BECOMING A MANAGED CARE ORGANIZATION: EXERIENCES IN LONG-TERM CARE

OPWDD WEBINAR

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Carol Raphael
Former CEO, Visiting Nurse Service of New York

The Visiting Nurse Service of New York

Who We Are:

- Founded in 1893 by Lillian D. Wald, VNSNY is the largest non-profit home health care agency in the U.S.
- Serves an average daily census of 31,000 patients (from newborns to seniors) in all five boroughs of NYC, plus Westchester and Nassau Counties
- Provides a range of services, including post-acute, long-term care, palliative & hospice, and mental health
- 15,000 employees – most are field staff providing direct care
- Serve a socio-economically diverse population

The "Henry Street Family" (*c*. 1900)

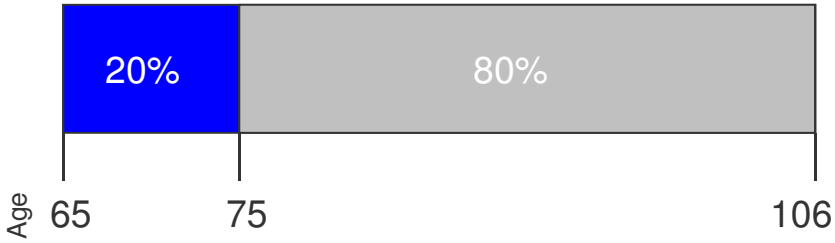
Visiting nurses in a row (date unknown)

VNSNY CHOICE Health Plans Managed Care Plans for High-Cost Dual-Eligibles in NYC

	Medicaid Managed Long Term Care (MLTC)	*Medicare Advantage* (Special Needs Plans)	*Medicaid Advantage* (Special Needs Plans)
Average Census	11,000 members	9,000 members	6,000 members
Benefits and Services Provided	Bundle of long-term care services, including home and community-based, adult day care, meals on wheels, and nursing homes Care management	Medicare Parts A, B and D; Supplemental Benefits: Dental, Vision, Hearing, & Transportation	Medicaid Full range of health services & supports, including: MD, Hospital, Maternity Care, eye care), Prescription Drugs, Treatment Adherence, Inpatient Drug & Alcohol Abuse services, Mental Health services
Payment Source	NYS Medicaid; partially capitated rate: risk-adjusted by population characteristics	Medicare; fully capitated rate: risk adjusted by individual characteristics	Medicaid: fully capitated rate for HIV/AIDS population

Profile of a Typical VNSNY CHOICE Medicaid Managed Long Term Care (MLTC) Member…

- Average member has 4 chronic illnesses
  - Most common:
    1) Diabetes
    2) Heart Disease
    3) Chronic Obstructive Pulmonary Disease
    4) Hypertension
- Average member has 4-5 functional deficits
- 54% suffer from moderate to severe cognitive impairment
- 77% have some level of urinary incontinence
- Spoken Language: 38% English, 38% Spanish, 11% Chinese, 12% other
- Average member is 82 years of age



Challenges of Building Plans for the Dual Eligibles

- **Challenge I:** Building the Infrastructure for a Health Plan
  - establishing membership services including call center
  - building a broad network including primary care physicians with geriatric competency
  - marketing 1:1 with cost of acquisition high
  - investing in IT systems
- **Challenge II:** Migrating from FFS to Risk Based "Global" Payments
  - estimating risk → submit "bids"
  - payments → network - hard to get discounts due to low volume

✓ **Focus on Aims:**
- preventing institutionalization
- reducing utilization – unnecessary services

Create an Effective Care Management Model

- ✓ **Model:**
  - Comprehensive health assessments (including behavioral health) – applies to entire population
  - In-person encounters (including home visits)
  - Specially-trained care managers with reasonable workloads – nurses within a multidisciplinary team
  - Transitional care focus
  - Self-management education and counseling
- ✓ **Key Elements:**
  - Long-term personal relationship with nurse care manager
  - Nurse care managers have lower “caseloads” than benchmark
  - Flexible benefits & culture of doing whatever it takes
  - Allocating more of premium to primary care and home care
  - Home visiting physicians and nurse practitioners
  - Change practices & relationships

VNSNY CHOICE Health Plans have Produced Measurable Outcomes

- High overall satisfaction reported for VNSNY MLTC plans: 88% satisfied overall (compared to 87% statewide); 95% satisfied with care manager (compared to 88% statewide)
- Only 4% of members are placed in a nursing home at any time
- **Primary Care:** 96% of our members had an annual primary care visit in 2010 – VNSNY is in the top 10% of all plans for this measure on last year's HEDIS data
- **Hospital Admissions:** Utilization data for a cohort of 573 members enrolled for 24 months showed significant reductions:
  - 54% decrease in hospital admissions
  - 24% decrease in readmits within 30 days to 16%
  - 27% decrease in ER visits

Challenges to Integrated Care

- Enrollment
- Capacity to provide complex care management
- Adequacy of provider network
- Evaluation of Quality
- Engagement and Protection of consumers

*Pr*omoting *I*ntegrated Care for *D*ual *E*ligibles (PRIDE)*

Goal: enhance the long-term viability and impact of high-performing integrated health plans for dual eligible population

- Objectives
  - Promote "scale-up" of high performing plans
  - Establish a small consortium and a visible platform to identify, synthesize and disseminate
    - Successful strategies and practices for overcoming key challenges, managing costs to the fullest extent possible, and delivering a quality experience and service
  - Address issues such as building networks, aligning plan/provider interests, engaging consumers and growing and retaining membership

* Funded by The Commonwealth Fund

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Desired Plan Attributes

- The consortium to Promote Integrated Care for Dual Eligibles (PRIDE) seeks to support the growth of plans in the following domains:
  - Leadership and Organizational Culture
  - Infrastructure to "Scale Up" and "Stretch out" while Maintaining Quality
  - Commitment to Fully Integrate Care through Mechanisms that Seek to Align Plan, Provider and Member Interests
  - Capacity to Deliver Comprehensive, Cohesive Coordinated Care
  - Capacity to Attract and Retain Members, Expand Enrollment, and Increase Retention