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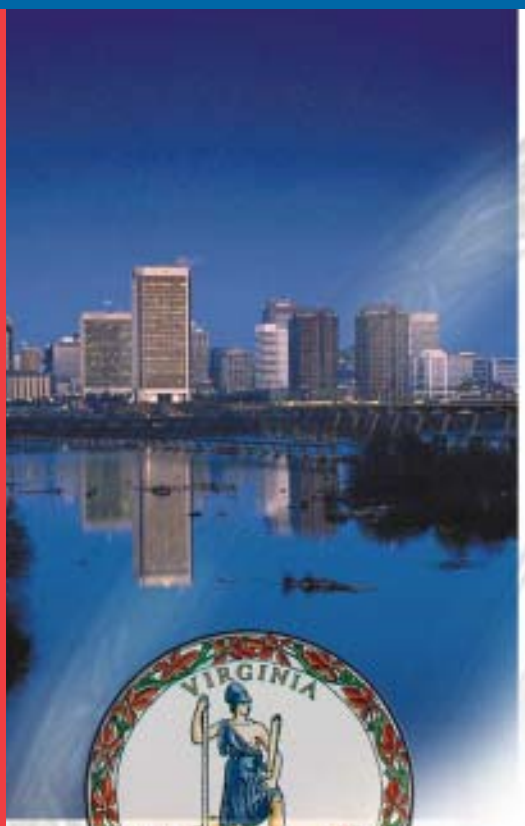
Commonwealth of Virginia

Department of Medical Assistance Services

Medallion II

External Quality Review



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Executive Summary
SFY 2004

Medallion II External Quality Review Executive Summary

Medallion II Overview

Managed care was first introduced to Virginia residents enrolled in Medicaid when the Commonwealth was granted a 1915(b) waiver from the Centers for Medicare and Medicaid Services (CMS) in 1991. This initial managed care program, called MEDALLION, was operated as a primary care case management model and was expanded to include the entire state in 1995. In 1996, Medallion II, a full-risk mandatory Medicaid managed care program, was developed to supplement the Commonwealth's previous initiatives to expand the use of managed care for the delivery of health care to Medicaid recipients. The intent of the program is to improve access to care, promote disease prevention, ensure quality care, and reduce Medicaid expenditures. Eligible Medicaid recipients enroll in a participating Managed Care Organization (MCO) of their choice and select a Primary Care Physician (PCP) to oversee their medical care. The MCO is responsible for developing and operating a provider network, negotiating fees with providers, and operating a system that provides utilization and quality oversight of the health services delivered to its enrollees. Of the four Medicaid programs operated through the Commonwealth of Virginia, Medallion II comprises the largest segment of Medicaid enrollees. In fact, enrollment in Medallion II has grown by almost 17% from 2003 to 2004 and has increased nearly 29% since 2002.

As of July 1, 2004, the following Medallion II MCOs were providing health care services to nearly 307,000 Commonwealth of Virginia Medicaid recipients:

- Anthem HealthKeepers Plus (formerly Trigon and including three MCO product lines),
- CareNet (operated by Southern Health Services Inc.),
- Sentara Family Care (operated by Optima Health),
- Health Plan of Virginia (operated by Wellpoint), and,
- Virginia Premier Health Plan (operated by Virginia Commonwealth University Health Care System).

External Quality Review

The Balanced Budget Act of 1997 (BBA) requires state Medicaid agencies that provide care to Medicaid enrollees through a managed care model to evaluate the quality of services furnished by each Medicaid managed care organization (MCO) annually. However, recognizing that appropriate access to the continuum of quality health services is vital to enable all Medicaid enrollees to achieve their best health states, the Virginia Department of Medical Assistance Services (DMAS) began contracting with an external quality review organization (EQRO) to conduct evaluations of its managed care organizations prior to implementation of the BBA.

DMAS contracted with Delmarva Foundation (Delmarva) to conduct external quality reviews of the Medallion II MCOs during the period July 1, 2003 through December 31, 2003. As the EQRO for the Commonwealth of Virginia, Delmarva provides quality oversight of the integrity of the Medicaid managed care system to ensure that Medicaid MCO enrollees receive quality health care through delivery systems that promote timeliness, accessibility, and coordination of all services. This was accomplished through a retrospective on-site assessment of each MCO's operational systems conducted during April and May of 2004 and a validation review of a state required performance improvement project. Each of these activities will be described below as well as overall and MCO specific findings and recommendations.

Operational Systems Review

The operational systems review provides an assessment of the structure, process, and outcomes of the MCO's internal operating systems. The purpose is to identify, validate, quantify, and monitor problem areas in the overall quality assurance program. The review incorporated regulations set forth under the Final Rule of the BBA that became effective on August 13, 2002. The BBA is the comprehensive revision to federal statutes governing all aspects of Medicaid managed care programs as set forth in section 1932 of the Social Security Act and title 42 of the *Code of Federal Regulations* (CFR), part 438 et seq. In support of these regulations and MCO contractual requirements, Delmarva evaluated the following systems:

- Enrollee Rights and Protections—Subpart C Regulation
- Quality Assessment and Performance Improvement—Subpart D Regulation
  - Access Standards
  - Structure and Operation Standards
  - Measurement and Improvement Standards
- Grievance Systems—Subpart F Regulation

It is expected that each MCO will utilize the review findings and recommendations for operational systems improvement to become fully compliant with all standards and requirements.

Operational Systems Methodology

For the operational review conducted for the second half of 2003, revised elements were incorporated into the standards to be inclusive of both the BBA and Medallion II contractual requirements. Compliance with all regulations under Subpart C, D, and F of the BBA was assessed. The approach to the review required Delmarva staff to conduct an evaluation of the MCO's administrative and operational systems to assess whether the MCO had the appropriate structure in place and had implemented key operational policies and procedures to meet statutory requirements. Before conducting the MCO's on-site evaluation, Delmarva reviewed documentation submitted by the health plan such as internal policies, procedures, enrollee handbooks, provider manuals, newsletters, and meeting minutes pertinent to the operational areas under review. During the on-site visit, Delmarva conducted interviews with key MCO personnel, examined actual case files, and reviewed additional documentation to confirm operational compliance with all performance standards.

As Delmarva review staff conducted the review, each element within a standard was rated as "met," "partially met," or "not met". Elements were then rolled up to create a determination of "met", "partially met", or "not met" for each of the standards related to enrollee rights and protections, quality assessment and performance improvement, and grievance system. Table 1 describes this scoring methodology.

Table 1. Rating Scale for Operational Systems Review

Rating	Rating Methodology
Met	All elements within the standard were met
Partially Met	At least half the required elements within the standard were met or partially met
Not Met	Less than half the required elements within the standard were met or partially met

Preliminary review results were provided to the MCOs for review and comment. The MCOs responded to the preliminary findings in the required period, and Delmarva and the DMAS considered all information and comments in preparing MCO specific reports.

Operational Systems Review Findings

This section presents an overview of the findings of Enrollee Rights and Protections (ER), Quality Assessment and Performance Improvement (QA), and Grievance Systems (GS) for the Medallion II MCOs. Figure 1 provides MCO comparison results for all review components. This is the first review cycle where UniCare, the newest MCO participating in the Medallion II program, was assessed on all review components since it now has sufficient data and enrollment periods necessary to conduct quality activities.

Figure 1. Summary Operational Systems Review Results

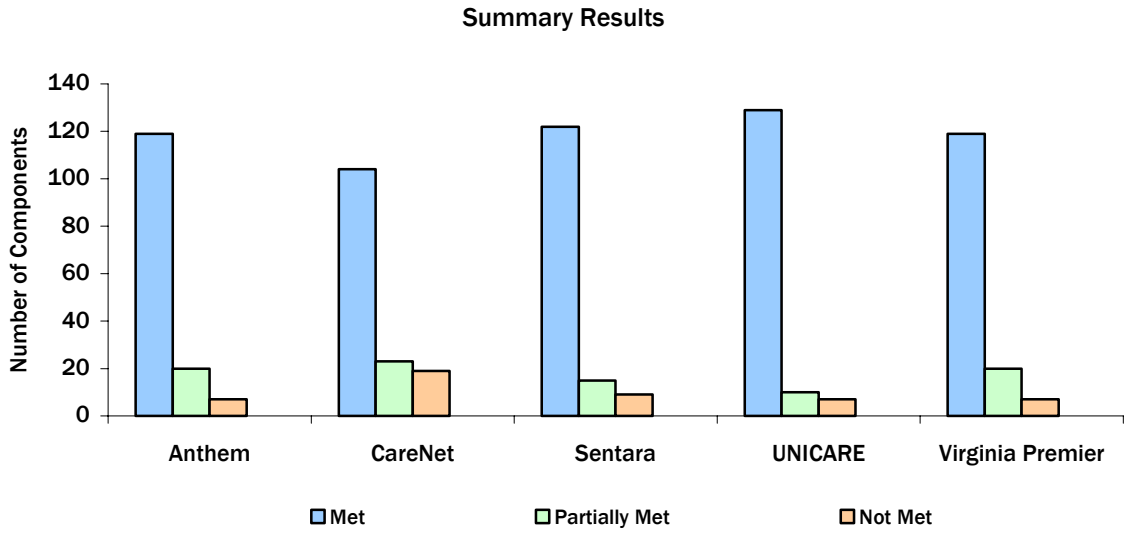

Table 2 provides an overview and comparison of MCOs by component performance for each of the MCO operational systems assessed as part of this review.

