Strategic Outlook for LTC Services:
Challenges and Opportunities for Not-for-profit Providers

LeadingAge New York
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LeadingAge™ New York formerly NYAHSA

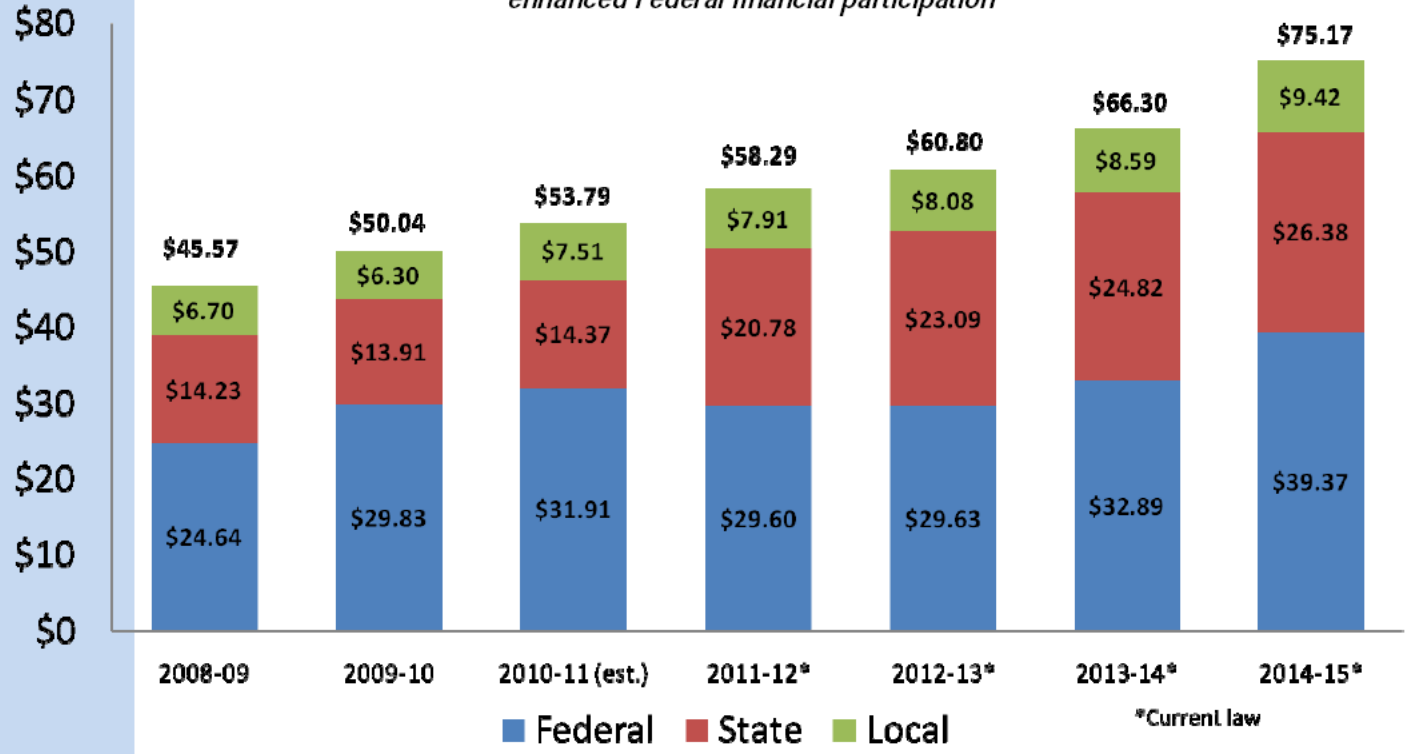
Presentation Agenda

- Medicaid redesign
- Basics of managed care
- Managed care under Medicaid redesign
- Federal policy developments
- Challenges/opportunities for NFP providers
- Considering other business lines
- Availability of capital
- Key Conclusions

Why Medicaid Redesign?

