

**NEW YORK STATE DEPARTMENT OF HEALTH**  
Office of Quality and Patient Safety

**PLAN – Technical REPORT  
FOR  
SENIOR WHOLE HEALTH**

**Reporting Year 2012**

March 2015

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## Section One: About This Report

New York State (NYS) is dedicated to providing and maintaining the highest quality of care for enrollees in managed long term care (MLTC) plans. MLTC enrollees are generally chronically ill, often elderly enrollees and are among the most vulnerable New Yorkers. The New York State Department of Health's (NYSDOH) Office of Quality and Patient Safety (OQPS) employs an ongoing strategy to improve the quality of care provided to plan enrollees, to ensure the accountability of these plans and to maintain the continuity of care to the public.

The MLTC Plan-Technical Reports are individualized reports on the MLTC plans certified to provide Medicaid coverage in NYS. The reports are organized into the following domains: Plan Profile, Enrollment, Utilization, Member Satisfaction, SAAM Quality of Clinical Assessments and Performance Improvement Projects (PIPs). When available and appropriate, the plans' data in these domains are compared to statewide benchmarks.

The final section of the report provides an assessment of the MLTC plan's strengths and opportunities for improvement in the areas of service quality, accessibility, timeliness, and utilization. For areas in which the plan has opportunities for improvement, recommendations for improving the quality of the MLTC plan's services are provided.

There are three (3) MLTC plan types:

- a) Partially Capitated
- b) Program of All-inclusive Care for the Elderly (PACE)
- c) Medicaid Advantage Plus (MAP)

A description of each of the plan types follows:

**Partially Capitated-** A Medicaid capitation payment is provided to the plan to cover the costs of long term care and selected ancillary services. The member's ambulatory care and inpatient services are paid by Medicare if they are dually eligible for both Medicare and Medicaid, or by Medicaid if they are not Medicare eligible. For the most part, those who are only eligible for Medicaid receive non MLTC services through Medicaid fee for service, as members in partially capitated MLTC plans are ineligible to join a traditional Medicaid managed care plan. The minimum age requirement is 18 years.

**PACE-** A PACE plan provides a comprehensive system of health care services for members 55 and older, who are otherwise eligible for nursing home admission. Both Medicaid and Medicare pay for PACE services on a capitated basis. Members are required to use PACE physicians. An interdisciplinary team develops a care plan and provides ongoing care management. The PACE plan is responsible for directly providing or arranging all primary, inpatient hospital and long term care services required by a PACE member. The PACE is approved by the Centers for Medicare and Medicaid Services (CMS).

**Medicaid Advantage Plus (MAP)-** MAP plans must be certified by the NYSDOH as MLTC plans and by CMS as a Medicare Advantage plan. As with the PACE model, the plan receives a capitation payment from both Medicaid and Medicare. The Medicaid benefit package includes the long term care services and the Medicare benefit package includes the ambulatory care and inpatient services.

An MLTC plan can service more than one of the above products and where applicable, the report will present data for each product.

In an effort to provide the most consistent presentation of this varied information, the report is prepared based upon data for the most current calendar year available. Where trending is desirable, data for prior calendar years may also be included. This report includes data for Reporting Year 2012.

**Section Two: Plan Profile**

Senior Whole Health (SWH) is a regional Managed Long Term Care (MLTC) plan with a Medicaid Advantage Plus (MAP) and partially capitated product line. Plan-specific information follows:

- Plan ID: 02932896
- Managed Long-term Care Start Date: 2008 (MAP) and 2012 (Partially Capitated)
- Product Line(s): MAP and Partially Capitated
- MLTC Age Requirement: 65 and older
- Contact Information: 200 S. Pearl St.  
Albany, NY 12202  
(866) 211-1777

