# Transformation and Quality Strategy: Access

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Presented by:
Lisa Bui, Quality Improvement Director
Allison Tonge, Operations and Policy Analyst
Anona Gund, Transformation Analyst

Oregon Health Authority

# Webinar objectives

- Walk through the Transformation and Quality Strategy (TQS) access component and subcomponents
  - Rational
  - 2018 CCO contract
  - TQS access component and subcomponents
- Review select access TQS examples
  - Access: Cultural Considerations
  - Access: Timely
- Wrap-up

# Deliverables schedule

## Due March 16, 2018

- 2015 – 2017 Transformation Plan benchmark report (closing report)
- Transformation Quality Strategy (TQS)
  - TQS effective January 2018

## Future

- TQS due annually on March 16 (effective January-December)
- TQS progress report due on September 30 (progress for January-June)

# Foundational principles

TQS is a means for CCOs to report health transformation and quality work. The work is determined, developed and implemented by the CCOs with the direction from the CACs, community, and CCO leadership. OHA's role is monitoring, spreading best practices and providing technical assistance for implementation with community and state subject matter experts.

**The template addresses three key principles:**

1. Meets CFR, OAR, 1115 waiver and CCO contractual requirements
2. Pushes health transformation through alignment with quality and innovation
3. Decreases administrative burden on CCOs
   - Template supports OHA processing of information to monitor CCOs' progress to benchmarks.
   - Template incorporates narrative style and specific/measurement methods.

# Components and subcomponents

- Access
  - Access: Availability of Services
  - Access: Cultural Considerations
  - Access: Quality and Appropriateness of Care Furnished to all Members
  - Access: Second Opinions
  - Access: Timely
- CLAS Standards and Provider Network
- Grievances and Appeals System
- Fraud, Waste and Abuse
- Health Equity and Data
  - Data
  - Cultural Competence
- Health Information Technology
  - Health Information Exchange Analytics
  - Patient Engagement
- Integration of Care
- Patient-Centered Primary Care Home
- Severe and Persistent Mental Illness
- Social Determinants of Health*
- Special Health Care Needs
- Utilization Review
- Value-based Payment Models

**Pending CMS approval*

# Access Subcomponents

- Access: Quality and Appropriateness of Care Furnished to all Members
- Access: Availability of Services
- Access: Second Opinions
- Access: Cultural Considerations
- Access: Timely

# Access and Medicaid

- In May 2016, the federal government issued regulations that clarified state Medicaid and CHIP agency responsibilities for ensuring that people enrolled in Medicaid and CHIP managed care plans have timely access to services covered under the contract.

- The 2018 CCO contract incorporates updated CFR

*OHA anticipates that the External Quality Review Organization (EQRO) will begin validating with External Quality Review (EQR) in 2019*

