

# Medicaid Care Management Quality Program Update: How Does Data Inform Quality Improvement?

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Presentation for the Medicaid Care Management Commission  
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# Agenda

- Overview of MCM Quality Program
- Key Indicators Report
  - How This Report is Used
- Quality In Action at the Health Plans
  - New Hampshire Healthy Families
  - Well Sense

# Overview of Quality Program

- Department of Health and Human Services
- External Quality Review Organization
  - Health Services Advisory Group, Inc (HSAG)
- Managed Care Organizations
- National Committee for Quality Assurance (NCQA)

# DHHS

- Tools
  - Measure review
  - Review and approval plans, reports and policies
  - Surveys
  - Projects
  - Focus Groups
- Turning data into action

# EQRO

- Validation of MCO performance improvement projects
- Validation of MCO performance measures
- Review of MCO compliance with the quality strategy/contract
- Validation of encounter data
- Validation or administration of provider and/or provider surveys
- Validation or administration of performance measures
- Performance improvement projects
- Focused studies

# MCO

- Quality Assurance and Improvement Plan (QAPI)
- Measures, Plans, Reports
- Surveys (member and providers)
- Consumer and Provider Advisory Boards
- Performance Improvement Projects
- Appeals and Grievances
- National Committee for Quality Assurance (NCQA) Accreditation

# Review of April Key Indicators Report

- Access and Use of Care
- Customer Experience of Care
- Provider Service Experience
- Utilization Management
- Grievances and Appeals
- Preventative Care
- Chronic Medical Care
- Behavioral Health Care
- Substance Use Disorder Care
- General

# Access to Care

- Access and Use of Care includes key indicators in the following areas:
  - Provider Network (2 measures)
  - Non-Emergent Medical Transportation (2 measures)
  - Ambulatory Care including Emergency Care (3 measures)
  - Inpatient Care (2 measures)

# Figure 1-1: Member Request for Assistance Accessing Providers

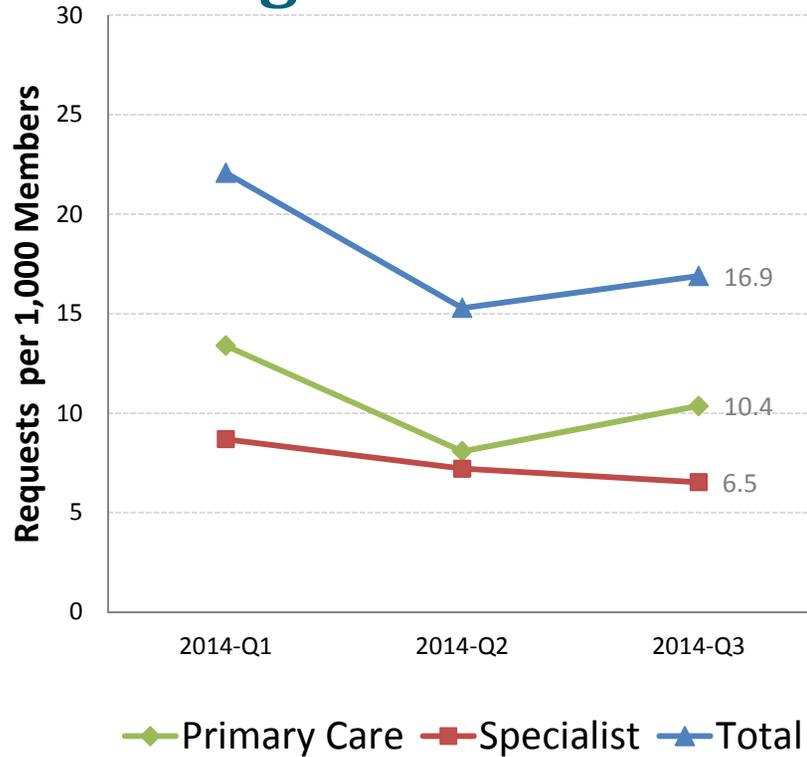
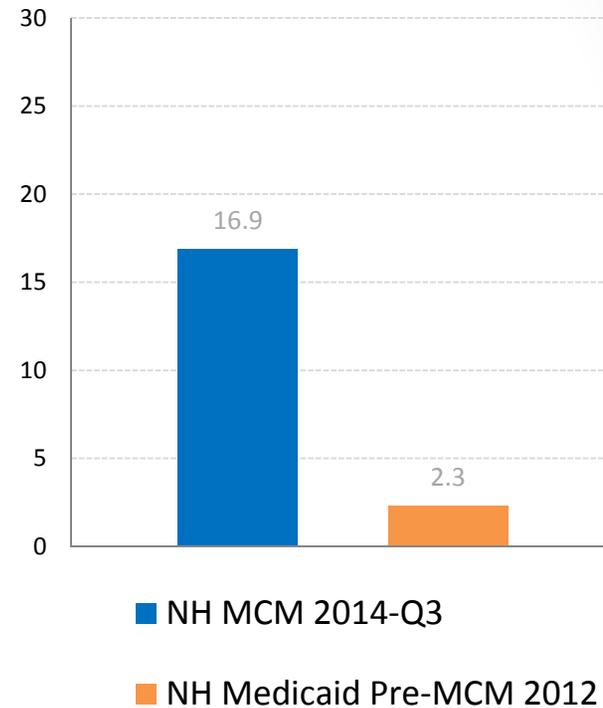


Chart unchanged from last month's report.



**Description:** Access to care is an important first step in meeting health care needs. A high volume of calls requesting assistance accessing providers could indicate problems with a provider network. This measure describes members requesting help finding and getting appointments for doctors, divided by the number of members. Multiple requests by a single member are all individually counted in the rate. The rate is shown per 1,000 members. For example, a rate of 11 specialists would indicate that out of every 1,000 members there were 11 individual requests for assistance in accessing a specialist.

**Frequency:** Reported quarterly, available approximately 3 months after end of the quarter.

# Figure 1-7: Emergency Department Visits

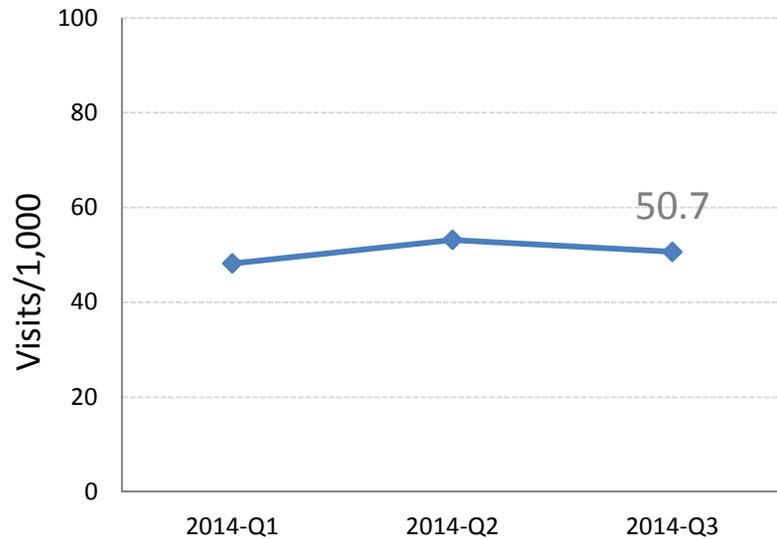
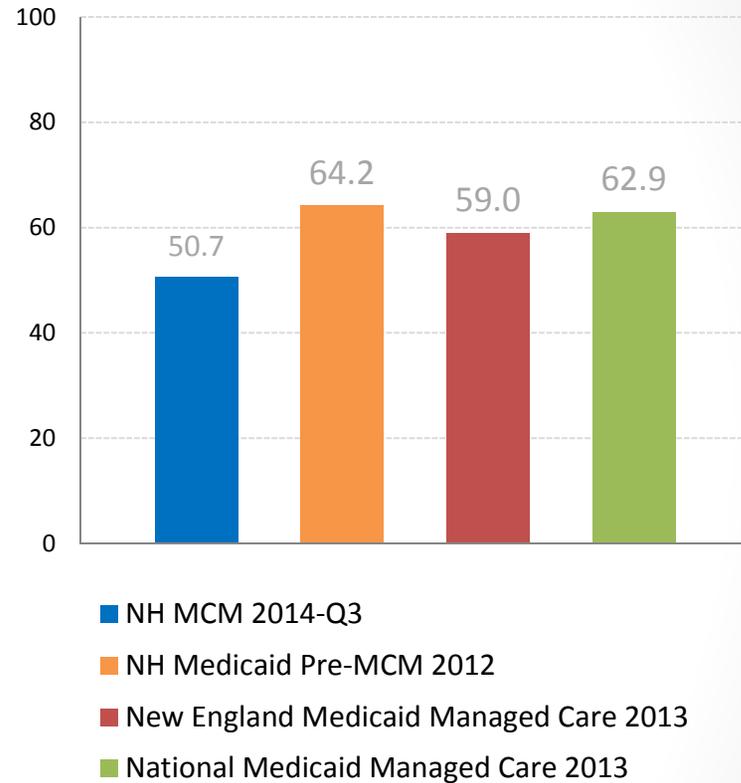


