



AFFORDABLE CARE ACT MASSACHUSETTS IMPLEMENTATION UPDATE

February 8, 2016

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

2/2/16 The Patient Centered Outcomes Research Institute, (PCORI), announced five grant opportunities. Created under ACA §6301, PCORI is an independent nonprofit organization, tasked with conducting patient-centered outcomes research and studies.

PCORI supports research that will provide reliable, useful information to help people make informed healthcare decisions and improve healthcare delivery and outcomes.

For all five opportunities, mandatory Letters of Intent (LOI) are due March 2, 2016 and applications are due June 6, 2016. The online application system used to apply for the opportunities is currently open.

For more information about PCORI, visit [PCORI](#)

For more information about PCORI funding opportunities, visit: www.pcori.org/funding-opportunities.

Improving Methods for Conducting Patient-Centered Outcomes Research - Cycle 1 2016: Funding is available to address gaps in research relevant to conducting Patient-Centered Outcomes Research (PCOR). These findings will be used in future PCORI Methodology Reports that are used to help clinicians and patients make informed care decisions. Eligible applicants include: private or public research organizations; nonprofit or for-profit organizations; university or college hospitals or healthcare systems; or local, state, or federal government agencies. \$12 million in funding is available for studies.

An announcement for this opportunity can be found at: PCORI.ORG

Communication and Dissemination Research - Cycle 1 2016: Funding is available for projects that address critical knowledge gaps in the communication and dissemination process of research results to patients, their caregivers, and clinicians. Eligible applicants include: private or public research organizations;

nonprofit or for-profit organizations; university or college hospitals or healthcare systems; or local, state, or federal government agencies. \$8 million in funding is available for studies.

An announcement for this opportunity can be found at: PCORI.ORG

Improving Healthcare Systems - Cycle 1 2016: Funding is available to study the comparative effectiveness of alternate features of healthcare systems (e.g., innovative technologies, incentive structures, service designs) intended to optimize the quality, outcomes, and/or efficiency of care for the patients they serve and that have the most potential for sustained impact and replication within and across healthcare systems. Healthcare systems encompass multiple levels (e.g., national, state and local health environments, organization and/or practice settings, family and social supports, and the individual patient) and include entities organized to deliver, arrange, purchase, and/or coordinate healthcare services.

Eligible applicants include any private or public sector research organization, nonprofit or for-profit organization, university or college hospital or healthcare system, laboratory or manufacturer, or unit of local, state, or federal government. \$16 million in funding is available for studies.

An announcement for this opportunity may be viewed at: PCORI.ORG

Assessment of Prevention, Diagnosis, and Treatment Options - Cycle 1 2016: Funding is available to conduct comparative effectiveness research (CER) designed to provide information that would inform critical decisions that face patients and caregivers, clinicians, policymakers, and healthcare system leaders. The premise of this research is that any new findings will inform and improve the critical choices made by patients and stakeholders in health care. This knowledge is intended to provide insight about the comparative benefits and harms of the options and provide information about outcomes that are important to patients.

Eligible applicants include any private or public sector research organization, nonprofit or for-profit organization, university or college hospital or healthcare system, laboratory or manufacturer, or unit of local, state, or federal government. \$32 million in funding is available for studies.

An announcement for this opportunity may be viewed at: PCORI.ORG

Addressing Disparities - Cycle 1 2016: Funding is available to conduct CER studies that evaluate and compare new and/or enhanced interventions to reduce or eliminate disparities in health and healthcare. Studies in this program should focus on overcoming barriers that may disproportionately affect the outcomes of specific groups of patients, or identify best practices for sharing results and information about patient-centered research across patient groups.

Eligible applicants include any private or public sector research organization, nonprofit or for-profit organization, university or college hospital or healthcare system, laboratory or manufacturer, or unit of local, state, or federal government. \$8 million in funding is available for studies.

An announcement for this opportunity may be viewed at: PCORI.ORG

Building Capacity of the Public Health System to Improve Population Health through National, Nonprofit Organizations, \$4002. Announced January 26, 2016.

Continued funds are available to national nonprofit organizations to provide capacity building assistance, working toward sustaining and improving the performance of the public health system, with a priority on state, tribal, local, and territorial health departments. Capacity-building assistance refers to methods for sharing knowledge, developing skills and creating institutional systems and capacity. Funded organizations will provide assistance such as improving public health and organizational systems, developing and maintaining public health partnerships and improving public health practice and services.

