External Quality Review Annual Technical Report

Fiscal Year 2015 – 2016

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

Final Report

Prepared for

Wisconsin Department of Health Services

Bureau of Managed Care

Prepared by

METASTAR

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Table of Contents

Executive Summary

External Quality Review Process

The Code of Federal Regulations (CFR) at 42 CFR 438 requires states that operate pre-paid inpatient health plans or managed care organizations (MCOs), including Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly (PACE), to provide for external quality review of these organizations and produce an annual technical report. To meet its obligations, the State of Wisconsin, Department of Health Services contracts with MetaStar, Inc.

This report covers the external quality review fiscal year from July 1, 2015, to June 30, 2016 (FY 15-16). Mandatory review activities 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. MetaStar also conducted one optional activity, care management review. Care management review assesses key areas of care management practice related to assurances found in the 1915 (b) and (c) Waivers, and also supports assessment of compliance with federal standards.

Compliance with federal standards, also called quality compliance review, follows a three-year cycle; one year of comprehensive review where all standards are assessed, followed by two years of targeted review of any standards an organization did not fully meet the previous year. Each organization's results are cumulative over the three-year period. FY 15-16 was the second year of the three-year cycle. Forty-four quality compliance review standards totaling 88 points apply to every organization, while one additional standard applies only to organizations operating Family Care Partnership and PACE. This one additional standard was removed from the aggregated results discussed in this report, in order to allow for valid comparisons among all organizations. The number of quality compliance standards assessed at each organization during FY 15-16 ranged from two to 26 standards.

Summary of Progress

- Every MCO made some progress in its overall results for quality compliance review since last year.
    - Seven of eight MCOs have achieved cumulative scores over 80 points, out of the total possible 88 points applicable to every organization. Last year, five of eight organizations scored 80 points or above.
    - In FY 15-16, the scores of all eight organizations ranged from 71 to 87 points. This compares to a range of 64 to 86 points in last year's review.

- Progress in aggregate for performance improvement projects is not able to be identified, as project topics, study populations, and project timeframes can vary widely across organizations.
- Each MCO receives an information systems capability assessment (ISCA) once every three years. During FY 15-16, ISCAs were conducted for three organizations; all demonstrated progress by working with providers to increase the use of standardized claim forms.

NOTABLE STRENGTHS

Quality Compliance Review - Enrollee Rights and Protections

- Every MCO has policies and processes in place to ensure their staff and affiliated providers are informed regarding members' rights and take those rights into account when furnishing services.
- All eight organizations have the capability to provide information to individual members in a manner and format they can easily understand, and have met information requirements related to the member handbook.
- Seven of eight organizations have met requirements related to:
    - Providing members with information about advance directives; and
    - Providing information in the provider directory as specified.

Quality Compliance Review – Quality Assessment and Performance Improvement

- Five of eight MCOs have fully met 19 or 20 of the 21 standards which comprise this area of review.
- MCOs demonstrated strength in the following areas related to timeliness:
    - Making prompt service authorization decisions and ensuring timely delivery of those services;
    - Complying with requirements for timely and accurate enrollments and disenrollments.
- Most or all organizations provided appropriate access to services for members in the following ways:
    - Facilitating members' access to second opinions, out-of-network providers and culturally competent service delivery as needed;
    - Authorizing and coordinating necessary services and supports;
- The following strengths related to the quality of care were identified:
    - Maintaining a health information system which collects, analyzes, and reports data, as well as preserving confidentiality of member information;

- Ensuring providers are not excluded from participating in federal health care programs, and overseeing responsibilities delegated to subcontractors/providers; and
- Having in effect mechanisms to assess quality and appropriateness of care, and to evaluate the organization's overall quality assessment and performance improvement program.

Quality Compliance Review - Grievance Systems

- Four of eight organizations have fully met all of the 16 standards which comprise this area of review. Two other organizations have met 15 standards.

Performance Improvement Projects Validation

- MCOs selected performance improvement study topics focused on improving a variety of important aspects of member care and services, based on organization-specific data and needs analysis.
- Four performance improvement projects from four different organizations met all validation standards and achieved improvement attributable to the implemented interventions.

Performance Measures Validation

- All eight MCOs' vaccination data were found to be compliant with the technical specifications for both quality indicators.
- For all MCOs and quality indicators, more than 98.1 percent of the total number of unique members included in MCOs' denominator files and the Department of Health Services' denominator files were common to both data sets.
- MetaStar reviewed a total of 330 member vaccination records for each quality indicator for measurement year (MY) 2015 and MY 2014. The measurement year is defined in the technical specifications attached to this report. The overall findings for both years were not biased, meaning the rates can be accurately reported.

Information Systems Capability Assessment

- All three organizations reviewed proactively monitored vendor relationships and capabilities, and maintained frequent communications to promptly identify and resolve issues.
- All three organizations reviewed were found to utilize analytic data to evaluate systems' performance.

Care Management Review

- Care management review indicated Family Care programs achieved aggregate results over 90 percent in both FY 14-15 and FY 15-16 for the following eight review indicators:
    - "Comprehensiveness of Assessment;"
    - "Reassessment Done when Indicated;"
    - "Timeliness of 12 Month Member-Centered Plan;"
    - "Timeliness of Service Authorization Decisions;"
    - "Risk Addressed when Identified;"
    - "Identified Needs are Addressed;"
    - "Member/Guardian/Informal Supports Included;" and
    - "Self-Directed Supports Option Offered."
- Care management review indicated Family Care Partnership programs achieved aggregate results over 90 percent both FY 14-15 and FY 15-16 for the following four review indicators:
    - "Reassessment Done when Indicated;"
    - "Timeliness of 12 Month Member-Centered Plan;"
    - "Identified Needs are Addressed;" and
    - "Member/Guardian/Informal Supports Included."

RECOMMENDATIONS

Quality Compliance Review - Enrollee Rights and Protections

- Maintain oversight of four organizations to ensure barriers to the timely completion of annual restrictive measures plan renewals are fully identified, related improvements are implemented, and ongoing monitoring is conducted.
- Ensure all MCOs have effective policies and processes in place so that restrictive measures plan renewals are regularly completed and submitted to the Department of Health Services in a timely manner, as required.
- Develop additional restrictive measures tools or guidance as needed. For example, consider developing a standard restrictive measures tracking log for use by all MCOs to improve consistency in tracking and monitoring.

Quality Compliance Review – Quality Assessment and Performance Improvement

- Ensure five MCOs improve processes related to member assessment and planning, with a focus on the consistent development of comprehensive member-centered plans.
- Follow up with four MCOs so that provider credentialing policies and procedures meet requirements and are effectively implemented.

- Provide oversight and technical assistance as needed to one organization that did not make progress in operation of its quality assessment and performance improvement program.

Quality Compliance Review - Grievance Systems

- Four organizations should focus monitoring efforts to ensure that notices of action are issued as required.

Performance Improvement Projects Validation

- Provide oversight and technical support to MCOs as needed to ensure they:
    - Clearly define study populations and use valid sampling techniques when applicable;
    - Develop interventions which are sufficient to be expected to improve outcomes; and
    - Fully analyze study data, including the evaluation of less than optimal results and impact of any project limitations.
- Consider options to increase project timeframes to allow adequate time to achieve improvement.

Performance Measures Validation

- Five MCOs should review and update their policies and procedures for vaccination contraindication reasons to ensure compliance with the Wisconsin Department of Health Services technical specifications, and confirm staff follows policies and procedures for documenting contraindications in member records.
- Three MCOs had decreased influenza vaccination rates between MY 2015 and MY 2014. Those MCOs should conduct an analysis to identify barriers to members receiving the influenza vaccine resulting in lower rates, and develop actionable plans for improvement.

Information Systems Capability Assessment

- One MCO should continue to consider the deployment of security and privacy precautions for the expanding use of mobile devices for accessing MCO information systems.
- One MCO should enhance data editing, linking, and matching across systems and functions, and document in its flowchart the data exchange and subsystems/functions that are responsible for the various processes in the overall information system.
- One MCO should continue to minimize professional information technology staff turnover rates to minimize potential disruptions to systems operations, increase the

proportion of claims that are auto-adjudicated, and conduct a primary source check for practitioner credentialing on a sample of providers.

Care Management Review

- Across Family Care programs, the overall rate of compliance for five review indicators declined since last year's review, and analysis indicated the year-to-year difference in the results was unlikely to be due to normal variation or chance. Readers may note that one of the review indicators with declining results, "Reassessment Done when Indicated," was also noted as a strength above. While aggregate results for this indicator were over 90 percent in each of the last two years, the rate of compliance declined from 96.2 percent in FY 14-15 to 92.8 percent in FY 15-16. The Department of Health Services should work with Family Care organizations to identify causes for the decline in results for all five review indicators, and implement any needed improvement efforts in the following areas of care management practice:
    - "Reassessment Done when Indicated;"
    - "Comprehensiveness of Most Recent Member-Centered Plan;"
    - "Plan Updated for Significant Changes;"
    - "Timely Coordination of Services;" and
    - "Follow-up to Ensure Services are Effective."
- Across Family Care Partnership programs, the overall rate of compliance for three review indicators declined since last year's review, and analysis indicated the year-to-year difference in the rates was unlikely to be the result of normal variation or chance. The Department of Health Services should work with Family Care Partnership organizations to identify causes for the decline in results, and implement any needed improvement efforts in the following areas of care management practice:
    - "Comprehensiveness of Most Recent Member-Centered Plan;"
    - "Plan Updated for Significant Changes;" and
    - "Follow-Up to Ensure Services are Effective."
- In addition, work with all organizations to improve results for "Notice of Action Issued in a Timely Manner when Indicated." This recommendation was also noted in last year's annual technical report.

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 and managed care organizations (MCOs) to provide for an external quality review of their managed care organizations. This report covers mandatory and optional external quality review (EQR) activities conducted by the external quality review organization (EQRO), MetaStar, Inc., for the fiscal year from July 1, 2015, to June 30, 2016 (FY 15-16). 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 15-16, the Wisconsin Department of Health Services (DHS) contracted with eight MCOs to administer these programs. 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; and one MCO operates programs for FC, FCP, and PACE.

Managed Care Organization	Program(s)
Care Wisconsin (CW)	FC; FCP
Community Care, Inc. (CCI)	FC; FCP; PACE
Community Care Connections of Wisconsin (CCCW)	FC
ContinuUs	FC
Independent Care Health Plan (*i*Care)	FCP
Lakeland Care District (LCD)	FC
My Choice Family Care (MCFC)*	FC
Western Wisconsin Cares (WWC)	FC

*Milwaukee County Department of Family Care changed its name to My Choice Family Care effective 7/1/15.

As the result of a competitive procurement, DHS certified two MCOs, LCD and CW, to expand FC into a new geographic service region where FC programs had not previously been available. The geographic service region consists of seven counties in northeast Wisconsin: Brown, Door, Kewaunee, Marinette, Menominee, Oconto, and Shawano counties. Implementation began in

Kewaunee and Oconto counties effective June 1, 2015; start-up in the remaining counties occurred during the first five months of FY 15-16.

During FY 15-16, CW was also certified to expand into additional counties currently being served by one other MCO, affording consumers in these areas more choice of MCO providers. On January 1, 2016, CW expanded its FCP program into Waukesha and Ozaukee counties in southeast Wisconsin. On June 1, 2016, CW expanded its FC program into the southwest part of the state in Crawford, Grant, Green, Iowa, Juneau, Lafayette, Richland, and Sauk counties.

Links to maps depicting the current FC and FCP/PACE geographic service regions and the MCOs operating in the various service regions throughout Wisconsin can be found at the following website:

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

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

https://www.dhs.wisconsin.gov/familycare/whatisfc.htm and

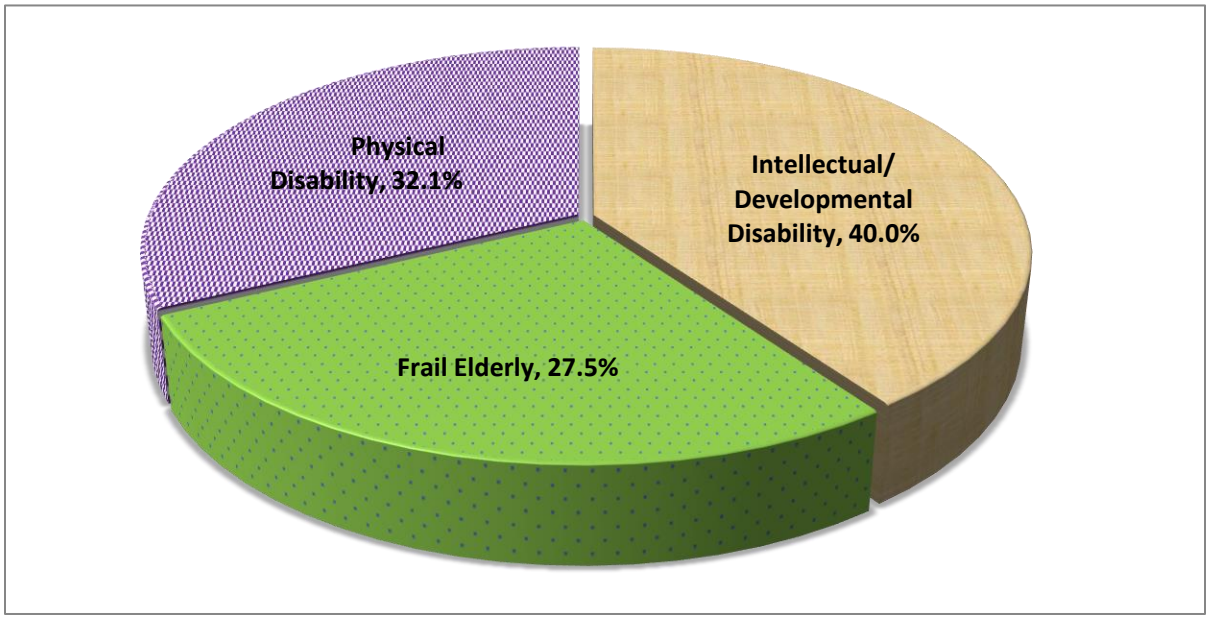
https://www.dhs.wisconsin.gov/familycare/fcp-overview.htm

As of June 30, 2016, enrollment for all programs was approximately 46,458. This compares to a total enrollment of 42,604 as of June 30, 2015. Enrollment data is available at the following DHS website:

https://www.dhs.wisconsin.gov/familycare/enrollmentdata.htm

The chart below shows the percent of total enrollment by the primary target groups served by FC, FCP and PACE programs; individuals who are frail elders, persons with intellectual/developmental disabilities, and persons with physical disabilities.

Total Participants in All Programs by Target Group June 30, 2016



Scope of External Review Activities

In FY 15-16, MetaStar conducted three mandatory review activities as specified in federal Medicaid managed care regulations found at 42 CFR 438.358: Assessment of compliance with 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 pertaining to these three activities also mandate that states assess the information systems capabilities of MCOs. Therefore, MetaStar conducted some information systems capability assessments (ISCAs) during FY 15-16. MetaStar also conducted an optional review activity, care management review (CMR).

Mandatory Review Activities	Scope of Activities
Quality Compliance Review	As directed by DHS, QCR activities generally follow a three-year cycle. The first year, MetaStar conducts a comprehensive review where all QCR standards are assessed; 44 standards for FC, and 45 standards for FCP/PACE. This is followed by two years of targeted or follow-up review for any standards an organization did not fully meet the previous year. Each organization's results are cumulative over the three-year period. FY 15-16 was the second year of the three-year cycle. The number of standards MetaStar reviewed per organization ranged from two to 26.
Performance Improvement Projects Validation	The 2015 DHS-MCO contract required all MCOs to make active progress each year on at least one clinical or non-clinical PIP relevant to long-term care. In FY15-16, MetaStar validated one or more PIPs for each MCO, for a total of nine PIPs. The PIP topics reviewed for each MCO are indicated in the chart on page 13.
Performance Measures Validation	Annually, MCOs must measure and report their performance using quality indicators and standard measures specified in the DHS-MCO contract. For FY 15-16, all MCOs were required to report performance measures data related to care continuity, influenza vaccinations, and pneumococcal vaccinations. MCOs operating FCP or PACE programs were also required to report data on dental visits as well as available measures of members' outcomes (i.e., clinical, functional, and personal experience outcomes) that the MCOs must report to CMS or any other entities with quality oversight authority over FCP and PACE programs. As directed by DHS, MetaStar validated two of these performance measures for every MCO: • Influenza vaccinations • Pneumococcal vaccinations.

	MCOs were directed to report data regarding the care continuity, dental visits, and other performance measures as applicable directly to DHS; MetaStar did not validate these measures.
Information Systems Capability Assessment	ISCAs 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 ISCAs for three MCOs during FY 15-16.
Optional Review Activities	**Scope of Activities**
Care Management Review	MetaStar conducts CMR to assess each MCO's level of compliance with its contract with DHS in key areas of care management practice. CMR activities and findings also help support QCR, and are part of DHS' overall strategy for providing quality assurances to CMS regarding the 1915 (b) and (c) Waivers which allow the State of Wisconsin to operate its Family Care programs. During FY 15-16, the EQR team conducted CMR activities during each MCO's annual quality review (AQR), and a total of 656 records were reviewed. CMR did not include the PACE program, as PACE was audited by CMS during FY 15-16. At the request of DHS, MetaStar also reviewed an additional 198 member records separate from AQR. These results were reported separately and are not included in the data for this report.

PIP Topics Reviewed for each MCO

MCO	PIP Topic
CW	• Treatment of cardiovascular disease (FCP) • Care transitions (FC)
CCI	• Fall risk (FC, FCP, PACE)
CCCW	• Preventative screening (FC)
ContinuUs	• Integrated employment (FC)
***i*Care**	• Hospital readmission (FCP)
LCD	• Member satisfaction (FC)
MCFC	• Advance care planning (FC)
WWC	• Behavioral support (FC)

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. As noted above, MetaStar did not conduct CMR for the PACE program in FY 15-16. See Appendix 3 for more information about the CMR methodology.

MCO/Program	CMR Sample Size
Family Care	
CW	63
CCI	133
CCCW	83
ContinuUs	73
LCD	38
MCFC	120
WWC	56
Total: Family Care	**566**
Family Care Partnership	
CW	30
CCI	30
*i*Care	30
Total: Family Care Partnership	**90**
Total: All Programs	**656**

Quality Compliance Review

QCR is a mandatory activity, conducted to determine the extent to which MCOs are in compliance with federal quality standards. QCR generally follows a three-year cycle. The first year, MetaStar conducts a comprehensive review, where all QCR standards are assessed for each MCO. This is followed by two years of follow-up or targeted review.

FY 15-16 was the first follow-up review year in the three-year cycle. For each MCO, MetaStar reviewed only those compliance standards the MCO did not fully meet during last year's comprehensive review.

Beginning in FY 14-15, MetaStar began scoring the QCR standards using a point system where numeric values are assigned to a standard rating structure:

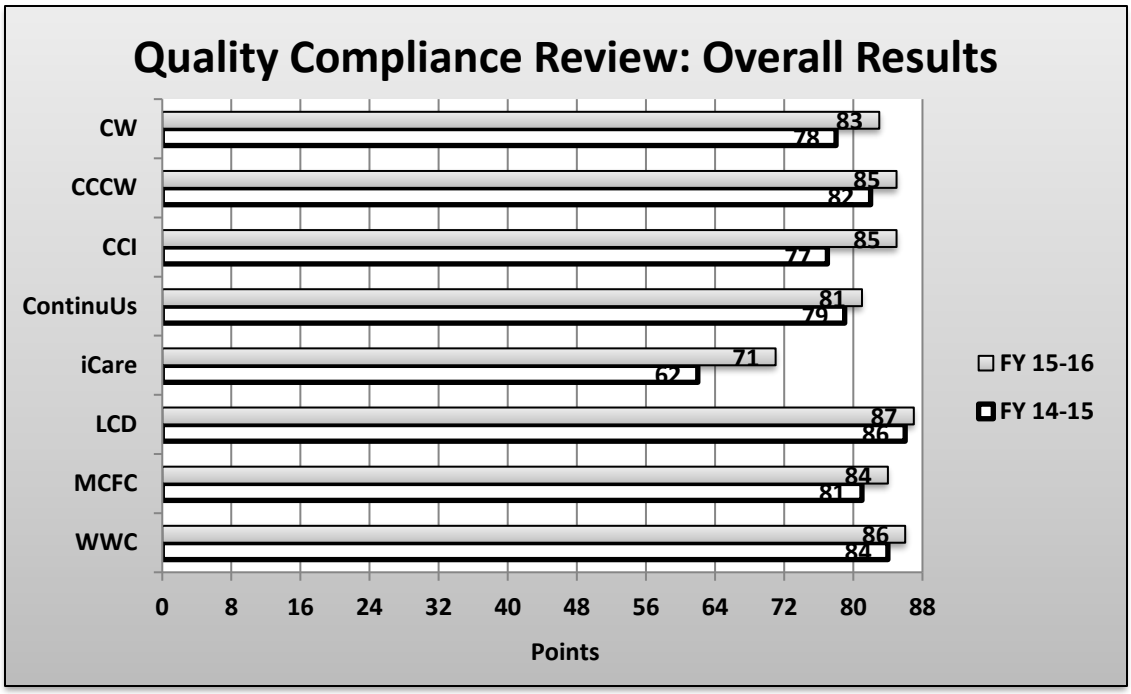
- Two points are awarded for a "met" score;
- One point is awarded for a "partially met" score; and
- Zero points apply to a score of "not met."

The number of points is cumulative over the three-year review cycle. By using this point system, MetaStar is able to recognize not only an organization's full compliance, but also its progress in meeting the requirements of each standard. See Appendix 1 for more information about the scoring methodology.

Forty-four standards totaling 88 points apply to every organization, while one additional standard (in the area of enrollee rights) applies only to organizations operating FCP/PACE. This one additional standard has been removed from the two bar graphs below titled, "Quality Compliance Review: Overall Results" and "Enrollee Rights and Protections," so as to allow for valid comparisons among all organizations.

Overall QCR Results by MCO

The following graph indicates each MCO's overall level of compliance in this year's review compared to its level of compliance in the FY 14-15 review. The bar labeled FY 15-16 represents the cumulative score each MCO achieved in the second year of the three-year cycle, where any additional points from this year's review were added to the MCO's score from last year. Every MCO made progress in its overall QCR results since last year's review. Seven of eight MCOs scored over 80 points out of the total possible 88. The scores of all eight MCOs ranged from 71 to 87 points.



