NEW YORK STATE | Department of Health | Medicaid Redesign Team

PAOP Project 11 Overview Presentation

Wednesday, December 14, 2016

Agenda Item	Slide
Project 11 Overview	3
Who is included in project 11 and why	4
Review of Project 11 measures	5
1. Primary/Preventive Care	6
2. ED use by the uninsured	7
3. CG-CAHPS	8
4. PAM	9
Project 11 Status in NYS	12

Project 11 Overview

Who & How

To be eligible for Project 11:

- PPS must pursue 10 other DSRIP projects
- PPS must demonstrate (at time of application)
  - Network's capacity to handle an 11th project
  - How the network is suited to serve UI, NU & LU populations in its region
  - Be a major DSRIP public hospital (given right of first refusal)

Goals

Project 11 is focused on the uninsured (UI), non-utilizing (NU), and low-utilizing (LU) Medicaid Enrollees

- Develop programming that promote activation and engagement among UI, NU & LU populations
- Increase the volume of non-emergency (primary, behavioral & dental) care provided to the UI, NU & LU population
- Form linkages between community-based primary and preventive services, as well as other community-based health services to sustain and grow the community, including patient activation in the region it serves

Origins

As part of the public comment period on the waiver and attachments, advocates strongly encouraged the state to include UI members in DSRIP so that this population could also utilize the benefits of a transformed health care system. Concerns were also raised about outreach and engagement of NU and LU Medicaid population to ensure these populations benefitted from DSRIP. Project 11 aims to address these concerns.

Project 11 Participants

PPS Participating in Project 11

1. OneCity Health (HHC)
2. Nassau Queens PPS
3. Finger Lakes PPS
4. Westchester Medical Center (WMC)
5. Alliance for Better Health Care
6. Care Compass Network
7. Staten Island PPS
8. Millennium Collaborative Care
9. Suffolk County Collaborative
10. Adirondack Health Institute
11. Central New York Care Collaborative
12. Albany Medical Center Hospital
13. North Country Initiative – Samaritan
14. Bassett Medical Center

Sources: MAPP DSRIP Performance Dashboards; *Project 2.d.i*

What populations are considered under Project 11?

Uninsured (UI) = Uninsured during the previous 12 months for a period longer than 3 continuous months

Low Utilizers (LU) = Enrolled in Medicaid during the previous 12 months with no longer than a 3 month continuous gap in enrollment and:

- Has two or more chronic conditions and no PCP visits in the previous 24 months;
- Has two or fewer PCP visits in the previous 12 months;
- Has received three or fewer qualifying medical services in the previous 12 months, including primary care, specialist care, emergency room care or an inpatient hospital admission; and/or
- Has only received emergency room, inpatient hospital services, eye care, and/or dental services in the previous 12 months.

Individuals cannot be considered low-utilizers if either of the two following conditions apply:

- The individual has received services for developmental disabilities (birth defects), nursing home, or ongoing behavioral health care; or
- The member has consented to and is enrolled in a Health Home.

Non Utilizers (NU) = is a Medicaid member with continuous enrollment for the previous 12 months without a gap in enrollment greater than three months, who has no claims for qualifying services. These services include primary care, specialist care, emergency department care, or an inpatient hospital admission.

How is performance on Project 11 measured?

Project 11 aims to understand the use of health services by the Medicaid clients included in the measures population, their experience and their current levels of activation and engagement in their own health and health care. It attempts to do this through four primary measures…

Measure Name	Description
1. Use of primary and preventive care services	• Utilization of primary and preventive care services by UI, NU, LU Medicaid populations
2. Emergency Department use for the uninsured	• Utilization of emergency department services by UI members
3. CG-CAHPS Survey of the uninsured	• Surveys deployed to UI members to understand patient experience over the course of care
4. Patient Activation Measure (PAM)	• Assessment tool that measures patient behavior, knowledge, and engagement in healthcare decisions

How is performance on Project 11 measured? (1 of 4)?

