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November 22, 2010

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Department of Health Services, State of Wisconsin

From: Ann Marie Ott, Vice-President
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Subject: Annual Report - External Quality Review Organization
Fiscal Year 2009-2010

The attached report is provided to you in order to meet Federal requirements for External Quality Review (EQR) found in 42 CFR 438.364, and to support Department of Health Services (DHS) efforts to ensure quality for enrollees in the Family Care, Family Care Partnership and PACE programs.

The report offers summaries and comparisons of the Managed Care Organizations' (MCOs) strengths, as well as recommendations to the MCOs and DHS to ensure compliance with Federal and State standards for access to care, and quality and timeliness of care. The summary of findings can be found on pages 17 through 47, with individual MCO reports and comparative charts available in the appendices to the report.

DHS has identified choice, access, quality, and cost-effectiveness as the primary goals of its Family Care programs. MetaStar's review activities identified a number of MCO strengths that align with these objectives.

Strengths of MCOs

One notable area of strength across all MCOs is assessing and addressing risk. During the review year, the EQR team found six records of members with complex situations involving medical, mental health, and/or social issues that were brought to the attention of DHS. However, no members with immediate health and safety issues were identified during SFY 09-10.

Successful approaches to care management in this area included establishing clear expectations for inter-disciplinary teams' (IDTs) use of assessment tools, specialized IDTs, consultations with behavior health specialists, and practice guidelines. DHS focused its training efforts in this area of care management, which contributed to the strong performance of MCOs.

MCOs also excelled at ensuring member rights and access to grievance systems. Organizations met nearly all standards for establishing effective systems to respond to appeals and grievances, and to ensure that members are free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. Reviewers noted that MCOs are successful in creating plans that allow members to live in the least restrictive environments.

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Quality and timeliness of assessments is another notable strength of care management delivery systems across MCOs. Interviews with care management teams at each MCO confirmed medical record review findings, that the effectiveness of the assessment process and collaboration among disciplines supports progress towards fully achieving the goals for the Family Care program.

Opportunities for Improvement

During fiscal year 2009-2010 DHS initiated efforts to address areas for improvement noted in previous reports. Examples of these efforts include:

- Collaboration with the State of Wisconsin Division of Hearings and Appeals, MCOs, and community stakeholder groups, to standardize Notices of Action and other member materials to empower members and ensure opportunities to exercise rights
- Formal communication of specific performance expectations to address non-compliance, and routine monitoring of MCOs' progress towards meeting these expectations
- Statewide training on key components of the Family Care program, including the exploration and identification of personal member outcomes, the Resource Allocation Decision-Making method (RAD), and assessing and addressing risk
- Completed work with the University of Wisconsin Center for Health Systems Research and Analysis and MetaStar to validate a tool for member outcome interviews using the Personal Experience Outcomes Integrated Interview and Evaluation System (PEONIES) methodology

Based on the findings summarized in this report, the Department and MCOs should focus their efforts to make improvements in the following areas:

- Continue efforts to ensure that MCOs employ effective methods to ensure IDTs explore, identify and document members' personal outcomes according to Family Care program standards
- Monitor IDTs use of the RAD to confirm that members are actively engaged in exploring cost-effective service options and are participating in all steps of the care planning process
- Confirm that MCOs have designed and implemented quality monitoring strategies that evaluate the quality and appropriateness of care

We also encourage the Department to take steps to establish expectations for improvement at some MCOs where some specific standards have not been met for several years in a row, and also for NorthernBridges MCO, which in its first year of operation did not achieve compliance with a significant number of quality standards.

Lastly, we extend our appreciation for the collaboration and support that MetaStar staff received from DHS and MCO staff in conducting all review activities during FY 2009-2010, and especially to the MCOs, for providing direct access to IDTs and members during the on-site visits.

cc: Susan Crowley, Administrator, Division of Long Term Care
Fredi-Ellen Bove, Deputy Administrator
Tom Lawless, Director, Bureau of Financial Management

EXTERNAL QUALITY REVIEW REPORT
WISCONSIN MEDICAID MANAGED CARE

FAMILY CARE, FAMILY CARE PARTNERSHIP AND PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY
STATE FISCAL YEAR 2009-2010

PREPARED FOR

WISCONSIN DEPARTMENT OF HEALTH SERVICES

PREPARED BY

NOVEMBER 5, 2010

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INTRODUCTION AND OVERVIEW

ACRONYMS AND ABBREVIATIONS

Please see Attachment 1 for definitions of all acronyms and abbreviations used in this report.

PURPOSE OF THE REPORT

This is the annual technical report that the State of Wisconsin must provide related to the operation of its Medicaid managed health and long-term care programs; Family Care (FC), Family Care-Partnership (FCP) (formerly known as the Wisconsin Partnership Program), and Program of All-Inclusive Care for the Elderly (PACE). The Wisconsin Department of Health Services (DHS) contracts with ten managed care organizations (MCOs) to administer these programs, which are considered pre-paid inpatient health plans (PIHPs).

As depicted in the table below, six MCOs operate Family Care programs; one MCO operates a Family Care-Partnership program; two MCOs operate both Family Care and Family Care-Partnership programs; and one MCO operates programs for Family Care, Family Care-Partnership and PACE.

OVERVIEW OF WISCONSIN'S FC, FCP AND PACE MCOS

MANAGED CARE ORGANIZATION	PROGRAM(S)
Care Wisconsin (CW)	**FC; FCP**
Community Care (CC)	**FC; FCP; PACE**
Community Care of Central Wisconsin (CCCW)	**FC**
Community Health Partnership (CHP)	**FC; FCP**
***Independent Care (iCare)**	**FCP**
Lakeland Care District (LCD), formerly known as Creative Care Options	**FC**
****Milwaukee County Care Management Organization (MCCMO) formerly known as Milwaukee County Department on Aging**	**FC**
Northern Bridges Managed Care Organization (NB)	**FC**
Southwest Family Care Alliance (SFCA)	**FC**
Western Wisconsin Cares (WWC)	**FC**

* Per its contract with DHS, the External Quality Review Organization conducts mandatory external quality reviews for MCO programs that have served members for at least one year. iCare began Family Care-Partnership operations in January 2010; therefore, an external quality review of its program did not occur during the year covered by this report.

** The Care Management Review portion of MCCMO's annual quality review did not evaluate care management services to members aged 59 years and younger, because MCCMO had implemented services to this age group less than one year prior to its SFY 09-10 review.

The Code of Federal Regulations (CFR) at 42 CFR 438 requires States that operate PHIPS to provide for an external quality review (EQR) of their managed care organizations, and to produce an annual technical report that describes the way in which the data from all EQR activities was reviewed, aggregated and analyzed, and conclusions drawn regarding the quality, timeliness, and access to care furnished by the MCOs. The report should also include an assessment of each MCO's strengths, progress, and opportunities for improvement. In addition, the report should identify any "Best Practices," and provide comparative information about MCOs.

To meet these obligations, States contract with a qualified external quality review organization (EQRO). The State of Wisconsin contracts with MetaStar, Inc., to conduct its EQR activities, and to produce the annual technical report. This report covers EQR activities conducted for the state fiscal year from July 1, 2009, to June 30, 2010 (SFY 09-10).

WISCONSIN'S EXTERNAL QUALITY REVIEW ORGANIZATION – METASTAR, INC.

Based in Madison, Wisconsin, MetaStar, Inc., has been a leader in health care quality improvement, independent quality review services, and medical information management for more than 35 years, and is a federally designated Quality Improvement Organization for Wisconsin. MetaStar is the EQRO contracted and authorized by DHS to provide independent evaluation of MCOs operating FC, FCP and PACE. MetaStar evaluates each MCO's compliance with federal Medicaid managed care regulations and its contract with DHS. Other services the company provides to the State of Wisconsin include independent review of Health Maintenance Organizations (HMOs) serving Badger Care and SSI Medicaid recipients. MetaStar also provides services to private clients as well as the State.

The MetaStar EQR team is comprised of registered nurses, a nurse practitioner, and licensed social workers, as well as other degreed professionals with extensive education and experience working with the target groups served by the MCOs - individuals who are frail elders, or adults who have physical or developmental disabilities, including individuals with co-morbidities (e.g., frail elder with mental illness, individual with developmental disability and substance abuse issues, individual with physical disability and traumatic brain injury). Review team experience includes professional practice in the FC and FCP programs as well as in other settings, including community programs, home health agencies, and community-based residential settings. Some reviewers have worked in primary and acute care facilities or other skilled nursing facilities. The EQR team also includes reviewers with quality assurance/quality improvement (QA/QI) education, and specialized training in evaluating performance improvement projects. Reviewers are required to maintain licensure, if applicable, and participate in additional relevant training throughout the year. MetaStar's review team management and staff for SFY 09-10 are listed in the chart on the inside cover of this report.

WISCONSIN'S MANAGED LONG-TERM CARE PROGRAMS FAMILY CARE, PARTNERSHIP, PACE

In the mid-1990's a broad consensus developed in Wisconsin regarding the need to redesign the state's long-term care system. Driving the discussion were concerns about the cost and complexity of the system, inequities in the availability of services, and projections of an aging population and increased need for long-term care. DHS engaged with multiple stakeholder groups to plan the redesign of the publicly supported long-term care system. The comprehensive planning process identified the following goals for the redesigned system:

- **Choice** - Give people better choices about the services and supports available to meet their needs;
- **Access** - Improve people's access to services;
- **Quality** - Improve the overall quality of the long-term care system by focusing on achieving people's health and social outcomes;
- **Cost Effectiveness** - Create a cost-effective long-term care system for the future.

By 1999, under Governor Tommy Thompson, the State was piloting three new service delivery models: FC, FCP and PACE. While each of these models incorporates managed care principles, in FCP and PACE interdisciplinary care management teams (IDTs) manage a benefit package that includes members' acute and primary health care services as well as their home and community-based long-term care services. In FC, IDTs manage members' home and community-based long-term care, and work closely with their health care providers to coordinate acute and primary care services, which remain outside the benefit package. MCOs contract with a network of providers to deliver health and long-term care services to their members. MCOs receive a monthly capitation payment for each member, and are responsible for meeting regulatory and contract requirements in a way that ensures service access, timeliness and quality. MCOs serve frail elders, as well as adults who have physical and/or developmental disabilities. In addition to target group criteria, new and continuing members must meet functional and financial eligibility guidelines and be a resident of the MCO's service area. MCO members are part of their interdisciplinary team, and should be included at every stage of assessment, care planning, and service authorization. They are also involved in ongoing program planning, implementation, evaluation, and improvement. For more information about FC, FCP and PACE, visit the following DHS websites:

- http://dhs.wisconsin.gov/LTCare/Generalinfo/WhatisFC.htm; and
- http://dhs.wisconsin.gov/wipartnership/2pgsum.htm

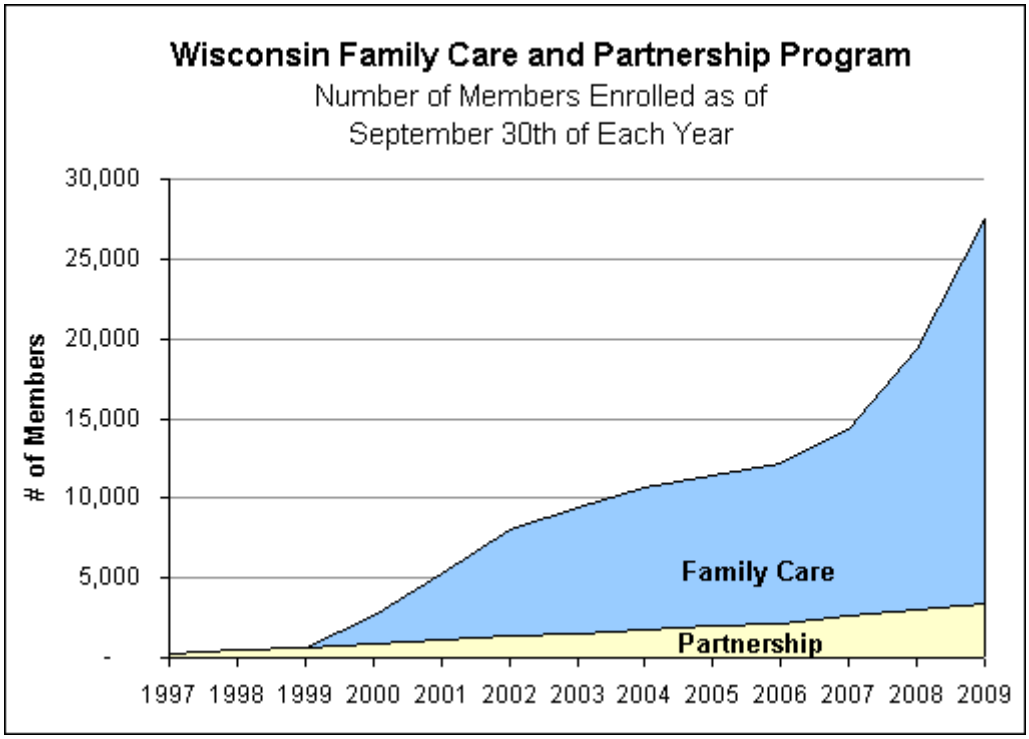
Between 1999 and 2006, MCOs were operating FC, FCP or PACE in approximately 12 percent of Wisconsin's 72 counties.

Managed and Long Term Care Expansion

In 2005, an independent evaluation of FC found that MCOs were providing quality care to members at substantial savings to Wisconsin's Medicaid program. In 2006, Governor Jim Doyle announced plans to expand FC statewide over five years. FC expansion began in 2007 and continues today. In SFY 09-10, four MCOs expanded FC into a total of 14 counties. One MCO expanded FCP into two counties. In addition, two MCOs began operating programs in Milwaukee County - one MCO began a FC program, and the other MCO began a FCP program – affording consumers in Wisconsin's most populous county more choice of MCO providers. Currently, FC is available in approximately 67 percent of Wisconsin counties, while FCP is available in 26 percent of counties and PACE is available in three percent.

Total enrollment as of July 1, 2010 for all programs was 34,400. The following table, taken from the DHS website cited below, depicts the census growth of FC, FCP and PACE over time.

CENSUS GROWTH OVER TIME



See Attachments 2 and 3 for point-in-time reports of FC, FCP and Pace enrollment data as of July 1, 2009 and June 1, 2010 respectively, including enrollment by program, MCO, county, and target group. Program start dates for the various counties in which programs are operating are also included, providing another way of looking at the expansion and development of these programs over the past several years. For a current monthly snapshot of FC, FCP and PACE enrollment data as well as census growth, visit the following DHS website:

http://dhs.wisconsin.gov/ltcare/Generalinfo/EnrollmentData.htm

SCOPE OF EXTERNAL REVIEW ACTIVITIES AND REVIEW METHODOLOGY

Annually, the EQRO evaluates whether FC, FCP and PACE MCOs are in compliance with federal Medicaid managed care regulations, specifically 42 CFR 438. The annual quality review addresses these areas: Quality Compliance Review (QCR); Care Management Review (CMR); and Validation of Performance Improvement Projects (PIP). The scope of QCR activities generally follows a three year cycle for each MCO; one year of comprehensive review, followed by two years of targeted review or follow-up. SFY 09-10 was the second year of the three year cycle for all of the MCOs reviewed except NorthernBridges, a start-up MCO that began in May 2009. A comprehensive review was conducted for NorthernBridges MCO.

Each year the EQRO also conducts Validation of Performance Measures specified in the DHS-MCO contract, and provides Information System Capabilities Assessments (ISCAs) as directed by DHS. These review activities are generally conducted separately from the annual quality review. In SFY 09-10, the EQR team conducted performance measures validation for every

MCO and every program (FC, FCP, PACE). An ISCA was conducted for NorthernBridges MCO.

QUALITY COMPLIANCE REVIEW

The QCR evaluates policies, procedures, and practices that affect the quality and timeliness of care and services that MCO members receive, as well as their access to services. To conduct the QCR, a mandatory EQRO review activity, the EQR team used the methodology contained in 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 review Protocol consists of five topic areas:

- Enrollee Rights
- Quality Assessment and Performance Improvement – Access to Services
- Quality Assessment and Performance Improvement – Structure and Operations
- Quality Assessment and Performance Improvement – Measurement and Improvement
- Grievance Systems

For SFY 09-10, at the direction of DHS, the QCR focused on reviewing measures that were scored "partially met" or "not met" during each MCO's previous annual quality review. The chart contained in Attachment 4 shows the SFY 09-10 QCR areas of focus for each MCO, based on SFY 08-09 findings. It should be noted that while there were designated focus areas, review results reflect findings from all areas. Results from each MCO's SFY 09-10 QCR are documented in the appendix section of each MCO's annual quality report, and can be found in Attachments 5 through 13 of this report.

The QCR also evaluated key elements of each MCO's quality management program, including the organization's quality improvement program description, work plan for calendar year (CY) 2010, and evaluation of its CY 2009 quality program activities, in order to identify how the organization approached and addressed the quality improvement recommendations identified during the SFY 08-09 annual quality review, and to ensure compliance with DHS requirements for quality management not addressed in DHS annual certification activities. One exception to this was NorthernBridges, a new MCO serving 11 counties in northwest Wisconsin, which began enrolling members in May 2009. The SFY 09-10 review marked the first QCR for NorthernBridges; therefore, the EQR team reviewed all applicable elements from the protocol's five topic areas.

Prior to conducting QCR activities, the EQR team reviewed background information about the organization, such as:

- The 2009 and 2010 Family Care program(s) contracts between DHS and the MCO;
- Related program operation references found on the DHS website:
  - http://dhs.wisconsin.gov/LTCare/ProgramOps/Index.htm;
- The EQRO's report detailing results of the MCO's annual quality review for SFY 08-09; and

- The DHS memo addressing required follow-up in relation to the SFY 08-09 annual quality review.

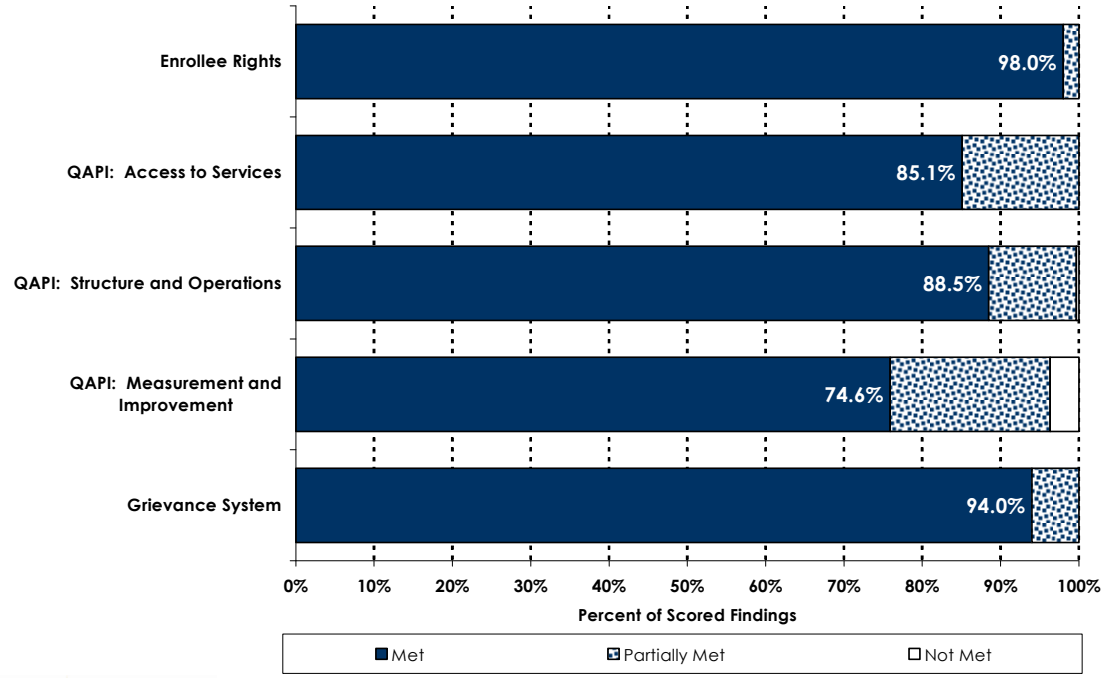
To conduct the QCR, the EQR team obtained and assessed a variety of MCO documents, in order to gain an understanding of the organization as well as the activities it had engaged in over the past year. Document requests were tailored to each MCO. Based on the document review, questions were developed tailored to each MCO, and on-site discussions were conducted with MCO management and staff. Some additional on-site document and file verification activities were also conducted. Post on-site, the EQR team requested and reviewed additional materials, as needed, in order to clarify information gathered during the on-site visit. Findings were analyzed and compiled using a three-point rating structure (met, partially met and not met) to assess the MCO's level of compliance with the QCR protocol standards.

- **Met** applied when all policies, procedures, and practices 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.

For findings of "partially met" or "not met," the EQR team documented the missing requirements related to the finding and provided recommendations.

The chart below depicts the overall QCR findings for SFY 09-10, expressed in terms of the percentage of met, partially met, and not met scores for each of the five review topic areas.

2009-2010 Quality Compliance Review Findings FC, FCP and PACE MCOs



CARE MANAGEMENT REVIEW

The CMR portion of the annual quality review determines a MCO's level of compliance with its contract with DHS; ability to safeguard members' health and welfare; and ability to effectively support IDTs in the delivery of cost effective, outcome-based services. The information gathered during CMR activities helps assess the access, timeliness, quality, and appropriateness of care an MCO provides to its members.

The CMR focuses on reviewing three key care management processes:

- Addressing risk at the member level;
- Working with members to identify personal outcomes; and
- Using the resource allocation decision method (RAD) to explore service options and make service authorization decisions to meet members' outcomes and needs.

To learn more about outcomes, review the section titled *What are outcomes, and why do they matter?* in the "Being a Full Partner" booklet available at the following DHS website:

- http://dhs.wisconsin.gov/LTCare/BeingAFullPartner.htm

To learn more about the RAD, visit this DHS website:

- http://dhs.wisconsin.gov/LTCare/ProgramOps/Index.htm

With direction from DHS, the EQRO selected a random sample of member records for review from each MCO. IDT assignments were considered in the sample selection, so that it included the greatest number of care management staff and service areas as possible. The sample also included a mix of participants who had been enrolled for less than a year, more than a year, or who were no longer enrolled. In addition, the sample included members from all of the target populations served by the MCO: frail elderly, physically disabled and developmentally disabled. The records selected included some individuals who also had mental illness, traumatic brain injury, and/or Alzheimer's disease.

The EQRO developed a standard review tool and reviewer guidelines based on DHS contract requirements and care management trainings. The EQR team conducted each record review using the DHS-approved review tool and guidelines to evaluate four categories of care management: Assessment, Care Planning, Service Coordination & Delivery, and Participant Centered Focus. If the EQR team identified a concern regarding member health or safety issues during a record review, it was brought to the attention of DHS by the CMR Lead and/or Project Manager the same day, followed by both verbal and written summaries. DHS staff continued to monitor the identified member's care until all issues were resolved to the satisfaction of the Department.

Individualized questions based on the record review results were developed, and on-site interviews were conducted with IDTs. The on-site interviews helped the EQR team clarify information gathered during record reviews as well as learn more about each organization's care management practice.

Additional input was solicited from IDT staff, including some with supervisory responsibilities, prior to the on-site visit using an anonymous, web-based survey. The survey collected information about the background, experience and training of the staff; feedback about the processes, tools, support, and training staff found most helpful to the provision of quality, cost-

effective care management services; and comments about the barriers they experienced that hindered or prevented effective care management service delivery.

Findings from all review components were analyzed and compiled using a binomial scoring system (met and not met) to rate the MCO's performance for each measure evaluated. For findings of "not met," the reviewers noted the key areas related to the finding and provided comments to identify the missing requirements.

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

The PIP validation portion of the annual quality review documents that a MCO's performance improvement project is designed, conducted, and reported in a methodologically sound manner, so that the data and findings can be used effectively for organizational decision-making. Validation of PIPs is a mandatory EQRO review activity.

DHS requires that during each contract period, MCOs must make active progress on at least one PIP relevant to long-term care. Also, MCOs operating FCP and PACE with acute and primary care in their benefit package must make active progress on one additional PIP relevant to clinical care. Through project design, ongoing measurements, and interventions, PIPs should achieve significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on outcomes and member satisfaction. MCOs are required to use a standardized PIP model or method, e.g., the Best Clinical and Administrative Practices (BCAP) method, and must document the status and results of each project in enough detail to show that it is making progress. One exception to this for the SFY 09-10 review period was NorthernBridges MCO. DHS waived the requirement for NB to conduct a PIP during its first year of operation.

