External Quality Review, 2007

Wisconsin Medicaid/BadgerCare & SSI HMO Program

Findings and Corrective Actions
Executive Summary Report

State of Wisconsin
Department of Health and Family Services
Division of Health Care Financing
Bureau of Managed Health Care Programs

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Quality Assessment and Performance Improvement

Table of Contents

External Quality Review, 2007
Wisconsin Medicaid/BadgerCare and SSI HMO Program

Findings and Recommendations Protocol #1, #2 & #3

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August 2007

Background—

The U.S. Department of Health and Human Services (HHS) implemented the provisions of the Balanced Budget Act of 1997 (BBA) managed care provisions through two regulations. One, the Medicaid Managed Care Final Rule, mandated the use of external quality review (EQR) and the other, the External Quality Review Final Rule, provided specific guidance to states on how external quality review was to be conducted and qualifications of entities able to conduct EQR.

The Wisconsin Department of Health and Family Services implements its external quality review action plan through a qualified external quality review organization (EQRO), which was selected by competitive bidding. Wisconsin's EQRO is MetaStar of Madison http://www.metastar.com/web/ . External quality review activities include managed care entities in the SSI program, as well.

MetaStar has concluded field activities and has submitted its final reports to the DHFS. This report provides a summary of the findings, including where partial or non-compliance was found. In these instances, the HMO was required to submit documentation of corrective actions taken or a plan for actions to be taken to remedy those areas. The Department's goal of full compliance across all the HMOs in the program will thus have been achieved with completion of any required HMO corrective actions.

This report summarizes compliance data gathered by the state's EQRO using the CMS-specified tool referred to as "Attachment C," the ISCA+, private accreditation status and as otherwise required by the mandatory EQRO Protocols.

This report does not provide details about the history of the state's Medicaid managed care program, its quality assessment and performance improvement strategy, results of assessments of the effect of the strategy, HMO-specific or aggregate clinical performance measure data or enrollee satisfaction data. That data is provided in other reports, available as follows:

- The Quality Assessment and Performance Improvement Strategic Plan is available online at: http://www.dhfs.state.wi.us/medicaid7/reports_data/pdfs/qapi2006-2008plan.pdf
- The biennial Quality Improvement and Performance Assessment Strategic Plan Assessment is available from the Department of Health and Family Services upon request. Contact information is on the next page.
- The MEDDIC-MS Goal-Setting results report for information on the effectiveness of Wisconsin's Targeted Performance Improvement Measure Goal-setting system and the technical specifications are available from the DHFS upon request.
- The listing of HMO performance improvement project topics reported since 1997 is available online at: http://www.dhfs.state.wi.us/medicaid7/providers/index.htm
- Full documentation of HMO accreditation status is available from the Department of Health and Family Services upon request.
- HMO-specific and program wide aggregate performance data reports are online at:
    - MEDDIC-MS Data Book Vol. 1: http://www.dhfs.state.wi.us/medicaid7/reports_data/pdfs/2005_vol1.pdf
    - MEDDIC-MS Data Book Vol. 2: http://www.dhfs.state.wi.us/medicaid7/reports_data/pdfs/2005vol2.pdf
    - MEDDIC-MS SSI Data Book: http://www.dhfs.state.wi.us/medicaid7/reports_data/pdfs/2005ssi.pdf
    - MEDDIC-MS Technical Specifications: http://www.dhfs.state.wi.us/medicaid7/reports_data/pdfs/ms2007techspec.pdf
    - MEDDIC-MS SSI Technical Specifications: http://www.dhfs.state.wi.us/medicaid7/reports_data/pdfs/ssi2007techspec.pdf
    - Enrollee satisfaction survey report: http://www.dhfs.state.wi.us/medicaid7/recipients/cahps/toc.htm
    - Wisconsin Medicaid HMO Report Card: http://www.dhfs.state.wi.us/medicaid7/recipients/hmoreportcard.htm
    - General quality and HMO contract information: http://www.dhfs.state.wi.us/medicaid7/providers/index.htm

The following table summarizes compliance status identified by the review for each HMO under the Protocol #1. It includes a description of corrective actions, if any, taken by the HMO in response and includes recommendations for further action by the Department, if any are required.

Wisconsin's HMO Accreditation Incentive program leverages provisions in the External Quality Review Final Rule (Non-duplication of Mandatory Activities, 42 CFR, §438.360) to provide the Department with documentation from private accreditation activities for those HMOs claiming private accreditation.

The rule provides that that documentation can be used to greatly reduce the volume of documentation required for EQR activities on the accredited HMOs. In addition, accreditation status of each HMO claiming third-party accreditation is subject to primary-source verification. Documentation of that verification is included in this report for each accredited HMO (Dean Health Plan, Group Health Cooperative-South Central, MercyCare, Security Health Plan, UnitedHealthcare [Americhoice], and Unity Health Plans.)

Note: This electronic version of the 2007 EQR activity does not include project management reports, the full HMO compliance reports or full EQRO PIP report evaluations (Protocol #3 reports). Those reports are available from the Department upon request.

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External Quality Review Results Summary, Protocol #1—2007 Review Period					
Plan	**MA/BC**	**SSI**	**Requirements not met or partially met**	**Corrective action taken**	**Actions & status**
Abri Health Plan	■	■	None	Not applicable.	Compliance
Children's Community Health Plan	■		• Change time period for prior authorization decisions from 15 calendar days to 14 calendar days in order to comply with Federal Regulations and WI State Statutes. • Develop method to inform CCHP members of providers' language capabilities. Recommend adding the information to CCHP's provider directory. • Develop and implement policies and procedures for performing peer reviews of provider records. (CCHP identified need.) • Continue process to select practice guidelines appropriate to meet the health care needs of CCHP's members. (CCHP identified need.) • Develop and implement policies and procedures regarding the use of restraints. • CCHP must implement a process to disseminate their practice guidelines to all affected providers and make them	• As of 5/30/2007, CCHP has updated their Denial and Grievance Policies changing the time period for making prior authorization decisions to 14 days. • CCHP has added a language spoken field to their provider directories and plan to have their database updated with this information by 12/31/2007. • CCHP policy QI002: Medical Records Maintenance and Access includes CCHP's peer review process. CCHP plans to begin conducting provider reviews in fall of 2007. • Preventive care, prenatal care and asthma guidelines will be reviewed at CCHP's 8/9/2007 Medical Advisory Committee meeting and then posted to the website. • CCHP has developed a draft policy, MR004: Use of Restraints, which will be presented to the Medical Advisory Committee for approval on 8/9/2007. • Once approved by CCHP's Medical Advisory Committee the Preventive care, prenatal care and asthma practice	Compliance. EQRO will verify completion of corrective action in 2008 EQR cycle.

External Quality Review Results Summary, Protocol #1—2007 Review Period					
Plan	**MA/BC**	**SSI**	**Requirements not met or partially met**	**Corrective action taken**	**Actions & status**
			available, upon request, to enrollees and potential enrollees.	guidelines will be posted to the website. The practice guidelines will also be available in hard copy upon request.	
CompCare	■		None	Not applicable.	Compliance
Dean Health Plan (Acc.)	■		None	Not applicable.	Compliance
Group Health Cooperative-South Central (Acc.)	■		None	Not applicable.	Compliance
Group Health Cooperative-Eau Claire	■		None	Not applicable.	Compliance
Health Tradition Health Plan	■		• Add verbiage to HTHP P&P ADM 6.2 V. Procedure for Expedited Appeals to indicate that expedited/urgent appeals/grievances should be resolved within 2 business days of receipt of the appeal/grievance or sooner, if possible, for MA/BC members. • Remove/replace outdated version of HTHP MA/BC Provider Directory on HTHP's website.	• HTHP updated P&P ADM 6.2, Section V: Procedure for Expedited Appeals, paragraph D (page 7) to indicate that expedited /urgent appeals/ grievances should be resolved within 2 business days of receipt of the appeal/grievance or sooner, if possible, for MA/BC members. A copy of the updated P&P was submitted to MetaStar on July 18, 2007. • HTHP has removed the outdated version of the MA/BC Provider Directory from their website.	Compliance. EQRO will review Expedited Appeals Process to verify full compliance in 2008 EQR cycle.
iCare		■	**1.** Medicaid G&A 004 member letter states the time period for an extension of the appeal/grievance review as 15 calendar days. **2.** Correct/update information	**1.** *i*Care will change time period for extension of appeal/grievance review in Medicaid G&A 004 member letter to 14 calendar days in order to comply with Federal Regulations and WI State Statutes. **2.** *i*Care will	Compliance. EQRO will review revised P/P, handbook and other documentation to verify full compliance in 2008 EQR cycle.

External Quality Review Results Summary, Protocol #1—2007 Review Period					
Plan	**MA/BC**	**SSI**	**Requirements not met or partially met**	**Corrective action taken**	**Actions & status**
			regarding the time period within which a member must request a continuation of benefits after requesting a Fair Hearing in the: **a.** Member Reduction/Termination Letter: states member must notify *i*Care within 10 days of the notice date to continue current level of service during appeal process. **b.** CM-032 Prior Authorization Process (13.1 and 13.2): length of time services continued while an appeal is pending is given as 10 days. **3.** ADM-053 Limited English Proficiency Translation and Interpreter Services: Correct/update information in step #17 (c) which states, "The LEP Coordinator evaluates language access activities consistent with steps 9 (a) and 9 (b) of this policy." Step #9 does not include an (a) or (b).	correct/update information regarding the time period within which a member must request a continuation of benefits after requesting a Fair Hearing in the: a. Member Reduction/Termination Letter: The fact that a benefit will continue during the appeal or DHA fair hearing process if the enrollee requests that it continue within 10 days of receiving the notice of action from *i*Care or before the effective date of the action, whichever is later b. CM-032 Prior Authorization Process (13.1 and 13.2): The fact that a benefit will continue during the appeal or DHA fair hearing process if the enrollee requests that it continue within 10 days of notification or before the effective date of the action, whichever is later. And that benefits must be continued until one (1) of the following occurs: The enrollee withdraws the appeal.	

External Quality Review Results Summary, Protocol #1—2007 Review Period					
Plan	**MA/BC**	**SSI**	**Requirements not met or partially met**	**Corrective action taken**	**Actions & status**
				A state fair hearing decision adverse to the enrollee is made. The authorization expires or the authorization service is met. *i*Care will clarify the process used by the LEP Coordinator to evaluate language access activities in their ADM-053 Limited English Proficiency Translation and Interpreter Services policies and procedures document.	
MercyCare Health Plan (Acc.)	■		None	Not applicable.	Compliance
Managed Health Services	■	■	None.	Not applicable.	Compliance.
Network Health Plan	■	■	SSI case management review revealed MCO failed to provide required language interpretation services in one case.	HMO will assure language interpretation needs are met.	Compliance. EQRO will follow-up on provision of language interpretation services in 2008 EQR.
Security Health Plan (Acc.)	■	■	None.	Not applicable.	Compliance.
UnitedHealthCare (Acc.)	■	■	None.	Not applicable.	Compliance.
Unity Health Plan (Acc.)	■		None	Not applicable.	Compliance

Protocol #2 Executive Summary of Results

Per the January 24, 2003 Federal Register, States that calculate performance measures for MCOs are exempt from Protocol 2 activity, as per the following guidance from CMS:

> "In the Medicaid managed care final rule under 438.240(c)(2) we permit States to calculate performance measures on the MCO's/PIHP's behalf in place of the MCO/PIHP calculating and reporting performance measures to the State. Under this circumstance, the validation of MCO/PIHP performance measures is not required as a mandatory activity but the State must submit the State-calculated performance measures to the EQRO for the EQR function as specified under §438.358(b)(2)....[1]"

§438.358(b)(2) simply lists the required three protocols[2]. This statement is further supported in a later response:

> We recognize that States may have MCOs and PIHPs submit encounter data to them instead of performance measures and, therefore, the State may be the entity calculating the performance measure. We have allowed for this in the quality assessment and performance improvement program requirements specified in §438.240 of the Medicaid managed care final rule. However, regardless of who calculates the performance measures, MCO and PIHP level performance measures must be calculated as required by the Medicaid managed care final rule and, if calculated by the MCO/PIHP, must be validated to provide information for the EQR function. We have added clarifying language under §438.358(b)(2) to recognize that States may be calculating the MCO/PIHP performance measures and in this circumstance the State would provide the information obtained from this activity to the EQRO for the EQR function.[3]

MEDDIC-MS (Medicaid Encounter Data Driven Improvement Core Measure Set) is Wisconsin's set of standardized performance measures for Family Medicaid and BadgerCare (the State Children's Health Insurance Program, SCHIP) managed care. Use of MEDDIC-MS was approved by the Centers for Medicare and Medicaid Services (CMS) as part of its review of the state's quality improvement strategy in August 2003. MEDDIC-MS is an automated system, utilizing HMO encounter data and other State-controlled electronic data sources. The State also utilizes CAHPS® Enrollee Satisfaction Survey results together with the MEDDIC-MS measures as part of its quality assessment

[1] 42 CFR Parts 433 and 438 – Medicaid Program; External Quality Review of Medicaid Managed Care Organizations; Final Rule, page 3588
[2] 42 CFR 438.358
[3] "42 CFR Parts 433 and 438 – Medicaid Program; External Quality Review of Medicaid Managed Care Organizations; Final Rule," page 3626

and performance improvement program. Therefore, because the State of Wisconsin has chosen to calculate performance measures for its HMOs through the use of encounter data and survey data, the State is exempt from mandatory review activity under Protocol 2 by the EQRO, except that it must provide results of data calculated to the EQRO.

