Long-Term and Post-Acute Care Transformation: Challenges and Opportunities

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Dan Heim
Executive Vice President

LeadingAge New York

Presentation Agenda

1. Background: Key Trends
2. Policy and Market Responses
3. Managed Care
4. Value-Based Payment
5. Medicare VBP and Alternative Payment Arrangements
6. Key Challenges and Opportunities

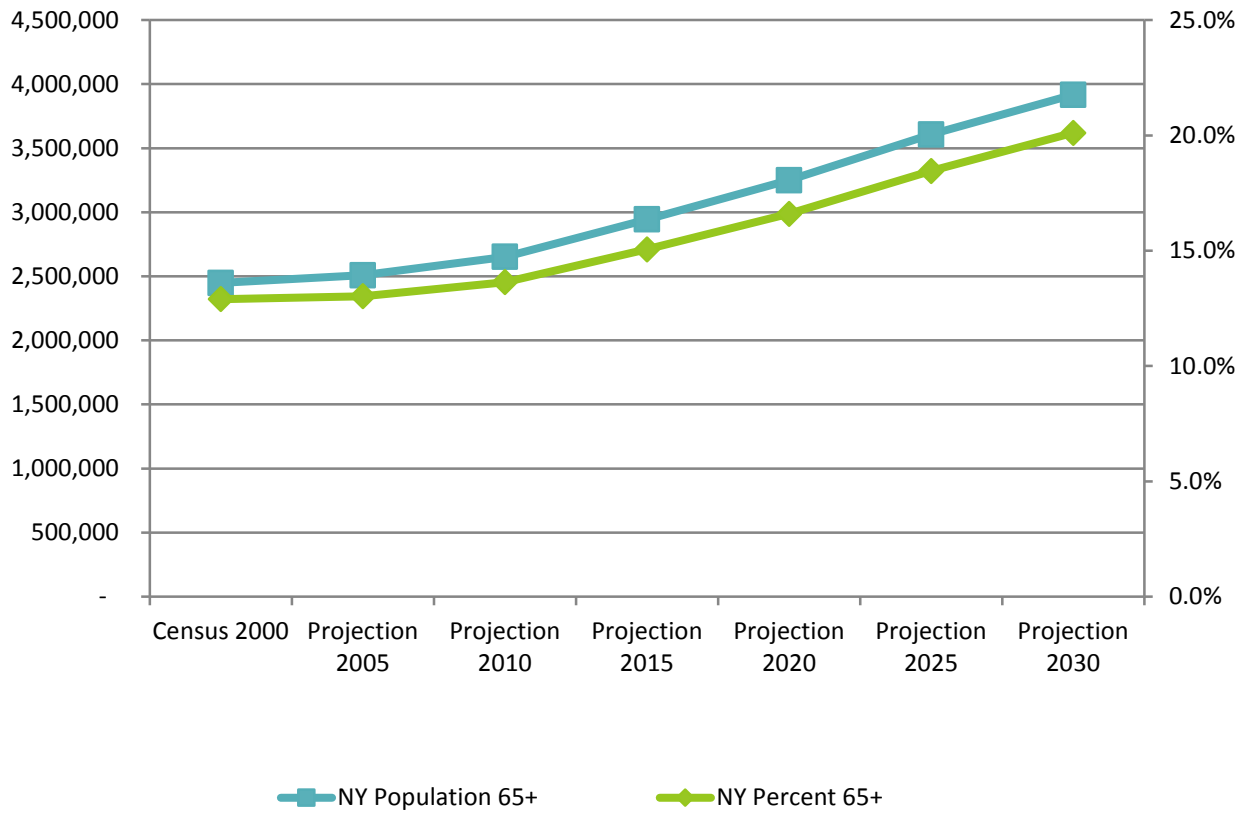
1. BACKGROUND: KEY TRENDS

Key Trends

- Aging population
- Prevalence of chronic disease
- Workforce/caregivers
- Baby Boomer preferences
- Spending

Demographics: Aging Population

By 2030, 20% of the NYS population will be 65 or older.



