External Quality Review

Fiscal Year 2018 – 2019

Annual Technical Report

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

Final Report

Prepared for

Wisconsin Department of Health Services

Division of Medicaid Services

Prepared by

METASTAR

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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 and managed care organizations, 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 (DHS) contracts with MetaStar, Inc.

This report covers the external quality review fiscal year from July 1, 2018, to June 30, 2019 (FY 18-19). Mandatory review activities conducted during the year included assessment of compliance with federal standards, validation of performance measures, validation of performance improvement projects, and information systems capabilities assessments. MetaStar also conducted one optional activity, care management review. Care management review assesses key areas of care management practice related to assurances found in the 1915(b) and 1915(c) Home and Community Based Services Waiver, and also supports assessment of compliance with federal standards.

Following is a brief summary of the review activities and results. A list of the specific review activities conducted for each of the managed care organizations begins on page 10. More detailed information regarding results of the various review activities, including identified progress, strengths, and opportunities for improvement, begins on page 14. See Appendix 3 for more information about external quality review and a description of the methodologies used to conduct review activities.

Quality Compliance Review

An assessment of compliance with federal standards, or a quality compliance review, is a mandatory activity, identified in 42 CFR 438.358, and is conducted according to federal protocol standards. Compliance standards are grouped into three general categories: Enrollee Rights and Protections; Quality Assessment and Performance Improvement; and Grievance Systems. The review generally follows a three-year cycle. The first year, MetaStar conducts a comprehensive review, where all standards are assessed for each organization. This is followed by two years of follow-up or targeted review. FY 18-19 was the second year of the three-year cycle; compliance standards not fully met in the prior review were reviewed for six managed care organizations.

All managed care organizations demonstrated a commitment to enrollee rights, as the majority of corresponding standards were fully met following the FY 18-19 review. Opportunities for improvement are related to policies and procedures for obtaining consent for the provision of

electronic materials to members, and ensuring the procedures and materials meet the Department of Health Services-Managed Care Organization Contract requirements.

Progress was made by all organizations for standards related to the Quality Assessment and Performance Improvement focus area. All managed care organizations demonstrated compliance with provider network adequacy and access to providers, and having mechanisms in place to assess the quality of care. Opportunities for improvement were identified in standards relating to care coordination, service planning, selection and retention of providers, participation in the organization's quality management program, and utilization.

The majority of grievance systems standards are fully compliant for all organizations, which demonstrates strong organizational structures and processes for members to exercise their rights related to grievances and appeals. Opportunity for improvement was identified in one standard related to issuing notices to members.

Validation of Performance Measures

Validation of performance measures is a mandatory review activity, required by 42 CFR 438.358, and is conducted according to federal protocol standards. The validation process assesses the accuracy of performance measures reported by the managed care organizations. The DHS contract with the managed care organizations specifies the quality indicators and standard measures organizations must calculate and report. MetaStar validated the completeness and accuracy of organizations' influenza and pneumococcal vaccination data for measurement year 2018. Technical definitions for each measure were provided by DHS.

Data for all managed care organizations were found to be compliant with the technical definitions for both the influenza and pneumococcal vaccination quality indicators. MetaStar reviewed a total of 270 member vaccination records for each quality indicator for measurement year 2018. The overall findings were not biased, meaning the rates can be accurately reported. However, one organization's results for the influenza vaccination was biased as the organization reported six members received the vaccination but the validation review discovered these members refused the vaccination.

Opportunities for improvement include ensuring organizational policies and procedures align with the DHS technical definitions for each quality indicator, implementing interventions to reduce inaccurate quality indicator submissions in the future, and ensuring documentation practices for members contraindicated from receiving influenza and pneumococcal vaccinations align with the technical definitions for each quality indicator.

Validation of Performance Improvement Projects

Validation of performance improvement projects is a mandatory review activity, required by 42 CFR 438.358, and is conducted according to federal protocol standards. The purpose of a performance improvement project is to assess and improve processes and outcomes of health care provided by the managed care organization. The validation process determines whether projects have been designed, conducted, and reported in a methodologically sound manner.

For FY 18-19, the DHS contract with the managed care organizations required all six organizations 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. MetaStar validated one or more projects for each organization, for a total of seven project validations.

All projects focused on improving key aspects of care for members, and were selected based on priorities of the managed care organizations and DHS. Documented, quantitative improvement in processes or outcomes of care was evident in two of the seven validated projects. In one of these projects, improvement was demonstrated to be the result of the interventions employed, and was sustained with repeat measures.

The reliability and validity of the projects' results are reported with an overall validation finding. Three of the projects received validation findings of fully "met," and four projects received validation findings of "partially met." Opportunities for improvement included recommendations to specify indicators that answer the project's study question, to document continuous efforts to analyze and determine the effectiveness of interventions as the project progresses, and to obtain a repeat measure for the project.

Information Systems Capabilities Assessment

An assessment of a managed care organization's information system is a part of other mandatory review activities, including validation of performance measures, and ensures organizations have the capacity to gather and report data accurately. The DHS contract with managed care organizations requires organization to maintain a health information system capable of collecting, analyzing, integrating, and reporting data. Each organization receives an information systems capabilities assessment once every three years; MetaStar conducted this review for two organizations during FY 18-19.

As a result of focusing on areas of improvement noted during the previous review in FY 15-16, both organizations fully met all requirements in all focus areas. Overall, the reviews found the managed care organizations to have the basic systems, resources, and processes in place to meet DHS requirements for oversight and management of services to members and support of quality and performance improvement initiatives.

Care Management Review

Care management review is an optional review activity that assesses key areas of care management practice related to assurances found in the 1915(b) and 1915(c) Home and Community Based Services Waiver, and helps determine an organization's level of compliance with its contract with DHS. All organizations demonstrated high levels of compliance with the areas of care management practice assessed. Opportunities for improvement were identified in standards related to comprehensive service planning, care coordination, and issuing notices to members.

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 Department of Health Services (DHS) 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, 2018, to June 30, 2019 (FY 18-19). 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 each activity 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 18-19 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

Prior to July of 2018, the FC program had been implemented in all counties in Wisconsin. The final phase of implementation included enrollment of individuals served by Tribal Health Care Agencies. Two agencies, Oneida and Menomonie, became part of LCI beginning in July of 2018.

Links to maps depicting the current FC and FCP/PACE geographic service regions (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.

