



AFFORDABLE CARE ACT MASSACHUSETTS IMPLEMENTATION UPDATE

March 24, 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 Announcements

3/18/2014 HHS/CMS Innovation Center issued a Request for Applications (RFA) to solicit applications for participation in the Medicare Care Choices Model (MCCM), §3021. MCCM is a new CMS initiative designed to test whether or not Medicare beneficiaries who meet hospice eligibility standards would elect hospice if they could continue to seek curative services. Currently, Medicare beneficiaries are required to forgo curative care in order to receive access to palliative care services offered by hospices. Under the initiative CMS will evaluate the effect on Medicare beneficiaries' quality of life while they are receiving both curative and palliative care.

The model will provide a new option for Medicare beneficiaries who have been diagnosed with advanced cancers, chronic obstructive pulmonary disease, congestive heart failure and HIV/AIDS who meet hospice eligibility requirements under the Medicare hospice benefit.

The CMS Innovation Center, authorized under ACA §3021, is tasked with testing new health care payment and service delivery models (such as MCCM) that enhance the quality of Medicaid, Medicare and the Children's Health Insurance Program while also lowering program costs. Applications are due June 19, 2014.

For more information or to submit an application please visit:
<http://innovation.cms.gov/initiatives/Medicare-Care-Choices/>

Epidemiology and Laboratory Capacity for Infectious Diseases (ELC) - Building and Strengthening Epidemiology, Laboratory and Health Information Systems Capacity in State and Local Health Departments, §4002. Announced March 14, 2014. Funding is available to enhance the capacity of public health agencies to effectively detect, respond, prevent and control known and emerging (or re-emerging) infectious diseases. Funding should be used for costs associated with planning, organizing, and the implementation of other program elements to build public health epidemiology, laboratory, and health information systems capacity. Eligible applicants are limited to current ELC grantees, including state health departments, and large local health departments. \$427,319,480 in total is available for 64 awards. Applications are due May 14, 2014.

The announcement may be viewed at: <http://www.grants.gov/web/grants/view-opportunity.html?oppId=252535>

The Patient Centered Outcomes Research Institute (PCORI), §6301, announced two grant opportunities on March 11, 2014. Created under ACA §6301, PCORI is an independent nonprofit organization, tasked with conducting patient-centered outcomes research and studies. For more information about PCORI, visit [PCORI](#). For more information about PCORI funding opportunities, visit: www.pcori.org/funding-opportunities.

Evaluation of Agency for Healthcare Research and Quality (AHRQ) Initiative to Accelerate the Dissemination and Implementation of Patient-Centered Outcomes Research (PCOR) findings into Primary Care. Funding is available to conduct a comprehensive, multi-year evaluation of AHRQ's three-year grant-funded initiative to accelerate the dissemination and implementation of PCOR findings to enhance heart health and improve the capacity of primary care practices. Eligible applicants include state, local and federal government agencies, public or private universities, and Indian/Native American tribal governments. \$14 million is available for one award. Letters of Intent are due May 23, 2014. Applications are due July 3, 2014.

The announcement may be viewed at: <http://grants.nih.gov/grants/guide/rfa-files/RFA-HS-14-009.html>

Accelerating the Dissemination and Implementation of PCOR Findings into Primary Care Practice. Funding is available to release and implement PCOR findings into primary care practices in order to improve health care quality, with specific focus on cardiovascular care. Eligible applicants include town, city, county and state governments, Native American tribal organizations, and private or public institutions of higher education. \$120 million in total for 8 awards available. Applications are due July 3, 2014.

The announcement may be viewed at: <http://grants.nih.gov/grants/guide/rfa-files/RFA-HS-14-008.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

3/17/14 CMS/HHS issued a proposed rule called "Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond." The proposed rule clarifies key policies applicable to Health Insurance Exchanges and the insurance market reforms under Title I of the ACA relating to: qualified health plan (QHP) quality reporting and enrollee satisfaction surveys; standards

for consumer notices related to plan policy coverage changes; modifications in the Small Business Health Options Program (SHOP); standards for Navigators and other consumer assisters and modified premium stabilization policies for 2015.

