



AFFORDABLE CARE ACT MASSACHUSETTS IMPLEMENTATION UPDATE

May 12, 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: [Mass.Gov](#)

Guidance

5/2/14 IRS/Treasury filed final regulations "Information Reporting for Affordable Insurance Exchanges." The final regulations update the [proposed rule](#) (which was published in the Federal Register on July 2, 2013). The final regulations provide guidance to Health Insurance Exchanges that offer qualified health plans (QHPs) to individuals regarding the information that must be reported to the IRS and statements that the Exchanges must provide to taxpayers and other tax-filers.

The final regulations require Exchanges to report information about individuals who enroll in QHPs and the monthly amount of any advanced tax credit payments received. QHPs are health plans that have been certified by an Exchange, provide essential health benefits (§1301) and follow established limits on cost-sharing. The required information will be electronically transmitted on a monthly basis to the IRS. The regulations also require that Exchanges provide each taxpayer or other designated adult who is enrolled in a QHP (or family member who is

enrolled in a QHP) with a statement containing all the information that is reported to the IRS.

The reporting helps the IRS with the calculation of the advance premium tax credits and assists with the annual reconciliation of the amount of the advance tax credit made with the final amount of the premium tax credit at tax filing time once the enrollee's income is known.

The reporting requirement applies to federal and state exchanges but only applies to individuals who enroll through the individual Exchanges, not the Small Business Health Options Program (SHOP) Exchange. This is because individual premium tax credits are not available through the SHOP exchange.

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 costs.

The premium tax credit is designed to make purchasing a health plan on the Exchange affordable for low and moderate income Americans by reducing a taxpayer's out-of-pocket premium cost. ACA §1401 amended the tax code to allow an advance, refundable premium tax credit to help individuals and families afford health insurance coverage. To be eligible to receive the premium tax credit, individuals and families must have incomes between 100%- 400 % FPL (or between 0% - 400% FPL if lawfully present and ineligible for Medicaid) and be enrolled in a QHP through an exchange. The individual must also be ineligible for government sponsored insurance and not have access to employer sponsored insurance that meets definitions of affordability and minimum essential coverage as established by ACA §1401. The amount of the premium tax credit is tied to the amount of the premium. Advance payments are made monthly under ACA §1412 to the issuer of the QHP in which the individual enrolls. ACA §1402 provides for the reduction of cost sharing (such as deductibles, copayments, and out-of-pocket maximum amounts) for certain individuals enrolled in QHPs offered through the Exchanges and §1412 provides for the advance payment of these reductions to issuers.

Read the rule (which was published in the Federal Register on May 7, 2014) at:

<http://www.gpo.gov/fdsys/pkg/FR-2014-05-07/pdf/2014-10419.pdf>

5/2/14 HHS/CMS filed a proposed rule called "Medicare Program; FY 2015 Hospice Wage Index and Payment Rate Update; Hospice Quality Reporting Requirements and Process and Appeals for Part D Payment for Drugs for Beneficiaries Enrolled in Hospice." The rule implements portions of ACA sections: 3004, 3132 and 3401.

The rule updates the Medicare hospice payment rates and the wage index for fiscal year (FY) 2015 and continues the phase out of the wage index budget neutrality adjustment factor (BNAF). According to CMS, the proposed rule reflects the agency's ongoing efforts to protect beneficiary access to patient-centered hospice care. The rule also solicits comments on two hospice-related definitions and on a process and appeals for Part D payment for drugs while beneficiaries are under a hospice election.

Comments are due July 1, 2014.

Read the rule (which was published in the Federal Register on May 8, 2014) at:

<http://www.gpo.gov/fdsys/pkg/FR-2014-05-08/pdf/2014-10505.pdf>

5/2/14 DOL/EBSA filed a proposed rule called "Health Care Continuation Coverage." The rule updates the employer model notices used to inform workers of their

eligibility to continue health care coverage through the [Consolidated Omnibus Budget Reconciliation Act](#) (COBRA). The updates clarify to workers that if they are eligible for COBRA continuation coverage when leaving a job, they may choose to instead purchase coverage through the [Health Insurance Marketplace](#).

