



AFFORDABLE CARE ACT MASSACHUSETTS IMPLEMENTATION UPDATE

September 8, 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 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

9/1/15 HHS/CMS issued a correction to the proposed rule called "Medicare Program; End-Stage Renal Disease Prospective Payment System, and Quality Incentive Program." The document corrects technical errors in the [proposed rule](#) that was published in the Federal Register on July 1, 2015.

The proposed rule implements portions of ACA §317 and §3401. The proposed rule updates payment policies and rates under the End-Stage Renal Disease (ESRD) Prospective Payment System for renal dialysis services furnished to beneficiaries on or after January 1, 2016. The rule also proposes new quality and performance measures designed to improve the quality of care rendered by dialysis facilities treating patients with ESRD.

Read the correction (which was published in the Federal Register on September 2, 2015) at: www.gpo.gov/fdsys/pkg/FR-2015-09-02/pdf/2015-21783.pdf

8/31/15 IRS/Treasury issued a Supplemental notice of proposed rulemaking called "Minimum Value of Eligible Employer-Sponsored Health Plans."

According to the IRS, the document withdraws, in part, a [notice of proposed rulemaking](#) published on May 3, 2013, relating to the health insurance premium tax credit enacted by the Affordable Care Act (including guidance on determining whether health coverage under an eligible employer-sponsored plan provides minimum value) and replaces the withdrawn portion with new proposed regulations providing guidance on determining whether health

coverage under an eligible employer-sponsored plan provides minimum value. The proposed regulations affect participants in eligible employer-sponsored health plans and employers that sponsor these plans.

The May 2, 2013 proposed regulations called "Minimum Value of Eligible Employer-Sponsored Plans and Other Rules Regarding the Health Insurance Premium Tax Credit" provide guidance on the health insurance premium tax credit (§1401, §1411) and affect individuals who enroll in qualified health plans through Affordable Insurance Exchanges and claim the premium tax credit, as well as Exchanges that make qualified health plans available to individuals and employers. The proposed regulations also provide guidance on determining whether health coverage under an eligible employer-sponsored plan provides minimum value (MV) and affect employers that offer health coverage and their employees.

Beginning in 2014, eligible individuals who enroll in, or whose family member enrolls in, coverage under a qualified health plan (QHP) through an Affordable Insurance Exchange (Marketplace) may receive a premium tax credit under section 36B of the IRS Code. Under section 36B, an eligible employer-sponsored plan provides MV only if the plan's share of the total allowed costs of benefits provided under the plan is at least 60%. ACA §1302 provides that, in determining the percentage of the total allowed costs of benefits provided under a group health plan, the [regulations](#) promulgated by HHS under section 1302(d)(2), dealing with actuarial value, apply.

Comments are due November 2, 2015.

Read the notice (which was published in the Federal Register on September 1, 2015) at: www.gpo.gov/fdsys/pkg/FR-2015-09-01/pdf/2015-21427.pdf

8/27/15 HHS/CMS issued a notice under the Paperwork Reduction Act of 1995 (PRA) seeking comments and requesting emergency review of a revision of a currently approved information collection activity related to Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment.

The ACA set up three risk-mitigation programs to stabilize premiums in the individual insurance market and minimize the effects of adverse selection that may occur as insurance reforms and the Exchanges launch in 2014. These programs include transitional reinsurance (§1341), temporary risk corridors programs (§1342), and a permanent risk adjustment program (§1343). Under ACA §1342, issuers of qualified health plans (QHPs) must participate in a risk corridors program. A QHP issuer will pay risk corridors charges or be eligible to receive risk corridors payments or based on the ratio of the issuer's allowable costs to the target amount. A risk corridors data collection applies to QHP issuers the individual and small group markets. Each QHP issuer is required to submit an annual report to CMS concerning the issuer's allowable costs, allowable administrative costs, premium, and proportion of market premium in QHPs.

Based on the CMS's identification of more significant data discrepancies than previously anticipated, the agency is requesting an emergency revision to the risk corridors data validation information collection requirement. All companies with QHP issuers must complete a checklist (The MLR Risk Corridors Submission Checklist and the Risk Corridors Data Discrepancy Worksheet) to attest that their submission complied with critical guidelines for risk corridors and medical loss ratio (MLR) data submission.

Comments are due September 3, 2015.

Read the notice (which was published in the Federal Register on August 31, 2015) at: www.gpo.gov/fdsys/pkg/FR-2015-08-31/pdf/2015-21476.pdf

8/27/15 HHS/FDA issued a notice called "Nonproprietary Naming of Biological Products; Draft Guidance for Industry; Availability."

The draft guidance describes the agency's thinking on the need for biological products licensed under 42 U.S.C. 262(a) or 262(k), as added by the Biologics Price Competition and Innovation Act of 2009 (BPCI Act), to bear a nonproprietary name that includes an FDA-designated suffix. The BPCI Act was enacted as part of the ACA.

ACA §7001-7003 amended the Public Health Service Act to create an abbreviated licensure pathway for biological products that are demonstrated to be "biosimilar" to or "interchangeable" with an FDA-licensed biological product. This pathway is provided in the part of the BPCI Act. Under the BPCI Act, a biological product may be demonstrated to be "biosimilar" if data show that, among other things, the product is "highly similar" to an already-approved

biological product. A biosimilar product is a biological product that is approved based on a showing that it is highly similar to an FDA-approved biological product, known as a reference product, and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Only minor differences in clinically inactive components are allowable in biosimilar products.

