Department for the Aging

DFTA's Healthcare Newsletter Summer/Fall 2018

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Federal News

Funding Bills: Following months of negotiations and revisions, Congress has reached an agreement on the $855 billion "minibus" package (*HR 6157*) that would combine two FY2019 spending bills. In addition to seeking a $21 billion increase in Defense spending (to a total of $675 billion), the $181 billion appropriations bill for the Departments of Health and Human Services (HHS), Education, and Labor would increase the HHS budget by $2.3 billion (for a total of $90.5 billion). Some of the provisions include:

- $39.1 billion for the National Institutes of Health (NIH) budget, an increase of 5.4 percent, fully funding the National Plan to Address Alzheimer's disease at $2.3 billion;
- $3.7 billion to a multi-agency effort to combat opioid abuse;
- $1.7 billion to prevent Social Security Disability fraud, abuse, and improper payments; and
- $2.2 billion for the Administration for Community Living (ACL), an increase of $25 million from FY2018. *(Please note: several non-healthcare related portions of aging services funding did increase modestly, including $5 million each for congregate meals and home-delivered meals; $5 million for the Aging Network Support funds new Care Corps Grants; and $1.5 million for some Native American programming. In addition, increased funding for the National Family Caregiver Support Program (NFCSP) included $300,000 each to begin implementation of the RAISE Family Caregiver Act and the Grandparents Raising Grandchildren Act.)*

Original versions of the bill were passed by the House (*359-49*) on June 28th and the Senate (*85-7*) on August 23rd; the two versions were then reconciled, with the Senate voting in favor (*93-7*) on September 18th.[1] Congressional leaders decided to use this final legislation as a means for funding the federal government through December 7th; this continuing resolution gives Congress more time to finalize the remaining appropriation bills funding other government agencies, attempting to avoid the third shutdown of the year.

ACA Update: While overall ACA repeal efforts have quieted down, the issue continues to arise in different venues. A recent lawsuit (Texas vs U.S.) by Republican officials from 20 states,[2] which started arguments on September 5th, is challenging the constitutionality of the law since the individual mandate was repealed under last year's tax reform bill. If Supreme Court nominee Brett Kavanaugh is confirmed, his presence on the court could threaten the future of the ACA if and when an appeal of the lawsuit reaches the Supreme Court. Depending on their timing, the nomination and the lawsuit could have a large impact on the November midterm Congressional elections.

[1] The final legislation removed an earlier provision from the Senate implementing price disclosure regulations (i.e., requiring drug companies to list their prices in TV ads). However, a similar provision may be included in future CMS regulations or other prescription drug reform legislation.

[2] The Trump administration's Department of Justice announced this past June that it would not defend the ACA law in the case, but 17 Democratic attorneys general – including NY's Barbara Underwood – agreed to represent the federal position.

Any legal rulings in favor of the Republican position would likely result in the discontinuation of enforcement of the ACA's regulation surrounding coverage of pre-existing conditions as well as other consumer protections. Given the large public support for continued coverage of pre-existing conditions, however, some Republican Senators have introduced legislation—The Ensuring Coverage for Patients with Pre-Existing Conditions Act—that would force health insurance plans to cover all individuals regardless of health status and regardless of the outcomes of recent lawsuits.[3] In addition, other Republican-sponsored legislation—such as redefining the employer mandate, repealing the ACA medical device tax, or expanding Health Savings Accounts and Flexible Spending Accounts—continued to be pushed in the House as other avenues for health reform and to peel away ACA provisions.

Regardless of lawsuits challenging the legality of the ACA, the Trump administration has continued its efforts to undermine the law's continued implementation, including reducing funding for advertising and navigators.[4] According to a July 2018 report from the Government Accountability Office, these efforts have led to both large premium increases and a decrease in enrollment in ACA-subsidized plans. More poignantly, recent polls show that the percentage of Americans without health insurance has begun to rise, the first time the uninsured rate has increased since the ACA was passed in 2008. Other recent Trump administration rule changes that are likely to have an impact on the long term stability of the ACA marketplace include:

- A Department of Labor rule, effective August 20th, allowing for the creation of association health plans, where small businesses and the self-employed can unite to create cheaper insurance plan options. These plans are exempt from meeting all ACA requirements;
- Extending the availability of "transitional" or short-term health plans, which are also currently exempt from meeting ACA marketplace requirements, for up to 12 months (previously only offered for up to three months) with the option of renewing for a maximum of 36 months; and
- Giving states more flexibility, beginning in 2020, to design their own versions of the ACA's essential health benefits and benchmarks offered on the marketplace.

