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External Quality Review
State of Connecticut

WellCare of Connecticut, Inc.

Draft

MERCER
Government Human Services Consulting

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Executive Summary

The State of Connecticut (State), Department of Social Services (DSS), has contracted with Mercer Government Human Services Consulting (Mercer) to be the State's External Quality Review Organization (EQRO). As required in 42CFR Part 438, Subpart E, Mercer completed an External Quality Review (EQR) of the managed care organization (MCO), WellCare of Connecticut, Inc., Preferred*One* (WellCare), formerly known as FirstChoice Health Plan in their regional office in North Haven, Connecticut on July 20, 2006. Annual EQRs are done in a three-year cycle; 2006 is the third year in the current cycle. During the first year, a comprehensive EQR was done; MCO compliance with all regulations related to the Balanced Budget Act of 1997 (BBA) was assessed. In 2007, the first year of a new three-year cycle the EQR will once again be comprehensive.

The content of this EQR included:

- implementation by WellCare of its corrective action plan (CAP) related to recommendations from the EQR of 2005;
- compliance of WellCare with Federal Medicaid Managed Care regulations and State standards relating to quality, timeliness, and access to services;
- performance improvement projects (PIPs) validation;
- performance measure (PM) validation;
- PM calculation; and
- at the request of DSS, WellCare's compliance with Healthcare For Uninsured Kids and Youth (HUSKY) B contractual requirements.

The following include the strengths of WellCare identified during the EQR, as well as recommendations for improvement in areas of weakness. Detailed information about each area can be found in the body of this report.

Strengths

The strengths of WellCare are:

- It is a part of a corporate health care company that is dedicated to providing health care services through government sponsored programs and as such, has a strong quality program focused on Medicaid populations. It provides national support for organizational policies, quality improvement (QI) programs, network management processes and practices, a 24-hour nurse advice line, and to their offices in North Haven, Connecticut information systems data management.
- The Credentialing and Recredentialing processes are well-organized and timely.
- Overall, the PIPs are well-documented, the progression of results can be tracked over time and the data methodology for PIPs is basically sound.

Recommendations

1. Develop and evaluate annually a Network Adequacy Plan incorporating the five Federally required elements.
2. Identify more accurate network adequacy ratios and mileage accessibility by conducting GeoAccess studies using appropriate populations. Expand monitoring efforts to availability measures and wait time determinations for high volume specialty providers to determine network adequacy.
3. Expand follow-up activities related to measuring timeliness and availability standards of primary care physician offices including primary verification of self reported data, to ensure they are adequate.
4. Revise Policy C12BL-BL48 (Healthcare For Uninsured Kids and Youth (HUSKY) B Billing and Payments) to comply with HUSKY B regulation wording.
5. Include information about the American Indian/Alaskan Native exclusion from premiums and co-payments in Member Handbook.
6. Conduct an analysis of encounter data for 15 – 20 year olds to determine the quantity and types of outpatient, provider office visits, and other health services (such as pregnancy services) that they may be receiving.
7. Continue to strategize ways of collaborating with community resources and provider networks to increase screening percentages for required EPSDT health screens for adolescents 15 –18 and for dental services in all age categories.
8. Monitor case manager documentation to ensure that policies related to CM case triggers, identification, and referral of cases are being followed and timely enrollment into CM occurs.

9. Enhance CM documentation.
10. Provide details particular to each request for service authorization in the explanation of the reason for an action taken by WellCare when preparing notices of action (NOA). Use layperson wording (seventh grade reading level) rather than clinical language in the NOA.
11. For performance improvement projects:
    - Update the rationale for the PIPs with new data from the health plan and current literature support for continuing the study on an annual basis.
    - Conduct an in-depth analysis of barriers related to the non-compliant population to formulate appropriate interventions to improve the results.
    - Add analysis documentation that describes techniques used for barrier analysis and specify what interventions are planned and implemented to address each barrier.
    - Evaluate benchmarks and attempt to use more comparable geographical or national norm data. Expand analysis to include interpretation of success compared to updated benchmark. Indicate the rationale for choosing benchmarks in the documentation of all studies.
12. For validation of performance measures:
    - Thoroughly review the SAS programming code for the Asthma Medications' measure and implement the updates as appropriate.
    - Expand measurement documentation for the EPSDT, Newborn Intensive Care Unit (NICU) Days, and Prenatal/Postpartum Care measures.
13. For the calculation of performance measures:
    - Evaluate prenatal care standards to identify barriers to decreasing NICU rates.
    - Continue breast cancer screening efforts and explore other options for increasing their mammogram compliance rate.

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Introduction

Federal regulations require that each state, that contracts with managed care organizations (MCOs) to deliver care to its Medicaid enrollees, have an independent External Quality Review Organization (EQRO) validate performance improvement projects (PIP) and performance measures (PM) done by the MCOs. An External Quality Review (EQR) is also required. The State of Connecticut (State), Department of Social Services (DSS) requested that Mercer Government Human Services Consulting (Mercer) complete an EQR of the MCOs who deliver services to Enrollees of the State's Medicaid HUSKY A program. Compliance with the HUSKY B contractual requirements was also included in the EQR.

Mercer requested certain documentation from each of the MCOs, which was reviewed prior to an on-site component of the Review. A list of the specific documents can be found in Appendix A of this report. The EQRO team interviewed WellCare staff in the organization's North Haven offices on July 20, 2006. Mercer used this process to understand WellCare's operations and how they contributed to compliance with federal regulations.

The information obtained from the documentation and interviews was not independently verified or audited by Mercer, other than as described in this report.

Nationally, WellCare is a health plan located in seven states that is dedicated to government-sponsored programs such as Medicare, Medicaid, and State Children's Health Insurance Programs. Their corporate headquarters is based in Tampa, Florida. Locally, in 2005, WellCare served 8 counties in Connecticut and had approximately 37,000 members enrolled in the combined HUSKY A (Medicaid – 35,000) and HUSKY B (S-Chip – 2,100) products. The health plan's provider network consists of 1,300 contracted primary care providers (PCPs), 3,000 specialty providers, and 22 hospitals. The company has approximately 75 personnel working in its North Haven office. Nationally, it operates its own integrated information systems and service platform that allows for regional and national data management for its provider network, quality improvement (QI) programs, and grievance and appeals monitoring.

WellCare subcontracts administrative and provider network service responsibilities with two entities – OptiCare for vision services and BeneCare for dental services.

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Methodology

As a consulting firm, Mercer has access to individuals with expertise in a variety of fields. For this EQR process, Mercer chose a specifically designated team with a variety of specialties, including clinical, analytical, coding, and information systems personnel, with talents that met the requirements of the EQR process.

The methodology used by Mercer during this review process was organized into five critical phases presented in the following diagram.

Request for Information

Mercer used the MCO Request for Information (RFI), designed by Mercer and modified to meet the needs of DSS to acquire information specific for all areas of the review. The specified information, such as policies and procedures (P&Ps), enrollee documents, and copies of program descriptions/evaluations were sent to Mercer prior to the on-site review. From the information received, Mercer identified records/files to be pulled for the on-site review relating to compliance, case management (CM), provider credentialing, and enrollee denials/appeals documentation.

Desk Review

Mercer reviewed all documents submitted by WellCare over a series of weeks. Mercer developed and utilized a comprehensive EQR Compliance Review tool, adapted from the Centers for Medicare & Medicaid Services (CMS) protocols to assess compliance. The tool was tailored to meet the specific reporting requirements and to address the key issues and priorities of DSS. The tool assisted the reviewers in grouping documents according to processes related to the main areas of the third year review. The focus of the desk review was to:

- assess the extent to which WellCare had implemented its corrective actions related to recommendations from the previous year's EQR;
- identify general compliance with both the Balanced Budget Act of 1997 (BBA) and State-contractual rules and regulations for timeliness of, and access to, covered services; and
- identify compliance with State contractual requirements for the HUSKY B and the HUSKY Plus populations, CM procedures and documentation, and the adequacy of the specialty provider network.

The information gleaned from the desk review assisted Mercer in focusing on-site observations and interviews in areas where additional information was needed. A listing of all material reviewed for the compliance review can be found in Appendix A.

On-Site Review

The compliance and performance improvement on-site review took place on July 20, 2006 (see agenda in Appendix B for a complete listing of the interview groupings and sequencing.). The on-site review began with a combined introductory session with all appropriate WellCare staff. WellCare executives provided an overview of the organization, its strategic plan for providing care services, and commentary and progress made correcting areas of improvement since the last EQR. During the sessions that followed, the reviewers conducted more focused interviews with staff and completed CM, credentialing, and grievance and appeals file reviews. The interviews again followed the major areas of required review – implementation of corrective actions, the quality and timeliness of, and access to, covered services as required by the State contract; and compliance with requirements for the HUSKY B and HUSKY Plus populations.

In following this sequence, Mercer complied with CMS regulations to conduct the EQR in a logical fashion that assisted in assessing WellCare's overall performance and its compliance with federal and State rules and regulations. Many of the interview groups were multidisciplinary and reflected the flow of processes conducted by various departments in delivering information, education, and health care services to its Medicaid enrollees.

At the end of the review phases, a comprehensive analysis was conducted of the information obtained from all activities. The results of this analysis make up this report and are written in a format consistent with federal protocols to easily identify compliance with BBA standards, as written in the *Federal Register*, June 14, 2002.

To summarize, Mercer followed CMS' protocol for monitoring Medicaid MCOs for all review areas and used the required seven activities:

1. planning for compliance monitoring activities;
2. obtaining background information from the State Medicaid Agency;
3. documenting the review;
4. conducting interviews;
5. collecting any other accessory information;
6. analyzing and compiling findings; and
7. producing a report which contains the final analysis and findings of the review.

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Compliance with Federal Medicaid Managed Care Regulations — Review of 2005 Corrective Action Plan

Enrollee Rights and Protection

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations from 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Enrollee Rights and Protection	Written notice of termination of a contracted provider is provided within 15 days after receipt of issuance of the termination notice, to each enrollee who receives his/her primary care from, or is seen on a regular basis implemented for PCPs, but not for specialists. Define the process of notifying enrollees about their terminated specialists within 15 days by including in a policy and in the provider manual.	Policy development, review of internal and external communication materials.	Partially Met Met

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations from 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Comments: A policy has been developed, approved, and implemented which outlines the process for notifying enrollees about their terminated specialists. Documentation demonstrated that a written notice of termination of a contracted provider was sent consistently within 15 days after receipt of issuance of the termination notice to each enrollee who was seen on a regular basis by a specialist. Terminations were documented in the credentialing minutes. Enrollee notifications were catalogued for each provider termination and a notation was entered into WellCare's information system for each enrollee to document tracking of the notice. However, Mercer placed the document into a Microsoft Word format and it was identified as being at the 12th grade level on the Flesch-Kincaid scale. The notice must be written at a seventh grade level (or as close as possible) to meet State requirements.			
Recommendations: Rewrite the notice of termination to achieve a reading level as close as possible to the seventh grade level.			

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations from 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Grievance and Appeals	Ensure that the staff compose the explanation of the reason for a notice of action (NOA) decision rationale for denial of services in language for the layperson versus at a high clinical level.	Revision of NOA correspondence internally/vendor notifications.	Not Met

Comments:

The explanation of any medical necessity denials of service must be written in words understandable to enrollees to assist them in their decisions regarding their appeal rights. A review of the notice of action letters demonstrated that the commentary provided to members by WellCare does not adequately explain the rationale for the denial of services. The notice of action letters gave the following explanation for a denial: "The documents your doctor has given Preferred*O*ne do not prove medical need. Your doctor can call Preferred One for more information."

Documentation related to oversight of delegated utilization management audits and specifically to denials and NOA's appeared appropriate in terms of notification processes being followed consistently. However, the denial notices of action used by BeneCare were also at a level that was not understandable for enrollees.

Recommendations:

Customize the explanation of all medical necessity denials (non-delegated and delegated) and make them specific to the service requested, in words as close to a seventh grade reading level as possible, and include sufficient information for the member to consider in making appeal decisions.

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations from 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Standards for Timeliness and Access to Services	Review and update the 2005 QI program description to accurately reflect Medicaid access and availability standards.	Update 2005 and 2006 QI Program Description.	Met
Comments: Correct Medicaid access and availability standards have been included in both the 2005 and 2006 QI Program Descriptions.			
Recommendations: None			

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations from 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Standards for Timelines and Access to Services	Assess the need to expand the network beyond the minimum enrollment parameters to improve appointment availability.	Conduct annual GeoAccess analysis, appointment access survey, and analysis of member complaints regarding access to care to assess need for network expansion.	Partially Met

Comments:

Network adequacy is measured in a variety of ways by WellCare:

- GeoAccess surveys,
- out-of-Network (OON) provider utilization annual review,
- review of member and provider access and timeliness complaints,
- surveys of providers to identify compliance with access/availability standards, and
- review of emergency department (ED) utilization.

P&Ps are well-written and are compliant with correct access and availability standards. They do require an annual GeoAccess analysis of network adequacy. When conducting GeoAccess studies, WellCare only utilizes providers who have active enrollee panels. The GeoAccess reports, however, are not specific to populations – e.g., obstetrics/gynecologists (OB/GYN) use total population instead of just women; pediatricians use total population, rather than just those ages 18 and under. The reports do show that even with erroneous additional population groups added in, the network standards for GeoAccess are met. For more accurate reporting, however, the reports to determine access for the correct populations do need to be corrected for future studies. The current reports demonstrate that for PCPs, the network can handle approximately 95,000 members.

The only specialty providers with available GeoAccess reports were dentists, pediatricians, OB/GYN, and vision providers. The network adequacy of other specialties with potential for access issues such as ear, nose, and throat specialists, dermatologists, cardiologists, gastroenterologists, and orthopedists are not measured.

Continued use of OON providers is one trigger used by the Provider Relations Representatives (PRRs) to target specific providers for recruitment efforts. Additional triggers used by PRRs to target providers for office visits or telephone conversations are a pattern of insufficient access/availability complaints by either members or providers, or survey results demonstrating availability or accessibility issues.

The Medical Director, Dr. David Wilcox, reviews ED utilization and has provided approximately 40 providers with information regarding unnecessary use of the ED for primary care services by enrollees.

Results of the April, 2006 *WellCare Connecticut Timely Access Survey Summary Report* demonstrated improvements in availability of provider appointments and a decrease in wait times for members.

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations from 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Documentation of analysis of GeoAccess reports and network adequacy issue discussions is demonstrated in meeting minutes.			
Recommendations: Identify true network adequacy ratios and mileage accessibility by conducting GeoAccess studies using appropriate populations. Conduct studies of high volume specialty providers to determine network adequacy.			

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations from 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Compliance with Specific Contract Requirements – HUSKY B, HUSKY Plus and HUSKY B Co-payment	Review and update the 2005 QI program to include HUSKY B.	Update 2005 and 2006 QI Program Description.	Met
Comments: The QI Program Description for 2006 has been modified to include HUSKY B.			
Recommendations: None			

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations from 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Compliance with Specific Contract Requirements – HUSKY B, HUSKY Plus and HUSKY B Co-payment	Implement planned system enhancements to track aggregate cost-sharing limit and repayment for HUSKY B members.	Policy and Procedure to track aggregate cost-sharing limit, co-payments and repayment. Implement system enhancements to track cost-sharing and repayment for HUSKY B members.	Met Met

Comments:

P&Ps to track aggregate cost-sharing limit and repayment for HUSKY B members were submitted. Policy C12BL-BL48 does mention excluding American Indian/Alaskan Native from billing. However, under the Adjustment section on page 4, there is an error. The policy states: "Premium refunds can also be issued for members who have paid at least three (3) months in advance and have requested a refund." To be compliant with HUSKY B contract 4.03 requirements, it should read: "If the family has paid premiums and/or co-payments for qualified American Indian/Alaskan Native children, it is the responsibility of the MCO to repay the premiums and/or co-payments to the family within three (3) months of the MCO's determination that they were paid."

Notification to providers of members meeting the out-of-pocket maximum is given through a customized membership identification card that the member would provide to them during an office visit.

Information systems enhancements to track cost-sharing and repayment for HUSKY B members have been developed and are operational.

Recommendations:

Revise Policy C12BL-BL48 (Healthcare For Uninsured Kids and Youth (HUSKY) B Billing and Payments) to comply with HUSKY B regulation 4.03 wording.

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Compliance with Standards for Timeliness and Access to Services

Standards for Timeliness and Access to Services	Analysis	2006 Findings
Coordination and provision of Early Periodic Screening Diagnosis and Treatment (EPSDT) screening services in accordance with the schedules for immunizations and periodicity of well-child services as established by the DEPARTMENT and federal regulations.	WellCare sends patient rosters to PCPs for notification of EPSDT screens that are due. Members receive letters on their birthdays reminding them of the EPSDT screening services that are required. The WellCare Nurse Line has the responsibility of outreaching to members due for EPSDT services. It is estimated that the Nurse Line reaches approximately 10 percent of the members. Adolescents and young adults ages 15 – 20 did not meet the 80 percent threshold for EPSDT screens.	Partially Met

Standards for Timeliness and Access to Services	Analysis	2006 Findings
Provide necessary coordination and CM services for children with special health care needs (CSHCNs).	Dental services have very low compliance percentages throughout all age ranges. As of the end of 2005, the 80 percent goal of children receiving EPSDT screens was met or exceeded in children under 1 year of age through age nine. Children age 10 – 14 received their screens 79.9 percent of the time. Adolescents 15 – 18 received their screens 71.9 percent and young adults ages 19 – 20 received their screens only 42.9 percent of the time. Dental services have thresholds ranging from 4.9 percent (ages 1 – 2) to 33.6 percent (ages 6 – 9) demonstrating low use of dental services. **Strengths:** WellCare is demonstrating improvement in increasing the numbers of children receiving EPSDT required screens. WellCare has identified the need to increase dental screens as a priority.	Met

Standards for Timeliness and Access to Services	Analysis	2006 Findings
	CM uses trigger diagnoses including special needs diagnosis, Department of Children and Families (DCF), and Supplemental Security Income (SSI) to identify CSHCNs. Approximately, 24 children are in the HUSKY Plus program.	

Recommendations:

Conduct an analysis of encounter data for 15 – 20 year olds to determine the types of outpatient provider, office visits, and other health services (such as pregnancy services) that they are receiving.

Continue to strategize ways of collaborating with community resources and provider networks to increase screening percentages for required EPSDT health screens for adolescents 15 –18 and for dental services in all age categories.

Compliance with Standards for Timeliness and Access to Services	Analysis	2006 Findings
The MCO shall provide all emergency services 24 hours each day, 7 days a week or arrange for the provision of said services 24 hours each day, 7 days a week through its provider network.	Providers are informed of the standards upon orientation and in their Provider Guidelines. Requirements for emergency services are listed in information provided to providers and to members.	Met
The MCO shall cover and pay for emergency services without regard to prior authorization and regardless of whether the provider that furnishes the services has a contract with the MCO.	There were no denials identified for the provision of ED services.	Met
The MCO shall not limit the number of emergency visits.	WellCare does not limit the number of ED visits, but does track utilization closely and intervenes with providers when patterns of member ED abuse occurs. **Strengths:** ED utilization tracking and follow up with providers conducted by the Medical Director is considered a 'best practice.'	Met
Recommendations: None		

Compliance with Standards for Timeliness and Access to Services	Analysis	2006 Findings
The MCO shall serve Members statewide. The MCO shall ensure that its provider network includes access for each Member to PCPs and OB/GYN providers at a distance of no more than 15 miles for PCPs and OB/GYNs and no more than 20 miles for general dentists as measured by the Public Utility Commission. The MCO shall ensure that its provider network has the capacity to deliver or arrange for all goods and services reimbursable under the Medicaid FFS program.	WellCare's monitoring of network adequacy for PCPs and OB/GYNs meet the required standard. The dental network GeoAccess studies showed that only 18 members or 0.1 percent of their enrollees did not have a dental provider within 20 miles.	Met
Recommendations: Identify more accurate network adequacy ratios and mileage accessibility by conducting GeoAccess studies using appropriate populations. (See Chapter 4, page 13 for discussion of this recommendation.)		

