

**EXTERNAL QUALITY REVIEW REPORT OF
FINDINGS FOR STATE FISCAL YEAR 2008 - 2009
WISCONSIN MEDICAID MANAGED CARE
ORGANIZATIONS
FAMILY CARE
MANAGED CARE ORGANIZATIONS
AND
FAMILY CARE PARTNERSHIP/PROGRAM OF ALL-INCLUSIVE
CARE FOR THE ELDERLY
MANAGED CARE ORGANIZATIONS**

**PREPARED FOR
WISCONSIN DEPARTMENT OF HEALTH SERVICES**

PREPARED BY



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THE EXTERNAL QUALITY REVIEW

Please see Appendix 2 for definitions of all acronyms and abbreviations used in this report.

OVERVIEW OF WISCONSIN MANAGED CARE ORGANIZATIONS

WISCONSIN FAMILY CARE MANAGED CARE ORGANIZATIONS

Each managed care organization (MCO) is under contract with the Wisconsin Department of Health Services (DHS) to provide long-term care services for elderly and physically or developmentally disabled consumers of services (members) who are eligible for the Family Care program and who choose to enroll in it. Each MCO is a partnership between the MCO in a single or multi-county service area in which it serves members and the State of Wisconsin. They involve members in the ongoing planning, implementation, evaluation, and improvement of services.

During the state fiscal year (SFY) from July 1, 2008, to June 30, 2009 (SFY 08-09), nine MCOs administered the Family Care program in Wisconsin and provided or coordinates services for enrolled members.

Table 1: Overview of Wisconsin Organizations Operating Family Care MCOs

Family Care MCO	Service Areas in Effect during the 2009 External Quality Review	People Served (Primary Target Group)		
		Frail Elderly	With Physical Disabilities	With Developmental Disabilities
* Care Wisconsin (CW-FC)	Central & Southeastern Wisconsin: Columbia, Dodge, Green Lake, Jefferson, Marquette, Washington, Waukesha & Waushara counties	Age 65 and older	Age 18 and older	Age 18 and older
Community Care (CC-FC)	Central & Southeastern Wisconsin: Kenosha, Ozaukee, Racine, Sheboygan, Washington & Waukesha counties	Age 65 and older	Age 18 and older	Age 18 and older
Community Care of Central Wisconsin (CCCW)	Central Wisconsin: Marathon, Portage & Wood counties	Age 65 and older	Age 18 and older	Age 18 and older
* Community Health Partnership (CHP-FC)	Western Wisconsin: Chippewa, Dunn, Eau Claire, Pierce & St. Croix counties	Age 65 and older	Age 18 and older	Age 18 and older
Creative Care Options (CCO)	East-Central Wisconsin: Fond du Lac County	Age 65 and older	Age 18 and older	Age 18 and older

Family Care MCO	Service Areas in Effect during the 2009 External Quality Review	People Served (Primary Target Group)		
		Frail Elderly	With Physical Disabilities	With Developmental Disabilities
Milwaukee County Department of Aging Care Management Organization (MCDA)	Southeastern Wisconsin: Milwaukee County	Age 60 and older	Age 60 and older	Age 60 and older
* NorthernBridges Managed Care Organization (NB)	Northwestern Wisconsin: Barron, Burnett, Douglas, Polk, & Washburn counties	Age 65 and older	Age 18 and older	Age 18 and older
Southwest Family Care Alliance (SFCA)	Southwestern Wisconsin: Crawford, Green, Lafayette, Richland & Sauk counties	Age 65 and older	Age 18 and older	Age 18 and older
Western Wisconsin Cares (WWC)	West-Central Wisconsin: Buffalo, Clark, Jackson, La Crosse, Monroe, Pepin, Trempealeau & Vernon counties	Age 65 and older	Age 18 and older	Age 18 and older

* Note: Under contract with DHS the External Quality Review Organization only reviews MCO programs that have served members or at least one year. CW-FC, CHP-FCP and NB began serving members in 2009. EQRs did not occur for these programs.

WISCONSIN FAMILY CARE PARTNERSHIP/PACE MANAGED CARE ORGANIZATIONS

The Family Care Partnership (FCP) program – formerly known as the Wisconsin Partnership Program – and the Program of All-Inclusive Care for the Elderly (PACE) are Medicaid managed care programs designed to provide eligible members with health and long-term care services. Both programs coordinate and provide health and long-term care services through an interdisciplinary team (team) approach.

During SFY 08-09, three MCOs administered the Family Care Partnership program, and one MCO also administered PACE in Wisconsin.

Table 2: Overview of Wisconsin Organizations Operating FCP & PACE MCOs

Program	MCO	Service Area	People Served (Primary Target Group)		
			Frail Elderly	With Physical Disabilities	With Developmental Disabilities
Family Care Partnership (FCP)	Care Wisconsin (CW-FCP)	South-Central Wisconsin: Dane County	Age 65 and older	Age 55 to 64	n/a
		South-Central Wisconsin: Columbia, Dodge, Jefferson & Sauk Counties	Age 65 and older	Age 55 to 64	Age 18 and older
	Community Care	Southeastern Wisconsin: Milwaukee County	Age 65 and older	Age 55 to 64	n/a

Program	MCO	Service Area	People Served (Primary Target Group)		
			Frail Elderly	With Physical Disabilities	With Developmental Disabilities
	(CC-FCP)	Southeastern Wisconsin: Kenosha, Ozaukee, Racine, Washington & Waukesha Counties	Age 65 and older	Age 55 to 64	Age 18 and older
	Community Health Partnership (CHP-FCP)	Western Wisconsin: Chippewa, Dunn, Eau Claire, Pierce & St. Croix Counties	Age 65 and older	Age 18 and older	n/a
PACE	Community Care (CC-PACE)	Southeastern Wisconsin: Milwaukee & Waukesha Counties	Age 55 and older	n/a	n/a

Information about the number of members served by each MCO in each county can be found through the DHS website:

<http://dhs.wisconsin.gov/lcicare/Generalinfo/EnrollmentData.htm>

OVERVIEW OF THE EXTERNAL QUALITY REVIEW ORGANIZATION

META STAR, INC.

Based in Madison, Wisconsin, MetaStar, Inc. is an External Quality Review Organization (EQRO) that provides independent review services to various organizations, including DHS.

DHS authorized MetaStar to conduct annual reviews of MCOs. MetaStar's responsibilities are to review, analyze and evaluate aggregated information about the health and long-term care services furnished to people enrolled in certain state-funded programs administered by MCOs that administer the Family Care, FCP and PACE programs.

REVIEW COMPONENTS

The 2008 – 2009 external quality review (EQR) focused on three areas:

- The Quality Compliance Review (QCR),
- The Validation of Performance Improvement Projects (PIPs), and
- The Care Management Review (CMR).



WISCONSIN FAMILY CARE MCOs' COMPLIANCE WITH MANAGED CARE REGULATIONS

WISCONSIN FAMILY CARE MCOs: EXECUTIVE SUMMARY

The 2009 EQR of the Family Care program determined whether Wisconsin MCOs that deliver care and services to members who are eligible for the Family Care program complied 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 and Prepaid Inpatient Health Plans: 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 MCO that affects the quality and timeliness of the care and services its Family Care members receive, and their access to those services.
- The **Validation of Performance Improvements Projects (PIPs)** is necessary to ensure that each Family Care MCO's contractually required annual PIP has been developed and implemented using proper technique and design so that the MCOs can use the projects' data and findings for its organizational decision making.
- The **Care Management Review (CMR)** determines each MCO's level of compliance with its contract with DHS, 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

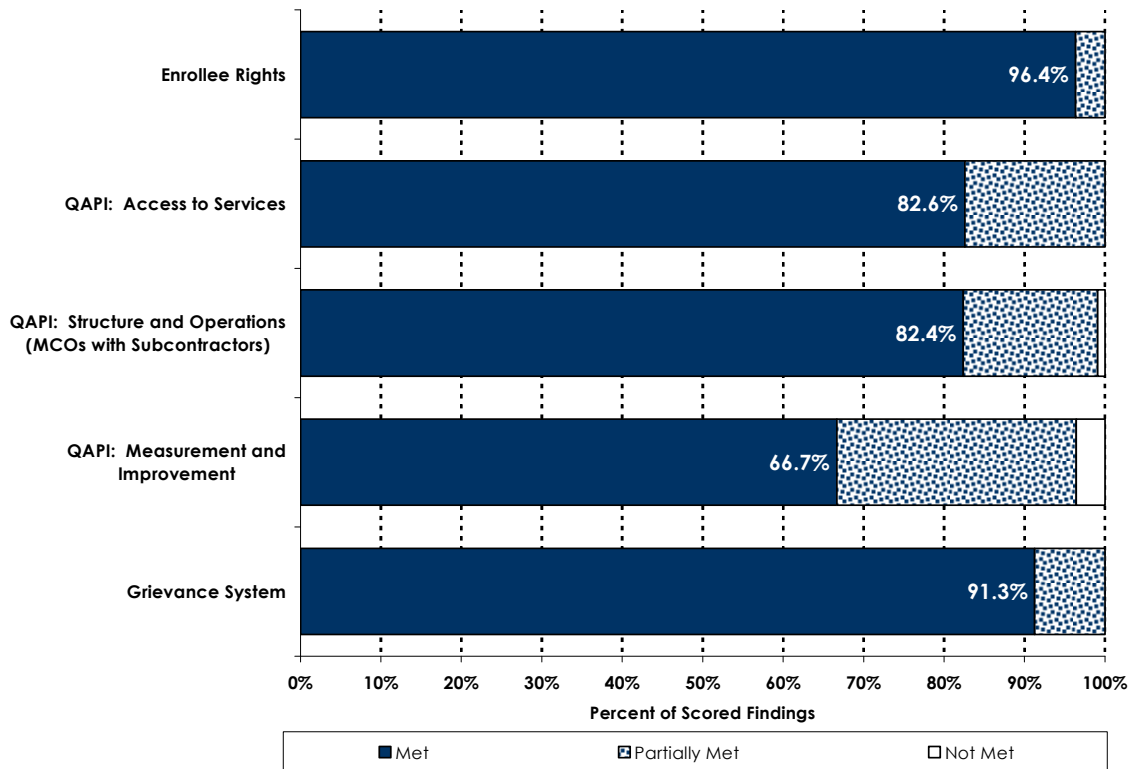
All Family Care MCOs demonstrated difficulties providing written letters called notices of action within regulated timeframes when MCO teams denied, limited, suspended or terminated members' services. Delays in issuing notices of action to members can result in members not fully understanding their appeal rights. This finding was evident throughout the Family Care MCOs' 2009 EQR in the QCR *Quality Assessment & Performance Improvement*, *QAPI Access to Services*, *QAPI Structure & Operations* and *Grievance Systems* sections. It was also evident in their CMRs.

Quality Compliance Review

On average, the six Family Care MCOs fully met most of the QCR standards. In two areas, *Enrollee Rights* and *Grievance Systems*, the MCOs in aggregate fully meet 96 percent of the standards. In the *QAPI Access to Services* category MetaStar rated all MCOs as partially or fully meeting all standards. Overall the MCOs had the most difficulty meeting the standards related to

QAPI Measurement & Improvement. Many of these difficulties were related to three MCOs that did not use an internal file review process throughout SFY 08-09. Two MCOs suspended their internal file review processes, one because it was expanding its Family Care service area and the other because it was revising its internal file review tools. The third MCO did not have an internal file review process; MetaStar encouraged it to develop one similar to another MCO's successful process.

Chart 1: 2009 Family Care MCOs' QCR Findings by Category

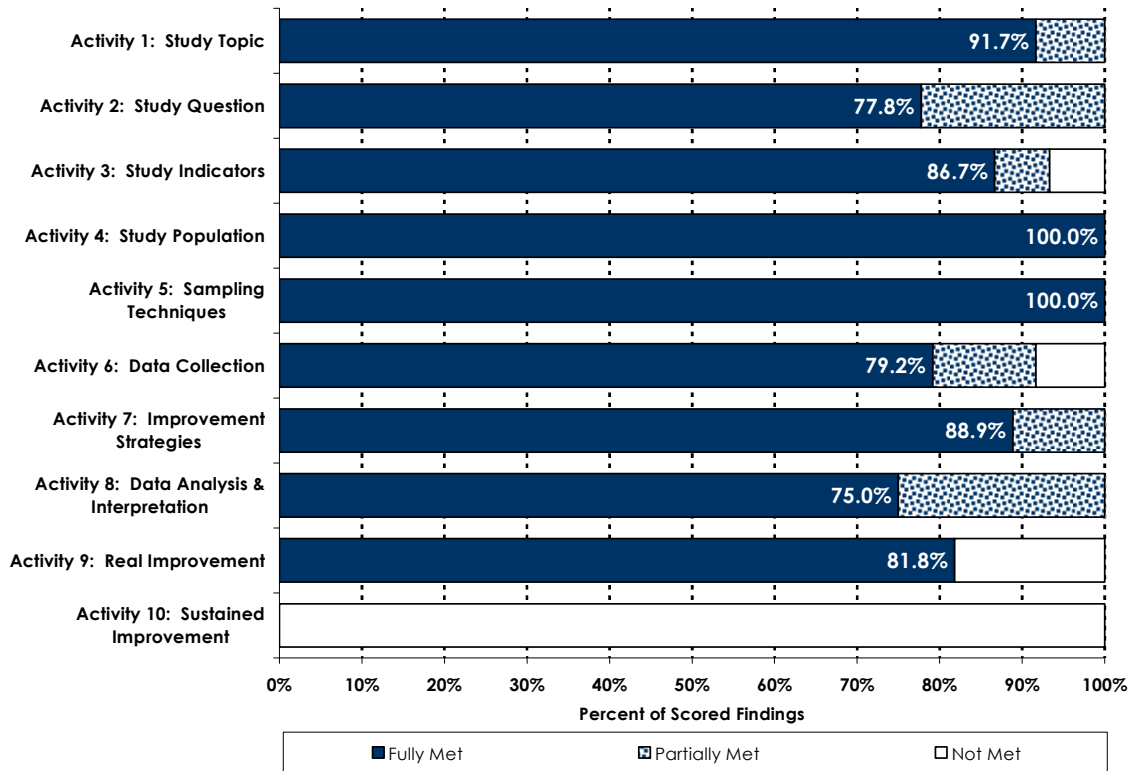


Validation of Performance Improvement Projects

Every eligible Family Care MCO was in compliance with its contract requirement to submit one PIP to DHS. In 2009 the MCOs worked on PIPs related to depression, diabetes, cognitive deficits, dementia, and falls prevention. MCOs that were eligible to be evaluated in the *Study Population* and *Sampling Techniques* categories (i.e., “activities”) met every standard in these categories. None of the projects were advanced enough to be evaluated in the *Sustained Improvement* activity. In the remaining six activities all Family Care MCOs experienced difficulty implementing at least one aspect of their projects.



Chart 2: 2009 Family Care MCOs' PIP Validation Findings by Activity

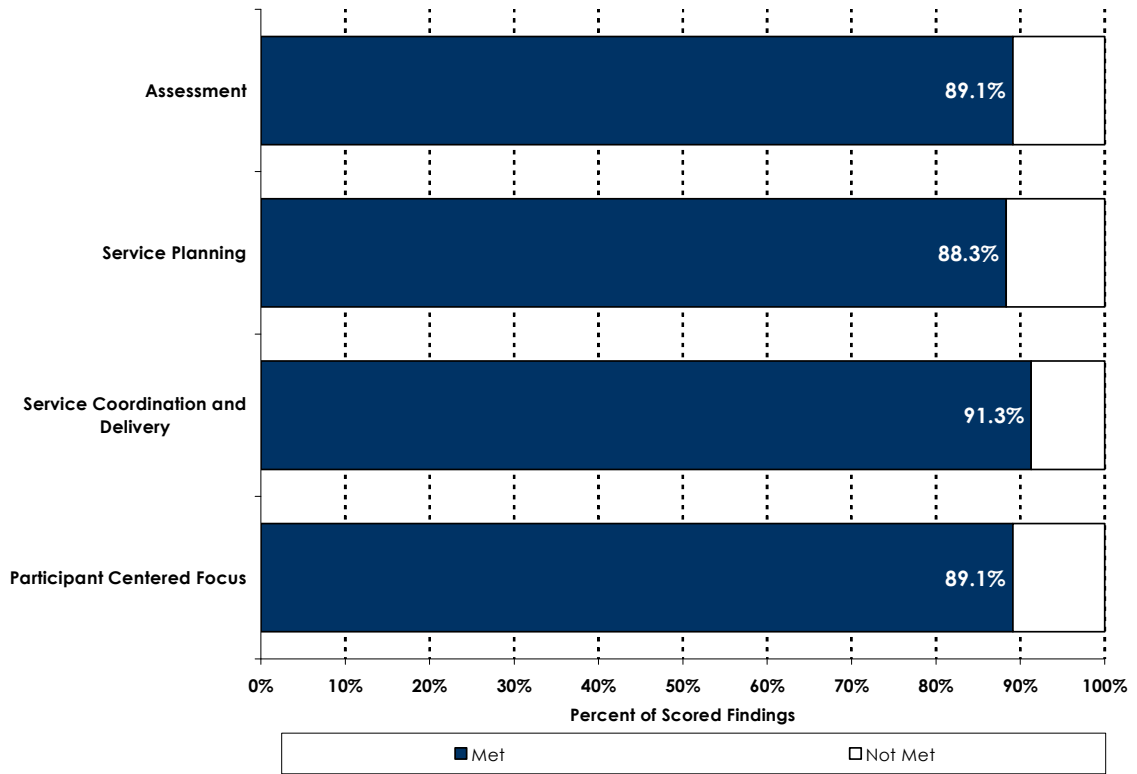


Care Management Review

MetaStar reviewers assessed the four categories of Family Care MCOs' care management processes, *Assessment*, *Service Planning*, *Service Coordination and Delivery*, and maintaining a *Participant-Centered Focus*, for the twelve months that preceded their 2009 EQRs to determine their compliance with their DHS contracts, their abilities to safeguard members' health and welfare, and the extent with which they work with members to identify the outcomes that members want and the resources they need to achieve them. In aggregate, the MCOs performed similarly on the four CMR categories.



Chart 3: 2009 Family Care MCOs' CMR Findings by Category



QUALITY COMPLIANCE REVIEWS

BACKGROUND & PURPOSE

The 2009 QCRs of the Wisconsin Family Care MCOs determined whether they delivered care and services to members eligible for Family Care in compliance with federal Medicaid Managed Care Regulations.

MetaStar conducted the QCRs in accordance with Federal Regulation 438, Subpart E, using the Centers for Medicare & Medicaid Services' (CMS'), *Monitoring Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans: A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et. al.*

The QCR process reviews, identifies and documents practices of each MCO that affect the quality and timeliness of the care and services its Family Care members receive, and their access to those services. Five topic areas make up the protocol:

- Enrollee Rights
- QAPI Access to Services
- QAPI Structure & Operations
- QAPI Measurement & improvement
- Grievance Systems

REVIEW METHODOLOGY

For the 2009 review MetaStar reviewed all five topic areas. MetaStar also evaluated the MCOs' annual workplans, tracking logs, any updated policies and procedures, and quality improvement (QI) projects related to the protocol topic areas.

MetaStar used each MCO's 2008 and 2009 Health and Community Services contracts with the DHS Division of Long Term Care and related program operation references found on the Family Care website:

<http://dhs.wisconsin.gov/lcicare/programops/index.htm>

Each MCO submitted all requested documents to MetaStar. The MetaStar EQR team assessed the documents before the on-site visits so it could tailor its questions to each MCO.

The MetaStar EQR team reviewed MCO documents prior to the on-site visit and interviewed each MCO's administrative and interdisciplinary team (i.e., "team") staff to determine compliance with the QCR standards. The MetaStar EQR team also interviewed members and providers to learn about their experiences working with the MCO. MetaStar used some of the information from these interviews to determine the MCOs' compliance with the standards in the five QCR categories.

Using selection criteria developed by MetaStar in cooperation with DHS the MetaStar EQR team asked to interview members from each MCO. The number of members and members' characteristics varied by MCO. MetaStar interviewed MCO service providers based on a list of all contracted providers in each MCO's provider network. MetaStar tailored the provider selection for each MCO.

Compiling & Analyzing Findings

MetaStar used a three-point rating structure (met, partially met, and not met) to assess each MCO's compliance level with the QCR protocol standards.

- **Met** applied when all policies, procedures, and practice aligned to meet the standard.
- **Partially met** applied when a MCO met the standard in practice but lacked written policies or procedures, had not finalized or implemented draft policies, or had written policies and procedures that were not implemented fully.
- **Not met** applied when the MCO did not meet the standard in practice and had not developed policies or procedures.

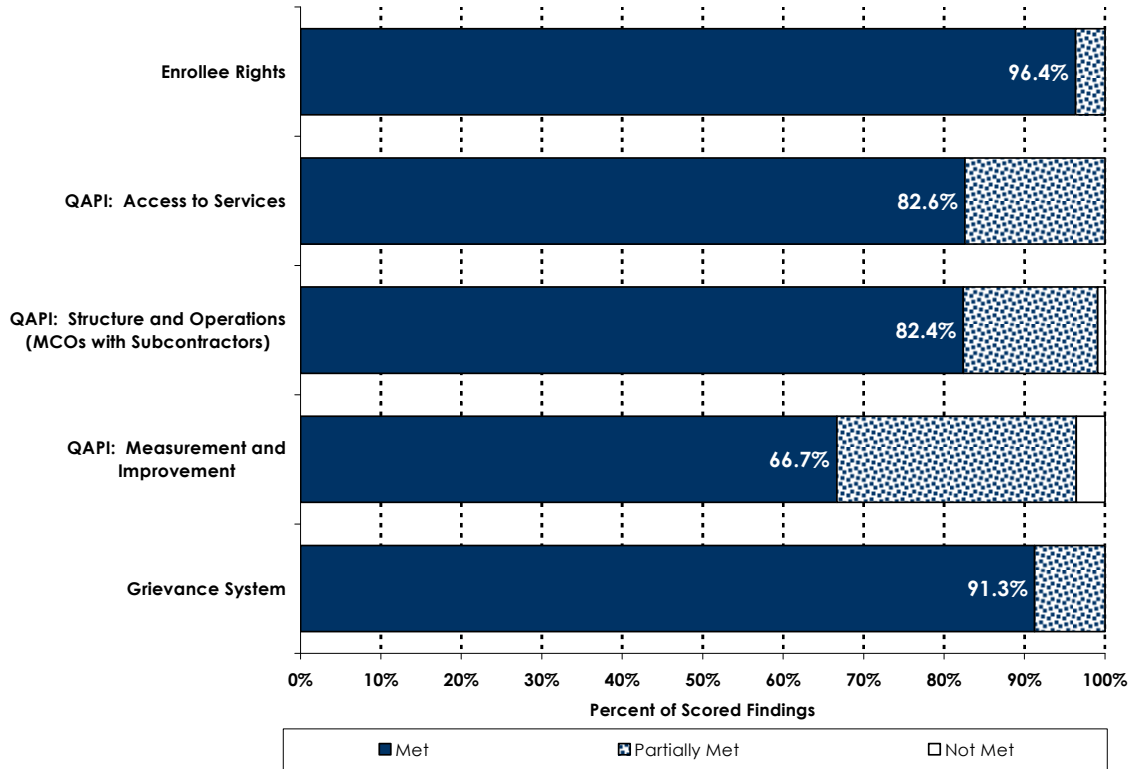
Reporting Evaluation Results to DHS

For each MCO the MetaStar EQR team compiled its findings into a preliminary written report that allowed the MCO to offer additional information. MetaStar received each MCO's comments and considered and incorporated them into a final report. Each individual MCO's final report detailed how well it complied with its contract and the QCR protocol standards during the review period. DHS requires each MCO to develop, submit to DHS within thirty days following the receipt of its final report, and implement an improvement plan or other follow-up action for any standard found to be partially met or not met.

OVERALL FINDINGS

On average the six Family Care MCOs fully met a majority of the QCR standards. In two areas they fully met the standards more than ninety percent of the time: *Enrollee Rights* and *Grievance Systems*. This is less compliant than last year when standards were fully met more than ninety percent of the time in three areas.

Chart 4: 2009 Family Care MCOs' QCR Findings by Category



The MCOs had the most difficulties implementing the *QAPI Measurement & Improvement* standards, fully meeting them 65 percent of the time and partially meeting them 31 percent of the time. The only not met QCR finding by any Family Care MCO was related to the *QAPI Measurement & Improvement* standards.

Table 3: 2009 Fully Met QCR Standards by Family Care MCO

MCO	Enrollee Rights	QAPI Access to Services	QAPI Structure & Operations (MCOs with subcontractors)	QAPI Structure & Operations (MCOs without subcontractors)	QAPI Measurement & Improvement	Grievance Systems	All QCR Standards
Community Care (CC-FC)	96.9%	82.6%	88.9%	n/a	78.6%	92.9%	89.9%
Community Care of Central Wisconsin (CCCW)	93.8%	82.6%	83.3%	n/a	71.4%	95.2%	88.4%
Creative Care Options (CCO)	100.0%	87.0%	88.9%	n/a	92.9%	97.6%	94.6%

MCO	Enrollee Rights	QAPI Access to Services	QAPI Structure & Operations (MCOs with subcontractors)	QAPI Structure & Operations (MCOs without subcontractors)	QAPI Measurement & Improvement	Grievance Systems	All QCR Standards
Milwaukee County Department of Aging Care Management Organization (MCDA)	93.8%	69.6%	77.8%	n/a	35.7%	81.0%	76.7%
Southwest Family Care Alliance (SFCA)	96.9%	78.3%	77.8%	n/a	28.6%	90.5%	81.4%
Western Wisconsin Cares (WWC)	96.9%	95.7%	77.8%	n/a	92.9%	90.5%	91.5%
All Family Care MCOs	96.4%	82.6%	82.4%	n/a	66.7%	91.3%	

Compliance rates by MCO varied within the five QCR review areas. CCO fully met all standards in the *Enrollee Rights* section and nearly 98 percent of the *Grievance Systems* standards. CC-FC, SFCA and WWC fully met 97 percent of the *Enrollee Rights* standards. WWC also met 96 percent of the *QAPI Access to Services* standards. CCCW fully met 95 percent of the *Grievance Systems* standards. Only WWC and CCO performed very well in the *QAPI Measurement & Improvement* category.

Appendix 3 enumerates each of the specific standards that applied in the QCR and the findings for each MCO.

A consistent theme throughout this year’s QCR for the Family Care MCOs was the impact of suspended or nonexistent internal file review programs. Two MCOs suspended their internal file review programs during SFY 08-09. One MCO suspended it because it was expanding into another Family Care service area. Another MCO suspended it because it was designing new internal file review tools to improve and streamline its internal file review process. At the time of its review, a third MCO did not have an established internal file review process.

WWC’s implementation of a new internal file review process helped the MCO to improve on many standards between the 2008 and 2009 reviews. WWC’s process now includes elements to determine whether teams assess and address member risks, and it tracks the timeframes for service authorization requests and decisions for both approvals and denials.

Problems related to incomplete or nonexistent internal file review processes impacted MCOs’ performance on *QAPI Access to Services*, *QAPI Structure & Operations*, *QAPI Measurement & Improvement* and *Grievance Systems* requirements and standards. Some MCOs have partially met requirements in each of these areas for two, three or four consecutive years.

One MCO has an active internal file review process, but it needs improving. It tracks service denials but not the timeliness of notifying members or providers that a team denied the service. It is a stand-alone process that does not compare the results of its process with other data sources, such as notice of action logs, to verify the issuance and timeliness of notices. It does not have an alternate method to determine if teams communicated service request approvals to members within fourteen days and does not evaluate whether teams apply practice guidelines consistently. The MCO should monitor the issuance of notices of action during internal file reviews to ensure that teams comply with issuing notices within the contract specified timeframes.

Another MCO has an insufficient internal file review process. It collects information on only a sample of members each month and does not review all member files each year. It should gather data to evaluate and monitor the quality and appropriateness of care management services.

Without internal file review two MCOs cannot verify when teams send out notices of action. These MCOs used to use internal file review to identify when notices were indicated but not sent. They do not monitor the implementation of practice guidelines because it used to be done through their internal file review processes. One MCO has no other mechanism to identify service under- or over-utilization. Both MCOs can use their future internal file review processes to assess the quality and appropriateness of care.

The MCO that did not have an internal file review process planned to monitor timeframes surrounding decision making timeframes through a process. However, because the process was not in place at the time of the review, MetaStar could not evaluate the MCO on related standards.

The report on each QCR section that follows this summary provides details about the opportunities each MCO has to improve during the next year and provides recommendations from the MetaStar EQR team to make improvements to become fully compliant with the federal QCR protocol.

ENROLLEE RIGHTS

Every MCO has a responsibility to help its members understand their rights so they can make decisions about the care and services they receive.

The *Enrollee Rights* category encompasses a wide variety of issues that MCOs must communicate clearly to its staff, contracted providers, and members. MCOs fully met the member rights standards 96 percent of the time on average. MetaStar scored none of the *Enrollee Rights* standards as “not met” during the 2009 EQR. CCO met every *Enrollee Rights* standard. Three MCOs met almost 97 percent of them (31 of 32 standards), and two MCOs met almost 94 percent of them (30 of 32 standards).

MCOs struggled most to meet the requirements to provide the names, locations, telephone numbers of, and non-English languages spoken by current contracted providers to all members. Some MCOs did not fully protect member privacy.

Appendix 3 enumerates each *Enrollee Rights* standard and finding by Family Care MCO.

Table 4: 2009 QCR Enrollee Rights Findings by Family Care MCOs

Of 39 standards, seven do not apply to Family Care MCOs. N = 32 standards

Family Care MCO	Met	Partially Met	Not Met
Community Care (CC-FC)	31	1	0
Community Care of Central Wisconsin (CCCW)	30	2	0
Creative Care Options (CCO)	32	0	0
Milwaukee County Department of Aging Care Management Organization (MCDA)	30	2	0
Southwest Family Care Alliance (SFCA)	31	1	0
Western Wisconsin Cares (WWC)	31	1	0
All Wisconsin Family Care Managed Care Organizations			
Average	30.8	1.2	0.0
Percent of Standards	96.4%	3.6%	0.0%

MCO Strengths

The MCOs demonstrated understanding of most *Enrollee Rights* standards and implemented processes to ensure they preserved members' rights.

All MCOs:

- Have written policies or procedures on member rights.
- Ensure their staff and contracted providers take members' rights into consideration when furnishing services to them and honor members' rights to be furnished health care services.
- Provide informational and instructional materials to potential and current members in a manner, format, and language members can understand.
- Make written Family Care information available in the prevalent, non-English languages in their service areas when necessary.
- Provide interpretation and translation services to their members free of charge.
- Make written materials available 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, and inform all members and potential members how to access materials in these formats.

- Notify members at least once a year that they can request and obtain information about their rights.
- Provide enrollment information to new members in a timely manner.
- Notify members at least thirty days before they implement a significant change in member rights.
- Give detailed information to members on their right to file an appeal or grievance, how and when to file, who is available to help members file, when and how hearings occur, and the different levels of hearings available to members (at the local level through the MCO, at the DHS level, or at the State fair hearing level).
- Give detailed information to providers on their right to file an appeal or grievance if a MCO does not cover a service already furnished.
- Have written policies and procedures about advance directives and inform members about them.
- Inform members that they can file any complaints they have about any provider not complying with their advance directives with the DHS survey and certification agency. In Wisconsin, this is the Division of Quality Assurance (DQA) at DHS.
- Provide detailed information so that all members understand the amount, duration and scope of benefits available once they enroll in a MCO. This information must include 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.
- Inform members how to obtain:
 - Services from providers outside of the MCOs' contracted provider networks.
 - Referrals for specialty care and other benefits not furnished by members' primary care providers.
 - Benefits that are available under the Wisconsin Medicaid program but are not part of the MCO's Family Care benefit package.
- Explain each member's responsibility to pay a cost share, an amount toward the cost of member's care based on each member's ability to pay.
- Have processes to assist members with limited decision making abilities to understand advance directives or give information on advance directives to members' families or surrogates.

- Document in members’ medical records whether they executed advance directives, educate staff on the MCO’s advance directive policies and procedures, and provide community education on advance directives directly or in partnership with contracted providers.
- Did not identify any providers who provided care that conflicts with members’ advance directives.
- Ensure they do not hold Family Care members liable for any covered services.
- Give members information on available treatment options and alternatives, presented in a manner appropriate to each member’s condition and ability to understand.

MCO Improvements from Previous Reviews

Compared to the previous year the MCOs improved upon their strengths and met more of the *Enrollee Rights* standards.

Table 5: 2008 – 2009 Enrollee Rights Findings for Family Care MCOs

	Met	Partially Met	Not Met
2008 Percent of Standards	95.3%	4.2%	0.5%
2009 Percent of Standards	96.4%	3.6%	0.0%
Change	+ 1.1%	- 0.6%	- 0.5%

Note: Improvement over time is evident when the percent of Met findings increases, the percent of Partially Met findings decreases, or the percent of Not Met findings decreases.

CC-FC

In 2008 CC-FC partially met the requirements to have written policies about member rights, advance directives and restrictive measures. By its 2009 review CC-FC obtained approval from DHS on its *Member Rights Policy and Procedure, Advance Directives Policy, and its Restrictive Measures Policy*. The MCO distributed these policies throughout the organization.

CC-FC & CCCW

During the 2008 review MetaStar reviewers found that CC-FC and CCCW partially met the requirement to inform members they can file a complaint with DHS DQA if they have concerns about non-compliance with their advance directives. During the 2009 review both MCOs met this requirement.

WWC

One MCO had one measure that was not met during the 2008 review, but it partially met it in 2009. During the 2008 CMR, MetaStar found evidence that an MCO staff member communicated a member’s protected health information (PHI) over e-mail. To address this issue the organization consulted with its privacy officer and amended its *Member Rights and*



Responsibilities policy that requires members to sign a release of information form to authorize communication through unencrypted e-mail. Although the MCO educated its teams on the amended policy in mid-2008, in its 2009 review MetaStar again found evidence that a team communicated PHI with several providers through e-mail without first securing a signed release of information form. In this situation, the team presented the form to the member, and the member signed it in February 2009; however, e-mail communication with providers began in August 2008.

MCO Opportunities for Improvement & EQRO Recommendations

MCOs did not uniformly meet the following *Enrollee Rights* standards during their 2009 EQRs. MetaStar provided recommendations to each MCO not in full compliance with the standards.

Non-English Languages Spoken by Providers

Three MCOs partially met the requirement to provide to all members the names, locations, telephone numbers of and non-English languages spoken by current contracted providers. One MCO received approval from DHS on its updated provider directory one month prior to its EQR visit but at the time of the visit had not provided copies to all members. The MCO stated that it did not intend to print the directory for dissemination until after expanding its service area. The MCO indicated that the directory is available upon request to members. Another MCO obtained information on the non-English language capacity of several providers but did not include this information in the recently printed provider network directory it distributed to members. Teams can access the directory on the MCO's internal electronic database or rely on prior knowledge when seeking out providers to meet members' cultural needs. The third MCO also updated its provider directory but at the time of the EQR visit had not shared it with members. In addition, the MCO did not list any non-English languages spoken by long-term care providers.

- **Recommendation:** When appropriate, these MCOs should query long-term care providers to determine their non-English language capability, update their provider directories to include the non-English languages spoken by providers, and distribute the amended provider directories to all members to ensure they have the most current information.

Protecting Members' Privacy

All members are guaranteed the right to be treated with respect and consideration for his or her dignity and privacy. Three MCOs partially met this requirement. In each case where MCOs partially met this standard communication by email was problematic. Two MCOs password protect emails that contain members' PHI or personally identifiable information (PII), but these emails should be encrypted. One of these MCOs does not have a policy by which all staff must abide that states the MCO's expectations on the use of email communication. The other MCO instructed its teams to inform members who prefer to communicate by email about associated privacy and security risks; however, this MCO also has not written these expectations into an organization-wide policy.

The third MCO amended its *Member Rights and Responsibilities Policy* to indicate that email is not an acceptable form of communication with providers. The MCO allows members to sign a release of information allowing unencrypted information exchange between providers and the MCO. However, during the 2008 CMR review, MetaStar's reviewers found teams communicated extensively with several providers without having filed a release of information. Further, the MCO completed several release forms the week prior to the CMR review, after the MCO received from MetaStar the sample of records to be reviewed.

- Recommendation: MCOs should develop and implement policies governing email communication and establish processes to monitor the use of email communication that contains information that identifies members. Email systems should be enhanced to encrypt email communication that contains PHI and PII to protect member information.

Policies Related to Restraint Use

Every member is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation. One MCO partially met this requirement. Although DHS approved this MCO's *Restrictive Measures Policy*, the MCO's teams did not recognize that specific devices or practices were restraints or restrictive measures. The MCO indicated it was in the process of securing training from DHS about restraints and restrictive measures.

- Recommendation: The MCO should develop a communication protocol between its Quality Management and Provider Contracts staff to ensure all departments focus their efforts in an effective manner. The MCO should monitor the use of its *Restrictive Measures Policy* to ensure teams accurately identify the use of restraints or restrictive measures to protect member rights.

Recommendation to DHS

DHS should provide training on restraints and restrictive measures to the MCO that requested it. This will help teams recognize the specific devices or practices that are restraints or restrictive measures.

QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT: ACCESS TO SERVICES

By contract each MCO must demonstrate that it can provide services to its members through the establishment of an adequate network of service providers. The contract with DHS requires each MCO to develop a provider network that is large enough, has a broad enough geographic distribution and a wide enough range of services to serve its members. Once the MCO establishes the provider network it is required to develop processes for authorizing service requests to ensure members have access to all services within the MCO's benefit package.

The MetaStar EQR team interviewed MCO administrative and team staff to determine compliance with the *QAPI Access to Services* standards and obtained feedback about each

standard. It also interviewed members and providers to learn about their experiences working with the MCO. The MetaStar EQR team used some of the information from these interviews to determine MCOs' compliance with the *QAPI Access to Services* standards.

All MCOs involve their members to develop care plans that meet members' personal outcomes and identified needs. MCOs ensure the providers with which they contract can provide necessary services. They have processes and systems in place to access specialized services, obtain second opinions, and seek providers outside their contracted networks when needed.

Most weaknesses related to MCOs implementing these standards were due to not fully communicating with members and providers details about the processes and timeframes necessary to authorize requested services. Some MCOs need to address internal issues related to the consistency with which they apply service authorization criteria. Most MCOs need to focus on improving the timeliness with which they provide notices of standard service authorization decisions following a request for service.

Combined, the six MCOs fully met fourteen of the 23 *QAPI Access to Services* standards. WWC fared the best in this category by meeting twenty standards and partially meeting one standard.

Five of the six MCOs partially met one standard related to the timely notification of standard service authorization decisions. This was a small improvement over last year's review when none of the MCOs met the standard. Only WWC provides notice of a standard service authorization decision within fourteen calendar days following the request for the service.

Appendix 3 enumerates each *QAPI Access to Services* standard and finding by Family Care MCO.

Table 6: 2009 QAPI Access to Services Findings by Family Care MCO

Of 28 standards, five do not apply to Family Care MCOs. N = 23 standards

MCO	Met	Partially Met	Not Met
Community Care (CC-FC)	19	4	0
Community Care of Central Wisconsin (CCCW)	19	4	0
Creative Care Options (CCO)	20	3	0
Milwaukee County Department of Aging Care Management Organization (MCDA)	16	7	0
Southwest Family Care Alliance (SFCA)	18	5	0
Western Wisconsin Cares (WWC)	22	1	0
All Wisconsin Family Care MCOs			
Average	19.0	4.0	0.0
Percent of Standards	82.6%	17.4%	0.0%

The MCOs demonstrated understanding of and were fully implementing most of the *QAPI Access to Services* standards. The average MCOs partially met four standards. None of the MCOs had *QAPI Access to Services* standards rated as not met in 2008.

MCO Strengths

All MCOs:

- Consider anticipated Medicaid enrollment and expected utilization of services.
- Consider the number and types of providers required to furnish the contracted services and the geographic locations of providers and members, considering the distance, travel time, means of transportation usually used by members, and whether the location provides physical access for members with disabilities. They also consider the number of network providers not accepting new MCO members.
- 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.
- Obtain in a timely manner and provide as long as necessary adequate out-of-network medical services covered by Family Care to members when the MCO provider network is not able to provide them.
- Work with out-of-network providers to ensure that the cost of services to members is no greater than they would have been if furnished within the provider networks.
- Ensure providers make medically necessary services available at all times to members who need them.
- Guarantee that a person or entity coordinates each member's primary health care services and guarantee the services are appropriate to meet the each member's needs.
- Provide services to all members because of their special health care needs.
- When authorizing initial and continuing services consult with providers requesting the services.
- Work with health care professionals with appropriate clinical expertise in treating members' conditions or diseases when deciding to deny a service authorization request or authorize a service in an amount, duration or scope that is less than what was requested.
- Expedite service authorization decisions within three days when following the standard fourteen-day timeframe could seriously jeopardize a member's life or health.

- Ensure that people who perform utilization management activities for the MCOs are paid so that they are not given incentives to deny, limit or discontinue medically necessary services for any member.

MCO Improvements from Previous Reviews

In 2009 the six MCOs together met slightly more *QAPI Access to Services* standards than in 2008.

Table 7: 2008 – 2009 QAPI Access to Services Findings for Family Care MCOs

	Met	Partially Met	Not Met
2008 Percent of Standards	80.3%	19.7%	0.0%
2009 Percent of Standards	82.6%	17.4%	0.0%
Change	+ 2.3%	-2.3%	--

Note: Improvement over time is evident when the percent of Met findings increases, the percent of Partially Met findings decreases, or the percent of Not Met findings decreases.

WWC

WWC showed the most improvement toward meeting the *QAPI Access to Services* standards. During the 2008 CMR, MetaStar reviewers found that the MCO’s teams did not always assess members for risks when indicated. WWC developed and implemented a risk assessment training in late 2008 that included risk scenarios to help teams identify risks, interventions to reduce risks, and processes for teams to follow if members refused or if the risk continued. In addition, its revised internal file review process includes elements to determine whether teams assess and address risks. Results from the MCO’s internal file review closely mirror the results from the 2009 CMR: the MCO assessed risk over 95 percent of the time and addressed it over ninety percent of the time. Risk assessment training is now part of an ongoing training and competency measurement for care management staff.

During the last year WWC also fully met the requirements that MCOs establish and follow written policies and procedures when processing requests for initial and continuing authorization of services and ensure the consistent application of review criteria when authorizing these services. WWC partially met these standards during the 2007 and 2008 reviews. The MCO’s service authorization policy states that the team makes all service authorization decisions involving the member and using the resource allocation decision (RAD) method. However, when MetaStar reviewed member files in 2007 and 2008 it found minimal reference to the RAD method when teams made service authorization decisions. Management requires teams to use the RAD method worksheets to document their decision making process on requests over \$500 for seven service categories (prevocational services, communication aids, home modifications, adaptive aids, durable medical equipment, residential services and services outside the benefit package). Through a retrospective RAD review process WWC supervisors evaluate teams’ understanding of the service authorization decision process to effectively monitor the consistency of decision making across teams. The MCO also changed its social and health assessment forms to prompt teams to document outcomes from the member’s perspective. Teams use the

assessments and the RAD worksheets as a foundation for the member centered plan (MCP) which the MCO also updated in 2008 to focus on member outcomes.

WWC provides notice of a standard service authorization decision within fourteen days following the request for the service. As noted in the previous section this was a problem for all of the MCOs. Only WWC implemented improvements in the last year to fully meet this requirement during the 2009 review. In 2008 WWC conducted a review of its internal monitoring reports from file reviews and results from the 2008 EQR and discovered that it needed additional areas for monitoring and a new standardized tool to complete file reviews. As a result the MCO revised its internal file review process to track timeframes for service authorization decisions for both approvals and denials. Internal monitoring results from third and fourth quarter of 2008 show that teams made 98 percent of service authorization decisions within the contract specified timeframes.

WWC & CCCW

After partially meeting the requirement in the 2008 review, WWC and CCCW fully met in the 2009 review the requirement to complete and approve members' ISPs and MCPs in a timely manner. WWC teams develop MCPs during a face-to-face visit with the member, identify personal outcomes and preferences, and obtain member input to accurately reflect the member's situation and interest. Through CCCW's electronic care management system supervisors can review reports on care plan timeliness. Supervisors conduct individualized training occurs with teams to re-educate staff on CCCW's expectations and improve results. Findings from MetaStar's CMR improved from 87 percent during the 2008 EQR to 93 percent during the 2009 EQR.

CC-FC

CC-FC improved between the 2008 and 2009 reviews from partially meeting to fully meeting the requirements to consider anticipated Medicaid enrollment and expected utilization of services and the number of network providers who do not accept new MCO members in establishing and maintaining its provider network. The Provider Network department began meeting with staff from the local Aging and Disability Resource Center to collaboratively identify gaps in the provider network related to needs of potential members who are on the waiting list. The provider network administrator works to fill the identified gap to ensure the network is adequate. CC-FC also updated its provider directory to indicate when primary care physicians do not accept new members and includes this information in its online provider directory. In addition, the MCO employs a residential coordinator to track the availability of residential providers and to act as a resource to teams when searching for residential placement options.

MCO Opportunities for Improvement & EQRO Recommendations

The MCOs did not uniformly meet the following *QAPI Access to Services* standards MCOs during their 2009 EQRs.

Written Agreements with Network Providers

For the second year in a row one MCO partially met the requirement to maintain and monitor a network of providers supported by written agreements. This MCO indicated that its providers signed new contracts in 2007. DHS requirements for contracts have not changed since 2007. This MCO uses “evergreen” contracts that renew automatically every year unless the MCO or the provider requests the contract be discontinued. In MetaStar’s review of forty provider files, it found seven contracts that providers signed within one week of the 2009 review, eight contracts signed prior to 2007, two out-of-network providers that did not use contracts, and one provider without a contract on file.

- **Recommendation:** This MCO should develop a process to verify that all contract files contain a copy of the most recent approved contract template signed by the provider and the MCO. The MCO should submit a plan to verify that all contracted providers have a current, signed contract per DHS requirements. This is the second year that MetaStar provided this recommendation to this MCO.

Timely Access to Care & Services

For the fourth consecutive year the same MCO partially met the standard requiring it to relay to providers Family Care expectations about members’ timely access to care and services. Beginning in 2007 the MCO’s provider contract templates included language directing providers to inform teams immediately if they cannot provide services as stated on the service authorization form within the specified timeframes. However, because providers do not sign new contracts every year, and MetaStar’s 2009 review of forty contract files found at least eight providers that had signed contracts older than the 2007 template, it is unclear how the MCO relayed expectations about timely access to care and services to those providers with contract templates that did not include the amended language.

- **Recommendation:** This MCO should provide direction to all providers, potentially through new contracts or information on the service authorization form, to contact the MCO team if they cannot provide services by the dates set forth on the service authorization. The MCO should identify the mechanism and timeframe to ensure all providers know the MCO’s expectations about timely service provision. This is the second year that MetaStar provided this recommendation to this MCO.

Coordinate Members’ Health Care Services

Two MCOs partially met the requirement to deliver primary care and coordinate health care services for all MCO members. During the 2009 CMR teams documented follow-up activities related to the effectiveness of services only 67 percent of the time at one MCO and 73 percent of the time at the other.

- **Recommendations:** Both MCOs should continue to monitor follow-up activities through an internal file review process to ensure teams provide appropriate

documentation. The MCO should collect data from its monitoring efforts and analyze the data to determine if it needs to develop an improvement plan.

Ongoing Monitoring by Appropriate Health Care Professionals

For the second year in a row an MCO partially met the requirement to assess its members' ongoing special conditions that require a course of treatment or regular care monitoring by appropriate health care professionals. During the 2009 CMR reviewers found teams did not always assess members for risks. When indicated, only eighty percent of members received necessary assessments. Of those members whom teams assessed for risk only 87 percent had the identified risk assessed by teams.

- Recommendation: The MCO should develop and implement a method to ensure its teams consistently assess members for risks regardless of whether the MCO uses an assessment worksheet or documents the assessment process in case notes. The MCO should document data from its monitoring efforts and develop a plan for improving its results.