In addition to on-going access to the results of each performance measure and the applicable technical specifications for each measure online at http://www.dhfs.state.wi.us/medicaid7/providers/index.htm the EQRO has been provided measure data tables on a sample of measures to support the measure validation function.

A review of these documents show the State has calculated standardized, nationally-recognized performance measures, and used the data in its ongoing quality assessment and performance improvement program and has provided the results to the State's EQRO.

Protocol #3 Executive Summary of Results

Validating Performance Improvement Projects

The Protocol calls for the EQRO to engage in two activities in the process of validating the MCO performance improvement project report. The following steps are included in the first activity, *Validating the MCO PIP Methodology*.

1. Review the selected study topic(s)
2. Review the study question(s)
3. Review selected study indicator(s)
4. Review the identified study population
5. Review sampling methods (if sampling was used)
6. Review the MCO/PHPS data collection procedures
7. Assess the MCO s/PHP s improvement strategies
8. Review data analysis and interpretation of study results
9. Assess the likelihood that reported improvement is real improvement
10. Assess whether the MCO/PHP has sustained its documented improvement

All of the steps in the Protocol are consistent with the process Wisconsin has had in place for a number of years. In fact, the Wisconsin process is more specific.

The second activity, *Verifying Actual PIP Study Results*, involves validation of the MCO performance improvement project results and is optional.

The Wisconsin Medicaid/BadgerCare and SSI HMO contract mandates that each HMO submit not less than two performance improvement project reports per calendar year. The reports are reviewed by the Department's EQRO (MetaStar). The EQRO provides comprehensive evaluation reports on each project reported by the HMO to the Department that includes analysis of methods, data, and findings. The reports are provided to the HMOs by the Department with recommendations for ways to improve future QAPI activities.

HMOs submitting the best examples of the reports each year are invited to share their experiences with all other MCOs at the DHFS *Symposium on Best Practices in Medicaid Managed Care Quality Improvement*.

Wisconsin DHFS/BMHCP External Quality Review 2007 Action plan for Medicaid/BadgerCare & SSI Managed Care programs

Audit activity for implementation of Protocol 1, Health Plan Compliance with Medicaid Managed Care Final Rule and Protocol 2, Validation of Performance Measure Data and Protocol 3, Validation of Performance Improvement Projects

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External Quality Review Project Lead

November 1, 2006

The EQRO Final Rule established requirements and procedures for external quality review (EQR) of Medicaid managed care organizations (MCOs & health plans).

The rule governs the operations of external quality review organizations (EQRO) in state oversight of Medicaid managed care programs. Nine protocols provide general guidance of EQRO oversight activities, three of which are termed "mandatory." They are:

(1) Determining MCO/PIHP compliance with federal Medicaid managed care regulations, with Attachments:
Attachment A: Summary of Compliance Determination Activities of Public and Private Quality Oversight Organizations;
Attachment B: Compliance Determination Activities for Individual Regulatory Provisions;
Attachment C: Sample Documentation and Reporting Tool.
(2) Validation of performance measures produced by an MCO or PIHP;
(3) Validation of performance improvement projects undertaken by an MCO/PHP;

The EQR activities include health plans contracting to serve Medicaid, BadgerCare and SSI populations and audit activities for all programs are conducted simultaneously. Accredited and non-accredited health plans are included in the audit activity.

EQR audit and reporting activities for **Protocol 1 &2**, will be submitted to the DHFS by July 31, 2007.

Planning for focused review of case management systems and assessments of SSI enrollees is the responsibility of the DHFS chief medical officer assigned to the SSI managed care program.

Arranging for provision of complete performance measure technical specifications and completion and documentation of the **Protocol 2** review for any SSI program performance measures other than MEDDIC-MS SSI is the responsibility of the chief medical officer assigned to the SSI managed care program.

Completion of the **Protocol 3** review will be completed and reports submitted to the Department/BMHCP by the EQRO as soon as possible after October 1, 2007. This consists of EQRO evaluation reports of health plan-submitted performance improvement project reports. These reports will be added to the DHFS summary report when they are completed.

Arranging for completion and documentation of the **Protocol 3** review for all SSI program health plans is the responsibility of the chief medical officer assigned to the SSI managed care program if the criteria, due dates or deliverables differ from those for the health plans in the Medicaid/BadgerCare program.

MetaStar is the external quality review organization for the Wisconsin Medicaid/BadgerCare and SSI program, which are administered by the Department of Health and Family Services.

This memorandum is to facilitate development of the action plan by the EQRO necessary to achieve completion of the audit activity goal described above.

Non-accredited health plans to be audited and reported on by not later than July 31, 2007:

1. Abri Health Plan (where policy/procedure for SSI differs from MA/BC)
2. Children's Community Health Plan
3. CompCare Health Plan
4. Group Health Cooperative-Eau Claire
5. Health Tradition Health Plan
6. iCare (abbreviated audit—SSI only)
7. Managed Health Services (where policy/procedure for SSI differs from MA/BC)
8. Network Health Plan (where policy/procedure for SSI differs from MA/BC)

These plans are not accredited by a private accreditation body recognized by the CMS and the DHFS and had comprehensive on-site audit activity in 2005. This list is not necessarily the order the audits are to occur. Note that if a plan has achieved accreditation, but it has not applied for and been granted participation in the DHFS Health Plan Accreditation Incentive Program, for the purposes of EQR, it is treated as a non-accredited plan.

The chief medical officer for the various special managed care programs such as Children Come First (CCF), CCO (Community Care Organization), ElderCare, Wrap Around Milwaukee (WAM), etc. are responsible for compliance with EQR requirements for those programs.

Comprehensive on-site reviews of the type employed in 2005 will not be required for all the above listed plans. New SSI program contractors will require *comprehensive* on-site review and documentation activity, if this was not included in the review in 2006. iCare had a comprehensive review in 2006 and so can have an abbreviated review in 2007. Health plans previously audited for the Medicaid/BadgerCare program entering the SSI managed care program in 2005 and which had SSI review included in the 2006 review can have abbreviated audit of criteria affecting the SSI portion of the plan's operations. For the remaining listed non-accredited plans, abbreviated on-site reviews occur.

Abbreviated on-site reviews will generally not require more than one business day. The *abbreviated* on-site activities will focus on the following:

- Follow-up on any areas of non-compliance or partial compliance noted in the 2006 EQR cycle. Verification of corrective actions taken by the health plan in response to the 2006 findings will be documented. This will include review of applicable policy and procedure

and verification of implementation (where appropriate) by review of process-related documentation, staff interviews and so on.

- Review of all new or revised policies and procedures in any area of compliance. CMS **Protocol 1 Attachment C** will be used in modified form to accommodate both MA/BC and SSI review as the audit document as in 2006. Prior to scheduling the on-site activity, the EQRO will provide a completed copy of the 2006 Attachment C document to each health plan with instructions to the plan to review each item and indicate where new or changed policy/procedure exist to guide the review. The plan will provide copies of that documentation to the EQRO prior to on-site activity.
- Any areas of concern identified by the Department/BMHCP for in-depth review on-site by the EQRO.

All health plans participating in the SSI program are subject to case management and enrollee assessment requirements focused review, using a tool and criteria specified by the Department, whether receiving full or abbreviated review. Reporting on this activity shall be included in the full and executive summary reports prepared by the EQRO under a distinct heading or section.

The following plans have qualified for continued participation in the DHFS Health Plan Accreditation Incentive Program. The health plan's documentation submitted about its accreditation for the Wisconsin Medicaid Health Plan Accreditation Program must be reviewed by the EQRO. The following health plans are in this category:

1. Dean Health Plan
2. Group Health Cooperative-South Central
3. MercyCare
4. Security Health Plan
5. UnitedHealthcare (Americhoice)
6. Unity Health Plans

Accredited health plans that have qualified for the DHFS Health Plan Accreditation Incentive Program are audited annually under **Protocol 1**, using documentation of the plan's accreditation survey and Health Plan Accreditation Standards Screen completed by the plan. Accreditation survey documentation and Accreditation Incentive Standards Screens must be updated by the plan whenever its accreditation status changes, it becomes accredited by a different accrediting body or it is re-accredited by the same body. Continuing accreditation status will be subject to primary source verification, i.e.: the accrediting body itself, not just the health plan.

Health plans that previously qualified for the accreditation incentive program, but have undergone changes of ownership, merger or other significant organizational changes defined by the Department/BMHCP may need to be brought under comprehensive review as though the plan was a new organization to the Medicaid/BadgerCare program, if the accrediting body has determined the accreditation is no longer applicable.

Review for SSI will center on those areas of policy or procedures which differ from what is in place for Medicaid/BadgerCare.

The DHFS/BMHCP will provide the updated survey documentation to the EQRO as necessary. If no changes have occurred with respect to a given plan's accreditation source and status since the last EQR cycle, *no additional documentation need be reviewed*. Exceptions to this include:

- Follow-up on all areas of non-compliance or partial compliance noted in the 2006 EQR cycle, if applicable. Verification of corrective actions taken by the health plan in response to the 2006 findings will be documented. This will include review of applicable policy and procedure and verification of implementation (where appropriate) by review of process-related documentation, staff interviews and so on.
- Any areas of concern identified by the Department/BMHCP for in-depth review on-site by the EQRO.

Scoring and assuring compliance—

Three point rating or scoring **-** This scale allows for credit when a requirement is partially met, if this level of performance is acceptable.

1 - Fully Met 2 - Partially Met 3 - Not Met

"Fully met" applies when the policy, procedure and practice all aligned to meet the requirement. "Partially met" applies when the requirement was met in practice, even though the health plan did not have directly relevant written policy or procedure. "Not met" applies when the requirement is not met in practice, nor addressed in policy and procedure.

The health plan will be informed of all "not met" and "partially met" findings and the expectation is that the health plan will take corrective action to fully meet the requirements, as soon as possible and prior to the final report being generated. The EQRO is responsible for gathering and documenting plan responses to all such findings for inclusion in the report to the Department/BMHCP.

Any plan that could not demonstrate full compliance would have to provide a *date for completion* of actions designed to achieve compliance. What the plan states it will do and when it will complete doing it will be documented in the report.

The EQRO will provide its findings to the health plan at the exit conference for each day on-site and at the final exit conference. Where possible, the health plan will provide a response to each finding at that time.

The EQRO will provide a written summary of its findings to the plan after all desk audit and field activities are complete in writing. This summary need not be provided to the Department/BMHCP. The plan will be allowed 10 business days to respond to the findings. During this time, the EQRO will work with the plan directly to achieve resolution of all issues.

Requests for clarification or dispute of any findings will not extend the response period, unless approved by the Department/BMHCP.

The plan's responses will be documented together with all findings by the EQRO and that report will be submitted to the Department/BMHCP. Open issues or any areas of less than full compliance that remain in dispute will be handled by the Department/BMHCP.

The department may, at its option, allow an extension of time for compliance, but that would be decided on a case-by-case basis. The health plan is required to request the extension in writing, give good reason for the requested time and give the department a date by which the non-compliance would be remedied and the documentation would be submitted to the department.

The department's expectation of the health plan is full compliance with all applicable requirements by the time the EQR cycle is complete and its responses to EQRO notification of partial compliance or non-compliance have been implemented. Any unresolved areas will be referred to the Department/BMHCP for action as described above to achieve compliance.

The health plan-specific reports provided to the department will include the compliance assessment on every requirement, using the report format agreed to and which identifies those requirements partially met and not met during the review, what actions have been taken by the plan to correct, if full compliance has been achieved and, if not, which elements are still not met. The plan would then be required to respond to any open issues as described above.

