WISCONSIN MEDICAID MANAGED LONG-TERM CARE
EXTERNAL QUALITY REVIEW

FAMILY CARE, FAMILY, CARE PARTNERSHIP, AND PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY
STATE FISCAL YEAR 2012 - 2013

PREPARED FOR

WISCONSIN DEPARTMENT OF HEALTH SERVICES

PREPARED BY

OCTOBER 29, 2013

External Quality Review Organization
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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 (PACE) 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, 2012, to June 30, 2013 (FY 12-13). 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 key areas of care management practice was also conducted related to assurances found in the 1915 (b) and (c) Waivers, and to support assessment of compliance with federal standards. FY 12-13 was the second year of a three-year review cycle for compliance with standards. Therefore, for each managed care organization, MetaStar reviewed only those compliance standards that were not fully met during the previous year's comprehensive review.

SUMMARY OF PROGRESS

- In FY 12-13, for the first time in the history of the Family Care program, three organizations met 100 percent of the federal quality compliance standards. All three organizations had compliance rates of 90 percent or higher during last year's review.
- Three other organizations also made progress related to compliance with standards, and for the first time achieved compliance rates of 90 percent or more.
- Eight of nine managed care organizations showed progress related to compliance with federal standards in FY 12-13, compared to the results in FY 11-12. Across organizations, the overall rate of compliance improved from 80.7 percent to 90.5 percent.
- Each program (Family Care, Family Care Partnership, PACE) improved its overall results in the areas of practice evaluated by care management review compared to the results in FY 11-12. For FY 12-13, the percent of care management review standards met was 89.4 percent, 82.6 percent, and 90.4 percent for Family Care, Family Care Partnership, and PACE, respectively.
- All managed care organizations were successful in securing pre-approval from the Department of Health Services for their proposed performance improvement projects.

- MCOs used a template for performance measure data submissions developed by DHS, which greatly increased the consistency and quality of the reported data.

NOTABLE STRENGTHS

- Consistent with the results of past reviews, managed long-term care organizations demonstrated strength related to compliance with enrollee rights standards.
    - In FY 12-13, the overall rate of compliance across all programs and organizations reached 95.8 percent for standards which address enrollee rights. This compares to an overall compliance rate of 86.1 percent in FY 11-12.
- Managed care organizations also continued to perform strongly related to compliance with grievance systems standards.
    - The overall rate of compliance across programs and organizations reached 95.1 percent in FY 12-13, an increase from 91.7 percent in last year's review.
- Over the past several years, managed care organizations have consistently performed well in addressing members' identified needs and including members and their supports in care management processes. During the past two years,
    - Results related to ensuring members' identified needs are addressed were 96.7 percent in FY 12-13, and 94.7 percent in FY 11-12.
    - Results related to ensuring members and their supports are included in care management processes and decision making were 97 percent in FY 12-13 and 97.4 percent in FY 11-12.
- Managed care organizations have demonstrated the ability to meet requirements related to the early stages of performance improvement projects by developing methodologically sound study topics, study questions, and study indicators.
- Related to performance measures validation standards, immunization rates calculated and reported by the MCOs can be relied upon to be accurate.

RECOMMENDATIONS

Enrollee Rights

- Ensure that two managed care organizations with partially met standards related to restraints and restrictive measures implement policies and procedures, develop monitoring systems, and conduct staff and provider training, as indicated, in order to protect members' rights.

Access/Quality

- Maintain oversight of two managed care organizations that have not achieved compliance with provider network standards.
- Ensure that all organizations have developed effective systems to monitor care management practice and member care.
- Encourage managed care organizations to focus quality assessment and performance improvement activities on elements that impact the quality of member care.
- Continue to provide technical assistance regarding quality improvement strategies so that all organizations can successfully use data to drive improvements.
- Encourage organizations to fully develop processes to monitor and detect under- and over-utilization.

Grievance Systems

- Ensure that managed care organizations have adequate systems in place to monitor notices of action.
- Assist managed care organizations to identify and spread best practices related to issuing timely notices of action when indicated.

Performance Improvement Projects

- Standardize the project timeline for performance improvement projects in order to ensure organizations make active progress on projects during each contract period.

Care Management Practice

- Ensure that, across programs, organizations focus efforts on improving the following areas of care management practice:
    - Improving the comprehensiveness of member-centered plans;
    - Conducting reassessments and updating member-centered plans when members have significant changes in situation or condition;
    - Following up with members to ensure services have been received and are effective, and consistently documenting follow-up in members' records;
    - Recognizing and responding to service requests in a timely manner, and consistently and accurately documenting requests and service decisions; and
    - Issuing notices to members, when indicated.

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, 2012, to June 30, 2013 (FY 12-13). See Appendix 3 for more information about external quality review and a description of the methodologies used to conduct review activities.

OVERVIEW OF WISCONSIN'S FC, FCP, AND PACE MCOS

During FY 12-13, the Wisconsin Department of Health Services (DHS) contracted with 10 managed care organizations (MCOs) to administer these programs, which are considered PIHPs. As noted in the table below, six MCOs operate only FC programs; one MCO operates only a FCP program; one MCO operates FC and FCP programs; one MCO operates programs for FC, FCP, and PACE. Additionally, one MCO ceased operating FC and FCP programs during the review year.

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)*	
Independent Care (iCare)	**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**

*As of 12/31/12, the contract between DHS and CHP ended.
**SFCA planned to change its name to ContinuUs effective 8/1/13.

During 2012, the state conducted a competitive procurement and awarded three MCOs the opportunity to expand their service areas into additional counties currently served by at least one other MCO; thus, affording consumers in those areas more choice of MCO providers.

On January 1, 2013, also as a result of competitive procurement, SFCA replaced CHP as the MCO responsible for delivery of FC services in five counties in northwest Wisconsin. CHP, which had been providing both FC and FCP, ceased operations effective 12/31/12. FCP was discontinued in these counties and SFCA offered all FCP members enrollment into FC.

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:

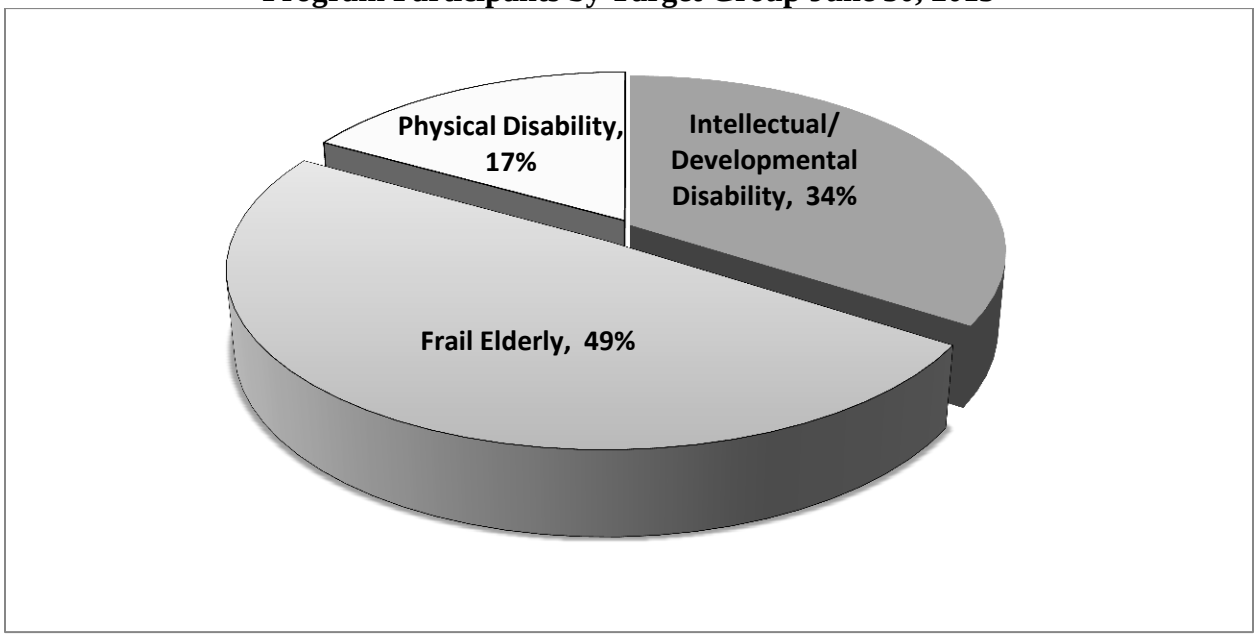
http://www.dhs.wisconsin.gov/familycare/mcos/index.htm

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

As of June 30, 2013, enrollment for all programs was approximately 40,400. This compares to a total enrollment of 39,054 as of June 30, 2012. 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 intellectual/developmental disabilities, and persons with physical disabilities.

Program Participants by Target Group June 30, 2013



Enrollment data is available at the following DHS website:
http://dhs.wisconsin.gov/ltcare/Generalinfo/EnrollmentData.htm

SCOPE OF FY 12-13 EXTERNAL REVIEW ACTIVITIES

In FY 12-13, 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 (QCR); validation of performance improvement projects (PIPs); and validation of performance measures. MetaStar also conducted an optional review activity, care management review (CMR).

Mandatory Review Activities	Scope of Activities
Quality Compliance Review	As directed by DHS, QCR activities generally follow a three year cycle. The first year, MetaStar conducts a comprehensive review where all QCR standards are assessed; 52 standards for FC, and 53 standards for FCP. This is followed by two years of targeted review or follow-up based on the results of the comprehensive review year. FY 12-13 was a **follow-up review year**. Therefore, for each MCO, the EQR team reviewed only those compliance standards the MCO did not fully meet in its previous full review in FY 11-12. The targeted areas of review for each MCO are indicated in the chart on page 10 and 11.
Performance Improvement Projects	The DHS-MCO contract requires all MCOs to make active progress each year on at least one 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 12-13, MetaStar validated one or more PIPs for each MCO, for a total of 10 PIPs. Two additional projects related to acute/primary care were not validated. Due to delay in CMS approval, the projects had not yet been implemented. The PIP topics reviewed for each MCO are indicated the chart on page 12.
Performance Measures	Annually, MCOs must measure and report their performance using quality indicators and standard measures specified in the DHS-MCO contract. For FY 12-13, all MCOs were required to report performance measures data 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 these MCOs provide to CMS for Medicare enrollees. As directed by DHS, MetaStar validated two of these performance measures for every MCO: • Influenza vaccinations • Pneumonia vaccinations. MCOs were directed to report data regarding the care continuity and dental visits performance measures directly to DHS; MetaStar did not

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

	validate these measures. MCOs were also directed to report the HEDIS data to DHS.
Optional Review Activities	**Scope of Activities**
Care Management Review	MetaStar conducts CMR to assess each MCO's level of compliance with its contract with DHS in key areas of care management practice. CMR activities and findings also 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. During FY 12-13, the EQR team conducted CMR activities during each MCO's annual quality review (AQR), a total of 636 record reviews. At the request of DHS, MetaStar also performed an additional 36 CMRs separate from AQR. These results were reported separately and are not included in the data for this report.

SCOPE OF EACH MCO'S ANNUAL QUALITY REVIEW

During FY 12-13, each MCO's AQR consisted of QCR, CMR, and PIP validation activities. It should be noted that, per the direction of DHS, MetaStar did not conduct review activities at CHP, as this MCO ceased operating FC and FCP programs effective December 31, 2012, and SFCA began providing FC services to that area as of January 1, 2013. EQR activities at SFCA were adjusted to reflect the transition in MCO provider in the area formerly served by CHP.

QCR Targeted Areas of Review for each MCO

As noted above, the QCR standards reviewed at each MCO were targeted to those standards not fully met in FY 11-12. The table below shows the QCR topic areas reviewed for each MCO. Each QCR topic is associated with one or more quality compliance standards. The number in parenthesis after each topic tells the number of compliance standards for each area of review. The check mark(s) in each column indicate that a corresponding number of compliance standards were reviewed in the QCR topic area for that MCO.

QCR TOPIC	CCCW	CCI	CW	*i*CARE	LCD	MCDFC	NB	SFCA	WWC
Enrollee Rights and Program Structure									
General Rules (1)	√	√	√	√					
Specific Rights (1)	√	√		√					
Information Requirements (6)		√		√				√	
Access to Services and Quality Monitoring									
Provider Selection and Retention (3)		√	√√	√√√	√		√		

QCR TOPIC	CCCW	CCI	CW	*i*CARE	LCD	MCDFC	NB	SFCA	WWC
Confidentiality (1)							√		
Enrollment and Disenrollment (3)		√√	√			√			
Availability of Services (3)				√					
Coordination and Continuity of Care (3)		√√	√	√√		√√	√√	√	√√
Coverage and Authorization of Services (3)	√	√√	√√	√		√√	√√	√	√
Practice Guidelines (3)		√√√		√					
Quality Assessment and Performance Improvement Program (QAPI) (3)		√		√		√		√	
Basic Elements of the QAPI Program (4)	√	√√√	√	√√√√		√	√√	√	
Quality Evaluation (2)		√		√√				√	
Health Information Systems (1)									
Grievance Systems									
Structure and Basic Requirements (6)		√√							
Communication to Members (3)	√	√	√	√	√	√	√	√	√
Processes if Member Chooses to Exercise his/her Rights (4)		√							
Resolution of Appeals (3)									
Total QCR Standards Reviewed for Each MCO	**5**	**22**	**9**	**19**	**2**	**8**	**9**	**7**	**4**

PIP Topic(s) Reviewed for each MCO

MCO	PIP Title
CCI	• Increasing Member and Staff Awareness/Use of Self-Directed Supports (SDS) • Reducing Cardiovascular Disease among Community Care Health Plan Partnership Members who are Diabetic and Hypertensive *
CCCW	Falls Prevention Project 2009 to 2012
CW	• The Hospital Re-Admit PIP • Care Transitions: Improving Coordination of Care
iCare	• Effectiveness of Transition of Care Protocol in Decreasing Hospital Re-Admissions • Increasing low density lipoprotein (LDL) Testing for FCP Members *
LCD	Falling Head Over Heals for Falls Reduction
MCDFC	Hypertension and the Role of Self-Monitoring Blood Pressure
NB	Measuring the effectiveness of Sure Step for frail elderly members at high risk of falls who are living in their own homes
SFCA	Fall Prevention Project
WWC	Falls Prevention PIP

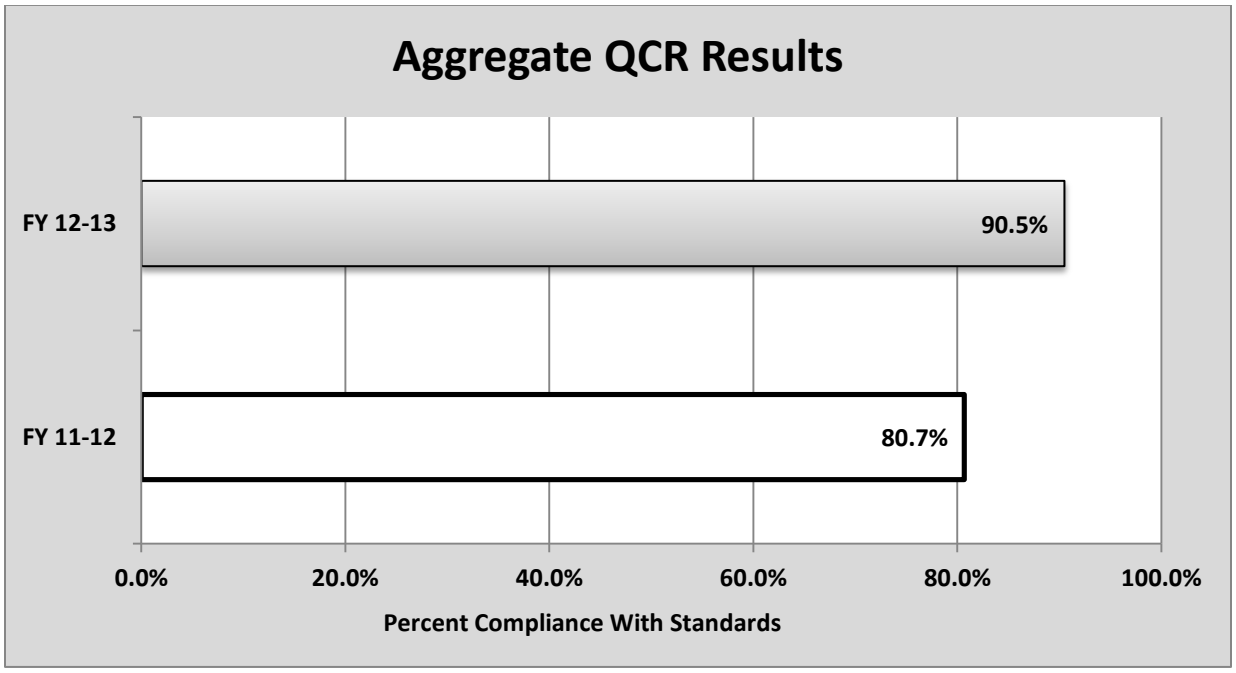
* PIP not validated as a result of the delay in approval from CMS and implementation.

QUALITY COMPLIANCE REVIEW

QCR is a mandatory activity which is conducted to determine the extent to which MCOs are in compliance with federal quality standards. QCR generally follows a three year cycle, one year of comprehensive review followed by two years of targeted review. The comprehensive review includes 52 total standards for MCOs operating FC and 53 standards for those operating FCP. Targeted review includes only those compliance standards MCOs did not fully meet during the previous comprehensive review year. FY 11-12 was a comprehensive review year; compliance reviews in FY 12-13 were targeted or focused.

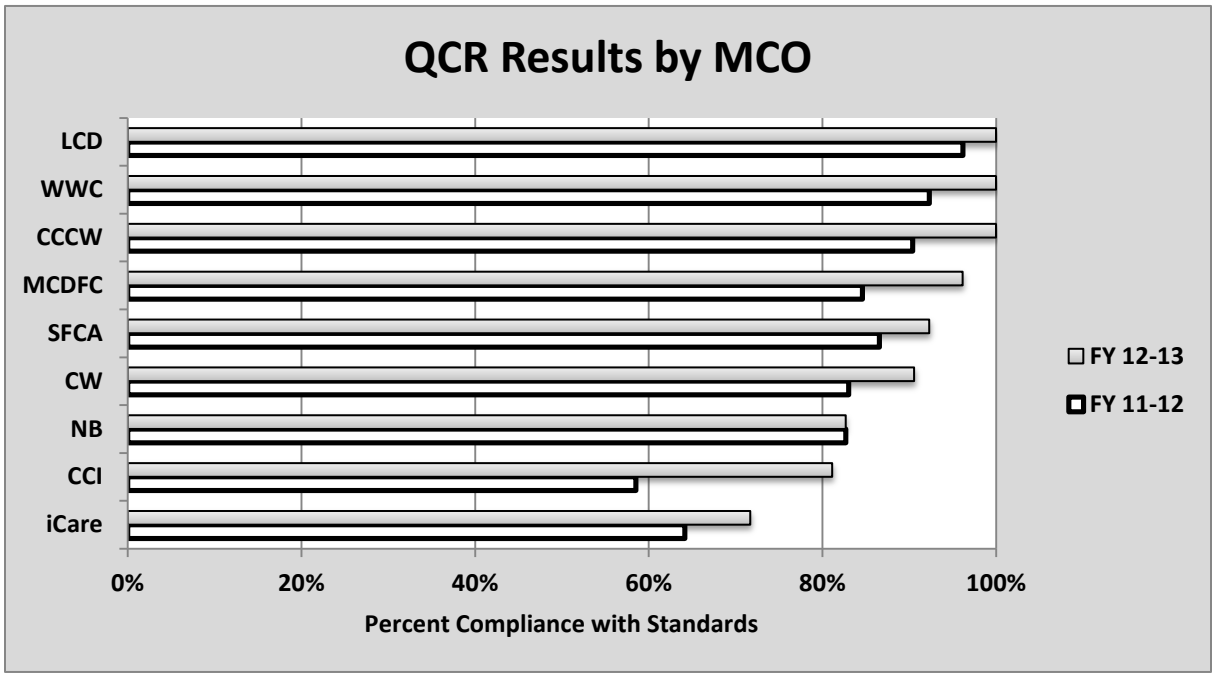
AGGREGATE RESULTS FOR QUALITY COMPLIANCE REVIEW

The graph below shows the aggregate results for QCR for FY 12-13, and compares the percentage of standards met in this year's review to MCOs' level of compliance in FY 11-12. The bar labeled FY 12-13 represents the QCR standards met in FY 11-12 plus additional standards met during this year's focused review. The reader should note that FY 11-12 includes the aggregate results of 10 MCOs, whereas FY 12-13 includes the results of nine MCOs.



- During FY 12-13, a total of 85 standards were reviewed among all MCOs.
- Results indicated that 40 of 85 standards (47.1 %) improved to fully met during the FY 12-13 review year.
- Therefore, 90.5 percent of all compliance standards are now met in aggregate.

The graph below shows QCR results as a percentage of total standards met for FY 11-12 and FY 12-13 for each MCO reviewed in FY 12-13. As above, the FY 12-13 results include all QCR standards met in FY 11-12 plus additional standards met during this year's focused review.



- Three organizations achieved 100 percent compliance, for the first time in the history of the FC program.
    - These organizations had each met 90 percent or more of the standards during the previous review.
- Compared to the results of last year's review, three additional MCOs attained a compliance rate of 90 percent of higher.
- Results for eight of nine MCOs showed progress since last year's review.

Focus Area Results for Quality Compliance Review

MetaStar has organized the federal protocols for quality compliance review into three focus areas:

- Enrollee Rights and Program Structure;
- Access to Services and Quality Monitoring; and
- Grievance Systems.