To evaluate the standard elements of a PIP, the EQR team used the methodology described in CMS' guide, Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities, and the Medicaid Managed Care Performance Improvement Project: Project Evaluation Checklist. The review protocol is used to assess the standard elements of a PIP:

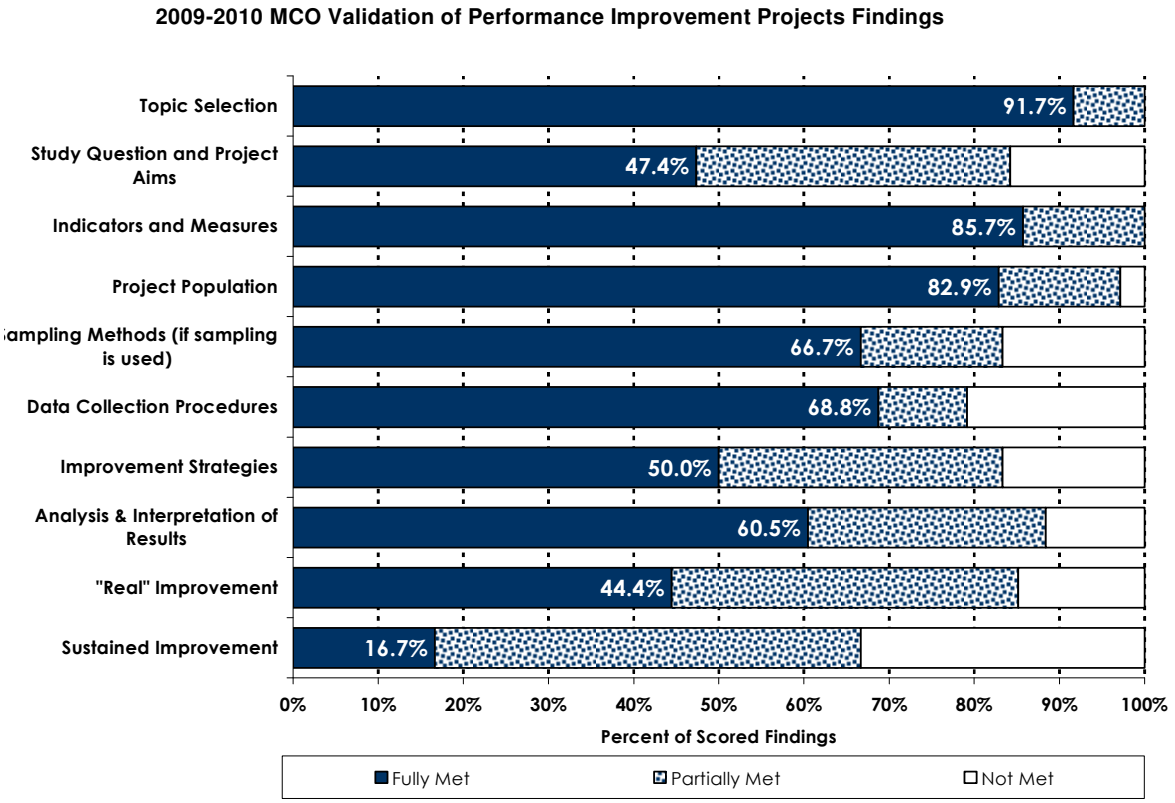
- Topic Selection
- Study Questions and Project Aims
- Indicators and Measures
- Project Population
- Sampling Methods (if sampling is used)
- Data Collection Procedures
- Improvement Strategies
- Analysis and Interpretation of Results
- "Real" Improvement
- Sustained Improvement

Each PIP was evaluated at whatever stage of implementation it was in at the time of the review. To conduct the PIP review, the EQR team obtained and assessed MCO documents, such as the MCO's annual PIP report; BCAP workbook or other project work plan/description; data on project measures; and other project information, e.g., related practice guidelines or member education materials. Following the document review, on-site interviews were conducted with the MCO's quality management staff and PIP project team members. The purpose of the discussion

was to follow up on questions related to project design and measures, implementation, data collection methods, results of data, and the plan for next steps.

Findings were analyzed and compiled using a three-point rating structure (met, partially met and not met) to assess the MCO's level of compliance with the PIP protocol standards, although some standards or associated indicators may have been scored "not applicable" due to the project's phase of implementation at the time of the review. For findings of "partially met" or "not met," the EQR team documented the missing requirements and provided recommendations.

The chart below depicts the overall PIP findings for SFY 09-10, expressed in terms of the percentage of met, partially met, and not met scores for each of the standard PIP elements.



REPORTING THE RESULTS OF EACH ANNUAL QUALITY REVIEW

For each MCO, the EQRO compiled findings from all three areas of review activities - QCR, CMR and PIP validation - into a preliminary written report, which provided information regarding both specific findings and overall performance, including strengths, opportunities for improvement, recommendations, and identification of any "Best Practices." The MCO was then given the opportunity to review the preliminary report and offer additional information. MCO comments were considered and, as appropriate, incorporated into the final report. The EQRO completed this entire process, and provided the final report to both DHS and the MCO within approximately 45 business days from the date of the MCO's on-site visit. After the receipt of each final report, DHS issued an annual quality review follow up letter to the MCO acknowledging the findings, and specifying the requirements and timeframes for any needed action.

VALIDATION OF PERFORMANCE MEASURES

The EQRO validates the performance measures as directed by DHS to ensure that MCOs have the capacity to gather and report data accurately, so that staff and management are able to rely on data when assessing program performance or making decisions related to improving members' health, safety, and quality of care. Validation of Performance Measures is a mandatory EQRO review activity.

Annually, MCOs are required to measure and report their performance, using quality indicators and standard measures specified in their contract with DHS. FCP and PACE providers must also report all of the Healthcare Effectiveness Data and Information Set (HEDIS) [1] quality indicators and supporting information that are provided to CMS for all Medicare enrollees.

For SFY 09-10, the EQR team validated performance measures that related to health and safety:

- Influenza vaccinations
- Pneumonia vaccinations
- Dental visits (FCP and PACE programs only)

For one additional performance measure related to continuity of care, each MCO calculated its own rate of performance, and the EQRO collected and delivered the information to DHS. The EQRO did not validate this measure.

Immunization Measures

Influenza vaccination rates were calculated by target group as the percent of MCO members whose service record contained documentation of having received an influenza vaccine from September 1, 2009, through December 31, 2009, out of the total members continuously enrolled during the measurement period. It should be noted that the vaccination rate for this measure did not include immunizations given for the H1N1 influenza.

Pneumonia vaccination rates were calculated by target group as the percent of MCO members whose service record contained documentation of having had a pneumovax vaccine within the last ten years (1999 - 2009), out of the total members continuously enrolled from July 1, 2009, through December 31, 2009. (Exception: For members in the frail elder target group [age 65 years and older], one vaccine administered at age 65 years or later counted as having had the pneumovax vaccine within the measurement period.)

Dental Measure

Dental visits were calculated by target group as the percent of MCO members whose service record contained documentation of having had a dental visit during the contract period January 1, 2009, through December 31, 2009, out of the total members with at least six months of eligibility during the measurement period. A dental visit was defined in the MCO contract with DHS as services from a dentist, dental hygienist, oral surgeon or orthodontist.

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)

Use of data

Each MCO submitted spreadsheets to the EQRO containing data regarding influenza and pneumonia immunizations and, if applicable, dental visits for its members. The EQR team worked with the MCO to discuss and resolve any issues with the data, and then calculated the rate for each of the performance measures. To validate the immunization and dental visit rates, the EQR Team requested 30 randomly selected member records for each of the three performance measures.

Reviewers checked each record to verify that it clearly documented the appropriate vaccination or dental visit in the appropriate time period. If the documentation was found, the reviewers considered the MCO's report of that member's vaccination or dental visit to be valid. If the record did not clearly record the appropriate vaccination or dental visit in the appropriate time period, the reviewer considered the MCO's report of that member's vaccination or dental visit to be invalid. Using the findings from the record samples, the EQR team then conducted statistical testing to determine if the MCO's data had produced accurate immunization and dental rates.

Care management turnover rates were reported as the percent of social service coordinators/social workers who separated during the contract period January 1, 2009 – December 31, 2009 out of the total employed by the MCO as of 12/31/08; and the percent of registered nurses who separated during the contract period January 1, 2009 - December 31, 2009, out of the total employed by the MCO as of 12/31/08. Separation was defined in the MCO contract with DHS as movement out of the organization (resigned, retired, terminated, etc.), and did not include either movement within the organization (transferred, promoted) or departure of temporary hires. As noted above, each MCO calculated its own rate for this performance measure.

For each MCO, the EQRO compiled findings into a written report that provided information regarding specific findings as well as recommendations, and provided the report to both DHS and the MCO.

INFORMATION SYSTEMS CAPABILITIES ASSESSMENT

An Information Systems Capabilities Assessment (ISCA) evaluates the extent to which an MCO's health information system (IS) is capable of collecting, analyzing, integrating and reporting valid encounter data, and other data (e.g., QA/QI, claims processing, enrollment/disenrollment, utilization, appeal and grievance, etc.) required by its contract with DHS.

ISCA activities are based on the CMS protocol, Monitoring Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans, Appendix Z: Information Systems Capabilities Assessment for Managed Care Organizations.

The review protocol evaluates each of the following areas within an MCO's IS and business operations:

- General Information
- Information Systems – Encounter Data Flow
- Encounter Data Collection
- Eligibility Enrollment Data Processing
- Practitioner Data Processing

- Vendor/Ancillary/Medical Record Data Collection
- System Security
- Vendor Oversight
- Requested Attachments for Desk Review

As directed by DHS, the EQRO assesses the IS capabilities of MCOs to meet certification standards and demonstrate the ability to comply with reporting requirements in the formats and timelines prescribed by DHS. For SFY 09-10, an ISCA was completed for NB MCO.

In addition to completing the ISCA tool, the EQR team obtained and evaluated pertinent documents related to NB's IS and operations. A member of the EQR team also visited on-site to conduct staff interviews and observe live demonstrations of the MCO's systems.

The EQRO analyzed and compiled its findings into a preliminary written report. The MCO was then give the opportunity to review the preliminary report and offer further information and comments before the report was finalized. The EQRO provided the final report to both DHS and the MCO. After receipt of the final report, DHS determined the requirements and timeframes for any needed action.

ORGANIZATION OF THE REMAINDER OF THE REPORT

The Summary of Findings which follows provides information regarding general themes and overall findings across MCOs identified during the SFY 09-10 annual quality review of Wisconsin's FC, FCP and PACE programs. CMS guidelines contained in its *State External Quality Review Tool Kit for State Medicaid Agencies* suggest discussion of the findings in relation to access to care, timeliness of care, and program quality. Therefore, the EQRO assigned the topics reviewed for the annual quality review to one or more of these domains, and organized the "Summary of Compliance with Standards" portion of the Summary of Findings into three main sections - "Access to Care," "Timeliness" and "Quality."

ASSIGNMENT OF REVIEW TOPICS TO ACCESS, TIMELINESS AND QUALITY DOMAINS

Compliance Review Standards	Access	Timeliness	Quality
QUALITY COMPLIANCE REVIEW			
• Enrollee Rights	*X*		*X*
• Quality Assessment and Performance Improvement - Access to Services	*X*	*X*	
• Quality Assessment and Performance Improvement - Structure and Operations	*X*	*X*	
• Quality Assessment and Performance Improvement - Measurement and Improvement			*X*
• Grievance Systems	*X*	*X*	
VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS			
• Number of PIPs per MCO			*X*
CARE MANAGEMENT REVIEW			
• Identifying member outcomes			*X*
• Authorizing services using the RAD	*X*	*X*	
• Addressing risk at the member level	*X*		

The information in each section is discussed in terms of overall strengths, opportunities for improvement, and progress related to administration of these Medicaid managed health and long-term care programs. Each section also identifies any "Best Practices," and includes recommendations. Reviewers defined "Best Practice" as innovative and effective activity, policy, procedure, or process of an MCO that meets or exceeds contract expectations; is fully implemented throughout the organization; has been sustained over time; has been shown to contribute to improvements in program operations or the quality of member care; *and* that other MCOs should consider replicating within their organizations.

SFY 09-10 findings regarding PIPs, performance measures validation, and the ISCA are summarized in separate sections which follow the "Summary of Compliance with Standards."

Individual reports containing the results and recommendations specific to each MCO's SFY 09-10 annual quality review can be found in Attachments 5 through 13, while MCO comparative information is contained in Attachments 14 through 17. The results of performance measures can be found in Attachment 18. ISCA results are contained in Attachment 19.

SUMMARY OF FINDINGS

SUMMARY OF COMPLIANCE WITH STANDARDS (QCR AND CMR)

ACCESS TO CARE

One of the primary goals of the DHS Family Care program identified on the DHS Family Care website "is improving people's access to services." To ensure access to services, MCOs are required to maintain a comprehensive network of providers and also identify and coordinate unpaid supports to meet members' personal outcomes and needs. Members, along with healthcare professionals assigned to their IDT, use the Resource Allocation Decision method (RAD) to explore service options and make agreements for the provision of care.

Findings indicate that, as a group, access to care is the greatest area of strength for MCOs. It is a broad category that includes review measures related to:

- Enrollee Rights;
- Quality Assessment and Performance Improvement (QAPI) - Access to Services;
- QAPI - Structure and Operations;
- Grievance Systems; and
- Care Management Practice.

Based on the results of the SFY 08-09 review, this year's QCR follow up review focused on measures such as assessing and addressing risk, appeals & grievance committee access, restrictive measures monitoring, ability of providers to ensure timely access to services, documenting follow-up activities related to effectiveness of services, provider network contracting and monitoring, monitoring performance of subcontracted entities (contracted care management units), provider network directory, face-face monitoring, ensuring that MCO's do not use providers that have been excluded from participating in federal health care programs, employee and provider background checks, provider credentialing, and care management practice. To assess care management practice, DHS instructed MetaStar to expand the CMR to include not only the review of member records, but also interviews with staff assigned to members' IDTs, (See additional details in the "Scope of External Review Activities and Review Methodology" section found earlier in this report.)

Assessing and Addressing Risk

One notable area of strength identified across MCOs is assessing and addressing member risk. Similar to results of the SFY 08-09 review, SFY 09-10 QCR results show that eight of nine MCOs received a score of met for this area, while one MCO (CCCW) received a partially met score. No MCO received an unmet score in this area. CMR results supported the QCR findings, as across MCOs, results of record reviews indicate that IDTs are highly effective in assessing and addressing risk. During the review year, the EQR team found six records of members with complex situations involving medical, mental health, and/or social issues that were brought to the attention of DHS. However, no members with immediate health and safety issues were identified during SFY 09-10.

The partially met score related to CCCW's failure to enter and analyze results from its internal file review process to determine if interdisciplinary teams (IDTs) are consistently assessing

members' risk. However, this MCO also developed and implemented a *Risk Assessment and Intervention Plan and Risk Reduction Policy*, as well as a Committee to assist in assessing and addressing member risk. The Informed Choice = Risk Reduction Committee is made up of MCO staff with varied expertise who provide consultation, education and support to IDTs, and was cited as a "Best Practice" in CCCW's annual quality review.

MCOs typically provide internal resources for assessing and addressing risk, such as:

- Behavioral health specialists who help educate and train IDTs about risk, provide case consultation, and/or assist in the development of behavior support plans;
- Specialized IDTs that focus on supporting higher risk members;
- Lower caseloads for IDT staff who work with members with mental health issues, allowing them to spend more time with members and serve as a resource for other staff;
- Assessment tools that help gather and explore information about risks and behaviors;
- Practice guidelines (e.g., for high risk diabetes and congestive heart failure) that include increasing interventions when conditions are unstable; and
- Other organizational policies, procedures and expectations related to assessing and addressing member risk.

In interviews with IDTs, some staff members talked about individualizing their approach to addressing member risk. Others noted that they address areas of risk frequently with members and provide consistent education to help ensure members have the information they need to make informed decisions. Many IDTs also talked about the value of communication and collaboration within and among teams as well as across their organization's care management units (CMUs), and described how they seek and share information with one another about successful strategies and useful resources, both through impromptu conversations and structured venues.

While assessing and addressing member risk is an area of strength for MCOs, the review identified opportunities for improvement: The CMR found that IDTs at several MCOs (NB, SFCA,WWC) do not always use the assessment tools available to them to assess members' needs and/or address areas of risk. Also, documentation at some MCOs (CW, LCD) did not always reflect that IDTs had reviewed and analyzed information from providers that may have been helpful in managing member risk, and ensuring health and safety. In addition, the annual quality review for two MCOs (SFCA, MCCMO) included recommendations regarding the need to develop stronger internal processes and resources to support IDTs in working with members whose situation or condition puts them at risk.

Grievance Systems

Another notable area of strength across MCOs is access to grievance systems. In SFY 09-10, every CMO fully met QCR measures related to ensuring that members have access to an effective process for grievance and appeals, and have access to the State's fair hearing system. This represents progress since the SFY 08-09 review when one MCO (SFCA) received a partially met rating for one of these measures. SFCA's 09-10 annual quality review noted that it has now

established separate appeal and grievance committees – composed of members, providers and health care professionals - for each of the eight counties in which it operates.

Member Rights

Another area of strength identified across MCO's relates to the right of all members to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. The inappropriate use of restraints or restrictive measures may limit members' access to personal freedom, use of their environment, or choice of providers and services; thus, denying members the opportunity to live in the least restrictive environment that meets their needs.

Similar to results of the SFY 08-09 review, SFY 09-10 QCR results show that eight of nine MCOs received a score of met for this area, while one MCO (NB) received a partially met score. No MCO received an unmet score in this area. While NB has a policy and procedure in place regarding the use of restraints and restrictive measures, interviews with IDTs found that staff at outlying offices reported differing levels of awareness of how to identify, obtain approval for, and monitor the use of restraints or restrictive measures. NB's annual quality review included recommendations to arrange staff training from DHS, and ensure all outlying offices have a consistent approach to identifying and monitoring the use of any restraint or restrictive measure.

Access to Providers

Another strength noted across MCOs relates to three measures that help ensure access to service providers, including ensuring MCO members have:

- Timely access to care and services;
- Have access to services 24 hours a day, seven days a week when medically necessary; and that
- Contract expectations regarding services provided by subcontracted entities are being met.

SFY 09-10 QCR results show that for each of these three measures, eight of nine MCOs received a score of met, one MCO received a partially met score, and no MCO received an unmet score. While this result was similar to the level of compliance found in SFY 08-09, it did represent progress for one MCO (MCCMO) which moved from partially met to a score of met for one of the measures. To ensure its providers are aware of requirements related to timely access to services, the MCO had obtained newly signed contracts from providers that had previously signed contracts prior to 2007.

One MCO (NB) received partially met scores for two of the measures. Due to Family Care expansion efforts during its first year of operation, the MCO had not yet developed a method to monitor providers to ensure they are providing timely access to care and services. This MCO's annual quality review included recommendations to develop a method for obtaining feedback from both staff and members regarding any provider quality concerns; develop a process for monitoring follow-up activities to ensure IDTs are taking steps to confirm their members are receiving timely services; and develop a process for monitoring providers to ensure their services are readily accessible 24 hours a day, seven days a week when needed.

Another MCO (SFCA) received a partially met for one of the measures. The MCO had made progress since SFY 09-10, in that it had recently established *Service Level Agreements* with its

contracted CMUs that identify key expectations and performance standards. However, the MCO had not yet conducted related monitoring. Therefore, SFCA's annual quality review included the recommendation to implement a mechanism for monitoring the performance of its CMUs for adherence to contract expectations.

Face-To-Face Contact Monitoring

Another area of strength identified across MCOs relates to a contract requirement that IDT staff must make at least one face-to-face contact quarterly with each member. In SFY 09-10, eight of nine MCOs met the requirement to have an effective process for monitoring compliance regarding face-to-face contacts. One MCO received a partially met score. No MCO received an unmet score in this area. This represented progress since the SFY 08-09 review when two of eight MCOs received a partially met rating for this measure. It should be noted that one of the MCOs (CC) which moved from partially met in SFY 08-09 to a score of met for SFY 09-10 had enhanced its electronic care management system, *Intergy*, in order to monitor quarterly face-to-face contacts on all members.

Interviews with IDTs supported the QCR finding, as many staff reported that they make frequent visits and contacts with members to get to know them, build relationships, provide education, and review their member-centered plans.

For the MCO (NB) with the partially met score, SFY 09-10 marked its initial QCR. The annual quality review for NB resulted in recommendations to develop and implement a process for monitoring IDT staff's compliance regarding quarterly face-to-face contacts with members.

Other Access to Care Strengths

Following are some additional examples of individual MCO strengths related to access to care as well as quality:

- NB developed a *First Visit Member Checklist Information* form that is included in its new member packets to remind IDT staff to review specific information with members, such as covered benefits, member rights, and how to reach the IDT both during and after business hours.
- WWC and MCCMO reported gathering information about members' annual financial eligibility determination one month before the reviews are due and distributing it to the assigned IDTs, so that assistance can be offered and provided, as needed, to help members complete their financial reviews on time.
- CCCW reported using resources to explore alternative tools, techniques, and strategies to reduce communication barriers for members with cognitive and/or communicative impairments.
- CCCW also reported negotiating contracts with disposable medical supply (DMS) distributors that benefit both members and the MCO. Members benefit because vendors now send products directly to their homes, reducing the wait time to receive needed DMS. In addition, vendors ship a specific number of items per month instead of a complete case, reducing the amount of space needed to store products at home. For the MCO the negotiations resulted in lower shipping costs, as well as a reduction in the minimum order total required for shipping.

The MCO also lowered costs by nearly eliminating the amount of time that IDTs spend delivering DMS products to members.

- CHP sends a letter to members and providers encouraging them to report information to the IDT, such as changes in member status or condition, the outcome of medical appointments, etc. The letter contains IDT contact information in large print. This was cited as a "Best Practice" in this MCO's annual quality review.

Resource Allocation Decision Method

One area of review where results were mixed relates to use of the Resource Allocation Decision Method (RAD). The RAD is a DHS-approved seven step decision-making process designed to help IDT staff engage with members to jointly identify core issues and relate them to desired outcomes; explore various options for services and supports; and choose the most cost-effective options that will meet the identified outcomes.

In interviews with IDTs, many staff across MCOs talked about how they have incorporated the RAD process into the way they think and practice, and many noted that the RAD is very helpful. In pre-onsite surveys, staff at three MCOs identified the RAD as one of the three most helpful things to the provision of quality, cost-effective care management services. Although reviewers noted variation among IDTs and across MCOs, many IDTs talked about including members and their supports in the RAD decision-making process. For example, IDTs at one MCO (WWC) talked about bringing the RAD form to members' homes, and using it to work through the process with members to help foster understanding about decision-making. At another MCO (LCD), IDTs indicated that they involve members in the RAD process, asking questions about their request or need until the core problem is identified, and then soliciting their ideas about how to address the problem or achieve the goal. IDTs and members then work to identify informal supports or unpaid service options first. Whenever the RAD process results in a denial, termination or reduction in services, a copy of the completed RAD worksheet is provided to the member, along with the related notice of action.

However, record reviews and discussions with IDTs also revealed that the ability to integrate the RAD into day-to-day practice, use the RAD process to stimulate creative thinking, and accurately document the discussion and decisions, varies among IDTs and across MCOs. For example, at many of the MCOs (CC, CHP, CW, MCCMO, SFCA) members' input is solicited, but final decisions are often made in MCO offices without members present. The *Service Authorization Process (RAD)* policy at one MCO (SFCA) directs IDTs to respond to *specific* requests for *specific new* services, possibly deterring IDTs from exploring core issues at the heart of more vague comments or requests. Documentation and IDT interviews indicate that at some MCOs (CCCW, MCCMO, NB), IDTs sometimes use the RAD to justify decisions about services, either because the decision has already been made, or because IDTs are fulfilling MCO requirements. In addition, IDTs at many of these same MCOs (CCCW, LCD, MCCMO, NB, SFCA) reported that documenting the decision-making process is burdensome, especially when options are limited or services are medically necessary. Others did not find the RAD useful, and felt the process can be manipulated to produce the desired outcome.

Cost Effectiveness in Decision-Making

Another area of review where results were mixed related to the ability of MCOs to effectively support IDTs in efforts to consider cost effectiveness as a component of decision-making.