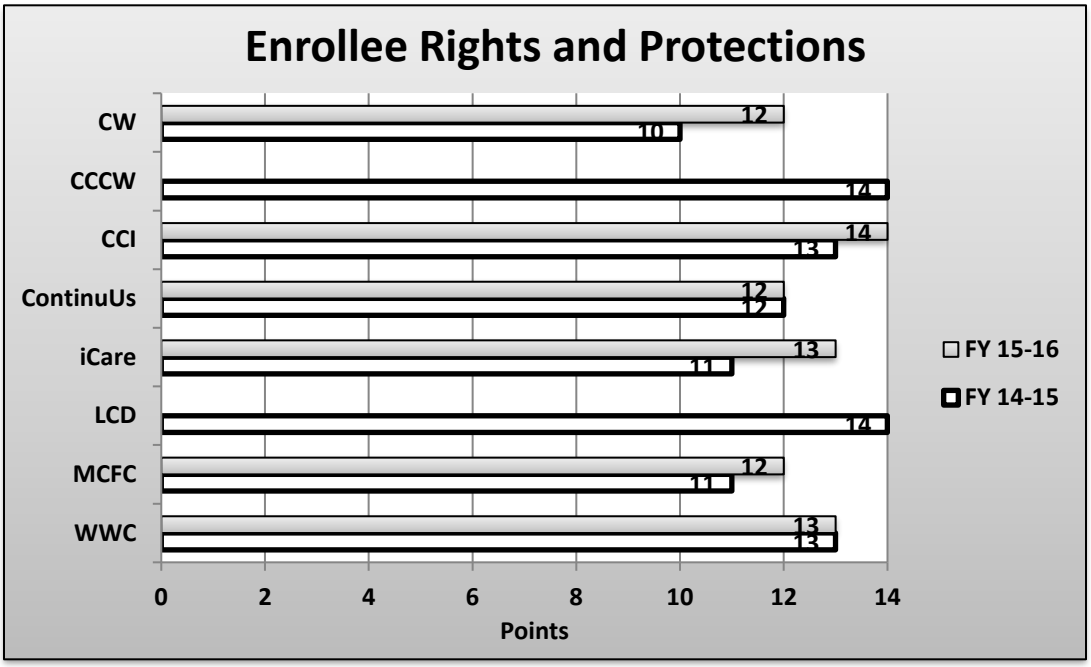
Each section that follows provides a brief explanation of a QCR focus area, followed by a bar graph and a table with additional information.

Results for Enrollee Rights and Protections

An 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 federal and state requirements and are capable of ensuring that members' rights are protected.

The following bar graph, E.1, indicates each MCO's level of compliance with the "Enrollee Rights and Protections" standards. The FY 15-16 results shown are cumulative over the current three-year cycle; any additional points from this year's review were added to the MCO's score from last year. The graph also compares this year's results to the MCO's level of compliance in FY 14-15. The two organizations where FY 15-16 results are not indicated had fully met all of the enrollee rights standards in last year's review. The graph also illustrates comparative results among MCOs.

Bar Graph E.1



The following table, E.2, lists all of the "Enrollee Rights and Protections" standards. Those standards/rows completely shaded in dark gray were not reviewed during FY 15-16, because all MCOs fully met these requirements in last year's review. The unshaded standards were re-reviewed in FY 15-16 for any MCO that had a "partially met" finding in FY 14-15. The first column in the table indicates the number assigned to the review standard. The second column describes the standard. The last column, which is subdivided by year and by rating, depicts the number of MCOs that received a "met" rating and the number of MCOs that received a "partially met" rating for the standard in FY 14-15 and FY 15-16. These two last subdivided columns were shaded differently for contrast by FY. It should be noted the current year's rating is cumulative during the three-year review cycle.

Using Standard #1 below as an example, in FY 14-15, seven MCOs met the standard and one MCO partially met the standard. In FY 15-16, MetaStar re-reviewed the standard for this one MCO, which received a "met rating" in this year's review. This result was added to the results from last year's review, indicating all eight MCOs have now met this standard.

Table E.2

#	Enrollee Rights and Protections	Ratings	
		Met	Partially Met
	General Rule		
1	**42 CFR 438.100;** The MCO must: • Have written policies regarding member rights; • Comply with any applicable federal and state laws that pertain to member rights; • Ensure its staff and affiliated providers take those rights into account when furnishing services.	**FY 14-15**	
		7	1
		FY 15-16	
		8	0
	Information Requirements		
2	**42 CFR 438.100; 42 CFR 438.10; DHS-MCO Contract Article IX.** The MCO must provide all notices, informational materials, and instructional materials relating to members in a manner and format that may be easily understood. The MCO must: • Make its written information available in the prevalent non-English languages in its service area; • Make oral interpretation services available free of charge for all non-English languages (not just those identified as prevalent); • Provide written materials that are in an easily understood language and format; • Make alternative formats available that take into consideration members' special needs; • Notify members of the availability of the above materials and services, including how to access them.	**FY 14-15**	
		8	0
3	**42 CFR 438.100; 42 CFR 438.10; DHS-MCO Contract Article IX.** General information must be furnished to members as required. The MCO must: • Notify members of their right to request and obtain information at least once a year, including information about member rights and protections, the Member Handbook, and Provider Directory; • Provide required information to new members within a reasonable time period and as specified by the DHS-MCO contract; • Provide at least 30 days written notice when there is a "significant" change (as defined by the state) in the information the MCO is required to provide its members; • Make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt of issuance of the termination notice, to members who received services from such provider.	**FY 14-15**	
		3	5
		FY 15-16	
		6	2
4	**42 CFR 438.100; 42 CFR 438.10; DHS-MCO Contract Article IX.** The MCO provides information to members in the Provider Directory as required by 42 CFR 438.10(f)(6) and the DHS-MCO contract.	**FY 14-15**	
		6	2
		FY 15-16	
		7	1

#	Enrollee Rights and Protections	Ratings	
		Met	Partially Met
5	**42 CFR 438.100; 42 CFR 438.10; DHS-MCO Contract Article IX.** The MCO provides information to members in the Member Handbook, as required by 42 CFR 438.10(f)(6), 42 CFR 438.10(g), and the DHS-MCO contract.	**FY 14-15**	
		7	1
		FY 15-16	
		8	0
6	**42 CFR 438.100; 42 CFR 438.10; 42 CFR 438.6; 42 CFR 422.128; DHS-MCO Contract Article X.** Regarding advance directives, the MCO must: • Maintain written policies and procedures in accordance with the DHS-MCO contract; • Provide written information to members regarding their rights under the law of the state including the right to formulate advance directives; • 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); • Include a clear and precise statement of limitation in its policies if it cannot implement an advance directive as a matter of conscience (The statement must comply with requirements listed in 42 CFR 422.128.); • Provide written information to each member at the time of MCO enrollment (or family/surrogate if member is incapacitated at time of enrollment), and must have a follow-up procedure in place to provide the information to the member when he/she is no longer incapacitated; • 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; • Ensure compliance with requirements of state law; • 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 Division of Quality Assurance.	**FY 14-15**	
		7	1
		FY 15-16	
		7	1
	Specific Rights		
7	**42 CRF 438.100; 42 CFR 438.102; DHS-MCO Contract Article X.** The MCO guarantees that its members have the right to: • Be treated with respect and consideration for his/her dignity and privacy; • Receive information on available treatment options and alternatives presented in a manner appropriate to the member's condition and ability to understand; • Participate in decisions regarding his/her 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 his/her medical records, and to request that they be amended or corrected in accordance with federal privacy and security standards;	**FY 14-15**	
		4	4

#	Enrollee Rights and Protections	Ratings	
		Met	Partially Met
	• Exercise their rights without fear of adverse treatment by the MCO or its providers; • Be free from unlawful discrimination. Healthcare professionals acting within their scope of practice may not be restricted from advising or advocating on behalf of the member.	FY 15-16 4	4
	Emergency and Post-stabilization Services		
8	**42 CFR 422.113; 42 CFR 438.114; DHS-MCO Contract Article VII.** ***Applies to Partnership and PACE programs only*** The MCO: • Must cover and pay for emergency services regardless of whether the entity that furnishes the services has a contract with the MCO; • May not deny payment for treatment obtained if a member had an emergency medical condition or a representative of the MCO instructs the member to seek emergency services; • May not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms; • May not refuse to cover emergency services based on lack of notification to MCO within 10 days of presentation for services; • May not hold members liable for payment of subsequent screening or treatment needed to diagnose the specific condition or stabilize the member. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is stabilized for transfer or discharge; • Must cover and pay for post-stabilization care services in accordance with provisions set forth in 42 CFR 422.113(c).	FY 14-15 3	0

Results for Quality Assessment and Performance Improvement

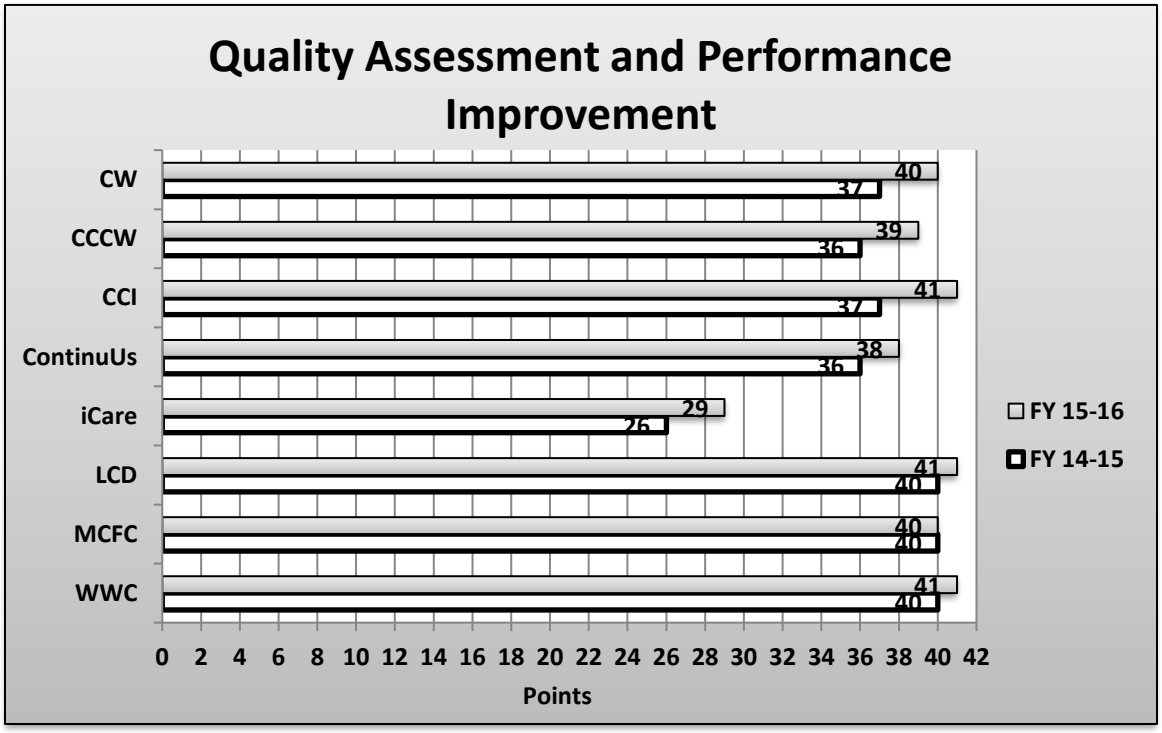
An MCO must provide members timely access to high quality long-term care and health care services by developing and maintaining the structure, operations, and processes to ensure:

- Availability of accessible, culturally competent services through a network of qualified service providers;
- Coordination and continuity of member care;
- Timely authorization of services and issuance of notices to members;
- Timely enrollments and disenrollments;
- An ongoing program of quality assessment and performance improvement; and
- Compliance with other requirements.

The following bar graph, Q.1, indicates each MCO's level of compliance with the "Quality Assessment and Performance Improvement" standards. The FY 15-16 results shown are cumulative over the current three-year cycle; any additional points from this year's review were

added to the MCO's score from last year. The graph also compares this year's results to the MCO's level of compliance in FY 14-15. The graph also illustrates comparative results among MCOs.

Bar Graph Q.1



The following table, Q.2, lists all of the "Quality Assessment and Performance Improvement" standards. Those standards/rows completely shaded in dark gray were not reviewed during FY 15-16, because all MCOs fully met these requirements in last year's review. The unshaded standards were re-reviewed in FY 15-16 for any MCO that had a "partially met" finding in FY 14-15. The first column in the table indicates the number assigned to the review standard. The second column describes the standard. The last column, which is subdivided by year and by rating, depicts the number of MCOs that received a "met" rating and the number of MCOs that received a "partially met" rating for the standard in FY 14-15 and FY 15-16. These two last subdivided columns were shaded differently for contrast by FY. It should be noted the current year's rating is cumulative during the three-year review cycle.

Using Standard #1 in the following table as an example, in FY 14-15, five MCOs met the standard and three MCOs partially met the standard. In FY 15-16, MetaStar re-reviewed the standard for these three MCOs, and one MCO received a "met rating" in this year's review. This result was added to the results from last year's review, indicating six MCOs have now met this standard.

Table Q.2

#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement	Ratings	
		Met	Partially Met
	Availability of Services		
1	**42 CFR 438.206**; **DHS-MCO Contract Articles VII. and VIII.** ***Delivery network*** The MCO maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, the MCO site must consider: • Anticipated Medicaid enrollment; • Expected utilization of services, considering Medicaid member characteristics and health care needs; • Numbers and types (in terms of training, experience and specialization) of providers required to furnish the contracted Medicaid services; • The number of network providers that 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. The delivery network provides female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services, when applicable per program benefit package.	**FY 14-15**	
		5	3
		FY 15-16	
		6	2
2	**42 CFR 438.206; DHS-MCO Contract Articles VII. and VIII.** ***Second opinion and out-of-network providers*** The MCO provides for a second opinion from a qualified health care professional within the network, or arranges for the member to obtain one outside the network, at no cost to the member, when applicable per program benefit package. If the network is unable to provide necessary services, covered under the contract, to a particular member, the MCO must adequately and timely cover these services out of network for the member as long as the MCO is unable to provide them. The MCO must coordinate with out-of-network providers to ensure that the cost of services to members is no greater than they would have been if furnished within the provider network.	**FY 14-15**	
		6	2
		FY 15-16	
		8	0

#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement	Ratings	
		Met	Partially Met
3	**42 CFR 438.206; DHS-MCO Contract Article VIII.** ***Timely access*** The MCO must: • Require its providers to meet state standards for timely access to care and services, taking into account the urgency of need for services; • Ensure that the network providers offer hours of operation that are not less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service, if the provider serves only Medicaid members; • Make services available 24 hours a day, 7 days a week when medically necessary; • Establish mechanisms to ensure compliance by providers; • Monitor providers regularly to determine compliance; • Take corrective action if there is a failure to comply.	**FY 14-15** 7 **FY 15-16** 7	 1 1
4	**42 CFR 438.206*;* DHS-MCO Contract Article VIII.** ***Cultural considerations*** The MCO must participate in the state's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The MCO must: • Incorporate in its policies, administration, provider contract, and service practice the values of honoring members' beliefs and cultural backgrounds; • Permit members to choose providers from among the MCO's network based on cultural preference; • Accept appeals and grievances from members related to a lack of access to culturally appropriate care.	**FY 14-15** 8	 0
	Coordination and Continuity of Care		
5	**42 CFR 438.208; DHS-MCO Contract Article V.** ***Primary care and coordination of health care services*** The MCO must implement procedures to deliver primary care (as applicable for FCP) and coordinate health care services for all MCO members. These procedures must do the following: • Ensure that each member has an ongoing 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; • Share with other providers serving the member the results of its identification and assessment of that member's needs to prevent duplication of activities;	**FY 14-15** 7	 1

#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement	Ratings	
		Met	Partially Met
	• Ensure protection of the member's privacy when coordinating care; • Facilitate direct access to specialists as appropriate for the member's special health care condition and identified needs.	FY 15-16	
		8	0
6	**42 CFR 438.208; DHS-MCO Contract Article III.** ***Identification:*** Identification and eligibility of individuals with special health care needs will be in accordance with the Wisconsin 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. The assessment must use appropriate health care professionals. ***Member-centered plan:*** The treatment plan must be: • Developed to address needs determined through the assessment; • Developed jointly with the member's primary care team with member participation, and in consultation with any specialists caring for the member; • Completed and approved in a timely manner in accordance with DHS standards.	FY 14-15	
		3	5
		FY 15-16	
		3	5
	Coverage and Authorization of Services		
7	**42 CFR 438.210; DHS-MCO Contract Article V.** ***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; • Ensure 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.	FY 14-15	
		7	1
		FY 15-16	
		8	0

#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement	Ratings	
		Met	Partially Met
8	**42 CFR 438.210; DHS-MCO Contract Article V.** ***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. <u>Standard Service Authorization Decisions</u> ***For Family Care and Partnership:*** • Decisions shall be made no later than fourteen (14) calendar days following receipt of the request for the service unless the MCO extends the timeframe for up to fourteen (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. ***For PACE:*** • Decisions on direct requests for services must be made and notice provided as expeditiously as the member's health condition requires but not more than 72 hours after the date the interdisciplinary team receives the request. The interdisciplinary team may extend this 72-hour timeframe by up to five (5) additional calendar days for either of the following reasons: a) The participant or designated representative requests the extension; or b) The team documents its need for additional information and how the delay is in the interest of the participant. <u>Expedited Service Authorization Decisions:</u> • 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 seventy two (72) hours after receipt of the request for service. • The MCO may extend the timeframes of expedited service authorization decisions by up to eleven (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.	**FY 14-15**	
		7	1
		FY 15-16	
		7	1
	Provider Selection		
9	**42 CFR 438.214; 42 CFR 438.12; DHS-MCO Contract Article VIII.** 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.	**FY 14-15**	
		4	4

#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement	Ratings	
		Met	Partially Met
	If an MCO declines to include individual providers or groups of providers in its network, it must give the affected provider(s) written notice of the reason for its decision.	FY 15-16	
		4	4
10	**42 CFR 438.214; DHS-MCO Contract Article VIII.** 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.	FY 14-15	
		5	3
		FY 15-16	
		7	1
11	**42 CFR 438.214** The MCO must comply: • With any additional requirements established by the state including ensuring providers and subcontractors perform background checks on caregivers in compliance with Wis. Admin. Code Chapter DHS 12. • 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.	FY 14-15	
		6	2
		FY 15-16	
		6	2
	Confidentiality		
12	**42 CFR 438.224; DHS-MCO Contract Article V.** The MCO must ensure that for medical records and any other health and enrollment information that identifies a particular enrollee, use and disclosure of such individually identifiable health information must be in accordance with the privacy requirements.	FY 14-15	
		8	0
	Enrollment and Disenrollment		
13	**42 CFR 438.226; 42 CFR 438.56**; **DHS-MCO Contract Article IV.** ***Disenrollment requested by the MCO*** The MCO must comply with enrollment and disenrollment requirements and limitations. The MCO may request a disenrollment if: • The member has committed acts or threatened to commit acts that pose a threat to the MCO staff, subcontractors, or other members of the MCO. This includes harassing and physically harmful behavior. • The MCO is unable to assure the member's health and safety because: ○ The member refuses to participate in care planning or to allow care management contacts; or ○ The member is temporarily out of the MCO service area. The MCO must have written policies and procedures that identify the impermissible reasons for disenrollment in accordance with the DHS-MCO contract.	FY 14-15	
		1	7
		FY 15-16	
		7	1

#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement	Ratings	
		Met	Partially Met
	The MCO shall submit to DHS a written request to process the disenrollment, which includes documentation of the basis for the request, a thorough review of issues leading to the request, and evidence that supports the request.		
14	**42 CFR 438.226; 42 CFR 438.56; DHS-MCO Contract Article IV.** ***Enrollment and disenrollment*** The MCO shall comply with the following requirements and use DHS-issued forms related to disenrollments. <u>*Processing Disenrollments*</u> The enrollment plan, developed in collaboration with the resource center and income maintenance agency, shall be the agreement between entities for the accurate processing of disenrollments. The enrollment plan shall ensure that: • The MCO is not directly involved in processing disenrollments, although the MCO shall provide information relating to eligibility to the income maintenance agency; • Enrollments and disenrollments are accurately entered in the Client Assistance for Re-employment and Economic Support (CARES) system, so that correct capitation payments are made to the MCO; and • Timely processing occurs, in order to ensure that members who disenroll have timely access to any Medicaid fee-for-service benefits for which they may be eligible, and to reduce administrative costs to the MCO and other service providers for claims processing. <u>*MCO Influence Prohibited*</u> • The MCO shall not counsel or otherwise influence a member due to his/her life situation (e.g., homelessness, increased need for supervision) or condition in such a way as to encourage disenrollment. <u>*Member Requested Disenrollment*</u> • All members shall have the right to disenroll from the MCO without cause at any time. • If a member expresses a desire to disenroll from the MCO, the MCO shall provide the member with contact information for the resource center and, with the member's approval, may make a referral to the resource center for options counseling. • The MCO is responsible for covered services it has authorized through the date of disenrollment. <u>*Interactions with Other Agencies Related to Eligibility and Enrollment*</u> • The MCO shall fully cooperate with other agencies and personnel with responsibilities for eligibility determination, eligibility re-determination, and enrollment in the MCO. This includes but is not limited to the resource center, income maintenance, and enrollment consultant if any. • The MCO shall participate with these agencies in the development and implementation of an enrollment plan that describes how the agencies will work together to assure accurate, efficient, and timely eligibility determination and re-determination and enrollment in the	**FY 14-15** 6	**FY 14-15** 2
		FY 15-16 7	**FY 15-16** 1

#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement	Ratings	
		Met	Partially Met
	MCO. The enrollment plan shall describe the responsibility of the MCO to timely report known changes in members' level of care, financial, and other circumstances that may affect eligibility, and the manner in which to report those changes. • The MCO shall jointly develop with the resource center protocols for disenrollments, per contract specifications.		
	Subcontractor/Provider Relationships and Delegation		
15	**42 CFR 438.230; DHS-MCO Contract Article VIII.** The MCO must: • Oversee and be accountable for any functions and responsibilities that it delegates to any subcontractor/provider; • Before any delegation, evaluate the prospective subcontractor/provider's ability to perform the activities to be delegated; • Have a written agreement that: ○ Specifies the activities and report responsibilities designated to the subcontractor/provider; and ○ Provides for revoking delegation or imposing other sanctions if the subcontractor/provider's performance is inadequate; • Monitor the subcontractor/provider's performance on an ongoing basis, identify deficiencies or areas for improvement, and take corrective action.	**FY 14-15** 7	1
		FY 15-16 7	1
	Practice Guidelines		
16	**42 CFR 438.236; DHS-MCO Contract Article VII.** The MCO adopts practice guidelines which: • Are based on valid and reliable clinical evidence; • Consider the needs of the MCO's members; • Are adopted in consultation with health care professionals; and • Are reviewed and updated periodically. The MCO disseminates the guidelines to all affected providers, and upon request, to members. The MCO applies the guidelines throughout the MCO in a consistent manner, e.g., decisions for utilization management, member education, service coverage.	**FY 14-15** 6	2
		FY 15-16 6	2