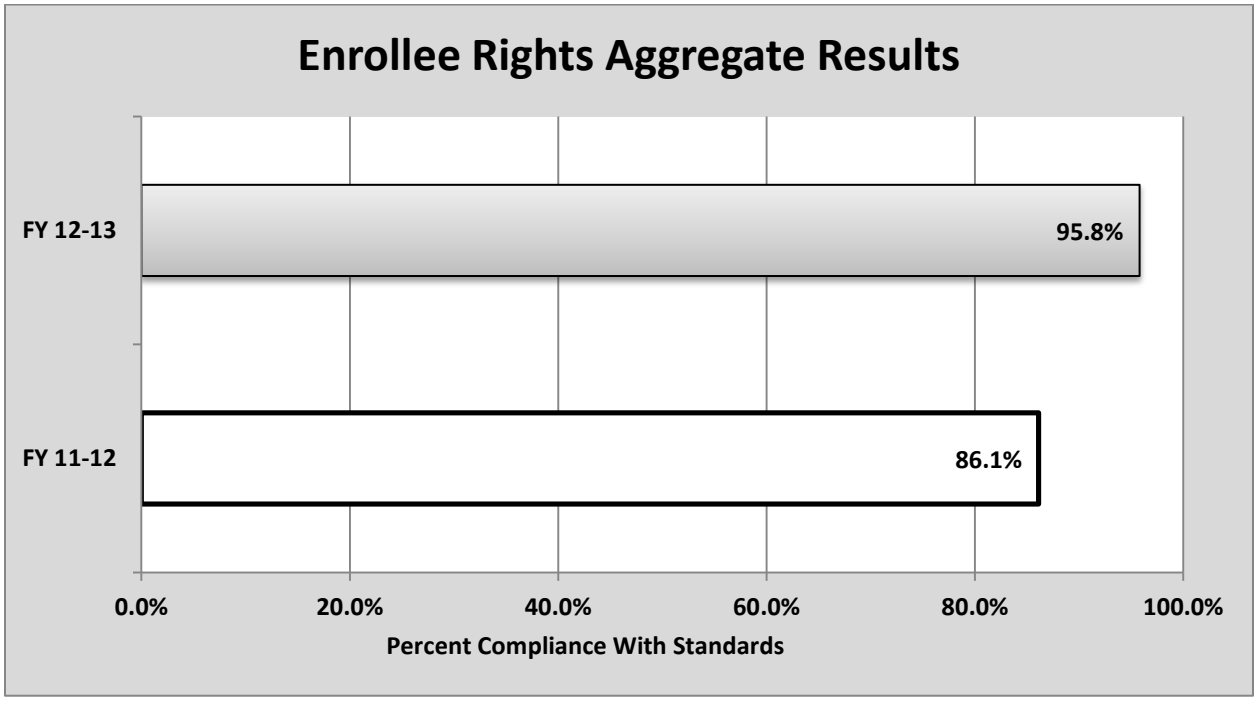
For more information about the review protocols and methodology, see Appendix 3.

Each section below provides a brief explanation of a QCR focus area, followed by a bar graph and a table with additional information.

Enrollee Rights and Program Structure

A MCO is responsible to help members understand their rights as well as to ensure those rights are protected. This requires an adequate organizational structure and sound processes that adhere to program requirements and are capable of ensuring that members' rights are protected.

The graph below shows the aggregate results for FY 12-13, for all of the standards related to "Enrollee Rights and Program Structure," and compares the percentage of standards met in this year's review to MCOs' level of compliance in FY 11-12. The bar labeled FY 12-13 represents the standards met in FY 11-12 plus additional standards met during this year's focused review. The reader should note that FY 11-12 includes the aggregate results of 10 MCOs, whereas FY 12-13 includes the results of nine MCOs.

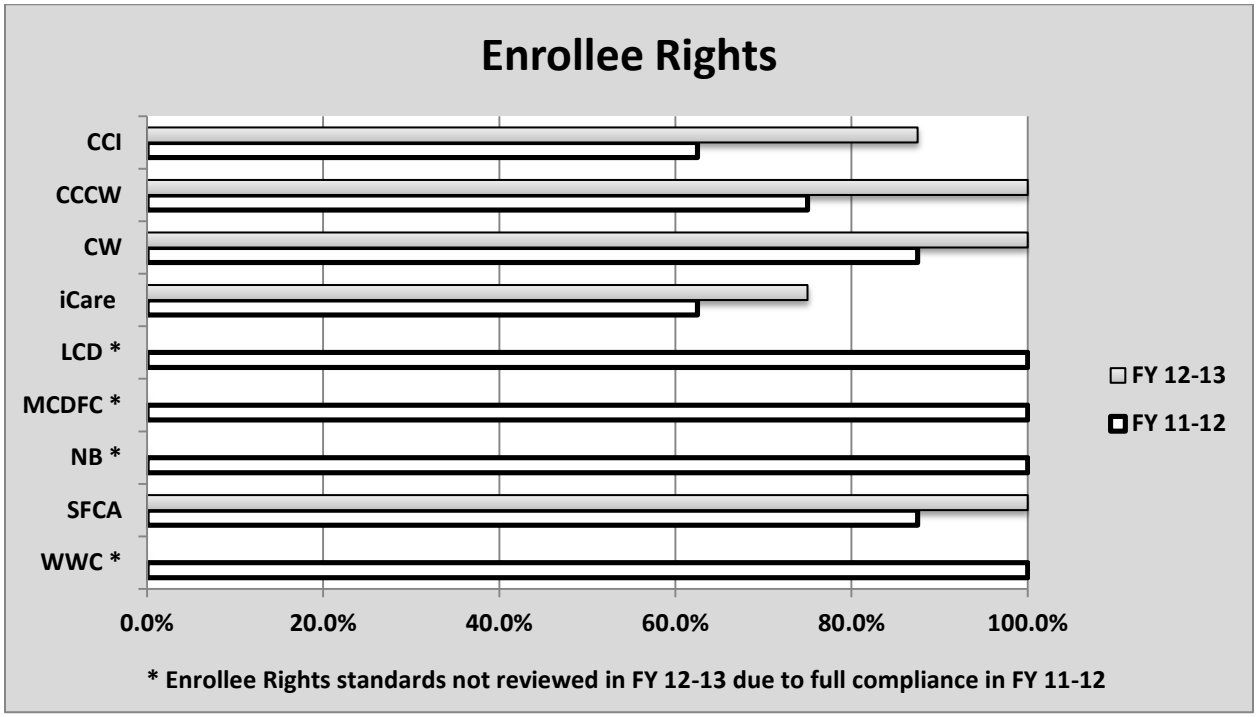


The table below lists each standard in the "Enrollee Rights and Program Structure" focus area, along with the number of MCOs meeting the standard for each review year in relation to the total number of MCOs reviewed. Results for FY 12-13 are cumulative and include the number of MCOs meeting the standard in FY 11-12 plus additional MCOs meeting the standard during this year's focused review. As noted above, nine MCOs were reviewed in FY 12-13, while 10 were reviewed in FY 11-12.

	Quality Compliance Review Standards – Enrollee Rights and Program Structure	FY 11-12	FY 12-13
	Numerator = Number of MCOs meeting the standard Denominator = Total number of MCOs reviewed		
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.	6/10	9/9
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	7/10	7/9
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	10/10	9/9
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	10/10	9/9

	Quality Compliance Review Standards – Enrollee Rights and Program Structure	FY 11-12	FY 12-13
	Numerator = Number of MCOs meeting the standard **Denominator = Total number of MCOs reviewed**		
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	10/10	9/9
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.	10/10	9/9
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.	10/10	9/9
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	6/10	8/9

The graph below shows results for the "Enrollee Rights and Program Structure" focus area as a percentage of total standards met for FY 11-12 and FY 12-13 for each MCO. The FY 12-13 results include all QCR standards met in FY 11-12 plus additional standards met during this year's focused review.



CONCLUSIONS

Progress

- During FY 12-13, seven of 10 standards reviewed for this focus area were met.
- All MCOs have fully met the "General Rules" requirement to have written policies and procedures in place regarding member rights.
- Seven of nine MCOs have fully met all indicators.
    - Three additional MCOs achieved fully met scores during FY 12-13.

Strengths

- Compliance with enrollee rights standards has been a consistent area of strength.
- In aggregate, MCOs' compliance rate has reached 95.8 percent for standards in this focus area, an increase from 86.1 percent.

Opportunities for Improvement

- Two organizations have not fully implemented policies, procedures, and monitoring systems related to restraints and restrictive measures.

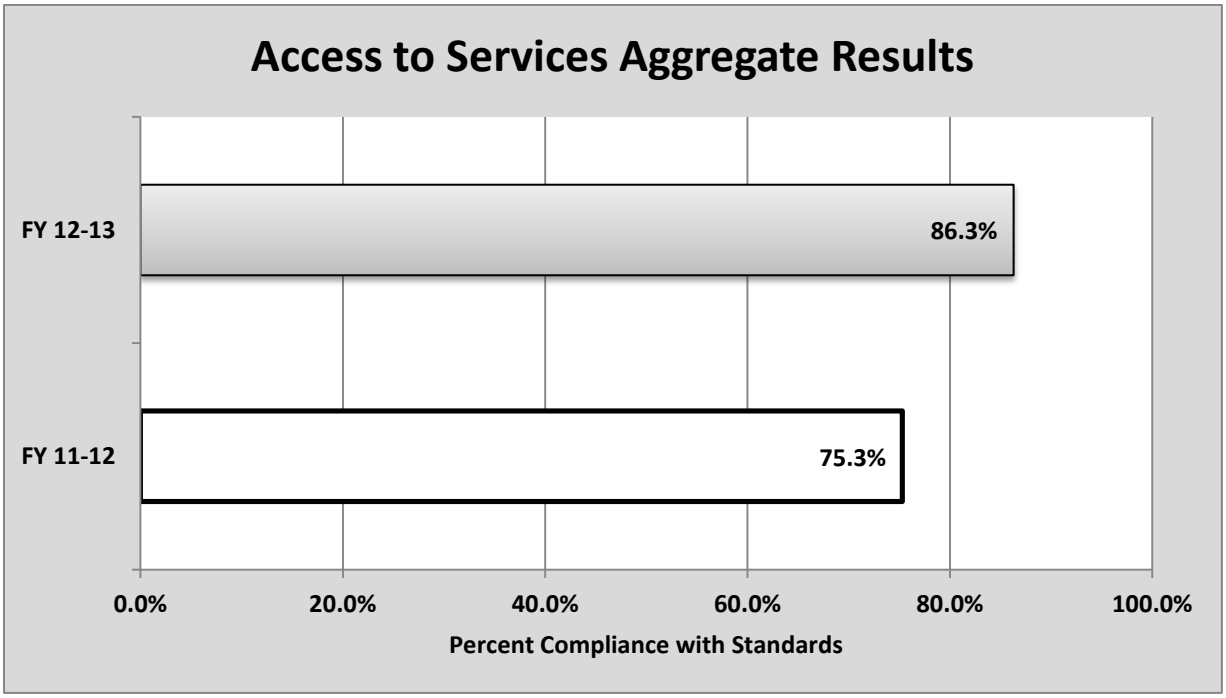
Access to Services and Quality Monitoring

A MCO must provide members with high quality long-term care and health care services through a network of appropriate and qualified providers. It must also have systems and processes for:

- Providing timely authorization of services;
- Ensuring coordination and continuity of care; and
- Coordinating with other agencies to support enrollment and disenrollment.

In addition, the MCO must have an ongoing Quality Assessment and Performance Improvement Program which assesses and improves the quality of care and services provided by the MCO and its service providers. Each MCO must have a structure which adheres to program requirements for documentation of quality management activities, findings, and results

The graph below shows the aggregate results for FY 12-13, for all of the standards related to "Access to Services and Quality Monitoring," and compares the percentage of standards met in this year's review to MCOs' level of compliance in FY 11-12. The bar labeled FY 12-13 represents the standards met in FY 11-12 plus additional standards met during this year's focused review. The reader should note that FY 11-12 includes the aggregate results of 10 MCOs, whereas FY 12-13 includes the results of nine MCOs.



The table below lists each standard in the "Access to Services and Quality Monitoring" focus area, along with the number of MCOs meeting the standard for each review year in relation to the total number of MCOs reviewed. Results for FY 12-13 are cumulative and include the number of MCOs meeting the standard in FY 11-12 plus additional MCOs meeting the standard during this year's focused review. As noted above, nine MCOs were reviewed in FY 12-13, while 10 were reviewed in FY 11-12.

	Quality Compliance Review Standards – Access to Services and Quality Monitoring	Finding FY 11-12	Finding FY 12-13
	Numerator = Number of MCOs meeting the standard Denominator = Total number of MCOs reviewed		
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	9/10	8/9
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.	7/10	8/9
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	4/10	7/9
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.	9/10	8/9
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 Documentation of the basis for the request,	9/10	9/9

	Quality Compliance Review Standards – Access to Services and Quality Monitoring	Finding FY 11-12	Finding FY 12-13
	Numerator = Number of MCOs meeting the standard **Denominator = Total number of MCOs reviewed**		
	○ 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.		
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: • 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	7/10	9/9
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 and; ○ Provides for revoking delegation or imposing other sanctions	10/10	9/9

	Quality Compliance Review Standards – Access to Services and Quality Monitoring	Finding FY 11-12	Finding FY 12-13
	Numerator = Number of MCOs meeting the standard **Denominator = Total number of MCOs reviewed**		
	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		
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	9/10	8/9
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	10/10	9/9
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 contract, 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	10/10	9/9
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	3/10	6/9

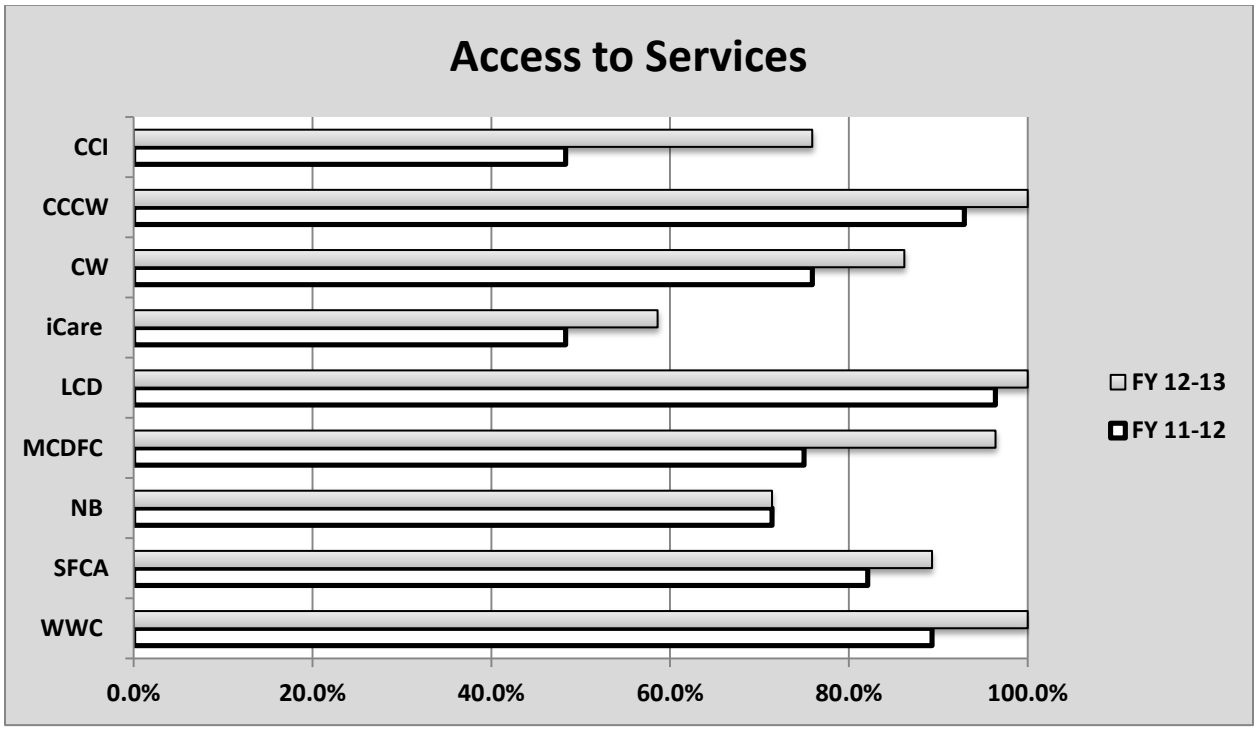
	Quality Compliance Review Standards – Access to Services and Quality Monitoring	Finding FY 11-12	Finding FY 12-13
	Numerator = Number of MCOs meeting the standard **Denominator = Total number of MCOs reviewed**		
	for FCP) and coordinate health care services for all MCO members. These procedures must 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		
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.	10/10	9/9
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.	2/10	5/9
Coverage and authorization of services			
14	**Authorization of Services** For processing requests for initial and continuing authorizations of services, the MCO must:	6/10	7/9

	Quality Compliance Review Standards – Access to Services and Quality Monitoring	Finding FY 11-12	Finding FY 12-13
	Numerator = Number of MCOs meeting the standard Denominator = Total number of MCOs reviewed		
	• 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		
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 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.	1/10	6/9
16	**Emergency and post-stabilization services - FCP Only** 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.	4/4	3/3

Quality Compliance Review Standards – Access to Services and Quality Monitoring		Finding FY 11-12	Finding FY 12-13
	Numerator = Number of MCOs meeting the standard Denominator = Total number of MCOs reviewed		
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	9/10	9/9
18	Practice guidelines are disseminated to affected providers and, upon request, to members.	9/10	8/9
19	Practice guidelines are applied throughout the MCO in a consistent manner, e.g., utilization management, member education, coverage of services, QAPI program.	8/10	9/9
Quality Assessment and Performance Improvement Program (QAPI)			
20	The MCO has an ongoing quality assessment and performance improvement (QAPI) program for the services it furnishes to members, which includes a description of: • Responsibility for the program • Member participation • Staff and provider participation	9/10	9/9
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	10/10	9/9
22	The quality work plan outlines the scope of activities, goals, objectives, timelines, responsible person, and is based on findings from QAPI program activities.	5/10	7/9
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.	6/10	6/9
24	The MCO must operate a system to assess and improve the quality and appropriateness of care furnished to members.	6/10	6/9
25	Quality and performance indicator data is used for quality management purposes, and is provided and interpreted for care managers and providers as indicated.	9/10	9/9
26	The MCO must report the status and results of each performance improvement project to the State as requested (conduct the number of PIPs	3/10	4/9

	Quality Compliance Review Standards – Access to Services and Quality Monitoring	Finding FY 11-12	Finding FY 12-13
		Numerator = Number of MCOs meeting the standard Denominator = Total number of MCOs reviewed	
	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.		
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.	8/10	8/9
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.	6/10	7/9
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).	10/10	9/9

The graph below shows results for the "Access to Services and Quality Monitoring" focus area as a percentage of total standards met for FY 11-12 and FY 12-13 for each MCO. The FY 12-13 results include all QCR standards met in FY 11-12 plus additional standards met during this year's focused review.



CONCLUSIONS

Progress

- During FY 12-13, 28 of 63 standards reviewed for this focus area were met.
- In aggregate, MCOs' compliance rate has reached 86.3 percent for standards in this focus area, an increase from 75.3 percent.
- All MCOs have fully met indicators related to enrollment and disenrollment.
    - Three additional MCOs achieved fully met scores in related indicators during FY 12-13.
- Seven of nine MCOs have fully met all indicators related to the provider network.
    - Three additional MCOs achieved fully met scores in related indicators during FY 12-13.
- Four of nine MCOs have fully met all indicators related to coordination of care and authorization of services.
    - Three additional MCOs achieved fully met scores in related indicators during FY 12-13.

Strengths

- In general, policies, procedures, and written materials are in place to provide guidance to IDT staff.
- Most MCOs have systems in place to clearly communicate information to staff regarding changes in policies and care management expectations.
- Organizations are increasingly seeking input from staff, members, providers, and other stakeholders to inform improvement efforts.
- MCOs have developed and utilize practice guidelines which are based on valid and reliable clinical evidence.
- The three MCOs which achieved 100 percent compliance with standards demonstrate strong quality assessment and performance improvement programs, and utilize multiple monitoring mechanisms.

Opportunities for Improvement

- Two of nine MCOs have not fully implemented processes to comply with standards related to provider contracting and monitoring.
- Only three of nine organizations have fully met all standards related to the quality assessment and performance improvement program.
    - MCOs should continue efforts to develop and sustain effective systems to monitor care management practice and quality of member care.
    - Organizations also have the opportunity to enhance the application of quality improvement strategies and use of data to drive improvement.

