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Healthcare Reform

ACA Status: Even though the Affordable Care Act (ACA) still remains law, the tax reform bill (see [Appendix](#)) signed by President Trump on December 22nd repealed the ACA's individual mandate requiring all individuals to have health insurance. Starting in 2019, this provision likely means millions of people will become uninsured. Those likely to drop their ACA insurance (young, healthy adults who cost insurers less) provided a counterbalance in the marketplaces to those enrollees who will likely keep buying insurance (poor, sick, and elderly individuals); with less healthy individuals buying insurance, the result will be more expensive premiums for the elderly, poor, and sick. This shift may ultimately place the ACA in a precarious position.

As part of her agreement to support the Republican tax reform, Sen. Susan Collins asked for a guarantee that Congress would pass ACA stabilization measures, including the Alexander-Murray¹ bill (also known as the [Bipartisan Health Care Stabilization Act of 2017](#)). To date, the bill has not been brought to a vote, and no additional efforts to continue cost-sharing reduction (CSR) payments² (which had been discontinued by President Trump in October) have been undertaken.

In spite of the numerous Republican efforts to repeal and destabilize the ACA, enrollment on the federal marketplace for 2018 health insurance coverage remained at high levels. (New York State also saw [higher enrollment](#) than the previous years.)

Now what? Following the passage of tax reform efforts, Republicans plan to focus on other health topics. Some suggested health reforms include repealing the ACA employer mandate (which requires employers to offer coverage to their employees) as well as increasing the number of tax exemptions for those individuals without insurance for 2018.³ In addition, on January 11th, the Trump administration issued [guidance from CMS](#) that supports state efforts to impose work or job-training requirements as a condition of eligibility for Medicaid for able-bodied adults. At least 10 states are considering this option, although [Democrats](#) and consumer advocates are questioning the legality of this restriction. It is also likely that Congressional Republicans will next pursue 'entitlement reform,' aiming to reduce spending on the Medicare and Medicaid programs in an effort to reduce the federal deficit.

Other Federal News

Future Direction of HHS: During a busy month of January, [HHS announced](#) that it was setting up a new division within its Office of Civil Rights to protect the "conscience and religious freedom" of health workers. The aim is to protect workers from carrying out actions and services

¹ In October 2017, Senators Alexander (R-TN) and Murray (D-WA) released a bipartisan compromise to help stabilize the ACA marketplaces, by continuing CSR payments for 2 years, allowing more state flexibility, and restoring federal funding for ACA outreach and enrollment.

² CSRs are subsidies paid to health insurance companies to supplement low-income enrollee's out-of-pocket costs (i.e. deductibles and copayments) on the ACA marketplace. (See Definition box.)

³ Although the individual mandate was repealed in the recent tax reform bill, this provision will not be effective until 2019, which means that individuals must still have health insurance in 2018 or pay a tax penalty.

they're religiously or morally against, such as assisted suicide, abortions, and gender reassignment surgery.

On January 24th, Alex Azar was confirmed by the Senate (55-43 vote) to be 24th Secretary of Health and Human Services (HHS). Previously an executive at pharmaceutical company Eli Lilly & Co., Azar vowed to address concerns over drug prices at his confirmation hearing.

Future Direction of CMS: The Trump administration continues to move in a different direction from the previous Obama administration. On December 15th, [CMS released new guidance](#) to all 50 state Medicaid directors that they will no longer accept proposals for new or renewed Medicaid waivers that rely on federal matching funds for Designated State Health Programs under Section 1115 waivers. (This is a large funding source of New York's DSRIP program, meaning that it will be difficult for the state to renew the program if it decides to do so after current funding ends in 2020.)

REMINDER

*...the Medicare Advantage Disenrollment Period (MADP) occurs every year from **January 1 to February 14**. Individuals looking to switch MA plans to traditional Medicare will see changes effective the first of the following month. Click [here](#) for more information.*

A recent analysis, authored by Mathematica Policy Research for the CMS Innovation Center, evaluated the [impact of the Medicare Chronic Care Management \(CCM\)](#) benefit. A new service since January 2015, CCM pays for non-face-to-face care (such as telephone calls and general care management) for traditional Medicare beneficiaries with multiple chronic conditions. The researchers found that the CCM service reduced Medicare expenditures by decreasing patient utilization (less hospitalizations, nursing home stays, and physician visits) while improving patient satisfaction and access to care. The CCM benefit provides for primary care physician (PCP) offices to subcontract with other organizations offsite for the service, making this benefit a possible revenue source for both PCPs and community-based organizations (CBOs). For more information, contact CommunityCare Link, a management services organization supported by DFTA and housed within DFTA's Aging in New York Fund.

