External Quality Review Annual Technical Report

Fiscal Year 2017 – 2018

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

Prepared for

Wisconsin Department of Health Services

Division of Medicaid Services

Prepared by

Final Report

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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, Family Care Partnership, 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 contracts with MetaStar, Inc.

This report covers the external quality review fiscal year from July 1, 2017, to June 30, 2018 (FY 17-18). 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(c) Home and Community Based Services Waiver, 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.

Summary of Progress

This section is intended to report about progress the managed care organizations made in response to MetaStar's recommendations related to external quality review activities which occurred during FY 16-17.

- For the six organizations reviewed during FY 16-17, a total of ten standards remained partially met at the conclusion of the review. Four managed care organizations effectively addressed recommendations to achieve compliance with four of the ten standards:
    - Two organizations improved practices to ensure renewal restrictive measures applications were comprehensive and timely to fully meet the standard related to specific rights.
    - One organization focused improvement efforts on comprehensiveness of member centered plans to fully meet the standard related to identification, assessment, and service plans.

    - One organization fully implemented a policy change related to enrollee's responsibility for services furnished.
- Aggregate progress for performance improvement projects is not able to be identified, as project topics, study populations, and project timeframes vary widely across organizations.
- Each managed care organization receives an information systems capability assessment once every three years. Two organizations received an information systems capabilities assessment in FY 17-18.
    - One organization has addressed or made improvements in all of the recommendations from the previous review and was fully met in all focus areas.
    - The other managed care organization was a new organization as of January 1, 2017 as a result of a merger; therefore, progress related to remediation of prior recommendations could not be detailed.
- Performance measure validation results remained consistent with prior review years.
- Each organization took action to respond to the care management review recommendations received in prior reviews. Most organizations were able to achieve overall improvement. Aggregate results for all programs showed compliance rates over 90 percent for eight of 14 care management review standards.

NOTABLE STRENGTHS

This section is intended to report on strengths of the managed care organizations. The following strengths were observed during the External Quality Review activities and Care Management Reviews:

Quality Compliance Review – Enrollee Rights and Protections

- Most or all of the organizations reviewed met requirements related to:
    - Providing information in member handbooks;
    - Advance directives;
    - Specific rights including the right to be free from any form of restraint or seclusion;
    - Provider-enrollee communications; and
    - Coverage and payment of emergency and post-stabilization services.

Quality Compliance Review – Quality Assessment and Performance Improvement

- Most or all of the organizations met requirements related to:
    - Second opinion and out-of-network providers;
    - Cultural considerations in the delivery of services;
    - Coverage and authorization of services;

- Confidentiality;
- Evaluation of the MCO's Quality Assessment and Performance Improvement program; and
- Health information systems.

Quality Compliance Review – Grievance Systems

- All organizations met most requirements related to this focus area, indicating this is an overall strength across organizations.

Performance Improvement Projects Validation

MetaStar validated eight performance improvement projects in FY 17-18. Common strengths identified among projects/MCOs include the following:

- 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.
- All eight projects were developed with clearly stated study questions.
- Most standards related to data collection procedures were met.

Information Systems Capabilities Assessment

MetaStar conducted information systems capabilities assessments for two MCOs in FY 17-18, and identified the following strengths:

- The reconciliation process of reported member cost share deductions is in-depth, ensuring discovery of any discrepancies or errors.
- The processes and systems capabilities available within the MCOs' provider information database are wide-ranging and available to multiple units within the organization.
- Reconciliation of provider data is performed and coordinated by staff in multiple units, allowing thorough validation to prevent redundancies and ensure accuracy. Changes and updates to provider information are uploaded nightly to the external directory providing members with access to the most current provider information.

Care Management Review

In FY 17-18, Family Care and Family Care Partnership programs maintained aggregate results over 90 percent for the following review indicators. All of these indicators were also above 90 percent in FY 16-17:

- "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 17-18, the only PACE maintained results over 90 percent for the review indicators listed below. The results for five of these indicators were also over 90 percent at the time of its last care management review in FY 16-17:

- "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/Family/Informal Supports Included"; and
- "Self-Directed Supports Option Offered".

RECOMMENDATIONS

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

Quality Compliance Review – Enrollee Rights and Protections

- Ensure five organizations develop policies and related procedures for the provision of electronic materials to members which meet all Wisconsin Department of Health Services requirements.

Quality Compliance Review – Quality Assessment and Performance Improvement

- Provide oversight and guidance to MCOs in order to ensure monitoring practices related to the availability of services, provider selection and retention and provider quality are sufficient.
- Assist MCOs in identifying the root cause for care management practices scoring below minimum thresholds, specifically follow-up and comprehensiveness of member centered plans.
- Ensure four organizations implement effective practices for dissemination of practice guidelines to providers, review and update the guidelines periodically as appropriate, as well as meet all other requirements.
- Provide oversight and guidance to organizations so that Quality Assessment and Performance Improvement Programs include opportunities for active member and

provider participation, and implement all required monitoring activities which are designed to produce data for quality improvement.
- Ensure utilization management processes focus on monitoring and analysis to detect both overutilization and underutilization of services.

Quality Compliance Review – Grievance Systems

- Provide oversight and guidance to five organizations to improve the issuance of notices to members in a timely manner when indicated.

Performance Improvement Projects Validation

Provide guidance and oversight for conducting and reporting performance improvement projects to ensure MCOs:

- 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, along with the method of selecting the study population.
- Ensure all data figures and numerical results are presented clearly and accurately throughout the final report.
- Consider the population size when selecting the study topics or indicators.
- Specify a data analysis plan and fully analyze study data.
- Analyze data in accordance with the identified indicator, and ensure conclusions are based on consideration of data from the entire study population.
- Conduct continuous cycles of improvement to evaluate the effectiveness of the interventions and make changes if improvement is not demonstrated.
- Address cultural or linguistic appropriateness of interventions.
- Ensure all data sources, procedures, and data collection instruments are clearly defined.
- Take study limitations into consideration in analysis to determine possible reasons for less than optimal performance.
- 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 of improvement that has been achieved.

Performance Measures Validation

Provide guidance and oversight to all programs to focus improvement efforts on the following areas:

- Ensure policies and procedures include all required information regarding contraindications as outlined in the DHS' technical specifications for the influenza vaccination.
- Ensure documentation practices for members contraindicated from receiving influenza and pneumococcal vaccinations meet DHS technical specifications.
- Ensure target group assignment for members eligible for the pneumococcal vaccine meet DHS specifications.

Information Systems Capabilities Assessment

Two MCOs received an information systems capabilities assessment in FY 17-18. The organizations' information systems are structured and implemented differently, according to each MCO's structure and operations; therefore, recommendations are individualized as follows:

- Ensure one MCO:
    - Considers a more proactive and systematic process to track and trend errors, as it relies on manual processes to validate the accuracy of data;
    - Considers transitioning from a manual pended claims review process to a system-generated trigger for review of pended claims approaching 30 days; and
    - Reprioritizes the timing for developing and implementing an automated data transfer process from one system to another.
- Ensure the other MCO:
    - Continues plans to consolidate the regional operating systems, databases, and associated policies and procedures across the merged organization;
    - Prioritizes efforts to remediate any challenges related to timely or accurate performance measurement reporting;
    - Develops a formal vendor management process, including a standardized process related to vendor procurement and contracting; and
    - Continues efforts to ensure the Third Party Administrator (TPA) provides confirmation of data upload of provider files and to obtain direct access to the TPA system to review authorizations to reduce errors and claims rejections.

Care Management Review

Provide guidance and oversight to all programs (Family Care, Family Care Partnership, 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.

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. 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, 2017, to June 30, 2018 (FY 17-18). See Appendix 3 for more information about external quality review and a description of the methodologies used to conduct review activities.

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. 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 17-18 annual EQR report, include MetaStar's assessment of key strengths and recommendations for improvement for each MCO.

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

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
Inclusa, Inc. (Inclusa)*	FC
Independent Care Health Plan (*i*Care)	FCP

Managed Care Organization	Program(s)
Lakeland Care, Inc. (LCI)	FC
My Choice Family Care, Inc. (MCFC)	FC

*Community Link, Inc., (CLI) changed its name to Inclusa, Inc. on September 1, 2017.

On February 1, 2018, DHS certified two MCOs, CW and MCFC, to expand into geographic service region (GSR) 12, providing consumers with access to FC in an area where it had not previously been available. The expansion made FC services available in every GSR throughout the State of Wisconsin. During FY 17-18, CW was certified to expand into GSRs 11 and 12 and one additional county of GSR 1. MCFC was certified to expand into GSRs 2, 3, and 12. Inclusa was certified into four additional counties of GSR 4 and one additional county of GSR 1. LCI was certified to expand to GSR 4 as of July 1, 2017. CCI was certified to expand PACE services into one county of GSR 11 on January 1, 2018.

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.

Details about the core values and operational aspects of these programs are found at the following websites:

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

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

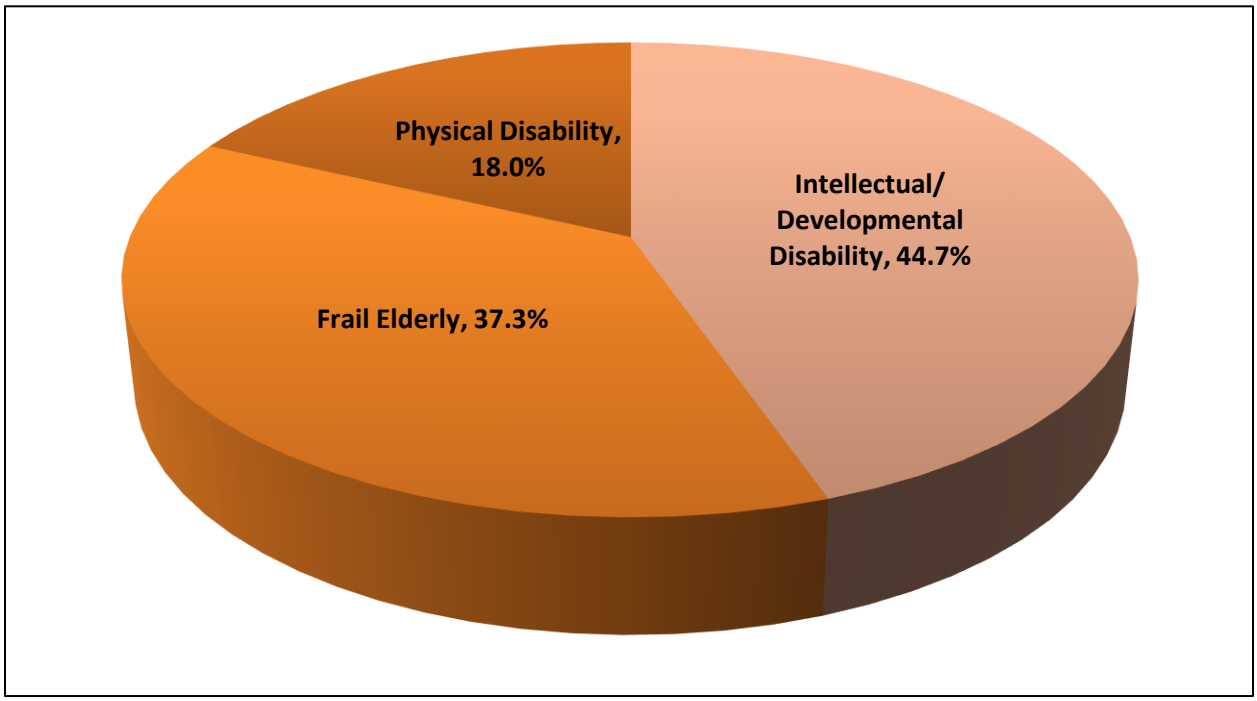
https://www.dhs.wisconsin.gov/familycare/pace.htm.

As of April 1, 2018, enrollment for all programs was approximately 51,453. This compares to last year's total enrollment of 48,948 as of June 30, 2017. The most current enrollment data is available at the following DHS website:

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

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

Total Participants in All Programs by Target Group April 1, 2018



Scope of External Review Activities

In FY 17-18, 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 information systems capabilities assessments (ISCAs) for some MCOs during FY 17-18. MetaStar also conducted an optional review activity, care management review (CMR) for all MCOs.

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; 43 standards for FC, and 44 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 17-18 was the first year of the three-year cycle.
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 17-18, MetaStar validated one or more PIPs for each MCO, for a total of eight PIPs. The PIP topics reviewed for each MCO are indicated in the chart on page 14.
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 17-18, 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 17-18.
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 (c) Waiver, which allows the State of Wisconsin to operate its Family Care programs. During FY 17-18, the EQR team conducted CMR activities during each MCO's external quality review, and 777 records were reviewed across all three programs.

	At the request of DHS, MetaStar also reviewed an additional 115 member records separate from EQR. These results were reported separately and are not included in the data for this report.

PIP Topics Reviewed for each MCO

MCO	PIP Topic(s)
CW	• Utilization of Self-Directed Supports (FC) • Diabetes Management (FCP)
CCI	• Dementia Care (FC) • Dementia Care (FCP/PACE)
Inclusa	• Dementia Care (FC)
***i*Care**	• Dementia Care (FCP)
LCI	• Member Satisfaction (FC)
MCFC	• Utilization of Self-Directed Supports (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	96
CCI	150
Inclusa	223
LCI	67
MCFC	121
Total: Family Care	**657**
Family Care Partnership/PACE	
CW	30
CCI - FCP	30
CCI - PACE	30
*i*Care	30
Total: Family Care Partnership/PACE	**120**
Total: All Programs	**777**

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 17-18 was the first year in the three-year cycle.

The QCR standards are scored 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.

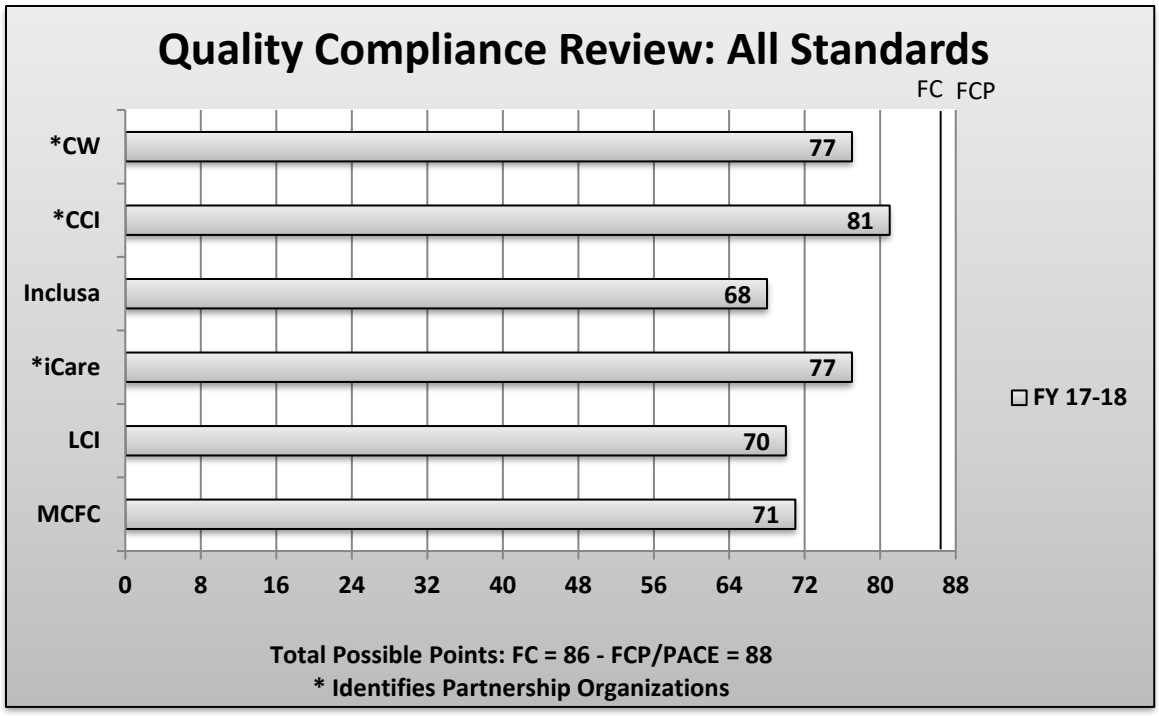
Forty-three standards totaling 86 points apply to every organization, while one additional standard (in the area of Enrollee Rights and Protections) applies only to organizations operating FCP/PACE. Therefore, 44 standards apply to the three organizations operating Family Care Partnership and PACE programs totaling 88 points, which is depicted in the relevant bar graphs in this section.

For detailed information about each standard in Enrollee Rights and Protections, Quality Assessment and Performance Improvement, and Grievance Systems, please see Appendix 4.

Overall QCR Results by MCO

The following graph indicates each MCO's overall level of compliance in this year's review.

The results for all six MCOs ranged from 68 to 81 points, with the number of points needed for full compliance ranging from seven to 18. As explained above, the total possible points for MCOs operating the FCP program is 88; those three organizations are denoted with an asterisk in the graph below. The other three organizations operate the FC program, with a total possible points of 86.



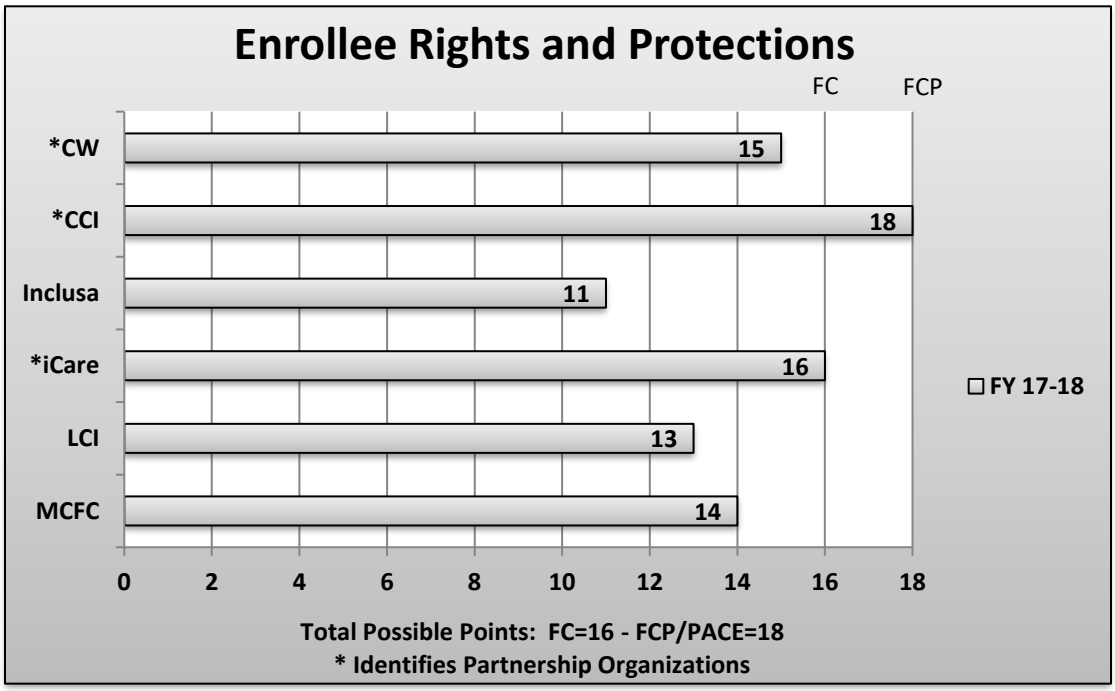
Each section that follows provides a brief explanation of a QCR focus area, followed by a bar graph and a table with additional information.

Results for Enrollee Rights and Protections

A MCO is responsible to help members understand their rights as well as to ensure those rights are protected. This requires an adequate organizational structure and sound processes that adhere to 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. As in the graph above, organizations operating the FCP program are denoted with an asterisk, and have 18 total possible points for this area of review, while MCOs operating the FC program have 16 total possible points.

Bar Graph E.1



The following table, E.2 lists the comparative findings by each standard. The first column indicates the number assigned to the review standard. The second column indicates the standard description. The remaining columns depict each MCO with its rating for this fiscal cycle, scored as Met (M), Partially Met (PM), Not Met (NM), or Not Applicable (N/A).