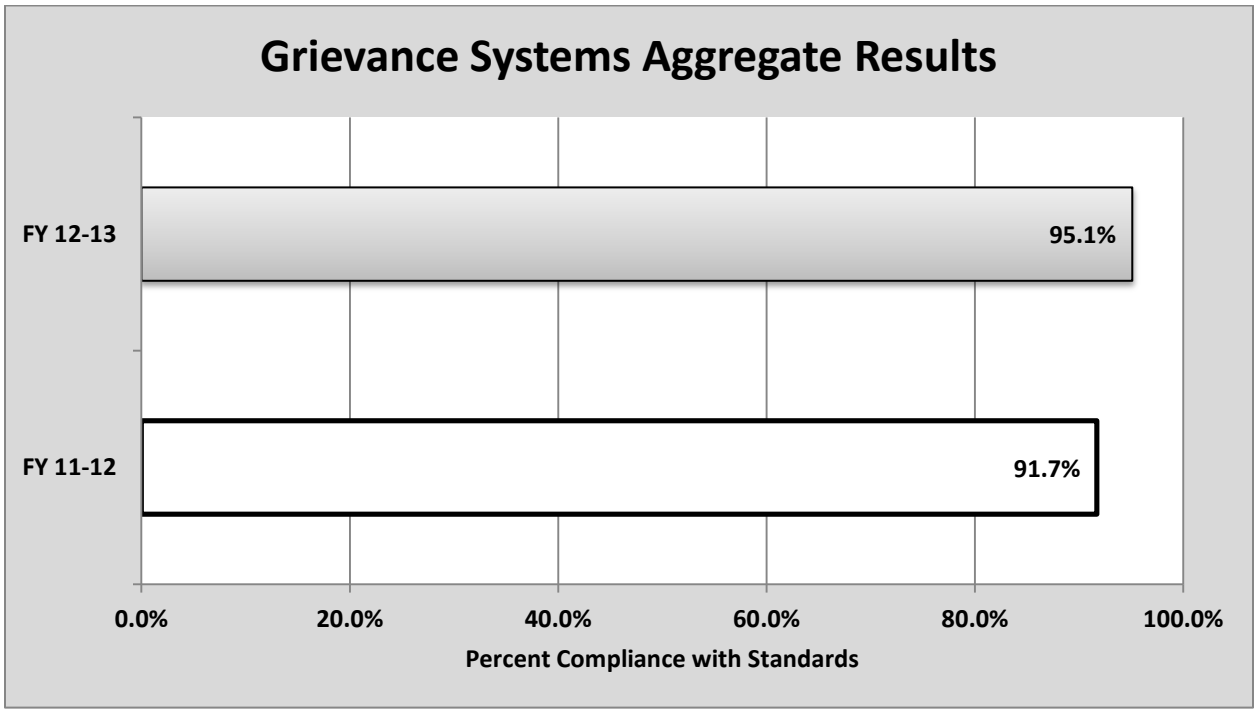
- Three MCO's have not fully developed processes to monitor and detect under- and over-utilization of services.

- Six of nine MCOs have opportunities to improve aspects of coordination of care and authorization of services.

GRIEVANCE SYSTEMS

The MCO must have the organizational structure and processes in place to provide a local system for grievances and appeals that also allows access to both DHS' grievances and appeals process, and the State Fair Hearing process. Policies and procedures must align with federal and state requirements.

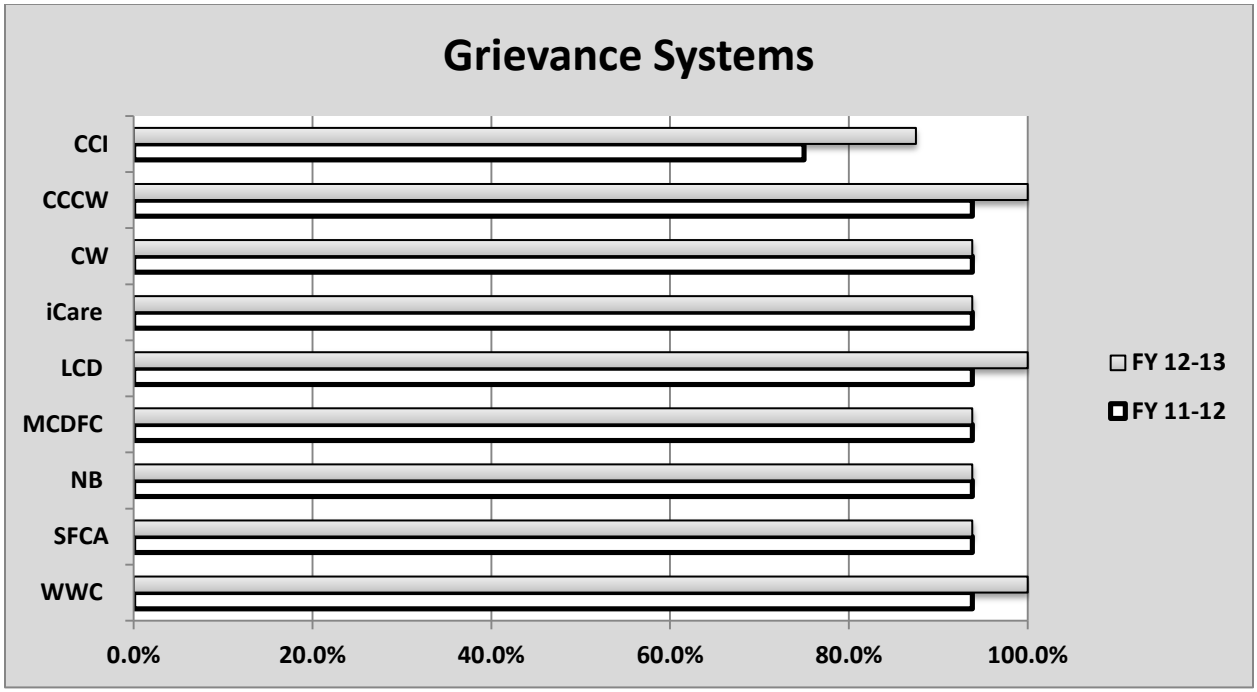
The graph below shows the aggregate results for FY 12-13, for all of the standards related to "Grievance Systems," and compares the percentage of standards met in this year's review to MCOs' level of compliance in FY 11-12. The bar labeled FY 12-13 represents the standards met in FY 11-12 plus additional standards met during this year's focused review. The reader should note that FY 11-12 includes the aggregate results of t10MCOs, whereas FY 12-13 includes the results of nine MCOs.



The table below lists each standard in the "Grievance Systems" focus area, along with the number of MCOs meeting the standard for each review year in relation to the total number of MCOs reviewed. Results for FY 12-13 are cumulative and include the number of MCOs meeting the standard in FY 11-12 plus additional MCOs meeting the standard during this year's focused review. As noted above, nine MCOs were reviewed in FY 12-13, while 10 were reviewed in FY 11-12.

#	Quality Compliance Review Standards – Grievance Systems	Finding FY 11-12	Finding FY 12-13
	Numerator = Number of MCOs meeting the standard Denominator = Total number of MCOs reviewed		
Structure and Basic Requirements			
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.	8/10	9/9
5	The MCO must provide sufficient information to providers to support members in exercising their rights.	9/10	8/9
Communication to members			
8	The notice of action (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	0/10	3/9
Processes 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.	9/10	9/9

The graph below shows results for the "Grievance Systems" focus area as a percentage of total standards met for FY 11-12 and FY 12-13 for each MCO. The FY 12-13 results include all QCR standards met in FY 11-12 plus additional standards met during this year's focused review.



CONCLUSIONS

Progress

- During FY 12-13, five of twelve standards reviewed for this focus area were met.
- Three of nine MCOs have fully met all indicators.
    - During FY 11-12, no MCOs had fully met all indicators related to Grievance Systems.

Strengths

- Compliance with grievance systems standards has been a consistent area of strength.
    - Eight of nine organizations are compliant with over 90 percent of standards.
- In aggregate, MCOs' compliance rate has reached 95.1 percent for standards in this focus area, an increase from 91.7 percent.
- MCOs have the basic structures and processes in place to ensure members are informed and supported relative to grievance and appeal rights.

Opportunities for Improvement

- MCOs should continue efforts to develop mechanisms to monitor and improve issuance of notices of action when indicated.

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

The purpose of a PIP is to assess and improve processes and outcomes of health care provided by the MCO. The DHS-MCO contract requires all MCOs to make active progress each year on at least one 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.

Validation of PIPs is a mandatory review activity which determines whether projects have been designed, conducted, and reported in a methodologically sound manner.

The study methodology is assessed through the following steps:

- Review the selected study topic(s);
- Review the study question(s);
- Review the selected study indicators:
- Review the identified study population;
- Review sampling methods (if sampling used);
- Review the data collection procedures;
- Assess the MCO's improvement strategies;
- Review the data analysis and interpretation of study results;
- Assess the likelihood that reported improvement is "real" improvement; and
- Assess the sustainability of the documented improvement.

MCOs must seek DHS approval prior to beginning each project. DHS has directed MetaStar to validate PIPs at their current stage of implementation in coordination with the annual EQR. More information about PIP Validation review methodology can be found in Appendix 3.

In FY 12-13, MetaStar validated one or more PIPs for each MCO, for a total of 10 PIPs. Two additional projects related to acute and primary care were not validated; implementation of these PIPs was postponed due to a delay in approval by CMS.

Seven of the validated projects were continued from prior years; five related to fall prevention and two related to decreasing hospital re-admissions.

Five PIPs initiated in FY 12-13 focused on:

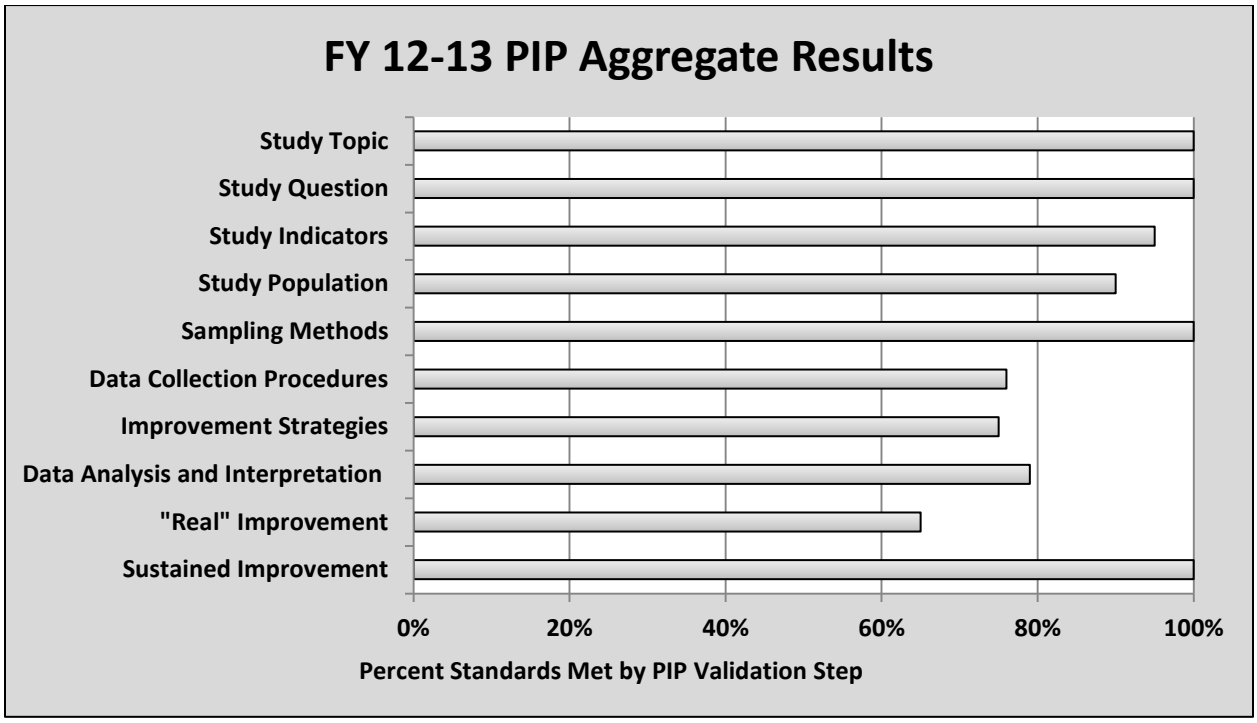
- Increasing awareness and use of self-directed supports;
- Reducing cardiovascular disease among members who are diabetic and hypertensive; *
- Increasing LDL testing; *
- Improving coordination of care during care transitions; and

- Evaluating the role of self-monitoring blood pressure.

  * PIP not validated as a result of delays in approval from CMS and implementation.

AGGREGATE RESULTS FOR PERFORMANCE IMPROVEMENT PROJECTS

The graph below shows the aggregated results, expressed as a percentage of "met" standards for each of the 10 steps. Some standards are not applicable to all projects due to study design, results, or implementation stage.



The table below lists each standard that was evaluated and indicates the number of projects meeting each standard. As noted above, some standards are not applicable to all projects due to study design, results, or implementation stage.

FY 12-13 Performance Improvement Project Validation Results		
	Numerator = Number of projects meeting the standard **Denominator = Number of projects applicable for the standard**	
Study Topic(s)		
1	The topic was selected through MCO data collection and analysis of important aspects of member needs, care, or services.	10/10
2	The project/study focused on improving key aspects of care and/or outcomes for members.	10/10
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.	10/10

FY 12-13 Performance Improvement Project Validation Results		
Study Indicator(s)		
4	The study used objective, clearly and unambiguously defined, measureable indicators and included defined numerators and denominators.	9/10
5	Indicators measure changes in any of the following: health or functional status, member satisfaction, processes of care with strong associations with improved outcomes.	10/10
Study Population		
6	The project/study clearly defined the relevant population (all members to whom the study question and indicators apply).	10/10
7	If the entire population was used, data collection approach captured all members to whom the study question applied.	4/6
8	If the entire population was not used, the selected at-risk population was defined (e.g., high-risk, high utilization, or high needs).	4/4
Sampling Methods		
9	Valid sampling techniques were used.	3/3
10	The sample contained a sufficient number of members.	3/3
Data Collection Procedures		
11	The project/study clearly defined the data to be collected and the source of that data.	7/10
12	Staff are qualified and trained to collect data.	8/10
13	The instruments for data collection provided for consistent, accurate data collection over the time periods studied.	5/8
14	The study design prospectively specified a data analysis plan.	9/10
Improvement Strategies		
15	Reasonable interventions were undertaken to address causes/barriers identified through data analysis and QI processes.	7/9
16	PDSA documentation included evidence that interventions were tested and findings used to move the project forward.	5/7
Data Analysis and Interpretation of Study Results		
17	Data analysis was performed, including initial and repeat measures, and identification of project/study limitations.	5/6
18	Numerical results and findings were presented accurately and clearly.	4/6
19	The analysis of study data included an interpretation of the extent to which the PIP was successful.	5/6
20	Follow-up activities (next steps) were clearly defined.	5/6
"Real" Improvement		
21	The same methodology as the baseline measurement was used, when measurement was repeated.	5/6
22	There was a documented, quantitative improvement in processes or outcomes of care.	3/6
23	The reported improvement appeared to be the result of the planned quality improvement intervention.	3/5
Sustained Improvement		
24	Sustained improvement was demonstrated through repeated measurements over comparable time periods.	2/2

PROJECT INTERVENTIONS AND OUTCOMES

The table below lists interventions selected and the project outcomes at the time of the validation.

PIP Interventions and Outcomes			
MCO	**Topic**	**Interventions**	**Outcomes**
CCI	Increasing Use of SDS	• Selected financial management service providers. • Developed an updated *SDS Resource Toolkit*.	Project still in implementation phase at the time of the EQR.
CCI	Reducing Cardiovascular Disease for Diabetic and Hypertensive Members	In development phase at the time of the EQR.	PIP not validated due to delayed CMS approval.
CCCW	Reducing Fall Risk	Members participated in an evidence-based exercise program and/or physical therapy.	Project demonstrated "real" improvement: Decreased fall risk for study participants.
CW	Reducing Hospital Re-admissions	• Implemented the *Hospital Summary* form to guide post-hospital care plans. • Measured adherence to use of *Hospital Summary.*	• Project demonstrated "real" improvement: Reduced hospital re-admissions by 5%. • Also demonstrated sustained improvement with repeat measures.
CW	Improving Coordination of Care Transitions, and Reducing Adverse Events	• Established a 72 hour follow-up expectation for MCO staff. • Developed *Care Transition Follow-Up Template.*	Project still in implementation phase at the time of the EQR.
*i*Care	Decreasing Hospital Re-admissions	• Established protocol for 72 hour follow-up visit with primary provider. • Developed associated tools for care managers.	Experienced difficulty with data collection procedures and MCO did not complete data analysis.
*i*Care	Increasing LDL Testing	In development phase at the time of the EQR.	PIP not validated due to delayed CMS approval.
LCD	Reducing Rate of Falls	• Implemented Vitamin D supplementation.	• Project demonstrated "real improvement": Decreased rate of falls in study population. • Also demonstrated sustained improvement with repeat measures.
MCDFC	Evaluating the Effect of Self-Monitoring Blood Pressure	• Developed an integrated approach to monitoring hypertension and diabetes.	Project in very early implementation phase at the time of the EQR.
NB	Reducing Number of Falls and Associated Hospital or Nursing Home Admissions	• Implemented *Sure Step* program including detailed assessment and follow-up.	Did not achieve improvement.
SFCA	Decreasing Fall Rate and Rate of Repeat Falls	• Implemented fall risk assessment tool	Did not achieve improvement.

PIP Interventions and Outcomes			
MCO	**Topic**	**Interventions**	**Outcomes**
		• Developed and implemented *Fall Prevention Practice Guideline* • Provided multiple fall prevention resources	
WWC	Reducing Fall Related Critical Incidents and Nursing Home Placements	• Developed and implemented fall risk assessment and intervention tool.	Project still in implementation phase at the time of the EQR.

CONCLUSIONS

Progress

- Three of 10 validated projects achieved documented, quantitative improvement which appeared to be the result of the interventions employed.
- Two of these three projects demonstrated sustained improvement with repeat measures.
- All MCOs obtained project approvals to conduct the required number of PIPs.

Strengths

- Indicators for the first five steps were "met" at rates from 90 to 100 percent, in aggregate.
- All study topics focused on improving key aspects of care and were selected based on MCO data and analysis.
- The three projects which resulted in improvement employed evidence-based interventions which were implemented systematically.

Opportunities for Improvement

- Data collection procedures should be established which clearly identify the source(s) of data and ensure its accuracy.
- MCOs should use continuous cycles of improvement to:
    - Test and measure the effectiveness of interventions prior to full implementation;
    - Address identified barriers; and
    - Adjust interventions as needed to achieve improvement.
- Three projects were completed, but did not result in improved outcomes.
- Six projects were in the initial or very early implementation phase at the time of the EQR and validation.
    - Some organizations should develop and complete projects in a reasonable timeframe, so that improvement related to quality of care can be achieved.

COMPLIANCE WITH PERFORMANCE MEASURE STANDARDS

As directed by DHS, MetaStar validated the accuracy and reliability of MCOs' influenza and pneumococcal immunization data for measurement year (MY) 2012. The MY was defined in the technical definitions provided by DHS for the influenza and pneumococcal measures. Consistent with the results of previous years, validation findings showed that MCOs are able to accurately report the data. An outcome related to the performance measures validation findings is that immunization rates calculated and reported by the MCOs can be relied upon to be accurate.

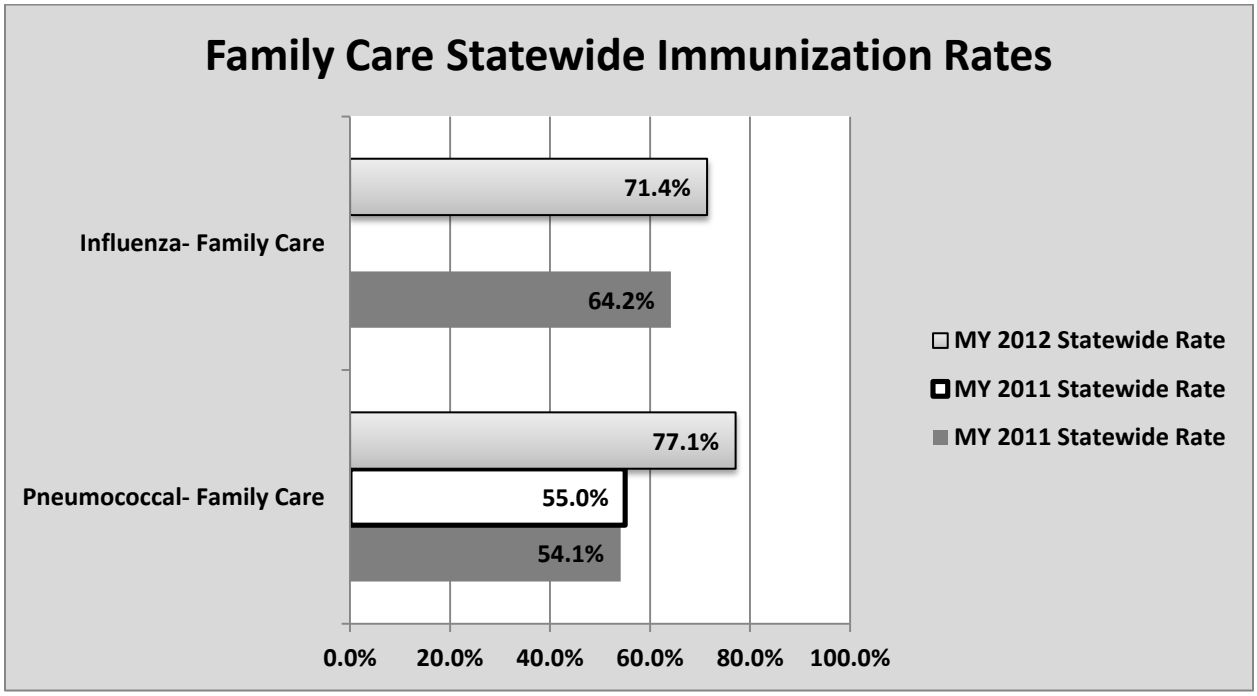
STATEWIDE IMMUNIZATION RATES BY PROGRAM

The results of statewide performance for immunization rates in FC, FCP and PACE are summarized below. It should be noted that for MY 2012, DHS changed the specifications for the influenza and pneumococcal measures to incorporate exclusions for each measure. The specification language also changed for the influenza and pneumococcal numerators and denominators. In addition, the MY 2011 data for FC and FCP includes the aggregated results of 10 MCOs, whereas MY 2012 includes the results of nine MCOs. Readers should consider these factors when comparing the data in the charts and graphs in the remainder of this section of the report.

