



## AFFORDABLE CARE ACT MASSACHUSETTS IMPLEMENTATION UPDATE

May 19, 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

**Center for Integrative Medicine in Primary Care Program**, \$5206. Announced May 12, 2014.

Applications are being accepted for the Center for Integrative Medicine in Primary Care (CIMPC) program. The purpose of the CIMPC is to incorporate a competency based Integrative Medicine (IM) curricula and practices into existing primary care residency and other health professions training programs. The CIMPC is expected to contribute to the evidence-base for IM, and to identify promising practices related to the integration of IM into primary care and interprofessional practice.

Eligible applicants include health professions schools, including an accredited school or program of public health, health administration, preventive medicine, or dental public health or a school providing health management programs, an academic health center, State or local government, or any other appropriate public or private nonprofit entity. All graduate medical education programs that apply must be accredited by the Accreditation Council on Graduate Medical Education (ACGME) or approved by the American Osteopathic Association (AOA). All public health programs must be accredited by the Council on Education for Public Health (CEPH). \$1,700,000 in funding is available for one award. Applications are due June 13, 2014.

The announcement may be viewed at: [HRSA](#)

**Reinvestment of Civil Money Penalties to Benefit Nursing Home Residents**, \$6111. Announced May 9, 2014. Funding is available through the Civil Money Penalties (CMP) collected from nursing homes

that don't meet the Medicare conditions of participation to support and further expand the National Partnership to Improve Dementia Care in Nursing Homes. The ACA established that 90 percent of the federal portion of CMP funds could be used to support activities that benefit nursing home residents, including projects that assure quality care within nursing homes. In March 2012, CMS launched the National Partnership to Improve Dementia Care in Nursing Homes to minimize the use of antipsychotic medications in individuals with dementia in the nursing home setting and to improve dementia care through the use of individualized, person-centered care approaches. The partnership promotes a systematic process to evaluate people and identify approaches that are most likely to benefit people living with dementia. Eligible applicants include organizations and associations that are authorized to administer grants in support of national and regional programs. \$500,000 in total for three awards is available. Applications are due June 26, 2014.

This announcement may be viewed at: [Grantsolutions.Gov](http://Grantsolutions.Gov)

**Frontier Community Health Integration Project Technical Assistance, Tracking and Analysis Program**, §3126. Announced May 8, 2014. Funding is available to provide technical and site implementation assistance, and other tracking and analytic activities to support providers who are participating in the Frontier Community Health Integration Project (FCHIP) demonstration. FCHIP helps identify potential new approaches to health care delivery, reimbursement and coordination in sparsely populated areas. Eligible applicants include federally recognized Indian Tribal organizations and governments, small businesses, private and nonprofit organizations, and city, town, county, and state governments. \$500,000 is available for one award. Applications are due June 19, 2014.

This funding announcement may be viewed at: [HRSA](http://HRSA)

## Grant Activity

**On May 12, 2014 DPH submitted a grant proposal to CDC for funding to implement the Tobacco Use Prevention - Public Health Approaches for Ensuring Quitline Capacity** under ACA §4002.

These funds are available to all state and territorial health departments to sustain and expand the capacity of a national smoking cessation helpline, known as the Quitline, so that all callers to the Quitline during a federal media campaign are offered at least one smoking cessation coaching call, either immediately upon calling or by being re-contacted within two to three days. The secondary purpose is to build the capacity of state tobacco control programs to implement evidence-based smoking cessation interventions in all 50 states.

Created through the CDC's first national tobacco education campaign (Tips From Smokers), the Quitline is a free telephone helpline (1-800-QUIT-NOW) which routes callers to their state quitlines, offering assistance and treatment for tobacco-related addiction and behavior issues. You can learn more about this program by visiting: <http://www.cdc.gov/tobacco/campaign/tips/about/campaign-overview.html>

Read the project abstract at: [Mass.gov](http://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

**5/12/14 OIG/HHS published a proposed rule "Medicare and State Health Care Programs: Fraud and Abuse; Revisions to the Office of Inspector General's Civil Monetary Penalty Rules".**

This proposed rule would amend the civil monetary penalty (CMP or penalty) rules of the Office of Inspector General (OIG) to incorporate new CMP authorities, including those under ACA sections 6402 and 6408, clarify existing authorities, and reorganize regulations on civil money penalties, assessments and exclusions to improve readability and clarity.

Comments are due on July 11, 2014.

Read the rule at: <http://www.gpo.gov/fdsys/pkg/FR-2014-05-12/pdf/2014-10394.pdf>

**4/30/14 HHS/CMS issued an ACA-related proposed rule called "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2015 Rates; Quality Reporting Requirements for Specific Providers; Reasonable Compensation Equivalents for Physician Services in Excluded Teaching Hospitals; Provider Administrative Appeals and Judicial Review; Enforcement Provisions for Organ Transplant Centers; and Electronic Health Record (EHR) Incentive Program."** The rule implements portions of the following ACA sections: 3001, 3004, 3005, 3008, 3021, 3025, 3106, 3123, 3124, 3133, 3141, 3313, 3401, 5503, 5504, 5506, 10309, 10312, 10313, 10319 and 10324.