Table E.2

MCO Comparative Findings by Standard							
		CW	CCI	Inclusa	*i*Care	LCI	MCFC
#	Standard	FY 17-18	FY 17-18	FY 17-18	FY 17-18	FY 17-18	FY 17-18
Enrollee Rights and Protections							
E1	General rule	M	M	PM	M	M	PM
E2	Information requirements: language and format	PM	M	PM	PM	PM	PM
E3	Information requirements: general	PM	M	PM	M	M	M
E4	Provider directory	M	M	M	PM	PM	M
E5	Enrollee handbook	PM	M	M	M	M	M
E6	Advance directives	M	M	PM	M	M	M
E7	Specific rights	M	M	PM	M	M	M
E8	Provider-enrollee communications	M	M	M	M	PM	M
E9	Emergency and post-stabilization services (FCP only)	M	M	N/A	M	N/A	N/A

ANALYSIS

This area of review consists of eight standards applicable to every organization, and one additional standard applicable to organizations operating FCP and PACE (Standards E1 - E9). 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, one fully met the requirements for all of the standards in this focus area. The findings for the other organizations show four MCOs with two or three partially met standards and one with five partially met standards. The primary reasons for standards found to be partially met were lack of written guidance addressing some of the requirements, as well as policies and procedures that were not fully implemented at the time of the review.

The documentation submitted and onsite discussions with MCO staff indicated that, in general, organizations have various policies and procedures in place and conduct regular training which addresses most of the requirements of this focus area. The general rule standard, E1, was met by four of six MCOs. One organization lacked a fully implemented member rights policy, while another organization did not ensure all providers had access to complete information related to member rights.

The standard, E2, regarding information requirements, contains specific conditions from the DHS-MCO contract regarding the provision of electronic materials to members, including the requirement that written consent must be obtained prior to providing the materials. The consent documentation must specify the media type and documents to be sent, and the materials must meet additional contract requirements. FY 17-18 was the first year these requirements were reviewed. This standard was partially met for five of six MCOs, as those organizations did not have policies or procedures in place to obtain members' written consent. The other aspects of this standard, such as requirements to provide written and oral information in easily understood languages and formats, were met by five of six organizations.

Additional standards address other information requirements, with results as follows:

- Two organizations did not fully meet E3, which addresses furnishing specific types of information to members. One organization did not have fully implemented policies or procedures, while a second organization lacked written guidance regarding members' rights to request and obtain a member handbook and provider directory at least once a year.
- Two organizations had online or printable provider directories that included inaccuracies and/or did not meet all requirements.
- One organization did not meet requirements related to member handbooks, as an outdated version was posted on its website.

- The standard, E6, includes multiple requirements related to advance directives. Five of six organizations fully met this requirement; however, one MCO did not have policies or procedures in place to achieve compliance.

Five of six organizations met standard E7, which addresses specific member rights, such as the right to be treated with respect, to receive information on available treatment options, and to request and receive copies of medical records, among others. This standard also includes the right to be free from any form of restraint or seclusion. One organization did not fully meet this standard, due in part to lack of fully implemented policies and procedures related to restrictive measures, and the untimely submission of restrictive measures renewal applications to DHS. However, results for this standard show progress from the FY 16-17 review: two organizations achieved fully met scores through implementation of improvement efforts, such as developing a checklist for care management staff to use to ensure comprehensiveness of renewal applications, and an automated due date notification system.

MCOs may not prohibit or restrict providers acting within their scope of practice from advising or advocating on behalf of a member. The related standard, E8, was fully met by five of six organizations. However, four of those five organizations received recommendations to update the available written guidance to include the specific reasons providers may advocate for members as listed in the standard. The MCO that did not meet the requirement had no written guidance for providers or staff.

The standard, E9, regarding coverage and payment for emergency and post-stabilization services applies only to organizations that operate FCP and PACE programs. All three relevant organizations met this standard.

CONCLUSIONS

The progress, strengths, and opportunities noted below are based on the findings, as indicated in bar graph E.1 and table E.2.

Progress

- Two organizations effectively addressed recommendations from FY 16-17 to ensure applications for renewal of restrictive measures plans were comprehensive and timely; and, therefore achieved full compliance in FY 17-18 with the standard related to specific rights, E7.

Strengths

- Five of six organizations fully met requirements related to:
    - Providing information in member handbooks (E5);

- Advance directives (E6);
- Specific rights including the right to be free from any form of restraint or seclusion (E7); and
- Provider-enrollee communications (E8).

- All three organizations with FCP programs fully met requirements related to coverage and payment of emergency and post-stabilization services (E9).

Opportunities for Improvement

- Based on the findings, areas of opportunity for improvement where half or more of MCOs did not fully meet requirements include the need to:
  - Develop policies and related procedures for obtaining consent for the provision of electronic materials to members, and ensure the procedures and materials meet DHS-MCO contract requirements (E2).
- Fully implement required policies and procedures.
- Ensure written guidance includes all aspects of each standard.

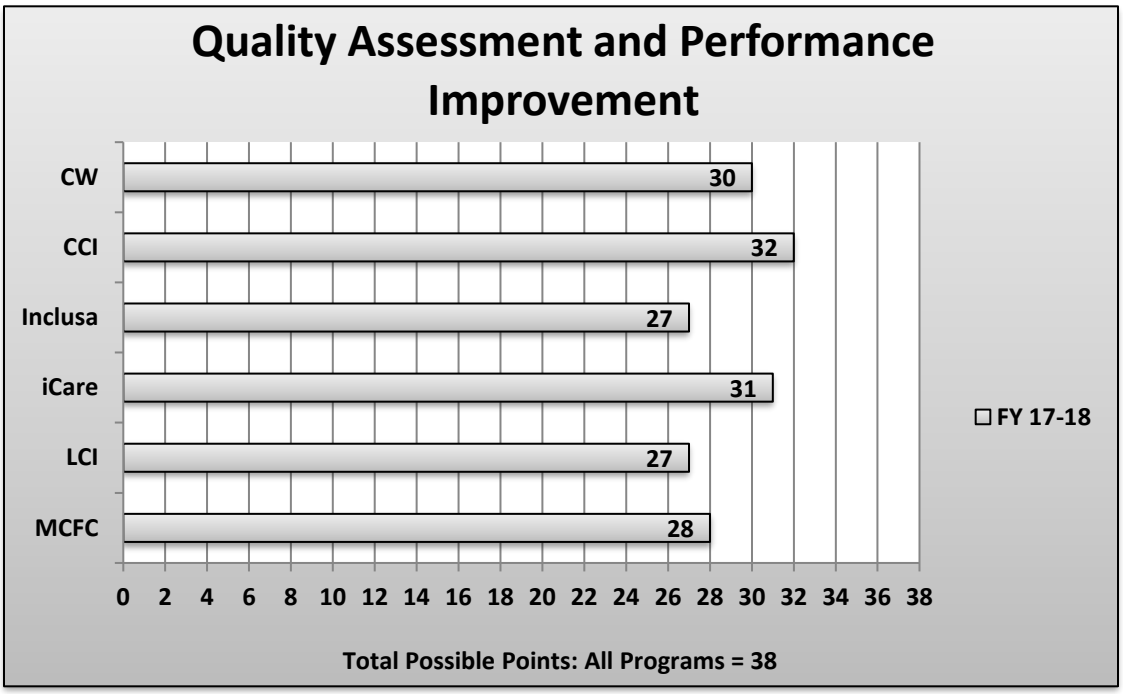
Results for Quality Assessment and Performance Improvement

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;
- 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.

Bar Graph Q.1



The following table, Q.2, lists the comparative findings by each standard. The first column indicates the number assigned to the review standard. The second column indicates the standard description. The following columns depict each MCO with its rating for this fiscal cycle, scored as Met (M), Partially Met (PM), Not Met (NM), or Not Applicable (N/A).

Table Q.2

MCO Comparative Findings by Standard							
		CW	CCI	Inclusa	*i*Care	LCI	MCFC
#	Standard	FY 17-18	FY 17-18	FY 17-18	FY 17-18	FY 17-18	FY 17-18
Quality Assessment/Performance Improvement							
Q1	Delivery network	M	PM	PM	M	PM	M
Q2	Second opinion and out-of-network providers	M	M	PM	M	M	M
Q3	Timely access	M	M	M	M	PM	PM
Q4	Cultural considerations	M	M	M	M	M	M
Q5	Coordination and continuity of care	PM	PM	PM	PM	PM	PM
Q6	Identification, assessment, and service plans	PM	PM	PM	M	PM	PM
Q7	Authorization of services	PM	M	M	M	M	M
Q8	Timeframe for authorization decisions	M	M	M	M	M	PM
Q9	Provider selection: credentialing and nondiscrimination	PM	PM	PM	PM	PM	PM

MCO Comparative Findings by Standard							
		CW	CCI	Inclusa	*i*Care	LCI	MCFC
#	Standard	FY 17-18	FY 17-18	FY 17-18	FY 17-18	FY 17-18	FY 17-18
Quality Assessment/Performance Improvement							
Q10	**Excluded providers**	M	PM	PM	M	PM	M
Q11	**State requirements: caregiver background checks**	PM	M	PM	PM	PM	PM
Q12	**Confidentiality**	M	M	PM	M	M	M
Q13	**Subcontractual relationships and delegation**	M	M	PM	M	PM	PM
Q14	**Practice guidelines**	PM	M	PM	PM	M	PM
Q15	**Quality assessment and performance improvement (QAPI) program**	PM	PM	PM	PM	PM	PM
Q16	**QAPI program basic elements: detect utilization**	PM	M	M	PM	PM	PM
Q17	**QAPI program basic elements: assess quality of care**	M	M	M	PM	PM	M
Q18	**Program review: evaluate QAPI program**	M	M	M	M	M	M
Q19	**Health information systems**	M	M	M	M	M	M

Analysis

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 19 standards.

Access to Services and Provider Network

Eight 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; and cultural competency in service provision.

MCOs must maintain and monitor 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; these requirements are evaluated under standard Q1. Three of six MCOs met this requirement. Of the three that were partially met, one MCO lacked a fully implemented policy and procedure related to the maintenance and monitoring of a provider network, while two did not provide sufficient evidence of monitoring the provider network for adequacy and gaps in service.

Standard Q2 indicates that MCOs must provide for a second opinion from a qualified health care professional within the network, or arrange for members to obtain one outside the network, at no

cost to members. Additionally, if the MCO's provider network is unable to provide necessary services, covered under the contract, the MCO must adequately and timely cover these services out of network for the member as long as the MCO is unable to provide them. Five of six MCOs met these requirements. One MCO partially met this requirement due to a lack of a fully implemented policy and procedure related to this standard.

Two additional standards relate to the availability of services, with results as follows:

- Four of six MCOs met Q3, which ensures that members have timely access to care and services. Two MCOs partially met this standard due to insufficient monitoring.
- Standard Q4 requires MCOs to participate in the state's efforts to promote the delivery of services in a culturally competent manner to all members; all MCOs met this requirement.

Standard Q9 requires MCOs to have written policies and procedures for the selection and retention of providers, and follow a documented process for credentialing and re-credentialing of providers who have signed contracts or participation agreements. Additionally, MCOs are required to monitor providers for ongoing compliance with requirements. All MCOs were partially met in FY 17-18. Three organizations did not demonstrate sufficient monitoring to ensure existing providers were compliant with state and federal requirements. One MCO did not have written policies or procedures related to re-credentialing, in addition to sufficient monitoring. Another MCO had inconsistencies with internal monitoring. The final organization had sufficient monitoring; however, the MCO did not have written policies and procedures at the time of the review.

MCOs may not employ or contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act; Q10 evaluates these requirements. Three of six MCOs partially met this standard. One MCO's internal monitoring process was recently updated to ensure a crosscheck between individual names and organization names; however, the process was not fully implemented at the time of the review and the prior process was not sufficient to meet the standard. One organization did not have a documented process for ensuring compliance at the time of the review. Evaluation of another MCO's practice identified that not all required provider types were included in the organization's internal monitoring.

Standard Q11 requires that MCOs comply with any additional requirements established by the state, and all applicable federal and state laws and regulations, including ensuring providers and subcontractors perform background checks on caregivers in compliance with Wisconsin Administrative Code Chapter DHS 12. One MCO met this requirement; five were partially met. One organization's monitoring was insufficient, because of inconsistencies identified in their internal monitoring. Another organization lacked a documented process for monitoring, and monitoring of licensed providers was insufficient for a different MCO. One MCO's process did

not include all required provider types and was not fully implemented at the time of the review. The remaining MCO had a process and monitoring system; however, the process for reviewing caregiver background checks with serious convictions was not evidenced.

MCOs must oversee and be accountable for any functions and responsibilities that it delegates to subcontractors (Q13). Three of six MCOs partially met this standard. One's process was not fully implemented at the time of the review, and two other MCOs' monitoring was insufficient to ensure 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.

MCOs are required to have procedures in place to coordinate services, or a person/entity designated as being responsible for coordinating services furnished to the member, which includes the services a member receives from any other provider. These requirements are evaluated under Q5. All MCOs partially met this standard, primarily due to a lack of documented follow up by the care teams to ensure covered and non-covered services are received and effective. All MCOs focused training and monitoring efforts on follow-up to member services; however, care management review results and MCO internal monitoring results demonstrated a need for continued improvement. One MCO partially met this standard due to interdisciplinary team (IDT) staff not consistently involved in the coordination of long-term care services.

Standard Q6 requires MCOs to ensure coordination and continuity of care through identification, assessment, and member-centered planning. 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. The member-centered plan (MCP) 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; and completed and approved in a timely manner in accordance to DHS standards. One MCO met this standard, while the other five MCOs were partially met. All MCOs took action to implement a new DHS-MCO contract requirement of assessing vulnerable high risk members (VHRM) through training and the development of new tools; however, two MCOs did not fully implement the contract requirements. All MCOs focused efforts on improving the comprehensiveness of MCPs through training and internal monitoring. Care management review results and MCO internal monitoring results for five MCOs indicated a need for continued improvement efforts.

Standard Q7 requires MCOs to have written policies and procedures to process requests for initial and continued authorizations of services. Five of six MCOs met this requirement. The MCO that partially met this requirement was due to IDT staff not consistently involved in

service authorization decisions. Additionally, decisions have to be made within specified timeframes and as expeditiously as the member's health condition requires, as required under standard Q8. Five of six MCOs met this requirement and one was partially met due to care management review results and internal monitoring results showing a need for continued improvement efforts.

Five of six organizations met the requirements of standard Q12, to ensure that use and disclosure of medical record information, as well as any other individually identifiable information, meets privacy and confidentiality requirements. The sixth organization had not fully implemented its relevant policies and procedures at the time of the review.

MCOs are required to adopt, disseminate, and apply practice guidelines. Two of six organizations fully met requirements for the standard, Q14. Four MCOs partially met the standard, at least in part due to lack of effective practices for disseminating the guidelines to affected providers. Additional reasons for lack of compliance include the following:

- Two organizations did not have written guidance that clearly addressed all aspects of the standard, and did not ensure the guidelines were reviewed and updated periodically as appropriate.
- One organization did not have fully implemented, consistent policies and procedures.

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.

The QAPI program must meet minimum requirements outlined in the DHS-MCO contract related to its administrative structures, stakeholder participation, quality work plan, and monitoring activities. The documentation received and onsite discussions with MCO staff indicate all organizations have active QAPI programs focused on monitoring and continuously improving quality, timeliness, and access to the health care and long-term care services provided to members. However, none of the six organizations fully met this standard, Q15. The review identified the following themes and reasons for lack of compliance:

- Five of six organizations had clear administrative structures that facilitate communication and coordination of quality improvement efforts; one organization did not have a fully implemented structure in place at the time of the review.
- Five of six MCOs did not have adequate mechanisms in place for members and/or providers to actively participate in the QAPI program.
- No organization was able to demonstrate that all required monitoring activities were conducted and produced data for quality improvement when indicated.
    - Four of the organizations did not provide evidence of provider quality activities such as monitoring access and conducting provider surveys.

    - Three organizations did not show effective monitoring of the accuracy of functional screens.
- MetaStar noted five of six organizations successfully implemented processes to monitor results of care management practice related to the support provided to vulnerable high-risk members, which was a new contract requirement in 2017.

MCOs must have mechanisms in effect to detect underutilization and overutilization of services. Two of six organizations fully met this standard, Q16, demonstrating dedicated committees and monitoring methods. The documentation submitted by the other four MCOs indicated efforts were focused primarily on cost reduction or cost containment, rather than use of mechanisms designed to detect issues with utilization of services. Another observation was that the approaches to detecting potential underutilization were limited in these organizations.

QAPI programs are also required to have methods in place to assess the quality and appropriateness of care furnished to members; this is evaluated under standard Q17. The documentation submitted and discussions with MCO staff revealed that all organizations have a primary internal file review method in place, as well as other processes, such as focused audits, peer review audits, and electronic reporting systems. Four organizations met this standard; however, all four also received recommendations to improve procedures for reporting and analysis of data. Of the two organizations that partially met requirements, one organization employed small sample sizes limiting confidence in the data and the other MCO did not effectively report the data for use in quality improvement; both organizations had limited written guidance for staff conducting the audits.

All six organizations met the final two standards related to QAPI programs.

- The standard, Q18, addresses the requirement to have a process in effect to evaluate the impact and effectiveness of an MCO's QAPI program to determine whether the program has achieved improvement in the quality of services provided to members. Each organization's summary document included relevant data, information and analysis, and focused on improvements to member care and care management, among other organizational priorities.
- MCOs must also maintain health information systems that allow for the collection, analysis, integration, and reporting of data. This standard, Q19, is evaluated at a high level for this review. Additional review is conducted and reported separately, through an Information System Capabilities Assessment (ISCA), once in the three year review cycle.

CONCLUSIONS

The progress, strengths, and opportunities noted below are based on the findings, as indicated in bar graph Q.1 and table Q.2, above:

Progress

- One organization effectively addressed recommendations from FY 16-17 to focus efforts on and improve comprehensiveness of member centered plans.

Strengths

- All six organizations met requirements addressing:
  - Cultural considerations in the delivery of services (Q4);
  - Evaluation of the MCO's QAPI program (Q18); and
  - Health information systems (Q19).
- Five of six organizations fully met requirements related to:
  - Second opinion and out-of-network providers (Q2);
  - Coverage and authorization of services (Q7, Q8); and
  - Confidentiality (Q12).

Opportunities for Improvement

- Based on the findings, areas of opportunity for improvement where half or more of MCOs did not fully meet requirements include the need to:
  - Monitor provider networks for adequacy and gaps in service (Q1);
  - Document a process for retention and re-credentialing of providers and ensure monitoring of the process is sufficient for compliance (Q9);
  - Ensure monitoring practices are implemented and sufficient for compliance with all state and federal requirements (Q10, 11);
  - Monitor providers for delegated responsibilities and performance (Q13);
  - Focus efforts to improve follow-up with members to ensure services have been received and are effective (Q5);
  - Improve the comprehensiveness of MCPs by ensuring all assessed needs are identified on the plan (Q6);
  - Implement effective practices for dissemination of practice guidelines to providers, review and update the guidelines periodically as appropriate, as well as meet all other requirements related to the adoption and application of practice guidelines;
  - Ensure QAPI programs include opportunities for member and provider participation, and conduct all required monitoring activities which are designed to produce data for quality improvement (Q15);

- Implement utilization management processes that focus on monitoring and analysis to detect both overutilization and underutilization of services (Q16).

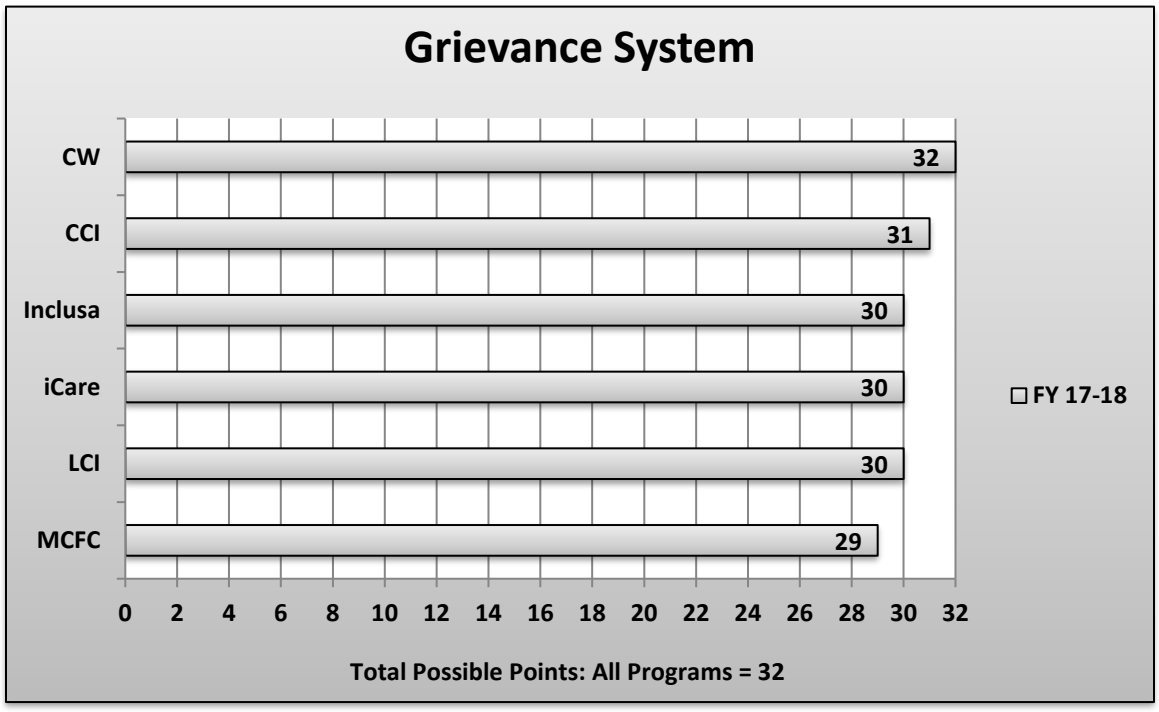
- Address recommendations to improve data collection, analysis, and reporting for methods of assessing the quality and appropriateness of care (Q17).

