



AFFORDABLE CARE ACT MASSACHUSETTS IMPLEMENTATION UPDATE

September 12, 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

9/8/16 CMS released a new Funding Opportunity Announcement (FOA) for the Accountable Health Communities (AHC) Model

Authorized under ACA §3021, the Accountable Health Communities (AHC) model focuses on the health-related social needs of Medicare and Medicaid beneficiaries, such as housing instability, hunger, and interpersonal violence. The AHC Model is based on emerging evidence that addressing health-related social needs through enhanced clinical-community linkages can improve health outcomes and reduce costs.

The original FOA requested applications for three different scalable tracks featuring interventions of varying intensity that would address health-related social needs for beneficiaries. After receiving significant interest, inquiries and stakeholder feedback, CMS has decided to make modifications to the Track 1 application requirements and is releasing a new FOA specific to Track 1 of the AHC Model. CMS believes two key modifications to Track 1 will make the model more accessible to a broader set of

applicants.

1. Reducing the annual number of beneficiaries applicants are required to screen from 75,000 to 53,000; and
2. Increasing the maximum funding amount per award recipient from \$1 million to \$1.17 million over 5 years.

Track 1 will support bridge organizations that are working to increase a patient's awareness of available community services through screening, information dissemination, and referral. The Track 1 approach seeks to address the decreased capacity of clinical delivery sites to respond to beneficiaries' health-related social needs because (1) health-related social needs remain undetected due to the lack of universal screening and (2) clinical delivery sites and patients may lack awareness about existing community service providers that could address those needs. Track 1 award recipients will partner with the state Medicaid agency, community service providers and clinical delivery sites to implement the Model.

Eligible applicants are community-based organizations, health care practices, hospitals and health systems, institutions of higher education, local government entities, tribal organizations, and for-profit and non-for-profit local and national entities with the capacity to develop and maintain relationships with clinical delivery sites and community service providers. **All applicants, including those who applied to Tracks 1, 2 or 3 in the previous FOA, are eligible to apply to this FOA. Applicants that previously applied to Track 1 of the AHC Model under the original FOA (# CMS-1P1-17-001) must re-apply using this FOA (# CMS-1P1-17-002) to be considered for the Model.**

The AHC Model is accepting applications for Track 1 at www.grants.gov through November 3, 2016.

Questions about the AHC Model can be sent to AccountableHealthCommunities@cms.hhs.gov.

Additional Information:

For more information about the AHC Model, see <https://innovation.cms.gov/initiatives/ahcm>.

For more information regarding the release, please see the CMS fact sheet here: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-09-08.html>

9/8/16 CMS published a Request for Information (RFI) on the State Innovation Models Initiative

Authorized under ACA §3021, the State Innovation Models (SIM) Initiative was launched in 2013 to test the ability of state governments to use their policy and regulatory levers to accelerate healthcare transformation efforts in their states, with a primary goal to transform over 80 percent of payments to providers into innovative payments and service delivery models. SIM has supported over 38 states (including Massachusetts), territories, and the District of Columbia in two rounds of awards. CMS is issuing this Request for Information (RFI) to obtain input on the design and future direction of the SIM Initiative.

CMS is seeking input from all interested parties on the following concepts related to the evolution of the SIM Initiative:

1. Partnering with states to implement delivery and payment models across multiple payers in a state that could qualify as Advanced Alternative Payment Models (APMs) or Advanced Other Payer APMs

under the proposed QPP, making it easier for eligible clinicians in a state to become qualifying APM participants and earn the APM incentive;

2. Implementing financial accountability for health outcomes for an entire state's population;
3. Assessing the impact of specific care interventions across multiple states; and
4. Facilitating alignment of state and federal payment and service delivery reform efforts, and streamlining interactions between the Federal government and states.

Comments are due October 28, 2016.

Read the RFI at <https://innovation.cms.gov/Files/x/sim-rfi.pdf>

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

9/9/16 HHS/CMS published a revision of an Information Collection Request (ICR) called "Medicare Self-Referral Disclosure Protocol"

ACA §6409 requires the HHS Secretary, in cooperation with the Office of Inspector General of the HHS, to establish a Medicare self-referral disclosure protocol ("SRDP"). The SRDP enables providers of services and suppliers to self-disclose actual or potential violations of the physician self-referral statute, section 1877 of the Social Security Act (the "Act").

ACA §6409(b) gives the Secretary the authority to reduce the amount due and owing for all violations of section 1877 of the Act. In establishing the amount by which an overpayment may be reduced, the Secretary may consider: the nature and extent of the improper or illegal practice; the timeliness of the self-disclosure; the cooperation in providing additional information related to the disclosure; and such other factors as the Secretary considers appropriate.

