



Care Management Organizations' Compliance with Managed Care Regulations

Care Management Organizations: Executive Summary

The 2007 EQR of the Family Care program determined whether Wisconsin CMOs that deliver care and services to members who are eligible for the Family Care program were in compliance with federal Medicaid managed care regulations, specifically Federal Regulation 438, Subpart E, using the Centers for Medicare & Medicaid Services' (CMS), "Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et. al."

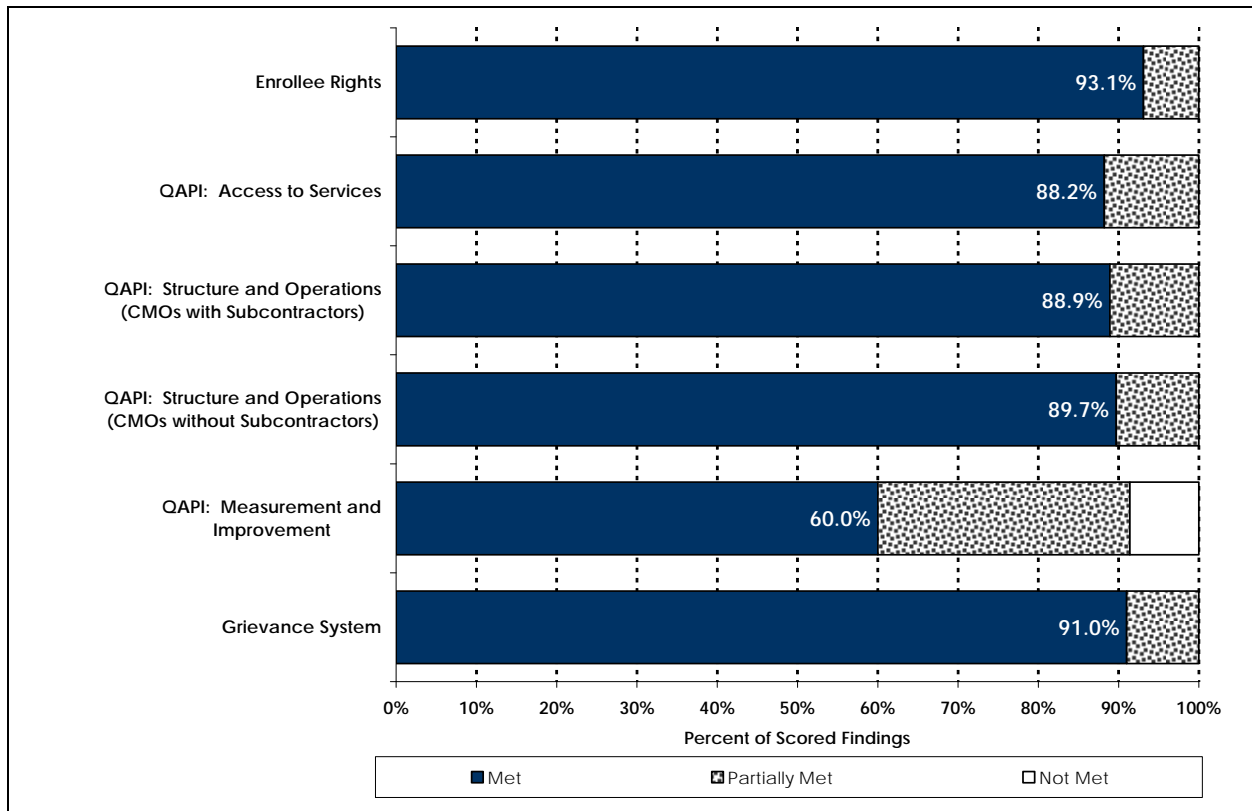
The EQR has three review components:

- The **Quality Compliance Review (QCR)** identifies and documents five practice categories of each CMO that affects the quality and timeliness of the care and services its Family Care members receive, as well as their access to those services.
- **Validation of Performance Improvements Projects (PIPs)** is necessary to ensure that each CMO's two contractually required annual PIPs have been developed and implemented using proper technique and design so that the CMOs can use the projects' data and findings for its organizational decision making.
- The **Care Management Review (CMR)** determines each CMO's level of compliance with its contract with the DHFS, ability to safeguard members' health and welfare, and ability to work with members to identify the outcomes that members want and the resources they need to achieve them.