Complete & Approve Members' Care & Service Plans in a Timely Manner

Half of the MCOs partially met the *QAPI Access to Services* standard requiring them to complete and approve in a timely manner their members' individual service plans (ISPs) and MCPs. The 2009 CMR at two MCOs found teams and members signed only 72 to eighty percent of MCPs within the past six months. At one of these MCOs only eighty percent of the MCPs were comprehensive. For the third MCO this is the second year with a partially met finding on this standard. Its 2009 CMR found that 73 percent of member records reviewed had care plans signed within the last six months compared to 57 percent during the 2008 CMR.

- Recommendations: MCOs should develop and implement a method to ensure teams review and the legal decision maker signs care plans within sixty days of the so ensure plans are comprehensive. MCOs should collect data from monitoring its efforts and analyze these data to determine if they need to develop an improvement plan. This is the second year MetaStar recommended this course of action for one of these MCOs.

Following Service Authorization Policies & Procedures

Two-thirds of the MCOs partially met the requirement to have in place and follow written policies and procedures when processing requests for initial and continuing authorization of services. One MCO does not have a process to evaluate the timeliness of service authorization requests, and another MCO had an updated policy that was not distributed it to staff at the time of its review. The other two MCOs distributed policies to their employees, but the 2009 CMRs showed that employees did not follow the policies because they did not understand them.

- Recommendations: Two MCOs need to implement a method to monitor the timeliness of service authorization request approvals to improve the rate at which teams make these decisions within contract timelines. Another MCO needs to distribute its approved *Service Authorization Policy* to staff and develop a process to monitor the consistent application of the policy across teams. The last MCO's *Service Authorization RAD Policy* is in place, but it should incorporate into its new internal file review process an element to evaluate the documentation of decision making processes.

Consistent Application of Review Criteria to Authorize Services

Half of the MCOs partially met the standard to have mechanisms in effect to ensure the consistent application of review criteria, the RAD, for authorization decisions when processing requests for initial and continuing authorization of services. One MCO suspended its monitoring of authorization activities while it develops a new internal file review process. DHS approved another MCO's policy, but the MCO did not distribute it because some teams did not understand it. The third MCO has a *Home Modifications Policy* packet that contains a question and answer document that identifies service exclusions that do not refer teams to complete the RAD process first.

- Recommendations: Until one MCO completes the redevelopment and implementation of a new internal file review process it should continue to actively monitor critical quality and timeliness authorization elements. At the second MCO consistency in decision making across teams lacks, in part, due to service authorization guidelines being construed as policy statements, not allowing teams to alter their authorization decision outside of the guidelines. This is the second year this MCO's teams expressed this sentiment. The MCO should distribute, implement and monitor its revised *Service Authorization Policy* along with a process to monitor the consistency of decision making across teams. It should analyze the monitoring results and, if warranted, develop an improvement plan. The third MCO should submit the *Home Modifications Policy* packet, including the question and answer document, to DHS for review and approval in accordance with DHS contract requirements. The MCO should ensure that the policy clearly indicates that the RAD method should be used to guide decision making and that the team retains decision making authority.

Recommendation to DHS

Once the MCO submits it, DHS should review the MCO's *Home Modifications Policy* packet, including the question and answer document, to ensure it meets DHS contract requirements.

Timely Notification of Service Denials or Limitations

Every MCO is required to notify the requesting provider and provide the affected member written notice of any decision to deny a request for service or to authorize a service in an amount,

duration or scope that is less than requested. For the second year in a row the same four MCOs partially met this standard. One MCO uses internal file review to identify if it sends notices of action in a timely manner. Its results indicated 83 percent adherence with the standard; however, the 2009 CMR found the MCO sent only 41 percent of notices within regulated timeframes. The CMR at another MCO found issuance of notices of action in a timely manner only 54 percent of the time. The notice of action logs at the two other MCOs only capture when a notice of action is sent. In the past both MCOs used internal file review to determine when notices were indicated but not sent. One MCO suspended its internal file review process when it expanded its service area, and another MCO suspended its internal file review process while creating different internal file review tools.

- **Recommendations:** MetaStar advised three MCOs to cross-check their notice of action logs with their internal file review results. One MCO was ready to do this. Two MCOs need to reinstate their internal file review processes to implement this recommendation. Another MCO should monitor the issuance of notices during internal file reviews to ensure that teams issue notices within the contract specified timeframes. The four MCOs should collect data from their monitoring efforts and perform data analysis to determine if they need to develop improvement plans.

Timely Notification of Standard Service Authorization Decisions

Only WWC fully met the standard to give members notice of standard service authorization decisions within fourteen days following the request for a service. This is a consistent problem for MCOs: the second consecutive year with a partially met finding for two MCOs, the third year for another two MCOs, and the fourth year for one MCO. The suspension of internal file review at the two MCOs limits their ability to track timeliness. Another MCO plans to monitor timeframes surrounding decision making timeliness through internal file review, but it had not yet implemented it at the time of the MCO's review. The fourth MCO uses internal file review but tracks only service denials, not timeliness. Finally, the MCO that has been out of compliance with the timeliness standard for four years does not have a means other than internal file review to determine if teams communicated service request approvals to members within the contractually required fourteen day timeframe required. During the 2008 CMR MetaStar reviewers found teams decided 88 percent of members' service requests in a timely manner. During the 2009 CMR compliance decreased to 85 percent.

- **Recommendations:** Despite the reasons given for not tracking the timeliness of all service authorization requests, all MCOs, if they have not already, should develop and implement processes to ensure teams make service authorization decisions and members receive notifications for both the approval or denial of service requests within the contractually stipulated fourteen-day timeframe. MCOs should monitor and collect data on their internal processes, analyze these data, identify when teams do not meet timeframes, and develop and implement improvement plans to ensure they uphold contract expectations.

QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT: STRUCTURE & OPERATIONS

By creating policies and procedures for key processes MCOs can improve how well staff performs those processes, several of which are tied to contract requirements.

Each of the six MCOs is expected to implement processes and procedures to meet thirteen *QAPI Structure & Operations* standards. In a change from last year's review, all of the Family Care MCOs employ subcontractors.

Full compliance with the *QAPI Structure & Operations* standards by the MCOs varied between 78 percent and 89 percent.

As noted for similar statutory requirements in the *QAPI Access to Services* section of this report, MCOs struggled most to provide notices of action to members in a timely manner. MCOs must send notices of action within fourteen days of the request for service requests that teams deny or limit, and within ten days of the action for services that teams terminate, suspend or previously authorized but reduced. None of the MCOs fully met this requirement.

Appendix 3 enumerates each *QAPI Structure & Operations* standard and finding by Family Care MCO.

Table 8: 2009 QAPI Structure & Operations Findings for Family Care MCOs with Subcontractors

Of 20 standards, two do not apply to Family Care MCOs with Subcontractors. N = 18 standards

MCO	Met	Partially Met	Not Met
Community Care (CC-FC)	16	2	0
Community Care of Central Wisconsin (CCCW)	15	3	0
Creative Care Options (CCO)	16	2	0
Milwaukee County Department of Aging Care Management Organization (MCDA)	14	4	0
Southwest Family Care Alliance (SFCA)	14	3	1
Western Wisconsin Cares (WWC)	14	4	0
All Wisconsin Family Care MCOs with Subcontractors			
Average	14.8	3.0	0.2
Percent of Standards	82.4%	16.7%	0.9%

MCO Strengths

The MCOs demonstrated understanding of the majority of the *QAPI Structure & Operations* standards and fully implemented most of them.

All MCOs:

- Implement written policies and procedures for the selection and retention of providers.
- Have provider selection policies and procedures that do not discriminate against particular practitioners that serve high risk populations or specialize in conditions that require costly treatment.
- Give written notification of their decisions when they decline to include individual or groups of providers in their provider networks.
- Specify to members the reasons for which MCOs may request that DHS disenroll a member and do not request members disenroll for reasons other than those permitted under the MCOs' contracts with DHS.
- Define and implement procedures related to member disenrollment requests to ensure transition plans are in place for members' services and supports.
- Allow members to disenroll when:
 - They move out of a MCO's service area.
 - Because of religious or moral objections, a MCO does not cover the services the member seeks.
 - They need related services performed at the same time, but not all related services are available within the MCO's provider network, and the member's primary care provider or another provider determines that receiving services separately would subject the member to unnecessary risk.
 - The MCO provides poor quality of care, lacks access to services covered under the MCO's contract with DHS, or lacks access to providers who are experienced in dealing with a member's health care needs.
- Approve requests for disenrollment under allowable circumstances, or refer members' disenrollment requests to DHS with information about the reasons cited in members' requests.
- Inform members who request disenrollment of their disenrollment dates.
- Oversee and are accountable for all functions and responsibilities they delegate to subcontractors.
- Evaluate prospective subcontractors' abilities to perform the activities to be delegated prior to the actual delegation of functions and responsibilities.

- Provide written agreements to their subcontractors which specify the activities and responsibilities designated to the subcontractors and reasons to revoke delegation or impose other sanctions if a subcontractor’s performance is inadequate.
- Along with their subcontractors, take corrective action when deficiencies or areas for improvement are identified.

MCO Improvements from Previous Reviews

The MCOs fully met slightly more of the *QAPI Structure & Operations* standards in 2009 than they did in 2008, but the proportion of not met standards also increased.

Table 9: 2008 – 2009 QAPI Structure & Operations Findings for Family Care MCOs with Subcontractors

	Met	Partially Met	Not Met
2008 Percent of Standards	81.5%	18.5%	0.0%
2009 Percent of Standards	82.4%	16.7%	0.9%
Change	+ 0.9	- 1.8	+ 0.9

Note: Improvement over time is evident when the percent of Met findings increases, the percent of Partially Met findings decreases, or the percent of Not Met findings decreases.

None of the MCOs administering the Family Care program worked without subcontractors at the time of the 2009 review.

CC-FC

CC-FC developed and implemented a process to credential long-term care providers and in 2008 verified the credentials of a randomly selected list of providers. It also improved its compliance with DHS requirements to ensure they do not contract with providers excluded from participation in federal health care programs. The MCO began to conduct monthly checks of websites to ensure providers maintain licensure and certification and are not excluded from participation in federal health programs. CC-FC reviewed the five residential providers using the stated process of verification and planned to continue this process and expand it to other providers in the benefit package.

MCO Opportunities for Improvement & EQRO Recommendations

Provider Credentialing & Criminal Background Checks

DHS requires MCOs to follow a documented process for the credentialing and recredentialing of contracted providers. Two MCOs partially met this requirement. Because one MCO has a credentialing policy and procedure in draft format, it partially met the standard. The other MCO partially met this requirement for three consecutive years. The MCO's contract service coordinators visit one-third of all providers annually to review requirements such as the completion of background checks on staff that come into direct contact with the MCO's members. Administrative staff reported that the contract service coordinators document “by

exception,” meaning they document the verification of background checks in the provider file only if it knows about issues or concerns.

- **Recommendations:** One MCO needs to submit and implement the final version of its *Provider Credentialing Process*, monitor it and determine if it needs to be amended. The other MCO should go into their subcontracted providers’ contract files to verify that criminal background checks occurred. The MCO should collect data from its monitoring efforts and perform data analysis to determine if it should develop an improvement plan.

Verification of Provider Education & Criminal Background Checks

Five MCOs partially met the *QAPI Structure & Operations* standard to comply with additional requirements established by DHS. The review of employee files at one MCO showed care manager files contained documentation of an educational degree, but as found during last year’s review one care manager has a degree unrelated to a human services field. Another MCO requires all providers to sign a form each year to attest they completed background checks on employees that come into direct contact with its members. However, at the time of the review, the MCO did not verify that providers complied with the contract requirements.

- **Recommendations:** MCOs not in compliance with these additional DHS requirements should develop and implement policies and procedures to ensure MCOs and their subcontractors complete criminal background checks at least every four years on all employees that come into direct contact with members. One of these MCOs partially met this standard for three consecutive years. One MCO should compile a list of all current care managers who do not possess a four-year bachelor’s degree in a human services field and ask DHS if it can waive the minimum qualifications. This MCO also needs to document that CMUs verify providers conduct criminal background checks. A second MCO does not have a process to verify that providers complete criminal background checks on employees that work with members. Another MCO has a process, requiring all providers to sign a form annually to attest they completed background checks on front-line staff, but the MCO does not verify that the providers comply with contract requirements. Another MCO should implement a process to verify that CMUs ensure their staff maintains current licensure and certification status, monitor the process, analyze data and determine if an improvement plan is warranted.

Recommendation to DHS

Because the review at one MCO found a care manager without a four-year bachelor’s degree in a human services field, DHS should discuss with the MCO whether it can waive the minimum qualifications.

Face-to-Face Care Management Visits

DHS requires MCOs to ensure that care managers have quarterly face-to-face contact with each member. One MCO collects this information through its internal file review process, but this is done on only a sample of members each month: it does not review all member files each year. This MCO was working to enhance its electronic care management system to identify the missed contact rate.

- **Recommendations:** MCOs should implement a method to collect and analyze data on quarterly care management face-to-face visits for all members to ensure compliance with contract requirements. The MCO should design a plan for improvement based on data analysis.

Provider Disclosure of Participation in Federal Health Care Programs

MCOs may not employ or contract with providers excluded from participation in federal health care programs such as Medicare or Medicaid. Only one MCO fully met this requirement. Two MCOs stated that they periodically check the DHS Medicaid websites to ensure providers are not excluded from participating in federal health care programs; however, MetaStar's reviewers found no verification of these checks in any of the provider files they examined at these MCOs. Additionally, one of these MCOs did not identify this step in its *Provider Credentialing Policy and Procedure*. Three other MCOs do not actively monitor providers to ensure they are not excluded or debarred from participation in federal health programs.

- **Recommendations:** MCOs should establish processes to verify that these exclusions have not occurred with any of their providers. They should include evidence of this verification in their provider contract files. For the second year in a row, MetaStar recommends that one MCO amend and submit its *Provider Credentialing* policies to include the process the MCO will use to verify that providers are indeed not excluded from participation in federal health care programs. Another MCO received this same recommendation for the first time.

Sending Notices of Action in a Timely Manner

None of the MCOs fully met the requirement to send notices of action in a timely manner. This *QAPI Structure & Operations* standard is similar to requirements about notices of action discussed in the *QAPI Access to Services* section of this report. MCOs must ensure they provide notices of action to members for service requests that teams deny or limit within fourteen days of the request, or the termination, suspension or reduction of previously authorized services within ten calendar days of the action. Please see the *Opportunities for Improvement* subsection in the *QAPI Access to Services* section of this report to see detailed explanations of why the MCOs did not fully meet this standard.

Recommendations: Please see the *QAPI Access to Services* section of this report for MetaStar's recommendations to help MCOs improve their timeliness with this obligation.

Ongoing Monitoring of Subcontractors' Performance

One MCO did not meet the requirement to monitor their subcontractors' performance on an ongoing basis. Upon expanding its service area, one MCO created care management (CMUs). During its 2009 review the MCO had not yet implemented a means to monitor contract expectations of the CMUs.

- Recommendations: The MCO should develop and implement a mechanism to monitor the performance of its CMUs for adherence to contract specifications.

Recommendation to DHS

DHS should work with this MCO to establish a periodic schedule to review the MCO's subcontractors.

QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT: MEASUREMENT & IMPROVEMENT

Under contract with DHS each MCO is required to have a comprehensive QAPI program that protects, maintains and improves the quality of care MCOs provide to their members. The QAPI program description, annual workplan, and annual program evaluation should include information about:

- Conducting PIPs
- Implementing processes to monitor and detect the under and over-utilization of services
- Implementing processes to monitor and assess the quality and appropriateness of care furnished to MCO members

The MCOs demonstrated noticeable difficulties with fully meeting the vast majority of the *QAPI Measurement & Improvement* standards. None of the MCOs fully met all of the *QAPI Measurement & Improvement* standards. Only two *QAPI Measurement & Improvement* standards were fully met by all six Family Care MCOs. Two MCOs had not met ratings, an increase from the 2008 EQR when only one MCO had a not met rating.

Although every MCO has a QAPI program, not every MCO implements all required program elements such as having an ongoing process for developing clinical practice guidelines.

Appendix 3 enumerates each *QAPI Measurement & Improvement* standard and finding by Family Care MCO.

Table 10: 2009 QAPI Measurement & Improvement Findings by Family Care MCO

N = 14 standards

MCO	Met	Partially Met	Not Met
Community Care (CC-FC)	11	3	0
Community Care of Central Wisconsin (CCCW)	10	3	1
Creative Care Options (CCO)	13	1	0
Milwaukee County Department of Aging Care Management Organization (MCDA)	5	9	0
Southwest Family Care Alliance (SFCA)	4	8	2
Western Wisconsin Cares (WWC)	13	1	0
All Wisconsin Family Care MCOs			
Average	9.3	4.2	0.5
Percent of Standards	66.7%	29.8%	3.6%

The MCOs worked on many different topics through their PIPs in 2009:

- Cognitive Decline
- Dementia (two MCOs)
- Fall Prevention
- Depression (two MCOs)

Most MCOs did not fully meet the *QAPI Measurement & Improvement* standards. Overall, they met only 67 percent of these standards. Two of the MCOs partially met eight or more of the fourteen standards.

MCO Strengths

Only one of the *QAPI Measurement & Improvement* standards was met by all MCOs during the 2009 EQR. MCOs periodically review and update their practice guidelines.

MCO Improvements from Previous Reviews

DHS waived standards related to PIPs for the Family Care program for the CC-FC for the 2008 review because the organization was in a start-up phase to expand the Family Care program into Racine and Kenosha counties in 2007. In the table below the 2008 aggregate findings do not include CC-FC data, but the 2009 aggregate findings do include the MCO's data.

Between 2008 and 2009, the number of fully met *QAPI Measurement & Improvement* standards improved little, from 64 to 67 percent fully met between 2008 and 2009. The decrease in partially met findings was somewhat offset by an increase in the not met findings.

Table 11: 2008 – 2009 QAPI Measurement & Improvement Findings for Family Care MCOs

	Met	Partially Met	Not Met
2008 Percent of Standards	63.9%	34.9%	1.2%
2009 Percent of Standards	66.7%	29.8%	3.6%
Change	+ 2.8%	- 5.1%	+ 2.4%

Note: Improvement over time is evident when the percent of Met findings increases, the percent of Partially Met findings decreases, or the percent Not Met findings decreases.

Three MCOs demonstrated some improvements over the past year.

WWC

In 2008 WWC partially met the standards requiring practice guidelines to be based on valid and reliable clinical evidence, consider the needs of the MCO's enrollees, be developed in consultation with health care professionals, and be distributed to all affected providers. WWC fully met these four requirements in the 2009 EQR. WWC incorporated into its prevention and wellness plan processes for practice guideline development and review and methods for dissemination of the guidelines to members and providers.

Because it did not have a process to monitor the implementation of practice guidelines during the 2008 review, WWC did not meet the standard that requires decisions for utilization management, enrollee education, coverage of services and other areas about which the guidelines apply to be consistent with the guidelines. During the 2009 review, WWC fully met the requirement. The MCO's *Prevention and Wellness* plan identifies and includes the process for practice guideline documentation and tracking. The MCO established a policy to review all guidelines every two years, and it tracks the implementation of the guidelines through its internal file review process.

MCOs must conduct performance improvement projects that achieve significant sustainable improvement in clinical care and non-clinical care areas that they expect to have a favorable effect on health outcomes and member satisfaction. MCOs must report the status and results of each PIP to DHS and complete each project in a reasonable time period. WWC improved from 2008 to 2009 on these standards, partially meeting them in 2008 and fully meeting them in 2009.

WWC's *Climbing out of Depression* PIP it began in 2008 progressed through its earlier design and implementation challenges and was very close to meeting the project's aims when it concluded in January 2009. WWC implemented the recommendations from MetaStar's 2008 PIP Validation Report and met all relevant criteria. Continuing through 2009 WWC planned to implement and monitor the depression guidelines and the Zung Assessment tool to ensure it sustains its improvements.

SFCA

SFCA improved between the 2008 and 2009 EQRs by fully meeting the requirements to consider the needs of its enrollees. The MCO developed its own depression guideline that considered the needs of its members. It also reviewed and periodically updated its practice guidelines. SFCA

issued its *Diabetic Practice Guideline* in March 2007 and revised it in March 2008. The MCO's policy is to review guidelines every two years for updates or changes.

MCO Opportunities for Improvement & EQRO Recommendations

Practice Guidelines Based on Clinical Evidence to Meet Members' Needs

Practice guidelines need to be based on valid and reliable clinical evidence and developed in consultation with health care professionals. Five of the six MCOs fully met both requirements. Although the MCO that partially met this standard has a diabetes management practice guideline in place, when developing other practice guidelines the MCO did not seek sufficient input from practitioners in related fields. It also did not consider tools validated by other health care professionals. This MCO partially met both of these standards for the second year in a row.

- **Recommendation:** The MCO should conduct additional research to identify a validated and evidence-based depression screening tool or guideline before fully implementing the screening tool or guideline.

Update Practice Guidelines

MCOs must periodically review and update their practice guidelines. Although an MCO developed some practice guidelines, it did not have a structured process to develop or periodically review and update guidelines. This MCO partially met this standard for two years.

- **Recommendation:** The MCO needs to develop and implement a structured process to assure the ongoing development and review of practice guidelines. Because this MCO administers other Medicaid managed care programs it can modify or build on the existing practice for its other programs or it can develop a distinct method based on the needs of its Family Care population.

Distribute Practice Guidelines to All Affected Providers & Members

MCOs must distribute practice guidelines to all affected providers. Care managers at one MCO only deliver practice guidelines to members if they are part of a PIP or pay-for-performance initiative. It did not share any practice guidelines with providers. Another MCO distributed its diabetes practice guideline to some providers during its April 2008 provider fair. However, this MCO did not follow through with the intentions it communicated in 2008 to conduct a second provider fair, and it did not post the guideline on its website for all providers. Aside from the diabetes guideline this MCO did not distribute any other practice guidelines.

- **Recommendations:** Both MCOs should develop a plan to revise and distribute all available practice guidelines to providers and, upon request, to members.

Consistency between Practice Guidelines & Related Decisions

Three MCOs partially met the standard that decisions for utilization management, member education, coverage of services, and other areas about which practice guidelines apply reflect the guidelines. One MCO's internal file review process does not evaluate whether teams apply practice guidelines consistently. In addition, it appears that the best practices of requesting and obtaining lab values of members with diabetes, which the MCO developed during an earlier pay-for-performance initiative, no longer occur. As a result, the MCO does not have a process to determine whether the use of practice guidelines is effective. As described in the *QAPI Access to Services* section of this report, an MCO's suspension of its internal file review process means it no longer monitors the implementation of practice guidelines. At the time of its 2009 review another MCO did not have a process in place to review guideline implementation. However, it planned to incorporate a practice guideline review into its member record review process. This MCO partially met this measure for two years in a row.

- **Recommendations:** One MCO should develop and implement a process to ensure MCO staff implements practice guidelines consistently. It also should find a way to ensure it consistently incorporates practice guidelines into utilization management, member education, coverage of services and other areas about which the guidelines apply. Another MCO should evaluate how its teams use practice guidelines such as through the internal file review process. The MCO should encourage teams to continue to engage in best practices based on former PIPs and pay-for-performance initiatives. The MCO should incorporate these steps into its quality workplan to evaluate the guidelines' effectiveness. The third MCO should continue its plans to develop and implement QAPI-related committees, involve members in quality initiatives, and use internally generated data to identify quality improvement activities. MetaStar strongly encourages this MCO to develop a more robust information system capable of generating reports to assure quality and monitor service utilization.

Ongoing QAPI Programs

DHS requires MCOs to have ongoing QAPI programs for the services they furnish to members. Two MCOs partially met this standard. One MCO's quality workplan was in draft status because it is working to expand its Family Care service area. The workplan was pending further development and improvement by the MCO's governing board. It did not identify areas about monitor to ensure member health and safety. It also did not assess compliance with quality and contract standards. For the third consecutive year MetaStar reviewers found the third MCO did not update its QAPI program description to reflect current information. Although it submitted a QAPI program description and workplan during its 2009 review it had not yet developed some areas in the program description: quality management committee, ensuring member involvement in quality activities and using utilization or quality monitoring data to identify improvement activities. In addition, this MCO's information system has limited capabilities to generate reports to support quality monitoring efforts.

- Recommendations: One MCO needs to develop a process to assure that teams implement guidelines as expected and in a manner consistent with the guidelines. This process should include a way to track and analyze results. The MCO should submit a copy of the guideline review to DHS once it develops it. Another MCO should finalize its 2009 quality workplan, secure approval of the plan from its governing board, and implement it. The MCO should update the plan to include focus areas with goals, objectives, and implementation timelines.

Recommendation to DHS

After the first MCO develops a process to assure that teams implement guidelines consistently, tracks and analyzes the results of this implementation, DHS will need to assess the results of the MCO's guideline review.

Conducting PIPs that Demonstrate Improvement over Time

Two MCOs partially met the requirement to conduct PIPs that focus on clinical or non-clinical areas. Although one MCO conducted a PIP that focused on improving member outcomes and includes necessary interventions, the PIP did not include ongoing measurements to identify significant improvement. The other MCO's PIP occurred for three years and not shown significant improvement. Staff changes and care management system data retrieval constraints delayed the project. This is primarily because like the first MCO, the PIP does not include ongoing measurements to identify significant improvement. As a result this MCO partially met this standard for the last three years.

- Recommendations: The first MCO should develop clearly stated PIP objectives and indicators for periodic measurement, analysis, and improvement identification over time. The other MCO should give detailed descriptions of how it plans to further measure and analyze each of its interventions to determine which one offers the most promising results. MetaStar advised the MCO to continue its acceleration toward the project's full implementation phase.

Ongoing PIPs

MCOs' PIPs must be ongoing, measure performance using objective quality indicators, implement systemic interventions to achieve improvement on quality, evaluate the effectiveness of the interventions, and plan and initiate activities to increase or sustain improvement. One MCO partially met and one MCO did not meet this requirement. The first MCO partially met this standard for three years. This year, it partially met the standard because the MCO conducted a PIP that focused on improving member outcomes and included necessary interventions, but the PIP documentation did not include ongoing measurements to identify significant improvement. The other MCO did not meet this standard because its PIP did not contain measurable indicators and did not include plan-do-study-act (PDSA) cycles to increase improvement.

- Recommendations: The MCO that partially met this requirement should provide detailed information about its measurement of intervention progress and analysis of measurement results to identify which intervention has the best chance of succeeding. The MCO that did not meet this requirement omitted measurable indicators and PDSA cycles from its project. This MCO should design indicators that contain clearly stated objectives and implement periodic PDSA cycles to increase the likelihood of meeting objectives and increasing overall improvement.

Reporting PIP Status & Results

DHS requires MCOs to report the status and results of each PIP to DHS and complete each project in a reasonable time period. Two MCOs partially met this requirement. Although one MCO's project was in place for three years, it did not collect initial data until 2009 and had not obtained repeat measurements at the time of this review. The timeframe to measure improvements for another MCO's PIP was long and did not provide sufficient information to document improvement in members' outcomes.

- Recommendations: The MCO with the project in place for three years should identify the reassessment, data collection processes, and remeasurement period timeframe. The other MCO should develop PIP measurements and collect data on them more frequently than annually to determine the PIP's progress. Ongoing monitoring will allow the MCO to identify needed changes to the PIP and further improvements.

Service Under- and Over-Utilization

MCOs must have mechanisms to detect both the under- and over-utilization of services. Only one MCO fully met this requirement. One MCO's review committee identified priorities for review activities, but it does not trend throughout the organization for under- and over-utilization of services. Another MCO's supervisors and teams monitor member service utilization on an individual member basis, but it, too, does not have a process to ensure appropriate utilization and monitor utilization trends on an organization-wide basis. This MCO partially met this standard for four consecutive years. The third MCO reviews utilization data at monthly QI meetings for each operating site, but the MCO does not have a standard process to determine and report on under- and over-utilization of services. Another MCO delegates utilization management to a best practice team (BPT) that reports its findings to the MCO's management staff. Since the BPT contractor changed in 2009, the MCO received utilization management data only through the third quarter of 2008. This MCO partially met this standard for three consecutive years.

The last MCO partially met this requirement during the 2006, 2007 and 2008 EQRs, and in its 2009 EQR MetaStar rated it as "not met" because it did not move forward with efforts it initiated in 2007 to develop an ongoing utilization management process. While this MCO monitored some service area trends based on feedback from its care management teams, its approach is insufficient to accurately identify the under- and over-utilization of services. This MCO intended to use a member record system to support future utilization management work.

- Recommendations: Five MCOs need to improve their utilization management processes. Four of these MCOs need to develop or incorporate processes to identify trends of service under- or over-utilization. One of these MCOs needs to focus on the accuracy of its utilization data. The MCO that received a “not met” score because it fully halted its internal file review process, the sole mechanism to identify service under- and over-utilization. It is imperative for this MCO implement a utilization management program.

Assessing the Quality & Appropriateness of Care

All MCOs also must have mechanisms to assess the quality and appropriateness of care provided to their members. Only two MCOs fully met this requirement. One MCO used an internal file review through the third quarter of 2008. It determined it needed to improve and streamline the process and suspended the internal file review process. During its 2009 EQR the MCO's new process was not in place. Another MCO maintains some processes to ensure member care quality and appropriateness, but during its 2009 review it did not have structured review process to ensure the quality and comprehensiveness of member assessments. This MCO partially met this requirement for two years. The MCO that suspended its internal file review because of Family Care expansion into neighboring counties collected information on critical incidents and relied on its quality alert system, but these strategies provided limited information to effectively assess the quality and appropriateness of care for all members. The last MCO has an internal file process its CMUs and BPT conduct. Because its BPT contractor changed, the MCO suspended feedback to CMUs for an interim period. The MCO intends to fully resume its internal file review protocol before the 2010 EQR.

- Recommendations: One MCO should continue with its plans to include in its internal file review a process to provide data to evaluate and monitor quality and appropriateness of care management services. Once it finalizes the review tools the MCO should develop a method to ensure the implementation of the review process is reliable and consistent. The MCO should forward to MetaStar the final copy of the review process, tools, guidelines, and initial internal file review results. Another MCO must also focus on its internal file review system. The new system, once implemented, should adequately assess quality and appropriateness of care. After implementation, the MCO must share this information within the MCO as part of its overall quality activities. After deciding that it needed to streamline its internal file review process, the third MCO should revise its current process and implement a new one. This MCO should also develop and submit a plan for its internal file review to MetaStar. The last MCO should fully implement its plan to resume all steps of its internal file review process so its CMU staff understands the review protocol and the review results.

Evaluating QAPI Program Effectiveness

One MCO partially met and one MCO did not meet the requirement to submit a review of its QAPI program impact and effectiveness to DHS. These evaluations should include the MCOs' performance on standard measures DHS requires them to report and the results of their PIPs.

They should also demonstrate that they have processes in effect to evaluate their QAPI programs. The MCO that partially met the standard updated the workplan status column of its 2008 quality workplan but included limited analysis about the effectiveness of its QAPI program. The MCO with the “not met” rating did not submit a QAPI program evaluation for the 2009. The MCO stated it was “not possible to evaluate [the QAPI program] as new processes were being developed throughout the agency.”

- **Recommendations:** Both MCOs should develop a process for program evaluation using data and information from its quality monitoring efforts such as quality indicators, internal file review results, quality alerts, critical incidents and provider complaints. The MCOs should evaluate the effectiveness of their processes and reporting systems. The MCO that did not submit its QAPI evaluation should submit its 2009 QAPI program evaluation, including an analysis of findings, an evaluation of the effectiveness of the program, its conclusions and discussion of next steps.

Recommendation to DHS

Once submitted, DHS will need to review the QAPI program evaluations from two MCOs to ensure they include the MCOs’ performance on standard measures DHS requires them to report and the results of their PIPs. The MCOs should also demonstrate that they have processes in effect to evaluate their QAPI programs.

GRIEVANCE SYSTEMS

When members are not satisfied with the services provided through the MCO or with decisions their team makes they have the right to appeal or grieve at three different levels: to the MCO, to DHS, or to the Division of Hearings and Appeals (i.e., “State fair hearing”).

Each MCO is required to have a local appeal and grievance process that provides access to the DHS appeal and grievance process and a State fair hearing process. Information on these processes must be included in the MCOs’ member handbooks so members know how to exercise their appeal and grievance rights. The information must also appear on the written notice of action letter that MCOs give to members when teams discontinue, reduce, limit or deny and item or service.

With their other quality review activities MCOs review data it collects related to member appeals and grievances to measure the quality of the services they provide. The occurrence of several similar appeals and grievances may indicate a trend that warrants further investigation.

Appendix 3 enumerates each *Grievance Systems* standard and finding by Family Care MCO.

Table 12: 2009 Grievance Systems Findings by Family Care MCO

N = 42 standards

MCO	Met	Partially Met	Not Met
Community Care (CC-FC)	39	3	0
Community Care of Central Wisconsin (CCCW)	40	2	0
Creative Care Options (CCO)	41	1	0
Milwaukee County Department of Aging Care Management Organization (MCDA)	34	8	0
Southwest Family Care Alliance (SFCA)	38	4	0
Western Wisconsin Cares (WWC)	38	4	0
All Wisconsin Family Care MCOs			
Average	38.3	3.7	0.0
Percent of Standards	91.3%	8.7%	0.0%

All MCOs have systems in place for members and providers to appeal and grieve teams' service decisions. They notify members of their appeal and grievance rights by mailing out notices of action under appropriate circumstances, but all MCOs struggle to meet statutorily defined timeframes and deadlines to mail them out. Often MCOs do not know whether they provide this information to members in a timely manner. For three MCOs this lack of knowledge is because they suspended or do not use internal file review processes to validate timeliness data entered in their notice of action logs.

MCO Strengths

The MCOs demonstrated understanding of most *Grievance Systems* standards and implemented processes to ensure members' rights to appeal and grieve were met. Five of the six MCOs fully met over ninety percent of the *Grievance Systems* standards. CCO fully met the 41 of the 42 standards.

All MCOs:

- Have grievance process and a standardized appeal process with access to the State's fair hearing system.
- Maintain records of grievances and appeals and review the information as part of their QAPI programs.
- Acknowledge the receipt of each appeal and grievance, and provide written notice of the status of each appeal and grievance.

- Have processes to reinstate services to members whose services were previously discontinued because their whereabouts were unknown.
- Inform members that they:
 - May file a grievance and an appeal with the MCO, DHS, or may request a State fair hearing.
 - Have the right to appeal any adverse service decisions such as the reduction, denial, suspension or termination of services within 45 days of the effective date of a written notice of action.
 - May file a grievance either orally or in writing.
 - May file an appeal either orally or in writing. Unless members request an expedited resolution members must follow oral filings with a written, signed appeal, and MCOs must confirm in writing the receipt of the member's oral appeal.
 - Can get assistance from the MCO to complete forms and take other procedural steps to resolve the appeal or grievance.
 - Can include people of their own choosing in the appeal, grievance, and State fair hearing processes.
 - Have the right to present evidence and examine their case file and other relevant documents before and during the appeal process.
 - Can request to continue to receive previously authorized benefits while a hearing is pending, but may be responsible for the cost of those benefits if the hearing decision upholds the MCO's action to reduce, deny, suspend or terminate services.
- Inform all providers and subcontractors when they enter into a contract with the MCO:
 - About their right to file grievances and appeals.
 - About the requirements and timeframes for filing a appeal or grievance.
 - About the availability of assistance in the filing process.
 - The toll-free telephone numbers that members can use to file a appeal or grievance by telephone.

- That they may file an appeal on behalf of a member if they have the member's written consent.
- That they may file grievances or request State fair hearings for the members they serve.
- That they cannot be punished by the MCO for requesting an expedited resolution or supporting a member's appeal.
- Send members notices of action which explain:
 - The action the MCO intends to take (reducing, denying, suspending or terminating services).
 - The reasons for the action.
 - The affected member's right to file an appeal with the MCO.
 - The member's right to request a State fair hearing.
 - The procedures for exercising members' rights.
 - The circumstances under which expedited resolution is available and how to request it.
 - The member's right to have benefits continue pending resolution of an appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay for the service costs.
- Extend the original three-day timeframe to make expedited service authorization decisions if the member requests it or the MCO can justify that it needs additional information to make the decision and how the extension is in the member's interest.
- Mail notices of action at least ten days before the date of the action except when the MCO establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction or State.
- Mail notices of action denying payment to providers whenever action is taken that affects a claim.
- Ensure that the people who make and grievance decisions appeals were not involved in any previous level of review or decision making on the appeal or grievance.
- If the MCO denies a member's request for an expedited appeal resolution transfer the appeal to the standard resolution timeframe and provide prompt notice to the member that this has occurred

- Continue members’ benefits, if requested, during the appeal, grievance and State fair hearing processes under statutorily defined circumstances.
- May recover the cost of services furnished to members who received services while their appeal or State fair hearing processes were pending but the final resolution of the appeal was adverse to the members.
- Reinstate services when the State fair hearing decision reverses a MCO’s decision to reduce, deny, suspending or terminate services.

MCO Improvements from Previous Reviews

The MCOs fully met more of the *Grievance Systems* standards in 2009 than they did in 2008. The percentage of partially met standards declined in the same time period.

Table 13: 2008 – 2009 Grievance Systems Findings for Family Care MCOs

	Met	Partially Met	Not Met
2008 Percent of Standards	94.2%	5.8%	0.0%
2009 Percent of Standards	91.3%	8.7%	0.0%
Change	- 2.9%	+ 2.9%	--

Note: Improvement over time is evident when the percent of Met findings increases, the percent of Partially Met findings decreases, or the percent of Not Met findings decreases.

MCOs’ improvements since the 2008 EQR were related to adhering to the statutorily defined timeframes of the appeal and grievance process.

WWC

WWC implemented an internal file review process to monitor timeframes related to service authorization requests. Through this process the MCO determined that teams decided 98 percent of member requests within the contract specified timeframe of fourteen calendar days or 28 calendar days if an extension was requested and granted.

CC-FC

CC-FC improved by providing a member with a notice when the MCO was not able to make a service authorization decision if it extended the original fourteen day decision making timeframe by an additional fourteen days.

MCO Opportunities for Improvement & EQRO Recommendations

As noted in the previous QCR sections, many weaknesses across the MCOs relate to difficulties adhering to statutorily defined timeframes to notify members about service decisions. In addition, MCOs do not consistently members consistently about their appeal rights.

Adhering to Notice of Action Timeframes

MCOs must mail notices of action at least ten days before the effective date of the action to terminate, suspend or reduce a previously authorized service except under certain circumstances defined by statute. Three MCOs partially met this requirement. One MCO that partially met these requirements in the 2007 and 2008 reviews continued to partially meet them in the 2009 review.

For standard service requests that teams deny or limit, MCOs must mail notices of action within fourteen days following the receipt of a service request, with a possible extension of up to fourteen additional calendar days. None of the MCOs met this standard. Three MCOs partially met this standard for two years, one MCO partially met it for three years, and one MCO partially met it for four years.

Three MCOs partially met the requirement that states if the MCO extends the timeframe for service authorization decision making, it must give the member a written notice of the reason along with information about the member's appeal and grievance rights. One MCO partially met this standard for two years.

Four MCOs partially met the requirement that states if a MCO cannot make a service authorization decision within fourteen days it must send the member a notice of action to indicate that the MCO is extending its deadline by another fourteen days. One MCO partially met this standard for two years and another MCO partially met it for three years.

- **Recommendations:** Despite the reasons for not adhering to notice of action timeframes, all MCOs, if they have not already, should:
 - Monitor the issuance of notices of action during internal file reviews to ensure teams comply with issuing notices within the contract specified timeframes: at least ten days in advance of a team's decisions to reduce, terminate or suspend previously authorized services; within fourteen days of the member's request for services when teams deny a service request; when requesting an extension to the fourteen day timeframe for decision making; and if teams cannot make service authorization decisions when a fourteen-day extension expires.
 - Send a member a notice of action when it cannot make a service authorization decision within fourteen days. The notice should indicate that the MCO is extending its deadline by another fourteen days.
 - Cross-check their internal file review results and their notice of action logs to ensure that teams issued notices of action when warranted in a timely manner. Three MCOs will need to institute or reinstitute internal file review processes to achieve this recommendation.

MCOs should collect data to monitor the situation, analyze the data, and develop an improvement plan based on the analysis.

Grievances Addressed by Professionals with Appropriate Clinical Expertise

DHS requires MCOs to have health care professionals with appropriate clinical expertise in treating the member's condition or disease determine the outcome of appeals and grievances related to clinical issues. One MCO partially met this standard during its 2009 review.

- **Recommendation:** The MCO should identify and recruit at least one health care professional or clinician to serve on its appeal and grievance committee as an ad hoc member when appeals and grievances focus on denials related to a member's medical condition or clinical issues. This health care professional or clinician must be included on the panel of those involved in making the decision about the appeal or grievance.

Determining Grievances & Appeals in Accordance with Statutory Timeframes

DHS requires MCOs to dispose of each grievance, resolve each appeal, and provide notice as expeditiously as the member's health condition requires and within statutorily defined timeframes. They must make decisions about grievances and notify members of these decisions within twenty days from the day the MCO receives the grievance. They also must resolve appeals and notify members of these decisions within twenty days from the day the MCO received the appeal. One MCO partially met these standards for three consecutive years. It also partially met the requirement that allows standard appeal and grievance timeframes and expedited appeal timeframes to be extended by up to fourteen days if the member requests an extension or the MCO identifies there is a need for additional information. The MCO must provide written notice to the member if the member did not request it.

- **Recommendation:** This MCO should identify the reasons for delayed decision making within the appeals and grievance log about resolving appeals in each instance a delay was requested, conduct an analysis of the reasons for the delays and develop a plan for improving the results. In addition, the MCO should specify the date teams notify members of the resolution of their appeal to ensure staff adheres to contact specified timelines.

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

BACKGROUND & PURPOSE

DHS requires Family Care MCOs to conduct one PIP each year. Each Family Care MCO must report to DHS on the status and results of each project and include enough detail to show that the MCO is making progress on each project.

Because Care Wisconsin, Community Health Partnership, and NorthernBridges each administered the Family Care program for the first year in 2009, these MCOs were exempt from conducting a PIP.

The MetaStar EQR team evaluated each MCO's PIPs to determine if the MCO used proper technique and design, and whether the MCO used the project's data and findings for its organizational decision making.

VALIDATION METHODOLOGY

The MetaStar EQR team includes reviewers with quality assurance (QA) experience and specialized training in evaluating each MCO's PIP report. The reviewers followed the *Medicaid Managed Care Performance Improvement Project Reviewer Guidelines* and the *Medicaid Managed Care Performance Improvement Project – Project Evaluation Checklist* to assess the standard elements of a PIP.

- Topic selection: To ensure the projects adequately reflected the needs of the enrolled population.
- Study questions and project aims: To ensure they were clear and measurable.
- Indicators and measures: To determine if they were clear, measurable and based on current clinical knowledge or health services research.
- Project population: To determine whether the project included all or part of the organization's population and how the MCO captured and selected the population.
- Data collection procedures and sampling methods: To determine if data were valid and reliable. This involved assessing sampling methods, data sources, data collection instruments and procedures, and the training and/or qualifications of data collectors.
- Improvement strategies: To determine if real, sustained improvements resulted from continuous cycles of measuring and analyzing performance.
- The project team's analysis and interpretation of results: To determine whether it used appropriate statistical analysis techniques.

- Assess “real” and “sustained” improvement in projects that showed improvement.

MetaStar evaluates PIPs by reviewing and analyzing documents the MCO submits including its annual report, Best Clinical and Administrative Practices (BCAP) Workbook or other project work plan/description, related data on project measures, and other related project information such as practice guidelines or member education materials.

The reviewers also interviewed each MCO’s quality management staff about the MCO’s two PIPs during the *QAPI Measurement & Improvement* section of the 2009 Quality Compliance Review. The MetaStar EQR team interviewed each project’s team members to follow-up on questions related to project design and measures, implementation, data collection methods, results of data, and plans for next steps.

Compiling & Analyzing Findings

MetaStar used a three-point rating structure (met, partially met, and not met) to assess the level of compliance with the PIP protocol standards.

- **Met** applied when the project components were in alignment to meet the standard.
- **Partially met** applied when a MCO fulfilled some, but not all, of the project components.
- **Not met** applied when the MCO did not meet any of the project components or reviewers could not ascertain from the documentation whether the MCO worked on the project components.

After each on-site visit the MetaStar EQR team performed a final analysis of the PIPs using a *PIP Validation Checklist* and entered its findings into MetaStar’s PIP database. MetaStar used these findings to develop recommendations for MCOs to improve their PIPs.

Reporting Validation Results to DHS

During the EQR process the MetaStar EQR team reviews each MCO’s PIP and, as part of each MCO’s final EQR report, provides its findings to each MCO and to DHS.

OVERALL FINDINGS

Every MCO serving Family Care members was in compliance with the contract requirement to submit one PIP to DHS.

In 2009 the MCOs worked on PIPs related to cognitive decline, dementia, fall prevention and depression. The falls prevention project continued from 2007, and one of the depression projects continued from 2008. The other depression project and the three projects related to dementia and cognitive decline were new in 2009.

Table 14: 2009 Family Care MCOs' PIP Validation Findings

	Met	Partially Met	Not Met
All Wisconsin Family Care MCOs	83.5%	11.5%	5.0%

Some standards do not apply to PIPs in earlier implementation phases. For example, projects that have been through one measurement cycle could not apply any of the standards related to sustained improvement in Activity 10. Project design also determines which standards apply. A project that is designed without focusing on a random member sample would not apply any of the standards related to sampling techniques in Activity 5.

It is important to recognize the number of applicable standards when looking at the percent of fully met standards. Depending on where a project was in its design and implementation at the time of its 2009 review it might have been eligible for a few or every activity's standards. The table below shows twelve Study Topic standards in total (two for each of the six MCOs) that applied in aggregate because every MCO was far enough in its project for MetaStar to evaluate them. By contrast, MetaStar could evaluate only one MCO on the one *Sustained Improvement* standard. If that MCO met the standard, the fully met rate for the *Sustained Improvement* activity would have been 00 percent. Because it was not met, the rate was zero percent.

Appendix 4 enumerates each *PIP Validation* standard and finding by Family Care MCO.