Compliance with Standards for Timeliness and Access to Services	Analysis	2006 Findings
The MCO shall maintain a provider network capable of delivering or arranging for the delivery of all covered health goods and services to all Members. In addition, the MCO's provider network shall have the capacity to deliver or arrange for the delivery or all the goods and services reimbursable under this contract regardless of whether all of the goods and services are provided through direct provider contracts. The MCO shall submit a file of their most current provider network listing to the DEPARTMENT or its agent. The file shall be submitted at a minimum, once a month in the format specified by the DEPARTMENT. In establishing and maintaining its provider network, the MCO shall consider the following: 1. Anticipated enrollment; 2. Expected utilization of services, 3. Taking into consideration the characteristics and health care needs of the specific Medicaid populations in the MCO; 4. The number and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services; the numbers of network providers who are not accepting new Medicaid patients; and 5. The geographic location of providers and Medicaid Members, considering distance, travel time, the means of transportation ordinarily used by Medicaid Members, and whether the location provides physical access for members with disabilities.	WellCare conducts GeoAccess studies annually to determine mileage accessibility to PCPs, OB/GYNs and nurse midwives, and general and pediatric dentistry providers. They also evaluate network adequacy by measuring ratios of members to providers. They have demonstrated that they have PCPs capable of handling 97,000 members. Currently, their enrollment is approximately 37,000. They only have 12 providers who are close to achieving a maximum capacity of 1,200 combined Medicaid enrollees in their practice. They do survey physicians regarding appointment availability and their willingness to accept additional members. They conduct office visits to newly credentialed potential high volume providers and high volume recredentialed PCPs to determine physical access for members with disabilities. No analysis could be seen that discusses or measures adequacies of other highly encountered specialties such as cardiologists, dermatologists, orthopedists, ear, nose and throat specialists, or gastroenterologists.	Partially Met

Compliance with Standards for Timeliness and Access to Services	Analysis	2006 Findings
	Strengths: WellCare does an excellent job of determining network adequacy for PCPs, OB/GYNs, nurse midwives, and dentists.	
Recommendation: Conduct studies to determine availability and wait time of specialty providers. Develop and evaluate annually a Network Adequacy Plan and incorporate the five required Federal elements.		

Compliance with Standards for Timeliness and Access to Services	Analysis	2006 Findings
The MCO shall ensure that the PCPs in its network adhere to the following PCP scheduling practices: 1. Emergency cases shall be seen immediately or referred to an emergency facility; 2. Urgent cases shall be seen within 48 hours of PCP notification; 3. Routine cases shall be seen within 10 days of PCP notification; 4. Well-care visits shall be scheduled within six weeks of PCP notification; 5. EPSDT/Health Track comprehensive health screens and immunizations shall be scheduled in accordance with the Department's Health Track periodicity and immunization schedules; 6. New Members shall receive an initial PCP appointment in a timely manner; (for those Members who do not access goods and services within the first six months of enrollment, the MCO shall identify and remedy any access problems; and 7. Waiting times at PCPs are kept to a minimum.	WellCare conducted a telephone survey of PCPs to determine compliance with scheduling practices. Of the 366 calls, 43.2 percent were incomplete, but the health plan used statistics from completed calls and determined a 98.3 percent compliance rate. Since such a significant proportion of PCPs failed to respond to the survey, the health plan has undertaken an audit to determine why providers did not answer, but the results were not available at the time of this external quality review. Correct time lines are documented in policies and WellCare has notified providers of their responsibilities in relation to availability and wait time standards. EPSDT screens have been addressed in Chapter 5, page 17. WellCare's measurement of availability and wait times was inadequate to determine actual practice standards compliance. The health plan needs to include 100 percent of the PCP sample in their calculation of a compliance rate. Any PCP not responding	Partially Met

Compliance with Standards for Timeliness and Access to Services	Analysis	2006 Findings
	should be counted as non-compliant as there is a high probability that they may not be responding because they are not be in compliance with the standards. Those PCPs not responding may need an office visit to determine scheduling practices or a 'secret shopper' call, etc. to determine their compliance.	
Recommendations: Expand activities related to measuring timeliness and availability standards, including primary verification of self-reported data, to ensure standards are met.		

Compliance with Standards for Timeliness and Access to Services	Analysis	2006 Findings
The MCO shall contract with a sufficient number and mix of specialists so that the Member population's anticipated specialty care needs can be substantially met within the MCO's network of providers. The MCO will also be required to have a system to refer Members to OON specialists if appropriate participating specialists are not available. The MCO shall make specialist referrals available to its Members when it is medically necessary and medically appropriate and shall assume all financial responsibility for any such referrals whether they be in-network or OON. The MCO shall ensure that the Member does not incur any costs for such referrals whether the referral is to an in-network or OON provider. The MCO must have policies and written procedures for the coordination of care and the arrangement, tracking, and documentation of all referrals to specialty providers.	No GeoAccess, availability measures, or wait time determinations are being conducted on specialty providers other than OB/GYNs. WellCare does have P&Ps that do allow for referral of members to OON specialists if appropriate participating specialists are not available. Documentation in the CM files did demonstrate that this process is being followed. The health plan does have policies in place to ensure that members do not incur costs for specialty referrals. The health plan information system is able to track referrals to specialty providers. All sections of this element were met except that there are no availability measures, or wait time determinations being conducted on specialty providers other than OB/GYNs to determine adequacy of number and mix.	Partially Met
Recommendations: Conduct, availability and wait time determinations on high volume specialty providers to determine network adequacy.		

Compliance with Standards for Timeliness and Access to Services	Analysis	Findings
The MCO shall contract with a sufficient number of dentists throughout the state to assure access to oral health care. The MCO shall: 1. Maintain an adequate dental provider network throughout the state's eight counties including access to orthodontic services. 2. Implement a plan that includes a systematic approach for enhancing access to dental care through monitoring appointment availability, provision of training to providers around issues of cultural diversity and any other specialized programs. 3. To ensure that access standards are met with respect to dental screens and appointment availability, the MCO shall ensure that the scheduling of a routine dental visit is within 6 weeks. 4. Provider for sufficient access to dental services for different age groups.	The BeneCare network has 390 providers at 187 locations. Providers include dentists and dental hygienists. GeoAccess studies demonstrate that all members have access to at least one BeneCare network provider within a 20-mile radius with the exception of 18 members in Litchfield, Connecticut (2 percent of that county's membership). Although the dental provider numbers and accessibility is not an issue, EPSDT statistics for the reporting period 7/1/05 – 12/31/05 demonstrate that only 21 percent of HUSKY A and 20 percent of HUSKY B members received any type of dental service. This demonstrates low utilization of dental services by WellCare's HUSKY population.	Met
Recommendations: WellCare is encouraged to continue conducting outreach activities to increase dental utilization.		

Compliance with Standards for Timeliness and Access to Services	Analysis	Findings
The MCO shall have systems in place to ensure access to medically necessary and medically appropriate well-care by its Members. The MCO shall develop procedures to identify access problems and shall take corrective action as problems are identified. These systems and initiatives shall include, but not be limited to: monitoring new members to ensure that a well-care appointment is scheduled within 6 months of enrollment for those whose last well-care visit does not fall within the recommended age appropriate schedules.	Members have a choice of PCPs. If no choice has been made within 45 days of enrollment, a reminder letter is sent to the member to choose a PCP. If member has not chosen a PCP by 90 days, three attempts to reach them by telephone are made. If they are contacted, assistance is given to help them choose a PCP. If unable to be contacted, a PCP is auto assigned by location to the member. Member complaints are reviewed regularly to also determine any access issues. In addition, the annual access and availability survey, identifies provider compliance with access and availability standards.	Met
Recommendations:: None		

As a component of the EQR, Mercer conducted three on-site record reviews – credentialing, appeals, and CM. CM was reviewed at the request of the State.

Credentialing Files Review

Credentialing files of general and specialty providers (physicians, advanced registered nurse practitioners, physician assistants, and chiropractors) who were terminated either by the plan or who had terminated their contract with the plan during 2005 were reviewed to determine:

- timeliness of credentialing and recredentialing activities;
- completeness of credentialing and recredentialing activities, and
- any evidence to suggest discrimination of the provider by the health plan.

WellCare is on a three-year recredentialing cycle, but does have a process for updating licenses, malpractice insurance, and drug enforcement administration (DEA) numbers if they are set to expire between the credentialing/recredentialing cycles. From the file review, it appears that all the records were compliant in the timeliness and completeness of the credentialing and recredentialing processes. All providers had current licenses, board certification inquiry noted when applicable, valid and active DEA numbers when applicable, checks for eligibility for federal programs, documentation of attestation of correctness and completeness of the application by the provider, documentation of primary source verification of education, of disciplinary actions against their license checked, of National Practitioner Data Bank (NPDB) inquiry, and initial on-site visit conducted by health plan with medical record review (MRR) when applicable. No on-site or medical record reviews scored low enough to require a corrective action plan. No evidence of any discrimination by the health plan was identified.

Recommendations

None

Appeals Files Review

A review of a sample of WellCare Grievance System member files was completed. The files were well-organized and complete. Time lines for decisions and member notification were met. The forms required by DSS were used in communicating with members. The number of initial authorization decisions overturned upon review by WellCare after a member appeal was reasonable. Fifty per cent of the notices of action (NOA) reviewed, included a reason for the action, which would be understandable to a layperson and provided details pertinent to the specifics of the service request.

Recommendations

- Provide details particular to each request for service authorization in the explanation of the reason for an action taken by WellCare when preparing NOAs.
- Use layperson wording at the seventh grade reading level rather than clinical language in the NOA.

Case Management/Disease Management Records Review

Ten medical records were reviewed to evaluate CM activities reflecting compliance with coordination and continuity of care. Documentation represented activity and services in 2005 and early 2006.

Documentation in cases demonstrated utilization review of requested services with extensive use of home health services for cases with special needs.

CM Case Triggers and Identification: The method case managers used for identification of cases for CM was not clearly identified in the documentation and appeared to not follow established health plan CM policies. One case had multiple (12) ED visits and inpatient admits since August 2004 before being admitted to CM in July 2005. Two cases mentioned referral to CM and DM but subsequent documentation did not indicate follow up. Only one case documented distribution of introduction materials describing the CM program.

Assessment and Care Plan: Cases included an initial assessment, but the assessment was brief and often lacked important data such as allergies, immunization status, psychosocial history and functional assessment.

Provider notes in three cases show history of depression and/or drug abuse but the problem was not addressed in the CM assessment or care plan. In another case, the provider described problems of obesity, speech delay, allergies and situational stressor (starting school) that were not addressed in the assessment, care plan or educational interventions for a juvenile asthmatic.

Treatment Goals and Progress: The documentation system did not provide a mechanism to document behaviorally specific goals and document progress made toward achieving goals. For example, goals for a diabetic client would be attendance at scheduled clinic/MD visits 100 percent of time; HbA1C level at or below 7 sustained for 6 months; absence of severe hypoglycemic event for 6 consecutive months ;and/or absence of diabetes related ED or IP admissions for 6 consecutive month,s etc.

Coordination of Resources: All cases reflected referral to medical resources, primarily home health and physicians through documentation of authorization for services; but, referral to community resources rarely occurred.

Education: Documentation did not include evidence of distribution of education materials about the CM program or disease specific educational material aimed at prevention or improved self-management of the disease process.

Recommendations

- Monitor case manager documentation to ensure that policies related to CM case triggers, identification, and referral of cases are being followed and timely enrollment into CM occurs.
- Document telephone contacts and educational mailing with dates including introductory CM materials.
- Develop a monthly CM peer review audit process focusing on documentation of:
  - essential assessment elements,
  - behaviorally specific goals,
  - progress and barriers toward meeting goals,
  - referral and coordination events, and
  - education contacts and interventions – specific telephone contacts and mailings (date and content).
- Prepare a prototype sample chart that shows evidence of 100 percent compliance with documentation standards and can provide a visual desk reference for Case Managers.

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Compliance with Specific Contract Requirements — HUSKY B, HUSKY Plus, and HUSKY B Co-Payment

HUSKY B and HUSKY Plus Requirements	Analysis	2006 Findings
The MCO has a written process to determine eligibility for HUSKY Plus programs. HUSKY Plus is available for CSHCNs who are enrolled in HUSKY B and fall within income bands 1 and 2. HUSKY B Members who fall into income band 3 are excluded from the HUSKY Plus program. Clinical eligibility for HUSKY Plus services is determined by the HUSKY Plus program. The MCO shall have final decision-making authority for those services for which they are at financial risk. The HUSKY Plus program shall have final decision-making authority for those supplemental services for which they are at financial risk. The HUSKY Plus programs shall be the documented payor of last resort.	WellCare has processes in place to determine eligibility for HUSKY Plus programs. If WellCare has a service not covered under their benefit plan, they deny the service following the correct denial notification process. The health plan then sends a referral to the HUSKY Plus program. All CSHCNs are automatically referred to HUSKY B Plus. The WellCare P&Ps adequately describe the processes for referral to HUSKY Plus.	Met

HUSKY B and HUSKY Plus Requirements	Analysis	2006 Findings
	HUSKY B members are included in the New Member Welcome calls and Health Risk Assessments (HRAs). These activities identify members who may be in need of a PCP appointment as well as CM services.	
Recommendations: None		

HUSKY B and HUSKY Plus Requirements	Analysis	2006 Findings
HUSKY B member referrals to HUSKY Plus include P&Ps and tracking information Referral The MCO shall refer Members who may have intensive behavioral health (BH) needs to HUSKY Plus Behavioral and Members who may have intensive physical health needs to HUSKY Plus Physical.	WellCare policies and procedures outline processes for referral of members to HUSKY Plus. Members are tracked via their information systems. All members who are referred to HUSKY PLUS are case managed. There were no HUSKY Plus BH referrals in 2005.	Met
Referral shall consist of completion of the HUSKY Plus Referral Form and submission of the form to the appropriate HUSKY Plus program a. The MCO shall refer and facilitate the referral process for all Members who have been identified by the MCO as potentially benefiting from HUSKY Plus. b. The MCO shall refer all Members for whom a referral has been requested to HUSKY Plus by a parent, Member, applicant, or provider.	WellCare utilizes the correct HUSKY Plus referral form.	Met
The MCO Shall contact the HUSKY Plus program to which it has a referral a Member within one month of the referral in order to confirm the Member's access to HUSKY Plus services. The MCO shall contact the DEPARTMENT if confirmation of HUSKY Plus eligibility has not been received.	The HUSKY Plus program handles all referrals promptly. A response to the referral is sent back within a month's period of time. If the forms were not sent back, a health plan nurse would call them. A monthly meeting is scheduled to facilitate instant referral calls.	Met

Recommendations:

None

HUSKY B and HUSKY Plus Requirements	Analysis	2006 Findings
The MCO tracks member referral, enrollment, and disenrollment for the HUSKY Plus Program and coordinates services with HUSKY Plus.	WellCare has a number of appropriate P&Ps that deal with the coordination of referrals to HUSKY Plus. Once a member is accepted into the HUSKY Plus program, the member is tracked for the duration of his/her enrollment in the program and/or with WellCare. Documentation of coordination and required reports are in evidence.	Met
Recommendations: None		

HUSKY B and HUSKY Plus Requirements	Analysis	2006 Findings
The MCO has documentation defining QM processes, results, and tracking for HUSKY B members.	WellCare has a variety of quality measures targeting HUSKY B members. They capture HUSKY B members in their PMs and track utilization statistics. Specifically, some of the reports for HUSKY B are: Hospital Inpatient Report, Ambulatory Services Report, Outpatient Prescription Drug Report, and ED Visit Report.	Met
Recommendations: None		

HUSKY B and HUSKY Plus Requirements	Analysis	2006 Findings
The global plan of care shall integrate HUSKY B services as set forth in Appendix A and HUSKY Plus services as set forth in Appendix B and C. The MCO shall be responsible for managing the utilization of HUSKY B services contained in the global plan of care.	WellCare has responded to requests from the State regarding BH expenditures in the HUSKY Plus program. The health plan is responsible for managing the utilization of HUSKY B services contained in the global plan of care. A variety of utilization reports as mentioned in the previous grid track utilization of the HUSKY B members.	Met
Recommendations: None		

HUSKY B and HUSKY Plus Requirements	Analysis	2006 Findings
The MCO has P&Ps for billing and collecting HUSKY B co-payments.	As per policy, invoices are mailed to HUSKY B members on the appropriate billing cycle based upon the program. The policy confirms that first month premium payment, accounts receivable, and deposits are in place to ensure that any premium received is controlled and credited to the members' accounts and deposited to the bank within 24 hours of receipt. Premium receipts returned by the bank for non-sufficient funds are returned to the member requesting replacement and a $30 administrative fee is assessed in accordance with the P&P. Members are terminated if replacement funds are not received by the delinquent date per State-mandated guidelines. In addition, the administrative fee is not used as a reason to terminate per State-mandated guidelines.	Met
Recommendations: None		

HUSKY B and HUSKY Plus Requirements	Analysis	2006 Findings
The MCO has P&Ps tracking of HUSKY B annual aggregate cost-sharing limit and repayment processes.	Policies and procedures to tract aggregate cost-sharing limit and repayment for HUSKY B members were submitted. Policy C12BL-BL48 does mention excluding American Indian/Alaskan Native from billing. However, under the Adjustment section on page 4, there is an error. The policy states: "Premium refunds can also be issued for members who have paid at least three (3) months in advance and have requested a refund." To be compliant with HUSKY B State policy, it should read: "If the family has paid premiums and/or co-payments for qualified American Indian/Alaskan Native children, it is the responsibility of the MCO to repay the premiums and/or co-payments to the family within three (3) months of the MCO's determination that they were paid." WellCare has one American Indian/Alaskan Native member in the HUSKY B program. The health plan has provided that member with a special ID card stating that no premiums or co-payments are to be charged. The Member Handbook does not contain information about the American	Met
Families of American Indian/Alaskan Native children who are Members of a Federally recognized tribe and who are in Income Band 1 or 2 are exempted from paying HUSKY B premiums or co-payments. The MCO shall ensure that the family is not charged any premiums or co-payments for qualified American Indian/Alaskan Native children as of the date DSS makes that determination.		Met
The MCO shall notify its providers and subcontractors for the American Indian/Alaskan Native exemption from premiums and co-payments. Member handbooks and information handouts developed by the MCO shall include information about the American Indian/Alaskan Native exclusion from premiums and co-payments. The MCO shall refer any Members who believe they qualify for the American Indian/Alaskan Native exemption to DSS for a determination of their qualification.		Partially Met
The MCO shall provide all qualified American Indian/Alaskan Native children in Income Bands 1 and 2 with Membership identification cards stating "no co-payments," and the MCO shall inform their HUSKY B providers and subcontractors that children with Membership cards so noted shall not be charged co-payments.		Met
If the family has paid premiums and/or co-payments for qualified American Indian/Alaskan Native children, it is the responsibility of the MCO to repay the premiums and/or co-payments to the family within three (3) months of the MCO's determination that they were paid. It is the responsibility of the MCO to review the Member accounts quarterly to determine which families have paid premiums and/or co-		Met

HUSKY B and HUSKY Plus Requirements	Analysis	2006 Findings
payments for qualified American Indian/Alaskan Native children. The quarterly review must be completed no later than 15 days after the end of each quarter. The MCO shall make the review available to DSS upon request	Indian/Alaskan Native exclusion since it is only relevant to one member. Providers are notified of the exclusion upon presentation of the ID card by the member.	
Recommendations: Revise Policy C12BL-BL48 (Healthcare For Uninsured Kids and Youth [HUSKY] B Billing and Payments) to comply with HUSKY B regulation wording. Include information about the American Indian/Alaskan Native exclusion from premiums and co-payments in Member Handbook.		

