



AFFORDABLE CARE ACT MASSACHUSETTS IMPLEMENTATION UPDATE

March 18, 2013

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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: [Mass.Gov](#)

Guidance

3/15/13 HHS, Labor and Treasury issued sub-regulatory technical guidance regarding the transition period for the state external review process under §2719 of the ACA. The bulletin, "Extension of the Transition Period for the Temporary NAIC-Similar State External Review Process under the Affordable Care Act," updates the previous technical release issued on [June 22, 2011](#) regarding the implementation of the consumer protection standards set forth in the Uniform Health Carrier External Review Model Act issued through the National Association of Insurance Commissioners (NAIC). The bulletin extends the transition period for states that have external review processes that are similar to the NAIC-process from January 1, 2014 to January 1, 2016 to bring their review processes into compliance with NAIC standards.

The [interim final regulations](#) relative to §2719 indicated that if a state's external review process does not meet the minimum 16 consumer protection standards based on the NAIC model, then

group health plans and health insurance issuers in that state must implement an external review process that meets those standards. In July 2011, a technical release was issued which established a set of temporary standards required for states to administer the external review process. The extension of the transition period will serve as a bridge until more clarification is released to states.

Read the bulletin at: <http://cciio.cms.gov/resources/files/appeals-technical-release-3-15-2013.pdf>

3/15/13 IRS/Treasury published a correction to the [proposed regulations](#) for "Shared Responsibility for Employers Regarding Health Coverage," that were published in the Federal Register on Wednesday, January 2. The corrections make clarifying and technical changes to the proposed regulations.

The proposed regulations relate to the Employer Shared Responsibility provisions under Section 4980H which was added to the IRS Code by ACA §1513. Starting in 2014, under these provisions, if employers with 50 or more full-time employees* do not offer affordable health coverage that provides a minimum level of coverage (§1501) to their full-time employees, they may be subject to an Employer Shared Responsibility payment if at least one of their full-time employees receives a premium tax credit (§1401, §1411) for purchasing individual coverage on one of the new Affordable Insurance Exchanges. 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.

*To be subject to the Employer Shared Responsibility provisions, an employer must have at least 50 full-time employees or a combination of full-time and part-time employees that is equivalent to at least 50 full-time employees (for example, 100 half-time employees equals 50 full-time employees). As defined by the statute, a full-time employee is an individual employed on average at least 30 hours per week (so half-time would be 15 hours per week).

Read the correction at: <http://www.gpo.gov/fdsys/pkg/FR-2013-03-15/pdf/2013-05954.pdf>

3/13/13 HHS/CMS published 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 2013 Rates; Hospitals' Resident Caps for Graduate Medical Education Payment Purposes; Quality Reporting Requirements for Specific Providers and for Ambulatory Surgical Centers," that was published in the Federal Register on October 3, 2012. The correction makes clarifying and technical changes to the final rule. This correcting document is applicable to discharges on or after October 1, 2012. The final rule implements portions of the following sections for the ACA: 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.

According to CMS, there have been other technical corrections previously issued that address this final rule (see the [Federal Register](#) on October 17, 2012 in addition to the [Federal Register](#) on October 3, 2012). 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 at: <http://www.gpo.gov/fdsys/pkg/FR-2013-03-13/pdf/2013-05724.pdf>

3/13/13 IRS/ Treasury published a correcting amendment and a correction to the final regulations for "Taxable Medical Devices," that were published in the Federal Register on Friday, December 7, 2012. The corrections make clarifying and technical changes to the final regulations. The corrections are effective on March 13, 2013 and are applicable after December 31, 2012.

The final regulations provide guidance on the imposition of an annual fee on medical device manufacturers and importers under ACA Reconciliation §1405. The regulations affect manufacturers, importers, and producers of taxable medical devices. The final regulation imposes an excise tax on the sale of certain medical devices by the manufacturer, producer, or importer of the device in an amount equal to 2.3% of the sale price and applies to sales of taxable medical devices after December 31, 2012.

Read the correcting amendment at: <http://www.gpo.gov/fdsys/pkg/FR-2013-03-13/pdf/2013-05703.pdf>

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

News

3/8/13 HHS sent letters to Kansas, Montana, Nebraska and Ohio to acknowledge the intent of the states to perform plan management activities that HHS would have otherwise performed under the Federally-facilitated Exchange Model. The letters acknowledge that these states have attested that they have the authority and the capacity to undertake implementation activities related to the certification of Qualified Health Plans (QHPs).

HHS released [guidance](#) that indicated that states can enter into a State-Partnership Model within the Federally-facilitated Exchange which would preserve the traditional role of state insurance departments. States can assume primary responsibility in plan management activities, consumer assistance activities, or both.

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. If states choose not to run either a State-Based Exchange or a State-Federal Partnership Exchange, the Department of Health and Human Services will run a Federally-facilitated Exchange (§1321). Under the Federally-facilitated Exchange, HHS will operate all Exchange functions including engaging stakeholders; certifying, recertifying and decertifying QHPs; determining eligibility for enrollment in a QHP through the Exchange and providing consumer support. QHPs are health plans that have been certified by an Exchange, provide essential health benefits (§1301) and follow established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts).

