NEW YORK STATE | Department of Health | Office of Health Insurance Programs

New York State Department of Health
Managed Long Term Care

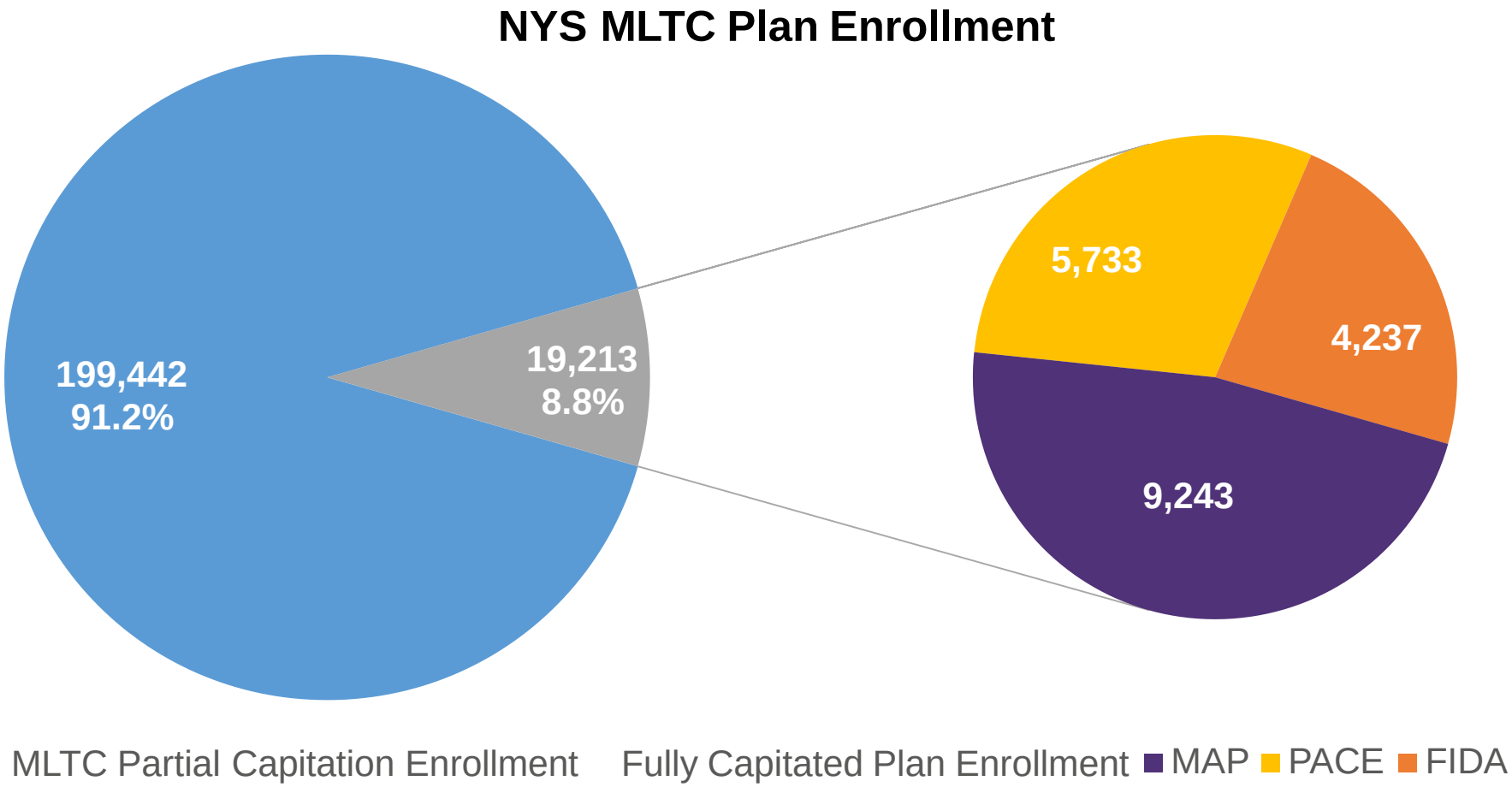
Value Based Payments Learning Series
Part 1

