AFFORDABLE CARE ACT
MASSACHUSETTS IMPLEMENTATION UPDATE

November 7, 2016

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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

10/31/16 The Massachusetts Division of Insurance is one of 22 state insurance regulators recently awarded grants from CMS through "The Health Insurance Enforcement and Consumer Protections Grant Program: Grants to States for Planning and Implementing the Insurance Market Reforms under Part A of Title XXVII of the Public Health Service Act, Cycle I." The funding was authorized under ACA §1003.

The Massachusetts Division of Insurance was granted more than $1.2 million of the total $25.2 awarded by CMS to audit health insurers to ensure compliance with the requirement to offer certain preventive care services without cost-sharing; examine carriers' compliance with federal and state guidance when calculating medical loss ratios for potential rebates to individuals and small businesses; and to determine whether health insurers have established systems that are not providing benefits for behavioral health and substance use services on par with what is provided for non-behavioral health services. The grant period is for 24 months beginning on October 31, 2016.

To learn more about the Massachusetts' award, visit: CMS.GOV

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

Guidance

11/3/16 HHS/CMS issued a final rule called "Medicare and Medicaid Programs; CY 2017 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; and Home

Health Quality Reporting Requirements." The final rule implements portions of the following ACA Sections: 3131, 3137 and 3401.

The final rule updates the Home Health Prospective Payment System (HH PPS) payment rates, including the national, standardized 60-day episode payment rates, the national per-visit rates, and the non-routine medical supply conversion factor; effective for home health episodes of care ending on or after January 1, 2017.

The rule also: implements the last year of the 4-year phase-in of the rebasing adjustments to the HH PPS payment rates; updates the HH PPS case-mix weights using the most current, complete data available at the time of rulemaking; implements the 2nd-year of a 3-year phase-in of a reduction to the national, standardized 60-day episode payment to account for estimated case-mix growth unrelated to increases in patient acuity between CY 2012 and CY 2014; finalizes changes to the methodology used to calculate payments made under the HH PPS for high-cost "outlier" episodes of care; implements changes in payment for furnishing Negative Pressure Wound Therapy using a disposable device for patients under a home health plan of care; discusses HHS' efforts to monitor the potential impacts of the rebasing adjustments; includes an update on subsequent research and analysis as a result of the findings from the home health study; and finalizes changes to the Home Health Value-Based Purchasing Model, which was implemented on January 1, 2016; and provides updates to the Home Health Quality Reporting Program.

Read the final rule at: https://www.gpo.gov/fdsys/pkg/FR-2016-11-03/pdf/2016-26290.pdf

10/31/16 Treasury/DOL/HHS issued a final rule called "Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance."

The final regulations relate to the definition of short-term, limited-duration insurance for purposes of the exclusion from the definition of individual health insurance coverage, and standards for travel insurance and supplemental health insurance coverage to be considered excepted benefits. The rule also amends a reference in the final regulations (published in the Federal Register on November 18, 2015) relating to the prohibition on lifetime and annual dollar limits.

The final rule limits the duration of short-term health plans to no more than three months, bans renewals and requires carriers to disclose that such plans are not minimum essential coverage (MEC, ACA §1501). Excepted benefits 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 market reforms under Title I of the ACA.

Read the final rule at: https://www.gpo.gov/fdsys/pkg/FR-2016-10-31/pdf/2016-26162.pdf

10/31/16 HHS/CMS issued a correction to the final rule called "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2017 Rates; Quality Reporting Requirements for Specific Providers; Graduate Medical Education; Hospital Notification Procedures Applicable to Beneficiaries Receiving Observation Services; Technical Changes Relating to Costs to Organizations and Medicare Cost Reports; Finalization of Interim Final Rules With Comment Period on LTCH PPS Payments for Severe Wounds, Modifications of Limitations on Redesignation by the Medicare Geographic Classification Review Board, and Extensions of Payments to MDHs and Low-Volume Hospitals. The final rule (which was published in the Federal Register on August 22, 2016) implements portions of the following ACA Sections: The final rule implements portions of the following ACA Sections: 1105, 1557, 3001, 3004, 3005, 3008, 3021, 3025, 3123, 3124, 3125, 3126, 3133, 3141, 3401, 5503, 5504, 5506, 10309, 10313, 10314, 10319, 10322 and 10324.

The final rule updates fiscal year 2017 Medicare payment policies and rates under the Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System. The final rule, which applies to approximately 3,330 acute care hospitals and approximately 430 LTCHs, impacts discharges occurring on or after October 1, 2016.

