AFFORDABLE CARE ACT
MASSACHUSETTS IMPLEMENTATION UPDATE

January 6, 2014

Quick Links

MA-ACA Website

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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

Nurse Faculty Loan Program (NFLP), §5311. Announced December 30, 2013. Funding is available to establish and operate an interest-bearing NFLP loan fund. Accredited schools of nursing or a department within the institution that offers an eligible advanced graduate nursing education program are eligible to apply. Awardees will provide loans to registered nurses for the completion of their graduate education to become qualified nursing faculty. In addition, the NFLP provides loan cancellation for approximately 85% of borrowers that serve as full-time faculty for an approved period of time. Loans provided to eligible students cannot exceed $35,500 per academic year for a maximum of 5 years. These funds may be used for tuition, fees, books, laboratory expenses and other reasonable educational costs. $22.5M in 110 awards is available.
Applications are due February 3, 2014.
The announcement can be viewed at: HRSA.Gov

Nurse Education, Practice, Quality and Retention (NEPQR) Program: Veteran's Bachelor of Science Degree in Nursing (VBSN) Program, §5309. Announced December 27, 2013. Funding is available for three-year cooperative agreements to develop and implement innovative career ladder programs that will increase the enrollment and graduation of veterans in Bachelor of Science in Nursing (BSN) programs. Projects will help veterans advance in nursing careers by awarding academic credit for prior military medical training and experience and building on combat medical skills and knowledge. Awardees will develop programs to

recruit veterans and prepare VBSN undergraduates for practice and employment in local communities. Funded programs will also include social supports, career counseling, mentorship and connections with veteran service organizations and community health systems to address the unique challenges that veterans face while transitioning to civilian life. Eligible applicants are accredited schools of nursing, health care facilities, or a partnership of such a school and a facility. A health care facility may include a health center, Indian Health Service health center, Native Hawaiian health center, Federally-qualified health center, rural health clinic, hospital, health clinic, nursing home, home health agency, hospice program, public health clinic, state or local department of public health, skilled nursing facility, or an ambulatory surgical center.
$2.8M in 8 awards is available.
Applications are due February 18, 2014.
The announcement can be viewed at: HRSA.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: Mass.Gov

Guidance

12/31/13 CMS issued a correction to the final rule called "Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2014." The document makes technical corrections to the final rule which was published in the Federal Register on August 6, 2013. The final rule implements portions of ACA §3108, §3137 and §3401.

The final rule updates the payment rates used under the prospective payment system (PPS) for skilled nursing facilities (SNFs) for FY 2014. In addition, it revises and rebases the SNF market basket, revises and updates the labor related share, and makes certain technical revisions to previous regulations.

To ensure accuracy in case-mix assignment and payment, in the final rule CMS adds an item to the Minimum Data Set (MDS) to record the number of distinct calendar days of therapy provided by all the rehabilitation disciplines to a beneficiary over the seven-day look-back period.

Based on the changes contained within the final rule, CMS estimates that aggregate payments to SNFs will increase by $470 million (or 1.3%) for FY 2014 relative to payments in FY 2013. According to CMS, the estimated increase is attributable to the 2.3% market basket increase.

Read the correction (which was published in the Federal Register on January 2, 2014) at: http://www.gpo.gov/fdsys/pkg/FR-2014-01-02/pdf/2013-31435.pdf

12/31/13 CMS issued a correction to the final rule "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; Payment Policies Related to Patient Status." The document makes technical corrections to the final rule which was published in the Federal Register on August 19, 2013. The rule implements portions of the following ACA sections: 3001, 3004, 3005, 3008, 3021, 3025, 3106, 3123, 3124, 3125, 3133, 3141, 5503, 5504, 5506, 3313, 3401, 10309, 10312, 10313, 10316, 10319, 10322 and 10324.

The final rule updates fiscal year (FY) 2014 Medicare payment policies and rates under the Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital Prospective Payment System (LTCH PPS). The final rule, which applies to approximately 3,400 acute care hospitals and approximately 440 LTCHs, will generally be effective for discharges occurring on or after October 1, 2013. According to CMS, under the rule, operating rates for inpatient stays in general acute care hospitals paid under the IPPS that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program will be increased by 0.7%. Those that do not successfully participate in the Hospital IQR Program will receive a 2.0% reduction in their annual increase. Beginning with FY 2015, hospitals that do not participate will lose one-quarter of a percentage increase in their payment updates.

