External Quality Review Annual Technical Report

Fiscal Year 2016 – 2017

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

Final Report

Prepared for

Wisconsin Department of Health Services

Division of Medicaid Services

Prepared by

METASTAR

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External Quality Review Organization
MetaStar, Inc. Suite 300 2909 Landmark Place Madison, Wisconsin 53713
Prepared by staff in the Managed Health & Long-Term Care Department
Primary Contacts
Jenny Klink, MA, CSW Vice President 608-441-8216 jklink@metastar.com
Alicia Stensberg, MA Project Manager 608-441-8255 astensbe@metastar.com
Don Stanislawski, BA Administrative Assistant 608-441-8204 dstanisl@metastar.com

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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 (FC), Family Care Partnership (FCP), and Program of All-Inclusive Care for the Elderly (PACE), to provide for external quality review of these organizations and to produce an annual technical report. To meet its obligations, the State of Wisconsin, Department of Health Services (DHS) contracts with MetaStar, Inc.

This report covers the external quality review fiscal year from July 1, 2016, to June 30, 2017 (FY 16-17). During the first half of FY 16-17, DHS contracted with eight MCOs to administer these programs. On January 1, 2017, three separate FC MCOs merged to create a new organization, reducing the number of contracted MCOs to six. Currently three MCOs operate only FC programs; one MCO operates only a FCP program; one MCO operates both a FC and a FCP program; and one MCO operates programs for FC, FCP, and PACE.

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 systems capabilities 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) Home and Community Based 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 16-17 was the third 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 FCP 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 16-17 ranged from one to 17 standards.

Summary of Progress

- Overall results indicate that every MCO addressed recommendations and made progress related to compliance with federal standards during the course of the current three-year review cycle, which began in FY 14-15 and ended with this year's review.

    - Of the six organizations that received a quality compliance review in FY 16-17, scores ranged from 85 to 87, out of the total 88 points applicable to every organization.
    - One organization made notable progress since last year's review, increasing its quality compliance score from 71 in FY 15-16 to 86 in FY 16-17.
- Aggregate progress for performance improvement projects is not able to be identified, as project topics, study populations, and project timeframes vary widely across organizations. However, all MCOs continued to ensure the following:
    - The data collection approach employed by each MCO captured all members to whom the study questions applied; and
    - MCO staff were qualified and trained to collect data.
- Two organizations received an information systems capabilities assessment in FY 16-17. Both MCOs had addressed recommendations from their previous reviews conducted in FY 13-14, and demonstrated progress in different areas, as follows:
    - One MCO amended policies, procedures, flowcharts, and narrative documents to include additional details to more fully describe organizational structures, areas of responsibilities, and interfaces that contribute to data collection, analysis, and reporting.
    - The other MCO enhanced its encounter data submission process to comply with state requirements and specifications, and implemented new procedures to assure the accuracy of vendor data prior to the submission of the encounter file.

NOTABLE STRENGTHS

Quality Compliance Review - Enrollee Rights and Protections

- Of the six MCOs reviewed in FY 16-17, three organizations have fully met the seven enrollee rights standards that apply to every organization during the course of the three-year review cycle. The other three organizations have fully met six of the seven standards. (Note: An eighth enrollee rights standard, applicable only to the three organizations that operate a FCP and/or PACE program, was fully met by all three MCOs in the first year of the three-year cycle.)

Quality Compliance Review – Quality Assessment and Performance Improvement

- Of the six organizations reviewed in FY 16-17, two have fully met all 21 quality assessment and performance improvement standards during the course of the three-year review cycle. The remaining four organizations have achieved compliance with either 19 or 20 of the 21 standards.
    - All six organizations achieved full compliance with 18 of the 21 standards.

Quality Compliance Review - Grievance Systems

- Five of the six MCOs reviewed in FY 16-17 have fully met all 16 of the grievance systems standards during the course of the three-year review cycle. One MCO met 14 of the 16 standards.

Performance Improvement Projects Validation

MetaStar validated 10 performance improvement projects in FY 16-17. Common strengths identified among projects/MCOs include the following:

- Study topics were selected based on MCO-specific data and needs analysis;
- Nine of 10 projects were developed with clearly stated study questions.
- Projects focused on improving a variety of key aspects of care and services for members;
- Most standards related to data collection procedures were met;
- Eight of 10 projects effectively used continuous cycles of improvement;
- Three projects from three organizations met all validation standards and achieved improvement attributable to the implemented interventions; and
- Five of the 10 performance improvement projects focused on dementia capable care, a DHS priority area.
    - Three of these five projects achieved documented, quantitative improvement, which appeared to be the result of the interventions employed.
    - Two of the projects fully met all applicable validation standards.

Performance Measures Validation

- Influenza vaccination rates increased for the PACE program, for one of the three MCOs operating the FCP program, and for four of the seven MCOs operating the FC program increased.
- Pneumococcal vaccination rates increased for the PACE program, for all three of the MCOs operating the FCP program, and for three of the seven MCOs operating the FC program.
- After resubmission from one MCO, the data from all MCOs met the technical specifications for both the influenza and pneumococcal vaccinations.

Information Systems Capabilities Assessment

MetaStar conducted information systems capabilities assessments for two MCOs in FY 16-17, and identified the following strengths:

- One MCO's electronic care management and service authorization system enables automated functions that lead to efficiency:

    - The Office of Inspector General dataset is loaded into this system to automatically cross-check exclusions from participation in federal Medicaid programs against the MCO's contracted providers.
    - Through this system, the MCO balances the amount of claims paid against the amount of claims submitted on a monthly basis, and compares this information with the encounter file created by its vendor to ensure accuracy of the file prior to submission to DHS.
    - Pre-established reports available from a "drop down" menu have been created in this system to provide staff with multiple methods to view the data on an as needed basis.
    - A temporary identification number is produced by this system when the MCO is transmitting protected health information or personally identifiable information to vendors regarding authorizations and claims, which enhances the security of confidential information.
- One organization encourages providers to communicate with MCO staff at the onset of claims submission regarding the preferred payee for services to trigger the processing system to send the claim directly to the payer of first resort to potentially increase efficiency and reduce the number of false denials.
- One MCO has a standing policy supporting binary claim determinations (paid or denied/rejected) to eliminate error prone decision-making layers and force providers to submit better claims at the onset.

Care Management Review

- In FY 16-17, FC programs maintained aggregate results over 90 percent for the following review indicators. Seven of these indicators were also above 90 percent in FY 15-16:
    - "Reassessment Done when Indicated;"
    - "Timeliness of 12 Month Member-Centered Plan;"
    - "Timeliness of Service Authorization Decisions;"
    - "Risk Addressed when Identified;"
    - "Timely Coordination of Services;"
    - "Identified Needs are Addressed;"
    - "Member/Guardian/Informal Supports Included;" and
    - "Self-Directed Supports Option Offered."

- In FY 16-17, FCP programs maintained aggregate results over 90 percent for the following review indicators. Five of these indicators were also above 90 percent in FY 15-16:
    - "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."

- In FY 16-17, the only PACE program maintained results over 90 percent for the review indicators listed below. PACE did not have a care management review in FY 15-16 because the federal Centers for Medicare & Medicaid Services reviewed the program. However, the results for all of these indicators were also over 90 percent at the time of its last care management review in FY 14-15:
  - "Timeliness of 12 Month Member-Centered Plan;"
  - "Risk Addressed when Identified;"
  - "Identified Needs are Addressed;"
  - "Member/Guardian/Informal Supports Included;" and
  - "Self-Directed Supports Option Offered."

RECOMMENDATIONS

Quality Compliance Review - Enrollee Rights and Protections

- Ensure three MCOs continue efforts to implement effective interventions to ensure applications for renewal of restrictive measures plans are comprehensive, and are submitted to DHS at least 30 days prior to the current plan's expiration.

Quality Compliance Review – Quality Assessment and Performance Improvement

Provide oversight to MCOs in order to ensure:

- Four organizations focus efforts on improving and monitoring mechanisms related to member assessment and the development of comprehensive and timely member-centered plans;
- One organization continues interventions to improve the timeliness of service authorization decisions; and
- One organization improves data collection and analysis mechanisms to effectively assess the quality and appropriateness of care furnished to members.

Quality Compliance Review - Grievance Systems

- Follow up with one MCO to ensure it continues efforts to attain compliance with standards for this focus area.

Performance Improvement Projects Validation

- Provide guidance and oversight for conducting and reporting performance improvement projects to ensure MCOs:
    - Select and define study indicators, using applicable numerators and denominators, to enable the study question to be answered;
    - Ensure all data figures and numerical results are presented clearly and accurately throughout the final report;
    - Ensure the sample contains a sufficient number of members to be fully representative of the MCO's population;
    - Specify a data analysis plan and fully analyze study data, including identification of follow-up actions based on analysis of data; and
    - Explicitly answer the study question and conclude whether the PIP project was successful.

Performance Measures Validation

- Ensure documentation practices for members contraindicated from receiving influenza and pneumococcal vaccinations meet DHS technical specifications.
- Two MCOs should conduct a root cause analysis to identify barriers to pulling the required data, as the pneumococcal data submitted did not initially match the DHS denominator data at the required 95 percent or greater agreement rate and the MCOs were required to resubmit data.

Information Systems Capabilities Assessment

Two MCOs received an information systems capabilities assessment in FY 16-17. The organizations' information systems are architected and implemented differently, according to each MCO's structure and operations; therefore, recommendations are individualized as follows:

- Ensure one MCO:
    - Develops a formal auditing process to reconcile any provider data entered into its electronic care management and service authorization system with the original source data to ensure accuracy;
    - Places a high priority on the following when the organization relocates its offices:
        - Developing policies and procedures related to systems security, access to the network, and vendor acquisition; and
        - Establishment of a secure, encrypted email system;
    - Completes a full test of the disaster recovery back-up system to ensure it is fully operational when needed; and

    - Continues with plans to revise confidentiality and security policies and procedures to include annual refresher training for all MCO staff.
- Ensure the other MCO:
    - Continues to focus on efforts to increase the proportion of claims that are submitted via electronic means;
    - Works with its vendor to obtain segment breakdowns of paper versus electronic claims, by service and by provider type, to allow the MCO to focus its efforts on service areas and providers with higher volume, cost, and need;
    - Develops policies and procedures/flowcharts to document the processes in place for the resolution of batch and other errors identified by DHS during the process of downloading and accepting the encounter files; and
    - Places a priority on developing and implementing testing plans to ensure provider data is not compromised when the organization transitions to a new integrated system to house all provider data.

Care Management Review

- Provide guidance and oversight to all programs (FC, FCP, and PACE) to focus improvement efforts on the following areas of care management practice:
    - Improving the comprehensiveness of member-centered plans;
    - Following up to ensure services have been received and are effective; and
    - Issuing notices to members in a timely manner when indicated.
- Ensure organizations operating FC and FCP programs consistently update plans when members have significant changes in situation or condition.
- Oversee FCP to improve the timeliness with which member-centered plans are reviewed and signed at the required six month intervals.

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 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 periodic external quality reviews of the 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, 2016, to June 30, 2017 (FY 16-17). 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 the first half of FY 16-17, the Wisconsin Department of Health Services (DHS) contracted with eight MCOs to administer these programs. On January 1, 2017, three separate FC MCOs merged to create a new organization, reducing the number of contracted MCOs to six.

As noted in the table below, currently three 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 Link, Inc. (CLI)*	FC
Independent Care Health Plan (*i*Care)	FCP
Lakeland Care, Inc. (LC)**	FC
My Choice Family Care, Inc. (MCFC)***	FC

***** Effective January 1, 2017, three separate FC MCOs, Community Care Connections of Wisconsin (CCCW), ContinuUs, and Western Wisconsin Cares (WWC) merged to create a new organization, Community Link, Inc.
******Effective January 1, 2017, Lakeland Care District reorganized from a public Family Care District to a private nonprofit corporation, Lakeland Care, Inc.
*******Effective September 1, 2016, My Choice Family Care transitioned from a department of Milwaukee County government to a private, nonprofit organization.

During 2016, DHS certified two MCOs, CCCW and MCFC, to expand into geographic service region (GSR) 14, providing consumers with access to FC in an area where it had not previously been available. In addition, CW was certified to expand into GSR 3, an area also being served by one other MCO, thus affording consumers in this region choice of MCO providers.

Links to maps depicting the current FC and FCP/PACE GSRs 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

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

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

As of June 30, 2017, enrollment for all programs was approximately 48,948. This compares to a total enrollment of 46,458 as of June 30, 2016. Enrollment data is available at the following DHS website:

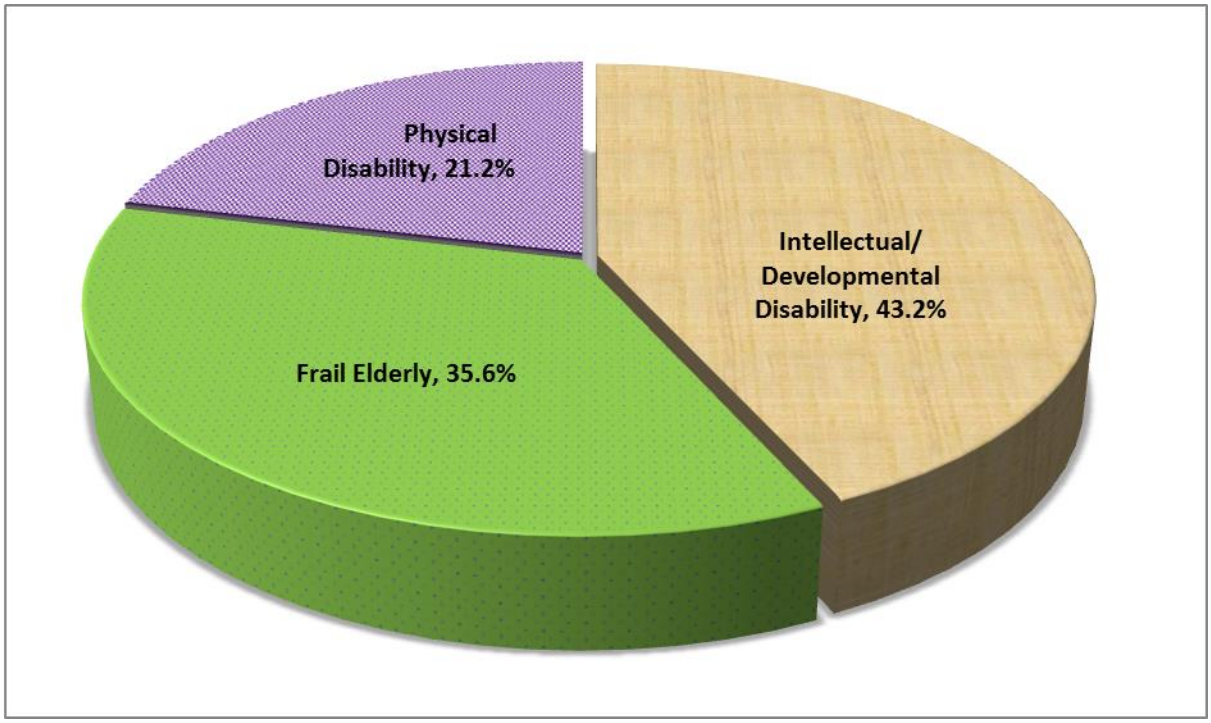
https://www.dhs.wisconsin.gov/familycare/enrollmentdata.htm

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.

On January 9, 2017, DHS implemented an enhancement to the Adult Long Term Care Functional Screen (LTC FS) known as target group automation. This enhancement created updated logic for target group determinations. As part of this process, DHS decided to change the way that it assigned a target group for people with physical disabilities (PD) age 65 or older. Those individuals are now assigned to the frail elder (FE) target group in the LTC FS. This reassignment occurs at the time functional eligibility is calculated or recalculated on or after January 9, 2017.

Over the course of 2017, all people who have a PD and are age 65 or older will be assigned to the FE target group. The data in the enrollment report has started to reflect this change, with PD target group numbers decreasing while FE target group numbers increase. People who are in the intellectual/developmental disability (I/DD) target group remain in the I/DD target group regardless of age.

Total Participants in All Programs by Target Group June 30, 2017



SCOPE OF EXTERNAL REVIEW ACTIVITIES

In FY 16-17, 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 capabilities assessments (ISCAs) during FY 16-17. 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 16-17 was the third year of the three-year cycle. The number of standards MetaStar reviewed per organization ranged from one to 17.

Mandatory Review Activities	Scope of Activities
Performance Improvement Projects Validation	The DHS-MCO contract requires each MCO to annually make active progress on at least one clinical or non-clinical PIP relevant to long-term care. In FY 16-17, MetaStar validated one or more PIPs for each MCO, for a total of 10 PIPs. The PIP topics reviewed for each MCO are indicated in the chart on page 15.
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 16-17, 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 other performance measures as applicable directly to DHS; MetaStar did not validate these measures.
Information Systems Capabilities 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 two MCOs during FY 16-17.
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) Home and Community Based Waivers, which allow the State of Wisconsin to operate its Family Care programs. During FY 16-17, the EQR team conducted CMR activities during each MCO's annual quality review (AQR), and a total of 748 records were reviewed across all three programs.

	At the request of DHS, MetaStar also reviewed an additional 101 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	• Diabetes management (FC) • Diabetes management (FCP)
CCI	• Frequency of behavioral symptoms (FC) • Dementia care (FCP/PACE)
CLI, formerly CCCW	• Dementia care (FC)
CLI, formerly ContinuUs	• Institute of Mental Disease (IMD) readmissions and inpatient mental health re-hospitalizations (FC)
CLI, formerly WWC	• Frequency of behavioral symptoms (FC)
*i*Care	• Dementia care (FCP)
LC	• Dementia early identification/screening (FC)
MCFC	• Dementia early identification/screening (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. See Appendix 3 for more information about the CMR methodology.

MCO/Program	CMR Sample Size
Family Care	
CW	88
CCI	140
CLI, formerly CCCW members	89
CLI, formerly ContinuUs members	70
CLI, formerly WWC members	55
LC	63
MCFC	123
Total: Family Care	**628**

MCO/Program	CMR Sample Size
Family Care Partnership/PACE	
CW	30
CCI - FCP	30
CCI - PACE	30
*i*Care	30
Total: Family Care Partnership/PACE	**120**
Total: All Programs	**748**

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 16-17 was the third year in the three-year cycle. For each MCO that received a QCR, MetaStar reviewed only those compliance standards the MCO did not fully meet during the two previous years.

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 3 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 15-16 and FY 14-15 reviews. The bar labeled FY 16-17 represents the cumulative score each MCO achieved in the third year of the three-year cycle, i.e., any additional points from this year's review were added to the MCO's score from the previous two years.

