

Home- and Community-based Long-Term Care in New York: Where Do We Go From Here?

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Medicaid in 2008 and Beyond: Challenges and Prospects
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Pillars of Home- and Community-based Long-Term Care

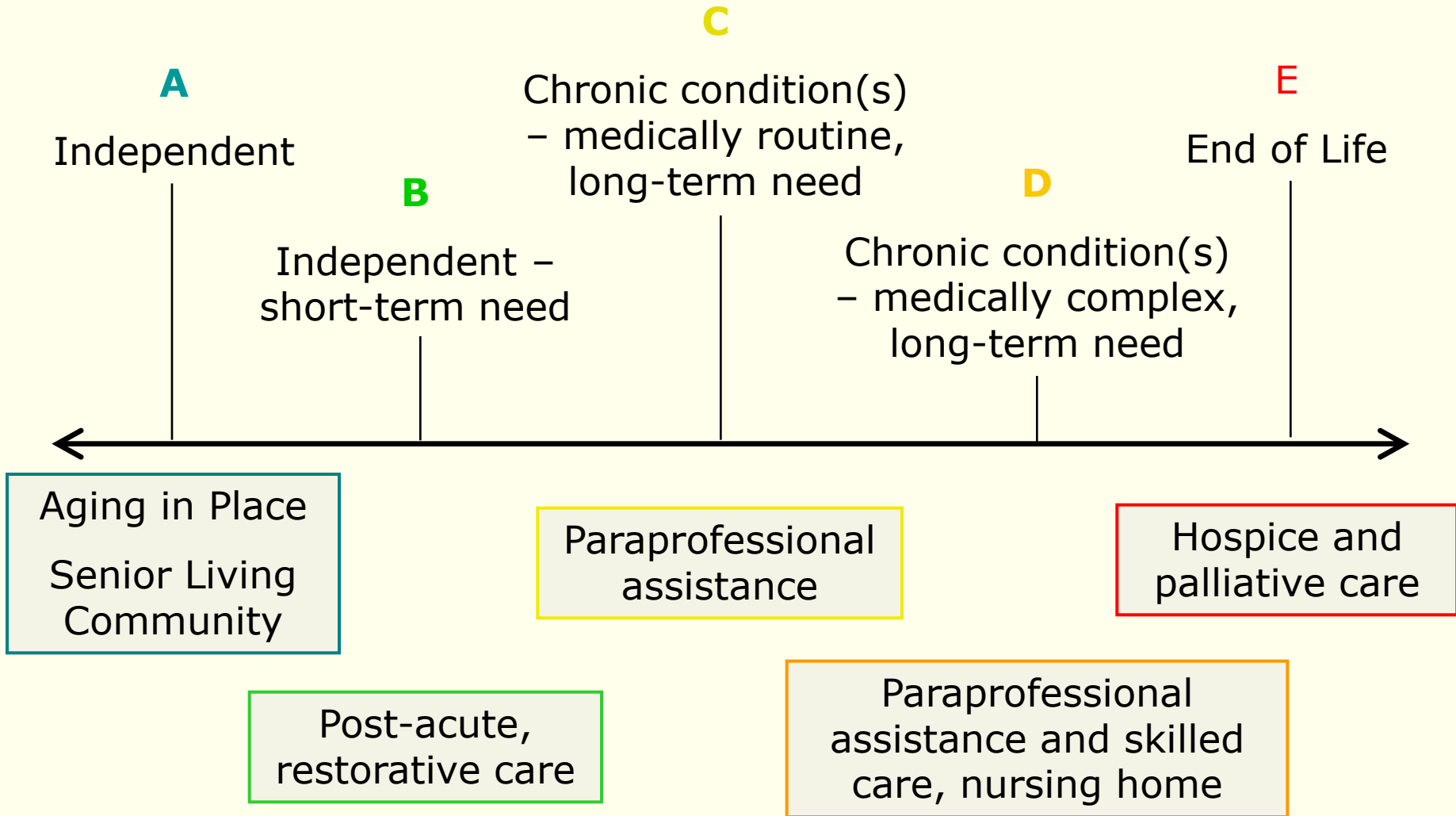
- I. Service Delivery Models
- II. Managed Care Plans
- III. Quality
- IV. Financing
- V. Workforce
- VI. Technology

