AFFORDABLE CARE ACT
MASSACHUSETTS IMPLEMENTATION UPDATE

February 11, 2013

Quick Links

MA-ACA Website

Join Our Mailing List

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

Health Center Controlled Networks (HCCNs), §10503. Announced February 6, 2013. Funding is available for existing HCCNs to facilitate the adoption, implementation and meaningful use of Health Information Technology. Eligible applicants must be 1) a non-profit organization, 2) a practice management network (i.e. HCCN) or certain Federally Qualified Health Centers, and 3) provide evidence of commitment to achieving the goals of the program. Under this initiative, applicants must effectively implement Electronic Health Record technology within the HCCN. In addition, applicants must propose making necessary technical upgrades and workflow changes to meet meaningful use requirements, and advance quality improvement. $2M in 4 awards is available.

Applications are due April 3, 2013.

The announcement can be viewed at: HRSA

Guidance

2/6/13 CMS issued a set of frequently asked questions (FAQs) which provides guidance to states on ACA implementation in several key areas including the Basic Health Program (BHP), the new increased federal medical assistance percentages (FMAPs) and how

states qualify, modified adjusted gross income (MAGI) issues, and the coverage of pregnant women and children.

Beginning January 1, 2014, ACA §2001 requires states to expand their Medicaid programs to individuals under 65 years of age with incomes at or below 133% FPL. (However, on June 28, 2012 the Supreme Court ruled that the Medicaid expansion was optional for states and that the HHS Secretary could not withdraw federal funding from non-expanding states' pre-existing Medicaid programs). 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 Americans will be eligible for premium tax credits (§1401, §1411) to make purchasing a health plan more affordable by reducing out-of-pocket premium costs. ACA §1331 authorizes a state to provide coverage to QHP-eligible individuals through the **BHP** for individuals between 134% and 200% (and lawfully present immigrants between 0% and 200%) of the Federal Poverty Level.

§2001 provides that states will receive an increased FMAP for all newly eligible individuals, defined as those who would not have been eligible in the state in December 2009. The FMAP for these newly eligible individuals will be 100% for calendar years 2014-2016, gradually declining to 90% in 2020 where it remains indefinitely. The FMAP for these newly eligible individuals will be 100% for calendar years 2014-2016, gradually declining to 90% in 2020 where it remains indefinitely. Expansion states, such as Massachusetts, that had previously expanded eligibility for Medicaid through 1115 waivers, will receive 75% FMAP in 2014 for those adults who otherwise would be newly eligible for Medicaid under the ACA, gradually increasing to 90% in 2020. More information on FMAP issues is available in the FAQs "Exchanges, Market Reforms and Medicaid" issued on December 10, 2012 at: http://www.medicaid.gov/State-Resource-Center/Frequently-Asked-Questions/Downloads/Governor-FAQs-12-10-12.pdf

Effective January 1, 2014, a methodology for determining income based on **MAGI** will apply to both Medicaid and CHIP eligibility for most enrollees, including pregnant women, children, parents and other caretaker relatives, and the newly eligible adult group (as applicable in a state that chooses to cover this group). This will standardize the income calculation nationally. In addition to a 5% FPL across-the-board income disregard for all MAGI populations, there will no longer be any disregards applied, unless an individual falls into one of the populations exempted from MAGI rules (such as the elderly or the disabled). This new methodology is aligned with the one that will be used to determine eligibility for the premium tax credits (§1401, §1411) and cost sharing reductions (§1402, §1411) available to certain individuals purchasing coverage on the Exchange.

Read the February 2, 2013 FAQs at: http://medicaid.gov/State-Resource-Center/Frequently-Asked-Questions/Downloads/ACA-FAQ-BHP.pdf

2/1/13 CMS/ HHS issued the final Rule "Medicare, Medicaid, Children's Health Insurance Programs: Transparency Reports and Reporting of Physician Ownership or Investment Interests" (known as the Sunshine law) as required by ACA §6002. The final rule will require manufacturers of drugs, devices, biologicals, and medical supplies covered by Medicare, Medicaid or the Children's Health Insurance Program (CHIP) to report payments or other transfers of value (including gifts, consulting fees, research activities, speaking fees, meals, and travel) provided to physicians or teaching hospitals to CMS. The final rule also requires manufacturers and group purchasing organizations (GPOs) to disclose/report annually to CMS physician ownership or investment interests.

