



AFFORDABLE CARE ACT MASSACHUSETTS IMPLEMENTATION UPDATE

July 13, 2015

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

The Million Hearts Cardiovascular Disease Risk Reduction Model, §3021. Announced June 28, 2015.

Funding is available to health care professionals for a randomized controlled trial to design sustainable models of care that help reduce 10-year atherosclerotic cardiovascular disease risk (ASCVD) and prevent heart attacks and strokes for Medicare beneficiaries.

Eligible applicants include private practices, community health centers and other community-based clinics, hospital-owned physician practices, hospital/physician organizations, or retail clinics. Selected applicants will be divided between intervention practices and control group practices. Intervention practices will receive a one-time \$10 per beneficiary fee to calculate a beneficiary's ASCVD risk score and to engage the patient in shared decision-making. In year one, CMS will make an additional \$10 monthly Cardiovascular Care Management payment per beneficiary for risk management for the highest-risk patients. During years two through five, intervention practices can receive a monthly CVD CM payment of up to \$10 per beneficiary based on the reduction of their high-risk beneficiary ASCVD risk scores. Control group practices will be paid a \$20 per-beneficiary payment (based on the estimated costs of preparing and transmitting the required data) for each reporting cycle.

Heart attacks and strokes are leading causes of death and disability in the United States. Co-led by CMS and the CDC, Million Hearts is a national HHS initiative which aims to prevent one million heart attacks and strokes by 2017.

Required Letters of Intent and applications are due September 10, 2015.

For more information about the Million Hearts Initiative, visit: HHS.GOV

View the announcement at: CMS.GOV

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: www.mass.gov/eohhs/gov/commissions-and-initiatives/healthcare-reform/national-health-care-reform-plan/grants-and-demonstrations.html

Guidance

7/9/15 HHS/FDA issued a notice called "Food Labeling; Nutrition Labeling of Standard Menu Items in Restaurants and Similar Retail Food Establishments; Extension of Compliance Date." The notice extends the compliance date for the [final rule](#) (which was published in the Federal Register on December 1, 2014) requiring disclosure of certain nutrition information for standard menu items in certain restaurants and retail food establishments. Covered establishments must now comply with the rule by December 1, 2016 (rather than by December 1, 2015 as originally prescribed by the final rule). According to the FDA, the extension is being granted in response to requests to allow covered establishments additional time to implement the requirements.

The final rule, authorized under ACA §4205, requires that calorie information be listed on menus and menu boards in restaurants and similar retail food establishments that are part of a chain and in vending machines with 20 or more locations. According to the FDA, the changes are being made to help combat obesity by assisting consumers in maintaining healthy dietary practices. New information will provide consumers with more nutritional information about the foods they eat outside of the home. These establishments will be required to clearly and conspicuously display calorie information for standard items on menus and menu boards, next to the name or price of the item.

Read the notice of the extension (which was published in the Federal Register on July 10, 2015) at: www.gpo.gov/fdsys/pkg/FR-2015-07-10/pdf/2015-16865.pdf

7/7/15 CMS/HHS issued a correcting amendment to the "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016" final rule. The correction fixes technical errors that appeared in the [final rule](#) which was published in the February 27, 2015 Federal Register).

The final rule set forth payment parameters and provisions related to the risk adjustment, reinsurance, and risk corridors programs; cost sharing parameters and cost-sharing reductions; and user fees for Federally-facilitated Exchanges. It also provides additional standards for the annual open enrollment period for the individual market for benefit years beginning on or after January 1, 2016, essential health benefits (EHB, §1301), qualified health plans (QHP), network adequacy, quality improvement strategies, the Small Business Health Options Program (SHOP, §1311(b)(1)(B)), to assist qualified small employers in facilitating the enrollment of their employees in qualified health programs), guaranteed availability, guaranteed renewability, [minimum essential coverage](#) (MEC, §1501), the [rate review program](#) (§1003), the [medical loss ratio program](#) (MLR, §10101), and other related topics.

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. 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 MEC. 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.

QHPs are health plans that have been certified by an Exchange, provide EHB 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 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. HHS administers the transitional reinsurance program and the temporary risk corridors program for Massachusetts issuers. Massachusetts administers its own, state-specific risk adjustment program through the Health Connector. All three programs began in 2014 and are designed to provide issuers with greater payment stability as insurance market reforms are implemented.

Read the correcting amendment at: www.gpo.gov/fdsys/pkg/FR-2015-07-07/pdf/2015-16532.pdf

7/6/15 HHS/CMS filed a proposed rule called “Medicare and Medicaid Programs; CY 2016 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; and Home Health Quality Reporting Requirements.” The proposed rule implements portions of the following sections of the ACA: 3006, 3131 and 3401.

