AFFORDABLE CARE ACT
MASSACHUSETTS IMPLEMENTATION UPDATE

December 30, 2013

Quick Links

MA-ACA Website

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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

12-month Cost Extension and Program Expansion Supplement for Surveillance Program Announcement: Behavioral Risk Factor Surveillance System (BRFSS), §4002. Announced December 18, 2013. Funds will provide a 12-month program cost expansion supplement to extend and continue funding for current BRFSS grantees. The program cost extension will provide financial and programmatic assistance to state health departments to 1) continue to maintain and expand specific surveillance using telephone and multimode survey methodology of the behaviors of the general population that contribute to the prevention of chronic diseases and injuries, 2) maintain and expand the collection, analysis, and dissemination of BRFSS data to state categorical programs for their use in assessing trends and evaluating programs, establishing program priorities, developing policy and targeting relevant population groups and 3) complete existing activities that may be jeopardized because of limited time and funds. Eligible applicants are those that are currently funded under BRFSS grants (all 50 State Health Departments, the District of Columbia Department of Health, and the Commonwealth of Puerto Rico Department of Health). $16 M in total for 52 CDC grant awards is available.

The BRFSS is the principal source of state-specific surveillance information about health risk behaviors and health status among the states' resident population. BRFSS is a system of random digit-dialing telephone and mixed-mode health surveys that target non-institutionalized adults, ages 18 years and older. BRFSS statistics have been used to support public health

programs and policies that seek to improve population health.

Applications are due January 21, 2014.
The announcement can be viewed at:
http://www.grants.gov/custom/viewOppDetails.jsp?oppId=249325

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: Mass.Gov

Guidance

12/20/13 Treasury/DOL/HHS filed a proposed rule called "Amendments to Excepted Benefits." The rule amends the agencies' regulations regarding excepted benefits, which are certain types of health-related benefits that that are generally exempt (on a limited or ancillary basis) from the health reform requirements established by the Health Insurance Portability and Accountability Act of 1996, known as HIPPA. HIPAA imposes non-discrimination/portability, privacy and security requirements on group health plans. Benefits that are excepted under HIPAA are not subject to the ACA's market reforms.

The proposed rule would expand excepted benefits in three ways: 1) identify certain employee assistance programs (EAPs) as excepted benefits, 2) permit self-insured plans to cover vision and dental benefits without an extra premium payment and 3) allow limited group wraparound coverage of individual coverage to be treated as excepted benefits.

Customarily EAPs are free programs offered by employers that provide an array of benefits to address circumstances that might adversely affect employees' work and health. Benefits may include: short-term substance abuse or mental health counseling or referral services, financial counseling and legal services.

Comments are due February 24, 2014.

Read the DOL fact sheet at: http://www.dol.gov/opa/media/press/ebsa/EBSA20132381.htm

Read the proposed rule (which was published in the Federal Register on December 24, 2013) at: http://www.gpo.gov/fdsys/pkg/FR-2013-12-24/pdf/2013-30553.pdf

12/20/13 HHS/CMS published a notice under the Paperwork Reduction Act of 1995 (PRA) that announces the establishment of a Computer Matching Agreement (CMA) with the State-Based Administering Entities (AEs). CMS is seeking comments on proposed information collection activities related to the State Health Insurance Exchange Incident Report.

According to CMS, AEs are state entities administering Insurance Affordability Programs that will use the data accessed through the CMS Data Services Hub (Hub) to make eligibility determinations for Insurance Affordability Programs and certificates of exemption. The AEs are required to report (in the State Health Insurance Exchange Incident Report) any suspected or confirmed incidents affecting loss or suspected loss of personally identifiable information within CMS-designated guidelines to their Center for Consumer Information and Insurance Oversight State Officer (who will then notify the affected federal agency data sources).

