



AFFORDABLE CARE ACT MASSACHUSETTS IMPLEMENTATION UPDATE

November 30, 2011

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.

Guidance

11/30/11 CMS filed an **ACA-related Medicare final rule** with comment period regarding hospital outpatient prospective payment (OPPS), ambulatory surgical center payment, hospital value-based purchasing (VBP) program, physician self-referral and provider agreement regulations on patient notification requirements. The rule implements portions of §3138, 3401, 6001, and 10324 of the ACA. The final rule is effective January 1, 2012. Comments on certain sections are due January 3, 2012.

Read the rule at: <http://www.gpo.gov/fdsys/pkg/FR-2011-11-30/pdf/2011-28612.pdf>

11/28/11 CMS filed a **final rule with comment period related to Medicare Part B payment policies and other ACA provisions**. Regulations are effective January 1, 2012. Comments on requested subjects are due by January 3, 2012.

Read the final rule at: <http://www.gpo.gov/fdsys/pkg/FR-2011-11-28/html/2011-28597.htm>

Prior guidance can be viewed at www.healthcare.gov

News

11/29/11 CMS announced that **Medicare has added coverage without cost sharing by enrollees for preventive services to reduce obesity**. These new services are being added to the existing group of free preventive services that are available to Medicare beneficiaries as a result of §4103 and §4104 of the ACA, including the preventive cardiovascular services added earlier this month.

More than 30% of Medicare beneficiaries are estimated to be obese. Screening for obesity and counseling for eligible beneficiaries by primary care providers in settings such as physicians' offices are covered under this new benefit. For a beneficiary who screens positive for obesity, the benefit would include one face-to-face counseling visit each week for one month and one face-to-face counseling visit every other week for an additional five months. The beneficiary may receive one face-to-face counseling visit every month for an additional six months (for a total of 12 months of counseling) if he or she has achieved a weight reduction of at least 6.6 pounds during the first six months of counseling. Obesity is defined as having a Body Mass Index of 30 or more. For example, that would be a man or woman with a height of 5-foot-4-inches weighing 175 pounds or more.

Through the end of October 2011, 22.6 million people with Original Medicare have received one or more of the free covered preventive services this year. This announcement complements the Million Hearts initiative led jointly by CMS and the CDC in partnership with other HHS agencies, communities, health systems, nonprofit organizations, and private sector partners across the country to prevent one million heart attacks and strokes in the next 5 years.

To read the final decision on the new national coverage determination, visit the CMS website at: [Decision](#).

For more information about Million Hearts, visit: millionhearts.hhs.gov.

11/29/11 HHS awarded approximately \$220 million in Affordable Insurance Exchange grants to 13 states to give them resources and flexibility in creating Exchanges to implement the ACA.

HHS also released a set of Frequently Asked Questions providing answers to questions to help states advance policy development as states work to develop Exchanges. For example, states that run Exchanges have more options than originally proposed when it comes to determining eligibility for tax credits and Medicaid. For example, HHS will also allow greater flexibility in eligibility determinations, allowing a state-based Exchange to permit the Federal government to determine eligibility for premium tax credits.

States receiving funding under this announcement include: Alabama, Arizona, Delaware, Hawaii, Idaho, Iowa, Maine, Michigan, Nebraska, New Mexico, Rhode Island, Tennessee, and Vermont. Of the 13 states awarded grants, 12 are receiving Level One grants, which provide one year of funding to states that have already made progress using their Exchange planning grant. The 13th state, Rhode Island, is receiving the first Level Two grant, which provides multi-year funding to states further along in the planning process. Forty-nine states and the District of Columbia have already received planning grants, and 45 states have consulted with consumer advocates and insurance companies. Thirteen states have passed legislation to create an Exchange.

To accommodate state legislative sessions and to give states more time to apply, HHS also announced a six-month extension for Level One establishment grant applications; applications now will be accepted until June 29, 2012 (the original deadline was December 30, 2011).