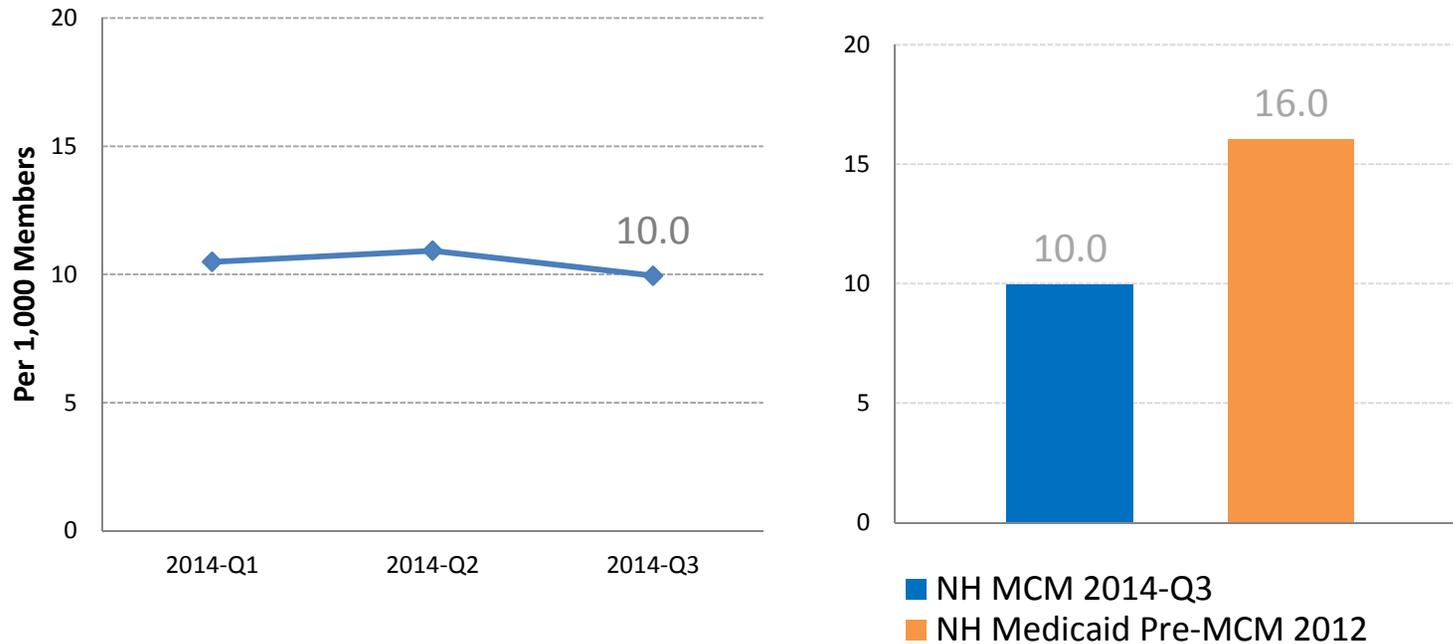
Chart unchanged from last month's report



**Description:** Measuring emergency department visits is a standard industry approach to better understand the use of emergency departments. This measure describes the number of emergency department visits, divided by the number of member months. The result is a quarterly rate of visits per 1,000 member months. Member months are a count of how many months each member was in the managed care program. A member who was in for the full quarter would add 3 member months to the total; a member who was in the program for 1 month would add only 1 month to the total. The denominator is divided by 1,000 to calculate a rate that can be more easily compared.

**Frequency:** Reported quarterly, available approximately 5 months after end of the quarter.

## Figure 1-8: Emergency Department Visits Potentially Treatable by Primary Care



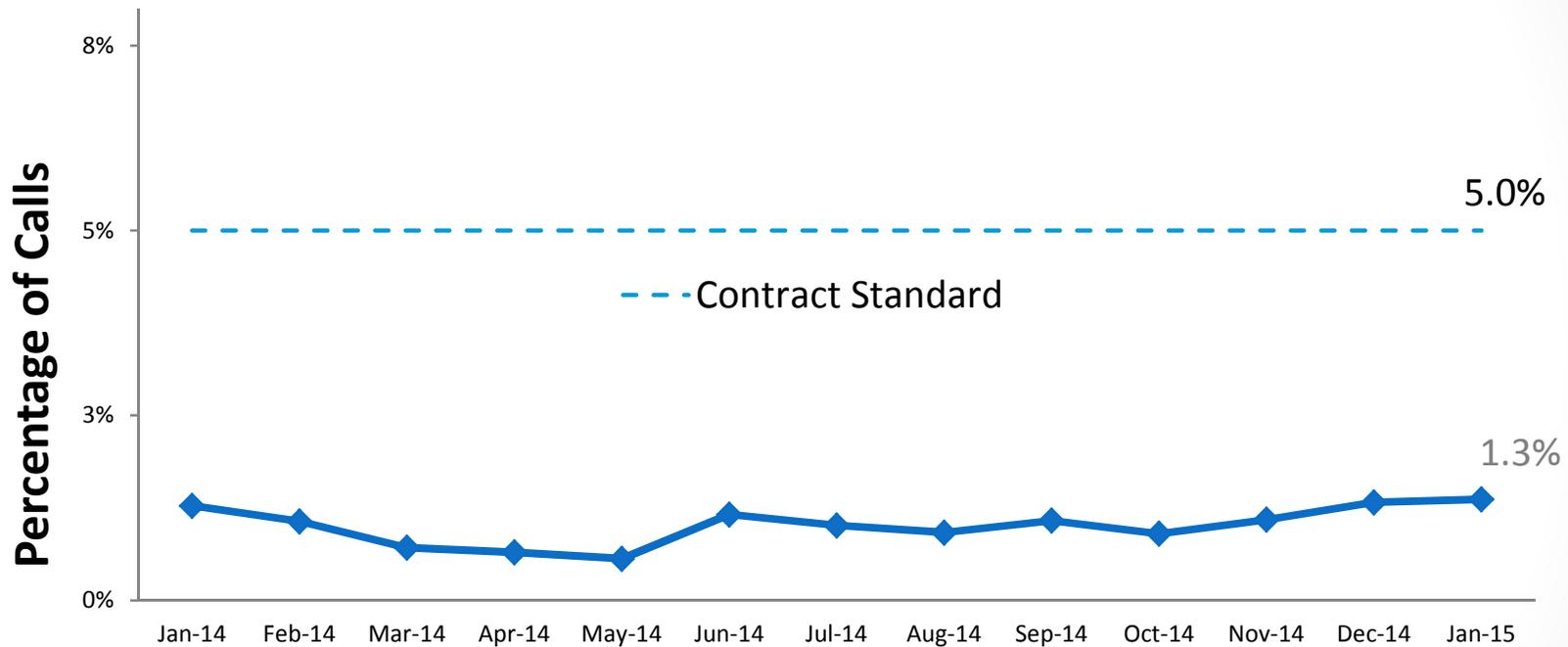
**Description:** The Emergency Department is not the best setting for primary care health services. A high or increasing number of visits could indicate that members are having difficulty accessing primary care services. **This measure describes emergency department visits for reasons that might have been managed in a doctor's office** (for example, colds, rashes, etc.), divided by the number of member months. The result is a quarterly rate of visits per 1,000 member months. Member months are a count of how many months each member was in the managed care program. A member who was in for the full quarter would add 3 member months to the total; a member who was in the program for 1 month would add only 1 month to the total. The denominator is divided by 1,000 to calculate a rate that can be more easily compared.