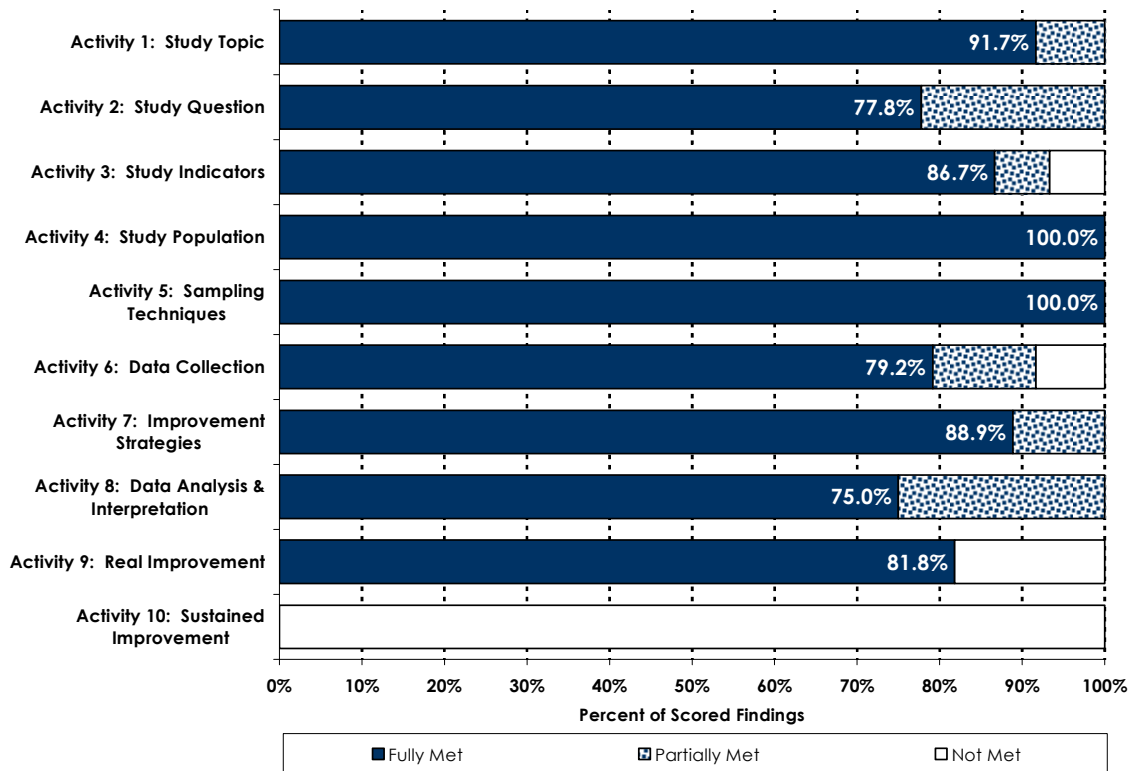
Table 15: 2009 Family Care MCOs' PIP Validation Findings by Activity

Activity	Number of Applicable Standards	Fully Met	Partially Met	Not Met
Activity 1: Study Topic	12	11	1	0
		91.7%	8.3%	0.0%
Activity 2: Study Question	18	14	4	0
		77.8%	22.2%	0.0%
Activity 3: Study Indicators	15	13	1	1
		86.7%	6.7%	6.7%
Activity 4: Study Population	14	14	0	0
		100.0%	0.0%	0.0%
Activity 5: Sampling Techniques	2	2	0	0
		100.0%	0.0%	0.0%
Activity 6: Data Collection	24	19	3	2
		79.2%	12.5%	8.3%
Activity 7: Improvement Strategies	18	16	2	0
		88.9%	11.1%	0.0%
Activity 8: Data Analysis & Interpretation	24	18	6	0
		75.0%	25.0%	0.0%
Activity 9: Real Improvement	11	9	0	2
		81.8%	0.0%	18.2%

Activity	Number of Applicable Standards	Fully Met	Partially Met	Not Met
Activity 10: Sustained Improvement	1	0	0	1
		0.0%	0.0%	100.0%

The graph that follows demonstrates the areas where the MCOs, overall, can improve their PIPs. The MCOs did the best with identifying *Study Populations* (all MCOs) and *Sampling Techniques* (where applicable). MCOs also did well with selecting their *Study Topics*, fully meeting 92 percent of the standards, and developing *Improvement Strategies*, fully meeting 89 percent of the standards. MCOs did not fully achieve the *Data Analysis & Interpretation* standards, meeting approximately three-quarters of the applicable standards in these activities. The one PIP that was eligible for the *Sustained Improvement* standard did not achieve it.

Chart 5: 2009 Family Care MCOs’ PIP Validation Findings by Activity



MCOs crafted and implemented some PIPs better than others, and most MCOs had difficulty with at least one aspect of their projects. WWC met every standard for which it was eligible with its *Climbing out of Depression* PIP, which continued for three years.

Table 16: 2009 Fully Met PIP Standards by Family Care MCO

MCO	PIP Topic	Percent Met
Western Wisconsin Cares (WWC)	Climbing Out of Depression	100%
Creative Care Options (CCO)	Improving the Early Identification and Treatment of Members with Dementia	95.8%
Community Care of Central Wisconsin (CCCW)	Dementia Screening	91.3%
Community Care (CC-FC)	Early Identification of Cognitive Decline in Members with Cognitive Deficit Diagnosis	90.0%
Milwaukee County Department of Aging Care Management Organization (MCDA)	Fall Prevention	80.8%
Southwest Family Care Alliance (SFCA)	Depression	39.1%

MCO Strengths

- All MCOs developed PIPs with topics that focus on improving care outcomes for their members.
- All MCOs clearly identified their PIPs’ relevant population.
- All PIPs demonstrated clearly defined data and data sources.
- All PIPs contain interventions with a good chance of succeeding.
- Where applicable:
 - PIPs based on the BCAP methodology contained clearly stated and measurable overall aims, typology aims, overall outcome measures and typology measures that link to associated aims
 - MCOs identified representative and generalizable study populations.
 - If an MCO studied the entire population it captured all enrollees in the study population. If it did not use the entire population it stratified the study population by high risk, high needs or high utilization members.
 - MCOs used valid sampling techniques and samples contained sufficient numbers of members.
 - MCOs documented improvements in processes and outcomes.

This following section notes opportunities for improvement, improvements over the 2008 EQR and recommendations when at least half of the PIPs were affected.

MCO Improvements from Previous Reviews

Continuing PIPs

It is easiest to determine if MCOs made improvements in their PIPs when they continue their projects between the two years being compared.

WWC

WWC made the greatest improvements between 2007 and 2008 in its ongoing *Climbing out of Depression* PIP. Of the six areas it partially met in 2008 it fully met every area in its 2009 review.

MCDA

MCDA's ongoing *Falls Prevention* PIP improved on one standard, BCAP typology measures link to associated aims, between the two years.

New PIPs

CC-FC wrote its first PIP for the Family Care program in 2009. For MCOs that began new projects which MetaStar reviewed for the first time in 2009, it was evident that the MCOs learned from past PIP processes. Their new projects tended to show improvements in areas that were partially met or not met in their earlier PIPs.

MCO Opportunities for Improvement & EQRO Recommendations

MetaStar did not identify opportunities for improvement that affected three or more of the Family Care MCOs.

All MCOs should move ahead with their PIPs – or, in the case of PIPs that ended, begin planning new PIPs – and seek technical assistance from MetaStar as needed.

The following report provides detailed recommendations for MCOs to improve their efforts toward:

- Selecting topics based on relevant data.
- Writing clear study questions.
- Developing clearly defined and measurable indicators.
- Using qualified staff to collect data.
- Using data collection instruments that provide for consistent, accurate data collection.
- Developing and adhering to a prospective data analysis plan.
- Conducting data analysis with initial and repeat measurements with identified limitations.
- Clearly presenting accurate numerical findings.
- Clearly stating project successes.

- Clearly defining follow-up activities (next steps).
- Ensuring baseline and repeat measurements are consistent.
- Determining whether improvements appear to be the result of planned interventions.
- Demonstrating sustained improvement.

PIP VALIDATION FINDINGS

Each MCO submitted to MetaStar its PIP and supporting documentation related to its interventions and data findings.

Of the six Family Care PIPs evaluated in SFY 2008 – 2009 four PIPs used the optional BCAP methodology:

- CCO: Improving the Early Identification and Treatment of Members with Dementia
- CCCW: Dementia Screening
- MCDA: Fall Prevention
- WWC: Climbing Out of Depression

When an MCO develops a PIP using the BCAP methodology it must address more detailed and stringent requirements than a PIP that is written without the method.

MCO Strengths

In their 2009 PIPs all MCOs implemented these PIP components.

Activity 1: Study Topic

All MCOs developed PIPs with topics that focus on improving key aspects of care or outcomes for members. The projects:

- Addressed high volume services or high-risk populations,
- Were aimed at identifying and correcting deficiencies in services, or
- Had goals to improve processes or outcomes of care or services provided to members.

CC-FC anticipated that “by identifying members in the early stages of dementia and coordinating proper treatment, the effects of disease can be staved off, thus maintaining members longer in the community.” Similarly, CCCW sought “to slow the progression of dementia through early identification, care management, and appropriate diagnosis and treatment while optimizing the quality of life for consumers at risk for Alzheimer’s disease and related dementias, and reduce avoidable costs due to institutionalization and complications related to dementia.” CCO focused on improving the rate of members agreeing to participate in the Cognistat screening process, who had previously refused it, by fifty percent.

Activity 2: Study Question

Each of the four MCOs that wrote PIPs based on the BCAP methodology developed clearly stated and measurable overall aim statements. The BCAP PIPs also contained clearly stated and measurable typology aims.

WWC worked on depression with a dual aim:

- “To reduce the number of members in the target population who initially scored a 50 or higher on the Zung scale, to scoring 49 or less by 25 percent.
- “By improving the MCO members’ ability to self-manage their depression, the average amount of care management time spent with members would be reduced by 20 percent.”

MCDA sought to “reduce high risk fallers within a closed cohort by two percentage points during a twelve month period beginning January 2008.”

Activity 3: Study Indicators

Each project that used the BCAP methodology contained one or more overall outcome measures and typology measures that linked to associated aims.

Activity 4: Study Population

Every MCO met the Study Population standards that were applicable to its PIP.

Each MCO identified a representative and generalizable study population, and these populations were relevant to each MCO's project. When an MCO studied an entire population, it captured all enrollees in the study population. When an MCO did not use the entire population, the study population was appropriately stratified by high-risk, high needs or high utilization.

The project population for CC-FC’s *Cognitive Decline* PIP consists of its members who participate in CC-FC’s Family Care program operating in Racine County. It is a closed cohort of 85 members who were enrolled on January 1, 2008, and who were age 65 when they enrolled in the project. The MCO excluded members from the cohort if they had a diagnosis of Alzheimer’s disease or other irreversible dementia, a developmental disability or traumatic brain injury, aphasia, or received hospice services. Members could also refuse to participate at any time during the project’s implementation.

MCDA conducted a fall prevention needs assessment using a representative sample of members served by three CMUs. The sample consisted of 200 members between ages 60 and 102. Assessment findings indicated that ninety members (44 percent of the sample) averaged two falls in the six months between January and June 2006. Based on these findings MCDA expanded the project scope so 23 CMUs screened members and implemented interventions during January

2009. By May 1, 2009, the MCO and its CMUs completed falls screening for 4399 enrolled members, 63 percent of the MCO's total population.

Activity 5: Sampling Techniques

As noted above MCDA studied a subset of the project’s eligible population. The sample was pulled correctly.

Activity 6: Data Collection

All MCOs met the standard that required them to clearly define the data to be collected and the source of the data.

Activity 7: Improvement Strategies

MCOs can determine the effectiveness of intervention activities by measuring project indicators’ change in performance over time. Interventions should make sense and be likely to succeed. All PIPs contained interventions that should succeed.

For example, CCCW’s strategies to achieve its aim included: “Screening members for dementia using an animal fluency screen, offering members who did not pass the animal fluency screen a more in-depth screening using the Cognistat Screen, referring members who did not pass the Cognistat Screen to their physician for further evaluation and treatment, and developing care management interventions to improve member safety and support members and caregivers in understanding dementia.”

Activity 9: Real Improvement

Four PIPs proceeded far enough to assess whether reported improvement is real improvement. PIP project teams documented improvements they noticed in their processes and/or outcomes.

CCCW, CCO and WWC documented and implemented numerous organizational improvements to address barriers to their projects’ implementation. They developed user-friendly training materials on the PIP topic, trained all care managers, and focused on member needs.

MCO Improvements from Previous Reviews

Table 17: 2008 – 2009 Family Care MCOs’ PIP Validation Findings

	Met	Partially Met	Not Met
2008 Percent of Standards	83.3%	16.7%	0.0%
2009 Percent of Standards	83.5%	11.5%	5.0%
Change	+ 0.2%	- 5.2%	+ 5.0%

Note: Improvement over time is evident when the percent of Met findings increases, the percent of Partially Met findings decreases, or the percent Not Met findings decreases.

A comparison of the findings met, partially met and not met in 2008 and 2009 shows that MCOs' understanding of the PIP process remained stable. The number of not met standards increased over last year when none of the MCOs had met findings.

Continuing PIPs

WWC

WWC made the greatest improvements between 2008 and 2009 in its ongoing PIP, *Climbing out of Depression*. Of the six areas that the MCO partially met in 2008 the MCO fully met them in the 2009 review. The improvements were distributed evenly among the PIP activities. The MCO updated its overall aim statement to clearly define the target population and new target date. It revised the intervention aim to reflect new strategies and included updated implementation timelines. The MCO clearly defined project measures' numerators and denominators. The annual PIP report provided details about data collection methods.

MCDA

MCDA also made an improvement in its *Fall Prevention* PIP that continued into its third year. In 2007 the MCO did not meet the BCAP requirement for the project to contain typology measures that link to associated aims. The MCO partially met this criterion in 2008 and fully met it in 2009. In addition, MCDA's *Falls Risk Assessment* flow sheet is available in its electronic care management system allowing for electronic data entry and report generation. In March 2009 the MCO expanded eligible member screening and offered interventions to all CMUs.

New PIPs

For MCOs that began new projects that MetaStar reviewed for the first time in 2009, it was evident that the MCOs had learned from past PIP processes. Their new projects showed some improvement in areas that they partially met in past PIPs.

CCO

In its new *Dementia* PIP CCO fully met the BCAP requirement for the project to contain typology measures that link to associated aims. Last year, the MCO partially met the requirement.

CCCW

CCCW also improved in its understanding and implementation of the PIP criteria between the two years. With its new *Dementia Screening* PIP, CCCW fully met the BCAP requirements to clearly state measurable typology aims.

MCO Opportunities for Improvement & EQRO Recommendations

Activity 1: Study Topic

MCOs selected five of the six PIP topics because of data collection and analysis, member input or DHS direction. Although it adapted a statewide pay-for-performance project into a PIP one MCO should have reviewed its internal data as part of a needs assessment.

- Recommendation: When developing its next PIP, the MCO should conduct a needs assessment based on its internal data.

Activity 2: Study Question

MCOs should clearly state in writing the questions the study or project is designed to answer. Stating the question helps maintain the focus of the PIP and sets the framework for data collection, analysis and interpretation. The detail that goes into developing the study questions depends upon the methodology each MCO used when creating its PIPs.

In 2009 four MCOs followed the BCAP methodology which has four *Study Question* components. MCDA's *Fall Prevention* PIP and WWC's *Climb out of Depression* PIP met all BCAP *Study Question* requirements. They had clearly stated and measurable overall and typology aims they related to goals and target dates. The other two BCAP PIPs partially met one or more of the *Study Question* requirements.

The overall aim should include a numerical stretch goal. One of the dementia projects partially met this standard. Although it was based on a pay-for-performance project, it did not identify a stretch goal or a target date.

BCAP typology aims should have measurable numeric goals and target dates. One of the dementia projects identified an intervention goal without a target date, partially meeting the standard. Another dementia PIP also partially met this standard; it identified target dates in PDSA worksheets but not in the aim statements as required by the BCAP methodology.

The two PIPs that did not use the BCAP methodology were required to clearly state the study questions. CC-FC's PIP about cognitive decline met this requirement, while another MCO's *Depression* PIP partially met it.

- Recommendations: One MCO needs to improve its study statement to set the direction for the second year of its project. MCOs should include target dates in their aim statements. Overall aim and intervention statements should include target goals as required by the BCAP methodology.

Activity 3: Study Indicators

MCOs should develop PIPs with indicators that measure changes in members' health or functional status, satisfaction or care processes that have strong associations with improved outcomes. The indicators measure important aspects that make a difference to members.

Projects should contain overall outcome measures and typology measures that link to associated typology aims.

One PIP partially met and one PIP did not meet the requirement for indicators to measure changes in health or functional status, satisfaction or care processes.

- **Recommendations:** This MCO that did not meet the standard to have clearly defined and measurable study indicators must identify indicators that allow for measurement of improvement in the member's health or functional status, member satisfaction, or a process of care that would be associated with improved outcomes. For its next PIP another MCO should establish baseline data from a needs assessment to help determine to what extent changes occur in the areas it identifies for improvement.

Activity 6: Data Collection

Four of the PIPs met all of the *Data Collection* criteria that to them.

DHS requires MCOs to use qualified staff to collect project data. One PIP did not meet this standard because MetaStar could not determine who entered the data and ran reports. Two MCOs partially met the requirement for their data collection instruments to provide for consistent and accurate data collection. DHS requires MCOs to create a prospective data analysis plan. One MCO did not meet this requirement because it did not identify a prospective data analysis plan in its PIP report. Another MCO's prospective data analysis plan addressed only the initial analysis in general terms and did not include reassessment and data collection for the remeasurement period later in 2009.

- **Recommendations:** When it submits future reports one MCO should describe the qualifications of the staff involved and the processes or checks in place to ensure the accuracy of the reports being generated. In its future projects, the MCO should have a fully developed data analysis plan to guide the project's progress. Next steps should include more details. The PIP team should identify their next steps and develop a corresponding data analysis plan to ensure that continued progress is made.

One MCO piloted the use of a depression screening tool. Although a MetaStar reviewer suggested piloting the tool, this did not constitute the *validation* of the tool. For future projects this MCO should use a screening tool that is recognized as valid in health care settings. Also, the MCO should develop a prospective data collection and analysis plan that aligns with its project's indicators.

Activity 7: Improvement Strategies

Five PIPs met all of the *Improvement Strategies* requirements. DHS requires MCOs to apply PDSA cycles appropriately and identify and address barriers to achieving improvement. One MCO described the use of a PDSA cycle for its depression screening tool, but it did not use PDSA cycles for other project steps. It identified barriers to using the screening tool but had not yet addressed the barriers by the 2009 review.

- Recommendations: This MCO should include frequency elements in the data collection and analysis plan that allow for modifications to enhance the likelihood of improvement. The MCO should research options for alternative screening tools used by others in applicable health care settings.

Activity 8: Data Analysis & Interpretation

The three dementia PIPs and one of the depression PIPs met every *Data Analysis & Interpretation* requirement. Data analysis should include initial and repeat measurements and should define analysis limitations. It should begin with an examination of the performance of selected indicators. MCOs should develop and follow a data plan. Two PIPs partially met these expectations. Although one project team reported that it planned to identify its baseline in the first year of its PIP, the PIP would have benefitted from more frequent measurement to assist with the evaluation of progress toward the goal. Measurement at intervals would have identified necessary changes to aid improvement. Although another PIP was in place for three years, it did not have defined analysis limitations.

Each PIP report should present its numerical indicator results in a way that provides clear, accurate, and easily understood information. One PIP partially met this standard because the data provided in the analysis results did not provide enough detail to understand the outcome of the analysis. Each PIP should clearly state its successes and progress. One MCO partially met standard because it did not indicate in its PIP report the likelihood of success or give an interim report on the PIP's success. Each PIP should clearly define the follow-up activities and next steps related to the data analysis and interpretation of the project results. Two PIPs partially met this standard. The MCOs did not clearly document all of the steps in their project plans related to follow-up activities. The next steps they identified were general and needed more detail.

- Recommendations: One MCO should identify the reassessment and data collection processes and the timeframe for the remeasurement period. It should specify the staff responsible for monitoring the completion of all initial risk assessments, running data reports, verifying the accuracy of the data, and completing the initial data analysis. The MCO also needs to specify timeframes for the due dates to complete the initial assessment and the reassessment phases. It should develop a corresponding data analysis plan to ensure it makes continued progress and define detailed next steps. Another MCO should put elements in the data collection and analysis plan that allow it to enhance the likelihood of improvement and expand the use of detailed data elements in documenting its findings. At a minimum, this MCO should document progress on a quarterly basis.

Activity 9: Real Improvement

Two PIPs were not advanced enough in their implementation to be evaluated on the *Real Improvement* standards. Three PIPs met all of these standards. PIPs must demonstrate consistency between baseline and repeat measurements. Because it did not collect baseline information prior to implementing its PIP, one MCO did not meet this requirement. Improvements should appear to be the result of planned interventions and not related to some disparate occurrence. At the time of the review the MCO that could have done so had not attempted to measure the impact of its interventions.

- Recommendations: The MCO should determine the baseline data for future projects before it implements interventions. Because of serious design flaws with its project the MCO plans to seek technical assistance to modify elements of its PIP.

Activity 10: Sustained Improvement

One MCO did not provide documentation that it completed periodic monitoring or repeat monitoring cycles. An evaluation of sustained improvement could occur. Although it was eligible to do it this MCO did not meet the standard to demonstrate sustained improvement.

- Recommendation: The MCO should fully document the next steps of the project in greater detail and include prospective dates for data collection and analysis.

CARE MANAGEMENT REVIEWS

REVIEW METHODOLOGY

The CMR provides data about the quality of care management services MCOs provide to Family Care members residing in Family Care service areas throughout Wisconsin.

MetaStar conducted a review of a random sample of members' service records for each MCO during SFY 2008 – 2009. The samples included a mix of participants who enrolled in the MCO during the year before the 2009 CMR, participants who had been enrolled for more than a year and participants who left the program since the 2008 CMR.

Table 18: Family Care MCO CMR Records Reviewed & Time Periods

Number of records reviewed and time period of review for each MCO

MCO	Number of Member Records Reviewed	Time period reviewed preceding 2009 EQR
Community Care of Central Wisconsin (CCCW)	30	March 2008 – March 2009
Community Care (CC)	30	September 2007 – September 2008
Creative Care Options (CCO)	30	January 2008 – January 2009
Milwaukee County Department on Aging Care Management Organization (MCDA)	110	March 2008 – March 2009
Southwest Family Care Alliance (SFCA)	30	March 2008 – March 2009
Western Wisconsin Cares (WWC)	30	February 2008 – February 2009

MetaStar's review team is comprised of registered nurses and licensed social workers and other degreed professionals with extensive experience working with frail elderly, physically disabled and developmentally disabled individuals. Their experience includes professional practice in a variety of settings including community based programs, home health agencies, community based residential settings, skilled nursing, primary and acute care facilities, and institutes of mental disease. Members of the review team also have education and experience working with members with mental health or substance use disorders. Reviewers must to maintain applicable licensure and participate in relevant training throughout the year. MetaStar based the CMR tool and reviewer guidelines on DHS contract requirements. MetaStar trained reviewers to use the DHS approved review tool, reviewer guidelines, and the review database. In addition to identifying any immediate member health or safety issues, MetaStar reviewed four categories of care management:

- Assessment
- Care Planning

- Service Coordination & Delivery
- Participant Centered Focus

Reviewers use nineteen indicators in these four categories to evaluate each MCO's performance.

Compiling & Analyzing Findings

MetaStar used a binomial scoring system (met and not met) to rate each MCO's performance for each measure evaluated. In addition, for findings of “not met” the reviewers noted the key areas related to the finding and provided comments about the missing requirements.

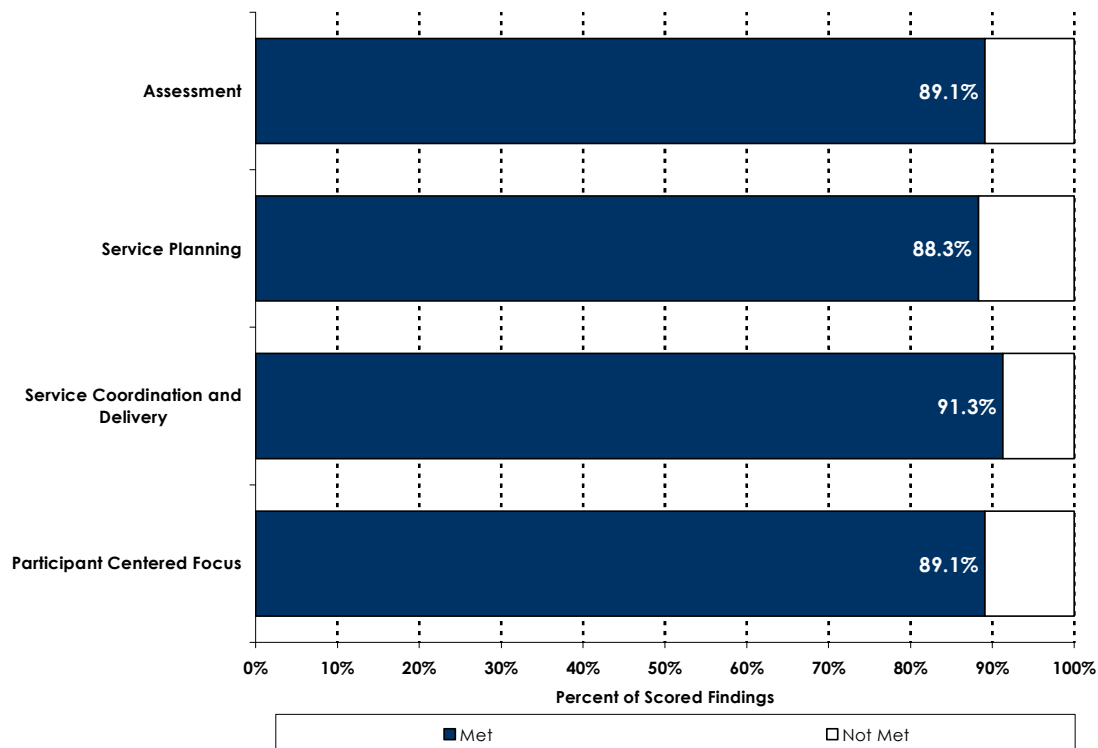
Reporting Evaluation Results to DHS

At the end of the record review MetaStar gave the MCO its findings from each individual record review and an explanation of the organization’s overall performance. After the MCO received its CMR results MetaStar gave it the opportunity to submit additional documentation for further consideration. MetaStar reviewers evaluated the additional documentation before issuing final results to the MCO and to DHS.

OVERALL FINDINGS

The MCOs fully met at least 88 percent of the measures in three of the four CMR categories.

Chart 6: 2009 Family Care MCOs’ CMR Findings by Category

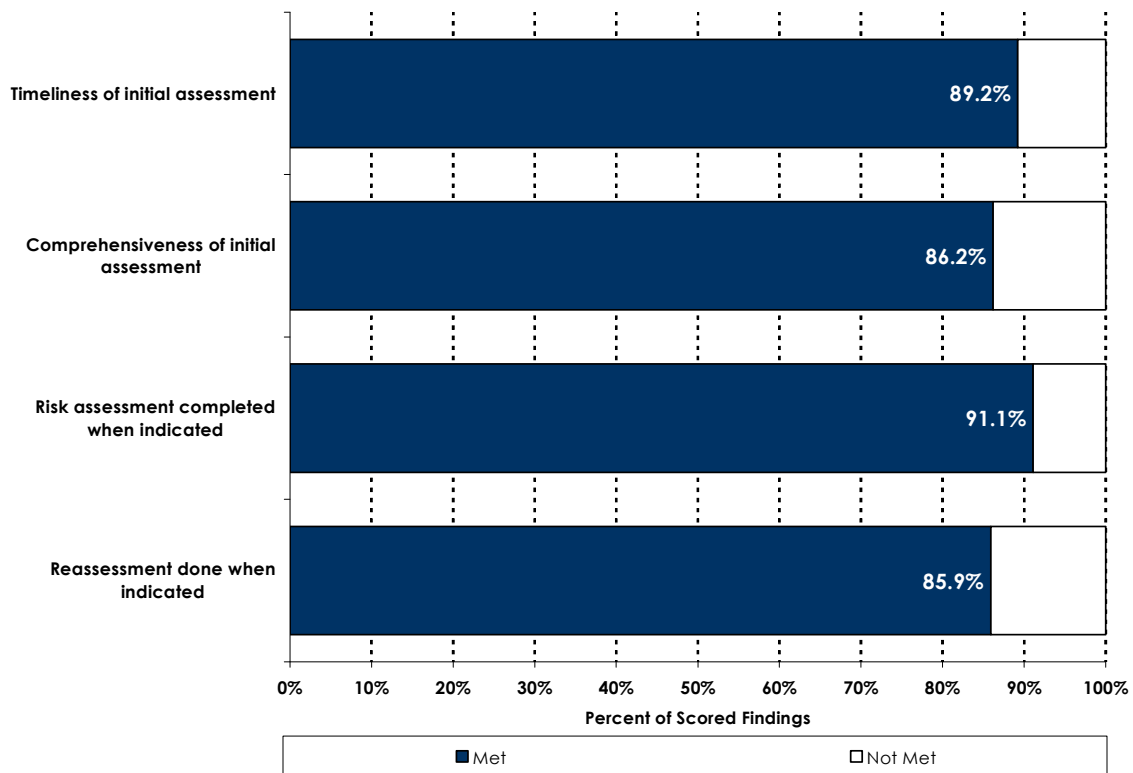


Appendix 5 contains detailed CMR findings for each MCO.

Assessment

The assessment category deals with activities that teams complete to obtain information about a member at times specified in the MCO's contract with DHS.

Chart 7: 2009 CMR Assessment Findings for Family Care MCOs

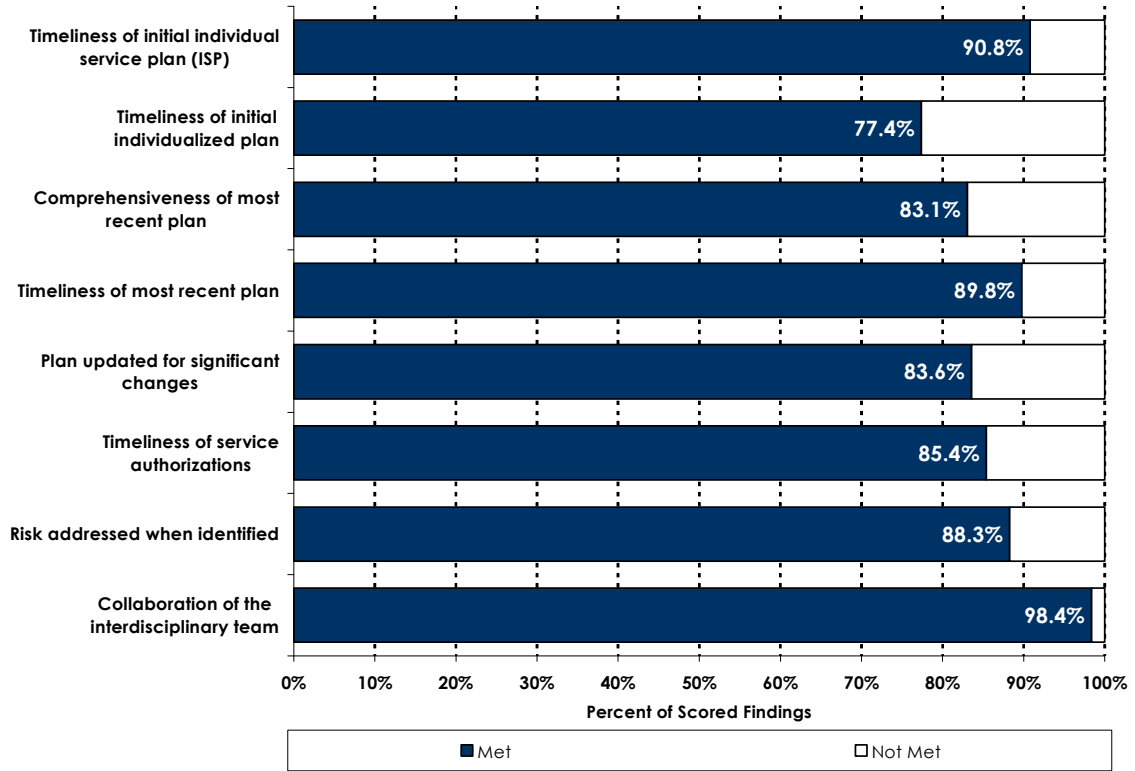


Eighty-nine percent of the MCOs' member records selected and reviewed met the requirement to have initial assessments done in a timely manner. MetaStar found 86 percent of initial assessments reviewed to be comprehensive. Teams did reassessments according to designated timeframes in 86 percent of records reviewed and completed risk assessments when indicated 91 percent of the time.

Service Planning

For this category, reviewers looked at various activities that reflect how well care teams plan members' services.

Chart 8: 2009 CMR Service Planning Findings for Family Care MCOs



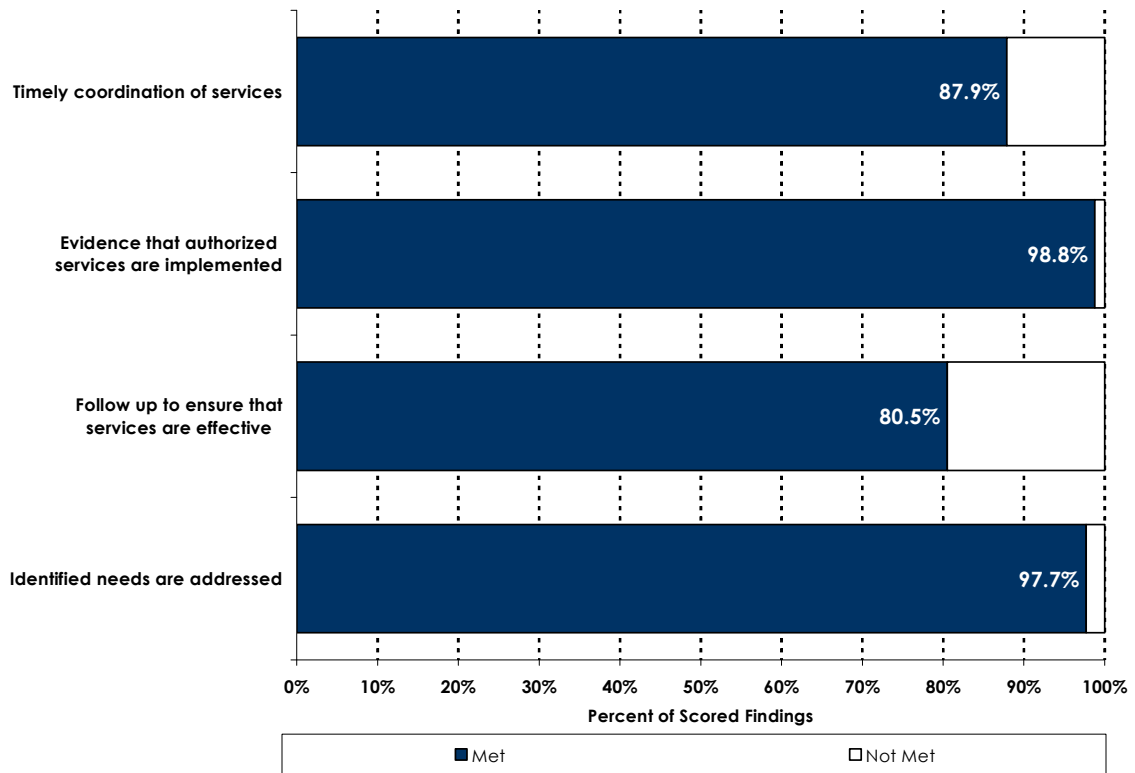
Overall, the MCOs scored moderately well, fully meeting most of the *Service Planning* activities eighty to ninety percent of the time. MetaStar reviewers found team collaboration to be the most evident service planning activity. Opportunities exist for MCOs to improve the timeliness of initial ISPs and the comprehensiveness of their members’ most recent plans.

Service Coordination & Delivery

This category deals with teams’ activities to coordinate and follow-up on members’ care and services.



Chart 9: 2009 CMR Service Coordination & Delivery Findings for Family Care MCOs



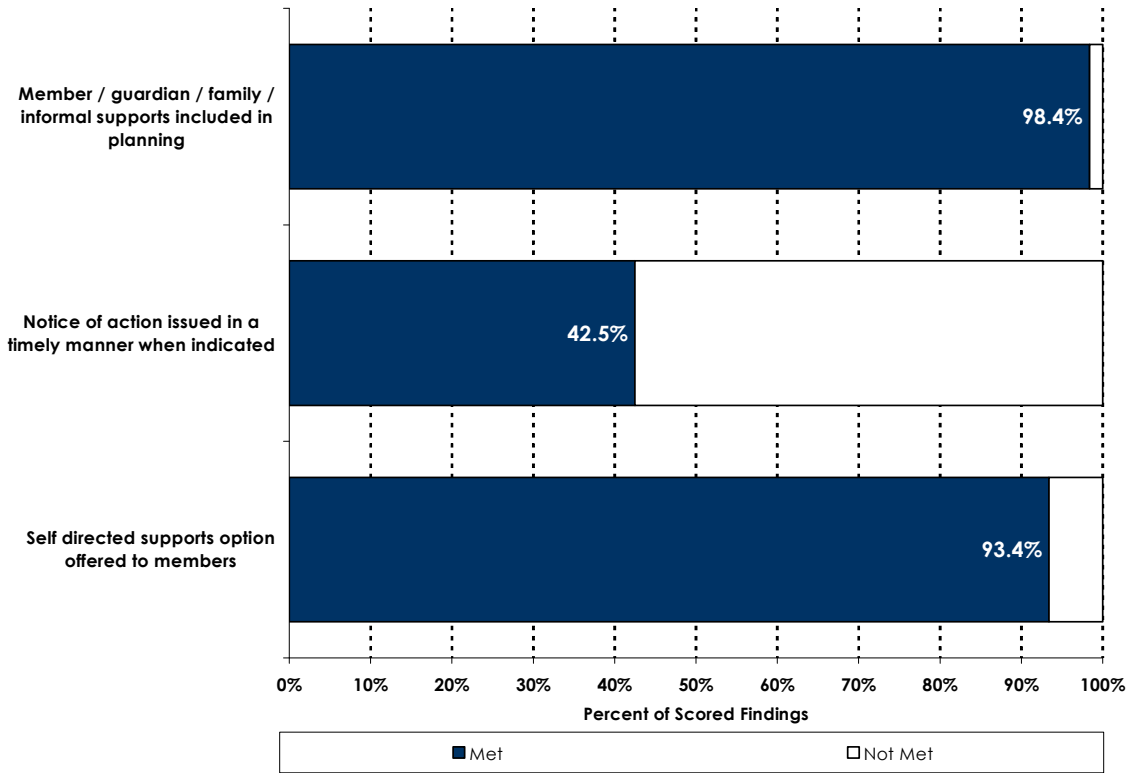
With a rate of almost 99 percent met, the MetaStar EQR team found evidence in almost every member record reviewed that the MCOs implemented authorized services. On average, the MCOs also did moderately well with the other three Service Coordination and Delivery measures, scoring over eighty percent on each of the measures.

Participant Centered Focus

This category deals with how well the teams focus on members' preferences and supports when managing their care.



Chart 10: 2009 CMR Participant Centered Focus Findings for Family Care MCOs



In aggregate MCOs either did very well on the *Participant Centered Focus* measures with scores over ninety percent or poorly with less than half of eligible members receiving a notice of action in a timely manner. The QCR of this report provides detailed information about the lack of notice of action timeliness.

Strengths & Opportunities for Improvement

As noted in the aggregated CMR categories above, the MCOs demonstrated exceptional performance (over 95 percent of indicators fully met) on four measures.

Table 19: 2009 Strengths by CMR Measure for Family Care MCOs

Category	Measure	Rate
Service Coordination & Delivery	Evidence that MCOs Implement Authorized Services	98.8%
Service Planning	Collaboration of the interdisciplinary team	98.4%
Participant Centered Focus	Member / guardian / family / informal supports included in planning	98.4%
Service Coordination & Delivery	Teams Address Members' Needs	97.7%

MCOs consistently demonstrated strength related to ensure they implement authorized services for members to achieve their outcomes. Interdisciplinary teams collaborate well to identify and

address members' needs. MCOs involve members, guardians and families and integrate informal supports in care planning.

MCOs struggled most with one measure related to issuing notices of action in a timely manner, achieving it less than half the time.

Table 20: 2009 Opportunities for Improvement by CMR Measure for Family Care MCOs

Category	Measure	Rate
Participant Centered Focus	Notice of action issued in a timely manner when indicated	42.5%

DETAILED FINDINGS

Assessment

Table 21: 2009 Family Care MCOs' CMR Assessment Findings

Assessment Measures N=4	Who is eligible for the measure?	Criteria	Statistics	Rate	
Timeliness of initial assessment	New enrollees & previous community waiver participants	Was the initial assessment done within 30 calendar days of enrollment? For previous community waiver participants, was a nursing assessment done within 30 days?	New enrollees & previous waiver participants:	65	89.2%
			Initial assessment done in a timely manner	58	
Comprehensiveness of initial assessment	New enrollees	Was the initial assessment completed in person and did it contain information about a member's issues, needs, strengths and resources?	New enrollees:	65	86.2%
			Initial assessment was comprehensive:	56	
Risk assessment completed when indicated	Any member at potential risk	For those members at potential risk, was a risk assessment completed when indicated?	Members at potential risk:	225	91.1%
			Risk assessment completed when indicated:	205	
Reassessment done when indicated	Any member who had a change in condition or living situation or when requested or to evaluate significant or proposed changes in services for previous community waiver participants	If the member was eligible to have a reassessment completed, was it done when indicated?	Members eligible for reassessment:	78	85.9%
			Reassessment done when indicated:	67	

Four measures are in the *Assessment* category. Overall 91 percent of member records reviewed met the *risk assessment completed when indicated* measure. MCOs achieved all other assessment categories in aggregate between 86 and 89 percent of the time.

Service Planning

Table 22: 2009 Family Care MCOs' CMR Service Planning Findings

Service Planning Measures N=8	Who is eligible for the measure?	Criteria	Statistics		Rate
Timeliness of initial individual service plan (ISP)	New enrollees	Was the initial ISP done within 10 business days of enrollment?	New enrollees:	65	90.8%
			Initial ISP done in a timely manner:	59	
Timeliness of initial individualized plan	New enrollees	Was the initial individualized plan done within 60 calendar days of enrollment?	New enrollees:	62	77.4%
			Initial assessment done in a timely manner:	48	
Comprehensiveness of most recent plan	All members	Was the most recent plan comprehensive?	All members:	255	83.1%
			Most recent plan was comprehensive:	212	
Timeliness of most recent plan	All members	Was the most recent plan reviewed within the last 6 months?	All members:	255	89.8%
			Most recent plan was done in a timely manner:	229	
Plan updated for significant changes	Members with significant changes	For those members with significant changes, was the plan updated with the significant changes?	Members with significant changes:	73	83.6%
			Plan updated:	61	
Timeliness of service authorizations	Members with service requests	For those members with service requests, were the service authorizations done in a timely manner?	Members with service requests:	233	85.4%
			Service authorizations done in a timely manner:	199	
Risk addressed when identified	Any member at risk	For those members with risk, was the risk addressed when identified?	Members at risk:	188	88.3%
			Risk was addressed when identified:	166	
Collaboration of the team	All members	Did all members of the team collaborate when providing care management?	All members:	258	98.4%
			All team members collaborated on the members' case management:	254	

Eight measures make up the *Service Planning* category. Ninety-eight percent of records reviewed across all MCOs showed evidence that teams collaborate when providing members' care management. In 91 percent of records reviewed teams completed members' initial ISPs within ten business days of enrollment. However, reviewers found that details in roughly 77 percent of the records reviewed that indicated they completed initial individualized plans within sixty days of enrollment.

Service Coordination & Delivery

Table 23: 2009 Family Care MCOs' CMR Service Coordination & Delivery Findings

Service Coordination and Delivery Measures N=4	Who is eligible for the measure?	Criteria	Statistics		Rate
Timely coordination of services	Members with any services	For those members who had services, was the coordination of services done in a timely manner?	Members with services:	257	87.9%
			Service coordination was done in a timely manner:	226	
Evidence that MCOs Implement Authorized Services	Members with authorized services	For those members who had authorized services, is there evidence that the authorized services were implemented?	Members with authorized services:	257	98.8%
			Evidence that authorized services were implemented:	254	
Follow-up to ensure that services are effective	Members with authorized services	For those members who had authorized services, was follow-up done to ensure that the authorized services were effective?	Members with authorized services:	257	80.5%
			Follow-up was done to ensure authorized services were effective:	207	
Teams Address Members' Needs	All members	All members are assumed to have needs. Were their needs addressed?	All members:	258	97.7%
			Identified needs were addressed:	252	

On average MCOs met each of the *Service Coordination & Delivery* measures at least eighty percent of the time. Four of the MCOs achieved full compliance on the measure *Evidence that MCOs Implement Authorized Services*.

Participant Centered Focus

Table 24: 2009 Family Care MCOs' CMR Participant Centered Focus Findings

Participant Centered Focus Measures N=3	Who is eligible for the measure?	Criteria	Statistics		Rate
Member / guardian / family / informal supports included in planning	All members	Was the member included in planning? If applicable, were the member's guardian, and/or family member, and/or informal supports included in the planning process?	All members:	258	98.4%
			Appropriate people included in planning:	254	
NOA issued in a timely manner when indicated	Members who whom a NOA was indicated	Was the NOA sent in a timely manner?	Members to whom a NOA was indicated:	73	42.5%
			The NOA was sent in a timely manner:	31	
SDS option offered to members	All members	Was the option of SDS offered to members?	All members:	227	93.4%
			Members who were offered the option of SDS:	212	

In every record MetaStar reviewed at CCCW, CCO and the SFCA it found evidence that the MCO involved the member and any guardians, family members or informal supports in the planning process. CCCW issued notices of action in a timely manner in every record the MetaStar EQR team reviewed. At the other MCOs MetaStar found evidence that teams sent notices of action in a timely manner in approximately half or fewer of the records it reviewed.

MCO STRENGTHS

In almost 99 percent of every eligible randomly selected member record it reviewed MetaStar found evidence that MCOs implemented authorized services. The six MCOs achieved six of the nineteen CMR measures at rates above 90 percent on average. This section highlights notable strengths.

Assessment

Assessment Comprehensiveness

CCO divided its assessment into individual domains which allows the quick update of any combination of relevant areas. This is an improvement since the 2008 EQR. Each assessment domain concludes with a section summary that requires teams to document member strengths and weaknesses, member preferences, member outcomes, and interventions.

Practice & Documentation Expectations

CCO developed and implemented *Best Practice Standards for Case Management* which provides a minimum set of practice and documentation expectations to teams to standardize their approach to assess and support members. CCO's development and implementation of these expectations is an improvement since its 2008 EQR.

Assessment Timeliness

CCO's policy, procedure, and process documents clearly define expectations for assessment timing and content. Through its internal file review process during the first three quarters of 2008 CCO supervisors provided monitoring and feedback to care managers about timely and comprehensive initial assessments. WWC and SFCA also provided feedback to care managers about the timeliness and quality of assessments through their internal file review processes. CCCW provided clear direction to care management teams about timeframes to complete initial assessments for new members. Upon enrollment with CCCW each member's record contains pre-populated fields about due dates for certain activities such as assessments. Teams and supervisors use one of several methods to keep track of timelines.

Standardized Assessments & Risk Assessments

CCO uses standardized assessment tools to screen for depression in members with and without a preexisting depression diagnosis, to evaluate members' risk for falls, and to identify members' risk for skin breakdown. CCO teams' frequent assessment of members' medications includes information about medication management and administration. WWC's standardized risk assessment tools and guidelines help teams identify members' risks for depression, falls and suicide. Teams assess all WWC members for falls during the initial assessment that occurs within thirty days of enrollment. CCCW's congestive heart failure and diabetes practice guidelines promote frequent reassessment of members with these diagnoses. CCCW teams consistently record flu and pneumonia vaccination status in the MCO's electronic documentation

system. Teams use cognitive screens such as the *Animal Fluency Questionnaire* to gather objective data about a member's cognition. SFCA's Richland County CMU frequently contacts members, knows when members experience changes in condition and situation, and reassesses members when needed.

Member Supports, Preferences & Outcomes

WWC's initial social and health assessments gather a wealth of information about the member such as the member's preferences, outcomes, who the member wants to assist (i.e., "support") him or her, and how much the member wants that support involved.

Routine Reviews

Usually along with the review of the MCP and ICP (i.e., "MCP/ISP review") WWC teams perform routine periodic health reviews every six months to note changes in members' health. CCCW's registered nurse service coordinators reassess all members every six months with the scheduled MCP reviews. Registered nurses at SFCA's Richland County CMU reassess members on an annual basis with the annual MCP review.

Service Planning

During the 2009 CMRs MetaStar found many service planning strengths at all MCOs and identified one service planning best practice. The assessment module at CCO summaries become MCPs. CCO modified its electronic documentation system to transfer information from assessments to MCPs. This reduces the number of times teams must document information and results in improved efficiency.

Identifying & Addressing Member Risks

CCO provides clear direction to teams to address identified member risks within the MCPs and revisit the risks at least every time they review the plan. MCDA activates daily check-ins for those members at risk during weather extremes. Teams document in case notes that they implement the procedures. CCCW's teams work with members and their supports to develop back-up plans for unplanned or emergent events. SFCA's Richland County CMU care managers and registered nurses recognize members' risks and address them through frequent member contacts, ongoing education, and suggestions.

Guidelines

CCO implemented written guidelines that describe when teams should consult with a supervisor. Written guidelines exist to help MCDA's teams make decisions about services. CCCW created clear written expectations about plan development and review timeframes for its teams.