RESULTS FOR GRIEVANCE SYSTEMS

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

Bar graph G.1 below indicates each MCO's level of compliance with the Grievance Systems standards.

Bar Graph G.1



The following table, G.2, lists the comparative findings by each standard. The first column indicates the number assigned to the review standard. The second column indicates the standard description. The following columns depict each MCO with its rating for this fiscal cycle, scored as Met (M), Partially Met (PM), Not Met (NM), or Not Applicable (N/A).

Table G.2

MCO Comparative Findings by Standard							
		CW	CCI	Inclusa	*i*Care	LCI	MCFC
#	Standard	FY 17-18	FY 17-18	FY 17-18	FY 17-18	FY 17-18	FY 17-18
Grievance System							
G1	General requirements	M	M	M	M	M	M
G2	Authority to file	M	M	M	M	M	M
G3	Procedures	M	M	M	M	M	M
G4	Notice of action (NOA): language, format, and content	M	M	M	M	PM	M
G5	NOA: timing of notice	M	PM	PM	PM	PM	PM
G6	Handling of grievances and appeals: general requirements	M	M	M	M	M	M
G7	Handling of grievances and appeals: local committee	M	M	M	M	M	PM
G8	Special requirements for appeals	M	M	M	M	M	M
G9	Resolution timeframes	M	M	M	PM	M	M
G10	Format and content of notice of resolution	M	M	M	M	M	M
G11	Expedited resolution of appeals	M	M	M	M	M	M
G12	Information to providers	M	M	PM	M	M	M
G13	Record keeping and reporting	M	M	M	M	M	PM
G14	Continuation of benefits	M	M	M	M	M	M
G15	Enrollee responsibility for services furnished	M	M	M	M	M	M
G16	Effectuation of reversed appeal resolutions	M	M	M	M	M	M

ANALYSIS

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, one fully met the requirements for all of the standards in this focus area. The findings for the other organizations indicate a range of one to three standards remaining partially met. Ten of the sixteen Grievance System standards were fully met by all organizations. These findings indicate this area of review is an overall strength across the MCOs.

All six MCOs demonstrated compliance with general requirements, such as having grievance and appeal processes in place; acknowledging members', legal decision makers' and providers' authority to file; and following filing and written acknowledgement timeframes. These requirements are addressed in standards G1, G2, and G3. Compliance was demonstrated by

submitted documents, discussions with MCO staff, as well as through verification of a sample of local appeal and grievance cases.

Notices to members must meet several requirements in standards G4 and G5.

- Notices must be in writing and meet language and format requirements to ensure ease of understanding for members. Organizations must also use DHS-issued templates for the notices. Five of six MCOs fully met this standard, G4. One organization's Notice of Non-Covered Benefit letter template did not align with the DHS template.
- The notices must be delivered to the member in the timeframes associated with each type of adverse decision. Additional requirements must be met if the MCO extends the timeframe for the decision making process. One organization fully met this standard, G5, while five MCOs received scores of partially met. Each of the five organizations had CMR scores indicating the need for improvement. MetaStar's review of the MCOs' monitoring data and improvement efforts demonstrated the monitoring and/or improvement efforts were not sufficient to ensure effectiveness of processes for issuing notices timely when indicated.

Three standards, G6, G7, and G8, address requirements related to the handling of grievances and appeals. Compliance with most of these standards was evidenced by the documents submitted, discussions with MCO staff, and the verification activity.

- MCOs must give members any reasonable assistance with procedural steps in the grievance and appeal process, allow members to involve anyone they choose, as well as attempt to resolve issues and concerns without formal hearings (G6). All six organizations met this standard, with most MCOs demonstrating strong systems for resolving grievances and appeals.
- Organizations must have processes in place regarding the individuals making decisions on grievances and appeals, and ensure privacy and confidentiality are respected. Five of six organizations fully met this standard, G7. One aspect of the standard requires the local committee to include a member representative; the MCO that did not fully meet this standard did not ensure a member representative was available to attend all local hearings.
- MCOs have special requirements for appeals, which include written confirmation of oral appeals, opportunities for members to present evidence and examine their records (G8). All six organizations met this requirement.

Requirements related to resolution and notification procedures are addressed in standards G9 and G10.

- MCOs are required to have a system in place to dispose of grievances and appeals as expeditiously as a member's situation and health condition requires, within established standard and expedited timeframes (G9). Five of six MCOs fully met this requirement.

For one organization, the grievance and appeal verification activity identified several records that did not meet the standard or extended resolution timeframes for issuing a written decision.

- The format and content of written notices of the disposition of appeals and grievances must meet several requirements. All six MCOs met these requirements, as demonstrated in documents submitted and the verification activity.

MCOs must establish and maintain an expected review process for appeals, when the MCO determines or the provider indicates that taking the time for a standard resolution could jeopardize the member's life, health, or functional ability. All six MCOs met the related standard, G11.

Standard G12 requires organizations to provide information about the member grievance system to all providers at the time they enter into a contract with the MCO. Five of six organizations met this requirement, while one organization did not meet this requirement in practice. The information was not present on the MCO's website or in a provider handbook, as stated in the subcontract.

MCOs are required to maintain records of grievances and appeals and review the information as part of the Quality Management Program. Five of six MCOs met this requirement, G13. One organization produced grievance and appeal quarterly reports, but did not demonstrate that the data was reviewed or analyzed as part of the Quality Management Program.

Requirements related to continuation of benefits are evaluated under standards G14 and G15.

- MCOs must continue members' benefits while an appeal is pending in certain circumstances, and continue or reinstate benefits as outlined in standard G14. All MCOs demonstrated that policies and practices align with this requirement.
- In addition, members may be held responsible to pay back the cost of these services if the appeal decision is not in the member's favor. The documents submitted and onsite discussions with MCO staff revealed that none of the six MCOs were attempting to recover costs from members in these circumstances. All organizations met this standard; however, four of the organizations received recommendations to include a clear statement of this practice in related policies and procedures and/or to ensure staff are educated on the practice. One organization showed progress from the FY 16-17 review, by fully implementing an updated policy which clarified the MCO no longer recovered costs.

Standard G15 addresses effectuation of reversed appeal resolutions. If the MCO or State Fair Hearing office reverses a decision about services not furnished during the appeal, the MCO must authorize and provide the services as expeditiously as the member's conditions requires. In addition, if the member received the services while the appeal was pending and is ruled in favor of the member, the MCO must pay for those services. All six organizations met this requirement.

CONCLUSIONS

The progress, strengths, and opportunities noted below are based on the findings, as indicated in bar graph G.1 and table G.2, above:

Progress

- One organization fully implemented the policy change of not sending invoices to members in an attempt to recover the cost of services provided while an appeal was pending, and therefore achieved compliance with standard G15.

Strengths

- All six organizations met requirements addressing:
    - General requirements for the grievance and appeal system (G1, G2, G3);
    - Handling of grievances and appeals general requirements (G6);
    - Special requirements for appeals (G8);
    - Format and content of notice of resolution (G10);
    - Expedited resolution of appeals (G11);
    - Continuation of benefits (G14);
    - Enrollee responsibility for services furnished (G15); and
    - Effectuation of reversed appeals (G16).
- Five of six organizations fully met requirements related to:
    - Notice of action format and content (G4);
    - Local committee handling of grievances and appeals (G7);
    - Resolution timeframes (G9);
    - Information to providers (G12); and
    - Record keeping and reporting (G13).

Opportunities for Improvement

- Based on the findings, areas of opportunity for improvement where half or more of MCOs did not fully meet requirements include the need to:
    - Focus efforts on monitoring and improving the results of issuing notices in a timely manner when indicated (G5).

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 17-18, 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 2017, organizations submitted proposals to DHS in January 2017. DHS directed MCOs to submit final reports by December 30, 2017. MetaStar validated one or more PIPs for each organization, for a total of eight 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 17-18 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.	8/8

FY 17-18 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.	8/8
Study Indicator(s)		
3	The study used objective, clearly and unambiguously defined, measureable indicators and included defined numerators and denominators.	6/8
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.	7/8
Study Population		
5	The project/study clearly defined the relevant population (all members to whom the study question and indicators apply).	4/8
6	If the entire population was used, data collection approach captured all members to whom the study question applied.	5/7
Sampling Methods		
7	Valid sampling techniques were used.	1/1
8	The sample contained a sufficient number of members.	1/1
Data Collection Procedures		
9	The project/study clearly defined the data to be collected and the source of that data.	5/8
10	Staff are qualified and trained to collect data.	8/8
11	The instruments for data collection provided for consistent, accurate data collection over the time periods studied.	4/8
12	The study design prospectively specified a data analysis plan.	7/8
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.	7/8
14	A continuous cycle of improvement was utilized to measure and analyze performance, and to develop and implement system-wide improvements.	5/8
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.	7/8
17	Numerical results and findings were presented accurately and clearly.	6/8
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.	5/8
"Real" Improvement		
19	The same methodology as the baseline measurement was used, when measurement was repeated.	6/8
20	There was a documented, quantitative improvement in processes or outcomes of care.	5/8
21	The reported improvement appeared to be the result of the planned quality improvement intervention.	5/5

FY 17-18 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.	0/0

PROJECT INTERVENTIONS AND OUTCOMES

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

Aim	Interventions	Outcomes	Validation Result	EQR Recommendations
MCO – Care Wisconsin				
Increase the number of members utilizing the self-directed supports (SDS) option.	Educated care team staff to increase understanding related to conversations with members about SDS and shared member-specific results. Identified staff in each county who served as content experts for SDS related questions. Developed a toolkit for staff to utilize when having SDS discussions with members. Developed a "Member Guide to SDS."	Project demonstrated "real" improvement; the usage of SDS increased from 17.81 percent in 2016 to 19.7 percent in 2017. The percent of members who indicated their care management team discussed SDS increased from 69.9 percent in 2016 to 71.3 percent in 2017.	Met	Obtain repeat measures to demonstrate sustainability.
Improve hemoglobin (HbA1c) index control for FCP members with diabetes, increase the percentage of members with diabetes who have an annual eye exam, and increase the percentage of	Developed a tip sheet that outlined expectations around using Motivational Interview techniques to help people obtain better diabetes management. Provided Care Teams with monthly data reports of new diabetic screening results.	Project did not demonstrate improvement.	Not Met	Define measurable indicators and ensure inclusion of members in the project adheres to the defined study population. Conduct additional continuous cycles of improvement if interventions are not effective.

Aim	Interventions	Outcomes	Validation Result	EQR Recommendations
members with diabetes who are on a statin medication.				Address cultural or linguistic appropriateness of interventions. Take study limitations into consideration in analysis. Ensure initial and repeat measures are comparable. Include data to demonstrate effectiveness of the intervention. Obtain repeat measures to demonstrate sustainability.
MCO – Community Care, Inc.				
Increase the completion rate of dementia screenings through a virtual dementia training program for staff.	Implemented a virtual training simulation and education process to care management staff in the test regions. Conducted a pre- and post-training survey to validate the desired impact of the project.	Project demonstrated "real" improvement: increased the rate of dementia screening in the test region from 26.04% in 2016 to 44.97% in 2017.	Met	Ensure all data sources and procedures are defined. Clearly describe the data collection instruments and process.
Reduce the use of antipsychotic medications for those with dementia, assess and potentially develop additional behavioral support plans, and provide education and resources to caregivers and providers on non-pharmacological approaches to behavioral or psychological symptoms of dementia.	Conducted medication reviews by pharmacists to focus on the reduction of use of antipsychotic medications. Developed behavioral support plans to address behavioral and psychological symptoms of dementia. Offered online training and educational resources to providers.	The project did not demonstrate quantitative improvement.	Not Met	Ensure indicators are defined to measure change in the desired outcome. Ensure inclusion of members in the project adheres to the defined study population. Clearly describe the data collection process and ensure it captures all members of the study population. Define data sources for all measures.

Aim	Interventions	Outcomes	Validation Result	EQR Recommendations
				Specify the data analysis plan. Describe how interventions were selected. Conduct and document continuous cycles of improvement in the report. Utilize data to calculate the results of the study questions. Ensure initial and repeat measures are comparable.
MCO – Inclusa, Inc.				
Increase the number of members with dementia who have a member-specific dementia care plan of action on their residential provider's care plan, and decrease the number of incidents of those members with dementia in the study population who have at least one identified behavioral symptom.	Implemented a Dementia Care Toolkit for residential providers to develop member-specific dementia care plans of action.	Project demonstrated "real" improvement: • Developed plans of action for 63% of members; and • Reduced incidents including behavioral symptoms during the 2017 study period by 53%, compared to 2016.	Met	Clearly define the method of selecting the study population.
MCO – Independent Care Health Plan				
Decrease the Caregiver Strain Index score for individuals supporting members with dementia.	Implemented care management strategies according to the *Dementia Care Management Interdepartmental Procedure* for all members with a diagnosis of dementia.	Project did not demonstrate improvement.	Not Met	Fully define the indicator. Clearly define the study population. Ensure the data collection approach captures all members of the population, and

Aim	Interventions	Outcomes	Validation Result	EQR Recommendations
	Assessed for caregiver stress quarterly.			results in accurate data. Clearly present numerical results. Analyze data in accordance with the identified indicator, and ensure conclusions are based on data from the entire study population.
MCO – Lakeland Care, Inc.				
Improve member satisfaction in how carefully the interdisciplinary team listens to the member when reviewing their member-centered plan.	Educated care management staff on effective communication and listening skills. Shared progress with care management staff on the return rate of member surveys and results.	Project demonstrated "real" improvement: increased the rate of member satisfaction of care through effective listening from 76.6% in 2016 to 81.1% in 2017 for Winnebago County, and from 77.2% in 2016 to 83.3% in 2017 for Manitowoc County.	Met	Sustain the level of improvement that has been achieved.
MCO – My Choice Family Care				
Increase the number of members utilizing the SDS option and mitigate risk for members identified by the MCO as vulnerable/high risk.	Continued a SDS workgroup to promote the SDS option and improve available resources. Created a Member Advisory Committee/ Member Forum to obtain member input on the SDS tools created by the SDS workgroup. Created additional processes and tools for caregiver screening prior to SDS authorization. Created tools and system changes to	Project demonstrated "real" improvement: • Increased the rate of members self-directing supports from 14.76% in 2016 to 16.79% in 2017. • Increased SDS transportation authorizations from 0.46% in 2016 to 0.77% in 2017. • 100% of new SDS caregivers completed an intensive caregiver risk	Met	Consider population size when selecting the study topic. Define data sources for all measures. Clearly describe the data collection process. Obtain repeat measures to demonstrate sustainability.

Aim	Interventions	Outcomes	Validation Result	EQR Recommendations
	ease the workload on interdisciplinary teams during the SDS authorization process.	screening process and received increased monitoring based on screening results.		

ANALYSIS

All MCOs obtained approvals to conduct the required number of PIPs during calendar year 2017. Projects focused on a variety of topics, with four projects continuing from the prior year, and four 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 four of the eight projects focused on this topic. Three of the four dementia projects achieved documented, quantitative improvement which appeared to be the result of the interventions employed. However, none of these projects fully met all applicable validation standards. In addition, for the MCO's with continuing PIPs, one of the four projects achieved documented, quantitative improvement, and the reported improvement appeared to be the result of the planned quality improvement intervention.

CONCLUSIONS

Based on findings, MetaStar identified the following strengths and opportunities for improvement:

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.
- All eight projects were developed with clearly stated study questions.
- Most standards related to data collection procedures were met.
- Five of eight projects effectively utilized continuous cycles of improvement.
- Two projects from two organizations met all validation standards and achieved improvement attributable to the implemented interventions.

Opportunities for Improvement

- 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, along with the method of selecting the study population.
- Ensure all data figures and numerical results are presented clearly and accurately throughout the final report.
- Consider the population size when selecting the study topics or indicators.
- Specify a data analysis plan and fully analyze study data.
- Analyze data in accordance with the identified indicator, and ensure conclusions are based on consideration of data from the entire study population.
- Conduct continuous cycles of improvement to evaluate the effectiveness of the interventions and make changes if improvement is not demonstrated.
- Address cultural or linguistic appropriateness of interventions.
- Ensure all data sources, procedures, and data collection instruments are clearly defined.
- Take study limitations into consideration in analysis to determine possible reasons for less than optimal performance.
- 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 of improvement that has been achieved.

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) 2017, which are set forth in Addendum IV. of the 2017 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 2017. The MY is defined in the technical definitions provided by DHS for the influenza and pneumococcal vaccination quality indicators. DHS updated the technical definitions in October 2017. The technical specifications can be found in Attachments 1 and 2. The review methodology MetaStar used to validate these performance measures can be found in Appendix 3.

Vaccination Rates by Program and MCO

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

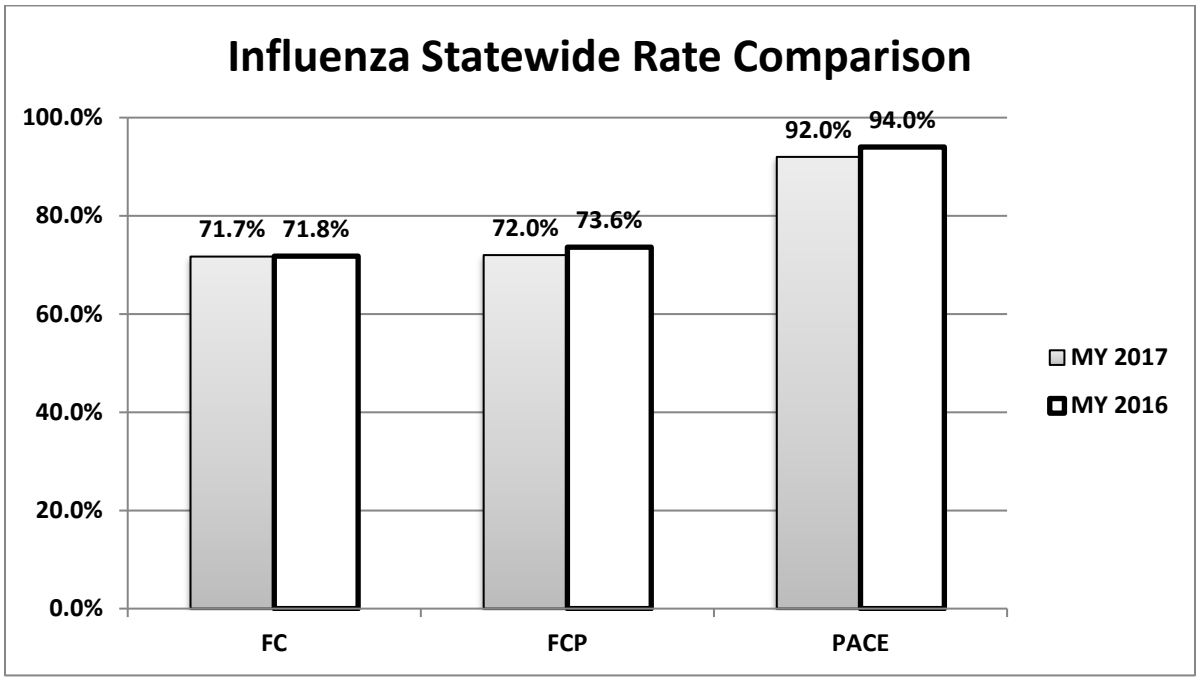
Influenza Vaccination Rates

The following table shows information about the influenza vaccination rates, by program, for MY 2017 and compares the 2017 rates to vaccination rates in MY 2016, which:

- Decreased 0.1 percentage points for FC members;
- Decreased 1.6 percentage points for FCP members; and
- Decreased 2.0 percentage points for PACE members.

