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 2010-2011

PREPARED FOR

WISCONSIN DEPARTMENT OF HEALTH SERVICES

PREPARED BY

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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), 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 only 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 (*i*Care)	FCP
*Lakeland Care District (LCD)	FC
Milwaukee County Department of Family Care (MCDFC), formerly known as Milwaukee County Care Management Organization	FC
NorthernBridges (NB)	FC
Southwest Family Care Alliance (SFCA)	FC
Western Wisconsin Cares (WWC)	FC

* Generally, the External Quality Review Organization conducts mandatory external quality reviews for MCO programs that have served members for at least one year, per its contract with DHS. Therefore, FY 10-11 review activities for three MCOs excluded some expansion areas where FC and/or FCP programs had been operating for less than one year.

The Code of Federal Regulations (CFR) at 42 CFR 438 requires states that operate PIHPS 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., (MetaStar) 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, 2010, to June 30, 2011 (FY 10-11).

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

Based in Madison, Wisconsin, MetaStar has been a leader in health care quality improvement, independent quality review services, and medical information management for more than 35 years, and is the 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, a physical therapist, licensed social workers, and 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.

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

In mid-1990 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 Long-Term Care Expansion

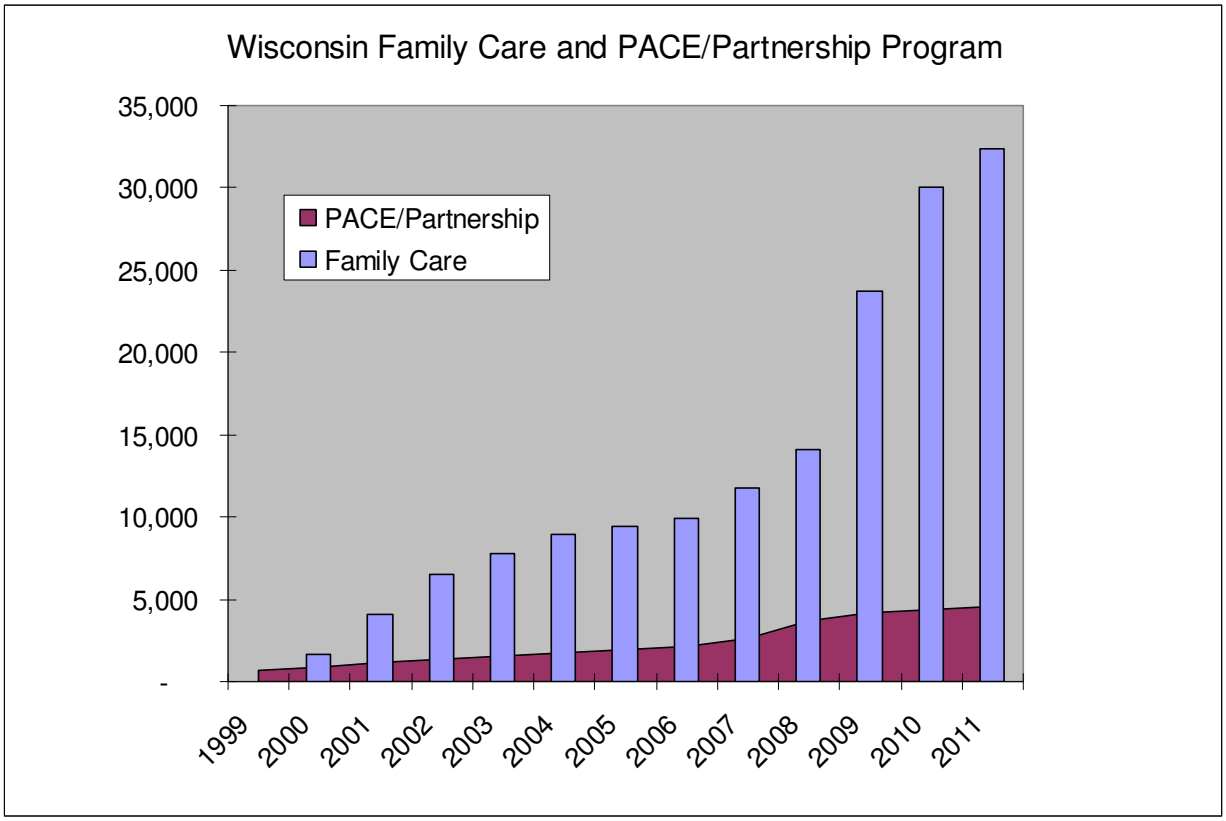
In 2005, an independent evaluation of FC found that MCOs were providing quality care to members at substantial savings to Wisconsin's Medicaid program. In 2006, Governor Jim Doyle announced plans to expand FC statewide over five years. FC expansion began in 2007 and continued through FY 10-11. During FY 10-11, three MCOs (CC, CCCW, LCD) expanded FC into a total of four counties, and one of those MCOs (CC) also expanded FCP into one county. Currently, FC is available in 57 of 72 (79%) Wisconsin counties, while FCP is available in 19 of 72 (26%) counties. PACE is available in Milwaukee and Waukesha Counties.

Visit the following website to view a map depicting the FC and FCP service areas (under the General Information tab):

http://www.dhs.wisconsin.gov/familycare/mcos/index.htm

Total enrollment as of June 30, 2011, for all programs was 36,966. The following table, based on information from the DHS website cited below, depicts the census growth of FC, FCP and PACE over time.

CENSUS GROWTH OVER TIME



For a current monthly snapshot of FC, FCP, and PACE enrollment data, including enrollment by program and target group, visit the following DHS website:

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

In July 2010, Wisconsin's Legislative Audit Bureau (LAB) was directed by the State Legislature to complete a comprehensive evaluation of the Family Care program. A report of the findings along with a series of questions and recommendations was published in April 2011. LAB's findings indicated Family Care has improved access to long-term care, ensured comprehensive care planning, and provided choices tailored to participants' individual needs.

However, LAB was unable to definitively determine the program's cost effectiveness at this time. The LAB report can be found on the following website:

http://legis.wisconsin.gov/lab/audit-reports/

Slowing the Growth of Community Based Long-Term Care Programs

In early 2011, Governor Scott Walker's 2011-2013 proposed biennial budget included a "cap" on the number of people allowed to enroll in the FC, FCP, and PACE managed long-term care programs. The budget, which was passed by the legislature and signed by the Governor in late June, prohibits DHS from enrolling more people into FC, FCP, and PACE than were participating in these long-term care programs as of July 1, 2011. The budget also includes funding within each year of the biennium to address the urgent needs of people placed on wait lists due to the cap.

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, subpart E. 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. FY 10-11 was a year of targeted review for every MCO except *i*Care. The FCP program operated by *i*Care in Milwaukee County began in January 2010; therefore, FY 10-11 was this MCO's initial review year and a comprehensive review was conducted.

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 FY 10-11, the EQR team conducted performance measures validation for every MCO and every program (FC, FCP, PACE). DHS did not request MetaStar to conduct any ISCAs during FY 10-11.

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 FY 10-11, 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 2 shows the FY 10-11 QCR areas of focus for each MCO, based on FY 09-10 findings. It should be noted that while there were designated focus areas, review results show findings from all areas and also reflect measures that were "met" in each MCO's most recent comprehensive review or in the first year of focused review. Results from each MCO's FY 10-11 QCR are documented in the appendix section of each MCO's annual quality report and can be found in Attachments 3 through 12 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) 2011, and evaluation of its CY 2009 or 2010 quality program activities, in order to identify how the organization approached and addressed the quality improvement recommendations identified during the FY 09-10 annual quality review, and to ensure compliance with DHS requirements for quality management not addressed in DHS annual certification activities.

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

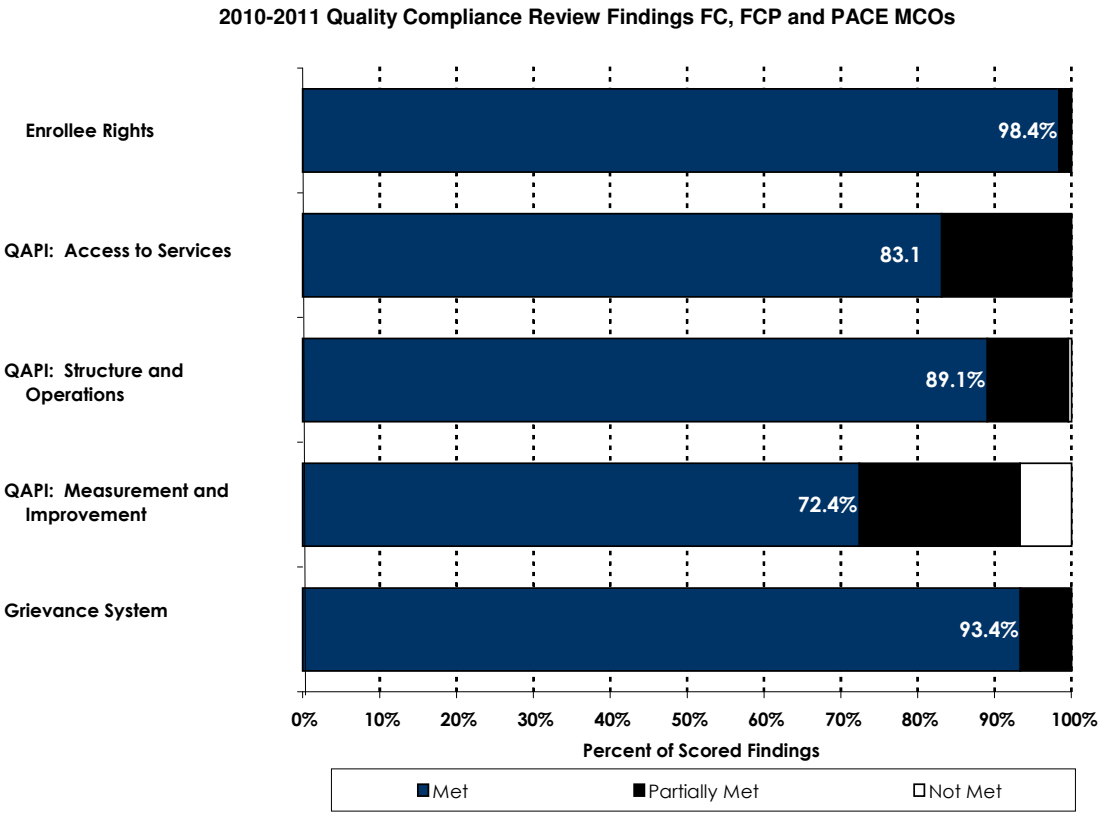
- The 2010 and 2011 Family Care program(s) contracts between DHS and the MCO;
- Related program operation references found on the DHS website:
  - http://dhs.wisconsin.gov/LTCare/ProgramOps/Index.htm;
- The EQRO's report detailing results of the MCO's annual quality review for FY 09-10; and
- The DHS memo to the MCO, which addressed the follow-up required in relation to the FY 09-10 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 and 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 specific 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 FY 10-11, expressed in terms of the percentage of met, partially met, and not met scores for each of the five review topic areas.



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 a 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, MetaStar 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 and 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 EQRO 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 (yes or no) to rate the MCO's performance for each measure evaluated. For findings of "no," 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.

