

COUNTY OF MILWAUKEE
Inter-Office Communication

Date: July 2, 2007
To: Supervisor Lee Holloway, Chairman, Milwaukee County Board of Supervisors
From: Jerome J. Heer, Director of Audits
Subject: Follow-up Review of the Department on Aging – Care Management Organization Provider Network Administration

We have completed a limited review of the Milwaukee County Department on Aging - Care Management Organization (CMO) provider network administration. This review was initiated in response to concerns brought to the attention of the Department of Audit regarding allegations of a lack of policy and criteria for participation in the network; the level of service quality, cost and CMO oversight of the two primary providers of supportive home care and personal care services; the basis for assignment of clients to Care Management Units (CMU); and conflict of interest issues associated with CMU referral of clients to affiliated entities.

Background

Family Care Program

The Milwaukee County Department on Aging (MCDA) operates a Care Management Organization (CMO) responsible for administering the Family Care Program in the County. The Family Care Program is a long-term care pilot program operating in selected Wisconsin counties under four federal Medicaid waivers. The program is a re-design of the State's long-term support systems, targeting eligible adults age 60 or older and eligible adults with disabilities. While other counties involved with the pilot program serve both population groups, Milwaukee County serves only eligible adults who are at least age 60. The program is intended to provide eligible individuals with better choices about their living arrangements and services they receive, improve access to services, enhance the quality of care, including an emphasis on both health and social outcomes, and establish a system that will be cost-effective into the future.

In May 2006, the State passed Senate Bill 653, legislation to expand the Family Care program statewide over the next five years. The Department of Health and Family Services has awarded \$1.4 million in planning grants to counties across the state to prepare for the program's expansion, including \$150,000 for Milwaukee County. The funding awarded to Milwaukee County is being used to develop a plan for a new managed care approach to providing long-term care for adults with disabilities under the age of 60.

The plan is being developed through a partnership between the Milwaukee County Department of Health and Human Services (DHHS) and two private agencies, Independent Care Health Plan and Community Care, Inc. In its most recent report to the Health & Human Needs Committee (file no. 07HN14), dated April 25, 2007, DHHS provided an update on the progress of the plan, including a discussion of the proposed organizational structure for a new Long-Term Care managed care system for Milwaukee County. As described in the report, the proposed organizational structure would consist of a combined CMO that would utilize the existing MCDA CMO infrastructure to administer the Family Care program for all eligible adults, regardless of age.

Care Management Organization

The budgeted number of clients served by the CMO has grown from 850 in 2000, the first year of Family Care, to 6,048 for 2007. The Department on Aging operates the CMO under the premise that

no County property tax levy will be required to fund the operation. Budgeted expenditures for the CMO in 2007 are approximately \$162 million. The CMO has approximately 60 full-time equivalent positions budgeted for 2007 plus staffing of some of its key administrative positions with contracted professionals.

Family Care Services

Family Care offers a broad array of services under its Long-term Care benefit package. The general categories of service available under Family Care and the corresponding CMO expenditures for 2006 are presented in **Table 1**.

Table 1
CMO – Service Expenditures
2006

Service Category	Amount Paid	% of Total
Residential Services	\$ 46,268,989	30.6%
Nursing Home	26,445,343	17.5%
Supportive Home Care	22,886,706	15.1%
Care Management	20,875,979	13.8%
Personal Care	11,783,049	7.8%
Day Services	6,696,584	4.4%
Meals	3,107,648	2.1%
Transportation	2,854,257	1.9%
Home Health Care	2,760,991	1.8%
Disposable Medical Supplies	2,527,014	1.7%
Durable Medical Equipment	1,914,851	1.3%
Financial Services	1,129,713	0.7%
Therapy	619,177	0.4%
Personal Response Unit	590,611	0.4%
Housing Miscellaneous Cost	302,532	0.2%
Mental Health Care	128,482	0.1%
Self-Directed Support	126,376	0.1%
Miscellaneous CMO Services	93,142	0.1%
Recreational Activities	6,268	0.0%
Total	\$ 151,117,712	100.0%

Source: CMO MIDAS computer system.