**Participating Counties and Programs**

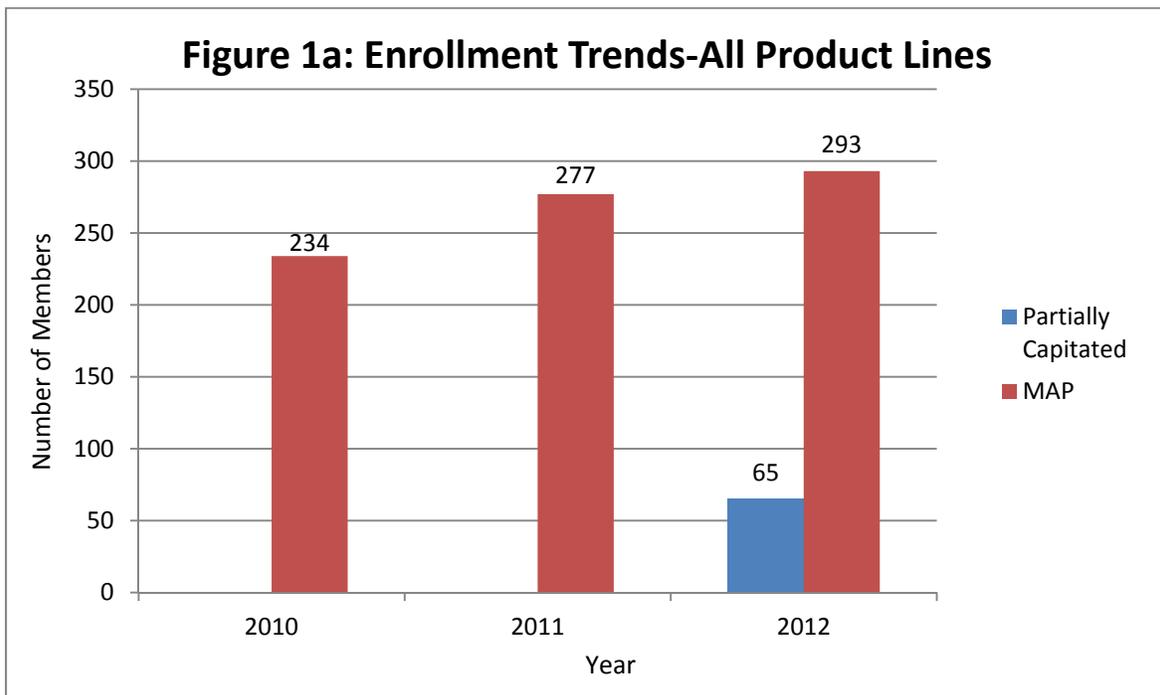
Albany	MAP	Columbia	MAP	Dutchess	MAP
Montgomery	MAP	Orange	MAP	Rensselaer	MAP
Saratoga	MAP	Schenectady	MAP	Ulster	MAP
Warren	MAP	Washington	MAP	Queens	MAP/Part Cap
Bronx	MAP/Part Cap	Kings	MAP/Part Cap	New York	MAP/Part Cap

### Section Three: Enrollment

Figure 1 depicts membership for the plan’s partially capitated and MAP product lines for calendar years 2010 to 2012, as well as the percent change from the previous year. Membership for the MAP line grew over this period, increasing by 18.4% from 2010 to 2011 and by 5.8% from 2011 to 2012. The partially capitated product line was introduced in 2012. The MAP product line was introduced in 2008. Figure 1a trends the enrollment for the partially capitated and MAP product lines.

**Figure 1: Membership: MAP- 2010-2012**

	2010	2011	2012
<b>Partially Capitated</b>			
Number of Members	N/A	N/A	65
% Change From Previous Year	N/A	N/A	N/A
<b>MAP</b>			
Number of Members	234	277	293
% Change From Previous Year	37.6%	18.4%	5.8%



## Section Four: Utilization

Figure 2 represents Senior Whole Health’s utilization of managed long term care services in 2011 and 2012. The services presented are those covered under the plan’s MAP product line. The 2011 data are from the NYSDOH’s MEDS II program and 2012 data are from the MEDS III program. It should be noted that utilization data for SWH’s partially capitated line were not available, since this product line was introduced in 2012.