Readers will note the bar graph does not include FY 16-17 overall results for two organizations, CCCW and ContinuUs. CCCW, ContinuUs, and WWC merged in the middle of the review year (effective January 1, 2017). CCCW and ContinuUs had not had a QCR prior to the time of the merger. The current direction from DHS is for the new organization, CLI, to receive a comprehensive QCR in fall 2017 to meet CMS reporting requirements.

Overall QCR results indicate five of the six organizations reviewed made additional progress in the last year. The one MCO that did not make progress had only one remaining partially met standard. The six organizations completing the three-year cycle have achieved scores ranging from 85 to 87, out of the total possible 88.

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

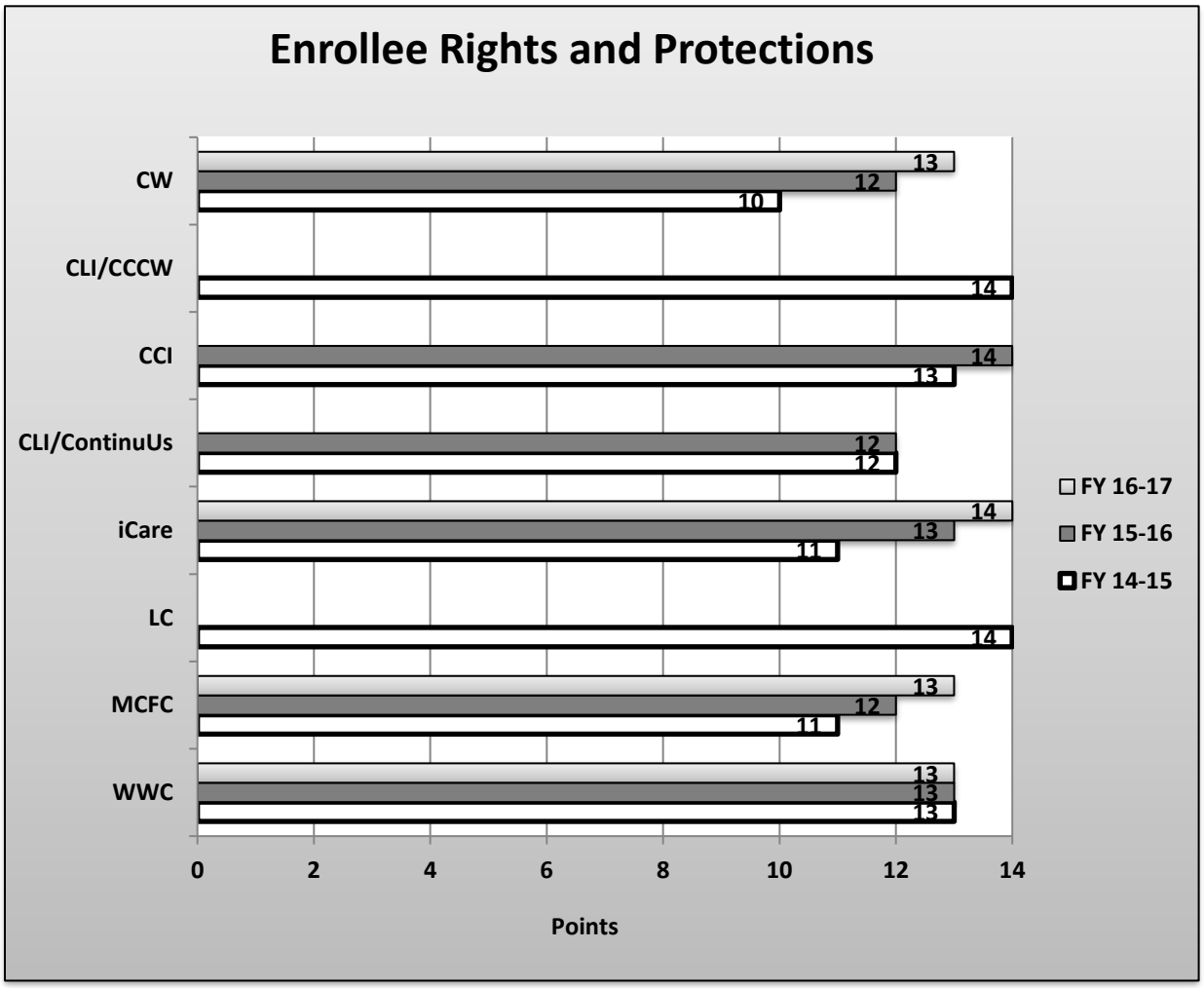
Results for Enrollee Rights and Protections

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 16-17 results shown are cumulative over the current three-year cycle, i.e., any additional points from this year's review were added to the MCO's score from the previous two years. The graph also compares this year's results to the MCO's level of compliance in FYs 14-15 and 15-16.

Readers will note the bar graph does not include FY 15-16 and/or FY 16-17 results for four organizations. As previously indicated, for each MCO that received a QCR, MetaStar reviewed only those compliance standards the MCO did not fully meet during the two previous years. Two of these MCOs (CCI, LC) had fully met all of the enrollee rights standards in either the first or second year of the current three-year review cycle. Two other MCOs (CCCW, ContinuUs) had not yet received a FY 16-17 QCR prior to the time of their merger with another FC MCO on January 1, 2017, although CCCW had also fully met all of the enrollee rights standards in a previous year of the review cycle. As noted above, the current direction from DHS is for the new organization, CLI, to receive a comprehensive QCR in fall 2017 to meet CMS reporting requirements.

Bar Graph E.1



The following table, E.2, lists the specific "Enrollee Rights and Protections" standards that required review in FY 16-17. The first column indicates the number assigned to the review standard. The second column describes the standard. The last two columns depict the number of MCOs MetaStar reviewed this year due to a "partially met" finding in last year's review; and of those MCOs reviewed, the number that achieved compliance and received a "met" rating in this year's review.

Table E.2

#	Enrollee Rights and Protections	Number of MCOs Reviewed in FY 16-17 due to Partially Met Rating in FY 15-16	MCOs Reviewed in FY 16-17 Achieving a Rating of Met
	Information Requirements		
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.	1	1
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.	1	1
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-	1	1

#	Enrollee Rights and Protections	Number of MCOs Reviewed in FY 16-17 due to Partially Met Rating in FY 15-16	MCOs Reviewed in FY 16-17 Achieving a Rating of Met
	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.		
	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; • 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.	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:

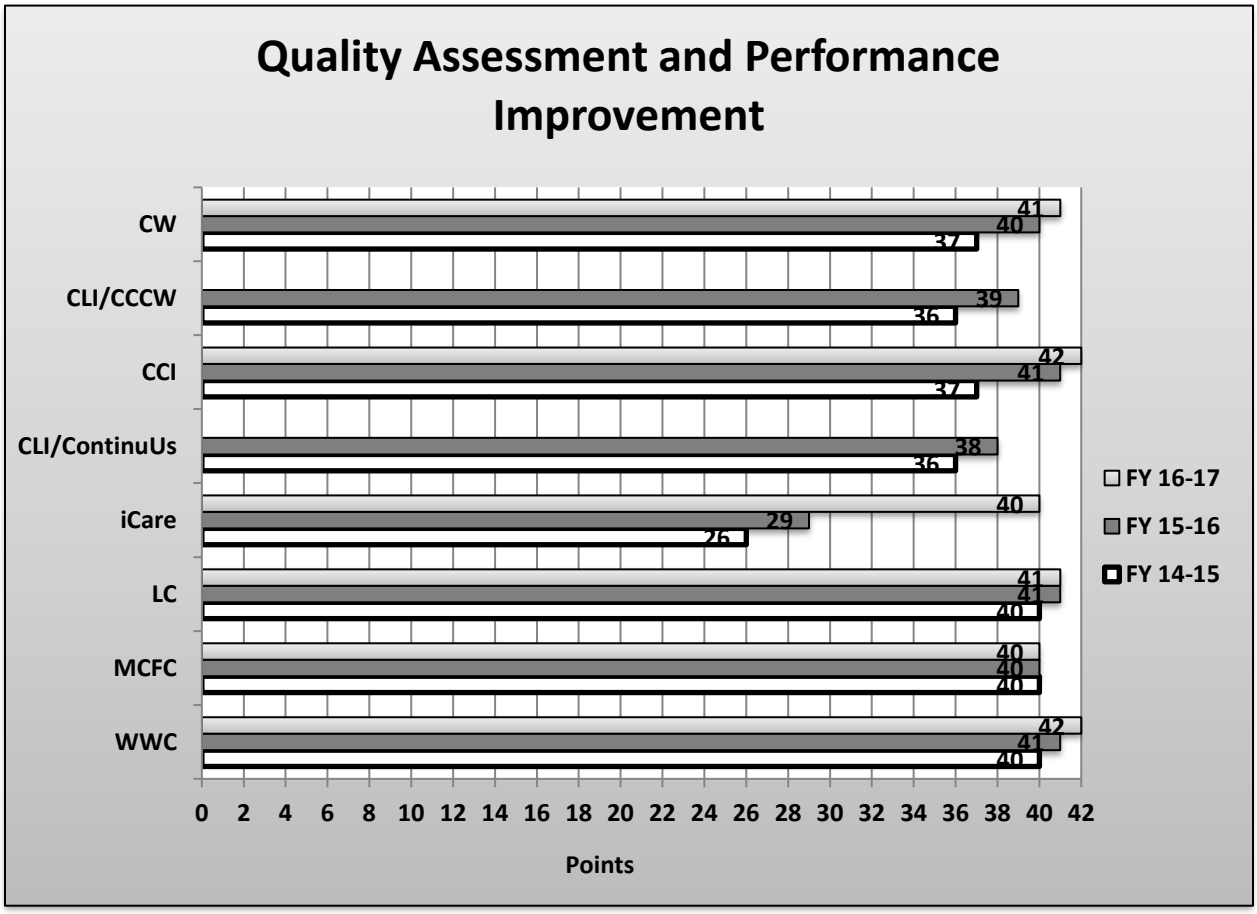
- Availability of accessible, culturally competent services through a network of qualified service providers;
- Coordination and continuity of member care;

- 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 16-17 results shown are cumulative over the current three-year cycle, i.e., any additional points from this year's review were added to the MCO's score from the previous two years. The graph also compares this year's results to the MCO's level of compliance in FYs 14-15 and 15-16.

Reviewers will note the bar graph does not include FY 16-17 results for two MCOs (CCCW and ContinuUs). These two organizations had not yet received a FY 16-17 QCR prior to the time of their merger with another FC MCO on January 1, 2017. As noted above, the current direction from DHS is for the new organization, CLI, to receive a comprehensive QCR in fall 2017 to meet CMS reporting requirements.

Bar Graph Q.1



The following table, Q.2, lists the specific "Quality Assessment and Performance Improvement" standards that required review in FY 16-17. The first column indicates the number assigned to the review standard. The second column describes the standard. The last two columns depict the number of MCOs MetaStar reviewed this year due to a "partially met" finding in last year's review; and of those MCOs reviewed, the number that achieved compliance and received a "met" rating in this year's review.

Table Q.2

#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement	Number of MCOs Reviewed in FY 16-17 due to Partially Met Rating in FY 15-16	MCOs Reviewed in FY 16-17 Achieving a Rating of 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.	1	1
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	1	1

#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement	Number of MCOs Reviewed in FY 16-17 due to Partially Met Rating in FY 15-16	MCOs Reviewed in FY 16-17 Achieving a Rating of Met
	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.		
	Coordination and Continuity of Care		
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.	4	0
	Coverage and Authorization of Services		
8	**42 CFR 438.210; DHS-MCO Contract Article V.** **Timeframe for decisions of approval or denial** The interdisciplinary team (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	1	0

#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement	Number of MCOs Reviewed in FY 16-17 due to Partially Met Rating in FY 15-16	MCOs Reviewed in FY 16-17 Achieving a Rating of Met
	the IDT receives the request. The IDT 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.		
	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. 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.	2	2
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;	1	1

#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement	Number of MCOs Reviewed in FY 16-17 due to Partially Met Rating in FY 15-16	MCOs Reviewed in FY 16-17 Achieving a Rating of Met
	the Rehabilitation Act of 1973; and the Americans with Disabilities Act of 1990, as amended.		
	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.
	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.
		1	1

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. *Processing Disenrollments* The enrollment plan, developed in collaboration with the aging and disability resource center (ADRC) 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 on the Client Assistance for Re-employment and Economic Support (CARES) system, so that correct capitation payments are made to the MCO; and	1	1

#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement	Number of MCOs Reviewed in FY 16-17 due to Partially Met Rating in FY 15-16	MCOs Reviewed in FY 16-17 Achieving a Rating of Met
	• 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. *MCO Influence Prohibited* • 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. *Member Requested Disenrollment* • 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 ADRC 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. *Interactions with Other Agencies Related to Eligibility and Enrollment* • 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 ADRC, 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 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 ADRC 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:	1	1

#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement	Number of MCOs Reviewed in FY 16-17 due to Partially Met Rating in FY 15-16	MCOs Reviewed in FY 16-17 Achieving a Rating of Met
	○ 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.		
	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.	2	2
	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;	2	2

#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement	Number of MCOs Reviewed in FY 16-17 due to Partially Met Rating in FY 15-16	MCOs Reviewed in FY 16-17 Achieving a Rating of Met
	• Monitors access to providers and verifies that services were provided; • Monitors the quality of subcontractor services.		
	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.	1	1
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.	1	0
	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.	1	1

Results for Grievance System

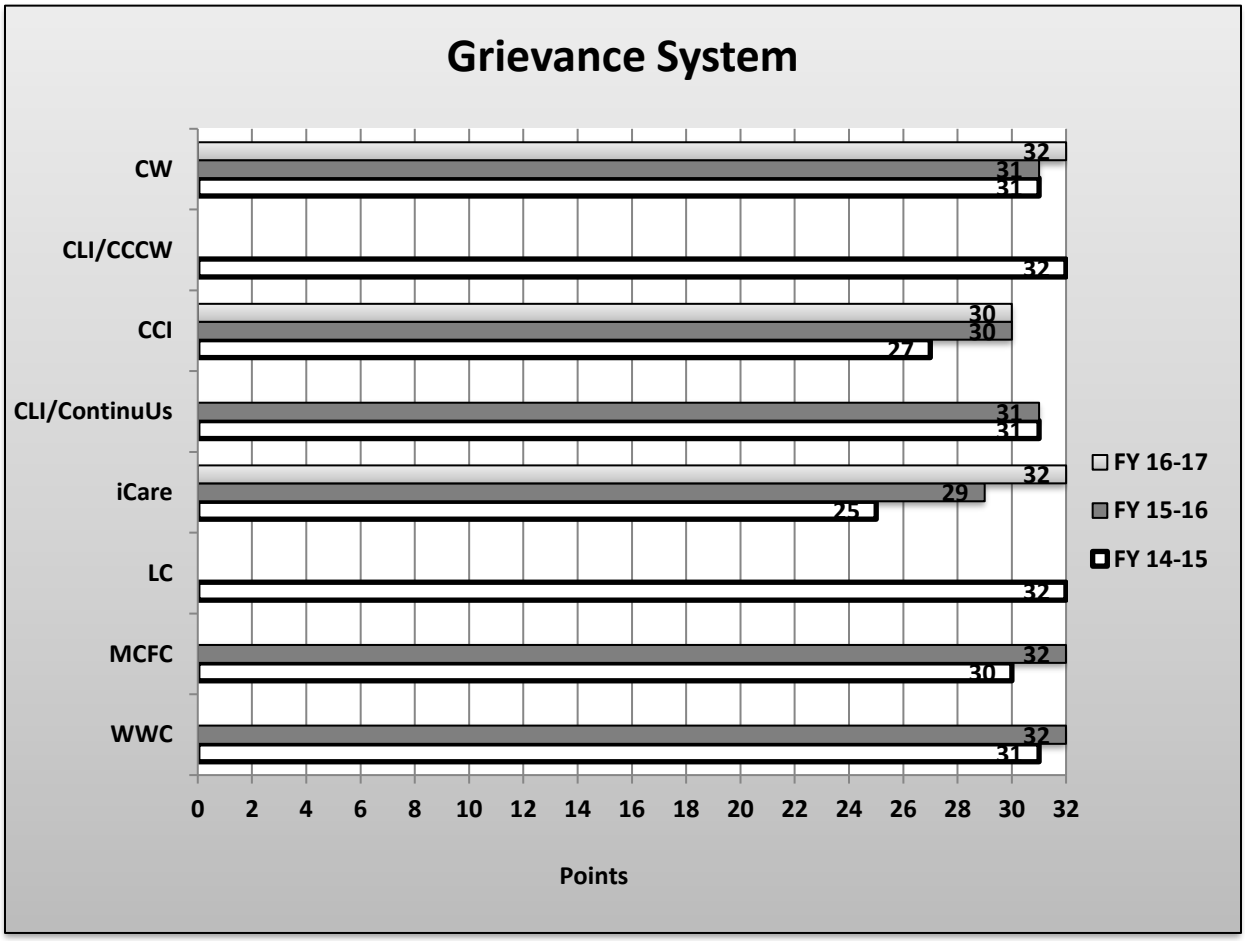
The MCO must have the organizational structure and processes in place to provide a local system for grievances and appeals that also allows access to both DHS' grievances and appeals process, and the State Fair Hearing process. Policies and procedures must align with federal and state requirements.

Bar graph G.1 below indicates each MCO's level of compliance with the "Grievance System" standards. The FY 16-17 results shown are cumulative over the current three-year cycle, i.e., additional points from this year's review were added to the MCO's score from the previous two years. The graph also compares this year's results to the MCO's level of compliance in FYs 14-15 and 15-16.

Readers will note the bar graph does not include FY 15-16 and/or FY 16-17 results for five organizations. As this was the third year of the three-year cycle, MetaStar reviewed only those compliance standards an MCO did not fully meet during the two previous years. Three of these MCOs (LC, MCFC, WWC) had fully met all of the grievance systems standards in either the first or second year of the current three-year review cycle. Two other MCOs (CCCW, ContinuUs) had not yet received a FY 16-17 QCR prior to the time of merger with another FC

MCO, on January 1, 2017, although CCCW had also fully met all of the grievance standards in a previous year of the review cycle.

Bar Graph G.1



The following table, G.2, lists the specific "Grievance System" standards that required review in FY 16-17. The first column indicates the number assigned to the review standard. The second column describes the standard. The last two columns depict the number of MCOs MetaStar reviewed this year due to a "partially met" finding in last year's review; and of those MCOs reviewed, the number that achieved compliance and received a "met" rating in this year's review.

