Department for the Aging

DFTA's Healthcare Newsletter *September 2017*

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ACA Repeal and Replacement

The Affordable Care Act (ACA) still remains the law of the land, after it was announced on September 26th that Senate Republicans' latest attempt at a repeal -- the Graham-Cassidy bill -- did not have enough support to be brought to a vote by the September 30th deadline.[1,2] Most insurance plans, healthcare provider groups, and patient advocate stakeholders came out strongly against any ACA repeal, including many governors (including at least 4 Republicans) and all 50 state Medicaid directors. Most Republican senators have expressed their desire to move on to other topics, including tax reform; in addition, some Democrats and Republicans hoped they could return to a bipartisan solution to incrementally fix the existing law.

The Graham-Cassidy bill—sponsored by Republican Senators Lindsay Graham (R-SC), Bill Cassidy (R-LA), Dean Heller (R-NV), and Ron Johnson (R-WI)—introduced an altered version of previous ACA repeal bills. It would have repealed major provisions of the ACA in favor of more state flexibility, including eliminating federal funding of ACA subsidies (used by low-income people to purchase coverage on a marketplace) and redirecting it as block grants back to the states to run their own healthcare programs with vast discretion over how to spend it.

Key Summary Points on the ACA Repeal

1) The ACA remains the law of the land after the latest Republican repeal effort—the "Graham-Cassidy bill"— failed to garner sufficient support in the Senate.
2) Although no official score was released, the bill would have likely reduced the federal deficit, mainly through massive Medicaid cuts, and given states more flexibility. It also would have caused millions to lose their health insurance coverage. Finally, it would have shifted funding away from states that previously expanded Medicaid towards those that did not; many analyses expected New York and California to receive the largest cuts, amounting to multiple billions of dollars annually.
3) There are no immediate plans for revising the ACA at this time, but many hope to continue bipartisan efforts to improve the legislation, including stabilization of the marketplace. The two senators who suspended efforts on their bipartisan bill after the introduction of the Graham-Cassidy legislation—Republican Lamar Alexander and Democrat Patty Murray—are considering the recommencement of work on that legislation.

In addition, the bill proposed the following:

- To allow states to establish health insurance plans outside ACA protections and mandates (including allowing insurers in some states to charge more for people with pre-existing conditions or to refuse to cover essential services);
- Immediate elimination of both individual and employer mandates; and
- To establish block grant per-capita Medicaid caps, while eliminating all federal funding to those states wishing to continue the ACA Medicaid expansion after 2020.

[1] This follows failed votes this past summer on different versions of repeal legislation in the Senate.

[2] As the Republicans planned to use the budget reconciliation process – which requires only a majority vote rather than 60 votes in the Senate – Congress would have needed to pass any legislation affecting the FY2017 budget before the end of the federal fiscal year (which ended September 30).

On September 25th, the Congressional Budget Office (CBO) released a preliminary analysis of the bill, estimating that it would likely have reduced the federal deficit by at least $133 billion, the same projected savings from the House-passed proposal, while shifting funding away from states that previously expanded Medicaid under the ACA towards those that did not. Other analyses predicted that those Democratic-leaning states that had already expanded Medicaid would have faced the largest funding cuts; for example, New York could have seen a $51.6 billion reduction in federal funding, or 35 percent cut, between 2020 and 2026. In addition, it would likely result in millions of people losing insurance over the next decade, although exactly how much would depend primarily on state implementation. The Center on Budget and Policy Priorities has estimated, based on previous CBO analyses of earlier repeal bills, that as many as 32 million people could lose coverage. A CBO analysis detailing the full effects of the proposal is expected within a few weeks' time.

Other Reform Proposals: Prior to this last-minute repeal attempt, there had been some bipartisan efforts to "repair" the ACA, mainly focused on stabilizing the healthcare marketplace. On July 31st, a coalition of about 40 House Republicans and Democrats – the *Problem Solvers Caucus* (led by Reps. Tom Reed (R-NY) and Josh Gottheimer (D-NJ)) – announced a 5-element plan to develop a healthcare stabilization bill. A bipartisan group of governors—led by John Kasich (R-OH) and John Hickenlooper (D-CO)—was working on its own plan to improve the ACA. The Senate HELP Committee – led by Sens. Lamar Alexander (R-) and Patty Murray (D) – also held hearings on similar stabilization efforts starting September 6th, but after strong opposition from the Trump administration and Republican leadership, this effort was abandoned in favor of pushing forward with one last repeal attempt.

