HEALTH INDUSTRY COLLABORATION EFFORT (ICE)

COMPLIANCE & UTILIZATION REPORT

CY 2015

Behavioral Health & Recovery Services

for

HEALTH PLAN OF SAN MATEO

November 15, 2016

ICE 2015 UM Delegation Required Reports	
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DEFINITIONS

ACUTE ADMITS

The number of admissions to a general hospital/acute care facility, including mental health. (See definition for non-acute care.)

ACUTE BEDDAYS

Those hospital days incurred during a specific reporting period that include medical, surgical, OB and mental health (in and out of area) that represents any risk (shared or full) to the Provider Organization. These exclude: newborns that leave the hospital with the mother and are considered "normal newborns". (This may or may not include subacute/acute rehab days.)

ADMINISTRATIVE DENIAL

Administrative denials are based on eligibility and carve-outs and are not included in denial counts as they are contract issues and therefore not reported to the Health Plans. Administrative denials are usually contracting issues with a facility rather than issues related to a practitioner or member; the facility may use the provider dispute resolution process; the member is held harmless and no member notification is sent.

APPEAL

A formal request by a practitioner or covered person for reconsideration of an adverse decision such as a utilization recommendation, with the goal of finding a mutually acceptable solution.

APPEALS MECHANISM

The formal process a service provider and/or member can use to request reconsideration of an adverse decision.

AVERAGE LENGTH OF STAY

Total beddays divided by total discharges or admits.

BENCHMARK

For a particular indicator or performance measure, the benchmarking process identifies the best performance in the industry (health care or non health care) for a particular process or outcome, determines how that performance is achieved, and applies the lessons learned to improve performance. Other comparative data Provider Organizations might use includes:
1) information obtained from other organizations through sharing or contributing to external reference databases;
2) information obtained from open literature, data gathering and evaluation by independent organizations regarding industry data;
3) performance of competitors; or
4) comparisons with other organizations providing similar health care services.
(Definition modified from Baldrige National Quality Program Health Care Criteria for Performance Excellence 2003.)

BEHAVIORAL HEALTH

Term for Mental Health services which may include substance abuse, chemical dependency for inpatient and outpatient. This broad term may also include evaluation and treatment of psychological and substance abuse disorders by either PCP or Behavioral Health providers.

CASE MANAGEMENT

The process for identifying covered persons with specific health care needs in order to facilitate the development and implementation of a plan to efficiently use health care resources to achieve optimum member outcome.

COMPLEX CASE MANAGEMENT

Complex case management is the coordination of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate the appropriate delivery of care and services.

COMMERCIAL POPULATION

Those members (subscribers and their dependents), usually birth through 64 years of age, which obtain health care coverage through their employers. This does not include Medicare or Medi-cal.

CONCURRENT REVIEW

An assessment which determines medical necessity or appropriateness of services as they are being rendered.

DELEGATION

A formal process by which a Managed Care Organization (MCO) gives another entity the authority to perform certain functions on its behalf. The authority may be delegated but, the **responsibility** for assuring that the function is performed appropriately, cannot be delegated.

DENIAL

The decision to refuse, deny or modify a request for services/referral.

EMERGENCY ROOM (ER) VISITS

Any visit to an emergency room that does not result in a hospital stay. (Patients admitted to the hospital from the ER should not be counted.)

ENROLLMENT

Current actual number of HMO covered lives that make up the Provider Organization managed care population. This number is usually categorized as commercial, senior, and Medi-Cal.

GOALS

A future condition or performance level that one intends to attain. Goals can be both short term and long term. Goals are ends that guide actions. Quantitative goals frequently referred to as "targets," include a numerical point or range. Targets can be projections based on comparative and/or competitive data.

GRIEVANCE/COMPLAINT
An expression of dissatisfaction by a member, either written or oral.

INPATIENT
Medical, surgical, OB and mental health services rendered in a facility. May or may not include services provided in subacute/acute rehab facilities.