Table G.2

#	Grievance System	Number of MCOs Reviewed in FY 16-17 due to Partially Met Rating in FY 15-16	MCOs Reviewed in FY 16-17 Achieving a Rating of Met
	Notices to Members		
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.	3	2
	Handling of Grievances and Appeals		

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;
	  ○ 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'
		1	1

#	Grievance System	Number of MCOs Reviewed in FY 16-17 due to Partially Met Rating in FY 15-16	MCOs Reviewed in FY 16-17 Achieving a Rating of Met
	are offered the choice to exclude any consumer representatives from participation in their hearing.		
	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.	1	1
	Continuation of Benefits While the MCO Appeal and State Fair Hearing are Pending		
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.	1	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.

Readers will note the columns for two organizations, CCCW and ContinuUs, are blank. As explained previously, CCCW, ContinuUs, and WWC merged in the middle of the review year. As MetaStar had not yet conducted QCR for CCCW and ContinuUs prior to the time of the merger, there are no results for these organizations in the following table.

QCR TOPICS and Number of Standards per Topic	CW	CCI	CCCW	ContinuUs	*i*Care	LC	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)								
QAPI Program (1)								
Basic Elements of the QAPI Program (2)					√			
Quality Evaluation (1)								
Health Information Systems (1)								

QCR TOPICS and Number of Standards per Topic	CW	CCI	CCCW	ContinuUs	*i*Care	LC	MCFC	WWC
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	**2**	**2**	**N/A**	**N/A**	**2**	**1**	**3**	**1**

CONCLUSIONS

Enrollee Rights and Protections

Based on the data in bar graph E.1 above, FY 16-17 results for the six MCOs reviewed in this area ranged from 13 to 14 points, for the seven Enrollee Rights standards applicable to every organization.

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

Progress

- This year, one additional MCO achieved full compliance with the Enrollee Rights standards.
- Of those MCOs with standards reviewed for this focus area, three of four made progress.

Strengths

- The six organizations that have completed the three-year review cycle have achieved compliance in seven of eight Enrollee Rights standards, addressing the following areas: general rule, information requirements, and emergency and post-stabilization services.

Opportunities

- Three MCOs should continue efforts to implement effective interventions to ensure applications for renewal of restrictive measures plans are comprehensive and submitted to DHS at least 30 days prior to the current plan's expiration.

Quality Assessment and Performance Improvement

Based on the data in bar graph Q.1 above, the results for the six MCOs reviewed in this area ranged from 40 to 42 points for the 21 standards in this review area.

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

Progress

- Two organizations achieved full compliance with all QAPI standards.
- Of those MCOs with standards reviewed for this focus area, five of six made progress.

Strengths

- The six organizations that have completed the three-year review cycle have achieved compliance in 18 of 21 QAPI standards, addressing the following areas: availability of

services, provider selection, confidentiality, enrollment and disenrollment, subcontractor/provider relationships and delegation, practice guidelines, QAPI program, quality evaluation, and health information systems.

Opportunities

- Four MCOs should focus efforts on improving and monitoring mechanisms related to member assessment and the development of comprehensive and timely member-centered plans.
- One organization should continue interventions to improve the timeliness of service authorization decisions.
- One MCO should improve data collection and analysis mechanisms to effectively assess the quality and appropriateness of care furnished to members.

Grievance Systems

Based on the data in bar graph G.1 above, the results for the six MCOs reviewed in this area ranged from 30 to 32 points for the 16 standards in this review area.

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

Progress

- This year, two additional MCOs achieved full compliance with the Grievance System standards.
- Of those MCOs with standards reviewed for this focus area, two of three made progress.
- At the conclusion of the three-year cycle, five of the six organizations reviewed have achieved compliance with the requirement to issue notices to members in a timely manner when indicated. This had previously been identified as an opportunity for improvement.

Strengths

- Five of the six organizations that have completed the three-year review cycle have achieved full compliance in Grievance System standards.

Opportunities

- One MCO should continue efforts to attain compliance with standards for this focus area.

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 16-17, 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. Since 2014, DHS has required all projects to be conducted on a calendar year basis. For projects conducted during 2016, organizations submitted proposals to DHS in February 2016. DHS directed MCOs to submit final reports by December 30, 2016. MetaStar validated one or more PIPs for each organization, for a total of 10 PIPs. More information about PIP validation review methodology can be found in Appendix 3.

AGGREGATE RESULTS FOR PERFORMANCE IMPROVEMENT PROJECTS

The following table 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 16-17 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.	9/10

FY 16-17 Performance Improvement Project Validation Results		
	Numerator = Number of projects meeting the standard Denominator = Number of projects applicable for the standard	
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.	9/10
Study Indicator(s)		
3	The study used objective, clearly and unambiguously defined, measureable indicators and included defined numerators and denominators.	7/10
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.	5/10
Study Population		
5	The project/study clearly defined the relevant population (all members to whom the study question and indicators apply).	8/10
6	If the entire population was used, data collection approach captured all members to whom the study question applied.	8/8
Sampling Methods		
7	Valid sampling techniques were used.	2/2
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.	8/10
10	Staff are qualified and trained to collect data.	10/10
11	The instruments for data collection provided for consistent, accurate data collection over the time periods studied.	8/10
12	The study design prospectively specified a data analysis plan.	7/10
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.	7/10
14	A continuous cycle of improvement was utilized to measure and analyze performance, and to develop and implement system-wide improvements.	8/10
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.	5/10
17	Numerical results and findings were presented accurately and clearly.	6/10
18	The analysis of study data included an interpretation of the extent to which the PIP was successful and defined follow-up activities as a result.	4/10
"Real" Improvement		
19	The same methodology as the baseline measurement was used, when measurement was repeated.	7/10
20	There was a documented, quantitative improvement in processes or outcomes of care.	4/10
21	The reported improvement appeared to be the result of the planned quality improvement intervention.	4/10

FY 16-17 Performance Improvement Project Validation Results		
	Numerator = Number of projects meeting the standard Denominator = Number of projects applicable for the standard	
Sustained Improvement		
22	Sustained improvement was demonstrated through repeated measurements over comparable time periods.	1/1

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				
Improve hemoglobin (HbA1c) index control for FC members with diabetes.	Conducted staff training for Motivational Interviewing (MI) techniques. Offered individual staff coaching on new skill development and implemented Peer Learning Groups. Encouraged staff to document diabetic data in the member's medical records.	Project did not demonstrate improvement.	Partially Met	Include MCO data when describing the study topic. Select indicators associated with improving member outcomes. Clearly define the study population with inclusion and exclusion criteria. Specify a data analysis plan and analyze data periodically. Select interventions taking into consideration the root causes or barriers for the problem identified. Clearly present numerical results and include periodic data in the report. Ensure the methodology for initial and repeat measures are comparable.

Aim	Interventions	Outcomes	Validation Result	EQR Recommendations
Improve HbA1c index control for FCP members with diabetes.	Targeted MI interventions to improve member outcomes related to glycemic control. Conducted staff training for MI techniques. Offered individual staff coaching on new skill development and implemented Peer Learning Groups.	Project did not demonstrate improvement in glycemic index control.	Partially Met	Establish indicators to measure each study question. Clearly define the study population with inclusion and exclusion criteria. Specify a data analysis plan and analyze data periodically to identify if changes in the project are warranted to improve the outcome. Ensure the methodology for all initial and repeat measures are comparable.
MCO – Community Care, Inc.				
Reduce the use of antipsychotic medications for those with dementia.	Offered online training coupon for residential providers. Promoted IDT approach in the development of Behavioral Support Plans. Conducted member-centered medication reviews by pharmacists in collaboration with prescribers to focus on the reduction of use of antipsychotic medications.	The project did not demonstrate quantitative improvement.	Not Met	Define measurable indictors, including numerators and denominators. Ensure indicators are defined to measure change in the desired outcome. Select and fully implement interventions which address root causes or barriers. Conduct and document continuous cycles of improvement in the report. Clearly present numerical results.
Increase the level of physical activity and reduce the incidence of maladaptive behavior for those with behavioral	Provided all study members a pedometer to track daily steps. Established an individualized goal for each study member	The project did not demonstrate quantitative improvement.	Not Met	Ensure the study question is simple and clearly defined. Ensure numerators and denominators define the study

Aim	Interventions	Outcomes	Validation Result	EQR Recommendations
support plans residing in residential facilities.	related to increasing daily steps. Partnered with providers to encourage members to increase steps/physical activity. Developed and shared behavior and activity tracking forms with providers.			indicators as well as measure change in the desired outcome. Select interventions which address root causes or barriers. Conduct continuous cycles of improvement throughout the study, and include documentation in the report. Clearly display data to enable the study question to be answered. Consider sample size of the study population to ensure results are fully representative of the MCO's population.
MCO – Community Care Connections of Wisconsin				
Increase the number of members with dementia who have a member-specific dementia care plan of action on their residential provider's care plan.	Implemented a Dementia Toolkit for selected residential providers to use with members. Offered a financial incentive to participating providers that implemented a more individualized dementia program.	Project demonstrated improvement: Increased the percent of members with dementia who have an individualized action plan from 0% to 68%. Increased the percent of participating providers offering a specialized dementia program from 0% to 22%.	Met	Clearly specify the data analysis plan and conduct analysis according to this plan.
MCO – ContinuUs				
Reduce the rate of readmission to an Institution for Mental Disease or a hospital for	Developed and implemented a consistent mental health committee consultation process.	Due to several issues with the study design, quantitative	Partially Met	Define indicators to measure results as intended. Explain all data

Aim	Interventions	Outcomes	Validation Result	EQR Recommendations
mental health reasons.		improvement could not be confirmed.		sources and ensure data is accurate. Ensure initial and repeat measures are comparable. Fully analyze data and identify follow-up actions as a result.
MCO – Independent Care Health Plan				
Decrease the Caregiver Strain Index score for individuals supporting members with dementia.	Used the *Dementia Care Management* procedure, which outlines care management standards of practice. Implemented additional case review for caregivers with higher caregiver strain scores. Developed and implemented member outcome templates.	Project did not demonstrate quantitative improvement.	Partially Met	Clearly define data collection procedures and ensure data is consistently collected. Ensure the study population size is adequate to have confidence in the results. Clearly present numerical results. Fully analyze data and identify follow-up activities.
MCO – Lakeland Care District				
Improve early and comprehensive identification of members in need of dementia screening.	Developed staff training materials and conducted training for administration of the *Mini-Cog Dementia Screen*. Educated members about dementia and the benefits of dementia screening. Administered the dementia screen to a targeted member group. Developed and tested a new tracking worksheet for data entry.	Project demonstrated “real” improvement: increased the rate of participation in the Mini-Cog Dementia screen from 0% to 96.86% between May 1, 2016 and July 31, 2016.	Met	Obtain repeat measures to demonstrate sustainability. Continue to sustain the level of improvement that has been achieved.

Aim	Interventions	Outcomes	Validation Result	EQR Recommendations
MCO – My Choice Family Care				
Increase the rate of dementia screening and submission of abnormal screening results to physicians.	Amended cognitive impairment screening guidelines and requirements, and provided training to care management teams. Altered a physician letter used to refer members for additional cognitive evaluation. Revised documentation worksheets in the electronic care management documentation system to enable automated reporting of information. Enabled care management unit (CMU) lead supervisors to generate the automated reports reflecting CMU staff compliance with the screening guidelines.	Project demonstrated improvement: Improved the rate of qualified members with the *Animal Naming Test* (ANT) screening administered from a recalculated baseline of 63% to 79% in 2016. Improved the rate of qualified members with both the ANT and *Mini-Cog* screening administered from a recalculated baseline of 26% to 71% in 2016. Improved the percentage of abnormal screening results reported to the member's physician from a recalculated baseline of 1.7% to 13.7% in 2016.	Met	Specify the data analysis plan. Obtain repeat measures to demonstrate sustainability.
MCO – Western Wisconsin Cares				
Reduce the average frequency of behavioral symptoms.	Provided increased support for providers in the development, assessment, and review of Behavior Support Plans and Restrictive Measures Plans. Developed tools to document and assess behaviors.	Project demonstrated improvement: Reduced maximum and average frequency of behaviors at the individual member level as measured by two indicators. Project demonstrated sustained improvement of average frequency	Met	Further quantify the effectiveness of the interventions.

Aim	Interventions	Outcomes	Validation Result	EQR Recommendations
		of behaviors for the study population as a group with repeat measures over a two-year period.		

CONCLUSIONS

All MCOs obtained approvals to conduct the required number of PIPs during calendar year 2016. Projects focused on a variety of topics, with one project continuing from the prior year, and nine PIPs addressing new topics. In late 2015, DHS encouraged MCOs to develop PIP proposals in alignment with state priorities. One DHS priority area encompassed dementia capable care, and five of the ten projects focused on this topic. Three of the five dementia projects achieved documented, quantitative improvement which appeared to be the result of the interventions employed. Two of these projects fully met all applicable validation standards. In addition, for the MCO with the continuing PIP, the project achieved documented, quantitative improvement, met all applicable validation standards, and 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.
- Nine of 10 projects were developed with clearly stated study questions.
- Most standards related to data collection procedures were met.
- Eight of 10 projects effectively utilized continuous cycles of improvement.
- Three projects from three organizations met all validation standards and achieved improvement attributable to the implemented interventions.

Opportunities for Improvement

- Include data and information specific to the MCOs' members when describing the reason for selecting the study topic.
- Select and define indicators, using applicable numerators and denominators, to enable the study question to be answered.
- Clearly describe the study population with inclusion and exclusion criteria, and any changes made during the project.
- Ensure all data figures and numerical results are presented clearly and accurately throughout the final report.
- Ensure the sample contains a sufficient number of members to be fully representative of the MCO's population.

    - Include documentation in the report to address any possible bias related to sampling methods.
- Conduct a root cause and/or barrier analysis prior to selecting interventions for the project, and ensure that interventions are sufficient to be expected to improve outcomes.
- Fully implement all stated interventions during the course of the project.
- Specify a data analysis plan and fully analyze study data, including identification of follow-up actions based on analysis of data.
- Ensure the methodology for initial and repeat measures are comparable.
- Explicitly answer the study question and conclude whether the PIP project was successful.
- Obtain repeat measures to demonstrate sustainability.

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) 2016, which are set forth in Addendum IV of the 2016 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 2016. The MY is defined in the technical definitions provided by DHS for the influenza and pneumococcal vaccination quality indicators. 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.

It should be noted that acute and primary care services, including vaccinations, are included in the FCP and PACE benefit package although are not among the services covered in the FC benefit package. However, in all three programs, coordination of long-term care with preventive health services is required. Care managers are expected to check on members' health services, such as vaccinations, to promote preventive care and wellness to ensure members stay as healthy as possible.

Readers should note, on January 9, 2017, DHS implemented an enhancement to the LTC FS known as target group automation. This enhancement created updated logic for target group determinations. As part of this process, DHS decided to change the way that it assigned a target group for people with PD age 65 or older. Those individuals are now assigned to the FE target group in the LTC FS. This reassignment occurs at the time functional eligibility is calculated or recalculated on or after January 9, 2017.

All people who have a PD and are age 65 or older are assigned to the FE target group. People who are in the I/DD target group remain in the I/DD target group regardless of age.

Vaccination Rates by Program and MCO

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

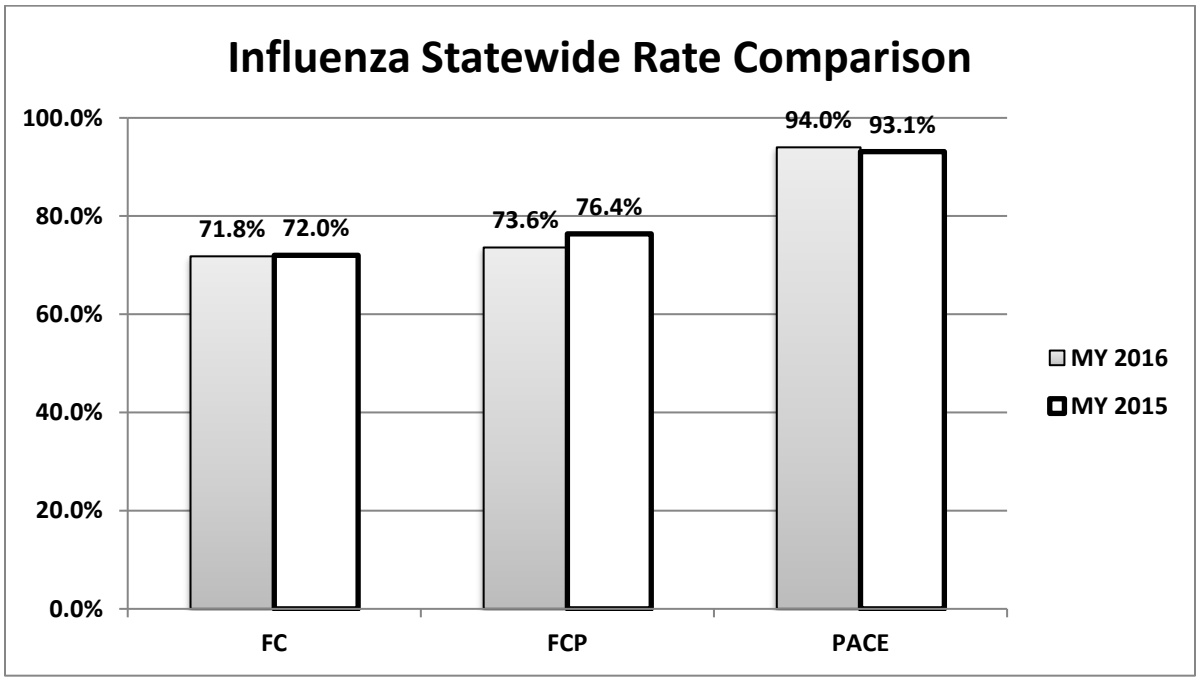
Influenza Vaccination Rates

The following table shows information about the influenza vaccination rates, by program, for MY 2016, and compares the 2016 rates to vaccination rates in MY 2015, which:

- Decreased 0.2 percentage points for FC members;
- Decreased 2.8 percentage points for FCP members; and
- Increased 0.9 percentage points for PACE members.

Statewide Influenza Vaccination Rates by Program				
	MY 2016			MY 2015
Program	Eligible Members	Number Vaccinated	Vaccination Rate	Vaccination Rate
Family Care	38,325	27,516	71.8%	72.0%
Family Care Partnership	2,537	1,866	73.6%	76.4%
PACE	536	504	94.0%	93.1%

Influenza statewide vaccination rates, by program, for MY 2016 and MY 2015 are shown in the following graph.



As shown in the table on the following page, among MCOs that operate FC, the MY 2016 influenza vaccination rates ranged from 68.3 percent to 77.3 percent. Among MCOs that operate FCP, the MY 2016 rates ranged from 61.8 percent to 82.5 percent. The MY 2016 rate for the one MCO that operates the PACE program was 94.0 percent.

