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ACA Repeal and Replacement

Market Stability: The Trump administration, including HHS Secretary Tom Price, has substantial power over the direction of the current ACA law, as it can implement significant changes to regulations without the consent of Congress. Using this regulatory pathway to effect change, on April 13th, CMS released [final rules on marketplace stabilization](#), which tightened the parameters around enrollment in insurance plans offered on the ACA marketplace, including:

- Shortened annual open enrollment period from 3 months to 6 weeks;
- Issued stricter documentation requirements to prove eligibility for special enrollment periods¹; and
- Eliminated the grace period for those who fail to pay their premiums.

In the future, the Trump administration may also seek to [support or destabilize](#) the ACA individual insurance marketplace by:

- Minimizing the federal government's participation and role in enrollment efforts;
- Reducing or changing the essential health benefits (e.g. mental health, mammography) that individual insurance plans offered on the ACA marketplace are required to cover;
- Weakening the individual mandate by loosening enforcement of penalties or changing who is exempt from the law; or
- Allowing more state flexibility through the ACA's [1332 State Innovation Waivers](#), including options to allow insurance plans to either deny coverage or charge higher rates for people with pre-existing conditions, or introduce work requirements for Medicaid-expansion recipients.

Key Summary Points on the ACA Repeal

- 1) Although originally thought dead for the time-being, the Trump administration has attempted to revive ACA repeal and replace discussions. It is now tasked with the responsibility of continuing to implement the ACA (in order to keep to his campaign promise of coverage for all) while also pursuing reform efforts.
- 2) Some states are considering pursuing the ACA's Medicaid expansion. In the meantime, the stability of the individual health insurance marketplaces has been brought into question, as some plans must decide by June whether to continue to offer their products.
- 3) While the question of whether to continue funding the ACA health insurance subsidies was deliberated during the debate on the government spending bill, the recent Congressional agreement kept the funding in place. Further ACA repeal and replace discussions will likely be debated at a later time, possibly in the next few weeks.

¹ Under the ACA, individuals who are sick or lose coverage outside of the standard enrollment window had access to special enrollment periods. Applicants now must demonstrate coverage "for one or more days during the 60 days preceding the date of the qualifying event that would make them eligible for special enrollment."

In addition, HHS has until May 22nd to decide if it wants to drop the appeal of the House Republican lawsuit claiming marketplace subsidies² as unconstitutional, which had been contested by the Obama administration. House Republicans have long seen this ACA provision as another government entitlement program, and claimed that the subsidies were illegal as congressional appropriations were not sought. Until the lawsuit is fully litigated, however, Republican leadership have [acknowledged](#) that the subsidies will [likely continue](#) through at least 2017, and possible for 2018 as well, in order to keep the individual insurance market stable. In fact, the recently-passed [continuing budget resolution](#) included approximately \$7 billion worth of funding to continue to pay for the ACA subsidies. Health insurance plans must now decide by June whether they want to remain in the ACA marketplaces, and given remaining uncertainty, some have already started to withdraw.

Revival of AHCA: Although the Republican effort to repeal and replace the ACA appeared to have been abandoned at the end of March, there have been renewed efforts to revive the AHCA legislation. Despite limited engagement by Speaker Ryan, President Trump has stated that his administration would continue to pursue healthcare reform, as many of his tax reform objectives are dependent on savings from healthcare reform. The administration has been actively meeting with many congressional Republicans to discuss possible changes in order to receive more support from both conservative and moderate members. While continued healthcare debates had been put on hold until after Congress returned from spring break, it appears that the AHCA has earned the support of the more conservative House Freedom Caucus following a recent flurry of amendments added to the legislation, including:

- Approval of an [amendment](#) introducing a national [risk-sharing program](#), which would add \$15 billion to the federal budget over 9 years (from January 2018 through December 2026) to help insurers pay for their high-cost, sickest enrollees; and
- Introduction of an [amendment](#) that would allow states to waive certain ACA protections and standards. It proposes to allow plans to charge individuals with pre-existing conditions higher premiums, or change the coverage of essential services (like mental health, substance abuse treatment, maternity care). Of note, the amendment would also exempt members of Congress from losing these ACA protections.

It seems that the debate over healthcare reform is far from finished, and the administration may call for a Congressional vote as early as this week. However, many experts still believe that the more conservative version of the legislation would not receive sufficient support from a more moderate Senate.

Impact on Older Adults: A recent [analysis by Avalere Health](#), funded by the SCAN Foundation, found that if the AHCA legislation—and its proposal to implement per-capita Medicaid limits—is passed, federal Medicaid spending over the next decade could decrease by \$44 billion for all dual eligibles. Much of this decrease is a result of eliminating ACA tax provisions that would significantly benefit the wealthiest Americans. The Medicaid loss would represent a 7% reduction in federal Medicaid spending for duals in New York State. For more information on how the AHCA could have impacted older adults in New York, see the Medicare Rights Center’s [state-specific fact sheets](#).