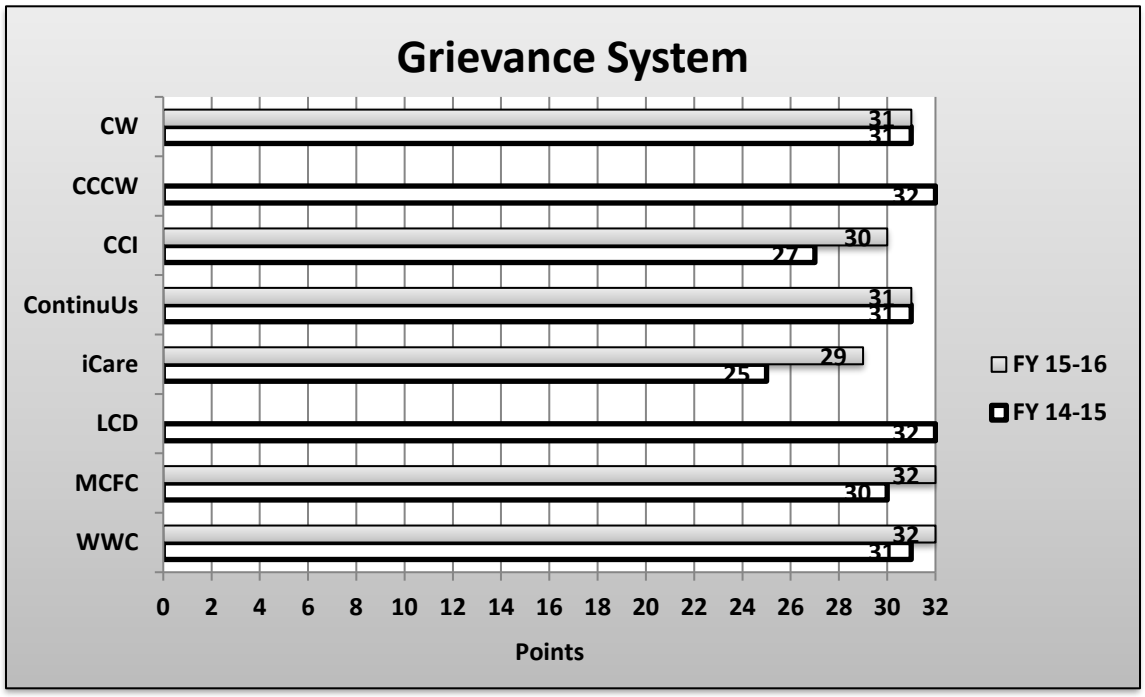
#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement	Ratings	
		Met	Partially Met
	Quality Assessment and Performance Improvement (QAPI) Program		
17	**42 CFR 438.240; DHS-MCO Contract Article XII.** The MCO has an ongoing quality assessment and performance improvement (QAPI) program for the services it furnishes to its members which meets at a minimum the following requirements outlined in the DHS-MCO contract: • Is administered through clear and appropriate administrative structures; • Includes member, staff, and provider participation; • Develops a work plan which outlines the scope of activities, goals, objectives, timelines, responsible person, and is based on findings from QAPI program activities; • Monitors quality of assessments and member-centered plans; • Monitors completeness and accuracy of functional screens; • Conducts member satisfaction and provider surveys; • Documents response to critical incidents; • Monitors adverse events, including appeals and grievances that were resolved; • Monitors access to providers and verifies that services were provided; • Monitors the quality of subcontractor services.	**FY 14-15** 5	 3
		FY 15-16 6	 2
	Basic Elements of the QAPI Program		
18	**42 CFR 438.240; DHS-MCO Contract Article XII.** The MCO must have in effect mechanisms to detect both underutilization and overutilization of services.	**FY 14-15** 6	 2
		FY 15-16 6	 2
19	**42 CFR 438.240; DHS-MCO Contract Article XII.** The MCO must have in effect mechanisms to assess the quality and appropriateness of care furnished to members.	**FY 14-15** 6	 2
		FY 15-16 7	 1
	Quality Evaluation		
20	**42 CFR 438.240; DHS-MCO Contract Article XII.** The MCO has in effect a process for an evaluation of the impact and effectiveness of its quality assessment and performance improvement program, to determine whether the program has achieved significant improvement in the quality of service provided to its members.	**FY 14-15** 6	 2
		FY 15-16 7	 1
	Health Information Systems		
21	**42 CFR 438.242; DHS-MCO Contract Article XII.** The MCO maintains a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments (for other than loss of Medicaid eligibility).	**FY 14-15** 8	 0

Results for 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.

Bar graph G.1 below indicates each MCO's level of compliance with the "Grievance Systems" standards. The FY 15-16 results shown are cumulative over the current three-year cycle; any additional points from this year's review were added to the MCO's score from last year. The graph also compares this year's results to the MCO's level of compliance in FY 14-15. The two organizations where FY 15-16 results are not indicated had fully met all of the grievance systems standards in last year's review. The graph also illustrates comparative results among MCOs.

Bar Graph G.1



The following table, G.2, lists all of the "Grievance Systems" standards. Those standards/rows completely shaded in dark gray were not reviewed during FY 15-16, because all MCOs fully met these requirements in last year's review. The unshaded standards were re-reviewed in FY 15-16 for any MCO that had a "partially met" finding in FY 14-15. The first column in the table indicates the number assigned to the review standard. The second column describes the standard. The last column, which is subdivided by year and by rating, depicts the number of MCOs that received a "met" rating and the number of MCOs that received a "partially met" rating for the standard in FY 14-15 and FY 15-16. These two last subdivided columns were shaded differently

for contrast by FY. It should be noted the current year's rating is cumulative during the three-year review cycle.

Using Standard #4 below as an example, in FY 14-15, seven MCOs met the standard and one MCO partially met the standard. In FY 15-16, MetaStar re-reviewed the standard for this one MCO, which received a "met rating" in this year's review. This result was added to the results from last year's review, indicating all eight MCOs have now met this standard.

Table G.2

#	Grievance System	Ratings	
		Met	Partially Met
	Definitions and General Requirements		
1	**42 CFR 438.400; 42 CFR 438.402** The MCO must have a grievance and appeal system in place that includes an internal grievance process, an appeal process, and access to the state's Fair Hearing system.	**FY 14-15** 8	 0
2	**42 CFR 438.402; DHS-MCO Contract Article XI.** ***Authority to file*** The MCO must accept appeals and grievances from members and their preferred representatives, including providers, with the member's written consent. The MCO must follow the state-specified filing timeframes associated with standard and expedited appeals.	**FY 14-15** 8	 0
3	**42 CFR 438.402; DHS-MCO Contract Article XI.** The member may file grievances orally or in writing. The member, representative, or the provider may file an appeal either orally or in writing, and (unless he or she requests expedited resolution) must follow an oral filing with a written, signed, appeal. The MCO must acknowledge in writing receipt of each appeal or grievance within five business days of receipt of the appeal or grievance.	**FY 14-15** 8	 0
	Notices to Members		
4	**42 CFR 438.404; 42 CFR 438.10; DHS-MCO Contract Article XI.** ***Language, content, and format requirements*** The notice must be in writing and must meet language and format requirements to ensure ease of understanding. The MCO must use the DHS-issued: • Notice of Action template; • Notification of Non-covered Benefit template; and • Notice of Change in Level of Care template.	**FY 14-15** 7 **FY 15-16** 8	 1 0

#	Grievance System	Ratings	
		Met	Partially Met
5	**42 CFR 438.404; 42 CFR 431.210; 42 CFR 431.211; 42 CFR 431.213; 42 CFR 431.214; DHS-MCO Contract Article V. and XI.** ***Timing of notice*** The notice must be delivered to the member in the timeframes associated with each type of adverse decision: • Termination, suspension, or reduction of service; • Denial of payment for a requested service; • Authorization of a service in an amount, duration, or scope that is less than requested; • Service authorization decisions not reached within the timeframes specified, on the date the timeframes expires; • Expedited service authorization decisions; • Some changes in functional level of eligibility. If the MCO extends the timeframe for the decision making process it must: • Give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees; and • Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.	**FY 14-15** 4 **FY 15-16** 4	4 4
	Handling of Grievances and Appeals		
6	**42 CFR 438.406; DHS-MCO Contract Article XI.** The MCO must give members any reasonable assistance in completing forms and taking other procedural steps in the grievances and appeals process. The MCO must designate a "Member Rights Specialist" who is responsible for assisting members when they are dissatisfied. The Member Rights Specialist may not be a member of the MCO grievance and appeal committee or represent the MCO at a State Fair Hearing. The MCO must attempt to resolve issues and concerns without formal hearings or reviews whenever possible through internal review, negotiation, or mediation. The MCO must allow members to involve anyone the member chooses to assist in any part of the grievance or appeal process, including informal negotiations.	**FY 14-15** 7 **FY 15-16** 8	1 0
7	**42 CFR 438.406; DHS-MCO Contract Article XI.** The MCO process must ensure that individuals who make decisions on grievances and appeals: • Have not been involved in any previous level of review or decision-making related to the issue under appeal; • Include health care professionals with appropriate clinical experience when deciding: ○ Appeal of a denial based on lack of medical necessity;	**FY 14-15** 6	2

#	Grievance System	Ratings	
		Met	Partially Met
		FY 15-16	
	○ Grievance regarding denial of expedited resolution of an appeal; ○ Grievance or appeal involving clinical issues; • Include at least one member (or guardian), or person who meets the functional eligibility requirements (or guardian) who is free of conflict of interest. The MCO must assure that all members of the grievance and appeal committee have agreed to respect the privacy of members, have received training in maintaining confidentiality, and that members' are offered the choice to exclude any consumer representatives from participation in their hearing.	7	1
8	**42 CFR 438.406;** ***Special requirements for appeals*** The MCO processes for appeals must: • Provide that oral inquires seeking to appeal an action must be confirmed in writing, unless the member or the provider requests expedited resolution; • Give members the opportunity to present evidence, and allegations of fact or law, in person or in writing at all levels of appeal; • Give the member and his/her representative the opportunity to examine the member's case record, including medical records and other documents, before and during the appeals process; • Include the member and/or representative or the legal representative of a deceased member's estate.	FY 14-15	
		8	0
	Resolution and Notification		
9	**CFR 438.408; DHS-MCO Contract Article XI.** ***Basic rule*** The MCO has a system in place to dispose of each grievance and resolve each appeal as expeditiously as the member's situation and health condition requires, within established timeframes for standard and expedited dispositions of grievances and appeals. ***Extension of timeframes*** The MCO may extend the timeframes by up to 14 calendar days if: • The member requests the extension; • The MCO shows that there is a need for additional information and how the delay is in the member's interests. ***Requirements following extension*** If the MCO extends the timeframes, it must give the member written notice of the reasons for the delay.	FY 14-15	
		5	3
		FY 15-16	
		8	0

#	Grievance System	Ratings	
		Met	Partially Met

10	**CFR 438.408; DHS-MCO Contract Article XI.**
	
	Format of notices
	The MCO must provide written notice of the disposition of appeals and grievances within required timeframes.
	
	If adverse to the member, the MCO must maintain a copy of the notification of appeal rights in the member's record.
	
	For expedited resolutions, the MCO must also make reasonable efforts to provide oral notice.
	
	Content of notices
	The written notice of the appeal resolution must include:
	• Results of the resolution process and date it was completed;
	• For appeals not resolved wholly in favor of the member:
	  ○ The right to request a State Fair Hearing and how to do so;
	  ○ The right to request to receive benefits while the hearing is pending and how to make the request;
	  ○ The member may be held liable for the cost of those benefits if the hearing decision upholds the MCO's action.
	
	The written notice of the grievance resolution must include:
	• Results of the resolution process and date it was completed;
	• For decisions not wholly in the member's favor, the right to request a DHS review and how to do so.
		FY 14-15
		7
			FY 14-15
			1

		FY 15-16 8	**FY 15-16** 0
	Expedited Resolution of Appeals		
11	**CFR 438.410; DHS-MCO Contract Article XI.** The MCO must establish and maintain an expedited review process for appeals, when the MCO determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function. The MCO must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. If the MCO denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the timeframe for standard resolution; • Make reasonable efforts to give the member prompt oral notice of the denial and follow up within 72 hours with a written notice.	**FY 14-15** 7	**FY 14-15** 1
		FY 15-16 8	**FY 15-16** 0
	Information About the Grievance System to Providers		
12	**CFR 438.414;** The MCO must provide the information about the grievance system to all providers and subcontractors at the time they enter into a contract.	**FY 14-15** 7 **FY 15-16** 7	 1 1
	Recordkeeping and Reporting Requirements		
13	**CFR 438.416; DHS-MCO Contract Article XI;**	**FY 14-15** 7	 1

#	Grievance System	Ratings	
		Met	Partially Met
	The MCO must maintain records of grievances and appeals and review the information as part of its Quality Management Program. The MCO shall submit a quarterly grievance and appeal report to DHS.	FY 15-16	
		8	0
	Continuation of Benefits While the MCO Appeal and State Fair Hearing are Pending		
14	**CFR 438.420** ***Continuation of benefits*** The MCO must continue the member's benefits if the: • Member or provider files the appeal timely; • Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; • Services were ordered by an authorized provider; • Original authorization has not expired; • Member requests the extension of benefits. ***Duration of continued benefits or reinstated benefits*** If the member requests, the MCO must continue or reinstate benefits until: • The member withdraws the appeal; • Ten days pass after the MCO mails the notice which provides the resolution of the appeal adverse to the member; • A State Fair Hearing Office issues a hearing decision adverse to the member; • The time period or service limits of a previously authorized service has been met.	FY 14-15	
		8	0
15	**CFR 438.420; DHS-MCO Contract Article XI.** ***Member responsibility for services while the appeal is pending*** If the final resolution of the appeal is adverse to the member, the MCO may recover the cost of services furnished to the member while the appeal is pending to the extent they were furnished solely because of the requirements of this section, unless DHS or the MCO determines that the person would incur a significant and substantial financial hardship as a result of repaying the cost of the services provided, in which case DHS or the MCO may waive or reduce the member's liability.	FY 14-15	
		7	1
		FY 15-16	
		7	1
	Effectuation of Reversed Appeal Resolutions	FY 14-15	
16	**CFR 438.424; DHS-MCO Contract Article XI.** ***Services not furnished while the appeal is pending*** If the MCO or the State Fair Hearing Officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires. ***Services furnished while the appeal is pending*** If the MCO or the State Fair Hearing Officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCO must pay for those services.	7	1
		FY 15-16	
		8	0

MCO Comparative Findings: QCR Standards Not Fully Met

The table below shows all of the QCR topic areas. 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 that area of review. The check mark(s) in each column shows, for each MCO, the corresponding number of compliance standards in the QCR topic area that remained partially met following this year's EQR.

QCR TOPICS and Number of Standards per Topic	CW	CCI	CCCW	ContinuUs	*i*Care	LCD	MCFC	WWC
Enrollee Rights and Protections (7 standards FC; 8 standards FCP/PACE)								
General Rule (1)								
Information Requirements (5)	√			√	√		√	
Specific Rights (1)	√			√			√	√
Emergency and Post-stabilization Services (1) **(Applies to FCP and PACE only)**								
Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement (21 standards)								
Availability of Services (4)				√	√√			
Coordination and Continuity of Care (2)	√		√		√	√	√	
Coverage and Authorization of Services (2)							√	
Provider Selection (3)			√√	√√	√√			√
Confidentiality (1)								
Enrollment and Disenrollment (2)					√√			
Subcontractual Relationships and Delegation (1)					√			
Practice Guidelines (1)	√				√			

QCR TOPICS and Number of Standards per Topic	CW	CCI	CCCW	ContinuUs	*i*Care	LCD	MCFC	WWC
QAPI Program (1)		√			√			
Basic Elements of the QAPI Program (2)				√	√√			
Quality Evaluation (1)					√			
Health Information Systems (1)								
Grievance Systems (16 standards)								
Definitions and General Requirements (3)								
Notices to Members (2)	√	√		√	√			
Handling of Grievances and Appeals (3)					√			
Resolution and Notification (2)								
Expedited Resolution of Appeals (1)								
Information about Grievance System to Providers (1)					√			
Recordkeeping and Reporting (1)								
Continuation of Benefits While Appeal is Pending (2)		√						
Effectuation of Reversed Appeal Resolutions (1)								
Total QCR Standards Not Fully Met For Each MCO	**5**	**3**	**3**	**7**	**17**	**1**	**4**	**2**

CONCLUSIONS

Enrollee Rights and Protections

Based on the data in bar graph E.1 above, FY 15-16 results for all eight MCOs in this area of review ranged from 12 to 14 points for seven Enrollee Rights standards applicable to every organization. This indicates progress since last year's review, when scores ranged from 10 to 14 points.

The progress, strengths, and opportunities noted below are based on the findings, as indicated in table E.2, above:

Progress

- This year, one additional MCO achieved full compliance with the Enrollee Rights standards. Three MCOs have now fully met these requirements during the current three-year cycle.
- One MCO fully met the general rule to have written policies regarding member rights, and to ensure its staff and affiliated providers to those rights into account when furnishing services. All eight MCOs have now met this standard.
- Since last year, three additional MCOs have met general information requirements to make a good faith effort to provide timely written notice to members who will be affected by the termination of a service provider from the MCO's network. Six of eight MCOs have now met this standard.
- One additional MCO met requirements related to providing information in the provider directory. Seven of eight organizations have now met this standard.
- One MCO met requirements related to providing information in the member handbook. All eight organizations have now met this standard.

Strengths

- All eight MCOs have policies and processes in place to ensure their staff and affiliated providers are informed regarding members' rights and take those rights into account when furnishing services.
- All eight MCOs have the capability to provide information to members in an easily understood manner and format, and have met information requirements related to the member handbook.
- Seven of eight organizations have met requirements related to:
    - Providing members with information about advance directives; and
    - Providing information in the provider directory.

Opportunities

- An area of opportunity for improvement, where four of eight MCOs did not fully meet requirements, is the need to ensure applications for renewal of restrictive measures plans are completed and submitted to DHS in a timely manner.

Quality Assessment and Performance Improvement

Based on the data in bar graph Q.1 above, the results for all eight MCOs in this area of review ranged from 29 to 41 points for the 21 standards in this review area. This indicates progress since last year's review, when scores ranged from 26 to 40 points.

The progress, strengths, and opportunities noted below are based on the findings, as indicated in table Q.2, above:

Progress

- Two MCOs achieved compliance with the requirement to provide for a second opinion and offer out-of-network providers as necessary.
- One MCO met requirements related to coordination of health care services.
- One MCO met requirements relevant to service authorization policies and procedures.
- Two MCOs met the requirement to ensure organizations do not contract with providers excluded from participation in federal health care programs.
- Six organizations achieved compliance with requirements regarding disenrollment requested by the MCO.
- One MCO met an additional enrollment and disenrollment standard addressing enrollment plans.
- One organization met the requirement related to mechanisms to assess the quality and appropriateness of care.
- One MCO met the quality evaluation requirements.
- One MCO achieved compliance with requirements regarding an adequate service delivery network.
- One organization met requirements related to its ongoing QAPI program.

Strengths

- Five of eight MCOs have fully met 19 or 20 of the 21 standards in this area.
- All eight organizations have achieved compliance with six of the 21 standards related to:
    - Second opinions and out-of-network providers;
    - Cultural considerations;
    - Coordination of services;
    - Service authorization policies and procedures;

    - Confidentiality; and
    - Health information systems.
- Seven of eight MCOs have fully met nine additional standards regarding:
    - Timely access to care and services;
    - Service authorization timeliness;
    - Ensuring providers are not excluded from participation in federal health care programs;
    - Enrollment and disenrollment (two standards);
    - Subcontractual relationships and delegation;
    - Basic elements of the QAPI program (two standards); and
    - Quality evaluation processes.

Opportunities

- Based on the findings, areas of opportunity for improvement where four or more of eight MCOs did not fully meet requirements include the need to:
    - Improve care management practices related to assessments and member-centered plans (MCPs), with priority on the development of comprehensive MCPs; and
    - Ensure policies and processes are in place for provider credentialing, as well as the ongoing verification and monitoring of licensure and/or certification of providers.

Grievance Systems

Based on the data in bar graph G.1 above, the results for all eight MCOs in this area of review ranged from 29 to 32 points for the 16 standards in this review area. This indicates progress since last year's review, when scores ranged from 25 to 32 points.

The progress, strengths, and opportunities noted below are based on the findings, as indicated in table G.2, above:

Progress

- This year, two additional MCOs achieved full compliance with the Grievance Systems standards. Four MCOs have now fully met these requirements during the current three-year cycle.
- One MCO met requirements related to the content of notices issued to members.
- One MCO met requirements involving resolution and mediation of grievances and appeals.
- Three organizations achieved compliance with requirements regarding resolution timeframes.

- One MCO met requirements addressing disposition notices.
- One organization met requirements related to expedited resolution of appeals.
- One MCO met requirements regarding grievances and appeals record keeping and reporting.
- One organization met requirements involving reversed appeals.
- One MCO met requirements related to grievance and appeal committee composition and training.

Strengths

- All eight organizations have achieved compliance with standards in the following topic areas:
    - Definitions and general requirements;
    - Resolution and notification;
    - Expedited resolution of appeals;
    - Record keeping and reporting; and
    - Effectuation of reversed appeal resolutions.
- Seven of eight MCOs have met requirements related to:
    - Handling of grievances and appeals;
    - Information about grievance systems to providers; and
    - Continuation of benefits while the appeal is pending.

Opportunities

- An area of opportunity for improvement, where four of eight MCOs did not fully meet the requirements, is the need to ensure notices are issued to members and are issued in a timely manner, 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 15-16, the DHS-MCO contract required all MCOs to make active progress on at least one clinical or non-clinical project relevant to long-term care. Active progress was defined as progress to the point of having implemented at least one intervention and measured its effects on at least one indicator.

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

The study methodology is assessed through the following steps:

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

MCOs must seek DHS approval prior to beginning each project. For 2015, as in 2014, DHS required all projects to be conducted on a calendar year basis. For projects conducted during 2015, organizations submitted proposals to DHS in January 2015. DHS directed MCOs to submit final reports by December 30, 2015. MetaStar validated one or more PIPs for each organization, for a total of nine PIPs. More information about PIP Validation review methodology can be found in Appendix 3.

AGGREGATE RESULTS FOR PERFORMANCE IMPROVEMENT PROJECTS

The table on the next page lists each standard that was evaluated and indicates the number of projects meeting each standard. Some standards are not applicable to all projects due to study design, results, or implementation stage.

FY 15-16 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.	9/9
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.	9/9
Study Indicator(s)		
3	The study used objective, clearly and unambiguously defined, measureable indicators and included defined numerators and denominators.	8/9
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.	9/9
Study Population		
5	The project/study clearly defined the relevant population (all members to whom the study question and indicators apply).	7/9
6	If the entire population was used, data collection approach captured all members to whom the study question applied.	7/7
Sampling Methods		
7	Valid sampling techniques were used.	1/2
8	The sample contained a sufficient number of members.	1/2
Data Collection Procedures		
9	The project/study clearly defined the data to be collected and the source of that data.	8/9
10	Staff are qualified and trained to collect data.	9/9
11	The instruments for data collection provided for consistent, accurate data collection over the time periods studied.	8/9
12	The study design prospectively specified a data analysis plan.	9/9
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.	7/9
14	A continuous cycle of improvement was utilized to measure and analyze performance, and to develop and implement system-wide improvements.	8/9
15	Interventions were culturally and linguistically appropriate.	5/6
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.	8/9
17	Numerical results and findings were presented accurately and clearly.	8/9
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.	4/9
"Real" Improvement		
19	The same methodology as the baseline measurement was used, when measurement was repeated.	9/9
20	There was a documented, quantitative improvement in processes or outcomes of care.	4/9
21	The reported improvement appeared to be the result of the planned quality improvement intervention.	4/4
Sustained Improvement		
22	Sustained improvement was demonstrated through repeated measurements over comparable time periods.	3/3

Project Interventions and Outcomes

The table below lists each project, its aim, 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. Each project listed below applies to adults only.

