



## AFFORDABLE CARE ACT MASSACHUSETTS IMPLEMENTATION UPDATE

November 18, 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

**Affordable Care Act - Teaching Health Center Graduate Medical Education (THCGME) Program**, \$5508. Announced October 31, 2013. Funding is available for FY 2014 THCGME program applications to support primary care residency programs in teaching health centers nationwide. The THCGME Program expands residency training in community-based settings. Residents can be trained in family and internal medicine, pediatrics, obstetrics and gynecology, psychiatry, and general and pediatric dentistry. Eligible applicants for program funds are community-based ambulatory patient care centers that operate a primary care medical or dental (general or pediatric) residency program. Under the THCGME Program, payments are made for direct expenses associated with sponsoring an approved graduate medical or dental residency training program and indirect expenses associated with the additional costs relating to training residents in such programs. HRSA will make payments to eligible teaching health centers to support direct and indirect expenses associated with accredited primary care medical and dental residency training. New applicants as well as current THCGME awardees who are proposing to further expand the number of new resident positions in FY 2014 beyond those already approved during FY 2013 must apply for the expansion through this funding announcement. The THCGME program payment is formula-based. The ACA directly appropriates \$230 million for Fiscal Years 2011 through 2015 to make payments to qualified teaching health centers to support the expansion of primary care medical and dental residency training in community-based ambulatory settings.

Applications are due December 2, 2013.

The announcement can be viewed at: [HRSA.Gov](http://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](http://Mass.Gov)

## Guidance

**11/8/13 HHS/CMS published a notice on information collection activities related to Sunshine Act Disclosures.** ACA §6002 requires applicable 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. Manufacturers and group purchasing organizations (GPOs) are also required 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 must be reported in a required format so that CMS can 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 requirement, 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.

CMS published a [final rule](#) in February 2013 to implement this program, which included several information collections subject to the Paperwork Reduction Act. This information collection request is to inform the public about information collected that is necessary for registration, attestation, dispute resolution and corrections, record retention, and submitting an assumptions document within Open Payments.

Comments on this information collection are due by December 9, 2013.

Read the notice at: <http://www.gpo.gov/fdsys/pkg/FR-2013-11-08/pdf/2013-26822.pdf> (See item #7)

**11/8/13 HHS/DOL/Treasury jointly issued final rules called "Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program Rule."** The final rules requires parity between mental health or substance use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations under group health plans and group and individual health insurance coverage. The final rules guarantee that health insurance plans

are generally not more restrictive for mental health/substance abuse disorders benefits than they are for medical/surgical benefits- this includes provisions such as co-pays, deductibles and visit limits.

The ACA builds on the Mental Health Parity and Addiction Equity Act (MHPAEA) and requires coverage of mental health and substance use disorder services as one of ten essential health benefits (EHB) categories. Under the EHB rule, individual and small group health plans are required to comply with these parity regulations. As required under ACA §1302(b), EHBs are a package of medical services and treatments which includes ambulatory and emergency care, maternity care, prescription drugs and other comprehensive health care services in ten statutory benefit categories, and are equal in scope to a typical employer health plan. Effective January 1, 2014, all plans sold in the exchanges and through the small group and individual markets must be equal in scope to the benefits covered by a typical employer plan and offer an EHB package of medical services and treatments in the ten prescribed categories.

Read a fact sheet about the MHPAEA rules at: [CMS](#)

Read the FAQs about the ACA (Set XVII) and Mental Health Parity Implementation issued on November 8, 2013 at: <http://www.dol.gov/ebsa/faqs/faq-aca17.html>

Read the MHPAEA final rules (published in the Federal Register on November 13, 2013) at: <http://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf>

The MHPAEA final rules also contain a technical amendment related to external review with respect to the Multi-State Plan Program (MSPP) administered by the Office of Personnel Management (OPM). Section 2719 of the PHS Act and its implementing regulations provide that group health plans and health insurance issuers must comply with either a state external review process or the federal external review process. According to the Departments, this approach to external review is required by ACA §1334.