Shari Barnes
Frances Daye

June 12, 2018

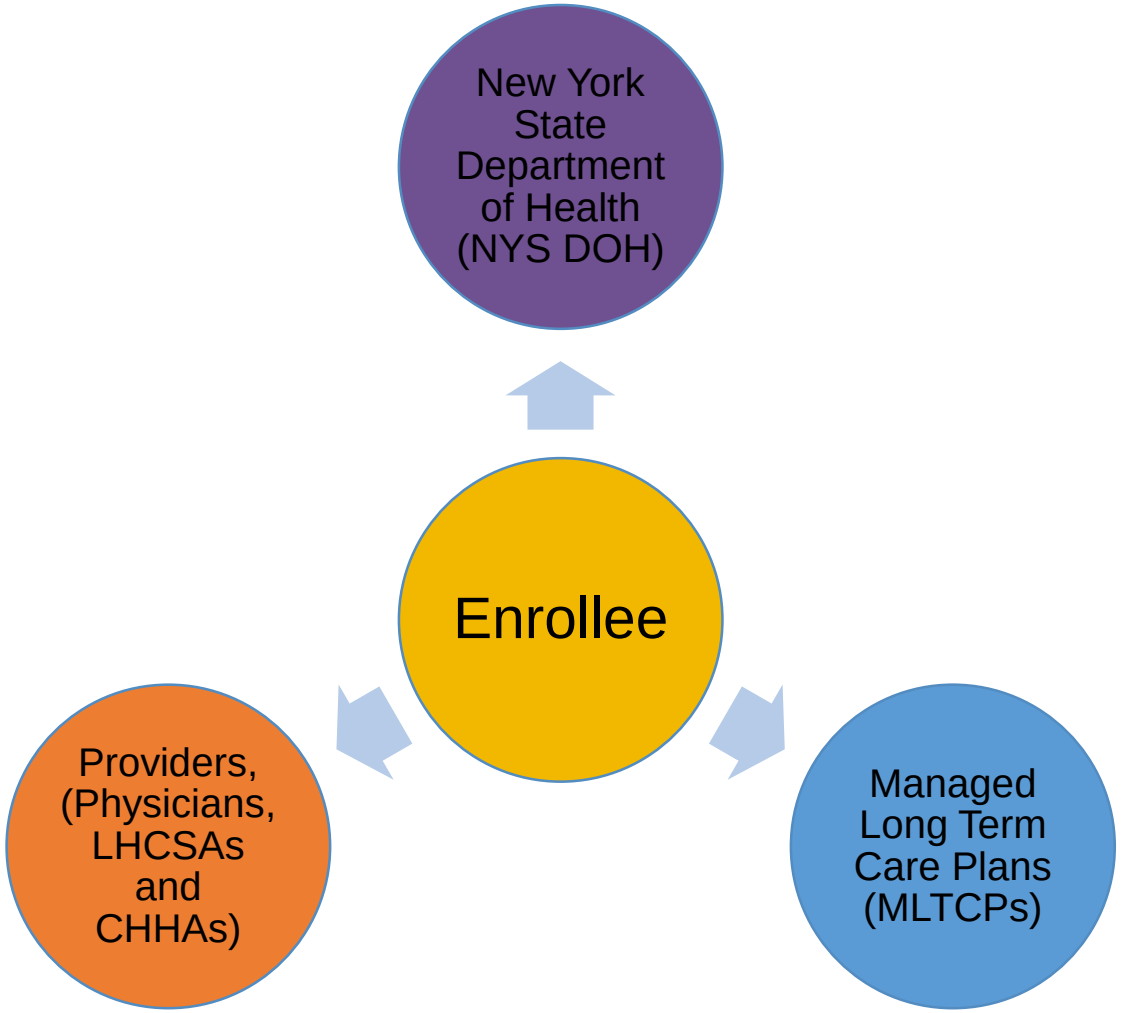
“WORKING TOGETHER IS SUCCESS”
Henry Ford

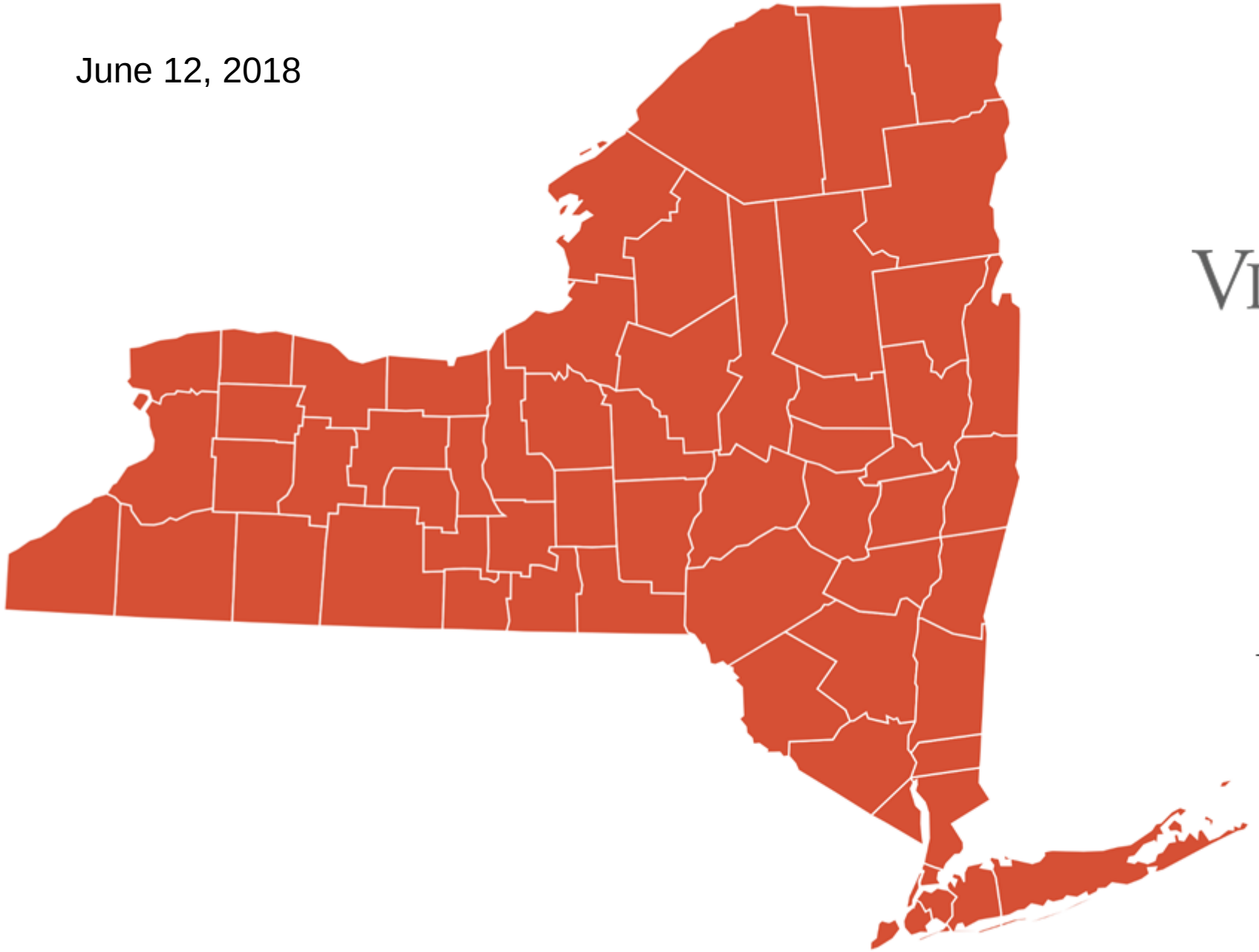
MLTC Plan Membership by Product Line



Source: NYS Department of Health, 2018 Monthly Medicaid Managed Care Enrollment, January 2018, https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/

