Centennial Care Reporting Instructions

Utilization Management Program Description, Work Plan, and Evaluation – Report #18

Related Contract Requirements

1. Section 4.12.10.5 – Standards for Utilization Management (UM)
2. Section 4.21 – Reporting Requirements
3. Section 7.3 – Failure to Meet Agreement Requirements

Attestation and Penalties

The managed care organization (MCO) shall ensure that all data is accurate and appropriately formatted in the report prior to submitting the report. Per Sections 4.21 and 7.3 of the Centennial Care contract, failure to submit accurate reports and/or failure to submit properly formatted reports may result in monetary penalties of $5,000 per report, per occurrence.

The MCO shall include a signed Centennial Care Report Attestation Form with each report submitted. Failure to submit a signed attestation form by the report due date will result in the entire report being late. Per Sections 4.21 and 7.3 of the Centennial Care contract, failure to submit timely reports may result in monetary penalties of $1,000 per report, per calendar day. The $1,000 per day damage amounts will double every ten calendar days.

Instructions

The MCO is required to submit the Utilization Management (UM) Program Description, Work Plan, and Evaluation on an annual basis no later than **June 30th** of each calendar year. If the report due date falls on a weekend or a State of New Mexico scheduled holiday, receipt of the report the next business day is acceptable.

Report #18 should describe the evaluation methods and results for the previous year and should describe the program, plan and activities for the upcoming year.

Report #18 must address physical health, behavioral health, and long-term care services.

An electronic version of the report shall be submitted via the State's secure DMZ FTP site. The date of receipt of the electronic version will serve as the date of receipt for the report. The MCO shall submit the electronic version of the report with the following file name: MCO.HSD18.CY##-CY##.v#. The "MCO" part of the labeling should be the MCO's acronym for their business name. With each report submission, change the calendar year (e.g., CY19-CY20) and the version number (e.g., v1), as appropriate. CY##'s shall correspond to the year of data provided for the evaluation and the year of data provided for the program description and work plan. The version number should be "1" unless the MCO is required to resubmit a report for a specified reporting period. In those instances, the MCO will use "2" and so on for each resubmission.

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Section I: UM Program Evaluation

The UM Program Evaluation must include an annual comprehensive evaluation of the previous year's utilization management plan addressing analysis of its performance in each required element, as well as identification of revisions determined necessary by the evaluation. A comprehensive UM program evaluation is one that includes an evaluation of the overall effectiveness of the UM program, an overview of UM activities, and an assessment of the impact of the UM program on management and administrative activities. The review and analysis of any impact from the previous year shall be incorporated in the development of the following year's UM Work Plan.

a) The annual written UM Program Evaluation must be submitted to the State and include a comprehensive evaluation of each required element listed in the prior year's UM Program Description and Work Plan. The comprehensive evaluation will detail the UM performance from the previous year including summation of all quality improvement activities that were initiated to address quality of care, member and provider satisfaction, service delivery as well as administrative functions. The UM plan evaluation will include a description of completed and ongoing Continuous Quality Improvement (CQI) activities, any problems discovered and remediation implemented to resolve any problems related to UM performance. The evaluation will determine and document actual UM performance results achieved during the year including improvements or lack of as well as an evaluation of the overall effectiveness of the UM program. There will be evidence that quality-related activities have contributed to meaningful improvements in the quality of utilization review as well as the quality of service delivery, including disease management strategies for chronic conditions, provided to members. The evaluation will also incorporate provider oversight implemented, opportunities for improvement identified by the MCO during their discovery processes, and remediation of any problems that came to light during the previous Fiscal Year. The UM Program Evaluation shall include:

    i. A narrative summary assessing the performance of all of the defined UM Plan requirements listed in the UM Plan requirements;

    ii. A comprehensive evaluation describing how MCO defined and detailed strategies and processes utilized were successfully implemented during the previous year; and

    iii. A UM plan to include an explanation of how the MCO will incorporate remediation for any findings discovered during the prior year and what measures will be implemented for the upcoming year to prevent the issues/problems from reoccurring.

