New York State Department of Health
Office of Quality and Patient Safety

2015

HIV Special Needs Plans

Care Management

Report

NEW YORK STATE | Department of Health

Introduction

The HIV Special Needs Plan (SNP) is a health plan for Medicaid recipients who are living with HIV/AIDS, and their Medicaid eligible children, regardless of the child's HIV/AIDS status. When a member joins an HIV SNP, that person is automatically enrolled into care management. Care management, also referred to as case management, is a multi-step process to ensure timely access to and coordination of medical and psycho-social services for a person living with HIV/AIDS and his or her family or close support system.

Care management activities are diverse. In addition to assisting clients to access and maintain specific services, care management activities may include negotiation and advocacy for services, consultation with providers, navigation through the service system, psycho-social support, supportive counseling, and general client education. SNPs provide the same services that are provided by other Medicaid managed care plans, and cover additional specialty services important to people living with HIV/AIDS.

The goal of care management is to promote and support independence and self-sufficiency. As such, the care management process requires the consent and active participation of the client in decision-making, and supports a client's right to privacy, confidentiality, self-determination, dignity, respect, nondiscrimination, compassionate non-judgmental care, a culturally competent provider, and quality case management services.

The intended care management outcomes of persons living with HIV/AIDS include:

- Early access to and maintenance of comprehensive health care and social services
- Improved integration of services provided across a variety of settings
- Enhanced continuity of care
- Prevention of disease transmission and delay of HIV progression
- Increased knowledge of HIV disease
- Greater participation in and optimal use of the health and social service system
- Reinforcement of positive health behaviors
- Personal empowerment
- An improved quality of life

HIV SNPs are responsible for helping to coordinate:

- All medical services
- Services not covered by regular Medicaid, but which support wellness (i.e., psycho-social case management, housing, counseling, peer support, legal assistance, etc.)
- Special programs for substance abusers, homeless people, and families affected by HIV/AIDS
- Services that are "carved out" or paid for through fee-for-service Medicaid

SNP providers (doctors, nurses, and other care providers who participate in HIV SNPs) understand members may need help with:

- Taking medications
- Behavioral health issues including mental health and substance use disorders
- Talking to loved ones about HIV

HIV SNPs were created because studies show that when people living with HIV/AIDS receive care from providers experienced in HIV health care, they live longer, healthier lives. All HIV SNPs are required to meet the New York State Department of Health (DOH) AIDS Institute quality standards for HIV/AIDS care.

Data/Methodology

The data used for this report are from the Health Plan Care Management Assessment Reporting Tool (CMART) and New York State Medicaid Data. These data sources provide information regarding which members received care management services and the scope and nature of those services, demographic information, a complete history of Medicaid claims and encounters, and information used for quality measurement. HIV SNP members are continually enrolled in care management. Members may require routine monitoring or may have episodes with acute needs during the year. To explore care management benefit to members in a continuous care management model, HIV SNP plans are directed to limit data in the CMART file to members with one or more acute episodes in the measurement year.

The Health Plan CMART is submitted annually to the DOH. This information documents the process of SNP-led care management services which includes:

- Acute/active episodes requiring care management
- Date acute/active episodes begin to receive care management
- For members with acute/active episodes begun in HIV SNP-led care management, CMART includes:
    - Start and end date of care management
    - Type of care management service received
    - Number of interventions
    - Type of interventions: letter, phone, in-person intervention

The Medicaid Data contains all claims and encounters data as well as demographics, diagnoses, etc. regarding HIV SNP members.

The Clinical DataMart is utilized to calculate quality measures consistent with Healthcare Effectiveness Data and Information Set (HEDIS©) quality measures from the National Committee for Quality Assurance (NCQA), and Prevention Quality Indicators (PQIs) from the Agency for Healthcare Research and Quality (AHRQ). PQIs can be used to identify potential problem areas in health care quality. These quality measures and quality indicators are used to better understand the quality of care provided to HIV SNP care management.

Limitations

The tables provided in this report are for comparison to the all-SNP rates/numbers only. These comparisons tell us many characteristics about the care managed recipients, however, the data does not tell us the reason(s) why the recipients are engaged in care

management program. Program variation between SNPs/programs limits the ability to compare one HIV SNP to another. SNPs differ in how care management services are carried out. Trends over time for a single plan may be useful, but because HIV SNPs can change their internal policies, discontinuities in the data may or may not reflect changes in practice. The variation in SNP-led care management programs may create differences in results that would not be apparent.