Enrollee Centered Care





VILLAGECAREMAX

The Road to Value-Based Payments

JUNE 12, 2018

Meet the Presenters

Emma DeVito
President & CEO
VillageCare

"The risk of a wrong decision is preferable to the terror of indecision."
Maimonides

Mary Ellen Connington
Executive Vice President, Managed Care
VillageCareMAX

"The biggest risk is not taking any risk….In a world that is changing really quickly, the only strategy that is guaranteed to fail is not taking any risks"
Mark Zuckerberg

Randi Roy
Chief Strategy Officer
VillageCare

"In God we trust. All others bring data."
W. Edward Deming

Agenda

- Background on VillageCare – Innovation History
- Network Integration for MLTC: LHCSA VBP
- Integrated Products: Physician IPA VBP
- Key Success Factors
- Challenges and Opportunities
- Meet the Presenters
- Questions

VillageCare: A History of Innovation

VillageCare has a long history of being on the leading edge of innovative service delivery and payment models

- 1980's: A leader in the response to the HIV/AIDS crisis
- 2012: Established VillageCare MAX (VCM)
- 2015: Risk arrangements at Village Center for Nursing and Rehabilitation (VCRN)
  - Participation with CMS as a Model 3 Episode Initiator in bundled payments -Full risk arrangement- upside and downside (Level 3)
  - VCRN is additional at risk for certain managed care payors through case rates
- 2017: VCM launches dual Special Needs Plan (dSNP) and Medicaid Advantage Plus (MAP);
- 2017-2018: Develops VBP with home care agencies and multiple physician IPA groups

Network Innovation: Building Partnerships with LHCSAs

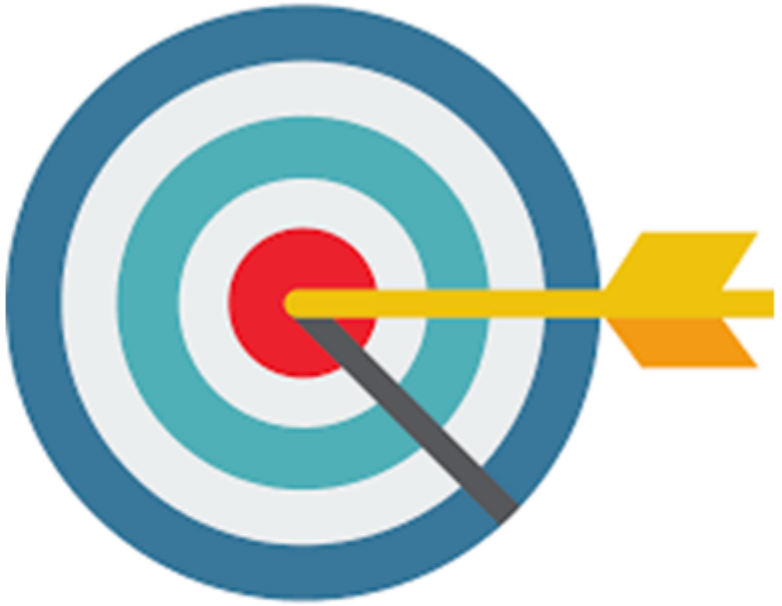
VCM partnered with network LHCSA's to enter into VBP arrangements:

- NYSDOH VBP requirement for December 2017
- Internal stakeholders: Leadership, Business Development, Quality, Provider Relations, Finance
- Formal process of information gathering and outreach
  - Invited 15 largest LHCSAs to table
  - Discussed successes and challenges
  - Reviewed scorecard on performance metrics (quarterly)
  - Criteria for next level of collaboration
- Identified those LHCSA partners motivated and capable to move to Level 2

Solidifying Partnerships: Working Toward Level 2

VCM selected key LHCSA's to move toward Level 2 VBP arrangements:

- Committed partnership between Plan & Provider
- Quality and Member Experience as table stakes
- Exploring target budgets (whether quality, efficiency or both)
  - Shared Savings (Level 1) VBP's as baseline
  - Level 2 reserved for LHCSA's with membership sufficient to establish a meaningful risk pool
  - Offer tools for LHCSA to manage the risk pool
  - Provide data transparency, i.e. dashboards for partners to see progress and course-correct as necessary

