2023 Transformation and Quality Strategy (TQS):

Utilization Review

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Housekeeping

- Please keep yourself on mute when you're not speaking.
- Type questions into the chat at any time.
- This webinar is being recorded. The slides and recording will be available on the Transformation Center TQS TA webpage.

Agenda

- TQS background
- Component overview and definitions
- Component requirements and scoring criteria
- Opportunities for improvement
- Example walk-through
- Q&A

TQS background

TQS foundational principles

The TQS addresses three key principles:

1. Meet relevant CFR, OAR, 1115 waiver and CCO contractual requirements
2. Pushes health transformation through alignment with quality and innovation
3. Decrease administrative burden

Why do the work

Efficiency
is doing things right;

Effectiveness
is doing the *right* things.

– Peter Drucker

2023 TQS components

Project needs to meet the requirements for each component assigned to it.

1	Behavioral Health Integration	**8**	PCPCH: Tier Advancement
2	CLAS Standards	**9**	Serious and Persistent Mental Illness (SPMI)
3	Grievance and Appeal System	**10**	Social Determinants of Health & Equity (SDOH-E)
4	Health Equity: Data	**11**	Special Health Care Needs (SHCN): Full Benefit Dual Eligible Population
5	Health Equity: Cultural Responsiveness	**12**	SHCN: Non-duals Medicaid Population
6	Oral Health Integration	**13**	Utilization Review
7	Patient-Centered Primary Care Home (PCPCH): Member Enrollment		

Access components removed from prior year.

2023 Utilization Review overview and definitions

Utilization review

This component refers to the process of reviewing, evaluating and ensuring **appropriate use of medical resources and services**. The review encompasses quality, quantity and appropriateness of medical care to achieve the most effective and economic use of health care services. (OAR 410-120-000)

Utilization review

42 CFR 438.330 requires that CCOs have an ongoing quality assessment and performance improvement (QAPI) program.

- Mechanisms to detect both underutilization and overutilization of services is a CFR-required component of QAPI.

CCOs shall maintain a health information system that meets the requirements of the Contract, as specified in 42 CFR 438.242, and that will collect, analyze, integrate and report data that can provide information on areas including but not limited to utilization of services (CCO Contract Ex B, Pt 7, Sec 1f).

2023 Utilization Review requirements, project considerations, and scoring criteria

Medicaid Efficiency and Performance Program (MEPP)

- CCOs participating in the Performance Based Reward incentive program under CCO 2.0 are required to participate in MEPP.
- MEPP is based on an efficiency and quality algorithm that reviews claims data and identifies adverse actionable events (AAE).
- CCOs are asked to design interventions for three different types of episodes (for example, diabetes, SUD and asthma) with the goal of improving outcomes as measured by AAE. Two of the three 2022 MEPP interventions can be application of MEPP analytics to support other quality initiatives related to specific episodes of care.

Medicaid Efficiency and Performance Program (MEPP) & TQS

- CCOs are required to utilize the Utilization Review TQS component area to satisfy the MEPP reporting requirements.
- A single set of requirements have been provided that address both the MEPP and TQS reporting requirements. An example of a utilization management project in the TQS template that meets the MEPP requirements has been provided.

Medicaid Efficiency and Performance Program (MEPP) & TQS

- When CCOs report on MEPP activities via TQS, they must also:
  - Describe what insights from the MEPP dashboard informed the decision to pursue the project, including statistics and an explanation of how the data specifically connects to the intervention;
  - Describe any significant changes to the opportunity (AAE) or the intervention that arose during implementation.
  - Clearly state whether your MEPP interventions were completed to fidelity and provide explanation if not.
  - Clearly identify the performance measurement strategy for the MEPP interventions and evaluate if you met your definition of success.

Note: This language is drawn from the TQS guidance posted on October 1st.

