



AFFORDABLE CARE ACT MASSACHUSETTS IMPLEMENTATION UPDATE

August 1, 2012

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 and Demonstration Announcements

Nationwide Program for National and State Background Checks for Direct Patient Access Employees of Long Term Care Facilities and Providers, \$6201. Announced July 24, 2012. Funding is available for states to participate in a nationwide program that will identify measures for long term care facilities and providers to conduct background checks on prospective employees who will have patient/resident access. States and territories are eligible for this opportunity. Applicants must guarantee that non-Federal funds will be available to cover a portion of costs in order to carry out this program in their state. CMS will provide a rate that is three times the amount a state guarantees. Grantees must be able to monitor provider compliance with the National Background Check Program; provide privacy and security safeguards; and provide an independent dispute/appeal process. \$140M in 54 awards with individual awards ranging from 1.5M - 3M.

Applications are due October 31, 2012.

The announcement can be viewed at: Grants.gov

Grant Activity

July 25, 2012 the Executive Office of Elder Affairs submitted an application to CMS/ the Administration for Community Living for an Enhanced Aging and Disability Resource Centers (ADRC) Options Counseling Program grant under §2405 of the

ACA. Funding is available to states to develop ADRCs that can serve as a national model for providing long term services and supports options counseling to state residents with these needs. The purpose of this grant is to fund states to develop and implement financially sustainable models that will serve people of all ages, disabilities and income levels. Massachusetts currently has two of the five grant required functions in place: a statewide network of ADRCs providing access to long term services and supports and a statewide Options Counseling program to help consumers make decisions regarding long term services and supports.

If awarded, the Executive Office of Elder Affairs and the Office of Disability Policy and Programs will use the funds to put in place the remaining key functions: Streamlined access to public programs; person-centered transition support to help consumers avoid re-hospitalization; and quality assurance. To build capacity to fully implement these functions, the applicant will partner with the Massachusetts Rehabilitation Commission and other state agencies to develop strategies for outreach and cross training. This will help the ADRCs serve as a more visible resource for underserved populations, with a special focus on veterans, people with serious mental illness and people with intellectual and developmental disabilities.

This funding opportunity also offers significant direction and support to the ADRCs to develop a self-sustaining system of reimbursement from the Veterans Health Administration, Medicaid-funded programs and, eventually, private payers. This project has strong potential to establish the ADRCs as an integral and enduring component of the aging and disability services delivery system in Massachusetts.

The project narrative can be viewed on our website under the Grants and Demonstrations section at: [Narrative](#)

Guidance

7/30/12 CMS published a proposed ACA-related Medicare notice called "Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2013." The notice applies to portions of the following sections: 3004, 3401, and 10319.

The notice updates the payment rates for inpatient rehabilitation facilities (IRFs) for federal fiscal year 2013 (for discharges occurring on or after October 1, 2012 and on or before September 30, 2013). The HHS Secretary is required to publish in the Federal Register on or before the August 1 that precedes the start of each fiscal year, the classification and weighting factors for the IRF prospective payment system's case-mix groups and a description of the methodology and data used in computing the prospective payment rates for that fiscal year.

Read the notice at: <http://www.gpo.gov/fdsys/pkg/FR-2012-07-30/pdf/2012-18433.pdf>

7/30/12 CMS published a proposed ACA-related Medicare rule called "Hospital Outpatient Prospective and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Electronic Reporting Pilot; Inpatient Rehabilitation Facilities Quality Reporting Program; Quality Improvement Organization Regulations." The rule implements portions of the following sections: 3004, 3121, 3137, 3138, 3401, 10317 and 10324.

The proposed rule would update the Medicare hospital outpatient prospective payment system and the Medicare ambulatory surgical center (ASC) payment system for Calendar Year 2013. In addition, the rule updates the requirements for the Hospital Outpatient Quality Reporting Program, the ASC Quality Reporting Program, and the Inpatient Rehabilitation Facility Quality

Reporting Program. The rule also proposes revisions to the electronic reporting pilot for the Electronic Health Record Incentive Program, and the various regulations governing Quality Improvement Organizations, including the secure transmittal of electronic medical information, beneficiary complaint resolution and notification processes, and technical changes.

Comments are due September 4, 2012. According to CMS, a final rule will be issued by November 1, 2012.