As shown in Table 1, substantial amounts were expended in 2006 for residential services (\$46.3 million), nursing homes (\$26.4 million), supportive home care (\$22.9 million), care management (\$20.9 million), and personal care (\$11.8 million). Together these five service categories account for \$128.3 million (85%) of the CMO's total service expenditures of \$151.1 million for 2006.

The delivery of member services is coordinated by the CMO principally through contracted Care Management Unit (CMU) agencies. CMU's are comprised of interdisciplinary teams, each of which consists of, at a minimum, the member, a human services worker, and a registered nurse. Interdisciplinary teams prepare member service plans that are based on member needs identified through functional screening and comprehensive assessment.

Member service plans describe the type of service or support to be furnished; the amount, frequency, and duration of each service; and the type of provider to furnish each service. Ultimately, the delivery of services is arranged using a service authorization, which is generated by care managers with input from the members. Service authorizations detail the type and level of service, and also identify the specific provider selected to deliver the service. Generally, providers are selected from the CMO provider network, discussed in the following section.

CMO Provider Network

Overview

The State contract requires the CMO to demonstrate adequate capacity to provide its membership with all the services available in the Family Care Long Term Care benefit package (Family Care services) either directly or through subcontract relationships with providers. The CMO has delivered the vast majority of Family Care services using contracted providers since its inception. In meeting the service needs of its members, the CMO has developed an extensive network of providers. The number of providers available through the network as of May 2007 is summarized by service category in **Table 2**. Table 2 also shows the number of members authorized, as well as the relative level of member participation associated with each service category.

Table 2
CMO Provider Network Participation
May 2007

Service Category	Providers Available*	Members Authorized**	Member Participation
Care Management	30	6,206	100.0%
Transportation	59	3,752	60.5%
Disposable Medical Supplies	12	3,528	56.8%
Supportive Home Care	35	3,416	55.0%
Personal Care	29	2,371	38.2%
Residential Services	238	1,528	24.6%
Durable Medical Equipment	13	1,487	24.0%
Meals	8	1,456	23.5%
Personal Response Unit	5	1,452	23.4%
Financial Services	9	1,012	16.3%
Day Services	60	812	13.1%
Nursing Home	31	630	10.2%
Therapy	72	449	7.2%
Home Health Care	22	420	6.8%
Mental Health Care	31	161	2.6%
Miscellaneous CMO Services	32	60	1.0%
Housing Miscellaneous Cost	12	45	0.7%
Recreational Activities	6	34	0.5%
Self-Directed Support	1	26	0.4%

Source: CMO MIDAS computer system.

* Providers of multiple services are represented in each service category they are contracted.

** Members often receive multiple services and are represented in each service category they are authorized.

Table 2 shows there is full member participation in care management since it is a mandated service. The table also shows that there is broad usage of transportation with 3,752 (60.5%), disposable medical supplies with 3,528 (56.8%), supportive home care, with 3,416 (55.0%), personal care, with 2,371 (38.2%), and residential services with 1,528 (24.6%) of total members authorized to receive these services.

According to CMO management, there is sufficient capacity across the provider network to serve its projected membership and this has to be demonstrated to DHFS as a requirement for annual renewal of the State contract.

The vast majority of providers participate in the network under the terms of a standard network contract arrangement. Standard network contracts do not guarantee any level of business to providers since provider selection under the Family Care program is driven by member choice. This can result in some providers being used infrequently or not at all.

However, the CMO has procured two providers, New Health Services and Supportive Home Care Options, in the areas of supportive home care and personal care services to serve as the designated sources for employing members' relatives and other individuals selected by members to be their caregivers. Member referrals are generally made to these two providers on an alternating basis. According to CMO management, these contracts originated from the County's request for proposal (RFP) process.

CMO management informed us that since the CMO has sufficient service capacity to meet member needs, it has, with the exception of limited service areas, closed the network to new providers. This is allowed under the State contract since it provides that "The CMO is not required to contract with providers beyond the number necessary to meet the needs of its members."

We also learned that management has undertaken efforts to decrease the number of providers in some service areas within the past few years to improve administrative efficiency and help contain costs. According to CMO management, the number of providers of durable medical equipment (DME) and durable medical supplies (DMS) has been reduced principally to those which carry a broad range of commonly used items or required specialty items. CMO management indicated that it is pursuing similar efforts in the area of case management.

