



## AFFORDABLE CARE ACT MASSACHUSETTS IMPLEMENTATION UPDATE

June 27, 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 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

**6/21/16 HHS/DOL/Treasury ("the Departments") issued FAQ Part 32 regarding the implementation of the ACA and the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).**

The Health Insurance Exchanges (ACA §1311, also known as Marketplaces) are designed to ensure that individuals and small businesses have access to affordable coverage through a competitive private health insurance market. The Exchanges offer "one-stop shopping" to assist individuals in finding, comparing and enrolling in private health insurance options.

In general, COBRA requires most group health plans to provide a temporary continuation of group health coverage that otherwise might be terminated. COBRA requires continuation coverage to be offered to covered employees, their spouses, their former spouses, and their dependent children when group health coverage would otherwise be lost due to certain specific events. Those events include the death of a covered employee, termination or reduction in the hours of a covered employee's employment for reasons other than gross misconduct, divorce or legal separation from a covered employee, a covered employee's becoming entitled to Medicare, and a child's loss of dependent status (and therefore coverage) under the plan.

A group health plan must provide qualified COBRA beneficiaries with a COBRA election notice that describes their rights to COBRA continuation coverage and how to make a COBRA coverage election. In general, the COBRA election notice must be written in a manner "calculated to be understood by the average plan participant."

In the FAQ, the Departments state that qualified beneficiaries may want to consider health coverage alternatives that are available through the Exchanges and compare them to COBRA continuation coverage. Also, some qualified beneficiaries may be eligible for financial assistance, including premium tax credits premium tax credits (§1401, §1411) and cost-sharing reductions (ACA §1402 and §1412). DOL has a model election notice that plans may use to satisfy the requirement to provide the election notice under COBRA. On May 8, 2013, DOL published [Technical Release 2013-02](#) that revised the model COBRA notice to include more detailed information to help make qualified beneficiaries aware of other coverage options available in the Exchanges. As described in that Technical Release and subsequent guidance, use of the model election notice will be considered by DOL to be good faith compliance with the election notice content requirements of COBRA until further rulemaking is issued and effective.

Read FAQ Part 32 at: [https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQS-32\\_Final-6-21-16.pdf](https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQS-32_Final-6-21-16.pdf)

**6/20/16 HHS/CMS issued a proposed rule called "Medicaid/CHIP Program; Medicaid Program and Children's Health Insurance Program (CHIP); Changes to the Medicaid Eligibility Quality Control and Payment Error Rate Measurement Programs in Response to the Affordable Care Act."**

This proposed rule updates the Medicaid Eligibility Quality Control (MEQC) and Payment Error Rate Measurement (PERM) programs based on the changes to Medicaid and the Children's Health Insurance Program (CHIP) eligibility under the ACA. The proposed rule would also implement various other improvements to the PERM program.

The ACA (including §1004, §1401, §1411 and §2001) mandated changes to the Medicaid and CHIP eligibility processes and policies to simplify enrollment and increase the share of the eligible population that is enrolled and covered.

The PERM program measures improper payments in the Medicaid program and CHIP. The improper payment rates are based on reviews of the fee-for-service, managed care, and eligibility components of Medicaid and CHIP.

The MEQC program is a separate eligibility review program set forth in section 1903(u) of the Social Security Act and requires states to report to the HHS Secretary the ratio of states' erroneous excess payments for medical assistance under the state plan to total expenditures for medical assistance.

Comments are due August 22, 2016.

Read the proposed rule (which was published in the Federal Register on June 22, 2016) at: <https://www.gpo.gov/fdsys/pkg/FR-2016-06-22/pdf/2016-14536.pdf>

**6/17/16 HHS/CMS issued a notice under the Paperwork Reduction Act of 1995 (PRA) seeking comments on four information collection activities.**

Comments are due July 18, 2016.

Read the notice at: <https://www.gpo.gov/fdsys/pkg/FR-2016-06-17/pdf/2016-14405.pdf>

**In item #1, HHS/CMS is seeking comments on the revision of a currently approved information collection activity related to Student Health Insurance Coverage.**

The notice includes a reminder to issuers that provides student health insurance coverage that such insurance issuers are subject to the prohibition on annual dollar limits under PHS Act section 2711 and §147.126 for policy years beginning on or after January 1, 2014, per the [final rule](#) (which was published on December 2, 2015) called "The Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017."

The notice also reminds insurance issuers that the [final rule](#) further provides that, for policy years beginning on or after July 1, 2016, student health insurance coverage is exempt from the actuarial value (AV) requirements under ACA §1302(d), but must provide coverage with an AV of at least 60%. This provision also requires issuers of student health insurance coverage to specify in any plan materials summarizing the terms of the coverage the AV of the coverage and the metal level (or the next lowest metal level) the coverage would otherwise satisfy under §156.140. According to CMS, this disclosure will provide students

with information that allows them to compare the student health coverage with other available coverage options.

