External Quality Review Annual Technical Report

Fiscal Year 2013-2014

Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly

Prepared for

Wisconsin Department of Health Services

Office of Family Care Expansion

Prepared by

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Executive Summary

External Quality Review Process

The Code of Federal Regulations at 42 CFR 438 requires states that operate pre-paid inpatient health plans to provide for an external quality review of their managed care organizations and to produce an annual technical report. Wisconsin's Medicaid managed long-term care programs; Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly (PACE) are considered pre-paid inpatient health plans. To meet its obligations, the Wisconsin Department of Health Services contracts with MetaStar, Inc.

This report covers the external quality review year from July 1, 2013, to June 30, 2014 (FY 13-14). Review activities required by 42 CFR 438 and conducted during the year included assessment of compliance with federal standards, validation of performance improvement projects, validation of performance measures and information system capability assessments. An optional review activity which assesses key areas of care management practice was also conducted, related to assurances found in the 1915 (b) and (c) Waivers and to support assessment of compliance with federal standards.

Summary of Progress

- During FY 13-14, one additional managed care organization achieved 100 percent compliance with the federal quality compliance standards. As a result, four organizations achieved full compliance with federal standards during the current three-year review cycle, which began in FY 11-12 and ended with this year's review.
- The remaining four organizations also made progress since last year related to compliance with federal quality standards; three of the four organizations achieved compliance rates of 90 percent or higher.
- Five of the 11 performance improvement projects validated by MetaStar achieved documented, quantitative improvement; four of these projects demonstrated sustained improvement.
- The Department of Health Services standardized the timeframe for conducting and reporting performance improvement projects in 2013, in order to ensure active progress is made during each contract period. The change addressed a recommendation made in previous external quality review reports.
- For the past two review years managed care organizations have been using technical specifications and a standardized template developed by the Department of Health Services for performance measures data submissions, which has greatly increased the consistency and quality of the reported data.

- Care management review showed improved overall results for the Family Care Partnership program, including notable improvement in two standards identified as areas of opportunity in last year's review:
    - Results for the standard, "Comprehensiveness of Most Recent Member-Centered Plan" were 92.2 percent in FY 13-14, compared to 72.2 percent in FY 12-13;
    - Results for the standard, "Plan Updated for Significant Changes" were 100 percent in FY 13-14, compared to 61.3 percent in FY 12-13.
- While noted as an area of strength in last year's review, results for both programs improved further for the care management review standard, "Risk Addressed When Identified."
    - Family Care results were 94.4 percent in FY 13-14, compared to 91.5 percent in FY 12-13;
    - Family Care Partnership results were 96.1 percent in FY 13-14, compared to 90.4 percent in FY 12-13.

Best Practice

One organization's approach to implementing performance improvement projects was identified as a "Best Practice" among managed care organizations. The organization aligns its projects with strategic goals, commits necessary resources, conducts regular measurement and plan-do-study-act cycles, and comprehensively analyzes results. In addition, the organization's success in conducting performance improvement projects has been evident over several external quality reviews.

Notable Strengths

- Managed care organizations developed and implemented plans to address findings and recommendations from the prior year's review that included efforts to enhance systems and improve policies and practices which impact the quality and timeliness of member care.
- Over the course of the three-year review cycle, managed care organizations achieved high levels of compliance with quality standards related to enrollee rights and grievance systems:
    - Seven of eight organizations achieved compliance rates of 100 percent with enrollee rights standards;
    - Five of eight organizations achieved compliance rates of 100 percent with grievance systems standards.
- All organizations were again successful in obtaining approval for their proposed performance improvement projects, demonstrating the ability to develop methodologically sound study topics, study questions, and study indicators.

- Managed care organizations have consistently demonstrated the ability to accurately calculate and report influenza and pneumococcal vaccination rates.
- Consistent with the results of previous years, managed care organizations continued to perform strongly in addressing members' identified needs and including members and their supports in care management processes:
    - FY 13-14 results for the standard, "Identified Needs are Addressed" were 97.7 percent for Family Care, and 97.8 percent for Family Care Partnership. FY 12-13 results were 96.7 percent and 97.8 percent, respectively.
    - FY 13-14 results for the standard, "Member/Guardian/Family/Informal Supports Included" were 99.4 percent for Family Care, and100 percent for Family Care Partnership. FY 12-13 results were 96.5 percent and 97.8 percent, respectively.

RECOMMENDATIONS

Enrollee Rights

- Ensure one organization fully implements policies and processes to comply with enrollee rights standards related to restrictive measures and advance directives.

Access/Quality

- Maintain oversight of two organizations that have not achieved full compliance with requirements to develop and maintain a fully operational and organizationally integrated Quality Assessment and Performance Improvement program.
- Ensure one organization fully implements monitoring processes for caregiver background checks, and also institutes a process to ensure services providers maintain licensure after initial credentialing.
- Ensure organizations have fully and accurately documented their current health information system practices and processes related to encounter data integration and creation from all data streams.
- In order to promote compliance with a new review standard identified in the updated CMS EQRO protocol, ensure managed care organizations understand requirements to take members' cultural and linguistic characteristics into account when developing and implementing performance improvement projects.
- Ensure four organizations incorporate continuous cycles of improvement and regular data analysis into their processes for conducting performance improvement projects.
- Based on the review findings of three MCOs, DHS should provide additional guidance and support regarding information system structure and processes, in order to improve the program-wide consistency of encounter data collection and reporting.

Grievance Systems

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

Care Management Practice

- The Family Care program should focus efforts on:
    - Improving the comprehensiveness of member-centered plans;
    - Updating member-centered plans when members have significant changes in situation or condition.
- The Family Care Partnership program should work to improve the timeliness with which member-center plans are reviewed and signed at the required six month intervals;
- Across both programs, ensure organizations make efforts to improve in these additional areas of care management practice:
    - Following up with members to ensure services have been received and are effective;
    - Issuing notices to members, when indicated.
- Support managed care organizations to provide adequate guidance, training, and oversight related to documentation practices, so that documentation in members' records is timely and accurately reflects the actions and interactions of care teams with members and their supports.

Introduction and Overview

Acronyms and Abbreviations

Please see Appendix 1 for definitions of all acronyms and abbreviations used in this report.

Purpose of the Report

This is the annual technical report that the State of Wisconsin must provide to the Centers for Medicare & Medicaid Services (CMS) related to the operation of its Medicaid managed health and long-term care programs; Family Care (FC), Family Care Partnership (FCP), and Program of All-Inclusive Care for the Elderly (PACE). The Code of Federal Regulations (CFR) at 42 CFR 438 requires states that operate pre-paid inpatient health plans (PIHPs) to provide for an external quality review of their managed care organizations. This report covers the mandatory and optional external quality review (EQR) activities outlined in 42 CFR 438 that were conducted by MetaStar, Inc., for the fiscal year from July 1, 2013, to June 30, 2014 (FY 13-14). See Appendix 3 for more information about external quality review and a description of the methodologies used to conduct review activities.

Overview of Wisconsin's FC, FCP, and PACE MCOs

During FY 13-14, the Wisconsin Department of Health Services (DHS) contracted with nine managed care organizations (MCOs) to administer these programs, which are considered PIHPs. As noted in the table below, five MCOs operate only FC programs; one MCO operates only a FCP program; one MCO operates FC and FCP programs; one MCO operates programs for FC, FCP, and PACE. Additionally, one MCO ceased operating FC during the review year.

Managed Care Organization	Program(s)
Care Wisconsin (CW)	FC; FCP
Community Care (CCI)	FC; FCP; PACE
Community Care of Central Wisconsin (CCCW)	FC
ContinuUs*	FC
Independent Care Health Plan (*i*Care)	FCP
Lakeland Care District (LCD)	FC
Milwaukee County Department of Family Care (MCDFC)	FC
Northern Bridges Managed Care Organization (NB)**	FC
Western Wisconsin Cares (WWC)	FC

*Southwest Family Care Alliance changed its name to ContinuUs effective 8/1/13.

**As of 12/31/13, the contract between DHS and NB ended.

During 2012, the state conducted a competitive procurement and awarded three MCOs the opportunity to expand their service areas into additional counties currently served by at least one at least one other MCO; thus, affording consumers in those areas more choice of MCO providers. One of the MCOs, MCDFC, expanded in FY 12-13. The other two, CW and ContinuUs, expanded into additional counties in FY 13-14. Effective August 1, 2013, ContinuUs expanded into eight additional counties; and from August to October 2013, CW staggered its expansion into eight other counties.

On January 1, 2014, also as a result of competitive procurement, CCCW replaced NB as the MCO responsible for delivery of FC services in 11 counties in northwest Wisconsin. NB ceased operations effective December 31, 2013.

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

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

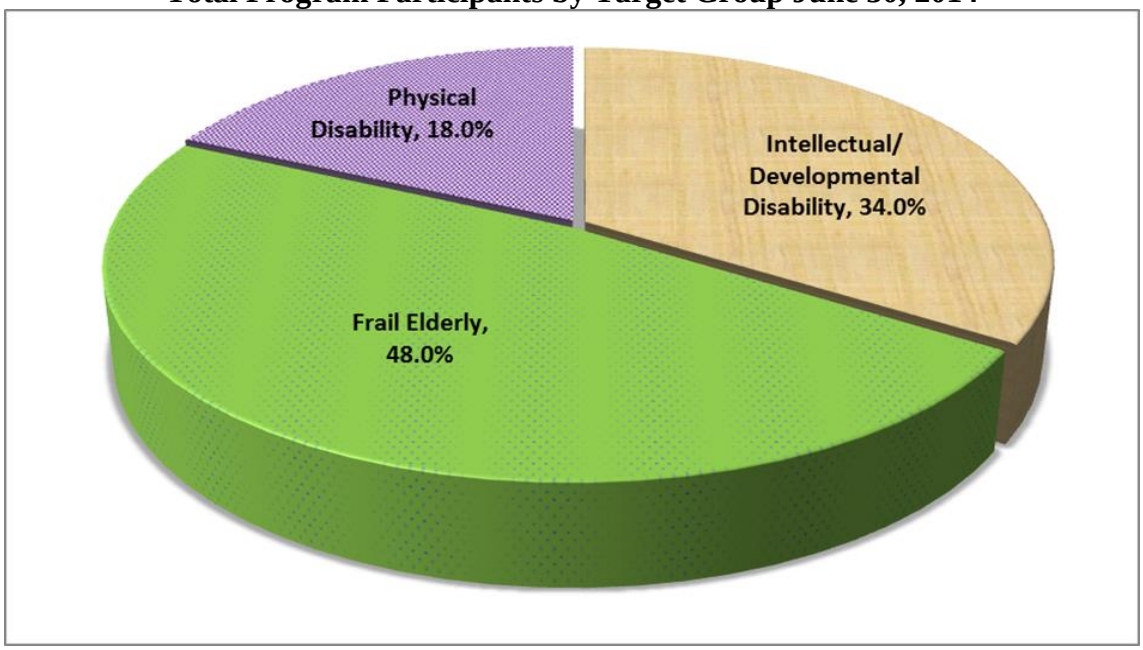
For details about the core values and operational aspects of these programs, visit these websites:

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

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

As of June 30, 2014, enrollment for all programs was approximately 41,352. This compares to a total enrollment of 40,400 as of June 30, 2013. The chart on the next page shows the percent of total enrollment by the primary target groups served by these programs; individuals who are frail elders, persons with intellectual/developmental disabilities, and persons with physical disabilities.

Total Program Participants by Target Group June 30, 2014



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

SCOPE OF FY 13-14 EXTERNAL REVIEW ACTIVITIES

In FY 13-14, MetaStar conducted three mandatory review activities as specified in federal Medicaid managed care regulations found at 42 CFR 438.358: Assessment of compliance with federal standards, referred to in this report as quality compliance review (QCR); validation of performance improvement projects (PIPs); and validation of performance measures. Federal regulations at 42 CFR 438.242 as well as CMS protocols which pertain to these three activities also mandate that states assess the information system capabilities of MCOs. Therefore, MetaStar conducted some information systems capability assessments (ISCAs) during FY 13-14. MetaStar also conducted an optional review activity, care management review (CMR), and began another optional review activity, encounter data validation..

Mandatory Review Activities	Scope of Activities
Quality Compliance Review	QCR activities generally follow a three year cycle in alignment with 42 CFR 438. The first year, MetaStar conducts a comprehensive review where all QCR standards are assessed; 52 standards for FC, and 53 standards for FCP. As directed by DHS, this is followed by two years of targeted review or follow-up based on the results of the comprehensive review year. FY 13-14 was the second **follow-up review year**. Therefore, for each MCO, the EQR team reviewed only those compliance standards which remained partially met following the comprehensive review of FY 11-12 or the initial follow-up review of FY 12-13. The targeted areas of review for each MCO are indicated in the chart on page 12 and 13.

Performance Improvement Projects	The DHS-MCO contract requires all MCOs to make active progress each year on at least one PIP relevant to long-term care. MCOs operating PACE or FCP programs must also make progress on at least one additional PIP relevant to acute and primary care. In FY 13-14, MetaStar validated one or more PIPs for each MCO, for a total of 11 PIPs. The PIP topics reviewed for each MCO are indicated the chart on page 14.
Performance Measures	Annually, MCOs must measure and report their performance using quality indicators and standard measures specified in the DHS-MCO contract. For FY 13-14, all MCOs were required to report performance measures data related to care continuity, influenza vaccinations, and pneumococcal vaccinations. MCOs operating PACE or FCP programs were also required to report data on dental visits as well as any available measures of members' outcomes (i.e., clinical, functional, and personal experience outcomes). As directed by DHS, MetaStar validated two of these performance measures for every MCO: • Influenza vaccinations • Pneumonia vaccinations. MCOs were directed to report data regarding the care continuity and dental visits performance measures directly to DHS; MetaStar did not validate these measures.
Information System Capabilities Assessment	Information System Capability Assessments are a required part of other mandatory EQR protocols. The DHS-MCO contract requires MCOs to maintain a health information system capable of collecting, analyzing, integrating, and reporting data; for example, data on utilization, grievances and appeals, disenrollments, and member and provider characteristics. As directed by DHS, each MCO receives an ISCA once every three years. MetaStar conducted three ISCAs during FY 13-14.
Optional Review Activities	**Scope of Activities**
Care Management Review	MetaStar conducts CMR to assess each MCO's level of compliance with its contract with DHS in key areas of care management practice as well as member health and safety. CMR activities and findings also help support QCR, and are part of DHS' overall strategy for providing quality assurances to CMS regarding the 1915 (b) and (c) Waivers which allow the State of Wisconsin to operate its Family Care programs. During FY 13-14, the EQR team conducted CMR activities during each MCO's annual quality review (AQR), a total of 617 record reviews. At the request of DHS, MetaStar also performed an additional 55 CMRs separate from AQR. These results were reported separately and are not included in the data for this report.

Encounter Data Validation	Encounter data validation determines whether encounter data submitted by MCOs is complete and accurate. Validation results can be used to assess and improve quality, monitor program integrity, and determine capitation payment rates. At the direction of DHS, validation activities were conducted for encounters related to the provision of long-term services and supports for three MCOs. The review began in FY 13-14, but was completed and reported in FY 14-15. Therefore, the results were not included in the data for this report.

Scope of each MCO's Annual Quality Review

During FY 13-14, the AQR for five MCOs consisted of QCR, CMR, and PIP validation activities. Three other MCOs had met all QCR standards in FY 12-13; therefore, AQR for these three organizations was limited to CMR and PIP validation. Three MCOs were selected by DHS for an ISCA review.

It should be noted that, per the direction of DHS, MetaStar did not conduct review activities at NB, as this MCO ceased operating FC effective December 31, 2013, and CCCW began providing FC services to that area as of January 1, 2014. EQR activities at CCCW were adjusted to reflect the transition in MCO provider in the area formerly served by NB.

MetaStar did not conduct CMR for the PACE program, as PACE was audited by CMS during FY 13-14.

QCR Targeted Areas of Review for each MCO

As noted above, the QCR standards reviewed at each MCO in FY 13-14 were targeted to those standards not fully met in FY 12-13. The table below shows the QCR topic areas reviewed for each MCO. Each QCR topic is associated with one or more quality compliance standards. The number in parenthesis after each topic tells the number of compliance standards for each area of review. The check mark(s) in each column indicate that a corresponding number of compliance standards were reviewed in the QCR topic area for that MCO.

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

QCR TOPIC	CW	CCI	CCCW	ContinuUs	*i*CARE	LCD	MCDFC	WWC
Confidentiality (1)								
Enrollment and Disenrollment (3)								
Availability of Services (3)					√			
Coordination and Continuity of Care (3)	√√			√	√√			
Coverage and Authorization of Services (3)	√	√		√				
Practice Guidelines (3)		√						
Quality Assessment and Performance Improvement Program (QAPI) (3)		√			√			
Basic Elements of the QAPI Program (4)	√	√√√		√	√√√		√	
Quality Evaluation (2)		√			√√			
Health Information Systems (1)								
Grievance Systems								
Structure and Basic Requirements (6)		√						
Communication to Members (3)	√	√		√	√		√	
Processes if Member Chooses to Exercise his/her Rights (4)								
Resolution of Appeals (3)								
Total QCR Standards Reviewed for Each MCO	**5**	**10**	**0**	**4**	**15**	**0**	**2**	**0**

PIP Topic(s) Reviewed for each MCO

MCO	PIP Title
CW	• Re-Admission Quality Improvement (continuing) • Care Transitions: Improving Coordination of Care
CCI	• Increasing Member and Staff Awareness/Use of Self-Directed Supports (SDS) • Reducing Cardiovascular Disease among Community Care Health Plan Partnership Members who are Diabetic and Hypertensive
CCCW	• PAP Test Preventative Screening Improvement Project
ContinuUs	• Falls Prevention Project
***i*Care**	• Reducing Cardiovascular Disease among *i*Care's FCP Members between the Ages of 18-75 years who are Diabetic • Reduce Readmission Rate within 30 Days of Discharge Among *i*Care FCP Dually Eligible Members 65 years and Older
LCD	• Falling Head Over Heals for Falls Reduction
MCDFC	• Hypertension and the Role of Self-Monitoring Blood Pressure
WWC	• Falls Prevention PIP

Number of Care Management Reviews Conducted by MCO and Program

MetaStar drew a sample of member records for each MCO and program based on a minimum of one and one-half percent of a program's enrollment or 30 records, whichever was greater. See Appendix 3 for more information about the CMR methodology.