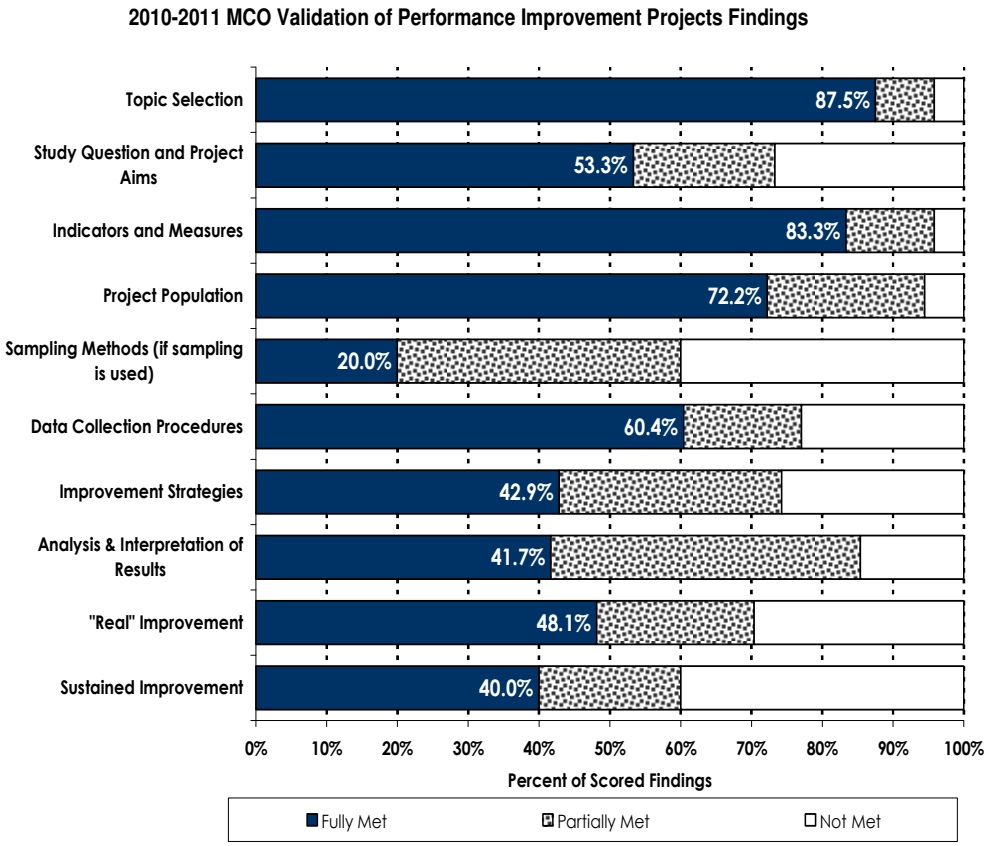
To evaluate the standard elements of a PIP, the EQR team used the methodology described in CMS' guide, *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities*, and the *Medicaid Managed Care Performance Improvement Project: Project Evaluation 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 FY 10-11, 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, MetaStar 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 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 the DHS-MCO contract. 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 FY 10-11, the EQR team validated performance measures that related to health:

- Influenza vaccinations
- Pneumonia vaccinations

For two additional performance measures, one related to continuity of care management and the other to dental visits, the EQRO collected information from the MCOs and delivered it to DHS. DHS did not direct the EQRO to validate these measures.

Immunization Measures

Influenza vaccination rates were calculated by target group as the percent of MCO members whose service record contained documentation of having received a seasonal influenza vaccine from September 1, 2010, through December 31, 2010, out of the total members continuously enrolled during the measurement period. The percent of members who received a specialty vaccination (e.g., H1N1) were not included in the measure.

Pneumonia vaccination rates were calculated by target group as the percent of MCO members whose service record contained documentation of having had a pneumovax immunization within the last ten years (2001 - 2010), out of the total members continuously enrolled from July 1, 2010, through December 31, 2010. For members in the frail elder target group, one vaccine administered at age 65 years or later counted as having had a pneumovax within the measurement period.

Use of data

Each MCO submitted spreadsheets to MetaStar containing data regarding influenza and pneumonia immunizations 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 rates, the EQR team requested 30 randomly selected member records for each of the performance measures.

Reviewers checked each 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 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. 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 rates.

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.

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

ORGANIZATION OF THE REMAINDER OF THE REPORT

The Summary of Findings that follows provides information regarding general themes and overall findings across MCOs identified during the FY 10-11 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, MetaStar 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.

FY 10-11 findings regarding PIPs and performance measures validation 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 FY 10-11 annual quality review can be found in Attachments 3 through 12, while MCO comparative information is contained in Attachments 13 through 16. The results of performance measures validation can be found in Attachment 17.

Summary of Findings

Summary of Compliance with Standards (QCR and CMR)

Access to Care

One of the primary goals of the 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 social service and health care professionals assigned to their IDT, use the 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, although there is opportunity across MCOs to improve consistency of care management practice. Access 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 FY 09-10 review, the FY 10-11 QCR focused on measures such as assessing and addressing risk, monitoring the level of face-to-face contacts with members, restrictive measures monitoring, provider network directory, monitoring the ability of providers to ensure timely access to services, follow-up to assure services have been received and are effective, ensuring that MCOs do not use providers that have been excluded from participating in federal health care programs, and employee and provider background checks monitoring. The CMR assessed care management practice, including areas related to access to care, such as service authorization decision making using the RAD, and assessing and addressing risk.

Assessing and Addressing Risk

For FY 10-11, assessing and addressing member risk continues to be a notable area of strength across MCOs. QCR results show that nearly every MCO scored "met" for this area. The CMR supported the QCR finding. Results of record reviews indicated that, across MCOs, IDTs are effective in assessing and addressing risk. While one MCO (CCCW) received a partially met score for this measure, this MCO also made progress over the past year by providing its IDT staff with additional training regarding risk, and by implementing a depression risk screen and a risk reduction guideline. However, the MCO needs to develop a process for monitoring the use and effectiveness of these tools.

Similar to results in FY 09-10, no members with immediate health and safety issues were identified during annual quality reviews in FY 10-11. During the course of the review year, among the total of 658 records reviewed, the EQR team found 18 records of members with complex situations involving medical, mental health, cultural, behavioral, and/or social issues.

All of these members were promptly referred to DHS for further follow up. While this may appear to be a substantial increase over the previous year when six members were brought to the attention of DHS, the increase is related to a change in MetaStar's practice where members with complex and concerning situations are referred prior to the time issues may rise to the level of immediate health and safety, so that DHS can actively engage and provide any needed guidance or support. In January 2011, DHS and MetaStar collaborated to identify a more efficient and effective means to monitor and track these referrals and began using DHS' secure communication system, SharePoint, for such purposes. Of the 13 referrals made using this new method, DHS had concluded its review on all but three as of the end of the fiscal year.

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;
- Standard assessment and specialty screening tools (e.g., depression scale, memory screen, falls assessment) 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
- Risk reduction guidelines, risk agreements, and other organizational policies, procedures, and tools related to assessing and addressing member risk.

In response to pre-onsite surveys, staff from every MCO reported having received some level of training from DHS related to risk over the past year, or from internal or other external resources, on topics such as assessing risk, risk agreements, behavior support plans, use of restraints and restrictive measures, client rights, abuse/neglect/financial exploitation, suicide prevention, and motivational interviewing. IDTs reported receiving training through a variety of approaches, including formal and in-service training events, regular staff meetings, peer mentors, and supervisor guidance. DHS supported training efforts by offering "Family Care Core Training" and "Phase II Care Management Training" to interested MCOs. The Core Training educates staff about key Family Care concepts such as member outcomes, the RAD method, and assessing and addressing risk. The Phase II training provides technical assistance and guidance regarding real case examples of members selected by the MCO. Nine hundred care management staff representing seven MCOs (CCCW, CW, LCD, MCDFC, NB, SFCA,WWC) took advantage of these training opportunities during 2010.

Reviewers found that, across MCOs, IDTs respect members' choices and their right to engage in risks while providing education about the potential consequences of the risks. IDTs re-visit areas of risk frequently with members and provide consistent education to help ensure members have the information they need to make informed decisions. Some IDTs individualize their approach to addressing risk. Others approach risk with the goal of reducing harm and engaging members without making judgments regarding their choices or actions. Reviewers noted that IDTs often seek information from a variety of sources (e.g., family members, guardians, medical providers, residential and home care providers) when assessing the presence of risk.

Instances of ongoing communication and collaboration with providers to facilitate care for members with complex conditions and behaviors were also found. In on-site interviews, IDTs also reported the value of communication and collaboration within and among teams as well as across their organization's care management units (CMUs). They described how they seek and share information with one another about successful strategies and useful resources, both through impromptu conversations and structured venues.

Notable progress was made by one MCO (CCCW), which changed its policy for contingency planning to require back-up plans for *all* members regardless of their living situation. Plans must document members' critical services and equipment needs as well as the alternative providers or supports, both formal and informal, needed to assure members' health and safety in the event that primary supports fail. This was cited as a "Best Practice" in CCCW's annual quality review. CCCW also implemented a *Risk Reduction Worksheet*, which considers members' decisional capacities, cultural values, societal norms, and emotional reasons for engaging in risks, and facilitates exploration of options for addressing the risks from both the member and the IDT perspective.

Progress was also made by another MCO (CW), which developed a "crisis house" within its provider network, providing IDTs with a resource for members who are at risk of losing their community placements due to challenging and/or dangerous behaviors.

At the time of its last annual quality review, another MCO (MCDFC) had just implemented new social and health assessment worksheets in its electronic care management system, *MIDAS*. Reviewers found that, over the past year, use of the worksheets has prompted teams to collect a variety of objective and subjective data to help in assessing members and identifying risks. The worksheets are discipline-specific, and guide social workers and nurses to take a comprehensive approach to exploring for potential health and safety concerns. They also help teams determine whether additional screening tools (e.g., Animal Naming Tool, Geriatric Depression Scale) should be completed.

While assessing and addressing member risk is an area of strength, the review also identified opportunities for improvement. The CMR found that IDTs at some MCOs (CW, NB) find it challenging to immediately assess and address risks and talked about getting to know members and building relationships before asking difficult questions or exploring sensitive issues. While building rapport with members is desirable and important, recommendations made to these MCOs by MetaStar included the need to provide training and support for teams to ensure that identifying member risks or taking action to address risks is not delayed.

Every MCO also needs to improve in the consistency of care management practice related to assessing, addressing, and/or documenting risk. For example, some MCOs (CCCW, CW, *i*Care, NB) need to support IDTs to assess risk in a manner that systematically and consistently explores the causes, contributing factors, and reasons members are engaging in risks. Other MCOs (CC, CHP, LCD, MCDFC, NB, SFCA,WWC) need to ensure that IDTs understand their responsibilities to manage member risk proactively and consistently. MetaStar made recommendations such as:

- IDTs need to take an active role in assessing and managing member risks even when other formal services are in place, such as residential services;
- MCOs must ensure all teams have adequate training and resources to proactively address mental health and behavioral health concerns;
- IDTs must be actively engaged in developing behavior support plans; coordinating plans with all parties involved; and regularly monitoring plans for effectiveness and ongoing need.

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 FY 10-11, nine of ten MCOs met the requirement to have an effective process for monitoring compliance regarding face-to-face contacts. Similar to last year's findings, one MCO (NB) received a partially met score, as it does not have a method in place to ensure teams are complying with this requirement.

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. However, in pre-onsite surveys and during on-site interviews, IDTs across MCOs expressed concerns about a variety of issues that negatively impact care management practice and their ability to spend time with members, including paperwork and reporting demands, system and process inefficiencies, and team structures or assignments that they believe result in high caseloads and excessive travel time. The annual quality reviews of several MCOs (CC, CHP, CW, MCDFC, NB, WWC) noted these types of concerns and included recommendations such as: review and evaluate systems, processes, and practices to identify barriers and inefficiencies and implement improvements; and engage care management staff in identifying and addressing barriers.

Member Rights

Another area of strength across MCOs relates to the requirement that MCOs have a written policy regarding member rights. For FY 10-11, nine of ten MCOs met this requirement. This represents progress for one MCO (NB), which moved from a score of partially met in FY 09-10 to a score of met for this year's review. During the past year, NB documented its member rights policy, and reviewers identified that its IDTs routinely discuss rights and responsibilities with members. One MCO (*i*Care), in its first year of operating a FCP program, received a not met score for this measure. The MCO has not yet developed a policy or procedure regarding the obligation to ensure members are aware of their rights. The need to develop and implement a member rights policy was among the recommendations made to *i*Care.

Another strength related to member rights identified across MCOs is 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. FY 10-11 QCR results show that nine of ten MCOs received a score of met for this area. Similar to last year's review, one MCO (NB) received a partially met score. While NB made progress over the past year by providing staff training and by developing a tracking system for securing DHS approval of restraints, recommendations provided to NB included the need to develop a plan for the periodic review of approved restraints through routine care management assessment activities that evaluate the continued appropriateness of any restraints or restrictive measures.

Access to Services and Providers

A notable area of strength evaluated under standards for enrollee rights, but also related to access to care regards the requirement that MCOs provide information to all enrollees about the names, locations, telephone numbers, and non-English languages of current contract providers. Every MCO met requirements related to the provider network directory. This represents progress for three MCOs (CCCW, MCDFC, NB), which moved from scores of partially met in last year's review to scores of met for FY 10-11. Over the past year, CCCW updated its provider directory to include the non-English languages spoken by providers and made the directory available online. CCCW then sent post cards to all its members announcing the availability of the online directory and provided a phone number to call for members who wanted a paper copy. At the time of its annual quality review, the organization's IDTs were following up with members. MCDFC also updated its provider network directory to include information about the non-English languages spoken by providers and offered a copy of the directory to all members. While NB met the requirements for this measure, reviewers recommended that the MCO work with DHS to determine the priorities for collecting other information required for inclusion in the provider network directory such as language capabilities and physical accessibility.