In addition, some lawmakers from both parties continued to propose throwing out the ACA in favor of other options, neither of which are likely to materialize. Members of the conservative *House Freedom Caucus* are still demanding total ACA repeal in favor of total state government control. Meanwhile, in early September, Senator Bernie Sanders (I-VT) again introduced the "Medicare for All Act of 2017", with 16 Democratic co-sponsors including Sen. Kirsten Gillibrand (D-NY), essentially creating a universal healthcare model by expanding the Medicare program to all Americans. There have been numerous other bills proposed by legislators, but at this time, none have gained any traction.

Trump Administration Efforts: Meanwhile, the Trump administration has shown its desire to undermine the integrity of the ACA through administrative actions, which can be implemented without the approval of Congress. The Department of HHS cut advertising funding for the 2018 ACA open enrollment period by 90 percent (from $100 million to $10 million), as well as a 42 percent cut in funding (from $62.5 million for 2017 to about $36 million next year) for all "navigator" organizations, which are grass-roots advocacy groups who assist people with enrollment in plans on the marketplaces.[3] The administration claimed navigator methods were ineffective, in addition to their belief that advertising was no longer necessary since more Americans knew about the ACA. In addition, the ACA enrollment period[4] was shortened 45 days, ending December 15th rather than January 31st.

[3] The navigator groups whose funding may be cut are only in those 38 states using the federal ACA marketplace, HealthCare.gov. Twelve other states, including New York State, run their own marketplaces and fund their own enrollment programs.

[4] While the Trump administration cut the period for enrollment into the federal health marketplace, New York state DOH officials announced that enrollment into the state marketplace will remain open until January 31, 2018.

Another major concern amongst stakeholders was whether or not the Trump Administration would eliminate or reduce subsidies under the ACA. At this point, the administration guaranteed that the subsidies (also known as cost-sharing reductions, CSR) were paid through at least September 2017. According to the latest CBO report, released August 15th, eliminating the ACA subsidies could increase premiums for individuals by an average of 20 percent next year and increase the deficit by $194 billion over the next 10 years. Without a congressional appropriation, however, the administration could stop the payments in any given month, leading to more uncertainty as insurers in most states have to make final decisions about 2018 market participation soon.

Other Federal News

HHS/CMS Updates: In addition to focusing on the future of the ACA, the Department of HHS has had an active few months.

CMS announced that the premiums for its prescription drug program, Medicare Part D, declined for the first time in five years; the average basic monthly premium was $33.50 in 2018 compared to $34.70 in 2017.[5] However, the program's overall costs continue to rise faster than other parts of Medicare due to the high costs of specialty drugs.

Did you know…

*…the annual Open Enrollment Period for Medicare plans is from **October 15 to December 7, 2017**. During this time period, Medicare beneficiaries can make changes to their Part D prescription drug plans and Medicare Advantage coverage.*

On September 14th, CMS announced the release of its newly designed Medicare card, part of its new fraud prevention initiative to combat identify theft. The new Medicare card will remove beneficiaries' Social Security numbers, which will be replaced with unique, randomly-assigned numbers (Medicare Beneficiary Identifier, or MBI). CMS will begin mailing the new cards to beneficiaries in April 2018, with a Congressional deadline to replace all existing Medicare cards by April 2019.

On September 20th, CMS released a request for information (RFI) seeking feedback on a possible new direction for its Center for Medicare and Medicaid Innovation (CMMI). Created under the ACA, the CMMI develops and tests healthcare payment and service delivery innovations; as expected, the RFI proposes a more market-driven focus, pursuing more flexibility in lieu of mandatory demonstrations. Comments must be submitted by November 20, 2017**.**

Finally, on September 29th, HHS Secretary Tom Price resigned amid controversy over his use of private charter planes paid with taxpayer funding. His official replacement has yet to be announced, but Acting Assistant Secretary for Health Don Wright was named as a temporary replacement.

***Other Legislation*:** On September 27th, the Senate unanimously passed the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017, (S. 870), which would give Medicare beneficiaries with chronic conditions the flexibility to be part of an accountable care organization (ACO) and expand telehealth services under Medicare Advantage. According to an August CBO report, it is estimated to reduce Medicaid and Medicaid spending by $217 million between fiscal years 2018 and 2022. The bill—sponsored by Senators

[5] New York State's Part D low-income subsidy amount will be $38.98 in 2018. Therefore, in 2018, the benchmark plans in New York State will have premiums of approximately this amount.

Orrin Hatch (R-UT), Johnny Isakson (R-GA), and Mark Warner (D-VA)—also included a 2-year extension of the Independence At Home (IAH) program, which began in 2012 under the ACA.