Federal Health Legislation: The past few months have seen a flurry of activity on prescription drug reform, including:

- Signed into law on May 30th by President Trump, the "Right to Try" law allows terminally-ill patients nationwide to directly request experimental treatments from pharmaceutical companies, bypassing the approval process of the Food and Drug Administration (FDA).[5] While the law had bipartisan support, most health experts believe it could put patients at risk and that there was no need for the law since existing review pathways are sufficient.

[3] More specifically, the legislation would amend the Health Insurance Portability and Accountability Act (HIPAA) to guarantee the availability of coverage for all those enrolled in the individual or group health insurance market and to prohibit discrimination against individuals based on health status (i.e., those with pre-existing conditions).

[4] For the 2nd straight year, CMS cut funding by $25 million (or 80% less than 2016 funding) to organizations that help people sign up for health coverage. CMS explained that the ACA insurance marketplaces are better established now than in previous years and that navigators historically have enrolled just a fraction of customers.

[5] Previously, 41 states had already passed their own laws allowing terminally ill patients to gain access to drugs that have not received full FDA approval. Right-to-try bills had been reintroduced in New York in the past, without advancing out of committee, but with passage of the federal law, a state-specific law would likely be redundant.

- Bipartisan measures addressing the opioid epidemic, from both the House and the Senate. The House passed (*396-14*) its package—the SUPPORT for Patients and Communities Act—on June 22nd, to improve opioid addiction treatment and prevention programs under Medicare and Medicaid. The Senate passed (*99-1*) its Opioid Crisis Response Act of 2018 package on September 17th, which now needs to be sent to a conference committee to reconcile the two versions. Both bills would authorize additional funding to states to pay for different treatments, increase funding for research, and introduce additional regulatory requirements. Many health stakeholders have come out in support of the legislation.[6]
- In May 2018, the Trump administration and HHS introduced its platform—American Patients First—to reduce prescription drug spending. The blueprint focuses primarily on Medicare regulatory redesign to increase competition and negotiations, incentivize lower prices, and decrease out-of-pocket expenses. Following the release of a Request for Information, whose responses were due in July, HHS Secretary Azar has been meeting with House and Senate Republicans to discuss next steps.

In addition, other pieces of legislation relevant to the senior population that have been introduced but not yet been brought to a vote include:

- Democratic-sponsored legislation to transition the country's current healthcare system towards single-payer options, such as a Medicare Buy-In option. As more Democrats push for single-payer healthcare reform at both national and state levels *(see story below about NY's legislation*), Republicans have begun to argue against these proposals, saying that any push towards single-payer would make the traditional Medicare program less financially stable. These arguments, ironically, do not mention recent Republican budget proposals to cut Medicare spending[7] and a push towards increasing the use of private managed care plans (i.e., Medicare Advantage).
- Bipartisan legislation was introduced in both the House and Senate to remove barriers to Diabetes Self-Management Training for Medicare beneficiaries.
- The Younger-Onset Alzheimer's Disease Parity Act, which would amend the Older Americans Act to serve individuals who are under the age of 60 but living with younger-onset Alzheimer's disease or other degenerative diseases.
- Hearings in the House to discuss an amended version of the EMPOWER Care Act, which helps older adults move out of institutions and back into their homes, and which would extend the Medicaid Money Follows the Person (MFP) program for one year.

Centers for Medicare and Medicaid Services (CMS): Over the past few months, CMS has introduced many proposed policy changes in payment and program designs, moving away and defining a new direction from the previous Obama administration. Examples include the following:

[6] The Senate Aging Committee held a hearing May 23rd on "Preventing and Treating Opioid Misuse Among Older Americans." Additionally, a July 2018 report from the University of Michigan—Older Adults' Experiences with Opioid Prescriptions—found that older adults are more likely to experience conditions resulting in pain, and therefore have an increased exposure to opioids.

[7] The 2019 budget proposal from House Republicans, released in June 2018, included a proposal for $537 billion in cuts to Medicare over the next 10 years.