Reporting—

Report format Protocol 1, Compliance with MA Managed Care Final Rule QAPI:

The reporting format will be generally consistent with Attachment C of **Protocol 1.** This incorporates the compliance rating system described above. It will be modified to allow documentation of audit results for both Medicaid/BadgerCare and SSI programs. In addition, the EQRO may document recommendations to assist the health plan with achieving compliance, however, the use of the recommendations by the plan is voluntary; the plan may choose to not follow the EQRO's recommendations*, but the plan is responsible for achieving full compliance and for documenting how it will do that.*

In addition, the final report to the department/BMHCP will include the required content as follows:
The report must also include the following for each activity conducted in accordance with § 438.358:

(i) Objectives.
(ii) Technical methods of data collection and analysis.
(iii) Description of data obtained.
(iv) Conclusions drawn from the data.

(2) An assessment of each MCO's or PIHP's strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients.

(3) Recommendations for improving the quality of health care services furnished by each MCO or PIHP.

(4) As the State determines, methodologically appropriate, comparative information about all MCOs and PIHPs.

(5) An assessment of the degree to which each MCO or PIHP has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR**.**

All health plans participating in the SSI program are subject to case management and enrollee assessment requirements focused review, using a tool and criteria specified by the Department, whether receiving full or abbreviated review. Reporting on this activity shall be included in the full and executive summary reports prepared by the EQRO under a distinct heading or section. Questions or concerns regarding this activity should be directed to the chief medical officer responsible.

The full report will also include the completed ISCA + (Information Systems Capabilities Assessment). The Executive Summary report will include a general description of methods, data used, overall results in terms of compliance, areas corrected and remaining areas of non- or partial compliance, if any.

Reporting the findings for accredited plans will follow the same general outline as described above, but based on accreditation survey documentation and the survey standards screen provided by the plans and the Health Plan Accreditation Incentive program application score sheet completed by the Department/BMHCP.

Protocol 1 written reports will be completed and provided to the Department/BMHCP by July 31, 2007. Any extensions to this deadline must be approved by the Department/BMHCP in writing.

Protocol 2 Validation of Performance measures

Reporting for findings on **Protocol 2** will include the same general headings as above, but developed along the lines of what is necessary to achieve the goals of the protocol with respect to the limited scope of calculation of performance measures in compliance with the MEDDIC-MS and MEDDIC-MS SSI Technical Specifications.

Arranging for completion and documentation of the **Protocol 2** review for any SSI program performance measures other than MEDDIC-MS SSI is the responsibility of the chief medical officer assigned to the SSI managed care program.

On-site activities for **Protocol 2** will not be necessary, unless specifically directed by the Department. MetaStar will coordinate these activities, if required. Delivery of the final report on **Protocol 2** will be by July 31, 2007.

To facilitate rapid implementation and completion of the audit plan, the DHFS/BMHCP requests the following be provided to the EQRO contract monitor in electronic format, if possible, the following:

1. MetaStar's 2007 external quality review implementation plan for:
   a. Compliance reviews as described above for Medicaid/BadgerCare and SSI program health plans.
   b. Compliance reviews as described above based on **Protocol 1** for accredited plans.

2. MetaStar plans for obtaining documentation from the plan and from the department *prior to* any on-site visits for desk audit and on-site audit preparations. The DHFS/BMHCP will provide the following on each health plan to be audited:

For any health plan that is new to the program or where any of the following information is known to have changed since January 2005:

- Organization name and mailing address
- Contact person's name, title, phone number, E-mail address
- Location for the onsite visit (e.g., headquarters address)
- Organizational charts or other structural descriptions of the health plan
- Total individuals enrolled (for current and previous year) in Medicaid/BadgerCare and SSI (for latest available month), where applicable.
- Total number of network practitioners (for current and previous year) with a breakdown by type, for example, primary care, OB/GYN, and other specialties
- Total number of network organizational providers (hospitals, ambulatory care, home care, laboratories, etc.)
- Service descriptions and benefit designs available to purchasers (disease management, for example)
- Delegated functions, if any.
- Health plan accreditation survey documentation from its most recent survey and documentation provided by the plan for participation in the Department's Health Plan Accreditation Incentive Program, as applicable.

3. MetaStar plans for informing the health plans of the planned on-site audit at least 30 calendar days prior to the visit and of what documentation the plan is to have ready for on-site review activities. Must be clear and specific as to what is required.

4. MetaStar plans for interviews with health plan staff, i.e. scheduling, questions to be used, documentation of activity. Recommend use of Attachment C of **Protocol 1**, but other formats MetaStar may recommend will be considered.

5. MetaStar plans and tools for off-site desk audit activities.

6. MetaStar plans and procedures for handling problems with the audit process itself and potentially serious problems observed or detected.

7. MetaStar plans and timelines for production of reports, including organization of reports, proposed content, review and editing procedures, completion deadlines. All reporting is to be done electronically.

8. MetaStar will provide bi-weekly progress reports to the Department/BMHCP on all **Protocol 1 and 2** review and reporting activities from the implementation of field activities until

acceptance by the Department/BMHCP of the final report for each health plan review under **Protocol 1** and acceptance by the Department of the final report for **Protocol 2**.

9. After the Department/BMHCP approves the final reports, MetaStar will distribute the final reports to the respective health plan contact people.

These materials should be submitted by February 1, 2007, or as soon as they are available.

Subsequent to review by the Department/BMHCP, a meeting to discuss the plans, tools and timelines will be scheduled. Implementation of the action plan will occur thereafter.

Please contact Gary Ilminen, RN at 608.261.7839 or ilmingr@dhfs.state.wi.us with any questions. Contact by e-mail is preferred.

Individual Health Plan
Compliance Report
Executive Summaries

WISCONSIN EXTERNAL QUALITY REVIEW 2007 PROTOCOL 1 REPORT

"MONITORING MEDICAID MANAGED CARE ORGANIZATIONS (MCOS) AND PREPAID INPATIENT HEALTH PLANS (PIHPS):

A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et. al."

PREPARED FOR
ABRI HEALTH PLAN

PREPARED BY

METASTAR

Higher quality. Healthier lives.

WISCONSIN'S EXTERNAL QUALITY REVIEW ORGANIZATION

JULY 2007

REVIEW METHODS

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- Collecting any other accessory information; e.g., from site visits, and
- Analyzing and compiling findings.

DESCRIPTION OF DATA OBTAINED FROM MCOS

MetaStar reviewers utilized a variety of data from the MCOs to determine compliance with regulations. These included documents regarding:

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- Health care access,
- Complaints, grievances and appeals,
- Language access policies and procedures,
- Utilization management,
- Provider/contractor services,
- Enrollee services,
- Contracted or subcontracted vendors,
- Encounter data policies and procedures, and
- Information Systems Capabilities Assessment (ISCA) – if not completed previously

ABRI HEALTH PLAN OVERALL COMPLIANCE RESULTS

MetaStar decided compliance with regulations through document review, interviews and walk-throughs during the on-site review.

ABRI HEALTH PLAN IMPROVEMENTS

- Brought CM program in-house so have tighter control over the quality of care management services their members receive resulting in better outcomes.
- Added the position of Transportation Coordinator to ensure Abri members in Milwaukee County receive timely and appropriate transportation services.
- Health Promotion and Outreach Coordinator visits schools and daycares to educate members on the importance of good dental hygiene. She also participates in community events to perform outreach to pregnant women and mothers.
- Abri implemented its first provider and member satisfaction surveys in 2006.
- A more formal process for monitoring and evaluating subcontractor performance was implemented in 2006.

ABRI HEALTH PLAN STRENGTHS

- Experienced and highly knowledgeable staff at all levels dedicated to improving the quality of care for all Abri members.
- Excellent communication and collaboration between areas/departments. Forward thinking and team approach to problem solving facilitates efficient and effective planning for the future
- Customer Service staff members that are fluent in German and Hmong and Spanish.
- Provision of benefits above and beyond contract requirements when needed to meet a member goal
- Impressive QAPI program and plan
- Keen focus on face to face contact with members in order to build trusting relationships with them, thereby increasing the CMs abilities to get members' needs met.
- CMs highly responsive to member needs. Excellent follow-up to ensure member received needed services.
- Comprehensive Assessments and re-assessments are performed timely.
- IPN has open network to encourage new physicians to join
- Strong, consistent prior authorization system with fast turnaround time of denials
- IVR system makes authorization information easy for providers to access
- Follow up calls to members who have Emergency Room visits
- Excellent documentation standards and practices for call logs and case notes.
- Good relationships with IPN providers, community service providers and area hospitals.

- Superior coordination with Behavioral Health providers and rapid deployment of related services.
- All of Abri's areas/departments and IPN administrators have shared access to a centralized health management system promoting timeliness and continuity of care for members.
- Member of Milwaukee HMOs Collaborative Joint PIP working to improve birth outcomes for the Milwaukee MA/BC population which was selected to be presented at the 2007 Symposium on Best Practices in Medicaid Managed Care Quality Improvement..

ABRI HEALTH PLAN OPPORTUNITIES FOR IMPROVEMENT

- Continue efforts to hire a Spanish speaking Case Manager.
- Continue plans for expansion into additional counties in order to increase SSI members' options for health care service providers.
- Use a PIP report format or tool that helps to ensure all Federal and State requirements for PIP reporting are met.
- Be sure to include in the PIP report sufficient detail information regarding the rationale behind decisions made and the processes used during the course of the PIP.

ABRI HEALTH PLAN AREAS OF PARTIAL COMPLIANCE, REQUIRED CORRECTION AND FOLLOW-UP

Areas of Partial Compliance

There were no areas of partial compliance identified.

Areas of Non-Compliance

There were no areas of non-compliance identified.

ABRI HEALTH PLAN AREAS OF REMAINING NON-COMPLIANCE

There are no areas of remaining non-compliance.

WISCONSIN EXTERNAL QUALITY REVIEW 2007 PROTOCOL 1 REPORT

"MONITORING MEDICAID MANAGED CARE ORGANIZATIONS (MCOS) AND PREPAID INPATIENT HEALTH PLANS (PIHPS):

A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et. al."

PREPARED FOR
CHILDREN'S COMMUNITY HEALTH PLAN

PREPARED BY

METASTAR

Higher quality. Healthier lives.

WISCONSIN'S EXTERNAL QUALITY REVIEW ORGANIZATION

JULY 2007

REVIEW METHODS

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- Utilization management,
- Provider/contractor services,
- Enrollee services,
- Contracted or subcontracted vendors,
- Encounter data policies and procedures, and
- Information Systems Capabilities Assessment (ISCA) – if not completed previously

CHILDREN'S COMMUNITY HEALTH PLAN OVERALL COMPLIANCE RESULTS

MetaStar decided compliance with regulations through document review, interviews and walk-throughs during the on-site review.

CHILDREN'S COMMUNITY HEALTH PLAN IMPROVEMENTS

Not applicable because this was the first year that CCHP was required to undergo a review.

CHILDREN'S COMMUNITY HEALTH PLAN STRENGTHS

- Experienced and highly knowledgeable staff members at all levels are dedicated to improving the quality of care for all CCHP members.
- Excellent communication and collaboration between areas/departments.
- Both the Member Handbook and Provider Manual are very complete and detailed without being overwhelming.
- Documented Policies and Procedures are well written and highly detailed.
- Effective use of outreach calls to new members for initiating contact and building a relationship with the member while identifying primary health care issues.
- Increasing the number of members that receive preventive dental services through promotion of the Clear Path Dental Program
- CCHP makes the final decision for all grievances/appeals and provider applications/credentialing.
- Has built good relationships with area hospitals and providers.
- Receives daily ER reports from all but one are hospital for use in UM activities.
- Consistent follow-up with members identified through having a high number of ER visits and provide education on the appropriate use of ER services.
- Monitors the adequacy of CCHP's provider network on an on-going basis. Actively recruiting all non-network providers practicing in CCHP's service areas.
- Full day Cultural Competency training is mandatory for all new providers and staff.
- Member of Milwaukee HMOs Collaborative Joint PIP working to improve birth outcomes for the Milwaukee MA/BC population.