Eligible applicants are limited to organizations previously awarded funding under this opportunity. There are fifty awards available.

Applications are due March 30, 2016.

To see a list of previous awardees, visit: CDC.GOV

The announcement may be viewed 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

2/1/16 CMS/HHS issued a notice called "Medicaid Program; Final FY 2013 and Preliminary FY 2015 Disproportionate Share Hospital Allotments, and Final FY 2013 and Preliminary FY 2015 Institutions for Mental Diseases Disproportionate Share Hospital Limits."

The notice announces each state's final federal share disproportionate share hospital (DSH) allotments for federal fiscal year (FY) 2013 and the preliminary federal share DSH allotments for FY 2015. The notice also announces the final FY 2013 and the preliminary FY 2015 limitations on aggregate DSH payments that states may make to institutions for mental disease (IMD) and other mental health facilities. In addition, this notice includes background information describing the methodology for determining these DSH allotments.

Currently, states make Medicaid DSH payments to hospitals that serve a disproportionate share of low income patients and have high levels of uncompensated care costs. At the same time as the ACA expands coverage that reduces levels of uncompensated care, it also reforms Medicaid DSH allotments to reflect anticipated changes in coverage. This notice describes that the DSH allotments and IMD DSH limits were calculated without ACA reductions due to a Congressional delay of those reductions.

Please note that Massachusetts has a longstanding federal waiver of DSH requirements, and instead, makes uncompensated care payments pursuant to its 1115 waiver. Massachusetts' DSH allotments finance the uncompensated care payments made under its 1115 waiver.

Read the notice (which was published in the Federal Register on February 2, 2016) at: <https://www.gpo.gov/fdsys/pkg/FR-2016-02-02/pdf/2016-01836.pdf>

1/29/16 IRS/Treasury issued Notice 2016-14, "Health Insurance Providers Fee; Procedural and Administrative Guidance," which provides guidance for fee year 2016 on how the definition of expatriate health plans under the Expatriate Health Coverage Clarification Act of 2014 (EHCCA) applies to the annual fee on health insurance providers required by ACA §9010. The notice provides that, solely for the 2016 fee year, the definition of expatriate health plan will be the same as provided in the U.S. Department of Health and Human Services medical loss ratio (MLR, a required percentage of premium dollars that insurance companies are required to spend on medical care and quality improvement activities) final rule [definition](#).

The ACA created the annual fee on certain health insurance providers which began in 2014. The Health Insurance Providers Fee [final rule](#) (which was published in the Federal Register on November 29, 2013) provides guidance on the annual fee imposed on covered health insurance plans engaged in the business of providing insurance for United States health risks under ACA §9010. The ACA defines a United States health risk to include the health risk of a U.S. citizen or a resident non-citizen.

The Expatriate Health Coverage Clarification Act of 2014 (EHCCA), exempts health plans directed at and used by expatriates from certain ACA requirements. Expatriate health plans are insured group health plans for individuals who reside outside of their home country for at least six months of the plan year and any covered dependent.

Additional information about the Health Insurance Providers Fee can be found at: <https://www.irs.gov/Businesses/Corporations/Affordable-Care-Act-Provision-9010>

Read Notice 2016-14 at: <https://www.irs.gov/pub/irs-drop/n-16-14.pdf>

1/29/16 CMS/HHS issued a proposed rule called “Medicare Program: Expanding Uses of Medicare Data by Qualified Entities.” The proposed rule implements new statutory requirements that would expand access to analyses and data under the qualified entity program.

According to CMS, the program will help providers, employers, and others make more informed decisions about care delivery. The new rules will allow organizations approved as qualified entities to confidentially share or sell analyses of Medicare and private sector claims data to providers, employers, and other groups who can use the data to support improved care. In addition, qualified entities will be allowed to provide or sell claims data to providers. The rule includes strict privacy and security requirements for all entities receiving Medicare analyses or data, as well as new annual reporting requirements.

The qualified entity program was authorized by ACA §10332 and allows organizations that meet certain qualifications to access to patient-protected Medicare data to produce public reports. Qualified entities must combine the Medicare data with other claims data (for example, private payer data) to produce quality reports that are representative of how providers and suppliers are performing across multiple payers, such as Medicare, Medicaid, or various commercial payers.

Comments are due March 29, 2016.