Overview – Historical Medicaid Spending ($ in Billions)

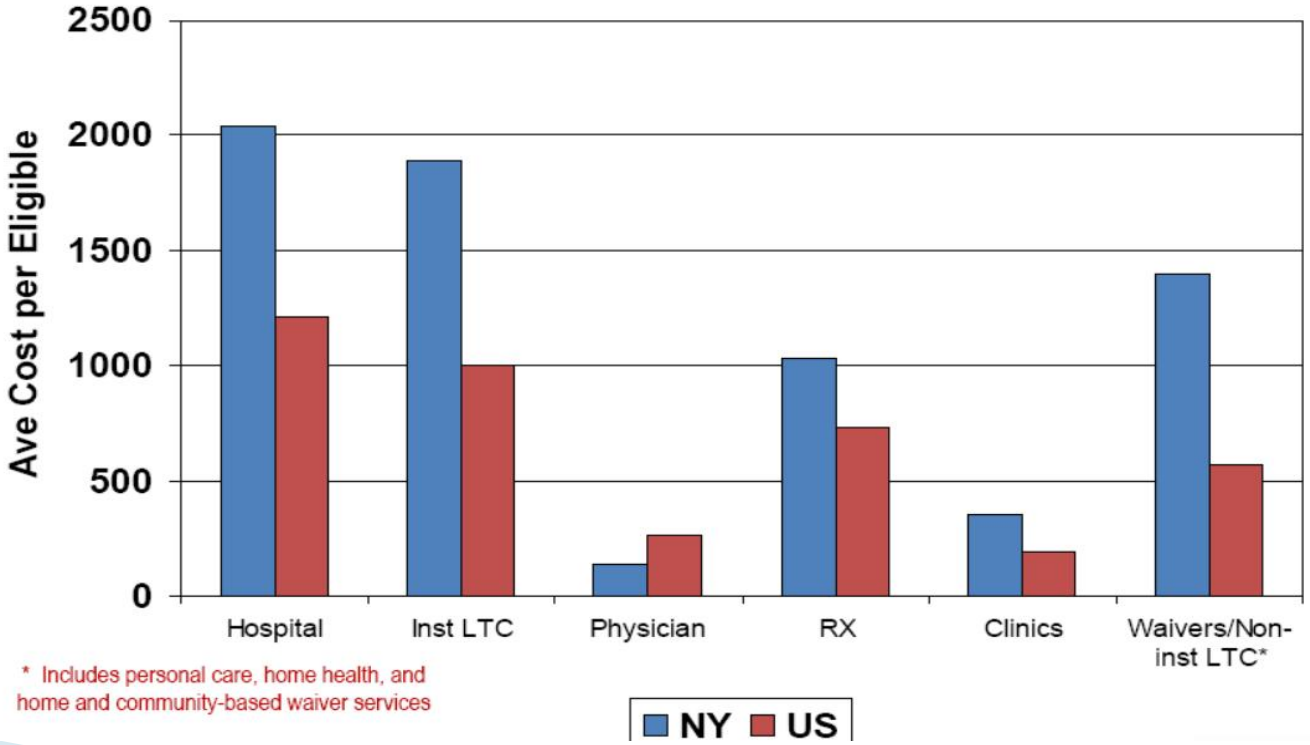
State share will increase markedly in 2011-12 due to local cap and phase-out of enhanced Federal financial participation



Why Medicaid Redesign?

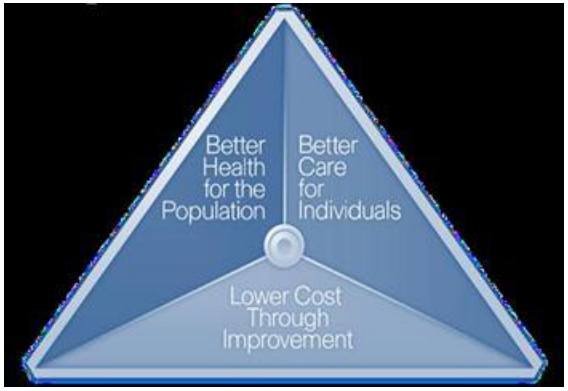
Overview:
Medicaid Spending NYS vs. U.S.