CHILDREN'S COMMUNITY HEALTH PLAN OPPORTUNITIES FOR IMPROVEMENT

- Continue efforts to hire Spanish speaking staff to perform outreach calls to new members whose primary language is Spanish. (CCHP identified need.)
- Develop a method to begin tracking the number/ percentage of members whose primary language is something other than English, delineated by language spoken.
- Explore the need to have member materials published in Braille. Possibly develop a mechanism for alerting CCHP when it is needed.
- Develop a policy and procedure for ensuring CCHP providers are informing members of their rights. It was suggested that CCHP require providers to have member rights documents signed by the member and placed in the members' charts.
- Develop a mechanism/trigger to indicate when a repeat provider site visit should be performed.
- Continue efforts to develop and implement a member satisfaction survey and member focus groups.
- Find a way to link CCHP's multiple databases so as to avoid duplicative work and reduce the possibility for error.
- Implement a process that ensures all P&Ps are reviewed for potential updates at least annually. Possibly use as an exercise to reinforce training of new staff members.
- Continue efforts to expand CCHP's service area to increase HMO options for MA/BC enrollees in other counties.
- Use a PIP report format or tool that helps to ensure all Federal and State requirements for PIP reporting are met.
- Be sure to include in the PIP report sufficient detail information regarding the rationale behind decisions made and the processes used during the course of the PIP.

CHILDREN'S COMMUNITY HEALTH PLAN AREAS OF PARTIAL COMPLIANCE, REQUIRED CORRECTION AND FOLLOW-UP

Areas of Partial Compliance

Issues

- Change time period for prior authorization decisions from 15 calendar days to 14 calendar days in order to comply with Federal Regulations and WI State Statutes.
- Develop method to inform CCHP members of providers' language capabilities. Recommend adding the information to CCHP's provider directory.
- Develop and implement policies and procedures for performing peer reviews of provider records. (CCHP identified need.)

- Continue process to select practice guidelines appropriate to meet the health care needs of CCHP's members. (CCHP identified need.)

Resolutions

- As of 5/30/2007, CCHP has updated their Denial and Grievance Policies changing the time period for making prior authorization decisions to 14 days.
- CCHP has added a language spoken field to their provider directories and plan to have their database updated with this information by 12/31/2007.
- CCHP policy QI002: Medical Records Maintenance and Access includes CCHP's peer review process. CCHP plans to begin conducting provider reviews in Fall of 2007.
- Preventive care, prenatal care and asthma guidelines will be reviewed at CCHP's 8/9/2007 Medical Advisory Committee meeting and then posted to the website.

Areas of Non-Compliance

Issues

- Develop and implement policies and procedures regarding the use of restraints.
- CCHP must implement a process to disseminate their practice guidelines to all affected providers and make them available, upon request, to enrollees and potential enrollees.

Resolutions

- CCHP has developed a draft policy, MR004: Use of Restraints, which will be presented to the Medical Advisory Committee for approval on 8/9/2007.
- Once approved by CCHP's Medical Advisory Committee the Preventive care, prenatal care and asthma practice guidelines will be posted to the website. The practice guidelines will also be available in hard copy upon request.

CHILDREN'S COMMUNITY HEALTH PLAN AREAS OF REMAINING NON-COMPLIANCE

There are no areas of remaining non-compliance.

WISCONSIN EXTERNAL QUALITY REVIEW 2007 PROTOCOL 1 REPORT

"MONITORING MEDICAID MANAGED CARE ORGANIZATIONS (MCOS) AND PREPAID INPATIENT HEALTH PLANS (PIHPS):

A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et. al."

PREPARED FOR

COMPCARE HEALTH SERVICES

PREPARED BY METASTAR, INC.,
WISCONSIN'S EXTERNAL QUALITY REVIEW ORGANIZATION

JULY 2007

REVIEW METHODS

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- Information Systems Capabilities Assessment (ISCA) – if not completed previously

CompCare Health Services Overall Compliance Results

MetaStar decided compliance with regulations through document review, interviews and walk-throughs during the on-site review.

CompCare Health Services Improvements

- Fourteen CompCare administrative staff have participated in Six Sigma Green Belt training on improvement methodology and leading process improvement or quality improvement activities.
- Implemented the McKesson Disease Management software program enabling quick identification of at-risk members so that the appropriate outreach and follow-up activities are performed.

CompCare Health Services Strengths

- Experienced and highly knowledgeable staff at all levels dedicated to improving the quality of care for all CompCare members.
- Organizational commitment to Six Sigma.
- Software that allows for more complete analysis and comparison of data to identify over/underutilization and practice patterns.
- Member Handbook is available in Spanish, Hmong, and Russian and Somali languages.
- Policy and Procedure, "Member Services: Medicaid Handbooks Non-English" documents the translation and distribution of member handbooks
- Grievance and Appeal letters include language that offers translation services in Spanish, Russian, Hmong and Laotian.
- Risk stratification and case management model to provide assistance to those who need it most
- Follow-up with members having a high number of ER visits, providing education on the appropriate use of ER services and additional case management services as needed.
- Sponsoring the ***Inspiring Healthcare Innovation Grant*** program; supporting health providers and organizations in making significant improvements in healthcare.
- The ***My Health Zone*** web application provides members with useful information, tools and activities supporting their efforts in making healthy lifestyle changes.
- Criteria and evidence based practice for service authorizations and provider review
- A&G member letters are very informative and thorough
- Formally documented process for monitoring of encounter data reporting.

CompCare Health Services Opportunities for Improvement

- Consider adding MA/BC specific information to CompCare's website beginning with the MA/BC Member Handbook and Provider Directory. (CompCare self-identified need.)
- For the next ***Inspiring Healthcare Innovation Grant*** awards think about encouraging providers/organizations to conduct improvement projects targeting CompCare's MA/BC populations.

COMPCARE HEALTH SERVICES AREAS OF REQUIRED CORRECTION AND FOLLOW-UP

Areas of Partial Compliance

There were no areas of partial compliance identified.

Areas of Non-Compliance

There were no areas of non-compliance identified.

COMPCARE HEALTH SERVICES AREAS OF REMAINING NON-COMPLIANCE

There are no remaining areas of non-compliance.

WISCONSIN EXTERNAL QUALITY REVIEW 2007 PROTOCOL 1 REPORT

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A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et. al."

PREPARED FOR
DEAN HEALTH PLAN, INC.

PREPARED BY METASTAR, INC.,
WISCONSIN'S EXTERNAL QUALITY REVIEW ORGANIZATION

JULY 2007

REVIEW METHODS

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NON-DUPLICATION OF MANDATORY ACTIVITIES

Federal Regulations allow for States to reduce duplication of mandatory activities in 42 CFR §438.360, "Nonduplication of mandatory activities." It states that, "To avoid duplication, the State may use, in place of a Medicaid review by the State, its agent, or EQRO, information about the MCO or PIHP obtained from a Medicare or private accreditation review to provide information otherwise obtained from the mandatory activities…."

Health plans in Wisconsin that are fully accredited may apply for the State's HMO Accreditation Incentive Program, which requires plans to submit full copies of all accreditation standards and reports used by the accrediting body in determining accreditation status. In addition, the Plan is required to provide documentation of an assessment of the compliance of the accreditation standards with applicable Medicaid HMO contract provisions, which implement provisions of the Rule. That documentation is provided through the use of the HMO Accreditation Standards Screen, which is completed at the time the Plan applies for the HMO Accreditation Incentive. Pursuant to 42 CFR §438.360 the state has determined the activities documented through the foregoing to be acceptable for external quality review in order to prevent duplication of mandatory activities. MetaStar reviewed those standards, additionally submitted documentation from the plans, and the plan's contracts with the State to determine compliance with Regulations.

Primary source verification of accreditation status:

Here are NCQA's results of your search on:
DEAN HEALTH PLAN, WI

Plan	Product Line/Product	Access & Service	Qualified Providers	Staying Healthy	Getting Better	Living with Illness	Overall Accreditation	Quality Plus Distinction
Dean Health Plan, Inc.	Commercial/HMO	★★★★	★★★★	★★★★	★★★★	★★★★	**EXCELLENT**	

Plan uses these names: **Dean Health Plan HMO**

Compare Selected Plans

Updated as of 6/30/07

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PREPARED FOR

GROUP HEALTH COOPERATIVE OF EAU CLAIRE

PREPARED BY METASTAR, INC.,
WISCONSIN'S EXTERNAL QUALITY REVIEW ORGANIZATION

JULY 2007

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GROUP HEALTH COOPERATIVE OF EAU CLAIRE OVERALL COMPLIANCE RESULTS

MetaStar decided compliance with regulations through document review, interviews and walk-throughs during the on-site review.

GROUP HEALTH COOPERATIVE OF EAU CLAIRE IMPROVEMENTS

- Fourteen GHC-EC employees have participated in Six Sigma Green Belt training on improvement methodology and leading process improvement or quality improvement activities.
- Implemented the ***Journey: Taking Steps to a Healthier You*** program offering discounts to GHC-EC members for local businesses providing health and wellness products or services.
- Implemented the McKesson Disease Management software program enabling quick identification of at-risk members so that the appropriate outreach and follow-up activities are performed.
- GHC-EC achieved the highest rates of any HMO within their service area for the 2006 NCQA CAHPS Survey, receiving a rate of 79.7% for Overall Health Plan and a rate of 86.5 % for Overall Healthcare.

GROUP HEALTH COOPERATIVE OF EAU CLAIRE STRENGTHS

- Experienced and highly knowledgeable staff at all levels dedicated to improving the quality of care for all GHC-EC members.
- Organizational commitment to Six Sigma.
- Software that allows for more complete analysis and comparison of data to identify over/underutilization and practice patterns.
- Member Handbook is available in Spanish, Hmong, and Russian and Somali languages.
- Policy and Procedure, “Member Services: Medicaid Handbooks Non-English” documents the translation and distribution of member handbooks
- Grievance and Appeal letters include language that offers translation services in Spanish, Russian, Hmong and Laotian.
- Risk stratification and case management model to provide assistance to those who need it most
- Follow-up with members having a high number of ER visits, providing education on the appropriate use of ER services and additional case management services as needed.
- Sponsoring the ***Inspiring Healthcare Innovation Grant*** program; supporting health providers and organizations in making significant improvements in healthcare.

- The ***My Health Zone*** web application provides members with useful information, tools and activities supporting their efforts in making healthy lifestyle changes.
- Criteria and evidence based practice for service authorizations and provider review
- A&G member letters are very informative and thorough
- Formally documented process for monitoring of encounter data reporting.

GROUP HEALTH COOPERATIVE OF EAU CLAIRE OPPORTUNITIES FOR IMPROVEMENT

- Consider adding MA/BC specific information to GHC-EC's website beginning with the MA/BC Member Handbook and Provider Directory. (GHC-EC self-identified need.)
- When feasible, consider developing a mechanism to measure member utilization of and satisfaction with the "Journey" discount program. Possibly get names of members from participating businesses then follow-up with a questionnaire to the members.
- For the next ***Inspiring Healthcare Innovation Grant*** awards think about encouraging providers/organizations to conduct improvement projects targeting GHC-EC's MA/BC populations.

GROUP HEALTH COOPERATIVE OF EAU CLAIRE AREAS OF REQUIRED CORRECTION AND FOLLOW-UP

Areas of Partial Compliance

There were no areas of partial compliance identified.

Areas of Non-Compliance

There were no areas of non-compliance identified.

GROUP HEALTH COOPERATIVE OF EAU CLAIRE AREAS OF REMAINING NON-COMPLIANCE

There are no remaining areas of non-compliance.

WISCONSIN EXTERNAL QUALITY REVIEW 2007 PROTOCOL 1 REPORT

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A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et. al."

PREPARED FOR
GROUP HEALTH COOPERATIVE OF SOUTH CENTRAL WISCONSIN

PREPARED BY METASTAR, INC.,
WISCONSIN'S EXTERNAL QUALITY REVIEW ORGANIZATION

JULY 2007

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Primary source verification of accreditation status:

Here are NCQA's results of your search on:
GROUP HEALTH COOPERATIVE OF SOUTH CENTRAL WISCONSIN, WI

Plan	Product Line/Product	Access & Service	Qualified Providers	Staying Healthy	Getting Better	Living with Illness	Overall Accreditation	Quality Plus Distinction
Group Health Cooperative of South Central Wisconsin	Commercial/HMO	★★★★	★★★★	★★★★	★★★★	★★★★	**EXCELLENT**	

Plan uses these names: **Group Health Cooperative**

Updated as of 6/30/07

WISCONSIN EXTERNAL QUALITY REVIEW 2007 PROTOCOL 1 REPORT

"MONITORING MEDICAID MANAGED CARE ORGANIZATIONS (MCOS) AND PREPAID INPATIENT HEALTH PLANS (PIHPS):

A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et. al."

PREPARED FOR
HEALTH TRADITION HEALTH PLAN

PREPARED BY

WISCONSIN'S EXTERNAL QUALITY REVIEW ORGANIZATION

JULY 2007

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- Provider/contractor services,
- Enrollee services,
- Contracted or subcontracted vendors,
- Encounter data policies and procedures, and
- Information Systems Capabilities Assessment (ISCA) – if not completed previously

HEALTH TRADITION HEALTH PLAN OVERALL COMPLIANCE RESULTS

MetaStar decided compliance with regulations through document review, interviews and walk-throughs during the on-site review.