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Validation of Performance Improvement Projects

Objective 1
To assess the methodology applied by WellCare for conducting a PIP.

Objective 2
To evaluate the overall validity and reliability of study results.

Objective 3
To assess compliance with State required specifications.

PIPs are an essential component of an MCO's Quality Program and are used to identify, assess, and monitor improvement in processes or outcomes of care. DSS selected all PIPs for inclusion in this review. Some of the selected projects were designed to apply DSS-developed specifications, some used Health Plan Employer Data and Information Set (HEDIS) 2005 specifications, and others used designs developed by the MCOs.

Four PIPs were reviewed for WellCare. The PIPs and the specifications to be applied included:

1. Improving Adolescent Access to Preventive Care Visits,
2. Decreasing Emergency Department Utilization and Inpatient Admissions for Members with Asthma,
3. Improving Asthma Medication Management, and
4. Improving Frequency of Prenatal Care and Timeliness of Postpartum Care.

Review Methodology

The PIP review process included application of the CMS protocol entitled ”Validating PIPs” and assessing for the compliance to the identified specifications applicable to each project. Mercer requested WellCare to submit information for a desk review. The desk review was completed by Mercer prior to the on-site visit. The purpose of the desk review was to identify issues for follow-up, clarity, and to minimize time requirements of the WellCare staff during the on-site process.

As required by the CMS validation protocol, Mercer made a determination of the overall validity and reliability of reported results, as well as a determination of confidence in the success and sustainability of improvement efforts. The following table illustrates the possible scores for each of these determinations.

Confidence in Reported Results				Confidence in Success and Sustainability of Improvement Efforts			
High	Moderate	Low	Results not Credible	High	Moderate	Low	Results not Credible
Fully compliant with standard protocol	Substantially validated and only minor deviations from standard protocol	Deviated from protocol such that the reported results are questionable	Deviated from protocol such that reported results are not validated	Success evident and sustained or lack of success addressed; actions linked to results	Success evident and/or sustained or lack of success addressed; actions not linked to results and/or repeat of prior year	Success not evident and/or sustained or lack of success addressed; actions not linked to results and/or repeat of prior year	Unable to validate results

The following table presents a summary of WellCare PIP results. Additional details of the findings and conclusions of each study follow the results chart.

Overall Results

	2002	2003	2004	2005	Benchmark Most recent	Confidence in Reported Results	Confidence in Success and Sustainability of Improvement Efforts	Compliance with Specifications
Improving Adolescent Preventive Care								
Members Aged 13 – 17 Who Had a Preventive Health Care Visit		Baseline 43%	50%	43%	60.93%	High	Low	Met
Goal	**80%**	**80%**	**80%**	**80%**				
Decreasing Emergency Department Utilization and Inpatient Admissions for Members with Asthma								
ED Utilization for All Members with Asthma		Baseline 31%	21.52%	14.45%	24%	Moderate	High	Met
Goal			**-5%**	**-5%**				
Inpatient Utilization for Members with Asthma		Baseline 4.9%	5.06%	3.23%	5.4%	Moderate	Moderate	Met
Goal			**-5%**	**-5%**				

	2002	2003	2004	2005	Benchmark Most recent	Confidence in Reported Results	Confidence in Success and Sustainability of Improvement Efforts	Compliance with Specifications
Improving Asthma Medication Management								
5 – 9 year olds			72.79%	88.19%	86.05%	High	High	Met
Goal			**72%**	**72%**				
10 – 17 year olds			66.33%	86.82%	75.16%	High	High	Met
Goal			**66%**	**66%**				
18 – 56 year olds			56.83%	78.62%	87.32%	High	High	Met
Goal			**62%**	**62%**				
5 – 56 year olds			66.11%	84.84%	83.72%	High	High	Met
Goal			66%	66%				
Improving Frequency of Prenatal Care and Timeliness of Postpartum Care*								
Percent of Women with a Live Birth with 81% or more Expected Prenatal Visits *	50%	59% 66%	59% 69.35%	69.5% 78.8%	83.71%	High	Moderate	Met
Goal	80%	80%	80%	80%				
Percent of Women with Post Partum Visits Between 21 – 56 Days After Delivery*	49%	50% 39%	47% 51.66%	48.9% 55.9%	83.33%	High	Not credible	Met
Goal	80%	80%	80%	80%				

* results for years 2003 – 2005 listed semi-annually

Name of Performance Improvement Project: Improving Adolescent Access to Preventive Care Visits

Dates in Study Period: 01/01/2003 to 12/31/2005

I. ASSESSMENT OF STUDY METHODOLOGY

Step 1. REVIEW OF SELECTED STUDY TOPIC(S)

Component/Standard		M	PM	NM	N/A	Comments
1.1	Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	X				There is a description of the selection of the study topic. It does target clinical (EPSDT) service relevant to the Medicaid population. it is aimed at improving preventive well care visits in the adolescent population from a baseline of 43 percent, It also addresses the State's PIP requirements.
1.2	Did the MCO's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services?	X				WellCare did address a broad spectrum of interventions associated with EPSDT screenings. They had interventions focused on both the member and the providers. A number of relevant educational materials were developed and telephone and mailing outreach initiatives were conducted.
1.3	Did the MCO's PIPs, over time, include all enrolled populations; i.e., did not exclude certain enrollees, such as those with special health care needs (SHCNs)?	X				The study included all members ages 13 –17 (changed after baseline to 12 – 21) who were continuously enrolled in the health plan during the measurement year allowing for an enrollment gap of one month. There were no additional exclusions.

Step 2. REVIEW OF THE STUDY QUESTION(S)

2.1	Was/were the study question(s) stated clearly in writing?	X				The study question was phrased clearly: "Will plan interventions to members and providers increase the rate of members ages 13 – 17 (12 – 21) who receive preventive health care visits?"

Step 3. REVIEW OF SELECTED STUDY INDICATOR(S)						
3.1	Did the study use objective, clearly defined, measurable indicators?	X				The study indicator reflected a quantitative characteristic of a discrete event. It was clear, unambiguously defined, and was pertinent to the study question: The percent of members, ages 13 – 17 years old, who were continuously enrolled in WellCare, during the measurement year, with no more than a one month gap in enrollment, who had a preventive health care visit during the measurement year. (Study changed after baseline to 12 -21 for compliance with DSS). The numerator and denominator were clearly defined.
3.2	Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care, with strong association with improved outcomes?	X				The study used an indicator, while not a measurement of health status, can reasonably be associated with the potential of improved health outcomes. The measure aimed to improve the rate of preventive health care visits for adolescents.
3.3	Was there documentation of chosen Performance Targets including benchmarks used, or rationale/justification for the chosen performance target?	X				Chosen performance targets – comparison benchmarks and comparison goals were in evidence for each year of the study.
Step 4. REVIEW OF IDENTIFIED STUDY POPULATION						
4.1	Did the MCO clearly define all Medicaid enrollees to whom the study question and indicators are relevant?	X				Yes, all members ages 13 – 17 years, continuously enrolled with no more than a one-month gap in enrollment. DSS changed the aged group to 12 – 21 and the health plan made the appropriate study modifications.
4.2	If the MCO studied the entire population, did its data collection approach capture all enrollees to whom the study question applied?	X				The data collection approach did capture the appropriate population.

Step 5. REVIEW OF SAMPLING METHODS						
5.1	Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?				X	Sampling was not used for this study.
5.2	Did the MCO employ valid sampling techniques that protected against bias? *Specify the type of sampling or census used.*				X	
5.3	Did the sample contain a sufficient number of enrollees?				X	
Step 6. REVIEW OF DATA COLLECTION PROCEDURES						
6.1	Did the study design clearly specify the data to be collected?	X				The study methodology clearly defined the data to be collected. Computer programming documents for the study were presented.
6.2	Did the study design clearly specify the sources of data?	X				Data sources were identified as claims and encounter data and specified exact CPT and ICD-9 codes used. The codes are consistent with Federal and State regulations regarding coding for EPSDT reporting.
6.3	Did the study design specify a systemic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	X				Encounter data and capitated physician reporting are monitored on an ongoing basis and benchmarked against fee-for-service (FFS) physicians to ensure accuracy of the data.
6.4	Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	X				Data specifications detailed in the provided documentation indicated consistent, accurate data collection over the study periods. Changes in age grouping required by DSS resulted in an initial study limitation, but this was adequately addressed in the study materials.

6.5	Did the study design prospectively specify a data analysis plan?	X				Study methodology was designed prior to implementing the baseline data collection. The programming materials were included in the PIP binder. An EPSDT Workgroup was formed to analyze data and recommend interventions.
6.6	Were qualified staff and personnel used to collect the data?	X				Information about the staff qualifications relevant to data collection was not available. However, the EPSDT Workgroup (later, the QI Intervention Work Group) is multidisciplinary with appropriate personnel. The programming materials submitted with the PIP demonstrate that they were written by a qualified person (people). There is both QI Committee and Medical Advisory Committee oversight of the PIP processes.
Step 7. ASSESSMENT OF IMPROVEMENT STRATEGIES						
7.1	Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?		X			Barriers were identified using information from a variety of resources including literature review, results of member satisfaction surveys, and volume of returned mail from sending outreach materials. Interventions included, but were not limited to: ▪ Active multidisciplinary EPSDT QI Improvement Workgroup. ▪ Screening reminders sent to PCPs and parents of members. ▪ Incentive telephone or Blockbuster gift cards sent to members who receive a well child visit. ▪ One-on-one provider education conducted during on-site MRRs. ▪ Plan performed telephone calls to members two months prior to their birthday to remind parents to schedule an EPSDT visit with the PCP.

						▪ Letters sent to PCP explaining appropriate coding of preventive health care visits, with an explanation of the schedule for well visits including types of services covered. ▪ Includes member Preventive Health Guidelines in new Member's Welcome Packet and includes child health check-up information in the New Member Welcome calls. ▪ Increased fee schedule for CPT Codes 99384 and 99394. Interventions, although additive in nature, have not significantly changed since the beginning of the study and the results continue to be static and do not meet targets. Interventions are general and targeted to the population as a whole. The member educational materials are well-designed and informative. More information could be gathered about the adolescents who are not compliant. The health plan needs to consider developing more specific interventions targeted to non-compliant members. A robust root cause analysis to determine member co-morbidities (especially pregnancy as prenatal medical office visits could be occurring, but not captured as these visits do not qualify as EPSDT visits; it would be interesting to know about ED usage also), gender, ethnic, and geographic issues as well as identifying trends or patterns of providers with high incidences of non-compliant members could be considered.

Step 8. REVIEW OF DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS						
8.1	Was an analysis of the findings performed according to the data analysis plan?		X			Analysis of data was divided into age range groups: 12 –14, 15 – 18, and 19 – 21 and consisted simply of identification of rate of compliance. Data analysis was consistent over the 3 years of the study, but was not creative, nor fact-finding. No in-depth analysis appears to have been done to discover more information about the non-compliant population. For example, did members who had no preventive visit, perceive that lack of transportation was an issue for them? It may or may not have been. Information from a member satisfaction survey was used by the health to explain a barrier to preventive visits and more information about transportation was being provided to all new members as an intervention. The intervention is appropriate as the survey showed that 36.1 percent of members did not know transportation was provided by the health plan. But, the relevance to this particular preventive study was not really confirmed.
8.2	Did the MCO present numerical PIP results and findings accurately and clearly?	X				Documentation of PIP results were presented on pages 4 and 5 of the study report. The information was documented in a consistent, easy-to-read format.
8.3	Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?	X				The analysis did identify initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten the internal validity.

8.4	Did the analysis of study data include an interpretation of the extent to which its PIP was successful and did it identify existing barriers that may be influencing indicators that did not meet established benchmarks?		X			The analysis of data did correctly conclude that the rate of compliance continues to be significantly lower than the state performance standard of 80 percent and also had fallen 7 percentage points below the 2004 results. No new barriers have been identified since the beginning of the study.
Step 9. ASSESSMENT OF IMPROVEMENT						
9.1	Was the same methodology as the baseline measurement, used, when measurement was repeated?	X				With the exception of the age requirement change, the methodology used was the same with repeated measurement.
9.2	Was there any documented, quantitative improvement in processes or outcomes of care?			X		No, the 2005 compliance rate actually decreased from the 2004 rate.
9.3	Does the reported improvement in performance have “face” validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?			X		There has been no improvement in performance.
9.4	Is there any statistical evidence that any observed performance improvement is true improvement?			X		There has been no improvement performance.
Step 10. ASSESSMENT OF SUSTAINED IMPROVEMENT						
10.1	Was sustained improvement demonstrated through repeated measurements over comparable time periods?			X		No.
ACTIVITY 2. VERIFICATION OF STUDY FINDINGS						
2.1	Were the initial study findings verified upon repeat measurement?	X				The findings were similar for the baseline and last year of study. The second year of the study when the age range expanded demonstrated an increase in compliance.

Summary of Results

The study design was well-written; it was clear, complete, and specific. The study methodology clearly defined the data to be collected. Computer programming documents for the study were reviewed. The documentation described a systematic method of collecting valid and reliable data that represented the entire population to which the study's indicators applied.

Chosen performance targets – comparison benchmarks and comparison goals were in evidence for each year of the study.

WellCare did address a broad spectrum of interventions associated with EPSDT screenings. An EPSDT Workgroup was formed to analyze data and recommend interventions. They designed interventions focused on both the member and the providers. A number of relevant educational materials were developed and telephone and mailing outreaches were conducted. The member educational materials are well-designed and informative. Interventions, although additive in nature, have not significantly changed since the beginning of the study and the results continue to be static and do not meet targets. Interventions are general and targeted to the population as a whole. No in-depth analysis appears to have been done to discover more information about the non-compliant population.

The analysis of data did correctly conclude that the rate of compliance continues to be significantly lower than the State performance standard of 80 percent and also had fallen 7 percentage points below the 2004 results. No new barriers have been identified since the beginning of the study.

PIP Recommendations

- Gather more information about the non-compliant adolescent population as the health plan needs to consider developing more specific interventions targeted to non-compliant members.
- Conduct an in-depth analysis of barriers related to the non-compliant population to formulate appropriate interventions to increase the rate of compliance with preventive visits.

Name of Performance Improvement Project: Decreasing Emergency Department Utilization and Inpatient Admissions for Members with Asthma

Dates in Study Period: 01/01/2003 to 12/31/2005

I. ASSESSMENT OF STUDY METHODOLOGY

Step 1. REVIEW OF SELECTED STUDY TOPIC(S)

Component/Standard		M	PM	NM	N/A	Comments
1.1	Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	X				The topic was selected based on data reflecting needs of the WellCare population as well as addressing the State's PIP requirements. Documented rationale addressed high prevalence and cost impact for the population to be included in the PIP.
1.2	Did the MCO's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services?	X				The PIP assessment and interventions initiated in 2003 and continuing into 2006 have addressed aspects of services that include member service, provider education, member education, utilization review, CM and now DM. A broad range of interventions were used within the scope of the PIP.
1.3	Did the MCO's PIPs, over time, include all enrolled populations; i.e., did not exclude certain enrollees, such as those with SHCNs?	X				The PIP included members age 2 and over and did not exclude members with SHCNs; although it should be noted that technical specifications cited in Tab 5 and 9 indicate exclusion of clients with Chronic Obstructive Pulmonary Disease (COPD) and Emphysema as applicable and directed per State DSS requirements.
Step 2. REVIEW OF THE STUDY QUESTION(S)						
2.1	Was/were the study question(s) stated clearly in writing?	X				The Study question was phrased clearly: "Will plan interventions to providers and members decrease ED visits and Inpatient Admissions for the eligible population?"

Step 3. REVIEW OF SELECTED STUDY INDICATOR(S)						
3.1	Did the study use objective, clearly defined, measurable indicators?	X				The Study identified two objectively defined and measurable indicators: 1. The percent of members age 2 and over who had a primary diagnosis of asthma at any time, for any service…during measurement year, who had an ED visit with a primary diagnosis of asthma in the measurement year. 2. The percent of members age 2 and over, who had a primary diagnosis of asthma at any time, for any service… during measurement year, who had an inpatient admission with a primary diagnosis of asthma in the measurement year.
3.2	Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care, with strong association with improved outcomes?	X				The Study used indicators that by proxy measure health status. While not defined as an indicator for the Study, it would be reasonable to support through literature review/research findings that the education and communication interventions implemented by WellCare might contribute to enrollee satisfaction.
3.3	Was there documentation of chosen Performance Targets including benchmarks used, or rationale/justification for the chosen performance target?		X			While a benchmark was identified at the beginning of the study in 2003, there does not appear to be documentation of subsequent updating of the benchmark based on 2004 and 2005 results and evaluation. The rationale and justification for the performance target should be addressed with each annual evaluation of results and plan for the upcoming year and represent geographically appropriate benchmarks.

Step 4. REVIEW OF IDENTIFIED STUDY POPULATION						
4.1	Did the MCO clearly define all Medicaid enrollees to whom the study question and indicators are relevant?	X				The Study clearly defined the enrollees to be included in the Study with measurable indicators: 1. The percent of members age 2 and over who had a primary diagnosis of asthma at any time, for any service who were continuously enrolled in the health plan for 6 months prior to the measurement year and 11 of 12 months during the measurement year, who had an ED visit with a primary diagnosis of asthma in the measurement year. 2. The percent of members age 2 and over, who had a primary diagnosis of asthma at any time, for any service who were continuously enrolled in the health plan for 6 months prior to the measurement year and 11 of 12 months during the measurement year, who had an inpatient admission with a primary diagnosis of asthma in the measurement year. The enrollee inclusion criteria utilized for the Study met the Connecticut DSS requirements.
4.2	If the MCO studied the entire population, did its data collection approach capture all enrollees to whom the study question applied?	X				The data collection approach captured enrollees with a diagnosis of asthma with specifications as stated and required by DSS.
Step 5. REVIEW OF SAMPLING METHODS						
5.1	Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?				X	Sampling was not used for this Study.

5.2	Did the MCO employ valid sampling techniques that protected against bias? Specify the type of sampling or census used.				X	
5.3	Did the sample contain a sufficient number of enrollees?				X	
Step 6. REVIEW OF DATA COLLECTION PROCEDURES						
6.1	Did the study design clearly specify the data to be collected?	X				The Study methodology clearly defined the data to be collected.
6.2	Did the study design clearly specify the sources of data?	X				Data sources were identified as claims and encounter data with specific reference to CPT and Diagnosis Code specifications.
6.3	Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	X				Supporting documentation details data collection methodology reflecting valid specifications compliant with DSS requirements.
6.4	Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	X				Data specifications detailed in documentation provide consistent and accurate data collection, although changes in DSS data requirements for 2005 reporting period resulted in analysis limitations.
6.5	Did the study design prospectively specify a data analysis plan?	X				Study methodology was specified originally for 2003 measurement period. Changes in methodology reflect DSS reporting requirements resulting in study limitations that were adequately addressed in the report of analysis.

