



AFFORDABLE CARE ACT MASSACHUSETTS IMPLEMENTATION UPDATE

November 10, 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

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

11/4/14 IRS Treasury issued [Notice 2014-69](#), called “Group Health Plans that Fail to Cover In-Patient Hospitalization Services.”

Notice 2014-69 advises employers and other taxpayers that employer-sponsored health plans that fail to provide substantial coverage for in-patient hospitalization services or for physician services do not provide minimum value as required by Section 36B of the IRS Code and the ACA. The notice also advises that IRS, Treasury, and HHS are considering whether the continuance tables underlying the [Minimum Value \(MV\) Calculator](#) produce valid actuarial results for plans with these designs. According to the notice, employers offering plans that fail to cover in-patient hospitalization or physician services should not rely solely on the MV Calculator to demonstrate that these plans provide minimum value for any portion of a taxable year.

Under Section 36B, a plan provides MV if the plan's share of the total allowed costs of benefits provided under the plan is at least 60% of the costs. §ACA 1302 provides that in determining the percentage of the total allowed costs of benefits provided by a group health plan or health insurance coverage under the IRS Code, regulations promulgated by the Secretary of HHS under section 1302(d)(2), addressing actuarial value, apply. On February 25, 2013 HHS published [final regulations](#) under section 1302(d)(2) that, for plans required to cover the essential health benefits (EHB), define the percentage of the total allowed costs of benefits.

The ACA established Affordable Health 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) requires that 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 EHB (§1301) and follow established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts).

As required under ACA §1302(b), EHBs are a package of medical services and treatments which includes ambulatory and emergency care, maternity care, prescription drugs and other comprehensive health care services in ten statutory benefit categories, and are equal in scope to a typical employer health plan. Effective January 1, 2014, all plans sold in the exchanges and through the small group and individual markets were required to be equal in scope to the benefits covered by a typical employer plan and offer an EHB package of medical services and treatments in the ten prescribed categories.

Read the notice at: www.irs.gov/pub/irs-drop/n-14-69.pdf

11/4/14 HHS/CMS issued a notice under the Paperwork Reduction Act of 1995 (PRA) seeking comments on the extension of a currently approved information collection activity related to health insurance annual eligibility redetermination, product discontinuation and renewal notices.

ACA §1411 directs the U.S. HHS Secretary to establish procedures to redetermine the eligibility of individuals for health insurance on a periodic basis in appropriate circumstances. §1321(a) provides authority for the Secretary to establish standards and regulations to implement the statutory requirements related to Exchanges, QHPs and other components of Title I of the ACA.

The [final rule](#) called “Patient Protection and Affordable Care Act; Annual Eligibility Redeterminations for Exchange Participation and Insurance Affordability Programs; Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges” (published in the Federal Register on September 2, 2014), specifies options for annual eligibility redeterminations and renewal and re-enrollment notice requirements for qualified health plans (QHPs) offered through the Exchange.

The final rule also amends the requirements for product renewal and re-enrollment (or nonrenewal) notices to be sent by QHP issuers in the Exchanges and specifies content for these notices. According to CMS, states that are enforcing the ACA may develop their own standard notices, for product discontinuances, renewals, or both, provided the State-developed notices are at least as protective as the federal standard notices.

Comments are due January 5, 2014.

Read the notice at: www.gpo.gov/fdsys/pkg/FR-2014-11-04/pdf/2014-26041.pdf

10/31/14 CMS/HHS issued a final rule called "Medicare Program; 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.

The annual rule updates and revises the End-Stage Renal Disease (ESRD) prospective payment system for calendar year 2015. The rule also establishes requirements for the ESRD quality incentive program for payment year 2016 and beyond. The changes apply to services furnished on or after January 1, 2014.

Additionally, the rule includes new quality and performance measures to improve the quality of care by outpatient dialysis facilities treating ESRD patients and proposes to expand competitive bidding for durable medical equipment, as required by the ACA.

Read the final rule (which was published in the Federal Register on November 6, 2014) at:
www.gpo.gov/fdsys/pkg/FR-2014-11-06/pdf/2014-26182.pdf

10/30/14 HHS/CMS issued a final rule called "Medicare and Medicaid Programs; CY 2015 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Requirements; and Survey and Enforcement Requirements for Home Health Agencies." The rule implements portions of ACA §3131 and §3401.

The final rule updates the 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 conversion factor under the Medicare prospective payment system for home health agencies (HHAs) for calendar year (CY) 2015.

As required by the ACA, the final rule implements the second year of the four-year phase-in of CMS' rebasing adjustments to the HH PPS payment rates. The ACA requires that beginning in CY 2014, CMS apply an adjustment to the national standardized 60-day episode rate and other applicable amounts to reflect 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, the average cost of providing care per episode, and other relevant factors. The adjustment must be phased-in over a four year period.

The rule also makes changes to the ACA-mandated Medicare home health beneficiary face-to-face encounter requirement. The ACA mandates that a certifying physician or allowable non-physician provider must have a face-to-face encounter with the beneficiary before they certify the beneficiary's eligibility for the Medicare home health benefit. The final rule institutes changes to this requirement.

Finally, this rule also discusses Medicare coverage of insulin injections under the HH PPS, the delay in the implementation of the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM), and a HH value-based purchasing model.

Read the final rule (which was published in the Federal Register on November 6, 2014) at:
www.gpo.gov/fdsys/pkg/FR-2014-11-06/pdf/2014-26057.pdf

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

Upcoming Events

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

Friday, November 21, 2014
1:00 p.m. -3:00 p.m.
1 Ashburton Place, 21st Floor
Boston, MA

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

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.



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