Influenza Vaccination Rates by Program and MCO in MY 2016 and MY 2015			
Program/MCO	**MY 2016 Rate**	**MY 2015 Rate**	**Percentage Point Change**
Family Care			
CCI	72.3%	71.7%	0.6%
CLI, formerly CCCW	68.7%	67.6%	1.1%
CLI, formerly ContinuUs	76.0%	77.1%	(1.1%)
CLI, formerly WWC	69.5%	72.0%	(2.5%)
CW	73.1%	72.4%	0.7%
LC	77.3%	77.2%	0.1%
MCFC	68.3%	70.0%	(1.7%)
Family Care Partnership			
CCI	82.5%	88.3%	(5.8%)
CW	76.1%	79.6%	(3.5%)
*i*Care	61.8%	61.7%	0.1%
PACE			
CCI	94.0%	93.1%	0.9%

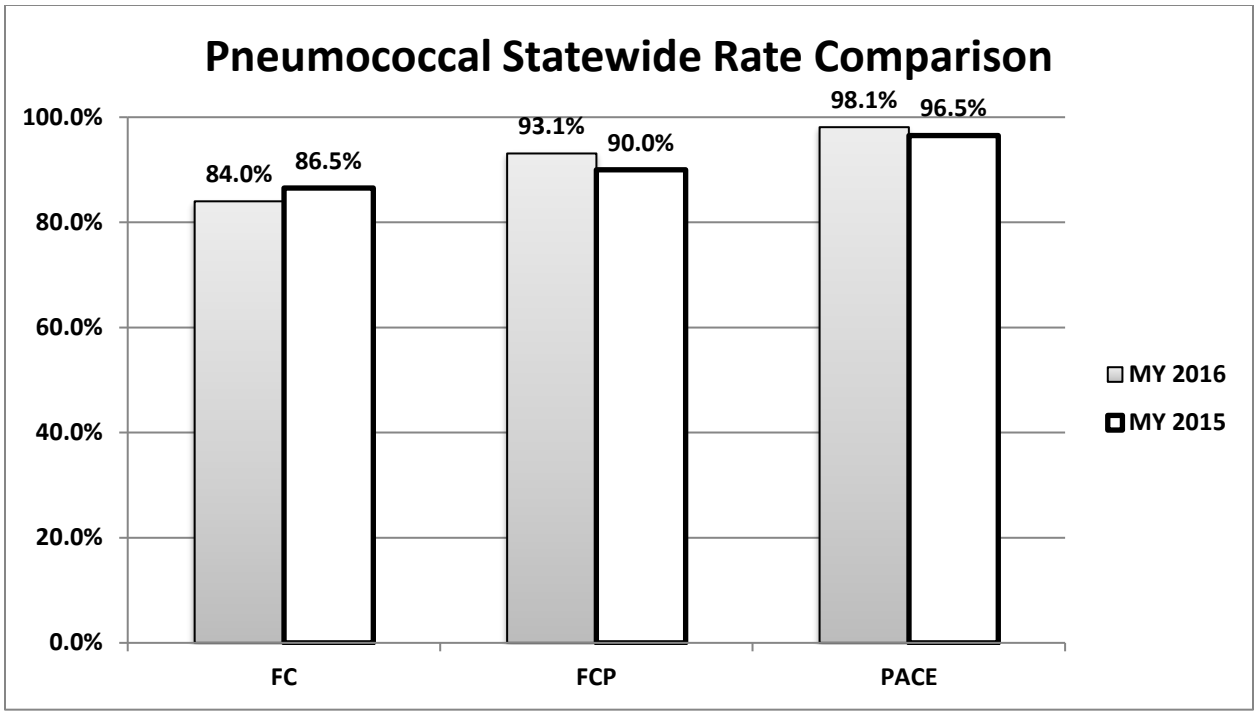
Pneumococcal Vaccination Rates

The table below shows information about the pneumococcal vaccination rates, by program, for MY 2016 and compares the 2016 rates to vaccination rates in MY 2015, which:

- Decreased 2.5 percentage points for FC members;
- Increased 3.1 percentage points for FCP members; and
- Increased 1.6 percentage points for PACE members.

Statewide Pneumococcal Vaccination Rates by Program				
	MY 2016			**MY 2015**
Program	**Eligible Members**	**Number Vaccinated**	**Vaccination Rate**	**Vaccination Rate**
Family Care	16,760	14,071	84.0%	86.5%
Family Care Partnership	1,055	982	93.1%	90.0%
PACE	476	467	98.1%	96.5%

Pneumococcal statewide vaccination rates, by program, for MY 2016 and MY 2015 are shown in the following graph.



As shown in the following table, among MCOs that operate FC, the MY 2016 pneumococcal vaccination rates ranged from 76.1 percent to 90.4 percent. Among MCOs that operate FCP, the MY 2016 rates ranged from 88.9 percent to 94.4 percent. The MY 2016 rate for the one MCO that operates PACE was 98.1 percent.

Pneumococcal Vaccination Rates by Program and MCO in MY 2016 and MY 2015			
Program/MCO	**MY 2016 Rate**	**MY 2015 Rate**	**Percentage Point Change**
Family Care			
CCI	87.7%	85.2%	2.5%
CLI, formerly CCCW	76.1%	77.0%	(0.9%)
CLI, formerly ContinuUs	87.5%	92.7%	(5.2%)
CLI, formerly WWC	90.4%	93.3%	(2.9%)
CW	87.5%	84.1%	3.4%
LC	88.6%	86.3%	2.3%
MCFC	78.8%	87.8%	(9.0%)
Family Care Partnership			
CCI	93.7%	92.2%	1.5%
CW	94.4%	92.6%	1.8%
*i*Care	88.9%	77.5%	11.4%
PACE			
CCI	98.1%	96.5%	1.6%

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. One MCO was required to resubmit pneumococcal data as the original submission did not meet the DHS technical specification requirements; the MCO submitted information for members aged 65 or older as of July 1, 2017 versus July 1, 2016. Following the resubmission, 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, 2016 and March 31, 2017; and
- All members in the pneumococcal data set were 65 or older on July 1, 2016.

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 99.6 percent of the total number of unique members included in the MCOs' and DHS' denominator files was common to the influenza data sets and 99.4% for the pneumococcal data sets. However, it should be noted that two MCOs were required to resubmit data for the pneumococcal measure because the initial submissions did not meet the required match within five percentage points. Upon resubmission, all MCOs met the required matches for both measures.

Vaccination Record Validation

To validate the MCOs' influenza and pneumococcal vaccination data, MetaStar requested 30 records of randomly selected members per quality indicator for each program the MCO operated during MY 2016. 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 2016 and MY 2015. The overall findings for both years were not biased, meaning the rates can be accurately reported.

Vaccination Record Validation Aggregate Results

MY 2016 Influenza and Pneumococcal Vaccination Record Validation				
Quality Indicator	**Total Records Reviewed**	**Number Valid**	**Percentage Valid**	**T-Test Result**
Influenza Vaccinations	330	310	93.9%	Unbiased
Pneumococcal Vaccinations	330	324	98.2%	Unbiased

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

Vaccination Record Validation Individual MCO Results

The following tables provide information about the validation findings for each MCO in MY 2016.

Results for Influenza Vaccination

MY 2016 Influenza Vaccination Record Validation by Program and MCO				
MCO	**Total Records Reviewed**	**Number Valid**	**Percentage Valid**	**T-Test Result**
Family Care				
CCI	30	27	90.0%	Unbiased
CLI, formerly CCCW	30	28	93.3%	Unbiased
CLI, formerly ContinuUs	30	25	83.3%	Biased
CLI, formerly WWC	30	25	83.3%	Biased
CW	30	30	100.0%	Unbiased
LC	30	30	100.0%	Unbiased
MCFC	30	27	90.0%	Unbiased
Family Care Partnership				
CCI	30	29	96.7%	Unbiased
CW	30	30	100.0%	Unbiased
*i*Care	30	30	100.0%	Unbiased
PACE				
CCI	30	29	96.7%	Unbiased

Results for Pneumococcal Vaccination

MY 2016 Pneumococcal Vaccination Record Validation by Program and MCO				
MCO	**Total Records Reviewed**	**Number Valid**	**Percentage Valid**	**T-Test Result**
Family Care				
CCI	30	28	93.3%	Unbiased
CLI, formerly CCCW	30	29	96.7%	Unbiased
CLI, formerly ContinuUs	30	30	100.0%	Unbiased
CLI, formerly WWC	30	28	93.3%	Unbiased
CW	30	30	100.0%	Unbiased

MY 2016 Pneumococcal Vaccination Record Validation by Program and MCO				
MCO	**Total Records Reviewed**	**Number Valid**	**Percentage Valid**	**T-Test Result**
Family Care				
LC	30	30	100.0%	Unbiased
MCFC	30	30	100.0%	Unbiased
Family Care Partnership				
CCI	30	30	100.0%	Unbiased
CW	30	30	100.0%	Unbiased
*i*Care	30	30	100.0%	Unbiased
PACE				
CCI	30	29	96.7%	Unbiased

CONCLUSIONS

- Influenza vaccination rates for the PACE program, for one of the three MCOs operating the FCP program, and for four of the seven MCOs operating the FC program increased.
- Pneumococcal vaccination rates for the PACE program, for all three of MCOs operating the FCP program, and for three of the seven FC programs increased.
- Validation of documentation in records resulted in two FC MCOs having biased results for the influenza vaccine, meaning that results cannot be accurately reported.
- Validation of documentation in records for the pneumococcal vaccine for all programs and all MCOs resulted in unbiased findings or accurately reported findings.

Information Systems Capabilities 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 16-17, MetaStar conducted ISCAs for two MCOs selected by DHS; one organization operates only a FC program, while the other operates only FCP.

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

Both MCOs provided the required general information. The MCOs identified and described the core functions of its key vendors and internal staff, as well as critical milestones and dates of the historical implementation of systems.

Section II: Information Systems - Encounter Data Flow

The two MCOs met all requirements in this section. Each organization described the process of certifying or validating the monthly encounter file created by its respective vendor prior to submission to DHS. Both MCOs detailed the process of resolving and correcting errors identified by DHS during the loading, accepting/rejecting, and certifying of the encounter file.

Section III: Data Acquisition – Claims and Encounter Data Collection

One MCO met all requirements in this area, while the other partially met the requirements. The organization that met all requirements described a unique sign-in process to the claims

processing portal where providers are able to view member specific authorizations and submit claims electronically. Any paper claim must be submitted using a proprietary form developed by the MCO's vendor, which includes the necessary fields for complete encounter reporting. This system ties authorizations to claims, preventing providers from submitting claims outside of the authorization limits. Pended claim reports are received weekly and monitored daily.

The other MCO identified that more providers are submitting claims electronically, but the organization continues to record and report some paper claims on separate in-house tools, such as Excel spreadsheets. In addition, this organization has a limited ability to break down claim categories by service type into those that are submitted by paper and those submitted electronically.

Section IV: Eligibility and Enrollment Data Processing

Both MCOs demonstrated compliance with all requirements in this area. Sufficient interfaces exist for each organization with the respective county ADRCs, and CARES and ForwardHealth interChange System websites, which result in prompt and verifiable enrollment and disenrollment processes. The organizations utilize information it receives from DHS on the 834 enrollment reports to effectively track and monitor enrollment to assure its accuracy and prevent coverage and capitation gaps. Each MCO establishes a unique identification (ID) number for each member using the member's Medicaid ID number to establish a Master Client Index (MCI) number for processing claims.

Section V: Practitioner Data Processing

One organization met all requirements in this area, while the other MCO partially met the requirements. One organization which did not fully meet requirements in this section noted its intent to complete a major integrative upgrade to incorporate all provider related data into one system to enhance efficiency of claims processing and care management functions and activities.

Section VI: System Security

Both MCOs demonstrated compliance with all requirements in this area. Disaster recovery systems are in place and tested routinely by each organization.

Section VII: Vendor Oversight

Both MCOs demonstrated compliance with all requirements in this area. Contracts or service level agreements are in place for all vendors and contractors that support the organizations' information systems and claims processing infrastructures. Each MCO has well-established procedures related to monitoring and oversight of vendor operations.

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

Both MCOs demonstrated compliance with all requirements in this area. Each organization utilizes DHS DataMarts for encounter report reconciliation and utilization management/unit cost analysis to aid in better understanding the characteristics, including demographics and acuity, of the enrolled membership, to predict future service trends.

Section X: Performance Measure

One organization met all requirements in this area, while the other MCO partially met the requirements. Both organizations produce yearly performance reports for the required performance measures: influenza and pneumococcal vaccinations. One MCO which did not fully meet all requirements in this section continues to focus efforts to improve its data collection procedures to identify and reach more members at risk in order to increase the numbers and rates of members who are immunized in a timely manner.

CONCLUSIONS

Overall, the reviews found the MCOs 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.

Progress

Both organizations demonstrated progress by addressing recommendations as a result of reviews that occurred in FY 13-14. One organization successfully addressed all stated recommendations from the previous review. The MCOs demonstrated progress in different areas of the review as follows:

- Policies, procedures, flowcharts, and narrative documents were amended to include additional details to more fully describe organizational structures, areas of responsibilities, and interfaces that contribute to data collection, analysis, and reporting.
- Enhancements were made to the encounter data submission process to comply with state requirements and specifications, and new procedures to assure the accuracy of vendor data prior to the submission of the encounter file were established.

Strengths

The FY 16-17 ISCA reviews found the MCOs exhibited strengths in the following areas:

- One MCO's electronic care management and service authorization system enables automated functions that lead to efficiency:
    - The Office of Inspector General dataset is loaded into this system to automatically cross-check exclusions from participation in federal Medicaid programs against the MCO's contracted providers.
    - Through this system, the MCO balances the amount of claims paid against the amount of claims submitted on a monthly basis, and compares this information with the encounter file created by its vendor to ensure accuracy of the file prior to submission to DHS.
    - Pre-established reports available from a "drop down" menu have been created in this system to provide staff with multiple methods to view the data on an as needed basis.
    - A temporary ID number is produced by this system when the MCO is transmitting protected health information or personally identifiable information to vendors regarding authorizations and claims, which enhances the security of confidential information.
- One MCO encourages providers to communicate with MCO staff at the onset of claims submission regarding the preferred payee for services to trigger the processing system to send the claim directly to the payer of first resort to potentially increase efficiency and reduce the number of false denials.
- One MCO has a standing policy supporting binary claim determinations (paid or denied/rejected) to eliminate error prone decision-making layers and force providers to submit better claims at the onset.

Opportunities for Improvement

The MCOs' information systems are architected and implemented differently, according to each organization's structure and operations; therefore, the opportunities are individualized to each MCO as follows:

- One MCO should:
    - Develop a formal auditing process to reconcile any provider data entered into its electronic care management and service authorization system with the original source data to ensure accuracy;
    - Place a high priority on the following when the organization relocates its offices:
        - Developing policies and procedures related to systems security, access to the network, and vendor acquisition; and
        - Establishment of a secure, encrypted email system;

- Complete a full test of the disaster recovery back-up system to ensure it is fully operational when needed; and
- Continue with plans to revise confidentiality and security policies and procedures to include annual refresher training for all MCO staff.

- One MCO should:
  - Continue to focus on efforts to increase the proportion of claims that are submitted via electronic means;
  - Work with its vendor to obtain segment breakdowns of paper versus electronic claims, by service and by provider type, to allow the MCO to focus its efforts on service areas and providers with higher volume, cost, and need;
  - Develop policies and procedures/flowcharts to document the processes in place for the resolution of batch and other errors identified by DHS during the process of downloading and accepting the encounter files; and
  - Place a priority on developing and implementing testing plans to ensure provider data is not compromised when the organization transitions to a new integrated system to house all provider data.

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

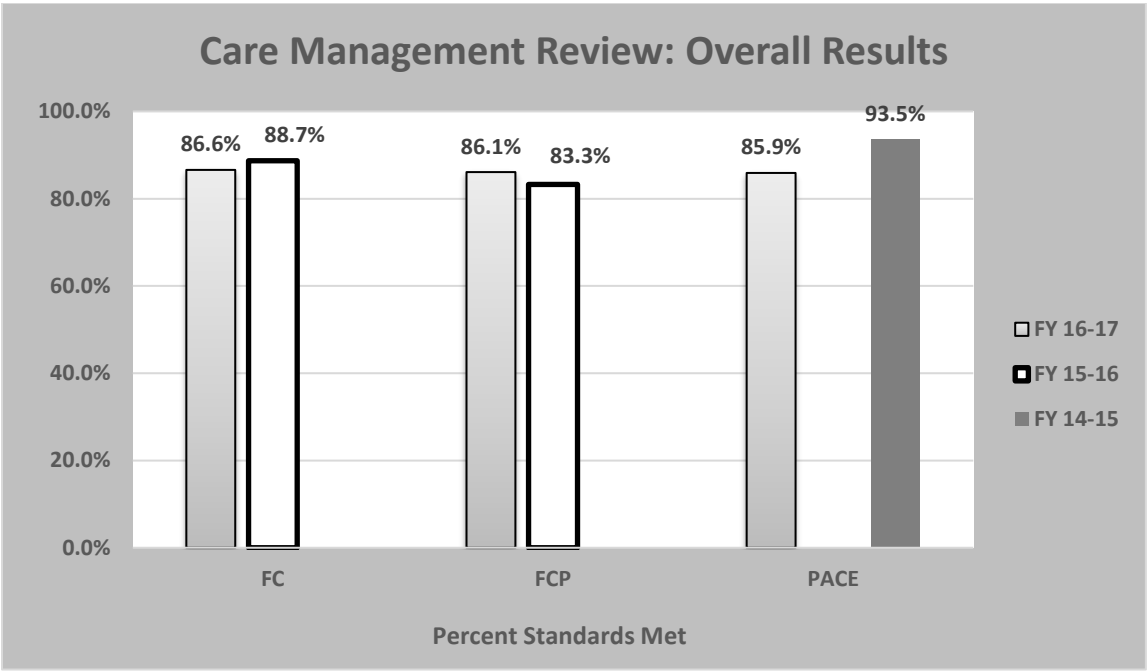
The four categories include a total of 14 review indicators. More information about the CMR review methodology can be found in Appendix 3.

Aggregate results for FY 16-17 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 16-17 review year for organizations operating programs for FC, FCP, and PACE. FY 15-16 results are provided for comparison for FC and FCP. MetaStar did not conduct CMR for PACE in FY 15-16, as CMS reviewed the program. Therefore, FY 14-15 results are provided for comparison for PACE.

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.