One MCO (CC) exhibited strength in this area by developing decision guidelines which incorporate information about Medicare coverage and "in lieu of service" that helps IDTs maximize the use of FC funds by identifying other appropriate payers of services as well as cost-effective service alternatives that meet members' needs. In addition, the MCO uses an electronic provider network database called the *Provider Enterprise System*, which provides IDTs with the most current listing of contracted providers and allows them to compare options by cost. Both the decision guidelines and the *Provider Enterprise* System were cited as a "Best Practice" in CC's annual quality review.

Another MCO (NB) keeps IDT staff apprised of changes to the provider network via weekly emails to its outlying offices containing rates and other information that is placed in a binder for staff use.

However, the annual quality review of three MCOs revealed that two (CCCW, CW) do not have a system available to help IDTs identify service costs. The third MCO (WWC) has information about costs available electronically, but some IDTs reported that the system is not useful because it is old and frequently not functioning. The annual quality review for these MCOs included recommendations regarding the need to develop efficient methods to provide accurate service cost information to IDTs, to support decision-making.

Another aspect of cost effectiveness noted during the review is efforts being made by several MCOs to explore and use informal and community resources to help meet members' needs and outcomes. For example, IDTs at one MCO (NB) reported compiling and sharing information about local volunteer and community resources. Another (CCCW) reported that IDT staff and members work together to identify and use informal, unpaid and community supports. Still another (LCD) reported that service authorization guidelines include examples of both MCO funded supports and informal supports.

While there are areas of strength related to considering cost effectiveness as a component of decision-making, the review also noted an opportunity for improvement: The CMR found instances at nearly half of the MCOs (CCCW, NB, SFCA, WWC) where members are paying out-of-pocket for services that are covered in the Family Care benefit package (e.g., incontinence supplies, supportive home care services). As this is prohibited by contract, recommendations to these MCOs included working with DHS and IDTs to ensure that members are not inappropriately paying for services to meet their identified needs and outcomes that are covered by the Family Care benefit.

Compliance with Provider Contracting Requirements

One notable area of opportunity for improvement identified across MCOs relates to the requirement that MCOs have processes in place for assuring that no payments are made for items or services provided by individuals or entities that have been excluded from participating in federal health care programs. In the SFY 08-09 review, only two of eight MCOs fully met this requirement. In this year's review, five MCOs received a score of met. Three organizations (CCCW, LCD, WWC) had developed policies and procedures, and had verified that their contracted providers are not excluded from participating in federal health care programs.

Therefore, these three MCOs moved from partially met scores in SFY 08-09, to scores of met for SFY 09-10. A fourth MCO (SFCA) had also made progress by developing and implementing a policy and procedure. However, the MCO did not retain evidence of its verification activities and, as a result, again received a score of partially met for this measure. SFCA's annual quality review included the recommendation to retain copies of verification in the provider contract files.

Two additional MCOs (CW, MCCMO) have received a partially met score for this measure for the past two and four review years, respectively. While both have made progress, CW's current policy and procedure does not reflect the actual practice of staff; therefore, its annual quality review included recommendations to amend the policy and procedure to accurately reflect the verification actions its staff performs. MCCMO developed a verification process that includes querying the Office of Inspector General website to check for providers that have been excluded from participating in federal health care programs. However, the process does not include steps to ensure that no payments are made to contracted owners/operators that have been excluded. MCCMO's annual quality review included recommendations to amend its *Federally Excluded Providers* procedure to ensure owners/operators are not on the list of excluded providers, including specifying how frequently the website will be queried, and "next steps' when it discovers that a provider is listed as an excluded party.

For a fourth MCO (NB), SFY 09-10 marked its first QCR. Its initial score for the measure was partially met. NB's annual quality review included recommendations to develop and implement a process to verify that it is not making payments to providers that are excluded from participating in federal health care programs, and to include evidence of verification activities in its provider contract files.

Compliance with Provider Background Checks

Another notable area of opportunity for improvement identified across MCOs relates to two QCR measures regarding the contract requirement to verify that periodic caregiver and criminal background checks are being conducted on providers, including contracted staff, who come into direct contact with members. Seven of nine MCOs received partially met scores for at least one of these measures, while two MCOs (CC, LCD) received a score of met for both measures. This reflects progress made by CC, which moved from a score of partially met for one of the measures to a score of met for SFY 09-10.

For one MCO (NB), SFY 09-10 marked its first QCR. Its initial scores for these measures were partially met. The remaining six MCOs (CCCW, CHP, CW, MCCMO, SFCA,WWC) have received partially met scores for one or both of these measures for at least the past two review years, including CHP and MCCMO, which have not fully met one or both measures for the past five years.

Review findings indicate that while progress has been made, the six MCOs either have not yet developed, or have not fully implemented, written policies and procedures for verifying that providers are conducting periodic caregiver and criminal background checks for employees who come into direct contact with members. For example, one MCO (CW) has a "*Criminal Background Checks for Providers"* policy requiring providers to complete an attestation form and submit it to the MCO. However, the attestation form was found in only three of 60 provider files reviewed by the EQR team. In addition, the MCO has not yet developed a process for verifying that required background checks are occurring.

A second MCO (MCCMO) required all providers to sign an attestation form in SFY 09-10 indicating that they are in compliance with completing background checks. However, MCCMO also does not have a policy or procedure for verifying that providers are completing background checks, although at the time of its annual quality review, the MCO had verified the completion of background checks on nine of its providers.

While a third MCO (CHP) had verified the completion of caregiver background checks on the employees of four supportive home care providers in its network, the review found that the MCO has not yet developed a procedure for conducting the reviews or a methodology for sampling providers.

Another MCO (WWC) recently implemented its *Audit Process for Provider Background Checks* policy and procedure and established a monitoring schedule for the next four years, but has not yet analyzed the results of background check verifications that have been completed, or provided feedback to the provider agencies.

While two additional MCOs (CCCW, SFCA) have developed policies and procedures to verify that providers are conducting caregiver and criminal background checks, the policies/procedures have not been implemented.

To improve findings related to the verification and completion of criminal and caregiver background checks, the annual quality review for these six MCOs contained recommendations such as:

- Develop and/or implement a written policy and procedure for conducting the verification of provider background checks.
- Ensure the procedure contains details regarding a sampling methodology, as well as a plan for "next steps" if it is discovered that a provider is not adhering to criminal and background check requirements.
- Analyze the results of background check verifications, and provide feedback to provider agencies.

TIMELINESS

Family Care MCOs have many requirements related to timeliness in their contract with DHS. MCOs must establish and maintain provider networks that have the capacity to provide timely and quality services to members. Care management teams must authorize, provide, arrange, and coordinate all services in the benefit package in a timely manner.

Specific timeframes are assigned to all key steps in the care planning process, including assessment, care planning, service authorization decision-making, as well as issuance of notices of action, when applicable. Timeliness standards create further assurances that access to care is maintained for members and is adapted to address the urgency of the members' needs for services. A number of timeliness standards found in the Family Care contract reflect Federal requirements.

Timeliness includes review measures related to:

- QAPI - Access to Services;
- QAPI – Structure and Operations, Grievance Systems; and
- Care Management Practice.

Based on the results of the SFY 08-09 review, this year's review focused on measures related to the timeliness of notices of action, service authorization decisions, member-centered plans

(MCPs), and appeal and grievance timeframes. Findings indicate that, as a group, MCOs have opportunities for improvement related to timeliness.

Timeliness of Notices of Action

One notable area of opportunity for improvement identified across MCOs is indicated by several QCR review measures related to having systems and processes in place for ensuring that when Notices of Action (NOAs) are warranted they are issued, and that they are issued within required timeframes:

One QCR measure related to the requirement to issue NOAs when warranted resulted in only three of nine MCOs receiving a score of met (CCCW, CHP, WWC), and six MCOs (CC, CW, LCD, MCCMO, NB, SFCA) receiving a score of partially met. At least one MCO's difficulty in this regard is related to its practice of differentiating whether the request is made by the member or by another party.

Two QCR review measures related to providing NOAs to members in a timely manner (for service requests that are denied or limited), resulted in all nine MCOs receiving scores of partially met for both measures.

For an additional measure related to providing NOAs to members in a timely manner (for termination, suspension or reduction of a previously authorized service), three of nine MCOs received a score of met (CCCW, LCD, SFCA), while six MCOs received a score of partially met.

While no MCO received an unmet score for any of these four measures, a majority of MCOs have received partially met scores for these measures for at least the past two review years, including some MCOs which have received partially met scores for the past three or four years. The CMR also found this to be a significant area of opportunity, as results show that across MCOs, IDTs frequently have difficulty identifying when NOAs are warranted and/or issuing NOAs within required timeframes.

Findings indicate that while MCOs have tools and methods for monitoring NOAs, such as tracking logs and/or processes for internal file review, opportunities exist at every MCO for improvements in systems, processes, and/or data collection and analysis.

For example, the annual quality review for one MCO (LCD) noted a strength in its use of the *Service Request System* database for monitoring the timeliness of NOAs. The system records information about decisions that result in denials, and reminds teams about required timeframes for issuing NOAs and conducting follow-up. However, the database only captures when a notice is actually sent. Similarly, the monitoring process used by at least three additional MCOs (CC, CW, SFCA) also fails to identify situations when an NOA *is warranted*, and only identifies situations when a notice is actually issued. As a result, these MCOs may be monitoring timeliness for just a subset of NOAs. The annual quality review for these MCOs included recommendations to develop or refine monitoring systems/processes to ensure IDTs are properly identifying situations when NOAs are warranted, as well as issuing NOAs in a timely manner.

Reviewers also found that one MCO (MCCMO) is in the process of revising its method for conducting internal file reviews and currently does not have a process for ensuring IDTs are issuing NOAs when warranted, or in a timely manner. This MCO's annual quality review included recommendations to finalize and implement its revised process, then collect and analyze monitoring data to determine a plan for any needed improvements. In addition, one MCO (NB) participating in its initial QCR does not yet have a monitoring process in place. This MCO's

annual quality review included recommendations to continue efforts to develop automated solutions for collecting data, and to implement an internal file review process.

While opportunities for improvement exist, review findings show that MCOs have been making some progress over the past review year. For example:

One MCO (CCCW) had developed and implemented an internal file review process that contains a supervisory review and a peer review component, along with a mechanism for providing timely feedback to IDT staff. However, analysis and comparison of internal file review results with tracking logs had not yet occurred.

One MCO (WWC) implemented a PIP focused on improving the ability of IDTs to issue NOAs in a timely manner when warranted, primarily by providing staff education. Application of the acquired knowledge was indicated by three outcome measures. Improvement was achieved for one measure, meeting a 90 percent goal for issuing NOAs within the required 14 day timeframe when service requests are denied. However, no improvement was shown for the other two measures. WWC's annual quality review included recommendations to analyze the data from the internal file review process and conduct a root cause analysis to determine why IDTs are not issuing NOAs when warranted and in a timely manner.

Three MCOs (LCD, SFCA,WWC) had gathered data through internal file reviews. However, the data had not yet been analyzed. Lack of data analysis affects the ability of MCOs to properly assess whether IDTs are issuing NOAs when warranted, or in a timely manner. Therefore, the annual quality review for these MCOs included recommendations such as analyze internal file review data, cross check the data with information from tracking logs, and design a plan for improvement based on the data analysis.

During SFY 09-10, DHS helped support progress related to NOAs by convening and facilitating a workgroup of MCO representatives and other stakeholders that developed an automated, standardized NOA format and directions.

Service Authorization Timeliness

Another notable area of opportunity for improvement is indicated by several QCR measures that assess whether MCOs have appropriate and adequate systems and processes in place to ensure the timeliness of service authorizations. For example, one measure assesses whether MCOs have policies and procedures in place for responding to service requests and authorizing services. SFY 09-10 results show that only three of nine MCOs (CHP, LCD, WWC) received a score of met for this measure, while six MCOs (CC, CCCW, CW, MCCMO, NB, SFCA) received a score of partially met. No MCO received a not met score.

Another QCR measure relates to the requirement to have systems and processes in place to monitor whether IDTs make prompt decisions regarding standard service authorizations and provide members with NOAs within 14 calendar days following requests. Only two of nine MCOs (LCD, WWC) received a met score for this area. However, this result did represent progress for LCD, which moved from a score of partially met in last year's review to a score of met for SFY 09-10. The review found that the MCO had developed an electronic system to document when NOAs are sent to members, and if the notices are sent timely. Seven MCOs (CC, CCCW, CW, CHP, MCCMO, NB, SFCA) received partially met scores for this measure, although CHP had made progress by developing a module within its electronic care management reporting system, *vPrime*, which was cited as a "Best Practice" in its annual quality review. The

Request/ Reduction screen is designed to capture all member requests and link them to the service authorization system.

While QCR results indicate there are opportunities for improvement across MCOs, findings also found some areas of strength. For example, one QCR measure relates to having processes in place to ensure members are provided timely written notice when decision-making needs to be extended beyond the initial 14 day timeframe. Six MCOs (CC, CCCW, CHP, CW, LCD, WWC) received a met score for this measure, while three MCOs (MCCMO, NB, SFCA) received a score of partially met. No MCO received a score of not met. This represents progress for two MCOs, CC and CW, which had amended policies and procedures to ensure that IDTs issue written notices regarding the extension of decision-making timeframes, and consequently moved from scores of partially met in last year's review to scores of met for SFY 09-10.

Findings also identified care management practice as an area of strength, as CMR results show that IDTs authorize services in a timely manner most of the time, and also follow up within a reasonable timeframe to ensure that services are effective. It should be noted that two MCOs made progress related to follow up by developing automated processes to support care management practice. CHP's Request/Reduction screen, described above, alerts IDTs to conduct follow-up activities after new services have started. Additionally, in response to findings from its SFY 08-09 review, another MCO (MCCMO) refined its electronic care management reporting system, *MIDAS*, to include automated prompts that remind IDTs to follow up with members after service authorizations have been entered in the system. However, findings at a third MCO (WWC) indicate that it does not have a system to ensure that *all* IDTs have mechanisms to track and provide timely follow-up.

Timeliness of Member-Centered Plans

Another area of opportunity for improvement is indicated by a QCR measure that assesses whether MCOs have systems and processes in place for monitoring the timeliness of MCPs. Six MCOs (CC, CHP, CW, MCCMO, NB, SFCA) received a score of partially met for this measure, while three MCOs (CCCW, LCD, WWC) received a score of met. There were no scores of not met. While results point to the need for improvement in this area, findings also indicate that MCOs have made some progress since SFY 08-09 by developing and implementing automated systems, and/or developing or improving processes for internal file review.

For example, SFY 09-10 results found that CC is in the process of automating MCP tracking and notification of due dates for its FC program, after analysis of findings from a SFY 08-09 internal chart audit indicated that use of a manual tracking system was a contributing factor to 16 percent of MCPs not being completed in a timely manner. CC developed and conducted a PIP in SFY 09-10, in response to SFY 08-09 CMR results that reflected its lack of a standardized chart audit process for overall care management. The chart audit tool developed as a result of the PIP was implemented in October 2009 - shortly prior to its SFY 09-10 annual quality review - and data analysis had not yet occurred. Therefore, recommendations for CC included the need to conduct monitoring and data collection efforts, perform data analysis, and design a plan for improvement based on the outcome.

CW also conducted a PIP in SFY 09-10 focused on improving the timeliness of MCPs. CMR results in SFY 08-09 had indicated the need for improving the MCO's performance in this area, and had been a recommendation in its previous annual quality review. The project included development of an electronic tracking and reporting tool in *vPrime*, CW's electronic care management reporting system. The process requires IDTs to input the signature date on MCPs

into the electronic system. However, the MCO had not verified the accuracy of the data, and had not yet implemented an internal file review process. CW's annual quality review included recommendations to verify the accuracy of the data entered into the system, analyze the reasons documented by IDTs as to why MCPs are not timely, develop additional interventions based on root cause analysis of the data, and determine a plan for improvement, as needed.

SFY 09-10 findings also identified that SFCA and MCCMO were making some progress related to their internal file review process. SFCA had recently implemented a process for internal file review, but had not yet analyzed the data. MCCMO revised and implemented its MCP and assessment process in *MIDAS*, its electronic care management reporting system, and is currently revising its internal file review process. However, the process had not been finalized and implemented at the time of its QCR. The annual quality review for these MCOs included recommendations to finalize and implement the internal file review process, and/or analyze data to determine if MCPs are being completed and signed within contract specified timeframes.

While opportunities for improvement remain regarding timeliness of MCPs, one area of strength for most MCOs is care management practice. Similar to results in SFY 08-09, CMR results for SFY 09-10 show that IDTs complete, review, and obtain signatures on MCPs within contract specified timeframes most of the time, although they are less successful at ensuring that MCPs are comprehensive. Comprehensiveness of MCPs is discussed further in the "Quality" section of this Summary of Findings.

Appeals and Grievances Timeliness

Another area of strength identified across MCOs is indicated by several measures related to having adequate systems and processes in place to meet appeal and grievance timeframes. In the SFY 08-09 review, six of eight MCOs received scores of met for all of the measures related to this area. In this year's review, seven of nine MCOs (CC, CCCW, CHP, CW, LCD, SFCA, WWC) received met scores for all of the measures. No MCO received a not met score. The results represent progress for CW. In SFY 08-09, the MCO had met all pertinent measures related to appeal and grievance timeframes, but one; it did not have a process for ensuring that contacts made orally by members seeking to appeal an action, or others on behalf of members, are treated as appeals for the purpose of establishing the earliest possible filing date. CW had amended policies and procedures to ensure that the date of an oral request for appeal starts the resolution timeframe, and consequently moved to a score of met for this measure.

One MCO (MCCMO) has received a partially met score for one measure related to appeal and grievance timeframes for the past four review years. The measure relates to the requirement that standard disposition of grievances and appeals may not exceed 20 business days from the day the MCO receives the grievance or appeal. The MCO has received a partially met score for another measure related to appeal and grievance timeframes for the past two review years. The measure concerns the requirement that standard appeal and grievance timeframes and expedited appeal timeframes may be extended by up to 14 days. Since the SFY 08-09 review, only 47 of 70 (67 percent) of grievances filed at the MCO's local level have been resolved within required timeframes. In addition, when timeframes have been extended, some of the reasons, such as the high volume of appeals or lack of available staff to arrange and conduct hearings, were not acceptable per the DHS-MCO contract. MCCMO has made progress by adding one staff member to assist with appeals for state fair hearings, identifying additional appeal and grievance committee members, and reassigning tasks and responsibilities to improve the organization's ability to resolve grievances and appeals within contract specified timeframes. MCCMO's

annual quality review included recommendations to continue monitoring the resolution of appeals filed at the local level to ensure compliance with timeliness requirements; conduct an analysis of the reasons for any delays in resolving appeals; and develop a plan for improving the timeliness of appeal and grievance resolutions.

For a second MCO (NB), SFY 09-10 marked its initial QCR. The MCO showed strength in this area by meeting all measures related to appeal and grievance timeframes, except one. Review results show that the MCO's appeal and grievance log shows several instances where member rights specialists confirmed the receipt of an appeal only by telephone; whereas, the 2010 DHS-MCO contract states that all appeals and grievances must be acknowledged in writing within five days of receipt. NB's annual quality review included recommendations to monitor the appeals and grievance log to ensure all appeals and grievances are acknowledged in writing within five days, and determine if a plan for improvement is needed.

QUALITY

In Family Care, quality is determined from a member-centered point of view. DHS assigns responsibility regarding quality to both program members, and to the MCOs that it contracts with for operating managed long-term care programs in the State of Wisconsin. Members are encouraged to identify personal outcomes for establishing a plan of care, and to utilize available appeal and grievance rights to improve the quality of their own services and supports. In addition, members are asked to participate in member interviews and MCO or DHS-sponsored surveys, and are asked to join councils and committees focused on program improvement. MCOs are required to maintain an ongoing quality management (QM) program to assess and improve the quality of care and services provided both by their own staff and by sub-contracted providers. QM activities must include identification of areas for improvement; data collection, evaluation and analysis; and development of improvement plans to remediate findings.

Quality includes review measures related to:

- Enrollee Rights
- QAPI – Measurement and Improvement
- Care Management Practice

SFY 09-10 findings indicate that, as a group, MCOs have both strengths and opportunities related to quality.

Assessment Process in Care Management

One notable area of strength identified across MCOs is the quality of the initial assessment process. Findings from CMR record reviews and IDT interviews show that MCOs typically use standardized assessment tools that promote consistent information gathering. Some tools contain questions and prompts to help IDTs think critically about the information they are learning. For example, one MCO's (CHP) assessment tool contains section summaries to help IDTs synthesize the information gathered in each section, and document member preferences, strengths, needs, and desired outcomes.

Before conducting an assessment, IDTs generally collect and review information from a variety of sources. The member's informal and formal supports, i.e., authorized representative, family members, and service providers, are typically invited to participate in the assessment process.

Many IDTs meet jointly with the member to complete the initial health and social assessments, reducing redundancy and helping focus both the member and the IDT staff on the concept of interdisciplinary care.

- At one MCO (NB), IDTs explained that they individualize the approach to assessments to remain sensitive to members' learning styles, levels of understanding, needs and preferences, including making adjustments in the amount and duration of assessment visits, as needed.
- At another MCO (LCD), IDTs reported listening, and taking the time to get to know members in order to identify outcomes.
- At a third MCO (WWC), IDTs talked about building relationships with members by letting members guide conversations, using words that make sense to members rather than jargon, and discussing their priorities first.

At several MCOs, IDTs enhance the quality of initial assessments by actions they take beforehand to help prepare members. For example, the review identified that staff at one MCO (CW) sends a letter to new members to introduce the concept of personal experience outcomes, and encourage members to think about outcomes in advance of their initial assessment visit. This was cited as a "Best Practice" in CW's annual quality review. Similarly, IDTs at another MCO (SFCA) reported explaining outcomes to newly enrolled members as soon as possible, to help them understand the concept and begin thinking about their goals, hopes and dreams. At another MCO (CHP), IDTs conduct "meet and greet" visits where they meet with members, educate them about the program, provide contact information, and begin to establish rapport prior to conducting the initial assessment. This was cited as a "Best Practice" in CHP's annual quality review.

While the initial assessment process is an overall area of strength, the review also identified opportunities for improvement: Findings indicate that the ability of IDTs to explore, identify and document measurable outcomes that represent members' goals, hopes, and dreams varies among IDTs and across MCOs. Every MCO made progress in this regard during SFY 09-10, by providing training on outcomes, and/or by arranging for IDTs to receive training provided by DHS. The Family Care Core Training conducted by DHS at MCOs across the state includes modules on member outcomes, the RAD method, and managing risk at the member level.

An opportunity for improvement is also indicated by findings that the policies, procedures and/or assessment tools used by three MCOs (CC, CCCW, CW) do not provide IDTs with the framework to encourage the exploration, identification and documentation of members' personal outcomes. The annual quality review for these MCOs included recommendations to improve assessment tools by revising them to include prompts and questions that focus on outcomes.

While a fourth MCO (MCCMO) has written guidance that focuses on member outcomes, for the year under review the MCO had also been using an assessment tool that did not encourage exploration and documentation of outcomes. MCCMO made progress by revising and implementing standardized health and social assessment tools within *MIDAS*, its electronic care management system. However, implementation occurred just prior to its annual quality review, and very few of the assessment worksheets were evaluated. Therefore, the EQR Team could not assess whether the worksheets improved the ability of IDTs to gather more personalized information and identify members' outcomes. The annual quality review for MCCMO included recommendations to provide focused monitoring of the new worksheets to ensure that assessments are comprehensive, and include information about members' strengths, preferences and outcomes.

SFY 09-10 results identified another area of opportunity regarding assessment: The process and tools used by two MCOs (SFCA, WWC) to meet the requirement for periodic (six month) assessments do not include cues to stimulate discussions about members' personal outcomes. In addition, one MCO (NB) participating in its initial annual quality review had not yet developed a process for periodically assessing members. The annual quality review for these MCOs included recommendations to develop or revise policies, processes and/or tools to provide IDTs with the framework needed to successfully explore, identify, and document members' personal outcomes on an ongoing basis.

Interdisciplinary Team Collaboration and Support

Another notable area of strength across MCOs is the level of communication and collaboration within and among IDTs. In pre-onsite surveys and during on-site interviews, social service coordinators, registered nurses and nurse practitioners consistently reported that their interdisciplinary team members, and the team approach to care management and decision making, are among the most helpful supports to the provision of quality, cost-effective care management services. Many IDT staff expressed that they highly value peers, co-workers and supervisors, and readily use one another as sources of information and support. Record reviews supported this finding, and typically documented ongoing communication and collaboration within IDTs. IDTs also reported the value of the support they receive from other co-workers in the MCO organization, such as behavioral health specialists, self-directed supports specialists, provider network staff, member rights specialists, and other staff that help support the quality of care management practice.