Read the proposed rule (which was published in the Federal Register on February 2, 2016) at: <https://www.gpo.gov/fdsys/pkg/FR-2016-02-02/pdf/2016-01790.pdf>

1/28/16 CMS/HHS issued a proposed rule called “Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations--Revised Benchmark Rebasing Methodology, Facilitating Transition to Performance-Based Risk, and Administrative Finality of Financial Calculations.” The proposed rule addresses changes to the Medicare Shared Savings Program (Shared Savings Program, ACA §3022), including provisions relating to the payment of Accountable Care Organizations (ACOs) participating in the Shared Savings Program. Under the Medicare Shared Savings Program, providers of services and suppliers that participate in an ACO continue to receive traditional Medicare fee-for-service (FFS) payments under Parts A and B, but the ACO may be eligible to receive a shared savings payment if it meets specified quality and savings requirements.

The proposed rule expands upon issues discussed in the Shared Savings Program [final rule](#) (which was published in the Federal Register on June 9, 2015). According to CMS, the proposed rule addresses changes to the Shared Savings Program that would modify the program’s benchmark rebasing methodology to encourage ACOs’ continued investment in care coordination and quality improvement, and identifies publicly available data to support modeling and analysis of these proposed changes. In addition, it would streamline the methodology used to adjust an ACO’s historical benchmark for changes in its ACO participant composition, offer an alternative participation option to encourage ACOs to enter performance-based risk arrangements earlier in their participation under the program, and establish policies for reopening of payment determinations to make corrections after financial calculations have been performed and ACO shared savings and shared losses for a performance year have been determined.

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. Coordinated care helps ensure that patients, especially the chronically ill, get the right care at the right time, with the goal of avoiding unnecessary duplication of services and preventing medical errors. According to CMS, 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.

Comments are due March 28, 2016.

Learn more about the Shared Savings Program at: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html?redirect=/sharedsavingsprogram/

Read the rule (which was published in the Federal Register on February 3, 2016) at: <https://www.gpo.gov/fdsys/pkg/FR-2016-02-03/pdf/2016-01748.pdf>

1/27/16 HHS/CMS issued the final rule “Medicaid Program; Face-to-Face Requirements for Home Health Services; Policy Changes and Clarifications Related to Home Health.” The final rule revises the Medicaid home health service definition consistent with ACA §6407 and section 504 of the Medicare Access and CHIP

Reauthorization Act of 2015 to strengthen the provision and integrity of home health services.

The final rule requires physicians to document face-to-face encounters with the Medicaid beneficiary for the authorization of home health services within certain timeframes. In addition, for medical supplies, equipment, and appliances, physicians (or certain authorized non-physician practitioners) must document the occurrence of a face-to-face encounter with the Medicaid eligible beneficiary within reasonable timeframes. In addition, the final rule clarifies that Medicaid home health services are not limited to home settings, and makes further changes to the requirements for coverage of medical supplies, equipment, and appliances under the home health benefit.

According to CMS, the rule aligns with Medicare requirements to the extent possible in order to help to streamline beneficiaries' access to needed items and maximize consistency in service delivery, as well as reduce administrative burden on the provider community.

Read the rule (which was published in the Federal Register on February 2, 2016): <https://www.gpo.gov/fdsys/pkg/FR-2016-02-02/pdf/2016-01585.pdf>

1/21/16 HHS/CMS issued a final rule with comment period called "Medicaid Program; Covered Outpatient Drugs." The final rule addresses key areas of Medicaid drug reimbursement policy for covered outpatient drugs (CODs) as well as the changes made to the Medicaid Drug Rebate program by the ACA. The [Medicaid Drug Rebate Program](#) is a program that includes CMS, state Medicaid agencies, and participating drug manufacturers that helps to offset the Federal and state costs of most outpatient prescription drugs dispensed to Medicaid patients.

The final rule implements changes to section 1927 of the Social Security Act made by §2501, §2503, and §3301(d)(2) of the Patient Protection and Affordable Care Act of 2010 and §1101(c) and §1206 of the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the ACA). According to CMS, the final rule assists states and the federal government in managing drug costs, establishes the long term framework for implementation of the Medicaid drug rebate program, and creates a more fair reimbursement system for Medicaid programs and pharmacies.