Statewide Influenza Vaccination Rates by Program				
	MY 2017			MY 2016
Program	Eligible Members	Number Vaccinated	Vaccination Rate	Vaccination Rate
Family Care	39,867	28,575	71.7%	71.8%
Family Care Partnership	2,571	1,852	72.0%	73.6%
PACE	499	459	92.0%	94.0%

Influenza vaccination statewide rates, by program, for MY 2017 and MY 2016 are shown in the following graph.



As shown in the table below, among MCOs that operate FC, the MY 2017 influenza vaccination rates ranged from 76.1 percent to 69.9 percent. Among MCOs that operate FCP, the 2017 rates ranged from 84.1 percent to 65.5 percent. The 2017 rate for the one MCO that operates the PACE program was 92.0 percent.

Influenza Vaccination Rates by Program and MCO in MY 2017 and MY 2016			
Program/MCO	**MY 2017 Rate**	**MY 2016 Rate**	**Percentage Point Change**
Family Care			
CCI	70.2%	72.3%	(2.1%)
CW	74.0%	73.1%	0.9%
Inclusa	71.3%	71.3%	None
LCI	76.1%	77.3%	(1.2%)
MCFC	69.9%	68.3%	1.6%
Family Care Partnership			
CCI	84.1%	82.5%	1.6%
CW	71.0%	76.1%	(5.1%)
*i*Care	65.5%	61.8%	3.7%
PACE			
CCI	92.0%	94.0%	(2.0%)

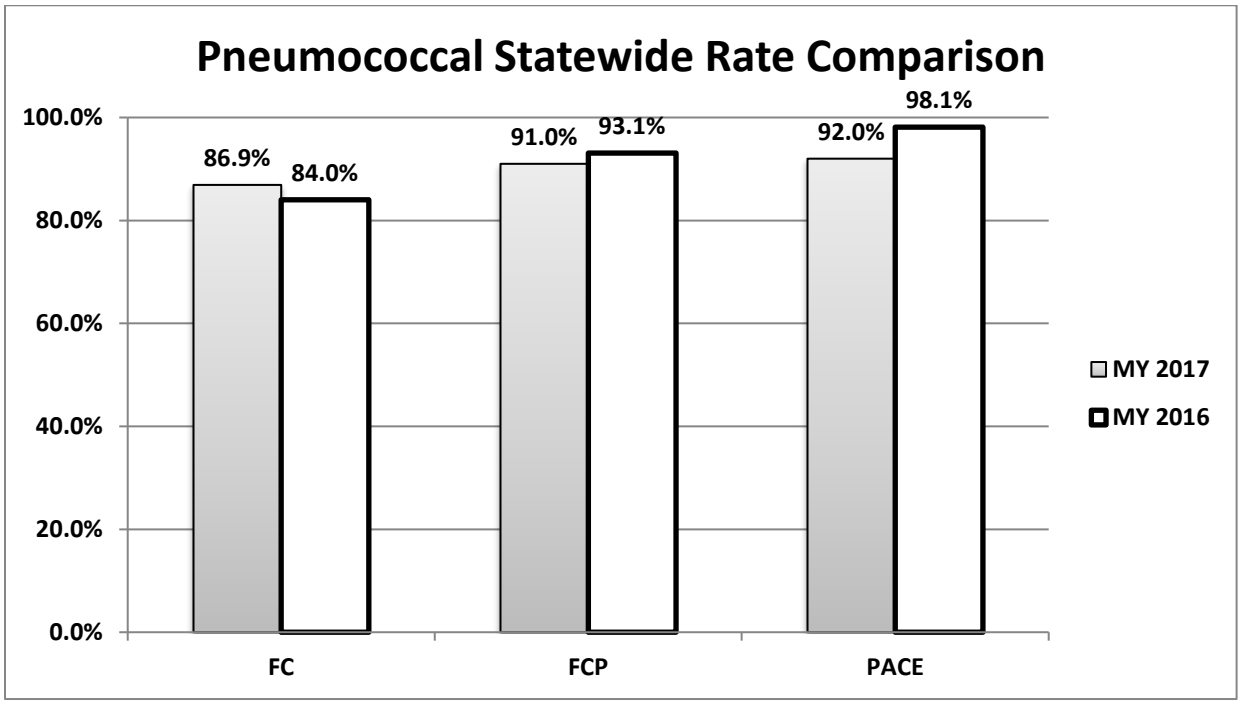
Pneumococcal Vaccination Rates

The table below shows information about the pneumococcal vaccination rates, by program, for MY 2017 and compares the 2017 rates to vaccination rates in MY 2016, which:

- Increased 2.9 percentage points for FC members;
- Decreased 2.1 percentage points for FCP members; and
- Decreased 6.1 percentage points for PACE members.

Statewide Pneumococcal Vaccination Rates by Program				
	MY 2017			MY 2016
Program	Eligible Members	Number Vaccinated	Vaccination Rate	Vaccination Rate
Family Care	18,006	15,646	86.9%	84.0%
Family Care Partnership	1,216	1,107	91.0%	93.1%
PACE	464	427	92.0%	98.1%

Pneumococcal vaccination statewide rates, by program, for MY 2017 and MY 2016 are shown in the following graph.



As shown in the table below, among MCOs that operate FC, the MY 2017 pneumococcal vaccination rates ranged from 90.0 percent to 83.5 percent. Among MCOs that operate FCP, the 2017 rates ranged from 95.2 percent to 82.8 percent. The 2017 rate for the one MCO that operates PACE was 92.0 percent.

Pneumococcal Vaccination Rates by Program and MCO in MY 2017 and MY 2016			
Program/MCO	**MY 2017 Rate**	**MY 2016 Rate**	**Percentage Point Change**
Family Care			
CCI	87.0%	87.7%	(0.7%)
CW	88.7%	87.5%	1.2%
Inclusa	83.5%	83.7%	(0.2%)
LCI	87.8%	88.6%	(0.8%)
MCFC	90.0%	78.8%	11.2%
Family Care Partnership			
CCI	82.8%	93.7%	(10.9%)
CW	95.2%	94.4%	0.8%
*i*Care	86.5%	88.9%	(2.4%)
PACE			
CCI	92.0%	98.1%	(6.1%)

Results of Performance Measures Validation

Technical Specification Compliance

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

- One MCO's initial data submission for the pneumococcal vaccination for the FC program included a copy and paste error where data was inputted two rows below the correct field. The MCO was required to resubmit the denominator file for this vaccination.
- Another MCOs' initial data submission for the influenza vaccination for the FC program included 102 members who were marked as "contraindicated" in the denominator file submission. The MCO was required to resubmit the denominator file twice to confirm whether members received the vaccination or had contraindications.

Comparison of MCO and DHS Denominators

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

For all MCOs and quality indicators, more than 98.6 percent of the total number of unique members included in the MCOs' and DHS' denominator files was common to both data sets.

However, it should be noted that two MCOs were required to resubmit data because their initial submissions were outside the five percentage point threshold established by DHS.

VACCINATION RECORD VALIDATION

To validate the MCOs' influenza and pneumococcal vaccination data, MetaStar requested 30 records of randomly selected members per quality indicator for each program the MCO operated during MY 2017. Whenever possible, the samples included 25 members reported to have received a vaccination and five members reported to have a contraindication to the vaccination. Three 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 270 member vaccination records for each quality indicator for MY 2017 and 330 member vaccination records for MY 2016. The overall findings for both years were not biased, meaning the rates can be accurately reported.

Vaccination Record Validation Aggregate Results

MY 2017 Influenza and Pneumococcal Vaccination Record Validation				
Quality Indicator	**Total Records Reviewed**	**Number Valid**	**Percentage Valid**	**T-Test Result**
Influenza Vaccinations	270	254	94.0%	Unbiased
Pneumococcal Vaccinations	270	262	97.0%	Unbiased

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

Vaccination Record Validation Individual MCO Results

The following tables provide information about the validation findings for each MCO in MY 2017. The findings were biased for the CW FCP influenza vaccination rate, meaning it cannot be accurately reported. Findings for both vaccinations for all other MCOs and programs were not biased, meaning they can be accurately reported.

Results for Influenza Vaccination

MY 2017 Influenza Vaccination Record Validation by Program and MCO				
MCO	**Total Records Reviewed**	**Number Valid**	**Percentage Valid**	**T-Test Result**
Family Care				
CCI	30	30	100%	Unbiased
CW	30	26	86.7%	Unbiased

MY 2017 Influenza Vaccination Record Validation by Program and MCO				
MCO	**Total Records Reviewed**	**Number Valid**	**Percentage Valid**	**T-Test Result**
Family Care				
Inclusa	30	26	86.7%	Unbiased
LCI	30	29	96.7%	Unbiased
MCFC	30	28	93.3%	Unbiased
Family Care Partnership				
CCI	30	30	100%	Unbiased
CW	30	25	83.3%	Biased
*i*Care	30	30	100%	Unbiased
PACE				
CCI	30	30	100%	Unbiased

Results for Pneumococcal Vaccination

MY 2017 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
CW	30	27	90.0%	Unbiased
Inclusa	30	29	96.7%	Unbiased
LCI	30	30	100%	Unbiased
MCFC	30	29	96.7%	Unbiased
Family Care Partnership				
CCI	30	30	100%	Unbiased
CW	30	30	100%	Unbiased
*i*Care	30	29	96.7%	Unbiased
PACE				
CCI	30	30	100%	Unbiased

Analysis

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. Influenza and pneumococcal vaccines prevent the unnecessary transmission of certain viral and bacterial infections to those at higher risk of complications from the diseases.

Consistent with the past several years, DHS provided MCOs with current technical specifications and data submission templates for each immunization. Each MCO submitted policies and procedures detailing guidance for staff related to assessing immunization status, offering the vaccines, providing education about preventative health services, and documenting vaccination

data into each respective electronic care management system. In 15 of 31 member records, MCO staff did not document the reason for the contraindication or noted a contraindication that did not align with the stated DHS technical specifications.

Clear expectations and standardized tools have improved the performance measure reporting and validation processes, with validation rates from MY 2016 to MY 2017 remaining stable for the influenza vaccine and declining slightly for the pneumococcal vaccine.

CONCLUSIONS

- MCOs should ensure that policies and procedures include all required information regarding contraindications as outlined in the DHS' technical specifications for the influenza vaccination.
- Ensure documentation practices for members contraindicated from receiving influenza and pneumococcal vaccinations meet DHS technical specifications.
- Two MCOs reported members assigned to the Physical Disability target group for the pneumococcal vaccination, which does not align with DHS technical specifications. The MCOs should conduct a root cause analysis and implement interventions to assure compliance with target group assignment.
- One MCO did not initially match the DHS denominator data for both immunizations and one MCO did not initially match for the pneumococcal measure. Those MCOs should conduct a root cause analysis to identify barriers to generating the required data.
- Two MCOs identified data submission issues related to human error with the use of Excel spreadsheets. Those MCOs should implement interventions to reduce the inaccurate submissions in the future.

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 17-18, MetaStar conducted ISCAs for two MCOs selected by DHS; one organization operates only a FC program, while the other operates the FC, FCP, and PACE programs.

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

Summary and Analysis 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 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 prior to submission to DHS. One organization processes all provider claims in-house with the exception of Medicare Part D pharmacy services, which are processed by its contracted vendor. The other organization utilizes a DHS approved third party administrator (TPA) to process claims and encounter data for state reporting; the MCO also submits member liability encounters (cost share and room and board payments) for all members along with care management time for one of its regional offices directly to DHS on a monthly basis. 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 met all but one of the requirements. The organization that met all requirements described the TPA's assignment of an internal control number (ICN) to each electronic claim prior to processing. The unique ICN allows tracking of claims for reporting workload, cycle time, and aging of claims. Paper claims are transferred to an Excel spreadsheet and submitted to the TPA's vendor for scanning and processing. This process ties authorizations to claims, preventing providers from submitting claims outside of the authorization limits. A dashboard report along with a pended claims report are received weekly and monitored daily. The TPA provides the MCO with provider specific performance reports on a monthly basis to identify those providers with the highest claim reject rates for potential provider outreach activities.

The other MCO had detailed processes and procedures to ensure claims accuracy; however, it was not utilizing a function available in its claims system to conduct a quantity validation of its claims and encounter data. Implementation of this function would result in the MCO fully meeting the requirements of this focus area.

Section IV: Eligibility and Enrollment Data Processing

Both MCOs demonstrated compliance with all requirements in this area. Sufficient interfaces existed for each organization with the respective county Aging and Disability Resource Centers, and the Client Assistance for Reemployment and Economic Support (CARES) and ForwardHealth interChange System websites, which result in prompt and verifiable enrollment and disenrollment processes. The organizations utilized information received 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 established a unique identification (ID) number for each member using the member's Medicaid ID number, and this ID number is linked to the DHS issued Master Client Index 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. The organization which did not fully meet requirements in this section noted it currently maintains two separate regional systems for tracking and maintaining provider contracting information. The MCO reported it planned conversion to one system for all provider information by July 1, 2018, which would address the inconsistencies between the two regional systems.

Section VI: System Security

Both MCOs demonstrated compliance with all requirements in this area. Disaster recovery systems were in place and tested routinely by each organization. One organization strengthened its security practices through the use of two-factor authentication on Windows-based servers. The other MCO transitioned all of its satellite care management and corporate hub offices to a key card/badge access system and removed the use of keys. This allowed for electronic monitoring of staff access to those areas.

Section VII: Vendor Oversight

One MCO met all requirements in this area, while the other met all but one of the requirements. The organization that met all requirements had a vendor agreement in place that supported the organization's information systems and internal claims processing infrastructure.

Staff at the other MCO noted it participated in frequent telephonic, electronic, and face-to-face communication with its contracted TPA to address and resolve issues. However, the organization did not have a formal vendor management process in place, and described plans to develop and implement this process in 2018.

Section VIII: Medical Record Data Collection

This section only applied to one MCO, which met all requirements for this focus area. The organization extracted internal encounters from medical records within its electronic care management documentation system for the FCP and PACE programs, and conducted volume checks as well as comparison of initial data pulls and final encounter data to ensure accuracy of the data.

Section IX: Business Intelligence

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

Section X: Performance Measure

Both MCOs demonstrated compliance with all requirements in this area. Each organization produced yearly performance reports for the required performance measures: influenza and pneumococcal vaccinations. Processes were in place at both organizations to extract, manipulate, and validate data prior to submission to DHS.

CONCLUSIONS

One organization fully met all requirements in all focus areas. 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

One MCO became a new organization effective January 1, 2017, as a result of merging three previous MCOs. Although each previous organization had recommendations from previous ISCA reviews, due to the merger and consolidation of systems and procedures, some recommendations were no longer relevant; therefore progress related to remediation of the previous recommendations can not be detailed.

The other organization demonstrated progress by addressing all of the recommendations identified during the review that occurred in FY 14-15. Process enhancements and further automation increased the accuracy of encounters submitted and decreased member enrollment discrepancies. System upgrades or installations are now subject to extensive testing (including regression testing) prior to full roll-out to ensure encounter data reporting is not adversely affected.

Strengths

The FY 17-18 ISCA reviews found the MCOs exhibited strengths in the following areas:

- One MCO receives greater than 95 percent of hospital, physician and facility claims electronically.
- The reconciliation process of reported member cost share deductions is in-depth, ensuring discovery of any discrepancies or errors.
- The processes and systems capabilities available within the MCO's provider information database are wide-ranging and available to multiple units within the organization.
- Reconciliation of provider data is performed and coordinated by staff in multiple units, allowing for thorough validation to prevent redundancies and ensure accuracy. Changes and updates to provider information are uploaded nightly to the external directory providing members with access to the most current provider information.
- One MCO utilizes a comprehensive and diverse list of tools and applications for financial information and analysis, including the ongoing ability to review and analyze the utilization of member services.
- The rate setting calculations and processes for in-house services provided at one MCO are sound and creative, combining productivity with cost-effectiveness. Monthly internal audits, utilization of external analytical resources, and the MCO's contract with a vendor

to certify Medicare bids allow the MCO to set rates, and trend costs, utilization, and risk adjustment for the Medicare population it serves through the PACE and FCP programs.

- One MCO's relationship with its contracted TPA is open and supportive:
    - The TPA possesses a wealth of knowledge related to the encounter data reporting requirements.
    - Monitoring and oversight ensures that the TPA meets contractual requirements for reporting and expectations established by the DHS master agreement.
    - The TPA sends the MCO provider specific performance reports on a monthly basis to identify providers with the highest reject rates for potential provider outreach activities.
- The finance and provider credentialing system was developed internally by the MCO which allows staff the ability to modify the system according to its reporting needs and priorities.

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:
    - Consider a more proactive and systematic process to track and trend errors, as it relies on manual processes to validate the accuracy of data.
    - Consider transitioning from a manual pended claims review process to a system-generated trigger for review of pended claims approaching 30 days.
    - Reprioritize the timing for developing and implementing an automated data transfer process from one system to another.
- The other MCO should:
    - Continue plans to consolidate the regional operating systems, databases, and associated policies and procedures across the merged organization.
    - Prioritize efforts to remediate any challenges related to timely or accurate performance measurement reporting.
    - Develop a formal vendor management process, including a standardized process related to vendor procurement and contracting.
    - Continue efforts to ensure the TPA provides confirmation of data uploads of provider files and to obtain direct access to the TPA system to review authorizations to reduce errors and claims rejections.

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

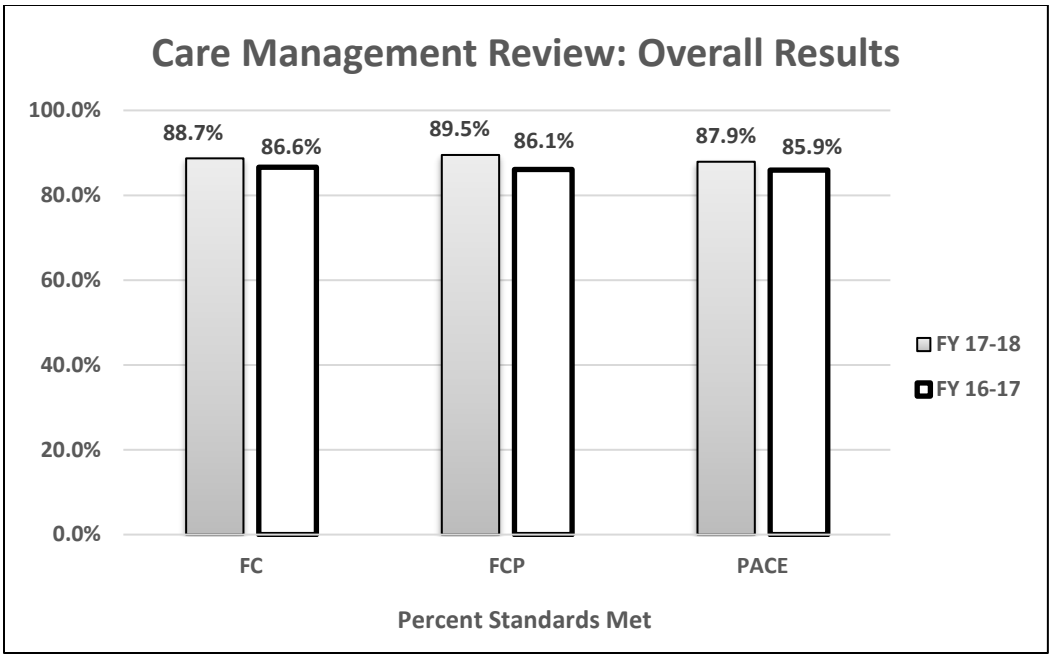
The four categories include a total of 14 review indicators. More information about the CMR review methodology can be found in Appendix 3.

Aggregate results for FY 17-18 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 that 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 17-18 review year for organizations operating programs for FC, FCP, and PACE. FY 16-17 results are provided for comparison.

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.