Comments are due October 27, 2015.

Read the notice (which was published in the Federal Register on August 28, 2015) at: www.gpo.gov/fdsys/pkg/FR-2015-08-28/pdf/2015-21383.pdf

8/27/15 HHS/ Health Resources and Services Administration (HRSA) HRSA released a notice called "340B Drug Pricing Program Omnibus Guidance."

HRSA administers section 340B of the Public Health Service Act, which is referred to as the "340B Drug Pricing Program." The notice proposes guidance for covered entities enrolled in the 340B Program and drug manufacturers that are required by section 340B of the PHS Act to make their drugs available to covered entities under the 340B Program. When finalized after consideration of public comments solicited by this notice, the guidance is intended to assist 340B covered entities and drug manufacturers in complying with the statute.

The 340B Drug Pricing Program requires drug manufacturers to provide outpatient drugs to eligible health care organizations and covered entities at significantly reduced prices. The 340B drug discount program allows eligible entities such as certain hospitals, and federally qualified health centers and other specified federal grantee clinics to purchase covered outpatient drugs at discounts. ACA §7101 expanded the types of covered entities eligible to participate in the 340B Program. As of January 1, 2015, there were 11,530 registered covered entities participating in the 340B Program.

Comments are due October 27, 2015.

More information on the 340B Drug Pricing Program is available at: www.hrsa.gov/opa/

Read the notice (which was published in the Federal Register on August 28, 2015) at: www.gpo.gov/fdsys/pkg/FR-2015-08-28/pdf/2015-21246.pdf

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

News

9/2/15 CMS awarded \$67 million in ACA funding to help consumers sign up for affordable Health Insurance Marketplace coverage in 2016. Under ACA §1311(i), Exchanges are required to establish a Navigator grant program to provide consumers with health insurance plan enrollment assistance.

100 organizations located in 34 states, not including Massachusetts, are receiving grant awards to help support outreach efforts designed to connect people with local help as they seek to understand the coverage options and financial assistance available at HealthCare.gov. The three year-long Marketplace Navigator grants will fuel efforts to help consumers enroll in health plans that fit their budget and health needs.

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. §1311(d) and §1311(i) also direct all Exchanges to award grants to Navigators that provide unbiased information to consumers about health insurance, the Exchange, qualified health plans, and insurance affordability programs including premium tax credits, Medicaid and the Children's Health Insurance Program (CHIP). Navigator programs provide outreach and education efforts and assistance applying for health insurance coverage.

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

9/1/15 CMS announced the creation of the Value-Based Insurance Design (VBID) Model under ACA §3021. This model is designed to improve care and reduce costs in Medicare Advantage Plans.

VBID, which was developed by CMS and the Medicaid Innovation Center, will test the hypothesis that giving Medicare Advantage plans flexibility to offer targeted extra supplemental benefits or reduced cost sharing to enrollees who have specified chronic conditions can lead to higher-quality and more cost-efficient care. The agency believes this will help health plans and consumers have the tools they need to improve costs and spend dollars more wisely.

The VBID Model will begin January 1, 2017 and run for five years. CMS will test the model with eligible Medicare Advantage plans in the following seven states: Arizona, Indiana, Iowa, Massachusetts, Oregon, Pennsylvania, and Tennessee. The participating plans have not been selected yet. CMS will hold a webinar introducing this model on September 24, 2015.

The webinar registration and additional information can be found at: CMS.GOV

8/27/15 CMS announced a new funding opportunity designed to enhance the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents. The Initiative is authorized under ACA §3021.

Funding will be awarded to organizations currently participating in the Initiative to test whether a new payment model for nursing facilities and practitioners will further reduce avoidable hospitalizations, lower combined Medicare and Medicaid spending, and improve the quality of care received by nursing facility residents.

The intent of this payment model is to reduce avoidable hospitalizations by funding higher-intensity interventions in nursing facilities for residents who may otherwise be hospitalized upon an acute change in condition. Improving the capacity of nursing facilities to treat medical conditions as effectively as possible within the facility has the potential to improve the residents' care experience at lower cost than a hospital admission. The model also includes payments to practitioners (i.e., physicians, nurse practitioners and physician assistants) similar to the payments they would receive for treating beneficiaries in a hospital. Practitioners would also receive new payments for engagement in multidisciplinary care planning activities.

The participating sites include the following organizations: Alabama Quality Assurance Foundation – Alabama; Alegen Health – Nebraska HealthInsight of Nevada – Nevada; Indiana University – Indiana; The Curators of the University of Missouri – Missouri; The Greater New York Hospital Foundation, Inc. – New York City and UPMC Community Provider Services – Pennsylvania.

The new four year payment phase of the initiative is slated run from October 2016 to October 2020.

For more information about this initiative, visit: CMS.GOV

Upcoming Events

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

Friday, September 11, 2015, 1:00 PM-3:00 PM
1 Ashburton Place, 21st Floor
Boston, MA

We welcome attendance at all meetings from all stakeholders and members of the public with an interest in One Care. 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.

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.



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