Division of Health Care Services

Medallion II and FAMIS
Annual MCO Monitoring Report

Fiscal Year:
July 2005 to June 2006

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SUMMARY – ANNUAL MONITORING STATUS REPORT
VIRGINIA MEDICAID MANAGED CARE ORGANIZATIONS

Introduction

There were seven Managed Care Organizations (MCOs) contracted with the Department of Medical Assistance Services (DMAS) at the beginning of fiscal year 2005. They delivered Medicaid Managed Care and Family Access to Medical Insurance Security (FAMIS) services to covered individuals in the Tidewater, Central Virginia, Northern, Western, and Southwestern regions of the Commonwealth of Virginia. The contracted MCOs include:

AMERIGROUP Corporation administers the Managed Care programs using the product name AMERIGROUP Virginia. AMERIGROUP Virginia is a Medicaid-only MCO and began operations in Virginia on September 1, 2005.

Anthem HealthKeepers Plus is offered by three separate legal Managed Care Organizations operating in three regions within the Commonwealth of Virginia. The three HMOs are HealthKeepers, Inc., Priority Health Care, Inc., and Peninsula Health Care, Inc.

Southern Health Services, Inc. administers the Managed Care programs using the product name Care*Net*. Southern Health is an MCO owned by Coventry Healthcare. Coventry Healthcare is a Maryland-based licensed insurance company and Southern Health is a Virginia-based licensed MCO.

Optima Health Plan administers the Managed Care programs using the product name Optima Family Care (formerly Sentara Family Care). Effective October 1, 2004, the product name was changed to Optima Family Care. Optima Health Plan is an MCO majority-owned by Sentara Healthcare. Sentara Healthcare is a Virginia-based integrated healthcare delivery system and Optima Health Plan is a Virginia-based licensed MCO.

WellPoint Health Networks, Inc. administers the Managed Care programs in Virginia using the product name UniCare Health Plan of Virginia. WellPoint is based in California and is a licensed MCO in several states, including Virginia. UniCare and Anthem merged as of January 1, 2006.

Virginia Premier Health Plan administers the Managed Care programs using the product name Virginia Premier. Virginia Premier is a Medicaid-only MCO owned by University Health Services which in turn is owned by the Medical College of Virginia. Virginia Premier is a Virginia-based licensed MCO.

This review is for DMAS contracted MCOs for fiscal year July 2005 to June 2006. This report reviews each MCO based on the submission of monthly, quarterly and annual reports and compliance to the Medallion II and FAMIS contracts. Reporting has been evaluated based on timeliness and content of the submitted information.

Performance Scoring

Scoring was based on the timeliness and content of submission.

The "Timeliness" scoring is as follows:

4 = on or before due date
3 = 1-10 days after due date
2 = 11-15 days after due date
1 = 16-29 days after due date
0 = 30+ days after due date

The "Content" scoring is as follows:

4 = meets standards fully
3 = missing some information, but submitted corrected information by deadline
2 = missing some information, but submitted corrected information 1-10 days after deadline
1 = missing some information, but submitted corrected information 11-15 days after deadline
0 = does not meet standards; not submitted within 15 days of deadline

Reporting Report Card Summary

Below are the reporting report card totals for each MCO. The detail can be found in each MCO's Reporting Report Card Section of this report.

In previous years, annual report submissions were scored based only on submission date of the required items. This is the first year that annual report submissions are based on submission date of the required items, as well as the content of the items. The scale used for scoring timeliness has not changed from previous years.

Scores are combined for Medallion II and FAMIS.

Fiscal Year	AMERIGROUP	Anthem - HealthKeepers, Inc.	Anthem - Peninsula Health Plan, Inc.	Anthem - Priority Health Plan, Inc.	Southern Health Services - CareNet	Optima Health Plan	UniCare Health Plan of Virginia	Virginia Premier Health Plan
2002		2.96	2.98	2.99	3.24	2.63	2.73	2.81
2003		2.49	2.51	2.52	2.90	2.95	3.74	2.16
2004		3.32	3.32	3.32	3.36	3.41	3.90	3.18
2005 *	3.84	3.89	3.89	3.89	4.00	3.97	4.00	3.78

*** Timeliness Score Only**

Fiscal Year	AMERIGROUP	Anthem	CareNet	Optima	UniCare	Virginia Premier
2005 **	3.91	3.95	4.00	3.99	4.00	3.86