The rule updates fiscal year (FY) 2015 Medicare payment policies and rates under the Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital Prospective Payment System (LTCH PPS). The rule, which applies to approximately 3,400 acute care hospitals and approximately 435 LTCHs, will generally be effective for discharges occurring on or after October 1, 2014. 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 and are meaningful electronic health record (EHR) users will be increased by 1.3%. Those that do not successfully participate in the Hospital IQR Program (and do not submit the required quality data) will receive a one-fourth reduction of the market basket update. Furthermore, any hospital that is not a meaningful EHR user will be reduced by one-quarter of the market basket update in 2015, with penalties growing over time.

Based on changes in the rule, Medicare payments to LTCHs in FY 2015 are projected to increase by approximately 0.8 percent as compared to FY 2014 Medicare payments. Total IPPS payments (capital and operating payments) are projected to decrease by \$241 million.

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 Hospital-Acquired Conditions Reduction Program, which will begin in FY 2015. The rule updates measures and financial incentives in the Hospital Value-Based Purchasing and Readmissions Reduction programs. Additionally, the rule makes several changes relating to direct graduate medical education and indirect medical education 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 that are participating in Medicare).

The ACA contains a hospital price transparency provision which requires that each hospital establish and develop a public a list of its standard charges for items and services. Under the proposed rule, HHS/CMS includes guidance to hospitals about this requirement.

The rule also 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) and implements certain statutory changes to the LTCH PPS under the ACA.

Comments are due June 30, 2014.

Read the rule (which was published in the Federal Register on May 15, 2014) at:

<http://www.gpo.gov/fdsys/pkg/FR-2014-05-15/pdf/2014-10067.pdf>

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

## News

**5/14/2014 The U.S. Preventive Services Task Force (USPSTF) issued a draft recommendation statement on Behavioral Counseling to Promote a Healthy Diet and Physical Activity for Cardiovascular Disease Prevention in Adults with Known Risk Factors.** The USPSTF recommends that overweight and obese adults who have additional cardiovascular disease (CVD) risk factors participate in intensive behavioral counseling interventions to promote a healthy diet and physical activity for CVD prevention. The USPSTF assigned a "B" rating to the recommendation, indicating that the Task Force recommends the service.

According to the USPSTF, CVD, primarily in the form of heart disease and stroke, is a leading cause of death in the United States. Adults who adhere to a healthy diet and physical activity have lower chances of cardiovascular death than those who do not. Furthermore, all individuals who follow healthy eating behaviors and increased physical activity will see benefits in their health.

The USPSTF's evidence review found that overweight or obese adults have an increased risk of CVD. Those adults who participate in intensive behavioral counseling had a moderate benefit on risk for CVD, including improvements in body mass index (BMI), blood pressure, lipids, fasting glucose, and levels of physical activity. The USPSTF found inadequate evidence that intensive behavioral counseling interventions lead to improvements in mortality or CVD rates.

However, none of the dietary intervention studies explicitly reported adverse events. Studies of physical activity interventions reported mostly minor adverse events, and intense physical activity was very rarely associated with cardiovascular events. The USPSTF found adequate evidence that the harms of behavioral counseling interventions are small to none.

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 recommendations are finalized with "B" ratings, then behavioral counseling to promote a healthy diet and physical activity for cardiovascular disease prevention in adults with known risk factors will be required to be covered without cost-sharing under the ACA.

Comments on the draft are due June 9, 2014 and can be submitted at:

<http://www.uspreventiveservicestaskforce.org/draftrec.htm>

Learn more about preventive services covered under the ACA at: [HHS.Gov](http://HHS.Gov)

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

**5/12/2014 Commonwealth Fund Report: ACA MLR Provision Has Yielded More Than \$3 Billion in Total Consumer Benefits.** The ACA has required health insurers to pay out a minimum percentage of premiums in the form of medical claims or quality improvement expenses-known as a medical loss ratio

(MLR). If an insurer uses 80 cents of every premium dollar to pay its customers' medical claims and carry out activities to improve the quality of care, it has a medical loss ratio of 80 percent. Insurers with MLRs below the minimum percentage must rebate the difference to consumers.

According to this report, in 2012 insurers paid consumers \$513 million in rebates, down nearly a half from the \$1 billion paid to consumers in 2011. These findings show that insurers are in better compliance with the MLR requirements set forth by the law. The report also finds that insurers reduced spending on brokers' fees, marketing and other administrative fees by \$1.4 billion in 2012 and that spending on improving the quality of care for patients did not change.

To find out more about the Commonwealth Fund and to read this report, please visit:  
[Commonwealthfund.org](http://Commonwealthfund.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](mailto:Donna.Kymalainen@umassmed.edu) to request accommodations

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

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