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

NYS MLTC Plan Enrollment

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Enrollment</th>
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<tbody>
<tr>
<td>MLTC Partial Capitation</td>
<td>199,442</td>
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<tr>
<td>Fully Capitated Plan</td>
<td>9,243</td>
</tr>
<tr>
<td>MAP</td>
<td>5,733</td>
</tr>
<tr>
<td>PACE</td>
<td>4,237</td>
</tr>
<tr>
<td>FIDA</td>
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</table>

Enrollee Centered Care

New York State Department of Health (NYS DOH)

Enrollee

Providers, (Physicians, LHCSAs and CHHAs)

Managed Long Term Care Plans (MLTCPs)
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 ICSP 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:

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reg 164</td>
<td>Enhanced member experience</td>
</tr>
<tr>
<td>Supporting the maturation of certain IPA’s to manage risk in the dual population</td>
<td>Deepened provider collaboration</td>
</tr>
<tr>
<td>Data Management</td>
<td>Improved quality of care delivery</td>
</tr>
<tr>
<td>Communication between partners</td>
<td>Improved efficiency around total cost of care</td>
</tr>
</tbody>
</table>
Q&A
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:
  
  o Article 49 Care Management/UR Registration
  o UAS Assessment
  o Nurse Practitioner (Preventive Health Screening/Immunizations)
  o 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
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

Premier LHCSA Quality Incentive Scores
2016 vs. 2017

<table>
<thead>
<tr>
<th>Measure</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls</td>
<td>95.0%</td>
<td>96.0%</td>
</tr>
<tr>
<td>ER</td>
<td>93.0%</td>
<td>92.0%</td>
</tr>
<tr>
<td>Lonely and Distressed</td>
<td>94.0%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Influenza Vaccine</td>
<td>83.0%</td>
<td>84.0%</td>
</tr>
<tr>
<td>Urinary Continence</td>
<td>77.0%</td>
<td>77.0%</td>
</tr>
<tr>
<td>Shortness of Breath</td>
<td>91.0%</td>
<td>88.0%</td>
</tr>
<tr>
<td>Pain Intensity</td>
<td>89.0%</td>
<td>89.0%</td>
</tr>
</tbody>
</table>

SWA Data

<table>
<thead>
<tr>
<th>Measure</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls</td>
<td>91%</td>
<td>92%</td>
</tr>
<tr>
<td>ER</td>
<td>94%</td>
<td>94%</td>
</tr>
<tr>
<td>Lonely and Distressed</td>
<td>88%</td>
<td>90%</td>
</tr>
<tr>
<td>Influenza Vaccine</td>
<td>77%</td>
<td>77%</td>
</tr>
<tr>
<td>Urinary Continence</td>
<td>79%</td>
<td>74%</td>
</tr>
<tr>
<td>Shortness of Breath</td>
<td>73%</td>
<td>87%</td>
</tr>
<tr>
<td>Pain Intensity</td>
<td>82%</td>
<td>86%</td>
</tr>
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</table>
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

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

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

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<thead>
<tr>
<th></th>
<th>Control</th>
<th>Intervention</th>
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<tbody>
<tr>
<td></td>
<td>Prior UAS</td>
<td>Recent UAS</td>
</tr>
<tr>
<td>Falls</td>
<td>95.20%</td>
<td>97%</td>
</tr>
<tr>
<td>ER</td>
<td>94%</td>
<td>94.60%</td>
</tr>
<tr>
<td>Pain Controlled</td>
<td>91.60%</td>
<td>88%</td>
</tr>
<tr>
<td>Loneliness and Distressed</td>
<td>97.60%</td>
<td>97.60%</td>
</tr>
<tr>
<td>Influenza Vaccine</td>
<td>88.20%</td>
<td>79.40%</td>
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<tr>
<td>NFLOC</td>
<td>89%</td>
<td>85%</td>
</tr>
<tr>
<td>Urinary Continence</td>
<td>88.20%</td>
<td>79.40%</td>
</tr>
<tr>
<td>Shortness of Breath</td>
<td>100%</td>
<td>92.50%</td>
</tr>
<tr>
<td>Pain Intensity</td>
<td>96.20%</td>
<td>93.40%</td>
</tr>
</tbody>
</table>

- Example:
  - Falls: Prior UAS 95.20% vs Recent UAS 97%
  - ER: Prior UAS 94% vs Recent UAS 94.60%
  - Pain Controlled: Prior UAS 91.60% vs Recent UAS 88%
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).
June 12, 2018

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
  
  o Serve as communicational liaison with Health Plans for Dashboard monitoring and data management.
  o 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.
  o Manage LHCSA intervention workflows for Quality Measure improvement.
  o 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.
  o Develop and implement with LHCSA and Article 49 training programs and processes for all field and office staff to improve health outcomes.
Q&A
WHAT WILL YOUR LEGACY BE?

Thank you.

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