**** Combined Score (Timeliness and Content)**

Contractual Requirements
ANNUAL REPORTS

License issued by State Corporation Commission

- The Contractor shall retain at all times a valid license issued by the State Corporation Commission (Article II, A., 1)

NCQA Accreditation

- The Contractor must demonstrate its ability to retain accreditation by the National Committee for Quality Assurance (NCQA). If not accredited by the NCQA, the Contractor must seek NCQA accreditation within six months after the start of this Contract, or thirty (30) calendar days after becoming eligible to seek NCQA accreditation, whichever is later. (Article II, A., 3).
- The Contractor must report to the Department any deficiencies noted within the previous year by NCQA within thirty (30) calendar days of being notified of the deficiencies, or on the earliest date permitted by NCQA. Denial of NCQA accreditation status may be cause for the Department to impose remedies or sanctions to include suspension, depending upon the reasons for denial by NCQA. (Article II, A., 3).

Financial Reports

- The MCO must submit to the Department a copy of all annual filings submitted to the Bureau of Insurance (BOI). A copy of these filings must be submitted to the Department on the same day on which it is submitted to the BOI. (Article II, A., 4)
- Any revisions to an annual BOI financial statement shall be submitted to the Department on the same day on which it is submitted to the BOI. (Article II, A., 4)

Basis of Accounting

- The Contractor shall operate and maintain an accounting system that either meets Generally Accepted Accounting Principles (GAAP) as established by the Financial Accounting Standards Board or can be reconciled to meet GAAP. (Article II, A., 5.)
- The Contractor must notify the Department prior to making any changes to its basis of accounting. (Article II, A., 5.)

Organizational Chart

- The Contractor shall submit an organizational chart that outlines the Medallion II operating division within its plan. The chart should include all divisions that handle Medallion II (claims, member services, outreach/marketing, health services, etc.). (Article II, Q.)

Contractor and Subcontractor Background History

- The Contractor shall submit an updated company background history that includes any awards, major changes or sanctions imposed since the last annual report. The

Contractor shall also submit the same information for all of its subcontractors. (Article II, Q.)

Network Provider Agreements

- Subcontracts with the MCO for delegated administrative and medical services must be submitted to the Department annually and at least thirty (30) calendar days prior to their effective date. (Article II, B., 3. and Attachment V).
- The Contractor shall notify the Department within thirty (30) business days of any changes to a network provider agreement made by the Contractor, a subcontractor, or network provider regarding termination, pending termination, or pending modification in the subcontractor's or network provider's terms and not otherwise addressed in Attachment V, Section C, that could reduce enrollee access to care. (Article II, J., 1, b)

Inpatient Hospitals

- The Contractor shall maintain in its network a sufficient number of inpatient hospital facilities which is adequate to provide covered services to its enrollees. The Contractor shall notify the Department within fifteen (15) calendar days of any changes to its contracts with hospitals if those changes impact the scope of covered services, the number of individuals covered and/or the units of service covered. (Article II, J., 6.)

Marketing Plan

- The MCO must submit to the Department for prior written approval a complete marketing plan. (Article II, C., 1., b)

Marketing Materials

- The MCO must submit all new and/or revised marketing and informational materials to the Department before their planned distribution. (Article II, C., 1., c)

Enrollee Information Packet

- The Department must receive a copy of this packet for review. The MCO must receive approval of the ID card from BOI and the Department prior to production of the cards. At a minimum, the enrollee information packet shall include:
  - An introduction letter (Article II, D., 15, a.)
  - A Medallion II identification card (Article II, D., 15., b. and E., 2.)
  - A description of the service area and Provider Directory (Article II, D., 15., c.)
  - Evidence of Coverage (Article II, D., 15. d. & e.; 16.; and 17.)
    - The Contractor must submit the EOC for approval annually and 30 calendar days prior to distribution (Article II, D., 16.)
    - The Contractor must submit updates to the EOC, with cover letter explicitly identifying sections that have changed annually and as needed 30 days prior to planned use (Article II, D., 16)

- The Contractor must submit all enrollment, disenrollment and educational documents and materials made available to Medallion II enrollees (Article II, F.)

Newborns

- The MCO must have written policies and procedures governing the identification of newborns by their network providers. (Article II, D., 2.)