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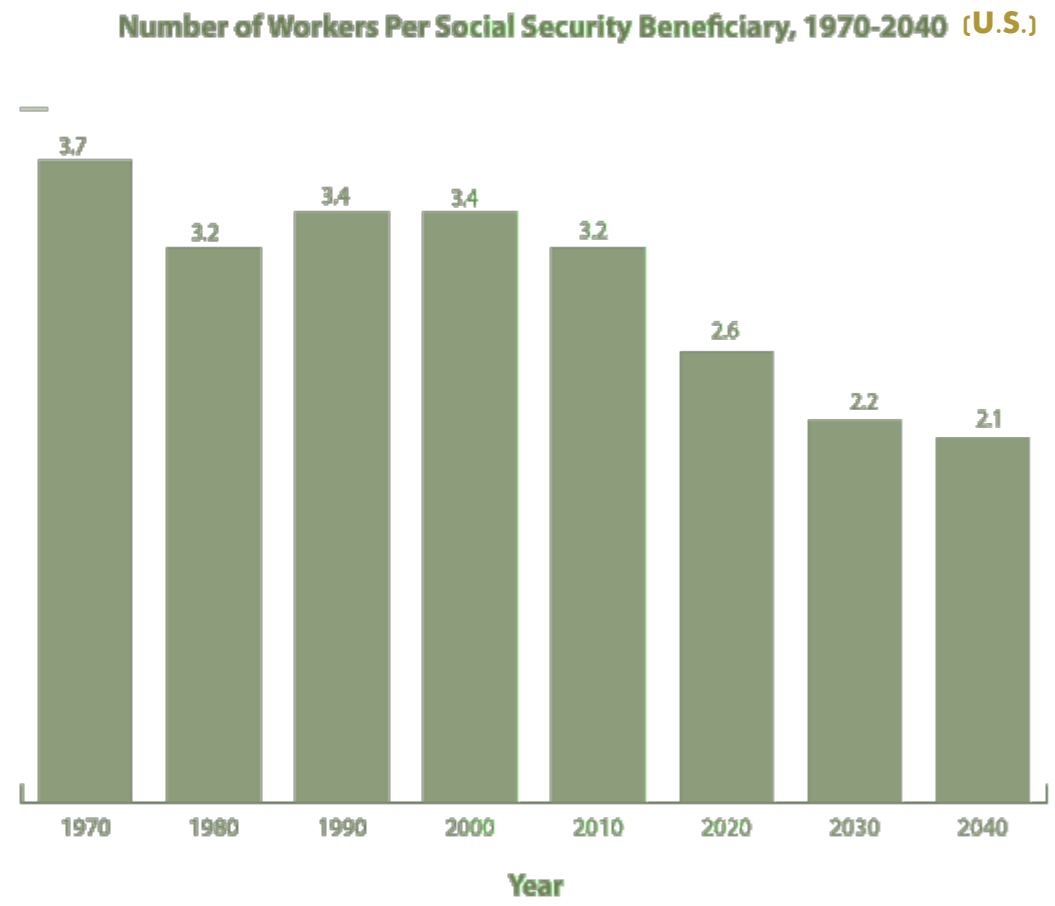
Prevalence of Chronic Disease and Disability

- 2/3 of Medicare beneficiaries have 2 or more chronic conditions
  - Obesity: Prevalence among Medicare beneficiaries has doubled since 1987
  - Diabetes: Prevalence has grown from 18% in 2002 to 27% in 2010
  - End Stage Renal Disease (ESRD): Prevalence has grown by 53% between 1999-2009

  (Source: AHA Trendwatch, Dec. 2012, citing CMS Chronic Condition Data Warehouse and U.S. Renal Data System)
- Disability:
  - 1985-1999: Level of disability among Americans age 65+ declined
  - 2000-2008: Disability among Americans age 85+ continued to decline; held steady among those age 65 to 84, and increased for those age 55 to 64 (Source: Demography and Economics of Aging, *Helping Americans Age in Place,* May 2013)

Workforce/Caregiver Implications



Source: Table IV.B2 in Social Security Administration (2008b).

Growing Need for Long-Term and Post-Acute Care (LTPAC) Workers

Occupation	2014	2024	Change Between 2014 and 2024		Average Annual Openings [a]
			Number	Percent	
Home Health Aides	161,970	235,310	73,340	45.3%	10,992
Personal Care Aides	164,700	215,950	51,250	31.1%	6,457
Registered Nurses	183,210	214,460	31,250	17.1%	7,447
Nursing Assistants	110,730	128,430	17,700	16.0%	4,271
Social Workers	60,530	70,330	9,800	16.2%	2,438
Licensed Practical and Licensed Vocational Nurses	51,550	60,870	9,320	18.1%	2,399
Medical Assistants	25,490	31,540	6,050	23.7%	1,136
Physical Therapists	16,740	21,650	4,910	29.3%	939
Emergency Medical Technicians and Paramedics	16,480	21,270	4,790	29.1%	749
Medical and Health Services Managers	31,580	35,520	3,940	12.5%	1,191
Dental Assistants	19,860	23,640	3,780	19.0%	869
Nurse Practitioners	11,420	15,080	3,660	32.0%	635
Physician Assistants	11,480	14,590	3,110	27.1%	569
Clinical, Counseling, and School Psychologists	15,450	18,130	2,680	17.3%	599
Speech-Language Pathologists	10,960	13,320	2,360	21.5%	512
Dental Hygienists	10,640	12,830	2,190	20.6%	395
Occupational Therapists	9,760	11,940	2,180	22.3%	407
Pharmacy Technicians	16,950	19,100	2,150	12.7%	383
Medical Records and Health Information Technicians	9,220	10,720	1,500	16.3%	356
Medical and Clinical Laboratory Technicians	8,830	10,280	1,450	16.4%	356
Diagnostic Medical Sonographers	5,270	6,660	1,390	26.4%	240
Radiologic Technologists	14,260	15,550	1,290	9.0%	398
Pharmacists	19,640	20,690	1,050	5.3%	563
Dietitians and Nutritionists	5,220	6,260	1,040	19.9%	143
Medical and Clinical Laboratory Technologists	10,420	11,410	990	9.5%	348
Orderlies	5,400	6,270	870	16.1%	209
Respiratory Therapists	6,410	7,100	690	10.8%	221
Surgical Technologists	5,510	6,180	670	12.2%	122
Cardiovascular Technologists and Technicians	3,050	3,680	630	20.7%	121
Psychiatric Aides	7,100	7,500	400	5.6%	200
Nurse Anesthetists	1,630	1,950	320	19.6%	70
Nurse Midwives	490	560	70	14.3%	19

