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Potential ACA Repeal:

Congressional Action: The Republicans have begun their efforts to repeal the Affordable Care Act (ACA), now that both the Senate (51-48) and House (227-198) passed a budget resolution through a reconciliation process that would defund major provisions of the ACA.¹ Congressional committees now have until January 27th to produce and agree on the overall repeal legislation. On his first day in office, President Trump signed an executive order which allows federal agencies to “waive, defer, grant exemptions from or delay” provisions of the ACA that impose regulatory or financial burdens. Any official replacement plan from the Administration is not expected until after the confirmation of Rep. Price (R-GA) for Secretary of Dept. of Health and Human Services (HHS), which had been slightly delayed due to increased criticism from Democrats regarding Price’s previous health-related investments during his Congressional tenure.

The expectation is that final repeal legislation will be signed by mid-February, before Congress takes its first 2017 recess, but it may take several weeks or months to complete the entire repeal strategy and to develop, pass, and implement a replacement plan. President Trump called for an immediate vote on ACA repeal simultaneously with a replacement, which should include “insurance for everybody”; Vice-President Pence subsequently said that their replacement plan would make health insurance “affordable for everyone.”

Key Summary Points on the ACA Repeal

- 1) Congressional Republicans and the Trump Administration have begun initial attempts at repealing the ACA.
- 2) Large disagreement on how long and what shape the process should take – may require several months for the repeal and replacement to be fully in place.
- 3) Repeal may result in the following impacts:
 - a. Up to a total of **32 million** US residents uninsured by 2026
 - b. An increase from **5% to 15%** in the proportion of uninsured NY residents, with a potential State budget deficit of more than **\$3 billion**
- 4) Replacement plans under consideration vary greatly – From the option to keep ACA within the state to complete repeal and privatization of the healthcare system.
- 5) Advocates and non-partisan groups believe most replacement plans would likely increase insurance costs for low and middle income consumers dramatically, leading some to forego insurance.

Advocacy: There has been much disagreement regarding the timeline of transition. More Republicans have begun to call to extend any repeal until a replacement is finalized, in order to ensure continued

¹ Components would include immediate elimination of the Medicaid expansion, federal subsidies, and the individual and employer mandates. However, most consumer protections and insurance market reforms would remain in place until further repeal reforms have been introduced and implemented.

coverage for many Americans, as well as to better understand any potential impacts on the federal budget. This comes as some Republican governors of states that took federal money to expand Medicaid² urge Congress to keep the expansion or implement a replacement plan immediately. Meanwhile, many Congressional hearings and roundtables have been scheduled to discuss changes to Medicaid, the role of the individual mandate, and general repeal and replace strategies.

Many [ACA advocates](#)³ – including Congressional Democrats, physician groups, healthcare unions and trade groups, and other stakeholders – have begun their defense of the program, as well as any attempts to overhaul Medicare or Medicaid, amidst fear that a repeal could have a negative impact on the country's healthcare system. With the help of [President Obama](#), Democrats have been mounting a united campaign against ACA repeal. In addition, the Democratic Governors Association (DGA), including policy chair NYS Governor Cuomo, sent a [letter](#) to Congressional leaders in late December opposing the repeal of the ACA over the impact it would have on states, particularly regarding concerns on Medicaid.

Replacement Proposals: Currently, there is no consensus around any specific replacement plan. Many have stated an interest in keeping the current—and popular—ACA consumer protections that dependents may remain on parents' insurances until the age of 26 as well as prohibiting denial of coverage based on pre-existing conditions; however, budget amendments presented to preserve these provisions were recently defeated in the Senate during reconciliation. In general, most alternative plans have supported varying versions of the following reforms:

- Eliminating coverage mandates on individuals and employers;
- Offering cheaper plan options with less required benefits;
- Allowing insurers to sell plans across state lines;
- Allowing insurers to charge higher premiums for older adults;⁴
- Creating state high-risk pools for patients with pre-existing conditions;
- Varying forms of premium subsidies or tax credits for low-income individuals;
- Encouraging expanded use of health savings accounts; and
- Converting Medicaid into a block grant or using per capita caps.