Aim	Interventions	Outcomes	Validation Result	EQR Recommendations
MCO – Care Wisconsin				
Increase use of angiotensin-converting enzyme inhibitor (ACE) and angiotensin receptor blocker (ARB) therapy for members with diabetes and hypertension	Sent letters to primary care physicians (PCPs) encouraging ACE or ARB therapy. Modified registered nurse (RN) tracking tools, assessment templates, and hospital discharge processes.	Project did not demonstrate improvement.	Partially Met	Clearly present data sources and provide numerical results for all indicators. Ensure data collection tools provide for consistent and ongoing data retrieval. Describe study limitations and take into consideration in analysis of results.
Decrease incidents related to care transitions	Expanded the role of the care transitions support RN to provide coordinated care. Developed *Discharge Planning Best Practice Guide* and *Care Transitions Guide*. Continued to collaborate with county Care Transitions Coalitions.	Project did not demonstrate improvement.	Partially Met	Describe study limitations and take into consideration in analysis of results.
MCO – Community Care, Inc.				
Increase percent of members scoring "Not At Risk for Falls"	Educated staff regarding falls and how exercise can decrease risk for falls. Implemented a 12-week exercise program.	Project did not demonstrate quantitative improvement.	Partially Met	Address all aspects of the project in the report. Select an adequate and representative sample. Ensure interventions are sufficient to be expected to improve outcomes.

Aim	Interventions	Outcomes	Validation Result	EQR Recommendations
				Describe study limitations and take into consideration in analysis of results.
MCO – Community Care Connections of Wisconsin				
Decrease percent of female members over 18 with an intellectual disability who have not completed Pap screening	Educated staff, members, their representatives, and PCPs regarding the importance of cervical cancer screening. Developed tools with suggestions for making preventive screening less traumatic.	Project demonstrated "real" improvement: decreased the percentage of members in the study population who have never had a Pap test, from 54 percent to 41.5 percent. Also, demonstrated sustained improvement with repeat measures.	Met	Continue to sustain the level of improvement that has been achieved.
MCO - ContinuUs				
Increase percent of members with a physical disability who pursue integrated employment as an outcome	Developed toolkit for staff and member education.	Project demonstrated "real" improvement: increased the percentage of cohort members who pursued integrated employment, from 37 percent to 54 percent.	Met	Obtain repeat measures to demonstrate sustainability.
MCO – Independent Care Health Plan				
Decrease hospital readmission rate	Emphasized care coordination activities during 30 day post-discharge period. Developed structured documentation template to improve communication. Updated written guidance for IDT staff.	Project did not demonstrate improvement.	Partially Met	Select interventions which address root causes or barriers, and include complete documentation in the report. Fully analyze data and measure effectiveness of interventions.

Aim	Interventions	Outcomes	Validation Result	EQR Recommendations
MCO – Lakeland Care District				
Decrease member dissatisfaction with participation in the member-centered planning process	Educated IDT staff on member participation in the member-centered planning process.	Project demonstrated "real" improvement: decreased member dissatisfaction from a baseline of 15.7 percent to 10 percent.	Met	Ensure indicators are consistent throughout the report. Clearly describe data displayed in graphs and charts.
MCO – My Choice Family Care				
Increase percent of members participating in advance care planning discussions and increase percent of members with completed Advance Directive documents	Implemented a structured process of facilitated advance care planning conversations.	Project did not demonstrate quantitative improvement, as confidence in the data was limited.	Partially Met	Ensure inclusion of members in the project adheres to the defined study population. Utilize valid sampling techniques. Take study limitations into consideration in analysis.
MCO – Western Wisconsin Cares				
Reduce the average frequency of behavioral symptoms	Provided team consultation for review, enhancement, or creation of behavior support plans for members in the study population.	Project demonstrated "real" improvement: reduced the average frequency of behaviors by 6.9 percent.	Met	Obtain repeat measures to demonstrate sustainability.

CONCLUSIONS

All MCOs obtained approvals to conduct the required number of PIPs during calendar year 2015. Projects focused on a variety of topics, with five projects continuing from prior years, and four PIPs addressing new topics. At the time the projects were validated, organizations had made active progress in each of the nine approved projects. Four projects achieved documented, quantitative improvement which appeared to be the result of the interventions employed. Each of these projects fully met all applicable validation standards, and three of four demonstrated sustained improvement with repeat measures.

Strengths

- Study topics were selected based on MCO-specific data and needs analysis.
- Projects focused on improving a variety of key aspects of care and services for members.
- Projects were developed with clearly stated study questions and indicators.
- Most standards related to data collection procedures were met.

- Eight of nine projects effectively utilized continuous cycles of improvement.
- Four projects from four organizations met all validation standards and achieved improvement attributable to the implemented interventions.

Opportunities for Improvement

- Establish and adhere to a project timeframe, from submission of the proposal through analysis of data and completion of the report, which provides adequate time to achieve improvement.
- Clearly describe the study population and any changes made during the project.
- Ensure valid sampling techniques are employed and yield a representative sample.
- Develop interventions which are sufficient to be expected to improve outcomes.
- Fully analyze study data:
    - Identify any project limitations.
    - Include discussion and analysis of less than optimal results.
    - Take study limitations into consideration when interpreting the success of the project.

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 other mandatory review activities, including Performance Measure Validation (PMV), and ensures MCOs have the capacity to gather and report data accurately. To meet this requirement, each MCO receives an ISCA once every three years as directed by DHS. The ISCAs are conducted and reported separately.

The MCO quality indicators for measurement year (MY) 2015, which are set forth in Addendum V. of the 2015 Family Care Programs' contract with DHS, provide standardized information about preventive health services and continuity of care. As directed by DHS, MetaStar validated the completeness and accuracy of MCOs' influenza and pneumococcal vaccination data for MY 2015. The MY is defined in the technical definitions provided by DHS for the influenza and pneumococcal vaccination quality indicators. DHS updated the technical definitions in September 2015. 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.

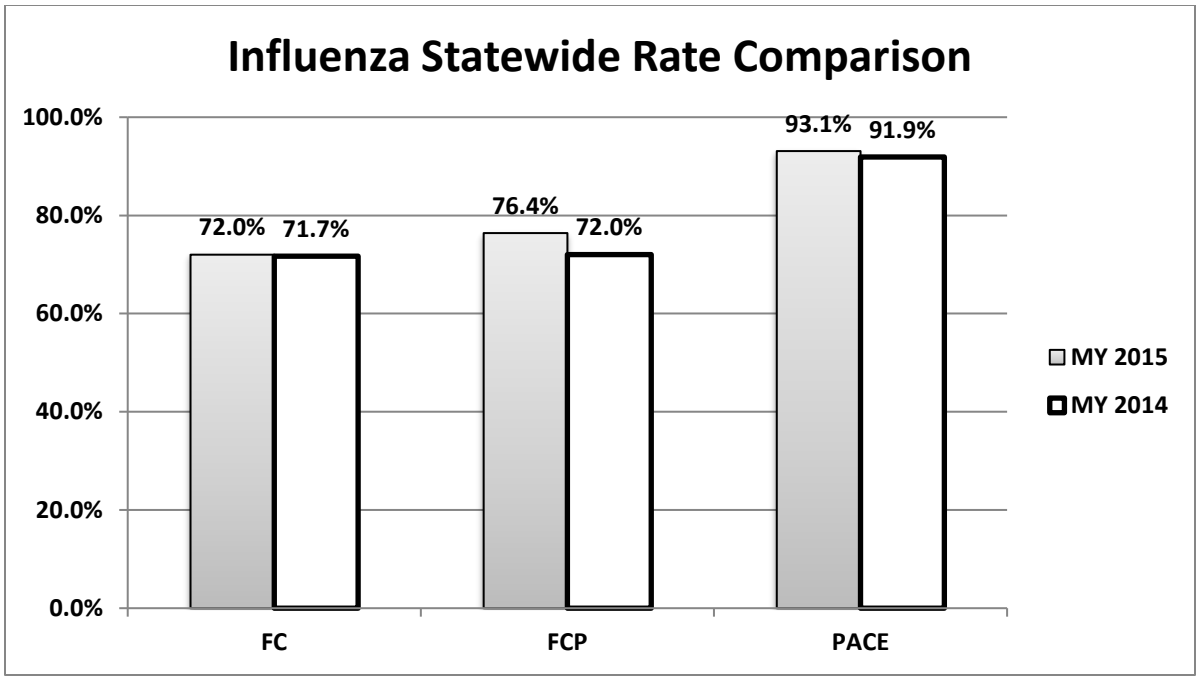
Influenza Vaccination Rates

The following table shows information about the influenza vaccination rates, by program, for MY 2015 and compares the 2015 rates to vaccination rates in MY 2014, which:

- Increased 0.3 percentage points for FC members;
- Increased 4.4 percentage points for FCP members; and
- Increased 1.2 percentage points for PACE members.

Statewide Influenza Vaccination Rates by Program				
	MY 2015			MY 2014
Program	Eligible Members	Number Vaccinated	Vaccination Rate	Vaccination Rate
Family Care	30,149	21,712	72.0%	71.7%
Family Care Partnership	2,247	1,717	76.4%	72.0%
PACE	505	470	93.1%	91.9%

Influenza statewide vaccination rates, by program, for MY 2015 and MY 2014 are shown in the following graph.



As shown in the table below, among MCOs that operate FC, the MY 2015 influenza vaccination rates ranged from 67.6 percent to 77.2 percent. Among MCOs that operate FCP, the MY 2015 rates ranged from 79.6 percent to 88.3 percent. The MY 2015 rate for the one MCO that operates the PACE program was 93.1 percent.

Influenza Vaccination Rates by Program and MCO in MY 2015 and MY 2014			
Program/MCO	**MY 2015 Rate**	**MY 2014 Rate**	**Percentage Point Change**
Family Care			
CCCW	67.6%	69.4%	(1.8%)
CCI	71.7%	69.8%	1.9%
ContinuUs	77.1%	74.3%	2.8%
CW	72.4%	74.4%	(2.0%)
LCD	77.2%	79.8%	(2.6%)
MCFC	70.0%	69.9%	0.1%
WWC	72.0%	71.9%	0.1%
Family Care Partnership			
CCI	88.3%	88.3%	0
CW	79.6%	71.7%	7.9%
*i*Care	61.7%	57.2%	4.5%
PACE			
CCI	93.1%	91.9%	1.2%

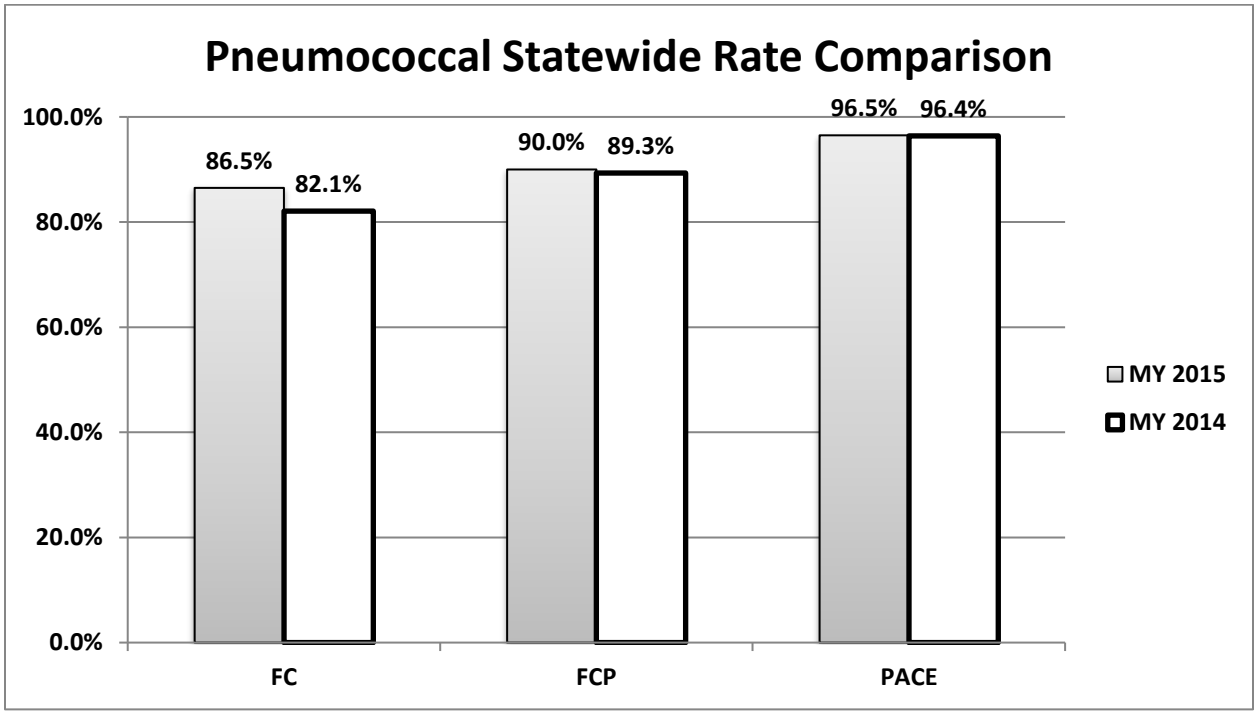
Pneumococcal Vaccination Rates

The table below shows information about the pneumococcal vaccination rates, by program, for MY 2015 and compares the 2015 rates to vaccination rates in MY 2014, which:

- Increased 4.4 percentage points for FC members;
- Increased 0.7 percentage points for FCP members; and
- Increased 0.1 percentage points for PACE members.

Statewide Pneumococcal Vaccination Rates by Program				
	MY 2015			MY 2014
Program	Eligible Members	Number Vaccinated	Vaccination Rate	Vaccination Rate
Family Care	14,634	12,656	86.5%	82.1%
Family Care Partnership	1,095	985	90.0%	89.3%
PACE	454	438	96.5%	96.4%

Pneumococcal statewide vaccination rates, by program, for MY 2015 and MY 2014 are shown in the following graph.



As shown in following table, among MCOs that operate FC, the MY 2015 pneumococcal vaccination rates ranged from 77.0 percent to 93.3 percent. Among MCOs that operate FCP, the MY 2015 rates ranged from 77.5 percent to 92.6 percent. The MY 2015 rate for the one MCO that operates PACE was 96.5 percent.

Pneumococcal Vaccination Rates by Program and MCO in MY 2015 and MY 2014			
Program/MCO	**MY 2015 Rate**	**MY 2014 Rate**	**Percentage Point Change**
Family Care			
CCCW	77.0%	72.4%	4.6%
CCI	85.2%	68.8%	16.4%
ContinuUs	92.7%	88.8%	3.9%
CW	84.1%	72.9%	11.2%
LCD	86.3%	86.7%	(0.4%)
MCFC	87.8%	84.6%	3.2%
WWC	93.3%	92.4%	0.9%
Family Care Partnership			
CCI	92.2%	88.7%	3.5%
CW	92.6%	91.2%	1.4%
*i*Care	77.5%	82.1%	(4.6%)
PACE			
CCI	96.5%	96.4%	0.1%

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. All MCOs' vaccination data were found to be compliant with the technical specifications for both quality indicators.

- All members who received the influenza vaccine did so between July 1, 2015 and March 31, 2016; and
- All members in the pneumococcal dataset were 65 or older on July 1, 2015.

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 98.1 percent of the total number of unique members included in MCOs' denominator files and DHS' denominator files were common to both data sets. However, it should be noted that one MCO was required to resubmit data because its initial submissions were outside the five percentage point threshold established by DHS. This means the MCO's submission was less than the 95 percent accuracy threshold between the DHS denominator file and the MCO denominator file.

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 2015. Whenever possible, the samples included 25 members reported to have received a vaccination and five members reported to have a contraindication to the vaccination. Five 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 330 member vaccination records for each quality indicator for MY 2015 and MY 2014. The overall findings for both years were not biased, meaning the rates can be accurately reported.

Vaccination Record Validation Aggregate Results

MY 2015 Influenza and Pneumococcal Vaccination Record Validation				
Quality Indicator	**Total Records Reviewed**	**Number Valid**	**Percentage Valid**	**T-Test Result**
Influenza Vaccinations	330	325	98.5%	Unbiased
Pneumococcal Vaccinations	330	322	97.6%	Unbiased

MY 2014 Influenza and Pneumococcal Vaccination Record Validation				
Quality Indicator	**Total Records Reviewed**	**Number Valid**	**Percentage Valid**	**T-Test Result**
Influenza Vaccinations	330	315	95.4%	Unbiased
Pneumococcal Vaccinations	330	319	96.7%	Unbiased

Vaccination Record Validation MCO Results

The following tables provide information about the validation findings for each MCO in MY 2015.

Results for Influenza Vaccination

MY 2015 Influenza Vaccination Record Validation by Program and MCO				
MCO	**Total Records Reviewed**	**Number Valid**	**Percentage Valid**	**T-Test Result**
Family Care				
CCCW	30	30	100%	Unbiased
CCI	30	30	100%	Unbiased
ContinuUs	30	30	100%	Unbiased
CW	30	30	100%	Unbiased
LCD	30	30	100%	Unbiased
MCFC	30	30	100%	Unbiased
WWC	30	25	83.3%	Biased

Family Care Partnership				
CCI	30	30	100%	Unbiased
CW	30	30	100%	Unbiased
*i*Care	30	30	100%	Unbiased
PACE				
CCI	30	30	100%	Unbiased

Results for Pneumococcal Vaccination

MY 2015 Pneumococcal Vaccination Record Validation by Program and MCO				
MCO	**Total Records Reviewed**	**Number Valid**	**Percentage Valid**	**T-Test Result**
Family Care				
CCCW	30	30	100%	Unbiased
CCI	30	26	86.7%	Biased
ContinuUs	30	30	100%	Unbiased
CW	30	30	100%	Unbiased
LCD	30	30	100%	Unbiased
MCFC	30	27	90.0%	Unbiased
WWC	30	29	96.7%	Unbiased
Family Care Partnership				
CCI	30	30	100%	Unbiased
CW	30	30	100%	Unbiased
*i*Care	30	30	100%	Unbiased
PACE				
CCI	30	30	100%	Unbiased

CONCLUSIONS

- Influenza vaccination rates declined between MY 2015 and MY 2014 for three MCOs. However, the statewide influenza vaccination rate increased for all three programs.
- The overall statewide pneumococcal vaccination rate increased for all three programs.
- For FC, one MCO had biased record review results for the influenza vaccination, and another MCO had biased record review results for the pneumococcal vaccination.
- Record review results for FCP and PACE were unbiased for both vaccinations. A finding of unbiased means the results can be accurately reported.

Information Systems Capability Assessment

ISCAs are a required part of other mandatory EQR protocols, such as compliance with standards and PMV, and help determine whether MCOs' information systems are capable of collecting, analyzing, integrating, and reporting data. ISCA requirements are detailed in 42 CFR 438.242, the DHS-MCO contract, and other DHS references for encounter reporting and third party claims administration. DHS assesses and monitors the capabilities of each MCO's information system as part of initial certification, contract compliance reviews, or contract renewal activities, and directs MetaStar to conduct the ISCAs every three years.

During FY 15-16, MetaStar conducted ISCAs for three MCOs selected by DHS. Two MCOs operate only a FC program, and the other operates both FC and FCP programs.

To conduct the assessment, each MCO (and its vendors, if applicable) completed a standardized ISCA tool, and provided data and documentation to describe its information management systems and practices. Reviewers evaluated this information and visited each MCO to conduct staff interviews and observe demonstrations. See Appendix 3 for more information about the review methodology.

Summary of Aggregate Results

This review evaluated the following categories: general information; information systems - encounter data flow; claims and encounter data collection; eligibility; practitioner data processing; system security; vendor oversight; medical record data collection; business intelligence; and performance measurement.

Section I: General Information

All three MCOs provided the required general information. One MCO transitioned its previously internal claims processing system to an external third party administrator (TPA), which spurred a re-design and re-alignment of the remaining in-house functions and systems. One MCO transitioned towards greater utilization of third party vendors and systems, and expects its information technology functions to become more distributed as expansions continue.

Section II: Information Systems - Encounter Data Flow

Two MCOs met all requirements for this section and one MCO met nearly all requirements for this section. One MCO uses in-house staff to create encounter records. This MCO identified an internal risk to be the recent 42 percent turnover rate with staff programmers. In an effort to mitigate the risk, the MCO utilizes contracted staff for limited functions. Two MCOs rely on a TPA to create encounter files, using DHS specifications and requirements, and submit the files to DHS. All three MCOs indicated a smooth transition from International Classification of Diseases (ICD) version 9 to ICD-10.

Section III: Claims and Encounter Data Collection
Two MCOs met all requirements for this focus area and one MCO met nearly all requirements for this focus area. One MCO has a high proportion of dually eligible members, due in part to its FCP program. As a result, a high rate of cross-over claims exists and auto-adjudication rates are low; the MCO is working on ways to increase the rates to align with DHS' good practice guidelines. One MCO should begin to track resolution timeliness of pending claims/encounters.

Section IV: Eligibility
Two MCOs met all requirements in this area and follow DHS guidelines for enrollment processing. One MCO met most of the requirements and is in the midst of increasing interoperability between two systems that contain enrollment data. The MCO should test and monitor its new and restructured systems and processes to assure smooth updates in data processing.

Section V: Practitioner Data Processing
All three MCOs met expectations in this area.

Section VI: System Security
All three MCOs met expectations in this area.

Section VII: Vendor Oversight
All three MCOs met expectations in this area.

Section VIII: Medical Record Data Collection
This section does not apply to any MCO as they do not collect or analyze medical records for encounter reporting purposes.

Section IX: Business Intelligence
All three MCOs met expectations in this area.

Section X: Performance Measurement
All three MCOs met expectations in this area.

CONCLUSIONS

Overall, the reviews found that all three MCOs have the basic systems, resources, and processes in place to meet DHS' requirements for oversight and management of services to members and support of quality and performance improvement initiatives.

Progress

All three organizations demonstrated progress by working with providers to increase the use of standardized claim forms. The MCOs demonstrated progress in different areas of the review as follows:

- One MCO implemented email encryption software, created and tested a comprehensive disaster recovery plan for the main site and three hubs, and documented the training plans and frequency of updates related to security/confidentiality.
- One MCO implemented enhanced policies and procedures to identify disbarred providers and for checking and updating other insurance of members, and created an enrollment flowchart.
- One MCO improved policies and procedures for maintaining and updating provider information on provider databases and enhanced visitor security arrangements.

Strengths

The FY 15-16 ISCA review found the MCOs exhibited strengths in the following areas:

- Three MCOs proactively monitored vendor relationships and capabilities, and maintained frequent communications to promptly identify and resolve issues.
- Three MCOs utilize analytic data to evaluate systems' performance.
- One MCO established an automatic update process when a provider file is extracted to add/insert the national provider identifier or tax identification number in the event this identifier is missing.
- Two MCOs established support mechanisms to ensure timely provider payments.
- One MCO created a mobile device manager position, responsible for mobile security, to accommodate the expanding utilization of mobile devices by its decentralized staff.
- One MCO implemented processes to test a live production file and anticipate effect of impact before submitting to DHS.
- One MCO established a help desk for providers to call to discuss issues related to filing claims, including the proper use of forms and codes as well as the timelines for submission.
- One MCO significantly increased the number of electronic claims as the result of the switch to utilizing a TPA.
- One MCO implemented software to monitor and audit user access roles.

