EXTERNAL QUALITY REVIEW REPORT
WISCONSIN MEDICAID MANAGED LONG-TERM CARE
FAMILY CARE, FAMILY CARE PARTNERSHIP AND PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY
STATE FISCAL YEAR 2011-2012

PREPARED FOR

WISCONSIN DEPARTMENT OF HEALTH SERVICES

PREPARED BY

PRELIMINARY: SEPTEMBER 7, 2012
FINAL: NOVEMBER 29, 2012

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EXECUTIVE SUMMARY

External Quality Review Process

The Code of Federal Regulations at 42 CFR 438 requires states that operate pre-paid inpatient health plans to provide for an external quality review of their managed care organizations and to produce an annual technical report. Wisconsin's Medicaid managed long-term care programs, Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly are considered pre-paid inpatient health plans. To meet its obligations, the State of Wisconsin contracts with MetaStar, Inc. This report covers the external quality review year from July 1, 2011, to June 30, 2012. Mandatory review activities conducted during the year included assessment of compliance with federal standards, validation of performance improvement projects, and validation of performance measures. Assessment of compliance in key areas of care management practice was also conducted related to assurances found in the 1915(c) Waiver, and to support assessment of compliance with federal standards. Information systems capabilities assessments were also conducted for a limited number of organizations.

Summary of Findings

Wisconsin's managed long-term care organizations continue to perform strongly in several areas related to program access, including:

- Ensuring members' rights;
- Providing effective systems and processes for grievances and appeals; and
- Ensuring a comprehensive network of qualified providers capable of providing timely, culturally competent services.

Overall, managed care organizations have the basic structures in place to assess and improve the quality of care, although many organizations need to improve the effectiveness of their quality assessment and performance improvement programs.

While managed care organizations have the systems, processes, and resources in place to ensure members' health and safety and support care management, most organizations continue to have opportunities to:

- Improve the consistency and effectiveness of care management systems and practices;
- More closely align practice with the core principles which have underpinned the Family Care model since its development, i.e., identifying members' personal experience outcomes; applying the Resource Allocation Decision Method to decision making; and managing members' risks.

Summary of Progress

Notable areas of progress over the past three review years include the following:

- Care managers have become increasingly proficient at assessing outcomes important to the member and documenting outcomes reflective of the member's voice.
- All managed care organizations have developed basic structures and processes to provide data for assessing and monitoring the access, timeliness, quality, and appropriateness of care provided to members.
- Some organizations have refined processes for using data and analysis to identify trends, drive decision making, and support the fundamental principle of member-centered care in DHS managed long-term care programs.
- Managed care organizations have made steady progress regarding the requirement to ensure that no payments are made for items or services provided by individuals or entities excluded from participating in federal health care programs.
- Managed care organizations have increasingly integrated technology into organizational operations and care management practice with the goal of increasing efficiency, timeliness, consistency and quality.

Recommendations

Ensure all organizations comply with requirements to conduct timely and thorough annual evaluations of Quality Assessment and Performance Improvement programs and develop comprehensive quality work plans based on the findings.

Encourage managed care organizations to focus quality assessment and performance improvement activities on elements that impact the quality of member care, such as

- Comprehensiveness of assessments and member-centered plans;
- Timeliness of service authorization decision making;
- Timeliness of issuance of notices of action; and
- Consistency of care management practice.

Improve provider network monitoring and quality by:

- Ensuring that processes are in place to verify providers, including owners/principals, have not been debarred from participating in federal health care programs;

- Defining for managed care organizations the frequency with which debarment should be monitored; and

- Ensuring all organizations meet requirements that periodic background checks are conducted on all employees and service providers who come into direct contact with members.

Support continued interdisciplinary team staff development to enhance skills related to identifying measureable outcomes and learning effective approaches for measuring progress towards outcomes achievement.

Continue to proactively engage with managed care organizations when members with complex situations or conditions are identified.

Establish a timeframe and related expectations for performance improvement project pre-approval submissions and/or adjust the schedule for project validation to ensure adequate time for organizations to meet requirements to make active progress on performance improvement projects during each contract period.

INTRODUCTION AND OVERVIEW

Acronyms and Abbreviations

Please see Appendix 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 to the Centers for Medicare & Medicaid Services (CMS) 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 Code of Federal Regulations (CFR) at 42 CFR 438 requires states that operate pre-paid inpatient health plans (PIHPs) to provide for an external quality review of their managed care organizations. This report covers mandatory and optional external quality review (EQR) activities conducted by MetaStar, Inc., for the fiscal year from July 1, 2011, to June 30, 2012 (FY 11-12). See Appendix 2 for more information about external quality review and a description of the methodologies used to conduct review activities.

The Wisconsin Department of Health Services (DHS) contracts with ten managed care organizations (MCOs) to administer these programs, which are considered PIHPs. As noted in the table below, six MCOs operate FC programs; one MCO operates only a FCP program; two MCOs operate FC and FCP programs; one MCO operates programs for FC, FCP, and PACE.

OVERVIEW OF WISCONSIN'S FC, FCP AND PACE MCOS

MANAGED CARE ORGANIZATION	PROGRAM(S)
Care Wisconsin (CW)	FC; FCP
Community Care (CCI)	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)	FC
Northern Bridges Managed Care Organization (NB)	FC
Southwest Family Care Alliance (SFCA)	FC
Western Wisconsin Cares (WWC)	FC

Note: On October 11, 2012, DHS announced that, as a result of a competitive procurement, SFCA will replace CHP as the MCO responsible for delivery of FC services in Chippewa, Dunn, Eau Claire, Pierce, and St. Croix counties effective January 1, 2013.

Brief History of Managed Long-Term Care in Wisconsin

In the middle of the 1990s, 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:

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.

DEVELOPMENT OF MANAGED LONG-TERM CARE

1999	DHS is piloting three new managed long-term care delivery models. FC, FCP or PACE operate in nine of 72 Wisconsin counties (12%).
2006	Pilot phase ends as DHS begins process of FC expansion statewide.
2011	A temporary "cap" is placed on program enrollments, although some enrollments continue.
2012	Enrollment cap is removed. Consumers in Racine and Kenosha counties are afforded more choice of MCO provider when one MCO expands FC and another expands FCP into these service areas. FC currently is available in 57 of 72 counties (79%); FCP is available in 19 counties (26%); and PACE is available in two counties (1%).

A map depicting the current FC, FCP and PACE service areas throughout Wisconsin can be found at the following website, under the General Information tab:

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

For details about the core values and operational aspects of these programs, visit these websites:

http://www.dhs.wisconsin.gov/LTCare/Generalinfo/WhatisFC.htm and

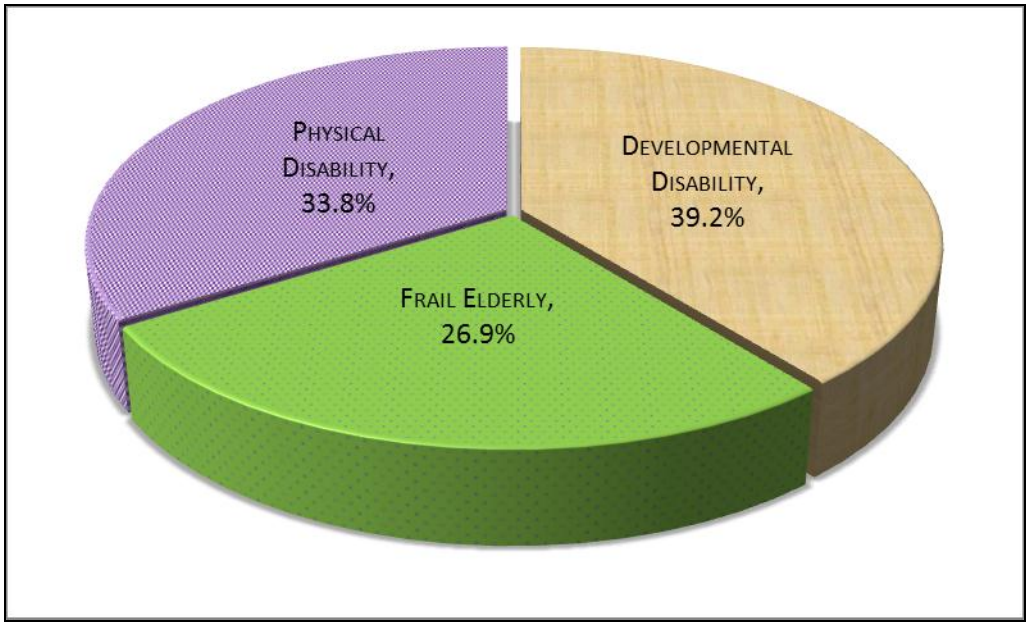
http://dhs.wisconsin.gov/wipartnership/2pgsum.htm

Total enrollment increased during the fiscal year. As of June 30, 2012, enrollment for all programs was 39,054. This compares to a total enrollment of 36,966 as of June 30, 2011.

The chart below shows the percent of total enrollment by the primary target groups served by these programs; individuals who are frail elders, persons with developmental disabilities, and persons with physical disabilities.

PROGRAM PARTICIPANTS BY PRIMARY TARGET GROUP

JUNE 30, 2012



Enrollment data is available at the following DHS website:

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

Highlights of State Quality Initiatives in FY 11-12

Based on findings and recommendations made by the Legislative Audit Bureau in its April 2011 report to the Joint Legislative Audit Committee as well as its own analysis, DHS prioritized efforts on a multi-faceted plan to ensure long term sustainability of the managed long-term care programs. In addition, DHS continued development of a "scorecard" of key performance indicators.

Developing a Plan for Long-Term Sustainability

During FY 11-12, DHS completed a comprehensive data analysis and consulted with a wide range of stakeholders to identify cost drivers and seek options to improve the cost-effectiveness and future fiscal sustainability of the state's long-term care programs. As a result, DHS developed a sustainability plan that includes proposals in several focus areas:

- Employment supports;
- Family Care administrative and program efficiencies;
- Family Care benefits;
- Residential services;
- Living well at home and in the community;
- Youth in transition;
- Include, Respect, I Self-Direct (IRIS) and self-directed supports.

As FY 11-12 ended, DHS was accepting comments and the sustainability plan was being refined.

Reporting on Family Care Key Performance Indicators

During FY 11-12, DHS focused efforts on increasing the use of data to evaluate the effectiveness and improve the quality of FC programs. DHS is working with the MCO quality management, fiscal, and performance measures workgroups as well as MCO leadership to develop a performance scorecard. It will be a report of key performance indicators required to be measured under DHS 10.46(3), Wisconsin Administrative Code, as well as other identified clinical, functional, personal experience, and other measures. The following indicators were among those identified for potential inclusion in the initial Family Care Key Performance Indicators Report:

- Rates of preventable hospitalizations and emergency room visits;
- Pressure sore rate;
- Percent of members who file DHS level grievances/appeals and Division of Hearings and Appeals level Fair Hearing requests, and their dispositions;
- Percent of members or representatives on governance boards and committees;
- Change in need for assistance with activities of daily living;
- Percent of non-retired members employed in any setting;
- Influenza vaccination rate;
- Measures related to Personal Experience Outcomes Integrated Interview and Evaluation System (PEONIES) data;
- Measures related to member satisfaction survey data.

The Family Care Key Performance Indicators report is expected to provide individual data regarding the performance of each MCO as well as aggregate data for FC, FCP, and PACE programs.

Other State Initiatives

DHS also engaged in other activities to support the quality of the state's long-term care programs, such as:

- Creating a Long-Term Care Functional Screen (LTC FS) section within DHS focusing on LTC FS oversight and development; and developing and implementing "Continued Skills Testing" for staff certified to conduct the LTC FS.
- Providing mutual opportunities for communication, problem solving, and program improvements by facilitating structured DHS-MCO workgroups. Active workgroups included:
    - DHS-MCO Leadership
    - Quality Management and Member Rights
    - Care Management
    - Provider Network and Integrated Employment
    - Information Technology
    - Fiscal

Scope of FY 11-12 External Review Activities

In FY 11-12, MetaStar conducted three mandatory review activities as specified in federal Medicaid managed care regulations found at 42 CFR 438.358: Assessment of compliance with federal standards, referred to in this report as quality compliance review; validation of performance improvement projects; and validation of performance measures. In addition, MetaStar conducted care management reviews and information system capability assessments and collaborated with the University of Wisconsin's Center for Health Systems Research and Analysis (CHSRA) to conduct and report member interviews.