A few Congressional proposals that have been floated in the past, including:

- [A Better Way](#) initiative offered by House Speaker Paul Ryan (R-WI);
- [Patient Choice, Affordability, Responsibility, and Empowerment \(CARE\) Act](#) sponsored by Senate Finance Chair Orrin Hatch (R-UT), Sen. Richard Burr (R-NC), and House Energy and Commerce Chair Fred Upton (R-MI);
- [Empowering Patients First Act \(HR 2300\) of 2015](#), proposed by Rep. Tom Price (R-GA), who is nominated for Secretary of Health and Human Services;
- [American Health Care Reform Act of 2017](#), sponsored by Rep. Phil Roe (R-TN) and supported by the Republican Study Committee (RSC); and
- [The Patient Freedom Act of 2017](#), a proposal introduced this week – from Sen. Bill Cassidy (R-LA) Sen. Susan Collins (R-ME), 2 other Republicans, allows states to keep the ACA if they choose.

² Out of the 31 states that implemented ACA Medicaid expansion, 16 have Republican governors.

³ Letters supporting ACA provisions have been sent to both Congress and the Trump transition teams from many healthcare stakeholders, including: Leadership Council of Aging Organizations; American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, and American College of Physicians; and American Medical Association.

⁴ Under the ACA, they can charge a maximum of 3x rate for younger people, but that could increase to as much as 5x.

Potential Impact: Recent reports have indicated that, under most ACA repeal proposals, a large majority of Americans covered through ACA mechanisms (i.e., Medicaid expansion and individual exchanges) will lose their current health insurance coverage and premiums would likely increase dramatically. The [Urban Institute](#) estimated that any “repeal and delay” plan – without immediate replacement – could increase the number of uninsured by as many as 30 million people nationally. The [Congressional Budget Office](#) (CBO) supported this finding, stating that elimination of the ACA’s mandate penalties and subsidies, but leaving some of the insurance market reforms in place, would leave 18 million people uninsured within the first year, increasing to 32 million by 2026.

On January 4th, the Cuomo administration [announced](#) the potential impact of an ACA repeal on New York State, if no replacement plan was enacted. More than 2.7 million New Yorkers could lose health insurance –including more than 1.6 million NYC residents—meaning the uninsured rate in the state could reach 15 percent, from its current low of 5 percent. Financially, a repeal could also result in a deficit of \$3.7 billion in the state budget, in addition to a loss of more than \$433 million for NYC to fund Medicaid locally.

Other National News:

Prescription Drug Pricing: Following Trump’s campaign promise to reign in prescription drug pricing, there has been a large push for reform from Congress and other stakeholders. Twenty Senate Democrats and Independents, including NY Senator Kirsten Gillibrand, sent a [letter](#) to President-Elect Trump in late December urging him to allow the Department of HHS to negotiate drug prices; create legislation to stop unjustified price hikes; and improve competition by allowing more generic competitors to enter the market. Legislation was introduced in early January, by both Rep. Peter Welch (D- VT)⁵ as well as 9 Democratic Senators, which would either permit the government to negotiate the price of prescription drugs covered by Medicare Part D and/or to import drugs from Canada. The amendment was recently voted down in the Senate, but may be revisited again later this year.

Governmental reports released in December 2016 support these calls for reform. A [bipartisan report](#) on drug prices from the Senate Aging Committee investigated the practices and rising prices of controversial prescription drug makers, and offered strategies such as speeding the review and approval of lower-cost generic drugs and empowering the Food and Drug Administration (FDA) to occasionally import medicines. The Department of HHS also released [reports](#) to Congress indicating that federal spending on drugs in Medicare, Medicaid, and the Veterans Affairs health program has dramatically increased, largely due to the soaring costs of expensive specialty medications.

Potential Medicare Reforms

While a repeal of the ACA would have a large impact on those ages 55-64, there would be limited impact on those over 65 (beyond some Medicare protections, like low-to-no cost preventive care and closing of Part D donut holes).

However, some of the Republicans’ additional proposals – that may increase individuals’ out-of-pocket payments – may include:

- *Funding premium supports, such as vouchers or tax credits, at fixed sums;*
- *Raising full eligibility age from 65 to 67; and*
- *Eliminating “Balanced Billing Protections” that deny doctors the right to charge patients more than Medicare reimbursements.*

Most of these changes, however, would need 60+ vote majority in the Senate, rather than using a reconciliation process.

