OMS – Related Provisions of ACA, Organized by Topic and Implementation date

*(**Disclaimer**: This is not in a complete summary of health reform provisions. It covers Medicaid benefits. Major changes in FMAP. The information pertaining to eligibility is limited due to MaineCare's minimal involvement with that category of provisions. It also does not attempt to consider the impact of Medicare changes on dual eligible's, except for a few pharmacy provisions.)*

Section of ACA	Subject	Effective Date; mandatory or optional	Status	Comments and Next Steps
		Pharmacy Provisions		
2501	**Prescription drug rebates** – "The flat rebate for single source and innovator multiple source outpatient prescription drugs would increase from 15.1 percent to 23.1 percent, except the rebate for clotting factors and outpatient drugs approved by the Food and Drug Administration exclusively for pediatric indications would increase to 17.1 percent. The basic rebate percentage for multi-source, non-innovator drugs would increase from 11 percent to 13 percent. Drug manufacturers would also be required to pay rebates for drugs dispensed to Medicaid beneficiaries who receive care from a Medicaid managed care organization (MCO). Total rebate liability would be limited to 100 percent of the average manufacturer price (AMP). *Additional revenue generated by these increases is remitted to the federal government.* Also, effective 3/23/10, the Reconciliation Bill narrowed the definition of a new formulation of drug for the purpose of applying the additional rebate. " (CMS)	1/1/10 Mandatory		• Implemented
2503	**Medicaid Pharmacy Reimbursement (AMP Fix)** "• Changes the Federal upper payment limit (FUL) to no less than 175 percent of the weighted average (determined on the basis of utilization) of the most recent AMPs for pharmaceutically and therapeutically equivalent multiple source drugs available nationally through commercial pharmacies. • Clarifies what transactions, discounts, and other price adjustments were included in the definition of AMP. • Clarifies that retail survey prices do not include mail order and long term care pharmacies. • Expands the disclosure requirement to include monthly weighted average AMPs and retail survey prices" (NCSL)	10/1/10 Mandatory		• No further action needed.

Section of ACA	Subject	Effective Date; mandatory or optional	Status	Comments and Next Steps
3301 & 1101 of RB	**Medicare Part D coverage gap discount program.** Drug manufacturers must agree to discount drugs by 50% for people in the coverage gap. The discount must be applied before any other assistance or coverage applies. Discount will increase to 75% and phase out Part D donut hole by 2020.	HHS must establish program by 1/1/11		• Federal program, no further action needed.
3309	**Elimination of Medicare Part D cost sharing for dual eligible's receiving HCBS.** The Low Income Subsidy provided to members enrolled in Medicare Part D plans will cover the remaining cost sharing responsibilities for full dual eligible's who qualify for HCBS.	1/1/12	Final Rule published 4/15/11.	• Will require Medicaid agencies to submit data at least monthly identifying these individuals by leveraging the existing data exchange currently used to identify their dual eligible individuals to CMS. • CMS will issue guidance regarding best practices for member notifications. • Cannot be provided retroactively, even if the beneficiaries LIS eligibility extends prior to 1/1/12. • Applicable to any members who qualifies for HCBS zero-cost sharing at any point in the year.
2502	**Eliminate exclusion of certain drugs.** Medicaid and Medicare will no longer exclude OTC smoking cessation drugs, barbiturates and benzodiazepines.	1/1/14		
Long Term Care Related Provisions				
6407	**"Face-to-face encounter with patient required before physicians may certify eligibility for home health services or durable medical equipment**-- Requires physicians to have a face-to-face encounter with the individual prior to issuing a certification for home health services. The Secretary would be authorized to apply the face-to-face encounter requirement to other items and services based upon a finding that doing so would reduce the risk of fraud, waste, and abuse. " (CMS)	1/1/11 Mandatory	Home Health (Section 40) rule adopted. Medicare rule promulgated. DME proposed rule effective 6/1 Medicaid Home Health Proposed Rule published 7/12/11-changes to practitioners, documentation and 90 days before or 30 days after vs. 6 months. DME-same practitioners as	