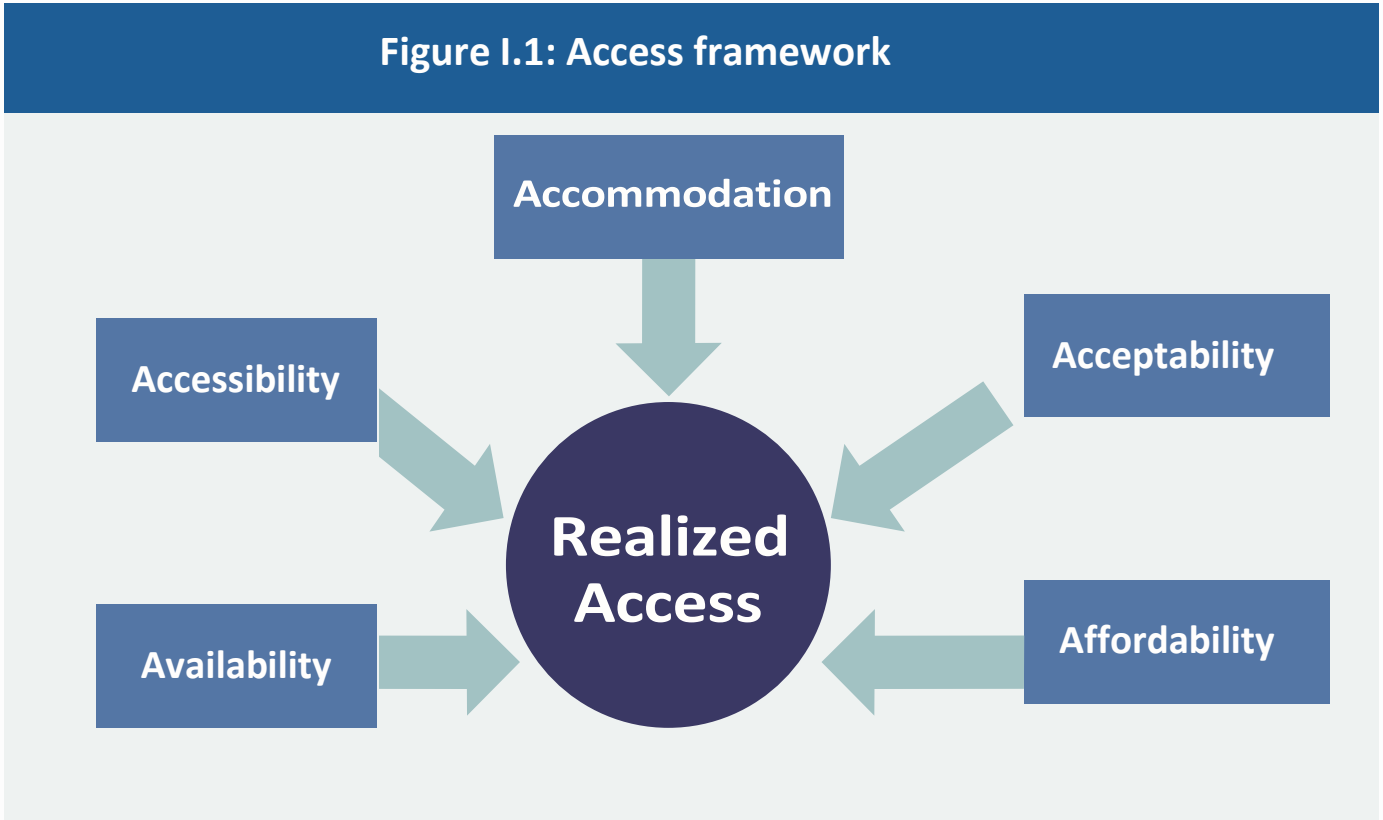
# Access and Medicaid

- CMS has not issued specific guidance regarding EQR scope or content of review

- CMS has issued general guidelines in a “toolkit” for states

https://www.medicaid.gov/medicaid/managed-care/downloads/guidance/adequacy-and-access-toolkit.pdf

# Access and Medicaid




This framework is similar to one proposed to CMS to enable it to monitor Medicaid enrollees' access to care across and within states for key services and populations covered by the program, regardless of the delivery system (that is, FFS, managed care, or waivers). The two frameworks are largely consistent. To view the "Proposed Medicaid Access Measurement and Monitoring Plan" visit https://www.medicaid.gov/medicaid/access-to-care/downloads/review-plans/monitoring-plan.pdf.

