AFFORDABLE CARE ACT
MASSACHUSETTS IMPLEMENTATION UPDATE

April 19, 2016

Quick Links

MA-ACA Website

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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

Creating a National Network of Partners to Promote Cancer Prevention through Human Papillomavirus (HPV) Vaccination, §4002. Announced April 12, 2016.

Funding is available to develop and maintain a national network of cancer-prevention organizations, convene a national meeting of cancer prevention and HPV immunization stakeholders, and fund and manage pilot projects that are designed to address the barriers to HPV vaccine uptake. These strategies are designed to increase public and provider understanding of the burden of HPV-associated cancers, and accelerate the full implementation of HPV vaccination recommendation and vaccine delivery so as to further the prevention of HPV associated cancers.

This application process is open to any type of entity or organization. $2,000,000 is available for one award.

Applications are due June 3, 2016.

View the announcement at: GRANTS.GOV

Behavioral Risk Factor Surveillance System, (BRFSS), §4002. Announced April 6, 2016.

Funding is available to continue to provide financial and technical assistance to state and territorial health departments to maintain behavioral surveillance through the BRFSS and increase the use of BRFSS data by health departments to inform public health actions to improve health.

The BRFSS is an annual telephone survey that collects data on emerging public health issues, health conditions, risk factors and behaviors of non-institutionalized adults ages 18 years and older. The BRFSS is the principal source of state-specific surveillance information about health risk behaviors and health status among the states' resident population.

BRFSS statistics have been used to support public health programs and policies that seek to improve population health.

Eligible applicants are limited to state governments previously awarded funding under this opportunity. Note that Massachusetts has not previously been awarded funding under this program.

Applications are due May 6, 2016.

View the announcement at: GRANTS.GOV

ACA Program for Early Detection of Certain Medical Conditions Related to Environmental Health Hazards, §10323(b). Announced April 8, 2016.

Continued funding is available to provide screening, health education, and outreach services for residents of a geographic area subject to declared public health emergencies under the Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA).

Eligible applicants are limited to states or organizations previously awarded funding under this opportunity. Note that Massachusetts has not previously been awarded funding under this program.

Applications are due May 6, 2016.

To view this announcement, visit: 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

4/11/16 IRS/Treasury issued Revenue Procedure 2016-24, which provides indexing adjustments for certain provisions under sections 36B and 5000A of the Internal Revenue Code.

Revenue Procedure 2016-24 updates the Applicable Percentage Table in § 36B(b)(3)(A)(i) to provide the Applicable Percentage Table for 2017 which is used to calculate an individual's premium tax credit. This revenue procedure also updates the required contribution percentage in § 36B(c)(2)(C)(i)(II) for plan years beginning after calendar year 2016. The percentage is used to determine whether an individual is eligible for affordable employer-sponsored minimum essential coverage (MEC, §1501) under § 36B. Additional details about the methodology to determine an individual's required contribution percentage and indexing adjustments for these amounts can be found in Revenue Procedure 2016-24. The contribution percentage is used to determine whether an individual is eligible for an exemption from the individual shared responsibility payment because of a lack of affordable MEC.

The individual shared responsibility provision requires each nonexempt individual to have basic health insurance coverage known as MEC, qualify for an exemption, or make a shared responsibility payment when filing their federal income tax return.

To be recognized as MEC, coverage must offer substantially the same consumer protections as those enumerated in the Title I of ACA relating to non-grandfathered, individual health insurance coverage to ensure consumers are receiving adequate coverage.

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. 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. 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 for certain individuals enrolled in QHPs offered through the Exchanges and §1412 provides for the advance payment of these reductions to issuers.

More information about the Individual Shared Responsibility Provision is available at the IRS Questions and Answers page at: https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision

Read Revenue Procedure 2016-24 at: https://www.irs.gov/pub/irs-drop/rp-16-24.pdf

4/6/16 HHS/DOL/Treasury announced updates to the Summary of Benefits and Coverage (SBC) template and Uniform Glossary. The improvements include an additional coverage example and language and terms to improve consumers' understanding of their health coverage. Health plans and issuers will use this final SBC template beginning on the first day of the first open enrollment period that begins on or after April 1, 2017.

ACA §10101(b) requires group health plans and health insurance coverage in the group and individual markets to provide an SBC and uniform glossary. The requirement is designed to help plans, employers and individuals better understand their health coverage, as well as to gain a better understanding of other coverage options for comparison. ACA §10101(b) requires that group health plans and health insurance carriers in the group and individual markets provide an SBC that concisely and accurately describes the benefits and coverage available under the applicable plan or coverage. Plans and issuers are also required to provide a comprehensive uniform glossary of commonly used health coverage and medical terms.