Tips, examples and resources

Establishing mechanisms to detect over/under utilization and monitoring over time

Diverse set of strategies:

- Quality measures
- Gaps in care analysis (under utilization)
- Member provided data (grievances, survey, other feedback)
- Statistical analysis of utilization measures (trend, variation, outlier)
- Clinical review

Quality measures as part of UM strategy

HEDIS Measure Examples

Over Utilization	Under Utilization
• Antibiotic Utilization • Plan All-Cause Readmissions • Acute Hospital Utilization • Emergency Department Utilization • Use of Imaging Studies for Low Back Pain • Non-recommended PSA-Based Screening in Older Men	• Child and Adolescent Well-Care Visits • Identification of Alcohol and Other Drug Services • Mental Health Utilization • Childhood Immunization Status • Various Cancer Screenings (breast, cervical, colorectal) • Comprehensive Diabetes Care

Gaps in care analysis

- Core set of services needed for the management of chronic disease and acute conditions
- Analysis to identify underutilization of this set of services
- Some overlap with HEDIS measures
- Develop policy and intervention strategies based on your findings

Member provided data

- Member provided data can provide insight into underutilization of services driven by gaps in access to care, provider behavior, and other structural barriers to accessing care

Statistical analysis strategies

- Trend analysis by category of service (or more granular) and by population cohort
  - Investigate deviations in trend (positive or negative) to determine underlying causes
- Variation/Outlier analysis
  - Patient – which patients have abnormal utilization patterns compared to other patients?
    - Frequent ED utilization
    - Abnormal prescription use patterns (drug shopping)
    - Repeat admissions
  - Providers – which providers have abnormal service provision or prescription patterns compared to peers?
    - Disproportionate use of higher levels of intervention
    - Repeat procedures/labs

Clinical review

- Clinically inappropriate services
  - Choosing wisely recommendations – are practices providing unnecessary services?
- Exacerbation of conditions that might be treated more efficiently with better upstream care
  - MEPP – AAEs – analytics to identify patterns to inform policy

Opportunities for improvement

2022 areas of opportunity

Across components:

Rationale – Why did your plan choose this project specific to your CCO's target population? What is the overarching idea or purpose behind the project? Make sure you can provide clear justification as to why and how a project was chosen and that it is directly relevant to the component. The scope of the project should not be too broad. Include the data used to identify any gaps, population and intervention (CCO-or region-specific data). Baseline data needs to be specific, relevant and meaningful.

> Demographics: Make sure you explain how your CCO *identified the target population* for the project.

For MEPP-related projects, include a robust description of how the MEPP data informed your intervention strategy. This should be more than an aggregate AAE rate for an episode. This could include analysis by population, by provider or groups of providers, by diagnosis, etc.

2022 areas of opportunity

Across components:

Progress – For continued projects, describe what happened in prior year. Describe if/how the project is changing this year, what targets/benchmarks were met and if not, why. Update revision dates, as necessary. Ensure progress to date needs is sufficiently detailed.

- Include meaningful data, charts, utilization information, etc.

2022 areas of opportunity (continued)

Details – More details to describe how project will address the gaps identified (project-specific as outlined in your written assessments).

Monitoring activities

- Ensure strong and clear correlation between the component and the activities and goals
- Activities should have enough specificity and detail that they can be *measured* over time
- Include activities for the year (or beyond) – not just one short-term process measure
- As projects mature, move toward more outcome measures
- Project should be able to demonstrate progress over time

Continued project – Ensure project and activities/strategies to date are sufficiently detailed. Include any modifications to activities, revisions to target dates/benchmarks and why they were made. For a continued project, the CCO should be able to demonstrate improvement over time.

2022 areas of opportunity (continued)

A SMART objective is one that is specific, measurable, achievable, relevant and timebound.