The IPPS pays hospitals for services provided to Medicare beneficiaries using a national base payment rate, adjusted for a number of factors that affect hospitals' costs, including the patient's condition and the cost of hospital labor in the hospital's geographic area.

According to CMS, the rule finalizes policies that continue a commitment to increasingly shift Medicare payments from volume to value, moving the Medicare program, and the health system at large, toward paying providers based on the quality, rather than the quantity of care they give patients.

Read the correction at: https://www.gpo.gov/fdsys/pkg/FR-2016-10-31/pdf/2016-26182.pdf

10/31/16 HHS/CMS issued a notice issued a notice under the Paperwork Reduction Act of 1995 (PRA) seeking comments on the extension of a currently approved information collection activity related to the Medicare Program/Home Health Prospective Payment System Rate Update for Calendar Year 2010: Physician Narrative Requirement and Supporting Regulation.

Section(o) of the Social Security Act (42 U.S.C. 1395x) specifies certain requirements that a home health agency must meet to participate in the Medicare program. ACA §6407(a) amends the requirements for physician certification of home health services contained in Sections 1814(a)(2)(C) and 1835(a)(2)(A) by requiring that, prior to certifying a patient as eligible for Medicare's home health benefit, the physician must document that the physician himself or herself or a permitted non-physician practitioner has had a face-to-face encounter (including through the use of tele-health services, subject to the requirements in section 1834(m) of the Act)," with the patient. ACA §6407(a) does not amend the statutory requirement that a physician must certify a patient's eligibility for Medicare's home health benefit.

Comments are due November 30, 2016.

Read the notice at: https://www.gpo.gov/fdsys/pkg/FR-2016-10-31/pdf/2016-26242.pdf (see item #6)

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

News

11/1/16 The U.S. Preventive Services Task Force (USPSTF) issued a draft recommendation statement on screening for obesity in children and adolescents. Based on its review of the evidence, the Task Force recommends screening for obesity in children and adolescents age 6 years and older and offering or referring those who have obesity to comprehensive, intensive behavioral interventions to promote improvements in weight status. The USPSTF assigned a "B" grade to this recommendation, demonstrating that the screening is recommended.

According to the Task Force, childhood and adolescent obesity is quite common in the United States; approximately 1 in 3 children and adolescents are currently overweight or have obesity. Childhood and adolescent obesity can cause health problems such as asthma, higher blood pressure, sleep apnea, or being bullied. Childhood and adolescent obesity may lead to health problems in adulthood, including obesity and related issues, such as diabetes and cardiovascular disease.

Because parents do not always recognize when their children are overweight, the USPSTF recommends looking at BMI (body mass index) as part of usual health care provides an opportunity to identify children who have obesity and refer them to a comprehensive program, leading to improved health outcomes. BMI is calculated from a child's height and weight and is plotted on a growth chart. Children with obesity, meaning they have a BMI at or above the 95th percentile for their age and sex, should be offered or referred to an intensive, comprehensive behavioral intervention. Such interventions may include: sessions with a health care professional for both the parents and child; information on healthy eating and safe exercise; supervised physical activity sessions; and tips on how to limit access to tempting foods and limit screen time.

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 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. If the recommendation on screening for obesity in children and adolescents is finalized with an "B" rating, then it will be required to be provided without cost sharing.

Comments are due November 28, 2016 and can be submitted at: https://www.uspreventiveservicestaskforce.org/Comment/Collect/Index/draft-recommendation-statement165/obesity-in-children-and-adolescents-screening1

Read the draft recommendation statement at: https://www.uspreventiveservicestaskforce.org/Page/Document/draft-recommendation-statement165/obesity-in-children-and-adolescents-screening1

Learn more about preventive services covered under the ACA at: HHS.Gov

Learn more about the USPSTF at: www.uspreventiveservicestaskforce.org

10/31/16 CMS announced over $25.2 million in grant awards to 22 state insurance regulatory agencies through "The Health Insurance Enforcement and Consumer Protections Grant Program: Grants to States for Planning and Implementing the Insurance Market Reforms under Part A of Title XXVII of the Public Health Service Act, Cycle I."

The funding, authorized under ACA §1003, is available to state insurance regulators to use for insurer compliance with key Affordable Care Act consumer protections. The award opportunity enables states to seek funding for activities related to planning and implementing select federal market reforms and consumer protections including: essential health benefits, preventive services, parity in mental health and substance use disorder benefits, appeals processes, and implementing the medical loss ratio provision.

Of the 22 states and the District of Columbia awarded grants, The Massachusetts Division of Insurance received granted more than $1.2 million.

More information about the Massachusetts award can be found under the *"Grant Activity"* section of this Update).

To learn more about this announcement, visit: CMS.GOV

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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