Plan Timeliness & Comprehensiveness

CCO's policy, procedure, and process documents clearly define expectations for MCP/ISP timing and content. WWC's MCPs and ISPs are comprehensive and contain current and historical information about members, their services and supports. WWC's supervisors, registered nurses and care managers track timelines related to service decisions and plan development and review. Their case notes document reasons why MCP/ISP timeframes cannot be met, for example, due to members' scheduling conflicts or time preferences. CCCW's electronic care management system pre-populates the MCP with a date for the next scheduled review in accordance with contract requirements. SFCA's Richland County CMU reviews MCPs and ISPs with newly enrolled members more quickly than required by contract. It reviewed the plans six months from the date of enrollment rather than six months from the date they first developed the MCP or ISP.

MCDA expects CMUs to review MCPs and ISPs with members at least every six months; however, MCDA advises plan reviews on a quarterly basis which is more frequent than required in its contract with DHS. Frequent review of members existing plans may help members achieve outcomes in an efficient way by ensuring that teams and providers deliver the right care and services at the right time. One MCDA CMU uses a template to ensure it consistently includes information in all of its MCPs. The template guides teams to incorporate the necessary information to understand how they coordinated members' care. MCDA tracks the timeframes for periodic MCP plan reviews. The method used by each CMU varies. Some CMUs created electronic systems to track dates while others enter dates manually into electronic or paper calendars. In some CMUs supervisors track timeframes and notify teams about the dates while in other CMUs the teams track this information themselves.

Timely Service Decisions

MCDA has written standards for timely service authorization decisions. CCO communicates clear direction to teams about contract requirements for timely service decisions. Teams track decision timeframes. Care managers can adopt one of many available methods such as supervisor reminders. CCO's focused monitoring assures teams make denials within contract timeframes. CCO analyzes its data to identify causes for untimely denials when results are less than its benchmark of ninety percent.

Service Authorization Decision-making

Members' outcomes are the focus of the RAD process. CCO teams work with members to identify outcomes and core problems. Using the RAD worksheet promotes thoughtful decisions and includes members. CCCW has clear written instructions for service authorizations timeframes. During interviews teams spoke confidently about decision making timeframes and the RAD process.

Collaboration

Joint visits to members by an MCO's care managers and registered nurses encourage collaboration during assessments and visits. SFCA's Richland County CMU registered nurses and care managers often visit members together, and when they do not they update their counterpart about their findings. At CCO a member's original team and his or her new team meet and share a verbal report when he or she transitions to a new team. Teams follow detailed guidelines to facilitate smooth transitions for members between the MCO's various teams. Most of CCCW's teams adhere to written expectations and visit members together during initial assessments. Some teams continue the practice of joint visits thereafter. WWC's teams communicate and collaborate with each other and with providers. Its teams visit members together. Social service specialists are part of the team and often see members routinely and accompany members to appointments. The social service specialist communicates information he or she gathers back to the registered nurse and care manager by direct report or by a written summary using the *Healthcare Provider Visit Form*.

Process Improvement

WWC's supervisors and its Quality Department staff provide feedback to registered nurses and care managers about documented activities through WWC's internal file review process. Teams receive feedback about the core problem, member outcomes, and their ability to include the member through the retrospective RAD review for service authorization decision making. MCDA care managers can seek peer input from the Peer Review Committee about topics such as resource utilization, standards of care, quality of care, best practices, and medical necessity. Richland CMU supervisors and SFCA quality managers review all RAD forms retrospectively and provide feedback to care managers about the decision making process. Richland CMU supervisors reviewed MCPs to ensure teams reviewed members' plans every six months and addressed needs identified on the LTC FS.

Service Coordination & Delivery

CCCW and SFCA's Richland County CMU demonstrated best practices related to the coordination and delivery of services. CCCW established agreements with local hospitals and clinics to access their electronic documentation systems. With permission from its members, CCCW teams have the ability to access the systems, review documentation such as progress notes and laboratory test results, and embed the information into the MCO's progress notes. The ready access to physician notes and lab results promotes continuity of care for members and uses service coordinators' time efficiently.

SFCA's Richland County CMU care managers use a *Health Communiqué* form to communicate with physicians and other providers when unable to attend appointments with members or communicate about concerns in between members' appointments. Physicians document the follow-up recommendations and appointment outcomes the form. Ongoing team communication with providers promotes continuity of care for members.

Timely Coordination of Services

CCO requires care managers to close documentation in the MCO's electronic care management system within one week. WWC provides clear written directions to teams about timeframe expectations for service coordination, delivery and follow-up. The BPT at MCDA and CMU supervisors use the internal file review process to review the timely coordination of covered and non-covered services.

Implementing Authorized Services

Program assistants at SFCA's Richland County CMU assist teams by providing member care management and completing various tasks such as attending appointments with members or providing transportation to them.

Effectiveness of Authorized Services

MCDA documented its expectations about monitoring and evaluating member status and outcomes. The structure of the case notes in MCDA's electronic documentation system prompts teams to document the effectiveness of services and the member's response. SFCA's Richland County CMU obtains and reviews provider progress notes. Some care managers and registered nurses summarized the information gleaned from reviewing provider notes within their case notes and also documented any actions they took based on the information.

SFCA's Richland County CMU works to establish open communication lines with providers to promote the continuity of health care. When a member enrolls SFCA's Richland County CMU sends a letter to the member's physician to inform him or her of the member's enrollment in Family Care. When members reside in nursing homes registered nurses review nursing home charts and receive frequent updates about members' status from nursing home staff. Teams also attend nursing homes' care conferences.

Addressing Identified Needs

SFCA's Richland County CMU care managers understand eligibility and benefit issues. They connect members with economic support staff to resolve these issues. WWC teams fully use the structure of the ISP to provide a clear picture about authorized services such as by including the name of the provider and the duration and frequency of services.

Participant Centered Focus

Inclusionary Planning

SFCA's Richland County CMU identifies and attends to members' preferences when planning care and documents member preferences well in member records.

Timely Issuance of Notices of Action

CCO has documented policies, processes, and guidelines about notices of action. The MCO monitored notice of action forms for the first three quarters of 2008. The MCO cemented expectations for teams to include members throughout the authorization decision making process and to notify members of denials before teams issue a notice of action. Teams must clearly document their actions in relation to these expectations. The MCO also implemented a standard process to ensure that members and their legal decision makers receive notices of action.

SFCA's Richland County CMU, CCCW, WWC and MCDA also provide clear written direction to teams about notice of action requirements and conduct focused monitoring of notices of action. CCCW teams verbalized understanding about actions which result in notices of action. The MCO monitors the issuance of notices of action when teams deny service requests. SFCA's Richland County CMU verbally informs members when it denies requests. Members do not need to wait to receive the written notice before discussing their rights to appeal decisions.

MCOs Offer the Self-Directed Supports Option

CCO's MCP signature page includes contract required language about self-directed supports (SDS) in accordance with DHS contract requirements. CCCW staff informs members of the opportunity to self-direct their plans and services and also documents the offers on the MCP signature page.

MCO IMPROVEMENTS FROM PREVIOUS REVIEWS

Table 25: 2008 - 2009 CMR Category Comparison for Family Care MCOs

Category	Measures compared	Met in 2008	Met in 2009	Percent Change between 2008 - 2009
Assessment	4 of 4	87.9%	89.1%	1.4%
Service Planning	8 of 8	86.7%	88.3%	1.9%
Service Coordination and Delivery	4 of 4	88.3%	91.3%	3.3%
Participant Centered Focus	3 of 3	64.5%	89.1%	38.0%

The following CMR areas improved between 2008 and 2009.

Table 26: 2008 – 2009 CMR Measures Showing Improvement for Family Care MCOs

Category	Measure	Met in 2008	Met in 2009	Percent Change between 2008 - 2009
Participant Centered Focus	Self directed supports option offered to members	32.9%	93.4%	184.0%
Service Planning	Comprehensiveness of most recent plan	71.4%	83.1%	16.4%
Service Coordination & Delivery	Teams Address Members' Needs	85.7%	97.7%	14.0%

The most notable improvement between the two years across all MCOs was the offer of the self-directed supports option to members.

Assessment

Initial Assessment Timeliness

CMUs have clearly written expectations from MCDA for the timely completion of initial assessments and reassessments. MCDA monitors assessment timeframes. Teams monitor assessment timeframes using the *New Family Care Case Checklist* designed by MCDA which calculates completion dates for required activities based on the member's enrollment date. MCDA provides retrospective focused monitoring of timely assessments through its internal file review process.

Initial Assessment Comprehensiveness

Rather than leave items blank CCO instructed teams to mark “not applicable” to items within the assessment domains if those items do not apply to the member. MCDA teams review information from other sources such as the Aging Resource Center and the LTC FS before visiting newly enrolled members. Using information from available resources is an efficient means to capture comprehensive information about members.

Risk Assessment Completed when Indicated

CCO clarified the interval for reassessing risk using standardized tools. For example, guidelines state “assess members’ cognition at a minimum of every six months and as needed” instead of “at the discretion of the nurse.” MCDA’s electronic member record and service authorization system prompts teams to complete additional specialty assessments depending upon the answers entered for basic assessments. Built-in prompts remind teams to fully explore members’ risks. CCO drafted standardized cognition assessment tools and guidelines for elderly members and members with physical disabilities. MCDA developed and implemented standardized assessments to evaluate risks for falls, cognition, caregiver stress, skin breakdown, nutrition and depression. SFCA emphasized the importance of risk identification by creating the depression screening tool as part of its PIP to identify members at risk for depression. Richland CMU staff

incorporated the screening tool into its assessment practice. WWC educated its teams about how to identify and address risks using various educational methods such as member scenarios it developed. It also enhanced the initial social assessment forms with prompts to identify risks within each assessment section and domain. It developed a member contact assessment tool to help teams evaluate whether members' requests to waive quarterly contacts are appropriate. The tool also helps teams determine when members may need more frequent team contact.

Reassessment Done when Indicated

Registered nurses visit MCDA members after a hospital discharge and conduct reassessments to ensure they identify new needs during the care transition.

Service Planning

Comprehensiveness of Most Recent Plan

WWC implemented an electronic application for the creation and review of MCPs and ISPs. Its plans are comprehensive and legible. Member demographic information included on the first page of the plan serves as a reminder to periodically review it and to determine that contact information remains current.

Timeliness of Service Authorizations

MCDA indicated plans to monitor the timeliness of decision making although it was not yet implemented at the time of its EQR. It will monitor decision making timeliness through the service authorization module of the MCO's electronic care management system. It plans to implement a change in its electronic care management system to enter the authorization into the system the same day the team receives the request. The authorization will pend until the team makes a decision. If team denies the service the system cancels authorization. If the team approves the service the system updates the authorization date. MCDA will be able to monitor timeframes by reviewing the authorization history. While the proposed plan appears sound MCDA did not identify an implementation date at its 2009 EQR.

Risk Addressed when Identified

CCO developed a checklist to help care managers focus their quality of care monitoring efforts and ensure health and safety for members in residential care settings. WWC established and conveyed expectations to address identified member risks. MetaStar reviewers noted the presence of risk agreements in appropriate circumstances during its CMR. SFCA's Richland County CMU care managers implemented interventions developed through the PIP for its members at risk for depression.

Team Collaboration

CCO revised its RAD worksheet and trained its staff to improve across teams the consistency of information gathering and processing during the decision making process. CCO established expectations for team communication with substitute care facilities. The CMR noted some records that contained weekly faxed updates and frequent team attendance at facilities' care conferences.

Service Coordination & Delivery

CCO requires care managers to close documentation in the MCO's electronic care management system within one week. This is an improvement from the 2008 EQR when documentation could remain open for one month. The structured focus notes within CCO's system require care managers to document contacts in four sections: information, action / intervention, member response, follow-up, and plan. This is an improvement from the 2008 EQR and encourages care managers to monitor the effectiveness of interventions while focusing on each member's perspective.

Participant Centered Focus

MCOs Offer the Self-Directed Supports Option

MCDA added to its MCP and ISP signature pages standardized language consistent with contract requirements about the team's offer of SDS and the member's decision to accept or decline SDS.

MCO OPPORTUNITIES FOR IMPROVEMENT & EQRO RECOMMENDATIONS

Opportunities for improvement related to meeting the CMR measures varied by MCO.

Assessment

Initial Assessment Timeliness & Comprehensiveness

While only one new member assessment at one MCO was not comprehensive in a sample of thirty members, the MCO's internal file review results during the first three quarters of 2008 indicate an average compliance rate of approximately 73 percent. Some teams at another MCO indicated they did not obtain certain information or use standardized assessments because members did not meet criteria to participate in pay-for-performance initiatives or because a related PIP ended. Teams did not provide some members with a dementia diagnosis from certain cognitive tests and screens because the pay-for-performance initiative allowed the MCO to exclude them despite whether a member's situation warranted assessment of the member's cognitive status. This MCO's staff also reported that the MCO no longer required CMUs to collect information about laboratory test results for members with diabetes because a related pay-for-performance initiative ended. However, it is good professional practice to obtain objective

data to monitor improvement or decline over time and tailor interventions regardless if a person is included in a project.

Although a third MCO uses an assessment form approved by DHS it should evaluate the structure of its assessment to ensure it contains the questions and prompts necessary to gather the desired information and meet the teams' needs. Although the assessment contains prompts to record member strengths and height, teams did not consistently include the information within the assessment. Member strengths should be the foundation of assessments. Details about members' height can be important when making decisions about adaptive equipment or interventions relative to weight control. Reviewers observed that teams did not use the MCO's assessment forms in the same manner. Some staff records many important details in the narrative summary sections of the assessment tool members' preferences, outcomes and socialization or spiritual needs while other staff records only minimal information about what is important to the member.

- **Recommendations:** MCOs must comprehensively assess members upon enrollment into Family Care. MCOs must ensure they address members in accordance with professional practice standards and recommendations whether or not members are participants of a MCO project or initiative. They also must ensure that all assessments are comprehensive and include information about members' strengths, preferences, outcomes and needs. One MCO, in particular, must ensure registered nurses summarize members' strengths within case notes since it recently changed its expectations for them to do so.

Risk Assessment Done when Indicated

At one MCO reviewers noted teams consistently assessed members for falls. However, reviewers did not observe the use of other newly developed risk tools and guidelines related to assessing depression and suicidal ideation.

- **Recommendation:** MCOs must ensure they consistently identify risk. Teams should gather thorough and specific information as rationale for noting the presence or absence of risk. This MCO, in particular, should ensure that teams consistently apply standardized risk assessment tools and guidelines. This may be accomplished by further educating teams and by adding a measure to the MCO's internal file review process.

At another MCO many members in the sample appeared to have risks present, and teams did not adequately explore those risks. Some members' risks related to their choices. For example, members may have chosen not to follow medical advice or accept recommended interventions. Other members were at risk for falls. While this MCO has a falls index available for teams to identify risks for falls teams did not consistently use the available tool. Similarly, the MCO also has a depression screening guideline but teams did not assess members who exhibited depression risks. Reviewers noted some members had cognitive impairments but teams did screen or assess them to gather objective information about their cognitive function.

- **Recommendations:** This MCO should improve the rate at which teams thoroughly assess and focus on members' choices related to the self-management of health care. It should ensure its teams consistently use available standardized tools. It should also develop and implement the use of additional assessment tools in areas relevant to this MCO's population such as cognition for members under age 65.

Reassessment Done when Indicated

An MCO's current internal file review tool monitors for the completion of the LTC FS when a member's condition or situation changes, but it does not measure whether teams complete or update existing MCO assessments. Since the LTC FS does not typically contain as much information as the MCO's assessment modules the MCO should ensure that teams reassess members according to contract requirements. Ensuring that teams update assessments will also help to ensure that teams update MCPs, because at this MCO the assessment summaries become MCPs.

Another MCO's internal file review found that teams did not do approximately forty percent of reassessments when indicated which supports its 2009 CMR findings. Reviewers noted that teams appeared to limit member visits to predetermined intervals, according to minimum standards, and did not consistently reassess members when unexpected changes occurred. The MCO may need to educate teams about contractual reassessment expectations. MCO supervisors should consider discussing all members at team meetings and identify members with changes that need reassessment. The MCO's health review documents changes in members' health status. The documentation of changes only, presumably from the members' "baseline" presentation during the initial assessment, appears to be a method of documenting by exception. Health reviews for members without health changes contained very little information and did not include information about the member's current preferences or outcomes.

At a third MCO, reminders and prompts in the electronic care management system help care managers meet contract requirements and assure members' health and safety. The system includes many features to ensure consistent practice across its CMUs, but reviewers observed registered nurses and care managers inconsistently using documents or features that do not have prompts within the system. For example, the worksheets that social work care managers use to document their assessments include a column to note interventions related to the findings. The feature appears to prompt the thought process from gathering information and taking action as a result. Reviewers observed some, but not all, care managers used the feature.

During QCR discussions at a fourth MCO team staff reported that "every contact is a reassessment" which indicates that teams understand expectations about reassessing members. However, results from this MCO's CMR indicate an inconsistency between what teams reported and what reviewers observed to be their practice. Teams did not reassess nearly 43 percent of members who experienced changes in their conditions or situations.

Member outcomes are an essential element to the Family Care program. Identifying members' outcomes is the first step to helping members achieve their goals. The initial assessment form the fifth MCO uses contains questions about outcomes. The questions appear to prompt yes or

no answers by inquiring whether any of the twelve Family Care outcomes apply to the member. Although the MCO provides an annual health assessment to members enrolled one year or more MetaStar could not find evidence that the MCO reassessed member outcomes. In many instances reviewers observed that members' outcomes documented on MCPs remained the same over time.

- **Recommendations:** Members must be reassessed when changes in their long-term care, health care conditions, situations change, and when members or providers request it. MCOs must ensure care managers have meaningful initial and ongoing conversations about outcomes with members. The first MCO should resume internal file reviews and include an indicator to measure teams' reassessment performance. The second and fourth MCOs should focus improvement efforts to ensure teams reassess members when warranted. The second MCO also should reassess members' preferences, outcomes and psychosocial status routinely and document all findings, not just changes, during health reviews to avoid having to look through historical documentation to determine members' baseline status. To ensure efficient and effective documentation, the third MCO should eliminate duplicative assessments within its electronic care management system and create clear expectations for the use of the system's features.

Service Planning

Timeliness of Initial Plans

Since last year's EQR, the rate at which an MCO made timely decisions about requests declined. Reviewers observed that many teams delayed decisions for newly enrolled members until they completed initial comprehensive assessment. Many initial ISPs listed care management as the only service at the time of enrollment and sometimes up until the time that teams completed the initial MCP. Gathering information, getting to know members, and completing the initial comprehensive assessment must be balanced with DHS contract required timeframes for decision making. Decisions should not be automatically postponed until the newly enrolled member's initial assessment is complete.

- **Recommendation:** MCOs must ensure that all members receive decisions about requests within contract timeframes and that members receive necessary services beginning at the time of enrollment.

Comprehensiveness of Most Recent Plan

MCPs must be comprehensive and include details about members' strengths and outcomes to provide a unique description of the member and a clear understanding of the approach teams use to coordinate care and services. MCPs and ISPs together must provide a unique description of the individual to assist the team, the member, and any service provider or other authorized party to have a clear understanding of the member's needs, strengths, and desires and how teams coordinate care and services. While overall plan comprehensiveness improved since last year's EQR an MCO has the opportunity to improve more. Reviewers observed that some teams refer

to information in other sections of the MCO's electronic care management system or in previous plans instead of ensuring they include details and historical information in the current plan. For example, an MCP stated, "Refer to [the electronic care management system] for past/present health problems, medications, allergies, wellness flow sheet and immunization status. Members preferences remain as previously stated. Interventions remain as previously stated." Members and other providers do not have access to the system or historical plans unless they retained a copy of documentation from an earlier date.

The MCO should focus on the member's outcomes and the services and supports necessary to achieve those outcomes. While teams structure all MCPs to contain similar outcomes generated from a drop-down menu, some teams successfully implemented personal information about member goals and outcomes within other areas of the MCP.

- **Recommendations:** The MCO must focus MCPs on members' outcomes and ensure teams document the outcomes in a manner that reflects members' voices. It should guide and instruct staff about best practices for comprehensiveness of MCPs and ISPs, educate teams about the expectations, and monitor the comprehensiveness of MCPs and ISPs for improvement. It should revise and refine the internal file review process to ensure the MCP format change does not diminish the MCP improvements.

A dated signature on the MCP and ISP by the member and their activated health care power of attorney or legal guardian signals agreement with the plan. At the same MCO as above, reviewers observed some instances the member, activated health care power of attorney or legal guardian signed but did not date plans case notes did not provide evidence that teams reviewed the plan on the date of the team's signature. Reviewers also observed inconsistent practice of involving both the member and activated alternate decision maker. In some instances, teams only reviewed plans with and secured signatures of members even though they had an authorized, legal representative. In other instances, teams only reviewed plans or secured signatures by persons other than members even though the person was not yet authorized to make those decisions for the member. Although this MCO sought a legal opinion and does not consider the MCP a healthcare document, inclusion of the member and their authorized representative and other supports as desired is a founding philosophical element of Family Care. The MCO's internal file review process found that the member or guardian signed ISPs and MCPs within timeframes at least 96 percent of the time during 2008 and at least 95 percent of the time during the first quarter of 2009. The difference between the MCO's findings and MetaStar's findings are due to different review processes. According to the MCO's file review guidelines, the MCO considers ISPs and MCPs signed by the member or the guardian to be timely. The MCO documents attempts by the team to secure the signature, whether the team actually obtained the signature. These details differ from MetaStar's process approved by DHS.

- **Recommendations:** The MCO must ensure that dates accompany members' signatures and those of their authorized representatives. It must secure the agreement of the member, their legal authorized representative, and other supports the member designates in the development and review of MCPs and ISPs.

Another MCO should consider whether its current MCP structure focuses on members' needs rather than strengths and outcomes. A numerical scale at the top of each outcome section indicates the level of needs in applicable areas based on needs identified in the LTC FS and the MCO's assessments. The assurance of members' health and safety begins by identifying and addressing their needs.

- Recommendation: Because members' outcomes are central to the Family Care philosophy, this MCO should focus MCPs on members' strengths and outcomes to enhance the member-centered care that this MCO strives to provide.

Teams develop plans with members and their supports. However, teams at one MCO mail out completed MCPs to members and guardians for signature after they are finalized in the MCO's electronic documentation system.

- Recommendation: While the practice of mailing signature pages may be a necessity in some instances, MetaStar recommends that the MCO ensures its standard practice includes obtaining members' agreements with the plan in person. If guardians cannot be present review the MCP with them by phone before mailing for signature.

Currently, the MCP structure an MCO provides to its CMUs allows only one member outcome per page. While the MCO indicates its teams can document multiple member outcomes by using multiple pages, the CMR found that teams appear to develop plans with a single member outcome which appears to be a general, broad statement about many things important to members.

- Recommendation: MCPs must include outcomes identified with all members, both new and existing enrollees, and be documented in a manner which clearly reflects members' voices.

One MCO has a form which members who are competent and cognitively aware may complete to designate another person to represent the member in care planning activities and sign MCO forms such as MCP signature pages. One record in the MCO's sample of CMR records reviewed contained this form; however, the care manager relied on the designated individual rather than working to include the member in the MCP process. Supervisors indicated that although the alternate signatory process exists, teams should continue to include the member in plan development and review.

- Recommendation: The MCO should obtain guidance from DHS about the MCO's process that members can designate an alternate decision-maker or signatory. If the process continues teams must include and engage the member in the MCP development and review.

Recommendation to DHS:

DHS should provide guidance to the MCO on the above process.

Timeliness of Most Recent Plan

The CMR found that teams at one MCO review plans with members on time at an appropriately scheduled interval, but the review also found that teams did not consistently update MCPs or ISPs at non-scheduled intervals for members with changes. The MCO's internal file review results showed that teams did not update 38 percent of plans. Teams bring along the previous MCP or ISP to review with members to create a current plan. This approach is a good foundation for member centered care and helps members to become familiar with their plans. However, teams return to the office to create the new version of the plan and often mail the new plan to members or guardians for signatures. Reviewers noted some instances where teams had to track the return of the signature pages or their return took extended amounts of time. During conversations with teams some registered nurses and care managers expressed that members were not sure what their plan was or what it meant relative to the care they received as members of the MCO. The MCO has an opportunity to expand its current plan development and review process and make planning more efficient by reducing the time it spends tracking signature pages. It can provide members another opportunity to understand how the plan guides their care.

- **Recommendations:** This MCO must ensure teams update MCPs and ISPs when members experience changes in their situations and conditions. Teams should review the final updated MCP or ISP with members and secure needed signatures during a face-to-face visit.

Plan Updated for Significant Changes

While only one member in an MCO's small sample of CMR records did not have an updated MCP despite a change in condition, the MCO's internal file review results demonstrated varying compliance during the first three quarters of 2008 (83 percent to 97 percent). Due to the changes in this MCO's documentation systems the MCO suspended file reviews. The MCO acknowledged that resuming file reviews as soon as possible was a priority. MetaStar and the MCO agreed that continued monitoring is imperative. The MCO also agreed that it must do focused monitoring to ensure the link between assessments and MCPs results in plans that are comprehensive, accurate, and current.

- **Recommendations:** The MCO should resume internal file reviews and ensure that teams update plans for significant changes in members' conditions and situations.

Timeliness of Service Authorizations

DHS requires MCOs to make decisions about requests within specified timeframes. An MCO currently monitors denials to ensure teams make decisions in a timely manner. In the past the MCO monitored all decisions through its internal file review process. The MCO indicated it would soon implement a process that would gather data about all approvals and denials from its electronic care management system. The MCO planned to add an element to its file review process to assure the system data were valid. The rate at which another MCO made decisions within specified timeframes declined slightly since the 2008 EQR. In records and during team conversations MetaStar identified the need to gather additional information to make a decision contributed to delays. The CMR identified three instances when occupational therapy and

physical therapy consultations caused decisions to extend beyond timeframes. During discussions CMU staff reported that some providers completed consultations more quickly. Teams use these providers when time constraints exist. Additionally, some teams may not understand that others can request items on behalf of members and teams can consider requests for items outside of the Family Care benefit package. It was clear that CMUs have different expectations for teams to use the RAD method. Some CMUs require teams to use the RAD method for all decisions, and some teams indicated that other CMUs did not have the same requirements.

- Recommendation: MCOs must ensure that teams make all service authorization decisions within contract timeframes through consistent, systematic monitoring. The second MCO needs to develop and implement strategies to ensure teams make service authorization decisions for approvals and denials within the contract specified timeframes. The MCO must respond to requests for services and make decisions within required timeframes. Education and feedback through focused monitoring may be two methods to improve teams' understanding and practice. The MCO should establish a consistent practice across all CMUs about the use of the RAD method.

During QCR team discussions, an MCO's teams voiced a clear understanding of the timeframes to respond to requests. This MCO has written expectations which convey the contractually required timeframes. It established methods for teams to document the decision making process in a structured way through its implementation of the ROSDD (Request, Outcome, Support option, Discussion, Decision), what they consider to be a "shortcut way to document the RAD." Despite both of these facts, this MCO's rates for timely decision making declined since the 2008 CMR. In 2008 the MCO expanded Family Care into neighboring counties, and care management staff including team members and supervisors from the original county served as mentors to new staff in two new counties. The decline in timely decisions could be due, in part, to obligations related to organizational development as a result of the expansion initiative.

- Recommendation: The MCO must ensure that teams make decisions about services within contract timeframes and implement focused monitoring.

Risk Addressed when Identified

While teams respect members' preferences and rights to choose, MCOs must maintain the responsibility to continually inform and educate members about the potential consequences associated with their preferences and choices and offer interventions that reduce harm and minimize risks. The record review at an MCO identified instances when adhering to members' preferences placed members at risks. Respect for member preferences must not outweigh the responsibility to identify and address risks.

At another MCO the rate at which teams addressed identified risks declined slightly since last year's EQR. Reviewers found risk agreements related to member choice in some members' records but did not always see corresponding information within MCPs. The MCO's internal file review process does not measure whether teams address risks or whether teams write comprehensive MCPs. During discussions with teams in the QCR portion of the review it was

not always clear that teams monitor for and identify the presence of restraints and restrictive measures.

- **Recommendations:** Member choice must be balanced by continued ongoing efforts to reduce harm and ensure members and guardians make informed decisions. MCOs must ensure that teams address risks identified during assessments. Teams should incorporate interventions and education about member risk into MCPs rather than a separate form to maximize team efficiency and member understanding. The second MCO should implement focused monitoring to ensure that teams identify members' risks and create comprehensive MCPs. It also must improve care managers' understanding of restraints and restrictive measures, including the MCO's policy and procedure on restraints and restrictive measures.

Service Coordination & Delivery

Timely Service Coordination

Reviewers observed situations where it appeared that care managers and registered nurses relied on providers to do the bulk of member care coordination such as exploring behaviors, developing behavior plans, facilitating discharges, or ensuring information sharing between multiple providers for members with complex situations. While collaborating with providers is imperative for providing quality member care, the MCO should clarify its teams' responsibilities for certain activities.

- **Recommendations:** The MCO should explore whether it relies too heavily on external providers or informal supports for service coordination. The MCO should reevaluate teams' involvement in service coordination and delivery activities. The MCO could accomplish this by reviewing records of members with hospitalizations and complex care situations and talking with staff and providers. MCO monitoring should also provide insight about whether the current case load ratio of staff to members impacts desired service coordination timeframes.

At one MCO teams often provide services directly to members. Teams may transport members to appointments, and service coordinators may provide short-term skilled nursing tasks until a provider can meet a member's needs. In some instances, it appeared that teams had less contact with members once it involved providers such as home health or hospice. The responsibilities between two agencies providing similar services were unclear. Ultimately, the MCO remains responsible for the provision of care management and the assurance of quality, whether its own service coordinators provide services or services or a contracted agency provides them. The MCO did not have documented expectations about care management practice when it involved providers such as hospice and home health agencies.

- **Recommendation:** The MCO must remain actively involved in members' care and ensure that contractors provide quality care to meet members' needs and the MCO's expectations. Written expectations, additional team education, and ongoing support may be necessary.

Reviewers observed that care managers and registered nurses at one MCO reviewed and signed case notes months after writing them. Staff indicated the delay between the review and signing of entered case notes would not be a future concern once the MCO transitioned to documentation within a new electronic care management system. Once the transition occurs the MCO will require case note entry into the system within five days of team contact.

- Recommendation: Once the system transition occurs the MCO should perform focused monitoring of the newly implemented electronic care management system ensure that teams' case note entry is timely and accurate.

Evidence that MCOs Implement Authorized Services

At one MCO reviewers found provider progress notes embedded within the MCO's case notes but reviewers could not determine if the MCO's service coordinator took action after gathering and reviewing the information. For example, a provider note may have indicated a change in behavior or a new problem, but the MCO's documentation only indicated that the service coordinator reviewed the provider's note. It did not specify what information he or she gathered, what he took as a result, or how he evaluated the interventions. Overall, teams did not consistently determine intervention effectiveness. Timely follow-up to ensure effectiveness and satisfaction is imperative to determine whether the current plan is working as intended.

- Recommendation: The MCO should ensure that case notes clearly document details about information discovered or provided, the actions taken, and the evaluation of those actions.

Follow-up to Ensure Service Effectiveness

One MCO should increase the direct involvement of MCO staff in service coordination and follow-up activities and clearly document these activities.

Participant Centered Focus

Inclusionary Planning

Reviewers found paperwork about alternate decision makers in most records reviewed at one MCO. However, in some instances care managers secured a signature from a person other than the member despite the lack of documentation to indicate this person was the activated health care agent. Although the MCO's contract with its CMUs indicates that advanced directives, guardianship, and power of attorney documentation must be present in member records, it does not mandate the inclusion of activation paperwork.

- Recommendations: The MCO must ensure that care managers know and understand the legal status of members' alternate decision makers. It should require member records to contain paperwork about the activation of health care agents. The MCO must include legal decision makers and continue to include members as part of the

team as much as possible and in accordance with DHS expectations. The MCO should establish clear care management expectations when legal decision makers do not fulfill their duties and fully participate in the member's care. The MCO should educate care managers about its expectations and monitor to ensure they implement them.

Timely Issuance of Notices of Action

MCOs must ensure that teams issue notices of action in a timely manner. One MCO's *Notice of Action* tracking log does not capture when a member made a request but the team did not issue a notice. Results from the MCO's internal file reviews indicated only 57 percent of members received a notice of action when warranted, while the *Notice of Action* log indicated teams issued notices in a timely manner 99 percent of the time.

- **Recommendation:** For the MCO to ensure that members receive notices of action in a timely manner the MCO should reconcile results from internal file reviews with its *Notice of Action* log to ensure that teams issue them when warranted within contractual timelines.

The rate at which one MCO's members receive notices of action declined since the 2008 EQR. The MCO has documented expectations about notices of action and monitors the issuance of notices of action through its internal file review process. MetaStar reviewers' findings differ from rates reported through the MCO's internal file review process. During 2008 the MCO found that CMUs issued notices at a combined rate of 83 percent. Results from the first quarter of 2009 found that CMUs issued notices between 92 and 100 percent of the time. The MCO's reviewer guidelines indicate it only monitors instances when teams reduce services or deny requests.

Reviewers found situations in which teams did not issue written notice when decisions for requests they extended beyond the initial fourteen-day timeframe but did document the member's verbal agreement in case notes. Reviewers found differing expectations in the MCO's contract with its CMUs. One area of the contract indicates that service authorization decisions may be extended to 28 days if documentation in the member record reflects that the member approved of the extension. Another area indicates that the MCO must issue a written notice.

- **Recommendations:** When decisions about requests cannot be made during required timeframes the MCO must issue written notices to members and secure the member's agreement. The MCO should expand its internal file review process to monitor the issuance of notices for decision making extensions. The MCO should explore other reasons why they do not issue notices or do not issue them in a timely manner. It should determine an effective solution to remedy its non-compliance with this requirement.

During the 2008 CMR one MCO issued every notice of action when warranted. The results of its 2009 CMR indicate a substantial decline in this process. Although only a small number of records in the MCO's review sample applied to the review criteria it appeared that teams did not

issue notices of action for decisions that they delayed and extended beyond contract timeframes. The MCO currently monitors notices of action, but it does not monitor the timeframes when requests result in approvals.

- Recommendations: The MCO must ensure it issues notices of action when approvals extend beyond contract timeframes. Similar to MetaStar's recommendations from the 2008 EQR, the MCO must implement an internal file review process to ensure it provides quality, timely care to its members. Doing so will not only ensure that the MCO delivered quality care, but it should also give the MCO additional information about actual care management practice, how it differs from current policies and processes, and areas where teams need additional guidance and education.

MCOs Offer the Self-Directed Supports Option

MCOs should ensure that teams include contractually required language offering SDS on MCP and ISP signature pages. They should ensure that care managers documenting SDS offers to all members and verify check boxes and signatures that confirm members' choices to accept or decline the offer.



WISCONSIN FAMILY CARE PARTNERSHIP/PACE MCOs' COMPLIANCE WITH MANAGED CARE REGULATIONS

WISCONSIN FAMILY CARE PARTNERSHIP/PACE MCOs: EXECUTIVE SUMMARY

The 2008 EQR of the Family Care Partnership (FCP) and Program of All-Inclusive Care for the Elderly (PACE) determined whether Wisconsin prepaid inpatient health plans that deliver care and services to members who are eligible for the FCP and PACE programs were in compliance with federal Medicaid Managed Care Regulations.

The EQR has three review components:

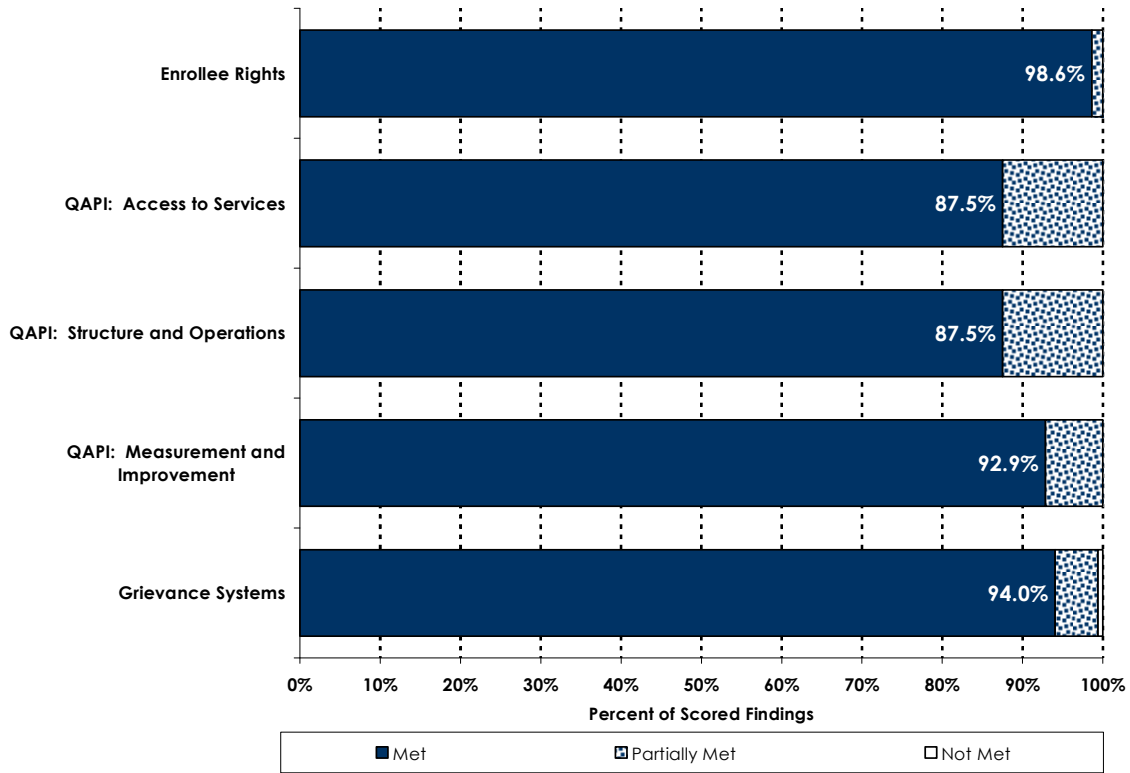
- The **Quality Compliance Review (QCR)** identifies and documents five practice categories of each MCO with an FCP or PACE program that affects the quality and timeliness of the care and services its FCP or PACE members receive, and their access to those services.
- The **Validation of Performance Improvements Projects (PIPs)** ensures that each FCP MCO developed and implemented two contractually required annual PIPs using proper technique and design so that the MCOs can use the projects' data and findings for their organizational decision making.
- The **Care Management Review (CMR)** determines each MCO with a FCP or PACE program's level of compliance with its DHS contract, its ability to safeguard members' health and welfare, and 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 four FCP and PACE programs at three MCOs fully met most of the QCR standards. Only one program received not met finding. Overall the MCOs' performance is similar to what MetaStar found during the 2007 EQR.

Chart 11: 2008 QCR Findings by Category for MCOs with FCP or PACE Programs

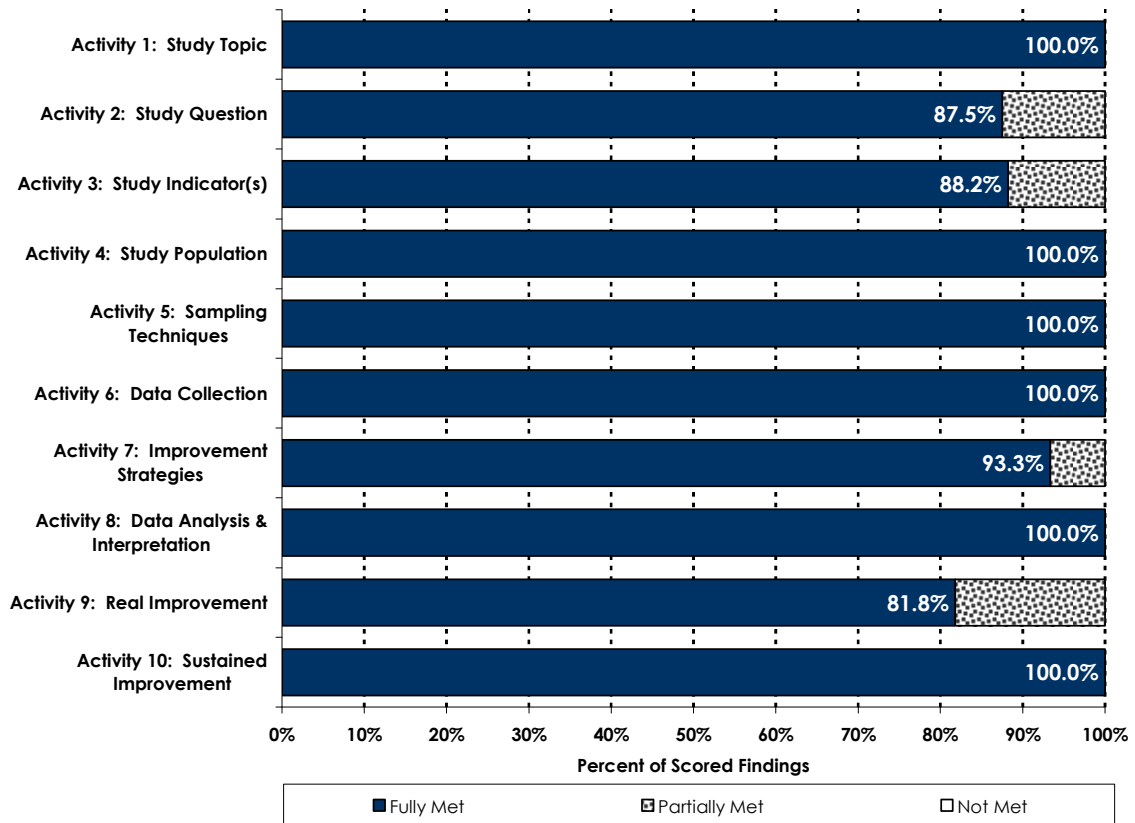


Compared to the other QCR categories, the MCOs experienced some difficulty meeting the *QAPI Access to Services* standards and the *QAPI Structure & Operations* standards.

Validation of Performance Improvement Projects

Every MCO serving members enrolled in the FCP program was in compliance with the contract requirement to submit two PIPs to DHS. In 2008 the MCOs worked on PIPs related to persistent pain, home care, mission effectiveness, scheduling management and diabetes. Although some MCOs crafted and implemented PIPs better than others, all MCOs struggled with at least one aspect of their projects. Overall, the PIPs showed substantial improvements between the 2007 and 2008 reviews in data collection procedures and implementing PDSA cycles. All MCOs should move ahead with their PIPs and seek technical assistance from MetaStar as needed.

Chart 12: 2008 PIP Validation Findings by Activity for MCOs with FCP or PACE Programs



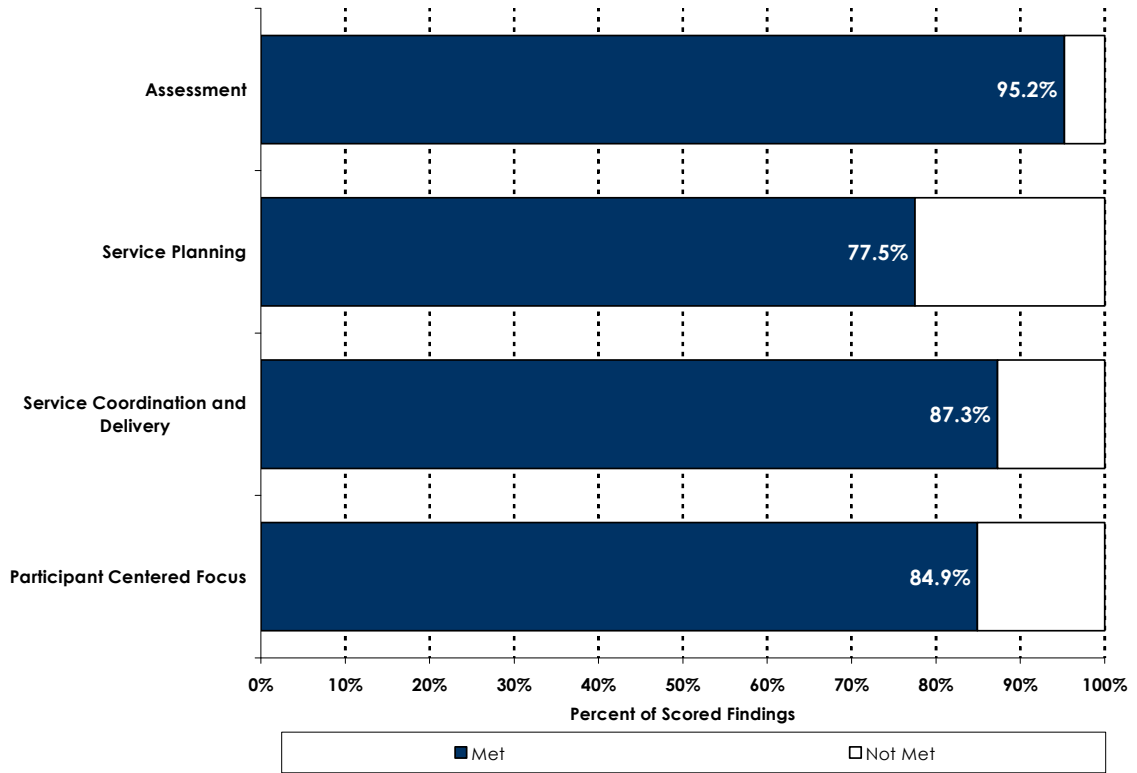
Care Management Review

During the on-site 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 CMRs for MCOs with FCP or PACE programs

MCOs demonstrated exceptional performance in determining that teams implemented authorized services, used collaborative methods among their teams to plan for and manage their members' care, completed risk assessments when indicated, developed comprehensive initial assessments and involved the members, their guardians, family and informal supports in planning.

MCOs showed difficulties incorporating member preferences and outcomes in care plans and ensuring that each member's most recent plan is comprehensive.

Chart 13: 2008 CMR Findings by Category for MCOs with FCP or PACE Programs



QUALITY COMPLIANCE REVIEWS

BACKGROUND & PURPOSE

The 2008 QCRs of MCOs that administer the FCP or PACE programs determined whether the MCOs deliver care and services to members eligible for the FCP and PACE programs complied with federal Medicaid Managed Care Regulations. Three MCOs conduct these programs in Wisconsin:

- Care Wisconsin: Family Care Partnership (CW-FCP)
- Community Health Partnership: Family Care Partnership (CHP-FCP)
- Community Care: Family Care Partnership and PACE (CC-FCP, CC-PACE)

MetaStar conducted the QCRs in accordance with Federal Regulation 438, Subpart E using 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 QCR process reviews, identifies, and documents each MCO's practices that affect the quality and timeliness of the care and services its FCP or PACE members receive and their access to those services. Five topic areas make up the protocol:

- Enrollee Rights
- QAPI Access to services
- QAPI Structure & Operations
- QAPI Measurement & Improvement
- Grievance Systems

REVIEW METHODOLOGY

For the 2008 review the MetaStar EQR team reviewed all five topic areas of the QCR protocol. MetaStar also evaluated each MCO's annual workplan, tracking logs, any updated policies and procedures, and QI projects.

To evaluate the PACE program, MetaStar used the 2008 PACE contract between Community Care, Inc. and the Department of Health and Family Services (DHFS) Division of Long Term Care. To evaluate the FCP program, MetaStar used each FCP MCO's 2008 Health and Community Services contract with the DHFS Division of Long Term Care.

Each MCO submitted all requested documents to MetaStar. These did not include any documents used for the 2007 reviews unless a MCO's documents had changed since then. The MetaStar EQR team assessed the documents before the on-site visits so it could tailor its questions to each MCO.

The MetaStar EQR team interviewed MCOs' various staff from numerous departments and functions. Prior to each on-site visit MetaStar's EQR team asked each MCO to arrange for members and providers in the MCO's provider network to be available for personal interviews.

Compiling & Analyzing Findings

MetaStar used a three-point rating structure (met, partially met, and not met) to assess each MCO's compliance level with the QCR protocol standards.

- **Met** applied when all policies, procedures, and practice were in alignment to meet the standard.
- **Partially met** applied when a MCO met the standard in practice but lacked written policies or procedures, or when the MCO had not finalized or implemented draft policies.
- **Not met** applied when the MCO did not meet the standard in practice and had not developed policies or procedures.