Overall Findings

Quality Compliance Review

On average, the five CMOs fully met most of the QCR standards. In four of the review areas – Enrollee Rights, Access to Services, Structure and Operations (for all CMOs, regardless of whether they employ subcontractors) and Grievance Systems – all of the CMOs had their compliance with all standards rated as partially met or fully met. In aggregate, the CMOs struggled most to meet the standards related to Measurement and Improvement.



None of the CMOs fully met every QCR standard, but most of the CMOs met at least eighty percent of the QCR standards overall.

Related to Enrollee rights, all CMOs provide:

- Informational and instructional materials to potential enrollees and current members in a manner, and format and language members can understand.
- Interpretation and translation services to their members free of charge.
- Detailed information so that all members understand the amount, duration and scope of benefits available once they enroll in a CMO and the relevant procedures for obtaining these benefits; available treatment options or alternatives and the risk, benefits and consequences of treatment and non-treatment; and, how to obtain a second opinion.



CMOs treat members with respect and with due consideration for his or her dignity and privacy. They focus on member-centered communication between health care providers and CMO teams.

To ensure members' Access to Services, CMOs anticipate Family Care enrollment and expected utilization of services considering Family Care member characteristics and health care needs. They provide second opinions from a qualified health care professional within the network or arrange for members to obtain second opinions from out-of-network providers at no cost and furnish any necessary out-of-network medical services covered by Family Care to members when the CMO provider network is not able to provide them. CMOs coordinate members' care with other providers and CMOs and share the results of members' assessment needs to keep plans from duplicating services and activities, all the while protecting members' privacy.

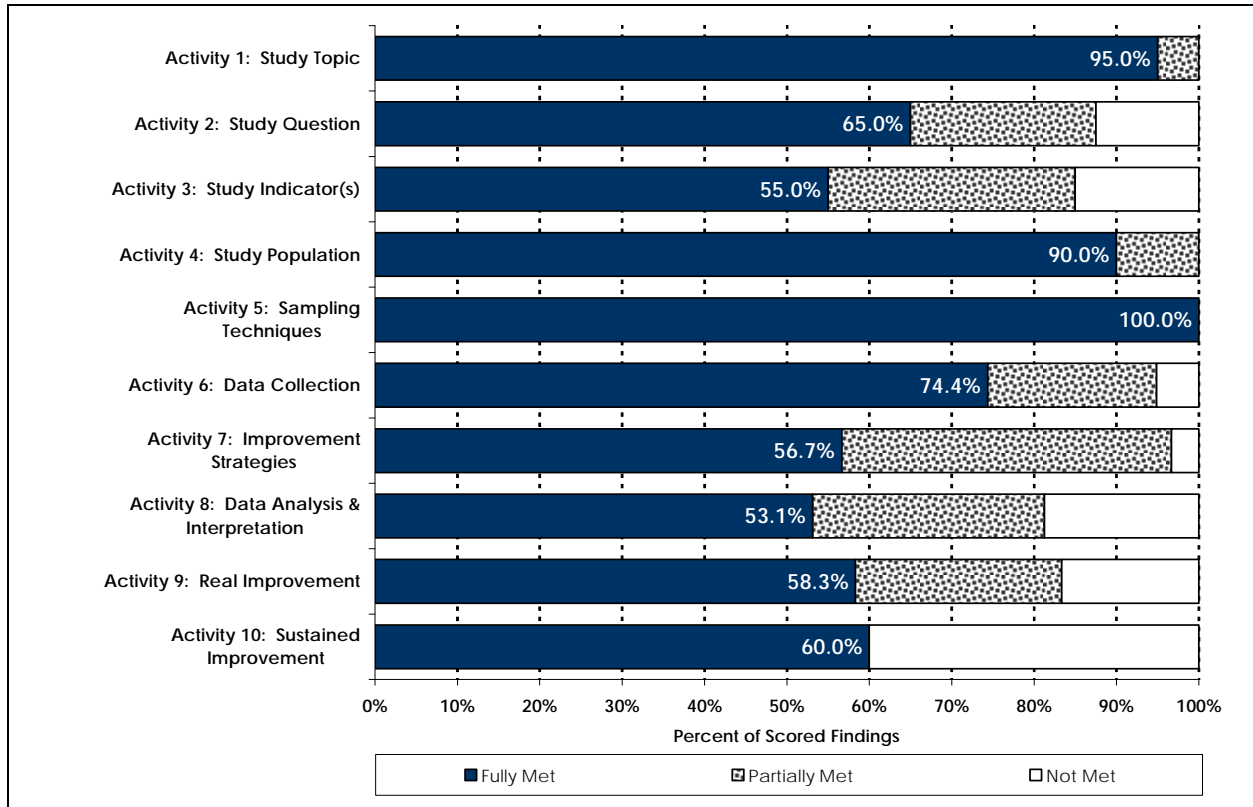
In regards to the Structure and Operations standards, all CMOs have defined and implemented procedures related to member disenrollment requests to ensure transition plans are in place for members' services and supports.