HEALTH TRADITION HEALTH PLAN IMPROVEMENTS

- Organized a Compliance committee which met for the first time in December 2006.
- Adopted NCQA Standards and Guidelines for the Accreditation of MCO's Credentialing/Re-credentialing Guidelines.
- Published an article regarding Advance Directives in their MA/BC Member Newsletter
- Conducted training on Advance Directives for all HTHP staff members.
- Assembled a workgroup to focus expanding the health and wellness information available on HTHP's website, including links to other qualified health related sites.
- Added Mayo Clinic's Medical Emergency Form to the HTHP website, encouraging members to use for keeping loved ones' medical information handy in case of an emergency.

HEALTH TRADITION HEALTH PLAN STRENGTHS

- Experienced and knowledgeable staff dedicated to improving the quality of care for all HTHP members.
- Excellent oversight of subcontracted/delegated responsibilities.
- Follow NCQA standards for Credentialing and Recredentialing.
- Thorough provider site review process even checks handicap accessibility
- Work closely with members and providers to identify and resolve issues as quickly as possible to ensure that members receive timely and appropriate care.
- Emphasis on provider and member education. Utilization of several different venues to convey information including newsletter, website and targeted mailings
- Care managers work collaboratively with members and providers to obtain all information prior to issuance of denial letter
- Comprehensive, yet user-friendly database for grievances and appeals
- Inclusion of translator letter with all member mailings as a repeated reminder to enrollees ensures that their language needs can be met.
- Excellent process for recruiting physician champions, including a documented Physician Champion job description with expectations and projected time commitments giving provider candidates the details necessary for deciding if they are able to take on the additional demands of the role.

- Pediatric Lead Toxicity Screening Reminder PIP chosen to be shared at the Best Practice Seminar, the second year in a row that one of HTHP's PIP was chosen to be presented.

HEALTH TRADITION HEALTH PLAN OPPORTUNITIES FOR IMPROVEMENT

- Add verbiage to HTHP P&P documents ADM 6.1 and ADM 6.2 (Non-ERISA versions) that IRO information is not applicable to MA/BC members.

HEALTH TRADITION HEALTH PLAN AREAS OF PARTIAL COMPLIANCE, REQUIRED CORRECTION AND FOLLOW-UP

Areas of Partial Compliance

Issues:

- Add verbiage to HTHP P&P ADM 6.2 V. Procedure for Expedited Appeals to indicate that expedited/urgent appeals/grievances should be resolved within 2 business days of receipt of the appeal/grievance or sooner, if possible, for MA/BC members.
- Remove/replace outdated version of HTHP MA/BC Provider Directory on HTHP's website.

Resolution:

- HTHP updated P&P ADM 6.2, Section V: Procedure for Expedited Appeals, paragraph D (page 7) to indicate that expedited /urgent appeals/ grievances should be resolved within 2 business days of receipt of the appeal/grievance or sooner, if possible, for MA/BC members. A copy of the updated P&P was submitted to MetaStar on July 18, 2007.
- HTHP has removed the outdated version of the MA/BC Provider Directory from their website.

Areas of Non-Compliance

There were no areas of non-compliance identified.

HEALTH TRADITION HEALTH PLAN AREAS OF REMAINING NON-COMPLIANCE

There are no remaining areas of non compliance.

WISCONSIN EXTERNAL QUALITY REVIEW 2007 PROTOCOL 1 REPORT

"MONITORING MEDICAID MANAGED CARE ORGANIZATIONS (MCOS) AND PREPAID INPATIENT HEALTH PLANS (PIHPS):

A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et. al."

PREPARED FOR
INDEPENDENT CARE HEALTH PLAN

PREPARED BY

WISCONSIN'S EXTERNAL QUALITY REVIEW ORGANIZATION

JULY 2007

REVIEW METHODS

MetaStar, the External Quality Review Organization (EQRO) for Wisconsin's Medicaid program, conducted an independent review of Wisconsin's Medicaid Managed Care Organizations (MCOs). This review was conducted per Federal Regulation 438, Subpart E. In conducting this review, MetaStar used the Final Protocol Version 1.0, "Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et.al."

This review was designed to collect information documenting the effect of MCO practices regarding quality and timeliness of, and access to, care and service provided to Medicaid beneficiaries by Medicaid MCOs.

Per the Protocol, MetaStar used a combination of activities to conduct and complete the review. Activities completed, in order, included:

- Planning for compliance monitoring activities,
- Obtaining background information from the State Medicaid agency,
- Document review,
- Conducting interviews,
- Collecting any other accessory information; e.g., from site visits, and
- Analyzing and compiling findings.

DESCRIPTION OF DATA OBTAINED FROM MCOS

MetaStar reviewers utilized a variety of data from the MCOs to determine compliance with regulations. These included documents regarding:

- General documentation,
- Staff planning, education, development and evaluation,
- Fraud and abuse,
- Quality documentation, policies and procedures (QAPI, PIP),
- Health care access,
- Complaints, grievances and appeals,
- Language access policies and procedures,
- Utilization management,
- Provider/contractor services,
- Enrollee services,
- Contracted or subcontracted vendors,
- Encounter data policies and procedures, and
- Information Systems Capabilities Assessment (ISCA) – if not completed previously

INDEPENDENT CARE HEALTH PLAN (ICARE) OVERALL COMPLIANCE RESULTS

MetaStar decided compliance with regulations through document review, interviews and walk-throughs during the on-site review.

INDEPENDENT CARE HEALTH PLAN IMPROVEMENTS

- Created a separate publication, the SSI Provider Supplement, identifying which ***i***Care providers speak other languages in addition to English. The supplement also identifies providers that have sign language capabilities. The SSI Provider Supplement was mailed to all ***i***Care SSI members in September 2006.
- Added statements to the Enrollee Handbook in Russian and Laotian stating that the handbook is available for translation in these languages
- Have posted their Clinical Practice Guidelines to the ***i***Care website.
- Streamlined their assessment processes and tools so that assessments are completed more efficiently and therefore timely.
- Amended policy CM-004, "Continuity and Coordination of Care" to explicitly state/further clarify 60 day minimum coverage of current medications after date of enrollment
- Revised their appeals and grievances letters per MetaStar reviewers' recommendations after the 2006 review.

INDEPENDENT CARE HEALTH PLAN STRENGTHS

- Experienced and highly knowledgeable staff at all levels is dedicated to improving the quality of care for all ***i***Care members.
- Onsite staff who are bilingual in Spanish, Hmong and Laotian
- Use of Flesch-Kincaid software to check for grade level readability in member informational materials
- Focus on whole person including behavioral health, housing and transportation issues
- Provide additional benefits outside of package that benefit members' overall health.
- High risk team and risk stratification model to provide intensive care management to individuals who need it the most
- Protocol to Contact Hard to Reach Members: Excellent detailed steps including many creative methods of trying to locate members and procedure for documentation
- Protocol for Accessing Emergency Dental Services: Excellent in addressing all types of dental needs (including emergencies) very specifically
- Integrated Case Management Model: includes multidisciplinary team and focuses on those with special needs/high utilization
- Documented Policies and Procedures are very well written and highly detailed.

INDEPENDENT CARE HEALTH PLAN OPPORTUNITIES FOR IMPROVEMENT

- Update all documentation so that "Hearing Committee" (per ***i***Care) is consistently used as the title for the committee responsible for reviewing member grievances and appeals.
- Remove iCare address/contact information from footer on all but last page of multiple-page letters to avoid reader confusion regarding content of letters.
- Add information in Russian to alternative language information and include in all member letters.
- Update Member Handbook, letters and documentation so that title of Medicaid Managed Care Ombudsman and terminology used for appeals, grievances and complaints are consistent within and across all documents.
- Add SSI Managed Care External Advocate contact information to Medicaid G&A member letters.
- Update verbiage used in 2nd paragraph of Medicaid G&A 007 to clarify the action ***i***Care wishes the member to take based on the Hearing Committee's decision. This may require separate statements; one for each possible outcome.
- Correct/update references listed for CM-002 Advance Directives Process P&P.
- Add the contact information for the SSI Managed Care External Advocate (See DHFS "A Guide to the Wisconsin Medicaid Supplemental Security Income (SSI) HMO Programs") to the member handbook.

INDEPENDENT CARE HEALTH PLAN AREAS OF PARTIAL COMPLIANCE, REQUIRED CORRECTION AND FOLLOW-UP

Areas of Partial Compliance

Issues:

1. Medicaid G&A 004 member letter states the time period for an extension of the appeal/grievance review as 15 calendar days.
2. Correct/update information regarding the time period within which a member must request a continuation of benefits after requesting a Fair Hearing in the:
    a. Member Reduction/Termination Letter: states member must notify ***i***Care within 10 days of the notice date to continue current level of service during appeal process.
    b. CM-032 Prior Authorization Process (13.1 and 13.2): length of time services continued while an appeal is pending is given as 10 days.
3. ADM-053 Limited English Proficiency Translation and Interpreter Services: Correct/update information in step #17 (c) which states, "The LEP Coordinator evaluates

language access activities consistent with steps 9 (a) and 9 (b) of this policy." Step #9 does not include an (a) or (b).

Resolution:

1. iCare will change time period for extension of appeal/grievance review in Medicaid G&A 004 member letter to 14 calendar days in order to comply with Federal Regulations and WI State Statutes.

3. ***i***Care will correct/update information regarding the time period within which a member must request a continuation of benefits after requesting a Fair Hearing in the:

c. Member Reduction/Termination Letter: The fact that a benefit will continue during the appeal or DHA fair hearing process if the enrollee requests that it continue within 10 days of receiving the notice of action from ***i***Care or before the effective date of the action, whichever is later

d. CM-032 Prior Authorization Process (13.1 and 13.2): The fact that a benefit will continue during the appeal or DHA fair hearing process if the enrollee requests that it continue within 10 days of notification or before the effective date of the action, whichever is later. And that benefits must be continued until one (1) of the following occurs:

- The enrollee withdraws the appeal.
- A state fair hearing decision adverse to the enrollee is made.
- The authorization expires or the authorization service is met.

2. iCare will clarify the process used by the LEP Coordinator to evaluate language access activities in their ADM-053 Limited English Proficiency Translation and Interpreter Services policies and procedures document.

Areas of Non-Compliance

There were no areas of non-compliance identified.

INDEPENDENT CARE HEALTH PLAN AREAS OF REMAINING NON-COMPLIANCE

There are no areas of remaining non-compliance.

WISCONSIN EXTERNAL QUALITY REVIEW 2007 PROTOCOL 1 REPORT

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A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et. al."

PREPARED FOR MANAGED HEALTH SERVICES

PREPARED BY

WISCONSIN'S EXTERNAL QUALITY REVIEW ORGANIZATION

JULY 2007

REVIEW METHODS

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- Conducting interviews,
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- Quality documentation, policies and procedures (QAPI, PIP),
- Health care access,
- Complaints, grievances and appeals,
- Language access policies and procedures,
- Utilization management,
- Provider/contractor services,
- Enrollee services,
- Contracted or subcontracted vendors,
- Encounter data policies and procedures, and
- Information Systems Capabilities Assessment (ISCA) – if not completed previously

MANAGED HEALTH SERVICES OVERALL COMPLIANCE RESULTS

MetaStar decided compliance with regulations through document review, interviews and walk-throughs during the on-site review.

MANAGED HEALTH SERVICES IMPROVEMENTS

- Implemented a new process utilizing the Predictive Risk Report MHS receives from the State as a pre-screening tool, quickly identifying new SSI members who may require intensive medical care and case management services.
- Condensed the questions on the HRA tool and shortened it from a 44 question survey to only 29 questions.
- Implemented several strategies in order to increase the number of SSI Members they were able to contact and complete an HRA, including:
  - ♦ Having vendors complete HRAs during member visits.
  - ♦ Encouraged MHS staff to request updated demographics on all member encounters and enter the information into the MHS' system.
  - ♦ MHS staff working overtime to search for member phone numbers and attempt to contact members beyond their normal business hours.
  - ♦ Explored other administrative systems as potential sources of enrollee contact information.
- Created the Encounter Submission Summary Report, an "output summary" file used to validate MHS' encounter data submission by comparing it to the State report of the number of MHS records received and processed.