Program/MCO	CMR Sample Size
Family Care	
CW	57
CCI	123
CCCW	52
ContinuUs	72
LCD	40
MCDFC	123
WWC	60
Total: Family Care	**527**
Family Care Partnership	
CW	30
CCI	30
*i*Care	30
Total: Family Care Partnership	**90**

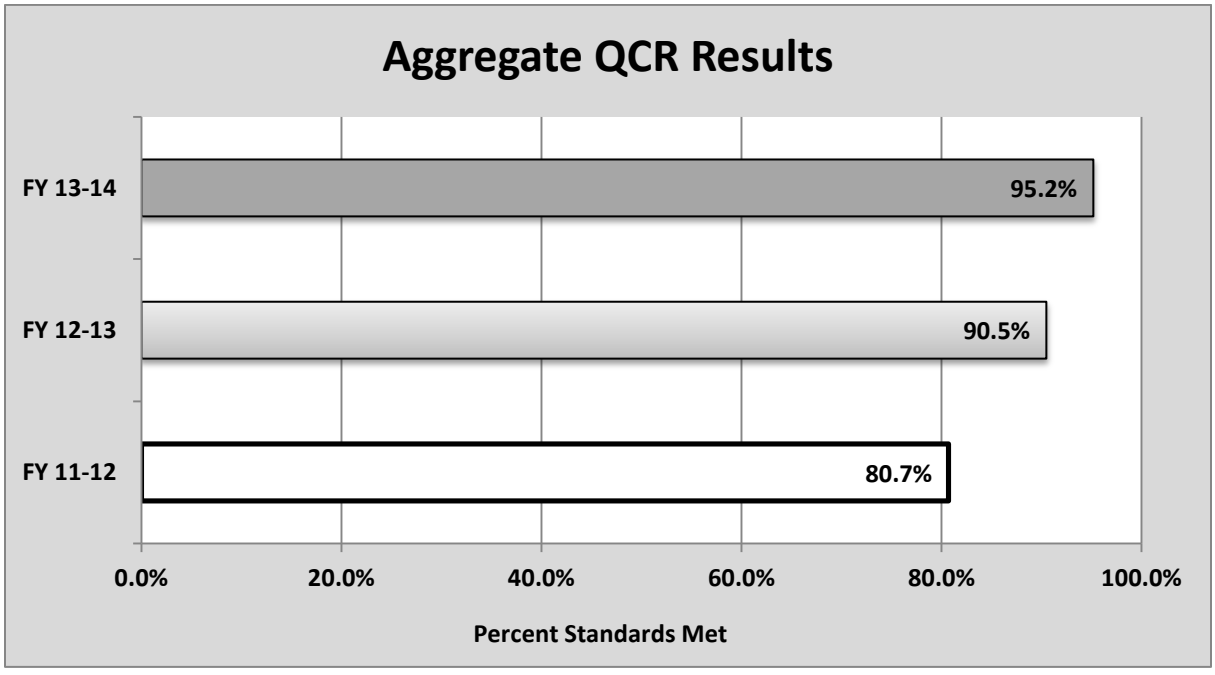
Quality Compliance Review

QCR is a mandatory activity required by 42 CFR 438 which is conducted to determine the extent to which MCOs are in compliance with federal quality standards. QCR generally follows a three year cycle, one year of comprehensive review followed by two years of targeted review. The comprehensive review includes 52 total standards for MCOs operating FC and 53 standards for those operating FCP. Targeted review includes only those compliance standards MCOs did not fully meet during the previous comprehensive review year. FY 11-12 was a comprehensive review year; compliance reviews in FYs 12-13 and 13-14 were targeted or focused.

Aggregate Results for Quality Compliance Review

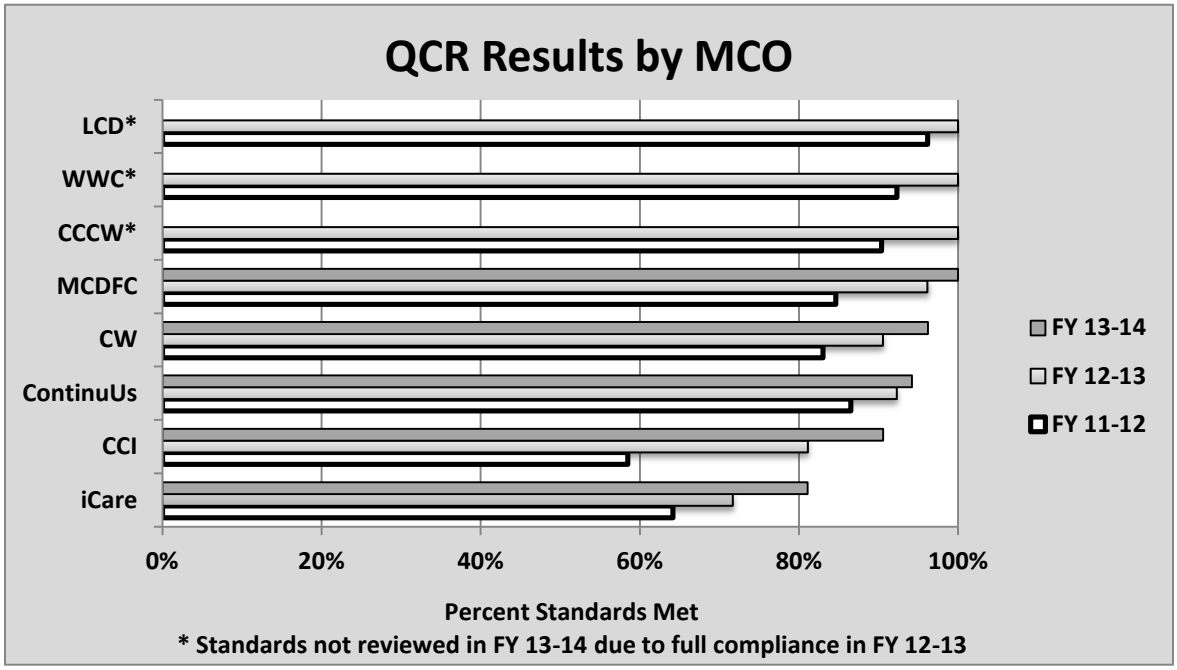
The graph below shows the aggregate results for QCR for FY 13-14, and compares the percentage of standards met in this year's review to MCOs' level of compliance in the previous two years.

Readers should note the following: The results are cumulative over the past three years, i.e., the bar labeled FY 13-14 represents the cumulative number of QCR standards MCOs met during the current three-year review cycle which began in FY 11-12, and ends with this year's review. Similarly, the bar labeled FY 12-13 represents the QCR standards met in FY 11-12 plus additional standards met during the FY 12-13 review. Additionally, FY 13-14 includes the aggregate results of eight MCOs, whereas FY 12-13 includes the results of nine MCOs and FY 11-12 includes the results of 10 MCOs.



- During FY 13-14, a total of 36 standards were reviewed among eight MCOs. This compares to 85 standards reviewed in FY 12-13 among nine MCOs.
- Results for FY 13-14 indicated that 16 of the 36 standards (44.4 %) improved to fully met.
- Over the three-year review cycle, the aggregate rate for compliance with standards improved steadily, from 80.7 percent in FY 11-12 to 95.2 percent in FY 13-14.

The graph below shows QCR results as a percentage of the total standards met for each MCO reviewed in FY 13-14, and compares the results to the two previous years. As explained above, the results are cumulative over the three-year review cycle.



- One additional MCO attained a compliance rate of 100 percent in FY 13-14, in addition to the three MCOs that achieved it during FY 12-13.
- Three other MCOs met additional QCR standards that resulted in compliance levels above 90 percent.
- Every MCO has shown steady progress related to compliance with standards over the three-year review cycle.

Focus Area Results for Quality Compliance Review

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

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

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

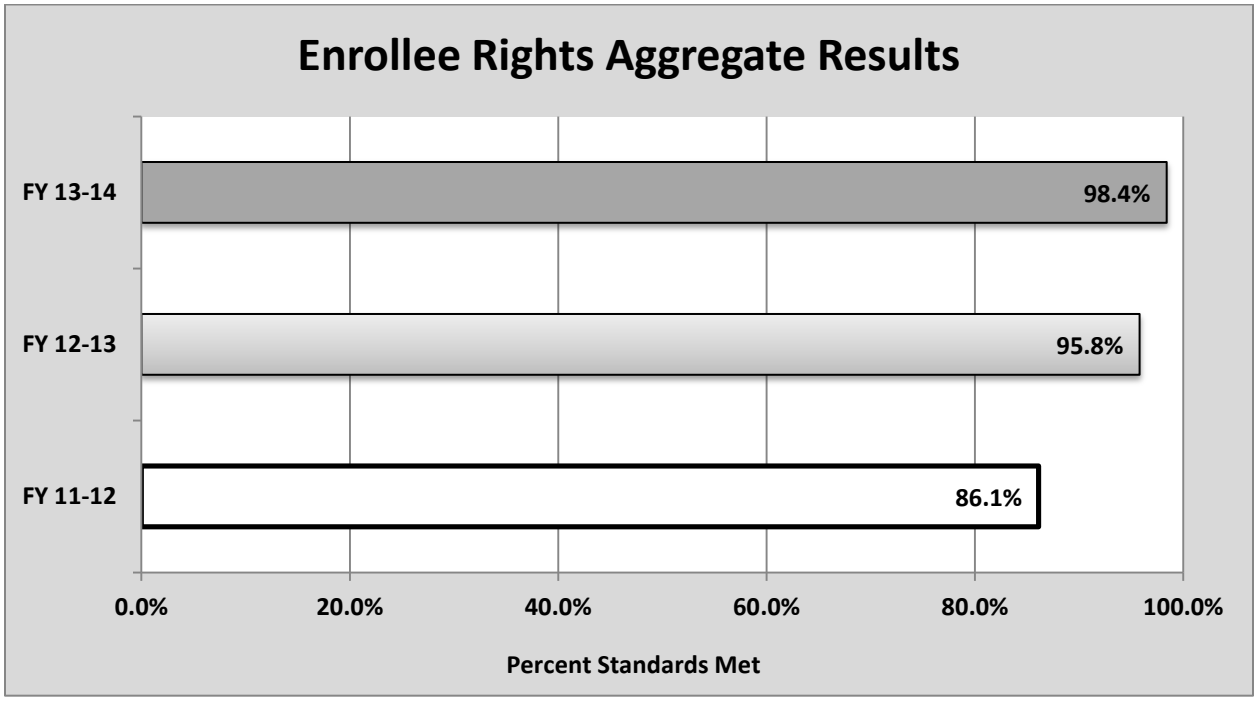
Each section below provides a brief explanation of a QCR focus area, followed by a bar graph and a table with additional information.

Enrollee Rights and Program Structure

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

The graph below shows the aggregate results for FY 13-14 for all of the standards related to "Enrollee Rights and Program Structure," and compares the percentage of standards met in this year's review to MCOs' level of compliance in the previous two years.

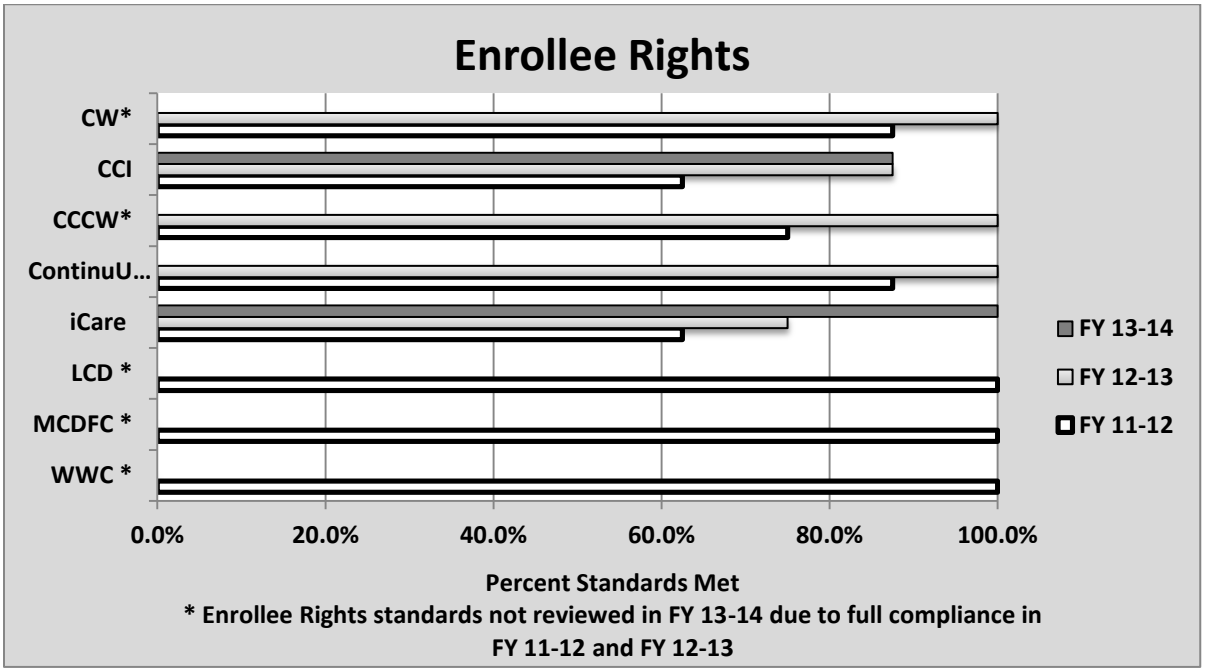
Readers should note the following: The results are cumulative over the past three years, i.e., the bar labeled FY 13-14 represents the cumulative results during the current three-year review cycle, which began in FY 11-12 and ends with this year's review. Similarly, the bar labeled FY 12-13 represents the standards met in FY 11-12 plus additional standards met during the FY 12-13 review. Additionally, FY 13-14 includes the aggregate results of eight MCOs, whereas FY 12-13 includes the results of nine MCOs and FY 11-12 includes the results of 10 MCOs.



The table below lists the standards, by number, in the "Enrollee Rights and Program Structure" focus area which required review during FY 13-14. For each standard, the columns on the right indicate the number of MCOs that required review, along with the resulting number of MCOs that fully met the standard. For example, two MCOs partially met Enrollee Rights Standard #2 during FY 12-13 and therefore, required review in FY 13-14. One of those two MCOs fully met the standard during FY 13-14.

	Quality Compliance Review Standards – Enrollee Rights and Program Structure	Number of MCOs Reviewed in FY 13-14 Due to Partially Met Findings in FY 12-13	Of the MCOs Reviewed in FY 13-14, the Number That Achieved a Finding of Met
Specific Rights			
2	The MCO guarantees that its members have the right to: • Be treated with respect and consideration for their dignity and privacy • Receive information on available treatment options and alternatives • Health care professionals acting within their scope of practice may not be restricted from advising or advocating on behalf of the member • Participate in decisions regarding their health care, including the right to refuse treatment • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation • Request and receive a copy of their medical records, and to request that they be amended or corrected in accordance with federal privacy and security standards	2	1
Information Requirements			
8	Regarding advance directives, the MCO must: • Have written policies and procedures • Provide written information to all adult members (or their family or surrogate if incapacitated) at the time of their enrollment • Update written information to reflect changes in State law as soon as possible (but not later than 90 days after the effective date of the change) • Document in the medical record whether or not the individual has executed an advance directive and must not discriminate based on its presence or absence • Provide education for staff and the community on issues concerning advance directives • Inform individuals that complaints concerning non-compliance with any advance directive may be filed with the State survey and certification agency	1	1

The graph below provides MCO comparative information regarding QCR results for "Enrollee Rights and Program Structure" standards. The results are shown as a percent of the total standards met for each MCO reviewed in FY 13-14, and compared to the results for the two previous years. As explained above, the results are cumulative over the three-year review cycle.



CONCLUSIONS

Progress

- During FY 13-14, two of three standards reviewed for this focus area were met.
- One additional MCO achieved full compliance with Enrollee Rights standards.
- MCOs' aggregate compliance rate reached 98.4 percent for standards in this focus area. This compares to 95.8 percent in FY 12-13 and 86.1 percent in FY 11-12.
- Over the course of the three-year cycle, seven of eight MCOs have fully met all review standards related to ensuring enrollee rights.

Strengths

- MCOs have the basic structures and processes in place to ensure members understand their rights, and that those rights are protected.

Opportunities for Improvement

- One organization should fully implement all aspects of its revised policies and procedures related to restraints and restrictive measures and monitor the impact of these improvement efforts over time.

Access to Services and Quality Monitoring

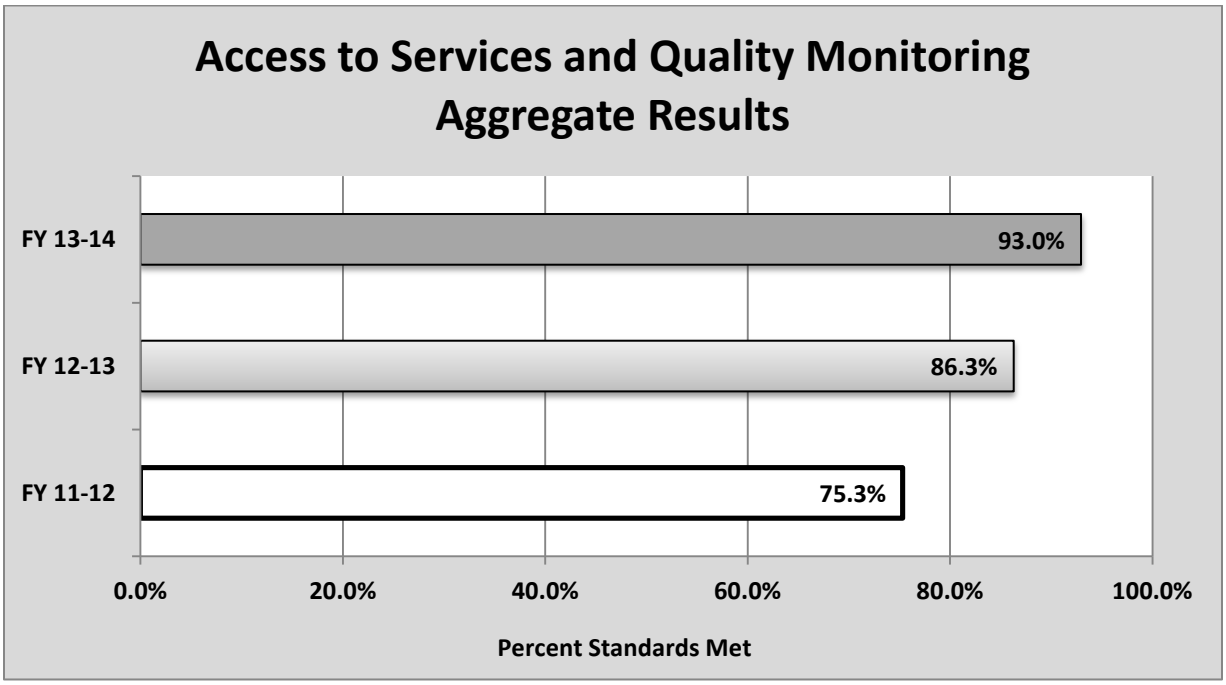
A MCO must provide members with high quality long-term care and health care services through a network of appropriate and qualified providers. It must also have systems and processes for:

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

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

The graph below shows the aggregate results for FY 13-14 for all of the standards related to "Access to Services and Quality Monitoring," and compares the percentage of standards met in this year's review to MCOs' level of compliance in the previous two years.

Readers should note the following: The results are cumulative over the past three years, i.e., the bar labeled FY 13-14 represents the cumulative results during the current three-year review cycle, which began in FY 11-12 and ends with this year's review. Similarly, the bar labeled FY 12-13 represents the standards met in FY 11-12 plus additional standards met during the FY 12-13 review. Additionally, FY 13-14 includes the aggregate results of eight MCOs, whereas FY 12-13 includes the results of nine MCOs and FY 11-12 includes the results of 10 MCOs.



The table below lists the standards, by number, in the "Access to Services and Quality Monitoring" focus area which required review during FY 13-14. For each standard, the columns on the right indicate the number of MCOs that required review, along with the resulting number of MCOs that fully met the standard.

