Quality Improvement and Utilization Management Evaluation's Executive Summary

Current Measurement Year: 2022

Executive Summary: Description of Completed and Ongoing QI Activities

ABH has been a Managed Behavioral Healthcare Organizations (MBHO) since 2014. ABH's QI program is modeled after the National Committee for Quality Assurance (NCQA), an organization dedicated to improving health care quality. This model allows ABH to incorporate a comprehensive method of tracking, measuring, and ultimately improving the quality and safety of care to ABH members. Elements of this comprehensive approach ABH takes to QI are UM, Care Coordination, Provider and Practitioner oversight via the formal Credentialing and Re-Credentialing process, tracking and trending HEDIS and other Performance Measures, and various other QI projects.

ABH works collaboratively with our Provider Network, the Health Plans, and the medical community to ensure continual quality assessment through the tracking and trending of measures, identification of opportunities for improvement, measurement, intervention, and re-measurement of service, utilization, and quality goals.

This document represents a summary of quality activities and accomplishments for the calendar year 2022. This report was written collaboratively by the Quality Management and Improvement Director and the Director of Utilization Management and reviewed by the Quality Management Committee, which serves as the organization's oversight body.

Key Initiatives

- Increase provider awareness of follow up measure by disseminating quarterly gap reports which specify which members were compliant and non-compliant after behavioral health hospitalization measure and who were readmitted within 30 days.
- QI Department to outreach to members discharged from an inpatient behavioral health admission to provide members with appointment information, to assist in rescheduling the appointment if needed, and to gather data on reasons the appointment was missed or rescheduled.
- In response to the ongoing COVID 19 pandemic, ensure all network providers continue to offer services via telehealth.
- Increase provider awareness of their timely access to service results using quarterly scorecards.
- Increase credentialing of Licensed Clinical Social Workers at FQHC's to support the integration of behavioral healthcare and medical healthcare service delivery models.
- Increase compliance with 7 and 30 day follow up after behavioral health hospitalization
- Improve medical - behavioral healthcare coordination for plan members

Accomplishments

- Met all Provider Network Ratio Standards.
- Achieved a Member Experience Satisfaction Score of 4.5 out of 5 for 2021.
- Expanded tele-health services for all providers.
- Completed virtual medical record audits of all providers in the network.
- Offered two virtual trainings to all network providers.
- Transitioned to a new website platform.
- Collaborated with a health plan on improving the 7 and 30 day follow up after hospitalization measure.

- Quarterly meetings with all Regional Care Centers (RCCs) to review quality measures, opportunities for improvement, and to develop intentional interventions.
- Initiated a provider scorecard with secret shopper call results for timely access to services.
- Provided health plans with quarterly evaluations
- Created a standardized monitoring tool and streamlined the auditing process
- Coordination of care between Behavioral Health providers and from Behavioral Health providers to Medical providers was recorded and reached an average of 100% in BH – BH and 98% for BH – Medical coordination.

Barriers to Achieving Objectives

Member follow-up after hospitalization was a barrier for ABH providers in 2021. Despite initiatives to improve compliance rates for follow up after discharge appointments (both 7 day and 30 day), the rates for 2021 were lower than those in 2020. The follow up appointments are consistently being scheduled by the hospital that discharges the members, but members often fail to keep the appointment. Despite the increased availability of telehealth in response to social distancing, compliance with follow up appointments decreased in 2021. COVID was likely a contributing factor to this decrease.

Analysis and Evaluation of QI Program Effectiveness

The ABH QI/UM Program continued to grow in 2021. ABH developed initiatives with the Health Plans and ABH Providers to ensure that ABH goals outlined in the work plan were addressed. The staffing outlined in the 2021 QI Program Description was adequate. Consideration may be given to the addition of a case manager or to add case management duties to the existing Care Coordination Assistant position. The Quality Management Committee analyzed and evaluated the 2021 QI Program and determined it was effective. ABH consistently evaluated member quality of care when complaints were received. All complaints resulted in agreeable resolutions and there were no quality of care concerns for 2021. The results from the 2021 member experience survey supported overall member satisfaction with providers.

Providers were faced with increased clinical vacancies during 2021, which negatively impacted timely access to services, specifically initial therapy appointments. Vacancies did not affect compliance with Specialist and follow up after hospitalization appointments. Providers received individualized scorecards and received a follow up secret shopper call to determine if interventions applied improved the outcome. This process was effective in correcting deficiencies and will continue in 2022.

Adequacy of QI Resources

October 1, 2021 ABH contracted with Sunshine Health in Region 1. This increased the number of Child Welfare members served by ABH. The following actions occurred to improve adequacy of resources as a result of this contract:

- Expanded the network by credentialing practitioners and providers specifically for this health plan.
- Membership dropped with the end of the Lighthouse contract, ultimately the total membership was less overall.