⁵ See [Medicare Prescription Drug Price Negotiation Act](#) (H.R. 242) legislation.

VA Healthcare Reform: Prior to inauguration, Trump was considering creating a “public/private option” for the U.S. Department of Veterans Affairs (VA) and met with five health care leaders to discuss it. In related news, Dr. David Shulkin – former CEO of NYC’s Beth Israel Medical Center from 2005 to 2009 – was announced as nominee for VA Secretary; he currently serves as undersecretary for health at the VA under President Obama.

Medicare-Medicaid ACO Model: In mid-December, CMS announced the [Medicare-Medicaid Accountable Care Organization](#) (MMACO) Model, a new initiative designed to improve the quality of care and lower costs for dual eligibles, beneficiaries who are enrolled in both Medicare and Medicaid. It will allow *Medicare Shared Savings Program* ACOs to take on accountability for the quality of care and both Medicare and Medicaid costs for duals. CMS is accepting letters of intent from up to 6 states that wish to design certain state-specific elements of the model, with priority given to those states with a low Medicare ACO saturation. However, it is important to consider that if Rep. Tom Price is approved as HHS Secretary, and if the ACA is repealed, the future of any mandatory CMMI demonstration projects will remain uncertain.

PACE Expansion: CMS is currently soliciting [feedback](#) on a 5-year program that would expand the Program of All-Inclusive Care for the Elderly (PACE) to younger dual eligibles. Under the bipartisan [PACE Innovation Act](#), which was signed into law in November 2015 and provides authority to test the application of PACE-like models for additional populations, the new “Person Centered Community Care” (P3C) model would target dual eligibles over age 21 with mobility-related disabilities who would need a skilled nursing facility but are currently ineligible for PACE. Comments are due by February 10, 2017.

State News:

State of the State & Budget Proposal: During the week of January 9th, Governor Cuomo presented his [State of the State](#) addresses at 6 different locations, highlighting his legislative agenda for 2017-2018. This was followed, on January 17th, by the release of his [\\$152.3 billion budget proposal](#) for 2017-18; a final state budget is due on April 1st. While he briefly mentioned his administration’s fight to preserve the ACA against repeal, including the authority to adjust spending depending on federal changes, little specifics on healthcare were offered. At \$18.3 billion, Medicaid is the largest item of the overall budget, accounting for about 12 percent, although its growth has remained within the state’s required Medicaid cap.⁶ Other proposals include:

- A plan to cap the rising costs of prescription drugs reimbursed under Medicaid, aided by a state review board;
- Proposal to eliminate the law that allows legally-responsible individuals to refuse to pay the cost of caring for an institutionalized family member receiving Medicaid;
- \$225M to support the 2018 minimum wage increases for Medicaid health care workers;
- Possible \$50M reduction in Medicaid funding for School Supportive Health Services in NYC;
- Elimination of the (underutilized) funding for the 2015 wage increase COLA to direct care workers and providers;
- Continues the \$1M increase for the Community Services for the Elderly (CSE) program and \$1.1M in discrete transportation funding to localities;

⁶ The total cost of the program, including federal contributions, is projected to be \$65.2 billion next fiscal year. The Medicaid cap, based on a 10-year rolling average of the Medical Consumer Price Index, is currently estimated at 3.2 percent.

- \$500M in capital grants for Essential Health Care Providers, which could pay for hospital mergers or acquisitions, including a \$50 million investment for the Montefiore Health System in order to expand into the Bronx and lower Hudson Valley;
- Continues the \$25M investment in care and support services for individuals with Alzheimer's disease and their caregivers;
- Three-year extension of the state's [Health Care Reform Act](#) (HCRA), which directs hospital reimbursement and other initiatives based on taxes on private insurers and healthcare providers; and
- Raising the cost of the Essential Plan (an ACA health insurance option) for low-income residents.

