AFFORDABLE CARE ACT
MASSACHUSETTS IMPLEMENTATION UPDATE

March 02, 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

Partnerships—Building Capacity of the Public Health System to Improve Population Health through National, Nonprofit Organizations—financed in part by 2013 Prevention and Public Health Funds, §4002. Announced February 23, 2015.

Funding is available to strengthen the infrastructure and improve the performance of the public health system through the provision of capacity-building assistance (CBA). The purpose of this program is to ensure the provision of CBA to optimize the quality and performance of public health systems, the public health workforce, public health data and information systems, public health practice and services, public health partnerships, and public health resources.

Eligible applicants are limited to national nonprofit 501(c)(3) and nonprofit (c)(6) IRS status other than institutions of higher education. $70,000,000 in total is available for 50 awards.

Applications are due March 24, 2015.

This announcement may be viewed at: GRANTS.GOV

Grant Activity

On February 19, 2015, DPH was awarded $1,439,443 by HHS for the Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program, under ACA §2951. The funding will allow states to continue to expand voluntary, evidence-based home visiting services to women during pregnancy and to parents with young children.

Massachusetts will use the funds to address service gaps and improve maternal and early childhood health and development. Specifically, the Massachusetts Maternal, Infant, and Early Childhood Home Visiting (MA MIECHV) program will serve high-need populations including immigrants, homeless and impoverished families, teens, and families impacted by substance use, mental health issues, and domestic violence.

In total, HHS awarded $386 million in funding to all 50 states, including Massachusetts for the National MIECHV program. The National MIECHV program facilitates collaboration and partnership at the federal, state, and community levels to improve health and development outcomes for at-risk children using evidence-based home visiting programs. Funds were awarded to states currently funded under the MIECHV program.

To learn more about the MIECHV program please visit: HRSA.GOV

View the MIECHV grant abstract at: www.mass.gov/eohhs/docs/eohhs/healthcare-reform/grants/150219-sec-2951-early-childhood-home-visiting-initiative.pdf

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

2/24/15 CMS issued a notice under the Paperwork Reduction Act of 1995 (PRA) seeking comments on the extension of a currently approved information collection activity related to the ACA's Summary of Benefits and Coverage (SBC) and Uniform Glossary. ACA §10101(b) requires that group health plans and health insurance carriers in the group and individual markets provide an SBC that concisely and accurately describes the benefits and coverage available under the applicable plan or coverage.

According to CMS, in order to implement the disclosure requirements in the SBC rules, the collection of information request relates to the provision of the following: summary of benefits and coverage, which includes coverage examples; a uniform glossary of health coverage and medical terms; and a notice of modifications.

Comments are due March 26, 2015.

Read the notice at: www.gpo.gov/fdsys/pkg/FR-2015-02-24/pdf/2015-03650.pdf

2/24/15 HHS/CMS issued a correction to a final rule called "Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Physician-Owned Hospitals: Data Sources for Expansion Exception; Physician Certification of Inpatient Hospital Services; Medicare Advantage Organizations and Part D Sponsors: CMS-Identified Overpayments Associated with Submitted Payment Data." The correction fixes technical errors that appeared in the final rule (which was published in the Federal Register on November 10, 2014).

The rule implements portions of the following ACA sections: 3138, 3401, 4104, 10319 and 10324. The rule updates the Medicare hospital outpatient prospective payment system (OPPS) and the Medicare ambulatory surgical center payment system for CY 2015. According to CMS, the rule implements changes to move from a hospital OPPS and fee schedule to a complete PPS. Under the policy, CMS will make a single payment for all related or adjunctive hospital services provided to a patient in the furnishing of certain primary procedures. The rule also establishes changes to quality reporting programs, partial hospitalization program rates and the overpayment recovery and appeals process for Medicare Part C and Part D.

