A Roadmap to a Rational, Sustainable, and Replicable System of LTC Services in the Eastern Adirondacks

LeadingAge New York

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We gratefully acknowledge the NYS Health Foundation, the members of the Eastern Adirondack Long Term Care Coalition, the NYS Department of Health and other key stakeholders who provided invaluable information, feedback and financial support to make this project possible.

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Today's Discussion

- Project overview
- Review key North Country demographics and current state initiatives
- Review Demand Projection model and major findings
- Discuss draft recommendations and obtain feedback
- Next steps

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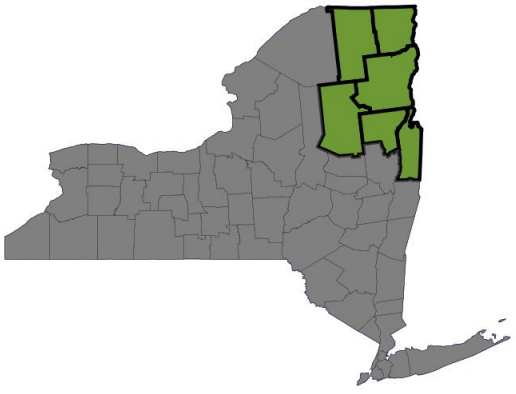
Project Overview



Clinton
Essex
Franklin
Hamilton
Warren
Washington

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Grant Objectives

- Assess demand and supply of long-term care supports and services (LTCSS) in the 6-county Eastern Adirondacks region
- Identify the needed configuration of services in the region and develop an action plan to rebalance those services
- Pursue opportunities to enhance operational efficiencies and promote financial stability
- Pursue regulatory flexibility targeted towards the needs of the region
- Timeframe: October 1, 2013 – September 30, 2014

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Grant Key Deliverables

1. A core group of partner organizations and their governance bodies – The Eastern Adirondacks Long Term Care Coalition (EALTCC)
2. A long-term care supports and services needs assessment and service gaps analysis for the region
3. A draft strategic action plan that addresses the needs assessment and service gaps analysis
4. A community forum where the draft strategic action plan will be presented and discussed with a larger stakeholder group
5. A final version of the strategic action plan

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EALTCC Members

- Skilled nursing facilities
- Hospitals
- Adult care facilities/assisted living
- Adult day health care programs
- Senior housing
- Home and community-based services
  - County Offices for the Aging
  - CHHAs
  - LTHHCPs
  - Consumer directed programs
- Hospice/Palliative care
- Managed care
- Hudson Headwaters Health Network
- Adirondack Health Institute
- Iroquois Healthcare Alliance

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Summary to Date

- Held three coalition meetings
  - November 2013 (Lake Placid) – background and demographics
  - March 2014 (Lake George) – Demand Projection model assumptions
  - June 2014 (Plattsburgh) – Demand Projection model results and draft recommendations
- Met with NYS DOH to review draft recommendations
- Reviewed draft recommendations with sub-group of coalition members
- Planned for today's symposium

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Key Demographics in the Eastern Adirondacks

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Population Density

County	Population	# Square Miles	Persons per Square Mile
Clinton	81,654	1,038	79.1
Essex	38,961	1,794	21.9
Franklin	51,795	1,629	31.7
Hamilton	4,778	1,717	2.8
Warren	65,538	867	75.8
Washington	62,934	831	76.1
New York State	19,570,261	47,126	411.2

Source: 2010 Census

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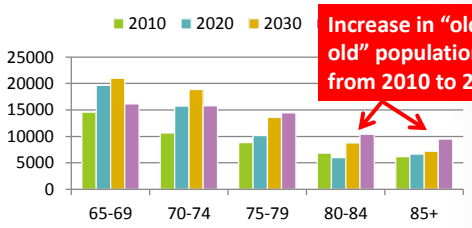
Current and Projected Population by Age Group: Six-County Total

The population for the six counties will grow about 2.3% from 2010 to 2020, but grows at a decreased rate of about 1.9% from 2020 through 2030.