Other types of organizational support provided to IDTs also helps strengthen the quality of care management For example, at some MCOs management fosters communication within and among IDTs by arranging the office space to enhance the physical proximity of team members. In addition, many MCOs regularly conduct team meetings where IDTs have the opportunity to brainstorm options with their peers and supervisors, share successes and challenges, and seek and provide information and feedback. At many MCOs, IDTs regularly meet together with their supervisors, and one MCO (LCD) reported that it has written expectations in place for IDTs to consult with and involve their supervisors. Another MCO (CC) reported emailing a weekly newsletter to all care management staff, providing IDTs with important information such as provider quality issues, practice expectations, and policy changes. This was noted as a "Best Practice" in CC's annual quality review

Provider Quality

Another area of strength noted across MCOs is reflected in the efforts of several organizations to monitor provider quality and improve provider relations. For example, several MCOs have developed and implemented electronic systems for better reporting and tracking of events, such as critical incidents (falls, medication errors) reported by providers, as well as provider quality concerns identified by IDTs or reported by members, guardians, and/or family members. Typically, these "quality alerts" are documented in the electronic reporting system by IDTs.

- One MCO (LCD) reported that its electronic system enables staff in the provider network department to monitor the quality of providers more effectively.

- At another MCO (CCCW), the electronic reporting system created by its provider network department enables the MCO to monitor and document follow-up actions related to provider quality alerts.
- At a third MCO (CW), its critical incident reporting system was refined to review, evaluate and ensure that follow-up actions with providers are being documented by MCO staff, in order to "close the loop" and ensure concerns are remedied.
- A fourth MCO (WWC) reported taking a "next step" related to its electronic reporting system, by making the connection between its quality and provider relations departments; staff in these departments meets together on a weekly basis to review and remedy quality concerns.

Many MCOs recognize that provider input and relationship building is crucial - especially considering the rapid expansion of Family Care - and make efforts to improve communication and coordination with providers. For example, one MCO (SFCA) surveyed its contracted providers in late 2009 to identify areas of improvement related to the provider network. Overall feedback centered on communication and training, and as a result, monthly training sessions are being scheduled for providers. In addition, provider bulletins are issued, both electronically and in paper format, about every six weeks. The bulletins provide information related to policies and procedures affecting providers, and give notice of upcoming training opportunities. Another MCO (CCCW) includes providers on its quality committee and provider quality subcommittee, giving the MCO a unique perspective and partnership with providers. To help improve communication and coordination with residential care providers (i.e., community based residential facilities, nursing homes), many MCOs have decreased the number of IDTs interacting with a facility, or have developed specialty teams that work solely with members living in residential care settings.

Member Rights

One area of review where results were mixed relates to members' rights to respect, dignity and privacy. SFY 09-10 findings show that six of nine MCOs (CC, CCCW, CHP, CW, LCD, MCCMO) received a score of met for a QCR measure which includes members' right to privacy in the communication of protected health information (PHI). This represented progress for CCCW, which moved from a score of partially met in the SFY 08-09 review, to a score of met for this year's review. CCCW's progress related to its implementation of a *Confidentiality Policy and Procedure* as well as an *Agreement and Consent for Email Communications* form. While no MCO received a score of not met for this measure, three MCOs (NB, SFCA, WWC) received partially met scores and have the opportunity for improvement.

SFCA had made progress by developing and implementing an *Email Use Policy* and *Business Partner Email Use Policy*. Although the MCO's email system encrypts information and monitors outgoing email for the use of PHI, review findings indicate that the organization does not have a way to monitor the email systems of its contracted CMUs, and reviewers noted several instances of emails containing PHI in member records. SFCA's annual quality review included recommendations to establish a process to monitor the use of email communication by contracted CMUs.

NB and WWC do not have an encrypted email system. NB also has not yet developed a policy governing email communication, although record reviews and interviews with IDTs found that

email is sometimes used to communicate with providers. While WWC has a *Member Rights and Responsibilities* policy that requires IDTs to obtain members' written consent to communicate via email, reviewers found evidence that IDTs continue to communicate with members and providers through unencrypted email without signed release forms authorizing such communication. The annual quality review for these MCOs included recommendations to develop or amend policies and procedures related to email communication; establish a systematic process to monitor the use of email communication containing member identifying information; and analyze data from monitoring efforts to determine if a plan for improvement is needed.

Clinical Practice Guidelines

Another area of review where results were mixed relates to several QCR measures regarding the requirement that MCOs have clinical practice guidelines in place that meet the needs of enrollees, are current, based on valid and reliable clinical evidence, developed in consultation with health care professionals, disseminated to all affected providers, and are applied consistently. SFY 09-10 findings show that six of nine MCOs (CC, CCCW, CHP, CW, LCD, WWC) received a score of met for all six related measures. This represents progress for CC, which moved two scores from partially met in the SFY 08-09 review to scores of met, resulting in this MCO meeting all six measures for this year's review. CC had made progress by revising procedures to include expectations that practice guidelines are reviewed and updated annually, and that the use of its practice guidelines is monitored through the internal file review process.

Three MCOs have an opportunity for improvement related to clinical practice guidelines: One MCO (MCCMO) received partially met scores for two of six measures; one MCO (SFCA) received partially met scores for four of six measures; and one MCO (NB) received scores of not met for all six measures.

Review findings show that MCCMO has had difficulty consistently meeting these measures the past five review years. For example, one measure relates to the requirement that practice guidelines need to be disseminated to all affected providers. The review found that although clinical practice guidelines are available to providers on the provider portal of MCCMO's electronic care management system, the MCO does not have a systematic process for ensuring providers actually receive copies of the practice guidelines. A second measure includes the expectation that practice guidelines are applied consistently and appropriately. At the time of its annual quality review, the MCO was revising its internal file review process and did not have a current process in place for assessing the appropriate use of clinical practice guidelines. MCCMO's annual quality review included recommendations to develop a systematic process to ensure practice guidelines are disseminated to all affected providers; and to develop a means to evaluate IDTs' use of practice guidelines, potentially through the planned revisions to its internal file review process.

SFCA has had difficulty meeting four review measures related to clinical practice guidelines for the past two and three review years. Review findings show that this MCO has only one practice guideline in place, diabetes management. SFCA reported that its Prevention and Wellness Committee plans on developing additional guidelines when the committee is fully staffed. The MCO has made some progress in that it recently implemented an internal file review process that incorporates a review for the use of clinical practice guidelines. However, the file review data has not yet been analyzed to determine if IDTs are using the practice guideline. SFCA's annual quality review included recommendations to expedite plans to identify and adopt additional clinical practice guidelines and related educational materials; disseminate the materials to

members and providers, as appropriate; and analyze the results from the internal file review process to ensure clinical practice guidelines are consistently implemented by IDTs, and are incorporated into other functions of the organization in a consistent manner.

NB received scores of not met for all six measures related to clinical practice guidelines. SFY 09-10 marked its first QCR, and the review findings show that the MCO has not yet developed or adopted any clinical practice guidelines. NB's annual quality review included recommendations to develop or adopt clinical practice guidelines based on valid and reliable clinical evidence that consider the needs of the MCO's members.

Quality and Comprehensiveness of Member-Centered Plans

An area of opportunity across MCOs relates to the quality and comprehensiveness of MCPs. Directly related to the challenges in identifying and documenting outcomes during assessments, SFY09-10 CMR findings show that outcomes are not consistently documented on MCPs in a way that supports measurement of their progress, and often are not framed in a way that represents members' perspectives regarding their personal goals, hopes or dreams. Other findings that point to issues with MCP quality and comprehensiveness include:

- At MCCMO, many plans do not contain personal outcomes, preferences or strengths, but rather members' statements of satisfaction or fact.
- At CC, rather than developing MCPs jointly with members, MCPs are presented to members containing outcomes and goals that IDTs have decided members should work on.
- At SFCA, IDTs do not always involve members in prioritizing the personal outcomes to address on the MCP.
- At SFCA and WWC, interventions listed on MCPs do not always support achievement of the outcomes under which they are listed.
- MCPs at CC, CHP, LCD and NB do not consistently contain information regarding members' identified needs and/or services.
- At WWC, MCPs are only updated at six months reviews, even if significant changes take place and/or new outcomes are identified between scheduled reviews.

While opportunities for improvement exist related to the quality and comprehensiveness of MCPs, SFY 09-10 findings indicate that four MCOs (CC, CHP, MCCMO, SFCA) have been making progress by engaging in efforts to revise the format of their MCPs in order to help place focus on members' outcomes.

In planning the redesign of its MCP, CC's "first step" was to gain input from members via feedback elicited from its Consumer Advisory Committee. This helped the MCO design a tool that is understandable from the member's perspective. IDTs piloted several iterations of the redesigned MCP before it was submitted to DHS for approval. This process was cited as a "Best Practice" in CC's annual quality review. However, the new MCP had not yet been fully implemented at the time of the MCO's review in October 2009, and as a result, the EQR team was unable to evaluate the effectiveness of the new format. CC reported that staff training was planned for November 2009, with organization-wide implementation of the new MCP format to follow.

Based on recommendations from its SFY 08-09 annual quality review, CHP had redesigned its MCP to meet contract standards, and also created a *Critical Thinking Job Aide* for IDTs to use when developing MCPs. However, the documents were not fully implemented at the time of its SFY 09-10 annual quality review.

MCCMO and SFCA had revised their MCP formats during 2010, but had implemented the redesigned MCPs just shortly before their annual quality reviews. As a result, most of the MCPs in the review samples were not in the redesigned format, and the EQR team was unable to evaluate the effectiveness of the changes.

Monitoring Access to and Quality of Care

A notable area of opportunity for improvement relates to the requirement that MCOs have an effective process in place, such as an internal file review process, to provide data for assessing and monitoring the access, timeliness, quality, and appropriateness of care provided to members. Issues related to the lack of processes for internal file review, or the failure of MCOs to fully implement review processes have been noted elsewhere in this Summary of Findings, along with some areas of progress. MCOs have had difficulty in consistently meeting this measure over the past several years, and QCR results for SFY 09-10 show that eight of nine MCOs received partially met scores for this area. In addition, one MCO participating in its initial annual quality review received a score of not met. No MCO received a score of met.

Review findings show that six MCOs have implemented processes for internal file review, but have failed to analyze the data:

- With a total enrollment of approximately 2,900 at the time of its annual quality review in September 2009, CHP had thus far conducted internal file review on just 24 member records in 2009. In on-site discussions, staff reported that file reviews were focusing on topics such as outcomes, in order to provide feedback to staff. However, data analysis had not yet been conducted.
- LCD had implemented a revised internal file review process. Staff reported that supervisors and quality staff conduct internal file reviews at least twice per year for each IDT and provide feedback about compliance and opportunities for improvement in care management practice. However, the MCO had analyzed just three of the internal file review elements; data on the remaining 16 internal file review elements had not been analyzed.
- WWC reported that it conducts internal file reviews to provide information back to IDTs about their practice. Supervisors review more documentation for new staff and taper the level of review as staff demonstrates skill and success. However, the MCO's internal file review data indicated many areas of low compliance with contract requirements, i.e., of the 19 areas measured through the internal file review process, almost half fell below a 70 percent compliance rating with no areas above 90 percent compliance. Despite this, analysis of the data had occurred for only a few areas.
- CC, CCCW and SFCA had developed and implemented internal file review processes shortly before their annual quality review and had not yet conducted data analysis.

To improve findings related to internal file reviews, the annual quality review for these six MCOs included one or more of the following recommendations: increase the number and frequency of internal file reviews; analyze the data collected from internal file reviews to systematically assess the quality and appropriateness of care; conduct data analysis in a timely manner; and design a plan for improvement, as needed, based on data analysis.

At the time of their annual quality reviews, three additional MCOs (CW, MCCMO, NB) did not have a process in place for conducting internal file reviews. MCCMO was revising its internal file review process. CW and NB had not yet developed and implemented an internal file review process, although CW had made some progress by convening a "Team Practice Group" in October 2009, with the purpose of developing consistent strategies for evaluating and monitoring NOAs, MCPs, chart audits, RAD-related documentation, and other issues related to care management practice. The annual quality review for these three MCOs included recommendations to finalize and implement an internal file review process; collect and analyze data to evaluate and monitor the quality and appropriateness of care management services; and determine a plan for improvement based on the data analysis.

Quality Management Program Work Plans

Another notable area of opportunity concerns two QCR measures related to the requirement to have in place an ongoing quality assessment and performance improvement (QAPI) program, as well as a process for evaluating the impact and effectiveness of the QAPI program and submitting the results for DHS review, including the results of its performance of standard measures and PIPs. The measure related to having an ongoing QAPI program in place is actually an area of mixed results, as five MCOs (CC, CHP, LCD, MCCMO, WWC) received scores of met for this measure while four MCOs (CCCW, CW, SFCA, NB) received scores of partially met. No MCO received a score of not met for this measure.

CCCW has received a partially met score for this measure for the past four review years. SFY 09-10 review findings show that while this MCO's QAPI program description identifies the basic elements of a quality program (i.e., member satisfaction, utilization management, critical incident monitoring, etc.), the quality work plan does not include activities related to these elements; instead, the work plan focuses on follow up activities from the SFY 08-09 annual quality review and monitoring of quality indicators. In addition, during on-site discussions, management staff at the MCO talked about several quality initiatives and activities that had not been identified on the work plan. While the MCO has opportunities for improvement regarding its quality program, the review also noted an area of strength that was cited as a "Best Practice" in CCCW's annual quality review: The MCO includes providers on its quality committee. CCCW has also developed a provider quality subcommittee which affords the MCO a unique perspective and partnership with providers. For example, providers assisted the MCO in the development of a 2009 Provider survey, and its *Policy and Procedure for Certifying that Network Providers are Eligible to Participate in Federal Health Care Programs*, and *Policy and Procedure for Monitoring Provider Compliance with Caregiver Background Check Requirements*. In addition, provider representatives participate in time-limited workgroups to assist in achieving goals and objectives identified on the work plan of the CCCW's provider quality council.

CW's CY 2009 quality work plan specifies objectives, but lacks details on activities and timeframes. The work plan also refers to reports for indicators of progress, but states that some reports are still under development. On-site discussions at this MCO also identified several quality initiatives and activities that had not been identified on its quality work plan.

SFCA's CY 2010 quality work plan was developed before its 2009 work plan was evaluated. In addition, the plan does not include measures of how to assess progress or achievement of identified goals and objectives, and lacks information about the MCO's current activities regarding utilization management/utilization review.

To improve findings related to QAPI program work plans, the annual quality review for these three MCOs included one or more of the following recommendations:

- Develop the CY 2010 quality work plan based on an evaluation of the 2009 quality program;
- Incorporate all quality initiatives occurring throughout the organization into the CY 2010 quality work plan; and
- Include goals, details of activities, measures of success, timeframes, and persons responsible for each activity; and conduct periodic reviews of the quality work plan.

The quality work plan at NB was still in draft form at the time of its annual quality review. The annual quality review for this MCO in its first year of operation identified the need for the organization to systematically prioritize quality efforts, and ensure that planned quality activities will provide meaningful results. Recommendations included finalizing the CY 2010 quality work plan, securing approval of the plan from the MCO's governing board, implementing the plan, and establishing at least quarterly reviews to evaluate work plan progress and priorities.

Quality Management Program - Annual Evaluations

While at least half of MCOs met the requirement to have an ongoing QAPI program in place, across MCOs, organizations had greater difficulty evaluating their own QAPI programs and reporting the results. Only two MCOs (CC, LCD) received a score of met for this measure. SFY 09-10 findings show that LCD developed a *Quality Plan Progress Table* to track progress toward quality work plan objectives, note discoveries, and reflect on outcomes and implications of measures and objectives. The MCO's leadership team reviews the *Quality Plan Progress Table* monthly to identify successes and determine if measures and/or objectives should be modified. During on-site discussions, MCO management and staff commented that the review of the table "holds [the MCO] accountable and forces them to have the quality plan at the forefront" of practice. This was cited as a "Best Practice" in LCD's annual quality review.

While six MCOs (CCCW, CHP, CW, MCCMO, SFCA, WWC) received scores of partially met for the measure, this represented progress for CCCW, which moved from a score of not met in the SFY 08-09 review to a score of partially met for SFY 09-10. However, three MCOs (CHP, CW, SFCA) which had received scores of met in last year's review, were scored as partially met for this review year. The annual quality review of these MCOs included recommendations to include an analysis of the effect and success of the QAPI program in the evaluation of the program, including analysis or comparison of findings over time; details on processes, barriers or challenges; interventions or improvements made to quality activities or processes; and conclusions and next steps, based on findings.

One additional, MCO (NB) participating in its initial annual quality review, received a score of not met for this measure. NB's annual quality review included recommendations to 1) develop a process for program evaluation utilizing data and information from monitoring efforts, e.g.,

quality indicators, internal file review results, quality alerts, etc., and evaluate the effectiveness of newly developed processes and reporting systems; and 2) develop an evaluation for its QAPI program that includes analysis of the effect and success of the program, barriers or challenges, improvements, conclusions, and next steps.

Utilization Management

Another area of opportunity for improvement relates to the requirement that MCOs have mechanisms in place to detect both under- and over-utilization of services. Similar to the results of the SFY 08-09 review, SFY 09-10 QCR results show that five MCOs (CCCW, MCCMO, NB, SFCA, WWC) received a score of partially met for this area. CCCW and MCCMO have received scores of partially met in at least the past four review years. SFCA has received a combination of partially met and unmet scores for the past four years. Four MCOs (CC, CHP, CW, LCD) fully met this standard. No MCO received a score of not met.

The results represented progress for two MCOs. For example, CC has completed organization-wide implementation of standardized processes for utilization management, and thus moved from a score of partially met in last year's review to a score of met for SFY 09-10. In order to gauge the progress of "bringing the costs of care under management," CC had developed a *Family Care Cost Trend Report* which includes the actual costs of care provided over time in each of its Family Care service areas and for each target group. On a weekly basis, utilization reports are reviewed by operations department staff to identify potential duplication of services, open authorizations and pended claims, and determine whether utilization is within industry or historical benchmarks. Analysis of the utilization data and trend reports includes strengths, challenges, areas to study further, and specific goals for the coming year.

Progress at a second MCO was indicated by its move from a score of not met in last year's review to a score of partially met for SFY 09-10. Since its SFY 08-09 review, SFCA had implemented a utilization review and utilization management committee, and had hired an auditor to focus on program integrity by identifying and addressing any provider payment discrepancies. In addition, the MCO reported generating monthly reports that compare costs associated with Long-Term Care Functional Screen (LTC FS) data to authorized services. The reports are shared with care management staff on a per member basis to assist in identifying potentially duplicative services and unique expenditures per month, and in monitoring the authorization and usage of services by members at the non-nursing home level of care. SFCA's annual quality review included recommendations to continue working on development of a more structured review process to detect both under- and over-utilization of services. In addition, it was recommended that the MCO include details regarding its utilization review and utilization management activities in its CY 2010 quality work plan, and conduct an analysis of the data collected to determine if a plan for improvement is needed.

While four additional MCOs received scores of partially met for this measure, the review noted some progress.

- WWC is in the planning stage for development of an in-depth, multi-disciplined data analysis process related to utilization management. The MCO has developed a spreadsheet to enable the organization to trend utilization data from various reports, but the utilization management and review process is not yet fully implemented.
- CCCW reported that one goal of its utilization committee is to develop a system to proactively review the provider network for adequacy and cost, in order to

assess needs related to expansion and new enrollees. To better understand costs, benchmarking methods are underway to determine a starting point for per member per month service costs and analysis.

The annual quality review for these two MCO's included recommendations to incorporate a review process for identifying trends in under- and over-utilization of services organization-wide, and conduct an analysis of the data collected to determine if a plan for improvement is needed.

- At MCCMO, utilization studies conducted in 2009 did not provide definitive results regarding under- or over-utilization of services.
- While NB has developed a process for IDTs to compare the usage of services to the authorized amount, areas of under- and over-utilization of services have not yet been identified.

The annual quality review for these two MCO included recommendations to develop, document, and implement an ongoing, systematic process to monitor organization-wide trends and identify areas of both under- and over-utilization.

SUMMARY OF PERFORMANCE IMPROVEMENT PROJECTS

SFY 09-10 findings show that, for most MCOs, there are significant areas of opportunity related to developing and conducting PIPs that result in real and sustained improvement.

Every MCO met contract requirements to conduct at least one PIP per year relevant to long-term care, and for MCOs operating FCP and PACE programs to conduct at least one additional PIP related to clinical care. Eight MCOs worked on a total of 12 PIPs during SFY 09-10, including three projects continued from SFY 08-09, and nine new PIPs. For one MCO (NB) in its first year of operation, DHS waived the requirement to initiate and conduct a PIP.

Continuing PIPS included projects related to:

- Improving the early detection and treatment of dementia;
- Reducing the rate of members assessed at high risk for falls; and
- Improving the diagnosis and treatment of depression.

New PIPs for SFY 09-10 included nine projects and seven topics areas:

- Falls prevention (two projects)
- Assessing high risk health issues in the developmentally disabled population
- Pain assessment
- Medication management and reconciliation
- Timeliness (two projects – one focused on MCPs, and the other on NOAs)
- Chart audit process
- Electronic tracking of the RAD process
- Improving members' employment outcomes

The PIP review protocol consists of ten standard elements and 32 related indicators or measures. It's important to note that the standards and indicators that were evaluated for each PIP varied,

depending on the design of the project and its stage of implementation at the time of the MCO's SFY 09-10 review. For example, if a project was designed without focusing on a random member sample, the standard and indicators related to sampling methods did not apply. Similarly, for a PIP in the earlier phases of implementation, it's likely that some standard review elements and indicators, such as analysis and interpretation of results, real improvement, and sustained improvement were not applicable.

Two MCOs (LCD, MCCMO) each conducted their PIP using the BCAP methodology, which involves more detailed and stringent requirements than a PIP that uses another methodology.

Due to the wide variety of project topics and varied stages of implementation, recommendations made by the EQR team are not included in this summary, but can be found in each MCO's annual quality report in Attachments 5 through 13 of this report.

Reviewers noted some areas of strength across MCOs. For example, several MCOs (CC, CHP, CW, WWC) used multi-disciplinary or inter-departmental teams, workgroups or committees to design, implement and monitor their PIP projects, including managers and supervisors, care managers, therapists, IT staff, QI staff, MCO members, and others. In addition, Several MCOs (CC, CHP, CW, LCD) utilized electronic systems and created reports to assist in project monitoring, and data collection and analysis.

Topic Selection

A notable area of strength identified across MCOs concerns two indicators related to the standard review element, *Topic Selection*:

- All eight MCOs were found to have selected study topics that focused on improving health outcomes and member satisfaction for each of the 12 PIPs reviewed.

- Ten of the 12 projects had adequately researched the topic to confirm that a problem exists, the nature of the problem, and desired improvements. Two PIPS conducted by two MCOs (CC, CHP) received partially met scores for this measure, as neither MCO had conducted adequate research to show the existence or the extent of the problem related to their selected PIP topic.

Indicators and Measures

Another area of strength identified across MCOs concerns two indicators related to the standard review element, *Indicators and Measures*:

- Eight PIPs conducted by five MCOs had clearly defined, measurable indicators. Three MCOs (CHP, MCCMO, SFCA) and four PIPs received a partially met score for one of these measures. For two PIPs being conducted by CHP, some indicators were not clearly defined or measurable. MCCMO is conducting its PIP using the BCAP methodology, and therefore needed to frame its overall project aim statement as an outcome measure that defines the purpose of the project. However, reviewers found that the PIP included a mixture of process and outcome measures. SFCA had not clarified the project measures in its PIP report.

- For all eight MCOs, indicators were able to measure changes in health/functional status, satisfaction, or care processes for each of the 12 PIPs reviewed.

Project Population

Another area of strength identified across MCOs concerns two indicators related to the standard review element, *Project Population*:

- All eight MCOs were found to have identified a representative and generalizable study population for each of the 12 PIPs reviewed.
- Ten of 11 projects conducted by seven MCOs had clearly defined the relevant population. The PIP conducted by one MCO (MCCMO) received a partially met score for this measure. The MCO had not clearly defined exclusions from the population when defining the population to be included. For the PIP conducted by an eighth MCO, this measure was not applicable.