[a]Annual openings reflect creation of new positions in the occupation and replacement for those retiring or otherwise leaving the occupation.

Source: New York State Department of Labor, Jobs in Demand/Projects, Long-Term Occupation Projections, 2012-2022.

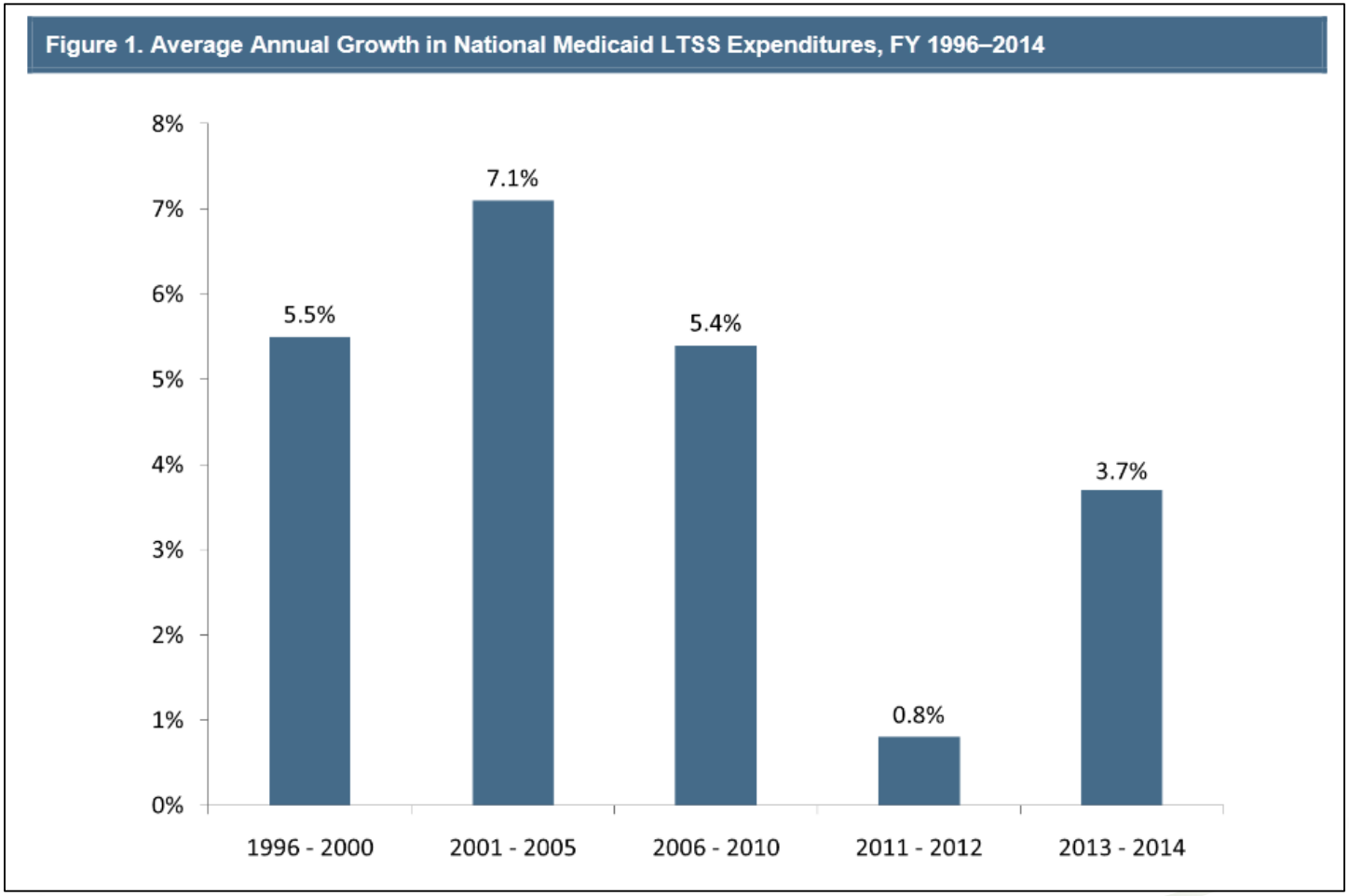
Center for Health Workforce Studies, 2016