Mandatory Review Activities	Scope of Activities
Quality Compliance Review	As directed by DHS, quality compliance review (QCR) activities generally follow a three year cycle, one year of comprehensive review followed by two years of targeted review or follow-up. FY 11-12 was a comprehensive review year; therefore, the EQR team reviewed all compliance standards for all MCOs.
Performance Improvement Projects	The DHS-MCO contract requires all MCOs to make active progress each year on at least one performance improvement project (PIP) relevant to long-term care. MCOs operating PACE or FCP programs must also make progress on at least one additional PIP relevant to acute and primary care. In FY 11-12, MetaStar validated one or more PIPs for each MCO, for a total of 14 PIPs.
Performance Measures	Annually, MCOs must measure and report their performance using quality indicators and standard measures specified in the DHS-MCO contract. For FY 11-12, all MCOs were required to report performance measures data to DHS related to care continuity, influenza vaccinations, and

	pneumococcal vaccinations. MCOs operating PACE or FCP programs were also required to report data on dental visits as well as all of the Healthcare Effectiveness Data and Information Set (HEDIS®)[1] data which FCP and PACE MCOs provide to CMS for Medicare enrollees. As directed by DHS, the EQR team validated two of these performance measures for every MCO: • Influenza vaccinations • Pneumonia vaccinations MetaStar collected information and data from MCOs regarding the care continuity and dental visits performance measures and delivered it to DHS but did not validate these measures. MetaStar also collected and delivered the HEDIS data to DHS.

Optional Review Activities	Scope of Activities
Care Management Review	MetaStar performed care management reviews (CMR) to assess each MCO's level of compliance with its contract with DHS in key areas of care management practice. During FY 11-12, the EQR team conducted CMR activities during each MCO's annual quality review (AQR), a total of 661 record reviews. CMS conducted a PACE audit in FY 11-12; therefore, MetaStar did not review the PACE program. At the request of DHS, MetaStar also performed an additional 81 CMRs separate from AQR. These results were reported separately and are not included in the data for this report.
Information System Capabilities Assessments	During FY 11-12, MetaStar also performed information system capability assessments (ISCAs) to evaluate the extent of MCOs' health information systems capabilities to meet DHS-MCO contract requirements for collecting, analyzing, integrating, and reporting valid encounter data and other data. As directed by DHS, the EQR team conducted ISCAs for three MCOs: CW, LCD, and WWC.
Member Interviews	At the request of DHS, MetaStar conducted 550 PEONIES member interviews. The member interview results were reported separately by CHSRA and are not included in the data for this report.

Scope of each MCO's Annual Quality Review

During FY 11-12, each MCO's AQR consisted of QCR, CMR, and PIP validation activities. It should be noted that two MCOs, NB and *i*Care, began operations in 2009 and 2010, respectively. An initial comprehensive review was conducted at each of these MCOs the year after start-up. MetaStar repeated comprehensive reviews for these MCOs in 2012 at the request of DHS due to the number of standards not fully met during the initial comprehensive reviews and to align these two MCOs with the full review year for all other MCOs.

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

Individual reports containing the results and recommendations specific to each MCO's FY 11-12 AQR can be found in Attachments 1 through 10, while MCO comparative information is contained in Appendices 3 and 4.

Performance measures validation and ISCAs were conducted and reported separately from the other AQR activities. Results can be found in Attachments 11 through 14.

SUMMARY OF FINDINGS

Compliance with Standards (QCR, CMR, PIP)

Organizational systems, processes, and care management practices of MCOs are member-centered and reflect respect for the rights of members.

Compliance with enrollee rights standards has been a consistent area of strength across MCOs since the previous full review year in FY 08-09. Aggregate results for FY 11-12 show a compliance rate of 86.3 percent with the eight QCR indicators comprising the "Enrollee Rights and Program Structure" area of review. Four of the ten MCOs fully met all eight indicators in this category. Quality compliance review findings, including MCO comparative information can be found in Appendix 3.

Five of the eight Enrollee Rights indicators relate to the right of members to have available current and accurate information in accessible languages and formats, including a member handbook and provider directory. All ten MCOs fully met these five indicators. These results reflect progress made by four MCOs over the past three review years: Three of the MCOs lacked complete provider directories at the time of the previous full review in FY 08-09, while a fourth MCO did not fully meet provider directory requirements at the time of its initial annual quality review in FY 09-10.

Review findings for seven MCOs indicated that these organizations provide a variety of resources and tools, such as written materials for members, and checklists, electronic references, in-house behavioral health and member rights specialists, and training for staff to help assure members' rights. The EQR team noted a "Promising Practice" at one MCO, where the quality assurance director conducts all new employee orientation related to member rights to ensure consistency in the message that staff receive. **(See Attachment 15 for a list of the promising and best practices cited in this report.)**

In aggregate, results for the eight Enrollee Rights indicators represent a decrease in the rate of compliance compared to the three previous review years, when overall compliance rates ranged from 96 percent to 98 percent. The decrease relates to reviewers' observations that policies and procedures could be improved to provide clear and accessible written guidance for staff and providers regarding member rights. As a result, MetaStar provided recommendations to seven of ten MCOs to improve, develop, or streamline policies relating to overall member rights, privacy, restrictive measures, or advance directives.

Compliance with "Grievance Systems" standards has also remained a consistent area of strength across MCOs since FY 08-09.

Results for this area of QCR indicates that all MCOs have adequate appeal and grievance systems in place, providing members access to processes for exercising rights to express dissatisfaction and resolve disagreements with the MCO.

Aggregate results for FY 11-12 show a compliance rate of 91.3 percent with the 16 indicators comprising this area of review. Eight MCOs met 15 of 16 indicators. This compares with compliance rates consistently ranging from 91 percent to 94 percent in the previous three review years. Review findings for eight of ten MCOs indicated that MCOs have a philosophy that supports strong internal systems to attempt to resolve appeals and grievances through internal review, negotiation, or mediation.

QCR and CMR results consistently show a high rate of compliance across MCOs related to the right of members and their supports to be included in care management processes and participate in decisions. For example, for FY 11-12 the CMR indicator, "Member/Guardian/Family/Informal Supports Included," showed an average compliance rate of 97.4 percent. This compares with compliance rates consistently near 95 percent or above in the three previous review years.

An area of progress since FY 08-09 relates to the right of members to confidentiality in the communication of protected health information (PHI). A QCR element contained in the "Access to Services and Quality Monitoring" area of review requires MCOs to have systems and processes in place, such as policies, procedures, and capabilities to ensure that medical, enrollment, and other personally identifiable information is handled in accordance with regulations. In FY 08-09, three MCOs did not fully meet requirements to have adequate systems and processes in place to ensure confidentiality of PHI, while a fourth MCO did not fully meet requirements at the time of its initial annual quality review in FY 09-10. Three of these four MCOs fully met these requirements by FY 11-12. As a result, nine of ten MCOs are currently adhering to confidentiality requirements.

MCOs have the structures and processes in place to maintain and monitor a network of qualified service providers sufficient to provide adequate access to all services covered under the DHS-MCO contract.

Access to providers and services has been a consistent area of strength since the previous full review year. Aggregate results for FY 11-12 show a compliance rate of 96.7 percent for three QCR indicators related to the service delivery network, including the MCO's ability to:

- Establish and maintain a network of qualified providers;
- Monitor providers' ability to meet standards for timely access to care and services; and
- Ensure providers deliver services in a culturally competent manner.

The EQR team noted some Promising Practices related to ensuring provider quality: At one MCO, staff completes a *Provider Integrity Form* to report provider quality issues to the provider network department. The forms are reviewed at staff meetings, included in supervisor consultations with individual staff, and reported weekly to regional managers. At another MCO, care management staff complete surveys about the quality of providers, which result in a "star rating." Ratings are available within the MCO's service authorization system and provide care managers with additional information about provider quality to support decision making.

Nine of ten MCOs fully met the requirement to have written policies, procedures, and processes in place for the selection, retention, and credentialing of providers. The results represent progress made by three MCOs since FY 08-09. A fourth MCO has not fully met these requirements since the time of its initial annual quality review in FY 10-11 and must develop a process to include certified adult family homes in its provider network.

Results were mixed regarding two other QCR indicators related to provider credentialing, the requirement that MCOs have processes in place for ensuring:

- No payments are made for items or services provided by individuals or entities that have been excluded/debarred from participating in federal health care programs; and
- Periodic criminal and caregiver background checks are conducted on employees and providers who come into direct contact with MCO members.

MCOs have made steady progress since the previous full review in meeting the requirement to check for provider debarment. For example, in FY 08-09 only two of eight MCOs received scores of met for this indicator. By FY 11-12, seven of ten MCOs had fully met this requirement. In addition, reviewers cited a "Best Practice" at one MCO, which uses an automated process to conduct monthly checks of its contracted providers to ensure they have not been excluded from participating in federal health care programs. Two of three MCOs not meeting this requirement had conducted provider verification just prior to the EQR team's on-site visit; and two MCOs did not have verification for all providers in the review sample.

MCOs should improve existing processes for monitoring debarment to ensure that searches include the names of owners/principals. MetaStar recommends that DHS contribute to improvement by clearly defining the frequency with which debarment should be monitored as well as expectations regarding monitoring of owners/principals.

Progress was more limited regarding requirements contained in the DHS-MCO contract to ensure that periodic criminal and caregiver background checks are conducted on employees and providers who come into direct contact with MCO members. In FY 08-09, only one MCO received a score of met for this indicator. Some progress has been made; in FY 11-12, four of ten MCOs fully met this requirement.

The remaining six MCOs received recommendations such as:

- Continue to conduct background checks at required intervals;
- Improve processes for monitoring background checks for sole proprietors/individual owner-operators; and
- Fully implement, analyze, and sustain policies and practices related to background checks.

While MCOs have the basic structures in place to assess and improve the quality of care, many MCOs have the opportunity to improve the effectiveness of their quality assessment and performance improvement (QAPI) programs.

A set of ten indicators included in the "Access to Services and Quality Monitoring" area of QCR relates to the requirement that MCOs implement an ongoing QAPI program. Aggregate results for these ten indicators show a compliance rate of 72 percent for this area of review.

A closer look shows the rate is primarily attributable to three MCOs with compliance rates ranging from 30 to 50 percent for these ten indicators. Two of the MCOs were undergoing quality department restructuring at the time of their annual quality reviews and have the opportunity to improve data-driven analysis, planning, and evaluation as they operationalize the new structures. A third MCO has been operating its FCP program for just two years and needs to expand the focus and increase integration of its QAPI program, especially as it relates to FCP.

By contrast, four MCOs performed strongly in this area; two MCOs fully met all ten indicators, and two MCOs met nine of ten indicators. These MCOs have made continued progress over the last few years and reviewers observed some common characteristics among these high performers, such as:

- A quality program that is well-integrated organizationally;
- An increasing focus on the use of data and analysis to identify problems and drive decision making; and
- A culture of quality improvement that is evident throughout the organization.

Reviewers identified Promising Practices at two of these MCOs: One MCO uses a *Quality Improvement Dashboard* to track details and progress made on QAPI program goals. The Dashboard includes each goal with baseline measurement, quarterly indicators showing any progress, the person responsible for tasks, and commentary on progress for each indicator. Another MCO produces a *Quarterly Indicator Report* to provide a readily understandable graphic display of key results of QAPI activities as a way of sharing information across the organization.

Four of the ten QAPI measures are indicative of having a *basic structure* in place to assess and improve the quality of care. This was identified as an area of strength, as aggregate results show a compliance rate of 93 percent with these four indicators:

- The QAPI program of every MCO includes all federal and state required elements;
- All MCOs maintain health information systems capable of collecting and reporting data;
- Nine of ten MCOs have ongoing QAPI programs which are organized as required by the DHS-MCO contract;
- Eight of ten MCOs have processes in place to annually evaluate their QAPI programs.

Results were mixed for the remaining six QCR indicators related to ensuring an *effective* QAPI program. For example:

- Five MCOs have the opportunity to improve the comprehensiveness of quality work plans and ensure that plans are developed based on findings and analysis of the previous year's QAPI activities. Related to this finding, two of these MCOs also need to conduct timely and thorough annual evaluations of their QAPI programs.
- In order to move toward full compliance, four MCOs need to implement or improve processes for monitoring and detecting under- and over-utilization. Common recommendations provided to these MCOs related to analyzing available data, taking action based on findings, and integrating utilization management throughout the organization.
- Seven MCOs did not fully meet a QCR indicator related to the requirement to conduct PIPs each year which produce new information on the quality of care.

To address a notable opportunity for improvement identified during the FY 09-10 AQR cycle, DHS required MCOs to submit projects for pre-approval beginning January 1, 2011. Nine of ten MCOs received approval and conducted the required number of PIPs, for a total of 14 projects.

Reviewers found that study methodologies overall were improved as a result of the pre-approval process; however, time to conduct the projects was limited due to several factors. At the time of each MCO's required PIP validation, the implementation and analysis phases were completed in only seven projects, while just three of those seven demonstrated improvement in processes or outcomes of care. Most MCOs continue to have opportunities to strengthen PIP methodology, although one organization successfully completed two very strong projects.

An area where progress has been made relates to the requirement of having effective processes in place to provide data for assessing and monitoring the access, timeliness, quality, and appropriateness of care provided to members. In FY 09-10, no MCO fully met this requirement. However, in FY 10-11, six MCOs had made enough progress to receive scores of met for this review indicator and all but one was able to maintain the progress in FY 11-12. In addition, one MCO moved from a score of partially met in last year's review to a score of met for this year. As a result, six of ten MCOs fully met this requirement in FY 11-12. Four MCOs received recommendations for improvement, such as:

- Ensure the effectiveness of data collection methods;
- Conduct data analysis;
- Provide feedback to staff; and
- Develop improvement efforts based on findings.