Section of ACA	Subject	Effective Date; mandatory or optional	Status	Comments and Next Steps
			Home Health except for Certified Nurse Practitioner.	
2402	**Removal of barriers to providing home and community-based services (1915(i) amendments)--** Removes barriers to providing HCBS by giving States the option to provide more types of HCBS through a State plan amendment to individuals with higher levels of need, rather than through a waiver, and to extend full Medicaid benefits to individuals receiving HCBS under a State plan amendment. Allows for less rigorous medical eligibility criteria, income eligibility up to 300% of the SSI rate, targeted services to specific population groups. Does not allow for waiting list. (CMS)	4/1/10 Optional		• (i)SPA may be used in development of PNMI solutions.
2401	**Community First Choice Option (a.k.a. 1915(k).** Option to provide home and community based attendant care and support services to those who are medically NF eligible to assist with ADLs, IADLs or health-related tasks. Available for those under 150% FPL or above 150% FPL and NF eligible. LOC determination for those above 150% FPL. Annual verification of income. States, at their option, may also provide transition costs, such as the first month's rent; rent or utility deposits; and kitchen supplies, bedding, and other necessities for an individual to move from a nursing facility to the community. States may also cover additional items noted in an individual's care plan that will increase independence or substitute for personal assistance. New spousal impoverishment protections apply. Must be statewide Cannot target Mandatory use of Person Centered Planning process. Allow self-direction (hire, fire etc.). State must establish a voluntary training program for members to teach them	10/1/11 Optional		

Section of ACA	Subject	Effective Date; mandatory or optional	Status	Comments and Next Steps
	how to self-direct. Excluded services: room and board, special education and related services, vocational rehabilitation services, assistive technology devices (except those defined at 441.520(a)(5), medical supplies and equipment, home modifications. *Provides 6 percentage points increase in FMAP for the services.*			
10202	**Incentives to States to offer HCBS as alternative to institutional care (State Balancing Incentive Payments Program).** States that undertake specified reforms to divert people from NFs to HCBS may receive FMAP increase of 2 or 5 percentage points if they meet target percentage (25% or 50%, depending on state's baseline) of long term services and supports (LTSS) spending that is HCBS. May be done with either a SPA or a waiver. (Applies to states where less than 50% of LTC expenditures are going to HCBS)	10/1/11 – 9/30/2015 Optional – State must apply and be selected		
	Prevention Services			
4107	**Tobacco cessation services for pregnant women.** States must cover counseling, pharmacological smoking cessation services for pregnant women.	10/1/10 Mandatory	Maine already provides services required by law.	• No further action needed.
4108	**Grant program for states to provide incentives to Medicaid beneficiaries to prevent chronic disease.** "These programs must be comprehensive and uniquely suited to address the needs of Medicaid eligible beneficiaries and must have demonstrated success in helping individuals lower or control cholesterol and/or blood pressure, lose weight, quit smoking and/or manage or prevent diabetes, and may address co-morbidities, such as depression, associated with these conditions. (Appropriates $100 million for this purpose, and grant awards will be awarded beginning January 1, 2011). Grants will be awarded over a five-year period, and the program must be carried out by a State within a three-	1/1/11 Grant Optional		