Another area of strength regarding access to providers is four measures related to monitoring the adequacy of the provider network and one measure related to providing access to out-of-network providers. Eight of ten MCOs met requirements for these standards, although in pre-onsite surveys several respondents commented on the need for more availability of specific types of providers, including providers of mental health services, residential providers, and transportation providers. Only two MCOs (*i*Care, NB) did not fully meet the requirements. Similar to the results of its previous annual quality review, NB partially met four of the five measures. Recommendations MetaStar provided to NB included the need to recruit providers to address gaps in its current network and ensure access to all services necessary to meet member outcomes. Participating in its first annual quality review, *i*Care received partially met scores for two of the measures. Both MCOs are working with DHS to address the concerns. Neither MCO has implemented a utilization management approach that provides sufficient data for fully evaluating its network needs or anticipating utilization of services. In addition, for *i*Care, reviewers identified some issues regarding the need to update provider contracts and assure that signed contracts are on file for all providers.

Two additional measures that help ensure access to services are areas of strength: ensuring MCO members have timely access to care and services; and have access to services 24 hours a day, seven days a week when medically necessary. FY 10-11 QCR results show that for each of these measures, eight of ten MCOs received a score of met, while two MCOs (*i*Care, NB) received partially met scores for one or both of these measures.

Similar to the results of its FY 09-10 review, NB received partially met scores for both of the measures. Recommendations included the need to collect sufficient data to conduct effective analysis of its network needs. *i*Care received a partially met for one of the measures. While the MCO has established a process to verify members' timely access to acute and primary care services, it has not yet established a means to monitor members' timely access to care and services provided by long-term care service providers.

An area of opportunity noted in last year's annual report relates to the requirement that MCOs ensure subcontracted entities adhere to DHS contract expectations. One MCO (SFCA) had received a partially met score for this measure, because it needed to implement a mechanism for monitoring the performance of its contracted care management units. The MCO addressed this issue in December 2010 by changing its structure for delivering care management services, ending contracts with county-based care management units and directly employing its care management staff. Thus, SFCA received a score of met for this measure in the FY 10-12 review.

Resource Allocation Decision Method

An area of review where results remain 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 effective and cost-effective options that will meet the identified outcomes.

In record reviews and in interviews with IDTs, MetaStar reviewers saw evidence of progress at some MCOs, including CHP, CC, and SFCA. Here, teams are moving beyond thinking about the RAD as another form to be filled out or requirement to be met, toward a better understanding of the RAD as a decision making process with improved ability to link decisions to member outcomes. MCOs support teams by providing written expectations regarding use and documentation of the RAD, tools and processes to support decision making, RAD training, and other guidance. For example, over the past year two MCOs (CW, CCCW) made progress by revising guidelines and/or tools provided to teams for use of the RAD method and documentation of decision making in member records. Another MCO (*i*Care helped its IDTs begin to think and practice in terms of the RAD by creating RAD posters, which teams placed in their office space to serve as a visual reminder and reference tool. Also, in response to pre-onsite surveys, staff at every MCO reported having received RAD training during the past year. However, some survey responders indicated they would like more training, continuing education, and guidelines, including additional training on the RAD.

In on-site interviews, teams across MCOs talked about steps they take to educate members about the RAD, using both written materials and verbal explanations. Teams at several MCOs indicated they introduce the concept of the RAD early in members' enrollment. For example, WWC added a handout to information packets distributed to all newly enrolled members explaining the seven steps of the RAD. Staff at CHP talked about introducing the RAD during members' initial "meet and greet" sessions. Teams also talked about the different approaches they use to involve members in decision making and ensure they understand the results - from going through the RAD process over the phone when members call with a service request; to bringing a RAD form to members' homes and using it to work through the process; to applying

the RAD method during member-centered plan (MCP) reviews; to reviewing RAD worksheets and related notices of action (NOAs) with members.

Across MCOs, teams described working with members and their supports to identify core issues, discuss potential options, and make cost-effective decisions that meet members' outcomes.

The review also revealed areas of opportunity for improvement across MCOs related to members' service requests as well as the ability of teams to fully integrate the RAD process into their day-to-day practice and accurately document the discussion and decisions. For example, the record review indicated that teams at several MCOs (CC, CHP, *i*Care, LCD, MCDFC, NB, WWC) do not always recognize or respond to member requests. This often occurs, for example, when IDTs divide requests into "types" such as needs versus wants; or requests made by members versus those made by family members or service providers on behalf of members. MetaStar made recommendations such as:

- Educate IDTs about what constitutes a request, and work with IDTs to ensure that all requests are being recognized and responded to;
- Avoid practices that label or categorize requests into certain types;
- Improve IDT documentation of requests in members' records;
- Ensure that IDTs work with members to apply the RAD method to all requests; and
- Conduct related monitoring as part of internal file review processes.

To help support MCOs in this regard, as of the date of this report, DHS was working on guidance related to identifying when a request has been made.

Another area of opportunity identified by MetaStar is the need to ensure IDTs create consistent member involvement throughout the entire RAD process. This is similar to the results reported for the FY 09-10 annual quality review. One of FC's foundational concepts is that each member (or the member's legal guardian or activated power of attorney for health care, if applicable) is a *full partner* on his/her care team and should be involved in every part of the process. The "Being a Full Partner" booklet produced by DHS and provided to all members, explains this concept and the expectation that members will fully participate in identifying their personal outcomes as well as in service planning and decision making using the RAD method. As noted earlier, the "Being a Full Partner" booklet can be found at:

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

FY 10-11 findings indicated that teams at more than half of the MCOs (CC, CHP, CW, MCDFC, NB, WWC) solicit member input and may complete parts of the RAD with the member but then return to the office where final decisions are often made by teams or others at the MCO, or team decisions are reviewed or approved by management prior to authorizing services. This finding was supported by response to pre-onsite surveys, where some IDTs asserted that teams "know the members best," and expressed the desire for more autonomy to make decisions without having to seek input or approval from committees, supervisors, or others.

Recommendations made to these MCOs included the need to align decision making and service authorization practices with DHS expectations regarding involving members throughout the entire RAD process, and to ensure that decisions are made by those closest to, and most knowledgeable about, the members' needs and preferences.

A third area of opportunity identified across MCOs is the need to improve consistency of practice in teams' application and documentation of the RAD decision method.

Recommendations for several MCOs (CC, CHP, CW, WWC) related to this issue and included one or more of the following:

- Ensure consistency of practice in the ability of teams to identify core issues and apply them to members' outcomes;
- Confirm teams consistently explore all options to potentially meet required outcomes and provide members with information about community resources;
- Improve the ability of teams to determine which option is the most effective and cost effective in meeting the desired outcomes; and
- Since the RAD is documented in limited circumstances, expand and improve current systems in order to ensure that all IDTs competently and consistently implement the RAD methodology.

Similar to feedback provided by IDTs in last year's annual quality review, many teams reported that documenting the decision-making process is burdensome, especially when the MCO requires completion of the RAD for every request, including "standard" items that teams feel must be provided to meet members' needs, such as disposable medical supplies for chronic conditions (e.g., diabetic supplies, oxygen, incontinence supplies).

Support for Decision-Making and Service Authorization

Another area of review where results were somewhat mixed relates to the ability of MCOs to provide effective tools and support for IDTs to help facilitate decision making and service authorization and, thus, members' access to care and services. For example, having information readily available about providers, services, service costs, and quality allows for meaningful exploration of options with members and facilitates decision making. Having efficient processes for service authorization ensures members have ready access to needed services. The majority of MCOs (CC, CCCW, CHP, iCare, LCD, MCDFC, SFCA, WWC) exhibited strengths in providing support for decision making and service authorization. For example:

- CC uses an electronic provider database called the *Provider Enterprise System.* This system creates efficiencies for care managers by providing access to a current listing of contracted providers, allowing IDTs to research services and compare costs. The *Provider Enterprise System* was noted as a "Best Practice" in the FY 09-10 annual quality review and was again cited as such in this years' review, because the MCO remains vested in ensuring the information in the system is accurate, available, and useful.
- CC made improvements to its electronic service authorization system by creating drop down menus so staff can easily select a vendor and product. Once the needed quantity is entered, the system automatically calculates the total cost and authorizes the item or service for a set period of time, unless manually adjusted by the IDT. At the time of on-site interviews, IDTs spoke positively about how this enhancement has

reduced their administrative workload; previously they had to enter all of the information manually.

- At CCCW, reviewers found that information about service costs and options is available to teams. In interviews with IDTs, care managers noted that cost is not the only factor in decision making; rather, they focus on outcomes and member safety.
- Reviewers noted that *i*Care has systems in place to keep IDTs apprised of changes in the provider network and current availability of services, such as residential openings.
- Over the past year, LCD made progress by developing guidance called the *Care Coordination Proces,s* which helps ensure that teams do not skip required steps when processing member requests for services.
- MCDFC's annual quality review noted that the MCO clearly documents expectations for service authorization decision making and provides references and resources to support teams.
- SFCA created a "go to" list on its intranet system as a resource for IDT staff. The "go to" list identifies certain SFCA staff with expertise in particular provider types, for example, staff with expertise in durable medical equipment, representative payee services, or adult family homes.
- Over the past year, WWC successfully piloted the use of a "purchasing expert" in one of its locations to support the ability of IDTs to efficiently explore service options and costs.

While the EQR team identified strengths and progress across MCOs, opportunities for improvement were also noted. For example, reviewers found that CC needs to ensure that its teams have access to information about community resources and unpaid support options, and explore these options with members during the RAD process. While CHP has resources and staff with expertise to help IDTs gather more information and make decisions about the most effective services, recommendations for this MCO and others (CW, *i*Care) included making information about service costs, provider contract expectations, and provider quality more readily available and accessible to IDTs.

At some MCOs (CHP, MCDFC, LCD, WWC) decisions by IDTs must sometimes be reviewed or approved by managers or others before decisions are finalized or services authorized. Guidance at *i*Care prompts teams to consider requiring members to achieve incremental goals prior to authorizing bigger investments in services. Recommendations for these MCOs included ensuring that these decision making practices align with DHS expectations and requirements.

An area of notable opportunity identified across MCOs relates to decisions about the use of members' personal resources for services in the benefit package. Similar to the results of last year's annual quality review, the FY 10-11 CMR found that many MCOs (CCCW, CHP, *i*Care, LCD, MCDFC, NB, SFCA) need to provide policies and procedures, training, and/or monitoring to ensure that members are not paying out-of-pocket for services that are covered in the FC or FCP benefit package. Recommendations to these MCOs included one or more of the following:

- Work with DHS to assure policies and practices align with DHS requirements;
- Educate IDTs to ensure teams understand and implement contract requirements related to use of personal resources;

- Ensure policies and procedures provide information for determining whether use of personal resources is acceptable and include expectations for related member counseling;
- Develop and implement policies/procedures regarding decision making for over-the-counter medications; and
- Monitor care management practice to ensure that members are not inappropriately paying for services to meet their identified needs and outcomes that are covered by the FC or FCP benefit.

Service Coordination and Follow-up

Another area where results were mixed relates to the requirement that IDTs coordinate members' care and conduct timely follow-up to ensure services have been received and are effective. FY 10-11 CMR results showed that follow-up to ensure service effectiveness is a notable area of opportunity for many MCOs. CMR recommendations made to many MCOs (CC, CHP, LCD, MCDFC, NB, WWC) included one or more of the following:

- Ensure that IDTs consistently follow up with members and/or their supports to confirm services have been received and are of expected quality;
- Help IDTs take a proactive approach to follow-up rather than relying on members and supports to call them;
- Confirm that documentation in member records reflects follow-up actions and
- Ensure follow-up is conducted, regardless of whether the services/supports are funded by the MCO.

Results of the QCR were more positive: Seven of ten MCOs received a score of met for a measure related to documentation of follow-up activities, while three MCOs (*i*Care, NB, WWC) received scores of partially met. WWC's annual quality review exemplifies the mixed nature of the QCR and CMR results: The MCO's internal file review process, which includes an element to measure documentation of care coordination and follow-up by IDTs, showed improvement for this QCR standard. However, WWC's CMR identified a number of situations where IDTs did not document follow-up actions related to some needs and services of members, such as health services or services provided by informal supports. Neither of the other two MCOs with partially met scores currently has a method to ensure that all services, whether within or outside the program's benefit package, are effectively coordinated for members. One MCO (CCCW) made progress related to follow-up by enhancing automated systems. For example, the MCO developed and implemented a "folder" within its electronic care management system, *Cognos*, to track data, including tracking the timeliness of follow-up activities, service authorization decisions, and issuance of NOAs. As a result of its progress, CCCW moved from a partially met score for this measure in last year's review to a score of met for FY 10-11.