- Patient-Driven Payment Model (PDPM): While increasing the rates for nursing homes by 2.4 percent for FY 2019,[8] CMS also announced a change in their payment method for nursing homes effective October 1, 2019. As part of the industry's move towards value-based payment (VBP), rather than payment by volume, the new case-mix model will focus on patients' level of need/sickness (resident classification) rather than the amount of service/therapy received (resource utilization).
- Payment for Telehealth: CMS proposed changing payment policies in 2019 to reimburse for virtual visits, to include those beneficiaries beyond strictly remote and rural areas, which could benefit the elderly and disabled suffering from transportation barriers.
- Indication-based Formulary Design: starting in 2020, Medicare Part D plans and Medicare Advantage Plans with Part D coverage will have more flexibility to tailor their formularies to limit which prescription drugs can be used for different health conditions, although they are still required to ensure that other therapeutically similar drugs will remain on formulary for the drug's non-covered indications.[9] The hope is that these changes will enable plans to negotiate lower prices, giving more choices to patients.
- Data Driven Patient Care Strategy: As part of its patient data collaboration effort—MyHealthEData, CMS Administrator Verma announced the intention to make data—from both traditional Medicare and Medicare Advantage—more accessible and usable in a secure manner for government policymakers, researchers, and patients themselves. In a related move, CMS also introduced the Drug Spending Dashboard, which will provide users with more cost information about prescription medications under Medicare (Parts D and B) as well as Medicaid.

MEDICARE REMINDERS

As a reminder, in an effort to reduce identify theft, CMS has been distributing new Medicare cards with new unique Medicare numbers rather than an individual's Social Security Number. The new cards are being sent out to beneficiaries in geographical waves by April 2019; as of August 20th, residents of New York should have received new cards in the mail. After receiving their new card, beneficiaries are advised to: 1) destroy old Medicare cards; 2) use the new card right away; and 3) beware of scams. Visit Medicare.gov/newcard or call 1-800-MEDICARE (1-800-633-4227) to check on mailing status or to access educational materials.

In addition, CMS has extended the availability for time-limited equitable relief for those individuals who previously delayed enrolling in Medicare Part B in favor of receiving a subsidy for purchasing Marketplace coverage instead. For those that are eligible, individuals can enroll in Part B Medicare with no or reduced late penalties under a recent CMS initiative, Part B Special Enrollment Period; this opportunity lasts until ***September 30, 2018****. For more information, visit MedicareInteractive.org.*

To help assist individuals and caregivers with their Medicare options, DFTA would like to highlight additional resources from the National Council on Aging (NCOA) and the Medicare Rights Center.

[8] The rate increase, mandated by the 2018 Bipartisan Budget Act, will infuse the nursing home industry with an additional $850 million in FY2019 (starting October 1).

[9] Currently, a plan can favor one drug over another by including a medication on its formulary or not; placing it on a lower cost-sharing tier; or putting coverage restrictions, like prior authorization, quantity limits, or step therapy on the less preferred medication.

In addition, recent Medicare benefits and other opportunities have become available for Community-based Organizations (CBOs) to partner with healthcare organizations and/or bill for Medicare funding, including:

- Expanded Medicare Diabetes Prevention Program (MDPP) Model: Starting in April 2018, CMS expanded the previous demonstration program and is encouraging non-clinical CBOs to enroll as Medicare providers/suppliers in order to be reimbursed for delivery of the program. The MDPP program targets beneficiaries who are at risk of developing type-2 diabetes, and providers are reimbursed by Medicare based on patient attendance and achieving 5 percent weight loss benchmarks.
- Chronic Care Management: Chronic care management (CCM) is a Medicare Part B benefit to expand care coordination and patient coaching to improve the health and wellbeing of individuals with two or more chronic conditions. Delivered under the supervision of a primary care physician or non-physician provider (nurse practitioner or physician assistant), CBOs may consider paid partnerships to help implement CCM services to help sustain chronic disease self-management education programs in the community.
- Flexibility in Medicare Advantage: On April 2nd, CMS also announced planned policy changes related to Medicare Advantage plans[10] in its Final Rule Implementing Policy and Technical Changes to Part C and Part D for CY 2019. Under the Final Rule, CMS aims to expand its definition of what it deems as "primarily health-related", thereby expanding the range of supplemental benefits covered by Medicare Advantage plans in 2019 (including—but not limited to—adult day care, caregiver support, transportation, home-delivered meals, or air conditioners and other home modifications). Due to the fact that plans were required to submit their 2019 benefit packages to CMS by June 4th, a mere two months after the announcement, the inclusion of any new supplemental benefits will likely be delayed until 2020.