Read the press release at:

[Press Release](#)

Read the regulation at: <http://www.gpo.gov/fdsys/pkg/FR-2012-07-30/pdf/2012-16813.pdf>

7/30/12 CMS published a proposed ACA-related Medicare rule called "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, DME Face-to-Face Encounters, Elimination of the Requirement for Termination of Non-Random Prepayment Complex Medical Review and Other Revisions to Part B for CY 2013." The rule implements portions of the following sections: 3002, 3003, 3025, 3104, 3105, 3134, 3135, 4105, 6407, 10311 and 10331.

The proposed rule addresses changes to the physician fee schedule, payments for Part B drugs, and other Medicare Part B payment policies. It would also implement provisions of the ACA that establish a face-to-face encounter as a condition of payment for certain durable medical equipment (DME) items. The proposed rule would also continue the implementation of the physician value-based payment modifier that was included in the ACA by providing choices to physicians regarding how to participate.

Comments are due September 4, 2012. According to CMS, a final rule will be issued by November 1, 2012.

Read the press release at:

[Press Release](#)

Read the regulation at: <http://www.gpo.gov/fdsys/pkg/FR-2012-07-30/html/2012-16814.htm>

7/27/12 CMS published an ACA-related notice called "Medicare Program; Hospice Wage Index for Fiscal Year 2013." The notice applies to portions of §3132 and §3004.

This notice updates the hospice wage index for fiscal year (FY) 2013 and continues the phase-out of the wage index budget neutrality adjustment factor (BNAF), with an additional 15% BNAF reduction, for a total BNAF reduction through FY 2013 of 55%. The BNAF phase-out will continue with successive 15% reductions from FY 2014 through FY 2016. The notice clarifies that providers should report additional diagnoses on hospice claims. The notice also includes an update on the status of hospice payment reform and the quality reporting program as required by the ACA.

Read the notice at: <http://www.gpo.gov/fdsys/pkg/FR-2012-07-27/pdf/2012-18336.pdf>

Prior guidance can be viewed at: www.healthcare.gov

News

7/30/12 CMS announced the five sites participating in the Graduate Nurse Education Demonstration under §5509 of the ACA. Under the Graduate Nurse Education Demonstration, CMS will provide reimbursement payments of up to \$50 million annually over

four years for the cost of providing clinical training of advanced practice registered nurses (APRNs) added as a result of the demonstration.

The primary goal of the demonstration is to increase the provision of qualified training to APRN students. The training will provide APRNs with the clinical skills to provide primary care, preventive care, transitional care, chronic care management, and other services appropriate for Medicare beneficiaries.

As part of the demonstration, the five participating hospitals are required to partner with accredited schools of nursing and non-hospital community-based care settings. Payments to the participating hospitals will be linked directly to the number of additional APRNs that the hospitals and their partnering entities are able to train as a result of their participation in the demonstration.

The five sites are: 1) Hospital of the University of Pennsylvania (Philadelphia, PA), 2) Duke University Hospital (Durham, NC), 3) Scottsdale Healthcare Medical Center (Scottsdale, AZ), 4) Rush University Medical Center (Chicago, IL) and 5) Memorial Hermann-Texas Medical Center Hospital (Houston, TX).

For more information, visit: innovation.cms.gov/initiatives/GNE

7/27/12 CMS announced that one new Consumer Oriented and Operated Plan (CO-OP) repayable loan will be awarded to a non-profit entity to help establish private non-profit, consumer-governed health insurance companies that offer qualified health plans in the health insurance exchanges. Established under §1322 of the ACA, the goal of CO-OP program is to create a new CO-OP in every state in order to expand the number of exchange health plans with a focus on integrated care and plan accountability.

The non-profit receiving a loan is: **Colorado Health Insurance Cooperative, Inc. (CHI)**, a CO-OP that received a \$69,396,000 loan to offer benefit plans designed for individuals and employers on a state-wide basis, both inside and outside of the Health Insurance Exchange in Colorado. CHI plans to offer qualified health plans at the Silver and Gold benefit levels in both the individual and Small Business Health Options Program (SHOP) Exchange markets. CHI is also planning to offer at least one plan in the small group market.