As described in the final rule, changes to rebate percentages outlined in the ACA have resulted in increased Medicaid rebates being paid to the federal and state government by manufacturers of CODs, including higher cost brand name drugs. The final rule provides for added steps to ensure that the federal and state government will save money in managing Medicaid drug costs, including the following: 1) creates a regulatory definition for Average Manufacturer Price (AMP), a key concept underlying the Medicaid Drug Rebate Program, which is the agency's key metric both for the determination of manufacturer rebates as well as pharmacy reimbursement for certain generic drugs that are subject to the Federal Upper Limit (FUL); 2) updates the FUL formula for the payment of certain generic drugs, which creates an incentive for pharmacies to utilize generic drugs because pharmacy costs for these drugs will be regularly updated; and 3) implements the ACA provision that extended rebates to CODs provided to beneficiaries enrolled in Medicaid managed care organizations.

According to CMS, the final rule also: 1) clarifies many of the changes made to the Medicaid Drug Rebate Program by the ACA and provides drug manufacturers with the regulatory guidance necessary to ensure proper calculation and reporting of drug product and pricing information and 2) ensures that pharmacy reimbursement is aligned with the acquisition cost of drugs and that the states pay an appropriate professional dispensing fee.

The agency has not finalized all aspects on the definition of line extension drugs (new formulations of a drug, such as extended release formulations) and is seeking additional comments on that topic.

The final rule is effective on April 1, 2016 and state Medicaid agencies are required to comply with the rule by submitting a State Plan Amendment by June 30, 2017 to be effective no later than April 1, 2017.

Comments are due April 1, 2016.

For more information, including summaries of key provisions of the final rule, visit the Covered Outpatient Drugs Policy, at: <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/prescription-drugs/covered-outpatient-drugs-policy.html>

Read the rule (which was published in the Federal Register on February 1, 2016) at: <https://www.gpo.gov/fdsys>

</pkg/FR-2016-02-01/pdf/2016-01274.pdf>

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

News

2/1/16 The Medicaid and CHIP Payment and Access Commission (MACPAC) issued a report, "Report to Congress on Medicaid Disproportionate Share Hospital Payments."

The Protecting Access to Medicare Act of 2014 required MACPAC to produce annual reports on Medicaid disproportionate share hospital (DSH) payments, specifically to analyze how state allotments relate to three factors: 1) changes in the number of uninsured individuals, 2) amounts and sources of hospitals' uncompensated care costs, and 3) the number of hospitals with high levels of uncompensated care that also provide access to essential community services for low-income, uninsured, and vulnerable populations.

MACPAC was established by the Children's Health Insurance Program Reauthorization Act and later expanded and funded through ACA §2801 and §10607. The commission consists of experts, government officials, executives and medical professionals. MACPAC is tasked with reviewing state and federal Medicaid and CHIP access and payment policies and making recommendations to Congress, the HHS Secretary, and the states on a wide range of issues affecting Medicaid and CHIP populations, including the implementation of health care reform.

Read the DSH report at: <https://www.macpac.gov/wp-content/uploads/2016/01/Report-to-Congress-on-Medicaid-Disproportionate-Share-Hospital-Payments.pdf>

1/28/16- 1/29/16 The Medicaid and CHIP Payment and Access Commission (MACPAC) held a public meeting in Washington, D.C. The meeting kicked off with a preview of draft material about children's coverage and affordability considerations from the Commission's March report to Congress. Topics covered in the report include: sources of coverage for children if the Children's Health Insurance Program (CHIP) funding expires; affordability of Exchange coverage for children currently covered by CHIP; comparing CHIP benefits to other sources of coverage and network adequacy and the future of CHIP.

Presentations were given on the following topics - design considerations for the future of children's coverage: focus on affordability; affordability for children in separate CHIP versus employer-sponsored insurance; MACPAC's work on children's coverage and next steps; functional assessments for long-term services and supports; providers serving Medicaid patients; a historical review of proposals to reform Medicaid; addressing growth in federal Medicaid spending; selected financing alternatives; and the Medicaid outpatient drug rule.

View the meeting agenda at: <https://www.macpac.gov/wp-content/uploads/2015/05/Jan2016-Agenda-Revised.pdf>

View the meeting materials at: <https://www.macpac.gov/wp-content/uploads/2016/01/January-2016-Meeting-Materials.pdf>

Upcoming Events

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

Implementation Council Meeting
February 12, 2016
1:00 PM - 3:00 PM
1 Ashburton Place, 21st Floor
Boston, MA

Implementation Council Meeting
March 18, 2016
1:00 PM - 3:00 PM

Health Policy Commission, 50 Milk Street, 8th Floor Public Meeting Room
Boston, MA

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

MBTA and driving directions to 50 Milk Street are available here: <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/directions-to-50-milk-st.pdf>

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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