Reporting Evaluation Results to DHS

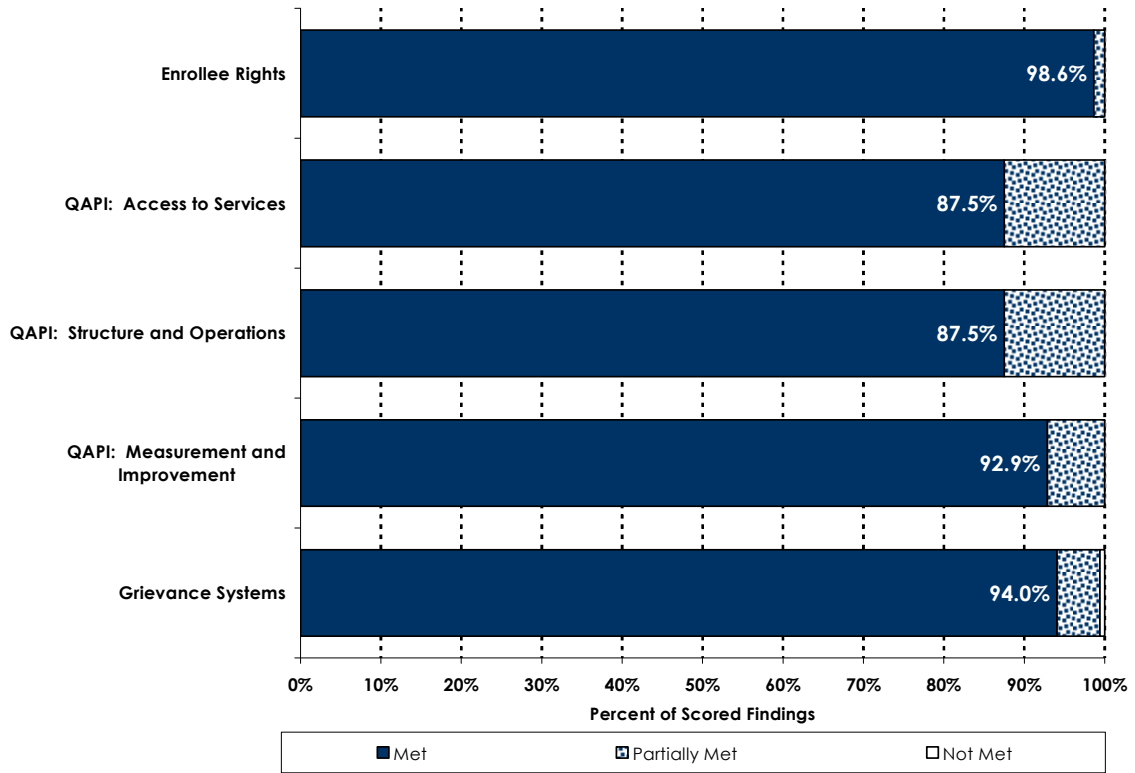
For each MCO the MetaStar EQR team compiled its findings into a preliminary written report that allowed the MCO to offer additional information. MetaStar received each MCO's comments, and considered and incorporated them into a final report. Each MCO's final report details how well it complied with its contract and the QCR protocol standards during the review period.

OVERALL FINDINGS

On average the four programs at the three MCOs fully met most of the QCR standards. Only one MCO/program had a not met finding, in the *Grievance Systems* category. Overall, the MCOs' performance is similar to what MetaStar found during the 2007 EQR.



Chart 14: 2008 QCR Findings by Category for MCOs with FCP or PACE Programs



In aggregate, the MCOs struggled most to meet the *QAPI Access to Services* standards and the *QAPI Structure & Operations* standards.

None of the MCOs FCP or PACE programs fully met every QCR standard, but all programs met the majority of standards. All four programs across the three MCOs fully met more than 90 percent of the standards. Compliance rates varied within the five QCR review areas. Two of the four programs met 100 percent of standards in at least one of the five review areas.

Table 27: 2008 Percent of Fully Met QCR Standards by MCOs with FCP or PACE Programs

Program	MCO	Enrollee Rights	QAPI Access to Services	QAPI Structure & Operations	QAPI Measurement & Improvement	Grievance Systems	All QCR Standards
FCP	Care Wisconsin (CW-FCP)	100.0%	85.7%	83.3%	92.9%	90.5%	91.4%
	Community Care (CC-FCP)	97.3%	85.7%	88.9%	92.9%	95.2%	92.8%

Program	MCO	Enrollee Rights	QAPI Access to Services	QAPI Structure & Operations	QAPI Measurement & Improvement	Grievance Systems	All QCR Standards
	Community Health Partnership (CHP-FCP)	100.0%	92.9%	88.9%	92.9%	95.2%	95.0%
PACE	Community Care (CC-PACE)	97.3%	85.7%	88.9%	92.9%	95.2%	92.8%
MCOs with FCP or PACE programs		98.6%	87.5%	87.5%	92.9%	94.0%	

Appendix 6 contains detailed findings for each MCO's FCP or PACE program.

Most MCOs had difficulties related to meeting contractual requirements on time. All MCOs partially met the requirements to complete and approve MCPs and ISPs and send notices of action and service authorization denials in a timely manner. Some MCOs need to improve their compliance with requirements to have quarterly face-to-face meetings with FCP and PACE program members and follow service authorization policies and procedures.

ENROLLEE RIGHTS

Every organization has a responsibility to help its members understand their rights so they can make informed decisions about the care and services they receive.

The MetaStar EQR team interviewed appropriate MCO staff to determine compliance with the *Enrollee Rights* standards. During each interview, MetaStar reviewers obtained feedback from MCO administrative staff and teams about each *Enrollee Rights* standard. The MetaStar EQR team also interviewed members and providers to learn about their experiences working with the MCO. MetaStar used some of the information from these interviews to determine MCOs' compliance with the *Enrollee Rights* standards.

The *Enrollee Rights* category encompasses a wide variety of issues that MCOs must communicate clearly to its staff, contracted providers, and members. Appendix 6 contains every *Enrollee Rights* standard by MCO and FCP or PACE program. MCOs fully met the member rights standards over 98 percent of the time, on average, a slight overall improvement from the 2007 EQR. MetaStar did not score any *Enrollee Rights* standards as "not met" during the 2008 EQR. Two programs met every *Enrollee Rights* standard and the other two partially met all but one of the standards. MCOs demonstrated strong commitments to treating their members with dignity, respect and consideration for members' privacy.

MCOs struggled most to meet the requirement to provide the names, locations, telephone numbers of, and non-English languages spoken by current contracted providers to all members. Half of the programs met this standard; the other half partially met it.

Table 28: 2008 Enrollee Rights Findings for MCOs with FCP or PACE Programs

Of 39 standards, two do not apply to MCOs with FCP or PACE programs.. N = 37 standards

Program	MCO	Met	Partially Met	Not Met
FCP	Care Wisconsin (CW-FCP)	37	0	0
	Community Care (CC-FCP)	36	1	0
	Community Health Partnership (CHP-FCP)	37	0	0
PACE	Community Care (CC-PACE)	36	1	0
All Wisconsin MCOs with FCP or PACE programs				
Average		36.5	0.5	0.0
Percent of Standards		98.6%	1.4%	0.0%

The MCOs demonstrated understanding of the vast majority of the *Enrollee Rights* standards and implemented processes to ensure they met members’ rights. Half of the programs partially met one *Enrollee Rights* standard. The other two programs fully met every *Enrollee Rights* standard.

MCO Strengths

The MCOs demonstrated compliance with the majority of the *Enrollee Rights* standards. All MCOs:

- Have written policies on member rights.
- Ensure their staff and contracted providers take members’ rights into consideration when furnishing services to them.
- Provide informational and instructional materials to potential members and current members in a manner, and format, and language members can understand.
- Make written MCO information available in the prevalent, non-English languages in their service areas when necessary.
- Provide interpretation and translation services to their members free of charge.
- Have written material available in alternate formats that take into account the special needs of their members.
- Notify members of their right to request and obtain information at least once a year about their rights.
- Provide enrollment information to new members in a timely manner.

- Notify members at least thirty days before it implements a significant change in member rights.
- Tell affected members within fifteen days whenever a provider is no longer contracted to provide services.
- Allow freedom of choice for female members to access a woman's specialist or when age-appropriate obtain the services of qualified family planning providers.
- Give information to their members on their right to file an appeal or grievance, how and when to file, who is available to help members file, when and how hearings occur, and the different levels of hearings available to members (at the local level through the MCO, at the DHS level, or at the State fair hearing level).
- Give detailed information to providers on their right to file an appeal or grievance if a MCO does not cover a service already furnished.
- Provide detailed information so that all members understand the amount, duration, and scope of benefits available once they enroll in a MCO and the relevant procedures for obtaining these benefits; available treatment options or alternatives and the risk, benefits and consequences of treatment and non-treatment; how to obtain a second opinion; and, information about post-stabilization care service rules related to the financial responsibility of care provided.
- Inform members how to obtain:
 - Services from providers outside of the MCOs' contracted provider networks.
 - After hours and emergency services.
 - Referrals for specialty care and other benefits not furnished by members' primary care providers.
 - Benefits that are available under the Wisconsin Medicaid program but are not part of a MCO's benefit package.
- Explain each member's responsibility to pay a cost share, an amount based on each member's ability to pay toward the cost of member's care.
- Provide grievance, appeal, and fair hearing procedures and timeframes in a DHS-developed or DHS-approved description that includes the right to file grievances and appeals and for State fair hearing the right to a hearing, the method to obtain a hearing, and the rules that govern representation at the hearing.

- Inform members about advance directives, applicable Wisconsin law, and if the law changes information about the law change within ninety days of the effective date of the change.
- Inform members with complaints concerning non-compliance with an advance directive that they may file a complaint with DHS DQA.
- Have processes to assist members with limited decision making abilities to understand advance directives or give information on advance directives to members' families or surrogates.
- Document in members' medical records whether members' have executed advance directives, educate their staff on MCOs' advance directive policies and procedures, and provide community education on advance directives directly or in partnership with contracted providers.
- Did not identify any providers who provided care that conflicted with members' advance directives.
- Must not charge members for services included in the FCP or PACE benefit packages.
- Should provide to the extent available quality and performance indicators such as disenrollment rates and member satisfaction.

All members:

- Are guaranteed the right to be treated with respect and due consideration for their dignity and privacy.
- Are guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Have the right to be furnished health care services.

Improvements from Previous Reviews

Compared to the previous year in the 2008 review the four programs improved upon their strengths and met more of the *Enrollee Rights* standards.

Table 29: 2007 – 2008 Enrollee Rights Findings for MCOs with FCP or PACE Programs

	Met	Partially Met	Not Met
2007 Percent of Standards	97.3%	2.7%	0.0%
2008 Percent of Standards	98.6%	1.4%	0.0%
Change	+ 1.6%	- 1.3%	--

Note: Improvement over time is evident when the percent of Met findings increases, the percent of Partially Met findings decreases, or the percent of Not Met findings decreases.

CHP-FCP

During the 2007 review MetaStar reviewers noted that CHP-FCP’s online provider directory informed users of the non-English languages spoken by providers but the MCO’s written materials it distributed to members did not contain these details. Prior to the 2008 review CHP-FCP’s provider relations department queried providers about their capacity to speak alternate languages, included this information in the online directory on CHP-FCP’s website, and distributed an updated provider directory to members.

CW-FCP

CW-FCP improved between the two reviews to fully meet the requirement to provide detailed information about grievances and appeals to its members. Teams review appeal and grievance rights with members every six months during care plan reviews or sooner if issues arise. The MCO attaches to the notice of action form information about appeal rights, titled *What If I Do Not Agree with This Decision*, and the document refers members to the MCO’s *Evidence of Coverage* booklet for more information.

CC-FCP & CC-PACE

CC-PACE improved from a not met finding in 2006 to a partially met finding in 2007 related to its responsibility to inform members they can file with DHS DQA their complaints about non-compliance with their advance directives. In the 2008 review CC-PACE fully met this requirement. Based on a recommendation from the 2006 review for CC-PACE program the MCO amended its 2007 PACE member handbook to include information on how members can file a complaint about non-compliance with an advance directive. However, at the time of the 2007 review Community Care had not provided this information to its PACE members. By the 2008 review CC-PACE and CC-FCP included information on how to file a complaint about non-compliance with an advanced directive in their member handbooks.

MCO Opportunities for Improvement & EQRO Recommendations

MCOs and their programs did not uniformly meet the following *Enrollee Rights* standards at the time of their 2008 EQRs.

Non-English Languages Spoken by Providers

Two of the four programs met the requirement to give information to its members about the non-English languages spoken by providers. These two programs partially met this requirement for four years. Two programs updated their provider directories but they still omit the non-English languages its long-term care providers speak.

- Recommendations: These programs should distribute the approved provider directories to all members. They should query long-term care providers to determine their non-English language capacity and give members this information in writing.

QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT: ACCESS TO SERVICES

Each MCO and program must demonstrate it can provide services to its members through an adequate provider service network of service providers. Its contract with DHS requires each MCO and program to develop a provider network that is large enough, has a broad enough geographic distribution, and a wide enough range of services to serve its members. Once an MCO/program establishes a provider network it is required to develop processes to authorize service requests to ensure members have access to all services within the program's benefit package.

The MetaStar EQR team interviewed appropriate MCO administrative and team staff to determine each MCO/program's compliance with the *QAPI Access to Services* standards and obtained feedback about each *QAPI Access to Services* standard. The MetaStar EQR team also interviewed members and providers to learn about their experiences working with the MCO. MetaStar used some of the information from these interviews to determine program compliance with the *QAPI Access to Services* standards.

Appendix 6 contains detailed findings about every *QAPI Access to Services* finding by MCO and FCP or PACE program.

All MCOs require providers to sign a contract or a letter of agreement which gives the MCOs new providers' characteristics and updated information about providers already under contract. MCOs review service access complaints and grievances to determine if provider networks meet members' needs. When existing contracted providers cannot meet members' specialized needs or provide necessary care the MCOs identify and use out-of-network providers to ensure they meet members' needs. MCOs are responsive to the members' needs and try to recruit providers into their contracted networks to meet those needs. When MetaStar's EQR team interviewed providers under contract with the MCOs most described their relationships with the MCOs as collaborative.

Combined, the four programs at the three MCOs fully met 24 of the 28 *QAPI Access to Services* standards. CHP-FCP performed the best of the four programs in this category by fully meeting 26 of the standards and partially meeting two standards.

Only CHP-FCP fully met two *QAPI Access to Services* standards. The other three programs partially met the requirements for MCOs and their subcontractors to have in place and follow written policies and procedures when processing requests for initial and continuing authorization of services. DHS requires the MCOs to notify the requesting provider and give the member written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested.

Table 30: 2008 QAPI Access to Services Findings for MCOs with FCP or PACE Programs

N = 28 standards

Program	MCO	Met	Partially Met	Not Met
FCP	Care Wisconsin (CW-FCP)	24	4	0
	Community Care (CC-FCP)	24	4	0
	Community Health Partnership (CHP-FCP)	26	2	0
PACE	Community Care (CC-PACE)	24	4	0
All Wisconsin MCOs with FCP or PACE programs				
Average		24.5	3.5	0.0
Percent of Standards		87.5%	12.5%	0.0%

The MCOs demonstrated understanding of and fully implemented most of the *QAPI Access to Services* standards. MetaStar rated at least two *QAPI Access to Services* standards rated as partially met for each of the four programs.

MCO Strengths

All MCOs:

- Maintain and monitor networks of appropriate providers supported by written agreements and sufficient to provide adequate access to all contractually covered services.
- Consider anticipated Medicaid enrollment and expected service utilization to establish and maintain the provider network.
- Consider the number and types of providers required to furnish the contracted services.
- Provide for female members direct access to a women’s health specialist in addition to primary care.

- Provide for 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.
- Obtain in a timely manner and provide as long as necessary adequate services for their members when provider networks cannot provide contractually covered necessary medical services.
- Work with out-of-network providers to ensure that the cost of services to members is no greater than it would have been if furnished within the provider networks.
- Inform providers of the need to ensure timely access to care and services taking into account the urgency of need for services.
- Ensure providers make medically necessary services available at all times to members who need them.
- Cover and pay for emergency services despite whether the provider or entity that furnishes the care is in the provider network. MCOs do not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.
- Guarantee that a person or entity coordinates each member's primary health care services appropriate to each member's needs.
- Coordinate members' care with other providers and MCOs and share the results of members' assessment needs to keep MCOs from duplicating services and activities, all the while protecting members' privacy.
- Provide services to all members because of their special health care needs.
- Assess its members' ongoing special conditions that require a course of treatment or regular care monitoring by appropriate health care professionals.
- Facilitate access to specialists appropriate for members' special health care conditions and needs.
- When authorizing initial and continuing services consult with providers requesting the services when appropriate.
- Work with health care professionals with appropriate clinical expertise in treating members' conditions or diseases when deciding to deny a service authorization request or authorize a service in an amount, duration, or scope that is less than what was requested.

- Ensure that people who perform utilization management activities for the MCOs do not have incentives to deny, limit, or discontinue medically necessary services for any member.
- Do not hold members liable to pay for screening or treatment needed to diagnose a specific condition or stabilize the member. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is stabilized for transfer or discharge. The MCO must pay for post-stabilization care services.

MCO Improvements from Previous Reviews

In 2008 as a group the four programs at the three MCOs fully met slightly fewer standards than during their 2007 reviews. The number of partially met findings increased but MetaStar scored none of the standards as “not met.”

Table 31: 2007 – 2008 QAPI Access to Services Findings for MCOs with FCP or PACE Programs

	Met	Partially Met	Not Met
2007 Percent of Standards	88.6%	10.7%	0.7%
2008 Percent of Standards	87.5%	12.5%	0.0%
Change	- 0.9%	+ 1.8%	- 0.7%

One MCO made one improvement between the 2007 and 2008 reviews. Community Care updated its written and online FCP and PACE provider directories to indicate when primary care physicians do not accept new members.

MCO Opportunities for Improvement & EQRO Recommendations

The MCOs/program did not uniformly meet the following *QAPI Access to Services* standards.

Complete & Approve Members’ Care & Service Plans in a Timely Manner

All four programs partially met the requirement to complete and approve members’ ISPs and MCPs in a timely manner. The CMR review of three programs found teams and members signed care plans within six months prior to the 2008 review in 71 to 83 percent of member records. The other program’s CMR showed only 47 percent of plans were comprehensive. The majority of this program’s plans did not include how the program provided acute and primary care to members.

- Recommendations: MetaStar instructed one program to develop and implement a method to ensure care plans provide a unique description of the member and describe the approach the team uses to coordinate the member’s care and services. MetaStar advised another program to develop and implement a method to ensure it reviews care plans within six months in accordance with their contracts. The other two programs

should improve the percentage of care plans they develop and sign within contract timeframes. MetaStar advised each MCO to collect data from its monitoring efforts and perform data analysis to determine if they need to develop improvement plans.

Following Service Authorization Policies & Procedures

Three programs partially met the requirement for MCOs and their subcontractors to have in place and follow written policies and procedures when processing requests for the initial and continuing authorization of services. Although two programs have written policies and procedures about timely decision making, the results of their internal monitoring efforts and their 2008 CMRs demonstrated that these organizations did not follow these policies and procedures. The programs did not use an internal monitoring process. They developed a tool to monitor member records but not monitor decisions related to the timeliness of approvals, only denials. The third program's approved service authorization policy incorporated the RAD method and stated that teams should use the RAD as the mechanism to make decisions. During the 2008 CMR MetaStar teams could not discern that teams used the RAD. However, at this MCO during the 2008 QCR teams relayed a comprehensive understanding of the RAD method to identify members' requests and outcomes to make service authorization decisions.

- Recommendations: MetaStar instructed one program to develop and relay expectations about decision making documentation to ensure its teams follow the service authorization policy developed by DHS. Its MCO should evaluate the use of the RAD method when conducting internal file reviews. The other two programs partially met this standard for two years. They should improve the rate at which they make service authorizations. MetaStar advised all three programs to collect data from their monitoring efforts to determine the best way to make these changes occur.

Timely Notification of Service Decisions, Denials, or Limitations

Three programs did not fully meet the standard to notify requesting providers and give members written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. Two programs developed a *Service Authorization-Team Decision* tracking system to track service authorization request denials or the reduction or termination of existing services. The 2008 CMR found teams of these two programs issued notices of action in a timely manner only 23 to 27 percent of the time. The CMR at the third program found when teams denied, reduced, or terminated services they sent notices of action within contract timeframes 64 percent of the time.

All four programs across the three MCOs did not fully meet the requirement to provide members notice about standard service authorization decisions within fourteen days after requesting a service. One program's 2008 CMR found when teams denied, reduced or terminated services teams sent notices of action within contract timeframes 78 percent of the time. Another program's CMR found teams responded to service requests with an approval or denial within the contract specified timeframe of fourteen days only eighty percent of the time. As noted earlier, two programs have written policies and procedures to guide timely decision making but the

results of their internal monitoring efforts and the 2008 CMR demonstrated that they do not follow these policies and procedures.

- **Recommendations:** MetaStar advised the three programs to track the issuance of notification letters during its internal file review or chart audit processes and collect data from their monitoring efforts to determine the best way to make these changes occur.

QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT: STRUCTURE & OPERATIONS

By creating policies and procedures for key processes MCOs can improve how well staff performs those processes, several of which are tied to contract requirements.

The MetaStar EQR team interviewed appropriate MCO staff to determine compliance with the *QAPI Structure & Operations* standards. During each interview the MetaStar EQR team obtained feedback from MCO administrative and team staff about processes MCOs to ensure they meet the standards. The MetaStar EQR team also interviewed members and providers to learn about their experiences working with the MCO. MetaStar used some of the information from these interviews to determine MCOs' compliance with the *QAPI Structure & Operations* standards.

Appendix 6 contains detailed information about each *QAPI Structure & Operations* standard for each MCO and FCP or PACE program.

DHS expects each of the three MCOs with FCP or PACE programs to implement processes and procedures to meet eighteen *QAPI Structure and Operation* standards. The four MCOs fully met sixteen of the eighteen standards. None of the MCOs met each of the eighteen *QAPI Structure & Operations* standards.

Overall the MCOs struggled to fully meet requirements related to ensuring contracted providers conduct criminal background checks on employees that come into direct contact with MCO members and ensure that teams provide notices of action to members in a timely manner.



Table 32: 2008 QAPI Structure & Operations Findings for MCOs with FCP or PACE Programs

Of 20 standards, two do not apply to MCOs with FCP or PACE programs. N = 18 standards

Program	MCO	Met	Partially Met	Not Met
Family Care Partnership	Care Wisconsin (CW-FCP)	15	3	0
	Community Care (CC-FCP)	16	2	0
	Community Health Partnership (CHP-FCP)	16	2	0
PACE	Community Care (CC-PACE)	16	2	0
All Wisconsin MCOs with FCP or PACE programs				
Average		15.8	2.3	0.0
Percent of Standards		87.5%	12.5%	0.0%

The MCOs demonstrated understanding of the majority of the *QAPI Structure & Operations* standards fully implemented most of them. Each of the three MCOs with FCP or PACE programs had difficulty meeting some standards resulting in scores of partially met during the 2008 EQR.

MCO Strengths

All MCOs:

- Implement written policies and procedures to select and retain providers.
- Follow documented processes to credential and recredential providers who have signed contracts or participation agreements.
- Have provider selection policies and procedures that do not discriminate against practitioners that serve high risk populations or specialize in conditions that require costly treatment.
- Give written notification of their decisions when they decline to include individual or groups of providers in their provider networks.
- Specify to members the reasons for which MCOs may request that DHS disenroll a member and do not request members disenroll for reasons other than those permitted under the MCOs' contracts with DHS.
- Define and implement procedures related to member disenrollment requests to ensure transition plans are in place for members' services and supports.
- Allow members to disenroll when:

- Members move out of a MCO's service area.
- Because of religious or moral objections a MCO does not cover the services the member seeks.
- Members need related services performed at the same time, but not all related services are available within the MCO's provider network, and the member's primary care provider or another provider determines that receiving services separately would subject the member to unnecessary risk.
- The MCO lacks access to services covered under the MCO's contract with DHS or lacks access to providers experienced with a member's health care needs.
- Approve requests for disenrollment under allowable circumstances or refer members' disenrollment requests to DHS with information about the reasons cited in members' requests.
- Inform members who request disenrollment of their disenrollment dates.
- Oversee and are accountable for all functions and responsibilities they delegate to subcontractors.
- Evaluate prospective subcontractors' abilities to perform delegated activities prior to the actual delegation of functions and responsibilities.
- Provide written agreements to their subcontractors which specify the activities and responsibilities designated to the subcontractors and reasons to revoke delegation or impose other sanctions if a subcontractor's performance is inadequate.
- Monitor their subcontractors' performance and subject them to review according to a DHS defined schedule.
- Take corrective action if the MCOs identify subcontractor deficiencies or areas needing improvement.

MCO Improvements from Previous Reviews

Overall in 2008 the four programs at the three MCOs fully met fewer standards than during their 2007 reviews resulting in more partially met findings.

Table 33: 2007 – 2008 QAPI Structure & Operations Findings for MCOs with FCP or PACE Programs

	Met	Partially Met	Not Met
2007 Percent of Standards	91.6%	7.4%	1.1%
2008 Percent of Standards	87.5%	12.5%	0.0%
Change	- 4.1%	+ 5.1%	- 1.1%

Note: Improvement over time is evident when the percent of Met findings increases, the percent of Partially Met findings decreases, or the percent of Not Met findings decreases.

Community Care

Reviewers noted one improvement. In 2008 Community Care developed and implemented a process to credential long-term care FCP and PACE providers and verified the credentials of a random list of providers. These activities moved Community Care from a partially met to fully met score on this requirement.

MCO Opportunities for Improvement & EQRO Recommendations

Provider Disclosure of Participation in Federal Health Care Programs

An MCO stated that it checks with the Office of the Inspector General (OIG) to verify if the OIG excluded a provider from participation in federal health care programs. The MCO stated it keeps a copy of the inquiry in provider contract files. MetaStar reviewers did not find copies of these inquiries in any provider files reviewed.

- Recommendation: The MCO should place a screen print of the OIG website check for each provider in each provider’s file.

Additional State Requirements

MCOs must comply with additional requirements established by the State. In Wisconsin MCOs must ensure that contracted providers perform background checks on staff that work directly with MCO members. MCOs also must meet with members face-to-face at least quarterly. None of the MCOs fully complied with each of the additional requirements.

Criminal Background Checks

One MCO requires all providers to sign a form annually to attest that they have completed background checks on employees that come into direct contact with members. However, the MCO does not have plans to conduct spot checks to verify providers comply with contract requirements. Another MCO does not verify contracted providers conduct the criminal background checks.

- Recommendations: These MCOs should implement processes to verify they and their providers conduct the background checks.

Quarterly Face-to-Face Visits with Members

At the time of its review one program had just begun gathering and analyzing data related to quarterly face-to-face visits between care managers and members. Two programs collect information on quarterly face-to-face contacts with members through its internal file review process. Because they conduct the internal file review on a monthly sample of members they do not review every member file each year. They were updating their electronic care management systems to give management staff the ability to query the system and identify the rate of missed contacts.

- **Recommendations:** These programs should develop and implement a method to collect and analyze data on quarterly care management face-to-face visits for all members and design an improvement plan based on the analysis.

Providing Timely Notices of Action to Members

As noted in the *QAPI Access to Services* section of this report none of the MCOs with FCP or PACE programs fully met the standard to give members notice about their standard service authorization decisions within fourteen days following the request for a service.

- **Recommendations:** MetaStar advised one MCO to continue to monitor the use of its *Decision Due Date Report* and *Member Requests Log* to track the issuance of notification letters during internal file reviews to assure teams respond to members within the contract specified timeframes. Another MCO should use its *Resource Allocation Decision Log* for the same purpose. To improve the rate at which it communicates service authorization denials in writing and within fourteen days of the request, two programs should continue to monitor the *Service Allocation/Team Decision* tracking system. All MCOs should collect and analyze data to determine the best way to change and whether an improvement plan is warranted.

QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT: MEASUREMENT & IMPROVEMENT

Each MCO's contract with DHS requires the MCO to have a comprehensive QAPI program that protects, maintains, and improves the quality of care MCOs provide. The QAPI program description, annual workplan, and annual program evaluation should include information about conducting PIPs, implementing processes to monitor and detect the under- and over-utilization of services, and implementing processes to monitor and assess the quality and appropriateness of care furnished to MCO members.

The MetaStar EQR team reviewed MCO documents prior to the on-site visit and interviewed each MCO's administrative and team staff to determine compliance with the *QAPI Measurement & Improvement* standards. The MetaStar EQR team also interviewed members and providers to learn about their experiences working with the MCO. MetaStar used some of the information from these interviews to determine MCOs' compliance with the *QAPI Measurement & Improvement* standards.

The MCOs with FCP or PACE programs made major improvements to fully meet substantially more *QAPI Measurement & Improvement* standards during their 2008 reviews compared to the 2007 reviews. Together the four programs at the three MCOs fully met eleven of the fourteen standards. Each program partially met only one of the fourteen standards.

Table 34: 2008 QAPI Measurement & Improvement Findings for MCOs with FCP or PACE Programs

N = 14 standards

Program	MCO	Met	Partially Met	Not Met
FCP	Care Wisconsin (CW-FCP)	13	1	0
	Community Care (CC-FCP)	13	1	0
	Community Health Partnership (CHP-FCP)	13	1	0
PACE	Community Care (CC-PACE)	13	1	0
All Wisconsin MCOs with FCP or PACE programs				
Average		13.0	1.0	0.0
Percent of Standards		92.9%	7.1%	0.0%

During the 2008 EQR the FCP MCOs submitted documentation and shared information during the on-site review with the MetaStar EQR team about their PIPs related to persistent pain, home care, mission effectiveness, scheduling management, and diabetes.

MCO Strengths

All MCOs demonstrated understanding of the *QAPI Measurement & Improvement* standards. All MCOs:

- Adopt practice guidelines that:
 - Are based on valid and reliable clinical evidence or a consensus of health care professionals in the relevant field.
 - Consider the needs of the MCO members
 - Are adopted in consultation with contracting health care professionals, and
 - Are reviewed and updated periodically, as appropriate.
- Distribute clinical and practice guidelines and educational materials to all providers affected by the guidelines, all members, and potential MCO enrollees if they ask to see them.

- Make decisions for utilization management, enrollee education, coverage of services consistent with practice guidelines.
- Incorporate practice guidelines into their QAPI programs.
- Have PIPs that achieved significant and sustained improvements in clinical or non-clinical care areas and have favorable effects on health outcomes and member satisfaction.
- Have ongoing PIPs that focus on clinical and non-clinical outcomes.
- Reported the status and results of each PIP to DHS and completed each project in a reasonable time period.
- Use established mechanisms to detect both the under- and over-utilization of services.
- Submitted QAPI program evaluations that included reviews of the impact and effectiveness of their QAPI programs, information on the performance of standard measures they must report, PIP results, and their processes to assess their QAPI programs.

MCO Improvements from Previous Reviews

Overall in 2008 the four programs at the three MCOs improved to fully meet thirty percent more standards compared to during their 2007 reviews.

Table 35: 2007 – 2008 QAPI Measurement & Improvement Findings for MCOs with FCP or PACE Programs

	Met	Partially Met	Not Met
2007 Percent of Standards	62.9%	35.7%	1.4%
2008 Percent of Standards	92.9%	7.1%	0.0%
Change	+ 30.0%	- 28.6%	- 1.4%

Note: Improvement over time is evident when the percent of Met findings increases, the percent of Partially Met findings decreases, or the percent Not Met findings decreases.

CW-FCP

MCOs must distribute practice guidelines to all affected providers. CW-FCP fully met this requirement by developing a webpage available to providers with links to resources for practice guidelines.

CW-FCP & CHP-FCP

CW-FCP and CHP-FCP make decisions that are consistent with practice guidelines or utilization management, enrollee education, coverage of services, and other areas where the guidelines apply. CW-FCP implemented processes to ensure consistency in the application of practice guidelines and outlined the various processes in place to monitor guideline consistency and use. The outline includes a table of items to monitor, the information source, the review frequency, and the identification of the individuals responsible for the review tasks. Some of these processes include supervisors monitoring guideline use by individual teams, implementing guidelines developed through quality improvement projects, and monitoring team facilitators' weekly team meetings. CHP-FCP developed and implemented a record review process to ensure teams consistently implement practice guidelines.

All MCO with FCP Programs

Every MCO with a FCP program improved to fully meet the requirement to conduct PIPs that show sustainable improvement over time and have a favorable effect on health outcomes and member satisfaction. Most MCOs made improvements to their ongoing PIPs. CHP-FCP was in the final stages of implementing two PIPs that showed significant improvement over time. Community Care concluded its diabetes PIP and planned to implement a diabetes clinical practice guidelines for all members with a diagnosis of diabetes. It also planned to introduce clinical guidelines during new clinical staff orientation and track guideline use through annual peer chart audits and electronic health record queries. Community Care's FCP program redesigned and started the next implementation phase of its persistent pain PIP and focused the project to develop and implement functional goals for high risk members with consistently high pain scores.

Every MCO with a FCP program must report the status and results of each PIP to DHS and complete each project in a reasonable time period. FCP programs that partially met this requirement during the 2007 EQR fully met it during the 2008 EQR.

During the 2007 EQR every MCO partially met the requirement to submit evaluations of their QAPI programs including reviews of the impact and effectiveness of their QAPI programs, information on the performance of standard measures they must report, PIP results (for FCP programs), and their processes to assess their QAPI programs. Each MCO fully met this requirement during the 2008 EQR.

MCO Opportunities for Improvement & EQRO Recommendations

Conducting Ongoing PIPs that Demonstrate Improvement over Time

One MCO's diabetes management PIP did not specify interventions and did not have measures to evaluate the effectiveness of its interventions. Its data analysis referenced interventions for best practice indicators but the MCO did not provide corresponding data for those claims.

- Recommendation: For its next PIPs the MCO should develop and implement specific interventions aimed toward achieving its desired results and develop measures to evaluate intervention effectiveness.

Service Under- and Over-Utilization

MCOs must have mechanisms in place to detect both the under- and over-utilization of services. Two programs partially met this requirement. Although they reviewed utilization at monthly QI meetings they did not have standard processes to determine the under- or over-utilization of services.

- Recommendation: Two programs should continue its efforts to develop utilization management processes and reports and include this information in its QAPI program description. One of these programs should also monitor service utilization and identify other areas of service utilization to review.

Assessing the Quality & Appropriateness of Care

One program partially met the requirement to assess service quality such as through a peer review approach. Although the MCO has a system to monitor teams' care quality practice leads conduct internal chart review it does not use standard criteria as a basis for review activities and does not have a process to track review results across teams. It conducts record reviews only as part of annual employee performance reviews which may not be frequent enough to identify quality of care issues. As this MCO expands into new service areas it will be critical for it to assure consistent care quality throughout the organization.

- Recommendation: The MCO should develop and implement a minimum set of criteria to assure that teams provide quality and appropriate care to members. The MCO should collect these data consistently across teams. The MCO should conduct record reviews more frequently to identify and address any quality of care concerns in a timelier manner.

GRIEVANCE SYSTEMS

When members are not satisfied with the services provided through the MCO or with decisions their team makes they have the right to appeal or grieve at three different levels: to the MCO, to DHS, or to the Division of Hearings and Appeals (i.e., "State fair hearing").

DHS requires each MCO to have a local appeal and grievance process that provides access to the DHS level appeal and grievance process and a State fair hearing process. MCOs must include information on these processes in member handbooks so members know how to exercise their appeal and grievance rights. The information must also appear on the written notice of action letter that MCOs give to members when it discontinues, reduces, limits or denies an item or service.

MCOs can review data it collects related to member appeals and grievances to measure the quality of the services they provide. The occurrence of several similar appeals and grievances may indicate a trend that warrants further investigation.

On average all MCOs with FCP and PACE programs met 94 percent of the *Grievance Systems* standards. The four programs at the three MCOs partially met two or more standards related to tracking the timeliness of issuing written notices of action to their members.

Table 36: 2008 Grievance Systems Findings for MCOs with FCP or PACE Programs

N = 42 standards

Program	MCO	Met	Partially Met	Not Met
FCP	Care Wisconsin (CW-FCP)	38	3	1
	Community Care (CC-FCP)	40	2	0
	Community Health Partnership (CHP-FCP)	40	2	0
PACE	Community Care (CC-PACE)	40	2	0
All Wisconsin MCOs with FCP or PACE programs				
Average		39.5	2.3	0.3
Percent of Standards		94.0%	5.4%	0.6%

The MCOs demonstrated understanding of and fully implemented the majority of the *Grievance Systems* standards.

MCO Strengths

All MCOs:

- Have systems in place for members including a grievance process, standardized appeal process, and access to the State’s fair hearing system, and ensure that all parts of these processes occur within regulated timeframes.
- Maintain records of appeals and grievances and review the information as part of their QAPI programs.
- Acknowledge the receipt of each appeal and grievance, and provide in writing notice of the disposition of each appeal and grievance.
- Inform members that they:
 - May file a grievance and an appeal with the MCO, DHS, or request a State fair hearing.

- Have the right to appeal any adverse service decisions such as the reduction, denial, suspension, or termination of services.
- May file a grievance either orally or in writing.
- May file an appeal either orally or in writing. Unless members request an expedited resolution they must follow oral filings with a written, signed appeal, and MCOs must confirm in writing the receipt of the member's oral appeal.
- Can get assistance from the MCO to complete forms and take other steps to resolve the appeal or grievance.
- Can include people of their own choosing in the appeal, grievance, and State fair hearing processes.
- Have the right to present evidence and examine their case file and other relevant documents before and during the appeal process.
- Can request to continue to receive previously authorized benefits while a hearing is pending but may be responsible for the cost of those benefits if the hearing decision upholds the MCO's action to reduce, deny, suspend, or terminate services.
- Inform all providers and subcontractors when they enter into a contract with the MCO:
 - About their right to file grievances and appeals.
 - About the requirements and timeframes to file an appeal or grievance.
 - About the availability of assistance in the filing process.
 - The toll-free telephone numbers that members can use to file an appeal or grievance by telephone.
 - That they may file an appeal on behalf of a member if they have the member's written consent.
 - That they may file grievances or request State fair hearings for the members they serve.
 - That they cannot be punished by the MCO for requesting an expedited resolution of supporting a member's appeal.
- Send members notices of action which explain:

- The action the MCO intends to take (reducing, denying, suspending or terminating services).
- The reasons for the action.
- The affected member's right to file an appeal with the MCO.
- The member's right to request a State fair hearing.
- The procedures for exercising members' rights.
- The circumstances under which expedited resolution is available and how to request it.
- The member's right to have benefits continue, if requested, pending the resolution of an appeal, how to request that services continue, and the circumstances under which the member may be required to pay for the cost of services.
- Mail notices of action:
 - At least ten days before the date of the action.
 - That deny payment to providers whenever action is taken that affects a claim.
 - To members when the MCO is unable to make a service authorization decision if it extends the original fourteen day timeframe by an additional fourteen days.
- Make expedited authorization decisions and provide notice as expeditiously as the member's health requires and no later than three working days after it receives the service request. MCOs may extend timeframes by up to fourteen days if the member requests the extension or the MCO justifies a need for additional information and how the extension is in the member's interest.
- Have processes to reinstate services to members whose services were previously discontinued because their whereabouts were unknown.
- Ensure that the people who make decisions on the grievances and appeals were not involved in any previous level of review or decision making and are health care professionals who have the appropriate clinical expertise in treating the member's condition or disease.
- Transfer appeals to the timeframe for standard appeal resolution when requests for expedited appeal resolution are denied and provide prompt notice to the member.
- Continue members' benefits, if requested, during the appeal, grievance, and State fair hearing processes under statutorily defined circumstances.

- Are aware they have the ability to recover the cost of services furnished to members who received services while their appeal or State fair hearing processes were pending but the final resolution of the appeal were adverse to the members.
- Reinstate services when the State fair hearing decision reverses a MCO’s decision to reduce, deny, suspend, or terminate services.

MCO Improvements from Previous Reviews

The MCOs/programs fully met fewer *Grievance Systems* standards in 2008 than they did in 2007.

Table 37: 2007 – 2008 Grievance Systems Findings for MCOs with FCP or PACE Programs

	Met	Partially Met	Not Met
2007 Percent of Standards	96.2%	3.8%	0.0%
2008 Percent of Standards	94.0%	5.4%	0.6%
Change	- 2.2%	+ 1.6%	+ 0.6%

Note: Improvement over time is evident when the percent of Met findings increases, the percent of Partially Met findings decreases, or the percent of Not Met findings decreases.

None of the MCOs/programs made improvements on any of the *Grievance Standards* between the 2007 and 2008 reviews.

MCO Opportunities for Improvement & EQRO Recommendations

Each MCO has difficulty tracking if it mails notices of action to members in a timely manner.

Timeliness of Mailing Notices of Action

MCOs must mail notices of action at least ten calendar days before the effective date of the action for termination, suspension, or reduction of a previously authorized service. All four programs at the three MCOs partially met this requirement. One program’s 2008 CMR found when teams denied, reduced, or terminated services it sent notices of action within contractual timeframes 78 percent of the time. Another program’s notice of action template did not indicate an effective date of action when teams reduced or terminated services. As noted in the *QAPI Access to Services* section of this report two programs developed a *Service Authorization/Team Decision* tracking system to track service authorization denials, reductions or terminations. The 2008 CMR found they issued notices of action only 23 to 27 percent of the time.

For standard service requests they deny or limit, an MCO must mail notices of action within fourteen calendar days after it receives a request with a possible extension of up to fourteen additional calendar days if the member or provider requests an extension. None of four programs fully met this requirement.

If an MCO extends the timeframe for service authorization decision making it must give the member written notice of the reason along with the member’s appeal and grievance rights. One

MCO/program partially met this requirement. Its *Notice of Action* policy does not specify that teams provide written notice to a member when teams request an extension to the service authorization decision making timeframe. MetaStar reviewers could not determine how the MCO informed members of their right to refuse the fourteen day extension time period.

- Recommendations: Despite the reasons for not mailing notices of action in a timely manner all MCOs/programs should include the effective date of action on its notice of action template they reduce or terminate services. They should notify members of the effective date of action when they explain the reason for the service reduction or termination. MCOs should monitor their *Timeliness of Notice of Action* log or similar tracking mechanisms. They should track the issuance of notices of action during internal file reviews to ensure teams comply with contractually specified timeframes. If not already in place MCOs should develop effective processes to improve the rates by which they provide written notice of service authorization denials within fourteen days. MetaStar specifically advised one MCO/program to change its *Handling Requests for Services Sending Notices of Action* policy to specify that teams should send members a written notice when teams request the extension.

Treating Oral & Written Appeal Inquiries Identically

An MCO's appeal process must treat members' oral inquiries seeking to appeal an action as actual appeals to establish the earliest possible filing date. MetaStar scored one MCO/program as "not met" on this requirement. During its review the MCO stated that the appeal resolution timeframe begins on the date the MCO receives the signed appeal from the member. If the member files an oral appeal the MCO sends the member a summary of the appeal in written format and requests that the member sign and return the appeal form. The MCO indicated that sometimes members do not return the signed form and the appeal does not proceed.

- Recommendations: The MCO should change its twenty day resolution timeframe for appeals to begin on the date of the oral appeal regardless of when or whether a member later submits a written appeal. To ensure that members know their appeal rights staff should follow-up with members when they do not return a signed written appeal to the MCO.

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

BACKGROUND & PURPOSE

MCOs under contract with DHS to administer the FCP program must conduct two PIPs each year. Each MCO must report to DHS each project's status and results and include enough detail to show that the MCO makes progress on each project.

The MetaStar EQR team evaluated each MCO's PIPs to determine if they use proper technique and design to use the project's data and findings for its organizational decision making.

VALIDATION METHODOLOGY

The MetaStar EQR team includes reviewers with QA experience and specialized training in to evaluate each MCO's PIP reports. The reviewers followed the *Medicaid Managed Care Performance Improvement Project Reviewer Guidelines* and the *Medicaid Managed Care Performance Improvement Project – Project Evaluation Checklist* to assess the standard elements of a PIP.

- Topic selection: To ensure the projects adequately reflected the needs of the enrolled population.
- Study questions and project aims: To ensure that they were clear and measurable.
- Indicators and measures: To determine if they were clear, measurable, and based on current clinical knowledge or health services research.
- Project population: To determine whether the project included all or part of the organization's population and how the MCO captured and selected the population.
- Data collection procedures and sampling methods: To determine if data were valid and reliable from sampling methods, data sources, data collection instruments and procedures, and data collector qualifications and training.
- Improvement strategies: To determine if real sustained improvements resulted from continuous cycles of measuring and analyzing performance.
- The project team's analysis and interpretation of results: To determine whether it used appropriate statistical analysis techniques.
- Assess "real" and "sustained" improvement in projects that showed improvement.

Documents reviewed prior to each on-site review include the annual PIP report submitted by the MCO, BCAP workbook or other project work plan/description, related data on project measures,

and other related project information such as related practice guidelines or member education materials.

The reviewers interviewed each MCO's quality management staff about the MCO's two PIPs during the *QAPI Measurement & Improvement* section of the 2008 QCR. The MetaStar EQR team interviewed each project's team members to follow-up on questions related to project design and measures, implementation, data collection methods, results of data, and plans for next steps.

Compiling & Analyzing Findings

MetaStar used a three-point rating structure (met, partially met, and not met) to assess the level of compliance with the PIP protocol standards.

- **Met** applied when the project components aligned to meet the standard.
- **Partially met** applied when a MCO fulfilled some but not all of the project components.
- **Not met** applied when the MCO did not meet any of the project components or reviewers could not ascertain from the documentation whether the MCO worked on the project components.

After each on-site visit the MetaStar EQR team performed a final analysis of the PIPs using a *PIP Validation Checklist* and entered its findings into MetaStar's PIP database. It used findings to develop recommendations for each MCO to improve its PIPs.

Reporting Validation Results to DHS

During the EQR process, the MetaStar EQR team reviews each MCO's PIPs and as part of each MCO's final EQR report provides its findings to each MCO and to DHS.

OVERALL FINDINGS

Every MCO serving members enrolled in the FCP program was in compliance with the contract requirement to submit two PIPs to DHS. Performance improvement projects by PACE programs are reviewed nationally.

In 2008, the MCOs worked on PIPs related to persistent pain, home care, mission effectiveness, scheduling management, and diabetes.

The two diabetes projects, scheduling management, and persistent pain projects continued from 2007. The other two projects, *Mission Effectiveness* and *Improving Home Care Services for Members with Complex Needs or Situations*, were new in 2008.

Table 38: 2008 PIP Validation Findings for MCOs with FCP Programs

	Met	Partially Met	Not Met
All Wisconsin FCP MCOs	94.7%	5.3%	0.0%

Some standards do not apply to PIPs in earlier implementation phases. For example, projects that have been through one measurement cycle could not apply any of the standards related to sustained improvement in Activity 10. Project design also determines which standards apply. A project designed without pulling a sample group would not be eligible for any standards related to sampling techniques in Activity 5.

It is important to recognize the number of applicable standards when looking at the percent of fully met standards. Every PIP met the six applicable *Study Topic* standards (two *Study Topic* standards for each of the three PIPs). By contrast the *Sustained Improvement* standards were also fully met by 100 percent of the PIPs but only one standard applied among all six PIPs because of the projects’ designs and implementation phases.