Having effective processes in place to assess and monitor access, timeliness, quality, and appropriateness of member care clearly remains an area of continued opportunity for many MCOs and is related to the effectiveness of care management systems and practices discussed below.

MCOs have information systems in place as well as policies, procedures, tools, and other resources to ensure members' health and safety and support care management practice. Progress has been made in some key areas, but most MCOs continue to have opportunities to improve the consistency and effectiveness of care management systems and practices.

Training, Tools, and Resources to Support Care Management Practice

Review findings indicate that an area of strength for many MCOs is the initial and ongoing staff training focused on care management practice and the core principles of FC, i.e., identifying members' personal experience outcomes; applying the Resource Allocation Decision Method (RAD) to decision making; and managing risk at the member level.

During on-site discussions and in responses to pre-onsite surveys conducted over the past three review years, interdisciplinary team (IDT) staff across MCOs have consistently reported receiving training on topics related to developing and documenting members' personal experience outcomes, strength-based assessment, member-centered care planning, using the RAD, assessing and addressing risk, restraints and restrictive measures, and other topics.

MCOs provide training using a variety of approaches and formats, such as formal and in-service training, one-on-one guidance from supervisors, and group discussions during unit meetings. An area of progress since the previous full review year is the increasing development of computer and web-based applications for care management training. One MCO's approach to web-based training is a promising practice. The MCO uses software that allows uploading of training content, such as webinars and presentations, and fosters collaborative learning via bi-directional sharing of questions and answers. The MCO also has the capability to monitor and track staff's use of the site.

MCOs have systems, tools, processes, and resources to support key areas of care management practice, such as assessment, care planning, and decision making. MCOs make resources available to staff electronically so they are easily accessible. Examples include:

- Standardized assessment and specialty screening tools;
- In-house professionals and specialists in mental and behavioral health as well as behavioral health and risk oversight committees;
- Clinical practice guidelines;
- Risk reduction guidelines and agreements; and
- Service authorization policies, RAD worksheets and quick reference guides, and other organizational tools, policies, and procedures.

Since the previous full review, five MCOs made progress related to ensuring service decisions are timely and consistent. These MCOs took action such as developing and/or enhancing automated systems for authorizing services and tracking timelines for decision-making, issuance of notices of action (NOAs), and follow-up. For example, one MCO's provider information system was cited as a "Best Practice" in the past two review years.

Another area of progress over the last four years relates to clinical practice guidelines. A set of three QCR indicators contained in the "Access to Services and Quality Monitoring" area of review assesses whether MCOs disseminate and consistently apply clinical practice guidelines which are current, based on valid and reliable evidence, and meet the needs of members. In FY 11-12, eight of ten MCOs fully met these requirements.

Assessing and Addressing Risk

Assessing and addressing risk has consistently been noted as an area of strength since the previous full review. Overall MCOs continue to exhibit strength in this area. For example:

- FY 11-12 aggregate results for the CMR indicator, "Reassessment Done When Indicated," showed a compliance rate of 89.1 percent. This compares to a compliance rate of 87.8 percent in both FYs 09-10 and 10-11.
- Results for the CMR indicator, "Member's Identified Needs Addressed," showed a compliance rate of 94.4 percent. This is consistent with the results of the previous two years, when aggregate scores for this measure were in the range of 93 to 95 percent.
- Results for the CMR indicator, "Risk Addressed When Identified," showed a compliance rate of 86.3 percent. This compares to compliance rates ranging from 89.5 to 92.3 in the previous two years, although it should be noted that compliance with the indicator is only assessed for records in the review sample where risk is identified. For FY 11-12, the criteria applied to 441 of 661 total records reviewed.

However, review findings indicate MCOs have the opportunity to improve the consistency of member education and implementation of interventions focused on harm reduction when members engage in risks. For example, while MCOs provide IDTs with guidance and resources, care managers do not always access the available resources or consistently adhere to MCO guidance:

- At six of ten MCOs evidence of member education, such as discussing options to minimize risk and reduce harm, was not always evident in members' records;
- At five MCOs care managers did not fully assess or explore members' choices and why members were continuing to engage in risks;
- At two MCOs many member-centered plans (MCPs) lacked documentation of identified risks along with related plans or interventions, even though MCO guidance instructed care managers to include this information on the MCPs;
- As the result of IDT interviews at two MCOs, reviewers observed that some care managers did not fully access the MCO resources available for guidance and support when addressing complex situations involving member risk.

The EQR team identified a Promising Practice at one MCO, where care managers engage members in the RAD to explore how specific risks may support or become barriers to achieving their outcomes. This method encourages discussion and discovery of safe and acceptable ways to mitigate the risks. During on-site discussions, IDT staff reported use of this approach usually leads to discovery of alternative solutions and often makes use of a formal risk agreement unnecessary.

During the course of the review year, MetaStar identified one member with an immediate health and safety issue among the total of 661 records reviewed. The member was promptly brought to the attention of both the MCO and DHS.

Thirty additional members with complex situations involving medical, mental health, behavioral, and/or social issues were also identified to the MCOs and referred to DHS for follow up. DHS and MetaStar fully implemented this proactive approach in FY 10-11, allowing DHS the opportunity to engage with the MCOs and provide any needed guidance and support. Referrals also support the MCOs and DHS in determining whether further MCO review of care management practice is needed, in order to prevent health and safety issues in the future.

Comprehensiveness of Assessments and Member-Centered Plans

An area of opportunity across MCOs relates to a QCR indicator that looks at the quality of identification, assessment, and care planning processes. For FY 11-12, eight of ten MCOs did not fully meet this measure. Recommendations focused on the MCOs' need to make better use of monitoring and data analysis and improve the comprehensiveness of assessments and MCPs.

A continuing area of opportunity has been the requirement to periodically re-assess members in order to identify new or changing outcomes, strengths, preferences, conditions, and/or needs. CMR results supported this finding; aggregate results for the CMR indicator, "Comprehensiveness of Most Recent Assessment," were 71.4 percent. Areas of most frequent non-compliance included failure to fully assess members' needs, ongoing conditions, and informal supports. This compares to compliance rates ranging from 82 to 84 percent for this indicator in the previous two review years. MCOs operating both FC and FCP programs, or only FCP, saw a decline in the rate of compliance for this indicator compared to MCOs operating only FC. Two FC only MCOs improved performance in this area.

Relatedly, the quality and comprehensiveness of MCPs has been noted as an area of opportunity for the past three review years. Seven of ten MCOs improved their rate of compliance in FY 11-12 regarding "Comprehensiveness of Most Recent Plan," a CMR indicator which reflects requirements contained in Article V.(C.) of the DHS-MCO contract. However, aggregate results indicate a compliance rate of 67 percent for this measure. By far the most frequent reason for non-compliance was failure to include information about members' identified needs and services on MCPs. Another frequent reason was failure to document how members' acute and primary care services would be coordinated.

A closer look shows that five of six MCOs operating only FC programs had compliance rates of 80 percent or higher, and each of these MCOs had improved results compared to FY 10-11. Results for the four MCOs operating both FC and FCP, or only FCP, were much lower overall, although results for two of these MCOs did improve.

Since the previous full review year in FY 08-09, at least four MCOs enhanced care management systems to allow for the electronic transfer of information from assessments into MCPs, with the goals of improving the quality of assessments and increasing efficiency and consistency in care management practice. Three of these were among the MCOs with increased rates of compliance in this year's review.

While progress has been made, MCOs can continue to improve MCP comprehensiveness by ensuring that all needs and services appear on plans, and that they relate to members' outcomes or assessed needs.

Reviewers noted an area of progress related to the comprehensiveness of assessments and MCPs: Over the past three review years, IDTs have become increasingly proficient at assessing outcomes important to the member and documenting outcomes reflective of the member's voice. Almost all MCPs reviewed over the course of the FY 11-12 review year contained at least one outcome important to the member. Only four percent of the MCPs reviewed did not include outcomes or outcomes expressed in the member's voice.

MCOs provide a variety of tools and resources to support staff's understanding and skills in outcomes development. The following examples were identified as Promising Practices:

- Two MCOs have developed care management handbooks with guidance that focus on the purpose, core philosophies, and best practices underpinning care management, including personal experience outcomes;
- One MCO's *Social Field Reassessment Tool* contains suggested opening questions and talking points to help care managers effectively engage with members to gather more information that may lead to outcomes;
- A staff education tool used by another MCO includes a table and worksheet containing examples of member outcomes and probing questions to use during member interviews.

While IDTs across MCOs engage with members and their supports to identify outcomes and document them on MCPs, some MCOs need to further develop the ability of IDTs to frame outcomes in a way that is measurable and clearly identify the interventions needed to support the outcomes. Additionally, care managers need to consistently take the next step to measure and document the progress toward achievement of identified outcomes.

Timely Service Authorization and Service Coordination/Follow-Up

As noted in both FY 09-10 and FY 10-11, an area of opportunity relates to requirements that MCOs have adequate systems and practices in place to ensure timely decisions and service authorizations related to initial and continuing service requests, as well as to ensure timely issuance of NOAs, when warranted. Results from the FY 11-12 review continue to indicate that MCOs are not fully complying with requirements related to the service authorization process. For example:

- Two QCR indicators contained in the "Access to Services and Quality Monitoring" area of review relate to service authorization processes and timeframes for decision making and member notification. Aggregate results for these two indicators showed a compliance rate of 35 percent. Only one MCO fully met both measures.
- A related indicator contained in the "Grievance Systems" area of review relates to issuing NOAs, when indicated. No MCO fully met the requirements for this indicator.

CMR results support the QCR findings. For example:

- FY-11-12 aggregate results for the CMR indicator, "Timeliness of Service Authorization Decisions," were 80.3 percent. This compares to compliance results for FYs 09-10 and 10-11 of 81.9 percent and 72.5 percent, respectively.
- Results for the indicator, "NOA Issued When Indicated," were 40.1 percent. While this is similar to results from the two previous years, as noted previously, compliance with the indicator is only assessed for records in the review sample where an NOA is indicated. In FY 11-12, the criteria applied to 287 of 661 total records reviewed.

Review findings indicated that MCOs need to improve the ability of care managers to:

- Consistently identify requests;
- Respond to requests within required timeframes;
- Accurately document the date of requests;
- Identify when NOAs are warranted; and
- Issue NOAs within required timeframes.

MetaStar provided recommendations to several MCOs to continue monitoring and analysis in order to identify barriers, develop strategies for improvement, and ensure consistent application of policies and practices for decision making, service authorization, and issuance of NOAs.

MCOs also have the opportunity to improve consistency of care management practice related to ensuring services are coordinated in a timely manner, and that care managers follow up with members to confirm services are being delivered, are of expected quality, and are meeting members' needs. As a group, MCOs were more successful in this review area during FY 09-10, but were unable to sustain this level of performance during the following two review years. For example:

- Aggregate results for "Timely Coordination of Services" were 79.5 percent in FY 11-12 and 73.6 percent in FY 10-11, compared to a compliance rate of 84.9 in FY 09-10. By far the most frequent reason for non-compliance in this year's review was failure to coordinate services in the program benefit package in a timely manner. Other frequent reasons noted by reviewers were lack of timely coordination of health-related services and/or community services.
- Aggregate results for a related CMR indicator, "Follow-Up to Ensure Service Effectiveness" showed a compliance rate of 58.6 percent in FY 11-12 and 59.3 percent in FY 10-11, compared to a compliance rate of 83.4 in FY 09-10.

For more information, including individual MCO results and MCO comparative data see Appendix 3.

Compliance with Performance Measures Standards

MCOs are able to produce accurate performance measures data.

MetaStar validated the accuracy and reliability of calendar year (CY) 2011 influenza and pneumovax immunization data submitted by all ten MCOs. Consistent with the results of previous years, validation findings indicated that MCOs' immunization data are accurate.

The CY 2011 aggregate data showed an influenza vaccination rate for FC members of 64.2 percent. This represented improvement since CY 2010, when FC members were immunized at a rate of 58.4 percent. The influenza vaccination rate for FCP members was 70.5 percent. This was about the same as in 2010, when FCP members were immunized at a rate of 71 percent.

For the pneumovax immunization, eight MCOs used specifications contained in the DHS-MCO 2011 contract to calculate the immunization rate, while two MCOs used different specifications contained in the 2012 contract. DHS approved the use of either the 2011 or 2012 specifications. This needs to be taken into account when reviewing or comparing the results among MCOs. The two methodologies produced pneumovax immunization rates for FC members ranging from 54.1 to 55 percent. Pneumovax immunization rates for FCP members ranged from 56.8 percent to 76.7 percent.

MetaStar provided MCOs with the following recommendations:

- Compare rates against the statewide and/or national benchmarks and employ improvement strategies to ensure the highest immunization rates possible.
- Ensure denominator data is obtained through DHS' ForwardHealth interChange System and work with DHS to resolve any data discrepancies.

See Appendix 5 for more information, including MCO-specific results and comparative data.

Compliance with Information Systems Requirements

Organizations have systems, structures, and processes in place to comply with DHS reporting requirements. Results indicated areas of strength as well as opportunities for improvement.