Network Participation - Policy and Criteria

Among the concerns brought to our attention was a lack of policy and criteria for participation in the network. However, we found that the CMO has a formal policy that contains criteria regarding network participation. The policy provides guidance to CMO staff in the handling of prospective provider inquiries and processing of new provider applications.

Although the CMO does have a formal policy and criteria relating to network participation, there are a number of factors that may create the perception among prospective providers that decisions regarding their requests to participate in the network are arbitrary or even unfair. Among these factors are the following:

- Generally, prospective provider requests to participate in the network are declined. Under the provider network structure there is limited opportunity for new providers to participate in the network due to the adequacy of CMO service capacity. These circumstances result in the use of providers who are already participating in the network to the dismay of prospective providers, which may be excluded from the network simply because there is no need for them.

- The lack of a forum to communicate the status of network opportunities. According to the CMO contract administrator, there hasn't been a need to recruit providers due to the sufficiency of service capacity and the broad interest and availability of social service providers in the community. However, since the status of network opportunities is not publicized by the CMO, prospective providers are placed in the position of having to initiate contacts with staff to find this out.
- The lack of awareness of the CMO application policy. The CMO application policy is maintained on a CMO computer system that is unavailable to providers that are not part of the network.
- The application policy grants considerable authority to the CMO contract specialists but provides only general guidelines for them to follow. The contract specialist's are designated as the point of contact for prospective provider inquiries and are responsible for applicant screening. Ultimately, the policy states that contract specialists determine whether or not to recommend providers for review by the Provider Network Committee, the final substantive step of the process before execution of a contract. Although the policy assigns the contract specialists with this broad level of authority, it provides only general guidelines with which to make decisions. As examples, the policy states that the contract specialist is to "gather information in response to all prospective provider inquiries" and "consideration will be given to all prospective providers based on access and capacity of the provider network to meet member needs" rather than providing tangible criteria that could be compiled in a standardized checklist or evaluation template.
- Failure of some members of the contract specialist staff to provide written notice of the reason that a provider is not being considered for participation in the network, as specified by CMO policy. Based on records we reviewed for 2006, not all contract specialists performed this step.

To provide a more effective means of managing provider inquiries and improve the process for screening provider applicants, we recommend that MCDA management:

1. *Publicize the status of provider network opportunities as well as the provider application policy on the MCDA segment of the County's website accessible by the general public.*
2. *Revise the provider application policy to provide more definitive and objective criteria for use by contract specialists in screening providers. The criteria could be compiled into a standardized checklist or evaluation template.*
3. *Ensure that all contract specialists adhere to CMO policy regarding the issuance of rejection notices to providers indicating the reason the provider is not being considered for participation in the network.*

Supportive Home Care and Personal Care Services

Concerns have been expressed about the quality and cost of services associated with New Health Services (NHS) and Supportive Homecare Options (SHO), the two primary providers of supportive home care and personal care services. Concerns were also expressed that although these providers are the only two designated sources for employing member relatives and other member preferred caregivers to provide these services, they decline members who are difficult to serve.

Supportive home care services consist of household tasks and supervision whereas personal care services consist of hands-on assistance with activities of daily living. These services are a substantial component of the Family Care benefit. As previously noted in Tables 1 and 2, 3,416 (55%) of the members are authorized for supportive home care with expenditures totaling \$22.9 million in 2006 for this service.

Approximately 38% (2,371) of members are authorized for personal care and \$11.8 million was expended in 2006 for this service.

Table 3 shows that together, NHS and SHO account for \$18.9 million (83%) of the \$22.9 million expended on supportive home care in 2006. NHS and SHO also account for \$7.0 million (60%) of the \$11.8 million expended on personal care in 2006. Across both service types, NHS and SHO were paid a combined total of \$25.9 million (75%) of the \$34.7 million expended in 2006.