CMS Informational Releases

The following informational bulletins and letters were released by CMS over the summer:

- 2017 Spousal Impoverishment Standards: identifying the minimum and maximum amount of resources and income protected for the community spouse in 2017
- Strategies to Streamline Transitions for Medicaid-eligible Beneficiaries Who Newly Qualify for Medicare
- Implications of the *21st Century Cures Act* for Special Needs Trusts and Medicaid Eligibility

State News

ACA Repeal and Impact on New York: According to Governor Cuomo, the Graham-Cassidy bill would have likely cut federal funding for New York by $18.9 billion by 2026 and resulted in 2.7 million New Yorkers losing health insurance coverage. During previous ACA repeal efforts, Governor Cuomo and Attorney General Schneiderman stated their intent to sue the federal government if the ACA were to be repealed. In June, the Governor also announced a directive to safeguard health insurance coverage -- any plan that withdraws from the New York State of Health marketplace would be barred from Medicaid; health plans, however, questioned the legality of this directive. His proposal would also guarantee the 10 essential benefits already required under the ACA, while preventing any discrimination based on gender, age, or pre-existing conditions.[6]

NY State of Health: While the Trump administration cut the period for enrollment into the federal health marketplace, state DOH officials announced that enrollment into the state marketplace (NY's State of Health) will remain open until January 31, 2018. The latest enrollment data shows that the rate of uninsured New Yorkers has fallen to its lowest level ever recorded—from 10 percent, when the state marketplace opened, to 5 percent; however, 1.1 million New Yorkers under the age of 64 still remain uninsured.

In mid-August, the NYS Department of Financial Services (DFS) announced the 2018 premiums that will be offered for different insurance plans listed on the state's marketplace. On average, premiums will increase by 14.6 percent for individual plans and by 9.3 percent for small group plans. Rates for individuals were 55 percent lower, adjusting for inflation, than they were prior to the establishment of the state marketplace in 2014. It was also reported that nearly 60 percent of individuals who shopped on the NY State of Health last year qualified for financial assistance, some in the form of tax credits.

Over the summer, it was announced that both Affinity Health Plan and CareConnect (operated by Northwell Health) would be withdrawing from the state's health insurance marketplace for 2018. Even without these two choices, New York State consumers will have 12 options to choose from next year. It was also announced that Fidelis Care[7]–which offered plans on the state's insurance marketplace—was sold to the for-profit Centene Corporation, the country's largest Medicaid managed care organization.

[6] New York, in fact, is one of only two states in the nation that already prohibits any form of age rating, which keeps premiums lower for older people, but makes them more expensive for younger people.

[7] Fidelis also operated Medicaid managed care and Medicare Advantage products in New York as well.

Disproportional Share Hospital (DSH) program: Regardless, the state could lose $2.6 billion annually in federal funding by 2025 under an existing ACA measure – cuts in Medicaid to the Disproportional Share Hospital (DSH) program. DSH funding goes to public and safety net hospitals that care largely for the uninsured, and New York is expected to see the largest amount of cuts compared to any state. It is expected to have an enormous impact on NYC's Health + Hospitals (H+H) system, which treats approximately 425,000 uninsured patients per year and could lose more than $300 million in federal funding next year. While these cuts have previously been delayed many times, they officially took effect October 1, 2017; however, there was some indication that Congress would try to find a bipartisan fix.

State Court Cases: The New York State Court of Appeals unanimously ruled against the right to "aid in dying" on September 7th, *Myers v. Schneiderman*, stating that terminally-ill patients do not have a constitutional right to physician-assisted suicide; however, the court left the door open for supporters to pursue legislation to regulate the process. While some states have laws allowing this process, recent state and federal court decisions have affirmed states' rights in prohibiting assisted suicide as well.

The New York Appellate Division, 2nd Department, also announced two other decisions on September 13th—*Andreyeyeva v. New York Health Care* and *Moreno v. Future Care Health Services*—that could have a large impact on the home care industry and their patients. The court ruled that home care aides who do not reside with their employers must be paid at least the minimum wage for all 24 hours of a live-in shift, rejecting the state's "13-Hour Rule"–based on a 2010 NYS Department of Labor (DOL) opinion letter—as violating minimum wage laws.[8] The previous DOL interpretation meant home care agencies would typically pay non-residential aides for 13 hours of work, as long as the aides were also given 8 hours for sleep (including 5 hours of uninterrupted sleep time) and three hours for meals. DOL and DOH are reviewing the decision, but unless it is appealed again, home care agencies would be required to pay an additional 11 hours of wages and could owe aides up to six years' worth of back pay. The ruling also comes as the state is in the midst of implementing a higher minimum wage, to reach $15 per hour for big employers (11 employees or more) in NYC by the end of 2018.