6.6	Were qualified staff and personnel used to collect the data?	X				Medical Advisory Minutes provided in the documentation show Medical oversight of the PIP with credentials of participating members. This group is the principle body overseeing the Asthma Care and Prevention QI Project Work Group. Documentation does provide evidence that professionals with respiratory health care experience or education or other specific credentials were included in collection analysis and directing or supporting interventions for improvement.
Step 7. ASSESSMENT OF IMPROVEMENT STRATEGIES						
7.1	Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	X				Interventions were broad in scope and addressed many causes/barriers although documentation of analysis was not a robust discussion of barriers contributing to utilization using traditional QI analytical techniques. Interventions in 2005 were identified and included developing/distributing laymen's version of clinical practice guidelines and revised provider fax program. Interventions in 2005 also were a continuation of interventions initiated in 2003 and 2004 with a shift in 2006 toward using the Asthma Disease Management program structure and processes as the primary intervention strategy.
Step 8. REVIEW OF DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS						
8.1	Was an analysis of the findings performed according to the data analysis plan?	X				Data analysis was completed consistently over the three years of the Study with the exception of DSS specification requirement changes. Specific plans for data analysis at the beginning of each measurement period were not documented.
8.2	Did the MCO present numerical PIP results and findings accurately and clearly?	X				Findings were reported on page 5 of the QI Documentation Form, providing easy reference to results for each measurement period and progress with improvement over all three measurement periods.

8.3	Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?		X			The analysis showed repeated measurements for three measurement periods: 2003, 2004 and 2005. Statistical significance was addressed in the analysis. Robust analysis addressing contributing factors to results, internal and external validity factors and study limitations were not documented.
8.4	Did the analysis of study data include an interpretation of the extent to which its PIP was successful and did it identify existing barriers that may be influencing indicators that did not meet established benchmarks?		X			The analysis included interpretation of results and identification of additional barriers. Robust analysis addressing contributing factors to results, internal and external validity threats and study limitations was not documented. Specific follow-up activities were not identified. Asthma Care and Prevention QI Project Minutes documented analysis from April 2003 through April 2005 but appear to be integrated in other committees from May 2005 forward with less detail regarding analysis and discussion of contributing factors to success and follow-up activities.
Step 9. ASSESSMENT OF IMPROVEMENT						
9.1	Was the same methodology as the baseline measurement, used, when measurement was repeated?	X				Methodology from baseline to Re-measurement Period 2 and Re-measurement Period 3 was changed to meet DSS specifications. Change to specifications was clearly documented.
9.2	Was there any documented, quantitative improvement in processes or outcomes of care?	X				ED visits reduced from 31 percent in the baseline measure year (2003) to 14.45 percent in Re-measurement Period 2 (2005). Inpatient admissions reduced from 4.9 percent in the baseline measure year (2003) to 3.23 percent in Re-measurement Period 2 (2005).

9.3	Does the reported improvement in performance have “face” validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?	X				The decrease in ED utilization associated with Measure 1 appears to reflect progressive improvement over Re-measurement Period 1 and Re-measurement Period 2 resulting from interventions implemented in 2003 and 2004. Improvement and contributions of interventions to improvement for inpatient utilization is more suspect as progress is not sustained over measurement periods and not yet statistically significant.
9.4	Is there any statistical evidence that any observed performance improvement is true improvement?	X				The decrease in ED utilization associated with Measure 1 was statistically significant reflecting observed improvement resulting from interventions implemented in 2003 and 2004. Improvement and contributions of interventions to improvement for inpatient utilization is more suspect as progress is not sustained over measurement periods and not yet statistically significant.
Step 10. ASSESSMENT OF SUSTAINED IMPROVEMENT						
10.1	Was sustained improvement demonstrated through repeated measurements over comparable time periods?	X				The decrease in ED utilization associated with Measure 1 appears to reflect progressive improvement over Re-measurement Period 1 and Re-measurement Period 2 resulting from interventions implemented in 2003 and 2004. Improvement and contributions of interventions to improvement for inpatient utilization is more suspect as progress is not sustained over measurement periods and not yet statistically significant.

ACTIVITY 2. VERIFICATION OF STUDY FINDINGS						
2.1	Were the initial study findings verified upon repeat measurement?	X				The decrease in ED utilization associated with Measure 1 appears to reflect progressive improvement over Re-measurement Period 1 and Re-measurement Period 2 resulting from interventions implemented in 2003 and 2004. Improvement and contributions of interventions to improvement for inpatient utilization is more suspect as progress is not sustained over measurement periods and not yet statistically significant.

Summary of Results

Results of the study indicated a significant decrease in ED utilization over baseline for Measure 1. Measure 2 results decreased from baseline and the first re-measurement period; however, it was not statistically significant. Re-measurement results were calculated using 2004 specifications required by DSS and 2003 specifications. While the specifications for the study changed for the re-measurement periods, the impact to results appears to be minimal.

The decrease in ED utilization associated with Measure 1 appears to reflect progressive improvement over Re-measurement Period 1 and Re-measurement Period 2 resulting from interventions implemented in 2003 and 2004. Improvement and contributions of interventions to improvement for inpatient utilization is more suspect as progress is not sustained over measurement periods and not yet statistically significant.

Benchmark data appears to be from 2003 and represents a different regional area with different environmental and practice attributes. Subsequent analyses of re-measurement periods do not appear to address benchmarks.

Interventions were broad in scope and addressed many causes/barriers although documentation of analysis was not a robust discussion of barriers contributing to high utilization using traditional QI analytical techniques. Interventions in 2005 were a continuation of interventions initiated in 2003 and 2004 with a shift in 2006 toward using the DM program structure and processes as the primary intervention strategy. Documentation currently does not allow the reader to know what barrier the intervention or DM program activity will address.

Documentation submitted does not include the techniques used to complete the root cause analysis although barriers and causes were identified in the Asthma Care and Prevention Work Group Report (2004 Annual QI Program Evaluation) found in Tab 73; but not provided, yet showing the same level of analysis for 2005.

The Study should be considered reliable and valid with the confidence in reported results and ongoing improvement opportunity.

PIP Recommendations

- Add analysis documentation that describes techniques used for barrier analysis and specify what interventions are planned and implemented to address each barrier.
- Evaluate benchmarks and attempt to use more comparable geographical or national norm data. Expand analysis to include interpretation of success compared to updated benchmark.

Name of Performance Improvement Project: Improving Asthma Medication Management

Dates in Study Period: 01/01/2004 to 12/31/2005

I. ASSESSMENT OF STUDY METHODOLOGY

Step 1. REVIEW OF SELECTED STUDY TOPIC(S)

Component/Standard		M	PM	NM	N/A	Comments
1.1	Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	X				There is a description of the selection of the study topic. It does target an area of enrollee need and is supported by both national and local health plan data. The study is aimed at improving the rate appropriate medication therapy for members with persistent asthma.
1.2	Did the MCO's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services?	X				WellCare did address a broad spectrum of key aspects of enrollee care and services. The implemented interventions were designed to resolve ED and hospital admission issues, provider performance and education needs, member utilization and educational needs, and pharmaceutical issues.
1.3	Did the MCO's PIPs, over time, include all enrolled populations; i.e., did not exclude certain enrollees, such as those with SHCNs?	X				The study included all members ages 5 – 56 who were continuously enrolled during the measurement year, with no greater than a one month gap in the measurement year or the year prior to the measurement year, and who were identified as having persistent asthma in the year prior to the measurement year, and who had at least one dispensed prescription for inhaled corticosteroids, nedocromil, cromolyn sodium, leukotriene modifiers or methylxanthines in the measurement year. There were no other population exclusions.
Step 2. REVIEW OF THE STUDY QUESTION(S)						
2.1	Was/were the study question(s) stated clearly in writing?	X				The study is a HEDIS® measure. The study question was phrased clearly: "Will plan interventions to members and providers improve the rate of members with persistent asthma receiving appropriate medication therapy?"

Step 3. REVIEW OF SELECTED STUDY INDICATOR(S)						
3.1	Did the study use objective, clearly defined, measurable indicators?	X				The measures were objective and clearly defined. The measures were stratified into 3 age groupings and an overall rate (5 – 9 years, 10 – 17 years, 18 – 56, and 5 – 56 years) as required by HEDIS.
3.2	Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care, with strong association with improved outcomes?	X				The indicators measured processes of care – increasing the use of appropriate asthma medications for members with persistent asthma - which literature associates with the potential for improved outcomes.
3.3	Was there documentation of chosen Performance Targets including benchmarks used, or rationale/justification for the chosen performance target?		X			There were chosen performance targets for each measure, although they did not appear to be consistent. Each benchmark was a HEDIS benchmark from a different health plan located in different states other than Connecticut. The rationale for choosing these benchmarks was not documented.
Step 4. REVIEW OF IDENTIFIED STUDY POPULATION						
4.1	Did the MCO clearly define all Medicaid enrollees to whom the study question and indicators are relevant?	X				Yes.
4.2	If the MCO studied the entire population, did its data collection approach capture all enrollees to whom the study question applied?	X				The data collection approach did capture the appropriate population.
Step 5. REVIEW OF SAMPLING METHODS						
5.1	Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?				X	Sampling was not used for this study.
5.2	Did the MCO employ valid sampling techniques that protected against bias? *Specify the type of sampling or census used.*				X	

5.3	Did the sample contain a sufficient number of enrollees?				X	
Step 6. REVIEW OF DATA COLLECTION PROCEDURES						
6.1	Did the study design clearly specify the data to be collected?	X				The study methodology clearly defined the data to be collected. Computer programming documents for the study were presented. There were a couple of SAS programming errors identified. (More explanation is provided in Chapter 8 Performance Measures.)
6.2	Did the study design clearly specify the sources of data?	X				Data sources were identified as claims and encounter data and specified exact CPT, UB-92, NDC, and ICD-9 codes used. The codes are consistent with HEDIS specifications.
6.3	Did the study design specify a systemic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	X				Encounter data and capitated physician reporting are monitored on an ongoing basis and benchmarked against FFS physicians to ensure accuracy of the data. Exact details of guidelines or processes used to collect the data were identified.
6.4	Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	X				Data specifications detailed in provided documentation indicated consistent, accurate data collection over the study periods. Changes in age grouping required by DSS resulted in an initial study limitation, but this was adequately addressed in the study materials.
6.5	Did the study design prospectively specify a data analysis plan?	X				Study methodology was designed by National Committee for Quality Assurance (NCQA) as a HEDIS study. The programming materials were included in the PIP binder.

6.6	Were qualified staff and personnel used to collect the data?	X				Information about the staff qualifications relevant to data collection was not available. However, the Asthma Care QI Workgroup is multidisciplinary with appropriate personnel. The programming materials submitted with the PIP demonstrate that they were written by a qualified person (people). There is both QI Committee and Medical Advisory Committee oversight of the PIP processes.
Step 7. ASSESSMENT OF IMPROVEMENT STRATEGIES						
7.1	Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	X				Barriers were identified using literature and Task Force group consensus. Good use of current literature and clinical guidelines to support interventions chosen. Interventions included, but were not limited to: ▪ Contracted for home health visits to evaluate asthma issues in the home environment. ▪ Developed a variety of educational material targeted to specific populations – third trimester pregnant women, members with ED visits for asthma, all members with asthma to educate about allergies and proper use of medications. ▪ Developed a 'Fax Alert' system to notify PCPs of ED visits and hospital admissions for asthma and for members receiving more than 4 rescue inhalers in a 3 month period or who were not on an inhaled corticosteroid. Faxes included National Asthma Education and Prevention Program (NAEPP) Guidelines for the pharmacological management of asthma and WellCare's preferred asthma drug list.

						▪ Included "Clinical Practice Guidelines for the management of asthma" in new provider manual. Translated guidelines into lay language and mailed to members. ▪ Expanded DM program to proactively identify asthma members. Published articles in a variety of member and provider newsletters.
Step 8. REVIEW OF DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS						
8.1	Was an analysis of the findings performed according to the data analysis plan?	X				Analysis of data was conducted according to HEDIS specifications. Data analysis appears comprehensive.
8.2	Did the MCO present numerical PIP results and findings accurately and clearly?		X			The analysis did identify initial and repeat measurements, statistical significance comments, and findings. There was one error in the PIP relating to the baseline analysis for the 18 – 56 year group. The rate given on pages 6 and 7 is different from each other. The analysis on page 7 identifies the rate for the 18 – 59 (sic) as 58.52 percent, while the result on page 6 identifies the rate as 56.83 percent. This needs corrected in further study reports.
8.3	Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?	X				The analysis did identify initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurement, and factors that threaten the internal validity. Changes to HEDIS specifications between years 2004 and 2005 were mentioned.
8.4	Did the analysis of study data include an interpretation of the extent to which its PIP was successful and did it identify existing barriers that may be influencing indicators that did not meet established benchmarks?	X				An analysis of the success of the study was done. The rates improved to a significant degree over the two years of the study. Additional interventions were implemented during the second year of the study.

Step 9. ASSESSMENT OF IMPROVEMENT						
9.1	Was the same methodology as the baseline measurement, used, when measurement was repeated?	X				Technical specifications were changed by HEDIS and WellCare followed each year's specifications. These 2006 (for 2005 data) specifications included a slight change in the definition of persistent asthma and an additional ICD-9 Code was added to identify emphysema and COPD. The essential methodology of the study was not significantly changed, however.
9.2	Was there any documented, quantitative improvement in processes or outcomes of care?	X				Yes. There was significant quantitative increase in all four measures.
9.3	Does the reported improvement in performance have "face" validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?	X				Yes. There seems to be excellent correlation between the interventions and the results. WellCare took a multi-faceted approach to implementing interventions and focused on a variety of areas including pharmacy utilization, hospital and ED utilization, provider issues, member issues, educational needs, and clinical guideline issues.
9.4	Is there any statistical evidence that any observed performance improvement is true improvement?	X				Yes. All four measures (even including the one reported differently) showed statistically significant improvement. While none of the indicators met the benchmark in the baseline year, 3 out of 4 met their benchmark target in the second year of the study. The one indicator concerning 18 – 56 year olds, although not meeting its target, did show a significant improvement.

Step 10. ASSESSMENT OF SUSTAINED IMPROVEMENT						
10.1	Was sustained improvement demonstrated through repeated measurements over comparable time periods?	X				Yes. See 9.4 for comments.
ACTIVITY 2. VERIFICATION OF STUDY FINDINGS						
2.1	Were the initial study findings verified upon repeat measurement?	X				Yes.

Summary of Results

The PIP was well-organized and written. It demonstrated success in outcome improvement and a creative approach to interventions. The study methodology clearly defined the data to be collected. Data specifications detailed in the provided documentation indicated consistent, accurate data collection over the study periods. Changes in age grouping required by DSS resulted in an initial study limitation, but this was adequately addressed in the study materials. The analysis did identify initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurement, and factors that threaten the internal validity. Changes to HEDIS specifications between years 2004 and 2005 were mentioned.

There were chosen performance targets for each measure, although they did not appear to be consistent. Each benchmark was a HEDIS benchmark from a different health plan located in different states other than Connecticut. The rationale for choosing these benchmarks was not documented.

WellCare did address a broad spectrum of key aspects of enrollee care and services. The implemented interventions were designed to resolve ED and hospital admission issues, provider performance and education needs, member utilization and educational needs, and pharmaceutical issues.

There was significant quantitative increase in all four measures and there seems to be excellent correlation between the interventions and the results. WellCare took a multi-faceted approach to implementing interventions and focused on a variety of areas including pharmacy utilization, hospital and ED utilization, provider issues, member issues, educational needs, and clinical guideline issues.

PIP Recommendation

- Indicate rationale for choosing benchmarks in the study documentation.

Name of Performance Improvement Project: Improving Frequency of Prenatal Care and Timeliness of Postpartum Care

Dates in Study Period: 07/01/2002 to 12/31/2005

I. ASSESSMENT OF STUDY METHODOLOGY

Step 1. REVIEW OF SELECTED STUDY TOPIC(S)

Component/Standard		M	PM	NM	N/A	Comments
1.1	Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	X				There is a description of the selection and prioritization of the study. The PIP targets improving the frequency of prenatal care and timeliness of postpartum care with the hope of improving birth outcomes and decreasing costs of hospitalizations related to sick newborns. Information from the literature as well as health plan data was used to support the study selection. The rationale does not appear to have been updated since inception of the study. Although not mandatory, it should be updated annually with relevant data.
1.2	Did the MCO's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services?	X				Over time, the health plan addressed member education and access issues as well as education issues for providers.
1.3	Did the MCO's PIPs, over time, include all enrolled populations; i.e., did not exclude certain enrollees, such as those with SHCNs?	X				By nature of the study, populations who were not pregnant were excluded. For one measure, the study included women who delivered a live birth in the measurement period and who were effective on the date of the prenatal visits and the date of delivery. For another measure, women were included who delivered a live birth during the measurement year and were effective with the plan on the date of delivery and were continuously enrolled for 56 days after delivery.

Step 2. REVIEW OF THE STUDY QUESTION(S)						
2.1	Was/were the study question(s) stated clearly in writing?	X				There were two study questions and both were phrased clearly: 1. "Will targeted member and provider interventions improve the percentage of women who receive the expected number or prenatal visits?" 2. "Will targeted member and provider interventions improve the percentage of women who have a visit within 21 – 56 days after delivery?"
Step 3. REVIEW OF SELECTED STUDY INDICATOR(S)						
3.1	Did the study use objective, clearly defined, measurable indicators?	X				Both measures were clearly defined, objective, and measurable. The first indicator was a HEDIS-like measures as the numerator inclusion differs from HEDIS. The second measure was a HEDIS one.
3.2	Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care, with strong association with improved outcomes?	X				The measures were process measures associated with improved birth outcomes.
3.3	Was there documentation of chosen Performance Targets including benchmarks used, or rationale/justification for the chosen performance target?		X			The baseline benchmarks had as their source the 2002 NCQA 90th percentile score for HEDIS. The continuing chosen benchmarks seem unrealistically high considering their baseline result was 30.1 percentage points below the chosen benchmark of 72.7 percent. In 2004, a new benchmark of 83.71 percent was taken from University Health Plan even though the measures had not met the original lower benchmark.
Step 4. REVIEW OF IDENTIFIED STUDY POPULATION						
4.1	Did the MCO clearly define all Medicaid enrollees to whom the study question and indicators are relevant?	X				The first indicator did not follow HEDIS specifications exactly for numerator inclusion. It was more restrictive, but acceptable as it was measuring a more specific indicator. The second indicator followed HEDIS specifications.