Section of ACA	Subject	Effective Date; mandatory or optional	Status	Comments and Next Steps
	year period." (NCSL)			
4106	**Preventative Services.** Provides 1 percentage point increase in FMAP for the preventative services set out by the US Preventative Services Task Force. Prohibits co-payments on those services.	1/1/13 Optional coverage, mandatory co-pay prohibition	Maine presently provides the preventative care services and vaccines required. However, we do impose copayments on some services as well as drugs, including smoking cessation drugs.	
	Miscellaneous Services, Including Payments to Providers			
2707	**Demonstration Project for Medicaid Emergency Psychiatric Care.** $75 million was appropriated for FY 2011 – 12/31/15 for demonstrations in up to 8 states to reimburse IMDs for services to Medicaid beneficiaries (between 21 & 64) to stabilize an emergency psychiatric condition).	10/1/10 – 12/31/15 Grant opportunity	The grant information has been finalized and MaineCare has developed a workgroup that is coordinating with Spring Harbor and Acadia Hospital.	• In progress.
2302	**Hospice care for children** -- Allows children who are enrolled in either Medicaid or CHIP to receive hospice services without foregoing curative treatment related to a terminal illness.	3/23/10 Mandatory	Implemented 10/2010 by emergency rule. Final rule adopted. State Plan Amendment Preprint received 5/31. See SMD letter 10-018.	• SPA submitted
2303	**State eligibility option for family planning services** – "Adds a new optional categorically-needy eligibility group to Medicaid comprised of men and non-pregnant women with income up to 200% FPL (the highest level applicable to pregnant women covered by MaineCare). Benefits would be limited to family planning services and supplies, including related medical diagnostic and treatment services. FMAP for "Family Planning services and supplies" is 90%.	3/23/10 Optional	Adopting this option would allow Maine to match state CDC dollars now being spent for Family Planning services for people below 200% of the poverty level.	

Section of ACA	Subject	Effective Date; mandatory or optional	Status	Comments and Next Steps
	FMAP for "Family planning-related services" is at regular rate." (CMS)			
2301	**Coverage of services provided in Freestanding birth centers is required.** Freestanding birth centers are facilities separate from hospitals that provide prenatal, labor and delivery, and post-partum care. The state must cover a free standing birth center that is "licensed or otherwise approved by the State to provide prenatal labor and delivery or postpartum care and other ambulatory services that are included in the plan; and … that complies with such other requirements relating to the health and safety of individuals furnished services by the facility as the State shall establish."	3/23/10 Mandatory. If legislation is needed to implement, states have until the 1st day of the quarter after the 1st session of the legislature	Maine has one freestanding birth center operated by midwives. Neither freestanding birth centers nor midwives are licensed under Maine Law. (*Nurse* midwives, however, are licensed and covered by MaineCare as APRNs).	• Not applicable to Maine.
6505	**No payments to entities outside the United States.** "[T]he State shall not provide any payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States; . . .". (ACA)	1/1/11 Mandatory	Adopted in Chapter I rule. State plan amendment filed. SMD letter indicates that providers just across the border may obtain addresses within the state so that people on the border do not lose access to services. Only four LCSWs and one hospital likely affected, but important to maintain access on the border, particularly in emergencies. It has been determined that the provider is authorized to practice outside of the United States as long as they have a mailing address in the United States. Therefore, this will not	