**Figure 2: Encounter Data Per Member Per Year (PMPY) 2011-2012**

MAP MLTC Services	2011 Averages			2012 Averages		
	SWH MAP 2011	MAP Average	Statewide Average	SWH MAP 2012	MAP Average	Statewide Average
Home Health Care- Nursing (visits)	21.70↑	9.30	12.13	N/A*	4.68	7.16
Home Health Care- Physical Therapy (visits)	1.20	1.00	1.63	N/A*	0.31	0.91
Personal Care (hours)	37.00↓	106.90	132.80	50.79↓	92.16	90.64
Transportation (one-way trips)	6.50↓	14.47	23.73	8.06↓	11.32	15.65
Nursing Home (days)	0.33	0.20	0.40	0.60	0.15	0.11
Dental (visits)	0.56	0.77	0.73	0.72	0.69	0.52
Optometry (visits)	0.64	0.38	0.45	0.86	0.38	0.25
Podiatry (visits)	2.70	2.71	0.80	1.86	1.95	0.45
Primary Care (PCP) (visits)	16.70↑	12.17	10.98	11.60↑	9.43	5.80
Physician Specialist (visits)	15.80↑	12.09	10.98	9.29	9.00	5.70
Emergency Room (discharges)	0.96	1.20	0.56	0.92	0.95	0.46
Hospitalizations (days)	4.90	3.56	3.21	0.97	1.90	1.18

↓ Indicates MEDS encounter data results below MAP and/or statewide averages

↑ Indicates MEDS encounter data results above MAP and/or statewide averages

\* Data not reported/not available

### Senior Whole Health 2012 vs. MAP and Statewide Averages:

PCP and physician specialist visit utilization were reported higher than MAP and statewide averages for the 2012 year. Personal care hours, one-way trips and days spent in the hospital were reported lower than MAP and statewide averages.

### Senior Whole Health 2011 vs. Senior Whole Health 2012:

There was an increase in personal care and transportation utilization from 2011 to 2012, while there was a decrease in PCP visits, specialist visits, and days spent in the hospital.

## **Section Five: Member Satisfaction**

I PRO, in conjunction with the NYSDOH, conducted a member satisfaction survey in 2012. The NYSDOH provided the member sample frame for the survey, which included the primary language for the majority of members. From this file, a sample of 600 members from each plan was selected, or the entire membership if the plan's enrollment was less than 600. Of the 9,959 surveys that were mailed, 613 were returned as undeliverable due to either mailing address issues or the member was deceased. This yielded an adjusted population of 9,346. A total of 2,522 surveys were completed, yielding an overall response rate of 27.0%.

Neither of Senior Whole Health's product lines were included in the survey, as their MAP product line had been discontinued and their partially capitated line was still too new for evaluation.

## Section Six: SAAM-Quality of Clinical Assessments

The Semi Annual Assessment of Members (SAAM) is the assessment tool utilized by the MLTC plans to conduct clinical assessments of members, at start of enrollment and at six month intervals thereafter. There are fifteen (15) care categories, or domains in SAAM, as follows:

Diagnosis/Prognosis/Surgeries	Falls
Living arrangements	Neuro/Emotional Behavioral Status
Supportive assistance	ADL/IADLs
Sensory status	Medications
Integumentary status	Equipment Management
Respiratory status	Emergent Care
Elimination status	Hospitalizations
	Nursing Home Admissions

SAAM data are submitted to the NYSDOH twice annually, in January and July. The January submission consists of assessments conducted between July and December of the prior year, the July submission consists of assessments conducted between January and June of the same year. Twice annually, following submissions, the NYSDOH issues plan specific reports containing plan mean results and comparison to statewide averages.

In 2007, the SAAM was expanded beyond its role as a clinical assessment tool, to determine MLTC plan eligibility. An eligibility scoring index was created; the scoring index consists of 13 items /questions, as follows:

Urinary Incontinence	Bathing
Urinary incontinence frequency	Toileting
Bowel incontinence frequency	Transferring
Cognitive functioning	Ambulation/Locomotion
Confusion	Feeding/Eating
Anxiety	
Ability to dress upper body	
Ability to dress lower body	

Each item has a point value; a combined total score of 5 or greater constitutes MLTC eligibility.