**Frequency:** Reported quarterly, available approximately 5 months after end of the quarter.

# Customer Experience of Care

- Customer Experience of Care includes key indicators in the following areas:
  - Member Communications (2 measures)
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS) – (Report)

## Figure 2-2: Member Communications: Calls Abandoned



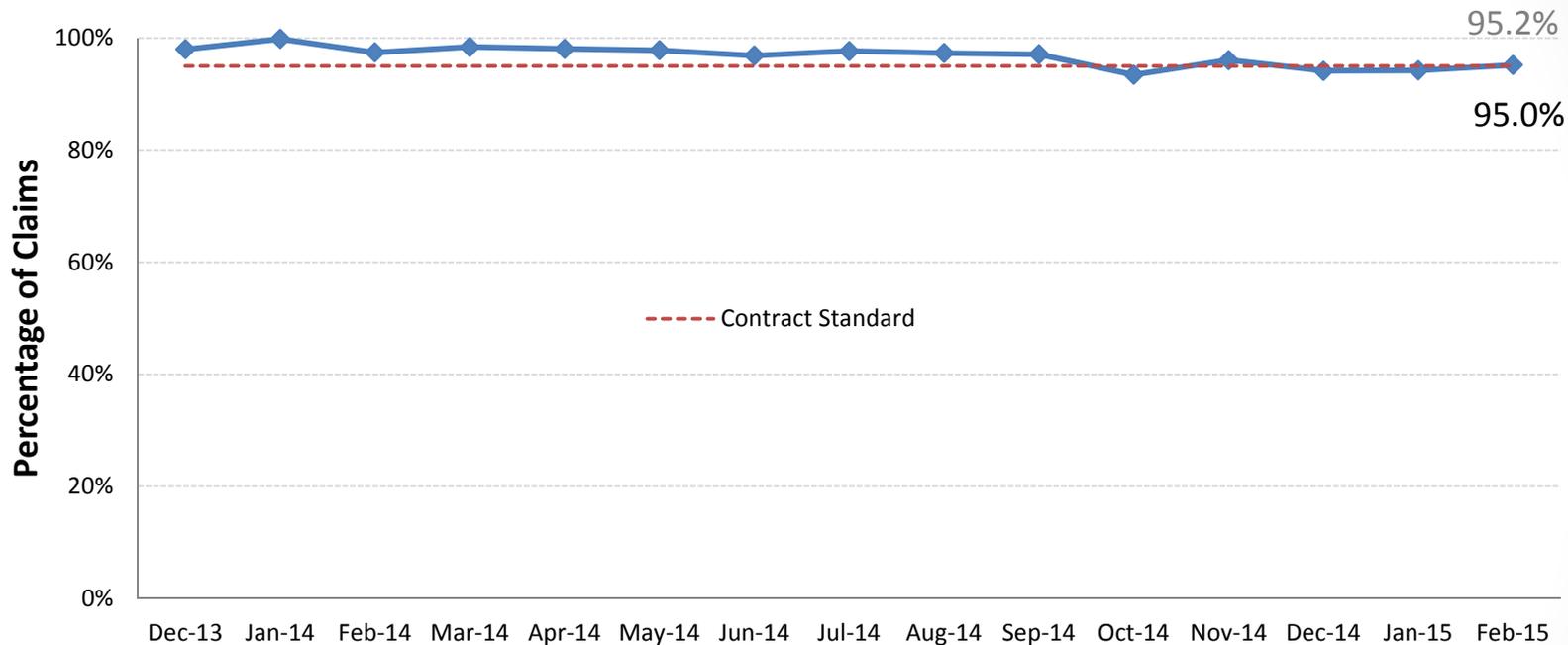
**Description:** Minimizing the number of calls that are abandoned is an important component of customer experience of care. A rising percentage of calls abandoned could indicate problems within a call center. The MCM contract standard for this measure is less than 5% of calls are abandoned. This measure describes the number of calls from a member to their MCO that were abandoned, divided by the number total number of calls, as a percentage.

**Frequency:** Reported monthly, available approximately 2 months after end of the month.

# Provider Service Experience

- Provider Service Experience includes key indicators in the following areas:
  - Claims Processing (4 measures)
  - Provider Call Center (2 measures)
  - Provider Satisfaction Survey (Report)

# Figure 3-1: Professional and Facility Claims Processed in 30 Days



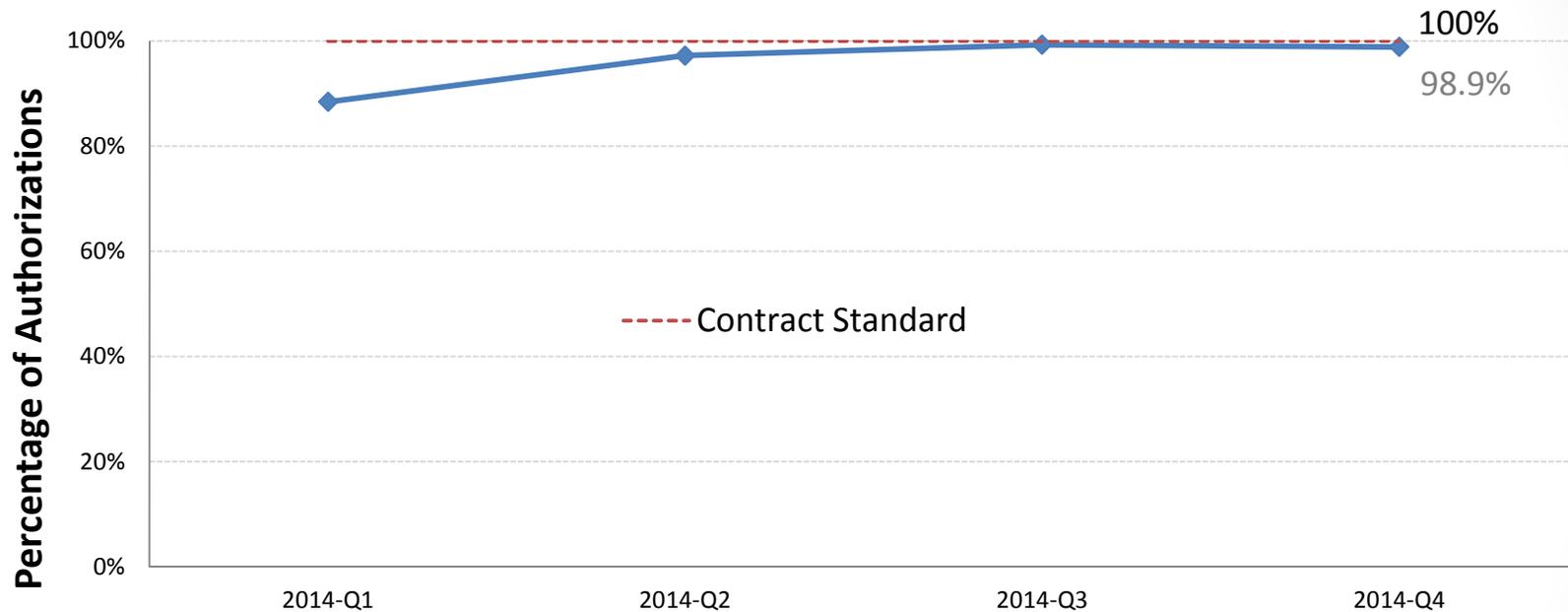
**Description:** Paying claims within 30 days is an important component of a good provider service experience. Claims must be “clean” of any inaccuracies in order to pay. A falling number of claims processed within 30 days could impact how quickly providers receive payment. The MCM contract standard for this measure is 95%. This measure describes the number of claims paid or denied in the month, divided by the number of claims received in the month, as a percentage.

**Frequency:** Reported monthly, available approximately 2 months after end of the month.

# Utilization Management

- Utilization Management includes key indicators in the following areas:
  - Service Authorization Processing (3 measures)
  - Service Authorization Determination (1 table)
  - Pharmacy Utilization Management (1 measure)

# Figure 4-3: Pharmacy Service Authorization Processing Rate



Description: When pharmacy services requiring prior authorization are needed, a service authorization decision must be made within 24 hours. Longer times for authorization may contribute to member difficulties getting needed or timely care. This measure describes the number of pharmacy authorizations, both approved and denied, divided by the total number of pharmacy authorization requests received, as a percentage. The contract standard is 100%.

Frequency: Reported quarterly, available approximately 3 months after end of the quarter.