INTERVENTION
An action taken to increase the probability that desired outcomes will occur.

LENGTH OF STAY
The number of days from admission to discharge, excluding the last day of the stay and any denied days.

MEDI-CAL POPULATION
Those members enrolled in the California state Medicaid program and participate in the Managed Medi-Cal Program.

MEMBER
An individual who is a participant in a health plan (and your Provider Organization), and who, with other participants, comprise the enrollment.

MEMBER MONTHS
The sum of the enrollment for the reporting period, e.g.: total of three months enrollment.

MONITOR
A periodic or on-going performance measurement to determine opportunities for improvement and/or the effectiveness of interventions.

NON-ACUTE CARE
Inpatient care, including: hospice, nursing home, rehabilitation, skilled nursing, transitional care and respite care; regardless of the type of facility.

OUTCOME
The results achieved through the performance of a function or process.

OUTPATIENT
All services not included in the definition of acute beddays or inpatient.

OVERTURNED
When an appeal for denied services is deemed appropriate, and the denial is reversed and services are approved.

OVERUTILIZATION
Provision of services that were not clearly indicated or provision of services that were indicated in either excessive amounts or in a higher-level setting than appropriate.

PEER REVIEW
Evaluation of the performance of colleagues by professionals with similar types of degrees and/or specialty.

PERFORMANCE GOALS
The desired level of achievement of standards of care or service. These may be expressed as desired minimum performance levels (thresholds), industry best standards (benchmarks), or the permitted variance from the standard. Performance goals are usually not static but change as performance improves and/or the standard of care is redefined.

PRACTICE GUIDELINES
Systematically developed descriptive tools or standardized specifications for care to assist practitioner in making decisions about appropriate health care for specific clinical circumstances.

PRIOR REVIEW / PRECERTIFICATION/AUTHORIZATION/CERTIFICATION / DETERMINATION
Prior assessment that proposed services are appropriate for a particular patient and will be covered by the Managed Care Organization (MCO). Payment for services depends on whether the patient and the category of service are covered by the member's benefit plan and the eligibility of the patient at the time of service.

PTMPY
Per Thousand Members Per Year

READMISSION
Admission within 31 days of discharge for the same or similar diagnosis.

REFERRAL
A request for authorization of services.

RETROSPECTIVE REVIEW
Assessment of the appropriateness of medical services on a case-by-case basis or aggregate basis after the services have been provided.

SENIOR/MEDICARE POPULATION
Those members eligible for Medicare, age 65 or older and/or disabled.

SPECIAL NEEDS PLANS (SNP)
Medicare managed care plans which are focused on vulnerable groups of Medicare beneficiaries: the institutionalized, dual-eligible (Medicare, Medi-Cal), and beneficiaries with severe or disabling chronic conditions. The goal of Special Needs Plans is for improvement in care for beneficiaries with special needs through improved coordination and continuity of care.

STANDARDS
Authoritative statements of (1) minimum levels of acceptable performance; or results, (2) excellent levels of performance or results; or (3) the range of acceptable performance or results.

THRESHOLD
A pre-established level of performance that, when not met, results in initiating further in-depth review to determine if a problem or opportunity for improvement exists. A pre-established level of performance refers to a minimum performance position on a performance measurement scale determined by the organization. A threshold performance level permits evaluation relative to past performances, assists in projection and establishing future goals, and provides appropriate comparison. When a threshold is not met, it triggers the initiation of further in-depth review to identify a problem or opportunity for improvement.

TRANSITIONS OF CARE
1. Transitions of care refers to the movement of patients between health care practitioners and settings as their conditions and care needs change during the course of a chronic or acute illness. (National Transition of Care Coalition)
2. Movement of a member from one care setting to another as the member's health status changes; for example moving from home to a hospital as a result of an exacerbation of a chronic condition or moving from the hospital to a rehabilitation facility after surgery. (NCQA)

TURN AROUND TIME (TAT)
The amount of time (usually days) from the receipt of a request/referral until the determination is made.