Assignment of Enrollees to a PCP

- The MCO must have written policies and procedures for assigning enrollees to a PCP (Article II, D., 12.)
- The MCO must submit changes to written policies and procedures for assigning enrollees to a PCP at least 30 calendar days prior to implementation of any changes (Article II, D., 12.)

Access to Needed Services

- The MCO must have written policies and procedures for ensuring access to needed services for enrollees with disabling conditions, chronic illnesses, or children with special health care needs (Article II, D., 12., b.)

Verification of Member Enrollment

- The MCO must have written policies and procedures for in- and out-of-network providers to verify member enrollment (Article II, D., 11.)

Enrollee Transition to a New PCP

- The MCO must have written policies and procedures for enrollee transition to new PCP (Article II, K.)
- The MCO must submit changes to written policies and procedures for enrollee transition to a new PCP at least 30 calendar days prior to effective date of provider disenrollment

Provider Disenrollment – PCPs

- The MCO must have written policies and procedures related to provider disenrollments of PCPs (Article II, K., 5.)

Provider Disenrollment – Other Providers

- The MCO must have written policies and procedures related to provider disenrollments of other network providers (Article II, K., 5.)

Notification of Panel Composition

- The MCO must have written policies and procedures for notifying PCPs of Panel Composition (Article II, D., 10.)

Credentialing/Recredentialing Policies and Procedures

- The MCO must have written policies and procedures for the credentialing process that matches the credentialing and recredentialing standards from NCQA (Article II, L., 5.)

Quality Improvement Program

- The MCO must have a Quality Improvement Program (Article II, L.)

HEDIS Measures

- The MCO must provide the Department with the results of the following items: Breast Cancer Screening; (ii) Adolescent Well-Care Visit; (iii) Prenatal and Postpartum Care; (iv) Childhood Immunization Status; (v) Adolescent Immunization Status; (vi) Well-Child Visits in the 3rd, 4th, 5th and 6th years of life; (vii) Comprehensive Diabetes Care; (viii) Asthma - Appropriate Use of Medication; (ix) Beta Blocker Treatment After a Heart Attack; (x) Asthma Management Quality Study; and (xi) HEDIS/CAHPS 2.0H Adult Survey (Article II, L.)

Other Measures

- The MCO must provide the Department with the results of the following items: (i) Prior Year's Outcomes, including results of HEDIS and other performance measures, quality studies and other activities as documented in QIP with completion dates; (ii) Results of Internal Quality Studies (prenatal care, identification of individuals who may be pregnant, and the application of appropriate treatments for high-risk individuals) (Article II, L., 1.); (iii) Percent of two year olds who have received each immunization specified by ACIP standards (Article II, G., 31); High risk pregnancy women and infant outcomes and measurements (Article II, G., 12., b.)

Practice Guidelines

- The MCO must provide the Department with a copy of its practice guidelines annually (Article II, L., 6., b.)

Utilization Management Plan

- The MCO must provide the Department with its Utilization Management Plan annually and upon revision. (Article II, L., 4.)

Electronic Data Submission Including Encounter Claims

- The MCO must provide the Department of its plan used to evaluate the completeness of encounter data (Article II, P., 6.)
- The MCO must report to the Department any deficiencies found through review process within 60 calendar days
- The MCO must submit to the Department a corrective action plan to address any deficiencies within 30 calendar days after notification of any deficiencies

Children with Special Health Care Needs – Medallion II only

- The MCO must have written policies and procedures for completion of assessments of Children with Special Health Care Needs (Article II, R., 2.)

Medical Records Safeguarded Against Loss

- The MCO must have written polices and procedures to ensure that medical records are safeguarded against loss, destruction or unauthorized use (Article II, M., a.)
- The MCO must submit to the Department any changes to these policies and procedures upon change.

Release of Medical Record Information

- The MCO must have written policies and procedures for the release of medical record information and obtaining consent for treatment (Article II, M., a.)
- The MCO must submit to the Department any changes to these policies and procedures upon change.

Transfer of Records

- The MCO must have written policies and procedures to provide for prompt transfer of records to other in-or-out-of-network providers for the medical management of the enrollee (Article II, M., b.)
- The MCO must submit to the Department any changes to these policies and procedures upon change.

Federally Qualified Health Centers & Rural Health Clinics – Medallion II only

- The MCO must provide to the Department a list of contracted Federally Qualified Health Clinics and Rural Health Clinics (Article II, J., 1., e.)