² Approximately 6 million people have received the ACA subsidies, helping to lower costs of insurance deductibles, copayments, and coinsurances.

ACA Medicaid Expansion: Following the uncertainty regarding the direction of healthcare reform—and more specifically Medicaid reform—some states are finally considering pursuing the ACA’s Medicaid expansion option. Of the [19 \(mostly Republican-leaning\) states](#) that have not yet expanded their Medicaid programs, at least 9 are also considering the possibility; some even introducing legislation.³ This continued push to expand Medicaid is supported by a [new study published in Health Affairs](#), which concludes that Medicaid expansion didn’t result in increased pressure on state budgets, contrary to what critics have claimed. According to the study, “expansion states” relied on increases in federal funding, and were not faced with the choice of increasing state Medicaid spending or making reductions to other programs.

Other National News

Executive Federal Budget: A first look at the just-passed budget resolution, which is expected to be voted on by Congress by the end of the week, suggests that most of FY2017 discretionary funding – including for programs under the Older Americans Act – will remain similar to the previous year’s levels. It is expected that May or June will bring more specific details on the FY2018 budget proposal for the year beginning this October – which may contain significant cuts to certain senior services and health programs – from both the Trump administration and Congress.

At the end of March, in testifying to a subcommittee of the House Appropriations Committee, HHS Secretary Price defended the need for more control of fraud and abuse in the Medicaid program. And the Senate Special Committee on Aging came out in a bipartisan effort against the FY2018 proposed budget cuts to the National Institutes of Health (NIH) – which would represent \$5.8 billion of the \$15 billion in cuts to the Dept. of Health and Human Services (HHS). The NIH is a major source of funding for research on topics such as dementia and Alzheimer’s diseases.

Impact on NYC: [According to different sources](#), New York City could lose somewhere between \$535 million and \$760 million, or approximately 1.3 percent of total city revenue, as a result of federal funding cuts proposed by President Trump. Notably, this may result in elimination or reduction of funding for the Community Development Block Grant program, the Low-Income Home Energy Assistance Program, the Community Service Block Grant program, and other HHS funding for chronic disease prevention.

CMS Administration Updates: In recent weeks, we have received a little more insight on how the Trump administration – and therefore HHS Secretary Price – will seek additional healthcare reforms for Medicaid and Medicare, including a focus on fraud and abuse, reduction on regulatory issues, changes in quality measurement, and more clarity on whether they will continue to pursue alternative payment models. The Government Accountability Office (GAO) issued [a report to the Senate Committee on Finance](#), advocating for CMS to enhance their efforts in working with state Medicaid agencies to pursue improper payments. In addition, Senator Grassley (R-IA) has asked CMS to tighten oversight of Medicare Advantage plans following [concerns of billions of dollars](#) in overpayments.

CMS is also seeking feedback on [“Welcome to Medicare” packets](#) sent to those individuals, living in the US and abroad, who become eligible and enrolled in Medicare; a Spanish version is available as well. Responses should be submitted by May 5th.

³ Thirty-one states have already participated in the ACA Medicaid expansion, including 15 led by Republican governors. In Kansas, the legislature voted to expand Medicaid, but Republican Governor Sam Brownback then vetoed the bill.

Income Eligibility Guidelines: On March 24th, HHS/CMS released updated [2017 federal poverty level standards](#), which are updated annually adjusting for inflation and price increases. The guidelines help determine eligibility for programs like Medicaid, the Community Services Block Grant program, and payments for ACA health subsidies; it also determines the financial eligibility for the [Medicare Savings Program](#), which can help dual-eligibles pay premiums and out-of-pocket expenses through Medicaid. In 2017, for an individual living in one of the 48 contiguous states or the District of Columbia, the annual poverty guideline is \$12,060, adding \$4,180 for each additional person; this compares to \$11,770 for an individual in 2016.

Accountable Health Communities: Over a five year period, CMS plans to implement and test the three-track [Accountable Health Communities](#) (AHC) model to support local communities in addressing the health-related social needs by bridging the gap between clinical care and community service providers. (The three tracks are: Awareness Track, Assistance Track, and Alignment Track.) This program tests the ability of clinical delivery sites and social service community-based organizations (CBOs) to partner, and thereby improve outcomes and reduce costs. However, no funds from CMS grant awards may be used to compensate CBOs for their services (e.g., housing, food, violence intervention programs, utilities, or transportation); funds may only be used to support the infrastructure and staffing needs of bridge organizations.