Compliance with Provider Contracting Requirements

Another area of mixed results 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. While this has been a long-standing area of opportunity for improvement, MCOs have made progress in meeting this measure over the past three review years. In FY 08-09, for example, just two of eight MCOs

(25%) fully met this requirement. Results for FY 10-11 show that six of ten MCOs (60%) received scores of met this measure. The results represent progress for MCDFC. Monthly, a feature within MCDFC's *MIDAS* system automatically checks the Office of Inspector General (OIG) website and generates a report identifying any MCDFC contracted providers, or providers with closely spelled names, that appear on the OIG report of providers excluded from participation in federal health care programs. The MCO followed recommendations to amend its procedure to also include a process for ensuring individuals/business owners are not among those listed as excluded parties and, thus, moved from a partially met score in last year's review to a score of met for FY 10-11.

Another MCO (NB) made progress by moving from a score of not met in FY 09-10 to a score of partially met in this year's review. Over the past year, NB developed policies for selection, retention, and credentialing/re-credentialing of providers and also developed a process to identify providers that have been excluded from participating in federal health care programs. Recommendations for NB included the need to enhance its verification process to include identification of individuals/business owners who have been excluded.

Three other MCOs (CW, *i*Care, SFCA) also received scores of partially met. CW and SFCA have received partially met scores for this measure for the past three review years. Over the past year, CW made progress by developing a *Verification of Potential and Contracted Provider Credentials* policy and procedure; however, at the time of CW's annual quality review, the policy was still in draft form. Recommendations provided to this MCO were to finalize the policy and submit it to DHS for approval. At SFCA and *i*Care, reviewers found that the processes established for ensuring providers have not been excluded from participating in federal health care programs were not fully implemented. MetaStar recommended that these MCOs implement processes that have been established to verify providers, including individuals/business owners, have not been excluded from participating in federal health care programs.

Compliance with Provider Background Checks

A notable opportunity for improvement identified across MCOs relates to two QCR measures regarding the DHS-MCO contract requirement to verify that periodic caregiver and criminal background checks are conducted on employees and providers who come into direct contact with members. While all but one MCO (*i*Care) fully met requirements to conduct periodic background checks on their employees, only half of MCOs met requirements to ensure that periodic background checks are conducted on the employees of contracted providers who come into direct contact with MCO members. Five of ten MCOs (CCCW, CHP, CW, NB, SFCA) received scores of partially met in this area of review; one MCO (*i*Care) received a score of not met. Only four MCOs fully met the requirements (CC, LCD, WWC, MCDFC).

The results represent progress for MCDFC and WWC, which moved from scores of partially met in last year's review to scores of met for FY 10-11. Since its last annual quality review, MCDFC developed and implemented a policy and procedure for verifying providers' compliance with conducting background checks. While MCDFC has now met this requirement, reviewers provided a number of recommendations to help improve the comprehensiveness of the MCO's policy/procedure. At the time of last year's review, WWC had implemented its *Audit Process for Provider Background Checks* policy and procedure, but had not yet completed the

audit process. The FY 10-11 review found that WWC has now fully implemented its caregiver background check audit process and has developed a system to organize data for ease of analysis.

Of the five MCOs with partially met scores, CW and SFCA have not met the requirement to verify providers' compliance with conducting background checks for the past three review years; CCCW for the past five review years; and CHP for the past six review years. NB, a newer MCO in its second year of operation, has scored partially met the past two years. Despite these results, reviewers noted some progress. For example:

- CCCW's purchase of service contracts include links to websites (i.e., State Department of Justice and DHS) to guide providers to resources and references for conducting background checks. In addition, since its last annual quality review, CCCW implemented a process to verify providers' compliance with background checks. However, the MCO focused on verifying background checks only for providers' more recently hired employees. A recommendation for CCCW was to expand its provider background check verification process to include a random sample of employees that have been employed longer than four years.
- CHP made progress since its last review by developing the *Provider Criminal Background Check Assurance* policy and procedure and obtaining approval from DHS. However, at the time its review, the MCO had not fully implemented the process. Recommendations for CHP were to implement and monitor the policy and procedure, and develop a plan of correction or "next steps" if monitoring identifies providers that are not complying with requirements to conduct criminal and caregiver background checks on their employees.
- CW and NB had implemented a process that requires providers to sign a form attesting that they are in compliance with the background checks requirement. However, neither MCO had included a step in their procedure to verify provider compliance. Recommendations for these MCOs included adding a verification step to current procedures to confirm providers' compliance with requirements as well as procedures for follow up actions when non-compliant providers are identified.
- SFCA made progress by implementing a provider quality assessment process that includes a step to verify whether providers are complying with requirements to conduct background checks. The MCO's annual quality review recommended that the MCO further improve this process and meet requirements by developing a method for follow-up when providers are out of compliance with background check requirements and a sampling methodology that ensures all providers are monitored on a periodic cycle.

One MCO (*i*Care) received a score of not met related to background check requirements. In its first year of operating the FCP program, *i*Care had not yet developed processes to verify that background checks are conducted on employees or providers that come into direct contact with MCO members.

Timeliness

The DHS/MCO contract contains many requirements for Family Care MCOs related to timeliness. 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.

Timeliness standards create further assurances that access to care and services is maintained for members and is adapted to address the urgency of each member's needs.

Specific timeframes are assigned to all key steps in the care management process, including assessment, care planning, service authorization decision-making, and issuance of notices of action, when applicable. A number of timeliness standards found in the DHS-MCO contract reflect federal requirements.

Protocol review areas that relate to timeliness include:

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

Based on the results of the FY 09-10 review, this year's review focused on measures related to the timeliness of notices of action, service authorization decisions, MCPs, and appeal and grievance timeframes. Findings indicate that, as a group, MCOs have opportunities for improvement related to timeliness, particularly in areas related to making timely service authorization decisions and issuing NOAs, developing or enhancing monitoring systems, and conducting data analysis and performance improvement activities.

Timeliness of Service Authorization Decisions and Issuance of Notices of Action

A notable area for improvement identified across MCOs relates to the requirement that MCOs have adequate systems and processes in place to ensure that service authorization decisions are made in a timely manner, when NOAs are warranted they are issued, and NOAs are issued within required timeframes. Ten QCR review measures assess various aspects of compliance. In this year's review, at least half or more of the MCOs received scores of partially met for six of the ten measures. While no MCO received an unmet score for any of the measures, several MCOs have partially met three or more of these measures for the past three to five review years. CMR results supported the QCR findings, as the CMR found issuing NOAs when warranted and in a timely manner is an area of significant opportunity.

CMR results were more positive regarding service authorization decision making. This pointed to some strength in care management practice; however, opportunity for improvement exists, as record reviews found instances of lack of timeliness in decision making in approximately one-third of the records reviewed during the course of the year. CMR results for some MCOs (CC, CCCW, LCD, MCDFC) noted that IDTs are aware of and strive to adhere to required timeframes, or that the MCO strives to ensure consistent decision making practices. However, across MCOs, reviewers noted that IDTs frequently have difficulty recognizing requests, responding to requests within required timeframes, accurately documenting the date of requests, identifying when NOAs are warranted, and/or issuing NOAs within required timeframes.

As noted earlier in this report (see Access to Care/Resource Allocation Decision Method), several MCOs (CC, CHP, CW, *i*Care, LCD, MCDFC, NB, WWC) need to improve the ability of IDTs to successfully identify, respond to, and/or accurately document requests for services. MetaStar reviewers identified records at CW, LCD, NB, and WWC, for example, where teams failed to recognize requests, and therefore failed to respond consistently or in a timely manner. At MCDFC and *i*Care, some decisions were delayed because teams were waiting for input from physicians, therapists, or others. At CC and *i*Care, reviewers found that IDTs did not always accurately document the dates of requests, leading to decision making and NOA issuance outside the required timeframes. These MCOs received recommendations such as:

- Educate IDTs regarding requirements and timeframes for decision making and issuance of NOAs;
- Ensure teams are accurately documenting dates of requests;
- Establish a process to ensure members receive NOAs when teams are unable to meet the contract-specified timeframes for decision making; and
- Improve the rate at which teams make decisions within required timeframes as well as issue notices of action.

To provide further guidance to MCOs and IDTs regarding NOA issuance, DHS provided a "Notice of Action Frequently Asked Questions" document in October 2010, with the intent of periodically updating it to include additional questions/answers.

Monitoring systems at some MCOs (CHP, CW, *i*Care, MCDFC, NB, SFCA) need to be developed or enhanced. MetaStar made recommendations to *i*Care and NB to develop and implement mechanisms to monitor timeliness of service decisions and issuance of NOAs. Additionally, recommendations were provided to other MCOs regarding the need to enhance or improve monitoring systems and processes because the current approaches were not entirely effective.

For example, CW uses both a tracking log and internal file review (IFR) tool to track NOA timeliness. However, the tracking log only captures instances when an NOA is actually issued, and the IFR tool does not include an element to measure whether NOAs are issued *when warranted*.

CHP uses an electronic system called the *Request/Reduction (R/R) Screen* to document steps in the decision making process and adherence to timeliness standards. IDT staff record information directly in the R/R Screen, or to reduce duplicative documentation, document the information in a case note and then electronically link the note to the R/R Screen. IDTs review daily reports that are generated from the R/R Screen reminding them of active requests, timelines for decision making and NOA issuance, and areas where needed follow up has not yet been documented. MetaStar noted the delivery and use of real-time data from the R/R Screen helps promote timely and quality care to members and cited this as a "Best Practice" in CHP's annual quality review. However, reviewers observed some inconsistent use of the R/R Screen. Reviewers also identified that the way the R/R Screen currently works does not always result in accurate data, and CHP does not have a process to validate its accuracy. CHP's annual quality review included recommendations to examine the R/R Screen structure; seek input from all parties who use the system; and implement solutions which result in accurate data and efficient use.

Reviewers noted that MCDFC and SFCA use a *Notice of Action Log* in *MIDAS*, the electronic care management system used by both MCOs. For SFCA, this was a process improvement since its last review; the MCO had previously been using a spreadsheet. The *MIDAS* system automatically calculates the effective date to comply with contract requirements in instances where services are being reduced, terminated, or suspended, improving the timeliness for these types of notifications to at or near 100 percent according to data provided by MCDFC and SFCA. Compliance for both MCOs was noted to be lower for other types of NOAs, such as those related to requests that are denied or limited, or when decisions are delayed.

MCDFC identified that, in many cases, untimely NOA issuance by its IDTs related to delayed decision making when teams waited for therapy evaluations prior to deciding about equipment purchases. As a result of this finding, MCDFC re-educated its teams regarding expectations for NOA issuance and provided supervisors with detailed data so that they could individually follow up with IDTs identified as having late NOAs.

Opportunities were identified at many MCOs (CC, CCCW, CHP, CW, LCD, MCDFC, SFCA) regarding the need to collect and/or analyze monitoring data, identify root causes and barriers related to making timely decisions and issuing NOAs, and develop and implement plans for improvement. For example, at the time of its annual quality review, SFCA had not analyzed monitoring data to determine the root causes of untimely service authorization decisions and lack of compliance in issuing NOAs when requests were denied or limited, or when decisions were not made within required timeframes. SFCA's annual quality review included recommendations to analyze data, confirm assumptions regarding root causes, and develop interventions to improve the timeliness of service authorization decisions and issuance of NOAs.

Some MCOs made progress since last year's reviews by developing or refining automated approaches to track and collect data. For example, at the time of its review, CCCW had recently implemented a *Service Authorization Folder* in its electronic care management system *Cognos*, to track timeliness of service authorization decisions, issuance of NOAs, and follow-up activities. The MCO had generated a report from the *Service Authorization Folder*, but at the time of its review had not yet analyzed the data to assess compliance with contract requirements for elements related to service authorization decision making and NOA monitoring. This MCO's annual quality report included recommendations to analyze the results of timeliness data generated from the *Service Authorization Folder*. In addition, it was recommended that the MCO temporarily incorporate a step in its IFR process to verify that data generated from the automated system is accurate and the system is functioning as intended.

LCD also made progress by re-designing its IFR process to contain additional elements, including a measure to identify whether NOAs were being issued when warranted and in a timely manner. As a result of analyzing data from the IFR process and other sources, LCD developed an enhancement called the *Care Coordination Process* in its electronic care management system *eCET*. LCD's system links a variety of required elements related to service authorization decision making, increasing the awareness and ability of IDTs to follow all of the steps in the service authorization process, from member request through the RAD and decision making to the issuance of NOAs. This MCO's annual quality report included the recommendation to fully implement this process.

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 ensuring the timeliness of MCPs. Over half of MCOs (CC, CHP, CW, *i*Care, MCDFC, NB) received a score of partially met for this measure, while four MCOs (CCCW, LCD, SFCA, WWC) received a score of met. This represents progress for SFCA, which moved from a score of partially met in last year's review to a score of met for FY 10-11. SFCA made progress in ensuring MCP timeliness through use of a policy and procedure for establishing review timeframes, in combination with a "Review Calculator" tool in its electronic care management system, *MIDAS*.