4.2	If the MCO studied the entire population, did its data collection approach capture all enrollees to whom the study question applied?	X				Initially, the study was conducted with a strictly administrative data collection methodology. Starting with the measurement period, 7/1/2003 – 12/31/2003, the methodology changed to a hybrid type in which MRR was also conducted. The hybrid methodology would open the access to the possibility of collecting data on more members of the defined population.
Step 5. REVIEW OF SAMPLING METHODS						
5.1	Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?				X	No sampling was used in this study.
5.2	Did the MCO employ valid sampling techniques that protected against bias? *Specify the type of sampling or census used.*				X	
5.3	Did the sample contain a sufficient number of enrollees?				X	
Step 6. REVIEW OF DATA COLLECTION PROCEDURES						
6.1	Did the study design clearly specify the data to be collected?	X				The data for the second indicator was collected using HEDIS specifications. The data for the first indicator followed a logical process to arrive at accurate results.
6.2	Did the study design clearly specify the sources of data?	X				The documents provided included computer processes and coding.
6.3	Did the study design specify a systemic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	X				The study design always represented the universe of pregnant women with specified enrollment characteristics. The baseline year only used administrative data to capture results, but this was changed in the following study years to a hybrid methodology which does allow for the possibility of inclusion of actual results from more members.

6.4	Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	X				The data collection methodology improved the results once the baseline study moved toward a hybrid methodology.
6.5	Did the study design prospectively specify a data analysis plan?	X				The study for the first indicator followed DSS requirements. The study for the second indicator followed the HEDIS format.
6.6	Were qualified staff and personnel used to collect the data?	X				No information was provided relating to staff used to collect data. However, a Perinatal Work Group, Perinatal Case Managers, QI, and Medical Advisory individuals all had input into data collection and analysis. From the listing of attendance in minutes, it appears the health plan had qualified staff collecting the data and overseeing the project.
Step 7. ASSESSMENT OF IMPROVEMENT STRATEGIES						
7.1	Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?		X			The barriers to care were identified through a literature review in 2002. There was minimal investigation into barriers specific to the health plan until 2005. Interventions were taken, but the success of the project may have been strengthened if barriers specific to their members were targets of intervention processes. The interventions included activities such as: ▪ educational mailings to members; ▪ sending copy of pre-certification letter to member and provider; ▪ mailings responding to member's request for additional information; ▪ provision of a telephone card for member to use in calling resources; ▪ mailing postpartum visit reminder cards; ▪ provider visits to inform them of program;

						▪ article in Provider newsletter and member newsletter; ▪ mailing of appropriate billing codes to providers; and ▪ implemented new member welcome outreach calls to identify pregnant members. The Perinatal Work Group had a very nice action plan that tracked interventions by month.
Step 8. REVIEW OF DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS						
8.1	Was an analysis of the findings performed according to the data analysis plan?	X				The plan for data analysis was to follow HEDIS specifications and/or DSS specifications. WellCare provided computerized documentation of codes used and processes followed.
8.2	Did the MCO present numerical PIP results and findings accurately and clearly?	X				Yes.
8.3	Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?		X			The results indicated whether the figures were significant statistically or not. It also identified when methodology changed. However, the analysis did not include a discussion of the effect/impact the change in methodology (from using administrative data to hybrid collection) had in relation to the next re-measurement period/year's results.

8.4	Did the analysis of study data include an interpretation of the extent to which its PIP was successful and did it identify existing barriers that may be influencing indicators that did not meet established benchmarks?		X			The analysis of the study results did include an interpretation of the extent to which the PIP was successful. But, the health plan continued to rely on a 1993 article and a grid from a medical textbook for identification of barriers. The documentation did not demonstrate that a thorough examination of barriers specific to their members was ever done until 2005. In 2005, they did identify one new barrier. They identified that the health plan frequently did not know that a member was pregnant until they delivered. But, there was no analysis of the effect of this intervention on the improvement in results for the 7/01/2005 – 12/31/2005. There was no indication of analysis of the results of implementation of a CM program on results.
Step 9. ASSESSMENT OF IMPROVEMENT						
9.1	Was the same methodology as the baseline measurement, used, when measurement was repeated?	X				No, there was a change from administrative data collection to a hybrid collection, but this was well-documented and appropriate.
9.2	Was there any documented, quantitative improvement in processes or outcomes of care?		X			There was significant or slight increase in results, with the exception of 1 year (2004), for Indicator 1 concerning an increase in prenatal visits. Indicator 2 concerning postpartum visits showed variable results with some years showing improvement and other years showing a decline. The most recent findings did show a significant improvement, but this has not been a consistent finding over the life of the study.

9.3	Does the reported improvement in performance have “face” validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?		X			For Indicator 1, the improvement in results could be an effect of the planned improvements, but there is no analysis of results by members who participated in any of the interventions versus those who did not. So, it is difficult to determine whether the success was as a result of the interventions or not. However, it is reasonable to assume that the concentration on intervention activities probably affected the results. For Indicator 2, there was such variability in the results, that face validity could not be established.
9.4	Is there any statistical evidence that any observed performance improvement is true improvement?	X				Indicator 1 indicated true improvement fairly consistently. Indicator 2 showed some improvement by the fourth year (sixth measurement period) of the study that was statically significant over previous years.
Step 10. ASSESSMENT OF SUSTAINED IMPROVEMENT						
10.1	Was sustained improvement demonstrated through repeated measurements over comparable time periods?		X			Indicator 1 had fairly consistent sustained improvement in the measure. Indicator 2 did not show sustained improvement.
ACTIVITY 2. VERIFICATION OF STUDY FINDINGS						
2.1	Were the initial study findings verified upon repeat measurement?	X				Yes.

Summary of Results

The rationale for this study does not appear to have been updated since inception of the study. Although not mandatory, it should be updated annually with relevant data. This study used two measures that were clearly defined, objective, and measurable. The first indicator was a HEDIS-like measures and the second measure was a HEDIS one. The chosen benchmarks seemed unrealistically high for the ongoing results.

The plan for data analysis was to follow HEDIS specifications and/or DSS specifications. WellCare provided computerized documentation of codes used and processes followed. The PIP identified when methodology changed. However, the analysis did not include a discussion of the effect/impact the change in methodology (from using administrative data to hybrid collection) had in relation to the next re-measurement period/year's results. The analysis of barriers and the effects of intervention on results was weak in this PIP.

For Indicator 1, the improvement in results could be an effect of the planned improvements, but there is no analysis of results by members who participated in any of the interventions versus those who did not. So, it is difficult to determine whether the success was as a result of the interventions or not. However, it is reasonable to assume that the concentration on intervention activities probably affected the results. For Indicator 2, there was such variability in the results, that face validity could not be established.

PIP Recommendation

- Update the rationale for the PIP with new data from the health plan and current literature support for continuing the study on an annual basis.
- Consider using NCQA Medicaid National Average scores as a benchmark for this study, until results improve.
- Conduct a more robust analysis of current barriers and effects of interventions on compliant versus non-compliant members.

8

Validation of Performance Measures

Objective 1
To evaluate the accuracy of Medicaid PMs reported by WellCare.

Objective 2
To determine the extent to which Medicaid-specific PMs calculated by an MCO followed specifications established by DSS for the calculation of PMs.

Objective

The purpose of this review is to assess the validity of the following PMs undertaken by WellCare for the time period Calendar Year (CY) 2005:

Measure 1 — Asthma Medications;
Measure 2 — EPSDT;
Measure 3 — Newborn Intensive Care Unit (NICU) Days; and
Measure 4 — Prenatal/Postpartum Care.

Assessment of Strengths and Weaknesses

An information request was developed to gather information from WellCare regarding the PMs, and a review of the documentation was performed. The following steps were completed, and key questions answered (as applicable), in validating each measure:

- Assess documentation of processes used to calculate and report PMs.
- Do appropriate and complete measurement plans and programming specifications exist that include data tables used and programming logic?
- Review processes used to produce denominators.
- Are data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) complete and accurate?
- Is continuous enrollment criteria correctly applied?
- Are age and gender specifications adhered to?
- Are clinical codes (e.g., ICD-9, CPT, DSM-IV) used appropriately?
- Are member months or member years calculated correctly?
- Review processes used to produce numerators.
- Are data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO network) complete and accurate?
- Are correct time parameters (e.g., admission and discharge dates or treatment start and stop dates) used?
- Are MRR documentation and tools adequate?
- If hybrid method was used, is the integration of administrative and medical record data adequate?
- If hybrid method or solely MRR was used, do the results of the MRR validation substantiate the reported numerator?

- Assess the sampling processes.
- Is sample unbiased?
- Does sample treat all measures independently?
- Are sample size and replacement methodology specifications met?
- Assess submission of required PM reports to DSS.
- Are DSS specifications for reporting PMs followed?

After all audit elements were assessed, a validation finding for each measure was determined based on the magnitude of errors detected in the review, according to the following scale:

Validation Findings

Fully Compliant	Substantially Compliant	Not Valid	Not Applicable
Measure was fully compliant with DSS specifications	Measure was substantially compliant with DSS specifications and had only minor deviations that did not significantly bias the reported rate	Measure deviated from DSS specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required	Measure was not reported because MCO did not have any Medicaid enrollees that qualified for the denominator

A summary of the results is presented in the following table. A detailed presentation of the findings and conclusions of each measure follows:

PM	2005 Validation Findings
Asthma Medications	Substantially Compliant
EPSDT	Fully Compliant
NICU Days	Fully Compliant
Prenatal/Post Partum Care	Fully Compliant

Conclusions Drawn

The validation findings assigned to each measure are based on the documentation provided. Specific issues with each PM follow:

PM	2003 Validation Findings	2004 Validation Findings	2005 Validation Findings	Issues
Asthma Medications	N/A	Fully Compliant	Substantially Compliant	The following inconsistencies were noted in the SAS programming code. Mercer would like WellCare to verify these notations and update the coding where necessary. In identifying eligibility, the SAS code specifies continuous enrollment parameters in data step elig05a. It appears that the code specifies eligibility using a maximum enrollment date of December 31, 2005 and should specify enrollment **prior to** December 31, 2005. The code reads: intnx (‘day’, maxterm, -1, ”b’) **=** &enddate; Suggested **update:** intnx (‘day’, maxterm, -1, ”b’) **<=** &enddate; The HEDIS 2006 specifications state the following: “To calculate dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and **round down** to convert.” The SAS coding utilizes the general “Round” function which rounds up, not down. Suggested **update:** The “Floor” function should be utilized to round down and accurately reflect the HEDIS specifications. Data step “rxcheck1” is designed to include the records in rx3 only, and exclude the records in the “other” data (nonmedsing). The logic expression “if rx and oth then delete” is not correct. This results in “rxcheck1” including those records only occurring in “other” in addition to those only in “rx3”.

PM	2003 Validation Findings	2004 Validation Findings	2005 Validation Findings	Issues
				Suggested **update:** The logic expression should be "if rx and **not** oth" The de-dup procedure for denom05c incorrectly deletes records for the current measurement year and keeps prior year records. SAS always deletes the second year of data in the de-dup process and the code is set-up with 2005 as the second year. This affects the age grouping for the denominator, specifically where individuals are on the cusp of an age bracket. The current year age group should be included in the current measurement year calculation, not the prior year age group.
EPSDT	Substantially Compliant	Fully Compliant	Fully Compliant	SAS coding includes several codes on the Health Track Codes Listing including: 3000Y, 99245, 99244, 99243, 99242, 99241, 99215, 9938R, 9938T, 9939R, 9939T, 9943R, 9943T. These are State codes for office visits, which should have been removed as of 2003. The effect of including these old codes is likely null, but the coding should be cleaned up to reflect the accurate codes for the current time period. There is a calculation error on the HUSKY B (07/01/05 – 12/31/05) report. Row 12d in the 19-20 age grouping should reflect 25 percent not 4.3 percent (1/4 = 25 percent). Considering this line item is not required according to the DSS specifications this does not affect the validity of this measure, but should be corrected for future reference.
NICU Days	Substantially Compliant	Fully Compliant	Fully Compliant	The labeling of this measure in the documentation, programming code, and final report is incorrect. The measure is calculated by dividing the number of eligible member months into the number of identified NICU Days and multiplying the result by 12,000, which results in NICU Days per 1,000 Members not Member Months. The label should be updated to commensurate with the calculation reflecting NICU Days per 1,000 members.
Prenatal/Post-Partum Care	Substantially Compliant	Fully Compliant	Fully Compliant	Inconsistencies in individual line items in the final report may benefit from the support of caveats specifying unique data rationales for discrepancies in totals. For instance, notating the number of multiple births included in the number of deliveries will verify the associated total births (live births - fetal deaths).

The Asthma Medications measure declined from a fully compliant measure in 2004 to a substantially compliant measure in 2005 due to the identification of several inconsistencies in the SAS programming code. The individual effects of these coding issues may be small, but when considered overall the results of the measure may be significantly impacted. The EPSDT, NICU Days, and Prenatal/Post-Partum Care measures maintained their fully compliant status although areas of concern were identified for each.

Recommendations

- Thoroughly review the SAS programming code for the Asthma Medications' measure and implement the suggested updates as appropriate.
- Incorporate the previously identified comments for the most accurate and current measurement documentation into the EPSDT, NICU Days, and Prenatal/Postpartum Care measures.

9

Calculation of Performance Measures

Objective 1
To calculate Medicaid PMs for WellCare in accordance with specifications prescribed by DSS.

Objective 2
To provide information to DSS on the extent to which WellCare's information systems provided accurate and complete information necessary for the calculation of PMs.

The purpose of this component of the EQR was to use WellCare's encounter data (submitted monthly by WellCare to Mercer) to calculate the following six measures:

- Measure 1 –NICU Admits/100 Births;
- Measure 2 – ED Usage/1,000 Member Months;
- Measure 3 – Readmission Rates;
- Measure 4 – Diabetic Retinal Exams;
- Measure 5 – Breast Cancer Screening/Mammography; and
- Measure 6 – ED Usage by Asthmatics.

Baseline rates for 4 of the measures were established 2 years ago. In calculating these measures again, we were able to assess if WellCare had improved performance in these areas. Specifications for the ED visits per 1,000 member months changed this year; however, all 3 years were recalculated using the new methodology. The change was made so that the specifications match a report that the State currently receives from the health plans. The last measure related to ED usage by asthmatics, replaced the previous year's Provider Network Adequacy measure. Last year's calculation represents the baseline measurement.

Assessments and Measurements

The reporting period for the measurements was CY 2005, which includes January 1, 2005 through December 31, 2005.

Measure 1 – NICU Admits/100 Births
Description: Percentage of live newborns during the reporting period who were admitted to the NICU.

The denominator was the number of live births that occurred during the reporting period. Births were determined using the ICD9 codes 640–669 where the fifth digit was a "1" or "2" (this indicates a delivery occurred), 650 (with or without fourth and fifth digits), and V27.0, V27.2, V27.3, V27.5 and V27.6. The numerator was the number of admissions to the NICU determined by revenue codes 0172, 0173, and 0174 or CPT4 codes 99295, 99296, 99298, and 99299.

Measure	Value		
	2003	2004	2005
Number of NICU Admissions	52	96	129
Number of Births	527	780	822
NICU Admits/100 Births	**9.9%**	**12.3%**	**15.7%**

National rates vary from 8 to 12 percent for this measure. The overall rate for the 4 State health plans in 2005 was 11.7 percent. WellCare's 2005 rate is higher than both the national and State overall rates and has increased since last year.

Measure 2 – ED Usage/1,000 Member Months
Description: Number of ED visits during the reporting period per 1,000 member months.

The denominator was the number of member months for CY 2005. The numerator was the number of ED visits between January 1, 2005 and December 31, 2005, where ED visits were defined by revenue codes 0450, 0451, 0452, and 0459. Any visits that resulted in a hospital admission were excluded in the numerator as this is how WellCare reports to the State.

Measure	Value		
	2003	2004	2005
Number ED Visits	13,370	18,937	23,005
Member Months	219,603	333,358	391,194
ED Usage/1,000 Member Monthss	**60.9**	**56.8**	**58.8**

Methodology for this measure changed to match State reports more closely. The rate for the State overall for 2003 was 58.0, 2004 was 55.5, and for 2005 was 61.1. Benchmarks are highly variable as a variety of measurement types are used in the literature. Consensus is that rates are going up, but there is no agreement as to how to measure this. Another factor to keep in mind is that according to HEDIS, the Medicaid rates are triple those of commercial plans and so we would expect a higher rate of usage. WellCare's 2005 rate is higher than last year but is lower than the State's overall rate.

Measure 3 – Readmission Rates
Description: Rate of hospital readmissions for same or similar diagnosis within seven days of discharge.

The denominator was the number of hospital discharges between January 1, 2005 and December 31, 2005. The numerator was the number of hospital readmissions within seven days of a hospital discharge for a same or similar diagnosis. Only primary diagnosis codes were used to calculate this measure. Only the first three digits of the diagnosis code were used for this analysis. Prior to counting readmissions, it is important to apply a continuing stay criteria so that the readmission rate is not artificially inflated. This entails combining stays for a member who had a date of admission on the same date as a discharge or within one day of discharge. This removed the impact of any interim billing that might exist.

Measure	Value		
	2003	2004	2005
Number of Readmits	20	16	37
Number of Discharges	1,950	2,824	3,716
Readmission Rates	**1.0%**	**0.6%**	**1.0%**

No national benchmarks are available for this measure. It is being tracked annually to determine if there are any significant changes. The State plan average for 2005 was 1.2 percent, up from 0.8 percent in 2004. Although WellCare's 2005 rate is higher than that of 2004, it is lower than the State's overall rate for 2005.

Measure 4 – Diabetic Retinal Exam
Description: Percent of members 18 – 75 years of age with diabetes (Type 1 and 2) who were continuously enrolled during the study period who had a retinal eye exam performed during the study period.

The denominator was the number of members between 18 and 75 years of age as of December 31, 2005, who were enrolled during the study period with no more than a one-month gap in enrollment. These members had an administrative record of diabetes during the study period or in the year prior to the study period. Diabetes was determined by either of two methodologies. The first was an administrative record of a diabetic prescription using the list of drugs provided by NCQA. The second way of determining a diabetic was a diagnosis code of 250, 357.2, 362.0, 366.41, 648.0, or a DRG code of 294 or 205 with either two outpatient or physician administrative records on different dates of service or one inpatient or ED record. The numerator was the number of members who received a retinal eye exam defined by the CPT codes 67101, 67105, 67107, 67108, 67110, 67112, 67141, 67145, 67208, 67210, 67218, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92225, 92226, 92230, 92235, 92240, 92250, 92260, 92287, 99204, 99205, 99214, 99215, 99242, 99243, 99244, 99245, ICD-9 procedure codes 14.1, 14.2, 14.3, 14.4, 14.5, 14.9, 95.02, 95.03, 95.04, 95.11, 95.12, 95.16 or an ICD-9 diagnosis code of V72.0 between the dates of January 1, 2005 and December 31, 2005. These codes are specified by NCQA in the HEDIS 2006 manual, volume 2.

Measure	Value		
	2003	2004	2005
Number of members receiving eye exam	27	31	447
Continuously enrolled eligibles	161	254	525
Diabetic Retinal Exam	**16.8%**	**12.2%**	**85.1%**

HEDIS benchmarks for Medicaid plans for this measure were 54.0 percent in 2002, 51.6 percent in 2003, 45.0 percent for 2004 and 44.1 percent in 2005. The State's overall rate is 87.8 percent for 2005. WellCare is above the national average but is below the overall state rate. The 2005 measures increased substantially when compared to the previous years as a change was made to the HEDIS specifications. The diagnosis code of V72.0 (general eye exam) was added to the codes used to identify the numerator. There is no way to identify that a dilated eye exam was performed using administrative data and therefore V72.0 was added as a proxy.

Measure 5 – Breast Cancer Screening/Mammography
Description: Percent of women ages 41 – 69 as of December 31, 2005, who were continuously enrolled during the reporting period, did not have bilateral mastectomies and who had a mammogram during the reporting period.

