



## AFFORDABLE CARE ACT MASSACHUSETTS IMPLEMENTATION UPDATE

October 7, 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 Announcements

**Patient-Centered Outcomes Research (PCOR) for Treatment Options in Uterine Fibroids: Developing a Prospective Multi-Center Practice-based Clinical Registry, §6301.** Announced September 30, 2013. Funding is available to examine the relative effectiveness of treatment options for women of childbearing age with uterine fibroids. One application will be funded that will include a registry Research and Data Coordinating Center (RDCC) to build a registry infrastructure that involves six to ten separate and geographically diverse clinical centers. In addition, three research studies must be included in the registry application.

Examples of research studies that are responsive to the funding opportunity include, but are not limited to: 1) Conducting a study using clinical and patient reported data to identify demographic, patient reproductive preference, comorbidities as well as social and economic factors associated with long term outcomes such as sustained symptom relief, quality of life and reproductive outcomes of various treatment options, or 2) designing and conducting a large and representative comparative study to determine whether a particular procedure is associated with improved symptoms, decreased need for a repeat procedure and improved reproductive outcomes. Applications must include a patient and stakeholder engagement plan. Research studies proposed as part of developing the registry must be designed to make a significant impact in advancing the available evidence and have a substantial capacity to inform decision-making that improves patient-centered outcomes.

Eligible entities include public or non-profit private institutions, such as a university, college, or a faith-based or community-based organization; a unit of local or state government; or Indian/Native American Tribal Government or other Indian/Native American Tribally Designated Organizations. \$4,000,000 in funding is available for 1 award.

Optional letters of intent are due November 15, 2013.  
Applications are due December 15, 2013.

The announcement can be viewed at:

<http://www.grants.gov/custom/viewOppDetails.jsp?oppId=243947>

## Grant Activity

**On September 23, 2013, the Division of Insurance (DOI) was awarded \$3,394,884 under the "Grants to States to Support Health Insurance Rate Review and Increase Transparency in Health Care Pricing, Cycle III" program, authorized by ACA §1003.**

DOI will use this grant for support of activities intended to enhance its current health insurance rate review process. The proposed enhancements include development of new tools for reviewing and determining the reasonableness of rate proposals, expansion of the array of materials collected from filing companies, expansion of the scope and types of rates reviewed, development of additional technical tools to assist in review, and development of new consumer-oriented materials, many web-based, to provide additional transparency in the rate review process and the cost of health insurance products in Massachusetts' small group and individual marketplace.

In addition, DOI intends to expand the array of materials that it collects on carriers' projected cost increases for large health care providers since initial data supports an analysis that those costs are the foundation for most premium increases in Massachusetts. DOI will need to enhance its existing tools and also develop new ones to allow carriers to expand upon claims trends details to track spending in these areas and develop internal models to assist the actuaries in evaluating utilization forecasts. DOI intends also to expand upon its commissioned studies to evaluate Massachusetts market conditions and structures that affect the cost drivers leading to rate increases, examine utilization, technology and unit cost trends in the market, and look at ways to impact the increase in health costs.

Finally, DOI intends to standardize further the data received in the rate review process, to enhance the consumer information that is made available on DOI's website associated with the rates of all the products that are available in the market, and provide more ready access to information on the rate review process.

The [rate review program](#) under §1003 requires that insurers seeking rate increases of 10% or more for non-grandfathered plans in the individual and small group markets publicly and clearly disclose the proposed increases and the justification for them. Such increases are reviewed by either state or federal experts (in states that do not have a rate review program deemed effective by HHS) to determine whether they are unreasonable. Although the ACA does not grant HHS the authority to block a proposed rate increase, companies whose rates have been determined unreasonable must either reduce their rate hikes or post a justification on their website within 10 days of the rate review determination. CMS determined that both the individual and small-group markets in Massachusetts meet standards under §1003 and that the Commonwealth does have an effective rate review process.

Read the grant abstract at: [Mass.Gov](#)

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](http://Mass.Gov)

## Guidance

**10/2/13 DOL issued a correction to a final rule called, "Regulations Implementing the Byrd Amendments to the Black Lung Benefits Act: Determining Coal Miners' and Survivors' Entitlement to Benefits."** The final rule implements amendments to the Black Lung Benefits Act (BLBA) made by ACA §1556. The document makes technical corrections to the [final rule](#) which was published in the Federal Register on September 25, 2013.