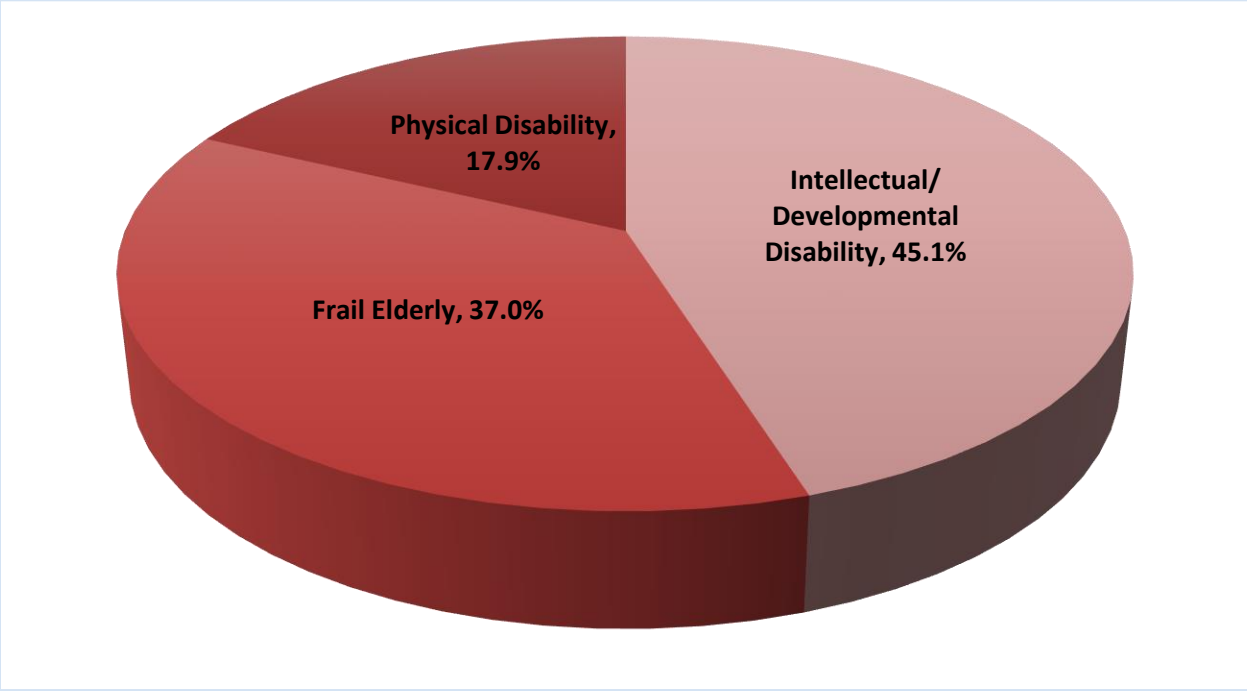
https://www.dhs.wisconsin.gov/familycare/fcp-overview.htm.

As of July 1, 2019, enrollment for all programs was approximately 53,751. This compares to last year's total enrollment of 51,453 as of April 1, 2018. 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 July 1, 2019



Scope of External Review Activities

In FY 18-19, 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 measures; and
- Validation of performance improvement projects (PIPs).

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 18-19. 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

Mandatory Review Activities	Scope of Activities
	the previous year. Each organization's results are cumulative over the three-year period. FY 18-19 was the second year of the three-year cycle. The number of standards MetaStar reviewed per organization ranged from seven to 18.
Validation of Performance Measures	Annually, MCOs must measure and report their performance using quality indicators and standard measures specified in the DHS-MCO contract. For FY 18-19, 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.
Validation of Performance Improvement Projects	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 18-19, MetaStar validated one or more PIPs for each MCO, for a total of seven PIPs. The PIP topics reviewed for each MCO are indicated in the table on page 12.
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 18-19.

Optional Review Activities	Scope of Activities
Care Management Review	MetaStar conducts CMR to assess each MCO's level of compliance with its contract with DHS in key areas of care management practice. CMR activities and findings also help support QCR, and are part of DHS' overall strategy for providing quality assurances to CMS regarding the 1915(b) and 1915 (c) Waiver, which allows the State of Wisconsin to operate its Family Care programs. During FY 18-19, the EQR team conducted CMR activities during each MCO's annual quality review (AQR), and a total of 818 records were reviewed across all three programs. At the request of DHS, MetaStar also reviewed an additional 89 member records separate from AQR. These results were reported separately and are not included in the data for this report.

PIP Topics Reviewed for each MCO

MCO	PIP Topic(s)
CW	• Dementia Care (FC/FCP)
CCI	• Dementia Care (FC) • Colorectal Cancer Screening (FCP/PACE)
Inclusa	• Choking Risk (FC)
***i*Care**	• Reduce Readmission Rate (FCP)
LCI	• Advance Care Planning (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	122
CCI	157
Inclusa	214
LCI	80
MCFC	125
Total: Family Care	**698**

MCO/Program	CMR Sample Size
Family Care Partnership/PACE	
CW	30
CCI - FCP	30
CCI - PACE	30
*i*Care	30
Total: Family Care Partnership/PACE	**120**
Total: All Programs	**818**

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 18-19 was the second year in the three-year cycle. MetaStar reviewed only those compliance standards the MCO did not fully meet during the previous year.

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) 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 bar graph for each QCR focus area.