Managed LTC Updates: A United Hospital Fund report, released in June, highlights that statewide enrollment in the Managed Long-Term Care (MLTC) program grew 14 percent in 2015 and another 20 percent in 2016. As of September 2017, there were 189,071 enrollees across the state, of whom 144,761 (or 77 percent) were located in NYC. However, North-Shore-LIJ Health Plan MLTC notified their enrollees[9] in September that the plan would no longer operate an MLTC program after December 31, 2017—this following the closure in some counties of GuildNet and HomeFirst MLTC plans announced earlier this year. Current enrollees will automatically be transferred to Centers Plan for Healthy Living MLTC effective December 1, 2017, unless they choose an alternative plan by November 10, 2017.

The HHS Office of Inspector General (OIG) released a report in September stating that the state's Medicaid program made $1.4 billion of improper payments to MLTC plans in fiscal year 2014. Specifically, State DOH did not ensure that MLTC plans properly documented individuals' eligibility assessments, nor whether the plans provided community-based services according to

[8] New York's law requires the minimum wage be paid "for the time an employee is permitted to work, or is required to be available for work at a place prescribed by the employer."

[9] As of September 2017, there were 5,645 individuals in Nassau, Suffolk, and NYC counties.

the enrollees' written care plans, all of which are requirements spelled out in the plans contracts with the state. However, contracts did not include language enabling the state to recover payments from providers who don't meet their obligations. State Medicaid director Jason Helgerson said the state is working to improve compliance and monitoring, but disagreed with the OIG's overall assessments as he believes many of the issues were clerical errors.

***DSRIP Update*:** The state is now currently in Year 3 of DSRIP, which started on April 1, 2017. As part of its waiver agreement with CMS, the state agreed to require that at least 80 percent of all managed care organization (MCO) payments use value-based payment (VBP) methodologies by the end of the DSRIP program (April 2020). The approved roadmap says the state must reach this minimum target in order to receive federal funding; if this target is not met, federal funding will be reduced.

Upcoming Trainings

The State DOH and some of the local performing provider systems (PPS) continue to hold free trainings on how organizations can prepare for the future of value-based payment. The NYSDOH will host its next VBP Bootcamp at 5 different locations; the NYC training will be held on Wednesday, October 18th. In addition, the Bronx Health Access PPS will also be offering a training on Evaluation and Developing a Value Proposition for their CBO social service partners on Friday, October 20th.

All Level 2 and 3 VBP arrangements must implement interventions addressing a minimum of one social determinant of health, and providers will receive a funding advance to invest in an intervention.[10] In addition, every Level 2 or 3 VBP arrangement must also include a minimum of one Tier 1 CBO (non-profit, non-Medicaid billing, community-based social and human service organization) starting *January 2018*. CBOs who enter into VBP arrangement contracts are not required to take on any financial risk, and the state expects that most CBO payments will remain on a fee-for-service basis. However, if the CBO is willing to do so, it may be able to contract to receive a portion of the shared savings.

The configuration of VBP arrangements for MLTC plans is notably different from those arrangements outlined for mainstream Medicaid managed care. The state requires every MLTC plan to convert its provider contracts into "MLTC Level 1 VBP arrangement contracts" at a minimum, which is defined as a performance bonus agreement, *prior to 2018*.[11] Under the MLTC Level 1 arrangement, providers can receive either incentive payments for reporting data and/or a portion of shared savings (i.e., bonuses) if they meet performance targets of state-recommended quality measures. While the state requires that all "category 1" quality measures be reported, MLTC plans and providers can choose which measures will be linked to payment in each contract arrangement.

Local News

LGBTQ Healthcare Bill of Rights: Over the summer, the de Blasio administration and the NYC Department of Health and Mental Hygiene (DOHMH) announced a LGBTQ Health Care Bill of Rights, which highlights existing protections at city, state, and federal levels to protect against discrimination in all healthcare settings. Protections include the right to have one's gender identity recognized and accommodated, and the right to choose who will make medical decisions if an individual is unable to do so.

[10] Level 1 arrangements are not required to address SDH, but can receive additional payment bonuses if they do.

[11] MLTC plans and their providers may choose to move forward on their own and engage in Level 2 or 3 VBP arrangements instead.