ISCAs were conducted for three MCOs during FY 11-12. Individual MCO results for the eight focus areas comprising the ISCA showed an average compliance rate ranging from 82.7 percent to 97.1 percent.

All three MCOs have security structures and processes in place to maintain and monitor PHI within their information systems. Results indicated the MCOs have:

- Effective PHI security arrangements with access limits to shared drives, authorized groups, and remote access via virtual private network (VPN) and other remote applications; and
- Good mechanisms in place for backing up and storing PHI data.

Use of a contracted third party administrator (TPA) by one MCO has resulted in better processes and procedures for standard claims adjudication and encounter production compared to the two MCOs doing internal claims processing. For example, reviewers noted greater use of formal, standardized processes for creating and ending authorizations at the MCO using a TPA, as well as the ability to monitor and reconcile claims with providers in "real time."

The MCOs have the opportunity to improve the reconciliation process for all aspects of eligibility. MetaStar provided recommendations such as:

- Clarify and confirm the process steps for reconciling level of care and enrollment discrepancies, for example, by developing a process flowchart and written policies/procedures, and by using the State's ForwardHealth interChange System.

- Improve lines of communication by reducing reliance on paper forms, and by addressing communication challenges related to program expansion into new services areas and the regionalization of Income Maintenance agencies.
- Develop and implement more systemic and automated linking procedures for reconciliation among enrollment, capitation, and claim figures.

For more information regarding the ISCA results, see Appendix 5.

APPENDIX 1

List of Acronyms and Abbreviations

AQR	Annual Quality Review
BCAP	Best Clinical and Administrative Practices
CCI	Community Care, Inc., Managed Care Organization
CCCW	Community Care of Central Wisconsin, Managed Care Organization
CFR	Code of Federal Regulations
CHSRA	Center for Health Systems Research and Analysis
CY	Calendar Year
CMR	Care Management Review
CMS	Centers for Medicare & Medicaid Services
CHP	Community Health Partnership, Managed Care Organization
CW	Care Wisconsin, Managed Care Organization
DHS	Wisconsin Department of Health Services
EQR	External Quality Review
EQRO	External Quality Review Organization
FC	Family Care
FCP	Family Care Partnership
FY	Fiscal Year
HEDIS	Healthcare Effectiveness Data and Information Set (HEDIS is a registered trademark of the National Committee for Quality Assurance.)
*i*Care	Independent Care, Managed Care Organization
IDT	Interdisciplinary Team
IS	Information System
ISCA	Information Systems Capabilities Assessment
LCD	Lakeland Care District, Managed Care Organization
LTC FS	Long-Term Care Functional Screen
MCDFC	Milwaukee Department of Family Care, Managed Care Organization
MCI	Master Customer Index

MCO	Managed Care Organization
MCP	Member-Centered Plan
NB	NorthernBridges, Managed Care Organization
NOA	Notice of Action
PACE	Program of All-Inclusive Care for the Elderly
PEONIES	Personal Experience Outcomes Integrated Interview and Evaluation System
PHI	Protected Health Information
PIHP	Pre-paid Inpatient Health Plan
PIP	Performance Improvement Project
QAPI	Quality Assessment and Performance Improvement
QA/QI	Quality Assurance/Quality Improvement
QCR	Quality Compliance Review
RAD	Resource Allocation Decision Method
SFCA	Southwest Family Care Alliance, Managed Care Organization
TPA	Third Party Administrator
VPN	Virtual Private Network
WWC	Western Wisconsin Cares, Managed Care Organization

APPENDIX 2

Requirement for External Quality Review

The Code of Federal Regulations at 42 CFR 438 requires states that operate PIHPs to provide for an 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 provided across 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).

MetaStar - Wisconsin's External Quality Review Organization

The State of Wisconsin contracts with MetaStar, Inc., to conduct its EQR activities and to produce the annual technical report. 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.

In addition to evaluating each MCO's compliance with federal Medicaid managed care regulations, MetaStar also assesses each MCO's compliance with its contract with DHS. Other services the company provides to the State of Wisconsin include EQR of health maintenance organizations serving BadgerCare and Supplemental Security Income Medicaid recipients. MetaStar also provides services to private clients as well as the State. Additionally, MetaStar operates the Wisconsin Health Information Technology Extension Center, which provides information, technical assistance, and training to support the efforts of health care providers to become meaningful users of certified electronic health record technology.

The MetaStar EQR team is comprised of registered nurses, a nurse practitioner, a physical therapist, licensed and/or certified social workers, and other degreed professionals with extensive education and experience working with the target groups served by the MCOs. Review team experience includes professional practice in the Family Care and Family Care Partnership 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 (QA/QI) improvement 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. All reviewers are trained annually to use current review tools, guidelines, databases, and other resources.

Review Methodologies

Quality Compliance Review

The QCR evaluates policies, procedures, and practices which affect the quality and timeliness of care and services provided to MCO members, as well as members' access to services. To conduct the QCR, a mandatory EQRO review activity, the EQR team used the methodology contained in the CMS guide, *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*.

In preparation for the FY 11-12 comprehensive review year, MetaStar sought input from DHS and reviewed thresholds for compliance for all review standards. Review elements in the protocol were then reorganized with the goals of limiting duplication, increasing the clarity of information and findings, and streamlining recommendations while remaining in alignment with federal requirements.

Prior to conducting review activities, MetaStar obtained information from DHS about its contractual and performance expectations, and its work with the organization over the past year. MetaStar also reviewed the following background information about the MCO:

- The MCO's 2011 and 2012 FC program contracts with DHS
- Related program operation references found on the DHS website: http://dhs.wisconsin.gov/LTCare/ProgramOps/Index.htm
- MetaStar quality and compliance reports from reviews conducted in 2010 and 2011
- DHS correspondence with the MCO about expectations and performance during the previous 12 months
- Most recent results of compliance, certification, and business plan reviews conducted by DHS.

In addition to document review, on-site discussions were held with MCO administrators and staff responsible for compliance and improvement efforts, and separate discussions were held with IDT staff. In order to clarify information gathered during review activities, the EQR team also requested and reviewed additional documents provided by MCO staff, as needed.

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

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

- **Not met** applied when the MCO did not meet the requirements 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, as indicated. In some instances, recommendations were made for requirements met at a minimum.

Validation of Performance Improvement Projects

PIP validation, a mandatory EQRO review activity, 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. To evaluate the standard elements of a PIP, the EQR team used the methodology described in the 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 EQR team evaluated each PIP at whatever stage of implementation it was in at the time of the review. To conduct the PIP review, MetaStar obtained and assessed DHS and MCO documents, such as:

- DHS memo and notes related to initial approval of the project
- The MCO's annual report of the status and results of each PIP
- Best Clinical and Administrative Practices (BCAP) workbook or other project work plan/description
- Data on project measures
- 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, data analysis, 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, as indicated.

Validation of Performance Measures

Validating performance measures is a mandatory EQRO review activity which ensures 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. The EQR team conducted validation activities as outlined in the CMS publication, *Validating Performance Measures, A Protocol for Use in Conducting External Quality Review Activities, Final Protocol, Version 1.0, May 1, 2002*.

To complete the validation activities, the EQR team reviewed the data and rates reported by each MCO using DHS contract criteria for each quality indicator, and completed a data worksheet to calculate final immunization rates. When necessary, MetaStar contacted the MCO to discuss any issues with the data. Steps of the review process ensured that:

- Master Customer Index (MCI) numbers were not duplicated in a data file;
- MCI numbers included in the MCOs denominator file were also included in the MCOs numerator file;
- MCO reported numerators met DHS contract specifications;
- MCO reported denominators met contract specifications;
- Final rates were calculated using standardized data worksheets.

To complete the validation step as outlined by CMS, the EQR team completed a validation worksheet on 30 randomly selected members for each measure to determine the final validation finding. The steps of the validation process included:

- Checking each member's service record to verify that it clearly documented the appropriate immunization in the appropriate time period;
- Documenting whether the MCO's report of the member's immunization was valid or invalid;
- Conducting statistical testing using the t-test to determine if rates were unbiased, meaning that they could be accurately reported. If MetaStar validated a sample (subset) from the total eligible population for the measure, the t-test was used to determine bias at the 95 percent confidence level.

For areas where the MCO did not meet specifications, the EQR team documented the findings and provided recommendations, as indicated.

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. CMR activities and findings help support QCR, and are part of DHS' overall strategy for providing quality assurances to CMS regarding the 1915 (b) and (c) Waivers which allow the State of Wisconsin to operate its Family Care programs. The EQR team conducted CMR activities using a review tool and reviewer guidelines developed by MetaStar and approved by DHS.

The CMR focused on reviewing three key care management processes:

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

To learn more about outcomes, review the section, *What are outcomes, and why do they matter?* contained 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 primary target populations served by the MCO; individuals who are frail elders, persons who are physically disabled, and persons who are developmentally disabled. The records selected included some individuals who also had mental illness, traumatic brain injury, or Alzheimer's disease/dementia. The EQR team used a standard review tool and reviewer guidelines based on DHS contract requirements and care management trainings. In addition to identifying any immediate member health or safety issues, the EQR team evaluated four categories of care management practice:

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

The four categories are made up of 14 indicators that reviewers used to evaluate care management performance during the 6-12 months prior to the review. The EQR team also

compared information from each member's record in the sample with the member's most recent LTC FS and provided the comparisons to DHS.

MetaStar used a binomial scoring system (yes and no) to evaluate the presence of each required element in member records. For findings of "no," the EQR team noted the key areas related to the finding and provided comments to identify the missing requirements.

The EQR team developed individualized questions based on the record review results, and conducted on-site interviews with IDTs. The on-site interviews helped reviewers 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, about two weeks prior to the on-site visit using an anonymous, web-based survey. The pre-onsite surveys conducted in FY 11-12 included questions about:

- Professional discipline
- Caseload size
- Improvements or positive changes related to the core principles of care management
- Documentation or paperwork barriers
- Suggestions to improve the efficiency and effectiveness of care management practice.

Information Systems Capabilities Assessment

An ISCA evaluates the extent to which an MCO's health information system (IS) is capable of collecting, analyzing, integrating and reporting valid encounter data and other data (e.g., QA/QI, claims processing, enrollment/disenrollment, utilization, appeal and grievance, etc.) required by its contract with DHS. Activities are conducted using an ISCA tool based on the CMS guide, *Monitoring Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans, Appendix Z: Information Systems Capabilities Assessment for Managed Care Organizations*.

Prior to conducting review activities, the EQR team met with staff in the DHS Division of Long Term Care, Office of Family Care Expansion and Bureau of Financial Management to develop the review methodology and tailor review activities to reflect DHS expectations for compliance. In addition to the CMS EQRO protocol, resources used to conduct an ISCA included encounter reporting reference materials and the CY 2011 and 2012 DHS-MCO contracts. These references can be found at the following websites:

http://www.dhs.wisconsin.gov/ltcare/ProgramOps/Index.htm

http://www.dhs.wisconsin.gov/ltcare/StateFedReqs/FC-RC-CMO-Contracts.htm#cmo

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

- General Overview
- Information Systems and Encounter Data Flow
- Claims and Encounter Data Collection
- Eligibility Enrollment Data Processing
- Practitioner Data Processing
- Systems Security
- Vendor Oversight
- Business Intelligence – Finance
- Requested Attachments for Desk Review.

As directed by DHS, the EQR team assessed each MCO's IS capabilities to meet certification standards and demonstrate its ability to comply with reporting requirements in the formats and timelines prescribed by DHS.

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

For areas where the MCO did not meet specifications, the EQR team documented the findings and provided recommendations.

APPENDIX 3

Quality Compliance Review Findings

During a full review year, MCO performance can be evaluated by considering the overall number of standards met. Three MCOs (CCCW, LCD, WWC) met at least 90 percent of the comprehensive review standards. Reviewers noted similar key strengths for the organizations most successful in meeting standards at the time of AQR:

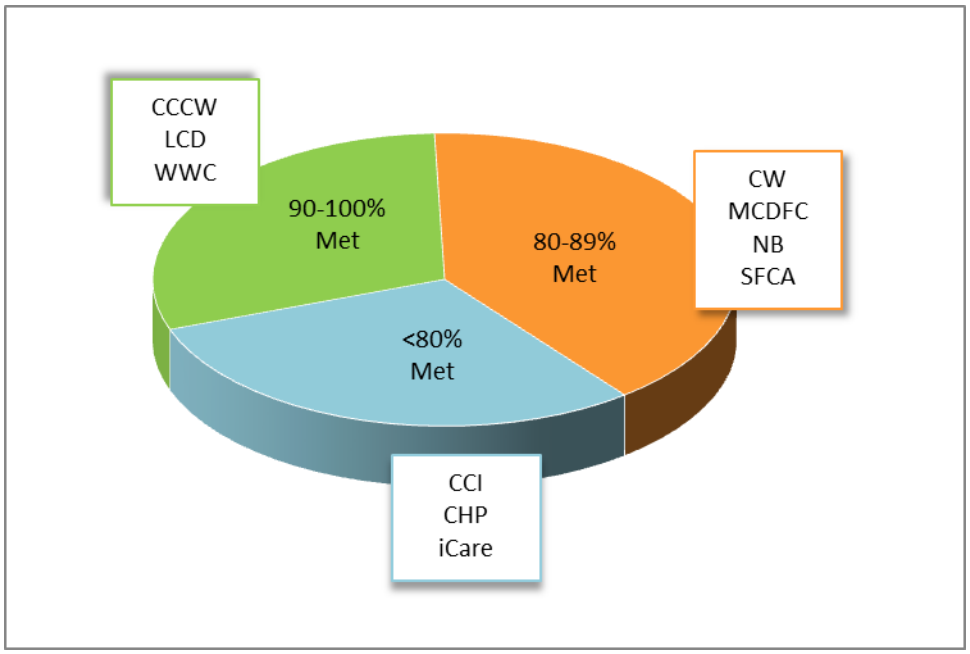
- Strong continuous improvement culture emphasizing the use of data to support decisions;
- Clear focus on members: providing quality services, seeking input, and supporting outcomes through all aspects of the organization; and
- Effective and inclusive communication systems: all staff and stakeholders are valued and engaged as active partners.