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

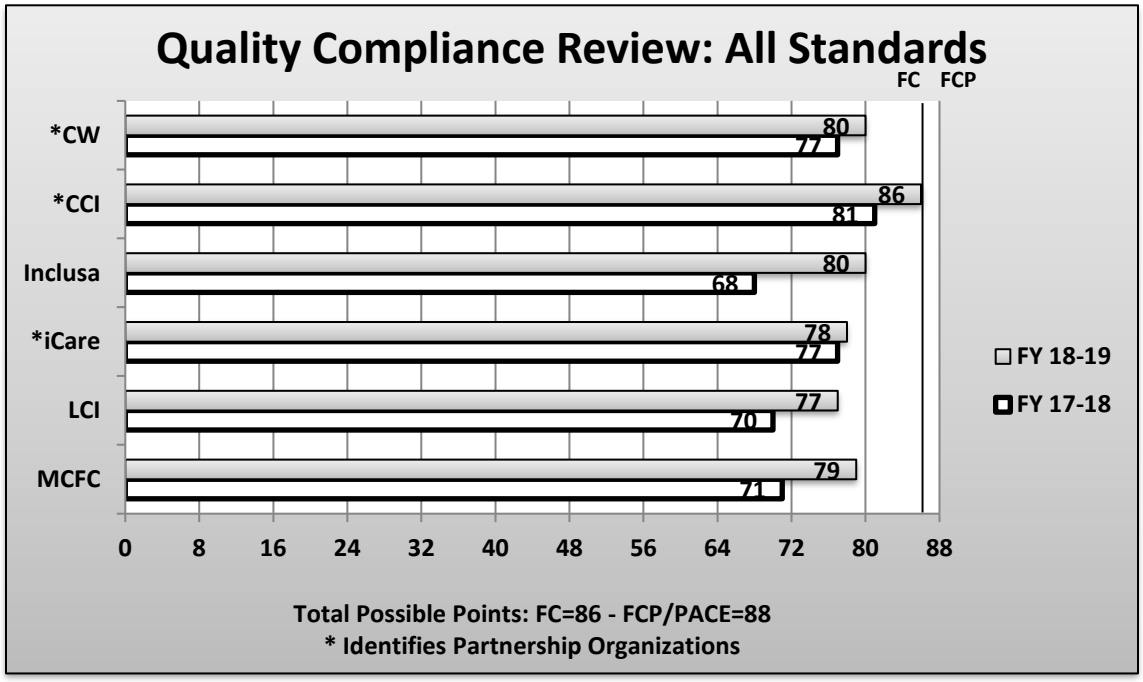
Overall QCR Results by MCO

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

The results for each organization are compared to the MCO's level of compliance in last year's review. This year's results represent the cumulative score each MCO achieved in the second year of the three-year cycle, i.e., any additional points from this year's review were added to the MCO's score from the previous year.

The results for all six MCOs ranged from 77 to 86 points, with the number of points needed for full compliance ranging from two to 10 in year two. 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. Appendix 5 details how each organization scored for each standard in FY 17-18 and FY 18-19.

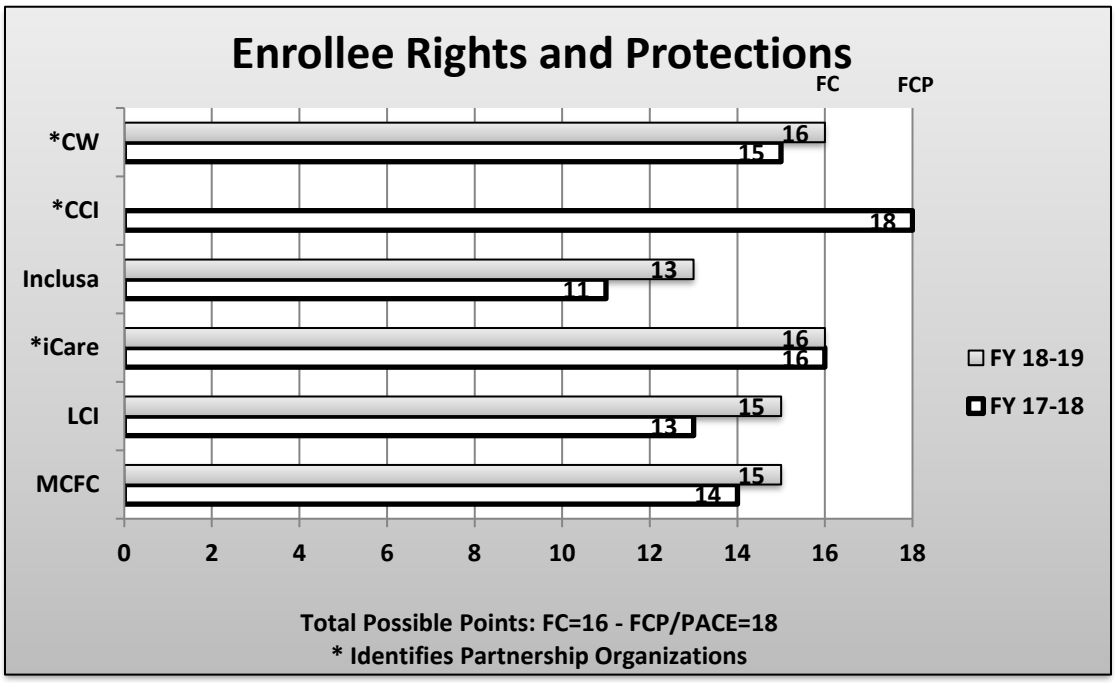
Results Enrollee Rights and Protections

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. 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.

The FY 18-19 results shown are cumulative over the current three-year cycle, i.e., any additional points from this year's review were added to the MCO's score from last year The graph also compares this year's results to the MCO's level of compliance in FY 17-18.

Bar Graph E.1



The following table, E2 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 indicate each MCO with its rating for this fiscal cycle, scored as "met" (M), "partially met" (PM), "not met" (NM), or "not applicable" (N/A). Those standards highlighted in grey were scored M in FY 17-18 and were not reviewed this cycle.

Table E.2

	MCO Comparative Findings by Standard						
		CW	CCI	Inclusa	*i*Care	LCI	MCFC
#	Standard	FY 18-19	FY 18-19	FY 18-19	FY 18-19	FY 18-19	FY 18-19
Enrollee Rights and Protections							
E1	General rule	M	M	PM	M	M	M
E2	Information requirements: language and format	PM	M	M	PM	M	PM
E3	Information requirements: general	PM	M	PM	M	M	M
E4	Provider directory	M	M	M	PM	PM	M
E5	Enrollee handbook	M	M	M	M	M	M
E6	Advance directives	M	M	PM	M	M	M
E7	Specific rights	M	M	M	M	M	M

	MCO Comparative Findings by Standard						
		CW	CCI	Inclusa	*i*Care	LCI	MCFC
#	Standard	FY 18-19	FY 18-19	FY 18-19	FY 18-19	FY 18-19	FY 18-19
Enrollee Rights and Protections							
E8	Provider-enrollee communications	M	M	M	M	M	M
E9	Emergency and post-stabilization services (FCP only)	M	M	N/A	M	N/A	N/A

ANALYSIS

Of the six organizations reviewed this year, one had previously achieved full compliance with the standards in this focus area in the prior review. A total of eight standards remained "partially met" among the other five MCOs: three of the eight standards reviewed were found to be fully met during the FY18-19 EQR. The primary reasons for standards to remain 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 reviewed for two MCOs this year; one of the organizations successfully addressed recommendations to fully implement a member rights policy and was found fully met for this standard. The other organization under review was unable to demonstrate that providers were educated on member rights and remained partially met.

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 reviewed for five of the six MCOs in FY 18-19; two of the five were found to be fully met, while the other three remain partially met. The partially met organizations did not have fully implemented policies or procedures 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 all of the organizations.

