DATE: January 14, 2019

TO: Jeanne M. Lambrew, Ph.D. Acting, Commissioner, DHHS

THROUGH: Sarah Taylor, Director, Division of Licensing and Certification

FROM: Larry D. Carbonneau, Manager, Health Care Oversight, DLC
      Richard S. Lawrence, Senior Health Care Financial Analyst, DLC

SUBJECT: Application of Issuance of Certificate of Authority – AMH Health, LLC HMO.

Subject to the Maine Certificate of Need Act of 2002, a person may apply to the superintendent of insurance for and obtain a certificate of authority to establish, maintain, own, merge with, organize or operate a health maintenance organization in compliance with the Maine Insurance Code. A person may not establish, maintain, own, merge with, organize or operate a health maintenance organization in this State either directly as a division or a line of business or indirectly through a subsidiary or affiliate, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with, a health maintenance organization without obtaining a certificate of authority. See 24-A M.R.S. §4203 (1).

The superintendent of insurance shall issue or deny a certificate of authority to any person filing an application pursuant to section 4203 within 50 business days of receipt of the notice from the Department of Health and Human Services that the applicant has been granted a certificate of need or, if a certificate of need is not required, within 50 business days of receipt of notice from the Department of Health and Human Services that the applicant is in compliance with the requirements of paragraph B below. Issuance of a certificate of authority shall be granted upon payment of the application fee prescribed in section 4220 if the superintendent is satisfied that the following conditions are met as set out in 24-A M.R.S. §4204 (2-A).

A. The Commissioner of Health and Human Services certifies that the health maintenance organization has received a certificate of need or that a certificate of need is not required pursuant to Title 22, chapter 103-A.

Met: A letter of Non-Applicability for this project in regard to the Certificate of Need statute was forwarded to the applicant and the Bureau of Insurance on November 21, 2018. As the reason for this determination, the letter of non-applicability cited section §330 (2):

22 M.R.S. §330. Notwithstanding section 329, the requirements of this Act do not apply with respect to: [] 2. Activities or acquisitions by or on behalf of a health maintenance organization or a health care facility controlled, directly or indirectly, by a health maintenance organization or combination
of health maintenance organizations to the extent mandated by the National Health Policy, Planning and Resources Development Act of 1974, as amended, and its accompanying regulations;

B. If the Commissioner of the Department of Health and Human Services has determined that a certificate of need is not required: the Commissioner makes a determination and provides a certification to the superintendent that the following requirements have been met. (Please note that the numbering of the following paragraphs is in accordance with section 4204 (2-A) (B) of Title 24-A. There are no paragraphs numbered (1), (2), or (3) in this section of the statute).

(4) The health maintenance organization must establish and maintain procedures to ensure that the health care services provided to enrollees are rendered under reasonable standards of quality of care consistent with prevailing professionally recognized -standards of medical practice. These procedures must include mechanisms to ensure availability, accessibility and continuity of care.

Met: The applicant provided a detailed 2018 Medicare Quality Improvement Program Description which provides an overview of its various Quality Management Committees. This overview outlines the essential components for a comprehensive, integrated, and collaborative quality program. The Medicare Quality Management Committee (MQMC) is the overseeing body of the Quality Program. The responsibility of the MQMC extends to the following:

- Review and approve Quality Management (QM) Trilogy Documents: Program Description, Work Plan, and Annual QM Evaluation
- Review standardized reports (at least annually) reflecting progress towards goals, actions taken, improvements
- Analyze, review and make recommendations regarding the planning, implementation, measurement, and outcomes of the clinical/service Quality Improvement Programs.
- Review, monitor and evaluate program compliance against Anthem, Inc., State, Federal and CMS standards
- Oversight of the overall effectiveness of the Special Need Plan (SNP) Model of Care (MOC) goals
- Review overall regional and corporate quality program effectiveness including, but not limited to member and provider satisfaction, quality of care, and accessibility and availability of care and services.

(5) The health maintenance organization must have an ongoing internal quality assurance program to monitor and evaluate its health care services including primary and specialist physician services, ancillary and preventive health care services across all institutional and non-institutional settings. The program must include, at a minimum, the following:

(a) A written statement of goals and objectives that emphasizes improved health outcomes in evaluating the quality of care rendered to enrollees;
(b) A written quality assurance plan that describes the following:

(i) The health maintenance organization's scope and purpose in quality assurance;

Met: The scope of the QI Program is comprehensive, systematic and continuous, encompassing the full spectrum of medical, pharmaceutical, and behavioral health care, services and programs. It applies to all member demographic groups, care settings, and types of services afforded to Medicare Advantage and Medicare Special Needs Plan members. Processes and procedures are designed to ensure that covered services are available and accessible to all members regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability, and that covered services are provided in a culturally and linguistically appropriate manner. The QI Program addresses the quality of clinical care and non-clinical aspects of service.

(ii) The organizational structure responsible for quality assurance activities;

Met: The applicant provided a complete description of the organizational structure responsible for quality assurance activities on pages 12-19 of the QIPD. Those responsible include the Health Plan Board of Directors, Senior Executive Leadership, Corporate Clinical and Regional Quality Management.