# Access and Medicaid

- **Availability** addresses whether provider networks are sufficient to meet the needs of enrollees. Availability is a function of the number of providers, their willingness to participate in the program, and their ability to offer timely appointments. Provider participation, in turn, is influenced by reimbursement rates, timeliness of payment, and administrative burden.
- **Accessibility** involves the proximity of providers to enrollees, based on geographic time and distance. For long-term services and supports (LTSS) provided in a home or community setting, accessibility can be expressed as the time and distance for caregivers to travel to enrollees' residences. At the point of care, accessibility is determined by physical access, such as ramps, and providers' ability to communicate in non-English languages or sign language.
- **Accommodation** is the extent to which a provider's operating hours, appointment policies, language and cultural competencies, and approach to communications meet enrollees' constraints and preferences.
- **Acceptability** captures whether enrollees and providers are comfortable with and relate well to one another, and the extent to which managed care plans and providers respect and respond to enrollees' concerns and preferences.
- **Affordability** encompasses the costs that enrollees incur relative to their ability to pay, subject to Medicaid and CHIP rules limiting enrollee cost-sharing amounts.
- **Realized access** addresses managed care enrollees' actual use of the services covered under the contract. For monitoring purposes, it is most important to measure the use of clinically recommended care, such as preventive screenings and immunizations, as well as services that could be markers of potential access problems, such as hospital admissions for chronic conditions that can be avoided through regular outpatient care.

# Access and Medicaid

- Primary monitoring activities:
  - Activities that draw a direct correlation, from member generated data, to the ability to access services (for example, complaints, utilization rates and member surveys)
- Secondary monitoring activities:
  - Activities that use primary data, but do not provide a direct correlation to access (for example, provider surveys, performance metrics, ratio of providers to members, referral patterns, average wait times)

- Resources:

  https://www.medicaid.gov/medicaid/access-to-care/downloads/review-plans/or-amrp-16.pdf

  http://www.oregon.gov/oha/HPA/HP-MAC/Documents/MAC-oralhealthframework-Oct2016.pdf

# 2018 CCO Contract and Access

- CCO contract has many sections and subsections that address access and accessibility of services.

- CCO contract also cites OAR and CFR.

- Primary CCO contract sections that address access and accessibility:
  - Exhibit B—Part 2
  - Exhibit B—Part 4
  - Exhibit B—Part 9
  - Exhibit G

# TQS and Access

TQS access requirements within CCO Contract Exhibit B—Part 9(2)(g)(3)

- *Contractor shall include in the annual QAPI program evaluation:*
  - An assessment of the quality and appropriateness of care furnished to all members, availability of services, second opinions, timely access and cultural considerations, with a report of aggregate data indicating methods used to monitor compliance.

# Access Subcomponents

- All 5 access subcomponents must be addressed in the TQS.

- CCOs should insert additional tables in **Section 2: Transformation and Quality Program Details** of the template until all access subcomponents are addressed.

  - Access: Quality and Appropriateness of Care Furnished to all Members
  - Access: Availability of Services
  - Access: Second Opinions
  - Access: Cultural Considerations
  - Access: Timely

# Access – Cultural Considerations

| A. TQS COMPONENT(S) – **Access (cultural considerations), utilization review** | | | |
|---|---|---|---|
| **Primary Component:** | Access | **Secondary Component:** | Utilization review |
| **Additional Components:** | Add text here. | | |
| **Subcomponents:** | Access: Cultural considerations | **Additional Subcomponent(s):** | Add text here. |

| B. NARRATIVE OF THE PROJECT OR PROGRAM |
|---|
| The ExampleCCO QIC will coordinate with behavioral health contractors and subcontractors to analyze interpretive services utilization rates for CCO members who identify their primary language as not English. The QIC will delegate to the ExampleCCO Quality Management team and ExampleCCO integration team to use data collected to compare utilization rates over time and geographic distribution and investigate whether there is national data available (or comparisons from other states) to establish an appropriate benchmark. |

| C. QUALITY ASSESSMENT | |
|---|---|
| **Evaluation Analysis:** | Use of interpretive services by CCO behavioral health (BH) providers' offices has been stable over the past four years. The average rate of requests received for interpreters was 2.5 per clinic per quarter. However, the percent of members enrolled in the CCO whose primary language is identified as not English increased 25% over the last two years and there has been a slight decrease in the BH utilization rates in the last four years. |