Family Care Statewide Immunization Rates

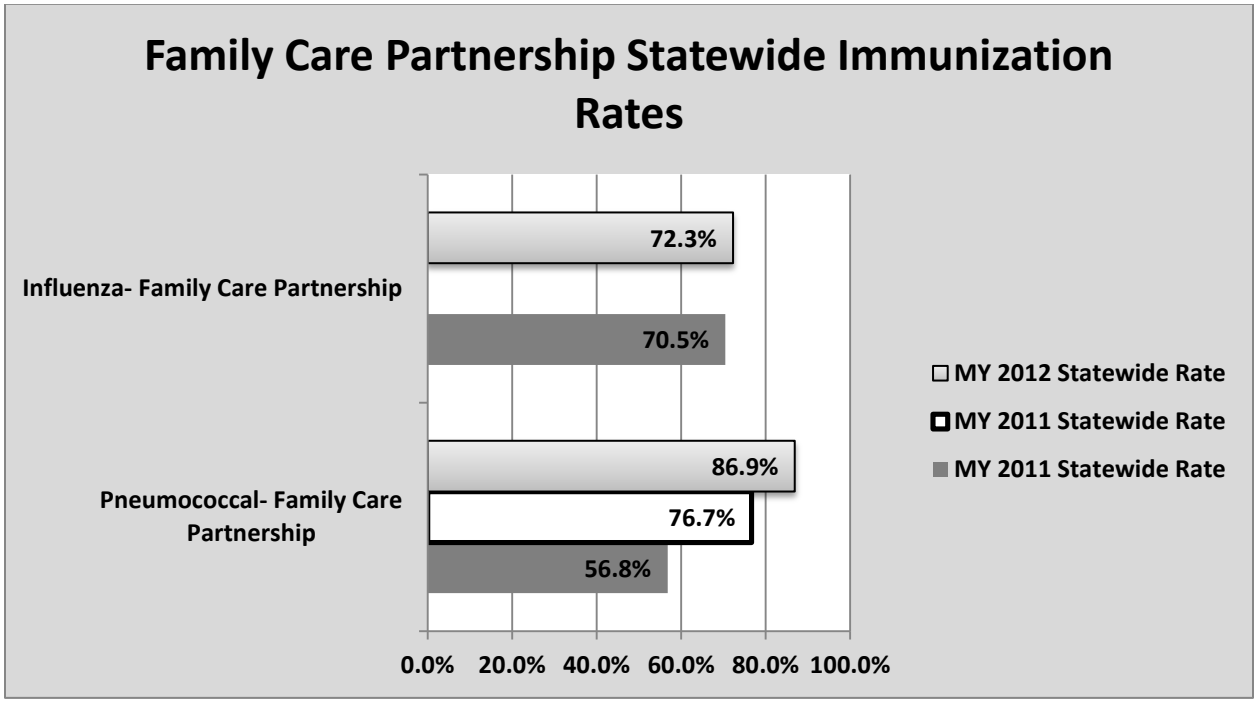
The graph below shows the aggregated rate of immunization for FC members in MY 2012, for influenza and pneumococcal vaccinations. The immunization rates for MY 2011 are also shown for comparison.

Readers will note that the pneumococcal immunization for 2011 is depicted as two different rates. The reason for this is seven FC 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.



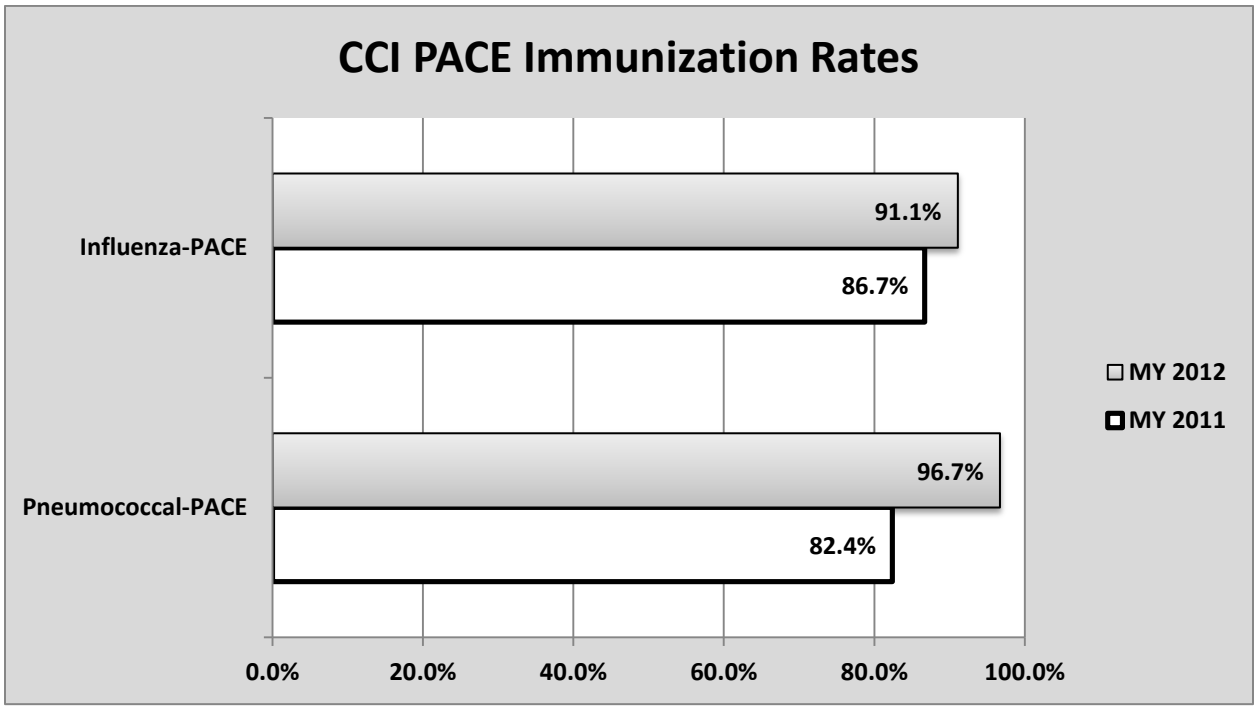
Family Care Partnership Statewide Immunization Rates

The graph below shows the aggregated rate of immunization for FCP members in MY 2012, for influenza and pneumococcal vaccinations. The immunization rates for MY 2011 are also shown for comparison. Again, readers should note that the pneumococcal immunization for 2011 is depicted as two different rates. The reason for this is that two FCP 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.



Immunization Rates for PACE

As just one MCO operates the PACE program, aggregated statewide immunization data is not applicable. The graph below shows MY 2012 results for this single PACE MCO, for influenza and pneumococcal vaccinations. The immunization rates for MY 2011 are also shown for comparison.



RESULTS OF PERFORMANCE MEASURES VALIDATION

MetaStar validated influenza and pneumococcal immunization data submitted by nine MCOs. The MCOs were directed to submit the data to MetaStar by May 1, 2013. Data for a tenth MCO was reported by the MCO and submitted to DHS, but was not validated by Metastar due to the MCO's closure on December 31, 2012. The methodology used to gather and review the data and conduct validation activities can be found in Appendix 3.

AGGREGATE RESULTS OF PERFORMANCE MEASURES VALIDATION

The aggregate results of the performance measures validation (PMV) process for MY 2012 are summarized on the next page. Results for MY 2011 are also provided for comparison.

MY 2012 Performance Measure Validation Results for FC, FCP, and PACE						
Quality Indicator	**Sample or Population**	**# Records Reviewed**	**# Valid Records**	**# Invalid Records**	**% Valid**	**t-test result**
Influenza	360	360	353	7	98.1%	Unbiased*
Pneumococcal	360	360	356	4	98.9%	Unbiased*

MY 2011 Performance Measure Validation Results for FC, FCP, and PACE						
Quality Indicator	**Sample or Population**	**# Records Reviewed**	**# Valid Records**	**# Invalid Records**	**% Valid**	**t-test result**
Influenza	420	420	410	10	97.6%	Unbiased*
Pneumococcal	420	420	412	8	98.1%	Unbiased*

*A finding of "unbiased" means the measure can be accurately reported.

INDIVIDUAL MCO RESULTS OF PERFORMANCE MEASURES VALIDATION

Individual results of MY 2012 PMV by program and MCO are summarized below.

Results for Influenza Immunization for MCOs Operating Family Care

MY 2012 Performance Measure Validation Results for FC MCOs – Influenza Immunization						
MCO	**Sample or Population**	**# Records Reviewed**	**# Valid Records**	**# Invalid Records**	**% Valid**	**t-test result**
CCCW	30	30	28	2	93.3%	Unbiased
CCI	30	30	30	0	100%	Unbiased
CW	30	30	30	0	100%	Unbiased
LCD	30	30	30	0	100%	Unbiased
MCDFC	30	30	30	0	100%	Unbiased
NB	30	30	30	0	100%	Unbiased
SFCA	30	30	30	0	100%	Unbiased
WWC	30	30	29	1	96.7%	Unbiased

Results for Influenza Immunization for MCOs Operating Family Care Partnership

MY 2012 Performance Measure Validation Results for FCP MCOs – Influenza Immunization						
MCO	**Sample or Population**	**# Records Reviewed**	**# Valid Records**	**# Invalid Records**	**% Valid**	**t-test result**
CCI	30	30	30	0	100%	Unbiased
CW	30	30	30	0	100%	Unbiased
*i*Care	30	30	26	4	86.7%	Unbiased

Results for Influenza Immunization for the MCO Operating PACE

MY 2012 Performance Measure Validation Results for PACE MCO – Influenza Immunization						
MCO	**Sample or Population**	**# Records Reviewed**	**# Valid Records**	**# Invalid Records**	**% Valid**	**t-test result**
CCI	30	30	30	0	100%	Unbiased

Results for Pneumococcal Immunization for MCOs Operating Family Care

MY 2012 Performance Measure Validation Results for FC MCOs – Pneumococcal Immunization						
MCO	**Sample or Population**	**# Records Reviewed**	**# Valid Records**	**# Invalid Records**	**% Valid**	**t-test result**
CCCW	30	30	28	2	93.3%	Unbiased
CCI	30	30	30	0	100%	Unbiased
CW	30	30	30	0	100%	Unbiased
LCD	30	30	30	0	100%	Unbiased
MCDFC	30	30	30	0	100%	Unbiased
NB	30	30	30	0	100%	Unbiased
SFCA	30	30	30	0	100%	Unbiased
WWC	30	30	30	0	100%	Unbiased

Results for Pneumococcal Immunization for MCOs Operating Family Care Partnership

MY 2012 Performance Measure Validation Results for FCP MCOs – Pneumococcal Immunization						
MCO	**Sample or Population**	**# Records Reviewed**	**# Valid Records**	**# Invalid Records**	**% Valid**	**t-test result**
CCI	30	30	30	0	100%	Unbiased
CW	30	30	30	0	100%	Unbiased
*i*Care	30	30	26	4	86.7%	Unbiased

Results for Pneumococcal Immunization for the MCO Operating PACE

MY 2012 Performance Measure Validation Results for PACE MCO – Pneumococcal Immunization						
MCO	**Sample or Population**	**# Records Reviewed**	**# Valid Records**	**# Invalid Records**	**% Valid**	**t-test result**
CCI	30	30	28	2	93.3%	Unbiased

CONCLUSIONS

Progress

- Results indicate the aggregated influenza and pneumococcal vaccination rates increased for both FC and FCP compared to the aggregated vaccination rates for these programs in 2011. The rate of influenza and pneumococcal vaccinations also increased for the PACE program. However, progress must be considered in the context of these factors: For MY 2012, DHS changed the specifications for the influenza and pneumococcal measures. In addition, the MY 2011 data includes the aggregated results of 10 MCOs, whereas MY 2012 includes the results of nine MCOs.
- MCOs used a template for data submissions developed by DHS, which greatly increased the consistency and quality of the reported data.

Strengths

- Immunization rates calculated and reported by the MCOs can be relied upon to be accurate.

Recommendations

- Provide technical assistance to MCOs as needed, to ensure internal data queries are created to pull the correct information for performance measures based on DHS specifications.

CARE MANAGEMENT REVIEW

CMR is an optional activity which helps determine a MCO's level of compliance with its contract with DHS; ability to safeguard members' health and welfare; and ability to effectively support care management teams in the delivery of cost effective, outcome-based services. As directed by DHS, four review categories were used to evaluate care management practice:

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

The four categories consisted of a total of 13 review indicators. More information about the CMR review methodology can be found in Appendix 3.

Aggregate results for FY 12-13 CMRs conducted as part of each MCO's annual EQR are displayed in several graphs below and compared to results from the MCO's previous review year. When reviewing and comparing results, the reader should take into account the size of the total sample of records reviewed by MetaStar may vary year to year. Additionally, not all review indicators necessarily apply to every record in the review sample. This means that even if the size of the CMR sample is the same from one year to the next, the number of records to which a specific review indicator applies will likely differ.

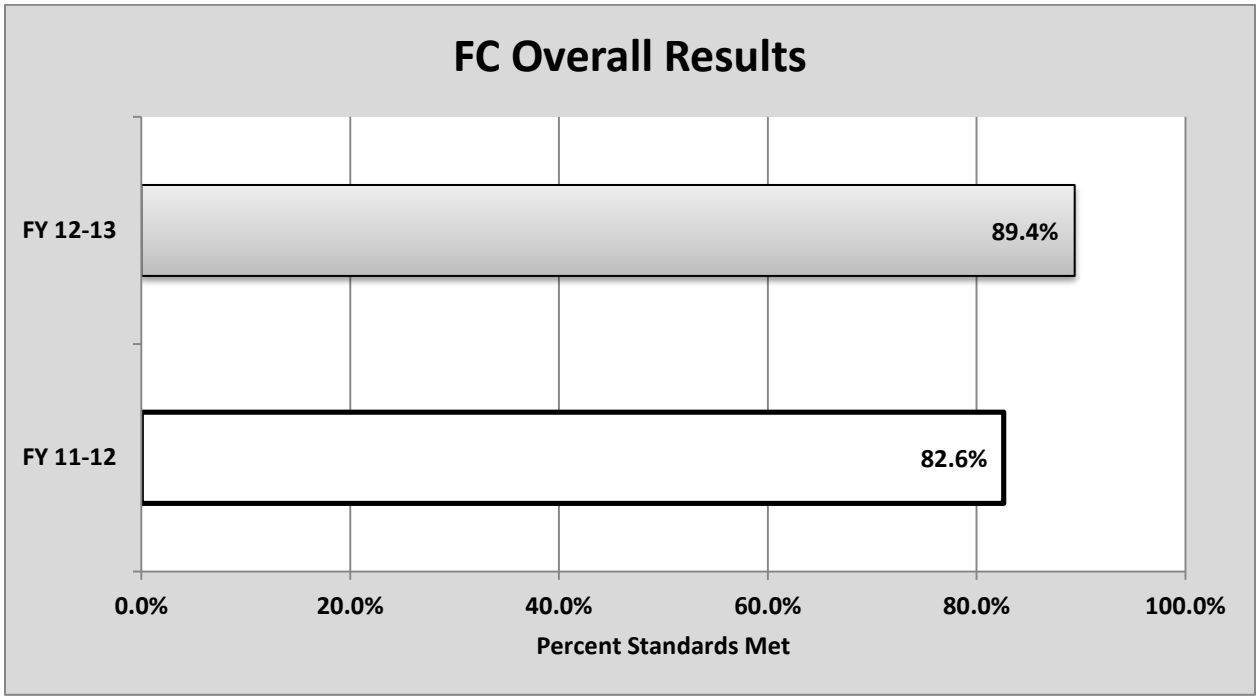
OVERALL RESULTS BY PROGRAM

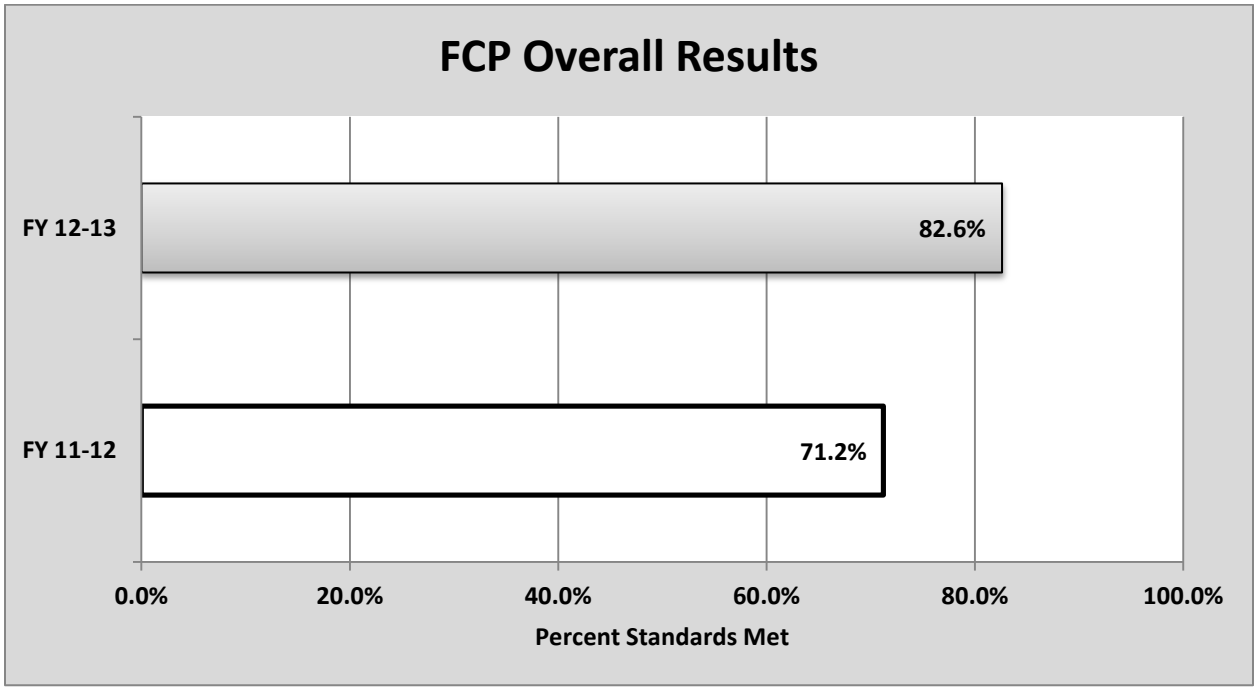
The first two following graphs show the overall percent of standards met for all review indicators for CMRs conducted during the FY 12-13 review year for the organizations operating FC and FCP programs. FY 11-12 results are also provided for comparison. The reader should note that FY 11-12 includes the aggregate results of 10 MCOs, whereas FY 12-13 includes the results of nine MCOs.

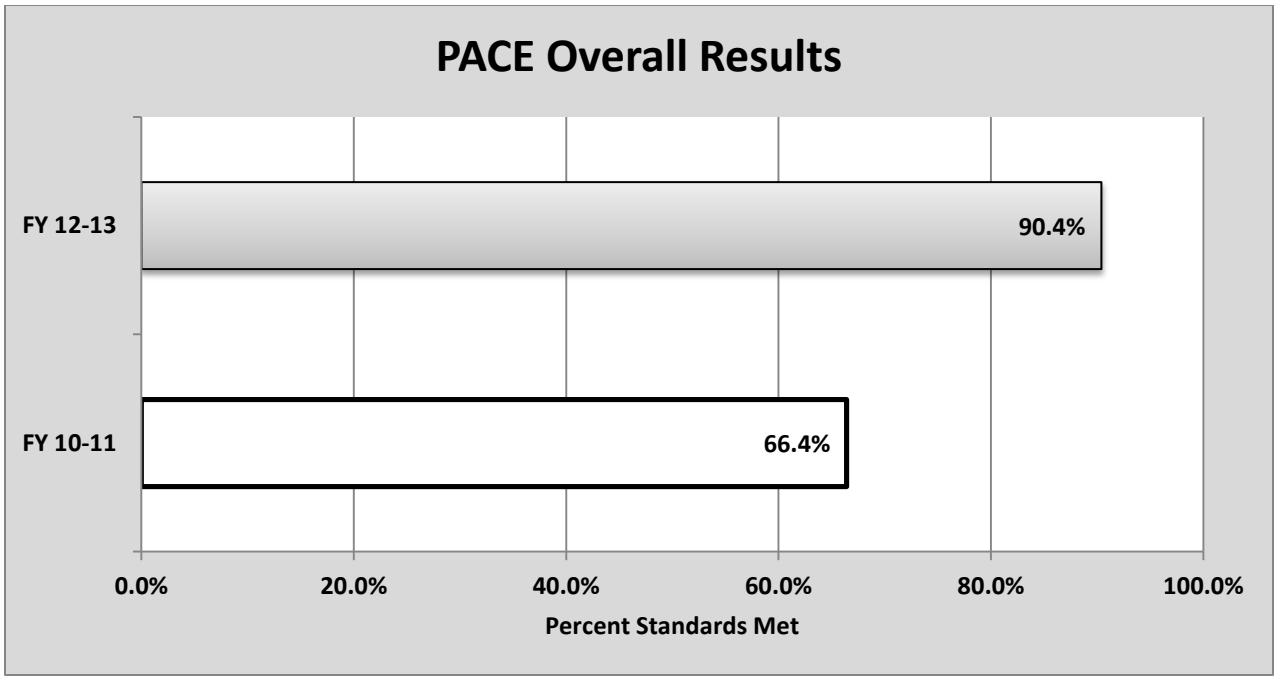
The third graph shows the FY 12-13 results for the one organization operating PACE. At the direction of DHS, MetaStar did not conduct a PACE CMR in FY 11-12 due to a CMS program review that year. Therefore, FY 10-11 comparison results are provided for PACE.