Table 3
2006 Expenditures
Supportive Home Care and Personal Care Services

<u>Provider</u>	<u>Supportive Home Care</u>	<u>Personal Care</u>	<u>Total</u>
NHS and SHO	\$18,892,526	\$ 7,034,313	\$25,926,839
Others	<u>3,994,180</u>	<u>4,748,736</u>	<u>8,742,916</u>
Total	\$22,886,706	\$11,783,049	\$34,669,755

Source: CMO MIDAS Computer System

Concerns expressed about NHS and SHO

The CMO is Unresponsive to Complaints about NHS and SHO service delivery.

The foundation for ensuring that supportive home care and personal care services are delivered as specified in the member's care plan is the provider's quality assurance (QA) program. A sound provider QA program promotes the delivery of quality services through proper training and supervision of workers. The program should also include a mechanism to capture feedback about problems with service quality and a means to ensure corrective action is taken when necessary.

In its contracts with these two providers, the CMO sets forth a number of provisions related to quality assurance process requirements, including those we recommended as a result of a previous audit of Supportive Homecare Options, report issued July 2003. These requirements call for the completion of training, evaluation of each caregiver's ability to provide prescribed services, and monitoring and supervision to ensure that services are provided as specified in the member's care plan. The contract also calls for the providers to conduct a minimum number of weekly, random member satisfaction calls and to establish central log to document all complaints and to develop standard procedures to provide consistent guidance in the handling of complaints and proper documentation of efforts to resolve issues.

Beyond the complaint management requirements placed on NHS and SHO, the CMO maintains a complaint resolution process driven by the CMO provider complaint procedure, set-forth in the MCDA procedure manual. The provider complaint procedure states that the care management team is responsible for notifying a CMO contract specialist when situations or actions of the providers adversely impact the health and safety of the member. Information about the complaints is documented and entered on the MIDAS computer system by contract administration staff.

To evaluate the responsiveness of CMO staff in resolving complaints, we compiled the MIDAS data for all complaints received in 2006. We found that a total of 174 complaints, involving approximately 100 providers, were registered and that 131 (75%) of the complaints were resolved as of June 8, 2007.

In addition, our analysis showed that it took an average of 22 days to resolve these complaints and that the 43 unresolved complaints have been outstanding an average of 373 days.

Furthermore, we learned that only five complaints involving NHS and SHO were received during 2006. However, none of these complaints are shown as being resolved and all five have been outstanding for well in excess of a year.

We also noted that in three instances, the date shown for complaint resolution preceded the date of receipt of the complaint.

Based on this information, it appears that the CMO's responsiveness to complaints and management oversight of the complaint process is in need of improvement.

The CMO contract administrator informed us that there hasn't been analysis of complaint data. Consequently, there is no assurance that complaints are addressed in a timely manner and that problems with providers or service areas are identified. Management also indicated that a revised complaint policy is being developed and it will include a progressive disciplinary component, which will be incorporated into contracts with providers.

To enable management to gauge staff responsiveness in resolving complaints, identify problematic providers and service areas, and provide information useful in administering its new complaint policy, we recommend that CMO management:

4. *Periodically conduct trend analysis of complaint data maintained in the MIDAS system, and*
5. *Develop system edits in MIDAS to prevent or flag instances of missing or illogical data.*

The quality of services provided by NHS and SHO is substandard; employees often fail to show up, staffing for services is not timely, even in emergency situations. As noted earlier, care management staff are responsible for notifying a CMO contract specialist of situations or actions of the providers that adversely impact the health and safety of the member. However, only a total of five of these complaints relating to NHS and SHO were logged by the CMO in 2006, suggesting that if services were problematic, the volume of complaints would be considerably greater.

As part of its Quality Improvement (QI) program the CMO conducted a supportive home care satisfaction survey of members who are served by their relatives and are also employees of SHO. The survey was undertaken to gain insight into member satisfaction regarding supportive home care services provided by the relatives. The survey was conducted in April 2006 and members gave high marks regarding work quality and the level of comfort with the caregiver. This seems to indicate that at least this segment of members were pleased with the quality of services received.

The survey also included a few questions relating to the timeliness of the caregivers, which could be used to assess the effectiveness of the provider's quality assurance program. However, the answers to these questions were not included in the survey results. It could also prove useful to include questions designed to identify whether problems exist with the failure of caregivers to show-up. Furthermore, the CMO would gain valuable insights if future survey work included members served by individuals who are not relatives.