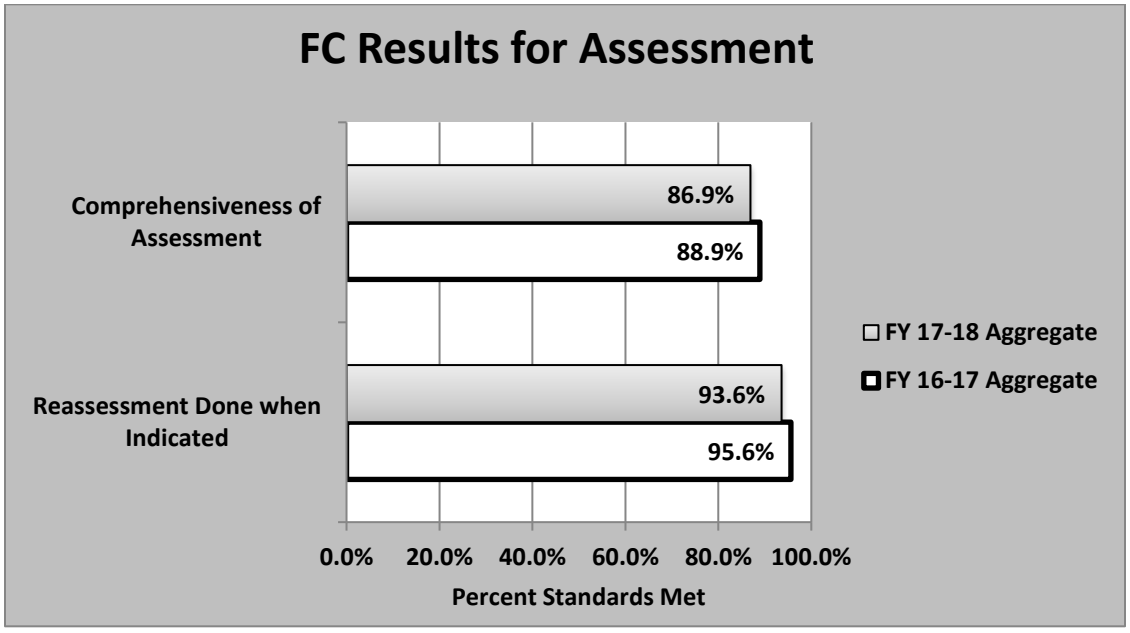
Results for each CMR Focus Area

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 17-18 CMR results by program (FC, FCP, and PACE) for each review indicator that comprises the category. FY 16-17 results are also provided for comparison.

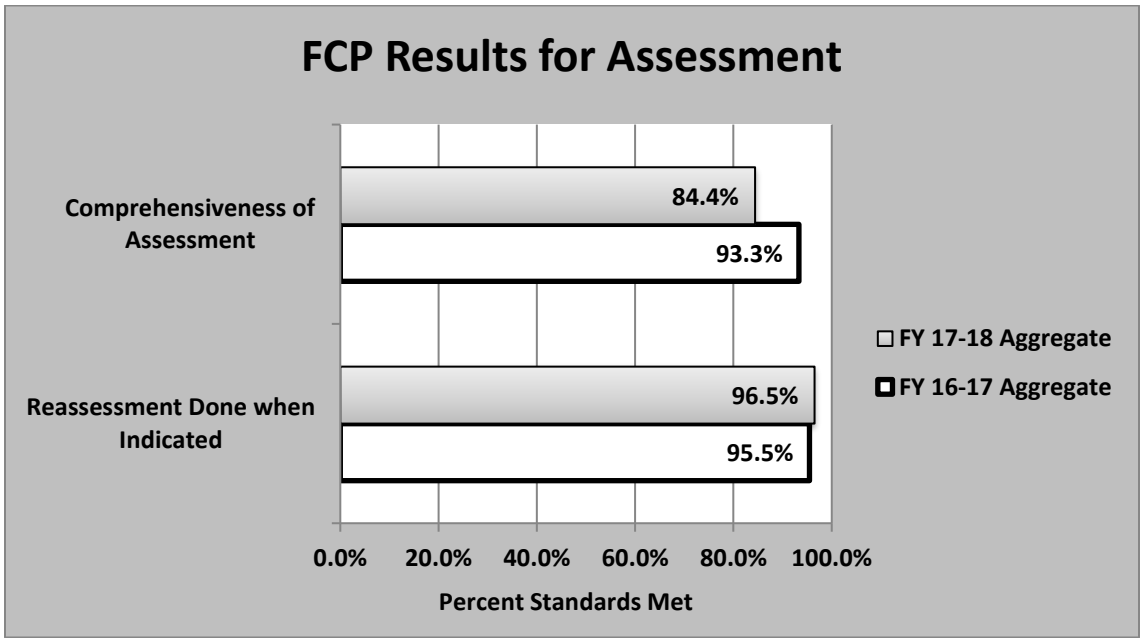
Assessment Focus Area

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

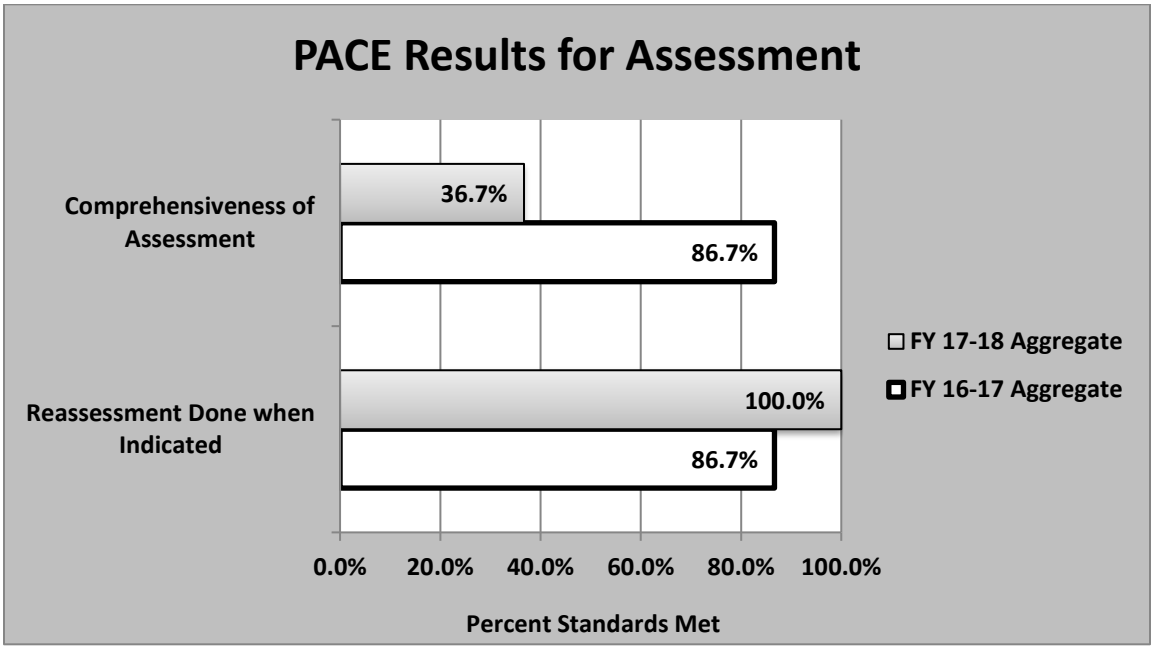
Results for Assessment for MCOs Operating FC:



Results for Assessment for MCOs Operating FCP:



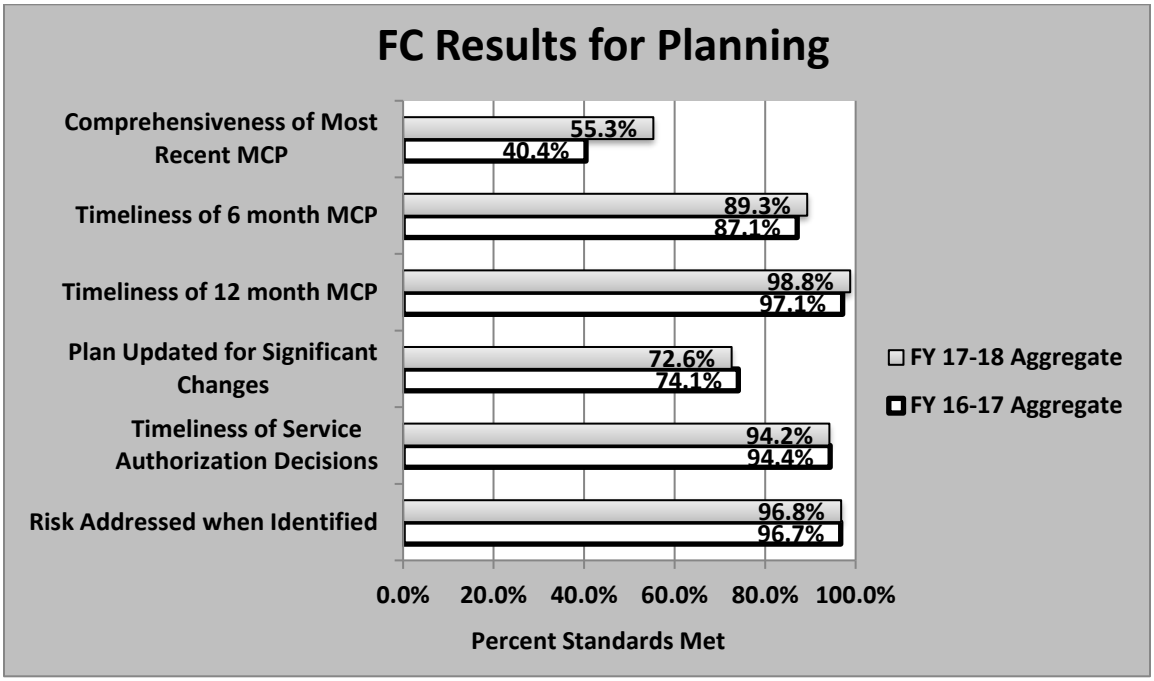
Results for Assessment for the MCO Operating PACE:



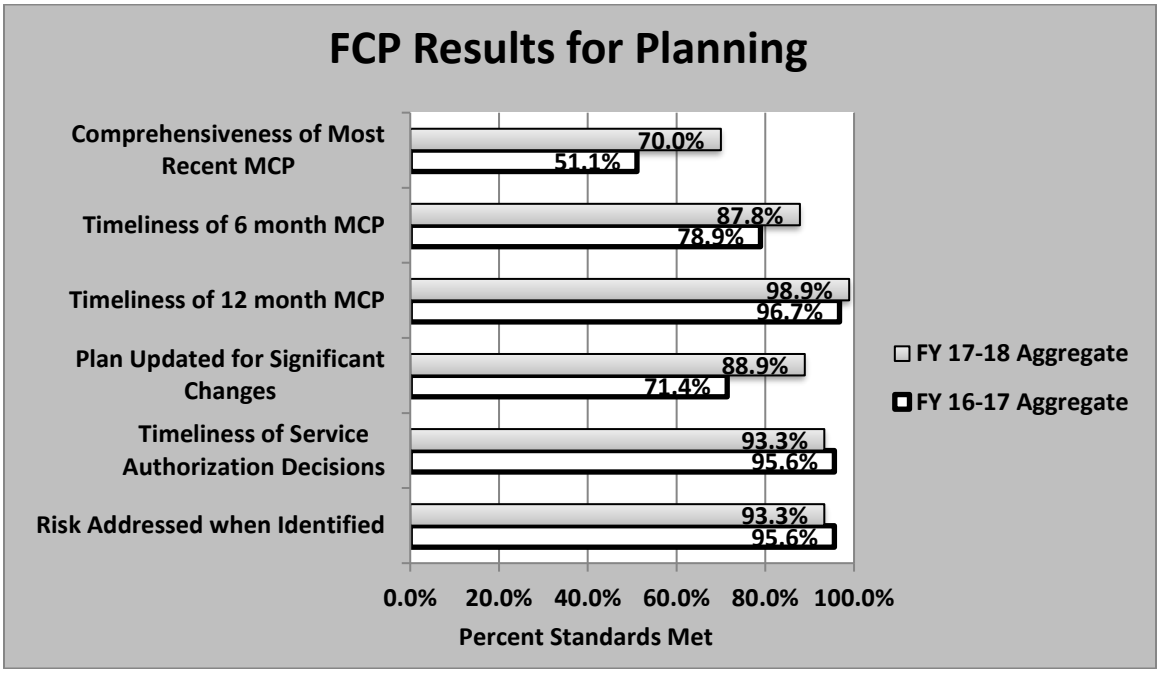
Care Planning Focus Area

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

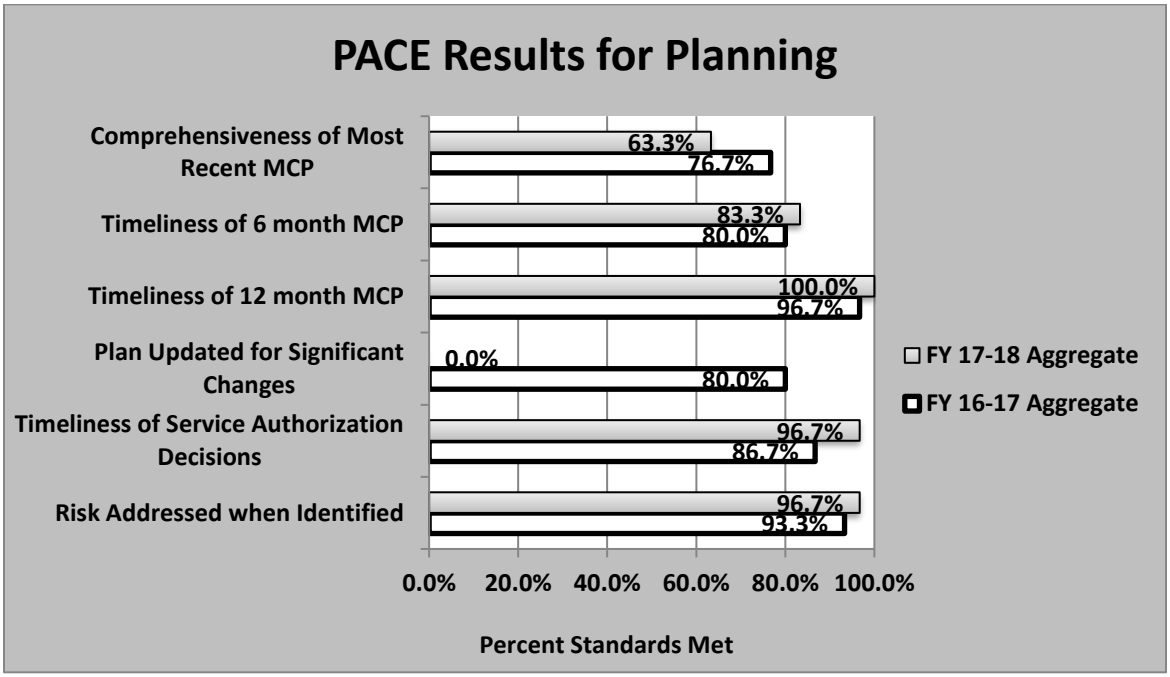
Results for Care Planning for MCOs Operating FC:



Results for Care Planning for MCOs Operating FCP:



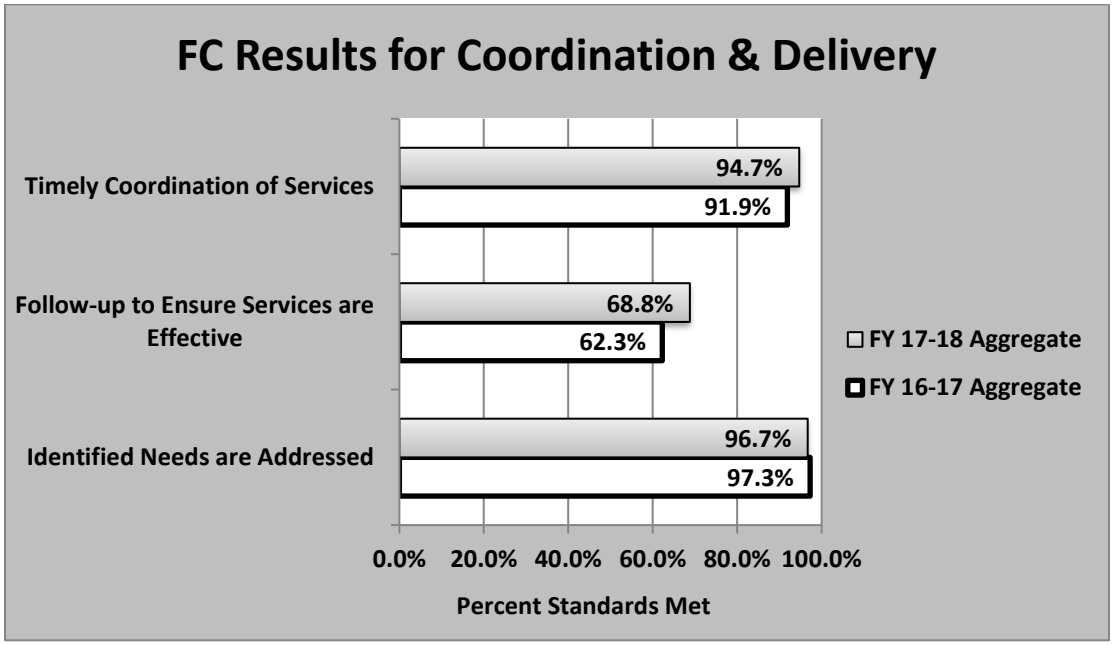
Results for Care Planning for the MCO Operating PACE:



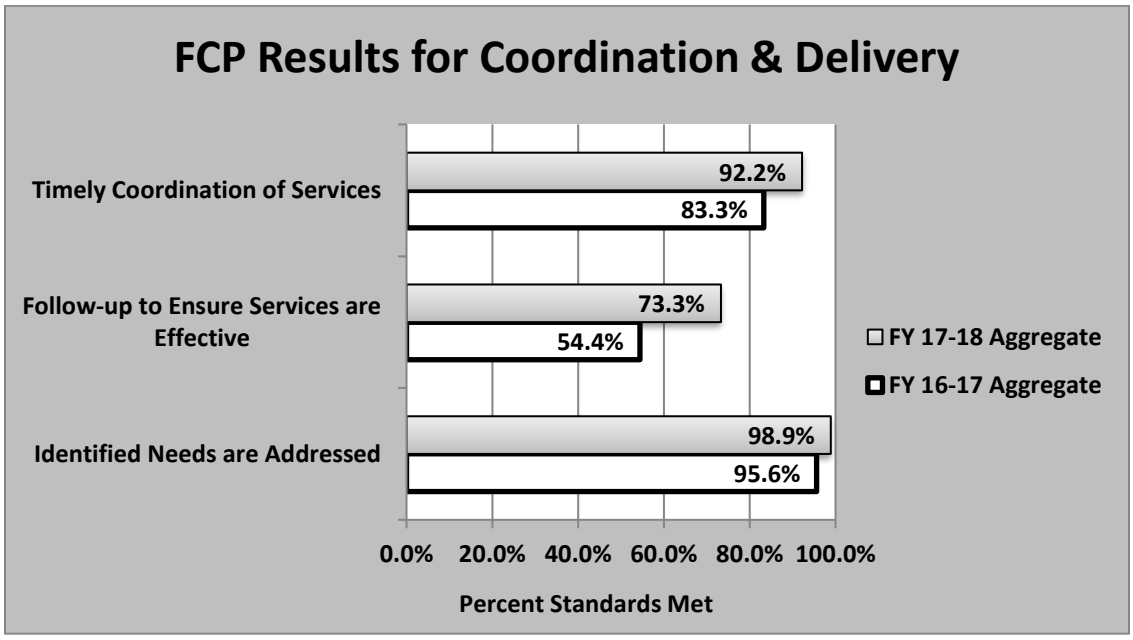
Coordination and Delivery Focus Area

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.