According to CMS, the increased transparency is intended to help reduce the potential for conflicts of interest that physicians or teaching hospitals could face as a result of their

relationships with manufacturers and expose financial relationships between physicians and the industries in which they work. Data collection will begin on August 1, 2013 in order to give manufacturers and GPOs time to prepare and manufacturers and GPOs will report the data for August through December of 2013 to CMS by March 31, 2014. CMS will release the data on a public website by September 30, 2014. CMS is developing an electronic system to facilitate the reporting process. GPOs, as well as the physicians and teaching hospitals, will have an opportunity to review and correct reported information prior to its publication. The ACA provides that violators of the reporting requirements will be subject to civil monetary penalties, capped at $150,000 annually for failing to report, and $1,000,000 for knowingly failing to report.

§6002 also preempts any state or local laws requiring reporting of the same types of information regarding payments or other transfers of value made by applicable manufacturers to covered recipients. Under the rule, no state or local government may require the separate reporting of any information regarding a payment or other transfer of value that is required to be reported under this statute, unless such information is being collected by a federal, state, or local governmental agency for public health surveillance, investigation, or other public health purposes or health oversight. According to CMS, this creates the possibility of cost-savings, since a single reporting system for reporting this information is less burdensome than multiple programs.

Read the CMS press release at: Press Release

Read the CMS fact sheet at: Fact Sheet

Read the final rule (which was published in the Federal Register on February 8, 2013) at: Final Rule

2/1/13 DOL/HHS/Treasury issued a notice of proposed rulemaking (NPRM) called "Coverage of Certain Preventive Services Under the Affordable Care Act." The proposed rule implements provisions under ACA §1001(2713) that provide women with coverage for preventive care that includes contraceptive services without cost sharing, while respecting the concerns of certain religious organizations, including eligible organizations that are religious institutions of higher education, that establish or maintain or arrange health coverage. Under §1001(2713) non-exempt, non-grandfathered group health plans are required to provide such coverage. Group health plans of "religious employers" are exempted from the requirement to provide contraceptive coverage if they have religious objections to contraception.

The 2013 NPRM builds on the proposals in the Advance NPRM (published in the Federal Register on March 21, 2012) to provide women with coverage for free recommended preventive care (including contraception) without cost sharing, while also ensuring that non-profit organizations with religious objections won't have to contract, arrange, pay, or refer for insurance coverage for these services to their employees or students.

The proposed rules would make two key changes to the preventive services coverage rules. First, the NPRM amends the criteria for the religious employer exemption to clarify that, for example, a house of worship, would not be excluded from the exemption because it provides charitable social services to people of different religious faiths or employs people of different religious faiths. Religious-affiliated insurers would still be exempt from paying for the coverage directly, but their employees would still be able to access contraception without any cost-sharing through their insurance company.

Second, the proposed rules would establish accommodations for health coverage established or

maintained by eligible organizations, or arranged by eligible organizations that are religious institutions of higher education, with religious objections to contraceptive coverage. Under the proposed accommodations, the eligible organizations would not have to contract, arrange, pay or refer for any contraceptive coverage to which they object on religious grounds. Plan participants would receive contraceptive coverage through separate individual health insurance policies, without cost sharing or additional premiums. The rule proposes accommodations for both insured and self-insured group health plans. With respect to insured group health plans, eligible religious organizations would provide notice to their insurer and the insurer would then notify enrollees that it is providing them with no-cost contraceptive coverage through separate individual health insurance policies. With respect to self-insured group health plans, eligible religious organizations would notify the third party administrator, which would then automatically work with a health insurance issuer to provide separate, individual health insurance policies at no cost for participants. With respect to self-insured plans, as well as student health plans, these religious organizations would provide notice to their third party administrator. In turn, the third party administrator would work with an insurer to arrange no-cost contraceptive coverage through separate individual health insurance policies. The NPRM also proposes that eligible religious institutions of higher education that arrange for student health insurance coverage may utilize the accommodations laid out for employers with an insured group health plan.