Boomer Preferences

- People now aged 65 are expected to live well into their 80s with the vast majority preferring to ‘‘age in place’’ (i.e., grow old in their current homes) (Source: *Federal Register, CDC proposed information collection 11/14/13*)
- Boomers are more racially and ethnically diverse than prior generations (Source: 65+ in the United States: 2010 , U.S. Census Bureau 2014)
- Boomers are more educated and can be expected to be more engaged in their care (Source: AHA, citing U.S. Census Bureau, CPS 2005)

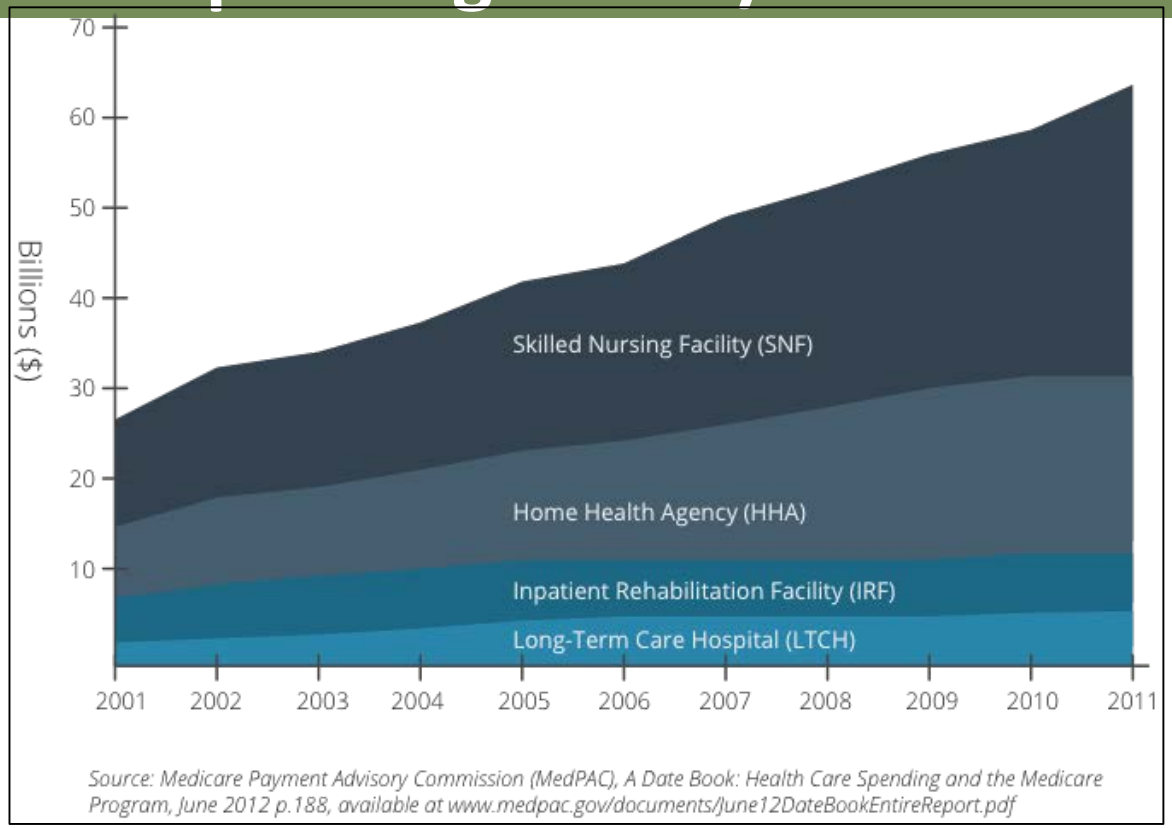
Long-Term Care (LTC) Spending Growth Across All Payers

LTSS spending growing at higher rate nationwide, primarily due to HCBS growth.



Eiken, Truven Health Analytics for CMS, Apr. 2016.

Medicare Post-Acute Care (PAC) Spending Grows/Varies



Source: Medicare Payment Advisory Commission (MedPAC), A Date Book: Health Care Spending and the Medicare Program, June 2012 p.188, available at www.medpac.gov/documents/June12DateBookEntireReport.pdf

- Medicare spending on post-acute care has more than **doubled** since **2000**; per capita spending has grown by **90%.** (MedPac testimony before House WAM, June 2013)
- IOM concluded that spending on post-acute care around the country accounts for **73%** of the regional variation in Medicare spending.