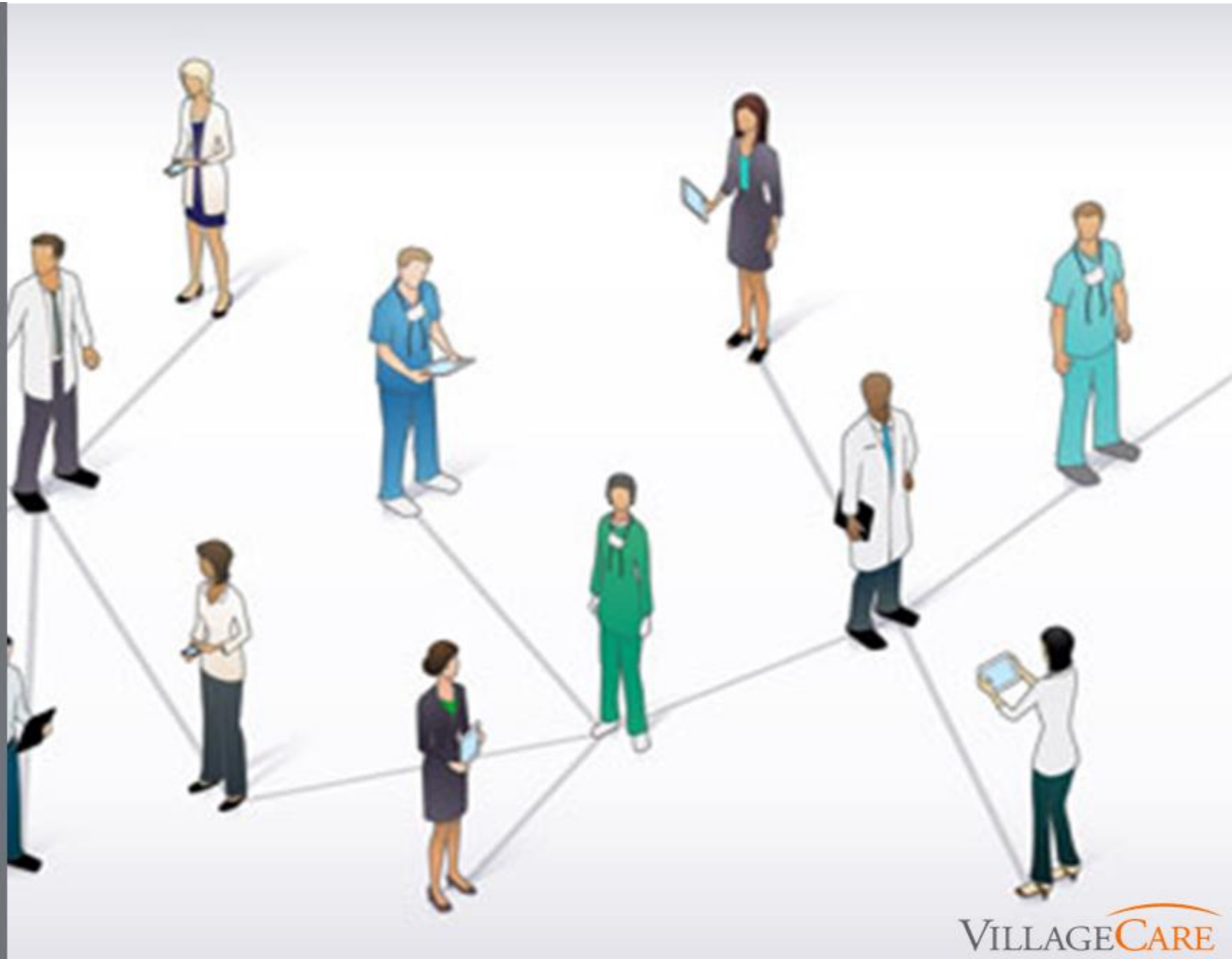


Integrated Care L2 VBP: Total Care for Sub-Population Utilizing MAP

VCM has focused on refining its primary care network: aligning incentives for Quality and Efficiency around the dual eligible population we mutually serve

Level 2 VBP TCSP reserved for IPA's with sufficient membership to support a risk pool

- Trust and transparency essential
- Quality and member experience table stakes
- Target budgets project expected spend/revenue. Adjusters safeguard superior performance
- Tools and Support: Implementation of embedded plan staff, e.g. UM, Member Services and CM at IPA offices to support integrated care model, CM Delegation
- Data Sharing, through dashboards, reports and API's detect negative trends and course correct. Examples, Healthix, Cloud data warehouse, Part D data
- Quarterly reconciliations/Annual True Up



Key Success Factors

Success in VBP will be the result of the following factors:

- Collaboration and transparency between all partners involved in arrangement
- Cultivation of scale
- Focus on quality and member experience
- Use of data and tools to drive performance and outcomes
- Accountability

Challenges and Opportunities

The move towards VBP has presented VCM with some challenges while creating some new and exciting opportunities:

Challenges

Reg 164

Supporting the maturation of certain IPA's to manage risk in the dual population

Data Management

Communication between partners

Opportunities

Enhanced member experience

Deepened provider collaboration

Improved quality of care delivery

Improved efficiency around total cost of care

Q&A

PREMIER
home health care services, inc.

Premier Home Health Care Services, Inc.

Observe, Ask & Report (OAR) Program
&
Continuity of Care Pilot

2017-2018

Meet the Presenters

Christy Johnston
Premier Home Health Agency

Alexis Varela Ratner
Premier Home Health Agency

"There are risks and costs to action. But they are far less than the long range risks of comfortable inaction."
John F. Kennedy

Premier Home Health Care Services, Inc.

Service Summary Overview:

- Premier Home Health Care Services, Inc., has been operating in New York for over 25 years and serves approximately 20,000 LTC members on a monthly basis through varied contracts with the majority of Health Plans in the New York region.

- Premier maintains a comprehensive community based service delivery platform to meet Health Plan and member needs. The multi-prong service platform includes:

    - Article 49 Care Management/UR Registration
    - UAS Assessment
    - Nurse Practitioner (Preventive Health Screening/Immunizations)
    - Licensed Home Care Services Agency

Managed Long Term Care & Value Based Payment—

- Premier entered first risk arrangement with MLTC in 2012
    - It requires providers and plans to share data, identify areas for improvement, and flexibility and support to implement interventions necessary to increase quality measures.
    - It is critical that providers understand and focus on impacting quality measures positively, which helps achieve better performance outcomes for the plan and most importantly for plan members.
- In 2017, Premier Implemented the Observe/Ask/Report (OAR), LHCSA Interdisciplinary Team (IDT) model as a vehicle to remove siloes and emphasize person-centered care planning and in 2018 implemented OAR II, adding in:
    - Real-time automated Aide-Member Reporting & Intervention
    - Population Data Aggregation

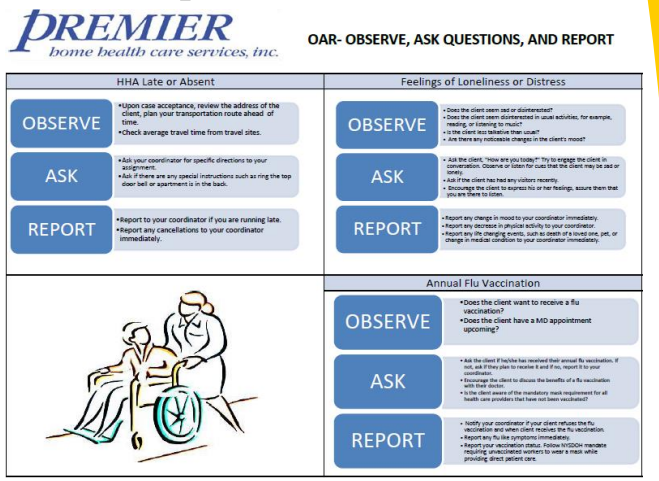
PREMIER home health care services, inc.

