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MQISSP — UNDER-SERVICE UTILIZATION MONITORING STRATEGY

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Draft and Subject to Revision

Purpose

The goal of Medicaid Quality Improvement and Shared Savings Program (MQISSP) is to improve the member experience, increase the quality of Medicaid primary care, and enhance care coordination activities such that medically unnecessary and inappropriate utilization is decreased and member health outcomes improve. The Connecticut Department of Social Services (DSS) recognizes there is a potential risk in a shared savings model that members are diverted from a provider practice or discouraged from medically necessary services in an effort to drive increased savings or limit the number high-risk members a provider may serve. The MQISSP Under-Service Utilization Strategy was developed in response to this potential risk and is an approach designed to identify potential under-service utilization or inappropriate reductions in access to medically necessary care. It is important to also note that the Connecticut Medicaid Fee-for-Service model offers limited financial incentives to under-service utilization practices. At its core, the program is not a gate-keeper or managed care model, and members are allowed to self-refer to any participating provider. MQISSP adds the following five-pronged approach to try to improve and increase right-care, and includes an incentive to reduce emergency department use, readmissions, and ineffective services.

Five-Pronged Approach

DSS recognizes that identification of under-service utilization practices is complex, and no one strategy alone can adequately ameliorate the risk. For MQISSP, DSS proposes a strategy that encompasses several monitoring methods. These methods are demonstrated in the diagram on the right and represent an approach designed to provide the best opportunity to identify under-service utilization practices, inappropriate member-shifting (sometimes referred to as “cherry-picking”), diminished access to medically necessary services, or other early warning indicators of under-service utilization practices.

1. Preventative and Access to Appropriate Care Measures

Of the 28 MQISSP Quality Measures, 22 track preventative care rates or monitor appropriate clinical care for specific health conditions. Tracking these measures, and comparing to historical rates, can provide actionable information regarding clinical quality and act as a bellwether for decreased access to medically necessary care. The preventative and access to appropriate clinical care measures include the following:

Table 1: Preventative Care and Access to Appropriate Clinical Care Measures		
Adolescent Well Care Visits	Annual Fluoride Treatment Ages Birth to 4 Years	Annual Monitoring for Persistent Medications
Asthma Medication Ratio	Behavioral Health Screen	Breast Cancer Screening
Cervical Cancer Screen	Chlamydia Screen in Women	Developmental Screening in First 3 Years of Life
Diabetes Eye Exam	Diabetes HbA1c Screening	Diabetes: Attention for Nephropathy
Follow-up Care for Children Prescribed ADHD Medication	Frequency of Ongoing Prenatal Care	HPV for Female Adolescents
Medication Management for People with Asthma	Metabolic Monitoring for Children and Adolescents on Antipsychotic Medication	Oral Evaluation; Dental Services
Post Hospital Admission Follow-up	Prenatal and Postpartum Care	Well-Child Visits in the first 15 Months of Life
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		

2. Member Surveys

Included within the MQISSP measure set is the Person-Centered Medical Home (PCMH) CAHPS survey.[1] This is a standardized member survey, conducted annually to determine member satisfaction with services and service providers. Many of the PCMH CAHPS questions solicit information that may suggest under-service utilization practices. Below are a few examples of questions that may inform whether under-service utilization may be present.

- In the last 12 months, how many days did you usually have to wait for an appointment when you needed care right away?
- In the last 12 months, how often were you able to get the care you needed at your provider's office during evenings, weekends, or holidays?
- Did this provider's office give you the information about what to do if you needed care during evenings, weekends, or holidays?

In addition to the PCMH CAHPS survey, DSS may add specific questions from the CAHPS Cultural Competency Supplemental Item Set [2] as a mechanism to monitor MQISSP cultural competency care coordination requirements. While not a direct indication of under-service utilization practices, they provide important information regarding the member experience that can discourage members from accessing needed care. (The number in parenthesis indicates the question number from the survey).

- In the last 12 months, how often have you been treated unfairly at this provider's office because of your race or ethnicity? (CU14)
- In the last 12 months, how often were you treated unfairly at the provider's office because you did not speak English very well? (CU24)

[1] PCMH Consumer Assessment of Healthcare Providers (CAHPS) Survey: https://cahps.ahrq.gov/surveys-guidance/survey4.0-docs/1314_About_PCMH.pdf

[2] CAHPS Cultural Competency Supplemental Item Set: https://cahps.ahrq.gov/surveys-guidance/survey4.0-docs/2312_about_cultural_comp.pdf

- An interpreter is someone who helps you talk with others who do not speak your language. Interpreters can include staff from the provider's office or telephone interpreters. In the last 12 months, was there any time when you needed an interpreter at this provider's office? (CU25)
- In the last 12 months, did anyone in this provider's office let you know that an interpreter was available free of charge? (CU26)
- In the last 12 months, how often did you use an interpreter provided by this office to help you talk with his provider? (CU27)

3. Member Education and Grievances

All members will receive notification of prospective assignment based on the retrospective attribution process. The notice will contain information sufficient to put the member on notice that the provider they are assigned to has an opportunity to receive a portion of any avoided costs if the care provided meets minimum quality thresholds. All members will retain all Medicaid grievance processes and are educated on the process to submit grievances through their Member Handbook. Grievances may be submitted in several ways; in writing, by fax, by email or by phone. In addition to submitting a grievance through the State's Administrative Services Organization, members are provided information on submitting a grievance directly to DSS, the Office of the Healthcare Advocate or to the Office of Civil Rights in Washington, DC. Monitoring these grievances is an oversight function currently incorporated in the program and will continue to be monitored.

4. Secret Shopper

DSS may develop a secret shopper process for the MQISSP to: monitor the program; identify access to care issues, and; evaluate provider practices including under-service utilization practices and inappropriate member-shifting (sometimes referred to as "cherry-picking").

5. Shared Savings Design Elements

The MQISSP model design has several elements that may act as deterrents to providers underserving members as a means of increasing potential shared savings. Elements in the model design include the following:

- Savings Cap: Participating Entities will not be allowed to contribute more than 10% of its expected expenditures to the shared savings pool.
- Minimum Savings Rate: The MQISSP will not require Participating Entities to exceed a minimum savings rate to be eligible to share in savings.
- Upside-only Model: In the event that a Participating Entity's performance year costs exceeds their expected costs, that Participating Entity will not be required to pay back costs that exceed the expected costs.
- High Cost Claims Truncation: Claims costs exceeding the ninety-ninth percentile (subject to data review) will be excluded from the shared savings calculation.
- Concurrent Risk Adjustment Methodology: Risk scores will be calculated to compare a MQISSP Participating Entity's level of risk relative to non-Participating Entities.