AFFORDABLE CARE ACT
MASSACHUSETTS IMPLEMENTATION UPDATE

September 21, 2015

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

Nurse Anesthetist Traineeships, §5308. Announced September 11, 2015.

Funding is available to provide traineeship support for licensed registered nurses enrolled as full-time students in an accredited graduate-level nurse anesthesia program. This opportunity will train nurses to become nurse anesthetists. Traineeships will pay full or partial costs of tuition, books/e-Books, and fees, and the reasonable living expenses (stipends) of trainees during the period for which the traineeship is provided.

Eligible applicants are limited to schools of nursing, nursing centers, academic health centers, state or local governments and other public or private nonprofit entities determined eligible by the Secretary of the U.S. Department of Education that are accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs. $2,250,000 is available for 80 awards.

Applications are due November 20, 2015.

The announcement may be viewed at: HRSA.GOV

Nurse Faculty Loan Program (NFLP), §5311. Announced September 11, 2015. Funding is available to increase the number of qualified nursing faculty and staff at graduate nursing schools. The NFLP is designed to prepare and train qualified nurse educators to fill faculty vacancies and increase the number of trained nurses entering the workforce. According to HRSA, this goal is accomplished by supporting schools of nursing that prepare graduates to serve as nurse faculty.

Eligible applicants are limited to accredited schools of nursing that offer educator coursework as part of an advanced education nursing degree program(s) that prepares the student to serve as nursing faculty. $22,500,000 is available for 100 awards.

Applications are due November 30, 2015.

This announcement may be viewed at 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: http://www.mass.gov/eohhs/gov/commissions-and-initiatives/healthcare-reform/national-health-care-reform-plan/grants-and-demonstrations.html

Guidance

9/15/15 HHS/FDA issued a draft guidance document for industry called "A Labeling Guide for Restaurants and Retail Establishments Selling Away-From-Home Foods--Part II (Menu Labeling Requirements in Accordance with 21 CFR 101.11)."

According to HHS, the final guidance will help certain restaurants and similar retail food establishments comply with the menu labeling requirements, including the requirements to provide calorie and other nutrition information for standard menu items, including food on display and self-service food. The draft guidance uses a question and answer format and is intended to help covered restaurants and similar retail food establishments comply with the nutrition labeling requirements of the final rule (which was published in the Federal Register on December 1, 2014).

ACA §4205 requires that calorie information be listed on menus and menu boards in restaurants and similar retail food establishments that are part of a chain and in vending machines with 20 or more locations. According to the FDA, the requirements will help combat obesity by assisting consumers in maintaining healthy dietary practices. New information will provide consumers with more nutritional information about the foods they eat outside of the home. These establishments will be required to clearly and conspicuously display calorie information for standard items on menus and menu boards, next to the name or price of the item.

Comments are due November 2, 2015.

Read the draft guidance (which was published in the Federal Register on September 16, 2015) at: http://www.gpo.gov/fdsys/pkg/FR-2015-09-16/pdf/2015-23232.pdf

9/15/15 HHS/CMS issued a notice reopening the comment period for a proposed rule called "Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities." The proposed rule (which was published in the Federal Register on July 16, 2015) implements portions of ACA §6101, §6102, §6121 and §6401.

The proposed rule would revise the requirements that long-term care facilities must meet to participate in the Medicare and Medicaid programs. These proposed changes are necessary to reflect the substantial advances that have been made over the past several years in the theory and practice of service delivery and safety. These proposals are an integral part of CMS's efforts to achieve broad-based improvements both in the quality of health care furnished through federal programs, and in patient safety, while at the same time reducing procedural burdens on providers.

Comments are now due October 14, 2015.

Read the notice at: http://www.gpo.gov/fdsys/pkg/FR-2015-09-15/pdf/2015-23110.pdf

9/14/15 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 Cost-Sharing Reduction Reconciliation.

According to CMS, the data collection will be used by HHS to make payments or collect charges from health insurance issuers under the following ACA programs: advance payments of the premium tax credit, advanced cost-sharing reductions, and Marketplace (Exchange) user fees. According to CMS, the data collection establishes the data elements that a QHP issuer would be required to report to HHS in order to establish the cost-sharing reductions provided on behalf of enrollees for the benefit year and eliminates some data elements and requires summary plan level reporting and reporting in the 2016 reconciliation cycle on the dollar amount of 2014 cost- sharing reductions used in calculations for medical loss ratio and risk corridors programs reporting.