The Black Lung Benefits Act provides benefits, in cooperation with the states, to coal miners who are totally disabled due to pneumoconiosis (black lung disease) and to the surviving dependents of miners whose death was due to such disease; and to ensure that in the future adequate benefits are provided to coal miners and their dependents in the event of their death or total disability due to pneumoconiosis. The amendments reinstate two provisions regarding coal miners' and survivors' entitlement to benefits that had been previously repealed from the BLBA.

The first amendment provides a presumption of total disability or death caused by pneumoconiosis for coal miners who worked for at least 15 years in underground mining and who suffer or suffered from a totally disabling respiratory impairment. The second amendment provides automatic entitlement for eligible survivors of miners who were themselves entitled to receive benefits as the result of a lifetime claim.

The final rule addresses both new methods of establishing entitlement- the automatic entitlement of certain survivors and the 15-year presumption as it applies to both miners' and their survivors' claims. From 1982 until the ACA was enacted, survivors of a coal miner who was totally disabled due to pneumoconiosis had to prove that pneumoconiosis had caused the miner's death to be entitled to benefits. Since the ACA was passed several U.S. Appeals courts have upheld the ACA amendment that automatically continues benefits to a miner's eligible survivors if the miner was entitled to benefits on a claim filed prior to death and also upheld the reinstated 15-year presumption.

For more information on the BLBA visit: [DOL.Gov](http://DOL.Gov)

Read the correction at: <http://www.gpo.gov/fdsys/pkg/FR-2013-10-02/pdf/2013-23928.pdf>

**9/30/13 CMS/HHS issued an interim final rule with comment period called "Medicare Program; FY 2014 Inpatient Prospective Payment Systems: Changes to Certain Cost Reporting Procedures Related to Disproportionate Share Hospital Uncompensated Care Payments."** The rule implements portions of ACA §3133.

§3133 modifies the methodology for computing the Medicare disproportionate share hospital (DSH) payment adjustment beginning in fiscal year (FY) 2014. Currently, hospitals qualify for a DSH payment adjustment under a statutory formula that considers their Medicare utilization due to beneficiaries who also receive Supplemental Security Income (SSI) benefits and their Medicaid utilization.

According to the rule, beginning in FY 2014 hospitals that are eligible for Medicare DSH payments will receive 25% of the amount they previously would have received under the current statutory formula for Medicare DSH payments. The remaining amount, equal to an estimate of 75% of what otherwise would have been paid as Medicare DSH payments, reduced

for changes in the percentage of individuals under age 65 who are uninsured, will become available to make additional payments to each hospital that qualifies for Medicare DSH payments and that has uncompensated care. Each Medicare DSH hospital will receive an additional amount based on its estimated share of the total amount of uncompensated care reported for all Medicare DSH hospitals for a given time period.

The rule revises certain policies and processes described in the FY 2014 IPPS/LTCH PPS [final rule](#). Specifically, the rule revises certain operational considerations for hospitals with Medicare cost reporting periods that span more than one Federal fiscal year and also makes changes to the data that will be used in the uncompensated care payment calculation in order to ensure that data from Indian Health Service (IHS) hospitals are included in Factor 1 and Factor 3 of that calculation.

Comments are due November 29, 2013.

Read the rule (which was published in the Federal Register on October 3, 2013) at: <http://www.gpo.gov/fdsys/pkg/FR-2013-10-03/pdf/2013-24209.pdf>

**10/1/13 HHS/CMS issued a correction to a final rule called "Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2014."** The rule implements portions of ACA §3108, §3137 and §3401. The document makes technical corrections to the [final rule](#) which was published in the Federal Register on August 6, 2013.

The final rule is effective on October 1, 2013. 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 October 3, 2013) at: <http://www.gpo.gov/fdsys/pkg/FR-2013-10-03/pdf/2013-24080.pdf>

**10/1/13 HHS/CMS issued a correction to the 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 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. The document makes technical corrections to the [final rule](#) which was published in the Federal Register on August 19, 2013.

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 October 3, 2013) at: <http://www.gpo.gov/fdsys/pkg/FR-2013-10-03/pdf/2013-24211.pdf>

**9/30/13 The U.S. Office of Personnel Management (OPM) issued a final rule called "Federal Employees Health Benefits Program: Members of Congress and Congressional Staff."** The final rule amends the Federal Employees Health Benefits (FEHB) Program eligibility regulations regarding coverage for Members of Congress and congressional staff in order to comply with ACA §1312. The final rule limits the availability of health benefits plans available for purchase by Members of Congress and congressional staff through OPM.