Figure 3 contains Senior Whole Health's partially capitated plan's January 2013 summary SAAM assessment results, for the 13 eligibility index items. Included also are the number of falls resulting in medical intervention and frequency of pain.

Figure 4a contains Senior Whole Health's MAP plan's January 2013 summary SAAM assessment results, and Figure 4b contains SAAM assessment results from July 2011 through January 2013, for the 13 eligibility index items. Included also are the number of falls resulting in medical intervention and frequency of pain.

Figures 4c and 4d are graphical representations of the data in Figure 4b.

**Figure 3: Senior Whole Health Partially Capitated and Statewide SAAM Data 2012**

SAAM Item	SWH Average July 2012	Statewide Average July 2012	SWH Average Jan 2013	Statewide Average Jan 2013
	N=.	N=58,878	N=53	N=78,216
Ambulation –Average score on a scale of 0-6, 0 highest level	.	2.3	2.5	2.2
Bathing-Average score on a scale of 0-5, 0 highest level	.	2.5	2.9	2.5
Transferring-Average score on a scale of 0-6, 0 highest level	.	1.5	1.9	1.5
Upper Body Dressing-Average score on a scale of 0-3, 0 highest level	.	1.6	1.7	1.6
Lower Body Dressing-Average score on a scale of 0-3, 0 highest level	.	1.9	2.0	1.9
Toileting-Average score on a scale of 0-4, 0 highest level	.	0.8	1.6↓↓	0.8
Feeding/Eating-Average score on a scale of 0-5, 0 highest level	.	0.7	0.9	0.7
Urinary Incontinence Frequency-% incontinent more than once/week	.	87.0%	91.2%	86.8%
Bowel Incontinence Frequency-% with any bowel incontinence	.	19.9%	38.4%↑	20.9%
Cognitive Functioning- % with any degree of cognitive impairment	.	59.6%	76.9%↑	58.0%
When Confused- % with any level of confusion	.	62.6%	73.0%↑	62.7%
When Anxious- % with any level of anxiety	.	61.2%	57.7%	61.5%
Frequency of Pain- % experiencing pain at least daily	.	53.0%	55.8%	54.1%
Falls Resulting in Medical Intervention- % of members experiencing at least one fall which required medical intervention	.	48.6%	50.0%	46.8%
↑ indicates a percentage that is 5 or more percentage points greater than the statewide average				
↓ indicates a percentage that is 5 or more percentage points lower than the statewide average				
↓↓ indicates an ADL/IADL level worse than the statewide average				

SAAM data were only available for the January 2013 submission for SWH’s partially capitated product line, since it was introduced in 2012. These data indicate that SWH partially capitated members appear to have higher rates for certain behavioral health problems when compared to plans statewide. The percent of members suffering from cognitive impairment and confusion exceeded the statewide average by about 19 percentage points and 10 percentage points, respectively. It should be noted that the SAAM questions pertaining to these conditions contain a high level of subjectivity on the part of the assessor and may be scored based upon behavior/attitude exhibited solely at the time of the assessment visit.

Data from the January submission period also indicate that a greater percentage of SWH members suffered from bowel incontinence, and had a toileting score that was lower than the statewide average. It should be noted also that the sample for this period was small, limiting the significance of these results