The denominator was the number of women 41 – 69 years of age as of December 31, 2005, who were enrolled with no more than a one-month gap during the enrollment period, who did not have a bilateral mastectomy on or before December 31, 2005. Bilateral mastectomy was determined with ICD9 procedure codes 85.42, 85.44, 85.46, or 85.48 or CPT codes 19180, 19200, 19220 or 19240. The numerator was the number of women who received a mammogram between January 1, 2005 and December 31, 2005. Mammograms were defined by CPT codes 76090, 76091 or 76092 or ICD9 codes V76.11 or V76.12, or revenue codes 0401 or 0403.

Measure	Value		
	2003	2004	2005
Number of women with mammograms	106	158	195
Number of women continuously enrolled	470	681	765
Breast Cancer Screening/Mammography	**22.6%**	**23.2%**	**25.5%**

Benchmarks are not available for this measure as specifications vary widely. The State plan average in 2003 was 31.4 percent, 2004 was 31.9 percent and in 2005 was 34.8 percent. WellCare's 2005 rate is substantially lower than the State overall rate for 2005.

Measure 6 – ED Usage by Asthmatics

Description: Percent of asthma patients greater than age two as of December 31, 2005 who were continuously enrolled during the reporting period and for the six months preceding the reporting period, who received a service with a primary diagnosis of asthma in the six months preceding the reporting period, who had one or more ED visits during the reporting period and who did not have a non-primary diagnosis of COPD or Emphysema on the same encounter as a primary asthma diagnosis during the reporting period or preceding six month period.

The denominator was the number of members greater than two years of age, who were enrolled with no more than a one month gap during the enrollment period and the previous six months and who had a diagnosis of asthma during the six months prior to the reporting period. The numerator was the number of members greater than two years of age on December 31, 2005 who had an asthma diagnosis during the six months preceding the reporting period, who had a visit to an ED during the reporting period and who did not have COPD or Emphysema. Asthma diagnoses were identified by the ICD9 code of 493, regardless of the fourth or fifth digits. COPD and Emphysema were identified using ICD9 codes 491.20, 491.21, 943.2, 943.20, 493.21, 493.22, 496.xx, 506.4, 518.1, 518.2, 492.xx or 506.xx. Emergency department visits were identified using revenue codes 0450, 0451, 0452, 0459, 0981 or CPT codes 99281, 99282, 99283, 99284, 99285 or 99288. Inpatient and outpatient records were compared and for those claims with equal dates of service only one was used. Any ED visits resulting in a hospital admission were excluded.

Measure	Value		
	2003	2004	2005
Number of asthmatics who were seen in the ED	N/A	62	104
Total of asthmatic members	N/A	408	604
ED Usage by Asthmatics	**N/A**	**15.2%**	**17.2%**

Benchmarks for this measure are not available. Mercer will track these rates annually. The State's overall rate for this measure in 2005 is 15.4 percent. WellCare's rate is higher than the State's overall rate and has increased over the previous year..

Recommendations

- Evaluate the prenatal care standards and perhaps implement more rigorous standards for high-risk pregnancies as the NICU usage has increased to more than the national average.
- Continue the breast cancer screening efforts and explore other options for increasing mammogram compliance.

Appendix A

Appendix A – Documentation Submitted for Review

Chapter 1: Enrollee Rights and Protection

- Policy and Procedure CT4CS 04-28, Enrollee Notification of Terminated Specialty Provider
- Terminated Specialist Letter
- Policy and Procedure CT4UM 10; Transition of Care/Continuity of Care
- Participating Provider Manual, Section 2, Page 7

Chapter 2: Grievance and Appeals

- Policy and Procedure CT4UM 19; Notice of Action
- WellCare Sample Notices of Action
- Benecare Policy
- Benecare Sample Notice of Action
- Benecare Oversight Tool Results
- OptiCare Policy 0700-AS
- OptiCare Sample Notice of Action
- OptiCare Oversight Tool Results
- CTS Policy
- CTS Sample Notice of Action
- CTS Oversight Tool Results
- CompCare Policy
- CompCare Sample Notice of Action
- Compcare Oversight Tool Results

Chapter 3: Network Access and Availability

- 2005 WellCare Quality Improvement Program Description
- 2006 WellCare Quality Improvement Program Description
- Policy and Procedure CT4PR 01; Provider Network Development and Adequacy
- WellCare GEO Access Maps and Reports Identifying PCPs
- WellCare GEO Access Maps and Reports Identifying OB-GYNs
- Benecare GEO Access Maps and Reports Identifying Behavioral Health Providers
- OptiCare GEO Access Maps and Reports Identifying Vision Providers
- Policy and Procedure CT4PR 11; Provider Relations Roles and Responsibilities
- Participating Provider Recruitment Brochure
- Memorandum to the Medical Advisory Committee, April 13, 2006
- Medical Advisory Committee Minutes, April 18, 2006, page 15 – 16
- Quality Improvement Committee Minutes, May 23, 2006, page 30
- Policy and Procedure CT4PR 02 PCP Scheduling and Capacity/Network Availability and Accessibility
- Participating Provider Agreement page 30 (A.)
- Participating Provider Manual, Section 3, page 4
- Participating Provider Newsletter, Spring 2006
- CT Accessibility Survey Script
- CT After Hours Audit Script
- WellCare CT Timely Access Survey Summary Report (Appointment Availability)
- WellCare CT Timely Access Survey Summary Report (After Hours)
- Memorandum to the Medical Advisory Committee – May 16, 2006
- Medical Advisory to Committee Minutes, May 16, 2006, pages 9 – 10
- Quality Improvement Committee Minutes, May 23, 2006, pages 10 – 11
- Access and Availability Corrective Action Plan Sample Letters
- After Hours Corrective Action Plan Sample Letters

Chapter 4: Compliance with HUSKY b, HUSKY Plus and HUSKY B Co-payment Contract Requirements

- 2006 QI Program Description
- HUSKY B EPSDT Reporting for period 07/01/05 – 12/31/05
- HUSKY B Hospital Inpatient Report for period 07/01/05 – 12/31/05
- HUSKY B Ambulatory Services report for period 07/01/05 – 12/31/05
- HUSKY B Outpatient Prescription Drug Utilization report for period 07/01/05 – 12/31/05
- HUSKY B ER Visit report for period 07/01/05 – 12/31/05
- HUSKY B Ambulatory Services report for period 07/01/04 – 06/30/05
- HUSKY B Two Year Immunization Status report for period 07/01/04 – 06/31/05
- HUSKY B Well Child Visits Reporting for period 07/01/04 – 06/30/05
- Performance Improvement Project Binders
- Medical Advisory Committee Minutes, April 18, 2006, page 15
- Quality Improvement Committee Minutes, April 11, 2006, page 27
- Policy and Procedure C12BL-BL48; Healthcare for Uninsured Kids and Youth (HUSKY) B Billing and Payments
- Policy and Procedure CT4CS 04 Administration of Out-of-Pocket Maximums for HUSKY B
- Screenshot of Paradigm with co-payment deduction prior to OOP maximum being reached
- Screenshot of Paradigm with no co-payment deduction after OOP maximum has been reached
- Sample HUSKY B identification card after OOP maximum has been reached
- Vendor Co-payment report, through 2005Q3
- Vendor Co-payment report, through 2005Q4

Chapter 5: Medical Record Review

- Listing of practitioners who have been terminated (either voluntarily or involuntarily) during the credentialing/recredentialing process during CY 2005
- Policy and Procedure CT4CM 01; Case Management Services Policy
- Listing of enrollees who have been Case Managed between October 1, 2005 and December 31, 2005
- Policy and Procedure C7 QI 04-07; Asthma Disease Management
- Policy and Procedure C7 QI 04-19; Diabetes Disease Management
- Listing of enrollees who have been Disease Managed between October 1, 2005 and December 31, 2005
- HUSKY A Notice of Action Log 2005
- HUSKY B Denial Log
- Policy and Procedure CT4CS 05; Customer Service Grievance
- Copy of Customer Service Contact Log

Chapter 6: Quality Assessment and Performance Improvement; Binder #1 (QAPI)

- Policy and Procedure C7 QI 04-15; Medical Record Review
- Policy and Procedure CT4PR 10; Provider Orientation
- Participating Provider Agreement
- Participating Provider Reference Manual
- Quick Reference Guides
- Policy and Procedure CT4PR 05-01; Provider Network Development and Adequacy
- Policy and Procedure CT4PR 05-06; Minority Recruitment and Retention
- Provider Recruitment Brochure
- Provider Relation Access and Availability report and Memorandum to the MAC
- GEO Access Reports and Maps
- Medical Advisory Committee Minutes, April 18, 2006, pages 15 – 16

- Quality Improvement Committee, May 23, 2006, page 30
- Policy and Procedure (C7CR 04-56; Ongoing Monitoring of Providers
- Policy and Procedure C7CR 04-CR43; State Disciplinary Action/Sanction Review
- Credentialing Committee Minutes, April 28, 2005, page 5
- Credentialing Committee Minutes, May 26, 2005, page 2
- Credentialing Committee Minutes, June 30, 2005, page 2
- Credentialing Committee Minutes, February 21, 2006, pages 4 – 5
- 2005 Credentialed Providers Monthly Report
- YTD2006 Credentialed Providers Monthly Report
- Key Indicator Report, October 2005
- Service Fund Report
- Claim File – Monthly file for prior month's paid claims
- PCP Pharmacy Profile, February 2006
- Capitation File – Monthly file for current month's capitation payments
- Policy and Procedure CT4PR 02; PCP Scheduling and Capacity/Network Availability and Accessibility
- Participating Provider Agreement, page 30 (A.)
- Participating Provider Manual, Section 3, pages 4 – 5
- Participating Provider Newsletter, Spring 2006
- CT Accessibility Survey Script
- CT After Hours Audit Script
- Provider Relations Access and Availability Report to the MAC
- CT Access and Availability Survey Results Report
- CT After Hours Audit Results Report Medical Advisory Committee Minutes, May 16, 2006, pages 9 – 10
- Quality Improvement Committee Minutes, May 23, 2006, pages 10 – 11
- Access and Availability Corrective Action Plan Sample Letters

- After Hours Corrective Action Plan Sample Letters
- Participating Provider Newsletter, Fall/Winter 2005
- Participating Provider Newsletter, Spring 2006
- Provider Bulletin, “Flu Vaccination Season, 2005 – 2006,” October 27, 2005
- Provider Fee Schedule Enhancement August 5, 2005
- Provider Notification of Standardized OB Notification Forms, October, 2005
- Behavioral Health Partnership Overview, November, 2005
- FAQs Regarding the Behavioral Health Partnership
- Provider Bulletin, “PreferredOne Introduces Mandatory Drug Formulary,” January 5, 2006
- HUSKY A Member Handbook
- HUSKY B Member Handbook
- Customer Service Quality Improvement Workgroup Minutes, February 28, 2006, pages 5 – 6
- Customer Service Quality Improvement Workgroup Minutes, March 30, 2006, pages 3 – 4
- CAHPS Survey Instrument
- CAHPS Summary Survey Results
- Medical Advisory Committee Meeting Minutes, February 21, 2006, pages 7 – 8
- Quality Improvement Committee Minutes, March 14, 2006, pages 7 – 9
- Member Advisory Workgroup Minutes, March 22, pages 9 – 11
- Policy and Procedure CT4CS 05-05; Grievance and Complaint Resolution
- Screenshot of Paradigm CSCL
- Medicaid Member Grievance and Complaints Report, 2005
- Customer Service Quality Improvement Workgroup Minutes, February 28, 2006, pages 5 – 6
- Medicaid Member Grievance and Complaints, page 2
- Customer Service Quality Improvement Workgroup Minutes, February Workgroup Minutes, February 28, 2006, pages 5 – 6
- Customer Service Quality Improvement Workgroup Minutes, March 30, 2006, pages 2 – 3

- Quality Improvement Program Description 2005
- Quality Improvement Program Description 2006
- Medical Advisory Committee Minutes, May 3, 2005, page 6
- Quality Improvement Committee Minutes, May 31, 2005, page 2
- Medical Advisory Committee Minutes, March 21, 2006, page 13
- Quality Improvement Committee Minutes, April 11, 2006, pages 12 – 13
- 2005 Quality Improvement Workplan
- 2006 Quality Improvement Workplan
- Medical Advisory Committee Minutes, May 3, 2005, page 6
- Medical Advisory Committee Minutes, March 21, 2006, pages 13 – 14
- Quality Improvement Committee Minutes, April 11, 2006, pages 21 – 22
- 2005 Quality Improvement Annual Program Evaluation
- Medical Advisory Committee Minutes, March 21, 2006, pages 11 – 12
- Quality Improvement Committee Minutes, April 11, 2006, pages 11 – 12
- Utilization Management Program Description
- Medical Advisory Committee Minutes, March 21, 2006, pages 14 – 15
- Quality Improvement Committee Minutes, April 11, 2006, pages 14 – 15
- Minutes of a Meeting of the Board of Directors of WellCare of Connecticut, Inc., March 30, 2006, pages 1 – 2
- 2005 Utilization Management Workplan
- 2006 Utilization Management Workplan
- Medical Advisory Committee Minutes, June 7, 2005, page 17
- Quality Improvement Committee Minutes, June 13, 2005, page 15
- Medical Advisory Committee Minutes, April 18, 2006, page 13
- Quality Improvement Committee Minutes, April 11, 2006, page 23
- 2004 – 2005 Case Management Program Description

- 2006 Case Management Program Description
- 2004 – 2005 Perinatal Management Program Description
- 2006 Perinatal Management Program Description
- Quality Improvement Committee Minutes, April 11, 2006, pages 25 – 26
- Medical Advisory Committee Minutes, April 18, 2006, pages 13 – 15
- 2005 Asthma Disease Management Program Description
- 2005 Diabetes Disease Management Program Description
- Medical Advisory Committee Minutes, June 7, 2005, pages 20 – 21
- Quality Improvement Committee Minutes, June 13, 2005, page 18
- Quality Improvement Committee Minutes, June 13, 2005, pages 4 – 7, pages 11 – 12, pages 19 – 21, and page 25
- Medical Advisory Committee Minutes, June 7, 2005, pages 6 – 8 and pages 13 – 14
- Medical Advisory Committee Minutes, January 17, 2006, pages 9 – 10
- Quality Improvement Committee Minutes, February 14, 2006, pages 6 – 12
- Quality Improvement Committee Minutes, March 21, 2006, pages 5 – 7, pages 12 – 16
- QIA – Improving Adolescent Access to Preventive Healthcare
- QIA – Improving Asthma Medication Management
- QIA – Improving Frequency of Prenatal Care and Timeliness of Postpartum Care
- QIA – Descreasing ER Utilization and Inpatient Admissions for Members with Asthma
- Policy and Procedure CT4UM 04-10; Transition/Continuity of Care
- Policy and Procedure CT4UM 05-06; Screening Pregnant Members for Case Management
- HUSKY Behavioral Health Care-Out, Coverage and Coordination of Medical and Behavioral Services, November 3, 2005
- HUSKY Behavioral Health Carve-Out Transition Meeting, Agenda and Minutes, January 19, 2006
- MCO Interface Meeting – Preferred One and CT Behavioral Health Partnership Agenda, March 29, 2006
- Member Newsletter, “Important Information About Changes Affecting Behavioral Healthcare for You or Your Child, 4th Q 2005
- Key Indicator Report

- Authorization Reports
- Profitability Reports
- Monthly Call Center Statistics
- Customer Service Quality Improvement Workgroup Minutes, February 28, 2006, pages 3 – 4
- Policy and Procedure C7AG 05-AG4.5; Provider Claim Appeals
- Utilization Management Review Workgroup Minutes, December 20, 2005, page 5
- 2005 Provider Claims Appeals/1000j Claims Denials by Appeal Reason
- Medical Advisory Committee Minutes, May 16, 2006, page 11
- Policy and Procedure CT4CS 04-028; Member Rights, page 2, procedure 7
- Corporate Off-Site Staff Communication Meeting Minutes, May 5, 2005, page 3, item II
- Corporate Off-Site Staff Communication Meeting Sign-in Sheet, May 5, 2005
- Screenshot of WellCareLink Website
- Screenshot of WellCare University Website
- Screenshot of WellCare Corporate Policies and Procedures Website
- Policy and Procedure C6CS 04-007, Advance Directives, page 2, procedure 8
- Corporate Off-Site Communication Meeting Minutes, June 16, 2005, page 3, item V
- Corporate Off-Site Communication Meeting Sign-in Sheet, June 16, 2005
- Corporate Off-Site Communication Meeting Presentation, June 16, 2005
- Customer Service Staff Meeting Minutes, December 5, 2005, page 2
- Claims Integrity Staff Meeting Minutes, May 24, 2005, pages 1 – 3
- Marketing and Sales Staff Meeting Minutes, May 31, 2005, pages 1 – 3
- Policy and Procedure C7QI 04-06 Inter-Rater Reliability
- Nurse Reviewer Inter-rater Reliability, July 2005
- Medical Director Inter-rater Reliability, April 2006
- Compliance Training, HUSKY A and HUSKY B Contract Presentation, August 2005

- Memo Re: HUSKY Contract Compliance Training, September 14, 2005
- HUSKY A Contract Training Sign-in Sheets, July 28, 2005, August 4, 23, 30 and 31, 2005
- HUSKY A Contract Training Sign-in Sheets, August 30 and 31, 2005 and September 8 and 13, 2005
- Fraud and Abuse Training Sign-in Sheet, January 26 and 27, 2006
- Fraud and Abuse Training Presentation, January 26 and 27, 2006
- WellCare HIPAA Compliance Training Program Presentation for New Associates
- WellCare Trust Corporate and Ethics Compliance Program Presentation for New Associates
- Certification and Agreement of Compliance Related to the Trust Program for New Associates
- HIPAA Privacy Training and Policy and Procedure New Associate Acknowledgement Disclaimer Form
- WellCare New Associates Confidentiality Agreement
- Policy and Procedure CT4CM 06 and 07; Identification of Children With Special Needs, HUSKY A and B
- Policy and Procedure CT4CM 09; Referral to HUSKY Plus Policy
- HUSKY Plus Referral Form
- Policy and Procedure CT4CM 08; Case Coordination with HUSKY Plus Policy
- E-mail from HUSKY Plus Program May 18, 2005
- Policy and Procedure CT4CM 07; Identification of Children with Speical Needs
- Policy and Procedure CT4CM 09; Referral to HUSKY Plus Policy
- Policy and Procedure CT4CM 0-8; Case Coordination with HUSKY Plus Policy
- HUSKY Plus Member Tracking Form
- 2006 QI Program Description
- HUSKY B EPDST Reporting for Period 07/01/05 – 12/31/05
- HUSKY B Hospital Inpatient Report for Period 07/01/05 – 12/31/05
- HUSKY B Ambulatory Services Report for Period 07/01/05 – 12/31/05
- HUSKY B Outpatient Prescription Drug Utilization Report for Period 07/01/05 – 12/31/05
- HUSKY B ER Visit Report for Period 07/01/05 – 12/31/05