1. Use of primary and preventive care services
2. Emergency Department use for the uninsured
3. CG-CAHPS Survey of the uninsured
4. Patient Activation Measure (PAM)

Primary/Preventive Care – (P4R DY2, P4P DY3-DY5)

- Measure: Non-use of primary and preventive care services – Percent of attributed Medicaid members with no claims history for primary care and preventive services in measurement year (MY) compared to same in baseline year (for NU and LU Medicaid Members)
- Performance Goal: Ratio < 1

$$\text{Numerator} = \frac{\text{\% NU \& LU Medicaid members who do not have } \geq \text{ one claim with preventive services CPT or equivalent code}}{\text{Baseline \% of NU \& LU Medicaid Members who do not have } \geq \text{ one claim with a preventive services CPT or equivalent code}} = \text{Denominator}$$

How is performance on Project 11 measured? (2 of 4)?

1. Use of primary and preventive care services
2. Emergency Department use for the uninsured
3. CG-CAHPS Survey of the uninsured
4. Patient Activation Measure (PAM)

ED use by uninsured – (P4R DY2, P4P DY3-DY5)

- Measure: Emergency Department use by insured persons as measured by percent of ED claims compared to same in baseline year
- Performance Goal: Ratio < 1

$$\frac{\text{Numerator: Annual measure of \# of ED visits for self-pay per 100 ED visits}}{\text{Denominator: Baseline measure \# of ED visits for self-pay per 100 ED visits}}$$

How is performance on Project 11 measured? (3 of 4)?

1. Use of primary and preventive care services
2. Emergency Department use for the uninsured
3. CG-CAHPS Survey of the uninsured
4. Patient Activation Measure (PAM)

CG-CAHPS for uninsured – (P4R DY2-DY5)

- Surveys must be conducted annually for each measurement period. An annual survey may be used in one or two measurement periods.
- Surveys must be administrated consistently across demonstration years (DY) to avoid introducing biases to results. The following methods may be used:
  - In-Person at provider sites
  - Phone
  - Mail
- PPS required to successfully complete and submit 250 survey responses to earn a total AV of 1

CG-CAHPS Composite Measures

Measure
1. Getting timeline appointments, care, and information
2. How well doctors (or providers) communicate with patients
3. Helpful, courteous, and respectful office staff
4. Patients' rating of doctor (or provider)

How is performance on Project 11 measured? (4 of 4)?

1. Use of primary and preventive care services
2. Emergency Department use for the uninsured
3. CG-CAHPS Survey of the uninsured
4. Patient Activation Measure (PAM)

Patient Activation Measure (PAM) (P4R DY2, P4P DY3-DY5)

- PAM is a 10 question survey that identifies where an individual falls within four different levels of activation. This gives providers and health coaches insight to more effectively support each individual.
- Each point increase in PAM score correlates to a 2% decrease in hospitalization and 2% increase in medication adherence.

Current PAM- 10 Survey

1.	When all is said and done, I am the person who is responsible for taking care of my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
2.	Taking an active role in my own health care is the most important thing that affects my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
3.	I know what each of my prescribed medications do	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
4.	I am confident that I can tell whether I need to go to the doctor or whether I can take care of a health problem myself.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
5.	I am confident that I can tell a doctor concerns I have even when he or she does not ask.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
6.	I am confident that I can follow through on medical treatments I may need to do at home	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
7.	I have been able to maintain (keep up with) lifestyle changes, like eating right or exercising	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
8.	I know how to prevent problems with my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
9.	I am confident I can figure out solutions when new problems arise with my health.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
10.	I am confident that I can maintain lifestyle changes, like eating right and exercising, even	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A

How is performance on Project 11 measured? (4 of 4 con't)?

1. Use of primary and preventive care services
2. Emergency Department use for the uninsured
3. CG-CAHPS Survey of the uninsured
4. Patient Activation Measure (PAM)

- Anyone receiving at least two PAMs becomes eligible and is placed in the cohort corresponding to the year they received their first PAM
- Average increase in each cohort's PAM score determines the AV award (cohorts are weighted based on size)