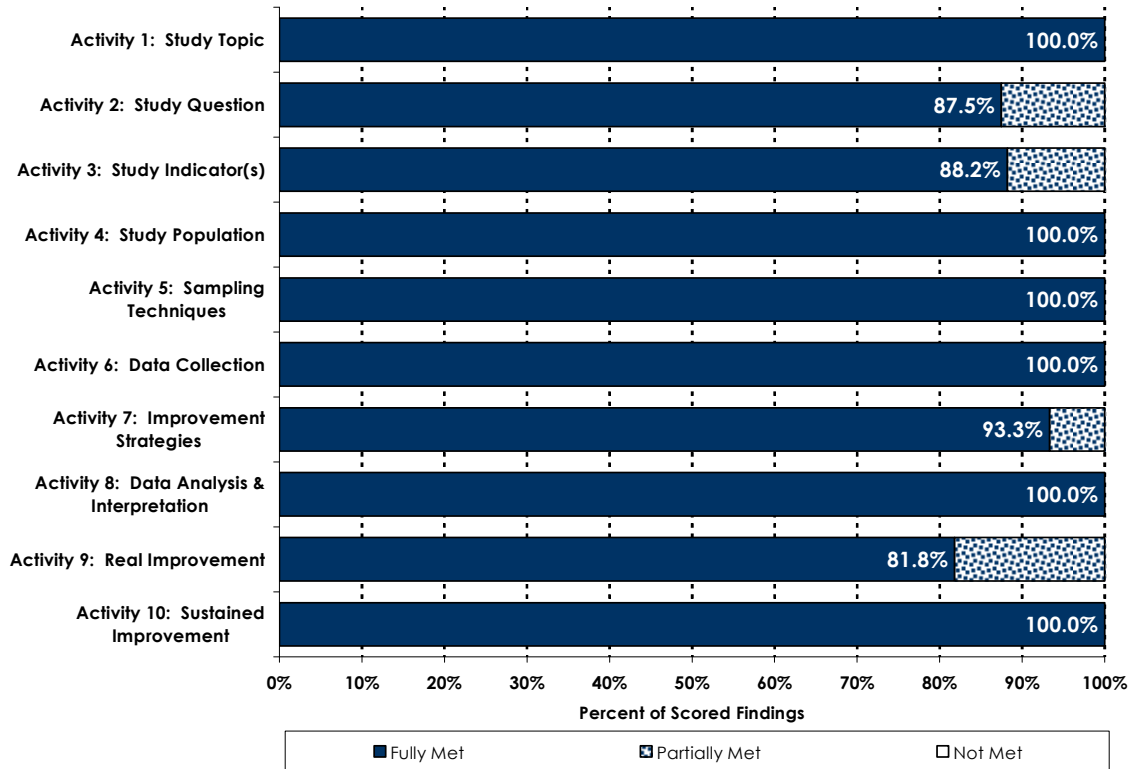
Appendix 7 describes each *PIP Validation* standard and finding for each FCP MCO.

Table 39: 2008 PIP Validation Findings by Activity for MCOs with FCP Programs

PIP Activity	Number of Applicable Standards	Fully Met	Partially Met	Not Met
Activity 1: Study Topic	10	10	0	0
		100.0%	0.0%	0.0%
Activity 2: Study Question	16	14	2	0
		87.5%	12.5%	0.0%
Activity 3: Study Indicators	17	15	2	0
		88.2%	11.8%	0.0%
Activity 4: Study Population	12	12	0	0
		100.0%	0.0%	0.0%
Activity 5: Sampling Techniques	2	2	0	0
		100.0%	0.0%	0.0%
Activity 6: Data Collection	24	24	0	0
		100.0%	0.0%	0.0%
Activity 7: Improvement Strategies	15	14	1	0
		93.3%	6.7%	0.0%
Activity 8: Data Analysis & Interpretation	23	23	0	0
		100.0%	0.0%	0.0%
Activity 9: Real Improvement	11	9	2	0
		81.8%	18.2%	0.0%
Activity 10: Sustained Improvement	2	2	0	0
		100.0%	0.0%	0.0%

The graph below demonstrates the areas where overall the programs can improve their PIPs. They performed well in all activities, fully meeting every standard related to *Study Topic*, *Study Population*, *Sampling Techniques*, *Data Collection*, *Data Analysis & Interpretation* and *Sustained Improvement*.

Chart 15: 2008 PIP Validation Findings by Activity for MCOs with FCP Programs



Two CC-FCP PIPs met every applicable PIP standard. The other four PIPs had difficulty with at least one aspect of their projects.

Table 40: 2008 Percent of Fully Met PIP Standards for MCOs with FCP Programs

FCP MCO	PIP Topic	Percent Met
Community Care Health Plan (CC – FCP)	Diabetes Mellitus	100%
Community Care Health Plan (CC – FCP)	Mission Effectiveness	100%
Care Wisconsin (CW – FCP)	Functional Goals for Members with Persistent Pain	96.0%
Care Wisconsin (CW – FCP)	Improving Home Care Services for Members with Complex Needs or Situations	95.8%
Community Health Partnership (CHP – FCP)	Scheduling Management	95.5%

FCP MCO	PIP Topic	Percent Met
Community Health Partnership (CHP – FCP)	Diabetes Management	81.8%

MCO Strengths

All PIPs:

- Had clearly defined measurable indicators.
- Had clearly defined relevant populations.
- Clearly defined data and data sources.
- Used qualified staff to collect data.
- Used data collection instruments that provided for consistent and accurate data collection.
- Had prospective data analysis plans.
- Clearly presented accurate numerical findings.
- Clearly stated project successes and progress.
- Clearly defined follow-up activities (next steps).
- Where applicable:
 - PIP topics were based on relevant data.
 - MCOs developed PIPs with topics that focus on improving member care outcomes.
 - All PIPs using the BCAP methodology had clearly stated and measurable overall typology aims that included numerical goals and target dates.
 - All PIPs using the BCAP methodology contained overall outcome typology measures that link to associated aims.
 - PIPs identified a representative and generalizable study population.
 - If the entire population was used, all enrollees were captured.

- If the entire population was not used, it was stratified by high risk, high needs, or high utilization.
- MCOs used valid sampling techniques and samples contained sufficient numbers.
- MCOs applied PDSA cycles appropriately.
- PIPs identified and addressed barriers.
- Data analysis included initial and repeat measurements and identified limitations.
- Baseline and repeat measurements were consistent.
- PIPs demonstrated sustained improvement.

The following section notes opportunities for improvement, improvements over the previous year's EQR, and recommendations when they affected at least half of the PIPs.

MCO Improvements from Previous Reviews

Across the projects, most improvements related to data collection and analysis.

Continuing Projects

It is easiest to determine if MCOs made improvements in their PIPs when they continue their projects between the two years being compared.

CC-FCP

CC-FCP made its greatest improvements between 2007 and 2008 in its *Diabetes* PIP. In 2008 the PIP fully met each of the six areas that it partially met in the 2007 review.

CHP-FCP

CHP-FCP also made improvements with its *Scheduling Management* PIP between the two years. In 2008, this PIP also fully met each of the five areas that it partially met in the 2007 review.

CW-FCP

CW-FCP improved in its *Persistent Pain* PIP by fully meeting three of four standards that it partially met in 2007 and fully meeting one standard it did not meet in 2007.

New Projects

For MCOs that began new projects that MetaStar reviewed for the first time in 2008 it was evident in two projects that the MCOs implemented improvements based on previous learnings from the PIP process.

CW-FCP

CW-FCP's new PIP, *Improving Home Care Services for Members with Complex Needs or Situations*, fully met four standards it partially met in its 2007 PIP.

CC-FCP

CC-FCP's new PIP also fully met one standard that it did not meet last year. CC-FCP's *Mission Effectiveness* PIP improved to fully meet three areas that it partially met in its 2007 PIP.

MCO Opportunities for Improvement & EQRO Recommendations

MetaStar did not identify opportunities for improvement that affected three or more of the Family Care Partnership PIPs.

MCOs can improve their efforts toward clarifying projects' study questions; ensuring indicators measure changes in health or functional status, member satisfaction or care processes; Developing a prospective data analysis plan and interventions with a good chance of succeeding; documenting improvements in outcomes and processes; and ensuring improvements appear to be the result of planned interventions.

PIP VALIDATION FINDINGS

Each MCO submitted its PIPs and supporting documentation related to its interventions and data findings to MetaStar

MCO Strengths

In their 2008 PIP reports all MCOs implemented these PIP components.

Activity 1: Study Topic

They based topic selection on relevant data. MCOs selected the topics through data collection, analysis, and member input.

They developed PIPs with topics that focus on improving key aspects of care and/or outcomes for members. The projects addressed high volume services or high-risk populations, were aimed at identifying and correcting deficiencies in services, and had goals to improve processes or outcomes of care or services provided to members.

For its *Functional Goals for Members with Persistent Pain* PIP CW-FCP used American Geriatrics Society data to choose its study topic. The Society persistent pain existed in up to fifty percent in community-dwelling elders. Seventy-five percent of new enrollees in a 2005 CW-FCP study reported the existence of persistent pain.

CC-FCP's *Mission Effectiveness* PIP is relevant to its membership as members are at the core of CC-FCP's mission and frames how "services are delivered to and received by the participant." Between 2004 and 2005 CC-FCP conducted focus groups as part of a participant-centered initiative and found some members did not feel included in the care planning process to the extent they desired.

Activity 2: Study Question

When using the BCAP methodology PIPs had clearly stated and measurable overall and typology aims that included numerical goals and target dates.

In its *Persistent Pain* PIP CC-FCP developed an overall aim to "demonstrate a reduction in minimum pain ratings in at least 75 percent of those members identified as having minimum pain ratings greater than or equal to five during the first quarter of 2008." Typology aims ensured that teams documented member pain ratings at least once every two months, stratified members into a high need category by pain rating scores of five or greater, and established functional goals all members with a minimum pain rating of five or greater.

In the project documentation for its *Diabetes Mellitus* PIP CC-FCP clearly stated project aims that established the framework for project implementation. The MCO described its overall project aim as "85 percent of its community-dwelling members, who have a diagnosis of diabetes mellitus, will achieve a lipoprotein level of 100 or less, and will obtain an annual dilated ophthalmology exam and biannual foot exam by October 2008." The MCO wrote four distinct and measurable typology aims. All of the project aim statements included target goals and timeframes.

Activity 3: Study Indicators

All PIPs had clearly defined measurable indicators. When using the BCAP methodology PIPs contained overall outcome and typology measures linked to associated aims.

CHP-FCP based its *Diabetes Mellitus* PIP study indicators on its diabetes best practice standards to prevent cardiovascular, ocular and renal problems in members with diabetes. CW-FCP identified five study indicators for its *Improving Services for Members with Complex Home Care Needs or Situations* PIP. Three indicators measure member satisfaction levels, one measures the continuity of home care workers, and the other measures the percentage of calls members make to the MCO's on-call system.

Activity 4: Study Population

Each project identified a representative and generalizable study population. All PIPs had clearly defined relevant populations. If the PIP used the entire population it captured all members. If it did not use the entire population PIPs stratified members by high risk, high needs, or high utilization.

They study population for CHP-FCP's *Scheduling Management* PIP consisted of all CHP-FCP members who received daily living assistance service through the MCO's Home Care department. CW-FCP geared its *Persistent Pain* PIP toward improving pain ratings for members who identified themselves as being in moderate to high levels of pain. The stratification indicator identified the target population for this project, members who scored five or greater on the pain scale during the first quarter of 2008.

Activity 5: Sampling Methods

One MCO used a sample to select members for its PIP. Proper sampling techniques are necessary to provide valid, reliable, and generalizable information on the quality of care provided. At the beginning of its *Diabetes Mellitus* project CC-FCP identified all members with a diagnosis of diabetes. The MCO stratified a representative sample of the target population to target project interventions. Members in the sample attended one of the MCO's day program sites and had to have a life expectancy greater than six months, were 80 years of age or less, had functional independence based on a national PACE assessment for activities of daily living and no diagnosis of dementia.

Activity 6: Data Collection

Each PIP's prospective data analysis plan clearly defined the source of data it would collect. Qualified staff collected consistent and accurate project data. CW-FCP care teams and nurses documented pain rating scores in the assessment module of its electronic medical record. A data analyst pulled the pain rating data from the system. A process improvement specialist collected functional goal data from member records and analyzed the data to evaluate the PIP's progress.

Activity 7: Interventions & Improvement Strategies

The MCOs applied PDSA cycles appropriately. Each project identified barriers and addressed them. In its *Diabetes Mellitus* PIP CC-FCP's project interventions targeted improvements in the organization's diabetes clinical practice. It developed practice guidelines for diabetes care for clinical staff and MCO education efforts. The MCO has treatment guidelines for diabetic medication use, diabetes care guidelines for clinicians, and a foot assessment guideline. The MCO implemented a prompt in the MCO's electronic medical record system for physicians to conduct a foot exam when required.

In its *Complex Home Care Needs and Situations* PIP CW-FCP implemented several improvement strategies related to identifying members for the project population. CC-FCP said

the identification process appears to be working well but would continue to review the process during planned PDSA cycles. The MCO developed a new process to improve internal communication and coordination between care teams and the home care department to identify member-specific intervention strategies. The MCO developed a high-needs workgroup to review the information from care teams, home care staff and selected MCO members to develop a proactive approach to address member-specific needs and issues. Staff involved in the project reported that this process helped to better coordinate services and identify and address members' concerns before they became crises.

Activity 8: Data Analysis & Interpretation

When applicable all of the PIPs included data analysis with initial and repeat measurements and identified limitations. The PIPs had clearly presented and accurate numerical findings, clearly stated project successes and progress, and clearly defined follow-up activities (next steps).

In its *Persistent Pain* PIP CW-FCP used the PDSA method on an ongoing basis to analyze data to track its progress on the project's implementation, identify barriers, and develop next steps. The MCO tracked pain rating scores over time and compared these scores with baseline data. It initiated data collection on the PIP's intervention measures and provided some initial data on the number of members in the project with documented pain management functional goals.

For its *Scheduling Management* PIP CHP-FCP conducted an ongoing data analysis on the number of unscheduled home care visits. When it began the project CHP-FCP conducted weekly analysis. The analysis decreased to monthly then quarterly. Baseline data showed 44 percent of visits were unscheduled when the MCO sent home care schedules to members. Within eleven months the project reduced the unscheduled visit rate to five percent.

Activity 9: Real Improvement

All PIPs demonstrated consistency between baseline and repeat measurements. Both CW-FCP in its *Persistent Pain* PIP and CC-FCP in its *Diabetes Mellitus* PIP repeated PDSA cycles to review data, identify project barriers, and make ongoing improvements.

Activity 10: Sustained Improvement

When feasible PIPs should demonstrate sustained improvement through periodic monitoring and repeated measurements over time. This standard applied to both of CHP-FCP's PIPs. Both PIPs have processes monitor when the project sustains improvement and periodically conducted repeat measurements.

MCO Improvements from Previous Reviews

A comparison of the findings met, partially met, and not met in 2007 and 2008 shows MCOs' understanding of the PIP process improved. The rate of partially met findings declined by nineteen percent.

Table 41: 2007 – 2008 PIP Validation Findings for MCOs with FCP Programs

	Met	Partially Met	Not Met
2007 Percent of Standards	69.5%	24.7%	5.7%
2008 Percent of Standards	94.7%	5.3%	0.0%
Change	+ 25.2%	-19.4%	- 5.7%

Note: Improvement over time is evident when the percent of Met findings increases, the percent of Partially Met findings decreases, or the percent of Not Met findings decreases.

Across the projects most improvements related to data collection and analysis.

Continuing PIPs

CC-FCP

CC-FCP made its greatest improvements between 2007 and 2008 in its *Diabetes* PIP. In 2008 the PIP fully met each of the six areas that it partially met in the 2007 review. It contained clearly stated and measurable BCAP typology aims with numeric goals and target dates and linked to associated aims. It clearly defined its data and data sources and used qualified staff to collect data. Its data analysis included initial and repeat measurements and identified limitations.

CHP-FCP

CHP-FCP also made improvements with its *Scheduling Management* PIP between the two years. In 2008 this PIP also fully met each of the five areas that it partially met in the 2007 review. It clearly defined data and data sources, used data collection instruments to collect consistent and accurate data, applied PDSA cycles appropriately, and presented accurate and clear numeric findings and follow-up activities.

CW-FCP improved in its *Persistent Pain* PIP by fully meeting three of four standards that it partially met in 2007 and fully meeting one standard that was not met in 2007. It clearly defined its data and data sources, used qualified staff to collect data, used data collection instruments to collect consistent and accurate data, and implemented a prospective data analysis plan.

New PIPs

For MCOs' new projects that MetaStar reviewed for the first time in 2008, MetaStar found evidence in two projects that the MCOs implemented improvements based on previous learnings from the PIP process.

CW-FCP

CW-FCP's new PIP, *Improving Home Care Services for Members with Complex Needs or Situations*, fully met four standards that had been partially met in its 2007 PIP. It contained clearly defined and measurable indicators, data, and data sources. It used data collection instruments to collect consistent and accurate data. It clearly defined follow-up activities. The

new PIP also fully met one standard it did meet last year. When a project does not use an entire population it should stratify the population by high-risk, high needs, or high utilization members.

CC-FCP

CC-FCP's *Mission Effectiveness* PIP improved to fully meet three areas that it partially met in its 2007 PIP. It used clearly defined data and data sources, data collection instruments to obtain consistent and accurate data, and presented its numeric findings in an accurate and clear way.

MCO Opportunities for Improvement & EQRO Recommendations

Activity 2: Study Question

Each MCO to clearly state in writing the questions the project is designed to answer. Stating the question helps maintain the PIP focus and sets the framework for data collection, analysis, and interpretation. The detail that goes into developing the study questions depends upon the methodology each MCO chose to use when creating its PIPs.

Study questions should be clearly stated in writing and relevant to the project purpose or overall aim. Two PIPs partially met this standard. Although the PIPs identified study questions the projects lacked a clearly defined improvement statement for moving into its next phase of project implementation.

- Recommendations: When designing future projects or revising existing ones MCOs should develop clear and specific statements about what improvements they want to make.

Activity 3: Study Indicators

MCOs should develop PIPs with indicators that measure changes in members' health or functional status, satisfaction, or care processes that have strong associations with improved outcomes. Two PIPs partially met these criteria. One PIP identified processes of care associated with improved outcomes, but at the time of the review it had not yet obtained data from these processes of care. This PIP and another from the same MCO would benefit from developing indicators to evaluate the effectiveness of project interventions.

- Recommendations: In its *Persistent Pain* PIP the MCO should continue to monitor that care teams obtain pain readings from all members to assure it makes and sustained progress on the project.

Activity 7: Improvement Strategies

MCOs can determine the effectiveness of intervention activities by measuring project indicators over time. Interventions should make sense and have a good chance of succeeding. One PIP did not meet this requirement because it did not specify interventions.

- Recommendations: The MCO should develop clear interventions with measures so it can correlate the project's intervention effectiveness to the project's outcomes.

Activity 9: Real Improvement

Project teams should document in the PIP report improvements in processes and outcomes. Improvements should be the result of planned interventions and not some disparate occurrence. One PIP partially met these requirements. Improvements occurred over time but the project team could not attribute these improvements to any specific interventions because the it did not specify or measure any interventions.

- Recommendations: The MCO should develop specific interventions to make desired the improvements. It should identify intervention indicators and measures to analyze if the interventions have desired effects. Measure results are important for organization-wide decision making about whether to replicate the interventions.

CARE MANAGEMENT REVIEWS

BACKGROUND & PURPOSE

The CMR determines each MCO's level of compliance with its contract with DHS, 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.

REVIEW METHODOLOGY

MetaStar assessed four categories of MCOs' care management processes for the twelve months that preceded each MCO's 2008 EQR:

- Assessment
- Care planning
- Service coordination and delivery
- Participant centered focus

At each MCO the MetaStar EQR team conducted an on-site review of a random sample of members' service records. For the 2008 reviews MetaStar randomly selected records from members who an MCO enrolled as of a specified 2007 date. (See the *CMR Record Reviews* table below for MCOs with FCP or PACE programs.) Depending on the MCO the samples included a mix of members who enrolled during the prior year, members who had been enrolled with the MCO for more than a year, or members who left the program after the specified date but before the date of the on-site review.

Table 42: 2008 CMR Record Reviews for MCOs with FCP or PACE Programs

Number of records reviewed and time period of review for each MCO

Program	MCO	Number of Member Records Reviewed	Time period reviewed preceding 2008 EQR
FCP	Care Wisconsin (CW-FCP)	30	August 2007 – August 2008
	Community Care (CC-FCP)	30	September 2007 – September 2008
	Community Health Partnership (CHP-FCP)	30	September 2007 – September 2008
PACE	Community Care (CC-PACE)	30	September 2007 – September 2008

Compiling & Analyzing Findings

MetaStar used binomial scoring (**met** or **not met**) to rate each MCO's performance for each measure. For measures that were not met the reviewers noted the key areas related to the finding and provided comments to identify the missing requirements.

After each record review the MetaStar EQR team entered its review findings into its CMR database. MetaStar provided MCO its findings and comments from each individual member record reviewed and a summary report of the MCO’s overall performance.

During the 2008 QCR interview the MetaStar EQR team spoke with each MCO’s staff about trends and patterns it observed during the CMR. The trends and patterns provide a link between the MCO’s care management practices, its policies, and the federal Medicaid managed care regulations. During conference calls with each MCO after its review the MetaStar EQR team identified strengths and opportunities for improvement including the care management service delivery elements where the MetaStar EQR team advised caution.

Reporting Evaluation Results to DHS

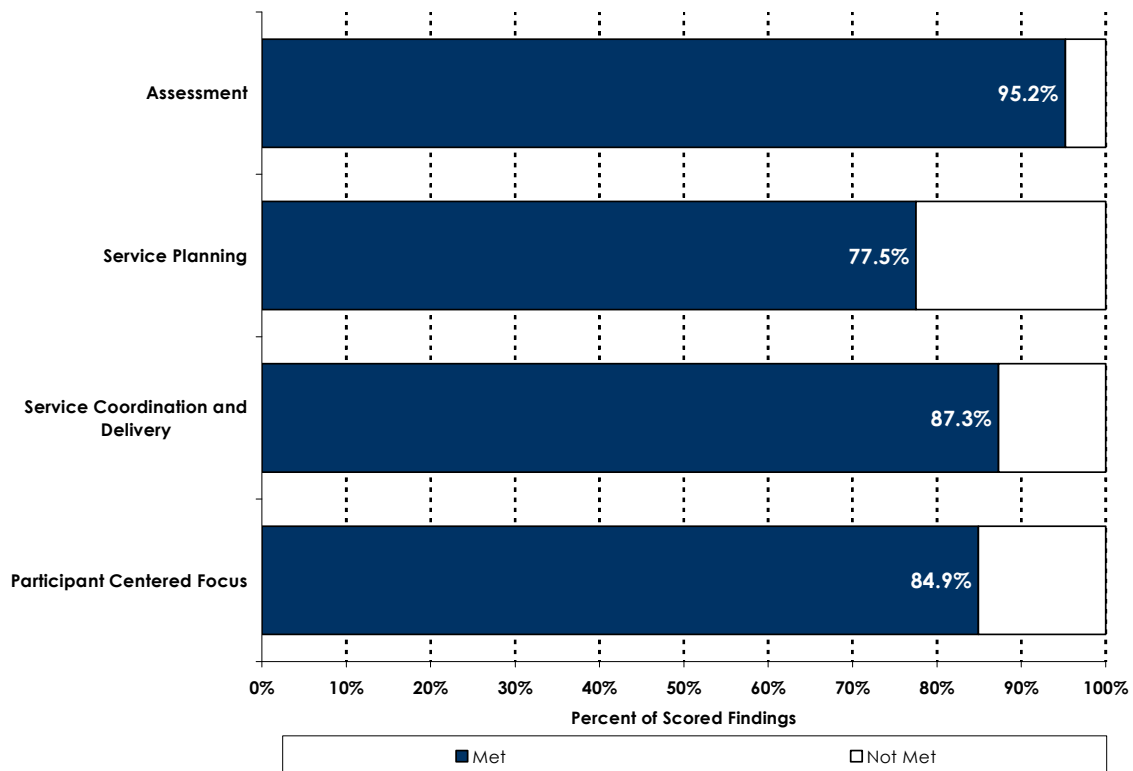
As part of each MCO’s final EQR report MetaStar provides its CMR findings to each MCO and to DHS.

OVERALL FINDINGS

Aggregated by each CMR category the MCOs fully met at least three-quarters of the measures in three of the four categories.

Appendix 8 contains detailed CMR findings for each MCO with a FCP or PACE program.

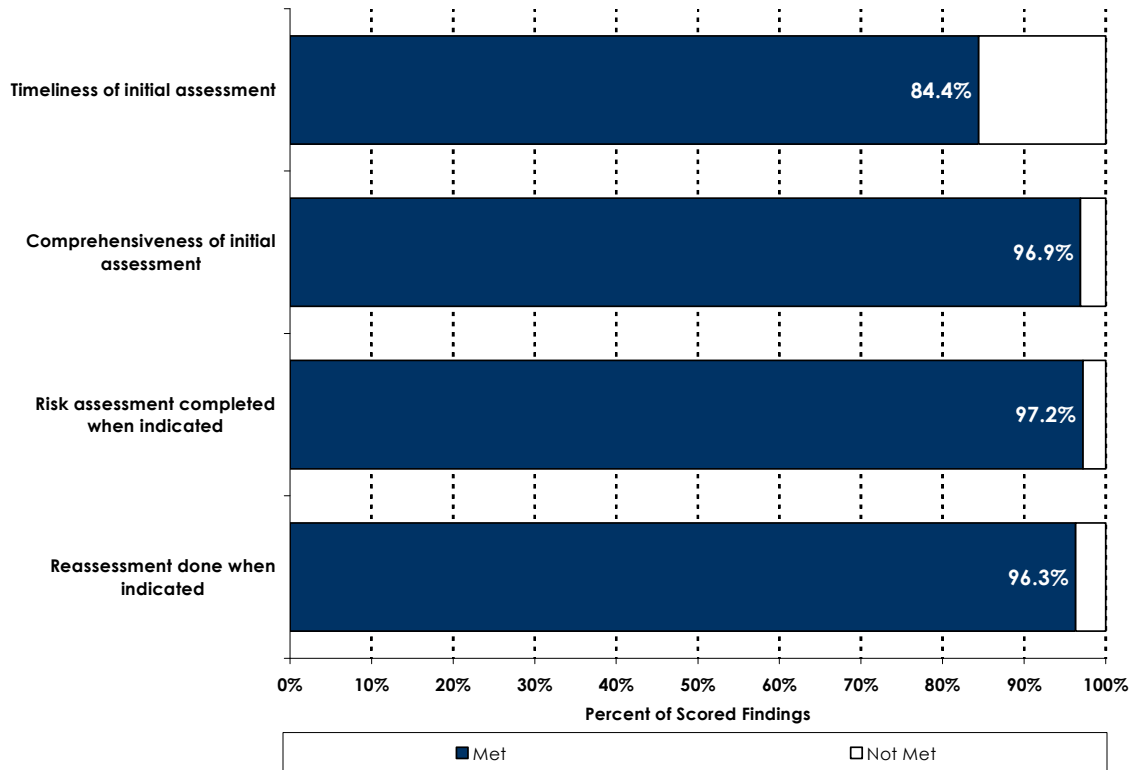
Chart 16: 2008 CMR Findings by Category for MCOs with FCP or PACE Programs



Assessment

Member assessment forms the foundation of effective care management. Thorough assessments provide a wealth of information about members, their supports, service needs, and living situations. All MCOs' procedures, standards, and training contributed to a high level of performance in this area.

Chart 17: 2008 CMR Assessment Findings for MCOs with FCP or PACE Programs

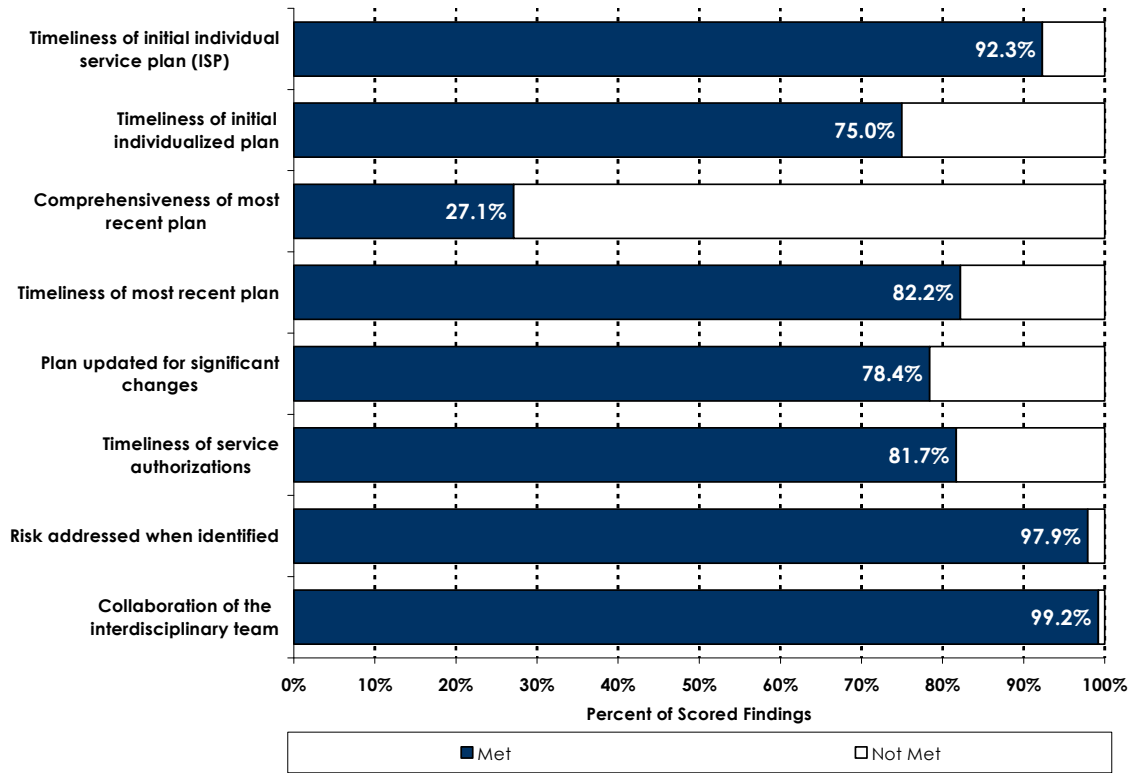


Approximately 84 percent of the MCOs' member records MetaStar selected and reviewed met the requirement to have initial assessments done in a timely manner. MetaStar found that almost every initial assessment it reviewed to be comprehensive. MCOs consistently completed risk assessments. They did reassessments within designated timeframes in 96 percent of records reviewed, an improvement over last year's finding.

Service Planning

Various care management activities reflect how well teams plan members' services.

Chart 18: 2008 CMR Service Planning Findings for MCOs with FCP or PACE Programs



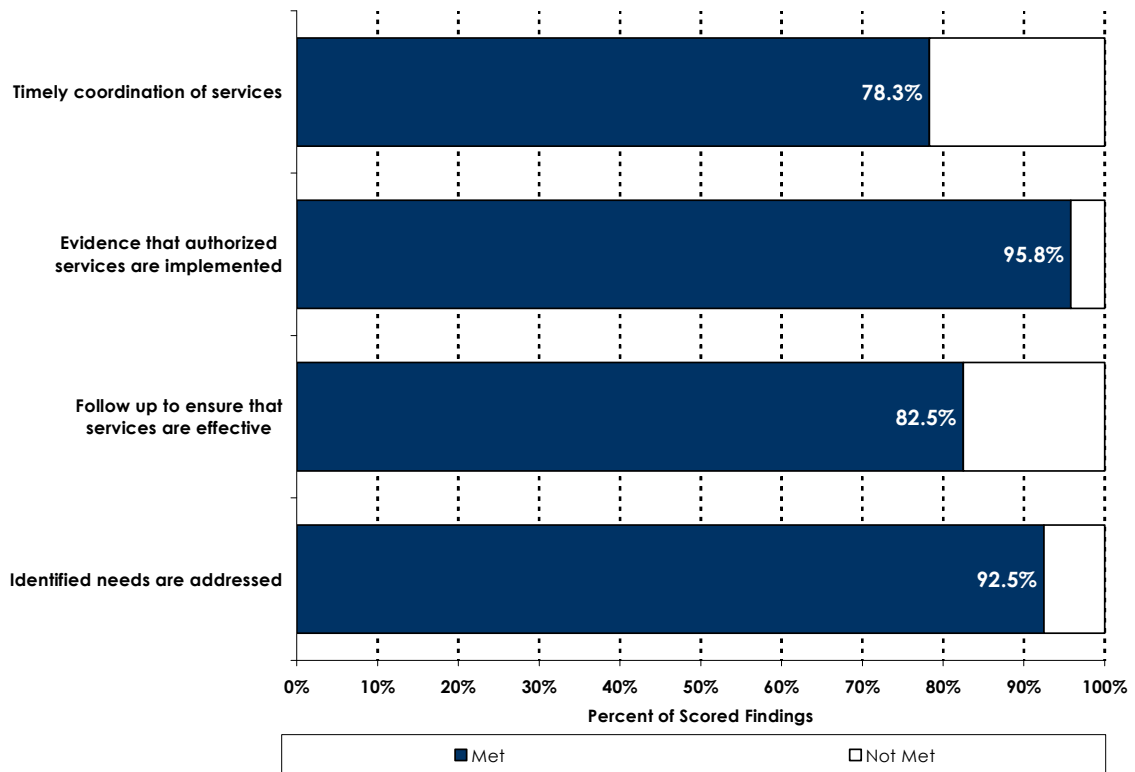
MetaStar reviewers found the comprehensiveness of the recent plan to be lacking with less than thirty percent of the records they reviewed meeting contractual requirements. MCOs need to pay attention to the timeliness related to the development of the individualized plan and updating plans for significant changes. By contrast, MCOs do an excellent job of addressing members’ risk once identified and collaborating within interdisciplinary teams.

Service Coordination & Delivery

The measures in this category relate to the teams’ activities to coordinate and monitor members’ care and services.



Chart 19: 2008 CMR Service Coordination & Delivery Findings for MCOs with FCP or PACE Programs



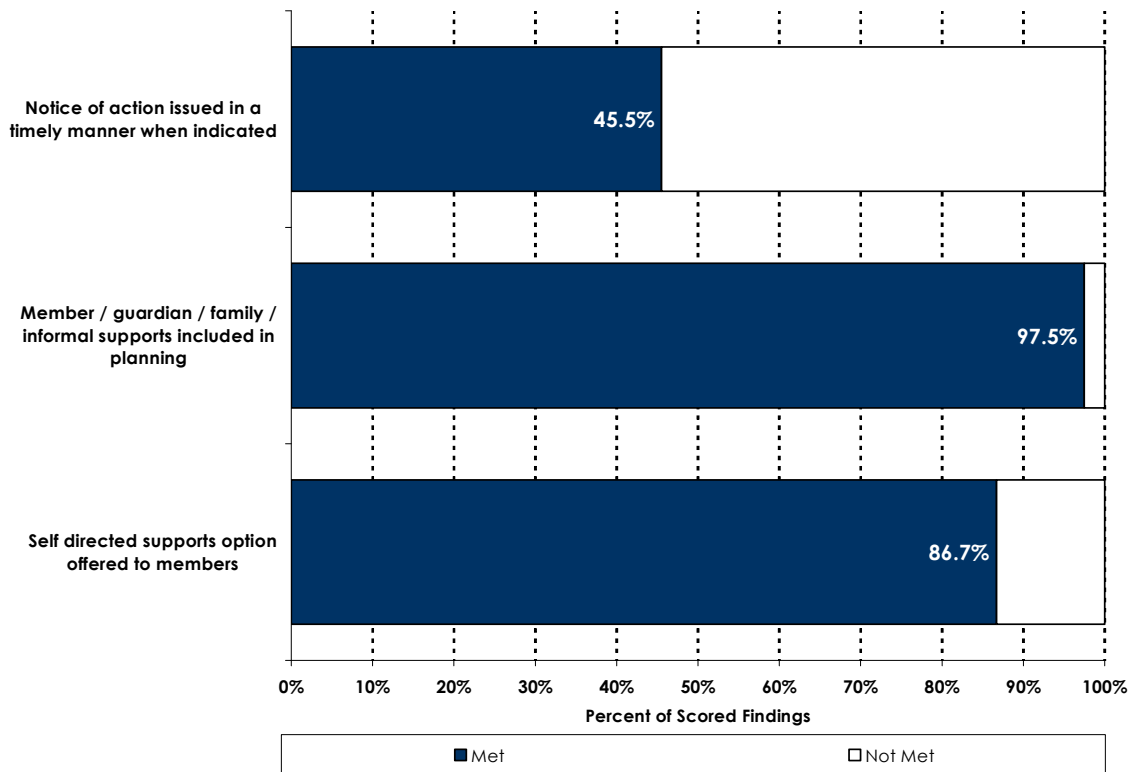
With a rate of almost 96 percent met the MetaStar EQR team found evidence in almost every member record it reviewed that teams implemented authorized services. The MCOs also did well to address members’ needs. The MCOs did moderately well with following up to ensure that services are effective and address identified needs. MCOs can improve by coordinating services in a timelier manner.

Participant Centered Focus

Care that is truly member centered focuses on members’ outcomes, preferences, and individual members’ supports.



Chart 20: 2008 CMR Participant Centered Focus Findings for MCOs with FCP or PACE Programs



MCOs’ performance on *Participant Centered Focus* measures was mixed. They included members, their guardians, family, and other informal supports in planning. MCOs did moderately well at offering the self-directed supports (SDS) option to members. However, the MCOs struggled to issue notices of action in a timely manner when indicated, meeting this measure in less than half of the records reviewed.

Strengths & Opportunities for Improvement

As noted in the aggregated CMR categories above the MCOs demonstrated exceptional performance (over 95 percent of indicators fully met) on seven measures.



Table 43: 2008 Strengths by CMR Measure for MCOs with FCP or PACE Programs

Category	Measure	Rate
Service Planning	Collaboration of the interdisciplinary team	99.2%
Service Planning	Risk addressed when identified	97.9%
Participant Centered Focus	Member / guardian / family / informal supports included in planning	97.5%
Assessment	Risk assessment completed when indicated	97.2%
Assessment	Comprehensiveness of initial assessment	96.9%
Assessment	Reassessment done when indicated	96.3%
Service Coordination and Delivery	Evidence that MCOs Implement Authorized Services	95.8%

MCOs consistently ensured teams implemented authorized services. They address risks when identified and reassess members when necessary. They create comprehensive initial assessments and perform risk assessments to ensure members' health and safety. MCOs involve members, guardians, and families, and informal supports in care planning. It was highly evident across the MCOs that team members collaborate with each other placing the member first.

MCOs struggled most with two measures meeting them about one-fourth and one-half of the time.

Table 44: 2008 Opportunities for Improvement by Overall CMR Measure for MCOs with FCP or PACE Programs

Category	Measure	Rate
Participant Centered Focus	Notice of action issued in a timely manner when indicated	45.5%
Service Planning	Comprehensiveness of most recent plan	27.1%

Although initial assessments are comprehensive MCOs do not excel preparing and implementing members' initial individualized plans in a timely manner. In addition, every MCO demonstrated difficulties related to issuing and mailing notices of action to members within the contractually stipulated deadlines.

DETAILED FINDINGS

Assessment

This category deals with activities that interdisciplinary care teams complete to obtain information about a member at timeframes specified by the MCO's contract with DFS.

Table 45: 2008 CMR Assessment Findings for MCOs with FCP or PACE Programs

Assessment Measures N=4	Who is eligible for the measure?	Criteria	Statistics		Rate
Timeliness of initial assessment	New members	Was the initial assessment done within 4 weeks of enrollment?	New members:	32	84.4%
			Initial assessment done in a timely manner:	27	
Comprehensiveness of initial assessment	New members	Was the initial assessment completed in person and did it contain information about a member's issues, needs, strengths and resources?	New members:	32	96.9%
			Initial assessment was comprehensive:	31	
Risk assessment completed when indicated	Any member at potential risk	For those members at potential risk, was a risk assessment completed when indicated?	Members at potential risk:	109	97.2%
			Risk assessment completed when indicated:	106	
Reassessment done when indicated	Any member enrolled one year or longer, or who had a change in living situation, or the team identified a risk to the member	If the member was eligible to have a reassessment completed, was it done when indicated?	Members eligible for reassessment:	54	96.3%
			Reassessment done when indicated:	52	

Overall, 97 percent of member records reviewed met the *comprehensiveness of initial assessment* and *risk assessment completed when indicated* measures. MCOs achieved the other assessment categories between 80 to 90 percent of the time.

Service Planning

For this category reviewers looked at various activities that reflect how well care teams plan members' services.

Table 46: 2008 CMR Service Planning Findings for MCOs with FCP or PACE Programs

Service Planning Measures N=7	Who is eligible for the measure?	Criteria	Statistics		Rate
Timeliness of initial individualized plan	New members	Was the initial individualized plan done within 8 weeks of enrollment?	New members:	26	92.3%
			Initial assessment done in a timely manner:	24	
Comprehensive-ness of most recent plan	All members	Was the most recent plan comprehensive?	All members:	32	75.0%
			Most recent plan was comprehensive:	24	
Timeliness of most recent plan	All members	Was the most recent plan reviewed at least every 6 months?	All members:	118	27.1%
			Most recent plan was done in a timely manner:	32	
Plan updated for significant changes	Members with significant changes	For those members with changes in health, psychosocial status, or setting that changed the way they needed or received care, was the plan updated with the significant changes?	Members with significant changes:	118	82.2%
			Plan updated:	97	
Timeliness of service authorizations	Members with service requests	For those members with service requests, were the service authorizations done in a timely manner?	Members with service requests:	37	78.4%
			Service authorizations done in a timely manner:	29	
Risk addressed	Any member at risk	For those members with risk, was the	Members at risk:	115	81.7%

Service Planning Measures N=7	Who is eligible for the measure?	Criteria	Statistics	Rate
when identified		risk addressed when identified?	Risk was addressed when identified:	94
Collaboration of the team	All members	Did all members of the team collaborate when providing care management?	All members:	96
			All team members collaborated on the members' case management:	94
				97.9%

Approximately 98 percent of records MetaStar reviewed at all MCOs showed evidence that MCO team members collaborated. *Timeliness of the most recent plan* plummeted in the last year from 69 percent to 27 percent.

Service Coordination & Delivery

This category deals with teams' activities to coordinate and follow-up with members' care and services.

Table 47: 2008 CMR Service Coordination and Delivery Findings for MCOs with FCP or PACE Programs

Service Coordination and Delivery Measures N=4	Who is eligible for the measure?	Criteria	Statistics	Rate
Timely coordination of services	Members with any services	For those members who had services, was the coordination of services done in a timely manner?	Members with services:	120
			Service coordination was done in a timely manner:	94
Evidence that MCOs Implement Authorized Services	Members with authorized services	For those members who had authorized services, is there evidence that the authorized services were implemented?	Members with authorized services:	120
			Evidence that authorized services were implemented:	115
Follow-up to ensure that services are effective	Members with authorized services	For those members who had authorized services, was follow-up done to ensure that the authorized services were effective?	Members with authorized services:	120
			Follow-up was done to ensure authorized services were effective:	99
Teams Address Members' Needs	All members	All members are assumed to have needs. Were their needs addressed?	All members:	120
			Identified needs were addressed:	111

Overall MCOs met each *Service Coordination & Delivery* measure between 78 and 96 percent of the time. MCOs need to pay most attention to the *timely coordination of services*.

Participant Centered Focus

This category concerns how well teams focus on members' preferences and supports when managing their care.



Table 48: 2008 CMR Participant Centered Focus Findings for MCOs with FCP or PACE Programs

Participant Centered Focus Measures N=3	Who is eligible for the measure?	Criteria	Statistics		Rate
Notice of action issued in a timely manner when indicated	All members	Were the members' preferences and/or outcomes incorporated into their plan?	All members:	44	45.5%
			Member MCOs with preferences / outcomes incorporated:	20	
Member / guardian / family / informal supports included in planning	All members	Was the member included in planning? If applicable, were the member's guardian, and/or family member, and/or informal supports included in the planning process?	All members:	120	97.5%
			Appropriate people included in planning:	117	
Self directed supports option offered to members	All members	Was the option of self directed supports offered to members?	All members:	120	86.7%
			Members who were offered the option of self directed supports:	104	

Teams incorporated member preferences and outcomes into plans only 45 percent of the time, a decline from last year they did it approximately three-fourths of the time. Reviewers found substantially more evidence that teams issued notices of action in a timely manner compared to last year when they found it in only one-fourth of the records they reviewed.

MCO STRENGTHS

Assessment

Timeliness of Initial Assessment

CHP-FCP employs several monitoring activities to assure teams complete assessments on time. Reviewers learned that supervisors conduct file reviews of two randomly selected member records each month and use a checklist to assure consistency among reviewers. The MCO collects the member's first face-to-face visit date. The MCO monitors when teams delay face-to-face visits or visits do not occur within the MCO's stated guidelines. It tracks and measures the rate and frequency of quarterly face-to-face visits or phone contacts.

Comprehensiveness of Initial Assessment

Community Care has several strengths in both programs that promote comprehensive initial assessments. It has standardized assessment forms to ensure that all disciplines assess members consistently. The MCO includes copies of the *Geriatric Depression Scale*, the *Braden Scale*, and the *Mini Mental Status Exam* in their assessments. These provide excellent objective information to the teams as they gain knowledge about new members.

CHP-FCP has standardized documentation procedures and assessment forms for each discipline on the interdisciplinary team. These tools captured members' needs, strengths, preferences, informal supports, long-term care outcomes, and any ongoing conditions that would require

regular care treatment or monitoring. The use of standardized assessment tools promotes consistency among team members' assessments.

CW-FCP has several strengths promoting comprehensive member assessments. The use of standardized assessment forms ensures they contain the same basic information. The MCO defined each discipline's role in assessing members and expects each discipline to share information with the rest of the team. Teams often copy into the LTC FS information the registered nurse gathered and summarized. This is another successful demonstration of information sharing important to care coordination.

Service Planning

Comprehensiveness of Most Recent Plan

CHP-FCP has a written expectation for the development and review of MCPs and ISPs. The process its teams use to review plans is a best practice. Teams review the previous plan with the member before developing the new plan. Teams make at least two visits with the member, one visit to review the previous plan and another visit to review and sign the updated plan.

Timeliness of Service Authorizations

CHP-FCP has a tool called a "job aide" which teams use as guidance when members make requests. The job aide helps teams determine the appropriateness of any request. It also guides teams on documenting the critical thinking process about requests. Tools like the job aide help teams to focus on creative member centered care and assure consistent decision making.

Risk Addressed when Identified

Addressing risk with members is a key component of ensuring their health and safety. Community Care and CHP-FCP teams do an excellent job of addressing risks with members. Community Care's documentation reflected that teams provide education and support to members at risk; MetaStar found this information in the nursing documentation. CHP-FCP's documentation reflected that teams provide education and support to members at risk especially when related to members' choice.

Records reviewed at CW-FCP demonstrated that care managers provide education and support about issues involving member risk related to condition or member choice. This practice is consistent with the MCO's expectations that members receive necessary education to make informed decisions. The MCO has a policy about risk agreements when members' health or safety or ability to live in the community is in jeopardy. Its practice guidelines provide a way to ensure that care managers consistently address areas of risk identified through standardized assessment.

Collaboration of the Interdisciplinary Team

Communication and collaboration are important factors to providing interdisciplinary care to members. All of the records reviewed indicated that this occurs between team members at Community Care. Teams meet regularly and are guided by team facilitators.

CHP-FCP teams excel in this indicator. Examples of communication and collaboration found during the record review included consistent documentation of team meetings in the member record (although details of those discussions were not documented), use of team communication forms to clarify orders and update providers on members' concerns and/or status, and the use of back up plans.

Service Coordination & Delivery

Timely Coordination of Services

Coordination is one of the primary responsibilities of care managers. Community Care results improved in the indicator for timely coordination of services from last year for both FCP and PACE. Community Care emphasizes care coordination in its service authorization policy which instructs teams to note when service delays are greater than thirty days.

Teams Address Members' Needs

After teams identify needs through the assessment process they must ensure they address them with members. Community Care exhibits strength in using resources to address the needs of members. For example, reviewers noted many records with chaplain involvement to meet members' spiritual needs.

Participant Centered Focus

Integrated Planning

Community Care does an excellent job of involving its members, their family members, legal representatives, and informal supports in their planning process. In both the FCP and PACE programs reviewers found evidence that this important planning process component was in place which leads to improved member communication and care. Community Care earned perfect scores in all FCP and PACE program member records MetaStar reviewed.

CHP-FCP care managers involve members and their supports in the planning process. Like at CW-FCP, this is a best practice. Reviewers found evidence of teams' respect for members' throughout the documentation. The MCO procedures clearly state that teams need to involve members and any formal or informal supports when developing MCPs.

