



AFFORDABLE CARE ACT MASSACHUSETTS IMPLEMENTATION UPDATE

May 11, 2015

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

Adult Medicaid Quality: Improving Maternal and Infant Health Outcomes in Medicaid and CHIP, \$2701.
Announced May 5, 2015.

Funding is available for state Medicaid agencies to support the CMS Center for Medicaid and CHIP Services (CMCS) Maternal and Infant Health Initiative: Improving the Health of Mothers and Infants in Medicaid and CHIP – Investing in the Future of Our Nation. CMCS is seeking to increase the rate and content of postpartum visits and also increase the rate of intended pregnancies through increased use of effective contraception. The data gathered through this project will be used to improve CMCS' understanding of the provision of contraceptive services in Medicaid and CHIP populations.

Eligible applicants are limited to state Medicaid Agencies. \$10,000,000 is available for twenty-five awards.

Voluntary Letters of Intent are due June 3, 2015.

Applications are due July 27, 2015.

View the announcement at: GRANTS.GOV

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

5/5/15 HHS/CMS issued a correction to the proposed rule called "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2016 Rates; Revisions of Quality Reporting Requirements for Specific Providers, including Changes Related to the Electronic Health Record Incentive Program." The correction makes technical changes to the [proposed rule](#) published in the Federal Register on April 30, 2015. The rule implements portions of the following ACA Sections: 1105, 3001, 3003, 3004, 3005, 3008, 3021, 3025, 3106, 3123, 3125, 3133, 3141, 3313, 3401, 10309, 10312, 10313, 10314, 10319 and 10324.

The proposed rule updates fiscal year 2016 Medicare payment policies and rates under the Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS). The proposed rule, which applies to approximately 3,400 acute care hospitals and approximately 435 LTCHs, will affect discharges occurring on or after October 1, 2015.

The IPPS pays hospitals for services provided to Medicare beneficiaries using a national base payment rate, adjusted for a number of factors that affect hospitals' costs, including the patient's condition and market conditions to the hospital's geographic area.

According to CMS, the proposed rule proposes policies that continue a commitment to increasingly shift Medicare payments from volume to value. The proposed rule includes policies that focus on paying providers based on quality rather than the quantity of care they give patients and support building a health care system that delivers better care, spends health care dollars more wisely and results in improved health outcomes for individuals.

Read the correction at: www.gpo.gov/fdsys/pkg/FR-2015-05-05/pdf/C1-2015-09245.pdf

5/1/15 HHS/CMS issued an interim rule with comment called "Medicare Program; Changes to the Requirements for Part D Prescribers." The rule implements portions of ACA §6405.

The rule revises requirements related to beneficiary access to drugs covered under Medicare Part D and makes changes to the [final rule](#) published on May 23, 2014 that requires prescribers of Part D drugs to enroll in or have validly opted out of Medicare.

Comments are due July 6, 2015.

Read the rule (which was published in the Federal Register on May 6) at: www.gpo.gov/fdsys/pkg/FR-2015-05-06/pdf/2015-10545.pdf

5/1/15 IRS/Treasury issued a correction and a correcting amendment to the final regulation called "Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for

Charitable Hospitals; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return. The correction and correcting amendment fix technical errors that appeared in the [final regulation](#) (which was published in the Federal Register on December 31, 2014).

The regulations provide guidance on the requirements for charitable hospital organizations added by ACA §9007. The regulations provide guidance on the requirements described in section 501(r) of the IRS Code, the entities that must meet these requirements, and the reporting obligations relating to these requirements under section 6033 of the IRS Code. In addition, the final regulations provide guidance on the consequences for failing to satisfy the section 501(r) requirements. The regulations apply to taxable years beginning one year after December 29, 2014.

ACA §9007 requires charitable hospitals (which are tax-exempt) to 1) limit the amounts charged to patients eligible for financial assistance so that the amount is generally not more than the amount billed to patients with Medicare or private insurance, 2) establish and broadly disclose their financial assistance policies so that the eligibility criteria and application method is clear to patients, 3) follow reasonable billing and collection requirements and 4) perform a community health needs assessment (CHNA) every three years and disclose steps the hospital is taking to address any identified needs.