Based on changes in the final rule, Medicare payments to LTCHs in FY 2014 are projected to increase by approximately $72 million (or 1.3%) as compared to FY 2013 Medicare payments. Total IPPS payments (capital and operating payments) are projected to increase by $1.2 billion.

In addition to setting the standards for payments for Medicare-covered inpatient services, the FY 2014 hospital payment rule describes the process for implementing the new Hospital-Acquired Conditions (HAC) Reduction Program, which will begin in FY 2015. The rule updates measures and financial incentives in the Hospital Value-Based Purchasing (VBP) and Readmissions Reduction programs. Additionally, the rule makes several changes relating to direct graduate medical education (GME) and indirect medical education (IME) payments and also establishes new or revised requirements for quality reporting by specific providers (acute care hospitals, PPS-exempt cancer hospitals, LTCHs, and inpatient psychiatric facilities (IPFs)) that are participating in Medicare.

Read the correction (which was published in the Federal Register on January 2, 2014) at:
http://www.gpo.gov/fdsys/pkg/FR-2014-01-02/pdf/2013-31432.pdf

12/31/13 HHS filed a proposed rule called "Administrative Simplification: Certification of Compliance for Health Plans." The rule implements portions of ACA §1104. The proposed rule would require a controlling health plan (CHP) to submit information and documentation demonstrating that it is compliant with certain standards and operating rules adopted by the HHS Secretary under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The proposed rule would also establish penalty fees for a CHP that fails to comply with the certification of compliance requirements.

According to HHS, a CHP either controls its own business activities, actions, or policies; or is controlled by an entity that is not a health plan. The rule proposes that CHPs must submit certain information and documentation that demonstrates compliance with the adopted standards and operating rules for three electronic transactions: eligibility for a health plan, health care claim status, and health care electronic funds transfers (EFT) and remittance advice. Documentation would be an indication that a CHP has completed some internal and external testing.

Comments are due March 3, 2014.

Read the rule (which was published in the Federal Register on January 2, 2014) at:
http://www.gpo.gov/fdsys/pkg/FR-2014-01-02/pdf/2013-31318.pdf

12/30/13 IRS/Treasury issued two notices containing proposals that provide guidance to charitable hospital organizations under ACA §9007.

The first notice (Notice 2014-3) includes a proposed revenue procedure that provides a process for charitable hospitals that fail to comply with the Internal Revenue Code requirements (that stipulate a hospital's charitable, tax-exempt designation) to correct and disclose those failures. In return for following the corrections process, charitable hospitals would receive assurance that they will not confront the possible loss of tax-exempt status as long as their mistakes were not "willful or egregious" and the hospital quickly corrects any errors.

This second notice (Notice 2014-2) confirms that charitable hospital organizations can rely on previously released proposed regulations (published in the Federal Register on June 26, 2012 and April 5, 2013) regarding their responsibilities (and the consequences for failing to meet any of the requirements) related to their tax-exempt status. ACA Section 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.

Comments on Notice 2014-3 are due March 14, 2014.

Read Notice 2014-3 at:
http://www.irs.gov/pub/irs-drop/n-14-03.pdf
Read Notice 2014-2 at:
http://www.irs.gov/pub/irs-drop/n-14-02.pdf
Visit the IRS for additional information: IRS.Gov

12/30/13 HHS/CMS issued a correction to the final rule "Patient Protection and Affordable Care Act; Program Integrity: Exchange, Premium Stabilization Programs, and Market Standards; Amendments to the Notice of Benefit and Payment Parameters for 2014." The document makes technical corrections to the final rule. The final rule finalizes standards to protect federal funds and ensure that that health insurance issuers and Exchanges (Marketplaces) comply with federal policies so that consumers have access to health insurance.

The rule outlines oversight and financial integrity guidelines with respect to Exchanges, Qualified Health Plan (QHP) issuers in Federally-facilitated Exchanges (FFEs), and states with regard to the operation of risk adjustment and reinsurance programs (also known as premium stabilization programs). Under the rule, HHS creates oversight of advance payments of the premium tax credit and cost-sharing reductions including requirements governing the maintenance of records, annual reporting of summary statistics, and audits.

Additional provisions are established for special enrollment periods, HHS-approved survey vendors that may conduct enrollee satisfaction surveys on behalf of QHP issuers in Exchanges, and oversight of QHP issuers in an FFE. The rule strengthens financial integrity provisions and protections against fraud and abuse (consistent with Title I of the ACA) as laid out in a proposed rule "Patient Protection and Affordable Care Act; Program Integrity: Exchange, SHOP, Premium Stabilization Programs, and Market Standards" (published in the Federal Register on June 19, 2013).