**Figure 4a: Senior Whole Health MAP and Statewide SAAM Data 2012**

SAAM Item	Plan Mean July 2012 N=326	Statewide Mean July 2012 N=58,552	Plan Mean Jan 2013 N=108	Statewide Mean Jan 2013 N=78,161
Ambulation –Average score on a scale of 0-6, 0 highest level	2.1	2.3	2.0	2.2
Bathing-Average score on a scale of 0-5, 0 highest level	2.1	2.5	2.5	2.5
Transferring-Average score on a scale of 0-6, 0 highest level	1.2	1.5	1.5	1.5
Upper Body Dressing-Average score on a scale of 0-3, 0 highest level	0.5	1.6	1.3	1.6
Lower Body Dressing-Average score on a scale of 0-3, 0 highest level	0.8	1.9	1.9	1.9
Toileting-Average score on a scale of 0-4, 0 highest level	0.2	0.8	1.1	0.8
Feeding/Eating-Average score on a scale of 0-5, 0 highest level	0.3	0.7	0.7	0.7
Urinary Incontinence Frequency-% incontinent more than once/week	87.3%	87.0%	84.2%	86.8%
Bowel Incontinence Frequency-% with any bowel incontinence	19.3%	20.1%	36.0%↑	20.9%
Cognitive Functioning- % with any degree of cognitive impairment	91.4%↑	59.3%	76.0%↑	58.0%
When Confused- % with any level of confusion	87.5%↑	62.3%	76.0%↑	62.7%
When Anxious- % with any level of anxiety	88.9%↑	61.1%	92.0%↑	61.5%
Frequency of Pain- % experiencing pain at least daily	51.7%	53.1%	40.0%↓	54.1%
Falls Resulting in Medical Intervention- % of members experiencing at least one fall which required medical intervention	49.6%	48.7%	37.5%↓	46.8%
↑ indicates a percentage that is 5 or more percentage points greater than the statewide average				
↓ indicates a percentage that is 5 or more percentage points lower than the statewide average				

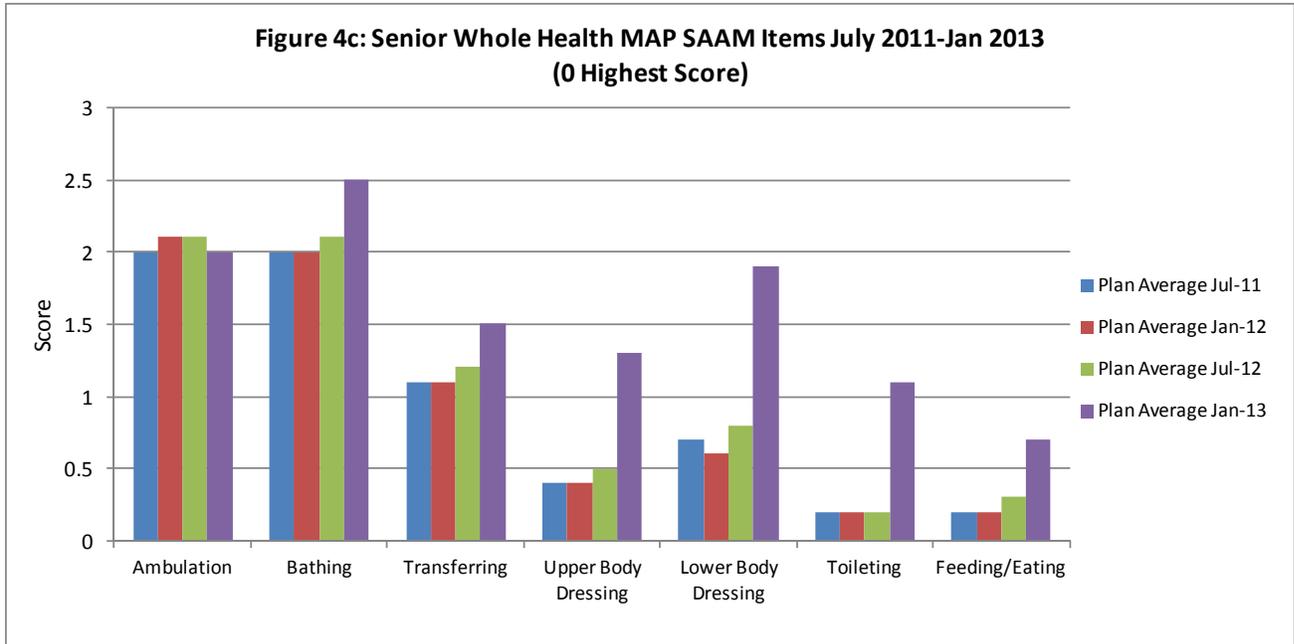
SAAM data for SWH’s MAP product line reveal a higher prevalence of cognitive impairment, confusion and anxiety when compared with averages from the state from both submission periods. While the state averages remained relatively constant throughout both submission periods, the averages for SWH fluctuated; in the January submission the percent of members suffering cognitive impairment was 76.0% while in July it was 91.4%. Additionally, in the January submission the percent of members suffering confusion was 76.0% while in July it was 87.5%.