New York is above national average in Medicaid spending in all service categories except for physicians



* Includes personal care, home health, and home and community-based waiver services

The State's Medicaid Redesign Priorities



- Achieve the federal "triple aim"
  - Population health
  - Improved care
  - Lower cost
- Reduce uncertainty and risk for the state
- Contract with, and pay, fewer entities
- "Care management for all"
- Integrate Medicaid with Medicare
- Access federal funding

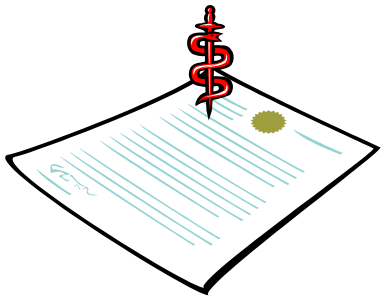
Medicaid Redesign in Action

- Implement global cap on state Medicaid spending
- Add more services to managed care benefits
- Require more recipients to join “mainstream” plans
- Require most HCBS recipients to join MLTC plans
- Enroll certain dual eligibles in integrated Medicare/ Medicaid managed care starting in 2014
- Use health homes, medical homes and ACOs to coordinate care and network services
- **Enroll all Medicaid recipients in managed care/ coordinated care models within 5 years**

Defining Features of Managed Care

- Care coordination and management
- Preventative health benefits
- Capitation and risk
- Single point of contact
- Provider network
- Added benefits or lower cost-sharing

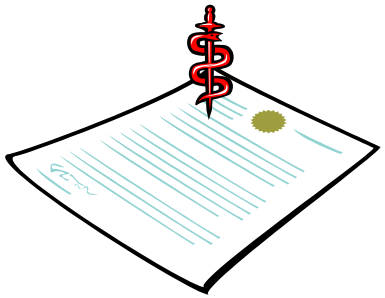
Types of Managed Care Plans



1. ***Commercial Managed Care***
   - Preferred provider organizations
   - Health Maintenance Organizations
   - Exclusive Provider Organizations

2. ***Medicare Managed Care***
   - Medicare Advantage
   - Medicare special needs plans (e.g., Evercare)

Types of Managed Care Plans



3. ***Medicaid Managed Care***
   - Mainstream Medicaid Managed Care
   - Family Health Plus/Child Health Plus
   - Healthy New York
   - HIV Special Needs Plans (HIV-SNPs)
   - Managed Long Term Care (MLTC)

4. ***Medicaid and Medicare (Dual eligibles)***
   - Medicaid Advantage
   - Medicaid Advantage Plus (MAP)
   - Programs of All-Inclusive Care for the Elderly (PACE)

Spotlight: MLTC

- A NY state-created managed care plan for Medicaid recipients who need LTC and are typically able to live in the community
- Receive a monthly Medicaid premium for each enrollee that covers all LTC services and coordination of other health care services
  - Plans are not responsible for Medicare services
- Some plans are operated by entities that directly provide some services, while others assemble networks of unaffiliated providers

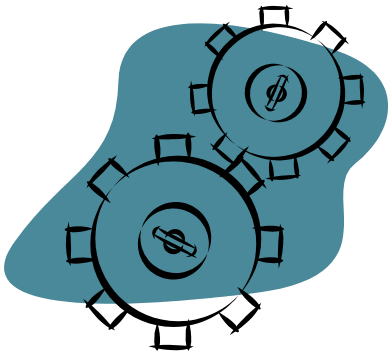
Spotlight: MAP

- NY-based managed care plan for dual eligible recipients who need LTC and are typically able to live in the community
- Combines a Medicare Advantage plan and a Medicaid MLTC plan
  - Receive monthly premiums from Medicaid that cover all LTC services and Medicare that cover all Medicare services
- Some plans are operated by entities that directly provide some services, while others assemble networks of unaffiliated providers

Spotlight: PACE

- Serves nursing home eligible persons age 55+ living in the community
- An integrated managed care model
  - emphasizes care coordination, with Interdisciplinary team meeting regularly to manage care plans
  - coordinates/finances all preventive, acute, LTC, social, transportation and support services
- Receives Medicaid/Medicare premiums
- Serves enrollees in the home and in day centers, most of which include clinics