Read the FAQs at:

http://cciio.cms.gov/resources/files/Files%202011282011/exchangeqa_11_29_11.pdf

For more information on the states receiving grants, visit:

<http://www.healthcare.gov/news/factsheets/2011/05/exchanges05232011a.html>

11/28/11 HHS/The Center for Consumer Information and Insurance Oversight (CCIIO)

rejected requests from Indiana and Louisiana for waivers which would have allowed insurers in those states to phase in the ACA's medical loss ratio (MLR) requirements.

The ACA allows the Secretary to adjust the medical loss ratio (MLR) standard for a state if it is determined that meeting the 80% MLR standard may destabilize the individual insurance market. In order to qualify for this adjustment, a state must demonstrate that requiring insurers in its individual market to meet the 80% MLR has a likelihood of destabilizing the individual market and result in fewer choices for consumers. As part of the ACA, if insurers fall short of the standards in 2011, they'll have to issue rebates for that amount in 2012.

CCIIO determined that the states' health plans can meet the MLR threshold set in the ACA and that consumers will get better value without an adjustment. **Indiana** requested that the MLR percentages be set at 65% in 2011, 68.75% in 2012 and 72.5% in 2013. But CCIIO responded that the evidence presented by the state "does not establish a reasonable likelihood" that the 80% standard would destabilize the Indiana market. CCIIO said that many issuers won't owe rebates because they meet the 80% threshold and that those that will be expected to pay are sufficiently profitable, or are adapting their business models, to absorb the impact of the payments. Indiana also had asked for an MLR percentage of 76.25% for 2014, a permanent waiver for consumer-driven health plans (often known as high-deductible plans) and a waiver for new entrants into the individual market until 2014. But HHS officials said they only have the authority to grant adjustments for three years in the individual market.

Louisiana asked for an adjustment of the standard to 70% for 2011 and 75% for 2012. CCIIO responded that there is no "reasonable likelihood" that the 80% MLR standard would destabilize the market in Louisiana. CCIIO said that many insurers already meet the MLR standard and that the others are either sufficiently profitable or are adapting their business models so that they can remain profitable in the individual market.

HHS has approved waivers for Georgia, Iowa, Kentucky, Maine, Nevada, and New Hampshire. In July HHS denied North Dakota's request for a waiver. In September HHS denied Delaware's request. The other states that have applied and are awaiting determinations include: Kansas, Florida, Michigan, Texas, Oklahoma, North Carolina and Wisconsin. For more information on states and the MLR requirements visit the Center for Consumer Information and Insurance Oversight (CCIIO) website at: <http://cciio.cms.gov/programs/marketreforms/mlr/index.html>

11/23/11 President Obama announced his intention to nominate Marilyn Tavenner to succeed Donald M. Berwick as administrator of the Centers for Medicare and Medicaid Services (CMS). Tavenner will serve as administrator on an acting basis during the confirmation process, which will be handled by the Senate Finance Committee. Berwick's resignation is effective December 2, 2011. His recess appointment was set to expire December 31, 2011. Tavenner has been the principal deputy administrator at CMS since February 2010 and served as acting administrator from February to July 2010. A former secretary of health and human resources in Virginia, Tavenner is expected to be confirmed.

President Obama nominated Berwick three times but could never get a confirmation hearing. As a result, Obama appointed him during the July 2010 recess because he believed that Berwick was the best choice to lead the implementation of reforms under the ACA, but that only allowed him to serve through the end of this year. It was not clear Wednesday when the White House would send Tavenner's formal nomination up to Capitol Hill or when a confirmation hearing would be held.

In an email to HHS staff, Secretary Kathleen Sebelius praised Berwick and said Tavenner has been his partner. Tavenner has a strong knowledge of Medicare and Medicaid reimbursement

policy. After her almost 20 years in nursing, 3 years as a hospital CEO and 10 years in various senior executive level positions for Hospital Corporation of America, she became Virginia's secretary of health and human resources in Governor Tim Kaine's administration. She oversaw a dozen health agencies, including the state's Medicaid program. The outgoing CMS administrator Berwick did not say what his immediate plans are. Berwick is expected to return to his home in Boston and spend time with his family before deciding his next move.