MLTC Updates: The Managed Long-Term Care (MLTC) Value-Based Payment (VBP) Clinical Advisory Group (CAG) released their [MLTC Recommendation Report](#) at the end of 2016, and was posted for public comment until January 9, 2017. The report informs providers and payers of the details of each VBP arrangement while suggesting associated quality measures (i.e. such as falls reductions). Recommendations from the CAG will be further explored throughout the early phases of VBP implementation. Recall that under NYS's DSRIP program, all managed care plans must have entered into at least 80% of payment arrangements as VBP. While the state believes that any savings accrued from VBP for duals (who are required to enroll in an MLTC plan) will accrue to Medicare rather than Medicaid, NYSDOH will continue to work more with CMS on this topic.

In other MLTC news, nonprofit [CenterLight Healthcare](#) has sold their Bronx-based MLTC Select plan to for-profit Centers Health Care (who operates *Centers Plan for Healthy Living MLTC* from Staten Island), making it the 3rd largest MLTC in the state. CenterLight's nearly 5,000 members will automatically transition into Centers Plan on February 1st, unless they had already chosen to change MLTC plans by January 11th. Both plans have insisted on a smooth transition; regardless, many advocates fear a reduction in home care hours. Having recently stopped its offering of a FIDA plan at the end of 2016, CenterLight's only managed care products include its PACE plan and Medicare Special Needs Plan (SNP). This news comes following November's announcement of GuildNet's leaving the MLTC market outside of NYC; however, GuildNet has since stated that they will continue to offer coverage in Westchester and Long Island while they work with the NYS Department of Health (DOH) to better address their needs.

DSRIP Update: The DSRIP Independent Assessor (Public Consulting Group Inc. (PCG)) recently finalized their [Mid-Point Assessment](#) reports for all 25 statewide PPS organizations. As we approach the end of DSRIP Year 2 – ending March 31, 2017 – more than half the federal money awarded to the PPSs remains unspent. However, of those funds already awarded, more than 70% have been received by hospitals and the management offices/governance structures of each PPS; the assessment encourages PPSs to better engage and fund their key partners, especially community-based organizations, going forward.

NY Hospital Pricing: A new study prepared by Gorman Actuarial shows that hospital pricing in New York varies widely, especially downstate, and appears to depend on market leverage (i.e., its bargaining power when negotiating with insurers) rather than quality. The report – [Why Are Hospital Prices Different? An Examination of New York Hospital Reimbursement](#) – was sponsored in part by the Cuomo administration and the NYS Health Foundation. The highest-priced facilities charged insurers 2.2 to 2.7 times more than the lowest-priced hospitals. Generally speaking, hospitals that are part of a hospital system with a large market share tend to be higher-priced as a result of the power of that hospital system in contract negotiations, regardless of the individual hospital's size or market share. While there

was no correlation upstate, hospitals in NYC and downstate serving more Medicare and Medicaid patients tended to fetch lower prices in the private commercial market.

Safety-Net Hospital Help: Gov. Cuomo recently vetoed [legislation](#) on New Years' Eve that would narrowly define "safety net hospitals," which provide care to a high percentage of uninsured and Medicaid patients, providing them with additional state aid. The bill, which surprisingly passed both houses of the state Legislature in June, would also instruct the state to raise Medicaid reimbursement rates for hospitals that meet the new criteria. This comes as the outlook for federal health care funding is uncertain, pending the repeal and any replacement of the ACA. Cuomo did propose funding for "health care transformation activities" in his 2017-18 executive budget, and plans to move forward with other hospital reforms, such as the likely merger of at least 3 Brooklyn hospitals (following the report discussed in last month's newsletter).

Local News:

Mayor de Blasio's #GetCoveredNYC: As a record number of people nationwide signed up for insurance for 2017 under the ACA, in anticipation of any repeal changes, the De Blasio administration also hopes to help 50,000 uninsured New Yorkers get coverage through either private health insurance plans or through Medicaid by the end of open enrollment on January 31, 2017. This would represent about 10 percent of the total number of people who remain eligible for health insurance and are currently unenrolled. Announcing its [#GetCoveredNYC initiative](#)⁷ in late December, the city has planned a grassroots effort, knocking on doors and calling homes to try and persuade eligible locals to sign up. The initiative is aimed at patients who live near the city's public hospitals and use the emergency rooms there but do not sign up for health care. The campaign will cost the city \$8 million, but it expects to recoup the cost in savings of up to \$40 million for the NYC Health + Hospitals Corporation.