Read the correction (which was published in the Federal Register on May 4, 2015) at: www.gpo.gov/fdsys/pkg/FR-2015-05-04/pdf/2015-10341.pdf

Read the correcting amendment (which was published in the Federal Register on May 4, 2015) at: www.gpo.gov/fdsys/pkg/FR-2015-05-04/pdf/2015-10340.pdf

5/1/15 HHS/CMS issued a notice under the Paperwork Reduction Act of 1995 (PRA) seeking comments on the revision of a currently approved information collection activity related to the Skilled Nursing Facility and Skilled Nursing Facility Health Care Complex Cost Report Form.

Under the Social Security Act, providers of services participating in the Medicare program are required to submit information (including adequate cost data and cost reports) on an annual basis in order to achieve settlement of costs for health care services rendered to Medicare beneficiaries. CMS uses the Form CMS-2540-10 cost report to determine a provider's reasonable cost incurred in furnishing medical services to Medicare beneficiaries and reimbursement due to or from a provider.

ACA §3132 made revisions to this form in accordance with the statutory requirement for hospice payment reform.

Comments are due June 30, 2015.

Read the notice at: www.gpo.gov/fdsys/pkg/FR-2015-05-01/pdf/2015-10208.pdf (see item #3)

4/30/15 HHS/CMS issued a proposed rule called "Medicare Program; FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements." The rule implements portions of ACA §3004, §3132 and §3401.

The proposed rule updates fiscal year 2016 Medicare payment rates and the wage index for hospices serving Medicare beneficiaries. According to CMS, the proposed hospice payment rule reflects the ongoing efforts by the agency to support beneficiary access to hospice care.

Comments are due June 23, 2015.

Read the rule (which was published in the Federal Register on May 5, 2015) at: www.gpo.gov/fdsys/pkg/FR-2015-05-05/pdf/2015-10422.pdf

4/24/15 HHS/CMS issued a proposed rule called "Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System – Update for Fiscal Year Beginning October 1, 2015 (FY 2016)." The rule implements portions of ACA §3401 and §10322.

The proposed rule outlines fiscal year 2016 Medicare payment policies and rates for the Inpatient Psychiatric

Facilities Prospective Payment System.

The proposed rule also updates the Inpatient Psychiatric Facility Quality Reporting Program, which requires participating facilities to report on quality measures or incur a reduction in their annual payment update. Additionally, the rule expands the measure sets in future fiscal years and changes certain data reporting requirements for these measures.

Comments are due June 23, 2015.

Read the rule (which was published in the Federal Register on May 1, 2015) at: www.gpo.gov/fdsys/pkg/FR-2015-05-01/pdf/2015-10208.pdf

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

News

5/6/15 The U.S. Preventive Services Task Force (USPSTF) issued draft recommendation statements on behavioral and pharmacotherapy interventions for tobacco smoking cessation in adults, including pregnant women.

Based on their findings, the USPSTF recommends that clinicians should ask all adults about tobacco use and provide FDA approved pharmacotherapy or behavioral interventions (alone or in combination) for cessation in adults who use tobacco. The Task Force assigned an "A" rating to this recommendation, indicating that the Task Force recommends the service.

The USPSTF recommends that clinicians ask all pregnant women about tobacco use and provide behavioral interventions for cessation in pregnant women who use tobacco. The Task Force assigned an "A" rating to this recommendation, indicating that the Task Force recommends the service.

The USPSTF's review also concluded that the current evidence is insufficient to assess the effectiveness of pharmacotherapy interventions for tobacco cessation in pregnant women and assigned an "I" rating to the recommendation. The "I" rating indicates that the Task Force does not recommend the service.

Separately, the USPSTF also concluded that there is insufficient evidence to recommend electronic nicotine delivery systems to adults for tobacco cessation. It is recommended that clinicians direct patients who smoke tobacco to other cessation interventions with established effectiveness and safety. As a result, the Task Force assigned an "I" rating to the recommendation.