Age Cohorts	Population				Annual Population Growth		
	2010	2020	2030	2040	2010-2020	2020-2030	2030-2040
65-69	14,588	19,659	21,018	16,140	3.48%	0.69%	-2.32%
70-74	10,641	15,733	18,852	15,782	4.79%	1.98%	-1.63%
75-79	8,824	10,159	13,626	14,467	1.51%	3.41%	0.62%
80-84	6,846	5,987	8,777	10,422	-1.25%	4.66%	1.87%
85+	6,160	6,647	7,172	9,494	0.79%	0.79%	3.24%
Total 65+	**49,069**	**60,205**	**71,475**	**68,345**	**2.27%**	**1.87%**	**-0.44%**

Source: Program on Applied Demographics, Cornell University

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Income and Poverty Profile

County	Median Household Income	% of 65+ Population in Poverty	Households with individuals 65 years and over	
			Number	Percent
Clinton	$49,260	12.4	7,882	25.0
Essex	$46,629	8.1	5,146	31.6
Franklin	$43,673	12.4	4,988	26.2
Hamilton	$51,142	8.0	822	36.3
Warren	$53,877	5.3	8,141	29.1
Washington	$50,117	7.9	6,801	28.2
NYS	**$56,951**	**11.5%**	**1,925,416**	**26.3%**

Source: Program on Applied Demographics, Cornell University

Drives demand for Medicaid services

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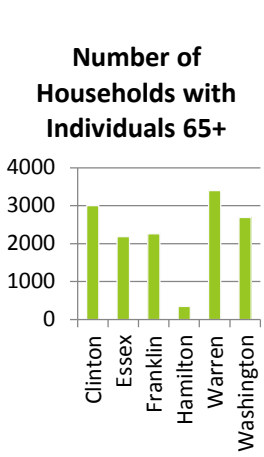
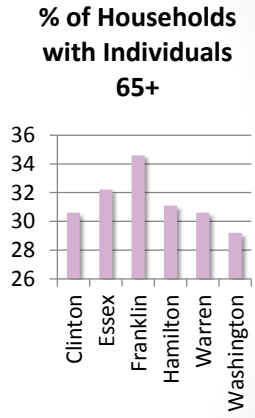
Percent of 65+ Living Alone

County	Householder living alone 65 years or older	
	Number	Percent
Clinton	3,170	30.6
Essex	2,211	32.2
Franklin	2,277	34.6
Hamilton	344	31.1
Warren	3,354	30.6
Washington	2,708	29.2
Total	**14,064**	**31.2%**





Living alone is risk factor for poorer overall health

Sources: American Community Survey: 2008-2012; 2010 Census

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Health Characteristics

Health Status/Health Behaviors	North Country	Upstate
% Adults with Hypertension	33.2	30.4
% Adults with Diabetes	10.4	9.5
% Adults with Asthma	12.6	10.8
% Adults Smoking	23.3	21.1
% Adults Obese	30.5	27.1

Higher rates of these conditions have major implications on demand for services

Mortality/Cases per 100,000 population	North Country	Upstate
Chronic Lower Respiratory Disease Mortality	59.0	52.9
Heart Disease Mortality	218.8	240.0
Diabetes Mortality	22.6	20.0

Source: 2013 Center for Workforce Studies Health Workforce Planning Guide

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Health Workforce

Health Occupations, per 100,000	North Country	Upstate
All Physicians	233	259
Primary Care Physicians	98	100
Dentists	46	62
Physician Assistants	57	88
Nurse Practitioners/Midwives	60	94
Registered Nurses	1,317	1,372
Licensed Practical Nurses	589	528
Occupational Therapists	33	52
Physical Therapists	72	86
Respiratory Therapists	16	31
Social Workers	114	190

Shortage in LTCSS-related occupations

Source: 2013 Center for Workforce Studies Health Workforce Planning Guide

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Caregiver Ratios
Projection for six-county region

Age Group	2010	2015	2020	2025	2030	2035	2040
15-64	210,180	206,471	200,075	191,772	183,390	178,067	174,079
Female 45-64	44,815	44,594	41,995	38,060	35,278	34,402	34,340
65-69	14,588	17,912	19,659	21,554	21,018	18,034	16,140
70-74	10,641	12,821	15,733	17,228	18,852	18,366	15,782
75-79	8,824	8,478	10,159	12,464	13,626	14,862	14,467
80-84	6,846	6,200	5,987	7,151	8,777	9,579	10,422
85+	6,160	6,687	6,647	6,570	7,172	7,173	7,174
Caregiver Ratio	7.3 to 1	6.7 to 1	6.3 to 1	5.8 to 1	4.9 to 1	4.8 to 1	4.8 to 1
NYS	**6.9 to 1**	**6.7 to 1**	**6.7 to 1**	**6.4 to 1**	**5.7 to 1**	**4.9 to 1**	**4.5 to 1**