QI Committee Structure

ABH is the governing body for all activities as defined by contractual obligations. The Quality Management Committee (QMC) consists of the ABH Director, the ABH Medical Director, the Quality Management and Improvement Director, the Director of Care Management, the Director of Network Management, the Accreditation and Quality Improvement Manager, and the Reporting and Data Analysis Team.

The existing Quality Management Committee structure is effective. The involvement of the Medical Director in the QMC and the subcommittees as well as the involvement of providers and practitioners in the subcommittees is adequate to ensure quality and safety of clinical care and services to ABH members. There is an ongoing need for four (4) QMC subcommittees: Quality, Credentialing, QI-UM, and Rights, Responsibilities, and Safety. There is no need to add subcommittees at this time.

Practitioner Participation and Leadership Involvement in the QI Program

Providers and practitioners have the opportunity to participate in the Quality Management Committee's (QMC) subcommittees. The following subcommittees include provider and practitioner participation: Credentialing, Quality, QI-UM and Rights, Responsibilities, and Safety. The ABH Medical Director also has an active role in the QMC and its subcommittees.

Summary of Overall Effectiveness

The QI Program oversees both clinical quality outcomes and service utilization measures. The range of clinical activities monitored by the QI Program include access for urgent, emergent, and routine appointment times, Care Coordination between Behavioral Health and Behavioral Health Providers, and Behavioral Health and Medical Providers. Provider and Practitioner credentialing and re-credentialing falls under the QI Program, as well as HEDIS and other performance outcomes, Behavioral Health screening programs, Clinical Practice Guidelines, and medical records documentation audits. The service component of the program includes utilization management, accessibility of care, member/provider satisfaction, member inquiries, member complaints, Member Self-Management Tools, Fraud/Waste/Abuse Prevention, and Coordination of Care.

COVID 19 was a catalyst for change within the network during 2020. ABH staff transitioned to 100% remote work beginning in March 2020 and will remain working remotely indefinitely. ABH quickly resolved any obstacles to remote work and ultimately had a smooth transition with no disruption to member services. The ABH network of providers also were successful in implementing telehealth for all members. Telehealth, though used in prior years, was the sole means of outpatient service delivery during COVID in 2020 and continued into 2021. Face to face appointments resumed in 2021 with a telehealth option for those members who prefer that delivery method.

The QI program was effective in 2021. Despite ongoing challenges posed by COVID, ABH was able to successfully monitor 100% of in network providers, offered virtual training twice to all network providers, increased the number of providers credentialed in the network, completed the annual member experience survey, addressed access to care with providers who were non-compliant with standards, and resolved data gaps related to call center metrics. The Quality Management Committee (QMC) and its subcommittees met at intervals as outlined within the QI Program Description. The ABH Medical Director had an active role in the QMC and there was an increased provider participation in the QMC Subcommittees this year. The QMC and its subcommittees were successful in discussing topics as

outlined in the QIPD, collaboratively making decisions to improve the QI Program, and in determining future goals.

Annual Evaluation of the UM Program

UM Program Structure, Scope and Processes

ABH considers member and practitioners experience data when evaluating the UM Program.

Member experience: There were no member complaints directed toward the UM Program in 2022.

ABH evaluates provider satisfaction through an annual satisfaction survey.

Access Behavioral Health's (ABH) overall provider satisfaction score for 2022 was 4.25 out of 5.0, meeting the established scoring goal set after analysis of the 2021 survey results. In 2022, scores improved for three of the four lowest scoring areas in 2021 (overall satisfaction with ABH, ABH compared to other Medicaid health plans, claims complaint resolution process). One of the 2021 four lowest scoring areas (claims submission process) remained in the four lowest scoring areas of the survey for 2022. There were 11 respondents to the UM section of the provider survey. The five survey questions related to the UM process scored 4.2 or higher (out of 5) and improved from 2021 to 2022, except for "I am satisfied with the authorization process." The score for this question dropped from 4.32 (with 8 respondents) in 2021 to 4.2 in 2022.

There were no practitioner complaints directed toward the UM Program in 2022.

In 2022, ABH continued to improve collaboration with the medical delivery system in to following ways:

- Continued participation in clinical case reviews with the Health Plans;
- Participation in collaborative performance improvement projects; and
- Streamlining the behavioral health referral process from the health plans with which ABH contracts
    - Improved documentation and reporting of referrals received and referral outcomes; and
    - Improved communication of referrals outcomes back to the referral source
    - Use of a daily automated data feed to improve coordination of care for follow up after an emergency department visit for mental health or substance abuse.

