Special Needs Plan Model Of Care Annual Evaluation

Life Improvement Plan
CompleteCare

2019 Review

 © 2020 HF Management Services, LLC

Overview

Healthfirst's Special Needs Plan Model of Care is a collaborative process of assessing, planning and facilitating care coordination, evaluation and advocacy for options and services to meet the comprehensive medical, behavioral health, and psychosocial needs of the member, all while promoting quality and improving member's health.

The Healthfirst Model of Care metrics are implemented and monitored in compliance with:

- Chapter 5 and Chapter 16b of the CMS Medicare Managed Care Manual
- Individual CMS-approved Model of Care

Annually, Healthfirst senior management and clinical leadership set targets for the performance of the individual CMS approved Model of Care goals. Model of Care committee members monitor trends and act on indices that determine if measurable outcomes for the Model of Care targets are being met. When targets are not met, root cause analysis and process evaluation are performed; changes are implemented as needed.

© 2020 HF Management Services, LLC

Healthfirst Model of Care Goals

The goals and health outcomes of the Model of Care used to improve the health care needs of Healthfirst Life Improvement Plan and CompleteCare members are:

- Improve access to essential and affordable medical, mental health, long term care and social services;
- To improve coordination of care through targeted care management activities;
- To improve seamless transitions of care across healthcare settings, providers and health services;
- To improve access to preventive health services;
- To assure appropriate utilization of services;
- To improve beneficiary health outcomes across the continuum of care; and
- Reduce avoidable admissions & maintaining the member in optimal health status in the community.

© 2019 HF Management Services, LLC
healthfirst®
Health Insurance for New Yorkers

Life Improvement Plan 2019 Summary

2019 Highlights

- 47% Life Improvement Plan Model of Care **Metrics improved** from 2018
- All Life Improvement Plan Model of Care metrics met in 2019

Metric Groups	# metrics / category	2018 Rate Comparison		
		No Change	Improved	Declined
Clinical Care	3	1	2	0
Vaccines	2	1	1	0
Screenings	3	0	3	0
Access to Care	6	4	2	0
Pharmacy	3	0	0	3
Total	17	6	8	3
	%	35%	47%	18%

© 2020 HF Management Services, LLC

Life Improvement Plan: Targets Met

Metric Category	Measure	2019 Goal	2019 Result	2018 Rate & Year to Year Comparison
Clinical Care	Emergency Room utilization per 1000 members per year	669	656	657 (0%)
	Hospital Admission per 1000 members per year	345	337	347 (-3%)*
	Potentially Preventable Readmission Rate	14%	10%	12% (-15%)*

*Clinical Care: % decline = improvement

Metric Category	Measure	2019 Goal	2019 Result	2018 Rate & Year to Year Comparison
Vaccines	Flu	69%	69%	69% (0%)
	Pneumonia	56%	58%	59% (-1%)
Screenings	Breast cancer screening	81%	82%	81% (+1%)
	Colorectal cancer Screening	70%	73%	72% (+2%)
	Bone Density Check	56%	63%	46% (+38%)

© 2020 HF Management Services, LLC
healthfirst Health Insurance for New Yorkers

Life Improvement Plan: Targets Met

Metric Category	Measure	2019 Goal	2019 Result	2018 Rate & Year to Year Comparison
Access to Care	Members 20 - 44 years with access to ambulatory care in calendar year	94%	94%	94% (0%)
	Members 45 - 64 years with access to ambulatory care in calendar year	97%	98%	98% (0%)
	Members 65+ years with access to ambulatory care in calendar year	97%	97%	97% (0%)
	Members with diabetes) who had medical attention for nephropathy	96%	96%	96% (0%)
	Members with PCP visit during calendar year	91%	93%	91% (+2%)
	Members visiting PCP within 30 days following an ER visit	57%	59%	57% (+3%)

Metric Category	Measure	2019 Goal	2019 Result	2018 Rate & Year to Year Comparison
Pharmacy	Possession of Cholesterol Medication	79%	82%	87% (-5%)
	Possession of Hypertension Medication	84%	85%	89% (-4%)
	Possession of Diabetic Medication	84%	87%	89% (-3%)

© 2020 HF Management Services, LLC

healthfirst®
Health Insurance for New Yorkers

Life Improvement Plan Best Practices

- Developed a standardized approach to transitions of care including admission notification, readmission risk scoring, discharge planning and post-discharge care coordination including PCP follow-up, medication review and education on readmission prevention.
- Community Health Coordinators collaborated with pharmacy to perform targeted calls and home visits to support medication adherence.
- Community Health Coordinators collaborated with Clinical Quality to perform targeted calls and home visits to support members in completing bone density exams.