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The New York Landscape

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NYS Policies, Responses and Implications

- Medicaid Spending/Redesign
- Managed Care
- Other Coordinated /Collaborative Care Models
- Delivery System Realignment

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The State's Medicaid Redesign Priorities

- Reduce Medicaid costs
- Less uncertainty and risk for the state
- Contract with, and pay, fewer entities
- "Care management for all"
- Integrate Medicaid with Medicare
- Access federal investment
- Delivery system realignment

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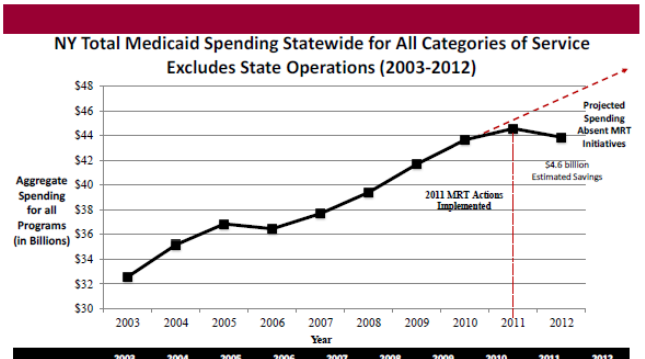
Medicaid Spending

- Began to turn the corner in 2012



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Total Medicaid Spending	$32.6B	$35.2B	$36.9B	$36.5B	$37.7B	$39.4B	$41.7B	$43.7B	$44.6B	$43.9B
# of Recipients	4,266,535	4,593,566	4,732,563	4,729,166	4,621,909	4,656,354	4,910,511	5,211,511	5,396,521	5,578,143
Cost per Recipient	$7,635	$7,658	$7,787	$7,710	$8,158	$8,464	$8,493	$8,379	$8,261	$7,864

NOTE: The number of recipients equals the sum of all unique recipients that received a Medicaid service within the fiscal year.

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Medicaid Redesign in Action

- Adding more services to managed care benefits
- Requiring more recipients to join "mainstream" Medicaid managed care
- Requiring more LTC recipients to join managed long term care plans
- Enroll dual eligibles in integrated Medicare/Medicaid managed care plans starting in 2015
- Use health homes, medical homes and ACOs to coordinate care and network services
- Enroll nearly all Medicaid recipients in managed care/ coordinated care models by 2017
- **Within 5 years,** requiring 90% of all Medicaid payments from managed care plans to providers to be "value based"

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Mandatory MLTC Enrollment Plan

- Mandatory population: dual eligible, aged 21+, need community-based LTC services for 120 days or more
  - Includes personal care, home care, consumer-directed care and adult day health care
  - Excludes certain waiver programs and Medicaid assisted living programs for now
- Mandatory enrollment began July 1, 2012 in NYC for any new cases meeting the mandatory definition
- People have 60 days to choose an MLTC plan, and are auto-enrolled if they do not
- Phase-in to other areas of state between now and Feb. 2015 as MLTC plan capacity is established

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Mandatory MLTC Enrollment Plan

2014-2015 MLTC Transition Timeline

Month	NEW SCHEDULE
August	Dutchess, Montgomery, Broome, Fulton, Schoharie,
September	Delaware, Warren
October	Niagara, Madison, Oswego
November	Chenango, Cortland, Livingston, Ontario, Steuben, Tioga, Tompkins, Wayne
December	Genesee, Orleans, Otsego, Wyoming
January	Chautauqua, Chemung, Seneca, Schuyler, Yates Allegany, Cattaraugus
February	Clinton, Essex, Franklin, Hamilton, Jefferson, Lewis, St. Lawrence,

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Managed Care Enrollment of the Nursing Home Population

- Under NYS's latest proposal, Medicaid recipients who will need permanent placements in NHs must join/remain in a managed care plan:
  - Beginning Jan. 2015 (downstate) and July 2015 (upstate): Any dual eligible or Medicaid-only recipient already permanently placed in a NH will remain in FFS for the duration of his/her stay
  - Any dual eligible new to Medicaid and/or permanently placed after Jan. 2015 (downstate) or July 2015 (upstate) must join or remain in a MLTC plan
  - Any Medicaid-only recipient new to Medicaid and/or permanently placed after Jan. 2014 (downstate) or July 2015 (upstate) must remain in a mainstream Medicaid managed care plan or MLTC or join a mainstream plan