The proposed rule updates Home Health Prospective Payment System (HH PPS) rates, including the national, standardized 60-day episode payment rates, the national per-visit rates, and the non-routine medical supply (NRS) conversion factor under the Medicare prospective payment system for home health agencies (HHAs), effective for episodes ending on or after January 1, 2016.

The proposed rule implements a payment model authorized under the ACA which, according to CMS, leverages the successes of and lessons learned from other value-based purchasing programs and demonstrations. The model would apply a payment reduction or increase to current Medicare-certified HHA payments, depending on quality performance, for all agencies delivering services within nine randomly-selected states. Payment adjustments would be applied on an annual basis, beginning at 5% and increasing to 8% in later years of the initiative. As proposed, the Home Health Value-Based Purchasing model would test whether incentives for better care can improve outcomes in the delivery of home health services.

Comments are due September 4, 2015.

Read the proposed rule (which was published in the Federal Register on July 10, 2015) at: www.gpo.gov/fdsys/pkg/FR-2015-07-10/pdf/2015-16790.pdf

7/1/15 HHS/CMS filed a proposed rule called “Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Short Inpatient Hospital Stays; Transition for Certain Medicare-Dependent, Small Rural Hospitals under the Hospital Inpatient Prospective Payment System.” The proposed rule implements portions of the following sections of the ACA: 3138, 3139, 3401, 4104, 10319 and 10324.

The proposed rule updates CY 2016 Medicare payment policies and rates for hospital outpatient departments (HOPDs), ambulatory surgical center (ASCs), and partial hospitalization services provided by community mental health centers (CMHCs), and promotes refinements to programs that encourage high-quality care in these outpatient settings. According to CMS, approximately 3,800 hospitals and 60 CMHCs are paid under the outpatient prospective payment system (OPPS), while approximately 5,300 ASCs are paid under the ASC payment system. The OPPS provides payment for most HOPD services, including partial hospitalization services furnished by HOPDs and CMHCs.

Comments are due August 31, 2015.

Read the proposed rule (which was published in the Federal Register on July 8, 2015) at: www.gpo.gov/fdsys/pkg/FR-2015-07-08/pdf/2015-16577.pdf

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

News

7/7/15 The U.S. Preventive Services Task Force (USPSTF) issued a final recommendation statement

about screening for speech and language delay and disorders in children age 5 years or younger. The USPSTF concluded that the current evidence is insufficient to determine the effectiveness of screening for speech and language delay and disorders and assigned an "I" rating to the recommendation. The "I" rating indicates that the evidence on screening is insufficient for the Task Force to recommend the service.

The USPSTF's evidence review found that information about the incidence of speech and language delays and disorders in young children in the United States is limited. In 2007, about 2.6% of children ages 3 to 5 years received services for speech and language disabilities under federal guidelines (specifically, the Individuals With Disabilities Education Act). Screening is an imperfect tool because screening instruments often have difficulty distinguishing between delays and disorders. Additionally, while the majority of school-age children with language disorders present with language delays as toddlers, some children outgrow their language delay.

According to the USPSTF, children with speech and language delays develop speech or language in the correct sequence but at a slower rate than expected, while children with speech and language disorders develop speech or language that is qualitatively different from typical development. The Task Force looked at evidence on whether routinely screening all children under age 5 for speech and language delays and disorders leads to improvements in speech, language, or other outcomes, such as academic achievement. The USPSTF determined that more evidence is needed on whether formal screening in primary care settings accurately identifies children who need interventions and whether identification ultimately results in important benefits.

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 assigns 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 the patient will receive a substantial or moderate benefit.

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 began on or after September 23, 2010. Since the screening recommendation was finalized with an "I" rating, then this service does not have to be provided without cost sharing.

Read the final recommendation statement at: www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/speech-and-language-delay-and-disorders-in-children-age-5-and-younger-screening

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

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

Upcoming Events

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

Friday, July 24, 2015, 1:30 PM - 3:30 PM
Transportation Building
10 Park Plaza
Boston, MA

Friday, September 11, 2015, 1:00-3:00 PM
1 Ashburton Place, 21st Floor
Boston, MA

We welcome attendance at all meetings 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.



Follow **MassHealth** on YouTube!



Follow **MassHealth** on YouTube!

To subscribe to receive the ACA Update, send an email to: join-ehs-ma-aca-update@listserv.state.ma.us. To unsubscribe from the ACA Update, send an email to: leave-ehs-ma-aca-update@listserv.state.ma.us. Note: When you click on the sign up link, a blank e-mail should appear. If your settings prevent this, you may also copy and paste join-ehs-ma-aca-update@listserv.state.ma.us into the address line of a blank e-mail. Just send the blank e-mail as it's addressed. No text in the body or subject line is needed.