Opportunities for Improvement

The MCOs' information systems are architected and implemented in their own way; therefore, the opportunities are individualized to each MCO as follows:

- One MCO should continue to work with Aging and Disability Resource Centers (ADRCs) to ensure that notifications of enrollment are received prior to the start date, in

the few instances when this does not occur, and continue to consider the deployment of security and privacy precautions for the expanding use of mobile devices for accessing information systems.

- One MCO should:
    - Enhance data editing, linking, and matching across systems and functions;
    - Document in its flowchart the data exchange and subsystems/functions that are responsible for the various processes in the overall information system;
    - Ensure vaccination data submitted to DHS and MetaStar for PMV conform to DHS technical guidelines for the correct inclusion of members in both denominator and numerator; and
    - In advance of PMV, test processes to ensure the MCO's list of eligible members is accurate.
- One MCO should:
    - Consider creating and maintaining a security access matrix by function, unit, and other applicable parameters, instead of relying on ad hoc arrangements and contingencies when staff are hired or change position;
    - Continue to minimize professional information technology staff turnover rates to minimize potential disruptions to systems operations;
    - Increase the proportion of auto-adjudicated claims. In the FCP program, the auto-adjudication rates are particularly low, due to a higher proportion of dually eligible Medicare-Medicaid members;
    - Conduct a primary source check for practitioner credentialing on a sample of providers to verify vendor credentialing findings; and
    - Document, through policies and/or procedures, processes for the following:
        - Training for encounter data file creation. Best practice documentation would include a comprehensive flowchart of the process, and training modules and outcomes to demonstrate proficiency;
        - Creating reports for results of any reconciliation with source systems and data entry audits;
        - Retaining records beyond the record retention schedule; and
        - Ensuring timely entry of data into a credentialing system and the claims processing system.

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

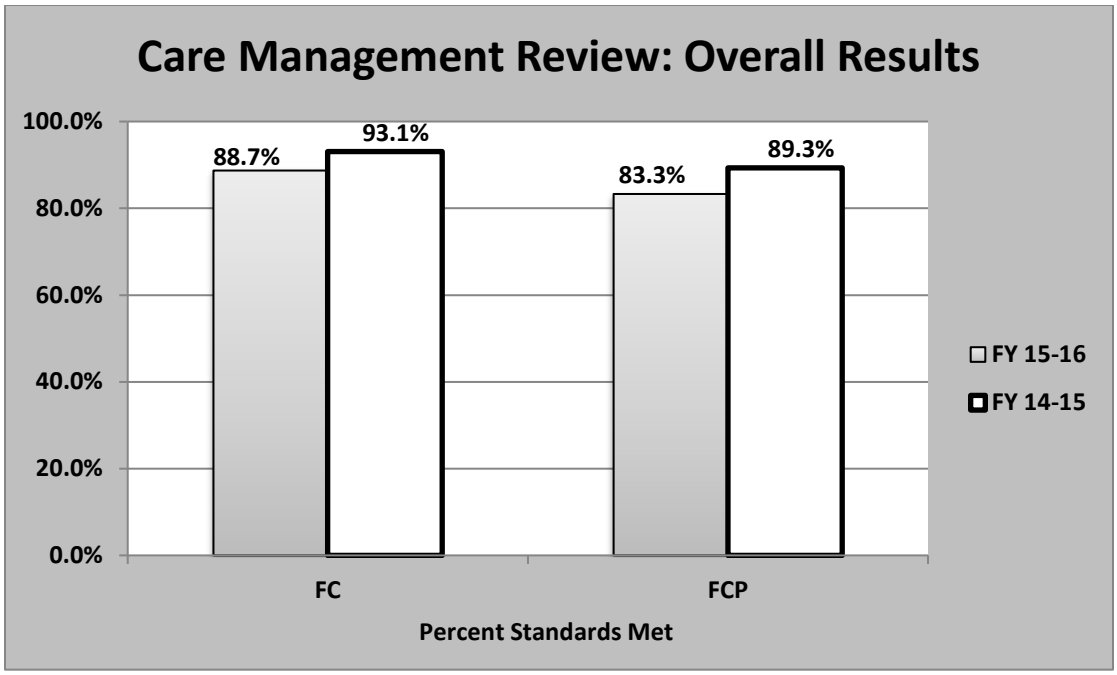
The four categories include a total of 14 review indicators. More information about the CMR review methodology can be found in Appendix 3.

Aggregate results for FY 15-16 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 graph shows the overall percent of standards met for all review indicators for CMRs conducted during the FY 15-16 review year for organizations operating programs for FC and FCP. FY 14-15 results are provided for comparison. As noted earlier in this report, MetaStar did not conduct a PACE CMR in FY 15-16, as 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.



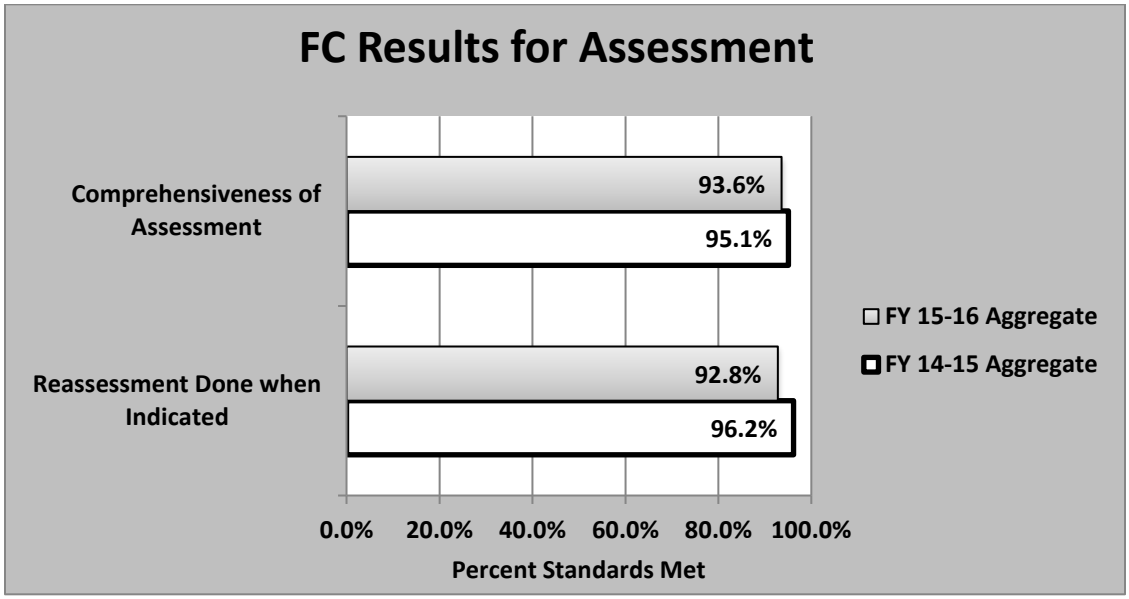
Results for each CMR Focus Area

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 15-16 CMR results by program (FC, FCP) for each review indicator that comprises the category. FY 14-15 results are provided for comparison. As noted above, MetaStar did not conduct CMR for PACE in FY 15-16.

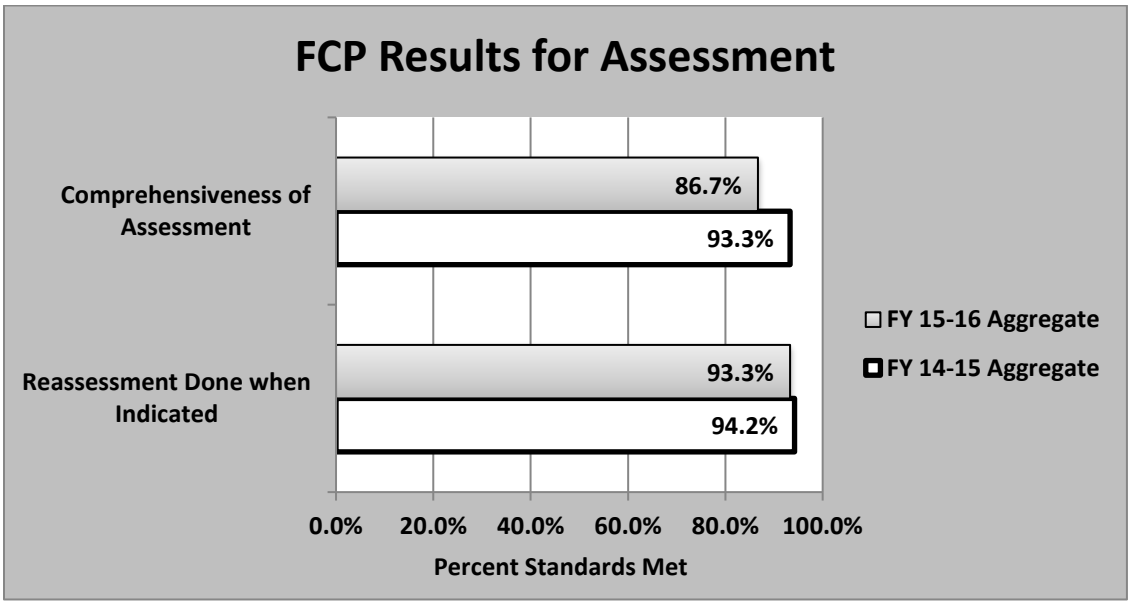
Assessment Focus Area

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:

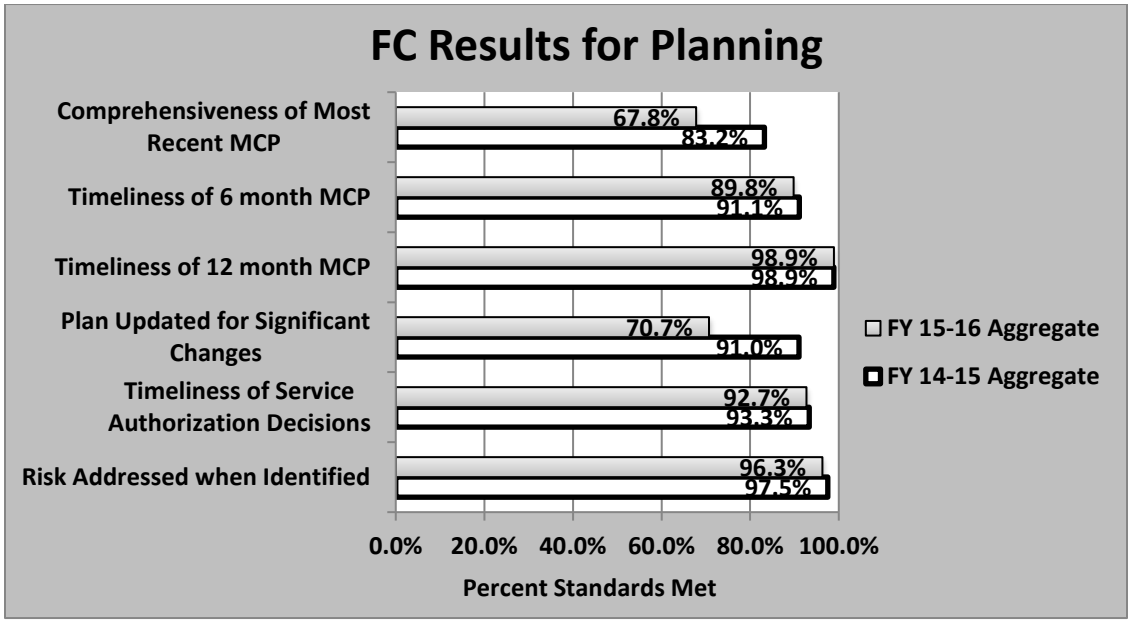


CARE PLANNING FOCUS AREA

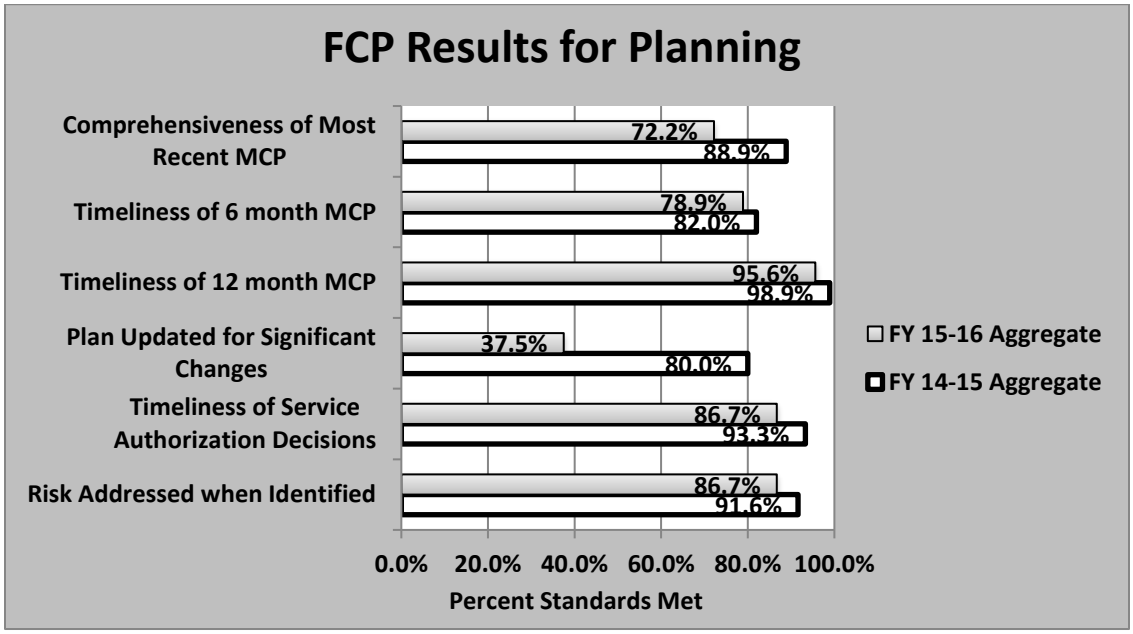
The MCP and Service Authorization document must identify all services and supports to be coordinated consistent with information in the comprehensive assessment, and must be developed and updated according to the timelines and conditions described in the DHS-MCO contract. Additionally, the record must 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.

Results for Care Planning for MCOs Operating FC:



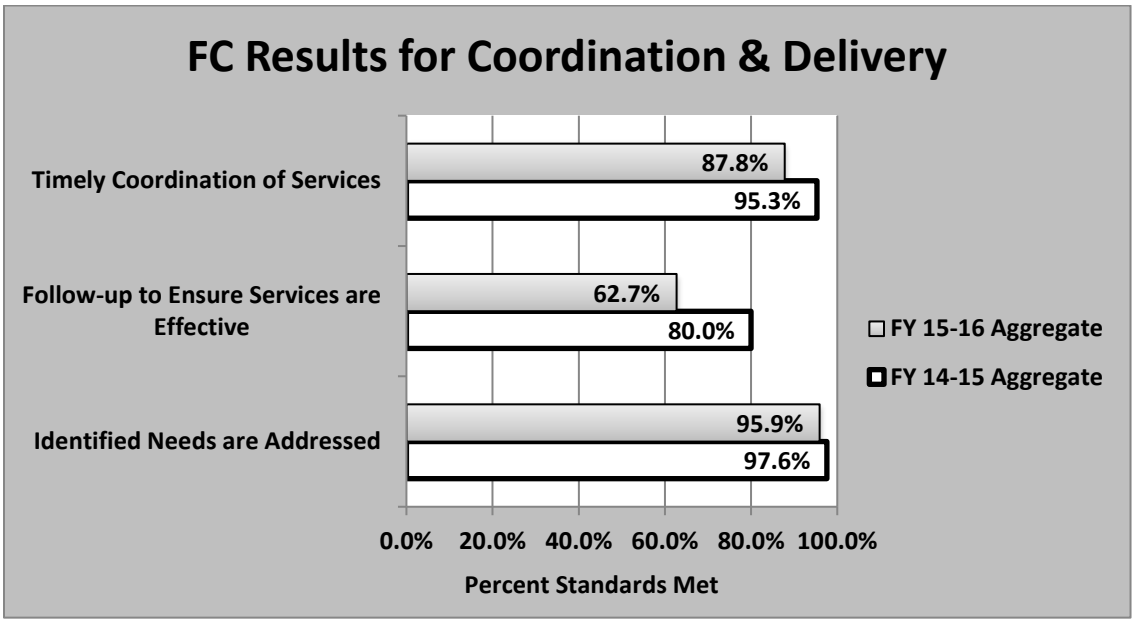
Results for Care Planning for MCOs Operating FCP:



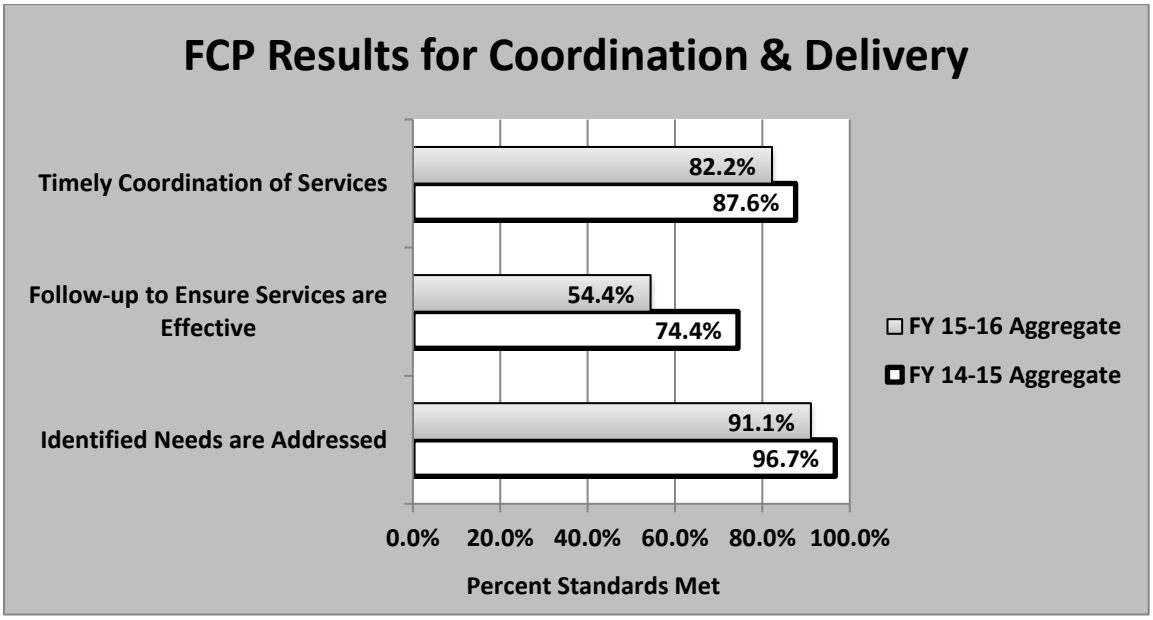
Coordination and Delivery Focus Area

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:

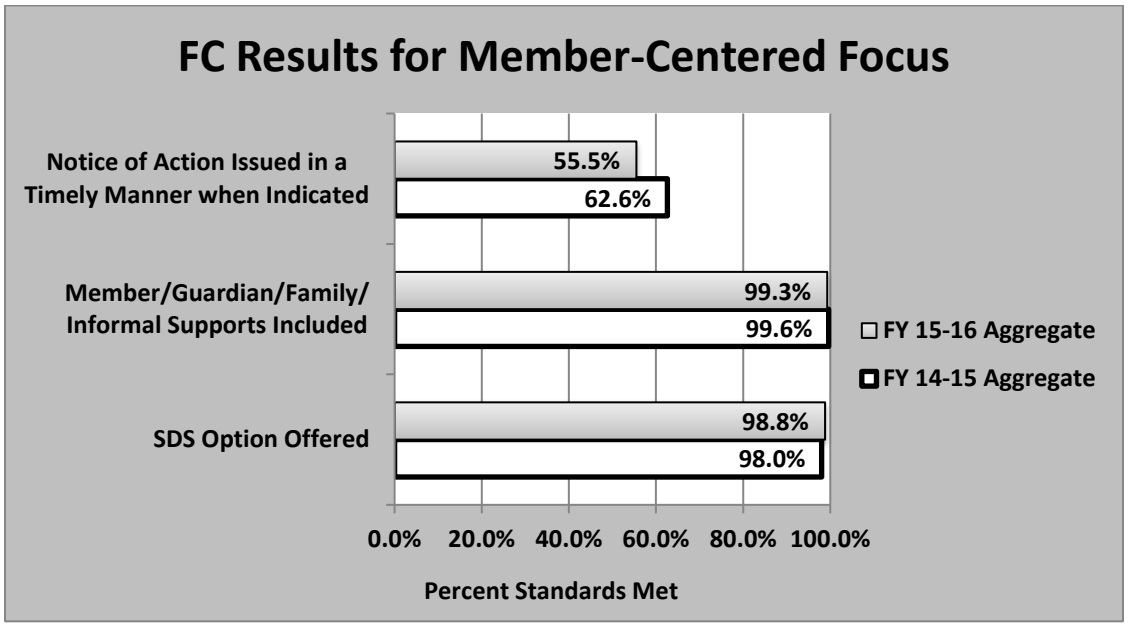


Member-Centeredness Focus Area

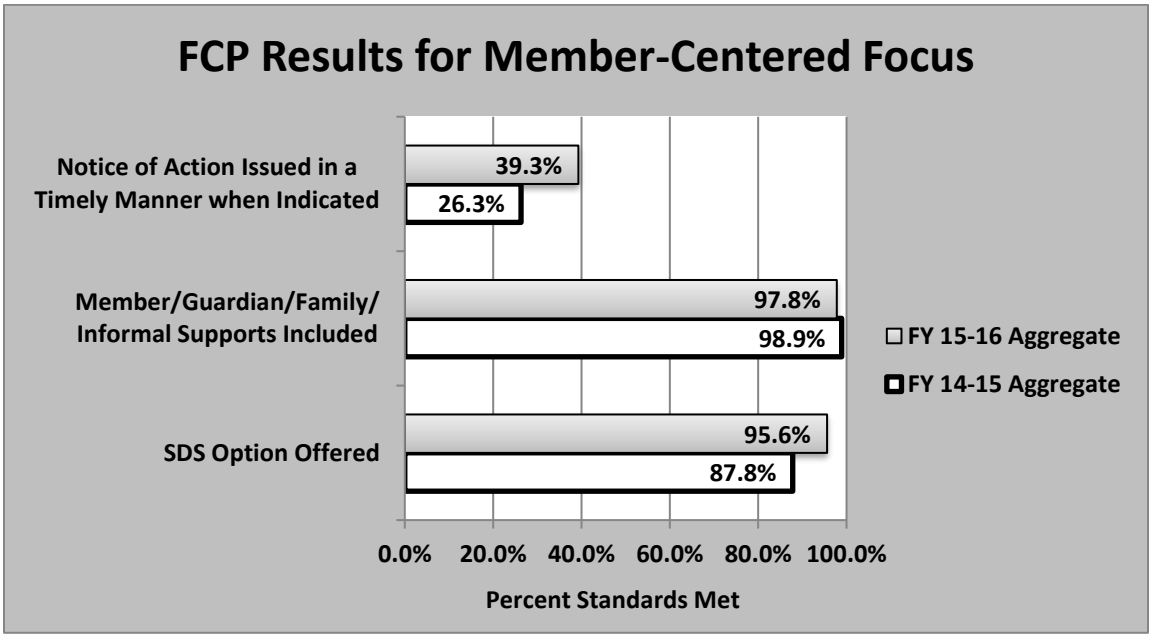
The record should document the IDT staff includes the member and his/her supports in care management processes; that staff protects member rights by issuing notices in accordance with requirements outlined in the DHS-MCO contract; and that the self-directed supports (SDS) option has been explained and 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 "no" (meaning the indicator was not met).