Take Care New York 2020: In December, NYC's Department of Health and Mental Hygiene (DOHMH) released the first annual progress report on [Take Care New York 2020](#), their plan to improve community health.

Did you know?

According to a recent [NY Times article](#), about one-third of Americans older than 65 now live alone, and half of those over 85 do. The article focuses on the physical, mental, and emotional impacts of social isolation, especially for the elderly.

The opioid epidemic is not only for younger adults; a recent [article](#) reports on how older adults are struggling with opioid addictions, sparked by physicians' prescriptions of pain medicine.

A new [study](#) released Harvard researchers in JAMA in late December evaluated whether Medicare patient outcomes differ between those who are treated by male and female (internists) physicians. Findings indicate that patients treated by female physicians had slightly but statistically significantly lower mortality and readmission rates. The authors estimate that approximately 32,000 fewer lives would die every year if male physicians could achieve the same outcomes as female physicians.

⁷ Visit the campaign: <https://www1.nyc.gov/assets/ochia/downloads/pdf/fly-933-gencov-english.pdf>

Suggested Reading

“How Repeal of the ACA will Hurt Older Americans”: Community Catalyst, a national non-profit advocacy organization, identifies how adults over age 50 may be affected by possible reforms under President Trump, including ACA repeal and Medicare or Medicaid reforms.

'Building a System that Works: The Future of Health Care': A new Health Affairs article by DHHS Secretary Burwell outlining her vision for the future of health care. In it, she touts collaboration with stakeholders in advancing crucial Delivery System Reform efforts — including ongoing CMMI initiatives.

CMS Person and Family Engagement Strategy: One of the six goals outlined in this CMS strategy is to strengthen person and family engagement as partners in care. The CMS Person and Family Engagement Strategy will serve as a guide for the implementation of person and family engagement principles and strategies throughout CMS programs.

Ask us anything! Please let us know if there is anything you'd like to know more about regarding healthcare reform. Email Meghan, DFTA Division of Planning and Technology (P&T), at MShineman@aqing.nyc.gov.

NOTEWORTHY ACRONYMS & DEFINITIONS

ACA = Affordable Care Act (also known as Obamacare)

ACO = Accountable Care Organization

CMMI = Center for Medicare and Medicaid Innovation

CMS = Centers for Medicare & Medicaid Services

Fully Integrated Duals Advantage (FIDA): The FIDA demonstration program fully integrates all Medicare and Medicaid benefits for dual eligibles aged 21 or older and in need of long term care, living in New York City or Nassau County. (FIDA is expected to expand into Suffolk and Westchester counties sometime in 2017.) The current CMS demonstration has been extended through the end of 2019.

MLTC = Managed Long-Term Care

Program of All-Inclusive Care for the Elderly (PACE): a joint Medicare and Medicaid program that helps people 55 years or older meet their health care needs in the community instead of going to a nursing home or other care facility. To qualify for PACE, you must: Live in the service area of a PACE organization; Need a nursing home-level of care (as certified by your state); and Be able to live safely in the community with help from PACE. It provides all the care and services covered by Medicare and Medicaid, as authorized by an interdisciplinary healthcare team, including coverage for prescription drugs, doctor care, transportation, home care, checkups, hospital visits, and nursing home stays when necessary.

PPS = Performing Provider System

Special-Needs Plan (SNP): a type of Medicare Advantage Plan (like an HMO or PPO) that tailors its benefits, provider choices, and drug formularies to best meet the specific needs of the groups it serves. Membership is often limited to people with specific diseases or characteristics.

Value-based Payment (VBP): Recall that VBP is a strategy used by health payers to promote quality and value of health care services, with the goal of shifting from pure volume-based payment, as exemplified by fee-for-service payments, to payments that are more closely related to outcomes. Examples of such payments include pay-for-performance programs that reward improvements in quality metrics; bundled payments that reduce avoidable complications; global trend rate targets that tie upside and downside payments to specific quality scorecards in addition to actual to target cost trend rate. For more information on New York State's policy, visit: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_reform.htm.