



AFFORDABLE CARE ACT MASSACHUSETTS IMPLEMENTATION UPDATE

October 19, 2015

Quick Links

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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

Health Center Program's Service Area Competition – Additional Areas, \$4206. Announced October 14, 2015.

Funding is available to improve the health of underserved communities and vulnerable populations across the country by assuring continued access to comprehensive, culturally competent, quality primary health care services. Health Center Program funds support a variety of community-based and patient-directed public and private nonprofit organizations that provide primary and preventive health care services to underserved populations nationally.

Eligible applicants are limited to public or nonprofit private entities, including tribal, faith-based, or community-based organizations that provide comprehensive primary health care services to a qualified service area located in California, Illinois, Kansas, Massachusetts, Missouri, New York, and West Virginia. \$10,825,654 is available for seven awards.

Applications are due December 14, 2015.

The announcement may 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: www.mass.gov/eohhs/gov/commissions-and-initiatives/healthcare-reform/national-health-care-reform-plan/grants-and-demonstrations.html

Guidance

10/16/15 HHS/CMS issued a notice under the Paperwork Reduction Act of 1995 (PRA) seeking comments on the revision of a currently approved information collection activity related to the Evaluation of the Graduate Nurse Education (GNE) Demonstration Program.

The GNE Demonstration, which is mandated under ACA §5509, states that the five selected demonstration sites receive “payment for the hospital’s reasonable costs for the provision of qualified clinical training to advance practice registered nurses.” Furthermore, §5509 also requires that an evaluation of the GNE Demonstration must be completed no later than October 17, 2017. The evaluation includes analysis of the following: (1) growth in the number of advanced practice registered nurses with respect to a specific base year as a result of the demonstration; (2) growth for each of the following specialties: clinical nurse specialist, nurse practitioner, certified nurse anesthetist, certified nurse-midwife; and (3) costs to the Medicare program as result of the demonstration.

According to HHS/CMS, the information collected through the evaluation of the GNE project will be used to meet the requirements specified under §5509, to determine the overall effectiveness of the GNE project, to understand how the demonstration is implemented overall, how that implementation has changed over time, which aspects of the demonstration have been successful or unsuccessful, and what plans the sites have for the remainder of the implementation and after the demonstration formally ends.

Comments are due December 15, 2015.

Read the notice at: www.gpo.gov/fdsys/pkg/FR-2015-10-16/pdf/2015-26390.pdf (see item #2)

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

News

10/14/15 HHS awarded \$240 million in funding to the National Health Service Corps (NHSC) and NURSE Corps scholarship and loan repayment programs. \$176 million in funding for the awards was provided through the ACA §5207. Funds will help increase access to primary care services in underserved communities by increasing the size of the primary care workforce.

The NHSC and the NURSE Corps provide funding to primary care clinicians and students in exchange for their service in underserved communities. These programs also assist in removing financial barriers for health professionals interested in practicing a primary care discipline, enabling them to pursue community-based careers. These awards will support the following programs: the National Health Service Corps Scholarship Program; the National Health Service Corps Loan Repayment Program; the National Health Service Corps Students to Service Loan Repayment Program; the NURSE Corps Scholarship Program; NURSE Corps Loan Repayment Program; the Faculty Loan Repayment Program, and the Native Hawaiian Health Scholarship Program.

Currently, more than 9,600 NHSC primary care medical, dental, nursing and behavioral and mental health practitioners are providing care to people living in underserved areas. Additionally, over 2,000 NURSE Corps nurses are also working in communities to improve access to care.

For more information about NHSC programs, please visit: HRSA.GOV

For more information about NURSE Corps programs, visit: HRSA.GOV

For more information about this announcement, visit: HHS.GOV

10/12/15 The U.S. Preventive Services Task Force (USPSTF) issued a final recommendation statement on screening for high blood pressure in adults. The USPSTF concluded that screening people ages 18 and older for high blood pressure has a beneficial impact on important health outcomes. The Task Force assigned an “A” rating to the recommendation, indicating that the USPSTF recommends the service because there is high certainty that the net clinical benefit is substantial.