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FIDA: Integrated Care for Duals

- Fully Integrated Duals Advantage (FIDA) is a federally approved demo to integrate care for Medicaid/Medicare eligibles
- Will be conducted in NYC, Long Island and Westchester County
- Comprehensive benefits encompassing Medicaid and Medicare covered services
- NYS planning for voluntary and "passive" enrollment of the mandatory MLTC population into FIDA plans:
  - *Jan. 2015:* Voluntary enrollment for adults in Bronx, Kings, Nassau, New York, Queens, and Richmond counties
  - *April 2015:* Passive enrollment in the 6 counties; voluntary enrollment for adults in Suffolk and Westchester counties
  - *July 2015:* Passive enrollment in Suffolk and Westchester
  - *Dec. 2017:* End of demonstration
- Eventual plan is to go statewide with this initiative

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Other Medicaid Redesign Initiatives

- NYS is seeking to utilize managed care to address the needs of other Medicaid recipients
  - Special needs Health and Recovery Plans (HARPs) for individuals with significant behavioral health needs
  - Developmental Disabilities Individual Support and Care Coordination Organizations (DISCOs) for individuals needing specialized developmental disabilities services
- The state has received a "Balancing Incentive Program" grant of up to $600 million over 3 years
  - NYS must assure that at least 50% of its LTC Medicaid funding goes towards community-based vs. facility-based services
  - Implement key structural reforms
- Supportive housing has emerged as a key enabler of redesign
  - Address high cost Medicaid beneficiaries
  - Olmstead community transition plan
  - Focused state funding for rental subsidies, pilots and capital

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Other Coordinated/Collaborative Care Models

- Health homes (HHs) provide care management of health, behavioral health and social supports for Medicaid beneficiaries
- Patient centered medical homes (PCMHs) use primary care physicians to coordinate care and follow patients across settings
- 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
- These models begin to break down silos between primary, acute, LTC, social, mental health, behavioral health and disability services

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Delivery System Realignment

- MRT Waiver is the blueprint for provider integration and delivery system realignment, with funding over 5 years as follows:
  - $500 million for Interim Access Assurance Fund – stop-gap funding for financially distressed and public hospitals
  - $6.42 billion for Delivery System Reform Incentive Payment (DSRIP) – including planning grants and provider Incentive payments
  - $1.08 billion for Health Home development and investments in LTC, workforce and enhanced behavioral health services
- DSRIP overall goals:
  - Promote community-level collaborations with multiple physical health and behavioral health provider types involved, including LTC
  - Achieve a 25% reduction in avoidable hospital use over 5 years
- DSRIP projects are expected to:
  - Be hospital-led in most cases
  - Be limited to only 1-2 projects per region of the state
  - Potentially lead to major delivery system realignment in the future
  - Affect all payers, not just Medicaid/safety net

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Role of LTCSS Providers in North Country Health System Redesign

- LTCSS providers offer critical services:
  - Chronic disease management
  - Prevention and health promotion services
  - Post-acute services to help reduce hospital readmissions
  - Comprehensive assessments, care planning and care coordination
  - Facility-, community- and home-based services and supports
  - Home health, adult day health and personal care services on a long term basis
- The success of many new models of care delivery and payment will depend on relationships and partnerships between LTCSS providers and hospitals, primary care providers, behavioral health providers, payers and others.

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Major Factors Influencing LTCSS Providers in the North Country

- Reimbursement constraints
- Changes in payment and healthcare delivery
- Implementation of new models of care
- Workforce/informal caregiver availability
- Access to practitioner/professional services
- Geography and proximity
- Lack of technology resources
- Diseconomies of scale

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LTCSS Demand Projection Model

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Goals and Methodology

- Develop an interactive model to estimate demand for long term care supports and services in 6-county region taking into account key influencers
- The model takes into consideration:
  - Changes in demand for five major services (nursing home, assisted living program, home health care, personal care and adult day health care)
  - Baseline utilization patterns
  - Demographic projections
  - A number of key assumptions based on research and group discussion