Starting in 2014, CO-OPs will be able to offer plans both inside and outside of health insurance exchanges and will operate in 18 states, including: Colorado, Utah, Kentucky, Vermont, Arizona, Connecticut, Michigan, Nevada, Maine, South Carolina, Oregon, New Mexico, Montana, Iowa, Nebraska, Wisconsin, New Jersey, and New York. CMS awarded the first round of CO-OP loans on February 21, 2012. To date, a total \$1,399,051,940 has been awarded. CMS will continue to review applications on a quarterly schedule through December 31, 2012 and announce additional awardees on a rolling basis. According to CMS, CO-OP loans are only made to private, nonprofit entities that demonstrate a high probability of financial viability.

For more information, including a list of previous CO-OP loans awarded, visit: <http://www.healthcare.gov/news/factsheets/2012/02/coops02212012a.html>

7/26/12 HHS Secretary Sebelius and Attorney General Eric Holder announced a new public-private partnership between government and insurers to combat health care fraud, which costs taxpayers and the health care industry billions of dollars per year. Partners will share information such as claims data from different companies to identify patterns of abuse and to improve detection and prevent payment of fraudulent health care billing across both public and private payers. Specifically, the partnership will have the ability to stop payments billed to different insurers for care delivered to the same patient on the same

day in two different cities. This can prevent losses to both government and private health plans before they occur.

The partnership builds on the health care fraud tools authorized by the ACA. This includes: 1) enhanced screenings of Medicare and Medicaid providers and suppliers to keep fraudulent providers and suppliers out of the program and 2) the suspension of payments to providers and suppliers engaged in suspected fraudulent activity. HHS's efforts to date have resulted in \$10.7 billion in recoveries of health care fraud over the last three years.

Over one dozen organizations and government agencies have already joined the partnership. Read more, including the full list of participants, at:

<http://www.hhs.gov/news/press/2012pres/07/20120726a.html>

For information on this partnership and HHS' work to combat health care fraud, visit:

<http://www.healthcare.gov/news/factsheets/2011/03/fraud03152011a.html> and www.stopmedicarefraud.gov

7/25/12 CMS announced that as a result of the ACA, over 5.2 million seniors and people with disabilities with **Medicare Part D who reached the gap in coverage known as the "donut hole"** have received an automatic discount on their prescription drugs. CMS data show 1,093,242 Medicare beneficiaries have benefitted from the discount in the first six months of 2012. In Massachusetts, as of June 30, 2012, 17,676 individuals had received an average discount amount per beneficiary of \$608.50. Last year, the ACA provided a 7% discount on covered generic medications for people who hit the donut hole. This year beneficiaries will receive a 14% discount on generics and a 50% discount on their covered brand name prescription drugs. In 2010, nearly 4 million beneficiaries who hit the donut hole received a one-time \$250 rebate under the ACA to help them afford prescription drugs in the coverage gap. These discounts will continue to grow over time until the donut hole is closed completely in 2020 as required by §1101.

In addition, through §4103 and §4104 of the ACA, HHS announced that over 16 million people with original Medicare received at least one **free preventive service** during the first six months of 2012, including 1.35 million people who received an Annual Wellness Visit.

For the CMS data, visit: <http://www.cms.gov/Plan-Payment/>

For more information on the donut hole coverage, visit: [cms.gov](http://www.cms.gov)

For more information on the free preventive services, visit:

<http://www.hhs.gov/news/press/2012pres/07/20120710a.html>

7/24/12 The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) released a report called "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision." The report updates their March 2012 estimate of the budgetary effects of the ACA coverage provisions, reducing the costs of those provisions of the law by \$84 billion over the next 11 years, to take into account the Supreme Court decision issued on June 28, 2012 which essentially makes the Medicaid eligibility expansion provision voluntary for states.

According to the updated report, CBO/ JCT estimate that the insurance coverage provisions of the ACA will have a net cost of \$1.168 trillion over the 2012-2022 period, compared with \$1.252 trillion projected in the earlier estimate for that same 11-year period. The new analysis applied only to the coverage provisions and was not a comprehensive review of the entire law, which CBO/JCT has estimated will reduce the federal deficit overall.