ACA §1411 and §1413 require the Secretary of HHS to establish a program for determining eligibility for certain Insurance Affordability Programs, providing certifications of exemption, and authorizing the use of secure, electronic interfaces and an on-line system for the verification of eligibility. Eligibility determinations include initial determinations made upon application, renewals, annual or periodic redeterminations, and appeals. Data will be matched by CMS for the purpose of eligibility determinations and enrollment in Insurance Affordability Programs (such as advance payments of the premium tax credit (§1401, §1411 and §1412); cost sharing reductions (§1402); Medicaid and the CHIP (pursuant to §1413); or a State's Basic Health Program (BHP), if applicable, (under §1331) and eligibility determinations for exemptions.

Comments on the notice are due 60 days after its publication in the Federal Register.

Read the notice at:
http://www.gpo.gov/fdsys/pkg/FR-2013-12-20/pdf/2013-30337.pdf (see item #2)

12/20/13 HHS/CMS issued a final notice called "Health Insurance Exchanges: Approval of Ambulatory Health Care as Accrediting Entity of Qualified Health Plans." This final notice announces CMS' decision to approve the Accreditation Association for Ambulatory Health Care (AAAHC) for recognition as an accrediting entity for the purposes of fulfilling the accreditation requirement as part of qualified health plan (QHP) certification. Federal regulations require HHS to publish a notice identifying the accrediting entity, summarizing its analysis of whether the accrediting entity meets certain criteria, and providing a minimum 30-day public comment period. CMS published this notice in the Federal Register on September 13, 2013.

The ACA established Affordable Insurance Exchanges (§1311(b)) to provide individuals and small business employees with access to health insurance coverage effective January 1, 2014. 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.

In a final rule published on July 20, 2012, HHS established the first phase of an intended two-phased approach to implement the standards established under the ACA for QHPs to be accredited and proposed both the National Committee for Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC) as recognized accrediting entities. In the first phase, the NCQA and the URAC would be recognized as accrediting entities on an interim basis and in future rulemaking, HHS would adopt a criteria-based review process in phase two. NCQA and URAC were notified later in 2012 that both had met the requirements in be recognized as an accrediting entity and were recognized by the Secretary as accrediting entities for the purposes of QHP certification. On February 25, 2013, HHS published a subsequent final rule which amended the accrediting rules to establish an application and review process to allow additional accrediting entities to seek recognition.

According to CMS, after completing analysis and a review of received public comments, the agency has determined that the AAAHC meets the requirements and criteria to be recognized as an accrediting entity. This final notice formally acknowledges the HHS Secretary's approval of AAAHC's application to become an accrediting entity for the purposes of QHP certification.

Read the final notice (which was published in the Federal Register on December 23, 2013) at:
http://www.gpo.gov/fdsys/pkg/FR-2013-12-23/pdf/2013-30522.pdf

12/19/13 CMS released a notice containing the 2014 updates to the core set of children's health care quality measures for Medicaid and the Children's Health Insurance Program (CHIP) (Child Core Set) and to the core set of health care quality measures for adults enrolled in Medicaid (Adult Core Set).

ACA §2701 requires the HHS Secretary to identify and publish a core set of health quality measures for adult Medicaid enrollees. In January 2012, CMS released its initial core set of health care quality measures for adults enrolled in Medicaid (Adult Core Set) for voluntary use by Medicaid. To aid in the assessment of the quality of care for Medicaid-eligible adults, the ACA requires that the HHS Secretary also publish annual updates, beginning in January 2014, to the initial core set of adult health quality measures that incorporate new or enhanced quality measures.

For the 2014 update, CMS worked with the National Quality Forum's NQF Measures Application Partnership (MAP) to review the Adult Core Set and identify ways to improve it. Based on that feedback, one measure (Annual HIV/AIDS Medical Visit) will be retired and replaced by HIV Viral Load Suppression.

Additional information about the MAP review process can be found at: Medicaid.Gov

Read the notice at: http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-19-13.pdf

12/18/13 HHS/CMS issued a payment notice called "Basic Health Program: Proposed Federal Funding Methodology for Program Year 2015" which provides the proposed funding methodology and data sources necessary to determine federal payments for states electing to implement a Basic Health Program (BHP) in 2015.