Measures

This report represents the HIV SNP population during 2015 and contains the following three sections.

- **Outreach:** Descriptive statistics and process measures for members contacted for acute/active care management services.
- **Engagement:** Descriptive statistics and process measures for members engaged in acute/active care management services.
- **Quality Measures:** Quality measures for members engaged in care management services at any point in the calendar year.

Outreach

HIV SNPs members are automatically enrolled in care management. Care managers typically monitor member health and needs via the telephone. When the care manager determines there are specific needs for the member, the acute/active episode is started. An episode is a distinct unit of acute/active care management with a begin date and an end date. The acute/active episodes that have a need for interventions are submitted on the DOH CMART.

Table 1 shows the population of the SNPs as of December 31, 2015, and the total number of care management acute/active episodes for the entire year of 2015.

Table 1: Acute/Active Episodes

SNP	Population	Total Episodes
Amida Care	6,067	169
MetroPlus SNP	4,939	3,622
VNSNY Choice Select Health	4,497	4,669
All SNPs	15,503	8,460

Once the care managers are aware that a member of a SNP has a need for an acute/active episode, the care manager contacts the member to verify the services needed. This is the outreach phase. Outreach is primarily conducted by phone, but there are examples when it is conducted in-person. Table 2 shows the percentage of SNP care management acute/active episodes in which the member was contacted and in what time frame.

Across all SNPs, more than half of outreach efforts end in a successful contact. Overall, almost half the successful contacts occur the same day the acute/active episode starts.

Table 2: Acute/Active Members Contacted

	Acute/ Active	Contacted Same Day		Contacted 1-30 Days		Contacted 31+ Days		Contacted Total	
		N	%	N	%	N	%	N	%
Amida Care	169	22	22	51	52	25	26	98	58
MetroPlus SNP	3,622	54	2	1,501	45	1,817	54	3,372	93
VNSNY Choice Select Health	4,669	2,742	100	0	0	0	0	2,742	59
All SNPs	8,460	2,818	45	1,552	25	1,842	30	6,212	73

Once the SNP contacts the member, the member may choose to engage in an acute/active care management episode or decline the offer. Table 3 shows the percentage of contacted members who engage in SNP-led care management services. Across all SNPs, over half the members who participate in SNP-led care management engage within a month of the acute/active episode start date.

Table 3: Contacted Members Engaged

	Contacted	Engaged Same Day		Engaged 1-30 Days		Engaged 31+ Days		Engaged Total	
		N	%	N	%	N	%	N	%
Amida Care	98	22	22	50	51	26	27	98	100
MetroPlus SNP	3,372	29	1	844	27	2,244	72	3,117	92
VNSNY Choice Select Health	2,742	2,742	100	0	0	0	0	2,742	100
All SNPs	6,212	2,793	47	894	15	2,270	38	5,957	96

Engagement

Members who are engaged in acute/active care management receive interventions. Services and referrals made to the member engaged in acute/active care management are based on an individualized plan of care.

A member may engage in acute/active care management more than one time during the measurement year; therefore, the member would have more than one episode during the measurement year. The annual files capture acute episodes that may span more than the measurement year and could be engaged for much more than a year.

Services offered to members within the care management programs will differ by SNP and by member needs. These differences impact the duration of engagement and the number of interventions provided to engaged members. Table 4 shows the mean number of days engaged in each acute/active care management episode and mean number of interventions per acute/active episode, stratified by the number of days to closure per each acute/active episode.

Table 4: Mean Number of Days Engaged and Interventions, by Episode Duration

	1-30 Days		31+ Days	
	Mean Days	Mean Interventions	Mean Days	Mean Interventions
AmidaCare	23.0	3.5	143.7	10.1
MetroPlus SNP	14.3	0.6	844.1	0.9
VNSNY Choice Select Health	16.0	6.7	181.9	12.4
All SNPs	15.9	6.3	311.3	10.0

The three SNPs vary in both the mean number of interventions and the mean length of the acute/active care management episodes. The variation is largely driven by differences in member's needs to successfully meet the goals of their care plan. One method used to determine the success of care management is to look at the reason the episode closed.

Table 5 shows the number of closed episodes by reason for closure.