To enhance the value of member feedback regarding the quality of supportive home care and personal care services provided, we recommend that CMO management:

6. *Ensure that information and feedback regarding the timeliness and reliability of caregivers is included in future surveys and survey results.*

There is no rate advantage associated with the use of NHS and SHO vs. licensed home health agencies.

According to CMO management, using NHS and SHO via the purchase of service contract is more efficient and economical than acquiring supportive home care and personal care services through other providers under the standard network contract arrangement.

Under the NHS and SHO contract arrangement, the providers agree to hire and train individuals, most often a relative of the CMO member, to provide the services. The CMO compensates these providers with the reimbursement of employee wages and payroll taxes and payment of a monthly management fee based on the number of members served. Providers acquired under the standard network contract are paid a flat unit rate determined by the provider.

A comparison of the estimated average hourly rates paid to NHS and SHO with those charged by other network providers for supportive home care and personal care services is shown in **Table 5**.

Table 5
Estimated Average Hourly Rates
Supportive Home Care and Personal Care Services

Provider	Supportive Home Care	Personal Care
New Health Services/Supportive Homecare Options	\$11.20 *	\$12.30 *
Other network providers	<u>15.84</u>	<u>19.53 **</u>
Difference	\$ 4.64	\$ 7.23
* Includes an estimate of monthly management fee costs. ** Includes an estimate of Title 19 travel time costs. Source: Auditor calculations using CMO rate listing for these services.		

As shown in Table 5, the average supportive home care rate for other network providers of \$15.84 is \$4.64 (41.4%) higher than the comparable rate of \$11.20 for NHS and SHO and the average personal care rate of \$19.53 for other network providers is \$7.23 (58.8%) higher than the comparable rate of \$12.30 for NHS and SHO. Based on these figures, if purchase of service contracting with NHS and SHO were to be completely discontinued in favor of the standard network contract arrangement with other providers, the CMO's annual expenditures for supportive home care would increase an estimated \$7.8 million and annual expenditures for personal care services would increase an estimated \$4.1 million, for an estimated combined total increase of \$11.9 million.

Realistically, the \$11.9 million figure is probably somewhat overstated since the CMO would likely negotiate rate concessions from the home health agencies in exchange for a higher level of referrals. However, it remains clear that substantial savings are achieved through use of the purchase of service arrangement with NHS and SHO for supportive home care and personal care services.

In addition to the fiscal advantages associated with the contractual arrangement with NHS and SHO, the CMO realizes administrative efficiencies due to the high concentration of members vested with the two providers. For instance, the member referral process for these agencies has been streamlined, freeing-up time that care management staff would otherwise expend on locating a suitable provider. As

other examples, fewer CMO contract administration resources are required for functions such as provider oversight and billing resolution because of the high concentration of members served by the two providers.

As a trade-off for the fiscal and administrative benefits associated with purchase of service contracting with NHS and SHO, the CMO forfeits the regulatory oversight and enforcement functions applicable to State licensed agencies procured under the standard network contract arrangement. However, according to CMO management, its strategy is to utilize NHS and SHO to provide services to members with higher levels of functionality, eliminating the need for State regulatory oversight, which has a clinical emphasis. Conversely, members who require complicated or involved tasks for their care are declined by NHS and SHO and referred to home health agencies, which are better suited to care for these high need individuals. Ultimately, the outcome of this strategy is increased cost savings by serving individuals who require a relatively lower level of care using the most cost effective providers.

NHS and SHO selectively accept member referrals, declining members requiring more intensive care. This practice is acknowledged by CMO management as being consistent with the CMO cost savings strategy of matching members with providers according to the level of their needs, as described in the previous paragraph.

Assignment of Members to Care Management Units

The CMO contracts with providers to operate Care Management Units (CMU). The CMU's are responsible for providing comprehensive care management services to members through interdisciplinary teams consisting of a member, a care manager and a registered nurse. The CMO is responsible for assigning new members to one of the 29 contracted CMU providers or to the CMO operated CMU. One staff member performs this function.