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

- Two organizations were reviewed for E3, which addresses furnishing specific types of information to members. Both remained partially met; 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 were reviewed for provider directory requirements, E4, and continued to have online or printable provider directories that included inaccuracies and/or did not meet all requirements.
- One organization was reviewed for member handbook requirements, E5, and successfully addressed recommendations from the prior review.
- The standard, E6, includes multiple requirements related to advance directives. One organization was reviewed and remained partially met, as the MCO did not have policies or procedures in place to achieve compliance.

The standard, E7, addresses specific member rights, such as the right to be treated with respect, to receive information on available treatment options, to request and receive copies of medical records, and the right to be free from any form of restrain or seclusion, was reviewed for one organization. This organization did not have fully implemented policies and procedures related to restrictive measures and the untimely submission of restrictive measures renewal applications to DHS in the prior review. The recommendations were successfully addressed and the MCO was found to be fully met.

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 reviewed for one organization; the organization successfully addressed the recommendations and was found to be fully met.

CONCLUSIONS

The progress, strengths, and opportunities noted below are based on the findings of the standards reviewed in FY 18-19, as indicated in bar graph E.1 and table E.2.

Progress

- One organization effectively addressed recommendations related to general requirements (E1).
- Two organization fully implemented and met the requirements for providing electronic materials to members (E2).
- One organization effectively addressed recommendations related to the member handbook (E5).
- One organization effectively addressed recommendations to implement policies and procedures related to restrictive measures, and ensuring applications for renewal of restrictive measures plans were timely (E7).

- One organization effectively addressed recommendations related to providers advocating or advising members (E8).

Strengths

- All organizations fully meet requirements related to:
    - Providing information in member handbooks (E5);
    - Specific rights including the right to be free from any form of restraint or seclusion (E7); and
    - Provider-enrollee communications (E8).

- Five of six organizations fully meet requirements related to:
    - The general rules of enrollee rights (E1); and
    - Advance directives (E6);

Opportunities for Improvement

- 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).

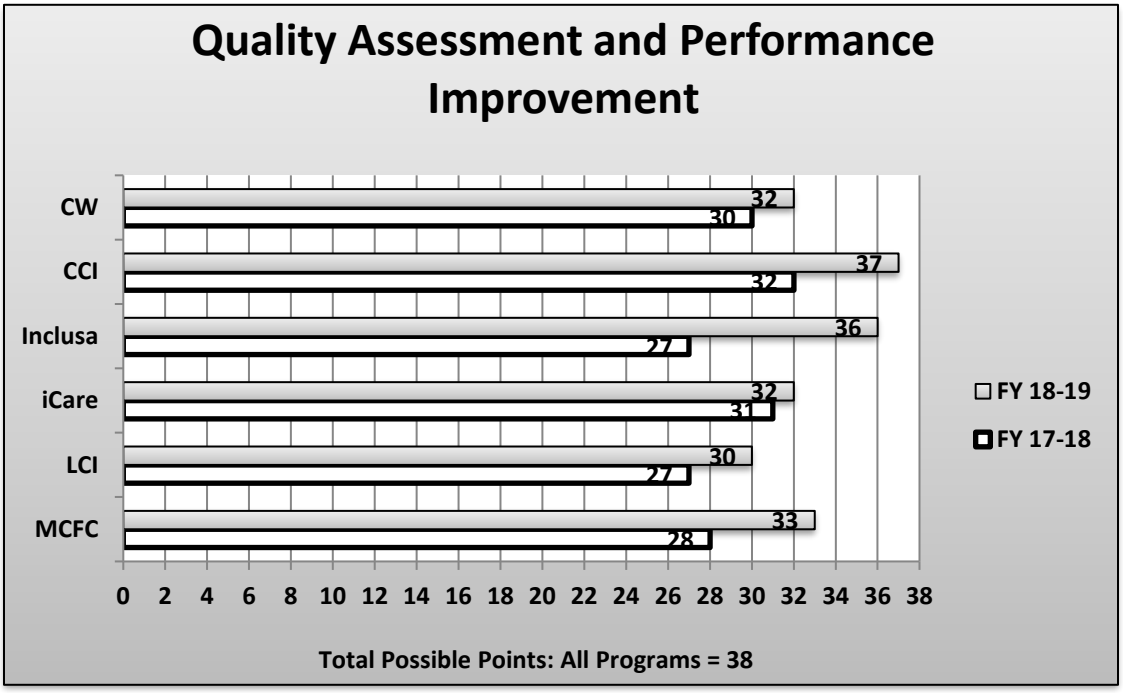
Results Quality Assessment and Performance Improvement

The standards covering this broad area of review can generally be divided into three areas: access to services and provider network; care coordination and service authorization; and quality assessment and performance improvement. The focus area consists of a total of 19 standards. A 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 remaining columns indicate each MCO with its rating for this fiscal cycle, scored as "met" (M), "partially met" (PM), "not met" (NM), or "not applicable" (N/A). Those standards highlighted in grey were scored M in FY 17-18 and were not reviewed this cycle.

Table Q.2

MCO Comparative Findings by Standard							
		CW	CCI	Inclusa	*i*Care	LCI	MCFC
#	Standard	FY 18-19	FY 18-19	FY 18-19	FY 18-19	FY 18-19	FY 18-19
Quality Assessment/Performance Improvement							
Q1	Delivery network	M	M	M	M	M	M
Q2	Second opinion and out-of-network providers	M	M	M	M	M	M
Q3	Timely access	M	M	M	M	M	M
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	M	M	PM	M	PM	PM
Q7	Authorization of services	PM	M	M	M	M	M
Q8	Timeframe for authorization decisions	M	M	M	M	M	M

MCO Comparative Findings by Standard							
		CW	CCI	Inclusa	*i*Care	LCI	MCFC
#	Standard	FY 18-19	FY 18-19	FY 18-19	FY 18-19	FY 18-19	FY 18-19
Quality Assessment/Performance Improvement							
Q9	Provider selection: credentialing and nondiscrimination	PM	M	M	PM	PM	PM
Q10	Excluded providers	M	M	M	M	PM	M
Q11	State requirements: caregiver background checks	M	M	M	PM	PM	M
Q12	Confidentiality	M	M	M	M	M	M
Q13	Subcontractual relationships and delegation	M	M	M	M	PM	M
Q14	Practice guidelines	PM	M	M	PM	M	PM
Q15	Quality assessment and performance improvement (QAPI) program	PM	M	M	PM	PM	M
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	M	M	M
Q18	Program review: evaluate QAPI program	M	M	M	M	M	M
Q19	Health information systems	M	M	M	M	M	M

ANALYSIS

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. Seven of the eight standards were reviewed in FY 18-19

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 MCOs were reviewed for this standard and all three sufficiently addressed recommendations for policy implementation and monitoring the provider network for adequacy.