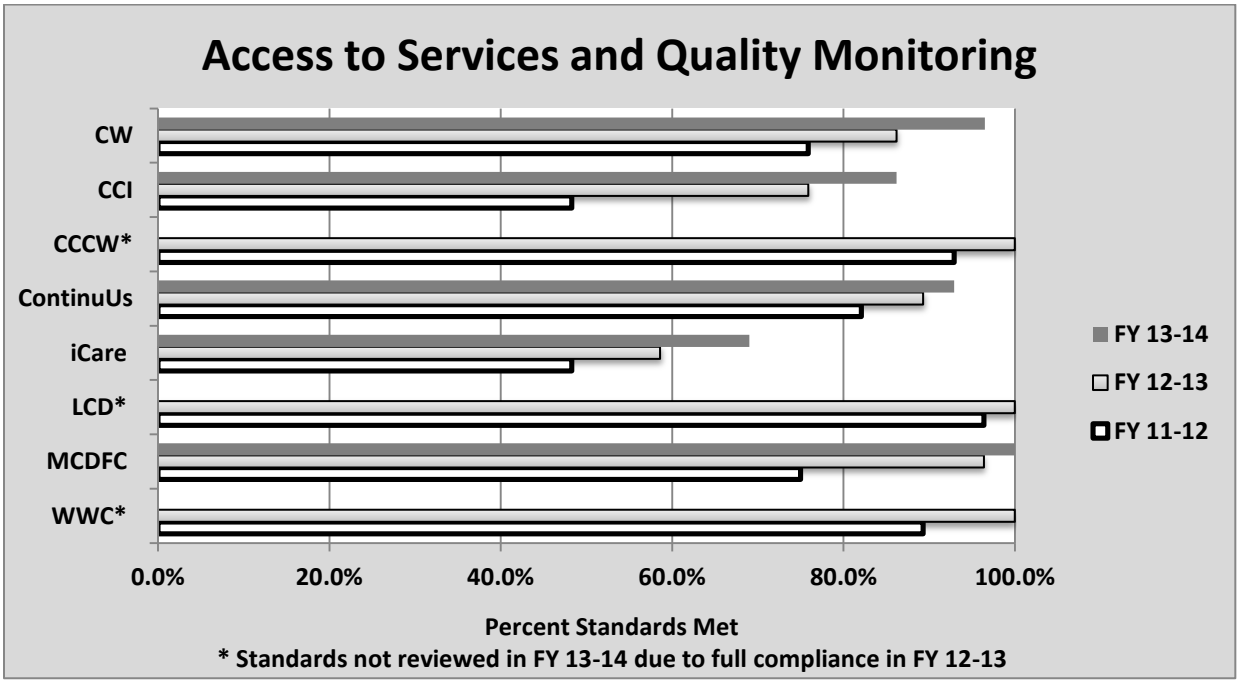
	Quality Compliance Review Standards – Access to Services and Quality Monitoring	Number of MCOs Reviewed in FY 13-14 Due to Partially Met Findings in FY 12-13	Of the MCOs Reviewed in FY 13-14, the Number That Achieved a Finding of Met
Provider Selection			
1	The MCO must: • Implement written policies and procedures for selection and retention of providers • Follow a documented process for credentialing and re-credentialing of providers who have signed contracts or participation agreements • Implement provider selection policies and procedures to ensure non- discrimination against particular practitioners that serve high risk populations or specialize in conditions that require costly treatment • Give the affected providers written notice of the reason for its decision, if the MCO declines to include individual or groups of providers in its network	1	0
2	MCOs may not employ or contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act	1	1
3	The MCO must comply: • With any additional requirements established by the State including caregiver background checks for interdisciplinary team (IDT) staff and provider staff that come in direct contact with a member • With all applicable federal and state laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act of 1990 as amended	1	0
Availability of Services			
8	**Delivery Network** The MCO maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, the MCO site must consider: • Anticipated Medicaid enrollment • Expected utilization of services, considering Medicaid member characteristics and health care needs	1	1

	Quality Compliance Review Standards – Access to Services and Quality Monitoring	Number of MCOs Reviewed in FY 13-14 Due to Partially Met Findings in FY 12-13	Of the MCOs Reviewed in FY 13-14, the Number That Achieved a Finding of Met
	• Numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services • The number of network providers who are not accepting new MCO members • The geographic location of providers and MCO members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities		
Coordination and Continuity of Care			
11	**Primary care and coordination of health care services** The MCO must implement procedures to deliver primary care (if applicable for FCP) and coordinate health care services for all MCO members. These procedures must do the following: • Ensure that each member has an on-going source of primary care appropriate to his/her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member • Coordinate the services the MCO furnishes to the member with services the member receives from any other provider of health care or insurance plan • Facilitate access to specialists appropriate for the member's special health care condition and identified needs • Allows freedom of choice for female members to access a woman's specialist or, when age-appropriate, obtain the services of qualified family planning providers (FCP) • Share with other providers serving the member the results of its identification and assessment of that member's needs to prevent duplication of activities • Protection of the member's privacy when coordinating care	2	0
13	**Identification** The State must implement mechanisms to identify persons with special health care needs. (Annual Long-Term Care Functional Screen). **Assessment** The MCO must implement mechanisms to assess each member in order to identify special conditions that require treatment and care monitoring (must use appropriate health care professionals). **Member-Centered Plan (MCP)** The MCP must be determined through assessment, developed with the member, the member's primary care provider, and in consultation with any specialists. It must be completed and approved in a timely manner in accordance with DHS standards.	3	2

	Quality Compliance Review Standards – Access to Services and Quality Monitoring	Number of MCOs Reviewed in FY 13-14 Due to Partially Met Findings in FY 12-13	Of the MCOs Reviewed in FY 13-14, the Number That Achieved a Finding of Met
Coverage and authorization of services			
14	**Authorization of Services** For processing requests for initial and continuing authorizations of services, the MCO must: • Have in place and follow written policies and procedures • Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions • Consult with the requesting provider when appropriate • Assure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease	1	1
15	**Timeframe for Decisions of Approval or Denial** The IDT staff shall make decisions on requests for services and provide notice as expeditiously as the member's health condition requires. **Standard Service Authorization Decisions** Decisions shall be made no later than 14 calendar days following receipt of the request for the service unless the MCO extends the timeframe for up to 14 additional calendar days. If the timeframe is extended, the MCO must send a written notification to the member no later than the fourteenth day after the original request. **Expedited Service Authorization Decisions:** If following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO shall make an expedited service authorization no later than 72 hours after receipt of the request for service. The MCO may extend the timeframes of expedited service authorization decisions by up to 11 additional calendar days if the member or a provider requests the extension or the MCO justifies a need for additional information. For any extension not requested by the member, the MCO must give the member written notice of the reason for delay of decision.	2	1
Practice Guidelines			
18	Practice guidelines are disseminated to affected providers and, upon request, to members.	1	0
Quality Assessment and Performance Improvement Program (QAPI)			
22	The quality work plan outlines the scope of activities, goals, objectives, timelines, responsible person, and is based on findings from QAPI program activities.	2	1
Basic Elements of the QAPI Program			
23	The MCO must have processes in effect to monitor and detect both under- and over-utilization of services.	3	1

	Quality Compliance Review Standards – Access to Services and Quality Monitoring	Number of MCOs Reviewed in FY 13-14 Due to Partially Met Findings in FY 12-13	Of the MCOs Reviewed in FY 13-14, the Number That Achieved a Finding of Met
24	The MCO must operate a system to assess and improve the quality and appropriateness of care furnished to members.	2	0
26	The MCO must report the status and results of each performance improvement project to the State as requested (conduct the number of PIPs required by its contract and obtain State approval for each required project whether new or continuing). Each PIP must be completed in a reasonable time period so as to generally allow information on the success of PIPs in the aggregate to produce new information on quality of care every year.	4	3
Quality Evaluation			
27	The MCO has in effect a process for an annual evaluation of its quality assessment and performance improvement program, which addresses the basic elements and activities of the program.	1	0
28	The annual evaluation shall determine whether the program has achieved significant improvement on the quality of health care and services provided to its members.	2	0

The graph below provides MCO comparative information regarding QCR results for "Access to Services and Quality Monitoring" standards. The results are shown as a percent of the total standards met for each MCO reviewed in FY 13-14, and compared to the results for the two previous years. As explained above, the results are cumulative over the three year review cycle.



CONCLUSIONS

Progress

- During FY 13-14, 11 of 27 standards reviewed for this focus area were met.
- Five MCOs met additional standards related to the QAPI program:
    - Six of eight MCOs have now fully met all related review indicators.
    - Last year, only three of nine organizations met all of the review standards related to having an effective QAPI program.
- One additional MCO achieved full compliance with all of the Access to Services and Quality Monitoring standards.
- MCOs' aggregate compliance rate reached 93 percent for standards in this focus area. This compares to 86.3 percent in FY 12-13 and 75.3 percent in FY 11-12.
- Over the course of the three-year cycle, four of eight MCOs have fully met all of the review standards related to ensuring access to services and quality monitoring.

Strengths

- All organizations have systems and processes in place to ensure members' protected health and personally identifiable information is used and disclosed in accordance with regulatory requirements**.**
- MCOs have developed and utilize practice guidelines which are based on valid and reliable clinical evidence. Seven of eight MCOs are in full compliance with requirements related to practice guidelines.
- Seven of eight MCOs have met requirements to establish, maintain, and monitor a network of providers sufficient to provide adequate access to all services covered in the DHS-MCO contract. The remaining organization made progress toward compliance during FY 13-14.

Opportunities for Improvement

- Two organizations should continue efforts to develop and sustain fully operational and organizationally integrated QAPI programs, including:
    - Ensuring quality work plans and related documents reflect all required and prioritized activities.
    - Developing systems and processes to conduct regular utilization monitoring, particularly under-utilization.
    - Fully implementing systems which use data to assess and improve the quality of care provided to members.
    - Annually evaluating the QAPI program with a focus on assessing its impact on the quality of care and services provided to members.

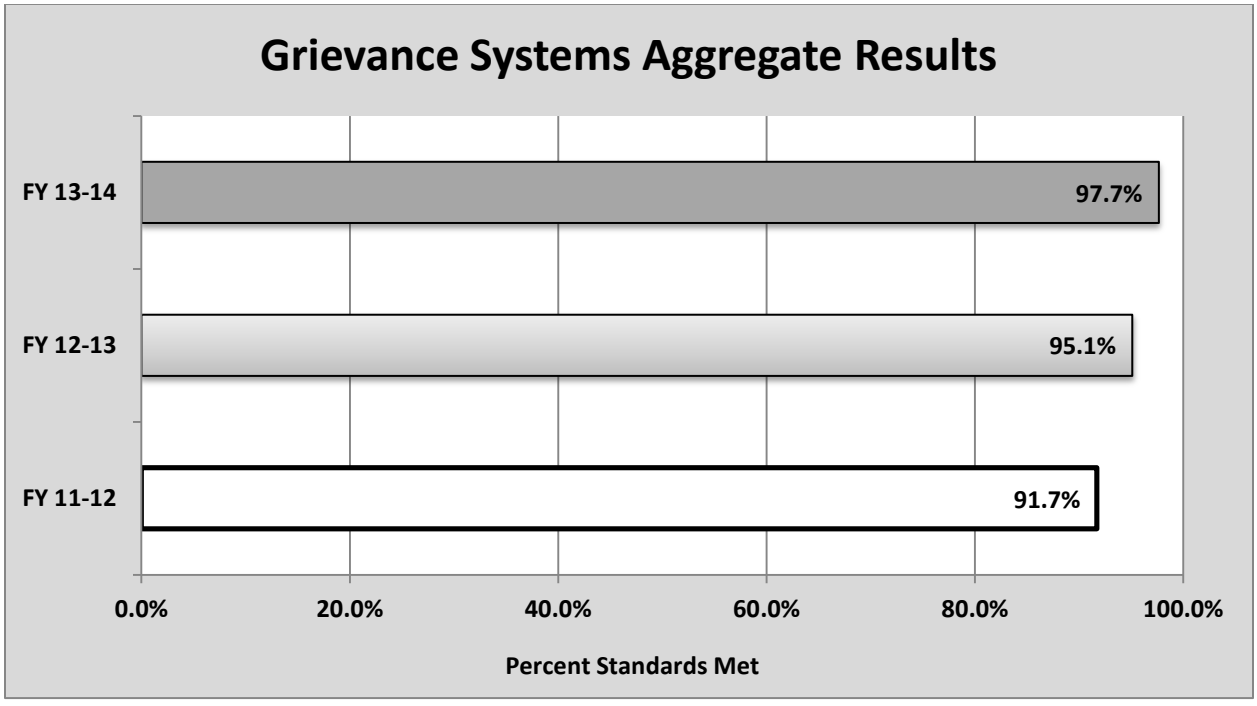
- One organization should fully implement a consistent monitoring process related to caregiver background checks, and should also institute a process to ensure long-term care service providers maintain licensure after initial credentialing.

Grievance Systems

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

The graph below shows the aggregate results for FY 13-14 for all of the standards related to "Grievance Systems," and compares the percentage of standards met in this year's review to MCOs' level of compliance in the previous two years.

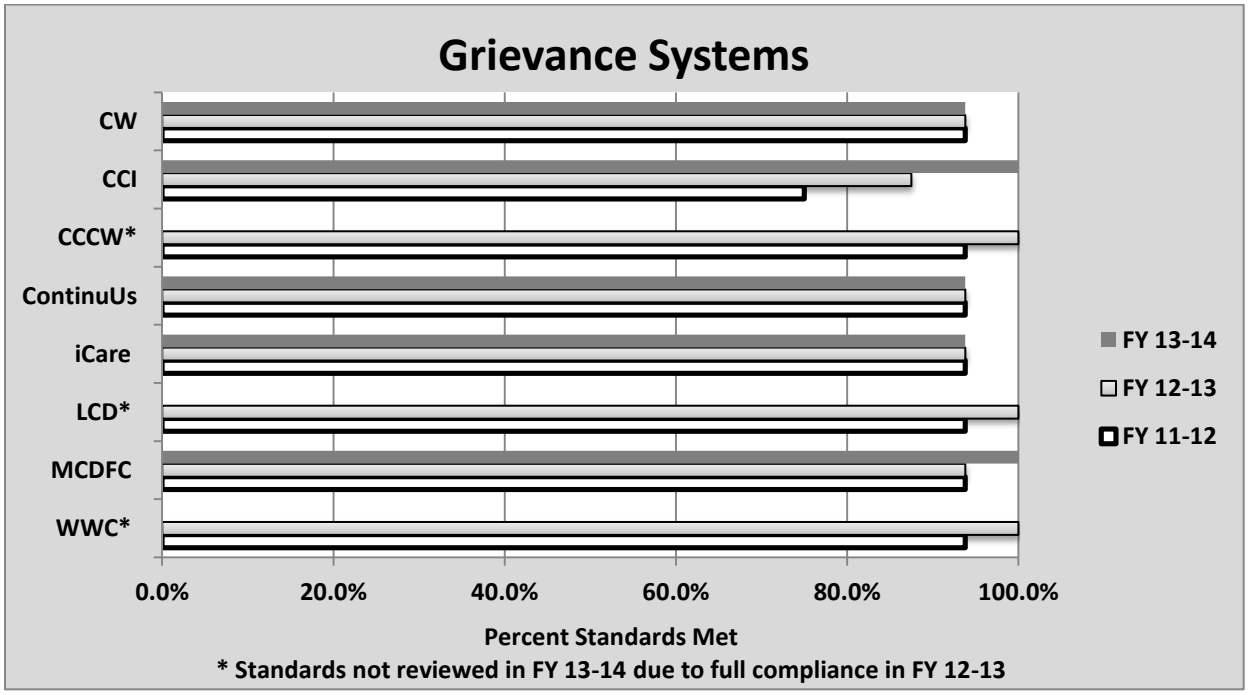
Readers should note the following: The results are cumulative over the past three years, i.e., the bar labeled FY 13-14 represents the cumulative results during the current three-year review cycle, which began in FY 11-12 and ends with this year's review. Similarly, the bar labeled FY 12-13 represents the standards met in FY 11-12 plus additional standards met during the FY 12-13 review. Additionally, FY 13-14 includes the aggregate results of eight MCOs, whereas FY 12-13 includes the results of nine MCOs and FY 11-12 includes the results of 10 MCOs.



The table below lists the standards, by number, in the "Grievance Systems" focus area which required review during FY 13-14. For each standard, the columns on the right indicate the number of MCOs that required review, along with the resulting number of MCOs that fully met the standard.

	Quality Compliance Review Standards – Grievance Systems	Number of MCOs Reviewed in FY 13-14 Due to Partially Met Findings in FY 12-13	Of the MCOs Reviewed in FY 13-14, the Number That Achieved a Finding of Met
Structure and Basic Requirements			
5	The MCO must provide sufficient information to providers to support members in exercising their rights.	1	1
Communication to members			
8	A notice must be delivered to the member for the following reasons and in the timeframes associated with each type of adverse decision as required by 42 CFR 438.400-424 and the DHS contract with MCOs. • Denial of service • Termination, suspension, or reduction of service • Delay in decision making or extension of timeframe for the decision making process	5	2

The graph below provides comparative information regarding QCR results for "Grievance Systems" standards. The results are shown as a percent of the total standards met for each MCO reviewed in FY 13-14, and compared to the results for the two previous years. As explained above, the results are cumulative over the three year review cycle.



CONCLUSIONS

Progress

- During FY 13-14, three of six standards reviewed for this focus area were met.
- Two additional MCOs achieved full compliance with Grievance Systems standards.
- MCOs' aggregate compliance rate reached 97.7 percent for standards in this focus area. This compares to 95.1 percent in FY 12-13 and 91.7 percent in FY 11-12.
- Over the course of the three-year cycle, five of eight MCOs have fully met all review indicators related to Grievance Systems.

Strengths

- MCOs have the basic structures and processes in place to ensure members are informed and supported relative to grievance and appeal rights.

Opportunities for Improvement

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

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

The purpose of a PIP is to assess and improve processes and outcomes of health care provided by the MCO. For FY 13-14, the DHS-MCO contract required all MCOs to make active progress each year on at least one PIP relevant to long-term care. MCOs operating PACE or FCP programs must also make progress on at least one additional PIP relevant to acute and primary care.

Validation of PIPs is a mandatory review activity, required by 42 CFR 438, which determines whether projects have been designed, conducted, and reported in a methodologically sound manner.