Grievances and Appeals Policies and Procedures

- The MCO must submit to the Department the written policies and procedures which describe the grievance and appeals process and how it operates (Article II, S., 3.)
- The MCO must submit to the Department any changes to these policies and procedures upon change.

Enrollee Rights

- The MCO must submit to the Department written policies and procedures regarding enrollee rights (Article II, D., 14.)

Confidentiality of Data

- The MCO must submit to the Department written policies and procedures for maintaining the confidentially of data, including medical records and enrollee information and appointment records for treatment of sexually transmitted diseases (Article IX, B.)

Insurance Coverage Verification

- The MCO must submit to the Department verification of the following insurance coverage: (i) professional liability insurance for the contractor's medical director; (ii) workers' compensation; (iii) employer's liability; (iv) commercial general liability; and (v) automobile liability (Article XI, J.)

Substance Abuse Services

- The MCO must submit to the Department written policies and procedures addressing coordination of substance abuse services for pregnant women (Article II, G., 37., i.)

Sterilizations and Hysterectomies

- The MCO must submit to the Department written policies and procedures used to monitor compliance for sterilizations and hysterectomies (Article II, Q.)

Toll-Free Phone Line

- The MCO must submit to the Department the process that is utilized to meet the requirement that a toll free, 24 hour, 7 day a week, phone line, staffed by medical professionals to assist enrollees is in place (Article II, J., 12.)

Formulary

- If the MCO establishes a formulary, the formulary and pre-authorization requirements must be submitted to the Department annually (Article II, G., 27.)
- Any updates to the formulary must be submitted to the Department prior to their effective date (Article II, G., 27.)

Atypical Utilization

- The MCO must monitor and report atypical drug utilization, providing number of requests and number of denials to the Department (Article II, G., 27.)

Enhanced Services

- The MCO must inform the Department prior to implementing any new enhanced services and 30 calendar days prior to implementing revisions to existing enhanced services (Article II, G., 44.)
- The MCO must inform the Department 30 calendar days prior to implementing any new enhanced services.

Health Education and Prevention Plan

- The MCO must submit to the Department its Health Education and Prevention Plan annually and prior to planned implementation (Article II, I.)
- The MCO must submit to the Department changes to the Health Education and Prevention Plan prior to planned implementation.

Health Education Materials

- The MCO must submit to the Department all member health education materials, including newsletters sent to members annually and prior to planned distribution (Article II, I.)

Physician Incentive Plan

- The MCO must submit its Physician Incentive Plan to the Department (Article II, K., 7.)
- If the Physician Incentive Plan is found to be potentially cost avoidant by limiting referral specialty care, contractor must demonstrate that all medically necessary referrals were authorized.

Audit by Independent Auditor

- The MCO must submit to the Department the results of the audit by an independent auditor within 30 calendar days of audit completion and at the time of submission to the BOI (Article II, W.)
- The Department reserves the right to require the Contractor to engage the services of an outside independent auditor to conduct a general audit. The results of which must be submitted to the Department within 30 days of completion of the audit (Article II, W.)

Fraud and Abuse

- The MCO must submit to the Department its Program Integrity Plan. The Program Integrity Plan is the MCOs' policies and procedures for ensuring protection against actual or potential fraud and abuse. The MCO must submit to the Department its written policies and procedures for the prevention, detection, and reporting of incidents of potential fraud and abuse by enrollees, by network providers, by subcontractors, and by the Contractor (Article II, T., 2.)

Plan for High Risk Pregnant Women and Infant

- The MCO must submit to the Department its Plan for High Risk Pregnant Women and Infants (Article II, G., 12., b.)

Certification of Need

- The MCO must submit to the Department documentation of how the requirement of a certification of need for admission to a free-standing psychiatric hospital and for psychiatric services resulting from an EPSDT screening as defined in 42 C.F.R. 441.152 is met (Article II, G., 30.)
- The MCO must submit to the Department any changes in how this requirement is met upon any change in procedures (Article II, G., 30.)

Referral Guidelines

- The MCO must submit to the Department its referral guidelines that demonstrate the conditions under which PCPs make arrangements for referrals to specialty care networks (Article II, L., 2., d.)

Provider Manual

- If the MCO uses the Provider Manual as a supplement to the Provider Agreement, all sections pertaining to Medallion II must be submitted (Attachment V.)