Results for Member-Centered Focus for MCOs Operating FC:



Results for Member-Centered Focus for MCOs Operating FCP:



CONCLUSIONS

The FY 15-16 CMR overall results for both FC and FCP declined since last year's review. Analysis indicated the year-to-year difference in the overall rate for both programs was unlikely to be the result of normal variation or chance. MetaStar did not identify progress for either program in FY 15-16.

Strengths

- In FY 15-16, FC programs maintained aggregate results over 90 percent for the following review indicators. The aggregate results for these indicators were also over 90 percent in FY 14-15:
    - "Comprehensiveness of Assessment;"
    - "Reassessment Done when Indicated;"
    - "Timeliness of 12 Month MCP;"
    - "Timeliness of Service Authorization Decisions;"
    - "Risk Addressed when Identified;"
    - "Identified Needs are Addressed;"
    - "Member/Guardian/Informal Supports Included;" and
    - "SDS Option Offered."
- In FY 15-16, FCP programs maintained aggregate results over 90 percent for the following review indicators. The aggregate results for these indicators were also over 90 percent in FY 14-15:

- "Reassessment Done when Indicated;"
- "Timeliness of 12 Month MCP;"
- "Identified Needs are Addressed;" and
- "Member/Guardian/Informal Supports Included."

Opportunities

- For FC, the overall rate of compliance for five review indicators declined, and analysis indicated the year-to-year difference in the results was unlikely to be due to normal variation or chance. Readers should note that one of the review indicators with declining results, "Reassessment Done when Indicated," was also noted as a strength above. While aggregate results for this indicator were over 90 percent in each of the last two years, the rate of compliance declined from 96.2 percent in FY 14-15 to 92.8 percent in FY 15-16. FC has the opportunity to identify causes for the decline for all five of these review indicators, and implement needed improvement efforts:
  - "Reassessment Done when Indicated;"
  - "Comprehensiveness of Most Recent MCP;"
  - "Plan Updated for Significant Changes;"
  - "Timely Coordination of Services;" and
  - "Follow-up to Ensure Services are Effective."
- For FCP, the overall rate of compliance for three review indicators declined, and analysis indicated the year-to-year difference in the rates was unlikely to be the result of normal variation or chance. FCP has the opportunity to identify causes for the decline and implement needed improvement efforts in the following areas of CMR results:
  - "Comprehensiveness of Most Recent MCP;"
  - "Plan Updated for Significant Changes;" and
  - "Follow-Up to Ensure Services are Effective."
- In addition, for both programs, "Notice of Action Issued in a Timely Manner when Indicated" remains an area of opportunity for improvement. As noted in last year's annual technical report, this has been a long-standing area of concern.

ANALYSIS

TIMELINESS, ACCESS, QUALITY

The CMS guidelines regarding this annual technical report direct the EQRO to provide an assessment of the MCOs' strengths and weaknesses with respect to quality, timeliness, and access to health care services. A high level of compliance with these review activities provides assurances that MCOs are meeting requirements related to access, timeliness, and quality. The analysis included in this section of the report, along with each MCO's summary of findings located in Appendix 2, are intended to provide that assessment. The executive summaries in Appendix 2, which are taken from each MCO's FY 15-16 annual EQR report, include MetaStar's assessment of key strengths and recommendations for improvement for each MCO.

As noted earlier in this report, QCR follows a three-year cycle. The first year MetaStar conducts a comprehensive review, where all QCR standards are assessed for each MCO. This is followed by two years of targeted review where, for each MCO, only those standards not fully met the previous year are reassessed. FY 15-16 was the second year of the three-year cycle; a targeted review year. Starting with the FY 14-15 review year, MetaStar began scoring the QCR standards using a point system. Forty-four standards apply to every organization, and carry a maximum possible score of 88 points. The overall score for an organization is cumulative during each year of the three-year cycle. While individual MCO results varied, every organization made some progress in its overall QCR results in FY 15-16. Seven of eight organizations have achieved cumulative scores over 80 points, out of the total possible 88. The scores of all eight organizations ranged from 71 to 87 points.

The validation of PIPs indicated four different organizations conducted four methodologically sound projects which achieved improvement in member care. All eight MCOs demonstrated active progress in all nine projects reviewed. It is difficult to identify progress in aggregate, as project topics and study populations vary widely across organizations. Also, some projects are continued from one year to the next.

The validation of two performance measures, influenza and pneumococcal vaccination rates, found all eight MCOs' vaccination data to be compliant with the technical specifications for both quality indicators. The overall validation findings were not biased for either indicator, meaning the vaccination rates can be accurately reported.

ISCAs conducted for three MCOs found all three organizations to have the basic systems, resources, and processes in place to meet DHS' requirements for oversight and management of services to members and support of quality and performance improvement initiatives.

CMR aggregate results for FC showed compliance rates over 90 percent for eight of 14 CMR standards. Aggregate results for FCP showed compliance rates over 90 percent for five standards. However, the overall rate of compliance with all of the CMR standards declined for both programs, and MetaStar's analysis indicated the year-to-year decline in the rates was not likely attributable to normal variation or chance.

Quality Compliance Review

Enrollee Rights and Protections

This area of review consists of seven standards applicable to every organization, and one additional standard applicable to organizations operating FCP and PACE. The standards address members' general rights, such as the right to information, as well as specific rights related to dignity, respect, and privacy.

Last year, two MCOs fully met the requirements for all of the standards in this area of review. The remaining six MCOs did not fully meet the requirements in some areas, and individual results ranged from one to four "partially met" standards. FY 14-15 aggregate findings identified two areas in need of improvement: notifying affected members regarding the termination of a contracted provider, and use of restrictive measures. These were among the Enrollee Rights standards reassessed in this year's EQR. FY 15-16 results showed progress related to notifying members about a provider termination. Compliance with requirements surrounding use of restrictive measures remains an area for improvement.

MCOs are required to make a good faith effort to give timely written notice to members who will be affected by the termination of a service provider from the organization's provider network. Last year, five organizations did not fully meet this requirement. This year, three of the five organizations fully met this standard. The results indicated that all five organizations had acted upon recommendations from last year's review by developing written policies, procedures, and/or template letters to be used for notifying members. However, the new policies and processes were not considered fully implemented at two organizations, as reviewers were unable to confirm that related training/education had been completed for all affected staff. These MCOs were advised to ensure the policy and procedure has been reviewed with all affected staff and is fully implemented.

Members' specific rights include the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. Last year, four MCOs did not fully meet this requirement. The restrictive measures tracking logs of these organizations showed members whose renewal applications had not been submitted to DHS in a timely manner, and members' restrictive measures plans had expired without new, approved plans in place. Recommendations included the need to conduct analysis, identify barriers, and implement strategies to improve the timeliness of restrictive measures plan renewals. This year, all four

MCOs again received scores of "partially met" for this standard, as each organization's tracking log continued to document instances where restrictive measure renewal applications were not submitted to DHS in a timely manner and members' restrictive measures plans were expired. Reviewers noted variability from organization to organization in the restrictive measures log format and the level of information documented for use in tracking and monitoring.

The documentation submitted by MCOs and discussions with staff indicated the organizations took varying levels of action and used different approaches to try and make progress in this area. Following are some examples of the actions taken:

- One organization made significant revisions to its *Restrictive Measures* policy and procedure. The changes clarified or added guidance for staff and providers in several areas, such as requirements for both initial and renewal applications, timeliness criteria for restrictive measures renewal applications, expectations regarding monitoring and documentation, and other guidance. (Prior to its revision, the MCO's policy and procedure had not clearly described the process for annual review and approval of restrictive measures, which was a contributing factor to its "partially met" score in last year's review.)
- The restrictive measures lead at this same organization reported recently instituting weekly telephone calls to work one-on-one with staff in one of its care management units serving the bulk of its members with restrictive measures. During the weekly calls, the lead staff answers questions regarding restrictive measures and renewal applications, helps work through problems, and monitors progress.
- Another organization reported adding a staff member from the provider network department to its restrictive measures committee, to facilitate communication and coordination with providers related to restrictive measures requirements, such as submission of needed documentation.
- A third organization implemented a procedure which assigns a quality program specialist the responsibility to notify and monitor providers regarding submission of restrictive measure plan renewals. Reviewers noted the procedure contains detailed steps, timelines, and email templates for notifying providers as well as care management staff, the restrictive measures lead, and others.

One MCO had made minimal progress in improving the timeliness of restrictive measures renewal applications since last year's review. MetaStar recommended this organization place priority on identifying the causes and contributing factors related to the lack of timely submission of restrictive measures plan renewals, develop and implement an action plan based on the results of analysis, and closely monitor the plan to ensure its effectiveness. The other three MCOs received a recommendation to conduct analysis, continue to identify barriers, and take further action, as needed, to improve timeliness.

Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement

The standards covering this broad area of review can generally be divided into three areas: access to services and provider network; care coordination and service authorization; and quality assessment and performance improvement. The focus area consists of a total of 21 standards. Last year, results for seven of eight MCOs ranged from two to six "partially met" scores, while one organization had 16 standards which were "partially met." Results from FY 15-16 show most MCOs made progress.

FY 14-15 aggregate findings identified three standards needing the most improvement. These related to ensuring disenrollment policies include all required aspects, conducting assessments and developing MCPs, and implementing consistent policies and procedures for selection and credentialing of providers. Most organizations achieved compliance with disenrollment policies; however, no progress was noted for the other two standards.

MCOs must comply with enrollment and disenrollment requirements and limitations, including the requirement to have in place written policies and procedures that identify the impermissible reason for disenrollment. Of the seven MCOs that had not previously met this standard, six organizations effectively revised and implemented policies or procedures to include the necessary information. One MCO that did not meet this standard developed and disseminated a policy; however, the policy did not include any procedures to guide staff and ensure consistent practice.

Organizations must have mechanisms in place for assessing members and developing plans of service based on the assessments. Last year, five organizations did not fully meet this standard. CMR results indicated four of the MCOs needed to improve comprehensiveness of members' assessments and member-centered plans, as well as other related aspects of care management practice. One organization's policy did not align with contract-required timeframes. This year, all five MCOs again received scores of "partially met" for this standard. One MCO's policy was updated to align with requirements; however, its CMR results showed a declining trend in MCP measures. All five organizations' CMR scores showed a continuing need for improvement related to comprehensiveness of MCPs; some also indicated opportunities to improve other aspects of assessment or planning. The MCOs all implemented interventions such as training or utilization of written guidance, though had not yet demonstrated consistent improvement.

Maintaining a network of appropriate and qualified service providers requires having systems and processes in place related to provider selection, retention, and credentialing. In FY 14-15, four organizations did not fully meet this standard. While each organization took some action to address MetaStar's recommendations, the document review and provider file verification activity again identified inconsistencies and discrepancies with provider credentialing processes.

This year, all four organizations again received "partially met" scores. Some of the issues identified included:

- Lack of consistent application of policies, such as instances of expired contracts;
- Procedures not fully or effectively implemented to ensure providers have or maintain current licensure or certification;
- Discrepancies between services the providers are contracted to provide and licensures obtained; and
- Revised policies or procedures which have not been fully implemented.

In addition to the standards prioritized for improvement discussed above, further observations are described below.

Access to Services and Provider Network

Ten standards address requirements related to service access covering the adequacy of the service delivery network: provider selection, retention, and credentialing; subcontracting and delegation; timely access to care and services; cultural competency in service provision; and processes for timely enrollment/disenrollment.

With the progress achieved during FY 15-16, four of eight organizations now fully meet all of these ten standards. The four remaining MCOs should address recommendations related to provider credentialing, as discussed above. Three of those four organizations also lack full compliance with other standards related to the service delivery network related to ensuring:

- Adequacy of the service delivery network;
- Timely access to care and services;
- Contracted providers are not excluded from participation in federal health care programs; and
- Compliance with background check requirements.

The EQR found the MCOs' related processes either did not collect enough data, or did not fully evaluate information available to demonstrate compliance.

Care Coordination and Service Authorization

Five standards address requirements related to coordination and continuity of care, coverage and authorization of services, and practice guidelines. Two organizations achieved progress by meeting standards focused on coordination of care and authorization of services. No progress was noted regarding requirements to adopt, disseminate, and apply practice guidelines; two MCOs received "partially met" scores. Both developed or revised policies and procedures and have information available for providers on its MCO website, but did not fully meet requirements, including ensuring providers were aware of or had access to the guidelines.

Quality Assessment and Performance Improvement

Five standards address requirements that MCOs have in place a QAPI program, and that they maintain a health information system that collects, analyzes, and reports data. This area was identified as a strength in last year's review, with six of eight organizations meeting at least four of five standards. Progress was noted during the FY 15-16 review, as two organizations met standards related to:

- Meeting QAPI program structure and minimum requirements;
- Having mechanisms in place to assess the quality and appropriateness of care; and
- Conducting an evaluation of the effectiveness of the QAPI program.

Now, five MCOs meet all requirements of this section, and two MCOs meet four of five standards. MetaStar's review again identified strengths among these organizations, such as demonstrating an organization-wide culture of continuous improvement, and consistently utilizing data, analysis, and monitoring to improve member care. The remaining organization did not make progress and received a recommendation to place priority on improving the MCO's QAPI program.

Grievance Systems

This area of review consists of sixteen standards applicable to all organizations. The standards comprising this area of review address requirements that MCOs maintain an effective system for members to exercise their rights related to grievances and appeals. Most organizations evaluated during FY 15-16 made progress in this area.

Last year, two MCOs fully met the requirements for all of the standards in this area of review. The remaining six MCOs did not fully meet requirements in some areas, with individual results ranging from one to seven "partially met" standards. This year's review confirmed two additional MCOs have achieved full compliance with the grievance systems standards. Results for the remaining four MCOs ranged from one to three "partially met" standards.

Two areas identified last year in which three or more organizations needed to focus improvement efforts were around timely disposition of local appeals and grievances and timely issuance of notices of action. Results in FY 15-16 showed improvement with timely disposition of local appeals and grievances. Further improvement efforts are needed regarding the issuance of notices of action.

Organizations are required to dispose of all appeals and grievances at the organizational level within 20 business days. An additional 10-day extension may be granted in certain circumstances. Last year's review identified five MCOs had met this standard, while three organizations did not fully meet the requirements. Verification activities conducted by MetaStar during FY 15-16 confirmed these three organizations are disposing of local appeals and grievances in the required timeframes. All eight organizations have now fully met this standard.

Notices of action are required to be issued within required timeframes. Last year's review identified four organizations that did not fully meet this requirement. This year's review again showed all four organizations are not fully compliant in this area. CMR results in this area remained low. Actions taken did not result in sustained improvement. Review activities showed that all four organizations should focus monitoring efforts to ensure that notices of action are issued as required, which may improve results in care management reviews.

Three standards relate to the handling of grievances and appeals. The DHS-MCO contract identifies several requirements for grievance and appeal processes as well as the composition and functioning of the grievance and appeal committee. Results from last year's review showed two MCOs did not have processes in place to fully meet all of the requirements for different reasons. The FY 15-16 results confirmed one MCO has revised and implemented policies to reflect the requirements and has now fully met all three of these standards.

For the other MCO, one standard remains partially met; documentation submitted by the organization did not consistently align with an aspect of the requirements to include a program member on the committee.

Since last year's review individual MCOs made progress related to other grievance systems standards. The results for FY 15-16 showed every MCO has now fully met 12 of the 16 grievance systems standards.

Validation of Performance Improvement Projects

MCOs must have an ongoing program of PIPs designed to achieve improvement in clinical and nonclinical aspects of care. Annually, MetaStar validates projects conducted by all MCOs. For 2015, DHS required organizations to make active progress on at least one project. Eight MCOs submitted a total of nine projects for validation. A variety of study topics were selected based on MCO priorities and data analysis.

Beginning in calendar year 2014, DHS implemented a required timeframe for project approval and final report submissions. For calendar year 2015, proposals were submitted to DHS in January 2015, with final reports for validation due by December 30, 2015.

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.

Organizations achieved active progress in each project, by implementing at least one intervention and measuring its effectiveness. Four of nine projects resulted in quantitative improvement which appeared to be the result of the interventions employed. Each of these projects fully met all applicable validation standards, demonstrating they were designed and conducted in a methodologically sound manner. Four different organizations conducting these four projects improved member care related to a variety of important aspects of care:

- Preventive screening for members with an intellectual disability;
- Integrated employment for members with a physical disability;
- Member-centered planning; and
- Frequency of behavioral symptoms.

Of the remaining five projects which did not attain quantitative improvement, two demonstrated difficulties with definition of the study population and use of sampling methods. Reviewers noted that all five projects had limitations or barriers to improvement which were not successfully addressed or taken into consideration in the analysis of results. In some cases, the limited time between the receipt of project approval and the final report submission deadline may have contributed to the lack of improvement, as well.

Validation of Performance Measures

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

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

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 98.1 percent of the total number of unique members included in MCOs' denominator files and DHS' denominator files were common to both data sets. However, it should be noted that one MCO was required to resubmit data because its initial submissions were outside the five percentage point threshold established by DHS.

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 2015. Whenever possible, the samples included 25 members reported to

have received a vaccination and five members reported to have a contraindication to the vaccination. Five MCOs operated programs for which no members were reported as having contraindications for either one or both of the quality indicators.

MetaStar reviewed a total of 330 member vaccination records for each quality indicator for MY 2015 and MY 2014. The overall findings for both years were not biased, meaning the rates can be accurately reported.

MCOs also vary with regard to tracking and reporting vaccination exclusions and refusals. As a result, MetaStar made recommendations to evaluate these situations to identify actionable plans to improve vaccination rates.

Consistent with the past three years, DHS provided MCOs with current technical specifications and data submission templates. Clear expectations and standardized tools have improved the performance measure reporting and validation processes. Policies and procedures regarding contraindication reasons vary among MCOs and some are inconsistent with DHS technical specifications. Five MCOs should review and update their policies and procedures for vaccination contraindication reasons to ensure compliance with DHS technical specifications, and confirm staff follow policies and procedures for documenting contraindications in member records.

Information Systems Capability Assessment

This review activity was conducted for three MCOs; two operate FC only and the other operates both FC and FCP programs. The review found that these MCOs have the basic systems, resources, and processes in place to meet DHS' requirements for oversight and management of services to members, and to support quality and performance improvement initiatives.

All three organizations demonstrated progress by working with providers to increase the use of standardized claim forms. All three MCOs exhibited strengths by proactively monitoring vendor relationships and capabilities, and maintaining frequent communications to promptly identify and resolve issues. Additionally, the organizations utilized analytic data to evaluate systems' performance.

Two MCOs should enhance documentation in various areas. One MCO should document in its flowchart the data exchange and subsystems/functions that are responsible for the various processes in the overall information system. One MCO should document the processes for the following: training for encounter data file creation; creating reports for results of any reconciliation with source systems and data entry audits; retaining records beyond the record retention schedule; and ensuring timely entry of data into a credentialing system and the claims processing system.

Care Management Review

Member Health and Safety

Over the course of FY 15-16, MetaStar did not identify any members with unaddressed health and safety issues during CMR, out of 656 total member records selected and reviewed during this year's EQR activities. However, 13 members with complex situations involving medical, mental health, behavioral, cognitive, and/or social issues were identified, and were brought to the attention of the MCOs and referred to DHS. This proactive approach was implemented in FY 10-11, and gives DHS the opportunity to engage with the MCO and provide any needed guidance related to the specific member. This approach 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.

In addition to standard EQR activities for FY 15-16, DHS also directed MetaStar to re-review the records of eight members identified in the FY 14-15 review as having health and safety issues and/or complex and challenging situations. This was an additional step to ensure that MCOs continued to address quality of care concerns following initial remediation efforts. The individual record review results were provided to DHS and to the MCO, but were not included in the aggregate results in this report. Of the eight member records re-reviewed in FY 15-16, four demonstrated the MCOs had sufficiently addressed the issues or situations. The other four records indicated complex and challenging situations were continuing, and these members were referred to DHS again for additional oversight, assistance, and monitoring.

Over the course of the fiscal year, MetaStar also reviewed another 198 member records outside of annual EQR activities, and followed the referral process described above for any member identified as having health and safety issues and/or complex and challenging situations. Again, these reviews were not included in the results for this report.

Overall Results

During FY 15-16 every organization took some action to respond to the CMR recommendations they received related to the FY 14-15, although the actions taken by MCOs had limited success in achieving the desired improvements. FY 15-16 aggregate results for FC showed compliance rates over 90 percent for eight of 14 CMR standards, while aggregate results for FCP showed compliance rates over 90 percent for five standards. However, the FC program was not able to maintain the progress in several CMR standards identified in last year's review, and the overall rate of compliance with all of the CMR standards declined for both programs.

Recommendations in the FY 14-15 annual technical report addressed the need for both programs to focus improvement efforts in two areas: following up with members, and issuing notices to members in a timely manner, when indicated. FC also received a recommendation to continue to work on improving the comprehensiveness of MCPs. FCP received additional recommendations

related to improving the timeliness with which MCPs are reviewed and signed at required six-month intervals, and updating MCPs when members have significant changes. Actions MCOs took to address the recommendations included:

- Provided staff education/training;
- Conducted monitoring;
- Developed new tools or templates; and
- Updated policies, procedures, or other guidance.

FY 15-16 results showed the percent of all CMR standards met by FC, aggregated across the seven FC organizations was 88.7 percent. This compares to an aggregate rate of 93.1 percent in FY 14-15. For FCP, the overall percent of all CMR standards met in FY 15-16, aggregated across three FCP MCOs was 83.3 percent. This compares to an aggregate rate of 89.3 percent in FY 14-15. For both programs, MetaStar's analysis indicated the year-to-year decline in the rates of compliance was not likely attributable to normal variation or chance.

Regarding specific standards, results for the standard, "Notice of Action Issued in a Timely Manner when Indicated" had a slight positive change for FC and FCP; however, analysis indicated the year-to-year change in both programs was likely due to normal variation or chance.

Results for both FC and FCP identified the following three standards had declined since last year's review, and analysis indicated the year-to-year difference was unlikely to be due to normal variation or chance. These standards had been noted as areas of progress for FC in last year's annual technical report, although all three had also been identified as areas in need of further improvement for either one or both programs.

- "Comprehensiveness of Most Recent MCP;"
- "Plan Updated for Significant Changes;" and
- "Follow-up to Ensure Services are Effective."

Results for FC identified two additional standards had declined since last year's review, and analysis indicated the year-to-year difference in the results was unlikely to be due to normal variation or chance. Again, these standards had been noted as areas of progress for FC in last year's review.