The rule also amends standards and adopts provisions in the "Amendments to the HHS Notice of Benefit and Payment Parameters for 2014" interim final rule (published in the Federal Register on March 11, 2013), related to risk corridors and cost-sharing reduction reconciliation.

Starting October 1, 2013, qualified individuals and qualified employees may purchase private health insurance coverage through competitive marketplaces called Affordable Insurance Exchanges, or "Exchanges" (also called Health Insurance Marketplaces). 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.

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). A QHP must have a certification by each Exchange in which it is sold. ACA §1311 and subsequent regulations provide that, in order to be certified as a QHP and operate in the Exchanges that will be operational in 2014, a health plan must be accredited on the basis of local performance by an accrediting entity recognized by HHS.

The premium tax credit is designed to make purchasing a health plan on the Exchange affordable for low and moderate income Americans by reducing a taxpayer's out-of-pocket premium cost. To be eligible to receive the premium tax credit, individuals and families must have incomes between 100%- 400 % FPL (or between 0% - 400% FPL if lawfully present and ineligible for Medicaid) and be enrolled in a qualified health plan (QHP) through an exchange. The individual must also be ineligible for government sponsored insurance and not have access to employer sponsored insurance that meets definitions of affordability and minimum essential coverage as established by ACA §1401. Advance payments are made monthly under ACA §1412 to the issuer of the QHP in which the individual enrolls. ACA §1402 provides for the reduction of cost sharing for certain individuals enrolled in QHPs offered through the Exchanges and §1412 provides for the advance payment of these reductions to issuers.

The ACA established 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) to provide payments to health insurance issuers that cover higher-risk populations and to more evenly spread the financial risk borne by issuers. The transitional reinsurance program and the temporary risk corridors program, which begin in 2014, are designed to provide issuers with greater payment stability as insurance market reforms are implemented. The reinsurance program will reduce the uncertainty of insurance risk in the individual market by partially offsetting risk of high-cost enrollees. The risk corridors program, which is a federally administered program, will protect against uncertainty in rates for qualified health plans by limiting the extent of issuer losses and gains.

Read the correction (which was published in the Federal Register on December 31, 2013) at: http://www.gpo.gov/fdsys/pkg/FR-2013-12-31/pdf/2013-31319.pdf

12/27/13 HHS/CMS issued a notice under the Paperwork Reduction Act of 1995 (PRA) seeking comments on proposed information collection activities related to a payment collections operations contingency plan. According to CMS, the data collection will be used by HHS to make payments or collect charges from health insurance issuers under the following ACA programs: advance payments of the premium tax credit, advanced cost-sharing reductions, and Marketplace (Exchange) user fees. A template will be used to make payments in January 2014 and as may be required based on HHS's operational progress.

Beginning October 1, 2013, qualified individuals and qualified employees could purchase private health insurance coverage through Exchanges (Marketplaces) for January 1, 2014 effective dates. 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. Furthermore, an Exchange makes an advance determination of tax credit eligibility for individuals who enroll in a qualified health plan (QHP) through the Exchange and pursue financial assistance (§1401, 1411, and 1412). QHPs are health plans that have been certified by an Exchange, provide essential health benefits (EHB, §1301) and follow established limits on cost-sharing (such as reduced deductibles, copayments, and out-of-pocket maximum amounts).

Using information available at the time of an individual applicant's enrollment, the Exchange determines whether the individual meets income and other requirements for advance payments and the amount of the advance payments that can be used to pay premiums. Advance payments are made periodically to the issuer of the QHP in which the individual enrolls (§1412). §1402 provides for the reduction of cost sharing for certain individuals enrolled in a QHP through an Exchange and §1412 provides for the advance payment of these reductions to health insurance issuers. Moreover, the ACA directs the issuers to reduce EHB cost sharing for individuals with household incomes between 100% and 400% FPL who are enrolled in a silver level QHP through an individual market Exchange and who are eligible for advance payments of the premium tax credit.

Comments are due January 27, 2014

Read the notice at:
http://www.gpo.gov/fdsys/pkg/FR-2013-12-27/pdf/2013-31015.pdf (see item #2)

12/27/13 HHS/CMS issued a notice under the Paperwork Reduction Act of 1995 (PRA) seeking comments on proposed information collection activities related to rate increase disclosure and review reporting requirements. According to CMS, the notice explains that the transitional health plans (non-grandfathered coverage in the small group and individual health insurance markets which may have otherwise been canceled or terminated but authorized to continue for an additional policy year by HHS on November 14, 2013) are subject to the ACA's rate review process and to use the agency's rate review justification system and templates which were required and utilized prior to April 1, 2013.