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2. POLICY AND MARKET RESPONSES

New Care and Payment Models

- Advance Triple Aim through new models
- Hold providers and payers accountable for outcomes by realigning incentives
  - Managed and accountable care
  - Readmission penalties
  - Episodic payments
  - Value-based payment
- Focus on performance measurement/transparency
- New emphasis on social determinants and supports (including housing)

NY's Response: Medicaid Redesign

Care Management for All

- Managed care, health homes, PCMH

Delivery System Reform

- DSRIP PPSs

Payment Reform

- Value-Based Payment

Market Responses to Medicaid Redesign

- ***Affiliation, integration, consolidation***
- ***Shrinking not-for-profit LTPAC sector***
- Nursing home “culture change” movement
- Care coordination
- “Cascade of care”
- Housing with services
- Community-based wellness services
- Growing use of technology
- Quality and cost measurement

Market Responses: Affiliation, Integration, Consolidation

- New models of care and payment driving integration
- Demand:
  - Scale
  - Organized continuum of care
  - HIT/HIE
  - Data and analytics
  - Capital
- Large market share necessary for population health, value-based payment and managed care strategies
- Challenging operating environment
- Limited access to capital - rating agencies, lenders/investors prefer diversified organizations
- Cost savings through scale and clinical integration to counteract reduced revenues

Market Responses: Capacity and Ownership

- Nursing homes

Sponsor	2006	2014	2016	Percentage Change: 2006-16
For-Profit	322	350	370	14.9%
Not-for-Profit	283	237	222	-21.6%
Governmental	53	37	34	-35.8%

- HCBS
  - *Major increase in CHHA capacity:* 36% increase in total downstate approved service areas
  - Contraction in LTHHCP, ADHC
- ALP
  - *Steady increase in capacity:* 20+% increase in capacity since 2011
  - More growth expected