These attributes were identified through discussions with staff at all levels of these organizations and observed through the review of many processes associated with MCO operations. Please see the individual reports of these organizations for details (Attachments 1 to 10).

It is notable that several of the MCOs which met fewer standards reported goals to improve or re-structure their quality programs and communication systems.

The chart below illustrates the performance of all ten MCOs by percentage of QCR standards met.

Percent of Quality Compliance Standards Met



APPENDIX 3A

The tables in appendices 3A and 3B below list the QCR standards and the results for each MCO. Two tables are included for display purposes: MCOs Operating More than One Program, and MCOs Operating Family Care Only.

Quality Compliance Review Findings – MCOs operating more than One Program

Enrollee Rights and Program Structure Findings		CHP	CC	CW	iCare
General Rules					
1	The MCO has written policies regarding member rights and ensures that its staff and providers take those rights into account when furnishing services.	Met	Partially Met	Partially Met	Partially Met
2	The MCO guarantees that its members have the right to: • Be treated with respect and consideration for their dignity and privacy • Receive information on available treatment options and alternatives • Health care professionals acting within their scope of practice may not be restricted from advising or advocating on behalf of the member • Participate in decisions regarding their health care, including the right to refuse treatment • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation • Request and receive a copy of their medical records, and to request that they be amended or corrected in accordance with federal privacy and security standards.	Partially Met	Partially Met	Met	Partially Met
Information Requirements					
3	The MCO must provide materials for members and potential members in an accessible language: • Written information is available in languages prevalent in the MCO service area • Oral interpretation services are available free of charge • Members are notified of the availability of the above materials and services, including how to access them.	Met	Met	Met	Met
4	The MCO must provide written materials for members and potential members in an appropriate format: • The language and format is easily understood • Alternative formats are available and take into consideration members' special needs • Members are notified of the availability of the above materials and services, including how to access them.	Met	Met	Met	Met

5	General information must be furnished to members as required. The MCO: • Notifies members of their right to request and obtain information at least once a year about their rights • Provides required information to new members within a reasonable time period and as specified by the State • Provides at least thirty days notice of "significant" change (as defined by DHS) in information requirements Makes a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt of issuance of the termination notice, to members who received services from such provider.	Met	Met	Met	Met
6	The MCO provides information to members in the Provider Directory as required by 42 CFR 438.10(f)(6) and Article IX.D.5 of the 2011 State contract with MCOs.	Met	Met	Met	Met
7	The MCO provides information to members in the Member Handbook, as required by 42 CFR 438.10(f)(6) and 42 CFR 438.10(g) and Article IX.,C., of the 2011 State contract with MCOs.	Met	Met	Met	Met
8	Regarding advance directives, the MCO must: • Have written policies and procedures • Provide written information to all adult members (or their family or surrogate if incapacitated) at the time of their enrollment • Update written information to reflect changes in State law as soon as possible (but not later than 90 days after the effective date of the change) • Document in the medical record whether or not the individual has executed an advance directive and must not discriminate based on its presence or absence • Provide education for staff and the community on issues concerning advance directives Inform individuals that complaints concerning non-compliance with any advance directive may be filed with the State survey and certification agency.	Met	Partially Met	Met	Partially Met
	Met Findings by MCO	**7**	**5**	**7**	**5**
	Partially Met Findings by MCO	**1**	**3**	**1**	**3**
	Not Met Findings by MCO	**0**	**0**	**0**	**0**

Access to Services and Quality Monitoring		**CHP**	**CC**	**CW**	**iCare**
Provider Selection					
1	The MCO must: • Implement written policies and procedures for selection and retention of providers • Follow a documented process for credentialing and re-credentialing of providers who have signed contracts or participation agreements • Implement provider selection policies and procedures to ensure non- discrimination against particular practitioners that serve high risk populations or specialize in conditions that require costly treatment Give the affected providers written notice of the reason for its decision, if the MCO declines to include individual or groups of providers in its network.	Met	Met	Met	Partially Met

2	MCOs may not employ or contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Act.	Partially Met	Met	Partially Met	Partially Met
3	The MCO must comply with: ● Any additional requirements established by the State including caregiver background checks for IDT staff and provider staff that come in direct contact with a member ● All applicable federal and state laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act of 1990 as amended.	Partially Met	Partially Met	Partially Met	Partially Met
Confidentiality					
4	The MCO must ensure that for medical records and any other health and enrollment information that identifies a particular enrollee, use and disclosure of such individually identifiable health information must be in accordance with the privacy requirements.	Met	Met	Met	Met
Enrollment and Disenrollment					
5	**Disenrollment requested by the MCO** The MCO must have processes in place to monitor disenrollment and ensure: ● The MCO does not counsel or otherwise influence a member in such a way as to encourage disenrollment ● The MCO's intention to disenroll a member shall be submitted to the Department for a decision by a written request to process the disenrollment, which includes: ○ Documentation of the basis for the request, ○ A thorough review of issues leading to the request, and ○ Evidence that supports the request. The MCO may request a disenrollment if: ● The member has committed acts or threatened to commit acts that pose a threat to the MCO staff, subcontractors, or other members of the MCO. This includes harassing and physically harmful behavior. The MCO is unable to assure the member's health and safety because: ● The member refuses to participate in care planning or to allow care management contacts; or ● The member is temporarily out of the MCO service area.	Met	Partially Met	Met	Met
6	**Procedures for voluntary disenrollment** All members shall have the right to disenroll from the MCO without cause at any time. The enrollee (or his or her representative) must submit an oral or written request to the MCO to process disenrollment. If a member expresses a desire to disenroll from the MCO, the MCO shall provide the member with contact information for the resource center and, with the member's approval, may make a referral to the resource center for options counseling. The MCO is responsible for covered services it has authorized through the date of disenrollment. An enrollment plan must be developed in collaboration with the Aging and Disability Resource Center and Income Maintenance agency and shall be an agreement between entities for the accurate processing of disenrollments. The enrollment plan shall ensure that:	Met	Partially Met	Partially Met	Met

	• The MCO is not directly involved in processing disenrollments although the MCO shall provide information relating to eligibility to the income maintenance agency • Enrollments and disenrollments are accurately entered on CARES so that correct capitation payments are made to the MCO Timely processing occurs, in order to ensure that members who disenroll have timely access to any Medicaid fee-for-service benefits for which they may be eligible, and to reduce administrative costs to the MCO and other service providers for claims processing • The MCO is responsible for covered services it has authorized through the date of disenrollment.				
7	**Subcontractor Relationships and Delegation** The MCO must: • Oversee and be accountable for any functions and responsibilities that it delegates to any subcontractor • Evaluate the prospective subcontractor's ability to perform the activities to be delegated • Have a written agreement that: ○ Specifies the activities and report responsibilities designated to the subcontractor ○ Provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate • Monitor the subcontractor's performance on an ongoing basis, identify deficiencies or areas for improvement, and take corrective action.	Met	Met	Met	Met
Availability of Services					
8	**Delivery Network** The MCO maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, the MCO site must consider: • Anticipated Medicaid enrollment • Expected utilization of services, considering Medicaid member characteristics and health care needs • Numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services • The number of network providers who are not accepting new MCO members • The geographic location of providers and MCO members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities.	Met	Met	Met	Partially Met

9	The MCO must: • Require its providers to meet State standards for timely access to care and services, taking into account the urgency of need for services • Ensure that the network providers offer hours of operation that are not less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service, if the provider serves only Medicaid members • Makes services available 24 hours a day, 7 days a week when medically necessary • Establishes mechanisms to ensure compliance by providers • Monitors providers regularly to determine compliance • Takes corrective action if there is a failure to comply.	Met	Met	Met	Met
10	**Cultural Considerations** The MCO must participate in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including for those with limited English proficiency and diverse cultural and ethnic backgrounds. The MCO shall incorporate in its policies, administration, provider contracts, and service practice, the values of honoring members' beliefs. The MCO shall permit members to choose providers from among the MCO's network based on cultural preference. The MCO shall accept appeals and grievances from members related to a lack of access to culturally appropriate care.	Met	Met	Met	Met
Coordination and Continuity of Care					
11	**Primary care and coordination of health care services** The MCO must implement procedures to deliver primary care (if applicable for FCP) and coordinate health care services for all MCO members. These procedures must do the following: • Ensure that each member has an on-going source of primary care appropriate to his/her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member • Coordinate the services the MCO furnishes to the member with services the member receives from any other provider of health care or insurance plan • Facilitate access to specialists appropriate for the member's special health care condition and identified needs • Allows freedom of choice for female members to access a woman's specialist or, when age-appropriate, obtain the services of qualified family planning providers (FCP) • Share with other providers serving the member the results of its identification and assessment of that member's needs to prevent duplication of activities • Protection of the member's privacy when coordinating care.	Partially Met	Partially Met	Partially Met	Partially Met

12	The MCO provides for a second opinion from a qualified health care professional within the network, or arranges for the member to obtain one outside the network, at no cost to the member. If the network is unable to provide necessary services, covered under the contract, to a particular member, the MCO must provide adequate and timely services out of network for the member as long as the MCO is unable to provide them. The MCO must work with out-of-network providers to ensure that the cost of services to members is no greater than they would have been if furnished within the provider networks.	Met	Met	Met	Met
13	**Identification** The State must implement mechanisms to identify persons with special health care needs. (Annual Long Term Care Functional Screen). **Assessment** The MCO must implement mechanisms to assess each member in order to identify special conditions that require treatment and care monitoring (must use appropriate health care professionals). **Member Centered Plan** The MCP must be determined through assessment, developed with the member, the member's primary care provider, and in consultation with any specialists. It must be completed and approved in a timely manner in accordance with DHS standards.	Partially Met	Partially Met	Partially Met	Partially Met
Coverage and authorization of services					
14	**Authorization of Services** For processing requests for initial and continuing authorizations of services, the MCO must: • Have in place and follow written policies and procedures • Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions • Consult with the requesting provider when appropriate • Assure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.	Partially Met	Partially Met	Met	Met
15	**Timeframe for Decisions of Approval or Denial** The IDT staff shall make decisions on requests for services and provide notice as expeditiously as the member's health condition requires. **Standard Service Authorization Decisions** Decisions shall be made no later than 14 calendar days following receipt of the request for the service unless the MCO extends the timeframe for up to 14 additional calendar days. If the timeframe is extended, the MCO must send a written notification to the member no later than the fourteenth day after the original request. **Expedited Service Authorization Decisions:** If following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO shall make an expedited service authorization no later than	Partially Met	Partially Met	Partially Met	Partially Met

	72 hours after receipt of the request for service. The MCO may extend the timeframes of expedited service authorization decisions by up to 11 additional calendar days if the member or a provider requests the extension or the MCO justifies a need for additional information. For any extension not requested by the member, the MCO must give the member written notice of the reason for delay of decision.				
16	**Emergency and post-stabilization services** The MCO must cover and pay for emergency services regardless of whether the entity that furnishes the services has a contract with the MCO; and The MCO may not deny payment for treatment obtained if a member had an emergency medical condition or a representative of the MCO instructs the member to seek emergency services. The MCO does not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. The MCO does not hold members liable for payment of subsequent screening or treatment needed to diagnose the specific condition or stabilize the member. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is stabilized for transfer or discharge. The MCO must cover and pay for emergency services and post-stabilization care services.	Met	Met	Met	Met
Practice Guidelines					
17	Practice guidelines are adopted which: • Are based on valid and reliable clinical evidence • Consider the needs of the MCO's members • Are developed in consultation with health care professionals/affiliated providers • Are reviewed and updated periodically.	Met	Partially Met	Met	Met
18	Practice guidelines are disseminated to affected providers and, upon request, to members.	Met	Partially Met	Met	Met
19	Practice guidelines are applied throughout the MCO in a consistent manner, e.g., utilization management, member education, coverage of services, QAPI program.	Met	Partially Met	Met	Partially Met
Quality Assessment and Performance Improvement Program (QAPI)					
20	The MCO has an ongoing QAPI program for the services it furnishes to members, which includes a description of: • Responsibility for the program • Member participation • Staff and provider participation.	Partially Met	Met	Met	Met
21	The QAPI program includes these basic elements per 42 CFR 438.240: • Performance Improvement Projects • Performance Measurement Data • Mechanisms to detect both under- and over-utilization of services	Met	Met	Met	Met