UPHELD
When an appeal for denied services is not overturned (denial stands).

UNDERUTILIZATION
Failure to provide appropriate services.

FORMULAS

These formulas are generic. Use population-specific membership and utilization data where indicated. Note that when completing a quarter or semi-annual report the formulas should cover the three (or six) month reporting period for each quarter or six month period being reported.

BEDDAYS per 1000

$$\frac{\text{Total Raw Beddays (for report period)}}{\text{Enrollment}} \times \frac{365}{\text{\#days in report period}} \times 1000$$

NOTE: Divide total raw beddays incurred by enrollment, multiply this result by result of 365 divided by # days in reporting period, multiply that result by 1000.

ADMITS per 1000

$$\frac{\text{Total Admissions (for report period)}}{\text{Enrollment}} \times \frac{365}{\text{\#days in report period}} \times 1000$$

NOTE: Divide total admissions incurred by enrollment, multiply this result by 365 divided by # of days in reporting period, and multiply that result by 1000.

AVERAGE LENGTH OF STAY

$$\frac{\text{Total Raw Beddays (for report period)}}{\text{Total Discharges (for report period) } \textit{OR} \text{ Total Admits (for report period)}}$$

NOTE: Divide total raw beddays incurred by total discharges OR total admits

READMITS per 1000

$$\frac{\text{Total Raw Readmissions (for report period)}}{\text{Enrollment}} \times \frac{365}{\text{\#days in report period}} \times 1000$$

NOTE: Divide total raw readmissions incurred by enrollment, multiply this result by 365 divided by # days in reporting period, and multiply that result by 1000

EMERGENCY ROOM DENIAL RATE per 1000

$$\frac{\text{Total Raw ER Visits (for report period)}}{\text{Enrollment}} \times \frac{365}{\text{\#days in report period}} \times 1000$$

NOTE: Divide total raw # ER days incurred by enrollment, multiply this result by result of 365 divided by # days in reporting period, and multiply that result by 1000.

DENIAL RATE (%)

Total # Denials (for report period) X 100
Total # Referrals Processed (for report period)

NOTE: Divide total #denials by total # referrals processed, multiply this result by 100

**Administrative denials are not to be included in reported denial statistics. Administrative denials are based on eligibility and carve-outs. Benefits should be included in denial stats and would not be considered an administrative denial.*

DENIAL RATE per 1000

Total Raw # of Denials (for report period) X 365 X 1000
Enrollment #days in report period

NOTE: Divide total raw # denials incurred by enrollment, multiply this result by result of 365 divided by # days in reporting period, multiply that result by 1000.

**Administrative denials are not to be included in reported denial statistics. Administrative denials are based on eligibility and carve-outs. Benefits should be included in denial stats and would not be considered an administrative denial.*

REFERRAL TURN AROUND TIME (TAT) PERCENT (% OF REFERRALS MEETING TAT STANDARDS)

Total # Referrals Meeting TAT (for report period) X 100
Total # Referrals Processed (for report period)

NOTE: Divide total # referrals meeting TAT by total # referrals processed, multiply this result by 100

INPATIENT AND OUTPATIENT METRICS CALENDAR YEAR 2015
CAREADVANTAGE, CMC, AND MEDI-CAL

The Provider Organization may attach a separate internal system generated report that includes all of the listed data types.

