MEASURING ACCESS

A managed care perspective on measuring and improving access to health care services.

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Subcommittee on Access
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OVERVIEW

- Medicare Advantage Requirements
- National Committee for Quality Assurance (NCQA) Standards
- Setting Standards
- Quality Improvement Flow
- Public Health Measures: Agency for Healthcare Research and Quality (AHRQ)

MEDICARE ADVANTAGE REQUIREMENTS

Medicare Managed Care Manual, Chapter 4 - Benefits and Beneficiary Protections, Part II, Section 110

- Maintain and monitor a network of appropriate providers, supported by written arrangements, that is sufficient to provide adequate access to covered services to meet the needs of the population served.
- Establish and maintain provider network standards that:
  - Define the types of providers to be used when more than one type of provider can furnish a particular item or service;
  - Identify the types of mental health and substance abuse providers in their network; and
  - Specify the types of providers who may serve as a member's primary care physician.
- Employ written standards for timeliness of access to care and member services that meet or exceed such standards as may be established by CMS, make these standards known to all first tier and downstream providers, continuously monitor its provider networks' compliance with these standards, and take corrective action as necessary. The MAO must also ensure that, when medically necessary, services are available 24 hours a day, 7 days a week.
- Establish, maintain, monitor and validate credentials for a panel of primary care providers from which the member may select a personal primary care provider.

MEDICARE ADVANTAGE REQUIREMENTS (CONTINUED)

Medicare Managed Care Manual, Chapter 4 - Benefits and Beneficiary Protections, Part II, Section 110

- Provide or arrange for necessary specialist care, and in particular give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services.
- Ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all members, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds.
- Establish and maintain written standards, including coverage rules, practice guidelines, payment policies and utilization management protocols that allow for individual medical necessity determinations.
- Provide coverage for ambulance services, emergency and urgently-needed services, and post-stabilization care services
- Has a quality improvement program as outlined in Chapter 5 of this Manual. The quality improvement program must have a chronic care improvement program that provides:
  - Methods for identifying MA enrollees with multiple or sufficiently severe chronic conditions who would benefit from participating in a chronic care improvement program; and
  - Mechanisms for monitoring MA enrollees who are participating in the chronic care improvement program (See Chapter 5 of this manual, "Quality Improvement and Reporting," for further guidance on chronic care improvement programs).

NATIONAL COMMITTEE FOR QUALITY ASSURANCE STANDARDS

QI 4: Availability of Practitioners:
The organization ensures that its network has sufficient numbers and types of practitioners who provide primary care, behavioral healthcare and specialty care.

Intent

The organization maintains an adequate network of primary care, behavioral healthcare and specialty care practitioners (SCP) and monitors how effectively this network meets the needs and preferences of its membership.

Element A: Cultural Needs and Preferences

The organization:

1. Assesses the cultural, ethnic, racial and linguistic needs of its members.
2. Adjusts the availability of practitioners within its network, if necessary.

Element B: Practitioners Providing Primary Care

To ensure the availability of practitioners who provide primary care services, including general medicine or family practice, internal medicine and pediatrics, the organization:

1. Establishes quantifiable and measurable standards for the number of each type practitioners providing primary care.
2. Establishes quantifiable and measurable standards for the geographic distribution of each type of practitioner providing primary care.
3. Annually analyzes performance against the standards for the number of each type of practitioner providing primary care.
4. Annually analyzes performance against the standards for the geographic distribution of each type of practitioner providing primary care.

NATIONAL COMMITTEE FOR QUALITY ASSURANCE STANDARDS

QI 4: Availability of Practitioners:
The organization ensures that its network has sufficient numbers and types of practitioners who provide primary care, behavioral healthcare and specialty care.

Element C: Practitioners Providing Specialty Care

To ensure the availability of specialty care practitioners (SCP) in its delivery system, the organization:

1. Defines the types of practitioners who serve as high-volume SCPs.
2. Establishes quantifiable and measurable standards for the number of each type of high-volume SCPs.
3. Establishes quantifiable and measurable standards for the geographic distribution of each type of high-volume SCPs.
4. Analyzes performance against the standards at least annually.

Element D: Ensuring Availability of Behavioral Healthcare Practitioners

To ensure the availability of high-volume behavioral healthcare practitioners in its delivery system, the organization:

1. Defines the types of practitioners who serve as high-volume behavioral healthcare practitioners.
2. Establishes quantifiable and measurable standards for the number of each type of high-volume behavioral healthcare practitioners.
3. Establishes quantifiable and measurable standards for the geographic distribution of each type of high-volume behavioral healthcare practitioners.
4. Analyzes performance against the standards annually.

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NATIONAL COMMITTEE FOR QUALITY ASSURANCE STANDARDS

QI 5: Accessibility of Services

The organization establishes mechanisms to ensure access to primary care services, behavioral healthcare services and member services.

Intent

The organization provides and maintains appropriate access to primary care, behavioral healthcare and member services.