	• Mechanisms to assess the quality and appropriateness of care furnished to members "with special health care needs." The QAPI program also includes these DHS-requirements: • Monitoring quality of assessments and member centered plans • Monitoring completeness/accuracy of functional screens • Member satisfaction surveys • Provider surveys • Response to critical incidents • Monitoring adverse events, including appeals and grievances • Monitoring access to providers and verifying that services were provided.				
22	The quality work plan outlines the scope of activities, goals, objectives, timelines, responsible person, and is based on findings from QAPI program activities.	Partially Met	Partially Met	Met	Partially Met
Basic Elements of the QAPI Program					
23	The MCO must have processes in effect to monitor and detect both under- and over-utilization of services.	Partially Met	Partially Met	Partially Met	Partially Met
24	The MCO must operate a system to assess and improve the quality and appropriateness of care furnished to members.	Partially Met	Partially Met	Met	Partially Met
25	Quality and performance indicator data is used for quality management purposes, and is provided and interpreted for care managers and providers as indicated.	Met	Met	Met	Partially Met
26	The MCO must report the status and results of each performance improvement project to the State as requested (conduct the number of PIPs required by its contract and obtain State approval for each required project whether new or continuing). Each PIP must be completed in a reasonable time period so as to generally allow information on the success of PIPs in the aggregate to produce new information on quality of care every year.	Partially Met	Not Met	Met	Partially Met
27	The MCO has in effect a process for an annual evaluation of its quality assessment and performance improvement program, which addresses the basic elements and activities of the program.	Partially Met	Met	Met	Partially Met
Quality Evaluation					
28	The annual evaluation shall determine whether the program has achieved significant improvement on the quality of health care and services provided to its members.	Partially Met	Partially Met	Met	Partially Met
Health Information Systems					
29	The MCO maintains a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments (for other than loss of Medicaid eligibility).	Met	Met	Met	Met
	Met Findings by MCO	**16**	**14**	**22**	**14**
	Partially Met Findings by MCO	**13**	**14**	**7**	**15**
	Not Met Findings by MCO	**0**	**1**	**0**	**0**

Grievance Systems		CHP	CC	CW	iCare
Structure and Basic Requirements					
1	The MCO must ensure that staff assigned responsibility for responding to member expressions of dissatisfaction or disagreement with actions offer the appropriate options available to the member as described in the DHS contract with the MCO.	Met	Met	Met	Met
2	The MCO must accept appeals and grievances from members and their preferred representatives, including providers with the member's consent. A representative of a deceased member's estate may file an appeal or grievance. The MCO must accept appeals and grievances according to DHS requirements in order to establish the earliest and appropriate filing date. The MCO must have a system to provide assistance to members to exercise their rights.	Partially Met	Partially Met	Met	Met
3	The MCO policies and procedures include information that describes the oral and written options for filing appeals and grievances, including details for expedited appeals.	Met	Met	Met	Met
4	The MCO's grievance systems structure must identify roles and responsibilities for all staff engaged in supporting members to exercise their rights.	Met	Met	Met	Met
5	The MCO must provide sufficient information to providers to support members in exercising their rights.	Met	Partially Met	Met	Met
6	The MCO must keep records of appeals and grievances.	Met	Met	Met	Met
Communication to members					
7	MCOs must use the standardized Notice of Action (NOA) templates to inform a member of termination, reduction, and denial of services. The NOA template must also be used when a service authorization decision is delayed.	Met	Met	Met	Met
8	The NOA must be delivered to the member for the following reasons and in the timeframes associated with each type of adverse decision as required by 42 CFR 438.400-424 and Article V.,J., and Article XI of the 2011 State contract with MCOs: • Denial of service • Termination, suspension, or reduction of service • Delay in decision making or extension of timeframe for the decision making process.	Partially Met	Partially Met	Partially Met	Partially Met
9	If the member's health condition requires, adverse decision notices in the categories noted above must be delivered/mailed in the expedited timeframes noted in the contract.	Met	Met	Met	Met
Process if member chooses to exercise his/her rights					
10	The MCOs appeal and grievance policies and procedures must reflect the timeframes associated with standard and expedited appeals for the MCO appeal process, the DHS process, and DHA Fair Hearings. The MCO must acknowledge receipt of appeals for which it has responsibility and take steps to resolve standard and expedited appeals and grievances in the required timeframes.	Met	Partially Met	Met	Met
11	The MCO has a process in place to support members in examining their records and to provide information during a hearing.	Met	Met	Met	Met
12	The MCO hearing process cannot include individuals who were involved in any previous level of review or decision-making/participation in the resource allocation decision method.	Met	Met	Met	Met
13	The MCO must continue the member's benefits pending resolution of the appeal if applicable timeframes are met, unless the member declines the continuation.	Met	Met	Met	Met
Resolution of Appeals					
14	The MCO must issue a written notice of the disposition of an MCO level appeal according to requirements.	Met	Met	Met	Met

	The method must provide information about additional rights the member has to address the issue within the timeframes assigned, including those for expedited appeals.				
15	The MCO takes steps to respond to decisions by the MCO's appeal and grievance committee, DHS directives, and Division of Hearing and Appeals remands within the timeframes associated with each type of appeal decision.	Met	Met	Met	Met
16	The NOA requirements include notification to the member that he/she may be held liable for the costs of continued benefits if the appeal is later dismissed; this contract offers the MCO the opportunity to recover costs.	Met	Met	Met	Met
	Met Findings by MCO	**14**	**12**	**15**	**15**
	Partially Met Findings by MCO	**2**	**4**	**1**	**1**
	Not Met Findings by MCO	**0**	**0**	**0**	**0**

APPENDIX 3B

Quality Compliance Review Findings – MCOs Operating Family Care Only

Enrollee Rights and Program Structure Findings		WWC	LCD	MCDFC	CCCW	NB	SFCA
General Rules							
1	The MCO has written policies regarding member rights and ensures that its staff and providers take those rights into account when furnishing services.	Met	Met	Met	Partially Met	Met	Met
Specific Rights							
2	The MCO guarantees that its members have the right to: • Be treated with respect and consideration for their dignity and privacy • Receive information on available treatment options and alternatives • Health care professionals acting within their scope of practice may not be restricted from advising or advocating on behalf of the member • Participate in decisions regarding their health care, including the right to refuse treatment • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation • Request and receive a copy of their medical records, and to request that they be amended or corrected in accordance with federal privacy and security standards.	Met	Met	Met	Met	Met	Met
Information Requirements							
3	The MCO must provide materials for members and potential members in an accessible language: • Written information is available in languages prevalent in the MCO service area • Oral interpretation services are available free of charge • Members are notified of the availability of the above materials and services, including how to access them.	Met	Met	Met	Met	Met	Met
4	The MCO must provide written materials for members and potential members in an appropriate format: • The language and format is easily understood • Alternative formats are available and take into consideration members' special needs • Members are notified of the availability of the above materials and services, including how to access them.	Met	Met	Met	Met	Met	Met

5	General information must be furnished to members as required. The MCO: • Notifies members of their right to request and obtain information at least once a year about their rights • Provides required information to new members within a reasonable time period and as specified by the State • Provides at least thirty days notice of "significant" change (as defined by DHS) in information requirements • Makes a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt of issuance of the termination notice, to members who received services from such provider.	Met	Met	Met	Met	Met	Met
6	The MCO provides information to members in the Provider Directory as required by 42 CFR 438.10(f)(6) and Article IX.D.5 of the 2011 State contract with MCOs.	Met	Met	Met	Met	Met	Met
7	The MCO provides information to members in the Member Handbook, as required by 42 CFR 438.10(f)(6) and 42 CFR 438.10(g) and Article IX.,C., of the 2011 State contract with MCOs.	Met	Met	Met	Met	Met	Met
8	Regarding advance directives, the MCO must: • Have written policies and procedures • Provide written information to all adult members (or their family or surrogate if incapacitated) at the time of their enrollment • Update written information to reflect changes in State law as soon as possible (but not later than 90 days after the effective date of the change) • Document in the medical record whether or not the individual has executed an advance directive and must not discriminate based on its presence or absence • Provide education for staff and the community on issues concerning advance directives • Inform individuals that complaints concerning non-compliance with any advance directive may be filed with the State survey and certification agency.	Met	Met	Met	Partially Met	Met	Partially Met
	Met Findings by MCO	**8**	**8**	**8**	**6**	**8**	**7**
	Partially Met Findings by MCO	**0**	**0**	**0**	**2**	**0**	**1**

	Access to Services and Quality Monitoring	WWC	LCD	MCDFC	CCCW	NB	SFCA
Provider Selection							
1	The MCO must: • Implement written policies and procedures for selection and retention of providers • Follow a documented process for credentialing and re-credentialing of providers who have signed contracts or participation agreements • Implement provider selection policies and procedures to ensure non- discrimination against particular practitioners that serve high risk populations or specialize in conditions that require costly treatment • Give the affected providers written notice of the reason for its decision, if the MCO declines to include individual or groups of providers in its network.	Met	Met	Met	Met	Met	Met
2	MCOs may not employ or contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Act.	Met	Met	Met	Met	Met	Met
3	The MCO must comply: • With any additional requirements established by the State including caregiver background checks for IDT staff and provider staff that come in direct contact with a member • With all applicable federal and state laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act of 1990 as amended.	Met	Partially Met	Met	Met	Partially Met	Met
Confidentiality							
4	The MCO must ensure that for medical records and any other health and enrollment information that identifies a particular enrollee, use and disclosure of such individually identifiable health information must be in accordance with the privacy requirements.	Met	Met	Met	Met	Partially Met	Met
Enrollment and Disenrollment							
5	**Disenrollment requested by the MCO** The MCO must have processes in place to monitor disenrollment and ensure: • The MCO does not counsel or otherwise influence a member in such a way as to encourage disenrollment. • The MCO's intention to disenroll a member shall be submitted to the Department for a decision by a written request to process the disenrollment, which includes: o Documentations of the basis for the request. o A thorough review of issues leading to the request, and	Met	Met	Met	Met	Met	Met

	○ Evidence that supports the request. The MCO may request a disenrollment if: ● The member has committed acts or threatened to commit acts that pose a threat to the MCO staff, subcontractors, or other members of the MCO. This includes harassing and physically harmful behavior. The MCO is unable to assure the member's health and safety because: ● The member refuses to participate in care planning or to allow care management contacts; or ● The member is temporarily out of the MCO service area.						
6	**Procedures for voluntary disenrollment** All members shall have the right to disenroll from the MCO without cause at any time. The enrollee (or his or her representative) must submit an oral or written request to the MCO to process disenrollment. If a member expresses a desire to disenroll from the MCO, the MCO shall provide the member with contact information for the resource center and, with the member's approval, may make a referral to the resource center for options counseling. The MCO is responsible for covered services it has authorized through the date of disenrollment. An enrollment plan must be developed in collaboration with the Aging and Disability Resource Center and Income Maintenance agency and shall be an agreement between entities for the accurate processing of disenrollments. The enrollment plan shall ensure that: ● The MCO is not directly involved in processing disenrollments although the MCO shall provide information relating to eligibility to the income maintenance agency ● Enrollments and disenrollments are accurately entered on CARES so that correct capitation payments are made to the MCO ● Timely processing occurs, in order to ensure that members who disenroll have timely access to any Medicaid fee-for-service benefits for which they may be eligible, and to reduce administrative costs to the MCO and other service providers for claims processing ● The MCO is responsible for covered services it has authorized through the date of disenrollment.	Met	Met	Partially Met	Met	Met	Met