Although HHS has previously outlined many of the major provisions in the rule, the rule further addresses various requirements applicable to health insurance issuers in order to improve consumer protections and stabilize premiums. Under the rule, HHS requires that insurers provide clear information to consumers when they make changes to their policies, such as discontinuing or renewing plans. The rule provides additional guidance to Navigator, non-Navigator and certified application counselors to protect consumers and prohibit assisters from specific solicitation activities. Several technical amendments address issues such as due dates for premium payments, notices of annual open enrollment periods, and special enrollment periods.

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 in 2014, where low and moderate income Americans may 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).

The ACA established three risk-mitigation programs, which HHS began operationalizing in 2014, 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. 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.

Comments are due April 21, 2014.

Read the proposed rule (which was published in the Federal Register on March 21, 2014) at:

<http://www.gpo.gov/fdsys/pkg/FR-2014-03-21/pdf/2014-06134.pdf>

3/17/14 CMS/HHS filed a correction to an ACA-related final rule called "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 March 18, 2014) at: <http://www.gpo.gov/fdsys/pkg/FR-2014-03-18/pdf/2014-05837.pdf>

3/17/14 CMS/HHS issued a correction to an ACA-related 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 2013 Rates; Hospitals' Resident Caps for Graduate Medical Education Payment Purposes; Quality Reporting Requirements for Specific Providers and for Ambulatory Surgical Centers."

The document makes additional technical corrections to the [final rule](#) which was published in the Federal Register on August 31, 2012.

The final rule implements portions of the following sections: 3001, 3005, 3008, 3011, 3014, 3021, 3025, 3106, 3123, 3124, 3125, 3137, 3141, 3401, 5503, 5506, 10302, 10309, 10312, 10313, 10314, 10319, 10322 and 10324.

The rule revises the Medicare hospital inpatient prospective payment systems (IPPS) for operating and capital-related costs of acute care hospitals. The changes are generally applicable to discharges occurring on or after October 1, 2012. The rule also updates the rate-of-increase limits for certain hospitals excluded from the IPPS that are paid on a reasonable cost basis subject to these limits. The updated rate-of-increase limits will be effective for cost reporting periods beginning on or after October 1, 2012.

The rule updates the payment policies and the annual payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs). Generally, the changes will be applicable to discharges occurring on or after October 1, 2012. In addition, the rule implements changes relating to determining a hospital's full-time equivalent (FTE) resident cap for the purpose of graduate medical education (GME) and indirect medical education (IME) payments. The rule establishes new requirements 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. The rule also establishes requirements for the Hospital Value-Based Purchasing (VBP) Program and the Hospital Readmissions Reduction Program.

Read the correction (which was published in the Federal Register on March 18) at: <http://www.gpo.gov/fdsys/pkg/FR-2014-03-18/pdf/2014-05836.pdf>

3/14/14 HHS/CMS issued an interim final rule with comment period called "Patient Protection and Affordable Care Act; Third Party Payment of Qualified Health Plan Premiums." The rule

requires that Health Insurance Exchange issuers of qualified health plans (QHPs), including stand-alone dental plans (SADPs), immediately begin accepting payments for enrollee premiums and cost sharing from third party payers such as the Ryan White HIV/AIDS Program, Indian tribes, tribal organizations, urban Indian organizations, and other relevant federal and state government programs.

According to the rule, CMS has discouraged QHP issuers to accept third party payments from hospitals, other healthcare providers, and other commercial entities because of concerns that such a practice could bias the insurance risk pool and create an uneven field in the Exchanges. However, the agency does not intend to discourage QHP issuers from accepting third party premium and cost-sharing payments made by organizations such as the Ryan White HIV/AIDS Program, Indian tribes, and other state and federal government programs. Under the rule, CMS encourages QHP issuers to accept such third party payments of premium and cost-sharing amounts by these entities.