MANAGED HEALTH SERVICES STRENGTHS

- Experienced and highly knowledgeable staff at all levels dedicated to improving the quality of care for all MHS/NHP members. Excellent communication and collaboration between areas/departments.
- Exceptional working relationship with specialty provider groups and collaborating with them on several outreach and improvement projects.
- Close working relationships with subcontracted entities including frequent communication and comprehensive oversight.
- Use of TeleVox software to locate most recent phone number and address for members and to perform automated reminder/ outreach calls to members.
- Member advocates are trained on all product lines and are familiar with each others' cases so they can act as back-up for each other as needed.
- Member advocates meet weekly to discuss open cases and consult with an RN at DHFS and the MCO Ombudsman.

- Member Advocates actively participate in meetings held at various community-based organizations to better understand and focus on issues impacting members.
- Follow-up with members identified as having a high number of ER visits and provide education on the appropriate use of ER services.
- Follow-up with members being discharged from inpatient hospital care to ensure they receive the appropriate transition services and follow-up care.
- Experienced Case Coordination staff who work in collaboration between departments or entities to ensure the care is meeting individualized member needs
- In house resources for staff to utilize in meeting member needs, such as utilization of internal PNCC program for a pregnant SSI member
- Director of Provider Contracting attends UR meetings and uses this information to identify areas where new providers need to be added
- Creative thinking to improve the completion rate of initial Health Risk Assessment.
- 2006 PIP Risk Management Stratification was selected to be presented at the 2007 Symposium on Best Practices in Medicaid Managed Care Quality Improvement.
- Member of Milwaukee HMOs Collaborative Joint PIP working to improve birth outcomes for the Milwaukee MA/BC population also selected to be presented at the 2007 Symposium on Best Practices.

MANAGED HEALTH SERVICES OPPORTUNITIES FOR IMPROVEMENT

- Consider adding more information regarding the member grievances and appeals processes to the Member Handbook.
- Ensure that all P&Ps are reviewed for potential updates at least annually. Possibly use as an exercise to reinforce training of new staff members.

MANAGED HEALTH SERVICES AREAS OF PARTIAL COMPLIANCE, REQUIRED CORRECTION AND FOLLOW-UP

Areas of Partial Compliance

There were no areas of partial compliance identified.

Areas of Non-Compliance

There were no areas of non-compliance identified.

MANAGED HEALTH SERVICES AREAS OF REMAINING NON-COMPLIANCE

There are no areas of remaining non-compliance.

WISCONSIN EXTERNAL QUALITY REVIEW 2007 PROTOCOL 1 REPORT

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A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et. al."

PREPARED FOR
MERCYCARE INSURANCE COMPANY

PREPARED BY METASTAR, INC.,
WISCONSIN'S EXTERNAL QUALITY REVIEW ORGANIZATION

JULY 2007

REVIEW METHODS

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This review was designed to collect information documenting the effect of MCO practices regarding quality and timeliness of, and access to, care and service provided to Medicaid beneficiaries by Medicaid MCOs.

NON-DUPLICATION OF MANDATORY ACTIVITIES

Federal Regulations allow for States to reduce duplication of mandatory activities in 42 CFR §438.360, "Nonduplication of mandatory activities." It states that, "To avoid duplication, the State may use, in place of a Medicaid review by the State, its agent, or EQRO, information about the MCO or PIHP obtained from a Medicare or private accreditation review to provide information otherwise obtained from the mandatory activities…."

Health plans in Wisconsin that are fully accredited may apply for the State's HMO Accreditation Incentive Program, which requires plans to submit full copies of all accreditation standards and reports used by the accrediting body in determining accreditation status. In addition, the Plan is required to provide documentation of an assessment of the compliance of the accreditation standards with applicable Medicaid HMO contract provisions, which implement provisions of the Rule. That documentation is provided through the use of the HMO Accreditation Standards Screen, which is completed at the time the Plan applies for the HMO Accreditation Incentive. Pursuant to 42 CFR §438.360 the state has determined the activities documented through the foregoing to be acceptable for external quality review in order to prevent duplication of mandatory activities. MetaStar reviewed those standards, additionally submitted documentation from the plans, and the plan's contracts with the State to determine compliance with Regulations.

Primary source verification of accreditation status:

Here are NCQA's results of your search on:
MERCYCARE HMO, WI

Plan	Product Line/Product	Access & Service	Qualified Providers	Staying Healthy	Getting Better	Living with Illness	Overall Accreditation	Quality Plus Distinction
MercyCare Health Plans	Commercial/HMO	★★★	★★★★	★★★★	★★★★	★★★★ More Details	**EXCELLENT**	

Plan uses these names: **MercyCare HMO; MercyCare Health Plans**

Updated as of 6/30/07

WISCONSIN EXTERNAL QUALITY REVIEW 2007 PROTOCOL 1 REPORT

"MONITORING MEDICAID MANAGED CARE ORGANIZATIONS (MCOS) AND PREPAID INPATIENT HEALTH PLANS (PIHPS):

A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et. al."

PREPARED FOR
NETWORK HEALTH PLAN

PREPARED BY

WISCONSIN'S EXTERNAL QUALITY REVIEW ORGANIZATION

JULY 2007

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- Conducting interviews,
- Collecting any other accessory information; e.g., from site visits, and
- Analyzing and compiling findings.

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MetaStar reviewers utilized a variety of data from the MCOs to determine compliance with regulations. These included documents regarding:

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- Fraud and abuse,
- Quality documentation, policies and procedures (QAPI, PIP),
- Health care access,
- Complaints, grievances and appeals,
- Language access policies and procedures,
- Utilization management,
- Provider/contractor services,
- Enrollee services,
- Contracted or subcontracted vendors,
- Encounter data policies and procedures, and
- Information Systems Capabilities Assessment (ISCA) – if not completed previously

NETWORK HEALTH PLAN (NHP) OVERALL COMPLIANCE RESULTS

MetaStar decided compliance with regulations through document review, interviews and walk-throughs during the on-site review.

NETWORK HEALTH PLAN IMPROVEMENTS

- Implemented a new process utilizing the Predictive Risk Report NHP receives from the State as a pre-screening tool, quickly identifying new SSI members who may require intensive medical care and case management services.
- Condensed the questions on the HRA tool and shortened it from a 44 question survey to only 29 questions.
- Implemented several strategies in order to increase the number of SSI Members they were able to contact and complete an HRA, including:
    - Having vendors complete HRAs during member visits.
    - Encouraged NHP staff to request updated demographics on all member encounters and enter the information into the NHP's system.
    - NHP staff working overtime to search for member phone numbers and attempt to contact members beyond their normal business hours.
    - Explored other administrative systems as potential sources of enrollee contact information.
- Created the Encounter Submission Summary Report, an "output summary" file used to validate NHP's encounter data submission by comparing it to the State report of the number of NHP records received and processed.

NETWORK HEALTH PLAN STRENGTHS

- Experienced and highly knowledgeable staff at all levels dedicated to improving the quality of care for all NHP members. Excellent communication and collaboration between areas/departments.
- Exceptional working relationship with specialty provider groups and collaborating with them on several outreach and improvement projects.
- Close working relationships with subcontracted entities including frequent communication and comprehensive oversight.
- Use of TeleVox software to locate most recent phone number and address for members and to perform automated reminder/ outreach calls to members.
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- Member advocates meet weekly to discuss open cases and consult with an RN at DHFS and the MCO Ombudsman.

- Member Advocates actively participate in meetings held at various community-based organizations to better understand and focus on issues impacting members.
- Follow-up with members identified as having a high number of ER visits and provide education on the appropriate use of ER services.
- Follow-up with members being discharged from inpatient hospital care to ensure they receive the appropriate transition services and follow-up care.
- Experienced Case Coordination staff who work in collaboration between departments or entities to ensure the care is meeting individualized member needs
- In house resources for staff to utilize in meeting member needs, such as utilization of internal PNCC program for a pregnant SSI member
- Director of Provider Contracting attends UR meetings and uses this information to identify areas where new providers need to be added
- Creative thinking to improve the completion rate of initial Health Risk Assessment.
- 2006 PIP Risk Management Stratification was selected to be presented at the 2007 Symposium on Best Practices in Medicaid Managed Care Quality Improvement.
- Member of Milwaukee HMOs Collaborative Joint PIP working to improve birth outcomes for the Milwaukee MA/BC population also selected to be presented at the 2007 Symposium on Best Practices.

NETWORK HEALTH PLAN OPPORTUNITIES FOR IMPROVEMENT

- Consider adding more information regarding the member grievances and appeals processes to the Member Handbook.
- Ensure that all P&Ps are reviewed for potential updates at least annually. Possibly use as an exercise to reinforce training of new staff members.

NETWORK HEALTH PLAN AREAS OF PARTIAL COMPLIANCE, REQUIRED CORRECTION AND FOLLOW-UP

Areas of Partial Compliance

There were no areas of partial compliance identified.

Areas of Non-Compliance

There were no areas of non-compliance identified.

NETWORK HEALTH PLAN AREAS OF REMAINING NON-COMPLIANCE

There are no areas of remaining non-compliance.

WISCONSIN EXTERNAL QUALITY REVIEW 2007 PROTOCOL 1 REPORT

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A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et. al."

PREPARED FOR
SECURITY HEALTH PLAN

PREPARED BY METASTAR, INC.,
WISCONSIN'S EXTERNAL QUALITY REVIEW ORGANIZATION

JULY 2007

REVIEW METHODS

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Primary source verification of accreditation status:

Here are NCQA's results of your search on:
SECURITY HEALTH PLAN, WI

Plan	Product Line/Product	Access & Service	Qualified Providers	Staying Healthy	Getting Better	Living with Illness	Overall Accreditation	Quality Plus Distinction
Security Health Plan of Wisconsin, Inc	Commercial/HMO	★★★★	★★★★	★★★★	★★★★	★★★★	**EXCELLENT**	
						More Details		
Plan uses these names: **Security Health Plan of Wisconsin; Inc**								
Security Health Plan of Wisconsin, Inc	Medicare/HMO	★★★★	★★★★	★★★★	★★★★	★★★★	**EXCELLENT**	
						More Details		
Plan uses these names: **Advocare**								

Updated as of 6/30/07

WISCONSIN EXTERNAL QUALITY REVIEW 2007 PROTOCOL 1 REPORT

"MONITORING MEDICAID MANAGED CARE ORGANIZATIONS (MCOS) AND PREPAID INPATIENT HEALTH PLANS (PIHPS):

A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et. al."

PREPARED FOR
UNITED HEALTHCARE OF WISCONSIN
AMERICHOICE (SSI EXP.)

PREPARED BY

METASTAR

Higher quality. Healthier lives.

WISCONSIN'S EXTERNAL QUALITY REVIEW ORGANIZATION

JULY 2007

REVIEW METHODS

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UNITED HEALTHCARE OF WISCONSIN OVERALL COMPLIANCE RESULTS

MetaStar decided compliance with regulations through document review, interviews and walk-throughs during the on-site review.

UNITED HEALTHCARE OF WISCONSIN IMPROVEMENTS

- Added a Field-based Outreach Manager and Coordinators to target members their outreach vendor was not able to contact. The Field-based Outreach team activities increased UHC/AC's member contact rate from 36% to 40%.
- Implemented Disease Management Programs designed to facilitate the continuity and coordination of care for members and promote member compliance with comprehensive care measures.
- Implemented new processes allowing SSI members to continue the medications they were taking at the time of enrollment for 90 days (DHFS contract requires 60 days) to ensure continuity of care for SSI pharmacy management.
- Created the Service QI Committee whose purpose is to implement service improvement activities, solicit feedback from enrollees, review and act upon trends in service quality metrics including member surveys, complaints, appeals/grievances, provider surveys and other enrollee or provider input.
- Performed an aggressive outreach campaign to improve blood lead testing for children successfully testing 193 children.
- Held a leadership role in the community Lead Testing subcommittee.

UNITED HEALTHCARE OF WISCONSIN STRENGTHS

- Experienced and highly knowledgeable staff at all levels dedicated to improving the quality of care for all UHC/AC members.
- Excellent communication and collaboration between areas/departments. Team approach to problem solving facilitates efficient and effective planning for the future
- Use of TeleVox software to locate most recent phone number and address for members.
- Specialty Case Managers with expertise in specific clinical/high-risk areas including Maternal & Child Health, AIDS, Behavioral Health, and Domestic Violence.
- Comprehensive Assessments and re-assessments are performed timely. Separate, customized assessments utilized for members with chronic/high-risk conditions.
- Daily consults with United Behavioral Health, their mental health services provider, facilitates superior coordination with Behavioral Health providers and rapid deployment of related services.
- Consistent follow-up with members identified as having a high number of ER visits and provide education on the appropriate use of ER services.