- "Reassessment Done when Indicated;" and
- "Timely Coordination of Services."

The reasons for the decline in CMR results were not always clear, and nearly every MCO received a recommendation to conduct analysis to identify the root causes.

A factor affecting results for comprehensiveness of the MCP in both programs and for the majority of MCOs was the failure to document information about some member needs and services on the MCP. Some examples include lack of documentation indicating how

acute/primary care would be coordinated, the type of equipment needed by the member to complete activities of daily living, and failure to document medical conditions identified elsewhere in the record.

As indicated in the EQR reports of the individual MCOs, MetaStar also noted other possible contributing factors to the decline in CMR results, such as:

- Personnel changes and/or staff turnover at two MCOs; and
- Issues with the electronic documentation system at two other MCOs, including
    - Challenges with the organization's transition to a new electronic documentation system; and
    - Lack of integration between the MCO's service authorization and MCP documentation systems.

APPENDIX 1 – LIST OF ACRONYMS

ACE	Angiotensin-Converting Enzyme Inhibitor
ADRC	Aging & Disability Resource Center
AQR	Annual Quality Review
ARB	Angiotension Receptor Blocker
CARES	Client Assistance for Re-employment and Economic Support
CCCW	Community Care Connections of Wisconsin, Managed Care Organization
CCI	Community Care, Inc., Managed Care Organization
CFR	Code of Federal Regulations
CMR	Care Management Review
CMS	Centers for Medicare & Medicaid Services
CW	Care Wisconsin, Managed Care Organization
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
ICD	International Classification of Diseases
IDT	Interdisciplinary Team
IS	Information System
ISCA	Information Systems Capability Assessment
LCD	Lakeland Care District, Managed Care Organization
MCFC	My Choice Family Care, Managed Care Organization
MCO	Managed Care Organization

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

MCP	Member-Centered Plan
MY	Measurement Year
NCQA	National Committee for Quality Assurance
PACE	Program of All-Inclusive Care for the Elderly
PCP	Primary Care Physician
PIP	Performance Improvement Project
PMV	Performance Measures Validation
QAPI	Quality Assessment and Performance Improvement
QCR	Quality Compliance Review
RN	Registered Nurse
SDS	Self-Directed Supports
TPA	Third Party Administrator
WWC	Western Wisconsin Cares, Managed Care Organization

APPENDIX 2 – EXECUTIVE SUMMARIES

Care Wisconsin – Executive Summary

This section of the report summarizes the results of the fiscal year (FY) 15-16 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.

In FY14-15 MetaStar conducted CW's annual quality review (AQR) in March 2015. At the MCO's request this year's review was conducted early, in October and November 2015.

Care Wisconsin operates the Family Care and Family Care Partnership programs in multiple counties in the western, south-central, and southeastern portions of the state. Additionally, in June 2015, the organization began expanding its Family Care program into a new service region in northeastern Wisconsin. At the direction of the Department of Health Services, a review of member care in this new service area will be conducted and reported separately from the annual quality review activities reported here.

Key findings from the review activities discussed in this report are summarized below. Additional, detailed information can be found in the body of the report. Please note that Quality Compliance Review follows a three year cycle; one year of comprehensive review, where all standards are assessed, followed by two years of targeted review of any standards the organization did not fully meet the previous year. FY 15-16 was a targeted review year.

Review Activity	FY 15-16 Results	Comparison to FY 14-15 Results
Quality Compliance Review	• 10 Standards reviewed • 5 Standards received "met" rating • 85: Cumulative compliance score out of a possible 90 points in second year of three-year review cycle	• 45 Standards reviewed • 35 Standards received "met" rating • 80: Compliance score out of a possible 90 points in first year of three-year review cycle
Care Management Review	<u>Family Care</u> • 8 of 14 Standards met at a rate of 90 percent or higher • 83.8 percent: Overall rate of standards met by this organization for all review indicators	<u>Family Care</u> • 11 of 14 Standards met at a rate of 90 percent or higher • 92 percent: Overall rate of standards met by this organization for all review indicators

Review Activity	FY 15-16 Results	Comparison to FY 14-15 Results
	Family Care Partnership • 6 of 14 Standards met at a rate of 90 percent or higher • 83.7 percent: Overall rate of standards met by this organization for all review indicators	Family Care Partnership • 8 of 14 Standards met at a rate of 90 percent or higher 87.6 percent: Overall rate of standards met by this organization for all review indicators

CW – Progress Related to Quality Compliance Review

This section is intended to report about progress the managed care organization made in response to MetaStar's recommendations from the FY 14-15 Quality Compliance Review.

Care Wisconsin addressed, effectively, recommendations made in the FY 14-15 Quality Compliance Review as follows:

- The organization documented its current process and developed a letter template to meet the requirement to provide written notice to members who will be affected by the termination of a provider contract.
- Care Wisconsin improved its online searchable Family Care and Family Care Partnership provider directories, so that information about the availability of any alternate language(s) is being consistently displayed.
- The disenrollment policy and procedure was revised to include the impermissible reasons for requesting member disenrollment, as required.
- The organization has developed and implemented an annual quality work plan, which includes detail for all required and priority areas, and clearly outlines the scope of activities, goals, objectives, timelines, and responsible person(s).
- MetaStar confirmed Care Wisconsin has standard procedures in place which provide staff with consistent guidance for responding to members' requests for a second opinion.

In reviewing the following strengths and recommendations, readers should consider that the fiscal year 2015-2016 Quality Compliance Review was limited to those areas which were not fully met during the previous year.

CW - Strengths

- The organization's *Operations Manual* provides staff with clear direction for care management practice and web-based resources for member education.

- Care Wisconsin's process for informing and/or training staff regarding new or revised policies and practices includes a variety of approaches tailored to the needs of staff and significance of the change.

CW – Recommendations

Following are recommendations for improvement related to Quality Compliance Review Standards that were rated as not fully met, and Care Management Review results in need of improvement:

- Place priority on identifying the causes and contributing factors related to the lack of timeliness in submitting restrictive measures plan renewals to the Department of Health Services at least 30 days prior to the expiration of the current plan. Develop and implement an action plan based on the results of analysis, and closely monitor the plan to ensure its effectiveness.
- Develop and implement systematic processes for reviewing and disseminating practice guidelines to providers.
- Complete implementation of the revised policy and procedure, *Health Care Wishes and Advance Directives*.
- Place priority on identifying the root causes for the decline in the Family Care and Family Care Partnership programs and implement improvement efforts on:
    - Updating member-centered plans when significant changes in situation or condition occur.
- Continue focused efforts to monitor and improve the timely issuance of notices to members in the Family Care and Family Care Partnership programs.
- Continue to monitor documentation practices of care management staff and implement improvement efforts as needed.
- For Family Care, place priority on identifying the root causes for the decline in the following areas of care management review results and implement improvement efforts on:
    - Improving the comprehensiveness of member-centered plans;
    - Completing member-centered plan reviews within required timeframes; and
    - Following up with members and their supports to ensure services have been received and are effective.
- For Family Care Partnership, continue to focus efforts to improve results in the following areas of care management practice:
    - Improving the comprehensiveness of assessments and member-centered plans;
    - Completing member-centered plan reviews within required timeframes;
    - Addressing members' identified risks;
    - Following up with members and their supports to ensure services have been received and are working effectively for the member.

The additional recommendations below are opportunities for continued improvement in areas of the Quality Compliance Review where the managed care organization received a "met" rating, and/or other observations related to Care Management Review:

- Review and compare the *Quality Oversight of Contracted Services: Provider Suspension and/or Termination and Appeals* policy/procedure and *Process for Communicating Provider Contract Terminations* flow chart. Revise as needed to ensure the guidance they contain is consistent, and that both documents accurately reflect the current process, roles, and responsibilities of all parties.

Community Care Connections of Wisconsin – Executive Summary

This section of the report summarizes the results of the fiscal year (FY) 15-16 annual quality review conducted by MetaStar, Inc., for the managed care organization, Community Care Connections of Wisconsin. MetaStar is the external quality review organization contracted and authorized by the Wisconsin Department of Health Services to provide independent evaluations of managed care organizations that operate Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly.

Community Care Connections of Wisconsin operates the Family Care program in 16 counties in central and northwest Wisconsin.

Key findings from the review activities discussed in this report are summarized below. Additional, detailed information can be found in the body of the report. Please note that Quality Compliance Review follows a three year cycle; one year of comprehensive review, where all standards are assessed, followed by two years of targeted review of any standards the organization did not fully meet the previous year. FY 15-16 was a targeted review year.

Review Activity	FY 15-16 Results	Comparison to FY 14-15 Results
Quality Compliance Review	• 6 Standards reviewed • 3 Standards received "met" rating • 85: Cumulative compliance score out of a possible 88 points in second year of three-year review cycle	• 44 Standards reviewed • 38 Standards received "met" rating • 82: Compliance score out of a possible 88 points in first year of three-year review cycle
Care Management Review	<u>Family Care</u> • 9 of 14 Standards met at a rate of 90 percent or higher • 91.2 percent: Overall rate of standards met by this organization for all review indicators	<u>Family Care</u> • 9 of 14 Standards met at a rate of 90 percent or higher • 92.3 percent: Overall rate of standards met by this organization for all review indicators

CCCW – Progress Related to Quality Compliance Review

This section is intended to report about progress the managed care organization made in response to MetaStar's recommendations from the FY 14-15 Quality Compliance Review.

Community Care Connections of Wisconsin addressed, effectively, recommendations made in the FY 14-15 Quality Compliance Review as follows:

- The organization developed and implemented a process to ensure the MCO does not employ or contract with providers who have been excluded from participation in federal health care programs.
- Community Care Connections of Wisconsin educated staff and implemented monitoring to improve follow-up to ensure services and supports are effective for members.
- The written disenrollment procedure in the *IDT Staff Handbook* was revised to include the impermissible reasons for requesting member disenrollment, as required.

In reviewing the following strengths and recommendations, readers should consider that the FY 15-16 Quality Compliance Review was limited to those areas which were not fully met during the previous year.

CCCW – Strengths

- Community Care Connections of Wisconsin has a structured Quality Management program which includes systematic collection, analysis, and utilization of data to improve the quality of member care and organizational operations.
- Staff input is valued and utilized for improvement efforts.
- The organization has detailed written guidance for staff and follows a consistent and systematic approach when revision and clarification of information is needed.

CCCW – Recommendations

Following are recommendations for improvement related to Quality Compliance Review Standards that were rated as not fully met, and Care Management Review results in need of improvement:

- Place priority on maintaining and monitoring a network of qualified providers:
    - Develop systematic methods to monitor provider contracting procedures.
    - Institute a process to ensure all relevant providers have and maintain appropriate licensure or certification appropriate for the services it has contracted to provide.
    - Fully implement a comprehensive, consistent caregiver background check monitoring process including evaluation of compliance and follow-up actions.
    - Assess the effectiveness of the organization's current procedure for updating the provider directory. Make process improvements, as needed, to ensure that

information about changes is received timely and the online provider directory is updated promptly.

- Continue efforts to monitor, analyze, and improve processes related to the development of comprehensive, timely, and current member-centered plans.

The additional recommendations below are opportunities for continued improvement in areas of the Quality Compliance Review where the managed care organization received a "met" rating, and/or other observations related to Care Management Review:

- Continue monitoring of care management staff follow-up to ensure covered, non-covered, health-related, and community services are effective for members. Implement additional improvement efforts if needed.

Community Care, Inc. – Executive Summary

This section of the report summarizes the results of the fiscal year (FY) 15-16 annual quality review conducted by MetaStar, Inc., for the managed care organization, Community Care, Inc. MetaStar is the external quality review organization contracted and authorized by the Wisconsin Department of Health Services to provide independent evaluations of managed care organizations that operate Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly.

Community Care operates the Family Care program in 14 counties, Family Care Partnership program in nine counties, and the Program of All-Inclusive Care for the Elderly in two counties in southeast and east central Wisconsin.

Key findings from the review activities discussed in this report are summarized below. Additional, detailed information can be found in the body of the report. Please note that Quality Compliance Review follows a three year cycle; one year of comprehensive review, where all standards are assessed, followed by two years of targeted review of any standards the organization did not fully meet the previous year. FY 15-16 was a targeted review year.

Review Activity	FY 15-16 Results	Comparison to FY 14-15 Results
Quality Compliance Review	• 11 Standards reviewed • 8 Standards received "met" rating • 87: Cumulative compliance score out of a possible 90 points in second year of three-year review cycle	• 45 Standards reviewed • 34 Standards received "met" rating • 79: Compliance score out of a possible 90 points in first year of three-year review cycle

Review Activity	FY 15-16 Results	Comparison to FY 14-15 Results
Care Management Review	Family Care • 8 of 14 Standards met at a rate of 90 percent or higher • 87.6 percent: Overall rate of standards met by this organization for all review indicators Family Care Partnership • 6 of 14 Standards met at a rate of 90 percent or higher • 83.5 percent: Overall rate of standards met by this organization for all review indicators Program of All-Inclusive Care for the Elderly • Care Management Review was not conducted this year, as this program was audited by the Centers for Medicare & Medicaid Services	Family Care • 12 of 14 Standards met at a rate of 90 percent or higher • 95.8 percent: Overall rate of standards met by this organization for all review indicators Family Care Partnership • 8 of 14 Standards met at a rate of 90 percent or higher • 90.2 percent: Overall rate of standards met by this organization for all review indicators Program of All-Inclusive Care for the Elderly • 10 of 14 Standards met at a rate of 90 percent or higher • 93.5 percent: Overall rate of standards met by this organization for all review indicators

CCI – Progress Related to Quality Compliance Review

This section is intended to report about progress the managed care organization made in response to MetaStar's recommendations from the FY 14-15 Quality Compliance Review.

Community Care addressed, effectively, recommendations made in the FY 14-15 Quality Compliance Review as follows:

- Written guidance and procedures were developed and implemented to provide a good faith effort to give written notification of termination of a contracted provider to members who received services from such providers.
- The organization revised its *Provision of Family Planning Services and Women's Health Care Services* policy and procedure to align with the requirement to provide direct access to women's health services.
- The *Member Disenrollment* policy and procedure was revised to include the impermissible reasons for requesting member disenrollment, as required.
- Community Care improved mechanisms to assess the quality and appropriateness of care to members.

- The organization improved its process for and documentation of the evaluation of the impact and overall effectiveness of the Quality Assessment and Performance Improvement program on the quality of service provided to members.
- The organization effectively revised appeal and grievance policies and procedures to include all required contract elements.

In reviewing the following strengths and recommendations, readers should consider that the fiscal year 2015-2016 Quality Compliance Review was limited to those areas which were not fully met during the previous year.

CCI – Strengths

- Community Care demonstrated effective organizational capabilities to achieve a notable improvement in compliance with standards since the last review.
- The organization restructured the member rights specialist roles to include a dedicated person that consistently attempts informal negotiation and resolution on all grievances and appeals.

CCI – Recommendations

Following are recommendations for improvement related to Quality Compliance Review Standards that were rated as not fully met, and Care Management Review results in need of improvement:

- Fully implement restructuring of the Quality Assessment and Performance Improvement program, and update documentation to clearly describe the administrative structure and related responsibilities.
- Fully implement mechanisms for members of all programs to actively participate in quality assessment and performance improvement activities, and clearly document this participation.
- Develop a clear and comprehensive quality plan which is based on findings from the quality evaluation.
- Include all required and prioritized monitoring activities on the quality plan, and identify remediation efforts for those areas in need of improvement.
- Ensure the *Quality Program Plan Metrics* report contains useful data, and that actions taken as a result of analysis are documented.
- Continue focused efforts to monitor and improve the timely issuance of notices to members in the Family Care and Family Care Partnership programs.
- Ensure members are consistently informed about the process and options for addressing the inability to pay following an appeal decision that is adverse to the member. Additionally, ensure the procedure in the *Cost Recovery from Members* policy is

uniformly applied, and all members are assessed for the ability to repay prior to issuing an invoice related to recovering the cost of services provided during the time the appeal was pending.

- Conduct additional analysis to identify the root cause or causes for the overall decline in care management review results for both programs.

- For Family Care, focus efforts on improving results in the following areas of care management practice:
    - Improving the comprehensiveness of member-centered plans;
    - Ensuring member-centered plans are updated for significant changes;
    - Improving the timely coordination of services; and
    - Improving follow up with members to ensure services have been received.
- For Family Care Partnership, focus efforts on improving results in the following areas of care management practice:
    - Improving the comprehensiveness of assessments and member-centered plans;
    - Ensuring member-centered plans are updated for significant changes;
    - Improving the timely coordination of services; and
    - Improving follow up with members to ensure services have been received.

The additional recommendations below are opportunities for continued improvement in areas of the Quality Compliance Review where the managed care organization received a "met" rating, and/or other observations related to Care Management Review:

- Review and report all full file audit (member file review) indicators, rather than only the selected key indicators.
- In addition to the full file audit, ensure that monitoring is adequate to assess quality of care in all programs and for a variety of indicators, as identified through quality improvement activities.

ContinuUs – Executive Summary

This section of the report summarizes the results of the fiscal year (FY) 15-16 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 Wisconsin counties, including in the southwest, northwest, southeast and east central parts of the state.

Key findings from the review activities discussed in this report are summarized below. Additional, detailed information can be found in the body of the report. Please note that Quality

Compliance Review follows a three year cycle; one year of comprehensive review, where all standards are assessed, followed by two years of targeted review of any standards the organization did not fully meet the previous year. FY 15-16 was a targeted review year.

Review Activity	FY 15-16 Results	Comparison to FY 14-15 Results
Quality Compliance Review	• 9 Standards reviewed • 2 Standards received "met" rating • 81: Cumulative compliance score out of a possible 88 points in second year of three-year review cycle	• 44 Standards reviewed • 35 Standards received "met" rating • 79: Compliance score out of a possible 88 points in first year of three-year review cycle
Care Management Review	Family Care • 11 of 14 Standards met at a rate of 90 percent or higher • 93.2 percent: Overall rate of standards met by this organization for all review indicators	Family Care • 10 of 14 Standards met at a rate of 90 percent or higher • 94.8 percent: Overall rate of standards met by this organization for all review indicators

ContinuUs – Progress Related to Quality Compliance Review

This section is intended to report about progress the managed care organization made in response to MetaStar's recommendations from the FY 14-15 Quality Compliance Review. ContinuUs addressed, effectively, recommendations made in the FY 14-15 Quality Compliance Review as follows:

- ContinuUs implemented a disenrollment procedure that includes the impermissible reasons for requesting a member disenrollment.
- The organization provided documentation indicating signed enrollment plans with Aging & Disability Resource Centers and Income Maintenance agencies are in place, covering all counties in its service area.

In reviewing the following recommendations, readers should consider that the FY 15-16 Quality Compliance Review was limited to those areas which were not fully met during the previous year.

ContinuUs – Recommendations

Following are recommendations for improvement related to Quality Compliance Review Standards that were rated as not fully met, and Care Management Review results in need of improvement:

- Obtain and analyze all data necessary to evaluate and ensure adequacy of the provider network, for all service types and in all geographic areas.
- Ensure all policies, procedures, and practices related to credentialing and re-credentialing of providers are adequate and consistently followed:
    - Finalize and fully implement the *Provider Certification Credentialing* policy and procedure.
    - Ensure the newly implemented procedure to monitor licensure and certification of practitioners is sufficient and effective.
    - Improve processes to monitor and address expiration of provider contracts, as well as licensure and certification of all provider types.
    - Consider improving documentation of verification of provider credentials.
- Evaluate and revise the organization's monthly process for identifying providers that have been excluded from participation in federal health care programs, to include investigation of all potentially excluded providers.
- Conduct analysis, identify barriers, and take further action as needed to improve the timeliness of restrictive measures applications/renewals.
- Fully implement the planned Utilization Review/Utilization Management program, including the development of consistent mechanisms to detect both underutilization and overutilization of services.
- Ensure monitoring and improvement efforts are adequate to improve the timely issuance of notices to members when indicated.
- Identify the root causes for the decline in the following areas of care management review results and implement improvement efforts related to:
    - Following up with members and their supports to ensure services have been received and are effective; and
    - Completing re-assessments when indicated.
- Complete implementation of the *Notifying Members When a Provider Contract is Terminated* policy and procedure.

The additional recommendations below are opportunities for continued improvement in areas of the Quality Compliance Review where the managed care organization received a "met" rating, and/or other observations related to Care Management Review:

- Make good faith efforts to engage with Aging & Disability Resource Centers and Income Maintenance agencies in the organization's service area with the goal of working collaboratively to review and update enrollment plans, so the plans fully and accurately reflect the role of all parties and contain all required elements.
- Evaluate the *Risk Assessment Worksheet* tool and its utilization, to ensure it is effective, and accurately captures members' level of risk.

Independent Care Health Plan – Executive Summary

This section of the report summarizes the results of the fiscal year (FY) 15-16 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 four counties in southern Wisconsin.

Key findings from the review activities discussed in this report are summarized below. Additional, detailed information can be found in the body of the report. Please note that Quality Compliance Review follows a three year cycle; one year of comprehensive review, where all standards are assessed, followed by two years of targeted review of any standards the organization did not fully meet the previous year. FY 15-16 was a targeted review year.

Review Activity	FY 15-16 Results	Comparison to FY 14-15 Results
Quality Compliance Review	• 26 Standards reviewed • 9 Standards received "met" rating • 73: Cumulative compliance score out of a possible 90 points in second year of three-year review cycle	• 45 Standards reviewed • 19 Standards received "met" rating • 64: Compliance score out of a possible 90 points in first year of three-year review cycle
Care Management Review	<u>Family Care Partnership</u> • 5 of 14 Standards met at a rate of 90 percent or higher • 82.6 percent: Overall rate of standards met by this organization for all review indicators	<u>Family Care Partnership</u> • 9 of 14 Standards met at a rate of 90 percent or higher • 90.2 percent: Overall rate of standards met by this organization for all review indicators

iCare – Progress Related to Quality Compliance Review

This section is intended to report about progress the managed care organization made in response to MetaStar's recommendations from the FY 14-15 Quality Compliance Review.

Independent Care Health Plan addressed, effectively, recommendations made in the FY 14-15 Quality Compliance Review, as follows:

- Independent Care Health Plan transitioned to the Department of Health Services issued templates for notices to members and for disposition of appeals and grievances to gain compliance with contract requirements.
- The organization added the review of grievance information to the quality program.
- Independent Care Health Plan improved its systems to ensure local appeals and grievances are completed within the contract timeframes.
- The member handbook was revised to include all required information.
- Independent Care Health Plan developed and implemented a procedure and letter template that meets the requirement to make a good faith effort to give timely written notice to members who will be affected by the termination of a service provider from the organization's provider network.
- The organization developed and implemented a process to track and document providers excluded from participation in federal health care programs.
- Written guidance and procedures were developed to ensure member access to a second opinion for medical services.
- Independent Care Health Plan updated policies related to service authorization decisions to align with requirements in the DHS-MCO contract.