OAR I- Observe, Ask & Report

- The OAR Program (Observe, Ask, & Report) was developed in 2016 and launched company-wide in 2017.
- The main focus was training all administrative and clinical staff on the Interdisciplinary Team (IDT), care management process, and specialty training for aides regarding changes in members' conditions and satisfaction indicators.
- The specialty training on specific health plan quality measures was used to:
  - Educate administrative, aide and clinical field staff to issues impacting members' health outcomes; and
  - Provide an initial reporting mechanism to improve care outcomes on a more timely basis.

OAR I- Observe, Ask & Report

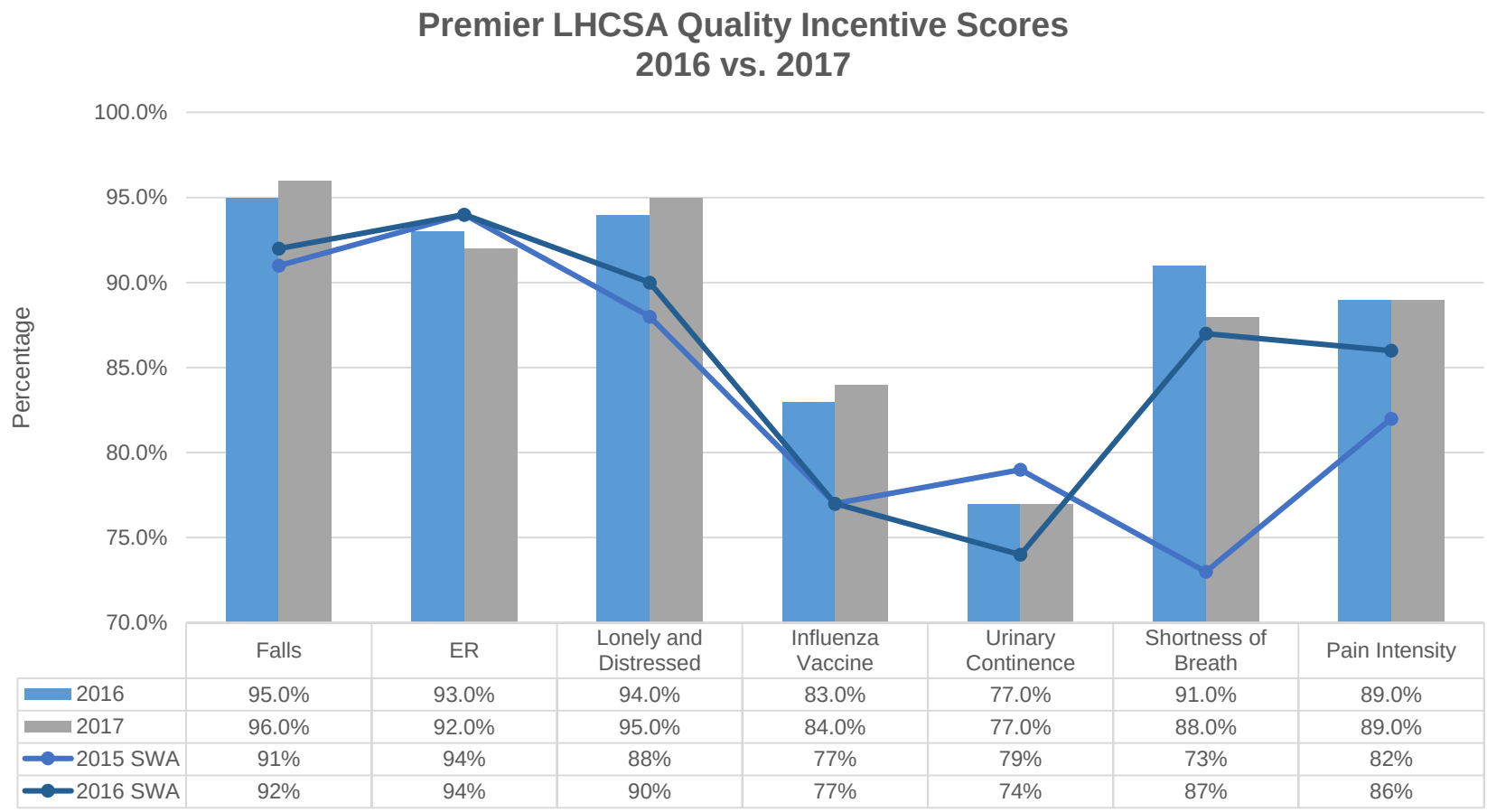
- MLTC quality measure educational modules were developed for the original OAR program and are reinforced in the OAR II program:



  - Reduction in Falls
  - ER visit reduction
  - Pain Management
  - Increased involvement decision making
  - Decrease in members reporting feelings of loneliness or distress
  - Improvement in flu vaccination rates
  - Increase in the perception of quality of care
  - Improvement and stabilization of urinary incontinence*
  - Improvement and stabilization in shortness of breath (SOB/dyspnea)*

* Added in OAR II Program

Premier LHCSA Quality Incentive Data



	Falls	ER	Lonely and Distressed	Influenza Vaccine	Urinary Continence	Shortness of Breath	Pain Intensity
2016	95.0%	93.0%	94.0%	83.0%	77.0%	91.0%	89.0%
2017	96.0%	92.0%	95.0%	84.0%	77.0%	88.0%	89.0%
2015 SWA	91%	94%	88%	77%	79%	73%	82%
2016 SWA	92%	94%	90%	77%	74%	87%	86%

Continuity of Care Pilot

- Healthfirst and Premier Home Health Care Services, Inc. collaborated to pilot an interdisciplinary team approach for members who receive services from Premier's care manager, UAS RN, PCA and supervisory RN services.