Federal Legislation: On January 22nd, the [RAISE \(Recognize, Assist, Include, Support, and Engage\) Family Caregivers Act](#) of 2017 was signed into law. The [bipartisan law](#)⁴ calls for the development, within the next 18 months, of a national strategy for supporting the more than 40 million Americans who are family caregivers for older adults and individuals with disabilities. The goal would be to help caregivers better coordinate care and receive information, referrals, and resources; this includes promoting more person/family-centered care as well as increasing training, respite and financial security options. It also calls for the establishment of an advisory council composed of stakeholders from the public and private sectors, which shall terminate after five years.

In addition, bipartisan legislation was introduced in mid-December 2017 to renew and expand the [Money Follows the Person \(MFP\)](#) demonstration program, which aims to help older adults and individuals with disabilities transition from institutional to home and community-based care. Although it expired in October 2016, the "Ensuring Medicaid Provides Opportunities for Widespread Equity, Resources, and Care Act" – or [EMPOWER Care Act](#) – proposes to extend and improve the MFP demo for another five years.

⁴ Introduced in the U.S. Senate by Senators Susan Collins (R-ME) and Tammy Baldwin (D-WI), and in the U.S. House by Representatives Gregg Harper (R-MS) and Kathy Castor (D-FL).

State News

State Budget: On January 16th, Governor Cuomo unveiled his [FY 2019 Executive Budget](#) plan, proposing \$168.2 billion in spending, which attempts to address a \$4.4 billion deficit, caps spending at less than a 2 percent increase, and combats known and uncertain federal reforms.⁵ The budget must be approved by the final day of the NY State fiscal year, March 31st. Some relevant [healthcare](#) proposals include the following:

Supporting Healthy Aging: Proposes to create a series of policies to prepare for the growing aging population, including launching a Long Term Care Planning Council, setting the goal that 50 percent of all health systems be age-friendly within the next five years, and expanding awareness of advanced care planning;

Long Term Care:

- 1) Proposes to increase the eligibility threshold⁶ for enrolling in MLTC plans, while limiting MLTC enrollees from changing their plans (after a 30-45 day enrollment period) more than once over a 12-month period;
- 2) Proposes eliminating the spousal refusal provision under Medicaid, a law that allows individuals to refuse⁷ to pay for the care of a sick spouse;
- 3) Expands the assisted living program (ALP) by increasing the number of beds and including the benefit under the MLTC program. Also proposes a pilot program that would subsidize the cost of ALP for those with Alzheimer's and dementia⁸ who are not eligible for Medicaid;

Establishes a “Health Care Shortfall Fund”: As a way to mitigate the risk of losing federal funding, a new \$1 billion fund will be established to ensure the continued availability of healthcare dollars in New York, for things such as the state’s Essential Plan.⁹ It will be supported in part by proceeds from any insurer conversion (from non-profit to for-profit status) as well as other new taxes on insurers and opioid manufacturers; and

Health Insurance:

- 1) Imposes a “Healthcare Insurance Windfall Profit Fee”: under federal tax reform, health insurance companies’ corporate taxes will be cut by 40 percent. A proposed 14 percent surcharge on health insurance companies aims to recapture the \$140 million in expected tax savings;
- 2) Would allow the DOH Commissioner to apply penalties (reduction of Medicaid premiums) to managed care plans that do not submit PPS partnership plans by July 1, 2018; and
- 3) Proposes to prospectively cut Medicaid payments to any Medicaid managed care or long-term care Health Maintenance Organization (HMO) that has excess reserves across all lines of business.

⁵ This followed the Governor’s [2018 State of the State address](#), on January 3rd, which outlined some of his proposals for the upcoming state budget.

⁶ Applicants to the MLTC program—after October 1, 2018—would need to score 9 or higher on the UAS assessment in order to enroll in the program. Individuals needing LTC with a score below would need to enroll in mainstream Medicaid managed care plans or apply for care through their local district social service.

⁷ Available only in New York, Florida, and Connecticut, this provision (also known as [spousal impoverishment](#)) helps protect a couple’s assets and savings.