(iii) Contractual arrangements, in appropriate instances, for delegation of quality assurance activities;

Met: Activities may be delegated to certain vendors by Letter of Agreement or by Contract. The scope of delegated activities, which may contain more than one delegated function and service, is defined in a Delegation Agreement. The Clinical Delegation Oversight team conducts pre-delegation and annual audits, and reports results to the Health Plan, which has responsibility and accountability for oversight of all delegated activities. Vendors are subject to annual audits, adherence to CMS general compliance guidelines and corrective actions.

The Medicare Compliance department oversees the First Tier, Down Stream and Related Entities (FDR) Oversight Program for vendors contracted to provide administrative or health care services for Medicare enrollees. Oversight is also provided by the Vendor Selection and Oversight Committee (VSOC), which has the final authority to approve the delegation based on audit results.

The Quality Management department coordinates with the Delegation workgroup and the VSOC for oversight monitoring, and ensures appropriate reporting and documentation has occurred on behalf of any activities covered under State and Federal Regulatory Standards.

(iv) Confidentiality policies and procedures;

Met: The Health Plan is committed to protecting member confidentiality in accordance with applicable Federal and State laws, regulations and regulatory and/or contractual...
requirements. A key component of that commitment includes complying with all applicable Federal and State laws, and contractual obligations pertaining to privacy and security, especially but not exclusively, the Health Insurance Portability and Accountability Act of 1996.

A library providing training materials for associates, and detailed policies and procedures that specify the protocols for protecting member privacy are maintained to ensure full compliance with all Health Insurance Portability and Accountability Act (HIPAA) rules. The Health Plan ensures enrollee information is used in accordance with HIPAA and other State and Federal requirements through:

- Enforcement of the Privacy Program which includes physical, technical, and administrative safeguards of member health and enrollment information
- Training on HIPAA requirements
- Technology to support data transmission and communication safeguards

(v) A system of ongoing evaluation activities;
  Met: Pages 6-9 and page 17 of the QIPD describes the goals and actions to undertaken during the year and the resources devoted to quality management evaluation activities.

(vi) A system of focused evaluation activities;
  Met: The DHHS Application pages 32-204, items A-8 through A-13 describe Anthem’s focused evaluation activities including peer review, developing and disseminating clinical guidelines, conducting quality management studies, conducting intervention and assessment when opportunities for improvement are identified, monitoring and evaluating continuity of care and utilization and the applicants plan for evaluating the performance of its QMP.

(vii) A system for reviewing and evaluating provider credentials for acceptance and performing peer review activities; and
  Met: The DHHS Application pages 205-220, Item B describes the provider’s credentialing policies and procedures

(viii) Duties and responsibilities of the designated physician supervising the quality assurance activities;
  Met: DHHS application Section A-4 provides a job description and credentials of applicant’s Medical Director: Resume of Chimene Liburd, MD, VP Clinical Operations, Medicare Advantage Chief Medical Officer.

(c) A written statement describing the system of ongoing quality assurance activities including:

(i) Problem assessment, identification, selection and study;
  Met: DHHS Application Section A-11 describes the plan for assessment, identification, selection and study of problems encountered.

(ii) Corrective action, monitoring evaluation and reassessment; and
Met: DHHS Application Section A-12 describes the applicant’s plan for monitoring evaluation and reassessment.

(iii) Interpretation and analysis of patterns of care rendered to individual patients by individual providers;

Met: DHHS Application Section 10 through Section 12 describes the collection, interpretation and analysis of patterns of care rendered to individual patients by individual providers.

(d) A written statement describing the system of focused quality assurance activities based on representative samples of the enrolled population that identifies the method of topic selection, study, data collection, analysis, interpretation and report format; and

Met: Pages 30-32 of the QIPD describes the Quality Improvement Projects undertaken by the provider both on a regional and state level.

(e) Written plans for taking appropriate corrective action whenever, as determined by the quality assurance program, inappropriate or substandard services have been provided or services that should have been furnished have not been provided.

Met: Ongoing compliance to policies and procedures is assessed through a variety of methods. Providers failing to meet established standards, such as the presence of sanctions or limitations on licensure, instances of poor quality, etc., will be reviewed by the appropriate Committee, with avenues of recourse being corrective actions, sanctions, or provider termination. Reporting to appropriate regulatory bodies will occur as needed.

(6) The health maintenance organization shall record proceedings of formal quality assurance program activities and maintain documentation in a confidential manner. Quality assurance program minutes must be available to the Commissioner of Health and Human Services.

Met: Page 10 of QIPD discusses data collection and taking of minutes. Furthermore, as required in subpart (6) of Section 4204(2-A) (B), unless limited by CMS regulations, AMH commits to make available to DHHS the minutes of quality assurance program activities upon DHHS request.

(7) The health maintenance organization shall ensure the use and maintenance of an adequate patient record system that facilitates documentation and retrieval of clinical information to permit evaluation by the health maintenance organization of the continuity and coordination of patient care and the assessment of the quality of health and medical care provided to enrollees.

Met: DHHS Application, Section A-12 describes the plan for monitoring and evaluating the continuity of care and utilization.