3. MANAGED CARE

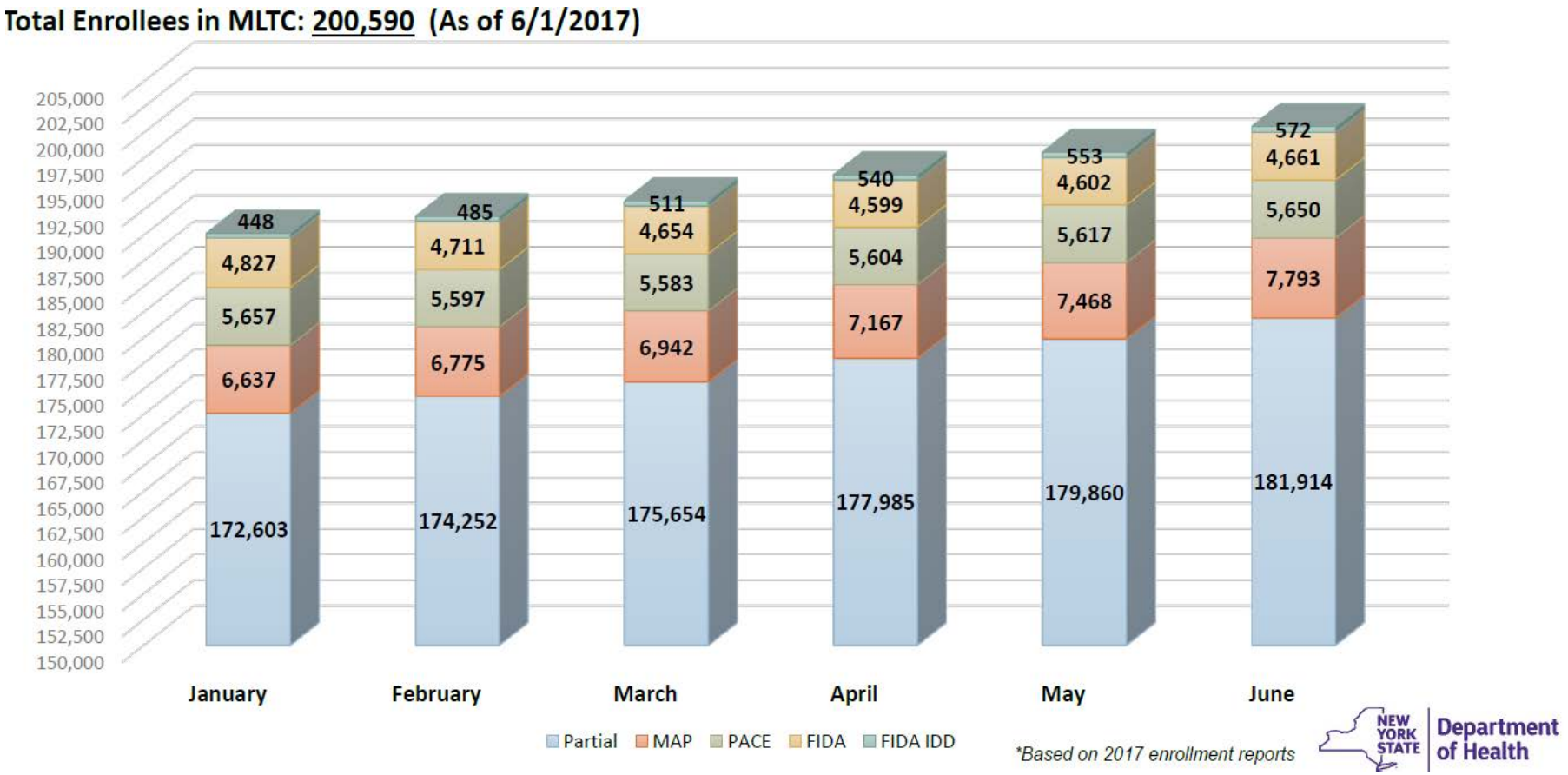
LTPAC Managed Care Payers

- Medicare covered services:
  - Medicare Advantage (MA)
  - Medicare Advantage Special Needs Plans (I-SNPs, D-SNPs, C-SNPs)
- Medicaid covered services:
  - Managed Long-Term Care (MLTC)
  - Mainstream Medicaid Managed Care (MMC)
- Medicare and Medicaid (dual) covered services:
  - Program for All-Inclusive Care for the Elderly (PACE)
  - Medicaid Advantage Plus (MAP)
  - Fully Integrated Duals Advantage (FIDA) (Downstate)
  - HIV SNP
- Commercial health plans for covered post-acute care

Managed Care Transition

- Mandatory statewide for dual eligibles, aged 21+, who:
  - Need community-based LTC services for 120+ days; or
  - Permanently placed in a nursing home after Feb. 1, 2015 (downstate) or July 1, 2015 (upstate)
- Community-based LTC includes personal care, home health care, consumer-directed care and adult day health care
- Currently excludes NHTD and TBI waivers and ALPs
- Duals required to join MLTCs; mainstream for Medicaid-only
- Working through a series of implementation issues

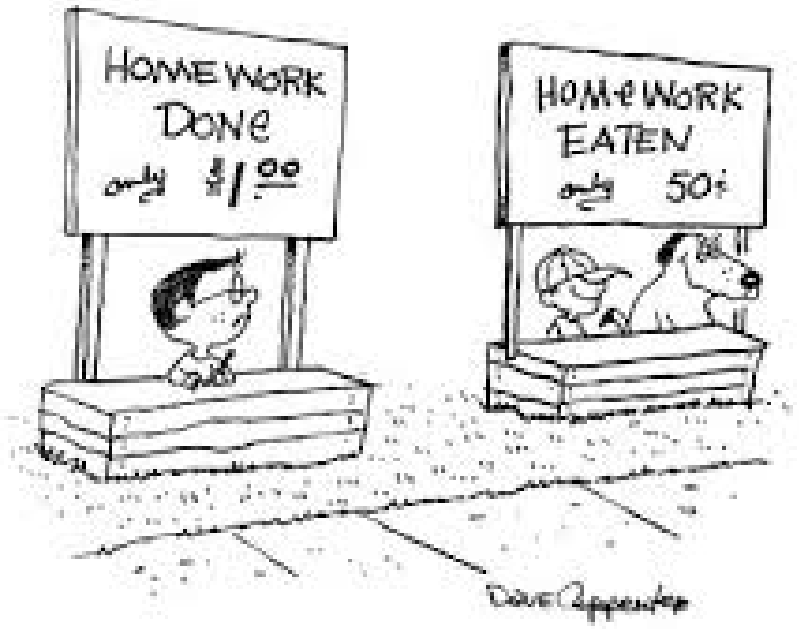
Current Statewide MLTC Enrollment



Source: NYS DOH, July 2017 Managed Care Policy and Planning Meeting.

Implications of Mandatory Managed Care

- After 2020, nursing home rates will be negotiated and may change from current levels
- Other LTC rates are already negotiated
- Volume, case mix, and mix of services changing due to utilization management
- Process/timing of payments to providers changing
- Changes to networks and referral patterns
- Mounting fiscal pressure on plans and providers
- Opportunities for shared Medicaid savings limited