The study methodology is assessed through the following steps:

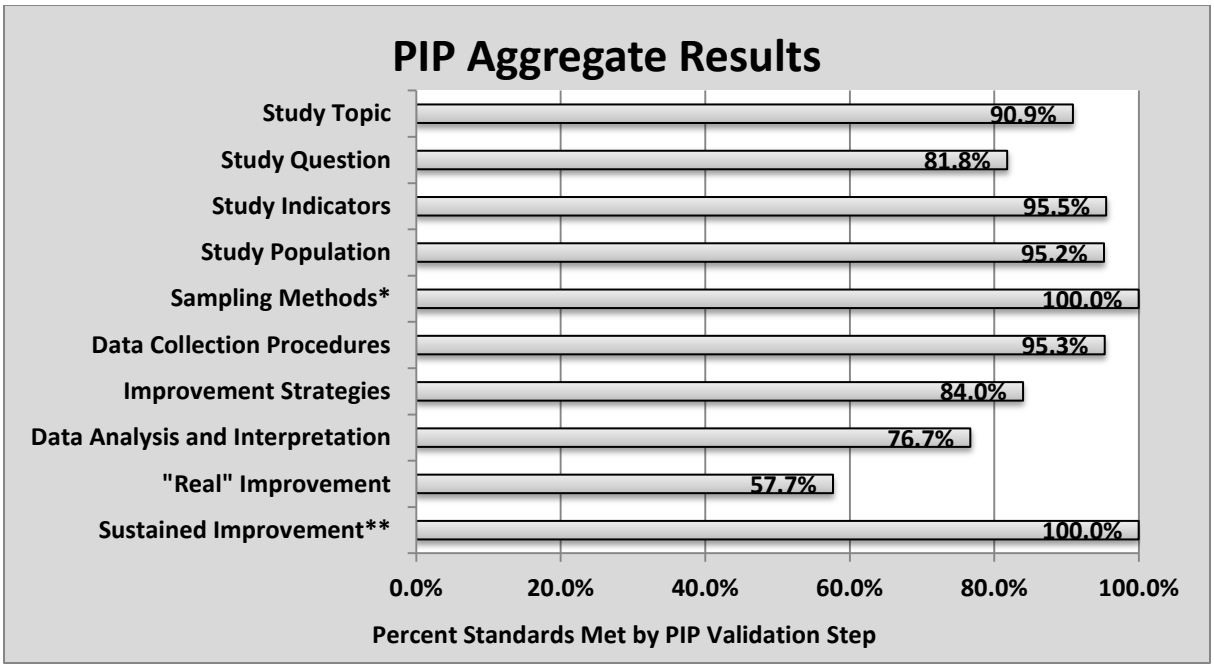
- Review the selected study topic(s);
- Review the study question(s);
- Review the selected study indicators:
- Review the identified study population;
- Review sampling methods (if sampling used);
- Review the data collection procedures;
- Assess the MCO's improvement strategies;
- Review the data analysis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

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

In FY 13-14, MetaStar validated one or more PIPs for each MCO, for a total of 11 PIPs. Ten of the 11 projects were continued from prior years.

AGGREGATE RESULTS FOR PERFORMANCE IMPROVEMENT PROJECTS

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



Note: ***The step, "Sampling Methods," applied to just one project.
****The step, "Sustained Improvement," applied to four of the 11 projects.

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

FY 13-14 Performance Improvement Project Validation Results		
	Numerator = Number of projects meeting the standard Denominator = Number of projects applicable for the standard	
Study Topic(s)		
1	The topic was selected through MCO data collection and analysis of important aspects of member needs, care, or services.	10/11
Study Question(s)		
2	The problem to be studied was stated as a clear, simple, answerable question(s) with a numerical goal and target date.	9/11
Study Indicator(s)		
3	The study used objective, clearly and unambiguously defined, measureable indicators and included defined numerators and denominators.	11/11
4	Indicators are adequate to answer the study question, and measure changes in any of the following: health or functional status, member satisfaction, processes of care with strong associations with improved outcomes.	10/11
Study Population		
5	The project/study clearly defined the relevant population (all members to whom the study question and indicators apply).	10/11
6	If the entire population was used, data collection approach captured all members to whom the study question applied.	10/10
Sampling Methods		
7	Valid sampling techniques were used.	1/1
8	The sample contained a sufficient number of members.	1/1

FY 13-14 Performance Improvement Project Validation Results		
	Numerator = Number of projects meeting the standard Denominator = Number of projects applicable for the standard	
Data Collection Procedures		
9	The project/study clearly defined the data to be collected and the source of that data.	11/11
10	Staff are qualified and trained to collect data.	10/11
11	The instruments for data collection provided for consistent, accurate data collection over the time periods studied.	10/10
12	The study design prospectively specified a data analysis plan.	10/11
Improvement Strategies		
13	Interventions were selected based on analysis of the problem to be addressed and were sufficient to be expected to improve outcomes or processes.	9/10
14	A continuous cycle of improvement was utilized to measure and analyze performance, and to develop and implement system-wide improvements.	7/10
15	Interventions were culturally and linguistically appropriate.	5/5
Data Analysis and Interpretation of Study Results		
16	Analysis of the findings was performed according to the data analysis plan, and included initial and repeat measures, and identification of project/study limitations.	7/10
17	Numerical results and findings were presented accurately and clearly.	7/10
18	The analysis of study data included an interpretation of the extent to which the PIP was successful and defined follow-up activities as a result.	9/10
"Real" Improvement		
19	The same methodology as the baseline measurement was used, when measurement was repeated.	6/10
20	There was a documented, quantitative improvement in processes or outcomes of care.	4/10
21	The reported improvement appeared to be the result of the planned quality improvement intervention.	5/6
Sustained Improvement		
22	Sustained improvement was demonstrated through repeated measurements over comparable time periods.	4/4

PROJECT INTERVENTIONS AND OUTCOMES

The table below lists each project with the interventions selected and the project outcomes at the time of the validation. An overall validation result is also included to indicate the level of confidence in the organizations' reported results. See Appendix 3 for additional information about the methodology for this rating.

PIP Interventions and Outcomes

MCO	Topic	Interventions	Outcomes	Validation Result
CW	Improving Coordination of Care Transitions, and Reducing Related Incidents	• Established a 72 hour follow-up expectation for MCO staff. • Developed Care Transition Follow-Up tool and report. • Implemented fall assessment and intervention tools. • Conducted staff education.	• Project demonstrated "real" improvement: Incidents within 30 days of a care transition were reduced. • Also demonstrated sustained improvement with repeat measures.	Met

MCO	Topic	Interventions	Outcomes	Validation Result
CW	Reducing Hospital Re-admissions	• Implemented the Hospital Summary form to guide post-hospital care plans. • Measured adherence to use of Hospital Summary. • Implemented Care Transitions Template	• Project was methodologically sound, but did not demonstrate improvement.	Met
CCI	Increasing Use of Self-Directed Supports	• Developed an SDS Resource Toolkit and SDS Manual. • Conducted staff training.	• Project demonstrated "real" improvement for FCP/PACE: Utilization of SDS was increased. • Also demonstrated sustained improvement for FCP/PACE. • Results for FC members did not show a clear improvement trend.	Partially Met
CCI	Reducing Cardiovascular Disease for Diabetic and Hypertensive Members	• Educated primary care staff. • Provided data to primary care staff regarding members' blood pressure control and medications. • Provided DASH diet training	• Project still in progress; Has not yet demonstrated "real" improvement.	Partially Met
CCCW	Increasing Pap Test Preventative Screening	• Plan to provide education, advocacy, and resources to members and their supports.	• Project in very early implementation phase at the time of the EQR.	Not Applicable
ContinuUs	Decreasing Fall Rate for High Risk Frail Elders	• Developed a Falls Prevention Home Safety Checklist • Implemented the checklist for members of the study population	• Project demonstrated "real" improvement: Fall rate was reduced in study population.	Met
***i*Care**	Reducing Hospital Re-admission Rate	• Continued to use a structured care management procedure upon care transition. • Updated the procedure to distinguish between planned and unplanned transitions.	• Did not demonstrate improvement.	Partially Met
***i*Care**	Increasing LDL Testing	• Included information on diabetes care in member newsletter and on website. • Care managers routinely follow-up with members to encourage screening.	• Did not demonstrate improvement.	Partially Met

MCO	Topic	Interventions	Outcomes	Validation Result
LCD	Reducing Rate of Falls	• Implemented Vitamin D supplementation. • Developed care management tools and conducted staff education. • Continued use of a tracking form to streamline data collection. • Standardized faxes to communicate with physicians.	• Project demonstrated "real" improvement: Rate of falls was decreased in study population. • Also demonstrated sustained improvement with repeat measures.	Met
MCDFC	Increasing Rate of Controlled Blood Pressure (BP) for Members with Diabetes and Hypertension	• Increased care management contact to support members' adherence to BP self-monitoring and treatment • Developed diabetes related guidelines and procedures • Monitored members' results in collaboration with primary care providers	• Project demonstrated "real" improvement: Rate of members with controlled blood pressure was increased. • Also demonstrated sustained improvement with repeat measures.	Met
WWC	Reducing Fall Related Critical Incidents and Nursing Home Placements	• Developed and implemented fall risk assessment and intervention tool. • Conducted staff training.	• Did not demonstrate improvement.	Partially Met

CONCLUSIONS

Progress

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

Strengths

- A variety of study topics were chosen which had the potential to improve the quality or outcomes of member care.
- The study indicators and population were clearly defined overall; standards were met for these steps at a rate of 95 percent.
- Standards for data collection procedures were also met at a rate of 95 percent, indicating that most projects collected data which was valid and reliable.

- The five projects which resulted in improvement employed interventions which were sufficient to improve outcomes, as well as a continuous cycle of improvement.

Opportunities for Improvement

- Ensure the study topic is selected based on MCO-specific data and results in a study population of adequate size.
- State the study questions in a manner that is clear and answerable.
- Use continuous cycles of improvement to:
    - Test and measure the effectiveness of interventions prior to full implementation;
    - Address identified barriers; and
    - Adjust interventions as needed to achieve improvement.
- Analyze data on a regular basis, including identification of any project limitations.
- Present numerical findings accurately and clearly.
- Establish consistent baseline and repeat measures.
- Spread improvements beyond the study population as indicated.

Validation of Performance Measures

Validating performance measures is a mandatory EQR activity, required by 42 CFR 438, used to assess the accuracy of performance measures reported by the MCO, and to determine the extent to which performance measures calculated by the MCO follow state specifications and reporting requirements. As noted earlier in the "Introduction and Overview" section of this report, assessment of an MCO's information system is a part of performance measures validation and other mandatory review activities. To meet this requirement, each MCO receives an ISCA once every three years as directed by DHS. The ISCAs are conducted and reported separately.

As directed by DHS, MetaStar validated the completeness and accuracy of MCOs' influenza and pneumococcal vaccination data for measurement year (MY) 2013. The MY is defined in the technical definitions provided by DHS for the influenza and pneumococcal vaccination quality indicators. The specifications did not change from MY 2012 to MY 2013. The technical specifications can be found in Attachments 1 and 2. The review methodology MetaStar used to validate these performance measures can be found in Appendix 3.

Vaccination Rates by Program and MCO

The results of statewide performance for immunization rates in FC, FCP, and PACE are summarized below.

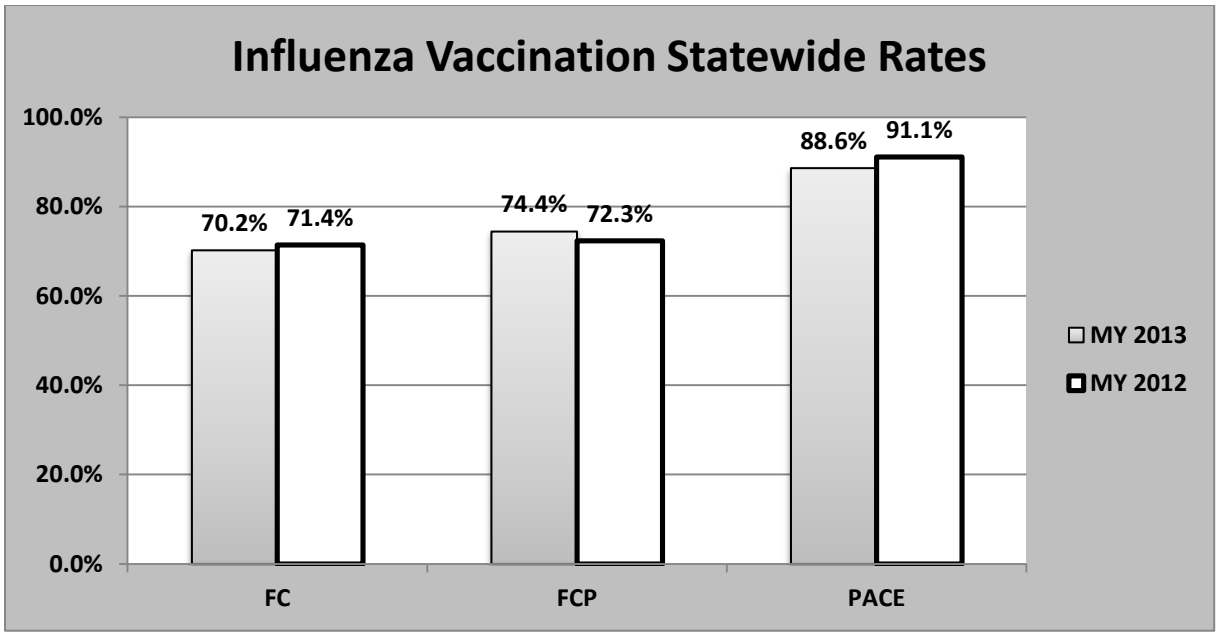
Influenza Vaccination Rates

The following table shows influenza vaccination rates by program for MY 2012 and MY 2013, which:

- Decreased by 1.2 percentage points for FC members;
- Increased by 2.1 percentage points for FCP members; and
- Decreased by 2.5 percentage points for PACE members.

Statewide Influenza Vaccination Rates by Program				
	MY 2013			MY 2012
Program	Eligible Members	Number Vaccinated	Vaccination Rate	Vaccination Rate
Family Care	33,496	23,524	70.2%	71.4%
Family Care Partnership	2,466	1,834	74.4%	72.3%
PACE	669	593	88.6%	91.1%

Influenza vaccination rates by program for MY 2012 and MY 2013 are shown in the following bar graph.



MY 2013 influenza vaccination rates by MCO and program are shown in the table below and are compared to the rates in MY 2012. For MCOs that operated FC, rates ranged from 49.0 percent to 79.5 percent. The rates ranged from 60.1 percent to 81.7 percent for MCOs that operated FCP. The rate for the one MCO that operated the PACE program during MY 2013 was 88.6 percent, a decrease of 2.5 percentage points from MY 2012 when the rate was 91.1 percent.

Influenza Vaccination Rates by MCO and Program MY 2012 and MY 2013			
Program/MCO	**MY 2012 Rate**	**MY 2013 Rate**	**Percentage Point Change**
Family Care			
CCCW GSR 4	71.9%	71.6%	(0.3)
CCCW GSR 7	58.2%	49.0%	(9.2)
CCI	69.0%	66.1%	(2.9)
ContinuUs	71.5%	73.7%	2.2
CW	73.8%	75.1%	1.3
LCD	73.4%	79.5%	6.1
MCDFC	75.8%	70.6%	(5.2)
WWC	70.5%	72.9%	2.4
Family Care Partnership			
CCI	87.5%	81.7%	(5.8)
CW	69.4%	78.5%	9.1
*i*Care	62.7%	60.1%	(2.6)
PACE			
CCI	91.1%	88.6%	(2.5)

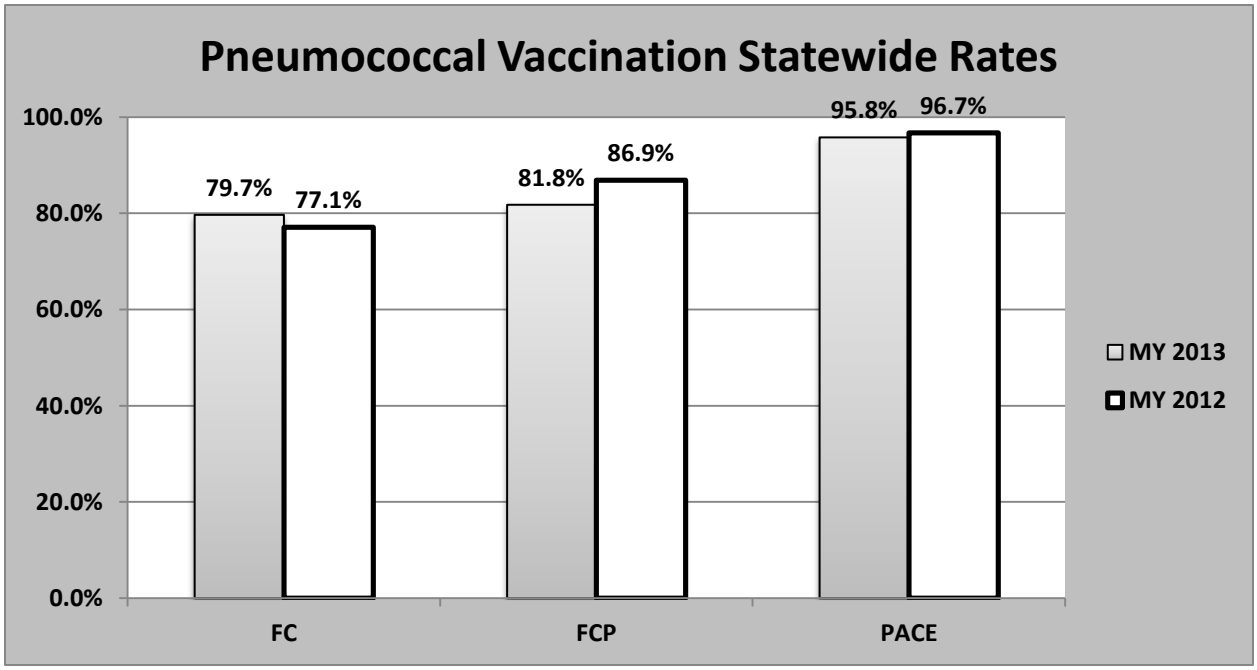
Pneumococcal Vaccination Rates

The following table below shows pneumococcal vaccination rates by program for MY 2012 and MY 2013, which:

- Increased by 2.6 percentage points for FC members;
- Decreased by 5.1 percentage points for FCP members; and
- Decreased by 0.9 percentage points for PACE members.

Statewide Pneumococcal Vaccination Rates by Program				
	MY 2013			MY 2012
Program	Eligible Members	Number Vaccinated	Vaccination Rate	Vaccination Rate
Family Care	14,827	11,818	79.7%	77.1%
Family Care Partnership	1,090	892	81.8%	86.9%
PACE	522	500	95.8%	96.7%

Pneumococcal vaccination rates by program for MY 2012 and MY 2013 are shown in the following bar graph.



MY 2013 pneumococcal vaccination rates by MCO and program are shown in the table below and are compared to the rates in MY 2012. For MCOs that operated FC, rates ranged from 63.2 percent to 92.5 percent. Rates ranged from 76.3 percent to 88.9 percent among MCOs that operated FCP. For the one MCO that operated PACE, the MY 2013 the rate was 95.8 percent, a decrease of less than one percentage point from MY 2012.

Pneumococcal Vaccination Rates by MCO and Program MY 2012 and MY 2013			
Program/MCO	**MY 2012 Rate**	**MY 2013 Rate**	**Percentage Point Change**
Family Care			
CCCW GSR 4	63.7%	63.2%	(0.5)
CCCW GSR 7	75.9%	79.7%	3.8
CCI	59.6%	64.2%	4.6
ContinuUs	84.7%	84.4%	(0.3)
CW	77.3%	81.7%	4.4
LCD	79.7%	84.0%	4.3
MCDFC	84.1%	84.7%	0.6
WWC	86.4%	92.5%	6.1
Family Care Partnership			
CCI	93.3%	88.9%	(4.4)
CW	85.6%	79.8%	(5.8)
*i*Care	77.7%	76.3%	(1.4)
PACE			
CCI	96.7%	95.8%	(0.9)

Results of Performance Measures Validation

Technical Specification Compliance

For each quality indicator, MetaStar reviewed the vaccination data submitted by each MCO for compliance with the technical specifications established by DHS. Five MCOs' vaccination data were found to be compliant with the technical specifications for both quality indicators. For the remaining three:

- Two MCOs reported members—five in one instance and 28 in the other—who received influenza vaccinations outside of the allowable timeframe of September 1, 2013, through March 31, 2014.
- One MCO had five members who were reported to have received a vaccination—four influenza and one pneumococcal—and were also reported to have contraindications to the vaccine.