Section of ACA	Subject	Effective Date; mandatory or optional	Status	Comments and Next Steps
			cause an access issue.	
2702	**Prohibits federal payment for Health Acquired Conditions.** Directs the Secretary to define HAC, consistent with the definition of hospital acquired conditions in Medicare, but considering differences between the two programs and not limiting it to conditions acquired in hospitals.	7/1/11 Mandatory Option to delay state implementation to 7/1/12	• In progress.	Maine statute also limits payments to any payer for HAC for a specific list of conditions. 22 MRSA § 1721. See SMD Letter 08-004 (regarding Medicare). CMS proposed regulations of 2/17/11 list Medicare HACs and would permit states to add to the list.
10201 (RB – 1202)	**Payments to primary care physicians** – Requires that Medicaid payment rates to primary care physicians for furnishing primary care services be no less than 100% of Medicare payment rates in calendar years 2013 and 2014. *Provides 100% federal funding for the incremental costs to States of meeting this requirement. (NCSL)*	1/1/13 Mandatory		• State plan amendment needed.
2551	**Medicaid DSH reductions.** Secretary uses methodology in law to reduce DSH to hospitals by a total of $14.1 billion between 2014 and 2020.	2014 – 2020 Mandatory	IMD's primarily the recipients of DSH funding in Maine.	• Awaiting further guidance from CMS.
2706	**Pediatric Accountable Care Organization (ACO) Demonstration Program** Establishes a demonstration project, authorizing participating states to allow pediatric medical providers who meet certain criteria to be recognized as accountable care organizations (ACOs) for the purposes of receiving incentive payments, in the same manner as an ACO would be recognized and provided with incentive payments under Medicare (as provided for in section 3022 of the bill).	1/1/12 – 12/31/16 Optional		• Maine does not have a Pediatric Hospital and therefore the state is not considering this at this time. • No further action needed.
2703	**State Plan Option Promoting Health Homes for Enrollees with Chronic Conditions** • Creates a new Medicaid state plan option. • Eligibility: There are 3 classes eligible to participate in health homes, members with: at least two chronic conditions or with one chronic condition and at risk of developing another chronic condition and/or those with SPMI. • Eligible members designate a provider as their	1/1/11 Optional	Decision making requires coordination with: • Maine's technical assistance grant obtaining assistance from CHCS to assist in maximizing ACA potential for improving quality in ambulatory	• In progress

Section of ACA	Subject	Effective Date; mandatory or optional	Status	Comments and Next Steps
	"health home". • Providers: In order to qualify the provider must meet certain standards established by the Secretary, including, demonstrating that they have the systems and infrastructure in place to provide comprehensive and timely high quality care either in-house or by contracting with a team of health professionals. Provider must use Health Information Technology. • Services/care required: comprehensive care management, care coordination, health promotion, comprehensive transitional care, including appropriate follow up, from inpatient to other settings, patient and facility support and referral to community and social support services. • The State must develop a mechanism to pay the health home for services rendered. • Independent evaluation required. • Teams of providers can be free-standing, virtual or based at a hospital, community health center, clinic, physician's office or physician group practice. • Requires designated providers to report to the state on all applicable quality measures in the state Medicaid program. • *Provides an enhanced match of 90 percent FMAP for two years for states that take up this option.* • *In addition, small planning grants may be available to help states intending to take up this option. Regular FMAP rules would apply." (NCSL)*		care, and • The Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration grant received. • PCMH & PCCM See SMD Letter 10-024. SPA template available from CMS. Implementation could be staged, allowing us to enroll different groups at different times to take full advantage of the 8 quarters of match. The 8 quarters will begin at the states discretion.	

Section of ACA	Subject	Effective Date; mandatory or optional	Status	Comments and Next Steps
2701	**Quality Measures for Maternity and Adult Health Services.** HHS will propose recommended standard quality measures for adults similar to CHIPRA to be implemented in the states.	1/1/11 – HHS proposes 1/1/12-HHS publishes 1/1/13 – States report		• These are recommended quality measures.
2704	**Demonstration Project to Evaluate Integrated Care around Hospitalization.** Secretary will establish demonstration project for up to 8 states to evaluate the use of bundled payments to hospitals and physicians for integrated care delivery. Episode of care that includes a hospitalization and for concurrent physicians' services provided during a hospitalization. States must specify one or more episodes of care they want to address and the services to be included in bundled payments. Requirements: • Program must have potential to lower costs under the Medicaid program while improving care for Medicaid beneficiaries. o The state may target to particular categories of beneficiaries, particular diagnoses or particular geographic regions. But must still be representative of the demographic and geographic composition of Medicaid beneficiaries nationally. • Focus on conditions where there is evidence of an opportunity for providers of services and suppliers to improve the quality of care furnished to Medicaid	1/1/12 Program will begin 12/31/16 Program ends 12/31/17 Secretary reports to Congress Demonstration opportunity		