Beginning October 1, 2013, qualified individuals and qualified employees could purchase private health insurance coverage through Exchanges (Marketplaces) for January 1, 2014 effective dates. The ACA established Affordable Insurance Exchanges (§1311(b)) to provide individuals and small business employees with access to health insurance coverage beginning January 1, 2014. Furthermore, an Exchange makes an advance determination of tax credit eligibility for individuals who enroll in a qualified health plan (QHP) through the Exchange and pursue financial assistance (§1401, 1411, and 1412). QHPs are health plans that have been certified by an Exchange, provide essential health benefits (EHB, §1301) and follow established limits on cost-sharing (such as reduced deductibles, copayments, and out-of-pocket maximum amounts).

Using information available at the time of an individual applicant's enrollment, the Exchange determines whether the individual meets income and other requirements for advance payments and the amount of the advance payments that can be used to pay premiums. Advance payments are made periodically to the issuer of the QHP in which the individual enrolls (§1412). §1402 provides for the reduction of cost sharing for certain individuals enrolled in a QHP through an Exchange and §1412 provides for the advance payment of these reductions to health insurance issuers. Moreover, the ACA directs the issuers to reduce EHB cost sharing for individuals with household incomes between 100% and 400% FPL who are enrolled in a silver level QHP through an individual market Exchange and who are eligible for advance payments of the premium tax credit.

Comments are due November 13, 2015.

Read the notice at: http://www.gpo.gov/fdsys/pkg/FR-2015-09-14/pdf/2015-22959.pdf

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

News

9/15/2015 HHS awarded over $500 million in funding under ACA §10503 to increase access to primary care at 1,344 health centers in every U.S. state, the District of Columbia, Puerto Rico, the U.S. Virgin Islands and the Pacific Basin.

According to HHS, the awards will help support health centers nationwide in providing

primary care services by hiring new health care providers and operating additional hours. $350 million in expanded service program awards will increase access to services such as medical, oral, behavioral, pharmacy, and vision care in approximately for 1,184 health centers. An additional $150 million in Infrastructure Investment program awards will be awarded to 160 health centers for facility renovation, expansion, or construction to increase patient or service capacity. These investments will help health centers reach an estimated 1.4 million new patients nationwide, including 26,602 patients in Massachusetts.

The expanded service program awardees included thirty five health centers in Massachusetts, receiving $10,055,576; while the Infrastructure Investment program awarded $3,999,046 to four health centers in Massachusetts.

For a complete list of Massachusetts Expanded Service awardees, visit: HRSA.GOV

For a complete list of Massachusetts Health Infrastructure Investment Program awardees, visit: HRSA.GOV

To read this announcement, visit: HHS.GOV

9/15/15 The U.S. Preventive Services Task Force (USPSTF) issued a draft recommendation statement on the use of aspirin to prevent cardiovascular disease (CVD) and cancer. The draft 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 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. If the recommendations on the use of aspirin to prevent CVD and cancer are finalized, then only aspirin usage for adults 50 to 59 years old who have increased risk of heart attack or stroke will be required to be provided by health plans without cost sharing.

Comments are due October 12, 2015 and can be submitted at:
http://www.uspreventiveservicestaskforce.org/Comment/Collect/Index/draft-recommendation-statement/aspirin-to-prevent-cardiovascular-disease-and-cancer

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

9/14/15 CMS announced that the deadline to submit letters of intent for The Million Hearts Cardiovascular Disease Risk Reduction Model application has been extended. The initiative is authorized under ACA §3021.

Funding is available to health care professionals for a randomized controlled trial to design sustainable models of care that help reduce 10-year atherosclerotic cardiovascular disease risk (ASCVD) and prevent heart attacks and strokes for Medicare beneficiaries. Eligible applicants include private practices, community health centers and other community-based clinics, hospital-owned physician practices, hospital/physician organizations, or retail clinics. Selected applicants will be divided between intervention practices and control group practices. Intervention practices will receive a one-time $10 per beneficiary fee to calculate a beneficiary's ASCVD risk score and to engage the patient in shared decision-making. In year one, CMS will make an additional $10 monthly Cardiovascular Care Management payment per beneficiary for risk management for the highest-risk patients. During years two through five, intervention practices can receive a monthly CVD CM payment of up to $10 per beneficiary based on the reduction of their high-risk beneficiary ASCVD risk scores. Control group practices will be paid a $20 per-beneficiary payment (based on the estimated costs of preparing and transmitting the required data) for each reporting cycle.

Heart attacks and strokes are leading causes of death and disability in the United States. Co-led by CMS and the CDC, Million Hearts is a national HHS initiative which aims to prevent one million heart attacks and strokes by 2017.

Required Letters of Intent and applications are now due on October 10, 2015.

For more information about the Million Hearts Initiative, visit: HHS.GOV

View the announcement at: CMS.GOV

Upcoming Events

Integrating Medicare and Medicaid for Dual Eligible Individuals (also known as One Care) Open Meeting

Wednesday, September 23, 2015
10:00 AM – 12:00 PM
Worcester Public Library
3 Salem Square
Saxe Room
Worcester, MA

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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