Timely Issuance of Notices of Action

Community Care’s management and teams shared that they use large secured “white boards” to document and track member requests. The definition of “when a request is actually a request” has been discussed by teams and their supervisors for clarity.

Offering SDS to Members

At all three MCOs the signature page of the MCP/ISP contains standard language explaining and offering this option to its members. The requirement to have this information presented to individual members of the FCP and PACE programs is new for this review period. Community Care has performed well in this indicator in the FCP and has an opportunity to continue to address the SDS option consistently in the PACE program. Care Wisconsin greatly improved its consistent, documented offer of SDS to members.

MCO IMPROVEMENTS FROM PREVIOUS REVIEWS

The care management reviewer guidelines for FCP and PACE MCOs changed between the 2007 and 2008 CMRs and added one *Service Planning* measure and one *Participant Centered Focus* measure. A comparison between the 2007 and 2008 rates can be done on the seven *Service Planning* measures and the two *Participant Centered Focus* measures in common between the two years.

Table 49: 2007 - 2008 CMR Category Comparison for MCOs with FCP or PACE Programs

Category	Measures compared	Met in 2007	Met in 2008	Percent Change between 2007 - 2008
Assessment	4 of 4	93.6%	95.2%	1.6%
Service Planning	7 of 8	80.2%	77.5%	-2.7%
Service Coordination and Delivery	4 of 4	86.6%	87.3%	0.7%
Participant Centered Focus	2 of 3	80.5%	84.9%	4.4%

MCOs improved in the following CMR areas between 2007 and 2008.

Table 50: 2007 – 2008 CMR Measures Showing Improvement for MCOs with FCP or PACE Programs

Category	Measure	Met in 2007	Met in 2008	Percent Change between 2007 - 2008
Participant Centered Focus	Notice of action issued in a timely manner when indicated	26.5%	86.7%	227.4%
Service Planning	Timeliness of most recent plan	72.5%	82.2%	13.4%
Service Planning	Timeliness of initial individualized plan	66.7%	75.0%	12.5%

The most notable improvement between the two years was with the *comprehensiveness of the initial assessment*. *Completing indicated risk assessments* also improved slightly between the two years showing a continued high level of adherence with this requirement across the four programs at the three MCOs.

Assessment

Timeliness of Initial Assessment

CW-FCP’s performance in the *timeliness of initial assessment* indicator improved since the prior year. Only one of eight new members’ initial assessments was late. Guidelines clearly state timeframes for initial and ongoing member contacts and assessments. Registered nurses conduct comprehensive assessments during the members’ pre-enrollment period with the MCO. The intake staff and the CW-FCP team meet to transfer information learned prior to enrollment. The MCO has clear expectations for the assigned team to assess members within four weeks of enrollment. Although the documents directing the timeliness of initial assessments do not have a revision date this appears to be an improvement since last year’s EQR.

Service Planning

Timeliness of Most Recent Plan

CC-FCP has clear guidelines to teams about timely development and review of plans. Its findings in this category improved substantially in this area from last year’s findings.

Timeliness of Service Authorizations

Teams at Community Care use the RAD method to make service authorization decisions. Unlike last year, MetaStar reviewers found RAD documentation in the records they reviewed. The MCO reported that it was working on guidelines to complement the RAD and assist teams when making decisions about services. Staff reported it tracks decisions and reviews the tracking log for trends during quality improvement review.

CW-FCP made improvements in its service authorization process since last year's EQR. It no longer discerns between "formal" and "informal" requests. The MCO now applies the contract timeframes to all requests.

Collaboration of the Interdisciplinary Team

CW-FCP's care managers indicated that access to electronic notes from physician clinics and the ability to embed the physician notes within the MCO's own documentation is an improvement made in the last year that contributes to efficient and effective care management. Reviewers also noted the use of an information sheet for in-home care providers that identifies the actions the caregivers should take when members do not answer their doors for scheduled visits and what cares are critical if a scheduling emergency exists.

Service Coordination & Delivery

MetaStar reviewers did not identify improvements made by a FCP or PACE MCO in the last year related to the *Service Coordination & Delivery* standards.

Participant Centered Focus

MetaStar reviewers did not identify improvements made by a FCP or PACE MCO in the last year related to the *Participant Centered Focus* standards.

MCO OPPORTUNITIES FOR IMPROVEMENT & EQRO RECOMMENDATIONS

Assessment

MetaStar reviewers did not identify opportunities for improvement related to the Assessment standards for any FCP or PACE MCO.

Service Planning

Timeliness of Initial Individualized Plan

A program's current peer review process does not address current contract required timeframes for MCP and ISP development. The MCO uses an internal file review tool for its FCP program based on a tool MetaStar uses that covers contract expectations.

- **Recommendation:** Because this MCO uses an effective internal file review tool in its Family Care program, MetaStar recommends the MCO's FCP and PACE programs adopt the tool to ensure its internal file review process covers all required elements. The MCO has already acknowledged that this will be an area of focus.

An MCO continues to have difficulty obtaining a signature on the initial plan by the appropriate legal decision makers.

- **Recommendation:** The MCO should assure that the appropriate legal decision makers assist with plan development and sign the plan.

Comprehensiveness of Most Recent Plan

The FCP and PACE 2008 DHS contract language about comprehensiveness of plans changed from last year. The FCP and PACE contracts state that an MCP should provide a unique description of the individual to assist the interdisciplinary team, the member, and any service provider or other authorized party to have a clear understanding of the member's needs, strengths, and desires and come to a common understanding of the approach the team will use to coordinate the member's care and services.

The indicator for *comprehensiveness of most recent plan* decreased this year at an MCO. The MCO has written expectations to develop and review MCPs and ISPs; however, the CMR identified several opportunities for the MCO improve MCP documentation. This MCO excels at assessing members. Often the MCO does not transfer important information about members' care in the assessments into the plan. The CMR found some handwritten plans that were difficult to read. The plan format leads teams to document areas with "not met" findings. Although this is a good process, it does not prompt teams to include outcomes that have been met but still require intervention or services to remain met.

- **Recommendation:** The MCO should revise its MCP/ISP to promote further individualization of plans and more details to provide a unique description of the individual, his or her outcomes, needs, and supports. MetaStar suggests removing format limits and encouraging documentation of all member outcomes, providing ample space to record member preferences, providing prompts to identify the role of formal or informal supports in members' lives rather than a default statement of "caregiver," and assuring that plans are legible for ease of reading and understanding.

One MCO implemented a new plan format. Plans in the new format lacked the consistent documentation of details that were often found elsewhere in the member record or that were more evident on previous plans. Teams did not clearly document members' needs, services, acute/primary care, preferences, and outcomes on the plans.

- **Recommendation:** Member-centered planning is an ongoing process and should be documented within the MCP/ISP. The MCO must ensure that plans are comprehensive to give all involved a clear understanding of the member.

None of the thirty records reviewed at one MCO met the plan comprehensiveness requirements. Two primary reasons contribute to the dramatic decline. The MCO changed its MCP/ISP format and its contract with DHS changed. In prior years the MCO's care plan had two parts: the ISP and supporting documents and assessments found throughout the member record. Essentially the MCO considered the entire member record to be part of the plan. MetaStar and DHS acknowledged this structure; the MCO performed well in *comprehensiveness of individualized plan* indicators during previous reviews. Changes in the MCO's contract with DHS require a

separate MCP and ISP for FCP programs beginning in 2008. Previously the MCO required a single document, the ISP.

The MCO changed its practice to comply with the new contract requirements by developing an MCP/ISP document that includes the current medication list, self-directed supports agreement, durable medical equipment and durable medical services summary, and an authorization report of services including adult day center, lifeline, oxygen, hearing, and vision. While the plan revisions represent an improvement since last year, DHS will need to evaluate the MCO's approach to determine whether it complies with the contract requirements. The signature page lacks a statement that assures members reviewed the multiple forms and documents. Reviewers could not verify if members considered the information as part of the overall plan review. More importantly, the additional reports make it difficult and confusing for members to see how services or items contribute to achieving outcomes.

The MCO's MCP/ISP structure limits members to identifying and pursuing two outcomes during a six month period. The MCO's administrators indicated that could teams add more outcomes, but none of the plans reviewed during the CMR had additional outcomes documented. The plan structure does not prompt teams to document members' preferences. Reviewers noted that plans often lacked identification of informal supports. Several MCPs and ISPs did not adequately reflect MCO staff involvement of MCO to coordinate members' acute and primary care even though reviewers noted acute and primary health coordination as this MCO's strength.

- Recommendation: The MCO should revise the MCP/ISP to promote further individualization of plans and allow more details to provide a unique description of the individual, his or her outcomes, needs and supports. MetaStar suggested the MCO remove system limits and encourage documentation of all member outcomes with enough space to record member preferences and providing prompts to identify the role of informal supports in members' lives rather than a default statement that identifies the team as responsible "unless otherwise noted." The MCO should consider if the number of documents it includes with the MCP/ISP is necessary and meaningful to members. If it continues to include other documents, the MCO should have members sign a statement indicating they reviewed, understand, and agree with the information presented in the attachments and with the MSP or ISP. In addition to changing the plan structure the MCO must ensure that teams understand the purpose of the MCP/ISP and record the care the MCO coordinates, the acute and primary health care it coordinates, and members' outcomes in a manner reflective of their voices.

Recommendation to DHS:

DHS will need to evaluate the MCO's new MSP/ISP document to determine whether it complies with the contract requirements.

Timeliness of Most Recent Plan

One MCO monitors member records to ensure that care managers conduct timely periodic visits with members, but it does not monitor the timeliness of health or social assessments after enrollment.

- **Recommendation:** The MCO must ensure that teams complete the plan review by the end of the sixth month after the previous plan review. The current guidelines allow teams to obtain member signatures up to two weeks after they develop the plan. The MCO should require teams to complete all aspects of the plan review, including signatures, within the contract timeframe. The MCO should also revise its internal monitoring process to align with the timeframe so it can analyze data for contract standards. The MCO should develop and implement a process to monitor if teams update members' plans when significant changes occur.

Plan Updated for Significant Changes

An MCO's MCP and ISP expectations do not address updates to plans to reflect changing member needs, conditions, or outcomes.

- **Recommendation:** Including review of MCP and ISP updates in the internal review process will help an MCO to monitor whether teams update plans at non-scheduled intervals such as a when the member has a change in living situation or condition. Teams should update the MCP and ISP when changes happen that affect the way a member needs or receives care, a best practice that focuses on member centered care. The MCO should have an internal review process to monitor teams' development of MCPs and ISPs and whether they update them at non-scheduled intervals.

Timeliness of Service Authorizations

While an MCO's CMR demonstrated that teams implemented authorized services they did not always make service decisions in a timely manner.

- **Recommendation:** The MCO should assure that the process that tracks decisions should be assessed or reviewed to assure that it applies consistency across teams with regards to decision making timeframes.

As noted by discrepancies between an MCO's decision log and documentation in member records, teams do not document requests consistently or do not consider all requests in the same manner.

- **Recommendation:** While review findings demonstrated that teams made service decisions in a timely manner the MCO should compare the findings from the record review to the decision log to ensure teams consistently track requests.

Although an MCO has very clear expectations about the RAD method member records did not show evidence that teams used the method. During this MCO's 2008 QCR care managers spoke with knowledge about the RAD process, how the process assists teams to make service decisions and get to the root cause of requests.

- Recommendation: The MCO should also revise care manager practice to document use of the RAD method in making decisions about services.

Collaboration of the Interdisciplinary Team

Although an MCO's teams successfully communicate and collaborate, one record in the CMR showed minimal social worker involvement since the member's nursing home became the permanent residence. During last year's EQR reviewers noted that the MCO assigns only a nurse practitioner to members who permanently reside in a nursing home. The MCO continued this practice despite DHS contract expectations to assign a team comprised of a social worker, registered nurse, and nurse practitioner to each member. The MCO's structure provides for routine needs to be met by the core team of the MCO nurse practitioner, nursing home social worker and nursing home registered nurse. A MCO social worker can provide consultation and support for the nurse practitioner on challenging cases. The MCO social worker can step outside of her consultant role and into a social work extender role if approved through the RAD method.

- Recommendation: The MCO should work with DHS to determine if the nursing home team structure is consistent with the interdisciplinary team requirements of its contract with DHS. It appears that assigning only an MCO nurse practitioner does not align with contract requirements. Nursing home members might not receive care in the same manner other MCO members who have a social services counselor and registered nurse assigned.

Recommendation to DHS

DHS should work with the MCO to determine if the nursing home team structure is consistent with the team requirements of the MCO's contract with DHS.

Service Coordination & Delivery

Timely Coordination of Services

While an MCO improved in this indicator from last year's review the CMR found that some services took longer than the acceptable timeframe to obtain.

- Recommendation: The MCO should monitor service coordination during internal file reviews.

Evidence that MCOs Implement Authorized Services

Because MetaStar's reviewers observed documentation inconsistencies in an MCO's case notes and MCPs and ISPs they had difficulty discerning an actual service start date or delivery date. Reviewers could not determine if another MCO's teams ensured providers delivered authorized services to members. Reviewers did not identify a link between service verification within the electronic documentation system and care managers' documentation of service implementation in the written case notes.

- **Recommendation:** Although these MCOs use a standardized documentation method they should consider developing and implementing documentation standards that specifically address follow-up for consistency among teams. One MCO should monitor these documentation standards during internal file review.

Follow Up to Ensure Services are Effective

Care managers must determine if interventions meet members' needs and outcomes.

- **Recommendation:** Although an MCO has a standardized method for documentation, it should consider developing and implementing documentation standards. It should also develop an overall internal file review process that addresses follow-up activities.

Participant Centered Focus

Timely Issuance of Notices of Action

The CMR found an MCO did not issue notices of action in a timely manner for its FCP and PACE programs even though teams appear to have a good understanding of the process.

- **Recommendation:** Although the MCO has policies and procedures place to ensure the timely completion of notices of action teams do not always send them to members. The MCO should emphasize the completion of this step for its members when the decision is to limit, terminate, or deny a service.

An MCO tracks the outcome of all service decisions using a decision log. It appears that teams might not consider all requests in the same manner as noted by discrepancies between the decision log and the documentation in the member records. The CMR at another MCO found requests not recorded on its timeliness of decision log or its *Notice of Action* log. It did not follow requests with timely decisions.

- **Recommendations:** MCOs must ensure that members receive notices of action within designated timeframes according to federal and state requirements. The MCO must monitor the issuance notices of action to ensure that teams consistently submit and document requests to track decision timeliness. Increased monitoring will help the MCO determine whether the root cause of the problem relates to a misunderstanding of

members' requests and needs or its internal process. After the MCO collects the data it should determine an effective solution to improve the compliance with this requirement and how best to educate and support teams to improve the rate at which members receive timely notice.

Offering SDS to Members

At one MCO supervisors do not monitor SDS compliance during the internal file review process.

- Recommendation: The MCO should monitor member records to ensure that care managers document offers of SDS to all members and check boxes and signatures are present to verify the offers and the members' choices to accept or decline the offer.



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APPENDIX 2: ACRONYMS & ABBREVIATIONS USED IN THIS REPORT

BCAP	Best Clinical and Administrative Practices	DHFS	Wisconsin Department of Health and Family Services (name prior to 2009)
BPT	Best Practice Team	DHS	Wisconsin Department of Health Services (current name)
CC-FC	Community Care Managed Care Organization: Family Care program	DQA	Division of Quality Assurance at the Wisconsin DHS
CC-FCP	Community Care Managed Care Organization: Family Care Partnership program	EQR	External Quality Review
CC-PACE	Community Care Managed Care Organization: Program of All-Inclusive Care for the Elderly	EQRO	External Quality Review Organization
CCCW	Community Care of Central Wisconsin Managed Care Organization: Family Care program	FCP	Family Care Partnership (formerly the Wisconsin Partnership Program)
CCO	Creative Care Options Managed Care Organization: Family Care program	ISP	Individual Service Plan
CFR	Code of Federal Regulations	LTC FS	Long-Term Care Functional Screen
CHP-FC	Community Health Partnership Managed Care Organization: Family Care program	MCDA	Milwaukee County Department on Aging Care Management Organization: Family Care program
CHP-FCP	Community Health Partnership Managed Care Organization: Family Care Partnership program	MCO	Managed Care Organization
CMR	Care Management Review	MCP	Member-Centered Plan
CMS	Centers for Medicare & Medicaid Services	NB	NorthernBridges Managed Care Organization: Family Care program
CMU	Care Management Unit	NOA	Notice of Action
CW-FC	Care Wisconsin Managed Care Organization: Family Care program	OIG	Office of the Inspector General
CW-FCP	Care Wisconsin Managed Care Organization: Family Care Partnership program	PACE	Program of All-Inclusive Care for the Elderly
		PDSA	Plan-Do-Study-Act (cycle)
		PHI	Protected Health Information
		PIHP	Prepaid Inpatient Health Plan
		PII	Personally Identifiable Information

PIP	Performance Improvement Project
QA	Quality Assurance
QAPI	Quality Assessment and Performance Improvement
QCR	Quality Compliance Review
QI	Quality Improvement
RAD	Resource Allocation Decision making (method)
SDS	Self-Directed Supports
SFCA	Southwest Family Care Alliance Managed Care Organization: Family Care program
SFY	State Fiscal Year
Team	Interdisciplinary Team
WWC	Western Wisconsin Cares Managed Care Organization: Family Care program



APPENDIX 3: 2009 QCR FINDINGS FOR FAMILY CARE MCOs

ENROLLEE RIGHTS

Enrollee Rights Standards	#	Community Care (CC-FC)	Community Care of Central Wisconsin (CCCW)	Creative Care Options (CCO)	Milwaukee County Department on Aging Care Management Organization (MCDA)	Southwest Family Care Alliance (SFCA)	Western Wisconsin Cares (WWC)
The MCO has a written policy about member rights.	1	Met	Met	Met	Met	Met	Met
The MCO ensures its staff and contracted providers take members' rights into consideration when furnishing services to them.	2	Met	Met	Met	Met	Met	Met
The MCO provides all enrollment notices, informational materials, and instructional materials relating to members and potential members in a manner and format that may be easily understood.	3	Met	Met	Met	Met	Met	Met
The MCO makes its written information available in the prevalent, non-English languages in its particular service area.	4	Met	Met	Met	Met	Met	Met
The MCO provides interpretation and translation services available to their members free of charge.	5	Met	Met	Met	Met	Met	Met
The MCO provides written materials in an easily understood language and format.	6	Met	Met	Met	Met	Met	Met
The MCO must have written material available in alternate formats that take into account the special needs of members.	7	Met	Met	Met	Met	Met	Met
The MCO notifies members of their right to request and obtain information at least once a year about their rights.	8	Met	Met	Met	Met	Met	Met
The MCO provides enrollment information to new members in a timely manner.	9	Met	Met	Met	Met	Met	Met
The MCO notifies members at least thirty days before a significant change in member rights is implemented.	10	Met	Met	Met	Met	Met	Met
The MCO must provide written notice of termination of a contracted provider within 15 days after issuance of the termination notice, to each member who received services from such provider.	11	This is not a contract requirement in the Family Care program.					
Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers must be provided to all members.	12	Partially Met	Partially Met	Met	Partially Met	Met	Met
The MCO allows freedom of choice for female members to access a woman's specialist or, when age-appropriate, obtain the services of qualified family planning providers.	13	Primary care is not a provision of the Family Care benefit package.					
The MCO provides information to all members on members' rights and responsibilities and information on grievance and fair hearing procedures.	14	Met	Met	Met	Met	Met	Met
The MCO provides information to all members on the amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled and the procedures for obtaining benefits, including authorization requirements.	15	Met	Met	Met	Met	Met	Met
The MCO informs members how to obtain services from providers outside of the MCO's contracted provider network.	16	Met	Met	Met	Met	Met	Met
The MCO informs members how to obtain after hours and emergency services.	17	The provision of emergency and post-stabilization of care services are not in the Family Care benefit package.					



Enrollee Rights Standards	#	Community Care (CC-FC)	Community Care of Central Wisconsin (CCCW)	Creative Care Options (CCO)	Milwaukee County Department on Aging Care Management Organization (MCDA)	Southwest Family Care Alliance (SFCA)	Western Wisconsin Cares (WWC)
The MCO provides information to all members about post-stabilization care service rules (related to the financial responsibility of care provided).	18	The provision of emergency and post-stabilization of care services are not in the Family Care benefit package.					
The MCO informs members how to obtain referrals for specialty care and other benefits not furnished by members' primary care providers.	19	Met	Met	Met	Met	Met	Met
The MCO explains each member's responsibility to pay a cost share – an amount, based on each member's ability to pay, toward the cost of member's care.	20	Met	Met	Met	Met	Met	Met
The MCO informs members how to obtain benefits that are available under the Wisconsin Medicaid program but are not part of the MCO's benefit package.	21	Met	Met	Met	Met	Met	Met
The MCO provides grievance, appeal, and fair hearing procedures and timeframes, in a State-developed or State-approved description, that includes the right to file grievances and appeals and, for State fair hearing, the right to a hearing, the method for obtaining a hearing and the rules that govern representation at the hearing.	22	Met	Met	Met	Met	Met	Met
The MCO provides grievance, appeal, and fair hearing procedures and timeframes, in a State-developed or State-approved description, that includes the requirements and timeframes for filing a appeal or grievance, the availability of assistance in the filing process, the toll-free numbers that the member can use to file a grievance or an appeal by phone, the fact that, when requested by the member, benefits will continue if the member files an appeal or a request for State fair hearing within the timeframes specified for filing and the fact the member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.	23	Met	Met	Met	Met	Met	Met
The MCO provides grievance, appeal, and fair hearing procedures and timeframes, in a State-developed or State-approved description, any appeal rights that the State chooses to make available to providers to challenge the failure of the organization to cover a service.	24	Met	Met	Met	Met	Met	Met
The MCO informs members about advance directives.	25	Met	Met	Met	Met	Met	Met
The MCO is required to have written policies and procedures about advance directives.	26	Met	Met	Met	Met	Met	Met
The MCO is required to provide written information on advance directives to each member at the time of initial enrollment.	27	Met	Met	Met	Met	Met	Met
The MCO is required to provide community education about advance directives either directly or in concert with other providers and must be able to document its community education efforts.	28	Met	Met	Met	Met	Met	Met
The MCO did not identify any providers who provided care that conflicts with members' advance directives.	29	Met	Met	Met	Met	Met	Met
The MCO informs members with complaints concerning non-compliance with an advance directive may be filed with the State survey and certification agency.	30	Met	Met	Met	Met	Met	Met
The MCO gives members information about physician incentive plans.	31	This standard does not apply to the Family Care program.					



Enrollee Rights Standards	#	Community Care (CC-FC)	Community Care of Central Wisconsin (CCCW)	Creative Care Options (CCO)	Milwaukee County Department on Aging Care Management Organization (MCDA)	Southwest Family Care Alliance (SFCA)	Western Wisconsin Cares (WWC)
If the State plan provides for mandatory enrollment the State or its contracted representative must provide information on MCOs either directly or through the MCO. The information must be furnished as follows: for potential members, within the specified timeframes, for members, annually and upon request, in a comparative, chart-like format. The following information must be furnished: the MCO's service area, the benefits covered under the contract, and any cost sharing imposed by the MCO.	32	This standard only applies to plans with mandatory enrollment.					
The MCO must not charge members for services included in the Family Care benefit package.	33	Met	Met	Met	Met	Met	Met
The MCO should provide, to the extent available, quality and performance indicators, including but not limited to disenrollment rates and member satisfaction.	34	n/a	n/a	n/a	n/a	n/a	n/a
All members are guaranteed the right to be treated with respect and due consideration for his/her dignity and privacy.	35	Met	Partially Met	Met	Met	Partially Met	Partially Met
The MCO gives members information on available treatment options and alternatives, presented in a manner appropriate to each member's condition and ability to understand.	36	Met	Met	Met	Met	Met	Met
An MCO cannot prohibit or restrict a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient, in regards to the member's health status, medical care or treatment options, including any alternative treatment that may be self-administered; any information the member needs to decide among all relevant treatment options; the risks, benefits, and consequences of treatment or non-treatment, and the member's right to participate in decisions about his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.	37	Met	Met	Met	Met	Met	Met
All members are guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.	38	Met	Met	Met	Partially Met	Met	Met
All members have the right to be furnished health care services.	39	Met	Met	Met	Met	Met	Met
Met Findings by MCO		31 (96.9%)	30 (93.8%)	32 (100%)	30 (93.8%)	31 (96.9%)	31 (96.9%)
Partially Met Findings by MCO		1 (3.1%)	2 (6.2%)	0 (0%)	2 (6.2%)	1 (3.1%)	1 (3.1%)
Not Met Findings by MCO		0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)



QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT: ACCESS TO SERVICES

QAPI Access to Services Standards	#	Community Care (CC-FC)	Community Care of Central Wisconsin (CCCW)	Creative Care Options (CCO)	Milwaukee County Department on Aging Care Management Organization (MCDA)	Southwest Family Care Alliance (SFCA)	Western Wisconsin Cares (WWC)
The MCO maintains and monitors networks of appropriate providers that are supported by written agreements and are sufficient to provide adequate access to all contractually covered services.	1	Met	Met	Met	Partially Met	Met	Met
In establishing and maintaining the provider network, the MCO must consider anticipated Medicaid enrollment and expected utilization of services.	2	Met	Met	Met	Met	Met	Met
In establishing and maintaining the provider network, the MCO must consider the numbers and types of providers required to furnish the contracted services.	3	Met	Met	Met	Met	Met	Met
In establishing and maintaining the provider network, the MCO must consider the number of network providers who are not accepting new MCO members.	4	Met	Met	Met	Met	Met	Met
In establishing and maintaining the network, the MCO must consider the geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities.	5	Met	Met	Met	Met	Met	Met
In addition to members' designated source of primary care, the MCO provides for its female members direct access to a women's health specialist.	6	Primary care is not a provision of the Family Care benefit package.					
The MCO provides for a second opinion from a qualified health care professional within the network or arranges for the member to obtain one outside the network, at no cost to the member.	7	Met	Met	Met	Met	Met	Met
If the network is unable to provide covered services to a member, the MCO must adequately and timely cover the services out of network for as long as the MCO is unable to provide them.	8	Met	Met	Met	Met	Met	Met
The MCO works with out-of-network providers to ensure that the cost of services to members is no greater than they would have been if furnished within the provider networks.	9	Met	Met	Met	Met	Met	Met
Providers ensure timely access to care and services, taking into account the urgency of need for services.	10	Met	Met	Met	Partially Met	Met	Met
Each MCO must monitor providers regularly to determine if they are making services available 24 hours a day, 7 days a week when medically necessary.	11	Met	Met	Met	Met	Met	Met
Ensure that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member.	12	Met	Met	Met	Met	Met	Met
The MCO coordinates members' care with other providers and MCOs and shares the results of members' assessment needs to keep plans from duplicating services and activities, all the while protecting members' privacy.	13	Met	Partially Met	Met	Met	Met	Partially Met
The MCO provides services to all members because of their special health care needs.	14	Met	Met	Met	Met	Met	Met



QAPI Access to Services Standards	#	Community Care (CC-FC)	Community Care of Central Wisconsin (CCCW)	Creative Care Options (CCO)	Milwaukee County Department on Aging Care Management Organization (MCDA)	Southwest Family Care Alliance (SFCA)	Western Wisconsin Cares (WWC)
The MCO assesses its members' ongoing special conditions that require a course of treatment or regular care monitoring by appropriate health care professionals.	15	Met	Partially Met	Met	Met	Met	Met
Members' Individual Service Plans and Member-Centered Plans are completed and approved in a timely manner.	16	Partially Met	Met	Met	Partially Met	Partially Met	Met
The MCO facilitates access to specialists appropriate for members' special health care conditions and needs.	17	Primary care is not a provision of the Family Care benefit package.					
The MCO and its subcontractors have in place and follow written policies and procedures when processing requests for initial and continuing authorization of services.	18	Partially Met	Partially Met	Met	Partially Met	Partially Met	Met
The MCO has in effect mechanisms to ensure consistent application of review criteria for authorization decisions when processing requests for initial and continuing authorization of services.	19	Met	Met	Partially Met	Partially Met	Partially Met	Met
When authorizing initial and continuing services, the MCO consults with providers requesting the services when appropriate.	20	Met	Met	Met	Met	Met	Met
The MCO works with health care professionals with appropriate clinical expertise in treating members' conditions or diseases when deciding to deny a service authorization request or authorize a service in an amount, duration or scope that is less than what was requested.	21	Met	Met	Met	Met	Met	Met
The MCO must notify the requesting provider, and give the member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested.	22	Partially Met	Met	Partially Met	Partially Met	Partially Met	Met
The MCO must provide notice of a standard service authorization decision within 14 calendar days following the request for service.	23	Partially Met	Partially Met	Partially Met	Partially Met	Partially Met	Met
The MCO must make an expedited authorization decision as expeditiously as the member's health condition requires and no longer than 3 working days after receipt of the request.	24	Met	Met	Met	Met	Met	Met
The MCO ensures that people who perform utilization management activities for the MCOs are paid so that they are not given incentives to deny, limit or discontinue medically necessary services for any member.	25	Met	Met	Met	Met	Met	Met
The MCO covers and pays for emergency services regardless of whether the provider or entity that furnishes the care has a contract with the MCO.	26	Primary care is not a provision of the Family Care benefit package.					
The MCO does not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.	27	Primary care is not a provision of the Family Care benefit package.					
The MCO does not hold members liable for payment of subsequent screening or treatment needed to diagnose the specific condition or stabilize the member. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is stabilized for transfer or discharge. Post-stabilization care services are covered and paid for by the MCO.	28	Primary care is not a provision of the Family Care benefit package.					
Met Findings by MCO		19 (82.6%)	19 (82.6%)	20 (87.0%)	16 (69.6%)	18 (78.3%)	22 (95.7%)
Partially Met Findings by MCO		4 (17.4%)	4 (17.4%)	3 (13.0%)	7 (30.4%)	5 (21.7%)	1 (4.3%)
Not Met Findings by MCO		0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)



QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT: STRUCTURE & OPERATIONS

QAPI Structure & Operations Standards	#	Community Care (CC-FC)	Community Care of Central Wisconsin (CCCW)	Creative Care Options (CCO)	Milwaukee County Department on Aging Care Management Organization (MCDA)	Southwest Family Care Alliance (SFCA)	Western Wisconsin Cares (WWC)
Each MCO must implement written policies and procedures for selection and retention of providers.	1	Met	Met	Met	Met	Met	Met
The MCO must follow a documented process for credentialing and recredentialing of contracted providers.	2	Met	Met	Met	Partially Met	Met	Partially Met
The MCO has provider selection policies and procedures that do not discriminate against particular practitioners that serve high risk populations or specialize in conditions that require costly treatment.	3	Met	Met	Met	Met	Met	Met
If the MCO declines to include providers in its network, it must give the affected providers written notice of the reason for its decision.	4	Met	Met	Met	Met	Met	Met
The MCO may not employ or contract with providers excluded from participation in federal health care programs.	5	Met	Partially Met	Partially Met	Partially Met	Partially Met	Partially Met
The MCO must comply with any additional requirements established by the State.	6	Partially Met	Partially Met	Met	Partially Met	Partially Met	Partially Met
The MCO must not request disenrollment for reasons other than those permitted under contract.	7	Met	Met	Met	Met	Met	Met
The MCO informs members about when they may ask to disenroll from a MCO.	8	The State does not limit disenrollment.					
The member must submit an oral or written request for disenrollment to the MCO.	9	Met	Met	Met	Met	Met	Met
The MCO allows members to disenroll when members move out of a MCO's service area; because of religious or moral objections, a MCO does not cover the services the member seeks; members need related services performed at the same time, but not all related services are available within the MCO's provider network, and the member's primary care provider or another provider determines that receiving services separately would subject the member to unnecessary risk; or the MCO provides poor quality of care, lacks access to services covered under the MCO's contract with the State, or lacks access to providers who are experienced in dealing with a member's health care needs.	10	Met	Met	Met	Met	Met	Met
An MCO may approve a request for disenrollment or refer the request to the State.	11	Met	Met	Met	Met	Met	Met
The MCO may refer members' disenrollment requests to the State with information about the reasons cited in members' requests.	12	Met	Met	Met	Met	Met	Met
The MCO uses grievance procedures in a timely manner to permit members to disenroll from MCOs by regulated deadlines.	13	The State does not require the use of the grievance process prior to disenrollment.					
The effective date of disenrollment must be no later than the first day of the second month following the month in which the member or the MCO files the request.	14	Met	Met	Met	Met	Met	Met
The MCO must ensure that they are providing notices of action to members in a timely manner (for service requests that are denied or limited, within 14 calendar days of the request; and for termination, suspension or reduction of a previously authorized service, within 10 calendar days of the action).	15	Partially Met	Partially Met	Partially Met	Partially Met	Partially Met	Partially Met
The MCO oversees and is accountable for all functions and responsibilities they delegate to subcontractors.	16	Met	Met	Met	Met	Met	Met



QAPI Structure & Operations Standards	#	Community Care (CC-FC)	Community Care of Central Wisconsin (CCCW)	Creative Care Options (CCO)	Milwaukee County Department on Aging Care Management Organization (MCDA)	Southwest Family Care Alliance (SFCA)	Western Wisconsin Cares (WWC)
The MCO evaluates prospective subcontractors' abilities to perform the activities to be delegated prior to the actual delegation of functions and responsibilities.	17	Met	Met	Met	Met	Met	Met
The MCO provides written agreements to their subcontractors which specify the activities and responsibilities designated to the subcontractors and reasons to revoke delegation or impose other sanctions if a subcontractor's performance is inadequate.	18	Met	Met	Met	Met	Met	Met
The MCO monitors its subcontractors' performance and subjects it to formal review according to a periodic schedule established by the State.	19	Met	Met	Met	Met	Partially Met	Met
The MCO and the subcontractor take corrective action if an MCO identifies deficiencies or areas for improvement.	20	Met	Met	Met	Met	Met	Met
Met Findings by MCO		16 (88.9%)	15 (83.3%)	16 (88.9%)	14 (77.8%)	14 (77.8%)	14 (77.8%)
Partially Met Findings by MCO		2 (11.1%)	3 (16.7%)	2 (11.1%)	4 (22.2%)	3 (16.7%)	4 (22.2%)
Not Met Findings by MCO		0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (5.5%)	0 (0%)



QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT: MEASUREMENT & IMPROVEMENT

QAPI Measurement & Improvement Standards	#	Community Care (CC-FC)	Community Care of Central Wisconsin (CCCW)	Creative Care Options (CCO)	Milwaukee County Department on Aging Care Management Organization (MCDA)	Southwest Family Care Alliance (SFCA)	Western Wisconsin Cares (WWC)
Practice guidelines need to be based on valid and reliable clinical evidence.	1	Met	Met	Met	Met	Partially Met	Met
Practice guidelines must consider the needs of the MCO's members.	2	Met	Met	Met	Met	Met	Met
Practice guidelines need to be developed in consultation with health care professionals.	3	Met	Met	Met	Met	Partially Met	Met
Practice guidelines need to be reviewed and updated periodically.	4	Met	Met	Met	Met	Met	Met
Practice guidelines need to be distributed to all affected providers.	5	Partially Met	Met	Met	Partially Met	Partially Met	Met
Decisions for utilization management, member education, coverage of services, and other are about which the guidelines apply are consistent with the guidelines.	6	Met	Met	Met	Partially Met	Partially Met	Met
The MCO must have an ongoing quality assessment and performance improvement program for the services it furnishes to members.	7	Partially Met	Partially Met	Met	Met	Partially Met	Met
Each MCO must conduct performance improvement projects. These projects must achieve significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction.	8	Met	Met	Met	Partially Met	Partially Met	Met
MCOs must have an ongoing program of performance improvement projects that focuses on clinical and non-clinical areas.	9	Met	Met	Met	Partially Met	Met	Met
The MCO must have an ongoing program of performance improvement projects that focus on clinical and non-clinical areas, measuring performance using objective quality indicators, implementing system interventions to achieve improvement in quality, evaluating the effectiveness of the interventions, and planning and initiating of activities to increase or sustain improvement.	10	Met	Met	Met	Partially Met	Not Met	Met
The MCO must report the status and results of each performance improvement project to the State as requested and complete each project in a reasonable time period.	11	Met	Met	Met	Partially Met	Partially Met	Met
Annually, the MCO must measure and report to the State its performance, using standard measures required by the State and/or submit to the State, data specified by the State that enables the State to measure the MCO's performance.	12	This measure is rated during the Performance Measure Validation process and is not reported in the EQR report.					
The MCO must have in effect mechanisms to detect both under- and over-utilization of services.	13	Partially Met	Partially Met	Met	Partially Met	Not Met	Partially Met
The MCO must have in effect mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs.	14	Met	Partially Met	Partially Met	Partially Met	Partially Met	Met
The MCO submits for State review the impact and effectiveness of its quality assessment and performance improvement program, including its performance on standard measures on which it is required to report and the results of its performance improvement projects, and the MCO has in effect a process for its own evaluation of its quality assessment and performance improvement program.	15	Met	Not Met	Met	Partially Met	Met	Met



QAPI Measurement & Improvement Standards	#	Community Care (CC-FC)	Community Care of Central Wisconsin (CCCW)	Creative Care Options (CCO)	Milwaukee County Department on Aging Care Management Organization (MCDA)	Southwest Family Care Alliance (SFCA)	Western Wisconsin Cares (WWC)
The MCO maintains a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of this subpart. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility.	16	This measure is rated during the Performance Measure Validation process and is not reported in the EQR report.					
Each MCO must collect data on member and provider characteristics through an encounter data system or other method as specified by the State.	17	This measure is rated during the Performance Measure Validation process and is not reported in the EQR report.					
The MCO must ensure that data received from providers is accurate and complete by verifying the accuracy and timeliness of reported data; screening the data for completeness, logic, and consistency; and collecting service information in standardized formats to the extent feasible and appropriate.	18	This measure is rated during the Performance Measure Validation process and is not reported in the EQR report.					
The MCO must make all collected data available to the State and upon request to CMS.	19	This measure is rated during the Performance Measure Validation process and is not reported in the EQR report.					
Met Findings by MCO	11 (78.6%)	10 (71.4%)	13 (92.9%)	5 (35.7%)	4 (28.6%)	13 (92.9%)	
Partially Met Findings by MCO	3 (21.4%)	3 (21.4%)	1 (7.1%)	9 (64.3%)	8 (57.1%)	1 (7.1%)	
Not Met Findings by MCO	0 (0%)	1 (7.1%)	0 (0%)	0 (0%)	2 (14.3%)	0 (0%)	



GRIEVANCE SYSTEMS

Grievance Systems Standards	#	Community Care (CC-FC)	Community Care of Central Wisconsin (CCCW)	Creative Care Options (CCO)	Milwaukee County Department on Aging Care Management Organization (MCDA)	Southwest Family Care Alliance (SFCA)	Western Wisconsin Cares (WWC)
Each MCO must have a system in place for members including a grievance process, an appeals process and access to the State's fair hearing system.	1	Met	Met	Met	Met	Met	Met
A member may file a grievance and an MCO level appeal and may request a fair hearing.	2	Met	Met	Met	Met	Met	Met
A provider, acting on behalf of a member and with the member's written consent, may file an appeal or grievance and may request a State fair hearing.	3	Met	Met	Met	Met	Met	Met
Members or providers may file an appeal or State Fair Hearing within 45 days of the date on the notice of action form.	4	Met	Met	Met	Met	Met	Met
Members may file a grievance either orally or in writing.	5	Met	Met	Met	Met	Met	Met
Members or providers may file an appeal either orally or in writing, and unless an expedited resolution is requested, must follow an oral appeal with a signed, written appeal.	6	Met	Met	Met	Met	Met	Met
The Notice of Action must explain the member's right to request a State fair hearing and the circumstances under which an expedited resolution is available and how to request it.	7	Met	Met	Met	Met	Met	Met
The Notice of Action must explain the member's right to have benefits continue pending the resolution of the appeal, how to request that services continue and the circumstances under which the member may be required to pay for the cost of the services.	8	Met	Met	Met	Met	Met	Met
Notices of Action must be mailed at least 10 calendar days before the effective date of the action for termination, suspension or reduction of a previously authorized service.	9	Partially Met	Met	Met	Partially Met	Met	Partially Met
The MCO must mail the notice of action at least 10 days before the date of action.	10	Met	Met	Met	Partially Met	Met	Partially Met
If a member's whereabouts are unknown, any discontinued service must be reinstated if his whereabouts become known during the time he is eligible for services.	11	Met	Met	Met	Met	Met	Met
The MCO must mail the notice of action at least 10 days before the date of action except when the MCO establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction or State.	12	Met	Met	Met	Met	Met	Met
The MCO must mail the notice of action for denial of payment at the time of any action affecting the claim.	13	Met	Met	Met	Met	Met	Met
Notices of action must be mailed within 14 calendar days following the receipt of request, with a possible extension of up to 14 additional calendar days if the member or provider requests an extension, for standard service request that are denied or limited.	17	Partially Met	Partially Met	Partially Met	Partially Met	Partially Met	Partially Met
If the MCO extends the timeframe for service authorization decision making, it must give the member written notice of the reason along with appeal and grievance rights.	15	Partially Met	Met	Met	Partially Met	Partially Met	Met
The MCO must provide the member with a notice if it is unable to make service authorization decisions if it extends the original 14 day timeframe by an additional 14 days.	16	Met	Partially Met	Met	Partially Met	Partially Met	Partially Met



Grievance Systems Standards	#	Community Care (CC-FC)	Community Care of Central Wisconsin (CCCW)	Creative Care Options (CCO)	Milwaukee County Department on Aging Care Management Organization (MCDA)	Southwest Family Care Alliance (SFCA)	Western Wisconsin Cares (WWC)
The MCO must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 3 working days after receipt of the request for service. Timeframes may be extended by up to 14 days if the member requests the extension or the MCO justifies a need for additional information and how the extension is in the member's interest.	17	Met	Met	Met	Met	Met	Met
The MCO must give members any reasonable assistance in completing forms and taking other procedural steps in filing appeals and grievances.	18	Met	Met	Met	Met	Met	Met
The MCO must acknowledge receipt of each appeal and grievance.	19	Met	Met	Met	Met	Met	Met
The MCO must ensure that individuals that make decisions on grievances and appeals were not involved in any previous level of review or decision making.	20	Met	Met	Met	Met	Met	Met
The MCO ensures that health care professionals with appropriate clinical expertise in treating the member's condition or disease determine the outcome of expedited appeals and grievances related to clinical issues.	21	Met	Met	Met	Met	Partially Met	Met
The process for appeals must provide that oral inquiries seeking to appeal an action are treated as appeals to establish the earliest possible filing date.	22	Met	Met	Met	Met	Met	Met
The MCO must provide the member a reasonable opportunity to present evidence during the appeal and grievance hearing, and provide the member an opportunity to examine his/her case file prior to or during the appeal process.	23	Met	Met	Met	Met	Met	Met
The process for appeals must include the member and his/her representative, or the legal representative of a deceased member's estate.	24	Met	Met	Met	Met	Met	Met
The MCO must dispose of each grievance, resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within State established timeframes.	25	Met	Met	Met	Partially Met	Met	Met
Standard disposition of grievances with notice to affected parties may not exceed 90 days from the day the MCO receives the grievance. Standard resolution of appeals with notice to affected parties no longer than 45 days from the day the MCO received the appeal.	26	Met	Met	Met	Partially Met	Met	Met
The MCO must provide the resolution of an expedited appeal to affected parties within 3 working days after receiving the appeal.	27	Met	Met	Met	Met	Met	Met
Standard appeal and grievance timeframes and expedited appeal timeframes may be extended by up to 14 days if the member requests an extension or the MCO identifies there is a need for additional information, and must provide written notice to the member if the extension was not requested by the member.	28	Met	Met	Met	Partially Met	Met	Met
The MCO will use the method identified by the State to notify a member of the disposition of a grievance.	29	Met	Met	Met	Met	Met	Met
The MCO must provide written notice of disposition of an appeal.	30	Met	Met	Met	Met	Met	Met



Grievance Systems Standards	#	Community Care (CC-FC)	Community Care of Central Wisconsin (CCCW)	Creative Care Options (CCO)	Milwaukee County Department on Aging Care Management Organization (MCDA)	Southwest Family Care Alliance (SFCA)	Western Wisconsin Cares (WWC)
The written notice of resolution must include the results of the resolution process, the date it was completed, the right to request a State fair hearing, the right to receive benefits while the hearing is pending, and that the member may be held liable for the cost of continued benefits if the hearing decision upholds the MCO's action.	31	Met	Met	Met	Met	Met	Met
The State must permit the member to request a State fair hearing within 45 days from the date of the MCO's notice of action.	32	Met	Met	Met	Met	Met	Met
The parties to the State fair hearing include the MCO and the member and his or her representative or the representative of a deceased member's estate.	33	Met	Met	Met	Met	Met	Met
The MCO must establish and maintain an expedited review process for appeals.	34	Met	Met	Met	Met	Met	Met
The MCO must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports a member's appeal.	35	Met	Met	Met	Met	Met	Met
If a request for an expedited appeal resolution is denied, the appeal must be transferred to the timeframe for a standard resolution and prompt notice must be provided to the member.	36	Met	Met	Met	Met	Met	Met
The MCO must provide information about the member grievance system to all providers at the time they enter into a contract.	37	Met	Met	Met	Met	Met	Met
The MCO must maintain records of appeal and grievances and must review the information as part of the MCO's quality program.	38	Met	Met	Met	Met	Met	Met
Benefits must continue pending the resolution of the appeal if the appeal is filed within 10 days of the notice of action, the appeal involves the termination, suspension, or limitation of a previously authorized service, the original period of the service authorization has not expired, and the member requests the continuation.	39	Met	Met	Met	Met	Met	Met
If the member requests that benefits continue, they must continue until the member withdraws the appeal, the member files a State fair hearing within 10 days of the MCO appeal resolution, the State fair hearing officer issues an adverse decision, or the time period of a previously authorized service expires.	40	Met	Met	Met	Met	Met	Met
The MCO may recover the costs of continued benefits if the appeal decision is adverse to the member.	41	Met	Met	Met	Met	Met	Met
If the MCO or State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.	42	Met	Met	Met	Met	Met	Met
Met Findings by MCO		39 (92.9%)	40 (95.2%)	41 (97.6%)	34 (81.0%)	38 (90.5%)	38 (90.5%)
Partially Met Findings by MCO		3 (7.1%)	2 (4.8%)	1 (2.4%)	8 (19.0%)	4 (9.5%)	4 (9.5%)
Not Met Findings by MCO		0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)



APPENDIX 4: 2009 PIP VALIDATION FINDINGS FOR FAMILY CARE MCOs

2009 Performance Improvement Projects	Community Care (CC-FC)	Community Care of Central Wisconsin (CCCW)	Creative Care Options (CCO)	Milwaukee County Department on Aging Care Management Organization (MCDA)	Southwest Family Care Alliance (SFCA)	Western Wisconsin Cares (WWC)
	Early Identification of Cognitive Decline in Members with Cognitive Deficit Diagnosis	Dementia Screening	Improving the Early Identification and Treatment of Members with Dementia	Fall Prevention	Depression	Climbing out of Depression
Topic based on relevant data.	Partially Met	Met	Met	Met	Met	Met
Topic focused on improving outcomes of care for members.	Met	Met	Met	Met	Met	Met
Clearly stated study questions, or	Met	n/a	n/a	n/a	Partially Met	n/a
• If BCAP Method, overall aim is clearly stated and measurable.	n/a	Met	Met	Met	n/a	Met
• If BCAP Method, overall aim includes numerical goal and target date.	n/a	Partially Met	Met	Met	n/a	Met
• If BCAP Method, typology aims are clearly stated and measurable.	n/a	Met	Met	Met	n/a	Met
• If BCAP Method, typology aims have numerical goals and target dates.	n/a	Partially Met	Partially Met	Met	n/a	Met
There are clearly defined, measurable indicators.	Met	n/a	n/a	n/a	Not Met	n/a
Indicators measure changes in health/functional status, satisfaction or care processes or	Partially Met	n/a	Met	Met	n/a	n/a
• If BCAP Method, project contains overall outcome measure(s).	Met	Met	Met	Met	n/a	Met
• If BCAP Method, project contains typology measures that link to associated aims.	Met	Met	Met	Met	n/a	Met
A representative and generalizable study population is identified.	n/a	n/a	n/a	Met	Met	n/a
The project/study clearly defines the relevant population.	Met	Met	Met	Met	Met	Met
If entire population is used, all members are captured or	n/a	n/a	n/a	Met	Met	n/a
If entire population is Not used, stratified by high-risk, high needs or high utilization.	Met	Met	Met	n/a	n/a	Met
Valid sampling techniques are used.	n/a	n/a	n/a	Met	n/a	n/a
Sample(s) contain sufficient number of members.	n/a	n/a	n/a	Met	n/a	n/a
Clearly defined data and data sources.	Met	Met	Met	Met	Met	Met
Qualified staff used to collect data.	Met	Met	Met	Not Met	Met	Met
Data collection instruments provide for consistent, accurate data collection.	Met	Met	Met	Partially Met	Partially Met	Met