Health + Hospitals (H+H): On September 25th, a new President/CEO was nominated to lead the City's public hospital system (H+H). Dr. Mitchell Katz, current director of the Los Angeles County Health Agency, will replace interim CEO Stanley Brezenoff to lead the system pending approval of the H+H Board of Directors. The nominee recently expressed in Crain's that he would like to continue current efforts in order to address H+H's fiscal challenges, including expanding primary care and shifting to outpatient services, but that the system will also need more "privately-insured patients" to be more diverse and secure.

H+H was also recently highlighted in a Commonwealth Fund report, "An Emerging Approach to Payment Reform: All-Payer Global Budgets for Large Safety-Net Hospital Systems," which discussed all-payer global budgets in large safety-net hospitals. The report details some of the initiatives that H+H and its PPS, OneCity Health, are using to transform care under DSRIP, including primary care improvement, collaborating with community partners, identifying high-need patients, and integrating behavioral health and primary care.

***Supportive Housing*:** H+H also announced in mid-August its partnership with social service agency Comunilife in constructing a supportive and affordable community residence building. The 89-unit building, located on the campus of H+H/Woodhull in Brooklyn, is expected to open in December 2018. More than half of the units will be designated for behavioral health patients discharged from Woodhull without permanent housing. The city's DOHMH will provide support services to residents, and Comunilife will offer on-site social services.

Did you know…

…the month of September is both Alzheimer's Awareness Month and National Senior Center Month? In addition, September 22nd was the 10th annual Falls Prevention Awareness Day (FPAD); the U.S. Senate recently passed a resolution designating the day nationally to raise awareness and encourage the prevention of falls among older adults.

… 1 in 3 Medicare beneficiaries, or 19 million people, are now enrolled in Medicare Advantage (MA) plans? Since the ACA passed in 2010, enrollment into this managed care sponsored program has grown by 71 percent and is expected to grow even more. In addition, UnitedHealthcare and Humana insurance companies account for a combined 41 percent of the country's entire MA market population.

…the Aging and Disability Business Institute has launched a new Readiness Assessment tool to help community-based organizations (CBOs) determine their capacity and preparedness for engaging in contractual partnerships with the healthcare sector?

…the Administration for Community Living (ACL) also launched a new website featuring a searchable database of nearly 200 community-based oral health programs for seniors, in addition to other resources?

Suggested Reading

***Capped Financing for Medicaid Does Not Account for the Growing Aging Population*:** *The AARP Public Policy Institute released a fact sheet in June 2017 discussing the House repeal legislation's (AHCA) proposal to shift to per-capita capped financing in Medicaid, and how it could constrain the Medicaid program in its ability to adequately serve beneficiaries. It includes projections showing that the proposal would not keep pace with changing demographics, such as the growing and aging of the 65 and older population.*

Medicare Rights Toolkits: *The Medicare Rights Center's MedicareInteractive.org offers resources to assist Medicare beneficiaries, their caregivers, and other stakeholders in understanding complex topics. Recent toolkits --* *Medicare and Medicaid long-term care coverage in New York State* *and* *Moving from the Marketplace to Medicare in New York State* *-- offer presentations and other informational materials on topics such as LTC program benefit comparisons (including coverage and eligibility) and how to enroll in different insurance plans.*

Why Loneliness Is a Public Health Threat*: this August article, published in Fortune magazine, describes how the growing trend of social isolation is a major public health threat contributing to premature deaths, similar to the impact of obesity. The impact of loneliness – whether it be smaller social networks or one's objective state of being alone – on mortality exceeds that of many leading health indicators.*

Ask us anything! Please let us know if there is anything more you'd like to know about healthcare reform. Email Meghan, DFTA Division of Planning and Technology, at MShineman@aging.nyc.gov.

NOTEWORTHY ACRONYMS & DEFINITIONS

ACA = Affordable Care Act (also known as Obamacare)

ACL = U.S. Administration of Community Living

Accountable Care Organization (ACO): groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to the patients they serve.

AHCA = American Health Care Act (also referred to as Trumpcare or Ryancare); House of Representative's 2017 ACA repeal legislation

Congressional Budget Office (CBO): U.S. federal agency responsible for offering nonpartisan analysis on the budget and economic impacts of proposed legislation.

CBO = Community-based Organizations

CMS = Centers for Medicare & Medicaid Services

DSRIP = Delivery System Reform Incentive Payment (DSRIP) program

HHS = U.S. Department of Health and Human Services

MLTC = Managed Long-Term Care

NYSDOH = New York State Department of Health

PPS = Performing Provider System

Value-based payment (VBP): payment based on quality of healthcare, rewarding value (keeping people healthy) rather than over volume (number of services provided).