Section of ACA	Subject	Effective Date; mandatory or optional	Status	Comments and Next Steps
	beneficiaries while reducing total expenditures. • Specify the 1 or more episodes of care, the services to be included in the bundled payments and the rationale behind selecting such episodes of care and services. • Ensure that beneficiaries are not liable for additional cost sharing • Participating hospitals to have robust discharge planning. • Ensure that the demonstration does not result in the Medicaid beneficiaries whose care is subject to payment being provided with fewer items and services for which medical assistance is provided under the state plan services.			
	Program Integrity Provisions			
6506 6402(a)	**Overpayments** – "Extends the period for States to recover overpayments due to fraud to one year after date of discovery of the overpayment, before an adjustment is made to the federal payment. If the State has not recovered the overpayment due to fraud within one year of discovery because there has not been a final determination of the overpayment amount, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or portion thereof) before the date that is 30 days after the date on which a final judgment (including, if applicable, a final determination on an appeal) is made. The *Secretary shall promulgate regulations that require States to correct Federally identified claims overpayments, of an ongoing or recurring nature, with new Medicaid Management Information System (MMIS) edits, audits, or other appropriate corrective action.* Section 6402(a) of the Affordable	3/23/10 Mandatory		

Section of ACA	Subject	Effective Date; mandatory or optional	Status	Comments and Next Steps
	Care Act also addresses overpayments. This provision, which amends the Act by creating a new section 1128J, has no impact on a State's obligations under section 6506 of the Affordable Care Act to return the Federal share. Instead, the new section 1128J(d)(2) of the Act makes *explicit that overpayments must be reported and returned to States within 60 days of identification or by the date any corresponding cost report is due, whichever is later.* This provision applies to providers of services, suppliers, Medicaid managed care organizations, Medicare Advantage organizations, and Medicare Prescription Drug Program sponsors. It does not apply to beneficiaries." (CMS) (emphasis added).			
6506	**Mandatory State use of national correct coding initiative** -- Requires States to make their MMIS methodologies compatible with Medicare's national correct coding initiative (NCCI) that promotes correct coding and controls improper coding.	9/1/10 Mandatory	This is in the MIHMS system.	• Already taken into account in MIHMS certification process. • Consistent review to ensure accuracy.
6401, 6402, 6501, 6502, 6503	**Program integrity provisions.** The ACA included numerous provisions in both Medicare and Medicaid to reduce fraud and abuse. These include --but are not limited to: - Required screening of providers and suppliers according to their level of risk of fraud, waste and abuse. (eff. 9/23/10) *(In progress)* - Required disclosure by providers and suppliers enrolling or reenrolling regarding affiliations with others that have uncollected debt, have had payments suspended, been excluded from a federal health care program, or had billing privileges revoked. *(In progress)*	9/23/10; 1/1/11 Mandatory March 25, 2011 per CMS. Screening for providers who are currently enrolled: 3/25/12 Tentative implementation date 3/1/13 or 7/1/13 pending timeline provided by Molina.	SPA has been approved. 4/1 deadline for implementation has been extended by CMS. No new date set. Research on impact of ordering/referring provider provision indicates possible access problem with many prescribers not enrolled. See NPRM on 9/23/10; final rule at 76 Fed. Reg. 5862 (2/2/11) Medicare and Medicaid Extenders Act of 2010.	• Work groups developed and conducting analysis and action plans on: - Ordering and Referring providers, - Enrollment and screening, - Assignment of risk to MaineCare-only providers. - Credible allegations of fraud (3/25/11) o Needed: rule change and statutory change - A CR is being developed for enrollment of ordering and referring. It will take approximately 4 months to complete this CR.