INPATIENT METRICS	2014 YTD	2015 Goal	Q1	Q2	1st Semi-Annual	Q3	Q4	2nd Semi-Annual	Annual
SENIOR									
Enrollment (self-reported)	NA	NA	10,033	10,033	10,033	10,033	10,033	10,033	10,033
Acute Beddays/1000	NA	NA	183.92	141.48	**162.7**	182.7	355.72	**269.21**	**215.96**
Acute Admits/1000	NA	NA	6.87	4.85	**5.9**	10.9	14.55	**12.73**	**9.30**
Acute Average LOS	NA	NA	19.00	12.00	**15.50**	8.00	19.00	**13.50**	**14.50**
Acute Readmits/1000	NA	NA	0.81	0.40	**0.61**	1.2	2.83	**2.02**	**1.31**
Medi-Cal									
Enrollment (self-reported)	NA	NA	113,623	113,623	113,623	113,623	113,623	113,623	113,623
Acute Beddays/1000	NA	NA	0.18	0.29	**0.23**	6.10	9.07	**7.58**	**3.91**
Acute Admits/1000	NA	NA	0.29	0.14	**0.21**	0.25	0.46	**0.36**	**0.29**
Acute Average LOS	NA	NA	5	2.67	**3.8**	21.4	19.54	**20.46**	**12.1**
Acute Readmits/1000	NA	NA	0.00	0.04	**0.02**	0.04	0.07	**0.05**	**0.04**
OUTPATIENT METRICS	**2014 YTD**	**2015 Goal**	**Q1**	**Q2**	**1st Semi-Annual**	**Q3**	**Q4**	**2nd Semi-Annual**	**Annual**
SENIOR									
BH Beddays/1000	NA	NA	1844.5	1844.5	**1844.46**	2560.7	2657.4	**2609.05**	**2226.76**
BH Admits/1000	NA	NA	36.1	29.5	**32.81**	22.4	11.2	**16.82**	**24.81**
BH Average LOS	NA	NA	17.33	14.14	**15.7**	13.5	15.29	**14.40**	**15.1**
BH Readmits/1000	NA	NA	492.7	469.7	**481.2**	456.8	414.3	**435.55**	**458.4**
Medi-Cal									
BH Beddays/1000	NA	NA	343.83	365.82	**354.82**	355.50	363.71	**359.61**	**357.22**
BH Admits/1000	NA	NA	23.09	24.66	**23.88**	25.41	24.49	**24.95**	**24.41**
BH Average LOS	NA	NA	7.40	8.29	**7.85**	9.1	6.43	**7.75**	**7.80**
BH Readmits/1000	NA	NA	91.1	105.9	**98.48**	112.0	110.1	**111.04**	**104.8**

Provider Organization Name: Behavioral Health & Recovery Services

CY 2015 Annual Report Inpatient and Outpatient

Report Type: Utilization

Inpatient Utilization: Goals, Analysis, Interventions and Evaluation			
Initial Work Plan Goals	**Planned Activities**	**Target Date(s) for Completion**	**Responsible Person(s) and Titles**
Establish UM Monitoring for Mild/Moderate Population.	Create a local UM Template for M/M and associated data collection tools.	12/31/2016	Scott Gruendl. Assistant Director
Reduction in Inpatient Readmissions.	Monitor Readmissions to Establish Baseline.	CY 2015	Scott Gruendl, Assistant Director
Identify trends in reporting data.	Review newly collected UM data on regular basis.	12/31/2016	Chad Kempel, Systems Engineer
Report Period	**Key Findings and Analysis** List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)	**Interventions / Follow-up Actions** State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)	**Remeasurement** State target date(s) for re-measurement or completion of follow-up actions.
Annual	Acute inpatient beddays increased across the year for Seniors as did readmissions.	Pull individual cases to determine the facts of the why these increases occurred. Develop intervention to be deployed the next quarter.	Deploy intervention by 1/1/2017 and monitor for Q1 and Q2.
	Outpatient days increased significantly over the reporting year for seniors and only slightly increased for the Mild/Moderate.	Explore the trends more closely and review individual cases to determine the cause for the trend and develop intervention.	Deploy intervention by 1/1/2017 and monitor for Q1 and Q2.
Report Period	**Key Findings and Analysis** List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)	**Interventions / Follow-up Actions** State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)	**Remeasurement** State target date(s) for re-measurement or completion of follow-up actions.
Annual	Since no goals were established, the main goal was to get a UM tool up and running which has been accomplished. Next will be to consistently and regularly use the tool so that it becomes a regularly used tool.	Consistently run the report each quarter and identify any trends identified in the data.	Successfully deploy the report for CY 2016 and quarterly for FY 17.