- To provide a structured approach to developing and designing a work plan
- To systematically monitor progress towards a target
- To set the stage for measuring performance and identifying opportunities for improvement
- To succinctly communicate intended impact and current progress to stakeholders
- To concretely describes how goals will be met

Example walk-through

Key highlights

C. Component prior year assessment

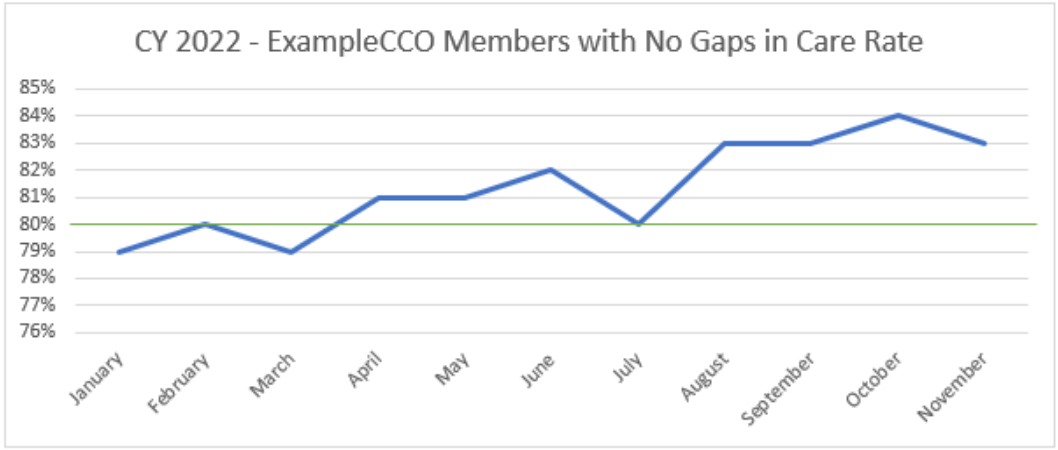
- Describe your utilization management process/program and how it addresses both under and over utilization.
- Include application of MEPP analytics as appropriate
- Provide specific examples
- Describe observations for prior year

Example:

- Includes a description of the various processes used to identify under and over utilization and shows and example. (analytics, internal review process, data sources, etc.)
- Includes relevant MEPP statistics related to diabetes (AAE rates)

C. **Component prior year assessment**: Include calendar year assessment for the component(s) selected with CCO- and region-specific data

ExampleCCO operates a robust utilization management program that includes tracking and trend analysis of utilization on a PMPM basis in all major service categories to identify potential under and over utilization of services. Additionally, to ensure quality of care and appropriate utilization, ExampleCCO's utilization management program actively tracks gaps in care in management of chronic diseases on a member-specific basis. Trend and gaps in care analysis are reviewed by an internal clinical advisory team. The team makes recommendations on policies to impact utilization based on the aforementioned analysis. Examples of policies include changes to prior authorization policy, provider engagement and incentive strategies to close gaps in care and/or to reduce utilization of low-value care, and member engagement strategies. Through these utilization management efforts, our organization targets having 80% of members with chronic disease having no gaps in care. The graphic below illustrates a rolling 12-month average of performance on this metric for CY 2022. ExampleCCO was able to exceed the target in aggregate for CY 2022 with performance at 85% compared to the target of 80% (based on the 12-month rolling average for December 2022).



In addition to the utilization management related analysis noted above, ExampleCCO leverages MEPP analytics provided by the state to further advance our utilization management efforts. Specifically, our CCO used MEPP to identify opportunity and inform strategies related to utilization of services to treat and manage diabetes. In the MEPP analytics for CY 2018-2021, diabetes is found to have an adverse actionable event (AAE) rate of 36%, which means that 36% of the costs of services were for services that could have potentially been avoided with better upstream care and active management. This compares to the prior period (CY 2017-2019) of 34%.