MCOs had more difficulty with assuring that, if the entire MCO enrollment is used as the study population, then all enrollees are captured. Ten of 12 PIPs used the entire population, but only five PIPs conducted by four MCOs (CC, CCCW, CW, SFCA) received a score of met for this indicator. Four PIPs conducted by three MCOs (CC, CW, CHP) received a score of partially met, while one PIP conducted by another MCO (MCCMO) received a score of not met. For the other two PIPs, one MCO (LCD) did not use the entire MCO enrollment. LCD received a score of met for this indicator because it was able to appropriately stratify its study population. For the other MCO, this indicator did not apply.

Data Collection Procedures

An area of mixed results identified across MCOs concerns three indicators related to the standard review element, *Data Collection Procedures*:

Six of the 12 PIPs reviewed for SFY 09-10 did not meet the requirement to develop a prospective data analysis plan for their PIP. Five PIPS did not have a written plan, resulting in a score of not met for five MCOs (CC, CCCW, CHP, MCCMO, SFCA). A sixth MCO (WWC) had developed a prospective data analysis plan; however, one of the data collection measures contained in the plan was flawed, resulting in a partially met score for its PIP. While half of the PIPs reviewed did not meet this indicator, the other six PIPs, conducted by four MCOs (CC, CHP, CW, LCD), received a score of met.

There were other areas of opportunity related to data collection and analysis, in that four PIPs did not meet an indicator which requires that qualified staff is used to collect data. Three PIPS conducted by three MCOs (CC, CHP, MCCMO) received a score of not met, and a second PIP also conducted by CHP received a score of partially met. The scores concerned a documentation issue, as these MCOs failed to fully document a plan for data collection, including identifying who would do the data collection and their qualifications. The remaining eight PIPS conducted by six MCO's fully met this measure.

Four PIPs conducted by four MCOs (CC, CHP, MCCMO, SFCA) had difficulty assuring that the data collection instruments they were using provided for consistent, accurate data collection.

Two MCOs (CC, CHP) received scores of not met for this measure, as a data collection tool was not provided with the PIP documentation. The two other MCOs received a score of partially met because the data reported was inconsistent or its source was unclear. However, eight PIPs conducted by six MCOs received a score of met for this measure.

While there were some areas of opportunity related to Data Collection Procedures, the review also identified an area of strength: Seven of eight MCOs and 11 PIPs were found to have clearly defined data and data sources for the 12 PIPs reviewed. The PIP for one MCO (MCCMO) received a partially met score for this measure. The number of members excluded from the project population was not calculated, contributing to an inaccurate cohort number.

Analysis and Interpretation of Results

Another area of mixed results identified across MCOs concerns four indicators related to the standard review element, *Analysis and Interpretation of Results*:

MCOs did show strength in this area, as nine PIPS conducted by seven MCOs (CC, CCCW, CHP, CW, LCD, MCCMO, WWC) had clearly defined follow-up activities or "next steps." One PIP conducted by CHP received a not met score for this indicator, and a PIP conducted by SFCA received a partially met score. The "next steps" for these PIPs had not been identified or had not been clearly defined. For the PIP conducted by an eighth MCO, this measure was not applicable. However, results were more mixed for other indicators related to the analysis and interpretation of results. For example, while six of the 12 PIPs reviewed met requirements to include initial and repeat measurements and identify limitations in data analysis, the other six PIPs received a score of either partially met or not met for this indicator. The six PIPs were conducted by four MCOs (CC, CHP, MCCMO, WWC), with CC and CHP each conducting two PIPs, and MCCMO and WWC each conducting one PIP. Results show that five PIPs conducted by CC, CHP, MCCMO and WWC received a score of partially met for this indicator, while the sixth PIP, conducted by CC, received a score of not met. The partially met scores related to incomplete data collection and/or analysis, such as failure to identify, clearly define or conduct repeat measures; failure to analyze data that had been collected; or the use of a statistically insignificant sample size. The not met score related to the MCO's failure to collect initial data to show that a problem exists or establish a baseline against which to measure. MCOs also had some difficulty clearly stating the progress and/or successes of their PIPs. For the eight PIPs to which this indicator applied, four received a score of met (CCCW, CW, LCD, WWC) and four received a score of partially met (CHP, CW, MCCMO, SFCA).

Project Aims

One notable area of opportunity for improvement relates to the standard review element, *Study Questions and Project Aims*:

Clearly stating the study question, or for BCAP, articulating an overall project aim that is clear and measurable, is a crucial step in setting the stage for the success of a PIP. However, the SFY 09-10 review found that only five of 12 PIPs had a study question or overall aim that was clearly stated and measurable. Seven PIPs conducted by six MCOs were unable to meet this indicator. Four PIPS conducted by three MCOs - including one PIP each conducted by CW and MCCMO, and two PIPs conducted by CC - received a score of partially met; and three PIPs conducted by three MCOs (CHP, CCCW, SFCA) received a score of not met. Five PIPS conducted by five MCOs (CC, CHP, CW, LCD, WWC) received a score of met for this indicator.

Improvement Strategies

Another area of opportunity for improvement identified across MCOs concerns three indicators related to the standard review element, *Improvement Strategies*:

PIPs need to develop and implement Plan-do-study-act (PDSA) cycles to monitor the effectiveness of project interventions. Success with this indicator is closely related to how well a MCO has done in developing a prospective data analysis plan for its PIP. For six of the 12 PIPs reviewed, PDSA cycles had either not been implemented or not fully documented, resulting in a not met score for three PIPs conducted by two MCOs (CHP, MCCMO), and a partially met score for three PIPs conducted by three MCOs (CC, CCCW, WWC). The remaining six PIPs conducted by four MCOs (CC, CW, LCD, SFCA) had implemented PDSA cycles, and therefore received a score of met for this indicator.

Seven of the 12 PIPs reviewed did not fully meet requirements to conduct data collection and analysis to identify barriers, and the steps that would be taken to address any barriers. Four PIPs conducted by three MCOs (CC, CHP, SFCA) received a partially met score for this indicator. The PIPs conducted by three of these MCOs lacked sufficient data collection and analysis to identify and address barriers to achieving desired outcomes. A fourth MCO had identified barriers for its PIP, but had not taken steps to address them. In addition, three PIPs conducted by three MCOs (CC, MCCMO, WWC) received a score of not met for this indicator. The MCOs had failed to conduct data analysis to identify barriers, and identify additional interventions to address any barriers. The SFY 08-09 annual quality review for MCCMO had included a recommendation that the MCO conduct a barrier analysis for this continuing PIP. However, MCCMO had failed to implement the recommendation. Five PIPs conducted by four MCOs (CC, CCCW, CW, LCD) received a score of met for this indicator.

A third indicator of improvement strategies where results were more mixed relates to whether project interventions have a good chance of success. Five projects and four MCOs received a score of partially met for this indicator. For two MCOs (CC, CHP) and three PIPs the scores related to interventions being minimally outlined or not fully documented for all outcomes. A third MCO (SFCA) had not conducted data analysis to determine the level of success of project interventions. For a fourth MCO (MCCMO), poor results during the first part of its project were not addressed via a barrier analysis, and thus continued, diminishing the chances of success for its project. Seven projects and six MCOs received a score of met for this indicator.

Overall Improvement

Another area of notable opportunity for improvement concerns several indicators related to two standard review elements, *"Real" Improvement* and *Sustained Improvement*.

One indicator relates to the requirement to document improvements in processes and/or outcomes resulting from the PIP. For the nine PIPs to which this indicator applied, only three PIPS conducted by three MCOs (CCCW, CW, SFCA) received a score of met. Six PIPs conducted by six MCOs received a partially met score for this indicator. The partially met scores for three of the MCOs (CHP, CW, MCCMO) relate to the failure to fully document improvements. In addition, the improvement documented by one MCO (CC) could not be linked to a planned intervention or process change. Two other MCOs (LCD, WWC) were not able to document improvement for one or more project outcomes, and need to identify and address barriers and continue to work on improving outcomes.

Another indicator assesses whether improvements appear to be the result of planned interventions. For the eight PIPS to which this indicator applied, only two PIPs conducted by two MCOs (CCCW, CW) received a score of met. Two MCOs (MCCMO, WWC) received a score of partially met. Based on the reports submitted by these two MCOs, reviewers were unable to fully assess the impact of interventions or significance of the results. In addition, four PIPs conducted by four MCOs (CW, CHP, LCD, SFCA) received a score of not met. One MCO (CW) failed to provide a written analysis of the data to explain the level of success of the project, including whether improvements resulted from project interventions. Two other MCOs (CHP, LCD) did not document improvements, and need to identify and address barriers and continue to work on improving outcomes. A fourth MCO (SFCA) conducting a continuing PIP did not collect data and do a barrier analysis to identify and address why the number of members willing to participate declined in the project's second year.

A third indicator assesses whether an MCO is able to demonstrate sustained improvement as the result of a PIP. Of the six PIPs to which this indicator applied, no project received a score of met. Four PIPs conducted by four MCOs (CCCW, CW, MCCMO, WWC) received a partially met score, while two PIPs conducted by two MCOs (LCD, SFCA) received a not met score for this indicator. For those MCOs with partially met scores, CCCW had not yet collected enough data to assess sustained improvement. For the PIPs conducted by CW, MCCMO and WWC, some or all of the data/ measures did not show consistent improvement. For LCD and SFCA, the two MCOs with not met scores, the PIP results did not demonstrate improvement.

While there were significant areas of opportunity related to these two standard review elements, the review also found an area of strength: Seven of ten PIPs to which this indicator applied provided consistent baseline and repeat measurements, and received a score of met for this measure. The PIPs were conducted by six MCOs (CC, CCCW, CHP, CW, SFCA, WWC). However, three PIPs conducted by three MCOs (CHP, LCD, MCCMO) received a score of partially met. CHP did not provide information to determine if baselines were established prior to creating a plan or starting interventions. While measurement occurred quarterly during the course of LCD's PIP, improvement did not occur and the MCO failed to identify and address the related barriers. In MCCMO's PIP, the population and timeframe for re-measurement were not clearly defined and tested for accuracy.

Opportunities for improvement regarding the ability of MCOs to develop and conduct PIPs that lead to real and sustained improvements were also noted in the SFY 08-09 annual quality review. Consequently, DHS monitored the progress of PIPs during SFY 09-10, and plans to make contract adjustments to the 2011 DHS-MCO contract to help improve PIP results, by requiring MCOs to obtain approval from DHS for the study questions and project aims and goals of each PIP.

SUMMARY OF VALIDATION OF PERFORMANCE MEASURES

During SFY 09-10, the EQR team validated the accuracy and reliability of 2009 performance measures data submitted by MCOs related to member dental visits (FCP and PACE only), influenza vaccinations and pneumonia vaccinations. Validation findings indicate that, as a group, MCO's are able to produce accurate performance measures data.

Dental Visits

Dental data from Partnership programs was submitted by three MCOs – CC, CHP and CW. CC also submitted dental data from its PACE program.

The reviewers found no significant discrepancies between the data reported and corresponding documentation in member records. All of the MCOs were able to produce dental performance measure data at a high rate of accuracy. For FCP, the dental data of two of three MCOs (CC and CHP) was found to be 100 percent accurate. Data from the third MCO (CW) was found to be 96.7 percent accurate. For the PACE program, the dental data was also found to be 96.7 percent accurate. Reviewers found only two member records of a total of 120 reviewed for the three MCOs where the dental visit date on file did not match what the MCO had reported.

Influenza Vaccinations

Every MCO submitted member influenza vaccination data for each of the programs it operates. The reviewers found no significant discrepancies between the data reported and corresponding documentation in member records. All nine MCOs were able to produce influenza vaccination performance measure data at a high rate of accuracy. Data submitted for the FCP and PACE programs was found to be 100 percent accurate. Data submitted for the nine FC programs ranged in accuracy from 86.7 percent to 100 percent. This included four MCOs (CHP, CW, LCD,MCCMO) with data found to be 100 percent accurate; two MCOs (CC, CCCW) with data found to be 96.7 percent accurate; two MCOs (SFCA, WWC) with data found to be 93.3 percent accurate; and one MCO (NB) with data found to be 86.7 percent accurate. Reviewers found 10 member records of a total of 270 reviewed where the date on file did not match the information the MCO had submitted.

Pneumonia Vaccinations

Every MCO submitted pneumococcal vaccination data for each of the programs it operates. For seven of nine MCOs, reviewers found no significant discrepancies between the data reported and corresponding documentation in member records. These MCOs were able to produce pneumonia vaccination performance measure data at a high rate of accuracy. Data submitted for two FCP programs (CW, CHP) was found to have an accuracy rate of 100 percent and 90 percent, respectively. Data submitted for eight FC programs ranged in accuracy from 89.7 percent to 100 percent, including one MCO (CHP) with data found to be 89.7 percent accurate, and seven MCOs (CC, CW, CCCW, LCD, MCCMO, NB, WWC) with data found to be 100 precent accurate.

While overall MCOs were able to accurately collect and report required performance measures data, reviewers found significant discrepancies between the pneumococcal vaccination data submitted by two MCOs, CC and SFCA, and related documentation in member records.

The data submitted by CC for both its FCP and PACE programs was only found to be 83.3 percent accurate. For PACE, reviewers found five member records out of 30 where either the full date was not entered, or the date on file did not match the immunization information submitted by the MCO. For FCP, reviewers identified five member records out of 30 where the record did not match the immunization information submitted by the MCO. Four of the five records

contained documentation that stated members had received vaccinations, but did not provide the vaccination dates.

The data submitted by SFCA for its FC program was only found to be 3.3 percent accurate. MetaStar reviewers confirmed that only one of 30 records in the sample contained a correctly reported pneumococcal immunization date. The MCO's guidelines direct staff to document the dates that immunizations are received or declined in the "Date Info Obtained" field in *MIDAS*, the MCO's electronic care management reporting system. However, four records did not have a date entered in this field. For an additional 25 records, the date contained in the "Date info Obtained" field did not match the immunization data the MCO had submitted.

Recommendations such as the following were included in a Performance Measures Report provided to each MCO:

- Standardize data collection processes to ensure accurate rate calculations. For example, when documenting dates for the performance measures (influenza, pneumococcal, and dental), only include dates (ideally in a format of month, day, and year) that the member received the immunization or went to the dentist in a single data field.
- Do not include dates of refusal, or contraindications; separate data collection fields should be used to capture refusal dates and contraindications.
- Review DHS instruction regarding the use of the Wisconsin Immunization Registry (WIR) system; a resource that can be used to confirm self-reports of vaccination dates.
- Review MCO documentation policies or guidelines with care management staff to ensure performance measures information is being collected, documented, and reported consistently within contract specified timeframes and within contract specifications for each performance measure.
- Ensure Master Customer Index (MCI) numbers are used during the data collection process.

For more information about the performance measures conducted by each MCO during SFY 09-10, including the findings detail, see Attachment 18.

SUMMARY OF INFORMATION SYSTEMS CAPABILITIES ASSESSMENT

During SFY 09-10, the EQR team completed an ISCA for NB MCO. Findings identified several areas of strength, as well as some opportunities for improvement. The MCO's areas of strength include:

- NB's member enrollment process is thorough and managed by knowledgeable staff.
- NB has a thorough process to gather and verify all provider data.
- Providers are able to complete on-line claim forms for professional, non-residential services.
- The MCO works extensively with its providers to ensure they can submit accurate claims in a timely manner.
- NB uses HIPAA compliant codes for every service authorization and service claim.

- NB compares its claims and encounter data to its financial data for a complete match twice monthly.
- In the five months it submitted encounter data files before its ISCA, NB encounter data was minimally rejected, and the MCO verified that all service line rejections were due to issues with one provider.
- Information system security processes at NB and its third party administrator (TPA), Vestica, related to data backup, physical computer security, network access, and disaster recovery planning are robust and well-documented.

The ISCA also identified some opportunities for improvement. Recommendations provided to NB include the following:

- Work proactively to implement processes that will identify coding and data entry errors prior to claims processing, in order to reduce the resources NB uses to do back-end clean up work of rejected or incorrectly paid claims.
- Inquire about the systems and strategies employed by other MCOs to ensure the accuracy of pre-claims data, as well as data that is manually entered, either in-house or by TPAs.
- In order to offer residential providers the same easy option for submitting claims that is already available to other providers, instruct the TPA to add an on-line residential services claim form.

For more detailed information regarding the results of NB's ISCA, see Attachment 19.

ATTACHMENT 1

LIST OF ACRONYMS AND ABBREVIATIONS

AQR	Annual Quality Review
BCAP	Best Clinical and Administrative Practices
CC	Community Care, Managed Care Organization
CCCW	Community Care of Central Wisconsin Managed Care Organization
CFR	Code of Federal Regulations
CY	Calendar Year
CMR	Care Management Review
CMU	Care Management Unit
CMS	Centers for Medicare & Medicaid Services
CHP	Community Health Partnership Managed Care Organization
CW	Care Wisconsin Managed Care Organization
DHS	Wisconsin Department of Health Services
DMS	Disposable Medical Supplies
EQR	External Quality Review
EQRO	External Quality Review Organization
FC	Family Care
FCP	Family Care-Partnership
HEDIS	Healthcare Effectiveness Data and Information Set (HEDIS is a registered trademark of the National Committee for Quality Assurance.)
HMO	Health Maintenance Organization
iCare	Independent Care Managed Care Organization
IDT	Inter-Disciplinary Team
IS	Information System
ISCA	Information Systems Capabilities Assessment
LCD	Lakeland Care District Managed Care Organization
LTC FS	Long-Term Care Functional Screen

MCCMO	Milwaukee County Care Management Organization
MCO	Managed Care Organization
MCP	Member-Centered Plan
NB	NorthernBridges Managed Care Organization
NOA	Notice of Action
PACE	Program of All-Inclusive Care for the Elderly
PDSA	Plan-Do-Study-Act cycle
PHI	Protected Health Information
PIHPS	Pre-paid Inpatient Health Plans
PIP	Performance Improvement Project
QAPI	Quality Assessment and Performance Improvement
QA/QI	Quality Assurance/Quality Improvement
QCR	Quality Compliance Review
QM	Quality Management
RAD	Resource Allocation Decision Method
SFCA	Southwest Family Care Alliance Managed Care Organization
SFY	State Fiscal Year
SSI	Supplemental Security Income
TPA	Third Party Administrator
WWC	Western Wisconsin Cares Managed Care Organization

ATTACHMENT 2

Family Care, Partnership and PACE Enrollment Data [1]

Monthly Snapshot as of July 1, 2009 Total MCO Enrollment by Target Group*

Program	Provider	Start Date	County Served	DD	FE	PD	**TG Unknown	Total
PACE	Community Care Health Plan	Nov-90	Milwaukee	12	750	128	4	894
	Community Care Health Plan	Mar-09	Waukesha	0	14	2	0	16
							Subtotal:	*910*
Partnership	Care Wisconsin Health Plan	Mar-08	Columbia	0	8	2	0	10
	Care Wisconsin Health Plan	Dec-95	Dane	26	594	400	5	1,025
	Care Wisconsin Health Plan	Aug-08	Dodge	2	8	6	0	16
	Care Wisconsin Health Plan	Sep-08	Jefferson	6	14	4	0	24
	Care Wisconsin Health Plan	Sep-08	Sauk	14	18	3	0	35
	Community Care Health Plan	Apr-07	Kenosha	0	14	8	0	22
	Community Care Health Plan	Nov-98	Milwaukee	2	102	28	2	134
	Community Care Health Plan	Jan-09	Ozaukee	2	2	2	0	6
	Community Care Health Plan	Jan-02	Racine	4	90	18	0	112
	Community Care Health Plan	Jan-09	Washington	2	3	5	0	10
	Partnership Health Plan	May-97	Chippewa	94	222	110	1	427
	Partnership Health Plan	May-97	Dunn	55	206	89	2	352
	Partnership Health Plan	May-97	Eau Claire	152	569	344	2	1,067
	Partnership Health Plan	Jul-08	Pierce	4	3	4	0	11
	Partnership Health Plan	Sep-08	St. Croix	12	4	7	0	23
							Subtotal:	*3,274*
Family Care	Care Wisconsin	Mar-08	Columbia	187	125	65	2	379
	Care Wisconsin	Aug-08	Dodge	172	69	35	1	277
	Care Wisconsin	Aug-08	Green Lake	64	38	9	0	111
	Care Wisconsin	Sep-08	Jefferson	377	186	66	2	631
	Care Wisconsin	Jul-08	Marquette	50	46	15	0	111
	Care Wisconsin	Apr-08	Washington	154	130	29	0	313
	Care Wisconsin	Jul-08	Waukesha	420	298	124	4	846
	Care Wisconsin	Jun-08	Waushara	83	81	23	0	187
	Community Care	Feb-07	Kenosha	416	331	243	8	998
	Community Care	Mar-08	Ozaukee	218	116	54	2	390
	Community Care	Jan-07	Racine	488	270	170	8	936
	Community Care	Feb-08	Sheboygan	361	273	104	3	741
	Community Care	Apr-08	Washington	130	95	32	2	259
	Community Care	Jul-08	Waukesha	281	162	50	5	498
	Community Care of Central Wisconsin	Nov-08	Marathon	442	330	103	2	877
	Community Care of Central Wisconsin	Apr-00	Portage	284	507	223	1	1,015

[1] Reference: Enrollment numbers from Wisconsin Department of Health Services Famliy Care and PACE/Partnership Enrollment Data website.

	Community Care of Central Wisconsin	Jan-09	Wood	283	238	69	2	592
Family Care, continued	Community Health Partnership	May-08	Chippewa	130	36	10	1	177
	Community Health Partnership	Jun-08	Dunn	77	16	11	0	104
	Community Health Partnership	Nov-08	Eau Claire	192	39	22	1	254
	Community Health Partnership	Jul-08	Pierce	84	47	21	0	152
	Community Health Partnership	Sep-08	St. Croix	152	70	34	0	256
	Creative Care Options of Fond du Lac County	Feb-00	Fond du Lac	393	472	181	1	1,047
	Milwaukee County Care Management Organization	Jul-00	Milwaukee	7	6,905	17	20	6,949
	Northern Bridges	Jul-09	Ashland	54	35	7	0	96
	Northern Bridges	May-09	Barron	112	86	25	0	223
	Northern Bridges	Jul-09	Bayfield	39	73	26	1	139
	Northern Bridges	Jun-09	Burnett	39	29	7	0	75
	Northern Bridges	May-09	Douglas	105	138	61	0	304
	Northern Bridges	Jun-09	Polk	84	38	17	0	139
	Northern Bridges	Jul-09	Rusk	58	61	13	0	132
	Northern Bridges	Jun-09	Washburn	59	65	25	0	149
	Southwest Family Care Alliance	Jul-09	Crawford	60	56	27	0	143
	Southwest Family Care Alliance	Jan-09	Green	78	109	53	0	240
	Southwest Family Care Alliance	Jul-09	Juneau	38	38	12	4	92
	Southwest Family Care Alliance	Jul-09	Lafayette	43	15	6	0	64
	Southwest Family Care Alliance	Jan-01	Richland	132	168	72	2	374
	Southwest Family Care Alliance	Sep-08	Sauk	146	121	62	4	333
	Western Wisconsin Cares	Mar-09	Buffalo	42	27	7	0	76
	Western Wisconsin Cares	Apr-09	Clark	113	62	14	1	190
	Western Wisconsin Cares	Dec-08	Jackson	91	81	25	0	197
	Western Wisconsin Cares	Apr-00	La Crosse	604	695	588	4	1,891
	Western Wisconsin Cares	Jan-09	Monroe	120	96	34	0	250
	Western Wisconsin Cares	Mar-09	Pepin	22	30	11	0	63
	Western Wisconsin Cares	Feb-09	Trempealeau	84	129	47	0	260
	Western Wisconsin Cares	Nov-08	Vernon	87	50	33	0	170
							Subtotal:	*23,700*
			TOTAL	**8,042**	**15,703**	**4,042**	**97**	**27,884**

*Target Groups: DD = Developmental Disability; FE = Frail Elderly; PD = Physical Disability

**TG Unknown = Members whose enrollment records cannot yet be matched with target-group information from their functional screens, usually because of the timing with which the data from the two sources are loaded into the central database

July 1, 2009

[1] Reference: Enrollment numbers from Wisconsin Department of Health Services Famliy Care and PACE/Partnership Enrollment Data website.