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. One MCO did not

fully meet the requirements of this standard in the prior review due to the full implementation of a policy. The issue has been remediated and the MCO was found to be fully met in FY 18-19.

An additional standard related to the availability of services was reviewed; Q3, which ensures that members have timely access to care and services. Two MCOs did not show evidence of sufficient monitoring in the prior review. Both MCOs effectively addressed the recommendations and were found to be fully met in this review.

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. Two MCOs effectively addressed recommendations related to monitoring long term care providers for compliance and policy implementation, and were found fully met in FY 18-19. Two organizations identified future plans for monitoring, but at the time of review, inconsistencies with internal monitoring were identified and the changes to monitoring practices had not been fully implemented. The other two MCOs had inconsistencies with internal monitoring and policy implementation, as well as discrepancies in the understanding of the requirements. Four MCOs remain partially met for this standard.

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 MCOs were not fully met following last year's review. Of the three, two successfully addressed recommendations for monitoring and policy implementation. The third MCO did not demonstrate sufficient monitoring and remains partially met.

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. Five of the six MCOs were reviewed for these requirements in FY18-19. Three MCOs were found fully met with this standard, as they successfully addressed recommendations for implementing a documented monitoring process. Two MCOs remain partially met due to inconsistencies in policies and procedures, monitoring practices, and discrepancies in the understanding of these requirements.

Standard Q13 requires MCOs to oversee and be accountable for any functions and responsibilities that it delegates to subcontractors. Three MCOs were reviewed for these requirements. Two were found fully met after successfully addressing recommendations from the prior review, related to monitoring practices. One MCO remains partially met for discrepancies with provider contracts, which outline the delegated responsibilities for the providers.

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. Four of the six standards were reviewed in FY 18-19.

MCOs are required to have procedures in place to coordinate services, or a person/entity designated to be 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 in the prior view, primarily due to a lack of documented follow up by the care teams to ensure covered and non-covered services were received and effective. For this year's review, all MCOs continued to focus 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's practice for involving the interdisciplinary team (IDT) staff in coordination of long-term care services consistently had not been remediated. All MCOs remain partially met for this standard.

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. Five of six MCOs were reviewed for this standard in FY 18-19. 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 two organizations showed improvements that were likely the results of the actions taken by the organization; these MCOs were found to be fully met. Care management review results and MCO internal monitoring results for the other three MCOs indicated a need for continued improvement efforts; these MCOs remain partially met.

Standard Q7 requires MCOs to have written policies and procedures to process requests for initial and continued authorizations of services. One MCO was reviewed this year; the MCO did not effectively address recommendations to ensure IDT staff are consistently involved in service authorization decisions and will remain partially met. Additionally, decisions have to be made within specified timeframes and as expeditiously as the member's health condition requires, as required under standard Q8. One MCO was reviewed for these requirements and the care management review results and internal monitoring results showed improving trends. The MCO was found fully met for Q8; all MCOs are fully met for this standard.

MCOs are required to adopt, disseminate, and apply practice guidelines, Q14. Four MCOs partially met the standard in FY 17-18. One organization was not fully met as a result of a policy not fully implemented; this was remediated in this review and the MCO is now fully met. The other three organizations did not effectively address recommendations from the prior review: 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. The other organization did not demonstrate effective practices for disseminating the guidelines to affected providers. Three MCOs remain partially met.

Quality Assessment and Performance Improvement

Five standards address requirements that MCOs have in place a Quality Assessment and Performance Improvement (QAPI) program, and that they maintain a health information system that collects, analyzes, and reports data. Three of the five standards were reviewed in FY 18-19.

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 (Q15). All six MCOs were partially met in the prior review. In the FY 18-19 review, three of the six MCOs had successfully addressed the recommendations and were found fully met. The remaining three MCOs were found to be partially met, as they did not have adequate mechanisms in place for members and/or providers to actively participate in the QAPI program. In addition, one of the three partially met organizations did not show effective monitoring of the accuracy of functional screens, and another did not provide evidence of conducting provider surveys.

MCOs must have mechanisms in effect to detect underutilization and overutilization of services (Q16). Four of six organizations were reviewed for this standard. The documentation submitted 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, or not yet fully implemented, in these organizations; these organizations remain partially met.

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. Two MCOs were reviewed for this requirement in FY 18-19. Both MCOs had successfully addressed the recommendations related to sampling and written guidance for conducting audits. The organizations were found to be fully met.

CONCLUSIONS

The progress, strengths, and opportunities noted below are based on the findings of the standards evaluated in FY 18-19, as indicated in bar graph Q.1 and table Q.2, above:

Progress

- Four organizations successfully addressed recommendations for three standards related to provider network access (Q1, Q2, Q3).
- Four organizations successfully addressed recommendations for three standards related to provider selection (Q9, Q10, Q11).
- Two organizations effectively implemented monitoring requirements related to sub-contractual relationships (Q13).
- Two organizations demonstrated improvements for one standard related to assessments and service plans (Q6).
- One organization demonstrated improvements related to timely service authorizations (Q8).
- One organization effectively addressed recommendations related to practice guidelines (Q14).
- Five organizations effectively addressed recommendations for two standards related to quality assessment and performance improvement (Q15, Q17).

Strengths

- At least five of six organizations fully met provider network requirements related to:
    - Network adequacy (Q1);
    - Out of network providers (Q2);
    - Timely access to services (Q3);
    - Debarment and exclusion (Q10); and
    - Provider delegations and responsibilities (Q13).
- All MCOs fully met requirements for timely service authorizations (Q8).
- All MCOs have mechanisms to assess the quality of care (Q17).

Opportunities for Improvement

- 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);