I. Service Delivery Models

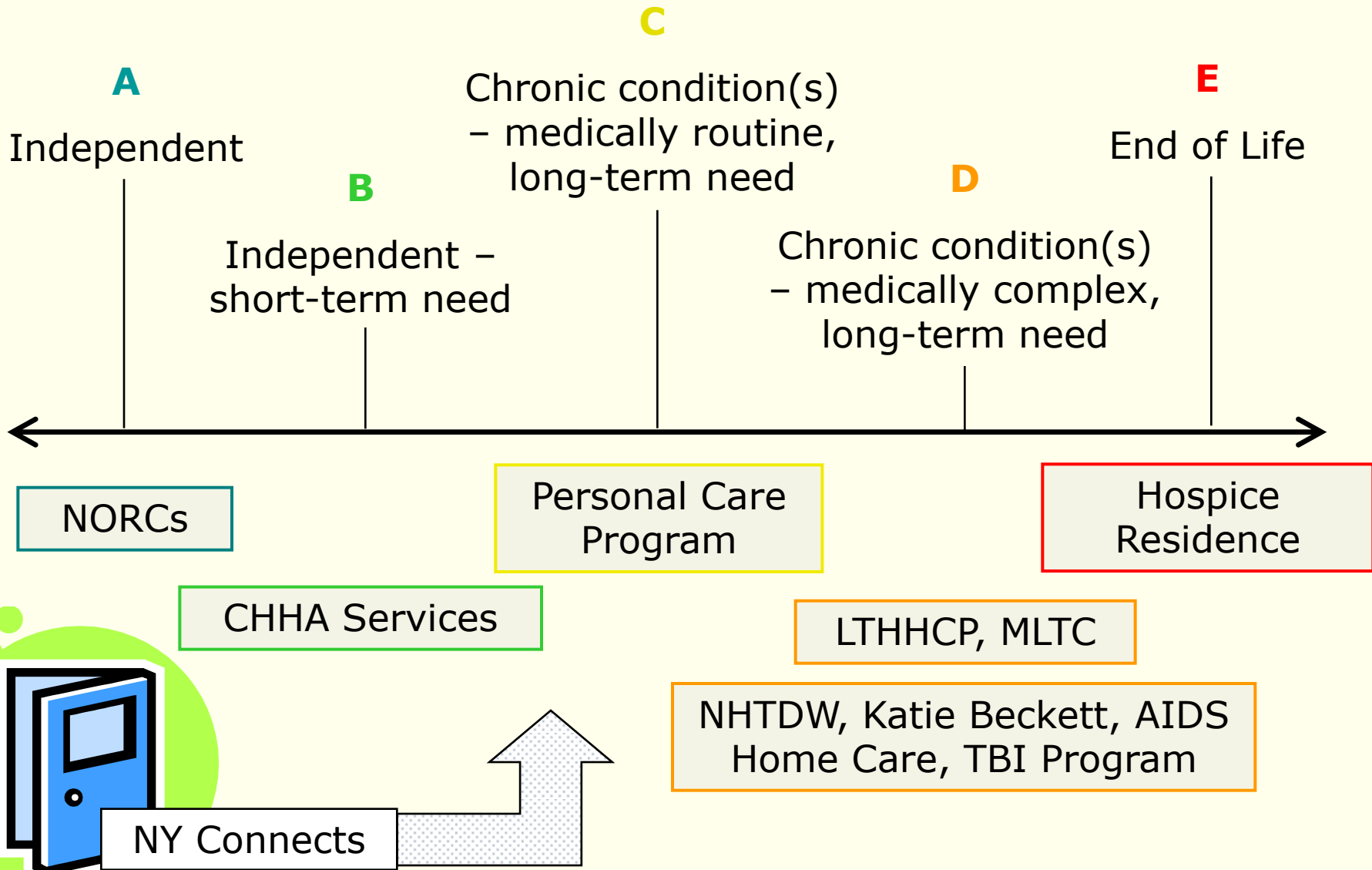
Ingredients for an Effective H&CB LTC Service Delivery System

- i. Range of accessible options
- ii. Ability to assess needs of people and match them to the different options
- iii. Ability for people to move along the LTC continuum as their circumstances change
- iv. Programs that move upstream to prevent disability and support aging in place
- v. Broadened unit of care with programs that actively engage patients *and* family (informal) caregivers

Long-term Care Continuum



New York's Home- and Community-based LTC Programs



II. Medicaid Managed Care Plans and Long-term Care

Potential of Managed Care Plans

- i. Clear accountability
- ii. Aligned incentives
- iii. Integration of acute and long-term care
- iv. Mitigation of cost-shifting
- v. Longitudinal care perspective

At the federal level ...