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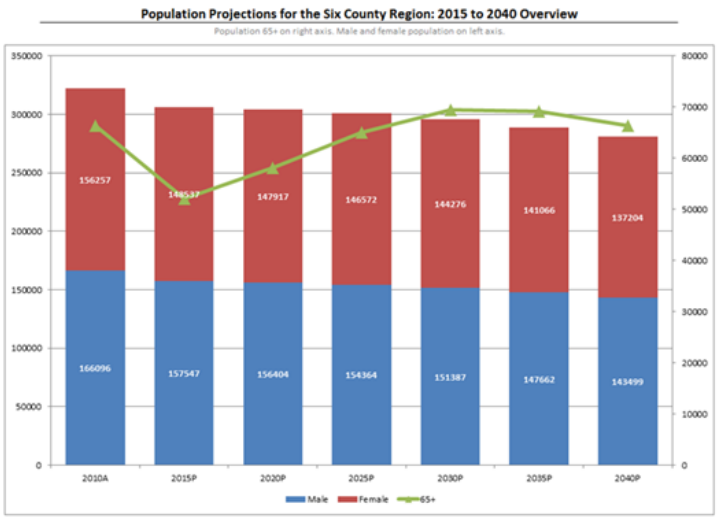
LTCSS Demand Projection Model



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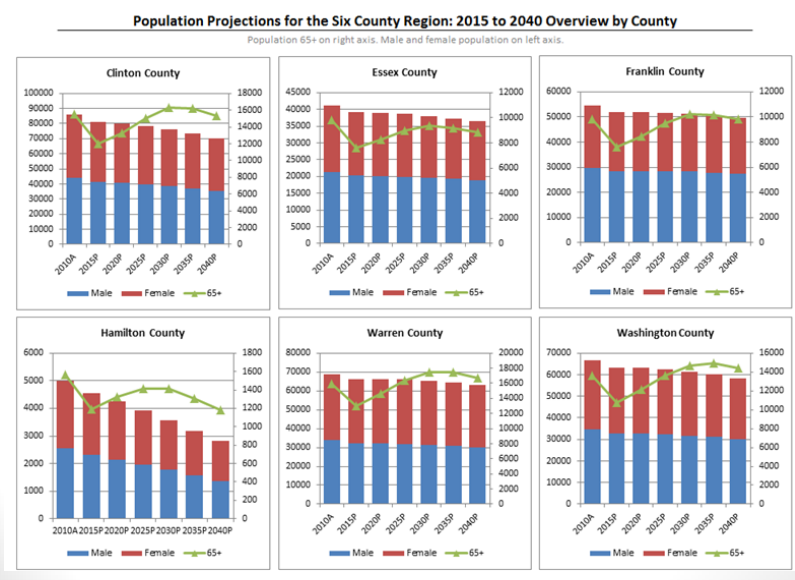
LTCSS Demand Projection Model



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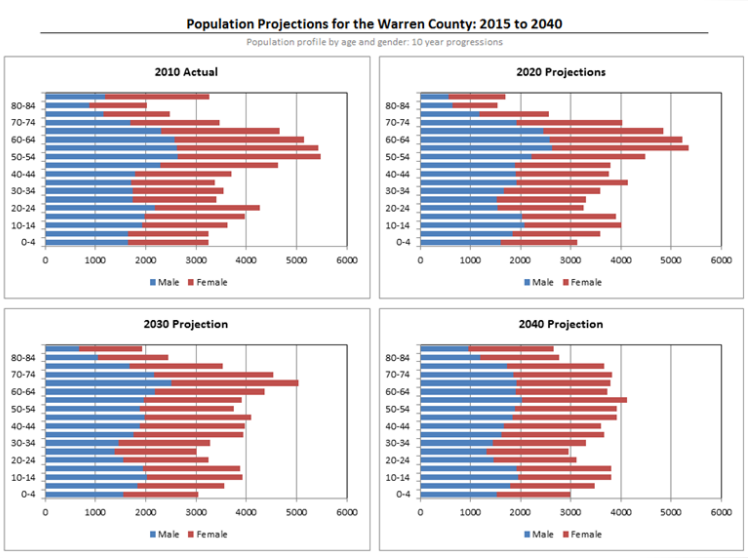
LTCSS Demand Projection Model



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LTCSS Demand Projection Model

