



AFFORDABLE CARE ACT MASSACHUSETTS IMPLEMENTATION UPDATE

December 2, 2013

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

Deliberative Approaches: Patient and Consumer Input for Implementing Evidence-Based Health Care (R21), §6301. Announced November 27, 2013. Funding is available for projects that use deliberative methods to understand and clarify public or patient values and concerns that affect the implementation of specific interventions, programs or policies to improve health care or research.

Projects funded under this opportunity will promote the active contribution of patients and the public to ensure that comparative effectiveness research is disseminated so that it can be implemented to improve health care. Projects will be funded through the Patient Centered Outcomes Research Institute (PCORI) and consistent with the ACA's requirement that the Agency for Healthcare Research and Quality (AHRQ) broadly disseminate research relevant to comparative clinical effectiveness research. Created under ACA §6301, PCORI is an independent nonprofit organization, tasked with conducting patient-centered outcomes research and studies.

Eligible entities include state, city/ township or county governments; Native American tribal governments (Federally recognized); Native American tribal organizations (other than Federally recognized tribal governments); private institutions of higher education or a public and state controlled institution of higher education. AHRQ intends to fund up to 5 awards, for a total of \$1.0 million for fiscal year 2014. Future year amounts will depend on the availability of funds.

Optional letters of intent are due January 6, 2014.

Applications are due February 7, 2014.

The announcement can be viewed at: <http://grants.nih.gov/grants/guide/rfa-files/RFA-HS-14-007.html>

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: Mass.Gov

Guidance

11/26/13 IRS/Treasury issued final regulations regarding "Health Insurance Providers Fee."

The regulations provide guidance on the annual fee imposed on covered health insurance plans engaged in the business of providing insurance for United States health risks under ACA §9010. The ACA defines a United States health risk to include the health risk of a U.S. citizen or a resident non-citizen.

Beginning in 2014, each health insurance plan with aggregate net premiums exceeding over \$25 million is liable for the annual fee due by September 30th of each fee year. The annual fee for each entity is determined by the ratio of the plan's net premiums for the previous calendar year and the aggregate net premiums of all qualified health insurance plans for the previous calendar year. Health plans that have net premiums that exceed \$25 million but are less than \$50 million will have 50% of their net premiums taken into account for this calculation. Entities with net premiums over \$50 million will have 100% of their net premiums taken into account for this calculation. The regulation establishes the aggregated annual fee for all entities at \$8 billion for 2014, \$11.3 billion for 2015 and 2016, \$13.9 billion for year 2017, and \$14.3 billion for 2018. The regulation also lists exemptions from the fee which include self-insured employers, government entities and certain nonprofit corporations.

Read the final regulations (which were published in the Federal Register on November 29, 2013) at: <http://www.gpo.gov/fdsys/pkg/FR-2013-11-29/pdf/2013-28412.pdf>

11/26/13 IRS/Treasury issued final regulations regarding "Rules Relating to Additional Medicare Tax." The final regulations relate to an Additional Hospital Insurance Tax on income above threshold amounts ("Additional Medicare Tax"), as added by ACA §10906 and §1401(b).

The 0.9% Additional Medicare Tax, which went into effect on January 1, 2013, applies to individuals' wages, other compensation, and self-employment income over certain thresholds. The threshold amounts are \$250,000 for married taxpayers who file jointly, \$125,000 for married taxpayers who file separately, and \$200,000 for all other taxpayers. Employers are responsible for withholding the Additional Medicare Tax from wages or compensation it pays to an employee in excess of \$200,000 in a calendar year.

Specifically, the final regulations provide guidance for employers and individuals relating to the implementation of the Additional Medicare Tax, including the requirement to withhold Additional Medicare Tax on certain wages and compensation, the requirement to file a return reporting Additional Medicare Tax, the employer process for adjusting underpayments and overpayments of the Additional Medicare Tax, and the employer and employee processes for filing a claim for refund of Additional Medicare Tax.