⁸ The program would offer as many as 200 vouchers that would cover up to 75 percent of the average private pay rate in the region.

⁹ Offered on the state’s healthcare marketplace, the Essential Plan is available for low-income adults aged 19-64 years who are not eligible for Medicaid or employer coverage.

Impact of Federal Reforms on New York: During his State of the State address, Governor Cuomo announced an aggressive plan to push back against the Republican tax reform, including a lawsuit challenging the legality of the law on a states' rights and equal protection basis. Another proposal was to eliminate the state income tax in favor of a payroll tax, which was a work-around response to the cap on the state and local tax (SALT) deductions under federal tax reform (see [Appendix](#)). Finally, the executive budget proposes to update last year's legislation to allow the state to create a plan in the event that federal Medicaid funding is reduced by \$850 million or more in FY2019 or 2020.

Medicaid enrollment: As previously mentioned, according to an NYS Department of Health (DOH) [Administrative Directive](#) published on October 24th, certain Medicaid applicants/recipients must apply for Medicare as a "condition of eligibility". New Medicaid applicants, as well as individuals renewing their Medicaid, aged 65 or older (or turning age 65 within the next three months) who are eligible but not currently enrolled, must submit proof of a Medicare application to their local district in order to receive/maintain their Medicaid. Failure to apply could result in a denial or discontinuation of Medicaid coverage. Approximately 5,500 NYC Medicaid enrollees already received notices sent December 18th and January 15th, informing them of the requirement; they have until February 7th to respond with proof of Medicare application or request an extension from NYC's Human Resources Administration (HRA).¹⁰ Two more "back-log" groups, totaling approximately 10,000 people, will also receive notices in the near future.

Health Care Facility Transformation Program: On January 8th, the state DOH announced the availability of \$203.7 million in funds under the second phase of the [Statewide Health Care Facility Transformation Program](#). (At least \$47 million will be available for community-based healthcare providers.¹¹) The objective of the program, which was originally launched in 2016, is to support mergers, acquisitions, capital projects, debt retirement or renovations. Applications are due March 14, 2018. The executive budget also allots an additional \$450 million for the third phase of this program, of which \$60 million must go to community-based health centers (of which \$20 million will be set aside for assisted living facilities).

Long Term Care: DOH held its final stakeholder meeting regarding the [future of integrated care](#) in New York State on December 8th. Stakeholders were asked to submit final comments about how future Medicare-Medicaid integrated care programs should be designed by January 12th. (As a reminder, current participation in the state's duals demonstration program—[Fully Integrated Duals Advantage](#) (FIDA)—remains far below initial estimates, and recent FIDA plan withdrawals have left a remaining [10 plans available in NYC](#) as of January 2018.). DFTA submitted a number of comments on behalf of our agency, providers, and the seniors we serve.

On January 5th, the [NYS Labor Department renewed](#) an emergency regulation that reinforces the policy of allowing employers to pay home care workers for 13 hours of a 24-hour shift. The emergency regulations were first issued in [October 2017](#), after state appellate court judges ruled in the workers' favor in [two class-action suits](#) in September. (The ruling stated that workers who do not reside with their employers must be paid at least the minimum wage for every awake hour on shift.) The Industrial Board of Appeals is expected to make a decision on the case in the near future.

¹⁰ Letter recipients should call the HRA Medicaid Helpline (888-692-6116) to request an extension, or they may call HIICAP or a local NY Connects program if they would like further assistance.

¹¹ Defined as diagnostic and treatment centers, mental health and alcohol and substance abuse treatment clinics, primary care providers and home care providers.

DSRIP Announcements: On January 3rd, DOH released a [statewide survey to all Community Based Organizations](#) (CBOs) in order to capture current services CBOs are providing that address Social Determinants of Health (SDH) and gauge CBO integration with the New York State Value Based Payment (VBP) program. The goal is also to build a public inventory of Tier 1, 2, and 3 CBOs (see [Definitions](#) box) that can be used to facilitate VBP contracting. The results of the survey are posted biweekly in the [VBP Resource Library](#). To date, 235 CBOs have responded to the survey, and approximately 44 percent have reported meeting with an MCO or a VBP contractor/provider.