  This new rule complements the recent enactment of the "Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act," included in the February 2018 Bipartisan Budget Act. The CHRONIC Care Act also improves the flexibility of Medicare Advantage plans in serving their chronically-ill enrollees by expanding supplemental benefits including non-medical services that may impact the social determinants of health of older adults with complex needs. For more information and guidance about how aging services CBOs might take advantage of these opportunities, DFTA recommends the resources from the National Council on Aging, the Aging and Disability Business Institute, and the SCAN Foundation.

State News

***Managed Long Term Care*:** In early September, it was announced that GuildNet—the insurance affiliate of nonprofit Lighthouse Guild and one of the NY State's largest and longest-serving managed long term care (MLTC) plans—would close as of December 1, 2018. As a precursor to the closure, the plan had stopped enrolling members in Long Island and Westchester

[10] About one-third of all Medicare beneficiaries are enrolled in Medicare Advantage plans, operated by private managed care organizations; in New York City, this ranges from a high of 57% in the Bronx to 37% in Manhattan.

since 2016.[11] This continues a trend of MLTC plans either leaving the market entirely, such as EmblemHealth and North Shore-LIJ Health Plan (Northwell Health), or withdrawing from certain counties like HomeFirst (a product of Elderplan). There have also been recent news reports that Independence Care Systems (ICS) may close this fall. According to NYS Department of Health (NYSDOH) policies, members of a closing plan will be auto-assigned to a new plan if they do not select one within 60 days after receiving official notice about the closing; the new plan must continue the same services for at least 120 days after enrollment, or until a new assessment has been completed and agreed upon.

NYSDOH has started to implement the following MLTC changes from the 2018 state budget:

- MLTC Enrollment Lock-In: members who enroll in a new MLTC after December 1, 2018 are given a 90-day "grace period" to transfer plans after enrollment, but will then be locked into the plan, disallowed from changing for the next 9 months. This policy does not impact those enrolled in Fully Integrated Duals Advantage (FIDA), Medicaid Advantage Plus (MAP), and the Program of All-Inclusive Care for the Elderly (PACE);
- Placement in Nursing Home: Once approval is granted by CMS,[12] MLTC plan members who have been "permanently placed" in a nursing home (as determined by a stay of 3 or more months with no plan to return to the community) will be disenrolled from the MLTC plan and enrolled in traditional fee-for-service Medicaid. These changes also would not impact those enrolled in FIDA, MAP, and PACE; and
- Limitation of LHCSA contracts: As of October 1, 2018, MLTC plans in New York City must reduce the number of licensed home care services agencies (LHCSAs) they contract with to one contract per 75 enrollees. This will change to one contract per 100 enrollees as of October 1, 2019.

Those who believe that they are negatively impacted by the MLTC closures or recent policy changes are urged to call the ICAN Ombudsprogram at 1-844-614-8800, or the DOH MLTC Complaint line at 1-866-712-7197, or to contact one of DFTA's NY Connects programs.

Home Care Workforce: Five home health aides and two nonprofit groups sued the state Department of Labor (DOL) in May over emergency regulations, issued and updated since October 2017, that would allow aides to be paid for only 13 hours of a 24-hour shift, assuming that they are allowed eight hours of sleep and three hours for meals. DOL held a public hearing on July 11th to seek input before adopting permanent regulations. No permanent regulations have been issued to date.

Relatedly, both state (Office of the Medicaid Inspector General and DOL) and local (NYC's Department of Consumer Affairs' Paid Care Division) government offices recently conducted investigations of home care agencies to identify suspected wage-parity and other related violations.[13] Given the inconsistency identified in the home care labor industry, state DOH hopes

[11] As of August 2018, GuildNet had a total of 7,316 members in its MLTC plan, 478 in its Medicaid Advantage Plus plan, and 417 in its FIDA plan. In order to be protected with "transition rights", these members should wait to receive official notice from state DOH prior to switching to an alternative among the remaining NYC managed care plans.

[12] For the time being, until CMS approval is obtain, existing policies and procedures remain in place. (Since 2015, all nursing home residents were required to enroll in MLTC plans.)