The USPSTF’s evidence review found that high blood pressure (hypertension) is a highly prevalent condition, affecting approximately 30% of the adult population. It is the most commonly diagnosed condition at outpatient office visits and also raises a person’s risk for heart attack, stroke, and kidney and heart failure. According to the Task Force, accurate screening and appropriate treatment of hypertension can help prevent strokes, heart attacks, and other health conditions. In 2010, high blood pressure was a primary or contributing cause of death for more than 362,000 Americans. High blood pressure is a leading cause of death in the United States, particularly among older Americans.

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 began on or after September 23, 2010. Since the screening recommendation was with an "A" rating, then this service must be provided without cost sharing.

Read the final recommendation statement at: www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/high-blood-pressure-in-adults-screening

Learn more about preventive services covered under the ACA at: HHS.Gov

Learn more about the USPSTF at: www.uspreventiveservicestaskforce.org

10/7/15 CMS announced results of the first shared savings performance year for the Comprehensive Primary Care (CPC) initiative, authorized by ACA §3021.

During this first shared savings performance year, the CPC initiative decreased Medicare Part A and Part B spending compared to spending targets while achieving high quality outcomes. The initiative generated a total of \$24 million in gross savings overall (excluding the CPC care management fees). These results reflect the work of 483 practices that served approximately 377,000 Medicare beneficiaries and more than 2.7 million patients overall.

Four of the CPC initiative's seven regions (Arkansas, Colorado, Cincinnati-Dayton region of Ohio, and Oregon) generated gross savings. The Greater Tulsa region decreased costs in excess of the CPC care management fees, generating net savings of \$10.8 million and earning more than \$500,000 in shared savings payments. None of the participating regions are in Massachusetts.

Launched in October of 2012, the CPC initiative is a multi-payer partnership between Medicare, Medicaid, commercial payers, and primary care practices in seven regions (Arkansas, Colorado, New Jersey, Oregon, Capital District and Hudson Valley in New York, Cincinnati-Dayton region in Ohio and Kentucky, and Greater Tulsa in Oklahoma). This initiative supports a core set of five "comprehensive" primary care functions: (1) risk-stratified care management; (2) access and continuity; (3) planned care for chronic conditions and preventive care; (4) patient and caregiver engagement; and (5) coordination of care across the medical neighborhood.

To learn more about this initiative, visit: CMS.GOV

10/7/15 CMS announced a new ACO Dialysis Model, authorized by ACA §3022. This model is designed to improve care for Medicare beneficiaries with kidney failure while reducing costs.

The Comprehensive End Stage Renal Disease (ESRD) Care (CEC) Model is a new ACO (Accountable Care Organization) model that is designed specifically for Medicare beneficiaries with ESRD and builds on experiences from other models and programs with ACOs, including the Pioneer ACO Model and the Medicare Shared Savings Program.

In the CEC Model, dialysis facilities, nephrologists, and other providers have joined together to form ESRD Seamless Care Organizations (ESCOs) to coordinate care for ESRD beneficiaries. ESCOs will be financially accountable for quality outcomes and Medicare Part A and B spending, including all spending for dialysis services, for their ESRD beneficiaries. This model is designed to encourage dialysis providers to think beyond their traditional roles in care delivery and support beneficiaries as they provide patient-centered care that will address beneficiaries' health needs in and out of the dialysis facility.

ACOs are groups of doctors, hospitals, and other health care providers who come together voluntarily to give coordinated high quality care to the Medicare patients they serve. Coordinated care helps ensure that patients, especially the chronically ill, get the right care at the right time, with the goal of avoiding unnecessary duplication of services and preventing medical errors. According to CMS, when an ACO succeeds in both delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program. Since passage of the ACA, more than 360 Medicare ACOs have been established in 47 states, serving over 5.6

million Americans with Medicare.

In total, thirteen applicants were selected to participate in the CEC Model. None of the applicants were from Massachusetts.

For more information on the CEC Model, please visit: CMS.GOV

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.



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