Table 2. Summary Operational Systems Review Results for each MCO.

	Anthem	CareNet	Sentara	UniCare	Virginia Premier
Enrollee Rights and Protections					
Met	37	28	40	42	35
Partially Met	7	13	6	3	9
Not Met	4	7	2	3	4
Quality Assessment and Performance Improvement					
Met	48	53	50	57	48
Partially Met	10	1	6	2	11
Not Met	2	6	4	1	1
Grievance Systems					
Met	34	23	32	30	36
Partially Met	3	9	3	5	0
Not Met	1	6	3	3	2
MCO Totals					
Met	119	104	122	129	119
Partially Met	20	23	15	10	20
Not Met	7	19	9	7	7
Total Components	146	146	146	146	146

Enrollee Rights and Protections Results

The review of enrollee rights and protections assesses the extent to which MCO staff and affiliated providers take into account the rights of enrollees when furnishing care and services. Navigating the health care delivery system can be quite challenging, particularly for individuals who may be unfamiliar with managed care principles. As such, it is critical that MCOs have a system in place that supports effective communication to a population with diverse needs to ensure access to necessary care and services. Enrollee communications need to be written in readable, easily understood language, and available in prevalent non-English languages as well as in alternative formats for enrollees with special needs. The availability of oral

and written translation services also must be communicated to enrollees. Procedures for safeguarding Protected Health Information and enrollee confidentiality need to be in place. Additionally, MCOs are required to ensure that enrollees have an opportunity to actively participate in decisions relating to their health care. In assessing the incorporation of enrollee rights and protections into the basic infrastructure of the MCO delivery system, the MCO's written policies and procedures and enrollee and provider communication materials were reviewed.

In general, the MCOs performed well on components of the review related to Enrollee Rights and Protections. There were, however, some consistent trends noted among the MCOs in the areas of formal written policies and enrollee communications. Identified needs include:

- Policies to reflect all required enrollee rights, procedures for communicating to enrollees that they are not liable in the event of MCO insolvency, the availability of a no cost second opinion, and the availability of information in alternative formats, and definitions and access procedures for emergency and post-stabilization situations.
- Revisions to enrollee materials that incorporate all required enrollee rights as well as locations of settings that furnish emergency and post-stabilization services covered by the MCO.
- The development of enrollee materials in alternative formats that consider the special needs of enrollees such as those who are visually limited or who have limited reading proficiency.

Table 3 provides a comparison of MCOs across Enrollee Rights and Protections components.

Table 3. Enrollee Rights and Protections Review Results for each MCO.

Review Elements	Anthem	CareNet	Sentara	UniCare	Virginia Premier
Subpart C Regulations: Enrollee Rights and Protections					
ER 1. Enrollee Rights and Protections Policies					
ER 1.1. Enrollee rights and responsibilities.	Partially met	Not met	Partially met	Partially met	Partially met
ER 1.2 Out-of-area coverage.	Met	Met	Met	Met	Met
ER 1.3 Restrictions on enrollee's freedom of choice among network providers (431.51).	Met	Not met	Met	Not met	Met
ER 1.4. Referrals to specialty care (422.113c).	Met	Met	Met	Met	Met
ER 1.5. Enrollee notification—termination/change in benefits, services, or service delivery site.	Not met	Partially met	Met	Met	Met
ER 1.6. Procedures that instruct how to contact enrollee services and a description of department and its functions.	Met	Not met	Met	Met	Met

Review Elements	Anthem	CareNet	Sentara	UniCare	Virginia Premier
Subpart C Regulations: Enrollee Rights and Protections					
ER 1.7. Procedures for grievances, appeals, and fair hearing procedures (438.10g, 438.400–438.424).	Met	Partially met	Met	Met	Met
ER 1.8. List of non-English languages spoken by contracted providers.	Met	Met	Met	Met	Met
ER 1.9. Provider-enrollee communications.	Met	Not met	Met	Met	Met
ER 1.10. Procedures for sharing information with enrollees—that they are not liable for payment in case of MCO insolvency.	Not met	Not met	Not met	Not met	Not met
ER 1.11. Process for enrollment and disenrollment from MCO.	Met	Partially met	Met	Met	Met
ER 2. Written Statement Upon Enrollment					
ER 2.1. Enrollee rights and responsibilities.	Partially met	Partially met	Partially met	Partially met	Partially met
ER 2.2. Enrollee identification cards—descriptions and how and when to use cards.	Met	Met	Met	Met	Met
ER 2.3. All benefits and services included and excluded as a condition of membership, including authorization requirements and any special benefit provisions that may apply to services	Met	Met	Met	Met	Met
ER 2.4. Procedures for obtaining out-of-area coverage.	Met	Met	Met	Met	Met
ER 2.5. Procedures for restrictions on enrollee's freedom of choice among network providers.	Met	Met	Met	Met	Met
ER 2.6. The MCO's policy on referrals for specialty care.	Met	Met	Met	Met	Met
ER 2.7. Procedures for notifying enrollees affected by the termination or change in benefits, services, or service delivery site.	Partially met	Partially met	Met	Met	Met
ER 2.8. Procedures on how to contact enrollee services and a description of the functions of enrollee services.	Met	Met	Met	Met	Met
ER 2.9. Procedures for grievances, appeals, and fair hearing procedures, and the amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled.	Met	Met	Met	Met	Met
ER 2.10. Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area, including identification of providers that are not accepting new patients. This includes, at a minimum, information on primary care physicians, specialists, and hospitals.	Met	Met	Met	Met	Met

Review Elements	Anthem	CareNet	Sentara	UniCare	Virginia Premier
Subpart C Regulations: Enrollee Rights and Protections					
ER 2.11. Procedures for provider-enrollee communications.	Met	Met	Met	Met	Met
ER 2.12. Procedures for providing information on physician incentive plans for those enrollees who request it.	Met	Partially met	Met	Met	Met
ER 2.13. Process for enrollment and disenrollment from MCO.	Met	Met	Met	Met	Met
ER 3. Information and Language Requirements					
ER 3.1. MCO written enrollee information is available in the prevalent, non-English languages spoken in its particular service area. (See DMAS contract)	Met	Met	Met	Met	Partially met
ER 3.2. Enrollee information is written in prose that is readable and easily understood.	Met	Met	Met	Met	Met
ER 3.3. State requires Flesch-Kincaid readability of 40 or higher (at or below 12th grade level).	Met	Met	Met	Met	Partially met
ER 3.4. Enrollee vital documents must be translated into non-English languages regularly encountered in the eligible population. Examples of vital documents include: "Applications, consent forms, letters containing important information about participation in programs (such as a cover letter outlining conditions of participation in a Medicaid managed care program)...notices advising people with limited English proficiency of the availability of free language assistance."	Met	Met	Met	Met	Met
ER 3.5. MCO has provided written material in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.	Met	Partially met	Partially met	Met	Not met
ER 3.6. MCO has policies and procedures in place to make interpretation services available and free of charge to each potential enrollee and enrollee. This applies to all non-English languages, not just those the state identifies as prevalent.	Met	Met	Met	Met	Met
ER 3.7. MCO has policies and procedures in place to notify its enrollees that oral interpretation is available for any language and written information is available in prevalent languages; and how to access those services.	Met	Met	Met	Met	Partially met
ER 3.8. MCO has policies and procedures in place to inform enrollees and potential enrollees that information is available in alternative formats and how to access those formats.	Not met	Not met	Not met	Met	Not met

Review Elements	Anthem	CareNet	Sentara	UniCare	Virginia Premier
Subpart C Regulations: Enrollee Rights and Protections					
ER 4. Protected Health Information					
ER 4.1. MCO has a confidentiality agreement in place with providers who have access to PHI.	Met	Met	Met	Met	Met
ER 4.2. The Contractor shall implement and maintain appropriate safeguards to prevent the use and disclosure of PHI.	Met	Met	Met	Met	Met
ER 4.3. The Contractor shall make an individual's PHI available to the Department within 30 days of an individual's request for such information as notified and in the format requested by the Department.	Partially met	Partially met	Met	Met	Partially met
ER 5. Emergency and Post-stabilization Services					
ER 5.1. MCO has policies and procedures in place that define emergency and post-stabilization situations, a description on what to do in an emergency, a telephone number and instructions for obtaining advice on getting care in an emergency, and that prior authorization is not needed.	Partially met	Partially met	Partially met	Met	Partially met
ER 5.2. MCO has given enrollee information on how to utilize after-hours medical advice and enrollee services department.	Met	Met	Met	Met	Met
ER 5.3. MCO has processes and procedures in place for obtaining emergency services, including use of the 911-telephone system or its local equivalent.	Met	Met	Met	Met	Met
ER 5.4. MCO has provided enrollees with a description of how to obtain emergency transportation and other medically necessary transportation (Medical HelpLine Access).	Met	Met	Met	Met	Met
ER 5.5. MCO has provided enrollees with locations of settings that furnish emergency and post-stabilization services covered by MCO.	Partially met	Partially met	Partially met	Partially met	Partially met
ER 6. Advanced Directives					
ER 6.1. The MCO has provided adult enrollees with written information on advance directives, including a description of the applicable state law.	Partially met	Partially met	Met	Met	Met
ER 6.2. MCO has requirements to allow enrollees to participate in treatment decisions/options.	Met	Met	Met	Met	Met
ER 6.3. Procedures to communicate the risks, benefits, and consequences of treatment or non-treatment.	Met	Met	Met	Met	Met