County	Gender	Age Group (Salient)	Age Group (Population)	Y2010	Adult Day Health	Assisted Living
Clinton County	Male	00-05	0-4	2088		
Clinton County	Male	06-11	5-9	2088		
Clinton County	Male	12-17	10-19	4471		
Clinton County	Male	18-44	20-44	15649	0.6	
Clinton County	Male	45-64	45-64	12746	2	
Clinton County	Male	65+	65+	7143	3.2	1.4
Clinton County	Female	00-05	0-4	1981		
Clinton County	Female	06-11	5-9	1981		
Clinton County	Female	12-17	10-19	4223		
Clinton County	Female	18-44	20-44	13693	0.4	
Clinton County	Female	45-64	45-64	11725	2.6	0.4
Clinton County	Female	65+	65+	8409	8.8	4.4
Essex County	Male	00-05	0-4	925		
Essex County	Male	06-11	5-9	925		
Essex County	Male	12-17	10-19	2105		
Essex County	Male	18-44	20-44	6498		0.2
Essex County	Male	45-64	45-64	6299		0.4
Essex County	Male	65+	65+	4564		0.6
Essex County	Female	00-05	0-4	927		
Essex County	Female	06-11	5-9	927		
Essex County	Female	12-17	10-19	2004		
Essex County	Female	18-44	20-44	4905		
Essex County	Female	45-64	45-64	5872		1.2
Essex County	Female	65+	65+	5271		1.8
Franklin County	Male	00-05	0-4	1463		
Franklin County	Male	06-11	5-9	1463		

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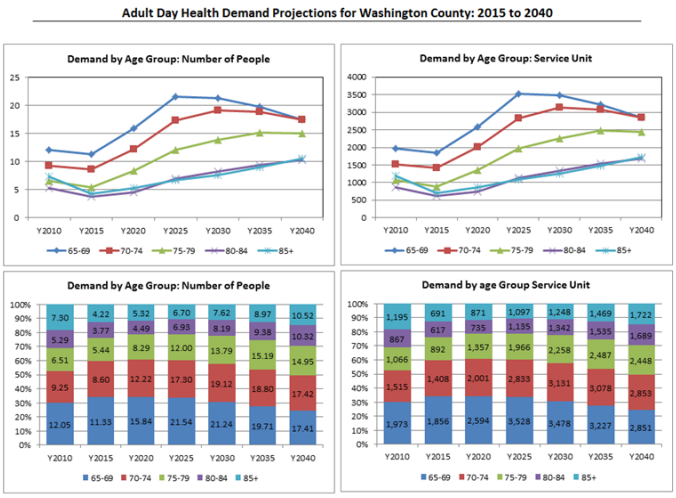
LTCSS Demand Projection Model



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Key Demand Assumptions

Key Assumption #1: With the exception of a decline between 2010 and 2015, the projected growth in the 65+ population between 2015 and 2035 will increase the demand for most health care services including acute care, skilled nursing facility, home care, home and community based services and other long term care services.

Key Assumption #2: The implementation of mandatory Medicaid managed care for the community-based and nursing home long term care populations will change the utilization of long term care services moving recipients to the least expensive and restrictive setting funding some services not previously covered.

Key Assumption #3: Growing penetration of Medicare Advantage plans and other care management programs (e.g. ACOs, PCMHs) will reduce hospitalizations and the use of post-acute services and delay the need for long term care services.

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Key Demand Assumptions

Key Assumption #4: The decrease in the number of available informal caregivers will increase the demand for some health care services including home care, adult day health care, assisted living, and other home and community based services (e.g. home-delivered meals, housekeeping, transportation) .

Key Assumption #5: An increase in the percentage of individuals 65+ living alone will increase the demand for the services listed under Key Assumption #4 above and will bolster the demand for residential care that nursing homes and assisted living programs provide.

Key Assumption #6: An increase in the percentage of 65+ in poverty will result in increased enrollment in Medicaid among seniors in the region and increased demand for Medicaid-funded services, and greater demand for affordable senior housing.