- The project, beginning July 2017, seeks to evaluate if improved communication between the member's care team results in more comprehensive and continuous care.

- The pilot goals are:
  - Provide team based services to assure coordinated, high-quality care to reach the client's goals
  - Improve the comprehensiveness, effectiveness and efficiency of services, as well as the satisfaction of clients and providers
  - Optimize communication and care coordination between the client's care team
  - Assure a shared client care plan between the licensed agency staff and Premier care managers with common interventions and goals
  - Assure timely follow-up to provide members with more comprehensive continuous care

Continuity of Care Pilot

- In the Pilot there are 3 comparison groups to evaluate outcomes:
- Premier Enhanced (intervention group); *n= 180 members*

  - This group has the following intervention:
    - Call-in number asking the PCAs a series of "Yes" or "No" questions at the end of their shift to identify any negative triggers in member's well-being that are tracked by daily reports

      --In-depth specialized Quality Incentive training for the Premier PCAs was conducted , which is part of the OAR II Initiative.
    - IDT Care Planning Call at the 6-month Reassessment

      --Involving Member, Care Management, LHCSA Supervisory RN and any additional individuals the member would like present

- Premier (control group); *n=180 members*

- Healthfirst members with no Premier services; *n= 180 members*

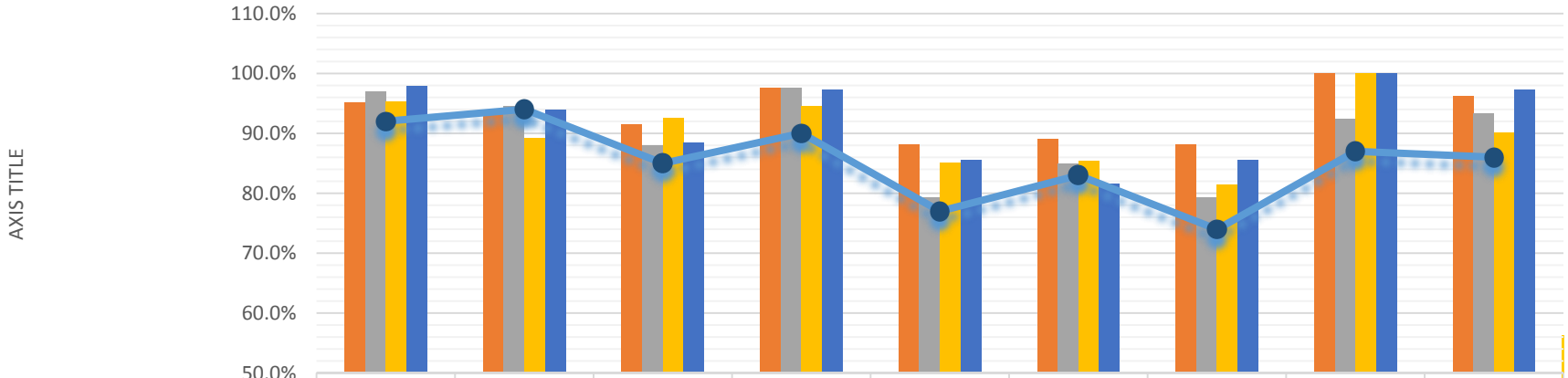
Intervention Group PCA Telephony System Questions

Did your patient go to the ER during the last 24-48 hours?
Did your patient fall during the last 24-48 hours?
Did your patient complain of pain and/or appear to have pain today?
Did your patient state that he or she feels sad, depressed or hopeless today?
Has there been a decline in member's urinary or bowel incontinence?
Did your patient experience shortness of breath during normal day –to day activities today?
Have you observed any other change in member's condition and/or behavior?
Has your patient received a flu vaccination within the last year?

PREMIER home health care services, inc.

Premier Pilot 6-Month Evaluation
Quality Incentive Data

Care Management , UAS & LHCSA IDT
Continuity of Care Program / OAR II Technology
Control and Intervention Group Comparison - 6 Month Evaluation



	Falls	ER	Pain Controlled	Loneliness and Distressed	Influenza Vaccine	NFLOC	Urinary Continence	Shortness of Breath	Pain Intensity
Control Prior UAS	95.2%	94%	91.6%	97.6%	88.2%	89%	88.2%	100%	96.2%
Control Recent UAS	97%	94.6%	88%	97.6%	79.4%	85%	79.4%	92.5%	93.4%
Intervention Prior UAS	95.3%	89.2%	92.6%	94.6%	85.1%	85.4%	81.5%	100%	90.1%
Intervention Recent UAS	98%	93.9%	88.5%	97.3%	85.6%	81.6%	85.6%	100%	97.3%
2016 SWA	92%	94%	85%	90%	77%	83%	74%	87%	86%

PREMIER home health care services, inc.