Review Elements	Anthem	CareNet	Sentara	UniCare	Virginia Premier
Subpart C Regulations: Enrollee Rights and Protections					
ER 6.4. MCO has policies and procedures to inform enrollees of direct access to women's health specialist within MCO network for routine and preventive care services, as well as a primary care provider.	Met	Met	Met	Met	Met
ER 6.5. MCO has policies and procedures to inform enrollees that they may obtain a second opinion from a qualified health care professional within the network or outside the network if necessary, at no cost to enrollee.	Not met	Not met	Met	Not met	Not met
ER 7. Rehabilitation Act, ADA					
ER 7.1. MCO complies with federal and state laws regarding enrollee confidentiality.	Met	Partially met	Partially met	Met	Partially met
ER 7.2. MCO has provided the enrollee with a description of its confidentiality policies.	Met	Met	Met	Met	Met
ER 7.3. MCO has provided enrollee with information on how to obtain a copy of their medical record and how to request records from the MCO.	Met	Partially met	Met	Met	Met

Quality Assessment and Performance Improvement Results

As Medicaid has moved into the managed care arena, health plans have been mandated to build quality and accountability into their health care delivery systems. Quality initiatives have the ability to enhance administrative and clinical practices, increase access to sources of care, promote quality by developing and encouraging use of accepted clinical practice standards, increase use of preventive services, decrease unnecessary hospitalizations, and build organizational capacity to improve managed care services.

The Quality Assessment and Performance Improvement program review is an assessment of each MCO's ability to develop a system for on-going monitoring and improvement activities and encompasses components that assess an MCO's ability to develop a comprehensive written quality management program description, develop policies and procedures for implementation of the program, and maintain appropriate documentation to substantiate that the program has been implemented as described. Specific components address access and availability of services, delivery of services in a culturally competent manner, coordination and continuity of care, provider selection and retention, adoption, dissemination, and application of clinical practice guidelines, and monitoring and oversight of delegated entities. Assessment is accomplished through review of written policies, procedures, and any other reports or documents submitted by the MCOs.

The MCOs demonstrated strong results in the area of Quality Assessment and Performance Improvement. Areas for improvement related primarily to policy development/revision and utilization management processes as identified below:

- Policies need to be developed or revised to address the availability of a no cost second opinion benefit, procedures to promote the delivery of services in a culturally competent manner to all enrollees, procedures to disseminate practice guidelines to all affected providers and, upon request, to enrollees, and procedures relating to extension time frames for expedited authorizations allowed under the Medallion II contract.
- Improved documentation is required that reflects a systematic process for monitoring and reporting utilization including the development of corrective action plans in response to identified over and under utilization of services.

Table 4 provides MCO comparisons for each component of the Quality Assessment and Performance Improvement standard.

Table 4. Quality Assessment and Performance Improvement Review Results for each MCO.

Review Elements	Anthem	CareNet	Sentara	UniCare	Virginia Premier
Subpart D Regulations: Quality Assessment and Performance Improvement					
QA 1. 438.206 Availability of services (b)					
QA 1.1. MCO has policies and procedures to maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract.	Met	Met	Met	Met	Met
QA 1.2. MCO has policies that allow enrollees with disabling conditions, chronic illnesses, or children with special health care needs to request their PCP be a specialist.	Met	Met	Not met	Met	Met
QA 2. 438.206 Availability of services (b)(2)					
QA 2.1. MCO has policies and procedures to inform enrollees of direct access to women's health specialist within MCO network for routine and preventive care services, as well as a primary care provider.	Met	Met	Met	Met	Met
QA 3. 438.206 Availability of services (b)(3)					
QA 3.1. MCO has policies and procedures to provide for a second opinion from a qualified health care professional within the network, or to provide for the enrollee to obtain one outside the network, at no cost to the enrollee.	Not met	Not met	Met	Not met	Partially met

Review Elements	Anthem	CareNet	Sentara	UniCare	Virginia Premier
Subpart D Regulations: Quality Assessment and Performance Improvement					
QA 4. 438.206 Availability of services (b)(4)					
QA 4.1. MCO has policies and procedures that provide necessary services out of network, if unable to cover necessary medical services required by enrollee.	Met	Partially met	Met	Met	Met
QA 5. 438.206(c) (2) Cultural considerations					
QA 5.1. The MCO has policies and procedures to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.	Partially met	Met	Partially met	Met	Not met
QA 6. 438.208 Coordination and continuity of care					
QA 6.1. MCO has policies and procedures in place to ensure coordinated care for all enrollees and provide particular attention to needs of enrollees with complex, serious, and/or disabling conditions.	Partially met	Met	Met	Met	Met
QA 7. 438.208(c) 1-3 Additional services for enrollees with special health care needs					
QA 7.1. The MCO makes a good faith effort to conduct an assessment of enrollees with complex, serious, and/or disabling conditions as identified and reported by the state, within 90 days receipt of notification of SSI children.	Partially met	Met	Met	Met	Met
QA 8. 438.208(c) (4) Direct access to specialists					
QA 8.1. The MCO has policies and procedures that allow an enrollee with special needs to access a specialist as is appropriate for the condition and identified needs.	Met	Not met	Met	Met	Met
QA 8.2. Referral guidelines that demonstrate the conditions under which PCPs arrange for referrals to specialty care networks.	Met	Met	Met	Met	Met
QA 9. 438.208 (d) (2) (ii–iii) Referrals and treatment plans					
QA 9.1. The MCO has a mechanism in place for the development of a treatment plan by the specialist in consultation with the enrollee's PCP, with enrollee participation, and is approved in a timely manner.	Met	Met	Met	Met	Met
QA 10. 438.208(e) Primary care and coordination program					
QA 10.1. MCO coordinates services furnished to enrollee with those of other MCOs, PIHP, PAHP to prevent duplication.	Partially met	Met	Met	Met	Partially met
QA 10.2. Coordination of care across settings or transitions in care.	Met	Met	Met	Met	Partially met
QA 10.3. MCO has policies and procedures to protect enrollee privacy while coordinating care.	Met	Met	Met	Met	Met

Review Elements	Anthem	CareNet	Sentara	UniCare	Virginia Premier
Subpart D Regulations: Quality Assessment and Performance Improvement					
QA 11. 438.210 (b) Coverage and authorization of services —processing of requests					
QA 11.1. The MCO has policies/procedures in place for processing requests for initial and continuing authorizations of services.	Met	Met	Met	Met	Met
QA 11.2. MCO has policies/procedures in place to ensure that preauthorization requirements do not apply to emergency care, family planning services, preventive services, and basic prenatal care.	Met	Met	Partially met	Met	Partially met
QA 11.3. The MCO monitors the application of review criteria for authorizations and takes corrective action to ensure consistent application.	Met	Met	Partially met	Partially met	Met
QA 11.4. The MCO has policies/procedures in place for staff to consult with requesting providers when appropriate.	Met	Met	Met	Met	Met
QA 11.5. If MCO delegates authorization decisions to subcontractors, the MCO has a mechanism to ensure that standards are met.	Met	Met	Met	Met	Met
QA 11.6. Subcontractor's utilization management plan is submitted annually and upon revision.	Met	Met	Not met	Met	Met
QA 11.7. The MCO has policies/procedures in place that state any decision to deny service authorization requests or to authorize services in an amount, duration, or scope less than requested be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.	Met	Met	Met	Met	Met
QA 11.8. MCO's service authorization decisions are completed within 2 days of receipt of all necessary information.	Met	Met	Met	Met	Met
QA 11.9. MCO is prohibited from providing incentives for denial, limiting, or discontinuing medical services for enrollees.	Met	Met	Partially met	Met	Partially met
QA 12. 438.210 (c) Coverage and authorization of services—notice of adverse action					
QA 12.1. MCO notifies provider and gives written notice of any decision to deny a service authorization request or to authorize as requested.	Met	Met	Met	Met	Met

Review Elements	Anthem	CareNet	Sentara	UniCare	Virginia Premier
Subpart D Regulations: Quality Assessment and Performance Improvement					
QA 13. 438.210 (d) (1) Time frame for decisions/standard authorization decisions					
QA 13.1. MCO provides decision notice as expeditiously as enrollee's health condition requires, not exceeding 14 calendar days following receipt of request for service, with possible extension up to 14 additional calendar days if enrollee requests extension or MCO justifies a need for additional information.	Met	Not met	Met	Met	Met
QA 14. 438.210 (d) (2) Time frame for decisions—expedited authorization decisions					
QA 14.1. The MCO has policies/procedures to make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than three working days after receipt of the request for service.	Met	Met	Met	Met	Met
QA 14.2. The MCO has policies and procedures relating to the extension time frames for expedited authorizations allowed under the state contract.	Not met	Not met	Not met	Met	Met
QA 15. 438.214 (b) Provider selection—credentialing and recredentialing requirements					
QA 15.1. The MCO has written policies/procedures for selection and retention of providers using 2003 NCQA guidelines.	Met	Met	Met	Met	Partially met
QA 15.2. MCO recredentialing process takes into consideration the performance indicators obtained through quality improvement projects (QIP), utilization management program, grievances and appeals, and enrollee satisfaction surveys.	Partially met	Met	Met	Met	Partially met
QA 15.3. MCO's policies and procedures identify the mechanism for reporting serious quality deficiencies, resulting in suspension or termination of a practitioner, to the appropriate authorities. There is evidence that this process is in place. There is a comprehensive provider appeals process. A review of provider appeals indicates that the process is followed according to policy and procedures.	Met	Met	Met	Met	Met
QA 16. 438.214 (c) Provider selection —nondiscrimination					
QA 16.1. MCO provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	Met	Met	Met	Met	Partially met
QA 17. 438.12 (a, b) Provider discrimination prohibited					
QA 17.1. For those individual or group providers who are declined, the MCO provides written notice with reason for decision.	Met	Met	Met	Met	Met