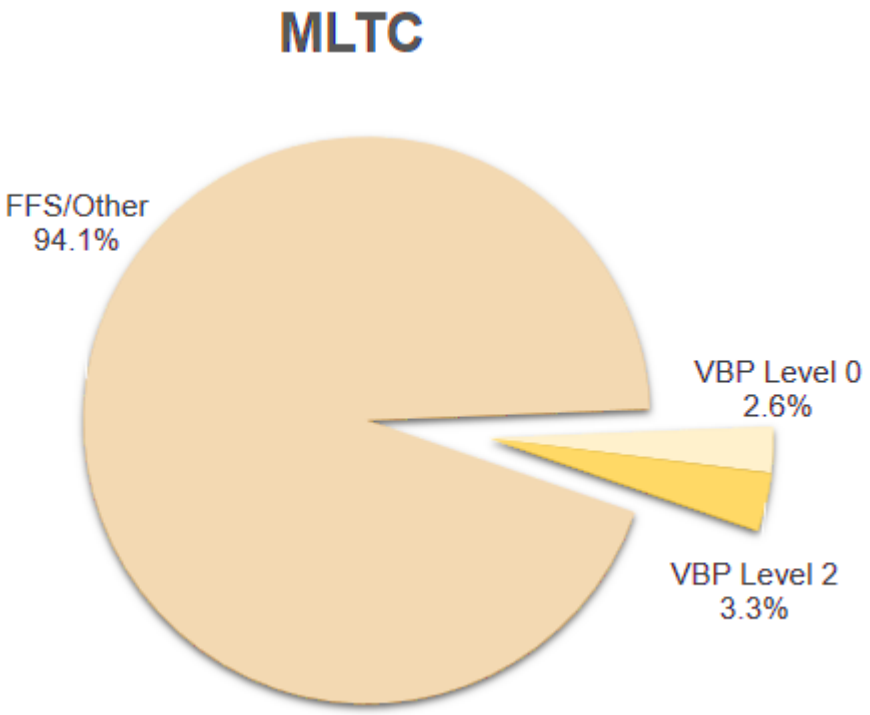
4. VALUE-BASED PAYMENT

New York's Value-Based Roadmap

- By 2019, all Managed Care Organizations (MCOs) must employ *non-fee-for-service* payment systems that reward value over volume for 80-90% of their provider payments
- Examples of VBP for a frail elderly population:
  - MLTC Level 1: Fee-for-Service (FFS) with a pay-for-performance element tied to avoidable hospital use and other quality metrics*
  - MMC Level 1: FFS with upside-only shared savings (shared savings available only when outcome scores sufficient)
  - Level 2: FFS with 2-sided risk sharing (upside available when outcome scores sufficient; downside reduced when outcome scores high)
  - Level 3: PMPM capitated payment for total care for subpopulation (with outcome-based component)

* The State has agreed to count these types of arrangements between MLTC plans and providers as Level 1.

VBP: Where We are Today



DOH survey results show that only 6% of MLTC payments are made via VBP arrangements. Most Level 2 arrangements were in Medicare Advantage Plans (MAP) (duals) plans.

Medicaid VBP Presents Challenges for LTPAC Providers

- Potential opportunities for LTPAC providers to share in savings

BUT

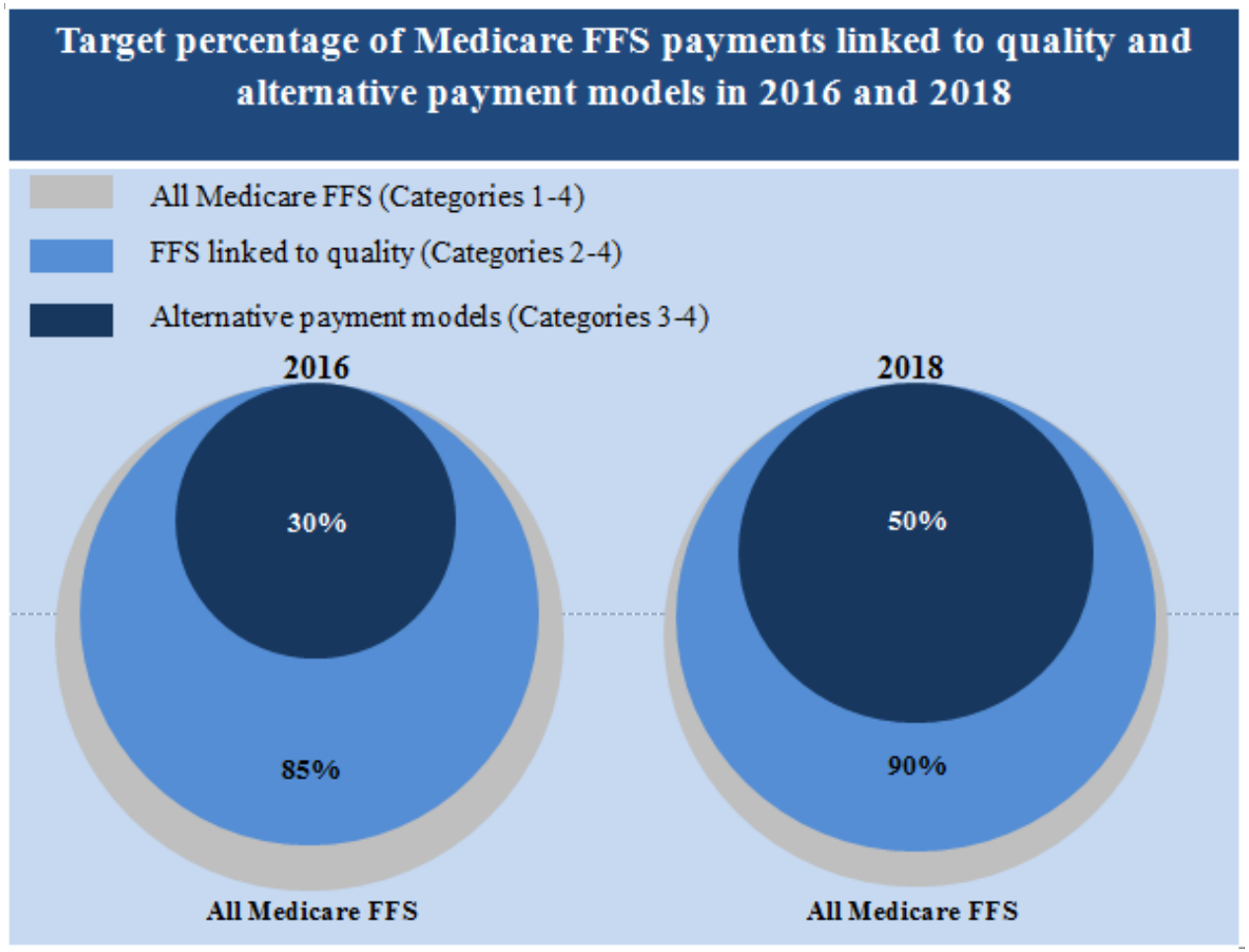
- The people we serve are dual eligible; and
- Most of the savings available would be derived from reductions in avoidable hospital use and would accrue to Medicare; and
- When we reduce hospital use, personal care hours, nursing home days, and ADHC visits increase, driving Medicaid spending growth.