[13] According to a NY State 2012 Home Care Wage Parity Law, employers are required to offer workers a minimum amount of supplementary compensation in the form of benefits or additional wages on top of their base pay. In addition, NYC's 2014 Paid Safe and Sick Leave Law requires employers with five or more employees (who work more than 80 hours per calendar year) to provide paid safe and sick leave to employees; employers with fewer than five employees must provide unpaid safe and sick leave.

that the limitation on number of home care agency MLTC contracts will help consolidate the industry and weed out bad actors.

ACA Impact and Insurance Options: In June, NY State health insurers asked for an average 24 percent increase in 2019 premiums for plans offered on the state marketplace, in order to circumvent the likely impact of younger and healthier individuals leaving the market as a result of the repeal of the individual mandate.[14] However, under direct order from Governor Cuomo to reject any increases tied to the repeal of the individual mandate, the state Department of Financial Services (DFS) approved in August an average 8.6 percent increase in premiums.

In addition, DFS also advised NY health insurers in June that, although federal regulations expanded the availability of short-term plans on the individual market, these plans would remain prohibited in New York, as they do not comply with state law requiring guaranteed renewal for policyholders and comprehensive coverage of essential health benefits.

NY Single-Payer Option: Much ado has recently been made about the New York Health Act (*A4738A*), Assembly Gottfried's annually sponsored legislation aiming to provide universal health coverage with no copays, deductibles, or premiums for all New Yorkers. A recent July 2018 analysis from the Rand Corporation and the New York State Health Foundation found that the proposed legislation would likely decrease total state healthcare spending and out-of-pocket spending for most New Yorkers, but would require significant new taxes for the wealthy. Many business groups and health industry stakeholders have voiced their concern about the uncertain impacts of the proposal. While the legislation has been passed by the Assembly each of the past four years, it has never been voted on in the State Senate. In addition, because the proposal would require that Medicare and Medicaid benefits be delivered through the new program, the state would need approval from CMS, which seems unlikely as the Trump administration has said they would likely deny such a request.

***DSRIP Announcements*:** DOH's new Bureau of Social Determinants of Health (bSDH) recently announced two upcoming opportunities for community-based and social service organizations. The new bureau will host an SDH Innovation Summit on September 26th to showcase the winners of its previous call for innovative solutions and share best practices in the fields of community-based organizations, healthcare providers and plans, and private sector technology firms. In addition, the bSDH released a survey on the creation and use of SDH assessment tools, due September 27th.

Local News

Health + Hospitals: Under new CEO Mitchell Katz, the city's public hospital system has been increasing its capacity to deliver primary and ambulatory care. Earlier this May, they announced a new marketing initiative, DOCS4NYC, aimed at recruiting 75 primary care physicians and nurse practitioners. More recently, H+H has been expanding its Gotham Health network of community health clinics to increase primary care delivery to some of the City's underserved populations. It opened a community health center in the Clifton section of Staten Island's North Shore, known as New York City Health + Hospitals/Gotham Health—Vanderbilt, back in July. This location brings additional primary care services to the only borough without a municipal hospital, and is expected to serve 4,500 patients this year, eventually growing to an annual volume of 15,000 patients and

[14] Ironically, enrollment in all programs offered on the NY State of Health, the state's marketplace, increased by almost 700,000 in 2018.

40,000 visits. In August, a new neighborhood clinic in the Bedford-Stuyvesant section of Brooklyn was opened as the last of six projects that are part of the mayor's Caring Neighborhoods Initiative. This location is projected to provide 3,000 visits in its first year, growing to 15,000 annual visits.

The ambulatory care division of H + H recently contacted DFTA to discuss possible collaborations to promote greater knowledge of and access to DFTA-funded aging services on the part of older H + H clients. Discussions of possible linkages are under currently exploration.

Brooklyn: As part of the state's $1.4 billion Vital Brooklyn Initiative, Governor Cuomo announced in August that more than $1.8 million will be used to add 31 new mobile food markets, food insecurity screening for seniors, and a variety of other food-related programs to address the lack of affordable, healthy food for Central Brooklyn residents. This follows his previous announcement in July that the initiative was committing $563 million to build more affordable-housing units, $3.1 million to improve community gardens, and $210 million for an ambulatory care network through One Brooklyn Health. Vital Brooklyn aims to reduce health disparities and tackle the social determinants of health of the borough's poorest residents.