Term	Definition
Individual Year End Score (IYES)	Individual score at end of MY
Eligible	≥2 IYES
Non-eligible	1 IYES **or** level 4 on first PAM assessment
Cohorts A-E	• Cohort A = individuals who receive first PAM assessment during MY 1 • Cohort B = individuals who receive first PAM assessment during MY 2 • Cohort C = individuals who receive first PAM assessment during MY 3 • Cohort D = individuals who receive first PAM assessment during MY 4 • Cohort E = individuals who receive first PAM assessment during MY 5
Cohort year end score (CYES)	Mean of eligible IYESs
Cohort year end change (CYEC)	$CYES_{(current)} - CYES_{(previous)}$
AV point determination per cohort	$\frac{\text{Number of eligible individuals by cohort for MY}}{\text{Total number of eligible individuals (all cohorts) for MY}}$
AV Calculation	• If CYEC ≤ 0.99, cohort achieves 0% of AV point • If CYEC ≥ 1 ≤ 1.99, cohort achieves 0.33 of AV • If CYEC ≥ 2 ≤ 2.99, cohort achieves 0.66 of AV • If CYEC ≥ 3.0, cohort achieves 1.0 of AV
Total achievement score	Total AVs achieved by MY

PAM Deployment

PPS are exploring various avenues of deploying PAM driven by partnerships, targeting, data sharing and training.

Core Components of PAM Delivery

Community Partnerships

PPS are working with safety net and non-safety net CBOs like Brooklyn Perinatal Network, Community Service Society of NY, Hudson Valley Community Services and Health Community Alliance

Targeting

- PPS are 'hot spotting' looking for individuals who are UI, NU, LU and have low levels of activation in their own health care
- PPS are grouping and creating a collaborative CBO network

Training

Insignia training includes:

- Guidance on correct PAM delivery
- Follow up services at the point of PAM delivery for connection with other community –based services