In reviewing the following recommendations, readers should consider that the fiscal year 2015-2016 Quality Compliance Review was limited to those areas which were not fully met during the previous year.

iCare – Recommendations

Since the last review, Independent Care Health Plan added staff resources and improved some process capabilities in an effort to make progress in priority areas identified last year. The organization's progress was not sufficient to achieve compliance. MetaStar recommends the organization continue to place priority on the following:

- Establish, monitor, and maintain a network of qualified providers for both long-term care and acute and primary services:
    - Respond to findings from the organization's own monitoring of network adequacy and timely access to services.
    - Institute a process to ensure all relevant providers have and maintain appropriate licensure or certification appropriate for the services it has contracted to provide.
    - Fully implement a comprehensive, consistent caregiver background check monitoring process.
    - Develop systematic methods to monitor provider quality and contracting procedures.

- Improve the organization's Quality Assessment and Performance Improvement Program:
    - Ensure the organization's quality program is administered through clear and appropriate administrative structures.
    - Provide sufficient opportunities for Family Care Partnership members and providers to participate in the organization's quality program.
    - Implement a quality planning process which ensures that all areas prioritized for improvement and all required monitoring activities are addressed.
    - Fully analyze available data and implement improvement efforts as needed.
    - Complete implementation of the Utilization Management procedure and ensure monitoring and analysis is sufficient to detect both underutilization and overutilization.
    - Revise internal file review methodology in order to obtain useful aggregate data to assess and improve the quality of care.
    - Continue development of the "quantitative" audits and ensure aggregate data is reported and analyzed effectively and consistently.
    - Develop a quality evaluation process which is adequate to assess the program's impact on the quality of care provided to members.

Following are additional recommendations for improvement related to Quality Compliance Review Standards that were rated as not fully met, and Care Management Review results in need of improvement:

- Place priority on identifying the root causes for decline in comprehensiveness of member-centered plans and implement improvement efforts.
- Continue to improve the functioning of the online provider directory:
    - Take steps to ensure the non-English languages spoken by providers are included, along with other required information, when printing out results of an online provider search; and
    - Ensure the directory consistently lists the current providers for each type of service.
    - Develop a process to regularly monitor the online provider directory to confirm it is being updated every two weeks per the organization's policy; consistently includes all required information; and that the directory information is accurate and up-to-date.
- Assess the effectiveness of the organization's current procedure for updating the provider directory. Make process improvements, as needed, to ensure that information about changes is received timely and the online provider directory is updated promptly.
- Focus efforts to improve results in the following areas of care management practice:
    - Complete member-centered plan reviews in a timely manner.

    - Update member-centered plans when significant changes in situation or condition occur.
    - Improve timeliness of service authorization decisions and coordination of services.
    - Address members' identified risks.
    - Follow up with members and their supports to ensure services have been received and are working effectively for the member.
    - Ensure member's identified needs are addressed.
    - Issue notices to members in a timely manner, when indicated.
- Develop and implement procedures for any areas of enrollment and disenrollment where written staff guidance is not currently in place.
- Make good faith efforts to engage with Aging & Disability Resource Centers and Income Maintenance agencies across Independent Care Health Plan's service area, with the goal of working towards Enrollment Plans that are developed collaboratively, fully reflect the role of all parties to the agreement, and contain all elements required by the organization's contract with the Department of Health Services.
- Ensure all requirements related to practice guidelines are met, and specifically take into consideration the needs of Family Care Partnership members.
- Develop systems to inform current providers when changes are made to the Provider Reference Manual to ensure their knowledge of all requirements.
- Ensure that training materials regarding the composition of the local grievance and appeal committee are consistent, align with Independent Care Health Plan's policy, and meet contract requirements.
- Continue efforts to update, review, and streamline policies and procedures to ensure clear guidance for staff.

The additional recommendations below are opportunities for continued improvement in areas of the Quality Compliance Review where the managed care organization received a "met" rating, and/or other observations related to Care Management Review:

- Develop and implement a systematic process for utilizing the MCO's appeals and grievances template letters to ensure members are receiving correct information and that the organization maintains contract compliance.
- Continue efforts to stabilize care management team assignments to promote continuity of care for members.

Lakeland Care District – Executive Summary

This section of the report summarizes the results of the fiscal year (FY) 15-16 annual quality review conducted by MetaStar, Inc., for the managed care organization, Lakeland Care District. MetaStar is the external quality review organization contracted and authorized by the Wisconsin

Department of Health Services to provide independent evaluations of managed care organizations that operate Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly.

Lakeland Care District operates the Family Care program in 13 counties in east-central and northeast Wisconsin.

In 2015, the organization began expanding its Family Care program into a new service region in northeastern Wisconsin. At the direction of the Department of Health Services, a review of member care in this new service area will be conducted and reported separately from the annual quality review activities reported here.

Key findings from the review activities discussed in this report are summarized below. Additional, detailed information can be found in the body of the report. Please note that Quality Compliance Review follows a three year cycle; one year of comprehensive review, where all standards are assessed, followed by two years of targeted review of any standards the organization did not fully meet the previous year. FY 15-16 was a targeted review year.

Review Activity	FY 15-16 Results	Comparison to FY 14-15 Results
Quality Compliance Review	• 2 Standards reviewed • 1 Standard received "met" rating • 87: Cumulative compliance score out of a possible 88 points in second year of three-year review cycle	• 44 Standards reviewed • 42 Standards received "met" rating • 86: Compliance score out of a possible 88 points in first year of three-year review cycle
Care Management Review	<u>Family Care</u> • 9 of 14 Standards met at a rate of 90 percent or higher • 89.9 percent: Overall rate of standards met by this organization for all review indicators	<u>Family Care</u> • 9 of 14 Standards met at a rate of 90 percent or higher • 94.1 percent: Overall rate of standards met by this organization for all review indicators

LCD – Progress Related to Quality Compliance Review

This section is intended to report about progress the managed care organization made in response to MetaStar's recommendations from the FY 14-15 Quality Compliance Review.

Lakeland Care District addressed, effectively, recommendations made in the FY 14-15 Quality Compliance Review as follows:

- The MCO Requested Disenrollment procedure was revised to include the impermissible reasons for requesting member disenrollment, as required.

In reviewing the following strengths and recommendations, readers should consider that the fiscal year 2015-2016 Quality Compliance Review was limited to those areas which were not fully met during the previous year.

LCD – Strengths

- The organization has a culture of continuous quality improvement. The MCO utilizes data, analysis, and monitoring for improvement efforts. This has been a consistent organizational strength for Lakeland Care District.
- The organization's *Best Practice Standards for Care Management* identifies core competencies and provides staff with clear direction and detailed guidance for care management practice.

LCD – Recommendations

Following are recommendations for improvement related to Quality Compliance Review Standards that were rated as not fully met, and Care Management Review results in need of improvement:

- Place priority on identifying the root causes for the decline in the standard, "Follow Up to Ensure Services are Effective."
- Continue monitoring and improvement efforts in the following areas of care management practice:
    - Completing assessments that are comprehensive;
    - Conducting reassessments, for six month periodic reviews and/or when indicated after changes in condition or situation occur;
    - Completing member-centered plans that are comprehensive; and
    - Updating member-centered plans when significant changes in situation or condition occur.

The additional recommendations below are opportunities for continued improvement in areas of the Quality Compliance Review where the managed care organization received a "met" rating, and/or other observations related to Care Management Review:

- Address the MCO's documentation expectations for how assessment and member-centered plan information is updated to reflect historical information and therefore provide an accurate status of members' current abilities and needs.
- Continue monitoring and improvement efforts regarding the timely issuance of notices of action, when indicated.

My Choice Family Care – Executive Summary

This section of the report summarizes the results of the fiscal year (FY) 15-16 annual quality review conducted by MetaStar, Inc., for the managed care organization, My Choice Family Care.

MetaStar is the external quality review organization contracted and authorized by the Wisconsin Department of Health Services to provide independent evaluations of managed care organizations that operate Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly.

My Choice Family Care operates the Family Care program in eight counties in southeastern Wisconsin.

Key findings from the review activities discussed in this report are summarized below. Additional, detailed information can be found in the body of the report. Please note that Quality Compliance Review follows a three year cycle; one year of comprehensive review, where all standards are assessed, followed by two years of targeted review of any standards the organization did not fully meet the previous year. FY 15-16 was a targeted review year.

Review Activity	FY 15-16 Results	Comparison to FY 14-15 Results
Quality Compliance Review	• 7 Standards reviewed • 3 Standards received "met" rating • 84: Cumulative compliance score out of a possible 88 points in second year of three-year review cycle	• 44 Standards reviewed • 37 Standards received "met" rating • 81: Compliance score out of a possible 88 points in first year of three-year review cycle
Care Management Review	<u>Family Care</u> • 6 of 14 Standards met at a rate of 90 percent or higher • 88 percent: Overall rate of standards met by this organization for all review indicators	<u>Family Care</u> • 8 of 14 Standards met at a rate of 90 percent or higher • 90.1 percent: Overall rate of standards met by this organization for all review indicators

MCFC – Progress Related to Quality Compliance Review

This section is intended to report about progress the managed care organization made in response to MetaStar's recommendations from the FY 14-15 Quality Compliance Review.

My Choice Family Care addressed, effectively, recommendations made in the FY 14-15 Quality Compliance Review as follows:

- Improvements were made to ensure the timely resolution of local grievances/appeals.
- My Choice Family Care updated its Appeals and Grievance Guideline to include the process for the organization to determine when to expedite an appeal.
- My Choice Family Care developed and implemented a standard process for educating contracted providers on all member rights, by adding a section to its Provider Handbook focused on the rights of members.

- The organization made significant revisions to its Restrictive Measures policy and procedure, clarifying or adding guidance for staff and providers in several areas, such as requirements for both initial and annual renewal applications, and timeliness criteria for restrictive measures renewal applications.

In reviewing the following strengths and recommendations, readers should consider that the fiscal year 2015-2016 Quality Compliance Review was limited to those areas which were not fully met during the previous year.

MCFC – Strengths

- The organization utilizes data, analysis, and monitoring for improvement efforts.

MCFC – Recommendations

Following are recommendations for improvement related to Quality Compliance Review Standards that were rated as not fully met, and Care Management Review results in need of improvement:

- Conduct analysis, identify barriers, and take further action as needed to improve the timely submission of restrictive measures renewal applications.
- Place priority on identifying the root causes for the decline in the following areas of care management review results and implement improvement efforts in:
    - Improving the timely coordination of services.
    - Following up with members and their supports to ensure services have been received and are effective.
- Focus improvement efforts in the following areas of care management practice:
    - Improve the comprehensiveness of member-centered plans, including ensuring all identified needs and services are addressed.
    - Ensure member-centered plans are reviewed and signed timely including by the appropriate legal decision maker at the required six month intervals.
    - Improve the timeliness of service authorization decisions.
- Ensure the new *Member Notification of Provider Termination* policy and procedure has been reviewed with interdisciplinary team staff in all care management units and is fully implemented.

The additional recommendations below are opportunities for continued improvement in areas of the Quality Compliance Review where the managed care organization received a “met” rating, and/or other observations related to Care Management Review:

- Continue efforts to improve the consistency of issuing timely notices to members when indicated.

- Ensure reassessments are completed for six month periodic reviews and/or when significant changes in situation or condition occur.
- Ensure that grievance letters sent to members include how to request a Department Review.
- Update the *Appeals and Grievance Guideline* to include the required language: The MCO must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.

Western Wisconsin Cares – Executive Summary

This section of the report summarizes the results of the fiscal year (FY) 15-16 annual quality review conducted by MetaStar, Inc., for the managed care organization, Western Wisconsin Cares. MetaStar is the external quality review organization contracted and authorized by the Wisconsin Department of Health Services to provide independent evaluations of managed care organizations that operate Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly.

Western Wisconsin Cares operates the Family Care program in eight counties in western Wisconsin. Key findings from the review activities discussed in this report are summarized below. Additional, detailed information can be found in the body of the report. Please note that Quality Compliance Review follows a three year cycle; one year of comprehensive review, where all standards are assessed, followed by two years of targeted review of any standards the organization did not fully meet the previous year. FY 15-16 was a targeted review year.

Review Activity	FY 15-16 Results	Comparison to FY 14-15 Results
Quality Compliance Review	• 4 Standards reviewed • 2 Standards received "met" rating • 86: Cumulative compliance score out of a possible 88 points in second year of three-year review cycle	• 44 Standards reviewed • 40 Standards received "met" rating • 84: Compliance score out of a possible 88 points in first year of three-year review cycle
Care Management Review	<u>Family Care</u> • 8 of 14 Standards met at a rate of 90 percent or higher • 87.7 percent: Overall rate of standards met by this organization for all review indicators	<u>Family Care</u> • 10 of 14 Standards met at a rate of 90 percent or higher • 93.4 percent: Overall rate of standards met by this organization for all review indicators

WWC – Progress Related to Compliance with Standards

This section is intended to report about progress the managed care organization made in response to MetaStar's recommendations from the FY 14-15 Quality Compliance Review.

Western Wisconsin Cares addressed, effectively, recommendations made in the FY 14-15 Quality Compliance Review as follows:

- The Disenrollment Policy was revised to include the impermissible reasons for requesting member disenrollment, as required.
- Improvements were made to ensure the timely resolution of local grievances/appeals.

In reviewing the following strengths and recommendations, readers should consider that the fiscal year 2015-2016 Quality Compliance Review was limited to those areas which were not fully met during the previous year.

WWC – Strengths

- The organization demonstrates a culture of continuous improvement, using various interventions, in an effort to improve organizational processes. This has been a consistent organizational strength for Western Wisconsin Cares.

WWC – Recommendations

Following are recommendations for improvement related to Quality Compliance Review Standards that were rated as not fully met, and Care Management Review results in need of improvement:

- Continue to identify barriers and implement improvement efforts for increasing the timeliness of completing annual renewals of restrictive measures plans. Ensure that restrictive measures plan renewals are sent to DHS at least 30 days prior to the expiration of the current plan.
- Ensure provider credentialing processes are followed consistently.
- Review policies and develop practices as needed to ensure all relevant providers and practitioners maintain licensure or certification.
- Place priority on identifying the root causes for the decline in the following areas of care management review results and implement improvement efforts on:
    - Improving the comprehensiveness of member-centered plans;
    - Updating member-centered plans when significant changes in situation or condition occur;
    - Issuing notices to members in a timely manner, when indicated.
- Focus efforts to improve results in the following areas of care management practice:
    - Completing member-centered plan reviews in a timely manner;

- Following up with members and their supports to ensure services have been received and are working effectively for the member.

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 pre-paid inpatient health plans to provide for external quality review (EQR) of their managed care organizations (MCO), 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 External Quality Review Organization.

MetaStar - Wisconsin's External Quality Review Organization

The State of Wisconsin contracts with MetaStar, Inc., to conduct EQR activities and produce reports of the results. 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 40 years, and represents Wisconsin in the Lake Superior Quality Innovation Network, under the Centers for Medicare & Medicaid Services (CMS) Quality Improvement Organization Program.

MetaStar conducts EQR of MCOs operating managed long-term programs, including Family Care (FC), Family Care Partnership (FCP), and Program of All-Inclusive Care for the Elderly (PACE). In addition, the company conducts 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. MetaStar also operates the Wisconsin Medicaid Health IT Extension Program in partnership with the Department of Health Services (DHS), 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. For more information about MetaStar, visit its website at www.metastar.com.

MetaStar Review Team

The MetaStar EQR team is comprised of registered nurses, a nurse practitioner, a physical therapist, licensed and/or certified social workers, , and other degreed professionals with extensive education and experience working with the target groups served by the MCOs. The EQR team is supported by other members of MetaStar's Managed Health and Long-Term Care Department as well as staff in other departments, including a data analyst with an advanced degree, a licensed HEDIS auditor, certified professional coders, and information technologies staff. Review team experience includes professional practice and/or administrative experience in

managed health and long-term care 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

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 the Code of Federal Regulations (CFR) at 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.*

Prior to conducting review activities, MetaStar worked with DHS to identify its expectations for MCOs, including compliance thresholds and rules for compliance scoring for each federal and/or regulatory provision or contract requirement.

MetaStar also obtained information from DHS about its work with the MCO. The following sources of information were reviewed:

- The MCO's current FC 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 14-15 external quality review report; and
- DHS communication with the MCO about expectations and performance during the previous 12 months.

MetaStar also conducted a document review to identify gaps in information necessary for a comprehensive EQR process and to ensure efficient and productive interactions with the MCO during the onsite visit. To conduct the document review, MetaStar gathered and assessed information about the MCO and its structure, operations, and practices, such as organizational charts, policies and procedures, results and analysis of internal monitoring, and information related to staff training.

Onsite or phone conference group discussions were held to collect additional information necessary to assess the MCO's compliance with federal and state standards. Participants in the sessions included MCO administrators, supervisors, and other staff responsible for supporting care managers, staff responsible for improvement efforts, and social work and RN care managers.

MetaStar also conducted some verification activities, and requested and reviewed additional documents, as needed, to clarify information gathered during the onsite visit. Data from some care management review (CMR) elements were considered when assigning compliance ratings for some focus areas and sub-categories.

MetaStar worked with DHS to identify 45 standards that include federal and state requirements; 44 of the standards were applicable to FC, and all 45 standards were applicable to FCP and PACE.

Focus Area	Related Sub-Categories in Review Standards
Enrollee Rights and Protections – 7 or 8 Standards	• General Rule Regarding Member Rights • Information Requirements • Specific Rights • Emergency and Post-stabilization Services
Quality Assessment and Performance Improvement (QAPI): Access, Structure and Operation, Measurement and Improvement – 21 Standards	• Availability of Services • Coordination and Continuity of Care • Coverage and Authorization of Services • Provider Selection • Confidentiality • Enrollment and Disenrollment • Subcontractual Relationships and Delegation • Practice Guidelines • QAPI Program • Basic Elements of the QAPI Program • Quality Evaluation • Health Information Systems
Grievance System – 16 Standards	• Definitions and General Requirements • Notices to Members • Handling of Grievances and Appeals • Resolution and Notification • Expedited Resolution of Appeals • Information About the Grievance System to Providers • Recordkeeping and Reporting Requirements • Continuation of Benefits While the MCO Appeal and State Fair Hearing are Pending • Effectuation of Reversed Appeal Resolutions

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

Met:

- All policies, procedures, and practices were aligned to meet the requirement, **and**
- Practices were implemented, **and**
- Monitoring was sufficient to ensure effectiveness.

Partially Met:

- The MCO met the requirements in practice but lacked written policies or procedures, **or**
- The organization had not finalized or implemented draft policies, **or**
- Monitoring had not been sufficient to ensure effectiveness of policies, procedures, and practices.

Not Met:

- 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.

Results were reported by assigning a numerical value to each rating:

- Met: 2 points
- Partially Met: 1 point
- Not Met: 0 points

The number of points were added and reported relative to the total possible points for each focus area, and as an overall score. The maximum possible points are 88 for FC, and 90 for FCP/PACE.

QCR activities follow a three-year cycle. The first year all QCR standards are assessed. The second and third years, only those standards not fully met in either the first or second year of the cycle are assessed. The overall QCR score reported for an organization is cumulative during each year of the three-year cycle. However, if a standard had previously been rated "partially met" (receiving one point), and the MCO receives a "met" rating during year two or three, an additional one point will be added to the previous year's score, so that the total point value received for any standard which is fully met during the course of the three-year cycle does not exceed two points. Similarly, the total point value received for any standard which remains partially met during the course of the three-year cycle will not exceed one point. While not likely

to occur, should a standard scored "partially met" change to a "not met" in a subsequent year during the three-year cycle, one point will be deducted from the score.

Validation of Performance Improvement Projects

The purpose of a performance improvement project (PIP) is to assess and improve the processes and outcomes of health care provided by an MCO. PIP validation, a mandatory EQR activity, documents that a MCO's PIP is designed, conducted, and reported in a methodologically sound manner. 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.*

MetaStar reviewed the PIP design and implementation using documents provided by the MCO. Document review may have been supplemented by MCO staff interviews, if needed.

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

MetaStar also 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.

Findings were initially compiled into a preliminary report. The MCO had the opportunity to review prior to finalization of the report.

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.*

MetaStar reviewed the most recent Information Systems Capability Assessment (ISCA) report for each MCO in order to assess the integrity of the MCO's information system. The ISCA is conducted separately, every three years, as directed by DHS.

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 measurement year (MY) 2015. To complete the validation work, MetaStar:

- 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 who 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. If the denominator was not within five percentage points of DHS' denominator, the MCO resubmitted data until the agreement threshold was met.
- Calculated the vaccination rates for each quality indicator by program and target group.
- Compared the MCO's rates for MY 2015 to both the statewide rates for MY 2015 and the MCO's rates for MY 2014.
- When necessary, MetaStar 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, information systems capability assessments (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. The MetaStar team based its assessment on information system requirements detailed in the DHS-MCO contract; other technical references, such as DHS encounter reporting reference materials; 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.

Prior to the review, MetaStar met with DHS to develop the review methodology and tailor the review activities to reflect DHS expectations for compliance.

MetaStar used a combination of activities to conduct and complete the ISCA, including reviewing the following references:

- DHS-MCO contract;
- EQR Protocol *Appendix V: Information Systems Capability Assessment – Activity Required for Multiple Protocols*, 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; and
- 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, as directed by the MCO. Reviewers also obtained and evaluated documentation specific to the MCO's information systems (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: Claims and 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/Enrollment Data Processing
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 oversight and data collection processes performed by service providers and other information technology vendors/systems (including internal systems) that support MCO operational functions, and provide data which relate to the generation of complete and accurate reporting. This includes information on stand-alone systems or benefits provided

through subcontracts, such as medical record data, immunization data, or behavioral health/substance abuse data.

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, if applicable.

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.

As directed by DHS, for each MCO, DHS also reviewed the records of any members identified in last year's CMR as having health and safety issues and/or complex and challenging situations. The results of these individual record reviews were provided to DHS and to the MCO, but were not included in the FY 15-16 aggregate results.

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.

Results for each indicator were compared to the results from the MCO's previous review to statistically evaluate whether any changes were likely attributable to an intrinsic change at the MCO, or were likely to have come about by normal variation or chance. The Chi-Square test was used to assess the statistical significance of the year-to-year change.

The table below provides specific information by program regarding the FY 14-15 statewide aggregate rate for each of the 14 CMR standards.

CMR Measure	FY 14-15 FC Aggregate Rate	FY 14-15 FCP Aggregate Rate
1A-Comprehensiveness of Assessment	95.1%	93.3%
1B-Re-Assessment Done When Indicated	96.2%	94.2%
2A-Comprehensiveness of Plan	83.2%	88.9%

CMR Measure	FY 14-15 FC Aggregate Rate	FY 14-15 FCP Aggregate Rate
2B-Timeliness of Most Recent Plan (6 months)	91.1%	82.0%
2F-Timeliness of Member-Centered Plan in Past 12 Months	98.9%	98.9%
2C-Plan Updated for Changes	91.0%	80.0%
2D-Timeliness of Service Authorization Decisions	93.3%	93.3%
2E-Risk Addressed	97.5%	91.6%
3A-Timely Coordination of Services	95.3%	87.6%
3B-Follow-Up Completed	80.0%	74.4%
3C-Identified Needs Addressed	97.6%	96.7%
4A-Notice of Action Issued	62.6%	26.3%
4B-Member/ Guardian/Supports Included	99.6%	98.9%
4C-Self-Directed Supports Offered	98.0%	87.8%
CMR Overall Results	**93.1%**	**89.3%**

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.