AFFORDABLE CARE ACT
MASSACHUSETTS IMPLEMENTATION UPDATE

July 8, 2013

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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

Support for Demonstration Ombudsman Programs Serving Beneficiaries of Financial Alignment Models for Medicare-Medicaid Enrollees, §3021. Announced June 28, 2013. Funding is available to states to create and provide Demonstration Ombudsman Program services to enrollees in the Financial Alignment Model. States that have a signed Memorandum of Understanding (MOU) with CMS to implement an approved Financial Alignment model are eligible to apply. The Financial Alignment Model is a Federal-State partnership that tests the alignment of service delivery and financing of the Medicare and Medicaid programs. The services of the Ombudsman Program include: providing education to beneficiaries and stakeholders; conducting outreach to beneficiaries regarding availability of services; and investigating and resolving complaints related to the Financial Alignment model. The Ombudsman Program will ensure that states, CMS, and stakeholders have information regarding the experience of enrollees. In addition, the program will recommend areas of improvement in the Financial Alignment Initiative. Approximately $12.17M in 10 awards is available.
Applications are due August 5, 2013.
The announcement can 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: Mass.Gov

Guidance

7/1/13 Treasury/IRS published a Notice of Proposed Rulemaking called "Information Reporting for Affordable Insurance Exchanges." The proposed regulations provide guidance to Health Insurance Exchanges regarding the information that must be reported to the IRS and statements that the Exchanges must provide to taxpayers and other designated adults.

The proposed regulations would require Exchanges to report information on individuals who enroll in Qualified Health Plans (QHPs) and the monthly amount of any advanced tax credit payments received. QHPs are health plans that have been certified by an Exchange, provide essential health benefits (§1301) and follow established limits on cost-sharing. The required information will be electronically transmitted on a monthly basis to the IRS. The proposed regulations also require that Exchanges provide each taxpayer or other designated adult who is enrolled in a QHP (or family member who is enrolled in a QHP) with a statement containing all the information that is reported to the IRS.

The ACA established Affordable Health 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 costs.

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. ACA §1401 amended the tax code to allow an advance, refundable premium tax credit to help individuals and families afford health insurance coverage. 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 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. The amount of the premium tax credit is tied to the amount of the premium. 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 (such as deductibles, copayments, and out-of-pocket maximum amounts) for certain individuals enrolled in QHPs offered through the Exchanges and §1412 provides for the advance payment of these reductions to issuers.

Comments are due September 3, 2013.

Read the proposed rule (which was published in the Federal Register on July 2, 2013) at: http://www.gpo.gov/fdsys/pkg/FR-2013-07-02/pdf/2013-15943.pdf

6/28/13 Treasury/DOL/HHS issued a final rule called "Coverage of Certain Preventive Services Under the Affordable Care Act." The final rule implements provisions under ACA §1001(2713) that provide women with coverage for preventive care that includes all-FDA approved contraceptive services without cost sharing, while respecting the concerns of certain religious organizations, including certain non-profit religious organizations. Under the final rule 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 final rule builds on (and reflect the agencies' response to feedback received on) the proposals in the Notice of Proposed Rulemaking (NPRM) published in the Federal Register on February 6, 2013 and requires that most health plans provide women with coverage for recommended preventive care without charging a co-pay, co-insurance or a deductible, 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.

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

The final rule amends the definition of "religious employer" for purposes of determining exemptions from having to provide contraceptive coverage under the preventive services coverage rules. The final rule eliminates the requirements that a religious employer: 1) have the indoctrination of religious values as its purpose, 2) primarily employ employees of the same religious faith and 3) who primarily serve people of the same religious faith. Such employers, primarily houses of worship, may exclude contraceptive coverage from their health plans for their employees and their dependents. The final rule also extends the current, temporary safe harbor for such religious organizations from health plan years beginning August 1, 2013 to January 1, 2013.

The final rule also provides accommodations for non-exempt, non-profit religious organizations that object to contraceptive coverage on religious grounds. Under the accommodations, the eligible organizations do not have to contract, arrange, pay or refer for any contraceptive coverage. The rule establishes accommodations for both insured and self-insured group health plans.

With respect to insured group health plans (including student health plans), eligible religious organizations must provide a copy of a "self-certification form" to its health insurance issuer. The plans must provide separate payments for contraceptive services available to the women in the health plan of the organization (at no cost to the women or organization). HHS expects that providing such payments will be cost-neutral to issuers.

With respect to self-insured group health plans, to be eligible for an accommodation, eligible religious organizations must provide a copy of its "self-certification form" to its third party administrator which would then provide or arrange separate payments for contraceptive services for women in the health plan (at no cost to the women or organization). According to HHS, the costs of the payments can be offset by adjustments in Exchange user fees paid by a health insurance issuer with which the third party administration has an arrangement.