Review Elements	Anthem	CareNet	Sentara	UniCare	Virginia Premier
Subpart D Regulations: Quality Assessment and Performance Improvement					
QA 18. 438.214 (d) Provider selection—excluded providers					
QA 18.1. MCO has policies/procedures and adheres to ineligible provider or administrative entity requirements set forth in K. Provider Relations.	Met	Met	Met	Met	Met
QA 19. 438.56 (b) Provider enrollment and disenrollment—requested by MCO					
QA 19.1. MCO has policies/procedures that define processes MCO follows when requesting disenrollment, and that the request is in accordance to state contract.	Met	Met	Met	Met	Met
QA 20. 438.56 (c) Provider enrollment and disenrollment—requested by enrollee					
QA 20.1. MCO has policies/procedures in place for enrollees to request disenrollment.	Met	Not met	Met	Met	Met
QA 20.2. MCO has policies/procedures and adheres to time frames established by state for notifying and transitioning enrollees to new PCPs after PCP disenrollment (30 calendar days for each).	Met	Met	Met	Met	Met
QA 21. 438.228 Grievance systems					
QA 21.1. MCO has a process for tracking requests for covered services that were denied.	Partially met	Met	Met	Met	Met
QA 21.2. MCO has process for fair hearing notification.	Met	Met	Met	Met	Met
QA 21.3. MCO has process for provider notification.	Met	Met	Met	Met	Met
QA 21.4. MCO has process for enrollee notification and adheres to state time frames.	Met	Met	Met	Met	Met
QA 22. 438.230 Subcontractual relationships and delegation					
QA 22.1. MCO evaluates prospective subcontractor's ability to perform the activities to be delegated before delegation occurs.	Met	Met	Met	Met	Met
QA 22.2. MCO has a written agreement that specifies the activities and report responsibilities designated to the subcontractor.	Met	Met	Met	Met	Met
QA 22.3. MCO has a process for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.	Met	Met	Met	Met	Met
QA 22.4. MCO performs an annual review of all subcontractors to evaluate performance and has a mechanism in place to report actions that seriously impact quality of care that may result in suspension/termination of licenses.	Met	Met	Met	Met	Met

Review Elements	Anthem	CareNet	Sentara	UniCare	Virginia Premier
Subpart D Regulations: Quality Assessment and Performance Improvement					
QA 23. 438.236 (a, b) Practice guidelines					
QA 23.1. *The MCO has adopted practice guidelines that meet current NCQA standards and the following:*					
QA 23.1. a). Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.	Met	Met	Met	Met	Met
QA 23.1. b). Consider the needs of enrollees.	Met	Met	Met	Met	Met
QA 23.1. c). Are adopted in consultation with contracting health care professionals, and	Met	Met	Met	Met	Met
QA 23.1. d). Are reviewed and updated periodically, as appropriate.	Met	Met	Met	Met	Met
QA 24. 438.236 (c) Dissemination of practice guidelines					
QA 24.1. The MCO has policies/procedures for the dissemination of guidelines to all affected providers and, upon request, to enrollees and potential enrollees.	Partially met	Met	Partially met	Met	Partially met
QA 25. 438.236 (d) Application of practice guidelines					
QA 25.1. MCO decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the established guidelines.	Met	Met	Met	Met	Met
QA 26. 438.240 Quality assessment and performance improvement program					
QA 26.1. MCO has an ongoing quality assessment and performance improvement program for the services provided to this population.	Partially met	Met	Met	Met	Met
QA 26.2. MCO is conducting 1 QIP to achieve, through ongoing measurement and interventions, demonstrable and sustained improvement in significant aspects of clinical and non-clinical care that can be expected to have a favorable effect on health outcomes and enrollee satisfaction.	Met	Met	Met	Met	Partially met
QA 26.3. The MCO corrects significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.	Partially met	Met	Met	Met	Met
QA 27. 438.240 (b) (2) Basic elements of QAPI program—under-/over utilization of services					
QA 27.1. MCO's QAPI program has mechanisms to detect both underutilization and overutilization of the Medallion II services.	Partially met	Met	Met	Partially met	Partially met

Review Elements	Anthem	CareNet	Sentara	UniCare	Virginia Premier
Subpart D Regulations: Quality Assessment and Performance Improvement					
QA 28. 438.240 (b) (3) Basic elements of QAPI program—care furnished to enrollees with special health needs					
QA 28.1. MCO QAPI program has mechanisms to assess the quality of care and services provided to enrollees with special needs.	Met	Met	Partially met	Met	Met
QA 29. 438.242 Health/management information systems					
QA 29.1. The MCO has information systems capable of furnishing timely, accurate, and complete information about the Medallion II program.	Met	Met	Met	Met	Met
QA 29.2. The MCO information system is capable of meeting requirements.	Met	Met	Met	Met	Met
QA 29.3. Furnishing DMAS with timely, accurate, and complete clinical and administrative information.	Met	Met	Met	Met	Met
QA 29.4. MCO ensures that data submitted by providers are accurate by meeting requirements.	Met	Met	Met	Met	Met
QA 29.5. MCO uses encryption processes to send PHI over the Internet.	Met	Not met	Not met	Met	Met

Grievance System Results

The grievance system provides an opportunity for an enrollee whose request for health services is reduced, denied or not acted upon promptly to request an appeal of the MCO's decision. Because the Medicaid population is a unique group, it is deemed important to review the notification processes and documents for consistency in messages being delivered to enrollees and to provide appropriate tracking mechanisms to ensure communication is being delivered in a timely manner. In assessing the MCO's ability to provide an effective system for managing grievances, the MCO's written policies and procedures, subcontractor requirements, denial case review, the MCO's complaints, grievances, and appeals tracking system, policies specifically related to notifying DMAS of appeals, and monitoring and evaluation of enrollee complaints, were reviewed.

In general, the review found that MCOs scored high in most Quality Assessment and Performance Improvement components. Opportunities for improvement include minor revisions to appeal policies and Notice of Action letters as follows:

- Procedures need to be formalized for extension of expedited appeal time frames and enrollee notification of the reason for delay.

- Procedures need to be documented for faxing appeal summaries to DMAS in expedited appeal cases.
- Notice of action letters need to be revised to describe requests for benefit continuation pending appeal resolution and potential enrollee liability.

The overall findings relating to the MCOs' Grievance System are provided in Table 5.

Table 5. Grievance System Review Results for each MCO.

Review Elements	Anthem	CareNet	Sentara	UniCare	Virginia Premier
Subpart F Regulations: Grievance Systems					
GS 1. 438.402 (a, b) Grievance system					
GS 1.1. MCO has written policies and procedures that describe the grievance and appeals process and how it operates.	Met	Met	Met	Met	Met
GS 1.2. The definitions for grievances and appeals are consistent with those established by the state in July 2003.	Met	Met	Met	Met	Met
GS 1.3. Policies/procedures describe how the MCO intends to receive, track, review, and report all enrollee inquiries, grievances and appeals for the Medallion II program separately from the commercial program.	Met	Met	Met	Met	Met
GS 1.4. Policies/procedures describe how MCO responds to grievances and appeals in a timely manner.	Met	Met	Met	Met	Met
GS 1.5. Policies/procedures describe the documentation process and actions taken.	Met	Met	Met	Met	Met
GS 1.6. Policies/procedures describe the aggregation and analysis of the data and use in quality improvement.	Met	Partially met	Met	Met	Met
GS 1.7. The procedures and any changes to the policies/procedures must be submitted to the DMAS annually.	Met	Met	Met	Met	Met
GS 1.8. MCO provides information about grievance and appeals system to all providers and subcontractors.	Met	Met	Partially met	Met	Met
GS 2. 438.402 (3) Filing requirements—procedures					
GS 2.1. The MCO has grievance and appeal forms and provides written procedures to enrollees who wish to register written grievances or appeals.	Met	Met	Met	Met	Met