How Medicaid Managed Care Works



- **The state:**
  - authorizes managed care organizations
  - contracts with managed care organizations
  - pays MCOs a fixed amount per enrollee
  - contracts with enrollment broker
- **The MCOs:**
  - assemble a provider network
  - contract with providers
  - determine medical necessity
  - coordinate enrollee's care
  - pay service provider(s)
- **The enrollment broker:**
  - provides information to recipients
  - facilitates enrollment in plans
  - offers dispute resolution

Managed Care Changes Incentives

Party	Issue	Fee-for-Service	Managed Care
Consumer	*Services*	Wide provider choice; minimal limits on services; limited care coordination	Provider choice limited; service limits; focus on care coordination
	Finances	Varying levels of cost sharing	Varying levels of cost sharing and incentives
Health care provider	*Services*	Driven by provider assessment of need, subject to review	Usually determined and authorized by plan
	Finances	State-set reimbursement, volume-driven	Rate negotiated with plan, volume controlled
Payer	*Services*	Scope driven by federal/ state laws, regs and policy	Scope driven by contract with managed care plan
	Finances	Total paid = rate times service utilization	Total paid = PMPM times # of enrollees

Mandatory MLTC Enrollment Plan

- Mandatory population: dual eligible, aged 21+, need community-based LTC services for 120 days or more
  - Includes personal care, CDPAP, CHHA, LTHHCP, ADHC
  - Excludes certain waivers, nursing homes and ALPs for now
- Mandatory enrollment slated to begin Summer 2012 in NYC for new cases in the mandatory population
- Phased in by service type, NYC borough and zip code
- People will have 60 days to choose an MLTC plan
- Phase-in to other areas of state between Jan. 2013 and June 2014 as MLTC capacity is established