Key highlights

D. Project context

- Describe how the project you selected addresses the findings from the process you previously described
- Include relevant anecdotes and context to support choosing the project

Example:

- Diabetes project robustly defended based on MEPP and other UM analysis
- Specific data provided that explicitly links intervention strategy (diabetes gap closure with limited set of providers in a community) to specific UM process findings

D. **Project context**: Include justification for the chosen or continued project with CCO- and region-specific data, and progress to date for continued projects

The diabetes episode represents the second highest total expenditure condition and the second highest AAE rate of all episodes in the MEPP dashboard. Based on this, ExampleCCO selected the diabetes episode as one of the three areas of focus for the MEPP program. This is a new intervention for the CCO this year, and is replacing a hypertension episode intervention (see Section 2 regarding discontinued interventions) Additionally, the gaps in care analysis supported additional efforts for improvement management of the condition. Lastly, monitoring of HbA1c for other quality programs indicated additional opportunity to improve outcomes.

ExampleCCO's clinical advisory team reviewed the analysis of the MEPP data, gaps in care analysis, and HbA1c data and noted that all three statistics showed greater opportunity in Community A compared to all other communities. The AAE rate for the diabetes in Community A (based on an analysis by zip code) is 45% compared to the CCO aggregate 36%. The majority of AAE costs are for ED utilization and inpatient admissions related to uncontrolled blood sugar. 35% of members with diabetes in Community A had gaps in care compared to the CCO-wide rate of 15-20%. 40% of members with diabetes in Community A had HbA1c rates indicating poor control compared to a CCO-wide rate of 20%. Further, the MEPP analysis highlighted that three practices in Community A bore the majority of AAE costs (65% of AAE costs in Community A).

Based on the analysis, the clinical advisory team recommended implementation of a targeted provider outreach program to ensure the three providers identified understand which patients with diabetes have gaps in care, that the practices are equipped with resources to connect patients with community and state resources to address food insecurity/healthy eating options, and that the practices are receiving information regarding ED visits and admissions/discharges for patients with diabetes (and other conditions) to ensure follow-up care that can prevent readmissions is received.

Key highlights

E. Project or program brief narrative description

- Describes intervention and key activities related to the intervention

Example:

- Brief explanation of diabetes intervention
- Listing of major processes associated with the intervention (gap in care reports, HbA1c reporting rates, care coordination strategy, community resources)

E. Project or program brief narrative description

ExampleCCO will implement a multipronged provider outreach and support strategy to ensure the target practices are well positioned to address gaps in care, community referral, and clinical follow-ups. In addressing these three areas, our CCO intends to impact both over and under utilization of services while improving quality of care for members with diabetes in Community A, which has been shown to have a disproportionate impact on the CCO's aggregate statistics. The primary intervention strategies for this project are described below.

- ExampleCCO will develop practice-specific gaps in care reporting for members with diabetes. This information will be shared with the three target practices through a mutually agreed to process, on a monthly basis.
- Quarterly reporting of the HbA1c will be provided to the three practices in Community A that are the focus of this project.

- ExampleCCO will facilitate formalizing care coordination agreements between the three target practices and Community A's local hospital to ensure the providers are communicating when attributed patients are seen in the ED or admitted to the hospital.
- ExampleCCO will identify resources in Community A that can support addressing food insecurity and access to healthy food for patients referred by the target practices. The contact/process information will be shared with the three practices to support referral.

Key highlights

F. Activities and monitoring for performance improvement

- Major process milestones for the project
- Performance measures
  - Baseline, targets, timelines

Example(s):

- Process measures associated with each of the key intervention activities (reporting process measure)
- Performance measure (gap in care rate)
  - Directly correlates with intervention
  - Aligned with UM strategy
- Additional examples provided as shown on next slides

F. Activities and monitoring for performance improvement

Activity 1 description: Gaps in Care Date Reporting and Improved Closure Rate

To support the target practices in addressing gaps in care for the target population, ExampleCCO will provide patient-level reporting the provider that identifies specific gaps in care. The practice can use the information for targeted patient outreach and to potentially inform changes to clinical practice flow to reduce the prevalence of gaps in care. The following steps outline the process for implementing this component of the project/intervention:

- Conduct outreach to target providers (3 providers in Community A)
- Develop and implement practice gaps in care reporting process, including goals
- Begin data reporting
- Ongoing follow-up/support to help practice reach gap closure goal (no more than 20% of patients with gaps in care related to treatment of diabetes)

☒ Short term or ☒ Long term

Monitoring measure 1.1	(short-term) Provider-specific reporting of gaps in care related to diabetes implemented			
Baseline or current state	**Target / future state**	**Target met by (MM/YYYY)**	**Benchmark / future state**	**Benchmark met by (MM/YYYY)**
No current reporting	Reporting to all three practices in place	05/2023	Same as target	Same as target

Monitoring measure 1.2	Gaps in care rate (% of continuously eligible members with diabetes that have gaps in care that did not get closed during the reporting period)			
Baseline or current state	**Target / future state**	**Target met by (MM/YYYY)**	**Benchmark / future state**	**Benchmark met by (MM/YYYY)**
Provider A – 35% Provider B – 38% Provider C – 33%	27.5% 29% 26.5%	12/2023	<20%	12/2024

Activity 2 description: HbA1c Data Reporting and Improved Management

To support the target practices in improving diabetes management of patients, ExampleCCO will provide the practices with quarterly HbA1c reporting. The practice can use the information to guide member engagement strategies. The HbA1c performance monitoring statistics will reflect the impact of all aspects of the project as they all contribute to better management of diabetes and improved control. The following steps outline the process for implementing this component of the project/intervention:

- Conduct outreach to target providers (3 providers in Community A)
- Develop and implement HbA1c reporting, including goals

- Begin data reporting
- Ongoing follow-up/support to help practice reach goal

☒ Short term or ☒ Long term

Monitoring measure 2.1	HbA1c poor control performance statistic reported to target practices (percent of diabetic patients with HbA1c level above 9.0%)			
Baseline or current state	**Target / future state**	**Target met by (MM/YYYY)**	**Benchmark / future state**	**Benchmark met by (MM/YYYY)**
None – not currently reported to practices	Reporting to all three practices in place	05/2023	Same as target	Same as target

Monitoring measure 2.2	Percent of members who have identified a primary language other than English and have LEP who have accessed a health care interpreter.			
Baseline or current state	**Target / future state**	**Target met by (MM/YYYY)**	**Benchmark / future state**	**Benchmark met by (MM/YYYY)**
Provider A – 40% Provider B – 42% Provider C – 38%	35% 37% 33%	12/2023	30% 32% 28%	12/2024

Activity 3 description: Care Coordination Agreements

A key activity in managing utilization and improving quality/outcomes is ensuring appropriate primary care follow-up following certain types of ED visits and after most inpatient admissions. To support the target practices in improving follow-up activities, the CCO will support the practices in developing care coordination agreements and protocols related to ED and inpatient admissions at Community A's local hospital.

ExampleCCO will do the following in support of this intervention:

- Conduct outreach to target providers (3 providers in Community A and Community A's local hospital)
- Facilitate a meeting between each of the practices and the hospital where care coordination and notification processes are established using industry standard guidelines with practice specific process modifications
- Support the practices in formalizing the agreement
- Period check-in to verify follow-up is occurring for the target population consistent with the agreements put in place.

☒ Short term or ☐ Long term

Monitoring measure 3.1	Care Coordination and Agreements Between Providers			
Baseline or current state	**Target / future state**	**Target met by (MM/YYYY)**	**Benchmark / future state**	**Benchmark met by (MM/YYYY)**
None – agreements not yet in place	Care coordination agreements in place between hospital and all three providers.	6/2023	Same as target	Same as target

Activity 4 description: Community Referral for Food Insecurity and Access to Healthy Food
Barriers to appropriate nutrition can result in challenges in management of diabetes. To support practices in both identifying nutrition-related barriers to diabetes management, ExampleCCO will identify available community resources and help the target practices with internal clinical and administrative process flows to identify and refer to community resources for diabetic patients in needs of support. The following steps will be implemented:

- Identify community resources related to nutrition and food insecurity in Community A
    - Includes identification of a process for referral and a point of contact to facilitate referrals from practices
- Conduct outreach to target providers (3 providers in Community A)
- Work with practices to develop and document practice protocols for asking diabetic patients about their access to appropriate nutrition
- Work with practices to develop and document practice protocols for referring positive screens for nutritional needs to community resources
- Follow-up to ensure protocol is being leveraged

☒ Short term or ☐ Long term

Monitoring measure 4.1	Community Referral Processes Implemented by Practice			
Baseline or current state	**Target / future state**	**Target met by (MM/YYYY)**	**Benchmark / future state**	**Benchmark met by (MM/YYYY)**
None – no documented process in place	Documented process for community referrals in place at all three target practices	6/2023	Same as target	Same as target

Key highlights

Section 2: Discontinued Project(s) Closeout

- Identity discontinued projects
- Defend discontinuation

Example(s):

- Prior year hypertension measure discontinued because intervention implemented to fidelity with no room to expand

Section 2: Discontinued Project(s) Closeout

E. **Project short title:** Medicaid Efficiency and Performance Program (MEPP) – Hypertension

F. **Project unique ID (as provided by OHA):** ###

G. **Criteria for project discontinuation:** Fully matured project that has met its intended outcomes

H. **Reason(s) for project discontinuation in support of the selected criteria above:**

ExampleCCO's 2022 MEPP projects include an intervention related to Hypertension. The intervention was to provide targeted patient education regarding home monitoring of blood pressure. Education materials were developed and sent to the target population (all individuals identified to have pre/hypertension). We attest that the intervention was completed to fidelity. The intervention was designed to be a one-time release of educational materials.

The performance measure related to the intervention was a process measure – educational materials sent to and received by 95% of members with pre/hypertension by 10/2022. While the intervention was implemented to fidelity, the actual rate of materials being received by members was 94%. The rate fell short of the target due to members having invalid mailing addresses. 6% of educational materials were returned to the CCO due to invalid addresses. As this project is being discontinued, it is being replaced by the diabetes related project described above.

2023 TQS technical assistance

Guidance documents: www.oregon.gov/oha/HPA/dsi-tc/Pages/Transformation-Quality-Strategy-Tech-Assist.aspx

Webinar series (October)

- ✓ **Purpose:** Provides technical assistance to CCOs for developing next year's TQS submission.
- ✓ Webinar series that covers general and component-specific lessons learned and changes for the coming year. Webinars include time for CCOs to ask OHA SMEs questions.

Office hours (November–March)

- ✓ **Purpose:** Allows CCO to ask questions as the CCO is developing and finalizing the TQS submission.
- ✓ Offered monthly until submission

Written and oral feedback for each CCO (early summer)

- ✓ **Purpose**: Provides CCOs feedback on strengths and weaknesses in documentation or structure of CCO health transformation and quality work.
- ✓ Written assessment with scores; required 60-minute call with OHA.

Q & A

Resources

OHA utilization review lead: Carrie Williamson: carrie.williamson2@dhsoha.state.or.us

MEPP review lead: Shane Mofford: shane.mofford@publicpolicyinsights.com

OHA TQS leads:

- ✓ Lisa Bui: Lisa.T.Bui@dhsoha.state.or.us
- ✓ Anona Gund: Anona.E.Gund@dhsoha.state.or.us
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All TQS resources, including the templates, guidance document, and technical assistance schedule are available on the **Transformation Center website**: www.oregon.gov/oha/HPA/dsi-tc/Pages/Transformation-Quality-Strategy-Tech-Assist.aspx

The templates and guidance document are also cross-posted on the **CCO Contract Forms page**: www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx

Thank You

Oregon Health Authority