Review Elements	Anthem	CareNet	Sentara	UniCare	Virginia Premier
Subpart F Regulations: Grievance Systems					
GS 2.2. The MCO provides reasonable assistance in completing forms and taking other procedural steps including, but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.	Met	Met	Met	Met	Not met
GS 3. 438.404 Notice of action					
GS 3.1. Notice of action is written according to language and format requirements set forth in GS. 438.10 Information Requirements.	Met	Met	Not met	Met	Met
GS4. 438.404 (b) Content of notice of action					
Content of NOA explains all of the following:					
GS 4.1. The action taken and reasons for the action.	Met	Met	Met	Met	Met
GS 4.2. The enrollee's right to file an appeal with MCO.	Met	Met	Met	Met	Met
GS 4.3. The enrollee's right to request a state fair hearing.	Met	Met	Met	Met	Met
GS 4.4. The procedures for exercising appeal rights.	Met	Met	Met	Met	Met
GS 4.5. The circumstances under which expedited resolution is available and how to request an expedited resolution.	Met	Met	Not met	Met	Met
GS 4.6. The circumstances under which the enrollee has the right to request that benefits continue pending appeal resolution and the circumstances under which the enrollee may be required to pay the costs of services.	Met	Not met	Not met	Partially met	Not met
GS 5. 438.416 Record-keeping and reporting requirements					
GS 5.1. The MCO maintains a record keeping and tracking system for inquiries, grievances, and appeals that includes a copy of the original grievance or appeal, the decision, and the nature of the decision.	Met	Met	Met	Met	Met
GS 6. 438.406 Handling of grievances and appeals—special requirements for appeals					
GS 6.1. MCO has policies that ensure that individuals who make decisions on grievances and appeals were not involved in previous levels of reviews or decision-making and are health care professionals with appropriate level of expertise in treating enrollee's condition or disease.	Partially met	Partially met	Met	Met	Met

Review Elements	Anthem	CareNet	Sentara	UniCare	Virginia Premier
Subpart F Regulations: Grievance Systems					
GS 6.2. MCO provides that oral inquires seeking to appeal an action are treated as appeals and confirmed in writing, unless enrollee or provider request expedited resolution.	Met	Met	Met	Met	Met
GS 6.3. MCO provides enrollee with reasonable opportunity to present evidence and allegation of the fact or law in person, as well as in writing.	Partially met	Partially met	Met	Met	Met
GS 6.4. MCO informs enrollee of limited time available for cases of expedited resolution.	Met	Met	Met	Met	Met
GS 6.5. MCO permits enrollee, representative, or legal representative of a deceased enrollee, before and during the appeal process, to examine the enrollee case file, including medical records, considered during the appeal process.	Met	Not met	Met	Met	Met
GS 6.6. MCO continues benefits while appeal or state fair hearing is pending.	Met	Not met	Met	Not met	Met
GS 7. 438.408 Resolution and notification: grievances and appeals—standard resolution					
GS 7.1. MCO responds in writing to standard appeals as expeditiously as enrollee's health condition requires—not exceeding 30 days from initial date of receipt of the appeal.	Met	Met	Met	Met	Met
GS 7.2. In cases of appeals decisions not being rendered within 30 days, MCO provides written notice to enrollee.	Met	Met	Partially met	Met	Met
GS 8. 438.408 Resolution and notification: grievances and appeals—Expedited Appeals					
GS 8.1. MCO has an expedited appeal process.	Met	Met	Met	Met	Met
GS 8.2. The Contractor shall issue decisions for expedited appeals as expeditiously as the enrollee's health condition requires, not exceeding three (3) working days from the initial receipt of the appeal.	Met	Met	Met	Met	Met
GS 8.3. MCO has a process for extension, and for notifying enrollee of reason for delay.	Not met	Not met	Met	Not met	Met
GS 8.4. MCO makes reasonable efforts to provide the enrollee with prompt verbal notice of any decisions that are not resolved wholly in favor of the enrollee and shall follow up within two calendar days with a written notice of action.	Met	Partially met	Met	Met	Met

Review Elements	Anthem	CareNet	Sentara	UniCare	Virginia Premier
Subpart F Regulations: Grievance Systems					
GS 9. 438.408 (b -d) Resolution and notification					
GS 9.1. Decisions by the MCO to expedite appeals are in writing and include decision and date of decision.	Met	Partially met	Met	Met	Met
GS 9.2. For decisions not wholly in favor of enrollee, the MCO provides the enrollee with the right to request a state fair hearing and how to do so, and the right to request to receive benefits while the hearing is pending and how to make the request, explaining that the enrollee may be held liable for the cost of those services if the hearing decision upholds the MCO.	Met	Partially met	Met	Partially met	Met
GS 9.3. MCO gives enrollee oral notice of denial and follow up within 2 calendar days with written notice.	Met	Partially met	Met	Not met	Met
GS 10. 438.408 (c) Requirements for state fair hearings					
GS 10.1. MCO educates enrollees on state's fair hearing process and that appeal must be in writing within 30 days of enrollee's receipt of notice of any action to deny, delay, terminate, or reduce services authorization request.	Met	Met	Met	Met	Met
GS 10.2. MCO provides state with a summary describing basis for denial and for appeal.	Met	Partially met	Met	Met	Met
GS 10.3. MCO faxes appeal summaries to state in expedited appeal cases.	Partially met	Partially met	Partially met	Partially met	Met
GS 11. 438.410 Expedited resolution of appeals, GS. 438.424 Effectuation of reversed appeal resolutions					
GS 11.1. The MCO must authorize the disputed services promptly and as expeditiously as the enrollee's health condition requires in cases where MCO or State Fair Hearing Department reverses a decision to deny, limit, or delay services, in cases where those services were not rendered.	Met	Not met	Met	Partially met	Met
GS 11.2. MCO provides reimbursement for those services in accordance with terms of final agreement by state's appeal division	Met	Not met	Met	Partially met	Met

Conclusions and Recommendations

The review of MCO systems for enrollee rights and protections, quality assessment and performance improvement and grievances, while looking at structure, process, and access of MCO operations, is a process which assures that the Medallion II structure is in fact stable and functioning well enough to result in

outcomes of quality. The reviews that have been completed in the past three years in fact substantiate that the structure of the Medallion II system performs well in relation to the standards reviewed. In the aggregate, nearly all components were met or at least partially met during the current review with the exception of one MCO. Although CareNet does not appear to have performed as well as the other MCOs primarily due to an absence of several formal policies and procedures, it has mechanisms in place to ensure compliance with contractual and federal requirements by the system itself. It is anticipated that with the development and/or revision of policies and procedures and the addition of language in several areas to enrollee materials by all Medallion II MCOs the aggregate scores would improve in the next review cycle.

In its review activities of the MCOs' operational systems Delmarva identified some components that could be strengthened by further modifications to the Medallion II contract. It is recommended that DMAS consider the following:

- Require that all program information documents be written at or below a 6th grade reading level rather than the required twelfth grade level. This change would enable the Medallion II program to be consistent with other state Medicaid managed care program requirements and facilitate improved program understanding by Medallion II enrollees.
- MCOs are increasingly utilizing the Internet to communicate information to enrollees. When this vehicle is utilized MCOs should be required to identify in the enrollee handbook what information is available on the Internet, locations of no cost access to the Internet and training, such as local public libraries, and alternative sources of information, such as Member Services.
- Enhance the provision requiring written enrollee confidentiality policies and procedures to include policies and procedures to monitor compliance and evidence of routine compliance audits, findings, and recommendations for corrective action. This will serve to highlight any potential issues and reinforce compliance with these procedures on an ongoing basis.
- Require that MCOs not only have mechanisms in place to detect over and under utilization of services but also demonstrate that corrective action is initiated and monitored for any identified opportunities for improvement. This will ensure that MCOs have a systematic process in place for facilitating appropriate utilization of services by Medallion II enrollees.

Conclusions and recommendations for individual MCOs are as follows:

Anthem

For the Operational Systems Performance Review Anthem met 27 of the 47 overall standards. One of the seven Enrollee Rights standards was fully met and the remaining group was partially met. Written policies regarding Enrollee Rights and Protections and Advanced Directives were areas for improvement, with changes to policy and the enrollee handbook required to achieve full compliance in these two areas. Of the 29 Quality Assurance and Performance Improvement standards, 18 achieved a score of fully met. Ten

standards were partially met and one standard was not met. Generally, recommendations address development or minor revisions of policies and the enrollee handbook. Of the 11 Grievance System standards, eight attained a fully met rating. Three standards were rated partially met. Only minor changes, however, to the enrollee complaint and appeal policies and enrollee materials are required to achieve full compliance for these standards. Specific recommendations addressing components either partially met or not met include:

- Revise enrollee handbook to include information on required enrollee rights; where to obtain post-stabilization services; Advance Directive information; availability of a second opinion from a qualified health care professional at no cost to the enrollee; and availability of practice guidelines for enrollees upon request.
- Develop policies to address required enrollee rights; Advance Directive information; the content and vehicle for communicating to enrollees that they are not liable for payment in case of MCO insolvency; procedures that ensure enrollees and potential enrollees are informed of the availability of information in alternative formats, with instructions on how to obtain those formats; procedures for making an individual's PHI available to DMAS; procedures for informing enrollees about the availability of a second opinion at no cost to the enrollee; procedures for promoting and evaluating the delivery of culturally competent services to enrollees; procedures to ensure coordinated care for all enrollees; and procedures that describe how Anthem tracks requests for covered services that were denied.
- Add time frames to the Medicaid Children with Special Health Care Needs (CSHCN) Program to meet Medallion II contractual requirement for completed assessments of identified children within 90 days.
- Revise the Transition of Care policy to include procedures for coordinating services furnished to enrollees with those of other MCOs, PIHPs, and PAHPs to prevent duplication.
- Revise existing policies to describe the extension time frames for expedited authorizations allowed under the state contract.
- Ensure that recredentialing policies and current practices are consistent in terms of requirements for office site visits and medical record reviews.
- Ensure that required reporting to the Quality Improvement Committee (QIC) of quality improvement indicators and subcommittee activity occurs according to the reporting calendar. If there is a reason for a delay in reporting it should be documented in the meeting minutes with the revised date for reporting.
- Revise the Member Complaint policy to address how the MCO ensures that individuals who make decisions on grievances were not involved in previous levels of reviews or decision-making.
- Revise the Member Appeals policy to include procedures for providing enrollees with a reasonable opportunity to present evidence in person as well as in writing and for extension time frames and enrollee notification of the reason for the delay. Additionally, a procedure for faxing expedited appeal summaries to DMAS needs to be included.