The rate review program under §1003 requires that insurers seeking rate increases of 10% or more for non-grandfathered plans in the individual and small group markets publicly and clearly disclose the proposed increases and the justification for them. Such increases are reviewed by either state or federal experts (in states that do not have a rate review program deemed effective by HHS) to determine whether they are unreasonable. Although the ACA does not grant HHS the authority to block a proposed rate increase, companies whose rates have been determined unreasonable must either reduce their rate hikes or post a justification on their website within 10 days of the rate review determination.

Comments are due February 25, 2014.

Read the notice at:
http://www.gpo.gov/fdsys/pkg/FR-2013-12-27/pdf/2013-30994.pdf (see item #1)

12/26/13 IRS/Treasury issued a correcting amendment and a correction to the final regulations called "Shared Responsibility Payment for Not Maintaining Minimum Essential Coverage." The corrections are effective December 26, 2013 and applicable beginning August 30, 2013.

The final regulations (which were published in the Federal Register on August 30, 2013) contain guidance related to the ACA's individual shared responsibility provision, eligibility for individual exemptions from the provision, and how the amount of the tax payment will be

calculated and collected when an individual must make the payment. The final regulations are effective on August 30, 2013 and broadly finalize the rules in the notice of proposed rulemaking published in the Federal Register on February 1, 2013.

Beginning in 2014, the individual shared responsibility provision requires each nonexempt individual to have basic health insurance coverage (known as minimum essential coverage, or MEC, §1501), qualify for an exemption, or make a shared responsibility payment when filing their federal income tax return. The requirement applies to adults, children (as tax dependents), seniors (most of whom will meet the coverage requirement through Medicare), and lawfully present immigrants.

The final regulations clarify the rules around those categories of individuals who are either entirely exempt from the requirement to maintain MEC or who are exempt from the associated tax penalty. According to the final regulations, individuals will not have to make a payment if coverage is unaffordable, if they spend less than three consecutive months without coverage, or if they qualify for an exemption for several other reasons, including hardship and religious beliefs. The final regulations also state that a taxpayer is treated as having coverage for a month so long as he or she has coverage for any one day of that month. The final regulations also provide an exemption for those individuals who would be eligible for Medicaid but for a state's choice not to expand Medicaid eligibility (pursuant to the Supreme Court decision). According to the Congressional Budget Office, less than 2% of Americans will be required to make a shared responsibility payment.

Largely consistent with the February 1, 2013 proposed rules, the final regulations explain what type of coverage is considered MEC. Generally, MEC includes government-sponsored coverage, employer-sponsored plans, individual coverage, grandfathered coverage, and other coverage designated as MEC by the HHS Secretary. MEC does not include certain specialized coverage. For example, state Medicaid programs that only provide pregnancy-related services for some pregnant women would not qualify as MEC. However, according to the IRS, the agency plans to issue future guidance excusing pregnant women with pregnancy-only coverage from the penalty for the months that they are covered in 2014.

The final regulations provide guidance on the liability for the shared responsibility payment for not maintaining MEC and reprise the statutory formula for calculating the penalty. According to the final regulations, the amount of the tax is the lesser of the applicable national average bronze plan premium or the sum of the monthly payment amounts.

Read the correcting amendment at: http://www.gpo.gov/fdsys/pkg/FR-2013-12-26/pdf/2013-30742.pdf
Read the correction at:http://www.gpo.gov/fdsys/pkg/FR-2013-12-26/pdf/2013-30740.pdf

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

News

12/31/12 The U.S. Preventive Services Task Force (USPSTF) issued a final recommendation statement onscreening for lung cancer. The USPSTF recommends annual screening for lung cancer in adults who are at high risk for lung cancer with low-dose computed tomography (LDCT), also known as CT scans. The USPSTF assigned a "B" rating to the recommendation, indicating that the Task Force recommends the service.

According to the USPSTF, smoking is the biggest risk factor for developing lung cancer, resulting in about 85% of lung cancers in the United States. The risk for developing lung cancer also increases with age, with most lung cancers occurring in people age 55 or older.

After reviewing the evidence, the USPSTF recommends screening people who are 55 to 80 years old and have a 30-pack-year or greater history of smoking, and currently smoke or have quit within the past 15 years. A "pack year" for a person is calculated as someone who has smoked an average of one pack of cigarettes per day for a year. For example, a person attains 30 pack years of smoking history by either smoking a pack a day for 30 years or two packs a day for 15 years. The USPSTF recommends the screening because the evidence suggests that it may prevent a significant number of lung cancer-related deaths. The USPSTF also recommends that screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits their life expectancy or their ability or willingness to have curative lung surgery.