**In item #2, HHS/CMS is seeking comments on the revision of a currently approved information collection activity related to the Affordable Care Act Internal Claims and Appeals and External Review Procedures for Non-grandfathered Group Health Plans and Issuers and Individual Market Issuers.**

Under the ACA §1001(\$2719), consumers have the right to appeal decisions made by health plans created after March 23, 2010. The law governs how insurance companies handle initial appeals and how consumers can request a reconsideration of a decision to deny payment. If an insurance company upholds its decision to deny payment, the law provides consumers with the right to appeal the decisions to an outside, independent decision-maker, regardless of the type of insurance or state an individual lives in.

Regulations issued by HHS, DOL and, and the Treasury standardize both an internal process and an external process that patients can use to appeal decisions made by their health plan. These rules more closely align the appeals process across all types of plans. Under the ACA, plans and issuers must comply with the state's external review process or the federal external review process.

According to the notice, information collection requirements are part of the reasonable procedures that an employee benefit plan must establish regarding the handling of a benefit claim.

Additional information on the regulatory requirements for the internal claims and appeals and external review processes is available at: [www.dol.gov/ebsa/healthreform/regulations/internalclaimsandappeals.html](http://www.dol.gov/ebsa/healthreform/regulations/internalclaimsandappeals.html)

**In item #3, HHS/CMS is seeking comments on the revision of a currently approved information collection activity related to Minimum Essential Coverage.**

ACA §6055 designates certain types of health coverage as [minimum essential coverage](#) (MEC). Other types of coverage, not statutorily designated and not designated as MEC in regulation, may be recognized by the HHS Secretary as MEC if certain substantive and procedural requirements are met.

To be recognized as MEC, coverage must offer substantially the same consumer protections as those enumerated in the Title I of ACA relating to non-grandfathered, individual health insurance coverage to ensure consumers are receiving adequate coverage. The [final rule](#): "Exchange Functions: Eligibility for Exemptions; Miscellaneous Minimum Essential Coverage Provisions" (which was published in the Federal Register on July 1, 2013) requires sponsors of other coverage that seek to have such coverage recognized a MEC to adhere to certain procedures. Sponsoring organizations must submit to HHS certain information about their coverage and an attestation that the plan substantially complies with the provisions of Title I of the ACA applicable to non-grandfathered individual health insurance coverage. Sponsors must also provide notice to enrollees informing them that the plan has been recognized as MEC for the purposes of the ACA's [shared responsibility requirement](#).

**In item #5, 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.

**6/17/16 HHS/CMS issued a notice under the Paperwork Reduction Act of 1995 (PRA) seeking comments on two information collection activities.**

Comments are due August 16, 2016.

Read the notice at: <https://www.gpo.gov/fdsys/pkg/FR-2016-06-17/pdf/2016-14409.pdf>

**In item #1, HHS/CMS is seeking comments on a new information collection activity related to Clearance for Evaluation of Stakeholder Training- Health Insurance Marketplace and Market Stabilization Programs.**

According to CMS, the agency is committed to providing appropriate education and technical outreach to states, insurance issuers, self-insured group health plans and third-party administrators (TPA) participating in the Exchange (Marketplace) and/or market stabilization programs mandated by the ACA. CMS continues to engage with stakeholders in the Marketplace to obtain input through Satisfaction Surveys following Stakeholder Training events. The notice states that the survey results will help to determine stakeholders' level of satisfaction with trainings, identify any issues with training and technical assistance delivery, clarify stakeholders' needs and preferences, and define best practices for training and technical assistance. CMS will continue to modify, enhance and develop Stakeholder Event forms for future years based on feedback from stakeholders.

In 2014, HHS implemented the [premium stabilization programs](#), which are designed to stabilize premiums in the individual and small group markets and minimize the effects of adverse selection that may occur as insurance reforms and the Exchanges launch. 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.

**In item #2, HHS/CMS is seeking comments on a new information collection activity related to The Health Insurance Enforcement and Consumer Protections Grant Program.**

ACA §1003 adds a new section 2794 to the Public Health Service Act (PHS Act) entitled, "Ensuring That Consumers Get Value for Their Dollars." Specifically, §1003 requires the HHS Secretary, in conjunction with the states, to establish a process for the annual review of health insurance premiums ([rate review program](#)) to protect consumers from unreasonable rate increases. Under that authorization, the HHS Secretary will award grants to states for planning and implementing the insurance market reforms and consumer protections under Part A of title XXVII of the PHS Act.

States that are awarded funds under this funding opportunity are required to provide CMS with four quarterly reports, one annual report per year (except for the last year of the grant) and a final report detailing the state's progression towards planning and/or implementing the market reforms under Part A of Title XXVII of the PHS Act.

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

## News

**6/16/16 HHS awarded nearly \$156 million in funding to support 420 health centers in 47 states, the District of Columbia and Puerto Rico to increase access to integrated oral health care services and improve oral health outcomes for Health Center Program patients.** Funding is authorized under ACA §4206.