In both of the instances described above, the non-compliant members were excluded from the reported vaccination rates.

Comparison of MCO and DHS Denominators

For each quality indicator and program, MetaStar evaluated the extent to which the members the MCOs included in their eligible populations were the same members that DHS determined should be included.

For all MCOs and quality indicators, more than 95 percent of the total number of unique members included in the MCOs' and DHS' denominator files was common to both data sets. However, it should be noted that two MCOs were required to resubmit data because their initial submissions were outside the five percentage point threshold established by DHS.

Vaccination Record Validation

To validate the MCOs' influenza and pneumococcal vaccination data, MetaStar requested 30 records for randomly selected members per quality indicator for each program the MCO operated during MY 2013. Whenever possible, the samples included 25 members reported to have received a vaccination and five members reported to have a contraindication to the vaccination. Four MCOs operated programs for which no members were reported as having contraindications for either one or both of the quality indicators.

As shown in the following tables, MetaStar reviewed a total of 360 member vaccination records for each quality indicator for MY 2013 and MY 2012. The overall findings for both years were not biased, meaning the rates can be accurately reported.

Vaccination Record Validation Aggregate Results

MY 2013 Influenza and Pneumococcal Vaccination Record Validation				
Quality Indicator	**Total Records Reviewed**	**Number Valid**	**Percentage Valid**	**T-Test Result**
Influenza Vaccinations	360	351	97.5%	Unbiased
Pneumococcal Vaccinations	360	355	98.6%	Unbiased

MY 2012 Influenza and Pneumococcal Vaccination Record Validation				
Quality Indicator	**Total Records Reviewed**	**Number Valid**	**Percentage Valid**	**T-Test Result**
Influenza Vaccinations	360	353	98.1%	Unbiased
Pneumococcal Vaccinations	360	356	98.9%	Unbiased

Vaccination Record Validation MCO Results

The following tables provide information about the validation findings for each MCO and program in MY 2013.

Results for Influenza Vaccination

MY 2013 Influenza Vaccination Record Validation by MCO				
MCO	**Total Records Reviewed**	**Number Valid**	**Percentage Valid**	**T-Test Result**
Family Care				
CCCW GSR 4	30	30	86.7%	Unbiased
CCCW GSR 7	30	29	96.6%	Unbiased
CCI	30	28	93.3%	Unbiased
ContinuUs	30	30	100.0%	Unbiased
CW	30	29	96.7%	Unbiased
LCD	30	30	100.0%	Unbiased
MCDFC	30	30	100.0%	Unbiased
WWC	30	30	100.0%	Unbiased
Family Care Partnership				
CCI	30	30	100.0%	Unbiased
CW	30	29	96.7%	Unbiased
*i*Care	30	30	100.0%	Unbiased
PACE				
CCI	30	30	100.0%	Unbiased

Results for Pneumococcal Vaccination

MY 2013 Pneumococcal Vaccination Record Validation by MCO				
MCO	**Total Records Reviewed**	**Number Valid**	**Percentage Valid**	**T-Test Result**
Family Care				
CCCW GSR 4	30	30	100.0%	Unbiased
CCCW GSR 7	30	29	96.6%	Unbiased
CCI	30	30	100.0%	Unbiased
ContinuUs	30	30	100.0%	Unbiased
CW	30	28	93.3%	Unbiased
LCD	30	30	100.0%	Unbiased
MCDFC	30	30	100.0%	Unbiased
WWC	30	30	100.0%	Unbiased
Family Care Partnership				
CCI	30	30	100.0%	Unbiased
CW	30	28	93.3%	Unbiased
*i*Care	30	30	100.0%	Unbiased
PACE				
CCI	30	30	100.0%	Unbiased

CONCLUSIONS

The review found that the vaccination rates reported by the MCOs and displayed in this report are accurate.

Practices for gathering information about vaccination status and contraindication status vary by MCO, as do policies and procedures for collecting, tracking, and reporting member vaccination data. This variation could account for some of the differences in the MCOs' rates. To provide further assurance that the vaccination data reported by MCOs are accurate and free of errors, DHS could:

- Provide the MCOs with clarification regarding the circumstances in which a physician recommendation that a member not be vaccinated should be counted as a contraindication;
- Update its data collection templates to include fields for MCOs to report continuous enrollment period start and end dates; and/or
- Require MCOs to provide MetaStar with the programming code they use to extract data for reporting.

Information Systems Capability Assessment

ISCAs are a required part of other mandatory EQR protocols, required by 42 CFR 438, which help determine whether MCOs' information systems are capable of collecting, analyzing, integrating, and reporting data.
ISCAs were conducted during FY 13-14 for three MCOs selected by DHS. Two of the MCOs operate FC programs, while the other MCO operates a FCP program.

Overall results indicated that all three organizations have the basic systems, resources, and processes in place to meet DHS requirements for collecting and submitting encounter data and calculating performance measures; though one MCO was advised to move the payment of certain claims from the MCO's Accounts Payable Department to its third party administrator (TPA) in order to provide greater assurances about the accuracy and completeness of its data.

Conclusions

Strengths

- Security structures and processes are in place for MCOs to maintain and monitor protected health information (PHI) within their information systems.
- Good communication exists between various organizational units of the MCOs and their vendors.

Opportunities for Improvement

- Ensure documented policies, procedures, and flowcharts represent current practices:
    - Include detailed, narrative descriptions of encounter data integration and creation from all data streams, so that the processes are completely and accurately represented;
    - Document the responsibilities of all relevant parties (MCO units, vendors, and DHS), including the relationships and interfaces among each.
- Develop and implement standardized processes to end existing service authorizations and create new authorizations if modifications are needed, or the authorization is extended beyond the original timeframe.
- Continue to reconcile provider credentialing and other data used for claims processing and the provider directory in order to eliminate duplicate provider entries and minimize potential provider service gaps.
- Enhance vendor oversight in the following ways:
    - Ensure that specific performance expectations regarding timeliness, completeness, and accuracy of claims processing are documented in agreements with TPAs, if the MCO independently contracts with a vendor and does not use the DHS Master Agreement;
    - Continue to monitor TPA performance on a daily basis.

- Maximize the use of encounter data by regularly:
    - Comparing claims to encounters to ensure the data accurately and fully represents the services provided to members, and;
    - Comparing encounter data to financial information to ensure consistency and to inform business decisions..

Care Management Review

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

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

The four categories consisted of a total of 14 review indicators, which includes a new care planning indicator added this year, "Timeliness of 12 month MCP." More information about the CMR review methodology can be found in Appendix 3.

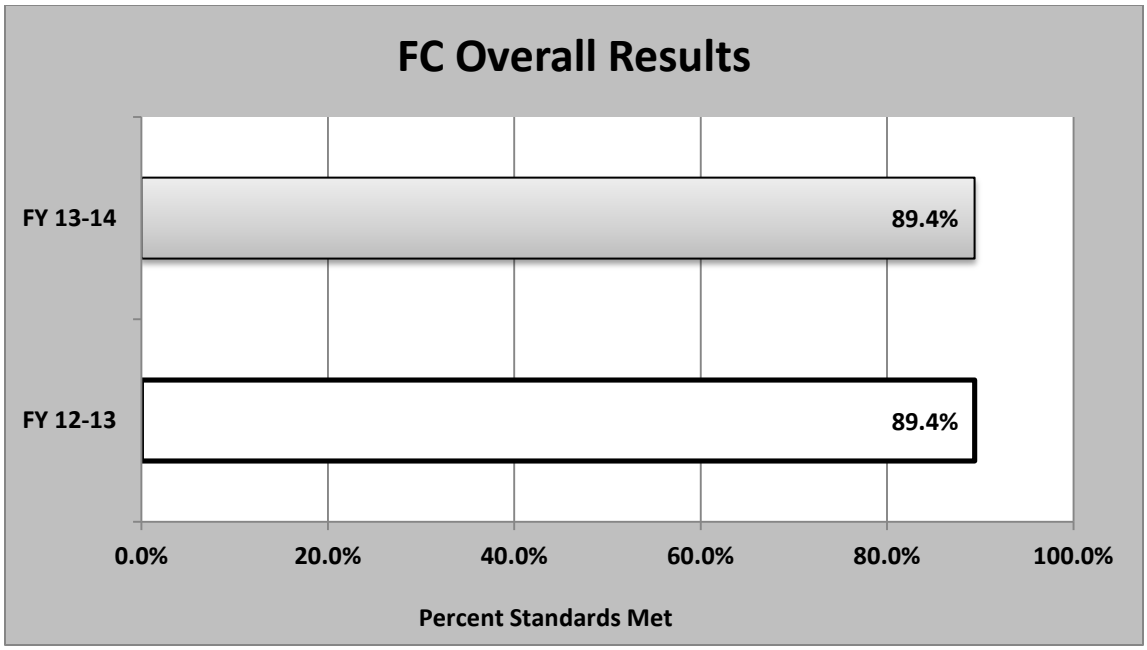
Aggregate results for FY 13-14 CMRs conducted as part of each MCO's annual EQR are displayed in several graphs below and compared to results from the previous review year. When reviewing and comparing results, the reader should take into account the size of the total sample of records reviewed by MetaStar may vary year to year. Additionally, not all review indicators necessarily apply to every record in the review sample. This means that even if the size of the CMR sample is the same from one year to the next, the number of records to which a specific review indicator applies will likely differ.

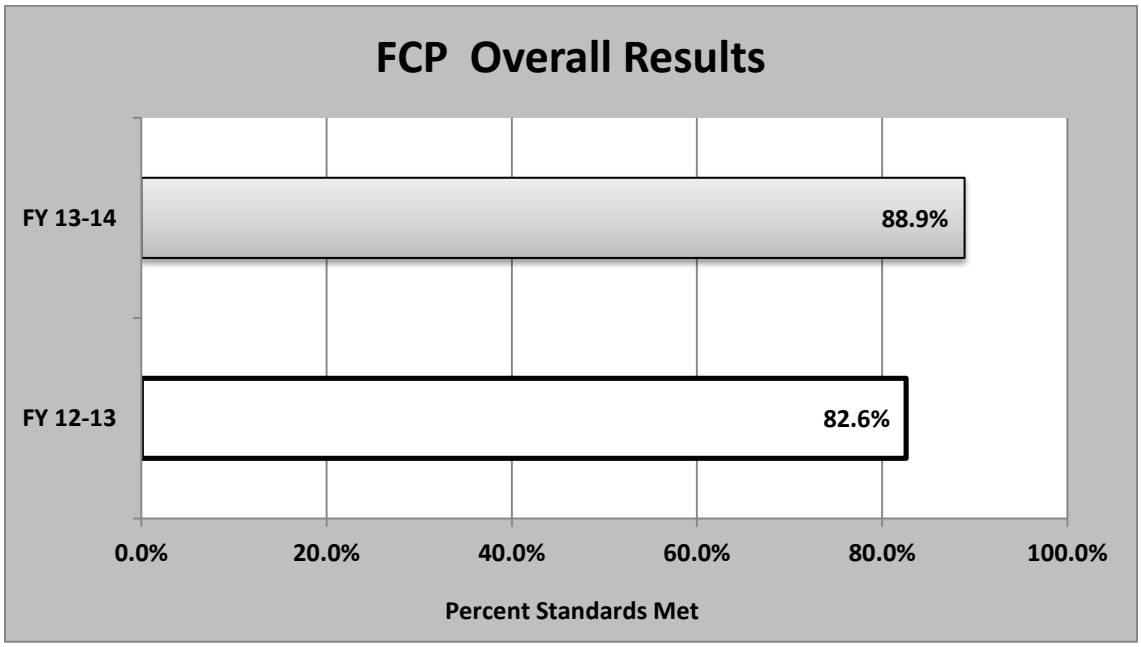
Overall Results by Program

The following two graphs show the overall percent of standards met for all review indicators for CMRs conducted during the FY 13-14 review year for organizations operating programs for FC and FCP. FY 12-13 results are also provided for comparison. The reader should note that FY 12-13 includes the aggregate results of nine MCOs, whereas FY 13-14 includes the results of eight MCOs. Also, PACE results are not included in this year's report because, as noted earlier, MetaStar did not conduct a PACE CMR in FY 13-14; CMS reviewed the PACE program.

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

The overall results indicate FC maintained the level of compliance achieved in last year's review, while FCP achieved additional progress in overall results.


FC Overall Results
FY 13-14
89.4%
FY 12-13
89.4%
0.0%
20.0%
40.0%
60.0%
80.0%
100.0%
Percent Standards Met


FCP Overall Results
FY 13-14
88.9%
FY 12-13
82.6%
0.0%
20.0%
40.0%
60.0%
80.0%
100.0%
Percent Standards Met

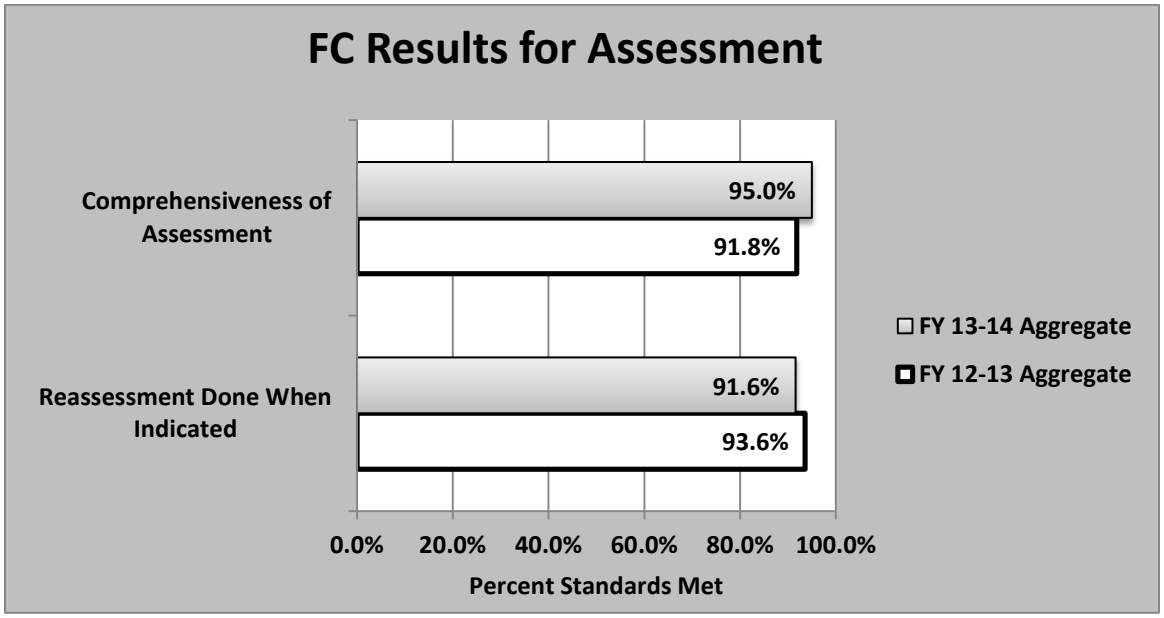
Results for each CMR Focus Area

Each of the four sub-sections below provides a brief explanation of one of the key categories of CMR, followed by bar graphs which display FY 13-14 CMR results by program (FC, FCP) for each review indicator that comprises the category. FY 12-13 results are also provided for comparison.

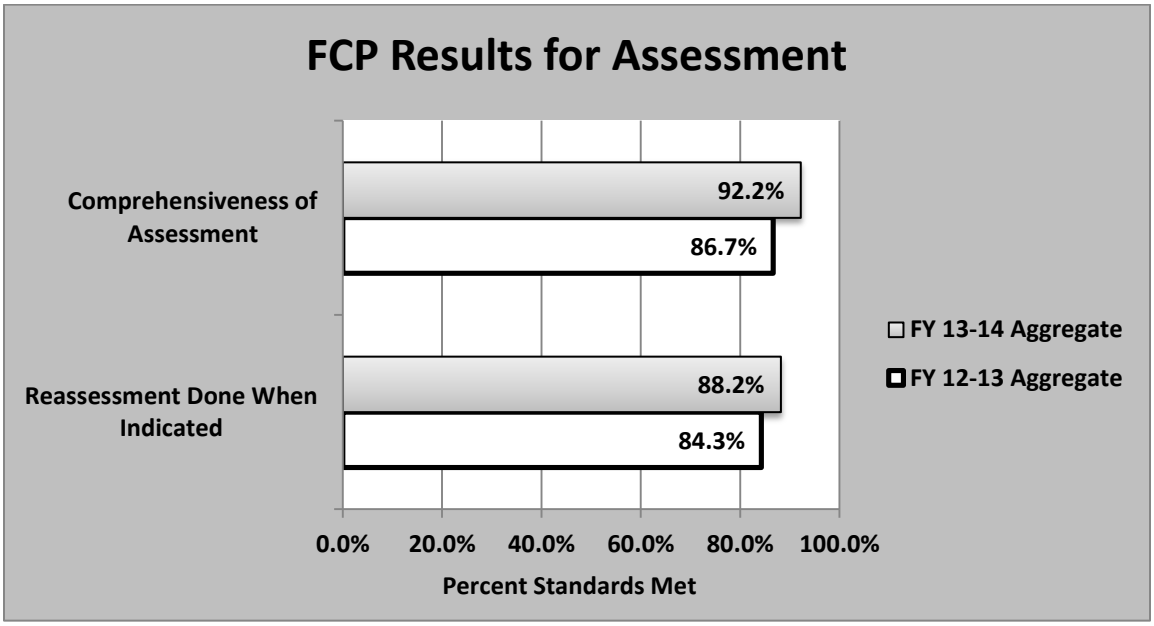
Assessment Focus Area

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

Results for Assessment for MCOs Operating FC:



Results for Assessment for MCOs Operating FCP:

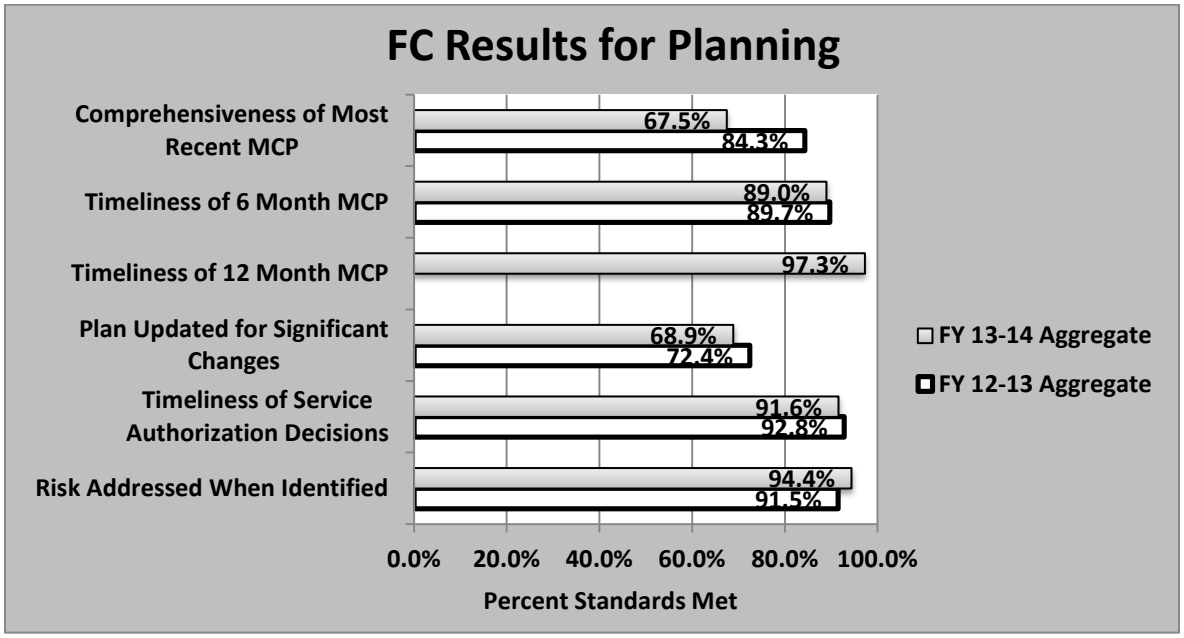


CARE PLANNING FOCUS AREA

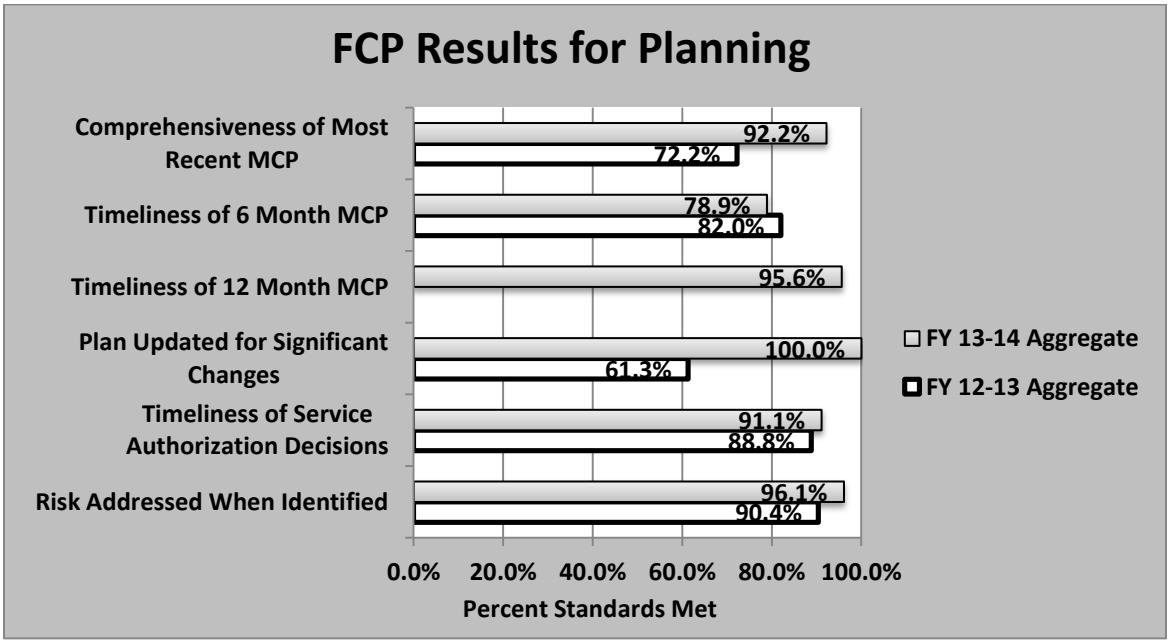
The MCP and Service Authorization document must identify all services and supports to be coordinated consistent with information in the comprehensive assessment, and must be developed and updated according to the timelines and conditions described in the DHS-MCO contract. Additionally, the record must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

As noted above, "Timeliness of 12 month MCP" is a new indicator added to this year's review; therefore, FY 12-13 results were not available for comparison in the following two bar graphs.

Results for Care Planning for MCOs Operating FC:



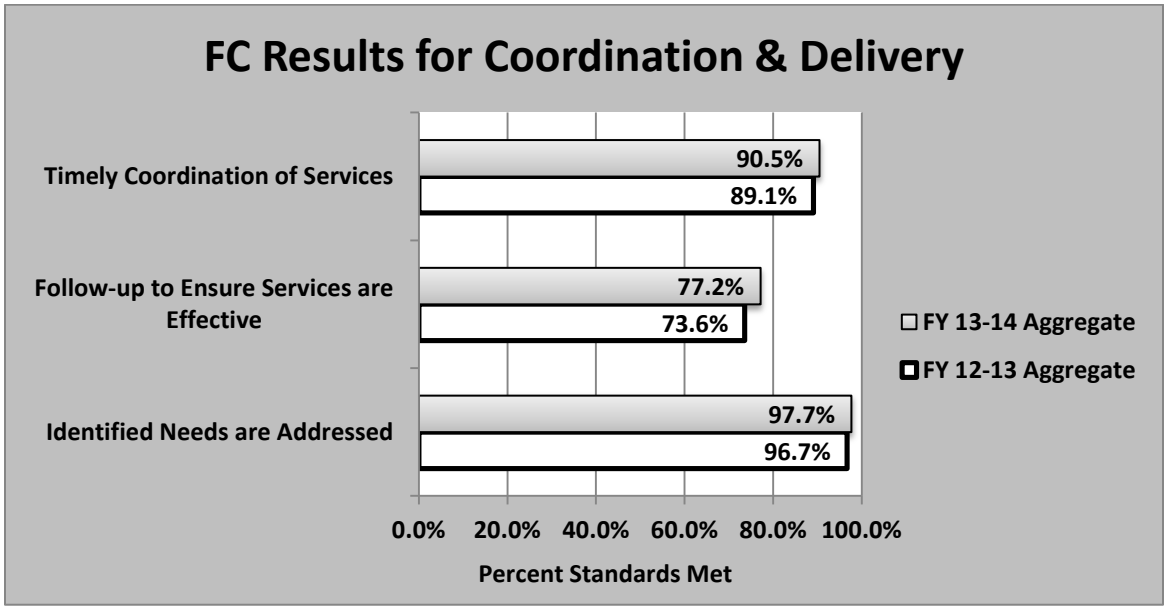
Results for Care Planning for MCOs Operating FCP:



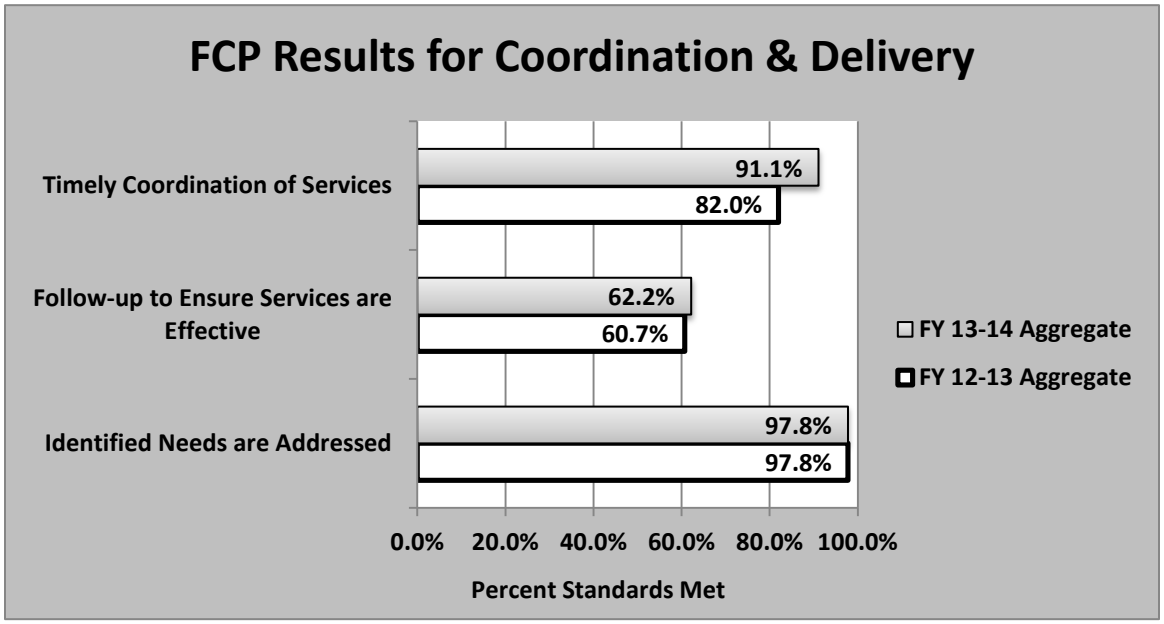
Coordination and Delivery Focus Area

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

Results for Coordination and Delivery for MCOs Operating FC:



Results for Coordination and Delivery for MCOs Operating FCP:

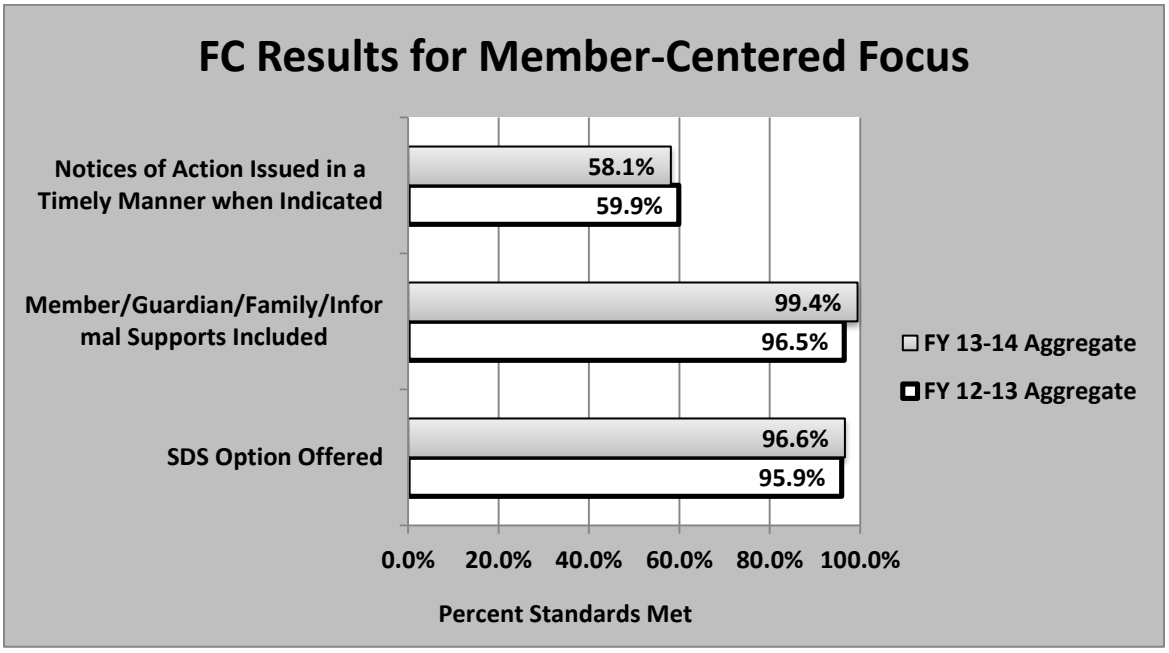


MEMBER-CENTEREDNESS FOCUS AREA

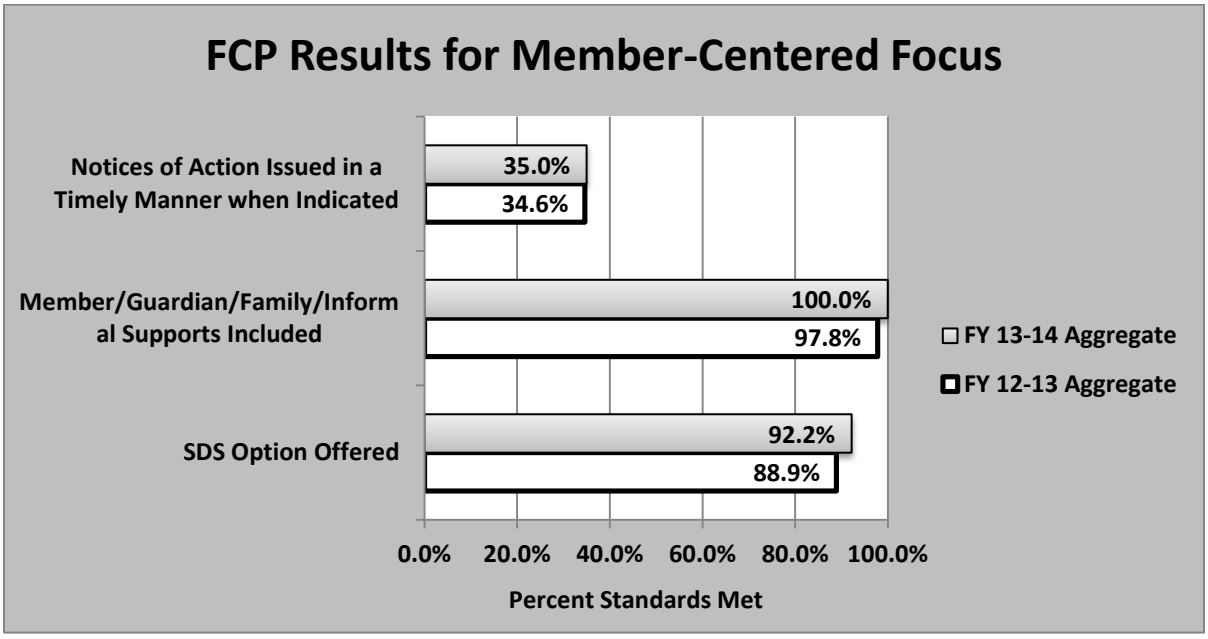
The record should document the IDT staff includes the member and his/her supports in care management processes; that staff protects member rights by issuing notices in accordance with requirements outlined in the DHS-MCO contract; and that the self-directed supports (SDS) option has been explained and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

In reviewing results in the two graphs below, readers should be aware that the indicator, "Notices Issued in a Timely Manner When Indicated" is scored on a per record basis. This means, for example, that if a record contains three instances where a notice is indicated, and the IDT issues a timely notice in two instances but not the third, the indicator would be scored as "not met."

Results for Member-Centered Focus for MCOs Operating FC:



Results for Member-Centered Focus for MCOs Operating FCP:



CONCLUSIONS

Progress

FC Progress

- FY 13-14 aggregate results for the FC program were 90 percent or higher for nine of 14 CMR indicators. In FY 12-13 aggregate results were over 90 percent for seven of 13 CMR indicators.

FCP Progress

- FY 13-14 aggregate results for the FCP program were over 90 percent for 10 of 14 CMR indicators, including two indicators that were met at 100 percent. In FY 12-13, aggregate results were 90 percent or higher for three of 13 CMR indicators.
- Aggregate results for the FCP program indicated notable progress in two areas of CMR. Both had been identified as areas of opportunity for improvement in last year's review:
    - "Comprehensive of Most Recent MCP" increased from 72.2 percent to 92.2 percent, the second year of notable progress in this area of review; and
    - "Plan Updated for Significant Changes" increased from 61.3 percent to 100 percent.

Strengths

- Performance remained strong and improved in both programs for the review indicator, "Risk Addressed when Identified."
    - The percent of standards met for FC and FCP were 94.4 percent and 96.1 percent, respectively.
- As has been the case over the past several review years, both programs continued to maintain a high level of compliance with the indicator, "Identified Needs Addressed."
    - Results for both FC and FCP were 97.7 percent and 97.8 percent, respectively.
- Performance also remained strong in both FC and FCP related to the right of members and their supports to be included in care management processes and to participate in decisions. Results for both programs improved compared to last year.
    - Results for the review indicator, "Member/Guardian/Family/Informal Supports Included" were 99.4 percent for FC, and 100 percent for FCP.

Opportunities

FC has the opportunity to improve results in the following areas of care management practice, which were also identified as areas for improvement in last year's review:

- Comprehensiveness of MCPs; and
- Updating MCPs when members have significant changes in situation or condition.

FCP has the opportunity to improve the timeliness with which MCPs are reviewed and signed by members or their legal decision makers within required six month intervals. Results were 78.9 percent in FY 13-14; a slight decrease from the previous year.

Both FC and FCP should focus on improving in the follow areas of care management practice. Results over time identify both as continuing areas of opportunity for improvement:

- Following up to ensure services have been received and are effective; and
- Issuing notices to members, when indicated.

ANALYSIS

TIMELINESS, ACCESS, QUALITY

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

As noted earlier in this report, QCR follows a three year cycle; one year of comprehensive review and two years of follow-up review. Each MCO's results are cumulative over the three year period. FY 13-14 was the third year of the cycle. Three MCOs had fully met all QCR standards following last year's review and did not have a QCR in FY 13-14. MetaStar conducted QCR for the remaining five MCOs, and for each MCO, addressed only those standards that had not been fully met in the first and second years of the review cycle. As a result, the analysis presented here is somewhat limited.

For the five MCOs where QCR was conducted, a summary of each MCO's findings can be found in Appendix 2, including MetaStar's assessment of key strengths and recommendations for improvement in the areas reviewed for each MCO. Any best or promising practices identified by reviewers are also documented although, again, these are more challenging to identify in follow-up years when the scope of the review is limited.

Over the course of the current three-year review cycle, 50 percent of MCOs (four of eight) have achieved full compliance with quality standards. FY 13-14 QCR results show seven of eight MCOs (88%) have reached rates between 90 and 100 percent for compliance with standards. This compares to six of nine MCOs (67%) in last year's review. Results during this period also indicate MCOs have continued to maintain or improve in most of the areas of care management practice evaluated by CMR, and have made progress in conducting and reporting PIPs. The results of ISCAs conducted at three MCOs indicate that they have basic systems, resources, and processes in place to meet DHS requirements for collecting and submitting encounter data and calculating performance measures. Findings from influenza and pneumonia vaccination measure validation were not biased, meaning the rates can be accurately reported. A high level of compliance with these review activities provides assurances that MCOs are meeting requirements related to access, timeliness, and quality.

FY 13-14 results indicate that MCOs developed and implemented plans to address the recommendations for improvement they received following last year's EQR. While activities and areas of focus varied, documents submitted as part of QCR indicated that all five MCOs made

efforts to enhance systems and improve policies and practices that impact the quality and timeliness of member care in areas such as assessment, member-centered planning, service authorization decision making, or issuing notices of action. However, the MCOs should conduct further monitoring and analysis, in order to identify barriers and fully implement and/or sustain the improvements.

Compliance with Standards

By fully meeting all of the remaining quality standards that remained partially met after its last review, one MCO achieved 100 percent compliance in FY 13-14. In addition, three other MCOs met additional QCR standards in FY 13-14, resulting in compliance levels above 90 percent.

As documented in each MCO's EQR report, MetaStar identified some common findings among these four MCOs which contributed to their progress. For example, these MCOs:

- Enhanced monitoring systems and tools, and increased the scope and/or frequency of monitoring and analysis;
- Developed or updated tools and/or made system enhancements to support care management practice; and
- Revised or finalized policies and procedures, and provided staff training.

A fifth MCO also made progress with QCR standards related to enrollee rights, provider monitoring and availability of services, quality assessment and performance improvement program, and care management. The MCO developed a clear action plan to address the findings and recommendations from its last review, and as a result, increased its rate of compliance from 71.7 percent in FY 12-13 to 81.1 percent in this year's review.

This fifth MCO also made efforts to respond to other key recommendations from last year's EQR to:

- Establish an effective and integrated quality assessment and performance improvement program; and
- Create expectations and methods for communication and collaboration among the MCO's Quality, Provider, and FCP Departments.