On September 25, 2013, CMS published a proposed rule which proposed requirements for state and federal administration of the BHP, including provisions regarding eligibility and enrollment, benefits, cost-sharing requirements and oversight activities. On December 23, 2013, CMS published a related payment notice to provide specific details on the funding methodology and data sources that CMS will use to calculate federal payments for states electing to implement a BHP in 2015.

Authorized by ACA Section 1331, the BHP 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 Marketplace (Exchange). Citizens and qualified non-citizens who have income between 133% FPL and 200% FPL, as well as lawfully present non-citizens who have income between 0% and 200% FPL, and who do not qualify for Medicaid, the Children's Health Insurance Program (CHIP) or other minimum essential coverage would be eligible for coverage through a BHP.

According to the proposed rule and payment notice, 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 qualified health plans through the Exchange.

Comments on the proposed funding methodology are due on January 21, 2014.

Read the notice (which was published in the Federal Register on December 23, 2013) at: http://www.gpo.gov/fdsys/pkg/FR-2013-12-23/pdf/2013-30435.pdf

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

News

12/23/13 HHS/CMS announced the establishment of 123 new Accountable Care Organizations (ACOs) that will provide approximately 1.5 million additional Medicare beneficiaries with access to high-quality coordinated care across the United States. More than 360 ACOs, that serve over 5.3 million Americans with Medicare, have been established since passage of the ACA in 2010.

ACOs are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to the Medicare patients they serve to helps ensure that patients, especially the chronically ill, get appropriate care, with the goal of avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds in both delivering high-quality care and spending health care dollars more efficiently, it will share in the savings it achieves for the Medicare program.

Authorized by ACA §3022, the Medicare Shared Savings Program (MSSP) helps to facilitate collaboration among providers to improve the quality of care for Medicare beneficiaries. Eligible providers, hospitals, and suppliers may participate in the MSSP through participation in an ACO.

The next application period for organizations interested in participating in the MSSP beginning January 2015 will be in the summer of 2014.

More information about the Medicare Shared Savings Program, including previously announced ACOs, is available at: CMS.Gov

For a list of the 123 new ACOs announced today, visit:
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/2014-ACO-Contacts-Directory.pdf

12/20/13 CMS issued a Request for Information (RFI) related to Accountable Care Organization (ACO) initiatives. The RFI is seeking comment on 1) approaches for increasing participation in the current Pioneer ACO Model through a second round of applications and 2) suggestions for new ACO models that encourage greater care integration and financial accountability.

ACOs are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to the Medicare patients they serve to helps ensure that patients, especially the chronically ill, get appropriate care, with the goal of avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds in both delivering high-quality care and spending health care dollars more efficiently, it will share in the savings it achieves for the Medicare program.

Established under §3022, the Pioneer ACO Model was designed for health care organizations and providers already experienced in organizing care for patients across care settings. The model offers participating ACOs a distinct set of payment arrangements and different methodologies for performing beneficiary alignment and expenditure calculations.

Comments are due March 1, 2014.

View the RFI at:
http://innovation.cms.gov/Files/x/Pioneer-RFI.pdf

Learn more about the Pioneer ACO Model at: http://innovation.cms.gov/initiatives/Pioneer-ACO-Model/

12/19/13 The Medicare Payment Advisory Commission (MedPAC) and the Medicaid and CHIP Payment and Access Commission (MACPAC) issued a joint report called "Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid."

The data book provides demographic and individual information, expenditures and health care utilization of individuals who are dually eligible for Medicare and Medicaid coverage. Eligibility for dual-eligible beneficiaries is based on age or disability and low income status. The jointly issued report describes the characteristics of dual eligible beneficiaries, eligibility pathways, utilization and cost of services, as well as information about spending on high-cost dual-eligible populations (LTSS and Alzheimer's or related dementia).