- ◆ There has been a move to managed care for Medicare beneficiaries.
 - Part D drug plans
 - Medicare Advantage plans
 - MA Special Needs Plans (SNPs)

Special Needs Plans (total and by target pop'n)				
	<i>National</i>		<i>New York</i>	
	Plans	Members	Plans	Members
Total	769	1,188,676	55	88,868
Duals	439	854,877	42	63,430
Chronic	241	200,218	4	2,883
Institutional	89	133,581	9	22,555

In New York...

- ◆ There has also been a directional shift to private health plans for Medicaid enrollees, but managed care penetration varies by beneficiary type.
 - 76% of non-elderly, non-disabled adults and children are enrolled in Medicaid health plans, vs.
 - 14% of elderly or disabled adults are enrolled in Medicaid health plans

How can the state take the next step and bring managed care to more of the costly Medicaid populations, including those who need LTC?

Managed LTC Plans in New York

- ◆ Enrollment is voluntary.
- ◆ Hybrid model – partial capitation for bundle of LTC, ambulatory and social services.
- ◆ Currently, 17 plans with 23,899 members.
- ◆ Members must be eligible for nursing home admission and thus, most members are elderly (average age is 71 yrs).

NYS “Medicaid Advantage Plus” Plans

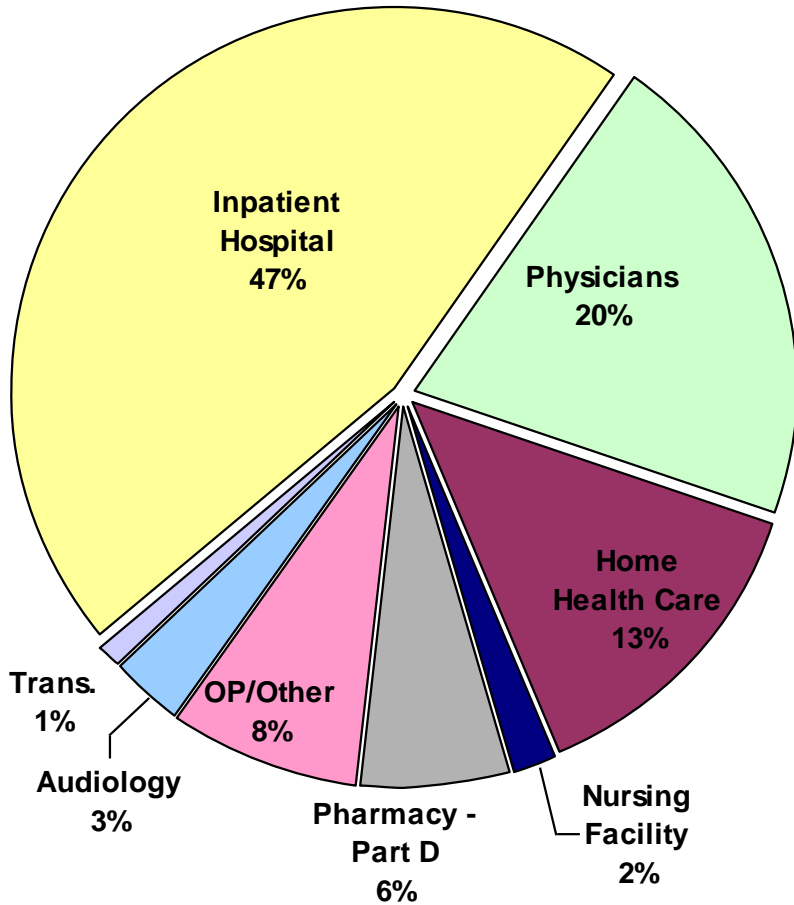
- ◆ NYS now requires that all new MLTC plans be integrated with a Medicare SNP.
- ◆ Plan structure creates *one accountable organization* that is responsible for management of acute and long-term care benefits, member utilization and costs.
- ◆ From member perspective, there is a single point of contact in order to access benefits.