Read the final regulations (which were published in the Federal Register on November 29, 2013) at: <http://www.gpo.gov/fdsys/pkg/FR-2013-11-29/pdf/2013-28411.pdf>

Read the IRS Questions and Answers about the tax at: <http://www.irs.gov/Businesses/Small-Businesses-&-Self-Employed/Questions-and-Answers-for-the-Additional-Medicare-Tax>

11/30/13 IRS/Treasury issued final regulations regarding "Net Investment Income Tax." The final regulations provide guidance on the general application of the Net Investment Income Tax and the computation of Net Investment Income rules which went into effect on January 1, 2013 and are effective for taxable years beginning after December 31, 2012. As required under ACA §1402(a)(1), and Section 1411 of the amended Internal Revenue Code, the regulation affects individuals, estates, and trusts. The 3.8% Net Investment Income Tax applies to individuals, estates and trusts that have certain investment income above certain threshold amounts.

Read the rule (which was published in the Federal Register on December 2, 2013) at:
<http://www.gpo.gov/fdsys/pkg/FR-2013-12-02/pdf/2013-28410.pdf>

11/30/13 IRS/Treasury issued a notice of proposed rulemaking regarding "Net Investment Tax." The proposed regulations provide guidance on the computation of net investment income as it relates to certain specific types of property. The notice also withdraws a previously issued proposed rule (which was published in the Federal Register on December 5, 2012), and instead seeks comments on the revised November 30, 2013 proposed rule. IRS/Treasury is seeking comments on several specific areas of the revised rule including two provisions of the rule affecting estates and trusts including distributions from foreign trusts. According to the agency, the IRS/Treasury will consider such comments in issuing future guidance.

The agency is also seeking comments on the collection of information for this proposed rule under the Paperwork Reduction Act of 1995 (PRA). Among other topics, comments are specifically requested concerning whether the proposed collection of information is necessary for the proper performance of the functions of the IRS, including whether the information will have practical utility.

Comments on the November 30, 2013 proposed rule are due March 3, 2014.
Comments on the collection of information for the proposed rule are due January 31, 2014.

Read the rule (which was published in the Federal Register on December 2, 2013) at:
<http://www.gpo.gov/fdsys/pkg/FR-2013-12-02/pdf/2013-28409.pdf>

For additional information on the Net Investment Income Tax, visit: <http://www.irs.gov/uac/Newsroom/Net-Investment-Income-Tax-FAQs>

11/25/13 HHS issued a proposed rule called "Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2015." The proposed rule sets forth payment parameters applicable to the 2015 benefit year and oversight provisions related to the premium stabilization programs. The rule proposes standards related to the advance payments of the premium tax credit, cost-sharing reductions, composite rating, privacy and security standards, the annual open enrollment period for 2015, the actuarial value (AV) calculator, the annual limitation on cost sharing for stand-alone dental plans, patient safety, and the Small Business Health Options Program (SHOP).

Beginning October 1, 2013, qualified individuals and qualified employees could purchase private health insurance coverage through Exchanges (Marketplaces) for January 1, 2014 effective dates. 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. §1311(b)(1)(B) also requires that the Small Business Health Options Program (SHOP) assist qualified small employers in facilitating the enrollment of their employees in qualified health programs (QHPs) offered in the small group market. QHPs are health plans that have been certified by an Exchange, provide essential health benefits ("EHB", §1301) and follow established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts).

In 2014, HHS will implement the premium stabilization programs, which will stabilize premiums in the individual and small group markets and minimize the effects of adverse selection that may occur as

insurance reforms and the Exchanges launch. 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. The transitional reinsurance program and the temporary risk corridors program, which begin in 2014, are designed to provide issuers with greater payment stability as insurance market reforms are implemented. The reinsurance program will reduce the uncertainty of insurance risk in the individual market by partially offsetting risk of high-cost enrollees. The risk corridors program, which is a federally administered program, will protect against uncertainty in rates for qualified health plans by limiting the extent of issuer losses and gains.

Under the rule, HHS proposes changes to the risk corridor and reinsurance programs. HHS proposes to decrease the reinsurance attachment point from \$60,000 to \$45,000 for the 2014 benefit year due to updated estimates that allow for greater payments from the contribution fund. HHS also proposes to modify the agency's contribution collection schedule for the reinsurance program. Under the rule, HHS proposes a change in small group participation in the risk adjustment and risk corridor programs, stating that a plan be classified as a small group plan (for purposes of risk adjustment) according to the employee counting method applicable under state law (as long as the method accounts for part-time employees).