Workers and their families who are eligible for employer-sponsored coverage generally must be informed of their right to purchase COBRA continuation coverage when they begin a job and when they separate from a job. The proposed changes to the model notices would offer information on more affordable options available through the Exchange (Marketplace), where workers and families may be eligible for financial assistance that would not otherwise be available for COBRA continuation coverage. Under the rule, in most cases, workers and their families eligible for, but not enrolled in, COBRA continuation coverage would be able to enroll in Marketplace coverage outside of the normal open enrollment period.

COBRA requires continuation coverage to be offered to covered employees, their spouses, former spouses, and dependent children when group health coverage would otherwise be lost due to certain specific events. Group health coverage for COBRA participants is often more expensive than the amount that active employees are required to pay, since the employer typically pays a portion of the cost of employees' coverage and the full cost can be charged to individuals receiving continuation coverage.

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 qualified health plan (QHP) more affordable by reducing out-of-pocket premium costs. 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).

Comments are due July 7, 2014.

Read the HHS Bulletin on COBRA-Qualified Beneficiaries and Special Enrollment Periods at: [CCIIO](#)

Read the FAQs about the DOL Model Notices at: <http://www.dol.gov/ebsa/faqs/faq-aca19.html>

Read the rule (which was published in the Federal Register on May 7, 2014) at: <http://www.gpo.gov/fdsys/pkg/FR-2014-05-07/pdf/2014-10416.pdf>

5/1/14 HHS/CMS filed a proposed rule called "Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System - Update for Fiscal Year Beginning October 1, 2014 (FY 2015)." The rule implements portions of ACA sections 3401 and 10322.

The proposed rule updates the prospective payment rates for Medicare inpatient hospital services provided by inpatient psychiatric facilities (IPFs). The changes are applicable to IPF discharges occurring during the fiscal year (FY) beginning October 1, 2014 through September 30, 2015. The rule also proposes a new methodology for updating the cost of living adjustment and proposes new quality measures and reporting requirements under the IPF quality reporting program.

Comments are due June 30, 2014.

Read the rule (which was published in the Federal Register on May 6, 2014) at: <http://www.gpo.gov/fdsys/pkg/FR-2014-05-06/pdf/2014-10306.pdf>

5/1/14 HHS/CMS filed a proposed rule called "Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2015."

The rule implements portions of ACA sections 3004, 3401 and 10319.

The proposed rule updates the Medicare payment policies and prospective payment rates for inpatient rehabilitation facilities (IRFs) for federal fiscal year (FY) 2015 (for discharges occurring on or after October 1, 2014 and on or before September 30, 2015). Under the rule, IRF PPS payments for FY 2015 are updated to reflect adjustments as mandated by the ACA. The rule also revises and updates quality measures and reporting requirements under the IRF Quality Reporting Program (IRF QRP).

Comments are due June 30, 2014.

Read the rule (which was published in the Federal Register on May 7, 2014) at:

<http://www.gpo.gov/fdsys/pkg/FR-2014-05-07/pdf/2014-10321.pdf>

5/1/14 HHS/CMS filed a proposed rule called "Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2015."

The rule implements portions of ACA sections 3401 and 6111.

The proposed rule updates the payment rates used under the prospective payment system (PPS) for skilled nursing facilities (SNFs) for fiscal year (FY) 2015. Based on proposed changes contained within this rule, CMS projects that aggregate payments to SNFs will increase by \$750 million from payments in FY 2014. This represents a higher update factor than the 1.3 % update finalized for SNFs last year. This estimated increase is attributable to adjustments required by statute. The proposed rule provides clarification of statutory requirements under ACA § 6111 regarding the approval and use of Civil Money Penalties imposed by CMS against nursing facilities.

Comments are due June 30, 2014.

Read the rule (which was published in the Federal Register on May 6, 2014) at:

<http://www.gpo.gov/fdsys/pkg/FR-2014-05-06/pdf/2014-10319.pdf>

5/1/14 HHS/CMS issued a notice under the Paperwork Reduction Act of 1995 (PRA) seeking comments on the revision of currently approved information collection activities related to Sunshine Act Disclosures.

ACA §6002 requires applicable manufacturers of drugs, devices, biologicals, and medical supplies covered by Medicare, Medicaid or the Children's Health Insurance Program (CHIP) to report payments or other transfers of value (including gifts, consulting fees, research activities, speaking fees, meals, and travel) provided to physicians or teaching hospitals to CMS. Manufacturers and group purchasing organizations (GPOs) are also required to disclose/report annually to CMS physician ownership or investment interests.