On August 1, 2012 about 47 million women gained guaranteed access to additional preventive services without cost sharing under §1001(2713). Women's preventive health services include well-woman visits, support for breastfeeding equipment, contraception, and domestic violence screening and counseling.

Comments are due April 8, 2013.

For more information on women's preventive services coverage, visit: Coverage

Read the HHS Press release at: Press Release

Read the Fact Sheet at: Fact Sheet

Read the NPRM (which was published in the Federal Register on February 6, 2013) at: NPRM

Prior guidance can be viewed at: www.healthcare.gov

News

2/7/13 CMS released its second annual report with new data about Medicare beneficiaries gaining access to additional benefits under the ACA, such as increased coverage of preventive services and lower cost-sharing for prescription drugs. The report showed that as a result of the ACA, 6.1 million seniors and people with disabilities with **Medicare Part D who reached the gap in coverage known as the "donut hole"** have received an automatic discount on their prescription drugs. In Massachusetts, 59,062 beneficiaries received an average prescription drug gap discount of $667 in 2012.

Last year, the ACA provided a 50% discount on covered brand name drugs and a 14% discount on covered generic medications for people who hit the donut hole.
This year beneficiaries will receive a 52.5% discount on their covered brand name prescription drugs and a 21% discount on generics. In 2010, nearly 4 million beneficiaries who hit the donut hole received a one-time $250 rebate under the ACA to help them afford prescription drugs in the coverage gap. These discounts will continue to grow over time until the donut hole is closed completely in 2020 as required by §1101.

Through §4103 and §4104 of the ACA, people with original Medicare receive **free preventive services**, including annual wellness visits. Prior to the ACA many people with Medicare had to pay for preventive health services. In 2012 alone, an estimated 34.1 million people with Medicare benefited from Medicare's coverage of preventive services with no cost-sharing. In Massachusetts, 853,754 Medicare beneficiaries utilized at least one free preventive service in 2012.

Read the report at: http://www.cms.gov/apps/files/MedicareReport2012.pdf

2/4/13 CMS announced the Comprehensive End-Stage Renal Disease (ESRD) Care Initiative for Medicare beneficiaries with ESRD to identify, test, and evaluate ways to improve health outcomes and reduce per capita Medicare expenditures. CMS will test and evaluate a new payment model with groups of health care providers and suppliers, known ESRD Seamless Care Organizations (ESCOs) under this initiative. The initiative, authorized under ACA §3021 and funded through the CMS Innovation Center, enhances care coordination of beneficiaries with ESRD and provides a more patient-centered experience that will improve health outcomes.

Eligible organizations (ESCOs) must include providers from dialysis facilities, nephrologists and other Medicare providers and suppliers experienced with providing care to members with ESRD. CMS expects that 10-15 ESCOs will participate and that each organization will serve at least 500 Medicare beneficiaries. CMS will use historical data to match beneficiaries with participating organizations with providers who are already providing care for members. Under the initiative, organizations will be financially and clinically responsible for all care provided to beneficiaries, not only services related to ESRD. Depending on the size of the dialysis facility, there are three payment tracks available to participating organizations. If an organization has a dialysis facility that is owned by a larger dialysis organization, it must participate in a risk-based payment arrangement. Other organizations will be eligible for the other payment tracks.

CMS will hold ESCOs financially accountable for providing quality care and improving the health outcomes of their beneficiaries. ESCOs will report on health outcome measures in the following five areas: preventative health, chronic disease management, care coordination and patient safety, patient and caregiver experience and patient quality of life.

Letters of Intent are due on March 15, 2013. Applications are due May 1, 2013.
Additional information about this demonstration, including how to apply, can be found at: Information

Read the press release from CMS at: Press Release

Visit the Demonstration website at: Initiative Website

View in the notice in the Federal Register at: Notice

Upcoming Events

Integrating Medicare and Medicaid for Dual Eligible Individuals Open Meeting
February 22, 2013
1 PM - 3 PM
State Transportation Building, Conference Rooms 1, 2, and 3
10 Park Plaza
Boston, MA

The purpose of this meeting is to continue discussion of key implementation topics for the Duals Demonstration. We welcome attendance from all stakeholders and members of the public with interest in the Demonstration. Reasonable accommodations will be made for participants who need assistance. Please send your request for accommodations to Donna Kymalainen at: Donna Kymalainen

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.