While progress was noted in all areas of the fifth MCO's review, some issues impacted the organization's ability to improve further. For example, changes in key staff occurred and time was required for new staff to review and modify processes. The MCO also reported significant staff turnover at the IDT level, and has identified the need to modify its supervisory structure. Additionally, in some cases, the organization had not completed or fully implemented improvement efforts at the time of this year's EQR.

Care Management Review

Member Health and Safety

Over the course of the fiscal year, MetaStar did not identify any members with unaddressed health and safety issues during CMR, out of 617 total records reviewed. MetaStar did identify 11 members with complex situations involving medical, mental health, behavioral, cognitive, and/or social issues. These members were brought to the attention of the MCOs and referred to DHS for follow-up. DHS and MetaStar fully implemented this proactive approach in FY 10-11. This gives DHS the opportunity to engage with the MCO and provide any needed guidance related to the specific member. It also allows the MCO and DHS to assess current care management practice, identify potential systemic improvements related to member care quality, and prevent the development of health and safety issues.

Overall Results

In FY 13-14, the aggregate percent of CMR standards "met" for FC was 89.4; the same result as the previous year. With the exception of one standard, "Comprehensiveness of Most Recent MCP," FY 13-14 results for the FC program showed small changes up or down for each of the CMR standards.

Among its recommendations in last year's report, MetaStar had identified two standards, "Comprehensiveness of Most Recent MCP" and "Plan Updated for Significant Changes," as areas in need of improvement for both FC and FCP. However, the results for FC decreased for both of these standards. While the decrease for "Plan Updated for Significant Changes" was slight (3.5 percent), results for "Comprehensiveness of Most Recent MCP" dropped by nearly 17 percent. The decrease can be attributed to implementation of a new MCP template by two MCOs, which resulted in plans that were missing required elements, such as information about members' services. One of these MCOs anticipated challenges and addressed them proactively by providing staff training and written guidance prior to implementation of the MCP. This helped the MCO avoid the steep drop in results for MCP comprehensiveness experienced by the other organization. Both MCOs are expected to focus improvement efforts in this area during the coming year.

For FCP, the aggregate percent of CMR standards "met" during FY 13-14 was 88.9 percent. This compares to 82.6 the previous year. The greatest improvement was in the assessment and planning categories, including an increase of 20 percentage points for the standard, "Comprehensiveness of Most Recent MCP," and nearly 40 percentage points for the standard, "Plan Updated for Significant Changes." As noted above, these two standards were identified as areas of opportunity for improvement in last year's review. Actions taken by MCOs to respond to recommendations for improvement were contributing factors in this year's improved results. Examples include the following:

- Increased the focus and/or frequency of monitoring through approaches such as internal file reviews, targeted audits, and supervisory feedback;
- Developed or improved tools to guide staff and supervisors; and
- Provided staff training.

This year's results also identified two review areas where both FC and FCP should continue efforts to improve:

- Following up to ensure services have been received and are effective;
- Issuing notices to members in a timely manner, when indicated;

FY 13-14 results for the standard, "Follow-up to Ensure Services are Effective" were 77.2 percent for FC and 62.2 percent for FCP, a slight increase for both programs.

The use of electronic prompts, which remind care managers to follow up, helped improve results for some MCOs. Care management practices which contributed to the results of the sole MCO to achieve over 90 percent for this standard included:

- Evidence of good coordination and communication between care managers and providers (e.g., regular written reports from providers, regular communication with providers by phone and email); and
- Care managers' frequent engagement with members.

A contributing factor to poor follow-up results for three MCOs continued to be documentation practices, such as very limited documentation in case notes and elsewhere, resulting in records that did not accurately reflect actions taken by care managers or the interactions they may have had with members and their supports.

FY 13-14 results for the standard, "Notices Issued in a Timely Manner when Indicated" were 58.1 percent for FC and 35 percent for FCP. Overall, neither program demonstrated real improvement since last year, when results were 59.9 percent and 34.6 percent, respectively. Both programs continue to be challenged primarily with issuing notices of action (NOAs) when indicated, but also with issuing notices in a timely manner. In addition, the fact that this indicator is evaluated on a "per record" basis must be taken into account when considering these results. This means, for example, that if a record contains three instances where a notice is indicated, and the IDT issues a timely notice in two instances but not the third, the indicator would be scored as "not met."

Documentation submitted as part of QCR indicated that all of these MCOs made efforts to improve in this area, and some made multiple efforts, such as:

- Revising policies and procedures related to issuing NOAs;

- Providing staff training;
- Enhancing electronic monitoring systems;
- Expanding the scope and/or increasing the frequency of monitoring.

One MCO also identified a staff person to serve as a NOA consultant to assist care managers.

Performance Improvement Projects

DHS requires MCOs to submit projects for pre-approval. All MCOs were successful in securing pre-approval for the specified number of projects during this cycle of review. The DHS pre-approval process focuses on the initial steps of the project, and most MCOs demonstrated strength in developing clearly defined projects through the first six steps related to:

- Study topic;
- Study question;
- Study indicators;
- Study population;
- Sampling methods (if applicable): and
- Data collection procedures.

MetaStar validates PIPs at their current stage of implementation in conjunction with the annual EQR, as directed by DHS. Ten of eleven projects validated were continued from prior years. Each of the ten continuing projects had implemented at least one intervention and measured its effectiveness. The one new project was in the early implementation phase at the time of the organization's EQR.

One organization's approach to implementing performance improvement projects was considered a "Best Practice" among managed care organizations. This MCO aligns its projects with strategic goals, commits necessary resources, conducts regular measurement with continuous cycles of improvement, and comprehensively analyzes results.

Most organizations developed effective improvement strategies and conducted methodologically sound data analysis. However, one MCO encountered difficulty obtaining data and did not utilize continuous cycles of improvement.

No standard timeline has existed for the submission and approval of project proposals. As a result, the projects have been in various stages of completion at the time they were validated. Five of the eleven projects demonstrated "real" improvement at the time of the review, and one additional project demonstrated some improvement.

MetaStar had previously recommended that DHS standardize project timelines in order to ensure organizations make active progress on projects during each contract period. Beginning in 2013, DHS implemented a required timeframe for project approval and final report submissions. The effect of this change will be evident in the next fiscal year.

Performance Measure Validation

DHS directed MetaStar to validate two performance measures; influenza and pneumococcal vaccination rates. Accurate and reliable performance measures inform stakeholders about access and quality of care provided by MCOs.

Five organizations submitted data that fully complied with technical specifications. All organizations submitted data that complied with the denominator thresholds established by DHS. Consistent with the results of previous years, the results from the vaccination record validation were not biased, meaning the results can be accurately reported.

For the second consecutive year, DHS directed MCOs to use existing technical specifications and data submission templates. These efforts have standardized the process for measure validation. MetaStar provided DHS with suggestions for future improvements to the specifications, guidance, and template.

Information Systems Capability Assessment

This review activity was conducted for three MCOs; two operating FC and one operating FCP. The review found that these three MCOs have the basic systems, resources, and processes in place to meet DHS requirements for collecting and submitting encounter data and calculating performance measures. The use of software and encryption technology support MCOs in meeting system security standards. Communication practices between MCOs and vendors also contribute positively to review findings. All three MCOs should enhance various flowcharts and other supporting documentation to ensure written materials accurately and fully represent practices and processes, especially as it relates to encounter data integration and creation.

APPENDIX 1 – LIST OF ACRONYMS

AQR	Annual Quality Review
BFM	Bureau of Financial Management
CCI	Community Care, Inc., Managed Care Organization
CCCW	Community Care of Central Wisconsin, Managed Care Organization
CFR	Code of Federal Regulations
CMR	Care Management Review
CMS	Centers for Medicare & Medicaid Services
CW	Care Wisconsin, Managed Care Organization
DHA	Division of Hearings and Appeals
DHS	Wisconsin Department of Health Services
EQR	External Quality Review
EQRO	External Quality Review Organization
FC	Family Care
FCP	Family Care Partnership
FY	Fiscal Year
HEDIS[1]	Healthcare Effectiveness Data and Information Set
*i*Care	Independent Care Health Plan, Managed Care Organization
IDT	Interdisciplinary Team
IS	Information System
ISCA	Information System Capability Assessment
LCD	Lakeland Care District, Managed Care Organization
MCDFC	Milwaukee Department of Family Care, Managed Care Organization
MCO	Managed Care Organization
MCP	Member-Centered Plan
MY	Measurement Year
NB	NorthernBridges, Managed Care Organization

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

NCQA	National Committee for Quality Assurance
NOA	Notice of Action
OFCE	Office of Family Care Expansion
PACE	Program of All-Inclusive Care for the Elderly
PHI	Protected Health Information
PIHP	Pre-paid Inpatient Health Plan
PIP	Performance Improvement Project
QAPI	Quality Assessment and Performance Improvement
QCR	Quality Compliance Review
SDS	Self-Directed Supports
TPA	Third Party Administrator
WWC	Western Wisconsin Cares, Managed Care Organization

APPENDIX 2 – EXECUTIVE SUMMARIES

Care Wisconsin – Executive Summary

This report summarizes the results of the fiscal year 2013-2014 annual quality review conducted by MetaStar, Inc., for the managed care organization, Care Wisconsin. MetaStar is the external quality review organization contracted and authorized by the Wisconsin Department of Health Services to provide independent evaluations of managed care organizations that operate Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly.

Care Wisconsin currently operates the Family Care program in 21 counties and the Family Care Partnership program in five counties in southeast, south-central, and northwest Wisconsin. Key findings from all review activities are summarized below:

Review Activity	FY 13-14 Results	Comparison to FY 12-13 Results
Quality Compliance Review	• 5 Standards reviewed • 3 of 5 Standards received "met" scores • 96.2 percent: Cumulative rate of compliance in third year of three-year review cycle	• 90.6 percent: Cumulative rate of compliance in second year of three-year review cycle
Performance Improvement Projects	*Care Transitions* project • Achieved improvement • 20 Standards applicable • 20 of 20 Standards received "met" scores *Re-admission* project • Methodologically sound but did not achieve improvement • 18 Standards applicable • 17 of 18 Standards received "met" scores	• Both performance improvement projects were continuing projects with revised goals and improvement strategies. The results are not directly comparable from year to year.
Care Management Review	Family Care • 8 of 14 Standards met at a rate of 90 percent or higher • 91.4 percent: Overall rate of standards met by this organization for all review indicators Family Care Partnership • 10 of 14 Standards met at a rate of 90 percent or higher • 91.9 percent: Overall rate of standards met by this organization for all review indicators	Family Care • 9 of 13 Standards met at a rate of 90 percent or higher • 89.4 percent: Overall rate of standards met across *all* Family Care programs Family Care Partnership • 6 of 13 Standards met at a rate of 90 percent or higher • 82.6 percent: Overall rate of standards met across *all* Family Care Partnership programs

In reviewing the following strengths and recommendations, readers should consider that the fiscal year 2013-2014 Quality Compliance Review was limited to those areas which were not fully met during the previous two years.

CW – Key Strengths

- Care Wisconsin identified key priorities, monitored progress, and made changes that focused on improvements for the organization.
- Application of continuous improvement approaches that were successful in performance improvement projects were expanded to other areas of the organization, such as the utilization management program.
- The resources allocated for improvement projects included the development and provision of multiple trainings for care management staff.

CW – Best or Promising Practices

Care Wisconsin's approach to implementing performance improvement projects is considered a "Best Practice" among managed care organizations. Care Wisconsin aligns its projects with strategic goals, commits necessary resources, conducts regular measurement and Plan-Do-Study-Act cycles, and comprehensively analyzes results. In addition, Care Wisconsin's success in conducting performance improvement projects has been evident over several external quality reviews.

CW - Recommendations

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

- Apply the improvement principles Care Wisconsin has used effectively in its performance improvement projects to care management improvement effort, in order to improve the following areas of care management:
    - Comprehensiveness of assessments;
    - Following up with members to ensure services have been received and are effective; and
    - Issuing notices to members, when indicated.
- For Family Care,
    - Continue efforts to improve the comprehensiveness of member-centered plans; and
    - Ensure care teams update members' plans when they have significant changes in situation or condition.
- Confirm that teams establish a plan for the frequency of face-to-face contacts with each member based on his/her unique situation, such as the complexity of the member's needs, and the risks present in his/her life.
- Ensure that documentation in the member record is timely and accurately reflects the care team's actions and interactions with the members and their supports.

- Analyze the implementation of the V-Prime module for the Resource Allocation Decision Method to ensure that it provides an accurate representation of care teams' service authorization practices.

Community Care Inc. – Executive Summary

This report summarizes the results of the fiscal year 2013-2014 annual quality review conducted by MetaStar, Inc., for the managed care organization (MCO), Community Care, Inc. MetaStar is the external quality review organization contracted and authorized by the Wisconsin Department of Health Services to provide independent evaluations of managed care organizations that operate Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly (PACE).

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

Review Activity	FY 13-14 Results	Comparison to FY 12-13 Results
Quality Compliance Review	• 10 Standards reviewed • 5 of 10 Standards received "met" scores • 90.6 percent: Cumulative rate of compliance in third year of three-year review cycle	• 81.1 percent: Cumulative rate of compliance in second year of three-year review cycle
Performance Improvement Projects	<u>*Self-Directed Supports* project</u> • Achieved improvement in the rate of usage of self-directed supports for Family Care Partnership and PACE members • 20 Standards applicable • 17 of 20 Standards received "met" scores <u>*Cardiovascular* project</u> • Demonstrated some early improvement; interventions are continuing • 18 Standards applicable • 13 of 18 Standards received "met" scores	Comparative results are not applicable: • *Self-Directed Supports* project had just been initiated at the time of the 12-13 review • *Cardiovascular* project had not yet been initiated
Care Management Review	<u>Family Care</u> • 9 of 14 Standards met at a rate of 90 percent or higher • 91.3 percent: Overall rate of	<u>Family Care</u> • 7 of 13 Standards met at a rate of 90 percent or higher • 89.4 percent: Overall rate of

	standards met by this MCO for all review indicators Family Care Partnership • 10 of 14 Standards met at a rate of 90 percent or higher • 92.0 percent: Overall rate of standards met by this MCO for all review indicators PACE Care Management Review was not conducted for the PACE program, as PACE was recently audited by the Centers for Medicare & Medicaid Services	standards met across all Family Care MCOs Family Care Partnership • 4 of 13 Standards met at a rate of 90 percent or higher • 82.6 percent: Overall rate of standards met across all Family Care Partnership MCOs

In reviewing the following strengths and recommendations, readers should consider that the fiscal year 2013-2014 Quality Compliance Review was limited to those areas which were not fully met during the previous two years.

CCI – Key Strengths

- Community Care developed plans to address priority areas for improvement since last year's review.
- The MCO promoted consistent care management practice through enhanced systems and processes, staff education, and feedback.
- Staff surveys were conducted to determine knowledge level before and after educational sessions, and the information was used to enhance future presentations and materials.
- The organization is shifting the focus of its restrictive measures program to protecting and restoring members' rights.

CCI - Recommendations

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

- Allow ample time to fully implement and sustain practices for those standards that remain partially met.
- Ensure that the organization's quality and related plans reflect all required and prioritized activities to guide a fully operational and integrated quality program focused on improving the quality of care and services provided to members.
    - Expedite completion of the *Risk Management Annual Plan,* as several key quality assessment and performance improvement program activities are the responsibility of the Risk Management Department.

- Ensure that the frequency of monitoring is adequate to measure the impact of improvement efforts in a timely manner.
- Continue to develop data systems and processes so that regular monitoring of under-utilization can be conducted in all programs.
- Continue to focus improvement efforts in the following areas of care management across all programs:
    - Follow up with members to ensure services have been received and are effective;
    - Issue notices to members, when indicated and;
    - Ensure care teams complete member-centered plan reviews in a timely manner.
- For Family Care,
    - Ensure member-centered plans include all services, whether authorized by the managed care organization or provided by natural supports, and ensure care teams update plans when significant changes in situation or condition occur.
- For Family Care Partnership,
    - Coordinate services in a timely manner.
- For Performance Improvement Projects, ensure that baseline and repeat measures are consistent, and enhance data analysis.
- Ensure that practice guidelines are disseminated to affected providers.

ContinuUs – Executive Summary

This report summarizes the results of the fiscal year 2013-2014 annual quality review conducted by MetaStar, Inc., for the managed care organization, ContinuUs. MetaStar is the external quality review organization contracted and authorized by the Wisconsin Department of Health Services to provide independent evaluations of managed care organizations that operate Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly.

ContinuUs operates the Family Care program in 21 counties around Wisconsin located in southwest, northwest, east central and southeast portions of the state. Key findings from all review activities are summarized below:

Review Activity	FY 13-14 Results	Comparison to FY 12-13 Results
Quality Compliance Review	• 4 Standards reviewed • 1 of 4 Standards received "Met" scores • 94.2 percent: Cumulative rate of compliance in third year of three-year review cycle	• 92.3 percent: Cumulative rate of compliance in second year of three-year review cycle
Performance Improvement Project	• Achieved improvement in fall rates for high risk frail elderly study population.	• The FY 12-13 project was also focused on fall prevention, but did not achieve improvement.

	• 18 Standards applicable • 17 of 18 Standards received "Met" scores	
Care Management Review	<u>Family Care</u> • 8 of 14 Standards met at a rate of 90 percent or higher • 90.3 percent: Overall rate of standards met by ContinuUs for all review indicators	<u>Family Care</u> • 7 of 13 Standards met at a rate of 90 percent or higher • 89.4 percent: Overall rate of standards met across all Family Care managed care organizations

In reviewing the following strengths and recommendations, readers should consider that the fiscal year 2013-2014 Quality Compliance Review was limited to those areas which were not fully met during the previous two years.

ContinuUs – Key Strengths

- The internal file review process was improved over the past year and provides regular, useful monitoring data.
- ContinuUs conducts comprehensive assessments that fully evaluate the needs and supports of the members served.
- The organization enhanced mechanisms to assess member risk and ensure adequate oversight for complex and high risk members, and provided related staff education.

ContinuUs - Recommendations

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

- Improve comprehensiveness of member-centered plans by conducting focused monitoring and providing additional training and guidance as needed.
- Conduct root cause analysis to understand and remediate reasons for the decline in results related to updating member-centered plans when members have significant changes in situation or condition.
- Continue to identify and act on barriers related to timely service authorization decision making and issuing notices to members, in order to improve consistency of care management practice in these areas.
- Implement additional focused monitoring mechanisms as needed to ensure improvement occurs and is sustained for these aspects of care management practice.
- Expand the use of the Home Safety Checklist to prevent falls, and analyze its effectiveness with other populations served by the organization.

Independent Care Health Plan – Executive Summary

This report summarizes the results of the fiscal year 2013-2014 annual quality review conducted by MetaStar, Inc., for the managed care organization, Independent Care Health Plan. MetaStar is the external quality review organization contracted and authorized by the Wisconsin Department of Health Services to provide independent evaluations of managed care organizations that operate Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly.

