Underservice workgroup, Complex Care Committee, MAPOC
Underservice monitoring recommendations
7.20.14

Metrics – high priority

- Percentage of individuals who fail to have an initial person-centered plan in writing developed by a team which includes the individual, a guardian or family member as well as support staff who were knowledgeable about the individual's medical and non-medical needs and goals/desires.
    - Within 30 days of completion of enrollment
    - Within 13 months of the last care plan
    - Within one month following a significant change in health status or transition between care settings
- Determine if people are getting the services – type, scope, and duration – that is included in their care plan or individual service plan
    - If they aren't getting services identified in the plan, why not? (for example -- lack of availability, sources of payment, or misunderstanding of need and how to use)
    - Evaluate outcomes – are people achieving their goals, as spelled out in the care plan?
- Percentage of individuals reporting a communication issue with their provider of medical or LTSS services and supports – in complaints and person experience of care surveys. Communication issues can arise from deafness, blindness, intellectual challenges, brain damage, dementia, speech problems, mental health challenges, different language, etc.
- Percentage of appointments where individuals had to wait more than a day to see a primary care provider for urgent issues or more than a week, to see a specialist or to receive a recommended procedure for urgent issues. [This would include those on Medicaid/Medicare not finding a qualified professional who accepted Medicaid or Medicare as well as those who had to wait to see an existing provider.]
    - Stratify by specialty type
    - Stratify by new patient, referral, maintenance, and follow up care
- Monitor adequacy of provider network
    - By specialty
    - By condition, i.e. providers with capacity to treat both brain injuries and behavioral health issues
    - Ensure that centers of excellence are included – to guard against "network management" that fosters cherry picking
    - Providers with expertise in complex conditions (for example[1], what is identified as severe mental health conditions depression, bipolar, schizophrenia), people who are dually diagnosed (with a mental health condition and a substance use condition)

    - Providers with expertise serving persons with co-morbid conditions (mental health and 'medical' conditions, oftentimes very intertwined due to medication side effects, etc.)
    - Providers with expertise serving subgroups such as adolescents, young adults, older adults (both adults with mental health conditions who are aging and older adults who are developing mental health conditions, Alzheimer's etc.)
    - Ensure no reductions in network adequacy after the initial or base year
- Populations for underservice monitoring --
    - Readmissions[2]
    - Ambulatory care-sensitive condition admissions
    - People without close family or caregiver involvement
    - People with high health costs
    - High utilizers of urgent care
    - People with behavioral health diagnoses
    - Limited English speakers
    - People with missed prescription refills
    - Repeated use of providers outside the neighborhood (what are they missing from inside the neighborhood options?)
    - People who opt-out of the health neighborhood
    - Interruptions or discontinuing usual treatment, prescriptions, labs, or transportation patterns for people with chronic illness
    - Adolescents, especially with mental health issues
    - People with a specific disability
    - People transitioning between levels of care
    - People with brain injury
    - People with multiple disorders
    - Monitor for the lack of professionals caring for someone with a complex condition, i.e. brain injury
- Services to monitor --
    - Access to specialists, for example, psychiatrists, mental health prescribers, oral health providers
    - Length of mental health treatment, ending too soon
    - Substance use treatment
    - Transportation
    - Oral health
    - Pain management services
    - Specialized mental health services, i.e. eating disorders, trauma services, problem sexual behavior
    - Cancer treatment, follow up
    - Reduction in prescriptions/requests for home care services relative to previously or a parallel population- hours/week, duration after traumatic incident, surgery, etc.

    - Reductions in prescriptions/requests for imaging services relative to previously or a parallel population (including CAT- scans, PET scans v. MRIs)
    - Reductions in duration or intensity of the "therapies"- PT, OT, ST- relative to previously or a parallel population
    - Reductions in referrals to specialists relative to previously or a parallel population, controlling for health status
- Providers/neighborhoods to monitor
    - Monitor for increasing or decreasing risk scores by provider/neighborhood[3] -- cherry picking, underservice and/or overbilling
    - Providers discharging or stopping care for people when they become heavy users of care
    - High provider turn over and movement between programs (pressure on providers to inappropriately reduce care?)
    - Where audits should focus –
        - Providers with a prior history of problems – either quality or financial, very high levels of savings
        - Providers with poor person experience of care scores
        - At random
    - Measures should focus on –
        - Treatment or referral patterns different from colleagues
        - Treatment patterns that vary from best practice guidelines
        - Changes in practice patterns over time
        - Different practice patterns by funding source within a provider's panel (i.e. uninsured vs. Medicaid vs. Medicare vs. private insurance)