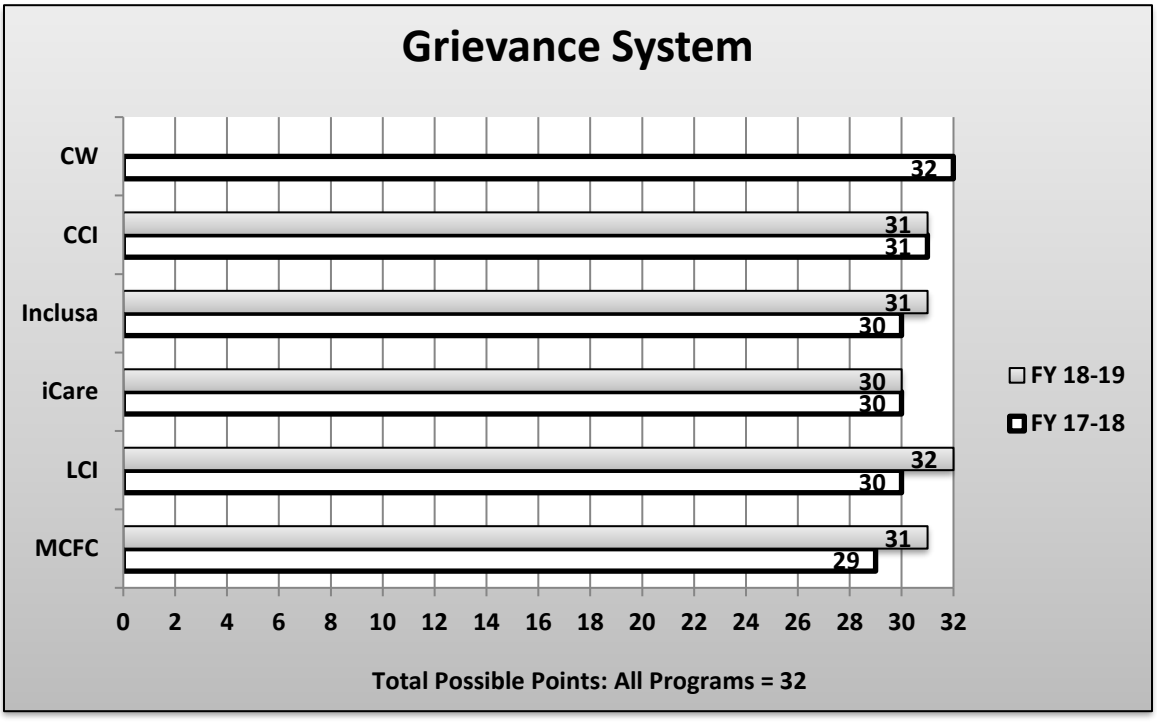
- Document a process for retention and re-credentialing of providers and ensure monitoring of the process is sufficient for compliance. Focus efforts on ensuring MCOs understand the pertinent regulations (Q9);
- Implement effective practices to review and update practice guidelines periodically as appropriate (Q14);
- Ensure QAPI programs include opportunities for member and provider participation (Q15); and
- Implement utilization management processes that focus on monitoring and analysis to detect both overutilization and underutilization of services (Q16).

Results Grievance Systems

This area of review consists of sixteen standards applicable to all organizations. The standards comprising this area of review address requirements that MCOs maintain an effective system for members to exercise their rights related to grievances and appeals. 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 remaining columns indicate each MCO with its rating for this fiscal cycle, scored as "met" (M), "partially met" (PM), "not met" (NM), or "not applicable" (N/A). Those standards highlighted in grey were scored M in FY 17-18 and were not reviewed this cycle.

Table G.2

MCO Comparative Findings by Standard							
		CW	CCI	Inclusa	*i*Care	LCI	MCFC
#	Standard	FY 18-19	FY 18-19	FY 18-19	FY 18-19	FY 18-19	FY 18-19
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	M	M
G5	NOA: timing of notice	M	PM	PM	PM	M	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	M
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	M	M	M	M
G13	Record keeping and reporting	M	M	M	M	M	M
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

Of the six organizations reviewed this year, one had previously achieved full compliance with the standards in this focus area in the prior review. A total of six standards remained "partially met" among the other five MCOs: four of the six MCOs were found to be fully met during the FY 18-19 EQR.

All six MCOs demonstrated compliance with general requirements in FY 17-18 review. The requirements remaining not fully met that were reviewed in FY 18-19 are related to the handling of the member appeal and grievances, including monitoring and reporting requirements.

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 (G4). One organization was not fully met in the prior review due to a *Notice of Non-Covered Benefit* letter template not aligning with the DHS template; this issue has been successfully addressed and the organization is fully met.
- 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 was fully met for this standard in FY 17-18 and five MCOs were reviewed. In FY 18-19 one organization effectively addressed recommendations and was fully met in this review. The other five 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 and remain partially met.

Organizations must have processes in place regarding the individuals making decisions on grievances and appeals, and ensure privacy and confidentiality are respected (G7). Five of six organizations were fully met in FY 17-18. The MCO evaluated in this review effectively addressed the recommendations related to requirements of the local committee composition and is now fully met.

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). One MCO was evaluated in this review. The grievance and appeal verification activity identified several records that did not meet the standard or extended resolution timeframes for issuing a written decision; therefore the MCO remains partially met for this standard.

Organizations are required to provide information about the member grievance system to all providers at the time they enter into a contract with the MCO (G12). One organization did not meet this requirement during last year's review. The organization effectively addressed recommendations and is now fully met.

MCOs are required to maintain records of grievances and appeals and review the information as part of the Quality Management Program (G13). Five of six MCOs fully met this standard in FY-18. 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. The MCO took actions to address this issue and the standard is now fully met.

CONCLUSIONS

The progress, strengths, and opportunities noted below are based on the findings of those standards reviewed in FY 18-19, as indicated in bar graph G.1 and table G.2, above:

Progress

- One organization effectively addressed two standards related to notices for members (G4, G5).
- One organization effectively addressed recommendations related to the local committee composition (G7).
- One organization effectively addressed recommendations related to provider information (G12).
- One organization effectively addressed recommendations related to reporting requirements (G13).

Strengths

- All six organizations fully met requirements related to:
    - Notice of action format and content (G4);
    - Local committee handling of grievances and appeals (G7);
    - Information to providers (G12); and
    - Record keeping and reporting (G13).
- Five of six organizations meet requirements for resolution timeframes (G9).

Opportunities for Improvement

- Focus efforts on monitoring and improving the results of issuing notices in a timely manner when indicated (G5).

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 definitions 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) 2018, which are set forth in Addendum IV of the 2018 DHS-MCO contract, 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 2018. The MY for the Influenza vaccination covers July 1, 2018 – March 31, 2019. The MY for the pneumococcal vaccination covers July 1, 2018 – December 31, 2018. The technical definitions provided by DHS for the MY influenza and pneumococcal vaccination quality indicators also includes each definition of the MY. The technical definitions are found in Attachments 1 and 2. The review methodology MetaStar used to validate these performance measures is 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.

