AFFORDABLE CARE ACT
MASSACHUSETTS IMPLEMENTATION UPDATE

November 27, 2012

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 Activity

November 14, 2012 The Health Connector submitted a Level 2 Exchange Establishment Grant to HHS under ACA §1311. If awarded, this grant will assist the Health Connector and supporting state agencies in successfully transitioning the Health Connector to an ACA-compliant, state-based Exchange while maintaining a commitment to the seamless coverage transition of existing members. The Health Connector must make modifications to its operational and technological infrastructure in order to best serve individuals and small businesses that will be shopping through the Exchange. This grant opportunity will support the development and stabilization of a single, integrated "real-time" eligibility system to determine eligibility for state and federally-subsidized health insurance coverage. This multi-agency project will enhance the shopping experience for individuals and small businesses shopping for health insurance through an Exchange. Among other projects, this opportunity will support the development and operation of a Massachusetts-specific risk adjustment program that will ensure stability in our merged market and will provide funding to develop and execute a robust outreach and education campaign designed to inform Massachusetts residents of the benefits available to them through the ACA and the Health Connector. CCIIO is expected to make award announcements in January 2013.

The grant abstract can be viewed on our website under the Grants section at: http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/grants/121114-sec-1311-project-

abstract.pdf

Guidance

11/27/12 CMS/HHS issued "Request for Information regarding Health Care Quality for Exchanges." The notice requests information regarding health plan quality management in Affordable Insurance Exchanges.

Beginning January 1, 2014, Affordable Insurance Exchanges, as authorized under ACA §1311 will provide individuals and small business employees with access to health insurance coverage. An Exchange both facilitates the purchase of Qualified Health Plans (QHP) by qualified individuals and provides for the establishment of a Small Business Health Options Program (SHOP). Exchanges will provide competitive marketplaces for individuals and small employers to directly compare options and purchase private health insurance. Starting in 2014, under the ACA, a QHP is an insurance plan that is certified by an Exchange, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements.

The ACA places quality-related requirements on health insurance issuers offering qualified health plans (QHPs) in the Exchange marketplace, including §1311 which directs QHP issuers to implement quality improvement strategies, enhance patient safety through specific contracting requirements, and publicly report quality data. The ACA also directs the HHS Secretary to develop and administer a quality rating system and an enrollee satisfaction survey system, the results of which will be available to Exchange consumers shopping for insurance plans. In addition, ACA §10329, which relates to plans both inside and outside the Exchange, directs the HHS Secretary to develop a methodology for calculating the value of a health plan.

In preparation for the implementation of the quality provisions affecting QHPs in the new Exchange marketplace under the ACA, HHS is requesting comments regarding existing quality measures and rating systems, strategies and requirements for quality improvement, purchasing strategies to promote care redesign and patient safety, as well as effective methodologies to measure health plan value. HHS is also seeking comments regarding the most effective ways to enhance and align the quality reporting and display requirements for QHPs starting in 2016 in conjunction with existing quality improvement initiatives, such as the National Quality Strategy.

Comments are due December 27, 2012.

Read the notice (which was published in the Federal Register on November 27, 2012) at: http://www.gpo.gov/fdsys/pkg/FR-2012-11-27/pdf/2012-28473.pdf

11/20/12 HHS/Department of Treasury/ Employee Benefits Security Administration (EBSA) filed a notice of proposed rulemaking called "Incentives for Nondiscriminatory Wellness Programs in Group Health Plans." The proposed rule implements and expands employment-based wellness programs to promote health and help control health care spending, while ensuring that individuals are protected from unfair health plan underwriting practices that could otherwise reduce benefits based on health status.

The rule proposes amendments to regulations, consistent with §1201 and §1251 of the ACA, regarding nondiscriminatory wellness programs in group health coverage. Specifically, the proposed regulations would increase the maximum permissible reward under a health-contingent wellness program offered in connection with a group health plan (and any related health insurance coverage) from 20% to 30% of the cost of coverage. The proposed

regulations would further increase the maximum permissible reward to 50% for wellness programs designed to prevent or reduce tobacco use. These regulations also include other proposed clarifications regarding the reasonable design of health-contingent wellness programs and the reasonable alternatives they must offer in order to avoid prohibited discrimination.