11/22/11 The National Association of Insurance Commissioners (NAIC) passed a resolution urging Congress and HHS to provide insurance agents and brokers with relief from the ACA's medical loss ratio (MLR) formula. The vote passed 26-20 during a conference call of insurance commissioners. The resolution calls on Congress to quickly consider legislation to amend the MLR provisions of the ACA in order to remove broker and agent compensation from the MLR calculation and it asks HHS to consider a menu of regulatory options.

Commissioners supporting the resolution posed it as a measure to preserve consumer access to agents and brokers, but consumer advocates were united in their opposition. Commissioners against the resolution said the vote was an uncharacteristic political move for the organization.

The MLR provision only allows insurance companies to spend 15 or 20% of their revenues on profit and administrative cost. Brokers want an exemption from the MLR because they're concerned insurers will cut commissions in order to release money for other uses. Under the medical loss ratio regulations created by the ACA, insurance companies in the individual and small-group market must spend at least 80% of premium dollars on health care services or quality improvements rather than administrative costs. If insurers do not meet that standard, they have to offer rebates to consumers. Under the MLR rule, brokers' fees are considered administrative costs. Brokers say that insurance companies are reducing their fees in order to trim administrative expenses. House bill H.R. 1206 sponsored by Michigan Republican Rep. Mike Rogers, would exempt fees charged by health insurance brokers from being classified as administrative costs under the regulations. Although the measure has 138 bi-partisan cosponsors it is unlikely to pass through Congress this year. The NAIC has been divided over the issue for months. In June, an NAIC task force agreed to support the Rogers bill but the full NAIC did not endorse it. Research done in May 2011 by the NAIC found that had the MLR provision of the ACA been in effect last year, consumers would have received about \$2 billion in rebates.

Read the NAIC resolution at: [NAIC Resolution](#)

More information about the MLR rules can be found at:

<http://cciio.cms.gov/programs/marketreforms/mlr/index.html>

11/18/11 CMS announced the first site selections under the Community Based Care Transition Program, §3026 of the ACA, which provides funding from the Innovation Center to demonstrations to community-based organizations partnering with eligible hospitals for care transition services.

CMS awarded program agreements to recipients that can demonstrate an overall reduction in Medicare expenditures over the program period. CMS did not provide savings estimates from the agreements. The funding for these services comes from the \$500 million dedicated to the Partnership for Patients program, which is charged with reducing hospital-acquired conditions by 40% and hospital readmissions by 20% by 2013. The program funds test models for improving care transitions for high-risk Medicare patients by managing patients when they are discharged from hospitals back to their homes or other institutions, such as nursing homes.

The sites include: Elder Services of the Merrimack Valley, Inc., in partnership with Anna

Jacques Hospital, Saints Medical Center, Holy Family Hospital, Lawrence General Hospital, and Merrimack Valley Hospital, and serving 23 cities/towns in the Merrimack Valley of Massachusetts and ten bordering cities/towns in southern New Hampshire where patients using these hospitals also reside.

For more information about the Community Based Care Transitions Program, visit:
<http://go.cms.gov/caretransitions>

Upcoming Events

Quarterly Affordable Care Act Implementation Stakeholder Meeting

Wednesday, December 21, 2011 from 10 AM- 11 AM
1 Ashburton Place, 21st Floor
Boston, MA

MFP Waiver Topical Discussion Group

Friday, December 16, 2011 from 10:30 AM - 12 PM
France Conference Room, UMass Medical School
333 South Street
Shrewsbury, MA

Money Follows the Person Working Group

Thursday, February 2, 2012 from 2 PM - 3:30 PM
Saxe Conference Room
Worcester Public Library
3 Salem Square
Worcester, MA

Please contact MFP@state.ma.us to attend the MFP meeting and to request reasonable accommodations.

More information on MFP can be found at: [Money Follows the Person](#)

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.