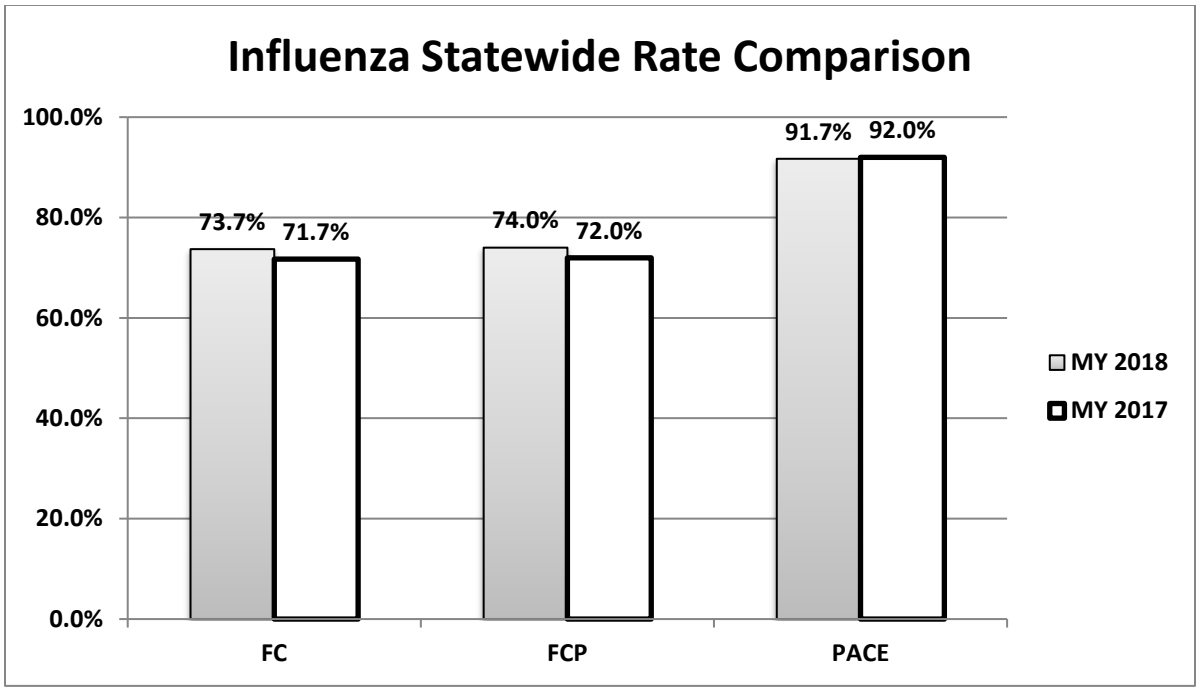
Influenza Vaccination Rates

The following table shows information about the influenza vaccination rates by program for MY 2018 and compares the MY 2018 rates to vaccination rates in MY 2017, which:

- Increased by 2.0 percentage points for FC members;
- Increased by 2.0 percentage points for FCP members; and
- Decreased by 0.3 percentage points for PACE members.

Statewide Influenza Vaccination Rates by Program				
	MY 2018			MY 2017
Program	Eligible Members	Number Vaccinated	Vaccination Rate	Vaccination Rate
Family Care	42,112	31,024	73.7%	71.7%
Family Care Partnership	2,856	2,114	74.0%	72.0%
PACE	484	444	91.7%	92.0%

Influenza vaccination statewide rates, by program, for MY 2018 and MY 2017 are shown in the following graph.



As shown in the table below, among MCOs that operate FC, the MY 2018 influenza vaccination rates ranged from 71.8 percent to 75.3 percent. Among MCOs that operate FCP, the MY 2018 rates ranged from 69.3 percent to 81.2 percent. The MY 2018 rate for the one MCO that operates the PACE program was 91.7 percent.

Influenza Vaccination Rates by Program and MCO in MY 2018 and MY 2017			
Program/MCO	**MY 2018 Rate**	**MY 2017 Rate**	**Percentage Point Change**
Family Care			
CCI	73.1%	70.2%	2.9%
CW	73.3%	74.0%	(0.7%)
Inclusa	74.8%	71.3%	3.5%
LCI	75.3%	76.1%	(0.8%)
MCFC	71.8%	69.9%	1.9%
Family Care Partnership			
CCI	81.2%	84.1%	(2.9%)
CW	74.1%	71.0%	3.1%
*i*Care	69.3%	65.5%	3.8%
PACE			
CCI	91.7%	92.0%	(0.3%)

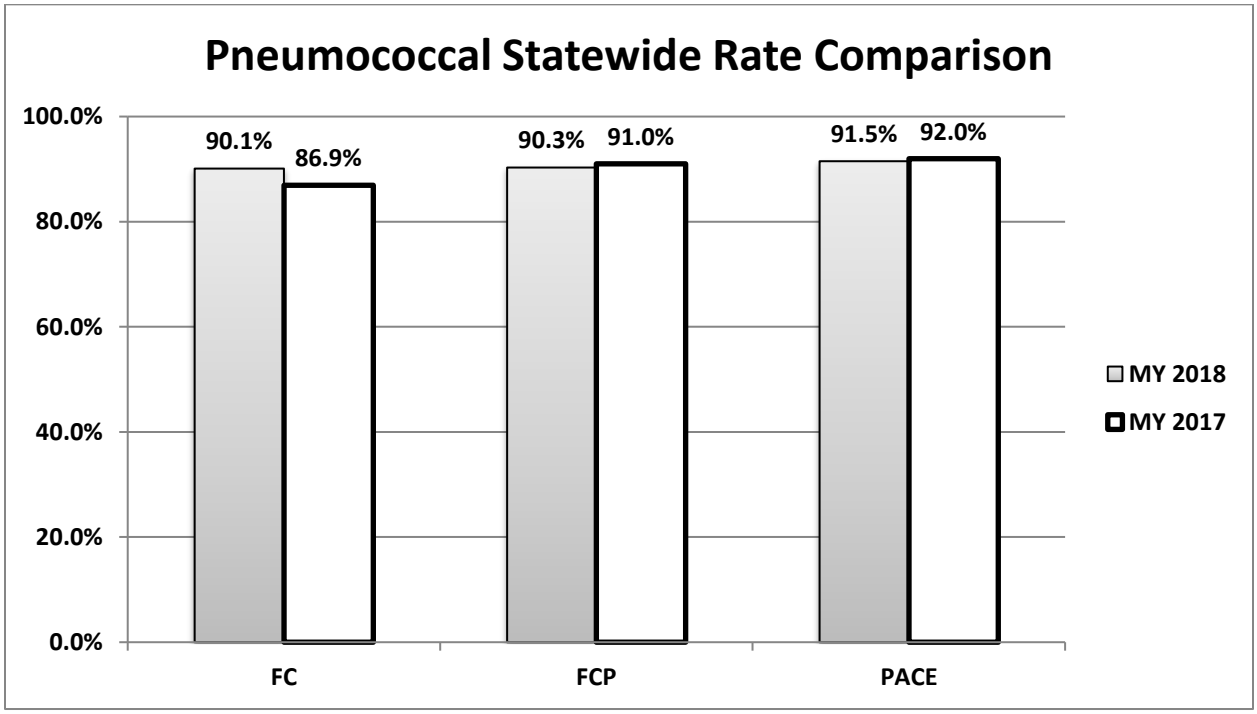
Pneumococcal Vaccination Rates

The table below shows information about the pneumococcal vaccination rates by program for MY 2018 and compares the MY 2018 rates to vaccination rates in MY 2017, which:

- Increased by 3.2 percentage points for FC members;
- Decreased by 0.7 percentage points for FCP members; and
- Decreased by 0.5 percentage points for PACE members.