Concerns were expressed that the CMO does not have a defined process for assigning members to CMU's and that the assignments are biased. However, we learned that the CMO has developed a methodology for selecting a CMU for each new member. The methodology is based on a hierarchy of defined factors, starting with member preference and including member ethnicity and language, special needs, special situations, and geographical proximity. In the event that none of these factors come into play for a particular member, CMU assignments are made on a rotating basis.

While the methodology is documented and provides an objective means for assigning members to CMU's, we were informed that this was implemented in the second half of 2006, so it is a fairly recent development. Prior to use of these guidelines, CMU assignment was handled informally, generally based on CMU availability, according to CMO management. Consequently, the previous process would have been more susceptible to the preferences of the individual responsible for the assignment function.

Provider Conflict of Interest

Another concern expressed to us was also addressed in our recently completed audit regarding CMO oversight of provider payments (report issued December 2006). In our audit report, we noted that a number of CMU's have affiliations with other CMO service providers, some of which share common ownership. As explained in our report, care managers who are employees of the CMU's are integrally involved with determining the type and level of services required by members, may also refer them to providers affiliated with the CMU. It was further explained that since the financial viability of many providers, and accordingly a common owner, hinge on the volume of business received under the Family Care Program, a conflict of interest exists between care manager responsibilities and loyalty to

Supervisor Lee Holloway, Chairman, Milwaukee County Board of Supervisors
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organizations affiliated with the care manager's employer. Therefore, the existence of common ownership serves as an incentive for care managers to engage in 'steering' or self-referral (referring of members to affiliated providers), creating an environment that could diminish care manager objectivity toward service quality issues of an affiliate.

We recommended that Department on Aging management collaborate with State Family Care Program administrators to develop a policy that addresses provider conflict of interest, self-referral, and steering issues. A status report of implementation of this and our other recommendations from the prior audit is due from the Department on Aging for the July 19, 2007, Finance and Audit Committee meeting.

During the course of our review, we noted that CMO management has taken steps to identify providers that show patterns of self-referral, through analysis of data maintained in its MIDAS computer system. This is a prerequisite to resolving the self-referral issue.

We wish to extend our appreciation to Department on Aging for their assistance and cooperation.

Management's response to our recommendations is attached.

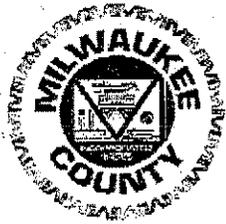
Please refer this report to the Finance and Audit Committee.

Jerome J. Heer

JJH/cah

Attachment

cc: Milwaukee County Board of Supervisors
Scott Walker, Milwaukee County Executive
Stephanie Sue Stein, Director, Department on Aging
Rob Henken, Director, Department of Administrative Services
Cynthia Archer, Fiscal & Budget Administrator, Department of Administrative Services
Scott Manske, Controller, Department of Administrative Services
Terrence Cooley, Chief of Staff, County Board
Steve Cady, Fiscal & Budget Analyst, County Board
Delores (Dee) Hervey, Chief Committee Clerk, County Board
Martin Weddle, County Board Research Analyst



DEPARTMENT ON AGING

Milwaukee County

STEPHANIE SUE STEIN Director
(414) 289-5950

sstein@milwaukeecounty.com



FAX: (414) 289-8590
TTY: (414) 289-8591
ELDERLINK: (414) 289-6874
TOLL FREE: 1-866-229-9695
www.milwaukee.gov/county/aging

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Date: June 27, 2007

To: Jerome J. Heer, Director of Audits
Paul Grant, Audit Supervisor
Joe Williams, Lead Auditor

From: Stephanie Sue Stein, Director, Department on Aging

Re: Follow-up Review of the Department on Aging Care Management
Organization Provider Network Administration.

The Milwaukee County Department on Aging commends the Milwaukee County Department of Audit for the professional and efficient manner in which the auditors completed the above referenced follow-up review. Mr. Grant and Mr. Williams were thorough, yet respectful at all times during the review.