- Member of Milwaukee HMOs Collaborative Joint PIP working to improve birth outcomes for the Milwaukee MA/BC population.
- UHC/AC's Wisconsin provider network is fully credentialed and re-credentialed according to NCQA requirements.

UNITED HEALTHCARE OF WISCONSIN OPPORTUNITIES FOR IMPROVEMENT

- Add verbiage to all grievances and appeals documentation to differentiate between "appeals" and "grievances" as defined by Federal regulations and State statutes.
- Add verbiage to the Provider Manual to differentiate "provider appeals" from "member appeals" and "member grievances" as defined by Federal regulations and State statutes.
- Add verbiage to the Provider Manual to inform providers of their ability to submit appeals and grievances on behalf of members.
- Check all grievances and appeals documentation to verify the timeframes for submission and resolution of appeals and grievances are correct.
- Add the WI MA Ombudsman's and the SSI External Advocate's contact information to the Complaints, Grievances, and Appeals section of the Member Handbook.
- Implement a process that ensures all P&Ps are reviewed for potential updates at least annually. Possibly use as an exercise to reinforce training of new staff members.
- Work on a way to isolate PIP data for UHC/AC's SSI population from data for your MA/BC population so the results will more accurately reflect your performance.

UNITED HEALTHCARE OF WISCONSIN AREAS OF PARTIAL COMPLIANCE, REQUIRED CORRECTION AND FOLLOW-UP

Areas of Partial Compliance

There were no areas of partial compliance identified.

Areas of Non-Compliance

There were no areas of non-compliance identified.

UNITED HEALTHCARE OF WISCONSIN AREAS OF REMAINING NON-COMPLIANCE

There were no areas of remaining non- compliance identified.

WISCONSIN EXTERNAL QUALITY REVIEW 2007 PROTOCOL 1 REPORT

"MONITORING MEDICAID MANAGED CARE ORGANIZATIONS (MCOS) AND PREPAID INPATIENT HEALTH PLANS (PIHPS):

A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et. al."

PREPARED FOR
UNITEDHEALTHCARE OF WISCONSIN, INC.

PREPARED BY METASTAR, INC.,
WISCONSIN'S EXTERNAL QUALITY REVIEW ORGANIZATION

JULY 2007

REVIEW METHODS

MetaStar, the External Quality Review Organization (EQRO) for Wisconsin's Medicaid program, conducted an independent review of Wisconsin's Medicaid Managed Care Organizations (MCOs). This review was conducted per Federal Regulation 438, Subpart E. In conducting this review, MetaStar used the Final Protocol Version 1.0, "Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et. al."

This review was designed to collect information documenting the effect of MCO practices regarding quality and timeliness of, and access to, care and service provided to Medicaid beneficiaries by Medicaid MCOs.

NON-DUPLICATION OF MANDATORY ACTIVITIES

Federal Regulations allow for States to reduce duplication of mandatory activities in 42 CFR §438.360, "Nonduplication of mandatory activities." It states that, "To avoid duplication, the State may use, in place of a Medicaid review by the State, its agent, or EQRO, information about the MCO or PIHP obtained from a Medicare or private accreditation review to provide information otherwise obtained from the mandatory activities…."

Health plans in Wisconsin that are fully accredited may apply for the State's HMO Accreditation Incentive Program, which requires plans to submit full copies of all accreditation standards and reports used by the accrediting body in determining accreditation status. In addition, the Plan is required to provide documentation of an assessment of the compliance of the accreditation standards with applicable Medicaid HMO contract provisions, which implement provisions of the Rule. That documentation is provided through the use of the HMO Accreditation Standards Screen, which is completed at the time the Plan applies for the HMO Accreditation Incentive. Pursuant to 42 CFR §438.360 the state has determined the activities documented through the foregoing to be acceptable for external quality review in order to prevent duplication of mandatory activities. MetaStar reviewed those standards, additionally submitted documentation from the plans, and the plan's contracts with the State to determine compliance with Regulations.

Primary source verification of accreditation status:

Here are NCQA's results of your search on:
UNITEDHEALTHCARE OF WISCONSIN, WI

Plan	Product Line/Product	Access & Service	Qualified Providers	Staying Healthy	Getting Better	Living with Illness	Overall Accreditation	Quality Plus Distinction
UnitedHealthcare of Wisconsin, Inc.	Commercial/HMO/POS Combined	★★★★	★★★★	★★★★	★★★★	★★★★	EXCELLENT	

Updated as of 6/30/07

WISCONSIN EXTERNAL QUALITY REVIEW 2007 PROTOCOL 1 REPORT

"MONITORING MEDICAID MANAGED CARE ORGANIZATIONS (MCOS) AND PREPAID INPATIENT HEALTH PLANS (PIHPS):

A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et. al."

PREPARED FOR
UNITY HEALTH INSURANCE

PREPARED BY METASTAR, INC.,
WISCONSIN'S EXTERNAL QUALITY REVIEW ORGANIZATION

JULY 2007

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Primary source verification of accreditation status:

Here are NCQA's results of your search on:
UNITY HEALTH PLAN, WI

Plan	Product Line/Product	Access & Service	Qualified Providers	Staying Healthy	Getting Better	Living with Illness	Overall Accreditation	Quality Plus Distinction
Unity Health Plans Insurance Corporation	Commercial/HMO/POS Combined	★★★★	★★★★	★★★★	★★★★	★★★★	EXCELLENT	

Updated as of 6/30/07

2007 CARE MANAGEMENT REVIEW
MEDICAID MANAGED CARE
SSI HMO SERVICES

EXECUTIVE REPORT

PREPARED FOR

THE STATE OF WISCONSIN
DEPARTMENT OF HEALTH AND FAMILY SERVICES
DIVISION OF HEALTH CARE FINANCING
BUREAU OF MANAGED HEALTH CARE PROGRAMS

PREPARED BY

WISCONSIN'S EXTERNAL QUALITY REVIEW ORGANIZATION

AUGUST 2007

SECTION ONE: PROCESS SUMMARY

A. External Quality Review Organization (EQRO) Information

EQRO	EQRO Management
MetaStar, Inc. Suite 300 2909 Landmark Place Madison, Wisconsin 53713	Sherrel Walker, RN, MPH, CPHQ Vice President for Managed Health and Long Term Care Services
	Theresa R. Fleck, BS, BS HMO Quality Lead Katy Geiger, RN, BSN MCO Quality Lead

B. SSI Care Management Review (CMR) Team Composition

MetaStar Staff Member	Roles
Lynn Polacek	• RN Reviewer • Participated in all of the on-site reviews. • Assisted with preparation of the initial CMR reports.
Katy Geiger	• RN Reviewer • Participated in the ***i***Care on-site review • Assisted with preparation of the initial CMR reports.
Mary Verberkmoes	• RN Reviewer • Participated in the MHS/NHP and Abri on-site reviews.
Jenny White	• RN Reviewer • Participated in the MHS/NHP and Abri on-site reviews.
Theresa R. Fleck	• Reviewer • Participated in all of the on-site reviews. • Assisted with preparation of the initial CMR reports.
Rachel Smith	• Reviewer • Participated in all of the on-site reviews.
Sherrel Walker	• Participated in the UHC/AC and MHS/NHP on-site reviews. • Assisted with preparation of the initial and final CMR reports
Danielle Sersch	• Administrative Assistant • Entered review data from abstraction tools into CMR database • Assisted with preparation of the initial CMR reports
Dan Mohr	• Administrative Assistant • Assisted with preparation of the initial CMR reports

C. Review Objective

Background

This report summarizes the key findings from the 2007 Care Management Review that MetaStar, Inc., conducted of the SSI Managed Care Programs in the State of Wisconsin.

Department of Health and Family Services (DHFS) authorized MetaStar to conduct a review of Health Maintenance Organizations (HMOs) contracted to provide services to the State's SSI population. MetaStar's responsibilities were to review, analyze and evaluate aggregated information about the care management services furnished to individuals enrolled in the SSI state funded programs.

For 2007, the following HMOs were reviewed:

- **Abri Health Plan (Abri)**
- **Independent Care Health Plan (*i*Care)**
- **Managed Health Services (MHS)**
- **Network Health Plan (NHP)**
- **United Healthcare of Wisconsin/AmeriChoice (UHC/AC)**

As defined in the Contract for Medicaid Services between the SSI HMOs and the Wisconsin DHFS, the HMOs will provide care coordination and case management services according to the contract's definition of care coordination. These services are to integrate the care coordination processes in response to a client's needs and strengths to ensure the achievement of desired outcomes and the effectiveness of services. Each HMO must have written guidelines in place which direct their care management program.

The review was to determine the HMO's level of compliance with the 2007 SSI HMO Services contract and evaluate whether care management systems are working as they were intended. The review was also to determine whether the HMO is working with members to identify the outcomes that members want and the resources they need to achieve them.

D. Review Methodology

The DHFS sent enrollment data files to MetaStar that contained member information for the SSI HMOs. For each HMO, MetaStar randomly selected thirty SSI members who were enrolled in the HMOs between January 1, 2004 and December 31, 2006. MetaStar conducted a case record review for each of the selected members at each HMO's office.

The review team was comprised of licensed registered nurses as well as other degreed professionals with experience working with frail elderly and physically and developmentally disabled individuals as well as persons with mental health diagnoses. All reviewers were trained to use the care management review tool and reviewer guidelines.

The review focus was on the following four elements of care management and coordination of care as defined by Federal Regulations and the 2007 SSI HMO Contract.

1. Assessment
2. Service Planning
3. Service Coordination and Delivery
4. Participant Centered Focus

Data and information sources for the review included but were not limited to:

- administrative data (e.g. membership and enrollment files, claims data),
- the completed comprehensive assessment and/or care plans,
- utilization and outcome information on members and
- case/progress notes

At the end of the record review, MetaStar reviewers spoke with HMO staff about trends and patterns observed during the record review. The trends and patterns provided a link between the HMO's care management practices, their policies and the Federal Regulations for Medicaid managed care. MetaStar reviewers also shared identified strengths and opportunities for areas of improvement.

E. Reporting and Follow-Up

Each of the SSI HMOs was given thirty (30) business days to review and respond to the initial report of MetaStar's findings from the review of their Care Management processes. One SSI HMO, Abri, had no comments. The comments, corrective action plans, and additional information (where submitted) of the remaining four HMOs have been incorporated in their individual, final reports.

MetaStar auditors will review and verify the activities and processes included in the HMOs' corrective actions as part of their 2008 External Quality Reviews for compliance with the CMS Protocols. In the case of Abri, MetaStar auditors will review and verify any activities and

processes implemented as improvements and/or corrective actions taken as a result of this review during Abri's 2008 External Quality Review for compliance with the CMS Protocols.

SECTION TWO: REVIEW FINDINGS AND ANALYSIS

Below is a summary of the review findings. MetaStar used a four-point system (met, partially met, not met, and not applicable) to rate the HMO's performance for each element of care management and coordination evaluated. In addition, for findings of "not met", the reviewers noted the key areas related to the finding and provided comments to identify the missing requirements.

A. Assessment Indicator Descriptions and Findings

Timeliness of Initial Assessment

Requirement: To be considered timely, the initial assessment is to be completed within 60 calendar days of the member's enrollment in the SSI HMO. The following table displays each of the HMOs' findings.

Table A.1: Timeliness of Completion of the Initial Enrollment Assessment

Timeliness Of Initial Assessment	Met #	Met %	Partially Met #	Partially Met %	Not Met #	Not Met %	Not Applicable
Abri Health Plan	16	53.3%	14	46.7%	0	0%	0
Independent Care (*i*Care)	25	83.3%	4	13.3%	1	3.3%	0
Managed Health Services	7	24.1%	20	69.0%	2	6.9%	1
Network Health Plan	8	26.7%	21	70.0%	1	3.3%	0
United Healthcare	4	13.3%	20	66.7%	6	20.0%	0

It should be noted that *i*Care has a higher number of completed initial assessments due to the rollover into the SSI program of members whom they were already serving. Of the thirty (30) records reviewed for *i*Care, only eight (8) members were new to the HMO.

The following table shows a breakdown of the timeliness for completion of the initial assessment for those eight (8) new members versus the twenty-two (22) existing members that rolled over to *i*Care's SSI plan. While looking at the data this way gives a more realistic picture of iCare's performance, *i*Care's completion rate remains impressive as compared to the other HMOs.