MedPAC is an independent Congressional agency established by the Balanced Budget Act of 1997 to advise Congress on issues affecting the Medicare program. In addition to advising Congress on payments to private health plans participating in Medicare and providers in Medicare's traditional fee-for-service program, MedPAC is also tasked with analyzing access to care, quality of care, and other issues affecting Medicare.

MACPAC was established by the Children's Health Insurance Program Reauthorization Act and later expanded and funded through ACA §2801 and §10607. The commission consists of experts, government officials, executives and medical professionals. MACPAC is tasked with reviewing state and federal Medicaid and CHIP access and payment policies and making recommendations to Congress, the HHS Secretary, and the states on a wide range of issues affecting Medicaid and CHIP populations, including health care reform. As required by statute, MACPAC submits reports to Congress annually in March and June which contain recommendations on a wide range of issues affecting Medicaid and CHIP.

Learn more about MACPAC at: http://www.macpac.gov/
Learn more about MedPAC at: http://medpac.gov/
Read the report at: MedPAC

12/17/13 The Patient-Centered Outcomes Research Institute (PCORI) Board of Governors convened and approved a total of $191 million in research funding awards to support patient-centered comparative clinical effectiveness research (CER). In total, the Board approved 82 new projects which aligned with the organization's National Priorities for Research and Research Agenda. Created under ACA §6301, PCORI is an independent nonprofit organization, tasked with conducting patient-centered outcomes research and studies.

Included in the total award amount, the Board approved $93.5 million to support 29 clinical research data networks that collectively will form a new resource known as PCORnet (the National Patient-Centered Clinical Research Network). PCORnet will be a large, national network for conducting clinical outcomes research. PCORnet will fund partnerships among health clinics, hospitals, and other health systems with the ability to collect and use information from multiple data sources such as electronic health records. PCORI also will support networks formed by patients and their partners to promote information exchange on a particular condition and find answers to improve their health outcomes.

In addition, as part of the total award amount approved, the PCORI Board approved $97.5 million in funding for 53 CER studies designed to answer questions of significance to patients and their caretakers. A portion of the CER awards will fund eight studies of ways to decrease rates of uncontrolled asthma among African Americans and Hispanics/Latinos, populations with children seriously affected by the condition.

Since it began funding CER studies in 2012, PCORI has awarded over $464 million in research support for a total of 279 projects.

View a list of awards at:
http://www.pcori.org/assets/2013/12/PCORI-August-2013-Cycle-Awards.pdf

Learn more about PCORnet at: PCORI

Commonwealth of MA News

MassHealth and Health Safety Net Regulation Changes
EOHHS has promulgated MassHealth and Health Safety Net regulations (with an effective date of January 1, 2014) to implement the Affordable Care Act (ACA). The proposed changes will affect MassHealth and Health Safety Net eligibility, benefits, and operational processes. Specifically, the regulation changes implement the categorical and financial requirements for MassHealth programs authorized by the ACA and changes in Massachusetts state law. In addition, the proposed regulations describe operational changes in the application and redetermination processes.

After taking into consideration all public comments and testimony regarding the proposed regulations, EOHHS published the final regulations in the Massachusetts Register on December 20, 2013, with the January 1, 2014 effective date. The regulations will also be posted online at http://www.mass.gov/eohhs/gov/laws-regs/masshealth/regulations/.

Upcoming Events

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

Friday, January 31, 2014
12:00 PM-2:00 PM
1 Ashburton Place, 21st Floor
Boston, MA

Friday, February 28, 2014
11:00 AM-1:00PM
1 Ashburton Place, 21st Floor
Boston, MA

MBTA and driving directions to 1 Ashburton Place are located here: www.mass.gov/anf

A meeting agenda and any meeting material will be distributed prior to the meeting.

Meetings of the Implementation Council are open to stakeholders and members of the public with an interest in One Care. 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.