The Court looked at the Medicaid provision that required states to comply with new eligibility requirements for Medicaid or risk losing their funding. As written in the ACA, if a state did not

expand their Medicaid programs to everyone up to 133% FPL, the HHS Secretary had the authority to withdraw all federal funding from the state's Medicaid program (§2001). The Supreme Court held that the HHS Secretary's power to punish non-expanding states by defunding their pre-existing Medicaid programs was unconstitutionally coercive because the expansion fundamentally alters the nature of the program. In most states Medicaid is currently a program for medically needy individuals. The Court wrote that the ACA expansion of the program to childless adults would turn Medicaid into a program for all needy individuals, not just medically needy individuals, and that changed the kind of program the states are required to run, not just the degree of coverage the states are required to provide. The Court's remedy was to prevent HHS from withdrawing pre-ACA Medicaid funding from states that refuse to expand (states could only lose new funds if they didn't comply with the new requirements), making expansion voluntary for the states and leaving states that want to expand free to do so.

CBO/ JCT's previous estimates reflected the assumption that every state would expand eligibility for coverage under its Medicaid program as required by the ACA. As a result of the Court's decision, CBO/ JCT now anticipate that some states will not expand their programs at all or will not expand coverage to the full extent authorized by the ACA. CBO/ JCT also expect that some states will eventually undertake expansions but will not do so by 2014 as specified in the ACA. As a result of the Supreme Court's decision, CBO/ JCT estimate that fewer people will be covered by the Medicaid program, more people will obtain health insurance through the Affordable Insurance Exchanges, and more people will be uninsured. Specifically, CBO/JCT estimate that, in 2022, Medicaid and the Children's Health Insurance Program (CHIP) are expected to cover about 6 million fewer people, about 3 million more people will be enrolled in Exchanges, and about 3 million more people will be uninsured than previously estimated.

The ACA expanded Medicaid eligibility to everyone up to 133% FPL (§2001) and provides subsidies and federal tax credits to buy private insurance to people with incomes between 100% FPL and 400% FPL (§1401). If a state does not implement the expansion, some people who would have received Medicaid could instead receive federal tax credits and other subsidies, but premium and cost-sharing requirements would be higher than they would be under Medicaid. Federal tax credits and subsidies, however, would not be available for people with incomes below 100% FPL since they are available only for those with incomes between 100% FPL and 400% FPL. As a result, the uninsured above 100% FPL could receive help, but those below 100% FPL may not.

Federal spending on Medicaid and CHIP over the 2012-2022 budget period will be an estimated \$289 billion less than previously expected, while the estimated cost tax credits and other subsidies for the purchase of health insurance through the Exchanges will increase by \$210 billion, according to the analysis. Small changes in other components of the budget estimates account for the remaining \$5 billion of the difference. Although there will be increased costs from greater participation in the Exchanges, that spending will be offset by reduced spending from lower Medicaid enrollment, resulting in the projected \$84 billion net savings to the federal government.

The report also includes the following key predictions. By 2022: 1) Two-thirds of people who would be newly eligible for Medicaid if all states expanded their programs would become eligible for Medicaid, 2) About 50% of potential newly eligible beneficiaries will live in states that partly expand Medicaid to a lower threshold than the 133% FPL authorized by the ACA, 3) Approximately 40% will be in states that expand coverage to 100% FPL, and 4) About one-third of potential newly eligible individuals will live in states that fully expand Medicaid, 5) and one-sixth of potential newly eligible individuals will live in states that do not expand Medicaid at all in the next decade.

Although the CBO/JCT projections make it seem as though states will be able to partially

expand their Medicaid programs over time, HHS has not issued any guidance on whether or not states can do smaller expansions or if they can expand the program after 2014. According to the report, if HHS determines that states do not have such flexibility, this estimate may change.

Read the report at:

<http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf>

Upcoming Events

Money Follows the Person Stakeholder Meeting

August 15, 2012, 2:00 PM - 3:30 PM

Worcester Senior Center

128 Providence Street

Worcester, MA 01545

Free parking is available at the Worcester Senior Center parking lot located behind the Center and is accessible from Spurr Street. Handicapped parking is available in this lot as well as along the front entrance driveway off of Providence Street. Please contact MFP@state.ma.us to RSVP and to request reasonable accommodations. Although RSVPs are greatly appreciated, they are not required.

An **MFP 101 introductory session** will also be at the Worcester Senior Center and will begin at 1:30 p.m. on August 15, 2012.

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.