Table A.1.a: iCare's Timeliness of Completion of the Initial Assessment – Roll-Over vs. New Members

Timeliness Of Initial Assessment	Met #	Met %	Partially Met #	Partially Met %	Not Met #	Not Met %	Not Applicable
iCare - New Members	4	50.0%	3	37.5%	1	12.5%	0
iCare Roll-over Members	21	95.5%	1	4.5%	0	0%	0

Comprehensiveness of Initial Assessment

Requirement: The assessment was comprehensive when it contained all of the following information:

- Diagnoses and health related services
- Mental health and substance use
- Demographic information (including ethnicity, education, living situation/housing, legal status)
- Activities of daily living (including bathing, dressing, eating)
- Instrumental activities of daily living (including medication management, money management, and transportation)
- Overnight care and employment
- Communication and cognition (ability to communicate, memory)
- Indirect supports (family, social and community network)
- General health and life goals

Table A.2: Comprehensiveness of the Initial Assessment

Comprehensiveness Of Initial Assessment	Met		Partially Met		Not Met		Not Applicable
	#	%	#	%	#	%	
Abri Health Plan	16	59.3%	2	7.4%	9	33.3%	3
Independent Care (***i***Care)	3	10.3%	26	89.7%	0	0%	1
Managed Health Services	8	61.5%	5	38.5%	0	0%	17
Network Health Plan	10	76.9%	3	23.1%	0	0%	17
United Healthcare	3	21.4%	11	78.6%	0	0%	16

The primary reasons for records receiving a "partially met" rating were that some sections of the assessment had not been completed or contained insufficient information and that the member's employment status and/or life goals had not been identified and/or documented. A causal factor for some of the HMOs may be that their assessment tools do not contain questions/fields to capture this information or their policies and procedures for completing initial assessments on members does not clearly instruct the care managers on how and where to document this information.

The nine (9) records that received a "not met" rating are due to Abri case managers, having failed to make direct contact with these members, performed the assessments solely through reviewing the members' claims data. The 2007 SSI HMO contract requires the HMO to make direct contact with the member in order to complete the assessment. Without direct contact with the member it is not possible for the case manager to meet the majority of the criteria for a comprehensive assessment. The 2007 contract also requires the HMO to submit detailed reports of member assessments to the Department. Assessments based on claims data only should not be reported as having been completed since no contact with the member has been made.

Re-Assessment Done When Indicated

Requirement: Re-assessment was done at least annually or when medically indicated. The HMO is to have a documented definition regarding when the re-assessments should be performed based on health and/or medical indication.

Table A.3: Re-Assessment Done When Indicated

Re-Assessment Done When Indicated	Met		Partially Met		Not Met		Not Applicable
	#	%	#	%	#	%	
Abri Health Plan	10	55.6%	6	33.3%	2	11.1%	12
Independent Care (***i***Care)	22	88.0%	2	8.0%	1	4.0%	5
Managed Health Services	0	0%	1	100%	0	0%	29
Network Health Plan	1	20.0%	1	20.0%	3	60.0%	25
United Healthcare	0	0%	1	100%	0	0%	29

The majority of records that received a "partially met" rating were due to the HMOs' inability to contact the members either because of inaccurate member contact information or the members did not respond to the HMOs' attempts to make contact.

The records that received "not met" ratings were primarily due to the HMO's lack of a policy and procedure for performing an annual assessment or because the assessment had been solely performed through a claims data review.

Summary

Contacting new SSI enrollees has proven to be a challenge for all of the SSI HMOs. Inaccurate member contact information at the time of enrollment and/or the enrollees' unresponsiveness to HMO contact attempts created barriers to completing the initial assessment within 60 days of enrollment.

In one case, the difficulty NHP experienced in trying to contact the member was exacerbated by the fact that the member had two different Medicaid identification numbers (MAID) in the States eligibility system, EDSNet. The member had been simultaneously enrolled in NHP under one MAID and Abri Health Plan under the other MAID. NHP had not been able to contact the member until April 2007 when a community advocate called them on behalf of the member with questions regarding the member's insurance coverage. It was during this discussion that NHP learned that the member had been receiving services through Abri and, through subsequent research learned of the multiple MAID issue. It is unknown how often situations like this occur and, if not currently under investigation; it may warrant further research by the HMOs and/or the DHFS/BMHCP.

All HMOs have detailed policies and procedures for contacting new enrollees through similar processes: making a certain number of telephone calls and then sending a letter to the enrollee. However, it was evident that these processes were not always being followed or closely monitored. In addition, the policy at several of the HMOs was to consider a case closed if, after making the aforementioned calls and sending letters, there was no response from the enrollee. It was found that a time period of 10 months to over a year could pass before a repeat attempt was

made to contact the enrollee. This was true even for those HMOs that had policies in place stating that the re-attempt to contact enrollees should occur more frequently.

It is important to note that the HMOs who appear to have the highest success rate for contacting enrollees have initiated additional contact attempts of making unannounced home visits to the enrollee's last known address.

B. Service Planning Indicator Descriptions

Timeliness of Most Recent Care Plan

Requirement: Developing a member centric care plan is a key component to providing services that meet enrollees' health and social needs. To meet the timeliness criteria, the care plan must be updated at least annually (13 months was used for the review) and when medically indicated. The table below displays the HMOs' results.

Table B.1: Timeliness of Most Recent Care Plan

Timeliness Of Most Recent Care Plan	Met		Partially Met		Not Met		Not Applicable
	#	%	#	%	#	%	
Abri Health Plan	15	83.3%	0	0%	3	16.7%	12
Independent Care (*i*Care)	28	96.6%	0	0%	1	3.5%	1
Managed Health Services	5	45.5%	3	27.3%	3	27.3%	19
Network Health Plan	9	69.2%	1	7.7%	3	23.1%	17
United Health Care	4	36.6%	0	0%	7	63.6%	19

Once an assessment was completed, most of the HMOs had processes in place that supported the completion of a care plan. One HMO did not have a care plan template in place requiring staff to document care plans in case notes. This may explain why there was a low rate of care plan completion. Charts were considered not applicable (N/A) when the HMO was not able to contact the enrollee to complete an assessment or the enrollee had disenrolled. Some HMOs were found to be completing initial care plans based on claims data when they had been unable to contact the enrollee to complete an assessment.

Comprehensiveness of Most Recent Care Plan

Requirement: The care plan included all of the following:

- Appropriate medical or health services that are consistent with PCP's clinical treatment plan and medical diagnoses
- Appropriate social services
- Reflection of the principles of recovery (self direction, individualized and person centered, empowerment, holistic, non linear, strengths based, peer support, respect, responsibility, and hope)
- Cultural sensitivity

Table B.2: Comprehensiveness of Most Recent Care Plan

Comprehensiveness Of Most Recent Care Plan	Met		Partially Met		Not Met		Not Applicable
	#	%	#	%	#	%	
Abri Health Plan	14	77.8%	3	16.7%	1	5.6%	12
Independent Care (*i*Care)	24	85.7%	4	14.3%	0	0%	2
Managed Health Services	6	54.6%	3	27.3%	2	18.2%	19
Network Health Plan	7	63.6%	3	27.3%	1	9.1%	19
United Health Care	4	36.4%	0	0%	7	63.6%	19

Care plans, where they existed, were generally found to be comprehensive, focusing for the most part on health and medical needs.

C. Service Coordination and Delivery Indicator Descriptions

Evidence that authorized services are implemented

Requirement: There was evidence in the claims data or case notes to indicate that authorized services have been implemented. The table below displays the HMOs' results.

Table C.2: Evidence that Authorized Services Were Delivered

Evidence that Authorized Services are Implemented	Met		Partially Met		Not Met		Not Applicable
	#	%	#	%	#	%	
Abri Health Plan	26	100%	0	0%	0	0%	4
Independent Care (*i*Care)	21	87.5%	2	8.3%	1	4.2%	6
Managed Health Services	18	90.0%	2	10.0%	0	0%	10
Network Health Plan	19	100%	0	0%	0	0%	11
United Healthcare	27	100%	0	0%	0	0%	3

For all of the HMOs, evidence was found of authorized services being implemented. Claims data demonstrate that members are accessing services and the HMOs are authorizing payment for services even if the HMO has been unable to contact the member for an assessment. A few records were found where the enrollee had no contact with the HMO nor had any claims been processed.

D. Participant Centered Focus Indicator Descriptions

Enrollee/Guardian Included In Planning

Requirement: The care plan was developed in consultation with the enrollee and the enrollee's legal guardian, if appropriate, with the enrollee having opportunity to provide input. Documentation of this was found in the enrollee's record or the care plan. The following table on displays the HMOs' results.

Table D.1: Enrollee/Guardian Included In Planning

Enrollee/Guardian Included in Planning	Met		Partially Met		Not Met		Not Applicable
	#	%	#	%	#	%	
Abri Health Plan	18	100%	0	0%	0	0%	12
Independent Care (*i*Care)	27	93.1%	2	6.9%	0	0%	1
Managed Health Services	8	88.9%	0	0%	1	11.1%	21
Network Health Plan	11	100%	0	0%	0	0%	19
United Health Care	4	100%	0	0%	0	0%	26

For enrollees with care plans in place, evidence was found in the case notes demonstrating enrollees' involvement in planning their services. Records were considered N/A if an assessment had never been completed, if they had refused case management or a care plan had not been completed at the time of the review.

Member Preferences/Outcomes Incorporated Into Care Plan

Requirement: All member preferences/outcomes were incorporated into the plan. If the member disagrees with the care plan, the HMO has documented the areas and reasons for the disagreement in the care plan as well as how the care plan will be implemented given the disagreement.

Table D.2: Member Preferences/Outcomes Incorporated Into Care Plan

Member Preferences/ Outcomes Incorporated Into Care Plan	Met		Partially Met		Not Met		Not Applicable
	#	%	#	%	#	%	
Abri Health Plan	18	100%	0	0%	0	0%	12
Independent Care (*i*Care)	24	82.8%	5	17.2%	0	0%	1
Managed Health Services	7	77.8%	1	11.1%	1	11.1%	21
Network Health Plan	11	100%	0	0%	0	0%	19
United Health Care	4	100%	0	0%	0	0%	26

Two HMOs did a better job of including the enrollee's social needs and outcomes in their care plans. Both HMOs have policies and procedures and/or care management tools that require these elements to be included in members' care plans.

Notice of Action Issued In a Timely Manner When Indicated

Requirement: The Notice of Action was sent at least 10 calendar days prior to the effective date of the reduction, denial or termination of service (a.k.a. Adverse Action).

Table D.3: Notice of Action Issued In a Timely Manner When Indicated

Notice Of Action Issued In A Timely Manner When Indicated	Met		Partially Met		Not Met		Not Applicable
	#	%	#	%	#	%	
Abri Health Plan	1	100%	0	0%	0	0%	29
Independent Care (*i*Care)	2	100%	0	0%	0	0%	28
Managed Health Services	0	0%	0	0%	0	0%	30
Network Health Plan	2	66.7%	0	0%	1	33.3%	27
United Health Care	1	100%	0	0%	0	0%	29

Only seven (7) out of the total one hundred fifty (150) records reviewed for all of the SSI HMOs contained situations where the HMO was required to send a Notice of Action letter to a member. Evidence was found in six (6) of the records that the Notice of Action letters had been sent within the required timeframe. The one (1) record that received a "not met" rating was because the Notice of Action letter had not been sent within the required timeframe.

SECTION THREE: CONCLUSIONS

The MetaStar reviewers did not find any health or safety concerns in the records that were reviewed.

All the HMOs have experienced and highly knowledgeable staff at all levels dedicated to improving the quality of care for all of their members. They were all extremely interested in any suggestions that would assist them with improving their care management and coordination processes.

The biggest challenge facing the HMOs is the inability to make contact with the majority of new and existing members. The HMOs reported contact success rates ranging from 37% to 50%, implying that the health/wellness status of majority of SSI population in the HMOs' service areas is not being assessed, nor are these members receiving case management services. However, it appears that most SSI enrollees are receiving services of some kind, as evidenced by claims data.

The HMOs that appear to have the greatest success in making and maintaining contact with their members are those with local outreach staff and care management staff who focus on making face-to-face contact with their clients.

The HMOs that had the most comprehensive assessments and care plans have policies and procedures and/or care management tools that guide the care manager/coordinator through the critical elements and require the assessments/care plans to be documented in the members' record.

It was discussed at a meeting between MetaStar and DHCF Administration that it would be helpful to HMOs for DHFS to hold a Symposium on Best Practices in Care Management, similar to the one they hold for Best Practices in Quality Performance Improvement. MetaStar highly recommends that the DHCF move forward with this idea as it would be a valuable resource for the HMOs, which could exponentially increase the speed at which improvements are made in the quality of care received by SSI members.