In addition, some PPSs have recently announced the following funding opportunities:

The **Nassau Queens PPS** announced the availability of \$1.8 million to 33 CBOs in Nassau and Queens counties for health-improvement initiatives. Its CBO Innovation Fund aims to provide financial resources to develop health-related programs spanning social services, food assistance, housing, education and employment.

One City Health, the H+H-sponsored PPS, announced a \$5 million [Innovation Award program](#) to design and implement innovative programs to reduce avoidable hospitalizations, improve community health outcomes, and address social determinants of health, such as housing and food security. The program will award up to 10 recipients, who must already be PPS partners, and applications are due March 2nd.

Local News

Lawsuit against Opioid Industry: Mayor de Blasio [announced](#) that NYC filed a \$500 million lawsuit in the New York State Supreme court on January 23rd against large opioid manufacturers and distributors. Similar to other state and local litigation against the pharmaceutical industry, the city is hoping to recover the current and future costs of trying to address the opioid epidemic. Several other NY counties have combined their cases against the industry, and Governor Cuomo is said to be considering a suit as well.

While many associate the opioid epidemic with younger adults, [older adults](#) are equally likely to struggle with opioid addictions, often sparked by physicians' prescriptions of pain medicine. A [September 2016 analysis](#) showed that Medicare beneficiaries have among the highest and most rapidly growing prevalence of opioid use disorder; more than 6 out of every 1,000 Medicare patients are diagnosed with an opioid disorder, compared with 1 of every 1,000 patients covered by commercial insurance plans. Another [September 2016 study](#) also found a significant increase in the abuse of prescription drugs among older adults since 2003.

Health + Hospitals (H+H): On January 18th, the new CEO and President of H+H, Dr. Mitchell Katz, [announced to the board of directors](#) his strategy for the hospital system – focusing less on hospitalizations and more on primary and ambulatory care. Dr. Katz was formerly director of the Los Angeles County (LAC) Health Agency, which was recently evaluated and compared to the city's H+H system in a recent [report by the Citizens Budget Commission](#). The CBC report notes that LAC's general population and health market both exhibit similarities to NYC, which is encouraging since Dr. Katz's previous tenure resulted in an improvement in the public hospitals' financial performance (largely due to changes in payor mix – decreasing the percentage of uninsured patients in favor of patients with managed care or other insurances). He was also able to enhance the quality of patients' care, largely due to operational reforms such as “re-organizing outpatient care delivery, implementing the medical home model, partnering with social service agencies to address social determinants of health, and implementing an electronic health records system.”

One Brooklyn Health: On January 24th, Governor Cuomo [announced \\$664 million in funding](#) for One Brooklyn Health – a new healthcare system composed of Interfaith Medical Center, Kingsbrook Jewish Medical Center, and Brookdale Medical Center – as part of the state’s [Vital Brooklyn initiative](#) to help transform central Brooklyn’s healthcare system. The funding aims to improve conditions and infrastructure at the three hospitals, reduce redundancy of services across facilities, and create a new 32-site ambulatory care network that will be partnered with a range of social service providers.

City Council Committee on Hospitals: As evidence of his continued focus on improving healthcare in NYC, new City Council Speaker Corey Johnson created a new [“Committee on Hospitals”](#) charged with overseeing the city’s public and private hospitals. The new committee will be led by new Councilmember Carlina Rivera and work to facilitate better relationships between communities and their hospitals.

Did you know...

... this year's flu season is the most widespread nationwide in the past 13 years? As a result, NY Governor Cuomo declared a public health emergency on January 26th. In addition, according to the city [Department of Health and Mental Hygiene](#), New York City is one of the regions seeing high “influenza-like illness” activity, above the national baseline.

...the [Medicare Low-Income Subsidy \(LIS\)](#), also known as “Extra Help,” helps low-income Medicare beneficiaries with Medicare Part D prescription drug costs? To learn more about the program and how you can apply, call [DFTA’s HIICAP](#) at (212) 602-4180.

...the Center for Medicare Advocacy released a [toolkit](#) to help Medicare beneficiaries and their families respond to Medicare denials for skilled nursing care?

Suggested Reading

[Medicare Spends More on Socially Isolated Older Adults](#): This November 2017 AARP Public Policy Institute report examines whether social isolation affects healthcare spending among older adults, similar to how it may negatively impact a person’s health as well. The authors found that a lack of social contacts among older adults is associated with an estimated \$6.7 billion in additional Medicare spending annually.