On April 6th, CMS announced their selection of 32 participants, representing 23 states, for two of the AHC tracks, to begin on May 1, 2017. The 12 organizations participating in the AHC Assistance Track will provide person-centered community service navigation services to assist high-risk beneficiaries with accessing needed services. The 20 participants of the AHC Alignment Track will also provide community service navigation services, as well as encourage community-level partner alignment to ensure that needed services and supports are available and responsive to beneficiaries' needs. [New York-Presbyterian Hospital](#) was awarded \$4.5 million as a participant in this track, screening Medicare and Medicaid patients in the Washington Heights/Inwood area. The final track, expected to be announced this summer, aims to increase awareness of community services through information and referrals.

Proposed Health Legislation: In early April, the leaders of the Senate Finance Committee [reintroduced legislation](#) that aims to improve health outcomes, streamline care coordination, and overhaul how Medicare pays for patients with chronic illnesses. The [CHRONIC Care Act of 2017](#) was previously introduced last December, and has bipartisan support from both the Committee Chairman Sen. Orrin Hatch (R-UT) and Sen. Ron Wyden (D-OR). Among its many provisions, the legislation proposes to extend the ACA's [Independence at Home](#) demonstration program, and also liberalizes the ability of Medicare Advantage plans to buy services outside of mandatory benefits to assist chronically-ill individuals.

[State News](#)

State Budget Update: The Governor and State legislature officially agreed on a [\\$153.1 billion state budget for FY2018](#) on April 9th. One of the larger topics under contention revolved around Gov. Andrew Cuomo's proposal for more unilateral control of state funds in order to develop the state's response to possible federal cuts. The final approved budget would give the State Director of Budget the flexibility to develop a plan if federal funding is reduced by more than \$850 million. [According to a [brief by the Fiscal Policy Institute](#), over \$70 billion of federal aid comes to New York State and its local governments, representing

more than one-third of the state's total revenue (nearly one-half of that total, or \$34 billion, is in Medicaid funding). Many state health and senior services programs could be at stake if federal funds were drastically cut.]

While not many health-related issues were specifically addressed in the final version, the budget did include the following measures:

- Funding for a 6.5 percent wage increase over the next two years for direct care professionals serving the developmentally disabled and behavioral health systems;
- Language that would require the state health commissioner to authorize fiscal intermediaries for the Consumer Directed Personal Assistance Program (CDPAP) before they can work with patients;
- Introduction of a growth cap on prescription drug spending in the state's Medicaid program (a weakened version from what Governor Cuomo had originally proposed);
- \$20 million over two years in Medicaid reimbursements to enhanced safety-net hospitals, a new category⁴ of hospitals that serve low-income New Yorkers; and
- \$500 million for the Health Care Facility Transformation Program,⁵ including a minimum of \$75 million to community-based providers, which would provide capital support to essential healthcare providers and would likely assist more mergers and consolidation in the market.

However, the final budget did not include an increase of the state's portion of the Supplemental Security Income rate (which provides financial assistance to aged, blind and disabled individuals with limited income), nor did it pass Assemblyman Gottfried's single-payer healthcare system amendment.

Medicaid funding: Given the continued uncertainty of federal healthcare reform, there has been continued debate over the AHCA's Collins-Faso amendment, which would require the state to pick up the county share of Medicaid costs (outside of NYC). [Governor Cuomo](#) and members of the state's Democratic congressional delegation released an alternative plan, the [Empire State Equity Act](#), on March 30th. The legislation would increase the federal government contribution to the state's Medicaid program by 4 percent,⁶ and would provide the state with an additional \$2.3 billion—the estimated cost of the original Collins-Faso amendment—effectively reducing what counties would pay. Meanwhile, Rep. Faso responded by introducing the [Property Tax Reduction Act](#) on April 6th, offering another way to shift the counties' cost of Medicaid onto the state. Both, however, are unlikely to be approved.

DSRIP Update: On March 30th, [CMS sent a letter](#) to the NYSDOH, approving the state's value-based purchasing (VBP) "roadmap", which outlines how the state plans to achieve payment reform as part of their DSRIP effort. Approval of the plan was required as part of New York's Section 1115 demonstration.

Hospital funding: A March 2017 report from the [New York State Health Foundation](#) evaluates the impact of the Indigent Care Pool (ICP) on hospitals in the state. Originally established to pay hospitals based on their level of need in providing charity care, it also caps the level of funding provided to public hospitals. Some of New York State's most profitable hospitals receive more than their fair share of indigent care

⁴ To meet the new criteria, hospitals must show that, in any of the last three years, at least 50 percent of their patients were uninsured or on Medicaid, at least 40 percent of inpatient discharges were billed to Medicaid, and no more than 25 percent of patients had commercial insurance. Generally, safety net hospitals must see a minimum of 3 percent uninsured patients.