Beginning October 1, 2013, qualified individuals and qualified employees could purchase private health insurance coverage through Exchanges 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 individuals would be eligible for premium tax credits (§1401, §1411) to make purchasing a QHP more affordable by reducing out-of-pocket premium costs. Furthermore, an Exchange makes an advance determination of tax credit eligibility for individuals who enroll in a QHP through the Exchange and pursue financial assistance (§1401, 1411, and 1412). QHPs are health plans that have been certified by an Exchange, provide essential health benefits (EHB, §1301) and follow established limits on cost-sharing (such as reduced deductibles, copayments, and out-of-pocket maximum amounts).

Comments are due May 13, 2014.

Read the rule (which was published in the Federal Register on March 19, 2014) at:
<http://www.gpo.gov/fdsys/pkg/FR-2014-03-19/pdf/2014-06031.pdf>

3/14/14 HHS issued a "Frequently Asked Question (FAQ)" document about health insurance coverage of same-sex spouses. The guidance applies to health insurance issuers offering non-grandfathered health insurance coverage in the group or individual markets (including qualified health plans (QHP) offered through Affordable Insurance Exchange).

Certain provisions of the ACA (guaranteed availability of coverage (§1201)) require those health insurance issuers offering non-grandfathered health insurance coverage in the group or individual markets (including qualified health plans offered through Affordable Insurance Exchanges or "Exchanges"²) to guarantee the availability of coverage.

According to the agency, CMS is issuing this guidance to clarify the current regulations' prohibition against discrimination based on sexual orientation. Insurers are not required to offer family coverage but if they do, under the guidance, married sex-sex couples will be eligible for a family health policy under the ACA beginning in 2015 (grandfathered plans must comply with the requirements in 2015).

Read the FAQ at: [CMS.Gov](http://www.cms.gov)

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

News

3/11/14 The U.S. Preventive Services Task Force (USPSTF) issued a final recommendation statement on primary care behavioral interventions to reduce illicit drug and nonmedical pharmaceutical use in children and adolescents. The USPSTF concluded that the current evidence is insufficient to assess the value of behavioral interventions in the primary care setting to prevent or reduce drug use in children and teens under age 18 and assigned an "I" rating to the recommendation. The "I"

rating indicates that the Task Force does not recommend the service. The recommendation applies to children or adolescents who are not known to be abusing or addicted to drugs.

According to the USPSTF, more than one in 10 teenagers aged 12 to 18 years in the United States use illegal drugs or misuse prescription or over-the-counter medicines. Furthermore, over 150,000 teens are seen in hospital emergency rooms annually as a result of such drug usage. Although the USPSTF's evidence review found that drug use can have significant health, educational, and social consequences, the Task Force could not find evidence to determine how primary care clinicians should intervene and instead appealed to the research community to search for ways to prevent and reduce illicit drug and nonmedical pharmaceutical use in children and adolescents.

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 recommendation was finalized with an "I" rating, behavioral interventions to reduce drug use will not be required to be covered without cost-sharing under the ACA.

Read the final recommendation statement at: [USPSTF](#)
Learn more about preventive services covered under the ACA at: [HHS.Gov](#)

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

Upcoming Events

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

Monday, April 18, 2014*
1:00 PM - 3:00 PM
State Transportation Building, Conference Rooms 1-3
10 Park Plaza
Boston, MA

*Note the date and time change

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.

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

Friday, March 28, 2014
1:00 PM - 3:00 PM
1 Ashburton Place, 21st Floor
Boston, MA

Friday, April 25, 2014
10:00 AM - 12:00 PM
Transportation Building
10 Park Plaza, Conference Rooms 1-3
Boston, MA

MBTA and driving directions to 1 Ashburton Place are located here: 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 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.