Despite their collective difficulties implementing the Measurement and Improvement requirements, individual CMOs made noteworthy improvements to their processes and procedures to help improve how they measure their progress and focus their improvement efforts.

To exercise their Appeal and Grievance rights, members can include individuals of their own choosing in the appeal, grievance process and State fair hearing processes. CMOs work with members to ensure they understand these rights and have appropriate representation in appeal and grievance matters.

Validation of Performance Improvement Projects

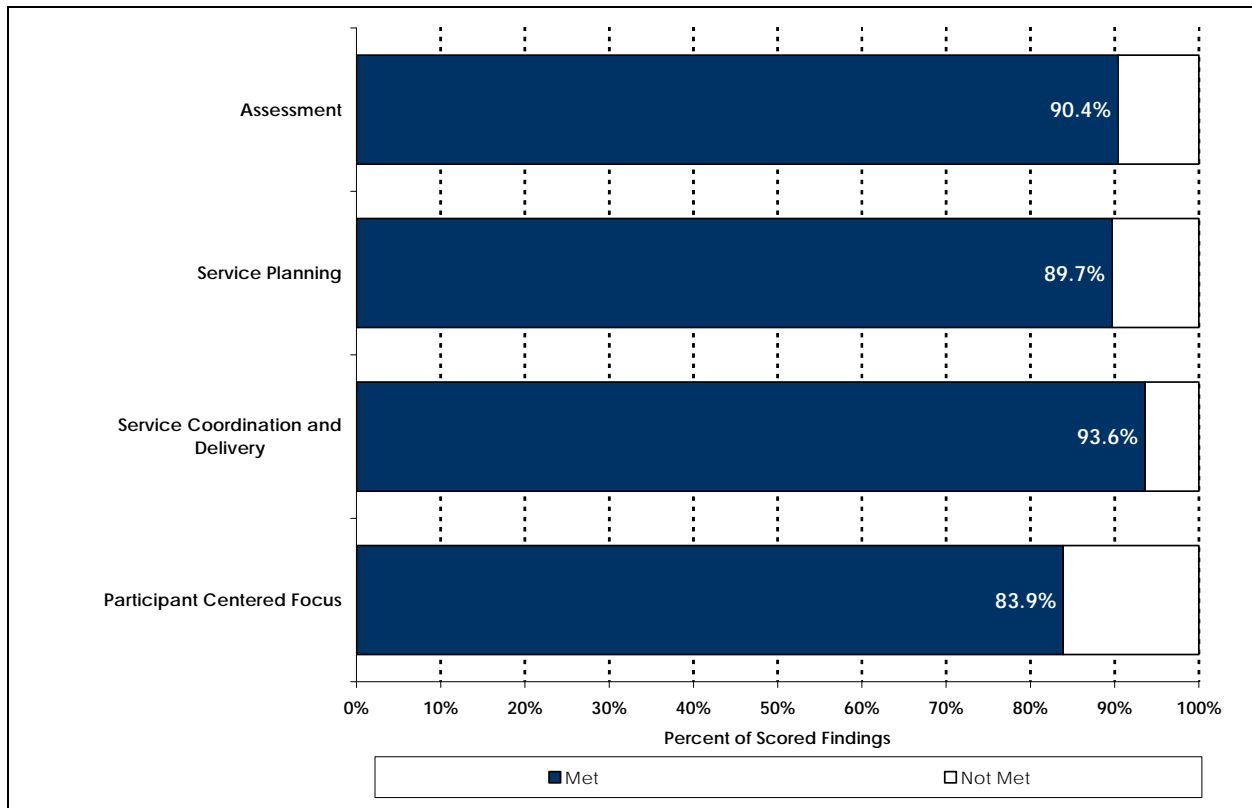
Every CMO that serves Family Care members was in compliance with its contract requirement to submit two PIPs to DHFS. In 2007, the CMOs worked on PIPs related to depression, falls prevention, diabetes management, self-management of congestive heart failure, and increasing the use of health care power of attorney by members. Although some PIPs were crafted and implemented better than others, all CMOs struggled with at least one aspect of their projects.