Element A: Assessment Against Access Standards

Using valid methodology, the organization collects and performs an annual analysis of data to measure its performance against standards for access to:

1. Regular and routine care appointments.
2. Urgent care appointments.
3. After-hours care.
4. Member Services, by telephone.

Element B: Behavioral Healthcare Access Standards

Using valid methodology, the organization collects and annually analyzes data to measure performance against standards for behavioral healthcare access to:

1. Care for a non-life-threatening emergency within 6 hours.
2. Urgent care within 48 hours.
3. An appointment for a routine office visit within 10 business days.

NATIONAL COMMITTEE FOR QUALITY ASSURANCE STANDARDS

QI 5: Accessibility of Services

The organization establishes mechanisms to ensure access to primary care services, behavioral healthcare services and member services.

Element C: Behavioral Healthcare Telephone Access Standards

Using valid methodology, the organization collects and analyzes data to measure its performance against the following behavioral healthcare telephone access standards:

1. The quarterly average for screening and triage calls shows that telephones are answered by a live voice within 30 seconds.
2. The quarterly average for screening and triage calls reflects a telephone abandonment rate within 5 percent.

NATIONAL COMMITTEE FOR QUALITY ASSURANCE STANDARDS

QI 6: Member Satisfaction
The organization implements mechanisms to assess and improve member satisfaction.

Intent

The organization monitors member satisfaction with its services and identifies areas of potential improvement.

Element A: Annual Assessment

To assess member satisfaction with its services, the organization annually evaluates member complaints and appeals using the following methods:

1. Draws appropriate samples from the affected population, if a sample is used.
2. Collects valid measurement data for each of the five required categories.
3. Analyzes data.

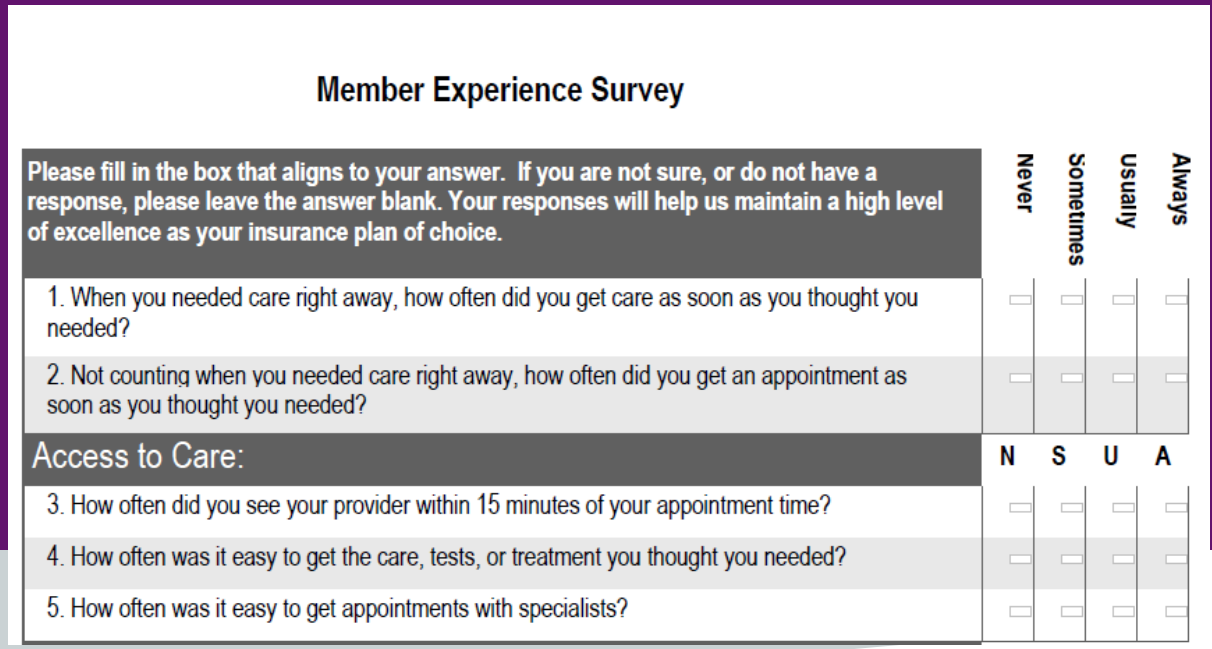
Element B: Opportunities for Improvement

The organization annually identifies opportunities for improvement, sets priorities and decides which opportunities to pursue based on analysis of the following information:

1. Member complaint and appeal data.
2. The CAHPS 5.0H survey.

THE ESSENTIAL QUESTION …

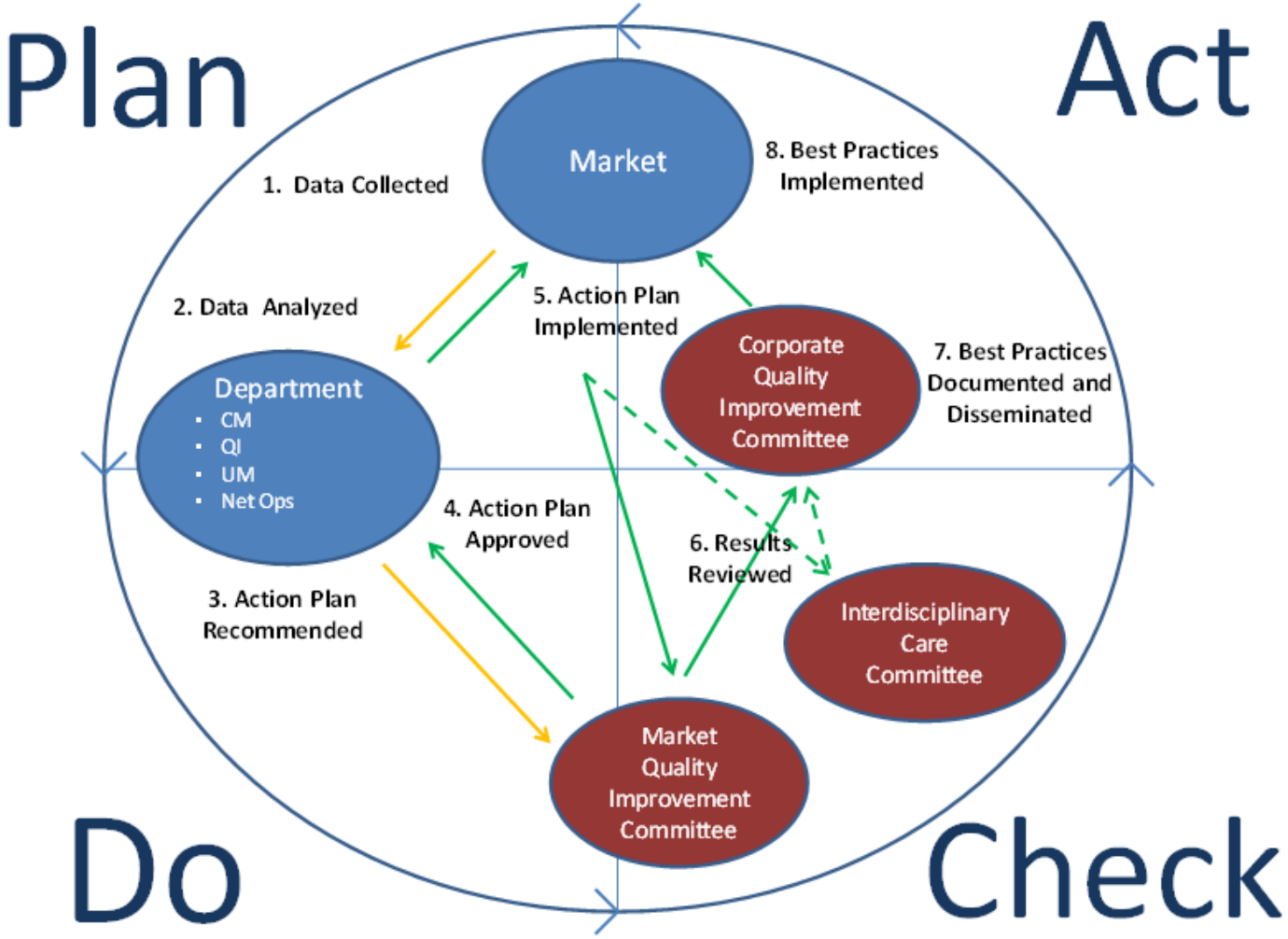
Are the standards set adequate to assure member satisfaction?



Member Experience Survey

Please fill in the box that aligns to your answer. If you are not sure, or do not have a response, please leave the answer blank. Your responses will help us maintain a high level of excellence as your insurance plan of choice.	Never	Sometimes	Usually	Always
1. When you needed care right away, how often did you get care as soon as you thought you needed?				
2. Not counting when you needed care right away, how often did you get an appointment as soon as you thought you needed?				
Access to Care:	**N**	**S**	**U**	**A**
3. How often did you see your provider within 15 minutes of your appointment time?				
4. How often was it easy to get the care, tests, or treatment you thought you needed?				
5. How often was it easy to get appointments with specialists?				

QUALITY IMPROVEMENT FLOW



AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ)

The Agency for Healthcare Research and Quality's (AHRQ) mission is to improve the quality, safety, efficiency, and effectiveness of health care for all Americans. As 1 of 12 agencies within the Department of Health and Human Services, AHRQ supports research that helps people make more informed decisions and improves the quality of health care services.

Preliminary Measure Set, National Healthcare Disparities Report: Access to Care Measures

Access to the Healthcare System

- Health Insurance Coverage
- Usual Source of Care
- Unmet Need
- Mental Health/Substance Abuse

Structural Barriers within the System

- Transportation
- Getting Care
- Waiting Times

Ability of Provider to Address Patient Needs

- Patient-Physician Communication
- Cultural Competency
- Health Information

http://www.ahrq.gov/research/findings/nhqrdr/nhdr02/premeasurea.html

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