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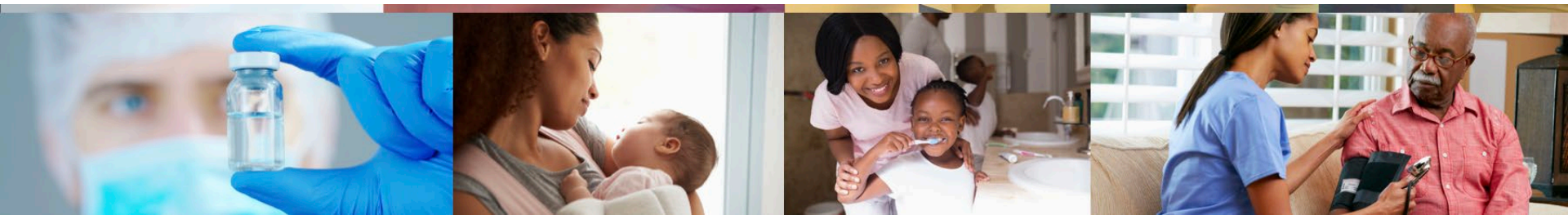
Behavioral Health System of Care Workgroup

October 28, 2020



Behavioral Health System of Care Workgroup Meeting – October 28, 2020

Agenda:

- Welcome and Introductions – Dr. Aliya Jones and Tricia Roddy
- Housekeeping and Roll Call – Chris Yeiser and Laura Spicer
- Rate-Setting Study Update – Jennifer McIlvaine
- MCO Network Update – Jennifer Briemann and Dr. Arethusa Kirk
- Public Comment

Housekeeping:

- Everyone is on Mute – Please don't un-mute yourself.
- Workgroup Members – To ask questions after the presentation:
  - Connected via Internet? Use the "raise your hand" feature on the "Participants" box.
    - Click this button:  to bring up the Participants box then click this button: 
    - Don't forget to un-raise your hand when your question is addressed.

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Rate-Setting Study Update

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MCO Provider Network Standards and Quality

Dr. Arethusa Kirk
Chief Medical Officer
UnitedHealthcare Community Plan, Maryland
October 28, 2020

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Overview

- Maryland Medicaid Waiver Program (HealthChoice) created in 1997.
- Since inception, has grown from 350,000 members to over 1,400,000 members.
- HealthChoice covers all populations and services except LTC, Dual Eligibles and Behavioral Health.
- Maryland MCO Association (MMCOA) was created by MCOs in 2017 to enhance collaboration with MDH in order to meet the overarching goals of continually delivering accessible, high quality, and cost effective care to the members in the HealthChoice program.

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MCOs in Maryland:

- Facilitate a health care delivery system organized to manage quality, cost, and utilization.
- Deliver Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs).
- Accept a set per member per month (capitation) payment for these services.
- The state contracts with 9 MCOs with different models to deliver Medicaid services to their beneficiaries.
- The HealthChoice program has evolved to coordinate and integrate care beyond traditional medical services, including addressing social determinants of health.

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MCOs Have Helped To Expand Access

- Membership in HealthChoice has almost doubled since the Affordable Care Act.
- The level of preventive care has expanded despite increase in membership and pent up demand for services.
- Four MCOs with statewide coverage.
- Focus on new member access to care and medical home (PCMH).

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MCOs Help Members Receive High Quality Care

- All plans are NCQA accredited with the majority of plans rated commendable by NCQA with 2 plans rated excellent.
- HEDIS and Value Based Purchasing rates among the highest in the nation among Medicaid plans.
- Provide unfunded benefits such as adult dental and vision.
- MCOs have helped reduce disparities in healthcare.

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Maryland MCOs Have High Satisfaction Rates

- MDH directed member (child) satisfaction surveys show overall plan satisfaction rates between 75% and 90% of national Medicaid Mean.
- MDH directed provider satisfaction surveys indicate 80% of PCPs either very satisfied to somewhat satisfied and almost 90% willing to recommend MCOs to patients or other providers.

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NCQA

All Managed Care Organizations (MCOs) are required to be accredited by NCQA (National Committee for Quality Assurance).

The NCQA standards are a roadmap for improvement and organizations such as ours use them to perform a gap analysis and align improvement activities with areas that are most important to our State partner.