In terms of physical health (when compared with the statewide average), the percentage of members suffering from bowel incontinence was higher for the January submission period. In contrast, there were fewer members who suffered from chronic pain and falls that resulted in medical intervention, especially in the January submission (falls were *slightly* higher in the July submission).

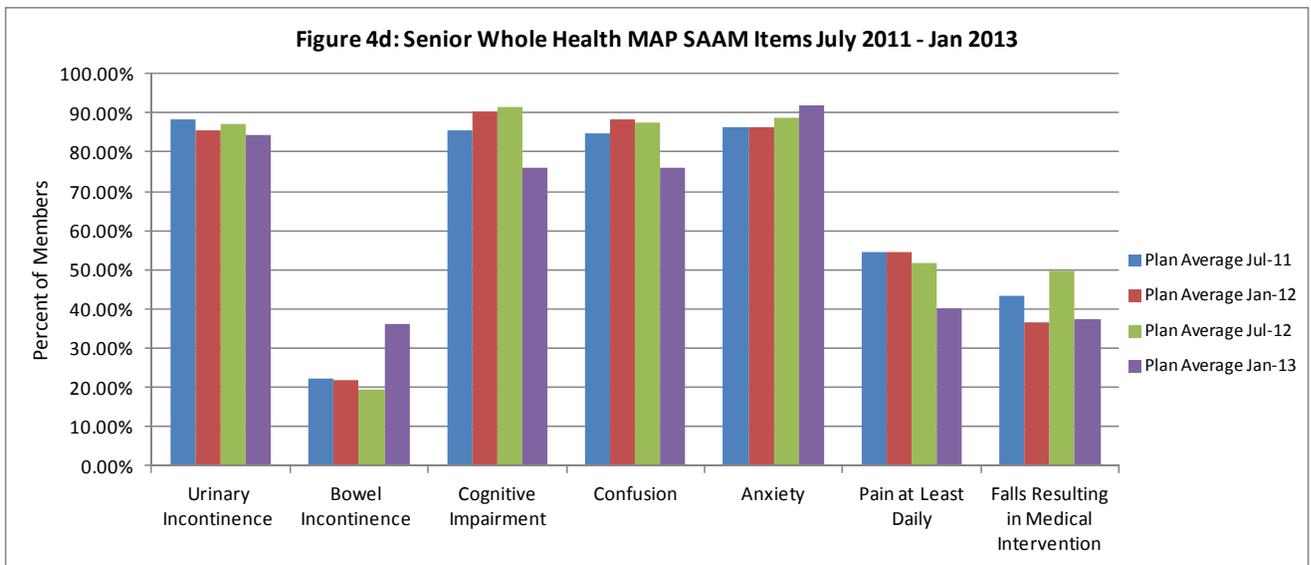
**Figure 4b: Senior Whole Health MAP SAAM Data 2011-2012**