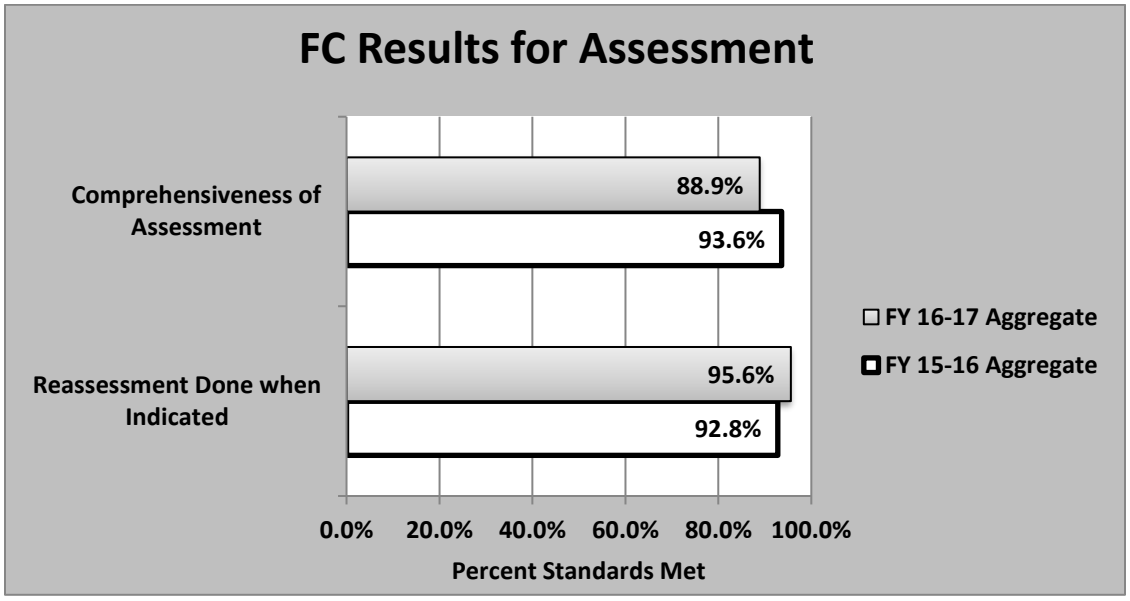
Results for each CMR Focus Area

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 16-17 CMR results by program (FC, FCP, PACE) for each review indicator that comprises the category. FY 15-16 results are provided for comparison for FC and FCP. As noted above, MetaStar did not conduct CMR for PACE in FY 15-16, so FY 14-15 results are provided for comparison for PACE.

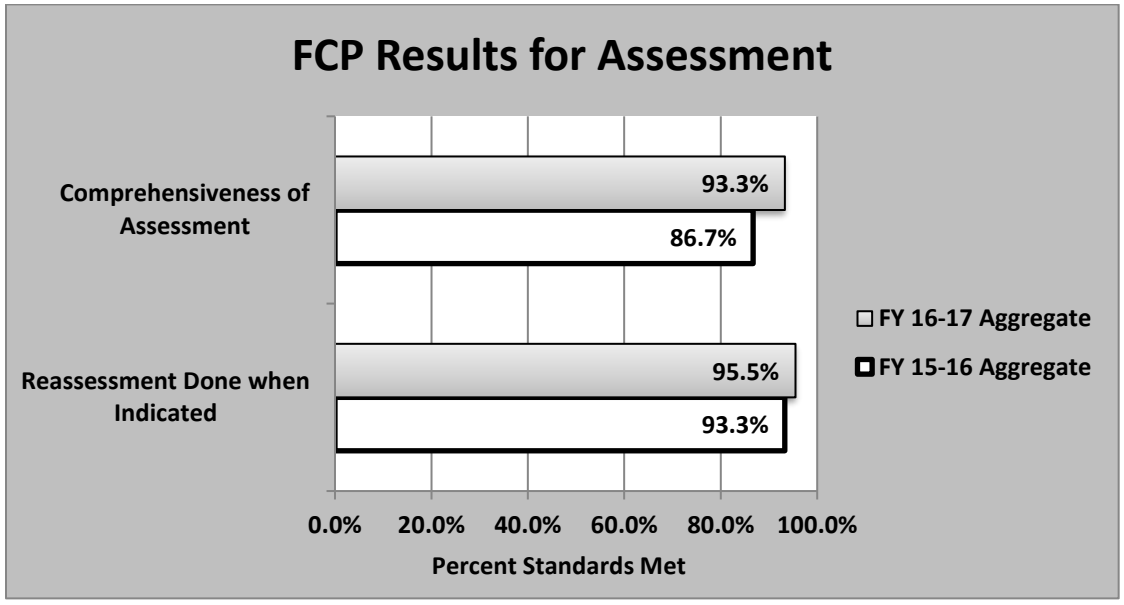
Assessment Focus Area

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.

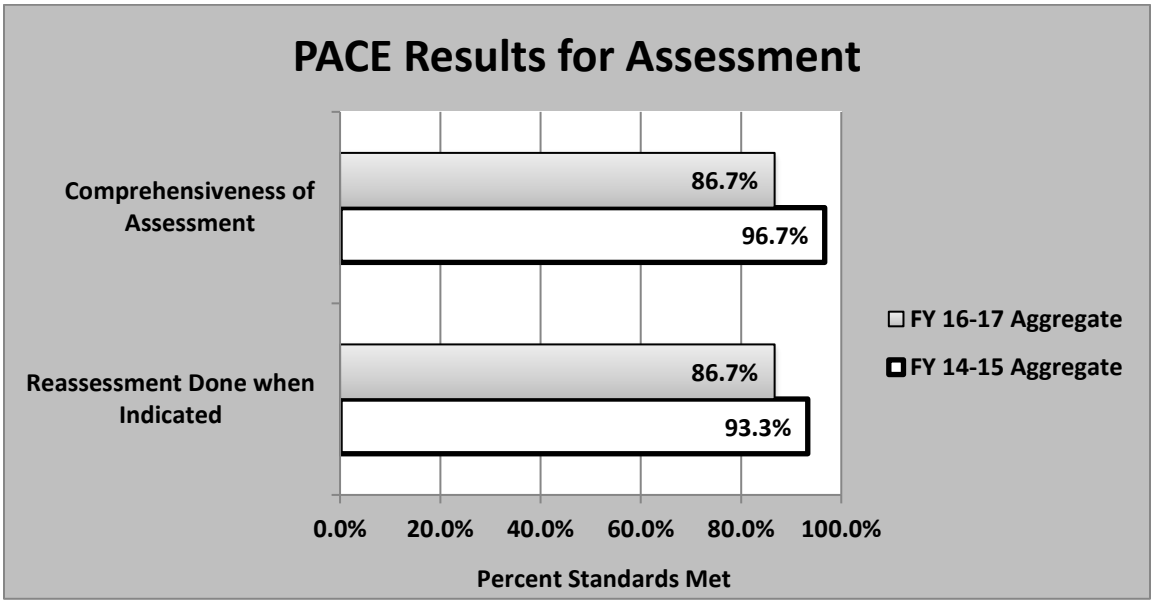
Results for Assessment for MCOs Operating FC:



Results for Assessment for MCOs Operating FCP:



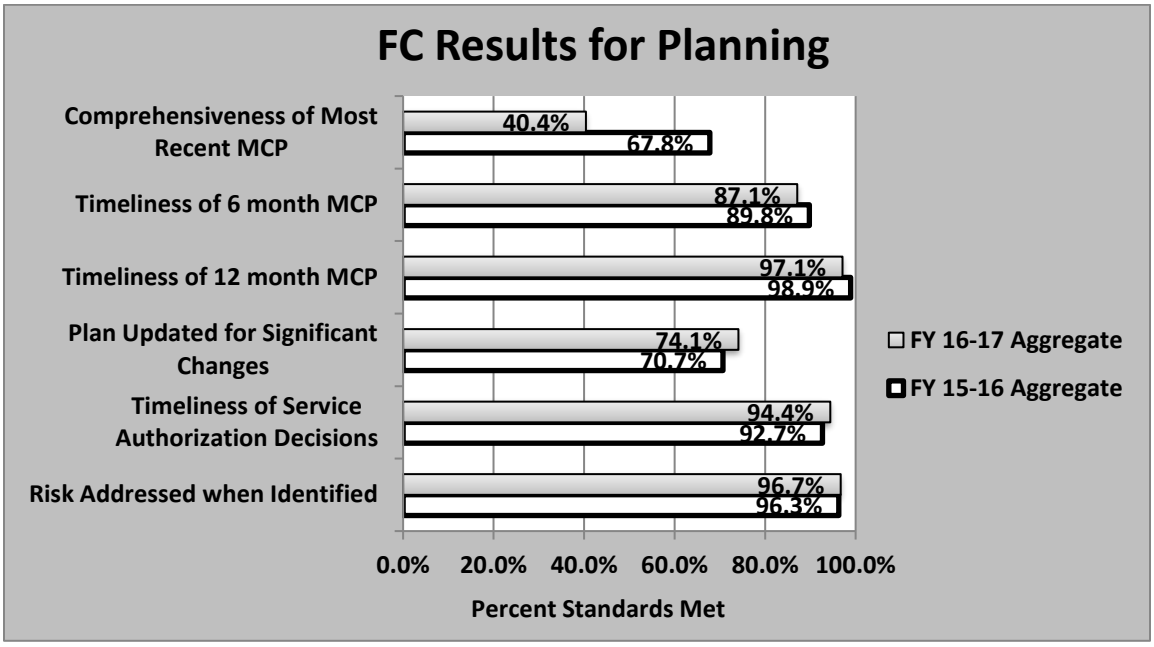
Results for Assessment for the MCO Operating PACE:



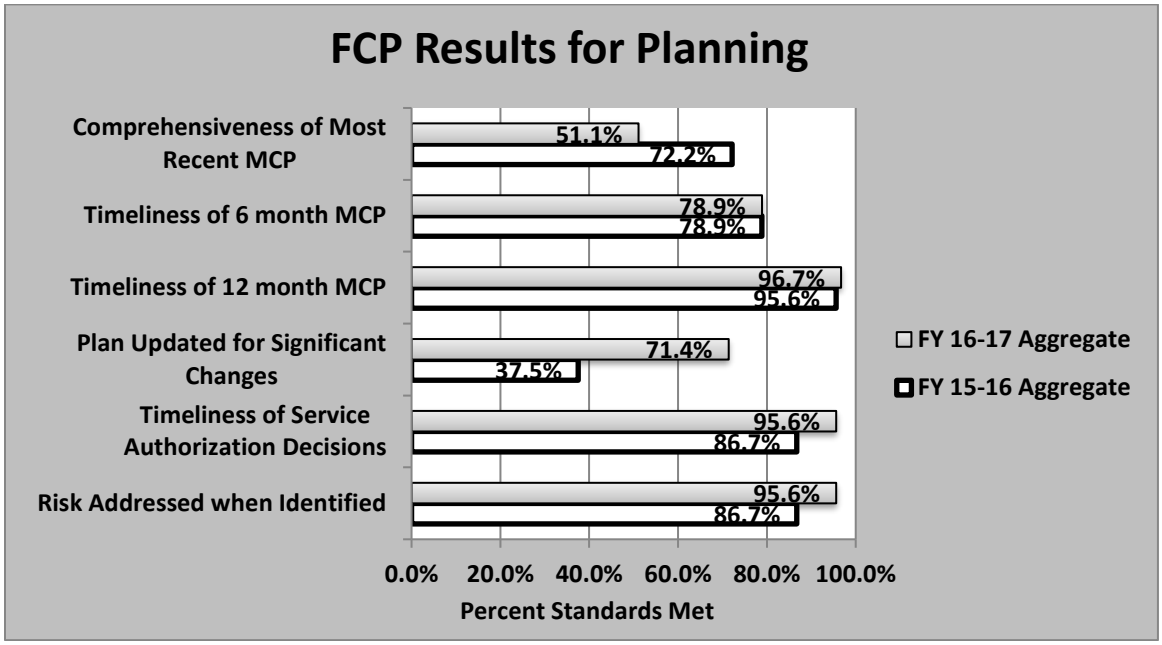
Care Planning Focus Area

The member-centered plan (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.

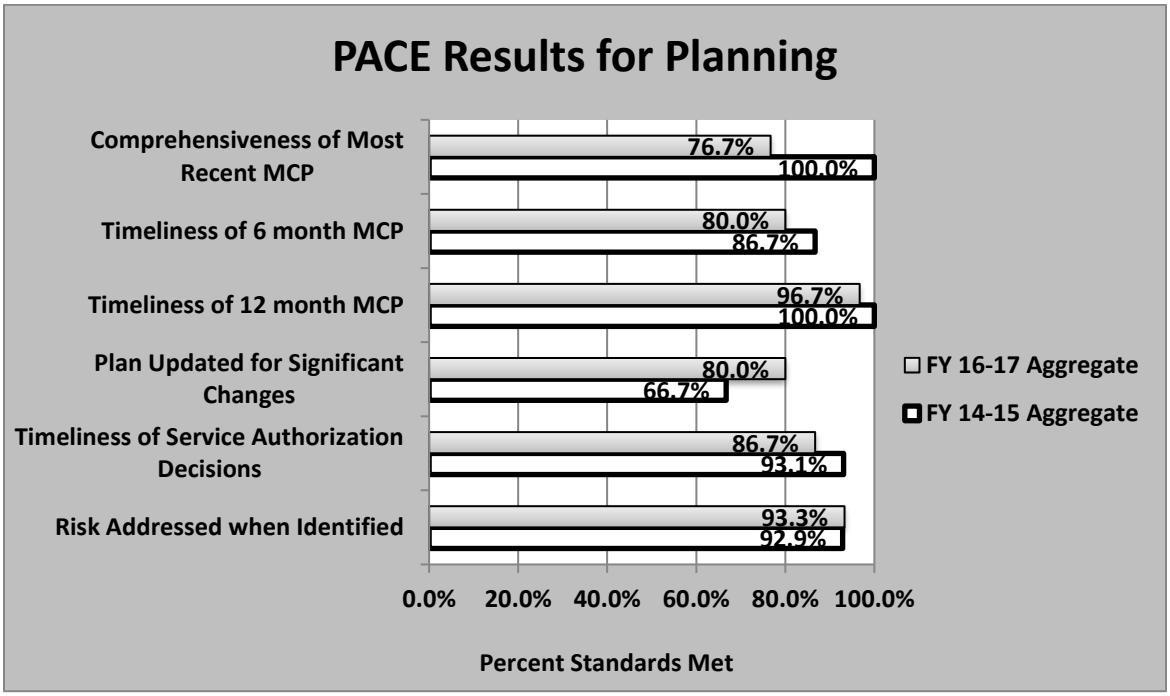
Results for Care Planning for MCOs Operating FC:



Results for Care Planning for MCOs Operating FCP:



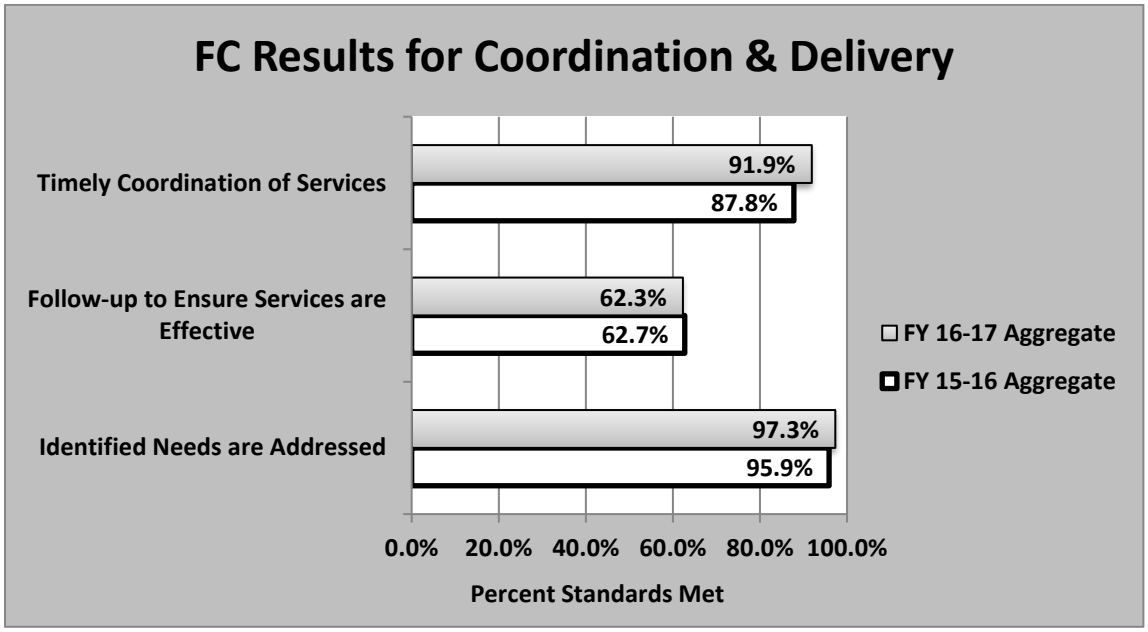
Results for Care Planning for the MCO Operating PACE:



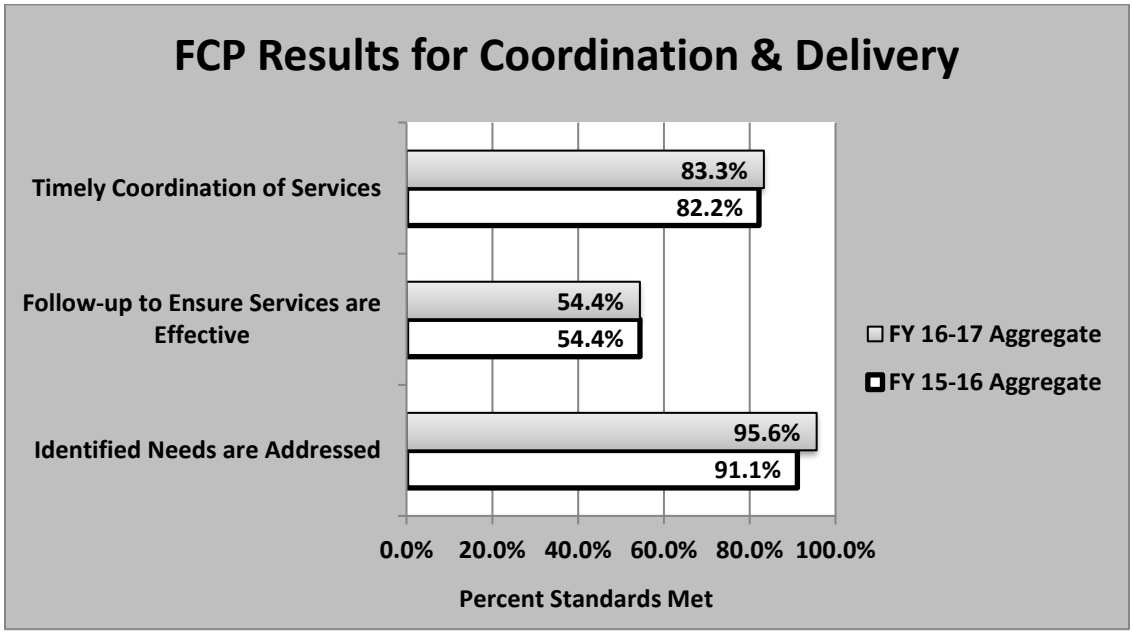
Coordination and Delivery Focus Area

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.