Contractual Requirements

QUARTERLY REPORTS

Bureau of Insurance (BOI) Financial Reports

- The MCO must submit to the Department a copy of all quarterly filings submitted to the BOI on the same day on which it is submitted to the BOI (Article II, A., 4.)
- The MCO must submit to the Department any revisions to a quarterly BOI financial statement on the same day on which it is submitted to the BOI.

Live Birth Outcomes Report

- The MCO must advise the Department of all live birth outcomes (Article II, D., 2).

High Risk Maternity and Infant

- The MCO must report summary and detailed information regarding high risk maternity and infants to the Department (Article II, G., 12., c.)

Provider file to DMAS

- The MCO must submit to the Department a complete provider file (Article II, J., 1., d.).

Disproportionate Share Hospital Report

- The MCO must submit the Disproportionate Share Hospital Report within thirty (30) days from the end of each quarter (Article II, Q. and Attachment VIII)

Provider Agreements

- The MCO must submit any additions or deletions of agreements involving: a clinic or group of physicians, an individual physician or facility within 30 days of the end of the quarter (Attachment V).

Contractual Requirements
MONTHLY REPORTS

Listing of Newborns

- The MCO must advise the Department of all newborns that do not receive an identification number within 60 days (Article II, D., 2.)

Returned ID Card List

- The MCO must submit a monthly report of returned ID cards. The report must identify all returned cards, with the enrollee's Medicaid/FAMIS Plus identification number, incorrect address, and correct address, if available (Article II, E., 2.)

ID Cards Mailed to New Enrollees

- The Contractor shall provide the Department the date and the number of identification cards mailed to new members enrolled each month (Article II, E., 2.)

ID Cards Re-issued During Prior Month

- The Contractor shall provide the Department the date and the number of identification cards that were re-issued during the prior month (Article II, E., 2.)

Wait and Abandonment

- Records of wait times and abandonment rates must be kept by the Contractor and reported to the Department. At a minimum the report shall identify the total call volume, wait time (in seconds), and the abandonment percentage rate. This applies to medical, lab, mental health, pharmacy, transportation and vision records. (Article II, H., 2.)

Electronic Provider File

- The MCO must submit an updated file with all of the changes to their network to the Enrollment Broker and fiscal intermediary (Article II, J., 1.)

Sentinel Events

- The Contractor must maintain a system for identifying and recording recipients' deaths and must provide the Department with reports of sentinel events monthly via the Sentinel Event Reporting Form (Article II, L., 9.)

Encounter Data Certification

- Any payment information from the MCO that is used for rate setting purposes (e.g. any encounter data) or any payment related data required by the state must be certified by the MCO's Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer of the MCO. The certifications shall attest that the MCO has reviewed the encounter data or other information and attests, based on best

knowledge, information, and belief as of the date signed and submitted that it is accurate, complete and truthful. (Article II, P., 4. and 7., Article II, T., 1.)

MCO Report

- The MCO Report must be submitted to the Department and must contain information on the number of enrollees; claims volume; claims processed; processing time for clean claims; inpatient authorizations; and number of primary care physicians (Article II, Q.)

Summary of Inquires, Grievances, and Appeals

- The MCO must submit this report to the Department. The report must contain the number of inquiries (total, source – members, providers); number of grievances (total, source – members, providers, type, and status); and number of appeals (total, type, and status). This applies to medical, lab, mental health, pharmacy, transportation and vision records. (Article II, S., 8.)

Grievance Log

- The Contractor must submit to the Department a detailed log of all recipient grievances and appeals and all provider grievances and appeals made on behalf of a recipient. The log must contain the following information for each grievance or appeal: (i) the date of the communication; (ii) the enrollee's Medicaid/FAMIS Plus identification number; (iii) whether the grievance or appeal was written or oral; (iv) indication of whether the dissatisfaction was a grievance or an appeal; (v) the category, specified in subsection a, of each inquiry; (vi) a description of subcategories or specific reason codes for each grievance and appeal. Attachment XIII contains illustrative examples of subcategories or specific reason codes; (vii) the resolution; and (viii) the resolution date. This applies to medical, lab, mental health, pharmacy, transportation and vision records. (Article II, S., 8.)

Appeal Log

- See information under "Grievance Log" above.

Third-Party Liability

- Any moneys recovered by third parties shall be retained by the MCO and identified to the Department. This includes comprehensive health coverage, workers' compensation, estate recoveries, and other coverage (i.e., trauma injuries) (Article IV, G.).