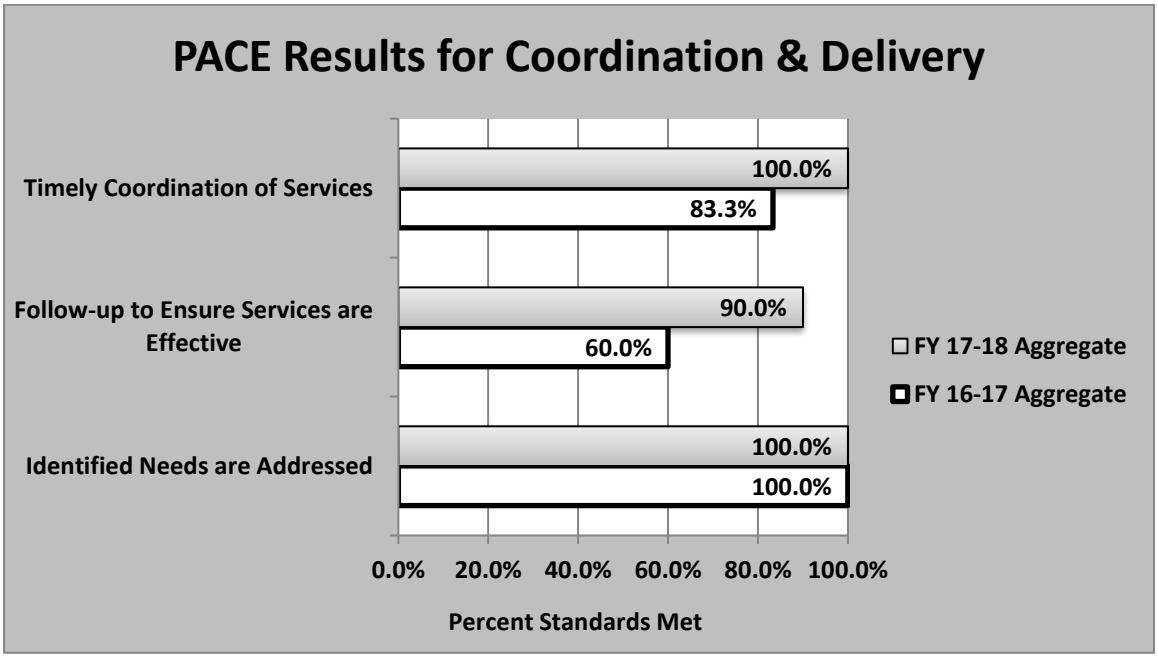
Results for Coordination and Delivery for MCOs Operating FC:



Results for Coordination and Delivery for MCOs Operating FCP:



Results for Coordination and Delivery for the MCO Operating PACE:

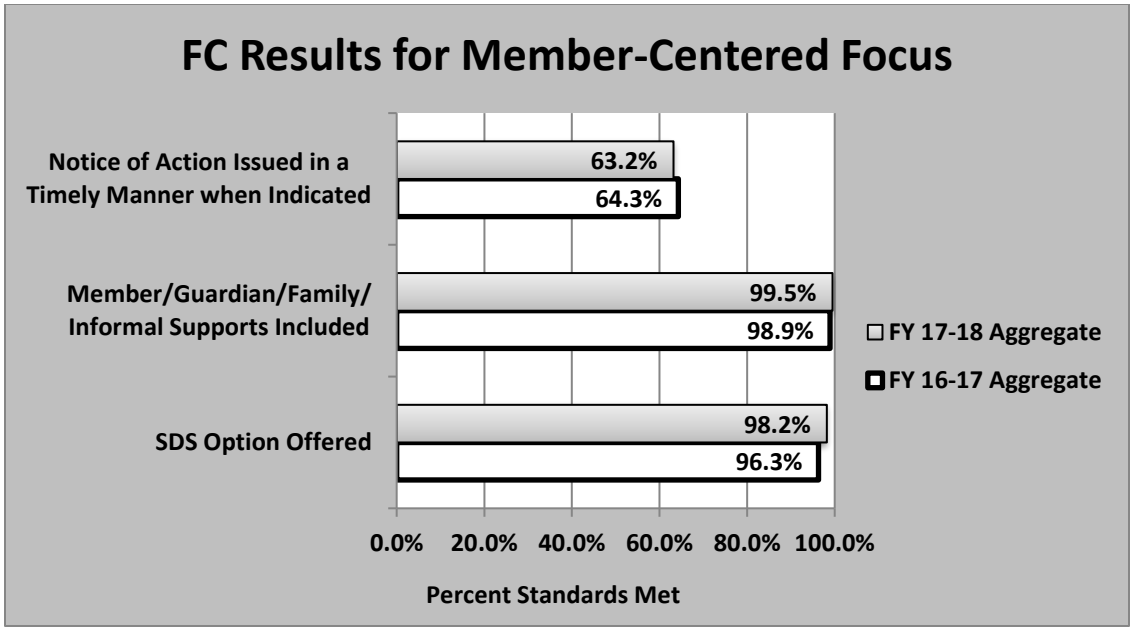


MEMBER-CENTEREDNESS FOCUS AREA

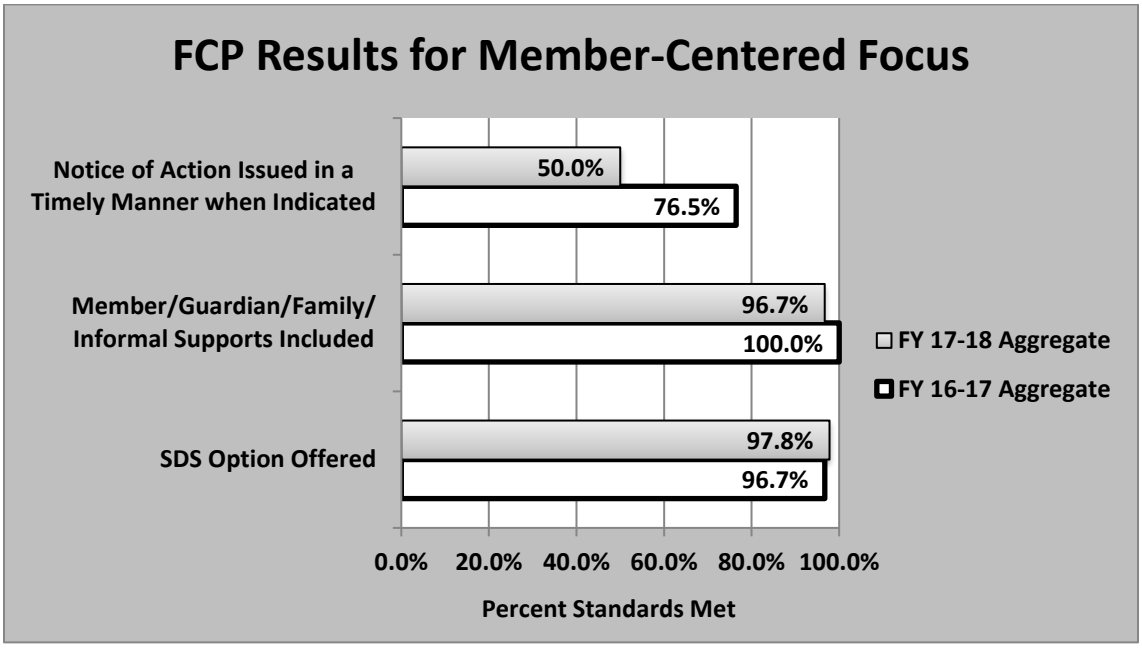
The record should document that the IDT staff includes the member and his/her supports in the care management processes; that staff protects member rights by issuing notices in accordance with requirements outlined in the DHS-MCO contract; and that the self-directed supports (SDS) option has been explained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

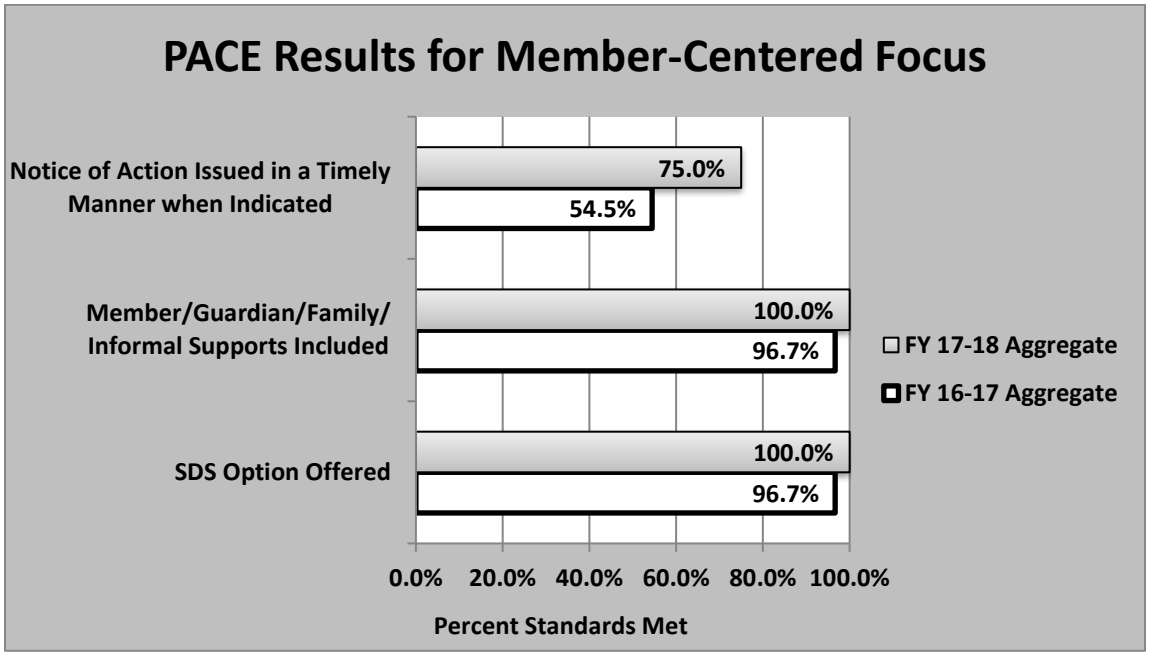
Results for Member-Centered Focus for MCOs Operating FC:



Results for Member-Centered Focus for MCOs Operating FCP:



Results for Coordination and Delivery for the MCO Operating PACE:



ANALYSIS

Member Health and Safety

Over the course of FY 17-18, MetaStar did not identify any members with unaddressed health and safety issues during CMR, out of 777 total member records selected and reviewed during this year's EQR activities. Fifteen 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 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 17-18, DHS also directed MetaStar to re-review the records of 15 members identified in last year's 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 15 member records re-reviewed in FY 17-18, 11 demonstrated the MCOs had sufficiently addressed the issues or situations. The other four records indicated complex and challenging situations were continuing, and these members were referred to DHS again for additional oversight, assistance, and monitoring.

Over the course of the fiscal year, MetaStar also reviewed another 100 member records outside of annual EQR activities, and followed the referral process described above for any member identified as having health and safety issues and/or complex and challenging situations. Again, these reviews were not included in the results for this report.

Overall Results

During the FY 17-18, every FC, FCP, and PACE organization took action to respond to the CMR recommendations received in FY 16-17. Most organizations were able to achieve overall improvement.

For FC, the percent of all CMR standards met in FY 17-18, aggregated across five FC organizations was 88.7 percent. This compares to 86.6 percent in FY 16-17. FY 17-18 aggregate results for FC 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 attributable to actions of the MCOs, and is unlikely to be the result of normal variation or chance.

For FCP, the percent of all CMR standards met in FY 17-18, aggregated across three FCP organizations was 89.5 percent. This compares to 86.1 percent in FY 16-17. FY 17-18 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 attributable to actions of the MCOs, and is unlikely to be the result of normal variation or chance.

For PACE, the percent of all CMR standard met in FY 17-18, for the one organization operating a PACE program, was 87.9 percent. This compares to 85.9 percent in FY 16-17. FY 17-18 aggregate results for PACE showed compliance rates 90 percent and above for nine of 14 CMR standards. Analysis indicated the year-to-year difference in the overall rates is likely due to normal variation or chance.

Recommendations for FC, FCP, and PACE in the FY 16-17 annual technical report, addressed the need for all programs to focus improvement efforts on improving the comprehensiveness of member-centered plans; following up to ensure services have been received and are effective; and issuing notice to members in a timely manner when indicated. FC and FCP programs also received recommendations to ensure organizations consistently update plans when members have significant changes in situation or condition. FCP received an additional recommendation to improve timeliness with which member-center plans are reviewed and signed at the required six-month intervals. Actions MCOs took to address the recommendation 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 follow-up to ensure member services had been received and are effective. FC and FCP improved in overall compliance rates for comprehensive MCPs. Analysis indicated the year-to-year difference in the overall rates for both indicators is likely attributable to actions of the MCOs, and is unlikely to be the result of normal variation or chance.

PACE improved overall compliance in issuing notices to members in a timely manner; and FCP had improvement in updating MCP's for significant changes in situation or condition, and timeliness with which member center plans were reviewed and signed at the required six-month interval. However, analysis indicated the year-to-year difference in the overall rates is likely due to normal variation or chance.

Results for all programs identified a decline for the indicator, "Comprehensiveness of Assessment". The 2018 DHS-MCO Contract included new requirements for assessing members for being vulnerable and high risk. All MCOs providing training on the new requirements; however, not all MCOs successfully implemented the changes. For FC and FCP, analysis indicated the year-to-year difference in the overall rates is likely due to normal variation or chance. For PACE, analysis indicated the year-to-year difference in the overall rates is unlikely to be the result of normal variation or chance.

FC and PACE programs identified a decline for the indicator, "Plan Updated for Significant Changes". For FC, analysis indicated the year-to-year difference in the overall rates is likely due to normal variation or chance. For PACE, analysis indicated the year-to-year difference in the overall rates is unlikely to be the result of normal variation or chance.

Other indicator declines included, "Comprehensiveness of Most Recent MCP" for the PACE program. For FC and FCP, "Timeliness of Service Authorization Decisions," and "Notice of Action Issued in a Timely Manner when Indicated". Analysis indicated the year-to-year difference in the overall rates is likely due to normal variation or chance.

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

- "Reassessment done when indicated"; and
- "Identified Needs are Addressed".

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

- "Timeliness of Service Authorization Decisions"; and
- "Member/Guardian/Family/Informal Supports Included".

CONCLUSIONS

Strengths

In FY 17-18, FC and FCP programs maintained aggregate results over 90 percent for the following review indictors. All of these indicators were also above 90 percent in FY 16-17:

- "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 17-18, the PACE program maintained aggregate results over 90 percent for the following review indicators.

- "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/Family/Informal Supports Included;" and
- "Self-Directed Supports Option Offered".

Opportunities for Improvement

- All programs should focus on improving in the following areas of care management:
  - "Comprehensiveness of Most Recent MCP";
  - "Plan Updated for Significant Changes";
  - "Notice of Action Issued in a Timely Manner when Indicated"; and
  - "Timeliness of 6 month MCP".

- In addition, FC and FCP should focus on improving results for "Follow-up to Ensure Services are Effective".
- For PACE, the overall rate of compliance for these indicators declined; analysis indicated the year-to-year difference in the overall rates is unlikely to be the result of normal variation or chance:
  - "Comprehensiveness of Assessment";
  - "Reassessment Done when Indicated";
  - "Comprehensiveness of Most Recent MCP"; and
  - "Plan Updated for Significant Changes".

APPENDIX 1 – LIST OF ACRONYMS

ADRC	Aging & Disability Resource Center
CARES	Client Assistance for Re-employment and Economic Support
CCI	Community Care, Inc., Managed Care Organization
CFR	Code of Federal Regulations
CMR	Care Management Review
CMS	Centers for Medicare & Medicaid Services
CW	Care Wisconsin, Managed Care Organization
DHS	Wisconsin Department of Health Services
EQR	External Quality Review
EQRO	External Quality Review Organization
FC	Family Care
FCP	Family Care Partnership
FY	Fiscal Year
HbA1c	Hemoglobin A1c
HEDIS[1]	Healthcare Effectiveness Data and Information Set
*i*Care	Independent Care Health Plan, Managed Care Organization
ICN	Internal Control Number
ID	Identification Number
IDT	Interdisciplinary Team
Inclusa	Inclusa, Inc., Managed Care Organization
IS	Information System
ISCA	Information Systems Capabilities Assessment
LCI	Lakeland Care, Inc., Managed Care Organization
MCFC	My Choice Family Care, Inc., Managed Care Organization
MCO	Managed Care Organization
MCP	Member-Centered Plan

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

MY	Measurement Year
NCQA	National Committee for Quality Assurance
NOA	Notice of Action
PACE	Program of All-Inclusive Care for the Elderly
PCP	Primary Care Provider
PIP	Performance Improvement Project
PMV	Performance Measures Validation
QAPI	Quality Assessment and Performance Improvement
QCR	Quality Compliance Review
RN	Registered Nurse
SDS	Self-Directed Supports
TPA	Third Party Administrator

APPENDIX 2 – EXECUTIVE SUMMARIES

Care Wisconsin (CW) – Executive Summary

This section of the report summarizes the results of the fiscal year (FY) 17-18 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 (PACE).

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 17-18 was a comprehensive review year.

Review Activity	FY 17-18 Results	Comparison to FY 16-17 Results
Quality Compliance Review	• 44 standards reviewed • 33 standards received "met" rating • 77: Compliance score out of a possible 88 points in first year of three-year review cycle	Quality Compliance Review follows a three-year review cycle; one year of comprehensive review followed by two years of targeted review. FY 17-18 is the first year in a new review cycle; last year's results are not comparable.
Care Management Review	<u>Family Care</u> • 9 of 14 standards met at a rate of 90 percent or higher • 91.6 percent: Overall rate of standards met by this organization for all review indicators <u>Family Care Partnership</u> • 9 of 14 standards met at a rate of 90 percent or higher • 89.4 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 • 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

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 related to standards that were not fully met during the FY 16-17 Quality Compliance Review.

Care Wisconsin effectively addressed the following recommendations:

- The organization fully implemented interventions in the *Care Wisconsin Restrictive Measures Corrective Action Plan*, which resulted in all members' restrictive measures renewal applications being submitted to the Wisconsin Department of Health Services at least 30 days prior to the current plan's expiration.

CW - Strengths

This section is intended to report on strengths of the managed care organization that are beyond basic compliance. The following strengths were observed during the review:

- The organization provides a variety of resources to care management staff that allows them to perform their roles effectively and consistently, including a robust training department that offers a variety of mandatory and optional continuing education opportunities.
- Care Wisconsin demonstrated a strong commitment to providing services in a culturally competent manner, including efforts to develop a comprehensive education and awareness program for all staff.
- The organization provides a variety of opportunities for interdisciplinary team staff involvement in the organization's Quality Program, including serving as subject matter experts and project champions.
- Care Wisconsin has a strong member-centered approach for working with members to resolve grievances and appeals informally at all levels of the organization.
- The organization's transition to a new care management system was methodical and organized, causing little disruption to daily work and yielded positive feedback from staff at all levels.

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:

- Develop a process to obtain members' written consent to receive electronic materials, which includes the media type and documents to be sent, as required by the organization's contract with the Wisconsin Department of Health Services.
- Implement systems to inform members of their right to request and obtain, at least once per year, the member handbook and provider directory.

- Ensure the organization has the most current version of the *Family Care Partnership Member Handbook for people enrolled in Medicaid only,* on its website.
- Align the organization's practice for authorizing services with its policy, to ensure coordination of services and decision authorizations meet contract requirements.
- Implement monitoring practices for provider credentialing to ensure all providers maintain current licensure.
- Develop a process for routinely monitoring all applicable providers for compliance with caregiver background checks.
- Ensure the following requirements are met related to the adoption, dissemination, and application of practice guidelines:
    - Consider the needs of the organization's members when selecting guidelines to adopt.
    - Review and update the guidelines as appropriate.
    - Disseminate the guidelines to affected providers.
    - Ensure staff uses available resources for prevention and wellness services.
- Ensure the organization's Quality Assessment and Performance Improvement program meets all requirements, including:
    - Provide opportunities for members and providers to actively participate in the organization's Quality Program, and maintain documentation of these efforts.
    - Conduct monitoring of the completeness and accuracy of the long-term care functional screen which produces data to determine the need for improvement efforts. Report data and analysis as part of the Quality Program.
    - Identify the responsible persons for objectives included in the quality plan.
- Ensure the Utilization Management program is focused on the collection and analysis of data to identify potential overutilization and underutilization of both long-term care and acute and primary care services. Maintain documentation of analysis and actions taken as a result.
- Ensure the Wisconsin Department of Health Services contract requirement to assess members for vulnerable high risk is fully implemented.
- Improve the comprehensiveness of member-centered plans by ensuring all identified member needs are identified on the plan.

The additional recommendations offered below reflect opportunities for continued improvement in areas of the Quality Compliance Review where the managed care organization fully met the standard, and/or other observations related to Care Management Review:

- Update relevant documents related to enrollee rights to include:
    - The requirement of providing 30 days written notice to members when there is a significant change in information.