Tobacco use is the leading preventable cause of disease, disability, and death in the United States. Cigarette smoking results in more than 480,000 premature deaths each year and accounts for approximately one in every five deaths. In pregnant women, smoking increases risk for prenatal complications such as miscarriage, stillbirth, and impaired lung function in childhood. An estimated 42.1 million U.S. adults currently smoke.

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 began on or after September 23, 2010. Only the tobacco cessation intervention recommendations that are finalized with an "A" rating will be required to be provided without cost sharing.

Comments are due June 1, 2015 and can be submitted at: uspreventiveservicestaskforce.org

Read the draft recommendation statement at: uspreventiveservicestaskforce.org

5/5/15 HHS announced that approximately \$101 million in Health Center New Access Point Grants was awarded to support 164 new health center sites across the country. The investments, authorized by ACA §10503, will increase access to comprehensive primary health care services in communities in 33 states and two U.S. territories. In total, these new health centers are projected to increase access to health care services for nearly 650,000 patients.

As community-based organizations, health centers are prepared to be responsive to the specific health care needs of their community. Health Center New Access Point Grants support the establishment of new service delivery sites and expand access to high quality health care. This investment will add to the more than 550 new health center sites that have opened as a result of the ACA. Currently, nearly 1,300 health centers operate more than 9,000 service delivery sites that provide care to nearly 22 million patients.

Health centers serve a crucial outreach function by providing individuals with the information and assistance they need to enroll in health insurance through the Health Insurance Exchange (Marketplace). Since 2013, health centers assisted more than 9 million individuals in their efforts to become insured.

In Massachusetts, \$704,167 was awarded to the Greater New Bedford Community Health Center, Inc., New Bedford to serve a proposed 3,150 new patients.

Read the full press release at: [here](#).

For a list of awardees by state, click [here](#).

5/4/15 HHS announced that the Pioneer ACO Payment Model saved more than \$384 million in two years, while advancing quality and value in health care.

Authorized by ACA §3022, the Pioneer ACO model was designed for health care organizations and providers already experienced in organizing care for patients across care settings. An independent evaluation report for CMS found that the model generated over \$384 million in savings to Medicare over its first two years, \$279.7 million in 2012 and \$104.5 million in 2013.

The Pioneer ACO Model, one of the first payment models launched by CMS, provides experienced health care organizations with accountability for quality and cost outcomes for their Medicare patients. Currently, the Pioneer ACO Model is serving more than 600,000 Medicare beneficiaries.

ACOs are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to the Medicare patients they serve to help ensure that patients, especially the chronically ill, get appropriate care, with the goal of avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds in both delivering high-quality care and spending health care dollars more efficiently, it will share in the savings it achieves for the Medicare program.

Since passage of the ACA, more than 360 Medicare ACOs have been established in 47 states, serving over 5.6 million Americans with Medicare.

To learn more about this announcement, visit: HHS.GOV

To read this report, visit: CMS.GOV

5/4/15 The Patient-Centered Outcomes Research Institute (PCORI) Board of Governors approved \$14 million in funding awards to determine the best aspirin dose to protect patients with heart disease.

Created under ACA §6301, PCORI is an independent nonprofit organization, tasked with conducting patient-centered outcomes and studies.

PCORI will fund a three year, \$14 million clinical trial at Duke University that is designed to determine the best dose

of aspirin to use to prevent heart attacks and strokes in people with heart disease. ADAPTABLE (Aspirin Dosing: A Patient-centric Trial Assessing Benefits and Long-term Effectiveness), will compare the benefits and harms of a low- and regular-strength daily dose of aspirin in patients diagnosed with heart disease.

The trial will be conducted in two stages, starting with a six-month protocol development and refinement phase. On the basis of a review of phase one activities, PCORI will decide whether the study will proceed to the implementation phase.

To learn more about this project, visit: PCORI.ORG

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Upcoming Events

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

Friday, May 29, 2015
1:00 PM - 3:00 PM
1 Ashburton Place, 21st Floor
Boston, MA

MBTA and driving directions to the Transportation Building are available here: www.mhd.state.ma.us/default.asp?pgid=dist/HQ_directions&sid=about.

MBTA and driving directions to 1 Ashburton Place are located here: www.sec.state.ma.us/secdir.htm.

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