§1312 specifies that the only health plans that the federal Government may make available under the FEHB Program are those that are either "created under" the ACA, or "offered through an Exchange established under" the Act. The health benefits plans for which OPM currently contracts with are not created under the ACA, nor are they offered through the Exchanges. As a result, Members of Congress and congressional staff who are employed by the official office of a Member of Congress may no longer purchase the health benefits plans with which OPM currently contracts.

Members of Congress and their congressional staff who are no longer eligible for enrollment in an FEHB health benefits plan will continue to receive a contribution from the federal Government toward the cost of their premiums for health plans purchased on the Exchange. According to the final rule, the amount of the employer contribution will be no greater than the federal Government contribution provided for other Federal employees eligible for FEHB coverage. OPM annually determines the federal Government contribution based on the average of health plan premiums for the two types of enrollments (self only and self and family) allowed in the FEHB Program.

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 (§1301) and follow established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts).

According to the final rule, because a federal Government contribution is treated as an employer contribution, Members of Congress and congressional staff must enroll in an appropriate Small Business Health Options Program (SHOP), as determined by the OPM Director, in order to receive a federal Government contribution. The final rule clarifies that SHOPS are designed to provide employer-sponsored group health benefits and, as a result, it is appropriate to provide an employer contribution to Members of Congress and congressional staff in a SHOP.

Read the final rule (which was published in the Federal Register on October 2, 2013) at: <http://www.gpo.gov/fdsys/pkg/FR-2013-10-02/pdf/2013-23565.pdf>

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

## News

**9/30/13 The U.S. Preventive Services Task Force (USPSTF) issued a draft 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. If the recommendation is finalized with an "I" rating then behavioral interventions to reduce drug use will not be required to be covered without cost-sharing under the ACA.

Comments on the draft are due October 28, 2013 and can be submitted at:  
[uspreventiveservicestaskforce](http://www.uspreventiveservicestaskforce.org)

Read the draft recommendation statement at:  
<http://www.uspreventiveservicestaskforce.org/draftrec.htm>

Learn more about preventive services covered under the ACA at: [HHS.Gov](http://www.hhs.gov)  
Learn more about the USPSTF at: <http://www.uspreventiveservicestaskforce.org/>

## Commonwealth of MA News

### MassHealth Section 1115 Demonstration Amendment

EOHHS received approval of an amendment to the MassHealth Section 1115 Demonstration from the Centers for Medicare and Medicaid Services (CMS) on October 1, 2013. The Demonstration provides federal authority for Massachusetts to expand eligibility, offer services that are not typically covered by Medicaid, use innovative service delivery systems that improve care, increase efficiency and reduce costs.

The approval allows the Commonwealth to sustain and improve its ability to provide coverage, affordability and access to health care by making changes to the demonstration that conform to the new coverage opportunities created under the ACA. These changes will also promote continuity of care. The amendment revises the Demonstration to reflect that the state is adopting the option to expand coverage to adults earning at or below 133% FPL. MassHealth plans to provide this coverage through MassHealth Standard and MassHealth CarePlus, a new coverage type designed specifically for the new adult group. Coverage for pregnant women, individuals with disability determinations, and parents will not change under the ACA transition.

The 1115 Demonstration approval documents, including the amendment, are available at:  
<http://www.mass.gov/eohhs/docs/eohhs/cms-waiver/ma-1115-amendment-approval-oct-1-2013.pdf>

## Upcoming Events

### Money Follows the Person (MFP) Stakeholder Meeting

October 23, 2013  
2:00 PM -3:30 PM  
Worcester Public Library  
3 Salem Street  
Worcester, MA 01608

Please contact [MFP@state.ma.us](mailto:MFP@state.ma.us) to RSVP and to request reasonable accommodations. Although RSVPs are greatly appreciated, they are not required.

### Integrating Medicare and Medicaid for Dual Eligible Individuals

#### Open Meeting

Wednesday, October 16, 2013  
2:00 PM - 4:00 PM  
State Transportation Building, Rooms 1, 2 & 3  
Boston, MA

The purpose of this meeting is to continue discussion of key implementation topics for the Duals Demonstration. Please visit the [Materials from Previous Meetings page](#) for information from previous Duals Open Meetings.

We welcome attendance from all stakeholders and members of the public with interest in the Demonstration. 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](mailto: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.