CBO and Value-Based Payment (VBP) Readiness: A Request For Proposal (RFP) was recently announced by the Fund for Public Health in New York City, in collaboration with the NYC Department of Health and Mental Hygiene (DOHMH), for a select group of CBOs to enhance their ability to address and measure the impact of social determinants of health within the emerging VBP paradigm. Up to ten (primarily tier-1 serving behavioral health clients) CBOs will be selected to earn up to $35,000 for participation in this project. Responses are due by October 10th to Kathryn Waller at kwaller@fphnyc.org.

Budget: As part of the 2019 City Budget, it was announced that the HealingNYC initiative, designed to combat drug addiction and overdose deaths, would receive a $22 million increase in funding, bringing the program's annual budget to $60 million. The additional funding will be used to expand the Relay program to five more hospitals, connecting overdose victims in the emergency room to peer wellness advocates, and will establish an End Overdose Training Institute to further distribution of naloxone, a drug that reverses opioid overdoses. To date, approximately 70,000 naloxone kits have been distributed, with the goal of giving out 30,000 more; emergency medical services first responders have also been asked to leave behind 5,000 naloxone kits at homes where they respond to an overdose. Finally, the DOHMH website lists approximately 700 participating pharmacies that should provide the drug without prescriptions. This follows the "I Saved a Life" public awareness campaign that debuted in 2017. According to former DOHMH Commissioner Bassett, there were 1,441 overdose fatalities in New York City in 2017.

Healthcare Jobs: According to monthly data from the state Department of Labor, New York City's healthcare sector employment increased by 3.9 percent in June, adding 27,800 new jobs to the local economy compared to the same month in 2017. Unlike statewide trends, where private-sector hospital jobs still outnumber home health care, in New York City, home health care employment increases outpaced those for all other health care sector positions, adding 17,900 new jobs, an increase of 11.6 percent. As hospitals shift more care to outpatient settings, jobs in ambulatory healthcare services continued to grow.

***Dementia Screening*:** Montefiore Health System and Albert Einstein College of Medicine have piloted a dementia-screening tool—The Picture-Based Memory Impairment Screening—that has patients recall images rather than words. It accurately detects early signs of cognitive decline

regardless of a person's ethnic background, native language, or education level, according to research published Wednesday in the *Journal of the American Geriatrics Society*. The tool takes about four minutes to administer and is offered in primary-care settings by different health professionals.

Did you know…

… April 6th was former NYS Medicaid Director Jason Helgerson's last day in that position. Before he left, Health Affairs published his blog, "Reflections from a Departing Medicaid Director," where he reflects on the past 11 years during his tenure as a Medicaid Director (seven of which were in New York) and lists his top 5 lessons learned.

***…**Nearly 550,000 New York City residents, or roughly 9 percent of the adult population, are depressed, according to an April 2018 report released by the NYC DOHMH. Adults ages 45 to 64 (11%) and 65 years or older (9%) were more likely to be depressed than 18 to 44 year olds (8%). Unfortunately, nearly two-thirds of those people receive no counseling or medication.*

…that July 30, 2018 marked the 53rd anniversary of Medicaid and Medicare?

…it was announced in early August that after four years as NYC Department of Health and Mental Hygiene (DOHMH) Commissioner, Mary Bassett would be leaving her post at the end of the month to take a position at the Harvard University School of Public Health. First Deputy Commissioner Oxiris Barbot will serve as acting commissioner.

…that CMS's National Training Program (NTP), its online Learning Management System (LMS), is now live? This free resource offers online trainings, webinars, and train-the-trainer workshops about Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Federally-facilitated Health Insurance Marketplace.

Suggested Reading

***Medicare Advantage Achieves Cost-Effective Care and Better Outcomes for Beneficiaries with Chronic Conditions Relative to Fee-for-Service Medicare*:** This July 2018 research report from Avalere finds that Medicare Advantage (MA) beneficiaries with hypertension, high cholesterol, and diabetes experienced significantly less hospital utilization and more rates of preventive care than people with those conditions in fee-for-service Medicare arrangements. Beneficiaries in MA plans had fewer inpatient hospital stays (23% fewer) and emergency room visits (33% fewer) relative to those in traditional Medicare.

Nursing Home Quality: Recent studies have reported on the varied levels of quality of care in nursing homes (including staffing ratio levels).