The findings and recommendations herein will assist the Milwaukee County Department on Aging in the ongoing efforts of this department to provide the highest quality of care for the Milwaukee County elderly served by the Family Care Program. Milwaukee County entered Family Care as a pilot with all of the challenges associated with a pilot program. New solutions and recommendations leading to the continued improvement of those processes necessary to efficiently operate this multi-million dollar program are greatly appreciated.

Cc: Maria Ledger, Assistant Director, CMO
Gail Cheatham, Assistant Director, Area Agency on Aging
Jim Hennen, Contract Administrator, CMO
Jim Hodson, Chief Financial Officer, CMO
Bill Bethia, Chief Information Officer, CMO
Jack Melton, Chief Clinical and Operations Officer, CMO

Reuss Federal Plaza - 310 West Wisconsin Avenue • Milwaukee, WI 53203

The mission of the Milwaukee County Department on Aging is to affirm the dignity and value of older adults of this county by supporting their choices for living in and giving to our community.

1. *Publicize the status of provider network opportunities as well as the provider application policy on the MCDA segment of the County's website accessible by the general public.*

The MCDA-CMO contract administrator and marketing and communication coordinator began to meet on June 25, 2007 to discuss redesign of the MCDA-CMO webpage. The new design to the webpage will include information for providers and potential providers prominently on the page. Included information will include the template standard network contract information regarding the provider network and contracting opportunities, provider application policy, application template and other related information for potential providers.

Estimated time of Completion: September 1, 2007.

2. *Revise the provider application policy to provide more definitive and objective criteria for use by contract specialists in screening providers. The criteria could be compiled into a standardized checklist or evaluation template.*

The MCDA-CMO and the Health and Human Services Department have a significant number of providers that are contracting with both agencies. This department has begun efforts in conjunction with HSSD to develop a single application for use by both departments. A workgroup comprised of staff from both departments is meeting to review and make recommendations regarding application revision to better serve the county departments. The revised application will include more standardized elements to assist in evaluating the application.

Estimated Time of Completion: September 1, 2007

3. *Ensure that all contract specialists adhere to CMO policy regarding the issuance of rejection notices to providers indicating the reason the provider is not being considered for participation in the network.*

All contract specialists will keep a record tracking when an application has been sent to a provider, completed application is received from the provider, action taken to review the application, date of decision on provider application and date correspondence is sent to the provider informing that provider of the decision. At least monthly, the Contract Administrator will review applications in progress with each contract specialist, including review of timely completion of reviews and notice to the provider.

Estimated Time of Completion: Completed

4. *Periodically conduct trend analysis of complaint data maintained in the MIDAS system.*

In conjunction with MCDA-CMO IT staff, the Contract Administrator and Contract Specialists will revise the provider concern/complaint records in MIDAS to more accurately reflect the review process of all provider complaints/concerns. IT enhancements will include capacity to identify concerns recorded solely for

informational purposes that require no further investigation (e.g. log all DHFS Division of Quality Assurance resolved statements of deficiency).
Complaints/concerns that require further investigation by MCDA-CMO will be reviewed weekly with Placement Team and Contract Specialists to review status of all open investigations.

Estimated Time of Completion:

IT development and process for trend analysis: Fall, 2007

Complaint/Concern weekly status review: Completed

5. *Develop system edits in MIDAS to prevent or flag instances of missing or illogical data.*

As noted in response to #4 above, the Contract Administrator in conjunction with IT, contract specialists and all CMO senior management will work to enhance MIDAS to provide greater functionality in the provider concern/complaint records.

Estimated Time of Completion: Fall, 2007

6. *Ensure that information and feedback regarding the timeliness and reliability of caregivers is included in future surveys and survey results.*

As part of the CMO quality plan, the CMO completes surveys and records survey results at least annually. Additional and targeted surveys are also conducted periodically under the direction of the CMO quality coordinator/Chief Clinical Officer. Further member survey information may be obtained pursuant to the contract between the CMO and each provider. The provider must conduct periodic surveys and provide survey results to the CMO.

The Contract Specialist in conjunction with the Chief Clinical Officer will develop a member survey for members receiving supportive home/personal care and incorporate timeliness and reliability of caregivers in the survey.

Estimated Time of Completion: November, 2007