Read the HHS Press release at: http://www.hhs.gov/news/press/2013pres/06/20130628a.html
Read the fact sheet about the final rule at: CMS.Gov
For more information on women's preventive services coverage, visit: HHS.Gov
Read the Updated Guidance on the Temporary Enforcement Safe Harbor at: CMS.Gov
Read the final rule (which was published in the Federal Register on July 2, 2013) at:
http://www.gpo.gov/fdsys/pkg/FR-2013-07-02/pdf/2013-15866.pdf

6/27/13 HHS/CMS issued a proposed rule called "Medicare and Medicaid Programs; Home Health Prospective Payment System Rate Update for CY 2014, Home Health Quality Reporting Requirements, and Cost Allocation of Home Health Survey Expenses." The rule implements portions of ACA §3131 and §3401.

The proposed rule updates the Home Health Prospective Payment System (HH PPS) rates, including the national, standardized 60-day episode payment rates, the national per-visit rates, the low-utilization payment adjustment (LUPA) add-on, the non-routine medical supplies (NRS) conversion factor, and outlier payments under the Medicare prospective payment system for home health agencies (HHAs), effective January 1, 2014. As required by the ACA, the rule also proposes rebasing adjustments, with a 4-year phase-in, to the national, standardized 60-day episode payment rates; the national per-visit rates; and the NRS conversion factor.

Finally, the proposed rule would also establish home health quality reporting requirements for CY 2014 payment and subsequent years and would clarify that a state Medicaid program must provide that, in certifying home health agencies, the state's designated survey agency must carry out certain other responsibilities that already apply to surveys of nursing facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID).

Comments are due August 26, 2013.

Read the proposed rule (which was published in the Federal Register on July 3, 2013) at: http://www.gpo.gov/fdsys/pkg/FR-2013-07-03/pdf/2013-15766.pdf

6/28/13 CMS announced that providers and suppliers will have additional time to comply with certain Medicare requirements under ACA §6407. The provision establishes a face-to-face encounter requirement for certain items of durable medical equipment (DME). Under the ACA, a physician is required to document that either a physician, nurse practitioner, physician assistant or clinical nurse specialist has had a face-to-face encounter with the patient. The encounter must occur within the 6 months before the order is written for the DME.

While the provision was originally effective July 1, 2013, CMS announced that the agency will start actively enforcing and will expect full compliance with the DME face-to-face requirements beginning on October 1, 2013. CMS announced the delay because of concerns that some providers and suppliers may need more time to establish the operational protocols necessary to comply with the requirement.

Read the announcement at: CMS.Gov

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

News

7/2/13 The Obama administration announced that it is delaying the implementation of the ACA's Employer Shared Responsibility provisions for one year. According to the Administration, the additional year will 1) provide federal agencies with time to work with stakeholders to simplify the employer reporting requirements about employee access to and enrollment in health insurance and 2) provide employers with transition time to test reporting systems and make any needed changes to their offered health benefits before payments are collected in 2014.

According to the Treasury, the agency will publish formal regulations this month to implement the transitional relief. On Wednesday, January 2, 2013, the IRS/Treasury published proposed regulations called "Shared Responsibility for Employers Regarding Health Coverage."

The proposed regulations relate to the Employer Shared Responsibility provisions under Section 4980H which was added to the IRS Code by ACA §1513. Starting in 2014, under these provisions, if employers with 50 or more full-time employees* do not offer affordable health

coverage that provides a minimum level of coverage (§1501) to their full-time employees, they may be subject to an Employer Shared Responsibility payment if at least one of their full-time employees receives a premium tax credit (§1401, §1411) for purchasing individual coverage on one of the new Affordable Insurance 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.

*To be subject to the Employer Shared Responsibility provisions, an employer must have at least 50 full-time employees or a combination of full-time and part-time employees that is equivalent to at least 50 full-time employees (for example, 100 half-time employees equals 50 full-time employees). As defined by the statute, a full-time employee is an individual employed on average at least 30 hours per week (so half-time would be 15 hours per week).

As a result, the employer mandate requiring companies to offer their employees health insurance will be delayed by one year.

Read the blog post by Mark Mazur, Assistant Secretary for Tax Policy, Treasury Department at: Treasury.Gov
Read the blog post by Valerie Jarrett, Senior Advisor to the President, Office of Public Engagement and Intergovernmental Affairs at: http://1.usa.gov/11YsI6J

6/28/13 HRSA announced the availability of $5.7M in grants for "Supporting the Continuum of Care: Building Ryan White Program Grantee Capacity to Enroll Eligible Clients in Affordable Care Act Health Coverage Programs." Authorized by the Public Health Service Act, as amended by the Ryan White HIV/AIDS Extension Act, funds are available to support and build the Ryan White Program to enroll eligible individuals in ACA coverage programs.