- An April 2018 study in the *Journal of the American Geriatrics Society*—Differences between Skilled Nursing Facilities in Risk of Subsequent Long-Term Care Placement—found that Medicare beneficiaries needing short-term rehab had a lower risk of being placed in a nursing home for the long-term if they stayed at nursing homes with higher quality scores (including excellent inspection ratings and higher nurse staffing levels).
- Another April 2018 Kaiser Family Foundation study—Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2009 Through 2016—stated that nursing home occupancy rates may be decreasing, but the needs of residents are greater; nearly half are diagnosed with dementia and about one-third exhibit psychiatric conditions.

This comes as a July Kaiser Health News/New York Times article reported that, according to Medicare payroll data, most U.S. nursing homes are inadequately staffed and have likely been overstating their staffing levels to the government for years. As a result of that report, in August the HHS Office of the Inspector General began investigating CMS oversight and enforcement of nursing home staffing standards; a final report is expected to be released in 2020.

Older Adults and Falls: Recent CDC studies on the costs, both financial and health-related, of falls by older adults indicate the importance of prevention and other strategic planning that must be devoted to this large public health challenge. A March 2018 study published in the *Journal of the American Geriatrics Society*—Medical Costs of Fatal and Nonfatal Falls in Older Adults—estimated that in 2015, medical costs attributable to fatal and nonfatal falls amounted to approximately $50 billion. In addition, the May 2018 Morbidity and Mortality Weekly report—Deaths from Falls Among Persons Aged ≥65 Years—found that fall-related deaths had increased by 31 percent from 2007 to 2016. These statistics only make recent resources even more valuable:

- In April 2018, Health Affairs drafted an article listing meaningful interventions, such as evidence-based practices, medication management, and possible insurance or other reimbursement possibilities.
- A June 2018 resource from the National Alliance for Caregiving and the National Council on Aging—Falls Prevention Conversation Guide for Caregivers—highlights risk factors, offers assessment tools, and suggests prevention action plans.

An Oral Health Benefit in Medicare Part B: It's Time to Include Oral Health in Health Care: This July 2018 white paper from Oral Health America discusses the issue of dental insurance coverage. Traditional Medicare does not include coverage for routine oral health care, creating disparities in access to checkups, cleanings, and x-rays, or restorative procedures (fillings, crowns, bridges and root canals), tooth extractions and dentures. The authors recommend and create a theoretical structure for a Medicare Part B dental benefit to close the gap between uninsured and insured older adults.

Racial, Ethnic, and Gender Disparities in Health Care in Medicare Advantage: This April 2018 CMS report highlights disparities in both patient experience and clinical care received by Medicare Advantage beneficiaries from 2015-2016. Overall, with the exception of Asian and Pacific Islander beneficiaries, those who identified as a racial or ethnic minority were found to consistently experience worse or similar care when compared to their white counterparts. Differences between men and women, however, were negligible.

Trends In Medicare Fee-For-Service Spending Growth For Dual-Eligible Beneficiaries, 2007–15: An August 2018 Commonwealth Fund–supported study in *Health Affairs* reports that Medicare spending growth for dual-eligible beneficiaries (those individuals with both Medicare and Medicaid coverage) has trended down since 2011. While spending on duals remains consistently higher than those enrolled in Medicare-only, the study suggests that the spending gap between duals and Medicare-only beneficiaries does not appear to be widening. In fact, the researchers report that average annual spending grew from 2007 to 2015 by 0.1 percent for duals, versus 0.2 percent for Medicare-only beneficiaries. Still, there was a greater decline in inpatient hospital spending for Medicare-only beneficiaries than for duals, raising questions about whether recent reforms to provider payment are enough to control costs for duals. The authors believe additional reforms need to focus on long-term nursing home patients, who had both high levels of spending growth.

***Using Telehealth to Improve Home-Based Care for Older Adults and Family Caregivers*:** This May 2018 paper from the AARP Public Policy Institute discusses the potential implications of the expanded use of telehealth, including enabling older adults to stay in their homes longer and limiting stress on family caregivers, in addition to reducing health costs. However, more research is still needed on its effectiveness and regulatory barriers need to be reduced.

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)

CMS = Centers for Medicare & Medicaid Services

DOHMH = NYC's Department of Health and Mental Hygiene

DSRIP = Delivery System Reform Incentive Payment (DSRIP) program

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

LTC/LTSS = Long-term care OR long-term services and supports

NYS DOH = New York State Department of Health

Social Determinants of Health (SDH): conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Value-based payment (VBP): payment based on quality of healthcare, rewarding value rather than volume.