# Grievances and Appeals

- Grievances and Appeals include key indicators in the following areas:
  - Counts of Grievances and Appeals (1 measure, 1 table)
  - Processing Timeframes (4 measures)

## Figure 5-2: Number of Appeals

	2014 Q1	2014 Q2	2014 Q3	2014 Q4
All Services	275	463	360	310
Services				
Inpatient Admissions	15	7	11	26
Outpatient Hospital	4	6	2	16
Physician Services	26	15	40	20
PT/OT/ST Therapies	26	21	22	22
<b>Pharmacy</b>	<b>171</b>	<b>375</b>	<b>243 ↓</b>	<b>184 ↓</b>
Other	19	29	30	30

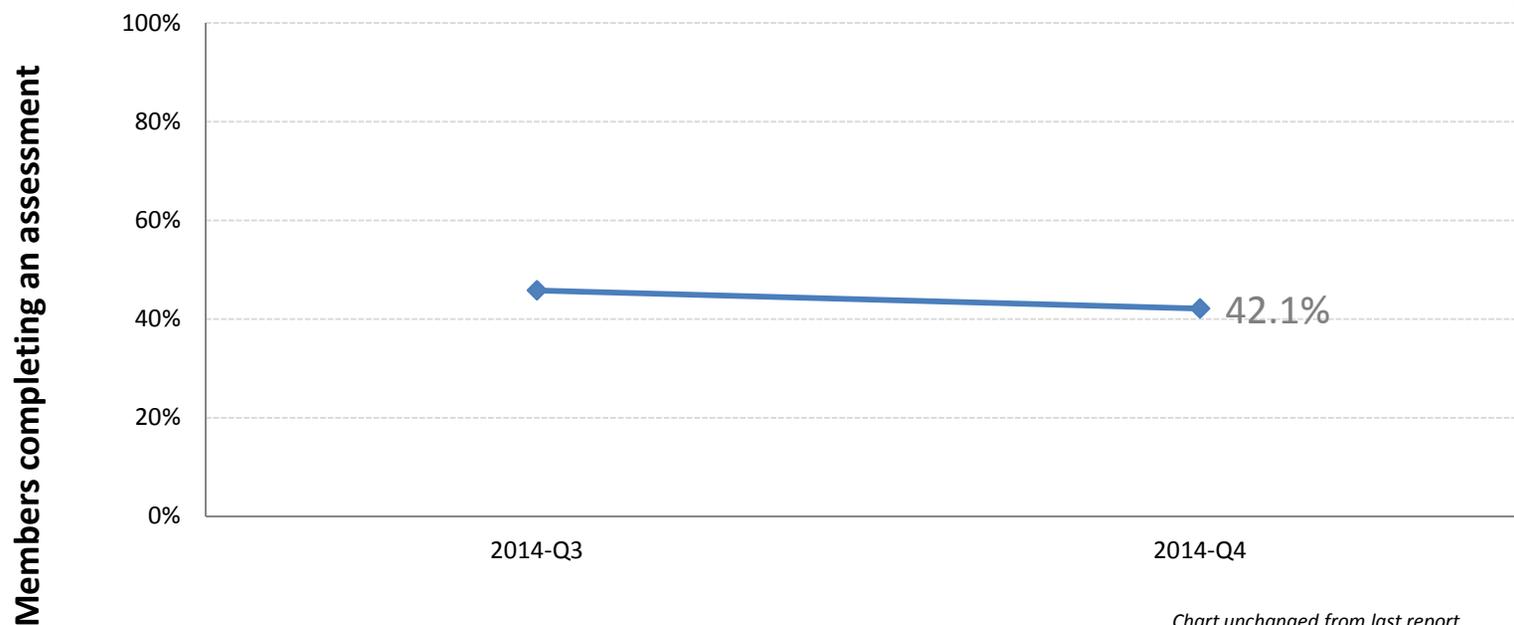
Description: Measuring the number of service authorization appeals by type of health care service is a standard industry approach to better understand health care services utilization. A rising number of appeals could indicate difficulties with utilization management or access to health care services. This measure counts the total number of appeals received, by selected categories of service, and the total of all appeals received.

Frequency: Reported quarterly, available approximately 2 months after end of the quarter.

# Preventive Care

- Preventive Care includes key indicators in the following areas:
  - Prevention Assessment (1 measure)
  - Healthcare Effectiveness Data and Information Set (HEDIS) Preventive Care Measures (81 measures, Summer 2015)

## Figure 6-1: Health Risk Assessment Completed for Members with Chronic Conditions



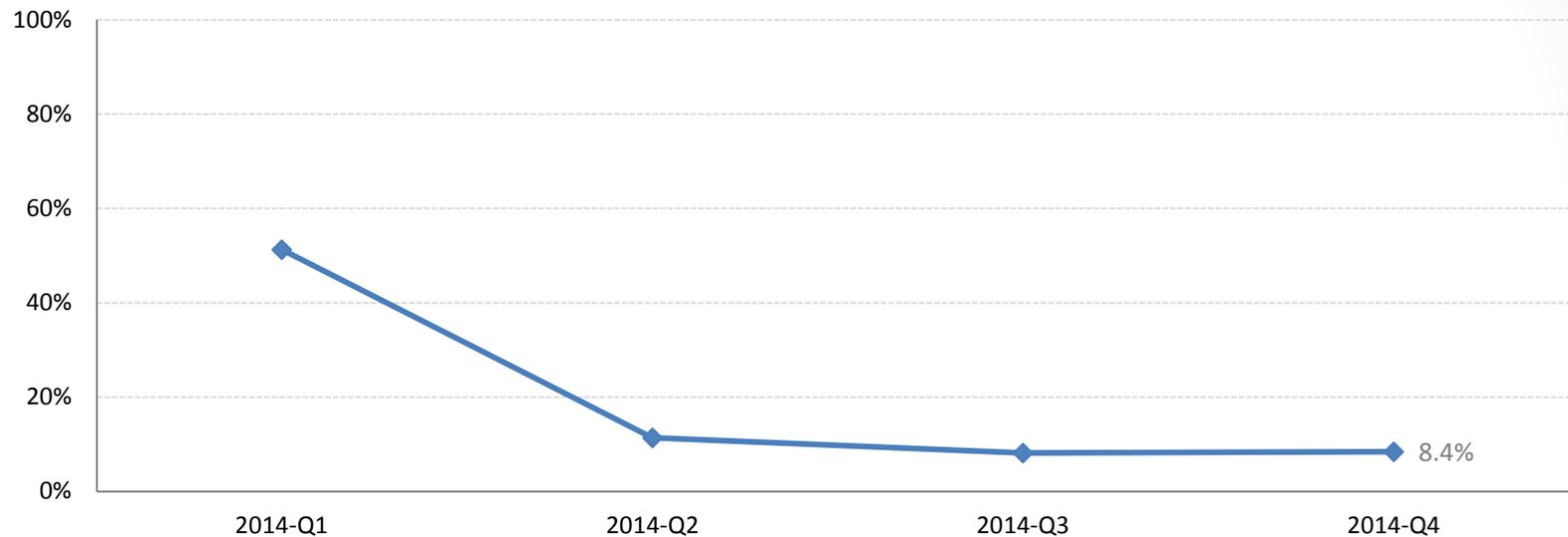
**Description:** Health risk assessments help a health plan understand what medical services a member with chronic conditions may need. Health risk assessments are helpful in identifying and addressing gaps in preventive services. A low or falling number of health risk assessments completed could contribute to missed opportunities to provide preventive care for members with chronic conditions. This measure counts the percentage of health risk assessments completed in the last 12 months for members with chronic conditions.