Comments on the proposed rule are due January 25, 2013.

Read the fact sheet at:
http://www.healthcare.gov/news/factsheets/2012/11/wellness11202012a.html
Read the rule (which was published in the Federal Register on November 26, 2012) at:
http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28361.pdf

11/20/12 HHS/CMS filed a proposed rule called "Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review." The proposed rule implements several key provisions of the ACA designed to prevent insurance companies from discriminating against people with pre-existing conditions and to protect consumers from insurance company abuses. Beginning in 2014, the rule bans insurers' ability to deny coverage based on pre-existing conditions (§1201) and limits premium variations due to family size, geography and tobacco use (§1201).

Provisions of the proposed rule implement ACA policies related to: fair health insurance premiums (§1201), guaranteed availability of coverage (§1201) guaranteed renewability of coverage (§1201), requirements that plans create a single risk pool in the individual and small group market (§1312), and enrollment in catastrophic plans (§1302(e)). It also amends the premium review standards for health insurance issuers and states regarding reporting, utilization, and collection of data and revises the timeline for states to propose state-specific thresholds for premium review and approval by CMS under §1003.

Comments on the proposed rule are due December 26, 2012.

Read the fact sheet at: http://www.healthcare.gov/news/factsheets/2012/11/market-reforms11202012a.html
Read the rule (which was published in the Federal Register on November 26, 2012) at:
http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28428.pdf

11/20/12 HHS filed a proposed rule called "Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation." As required by ACA §1302, effective January 1, 2014, all plans sold in the exchanges and through the small group and individual markets must offer a set of essential health benefits (EHB), a package of medical services and treatments which includes ambulatory and emergency care, maternity care, prescription drugs and other comprehensive health care services in ten categories.

The proposed rule outlines standards related to the coverage of EHB and the determination of actuarial value (AV) for health insurance issuers, while providing flexibility to states to shape how EHB are defined. Additionally, the rule proposes a timeline for when plans offering coverage in a Federally-facilitated Exchange or state Partnership Exchange must become accredited. The rule also proposes an application process for accrediting entities seeking to be recognized to fulfill the accreditation requirements for issuers offering coverage in any Exchange.

To streamline and standardize the calculation of AV for health insurance issuers, HHS provided an AV calculator, which issuers would use to determine health plan AVs based on a national, standard population, as required by law. The proposed AV calculator is posted on the CCIIO

website. The proposed tool allows users to measure the AV of health plans and compliance with AV standards established under ACA §1302(d).

Comments on the proposed rule are due December 26, 2012.

Read the fact sheet at:
http://www.healthcare.gov/news/factsheets/2012/11/ehb11202012a.html
Read the rule (which was published in the Federal Register on November 26, 2012) at:
http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28362.pdf
Read the State Medicaid Director Letter at:
http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-003.pdf
Learn more about the AV calculator at:
http://cciio.cms.gov/resources/EHBBenchmark/av-calculator-methodology.pdf

11/20/12 HHS issued a notice called "Recognition of Entities for the Accreditation of Qualified Health Plans." The notice announces the recognition of the National Committee for Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC) as recognized accrediting entities for the purposes of fulfilling the accreditation requirement as part of qualified health plan (QHP) certification.

Starting in 2014, under the ACA, a QHP is an insurance plan that is certified by an Exchange, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A QHP will have a certification by each Exchange in which it is sold. ACA §1311(c)(1)(D) specifies that to be a certified QHP and operate in the Exchange, a health plan must be accredited by a recognized accrediting entity on a uniform timeline established by the applicable Exchange.