- HUSKY B Ambulatory Services Report for Period 07/01/04 – 06/30/05
- HUSKY B Two Year Immunization Status Report for Period 07/01/04 – 06/30/05
- HUSKY B Well Child Visits Reporting for Period 07/01/04 – 06/30/05
- Performance Improvement Project Binders
- Quality Improvement Committee Minutes, April 11, 2006, page 27
- Medical Advisory Committee Minutes, April 18, 2006, page 15
- Policy and Procedure C12BL-BL48; Healthcare for Uninsured Kids and Youth (HUSKY) B Billing and Payments
- Policy and Procedure CT4CS-04; Administration of Out-of-Pocket Maximums for HUSKY B
- Screenshot of Paradigm with co-payment prior to OOP being reached
- Screenshot of Paradigm with no co-payment deduction after OOP maximum has been reached
- Sample HUSKY B identification card after OOP maximum has been reached
- Vendor Co-payment report, through 2005Q3
- Vendor Co-payment report, through 2005Q4

Chapter 6: Quality Assessment and Performance Improvement; Binder #2 (QAPI)

- Policy and Procedure C7QI 04-15; Medical Record Review
- Policy and Procedure CT4PR 10; Provider Orientation
- Participating Provider Agreement
- Participating Provider Reference Manual
- Quick Reference Guides
- Policy and Procedure CT4PR 05-01; Provider Network Development and Adequacy
- Policy and Procedure CT4PR 05-06; Minority Recruitment and Retention
- Provider Recruitment Brochure
- Provider Relation Access and Availability report and Memorandum to the MAC
- GEO Access Reports and Maps

- Medical Advisory Committee Minutes, April 18, 2006, pages 15 – 16
- Quality Improvement Committee, May 23, 2006, page 30
- Policy and Procedure C7CR 04-56; Ongoing Monitoring of Providers
- Policy and Procedure C7CR 04-CR43; State Disciplinary Action/Sanction Review
- Credentialing Committee Minutes, April 28, 2005, page 5
- Credentialing Committee Minutes, May 26, 2005, page 2
- Credentialing Committee Minutes, June 30, 2005, page 2
- Credentialing Committee Minutes, February 21, 2006, pages 4 – 5
- 2005 Credentialed Providers Monthly Report
- YTD2006 Credentialed Providers Monthly Report
- Key Indicator Report, October 2005
- Service Fund Report
- Claim File – Monthly file for prior month's paid claims
- PCP Pharmacy Profile, February 2006
- Capitation File – Monthly file for current month's capitation payments
- Policy and Procedure CT4PH 02; PCP Scheduling and Capacity/Network Availability and Accessibility
- Participating Provider Agreement, page 30 (A.)
- Participating Provider Manual, Section 3, pages 4 – 5
- Participating Provider Newsletter, Spring 2006
- CT Accessibility Survey Script
- CT After Hours Audit Script
- Provider Relations Access and Availability Report to the MAC
- CT Access and Availability Survey Results Report
- CT After Hours Audit Results Report Medical Advisory Committee Minutes, May 16, 2006, pages 9 – 10
- Quality Improvement Committee Minutes, May 23, 2006, pages 10 – 11

- Access and Availability Corrective Action Plan Sample Letters
- After Hours Corrective Action Plan Sample Letters
- Participating Provider Newsletter, Fall/Winter 2005
- Participating Provider Newsletter, Spring 2006
- Provider Bulleting, “Flu Vaccination Season, 2005 – 2006,” October 27, 2005
- Provider Fee Schedule Enhancement August 5, 2005
- Provider Notification of Standardized OB Notification Forms, October 2005
- Behavioral Health Partnership Overview, November, 2005
- FAQs Regarding the Behavioral Health Partnership
- Provider Bulletin, “Preferred One Introduces Mandatory Drug Formulary,” January 5, 2006
- HUSKY A Member Handbook
- HUSKY B Member Handbook
- Customer Service Quality Improvement Workgroup Minutes, February 28, 2006, pages 5 – 6
- Customer Service Quality Improvement Workgroup Minutes, March 30, 2006, pages 3 – 4
- CAHPS Survey Instrument
- CAHPS Summary Survey Results
- Medical Advisory Committee Meeting Minutes, February 21, 2006, pages 7 – 8
- Quality Improvement Committee Meeting Minues, March 14, 2006, pages 7 – 9
- Member Advisory Workgroup Minutes, March 22, pages 9 – 11
- Policy and Procedure CT4CS 05-05; Grievance and Complaint Resolution
- Screenshot of Paradigm CSCL
- Medicaid Member Grievance and Complaints Report, 2005
- Customer Service Quality Improvement Workgroup Minutes, February 28, 2006, pages 5 – 6
- Medicaid Member Grievance and Complaints Report, page 2
- Customer Service Quality Improvement Workgroup Minutes, February 28, 2006, pages 5 – 6

- Customer Service Quality Improvement Workgroup Minutes, March 30, 2006, pages 2 – 3
- Quality Improvement Program Description 2005
- Quality Improvement Program Description 2006
- Medical Advisory Committee Minutes, May 3, 2005, page 6
- Quality Improvement Committee Minutes, May 31, 2005, page 2
- Medical Advisory Committee Minutes, March 21, 2006, page 13
- Quality Improvement Committee Minutes, April 11, 2006, pages 12 – 13
- 2005 Quality Improvement Workplan
- 2006 Quality Improvement Workplan
- Medical Advisory Committee Minutes, May 3, 2005, page 6
- Medical Advisory Committee Minutes, March 21, 2006, pages 13 – 14
- Quality Improvement Committee Minutes, April 11, 2006, pages 21 – 22
- 2005 Quality Improvement Annual Program Evaluation
- Medical Advisory Committee Minutes, May 3, 2005, page 6
- Medical Advisory Committee Minutes, March 21, 2006, pages 13 – 14
- Quality Improvement Committee Minutes, April 11, 2006, pages 21 – 22
- 2005 Quality Improvement Annual Program Evaluation
- Medical Advisory Committee Minutes, March 21, 2006, pages 11 – 12
- Quality Improvement Committee Minutes, April 11, 2006, pages 11 – 12
- Utilization Management Program Description
- Medical Advisory Committee Minutes, March 21, 2006, pages 14 – 15
- Quality Improvement Committee Minutes, April 11, 2006, pages 14 – 15
- Minutes of a Meeting of the Board of Directors of WellCare of Connecticut, Inc., March 30, 2006, pages 1 – 2
- 2005 Utilization Management Workplan
- 2006 Utilization Management Workplan

- Medical Advisory Committee Minutes, June 7, 2005, pages 17
- Quality Improvement Committee Minutes, June 13, 2005, page 15
- Medical Advisory Committee Minutes, April 18, 2006, page 13
- Quality Improvement Committee Minutes, April 11, 2006, page 23
- 2004 – 2005 Case Management Program Description
- 2006 Case Management Program Description
- 2004 – 2005 Perinatal Management Program Description
- 2006 Perinatal Management Program Description
- Quality Improvement Committee Minutes, April 11, 2006, pages 25 – 26
- Medical Advisory Committee Minutes, April 18, 2006, pages 13 – 15
- 2005 Asthma Disease Management Program Description
- 2005 Diabetes Disease Management
- Medical Advisory Committee Minutes, June 7, 2005, pages 20 – 21
- Quality Improvement Committee Minutes, June 13, 2005, page 18
- Quality Improvement Committee Minutes, June 13, 2005, pages 4 – 7, pages 11 – 12, pages 19 – 21, and page 25
- Medical Advisory Committee Minutes, June 7, 2005, pages 6 – 8 and pages 13 –014
- Medical Advisory Committee Minutes, January 17, 2006, pages 9 – 10
- Quality Improvement Committee Minutes, February 14, 2006, pages 6 –12
- Quality Improvement Committee Minutes, March 21, 2006, pages 5 – 7, pages 12 – 16
- QIA – Improving Adolescent Access to Preventive Healthcare
- QIA – Improving Asthma Medication Management
- QIA – Improving Frequency of Prenatal Care and Timeliness of Postpartum Care
- QIA – Improving Decreasing ER Utilization and Inpatient Admissions for Members with Asthma
- Policy and Procedure CT4UM 04-10; Transition/Continuity of Care
- Policy and Procedure CT4UM 05-06; Screening Pregnant Members For Case Management

- HUSKY Behavioral Health Carve-Out, Coverage and Coordination of Medical and Behavioral Services, November 3, 2005
- HUSKY Behavioral Health Carve-Out Transition Meeting, Agenda and Minutes, January 19, 2006
- MCO Interface Meeting – Preferred One and CT Behavioral Health Partnership Agenda, March 29, 2006
- Member Newsletter, "Important Information About Changes Affecting Behavioral Healthcare for You or Your Child," 4th Q 2005
- Key Indicator Report
- Authorization Reports
- Profitability Reports
- Monthly Call Center Statistics
- Customer Service Quality Improvement Workgroup Minutes, February 28, 2006, pages 3 – 4
- Policy and Procedure C7AG 05-AG4.5; Provider Claim Appeals
- Utilization Management Review Workgroup Minutes, December 20, 2005, page 5
- 2005 Provider Claims Appeals/1000 Claims Denials by Appeal Reason
- Medical Advisory Committee Minutes, May 16, 2006, page 11
- Policy and Procedure CT4CS 04-028; Member Rights, page 2, procedure 7
- Corporate Off-Site Staff Communication Meeting Minutes, May 5, 2005, page 3, item II
- Corporate Off-Site Staff Community Meeting Sign-in Sheet, May 5, 2005
- Screenshot of WellCareLink Website
- Screenshot of WellCare University Website
- Screenshot of WellCare Corporate Policies and Procedures Website
- Policy and Procedure C6CS 04-007, Advance Directives, page 2, procedure 8
- Corporate Off-Site Communication Meeting Minutes, June 16, 2005, page 3, item V
- Corporate Off-Site Communication Meeting Sign-in Sheet, June 16, 2005
- Corporate Off-Site Communication Meeting Presentation, June 16, 2005
- Customer Service Staff Meeting Minutes, December 5, 2005, page 2
- Claims Integrity Staff Meeting Minutes, May 24, 2005, pages 1 – 3

- Marketing and Sales Staff Meeting Minutes, May 31, 2005, pages 1 – 3
- Policy and Procedure C7QI 04-06 Inter-Rater Reliability
- Nurse Reviewer Inter-Rater Reliability, July 2005
- Compliance Training, HUSKY A and HUSKY B Contract Presentation, August 2005
- Memo Re: HUSKY Contract Compliance Training, September 14, 2005
- HUSKY A Contract Training Sign-in Sheets, July 28, 2005, August 4, 23, 30, and 31, 2005
- HUSKY B Contract Training Sign-in Sheets, August 30 and 31, 2005 and September 8 and 13, 2005
- Fraud and Abuse Training Sign-in Sheet, January 26 and 27, 2006
- Fraud and Abuse Training Presentation, January 26 and 27, 2006
- WellCare HIPAA Compliance Training Program Presentation for New Associates
- WellCare Trust Corporate and Ethics Compliance Program Presentation for New Associates
- Certification and Agreement of Compliance Related to the Trust Program for New Associates
- HIPAA Privacy Training and Policy and Procedure New Associate Acknowledgement Disclaimer Form
- WellCare New Associates Confidentiality Agreement
- Policy and Procedure CT4CM 06 and 07; Identification of Children With Special Needs, HUSKY A and B
- Policy and Procedure CT4CM 09; Referral to HUSKY Plus Policy
- HUSKY Plus Referral Form
- Policy Procedure CT4CM 08; Case Coordination with HUSKY Plus Policy
- E-mail from HUSKY Plus Program May 18, 2005
- Policy and Procedure CT4CM 07 Identification of Children With Special Needs
- Policy and Procedure CT4CM 09; Referral to HUSKY Plus Policy
- Policy and Procedure CT4CM 08; Case Coordination with HUSKY Plus Policy
- HUSKIY Plus Member Tracking Form
- 2006 QI Program Description
- HUSKY B EPSKT Reporting for Period 07/01/05 – 12/31/05

- HUSKY B Hospital Inpatient Report for Period 07/01/05 – 12/31/05
- HUSKY B Ambulatory Services Report for Period 07/01/05 – 12/31/05
- HUSKY B Outpatient Prescription Drug Utilization Report for Period 07/01/05 – 12/31/05
- HUSKY B ER Visit Report for Period 07/01/05 – 12/31/05
- HUSKY B Ambulatory Services Report for Period 07/01/04 – 06/30/05
- HUSKY B Two Year Immunization Status Report for Period 07/01/04 – 06/30/05
- HUSKY B Well Child Visits Reporting for Period 07/01/04 – 06/30/05 Performance Improvement Project Binds
- Quality Improvement Committee Minutes, April 11, 2006, page 27
- Medical Advisory Committee Minutes, April 18, 2006, page 15
- Policy and Procedure C12BL-BL48; Healthcare for Uninsured Kids and Youth (HUSKY) B Billing and Payments
- Policy and Procedure (CT4CS-04; Administration of Out-of-Pocket Maximums for HUSKY B
- Screenshot of Paradigm with co-payment prior to OOP being reached
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- Medical Director Inter-rater Reliability, April 2006
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- Policy and Procedure CT4CM 09; Referral to HUSKY Plus Policy
- HUSKY Plus Referral Form
- Policy and Procedure CT4CM 08; Case Coordination with HUSKY Plus Policy

- E-mail from HUSKY Plus Program May 18, 2005
- Policy and Procedure CT4CM 07; Identification of Children with Special Needs
- Policy and Procedure CT4CM 09; Referral to HUSKY Plus Policy
- Policy and Procedure CT4CM 0-8; Case Coordination with HUSKY Plus Policy
- HUSKY Plus Member Tracking Form
- 2006 QI Program Description
- HUSKY B EPDST Reporting for Period 07/01/05 – 12/31/05
- HUSKY B Hospital Inpatient Report for Period 07/01/05 – 12/31/05
- HUSKY B Ambulatory Services Report for Period 07/01/05 – 12/31/05
- HUSKY B Outpatient Prescription Drug Utilization Report for Period 07/01/05 – 12/31/05
- HUSKY B ER Visit Report for Period 07/01/05 – 12/31/05
- HUSKY B Ambulatory Services Report for Period 07/01/04 – 06/30/05
- HUSKY B Two Year Immunization Status Report for Period 07/01/04 – 06/30/05
- HUSKY B Well Child Visits Reporting for Period 07/01/04 – 06/30/05
- Performance Improvement Project Binders
- Quality Improvement Committee Minutes, April 11, 2006, page 27
- Medical Advisory Committee Minutes, April 18, 2006, page 15
- Policy and Procedure C12BL-BL48; Healthcare for Uninsured Kids and Youth (HUSKY) B Billing and Payments
- Policy and Procedure CT4CS-04; Administration of Out-of-Pocket Maximums for HUSKY B
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- Vendor Co-payment report, through 2005Q3
- Vendor Co-payment report, through 2005Q4

Chapter 7: Grievance System

- Member Advisory Workgroup Charter
- Member Advisory Workgroup Minutes, December 15, 2005, pages 2 – 3
- Member Advisory Workgroup Minutes, December 15, 2005, pages 3 – 4
- Member Advisory Workgroup Minutes, December 15, 2005, pages 5
- Member Advisory Workgroup Minutes, March 22, 2006, pages 5 – 7
- Draft Member newsletter article on reporting transportation problems
- Draft HUSKY A Member handbook section on transportation
- Policy and Procedure CT4CS 05; Grievance and Complaint Resolution Process
- Screenshot of Paradigm CSCL
- Medicaid Member Grievance and Complaints Report, 2005
- Customer Service Quality Improvement Workgroup minutes, February 28, 2006, pages 5, 6
- Medicaid Member Grievance and Complaints Report, 2005
- Medicaid Member Grievance and Complaints Report, 2005, page 2
- Customer Service Quality Improvement Workgroup Minutes, February 28, 2006, page 6
- Customer Service Quality Improvement Workgroup Minutes, March 30, 2006, pages 2, 3
- Utilization Management Review Workgroup minutes, February 21, 2006, pages 5, 6
- Medical Advisory Committee Minutes, March 21, 2006, pages 4, 5
- Quality Improvement Committee Minutes, April 11, 2006, pages 4, 5
- HUSKY A Notice of Action Log 2005
- HUSKY B Denial Log

Appendix B

Appendix B – Agenda for On-Site Review Session and Attendees

MERCER
Government Human Services Consulting

WELLCARE OF CONNECTICUT, INC.
EXTERNAL QUALITY REVIEW AGENDA
BREAKOUT DISCUSSIONS

Date: July 20, 2006

Mercer
Nan Jeannero, RN, BSN, MBA
Nancy Abbott, RN, MSN, SpCLN
Jennie Echols, RN, DSN

DSS
Theresa Rugens

Note: Meeting times may vary based upon the results of the desk review.

8:30 a.m. to 8:45 a.m. **Location: Foxboro Conference Room**	***Introductions and Overview of EQR Opening Presentation*** **Attendees: Dan Parietti, COO; Rob Diaz, JD; David Wilcox, MD; Joanna Panzo; Mary Jane Toomey; Damion Fray; Christopher Savold; David Audie, Pharm D; Sharon Nisbet; Cassie McElveen; Sarah Tkacs; Jeffrey Ludy; Duane Grovenburg; Tony Tedeschi, Jean Holmes, Jocelyn Bayliss**
8:45 a.m. to 10:00 a.m.	***Corrective Action Plan*** **Attendees: Rob Diaz, JD; Sharon Nisbet; Mary Jane Toomey; David Wilcox, MD; Joanna Panzo; Tony Tedeschi; Christopher Savold; Jocelyn Bayliss; Jean Holmes**
11:00 a.m. to 1:00 p.m.	***Chart Reviews and Working Lunch***
1:00 p.m. to 2:30 p.m.	***Compliance to Access and Timeliness Requirements*** **Attendees: Rob Diaz, JD; Sharon Nisbet; Mary Jane Toomey; David Wilcox, MD; Joanna Panzo; Tony Tedeschi; Jocelyn Bayliss**

2:30 p.m. to 3:00 p.m.	***HUSKY B*** ▪ ***HUSKY Plus*** ▪ ***HUSKY B Aggregate Cost Sharing*** **Attendees: Rob Diaz, JD; Sharon Nisbet; Mary Jane Toomey; Joanna Panzo; Christopher Savold**
3:00 p.m. to 3:15 p.m.	***Break***
3:15 p.m. to 4:15 p.m.	***Performance Improvement Projects and Performance Measures*** **Attendees: Rob Diaz, JD; Sharon Nisbet; Mary Jane Toomey; Christopher Savold; Kathryn Cody; Bonnie Weber; Sylvia Hill**
4:15 p.m. to 5:00 p.m.	***Closing Summary*** **Attendees: Dan Parietti, COO; Rob Diaz, JD; David Wilcox, MD; Joanna Panzo; Mary Jane Toomey; Damion Fray; Christopher Savold; David Audie, Pharm D; Sharon Nisbet; Jeffrey Ludy; Duane Grovenburg; Tony Tedeschi, Jean Holmes, Jocelyn Bayliss**