The MCO monitors timeliness of MCPs through its IFR process. Monitoring data submitted by SFCA for 2010 indicated that 88 percent of MCPs were timely when required within ten days and were 92 percent timely at other required intervals – results which were supported by the CMR findings.

Except for iCare, the MCOs with partially met scores have not fully met this QCR measure the past two to five review years. CMR results were more positive and indicated that IDTs obtain signatures on MCPs within contract specified timeframes most of the time. While the CMR results point to strength in care management practice, this year's QCR results indicated that opportunities exist across MCOs to develop or improve monitoring systems, processes, and/or data collection and analysis related to timeliness of MCPs.

For example, reviewers found that NB had not yet developed a monitoring system to ensure MCPs are completed and signed in a timely manner. While *i*Care had developed a chart audit process to monitor access and quality of care, the MCO had not yet developed associated guidelines for use by reviewers when conducting the audits. This MCO's annual quality review also identified the need to develop and implement a method to ensure MCPs are reviewed and signed by the members' legal decision makers every six months. CC and MCDFC need to adjust or enhance monitoring systems or processes, as the monitoring methods currently used by these MCOs do not accurately measure compliance with DHS-MCO contract requirements. For example, MCDFC did make progress since its last review by re-designing its IFR process, including developing an automated process - the "A Audit" - for tracking and collecting data from *MIDAS*. "A Audit" reports generated from *MIDAS* provide information about certain member record quality indicators, including timeliness of MCPs. However, reviewers noted that the MCO is calculating timeliness for this measure when the signed MCP is received and filed by the IDT, not by the actual signature date on the document. DHS-MCO contract requirements are based on the signature date, indicating that the actual results may be a greater level of timeliness than the MCO's method of measurement indicates. Other MCOs (CC, CHP, CW, *i*Care) received recommendations to analyze monitoring data, identify root causes and barriers related to timeliness of MCPs, and develop and implement plans for improvement.

Appeals and Grievances Timeliness

A timeliness area of strength identified across MCOs relates to the requirement that MCOs must have adequate systems and processes in place to meet appeal and grievance timeframes. Four QCR measures evaluate this requirement.

Nine of ten MCOs received a score of met for all four measures. This represents progress for NB, which had met all but one of the measures in its FY 09-10 review. Over the past year, NB followed recommendations and put in place a process to ensure members filing local appeal/grievance receive timely written acknowledgement of the receipt of the appeal/grievance. Thus, the MCO moved from a score of partially met in last year's review to a score of met for FY 10-11.

MCDFC received scores of partially met for three of the four measures. During the past five years, the MCO has been unable to resolve member appeals and grievances in a timely manner; provide members with timely written notification of the resolution of local level appeals and grievances; or document and provide written notice to members of reasons for delays in scheduling hearings within contract timeframes. MCDFC's annual quality review included recommendations to:

- Document and analyze reasons for delays in resolving appeals and grievances; and
- Develop a plan to improve the timeliness of both resolving appeals/grievances and issuing written notification to members of appeal/grievance resolutions.

Quality

In Family Care, quality is determined from a member-centered point of view. DHS assigns responsibility regarding quality to both program members and the MCOs 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

Based on the results of the FY 09-10 review, the FY 10-11 QCR focused on measures related to quality monitoring, including communication of protected health information; clinical practice guidelines; the quality management program, work plan and evaluation; utilization management/utilization review; the quality and appropriateness of care; and performance improvement projects. The CMR focused on the quality of care management practice, including the comprehensiveness of the assessment and planning process, and assessment of member outcomes. FY 10-11 findings indicate that as a group, MCOs have both strengths and opportunities related to quality. For example, while a substantial number of MCOs made progress related to monitoring the quality and appropriateness of care and identifying member outcomes, opportunities exist across MCOs related to the quality and comprehensiveness of member-centered plans.

Assessment Process in Care Management – Assessment of Member Outcomes

FY 10-11 findings indicated that an area of strength across MCOs continues to be the quality of the initial assessment process. Similar to the results of last year's review, FY 10-11 findings indicated that MCOs typically use standardized assessment tools that promote consistent information gathering. MCOs also have in place policies, procedures, and other tools and organizational supports to help IDTs complete initial assessments that are timely and comprehensive. IDT social workers and nurses typically communicate and collaborate with each other during assessment and care planning, and members and their supports are almost always included in the assessment process.

Findings indicated that IDTs seek information from members, observe members' actions and responses, and also gather information from both formal and informal supports who know members well. Overall, IDTs take the time to establish rapport with members and use individualized approaches and interviewing techniques that help build relationships and facilitate information gathering.

MetaStar identified assessment of member outcomes as an area of progress, as overall findings indicated that IDTs have a good understanding of member-centered outcomes. Some examples include:

- In on-site interviews at CCCW, IDTs talked about using a variety of questions to discuss outcomes with members and stated that, as a result of training and MCO guidance, they are exploring further to get at core issues and identify more specific, personalized member outcomes. This was supported by the CMR results, as reviewers found individualized, measurable outcomes on MCPs. IDTs reported they try to explain and document outcomes, and the steps to achieve or support the outcomes, in ways that foster members' understanding and ownership. In pre-onsite surveys, teams specifically identified the "Personal Experience Outcomes Assessment and Evaluation Integrated Interview and Evaluation System" (PEONIES) training as helpful in learning to apply FC principles. A recommendation provided to this MCO was to support and educate IDTs in documenting outcomes of members with cognitive or communication barriers in ways that reflect their goals, hopes, and dreams.
- At CHP, reviewers found improvement in the identification and documentation of members' personal outcomes since last year's annual quality review. In interviews with IDTs, staff spoke about outcomes in ways that demonstrated understanding. In addition, nearly all the MCPs evaluated in the record review contained outcomes that reflected members' goals, hopes, and dreams, although some plans were missing other important elements necessary to explain or support the achievement of the outcomes. To facilitate sustaining the change created over the past year, MetaStar recommended that CHP ensure its system supports, such as written guidance and assessment tools, include expectations and prompts for interview techniques and assessment approaches that successfully identify member outcomes.
- At CW, improvement in the identification of member outcomes was noted across the organization, but especially in the FC program. The EQR team noted that revised social assessment tools used for the FC program are structured to identify members' strengths and preferences and include a thorough exploration for the presence of

member outcomes in all 12 of the FC outcome domains. Findings indicated that FC assessments tended to identify more member outcomes than those completed for CW members enrolled in FCP, and the outcomes were often measurable and reflective of members' personal goals, hopes, and dreams. Recommendations provided to CW included the need to improve assessment tools and expectations for the FCP program in order to assure IDTs explore all 12 outcome domains and better identify outcomes for FCP members.

- Based on analysis of IFR results, LCD developed staff training and education, which focused quality improvement efforts on exploration and documentation of outcomes. The MCO also created a tool that aligns with PEONIES. The *PEONIES Quick View List* supplements the MCO's assessment modules and serves as a reference for IDT staff when talking with members about outcomes. PEONIES is a project funded by DHS to develop a way of measuring and using personal experience outcomes for people receiving long-term care services. The Center for Health Systems Research & Analysis (CHSRA) developed the methodology; MetaStar supported the effort by conducting interviews in the first phases of the project. Information about member interviews conducted during FY 10-11 is provided to DHS using separate reports for each MCO. For more information about PEONIES, visit:

  http://www.chsra.wisc.edu/peonies/Personal%20Experience%20Outcomes.html

  Among its recommendations to LCD, MetaStar advised the MCO to evaluate whether IDTs consistently refer to and use the *PEONIES Quick View List*, and also determine whether use of the tool results in improved identification of members' personal outcomes.

While progress was made related to assessing member outcomes, opportunities remain. For example, assessment tools used by some MCOs are not structured in a way that helps stimulate critical thinking or exploration of members' personal outcomes. In addition, while many IDTs reported lots of positive feedback about the outcomes trainings they had received, records did not always reflect that outcomes had been thoroughly explored and reviewers did not always find measurable outcomes on MCPs. While some of these findings may relate to the retrospective nature of the review, MetaStar identified the need across MCOs to provide IDTs with continued education, support, and feedback related to identifying outcomes that are measureable and reflective of members' goals, hopes, and dreams; documenting MCPs that contain important elements necessary to explain or support the achievement of the outcomes; and encouraging the practice of routinely measuring the level of progress toward achievement of outcomes.

IDTs are required to periodically re-assess members in order to identify new or changing outcomes, strengths, preferences, and/or needs. An area of opportunity regarding assessment identified across MCOs relates to the quality of these periodic re-assessments. Nearly all MCOs (CC, CCCW, CHP, CW, LCD, SFCA, WWC) have the opportunity to improve assessment tools and/or processes to ensure that periodic re-assessments are occurring and are conducted prior to updating MCPs so as to inform planning activities; that IDTs are re-assessing members in all areas; and/or that re-assessment activities are fully documented in member records.

For example, CHP created a new tool for six month re-assessments, but findings indicated the tool does not require identification of member strengths, preferences, needs and outcomes, and does not contain exploratory questions to help expand on information and promote conversation with members. WWC also implemented a new social re-assessment tool in 2011; however, given the retrospective nature of the annual quality review, the EQR team was unable to assess the results. Reviewers did note that the tool does not include prompts, cues, or questions that would lead to exploration of new outcomes. Similarly, findings indicated that re-assessment tools and/or processes used at SFCA and CCCW do not promote in-depth exploration of member outcomes. At CC, CW, and LCD it did not appear that IDTs were always evaluating and /or documenting all required elements during re-assessments, including strengths, preferences, and outcomes. For example, reviewers noted that at CC, six month re-assessments sometimes contained the same information as previous assessments, even though the details were no longer accurate.

Quality and Comprehensiveness of Member-Centered Plans

Similar to the results of last year's review, the CMR indicated that an area of opportunity across MCOs continues to be the quality and comprehensiveness of MCPs. FY 10-11 findings showed that many MCPs did not include details found elsewhere in members' records, such as information about members' outcomes, strengths, preferences, informal supports, plans for coordinating services outside the benefit package, clinical and functional needs, and services (CC, CHP, CW, *i*Care, LCD, MCDFC, SFCA).

For example, since its last review, CC revised its MCP format to focus on members' outcomes and reviewers noted as an area of strength that MCPs contained outcome statements reflective of members' perspectives. However, many MCPs in the review sample failed to include other elements required by the DHS-MCO contract in order to meet the comprehensiveness standard. In FCP and PACE, reviewers noted that IDTs documented information about health and medical interventions - for example, nursing interventions or interventions related to falls risk - in discipline-specific plans within case notes and did not include the information on MCPs.

Some MCPs lacked information regarding the plan for achieving members' outcomes or did not include interventions that supported achievement of the identified outcomes (CHP, CW, LCD, iCare, WWC). An MCP reviewed at LCD is a good example. The MCP documented a member's outcome as "desire for privacy within her substitute care facility." However, the interventions listed on the MCP related to how the facility would help with the member's activities of daily living and did not include information about how the member's privacy would be ensured.

Other recommendations made to MCOs about MCP quality and comprehensiveness include:

- CC needs to support IDTs to include outcomes on MCPs that are currently met, but need support to be sustained, as well as outcomes that may take longer than six months to achieve. After CC has refined the outcomes assessment process, it should explore how teams prioritize what outcomes to include on MCPs.
- At CHP, IDTs need to include information on MCPs about behavior support plans and monitor the quality and effectiveness of the interventions;

- CW should focus efforts to ensure that MCPs are comprehensive and accurately reflect how members' needs and outcomes are supported as well as how members' health, safety, and well-being is being monitored.
- LCD needs to evaluate how to consistently include information about authorized disposable medical supplies on MCPs.
- MCDFC needs to monitor MCPs to ensure comprehensiveness, as many MCPs in the sample of records reviewed did not include details found elsewhere in member records.
- SFCA must ensure that IDTs document member strengths on MCPs.WWC needs to ensure that personal experience outcomes listed on MCPs are measureable and reflective of members' goals, hopes and dreams, and that MCPs document interventions that will support achievement of the outcomes.

While quality and comprehensiveness of MCPs is an area of opportunity across MCOs, review findings also identified some areas of progress and strength. Some examples include:

- In January 2011, CCCW implemented strengths-based planning meetings in which IDTs participate with their supervisors just prior to members' MCP reviews. Ideas gained from the meetings are presented to members during MCP planning discussions. At the time of on-site interviews, IDTs reported the process has been useful in creating plans that are more member-centered and that promote more efficient use of resources, because decisions about services are linked to members' abilities and strengths rather than only their needs.
- LCD provided guidance to IDTs, in the *2010 Tips for MCP*, to instruct staff about the types of information to be documented in member-centered plans.
- MCDFC and LCD have developed electronic systems that transfer information from assessments to MCPs in order to reduce the workload associated with duplicate documentation and to promote comprehensiveness.
- Since its last review, NB made efforts to improve its MCP format in order to improve plan comprehensiveness. The new format promotes identification and documentation of members' strengths as well as clinical outcomes, functional outcomes, and personal experience outcomes.