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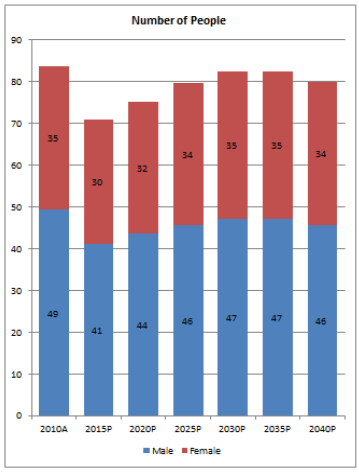
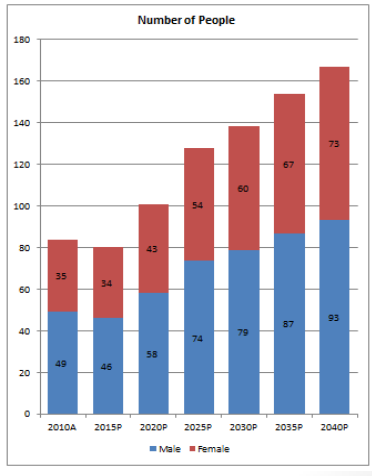
Demand Model - ADHC

Population change



Population change with scenario variables



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DIFFERENCE BETWEEN DEMOGRAPHICS ALONE AND SCENARIO

	2010	2015	2020	2025	2030	2035	2040
ADHC	0	9	25	48	56	71	87

Major Findings

- Demand for nursing home services will increase between 2010 and 2015 and then begin to decrease between 2015 and 2040.
- There will be an increase in demand for all other types of services in the model between 2015 and 2040: ALP, home health care, personal care and ADHC.

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Draft Recommendations

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Draft Recommendations

1. ***Increase alternatives to nursing home services*** by promoting the expansion of assisted living for Medicaid-eligible and low-income seniors and expanding adult day care and home care access and capacity. The projected population growth for adults 80+ in the region is expected to decline by about 3% between 2010 and 2020 and then grow by more than 25% each of the following two decades. Current estimates show that there are already shortages of nursing home beds, assisted living units and adult day health slots in some or all counties in the region. This recommendation includes creating the array of services and facilities to ensure adequate access to and funding for affordable senior housing and community medical and non-medical based services allowing individuals to age in place, engage in the community and lead purposeful lives.

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Draft Recommendations

2. ***Address health care workforce availability and preparation for realigned service delivery.*** The current availability of home health staff is one reason this region sees about 40% fewer patients referred to home health following acute care than the state average. The caregiver ratio is also declining by about 35% from 2010 to 2030 and then remains flat through 2040. This recommendation proposes interventions that enhance the ability to serve older adults in their homes by expanding the consumer directed personal assistance program, creating regional coalitions to address worker recruitment and retention, facilitating better use of professional and paraprofessional skills, and enhancing workforce education and training in care management, technology and other areas.

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Draft Recommendations

3. ***Address other service infrastructure issues.*** Currently some areas of the North Country are not able to maximize the use of telehealth or technology due to limited internet and broadband access limiting opportunities to increase efficiencies through technology. This recommendation includes improving telehealth and telemedicine capacity, expanding hospice and palliative care awareness and access, and pursuing regulatory reforms that will be needed to reconfigure and sustain LTCSS in rural areas.

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Draft Recommendations

4. ***More fully develop the concept of Villages for Successful Aging/Medical Villages*** with the goal of efficiently utilizing existing resources and consolidating the essential health, wellness, prevention, care coordination and social programs required for successful aging. Based on the population growth and an estimated 30 miles or 45 minute maximum drive time for area elders we believe there is a need for four to five Villages which would be co-located with existing senior living campuses. These Villages would have a wide array of both medical and non-medical services that are easily accessible.

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Draft Recommendations

5. ***Promote adoption of health information technology and exchange among long term care service providers*** and other providers and practitioners to create efficient and effective care delivery programs and services across all sites of care and in the community. Currently, long term care providers have limited access to health information prior to transfer and in the community on clients they serve; the acute care providers and community physicians also do not have access to ongoing services provided by long term care providers. This recommendation focuses on innovative ways to provide an elder with a personal health record that is comprehensive and easily accessible by all care team members.

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Draft Recommendations

6. ***Increase the Medicaid funding available to rural, essential services*** to assure that nursing home, home health care, adult day care and other services are available within a reasonable driving distance (within 30 miles). Providers who meet the essential services definition or have XX% (TBD) of total services provided to Medicaid participants would be provided a supplemental payment to compensate them for the higher costs per unit associated with small size and/or geographically dispersed patient volume.

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Next Steps

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