Read the correction at: www.gpo.gov/fdsys/pkg/FR-2015-02-24/pdf/2015-03760.pdf

2/23/15 IRS/Treasury issued Notice 2015-16, Excise Tax on High Cost Employer-Sponsored Health Coverage. According to the agency, the notice provides guidance concerning potential approaches to be incorporated into future proposed regulations regarding the excise tax on high cost employer-sponsored health coverage under on section 4980I of the IRS Code.

Section 4980I, which was added to the IRS Code by ACA §9001, applies to taxable years beginning after December 31, 2017. Under this provision, if the aggregate cost of applicable employer-sponsored coverage provided to an employee exceeds a statutory dollar limit, which is revised annually, the excess is subject to a 40% excise tax.

Comments are due May 15, 2015.

Read Notice 2015-16 at: www.irs.gov/pub/irs-drop/n-15-16.pdf

2/23/15 IRS/Treasury issued temporary regulations called Health Insurance Providers Fee, that provide rules for the definition of a covered entity for the 2015 fee year and each subsequent fee year for purposes of the fee imposed by ACA §9010. The ACA created an annual fee on certain health insurance providers beginning 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. On August 12, 2014, IRS/Treasury issued Notice 2014-47 clarifying the scope of the term "covered entity" and the fact that reporting is not required in 2014 for an entity that would not qualify as a covered entity, even if it is a member of a controlled group that is a covered entity.

Beginning in 2014, each health insurance plan with aggregate net premiums exceeding over $25 million is liable for the annual fee due by September 30th of each fee year. The annual fee for each entity is determined by the ratio of the plan's net premiums for the previous calendar year and the aggregate net premiums of all qualified health insurance plans for the previous calendar year. Health plans that have net premiums that exceed $25 million but are less than $50 million will have 50% of their net premiums taken into account for this calculation. Entities with net premiums over $50 million will have 100% of their net premiums taken into account for this calculation. The regulation establishes the aggregated annual fee for all entities at $8 billion for 2014, $11.3 billion for 2015 and 2016, $13.9 billion for year 2017, and $14.3 billion for 2018. The regulation also lists exemptions from the fee which include self-insured employers, government entities and certain nonprofit corporations.

Comments and requests for a public hearing are due May 27, 2015.

For additional information on the Health Insurance Providers Fee, visit the IRS at: www.irs.gov/Businesses/Corporations/Affordable-Care-Act-Provision-9010

Read the temporary regulations (which were published in the Federal Register on February 26, 2015) at: www.gpo.gov/fdsys/pkg/FR-2015-02-26/pdf/2015-03945.pdf and www.gpo.gov/fdsys/pkg/FR-2015-02-26/pdf/2015-03944.pdf

2/20/15 The US Office of Personnel Management (OPM) issued a final rule called "Patient Protection and Affordable Care Act; Establishment of the Multi-State Plan Program for the Affordable Insurance Exchanges."

The final rule implements modifications to the Multi-State Plan (MSP) Program based on the experience of the MSP Program to date. OPM established the MSP Program pursuant to ACA §1334. The final rule clarifies the approach used to enforce the applicable standards of the ACA with respect to health insurance issuers that contract with OPM to offer MSP options. The final rule also amends MSP standards related to coverage area, benefits, and certain contracting provisions under §1334 and also makes non-substantive technical changes.

Read the final rule (which was published in the Federal Register on February 24, 2015) at: www.gpo.gov/fdsys/pkg/FR-2015-02-24/pdf/2015-03421.pdf

2/19/15 CMS/HHS issued a rule called "Basic Health Plan; Federal Funding Methodology for Program Year 2016."

The rule provides the methodology and data sources necessary to determine federal payment amounts made in program year 2016 to states that elect to establish a Basic Health Plan (BHP) under the ACA to offer health benefits coverage to low-income individuals otherwise eligible to purchase coverage through Affordable Insurance Exchanges.

The BHP program, as authorized by §1331 and subsequent guidance, provides states the option to establish a health benefits coverage program for low-income individuals who would otherwise be eligible to purchase coverage through the Health Insurance Exchange. Under the BHP rules, citizens or lawfully present non-citizens who do not qualify for Medicaid, the Children's Health Insurance Program (CHIP) or other minimum essential coverage and have incomes between 133% FPL and 200% FPL are eligible for the BHP.