Member Rights

An area of review where results remained mixed relates to members' rights to respect, dignity, and privacy. FY 10-11 findings show that seven of ten MCOs (CC, CCCW, CHP, CW, *i*Care, LCD, MCCMO) met a QCR measure that includes the right of members to privacy in the communication of protected health information (PHI) and personal identifying information (PII). Three MCOs (NB, SFCA, WWC) received scores of partially met. SFCA and WWC have received scores of partially met for this measure for the last three review years and NB for the past two years. In last year's review, SFCA received a partially met score, in part, because it did not have a mechanism for monitoring email of its contracted care management units for PHI and PII. This became irrelevant in December 2010, when the organization began directly employing care managers. However, changing its structure for the delivery of care management services required the MCO to update its policies and procedures.

At the time of the FY 10-11 review, SFCA had made recent progress by updating its email use policies and conducting an initial analysis of filtered email during March 2011, with no significant issues identified. However, the MCO was still in the process of adopting additional policies and procedures to protect the confidentiality of member PHI and PII, and reviewers did note references to email communication to/from SFCA staff in some of the records reviewed.

WWC had also made progress since its FY 09-10 review, as the MCO began implementation of the *IronPort Encryption Appliance* by Cisco. The MCO focused the first phase of implementation on large providers, with a plan to educate its staff, smaller providers, and members in subsequent phases of the project. At the time of its review, substantial progress had been made but implementation had not been completed. WWC's annual quality review included recommendations to complete the project and establish a method to monitor the use of email encryption to ensure members' privacy rights.

While NB has a policy and procedure in place to limit access to information from member records to authorized individuals, the MCO does not yet have an effective system for ensuring secure email communications. Similar to recommendations made in last year's review, the FY 10-11 annual quality review recommended that NB enhance its email system to include encryption capabilities.

Clinical Practice Guidelines

Another area where results are 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. FY 10-11 results show that seven of ten MCOs (CC, CCCW, CHP, CW, LCD, MCDFC, WWC) received a score of met for all six related measures. This represents progress for MCDFC, which moved two measures from partially met in the FY 09-10 review to scores of met, resulting in this MCO meeting all six measures for FY 10-11. Findings indicated that MCDFC disseminates clinical practice guidelines to appropriate providers through a provider page in its *MIDAS* electronic care management system. MCDFC also made progress since last year's review by incorporating an "alert" to notify providers that a new or updated document is present and needs to be reviewed. The MCO reported plans to add a "receipt" feature as a way to confirm providers have read a new document. MCDFC also followed a previous recommendation to develop a means to evaluate the use of practice guidelines by care management teams. The MCO incorporated monitoring for aspects of care related to diabetes, depression screening, and other high risk areas into its re-designed internal file review process which was implemented during the past year. Clinical practice guidelines are also incorporated in certain objectives of the MCO's quality work plan.

Three MCOs (NB, SFCA, iCare) have opportunities for improvement related to clinical practice guidelines. For example, NB received a score of not met for two of the six measures. However, this also represents progress for the organization, which received not met scores for all six measures in last year's review. NB moved four scores from not met to met by developing and implementing a clinical practice guideline, *Preventative Health and Vaccination Date*, based on valid and reliable clinical evidence that considers the needs of its members.

The guideline encourages members to receive influenza and pneumococcal vaccinations when clinically indicated; outlines a process for providing members with related information from the Centers for Disease Control and Prevention; and includes procedures for IDTs to document member education and, as appropriate, receipt of the vaccination(s). However, two other measures remain not met, as NB's practice guideline does not identify the timeframe for periodic review and update, or describe a process for disseminating the guideline to all appropriate providers. NB's annual quality review included recommendations to identify how often clinical practice guidelines will be reviewed and how they will be disseminated to providers, and to develop additional clinical practice guidelines.

SFCA also has opportunities for improvement, although this MCO also made progress since last year's review when it received partially met scores for four of the six measures related to clinical practice guidelines. At the time of the FY 09-10 review, SFCA had only one practice guideline in place, related to diabetes management. During the course of the FY 10-11 review cycle, the MCO's Prevention and Wellness Committee was re-activated and focused on improving member care by providing and evaluating tools for teams. The committee developed one additional practice guideline for depression management, although the guideline was still in draft form at the time of the FY 10-11 review. However, as SFCA's guidelines are based on valid and reliable clinical evidence, and were developed in consultation with health care professionals, the MCO moved two measures from scores of partially met in the FY 09-10 review to scores of met for this year's review. Two other measures have remained partially met for the past three review years. SFCA continues to lack documentation to demonstrate that health care professionals have and apply the current best practice evidence when making decisions about the care of individual members. While the MCO has developed a policy titled *Creating Practice Guidelines*, the policy is in draft form and the MCO did not articulate a plan to finalize, approve, disseminate, and implement the policy. Recommendations for SFCA included the need to document the method it employs to ensure that health care professionals have and apply the current best clinical evidence when making care decisions and to continue developing relevant clinical practice guidelines.

*i*Care met four of the six measures related to clinical practice guidelines. One measure, related to the requirement to identify and use practice guidelines that are based on valid and reliable clinical evidence, was noted as an area of strength in *i*Care's annual quality review. The MCO received scores of partially met and not met for two measures. The partially met score relates to the requirement that practice guidelines need to be disseminated to all affected providers. Although clinical practice guidelines are posted on *i*Care's website, the MCO does not have a process to ensure affected providers actually receive copies of practice guidelines. The not met score relates to the MCO's need to document the process it uses to develop, approve, implement, and monitor the use of clinical practice guidelines, as well as its process for ensuring guidelines are disseminated, as appropriate. In order to improve its current practices related to clinical practice guidelines, this MCOs annual quality review included recommendations to develop, document, and monitor processes to ensure health care professionals have and apply the current best clinical evidence when making care decisions.

Monitoring Access to and Quality of Care

Monitoring access to and quality of care was considered an area of notable opportunity in last year's review, as no MCO fully met this measure.

The FY 10-11 review indicated this continues to be an area of opportunity for improvement but also showed substantial progress regarding the requirement to have an effective process in place, such as an internal file review or other process, to provide data for assessing and monitoring the access, timeliness, quality, and appropriateness of care provided to members. Six MCOs (CC, CCCW, LCD, MCDFC, SFCA WWC) made progress and moved from scores of partially met in the FY 09-10 review to scores of met for FY 10-11. Three other MCOs (CHP, CW, *i*Care) received scores of partially met. CHP and CW have scored partially met for this measure for the past two and three years, respectively. Similar to its results in FY 09-10, NB received a score of not met for this measure and needs to develop an integrated monitoring system that focuses on elements that impact the quality of member care, employs an effective sampling methodology, provides appropriate data for analysis, and includes strategies for improvement.

An area of opportunity in last year's review related to lack of analysis of monitoring data; six MCOs had implemented processes for internal file review but had not conducted data analysis. Findings for FY 10-11 indicated that five of the six MCOs (CC, CCCW, LCD, SFCA, WWC) received scores of met for this measure. The sixth MCO, CHP, again received a partially met score. Although CHP conducts IFRs and also collects data from its electronic Request/Reduction Screen, review findings indicated that the MCO had not analyzed the data to determine trends or areas for improvement. Additionally, the MCO reported its current software is unable to produce automated reports from the data already collected through the IFR process, and it was exploring options for a new member record system and database to address the issue.

The five other MCOs met requirements by taking action such as conducting monitoring and data analysis activities, enhancing monitoring systems, or developing interventions or changes in processes based on the results.

For example, shortly before last year's review, CCCW had developed and implemented an IFR process, which includes a *Peer Review Tool* and an *IDT Supervisor Review Tool*. The MCO had begun to collect data but had not entered the data into its established tracking system or analyzed the results. At the time of its FY 10-11 review, CCCW had collected and analyzed data and feedback from its two IFR tools through the fourth quarter of 2010. The MCO had made additional progress by developing an automated process to collect data from *Cognos*, its electronic care management system. A "Service Authorization Folder" was implemented in *Cognos* in January 2011 to track timeliness of service authorization decisions, follow-up activities, and issuance of NOAs. However, at the time of its review, the MCO had not yet analyzed data from the Service Authorization Folder. As noted previously in this report, (see Timeliness/Timeliness of Service Authorization Decisions and Issuance of Notices of Action) CCCW's annual quality review included recommendations to analyze data recently generated from the Service Authorization Folder and temporarily incorporate a step in the IDT supervisor file review process to verify the timeliness data that is now generated through *Cognos*, in order to ensure the data is accurate and the automated system is being used as intended.

LCD also made progress related to data analysis by refining its IFR process to include additional elements; cross-referencing data from IFRs with monitoring data from *eCET,* its electronic care management system; focusing on data analysis; and using the results of analysis to draw conclusions and implement improvements. For example, as a result of its monitoring and analysis efforts, the MCO developed the *Care Coordination Process*, guidance for care managers regarding all of the steps required in the decision making and service authorization process, and also developed staff training focused on identification of member outcomes. LCD's annual quality review included recommendations such as, fully implement the *Care Coordination Process*; increase the number of IFRs conducted to increase the validity of data results; and implement an inter-rater reliability process for IFRs to improve consistency of the data.

SFCA initiated an IFR process shortly before its FY 09-10 review. Since then, the MCO fully implemented its process and made additional progress by developing and implementing a comprehensive electronic system to record and monitor unintended events (i.e., critical incidents). Reviewers noted that the IFR tool and instructions are comprehensive and well-developed. IFR results are provided to care management supervisors who give direct feedback to IDTs. For example, teams receive qualitative feedback regarding decision making practices, which are monitored through the IFR process. 2010 IFR data showed a high level of compliance with requirements in some areas, such as timeliness of MCPs, but lack of compliance in other areas, such as issuance of timely NOAs, when indicated. These findings were similar to the CMR results. At the time of its annual quality review, the MCO had not yet conducted analysis to identify root causes in areas of low compliance or developed plans for improvement, and therefore partially met the criteria. MetaStar recommended that SFCA analyze available IFR data to determine interventions and set goals for improvement, and establish an inter-rater reliability process for IFR.

Since its last annual quality review, WWC also made progress related to ongoing monitoring and data analysis. The MCO analyzed and trended IFR data, developed an inter-rater reliability process to monitor consistency among staff who conduct IFRs, and provided immediate feedback from the IFR process to care managers. While data analysis indicated improvement in all 18 areas monitored, the MCO provides IDTs with advance notice prior to conducting file reviews. MetaStar recommended the MCO perform IFRs without giving advance notice to ensure findings are reflective of processes followed by IDTs. WWC targeted seven areas for interventions based on its analysis of root causes and barriers. For example, WWC's analysis of monitoring data found that documentation of the RAD was not being completed at the desired rate. At the time of its review, WWC was taking steps to identify the root cause and determine how best to intervene to obtain the desired results. Other interventions the MCO implemented based on IFR results include staff training and education and an *iCenter* to provide references and tools for staff.

CC uses a number of approaches to monitor the quality and appropriateness of care provided to members, including IFRs and compliance based tracking systems. Since its last annual quality review, CC made progress by adding monthly focused chart audits for its FC program aimed at providing more immediate feedback to care managers. In addition, the MCO performed nearly 1000 annual discipline-specific chart reviews for its FCP and PACE programs. Reviewers noted that some of the elements monitored in the chart reviews were related to quality and appropriateness of care, but others were related to documentation compliance. While data is

gathered and reported, at the time of its annual quality review, CC had not completed analysis to assess consistency among its various tracking methods. The MCO continues to track most data manually and reported that this is a barrier to analysis. The review also identified that the low number of records selected over time for the formal IFR process may limit the MCO's ability to analyze for trends.

CC has processes in place to share information learned from monitoring efforts and to facilitate consistent communication, in order to promote quality throughout the organization. While CC has now met this requirement, reviewers provided a number of recommendations to help the MCO maintain and improve its ability to meet contract expectations related to monitoring quality of care. Recommendations included:

- Increase the number of file review elements that relate to quality of care, fully analyze the resulting data, determine interventions based on root cause analysis, and complete re-measurement to assure improvement occurs;
- Analyze and compare data from the different tracking systems for accuracy and plan improvements based on the analysis;
- Complete plans to modify chart audit tools to continue to collect data to meet internal needs for information as well as to ensure compliance with DHS requirements;
- Expedite development of automated data collection systems to improve the timeliness of data analysis to support program decision making.