Table 5: Reasons for Closure

	N	Percent
Met program goals	2,783	85
Disengaged from episode	232	7
Refused to continue	214	7
Lost to follow up	33	1

An episode that met program goals is considered a success. Table 6 shows the percentage of acute/active episodes which closed with program goals met by SNP.

Please note this does not include episodes that are not closed within the measurement year. There may be episodes which successfully meet goals and close in the subsequent year.

Table 6: Met Program Goals

	Percent
AmidaCare	2
MetroPlus SNP	2
VNSNY Choice Select Health	96
All SNPs	

Quality Measures

Quality measures and PQIs used to measure performance across HIV SNPs can be used to identify problems, opportunities for improvement, and obtain a baseline assessment of current practices. They are used as a first step to establishing performance benchmarks for the care management group. Table 7 shows the performance by engaged care management members for each of the quality measures. The measures in Table 7 are expressed as the percentage of members meeting the criteria for the quality measures.

Table 7: Quality Measures

Measure	Percent
Adult BMI Assessment (ABA)	84
Follow Up After Hospitalization for Mental Illness - 7 days (FUH)	37
Follow Up After Hospitalization for Mental Illness - 30 days (FUH)	50
Antidepressant Medication Management - Continuation Phase (AMM)	36
Initiation of Alcohol and Other Drug Dependence Treatment (IET)	48
Engagement of Alcohol and Other Drug Dependence Treatment (IET)	10

The measures in Table 8 are rates of potentially preventable hospitalizations for specific chronic conditions. These chronic conditions are prevalent for many of the members engaged in care management. The measures are expressed as the rate of events per 100,000 members.

Table 8: Prevention Quality Indicators Rate per 100,000 Enrollees

PQI	Rate
Diabetes Short-Term Complications Admission Rate (PQI #1)	132
Diabetes Long-Term Complications Admission Rate (PQI #3)	313
COPD or Asthma in Older Adults Admission Rate (PQI #5)	2,747
Hypertension Admission Rate (PQI #7)	66
Heart Failure Admission Rate (PQI #8)	594
Dehydration Admission Rate (PQI #10)	330
Bacterial Pneumonia Admissions Rate (PQI #11)	792
Urinary Tract Infection Admission Rate (PQI #12)	330
Uncontrolled Diabetes Admission Rate (PQI #14)	66
Asthma in Younger Adults Admission Rate (PQI #15)	833
Lower-Extremity Amputation among Patients with Diabetes Rate (PQI #16)	16

Utilization

Utilization of medical services is a major component of the total cost of health care. One of the goals of care management is to lower utilization cost by decreasing emergency department and inpatient use, while simultaneously increasing outpatient use. The utilization shift is expected to cost less and improve member outcomes. Tables 9 – 11 show the utilization rates of emergency department, inpatient care, and outpatient care for anytime during the calendar year that the acute/active episode occurred.

Emergency department utilization is defined as visits to the emergency department that do not transfer to an inpatient stay. Inpatient utilization is defined as hospitalizations in a calendar year. Outpatient utilization is defined as ambulatory visits to providers.

Table 9: Emergency Department Rates per 1,000 member years

SNP	Rate
AmidaCare	2,322
MetroPlus SNP	1,014
VNSNY Choice Select Health	830
All SNPs	954

Table 10: Inpatient Rates per 1,000 member years

SNP	Rate
AmidaCare	1,177
MetroPlus SNP	337
VNSNY Choice Select Health	622
All SNPs	476

Table 11: Outpatient Rates per 1,000 member years

SNP	Rate
AmidaCare	21,163
MetroPlus SNP	10,913
VNSNY Choice Select Health	13,732
All SNPs	12,319

Appendix

Definitions/Descriptions

Care Management Episode: The time from onset in an acute/active care management program to closure. One member may have multiple episodes in the same measurement year.

Outreach: Active offering of care management services for the acute/active episode to the member by the SNP program staff. Offering occurs through phone calls, letters, and in-person discussions with the member.

Contacted: An acute/active care management episode that was contacted by a SNP-administered care management program.

Engaged: A contacted acute/active care management episode members that engaged in a SNP-administered care management program.

Engagement Rate: Number of acute/active episodes that engaged during the measurement year divided by the number of acute/active episodes contacted.

Contacted Same Day Rate: Number of acute/active episodes contacted on the same day the acute/active episode began divided by the total number of acute/active episodes contacted.