In accordance with the ACA, CMS established the SRDP on September 23, 2010, and information concerning how to disclose an actual or potential violation of section 1877 of the Act was posted on the CMS website. We are seeking approval to revise the currently approved ICR. Under the currently approved collection, a party must provide a financial analysis of overpayments arising from actual or potential violations of section 1877 of the Act based on a 4-year lookback period. On February 12, 2016, CMS published a final rule on the reporting and returning of overpayments. [See CMS-6037-F, Medicare Program: Reporting and Returning of Overpayments, 81 FR 7654 \(Feb. 12, 2016\) \(the "final overpayment rule"\)](#). The final overpayment rule establishes a 6-year lookback period for reporting and returning overpayments. We are revising the information collection for the SRDP to reflect the 6-year lookback period established by the final overpayment rule. The revision is necessary to ensure that parties submitting self-disclosures to the SRDP report overpayments for the entire 6-year lookback period. The 6-year lookback period applies *only* to submissions to the SRDP received *on or after* March 14, 2016, the effective date of the final overpayment rule; parties submitting self-disclosures to the

SRDP prior to March 14, 2016 need only provide a financial analysis of potential overpayments based on a 4-year lookback period.

CMS is also taking the opportunity to streamline and simplify the SRDP by issuing a required form for SRDP submissions.

Comments are due October 11, 2016.

Read the ICR at: <https://www.gpo.gov/fdsys/pkg/FR-2016-09-09/pdf/2016-21625.pdf>

9/6/16 HHS/CMS/OIG/ACF published an Interim Final Rule called "Adjustment of Civil Monetary Penalties for Inflation".

HHS is issuing a new regulation to adjust for inflation the maximum civil monetary penalty amounts for the various civil monetary penalty authorities for all agencies within HHS. HHS is taking this action to comply with the Federal Civil Penalties Inflation Adjustment Act of 1990 (the Inflation Adjustment Act), as amended by the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015. Civil monetary penalties may be assessed for violations of HHS regulations, including those related to Medicaid and Exchange eligibility. In addition, this interim final rule includes updates to certain agency-specific regulations to identify their updated information, and note the location of HHS-wide regulations.

This rule is effective on September 6, 2016.

Read the rule at: <https://www.gpo.gov/fdsys/pkg/FR-2016-09-06/pdf/2016-18680.pdf>

8/29/16 HHS/CMS issued a proposed rule called "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018."

The proposed rule sets forth payment parameters and provisions related to the risk adjustment program; cost-sharing parameters and cost-sharing reductions; and user fees for Federally-facilitated Exchanges and State-based Exchanges on the Federal platform. It also provides additional guidance relating to standardized options; qualified health plans (QHPs); consumer assistance tools; network adequacy; the Small Business Health Options Program ([SHOP](#), §1311(b)(1)(B)); stand-alone dental plans; fair health insurance premiums; guaranteed renewability; the [medical loss ratio program](#) (MLR, §10101); eligibility and enrollment; appeals; and other related topics.

Specifically, according to CMS, beginning in 2017, the proposed policies will take important steps to strengthen one of the Marketplace's key tools for protecting consumers' access to high-quality, affordable coverage options: the risk adjustment program. The rule introduces changes that will make risk adjustment even more effective at pooling risk, allowing issuers to focus on meeting the needs of consumers.

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 October 6, 2016.

Read the proposed rule (which was published in the Federal Register on 9/6/16) at:

<https://www.gpo.gov/fdsys/pkg/FR-2016-09-06/pdf/2016-20896.pdf>

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

News

9/7/16 CMS published an announcement "Round One State Innovation Model Initiative Test Awards Show Some Promising Progress and Lessons Learned"

The State Innovation Models (SIM) Initiative, funded under §3021 of the ACA, began in April 2013, and has supported over 38 states, territories and the District of Columbia in two rounds of awards. According to CMS, SIM states are testing strategies to transform health-care across their entire state, specifically to have a preponderance of payments to providers from all payers in the state be in value-based purchasing and/or alternative payment models.

In SIM Round 1, Model Test awards were made to six states: Arkansas, Massachusetts, Maine, Minnesota, Oregon, and Vermont. According to CMS, the SIM Initiative has made notable progress in accelerating health care transformation among the Round 1 Test states. The evaluation found that states have been successful in engaging a wide swath of the payer, provider, purchaser, and patient communities and building stakeholder consensus by balancing standardization and flexibility when expanding payment reforms statewide. States have leveraged multi-payer efforts to implement payment and delivery system reforms, engaged the provider community in SIM-related activities, and used a range of policy levers to effect change. Some of the most substantial changes to delivery systems and payment methods are in areas where public and private payers are working together to accelerate transformation.

The announcement notes that it remains too early to attribute specific quantitative results directly to the SIM Initiative. However, analyses based on Medicare and commercial populations show that states were making progress on health outcomes, such as declines in emergency room visits and inpatient readmissions through models pre-dating SIM and models upon which SIM efforts are expanding. Future evaluation reports will provide more detail on quantitative results and whether and how the SIM Initiative is affecting and accelerating trends in health outcomes and spending.

CMS supports states through SIM and other innovation efforts to move towards this vision of multi-payer delivery system reform across an entire state. Health system transformation and improvement happens at the state and local level and CMS will continue to support states in their transformation journey to improve care for people across the nation.

Read the announcement at: <https://blog.cms.gov/2016/09/07/round-one-state-innovation-model/>

Upcoming Events

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

Friday, September 16, 1:00 PM - 3:00PM
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.

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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