The FY 09-10 review had also identified another area of opportunity related to monitoring the quality and appropriateness of care; three MCOs did not have processes in place for conducting internal file reviews. Since the FY 09-10 review cycle, two MCOs (MCDFC, CW) have made progress in this regard.

MCDFC completed and fully implemented a re-design of its internal file review process and, thus, moved from a score of partially met in last year's review to a score of met in FY 10-11. The MCO's new process includes two components:

- "A Audit," an automated monthly report from *MIDAS*, MCDFC's electronic care management system, which focuses on compliance with requirements and clinical guidelines, such as timeliness of MCPs and depression and fall risk screening. The MCO's overall goal is 95 percent compliance. Regular feedback is provided to care manager lead supervisors, who use the data to address areas needing improvement. The MCO's findings indicate that, since its implementation in August 2010, A Audit indicators have shown improvement in overall compliance. For example, the cumulative percentage improved between August 2010 and March 2011 from 55 percent to 85 percent, with approximately one-third of care management units over 90 percent.
- "B Audit," IFRs conducted each month on a random sample of member records, focuses on documentation consistency, service utilization, high risk areas, and member-centered outcomes. The process includes individualized, qualitative feedback; however, results are not measured quantitatively.

MetaStar recommended that MCDFC also use a quantitative approach to measuring its "B Audit" results; analyze the data to identify root causes and barriers; and develop plans for improvement based on the results.

Since its last review, CW also made a number of improvements. The MCO implemented an IFR process; developed a Team Council to facilitate input from IDTs about the IFR process changes; completed 154 IFRs between May and October 2010; and provided related feedback to IDTs with a focus on "teaching opportunities" to strengthen care management practice.

In addition to IFRs, the MCO conducted tracking and monitoring of MCP timeliness, service authorizations, and issuance of NOAs using its electronic care management system, *vPrime*, as well as an Access database, and had made recent changes to its systems to enhance the consistency of data collection across the organization. While data from the IFR process was collected and summarized in a report, the data was not analyzed for trends, and opportunities for improvement had not been prioritized. CW's annual quality review noted that until data analysis is complete, the MCO will be unable to fully determine if full compliance with standards for timeliness, service authorization, and issuance of NOAs is being achieved. MetaStar also recommended that the MCO compare its IFR data with the data collected via *vPrime* to ensure accuracy and to identify any barriers or challenges to using one or both monitoring strategies.

*i*Care showed strength by implementing the *Partnership Chart Audit* process to monitor the quality and appropriateness of care. However, guidelines for reviewers had not yet been developed, and the number of reviews completed on a quarterly basis is too small to provide the opportunity for trend analysis. MetaStar provided *i*Care with several recommendations to improve findings related to monitoring care management activities, including:

- Develop guidelines to instruct staff in completing the chart audit process;
- Continue with plans to increase the sample size of member records reviewed; and
- Analyze the chart audit data to identify trends and areas in need of improvement.

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. Review results for FY 10-11 showed that just five MCOs (CC, CHP, CW, LCD, WWC) fully met this standard. This represents progress for WWC, which moved from a score of partially met in the FY 09-10 review to a score of met for this review year. WWC followed recommendations made in the FY 09-10 review and implemented a *Utilization Review and Management Program*. FY 10-11 review findings indicated that a data analysis group meets weekly. In addition, regular monitoring and trending of data related to NOA, MCPs, grievances, and member satisfaction included the study of possible under- and over-utilization. The MCO also completed additional data analysis, including cost per day information by target group and payment made for services actually utilized, rather than services authorized. The MCO also implemented a *Utilization Management Acuity Project*. While WWC has now fully implemented a mechanism to detect both under- and over-utilization of services, the review also noted that an opportunity exists for the MCO to more clearly present its data and analysis.

Four other MCOs (CCCW, MCDFC, NB, SFCA) received a score of partially met for requirements related to utilization management. It should be noted that CCCW, MCDFC, and SFCA have not fully met this measure for the past five or six review cycles, although findings indicated that some MCOs made some progress over the past year. Examples of progress include:

- A *Business Sustainability Committee* evolved at CCCW and placed emphasis on understanding utilization trends. The committee obtained state-wide utilization data, and also engaged both IDT and management staff to identify areas of potential over-utilization of services through the use of a suggestion box on its intranet. However, the MCO has not yet developed a means to assess under-utilization of services.
- Over the past year, NB's *Financial Metrics Group* has begun to address service utilization by identifying focus areas, such as per member per month expense in residential settings, and by obtaining data and generating reports from *Enterprise*, the MCO's electronic care management system. Findings indicated that NB has not yet conducted the analysis needed to identify utilization trends or retrieved data regarding potential under-utilization of services.
- SFCA followed previous recommendations to implement a utilization review/utilization management (UR/UM) committee. SFCA also developed a *UR/UM Program Description*, and drafted a document titled *UR/UM Document Review Methodology*, which outlines the data to be regularly reviewed. In addition, the MCO initiated a project to study a sub-set of members for potential over-utilization related to residential placement and home care services. However, reviewers found that SFCA has not yet begun to monitor for under-utilization.

Among the recommendations MetaStar provided to CCCW, SFCA, and NB was the need to develop a means to identify and regularly monitor for under-utilization of services.

MCDFC established processes for monitoring both under- and over-utilization of services. Over the past year, the MCO engaged in several utilization studies in relevant areas, such as transportation, medication management, and supportive home care services. However, the results documented by the MCO were general, primarily narrative, and provided little data to support decisions relative to utilization. Recommendations MetaStar provided to MCDFC included the need to include clear supporting documentation, such as data, analysis of data, and interventions employed to achieve improvement.

*i*Care received a score of not met regarding the requirement that MCOs have mechanisms in place to detect both under- and over-utilization of services. This MCO's annual quality review included the recommendation to establish an ongoing program for UM/UR.

Quality Management Program - Work Plan

Another area of opportunity is related to the requirement to have in place an ongoing quality assessment and performance improvement (QAPI) program. FY 10-11 findings showed that six MCOs (CC, CCCW, CW, LCD, MCDFC, WWC) received a score of met for this QCR measure, three MCOs received a score of partially met, and one MCO received a score of not met.

While review findings indicated that opportunities for improvement exist across MCOs, some areas of strength were identified. Of particular note is LCD's quality management program, which MetaStar designated "Best Practice." LCD's quality program description and work plan were very well written with a structure and timetable that was easy to follow. The quality plan met all requirements, including identification of goals and objectives for improvement in all focus areas. Each program objective was measurable and documented the person responsible for

each task. LCD has developed effective tools, including a *Quality Progress Table* and *Quality Dashboard* for managing work timelines and tracking progress toward goals. The MCO monitors on a regular basis and measures progress toward objectives by reviewing data, analyzing implications of identified barriers, and planning for next steps for all work plan deliverables. Results are documented for routine committee meeting review.

Additional examples of individual MCO strengths related to quality management include the following:

- At CC, Team Facilitators in the FCP and PACE programs help bridge communication between IDTs and others in the organization, such as the Quality Team.
- At CCCW, SFCA, and WWC, staff input is actively sought and valued in order to identify barriers, streamline processes, and create improvements. For example, at WWC, staff participated in a software advisory test group, providing MCO management the opportunity to conduct rapid plan-do-study-act (PDSA) cycles prior to organization-wide implementation of software changes.
- At CW, a Quality Festival is held annually to communicate quality initiatives to staff and to the Member Advisory Council.
- MCDFC completed two key quality initiatives since its last review: The MCO implemented an automated method of collecting selected quality indicator data from member records and developed a care management core competency test instrument and process.

Since last year, two MCOs (CCCW and CW) made progress related to having an effective QAPI program and moved from scores of partially met in the FY 09-10 review to scores of met for this review cycle. For example, CCCW followed recommendations contained in its FY 09-10 annual quality review and modified its 2010 quality work plan to include key quality initiatives as well as detailed monitoring and improvement goals that support broader organizational objectives in four focus areas. Reviewers noted that CCCW adopted the *Quality Plan Progress Table,* which was developed by LCD and noted as a "Best Practice" in LCD's FY 09-10 annual quality review. CCCW has successfully used the *Quality Plan Progress Table* to facilitate working timelines, making it easier for its quality team to track progress on goals. The MCO holds monthly management meetings to assess progress toward achievement of quality objectives and has established feedback loops on all organizational levels to create improvements.

CW improved its quality management approach by focusing efforts on increasing member input through a Member Advisory Council and using the feedback to foster improvements. For example, one initiative undertaken by the Member Advisory Council was to improve care management practices related to member transitions when IDT assignments change. Additionally, the MCO's quality program description documents the roles and responsibilities of numerous committees involved in monitoring quality. Review findings indicated that the MCO's 2010 quality work plan was routinely reviewed and updated and was organized to highlight focus areas to promote a clear understanding of quality efforts throughout the organization. The MCO also made system changes to enhance the consistency of data collection. While CW has now met this requirement, reviewers provided a number of recommendations to help the MCO maintain and improve its ability to meet contract expectations related to having an effective QAPI program. Recommendations included:

- Enhance the quality work plan by including all elements noted in the DHS-MCO contract related to quality management;
- Identify measurable goals for each quality activity;
- Include more details about methods for data collection and data analysis;
- Expand the Member Advisory Council to all regions of the MCO; and
- Work together with DHS to ensure a full understanding of the MCO's quality objectives, including those that may not be documented on the MCO's quality work plan.

Three other MCOs (CHP, NB, SFCA) received scores of partially met regarding the requirement to have an effective QAPI program in place, and one MCO (*i*Care) received a score of not met.

While CHP has met this measure in the past, the MCO was unable to fully meet requirements regarding its QAPI program in this year's review. Like CW, the MCO did make improvements to its quality management approach by increasing member input through its Member Advisory Council and using the feedback to foster improvements. For example, the Council identified concerns about the cost of durable medical equipment. As a result, the MCO partnered with a provider that offers recycled electric wheelchairs at a lower cost. CHP also made changes to its structure for quality oversight, linking staff responsible for functional areas and activities related to quality assurance and improvement to a Quality and Compliance Sub-Committee. While integrating quality throughout the organization is considered a "Best Practice" at CHP, MetaStar was unable to identify an individual ultimately responsible for quality management as required in the DHS-MCO contract and recommended that CHP review the current structure of its quality management program with DHS. Given the delegation of quality activities throughout the organization, MetaStar also recommended that CHP clearly document and implement a plan to ensure effective communications and coordination among all staff with assigned responsibilities for work plan deliverables. In addition, while the MCO's quality work plan was routinely reviewed, updated, and organized to highlight focus areas, the review identified opportunities for improvement. Recommendations included:

- Make several additions to the work plan to include all areas of quality management designated in the DHS-MCO contract, including utilization management, Long-Term Care Functional Screen quality, appeals and grievances, disenrollment monitoring, and monitoring member access to services and appropriateness of care;
- Include timeframes for all goals and objectives.

While NB also received a partially met score for this measure, the MCO made progress since its FY 09-10 review by finalizing its quality work plan and getting the plan approved by its governing board. Reviewers noted that NB's quality work plan included basic requirements for monitoring quality and was structured to address four focus areas. However, the plan did not indicate how, when, and who is responsible to carry out the planned goals and outcome measures. It also did not include data and analysis to determine if priorities or measures needed to be adjusted based on findings. The MCO completed a quality initiative by developing an *Operational Plan* that includes 18 key components as well as sequential steps for implementing and tracking progress toward organizational goals. NB's annual quality review included recommendations, such as:

- Enhance the quality work plan based on analysis of previous quality program activities, baseline data, and information from quality monitoring activities; and

- Explore with DHS how the *Operational Plan* will help meet contract requirements in relation to quality management activities.

SFCA has partially met this measure for the past three review years. The MCO showed strength, by completing many of its planned quality initiatives and further developing systems to enhance monitoring efforts, despite a major organizational change in late 2010.

For example, the MCO implemented a comprehensive electronic system to record and monitor unintended events. The MCO's *2011 Quality Work Plan* was structured to address four focus areas and included most of the areas required in the DHS-MCO contract. The work plan was developed with input from various MCO staff, including member rights, provider network, fiscal, and care management staff. SFCA also followed previous recommendations to incorporate measures and timeframes into its quality work plan. Yet, review findings indicated that in several areas, the MCO's data, description of interventions, and analysis of results remained limited. For example, SFCA used its monitoring systems, such as IFRs and grievance and appeal processes, to collect detailed information but had not yet analyzed the data for root cause. Findings also indicated that SFCA has not yet developed a quality oversight committee structure. This MCO's annual quality review included recommendations such as:

- Include all current QAPI initiatives in the quality work plan;
- Analyze available data; and
- Implement a quality management committee, and include both administrative and clinical personnel on the committee.