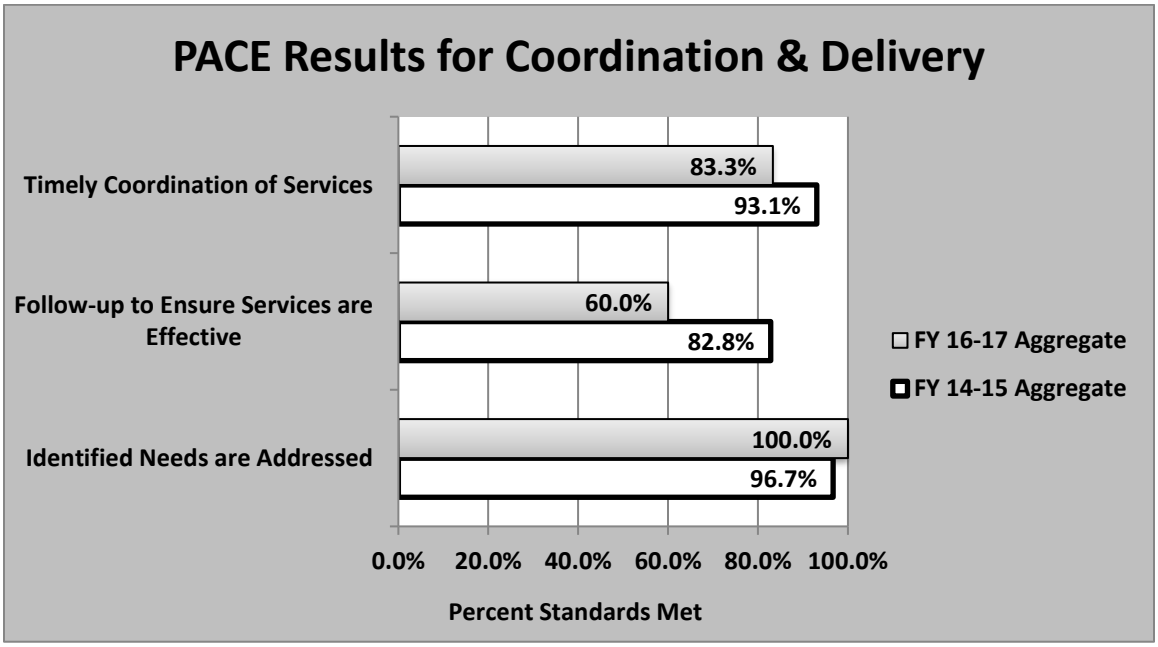
Results for Coordination and Delivery for MCOs Operating FC:



Results for Coordination and Delivery for MCOs Operating FCP:



Results for Coordination and Delivery for the MCO Operating PACE:

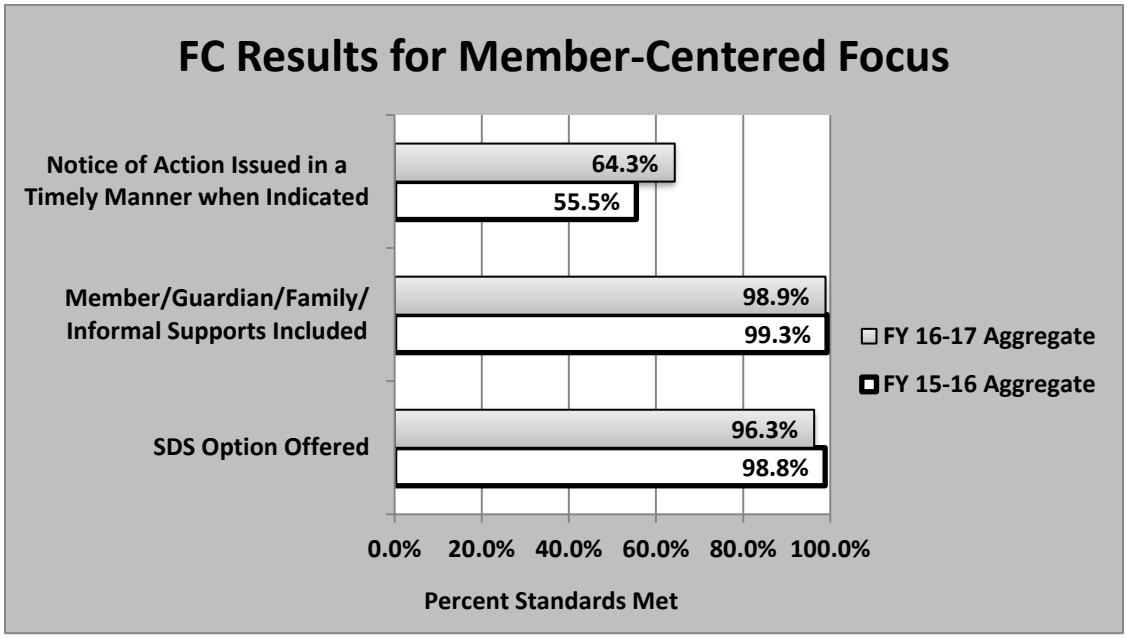


MEMBER-CENTEREDNESS FOCUS AREA

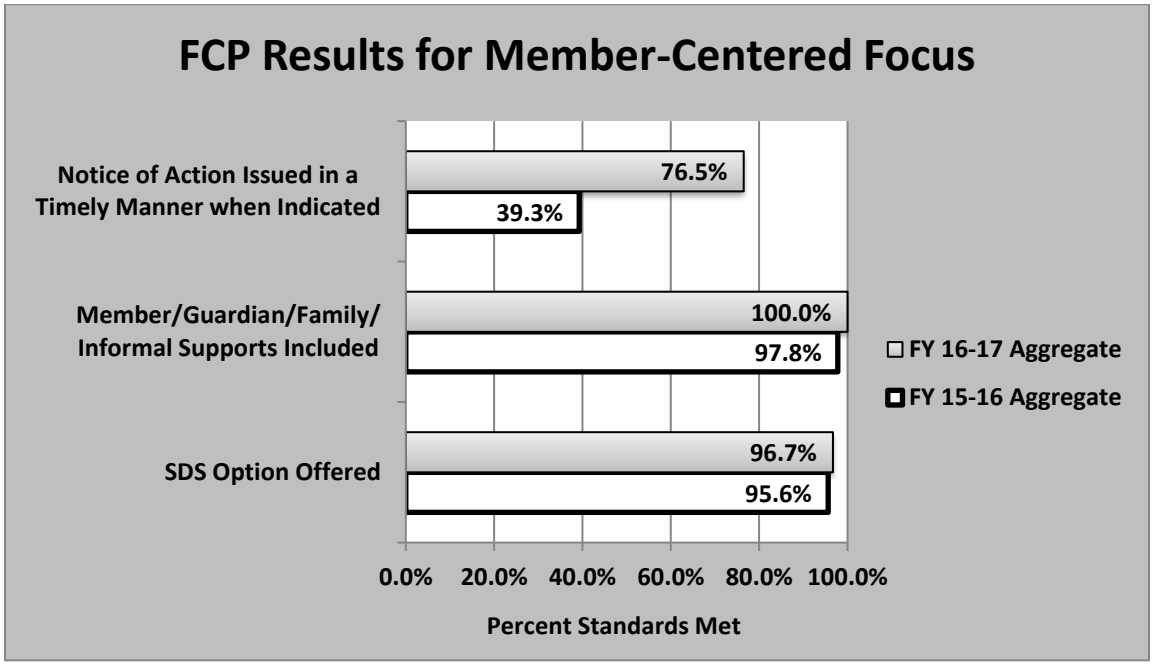
The record should document the IDT staff includes the member and his/her supports in care management processes; that staff protects member rights by issuing notices in accordance with requirements outlined in the DHS-MCO contract; and that the self-directed supports (SDS) option has been explained and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

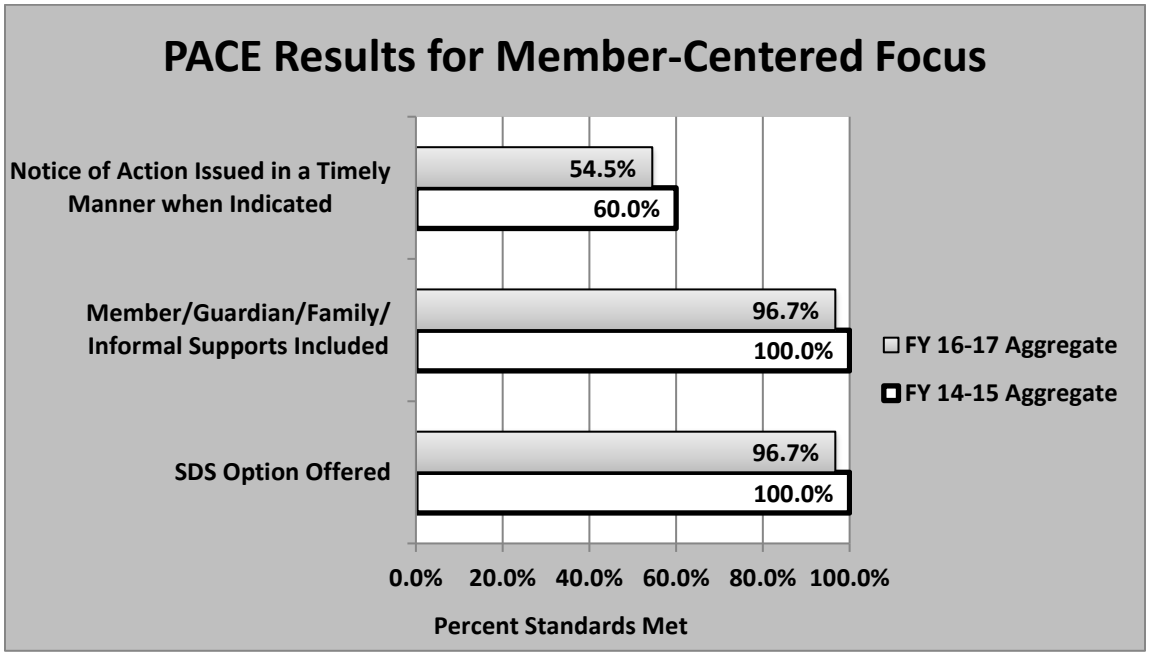
Results for Member-Centered Focus for MCOs Operating FC:



Results for Member-Centered Focus for MCOs Operating FCP:



Results for Coordination and Delivery for the MCO Operating PACE:



CONCLUSIONS

The FY 16-17 CMR overall results for FC declined since last year's review. Analysis indicated the year-to-year difference in the overall rates is unlikely to be the result of normal variation or chance. This is the second year FC results have declined. The FY 16-17 CMR overall results for FCP increased compared to its results in FY 15-16. However, analysis indicated the year-to-year difference in the overall rates is likely due to normal variation or chance. In addition, the FY 16-17 overall results for PACE declined from its previous review in FY 14-15. Analysis indicated the year-to-year difference in the overall rates is unlikely to be the result of normal variation or chance.

Strengths

- In FY 16-17, FC programs maintained aggregate results over 90 percent for the following review indicators. Seven of these indicators were also above 90 percent in FY 15-16:
    - "Reassessment Done when Indicated;"
    - "Timeliness of 12 Month MCP;"
    - "Timeliness of Service Authorization Decisions;"
    - "Risk Addressed when Identified;"
    - "Timely Coordination of Services;"
    - "Identified Needs are Addressed;"
    - "Member/Guardian/Informal Supports Included;" and
    - "SDS Option Offered."

- In FY 16-17, FCP programs maintained aggregate results over 90 percent for the following review indicators. Five of these indicators were also above 90 percent in FY 15-16:
    - "Comprehensive 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 16-17, the only PACE program maintained results over 90 percent for the following review indicators. The results for all of these indicators were also over 90 percent in FY 14-15:
    - "Timeliness of 12 Month MCP;"
    - "Risk Addressed when Identified;"
    - "Identified Needs are Addressed;"
    - "Member/Guardian/Informal Supports Included;" and
    - "SDS Option Offered."

Opportunities

- All programs (FC, FCP, and PACE) should focus on improving in the following areas of care management practice:
    - "Comprehensiveness of Most Recent MCP;"
    - "Follow-up to Ensure Services are Effective;" and
    - "Notices Issued in a Timely Manner when Indicated."
- In addition, FC and FCP should focus on improving results for:
    - "Plan updated for Significant Changes."
- FCP should also focus on improving results for:
    - Timeliness of 6 month MCP."
- For FC, the overall rate of compliance for seven review indicators declined. For the following four indicators, analysis indicated the year-to-year difference in the results was unlikely to be due to normal variation or chance:
    - "Comprehensiveness of Assessment;"
    - "Comprehensiveness of Most Recent MCP;"
    - "Timeliness of 12 month MCP;" and
    - "SDS Option Offered."

Readers should note that two FC review indicators with declining results, “Timeliness of 12 month MCP” and “SDS Option Offered” were also noted as a strength above. While aggregate results for these indicators were over 90 percent in each of the last two years, the rate of compliance for “Timeliness of 12 month MCP” declined from 98.9 percent in FY 15-16 to 97.1 percent in FY 16-17. The rate of compliance for “SDS Option Offered” declined from 98.8 percent in FY 15-16 to 96.3 percent in FY 16-17. As noted, analysis indicated the year-to-year difference in these results was unlikely to be the result of normal variation or chance. The MCOs that operate the FC program should identify causes for the decline for these review indicators, and implement needed improvement efforts.

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 16-17 annual EQR report, include MetaStar's assessment of areas of progress and key 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 or follow-up review where, for each MCO, only those standards not fully met the previous year are reassessed. FY 16-17 was the third year of the three-year cycle, and since the scope of each MCO's review was limited, specific organizational strengths could not be readily identified.

While individual MCO results varied, every organization made progress in its overall QCR results during the three-year cycle, which began in FY 14-15 and ended with this year's review. The results indicated that all organizations possess the majority of structural and operational characteristics required to deliver quality care and ensure members have timely access to information and services.

The validation of PIPs indicated that eight projects effectively utilized continuous cycles of improvement. All eight MCOs selected study topics based on MCO-specific data and needs analysis. 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.

Two organizations received an ISCA in FY 16-17. Both MCOs had addressed recommendations from the previous reviews conducted in FY 13-14, and demonstrated progress in different areas. The results indicated both organizations have the basic systems, resources, and processes in place to accurately and completely collect, analyze, integrate, and report data on member and provider characteristics, and on services furnished to members.

Regarding CMR, the FY 16-17 overall percent of standards met for organizations operating FC and FCP were 86.6 percent and 86.1 percent, respectively. The percent of standards met for PACE was 85.9 percent. While the review identified areas of opportunity for improvement in all three programs, results indicated MCOs have adequate systems and processes in place to effectively support care management practice and safeguard members' health and welfare.

QUALITY COMPLIANCE REVIEW

Overall, QCR results revealed that MCOs achieved compliance in 21 of 32 standards reviewed (66%) during this third year of the three-year cycle. Over half of the standards reviewed were attributable to one organization that made notable progress by receiving "met" scores for 15 of 17 standards reviewed. Two main opportunities for improvement remain, related to the specific right to be free from any form of restraint, and the requirement to conduct assessments and develop MCPs.

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.

Of the six organizations reviewed this year, two had previously achieved full compliance with standards in this area during the current three-year cycle. A total of six standards had remained "partially met" among the other four MCOs: three of the six were found to be fully met during the FY 16-17 EQR.

Last year's review identified an opportunity for improvement related to ensuring members' specific rights to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. Of the six organizations reviewed this year, three MCOs had not fully met this requirement. Results of the review showed that all three again received scores of "partially met," and this continues to be an area for improvement.

Each organization took action based on MetaStar's previous recommendations to conduct analysis, identify barriers, and take action to improve the timeliness of submission of renewal restrictive measures applications to DHS. Analyses revealed the need to improve monitoring or efficiency of process workflows, as well as reduce delays and missing aspects of the applications. Examples of actions taken by the MCOs included increasing contact with and education of providers to improve timeliness of submitted information, and leveraging technology to improve efficiency of processes.

Though some progress was observed, the restrictive measures tracking logs of all three organizations continued to show members whose renewal applications had not been submitted to DHS in a timely manner, resulting in some plans expiring without new, approved plans in place. Factors contributing to the lack of progress included, for example; interventions that were not fully implemented or had not yet demonstrated effectiveness, as well as applications continuing to be submitted without all required elements.

The other three standards evaluated in the "Enrollee Rights and Protections" focus area all received scores of "met" as a result of this year's review:

- In two cases, new or revised policies and procedures had not been fully implemented at the time of the previous review. A "met" score was received this year, as the MCOs provided evidence of full implementation.
- In the third case, the MCO responded to a recommendation to develop a process for regular monitoring to ensure effectiveness.

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.

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.

Of the six organizations reviewed this year, four had previously achieved compliance with standards in this area during the current three-year cycle. A total of eight standards had remained "partially met" among the other two MCOs, with seven of eight attributable to one organization.

All eight standards were found to be "met" as a result of the FY 16 – 17 review as follows:

- Two organizations achieved compliance with the standard related to provider selection and credentialing. Both organizations revised written guidance and developed or improved monitoring processes to ensure effectiveness.
- One organization also updated and improved processes as well as associated written guidance to achieve compliance with the rest of the standards, which focused on availability of services; compliance with requirements, including caregiver background checks; enrollment and disenrollment; and subcontractual relationships and delegation.

However, MetaStar provided additional recommendations to help the organization sustain improvement and further improve aspects of its program beyond minimum compliance.

Care Coordination and Service Authorization

Six standards address requirements related to coordination and continuity of care, coverage and authorization of services, confidentiality, and practice guidelines.

Of the six organizations reviewed this year, two had previously achieved compliance with standards in this area during the current three-year cycle. A total of seven standards had remained "partially met" among the other four MCOs: just two of the seven were found to be fully met during the FY 16-17 EQR.

Last year's review identified an opportunity for improvement related to the requirement to have mechanisms in place for assessing members and developing plans of service based on the assessments. Of the six organizations reviewed this year, four MCOs had not fully met this requirement. Results of the review show that all four again received scores of "partially met" and this continues to be an area for improvement.

