



AFFORDABLE CARE ACT MASSACHUSETTS IMPLEMENTATION UPDATE

January 21, 2014

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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 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

1/10/14 DOL posted the 18th set of Frequently Asked Questions (FAQs) regarding the implementation of various provisions of the ACA. The FAQs have been prepared by the DOL, HHS, and the Treasury. This set of FAQs addresses coverage of preventive services, limitations on cost-sharing, expatriate health plans, wellness programs, fixed indemnity insurance, and the Mental Health Parity and Addiction Equity Act of 2008.

According to the FAQs, non-grandfathered group health plans and non-grandfathered health insurance coverage offered in the individual or group market will be required to cover certain medications without cost sharing for women who are at increased risk for breast cancer and at low risk for adverse medication effects. Under ACA §1001, all of the services recommended by the U.S. Preventive Services Task Force (USPSTF) 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 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 service. 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. Because this recommendation received a "B" rating the medication will be required to be covered without cost-sharing under the ACA.

The FAQs also address limitations on cost sharing. As required by §1302, beginning on or after January 1, 2015 annual cost sharing imposed by health plans on members must have an out-of-pocket maximum which limits overall out-of-pocket costs on all essential health benefits (EHB). According to the FAQ, plans and insurers are permitted to structure a benefit design using separate out-of-pocket limits, dividing the annual limit on out-of-pocket costs across multiple categories of benefits, provided that the combined amount of any separate out-of-pocket limits applicable to all EHBs under the plan does not exceed the annual limitation on out-of-pocket maximums for that year under §1302.

Among other topics, the agencies describe the impact of the ACA on the Mental Health Parity and Addiction Equity Act (MHPAEA). The ACA builds on 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 were required to 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 FAQ's at: <http://www.dol.gov/ebsa/faqs/faq-aca18.html>

1/10/14 CMS/HHS issued a final rule called "Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers." The final rule sets forth new requirements for several Medicaid authorities under which states may provide and pay for home and community-based long-term services and supports. According to CMS, the regulations enhance the quality of home and community-based services (HCBS) programs, provide additional protections to individuals that receive services under these Medicaid authorities and ensure that individuals receiving services and supports through Medicaid's HCBS programs have full access to the benefits of community living and are able to receive services in the most integrated setting.

The final rule amends the Medicaid regulations to outline state plan section 1915(i) home and community-based services (HCBS) under the Social Security Act as amended by the ACA. According to CMS, under the rule states have new flexibility in providing necessary and appropriate services to elderly and disabled populations. The final rule describes Medicaid coverage of the optional state plan benefit to furnish HCBS and draw federal matching funds. Consistent with the requirements of ACA §2601, the rule allows states to use a five-year renewal cycle to align concurrent waivers and state plan amendments that serve individuals eligible for both Medicaid and Medicare. In addition, the final rule also amends Medicaid

regulations to provide home and community-based setting requirements related to ACA §2401 for section 1915(k) of the Act, the Community First Choice State plan option.

Other key features of the rule: allows states to combine target groups within one 1915(c) waiver, establishes characteristics of home and community based settings across the various authorities the rule addresses (1915(c) (i) and (k)), and establishes person centered planning requirements.

HCBS became available in 1983 when Congress added section 1915(c) to the Social Security Act, giving states the option to receive a waiver of Medicaid rules governing institutional care. In 2005, HCBS became a formal Medicaid State plan option and now several states include HCBS services in their Medicaid State plans.

Read the final rule (which was published in the Federal Register on January 16, 2014) at: <http://www.gpo.gov/fdsys/pkg/FR-2014-01-16/pdf/2014-00487.pdf>

For more information regarding the Home and Community-Based Services available under Medicaid, please visit: <http://www.medicaid.gov/HCBS>

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

News

1/14/14 The U.S. Preventive Services Task Force (USPSTF) issued a final recommendation statement on screening for gestational diabetes in pregnant women. The USPSTF recommends screening for diabetes developed during pregnancy, or gestational diabetes, in asymptomatic pregnant women after 24 weeks of gestation. Gestational diabetes is the persistent inability to process starches or sugars into energy in women who did not have diabetes before pregnancy. The condition usually resolves after birth, but can put pregnant women and their babies at risk for health problems.

Maternal and fetal health issues caused by gestational diabetes include: labor and birth complications, preeclampsia (a condition in pregnant women characterized by high blood pressure that, if left untreated, may result in life-threatening seizures), and increased likelihood of developing diabetes later in life. Infants and children may suffer overly large birth weight, birth injuries, glucose intolerance, and obesity in childhood. According to the Task Force's research, the prevalence of gestational diabetes in the United States is 1% to 25%, depending on patient demographics and diagnostic thresholds. This is the first time the USPSTF has recommended any routine screening for gestational diabetes in pregnant women. In 2008, the panel found that the evidence was insufficient to suggest such tests either before or after 24 weeks.

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.

Since the USPSTF issued a "B" rating for the recommendation to screen all asymptomatic

women for gestational diabetes after 24 weeks of pregnancy, the screenings will be added to the benefits covered by insurers under the ACA without cost-sharing. According to the USPSTF, the prevalence of gestational diabetes in women is on the rise, as obesity, older age during pregnancy, and other risk factors become more common among pregnant women. The USPSTF also stated that the current evidence is insufficient to recommend that clinicians screen for gestational diabetes earlier than 24 weeks of pregnancy. This recommendation received an "I" rating so it will not be a covered benefit under the ACA without cost-sharing.

Read the USPSTF's final recommendations at: [USPSTF](#)

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

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

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.