This notice finalizes what was established in the final rule titled "Patient Protection and Affordable Care Act; Data Collection To Support Standards Related to Essential Health Benefits; Recognition of Entities for the Accreditation of Qualified Health Plans" (which was published in the July 20, 2012 Federal Register.) In the final rule HHS specified the requirements for accrediting entities to be recognized for the purposes of fulfilling the accreditation requirement as part of QHP certification. The final rule also established that the NCQA and URAC will be recognized as accrediting entities for the purposes of QHP certification. This notice serves as public notification that NCQA and URAC are recognized by the HHS Secretary as accrediting entities for the purposes of QHP certification.

Read the notice (which was published in the Federal Register on November 23, 2012) at:
http://www.gpo.gov/fdsys/pkg/FR-2012-11-23/pdf/2012-28440.pdf

Prior guidance can be viewed at www.healthcare.gov

News

Selection of the Benchmark Plan for Massachusetts
The Affordable Care Act ("ACA") requires that health plans offered in the small group and individual markets cover Essential Health Benefits ("EHBs") effective January 1, 2014. The EHBs are the medical services, supplies or prescription drugs required to be covered in all small group and individual health plans, but this does not include the level of cost-sharing (copayments, deductibles or coinsurance).

States were directed to define that state's EHBs by designating a "benchmark plan" selected from:

(1) one of the three largest small group plans; or
(2) one of the three largest state employee health plans; or
(3) one of the three largest federal employee health plans options; or
(4) the largest HMO plan offered in the state's commercial market.

The Division of Insurance (DOI) was designated by the Governor to select the benchmark plan for Massachusetts. To make the selection, the DOI coordinated an analysis of the 10 possible plan options. Based on the analysis, the DOI recommended that the benchmark plan be selected from one of the three small group plans based on the determination that all of these plans reflect the benefits currently available to individuals/small employers and all of these plans include all the Massachusetts mandated benefits available to individuals/small employers as of December 31, 2011.

The analysis showed that there are relatively minor differences in the benefits covered within the small group plans identified and the actuarial value of these plans differs by less than 50 cents on every $100 of premium. Consequently, the DOI recommended that the plan with the largest enrollment in the merged market, the Blue Cross Blue Shield of Massachusetts HMO Blue plan, be selected as the benchmark plan. As this plan does not include the required category for pediatric dental, the DOI, following guidance from the Centers for Medicare and Medicaid Services, recommended that the benchmark plan be supplemented with the pediatric dental benefit plan from the Commonwealth of Massachusetts Children's Health Insurance Program (CHIP).

For more information on the benchmark plan selected, visit the DOI website at: Mass.Gov

11/21/12 CMS announced the first participants in the Medicare Data Sharing for Performance Measurement Program as authorized ACA §10332. Three organizations, Health Improvement Collaborative of Greater Cincinnati, Kansas City Quality Improvement Consortium and Oregon Health Care Quality Corporation, have been certified by HHS as qualified organizations that can manage Medicare claims data under strict privacy guidelines. These organizations will create reports on provider performance with both Medicare and private insurance data. Employers and Consumer Organizations will use these reports to identify and reward health care providers in their area, and in addition, develop online tools to help consumers make health care choices.

Read the press release at: CMS.gov
Read more information about the Qualified Entity Program at: CMS.gov

11/20/12 The U.S. Preventive Services Task Force (USPSTF) issued a draft recommendation on screening for human immunodeficiency virus (HIV). The proposal recommends screening for all people between the ages of 15 and 65 and all pregnant women. Until now, USPSTF has suggested testing only for pregnant women and those at increased risk for the disease.

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. USPSPTF is accepting comments on the draft recommendation until December 17, 2012. The Task Force will review all comments as it develops its final recommendation on screening for HIV.

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 begin on or after September 23, 2010. The USPSTF has recommended an "A" rating for HIV screening in all adolescents and adults at increased risk for HIV infection. In addition, the USPSTF has recommended an "A" rating for HIV screening in all pregnant women.