**Frequency:** Reported quarterly, available approximately 2 months after end of the quarter.

# Chronic Medical Care

- Chronic Medical Care includes key indicators in the following areas:
  - Pharmacy Services (2 measures)
  - Healthcare Effectiveness Data and Information Set (HEDIS) Chronic Care Measures (81 measures, Summer 2015)

# Figure 7-1: Maintenance Medication Gaps



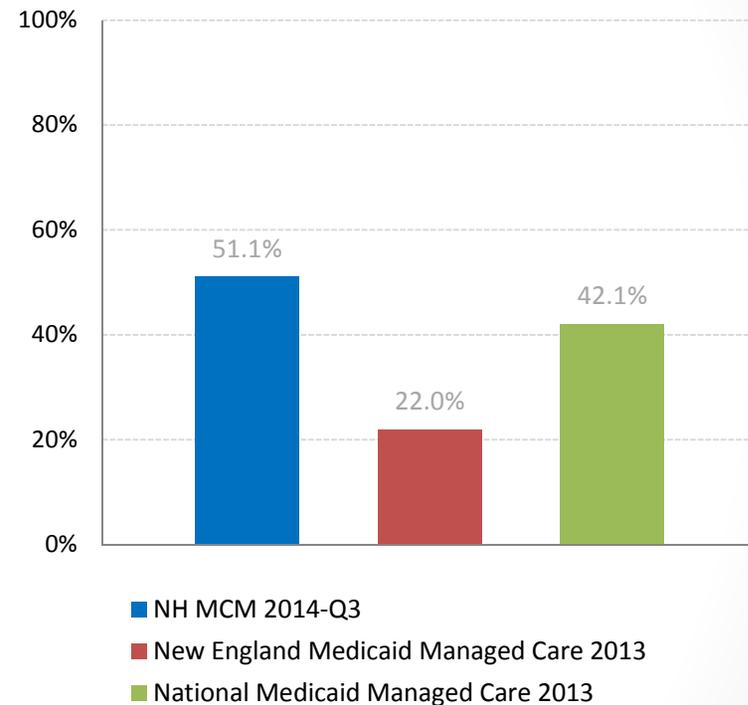
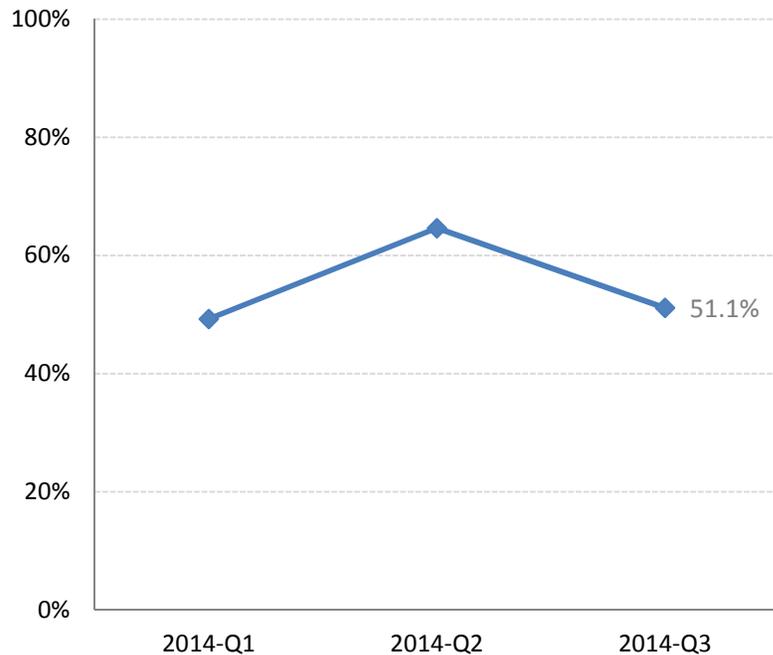
Description: Missing medication doses can contribute to poor health. A rising number of missed doses may indicate greater risk for adverse health outcomes. **This measure describes the number of maintenance medications with gaps greater than 20 days between refills**, divided by the number of members on maintenance medications, as a percentage. Maintenance medications are drugs that a member takes for longer than 120 days.

Frequency: Reported quarterly, available approximately 6 months after end of the quarter.

# Behavioral Health Care

- Behavioral Health Care includes key indicators in the following areas:
  - New Hampshire Hospital Discharges (2 measures)
  - Behavioral Health Survey (Report, Summer 2015)

# Figure 8-1: New Hampshire Hospital Members with Follow-up Appointment 7 Calendar Days Post Discharge



**Description:** A follow appointment within 7 days of discharge from a New Hampshire Hospital can help ensure that a member continues to improve and stays well after discharge. A low or falling number of follow up appointments within 7 days could indicate that better discharge planning is needed. This measure describes the number of adult members who were discharged from New Hampshire Hospital and followed-up with a provider within 7 days of discharge, divided by the total number of members discharged from New Hampshire Hospital, as a percentage.

**Frequency:** Reported quarterly, available approximately 3 months after end of the quarter.

# Figure 8-2: Readmission to New Hampshire Hospital at 30 days -Excluding New Hampshire Health Protection Program (NHHPP) Members

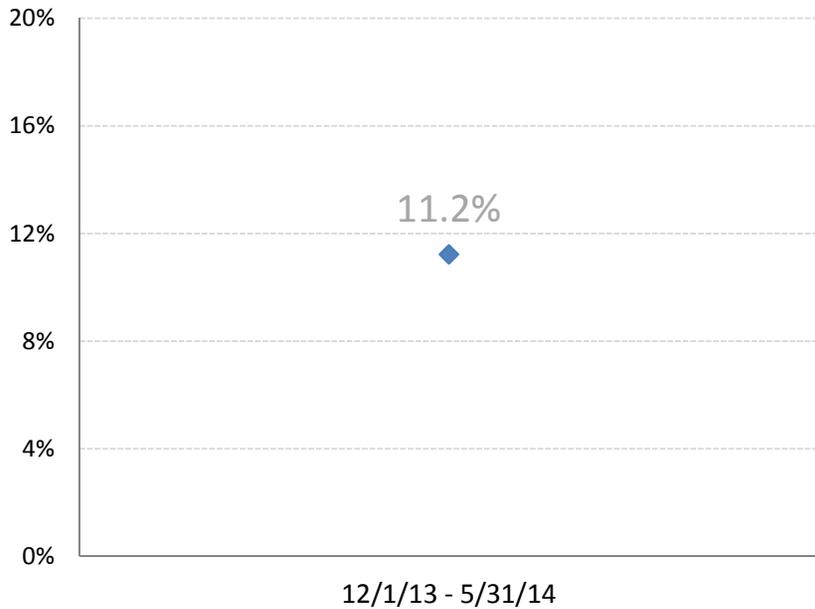
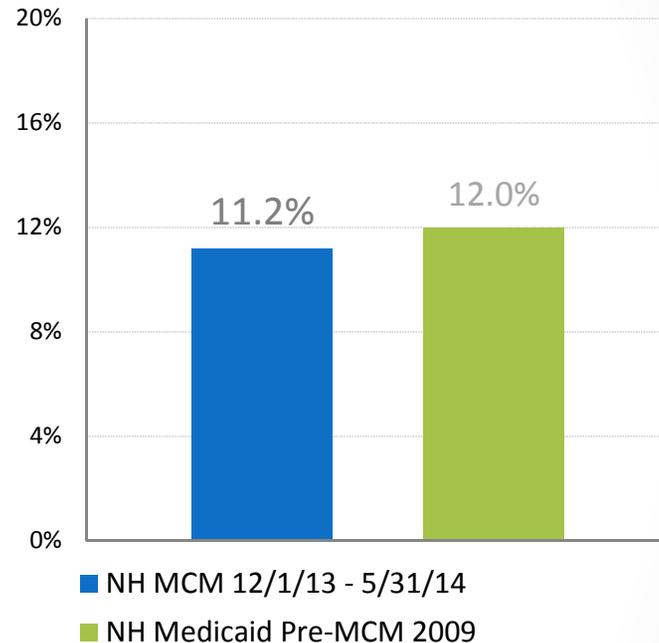


Chart unchanged from last report.



**Description:** Hospital readmissions can be an indication of avoidable difficulties transitioning from a hospital to an outpatient care setting. A high or increasing number of readmissions could indicate that better discharge planning is needed. This measure describes the number of adult members who were readmitted to New Hampshire Hospital within 30 days, divided by the total number of members discharged from New Hampshire Hospital, as a percentage.