Section of ACA	Subject	Effective Date; mandatory or optional	Status	Comments and Next Steps
	- Requires NPI on enrollment applications (eff. 1/1/11) *(In progress)* - Termination of provider participation in Medicaid if provider had been terminated under Medicare or another state's Medicaid program (eff. 1/1/11) *(In progress)* - Exclusion from participation of providers with ownership, control or management affiliations with entities that fail to repay overpayments or are excluded, suspended or terminated from Medicaid. (eff. 1/1/11) (REPEALED 12/15/10 Medicare and Medicaid Extenders Act) - Requires alternate payees (e.g. billing agents) that submit claims on behalf of health care providers to register with the state. (eff. 1/1/11). *(Completed)* - Requires states to contract with one or more Recovery Audit Contractors. (eff. 1/1/11). *(Was completed, now contract being re-looked at)* - Requires all ordering and referring providers to enroll. *(In progress)*		SPA has been drafted. Tribal consultation has been sent. SPA to be submitted (aprox.) 6/22/12.	***Please note, the enrollment and ordering and referring provisions were not implemented by MaineCare on the effective date because the Medicare PECOS system was not fully functional.*
	Expansion Provisions			
2001, 10201, RB 1201	**Coverage categories and income eligibility.** Establishes minimum income eligibility level of Modified Adjusted Gross Income (MAGI) at 133% of FPL for those under 65 and not entitled to Medicare, with state option to provide either traditional Medicaid or supplemental wrap-around benefits to those above 133%. (Existing eligibility threshold for pregnant women	1/1/14 Optional		

Section of ACA	Subject	Effective Date; mandatory or optional	Status	Comments and Next Steps
	remains the same.) Adds new mandatory categories of childless adults under 65, parents, and former foster care children under 26 (§ 2004). All eligible children whose parents choose coverage through the exchange must continue to receive EPSDT services.			
2004	**Former foster care children under 26.** Coverage is extended to this category if they were enrolled in Medicaid when they aged out of foster care. They are in this category if they do not fit another category or if their income exceeds the income eligibility limits for another category. State has option apply presumptive eligibility to this group. This group receives EPSTD.	1/1/14 Mandatory		
	The Exchange *-State Operated Exchange*-State operates all of the functions of the Exchange. HHS will certify state Exchanges by January 1, 2012. *-State Partnership Model*-Exchange is run in partnership between the state and HHS, States can use this model to transition to running their Exchange independently. *-Federally Facilitated Exchange*-HHS will ensure that there is a functioning exchange in the state. HHS will work with the state to ensure coordination with the state's ongoing role in managing the private insurance marker, Medicaid and CHIP. Must develop web based eligibility process.		Medicaid proposed rule published 8/14/11 8/12/11 Letter to Governor's from HHS Secretary Sebelius 125th Legislature: LD 1497: An Act to Comply with the Health Information Exchange Provision of the PPACA. Establishing the Maine Health Benefit Exchange. *Carried over.*	• "Establishment Grants" available to help states develop, implement, and establish Exchanges. Next application deadline: September 30, 2011. Applications accepted through June 2012 & funding available through 2014. • The first period in which new coverage options will be available is scheduled to begin in the fall of 2013. • Key: Engaging stakeholders prior to solicit feedback regarding design and implementation • Elements involved include: web based application, transition to Modified Adjusted Gross Income (MAGI), development of a basic health plan, operation: state only vs. state partnership vs. federally facilitated. • Ability to use "navigators" to support members in applying for benefits vs. sole use of state government workers.

Miscellaneous Provisions				
2001	**Benchmark coverage.** Newly eligible adults must receive at least basic bench-mark equivalent plans, with some exemptions. Law amends DRA to include pharmacy and mental health coverage as part of benchmark.	1/1/14 Mandatory	See Benefit Rules in SMDL 10-013.	
10201	**Waiver process.** "Increases the transparency of the Medicaid § 1115 waiver development and approval processes, at the State and federal levels by requiring the Secretary to promulgate regulations relating to the application and renewals of a demonstration project that provides for a process for public hearings." (CMS)	9/23/11	.	
2003	**Premium Assistance.** States must offer premium assistance for employer sponsored insurance (ESI) if it is cost effective to do so to adults as well as children. Member has choice of whether to receive premium assistance.	1/1/14 Optional	Maine already does this through the PHIP program.	• No further action needed.