CareNet

CareNet scored fully met in 27 of the 47 standards in the Operational Systems Performance Review. All seven of the Enrollee Rights standards were partially met. The standard related to written policies regarding enrollee rights and protections requires the development of several policies to be in compliance with the 2003 contractual and federal requirements. Although some of the information is described in the enrollee handbook, policies and procedures show that there are mechanisms in place to ensure compliance by the system itself. Twenty-two of the 29 Quality Assurance and Performance Improvement standards achieved a score of fully met. Five of the standards were partially met and one standard was not met. All recommendations address either revision of existing policies or development of new policies. Four of the 11 Grievance System standards attained scores of fully met. Six were partially met and one was not met. In order to receive full compliance for the Grievance and Appeals Performance Standards, Delmarva recommended minor revisions to existing Complaint/Grievance and Appeals policies. Specific recommendations addressing components either partially met or not met include:

- Revise enrollee handbook to include information on required enrollee rights; procedures for notifying enrollees when there are terminations and/or changes in benefits or services; where to obtain emergency and post-stabilization services; Advance Directive information; the availability of a second opinion at no cost to the enrollee; benefit continuation pending appeal resolution and the circumstances under which the enrollee may be required to pay the costs of services; and enrollee opportunity to present evidence and allegation of the fact or law in person, as well as in writing, when appealing an MCO decision.
- Develop policies to address required enrollee rights; Advance Directive Information; availability of a second opinion from a qualified health care professional; access to necessary, non-emergency services outside of the CareNet network when unavailable within the network; procedures that support access to a specialist for enrollees with special needs; procedures for enrollees to request disenrollment; enrollee freedom of choice among family planning providers; procedures to notify enrollees when there are terminations and/or changes in benefits, services, or service delivery sites; procedures for communicating with enrollees that they are not liable for payment in case of MCO insolvency; procedures to notify enrollees and potential enrollees of the availability of materials in alternative formats and how to access those formats; and procedures for making an individual's Protected Health Information (PHI) available to DMAS within 30 days of an individual's request and in the format requested by DMAS.
- Revise authorization policies to describe the extension time frames for standard and expedited authorization decisions allowed under the state contract.
- Revise the Emergency Services policy to include the definition of post-stabilization services and the waiver of prior authorization requirements.
- Revise Complaint/Grievance and Appeal Procedures policy to be consistent with BBA and DMAS required content.

Sentara

Sentara scored fully met in 31 of the 47 review standards. Two of the seven Enrollee Rights standards scored fully met and five were partially met. Of the 29 Quality Assurance and Performance Improvement standards, 23 achieved a score of fully met. Six of the standards were partially met. Generally, recommendations address development or revision of policies and enrollee materials, ensuring receipt of subcontractors' annual utilization management plans, and demonstrating evidence of an annual review of subcontractors. Of the 11 Grievance System standards, six attained fully met while four received partially met scores. Only minor changes, however, to the Notice of Action and enrollee appeal documents are required to achieve full compliance for these standards. The single unmet standard requires that the Notice of Action be available in other formats. Specific recommendations addressing components either partially met or not met include:

- Revise the enrollee handbook to include information on all required enrollee rights; where to obtain post-stabilization services; procedures for requesting a specialist as a PCP when an enrollee has a disabling condition or chronic illness or a child has special health care needs; absence of incentives for denying, limiting, or discontinuing services for enrollees; availability of practice guidelines for enrollees upon request; waiver of "prior authorization" for true emergencies; use of a "prudent layperson" standard for authorization/coverage of care; and a definition and process to follow for post-stabilization services with assurance of payment for these services.
- Develop policies to address specifically required enrollee rights; the content and vehicle for communicating to enrollees that they are not liable for payment in case of MCO insolvency; procedures that ensure enrollees and potential enrollees are informed of information available in alternative formats; procedures to allow enrollees with disabling conditions, chronic illnesses, or children with special health care needs to request their specialist to be a PCP; procedures for promoting and evaluating the delivery of culturally competent services to enrollees with limited English proficiency (LEP) and diverse cultural and ethnic backgrounds; and absence of incentives for denying, limiting, or discontinuing services for enrollees.
- Revise the Emergency Care and Treatment policy to include specific language on waiver of "prior authorization" for true emergencies, use of a "prudent layperson" standard for authorization/coverage of care, and a definition and process to follow for post-stabilization services with assurance of payment for these services.
- Revise the Services Requiring Authorization and Timeframes for Decisions policy to include waiver of preauthorization requirements for preventive services and the extension time frames for expedited authorizations.
- Revise the Inter-Rater Review Medical Care Management Staff policy to include clear audit criteria that are to be applied to a sample of records for each staff member and corrective action procedures with specific quantifiable goals for both nurses and physicians who authorize care and services.
- Provide copies of utilization management plans from each subcontractor for the time frame reviewed, with evidence that an annual review was conducted in 2003.

- Add the definition of enrollees with special needs to the population served by the Quality Improvement Program's scope and objectives.
- Revise the Authorization to Disclose PHI policy to include language that describes how Sentara uses encryption processes to send protected health information (PHI) over the Internet.
- Provide evidence that the 2003 annual review of all subcontractor grievance and appeal processes was in alignment with the DMAS contract modifications of July 2003.
- Add language to the Notice of Action documents to include how enrollees with special needs can obtain the information in alternative formats; the circumstances under which an expedited resolution is available and how to request an expedited resolution; and the circumstances under which an enrollee has the right to request benefit continuation pending appeal resolution and the circumstances under which the enrollee may be required to pay the cost of those services.
- Revise the enrollee document provided in appeals materials to state that in cases of appeal decisions not being rendered within 30 days, Sentara will provide written notice to enrollee.
- Revise the expedited appeals policy to include a process for faxing expedited appeals summaries to DMAS.

UniCare

UniCare achieved a fully met score in 34 of the 47 standards based upon review of documentation submitted for the Operational Systems Review. Three of the seven Enrollee Rights standards scored fully met and the remaining four standards were partially met. Twenty-six of the 29 Quality Assurance and Performance Improvement standards achieved a fully met determination. Two standards scored partially met. One quality standard was not met. Generally, recommendations address revision of policies, enrollee and provider materials, and improvements in documentation. Five of the 11 Grievance Systems standards attained a met determination and the remaining six standards received partially met scores. Only minor changes, however, to the standard and expedited appeal policies and the enrollee handbook are required to achieve full compliance for these standards. Specific recommendations addressing components either partially met or not met include:

- Revise the enrollee handbook to include information on required enrollee rights; the availability of a second opinion from a qualified health care professional at no cost to the enrollee; the right of benefit continuation when an appeal or state fair hearing is pending and the circumstances under which the enrollee may be required to pay for the costs of services; and MCO responsibilities when expedited decisions are not rendered within expected time frames.
- Develop new or revise existing policies and procedures to incorporate enrollee rights of benefit continuation when an appeal or state fair hearing is pending, receipt of family planning services from any qualified provider without a referral, and the availability of a second opinion at no cost to the enrollee.
- Develop a policy that describes the method and content of the communication to inform enrollees that they are not liable for payment in case of MCO insolvency.

- Revise the Pre-Services Authorization of Services policy to include language that explains that no preauthorization requirements exist for preventive services.
- Revise the provider directory to specifically identify where enrollees may obtain emergency and post-stabilization services.
- Revise the Physician Review Audits policy to identify who is responsible for subsequent monitoring and remeasurement of outcomes based on corrective action plans and reports to the Utilization Management committee.
- Improve compliance with established time frames for measuring, monitoring, reporting, and evaluating non-physicians and physicians.
- Add language to the Notice of Action documents that explains the circumstances under which the enrollee has the right to request that benefits continue pending appeal resolution and the circumstances under which the enrollee may be required to pay the costs of services.
- Improve documentation to clearly show what and how under/over utilization measures are collected and reported to the Quality Improvement committees at the local and corporate level.
- Revise expedited appeals policies to address MCO responsibilities when expedited decisions are not rendered within expected time frames.
- Revise both the standard and expedited appeals policies to include the process that the staff follows to communicate the authorization of disputed services promptly and expeditiously when a reversal decision is rendered by either UniCare or the state, procedures for reimbursing medically necessary services in accordance with the terms of the final agreement of the state's appeal division, and the liability of the enrollee for cost of services if the hearing decision upholds MCO.