The overall rate of standards met for each program was calculated by dividing the total number of review indicators scored "yes" (meaning the indicator was met), by the total number of applicable indicators.

The results indicate that across programs, MCOs have made progress in the areas of care management practice evaluated by CMR.


FC Overall Results
FY 12-13
89.4%
FY 11-12
82.6%
0.0%
20.0%
40.0%
60.0%
80.0%
100.0%
Percent Standards Met


FCP Overall Results
FY 12-13
82.6%
FY 11-12
71.2%
0.0%
20.0%
40.0%
60.0%
80.0%
100.0%
Percent Standards Met



Results for each CMR Focus Area

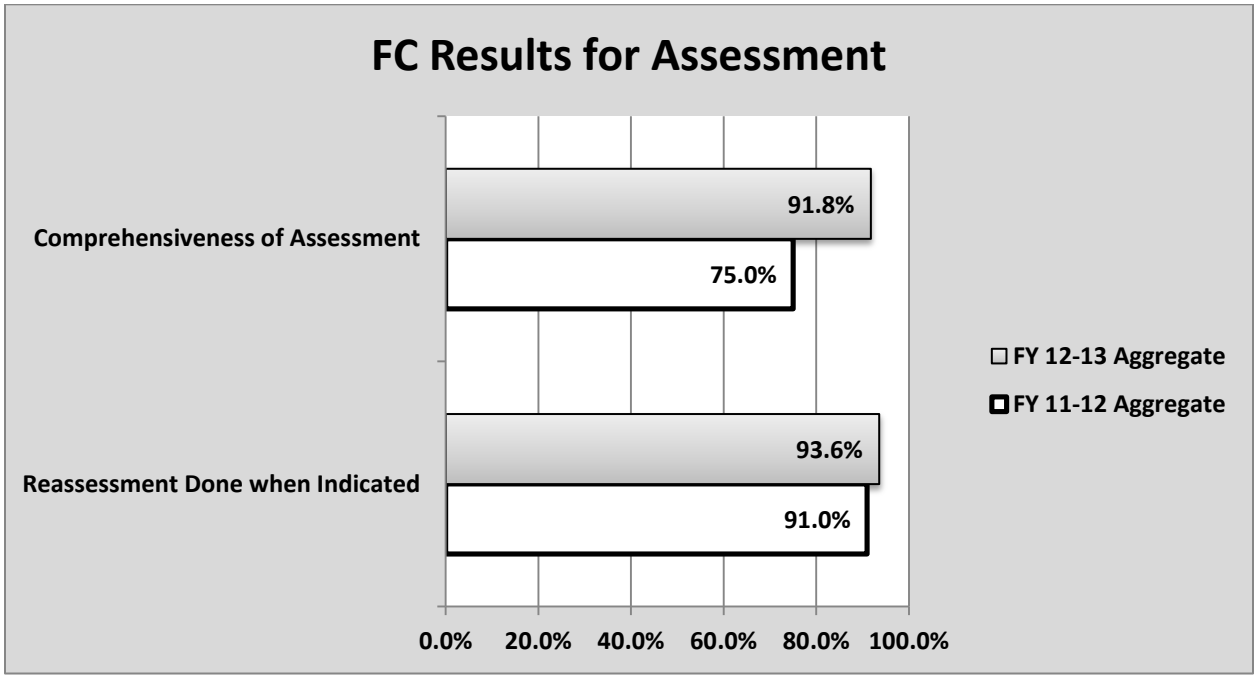
Each of the four sub-sections below provides a brief explanation of one of the key categories of CMR, followed by bar graphs which display FY 12-13 CMR results by program (FC, FCP, PACE) for each review indicator that comprises the category.

The first two graphs in each section represent the aggregate percent of standards met for MCOs operating FC and FCP programs. FY 11-12 results are also provided for comparison. The third graph in each section shows the FY 12-13 results for the one organization operating PACE. As noted above, MetaStar did not conduct CMR for the PACE program in FY 11-12; therefore, FY 10-11 results are provided for comparison.

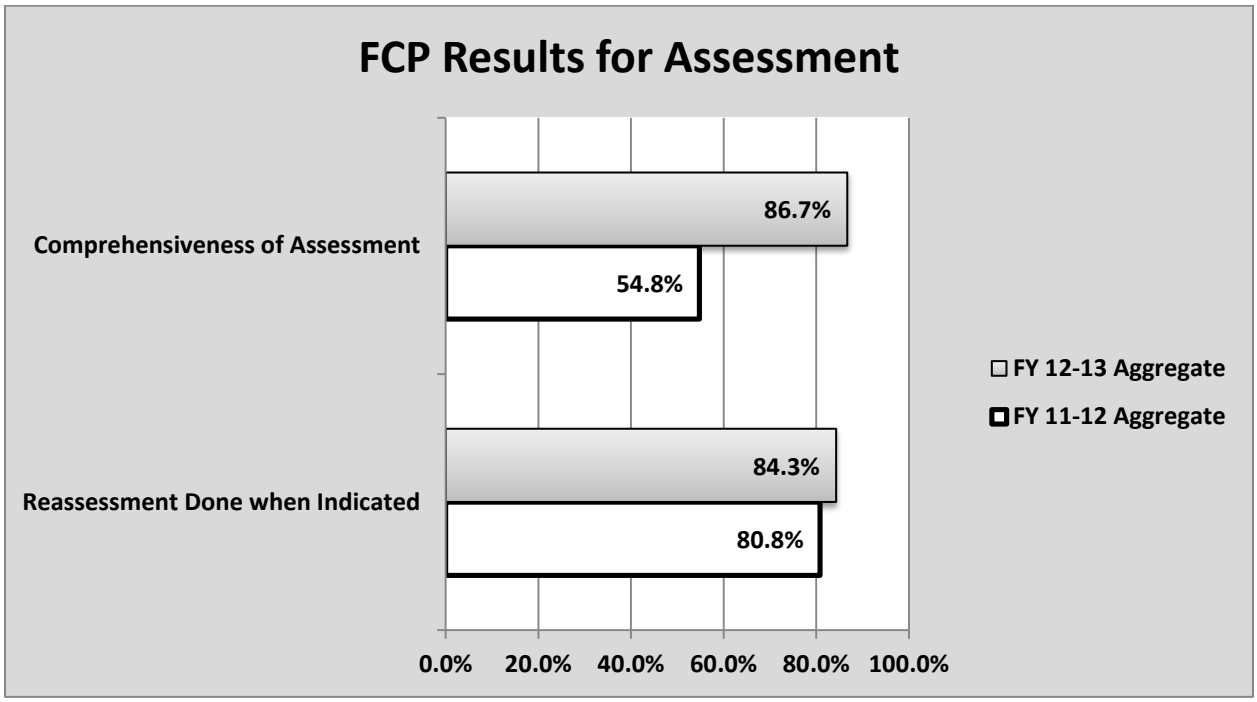
Assessment Focus Area

Interdisciplinary team (IDT) staff must comprehensively explore and document each member's personal experience outcomes, strengths, preferences, informal supports, and ongoing clinical or functional needs that require a course of treatment or regular care monitoring. The initial assessment and subsequent reassessments must meet the timelines and conditions described in the DHS-MCO contract.

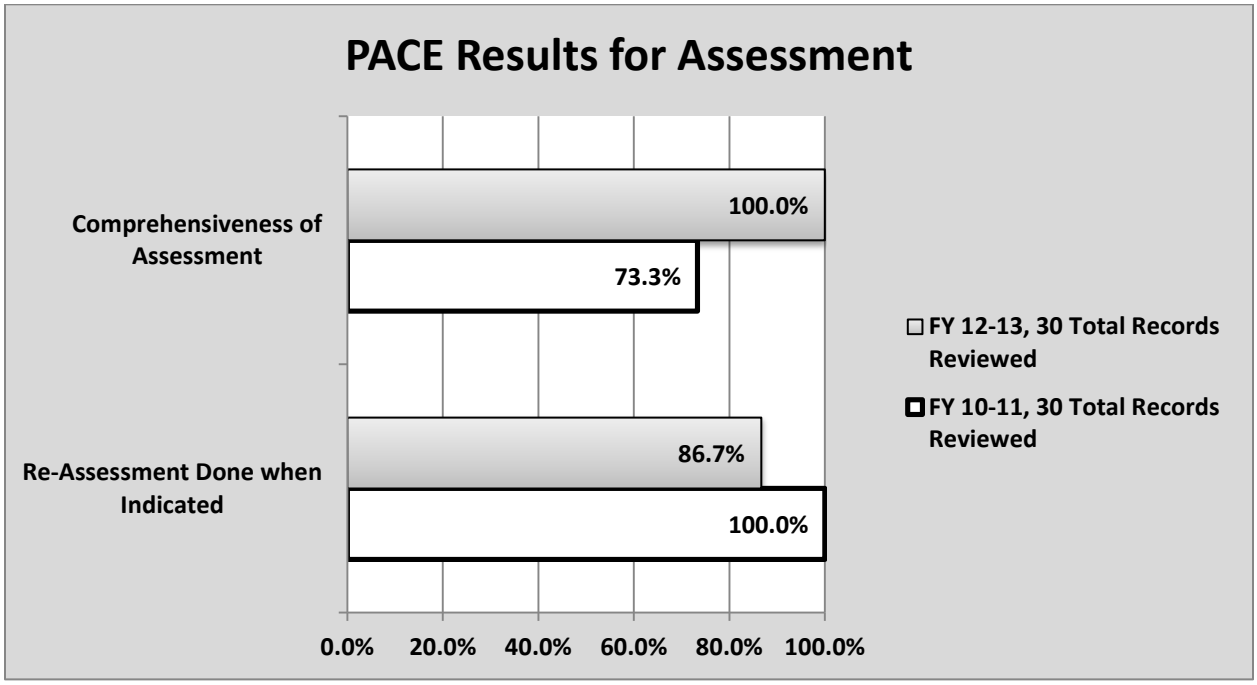
Results for Assessment for MCOs Operating FC:



Results for Assessment for MCOs Operating FCP:



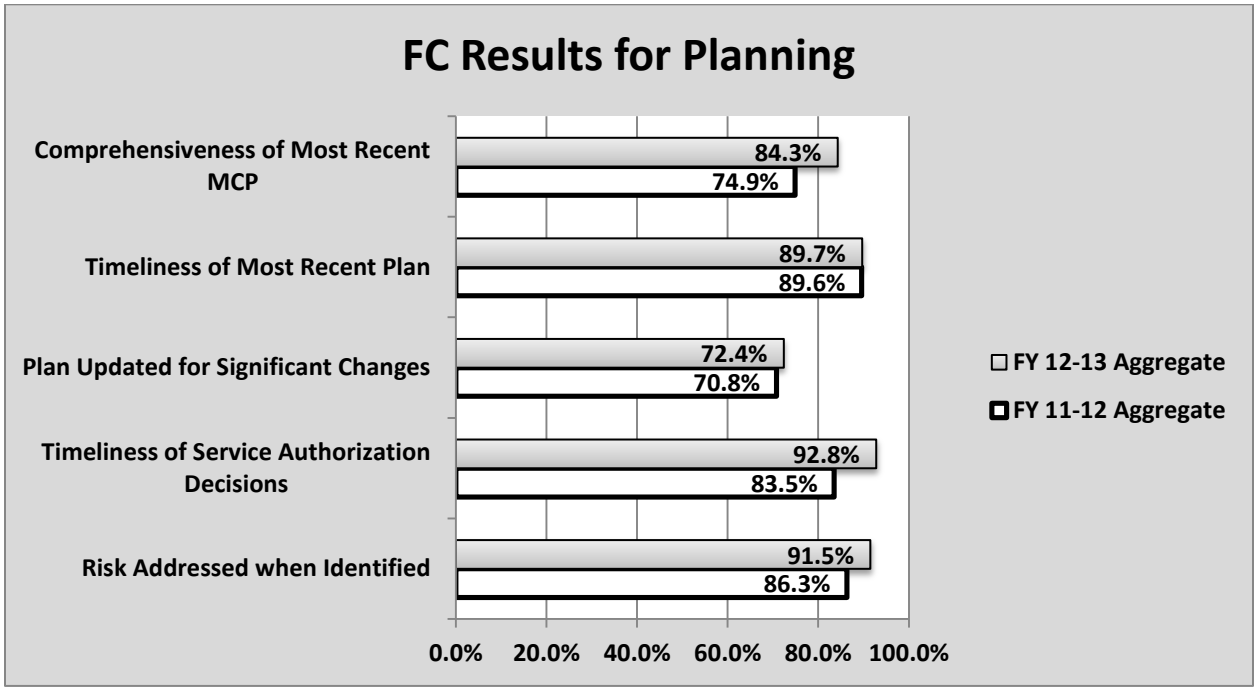
Results for Assessment for the MCO Operating PACE:



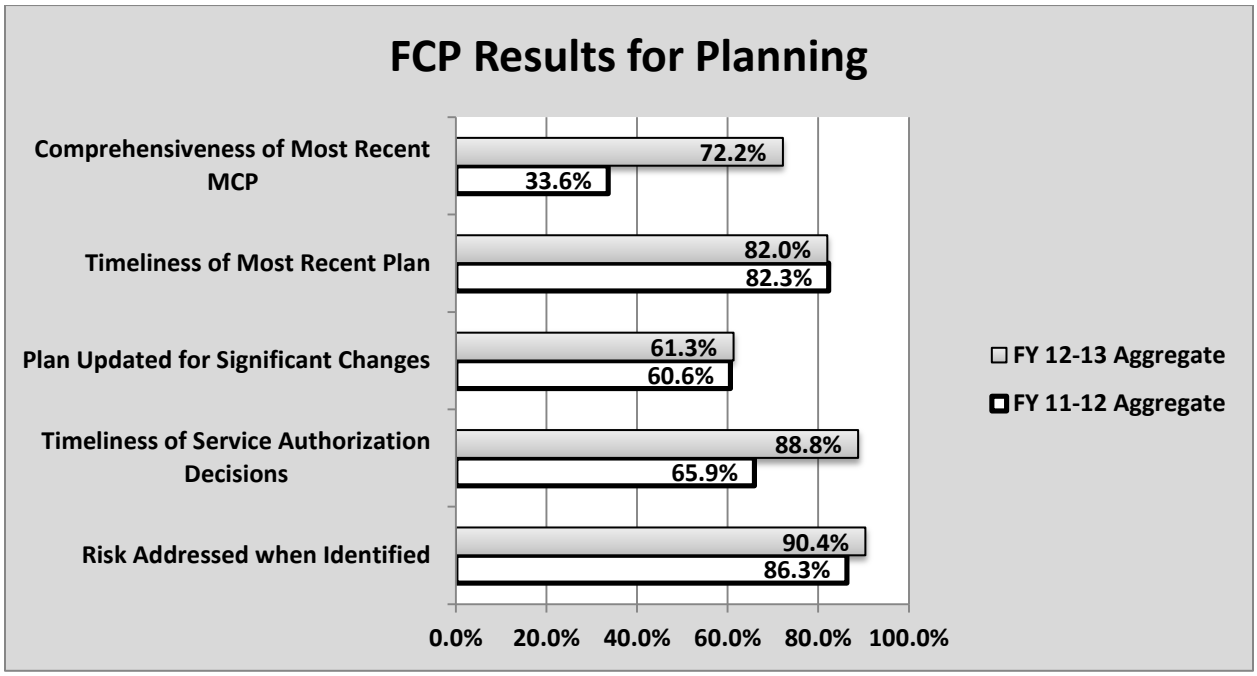
CARE PLANNING FOCUS AREA

The member-centered plan (MCP) and Service Authorization document must identify all services and supports to be coordinated consistent with information in the comprehensive assessment, and must be developed and updated according to the timelines and conditions described in the DHS-MCO contract. Additionally, the record must document that the IDT adequately addressed any risks related to the actions or choices of the member. The record should show that decisions regarding requests for services and decisions about member needs identified by IDT staff were made in a timely manner according to contract requirements.

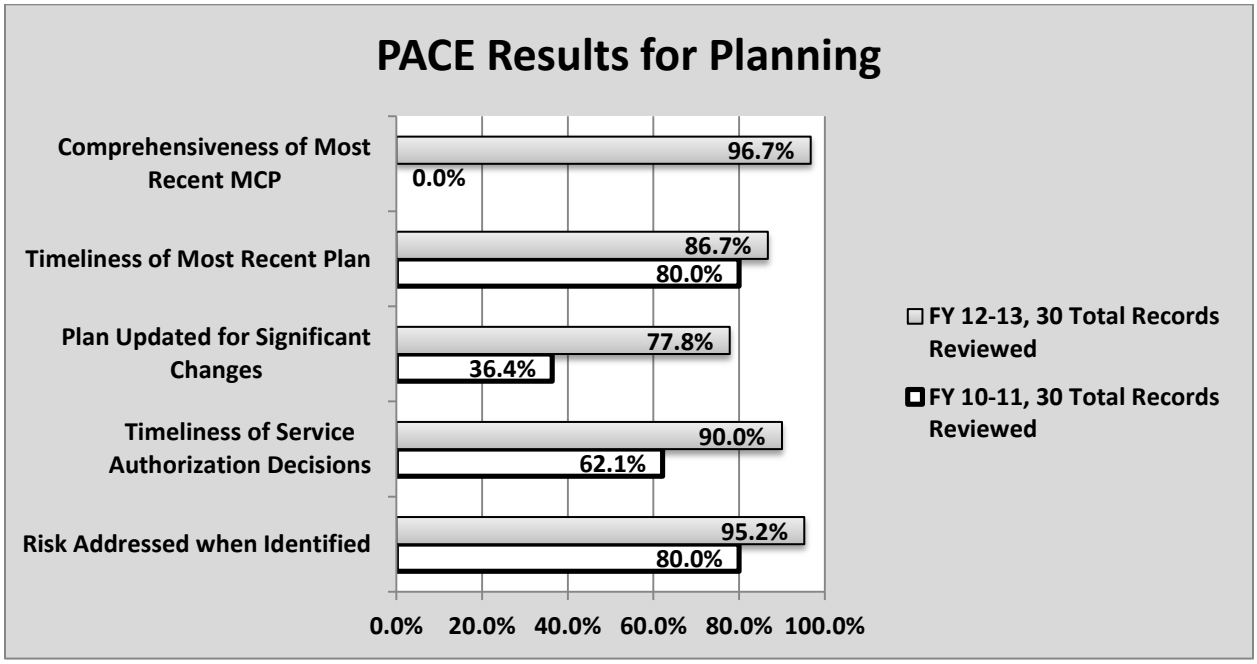
Results for Care Planning for MCOs Operating FC:



Results for Care Planning for MCOs Operating FCP:



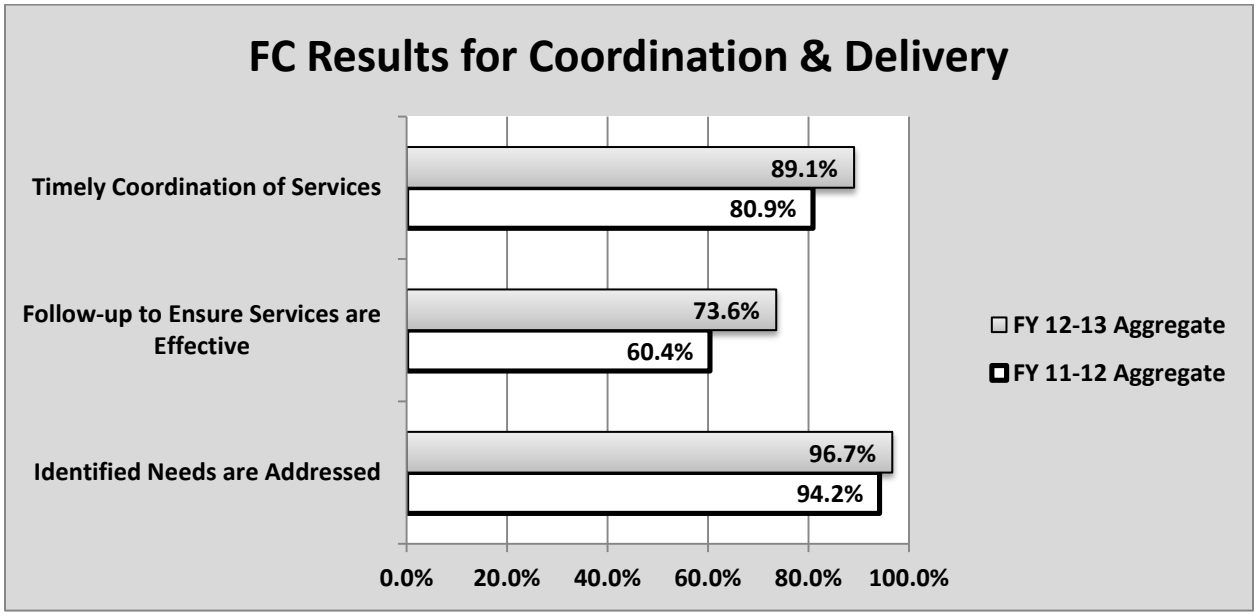
Results for Care Planning for the MCO Operating PACE:



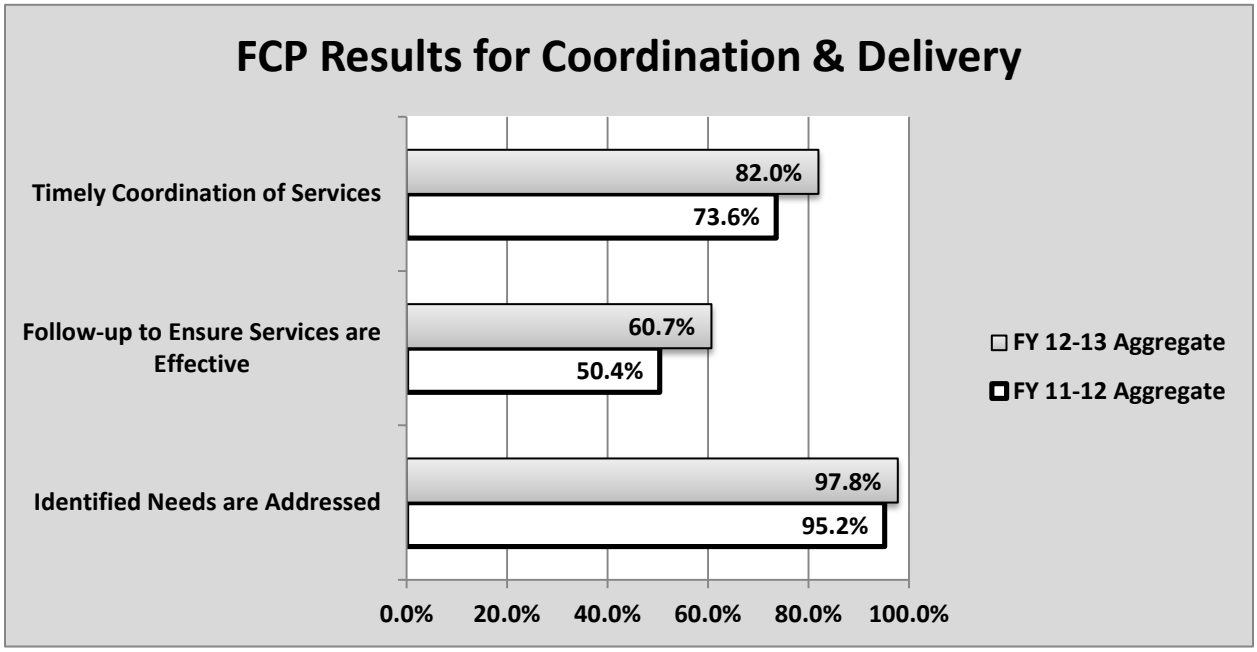
COORDINATION AND DELIVERY FOCUS AREA

The record must document that the member's services and supports were coordinated in a reasonable amount of time; that the IDT staff followed up with the member in a timely manner to confirm the services/supports were received and were effective for the member; and that all of the member's identified needs have been adequately addressed.