    - The specific reasons providers may advocate for members, as listed in the standard addressing provider-enrollee communication.
    - Documenting the organization's efforts to provide community education on advance directives.
- Include information in the organization's *Medicaid Grievances and Appeals Policy & Procedure* to state that appeals and grievances related to the lack of access to culturally appropriate care must be accepted.
- Address the following recommendations related to mechanisms to assess the quality and appropriateness of care:
    - Ensure that data and results from quality monitoring activities, such as the internal file review process, are collected and reported in a manner that can identify meaningful trends over time.
    - Consider modifying internal file review practices to ensure reliability of the data, such as discontinuing the inclusion of MetaStar care management review data, and reducing the number of reviewers.
    - Consider aggregating the peer review data to assess overall performance and improvement.
- Continue focused efforts to monitor and improve the timely issuance of notices to members for both programs.
- Update the *Medicaid Grievances and Appeals* policy to include that the organization does not bill members for services received while an appeal is pending, and how staff is to inform the member of this practice.
- Update the *Medicaid Grievances and Appeals* policy to include sending notices to members for long-term care functional screen level of care changes.
- Consider implementing mechanisms to track informal complaints resolved by the organization in order to identify any potential trends.

Community Care, Inc. (CCI) – Executive Summary

This section of the report summarizes the results of the fiscal year (FY) 17-18 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 (PACE).

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 17-18 was a comprehensive review year.

Review Activity	FY 17-18 Results	Comparison to FY 16-17 Results
Quality Compliance Review	• 44 standards reviewed • 37 standards received "met" rating • 81: Compliance score out of a possible 88 points in first year of three-year review cycle	Quality Compliance Review follows a three-year review cycle; one year of comprehensive review followed by two years of targeted review. FY 17-18 is the first year in a new review cycle; last year's results are not comparable.
Care Management Review	<u>Family Care</u> • 9 of 14 standards met at a rate of 90 percent or higher • 85.3 percent: Overall rate of standards met by this organization for all review indicators <u>Family Care Partnership</u> • 7 of 14 standards met at a rate of 90 percent or higher • 87.6 percent: Overall rate of standards met by this organization for all review indicators <u>PACE</u> • 10 of 14 standards met at a rate of 90 percent or higher • 87.9 percent: Overall rate of standards met by this organization for all review indicators	<u>Family Care</u> • 9 of 14 standards met at a rate of 90 percent or higher • 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>PACE</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

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 related to standards not fully met in FY 16-17 Quality Compliance Review.

Community Care, Inc. effectively addressed the following recommendation:

- The organization fully implemented the policy change of not sending invoices to members in an attempt to recover the cost of services provided while an appeal was pending.

CCI – Strengths

This section is intended to report on strengths of the managed care organization that are beyond basic compliance. The following strengths were observed during the review:

- Onsite visits with providers are conducted prior to contracting to ensure initial compliance and establish relationships.
- The MCO has a strong system in place for attempting to resolve grievances with members.

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:

- Develop a policy or written procedure for monitoring network adequacy, including monitoring of long-term care providers.
- Revise provider credentialing policies to include details on monitoring processes related to licensure, certification, debarment, and care giver background checks.
- Ensure the organization's Quality Assessment and Performance Improvement program meets all requirements, including:
    - Provide opportunities for members and providers to actively participate in the organization's Quality Program, and maintain documentation which aligns with practice.
    - Continue to afford opportunities for staff from various levels of the organization to participate in the Quality Program and document these efforts.
    - Conduct monitoring of care management practice related to the support provided to vulnerable high risk members.
- Enhance efforts to facilitate communication and coordination among all aspects of the Quality Program and between other functional areas of the organization, such as the functional screen department and Utilization Management Program.
- Focus efforts on improving the monitoring and results of issuing notices in a timely manner when indicated for all three programs.
- For all programs, ensure the new contract requirement to assess members for vulnerable high risk is fully implemented.
- In all programs, improve the comprehensiveness of member-centered plans by ensuring all identified member needs 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.

The additional recommendations offered below reflect opportunities for continued improvement in areas of the Quality Compliance Review where the managed care organization fully met the standard, and/or other observations related to Care Management Review:

- Update relevant documents related to enrollee rights to include:
    - The specific reasons providers may advocate for members, as listed in the standard addressing provider-enrollee communication.
    - The process for updating the paper version of the provider directory.
    - The requirement of providing 30 days written notice to members when there is a significant change in information.
- Related to the delivery of services in a culturally competent manner:
    - Ensure PACE members are aware that they may choose providers based on cultural preference, by adding the information to the PACE member handbook and/or relevant policies.
    - Include information in the organization's grievance policy to state that grievances related to the lack of access to culturally appropriate care must be accepted.
- Ensure data from monitoring methods are reported and analyzed effectively, and used for quality improvement as needed.

Inclusa, Inc. (Inclusa) – Executive Summary

This section of the report summarizes the results of the fiscal year 2017-2018 (FY 17-18) annual quality review conducted by MetaStar, Inc., for the managed care organization, Inclusa, Inc. Effective January 1, 2017, three separate Family Care Managed Care Organizations, Community Care Connections of Wisconsin, ContinuUs, and Western Wisconsin Cares, merged to create a new organization, Community Link, Inc. In September 2017, the organization changed their name to Inclusa, Inc. Staff from Inclusa, Inc. refer to the previous three organizations as the legacy organizations.

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

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 17-18 was a comprehensive review year.

Review Activity	FY 17-18 Results	Comparison to FY 16-17 Results
Quality Compliance Review	• 43 standards reviewed • 25 standards received "met" rating • 68: Compliance score out of a possible 86 points in the first year of a three-year review cycle	Quality Compliance Review follows a three-year review cycle. FY 17-18 is the first year in a new review cycle; last year's results are not comparable.
Care Management Review	<u>Family Care</u> • 9 of 14 standards met at a rate of 90 percent or higher • 88.5 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 • 87.2 percent: Overall rate of standards met by this organization for all review indicators *The Care Management Review results for Community Care Connections of Wisconsin, ContinuUs, and Western Wisconsin Cares were aggregated for each indicator. These results are reflected in the FY 16-17 results for comparison to FY 17-18.*

Inclusa – 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 16-17 Quality Compliance Review. Inclusa, Inc. was a new organization, effective January 1, 2017. No Quality Compliance Review was conducted in FY 16-17; therefore, there is no progress to report on.

Inclusa – Strengths

- The organization focused on minimizing any impact for members and staff during the transition.
- Inclusa, Inc. has a clearly defined communication protocol to ensure timely and consistent communication throughout the organization.
- The utilization management program effectively uses data and analysis, and maintains an emphasis on meeting members' needs.
- The organization has a strong member-centered approach in attempting to negotiate resolutions of appeals and grievances.

Inclusa – 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 ensuring policies and procedures are fully implemented and provide clear and consistent guidance to staff throughout the organization, to include:
    - Develop and deploy a consistent policy and procedure format, and ensure effective dates and revision dates are clearly indicated.
    - Ensure education is provided to all staff affected by policy and procedure changes.
    - Monitor changes in practice to ensure the effectiveness of newly created or modified policies and procedures.
- Complete staff education and full implementation of the organization's member rights policies, such as the *Member Rights and Responsibility Policy and Procedure* and the *Interpreter Services Policy*.
- Develop a process to obtain members' written consent to receive electronic materials, as required by the organization's contract with the Department of Health Services.
- Add language to the *Closure/Termination of a Service Provider Contract* procedure to include the required timeframe of notification to members within 15 days after receipt or issuance of the termination notice.
- Ensure compliance with requirements related to advance directives:
    - Develop and implement written policies and procedures which include all required elements.
    - Ensure required written information is provided to members about advance directives, and it is standardized throughout the organization.
    - Maintain documentation of community education regarding advance directives provided by the organization or in concert with other providers.
- Fully implement a consistent restrictive measures policy and procedure, which includes processes to ensure renewal applications are submitted to DHS in a timely manner.
- Fully implement policies and procedures ensuring confidentiality of member information, and monitor for effectiveness.
- Fully implement policies related to provider credentialing and monitoring of provider quality to ensure the organization is contracting with and utilizing qualified providers.
- Implement monitoring processes related to provider credentialing and quality throughout the service region to ensure practices are effective.
- Develop and implement mechanisms to adopt, disseminate, and apply practice guidelines which meet all requirements.
- Ensure compliance with all requirements related to the Quality Assessment and Performance Improvement Program, including:
    - Fully implement the Quality Management program administrative structure, and ensure that it is adequate to facilitate communication and coordination among all aspects of the program and between other functional areas of the organization that affect the quality of service delivery.

    - Fully implement mechanisms for providers, members, and staff to participate in the organization's Quality Management program.
    - Ensure all required monitoring is implemented throughout the organization and analyzed as part of the Quality Management program.
- Ensure that all providers are informed about member grievance systems at the time they enter into a contract.
- Focus efforts on monitoring and improving the following areas of care management practice:
    - Comprehensiveness of member-centered plans;
    - Following up with member and their supports to ensure services have been received and are effective; and
    - Issuing notices in a timely manner when indicated.

The additional recommendations offered below reflect opportunities for continued improvement in areas of the Quality Compliance Review where the managed care organization fully met the standard, and/or other observations related to Care Management Review:

- Update the searchable online provider directory to include the option to search for providers that speak non-English languages, so that members and staff may more readily access this information.
- Update relevant policies to include the specific reasons providers may advocate for members, as listed in the standard addressing provider-enrollee communication.
- Add written guidance to related policies and procedures to indicate the MCO must accept appeals and grievances from members related to a lack of access to culturally appropriate care.
- Ensure that data and results from quality monitoring activities, such as the member file review, are collected and reported in a manner that can be used for analysis and quality improvement.
- Update the *Grievance and Appeal Policy* to include that the MCO does not bill members for services received while an appeal was pending.
- Continue efforts to ensure that member-centered plans are updated when significant changes occur.

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

This section of the report summarizes the results of the fiscal year (FY) 17-18 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 (PACE).

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 17-18 was a comprehensive review year.

Review Activity	FY 17-18 Results	Comparison to FY 16-17 Results
Quality Compliance Review	• 44 standards reviewed • 33 standards received "met" rating • 77: Compliance score out of a possible 88 points in first year of three-year review cycle	Quality Compliance Review follows a three-year review cycle; one year of comprehensive review followed by two years of targeted review. FY 17-18 is the first year in a new review cycle; last year's results are not comparable.
Care Management Review	<u>Family Care Partnership</u> • 11 of 14 standards met at a rate of 90 percent or higher • 91.4 percent: Overall rate of standards met by this organization for all review indicators	<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

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 related to standards that were not fully met during the FY 16-17 Quality Compliance Review.

Independent Care Health Plan effectively addressed the following recommendations:

- Focused efforts to improve results of comprehensive member-centered plans.
- Corrected the contact number for member's filing a grievance or appeal in the FCP Provider Reference Manual.

iCare – Strengths

This section is intended to report on strengths of the managed care organization that are beyond basic compliance. The following strengths were observed during the review:

- The organization has a well-defined process for capturing and addressing member concerns, which includes quality staff oversight and tracking and trending of concerns.

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:

- Develop written guidance for receiving and documenting the member's consent prior to providing any member materials electronically, including specifying the media type and documents.
- Ensure that the organization's printable version of the online provider directory for members accurately reflects the physical accessibility for each provider.
- Focus efforts to improve care management follow-up to ensure services are effective.
- Implement routine monitoring to ensure provider compliance with licensure and caregiver background checks.
- Ensure consistency in monitoring of caregiver background checks for non-regulated providers.
- Ensure links on the organization's website used to disseminate practice guidelines to providers are current and functional, and implement monitoring processes to ensure effectiveness.
- Implement methods for Family Care Partnership providers to actively participate in the organization's Quality Program.
- Perform the following required activities and collect data to be used for quality improvement purposes: monitoring the accuracy of functional screens and conducting provider surveys.
- Ensure the Utilization Management program is focused on the collection and analysis of data to detect potential overutilization and underutilization of both long-term care and acute and primary care services. Conduct analysis to identify trends at the organization or system level.
- Revise internal file review data collection, presentation, and analysis procedures to provide data that can be utilized to identify areas needing improvement, as well as measure effectiveness of improvement efforts. For example, present data for each quarter rather than cumulatively, and include numerators and denominators.
- Develop or enhance written guidance for reviewers and use caution when comparing organization results to MetaStar's data.
- Expand monitoring for notices of action to include notices of non-covered benefit, and monitoring for notices that are indicated but not issued.
- Ensure that written decisions for local grievances and appeals are issued within the required contract timeframes.

The additional recommendations offered below reflect opportunities for continued improvement in areas of the Quality Compliance Review where the managed care organization fully met the standard, and/or other observations related to Care Management Review:

- Ensure that community education efforts regarding advance directives are easily accessed and clearly documented.
- Track acknowledgment letters for all grievances to ensure contract timeframes are used for all grievances and appeals.
- Ensure the DHS approval date is included on the *Change in Level of Care* template letter.

Lakeland Care, Inc. (LCI) – Executive Summary

This section of the report summarizes the results of the fiscal year (FY) 17-18 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 (PACE).

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 17-18 was a comprehensive review year.

Review Activity	FY 17-18 Results	Comparison to FY 16-17 Results
Quality Compliance Review	• 43 standards reviewed • 27 standards received "met" rating • 70: Compliance score out of a possible 86 points in first year of three-year review cycle	Quality Compliance Review follows a three-year review cycle; one year of comprehensive review followed by two years of targeted review. FY 17-18 is the first year in a new review cycle; last year's results are not comparable.
Care Management Review	<u>Family Care</u> • 10 of 14 standards met at a rate of 90 percent or higher • 89.4 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 • 86.5 percent: Overall rate of standards met by this organization for all review indicators

LCI – 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 related to standards that were not fully met during the FY 16-17 Quality Compliance Review.

The organization had one standard related to care coordination that was not fully met following the FY 16-17 Quality Compliance Review. The organization did not effectively address the recommendations to improve the comprehensiveness of member-centered plans.

LCI – Strengths

This section is intended to report on strengths of the managed care organization that are beyond basic compliance. The following strengths were observed during the review:

- The organization implemented a Care Management Practice Enhancement Committee, including interdisciplinary staff, which uses data and information to recommend improvements in care management practice and member experience.
- Lakeland Care, Inc. has a strong member-centered approach for working with members to resolve grievances and appeals informally at all levels of the organization.

LCI – 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:

- Develop written guidance for obtaining the member's consent prior to providing materials electronically, including specifying the media type and documents to be sent.
- Ensure the organization's online provider directory for members includes the service type of Assistive Technology/Communication Aids, and that it accurately reflects the service type for which the provider is contracted.
- Update relevant documents to include required information related to provider-enrollee communication.
- Utilize all data collected to assess the adequacy of the provider network.
- Place priority on ensuring the organization's provider network staff have a consistent understanding and application of provider expectations and monitoring practices, including:
    - Identifying barriers and addressing provider performance concerns related to timely access to services;
    - Verifying provider credentials and monitoring to ensure ongoing compliance;
    - Assuring all provider types within the benefit package are included in the monthly debarment verification;
    - Monitoring completion of caregiver background checks for all applicable providers;

    - Formalizing the documentation of provider quality concerns including documentation of follow-up and outcomes; and
    - Implementing a method to track and trend data obtained during onsite visits with providers.
- Assure monitoring practices for delegated responsibilities are implemented and monitored to assure compliance for all subcontractors.
- Focus efforts on monitoring and improving the following areas of care management practice:
    - Following up with members and their supports to ensure services have been received and are effective; and
    - Comprehensiveness of member-centered plans.
- Ensure the organization's Quality Assessment and Performance Improvement Program meets all requirements, including:
    - Make opportunities available for providers to actively participate in the organization's Quality Program;
    - Conduct monitoring of the completeness and accuracy of the long-term care functional screen which produces data to determine the need for improvement efforts;
    - Ensure the following required activities are completed and yield data: conduct provider surveys, monitor access to providers, and monitor the quality of subcontractor services;
    - Consider reporting all required monitoring activities through the Quality Program; and
    - Identify the responsible persons and timelines for objectives included in the quality plan, or reference the available information in a related document.
- Ensure utilization management approaches focus on monitoring and analysis to detect both overutilization and underutilization of services.
- Implement monitoring methods that employ adequate sample sizes and provide timely data for improvement efforts; take denominator size into consideration when analyzing information.
- Update the *Notice of Non-Covered Benefit* template letter to align with the Department of Health Services template.
- Focus efforts on monitoring and improving the results of issuing notices in a timely manner when indicated.

The additional recommendations offered below reflect opportunities for continued improvement in areas of the Quality Compliance Review where the managed care organization fully met the standard, and/or other observations related to Care Management Review:

- Ensure all relevant documents are aligned to meet requirements for providing required information to new members within 10 business days and include the timeframe of providing at least 30 days written notice when there is a significant change in information.
- Update relevant documents for advance directives, to specify that written information is updated to reflect changes in state law as soon as possible, but not later than 90 days after the effective date of the change.
- Include information in written guidance to identify processes for disseminating practice guidelines to providers, including a standard method of notifying providers of the presence of the guidelines on the organization's website.
- Ensure the evaluation of the Quality Program maintains its focus on achieving improvement in the quality of services provided to members, as the scope of the program has been expanded to include initiatives related to organizational effectiveness.
- Update the Lakeland Care Inc. *Local Appeal and Grievance Hearing Procedure* to include the frequency of training provided to committee members.
- Develop and document a process to ensure health care professionals are represented on the grievance and appeal committee to meet contract requirements.
- Update the *Appeal and Grievance System Policy* to specify that the organization does not bill members for services received while an appeal is pending, and educate and provide guidance to staff on how to inform members of this practice.

My Choice Family Care (MCFC) – Executive Summary

This section of the report summarizes the results of the fiscal year (FY) 17-18 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 (PACE).

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 17-18 was a comprehensive review year.

Review Activity	FY 17-18 Results	Comparison to FY 16-17 Results
Quality Compliance Review	• 43 standards reviewed • 28 standards received "met" rating	Quality Compliance Review follows a three-year review cycle; one year of comprehensive review followed by two

Review Activity	FY 17-18 Results	Comparison to FY 16-17 Results
	• 71: Compliance score out of a possible 86 points in first year of three-year review cycle	years of targeted review. FY 17-18 is the first year in a new review cycle; last year's results are not comparable.
Care Management Review	<u>Family Care</u> • 9 of 14 standards met at a rate of 90 percent or higher • 90.6 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 • 86.0 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 related to standards that were not fully met during the FY 16-17 Quality Compliance Review.

My Choice Family Care effectively addressed the following recommendations:

- The organization's improvement efforts resulted in all members' restrictive measures renewal applications being submitted to the Wisconsin Department of Health Services prior to the current plan's expiration.

MCFC – Strengths

This section is intended to report on strengths of the managed care organization that are beyond basic compliance. The following strengths were observed during the review:

- My Choice Family Care effectively customizes and uses its *Member Information Documentation and Authorization System* to streamline processes and produce data for monitoring.
- The organization provides a variety of internal resources to support member care.
- My Choice Family Care demonstrated a strong commitment to providing services in a culturally competent manner, including community outreach, trainings for staff, and contracting with providers who speak a variety of languages.

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:

- Ensure that mechanisms used to educate contracted providers on all member rights are readily available.
- Develop written guidance for obtaining the member's consent prior to providing materials electronically, including specifying the media type and documents to be sent.
- Conduct routine monitoring of timely access to services.
- Develop and implement a written process for re-credentialing providers and conduct monitoring of the process.
- Ensure the evaluation of caregiver background checks with serious charges is documented.
- Ensure that data and results from quality monitoring activities demonstrate aggregation and analysis of provider concerns.
- Focus efforts on monitoring and improving the following areas of care management practice:
    - Completion and documentation of follow-up with members and their supports to ensure services have been received and are effective;
    - Comprehensiveness, timeliness, and significant change updates of member-centered plans; and
    - Timeliness of service authorization decisions.
- Ensure the following requirements are met related to the adoption, dissemination, and application of practice guidelines:
    - Consider the needs of the organization's members when selecting guidelines to adopt;
    - Review and update the guidelines as appropriate;
    - Disseminate the guidelines to all affected providers; and
    - Ensure relevant guidelines are clearly identified for staff and providers.
- Ensure all required monitoring activities are conducted, yield data, and are reported for analysis and quality improvement as needed.
- Take additional recommendations into consideration related to the Quality Assessment and Performance Improvement Program:
    - Clearly document opportunities for member, staff, and provider participation in the program;
    - Consistently identify responsible persons and timelines on the quality plan; and
    - Ensure data from all required monitoring activities are reported as part of the program.
- Ensure utilization management processes are sufficient to detect both underutilization and overutilization of services as follows:
    - Develop an overall systematic approach with written guidance;
    - Document results, analysis, and actions taken to address issues or trends that are identified; and

    - Consider identifying a coordinating structure or committee.
- Focus efforts on improving the issuance of notices when indicated.
- Ensure the grievance and appeals committee is comprised of at least one member or guardian of a member who meets the functional eligibility of one of the target populations.
- Review data and analysis of grievances and appeals as part of the Quality Management Program.