Changes have also been made to the SBC to improve readability for consumers. The new templates include more information about cost sharing, such as enhanced language to explain deductibles and a requirement that plans address individual and overall out-of-pocket limits in the SBC. The improvements reflect input from consumer groups, the National Association of Insurance Commissioners, and other stakeholders.

Further information regarding the SBC and supporting materials can at: https://www.cms.gov/cciio/Resources/Forms-Reports-and-Other-Resources/index.html#Summary%20of%20Benefits%20and%20Coverage%20and%20Uniform%20Glossary and at: www.dol.gov/ebsa/healthreform/regulations/summaryofbenefits.html

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

News

4/12/16 The U.S. Preventive Services Task Force (USPSTF) issued a final recommendation statement on the use of aspirin to prevent cardiovascular disease (CVD) and cancer. The final recommendation statement includes several recommendations that address four different age groups.

According to the USPSTF, CVD and cancer are the leading causes of death for adults in the United States. Heart attacks and strokes are responsible for 30% of deaths, and colorectal cancer is the third most common cancer in the United States, causing an estimated 50,000 deaths in 2014.

The Task Force's review concluded that taking aspirin can help 50- to 69-year-olds who are at increased risk of CVD prevent heart attacks and stroke, as well as help prevent colorectal cancer, if taken for at least 10 years. The draft recommendation applies to people who are not at increased risk for bleeding, have at least a 10-year life expectancy, and are willing to take low-dose aspirin daily. The USPSTF recommends that adults aged 50 to 69 should talk with their doctor about their risk of CVD and the risk of bleeding, and discuss whether taking aspirin is right for them. The USPSTF stated that adults can reduce their risk of CVD and colorectal cancer by quitting smoking, eating a healthy diet, and engaging in physical activity. Additionally, keeping blood pressure and cholesterol under control can also help to prevent heart attacks and strokes.

Furthermore, the USPSTF specified that daily use of low-dose aspirin has the most overall benefit for people 50 to 59 years old who have increased risk of heart attack or stroke. The Task Force recommends aspirin use in this age group and assigned a "B" grade to the recommendation.

People 60 to 69 years old with increased risk can also benefit from taking aspirin. However, the overall benefit for this group is smaller, so the decision to take aspirin should be an individual one based on patients' risk for cardiovascular disease and bleeding, their overall health, and their personal values and preferences. The USPSTF assigned a "C" grade to this recommendation.

The Task Force also concluded that the current evidence is insufficient to assess the balance of benefits and harms of aspirin use in two age groups, adults younger than 50 or 70 and older, and assigned an "I" rating to the recommendation for these age groups.

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 only aspirin use in adults aged 50 to 59 years was finalized with a "B" rating, then such use will be required to be provided without cost sharing for that population.

Read the final recommendation statement at:
www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/aspirin-to-prevent-cardiovascular-disease-and-cancer

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

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

4/11/16 CMS/HHS announced the launch of the Comprehensive Primary Care Plus (CPC+) model, the largest-ever multi-payer initiative designed to improve quality and cost, giving doctors and patients more control over health care delivery. This initiative is authorized under the CMS Innovation Center, ACA §3021.

The CPC+ model will be implemented in up to 20 regions that CMS will select across the country and can accommodate up to more than 20,000 doctors and clinicians, providing care for up 25 million patients. According to CMS, the initiative is designed to provide doctors the freedom to care for their patients in the way they think will deliver the best outcomes and to pay them for achieving results and improving care.

Building on the Comprehensive Primary Care Initiative that was launched in late 2012, the five-year CPC+ model will increase support for patients with serious or chronic diseases in order to achieve their health goals; give patients 24-hour access to care and updated health information; deliver continued preventive care; engage patients and their families in their own care and work together with hospitals and other clinicians, including specialists, to provide better coordinated care for their patients.

Primary care practices will participate in one of two tracks. Both tracks will require practices to perform the functions and meet the criteria listed above, but practices in Track 2 will also provide more comprehensive services for patients with complex medical and behavioral health needs, including, as appropriate, a systematic assessment of their psychosocial needs and an inventory of resources and supports to meet those needs.

CMS will select regions for CPC+, soliciting applications from commercial insurers (including plans offered via state or federally facilitated Health Insurance Marketplaces), Medicare Advantage plans, states (through the Medicaid and CHIP programs, state employees program, or other insurance purchasing), Medicaid/CHIP managed care plans, state or federal high risk pools, self-insured businesses or administrators of a self-insured group. CMS will enter into a Memorandum of Understanding (MOU) with selected payer partners to document a shared commitment to align on payment, data sharing, and quality metrics in CPC+.

This five year model will begin in January 2017; applicants must respond to the CMS solicitation by June 1, 2016.

To view the CMS solicitation for applications, visit: CMS.GOV

To learn more about CPC+, 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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