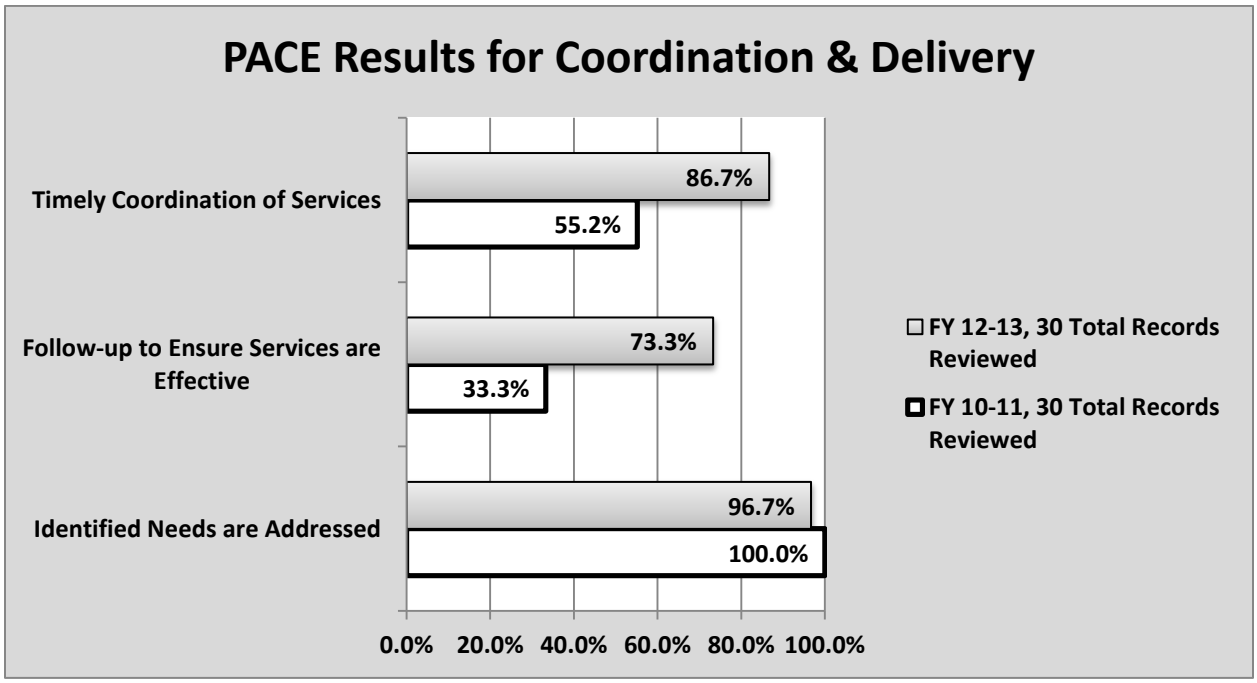
Results for Coordination and Delivery for MCOs Operating FC:



Results for Coordination and Delivery for MCOs Operating FCP:



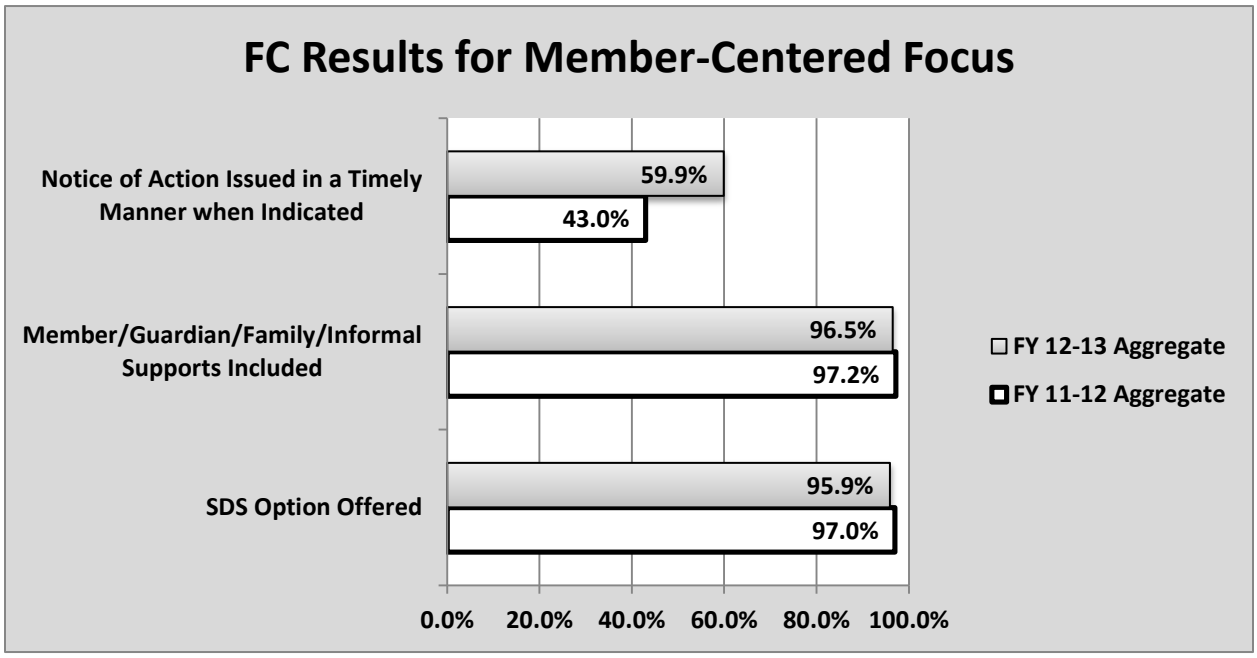
Results for Coordination and Delivery for the MCO Operating PACE:



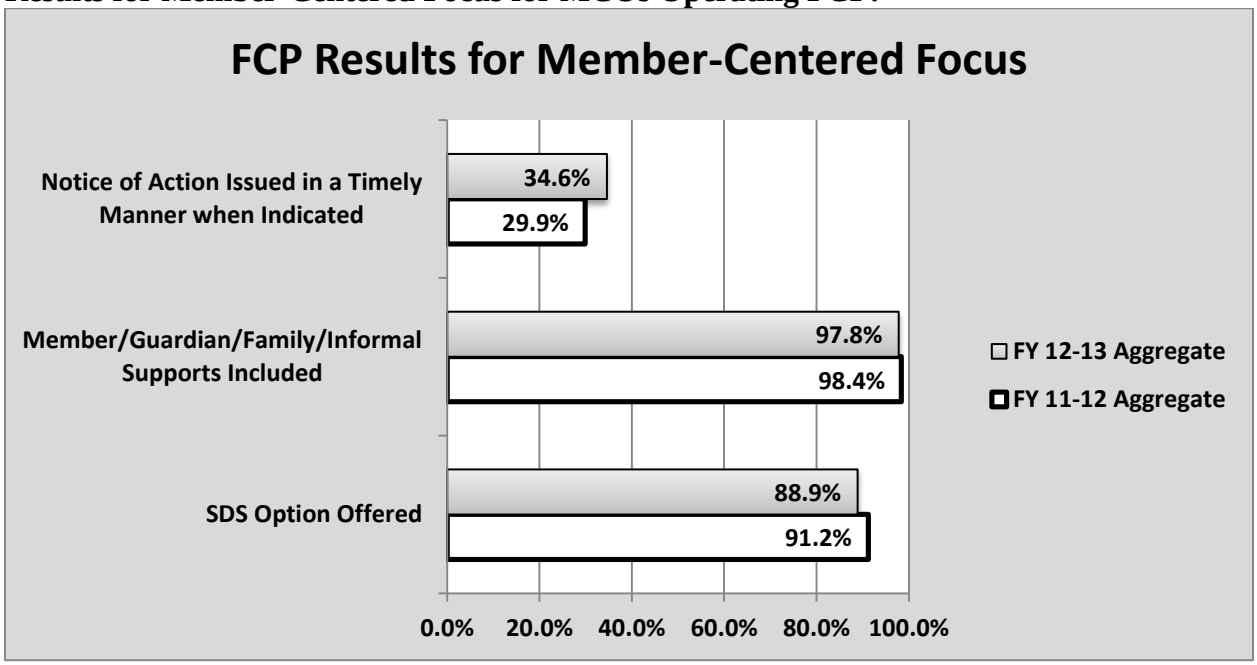
MEMBER-CENTEREDNESS FOCUS AREA

The record should document the IDT staff includes the member and his/her supports in care management processes; that staff protects member rights by issuing NOAs in accordance with requirements outlined in the DHS-MCO contract; and that the SDS option has been explained and offered to the member.

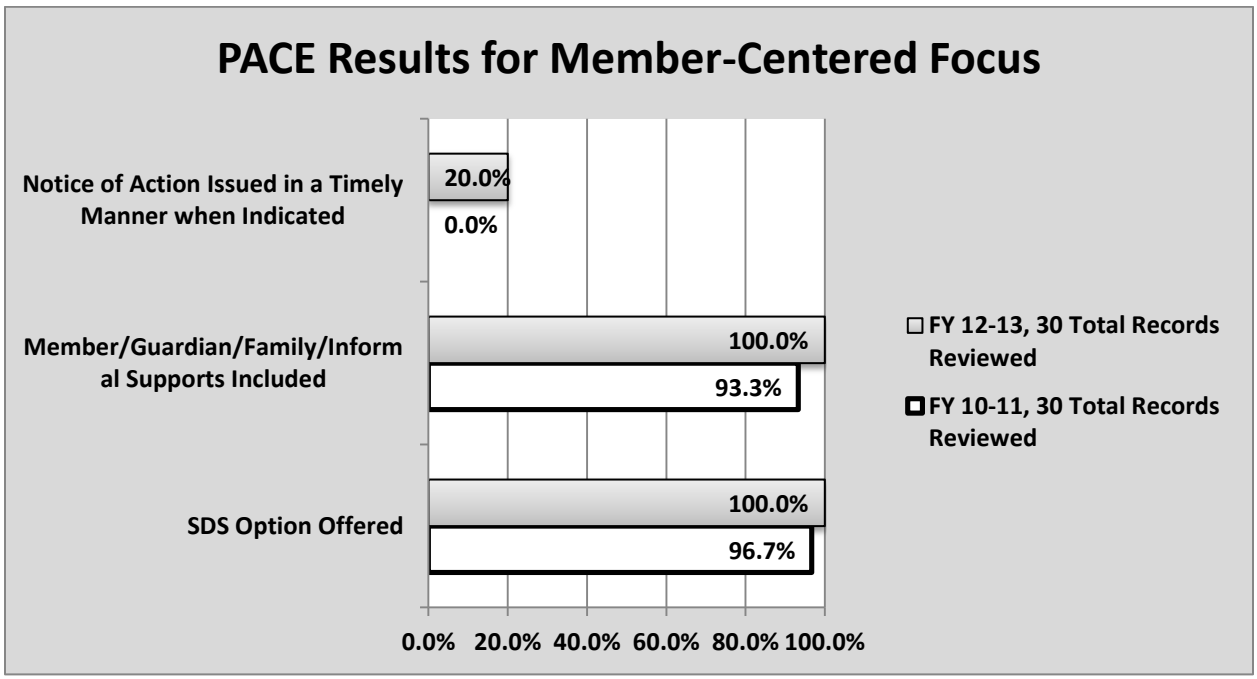
Results for Member-Centered Focus for MCOs Operating FC:



Results for Member-Centered Focus for MCOs Operating FCP:



Results for Member-Centered Focus for the MCO Operating PACE:



CONCLUSIONS

Progress

FC Progress

- FY 12-13 aggregate results for the FC program were over 90 percent for seven of the 13 CMR indicators. In FY 11-12, four review indicators achieved results over 90 percent.
- Results for the FC program indicate progress in ensuring that members are comprehensively assessed.
    - The review indicator, "Comprehensiveness of Most Recent Assessment" increased over 15 percentage points, from 75 percent in FY 11-12 to 91.8 percent in FY 12-13.

FCP Progress

- Aggregate results for the FCP program indicated notable progress in three areas of CMR, with increased compliance ranging from 22 to 38 percent since FY 11-12:
    - "Comprehensiveness of Most Recent Assessment" increased from 54.8 percent to 86.7 percent;

- "Comprehensive of Most Recent MCP" increased from 33.6 percent to 72.2 percent; and
- "Timeliness of Service Authorization Decisions" increased from 65.9 percent to 88.8 percent.

PACE Progress

- FY 12-13 results for PACE were over 90 percent for seven of the 13 CMR indicators, including three indicators at 100 percent. In FY 10-11, four review indicators achieved results between 90 and 100 percent.
- FY 12-13 results for PACE showed over 25 percentage points improvement in six areas of review since FY 10-11:
  - "Comprehensiveness of Most Recent Assessment" increased from 73.3 percent in to 100 percent;
  - "Comprehensiveness of Most Recent Plan" increased from zero to 96.7 percent;
  - "Plan Updated for Significant Changes" increased from 36.4 percent to 77.8 percent;
  - "Timeliness of Service Authorization Decisions" increased from 62.1 percent to 90 percent;
  - "Timely Coordination of Services" increased from 55.2 percent to 86.7 percent; and
  - "Follow-up to Ensure Services are Effective" increased from 33.3 percent to 73.3 percent.

Strengths

- Performance was strong across programs for the review indicator, "Risk Addressed when Identified." The percent of standards met for FC, FCP, and PACE were 91.5, 90.4, and 95.2, respectively.
- MCOs have maintained a high level of compliance with the indicator, "Identified Needs Addressed" over the past several review years.
  - In FY 12-13 the percent of standards met for FC, FCP and PACE were 96.7, 97.8, and 96.7, respectively.
- Across programs, MCOs continued to show strength related to the right of members and their supports to be included in care management processes and to participate in decisions. This has been a consistent result over the past several years.
  - FY 12-13 results for the review indicator, "Member/Guardian/Family/Informal Supports Included" were 96.5 percent for FC, 97.8 percent for FCP, and100 percent for PACE.

Opportunities

- While MCOs have made progress, requirements for comprehensiveness of member-centered plans remain an area for continued improvement for FC and FCP. FY 12-13 aggregate results were below 85 percent in both programs.
- FCP and PACE organizations should continue to improve performance for the indicator, "Reassessment Done when Indicated." FY 12-13 results for FCP and PACE were 84.3 percent and 86.7 percent, respectively.
- Across programs, the percent of standards met for the indicator "Plan Updated for Significant Changes" remains below 80 percent, indicating the need for continued improvement.
    - Results for FC were 72.4 percent in FY 12-13 compared to 70.8 in FY 11-12.
    - Resultsfor FCP programs were 61.3 percent in FY 12-13 compared to 60.6 percent in FY 11-12.
    - While PACE program improved since its last CMR, from 36.4 percent in FY 10-11 to 77.8 percent in FY 12-13, continued improvement is warranted.
- Across programs, MCOs should focus on improving care management practice related to following up to ensure services have been received and are effective, and documenting the results.
    - Results for this indicator in FY 12-13 for FC, FCP, and PACE were 73.6 percent, 60.7 percent, and 73.3 percent, respectively.
    - This was also identified as an area of opportunity in last year's review.
- With results ranging from 20 percent to 59.9 percent across programs, issuing NOAs, when indicated, remains an area of opportunity for all MCOs. *While improving, this has been identified as an area of opportunity over the past several review years.

*****However, the fact that this indicator is evaluated on a "per record" basis must be taken into account when considering these results. This means, for example, that if a record contains three instances where a notice is indicated, and the IDT issues a timely notice in two instances but not the third, the indicator would be scored as "not met."

ANALYSIS

TIMELINESS, ACCESS, QUALITY

The CMS guidelines regarding this annual technical report direct the external quality review organization (EQRO) to provide an assessment of the MCOs' strengths and weaknesses with respect to quality, timeliness, and access to health care services. The information in the appendix referenced below and analysis included in this section of the report are intended to provide that assessment.

The Executive Summary from each MCO's annual EQR report can be found in Appendix 2. They provide MetaStar's assessment of each MCO's key strengths as well as key recommendations related to the MCO's opportunities for improvement in all three areas of review - QCR, PIP, and CMR. Any best or promising practices identified by reviewers are also documented.

FY 12-13 overall results indicate that quality assessment and performance improvement continues to be the area of greatest opportunity across all three programs. While almost all MCOs have the basic structures are in place to assess and improve the quality of care, organizations should focus on improving the effectiveness of their quality management programs.

COMPLIANCE WITH STANDARDS

By fully meeting all of the remaining quality standards that were partially met in last year's review, three MCOs achieved 100 percent compliance in FY 12-13. This is a notable accomplishment for these three organizations, since it is the first time in the history of Wisconsin's Medicaid managed long-term care programs that full compliance with quality standards has been achieved.

In addition, three other MCOs met additional standards which resulted in levels of compliance above 90 percent.

Six of nine MCOs (67%) have now reached rates between 90 and 100 percent for compliance with standards. A high level of compliance provides assurances that MCOs are complying with requirements related to access, timeliness, and quality.

As documented in each MCO's FY 12-13 EQR report, MetaStar identified some common areas of strength among the three MCOs with the highest rates of compliance:

- An organizational commitment to continuous quality improvement is evident.
- Multiple monitoring methods are in place, and data is routinely collected, analyzed, and used to make decisions and drive improvement efforts.

- Policies and procedures are in place to guide organizational and care management practice and are regularly updated as needed.
- Staff at all levels contributes to improvement efforts.
- Clear and consistent practices are in place for organizational communication and staff education.

EQR results for the three other MCOs with compliance rates of 90 percent or more indicate they have also achieved or are moving towards similar areas of strength. Although progress varied by MCO, MetaStar identified some contributing factors in the FY 12-13 EQR reports of these organizations:

- Two MCOs were noted to be developing an approach to quality that is more structured and organizationally integrated.
- Improved processes for communication, both within the organization and with other agencies that impact MCO operations (e.g., Income Maintenance agencies and Aging & Disability Resource Centers) were identified at two MCOs.
- Two MCOs had implemented policies and procedures in areas such as enrollee rights and provider contracting to fully comply with requirements; and
- One MCO increased its monitoring and the use of data to drive improvements in member care.

The remaining three MCOs achieved rates for compliance with standards ranging from 72 to 83 percent.

One organization made moderate progress. This MCO fully met 12 of 21 quality compliance standards that had remained partially met in FY 11-12, and partially met one standard that had been "not met." Since last year, the MCO updated and implemented multiple policies and procedures to align with federal standards and contract requirements. This was a significant factor in its progress. However, 10 standards remain partially met; five of the standards relate to the MCO's quality assessment and performance improvement program and annual evaluation.

The other two MCOs made minimal to no progress in meeting compliance requirements since last year's review.

One organization met four of 19 quality compliance standards that had remained partially met in FY 11-12. MetaStar's assessment attributed this MCO's minimal progress to some key factors, including:

- The MCO did not have a well-defined plan to address findings from the FY 11-12 EQR.
- The organization does not have a structured, systemic quality improvement process.
- The organization lacks integration of its Quality, Provider, and FCP Departments.

Twelve of the 15 standards which remain partially met for this MCO include review elements related to:

- Provider selection;
- Coordination and continuity of care; and
- Quality assessment and performance improvement.