2009 Performance Improvement Projects	Community Care (CC-FC)	Community Care of Central Wisconsin (CCCW)	Creative Care Options (CCO)	Milwaukee County Department on Aging Care Management Organization (MCDA)	Southwest Family Care Alliance (SFCA)	Western Wisconsin Cares (WWC)
	Early Identification of Cognitive Decline in Members with Cognitive Deficit Diagnosis	Dementia Screening	Improving the Early Identification and Treatment of Members with Dementia	Fall Prevention	Depression	Climbing out of Depression
There is a prospective data analysis plan.	Met	Met	Met	Partially Met	Not Met	Met
Interventions have a good chance of succeeding.	Met	Met	Met	Met	Met	Met
PDSA cycles are appropriately applied.	Met	Met	Met	Met	Partially Met	Met
Barriers are identified and addressed.	Met	Met	Met	Met	Partially Met	Met
Data analysis includes initial and repeat measurements and identifies limitations.	Met	Met	Met	Partially Met	Partially Met	Met
Numerical findings are accurate and clearly presented.	Met	Met	Met	Met	Partially Met	Met
Project successes and progress is clearly stated.	Met	Met	Met	Met	Partially Met	Met
Follow-up activities (next steps) are clearly defined.	Met	Met	Met	Partially Met	Partially Met	Met
Baseline and repeat measurements are consistent.	n/a	n/a	Met	n/a	Not Met	Met
Improvements in processes and/or outcomes are documented.	n/a	Met	Met	n/a	Met	Met
Improvements appear to be the result of planned interventions.	n/a	Met	Met	n/a	Not Met	Met
Sustained improvement is demonstrated.	n/a	n/a	n/a	n/a	Not Met	n/a
Met Findings by MCO	90.0%	91.3%	96.0%	80.0%	40.9%	100.0%
Partially Met Findings by MCO	10.0%	8.7%	4.0%	16.0%	36.4%	0.0%
Not Met Findings by MCO	0.0%	0.0%	0.0%	4.0%	22.7%	0.0%



APPENDIX 5: 2009 CMR FINDINGS FOR FAMILY CARE MCOs

ASSESSMENT

Assessment Measures N=4	Who is eligible for the measure?	Criteria	Statistics	Community Care (CC-FC)		Community Care of Central Wisconsin (CCCW)		Creative Care Options (CCO)		Milwaukee County Department on Aging Care Management Organization (MCDA)		Southwest Family Care Alliance (SFCA)		Western Wisconsin Cares (WWC)		
				#	%	#	%	#	%	#	%	#	%	#	%	
Timeliness of initial assessment	New members & previous community waiver participants	Was the initial assessment done within 30 calendar days of enrollment? For previous community waiver participants, was a nursing assessment done within 30 days?	New members & previous waiver participants:	8	62.5%	7	100%	8	100%	26	96.2%	8	87.5%	8	75.0%	
			Initial assessment done in a timely manner	5		7		8		25		7		6		
Comprehensiveness of initial assessment	New members	Was the initial assessment completed in person and did it contain information about a member's issues, needs, strengths and resources?	New members:	8	62.5%	7	42.9%	8	87.5%	26	96.2%	8	100%	8	100%	
			Initial assessment was comprehensive:	5		3		7		25		8		8		
Risk assessment completed when indicated	Any member at potential risk	For those members at potential risk, was a risk assessment completed when indicated?	Members at potential risk:	16	56.3%	30	80.0%	27	100%	101	96.0%	27	92.6%	24	95.8%	
			Risk assessment completed when indicated:	9		24		27		97		25		23		
Reassessment done when indicated	Any member who had a change in condition or living situation or when requested or to evaluate significant or proposed changes in services for previous community waiver participants	If the member was eligible to have a reassessment completed, was it done when indicated?	Members eligible for reassessment:	8	62.5%	7	57.1%	10	90.0%	43	95.3%	6	100%	4	50.0%	
			Reassessment done when indicated:	5		4		9		41		6		2		
Overall Assessment Score by MCO				Overall Denominator:	40	60.0%	51	74.5%	53	96.2%	196	95.9%	49	93.9%	44	88.6%
				Overall Numerator:	24		38		51		188		46		39	



SERVICE PLANNING

Service Planning Measures N=8	Who is eligible for the measure?	Criteria	Statistics	Community Care (CC-FC)		Community Care of Central Wisconsin (CCCW)		Creative Care Options (CCO)		Milwaukee County Department on Aging Care Management Organization (MCDA)		Southwest Family Care Alliance (SFCA)		Western Wisconsin Cares (WWC)		
				#	%	#	%	#	%	#	%	#	%	#	%	
Timeliness of initial individual service plan (ISP)	New members	Was the initial ISP done within 10 business days of enrollment?	New members:	8	87.5%	7	100%	8	100%	26	88.5%	8	87.5%	8	87.5%	
			Initial ISP done in a timely manner:	7		7		8		23		7		7		
Timeliness of initial individualized plan	New members	Was the initial individualized plan done within 60 calendar days of enrollment?	New members:	8	100%	7	71.4%	6	83.3%	25	72.0%	8	75.0%	8	75.0%	
			Initial assessment done in a timely manner:	8		5		5		18		6		6		
Comprehensiveness of most recent plan	All members	Was the most recent plan comprehensive?	All members:	30	66.7%	30	83.3%	28	96.4%	107	80.4%	30	90.0%	30	90.0%	
			Most recent plan was comprehensive:	20		25		27		86		27		27		
Timeliness of most recent plan	All members	Was the most recent plan reviewed within the last 6 months?	All members:	30	73.3%	30	93.3%	28	92.9%	107	91.6%	30	90.0%	30	93.3%	
			Most recent plan was done in a timely manner:	22		28		26		98		27		28		
Plan updated for significant changes	Members with significant changes	For those members with significant changes, was the plan updated with the significant changes?	Members with significant changes:	8	50.0%	7	85.7%	10	90.0%	38	92.1%	6	88.3%	4	50.0%	
			Plan updated:	4		6		9		35		5		2		
Timeliness of service authorizations	Members with service requests	For those members with service requests, were the service authorizations done in a timely manner?	Members with service requests:	29	79.3%	24	87.5%	26	92.3%	103	84.5%	29	79.3%	22	95.5%	
			Service authorizations done in a timely manner:	23		21		24		87		23		21		
Risk addressed when identified	Any member at risk	For those members with risk, was the risk addressed when identified?	Members at risk:	14	64.3%	23	87.0%	20	95.0%	86	88.4%	23	95.7%	22	90.9%	
			Risk was addressed when identified:	9		20		19		76		22		20		
Collaboration of the team	All members	Did all members of the team collaborate when providing care management?	All members:	30	96.7%	30	96.7%	30	96.7%	108	100%	30	100%	30	96.7%	
			All team members collaborated on the members' case management:	29		29		29		108		30		29		
Overall Service Planning Score by MCO				Overall Denominator:	157	77.7%	158	89.2%	156	94.2%	600	88.5%	164	89.6%	154	90.9%
				Overall Numerator:	122		141		147				531		147	



SERVICE COORDINATION & DELIVERY

Service Coordination and Delivery Measures N=4	Who is eligible for the measure?	Criteria	Statistics	Community Care (CC-FC)		Community Care of Central Wisconsin (CCCW)		Creative Care Options (CCO)		Milwaukee County Department on Aging Care Management Organization (MCDA)		Southwest Family Care Alliance (SFCA)		Western Wisconsin Cares (WWC)	
				#	%	#	%	#	%	#	%	#	%	#	%
Timely coordination of services	Members with any services	For those members who had services, was the coordination of services done in a timely manner?	Members with services:	30	86.7%	30	93.3%	30	93.3%	107	86.0%	30	90.0%	30	83.3%
			Service coordination was done in a timely manner:	26		28		28		92		27		25	
Evidence that MCOs Implement Authorized Services	Members with authorized services	For those members who had authorized services, is there evidence that the authorized services were implemented?	Members with authorized services:	30	93.3%	30	96.7%	30	100%	107	100%	30	100%	30	100%
			Evidence that authorized services were implemented:	28		29		30		107		30		30	
Follow-up to ensure that services are effective	Members with authorized services	For those members who had authorized services, was follow-up done to ensure that the authorized services were effective?	Members with authorized services:	30	83.3%	30	66.7%	30	100%	107	80.4%	30	80.0%	30	73.3%
			Follow-up was done to ensure authorized services were effective:	25		20		30		86		24		22	
Identified Needs Were Addressed	All members	All members are assumed to have needs. Were their needs addressed?	All members:	30	96.7%	30	93.3%	30	100%	108	97.2%	30	100%	30	100%
			Identified needs were addressed:	29		28		30		105		30		30	
Overall Service Coordination and Delivery Score by MCO		Overall Denominator:	120	90.0%	120	87.5%	120	87.5%	429	90.9%	120	92.5%	120	89.2%	
		Overall Numerator:	108		105		118		390		111		107		



PARTICIPANT CENTERED FOCUS

Participant Centered Focus Measures N=3	Who is eligible for the measure?	Criteria	Statistics	Community Care (CC-FC)		Community Care of Central Wisconsin (CCCW)		Creative Care Options (CCO)		Milwaukee County Department on Aging Care Management Organization (MCDA)		Southwest Family Care Alliance (SFCA)		Western Wisconsin Cares (WWC)	
				#	%	#	%	#	%	#	%	#	%	#	%
Member / guardian / family / informal supports included in planning	All members	Was the member included in planning? If applicable, were the member's guardian, and/or family member, and/or informal supports included in the planning process?	All members:	30	100%	30	96.7%	30	100%	108	98.1%	30	100%	30	96.7%
			Appropriate people included in planning:	30		29		30		106		30		29	
Notice of action issued in a timely manner when indicated	Members who whom a notice of action was indicated	Was the notice of action sent in a timely manner?	Members to whom a notice of action was indicated:	13	53.8%	5	40.0%	3	33.3%	37	40.5%	10	30.0%	5	60.0%
			The notice of action was sent in a timely manner:	7		2		1		15		3		3	
Self directed supports option offered to members	All members	Was the option of self directed supports offered to members?	All members:	30	30.0%	30	100%	29	93.1%	108	90.7%	30	93.3%	30	96.7%
			Members who were offered the option of self directed supports:	9		30		27		98		28		29	
Overall Participant Centered Planning Score by MCO			Overall Denominator:	73	63.0%	65	93.8%	62	93.5%	253	86.6%	70	87.1%	65	93.8%
			Overall Numerator:	46		61		58		219		61		61	



APPENDIX 6: 2008 QCR FINDINGS FOR MCOs WITH FCP OR PACE PROGRAMS

ENROLLEE RIGHTS

Enrollee Rights Standards	#	Family Care Partnership (FCP)			PACE
		Care Wisconsin (CW-FCP)	Community Care (CC-FCP)	Community Health Partnership (CHP-FCP)	Community Care (CC-PACE)
The MCO has a written policy about member rights.	1	Met	Met	Met	Met
The MCO ensures its staff and contracted providers take members' rights into consideration when furnishing services to them.	2	Met	Met	Met	Met
The MCO provides all enrollment notices, informational materials, and instructional materials relating to members and potential members in a manner and format that may be easily understood.	3	Met	Met	Met	Met
The MCO makes its written information available in the prevalent, non-English languages in its particular service area.	4	Met	Met	Met	Met
The MCO provides interpretation and translation services available to their members free of charge.	5	Met	Met	Met	Met
The MCO provides written materials in an easily understood language and format.	6	Met	Met	Met	Met
The MCO must have written material available in alternate formats that take into account the special needs of members.	7	Met	Met	Met	Met
The MCO notifies members of their right to request and obtain information at least once a year about their rights.	8	Met	Met	Met	Met
The MCO provides enrollment information to new members in a timely manner.	9	Met	Met	Met	Met
The MCO notifies members at least thirty days before a significant change in member rights is implemented.	10	Met	Met	Met	Met
The MCO must provide written notice of termination of a contracted provider within 15 days after issuance of the termination notice, to each member who received services from such provider.	11	Met	Met	Met	Met
Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers must be provided to all members.	12	Met	Partially Met	Met	Partially Met
The MCO allows freedom of choice for female members to access a woman's specialist or, when age-appropriate, obtain the services of qualified family planning providers.	13	Met	Met	Met	Met
The MCO provides information to all members on members' rights and responsibilities and information on grievance and fair hearing procedures.	14	Met	Met	Met	Met
The MCO provides information to all members on the amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled and the procedures for obtaining benefits, including authorization requirements.	15	Met	Met	Met	Met
The MCO informs members how to obtain services from providers outside of the MCO's contracted provider network.	16	Met	Met	Met	Met
The MCO informs members how to obtain after hours and emergency services.	17	Met	Met	Met	Met
The MCO provides information to all members about post-stabilization care service rules (related to the financial responsibility of care provided).	18	Met	Met	Met	Met
The MCO informs members how to obtain referrals for specialty care and other benefits not furnished by members' primary care providers.	19	Met	Met	Met	Met
The MCO explains each member's responsibility to pay a cost share – an amount, based on each member's ability to pay, toward the cost of member's care.	20	Met	Met	Met	Met
The MCO informs members how to obtain benefits that are available under the Wisconsin Medicaid program but are not part of the MCO's benefit package.	21	Met	Met	Met	Met



Enrollee Rights Standards	#	Family Care Partnership (FCP)			PACE
		Care Wisconsin (CW-FCP)	Community Care (CC-FCP)	Community Health Partnership (CHP-FCP)	Community Care (CC-PACE)
The MCO provides grievance, appeal, and fair hearing procedures and timeframes, in a State-developed or State-approved description, that includes the right to file grievances and appeals and, for State fair hearing, the right to a hearing, the method for obtaining a hearing and the rules that govern representation at the hearing.	22	Met	Met	Met	Met
The MCO provides grievance, appeal, and fair hearing procedures and timeframes, in a State-developed or State-approved description, that includes the requirements and timeframes for filing a appeal or grievance, the availability of assistance in the filing process, the toll-free numbers that the member can use to file a grievance or an appeal by phone, the fact that, when requested by the member, benefits will continue if the member files an appeal or a request for State fair hearing within the timeframes specified for filing and the fact the member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.	23	Met	Met	Met	Met
The MCO provides grievance, appeal, and fair hearing procedures and timeframes, in a State-developed or State-approved description, any appeal rights that the State chooses to make available to providers to challenge the failure of the organization to cover a service.	24	Met	Met	Met	Met
The MCO informs members about advance directives.	25	Met	Met	Met	Met
The MCO is required to have written policies and procedures about advance directives.	26	Met	Met	Met	Met
The MCO is required to provide written information on advance directives to each member at the time of initial enrollment.	27	Met	Met	Met	Met
The MCO is required to provide community education about advance directives either directly or in concert with other providers and must be able to document its community education efforts.	28	Met	Met	Met	Met
The MCO did not identify any providers who provided care that conflicts with members' advance directives.	29	Met	Met	Met	Met
The MCO informs members with complaints concerning non-compliance with an advance directive may be filed with the State survey and certification agency.	30	Met	Met	Met	Met
The MCO gives members information about physician incentive plans.	31	This standard does not apply to the Family Care Partnership or PACE programs.			
If the State plan provides for mandatory enrollment the State or its contracted representative must provide information on MCOs either directly or through the MCO. The information must be furnished as follows: for potential members, within the specified timeframes, for members, annually and upon request, in a comparative, chart-like format. The following information must be furnished: the MCO's service area, the benefits covered under the contract, and any cost sharing imposed by the MCO.	32	This standard only applies to plans with mandatory enrollment.			
The MCO must not charge members for services included in the Family Care benefit package.	33	Met	Met	Met	Met
The MCO should provide, to the extent available, quality and performance indicators, including but not limited to disenrollment rates and member satisfaction.	34	Met	Met	Met	Met
All members are guaranteed the right to be treated with respect and due consideration for his/her dignity and privacy.	35	Met	Met	Met	Met
The MCO gives members information on available treatment options and alternatives, presented in a manner appropriate to each member's condition and ability to understand.	36	Met	Met	Met	Met
An MCO cannot prohibit or restrict a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient, in regards to the member's health status, medical care or treatment options, including any alternative treatment that may be self-administered; any information the member needs to decide among all relevant treatment options; the risks, benefits, and consequences of treatment or non-treatment, and the member's right to participate in decisions about his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.	37	Met	Met	Met	Met
All members are guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.	38	Met	Met	Met	Met



Enrollee Rights Standards	#	Family Care Partnership (FCP)			PACE
		Care Wisconsin (CW-FCP)	Community Care (CC-FCP)	Community Health Partnership (CHP-FCP)	Community Care (CC-PACE)
All members have the right to be furnished health care services.	39	Met	Met	Met	Met
Met Findings by MCO		37 (100%)	36 (97.3%)	37 (100%)	36 (97.3%)
Partially Met Findings by MCO		0 (0%)	1 (2.7%)	0 (0%)	1 (2.7%)
Not Met Findings by MCO		0 (0%)	0 (0%)	0 (0%)	0 (0%)



QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT: ACCESS TO SERVICES

QAPI Access to Services Standards	#	Family Care Partnership (FCP)			PACE
		Care Wisconsin (CW-FCP)	Community Care (CC-FCP)	Community Health Partnership (CHP-FCP)	Community Care (CC-PACE)
The MCO maintains and monitors networks of appropriate providers that are supported by written agreements and are sufficient to provide adequate access to all contractually covered services.	1	Met	Met	Met	Met
In establishing and maintaining the provider network, the MCO must consider anticipated Medicaid enrollment and expected utilization of services.	2	Met	Met	Met	Met
In establishing and maintaining the provider network, the MCO must consider the numbers and types of providers required to furnish the contracted services.	3	Met	Met	Met	Met
In establishing and maintaining the provider network, the MCO must consider the number of network providers who are not accepting new MCO members.	4	Met	Met	Met	Met
In establishing and maintaining the network, the MCO must consider the geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities.	5	Met	Met	Met	Met
In addition to members' designated source of primary care, the MCO provides for its female members direct access to a women's health specialist.	6	Met	Met	Met	Met
The MCO provides for a second opinion from a qualified health care professional within the network or arranges for the member to obtain one outside the network, at no cost to the member.	7	Met	Met	Met	Met
If the network is unable to provide covered services to a member, the MCO must adequately and timely cover the services out of network for as long as the MCO is unable to provide them.	8	Met	Met	Met	Met
The MCO works with out-of-network providers to ensure that the cost of services to members is no greater than they would have been if furnished within the provider networks.	9	Met	Met	Met	Met
Providers ensure timely access to care and services, taking into account the urgency of need for services.	10	Met	Met	Met	Met
Each MCO must monitor providers regularly to determine if they are making services available 24 hours a day, 7 days a week when medically necessary.	11	Met	Met	Met	Met
Ensure that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member.	12	Met	Met	Met	Met
The MCO coordinates members' care with other providers and MCOs and shares the results of members' assessment needs to keep plans from duplicating services and activities, all the while protecting members' privacy.	13	Met	Met	Met	Met
The MCO provides services to all members because of their special health care needs.	14	Met	Met	Met	Met
The MCO assesses its members' ongoing special conditions that require a course of treatment or regular care monitoring by appropriate health care professionals.	15	Met	Met	Met	Met
Members' Individual Service Plans and Member-Centered Plans are completed and approved in a timely manner.	16	Partially Met	Partially Met	Partially Met	Partially Met
The MCO facilitates access to specialists appropriate for members' special health care conditions and needs.	17	Met	Met	Met	Met
The MCO and its subcontractors have in place and follow written policies and procedures when processing requests for initial and continuing authorization of services.	18	Partially Met	Partially Met	Met	Partially Met
The MCO has in effect mechanisms to ensure consistent application of review criteria for authorization decisions when processing requests for initial and continuing authorization of services.	19	Met	Met	Met	Met
When authorizing initial and continuing services, the MCO consults with providers requesting the services when appropriate.	20	Met	Met	Met	Met
The MCO works with health care professionals with appropriate clinical expertise in treating members' conditions or diseases when deciding to deny a service authorization request or authorize a service in an amount, duration or scope that is less than what was requested.	21	Met	Met	Met	Met
The MCO must notify the requesting provider, and give the member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested.	22	Partially Met	Partially Met	Met	Partially Met



QAPI Access to Services Standards	#	Family Care Partnership (FCP)			PACE
		Care Wisconsin (CW-FCP)	Community Care (CC-FCP)	Community Health Partnership (CHP-FCP)	Community Care (CC-PACE)
The MCO must provide notice of a standard service authorization decision within 14 calendar days following the request for service.	23	Partially Met	Partially Met	Partially Met	Partially Met
The MCO must make an expedited authorization decision as expeditiously as the member's health condition requires and no longer than 3 working days after receipt of the request.	24	Met	Met	Met	Met
The MCO ensures that people who perform utilization management activities for the MCOs are paid so that they are not given incentives to deny, limit or discontinue medically necessary services for any member.	25	Met	Met	Met	Met
The MCO covers and pays for emergency services regardless of whether the provider or entity that furnishes the care has a contract with the MCO.	26	Met	Met	Met	Met
The MCO does not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.	27	Met	Met	Met	Met
The MCO does not hold members liable for payment of subsequent screening or treatment needed to diagnose the specific condition or stabilize the member. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is stabilized for transfer or discharge. Post-stabilization care services are covered and paid for by the MCO.	28	Met	Met	Met	Met
Met Findings by MCO		24 (85.7%)	24 (85.7%)	26 (92.9%)	24 (85.7%)
Partially Met Findings by MCO		4 (14.3%)	4 (14.3%)	2 (7.1%)	4 (14.3%)
Not Met Findings by MCO		0 (0%)	0 (0%)	0 (0%)	0 (0%)



QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT: STRUCTURE & OPERATIONS

QAPI Structure & Operations Standards	#	Family Care Partnership (FCP)			PACE
		Care Wisconsin (CW-FCP)	Community Care (CC-FCP)	Community Health Partnership (CHP-FCP)	Community Care (CC-PACE)
Each MCO must implement written policies and procedures for selection and retention of providers.	1	Met	Met	Met	Met
The MCO must follow a documented process for credentialing and recredentialing of contracted providers.	2	Met	Met	Met	Met
The MCO has provider selection policies and procedures that do not discriminate against particular practitioners that serve high risk populations or specialize in conditions that require costly treatment.	3	Met	Met	Met	Met
If the MCO declines to include providers in its network, it must give the affected providers written notice of the reason for its decision.	4	Met	Met	Met	Met
The MCO may not employ or contract with providers excluded from participation in federal health care programs.	5	Partially Met	Met	Met	Met
The MCO must comply with any additional requirements established by the State.	6	Partially Met	Partially Met	Partially Met	Partially Met
The MCO must not request disenrollment for reasons other than those permitted under contract.	7	Met	Met	Met	Met
The MCO informs members about when they may ask to disenroll from a MCO.	8	The State does not limit enrollment.			
The member must submit an oral or written request for disenrollment to the MCO.	9	Met	Met	Met	Met
The MCO allows members to disenroll when members move out of a MCO's service area; because of religious or moral objections, a MCO does not cover the services the member seeks; members need related services performed at the same time, but not all related services are available within the MCO's provider network, and the member's primary care provider or another provider determines that receiving services separately would subject the member to unnecessary risk; or the MCO provides poor quality of care, lacks access to services covered under the MCO's contract with the State, or lacks access to providers who are experienced in dealing with a member's health care needs.	10	Met	Met	Met	Met
An MCO may approve a request for disenrollment or refer the request to the State.	11	Met	Met	Met	Met
The MCO may refer members' disenrollment requests to the State with information about the reasons cited in members' requests.	12	Met	Met	Met	Met
The MCO uses grievance procedures in a timely manner to permit members to disenroll from MCOs by regulated deadlines.	13	The State does not require the use of the grievance process prior to disenrollment.			
The effective date of disenrollment must be no later than the first day of the second month following the month in which the member or the MCO files the request.	14	Met	Met	Met	Met
The MCO must ensure that they are providing notices of action to members in a timely manner (for service requests that are denied or limited, within 14 calendar days of the request; and for termination, suspension or reduction of a previously authorized service, within 10 calendar days of the action).	15	Partially Met	Partially Met	Partially Met	Partially Met
The MCO oversees and is accountable for all functions and responsibilities they delegate to subcontractors.	16	Met	Met	Met	Met
The MCO evaluates prospective subcontractors' abilities to perform the activities to be delegated prior to the actual delegation of functions and responsibilities.	17	Met	Met	Met	Met
The MCO provides written agreements to their subcontractors which specify the activities and responsibilities designated to the subcontractors and reasons to revoke delegation or impose other sanctions if a subcontractor's performance is inadequate.	18	Met	Met	Met	Met
The MCO monitors its subcontractors' performance and subjects it to formal review according to a periodic schedule established by the State.	19	Met	Met	Met	Met
The MCO and the subcontractor take corrective action if an MCO identifies deficiencies or areas for improvement.	20	Met	Met	Met	Met



QAPI Structure & Operations Standards	#	Family Care Partnership (FCP)			PACE
		Care Wisconsin (CW-FCP)	Community Care (CC-FCP)	Community Health Partnership (CHP-FCP)	Community Care (CC-PACE)
Met Findings by MCO		15 (83.3%)	16 (88.9%)	16 (88.9%)	16 (88.9%)
Partially Met Findings by MCO		3 (16.7%)	2 (11.1%)	2 (11.1%)	2 (11.1%)
Not Met Findings by MCO		0 (0%)	0 (0%)	0 (0%)	0 (0%)



QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT: MEASUREMENT & IMPROVEMENT

QAPI Measurement & Improvement Standards		Family Care Partnership (FCP)			PACE
		Care Wisconsin (CW-FCP)	Community Care (CC-FCP)	Community Health Partnership (CHP-FCP)	Community Care (CC-PACE)
Practice guidelines need to be based on valid and reliable clinical evidence.	1	Met	Met	Met	Met
Practice guidelines must consider the needs of the MCO's members.	2	Met	Met	Met	Met
Practice guidelines need to be developed in consultation with health care professionals.	3	Met	Met	Met	Met
Practice guidelines need to be reviewed and updated periodically.	4	Met	Met	Met	Met
Practice guidelines need to be distributed to all affected providers.	5	Met	Met	Met	Met
Decisions for utilization management, member education, coverage of services, and other areas about which the guidelines apply are consistent with the guidelines.	6	Met	Met	Met	Met
The MCO must have an ongoing quality assessment and performance improvement program for the services it furnishes to members.	7	Met	Met	Met	Met
Each MCO must conduct performance improvement projects. These projects must achieve significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction.	8	Met	Met	Met	Met
MCOs must have an ongoing program of performance improvement projects that focuses on clinical and non-clinical areas.	9	Met	Met	Met	Met
The MCO must have an ongoing program of performance improvement projects that focus on clinical and non-clinical areas, measuring performance using objective quality indicators, implementing system interventions to achieve improvement in quality, evaluating the effectiveness of the interventions, and planning and initiating of activities to increase or sustain improvement.	10	Met	Met	Partially Met	Met
The MCO must report the status and results of each performance improvement project to the State as requested and complete each project in a reasonable time period.	11	Met	Met	Met	Met
Annually, the MCO must measure and report to the State its performance, using standard measures required by the State and/or submit to the State data specified by the State that enables the State to measure the MCO's performance.	12	This measure is rated during the Performance Measure Validation process and is not reported in the EQR report.			
The MCO must have in effect mechanisms to detect both under- and over-utilization of services.	13	Met	Partially Met	Met	Partially Met
The MCO must have in effect mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs.	14	Partially Met	Met	Met	Met
The MCO submits for State review the impact and effectiveness of its quality assessment and performance improvement program, including its performance on standard measures on which it is required to report and the results of its performance improvement projects, and the MCO has in effect a process for its own evaluation of its quality assessment and performance improvement program.	15	Met	Met	Met	Met
The MCO maintains a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of this subpart. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility.	16	This measure is rated during the Performance Measure Validation process and it not reported in the EQR report.			
Each MCO must collect data on member and provider characteristics through an encounter data system or other method as specified by the State.	17	This measure is rated during the Performance Measure Validation process and it not reported in the EQR report.			
The MCO must ensure that data received from providers is accurate and complete by verifying the accuracy and timeliness of reported data; screening the data for completeness, logic, and consistency; and collecting service information in standardized formats to the extent feasible and appropriate.	18	This measure is rated during the Performance Measure Validation process and is not reported in the EQR report.			
The MCO must make all collected data available to the State and upon request to CMS.	19	This measure is rated during the Performance Measure Validation process and is not reported in the EQR report.			



QAPI Measurement & Improvement Standards	Family Care Partnership (FCP)			PACE
	Care Wisconsin (CW-FCP)	Community Care (CC-FCP)	Community Health Partnership (CHP-FCP)	Community Care (CC-PACE)
Met Findings by MCO	13 (92.9%)	13 (92.9%)	13 (92.9%)	13 (92.9%)
Partially Met Findings by MCO	1 (7.1%)	1 (7.1%)	1 (7.1%)	1 (7.1%)
Not Met Findings by MCO	0 (0%)	0 (0%)	0 (0%)	0 (0%)



GRIEVANCE SYSTEMS

Grievance Systems Standards	#	Family Care Partnership (FCP)			PACE
		Care Wisconsin (CW-FCP)	Community Care (CC-FCP)	Community Health Partnership (CHP-FCP)	Community Care (CC-PACE)
Each MCO must have a system in place for members including a grievance process, an appeals process and access to the State's fair hearing system.	1	Met	Met	Met	Met
A member may file a grievance and an MCO level appeal and may request a fair hearing.	2	Met	Met	Met	Met
A provider, acting on behalf of a member and with the member's written consent, may file an appeal or grievance and may request a State fair hearing.	3	Met	Met	Met	Met
Members or providers may file an appeal or State Fair Hearing within 45 days of the date on the notice of action form.	4	Met	Met	Met	Met
Members may file a grievance either orally or in writing.	5	Met	Met	Met	Met
Members or providers may file an appeal either orally or in writing, and unless an expedited resolution is requested, must follow an oral appeal with a signed, written appeal.	6	Met	Met	Met	Met
The Notice of Action must explain the member's right to request a State fair hearing and the circumstances under which an expedited resolution is available and how to request it.	7	Met	Met	Met	Met
The Notice of Action must explain the member's right to have benefits continue pending the resolution of the appeal, how to request that services continue and the circumstances under which the member may be required to pay for the cost of the services.	8	Met	Met	Met	Met
Notices of Action must be mailed at least 10 calendar days before the effective date of the action for termination, suspension or reduction of a previously authorized service.	9	Partially Met	Partially Met	Partially Met	Partially Met
The MCO must mail the notice of action at least 10 days before the date of action.	10	Met	Met	Met	Met
If a member's whereabouts are unknown, any discontinued service must be reinstated if his whereabouts become known during the time he is eligible for services.	11	Met	Met	Met	Met
The MCO must mail the notice of action at least 10 days before the date of action except when the MCO establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction or State.	12	Met	Met	Met	Met
The MCO must mail the notice of action for denial of payment at the time of any action affecting the claim.	13	Met	Met	Met	Met
Notices of action must be mailed within 14 calendar days following the receipt of request, with a possible extension of up to 14 additional calendar days if the member or provider requests an extension, for standard service request that are denied or limited.	14	Partially Met	Partially Met	Partially Met	Partially Met
If the MCO extends the timeframe for service authorization decision making, it must give the member written notice of the reason along with appeal and grievance rights.	15	Partially Met	Met	Met	Met
The MCO must provide the member with a notice if it is unable to make service authorization decisions if it extends the original 14 day timeframe by an additional 14 days.	16	Met	Met	Met	Met
The MCO must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 3 working days after receipt of the request for service. Timeframes may be extended by up to 14 days if the member requests the extension or the MCO justifies a need for additional information and how the extension is in the member's interest.	17	Met	Met	Met	Met
The MCO must give members any reasonable assistance in completing forms and taking other procedural steps in filing appeals and grievances.	18	Met	Met	Met	Met
The MCO must acknowledge receipt of each appeal and grievance.	19	Met	Met	Met	Met
The MCO must ensure that individuals that make decisions on grievances and appeals were not involved in any previous level of review or decision making.	20	Met	Met	Met	Met
The MCO ensures that health care professionals with appropriate clinical expertise in treating the member's condition or disease determine the outcome of expedited appeals and grievances related to clinical issues.	21	Met	Met	Met	Met



Grievance Systems Standards	#	Family Care Partnership (FCP)			PACE
		Care Wisconsin (CW-FCP)	Community Care (CC-FCP)	Community Health Partnership (CHP-FCP)	Community Care (CC-PACE)
The process for appeals must provide that oral inquiries seeking to appeal an action are treated as appeals to establish the earliest possible filing date.	22	Not Met	Met	Met	Met
The MCO must provide the member a reasonable opportunity to present evidence during the appeal and grievance hearing, and provide the member an opportunity to examine his/her case file prior to or during the appeal process.	23	Met	Met	Met	Met
The process for appeals must include the member and his/her representative, or the legal representative of a deceased member's estate.	24	Met	Met	Met	Met
The MCO must dispose of each grievance, resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within State established timeframes.	25	Met	Met	Met	Met
Standard disposition of grievances with notice to affected parties may not exceed 90 days from the day the MCO receives the grievance. Standard resolution of appeals with notice to affected parties no longer than 45 days from the day the MCO received the appeal.	26	Met	Met	Met	Met
The MCO must provide the resolution of an expedited appeal to affected parties within 3 working days after receiving the appeal.	27	Met	Met	Met	Met
Standard appeal and grievance timeframes and expedited appeal timeframes may be extended by up to 14 days if the member requests an extension or the MCO identifies there is a need for additional information, and must provide written notice to the member if the extension was not requested by the member.	28	Met	Met	Met	Met
The MCO will use the method identified by the State to notify a member of the disposition of a grievance.	29	Met	Met	Met	Met
The MCO must provide written notice of disposition of an appeal.	30	Met	Met	Met	Met
The written notice of resolution must include the results of the resolution process, the date it was completed, the right to request a State fair hearing, the right to receive benefits while the hearing is pending, and that the member may be held liable for the cost of continued benefits if the hearing decision upholds the MCO's action.	31	Met	Met	Met	Met
The State must permit the member to request a State fair hearing within 45 days from the date of the MCO's notice of action.	32	Met	Met	Met	Met
The parties to the State fair hearing include the MCO and the member and his or her representative or the representative of a deceased member's estate.	33	Met	Met	Met	Met
The MCO must establish and maintain an expedited review process for appeals.	34	Met	Met	Met	Met
The MCO must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports a member's appeal.	35	Met	Met	Met	Met
If a request for an expedited appeal resolution is denied, the appeal must be transferred to the timeframe for a standard resolution and prompt notice must be provided to the member.	36	Met	Met	Met	Met
The MCO must provide information about the member grievance system to all providers at the time they enter into a contract.	37	Met	Met	Met	Met
The MCO must maintain records of appeal and grievances and must review the information as part of the MCO's quality program.	38	Met	Met	Met	Met
Benefits must continue pending the resolution of the appeal if the appeal is filed within 10 days of the notice of action, the appeal involves the termination, suspension, or limitation of a previously authorized service, the original period of the service authorization has not expired, and the member requests the continuation.	39	Met	Met	Met	Met
If the member requests that benefits continue, they must continue until the member withdraws the appeal, the member files a State fair hearing within 10 days of the MCO appeal resolution, the State fair hearing officer issues an adverse decision, or the time period of a previously authorized service expires.	40	Met	Met	Met	Met
The MCO may recover the costs of continued benefits if the appeal decision is adverse to the member.	41	Met	Met	Met	Met



Grievance Systems Standards	#	Family Care Partnership (FCP)			PACE
		Care Wisconsin (CW-FCP)	Community Care (CC-FCP)	Community Health Partnership (CHP-FCP)	Community Care (CC-PACE)
If the MCO or State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.	42	Met	Met	Met	Met
Met Findings by MCO		38 (90.5%)	40 (95.2%)	40 (95.2%)	40 (95.2%)
Partially Met Findings by MCO		3 (7.1%)	2 (4.8%)	2 (4.8%)	2 (4.8%)
Not Met Findings by MCO		1 (2.4%)	0 (0%)	0 (0%)	0 (0%)



APPENDIX 7: 2008 PIP VALIDATION FINDINGS FOR MCOs WITH FCP PROGRAMS

2008 Performance Improvement Projects	Care Wisconsin (CW-FCP)		Community Care (CC-FCP)		Community Health Partnership (CHP-FCP)	
	Functional Goals for Members with Persistent Pain	Improving Home Care Services for Members with Complex Needs or Situations	Diabetes Mellitus	Mission Effectiveness	Scheduling Management	Diabetes Management
Topic based on relevant data.	Met	Met	Met	n/a	Met	Met
Topic focused on improving outcomes of care for members.	Met	Met	Met	n/a	Met	Met
Clearly stated study questions, or	n/a	n/a	Met	Met	Partially Met	Partially Met
<ul style="list-style-type: none"> • If BCAP Method, overall aim is clearly stated and measurable. 	Met	Met	Met	n/a	n/a	n/a
<ul style="list-style-type: none"> • If BCAP Method, overall aim includes numerical goal and target date. 	Met	Met	Met	n/a	n/a	n/a
<ul style="list-style-type: none"> • If BCAP Method, typology aims are clearly stated and measurable. 	Met	Met	Met	n/a	n/a	n/a
<ul style="list-style-type: none"> • If BCAP Method, typology aims have numerical goals and target dates. 	Met	Met	Met	n/a	n/a	n/a
There are clearly defined, measurable indicators.	Met	Met	Met	Met	Met	Met
Indicators measure changes in health/functional status, satisfaction or care processes or	Partially Met	Partially Met	Met	n/a	Met	Met
<ul style="list-style-type: none"> • If BCAP Method, project contains overall outcome measure(s). 	Met	Met	Met	n/a	n/a	n/a
<ul style="list-style-type: none"> • If BCAP Method, project contains typology measures that link to associated aims. 	Met	Met	Met	n/a	n/a	n/a
A representative and generalizable study population is identified.	n/a	n/a	Met	Met	n/a	n/a
The project/study clearly defines the relevant population.	Met	Met	Met	Met	Met	Met
If entire population is used, all members are captured or	n/a	n/a	n/a	n/a	Met	n/a
If entire population is Not used, stratified by high-risk, high needs or high utilization.	Met	Met	n/a	n/a	n/a	Met
Valid sampling techniques are used.	n/a	n/a	Met	n/a	n/a	n/a
Sample(s) contain sufficient number of members.	n/a	n/a	Met	n/a	n/a	n/a
Clearly defined data and data sources.	Met	Met	Met	Met	Met	Met
Qualified staff used to collect data.	Met	Met	Met	Met	Met	Met
Data collection instruments provide for consistent, accurate data collection.	Met	Met	Met	Met	Met	Met
There is a prospective data analysis plan.	Met	Met	Met	Met	Met	Met
Interventions have a good chance of succeeding.	Met	Met	Met	n/a	Met	Partially Met
PDSA cycles are appropriately applied.	Met	Met	Met	n/a	Met	Met
Barriers are identified and addressed.	Met	Met	Met	n/a	Met	Met



2008 Performance Improvement Projects	Care Wisconsin (CW-FCP)		Community Care (CC-FCP)		Community Health Partnership (CHP-FCP)	
	Functional Goals for Members with Persistent Pain	Improving Home Care Services for Members with Complex Needs or Situations	Diabetes Mellitus	Mission Effectiveness	Scheduling Management	Diabetes Management
Data analysis includes initial and repeat measurements and identifies limitations.	Met	Met	Met	n/a	Met	Met
Numerical findings are accurate and clearly presented.	Met	Met	Met	Met	Met	Met
Project successes and progress is clearly stated.	Met	Met	Met	Met	Met	Met
Follow-up activities (next steps) are clearly defined.	Met	Met	Met	Met	Met	Met
Baseline and repeat measurements are consistent.	Met	Met	Met	n/a	Met	Met
Improvements in processes and/or outcomes are documented.	Met	n/a	Met	n/a	Met	Partially Met
Improvements appear to be the result of planned interventions.	n/a	n/a	n/a	n/a	Met	Partially Met
Sustained improvement is demonstrated.	n/a	n/a	n/a	n/a	Met	Met
Met Findings by MCO	96.0%	95.8%	100.0%	100.0%	95.5%	81.8%
Partially Met Findings by MCO	4.0%	4.2%	0.0%	0.0%	4.5%	18.2%
Not Met Findings by MCO	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%



APPENDIX 8: 2008 CMR FINDINGS FOR MCOs WITH FCP OR PACE PROGRAMS

ASSESSMENT

Assessment Measures N=4	Who is eligible for the measure?	Criteria	Statistics	Family Care Partnership (FCP)						PACE	
				Care Wisconsin (CW-FCP)		Community Care (CC- FCP)		Community Health Partnership (CHP- FCP)		Community Care (CC-PACE)	
				#	%	#	%	#	%	#	%
Timeliness of initial assessment	New members	Was the initial assessment done within 4 weeks of enrollment?	New members:	8	87.5%	8	87.5%	8	75.0%	8	87.5%
			Initial assessment done in a timely manner	7		7		6		7	
Comprehensiveness of initial assessment	New members	Was the initial assessment completed in person and did it contain information about a member's issues, needs, strengths and resources?	New members:	8	100%	8	87.5%	8	100%	8	100%
			Initial assessment was comprehensive:	8		7		8		8	
Risk assessment completed when indicated	Any member at potential risk	For those members at potential risk, was a risk assessment completed when indicated?	Members at potential risk:	24	100%	29	96.6%	30	96.7%	26	96.2%
			Risk assessment completed when indicated:	24		28		29		25	
Reassessment done when indicated	Any member enrolled one year or longer, or who had a change in living situation, or the team identified a risk to the member	If the member was eligible to have a reassessment completed, was it done when indicated?	Members eligible for reassessment:	12	100%	18	100%	12	100%	12	83.3%
			Reassessment done when indicated:	12		18		12		10	
Overall Assessment Score by MCO		Overall Denominator:	52	98.1%	63	95.2%	58	94.8%	54	92.6%	
		Overall Numerator:	51		60		55		50		



SERVICE PLANNING

Service Planning Measures N=8	Who is eligible for the measure?	Criteria	Statistics	Family Care Partnership (FCP)						PACE	
				Care Wisconsin (CW-FCP)		Community Care (CC-FCP)		Community Health Partnership (CHP-FCP)		Community Care (CC-PACE)	
				#	%	#	%	#	%	#	%
Timeliness of initial individual service plan (ISP)	New enrollees	Was the initial ISP done within 10 business days of enrollment?	New enrollees:	7	100%	8	87.5%	4	100%	7	85.7%
			Initial ISP done in a timely manner:	7		7		4		6	
Timeliness of initial individualized plan	New enrollees	Was the initial individualized plan done within 60 calendar days of enrollment?	New enrollees:	8	50.0%	8	62.5%	8	87.5%	8	100%
			Initial assessment done in a timely manner:	4		5		7		8	
Comprehensiveness of most recent plan	All members	Was the most recent plan comprehensive?	All members:	28	0%	30	40.0%	30	46.7%	30	20.0%
			Most recent plan was comprehensive:	0		12		14		6	
Timeliness of most recent plan	All members	Was the most recent plan reviewed within the last 6 months?	All members:	28	71.4%	30	83.3%	30	93.3%	30	80.0%
			Most recent plan was done in a timely manner:	20		25		28		24	
Plan updated for significant changes	Members with significant changes	For those members with significant changes, was the plan updated with the significant changes?	Members with significant changes:	9	77.8%	12	66.7%	10	90.0%	6	83.3%
			Plan updated:	7		8		9		5	
Timeliness of service authorizations	Members with service requests	For those members with service requests, were the service authorizations done in a timely manner?	Members with service requests:	26	88.5%	29	72.4%	30	93.3%	30	73.3%
			Service authorizations done in a timely manner:	23		21		28		22	
Risk addressed when identified	Any member at risk	For those members with risk, was the risk addressed when identified?	Members at risk:	22	90.9%	30	100%	23	100%	21	100%
			Risk was addressed when identified:	20		30		23		21	
Collaboration of the interdisciplinary team	All members	Did all members of the interdisciplinary team collaborate when providing care management?	All members:	30	96.7%	30	100%	30	100%	30	100%
			All interdisciplinary team members collaborated on the members' case management:	29		30		30		30	
Overall Service Planning Score by MCO			Overall Denominator:	158	69.6%	177	78.0%	165	86.7%	162	75.3%
			Overall Numerator:	110		138		143		122	



SERVICE COORDINATION & DELIVERY

Service Coordination & Delivery Measures N=4	Who is eligible for the measure?	Criteria	Statistics	Family Care Partnership (FCP)						PACE	
				Care Wisconsin (CW-FCP)		Community Care (CC-FCP)		Community Health Partnership (CHP-FCP)		Community Care (CC-PACE)	
				#	%	#	%	#	%	#	%
Timely coordination of services	Members with any services	For those members who had services, was the coordination of services done in a timely manner?	Members with services:	30	80.0%	30	80.0%	30	66.7%	30	86.7%
			Service coordination was done in a timely manner:	24		24		20		26	
Evidence that MCOs Implement Authorized Services	Members with authorized services	For those members who had authorized services, is there evidence that the authorized services were implemented?	Members with authorized services:	30	90.0%	30	100%	30	93.3%	30	100%
			Evidence that authorized services were implemented:	27		30		28		30	
Follow-up to ensure that services are effective	Members with any services	For those members who had services, was follow-up done to ensure that the services were effective?	Members with services:	30	73.3%	30	90.0%	30	90.0%	30	76.7%
			Follow-up was done to ensure services were effective:	22		27		27		23	
Identified Needs Were Addressed	All members	All members are assumed to have needs. Were their needs addressed?	All members:	30	93.3%	30	93.3%	30	93.3%	30	90.0%
			Identified needs were addressed:	28		28		28		27	
Overall Service Coordination and Delivery Score by MCO			Overall Denominator:	120	84.2%	120	90.8%	120	85.8%	120	88.3%
			Overall Numerator:	101		109		103		106	



PARTICIPANT CENTERED FOCUS

Participant Centered Focus Measures N=3	Who is eligible for the measure?	Criteria	Statistics	Family Care Partnership (FCP)						PACE	
				Care Wisconsin (CW-FCP)		Community Care (CC-FCP)		Community Health Partnership (CHP-FCP)		Community Care (CC-PACE)	
				#	%	#	%	#	%	#	%
Notice of action issued in a timely manner when indicated	Members who whom a notice of action was indicated	Was the notice of action sent in a timely manner?	Members to whom a notice of action was indicated:	11	63.6%	13	23.1%	9	77.8%	11	27.3%
			The notice of action was sent in a timely manner:	7		3		7		3	
Member / guardian / family / informal supports included in planning	All members	Was the member included in planning? If applicable, were the member's guardian, and/or family member, and/or informal supports included in the planning process?	All members:	30	96.7%	30	93.3%	30	100%	30	100%
			Appropriate people included in planning:	29		28		30		30	
Self directed supports option offered to members	All members	Was the option of self directed supports offered to members?	All members:	30	80.0%	30	93.3%	30	100%	30	73.3%
			Members who were offered the option of self directed supports:	24		28		30		22	
Overall Participant Centered Focus Score by MCO		Overall Denominator:		71	84.5%	73	80.8%	69	97.1%	71	77.5%
		Overall Numerator:		60		59		67		55	