<b>SAAM Item</b>	<b>Plan Mean July 2011</b>	<b>Plan Mean Jan 2012</b>	<b>Plan Mean July 2012</b>	<b>Plan Mean Jan 2013</b>
	<b>N=268</b>	<b>N=280</b>	<b>N=326</b>	<b>N=108</b>
Ambulation – Average score on a scale of 0-6, 0 highest level	2.0	2.1	2.1	2.0
Bathing – Average score on a scale of 0-5, 0 highest level	2.0	2.0	2.1	2.5
Transferring – Average score on a scale of 0-6, 0 highest level	1.1	1.1	1.2	1.5
Upper Body Dressing – Average score on a scale of 0-3, 0 highest level	0.4	0.4	0.5	1.3
Lower Body Dressing – Average score on a scale of 0-3, 0 highest level	0.7	0.6	0.8	1.9
Toileting – Average score on a scale of 0-4, 0 highest level	0.2	0.2	0.2	1.1
Feeding/Eating – Average score on a scale of 0-5, 0 highest level	0.2	0.2	0.3	0.7
Urinary Incontinence Frequency – % incontinent more than once/week	88.3%	85.6%	87.3%	84.2%
Bowel Incontinence Frequency – % with any bowel incontinence	22.1%	21.9%	19.3%	36.0%
Cognitive Functioning – % with any degree of cognitive impairment	85.5%	90.5%	91.4%	76.0%
When Confused – % with any level of confusion	84.6%	88.3%	87.5%	76.0%
When Anxious – % with any level of anxiety	86.3%	86.4%	88.9%	92.0%
Frequency of Pain – % experiencing pain at least daily	54.7%	54.5%	51.7%	40.0%
Falls Resulting in Medical Intervention – % of members experiencing at least one fall which required medical intervention	43.2%	36.6%	49.6%	37.5%

**Figures 4c and 4d: Senior Whole Health MAP SAAM Data 2011-2012**



**Figure 4c:** Scores for the majority of activities of daily living in the above figure were highest in the January 2013 reporting period (indicating a lower level of ability to perform these tasks). It should be noted that the MAP sample size was the smallest during this period (n=108) and thus may be attributed to the variability in results.



**Figure 4d:** There was an overall decrease in the prevalence of urinary incontinence and pain among members from July 2011 to January 2013. The January 2013 reporting period had the lowest percentage of members suffering from cognitive impairment, confusion, pain and urinary incontinence, and the highest percentage suffering from anxiety and bowel incontinence. As noted above, this reporting period had the smallest sample size (n=108) and thus may not accurately reflect the overall behavioral and physical health profiles of these members.

## Section Seven: Performance Improvement Projects

MLTC plans conduct performance improvement projects (PIPs) on an annual basis. Proposed project topics are presented to IPRO and to the NYSDOH prior to the PIP period, for approval. Periodic conference calls are conducted during the PIP period to monitor progress.

The following represents a summary of SWH's PIP for 2012:

Topic: Monitoring and Assisting Plan Members Diagnosed with Congestive Heart Failure (CHF) and Chronic Obstructive Pulmonary Disorder (COPD)

Senior Whole Health's (SWH) project focused on their members who were diagnosed with CHF and/or COPD. Both conditions worsen with time and can have a deleterious effect on a patient's health if they are not managed or cared for properly. SWH's goal was to create a plan of care to manage and minimize health issues for their plan members diagnosed with CHF and COPD.

The plan's objectives were to:

- Prevent/reduce inpatient hospitalization admissions for members with CHF
- Prevent/reduce ED visits for members with CHF
- Prevent/reduce inpatient hospitalization admissions for members with COPD
- Prevent/reduce ED visits for members with COPD

Interventions were as follows:

- Targeted member education materials were distributed throughout the year, containing information related to the importance of visiting the PCP, communicating with them and being compliant with one's medication
- Nurse Care Managers (NCM) called the study population to help determine members' risk and the appropriate care plan
- There was a weekly review of all CHF and related inpatient admissions with a focus on opportunities for intervention
- New enrollees were screened for CHF
- Medication reviews were conducted with the member and the NCMs, PCPs and specialists
- 48-hour contact/visits upon discharge and an evaluation of the member and their family's care management skills
- Continuing education for staff members related to the best practices in the field for assisting members diagnosed with CHF
- Create and disseminate program improvement strategies and monitor with a member satisfaction survey related to the programs

Results are detailed below:

**Congestive Heart Failure (CHF)**

<b>ED Utilization Rates</b>		2009	2010	2011	2012
Number of CHF members with all cause ED visits		26	21	24	24
Number of CHF members		45	45	45	40
<b>Rate</b>		<b>57.8%</b>	<b>46.7%</b>	<b>53.3%</b>	<b>60.0%</b>
Number of all cause ED visits for CHF members		67	56	46	51
Number of all cause ED visits for all MAP members		247	294	266	327
<b>Rate</b>		<b>27.1%</b>	<b>19.0%</b>	<b>17.3%</b>	<b>15.6%</b>
Number of all cause ED visits by CHF members		67	56	46	51
Total number of CHF members		45	45	45	40
<b>Rate (visit per member)</b>		<b>1.5</b>	<b>1.2</b>	<b>1.0</b>	<b>1.3</b>