The ACA sets limits on cost sharing to protect individuals from excessive out-of-pocket expenses. Beginning in 2014, plans that cover EHB must cover a certain percentage of costs, known as AV or "metal levels." AV is calculated as the percentage of total average costs for covered benefits that a plan will cover and helps consumers distinguish the level of coverage offered by different health plans. To streamline and standardize the calculation of AV for health insurance issuers, HHS provided a AV calculator, which issuers use to determine health plan AVs based on a national, standard population. The tool allows users to measure the AV of health plans and compliance with AV standards established under ACA §1302(d). In the rule, HHS proposes to update the AV Calculator and Methodology for 2015 and proposes parameters under which the AV Calculator could be updated in future plan years.

Comments are due December 26, 2013.

Read the proposed rule (which was published in the Federal Register on December 2, 2013) at:
<http://www.gpo.gov/fdsys/pkg/FR-2013-12-02/pdf/2013-28610.pdf>

The proposed 2015 AV calculator and methodology can be accessed at:
[http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/index.html#Premium Stabilization Programs](http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/index.html#Premium%20Stabilization%20Programs)

11/22/13 CMS/HHS issued an ACA-related final rule called "Medicare and Medicaid Programs: Home Health Prospective Payment System Rate Update for CY 2014, Home Health Quality Reporting Requirements, and Cost Allocation of Home Health Survey Expenses." The rule implements portions of ACA §3131 and 3401.

To qualify for the Medicare home health benefit, a Medicare beneficiary must be homebound and under the care of a physician; have an intermittent need for skilled nursing care, or need physical therapy, or speech-language pathology; or continue to need occupational therapy. Medicare pays home health agencies through a prospective payment system (PPS) that pays higher rates for services furnished to beneficiaries with greater needs. Payment rates are based on relevant data from patient assessments conducted by clinicians as currently required for all Medicare-participating home health agencies. Home health payment rates are updated annually by the home health payment update percentage.

Beginning in CY 2014, as required by the ACA, the annual final rule applies an adjustment to the national, standardized 60-day episode rate that reflects factors such as changes in the number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode and the average cost of providing care per episode. The final rule also updates the national per-visit rates used to calculate low

utilization payment adjustments (LUPAs) and outlier payments under the Medicare prospective payment system for home health agencies. These changes would apply to services furnished on or after January 1, 2014.

Read the rule (which was published in the Federal Register on December 2, 2013) at:
<http://www.gpo.gov/fdsys/pkg/FR-2013-12-02/pdf/2013-28457.pdf>

11/22/13 CMS/HHS issued an ACA-related final rule called "Medicare Programs: End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies." The rule implements portions of ACA § 3401 and 3014.

The annual final rule updates and revises the End-Stage Renal Disease (ESRD) prospective payment system (PPS) for calendar year (CY) 2014. This rule also sets forth requirements for the ESRD quality incentive program (QIP), including for payment year (PY) 2016 and beyond. The changes are applicable to services furnished on or after January 1, 2014.

In addition, the final rule clarifies the grandfathering provision related to the 3-year minimum lifetime requirement for Durable Medical Equipment (DME), and provides clarification of the definition of routinely purchased DME. The final rule also makes a few technical amendments and corrections to existing regulations related to payment for durable medical equipment, prosthetics, orthotics, and supplies, items and services.

Read the rule (which was published in the Federal Register on December 2, 2013) at:
<http://www.gpo.gov/fdsys/pkg/FR-2013-12-02/pdf/2013-28451.pdf>

11/22/13 HHS/CMS published a notice under the Paperwork Reduction Act of 1995 (PRA) seeking comments on proposed information collection activities related to the annual medical loss ratio (MLR) and rebate calculation report and MLR rebate notices under ACA §10101.

The ACA's MLR rules establish the minimum dollar percentage that health insurance companies must spend of consumers' health insurance premiums on medical care and quality improvement activities, rather than on salaries, overhead or marketing. Starting with the 2011 reporting year, the ACA required insurance companies in the individual and small group markets to spend at least 80% of collected premium dollars on medical care and quality improvement activities; insurance companies in the large group market are required to spend at least 85%. Under the MLR rules, insurance companies that do not meet the MLR standard are required to provide rebates to their consumers. Rebates must be paid by August 1st each year and insurers made the first round of rebates to consumers in 2012. Insurance companies must report their MLR data (including information about any rebates it must provide, on an HHS form, for each state in which the issuer conducts business) to HHS on an annual basis. According to HHS, the data will allow residents of every state to have information about the value of the health plans offered by insurance companies in their state.

Based on past experience with MLR data collection and the evaluation process, HHS is updating the agency's projections regarding the numbers of submissions, rebates, and rebate notices.

Comments are due January 21, 2014.

Read the notice at: <http://www.gpo.gov/fdsys/pkg/FR-2013-11-22/pdf/2013-28049.pdf> (See item #5)

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

News

11/26/13 The U.S. Preventive Services Task Force (USPSTF) issued a final recommendation statement on screening for oral cancer in adults without signs or symptoms of oral cancer who are seen by primary care providers. The Task Force concluded that there is a lack of current concrete evidence to recommend that primary care clinicians perform screening for oral cancer on all adult patients. As a result, the USPSTF issued an "I" recommendation statement, which reflects that there is insufficient evidence for the USPSTF to make a recommendation. The recommendation applies to adults without signs or symptoms of oral cancer and is a recommendation about the practices of primary care professional; it does not apply to specialists (such as dentists and oral health professionals).

According to the Task Force, oral cancer (also known as oral cavity cancer) is a type of head and neck cancer that is found in the mouth and lips. The primary screening test for oral cancer is to look inside and feel a patient's mouth, face, and neck for potentially cancerous lesions, lumps, or other abnormalities. The screening can be performed by a primary care clinician, dentist, or other dental care professional.

The USPSTF's evidence review found that, although it is unclear whether or not screenings in primary care settings are constructive, adults can reduce their risk of oral cancer by avoiding smoking (and all forms of tobacco) and limiting their alcohol intake. Additionally, the USPSTF found that patients with lumps, bumps, or lesions in their mouths or on their lips should seek an examination by a health care professional.

Although screening for oral human papillomavirus (HPV) was not considered for this recommendation, the Task Force recognizes that it is a growing risk factor for developing oropharyngeal cancer. Oropharyngeal cancer is a type of head and neck cancer usually located farther in the back of the mouth and throat and may be tough to visualize in a primary care setting. According to the USPSTF, there has been limited research done on the relationship between oropharyngeal cancer and HPV, ways of preventing HPV infection, and new screening techniques for HPV-related head and neck cancer. As a result, the USPSTF emphasizes the need for additional research in these areas.

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 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. Because the final recommendation on primary care clinicians' screening asymptomatic adults for oral cancer received an "I" rating, the screenings will not be required to be covered without cost-sharing under the ACA.

Read the final recommendation statement at:

<http://www.uspreventiveservicestaskforce.org/uspstf13/oralcan/oralcanfinalrec.htm>

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

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

11/22/13 HHS announced that the deadline for enrolling in a qualified health plan (QHP) through an Exchange for coverage effective January 1, 2014, had been delayed from December 15, 2013 to December 23, 2013. Consumers must pay their first premium by December 31, 2013 for health insurance coverage that begins on January 1, 2014.

Beginning October 1, 2013, qualified individuals and qualified employees could purchase private health insurance coverage through Exchanges (Marketplaces) for January 1, 2014 effective dates. 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.

Learn more about Exchange open enrollment at: Healthcare.Gov

Commonwealth of MA News

On November 25, 2013, EOHHS submitted comments to HHS/CMS on the proposed rule called "Basic Health Program: State Administration of Basic Health Programs; Eligibility and Enrollment in Standard Health Plans; Essential Health Benefits in Standard Health Plans; Performance Standards for Basic Health Programs; Premium and Cost Sharing for Basic Health Programs; Federal Funding Process; Trust Fund and Financial Integrity." The proposed rule implements ACA §1331 which establishes standards for the Basic Health Program (BHP) which provides states the option to establish a health benefits coverage program for low-income individuals who would otherwise be eligible to purchase coverage through the Health Insurance Exchange (Marketplace).