Continuity of Care 6-Month Evaluation

- At the 6-month mark for the Pilot there were several Quality Incentives that showed significant improvement in the intervention group data versus the control group data from the baseline UAS to the recent UAS:

	Control		Intervention	
	Prior UAS	Recent UAS	Prior UAS	Recent UAS
Falls	95.20%	97%	95.30%	**98%**
ER	94%	94.60%	89.20%	**93.90%**
Pain Controlled	91.60%	88%	92.60%	88.50%
Loneliness and Distressed	97.60%	97.60%	94.60%	**97.30%**
Influenza Vaccine	88.20%	79.40%	85.10%	85.60%
NFLOC	89%	85%	85.40%	81.60%
Urinary Continence	88.20%	79.40%	81.50%	**85.60%**
Shortness of Breath	100%	92.50%		**100%**
Pain Intensity	96.20%	93.40%	90.10%	**97.30%**

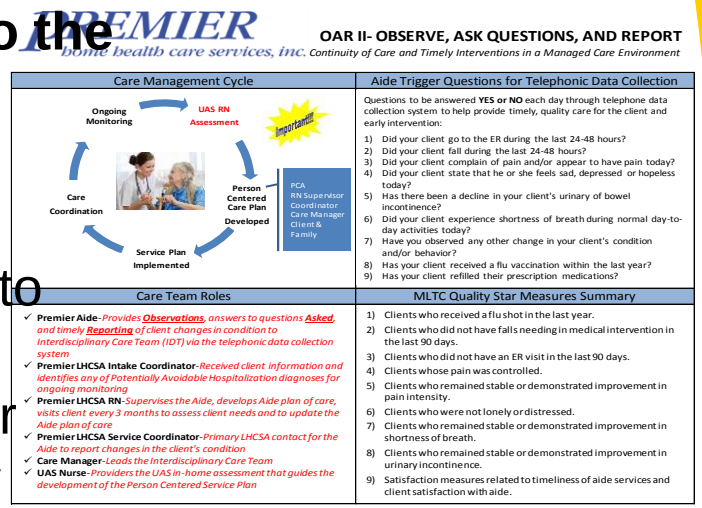
OAR II- Observe, Ask & Report

- Building upon the success of the OAR I Training Program and Continuity of Care Pilot, the OAR II Program was developed with a focus on Potentially Avoidable Hospitalization (PAH) Diagnosis and extensive Care Management / IDT cycle training, while additionally incorporating the telephonic-automated processes.

  - Training topics for OAR II include:
    - Care management cycle, roles of care team members, and the LHCSA/CM IDT;
    - MLTC quality measures and the OAR process;
    - Potentially Avoidable Hospitalization (PAH) diagnoses included in VBP arrangements;
    - Overview of cultural competency, behavioral health, and health literacy; and
    - Training on real-time, aide telephonic reporting and automated transmission of data to the IDT for member outcome intervention.

OAR II- Observe, Ask & Report

The true **incorporation of the aide into the communication process** and the management of these communications through the Care Management Cycle **empowers members of the IDT team** to turn real-time information into early interventions to improve overall member status, address issues related to quality measures, and reduce or avoid a hospitalization (PAH).



PREMIER home health care services, inc.

OAR II- OBSERVE, ASK QUESTIONS, AND REPORT

Continuity of Care and Timely Interventions in a Managed Care Environment

Care Management Cycle

Aide Trigger Questions for Telephonic Data Collection

Questions to be answered **YES or NO** each day through telephone data collection system to help provide timely, quality care for the client and early intervention:

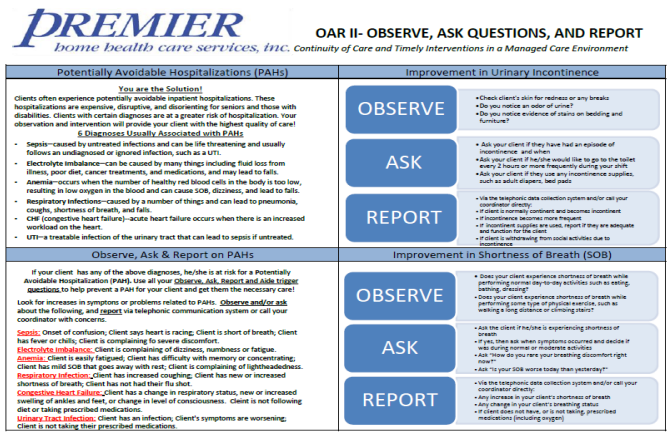
1) Did your client go to the ER during the last 24-48 hours?
2) Did your client fall during the last 24-48 hours?
3) Did your client complain of pain and/or appear to have pain today?
4) Did your client state that he or she feels sad, depressed or hopeless today?
5) Has there been a decline in your client's urinary of bowel incontinence?
6) Did your client experience shortness of breath during normal day-to-day activities today?
7) Have you observed any other change in your client's condition and/or behavior?
8) Has your client received a flu vaccination within the last year?
9) Has your client refilled their prescription medications?

Care Team Roles

- ✓ **Premier Aide**-*Provides **Observations**, answers to questions **Asked**, and timely **Reporting** of client changes in condition to Interdisciplinary Care Team (IDT) via the telephonic data collection system*
- ✓ **Premier LHCSA Intake Coordinator**-*Received client information and identifies any of Potentially Avoidable Hospitalization diagnoses for ongoing monitoring*
- ✓ **Premier LHCSA RN**-*Supervises the Aide, develops Aide plan of care, visits client every 3 months to assess client needs and to update the Aide plan of care*
- ✓ **Premier LHCSA Service Coordinator**-*Primary LHCSA contact for the Aide to report changes in the client's condition*
- ✓ **Care Manager**-*Leads the Interdisciplinary Care Team*
- ✓ **UAS Nurse**-*Providers the UAS in-home assessment that guides the development of the Person Centered Service Plan*

MLTC Quality Star Measures Summary

1) Clients who received a flu shot in the last year.
2) Clients who did not have falls needing in medical intervention in the last 90 days.
3) Clients who did not have an ER visit in the last 90 days.
4) Clients whose pain was controlled.
5) Clients who remained stable or demonstrated improvement in pain intensity.
6) Clients who were not lonely or distressed.
7) Clients who remained stable or demonstrated improvement in shortness of breath.
8) Clients who remained stable or demonstrated improvement in urinary incontinence.
9) Satisfaction measures related to timeliness of aide services and client satisfaction with aide.