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 begin on or after September 23, 2010. Because the recommendation on screening for lung cancer received a "B" rating the screenings will be required to be covered without cost-sharing under the ACA.

Read the final recommendation statement at:
http://www.uspreventiveservicestaskforce.org/uspstf13/lungcan/lungcanfinalrs.htm
Learn more about preventive services covered under the ACA at: HHS.Gov
Learn more about the USPSTF at: http://www.uspreventiveservicestaskforce.org/

12/24/13 The U.S. Preventive Services Task Force (USPSTF) issued a final recommendation statement on screening for risk assessment, genetic counseling, and genetic testing for BRCA-related cancer in women. The Task Force recommends that primary care providers screen women who have family members with breast or ovarian cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (known as BRCA1 or BRCA2). Women with a positive screen should receive genetic counseling and, if indicated after counseling, BRCA testing. BRCA1 and BRCA2 are human genes that belong to a class of genes known as tumor suppressors. Mutation of these genes has been linked to hereditary breast and ovarian cancer. BRCA1 and BRCA2 are acronyms for breast cancer susceptibility gene 1 and breast cancer susceptibility gene 2, respectively.

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 begin on or after September 23, 2010.

The USPSTF has recommended a "B" rating for screening women with a family history of breast or ovarian cancer for genetic breast cancer susceptibility and providing or referring women who screen positive for such symptoms for genetic counseling. According to the Task Force, women with BRCA gene mutations have a 70% chance of developing breast cancer (five times greater than the general population) and an increased lifetime risk for ovarian cancer (from 2% to as high as 46%).

However, The USPSTF recommends against routine genetic counseling or routine BRCA testing for women whose family history is not associated with an increased risk for potentially harmful mutations in the BRCA1 or BRCA2 genes. (This is a "D" recommendation which means that the screenings will not be required to be covered without cost-sharing under the ACA). The recommendation statement applies to women who have not been diagnosed with breast or ovarian cancer and who do not have family members with breast or ovarian cancer. According to the USPSTF, this applies to almost 90% of American women.

Read the final recommendation statement at:
http://www.uspreventiveservicestaskforce.org/uspstf12/brcatest/brcatestfinalrs.htm
Learn more about preventive services covered under the ACA at: HHS.Gov
Learn more about the USPSTF at: http://www.uspreventiveservicestaskforce.org/

12/23/13 The Patient-Centered Outcomes Research Institute (PCORI) announced the selection of the first 30 projects (Tier 1 awards) for funding through the pilot phase of its "Pipeline to Proposals" awards program. The pilot phase of the awards was made in the Western Region of the United States.

Each Tier I project (which received up to $15,000) will provide seed money to individuals, patients, groups or other healthcare stakeholders who have healthcare research ideas and who are committed to patient-centered research. The funds will be used to help award recipients build capacity, develop partnerships and engage community around a common healthcare research interest. The projects will help awardees create a research proposal and utilize tools to connect with other researchers to generate supports such as advisory councils and strategic plans.

View a list of awards at: PCORI.Org

For more information about PCORI, visit www.pcori.org

Commonwealth of MA News

MassHealth and Health Safety Net Regulation Changes
EOHHS has promulgated MassHealth and Health Safety Net regulations (with an effective date of January 1, 2014) to implement the Affordable Care Act (ACA). The proposed changes will affect MassHealth and Health Safety Net eligibility, benefits, and operational processes. Specifically, the regulation changes implement the categorical and financial requirements for MassHealth programs authorized by the ACA and changes in Massachusetts state law. In addition, the proposed regulations describe operational changes in the application and redetermination processes.

After taking into consideration all public comments and testimony regarding the proposed regulations, EOHHS published the final regulations in the Massachusetts Register on December 20, 2013, with the January 1, 2014 effective date. The regulations will also be posted online at

http://www.mass.gov/eohhs/gov/laws-regs/masshealth/regulations/.

Upcoming Events

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

Friday, January 31, 2014
12:00 PM-2:00 PM
1 Ashburton Place, 21st Floor
Boston, MA

Friday, February 28, 2014
11:00 AM-1:00PM
1 Ashburton Place, 21st Floor
Boston, MA

MBTA and driving directions to 1 Ashburton Place are located here: www.mass.gov/anf

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

Meetings of the Implementation Council are open to stakeholders and members of the public with an interest in One Care. 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.