Engaged Same Day Rate: Number of acute/active episodes engaged on the same day the acute/active episode began divided by the total number of acute/active episodes engaged.

Quality Measures

Improving Preventive Care

Adult BMI Assessment (ABA): Percent of members, with an outpatient visit, who had their BMI documented during the measurement year or the year prior to the measurement year.

Improving Outcomes for Persons with Mental Illness

Follow Up After Hospitalization for Mental Illness - 7 days (FUH): The percent of members who were seen on an ambulatory basis or who were in intermediate treatment with a mental health provider within 7 days of discharge.

Follow Up After Hospitalization for Mental Illness - 30 days (FUH): The percent of members who were seen on an ambulatory basis or who were in intermediate treatment with a mental health provider within 30 days of discharge.

Antidepressant Medication Management - Continuation Phase (180 days) (AMM): The percent of members who remained on antidepressant medication for at least six months.

Improving Outcomes for Persons with Substance Use Disorders

Initiation of Alcohol and Other Drug Dependence Treatment (IET): The percent of members who, after the first new episode of alcohol or drug dependence, initiated treatment within 14 days of the diagnosis.

Engagement of Alcohol and Other Drug Dependence Treatment (IET): The percent of members who, after the first new episode of alcohol or drug dependence, initiated treatment and had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

Prevention Quality Indicators; Reducing Avoidable Hospitalizations

Diabetes Short-Term Complications Admission Rate (PQI #1): Admissions for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 population; excludes obstetric admissions.

Diabetes Long-Term Complications Admission Rate (PQI #3): Admissions for a principal diagnosis of diabetes with long-term complications (renal, eye, neurological, circulatory, or complications not otherwise specified) per 100,000 population; excludes obstetric admissions.

COPD or Asthma in Older Adults Admission Rate (PQI #5): Admissions with a principal diagnosis of COPD or asthma per 100,000 population, ages 40 and older; excludes obstetric admissions.

Hypertension Admission Rate (PQI #7): Admissions with a principal diagnosis of hypertension per 100,000 population; excludes kidney disease combined with dialysis access procedure admissions, cardiac procedure admissions, and obstetric admissions).

Heart Failure Admission Rate (PQI #8): Admissions with a principal diagnosis of heart failure per 100,000 population; excludes cardiac procedure admissions and obstetric admissions.

Dehydration Admission Rate (PQI #10): Admissions with a principal diagnosis of dehydration per 100,000 population; excludes obstetric admissions.

Bacterial Pneumonia Admissions Rate (PQI #11): Admissions with a principal diagnosis of bacterial pneumonia per 100,000 population; excludes sickle cell or hemogobin-5 admissions, other indications of immunocompromised state admissions, and obstetric admissions.

Urinary Tract Infection Admission Rate (PQI #12): Admissions with a principal diagnosis of urinary tract infection per 100,000 population; excludes kidney or urinary tract disorder admissions, other indications of immunocompromised state admissions, and obstetric admissions.

Uncontrolled Diabetes Admission Rate (PQI #14): Admissions for a principal diagnosis of diabetes without mention of short-term (ketoacidosis, hyperosmolarity, or coma) or long-term (renal, eye, neurological, circulatory, or other unspecified) complications per 100,000 population; excludes obstetric admissions.

Asthma in Younger Adults Admission Rate (PQI #15): Admissions for a principal diagnosis of asthma per 100,000 population, ages 18 to 39 years; excludes admissions with an indication of cystic fibrosis or anomalies of the respiratory system and obstetric admissions.

Lower-Extremity Amputation among Patients with Diabetes Rate (PQI #16): Admissions for any-listed diagnosis of diabetes and any-listed procedure of lower-extremity amputation per 100,000 population; excludes any-listed diagnosis of traumatic lower-extremity amputation admissions, toe amputation admissions, and obstetric admissions.

Reducing Utilization Associated with Avoidable IP stays and ED visits

Ambulatory Care - Emergency Department (AMB-ED): Utilization of ambulatory care ED visits per 1,000 member years. Does not include mental health- or chemical dependency-related services.

Ambulatory Care - Outpatient (AMB-OP): Utilization of ambulatory care OP visits per 1,000 member years. Does not include mental health- or chemical dependency-related services.

Inpatient Utilization (IPU): Utilization of total acute inpatient stays per 1,000 member years. Does not include mental health- or chemical dependency-related inpatient stays.