<b>Inpatient Rates</b>		2009	2010	2011	2012
Number of CHF members with all cause IP admits		26	22	22	20
Number of CHF members		45	45	45	40
<b>Rate</b>		<b>57.8%</b>	<b>48.9%</b>	<b>48.9%</b>	<b>50.0%</b>
Number of all cause IP admits for CHF members		54	42	47	46
Number of all cause IP admits for all MAP members		124	203	178	25
<b>Rate</b>		<b>43.5%</b>	<b>20.7%</b>	<b>26.4%</b>	<b>20.4%</b>
Number of all cause IP admits by CHF members		54	56	46	46
Total number of CHF members		45	45	45	40
<b>Rate (admissions per member)</b>		<b>1.2</b>	<b>1.2</b>	<b>1.0</b>	<b>1.2</b>

Unfortunately, despite preliminary attempts, the COPD program was not initiated. The latter part of 2012 was focused on providing care management and transition planning, as the members in the MAP SWH upstate population ceased to be enrolled as of 12/31/12. However, 2009-2012 showed some progress made in reducing ED and hospital utilization rates amongst their plan members with CHF;

- The number of CHF members who utilized the ED decreased from 67 to 51 (where the relative rate change was 27.1% to 15.6%).
- The number of CHF members who had been hospitalized decreased from 54 to 46 (where the relative rate change was 43.5% to 20.4%).

## **Section Eight: Summary/Overall Strengths and Opportunities**

### ***Strengths***

#### **Performance Improvement Project**

Senior Whole Health's 2012 PIP was a continuation from their 2011 project which focused on improving the health of their members suffering from Congestive Heart Failure (CHF). The plan undertook numerous interventions to achieve their goal, including: member education and self-management, staff education, care plan revisions by a multidisciplinary team to prevent readmissions and a review of medication profiles. Although CHF is a condition that worsens with time, Senior Whole Health had some success with their project. ED visits for plan members diagnosed with CHF declined from 67 in 2009 to 51 in 2012, corresponding to an 11.5 percentage point decrease over this period. Inpatient admissions for members with CHF decreased from 54 to 46 from 2009-2012, with a relative decrease of 23.1 percentage points. More significant than outcome results, however, were the number of process interventions put into place for CHF care management.

#### **Frequency of Pain (MAP)**

SAAM data indicate that a lower percentage of SWH members appeared to have chronic pain when compared with the statewide average. This was true of both the January 2013 and July 2012 submission periods, although the difference seen between these two groups in the July submission was quite marginal (1.4 percentage points), while the difference in the January submission was more notable (14.1 percentage points).

### ***Opportunities***

#### **Behavioral Health (Partially Capitated and MAP)**

SAAM evaluation data from January 2013 and July 2012 indicate that behavioral health problems were quite prevalent amongst SWH's member population. For both measurement periods, the Senior Whole Health MAP average surpassed the statewide average, while the partially capitated member population had a higher prevalence of cognitive impairment and confusion for the January submission period (there were no data for the July submission as this plan was introduced in 2012).

These scores could be highly subjective due to the nature of the observer and the condition of the patient at the time of the assessment. IPRO recommends an inter-rater reliability project for future clinical assessments, to determine the validity of these results. Two assessors could independently conduct evaluations on the same group of members, to test the validity of responses.

#### **Encounter Data (MAP)**

Home nursing visit and physical therapy data were not reported, or were not available for reporting in 2012. Personal care hours and one way trips were reported below MAP and statewide averages, consistent with 2011 results.

It is recommended that SWH conduct a data validation study, through a review of care manager correspondence/ vendor data/ member records, in comparison to MEDS submission data, to determine if under reporting issues exist, or if there is inability to capture data for these services.