VBP Potential to Align Incentives

Yesterday's Incentives	Tomorrow's Incentives
Payers	Payers
Control utilization	Reduce demand through prevention
Emphasize lower cost settings and services	Emphasize lower cost settings and services
Reduce rates	Restructure rates to reward lower costs and higher quality
Providers	Providers
Increase admissions, NH days	Reduce demand through prevention
Increase services	Emphasize lower cost settings and services
Increase rates per day or episode	Provide high quality at lower overall cost to earn bonuses and share in savings

5. MEDICARE VBP AND ALTERNATIVE PAYMENT ARRANGEMENTS

Medicare's Value-Based Payment Plan



SNF Value-Based Purchasing Program:

- Oct. 1, 2016 - CMS to provide reports to SNFs on readmissions.
- Oct. 1, 2017- CMS to post readmission performance on NH Compare.
- Oct. 1, 2018 - VBP applies to SNF services.

Medicare VBP Initiatives Demand LTPAC Involvement

- Hospital VBP
  - Medicare Spending Per Beneficiary (MSPB) Measure
  - Readmissions Reduction Program
- SNF VBP
  - Readmissions reduction measure
  - Medicare Spending Per Beneficiary quality measure
- Bundled Payments
  - BPCI
  - CJR
- Shared Savings Program/Accountable Care Organizations
  - Shared savings is based on total per capita Medicare Part A and B spending, including post-acute care

Medicare SNF Value-Based Purchasing (SNF VBP) Program

The Protecting Access to Medicare Act of 2014 (PAMA) requires that VBP apply to SNF payments beginning in October 2018

- Two percent withhold of SNF Part A payments
- Partially earned back based on a SNF's re-hospitalization rate and level of improvement (50-70%)
- CMS tasked with:
  - specifying a risk adjusted re-hospitalization measure
  - calculating a score for each SNF
  - providing the measure and score reports to SNFs for review and make it available to the public

SNF Quality Reporting Program (QRP)

Four new measures from 2017 SNF PPS Rule:

- Discharge to Community: Assesses successful discharge to the community from a SNF setting -- no unplanned re-hospitalizations and no death in the 31 days following discharge from the SNF. (2018)
- Medicare Spending per Beneficiary: Holds SNF providers accountable for Medicare payments within an "episode of care", which includes the period during which a patient is directly under the SNF's care and a defined period after the end of the SNF treatment, which may be reflective of and influenced by the services furnished by the SNF. (2018)
- Potentially Preventable Readmission: Assesses the facility-level risk-standardized rate of unplanned, potentially preventable hospital readmissions for Medicare FFS beneficiaries in the 30 days post-SNF discharge. (2018)
- Drug Regimen Review: Assesses whether PAC providers were responsive to potential or actual clinically significant medication issue(s) when such issues were identified. (2020)

6. KEY CHALLENGES AND OPPORTUNITIES

Challenges Create Opportunities

Challenge	Opportunity	Strategies
Generating sufficient scale	• Population heath • Payer agreements • VBP and risk • Spread fixed costs	• Affiliation, merger • Service diversification • Integrated system (PPS) • Independent Practice Association
Avoiding hospitalizations	• DSRIP funds • Shared savings • Patient outcomes	• Evidence-based practices • Clinical collaborations • Training and education
Operating efficiency	• Payer preference • At-risk contracts • Episodic payment	• Business processes • Costing software • Service volume • Managed care contracting
Care coordination	• VBP and risk • Payer preference • Patient outcomes	• Clinical integration • Bi-directional info exchange • Training and education • Collaborations with payers

Challenges Create Opportunities

Challenge	Opportunity	Strategies
Episodic payment	• Medicare and commercial business • Profit	• Integrated system (PPS) • Evidence-based practices • Clinical collaborations • Costing software
Value-based payment	• Funding for operations and infrastructure	• Diversify services • Independent Practice Association • Managed care contracting • Duals and mainstream plans
Access to capital	• Investments in HIT, facilities and programs	• Mergers and affiliations • Obligated groups • State/federal funding programs • Value-based payment

Questions or Reactions?

Contact information:
Dan Heim
dheim@leadingageny.org
www.leadingageny.org
Phone: 518-867-8383

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