The additional recommendations offered below reflect opportunities for continued improvement in areas of the Quality Compliance Review where the managed care organization fully met the standard, and/or other observations related to Care Management Review:

- Update relevant documents for advance directives to specify that written information is updated to reflect changes in state law as soon as possible, but not later than 90 days after the effective date of the change.
- Update relevant materials for staff and providers to include the specific reasons providers may advocate for members, as listed in the standard addressing provider-enrollee communication.
- Evaluate overall trends for *Audit-A* and *Audit-B* results beyond the care management unit level, document this analysis, and take action as needed.
- Include documentation of analysis of the effectiveness of quality improvement activities and identified next steps in the annual quality evaluation.
- Ensure the Department of Health Services approval date is included on the *Notice of Change in Level of Care* template letter.
- Educate staff on the organization's practice not to request repayment from a member who chooses to continue benefits and receives an adverse decision, but they may be held liable. In addition, educate staff how to inform members of this practice.

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 Medicaid managed long-term programs, including Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly. 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 conducts EQR of Home and Community-based Medicaid Waiver programs that provide long-term support services for children with disabilities. MetaStar 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 physical therapist, a recreational therapist, a counselor, 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, schools, home health agencies, community-based residential settings, and the Wisconsin

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

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 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 CMR elements were considered when assigning compliance ratings for some focus areas and sub-categories.

MetaStar worked with DHS to identify 44 standards that include federal and state requirements; 43 of the standards were applicable to FC, and all 44 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 – 8 or 9 Standards	• General Rule • Information Requirements • Specific Rights • Provider-Enrollee Communications • Emergency and Post-stabilization Services
Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement – 19 Standards	• Availability of Services • Coordination and Continuity of Care • Coverage and Authorization of Services • Provider Selection • Confidentiality • Subcontractual Relationships and Delegation • Practice Guidelines • QAPI Program • Health Information Systems

Grievance System – **16 Standards**	• 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 86 for FC, and 88 for FCP/PACE.

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

Validation of Performance Improvement Projects (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.*

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

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

MetaStar reviewed the validity of the data and analyzed the reported vaccination rates for each quality indicator and program the MCO administered during measurement year (MY) 2017. 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
    - Confirming vaccination data reported for members that met specified age requirements.
- Verified that members included in the numerators met the technical specification requirements established by DHS, ensuring that vaccinations were given within the identified timeframe.
- 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 was required to resubmit data.
- Calculated the vaccination rates for each quality indicator by program and target group.
- Compared the MCO's rates for MY 2017 to both the statewide rates for MY 2017 and the MCO's rates for MY 2016.

- When necessary, MetaStar contacted the MCO to discuss any data errors or discrepancies.

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

- Reviewed each member's care management record to verify documentation of vaccinations, exclusions, and contraindications as defined by the technical specifications.
- Documented whether the MCO's report of the member's vaccination or exclusion is valid or invalid (the appropriate vaccination was documented for the current measurement year 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 determined bias at the 95 percent confidence interval).

Information Systems Capabilities Assessment

As a required part of other mandatory EQR protocols, information systems capabilities 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.

MetaStar's assessment was based on information system requirements detailed in the DHS-MCO contract, other reporting technical references, 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 Information Systems Capability Assessment (ISCA), including reviewing the following references:

- DHS-MCO contract;
- EQR Protocol *Appendix V: Information Systems Capability Assessment – Activity Required for Multiple Protocols*; and
- Third Party Administration (TPA) Claims Processing and encounter reporting reference materials:

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

https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Encounters_and_Reporting/pdf/Encounter_User_Guide.pdf.spage.

To conduct the assessment, MetaStar used the ISCA scoring 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 scoring tool, which was completed by the MCO and submitted to MetaStar. 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 scoring 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 systems 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)

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 17-18 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 16-17 statewide aggregate rate for each of the 14 CMR standards.

CMR Measure	FY 16-17 FC Aggregate Rate	FY 16-17 FCP Aggregate Rate
1A-Comprehensiveness of Assessment	88.9%	93.3%
1B-Re-Assessment Cone When Indicated	95.6%	95.5%
2A-Comprehensiveness of Plan	40.4%	51.1%
2B-Timeliness of Most Recent Plan (6 months)	87.1%	78.9%
2F-Timeliness of Member-Centered Plan in Past 12 Months	97.1%	96.7%
2C-Plan Updated for Changes	74.1%	71.4%
2D-Timeliness of Service Authorization Decisions	94.4%	95.6%
2E-Risk Addressed	96.7%	95.6%
3A-Timely Coordination of Services	91.9%	83.3%
3B-Follow-Up Completed	62.3%	54.4%
3C-Identified Needs Addressed	97.3%	95.6%
4A-Notice of Action Issued	64.3%	76.5%

CMR Measure	FY 16-17 FC Aggregate Rate	FY 16-17 FCP Aggregate Rate
4B-Member/ Guardian/Supports Included	98.9%	100.0%
4C-Self-Directed Supports Offered	96.3%	96.7%
CMR Overall Results	**86.6%**	**86.1%**

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.

APPENDIX 4 – QUALITY COMPLIANCE REVIEW STANDARDS FY 2017 – 2018

#	Enrollee Rights and Protections
	General Rule
1	**42 CFR 438.100; DHS-MCO Contract Article X.** The MCO must: • Have written policies regarding member rights • Comply with any applicable federal and state laws that pertain to member rights • Ensure its employees and contracted providers observe and protect those rights, and take those rights into account when furnishing services.
	Information Requirements
2	**42 CFR 438.100; 42 CFR 438.10; DHS-MCO Contract Article IX.** The MCO must provide all notices, informational materials, and instructional materials relating to members in a manner and format that may be easily understood. The MCO must: • Make its written information available in the prevalent non-English languages in its service area; • Make oral interpretation services available free of charge for all non-English languages (not just those identified as prevalent); • Provide written materials that are in an easily understood language and format; • Make alternative formats available that take into consideration members' special needs; • Make reasonable efforts to locate and use culturally appropriate materials; • Notify members of the availability of the above materials and services, including how to access them. Member materials shall be available to members in paper form, unless electronic materials are available and the member/legal decision maker has given prior consent to receiving materials electronically. The MCO must document the member's/legal decision maker's consent and meet other requirements specified in the DHS-MCO contract.
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 or issuance of the termination notice, to members who received services from such provider.
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.

#	Enrollee Rights and Protections
5	**42 CFR 438.100; 42 CFR 438.10; DHS-MCO Contract Article IX.** The MCO provides information to members in the Member Handbook, as required by 42 CFR 438.10(f)(6), 42 CFR 438.10(g), and the DHS-MCO contract.
6	**42 CFR 438.100; 42 CFR 438.10; 42 CFR 438.3; 42 CFR 422.128; DHS-MCO Contract Article X.** Regarding advance directives, the MCO must: • Maintain written policies and procedures in accordance with 42 CFR 422.128 and the DHS-MCO contract; • Provide written information to members regarding their rights under state law to make decisions concerning their medical care, accept or refuse treatment, and 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); • Provide members written information with respect to the MCO's policies regarding the above rights, including a clear and precise statement of limitation if it cannot implement an advance directive as a matter of conscience. The statement must comply with requirements listed in 42 CFR 422.128(b)(1)(ii)(A-C); • Provide written information to each member at the time of MCO enrollment (or family/surrogate if member is incapacitated at time of enrollment), and must have a follow-up procedure in place to provide the information to the member when he/she is no longer incapacitated; • Document in the medical record whether or not the individual has executed an advance directive; • Not condition the provision of care or otherwise discriminate based on whether or not a member has completed an advance directive; • Ensure compliance with requirements of state law regarding advance directives; • Provide education for staff on the MCO's advance directives policies/procedures; • Provide community education on advance directives and document these efforts. (MCO can provide directly or in concert with other providers/entities); • Inform individuals that complaints concerning non-compliance with any advance directive may be filed with the State of Wisconsin/Division of Quality Assurance.
	Specific Rights
7	**42 CFR 438.100; 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; • Be furnished health care services in accordance with 438.206 through 438.210. • Exercise their rights, and that the exercise of those rights does not adversely affect the way the MCO and its network providers treat members; • Be free from unlawful discrimination as specified in federal and state laws (including: Title VI of the Civil Rights Act of 1964; Age Discrimination Act of 1975; Rehabilitation Act of

#	Enrollee Rights and Protections
	1973; Title IX of Education Amendments of 1972; Titles II and III of the Americans with Disabilities Act; section 1557 of the Patient Protection and Affordable Care Act. **Legal Decision Makers** The MCO shall determine the identity of any and all legal decision makers for the member and the nature and extent of each legal decision maker's authority. The MCO shall include any legal decision maker in decisions relating to the member only to the extent consistent with the scope of the legal decision maker's authority.
	Provider-Enrollee Communication
8	**42 CFR 438.102; DHS-MCO Contract Article VIII.** The MCO may not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient for the following: • The member's health status, medical care, or treatment options, including any alternative treatment; • Any information the member needs to decide among all relevant treatment options; • The risks, benefits, and consequences of treatment or non-treatment; or • The member's right to participate in decisions regarding his or her health care.
	Emergency and Post-stabilization Services
9	**42 CFR 438.114; 42 CFR 422.113; DHS-MCO Contract Article VII.** ***Applies to Partnership and PACE programs only*** The MCO: • Must cover and pay for emergency services regardless of whether the entity that furnishes the services has a contract with the MCO; • May not deny payment for treatment obtained if a member had an emergency medical condition or a representative of the MCO instructs the member to seek emergency services; • May not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms; • May not refuse to cover emergency services based on lack of notification to MCO within 10 days of presentation for services; • May not hold members liable for payment of subsequent screening or treatment needed to diagnose the specific condition or stabilize the member. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is stabilized for transfer or discharge; • Must cover and pay for post-stabilization care services in accordance with provisions set forth in 42 CFR 422.113(c).

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

#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement
	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.
2	**42 CFR 438.206; DHS-MCO Contract Articles VII. and VIII** ***Second opinion and out-of-network providers*** The MCO provides for a second opinion from a qualified health care professional within the network, or arranges for the member to obtain one outside the network, at no cost to the member, when applicable per program benefit package. If the network is unable to provide necessary services, covered under the contract, to a particular member, the MCO must adequately and timely cover these services out of network for the member as long as the MCO is unable to provide them. The MCO must coordinate with out-of-network providers to ensure that the cost of services to members is no greater than they would have been if furnished within the provider network.
3	**42 CFR 438.206; DHS-MCO Contract Article VIII.** ***Timely access*** The MCO must: • Require its providers to meet state standards for timely access to care and services, taking into account the urgency of need for services; • Ensure that the network providers offer hours of operation that are not less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service, if the provider serves only Medicaid members; • Make services available 24 hours a day, 7 days a week when medically necessary; • Establish mechanisms to ensure compliance by providers; • Monitor providers regularly to determine compliance; • Take corrective action if there is a failure to comply.
4	**42 CFR 438.206*;* DHS-MCO Contract Article VIII.** ***Cultural considerations*** The MCO must participate in the state's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The MCO must: • Incorporate in its policies, administration, provider contract, and service practice the values of honoring members' beliefs and cultural backgrounds;

#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement
	• Permit members to choose providers from among the MCO's network based on cultural preference; • Accept appeals and grievances from members related to a lack of access to culturally appropriate care.
	Coordination and Continuity of Care
5	**42 CFR 438.208 (b. 1-4); DHS-MCO Contract Article V.** ***Primary care and coordination of health care services*** The MCO must implement procedures to deliver primary care (as applicable for FCP) and coordinate health care services for all MCO members. These procedures must do the following: • Ensure that each member has an ongoing source of primary care appropriate to his/her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member; • Coordinate the services the MCO furnishes to the member with services the member receives from any other provider of health care or insurance plan, including mental health and substance abuse services; • Share with other providers serving the member the results of its identification and assessment of that member's needs to prevent duplication of activities; • Ensure protection of the member's privacy when coordinating care; • Facilitate direct access to specialists as appropriate for the member's special health care condition and identified needs.
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.
	Coverage and Authorization of Services
7	**42 CFR 438.210; DHS-MCO Contract Article V.** ***Authorization of services*** For processing requests for initial and continuing authorizations of services, the MCO must: • Have in place and follow written policies and procedures; • Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; • Consult with the requesting provider when appropriate; • Ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a health care

#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement
	professional who has appropriate clinical expertise in treating the member's condition or disease.
8	**42 CFR 438.210; DHS-MCO Contract Article V.(K)(9)** ***Timeframe for decisions of approval or denial*** The IDT staff shall make decisions on requests for services and provide notice as expeditiously as the member's health condition requires. <u>Standard Service Authorization Decisions</u> ***For Family Care and Partnership:*** • Decisions shall be made no later than fourteen (14) calendar days following receipt of the request for the service unless the MCO extends the timeframe for up to fourteen (14) additional calendar days. If the timeframe is extended, the MCO must send a written notification to the member no later than the fourteenth day after the original request. ***For PACE:*** • Decisions on direct requests for services must be made and notice provided as expeditiously as the member's health condition requires but not more than 72 hours after the date the interdisciplinary team receives the request. The interdisciplinary team may extend this 72-hour timeframe by up to five (5) additional calendar days for either of the following reasons: a) The participant or designated representative requests the extension; or b) The team documents its need for additional information and how the delay is in the interest of the participant. <u>Expedited Service Authorization Decisions:</u> • If following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO shall make an expedited service authorization no later than seventy two (72) hours after receipt of the request for service. • The MCO may extend the timeframes of expedited service authorization decisions by up to eleven (11) additional calendar days if the member or a provider requests the extension or the MCO justifies a need for additional information. For any extension not requested by the member, the MCO must give the member written notice of the reason for delay of decision.
	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.
10	**42 CFR 438.214; DHS-MCO Contract Article VIII.**

#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement
	MCOs may not employ or contract with providers excluded from participation in federal health care programs under either section 1128 or Section 1128A of the Social Security Act.
11	**42 CFR 438.214** The MCO must comply: • With any additional requirements established by the state including ensuring providers and subcontractors perform background checks on caregivers in compliance with Wis. Admin. Code Chapter DHS 12. • With all applicable federal and state laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act of 1990, as amended.
	Confidentiality
12	**42 CFR 438.224; DHS-MCO Contract Article XIII.** The MCO must ensure that for medical records and any other health and enrollment information that identifies a particular member, use and disclosure of such individually identifiable health information must be in accordance with the privacy and confidentiality requirements in the DHS-MCO Contract Article XIII., and in 45 CFR parts 160 and 164 (subparts A and E) to the extent that these requirements are applicable.
	Subcontractor/Provider Relationships and Delegation

13	**42 CFR 438.230; DHS-MCO Contract Article VIII.**
	
	The MCO must:
	• Oversee and be accountable for any functions and responsibilities that it delegates to any subcontractor/provider;
	• Before any delegation, evaluate the prospective subcontractor/provider's ability to perform the activities to be delegated;
	• Have a written agreement that:
	  ○ Specifies the activities and report responsibilities designated to the subcontractor/provider; and
	  ○ Provides for revoking delegation or imposing other sanctions if the subcontractor/provider's performance is inadequate;
	• Monitor the subcontractor/provider's performance on an ongoing basis, identify deficiencies or areas for improvement, and take corrective action.

	Practice Guidelines
14	**42 CFR 438.236; DHS-MCO Contract Article VII.** The MCO adopts practice guidelines that meet the following requirements: • Are based on valid and reliable clinical evidence or a consensus of providers in the particular field; • Consider the needs of the MCO's members; • Are adopted in consultation with contracting health care professionals; and • Are reviewed and updated periodically as appropriate. The MCO disseminates the guidelines to all affected providers, and upon request, to members. Application of guidelines: • Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement
	• The MCO shall use practice guidelines for prevention and wellness services that include member education, motivation and counseling about long-term care and health care related services.
	Quality Assessment and Performance Improvement (QAPI) Program
15	**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; • Monitors results of care management practice related to the support provided to vulnerable high-risk members. • Conducts member satisfaction and provider surveys; • Documents incident management system activities; • Monitors appeals and grievances that were resolved; • Monitors access to providers and verifies that services were provided; • Monitors the quality of subcontractor services.
16	**42 CFR 438.240; DHS-MCO Contract Article XII.** The MCO must have in effect mechanisms to detect both underutilization and overutilization of services.
17	**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.
18	**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.
	Health Information Systems
19	**42 CFR 438.242; DHS-MCO Contract Article XII.** The MCO maintains a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments (for other than loss of Medicaid eligibility).

#	Grievance System
	Definitions and General Requirements
1	**42 CFR 438.400; 42 CFR 438.402; DHS-MCO Contract Article XI.**

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

#	Grievance System
	Handling of Grievances and Appeals
6	**42 CFR 438.406; DHS-MCO Contract Article XI.** The MCO must give members any reasonable assistance in completing forms and taking other procedural steps in the grievances and appeals process. The MCO must designate a "Member Rights Specialist" who is responsible for assisting members when they are dissatisfied. The Member Rights Specialist may not be a member of the MCO grievance and appeal committee or represent the MCO at a State Fair Hearing. The MCO must attempt to resolve issues and concerns without formal hearings or reviews whenever possible through internal review, negotiation, or mediation. The MCO must allow members to involve anyone the member chooses to assist in any part of the grievance or appeal process, including informal negotiations.

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' are offered the choice to exclude any consumer representatives from participation in their hearing.

8	**42 CFR 438.406; DHS-MCO Contract Article XI.** ***Special requirements for appeals*** The MCO processes for appeals must: • Provide that oral inquires seeking to appeal an action must be confirmed in writing, unless the member or the provider requests expedited resolution; • Give members the opportunity to present evidence, and allegations of fact or law, in person or in writing at all levels of appeal; • Give the member and his/her representative the opportunity to examine the member's case record, including medical records and other documents, before and during the appeals process; • Include the member and/or representative or the legal representative of a deceased member's estate.
	Resolution and Notification
9	**CFR 438.408; DHS-MCO Contract Article XI.** ***Basic rule*** The MCO has a system in place to dispose of each grievance and resolve each appeal as expeditiously as the member's situation and health condition requires, within established timeframes for standard and expedited dispositions of grievances and appeals. ***Extension of timeframes***

#	Grievance System
	The MCO may extend the timeframes by up to 14 calendar days if: • The member requests the extension; • The MCO shows that there is a need for additional information and how the delay is in the member's interests. ***Requirements following extension*** If the MCO extends the timeframes, it must give the member written notice of the reasons for the delay.

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

	Expedited Resolution of Appeals
11	**CFR 438.410; DHS-MCO Contract Article XI.** The MCO must establish and maintain an expedited review process for appeals, when the MCO determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function. The MCO must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. If the MCO denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the timeframe for standard resolution; • Make reasonable efforts to give the member prompt oral notice of the denial and follow up within two calendar days with a written notice.
	Information About the Grievance System to Providers
12	**CFR 438.414, DHS-MCO Contract Article XI.**

#	Grievance System
	The MCO must provide the information about the grievance system to all providers and subcontractors at the time they enter into a contract.
	Recordkeeping and Reporting Requirements
13	**CFR 438.416; DHS-MCO Contract Article XI and XII.** The MCO must maintain records of grievances and appeals and review the information as part of its Quality Management Program. The MCO shall submit a quarterly grievance and appeal report to DHS.
	Continuation of Benefits While the MCO Appeal and State Fair Hearing are Pending
14	**CFR 438.420; DHS-MCO Contract Article XI.** ***Continuation of benefits*** The MCO must continue the member's benefits if the: • Member or provider files the appeal timely; • Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; • Services were ordered by an authorized provider; • Original authorization has not expired; • Member requests the extension of benefits. ***Duration of continued benefits or reinstated benefits*** If the member requests, the MCO must continue or reinstate benefits until: • The member withdraws the appeal; • Ten days pass after the MCO mails the notice which provides the resolution of the appeal adverse to the member; • A State Fair Hearing Office issues a hearing decision adverse to the member; • The time period or service limits of a previously authorized service has been met.
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.
	Effectuation of Reversed Appeal Resolutions
16	**CFR 438.424; DHS-MCO Contract Article XI.** ***Services not furnished while the appeal is pending*** If the MCO or the State Fair Hearing Officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires. ***Services furnished while the appeal is pending*** If the MCO or the State Fair Hearing Officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCO must pay for those services.