Virginia Premier

Virginia Premier achieved a fully met determination in 29 of the 47 review standards. All seven of the standards for Enrollee Rights scored partially met. This area showed the greatest opportunity for improvement for Virginia Premier. Of the 29 Quality Assurance and Performance Improvement standards, 20 achieved a score of met. Eight standards were partially met. Generally, the recommendations for these standards address the development of policies and procedures, revisions to the existing enrollee handbook, documentation of a systematic process for monitoring utilization and developing corrective action plans when indicated, and consistency among credentialing and recredentialing policies and practice. One standard, Cultural Considerations, was not met. Virginia Premier performed well in the Grievance and Appeal Performance Review. Of the 11 Grievance Systems standards, nine attained a fully met designation, with only two standards scoring partially met. Minor additions to the grievance and appeals policy are required to achieve full compliance for these standards. Specific recommendations addressing components either partially met or not met include:

- Revise the Member Inquiries, Notices, Grievances, and Appeals Process policy to explain how Virginia Premier provides reasonable assistance in completing grievance and appeal forms and interpreter services with toll-free numbers that have adequate TTY/TTD and interpreter capability.
- Develop policies that include procedures for advising enrollees that they are not liable in the event that the MCO is declared insolvent; informing enrollees of the availability of information in alternative formats, with instructions on how to obtain those formats; making an individual's PHI available to DMAS within 30 days of the individual's request; informing enrollees of a second opinion benefit from a qualified health care professional at no cost to the enrollee; supporting the promotion and evaluation of the delivery of culturally competent services; explaining how Virginia Premier coordinates services with those provided by other MCOs; and identifying the types of services that do not require preauthorization consistent with contractual requirements.
- Revise coordination of care policies to explain what processes are in place to ensure the exchange of necessary information between medical and behavioral health providers.
- Revise enrollee handbook to include information on required enrollee rights; the availability of a second opinion from a qualified health care professional at no cost to the enrollee; a statement that Virginia Premier is prohibited from providing incentives for denying, limiting, or discontinuing medical services for its enrollees; and notice of the availability of practice guidelines and procedures for requesting a copy.
- Revise emergency service policy and enrollee handbook to include the definition of "post stabilization" services and the waiver of any pre-authorization requirements.
- Revise each of the Provider Directories to specifically include a notation that both emergency and post stabilization services are provided at all Virginia participating hospitals. Any exceptions should be clearly identified.
- Include a statement in the Provider Manual that addresses the prohibition against providing incentives for denying, limiting, or discontinuing medical services for its enrollees.
- Document committee review of utilization trends and implementation and monitoring of corrective action for over -and under utilization issues.
- Add language to the notice of action letters explaining that enrollees have the right to request that benefits continue pending appeal resolution and the circumstances under which they may be required to pay the cost of the services.
- Clearly define the quality improvement project (QIP) study topic, include MCO-specific data in the rationale, address any changes in goals, and analyze barriers to goal achievement.
- Ensure that its credentialing and recredentialing policies and procedures are clearly written and in agreement throughout the company. Practice should be consistent with the policies.

In addition to the above MCO specific recommendations it is further suggested that all Medallion II MCOs review the External Quality Review protocols established by the Center for Medicare and Medicaid Services for assessing Medicaid managed care plans, as this will benefit them in preparing for future reviews. This proactive approach will help to ensure that written policies and operational procedures are compliant with both the Balanced Budget Act managed care regulations and Medallion II contractual requirements.

Performance Improvement Project Validation Review

The Virginia Department of Medical Assistance Services (DMAS) requires all Managed Care Organizations (MCOs) participating in the Medallion II Program to have ongoing performance improvement projects (PIPs). The purpose of having MCOs conduct PIPs is to assist large systems in evaluating and improving health care processes that link to member outcomes.

PIP activity can offer states insight into the strengths and weaknesses of a MCO's quality management system (QMS), as many projects typically run two to three years and use numerous resources internally and externally to target specific providers, enrollees, and others to show meaningful improvement in one measure. A minimum expectation for PIP activity is that the MCO is able to report on their performance in a specific area by producing valid data that can be collected, measured, analyzed, and reported on an annual basis. For the 2004 contract year all Medallion II MCOs were required to submit one asthma related PIP to the EQRO for validation. DMAS directed all MCOs to utilize the National Committee for Quality Assurance's Quality Improvement Activity (QIA) Form as the tool for reporting their 2003 PIP activities. Review activity focused on assessing the soundness of each MCO's PIP design as reported on the QIA form and whether DMAS can have confidence in the reported results.

All of the Medallion II MCOs used audited Health Plan Employer Data and Information Set (HEDIS®) measures to evaluate performance in specific areas related to national benchmarks. Final HEDIS® reports are sent to MCOs in the summer; therefore, the MCOs submitted final PIPs to the EQRO in the fall of 2004.

Performance Improvement Project Validation Methodology

The guidelines utilized for PIP review activities were CMS' *Validation of PIPs* protocols. After developing a crosswalk between the QIA form and *Validating PIP Worksheet,* Delmarva staff developed review processes and worksheets using CMS' protocols as guidelines (2002). CMS' *Validation of PIPs* assists EQROs in evaluating whether or not the PIP was designed, conducted, and reported in a sound manner and the degree of confidence a state agency could have in the reported results.

Prior to the PIP review, training on the new validation requirements was provided to the Medallion II MCOs as well as Delmarva review staff. Delmarva presented a four-hour program to orient the MCOs to the new BBA requirements and PIP validation protocols so that they would be familiar with the protocols used to evaluate their performance. CMS' validation protocols, *Conducting and Validating Performance Improvement Projects,* were presented to the MCOs in hardcopy during the PowerPoint presentation. Delmarva nursing and

health analyst staff received one eight-hour didactic educational program on the new EQRO protocols. Training was provided as well on the QIA form.

The reviewers evaluated the entire project submission, although the minimum requirement is that each MCO review and analyze its baseline performance in 2003 to develop strong, self-sustaining interventions targeted to reach meaningful improvement.

A registered nurse, with over 20 years of Quality Improvement and managed care experience and over four years of quality improvement project review experience, completed the validation activity. A Review Manager assessed each validation worksheet and prepared a summary report for each MCO.

As Delmarva staff conducted the review, each component within a standard (step) was rated as "yes," "no," or "N/A" (not applicable). Components were then rolled up to create a determination of "met", "partially met", "unmet" or "not applicable" for each of the ten standards. Table 6 describes this scoring methodology.

Table 6. Rating Scale for Performance Improvement Project Validation Review

Rating	Rating Methodology
Met	All required components were present.
Partially Met	One but not all components were present.
Unmet	None of the required components were present.
Not Applicable	None of the required components are applicable.

Performance Improvement Project Validation Review Findings

This section presents an overview of the findings of the Validation Review conducted for an asthma PIP undertaken by each MCO. Each MCO's PIP was reviewed against all 27 components contained within ten standards. Figure 2 provides MCO comparison results for all review components.

Figure 2. Summary Performance Improvement Project Validation Review Results

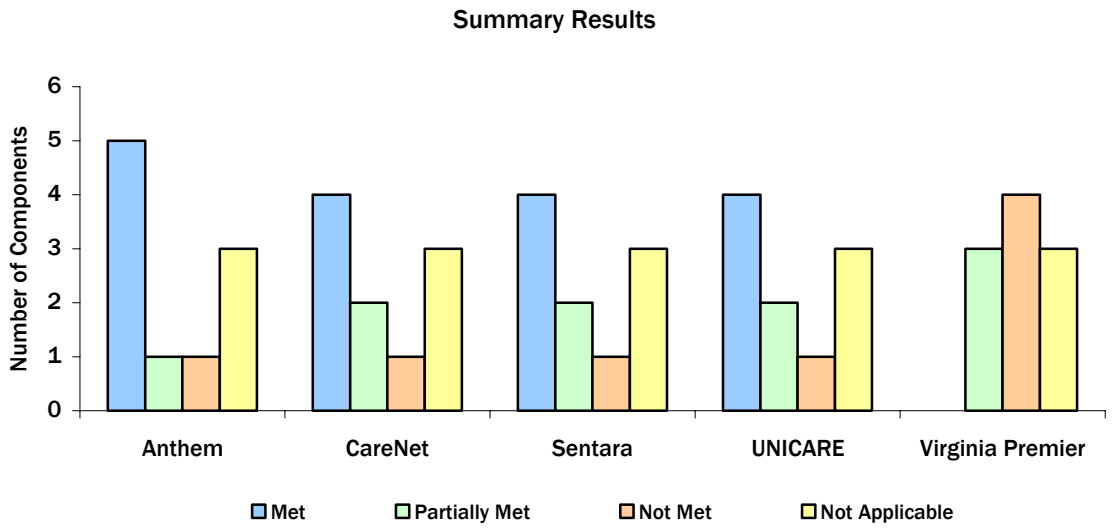

Table 7 provides an overview and comparison of MCOs for each of the PIP standards assessed as part of this review.

Table 7. Summary Performance Improvement Project Validation Review Results for each MCO.

	Anthem	CareNet	Sentara	UniCare	Virginia Premier
Standards 1 - 10					
Met	5	4	4	4	0
Partially Met	1	2	2	2	3
Unmet	1	1	1	1	4
N/A	3	3	3	3	3
Total Standards	10	10	10	10	10

Validation activities found all PIPs to be sound methodologically. Overall, MCOs scored high in the majority of components with the exception of one MCO. All MCOs included the entire eligible population in the performance improvement project therefore standard 5, Sampling Methods, was not applicable. Additionally, standards 9 and 10, Real Improvement and Sustained Improvement, as well as component 8.4 under standard 8, Data Analysis and Interpretation of Study Results, were not applicable for any of the MCOs since this was considered a baseline year for the project. There were some areas, however, where opportunities for improvement were consistent among the majority of MCOs. These were concentrated in standards 2 (Study Question) and 6 (Data Collection Procedures). Identified needs include:

- Documentation of a clear problem statement that describes the rationale for the performance improvement project.
- Documentation of data collection procedures that include evidence of a plan to audit data to ensure validity and reliability for each indicator, a plan to ensure that data collection tools provide for consistency and accuracy over time, and the qualifications of staff used to collect the data.