The NCQA Standards evaluate plans on:

- **Quality Management and Improvement.**
- **Population Health Management.**
- **Network Management.**
- **Utilization Management.**
- **Credentialing and Recredentialing.**
- **Member Experience.**
- **Medicaid Benefits and Services.**

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NCQA: Core Features

The standards provide a framework for implementing best practices to:

1. Apply a QI process to improve key operational areas.
2. Maintain an adequate practitioner network and access to care.
3. Establish timely and accurate credentialing and recredentialing processes.

<u>Why NCQA ?</u>

It is the most widely-recognized accreditation program in the United States and it offers the most comprehensive evaluation in the industry.

The NCQA requirements provide guidelines to ensure that consumers' rights are protected and their voices are heard by basing results on clinical performance (i.e., HEDIS measures) and consumer experience (i.e., CAHPS measures).

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Credentialing

While the details of the Credentialing Process varies across MCOs, all nine MCOs conduct the following:

Review and Update Credentialing Plans to maintain compliance with all state and federal regulatory requirements and accreditation requirements of the National Committee for Quality Assurance (NCQA).

Maintain a Review Committee which reviews credentialing applications and makes a final decision. (Example: The National Credentialing Committee is a peer review body of LIPs (licensed independent practitioners) from an MCO network that meets weekly and reviews all credentialing applications, The review process includes primary and secondary source verification documents as well as national practitioner databank [NPDB] research and OIG information.)

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Re-Credentialing

Each MCO engages in a Re-Credentialing process.

- This process occurs every 3 years.
- The process assures that all practitioners have updated documentation to verify adherence to specific guidelines, processes, and care provider performance standards.
- MCOs refer to the equivalents of their Quality Management database for information about provider performance. This includes items such as member complaints and quality of care issues.
- Providers are notified about Re-Credentialing timeframes and re-application process in advance of the start of the credentialing cycle.

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MCOs build relationships with their contracted providers. This has many advantages:

- MCOs can communicate changes (such as updates to program standards or quality of care standards) with providers quickly.
- Providers can ask questions, refer patients to health education classes, case management programs, as appropriate.
- This working relationship benefits overall coordination of care for the patient.

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Continuous Quality Review

Quality of Care is reviewed using:

- Quality of Care (QOC) investigations.
- Ongoing external Practitioner Sanctions monitoring.
- Real time intervention which is coordinated with credentialing.

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Continuous Quality Review

- The MCOs track and investigate complaints involving their network participating physicians, healthcare professionals, and facilities, including both member/enrollee and internally identified concerns.

-This process is structured to be compliant with state and federal regulatory requirements, Medicaid contractual requirements, as well as National Committee for Quality Assurance (NCQA) accreditation standards.

-MCOs may use a severity level “grading”, which is utilized to track and report the concerns investigated. Often, when moderate and serious concerns are determined to exist, an improvement plan is required to be implemented. These plans are assigned to address the perceived root cause of the issue. Improvement plans may range from education up to and including termination, depending on the circumstances.

-Both the NCQA and the State quality review include an assessment of policies, reports, and studies, along with a review of actual credentialing/recredentialing charts to ensure policies are being followed.

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MDH Quality Review

- MDH holds MCOs to an annual Systems Performance Review (SPR) that includes requirements regarding the Credentialing and Recredentialing process.

- This includes: timeliness of credentialing activities; review of qualifications, including licensure and any sanctions or Board of Physicians reviews or reporting; review of the MCOs annual credentialing program description and plan; and reporting to authorities any provider whose participation is reduced or rejected.

- MDH SPR Standard 4 and 4.1-4.12 hold MCOs accountable for the quality of its practitioner and facility network.

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Examples of Additional Quality Assurance Measures

- All MCO providers must be enrolled with the state under the federal managed care rules, so they are screened, validated, and enrolled in Medicaid through that process in addition to the ePrep credentialing process.
- Assignment of quality of care complaint “Severity Levels”, i.e. no quality of care issue identified to serious quality of care issue identified. (Driven by provider practice/behavior.)
- Implementing restrictions on a provider that departs from delivering the Standard of Care.
- If removed from a network, there is usually a set amount of time before that provider can apply to be credentialed into the network (i.e. 24 months before application will even be considered).
- Provider Termination based on quality of care deficiencies are reported to the State for tracking and follow up.

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Questions?

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Or

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Public Comment

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Next Meeting Dates

- November 20, 2020, 1-3PM
- December 10, 2020, 1-3PM

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