b) The annual UM Program Evaluation will also measure and report the MCO's performance, using aggregate data and other predefined sources of information, on each UM initiative implemented during the previous year including:

    i. The effectiveness of the UM Program during the previous year, as evidenced by measurable results;

    ii. The effectiveness of the UM Program during the previous year as evidenced by the MCO's defined goals and objectives;

iii. Evidence of the assessment and linkage of findings identified from multiple internal UM evaluations during the reporting year that warrant either corrective action plans or CQI activities such as the Member and Provider Satisfaction Survey, the EQRO Compliance Audit as well as the denial audits;

iv. Identification of revisions necessary for existing UM projects or initiatives; and

v. Successes and failures of strategies noted in the previous year's UM Plan, including analysis of contributing factors for both.

Section II: UM Program Description

The annual UM Program Description must be must describe the MCO's UM program structure and accountability mechanisms, including:

a) Scope of program;

b) Goals and objective;

c) Program structure, including:

   i. Organizational structure;

   ii. Authority and accountability; and

   iii. Committee structure.

d) Description of UM processes;

e) Description of UM networking and support;

f) Description of the following UM review processes:

   i. Pre-service review;

   ii. Concurrent review;

   iii. Post-service (retrospective) review;

   iv. Discharge planning;

   v. Second medical opinion;

   vi. Emergency department services;

   vii. Out of network; and

   viii. Tertiary care services.

g) Departmental staff;

h) Communication services/ timeliness of UM decision;

i) Denials, appeals, grievances;

j) Evaluation of new technology, experimental and investigative;

k) Inter-rater reliability; and

l) Integration with quality management.

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Section III: UM Work Plan

The annual UM Work Plan must include all required elements listed below. The comprehensive plan will detail the UM strategies for the coming year and must, at a minimum, include:

a) Planned UM improvement activities that will address quality of service delivery, member and provider satisfaction;

b) Disease management, as well as other applicable UM administrative functions;

c) Specific mechanisms for periodic data tracking and trending of UM performance indicators;

d) Periodic evaluation of the effectiveness of the UM interventions.

e) Incorporation of provider oversight implemented, opportunities for improvement identified by the State during their discovery processes, and remediation of any problems that came to light during the previous year;

f) Utilization review goals, objectives, and quality improvement activities for the year; timelines and responsible staff; planned monitoring for newly identified and previously identified issues; as well as CQI processes planned for the coming year secondary to the annual UM Evaluation findings;

g) Documentation that the UM Work Plan is developed jointly by key UM staff, including the Medical Director, as well as possible input from the Quality Improvement Committee;

h) Documentation that the UM Work Plan was officially approved by personnel as identified above and the State;

i) Specific plans for periodic tracking of inter-rater reliability, which must include potential activities to be taken if a lack of consistency in review, application of UM criteria, or care coordination performance is identified;

j) Specific plans for the regular evaluation of potential under and over utilization, including the criteria to be used for its identification;

k) Specific plans for targeted CQI approaches in UM domains identified in need of improvement for the coming year;

l) Specific plans to ensure adequate program structure and oversight with clear delegation of authority and accountability for all UM activities;

m) Specific plans that will ensure appropriate provisions of benefit coverage, application of clinical necessity, evaluation of effectiveness of care coordination; consistent application of discharge criteria, as well as cultural competence of care delivery;

n) Specific plans to ensure appropriately licensed and experienced health care practitioners with education, training, experience, and expertise perform utilization review decisions;

o) Specific plans for tracking and trending data sources such as the grievance, appeals and fair hearings reports for any real time evidence of access to care barriers, as well as anticipated mechanisms for timely interventions;

p) Internal processes for tracking turnaround times and compliance of utilization review decisions based on the definitions for urgent, emergent, and routine;

q) Specific plans to evaluate service outcomes, as well as a plan to improve clinical outcomes, as needed;

r) Processes to ensure that services are approved based on least restrictive environment, are sufficient in amount, duration, and scope, and can reasonably be expected to achieve the purpose for which the services are furnished; and

s) Specific activities planned for improving performance of internal care coordination activities including physical health and behavioral health care coordination with external managed care contractors and providers.