MCO specific validation review results by component for each of the ten standards are provided in Table 8.

Table 8. Performance Improvement Project Validation Review Results by Component for each MCO.

Review Elements	Anthem	CareNet	Sentara	UniCare	Virginia Premier
Study Methodology					
1. Study Topic					
1.1. Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care and services?	Yes	Yes	Yes	Yes	No
1.2. Did the MCO's PIP address a broad spectrum of key aspects of enrollee care and services?	Yes	Yes	Yes	Yes	Yes
1.3. Did the MCO's PIP include all enrolled populations; i.e., did not exclude certain enrollees such as with those with special health care needs?	Yes	Yes	Yes	Yes	Yes
2. Study Question					
2.1. Was there a clear problem statement that described the rationale for the study?	No	No	No	No	No
3. Study Indicator(s)					
3.1. Did the study use objective, clearly defined, measurable indicators?	Yes	No	Yes	Yes	No
3.2. Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes?	Yes	Yes	Yes	Yes	Yes
4. Study Population					
4.1. Did the MCO clearly define all Medicaid enrollees to whom the study question(s) and indicator(s) are relevant?	Yes	Yes	Yes	Yes	No
4.2. If the MCO studied the entire population, did its data collection approach capture all enrollees to whom the study question applied?	Yes	Yes	No	Yes	No

Review Elements	Anthem	CareNet	Sentara	UniCare	Virginia Premier
Study Methodology					
5. Sampling Methods					
5.1. Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	N/A	N/A	N/A	N/A	N/A
5.2. Did the MCO employ valid sampling techniques that protected against bias?	N/A	N/A	N/A	N/A	N/A
5.3. Did the sample contain a sufficient number of enrollees?	N/A	N/A	N/A	N/A	N/A
6. Data Collection Procedures					
6.1. Did the study design clearly specify the data to be collected?	Yes	Yes	Yes	Yes	Yes
6.2. Did the study design clearly specify the sources of data?	Yes	No	Yes	Yes	Yes
6.3. Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicator(s) apply?	Yes	No	No	No	No
6.4. Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	No	No	No	No	Yes
6.5. Did the study design prospectively specify a data analysis plan?	Yes	Yes	No	No	Yes
6.6. Were qualified staff and personnel used to collect the data?	No	No	No	No	Yes
7. Improvement Strategies					
7.1. Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	Yes	Yes	Yes	Yes	No
8. Data Analysis and Interpretation of Study Results					
8.1. Was an analysis of the findings performed according to the data analysis plan?	Yes	Yes	Yes	No	No
8.2. Did the MCO present numerical PIP results and findings accurately and clearly?	Yes	Yes	Yes	Yes	No
8.3. Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?	Yes	Yes	Yes	No	No
8.4. Did the analysis of study data include an interpretation of the extent to which its PIP was successful and follow-up activities?	N/A	N/A	N/A	N/A	N/A

Review Elements	Anthem	CareNet	Sentara	UniCare	Virginia Premier
Study Methodology					
9. Real Improvement					
9.1. Was the same methodology as the baseline measurement used when measurement was repeated?	N/A	N/A	N/A	N/A	N/A
9.2. Was there any documented quantitative improvement in processes or outcomes of care?	N/A	N/A	N/A	N/A	N/A
9.3. Does the reported improvement in performance have face validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?	N/A	N/A	N/A	N/A	N/A
9.4. Is there any statistical evidence that any observed performance improvement is true improvement?	N/A	N/A	N/A	N/A	N/A
10. Sustained Improvement					
10.1. Was sustained improvement demonstrated through repeated measurements over comparable time periods?	N/A	N/A	N/A	N/A	N/A

Conclusions and Recommendations

All MCO performance improvement projects were found to be sound methodologically. With the exception of one MCO, all MCOs performed well on the majority of review components. Improved documentation of the study population and analytic activities to identify barriers to goal achievement will assist Virginia Premier in developing effective interventions to demonstrate real and sustained improvement. Since some common trends in identified opportunities for improvement were noted among all MCOs a targeted training program might serve to strengthen activities related to the required asthma PIP as well as other PIPs under development or in various stages of implementation.

Conclusions and recommendations for individual MCOs are as follows:

Anthem

Anthem's PIP was sound methodologically and the descriptions followed the NCQA QIA form instructions for reporting. The purpose of their 2003 PIP was to promote the use of appropriate medications for long-term control of asthma. The 2003 PIP goal was to increase the percentage of enrollees with asthma who appropriately use asthma medications to 70%. Over time, Anthem showed evidence of real and sustained

improvement from 2000 to 2003. Their 2003 measurement was reported at the 75th percentile of HEDIS (68.93%). Recommendations to strengthen future PIP reporting activities include:

- Clearly stating the problem statement that supports the rationale of the study and
- When administrative systems are used to collect data for the indicator, documenting what efforts were taken to assure the system is valid (results of validity tests), the frequency of data collection, the plan of data analysis, and the qualifications of the staff responsible for collecting the data.

CareNet

CareNet's PIP study design was sound methodologically and the descriptions followed the NCQA QIA form instructions for reporting. The purpose of their 2003 PIP was to evaluate the care provided to Medallion II enrollees with asthma to determine the appropriateness of clinical management of these individuals. CareNet listed three goals for their 2003 PIP which were: 1) to increase the number of enrollees with asthma who had an influenza vaccination to 80%; 2) to decrease the number of enrollees with asthma who had an acute hospital admission to less than 10%; and 3) to decrease the number of enrollees with asthma who had an acute emergency department visit to less than 10%. Care Net reported in 2003, of the eligible enrollees who were targeted, 9.26% received an influenza vaccination, 11.9% were admitted to an acute hospital, and 54.63% had an emergency department visit. The MCO reported an improvement over time, as this was the fourth remeasurement cycle for these three indicators. Recommendations to strengthen future PIP reporting activities include:

- Describe results of internal data analysis that lends support for the study's rationale.
- Clearly state the problem statement that supports the rationale for the study; clearly specifying inclusion and exclusion criteria, such as age and enrollment, to define measurable indicators.
- Clearly identify which data sources are used to calculate the indicator.
- Describe efforts taken to assure the data is valid, including audits of the data collection, the plan of data analysis, and the qualifications of the staff responsible for collecting the data. Clarify whether the pharmacy data is collected manually or through an automated system.

Additionally, in order to maintain or to sustain improvement in the three areas, it might be beneficial for CareNet to develop a face-to-face intervention targeting providers who order care and services.

Sentara

Sentara's PIP study design was sound methodologically and the descriptions followed the NCQA QIA form instructions for reporting. The objective of their asthma PIP was "to achieve improved patient self-management of the disease process." Sentara listed their baseline goals for this project (1999 goals) as: 1) to decrease inpatient admissions for a primary diagnosis of asthma for a 5% improvement; 2) to decrease emergency department visits for a primary diagnosis of asthma for a 5% improvement; and 3) to increase the

use of appropriate medications by members with asthma for a 5% improvement. Sentara realized improvement in the first two performance measures for the first three years; however, results for 2003 showed that they did sustain improvement in the inpatient and emergency admissions measures. The same occurred for their third measure, use of appropriate medications in Medallion II enrollees diagnosed with asthma, after showing improvement for three years in a row. Recommendations to address identified opportunities for improvement include:

- Describe why this project was chosen for meaningful improvement in the Medallion II population.
- Provide a problem statement that supports the rationale.
- Describe efforts taken to assure the data is valid, including audits of the data collection, the plan of data analysis, and the qualifications of the staff responsible for collecting the data.

UniCare

UniCare's PIP was sound methodologically and the descriptions followed the NCQA QIA form instructions for reporting. The purpose of their 2003 PIP was to evaluate and improve performance in the appropriate use of asthma medications. The two goals of their PIP were: 1) to increase the percentage of enrollees with asthma who appropriately use asthma controller medications to at least 72.45% and 2) to decrease the percentage of enrollees with asthma who overuse reliever medications to 55.38%. UniCare completed their baseline measurement, established goals, developed interventions, and plans to re-measure and report their performance in one year. Recommendations to strengthen future PIP reporting activities include:

- Submit a problem statement that supports the rationale for the study.
- Describe efforts taken to assure the data is valid, including audits of the data collection, the plan of data analysis, and the qualifications of the staff responsible for collecting the data.
- Document a clear description of analysis activities that determine the specific interventions planned to show meaningful improvement in the two indicators.

Virginia Premier

Virginia Premier's PIP was sound methodologically and the descriptions followed the NCQA QIA form instructions for reporting. The purpose of VPHP's 2003 PIP was "to increase the use of controller medications in an effort to decrease hospital and emergency department utilization by carefully planning its interventions to build on the previous ones and to progressively improve our efforts each year". The three goals of this PIP were: 1) to increase the number of enrollees who had one or more filled prescriptions for an appropriate asthma medication to 64%; 2) to decrease the number of hospital admissions per 1000 enrollees with asthma to 2 per 1000 enrollees; and 3) to decrease the number of emergency department visits per 1000 enrollees with asthma to 350 per 1000 enrollees. VPHP reported 2002 and 2003 performance, of which 2003 is considered baseline for this activity. No barrier analysis was provided. The plan submitted interventions initiated in 2003 and planned for 2004. No project barriers were identified.