Overall, the PIPs showed substantial improvements between 2006 and 2007 in developing clearly stated and measurable aims and overall outcome measures, and applying quality improvement cycles appropriately. All CMOs should move ahead with their PIPs and seek technical assistance from MetaStar as needed.

Care Management Review

During the onsite review of member records, the MetaStar EQR team may identify health and/or safety concerns that could have had an immediate, serious effect on a member. In this event, the reviewers would initiate the Quality Concern Protocol. This occurred after the review of one member record at one CMO during the 2007 EQR.



The CMOs demonstrated outstanding performance in having members’ initial assessments done in a timely manner. Over ninety percent of these initial assessments reviewed were deemed to be comprehensive. Reassessments were also done according to designated timeframes in over ninety percent of records reviewed by the MetaStar EQR team. Collaboration within the interdisciplinary team was exemplary among the Service Planning measures. With a rate of almost 99 percent met, the MetaStar EQR team found evidence in almost every member record reviewed that the CMOs implemented authorized services.

Opportunities exist for CMOs to improve the frequency with which they update members’ plans when significant changes occur. All CMOs need to work to improve the issuance of notices of action in a timely manner whenever members’ services are reduced, denied, suspended or terminated. Four of five CMOs were found to have not offered an option to their members that would allow the members to self-direct the care and services they receive (“self-directed supports”).



Prepaid Inpatient Health Plans' Compliance with Managed Care Regulations

Prepaid Inpatient Health Plans: Executive Summary

The 2006 annual quality review (AQR) of the Wisconsin Partnership Program (WPP) and Program of All-Inclusive Care for the Elderly (PACE) determined whether Wisconsin prepaid inpatient health plans (the "Plans") that deliver care and services to members who are eligible for the Wisconsin Partnership and PACE programs were in compliance with federal Medicaid Managed Care Regulations.

