provided to (or on behalf of) eligible individuals if these individuals enrolled in QHPs through the Exchange.

Read the notice (which was published in the Federal Register on February 29, 2016) at: <https://www.gpo.gov/fdsys/pkg/FR-2016-02-29/pdf/2016-03902.pdf>

**2/26/16 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 Summary of Benefits and Coverage (SBC) and Uniform Glossary.**

ACA §10101(b) requires group health plans and health insurance coverage in the group and individual markets to provide a summary of benefits and coverage (SBC) and uniform glossary. The requirement is designed to help plans, employers and individuals better understand their health coverage, as well as to gain a better understanding of other coverage options for comparison. ACA §10101(b) requires that group health plans and health insurance carriers in the group and individual markets provide an SBC that concisely and accurately describes the benefits and coverage available under the applicable plan or coverage.

Health plans are also required to provide 60-days advance notice of any material modification in any of the terms of the plan or coverage that is not reflected in the most recently provided SBC and Uniform Glossary (the definitions of terms used in health insurance coverage).

Comments are due March 28, 2016.

The documents that are available for comment can be found at: [www.dol.gov/ebsa/healthreform/regulations/summaryofbenefits.html#proposed](http://www.dol.gov/ebsa/healthreform/regulations/summaryofbenefits.html#proposed)

Read the notice at: <https://www.gpo.gov/fdsys/pkg/FR-2016-02-26/pdf/2016-04318.pdf>

**2/25/16 HHS/CMS issued a proposed rule called "Medicare, Medicaid, and Children's Health Insurance Programs; Program Integrity Enhancements to the Provider Enrollment Process."**

The proposed rule implements portions of ACA §6401 that require Medicare, Medicaid, and Children's Health Insurance Program (CHIP) providers and suppliers to disclose certain current and previous affiliations with other providers and suppliers. The proposed rule also provides CMS with additional authority to deny or revoke a provider's or supplier's Medicare enrollment. In addition, this proposed rule requires that to order, certify, refer or prescribe any Part A or service, item or drug, a physician or, when permitted, an eligible professional must be enrolled in Medicare in an approved status or have validly opted-out of the Medicare program.

Comments are due April 25, 2016.

Read the proposed rule (which was published in the Federal Register on March 1, 2016) at: <https://www.gpo.gov/fdsys/pkg/FR-2016-03-01/pdf/2016-04312.pdf>

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

## News

### **3/1/16 The U.S. Preventive Services Task Force (USPSTF) issued a final recommendation statement on screening for impaired visual acuity, or vision impairment, in adults 65 and older who have not reported problems with their vision.**

The USPSTF's review concluded that the current evidence is insufficient to assess the balance of benefits and harms of screening older adults in a primary care setting for vision impairment if they have not reported any vision problems. As a result, the Task Force assigned an "I" rating to the recommendation, which is not a recommendation for or against screening.

According to the USPSTF, impairment of visual acuity is a serious public health problem in older adults. In 2011, about 12% of Americans ages 65 to 74 years and 15% of those age 75 years or older reported having problems seeing, even with glasses or contact lenses. Common causes of vision impairment are refractive errors (the reason most people wear glasses or contacts); cataracts, or the clouding of the eye's lens; and age-related macular degeneration (AMD), which distorts vision in the center of the eye.

In a primary care setting, clinicians usually check for eye conditions with an eye chart test. The Task Force found that while vision screening with an eye chart can identify people who have refractive errors, it does not accurately identify early-stage AMD or cataracts in people without symptoms of vision problems. Furthermore, the USPSTF stated that additional evidence is needed to more accurately screen for eye conditions in older adults in a primary care setting and to determine the link between vision screening and quality of life.

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. Under the ACA, only screenings for populations that were finalized with an "A" or "B" rating must be provided without cost sharing. Since the screening recommendation for impaired visual acuity in older adults was finalized with an "I" rating, then this service does not have to be provided without cost sharing.

Read the final recommendation statement at: [www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/impaired-visual-acuity-in-older-adults-screening](http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/impaired-visual-acuity-in-older-adults-screening)

Learn more about preventive services covered under the ACA at: [HHS.Gov](http://HHS.Gov)

Learn more about the USPSTF at: [www.uspreventiveservicestaskforce.org](http://www.uspreventiveservicestaskforce.org)

## 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](http://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](mailto:Donna.Kymalainen@umassmed.edu) to request accommodations.

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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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