According to CMS, the increased transparency is intended to help reduce the potential for conflicts of interest that physicians or teaching hospitals could face as a result of their relationships with manufacturers. Data must be reported in a required format so that CMS can release the data on a public website by September 30, 2014. CMS is developing an electronic system to facilitate the reporting process. GPOs, as well as the physicians and teaching hospitals, will have an opportunity to review and correct reported information prior to its publication. The ACA provides that violators of the reporting requirements will be subject to civil monetary penalties, capped at \$150,000 annually for failing to report, and \$1,000,000 for knowingly failing to report.

§6002 also preempts any state or local laws requiring reporting of the same types of information regarding payments or other transfers of value made by applicable manufacturers to covered recipients. Under the requirement, no state or local government may require the separate reporting of any information regarding a payment or other transfer of value that is required to be reported under this statute, unless such information is being collected by a federal, state, or local governmental agency for public health surveillance, investigation, or other public health purposes or health oversight. According to CMS, this creates the possibility of cost-savings, since a single reporting system for reporting this information is less burdensome than multiple programs.

CMS published a [final rule](#) in February 2013 to implement this program, which included several information collections subject to the Paperwork Reduction Act. This information collection request is to inform the public about information collected that is necessary for registration, attestation, dispute resolution and corrections, record retention, and submitting an assumptions document within Open Payments.

Comments are due June 2, 2014.

Read the notice (which was published in the Federal Register on May 5, 2014) at:
<http://www.gpo.gov/fdsys/pkg/FR-2014-05-05/pdf/2014-10228.pdf>

4/29/14 HHS/CMS issued a final rule with comment period called "Medicare Program; Prospective Payment System for Federally Qualified Health Centers; Changes to Contracting Policies for Rural Health Clinics; and Changes to Clinical Laboratory Improvement Amendments of 1988 Enforcement Actions for Proficiency Testing Referral." The final rule implements portions of ACA §10501.

The final rule with comment period implements methodology and payment rates for a prospective payment system (PPS) for federally qualified health center (FQHC) services under Medicare Part B beginning on October 1, 2014, as required by the ACA. Additionally, the rule also establishes a policy which allows rural health clinics (RHCs) to contract with nonphysician practitioners when statutory requirements for employment of nurse practitioners and physician assistants are met, and makes other technical and conforming changes to the RHC and FQHC regulations. Moreover, the final rule implements changes to the Clinical Laboratory Improvement Amendments (CLIA) regulations regarding enforcement actions for proficiency testing referrals.

FQHCs provide access to crucial primary and preventive health care and medical services to millions of patients in or from medically underserved areas nationally. Currently, Medicare currently pays FQHCs based on reasonable costs subject to established payment limits for covered services provide to Medicare beneficiaries. The ACA requires that a new Medicare PPS account for a number of factors, including the type, intensity, and duration of services provided in the FQHC setting. According to HHS/CMS, the new payment system will be implemented beginning on October 1, 2014 and FQHCs will be transitioned to the system throughout 2015.

Comments on specific sections are due July 1, 2014.

Read the rule (which was published in the Federal Register on May 2, 2014) at:
<http://www.gpo.gov/fdsys/pkg/FR-2014-05-02/pdf/2014-09908.pdf>

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

News

5/5/14 The U.S. Preventive Services Task Force (USPSTF) issued a final recommendation statement on the use of fluoride in children to help prevent dental decay. The USPSTF recommends that clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride, and apply fluoride varnish to the primary teeth of infants and children starting at the age of primary tooth eruption. According to the Task Force's research, tooth decay is the most common chronic disease in children in the United States. Both recommendations received a "B" rating from the USPSTF.

According to the USPSTF, any child with developing teeth can develop decay and approximately 42% of children ages 2 to 11 years have dental decay in their primary teeth. Tooth decay is preventable; if left untreated, it can result in health complications. However, fluoride is safe and easy for clinicians to apply and can benefit all children.

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. Because the recommendations were finalized with "B" ratings, the use of fluoride to help prevent dental decay in children from birth through age 5 will be required to be covered without cost-sharing under the ACA.

Read the final recommendation statement at:

<http://www.uspreventiveservicestaskforce.org/uspstf/uspsdnch.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/>

Upcoming Events

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

Friday, June 27, 2014
1:00 PM -3:00 PM
1 Ashburton Place, 21st Floor
Boston, MA

Friday, July 25, 2014
1:00 PM -3:00 PM
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.