**Frequency:** Reported **annually**, available approximately 3 months after end of the state fiscal year.

# Substance Use Disorder

- Substance Use Disorder Services Users and Utilization
  - Overall Rate of Any SUD Service
  - Outpatient Counseling
  - Medically Monitored Withdrawal
  - Opioid Treatment Center
  - Use of Buprenorphine
  - Partial Hospitalization
  - Intensive Outpatient Treatment
  - Inpatient Withdrawal
  - Rehabilitation
  - Mobile Crisis Intervention
  - Office Based Crisis Intervention
- Under data collection

# General

- The General domain includes key indicators in the following area:
  - External Quality Review Organization (EQRO) Technical Report (Report)

# Data Into Information

- Three examples:
  - Grievances and Appeals
  - Transportation
  - Pharmacy Service Authorizations

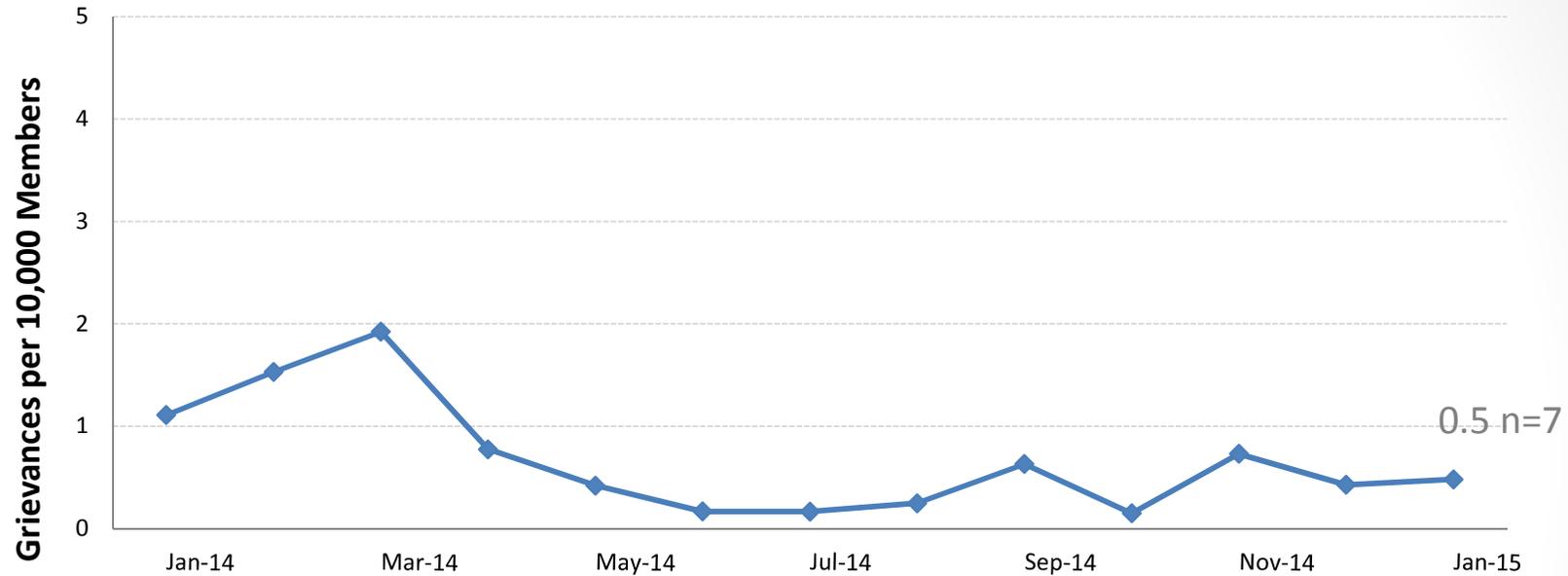
# Grievance and Appeals

- Grievance
  - “Grievance” means an expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member’s rights (42 CFR 438.400(b)).
  - Plain English: complaint
- Appeal
  - “Appeal” means a request for review of an action as described in this Agreement (42 CFR 438.400(b)).
  - Plain English: a response to a denied service

# Grievances

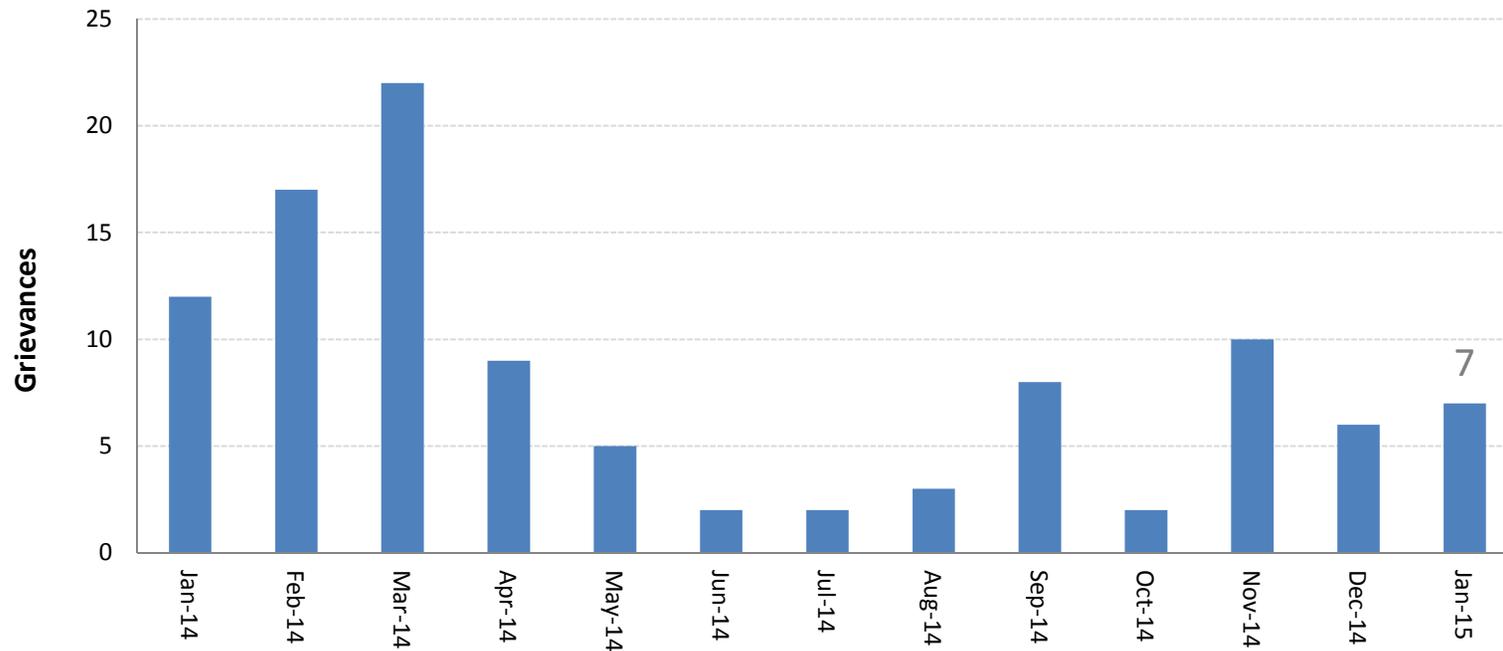
- What do we need to know
  - Beneficiaries needs a place to go when they are dissatisfied
  - Are there any early warning signs, either in the number or an single but serious event, that might first appear as grievances?
- Measures
  - Grievances (Volume of grievances)
  - Grievance Dispositions Made in 45 Calendar Days
  - Grievance log

## Figure 5-1: Grievances



Description: Grievances are counted when a member contacts the health plan with a concern or complaint. An increasing number of grievances, or a single serious grievance, could indicate that additional health plan attention is needed. This measure counts the total number of grievances received. The rate is shown per 10,000 members. For example, a rate of 1 grievance would indicate that out of every 10,000 members there was 1 individual filing of a grievance.

# Figure 5-1: Grievances



Description: Grievances are counted when a member contacts the health plan with a concern or complaint. An increasing number of grievances, or a single serious grievance, could indicate that additional health plan attention is needed. This measure counts the total number of grievances received each month.

Frequency: Reported monthly, available approximately 2 months after end of the month.

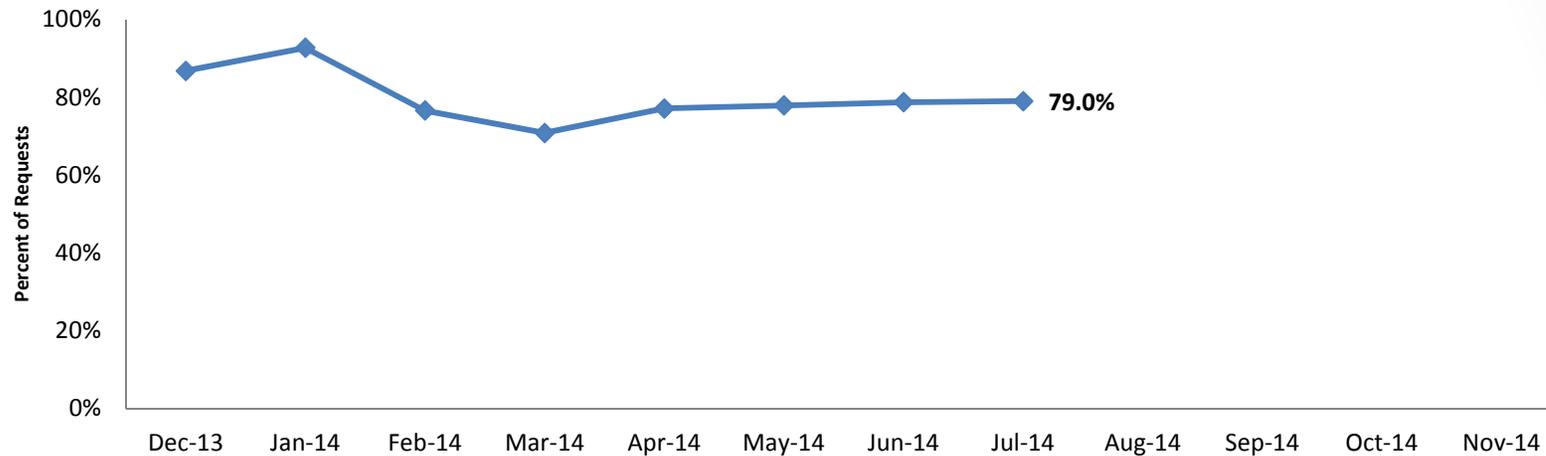
# Grievance Educational Efforts

- DHHS
  - Part of DHHS Client Services “script”
- MCO
  - Information located in Member Handbook, annual newsletter, a form on the website, all denial letters, email blast
  - Grievance and Appeals coordinator to assist with the process