7	**Subcontractor Relationships and Delegation** The MCO must: ● Oversee and be accountable for any functions and responsibilities that it delegates to any subcontractor ● Evaluate the prospective subcontractor's ability to perform the activities to be delegated ● Have a written agreement that: ○ Specifies the activities and report responsibilities designated to the subcontractor ○ Provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate ● Monitor the subcontractor's performance on an ongoing basis, identify deficiencies or areas for improvement, and take corrective action.	Met	Met	Met	Met	Met	Met
Availability of Services							
8	**Delivery Network** The MCO maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, the MCO site must consider: ● Anticipated Medicaid enrollment ● Expected utilization of services, considering Medicaid member characteristics and health care needs ● Numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services ● The number of network providers who are not accepting new MCO members ● The geographic location of providers and MCO members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities.	Met	Met	Met	Met	Met	Met
9	The MCO must: ● Require its providers to meet State standards for timely access to care and services, taking into account the urgency of need for services ● Ensure that the network providers offer hours of operation that are not less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service, if the provider serves only Medicaid members ● Makes services available 24 hours a day, 7 days a week when	Met	Met	Met	Met	Met	Met

	medically necessary • Establishes mechanisms to ensure compliance by providers • Monitors providers regularly to determine compliance • Takes corrective action if there is a failure to comply.						
10	**Cultural Considerations** The MCO must participate in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including for those with limited English proficiency and diverse cultural and ethnic backgrounds. The MCO shall incorporate in its policies, administration, provider contracts, and service practice, the values of honoring members' beliefs. The MCO shall permit members to choose providers from among the MCO's network based on cultural preference. The MCO shall accept appeals and grievances from members related to a lack of access to culturally appropriate care.	Met	Met	Met	Met	Met	Met
Coordination and Continuity of Care							
11	**Primary care and coordination of health care services** The MCO must implement procedures to deliver primary care (if applicable for FCP) and coordinate health care services for all MCO members. These procedures must do the following: • Ensure that each member has an on-going source of primary care appropriate to his/her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member • Coordinate the services the MCO furnishes to the member with services the member receives from any other provider of health care or insurance plan • Facilitate access to specialists appropriate for the member's special health care condition and identified needs • Allows freedom of choice for female members to access a woman's specialist or, when age-appropriate, obtain the services of qualified family planning providers (FCP) • Share with other providers serving the member the results of its identification and assessment of that member's needs to prevent duplication of activities • Protection of the member's privacy when coordinating care.	Partially Met	Met	Partially Met	Met	Partially Met	Met

12	The MCO provides for a second opinion from a qualified health care professional within the network, or arranges for the member to obtain one outside the network, at no cost to the member. If the network is unable to provide necessary services, covered under the contract, to a particular member, the MCO must provide adequate and timely services out of network for the member as long as the MCO is unable to provide them. The MCO must work with out-of-network providers to ensure that the cost of services to members is no greater than they would have been if furnished within the provider networks.	Met	Met	Met	Met	Met	Met
13	**Identification** The State must implement mechanisms to identify persons with special health care needs. (Annual Long Term Care Functional Screen). **Assessment** The MCO must implement mechanisms to assess each member in order to identify special conditions that require treatment and care monitoring (must use appropriate health care professionals). **Member Centered Plan** The MCP must be determined through assessment, developed with the member, the member's primary care provider, and in consultation with any specialists. It must be completed and approved in a timely manner in accordance with DHS standards.	Partially Met	Met	Partially Met	Met	Partially Met	Partially Met
Coverage and Authorization of Services							
14	**Authorization of Services** For processing requests for initial and continuing authorizations of services, the MCO must: • Have in place and follow written policies and procedures • Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions • Consult with the requesting provider when appropriate • Assure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.	Met	Met	Partially Met	Met	Partially Met	Met
15	**Timeframe for Decisions of Approval or Denial** The IDT staff shall make decisions on requests for services and provide notice as expeditiously as the member's health condition requires. **Standard Service Authorization Decisions** Decisions shall be made no later than 14 calendar days following receipt of the request for the service unless the MCO extends the timeframe for up to 14	Partially Met	Met	Partially Met	Partially Met	Partially Met	Partially Met

	additional calendar days. If the timeframe is extended, the MCO must send a written notification to the member no later than the fourteenth day after the original request. **Expedited Service Authorization Decisions:** If following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO shall make an expedited service authorization no later than 72 hours after receipt of the request for service. The MCO may extend the timeframes of expedited service authorization decisions by up to 11 additional calendar days if the member or a provider requests the extension or the MCO justifies a need for additional information. For any extension not requested by the member, the MCO must give the member written notice of the reason for delay of decision.						
16	**Emergency and post-stabilization services** The MCO must cover and pay for emergency services regardless of whether the entity that furnishes the services has a contract with the MCO; and The MCO may not deny payment for treatment obtained if a member had an emergency medical condition or a representative of the MCO instructs the member to seek emergency services. The MCO does not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. The MCO does not hold members liable for payment of subsequent screening or treatment needed to diagnose the specific condition or stabilize the member. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is stabilized for transfer or discharge. The MCO must cover and pay for emergency services and post-stabilization care services.	N/A – These services not included in the Family Care benefit package					
Practice Guidelines							
17	Practice guidelines are adopted which: • Are based on valid and reliable clinical evidence • Consider the needs of the MCO's members • Are developed in consultation with health care professionals/affiliated providers • Are reviewed and updated periodically.	Met	Met	Met	Met	Met	Met
18	Practice guidelines are disseminated to affected providers and, upon request, to members.	Met	Met	Met	Met	Met	Met

19	Practice guidelines are applied throughout the MCO in a consistent manner, e.g., utilization management, member education, coverage of services, QAPI program.	Met	Met	Met	Met	Met	Met
Quality Assessment and Performance Improvement Program (QAPI)							
20	The MCO has an ongoing QAPI program for the services it furnishes to members, which includes a description of: • Responsibility for the program • Member participation • Staff and provider participation.	Met	Met	Met	Met	Met	Met
21	The QAPI program includes these basic elements per 42 CFR 438.240: • Performance Improvement Projects • Performance Measurement Data • Mechanisms to detect both under- and over-utilization of services • Mechanisms to assess the quality and appropriateness of care furnished to members "with special health care needs." The QAPI program also includes these DHS-requirements: • Monitoring quality of assessments and member centered plans • Monitoring completeness/accuracy of functional screens • Member satisfaction surveys • Provider surveys • Response to critical incidents • Monitoring adverse events, including appeals and grievances • Monitoring access to providers and verifying that services were provided.	Met	Met	Met	Met	Met	Met
22	The quality work plan outlines the scope of activities, goals, objectives, timelines, responsible person, and is based on findings from QAPI program activities.	Met	Met	Partially Met	Met	Met	Partially Met
Basic Elements of the QAPI Program							
23	The MCO must have processes in effect to monitor and detect both under- and over-utilization of services.	Met	Met	Met	Met	Met	Met
24	The MCO must operate a system to assess and improve the quality and appropriateness of care furnished to members.	Met	Met	Met	Met	Partially Met	Met
25	Quality and performance indicator data is used for quality management purposes, and is provided and interpreted for care managers and providers as indicated.	Met	Met	Met	Met	Met	Met

26	The MCO must report the status and results of each performance improvement project to the State as requested (conduct the number of PIPs required by its contract and obtain State approval for each required project whether new or continuing). Each PIP must be completed in a reasonable time period so as to generally allow information on the success of PIPs in the aggregate to produce new information on quality of care every year.	Met	Met	Partially Met	Partially Met	Partially Met	Partially Met
Quality Evaluation							
27	The MCO has in effect a process for an annual evaluation of its quality assessment and performance improvement program, which addresses the basic elements and activities of the program.	Met	Met	Met	Met	Met	Met
28	The annual evaluation shall determine whether the program has achieved significant improvement on the quality of health care and services provided to its members.	Met	Met	Met	Met	Met	Partially Met
Health Information Systems							
29	The MCO maintains a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments (for other than loss of Medicaid eligibility).	Met	Met	Met	Met	Met	Met
	Met Findings by MCO	**25**	**27**	**21**	**26**	**20**	**23**
	Partially Met Findings by MCO	**3**	**1**	**7**	**2**	**8**	**5**
	Not Met Findings by MCO	**0**	**0**	**0**	**0**	**0**	**0**
	Not Applicable Findings by MCO	**1**	**1**	**1**	**1**	**1**	**1**

Grievance Systems		**WWC**	**LCD**	**MCDFC**	**CCCW**	**NB**	**SFCA**
Structure and Basic Requirements							
1	The MCO must ensure that staff assigned responsibility for responding to member expressions of dissatisfaction or disagreement with actions offer the appropriate options available to the member as described in the DHS contract with the MCO.	Met	Met	Met	Met	Met	Met
2	The MCO must accept appeals and grievances from members and their preferred representatives, including providers with the member's consent. A representative of a deceased member's estate may file an appeal or grievance. The MCO must accept appeals and grievances according to DHS requirements in order to establish the earliest and appropriate filing date. The MCO must have a system to provide assistance to members to exercise their rights.	Met	Met	Met	Met	Met	Met

3	The MCO policies and procedures include information that describes the oral and written options for filing appeals and grievances, including details for expedited appeals.	Met	Met	Met	Met	Met	Met
4	The MCO's grievance systems structure must identify roles and responsibilities for all staff engaged in supporting members to exercise their rights.	Met	Met	Met	Met	Met	Met
5	The MCO must provide sufficient information to providers to support members in exercising their rights.	Met	Met	Met	Met	Met	Met
6	The MCO must keep records of appeals and grievances.	Met	Met	Met	Met	Met	Met
Communication to Members							
7	MCOs must use the standardized Notice of Action (NOA) templates to inform a member of termination, reduction, and denial of services. The NOA template must also be used when a service authorization decision is delayed.	Met	Met	Met	Met	Met	Met
8	The NOA must be delivered to the member for the following reasons and in the timeframes associated with each type of adverse decision as required by 42 CFR 438.400-424 and Article V.,J., and Article XI of the 2011 State contract with MCOs: • Denial of service • Termination, suspension, or reduction of service • Delay in decision making or extension of timeframe for the decision making process.	Partially Met	Partially Met	Partially Met	Partially Met	Partially Met	Partially Met
9	If the member's health condition requires, adverse decision notices in the categories noted above must be delivered/mailed in the expedited timeframes noted in the contract.	Met	Met	Met	Met	Met	Met
Process if member chooses to exercise his/her rights							
10	The MCOs appeal and grievance policies and procedures must reflect the timeframes associated with standard and expedited appeals for the MCO appeal process, the DHS process, and DHA Fair Hearings. The MCO must acknowledge receipt of appeals for which it has responsibility and take steps to resolve standard and expedited appeals and grievances in the required timeframes.	Met	Met	Met	Met	Met	Met
11	The MCO has a process in place to support members in examining their records and to provide information during a hearing.	Met	Met	Met	Met	Met	Met
12	The MCO hearing process cannot include individuals who were involved in any previous level of review or decision-making/participation in the resource allocation decision method.	Met	Met	Met	Met	Met	Met
13	The MCO must continue the member's benefits pending resolution of the appeal if applicable timeframes are met, unless the member declines the continuation.	Met	Met	Met	Met	Met	Met
Resolution of Appeals							
14	The MCO must issue a written notice of the disposition of an MCO level appeal according to requirements. The method must provide information about additional rights the member has to address the issue within the timeframes assigned, including those for expedited appeals.	Met	Met	Met	Met	Met	Met

15	The MCO takes steps to respond to decisions by the MCO's appeal and grievance committee, DHS directives, and Division of Hearing and Appeals remands within the timeframes associated with each type of appeal decision.	Met	Met	Met	Met	Met	Met
16	The NOA requirements include notification to the member that he/she may be held liable for the costs of continued benefits if the appeal is later dismissed; this contract offers the MCO the opportunity to recover costs.	Met	Met	Met	Met	Met	Met
	Met Findings by MCO	**15**	**15**	**15**	**15**	**15**	**15**
	Partially Met Findings by MCO	**1**	**1**	**1**	**1**	**1**	**1**
	Not Met Findings by MCO	**0**	**0**	**0**	**0**	**0**	**0**

APPENDIX 4

PIP Validation Findings

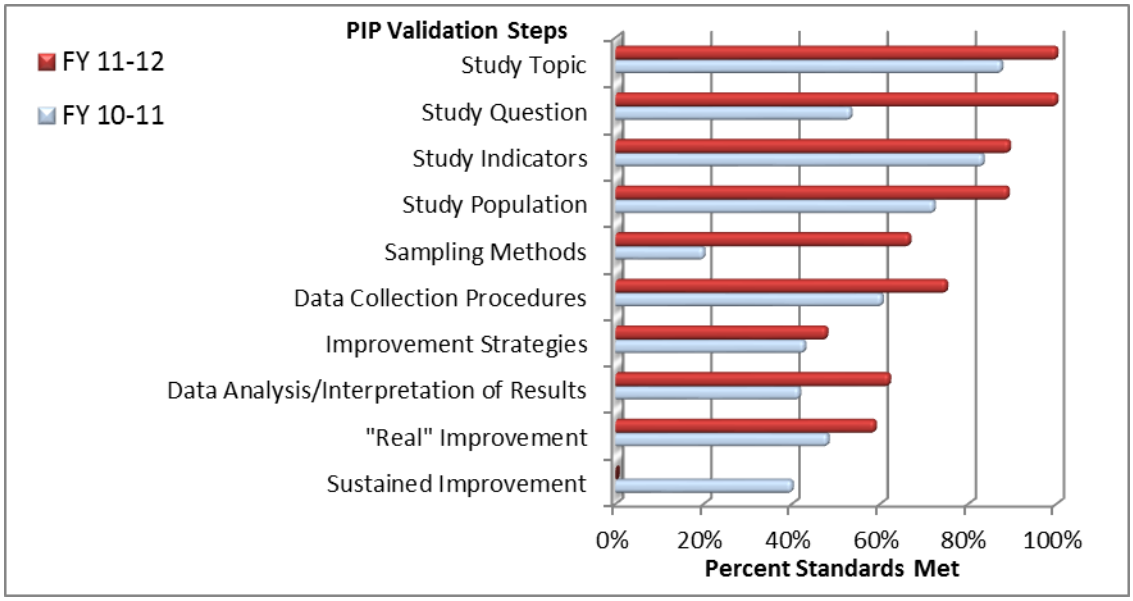
As stated previously in the report, DHS required MCOs to submit projects for pre-approval beginning January 1, 2011. In FY 11-12, MCOs conducted a total of 14 PIPs approved by DHS: ten new and four continuing projects. One proposed project was not approved prior to the MCO's AQR. PIPs were selected based on MCO-specific needs analysis and focused on improving member care and outcomes for a variety of topics.