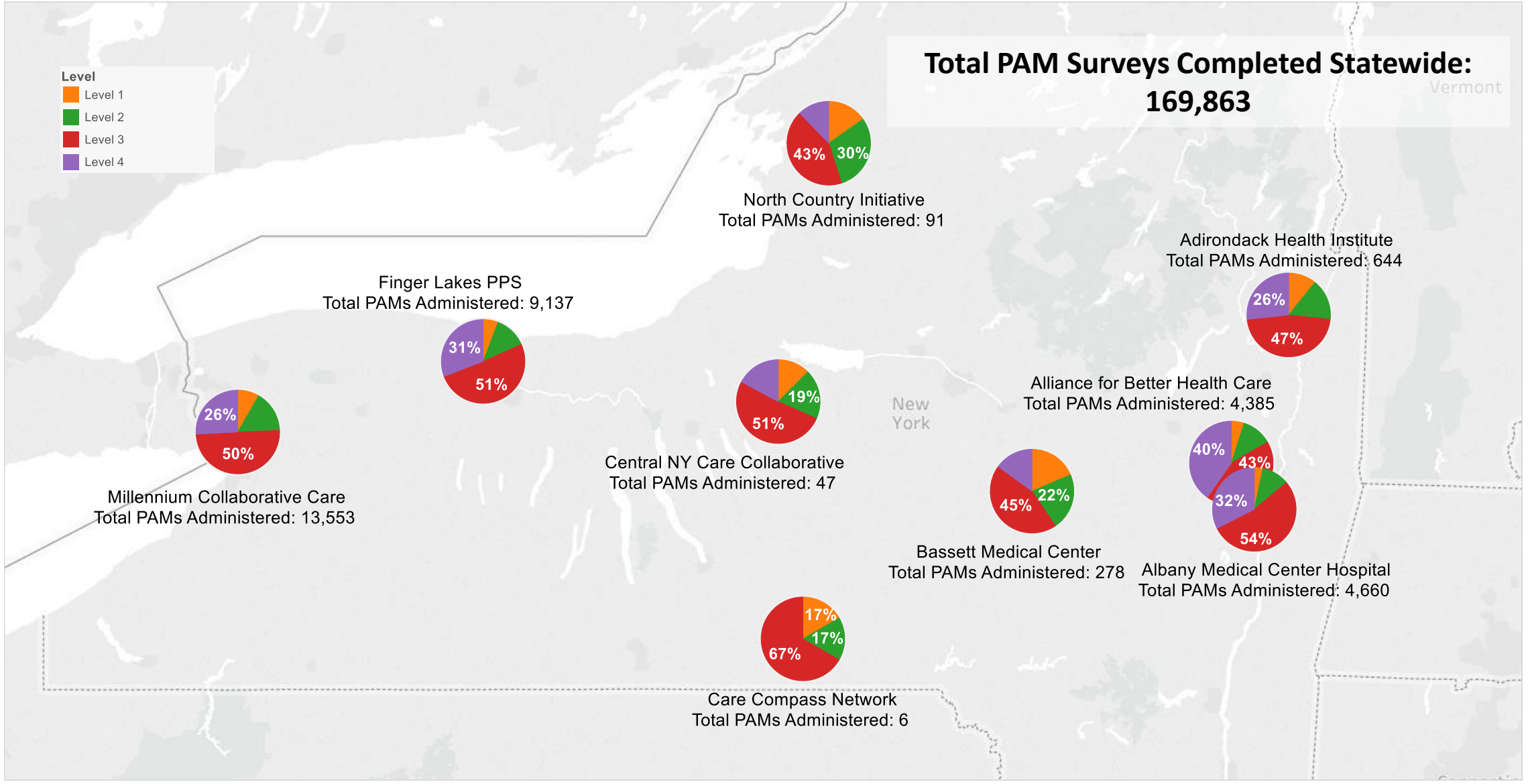
Data Sharing

- Collection of data and centralization for integration into care delivery (e.g. care plans, care coordination officials)
- Ensuring that patient data is distributed out to partner organizations to inform community programming