The BHP is federally funded by determining the amount of payments that the federal government would have made through the premium tax credit and cost sharing reductions (CSR) for individuals enrolled in BHP had they instead been enrolled in an Exchange. To calculate the amounts for each state, HHS/CMS is asking states for "reference premiums" for the second lowest cost silver plans in each geographic area in a state, as those amounts are a basic unit in the calculation of tax credits and CSRs under the Exchanges. Furthermore, reference premiums are critical components of the BHP payment methodology. According to HHS/CMS, the agency has the required data to

establish reference premiums for states with Exchanges that are operated by the Federally Facilitated Exchange (FFE) or are operated in partnership with the FFE, although the agency is seeking such information from the 17 states that are operating State Based Exchanges.

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).

Beginning January 1, 2015, states have an option to establish a BHP for certain individuals who meet the income criteria and would otherwise be eligible to obtain coverage through the Exchange. BHP benefits are required to include at least the ten essential health benefits specified in §1301. BHP monthly premiums and cost sharing cannot exceed what an eligible individual would have paid if the eligible individual were to receive coverage from a QHP through the Exchange. A state that operates a BHP will receive federal funding equal to 95% of the amount of the premium tax credits and the cost sharing reductions that would have otherwise been provided to (or on behalf of) eligible individuals if these individuals enrolled in QHPs through the Exchange.

Read the rule (which was published in the Federal Register on February 24, 2015) at: www.gpo.gov/fdsys/pkg/FR-2015-02-24/pdf/2015-03662.pdf

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

News

2/24/15 The Patient Centered Outcomes Research Institute (PCORI) awarded $64.1 million in funding to support five pragmatic clinical studies in four different states.

Funds will be used for five large patient-centered comparative effectiveness research (CER) studies that aim to answer critical clinical questions about care for cancer, back pain, and stroke. The awards are the first made as part of PCORI's Pragmatic Clinical Studies Initiative. This initiative is an effort to produce results that are broadly applicable to a greater variety of patients and care situations and can be more quickly taken up in routine clinical practice than previously funded initiatives.

The awards range from $7.75 million to $14.5 million each, and will be used for studies being conducted in Washington, California, North Carolina and Pennsylvania. Each of the studies will engage key patient and stakeholder groups, such as national advocacy organizations, major professional societies and associations, and payers, in their research design and implementation.

The Patient Centered Outcomes Research Institute (PCORI), created under ACA §6301, is an independent nonprofit organization, tasked with conducting patient-centered outcomes research and studies.

To learn more about these awards, visit: PCORI.ORG

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2/13/2015 The CMS Innovation Center issued a Request for Information (RFI) on Advance Primary Care Model Concepts.CMS is seeking input on initiatives to test innovations in advanced primary care, particularly mechanisms to encourage more comprehensiveness in primary care delivery.

Advanced primary care is based on principles of the Patient Centered Medical Home and builds on the care delivery models employed in other CMS model tests, including the Comprehensive Primary Care initiative. According to CMS, the information will help improve the care of patients with complex needs, facilitate robust connections to the medical neighborhood and community-based services and to move payment from encounter-based towards value-driven, population-based care.

The CMS Innovation Center, authorized under ACA §3021, is tasked with testing new health care payment and service delivery models that enhance the quality of Medicaid, Medicare and the Children's Health Insurance Program while also lowering program costs.

Comments are due March 16, 2015.

Learn more about the RFI at: CMS.GOV

Upcoming Events

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

Friday, March 13, 2015, 1:00 pm-3:00 pm
State Transportation Building
10 Park Plaza, Conference Rooms 2 & 3
Boston, MA

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

Friday, March 20, 2015, 2:00 pm-4:00 pm
State Transportation Building
10 Park Plaza, Conference Rooms 1-3
Boston, MA

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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