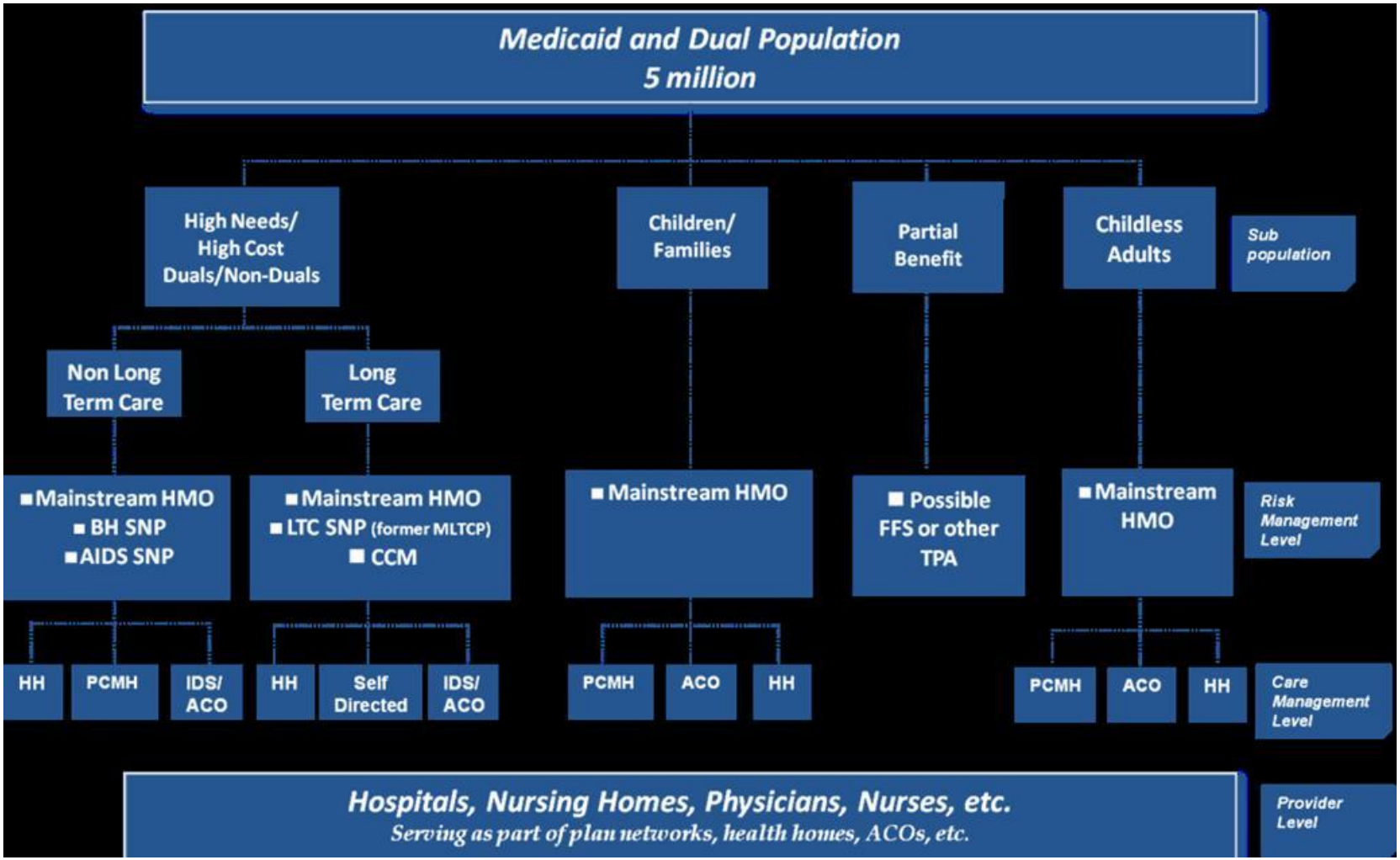
Integrating Care for Dual Eligibles

- Duals in NY are a large, diverse costly group to serve
  - 755,000 as of Dec. 2010
  - 15% of Medicaid recipients and 45% of Medicaid costs
- In 2011, NYS received a CMS demonstration planning grant
- Overall framework of NY's proposal
  - Fully-integrated Duals Advantage (FIDA) (managed care)
  - Health home (managed fee-for-service or MFFS)
  - Managed care waiver for OPWDD population
- Subject to federal approval, state and CMS to jointly integrate care for dual eligible recipients using managed care and MFFS models

Integrating Care for Dual Eligibles

- MFFS would begin in January 2013
  - Integrated care coordination through health homes
  - Target population is duals statewide with 2+ chronic conditions, HIV/AIDS and/or a mental illness, and do not need 120+ days of long-term supports and services (LTSS)
  - Estimated 126,000 recipients, or 18% of all duals
- FIDA would begin in January 2014
  - Comprehensive package of services through more integrated version of Medicaid Advantage Plus
  - Target population is duals in NYC, Nassau, Suffolk, and Westchester Counties that need 120+ days of LTSS
  - Estimated 123,800 recipients, or 17% of all duals
- OPWDD FIDA would begin in January 2014
  - Target population is up to 10,000 duals statewide with developmental disabilities aged 21+ years

Care Management for All: The State's Vision



Federal Policy Developments

- Supreme Court review and/or legislative activity may affect the fate of the ACA
- Focus on:
  - Insurance exchanges and addressing the uninsured
  - Medicare and Medicaid cost containment
  - New care coordination models (ACOs, medical homes, health homes)
  - Shared savings models (e.g., value-based purchasing) that reward providers and states for reducing federal outlays
  - "Bundling" of services and payments for episodes of care
  - Addressing dual eligibles through managed care and managed fee-for-service options
  - Quality measurement and incentives
  - Community-based service options
  - Health information technology deployment and interoperability among providers

Challenges and Opportunities for NFP Providers

- Medicaid dependence
- Shrinking private pay
- Higher unit costs
- Risk aversion
- Pace of change/decisions
- Infrastructure and capacity
- Capital and financing options
- Barriers to entry
- Lack of horizontal integration
- Threat of taxation

- More seniors needing services
- Models that people want
- Better quality outcomes
- Risk sharing
- Receptivity to restructuring
- Mission refinement
- Joint ventures and creativity
- Care management
- Network in communities
- Social accountability