Organizations, including school and academic health science centers, involved in addressing HIV/AIDS related issues are eligible to apply. The full award amount will be granted to 1 grantee over a three year period. The grantee will assess the Ryan White Program to review technical assistance needs for outreach and enrollment of minorities living with HIV/AIDS. In addition, the awardee will work with various federal agencies (including HRSA, CDC, SAMSHA and CMS) to determine best practices for outreach and enrollment activities to facilitate access to health care services in Medicaid and the Health Insurance Exchanges. The grantee is also expected to work with HHS agencies and national partners to develop strategies, tools and trainings for the Ryan White Program to use for outreach and enrollment.

Applications are due July 29, 2013.
The announcement can be viewed at: HRSA.Gov

7/2/13 HHS announced that approximately $32 million in *Connecting Kids to Coverage Outreach and Enrollment Grants* were awarded to 41 state agencies, community health centers, school-based organizations and non-profit groups in 22 states. In addition, two grantees are multistate organizations. The grant awards will be used to identify and enroll children eligible for Medicaid and the Children's Health Insurance Program (CHIP). The awards are part of the $140 million included in the ACA (§10203) and the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 for enrollment and renewal outreach efforts. Grant amounts range from $190,000 to $1 million.

According to HHS, 1.7 million children have gained healthcare coverage through Medicaid and CHIP since 2008.

The grants will: 1) Help promote enrollment outreach in schools, 2) Reduce health coverage

disparities by reaching out to subgroups of children that are less likely to be insured, 3) Improve application and renewal resources in local communities, 4) Streamline the enrollment process for applicants in other public benefit programs, and 5) Train community organizations about eligibility and the application process.

In Massachusetts, Health Care for All (HCFA) was awarded a $747,908 grant to increase health insurance retention rates across the state with a focus on Hispanic and Portuguese children and families.

For a list of grantees visit:
http://www.insurekidsnow.gov/professionals/CKCCycleIIIGrantAwards.pdf
Learn more about the awards at: http://www.insurekidsnow.gov/professionals/index.html

EOHHS News

Integrating Medicare and Medicaid for Dual Eligible Individuals Update
On June 27, the Executive Office of Health and Human Services (EOHHS) issued a Request for Responses (RFR) from qualified entities to provide Ombudsman services for One Care: MassHealth plus Medicare. EOHHS recognizes the importance of potential enrollees, their families, caregivers, and advocates having accessible avenues of support and assistance, and the need for strong oversight of One Care throughout its implementation. To serve this function EOHHS will select a qualified contractor to provide Ombudsman services for One Care.

Details about the qualifications, responsibilities, and requirements for potential bidders are provided in the RFR, along with information on how to submit responses. Responses to the RFR are due to MassHealth **by 4:00 PM (EDT), July 29, 2013**.

The RFR is available on the state procurement website Comm-PASS (www.comm-pass.com). To access the document:

1. In your browser, enter the URL: www.comm-pass.com.
2. Near the bottom of the page, click on the hyperlink "Search for Solicitations."
3. When the Search page comes up, scroll down to the section that says "Search by Specific Criteria." In the Document Number box, enter the following: **13CBEHSOMBUDSMANSVCSRFR**. Then click on the box "Search."
4. Click on the hyperlink, "There is 1 solicitation(s) found that match your search criteria." and it will take you to the Comm-PASS listing for this solicitation.
5. Click on "the eyeglasses on the right, under "View," and you will get the summary page.
6. Click on the blue tab called "Specifications" and you will see the RFR document and an attachment listed. To view the document, click on the eyeglasses to the right, under "View."

Any questions about the Ombudsman procurement should be directed to Lisa D. Wong, Procurement Coordinator, at Lisa.D.Wong@state.ma.us, or:

EOHHS
Attn: Lisa D. Wong
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Executive Office of Health and Human Services
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Boston, MA 02108
(617) 573-1683

Learn more about One Care at:
http://www.mass.gov/masshealth/duals

Upcoming Events

Integrating Medicare and Medicaid for Dual Eligible Individuals Implementation Council Meeting
July 12, 2013
1:00 PM - 3:00 PM
State Transportation Building, Conference Rooms 1, 2 and 3
10 Park Plaza
Boston, MA

Reasonable accommodations are available upon request. Please contact Kate Russell at Kate.Russell@umassmed.edu to request accommodations.

Quarterly Affordable Care Act Implementation Stakeholder Meeting
September 16, 2013
1:30 PM - 2:30 PM
1 Ashburton Place, 21st Floor
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.