PREMIER home health care services, inc.

OAR II- OBSERVE, ASK QUESTIONS, AND REPORT

Continuity of Care and Timely Interventions in a Managed Care Environment

Potentially Avoidable Hospitalizations (PAHs)

You are the Solution!

Clients often experience potentially avoidable inpatient hospitalizations. These hospitalizations are expensive, disruptive, and disorienting for seniors and those with disabilities. Clients with certain diagnoses are at a greater risk of hospitalization. Your observation and intervention will provide your client with the highest quality of care!

6 Diagnoses Usually Associated with PAHs

- Sepsis--caused by untreated infections and can be life threatening and usually follows an undiagnosed or ignored infection, such as a UTI.
- Electrolyte imbalance--can be caused by many things including fluid loss from illness, poor diet, cancer treatments, and medications, and may lead to falls.
- Anemia--occurs when the number of healthy red blood cells in the body is too low, resulting in low oxygen in the blood and can cause SOB, dizziness, and lead to falls.
- Respiratory Infections--caused by a number of things and can lead to pneumonia, coughs, shortness of breath, and falls.
- CHF (congestive heart failure)--acute heart failure occurs when there is an increased workload on the heart.
- UTI--a treatable infection of the urinary tract that can lead to sepsis if untreated.

Observe, Ask & Report on PAHs

If your client has any of the above diagnoses, he/she is at risk for a Potentially Avoidable Hospitalization (PAH). Use all your Observe, Ask, Report and Aide trigger questions to help prevent a PAH for your client and get them the necessary care!

Look for increases in symptoms or problems related to PAHs. **Observe and/or ask** about the following, and **report** via telephonic communication system or call your coordinator with concerns.

Sepsis: Onset of confusion; Client says heart is racing; Client is short of breath, Client has fever or chills; Client is complaining fo severe discomfort.
Electrolyte Imbalance: Client is complaining of dizziness, numbness or fatigue.
Anemia: Client is easily fatigued; Client has difficulty with memory or concentrating; Client has mild SOB that goes away with rest; Client is complaining of lightheadedness.
Respiratory Infection: Client has increased coughing; Client has new or increased shortness of breath; Client has not had their flu shot.
Congestive Heart Failure: Client has a change in respiratory status, new or increased swelling of ankles and feet, or change in level of consciousness. Client is not following diet or taking prescribed medications.
Urinary Tract Infection: Client has an infection; Client's symptoms are worsening; Client is not taking their prescribed medications.

Improvement in Urinary Incontinence

OBSERVE	• Check client's skin for redness or any breaks • Do you notice an odor of urine? • Do you notice evidence of stains on bedding and furniture?
ASK	• Ask your client if they have had an episode of incontinence and when • Ask your client if he/she would like to go to the toilet every 2 hours or more frequently during your shift. • Ask your client if they use any incontinence supplies, such as adult diapers, bed pads
REPORT	• Via the telephonic data collection system and/or call your coordinator directly: • If client is normally continent and becomes incontinent • If incontinence becomes more frequent • If incontinent supplies are used, report if they are adequate and function for the client • If client is withdrawing from social activities due to incontinence

Improvement in Shortness of Breath (SOB)

OBSERVE	• Does your client experience shortness of breath while performing normal day-to-day activities such as eating, bathing, dressing? • Does your client experience shortness of breath while performing some type of physical exercise, such as walking a long distance or climbing stairs?
ASK	• Ask the client if he/she is experiencing shortness of breath • If yes, then ask when symptoms occurred and decide if was during normal or moderate activities • Ask "How do you rate your breathing discomfort right now?" • Ask "Is your SOB worse today than yesterday?"
REPORT	• Via the telephonic data collection system and/or call your coordinator directly: • Any increase in your client's shortness of breath • Any change in your client's breathing status • If client does not have, or is not taking, prescribed medications (including oxygen)

PREMIER home health care services, inc.

PREMIER LHCSA QUALITY INCENTIVE PROGRAM UNIT – (P-QIP)

- Most recently, in recognition of the need to tie all the education, technology, and data components together, Premier established a new team within its LHCSA operations.

- LHCSA P-QIP Unit Operation – Quality Measure Score Responsibilities

  - Serve as communicational liaison with Health Plans for Dashboard monitoring and data management.
  - Monitor Measures **daily** from internal UAS and OAR II data by Health Plan, and report to Premier LHCSA contract teams / Aide/ Health Plan Care Manager IDTs to develop and implement member intervention.
  - Manage LHCSA intervention workflows for Quality Measure improvement.
  - Use aggregated data to monitor and improve population health outcomes by health plan, culture/language, PAH diagnosis, LHCSA service team, Article 49 Care Manager, or by aide.
  - Develop and implement with LHCSA and Article 49 training programs and processes for all field and office staff to improve health outcomes.

PREMIER home health care services, inc.

Q&A


collaboration
teamwork
cooperation
business
team
partnership
support
group
together
success
people
cooperate
join
project
person
work
solution
company
executive
united
network
communication
companion
strength
presentation
colorful
connection
leadership
management
gesture
symbol
friendship
interact
companionship
businessman
unity
trust
seminar
challenge
strong
professional
meeting
corporate
strategy
hands
connect
collaborate
organization
community
togetherness
relationship
agreement
creative
progress
partner
bonding
human
power
joint
communicate
manpower
social
union

WHAT WILL YOUR LEGACY BE?

Thank you.

NYS DOH

MLTCVBP@health.ny.gov

VillageCare Max

Emmy Devito: EmmaD@Villagecare.org

Mary Ellen Connington: MaryEllenC@villagecare.org

Randi Roy: RandiR@villagecare.org

Premier

Christy Johnston: cjohnston@phhc.com

Alexis Varela Ratner: avarela@phhc.com