VNSNY's Health Plans

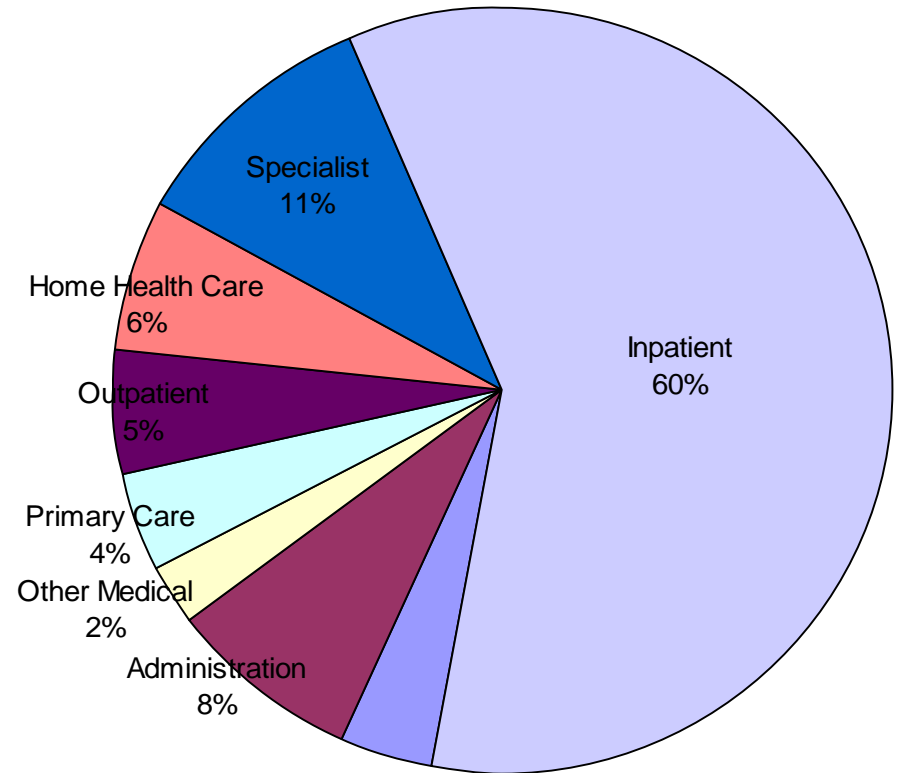
VNS CHOICE MLTC (1)	VNS CHOICE Medicare (SNP and Part D) (2)
YE'08 census target = 6,581 members	YE'08 census target = 1,900 members
Dual-eligible pop'n	Dual-eligible pop'n
Long-term Care	Hospitals, Doctors, Labs, Rxs
Support member in community; manage member across sites	Reduce hospital and ER costs; ensure regular source of primary care
<p style="text-align: center;">MLTC-Plus = (1) + (2)</p>	
<p style="text-align: center;">Laboratory for testing integrated delivery and financing across all care settings</p>	

VNS CHOICE Medicare Distribution of Medical Expenses

VNS CHOICE Medicare
(First Quarter 2008)



Typical Medicare Advantage Plan



III. Quality

Quality in Home- and Community-based LTC

1. Little clarity on quality standards in the home- and community-based LTC system.
 - What measures should be included?
 - What patient outcomes should providers strive for?
2. No consensus yet on vehicles the state can use to ensure and promote quality in the home- and community-based LTC system.
 - Accreditation
 - Regulation
 - Public disclosure
 - Pay-for-performance

Development of Uniform LTC Data Set for Community-based LTC Providers

- ◆ NYS legislature included money for DOH for improvements to LTC, including development of a uniform data set for community-based settings.
- ◆ Data set would serve as the basis for a common assessment tool at all points of entry into the LTC system.
- ◆ Assessment tool will incorporate consumer preference.

IV. Financing

Continued Strain on LTC System Anticipated in Future

- ◆ Demand for LTC will increase and outstrip system's ability to provide services, due to:
 - Increase in size of older population
 - Decrease in availability of informal caregivers
 - Workforce shortages

<i>Projections for size of 65+ population</i>			
	2000	2030	Growth
NYC	937,000	1.35 M	44%
NYS	2.45 M	3.92 M	60%
USA	35 M	71 M	102%

Lack of clear, predictable funding for LTC creates insecurity.

- ◆ Individuals are not adequately planning for their later years.
 - Post-retirement income → Social Security
 - Medical costs → Medicare
 - **Long-term care costs → ???**
- ◆ Medicare only covers a small set of skilled, post-acute care services for limited time.
- ◆ 1/3 of LTC is financed out-of-pocket (not including the value of care donated by family and friends).
- ◆ Assisted living facilities are priced out of reach of most seniors.
- ◆ Private LTC insurance is available but has only penetrated an estimated 10% of the market.

How can NYS use payment policy as a tool to shape the direction of LTC?

- ◆ Payment policy is a *primary lever* for the state to change the LTC system in order to:
 - Reward innovation, cost-effectiveness
 - Reward quality
 - Promote accountability, care coordination
 - Reward the kind of care that is valuable in a LTC population
 - Create an accurate reimbursement structure - through risk adjustment, case mix index.