# Non-Emergency Transportation

- What do we need to know
  - Are beneficiaries getting to their medical appointments when they need transportation assistance?
- Measure
  - Transportation Request Approved and Delivered

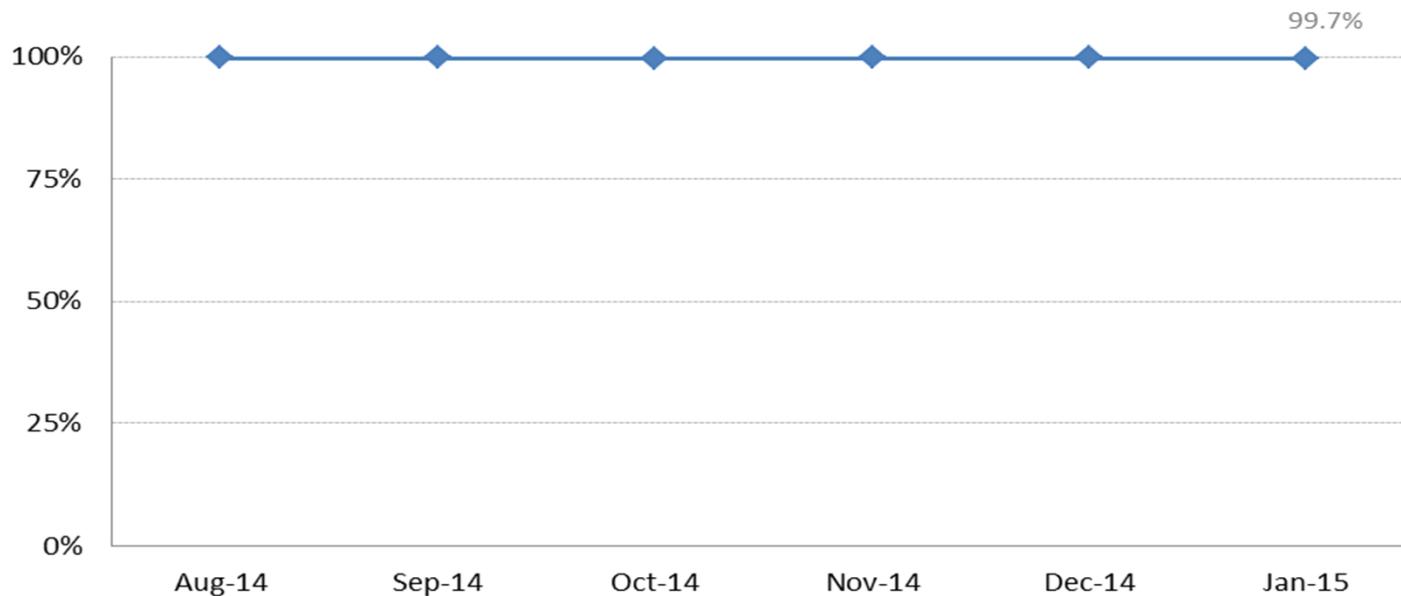
# Figure 1-4: Transportation Requests Approved and Delivered



Description: A lack of transportation can be a barrier to accessing health services. A low or falling rate of requests for transportation that have been made, but not approved and delivered could indicate that transportation needs are not being met. **This measure describes the number of non-emergent requests for transportation approved and delivered, divided by the total number of non-emergent transportation requests, as a percentage.** The types of transportation included in this measure are contracted transportation providers, volunteer drivers, member drivers, public transportation, and other.

Frequency: Reported monthly, available approximately 2 months after end of the quarter.

## Figure 1-4: Non-Emergent Transportation Requests Approved

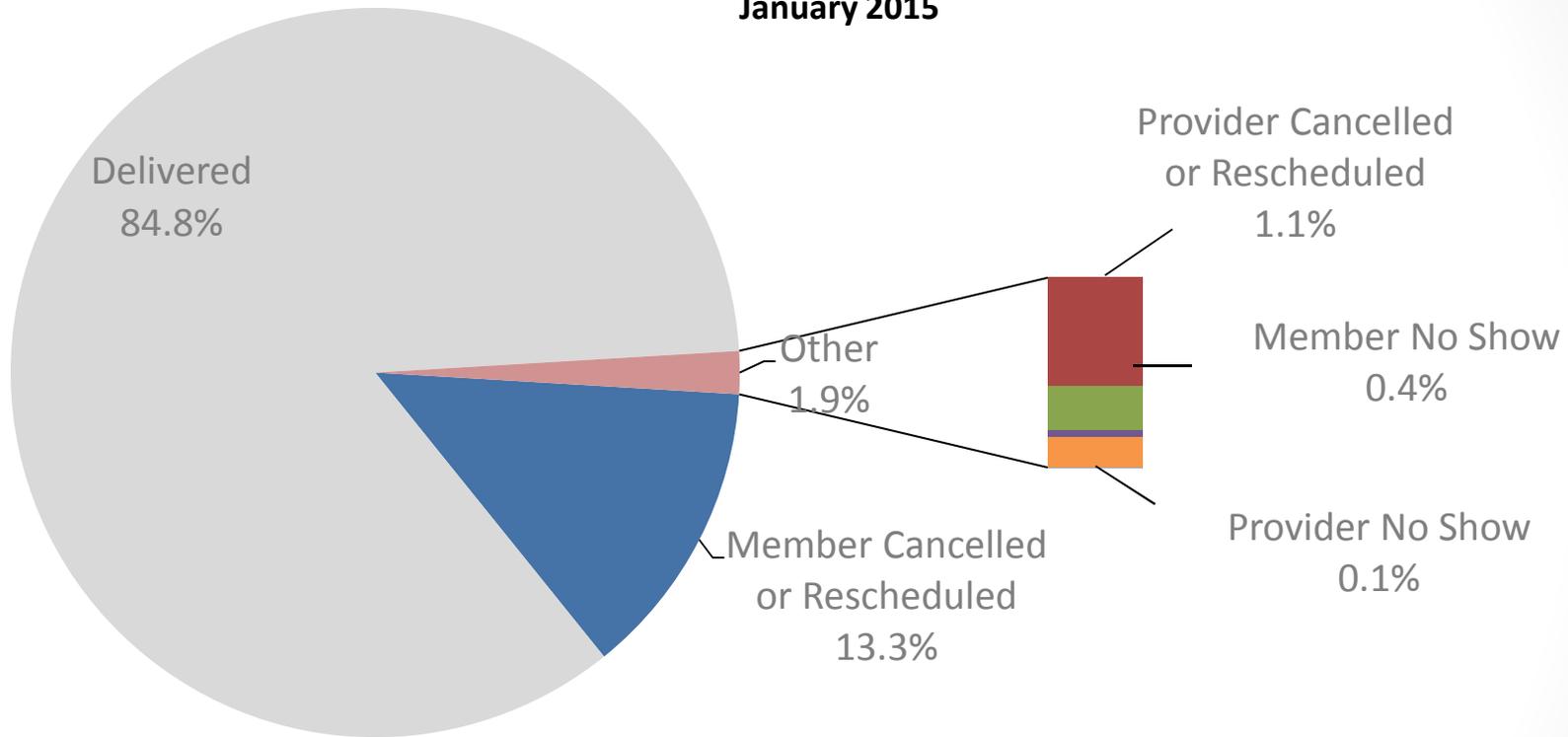


Description: A lack of transportation can be a barrier to accessing health services. A low or falling rate of requests for transportation that have been made, but not approved could indicate that transportation needs are not being met. **This measure describes the number of non-emergent requests for transportation approved, divided by the total number of non-emergent transportation requests, as a percentage.** The types of transportation included in this measure are contracted transportation providers, volunteer drivers, member drivers, public transportation, and other.