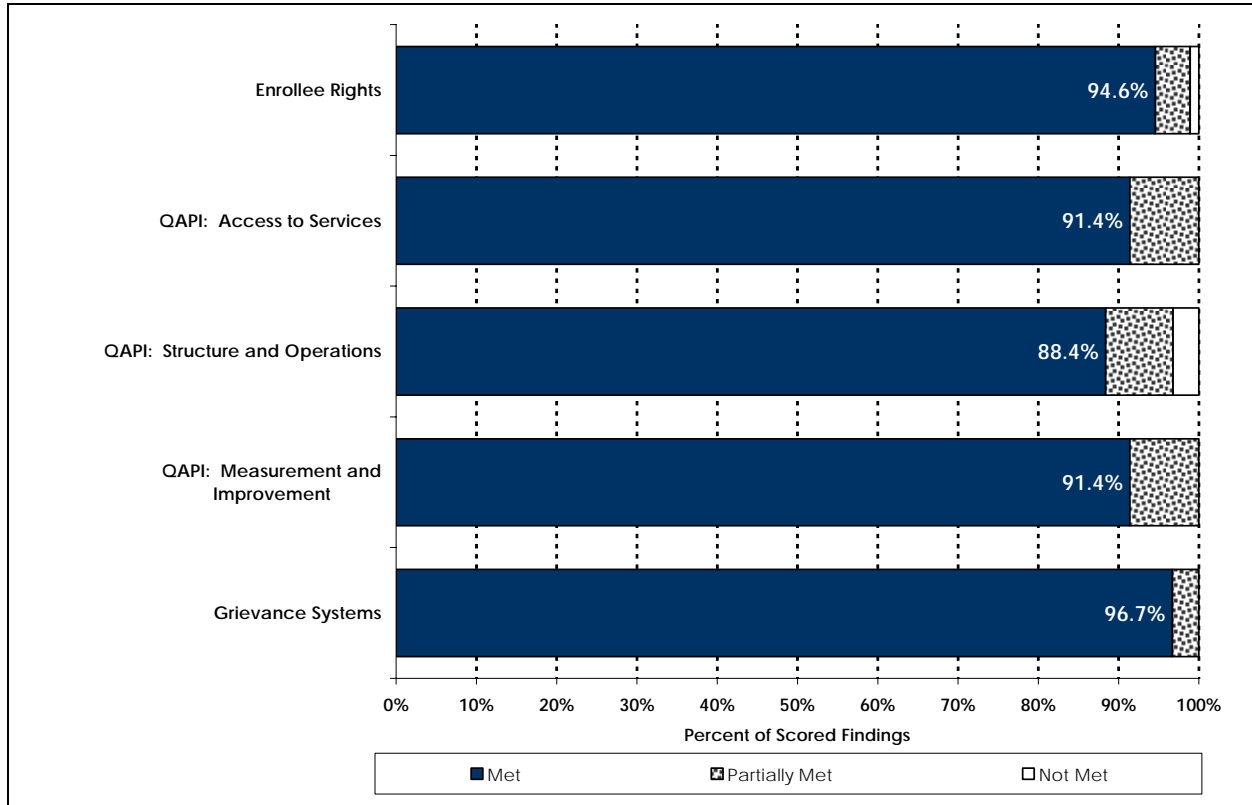
The AQR has three review components:

- The **Quality Compliance Review (QCR)** identifies and documents five practice categories of each Plan that affects the quality and timeliness of the care and services its WPP or PACE members receive, as well as their access to those services.
- **Validation of Performance Improvements Projects (PIPs)** is necessary to ensure that each WPP Plan's two contractually required annual PIPs have been developed and implemented using proper technique and design so that the Plans can use the projects' data and findings for their organizational decision making.
- The **Care Management Review (CMR)** determines each Plan's level of compliance with its contract with DHFS, ability to safeguard members' health and welfare, and ability to work with members to identify the outcomes that members want and the resources they need to achieve them.

Overall Findings

Quality Compliance Review

On average, the five Plans fully met most of the QCR standards. In three of the review areas – Access to Services, Measurement and Improvement and Grievance Systems – all of the Plans had their compliance with all standards rated as partially met or fully met.



Related to the Access to Services standards, one Plan asked all outpatient clinics with which it works to provide information about waiting room times. It then followed up by asking its members about their wait-time experiences, and it compared members' anecdotes with the information it obtained from the clinics and primary care providers. In interviews with the MetaStar EQR team, providers emphasized Plans' excellent practice of accompanying members to their medical appointments. This helps to ensure the continuity of care between physicians and Plans and reinforce physician education to members.