V. Workforce

Workforce capacity is a linchpin in the LTC system.

- ◆ Even if we solve issues around financing of LTC, there is no system without:
 - Sufficient *numbers* of the different types of caregivers needed to care for an aging population
 - Sufficient *training and competencies* among all caregivers around caring for an aging population

Unless action is immediately taken, the LTC workforce will lack the capacity (in both size and ability) to meet the needs of older patients in the future.

IOM Report - Retooling the Health Care Workforce for an Aging America (2008)

- ◆ There are anticipated shortages in many health care disciplines, and future health care needs and demands will outstrip the supply of workers.
- ◆ The existing education and training system does not adequately prepare workers to gain the skills and competencies required to care for complex older adults.
- ◆ By 2030, the U.S. will need an additional 3.5 million formal health care providers – a 35% increase over current levels – just to maintain today's ratio of providers to the total population.

Registered Nurses

- ◆ Nursing workforce is aging (and retiring); nursing school enrollments are insufficient to compensate for exits from the workforce.
 - BLS projects that by 2020, the RN shortfall will be 400,000.
- ◆ Less than 1% of RNs are certified in geriatrics.
 - Only 29% of bachelor's programs have a faculty member certified in geriatrics.
 - Only one-third of bachelor's nursing programs require any exposure to geriatrics at all.

Direct-Care Workers (DCWs)

- ◆ BLS projects that personal care aides and home health aides will be the 2nd- and 3rd-fastest growing occupations between 2006 and 2016.
 - Between 2000 and 2010, a projected additional 874,000 DCWs will be needed.
 - This number grows to ~1.2 million if replacement workers to mitigate attrition are taken into account.

To build the future workforce ...

- ◆ States should continue to bolster recruitment and retention of all disciplines required to provide H&CB LTC.
- ◆ State Medicaid programs should continue to increase pay and fringe benefits for DCWs via mechanisms such as wage pass-throughs.
- ◆ States and the federal government should increase minimum training standards for DCWs and create career advancement opportunities.

VI. Technology

Technology has the potential to enable Pillars I-V of the LTC system.

- i. Improved coordination and communication across providers and settings
- ii. Engagement of patients and family caregivers
- iii. Collection of standardized measures of quality in LTC
- iv. Assessment and matching of needs to programs
- v. Increasing workforce capacity

Technology has the potential to enable independence.

Telehealth in New York

- ◆ In 2007, NYS passed legislation that required DOH to develop and implement a Medicaid reimbursement rate for telemonitoring.
 - Feb. 2008 – rate structure finalized, with three payment tiers.
 - Experience to date – rate is adequate but patient assessment and reporting requirements are onerous.
- ◆ VNSNY has been testing telehealth among different patient groups since 2005.

Regional Health Information Organizations (RHIOs)

- ◆ \$1 billion investment over four years by NYS through HEAL-NY → RHIOs, to structure clinical data sharing among providers.
- ◆ RHIO members include hospitals, community health centers, nursing homes, home health agencies, physician practices.
- ◆ Focus is on data used in acute care settings – LTC providers and data need to be incorporated.

In conclusion ...

New York has many strengths in its LTC system.

- ◆ NYS offers more options and greater capacity in its LTC system, compared to other states.
- ◆ NYS has responded to consumer preference for alternatives to institutional care by continuing to rebalance LTC spending to HCBS.
 - In 2006, HCBS comprised 44% of LTC expenditures in NYS, compared to a national average of 39%.
- ◆ NYS is working to strengthen most of the pillars in the H&CB LTC system, but efforts to innovate in *quality* and in *payment policy* are still young.

New York should create a LTC system for the 21st century.

1. Recognize that the next generation of older New Yorkers will be different from the previous ...
 - Different preferences
 - Different needs

2. Rational service delivery system with accessible array of H&CB LTC options
3. Appealing and effective health plans
 - To attract a larger proportion of eligibles to enroll in managed care
 - To create a single organization accountable for member outcomes, utilization and costs
 - To create incentives for coordination of care across provider settings

4. Consensus on what defines *quality* H&CB LTC and vehicles to promote quality
5. Payment structure that
 - Values innovation
 - Values coordination of care over time and across settings
 - Provides accurate reimbursement for more complex care

6. H&CB LTC workforce with the capacity to support the needs of NY's aging population
7. Ways to educate and engage future consumers of LTC (and family caregivers) earlier
 - To promote informed decisions that reflect their own preferences