| D. PERFORMANCE IMPROVEMENT | | | | | |
|---|---|---|---|---|---|
| **Activity:** Coordinate with BH contractors and subcontractors to collect data on utilization of interpretive services by members over the last four years; compare utilization at BH locations with geographic distribution of members and member assignments; investigate national average for utilization and state trends to establish benchmark; make recommendations to QIC based on findings. | | | | ☐ Short-Term Activity or<br>☒ Long-Term Activity | |
| **How activity will be monitored for improvement** | **Baseline or current state** | **Target or future state** | **Time (MM/YYYY)** | **Benchmark or future state** | **Time (MM/YYYY)** |
| Interpretive services utilization | 2.5/clinic/quarter | TBD | 4/2017 | TBD | 4/2019 |



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# Access - Timely

| A. TQS COMPONENT(S) – **Access (timely access), special health care needs, integration of care** | | | |
|---|---|---|---|
| **Primary Component:** | Access | **Secondary Component:** | Special health care needs |
| **Additional Components:** | Integration | | |
| **Subcomponents:** | Access: Timely access | **Additional Subcomponent(s):** | Add text here. |

| B. NARRATIVE OF THE PROJECT OR PROGRAM |
|---|
| The ExampleCCO Quality Management (QM) team will coordinate with contractors and subcontractors to analyze wait times for dental care for CCO members who are identified as having special health care needs (SHCN). The CCO QM team will use data collected to compare wait times for standard vs. urgent dental care and emergency department use for dental services over the last five years, compare the length of wait time experienced by SHCN members and non-SHCN members and investigate whether national data is available (or comparisons from other states) to establish appropriate benchmark. |

| C. QUALITY ASSESSMENT | |
|---|---|
| **Evaluation Analysis:** | Average wait times for standard dental appointments for CCO members is X weeks. This meets the OAR and contract standard for wait times. This average includes SHCN members. However, the CCO quality team has noted through monitoring of grievances in 2017 that many of the dental access complaints submitted are made by SCHN members.<br>See attached supporting data and CCO policy and procedure on identification and definition of SHCN CCO members. |

D. PERFORMANCE IMPROVEMENT

| **Activity**: Coordinate with contractors and subcontractors to collect data on dental wait times for last five years. Stratify data by SHCN designation. Investigate national average to establish benchmark and make recommendations to quality improvement committee based on findings of analysis. | ☐ Short-Term Activity or<br>☒ Long-Term Activity |
|---|---|

| **How activity will be monitored for improvement** | **Baseline or current state** | **Target or future state** | **Time (MM/YYYY)** | **Benchmark or future state** | **Time (MM/YYYY)** |
|---|---|---|---|---|---|
| Dental care wait times (all CCO members) | X weeks for standard dental care | TBD | 9/2017 | Average wait times for SHCN members is equal to CCO member average ±5% | 4/2020 |



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# Wrap-up

- Each CCO structure is different—oversight and monitoring of access and how the CCO's QAPI program incorporates this will vary. The format of the TQS is intended to allow flexibility in reporting to adapt to this variability.
- Access component and subcomponents focus on 5 areas of access within the CCO contract—the TQS is not intended to be an exhaustive report of *everything* related to access in the CCO contract.
- Most CCOs are already doing access work/activities within their organization—TQS is intended to capture this work, not to add new access projects.

# Q&A

- Please type your questions and comments into the “Questions” box on your GoToWebinar control panel.
- We will continue to update our Frequently Asked Questions document after each webinar in this series.

# For more information:

- Presenter contacts:
  - Lisa Bui: Lisa.T.Bui@dhsoha.state.or.us
  - Anona Gund: Anona.E.Gund@dhsoha.state.or.us
  - Allison Tonge: Allison.M.Tonge@dhsoha.state.or.us

- All TQS resources, including the templates, guidance document, examples and technical assistance schedule are available on the **Transformation Center website**: http://www.oregon.gov/oha/HPA/CSI-TC/Pages/Transformation-Quality-Strategy.aspx
- The templates and guidance document are also cross-posted on the **CCO Contract Forms page**: http://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx