



## AFFORDABLE CARE ACT MASSACHUSETTS IMPLEMENTATION UPDATE

January 13, 2014

### 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 Activity

**On September 26, 2013, DPH was awarded \$794,303 from the CDC for an "Immunization Increasing Human Papillomavirus (HPV) Vaccination Coverage Rates among Adolescents" grant under ACA §4002.** The proposal seeks to support activities that will ensure that Massachusetts reaches the goal of 80% of all adolescents in the state receiving three doses of HPV vaccine by 13 - 15 years of age, regardless of race/ethnicity or socioeconomic status. Through these activities, DPH will build on the strengths of the Massachusetts Immunization Program and the Program's partners to successfully reach this goal and become a model for other states. In addition, DPH will also work with immunization providers to increase knowledge regarding HPV-related diseases and HPV vaccine safety.

The grant funds will be used to implement a comprehensive media campaign targeting parents and adolescents and to use focus-group-tested materials developed by CDC to increase awareness of the importance of HPV vaccine in preventing cancer and to increase demand for HPV vaccine.

Read the grant abstract at: <http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/grants/130909-sec-4002-hpv-vacc-rates-adolescents.pdf>

**On September 23, 2013, a consortium including DPH was awarded \$937,858 from the CDC for a "National Public Health Improvement Initiative - Capacity Building Assistance to Strengthen Public Health Infrastructure and Performance - Laboratory Efficiencies Initiative Supplement " grant under ACA §4002.** The proposal, submitted by the Northeast Environmental and Public Health Lab

Directors (NEEPHLD) consortium, will support public health [laboratories](#) to share testing resources for public health threats identified by the state, other health authorities and the CDC. As a member of the consortium, DPH was awarded \$5,000.

The Northeast Environmental and Public Health Lab Directors (NEEPHLD) group with participating members from the states of New York, New Jersey, Rhode Island, Connecticut, Massachusetts, Vermont, Maine, and New Hampshire was established in the 1980's and is ideally suited to facilitating interstate cooperation and sharing.

The NEEPHLD group will use the funds to expand its state public health laboratory group to evaluate shared testing as it currently exists within the eight-state consortium and the potential sustainability of increasing shared testing and other services.

Read the grant abstract at: <http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/grants/130829-sec-4002-national-public-health-improvement-initiative.pdf>

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

**1/8/14 CMS issued a correction to the final rule called "Medicare Program; Prospective Payment System and Consolidated Billing for [Skilled Nursing Facilities](#) for FY 2014."** The document makes additional technical corrections to the [final rule](#) which was published in the Federal Register on August 6, 2013. The final rule implements portions of ACA §3108, §3137 and §3401. (Technical corrections were also published in the Federal Register on [January 2, 2014](#).)

The final rule updates the payment rates used under the prospective [payment system](#) (PPS) for skilled nursing facilities (SNFs) for FY 2014. In addition, it revises and rebases the SNF market basket, revises and updates the labor related share, and makes certain technical revisions to previous regulations.

To ensure accuracy in case-mix assignment and payment, in the final rule CMS adds an item to the Minimum Data Set (MDS) to record the number of distinct calendar days of therapy provided by all the rehabilitation disciplines to a beneficiary over the seven-day look-back period.

Based on the changes contained within the final rule, CMS estimates that aggregate payments to SNFs will increase by \$470 million (or 1.3%) for FY 2014 relative to payments in FY 2013. According to CMS, the estimated increase is attributable to the 2.3% market basket increase.

Read the correction (which was published in the Federal Register on January 10, 2014) at: <http://www.gpo.gov/fdsys/pkg/FR-2014-01-10/pdf/2014-00277.pdf>

**1/8/14 CMS issued a correction to the final rule "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; Payment Policies Related to Patient Status."** The document makes technical additional corrections to the [final rule](#) which was published in the Federal Register on August 19, 2013. The rule implements portions of the following ACA sections: 3001, 3004, 3005, 3008, 3021, 3025, 3106, 3123, 3124, 3125, 3133, 3141, 5503, 5504, 5506, 3313, 3401, 10309, 10312, 10313, 10316, 10319, 10322 and 10324. (Technical corrections were also published in the Federal Register on [January 2, 2014](#).)

The final rule updates fiscal year (FY) 2014 Medicare payment policies and rates under the Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital Prospective Payment System (LTCH

PPS). The final rule, which applies to approximately 3,400 acute care hospitals and approximately 440 LTCHs, will generally be effective for discharges occurring on or after October 1, 2013. According to CMS, under the rule, operating rates for inpatient stays in general acute care hospitals paid under the IPPS that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program will be increased by 0.7%. Those that do not successfully participate in the Hospital IQR Program will receive a 2.0% reduction in their annual increase. Beginning with FY 2015, hospitals that do not participate will lose one-quarter of a percentage increase in their payment updates.

Based on changes in the final rule, Medicare payments to LTCHs in FY 2014 are projected to increase by approximately \$72 million (or 1.3%) as compared to FY 2013 Medicare payments. Total IPPS payments (capital and operating payments) are projected to increase by \$1.2 billion.

In addition to setting the standards for payments for Medicare-covered inpatient services, the FY 2014 hospital payment rule describes the process for implementing the new Hospital-Acquired Conditions (HAC) Reduction Program, which will begin in FY 2015. The rule updates measures and financial incentives in the Hospital Value-Based Purchasing (VBP) and Readmissions Reduction programs. Additionally, the rule makes several changes relating to direct graduate medical education (GME) and indirect medical education (IME) payments and also establishes new or revised requirements for quality reporting by specific providers (acute care hospitals, PPS-exempt cancer hospitals, LTCHs, and inpatient psychiatric facilities (IPFs)) that are participating in Medicare.

Read the correction (which was published in the Federal Register on January 10, 2014) at:  
<http://www.gpo.gov/fdsys/pkg/FR-2014-01-10/pdf/2014-00273.pdf>

**1/7/14 CMS issued a proposed rule called "Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs."** The proposed rule revises the Medicare Advantage (MA) program (Part C) regulations and prescription drug benefit program (Part D) regulations and implements certain provisions of the ACA.

According to CMS, the proposed rule would strengthen beneficiary protections, improve health care quality and reduce costs for Medicare beneficiaries with private MA and Part D prescription drug plans in Contract Year 2015. Additionally, the proposed changes would clarify program requirements, improve the agency's ability to identify reliable applicants for Part C and Part D program participation and remove habitually poor performers.

Medicare Advantage Plans, sometimes called "Part C" or "MA Plans," are offered by private companies approved by Medicare and provide both Part A (Hospital Insurance) and Part B (Medical Insurance) coverage. Medicare Advantage Plans may offer extra coverage, such as vision or dental and most include Medicare prescription drug coverage (Part D). Medicare pays a fixed amount for a member's care every month to the companies offering Medicare Advantage Plans and, per §1102 of the ACA, plans can no longer charge higher cost sharing than what a member in traditional Medicare pays.

ACA §6405 requires that physicians and non-physician practitioners who order durable medical equipment, prosthetics, orthotics and supplies or certify home health care must be enrolled in Medicare. The ACA also permits the HHS Secretary to extend these Medicare enrollment requirements to physicians and non-physician practitioners who order or certify all other categories of items or services in Medicare, including covered Part D drugs. Under the proposed regulation, CMS requires that physicians or non-physician practitioners who write prescriptions for covered Part D drugs must be enrolled in Medicare for their prescriptions to be covered under Part D.

Comments are due March 7, 2013.

Read the rule (which was published in the Federal Register on January 10, 2014) at:  
<http://www.gpo.gov/fdsys/pkg/FR-2014-01-10/pdf/2013-31497.pdf>

**1/6/14 IRS/Treasury issued final regulations, "Computation of, and Rules Relating to, Medical Loss Ratio."** The final regulations provide guidance to Blue Cross and Blue Shield organizations, and certain other qualifying health care organizations, on computing and applying the medical loss ratio (MLR) added to the Internal Revenue Code under ACA §10101 and §9016.

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.

The ACA requires 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.

The IRS Code grants preferential tax treatment to Blue Cross and Blue Shield organizations and certain other organizations that provide health insurance. Under the IRS final regulations, the failure to spend at least 85% of premium dollars on patient care leads to the loss of a special tax deduction. The final regulations provide details about how the MLR rule is computed in relation to tax procedures.

Read the final regulations (which were published in the Federal Register on January 7, 2014) at: <http://www.gpo.gov/fdsys/pkg/FR-2014-01-07/pdf/2014-00092.pdf>

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

## News

**1/7/2014 The CMS Office of the Actuary reported that health spending for Americans fell slightly** from 17.3% in 2011 to 17.2% in 2012, although the ACA's impact on overall health spending may have been limited because implementation was ongoing in 2012.

The actuaries reported that mixed spending trends in 2012, such as increased spending on hospital and physician care and slower price growth of prescription drugs, contributed to the decrease. According to the report, the ACA has helped to sustain slow growth in health care spending. ACA §3025 created the Hospital Readmissions reduction program, which requires CMS to reduce payments to hospitals that have had excess readmissions. According to WhiteHouse.gov, this policy has contributed to 130,000 fewer readmissions to hospitals for Medicare beneficiaries from January 2012 through August 2013, resulting in lower costs for Medicare and better care for Medicare beneficiaries.

In addition, the ACA's medical loss ratio (MLR) rules (§10101 and §9016) require 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 this MLR standard are required to provide rebates to their consumers. This provision led to estimated savings of \$5 billion over the past two years.

The National Health Expenditure Accounts (NHEA) are the official estimates of total health care spending in the United States. Since 1960, the NHEA has been measuring the annual U.S. expenditures for health care goods and services, public health activities, government administration, the net cost of health insurance, and investment related to health care. The data are presented by type of service, by source of funding, and by type of sponsor.

To read the report and for more information regarding CMS's Office of the Actuary, visit: <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>

## Commonwealth of MA News

### MassHealth and Health Safety Net Regulation Changes

EOHHS has promulgated MassHealth and Health Safety Net regulations (with an effective date of January 1, 2014) 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.

After taking into consideration all public comments and testimony regarding the proposed regulations, EOHHS published the final regulations in the Massachusetts Register on December 20, 2013, with the January 1, 2014 effective date. The regulations will also be posted online at <http://www.mass.gov/eohhs/gov/laws-regs/masshealth/regulations/>.

## Upcoming Events

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

Friday, January 31, 2014  
12:00 PM-2:00 PM  
1 Ashburton Place, 21st Floor  
Boston, MA

Friday, February 28, 2014  
11:00 AM-1:00PM  
1 Ashburton Place, 21st Floor  
Boston, MA

MBTA and driving directions to 1 Ashburton Place are located here: [www.mass.gov/anf](http://www.mass.gov/anf)

A meeting agenda and any meeting material will be distributed prior to the meeting.

Meetings of the Implementation Council are open to stakeholders and members of the public with an interest in One Care. Reasonable accommodations are available upon request. Please contact Donna Kymalainen at [Donna.Kymalainen@umassmed.edu](mailto:Donna.Kymalainen@umassmed.edu) to request accommodations.

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.