The funding enables health centers to expand integrated oral health care services and increase the number of patients served. With these awards, health centers nationwide will increase their oral health service capacity by hiring approximately 1,600 new dentists, dental hygienists, assistants, aides, and technicians to treat nearly 785,000 new patients.

Today, nearly 1,400 health centers operate approximately 9,800 service delivery sites in every U.S. state, D.C., Puerto Rico, the Virgin Islands and the Pacific Basin; these health centers employ more than 170,000 staff who provide care for nearly 23 million patients. In 2014, health centers employed over 3,700 dentists, more than 1,600 dental hygienists, and over 7,400 dental assistants, technicians and aides. They served about 4.7 million dental patients and provided nearly 12 million oral health visits.

There were 15 grants awarded to organizations in Massachusetts.

View a list of the Massachusetts grant awardees at: <http://bphc.hrsa.gov/programopportunities/fundingopportunities/oralhealth/fy16awards/ma.html>

To learn more about HRSA's Health Center Program, visit <http://bphc.hrsa.gov/about/index.html>

## Commonwealth of MA News

### MassHealth Section 1115 Demonstration Extension

The Massachusetts Executive Office of Health and Human Services (EOHHS) announces its intent to submit a request to amend and extend the MassHealth Section 1115 Demonstration ("Request") to the Centers for Medicare and Medicaid Services.

The MassHealth 1115 Demonstration provides federal authority for Massachusetts to expand eligibility to individuals who are not otherwise Medicaid or CHIP eligible, offer services that are not typically covered by Medicaid, and use innovative service delivery systems that improve care, increase efficiency, and reduce costs as a part of MassHealth restructuring. Federal authorization and funding for key aspects of the current 1115 Demonstration are only approved through June 30, 2017.

MassHealth plans to advance alternative payment methodologies and delivery system reform through accountable care organizations and community partners for behavioral health and long term services and supports. A significant focus will be placed on improving integration and delivery of care for members with behavioral health needs and those with dual diagnoses of substance abuse disorder; as well as integration of long term services and supports and health-related social services. In addition, MassHealth plans to expand treatment for individuals affected by substance use disorder and opioid addiction.

The Request does not affect eligibility for MassHealth. A more detailed public notice can be found at MassHealth's home page: [www.mass.gov/eohhs/gov/departments/masshealth/](http://www.mass.gov/eohhs/gov/departments/masshealth/), and the Request documents can be found at the MassHealth Innovations web site: [www.mass.gov/hhs/masshealth-innovations](http://www.mass.gov/hhs/masshealth-innovations). Paper copies of the documents may be obtained in person from 9 am-5 pm at EOHHS, One Ashburton Place, 11th Floor, Boston, MA 02108.

### Public Comment Period

EOHHS will host two public listening sessions in order to hear public comments on the Request. Stakeholders are invited to review the Request in advance and share with program staff at the listening sessions any input and feedback, or questions for future clarification. The listening sessions are scheduled as follows:

#### **Listening session #2** (*note that the first session was June 24, 2016*)

Date: Monday, June 27, 2016

Time: 2:00 – 3:30 pm

Location: Auditorium, Fitchburg Public Library, 610 Main Street, Fitchburg, MA

Communication Access Realtime Translation (CART) services and American Sign Language (ASL) interpretation will be available at both meetings. Please contact Donna Kymalainen at [Donna.Kymalainen@state.ma.us](mailto:Donna.Kymalainen@state.ma.us) or 617-886-8247 to request additional accommodations.

EOHHS will accept comments on the proposed Request through July 17, 2016. Written comments may be delivered by email or mail. By email, please send comments to [MassHealth.Innovations@state.ma.us](mailto:MassHealth.Innovations@state.ma.us) and include "Comments on Demonstration Extension Request" in the subject line. By mail, please send comments to: EOHHS Office of Medicaid, Attn: 1115 Demonstration Comments, One Ashburton Place, 11<sup>th</sup> Floor, Boston, MA 02108. Comments

must be received by July 17, 2016 in order to be considered. Paper copies of submitted comments may be obtained in person by request from 9 am-5 pm at EOHHS, One Ashburton Place, 11<sup>th</sup> Floor, Boston, MA 02108. Comments will be posted on the MassHealth 1115 Demonstration website: [www.mass.gov/eohhs/gov/departments/masshealth/masshealth-and-health-care-reform.html](http://www.mass.gov/eohhs/gov/departments/masshealth/masshealth-and-health-care-reform.html).

## Upcoming Events

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

July 22, 2016  
1:00 PM -3:00 PM  
1 Ashburton Place, 21st Floor  
Boston, MA

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**

June 29, 2016  
2:00 PM – 3:30 PM  
John W. McCormack Building  
One Ashburton Place - 21st floor Conference Rooms  
Boston, MA 02108

Please contact [MFP@state.ma.us](mailto:MFP@state.ma.us) for more information.

Click [link](#) for directions and parking information.

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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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