ATTACHMENT 3

Family Care, Partnership and PACE Enrollment Data [1]

Monthly Snapshot as of July 1, 2010 Total MCO Enrollment by Target Group*

Program	Provider	Start Date	County Served	DD	FE	PD	**TG Unknown	Total
PACE	Community Care Health Plan	Nov-90	Milwaukee	11	676	97	9	793
	Community Care Health Plan	Mar-09	Waukesha	0	33	10	1	44
							Subtotal:	*837*
Partnership	Care Wisconsin Health Plan	Mar-08	Columbia	3	21	7	0	31
	Care Wisconsin Health Plan	Dec-95	Dane	33	578	376	5	992
	Care Wisconsin Health Plan	Aug-08	Dodge	3	19	7	0	29
	Care Wisconsin Health Plan	Sep-08	Jefferson	18	25	11	0	54
	Care Wisconsin Health Plan	Sep-08	Sauk	12	31	8	1	52
	Community Care Health Plan	Apr-07	Kenosha	1	18	18	0	37
	Community Care Health Plan	Apr-10	Manitowoc	0	0	0	0	0
	Community Care Health Plan	Nov-98	Milwaukee	18	97	32	2	149
	Community Care Health Plan	Apr-10	Outagamie	7	6	5	0	18
	Community Care Health Plan	Jan-09	Ozaukee	5	7	4	0	16
	Community Care Health Plan	Jan-02	Racine	14	90	16	2	122
	Community Care Health Plan	Jan-09	Washington	3	7	6	0	16
	Community Care Health Plan	Mar-09	Waukesha	8	4	5	0	17
	Community Care Health Plan	Jul-10	Waupaca	4	21	3	0	28
	Independent Care, Inc.	Jan-10	Milwaukee	22	16	24	29	91
	Partnership Health Plan	May-97	Chippewa	96	240	95	1	432
	Partnership Health Plan	May-97	Dunn	61	198	76	2	337
	Partnership Health Plan	May-97	Eau Claire	182	592	302	3	1,079
	Partnership Health Plan	Jul-08	Pierce	6	8	3	0	17
	Partnership Health Plan	Sep-08	St. Croix	16	8	9	0	33
							Subtotal:	*3,550*
Family Care	Care Wisconsin	Mar-08	Columbia	181	133	73	2	389
	Care Wisconsin	Aug-08	Dodge	189	98	32	2	321
	Care Wisconsin	Aug-08	Green Lake	73	50	18	1	142
	Care Wisconsin	Sep-08	Jefferson	379	213	76	3	671
	Care Wisconsin	Jul-08	Marquette	59	56	18	0	133
	Care Wisconsin	Apr-08	Washington	153	141	28	0	322
	Care Wisconsin	Jul-08	Waukesha	481	310	103	5	899
	Care Wisconsin	Jun-08	Waushara	91	92	22	0	205
	Community Care, Inc.	Jan-10	Calumet	134	55	20	3	212
	Community Care, Inc.	Feb-07	Kenosha	469	341	254	4	1,068

[1] Reference: Enrollment numbers from Wisconsin Department of Health Services Family Care and PACE/Partnerhship Enrollment Data website.

Program	Provider	Start Date	County Served	DD	FE	PD	**TG Unknown	Total
	Community Care, Inc.	Nov-09	Milwaukee	429	169	237	3	838
Family Care, Continued	Community Care, Inc.	Apr-10	Outagamie	333	158	50	1	542
	Community Care, Inc.	Mar-08	Ozaukee	232	153	53	3	441
	Community Care, Inc.	Jan-07	Racine	493	323	175	6	997
	Community Care, Inc.	Feb-08	Sheboygan	368	289	98	3	758
	Community Care, Inc.	Oct-09	Walworth	168	136	63	1	368
	Community Care, Inc.	Apr-08	Washington	139	95	33	1	268
	Community Care, Inc.	Jul-08	Waukesha	317	172	62	1	552
	Community Care, Inc.	Jul-10	Waupaca	132	99	40	1	272
	Community Care of Central Wisconsin	Nov-08	Marathon	474	364	140	2	980
	Community Care of Central Wisconsin	Apr-00	Portage	283	501	207	2	993
	Community Care of Central Wisconsin	Jan-09	Wood	320	300	89	3	712
	Community Health Partnership	May-08	Chippewa	147	46	24	1	218
	Community Health Partnership	Jun-08	Dunn	84	24	22	1	131
	Community Health Partnership	Nov-08	Eau Claire	203	68	66	1	338
	Community Health Partnership	Jul-08	Pierce	82	52	23	0	157
	Community Health Partnership	Sep-08	St. Croix	162	86	37	1	286
	Lakeland Care District	Feb-00	Fond du Lac	394	506	187	3	1,090
	Lakeland Care District	Apr-10	Manitowoc	196	223	106	1	526
	Lakeland Care District	Jul-10	Winnebago	368	340	149	4	861
	Milwaukee County Care Management Organization	Jul-00	Milwaukee	784	6,467	192	18	7,461
	NorthernBridges	Jul-09	Ashland	79	56	30	0	165
	NorthernBridges	May-09	Barron	144	125	50	0	319
	NorthernBridges	Jul-09	Bayfield	35	56	27	1	119
	NorthernBridges	Jun-09	Burnett	42	27	9	0	78
	NorthernBridges	May-09	Douglas	149	163	59	1	372
	NorthernBridges	Aug-09	Iron	16	21	9	0	46
	NorthernBridges	Jun-09	Polk	91	55	23	0	169
	NorthernBridges	Aug-09	Price	60	72	20	0	152
	NorthernBridges	Jul-09	Rusk	62	75	19	0	156
	NorthernBridges	Aug-09	Sawyer	33	59	21	0	113
	NorthernBridges	Jun-09	Washburn	65	78	33	1	177
	Southwest Family Care Alliance	Jul-09	Crawford	71	52	28	0	151
	Southwest Family Care Alliance	Apr-10	Grant	107	88	37	1	233
	Southwest Family Care Alliance	Jan-09	Green	101	120	61	1	283
	Southwest Family Care Alliance	Apr-10	Iowa	42	27	7	1	77
	Southwest Family Care Alliance	Jul-09	Juneau	53	63	15	0	131
	Southwest Family Care Alliance	Jul-09	Lafayette	48	17	7	0	72
	Southwest Family Care Alliance	Jan-01	Richland	128	180	80	3	391

[1] Reference: Enrollment numbers from Wisconsin Department of Health Services Family Care and PACE/Partnerhship Enrollment Data website.

Program	Provider	Start Date	County Served	DD	FE	PD	**TG Unknown	Total
	Southwest Family Care Alliance	Sep-08	Sauk	160	137	79	4	380
Family Care, Continued	Western Wisconsin Cares	Mar-09	Buffalo	30	29	13	0	72
	Western Wisconsin Cares	Apr-09	Clark	121	76	20	1	218
	Western Wisconsin Cares	Dec-08	Jackson	86	76	22	0	184
	Western Wisconsin Cares	Apr-00	La Crosse	617	709	603	4	1,933
	Western Wisconsin Cares	Jan-09	Monroe	137	134	63	0	334
	Western Wisconsin Cares	Mar-09	Pepin	26	24	10	0	60
	Western Wisconsin Cares	Feb-09	Trempealeau	85	137	52	1	275
	Western Wisconsin Cares	Nov-08	Vernon	103	61	38	0	202
							Subtotal:	*30,013*
			TOTAL all Programs	**11,531**	**17,472**	**5,246**	**151**	**34,400**

*Target Groups: DD = Developmental Disability; FE = Frail Elderly; PD = Physical Disability

**TG Unknown = Members whose enrollment records cannot yet be matched with target-group information from their functional screens, usually because of the timing with which the data from the two sources are loaded into the central database.

August 6, 2010

[1] Reference: Enrollment numbers from Wisconsin Department of Health Services Family Care and PACE/Partnerhship Enrollment Data website.

ATTACHMENT 4
ANNUAL REPORT – QCR TOPICS FOR 2009-2010 BASED ON FINDINGS FROM 2008-2009

Access to Care

QCR Topic	CHP	CCI	CW	LCD	WWC	CCCW	NB*	SFCA	MC CMO
Enrollee Rights									
Provider network directory		✓				✓			✓
Restrictive measures monitoring									✓
Access to Services									
Ensuring timely access to services									✓
Documentation of follow up activities related to effectiveness of services					✓	✓			
Assessing and addressing risk						✓			
Structure and Operations									
Participation in federal health care programs			✓	✓	✓	✓		✓	✓
Background checks	✓		✓		✓	✓		✓	✓
Face-to-Face contact monitoring	✓	✓							
Provider Credentialing					✓				
Provider network contracting and monitoring									✓
Monitoring performance of subcontracted entities								✓	
Grievance Systems									
Appeal and grievance committee composition								✓	

* NB did not have a 2008-2009 QCR as it was in its first year of operation.

Timeliness

QCR Topic	CHP	CCI	CW	LCD	WWC	CCCW	NB*	SFCA	MC CMO
Access to Services									
Member Centered Plan monitoring	✓	✓	✓					✓	✓
Service Authorization process	✓	✓	✓	✓		✓		✓	✓
Grievance Systems									
Notices of Action	✓	✓	✓	✓	✓	✓		✓	✓
Appeal and Grievance timeframes			✓						✓

* NB did not have a 2008-2009 QCR as it was in its first year of operation.

Quality

QCR Topic	CHP	CCI	CW	LCD	WWC	CCCW	NB*	SFCA	MC CMO
Enrollee Rights									
Communication of protected health information					✓	✓		✓	
Measurement and Improvement									
Practice Guidelines		✓						✓	✓
Quality program work plan and evaluation	✓		✓		✓	✓		✓	✓
Performance Improvement Projects								✓	✓
Utilization review/ management		✓			✓	✓		✓	✓
Monitoring quality and appropriateness of care			✓	✓		✓		✓	✓

* NB did not have a 2008-2009 QCR as it was in its first year of operation.

External Quality Review Report
State Fiscal Year 2009-2010
Prepared By Metastar, Inc.

Individual MCO Reports (Attachments 5-13)

- Attachment 5: Care Wisconsin AQR Report
- Attachment 6: Community Care AQR Report
- Attachment 7: Community Care of Central Wisconsin AQR Report
- Attachment 8: Community Health Partnership AQR Report
- Attachment 9: Lakeland Care District AQR Report
- Attachment 10: MCDA Care Management Organization AQR Report
- Attachment 11: NorthernBridges AQR Report
- Attachment 12: Southwest Family Care Alliance AQR Report
- Attachment 13: Western Wisconsin Cares AQR Report

ATTACHMENT 14

QCR FINDINGS: MCOS OPERATING MORE THAN ONE PROGRAM (FC, FCP, PACE)

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

- **Met** applied when all policies, procedures, and practices aligned to meet the requirement.
- **Partially met** applied when the MCO met the requirements in practice, but lacked written policies or procedures; when the organization had not finalized or implemented draft policies; or the organization has written policies and procedures that have not been implemented fully.
- **Not met** applied when the MCO did not meet the requirements in practice and had not developed policies or procedures.

The tables below reflect each MCOs' findings for standards in each of the five Protocol review topics.

For the SFY 09-10 review, the DHS directed MetaStar to review measures that were partially met or not met during the previous years review. In addition, MetaStar evaluated the MCO's quality improvement program description, as well as the evaluation of its quality program activities and workplan DHS direction.

2009-2010 QCR ENROLLEE RIGHTS FINDINGS

Multiple Program MCOs				
Enrollee Rights Standards	**#**	**Care WI**	**CC**	**CHP**
The MCO has a written policy regarding member rights.	1	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
The MCO provides all enrollment notices, informational materials, and instructional materials relating to enrollees and potential enrollees in a manner and format that may be easily understood.	3	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
The MCO provides interpretation and translation services available to their members free of charge.	5	Met	Met	Met
The MCO provides written materials in an easily understood language and format.	6	Met	Met	Met
The MCO must have written material available in alternate formats that take into account the special needs of enrollees.	7	Met	Met	Met

Multiple Program MCOs									
Enrollee Rights Standards	**#**	**Care WI**		**CC**		**CHP**	
The MCO notifies members of their right to request and obtain information at least once a year about their rights.	8	Met		Met		Met	
The MCO provides enrollment information to new members in a timely manner.	9	Met		Met		Met	
The MCO notifies members at least thirty days before a significant change in member rights is implemented.	10	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 enrollee who received services from such provider.	11	**FC**		**FC**		**FC**	
		FCP	Met	**FCP/ PACE**	Met	**FCP**	Met
Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers must be provided to all enrollees.	12	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	**FC**		**FC**		**FC**	
		FCP	Met	**FCP/ PACE**	Met	**FCP**	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	
The MCO provides information to all enrollees 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	
The MCO informs members how to obtain services from providers outside of the MCO's contracted provider network.	16	Met		Met		Met	
The MCO informs members how to obtain after hours and emergency services.	17	**FC**		**FC**		**FC**	
		FCP	Met	**FCP/ PACE**	Met	**FCP**	Met
The MCO provides information to all members about post-stabilization care service rules (related to the financial responsibility of care provided).	18	**FC**		**FC**		**FC**	
		FCP	Met	**FCP/ PACE**	Met	**FCP**	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	
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	
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	
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	
The MCO provides grievance, appeal, and fair hearing procedures and timeframes, in a State-developed or	23	Met		Met		Met	

Multiple Program MCOs								
Enrollee Rights Standards	**#**	**Care WI**		**CC**		**CHP**		
State-approved description, that includes the requirements and timeframes for filing a grievance or appeal, the availability of assistance in the filing process, the toll-free numbers that the enrollee can use to file a grievance or an appeal by phone, the fact that, when requested by the enrollee, benefits will continue if the enrollee files an appeal or a request for State fair hearing within the timeframes specified for filing and the fact the enrollee may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the enrollee.								
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		
The MCO informs members about advance directives.	25	Met		Met		Met		
The MCO is required to have written policies and procedures regarding advance directives.	26	Met		Met		Met		
The MCO is required to provide written information on advance directives to each enrollee at the time of initial enrollment.	27	Met		Met		Met		
The MCO is required to provide community education regarding advance directives either directly or in concert with other providers and must be able to document its community education efforts.	28	Met		Met		Met		
The MCO did not identify any providers who provided care that conflicts with members' advance directives.	29	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		
The MCO gives members information about physician incentive plans.	31	**FC**		**FC**		**FC**		
		FCP	Met	**FCP/ PACE**	Met	**FCP**	Met	
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 enrollees, 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							
The MCO must not charge members for services included in the Family Care benefit package.	33	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	**FC**		**FC**		**FC**		
		FCP	Met	**FCP/ PACE**	Met	**FCP**	Met	
All members are guaranteed the right to be treated with respect and due consideration for her/her dignity and	35	Met		Met		Met		

Multiple Program MCOs				
Enrollee Rights Standards	**#**	**Care WI**	**CC**	**CHP**
privacy.				
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
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 enrollee's health status, medical care or treatment options, including any alternative treatment that may be self-administered; any information the enrollee needs in order 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 regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.	37	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
All members have the right to be furnished health care services.	39	Met	Met	Met
Findings for Family Care:				
Met Findings by MCO		**32 (100%)**	**32 (100%)**	**32 (100%)**
Partially Met Findings by MCO		**0 (0%)**	**0 (0%)**	**0 (0%)**
Not Met Findings by MCO		**0 (0%)**	**0 (0%)**	**0 (0%)**
Not Applicable Findings by MCO		**7**	**7**	**7**
Findings for Family Care Partnership/PACE:				
Met Findings by MCO		**38 (100%)**	**38 (100%)**	**38 (100%)**
Partially Met Findings by MCO		**0 (0%)**	**0 (0%)**	**0 (0%)**
Not Met Findings by MCO		**0 (0%)**	**0 (0%)**	**0 (0%)**
Not Applicable Findings by MCO		**1**	**1**	**1**

2009-2010 QCR Access to Services Findings

Multiple Program MCOs				
Access to Services Standards	**#**	**Care WI**	**CC**	**CHP**

Multiple Program MCOs								
Access to Services Standards	**#**	**Care WI**		**CC**		**CHP**		
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		
In establishing and maintaining the provider network, the MCO must consider anticipated Medicaid enrollment and expected utilization of services.	2	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		
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		
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 enrollees, and whether the location provides physical access for enrollees with disabilities.	5	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	**FC**		**FC**		**FC**		
		FCP	Met	**FCP/ PACE**	Met	**FCP**	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 enrollee.	7	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		
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		
Providers ensure timely access to care and services, taking into account the urgency of need for services.	10	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		
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		
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		
The MCO provides services to all members because of their special health care needs.	14	Met		Met		Met		

Multiple Program MCOs							
Access to Services Standards	**#**	**Care WI**		**CC**		**CHP**	
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	
Members' Individual Service Plans and Member-Centered Plans are completed and approved in a timely manner.	16	Partially Met		Partially Met		Partially Met	
The MCO facilitates access to specialists appropriate for members' special health care conditions and needs.	17	**FC**		**FC**		**FC**	
		FCP	Met	**FCP/ PACE**	Met	**FCP**	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	
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	
When authorizing initial and continuing services, the MCO consults with providers requesting the services when appropriate.	20	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	
The MCO must notify the requesting provider, and give the enrollee 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	
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	
The MCO must make an expedited authorization decision as expeditiously as the enrollee's health condition requires and no longer than 3 working days after receipt of the request.	24	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	
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	**FC**		**FC**		**FC**	
		FCP	Met	**FCP/ PACE**	Met	**FCP**	Met
The MCO does not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.	27	**FC**		**FC**		**FC**	
		FCP	Met	**FCP/ PACE**	Met	**FCP**	Met

Multiple Program MCOs							
Access to Services Standards	**#**	**Care WI**		**CC**		**CHP**	
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 enrollee, 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	**FC**		**FC**		**FC**	
		FCP	Met	**FCP/ PACE**	Met	**FCP**	Met
Findings for Family Care:							
Met Findings by MCO		**19 (82.6%)**		**19 (82.6%)**		**21 (91.3%)**	
Partially Met Findings by MCO		**4 (17.4%)**		**4 (17.4%)**		**2 (8.7%)**	
Not Met Findings by MCO		**0 (0%)**		**0 (0%)**		**0 (0%)**	
Not Applicable Findings by MCO		**5**		**5**		**5**	
Findings for Family Care Partnership/PACE:							
Met Findings by MCO		**24 (85.7%)**		**24 (85.7%)**		**26 (92.9%)**	
Partially Met Findings by MCO		**4 (14.3%)**		**4 (14.3%)**		**2 (7.1%)**	
Not Met Findings by MCO		**0 (0%)**		**0 (0%)**		**0 (0%)**	
Not Applicable Findings by MCO		**0**		**0**		**0**	

2009-2010 Structure and Operations Findings

Multiple Program MCOs				
Structure and Operations Standards	**#**	**Care WI**	**CC**	**CHP**
Each MCO must implement written policies and procedures for selection and retention of providers.	1	Met	Met	Met
The MCO must follow a documented process for credentialing and recredentialing of contracted providers.	2	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
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
The MCO may not employ or contract with providers excluded from participation in Federal health care programs.	5	Partially Met	Met	Met

Multiple Program MCOs							
Structure and Operations Standards	**#**	**Care WI**		**CC**		**CHP**	
The MCO must comply with any additional requirements established by the State.	6	Partially Met		Met		Partially Met	
The MCO must not request disenrollment for reasons other than those permitted under contract.	7	Met		Met		Met	
The MCO informs members about when they may ask to disenroll from a MCO.	8	**FC**		**FC**		**FC**	
		FCP	Met	**FCP/PACE**	Met	**FCP**	Met
The enrollee must submit an oral or written request for disenrollment to the MCO.	9	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	
An MCO may approve a request for disenrollment or refer the request to the State.	11	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	
The MCO uses grievance procedures in a timely manner to permit members to disenroll from MCOs by regulated deadlines.	13	**n/a**					
The effective date of disenrollment must be no later than the first day of the second month following the month in which the enrollee or the MCO files the request.	14	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	
The MCO oversees and is accountable for all functions and responsibilities they delegate to subcontractors.	16	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	
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	
The MCO monitors its subcontractors' performance and subjects it to formal review according to a periodic	19	Met		Met		Met	

Multiple Program MCOs				
Structure and Operations Standards	**#**	**Care WI**	**CC**	**CHP**
schedule established by the State.				
The MCO and the subcontractor take corrective action if an MCO identifies deficiencies or areas for improvement.	20	Met	Met	Met
Findings for Family Care:				
Met Findings by MCO		**15 (83.3%)**	**17 (94.4%)**	**16 (88.9%)**
Partially Met Findings by MCO		**3 (16.7%)**	**1 (5.6%)**	**2 (11.1%)**
Not Met Findings by MCO		**0 (0%)**	**0 (0%)**	**0 (0%)**
Not Applicable Findings by MCO		**2**	**2**	**2**
Findings for Family Care Partnership/PACE:				
Met Findings by MCO		**16 (84.2%)**	**18 (94.7%)**	**17 (89.5%)**
Partially Met Findings by MCO		**3 (15.8%)**	**1 (5.3%)**	**2 (10.5%)**
Not Met Findings by MCO		**0 (0%)**	**0 (0%)**	**0 (0%)**
Not Applicable Findings by MCO		**1**	**1**	**1**

2009-2010 QCR Measurement and Improvement Findings

Multiple Program MCOs				
Measurement and Improvement Standards	**#**	**Care WI**	**CC**	**CHP**
Practice guidelines need to be based on valid and reliable clinical evidence.	1	Met	Met	Met
Practice guidelines must consider the needs of the MCO's enrollees.	2	Met	Met	Met
Practice guidelines need to be developed in consultation with health care professionals.	3	Met	Met	Met
Practice guidelines need to be reviewed and updated periodically.	4	Met	Met	Met
Practice guidelines need to be disseminated to all affected providers.	5	Met	Met	Met
Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.	6	Met	Met	Met
The MCO must have an ongoing quality assessment and performance improvement program for the services it furnishes to enrollees.	7	Partially 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	8	Met	Met	Met

Multiple Program MCOs				
Measurement and Improvement Standards	**#**	**Care WI**	**CC**	**CHP**
favorable effect on health outcomes and member satisfaction.				
MCOs must have an ongoing program of performance improvement projects that focuses on clinical and non-clinical areas.	9	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
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
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			
The MCO must have in effect mechanisms to detect both under- and over-utilization of services.	13	Met	Met	Met
The MCO must have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.	14	Partially Met	**FC** Met **FCP/ PACE** Partially Met	Partially 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	Partially Met	Met	Partially 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			
Each MCO must collect data on enrollee and provider characteristics through an encounter data system or other method as specified by the State.	17			
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			

Multiple Program MCOs				
Measurement and Improvement Standards	**#**	**Care WI**	**CC**	**CHP**
The MCO must make all collected data available to the State and upon request to CMS.	19			
Findings for Family Care:				
Met Findings by MCO		**11 (78.6%)**	**14 (100%)**	**11 (78.6%)**
Partially Met Findings by MCO		**3 (21.4%)**	**0 (0%)**	**3 (21.4%)**
Not Met Findings by MCO		**0 (0%)**	**0 (0%)**	**0 (0%)**
Not Applicable Findings by MCO		**5**	**5**	**5**
Findings for Family Care Partnership /PACE:				
Met Findings by MCO		**11 (78.6%)**	**13 (92.9%)**	**11 (78.6%)**
Partially Met Findings by MCO		**3 (21.4%)**	**1 (7.1%)**	**3 (21.4%)**
Not Met Findings by MCO		**0 (0%)**	**0 (0%)**	**0 (0%)**
Not Applicable Findings by MCO		**5**	**5**	**5**

2009-2010 QCR Grievance Systems Findings

Multiple Program MCOs				
Grievance System Standards	**#**	**Care WI**	**CC**	**CHP**
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
An enrollee may file a grievance and an MCO level appeal and may request a fair hearing.	2	Met	Met	Met
A provider, acting on behalf of a member and with the member's written consent, may file a grievance or appeal and may request a State fair hearing.	3	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
Members may file a grievance either orally or in writing.	5	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
The Notice of Action must explain the enrollee'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
The Notice of Action must explain the enrollee's right to	8	Met	Met	Met

Multiple Program MCOs				
Grievance System Standards	**#**	**Care WI**	**CC**	**CHP**
have benefits continue pending the resolution of the appeal, how to request that services continue and the circumstances under which the enrollee may be required to pay for the cost of the services.				
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
The MCO must mail the notice of action at least 10 days before the date of action.	10	Met	Met	Met
If an enrollee'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
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 enrollee has been accepted for Medicaid services by another local jurisdiction or State.	12	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
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
If the MCO extends the timeframe for service authorization decision-making, it must give the enrollee written notice of the reason along with appeal and grievance rights.	15	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
The MCO must make an expedited authorization decision and provide notice as expeditiously as the enrollee'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 enrollee requests the extension or the MCO justifies a need for additional information and how the extension is in the enrollee's interest.	17	Met	Met	Met
The MCO must give enrollees any reasonable assistance in completing forms and taking other procedural steps in filing appeals and grievances.	18	Met	Met	Met
The MCO must acknowledge receipt of each grievance and appeal.	19	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
The MCO ensures that health care professionals with	21	Met	Met	Met

Multiple Program MCOs				
Grievance System Standards	**#**	**Care WI**	**CC**	**CHP**
appropriate clinical expertise in treating the member's condition or disease determine the outcome of expedited appeals and grievances related to clinical issues.				
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
The MCO must provide the enrollee a reasonable opportunity to present evidence during the appeal and grievance hearing, and provide the enrollee an opportunity to examine his/her case file prior to or during the appeal process.	23	Met	Met	Met
The process for appeals must include the enrollee and his/her representative, or the legal representative of a deceased enrollee's estate.	24	Met	Met	Met
The MCO must dispose of each grievance, resolve each appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within State established timeframes.	25	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
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
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
The MCO will use the method identified by the State to notify an enrollee of the disposition of a grievance.	29	Met	Met	Met
The MCO must provide written notice of disposition of an appeal.	30	Met	Met	Met
The written notice of resolution must include the results of the resolution process, the date is was completed, the right to request a State fair hearing, the right to receive benefits while the hearing is pending, and that the enrollee may be held liable for the cost of continued benefits if the hearing decision upholds the MCO's action.	31	Met	Met	Met
The State must permit the enrollee to request a State fair hearing within 45 days from the date of the MCO's notice of action.	32	Met	Met	Met

Multiple Program MCOs				
Grievance System Standards	**#**	**Care WI**	**CC**	**CHP**
The parties to the State fair hearing include the MCO as well as the enrollee and his or her representative or the representative of a deceased enrollee's estate.	33	Met	Met	Met
The MCO must establish and maintain an expedited review process for appeals.	34	Met	Met	Met
The MCO must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports an enrollee's appeal.	35	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
The MCO must provide information about the enrollee grievance system to all providers at the time they enter into a contract.	37	Met	Met	Met
The MCO must maintain records of grievance and appeals and must review the information as part of the MCO's quality program.	38	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
If the enrollee requests that benefits continue, they must continue until the enrollee withdraws the appeal, the enrollee 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
The MCO may recover the costs of continued benefits if the appeal decision is adverse to the enrollee.	41	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 enrollee's health condition requires.	42	Met	Met	Met
Findings for Family Care:				
Met Findings by MCO		**40 (95.2%)**	**40 (95.2%)**	**40 (95.2%)**
Partially Met Findings by MCO		**2 (4.8%)**	**2 (4.8%)**	**2 (4.8%)**
Not Met Findings by MCO		**0 (0%)**	**0 (0%)**	**0 (0%)**
Not Applicable Findings by MCO		**0**	**0**	**0**

Multiple Program MCOs				
Grievance System Standards	**#**	**Care WI**	**CC**	**CHP**
Findings for Family Care Partnership/PACE:				
Met Findings by MCO		**40 (95.2%)**	**40 (95.2%)**	**40 (95.2%)**
Partially Met Findings by MCO		**2 (4.8%)**	**2 (4.8%)**	**2 (4.8%)**
Not Met Findings by MCO		**0 (0%)**	**0 (0%)**	**0 (0%)**
Not Applicable Findings by MCO		**0**	**0**	**0**

ATTACHMENT 15

QCR FINDINGS: MCO OPERATING FAMILY CARE ONLY

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

- **Met** applied when all policies, procedures, and practices aligned to meet the requirement.
- **Partially met** applied when the MCO met the requirements in practice, but lacked written policies or procedures; when the organization had not finalized or implemented draft policies; or the organization has written policies and procedures that have not been implemented fully.
- **Not met** applied when the MCO did not meet the requirements in practice and had not developed policies or procedures.