MCOs addressed MetaStar's previous recommendations to improve areas of care management practice associated with this standard, such as comprehensiveness of assessments and MCPs. Actions taken included, for example, providing training, updating an assessment template, conducting internal file reviews, and updating a comprehensive MCP checklist. However, a change to the DHS-MCO contract included new requirements related to members who have complex medication regimens and/or have behavior modifying medications prescribed. The changes impacted the CMR results for "Comprehensiveness of Most Recent MCP" for each organization under review. CMR scores are one input to QCR scoring for this standard. Please refer to the Care Management Review observations in this section for additional information. Other reasons contributing to "partially met" scores included: lack of comprehensiveness of assessment, lack of timeliness of MCPs, as well as other reasons for lack of MCP comprehensiveness.

Results for the other three standards evaluated in the care coordination and service authorization subsection identified the following:

- One organization received a "partially met" score related to timeframes for decision of approval or denial of requests for services. The organization did not submit data to demonstrate effectiveness of its practices and MetaStar's CMR scores did not show improvement.
- Two organizations revised related policies and procedures and fully implemented them to achieve full compliance for the standard focused on practice 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.

Of the six organizations reviewed this year, four had previously achieved compliance with standards in this area during the current three-year cycle. A total of five standards had remained "partially met" among the other two MCOs: four of the five were found to be fully met during the FY 16-17 EQR.

Results for the standards evaluated in the quality assessment and performance improvement subsection identified the following:

- Two organizations achieved compliance for the standard related to operating a QAPI program that meets minimum requirements. Both organizations updated the quality program descriptions and administrative structures, as well as enhanced opportunities for stakeholder participation in the program as required. In addition, they demonstrated that all required monitoring activities were conducted.
- One organization also achieved compliance with standards focused on requirements to have mechanisms in effect to detect underutilization and overutilization of services, as well as evaluate the impact and effectiveness of the QAPI program, by updating and implementing consistent procedures in these areas.
- The same organization received a "partially met" score for the standard addressing mechanisms to assess the quality and appropriateness of care, as the documentation submitted did not demonstrate effectiveness of the current processes.
- MetaStar provided additional recommendations to both organizations with standards reviewed in this subsection to further improve aspects of the QAPI program beyond minimum compliance.

Grievance System
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.

Of the six organizations reviewed this year, three had previously achieved full compliance with standards in this area during the current three-year cycle. A total of six standards had remained "partially met" among the other three MCOs: four of the six were found to be fully met during the FY 16-17 EQR.

Last year's review identified an opportunity for improvement related to timely issuance of notices to members when indicated. Of the six organizations reviewed this year, three MCOs had not fully met this requirement. Results of the review show that two of three received "met"

scores. The two organizations receiving "met" scores both demonstrated that multiple monitoring methods were in place, and that interventions had been implemented to improve compliance. However, MetaStar recommended that both organizations maintain focused monitoring and other efforts to continue improvement. The standard remained "partially met" for one organization, as its selected interventions and monitoring had not yet resulted in improvement.

Results for the rest of the standards evaluated in the "Grievance System" focus area identified the following:

- One organization updated and implemented written policies and other materials to achieve compliance with two standards related to handling of grievances and appeals and providing information about the grievance system to providers and subcontractors.
- One MCO received a "partially met" score for the standard related to members' responsibility for services while the appeal is pending, as it did not fully implement the relevant policy change.

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 2016, DHS required organizations to make active progress on at least one project. Eight MCOs submitted a total of 10 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 2016, proposals were submitted to DHS in February 2016, with final reports for validation due by December 30, 2016.

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, through implementation of at least one intervention and measuring its effectiveness. Four of ten projects resulted in quantitative improvement which appeared to be the result of the interventions employed. Three 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:

- Early and comprehensive identification of members in need of dementia screening;
- Completion of dementia screening and submission of abnormal screening results to physicians;
- Development of a member-specific plan of action by the residential facility focused on dementia care; and
- Monitoring the frequency of behavioral symptoms.

All of the remaining five projects which did not attain quantitative improvement demonstrated difficulties with definition of the study indicators and two projects had challenges related to the definition of the study population. Reviewers noted that all five projects had limitations or barriers to improvement, such as small sample sizes or lack of comparable data between initial and repeat measures, which were not successfully addressed or taken into consideration in the analysis of results.

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 99.6 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 two MCOs were 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 2016. 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 2016 and MY 2015. The overall findings for both years were not biased, meaning the rates can be accurately reported.

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 do not include the specific contraindication information as outlined in DHS' technical specifications.

Information Systems Capabilities Assessment

This review activity was conducted for two MCOs; one operates only a FC program, and the other operates only a FCP program. 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.

Both organizations demonstrated progress by continuing to work with vendors to improve the accuracy of encounter data reporting to DHS. In addition, both MCOs updated policies, procedures, and flowcharts to more fully describe organizational structures, areas of responsibilities, and interfaces that contribute to data collection, analysis, and reporting. Each MCO has well-established procedures related to monitoring and oversight of vendor operations. One MCO exhibited strengths by enhancing functions within its electronic care management and service authorization system to improve efficiencies related to monitoring providers for debarment from participation in federal Medicaid programs, and to maintain the security of confidential information regarding claims and authorizations. Another MCO focused efforts on claims processing to reduce claims processing time and the occurrence of false denials. Additionally, the organizations utilized analytic data to evaluate systems' performance and predict future service trends.

Two MCOs should enhance documentation in various areas. One MCO should develop policies and procedures/flowcharts to document the processes in place for the resolution of batch and other errors identified by DHS during the process of downloading and accepting the encounter files. The other MCO should develop policies and procedures related to systems security, access to the network, and vendor acquisition when it relocates its offices. In addition, to mitigate the potential loss of data, one MCO should complete a full test of the disaster recovery back-up system to ensure it is fully operational when needed, and the other MCO should place a priority on developing and implementing testing plans to ensure provider data is not compromised when the organization transitions to a new integrated system to house all provider data.

Care Management Review

Member Health and Safety

Over the course of FY 16-17, MetaStar did not identify any members with unaddressed health and safety issues during CMR, out of 748 total member records selected and reviewed during this year's EQR activities. Ten 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 16-17, DHS also directed MetaStar to re-review the records of 23 members identified in the FY 15-16 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 23 member records re-reviewed in FY 16-17, 18 demonstrated the MCOs had sufficiently addressed the issues or situations. The other five 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 101 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. Three members from the focused reviews were referred to DHS for complex and challenging situations. Again, these reviews were not included in the results for this report.

Overall Results

During the FY 16-17, every FC and FCP organization took some action to respond to the CMR recommendations they received related to FY 15-16. PACE also took some action to respond to CMR recommendations related to FY 14-15. However, not all organizations were able to achieve overall improvement.

For FC, the percent of all CMR standards met in FY 16-17, aggregated across seven FC organizations was 86.6 percent. This compares to 88.7 percent in FY 15-16. FY 16-17 aggregate results for FC showed compliance rates over 90 percent for nine of 14 CMR standards. Analysis indicated the year-to-year difference in the overall rates is unlikely to be the result of normal variation or chance.

For FCP, the percent of all CMR standards met in FY 16-17, aggregated across three FCP organizations was 86.1 percent. This compares to 83.3 percent in FY 15-16. FY 16-17 aggregate results for FCP showed compliance rates over 90 percent for eight of 14 CMR standards. Analysis indicated the year-to-year difference in the overall rates is likely due to normal variation or chance.

For PACE, the percent of all CMR standards met in FY 16-17, for the one organization operating a PACE program, was 85.9 percent. This compares to 93.5 percent in FY 14-15. FY 16-17 aggregate results for PACE showed compliance rates over 90 percent for five of 14 CMR standards. Analysis indicated the year-to-year difference in the overall rates is unlikely to be the result of normal variation or chance.

Recommendations for FC and FCP in the FY 15-16 annual technical report, and for PACE in the FY14-15 annual technical report, addressed the need for all programs to focus improvement efforts on updating MCPs when members have significant changes and following up with members to ensure services have been received and are effective. FC also received recommendations to continue to work on improving the timeliness of reassessments and comprehensiveness of MCPs, as well as the timely coordination of services. FCP received an additional recommendation to improve the comprehensiveness of MCPs. PACE received an additional recommendation to improve issuing notices to members in a timely manner, when indicated. Actions MCOs took to address the recommendations included:

- Provided staff training;
- Conducted internal file reviews and monitoring;
- Revised tracking tools, internal file review process', MCP templates; and
- Completed root cause analysis.

All programs improved overall compliance rates in updating MCPs when members have significant changes. However, analysis indicated the year-to-year difference in the overall rates is likely due to normal variation or chance. All programs improved overall compliance rates in addressing member risk. For FC and PACE, analysis indicated the year-to-year difference in the overall rates is likely due to normal variation or chance. For FCP, analysis indicated the year-to-year difference in the overall rates is likely attributable to actions of the MCO, and is unlikely to be the result of normal variation or chance.

Results for FC identified two additional standards had increased since last year's review, and analysis indicated the year-to-year difference in the overall rates is likely attributable to actions of the MCO, and is unlikely to be the result of normal variation or chance:

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

Results for FCP identified one additional standard had increased since last year's review, "Timeliness of Service Authorization Decisions." Analysis indicated the year-to-year difference in the overall rates is likely attributable to actions of the MCO, and is unlikely to be the result of normal variation or chance.

Results for all programs identified a decline for the indicator, "Comprehensiveness of the MCP." All results were below 90 percent; FC was 40.4 percent and FCP was 51.1 percent. Analysis indicated the year-to-year difference in the overall rates is unlikely to be the result of normal variation or chance.

Results for all programs identified a decline for the indicator, "Follow-up to Ensure Services are Effective." However, analysis indicated the year-to-year difference in the overall rates is likely due to normal variation or chance, and all results were quite a bit lower than 80 percent. FC identified an increase for issuing NOAs in a timely manner. Analysis indicated the year-to-year difference in the overall rates is likely due to normal variation or chance. FCP also identified an increase for issuing NOAs in a timely manner. Analysis indicated the year-to-year difference in the overall rates is likely attributable to actions of the MCO, and is unlikely to be the result of normal variation or chance. However, all three programs are still below 80 percent. FC was 64.3 percent and PACE was 54.5 percent, quite a bit lower than 80 percent. Readers should be aware that denominators for this indicator are low when interpreting this report. This remains an area to continue to evaluate for all three programs.

Results for FC identified three additional standards had declined since last year's review, and analysis indicated the year-to-year difference in the overall rates is unlikely due to normal variation or chance:

- "Comprehensiveness of Assessment;"
- "Timeliness of 12 month MCP;" and
- "SDS Option Offered."

A factor affecting results for comprehensiveness of the MCP in all programs and all MCOs was most plans lacked documentation for a complex medication regimen, or documentation stating the rationale for use of behavior modifying medications prescribed and a detailed description of the member's behaviors indicating the need for the prescribed medications. The 2015 DHS-MCO contract was revised to include new requirements related to members who have a complex medication regimen (defined as having at least eight scheduled prescription medications), and/or behavior modifying medications prescribed. The member must be assessed and reassessed, for the desired responses and possible side effects of the medication, and for his/her understanding of the potential benefits as well as side effects of the medication. These requirements were taken into consideration in scoring during the FY 16-17 review year.

Other factors affecting comprehensiveness of the MCP include failure to document information about member needs and services, such as durable medical equipment and who is responsible for acute and primary care coordination.

MetaStar also noted other possible contributing factors to the decline in CMR results as indicated in the EQR reports of individual MCOs, such as plans not updated and signed by the members' legal decision maker within the required timeframes for the periodic review. Another contributing factor was members' current abilities/needs were not accurately described on MCPs.

APPENDIX 1 – LIST OF ACRONYMS

ADRC	Aging and Disability Resource Center
AQR	Annual Quality Review
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
CLI	Community Link, Inc., Managed Care Organization
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
FE	Frail Elderly Target Group
FY	Fiscal Year
GSR	Geographic Service Region
HbA1c	Glycated Hemoglobin
HEDIS[1]	Healthcare Effectiveness Data and Information Set
*i*Care	Independent Care Health Plan, Managed Care Organization
ID	Identification Number
IS	Information Systems
I/DD	Intellectual/Developmental Disability Target Group
IDT	Interdisciplinary Team
ISCA	Information Systems Capability Assessment

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

LC	Lakeland Care, Inc., Managed Care Organization
LTCFS	Long Term Care Functional Screen
MCFC	My Choice Family Care, Inc., Managed Care Organization
MCI	Master Client Index
MCO	Managed Care Organization
MCP	Member-Centered Plan
MI	Motivational Interviewing
MY	Measurement Year
NCQA	National Committee for Quality Assurance
PACE	Program of All-Inclusive Care for the Elderly
PD	Physically Disabled Target Group
PIP	Performance Improvement Project
PMV	Performance Measures Validation
QAPI	Quality Assessment and Performance Improvement
QCR	Quality Compliance Review
SDS	Self-Directed Supports
TPA	Third Party Administrator
WWC	Western Wisconsin Cares, Managed Care Organization

APPENDIX 2 – EXECUTIVE SUMMARIES

Care Wisconsin (CW) – Executive Summary

This section of the report summarizes the results of the fiscal year (FY) 16-17 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.

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 16-17 was a targeted review year.

Review Activity	FY 16-17 Results	Comparison to FY 15-16 Results
Quality Compliance Review	• 5 standards reviewed • 3 standards received "met" rating • 88: Cumulative compliance score out of a possible 90 points in third year of three-year review cycle	• 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
Care Management Review	<u>Family Care</u> • 8 of 14 standards met at a rate of 90 percent or higher • 85.1 percent: Overall rate of standards met by this organization for all review indicators <u>Family Care Partnership</u> • 8 of 14 standards met at a rate of 90 percent or higher • 86.6 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 • 83.8 percent: Overall rate of standards met by this organization for all review indicators <u>Family Care Partnership</u> • 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

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 15-16 Quality Compliance Review.

Care Wisconsin addressed, effectively, recommendations made in the FY 15-16 Quality Compliance Review as follows:

- The MCO completed implementation and staff training regarding updates to its *Health Care Wishes and Advance Directives* policy and procedure, to include guidance to inform members that complaints concerning non-compliance with an advance directive may be filed with the Division of Quality Assurance.
- The organization successfully implemented training for addressing member risk.
- The *Clinical Practice Guidelines* policy and procedure has been implemented and monitored to ensure accessibility to providers.
- The organization used a root cause analysis to identify barriers and develop focused improvement efforts related to issuing notices timely to members when indicated.

In reviewing the following recommendations, readers should consider that the FY 16-17 Quality Compliance Review was limited to those areas which were not fully met during the previous year.

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:

- Continue to implement the systemic interventions described in the *Care Wisconsin Restrictive Measures Corrective Action Plan*, conduct ongoing monitoring to assess the effectiveness of the interventions, and make adjustments or develop additional interventions as needed. In addition, ensure that all members' restrictive measures renewal applications are submitted to DHS at least 30 days prior to the current plan's expiration.
- For Family Care Partnership, place priority on identifying and remediating the root causes for the decline in the comprehensiveness of member-centered plans.
- For Family Care, focus efforts on improving results related to the comprehensiveness of member-centered plans.
- For Family Care Partnership, focus efforts on improving results related to:
    - Completing member-centered plan reviews within required timeframes; and
    - Updating member-centered plans when members have significant changes.
- For both programs, continue focused efforts to monitor and improve following up with members and their supports to ensure services have been received and are effective

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 for the standard, and/or other observations related to Care Management Review:

- For Family Care, focus efforts on improving results related to:
  - Comprehensiveness of assessments;
  - Completing member-centered plan reviews within required timeframes; and
  - Updating member-centered plans when members have significant changes.
- For Family Care Partnership, focus efforts on improving results for coordinating services in a timely manner.
- For both programs, continue focused efforts to monitor and improve the timely issuance of notices to members.
- Continue to monitor documentation practices of care management staff and implement improvement efforts as needed.

Community Care, Inc. (CCI) – Executive Summary

This section of the report summarizes the results of the fiscal year (FY) 16-17 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.

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 16-17 was a targeted review year.

Review Activity	FY 16-17 Results	Comparison to Previous Results
Quality Compliance Review	• 3 standards reviewed • 1 standard received "met" rating • 88: Cumulative compliance score out of a possible 90 points in third year of three-year review cycle	• 11 standards reviewed in FY 15-16 • 8 standards received "met" rating • 87: Cumulative compliance score out of a possible 90 points in second 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	<u>Family Care FY 15-16</u> • 8 of 14 standards met at a rate of 90 percent or higher

Review Activity	FY 16-17 Results	Comparison to Previous Results
	• 87.2 percent: Overall rate of standards met by this organization for all review indicators <u>Family Care Partnership</u> • 8 of 14 standards met at a rate of 90 percent or higher • 82.1 percent: Overall rate of standards met by this organization for all review indicators <u>Program of All-Inclusive Care for the Elderly</u> • 5 of 14 standards met at a rate of 90 percent or higher • 85.9 percent: Overall rate of standards met by this organization for all review indicators	• 87.6 percent: Overall rate of standards met by this organization for all review indicators <u>Family Care Partnership FY 15-16</u> • 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 <u>Program of All-Inclusive Care for the Elderly FY 14-15</u> • 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 (Note: Care Management Review was not conducted last year, as this program was audited by the Centers for Medicare & Medicaid Services.)

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 15-16 Quality Compliance Review.

Community Care, Inc. addressed, effectively, recommendations made in the FY 15-16 Quality Compliance Review as follows:

- The organization fully implemented the administrative structure of the Quality Assessment and Performance Improvement program, as well as mechanisms for members of all programs to actively participate in quality management activities.
- The quality plan was developed based on an evaluation and findings from the previous year's quality activities and included the minimum required areas.

In reviewing the following recommendations, readers should consider that the fiscal year 2016-2017 Quality Compliance Review was limited to those areas which were not fully met during the previous year.

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 the revised *Cost Recovery from Members* policy.
- Increase efforts to monitor and improve timely issuance of notices to members when indicated in all programs.
    - Ensure monitoring approaches and data analysis are adequate and effective in order to achieve improvement.
    - Select interventions which address identified root causes and barriers.
- In all programs, improve the comprehensiveness of member-centered plans by ensuring all identified member needs, including rationales for complex medication regimes and a description of behaviors for members' prescribed behavior modifying medications are identified on the plan.
- For all programs, continue efforts to improve follow-up with members to ensure services have been received and are effective.
- For Family Care, focus efforts on improving results for updating the member-centered plan for significant changes.
- For Family Care Partnership, conduct additional analysis to identify the root cause or causes for the decline in the timeliness of six-month 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 for the standard, and/or other observations related to Care Management Review:

- Continue efforts to develop the organization's Quality Assessment and Performance Improvement program:
    - Ensure the *2016 Quality Program Description* is fully updated to clearly reflect all current administrative structures.
    - Fully update the *2016 Quality Program Description* to describe all methods for members, staff, and providers to participate in the Quality Management program.
    - Review the *Long Term Care Functional Screen* monitoring and data analysis processes, and include clear documentation in the quality plan.
    - Continue efforts to facilitate communication and coordination among all aspects of the quality program and between other functional areas of the organization, and include comprehensive documentation in quality program documents.
    - Ensure the internal file review tool and process provide data specific to areas identified by the MCO as a priority and needing improvement.