Additional information on the regulatory requirements for the federal external review process is available at: <http://www.dol.gov/ebsa/healthreform/regulations/internalclaimsandappeals.html>

Additional information about the MSPP can be found at:

<http://www.opm.gov/healthcare-insurance/multi-state-plan-program/>

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

## News

**11/12/13 The U.S. Preventive Services Task Force (USPSTF) issued a draft recommendation statement on the use of vitamin and mineral supplements to prevent heart disease, stroke, and cancer.** The USPSTF issued three findings with respect to whether taking vitamin and mineral supplements might reduce the risk of cardiovascular disease (CVD) or cancer. The draft recommendation statement applies to healthy adults who have no known or suspected nutritional deficiencies; it does not apply to women who are pregnant or who may become pregnant.

Supplements are vitamins or minerals added to the diet. According to the USPSTF, vitamin and mineral supplements are commonly used in the United States and multivitamins (which contain many vitamins and minerals in one pill), are the most commonly used supplement. The USPSTF's review of the evidence found that 49% of adults used at least one dietary supplement in 2007 to 2010 and 32% of adults reported using a multivitamin or multi-mineral supplement.

The Task Force reviewed studies on multivitamins, paired supplements, and single vitamins and minerals and issued three recommendation statements. The current evidence is insufficient to recommend that taking multivitamins, paired vitamin and mineral supplements, or most single vitamins or minerals will help prevent CVD or cancer. Because the USPSTF does not recommend the

use of multivitamins or supplements to prevent CVD or cancer, the Task Force assigned an "I" rating to both of the recommendations. The USPSTF recommends against the use of two specific vitamin supplements (beta-carotene or vitamin E) supplements for the prevention of cardiovascular disease or cancer. As a result, this recommendation received a "D" rating. The Task Force found that beta-carotene supplements can also increase the probability that people who are already at risk for lung cancer (such as current smokers) will get lung cancer. According to the USPSTF, in general, the safest and most effective way for most people to get essential nutrients is to eat a healthy and balanced diet.

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. If the recommendations are finalized with "I" and "D" ratings then the use of vitamin and mineral supplements to prevent heart disease, stroke, and cancer will not be required to be covered without cost-sharing under the ACA.

Comments on the draft are due December 9, 2013 and can be submitted at:

[http://www.uspreventiveservicestaskforcecomments.org/?dno=aDR0ampMUUnFadIkIM2O\\$](http://www.uspreventiveservicestaskforcecomments.org/?dno=aDR0ampMUUnFadIkIM2O$)

Read the draft recommendation statement at:

<http://www.uspreventiveservicestaskforce.org/draftrec2.htm>

Learn more about preventive services covered under the ACA at: [HHS.Gov](http://www.HHS.Gov)

Learn more about the USPSTF at: <http://www.uspreventiveservicestaskforce.org/>

**11/7/13 HHS announced that \$150 million in Health Center New Access Point Grants was awarded nationally to support 236 new health center sites** across the country. The investments, authorized by ACA §10503, will increase access to preventive and primary health care to approximately 1.25 million additional patients. The sites will increase access to culturally competent primary health care services and improve the health status of underserved and vulnerable populations.

As community-based organizations, health centers are prepared to be responsive to the specific health care needs of their community. Health Center New Access Point Grants support the establishment of new service delivery sites and expand access to high quality health care. Health centers serve a crucial outreach function by providing individuals with the information and assistance they need to enroll in health insurance through the Health Insurance Exchange (Marketplace). Currently, approximately 1,200 health centers operate more than 9,000 service delivery sites that provide care to over 21 million patients nationally.

In Massachusetts, six grant awards totaling \$3,489,350 were made to serve a proposed additional 24,488 patients. Funded health centers include: Caring Health Center, Springfield; Family Health Center of Worcester, Inc., Worcester; Harbor Health Services, Mattapan; Island Health, Inc., West Tisbury; Manet Community Health Center, Inc., North Quincy and the South End Community Health Center, Boston.

View a list of Health Center New Access Point grants, listed by organization and state, at: [www.hrsa.gov/about/news/2013tables/newaccesspointawards/](http://www.hrsa.gov/about/news/2013tables/newaccesspointawards/).