The tables below reflect each MCOs' findings for standards in each of the five Protocol review topics.

For the SFY 09-10 review, the DHS directed MetaStar to review measures that were partially met or not met during the previous years review. In addition, MetaStar evaluated the MCO's quality improvement program description, as well as the evaluation of its quality program activities and workplan DHS direction.

2009-2010 QCR ENROLLEE RIGHTS FINDINGS

Family Care Only							
Enrollee Rights Standards	**#**	**CCCW**	**LCD**	**MCCMO**	**NB**	**SFCA**	**WWC**
The MCO has a written policy regarding member rights.	1	Met	Met	Met	Partially 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 enrollees and potential enrollees 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	Partially 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 enrollees.	7	Met	Met	Met	Partially Met	Met	Met

Family Care Only							
Enrollee Rights Standards	**#**	**CCCW**	**LCD**	**MCCMO**	**NB**	**SFCA**	**WWC**
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 enrollee who received services from such provider.	11						
Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers must be provided to all enrollees.	12	Partially Met	Met	Partially 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						
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 enrollees 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 MCO provides information to all members about post-stabilization care service rules (related to the financial responsibility of care provided).	18						
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	23	Met	Met	Met	Met	Met	Met

Family Care Only							
Enrollee Rights Standards	**#**	**CCCW**	**LCD**	**MCCMO**	**NB**	**SFCA**	**WWC**
requirements and timeframes for filing a grievance or appeal, the availability of assistance in the filing process, the toll-free numbers that the enrollee can use to file a grievance or an appeal by phone, the fact that, when requested by the enrollee, benefits will continue if the enrollee files an appeal or a request for State fair hearing within the timeframes specified for filing and the fact the enrollee may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the enrollee.							
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 regarding advance directives.	26	Met	Met	Met	Met	Met	Met
The MCO is required to provide written information on advance directives to each enrollee at the time of initial enrollment.	27	Met	Met	Met	Met	Met	Met
The MCO is required to provide community education regarding 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						
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 enrollees, 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						
The MCO must not charge members for services included in the Family Care benefit package.	33	Met	Met	Met	Partially 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						
All members are guaranteed the right to be treated with respect and due consideration for her/her dignity and privacy.	35	Met	Met	Met	Partially Met	Partially Met	Partially Met

Family Care Only							
Enrollee Rights Standards	**#**	**CCCW**	**LCD**	**MCCMO**	**NB**	**SFCA**	**WWC**
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 enrollee's health status, medical care or treatment options, including any alternative treatment that may be self-administered; any information the enrollee needs in order 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 regarding 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%)**	**32 (100%)**	**31 (96.9%)**	**25 (78.1%)**	**31 (96.9%)**	**31 (96.9%)**
Partially Met Findings by MCO		**1 (3.1%)**	**0 (0%)**	**1 (3.1%)**	**7 (21.9%)**	**1 (3.1%)**	**1 (3.1%)**
Not Met Findings by MCO		**0 (0%)**	**0 (0%)**	**0 (0%)**	**0 (0%)**	**0 (0%)**	**0 (0%)**
Not Applicable Findings by MCO		**7**	**7**	**7**	**7**	**7**	**7**

2009-2010 QCR Access to Services Findings

Family Care Only							
Access to Services Standards	**#**	**CCCW**	**LCD**	**MCCMO**	**NB**	**SFCA**	**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	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	Partially 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	Partially 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 enrollees, and	5	Met	Met	Met	Partially Met	Met	Met

Family Care Only							
Access to Services Standards	**#**	**CCCW**	**LCD**	**MCCMO**	**NB**	**SFCA**	**WWC**
whether the location provides physical access for enrollees with disabilities.							
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						
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 enrollee.	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	Partially 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	Partially 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	Partially Met	Met	Met	Partially 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
The MCO assesses its members' ongoing special conditions that require a course of treatment or regular care monitoring by appropriate health care professionals.	15	Partially Met	Met	Met	Met	Met	Met
Members' Individual Service Plans and Member-Centered Plans are completed and approved in a timely manner.	16	Met	Met	Partially Met	Partially Met	Partially Met	Met
The MCO facilitates access to specialists appropriate for members' special health care conditions and needs.	17						
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	Met	Partially 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	Met	Met
When authorizing initial and continuing services, the MCO consults with providers requesting the services	20	Met	Met	Met	Met	Met	Met

Family Care Only							
Access to Services Standards	**#**	**CCCW**	**LCD**	**MCCMO**	**NB**	**SFCA**	**WWC**
when appropriate.							
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 enrollee 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	Met	Partially 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	Met	Partially Met	Partially Met	Partially Met	Met
The MCO must make an expedited authorization decision as expeditiously as the enrollee'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						
The MCO does not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.	27						
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 enrollee, 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 Findings by MCO		**19 (82.6%)**	**22 (95.7%)**	**18 (78.3%)**	**11 (47.8%)**	**19 (82.6%)**	**22 (95.7%)**
Partially Met Findings by MCO		**4 (17.4%)**	**1 (4.3%)**	**5 (21.7%)**	**12 (52.2%)**	**4 (17.4%)**	**1 (4.3%)**
Not Met Findings by MCO		**0 (0%)**	**0 (0%)**	**0 (0%)**	**0 (0%)**	**0 (0%)**	**0 (0%)**
Not Applicable Findings by MCO		**5**	**5**	**5**	**5**	**5**	**5**

2009-2010 Structure and Operations Findings

Family Care Only							
Structure and Operations Standards	**#**	**CCCW**	**LCD**	**MCCMO**	**NB**	**SFCA**	**WWC**
Each MCO must implement written policies and	1	Met	Met	Met	Partially Met	Met	Met

Family Care Only							
Structure and Operations Standards	**#**	**CCCW**	**LCD**	**MCCMO**	**NB**	**SFCA**	**WWC**
procedures for selection and retention of providers.							
The MCO must follow a documented process for credentialing and recredentialing of contracted providers.	2	Met	Met	Partially Met	Partially 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	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	Met	Partially Met	Not Met	Partially Met	Met
The MCO must comply with any additional requirements established by the State.	6	Partially Met	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 enrollee 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 effective date of disenrollment must be no later than the first day of the second month following the month in which the enrollee 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

Family Care Only							
Structure and Operations Standards	**#**	**CCCW**	**LCD**	**MCCMO**	**NB**	**SFCA**	**WWC**
The MCO oversees and is accountable for all functions and responsibilities they delegate to subcontractors.	16	Met	Met	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	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	Not 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%)**	**17 (94.4%)**	**15 (83.3%)**	**13 (72.2%)**	**14 (77.7%)**	**16 (88.9%)**
Partially Met Findings by MCO		**2 (11.1%)**	**1 (5.6%)**	**3 (16.7%)**	**4 (22.2%)**	**3 (16.7%)**	**2 (11.1%)**
Not Met Findings by MCO		**0 (0%)**	**0 (0%)**	**0 (0%)**	**1 (5.6%)**	**1 (5.6%)**	**0 (0%)**
Not Applicable Findings by MCO		**2**	**2**	**2**	**2**	**2**	**2**

2009-2010 QCR Measurement and Improvement Findings

Family Care Only							
Measurement and Improvement Standards	**#**	**CCCW**	**LCD**	**MCCMO**	**NB**	**SFCA**	**WWC**
Practice guidelines need to be based on valid and reliable clinical evidence.	1	Met	Met	Met	Not Met	Partially Met	Met
Practice guidelines must consider the needs of the MCO's enrollees.	2	Met	Met	Met	Not Met	Met	Met
Practice guidelines need to be developed in consultation with health care professionals.	3	Met	Met	Met	Not Met	Partially Met	Met
Practice guidelines need to be reviewed and updated periodically.	4	Met	Met	Met	Not Met	Met	Met
Practice guidelines need to be disseminated to all affected providers.	5	Met	Met	Partially Met	Not Met	Partially Met	Met
Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.	6	Met	Met	Partially Met	Not Met	Partially Met	Met
The MCO must have an ongoing quality assessment and performance improvement program for the services it furnishes to enrollees.	7	Partially Met	Met	Met	Partially 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	8	Met	Met	Partially Met		Partially Met	Met

Family Care Only							
Measurement and Improvement Standards	**#**	**CCCW**	**LCD**	**MCCMO**	**NB**	**SFCA**	**WWC**
satisfaction.							
MCOs must have an ongoing program of performance improvement projects that focuses on clinical and non-clinical areas.	9	Met	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	Partially Met	Met	Partially Met		Partially Met	Partially 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	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						
The MCO must have in effect mechanisms to detect both under- and over-utilization of services.	13	Partially Met	Met	Partially Met	Partially Met	Partially Met	Partially Met
The MCO must have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.	14	Partially Met	Partially Met	Partially Met	Not Met	Partially Met	Partially 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	Partially Met	Met	Partially Met	Not Met	Partially Met	Partially 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						
Each MCO must collect data on enrollee and provider characteristics through an encounter data system or other method as specified by the State.	17						
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						
The MCO must make all collected data available to the State and upon request to CMS.	19	**N/A: This measure is rated during the Performance Measure Validation process and is not reported in the AQR report.**					

Family Care Only							
Measurement and Improvement Standards	**#**	**CCCW**	**LCD**	**MCCMO**	**NB**	**SFCA**	**WWC**
Met Findings by MCO		**9 (64.3%)**	**13 (92.9%)**	**7 (50%)**	**0 (0%)**	**3 (21.4%)**	**10 (71.4%)**
Partially Met Findings by MCO		**5 (35.7%)**	**1 (7.1%)**	**7 (50%)**	**2 (20%)**	**11 (78.6%)**	**4 (28.6%)**
Not Met Findings by MCO		**0 (0%)**	**0 (0%)**	**0 (0%)**	**8 (80%)**	**0 (0%)**	**0 (0%)**
Not Applicable Findings by MCO		**5**	**5**	**5**	**9**	**5**	**5**

2009-2010 QCR Grievance Systems Findings

Family Care Only							
Grievance System Standards	**#**	**CCCW**	**LCD**	**MCCMO**	**NB**	**SFCA**	**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
An enrollee 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 a grievance or appeal 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 enrollee'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 enrollee's right to have benefits continue pending the resolution of the appeal, how to request that services continue and the circumstances under which the enrollee 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	Met	Met	Partially 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	Partially Met	Partially Met	Met	Partially Met
If an enrollee'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	12	Met	Met	Met	Partially Met	Met	Met

Family Care Only							
Grievance System Standards	**#**	**CCCW**	**LCD**	**MCCMO**	**NB**	**SFCA**	**WWC**
establishes the fact that the enrollee has been accepted for Medicaid services by another local jurisdiction or State.							
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	Partially 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	Partially Met	Partially Met
If the MCO extends the timeframe for service authorization decision-making, it must give the enrollee written notice of the reason along with appeal and grievance rights.	15	Met	Met	Partially 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	Partially Met	Met	Partially Met	Partially Met	Partially Met	Partially Met
The MCO must make an expedited authorization decision and provide notice as expeditiously as the enrollee'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 enrollee requests the extension or the MCO justifies a need for additional information and how the extension is in the enrollee's interest.	17	Met	Met	Met	Met	Met	Met
The MCO must give enrollees 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 grievance and appeal.	19	Met	Met	Met	Partially 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	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 enrollee a reasonable opportunity to present evidence during the appeal and grievance hearing, and provide the enrollee 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 enrollee and his/her representative, or the legal representative of a deceased enrollee'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 enrollee's health condition requires, within State	25	Met	Met	Partially Met	Met	Met	Met

Family Care Only							
Grievance System Standards	**#**	**CCCW**	**LCD**	**MCCMO**	**NB**	**SFCA**	**WWC**
established timeframes.							
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	Partially 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	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	Partially Met	Met	Met	Met
The MCO will use the method identified by the State to notify an enrollee 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
The written notice of resolution must include the results of the resolution process, the date is was completed, the right to request a State fair hearing, the right to receive benefits while the hearing is pending, and that the enrollee 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 enrollee 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 as well as the enrollee and his or her representative or the representative of a deceased enrollee'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 an enrollee'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 enrollee 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 grievance and appeals 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	39	Met	Met	Met	Met	Met	Met

Family Care Only							
Grievance System Standards	**#**	**CCCW**	**LCD**	**MCCMO**	**NB**	**SFCA**	**WWC**
has not expired, and the member requests the continuation.							
If the enrollee requests that benefits continue, they must continue until the enrollee withdraws the appeal, the enrollee 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 enrollee.	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 enrollee's health condition requires.	42	Met	Met	Met	Met	Met	Met
Met Findings by MCO		**40 (95.2%)**	**41 (97.6%**	**34 (81%)**	**34 (81%)**	**39 (92.9%)**	**38 (90.5%)**
Partially Met Findings by MCO		**2 (4.8%)**	**1 (2.4%)**	**8 (19%)**	**8 (19%)**	**3 (7.1%)**	**4 (9.5%)**
Not Met Findings by MCO		**0 (0%)**	**0 (0%)**	**0 (0%)**	**0 (0%)**	**0 (0%)**	**0 (0%)**
Not Applicable Findings by MCO		**0**	**0**	**0**	**0**	**0**	**0**

ATTACHMENT 16

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS - FCP/PACE

The table below lists the indicators associated with the ten standard elements of the review. Some standards or associated indicators may not be applicable depending on the project's phase of implementation at the time of the review.

2009 - 2010 PIP Validation Findings

Performance Improvement Project Standards	#	Multiple Program Managed Care Organizations						
		Care WI – FC/FCP	Care WI – FCP	CC – FC	CC – FCP/PACE	CC – FCP/PACE	CHP – FC/FCP	CHP - FCP
		Member Centered Plan Timeliness	Falls Improvement	Ensuring standards based assessment of high risk health issues in the developmentally disabled population: pain and gastrointestinal components	Member Pain Assessment	Chart Audit Performance	Electronic Tracking of the RAD Process	Medication Management and Reconciliation
Topic based on relevant data	1a	Met	Met	Partially Met	Met	Met	Met	Partially Met
Topic focused on improving outcomes of care for members	1b	Met	Met	Met	Met	Met	Met	Met
Clearly stated study questions, or	2a	Met	Partially Met	Partially Met	Met	Partially Met	Met	Not Met
• if BCAP, overall aim is clearly stated and measurable	2b							
• if BCAP overall aim includes numerical goal and target date	2c							
• if BCAP typology aims are clearly stated and measurable	2d							
• if BCAP typology aims have numerical goals and target dates	2e							
There are clearly defined, measurable indicators	3a	Met	Met	Met	Met	Met	Partially Met	Partially Met
Indicators measure changes in health/functional status, satisfaction or care processes	3b	Met	Met	Met	Met	Met	Met	Met
• if BCAP, project contains overall outcome measure(s)	3c							
• if BCAP, project contains typology measures that link to associated aims	3d							
A representative and generalizable study population is identified	4a	Met	Met	Met	Met	Met	Met	Met

Performance Improvement Project Standards	#	Multiple Program Managed Care Organizations						
		Care WI – FC/FCP	Care WI – FCP	CC – FC	CC – FCP/PACE	CC – FCP/PACE	CHP – FC/FCP	CHP - FCP
		Member Centered Plan Timeliness	Falls Improvement	Ensuring standards based assessment of high risk health issues in the developmentally disabled population: pain and gastrointestinal components	Member Pain Assessment	Chart Audit Performance	Electronic Tracking of the RAD Process	Medication Management and Reconciliation
The project/study clearly defines the relevant population	4b	Met	Met	Met	Met	Met	Met	Met
If entire population is used, all enrollees are captured	4c	Partially Met	Met	Partially Met	Met	Met	Partially Met	Partially Met
If entire population is not used, stratified by high-risk, high needs or high utilization	4d							
Valid sampling techniques are used	5a							
Sample(s) contain sufficient number of members	5b					Met		
Clearly defined data and data sources	6a	Met	Met	Met	Met	Met	Met	Met
Qualified staff used to collect data	6b	Met	Met	Not Met	Met	Met	Not Met	Partially Met
Data collection instruments provide for consistent, accurate data collection	6c	Met	Met	Not Met	Met	Met	Met	Not Met
There is a prospective data analysis plan	6d	Met	Met	Not Met	Met	Met	Met	Not Met
Interventions have a good chance of succeeding	7a	Met	Met	Partially Met	Met	Partially Met	Met	Partially Met
PDSA cycles are appropriately applied	7b	Met	Met	Partially Met	Met	Met	Not Met	Not Met
Barriers are identified and addressed	7c	Met	Met	Not Met	Met	Partially Met	Partially Met	Partially Met
Data analysis includes initial and repeat measurements and identifies limitations	8a	Met	Met	Not Met	Met	Partially Met	Partially Met	Partially Met
Numerical findings are accurate and clearly presented	8b	Met	Met	Not Met	Met	Partially Met	Met	Met
Project successes and progress is clearly stated	8c	Partially Met	Met					Partially Met
Follow-up activities (next steps) are clearly defined	8d	Met	Met		Met	Met	Met	Not Met
Baseline and repeat measurements are consistent	9a	Met	Met		Met		Met	Partially Met
Improvements in processes and/or outcomes are documented	9b	Partially Met	Met		Partially Met			Partially Met
Improvements appear to be the result of planned interventions	9c	Not Met	Met					Not Met
Sustained improvement is demonstrated	10a	Partially Met						
Met Findings by MCO		**18 (78.3%)**	**21 (95.5%)**	**6 (35.3%)**	**19 (95%)**	**15 (75%)**	**13 (68.4%)**	**6 (27.25%)**

Performance Improvement Project Standards	#	Multiple Program Managed Care Organizations						
		Care WI – FC/FCP	Care WI – FCP	CC – FC	CC – FCP/PACE	CC – FCP/PACE	CHP – FC/FCP	CHP - FCP
		Member Centered Plan Timeliness	Falls Improvement	Ensuring standards based assessment of high risk health issues in the developmentally disabled population: pain and gastrointestinal components	Member Pain Assessment	Chart Audit Performance	Electronic Tracking of the RAD Process	Medication Management and Reconciliation
Partially Met Findings by MCO		4 (17.4%)	1 (4.5%)	5 (29.4%)	1 (5%)	5 (25%)	4 (21.1%)	10 (45.5%)
Not Met Findings by MCO		1 (4.3%)	0 (0.0%)	6 (35.3%)	0 (0.0%)	0 (0.0%)	2 (10.5%)	6 (27.25%)
N/A Findings by MCO		9	10	15	12	12	13	10

ATTACHMENT 17

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS – FAMILY CARE

The table below lists the indicators associated with the ten standard elements of the review. Some standards or associated indicators may not be applicable depending on the project's phase of implementation at the time of the review.