In 2022, ABH documented 415 referrals to behavioral health services from the health plans with which it contracts. This number of referrals was less than 2021 (583 referrals).

In 2022, ABH care coordinators made 83 referrals to health plan medical case management (70 in 2021). This demonstrates continued medical-behavioral health care coordination for plan members.

Both physician and first line clinical reviewer interrater-reliability testing resulted in no scores below 100%. Quarterly reviews were conducted in 2022 of a minimum of 1% of all reviewer decisions made for each contracted health plan.

ABH UM staff excelled in meeting post-hospitalization appointment scheduling metrics as well as meeting both Florida Medicaid and NCQA turnaround times for all types of UM reviews.

The ABH Medical Director and the ABH Quality Management Committee have reviewed the UM Program's structure, scope and process and determined the program as adequate to ensure quality and safety of clinical care and services to ABH members.

UM Program Resources

In 2022, Care Coordinator workloads and assignments were assessed based on recorded utilization management activity metrics (number of initial reviews, continued stay reviews, and discharge reviews). An increase in children's inpatient admissions, family team staffings, and Statewide Inpatient Psychiatric Program (SIPP) admissions were noted. Two vacant FTE positions were combined to create a new FTE position for another children's care coordinator with hiring planned for early 2023 (Note: hired January 2023)

New network providers were trained on use of the ABH provider portal for accessing member eligibility and claims status (implemented in 2020).

Physical resources available to staff were evaluated to ensure all staff had the equipment necessary to perform job functions.

- Additional needs identified - an eFax solution (note: implemented February 2023 through eGoldFax)

Information Sources used to Determine Benefit Coverage

Per Medicaid requirements, ABH follows the Florida Medicaid Coverage and Limitations Handbooks for Behavioral Health (Community Behavioral Health, Behavioral Health Targeted Case Management, Specialized Therapeutic Services and Statewide Inpatient Psychiatric Services); no changes recommended for 2023.

Information Sources used to Determine Medical Necessity: Level of Care (LOC) Criteria

ABH level of care criteria are objective, based on medical evidence, and are consistent with Florida Medicaid Coverage and Limitations Handbooks for Behavioral Health (Community Behavioral Health, Behavioral Health Targeted Case Management, Specialized Therapeutic Services and Statewide Inpatient Psychiatric Services), and the American Society of Addiction Medicine. The ABH Medical Director and other professionals within the ABH provider network annually review the criteria annually for current clinical and medical evidence. Through the ABH QI/UM Committee, the criteria are made available to other practitioners within the ABH network for review and feedback.

- Criteria are applied based on characteristics of the local delivery system
    - Opportunities identified: None
- Availability of alternative levels of care
    - Opportunities identified:
        - ABH continues to work cooperatively with the health plans and the Agency for Health Care Administration to provide in lieu of services and expanded benefits.
- Benefit coverage for alternative levels of care
    - Opportunities identified:

        - A provider contract was extended to Brave Health for telehealth only outpatient behavioral health services to members and allowing referrals without a need for prior authorization.
- Ability to provide all recommended services within the estimated length of stay
    - Opportunities identified: None

Changes to LOC Criteria for 2023:

- Mental Health Level of Care Criteria: Reviewed by David Josephs, PsyD and Lawrence E. Mobley. MD, FAPA; updated "DSM" to DSM 5"; no other updates recommended.
- Statewide Inpatient Psychiatric Program (SIPP) Level of Care Criteria: Reviewed by David Josephs, PsyD and Lawrence E. Mobley. MD, FAPA; no updates recommended.
- Substance Abuse Level of Care Criteria: Reviewed by Irvin Williams, PhD, MCAP and Lawrence E. Mobley. MD, FAPA; no updates recommended.

Level of involvement of the ABH Medical Director in the UM Program

The ABH Medical Director is a board-certified psychiatrist and has been employed by Access Behavioral Health since 2012. He is well versed in medical necessity criteria for behavioral health conditions. The level of involvement of the ABH Medical Director is assessed as adequate to ensure quality and safety of clinical care and services to ABH members.

The ABH Medical Director:

- Is responsible for the overall clinical operations of the ABH UM Program;
- Meets as needed with UM staff to assist with UM decisions;
- Reviews all inpatient readmissions within 7 days and any inpatient admission of a child age five or younger;
- Reviews all cases where medical necessity is questionable;
- Reviews practitioner annual satisfaction survey scores;
- Reviews all member and practitioner complaints related to the UM Program;
- Attends 100% of Quality Management Committee and Quality Improvement/Utilization Management Sub-Committee meetings; and
- Participates in the annual review and update of the ABH UM Program including review of medical necessity criteria and level of care criteria.