⁵ This Program includes \$50 million directed to Montefiore Medical Center to expand access to affordable healthcare in Westchester County, the lower Hudson Valley, and the Bronx.

⁶ The proposal would increase the amount of federal matching funds from roughly 50 percent to 54 percent.

pool funding, whereas the New York City public hospital system, Health + Hospitals, serves a disproportionate amount of care to uninsured New Yorkers, yet receives less payments than private hospitals.

NYSOFA and CDSMP: Partnered with NYSDOH and the Quality and Technical Assistance Center of New York (QTAC-NY), the State Office for the Aging (NYSOFA) received a grant from the federal Administration for Community Living (ACL) to increase access to evidence-based self-management programs for older adults and adults with disabilities suffering from chronic disease. As a partner in the grant, DFTA has agreed to identify senior centers and naturally occurring retirement communities (NORCS) interested in the programs. The grant targets hard-to-reach and underserved populations and areas of New York, and will advance programs such as the Chronic Disease Self-Management program (CDSMP) and the Diabetes Self-Management Program (DSMP). Offered in New York City in English, Spanish, Chinese and other languages, CDSMP and DSMP are 6-week evidence-based programs developed by Stanford University to teach adults with any kind of chronic health condition how to take better care of themselves. The initiative kicks off in New York City this May 2017.

Did you know?

...April was National Minority Health Month. In recognition, [CMS released data reports](#) evaluating quality of healthcare received in Medicare Advantage plans, which showed racial, ethnic, and gender differences.

...April 16th was also "[National Healthcare Decisions Day](#)," which aims to educate and promote the value of advance care planning.

...a recent [study](#) has linked the daily consumption of diet soda, which tends to be artificially sweetened, to an increased likelihood of suffering from dementia and stroke.

*...The National Resource Center for Participant-Directed Services (NRCPDS)—now under Applied Self Direction—will host a [Self-Direction Conference](#) on **May 8th and 9th, 2017** in Baltimore, MD.*

Suggested Reading

[Guide to Healthy Eating and Active Living in NYC:](#) This resource from the New York City Department of Health and Mental Hygiene (DOHMH) offers solutions to help shop for, choose, and prepare healthy foods and suggestions to create healthy habits to remain active and fit.

[Opportunities to Improve Nutrition for Older Adults and Reduce Risk of Poor Health Outcomes:](#) ACL released a new issue brief that discusses new opportunities to enhance nutrition and health for older adults. As people age they may experience malnutrition, which may lead to poorer health as well. This brief helps to improve older adults' nutritional welfare and health status.

[The Field Guide to Managed Care: A Primer:](#) The American Society on Aging's Generations journal released a spring supplement focusing on the opportunities and challenges aging services providers face when partnering with managed care organizations. It includes articles and case studies, and outlines how agencies can be prepared and succeed in managed care systems.

[Women and Long-Term Services and Supports:](#) AARP Public Policy Institute's new fact sheet describes the importance of long-term services and supports (LTSS) for women, especially as they have a higher likelihood of receiving services as well as providing (both paid and unpaid) care.

2016 Profile of Older Americans: The ACL also released the annual summary of the latest statistics on the older U.S. population, including income and poverty, living arrangements, education, health, and caregiving. Some of the highlights include: a 30 percent increase in the population of adults over the age of 65, which represents approximately 15 percent of the total U.S. population.

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, at MShineman@aqinq.nyc.gov.

NOTEWORTHY ACRONYMS & DEFINITIONS

ACA = Affordable Care Act (also known as Obamacare)

AHCA = American Health Care Act (also referred to as Trumpcare or Ryan care)

CMS = Centers for Medicare & Medicaid Services

DSRIP = Delivery System Reform Incentive Payment program

Dual eligibles: refers to those beneficiaries qualifying for both Medicare and Medicaid benefits. In the US, approximately 9.2 million people are eligible for "dual" status.

Electronic Health Records (EHR): Also known as Electronic Medical Records (EMR). Digitalized copies of patient's health records, available instantly and securely to the network of authorized providers responsible for the patient's care. Usually contains medical history/diagnosis, current medications, treatment histories, test results, etc. Visit the [Office of the National Coordinator for Health Information Technology](#) (ONC) for more information.

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

Medicare Advantage (MA): Medicare Advantage is a managed care plan that contracts with Medicare to coordinate all care and services for Medicare beneficiaries. Plans often cover additional services such as vision, hearing, and/or dental, in addition to Part D (prescription drug) coverage. Costs usually include a monthly premium, in addition to what the beneficiary would pay under traditional Medicare.

NYSDOH = New York State Department of Health