**11/5/13 The U.S. Preventive Services Task Force (USPSTF) issued a draft recommendation statement on screening for cognitive impairment in older adults.** The U.S. Preventive Services Task Force (USPSTF) concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for cognitive impairment. The USPSTF concluded that the current evidence is insufficient to assess the value of screening older adults for cognitive impairment and assigned an "I" rating to the recommendation. The "I" rating indicates that the Task Force does not recommend the service. The draft recommendation statement applies to adults who do not already illustrate symptoms of cognitive impairment.

Cognitive impairment, which ranges from mild cognitive impairment to severe dementia, includes many disorders that cause a person to experience problems with memory or other mental activities. Alzheimer's is one type of cognitive impairment that begins as mild memory problems and progresses to severe dementia. Aging is the main risk factor for cognitive impairment. During office visits, doctors can screen for cognitive impairment using brief question-and-answer assessments. Screening also can include tests that measure abilities related to brain function such as memory, language skills and range of attention.

According to the USPSTF, cognitive impairment affects millions of older Americans and dementia affects approximately 2.4 to 5.5 million Americans and its prevalence increases significantly with age. Although the USPSTF's evidence review found no evidence on whether early detection of cognitive impairment helps patients, caregivers, and doctors make decisions about health care or plan for the future, the Task Force did find that some screening tools can successfully identify people who have early stage dementia.

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. If the recommendation is finalized with an "I" rating then screening for cognitive impairment in older adults will not be required to be covered without cost-sharing under the ACA.

Comments on the draft are due December 2, 2013 and can be submitted at: [uspreventiveservicestaskforce](http://uspreventiveservicestaskforce)

Read the draft recommendation statement at: <http://www.uspreventiveservicestaskforce.org/draftrec.htm>

Learn more about preventive services covered under the ACA at: [HHS.Gov](http://HHS.Gov)  
Learn more about the USPSTF at: <http://www.uspreventiveservicestaskforce.org/>

## **Commonwealth of MA News**

### **MassHealth and Health Safety Net Regulation Changes**

EOHHS has posted proposed changes to MassHealth and Health Safety Net regulations 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.

The proposed regulations are available for review online at: [Mass.Gov](http://www.mass.gov) or may be requested in writing or in person from MassHealth Publications, 100 Hancock Street, 6th Floor, Quincy, MA 02171.

A public hearing will be held on Monday, December 2, 2013, at 10 am in the Worcester Public Library (Main), 3 Salem Square, Worcester, MA 01608, 508-799-1655. Written comments are due by Tuesday, **December 3, 2013 at 5pm**. Additional information about the hearing and instructions for submitting comments can be found at: <http://www.mass.gov/eohhs/docs/eohhs/eohhs-regs/ad-2013-aca-ph.pdf>.

The regulations proposed at a public hearing on November 4, 2013 are the same regulations to be proposed at the public hearing on December 2, 2013. There have been no changes in the interim. Comments and testimony provided in response to the public hearing on November 4, 2013 will be considered along with any additional comments and testimony received in response to the public hearing scheduled for December 2, 2013.

#### **MassHealth to hold One Care Q&A in Framingham**

MassHealth representatives will be in Framingham on Friday, November 22 for a presentation and Q&A on One Care. One Care is a new option for people with disabilities who are 21-64 years old to get the full set of services provided by MassHealth and Medicare, including Medicare Part D. More information about this free community information session is below.

**Date:** Friday, November 22, 2013  
**Time:** 1:00-3:00 PM  
**Location:** Framingham Public Library, Costin Room  
49 Lexington St., Framingham

American Sign Language interpreters and a CART Reporter will be present. Those who need language assistance to participate should email [onecare@state.ma.us](mailto:onecare@state.ma.us).

Bookmark the **Massachusetts National Health Care Reform website** at: [National Health Care Reform](http://www.mass.gov/nhcr) to read updates on ACA implementation in Massachusetts.

Remember to check the Mass.Gov website at: [Dual Eligibles](http://www.mass.gov) for information on the **"Integrating Medicare and Medicaid for Dual Eligible Individuals"** initiative.