Appendix C

Appendix C – MCO Corrective Action Plans

Item # Audit Topic	Mercer Audit Recommendations	Contract/BBA Standard	Corrective Action/Status	Owner(s)	Target Date	Reference Documents
1 Enrollee Rights	The areas of general information requirements not met be addressed and clearly included in the *Member Handbook* under the Enrollee Rights Section. Assure consistency of Enrollee Rights in both HUSKY A and HUSKY B *Member Handbooks*.	Final Rule: EQR of MCOs and PIHPs; 42 CFR Part 438.300 et. al. January 24, 2003 Subpart C. Enrollee Rights and Protection 438.100. States required to ensure that each enrollee of an MCO has the right to receive (1) information regarding his or her health care; be treated with respect and with due consideration of enrollee dignity and privacy; receive information on available treatment and alternatives that is presented in a manner appropriate to the enrollee's condition and ability to understand; participate in decisions regarding his or her health care, including the right to refuse treatment, and be free from any form of restraint or seclusion uses as a means of coercion, discipline, convenience or retaliation. HUSKY A Contract 3.03 Member Rights	These have been incorporated into the draft of the HUSKY A and B *Member Handbooks*. Final drafts are undergoing an internal review. Publish *Member Handbooks* upon DSS approval. HUSKY B *Member Handbook* has been completed as an internal draft and was sent to Donna Burtanger for review on 3/28/05. We will check with Donna Burtanger to ensure that this moves along.	Member Services – Chris Savold Cassie McElveen	3/1/05 HUSKY A Draft *Member Handbook* English version submitted to DSS on 3/4/05. DSS has a 30-day window for review. Check with DSS about its review on 4/4/05. Call to DSS on 4/5/05 indicated that the review of the HUSKY A *Member Handbook* has not been completed.	
2 Enrollee Rights	Review and update, as needed, provider contract, provider manuals, delegated review information, and internal staff education and communications to include updated Enrollee Rights.	Final Rule: EQR of MCOs and PIHPs; 42 CFR Part 438.300 et.al. January 24, 2003 Subpart C. Enrollee Rights and Protection 438.100. Provider-Enrollee Communications Medicaid beneficiaries are entitled to receive from their health care providers the full range of medical advice and counseling that is appropriate to their condition.	Member Services has communicated information on Enrollee Rights to provider relations. Provider relations is in the process of modifying relevant materials. This is largely done. Internal meetings to be held to ensure consistency among documents. Cassie McElveen, Sarah Tkacs,	Provider Relations – Tony Tedeschi	4/1/05 4/8/05	

Item # Audit Topic	Mercer Audit Recommendations	Contract/BBA Standard	Corrective Action/Status	Owner(s)	Target Date	Reference Documents
			and Jim Gaito to meet on 3/30/05. Information on Enrollee Rights needs to be communicated to P1 vendors. Scheduled to be sent to vendors by 4/8/2005			
3 Enrollee Rights	Develop and communicate clearly in appropriate level verbiage FCHP's role in coordination of care activities and assure information is consistent across enrollee information, P&Ps, and provider contracts and manuals	Final Rule: EQR of MCOs and PIHPs; 42 CFR Part 438.300 et.al. January 24, 2003 Subpart C. Enrollee Rights and Protection 438.100. Provider-Enrollee Communications Medicaid beneficiaries are entitled to receive from their health care providers the full range of medical advice and counseling that is appropriate to their condition.	Coordination of care needs to be addressed in provider Manual. Answered in *Member Handbook*.	Member Services – Chris Savold Chris to reach out to Sharon Nisbet	4/1/05	
4 Enrollee Rights	Develop a system to assure that significant changes in policy/benefits are consistently communicated to enrollees at least 30 days prior to implementation	Final Rule: EQR of MCOs and PIHPs; 42 CFR Part 438.300 et.al. January 24, 2003 Subpart C. Enrollee Rights and Protection 438.100. Provider-Enrollee Communications Medicaid beneficiaries are entitled to receive from their health care providers the full range of medical advice and counseling that is appropriate to their condition.	This is addressed in the draft *Member Handbooks*. There are notations in both *Member Handbooks* that indicate members will be informed 30 days in advance of significant changes in policy/benefits. A P&P needs to be developed. Draft P&P has been developed.	Member Services – Chris Savold Cassie McElveen	3/21/05 Done Completed	
5 Enrollee	Develop comprehensive P&Ps that fully address all aspects related to	Final Rule: EQR of MCOs and PIHPs; 42 CFR Part 438.300 et. al.	Have adapted P&Ps developed in Florida for	Member Services – Chris Savold	3/1/05	

Item # Audit Topic	Mercer Audit Recommendations	Contract/BBA Standard	Corrective Action/Status	Owner(s)	Target Date	Reference Documents
Rights	Advance Directives, including FCHP's role in providing information to the members and assuring vendors are complying appropriately.	January 24, 2003 Subpart C. Enrollee Rights and Protection 438.100. States required to ensure that each enrollee of an MCO has the right to receive (1) information regarding his or her health care; be treated with respect and with due consideration of enrollee dignity and privacy; receive information on available treatment and alternatives that is presented in a manner appropriate to the enrollee's condition and ability to understand; participate in decisions regarding his or her health care, including the right to refuse treatment, and be free from any form of restraint or seclusion uses as a means of coercion, discipline, convenience or retaliation.	use in the State. Completed for internal use. Info needs to be communicated to vendors	Cassie McElveen Vendor Management: CompCare – Joanna Benecare – Cassie OptiCare – Tony CTS – Cassie Delegation Oversight Materials need to be updated.	4/8/05	
6 Enrollee Rights	Include information regarding Advance Directives in the *Member Handbooks* and other distributions, as appropriate	42 CFR Part 438 Managed Care 438.6(i)(2)	This appears in the *Member Handbook* drafts. *Member Handbook* draft submitted 3/4/05.	Member Services – Chris Savold Cassie McElveen	3/1/05 3/4/05 4/30/05	
7 Enrollee Rights	Assure that information provided to enrollees regarding Advance Directives is identified as such to member recognition of this topic	42 CFR Part 438 Managed Care 438.6(i)(2)	Done included in draft *Member Handbook*	Member Services – Chris Savold Cassie McElveen	3/1/05	
8 Enrollee Rights	Assure provider contracts, manuals, and distributions provide inclusive information regarding Advance Directives and are consistent with enrollee information and congruent across all documents.	42 CFR Part 438 Managed Care 438.6(i)(2)	Member services has communicated information on Advance Directives to provider relations. Provider relations is in the process of modifying relevant materials. This is largely done. Information on Advance	Provider Relations – Tony Tedeschi, and Sarah Tkacs Tony to coordinate with Chris and Cassie	3/21/05 3/25/05 4/8/05	

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			Directives needs to be communicated to P1 vendors. This will be communicated to vendors by 4/8/05.			
9 Enrollee Rights	Develop an annual education plan that includes offerings on Advance Directives for staff, enrollees, and community education.	42 CFR Part 438 Managed Care 438.6(i)(2)		Jim Gaito The plan will include in-service training; communication to members via *Member Handbook* and newsletter; will consult with Regional MAC on how best to reach the community; make information available at health fairs and other events.	3/21/05	
10 QAPI Access Standards	Assure that staff performing outreach assessments are fully identifying complex and high-risk enrollees. Review and tighten identification criteria or institute clinical review of all assessments to triage high-risk or complex enrollees. For cases forwarded to CM/DM that are complex or high-risk, make an immediate outreach to enrollees rather than sending an introduction letter.	42 CFR Part 438 Managed Care 438.240 QAPI Program	P1 is meeting to discuss reorganization of Outreach component. P1 is forming Regional MAC. Turnaround plan including outreach has been approved. P1 is in the process of hiring two (2) for this function. Part of the outreach function will include follow up with members who have not utilized services. Information to identify high risk cases will be included in the outreach effort.	Member Services Chris Savold Health Services- Joanna Panzo Dr. Wilcox Health Services- Joanna Panzo Dr. Wilcox Gary Smart – External Relations	3/1/05 Target completion for Outreach 4/8/05	

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			One staff person has been hired for outreach and another will start next week			
11 QAPI Access Standards	If a medical management system is acquired, functionality should include UM, CM, and DM documentation components, including, but not limited to, screens for initial and ongoing HRAs, comprehensive care planning, and DM actions.	42 CFR Part 438 Managed Care 438.240 QAPI Program	Make more efficient use of existing Diamond system. Clarify Corporate plan re MMS Develop business plan to address system needs. Chris to touch base w/ Jack Shoemaker. Jack Shoemaker will be in CT in mid-April and this is among the items that will be discussed. Dr. Kunz will be consulted as well.	Health Services - Dr. Wilcox Joanna IS – Chris Savold	4/22/05	
12 QAPI Access Standards	Develop an implement an IRR audit process for MDs and all physicians involved in service denial decisions ensuring consistent application of criteria.	42 CFR Part 438 Managed Care 438.240 QAPI Program	This process is in place and Dr. Winokur was involved in January 2004. There are handwritten notes from the meeting that need to be typed. Dr. Smith will see to it that the notes are transcribed. The next meeting is scheduled for 4/2005. Dr. Wilcox will be receiving the cases for review during the week of 4/4/05.	Dr. Wilcox Dr. Kunz	4/22/05 Completed	
13 QAPI	Revise the disenrollment P&Ps to include those components identified	42 CFR Part 438 Managed Care	Correct information is now in draft Handbooks.	Member Services-	3/1/05	

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Structure and Operation Standards	as missing.	438.240 QAPI Program	Chris to check P&Ps to ensure that the criteria for disenrollment is accurate.	Chris and Cassie	Done	
14 QAPI Structure and Operation Standards	Review member service materials, provider contracts, and all other materials addressing disenrollment to assure congruence with updated P&Ps.	42 CFR Part 438 Managed Care 438.240 QAPI Program	Correct information is now in draft *Member Handbooks.* Chris to check P&Ps. Info needs to be reviewed by all owners in North Haven	Member Services- Chris Savold and Cassie McElveen PR – Tony Tedeschi and Sarah Tkacs	3/21/05 3/22/05	
15 QAPI	Assure that Clinical Practice Guidelines are developed with input from community providers.	42 CFR Part 438 Managed Care 438.240 QAPI Program	This will be met via the MAC. This is done and has been included in minutes	Health Services – Joanna Panzo	3/21/05 Complete	
16 QAPI	Develop a communication and distribution plan to disseminate Clinical Practice Guidelines to providers and members.	42 CFR Part 438 Managed Care 438.240 QAPI Program	There is a reference in the *Member Handbook* that this information is available on request. Info is also included in PR Manual.	Member Services- Chris PR- Tony	4/8/05	
17 QAPI	Translate Clinical Practice Guidelines to a "lay" level and continue to actively target members for whom Clinical Practice Guidelines are applicable.	42 CFR Part 438 Managed Care 438.240 QAPI Program		Corporate Quality - Sharon Nisbet	2/15/05 3/22/05	
18 QAPI	Include the availability of Clinical Practice Guidelines in the *Member Handbook* or other appropriate member materials.	42 CFR Part 438 Managed Care 438.240 QAPI Program	There is a reference in the *Member Handbook* that this information is available on request.	Member Services- Chris Savold Cassie McElveen	3/1/05 Complete	
19 QAPI	Develop methods to increase member participation or input into QAPI.	42 CFR Part 438 Managed Care 438.240 QAPI Program	P1 is working to put in place a MAC. Member participation on QAPI will be included in the scope of the	Health Services – Joanna Panzo Member Services- Cassie McElveen	3/15/05 3/23/05 Done?	

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			Committee's work. A regional MAC for New Haven has been formed and the first meeting held on 3/24/05.	Gary Smart – External Relations		
20 Grievance System	Develop processes congruent with the appeals policy related to a provider acting on behalf of a member and with the member's written consent and filing an appeal on the member's behalf. A mechanism to track this process is required to be developed.	42 CFR 438 Managed Care Subpart F 438.402 Grievance System	Conduct in-service training for Operations areas in North Haven to ensure that policy is consistently applied. Directors and managers will be trained and they will be responsible for imparting this information to the staff.	Health Services- Joanna Panzo	4/15/05	4/19/05
21 Grievance System	Clarify the policy that addresses when a provider may file grievance/State administrative hearing on behalf of the member. The reference to DSS Uniform Policy Manual Section 1525.05 did not clearly define what FCHP's policy was for any staff who would have to implement the policy.	42 CFR 438 Managed Care Subpart F 438.406 Grievance System	Policy is in place. We need to be sure that refresher information is provided to staff.	Health Services- Joanna Panzo	3/15/05	
22 PIPs	Develop or adopt a PIP design format that identified and addresses all key components to be included in a study.	42 CFR 438 Managed Care Subpart D 438.240 QAPI Systems (a)(2) (b) (1) (2) (3) (4)	Format has been adopted. Will be used retrospectively for 2004 and going forward.	Health Services- Joanna Panzo WellCare QA – Sharon Nisbet	4/1/05	
23 PIPs	Develop each of the categories of the PIP design thoroughly being sure to address all components clearly.	42 CFR 438 Managed Care Subpart D 438.240 QAPI Systems (a)(2) (b) (1) (2) (3) (4)	Format has been adopted. Will be used retrospectively for 2004 and going forward.	Health Services- Joanna Panzo WellCare QA – Sharon Nisbet	2/15/05	
24 PIPs	Assure that PIP design documentation identifies a clearly defined study question as this question provides focus and direction	42 CFR 438 Managed Care Subpart D 438.240 QAPI Systems (a)(2)	Format has been adopted. Will be used retrospectively for 2004	Health Services- Joanna Panzo	2/15/05	

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	for the project.	(b) (1) (2) (3) (4)	and going forward.	WellCare QA – Sharon Nisbet		
25 PIPs	Identify benchmarks or performance targets with defining rationale/ justification, including this information in the project documentation.	42 CFR 438 Managed Care Subpart D 438.240 QAPI Systems (a)(2) (b) (1) (2) (3) (4)	Format has been adopted. Will be used retrospectively for 2004 and going forward.	Health Services- Joanna Panzo WellCare QA – Sharon Nisbet	2/15/05	
26 PIPs	For PIPs using encounter data, include an assessment of the completeness of the encounter data.	42 CFR 438 Managed Care Subpart D 438.240 QAPI Systems (a)(2) (b) (1) (2) (3) (4)	In-process. Will be competed w/in the next two months.	IS- Chris Savold	2/15/05 3/31/05	
27 PIPs	For all studies, including those using HEDIS methodology, include detail regarding codes, numerator and denominator specifications, criteria for enrollment, etc.	42 CFR 438 Managed Care Subpart D 438.240 QAPI Systems (a)(2) (b) (1) (2) (3) (4)	This spoke to the need for methodology to be properly referenced in PIP studies. This has been done.	IS – Chris Savold	2/15/05	
28 PIPs	Describe in detail the analytical process used in analyzing project results.	42 CFR 438 Managed Care Subpart D 438.240 QAPI Systems (a)(2) (b) (1) (2) (3) (4)	This relates to doing a Root Cause Analysis and is part of the PIP design. This is in process. Nearly (95 percent) complete. Will be completed during the week of 4/4/05.	Health Services- Joanna Panzo WellCare QA – Sharon Nisbet IS – Chris Savold	2/15/05 3/31/05 4/8/05	
29 PMs	To achieve contract compliance, add the 19 – 20 age category to the EPSDT report.	42 CFR 438 Managed Care Subpart D 438.240 QAPI Systems (a)(2) (b) (1) (2) (3) (4)	This had been provided but apparently was overlooked by Mercer.	IS – Chris Savold	2/15/05 Done	
30 PMs	If any FCHP specific codes are used, a crosswalk is required that will match these codes to standard coding practices, including ICD-9, CPT4, and DSM-IV.	42 CFR 438 Managed Care Subpart D 438.240 QAPI Systems (a)(2) (b) (1) (2) (3) (4)	We are not using any home grown codes.	IS – Chris Savold	2/15/05 Done	
31	Update the programming code to	42 CFR 438 Managed Care	We follow DSS reporting	IS –	2/15/05	

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PMs	meet HEDIS specifications requiring primary diagnosis only. If the code is correct, a narrative should be added to measure definitions to reflect that only primary diagnosis is used even though there are three diagnoses fields.	Subpart D 438.240 QAPI Systems (a)(2) (b) (1) (2) (3) (4)	requirements and conventions. Chris to double back to Mercer to make sure that they understand this,	Chris Savold	Done 4/8/05	
32 PMs	For prenatal care reporting, update programming codes to comply with State contractual requirement that continuous enrollment criteria is used	42 CFR 438 Managed Care Subpart D 438.240 QAPI Systems (a)(2) (b) (1) (2) (3) (4)	We follow DSS reporting requirements and conventions.	IS – Chris Savold Health Services- Joanna Panzo	2/15/05 Done	
33 PMs	For NICU days, expand the definition to show how "admit type" and OB/GYN deliveries are determined.	42 CFR 438 Managed Care Subpart D 438.240 QAPI Systems (a)(2) (b) (1) (2) (3) (4)	This is done.	IS – Chris Savold Health Services- Joanna Panzo	2/15/05 3/23/05	
34 Calculation of PMs	ED usage is high. An evaluation should be conducted to determine which diagnoses are contributing to this high usage and develop evidence-based action plans, which would enhance PCP ambulatory care interventions.	42 CFR 438 Managed Care Subpart D 438.240 QAPI Systems (a)(2) (b) (1) (2) (3) (4)	This needs to be done.	Dr. David Wilcox Sharon Nisbet	3/15/05 3/23/05	
35 Calculation of PMs	FCHP had substantially higher readmission rates compared to the other MCOs. Determine why this is the case. Study past admissions to determine if they fall into particular diagnostic groups or particular physicians. Clinical Practice Guidelines for both physician office care and inpatient care for these groups should be developed.	42 CFR 438 Managed Care Subpart D 438.240 QAPI Systems (a)(2) (b) (1) (2) (3) (4)	This needs to be addressed. There are questions regarding the huge disparity between the rates we reported and those of the other three MCO We are working with CompCare out BH subcontractor to verify/correct data that has been submitted on readmissions.	Joanna Panzo Chris Savold	4/8/05 4/8/05 initial 4/22/05 final	
36	Reevaluate data collection/claims	42 CFR 438 Managed Care	Sharon Nisbet indicated	Tony Tedeshi	4/8/05	

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Calculation of PMs	efforts to determine if we are achieving a complete accounting of eye exams performed. Request that PCPs track diabetics. Send a report card on a quarterly basis listing all diabetic patients that have not had a retinal exam according to the administrative data. Review medical records in the above regard.	Subpart D 438.240 QAPI Systems (a)(2) (b) (1) (2) (3) (4)	that this information could be obtained through CRIMS and suggested that Matt Richardson or Bill Galloway be contacted. Chris Savold has spoken to Bill about CRIMS and this is underway	Chris Savold Needs follow up		
37 Calculation of PMs	Reevaluate data collection/claims efforts to determine if we are receiving all claims concerning mammograms. If the number of mammograms is correct, we should conduct a root cause analysis and implement activities over the next year to increase the number of screening mammograms. Additionally, members' PCPs could be sent a quarterly report listing the eligible women who have not received a mammogram within the last year.	42 CFR 438 Managed Care Subpart D 438.240 QAPI Systems (a)(2) (b) (1) (2) (3) (4)	We have researched this and will be sending notices to women in the targeted group.	Joanna Panzo	3/15/05 4/8/05	
38 IS	Ensure that reporting needs are prioritized effectively.	42 CFR 438 Managed Care Subpart D 438.242 Health IS		IS – Chris Savold	2/15/05 Done	
39 IS	Consider migrating remaining proprietary FCHP reporting code to the WellCare centrally managed repository (e.g., Cognos or SAS platform).	42 CFR 438 Managed Care Subpart D 438.242 Health IS	Data Integrity Plan developed and presented to DSS on 1/21/05. Use this as documentation?	IS – Chris Savold	3/21/05	
40 IS	Ensure adequate documentation of processes, computer source code, etc., exists in the event of IS staff turnover.	42 CFR 438 Managed Care Subpart D 438.242 Health IS	This has been documented.	IS – Chris Savold	3/21/05 Done	

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