Read the news bulletin on the draft recommendation on HIV screening at:
http://www.uspreventiveservicestaskforce.org/bulletins/hivbulletin.pdf
Read the factsheet on the draft recommendation on HIV screening at:
http://www.uspreventiveservicestaskforce.org/uspstf13/hiv/hivfact.pdf
Read the draft recommendation on HIV screening at:
http://www.uspreventiveservicestaskforce.org/uspstf13/hiv/hivadultart.htm

To comment on the draft recommendation on HIV screening visit: uspreventiveservices
Learn more about the USPSTF and the ACA at: Healthcare.Gov

11/19/12 The Board of Governors of PCORI (The Patient Center Outcomes Research Institute) approved a draft of the research methods (Revised Methodology Standards) to guide the development of comparative effectiveness research. The new standards reflect the input of public comments on a draft released earlier this year. Created under ACA §6301, PCORI is an independent nonprofit, expected to provide billions in federal funds for studies, and is tasked with conducting patient-centered outcomes research.

The revised standards incorporated PCORI's analysis and review of public comments solicited this fall on its draft Methodology Report. The report explores best practices for comparative effectiveness research and is intended to guide researchers as they formulate questions and determine the best methods to use in producing a PCORI-funded study. According to PCORI, applicants will be required to adhere to the standards in the finalized Methodology Report in future funding cycles. PCORI expects to issue a finalized and updated Methodology Standards narrative report, providing context for the standards, by next spring 2013.

During the meeting the Board of Governors also authorized the development of three targeted funding announcements to support studying treatment options for uterine fibroids; the safety and benefits of treatment options for severe asthma; and fall prevention in the elderly. PCORI Funding Announcements (PFAs) are issued to support a portfolio of comparative clinical effectiveness research based on PCORI's National Priorities for Research and Research Agenda.

Read the new methodology standards at: pcori.org

For more on funding announcements, visit: pcori.org

Learn more about PCORI at: http://www.pcori.org/about/

Upcoming Events

Money Follows the Person (MFP) Working Group Meeting
November 28, 2012, 2:00 PM -3:30 PM
State Transportation Building
10 Park Plaza
Boston, MA

Please contact MFP@state.ma.us if you would like to attend the meetings.
Requests for reasonable accommodations should be sent to MFP@state.ma.us. Although an RSVP is not required, it is appreciated.

An **MFP 101 introductory session** will also be held at the State Transportation Building on November 28, 2012 from 1:30 PM-2:00 PM for those not familiar with MFP.

Integrating Medicare and Medicaid for Dual Eligible Individuals Open Meeting
December 7, 2012, 10:00 AM - 12:00 PM
One Ashburton Place, 21st Floor, Conference Rooms 1, 2, and 3
Boston, MA

The purpose of this meeting is to continue discussion on key implementation topics for the Duals Demonstration.

We welcome attendance from all stakeholders and members of the public with interest in the Demonstration. 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

Integrating Medicare and Medicaid for Dual Eligible Individuals Quality Metrics Workgroup Meeting
December 7, 2012, 1:00 PM - 2:30 PM
One Ashburton Place, 21st Floor, Conference Rooms 1, 2, and 3
Boston, MA

The purpose of this meeting is to continue discussions with stakeholders regarding appropriate quality metrics for the Duals Demonstration. Stakeholders wishing to participate in a workgroup should RSVP to duals@state.ma.us by **5:00 PM, December 4, 2012**. Please provide your name and organizational affiliation (if any).

Participants should be prepared to engage in focused discussion and offer constructive input. To ensure a productive working session, we request that organizations identify the best representative to attend the workgroup meeting.
Reasonable accommodations will be made for participants who need assistance. In your RSVP to duals@state.ma.us, please note any request for accommodations.

Bookmark the **Massachusetts National Health Care Reform website** at: http://mass.gov/national health reform to read updates on ACA implementation in Massachusetts.

Remember to check http://mass.gov/masshealth/duals for information on the **"Integrating Medicare and Medicaid for Dual Eligible Individuals"** initiative.