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

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

Number of Workers Per Social Security Beneficiary, 1970-2040 (U.S.)

Year


3.7 3.2 3.4 3.4 3.2 2.6 2.2 2.1

Source: Table IV.B2 in Social Security Administration (2008b).
## Growing Need for Long-Term and Post-Acute Care (LTPAC) Workers

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

*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.
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 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.
2. POLICY AND MARKET RESPONSES
• 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
• 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

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<tbody>
<tr>
<td>For-Profit</td>
<td>322</td>
<td>350</td>
<td>370</td>
<td>14.9%</td>
</tr>
<tr>
<td>Not-for-Profit</td>
<td>283</td>
<td>237</td>
<td>222</td>
<td>-21.6%</td>
</tr>
<tr>
<td>Governmental</td>
<td>53</td>
<td>37</td>
<td>34</td>
<td>-35.8%</td>
</tr>
</tbody>
</table>

- 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
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

Total Enrollees in MLTC: **200,590** (As of 6/1/2017)

- **January**: 172,603 (Partial 6,637, MAP 4,827, PACE 5,657, FIDA 4,711, FIDA IDD 6,775)
- **February**: 174,252 (Partial 6,775, MAP 4,711, PACE 5,597, FIDA 4,654, FIDA IDD 6,942)
- **March**: 175,654 (Partial 6,942, MAP 5,583, PACE 5,597, FIDA 4,654, FIDA IDD 6,775)
- **April**: 177,985 (Partial 7,167, MAP 5,604, PACE 5,583, FIDA 4,599, FIDA IDD 6,942)
- **May**: 179,860 (Partial 7,468, MAP 5,617, PACE 5,583, FIDA 4,602, FIDA IDD 6,775)
- **June**: 181,914 (Partial 7,793, MAP 5,650, PACE 5,583, FIDA 4,661, FIDA IDD 6,775)

*Based on 2017 enrollment reports

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
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.
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

<table>
<thead>
<tr>
<th>Yesterday’s Incentives</th>
<th>Tomorrow’s Incentives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Payers</strong></td>
<td><strong>Payers</strong></td>
</tr>
<tr>
<td>Control utilization</td>
<td>Reduce demand through prevention</td>
</tr>
<tr>
<td>Emphasize lower cost settings and services</td>
<td>Emphasize lower cost settings and services</td>
</tr>
<tr>
<td>Reduce rates</td>
<td>Restructure rates to reward lower costs and higher quality</td>
</tr>
<tr>
<td><strong>Providers</strong></td>
<td><strong>Providers</strong></td>
</tr>
<tr>
<td>Increase admissions, NH days</td>
<td>Reduce demand through prevention</td>
</tr>
<tr>
<td>Increase services</td>
<td>Emphasize lower cost settings and services</td>
</tr>
<tr>
<td>Increase rates per day or episode</td>
<td>Provide high quality at lower overall cost to earn bonuses and share in savings</td>
</tr>
</tbody>
</table>
5. MEDICARE VBP AND ALTERNATIVE PAYMENT ARRANGEMENTS
SNF Value-Based Purchasing Program:

- Oct. 1, 2016 - CMS to provide reports to SNFs on readmissions.
- 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
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
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

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Opportunity</th>
<th>Strategies</th>
</tr>
</thead>
</table>
| Generating sufficient scale | • Population heath  
                          | • Payer agreements  
                          | • VBP and risk  
                          | • Spread fixed costs  |
| Avoiding hospitalizations  | • DSRIP funds  
                          | • Shared savings  
                          | • Patient outcomes  |
| Operating efficiency       | • Payer preference  
                          | • At-risk contracts  
                          | • Episodic payment  |
| Care coordination          | • VBP and risk  
                          | • Payer preference  
                          | • Patient outcomes  |

- **Strategies**
  - • Affiliation, merger  
  - • Service diversification  
  - • Integrated system (PPS)  
  - • Independent Practice Association  
  - • Evidence-based practices  
  - • Clinical collaborations  
  - • Training and education  
  - • Business processes  
  - • Costing software  
  - • Service volume  
  - • Managed care contracting  
  - • Clinical integration  
  - • Bi-directional info exchange  
  - • Training and education  
  - • Collaborations with payers
### Challenges Create Opportunities

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Opportunity</th>
<th>Strategies</th>
</tr>
</thead>
</table>
| 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?

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