To date, 17 states, including Massachusetts, and the District of Columbia have been conditionally approved to run State-Based Exchanges, where states will create and operate their own marketplaces. Seven states have been conditionally approved to run State Partnership Exchanges. Conditional approval reflects the progress that states have made and the expectation that enrollment in the Exchange will begin in October 2013 and that coverage through the Exchange for consumers and small businesses will begin in 2014.

To view Exchange letters from states, visit:

<http://www.healthcare.gov/law/resources/letters/index.html>

For more information on Exchanges, visit:

<http://www.healthcare.gov/exchanges>

3/7/13 CMS announced the fifth round of site selections under the Community-based Care Transition Program (CCTP), authorized by ACA §3026, which provides funding from the Innovation Center to community-based organizations partnering with eligible hospitals to test models for improving care transitions. The announcement of 20 new sites brings the current total to 102 sites working with CMS and local hospitals to provide support for high-risk Medicare patients following a hospital discharge as they move to new settings, including skilled nursing facilities and home. Community organizations help patients stay in contact with their doctors to ensure their questions are answered and they are taking medications they need to help them stay healthy. The program uses community groups to help provide home and community-based care to seniors who are especially likely to be readmitted after a hospital stay. With the addition of 20 new sites, approximately 700,000 seniors in over 40 states are now supported by CCTP.

CMS awarded program agreements to recipients that can demonstrate an overall reduction in Medicare expenditures over the program period. CMS did not provide savings estimates from the agreements. CCTP is part of the Partnership for Patients which is charged with reducing hospital-acquired conditions by 40% and hospital readmissions by 20% by 2013. Under the ACA, the CCTP program may spend up to \$500 million over five years and with the second round of site selections, CMS announced that the agency has committed half of the \$500 million allocated to CCTP. As part of their two-year agreement with the CMS Innovation Center, each organization will be paid a flat fee for helping to coordinate patient care after a hospital stay for each Medicare beneficiary who is at high risk for readmission to the hospital.

The fifth round of site participants are located in Alabama, Arizona, California, Colorado, Indiana, Kansas, Kentucky, Louisiana, Michigan, New Jersey, New York, Ohio, Pennsylvania, Rhode Island and Texas. None of the newly funded sites are located in Massachusetts.

The fourth round of site participants are located in Alabama, California, Colorado, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Maryland, Michigan, Mississippi, Missouri, Kansas, Montana, New York, North Carolina, Ohio, Oregon, South Carolina, Tennessee, Texas, Virginia and Washington. None of the fourth round sites are located in Massachusetts.

The third round of site participants are located in California, Connecticut, Florida, Illinois, Massachusetts, Minnesota, New York, North Carolina, Pennsylvania, Texas and Washington. In Massachusetts, Somerville-Cambridge Elder Services, a Massachusetts-designated Aging Services Access Point (ASAP) and an Area Agency on Aging (AAA), will partner with Mystic Valley Elder Services, Cambridge Health Alliance, Hallmark Health System and dozens of community-based health and social service providers to provide care transitions services in Middlesex County.

In March 2012 CMS announced the **second round of site selections** under this

program. This included: 1) Elder Services of Berkshire County, a Massachusetts-designated ASAP and federally-designated AAA in rural western Massachusetts, that will partner with Berkshire Medical Center and the Berkshire Visiting Nurse Association to improve care transition services for Medicare beneficiaries; and 2) Elder Services of Worcester, Massachusetts, a Massachusetts-designated ASAP and federally-designated AAA, that will partner with Bay Path Elder Services. They will provide care transitions services in partnership with seven hospitals, including: MetroWest Medical Center; St. Vincent Hospital; UMass Memorial Medical Center; Wing Memorial Hospital; Marlborough Hospital; Clinton Hospital, and HealthAlliance Hospital.

In November 2011 CMS announced the **first site selections** under this program. This included: 1) Elder Services of the Merrimack Valley, Inc., in partnership with Anna Jacques Hospital, Saints Medical Center, Holy Family Hospital, Lawrence General Hospital, and Merrimack Valley Hospital, and serving 23 cities/towns in the Merrimack Valley of Massachusetts and ten bordering cities/towns in southern New Hampshire where patients using these hospitals also reside.

The CMS Innovation Center will continue to accept applications and approve participants on a rolling basis as long as funds remain available. For more information on how to apply visit: [CMS.Gov](http://www.cms.gov)

For more information about the Community Based Care Transitions Program, including a complete list of all site selections announced, visit: <http://go.cms.gov/caretransitions>

Upcoming Events

Money Follows the Person (MFP) Stakeholder Meeting

March 19, 2013, 10:00 AM - 11:30 AM

State Transportation Building

10 Park Plaza

Boston, MA

Please contact MFP@state.ma.us if you would like to attend the meetings.

Requests for reasonable accommodations should be sent to MFP@state.ma.us. Although an RSVP is not required, it is appreciated.

Bookmark the **Massachusetts National Health Care Reform website** at: [National Health Care Reform](http://www.mass.gov/nhcr) to read updates on ACA implementation in Massachusetts.

Remember to check the Mass.Gov website at: [Dual Eligibles](http://www.mass.gov) for information on the **"Integrating Medicare and Medicaid for Dual Eligible Individuals"** initiative.