The first four validation elements (Study Topic, Study Question, Indicators, Population) were met at rates of 89 percent or greater in aggregate. This is improved from FY 10-11 and is likely a result of DHS review and technical assistance provided as indicated. Opportunities for further improvement are noted in the remaining steps, particularly for Improvement Strategies.

MCOs submitted potential projects throughout 2011 and in some cases were required to make modifications and re-submit to DHS. Due to the varied timing of submissions and PIP Validation during AQRs, MCOs had less than eight months between the approval and the validation for nine of fourteen projects. This limited the amount of progress that could be made, and no MCOs were able to demonstrate sustained improvement.

The graph below displays the aggregate results for FY 11-12, compared to FY 10-11. Aggregate results were obtained by calculating the percentage of standards met for all applicable elements under each of the ten validation steps.

Aggregate Performance Improvement Project Findings for FY 10-11 and FY 11-12



APPENDIX 4A

The tables below list the indicators associated with the ten standard elements of the review, and the results of the validation for each project. Some indicators were not applicable depending on the project's phase of implementation at the time of the review. Two tables are included for display purposes: MCOs Operating More than One Program, and MCOs Operating Family Care Only.

MCOs Operating More Than One Program									
MCO		**CHP**		**CC**		**CW**		**iCare**	
Program		FCP	FC/FCP	FC	FCP/PACE	FC/FCP	FCP	FCP	FCP
PIP Topic		Colorectal Screening	Star Method	Pain Control	RAD	RAD	Hospital Re-admission	Diabetic Labs	Hospital Re-admission
Study Topic(s)									
1	The topic was selected through MCO data collection and analysis of important aspects of member needs, care, or services.	Met	Met	Met	Met	Met	Met	Met	Met
2	The project/study focused on improving key aspects of care and/or outcomes for members.	Met	Met	Met	Met	Met	Met	Met	Met
Study Question(s)									
3	The problem to be studied was stated as a clear, simple, answerable question(s) with a numerical goal and target date.	Met	Met	Met	Met	Met	Met	Met	Met
Study Indicator(s)									
4	The study used objective, clearly and unambiguously defined, measureable indicators and included defined numerators and denominators.	Met	Met	Partially Met	Met	Met	Met	Met	Met
5	Indicators measure changes in any of the following: health or functional status, member satisfaction, processes of care with strong associations with improved outcomes.	Met	Met	Partially Met	Met	Met	Met	Met	Met
Study Population									
6	The project/study clearly defined the relevant population (all members to whom the study question and indicators apply).	Met	Met	Partially Met	Met	Met	Met	Met	Met
7	If the entire population was used, data collection approach captured all members to whom the study question applied.	N/A	Met	Not Met	N/A	Met	Met	Met	Partially Met

8	If the entire population was not used, the selected at-risk population was defined (e.g., high-risk, high utilization, or high needs).	Met	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Sampling Methods									
9	Valid sampling techniques were used.	Met	N/A	Met	N/A	Met	N/A	N/A	N/A
10	The sample contained a sufficient number of members.	Met	N/A	Met	N/A	Met	N/A	N/A	N/A
Data Collection Procedures									
11	The project/study clearly defined the data to be collected and the source of that data.	Met	Partially Met	Met	N/A	Met	Met	Met	Not Met
12	Staff are qualified and trained to collect data.	Met	Partially Met	Met	N/A	Met	Met	Met	Not Met
13	The instruments for data collection provided for consistent, accurate data collection over the time periods studied.	Met	Not Met	Not Met	N/A	Met	Met	Met	Not Met
14	The study design prospectively specified a data analysis plan.	Met	Not Met	Met	N/A	Met	Met	Met	Not Met
Improvement Strategies									
15	Reasonable interventions were undertaken to address causes/barriers identified through data analysis and QI processes.	Met	Partially Met	Partially Met	N/A	Met	Met	Partially Met	Partially Met
16	PDSA documentation included evidence that interventions were tested and findings used to move the project forward.	Partially Met	N/A	Met	N/A	Met	Met	Not Met	Not Met
Data Analysis and Interpretation of Study Results									
17	Data analysis was performed, including initial and repeat measures, and identification of project/study limitations.	Met	N/A	Partially Met	N/A	Met	Met	Partially Met	N/A
18	Numerical results and findings were presented accurately and clearly.	Partially Met	N/A	Partially Met	N/A	Met	Met	Partially Met	N/A
19	The analysis of study data included an interpretation of the extent to which the PIP was successful.	Met	N/A	Met	N/A	Met	Met	Partially Met	N/A
20	Follow-up activities (next steps) were clearly defined.	Met	N/A	Met	N/A	Met	Met	Met	N/A
"Real" Improvement									
21	The same methodology as the baseline measurement was used, when measurement was repeated.	Met	N/A	Not Met	N/A	Met	Met	Partially Met	N/A
22	There was a documented, quantitative improvement in processes or outcomes of care.	Met	N/A	Not Met	N/A	Met	Met	Not Met	N/A
23	The reported improvement appeared to be the result of the planned quality improvement intervention.	Met	N/A	N/A	N/A	Met	Met	N/A	N/A

Sustained Improvement									
24	Sustained improvement was demonstrated through repeated measurements over comparable time periods.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Met Findings by MCO		**20**	**7**	**11**	**6**	**22**	**20**	**12**	**6**
Partially Met Findings by MCO		**2**	**3**	**6**	**0**	**0**	**0**	**5**	**2**
Not Met Findings by MCO		0	2	4	0	0	0	2	5
Not Applicable Findings by MCO		**2**	**12**	**3**	**18**	**2**	**4**	**5**	**11**

APPENDIX 4B

MCOs Operating Family Care Only							
MCO		**WWC**	**LCD**	**MCDFC**	**CCCW**	**NB**	**SFCA**
PIP Topic		Fall Prevention	Fall Reduction	Employment	Fall Risk Reduction	Fall Reduction	Fall Prevention
Study Topic(s)							
1	The topic was selected through MCO data collection and analysis of important aspects of member needs, care, or services.	Met	Met	Met	Met	Met	Met
2	The project/study focused on improving key aspects of care and/or outcomes for members.	Met	Met	Met	Met	Met	Met
Study Question(s)							
3	The problem to be studied was stated as a clear, simple, answerable question(s) with a numerical goal and target date.	Met	Met	Met	Met	Met	Met
Study Indicator(s)							
4	The study used objective, clearly and unambiguously defined, measureable indicators and included defined numerators and denominators.	Partially Met	Met	Met	Met	Met	Met
5	Indicators measure changes in any of the following: health or functional status, member satisfaction, processes of care with strong associations with improved outcomes.	Met	Met	Met	Met	Met	Met
Study Population							
6	The project/study clearly defined the relevant population (all members to whom the study question and indicators apply).	Met	Met	Met	Met	Met	Met
7	If the entire population was used, data collection approach captured all members to whom the study question applied.	N/A	N/A	N/A	N/A	N/A	Met
8	If the entire population was not used, the selected at-risk population was defined (e.g., high-risk, high utilization, or high needs).	Met	Met	Met	Met	Met	N/A
Sampling Methods							
9	Valid sampling techniques were used.	N/A	N/A	Met	Partially Met	Partially Met	N/A
10	The sample contained a sufficient number of members.	N/A	N/A	Met	Partially Met	Not Met	N/A
Data Collection Procedures							
11	The project/study clearly defined the data to be collected and the source of that data.	Met	Met	Partially Met	Met	Met	Met
12	Staff are qualified and trained to collect data.	Met	Partially Met	Met	Met	Met	Met
13	The instruments for data collection provided for consistent, accurate data collection over the time periods studied.	Met	Partially Met	Partially Met	Met	Met	Met
14	The study design prospectively specified a data analysis plan.	Met	Met	Met	Met	Met	Met
Improvement Strategies							
15	Reasonable interventions were undertaken to address	N/A	Met	Not Met	Met	Met	Met

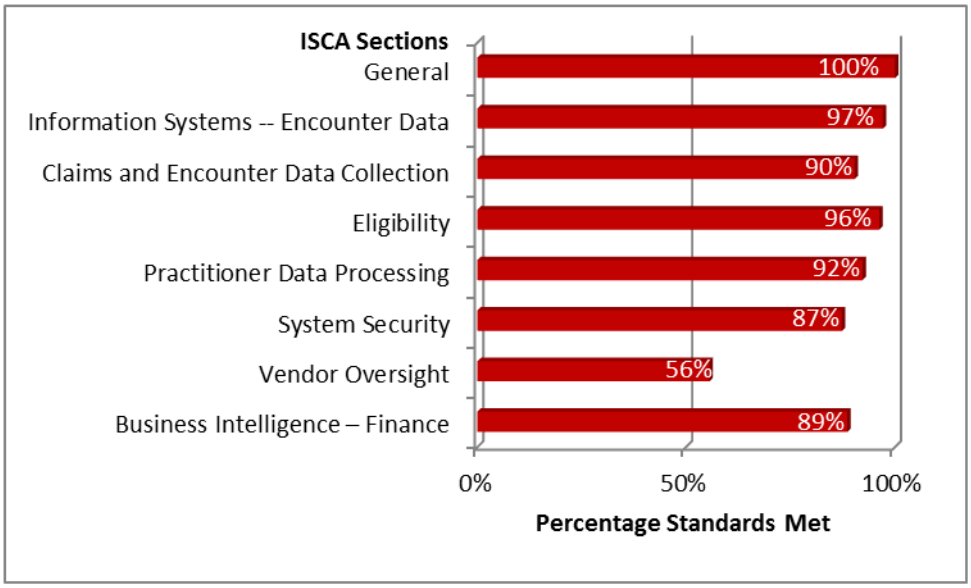
	causes/barriers identified through data analysis and QI processes.						
16	PDSA documentation included evidence that interventions were tested and findings used to move the project forward.	N/A	Met	Not Met	Partially Met	Not Met	Partially Met
Data Analysis and Interpretation of Study Results							
17	Data analysis was performed, including initial and repeat measures, and identification of project/study limitations.	N/A	Met	Partially Met	Partially Met	N/A	N/A
18	Numerical results and findings were presented accurately and clearly.	N/A	Partially Met	Partially Met	N/A	N/A	N/A
19	The analysis of study data included an interpretation of the extent to which the PIP was successful.	N/A	Met	Partially Met	N/A	N/A	N/A
20	Follow-up activities (next steps) were clearly defined.	N/A	Met	Met	N/A	N/A	N/A
"Real" Improvement							
21	The same methodology as the baseline measurement was used, when measurement was repeated.	N/A	Met	Not Met	N/A	N/A	N/A
22	There was a documented, quantitative improvement in processes or outcomes of care.	N/A	Not Met	Not Met	N/A	N/A	N/A
23	The reported improvement appeared to be the result of the planned quality improvement intervention.	N/A	N/A	N/A	N/A	N/A	N/A
Sustained Improvement							
24	Sustained improvement was demonstrated through repeated measurements over comparable time periods.	N/A	N/A	N/A	N/A	N/A	N/A
Met Findings by MCO		**10**	**15**	**12**	**12**	**12**	**12**
Partially Met Findings by MCO		**1**	**3**	**5**	**4**	**1**	**1**
Not Met Findings by MCO		**0**	**1**	**4**	**0**	**2**	**0**
Not Applicable Findings by MCO		**13**	**5**	**3**	**8**	**9**	**11**

APPENDIX 5

Information Systems Capabilities Assessment Findings

During FY11-12, the EQR team completed an ISCA for three MCOs: CW, LCD, and WWC. Findings identified several areas of strength, as well as some opportunities for improvement. The graph below displays the aggregate results for the three MCOs in each review area. Aggregate results were obtained by averaging the MCO individual scores for each ISCA section.

AGGREGATE ISCA FINDINGS FOR FY 11-12



The table below lists the ISCA standards and comparative results for each MCO:

ISCA SUMMARY COMPARING THREE MCOS

Section	CW	LCD	WWC
Section I: General	100%	100%	100%
Section II: Information Systems -- Encounter Data Flow	98.41%	96.07%	96.83%
Section III: Claims and Encounter Data Collection	93.11%	86.52%	91.45%
Section IV: Eligibility	95.24%	100%	93.45%
Section V: Practitioner Data Processing	95.24%	85.71%	95.83%
Section VI: System Security	97.62%	83.33%	80.95%
Section VII: Vendor Oversight	100%	33.33%	33.33%
Section VIII: Business Intelligence – Finance	97.50%	76.88%	91.25%
Total	**97.14%**	**82.73%**	**85.39%**