2009 - 2010 PIP Validation Findings

Performance Improvement Project Standards	#	Family Care Only					
		CCCW	LCD	MCCMO	NB	SFCA	WWC
		Early detection and treatment for members with dementia	Improving members' employment outcomes	Falls prevention	No PIP review – first year as an MCO	Improving the diagnosis and treatment of members with signs and symptoms of depression	Notice of action issuance
Topic based on relevant data	1a	Met	Met	Met		Met	Met
Topic focused on improving outcomes of care for members	1b	Met	Met	Met		Met	Met
Clearly stated study questions, or	2a	Not Met	Met			Not Met	Met
• if BCAP, overall aim is clearly stated and measurable	2b		Met	Partially Met			
• if BCAP overall aim includes numerical goal and target date	2c		Met	Partially Met			
• if BCAP typology aims are clearly stated and measurable	2d		Met	Partially Met			
• if BCAP typology aims have numerical goals and target dates	2e		Met	Partially Met			
There are clearly defined, measurable indicators	3a	Met	Met	Met		Partially Met	Met
Indicators measure changes in health/functional status, satisfaction or care processes	3b	Met	Met	Met		Met	Met
• if BCAP, project contains overall outcome measure(s)	3c		Met	Partially Met			
• if BCAP, project contains typology measures that link to associated aims	3d		Met	Met			
A representative and generalizable study population is identified	4a	Met	Met	Met		Met	Met
The project/study clearly defines the relevant population	4b	Met	Met	Partially Met		Met	N/A
If entire population is used, all enrollees are captured	4c	Met	Met	Not Met		Met	N/A
If entire population is not used, stratified by high-risk, high needs or high utilization	4d		Met				
Valid sampling techniques are used	5a		Met				Partially Met

Performance Improvement Project Standards	#	Family Care Only					
		CCCW	LCD	MCCMO	NB	SFCA	WWC
		Early detection and treatment for members with dementia	Improving members' employment outcomes	Falls prevention	No PIP review – first year as an MCO	Improving the diagnosis and treatment of members with signs and symptoms of depression	Notice of action issuance
Sample(s) contain sufficient number of members	5b		Met				Not Met
Clearly defined data and data sources	6a	Met	Met	Partially Met		Met	Met
Qualified staff used to collect data	6b	Met	Met	Not Met		Met	Met
Data collection instruments provide for consistent, accurate data collection	6c	Met	Met	Partially Met		Partially Met	Met
There is a prospective data analysis plan	6d	Not Met	Met	Not Met		Not Met	Partially Met
Interventions have a good chance of succeeding	7a	Met	Met	Partially Met		Partially Met	Met
PDSA cycles are appropriately applied	7b	Partially Met	Met	Not Met		Met	Partially Met
Barriers are identified and addressed	7c	Met	Met	Not Met		Partially Met	Not Met
Data analysis includes initial and repeat measurements and identifies limitations	8a	Met	Met	Partially Met		Met	Partially Met
Numerical findings are accurate and clearly presented	8b	Not Met	Met	Not Met		Partially Met	Met
Project successes and progress is clearly stated	8c	Met	Met	Partially Met		Partially Met	Met
Follow-up activities (next steps) are clearly defined	8d	Met	Met	Met		Partially Met	Met
Baseline and repeat measurements are consistent	9a	Met	Partially Met	Partially Met		Met	Met
Improvements in processes and/or outcomes are documented	9b	Met	Partially Met	Partially Met		Met	Partially Met
Improvements appear to be the result of planned interventions	9c	Met	Not Met	Partially Met		Not Met	Partially Met
Sustained improvement is demonstrated	10a	Partially Met	Not Met	Partially Met		Not Met	Partially Met
Met Findings by MCO		**18 (78.3%)**	**28 (87.5%)**	**7 (25%)**	*	**12 (52.2%)**	**14 (60.9%)**
Partially Met Findings by MCO		**2 (8.7%)**	**2 (6.25%)**	**15 (53.6%)**	*	**7 (30.4%)**	**7 (30.4%)**
Not Met Findings by MCO		**3 (13%)**	**2 (6.25%)**	**6 (21.4%)**	*	**4 (17.4%)**	**2 (8.7%)**
N/A Findings by MCO		**9**	**0**	**4**	*	**9**	**9**

ATTACHMENT 18

EXECUTIVE SUMMARY
2009 PERFORMANCE MEASURES
FAMILY CARE, FAMILY CARE PARTNERSHIP, AND PACE MANAGED CARE ORGANIZATIONS

PREPARED BY

JULY 7, 2010

External Quality Review Organization	Management and Staff
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EXECUTIVE SUMMARY

INTRODUCTION

For the 2009 contract year, Family Care Managed Care Organizations (MCOs) were required to collect and report information on performance measures. For 2009, these measures were:

- Care management team turnover
- Dental visits (Family Care Partnership and PACE programs only)
- Influenza vaccinations
- Pneumonia vaccinations

It is important that the Department of Health Services (DHS) and the MCOs accurately monitor these performance indicators because high turnover rates would reduce continuity of care for members and insufficient vaccination rates would expose members to avoidable health risks. As a result, DHS requires MCOs to report this information, and directs MetaStar, the Family Care External Quality Review Organization, to validate the performance measures for accuracy and reliability and to provide recommendations to MCOs for the purpose of improving monitoring of performance measures.

REVIEW METHODOLOGY

MetaStar conducts Performance Measure Validation activities based on established procedures approved by DHS. Reviewers are experienced and trained in the use of the tools used to validate the data. The validation process is intended to be a collaborative interaction with the goal of improving the quality of care and services provided to Family Care members.

To validate the immunization data, MetaStar reviewers requested service records of 30 randomly selected members the MCO reported to have received an influenza vaccination and 30 randomly selected members reported to have received a pneumonia vaccination. To validate the dental measure, MetaStar reviewers requested service records of 30 randomly selected members the MCO reported to have had a dental visit. MetaStar also requested the MCO's immunization documentation policies and procedures.

The reviewers checked each member's service record to verify that it clearly documented the appropriate vaccination in the appropriate time period. If the documentation was found, the reviewers considered the MCO's report of that member's vaccination to be valid. If the service record did not clearly record the appropriate vaccination in the appropriate time period, the reviewer considered the MCO's report of that member's vaccination to be invalid. When necessary, the reviewers contacted the MCO to discuss and possibly resolve any issues arising from the validation review.

The tables below summarize the overall statewide rates for care management turnover, influenza, pneumococcal vaccination rates, and dental rates for the MCO's providing the Family Care

benefit and the MCO's operating more than one program: Family Care, Family Care Partnership, and PACE.

CARE MANAGEMENT TEAM TURNOVER RATES

Each MCO submitted care management team turnover rates. Care management team turnover was reported by the MCOs as a percent of care management team members who separated during the measurement year (2009).

Care Management Team Turnover Rates Summary: Family Care Partnership and Pace

MCOs	Turnover Rate Social Service Coordinators	Turnover Rate Registered Nurses	Total Turnover Rate
Community Care Family Care Partnership and PACE Programs	13.0%	9.1%	10.7%
Care Wisconsin Family Care and Family Care Partnership Programs	11.0%	18.3%	14.8%
Partnership Health Plan and Community Health Partnership Family Care Programs	1.0%	9.6%	5.2%
Total Turnover Rates	5.9% (11/186)	12.6% (25/198)	9.4% (36/384)

Care Management Team Turnover Rates Summary: Family Care

MCOs	Turnover Rate Social Service Coordinators	Turnover Rate Registered Nurses	Total Turnover Rate
Community Care Family Care	11.7%	14.3%	12.6%
Community Care of Central Wisconsin	2.6%	5.7%	3.8%
Care Wisconsin Family Care	See below*	See below*	See below*
Community Health Partnership Family Care	See below**	See below**	See below**
Lakeland Care District	6.7%	15.4%	10.7%
Milwaukee County Department on Aging	29.0%	31.9%	30.0%)
NorthernBridges	8.2%	12.0%	9.5%
Southwest Family Care Alliance	10.7%	4.5%	8.0%
Western Wisconsin Cares	9.4%	9.1%	9.3%
Total Turnover Rates	6.1% (30/489)	18.1% (56/310)	16.9% (140/826)

*Care Wisconsin reported their social service coordinator and registered nurse turn over rates for the Family Care Program with their Family Care Partnership Plan rates (see rates above).

**CHP reported their social service coordinator and registered nurse turn over rates for the Family Care Program with their Partnership Health Plan Rates (see rates above).

INFLUENZA, PNEUMONIA IMMUNIZATION, AND DENTAL RATES

Each MCO submitted influenza immunization data. Influenza immunization rates were calculated as a percent of the members who received a vaccination between September 1, 2009 and December 31, 2009, and were continuously enrolled during the same period.

Each MCO submitted pneumococcal immunization data. Pneumococcal immunization rates were calculated as a percent of the members who received a vaccination between January 1, 1999 and December 31, 2009, and were continuously enrolled from July 1, 2009 through December 31, 2009; or were over 65 years old at the end of the measurement period, and received at least one pneumococcal vaccination on or after their 65th birthday.

Each Family Care Partnership and PACE MCO submitted dental data. Dental rates were calculated as a percent of MCO members who had a dental visit during 2009.

Statewide Family Care by target group

Target Group	Influenza Vaccination Rate	Pneumonia Vaccination Rate
Frail Elderly	61.8%	54.1%
With Physical Disabilities	59.6%	60.5%
With Developmental Disabilities	50.2%)	26.6%
With Unspecified Disability	49.5%	49.3%
All Target Groups	56.4% (13,161/23,315)	45.6% (9,771/21,418)

Statewide Family Care MCOs

Family Care MCOs	Influenza Vaccination Rate	Pneumonia Vaccination Rate
Community Care	54.8%	34.4%
Care Wisconsin	34.4%	31.9%
Community Health Partnership	46.0%	3.2%
Community Care of Central Wisconsin	70.9%	32.6%
Lakeland Care District	68.0%	35.1%
Milwaukee County Department on Aging	71.4%	72.1%
NorthernBridges	15.3%	21.0%
Southwest Family Care Alliance	54.7%	39.8%
Western Wisconsin Cares	56.7%	52.3%
All Family Care MCOs	56.4% (13,161/23,315)	45.6% (9,771/21,418)

Statewide Family Care Partnership by target group

Target Group	Influenza Vaccination Rate	Pneumonia Vaccination Rate	Dental Rates
Frail Elderly	74.6%	64.9%	47.0%
With Physical Disabilities	69.8%	58.2%	54.2%
With Developmental Disabilities	72.6%	34.2%	59.7%
With Unspecified Disability	62.9%	60.0%	57.7%
All Target Groups	72.1% (2,346/3,254)	57.1% (1,761/3,083)	52.0% (1,777/3,419)

Statewide Family Care Partnership MCOs

Family Care Partnership MCOs	Influenza Vaccination Rate	Pneumonia Vaccination Rate	Dental Rates
Care Wisconsin	63.2%	64.9%	54.5%
Community Care	77.0%	81.0%%	44.4%
Partnership Health Plan	76.4%	49.5%	51.6%
All Family Care Partnership MCOs	72.1%(2,346/3,254)	57.1%(1,761/3,083)	52.0%(1,777/3,419)

Community Care PACE

Target Group	Influenza Vaccination Rate	Pneumonia Vaccination Rate	Dental Rates
Frail Elderly	84.7%	88.8%	63.7%
With Physical Disabilities	81.3%	89.5%	65.1%
With Developmental Disabilities	93.1%	91.2%	71.4%
With Unspecified Disability	75.0%	100%	33.3%
All Target Groups	83.3% (695/834)	89.4% (722/808)	64.5% (574/890)

SUMMARY OF RECOMMENDATIONS

- Standardize data collection processes to ensure accurate rate calculations. For example, when documenting dates for the performance measures (influenza, pneumococcal, and dental), only include dates (ideally in a format of month, day, and year) that the member received the immunization or went to the dentist in a single data field; do not include dates of refusal, or contraindications. Separate data collection fields should be used to capture refusal dates and contraindications.
- Ensure MCI numbers are used during data collection processes.
- Review DHS instruction regarding the use of the Wisconsin Immunization Registry (WIR) system; a resource that can be used to confirm self-reports of vaccination dates.
- Review MCO documentation policies or guidelines with care management staff to ensure performance measures information is being collected, documented, and reported consistently within contract specified timeframes and within contract specifications for each performance measure.

ATTACHMENT 19

2009 INFORMATION SYSTEMS CAPABILITIES EVALUATION REPORT

PREPARED FOR

NORTHERNBRIDGES

PREPARED BY

NOVEMBER 13, 2009

External Quality Review Organization	Management and Staff
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OVERVIEW

MetaStar reviewers use the Information System Capabilities Assessment (ISCA) tool MetaStar reviewers utilize to collect information about the effect of Family Care Managed Care Organization (MCO) information management practices on Wisconsin Department of Health Services (DHS) FCP encounter data submission.

This ISCA was based on the CMS Protocol *"Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs)"*, Appendix Z: *"Information Systems Capabilities Assessment (ISCA) for Managed Care Organizations."*

Federal regulations and NorthernBridges' contract with DHS demarcate the MCO's information system (IS) requirements.

42CFR §438.242: HEALTH INFORMATION SYSTEMS

General rule: The State must ensure through its contracts that each MCO and Prepaid Inpatient Health Plan (PIHP) 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 disenrollments for other than loss of Medicaid eligibility.

(a) **Basic elements of a health information system:** The State must require, at a minimum, that each MCO and PIHP comply with the following:

1. Collect data on member and provider characteristics as specified by the State, and on services furnished to members through an encounter data system or other methods as may be specified by the State.

2. Ensure that data received from providers is accurate and complete by--

i. Verifying the accuracy and timeliness of reported data;

ii. Screening the data for completeness, logic, and consistency; and

iii. Collecting service information in standardized formats to the extent feasible and appropriate.

3. Make all collected data available to the State and to CMS, as required in this subpart.

I. Reports and Data

A. Management Information System (MIS)

1. *MIS Requirements*

The MCO shall meet all of the reporting requirements as specified in this contract in a timely way, assure the accuracy and completeness of the data, and submit the reports/data in a timely manner. Data submitted to DHS shall be supported by records available for inspection or audit by DHS. The MCO must be able to submit data and/or reports to DHS, or receive data and/or reports from DHS in a secure format. The MCO shall designate a contact person responsible for data reporting who is available to answer questions from DHS and resolve any issues regarding reporting requirements. The Chief Executive Officer or his/her designated person must certify the encounter data.

The MCO's Management Information System (MIS) shall be sufficient to support quality assurance/quality improvement requirements described in Article VI., *MCO Functions: Quality Assurance/Quality Improvement (QA/QI).*

2. *Claims Processing*

The MCO shall have a claims processing system which meets the specifications of Article V.C. (3), *Thirty Day Payment Requirement*, and (4), *Claims Retrieval System*.

3. *Encounter Reports*

For reporting periods during the [calendar] year, the MCO shall report member-specific data on the Long-Term Care Encounter Data system as directed by DHS. MCO staff will participate in the planning and development of data reporting requirements for implementation during the term of this contract consistent with all HIPAA requirements applicable to the MCO. This participation will include attending workgroup meetings, addressing necessary changes to local applications or databases, and cooperating with DHS on data submission protocol and testing.

Prior to the effective date of this contract for the [calendar] year, the MCO shall demonstrate it has the ability to:

a. Analyze, integrate and report data;

b. Capture and maintain a member level record of all services in the LTC benefit package provided to members by the MCO and its providers, in a computerized data base adequate to meet the reporting requirements of the contract;

c. Monitor enrollment and disenrollment, in order to determine which members are enrolled or have disenrolled from the MCO on any specific day;

d. Collect and accurately produce data, reports, and member histories including, but not limited to, member and provider characteristics, encounter data, utilization, disenrollments, solvency, member and provider appeals and grievances which satisfies the reporting requirements identified under B., *Reports: Regular Interval* and C., *Reports: As Needed* of this Article; and,

e. Ensure that data received from providers, and reported to DHS, is timely, accurate and complete, by:

i. Verifying the accuracy and timeliness of reported data;

ii. Screening the data for completeness, logic, and consistency;

iii. Collecting information on services in standardized HIPAA-compliant formats, such as the HCFA 1500 or UB92 format, or other uniform format, to the extent possible; and,

iv. Recording and tracking all services with a unique member identification number (the Medicaid ID number shall be recorded for all members who are Medicaid recipients or are eligible for the program under Family Care non-MA).

4. *Encounter Data Format*

The MCO shall report member-specific data to DHS in an encounter-data format specified by DHS and according to any HIPAA deadlines, standards and requirements applicable to the MCO. The specifications and HIPAA deadlines, standards and requirements are identified in documents found on the DHS Family Care website at:

https://www.wisconsinedi.org/MCOencounter/secureLogin.html

The MCO shall meet certification standards that demonstrate it has the ability to meet DHS reporting requirements in the formats and timelines prescribed by DHS. The MCO will provide data extracts, as necessary, for testing the reporting processes and will assist with and participate in the testing processes. The Department will provide MCOs with reasonable

advance notice of required changes to encounter reporting standards, formats and MIS capacity necessary to meet federal and state requirements.

REVIEW METHODS

MetaStar used a combination of activities to conduct and complete the review. DHS requires all MCOs serving Family Care members to complete the ISCA as a component of the Protocol 1, *"Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs),"* Protocol 2, *"Validating Performance Measures,"* and Protocol 4, *"Validating Encounter Data"* of the External Quality Review (EQR).

Some States, including Wisconsin, assess the capabilities of the MCO's IS as part of pre-contracting, contract compliance, or contract renewal activities. MCOs may not need to repeat this assessment process if the State completed an assessment through private sector accreditation or performance measures validation and gathered information that was the same as or consistent with ISCA requirements. The State or the MCO must make information from a previously conducted assessment available to the EQRO reviewers. Because NorthernBridges had not completed an IS assessment that included all of the elements found in the Protocols, it was subject to undergo all ISCA activities for this review.

In addition to completing the ISCA tool, MetaStar asked the MCOs to submit documentation specific to their IS and operations used to collect, process and report their Family Care claim and encounter data.

MetaStar's ISCA review evaluates each of the following areas within an MCO's IS and business operations:

- **Section I:** General Information
- **Section II:** Information Systems – Encounter Data Flow
- **Section III:** Encounter Data Collection
- **Section IV:** Eligibility/Enrollment Data Processing
- **Section V:** Practitioner Data Processing
- **Section VI:** Vendor/Ancillary/Medical Record Data Collection
- **Section VII:** System Security
- **Section VIII:** Vendor Oversight
- **Section IX:** Requested Attachments for Desk Review

The purpose of this evaluation was for MetaStar reviewers to assess the extent to which each MCO's information system is capable of producing valid encounter data and other data necessary to support quality assessment and improvement manage the care it delivers to its members. The scope of the evaluation included information regarding:

- The MCO's data collection systems used to support the clinical and administrative operations of the MCO, specifically the data it routinely collects to support the MCO's utilization management, grievance systems, and enrollment services.

- The MCO's processes to obtain data from the various resources that impact the MCO's information system (e.g., interdisciplinary teams, vendors and providers, DHS-provided reports derived from the CARES eligibility determination system, and the Medicaid Management Information System [MMIS] provided by the DHS Division of Health Care Access and Accountability and its vendor, EDS), and the extent to which the MCO requires and receives data in standardized formats.
- How the MCO collects and integrates member and provider data across all components of its network and how the MCO uses these data to produce comprehensive reports regarding member needs and service utilization and otherwise support their management processes.

A MetaStar reviewer visited the MCO to perform staff interviews and to observe live demonstrations of the MCOs' systems to:

- Verify the information submitted by the MCO in their completed ISCA tool and related documentation,
- Verify the structure and functionality of the MCO's IS and operations,
- Obtain additional clarification and information as needed,
- Inform DHS of any issues that might require technical assistance.

REVIEW FINDINGS AND REPORTS

The MetaStar reviewer provided her preliminary review findings to each MCO during the exit conference for the on-site visit. Where possible, the MCO provided a response to each finding at that time.

MetaStar sent a preliminary report summarizing its findings within one month of the on-site date. Each MCO had an opportunity to share its comments and feedback about its report before MetaStar finalized the report and sent it to DHS.

Any further action regarding outstanding issues pertaining to areas where MetaStar made recommendations or requested follow-up action is to be determined and monitored by the DHS/OFCE.

MCO Information and On-Site Visit Date

Description	MCO Information
MCO Review Coordinator	Jason Kohl Manager, Technology Services
Site Visit Date	November 3, 2009
Site Visit Location	NorthernBridges 15954 Rivers Edge Drive, #300 Hayward, WI 54843

MetaStar Review Team Composition

Reviewer	Role
Debra Morse, MPA, CPHQ, CHCA Information Systems Capabilities Assessment Lead	Lead reviewer. Reviewed documentation, participated in, and coordinated the ISCA evaluation review. Prepared the final review report

SUMMARIZED REVIEW FINDINGS

The following is a summary of MetaStar's 2009 IS Capabilities evaluation results for NorthernBridges.

MCO STRENGTHS

ENROLLMENT PROCESSES & DATA

- NorthernBridges member enrollment process is thorough and managed by knowledgeable staff.

PROVIDER DATA

- Before entering any provider data into Vestica's, the third party administrator's (TPA's), Enterprise System, NorthernBridges has a thorough process to gather and verify all provider data.

CLAIMS PROCESSING

- Vestica offers an Internet application, Web Claim Entry, which allows providers to complete online claim forms for Family Care professional (non-residential) services.

- When it's ISCA occurred NorthernBridges offered Family Care services to members for six months, and Vestica processed claims for five months. Because it was still in a start-up phase, NorthernBridges made a management decision to turn off the edit that requires providers to submit claims within ninety days of providing a service or item. Because the last roll-out to three counties occurred in August 2009, in November 2009 NorthernBridges management will assess providers' success with submitting timely claims. NorthernBridges works extensively with its providers to ensure they can submit accurate claims in a timely manner.

- For claims processing NorthernBridges does not use nonstandard codes including DHS SPC codes. The MCO uses HIPAA compliant codes for every authorization and claim. Because it does not use internally developed codes, it eliminates the opportunity for manual error when converting the internal codes to standard codes. Compared to SPC codes HIPAA codes more accurately describe the service the MCO provided to the member. The use of HIPAA codes allows NorthernBridges to perform more detailed service utilization analysis than would be possible with SPC codes.

- Using HIPAA compliant codes also helps with claims adjudication. NorthernBridges puts the provider's service authorization information, including the HIPAA codes and appropriate modifiers, in the provider's contract letter. The provider's claim must contain one of these HIPAA codes and no others to be paid. This provides a highly streamlined claim adjudication process.

- NorthernBridges compares its claims and encounter data to its financial data for a complete match twice monthly, a benefit over some MCOs which perform a complete finance / claim tie-out only once per month.

- NorthernBridges excels in educating its providers to submit accurate and timely claims. Between April and August 2009 it held eleven training sessions, one in each county it serve, to orient providers to the Family Care program and to submit claims. Prior to each session NorthernBridges mailed the participants it's billing training handbook, billing Frequently Asked Questions, its "Tips for Clean Claims" handout. In October 2009 NorthernBridges sent these materials to all 900 of its contracted providers in addition to instructions for electronic billing, who to call at NorthernBridges for assistance, hub office telephone numbers and the team leader names at each hub office.

- A team at Vestica works with providers who wish to bill through Vestica's Web Claim Entry form.

ENCOUNTER DATA INTEGRATION & SUBMISSION

- Vestica derives SPC codes for encounter reporting and reports both SPC and HIPAA compliant codes in the monthly encounter data submission.

- During the MCO's start-up phase Vestica submitted encounter data test files to the DHS encounter data submission application. Vestica ensured it was able to create accurate encounter data files through their Enterprise System. Vestica grouped institutional, residential and provider claims with adjustments in multiple iterations to ensure accuracy. They also tested certification and member transaction files.

- In the five months it submitted encounter data files before its ISCA, NorthernBridges encounter data were rejected at the following rates. NorthernBridges verified that all service line rejections were because one provider refused to obtain an NPI number.
  - May 2009 – 0% rejected
  - June 2009 – 0% rejected
  - July 2009 – 0.1% rejected, 12 out of 12,293 service lines
  - August 2009 – 0.05% rejected, 9 out of 17,175 service lines
  - September 2009 – 0.05% rejected, 13 out of 25,618 service lines

System Security

- Information system security processes at NorthernBridges and Vestica related to data backup, physical computer security, network access, and disaster recovery planning are robust and well-documented.

MCO Opportunities for Improvement / Recommendations

The MCO should strive to employ one source of entry for data to cascade throughout its enrollment and provider data systems.

Enrollment Processes & Data

- Continue working with Wonderbox, Vestica's IS vendor, to create custom enrollment data reports in Vestica's Enterprise System.

- Require Vestica to add more fields to the Enterprise System enrollment module so NorthernBridges' staff do not need to maintain duplicate data files that contain additional fields they use that not available currently in the Vestica system.

Provider Data

- NorthernBridges sends its provider spreadsheet to Vestica. Rather than upload it electronically, Vestica processors manually enter provider data into the Enterprise System. Because NorthernBridges and Vestica do not have a mechanism in place to verify whether the manual entry of provider data was done correctly at the time of the data entry, NorthernBridges discovers errors in provider data entry once a provider notifies NorthernBridges that it received an incorrectly paid claim or other communication. NorthernBridges should be proactive, not reactive, by implementing systems to catch data errors prior to claims processing and provider payment.

- Similarly, NorthernBridges spends a lot of time doing exception reporting on provider data. For example, if Vestica entered an incorrect code on a provider's rate schedule, NorthernBridges, not Vestica, remedies the situation. Often NorthernBridges must go into its care management system to see if the rate and code are correct there. Again, a proactive method to identify code entry errors, or finding a way for the care management system to interface with the Enterprise System, will benefit NorthernBridges and reduce the resources it uses to do back-end clean up.

- NorthernBridges should consider:

- Putting more edits into a pre-emptive pre-claims system for a proactive data auditing approach rather than catching data entry errors during its check cutting cycles.

- Requiring audits of all data entry performed by Vestica staff, including the manual entry of the information in the provider spreadsheets.

- Discussing with other MCOs the systems and strategies they employ to ensure pre-claims and manual entry data accuracy in-house or by their TPAs.

CLAIMS PROCESSING

- NorthernBridges should instruct Vestica to add an online Residential Services claim form to offer the same easy option for its residential providers to submit claims.

ADDITIONAL CONSIDERATIONS FOR DHS

- Because NorthernBridges and other MCOs use industry-standard HIPAA compliant codes in their service authorization and claims processing systems, other than being provided the SPC crosswalk, they does not have additional DHS resources available to assist it. In fact, DHS BITS staff encouraged NorthernBridges to employ package coding, which NorthernBridges found to be unacceptable because of its lack of detail. NorthernBridges anticipates the hiring of a coding specialist in OFCE to assist with questions related to the relationship between HIPAA compliant codes and SPC codes.