<u>Metrics—medium priority</u>

- Percentage of appointments missed due to lack of transportation -- identify reasons through a survey

<u>Process of effective underservice monitoring</u> – to include action planning and follow up

- Require applicants to the RFP to describe their plan for underservice monitoring and follow up in their application. NCQA requires an underservice monitoring plan for ACO certification; the state could use language from their standard for the RFP. Allow them to design a program that makes sense for that neighborhood population and resources. Assign this provision substantial points in scoring applications to foster innovation and promote neighborhoods that take underservice seriously.
- Provide a safe way for providers to identify and report underservice (whistleblower-type system)
    - Make all provider performance profiles, aggregate utilization profiles, available to other providers

- Re-evaluate underservice (and overtreatment) monitoring regularly, survey persons receiving care and providers to identify potential metrics, employ secret shopper surveys, change metrics and populations targeted regularly, learn from trends identified and new research
- Monitor all contracts and incentive arrangements in the neighborhood (contracts and subcontracts) to ensure there are no incentives to deny necessary care
- Monitoring should be designed to be constructive – access to necessary providers is already a problem, it is critical to assist providers in giving appropriate levels of care to every patient -- start with conversations with providers identified as underserving, provide technical assistance to improve care, and apply penalties if assistance has not addressed the problem. The program must balance constructive assistance with accountability – penalties, when warranted, must be applied to protect consumers.
- Survey local community providers, safety net, constituent workers, and social service organizations for underservice and quality
- Monitor marketing and decision support tools for cherry picking and steering for underservice to less comprehensive care or inappropriate caregivers
- In all monitoring, consider and investigate both ends of the utilization curve – over and underservice[4]
- Have a joint provider/person /family quality committee at each health neighborhood to track quality and undertreatment and guide quality improvements
- Monitor denied care or claims, or denied care requests/ prior authorization denials
- Robust follow up on any complaints of under-service or very low person experience of care respondents, include robust outreach for instances of underservice and low barriers to filing complaints/grievances

<u>Further considerations</u> –important recommendations to support underservice monitoring

- Ensure clear communication of rights of individuals including recourse policies and procedures, not only once but available on an ongoing basis. Include Patient Bill of Rights (as applicable, for individuals receiving services through DMHAS). Follow-up for both individual and provider/group on under-service and low care experience to improve care and reduce likelihood of continued underservice/low care experience.
- Ensure people with a predominant condition, such as mental health, intellectual disability, brain injury, etc. who seek care for other health conditions are treated for those conditions without looking 'through their primary condition lens.'
- Person-centered care plans must be in writing, approved/signed by the person/caregiver and a copy is supplied to the person/caregiver within 30 days
    - At a minimum the plan should include the person's goals and what is

necessary to achieve the goals
    - Document what input person/caregivers had into the plan
- Ensuring not only person-centered but person-driven care plans developed with appropriate authorizations that include all relevant people (as identified by the individual) and include short term, mid-term and long-term goals; with all neighborhood providers of services/supports included, or at the least identified
- Ensure that care plans also identify quality of life issues, including housing, social integration, work and volunteer activities (if desired), transportation
- Percentage of providers who lack specific training in the underlying disabilities/challenges (such as brain damage, mental health challenges, intellectual disabilities, etc.,) of the individuals they are serving/supporting
- Percentage of Care Plans containing items to which the individual, guardians, or family object. [i.e. the plan cannot be imposed by the professionals without buy-in by those affected. This includes a difference in willingness to undertake risk.]
- Percentage of individuals who fail to interact at least five times a week on the average with persons who are not paid to be with them. Can be included in person experience of care surveys. [Interactions may occur during activities such as working, volunteering, religious, social, sports, recreational, etc.]

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[1] For example is used throughout the document for illustrative purposes only. They are not meant to be a complete list or to be the only examples to which the measure applies.

[2] CT's MME 30 day readmission rates of 40% (people who are blind or have disabilities) and 35% (elderly) are far higher than US averages of 17 to 20% -- CT Medicare and Medicaid Eligibles: Review of Key Findings, Optumas, for MAPOC Complex Care Committee, 4/27/12

[3] Why Medicare Advantage Costs Taxpayers Billions More Than it Should, Center for Public Integrity, 6/4/14

[4] CrystalRun Health Care webinar, CT Health Policy Project, 4/17/14