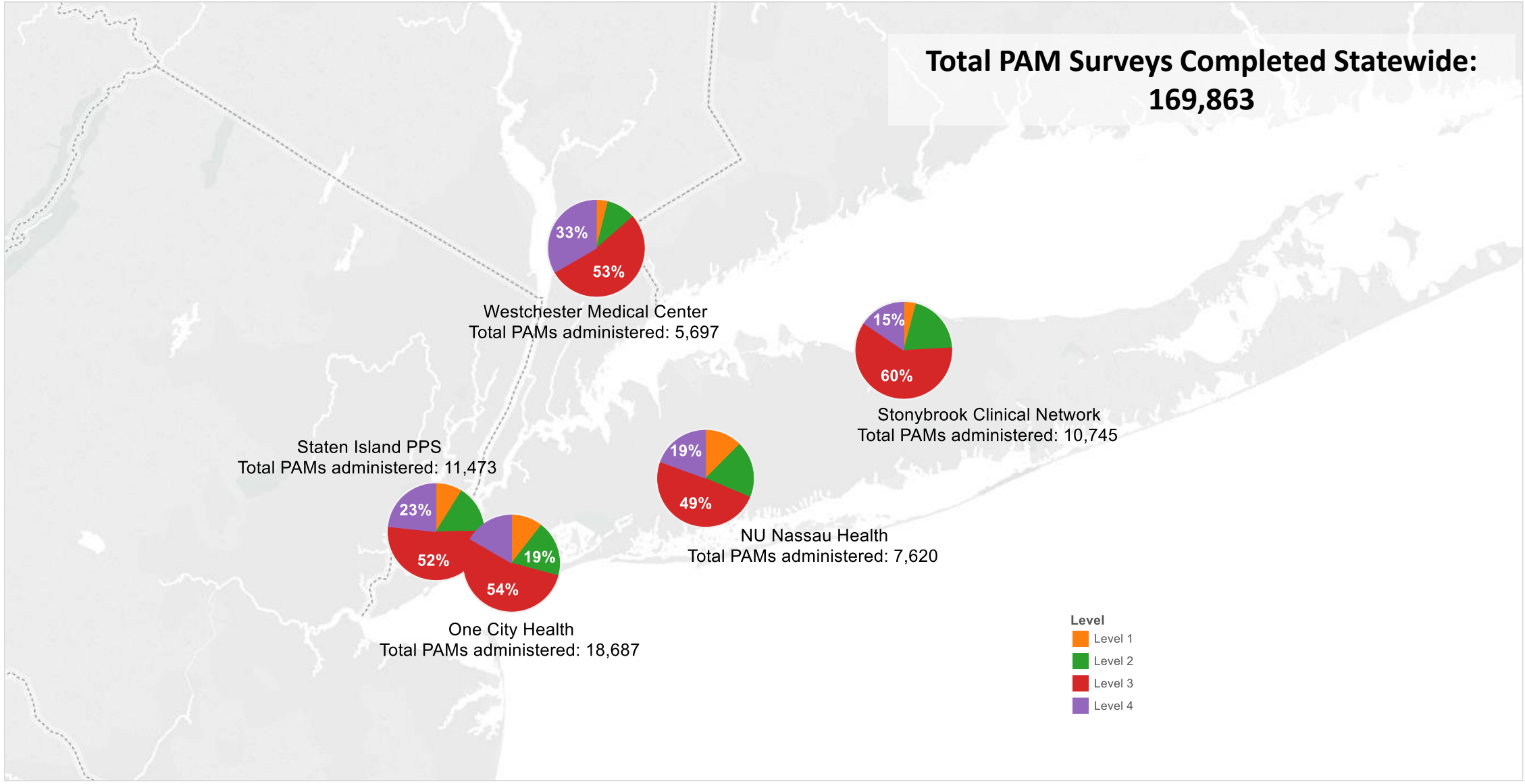
Example PPS Deployment Plan

- Alignment of Community Based Navigation (2.c.i) and Patient Activation (2.d.i) Project Teams and Clinical Governance resulted in:
  - Meaningful and aligned roll out of DSRIP programs into CBOs and community
  - Aligned 2.c.i and 2.d.i Milestones, reducing PPS PMO reporting efforts
  - Leverages local professionals including: navigators, health home care coordinators, etc.
- Target Populations and Info Sharing resulted in:
  - Hot Spot Analysis
  - Creating of "CBO Bundle" to encourage CBO involvement in related programs
  - Heavy Partner Education (i.e. Development of screening tool LU/NU, Overlap PPS Awareness, etc.)
  - Frequent communication with Master Trainers and Planning Team

What is the current state of PAM in NY State (upstate PPS)



What is the current state of PAM in NY (Downstate PPS)



Major operational barriers and successes

Below is a summary of feedback received from PPS to date related to their implementation experience:

	Training	***Data***	***Deployment & Programmatic***
Barriers	• Initial trainings offered by Insignia were seen as insufficient in preparing CBOs for PAM deployment • Setting expectations among CBOs can be difficult given the newness of the service	• Many PPS report CBO's experiencing difficulties developing systems to enable data sharing • The PAM tool tracks survey data but does not track coaching or patient navigation data • More data integration needed from MCOs and Health Homes to assist with identifying and targeting NU and LU	• 95 / 5 funding restrictions limit PPS ability to make payments out to CBOs, eroding trust and limiting CBO's effectiveness • Screening for NU / LU and IU status is often difficult given setting (e.g. food pantry)
Successes	• Several PPS report that training has been completed across most project partners, including several train-the-trainer programs across many PPS • Additional training between PPS and CBOs has created several spillover opportunities for alignment outside of 2.d.i	• Some PPS have begun to embed their PAM data into other platforms used and accessible across broader partnerships (patient consent, panel activities, navigation referral forms) • Some PPS coordinating across overlapping counties through sharing targeting of UI data	• Including "Coaching for Activation" as a part of the PAM tools basic use has been helpful in engaging patients at the instance of administering surveys • Some funding being given to CBOs to conduct "listening sessions" among consumers • Large CBO / PPS partnership work groups have been formed to identify mitigation opportunities

PAM by the numbers

PPS Name	Total Valuation over 5 Years	Actively Engaged Target	Actively Engaged Year
OneCity Health	$ 150,092,012	55,000	3
Nassau Queens PPS	$ 47,897,242	74,569	4
Finger Lakes PPS	$ 46,319,911	59,214	5
Westchester Medical Center (WMC)	$ 30,920,630	81,500	5
Alliance for Better Health Care	$ 21,587,885	14,715	4
Care Compass Network	$ 21,570,126	4,000	4
Staten Island PPS	$ 20,921,874	80,000	5
Millennium Collaborative Care	$ 19,390,257	81,000	5
Suffolk County Collaborative	$ 18,559,741	45,426	5
Adirondack Health Institute	$ 17,487,403	82,783	5
Central New York Care Collaborative	$ 14,879,396	22,300	4
Albany Medical Center Hospital	$ 12,714,561	34,872	4
North Country Health Initiative	$ 6,922,487	89,558	5
Leatherstockings PPS	$ 6,634,461	6,518	5

Provider Types	# of Providers
PCP	1061
Non- PCP	2393
Case Management	68
CBO	111
All Other	2229

Sources: MAPP DSRIP Performance Dashboards

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Questions