Considering New Business Lines

- Traditional service options
  - Nursing home service lines/specialties
    - Specialty units (e.g., vent, TBI, neurobehavioral, AIDS)
    - Outpatient therapies
    - Culture change models (e.g., Green House)
  - Home and community-based services
    - Licensed home care services agencies
    - Adult day services
  - Independent housing
    - Market rate, subsidized or mixed use
    - With or without supportive services
  - Assisted living
    - Medicaid and private pay
  - Retirement community
    - CCRC and “look alike” models

Considering New Business Lines

- Risk-bearing models
  - MLTC plans
  - PACE plans
  - Special Needs Plans
    - Institutional and dual eligible SNPs
- Network arrangements
  - Medical homes
  - Health homes
  - ACOs

Spotlight: Medical Home

- A care management health services model
- Focus on “following” patient across settings
  - Need to share clinical information through EHRs
- Primary care physician coordinates care
- Services through network of providers and health plans
- Medicare and Medicaid models emerging; incentives through “shared savings” arrangements
- LTC providers involved in networks

Spotlight: Health Home

- A care management service model covering health and social supports
- A “care manager” oversees services with a preventative focus
- Health records are shared among providers
- Services through network of providers, health plans and community-based organizations
- NYS initial focus on chronic health/behavioral health Medicaid population
- LTC model of health homes in the works

Spotlight: ACO

- Accountable Care Organizations (ACOs) are provider-led legal entities that:
  - Monitor patient care across multiple care settings for overall cost and quality for a defined population
  - Create incentives for providers to emphasize primary care, prevention and adherence to evidence-based guidelines
  - These practices reduce patient care costs, the surplus of which is shared among providers
- Authorized for Medicare and Medicaid
- NYS implementing as a demonstration

Availability of Capital

- Most not-for-profit LTC providers are not investment grade rated borrowers
  - Typically need credit enhancement (mortgage insurance, letters of credit, etc.)
- More stringent underwriting by lenders
- Fewer lenders in general
- Medicaid managed care is a concern
  - No assurance of capital cost reimbursement
- Nonetheless, there are opportunities
  - Rates are low
  - There are still lenders interested in LTC

Key Conclusions

- LTC providers face major marketplace dynamics in near future
  - Mandatory Medicaid managed long term care starting in 2012
  - Impacts of reimbursement changes and negotiated rates with managed care plans
  - Referring hospitals under pressure to minimize re-hospitalizations and ER use
  - Growth of care coordination models across primary, acute, LTC, mental health, behavioral health and disability services

Key Conclusions

- Need to monitor and benchmark performance on key indicators
  - Hospitalization rates
  - Quality measures
  - Consumer satisfaction
  - Unit cost of services
- Educate key stakeholders on your organization's performance and mission
  - Payers (e.g., managed care plans)
  - Referral sources (e.g., hospitals, physicians)
  - Other potential network partners
  - Consumers (e.g., clients, families)

Key Conclusions

- Evaluate “at risk” vs. “downstream”
  - Major, threshold decision
  - Taking on risk as a managed care provider or other insurance entity (e.g., CCRC)
  - Joint venturing to share risk
  - Downstream status (i.e., contracting with insurers) means some loss of control
  - Doing nothing may be the greatest risk of all
- Be open to new collaborations, lines of business and risk sharing opportunities
  - Consider service diversification
  - Networks may have more bargaining power

Discussion Questions

1. What are our core competencies, and how can we leverage them to be successful in this future scenario?
2. Do we want to take on risk? If so, how well positioned are we to do so?
3. Are we monitoring and benchmarking key indicators, and engaging in performance improvement?
4. Are we effectively educating key stakeholders (consumers, referral sources, payers) about what we have to offer?

Discussion Questions

5. What do we need to do to assure we are part of one or more provider networks?
6. Can and should we partner differently with hospitals and practitioners to reduce hospitalizations and ER use?
7. How are we positioned to collect patient information electronically and share it with other providers?
8. Should we consider new lines of business or changes to the ones we have?

For Further Information

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