© 2020 HF Management Services, LLC

healthfirst®
Health Insurance for New Yorkers

CompleteCare 2019 Summary

2019 Highlights

- 40 % CompleteCare Model of Care **Metrics improved** from 2018
- All CompleteCare Model of Care metrics met in 2019

Metric Groups	# metrics / category	2018 Rate Comparison		
		No Change	Improved	Declined
Clinical Care	3	1	1	1
Vaccines	2	1	0	1
Screenings	3	0	3	0
Access to Care	6	4	2	0
Pharmacy	3	1	0	2
Assessment & Outreach	3	1	2	0
Total	20	8	8	4
	%	40%	40%	20%

healthfirst® Health Insurance for New Yorkers

CompleteCare: Targets Met

Metric Category	Measure	2019 Goal	2019 Result	2018 Rate & Year to Year Comparison
Clinical Care	Emergency Room utilization per 1000 members per year	1004	873	825 (+5%)
	Hospital Admission per 1000 members per year	655	638	649 (0%)
	Potentially Preventable Readmission Rate	14%	11%	13% (-13%)*

*Clinical Care: % decline = improvement

Metric Category	Measure	2019 Goal	2019 Result	2018 Rate & Year to Year Comparison
Vaccines	Flu	81%	81%	82% (-1%)
	Pneumonia	84%	84%	84% (0%)
Screenings	Breast cancer screening	82%	88%	83% (+7%)
	Colorectal cancer Screening	74%	83%	77% (+7%)
	Bone Density Check	42%	68%	69% (+2%)

© 2020 HF Management Services, LLC

healthfirst®
Health Insurance for New Yorkers

CompleteCare: Targets Met

Metric Category	Measure	2019 Goal	2019 Result	2018 Rate & Year to Year Comparison
Access to Care	Members 20 - 44 years with access to ambulatory care in calendar year	100%	100%	100% (0%)
	Members 45 - 64 years with access to ambulatory care in calendar year	100%	100%	100% (0%)
	Members 65+ years with access to ambulatory care in calendar year	100%	100%	100% (0%)
	Members with diabetes) who had medical attention for nephropathy	96%	97%	96% (+1%)
	Members with PCP visit during calendar year	96%	96%	95% (+2%)
	Members visiting PCP within 30 days following an ER visit	65%	70%	70% (0%)

Metric Category	Measure	2019 Goal	2019 Result	2018 Rate & Year to Year Comparison
Pharmacy	Possession of Cholesterol Medication	80%	85%	89% (-3%)
	Possession of Hypertension Medication	85%	88%	88% (-2%)
	Possession of Diabetic Medication	86%	89%	89% (0%)

© 2020 HF Management Services, LLC

healthfirst®
Health Insurance for New Yorkers

CompleteCare: Targets Met

Metric Category	Measure	2019 Goal	2019 Result	2018 Rate & Year to Year Comparison
Assessment & Outreach	Members assigned to a care manager within 30 days of enrollment	98%	98%	98% (0%)
	Members outreached within 30 days of enrollment	95%	98%	95% (+2%)
	Members with monthly outreach	92%	100%	92% (+9%)

© 2020 HF Management Services, LLC

healthfirst
Health Insurance for New Yorkers

CompleteCare Best Practices

- The Monthly Outreach Assessment was updated in November 2019 to provide improved tracking of grievances and service requests and to ensure a follow-up action is taken anytime a grievance or service request is identified.
- Person Centered Service Plan (PCSP) Problem, Goal and Action (PGA) mapping was enhanced in 2019 and continues to be updated ongoing to ensure all issues identified in the Health Risk Assessment are addressed and outcomes are measurable.
- Tableau dashboard enhancements for staff performance tracking to align with Model of Care metrics. (e.g. PCSP timeliness and Transitions of Care).
- Health Information Exchange (HIE) leveraged for identification of Transitions, notification of admission and discharge.

© 2020 HF Management Services, LLC

Regulatory Requirements

42 CFR § 422.101(f)(1)(i)
Medicare Managed Care Manual, Chapter 5, section 20.2.2, MOC 2, Element B
Administer initial Health Risk Assessments (HRAs) to beneficiaries and comprehensive annual reassessments within 12 months of the last annual HRA.

42 CFR § 422.101(f)(1)(ii)
Medicare Managed Care Manual, Chapter 5, Section 20.2.2, MOC 2, Element C, Factor 1

Requirement	Life Improvement Plan	Life Improvement Plan / Senior Health Partners	CompleteCare
Initial Health Risk Assessment (HRA)	99.64%	N/A	100%
Timely Reassessment HRA	100%	58.7%*	55.4%*
Interdisciplinary Care Plans (ICPs)	91.06%	100.%**	93.4%**

Life Improvement Plan - HRA and ICP CAPs implemented in 2019. HRA CAP closed in 2019. ICP CAP is under review.
Life Improvement Plan / Senior Health Partners -N/A initial HRA (UAS) information not available for this population.
CompleteCare and Life Improvement Plan / Senior Health Partners
*HRA tracking methodology changed January – July 2019. HRA rates accepted tracking methodology implemented August 2019-December 2019 (UAS due and completed that month/UAS due that month).
**ICPs include all of 2019

© 2020 HF Management Services, LLC
healthfirst Health Insurance for New Yorkers

Clinical Support Operations Best Practices

- Create and maintain operational reporting that comprehensively represents Special Needs Plan Model of Care Health Risk Assessments and associated Individual Care Plans for all Life Improvement Plans members. Evaluate and up-date existing reporting, as needed.
- Monitor vendor performance against Service Level Agreements (SLAs) requirements and implement necessary operational processes when appropriate to assure overall compliance.

© 2020 HF Management Services, LLC