For the other organization, nine quality compliance standards had remained partially met in FY 11-12. The MCO did not meet any additional standards in FY 12-13; thus, the nine compliance standards remain partially met.

Review findings indicated the MCO did not sustain quality and compliance monitoring, address identified areas of concern, or analyze data to identify system-wide trends. As a result, the MCO did not adequately address opportunities for improvement identified in last year's review, including:

- Provider compliance with background check requirements;
- Confidentiality and protection of member information; and
- Monitoring the quality and appropriateness of member care.

CARE MANAGEMENT REVIEW

Member Health and Safety

Over the course of the fiscal year, MetaStar identified five members with health and safety issues during CMR, out of 636 total records reviewed (< 1%). MetaStar also identified 16 additional members with complex situations involving medical, mental health, behavioral, cognitive, and/or social issues. These members were brought to the attention of the MCOs and referred to DHS for follow-up. DHS and MetaStar fully implemented this proactive approach in FY 10-11. This gives DHS the opportunity to engage with the MCO and provide any needed guidance related to the specific member. It also allows the MCO and DHS to assess current care management practice, identify potential systemic improvements related to member care quality, and prevent the development of health and safety issues.

Overall Results

The overall percent of standards met (for all CMR indicators) improved in all three programs. Specific indicators which assess the timeliness of service authorization decisions and service coordination also showed improved results in all three programs. A third indicator which assesses MCP timeliness improved in two programs. However, MetaStar also identified some

areas where MCOs need to focus efforts in order to improve the quality and consistency of member care:

- Following up to ensure services have been received and are effective;
- Issuing NOAs in a timely manner, when indicated;
- Ensuring MCPs are comprehensive;
- Updating plans when members have significant changes in situation or condition.

Follow-up, comprehensiveness of MCPs, and appropriate issuance of NOAs were also discussed as areas of opportunity in last year's annual technical report. Some contributing factors included:

- MCO documentation practices, including some lack of consistency and accuracy in documenting dates of requests, service decisions, and follow-up;
- Failure to include all required elements on member-centered plans, such as needs and services identified elsewhere in the record.
- Continued challenges related to identifying member requests, responding to requests within required timeframes, understanding when NOAs are warranted, and issuing timely NOAs.

PERFORMANCE IMPROVEMENT PROJECTS

DHS requires MCOs to submit projects for pre-approval. All MCOs were successful in securing pre-approval for the specified number of projects during this cycle of review. This is an improvement from the previous year when one MCO did not meet this requirement. The DHS pre-approval process focuses on the initial steps of the project, and all MCOs demonstrated strength in developing clearly defined projects through the first five steps related to:

- Study topic;
- Study question;
- Study indicators;
- Study population; and
- Sampling methods (if applicable).

MetaStar validates PIPs at their current stage of implementation in conjunction with the annual EQR, as directed by DHS. In addition, no standard timeline exists for the submission and approvals of project proposals. As a result, the projects were in various stages of completion at the time they were validated and not all of the remaining standards applied to all projects. The results for the remaining five steps were mixed; and only two projects could be evaluated for the tenth and final step:

- Review the data collection procedures;
- Assess the MCO's improvement strategies;
- Review the data analysis and interpretation of study results;
- Assess the likelihood that reported improvement is "real" improvement; and
- Assess the sustainability of the documented improvement.

The findings demonstrated that organizations vary in the ability to conduct methodologically sound projects during the implementation and analysis phases and complete them in a timely manner. Similar to a recommendation made during the previous annual technical report, an opportunity exists to standardize project timelines in order to ensure organizations make active progress on projects during each contract period.

APPENDIX 1 – LIST OF ACRONYMS

AQR	Annual Quality Review
CCI	Community Care, Inc., Managed Care Organization
CCCW	Community Care of Central Wisconsin, Managed Care Organization
CFR	Code of Federal Regulations
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
DHA	Division of Hearings and Appeals
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
IFR	Internal File Review
LCD	Lakeland Care District, Managed Care Organization
MCDFC	Milwaukee Department of Family Care, Managed Care Organization
MCO	Managed Care Organization
MCP	Member-Centered Plan
MilES	Milwaukee County Income Maintenance Department
MY	Measurement Year
NB	NorthernBridges, Managed Care Organization

NCQA	National Committee for Quality Assurance
NOA	Notice of Action
PACE	Program of All-Inclusive Care for the Elderly
PIHP	Pre-paid Inpatient Health Plan
PIP	Performance Improvement Project
PMV	Performance Measures Validation
QAPI	Quality Assessment and Performance Improvement
QCR	Quality Compliance Review
SDS	Self-Directed Supports
SFCA	Southwest Family Care Alliance, Managed Care Organization
WWC	Western Wisconsin Cares, Managed Care Organization

APPENDIX 2 – EXECUTIVE SUMMARIES

Community Care of Central Wisconsin – Executive Summary

This report summarizes the results of the fiscal year 2012-2013 annual quality review conducted by MetaStar, Inc., for the managed care organization, Community Care of Central Wisconsin. MetaStar is the external quality review organization contracted and authorized by the Wisconsin Department of Health Services to provide independent evaluations of managed care organizations that operate Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly.

Community Care of Central Wisconsin operates the Family Care program in five counties in central Wisconsin. Key findings from all review activities are summarized below:

Since last year, Community Care of Central Wisconsin made progress in all three areas addressed by the external quality review. The managed care organization fully met five quality compliance standards that had remained partially met in fiscal year 2011-1012, resulting in 100 percent compliance. This is a notable achievement, since Community Care of Central Wisconsin is just the third Family Care managed care organization to fully meet all 52 quality compliance standards. Community Care of Central Wisconsin also performed strongly in several areas of Care Management Review. The organization showed improvement in 10 of 13 care management review indicators and achieved a compliance rate of 90 percent or higher for nine indicators, although reviewers also identified some potential areas of opportunity for improvement. The managed care organization concluded a performance improvement project on decreasing fall risk. The results demonstrated improvement, and all applicable review indicators for Performance Improvement Validation were fully met.

In reviewing the following strengths and recommendations, readers should consider that the fiscal year 2012-2013 Quality Compliance Review was limited to those areas which were not fully met in last year's comprehensive review.

CCCW - Key Strengths of the Organization

- Community Care of Central Wisconsin continues to exhibit multiple strengths that include:
    - Focusing on member-centeredness;
    - Promoting a culture of continuous improvement and innovation; and
    - Consistently involving staff and other stakeholders.
- Organizational challenges are seized upon as opportunities for re-evaluation and improvement.

- Community Care of Central Wisconsin has multiple monitoring methods in place and routinely collects and uses data to drive quality improvement efforts.
- Policies and processes guide organizational and care management practice and are continuously updated as needed.
- The managed care organization has several methods for training staff and has taken the next step to regularly evaluate training effectiveness.

CCCW - Best or Promising Practice

- The organization's *IDT Staff Handbook* is a clear and comprehensive guide for care managers, which MetaStar has identified as a "Best Practice." The handbook promotes consistency of care management practice and has contributed to organizational improvements in areas such as enrollee rights and the service authorization process. The handbook is regularly updated, and its use has been sustained over time.
- MetaStar has identified Community Care of Central Wisconsin's internet-based learning platform, *Bloomfire*, as a "Promising Practice," because it has the potential to positively impact the quality of program operations and member care.

CCCW - Recommendations

The recommendations are listed in order of priority from MetaStar's perspective.

- Provide training to help staff advance their understanding and skills related to properly assessing the balance between member choice and risk. Ensure all staff knows when and how to access the organization's many resources to gain new perspectives and receive guidance when responding to complex member situations.
- Continue work to improve the following areas of care management practice:
    - Updating member-centered plans when members have significant changes;
    - Following up with members to ensure services, including health-related and community services, have been received and are effective, and documenting follow-up in members' records; and
    - Ensuring notices of action are issued, when indicated.
- Proceed with planned efforts to enhance the internal file review process, e.g., to incorporate additional review elements and increase the sample size as indicated.
- Complete development and dissemination of the *Falls Prevention Practice Guideline*.

Community Care Inc. – Executive Summary

This report summarizes the results of the fiscal year 2012-2013 annual quality review conducted by MetaStar, Inc., for the managed care organization, Community Care, Inc. MetaStar is the external quality review organization contracted and authorized by the Wisconsin Department of Health Services to provide independent evaluations of managed care organizations that operate Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly (PACE).

Community Care operates Family Care in 11 counties, Family Care Partnership in nine counties, and PACE in two counties in southeast and east central Wisconsin. Key findings from all review activities are summarized below:

Based on the results of its fiscal year 2011-2012 external quality review, Community Care identified and addressed three focus areas:

- Updating and integrating policies and procedures;
- Improving the comprehensiveness of member-centered plans;
- Meeting performance improvement project requirements.

As a result of its actions, the organization fully met 12 additional quality compliance standards compared to last year's results, and improved results in all three programs for many elements of care management review.

Updating policies and procedures to align with requirements was a contributing factor to its success, particularly for review elements related to enrollee rights, grievance systems, member-centered planning, and care coordination. While Community Care made progress in several areas aligned with its organizational priorities, recommendations are included to address areas needing further improvement.

During the past year, Community Care also reorganized its Quality Improvement Program but made limited progress in monitoring and quality improvement efforts. For example, some of the quality compliance standards that remain partially met relate to the need to increase monitoring and improve care at the member level.

As a result of its third priority focus area, the organization partially met the requirement for two performance improvement projects; one focused on long-term care, and another focused on acute and primary care. Community Care began work on a performance improvement project focused on increasing the use of self-directed supports in September 2012. The project was in the implementation phase at the time of MetaStar's review and measurement of results was expected to begin in January 2013. A second project related to acute and primary care is developed but had not yet been implemented.

CCI - Key Strengths of the Organization

- Following its previous annual quality review, Community Care self-identified focus areas for improvement which aligned with the needs of the organization and were meaningful to its strategic plan.
- Community Care uses a structured member assessment process in all three programs that prompts a comprehensive review of all required elements, including member history, outcomes, and current status.
- In Family Care, member strengths are consistently identified and documented in assessments, and teams consistently involved members, authorized representatives, and other members of the team in the member-centered planning process.
- The managed care organization improved policies and procedures related to compliance with standards and care management practice, and integrated the policies and procedures across programs.
- Community Care has developed a wide range of high level operational, financial, and clinical metrics.
- The organization uses a variety of approaches that are effective in disseminating information to staff.
- The organization has initiated a well-designed performance improvement project focused on increasing self-directed supports.

CCI - Best or Promising Practice

The structure of the medication portion of Community Care's comprehensive assessment, combined with frequent medication assessment and review has the potential to positively impact member care. It is considered a "promising practice" that has the potential to be replicated in other organizations.

CCI - Key Recommendations

Key recommendations are summarized below, in the order of priority from MetaStar's perspective. Please see each individual section of the report for additional recommendations.

- Place priority on re-establishing formal monitoring processes, and increase monitoring and analysis of care at the member level in order to improve quality across all three programs.
- Work with the Department's restrictive measures lead and oversight team to review the Behavioral Health Tracking Project Charter and the organization's tracking and monitoring systems related to the use of restraints and restrictive measures to ensure a focus on the rights of individual members.

- Work with the Department of Health Services to evaluate the effectiveness of the company's reorganized Quality Improvement Program and other organization restructuring, to ensure that contract requirements related to quality management are met.
- Evaluate care management practice and the organization's guidance regarding service authorization decision-making, and take needed steps to:
    - Improve the accuracy and consistency of documentation of dates of service requests and decisions across care management staff and across programs; and
    - Ensure members and their supports are involved in decision making processes, and that their input and participation is documented.
- Analyze notice of action data and develop improvement initiatives as indicated to ensure that members receive notices of action when indicated.
- Increase the focus of utilization monitoring to include potential under-utilization and monitoring focused on Family Care members.
- Disseminate practice guidelines to all affected providers using a standardized process.
- Ensure all network providers receive up-to-date contracts which include language related to appeal options, as well as contact information for Community Care's member rights staff.
- Provide staff training and monitoring to ensure that all members are offered the option of self-directed supports.
- Work with the Department of Health Services to determine if the organization needs to take additional steps to address its concerns about eligibility and enrollment processing.

CCI – June 2013 CMR Recommendations

The recommendations are listed in order of priority from MetaStar's perspective.

- Ensure that NOAs are provided to members in a timely manner, when indicated, and when previously authorized service are no longer being paid for by the MCO.
- Implement improvement efforts focused on comprehensiveness of MCPs. For example:
    - Consider mechanisms to reduce or eliminate the process of manually entering details related to service authorizations;
    - Clearly specify the persons responsible for coordination of acute and primary care and the tasks they are assigned; and
    - Improve the consistency with which information related to members' needs for ADLs and IADLs is documented.
- Maximize the benefits of CCI's internal resources, such as Behavioral Health Specialists, when indicated.
- Ensure that all teams are using the most current versions of the MCP signature page to ensure compliance with required language for offering SDS.

- Monitor the use of the new social and health assessment templates to assure comprehensiveness.
- Use the CMR findings to identify areas where performance is less than desired, and conduct further exploration, monitoring, and improvement.

Care Wisconsin – Executive Summary

This report summarizes the results of the fiscal year 2012-2013 annual quality review conducted by MetaStar, Inc., for the managed care organization, Care Wisconsin. MetaStar is the external quality review organization contracted and authorized by the Wisconsin Department of Health Services to provide independent evaluations of managed care organizations that operate Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly.

Care Wisconsin operates the Family Care and Family Care Partnership programs in 10 counties in south central Wisconsin. Key findings from all review activities are summarized below:

Care Wisconsin's primary focus during the past year included addressing the Department of Health Services' performance expectations, undergoing a major reorganization, and participating in piloting sustainability initiatives. While Care Wisconsin focused most efforts on these priorities, the organization demonstrated improvement in meeting quality compliance and care management standards. During this review year, Care Wisconsin met four of the nine Quality Compliance Review standards resulting in a 90.6 percent overall compliance rate for this mandatory review activity compared to 83 percent in fiscal year 2011-2012.

In addition to the progress with improvement in quality compliance standards, MetaStar's Care Management Review demonstrated improvement or maintenance in 10 of 13 standards for the Family Care program and 11 of 13 standards for the Family Care Partnership program. However, these results must be considered in the context of the review process, including a smaller sample size of Family Care records, a small number of applicable occurrences for some measures, and limited documentation for certain elements.

The organization continued one of its performance improvement projects from last year on hospital readmissions. Data shows improvement in this area due to the interventions that have been implemented. The second performance improvement project is on the transition of care and was approved by DHS in March of 2012; therefore, work is not as advanced as with the first project. In general, other managed care organizations should consider Care Wisconsin's approach to designing and implementing performance improvement projects as a "Best Practice" model, as described below.

CW - Key Strengths of the Organization

- Performance improvement projects are driven by organizational needs and are meaningful to the managed care organization's strategic plan.
- Care Wisconsin emphasizes the importance of gathering and analyzing data as a means to better the quality of care and services throughout the managed care organization.
- The managed care organization supports care management service delivery in a variety of ways, including trainings, tools, resources, and information.
- Care Wisconsin made improvements to address compliance standards related to access and quality measures, while focusing on a variety of other key priorities for the organization.
- Care Wisconsin continues to work with the Department of Health Services towards program sustainability, and is an organization willing to pilot new initiatives.

CW - Best or Promising Practice

The MCO continues to choose performance improvement projects that meet the needs of members as well as align with the organization's philosophy for quality care and improvement. The topics for performance improvement projects are chosen carefully, while interventions are developed to aid in supporting the members and the organization to make a successful change. The improvement is evidenced by the reduction of member readmissions to hospitals by five percent over the past year. Performance improvement project success has been evident over several external reviews and therefore is considered to be a best practice.

CW - Recommendations

The recommendations are listed in order of priority from MetaStar's perspective.

- Assess the effectiveness of improvement efforts, including:
  - Analyze monitoring data periodically to evaluate improvement initiatives or process changes.
  - Refine sampling and audit timing for the member chart audit to ensure an adequate sample is reviewed throughout the year and that data is analyzed on a planned periodic cycle to evaluate outcomes resulting from organizational changes.
  - Monitor the impact of organizational/program changes.
  - Continue development and implementation of other planned initiatives to obtain further improvement related to:
    - Conducting re-assessments when indicated;
    - Following up on the effectiveness of services; and
    - Issuing notices of action when indicated.
  - Include both programs (Family Care and Family Care Partnership) in improvement efforts when indicated.

    - Continue improvement efforts in areas that directly affect member care and service delivery.
- Ensure that care management documentation accurately captures the actual date of member requests.

Obtain direction from the Department of Health Services regarding differentiating between "grievances" and "complaints" to ensure that members are informed about and understand how to exercise their rights.

- Work with the Department regarding the frequency of updates needed for Memorandums of Understanding with Aging and Disability Resource Centers and Income Maintenance agencies and methods to incorporate regionalization of Income Maintenance services.
- Provide results of monitoring and improvement efforts to staff on a regular schedule to reinforce efforts and celebrate successes.

CW May 2013 CMR - Recommendations

The recommendations are listed in order of priority from MetaStar's perspective.

Monitor the impact of organizational/program changes, including:

- Explore assessment practices and forms with DHS to ensure they align with expectations and result in comprehensive member assessments.
- Implement improvement efforts focused on comprehensiveness of member-centered plans, including updating plans for changes.
- Improve the consistency with which staff follow up and document the effectiveness of services.
- Ensure that care management documentation accurately reflects service authorizations, requests, and decisions.

Independent Care Health Plan - Executive Summary

This report summarizes the results of the fiscal year 2012-2013 annual quality review conducted by MetaStar, Inc., for the managed care organization, Independent Care Health Plan. MetaStar is the external quality review organization contracted and authorized by the Wisconsin Department of Health Services to provide independent evaluations of managed care organizations that operate Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly.

Independent Care Health Plan operates the Family Care Partnership program in three counties in southeast Wisconsin. Key findings from all review activities are summarized below and indicate that since its fiscal year 2011-2012 external quality review, the organization has made minimal progress related to compliance with standards and performance improvement projects.

Among several key contributing factors to this result, was the organization did not implement an effective plan of action to address all of the findings from last year's review. As a result, 15 of the 19 quality compliance standards reviewed by MetaStar remain partially met. The MCO demonstrated modest improvement in the "QCR Standards Combined" measure from 64.2 percent in FY 11-12 to 71.7 percent in FY 12-13 (see page 15). Six of the partially met standards were due to the organization's lack of a structured, systematic quality assessment and performance improvement program, while another four related to requirements to have an appropriate and qualified network of service providers.

The managed care organization also made minimal progress related to conducting performance improvement projects. The organization scored "met" for six of the 20 indicators applicable to its project related to long-term care. MetaStar did not score a second project related to health care as the project was delayed and had not yet been implemented.

The organization did make progress related to care management review, resulting in improved rates of compliance for 11 of the 13 review indicators. However, continued, focused attention to improvement is needed. The compliance rate for six care management review indicators remains below 80 percent and two quality compliance standards related to coordination and continuity of care remain partially met.

iCare - Key Strengths of the Organization

The organization's key areas of improvement are listed below:

- Independent Care Health Plan has integrated the organization's emphasis on preventative health services, such as periodic health screenings and diabetes management, into its Family Care Partnership program.
- The organization worked to refine its electronic health record, *TruCare*, to meet the unique needs of Family Care Partnership within its multi-faceted company.
- The organization added staff resources, including an eligibility and enrollment liaison and director level position, to support Family Care Partnership operations.
- Care management staff is enthusiastic about the Family Care Partnership program and report a culture of openness and teamwork.

iCare - Key Recommendations

- In order to address the results and recommendations of the FY 12-13 external quality review, develop a work plan in consultation with the Department of Health Services that details goals and priorities, actionable steps, reasonable timeframes, and a process for regular monitoring to evaluate the organization's progress.
- Place priority on the establishment of an effective and integrated quality assessment and performance improvement program which:
    - Collects and analyzes relevant data;

    - Establishes interventions to address needed improvements; and
    - Continuously measures progress and adjusts interventions as needed.
- Establish and fully implement processes to comply with "Access to Services" standards related to provider contracting and monitoring, including processes for:
    - ensuring long-term care providers maintain licensure;
    - periodically monitoring long-term care providers and owners to confirm they have not been barred from participating in federal health care programs;
    - monitoring to confirm providers are completing attestations during initial contracting and are conducting periodic criminal and caregiver background checks;
    - certifying and including one and two bed adult family homes in the provider network.
- Create expectations and methods for communication and collaboration among the MCO's Quality, Provider, and Family Care Partnership Departments, in order to integrate activities and work together more effectively to improve processes and outcomes of care.

iCare - Additional Recommendations

- Implement performance improvement projects to include an established data collection and analysis plan which ensures accurate data and adequate time for improvement to occur.
- Ensure standardized systems and documented processes are in place for key work, in order to decrease disruption and maintain consistency when personnel and organizational changes occur.
- Finalize draft policies and disseminate to staff.
- Evaluate service authorization practices in conjunction with utilization monitoring.
- Refine care management guidance and monitoring to ensure that care coordination and follow-up occur and are documented in members' records.
- In order to clearly identify the degree of members' abilities and disabilities, as well as meet members' needs and support identified outcomes, improve the consistency with which care managers
    - Gather and document objective data during member assessments;
    - Include identified needs, services, and supports on member-centered plans; and
    - Ensure plans are updated when members have changes in situation or condition.
- Closely monitor notices of action in order to further assess performance in this area and identify and implement needed improvements.
- Fully implement policies and processes to comply with "Enrollee Rights" standards related to restrictive measures and advance directives.