Frequency: Reported monthly, available approximately 2 months after end of the quarter.

# Figure 1-5: Scheduled Non-Emergent Transportation Results by Outcome

January 2015



	Member Cancelled or Rescheduled	Provider Cancelled or Rescheduled	Member No Show	Provider No Show	Delivered
Jan-15	2,376	13	78	13	15,210

# Transportation Story

- Is transportation an area of concern?
  - Yes, multiple grievances.
  - Yes, initial measure may have suggested a problem
- Is your data valid?
  - No...so begin with good measurement
- Is there a problem?
  - No...and yes
  - One MCO reviewing their transportation vendor relationship

# Pharmacy Services

- What do we need to know
  - Are beneficiaries getting the medications that they need?
- Measure
  - Pharmacy Service Authorizations Requests and Benefit Decisions

## Figure 4-4: Service Authorization Requests and Benefit Decisions by Type of Service (January 2015)

	2014 Q1			2014 Q2			2014 Q3		
Average Membership	111,241			118,362			123,116		
	Requested	Denied	% Denial	Requested	Denied	% Denial	Requested	Denied	% Denial
All Services	24,063	3,296	14%	29,463	5,194	18%	33,174	5,815	18%
Service Category	Requested	Denied	% Denial	Requested	Denied	% Denial	Requested	Denied	% Denial
In-Network Inpatient Admissions Non-Surgical	1,945	37	2%	2,806	36	1%	3,117	28	1%
In-Network Inpatient Admissions Surgical	214	2	1%	187	11	6%	194	3	2%
Out-of-Network Inpatient Admissions	344	14	4%	213	3	1%	361	33	9%
Outpatient Surgeries	1,202	77	6%	817	63	8%	473	77	16%
Community Mental Health Center	84	10	12%	191	10	5%	116	7	6%
Physician/Medical Services	2,492	143	6%	2,643	230	9%	3,317	364	11%
Psychology	278	13	5%	303	16	5%	361	7	2%
PT/OT/ST	2,120	143	7%	2,472	170	7%	3,422	189	6%
Wheelchair Van	497	16	3%	710	17	2%	1,652	11	1%
<b>Pharmacy</b>	<b>8,734</b>	<b>2,417</b>	<b>28%</b>	<b>12,766</b>	<b>4,163</b>	<b>33%</b>	<b>11,072</b>	<b>4,360</b>	<b>39%</b>
Private Duty Nursing	307	0	0%	279	1	0%	386	0	0%
Medical Supplies	1,381	55	4%	1,063	27	3%	1,592	19	1%
DME Pediatric and Adults	1,514	171	11%	1,318	38	3%	1,588	80	5%
Imaging Studies	1,794	94	5%	1,887	99	5%	3,792	372	10%
Other	909	99	11%	1,472	302	21%	1,393	255	18%

# Figure 4-4: Service Authorization Requests and Benefit Decisions by Type of Service (March 2015)

	2014 Q1			2014 Q2			2014 Q3		
Average Membership	111,241			118,362			123,116		
	Requested	Denied	% Denial	Requested	Denied	% Denial	Requested	Denied	% Denial
All Services	15,329	879	6%	16,697	1,031	6%	22,102	1,455	7%
Service Category	Requested	Denied	% Denial	Requested	Denied	% Denial	Requested	Denied	% Denial
In-Network Inpatient Admissions Non-Surgical	1,945	37	2%	2,806	36	1%	3,117	28	1%
In-Network Inpatient Admissions Surgical	214	2	1%	187	11	6%	194	3	2%
Out-of-Network Inpatient Admissions	344	14	4%	213	3	1%	361	33	9%
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PT/OT/ST	2,120	143	7%	2,472	170	7%	3,422	189	6%
Wheelchair Van	497	16	3%	710	17	2%	1,652	11	1%
<b>Pharmacy*</b>	<b>Pharmacy Data was removed and is currently being validated.</b>								
Private Duty Nursing	307	0	0%	279	1	0%	386	0	0%
Medical Supplies	1,381	55	4%	1,063	27	3%	1,592	19	1%
DME Pediatric and Adults	1,514	171	11%	1,318	38	3%	1,588	80	5%
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Other	909	99	11%	1,472	302	21%	1,393	255	18%

# Figure 4-4: Service Authorization Requests and Benefit Decisions by Type of Service (April 2015)

	2014 Q1			2014 Q2			2014 Q3			2014 Q4		
Average Membership	111,241			118,362			123,116			136,990		
	Requests	Denial	% Denial	Requests	Denial	% Denial	Requests	Denial	% Denial	Requests	Denial	% Denial
All Services	23,938	3,193	13%	31,200	2,898	9%	32,645	5,307	16%	27,613	4,521	16%
Service Category	Requests	Denial	% Denial	Requests	Denial	% Denial	Requests	Denial	% Denial	Requests	Denial	% Denial
In-Network Inpatient Admissions Non-Surgical	1,945	37	2%	2,806	36	1%	3,117	28	1%	2,729	28	1%
In-Network Inpatient Admissions Surgical	214	2	1%	187	11	6%	194	3	2%	140	5	4%
Out-of-Network Inpatient Admissions	344	14	4%	213	3	1%	361	33	9%	216	8	4%
Outpatient Surgeries	1,202	77	6%	817	63	8%	473	77	16%	393	57	15%
Community Mental Health Center	84	10	12%	191	10	5%	116	7	6%	127	0	0%
Physician/ Medical Services	2,492	143	6%	2,643	230	9%	3,317	364	11%	2,644	356	13%
Psychology	278	13	5%	303	16	5%	361	7	2%	426	13	3%
PT/OT/ST	2,120	143	7%	2,472	170	7%	3,422	189	6%	2,985	141	5%
Wheelchair Van	497	16	3%	710	17	2%	1,652	11	1%	1,473	7	0%
<b>Pharmacy</b>	<b>8,609</b>	<b>2,314</b>	<b>27%</b>	<b>9,091</b>	<b>1,744</b>	<b>19%</b>	<b>10,543</b>	<b>3,852</b>	<b>37%</b>	<b>7,030</b>	<b>2,817</b>	<b>40%</b>
Private Duty Nursing	307	0	0%	279	1	0%	386	0	0%	413	1	0%
Medical Supplies	1,381	55	4%	1,063	27	3%	1,592	19	1%	1,620	97	6%
DME Pediatric and Adults	1,514	171	11%	1,318	38	3%	1,588	80	5%	1,631	56	3%
Imaging Studies	1,794	94	5%	1,887	99	5%	3,792	372	10%	4,390	774	18%
Other	909	99	11%	1,472	302	21%	1,393	255	18%	1,018	154	15%

# MCO Step 2 Readiness

- Ongoing monitoring
  - Improving existing measures
    - Add new subpopulations: Special Needs, LTSS, Payer
    - Add a new LTSS domain to the KI report
  - Include LTSS providers in provider surveys
- Reports and Plans include LTSS populations
  - MCO Annual Reports
  - MCO Operational Plans (e.g. communication, care management, utilization management, provider training)
- Addressing issues systemically
  - Confirm that the data valid
  - Put the data in context
  - Solve the issue so that it doesn't reoccur

# New Step 2 Measures

- New CFI quality measures begin January 2016:
  - Care Plan Monitoring
    - Review
    - Inter-rater Reliability Assessment
  - Member Satisfaction Survey
    - Testing Experience and Functional Tools (TEFT)
  - Sentinel Event Tracking
    - Falls
    - Medication Errors
    - Abuse or Neglect
    - Avoidable Hospitalizations (e.g. UTI, pneumonia, readmissions)
  - Community Integration Plan
  - Case Management Standards (e.g. returned calls, monthly meetings, and caseload ratios)
- NF and DCYF services specific measures will be developed in January 2016 to be ready for MCO coverage in SFY 2017

# Quality In Action at the Health Plans

- NHHF
  - Comments
  
- WS
  - Comments

# Questions?

- Doris Lotz, MD, MPH
  - Medicaid Chief Medical Officer
  - [dlotz@dhhs.state.nh.us](mailto:dlotz@dhhs.state.nh.us)
- <http://www.dhhs.nh.gov/ombp/quality/documents/mcm-key-indicators-rpt.pdf>