(8) Enrollee clinical records must be available to the Commissioner of Health and Human Services or an authorized designee for examination and review to ascertain compliance with this section, or as considered necessary by the Commissioner of Health and Human Services.

Met: The Provider Services / Network Management areas have the following responsibilities in support of quality improvement:
Ensure the use and maintenance of an adequate patient record system that facilitates documentation and retrieval of clinical information. The record system should facilitate continuity and coordination of patient care, and assessment of the quality of health and medical care provided. The patient record system should also ensure the availability of clinical records to the Commissioner of the Department of Health and Human Services or authorized designee for examination and review to ascertain compliance, or as considered necessary by the Commissioner of the Department of Health and Human Services.

(9) The organization must establish a mechanism for periodic reporting of quality assurance program activities to the governing body, providers and appropriate organization staff.

Met: The Company’s Board of Directors (Board) has responsibility for organizational governance and in this capacity is the governing body of the Quality Management Program in select contracts. In those select contracts where there is a regulatory requirement the Board has designated the Enterprise Quality Oversight Committee to oversee the Quality Improvement Program and activities.

The Regional Vice President Medical Director (RVPMD) is the senior physician executive responsible for the QI program. The Director of Corporate Clinical Quality Management is the senior quality leader responsible for execution and outcomes of the QI program. Responsibilities of these leaders includes procuring adequate resources for QI program implementation, serving on the governing body, aligning the goals/objectives of the QI program with the business objectives, and setting QM priorities in conjunction with the Corporate Medicare and Regional Medical Directors. The RVPMD ensures the governing body’s review and approval of the QM Program Description, Work Plan and QM Program Evaluation.

The Company’s RVPMD provides overall direction and support to the QI program and is responsible for oversight of the clinical quality improvement operations including:

- Responsibility for the care delivered by contracted providers as well as the care coordination and utilization management activities of the Company.
- Ensures that evidence based practice is incorporated into the SNP MOC, medical guidelines, and utilization management activities.
- Leads the analysis of utilization data to identify areas of over and underutilization and develop corrective action plans.
- Is responsible for providing clinical guidance and oversight regarding the development, implementation, and evaluation of QIPs and CCIPs.
- Provides clinical guidance to ensure the coordination of Medicare, Medicaid, and community services to meet the identified needs of individual members.
- Reviews as appropriate data submitted for Part C and Part D CMS reporting.
- Reviews departmental policies and procedures.

The Corporate Clinical and Regional Quality Management Department supports the Company’s Quality Management Program in several areas, including:

- Healthcare Effectiveness Data and Information Set (HEDIS®) Technical Project Management, including coordination with HEDIS® certified software vendor and
certified HEDIS® compliance auditors state agency submission; data analysis and reporting; coordination of improvement activities across health plans; and communication of best practices;

- Project Management of the Member Satisfaction Survey, Consumer Assessment of Healthcare Providers and Systems (CAHPS®), Health Outcomes Survey (HOS®); analysis and report production; and satisfaction improvement activities across health plans;
- Project Management of the Provider Satisfaction Survey; analysis and report production; and;
- Coordination with the health plan in annual delegation oversight audit findings and improvement actions required
- Communication of best practices and technical assistance in study design, implementation and reporting of: Quality Assessment and Performance Improvement (QAPI) activities; Performance Improvement Projects (PIP); Quality Improvement Projects (QIP); Quality Improvement Activities (QIA), and other state and federal agency defined studies;
- Assistance in preparation of External Quality Review Organization (EQRO) audits

Medicare Member Grievance and Appeal Process oversight which includes monitoring and trending of appeals and complaints, , Review and investigation of Medicare related Quality of Care issues:

- Development of standardized policy and procedures for health plans based on goals and objectives
- Assists in the development of programs and interventions to meet the needs of frail and vulnerable members
- Establishing indicators for monitoring and evaluating the full spectrum of care and service provided to members for quality, safety, appropriateness, continuous improvement and satisfaction
- Ensuring compliance with regulatory organizations
- Integrating utilization information and quality issues by the Medicaid and Medicare utilization management teams into the quality management process
- Monitor over and under utilization
- Coordinating/performing medical record reviews and data collection
- Providing Network Performance & Planning department with quality information to be used as part of the recredentialing process
- Coordinating the quality assessment peer review process including participating in the development of remedial action plans for providers as indicated
- Participating in interdepartmental quality improvement teams
- Designing and implementing interventions to resolve identified quality issues and improve process, clinical, and financial outcomes
- Educating providers and associates about the QI Program
- Providing oversight of the Chronic Care Improvement Program (CCIP) and Quality Improvement Project (QIP) Programs and ensuring quarterly compliance and annual reporting to CMS and states where applicable.
The Commissioner of the Department of Health and Human Services shall make the certification required by this paragraph within 60 days of the date of the written decision that a certificate of need was not required. If the commissioner certifies that the health maintenance organization does not meet all of the requirements of this paragraph, the commissioner shall specify in what respects the health maintenance organization is deficient.

Recommendation:

CONU concludes that the applicant has satisfied the requirements of 24-A § 4204 (2-A) parts A and B and recommends that this application be Approved.