One MCO, *i*Care, received a not met score for this measure. MetaStar identified "Measurement and Improvement" standards and measures as the area of greatest opportunity for *i*Care, including those related to the requirement to have an ongoing, effective QAPI program. FCP is just one line of business for this company, and review findings indicated that quality activities required by the DHS-MCO contract for FCP were not identified in the company's organization-wide quality work plan. This MCO's annual quality review included a recommendation that *i*Care either incorporate all required quality activities into a FCP-specific quality work plan, or integrate the FCP-required elements into the organization's overall quality work plan.

Quality Management Program - Annual Evaluation

Another area of opportunity concerns a QCR measure related to the requirement that MCOs have a process in place for evaluating the impact and effectiveness of their QAPI programs. While only half of MCOs (LCD, CCCW, WWC, CC, CW) were able to successfully evaluate their quality programs and report the results, this represents progress for CCCW and WWC, which moved from scores of partially met in last year's review to scores of met for FY 10-11. Review findings indicated that each of these MCOs met requirements by developing a quality program evaluation that described the basic elements of the program, goals and objectives, activities, progress, identified barriers and trends, the data analysis conducted, interventions employed, and provided an assessment of the impact and effectiveness of the program.

Five other MCOs (CHP, iCare, MCDFC, NB, SFCA) received a score of partially met for this measure. This represents progress for NB, which moved from a not met score in last year's review to a score of met for FY 10-11.

Of the other MCOs with partially met scores, MCDFC has not fully met this measure for the past six review years. CHP and SFCA have not met this measure in the last two reviews.

The quality management program annual evaluations of CHP and *i*Care did not include adequate information and analysis regarding the impact and effectiveness of the QAPI programs of these organizations.

SFCA made progress by addressing previous recommendations to include measures, analysis, next steps, and comparison to prior year's findings in its quality program evaluation, and considerable improvement was evident. However, in several areas, data and descriptions of interventions and analysis remained limited. MCDFC also followed previous recommendations to describe its analysis of findings and the improvement achieved over time. However, the data was not consistently clear and analysis was sometimes subjective. Descriptions of interventions, mechanisms for measuring results, and next steps were limited in several areas of the evaluation. NB also made progress since last year by developing an annual evaluation of its quality program; however, the evaluation did not consistently include measures and baseline data in order to develop next steps for future planning and accomplish key objectives.

SUMMARY OF PERFORMANCE IMPROVEMENT PROJECTS

The DHS-MCO contract requires MCOs operating a FC program to conduct at least one PIP per year relevant to long-term care. For FY 10-11, one FC MCO (NB) did not meet this requirement. For MCOs operating a FCP and/or PACE program, two PIPs are required; one PIP relevant to long-term care and another PIP relevant to clinical care. For MCOs operating FC as well as FCP and/or PACE, the PIP relevant to long-term care can encompass more than one program as long as the PIP includes, studies, and focuses on both or all programs. For FY 10-11, one FCP MCO (*i*Care) did not meet this requirement.

Nine MCOs worked on a total of 14 PIPs during FY 10-11, including five PIPs continued from FY 09-10, and nine new PIPs. One MCO (LCD) conducted its PIP using the Best Clinical and Administrative Practices (BCAP) methodology; however, any defined performance improvement model may be utilized by MCOs.

Continuing PIPs included projects related to:

- Reducing the number of members who fall
- Improving the assessment and management of member pain issues
- Ensuring patient safety and preventing medication errors
- Increasing compliance rates for care management documentation standards
- Increasing the number of members who receive a notice of action according to DHS-MCO contract requirements

PIPS initiated in FY 10-11 related to:

- Increasing Hemoglobin A1c and LDL lab test compliance for diabetic members*
- Improving the assessment and management of member pain issues
- Improving practices related to fall prevention, investigation, and reporting
- Improving identification of member outcomes
- Ensuring members with developmental disabilities who need restrictive measures have an approved plan in place

- Reducing the impact of wounds on members and the cost of wound care
- Reducing the number of member complaints and increasing member satisfaction related to transportation services
- Protecting member rights by increasing the percentage of notices of action that are sent in a timely manner, when warranted
- Addressing barriers to employment for members*

*The PIPs of two MCOs (*i*Care, MCDFC) were initiated and approved by DHS; however, the PIPs were not validated by the EQRO, as they were in the early stages of implementation at the time of the annual quality reviews of these MCOs.

The PIP review protocol consists of ten standard elements and 32 related indicators or measures. It is important to note that the standards and indicators used to evaluate each PIP varied, depending on the design of the project and its stage of implementation at the time of the MCO's FY 10-11 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.

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 contained in Attachments 3 through 12. Overall, FY 10-11 findings show that most MCOs continue to have significant areas of opportunity related to developing and conducting PIPs.

During FY 10-11, DHS took steps to address one notable area of opportunity identified in the FY 09-10 review regarding the standard review element, *Study Questions and Project Aims*. Of the PIPs reviewed in the 09-10 cycle, findings indicated that requirements to have a study question or overall aim that is clearly stated and measurable were met just 47.4 percent of the time. 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. To foster improvement, DHS inserted language in the CY 2011 contract with MCOs requiring the submission of study questions and project aims or goals to DHS for review and approval while PIPs are in the planning stage, and before interventions are implemented. The 2011 contract requirement took effect in the middle of the fiscal year, which posed challenges for at least two MCOs, iCare and MCDFC. The impact of this change will not be evident until the next review cycle is completed, when the results of improvement efforts have been evaluated.

Additional notable areas of opportunity for improvement were identified regarding the latter stages of PIP project development, especially several indicators associated with the standard review elements, *Improvement Strategies* and *Analysis and Interpretation of Results*. Although some progress was made related to two other review elements, *Real Improvement* and *Sustained Improvement*, opportunities in these areas also continue to exist across MCOs.

Findings showed that overall, indicators related to the review element, *Improvement Strategies*, were met only 42.9 percent of the time. (Note: See the "Introduction and Overview" portion of this report for a chart depicting the overall findings for FY 10-11 for each of the standard PIP review elements.) This represents a further drop from FY 09-10 results, when just 50 percent of

the indicators evaluated for this element were met. The decline is related to two indicators that measure whether PDSA cycles are appropriately applied and whether project interventions have a good chance of success.

PIPs must use PDSA cycles to monitor the effectiveness of project interventions. Success with this indicator may be related to the quality of the prospective data analysis plan for a PIP.

In FY10-11, only four projects conducted by two MCOs (CW, WWC) fully met the requirement to develop and implement PDSA cycles. Three projects conducted by two MCOs (CC, LCD) received scores of partially met, while five projects conducted by four MCOs (CC, CCCW, CHP, SFCA) received scores of not met for this indicator.

Project interventions must be appropriate and effective so they have a good chance of success and result in real improvement. However, just six projects conducted by four MCOs (CHP, CW, LCD, WWC) received scores of met for this measure. Four projects conducted by two MCOs (CC, CW) received scores of partially met, while two projects conducted by two MCOs (CCCW, SFCA) received scores of not met. Due to its emphasis on conducting a thorough needs analysis prior to selecting a study topic, the DHS pre-approval process may facilitate improvement in this indicator. MCO-specific data obtained during the analysis may be used to develop interventions that are likely to be successful.

Findings also showed that across MCOs, indicators related to the review element, *Analysis and Interpretation of Results*, were fully met only 41.7 percent of the time - a decrease from FY 09-10, when 60.5 percent of the indicators evaluated for this element were met. One indicator that contributed to the decline relates to the requirement that follow-up activities or "next steps" be clearly defined. Clearly identifying planned next steps assists with continued progress towards stated goals and the ability to sustain improvement. For the 12 PIP projects reviewed during FY 10-11, only four projects conducted by three MCOs (CHP, CW, WWC) received a score of met for this indicator; seven projects conducted by four MCOs (CC, CCCW, CW, LCD) received a score of partially met; and one project conducted by SFCA received a score of not met. By contrast, this indicator had been identified as an area of relative strength in last year's review, when nine of 12 projects received a score of met for this measure; one received a score of partially met; and one received a score of not met. Three other indicators related to this review element also contributed to the overall poorer results. The three indicators measure whether data analysis included initial and repeat measures and identified limitations; whether numerical findings were accurate and clearly presented; and whether project successes and progress were clearly stated. In this year's review, the combined number of partially met and not met scores for these three measures increased by 25 percent compared to the results of the FY 09-10 review.

FY 10-11 findings showed progress related to two standard review elements, *Real Improvement* and *Sustained Improvement*. 48.1 percent of the indicators evaluated for *Real Improvement* were met in FY 10-11. While there is obviously room for improvement, the results show slight progress since FY 09-10, when 44.4 percent of the indicators related to this review element were met. Two indicators related to this review element contributed to the improved results. The indicators measure whether improvements in processes and/or outcomes are documented and whether improvements appear to be the result of planned interventions. For the first indicator, five projects conducted by three MCOs (CHP, CW, WWC) documented improvements in processes and/or outcomes and received a score of met for this measure. Three projects

conducted by three MCOs (CC, CW, SFCA) received a score of partially met, and four projects conducted by three MCOs (CC, CCCW, LCD) received scores of not met. By contrast, just three projects received a score of met for this measure in last year's review. For the second indicator, four PIPs conducted by three MCOs (CW, CHP, WWC) were able to show that improvements were the result of planned interventions and received a score of met for this measure.

One project conducted by CW received a score of partially met, and two projects conducted by CC received scores of not met. The indicator did not apply to five projects conducted by four MCOs. By contrast, just two projects received a score of met for this indicator in FY 09-10.

Sustained Improvement was also an area of progress, as two projects conducted by two MCOs (CHP, CW) demonstrated sustained improvement and received a score of met for this measure. One project conducted by WWC received a score of partially met, and two projects conducted by CC received scores of not met. This indicator did not apply to seven projects conducted by six MCOs. In last year's review, none of the six projects to which this indicator applied fully met this measure.

The review also identified areas of strength related to developing and conducting PIPs. While results have declined somewhat since the FY 09-10 review, three standard review elements continued to reflect areas of relative strength: *Topic Selection*, *Indicators and Measures*, and *Project Population*. For FY 10-11, indicators related to these review elements were met at a rate of 87.5 percent, 83.3 percent, and 72.2 percent, respectively.

Regarding the review element, *Topic Selection*, 11 of the 12 projects reviewed fully met requirements to adequately research the topic to confirm that a problem exists, the nature of the problem, and desired improvements. Only one project conducted by CCCW received a score of not met for this measure. In addition, ten projects fully met requirements to select study topics that focused on improving health outcomes and member satisfaction, while only two projects conducted by two MCOs (CCCW, LCD) received scores of partially met for this measure. It should be noted that while these indicators of successful *Topic Selection* have represented an area of strength for at least the past two review years, some topics selected by MCOs and reviewed by the EQRO have been more related to contract compliance than improvements in health and long-term care outcomes. With its PIP pre-approval process now in place, DHS is helping assure MCOs select PIP topics that are focused on improving outcomes for members.

Nine PIPs conducted by five MCOs (CC, CW, CHP, SFCA, WWC) fully met two measures related to *Indicators and Measures*. The projects had clearly defined indicators that measured change in health/functional status, satisfaction, or care processes. Two PIPs conducted by two MCOs (CCCW, CW) received scores of partially met or not met for these two measures. One other PIP conducted by LCD was evaluated based on the MCO's use of the BCAP methodology. This PIP fully met requirements to contain overall outcome measures and typology measures that link to associated outcomes.

While results related to the standard review element *Project Population* decreased approximately ten percent compared to the results of the FY 09-10 review, MCOs continued to show strength in the ability to identify a representative and generalizable study population. Ten of the PIPs reviewed received a score of met for this measure, while only two PIPs conducted by

CC received scores of partially met. Nine PIPs conducted by six MCOs (CC, CHP, CW, LCD, SFCA, WWC) were also successful in clearly defining the relevant population.

SUMMARY OF VALIDATION OF PERFORMANCE MEASURES

During FY 10-11, MetaStar validated the accuracy and reliability of 2010 performance measures data submitted by MCOs related to influenza and pneumovax immunizations.

Validation findings indicate that, as a group, MCOs are able to produce accurate performance measures data.

DHS denominator data was used to calculate all final MCO immunization rates. During the validation process, discrepancies were found in the DHS denominator data for members who enrolled mid-month, or who disenrolled in the months of September and December for the influenza indicator and July and December for the pneumovax indicator. While these discrepancies affected the calculations, the impact was not significant and, at the direction of DHS, no changes were made to the final rates.

For more information about the performance measures, including a summary of the overall statewide rates for influenza and pneumovax immunizations for MCOs operating FC, FCP, and PACE programs, see Attachment 17.