The proposed rule sets forth a framework for BHP eligibility and enrollment, benefits, delivery of health care services, transfer of funds to participating states, state administration and federal oversight. Citizens and qualified non-citizens who have income between 133% FPL and 200% FPL, as well as lawfully present non-citizens who have income between 0% and 200% FPL, and who do not qualify for Medicaid, the Children's Health Insurance Program (CHIP) or other minimum essential coverage are eligible for the BHP. States may implement the BHP beginning January 1, 2015, or at a later date.

According to the proposed rule, BHP benefits will include at least the ten essential health benefits specified in §1301. BHP monthly premiums and cost sharing cannot exceed what an eligible individual would have paid if the eligible individual were to receive coverage from a QHP through the Exchange. A state that operates a BHP will receive federal funding equal to 95% of the amount of the premium tax credits and the cost sharing reductions that would have otherwise been provided to (or on behalf of) eligible individuals if these individuals enrolled in QHPs through the Exchange.

The comment period has closed but a link to the September 25, 2013 Federal Register notice containing the proposed rule can be read at: <http://www.gpo.gov/fdsys/pkg/FR-2013-09-25/pdf/2013-23292.pdf>

The Massachusetts comment letter can be read online at the Massachusetts national health reform website under the State and Federal Communications section at:

<http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/state-fed-comm/131125-comment-letter.pdf>

MassHealth and Health Safety Net Regulation Changes

EOHHS has posted proposed changes to MassHealth and Health Safety Net regulations to implement the Affordable Care Act (ACA). The proposed changes will affect MassHealth and Health Safety Net eligibility, benefits, and operational processes. Specifically, the regulation changes implement the categorical and financial requirements for MassHealth programs authorized by the ACA and changes in Massachusetts state law. In addition, the proposed regulations describe operational changes in the application and redetermination processes.

The proposed regulations are available for review online at: Mass.Gov or may be requested in writing or in person from MassHealth Publications, 100 Hancock Street, 6th Floor, Quincy, MA 02171.

A public hearing will be held on Monday, December 2, 2013, at 10 am in the Worcester Public Library (Main), 3 Salem Square, Worcester, MA 01608, 508-799-1655. Written comments are due by Tuesday,

December 3, 2013 at 5pm. Additional information about the hearing and instructions for submitting comments can be found at: <http://www.mass.gov/eohhs/docs/eohhs/eohhs-regs/ad-2013-aca-ph.pdf>.

The regulations proposed at a public hearing on November 4, 2013 are the same regulations to be proposed at the public hearing on December 2, 2013. There have been no changes in the interim. Comments and testimony provided in response to the public hearing on November 4, 2013 will be considered along with any additional comments and testimony received in response to the public hearing scheduled for December 2, 2013.

Integrating Medicare and Medicaid for Dual Eligible Individuals (also known as One Care) Open Meeting

Thursday, December 5, 2013
1:00 PM - 3:00 PM
Worcester Public Library
3 Salem Street
Worcester, MA 01608

We welcome attendance 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

Massachusetts Health Homes Initiative Public Forum

Agenda: Payment, Oversight, and Quality Measures
December 5, 2013
10:00 AM - 12:00 PM
Saxe Room
Worcester Public Library
3 Salem St, Worcester, MA 01608

Please R.S.V.P. by 5 pm on Friday, November 29 to Donna Kymalainen at Donna.Kymalainen@state.ma.us. Reasonable accommodations are available upon request. Please contact Donna Kymalainen at Donna.Kymalainen@state.ma.us to request accommodations by 5 pm on Friday, November 29.

Integrating Medicare and Medicaid for Dual Eligible Individuals Implementation Council Meeting

Friday, December 20, 2013
1:00-3:00 PM
State Transportation Building, Conference Room 1-3
10 Park Plaza
Boston, MA

Meetings of the Implementation Council are open to 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.