[The Evolution of Private Plans in Medicare](#): This December 2017 issue brief from the Commonwealth Fund explores the major changes to Medicare private plans (Medicare Advantage or Part C), including its growth in the last two decades, and how policies have impacted plan participation and enrollment, premiums and cost-sharing, quality of care, and total costs to Medicare.

[A Framework for Medicaid Programs to Address Social Determinants of Health – Food Insecurity and Housing Instability](#): This December 2017 final report from the National Quality Forum identifies guidance for how state Medicaid programs can support collection of SDH data and better integrate health and social services.

[Cross-Sectoral Partnerships by Area Agencies on Aging: Associations with Healthcare Use and Spending](#): This January 2018 *Health Affairs* article examines the relationship of informal partnerships between AAAs and healthcare organizations, and its impact on healthcare use and spending. The authors found that these partnerships can significantly reduce hospital readmission rates and avoidable nursing home use for older adults.

Medicare Beneficiaries' Out-of-Pocket Health Care Spending as a Share of Income Now and Projections for the Future: A January 2018 Kaiser Family Foundation report examines how out-of-pocket costs for Medicare beneficiaries have grown over time and are projected to rise in the future. The authors found that the financial burden is especially higher for women aged 85 and older, in poor health, and with modest incomes.

Using Community Partnerships to Integrate Health and Social Services for High-Need, High-Cost Patients: This January 2018 issue brief from the Commonwealth Fund reviews the landscape of programs that connect healthcare providers with CBOs that address social needs for complex patients. It highlights the challenges and possible solutions to efficiently integrate healthcare and social services.

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)

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. DOH defines CBOs by the following tiers:

Tier 1: non-profit, non-Medicaid billing, community-based social and human service organization;

Tier 2: non-profit, Medicaid billing, non-clinical service providers; and

Tier 3: non-profit, Medicaid billing, clinical and clinical support service providers.

CMS = Centers for Medicare & Medicaid Services

Cost Sharing Reduction (CSR): A discount that lowers the amount a consumer is required to pay out-of-pocket (for deductibles, copayments, and coinsurance) if they are enrolled in a "silver" plan through the ACA marketplace. CSRs are available for those making between 100–250% of the Federal Poverty Level in household income.

DSRIP = Delivery System Reform Incentive Payment (DSRIP) program

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

NYSDOH = New York State Department of Health

PPS = Performing Provider System

SALT = State and local tax deduction

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

Appendix: Impact of the Tax Cuts and Jobs Act on Healthcare

Status of Tax reform bill: During the week before Christmas, both the Senate (51-49) and the House (223-201) passed the final version of the Republicans' \$1.5 trillion tax bill—[The Tax Cuts and Jobs Act](#)—on partisan lines. President Trump signed the bill into law on December 22nd, and it will be effective starting in 2018.

The final bill cuts the corporate tax rate permanently and eliminates many deductions. In addition, it cuts individual taxes for some (through 2025), but not for others. The bill also limits the state and local tax (SALT) deduction at a maximum of \$10,000. (Taxpayers would be able to choose to deduct from their property, sales, or income taxes.) As a result, individuals living in high tax states, such as New York, will likely see a raise in their overall taxes.

More specifically related to healthcare, the bill:

- Repeals the ACA's individual mandate, and its associated tax penalty (for not having insurance), effective in 2019. (Those without adequate insurance could still be subjected to a tax penalty in 2018, unless they qualify for an exemption.) This could lead to a loss of insurance for approximately [13 million individuals](#) over the next decade; and
- Preserves the deduction for medical expenses, but lowers the threshold to costs exceeding 7.5 percent of adjusted gross income in 2018 and 2019 (and then rises back to 10 percent beginning in 2020).

An estimated 80 percent of the benefits from the tax cut will benefit corporations and the 1 percent of American households with the largest incomes. The [CBO estimated](#) that enacting this legislation would raise the federal deficit by about \$1.46 trillion over the next decade, which would be paid by future generations to benefit mainly the rich and corporations today.

Additionally, under budgetary rules known as "PAYGO," an increase in the deficit would have triggered automatic cuts to federal 2018 spending by \$136 billion, including \$25 billion in Medicare funding. However, Republicans also passed a short-term spending bill that included a provision to waive the [Pay-As-You-Go Act of 2010](#), preventing these cuts for 2018. However, the tax reform bill still paves the way for the possibility of even steeper cuts in the future.