Independent Care Health Plan operates the Family Care Partnership program in three counties in southeast Wisconsin. Key findings from all review activities are summarized below:

Review Activity	FY 13-14 Results	Comparison to FY 12-13 Results
Quality Compliance Review	• 15 Standards reviewed • 5 of 15 Standards received "Met" scores • 81.1 percent: Cumulative rate of compliance in third year of three-year review cycle	• 71.1 percent: Cumulative rate of compliance in second year of three-year review cycle
Performance Improvement Projects	*Cardiovascular* project • Improvement was not achieved. • 17 Standards applicable • 8 of 17 Standards received "Met" scores *Readmission* project • Improvement was not achieved. • 17 Standards applicable • 12 of 17 Standards received "Met" scores	• Both projects had just been initiated at the time of the FY 12-13 review.
Care Management Review	Family Care Partnership • 7 of 14 Standards met at a rate of 90 percent or higher • 82.7 percent: Overall rate of standards met by this MCO for all review indicators	Family Care Partnership • 2 of 13 Standards met at a rate of 90 percent or higher • 82.6 percent: Overall rate of standards met across all Family Care Partnership MCOs

In reviewing the following strengths and recommendations, readers should consider that the fiscal year 2013-2014 Quality Compliance Review was limited to those areas which were not fully met during the previous two years.

_i_Care – Key Strengths

- Independent Care Health Plan developed a clear action plan to address findings and recommendations from the prior review.

- The organization has taken steps toward establishing an effective quality assessment and performance improvement program.
- Increased opportunities are available for inter-departmental collaboration and communication.
- Staff resources were added which help support Family Care Partnership operations, such as a department manager, and additional Quality Department staff.
- Independent Care Health Plan staff self-identified barriers and limitations in several areas.

***i*Care - Recommendations**

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

- Further develop and improve methods to assess and improve the quality of member care, such as the internal file review.
    - Follow-up on the organization's own recommendations to develop a standard audit methodology with increased inter-rater reliability.
- Fully implement a consistent caregiver background check monitoring process.
    - Ensure information submitted from providers is complete and timely, so that the MCO can determine if requirements are followed.
    - Establish a defined process for responding when prior convictions are noted.
    - Obtain guidance from the Department of Health Services regarding which providers are subject to caregiver background check requirements.
- Focus improvement in the following areas of care management:
    - Follow-up to ensure that services and support are adequate to meet member needs; and
    - Notices are issued to members when indicated.
- Continue efforts to fully implement an effective and integrated quality assessment and performance improvement program.
    - Ensure the organization-wide quality evaluation and work plan include adequate attention to the Family Care Partnership program; and
    - Continue operation of the Long-Term Care Quality Improvement Committee to maintain focus on the specific requirements of the Family Care Partnership program.
- Improve timeliness of care management practices, e.g., reassessments and member-centered plans completed every six months, and decisions made within required timeframes.
    - Conduct root cause or barrier analysis to identify contributing factors; and
    - Design interventions to address identified problems.

- Institute a process to ensure long-term care service providers maintain licensure after initial credentialing.
- Continue work to improve communication and collaboration among the MCO's Quality, Provider, Compliance, and Family Care Partnership Departments.

Milwaukee County Department of Family Care – Executive Summary

This report summarizes the results of the fiscal year 2013-2014 annual quality review conducted by MetaStar, Inc., for the managed care organization, Milwaukee County Department of Family Care (MCDFC). MetaStar is the external quality review organization contracted and authorized by the Wisconsin Department of Health Services to provide independent evaluations of managed care organizations that operate Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly.

MCDFC operates the Family Care program in eight counties in Southeastern Wisconsin. Key findings from all review activities are summarized below:

Review Activity	FY 13-14 Results	Comparison to FY 12-13 Results
Quality Compliance Review	• 2 Standards reviewed • 2 of 2 Standards received "met" scores • 100 percent: Cumulative rate of compliance in third year of three-year review cycle	• 96.2 percent: Cumulative rate of compliance in second year of three-year review cycle
Performance Improvement Project	• Improvement was achieved in the Performance Improvement Project, *Hypertension & the Role of Self-Monitoring Blood Pressure*. • The project was fully implemented and improvement was sustained. • 20 Standards applicable • 20 of 20 Standards received "Met" scores	• The Performance Improvement Project was in the very early stage of implementation and did not produce new information to improve the quality of member care.
Care Management Review	• 8 of 14 Standards met at a rate of 90 percent or higher • 83.3 percent: Overall rate of standards met by this managed care organization for all review indicators	• 7 of 13 Standards met at a rate of 90 percent or higher • 89.4 percent: Overall rate of standards met across all Family Care managed care organizations

In reviewing the following strengths and recommendations, readers should consider that the fiscal year 2013-2014 Quality Compliance Review was limited to those areas which were not fully met during the previous two years.

MCDFC – Key Strengths

- MCDFC identified key priorities for follow-up from the previous external quality review, monitored progress, and made changes that focused on improvements for the organization.
- The organization actively used data to drive key improvements.
- MCDFC conducts comprehensive assessments that fully evaluate the needs and supports of the members served.
- The organization has mechanisms in place to identify and address member risk.
- MCDFC used rapid improvement cycles and Plan-Do-Study-Act methodology in its PIP.

MCDFC - Recommendations

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

- Focus improvement efforts in the following areas of care management practice:
    - Improve the comprehensiveness of member-centered plans, including identification of member needs and supports and services to address those needs.
    - Continue to improve consistency related to issuing notices to members.
    - Increase efforts to ensure that both covered and non-covered services are coordinated in a timely manner.
    - Ensure member-centered plans are reviewed and signed timely by the appropriate legal decision maker at the required six month intervals. This recommendation was also made during last year's external quality review.

APPENDIX 3 – REQUIREMENT FOR EXTERNAL QUALITY REVIEW AND REVIEW METHODOLOGIES

REQUIREMENT FOR EXTERNAL QUALITY REVIEW

The Code of Federal Regulations at 42 CFR 438 requires states that operate PIHPs to provide for an EQR of their managed care organizations, and to produce an annual technical report that describes the way in which the data from all EQR activities was reviewed, aggregated, and analyzed, and conclusions drawn regarding the quality, timeliness, and access to care provided across MCOs. To meet these obligations, states contract with a qualified EQRO.

MetaStar - Wisconsin's External Quality Review Organization

The State of Wisconsin contracts with MetaStar, Inc., to conduct its EQR activities and to produce the annual technical report. Based in Madison, Wisconsin, MetaStar has been a leader in health care quality improvement, independent quality review services, and medical information management for more than 35 years, and represents Wisconsin in the Quality Innovation Network serving Michigan, Minnesota and Wisconsin, under the CMS Quality Improvement Organization Program.

In addition to conducting EQR of MCOs operating FC, FCP and PACE programs, the company provides EQR of health maintenance organizations serving BadgerCare Plus and Supplemental Security Income Medicaid recipients in the State of Wisconsin. MetaStar also provides services to private clients as well as the State. Additionally, MetaStar operates the Wisconsin Health Information Technology Extension Center, which provides information, technical assistance, and training to support the efforts of health care providers to become meaningful users of certified electronic health record technology.

The MetaStar EQR team is comprised of registered nurses, a nurse practitioner, a physical therapist, licensed and/or certified social workers, a licensed HEDIS auditor who is also a certified professional coder, and other degreed professionals with extensive education and experience working with the target groups served by the MCOs. The EQR team is supported by a data analyst with an advanced degree as well as other members of MetaStar's Managed Health and Long-Term Care and Information Technologies Departments. Review team experience includes professional practice and/or administrative experience in the FC and FCP programs as well as in other settings, including community programs, home health agencies, community-based residential settings, and DHS. Some reviewers have worked in skilled nursing and acute care facilities and/or primary care settings. The EQR team also includes reviewers with quality assurance/quality improvement education and specialized training in evaluating performance improvement projects. Reviewers are required to maintain licensure, if applicable, and

participate in additional relevant training throughout the year. All reviewers are trained annually to use current EQR protocols, review tools, guidelines, databases, and other resources.

Review Methodologies

Compliance with Standards Review/Quality Compliance Review

QCR, a mandatory EQR activity, evaluates policies, procedures, and practices which affect the quality and timeliness of care and services provided to MCO members, as well as members' access to services. The MetaStar team evaluated MCOs' compliance with standards according to 42 CFR 438, Subpart E using the CMS guide, *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations, A Mandatory Protocol for External Quality Reviews (EQR), Version 2.0.*

FY 13-14 was the third year of a three-year cycle. As such, it was considered the second "targeted" or follow-up review year. For each MCO, DHS directed MetaStar to review only those standards not fully met during either the first year of the cycle in FY 11-12, when all compliance standards were reviewed, or during the first follow-up year in FY 12-13.

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

- The MCO's 2013 and 2014 Family Care Program contracts with DHS, Division of Long-Term Support;
- Related program operation references found on the DHS website:
  - http://dhs.wisconsin.gov/familycare/mcos/index.htm
- FY 12-13 external quality review report;
- DHS correspondence with the MCO about expectations and performance during the previous 12 months; and
- Most recent results of compliance, certification, and business plan reviews conducted by DHS.

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

The federal protocols for external quality review were consolidated from five focus areas into three. The three focus areas are listed in the table below. This consolidated approach was developed and implemented by MetaStar in FY 11-12, in order to remove redundancies in the

previous methodology and provide a useful evaluation of the MCO's systems for those people who need it; DHS, various MCO staff, current and prospective members, and other stakeholders.

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

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

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

For findings of "partially met" or "not met," the EQR team documented the missing requirements related to the finding and provided recommendations, as indicated. In some

instances, recommendations were made for requirements met at a minimum. When a score change occurred, for example, from "partially met" in the previous review year to "met" in the current review, reviewers documented the findings which evidenced the improved score.

Validation of Performance Improvement Projects

PIP validation, a mandatory EQR activity, documents that a MCO's performance improvement project is designed, conducted, and reported in a methodologically sound manner, so that the data and findings can be used effectively for organizational decision-making. To evaluate the standard elements of a PIP, the MetaStar team used the methodology described in the CMS guide, EQR Protocol 3: *Validating Performance Improvement Projects (PIPs), A Mandatory Protocol for External Quality Reviews (EQR), Version 2.0.*

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

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

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

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

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

Based on the updated CMS EQR Protocol 3, Version 2.0, a new PIP review standard was added in FY 13-14 which requires MCOs to take into account the cultural and linguistic characteristics of members when developing project interventions. For this review year, the standard was only scored if it was met; otherwise, the standard was scored NA. This was at the direction of DHS, as for most MCOs, projects were already underway by the time they received information about the new requirement.

For findings of "partially met" or "not met," the EQR team documented the missing requirements and provided recommendations.

In addition, for this report, MetaStar assessed the validity and reliability of all findings to determine an overall validation result as follows:

- Met: High Confidence or Confidence in the reported PIP results.
- Partially Met: Moderate or Low Confidence in the reported PIP results.
- Not Met: Reported PIP results that were not credible.

Validation of Performance Measures

Validating performance measures is a mandatory EQR activity used to assess the accuracy of performance measures reported by the MCO, and to determine the extent to which performance measures calculated by the MCO follow state specifications and reporting requirements. This helps ensure MCOs have the capacity to gather and report data accurately, so that staff and management are able to rely on data when assessing program performance or making decisions related to improving members' health, safety, and quality of care. The MetaStar team conducted validation activities as outlined in the CMS guide, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO, A Mandatory Protocol for External Quality Reviews (EQR), September 2012*

Each MCO submitted data to MetaStar using standardized templates developed by DHS. The templates included vaccination data for all members that the MCO determined met criteria for inclusion in the denominator.

MetaStar reviewed the validity of the data and analyzed the reported vaccination rates for each quality indicator and program the MCO administered during MY 2013. To complete the validation work, Meta Star:

- Reviewed each data file to ensure there were no duplicate records;
- Confirmed that the members included in the denominators met the technical specification requirements established by DHS, including ensuring:
    - members reported to have contraindications were appropriately excluded from the denominator; and

    - when applicable, vaccination data were only reported for members that met specified age requirements;
- Confirmed that the members included in the numerators met the technical specification requirements established by DHS, including ensuring, when applicable, that vaccinations were given within the allowable time period;
- Determined the total number of unique members in the MCO and DHS denominators and calculated the number and percentage that were included in both data sets;
- Calculated the vaccination rates for each quality indicator by program and target group;
- Compared the MCO's rates for MY 2013 to both the statewide rates for MY 2013 and the MCO's rates for MY 2012; and
- When necessary, contacted the MCO to discuss any data errors or discrepancies.

MetaStar then randomly selected 30 members per indicator from each program operated by the MCO to verify the accuracy of the MCO's reported data. MetaStar took the following steps:

- Checked each member's service record to verify that it clearly documents the appropriate vaccination in the appropriate time period or appropriately documents any exclusion/contraindication to receiving the vaccination;
- Documented whether the MCO's report of the member's vaccination or exclusion is valid or invalid (the appropriate vaccination was documented in the appropriate time period or the MCO provided documentation for the exclusion);
- Conducted statistical testing to determine if rates are unbiased, meaning that they can be accurately reported (The logic of the t-test is to statistically test the difference between the MCO's estimate of the positive rate and the audited estimate of the positive rate. If MetaStar validated a sample [subset] from the total eligible population for the measure, the t-test was used to determine bias at the 95 percent confidence interval).

Information Systems Capability Assessment

As a required part of other mandatory EQR protocols, ISCAs help ensure that each MCO maintains a health information system that can accurately and completely collect, analyze, integrate, and report data on member and provider characteristics, and on services furnished to members. To conduct ISCAs, the MetaStar review team used information on system requirements detailed in the DHS-MCO contract; other technical references, such as the CMS guide, *EQR Protocol Appendix V: Information Systems Capability Assessment – Activity Required for Multiple Protocols*; and the Code of Federal Regulations at 42 CFR 438.242 .

The scope of the evaluation included assessment of the following:

- The MCO's data collection systems used to support the clinical and administrative operations of the MCO, specifically the data it routinely collects to support the MCO's utilization management, grievance systems, and enrollment services.
- The MCO's processes to obtain data from the various resources that impact its information system (e.g., interdisciplinary teams, vendors and providers, DHS-provided reports derived from the state's ForwardHealth interChange System) and the extent to which the MCO requires and receives data in standardized formats.
- How the MCO collects and integrates member and provider data across all components of its network and how the MCO uses these data to produce comprehensive reports regarding member needs and service utilization, and to otherwise support its management processes.

MetaStar used a combination of activities to conduct and complete the ISCA:

Prior to the review, MetaStar met with staff in DHS' Division of Long Term Care, Office of Family Care Expansion (OFCE) and Bureau of Financial Management Services (BFM) to develop the review methodology and tailor the review activities to reflect DHS expectations for compliance. MetaStar also reviewed the following references:

- The 2013 and 2014 DHS-MCO contracts for FC, FCP, and PACE:
  - http://www.dhs.wisconsin.gov/ltcare/StateFedReqs/FC-RC-CMO-Contracts.htm#cmo
- EQR Protocol Appendix V: Information Systems Capability Assessment – Activity Required for Multiple Protocols. The Protocol can be found at the following link:
  - http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html
- Encounter reporting reference materials:
  - http://www.dhs.wisconsin.gov/ltcare/ProgramOps/Index.htm

To conduct the assessment, MetaStar used the ISCA tool to collect information about the effect of the MCO's information management practices on encounter data submitted to DHS. Reviewers assessed information provided in the ISCA tool, which was completed and submitted to MetaStar by the MCO. Some sections of the tool may have been completed by contracted vendors, if directed by the MCO. Reviewers also obtained and evaluated documentation specific to the MCO's IS and organizational operations used to collect, process, and report claims and encounter data.

MetaStar visited the MCO to perform staff interviews to:

- Verify the information submitted by the MCO in its completed ISCA tool and in additional requested documentation;
- Verify the structure and functionality of the MCO's IS and operations;
- Obtain additional clarification and information as needed; and
- Identify and inform DHS of any issues that might require technical assistance.

Reviewers evaluated each of the following areas within the MCO's IS and business operations:

Section I: General Information
MetaStar confirms MCO contact information and obtains descriptions of the organizational structure, enrolled population, and other background information, including information pertaining to how the MCO collects and processes enrollees and Medicaid data.

Section II: Information Systems – Encounter Data Flow
MetaStar identifies the types of data collection systems that are in place to support the operations of the MCO as well as technical specifications and support staff. Reviewers assess how the MCO integrates claims/encounter, membership, Medicaid provider, vendor, and other data to submit final encounter data files to DHS.

Section III: Encounter Data Collection
MetaStar assesses the MCO and vendor claims/encounter data system and processes, in order to obtain an understanding of how the MCO collects and maintains claims and encounter data. Reviewers evaluate information on input data sources (e.g., paper and electronic claims) and on the transaction system(s) utilized by the MCO.

Section IV: Eligibility
MetaStar assesses information on the MCO's enrollment/eligibility data systems and processes. The review team focuses on accuracy of that data found through MCO reconciliation practices and linkages of encounter data to eligibility data for encounter data submission.

Section V: Practitioner Data Processing
MetaStar reviewers ask the MCO to identify the systems and processes in place to obtain and properly utilize data from the practitioner/provider network.

Section VI: System Security
MetaStar reviewers assess the IS security controls. The MCO must provide a description of the security features it has in place and functioning at all levels. Reviewers obtain and evaluate information on how the MCO manages its encounter data security processes and ensures data integrity of submissions.

Section VII: Vendor Oversight
MetaStar reviews MCO processes for recording information on stand-alone systems or benefits provided through subcontracts, such as medical record data, immunization data, or behavioral health/substance abuse data. The MCO is required to describe oversight of vendors and the data received from contracted providers. Contracted entities or administrators that process claims or provide encounter data to the MCO are included in this focus area.

Section VIII: Medical Record Data Collection
MetaStar reviews the MCO's system and process for data collected from medical record chart abstractions to include in encounter data submissions to DHS.

Section IX: Business Intelligence
MetaStar assesses the decision support capabilities of the MCO's business information and data needs, including utilization management, outcomes, quality measures, and financial systems.

Section X: Performance Measure
MetaStar gathers and evaluates general information about how measure production and source code development is used to prepare and calculate the measurement year measure report.

Care Management Review

CMR is an optional activity which determines a MCO's level of compliance with its contract with DHS; ability to safeguard members' health and welfare; and ability to effectively support IDTs in the delivery of cost effective, outcome-based services. The information gathered during CMR helps assess the access, timeliness, quality, and appropriateness of care a MCO provides to its members. CMR activities and findings help support QCR, and are part of DHS' overall strategy for providing quality assurances to CMS regarding the 1915 (b) and (c) Waivers which allow the State of Wisconsin to operate its Family Care programs. The EQR team conducted CMR activities using a review tool and reviewer guidelines developed by MetaStar and approved by DHS.

MetaStar randomly selected a sample of member records based on a minimum of one and one-half percent of total enrollment or 30 records, whichever is greater. The random sample included a mix of participants who enrolled during the last year, participants who had been enrolled for

more than a year, and participants who had left the program since the sample was drawn. In addition, members from all target populations served by the MCO were included in the random sample; frail elders, and persons with physical and intellectual/developmental disabilities, including some members with mental illness, traumatic brain injury, and Alzheimer's disease.

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

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

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

The care management review tool and reviewer guidelines are based on DHS contract requirements and DHS care management trainings. Reviewers are trained to use DHS approved review tools, reviewer guidelines, and the review database. In addition to identifying any immediate member health or safety issues, MetaStar evaluated four categories of care management practice:

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

The four categories are made up of 14 indicators that reviewers used to evaluate care management performance during the six months prior to the review. MetaStar also compared information from each member's record in the sample with the member's most recent Long-Term Care Functional Screen and provided the comparisons to DHS.

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

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

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