Lakeland Care District – Executive Summary

This report summarizes the results of the fiscal year 2012-2013 annual quality review conducted by MetaStar, Inc., for the managed care organization, Lakeland Care District. MetaStar is the external quality review organization contracted and authorized by the Wisconsin Department of Health Services to provide independent evaluations of managed care organizations that operate Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly.

Lakeland Care District operates the Family Care program in three counties in east central Wisconsin. Key findings from all review activities are summarized below:

During this review year, Lakeland Care District met the two remaining quality compliance standards which had not been fully met in last year's review, resulting in 100 percent compliance related to Quality Compliance Review. This is a notable achievement, as Lakeland Care District is just the second Family Care managed care organization to fully meet all 52 quality compliance standards. Lakeland Care District also performed strongly in several areas of Care Management Review. The organization achieved a compliance rate of 90 percent or higher for eight of 13 review indicators, although reviewers also identified some areas of opportunity for improvement. Lakeland Care District also made progress on its continuing performance improvement project on falls reduction, fully meeting 23 of 24 review indicators.

In reviewing the following strengths and recommendations, readers should consider that the fiscal year 2012-2013 Quality Compliance Review was limited to those areas which were not fully met in last year's comprehensive review.

LCD - Key Strengths of the Organization

- Lakeland Care District demonstrates a strong commitment to continuous quality improvement. The organization actively works to identify its strengths and understand its opportunities, and uses data to drive quality improvement efforts.
- The MCO has multiple monitoring methods in place related to care management practice and takes steps to improve and refine its methods, as warranted.
- The organization uses a variety of approaches to ensure changes in policies and care management expectations are clearly communicated to staff.
- Policies and procedures to guide organizational and care management practice are in place and are continuously updated as needed.

LCD - Recommendations

The recommendations are listed in order of priority from MetaStar's perspective.

- Focus improvement efforts on the following areas of care management practice:
    - Addressing members' identified risks;
    - Developing comprehensive member-centered plans;

- Updating plans when members have significant changes, or when requested;
- Following up with members to ensure services have been received and are effective.

Milwaukee County Department of Family Care – Executive Summary

This report summarizes the results of the fiscal year 2012-2013 annual quality review conducted by MetaStar, Inc., for the managed care organization, Milwaukee County Department of Family Care. MetaStar is the external quality review organization contracted and authorized by the Wisconsin Department of Health Services to provide independent evaluations of managed care organizations that operate Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly.

Milwaukee County Department of Family Care operates the Family Care program in three counties in southeast Wisconsin. Key findings from all review activities are summarized below:

Review findings indicate Milwaukee County Department of Family Care has made substantial progress since last year's review. The managed care organization fully met six of the eight Quality Compliance Review standards that had remained partially met in last year's review, resulting in a 96.2 percent overall compliance rate for this review activity. This compares to 84.6 percent in fiscal year 2011-2012.

Results for Care Management Review also demonstrated strong improvement compared to the results of last year's review. The rate of compliance increased for 11 of the 13 review indicators and the managed care organization scored over 90 percent for seven indicators. Last year, the organization scored over 90 percent for three review indicators.

The organization did not begin implementing its performance improvement project until February 2013. Data collection had not yet begun at the time the project was reviewed and validated. As a result, it could only be validated through the planning stages. However, the performance improvement project met all of the review elements which were applicable, indicating that the project is soundly structured.

MCDFC - Key Strengths of the Organization

- Milwaukee County Department of Family Care demonstrates a structured and integrated approach to quality.
- The organization actively works to use data to drive improvements.
- A mechanism to provide staff feedback is incorporated into monitoring processes.
- Improvements made to audit processes have resulted in a monitoring system that is focused on evaluating and improving the quality of member care.

- To help promote consistency in care coordination and continuity of member care, the managed care organization has worked to strengthen communication with its contracted care management units.
- Milwaukee County Department of Family Care seeks input and feedback from staff of all disciplines and levels within its organization and from its contracted care management units.

MCDFC - Recommendations

The recommendations are listed in order of priority from MetaStar's perspective.

- Focus improvement efforts in the following areas of care management practice:
    - Improving monitoring systems to include instances where notices of action are indicated but not issued;
    - Ensuring member-centered plans are reviewed and signed timely by the appropriate legal decision maker at the required six month intervals;
    - Making continued improvements in service coordination and follow-up;
    - Updating member-centered plans when members have significant changes between regular review times;
    - Exploring and documenting member strengths (i.e., personal characteristics of the member that can contribute to his/her success); and
    - Assessing member's informal and family supports, including caregiver strain, to explore what is needed to sustain, maintain, or enhance these existing supports.
- Proceed with implementation of the organization's performance improvement project so there is adequate time for improvement to occur.
- Continue to work together to formalize the process for collaboration between MCDFC, the Disability Resource Center of Milwaukee County, Milwaukee County Department on Aging, and Wisconsin Department of Health Services Milwaukee Economic Support (MilES), including periodic review and revision of the enrollment plan to identify and resolve problems related to enrollment and disenrollment.

NorthernBridges – Executive Summary

This report summarizes the results of the fiscal year 2012-2013 annual quality review conducted by MetaStar, Inc., for the managed care organization, NorthernBridges. MetaStar is the external quality review organization contracted and authorized by the Wisconsin Department of Health Services to provide independent evaluations of managed care organizations that operate Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly.

NorthernBridges operates the Family Care program in 11 counties in northwest Wisconsin. Key findings from all review activities are summarized below:

While the organization took steps to address areas of non-compliance, the efforts did not result in improvement sufficient to fully meet all the standards associated with the Quality Compliance Review. NorthernBridges met 43 of the 52 standards as it did in fiscal year 2011-2012, resulting in 87.2 percent overall compliance rate for this mandatory review activity.

The Care Management Review found that NorthernBridges achieved a compliance rate of 90 percent or higher for 6 of the 13 review indicators. Performance declined slightly for five indicators when compared to results in fiscal year 2011-2012. The compliance rates for three indicators are 76 percent or less. Overall, rates of compliance for the indicators vary greatly among hubs, so the results for the indicators with rates at 90 percent and higher should be considered with caution.

NorthernBridges staff increased its knowledge in designing and implementing Performance Improvement Projects. Its project, focused on falls prevention, raised staff awareness of practice guidelines for this area of member care. However, since it began operations, NorthernBridges has not completed a project that resulted in improvement to members' health or personal outcomes.

NB - Key Strengths of the Organization

- NorthernBridges staff is committed to making improvements and seeking technical assistance.
- Implementation of the MIDAS system contributed to significant improvement in conducting and documenting member assessments.
- NorthernBridges has well-documented policies and procedures for provider network management.

NB - Recommendations

The recommendations are listed in order of priority from MetaStar's perspective.

- Expedite analysis of data from review activities to determine root causes for variation in care management practice among NorthernBridges' hubs.
- Reduce the complexity and variety of care management practice reviews and conduct them continuously to identify potential health and safety concerns for members and ensure appropriateness of member care.
- Execute action plans and conduct rapid plan-do-study-act cycles that address priority areas for improvement.
- Focus improvements efforts in the following areas of care management practice:
    - Promoting the comprehensiveness of member-centered plans;
    - Expediting updates to plans of care when members experience changes in condition or living arrangements;

    - Promoting proactive coordination of care, including direct contact with members and providers to follow up; and
    - Following up with members and their paid and informal supports to ensure services are effective in meeting needs and reducing risks.
- Resume provider audits to ensure compliance with caregiver background checks and, when identified, address non-compliance in a timely manner.
- Develop a monitoring system to ensure staff complies with the steps necessary to encrypt email communications to protect members' personal information.

Southwest Family Care Alliance – Executive Summary

This report summarizes the results of the fiscal year 2012-2013 annual quality review conducted by MetaStar, Inc., for the managed care organization, Southwest Family Care Alliance. MetaStar is the external quality review organization contracted and authorized by the Wisconsin Department of Health Services to provide independent evaluations of managed care organizations that operate Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly.

Southwest Family Care Alliance operates the Family Care program in eight counties in southwest Wisconsin and five counties in northwest Wisconsin. The organization began service delivery in the northern area as of January 1, 2013; this area was previously served by another managed care organization. This report focuses on follow up from the fiscal year 2011-2012 annual quality review, including Care Management Review results from Southwest Family Care Alliance's southern service area. Findings related to care management in the northern service area are available in a separate report.

Key findings from all review activities are summarized below:

Since last year, Southwest Family Care Alliance completed two major initiatives: organizational and Quality Management Program restructuring, and implementation of a new electronic documentation and service authorization system. These accomplishments contributed to improvement in Quality Compliance Review standards and some Care Management Review results.

The organization fully met three of seven Quality Compliance Review standards that had remained partially met in fiscal year 2011-2012, resulting in a 92.3 percent overall compliance rate for this mandatory review activity compared to 86.5 percent in fiscal year 2011-2012.

MetaStar's Care Management Review demonstrated a decline in 8 of 13 indicators, and identified three members requiring additional DHS and MCO oversight due to complex needs or

health and safety issues. While 11 of 13 review indicators for care management scored above or near the fiscal year 2011-2012 statewide average and four indicators showed improvement, the overall findings should prompt additional monitoring and analysis.

Southwest Family Care Alliance concluded its performance improvement project aimed at fall prevention. An evidence-based practice guideline was developed as a result of the project; however, the study did not demonstrate that use of the guideline impacted the rate of falls.

In reviewing the following strengths and recommendations, readers should consider that the fiscal year 2012-2013 Quality Compliance Review was limited to those areas which were not fully met in last year's comprehensive review.

SFCA - Key Strengths of the Organization

- Southwest Family Care Alliance regularly evaluates opportunities for growth and change.
- The Quality Management Program structure includes an inter-departmental approach with several sub-committees.
- The organization values staff, provider, and member input and offers several options for participation, such as workgroups, focus groups, and surveys.
- The managed care organization consistently adds practice guidelines and other resources for care managers.
- Southwest Family Care Alliance has begun to utilize the knowledge and expertise available from experienced staff in the northern service area, e.g., to assist in the development of member advisory councils.

SFCA - Recommendations

The recommendations are listed in order of priority from MetaStar's perspective.

- Provide education to care management staff regarding the following areas:
    - Evaluation of cognition, including the need to access external resources when indicated; and
    - Assessment of the balance between member choice and risk, along with implementation of interventions to mitigate risks.
- Ensure that the organization has identified adequate internal and external resources and supports related to members with mental health challenges.
- Identify opportunities to expand the use of data to drive and monitor improvement efforts, for example:
    - Ensure monitoring is focused and timely in order to:
        - Evaluate the effectiveness of interventions; and
        - Assess the impact of organizational initiatives on member care.

    - Consider collecting and analyzing data from care management supervision activities.
    - Continue to explore electronic reporting options.
- Continue efforts to improve:
    - Timeliness of service authorization decisions; and
    - Issuance of notices of action when indicated.
- Regarding the organization's internal file review:
    - Implement additional reporting and analysis as planned to more specifically target improvement efforts; and
    - Conduct the review without advance notification of teams to ensure findings are reflective of current care management practice.

Western Wisconsin Cares – Executive Summary

This report summarizes the results of the fiscal year 2012-2013 annual quality review conducted by MetaStar, Inc., for the managed care organization, Western Wisconsin Cares. MetaStar is the external quality review organization contracted and authorized by the Wisconsin Department of Health Services to provide independent evaluations of managed care organizations that operate Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly.

Western Wisconsin Cares operates the Family Care program in eight counties in Western Wisconsin. Key findings from all review activities are summarized below.

During this review year, Western Wisconsin Cares met the remaining quality compliance standards which were not fully met in FY 11-12, resulting in 100 percent compliance related to quality compliance review. This is a notable achievement, since Western Wisconsin Cares is the first Family Care managed care organization to fully meet all 52 quality compliance standards.

Western Wisconsin Cares uses data for decision making and works to continuously improve organizational processes and care management. In addition to the progress in meeting quality compliance standards, MetaStar's Care Management Review demonstrated strong improvement, resulting in a compliance rate of over 90 percent for eight of 13 indicators. The organization continued its performance improvement project from last year on falls reduction. A comprehensive and evidence-based falls risk assessment was developed and implemented; measurement of results has not yet occurred.

In reviewing the following strengths and recommendations, readers should consider that the fiscal year 2012-2013 Quality Compliance Review was limited to those areas which were not fully met in last year's comprehensive review.

WWC - Key Strengths of the Organization

- Western Wisconsin Cares demonstrates a culture of continuous improvement.
- Clear and consistent practices are in place for organizational communication, including staff education.
- The organization acted promptly and methodically to address recommendations from the previous External Quality Review and worked with Office of Family Care Expansion to make improvements.
- Policies and procedures to guide care management practice are in place and updated as needed.
- Staff members regularly contribute to improvement efforts.
- The MCO has multiple monitoring methods in place and continuously improves the methods as warranted.
- Western Wisconsin Cares continued many planned improvements, although the enrollment cap was lifted and organizational priorities shifted to address the new enrollees.

WWC - Best or Promising Practice

The MCO uses a standardized approach to disseminate information to care management teams at all locations. The approach includes a communication approach that utilizes standard agendas and collective consideration of and responses to questions about policies and procedures. Up-to-date information is available to staff on the organization's *iCenter,* the intra-agency website. This communication process contributed to the MCO's achievement of full compliance, improvements in care management practice, has been sustained over time, is effective, and is considered a "Best Practice."

WWC - Recommendations

The recommendations are listed in order of priority from MetaStar's perspective.

- Ensure efforts related to improving the consistency of case note documentation are continued, as this initiative positively impacted multiple areas.
- Prioritize planned efforts to improve results related to updating member-centered plans to reflect changes in members' situation or condition.
- Continue development and implementation of other planned initiatives to obtain further improvement related to:
    - Conducting re-assessments when indicated;
    - Follow-up on effectiveness of services; and
    - Issuing notices of action when indicated.

- Continue the use of and further refine the approach for root cause analysis to assist in planning improvement interventions.
- Use rapid improvement cycles to test and measure the effectiveness of new interventions.
- Provide results of monitoring and improvement efforts to staff regularly to reinforce efforts and celebrate successes.

APPENDIX 3 – REQUIREMENT FOR EXTERNAL QUALITY REVIEW AND REVIEW METHODOLOGIES

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. To meet these obligations, states contract with a qualified 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 Plus 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 FC and FCP programs as well as in other settings, including community programs, home health agencies, and community-based residential settings. Some reviewers have worked in primary and acute care facilities or other skilled nursing facilities. The EQR team also includes reviewers with quality assurance/quality improvement 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

QCR, a mandatory EQR activity, 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. The MetaStar team evaluated MCOs' compliance with standards according to 42 CFR 438, Subpart E, using CMS' EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations.

FY 12-13 was a "targeted" review year. For each MCO, DHS directed MetaStar to review only those standards not fully met during FY 11-12, when all compliance standards were reviewed.

Prior to conducting review activities, MetaStar obtained information from DHS about its work with the MCO, including contractual and any additional performance expectations. The following sources of information were reviewed:

- The MCO's 2012 and 2013 Family Care Program contracts with DHS, Division of Long-Term Support;
- Related program operation references found on the DHS website:
  - http://dhs.wisconsin.gov/familycare/mcos/index.htm
- FY 11-12 external quality review report;
- DHS correspondence with the MCO about expectations and performance during the previous 12 months; and
- Most recent results of compliance, certification, and business plan reviews conducted by DHS.

MetaStar also obtained and reviewed information from the MCO, such as policies and procedures. On-site discussions were held with MCO administrators and staff responsible for improvement efforts. MetaStar requested and reviewed additional documents, as needed, to clarify information gathered during the on-site visit. Data from some Care Management Review elements were considered when assigning compliance ratings for some focus areas and sub-categories.

The federal protocols for external quality review were consolidated from five focus areas into three. The three focus areas are listed in the table below. This consolidated approach was developed and implemented by MetaStar in FY 11-12, in order to remove redundancies in the previous methodology and provide a useful evaluation of the MCO's systems for those people who need it; DHS, various MCO staff, current and prospective members, and other stakeholders.

Focus Area	Related Sub-Categories in EQRO Protocol
Enrollee Rights and Program Structure	MCO structure and operations to support program requirements and ensure member rights including: basic rights assurances and information requirements.
Access to Services and Quality Monitoring	Availability of services including: authorization of services as well as coordination and continuity of care. Structure and operations elements related to provider network. Measurement and Improvement including: practice guidelines, quality assessment and performance improvement program and evaluation, information systems to support decision-making.
Grievance Systems	Structure and basic requirements including: information provision and communication with members including the NOA. Grievance and Appeal Processes including: local, DHS, Division of Hearings and Appeals (DHA), and resolutions and notifications related to these options.

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

- **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. When a score change occurred, for example, from "partially met" in the previous review year to "met" in the current review, reviewers documented the findings which evidenced the improved score.

Validation of Performance Improvement Projects

PIP validation, a mandatory EQR 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 MetaStar team used the methodology described in the CMS guide, *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities.*

DHS requires that during each contract period, MCOs must make active progress on one or more PIPs relevant to long-term care, and for some MCOs, acute and primary care. DHS expects MCOs to conduct PIPs, which achieve significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on outcomes and member satisfaction. MCOs are required to use a standardized PIP model or method and must document the status and results of each project in enough detail to show that it is making progress.

Each PIP was evaluated at whatever stage of implementation it was in at the time of the review. To conduct the PIP review, the MetaStar staff obtained and assessed DHS and MCO documents, such as the

- DHS PIP approval memo and notes;
- MCO's annual PIP report;
- BCAP workbook or other project work plan/description;
- Data on project measures; and
- Other project information, e.g., related practice guidelines or member education materials.

Following the document review, on-site interviews were conducted with the MCO's quality management staff and PIP project team members. The purpose of the discussion was to follow up on questions related to project design and measures, implementation, data collection methods, results of data, and the plan for next steps.

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

For findings of "partially met" or "not met," the EQR team documented the missing requirements and provided recommendations. When a score change occurred, for example, from "partially met" in the previous review year to "met" in the current review, reviewers documented the findings which evidenced the improved score.

Validation of Performance Measures

Validating performance measures is a mandatory EQR 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 MetaStar team conducted validation activities as outlined in the CMS publication, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO*.

MCOs were encouraged to submit the immunization data for influenza and pneumococcal using a standardized worksheet provided by DHS.

To complete the validation activities, MetaStar reviewed the data and rates reported by each MCO using DHS contract criteria for each quality indicator, and calculated the final immunization rates. The steps to review each MCO's submission were:

- Ensure members were not duplicated in a data file;
- Confirm MCO reported numerators meet the definitions contained in the technical specifications;
- Confirm MCO reported denominators meet the definitions contained in the technical specifications;
- Compare the denominators reported by the MCO to DHS denominators and calculate the percentage of similarity between the denominators;
- Calculate final rates using standardized data worksheets.

To complete the validation step as outlined by CMS, MetaStar conducted a record review of 30 randomly selected members for each measure to verify the accuracy of the MCO's reported data. The steps of the validation process included:

- Check each member's service record to verify that it clearly documents the appropriate immunization in the appropriate time period, or appropriately documents any exclusion/contraindication to receiving the immunization;
- Document whether the MCO's report of the member's immunization or exclusion is valid or invalid; and
- Conduct statistical testing, using the t-test to determine if rates are unbiased, meaning that they can be accurately reported. (The logic of the t-test is to statistically test the difference between the MCO's estimate of the positive rate and the audited estimate of the positive rate. 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.)

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.

MetaStar randomly selected a sample of member records based on a minimum of one and one-half percent of total enrollment or 30 records, whichever is greater. The random sample included a mix of participants who enrolled during the last year, participants who had been enrolled for more than a year, and participants who had left the program since the sample was drawn. In addition, members from all target populations served by the MCO were included in the random sample; frail elders, and persons with physical and developmental disabilities, including some members with mental illness, traumatic brain injury, and Alzheimer's disease.

The sample of member records was reduced for two MCOs at the direction of DHS, due to their anticipated participation in an Internal File Review (IFR) validation pilot that was scheduled for the second quarter of 2013. MetaStar reviewed 30 member records during each organization's scheduled EQR in the fall of 2012. Then, due to a delay in the pilot project, DHS directed MetaStar to conduct additional CMR for these two MCOs in the second quarter of 2013 to meet the one and one-half percent sampling volume described above.

Prior to conducting the CMR, MetaStar obtained and reviewed policies and procedures from the MCO, to familiarize reviewers with the MCO's documentation practices.

During the review, MetaStar scheduled regular communication with quality managers or other MCO representatives to:

- Request additional documentation if needed;
- Schedule times to speak with care management staff, if needed;
- Update the MCO on record review progress; and
- Inform the MCO of any potential or immediate health or safety issues or members of concern.

The care management review tool and reviewer guidelines are based on DHS contract requirements and DHS care management trainings. Reviewers are trained to use DHS approved review tools, reviewer guidelines, and the review database. In addition to identifying any

immediate member health or safety issues, MetaStar evaluated four categories of care management practice:

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

The four categories are made up of 13 indicators that reviewers used to evaluate care management performance during the six months prior to the review. MetaStar also compared information from each member's record in the sample with the member's most recent Long-Term Care Functional Screen and provided the comparisons to DHS.

MetaStar initiated a Quality Concern Protocol if there were concerns about a member's immediate health and safety, or if the review identified complex and/or challenging circumstances that warranted additional oversight, monitoring, or assistance. MetaStar communicated findings to DHS and the MCO if the Quality Concern Protocol was initiated.

At the end of the record review, MetaStar gave the MCO and DHS the findings from each individual record review as well as information regarding the organization's overall performance.

MetaStar used a binomial scoring system (yes and no) to evaluate the presence of each required element in member records. In addition, for findings of "no," the reviewers noted the key areas related to the finding and provided comments to identify the missing requirement**.**