Independent Care Health Plan (*i*Care) – Executive Summary

This section of the report summarizes the results of the fiscal year (FY) 16-17 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.

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 16-17 was a targeted review year.

Review Activity	FY 16-17 Results	Comparison to FY 15-16 Results
Quality Compliance Review	• 17 standards reviewed • 15 standards received "met" rating • 88: Cumulative compliance score out of a possible 90 points in third year of three-year review cycle	• 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
Care Management Review	<u>Family Care Partnership</u> • 11 of 14 standards met at a rate of 90 percent or higher • 89.7 percent: Overall rate of standards met by this organization for all review indicators	<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

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 15-16 Quality Compliance Review.

Independent Care Health Plan addressed, effectively, recommendations made in the FY 15-16 Quality Compliance Review as follows:

- To help ensure the accuracy of information in the online provider directory, the organization developed and implemented a process for periodic monitoring of directory listings.

- The organization established monitoring processes to maintain a network of qualified providers for both long-term care and acute and primary services by:
    - Developing provider network adequacy processes based on data, including methods of gap analysis;
    - Implementing systems to monitor timely access to services;
    - Updating policies and procedures to give clear direction for credentialing audits and monitoring processes;
    - Instituting an auditing process to ensure all relevant providers have and maintain licensure or certification for the services they have contracted to provide; and
    - Implementing an internal audit of providers to ensure all entities have delegation language in place and/or signed delegation agreements on file to ensure consistent credentialing processes are followed.
- Independent Care Health Plan added procedural guidance to its Enrollment and Disenrollment policy and procedure in areas where staff guidance had previously been lacking. The organization now has policies and procedures in place covering all areas of enrollment and disenrollment, as required.
- The organization obtained an Enrollment and Disenrollment Plan with Kenosha County and updated plans with two other counties. Independent Care Health Plan now has an enrollment/disenrollment plan with each of the four counties in its service area.
- Independent Care Health Plan updated policies and procedures to meet requirements to adopt, disseminate, and apply practice guidelines.
- The organization updated policies, processes, and documentation related to its Quality Assessment and Performance Improvement program to:
    - Ensure the program is operated consistently through appropriate administrative structures;
    - Provide opportunities for Family Care Partnership members and providers to participate in the program; and
    - Meet other minimum requirements related to the quality work plan and specific activities of the program.
- Utilization management procedures were revised and implemented to ensure monitoring was conducted to detect over-utilization and under-utilization.
- The organization improved its process for and documentation of the evaluation of the impact and overall effectiveness of its quality program.
- The organization updated training materials regarding the composition of the local grievance and appeal committee to align with Independent Care Health Plan's policy, and meet contract requirements.
- Independent Care Health Plan developed a Provider Communication policy that outlines the processes to inform providers of updates and changes to the Provider Reference

Manual. As a result, providers were informed of updates made to the manual regarding grievance systems for members.
- Independent Care Health Plan improved care management practice through targeted trainings and supervisory oversight.

In reviewing the following, readers should consider that the FY 16-17 Quality Compliance Review was limited to those areas which were not fully met during the previous year.

iCare - 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:

- Improve data collection and analysis mechanisms to effectively assess the quality and appropriateness of care furnished to members:
    - Ensure specific aspects of member care and care management practice can be measured, in order to identify areas needing improvement and achieve improvement as necessary;
    - Expand monitoring and improvement initiatives beyond the member level; and
    - Consider revising the internal file review sampling methodology to obtain a more consistent, random sample.
- Focus efforts to improve results in the following areas evaluated by care management review:
    - Comprehensive member-centered plans;
    - Timely coordination of services; and
    - Follow-up to ensure services are effective.

While Independent Care Health Plan made progress to achieve compliance in most standards, MetaStar recommends the organization continue to focus efforts on the following priority areas where the organization received a "met" rating. Addressing these recommendations will help the organization sustain the improvements it has achieved over the last two years as well as further improve aspects of its program beyond minimum compliance.

- Continue to monitor and maintain a network of qualified providers:
    - Ensure all providers are given clear expectations regarding their responsibilities and roles for credentialing and caregiver background check procedures, especially those with older contracts prior to the 2016 version;
    - Analyze all monitoring processes and implement improvement efforts as needed for contracting and re-credentialing procedures; and

    - Ensure providers are consistently informed of all changes made to the organization's provider reference manuals so as to keep their knowledge of all requirements current.
- Continue efforts to develop and enhance the organization's Quality Assessment and Performance Improvement program:
    - Expand opportunities for providers, members, and staff to participate in the quality program and clearly document these mechanisms in the Quality Program Description or elsewhere;
    - Ensure the quality plan includes relevant initiatives to improve member care, in addition to elements focused on the development of processes and baselines, and monitoring for compliance; and
    - Ensure data can be captured and analyzed for trends for all required monitoring areas, and include documentation as part of the quality program.
- Continue efforts to improve the Family Care Partnership Utilization Management program:
    - Expand the analysis of utilization data beyond the member level to identify possible utilization issues at the system or organization level; and
    - Ensure the revised focus for 2017 continues to include sufficient monitoring to detect both over- and under-utilization of long-term care services, as well as acute and primary care services.
- Sustain results for notices issued timely when indicated by ensuring monitoring methods capture accurate data that is specific enough to identify any system or organizational level trends.

Following are additional recommendations for continued improvement in other areas where the managed care organization received a "met" rating:

- Ensure the quality evaluation process places sufficient emphasis on the evaluation of improvement in member care.
- Continue to improve the functioning of the online provider directory to ensure the information is clear and easy to use for members and their supports. Identify and eliminate listings in the online provider directory that are duplicative under the same service type.
- Update the organization's provider reference manuals to include information regarding clinical practice guidelines, as stated in the Provider Clinical Practice Guidelines policy and procedure.
- Correct the contact number for members filing an appeal or grievance in the FCP Provider Reference Manual.

Lakeland Care, Inc. (LC) – Executive Summary

This section of the report summarizes the results of the fiscal year (FY) 16-17 annual quality review conducted by MetaStar, Inc., for the managed care organization, Lakeland 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.

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 16-17 was a targeted review year.

Review Activity	FY 16-17 Results	Comparison to FY 15-16 Results
Quality Compliance Review	• 1 standard reviewed • The standard reviewed did not receive a "met" rating • 87: Cumulative compliance score out of a possible 88 points in third year of three-year review cycle	• 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
Care Management Review	<u>Family Care</u> • 9 of 14 standards met at a rate of 90 percent or higher • 86.5 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 • 89.9 percent: Overall rate of standards met by this organization for all review indicators

In reviewing the following, readers should consider that the fiscal year 2016-2017 Quality Compliance Review was limited to one standard which was not fully met during the previous year.

LC - Recommendations

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

- Place priority on improving the comprehensiveness of member-centered plans by

ensuring plans identify the frequency of face-to-face contacts, document all assessed member needs, and include rationales for complex medication regimes and a description of behaviors for members prescribed behavior modifying medications.

- Continue to focus efforts on improving results in the following areas evaluated by Care Management Review:
    - Comprehensiveness of Assessment;
    - Plan Updated for Significant Changes;
    - Follow-up to Ensure Services are Effective; and
    - Notices Issued in a Timely Manner when Indicated.

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 for the standard, and/or other observations related to Care Management Review:

- Implement the organization's planned improvement efforts to address documentation expectations for updating assessments and member-centered plans to identify current and historical information to provide an accurate reflection of members' current needs and abilities.

My Choice Family Care (MCFC) – Executive Summary

This section of the report summarizes the results of the fiscal year (FY) 16-17 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.

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 16-17 was a targeted review year.

Review Activity	FY 16-17 Results	Comparison to FY 15-16 Results
Quality Compliance Review	• 4 standards reviewed • 1 standard received "met" rating • 85: Cumulative compliance score out of a possible 88 points in third year of three-year review cycle	• 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

Review Activity	FY 16-17 Results	Comparison to FY 15-16 Results
Care Management Review	Family Care • 8 of 14 standards met at a rate of 90 percent or higher • 86 percent: Overall rate of standards met by this organization for all review indicators	Family Care • 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

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 15-16 Quality Compliance Review.

My Choice Family Care addressed, effectively, recommendations made in the FY 15-16 Quality Compliance Review as follows:

- The *Member Notification of Provider Termination* policy, procedure, and template notification letter have been fully implemented and a monitoring process is in place to ensure affected members receive timely written notice regarding the termination of a provider from the organization's network.
- The organization improved care management review results for the indicator, "Reassessment Done when Indicated."

In reviewing the following, readers should consider that the FY 16-17 Quality Compliance Review was limited to those areas which were not fully met during the previous year.

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:

- 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 comprehensiveness of member-centered plans.
    - Ensuring member-centered plans are reviewed and signed timely by the appropriate legal decision maker at the required six month intervals.
- Focus improvement efforts in the following areas of care management practice:
    - Timeliness of service authorization decisions.
    - Timely Coordination of Services
    - Follow-up to Ensure Services are Effective

- Take action, as needed, to improve the comprehensiveness of restrictive measures application materials with the goal of reducing delays in application approvals, and shortening or eliminating the amount of time members' restrictive measures plans are expired without new, approved plans in place.

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 for the standard, and/or other observations related to Care Management Review:

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

Western Wisconsin Cares (WWC) – Executive Summary

This section of the report summarizes the results of the fiscal year (FY) 16-17 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.

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 16-17 was a targeted review year.

Review Activity	FY 16-17 Results	Comparison to FY 15-16 Results
Quality Compliance Review	• 2 standards reviewed • 1 standard received "met" rating • 87: Cumulative compliance score out of a possible 88 points in third year of three-year review cycle	• 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
Care Management Review	<u>Family Care</u> • 7 of 14 standards met at a rate of 90 percent or higher • 86.9 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 • 87.7 percent: Overall rate of standards met by this organization for all review indicators

WWC - 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 15-16 Quality Compliance Review.

Western Wisconsin Cares addressed, effectively, recommendations made in the FY 15-16 Quality Compliance Review as follows:

- Improvements were made in written staff guidance and tools, as well as monitoring processes to ensure provider credentialing practices are consistent and meet requirements.

In reviewing the following strengths and recommendations, readers should consider that the fiscal year 2016-2017 Quality Compliance Review was limited to those areas which were not fully met during the previous year.

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:

- Systematically assess the various interventions the MCO has implemented related to restrictive measures applications/renewals to identify those most effective in facilitating the timely submission of restrictive measures renewal applications. Continue to gather and analyze data to identify and address barriers and monitor the organization's progress in submitting restrictive measures renewal applications to DHS at least 30 days prior to expiration of a member's current plan.
- Update the organization's *Use of Restrictive Measures Policy* to identify the additional staff that has been added to the Restrictive Measures Review Committee, and to include steps and timelines for completing annual renewals of restrictive measures plans.
- Place priority on identifying the causes for the decline in care management review results for the standard, "Comprehensiveness of Assessment," and implement improvement efforts.
- In addition, focus efforts on improving results in the following areas evaluated by care management review:
    - Comprehensiveness of Most Recent Member-Centered Plan;
    - Plan Updated for Significant Changes;
    - Follow-up to Ensure Services are Effective; and
    - Notices Issued in a Timely Manner when Indicated.

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 for the standard, and/or other observations related to Care Management Review:

- Ensure audits of new provider files are consistently completed in a timely manner.
- Evaluate policies and practices related to assessment and planning for members with complex medication regimens and/or behavior modifying medications, and remediate as indicated.

APPENDIX 3 – REQUIREMENT FOR EXTERNAL QUALITY REVIEW AND REVIEW METHODOLOGIES

REQUIREMENT FOR EXTERNAL QUALITY REVIEW

The Code of Federal Regulations (CFR) at 42 CFR 438 requires states that operate pre-paid inpatient health plans and managed care organizations (MCO) to provide for external quality reviews (EQR). To meet these obligations, states contract with a qualified external quality review organization (EQRO).

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 care 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 MCOs serving BadgerCare Plus, Supplemental Security Income, Special Managed Care, and Foster Care Medical Home Medicaid recipients in the State of Wisconsin. MetaStar also provides other services for the state as well as for private clients. 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 clinical nurse specialist, 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 Healthcare Effectiveness Data and Information Set (HEDIS®)[2] 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 the Wisconsin Department of Health Services (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

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

improvement education and specialized training in evaluating performance improvement projects. Reviewers are required to maintain licensure, if applicable, and participate in additional relevant training throughout the year. All reviewers are trained annually to use current EQR protocols, review tools, guidelines, databases, and other resources.

REVIEW METHODOLOGIES

Compliance with Standards Review/Quality Compliance Review (QCR)

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

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 Family Care Program contracts with DHS;
- Related program operation references found on the DHS website: https://dhs.wisconsin.gov/familycare/MCOs/index.htm;
- The previous 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.

Discussions were held onsite or by phone conference 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 registered nurse care managers.

MetaStar also conducted some onsite 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. As indicated in the table below, the one additional standard reviewed for FCP and PACE is part of the "Enrollee Rights and Protections" focus area.

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: 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 requirements, **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 findings 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:

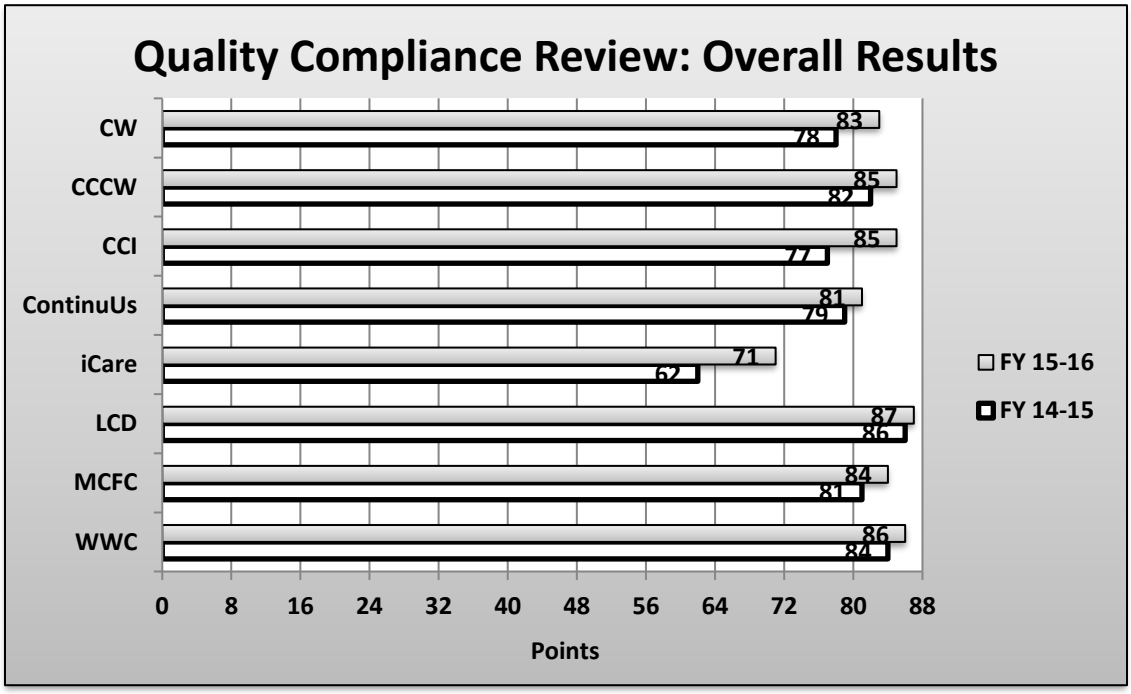
- Met: 2 points
- Partially Met: 1 point
- Not Met: 0 points

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.

The graph below provides specific information by MCO regarding the FY 15-16 overall QCR results. The graph shows the results for the 44 standards that applied to every organization and carried a maximum possible score of 88 points. The points for the one additional standard applicable only to FCP and PACE were removed from the graph in order to allow for valid comparisons among organizations.



Validation of Performance Improvement Projects (PIP)

The purpose of a 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.*

Per CMS guidelines, prior to conducting performance measures validation activities, MetaStar reviewed the most recent Information Systems Capability Assessment (ISCA) report for each MCO 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 Capabilities 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; 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
- Third Party Administration (TPA) Claims Processing and encounter reporting reference materials: https://www.dhs.wisconsin.gov/familycare/mcos/index.htm.

To conduct the assessment, MetaStar used the ISCA tool to collect information about the effect of the MCO's information management practices on encounter data submitted to DHS. Reviewers assessed information provided in the ISCA tool, which was completed and submitted to MetaStar by the MCO. Some sections of the tool may have been completed by contracted vendors, if directed by the MCO. Reviewers also obtained and evaluated documentation specific to the MCO's 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: Data Acquisition - 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 and 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. (The review of this section is only for FC, FCP, and PACE programs at the request of DHS)

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. (The review of this section is only for FC, FCP, and PACE programs at the request of DHS)

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, MetaStar 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 15-16 statewide aggregate rate for each of the 14 CMR standards.

CMR Measure	FY 15-16 FC Aggregate Rate	FY 15-16 FCP Aggregate Rate
1A-Comprehensiveness of Assessment	93.6%	86.7%
1B-Re-Assessment Cone When Indicated	92.8%	93.3%
2A-Comprehensiveness of Plan	67.8%	72.2%
2B-Timeliness of Most Recent Plan (6 months)	89.8%	78.9%
2F-Timeliness of Member-Centered Plan in Past 12 Months	98.9%	95.6%
2C-Plan Updated for Changes	70.7%	37.5%
2D-Timeliness of Service Authorization Decisions	92.7%	86.7%
2E-Risk Addressed	96.3%	86.7%
3A-Timely Coordination of Services	87.8%	82.2%
3B-Follow-Up Completed	62.7%	54.4%
3C-Identified Needs Addressed	95.9%	91.1%
4A-Notice of Action Issued	55.5%	39.3%

CMR Measure	FY 15-16 FC Aggregate Rate	FY 15-16 FCP Aggregate Rate
4B-Member/ Guardian/Supports Included	99.3%	97.8%
4C-Self-Directed Supports Offered	98.8%	95.6%
CMR Overall Results	**88.7%**	**83.3%**

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.