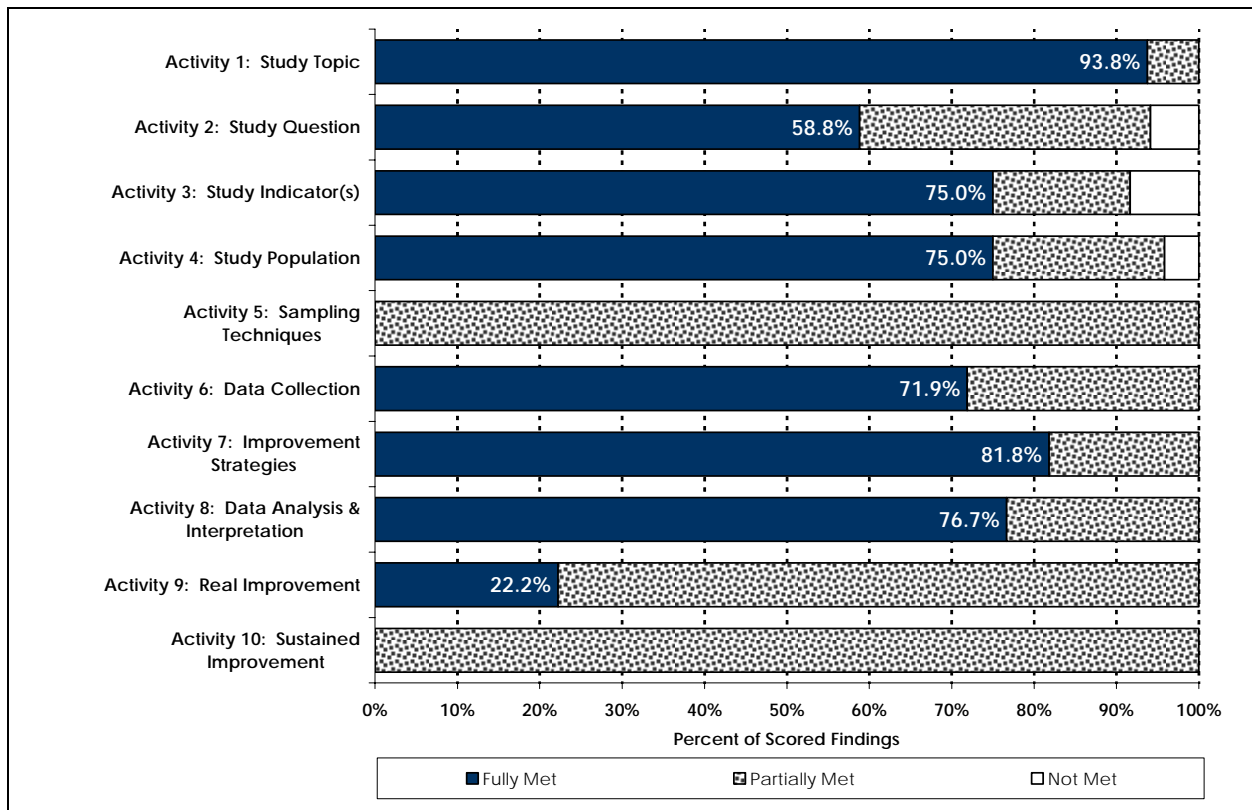
The implementation of electronic decision support and member record systems has greatly enhanced some Plans' abilities to collect and analyze various types of information which led to their high scores on the Measurement and Improvement standards.

In aggregate, the Plans struggled most to meet the standards related to their Structure and Operations related to monitoring and evaluating their subcontractors' performance.



Validation of Performance Improvement Projects

Every Plan serving members enrolled in the WPP was in compliance with the contract requirement to submit two PIPs to DHFS. In 2006, the Plans worked on PIPs related to diabetes, urinary incontinence, persistent pain, vocational futures planning, wound care and falls management. Although some PIPs were crafted and implemented better than others, all Plans struggled with at least one aspect of their projects. Overall, the PIPs showed substantial improvements between 2005 and 2006 in defining their study populations and data collection procedures. All Plans should move ahead with their PIPs and seek technical assistance from MetaStar as needed.



Care Management Review

During the onsite review of member records, reviewers may identify health and/or safety concerns that could have had an immediate, serious effect on the member. In this event, the reviewers would initiate the Quality Concern Protocol. This did not occur during any of the Plans' care management reviews.

Plans demonstrated exceptional performance in meeting deadlines for performing members' initial assessments, determining that authorized services are implemented, and using collaborative methods among their interdisciplinary teams to plan for and manage their members' care.

Plans showed difficulties obtaining members' written consent for their treatment and care plans, which is documented by members signing their initial individualized care plans. Plans also demonstrated impediments related to sending out written letters, called *notices of action*, within regulated timeframes when teams denied, limited, suspended or terminated members' services. Delays in issuing notices of action to members can result in members not fully understanding their appeal rights.