OVER & UNDER UTILIZATION AND TIMEFRAME COMPLIANCE METRICS CALENDAR YEAR 2015

CAREADVANTAGE, CMC, AND MEDI-CAL

The Provider Organization may attach a separate internal system generated report that includes the listed data types. Below are suggested over/under utilization metrics. Health Plans to inform contracted Provider Organizations regarding any required over/under utilization metrics.

OVER & UNDER UTILIZATION STATISTICS	2013 YTD	2014 Goal	Q1	Q2	1st Semi-Annual	Q3	Q4	2nd Semi-Annual	Annual
SENIOR									
Enrollment (self-reported)			10,033	10,033	10,033	10,033	10,033	10,033	10,033
Behavioral Health									
Total # auths			177	165	342	295	257	552	894
Total # auths PTMPY			72	67	69	138	119	129	99
Medi-Cal									
Enrollment (self-reported)			113,623	113,623	113,623	113,623	113,623	113,623	113,623
Behavioral Health									
Total # auths			1,006	980	1,986	982	946	1,928	3,914
Total # auths PTMPY			36	35	35	71	35	53	44

REFERRAL TIMEFRAME COMPLIANCE	2013 YTD	2014 Goal	Q1	Q2	1st Semi-Annual	Q3	Q4	2nd Semi-Annual	Annual
SENIOR									
Routine									
Total # auths compliant			169	150	319	241	222	463	782
Auths compliant by %			100%	100%	100%	100%	100%	100%	100%
Average TAT in days			1	1	1	2	2	2	2
Urgent									
Total # auths compliant			8	15	23	54	35	89	112
Auths compliant by %			88%	80%	84%	85%	83%	84%	84%
Average TAT in hours & minutes			2:20	2:00	2:10	3:14	2:51	3:04	2:55
Medi-Cal									
Routine									
Total # auths compliant			847	811	1,658	815	762	1,577	3,235
Auths compliant by %			100%	100%	100%	100%	100%	100%	100%
Average TAT in days			2	1	2	3	1	2	2
Urgent									
Total # auths compliant			159	169	328	167	184	351	679
Auths compliant by %			84%	82%	83%	85%	89%	87%	85%
Average TAT in hours & minutes			1:55	2:10	2:03	2:55	2:40	2:48	2:21

Provider Organization Name:	Behavioral Health & Recovery Services
Report Type:	**Annual for Over & Under Utilization and Timeframe Compliance**

Utilization and Referral Timeframe Compliance (NCQA UM5): Goals, Analysis, Interventions and Evaluation

Initial Work Plan Goals	Planned Activities	Target Date(s) for Completion	Responsible Person(s) and Titles
Deploy UM Tool.	Create data monitoring tool for authorizations.	12/31/2016	Scott Gruendl, Assistant Director
Establish monitoring of authorization process that measures turn around time.	Create data monitoring tool for authorizations.	12/31/2016	Scott Gruendl, Assistant Director
Monitor compliance of "Urgent" organizational determinations.	Create data monitoring tool for authorizations.	12/31/2016	Scott Gruendl, Assistat Director

Report Period	Key Findings and Analysis List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)	Interventions / Follow-up Actions State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)	Remeasurement State target date(s) for re-measurement or completion of follow-up actions.
Annual	The UM tool needs additional work to make the TAT data report correctly. The percent of authorization compliant and the Turn Around Time numbers are suspect.	Complete additional report logic and design and test the report for accurracy.	Modify, test, and deploy the report by 12/31/16.

Report Period	Key Findings and Analysis List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)	Interventions / Follow-up Actions State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)	Remeasurement State target date(s) for re-measurement or completion of follow-up actions.
Annual	Reporting days, hours, and minutes for Turn Around Times required some manual intervention to collect and report data.	Modify the report so that the days, hours, and minutes for Turn Around Times is gathered automatically and reported with no intervention.	Modify, test, and deploy the report by 12/31/16.