Statewide Pneumococcal Vaccination Rates by Program				
	MY 2018			MY 2017
Program	Eligible Members	Number Vaccinated	Vaccination Rate	Vaccination Rate
Family Care	18,742	16,891	90.1%	86.9%
Family Care Partnership	1,402	1,266	90.3%	91.0%
PACE	459	420	91.5%	92.0%

Pneumococcal vaccination statewide rates, by program, for MY 2018 and MY 2017 are shown in the following graph.



As shown in the table below, among MCOs that operate FC, the MY 2018 pneumococcal vaccination rates ranged from 88.0 percent to 94.1 percent. Among MCOs that operate FCP, the MY 2018 rates ranged from 82.7 percent to 93.3 percent. The MY 2018 rate for the one MCO that operates PACE was 91.5 percent.

Pneumococcal Vaccination Rates by Program and MCO in MY 2018 and MY 2017			
Program/MCO	**MY 2018 Rate**	**MY 2017 Rate**	**Percentage Point Change**
Family Care			
CCI	89.9%	87.0%	2.9%
CW	89.1%	88.7%	0.4%
Inclusa	88.0%	83.5%	4.5%
LCI	94.1%	87.8%	6.3%
MCFC	91.9%	90.0%	1.9%
Family Care Partnership			
CCI	82.7%	82.8%	(0.1%)
CW	93.3%	95.2%	(1.9%)
*i*Care	86.8%	86.5%	1.3%
PACE			
CCI	91.5%	92.0%	(0.5%)

Results of Performance Measures Validation

Technical Definitions Compliance

For each quality indicator, MetaStar reviewed the vaccination data submitted by each MCO for compliance with the technical definitions established by DHS. For both quality indicators, data for all MCOs were found to be compliant with the technical definitions. All members who received the influenza vaccine did so between July 1, 2018 and March 31, 2019. All eligible members who received the pneumococcal vaccination were 65 years of age or older on July 1, 2018.

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. All discrepancies identified are compiled into lists and provided to each MCO for further investigation into the cause.

For all MCOs and quality indicators, more than 99.8% percent of the total number of unique members included in the MCOs' and DHS' denominator files were common to both data sets. One organization submitted data for the pneumococcal vaccination in which almost 60 percent of the 25 members on the discrepancy list were under the age of 65 as of July 1, 2018.

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 2018. 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.

Vaccination Record Validation Aggregate Results

As shown in the following tables, MetaStar reviewed a total of 270 member vaccination records for each quality indicator for MY 2018 and MY 2017. The overall findings for both years were not biased, meaning the rates can be accurately reported.

MY 2018 Influenza and Pneumococcal Vaccination Record Validation				
Quality Indicator	**Total Records Reviewed**	**Number Valid**	**Percentage Valid**	**T-Test Result**
Influenza Vaccinations	270	262	97.0%	Unbiased
Pneumococcal Vaccinations	270	270	100%	Unbiased

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

Vaccination Record Validation Individual MCO Results

The following tables provide information about the validation findings for each MCO in MY 2018. The findings were biased for the MCFC 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 2018 Influenza Vaccination Record Validation by Program and MCO				
MCO	**Total Records Reviewed**	**Number Valid**	**Percentage Valid**	**T-Test Result**
Family Care				
CCI	30	30	100.0%	Unbiased
CW	30	30	100.0%	Unbiased
Inclusa	30	30	100.0%	Unbiased
LCI	30	30	100.0%	Unbiased
MCFC	30	23	76.7%	Biased

MY 2018 Influenza Vaccination Record Validation by Program and MCO				
MCO	**Total Records Reviewed**	**Number Valid**	**Percentage Valid**	**T-Test Result**
Family Care Partnership				
CCI	30	30	100.0%	Unbiased
CW	30	30	100.0%	Unbiased
*i*Care	30	29	96.7%	Unbiased
PACE				
CCI	30	30	100.0%	Unbiased

Results for Pneumococcal Vaccination

MY 2018 Pneumococcal Vaccination Record Validation by Program and MCO				
MCO	**Total Records Reviewed**	**Number Valid**	**Percentage Valid**	**T-Test Result**
Family Care				
CCI	30	30	100.0%	Unbiased
CW	30	30	100.0%	Unbiased
Inclusa	30	30	100.0%	Unbiased
LCI	30	30	100.0%	Unbiased
MCFC	30	30	100.0%	Unbiased
Family Care Partnership				
CCI	30	30	100.0%	Unbiased
CW	30	30	100.0%	Unbiased
*i*Care	30	30	100.0%	Unbiased
PACE				
CCI	30	30	100.0%	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 definitions 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 seven of the member records reviewed for evidence of the influenza vaccination being provided to the member during the measurement year, documentation for six members identified the member refused the vaccination, and documentation for one member reflected the member reported receiving the

vaccination in calendar year 2018 but did not specify a date. In addition, documentation for one of the contraindications for the influenza vaccination noted the member had an egg allergy. According to DHS technical definitions, egg allergies are no longer acceptable as a contraindication; persons with a history of egg allergy of any severity may receive any licensed, recommended, and age appropriate influenza vaccine and the member is to be included in the denominator.

Clear expectations and standardized tools have improved the performance measure reporting and validation processes, with validation rates from MY 2017 to MY 2018 improving for both the influenza and pneumococcal vaccines, with the pneumococcal vaccine validation rate at 100 percent for MY 2018.

CONCLUSIONS

- MCOs should ensure that their respective policies and procedures include all required information regarding contraindications as outlined in the DHS' technical definitions.
- Ensure documentation practices for members contraindicated from receiving influenza and pneumococcal vaccinations meet DHS technical definitions.
- Three MCOs reported members assigned to the Physical Disability target group and one MCO did not report any members assigned to the Intellectual/Developmental Disability target group for the pneumococcal vaccination, which does not align with DHS technical definitions. The MCOs should conduct a root cause analysis and implement interventions to assure compliance with target group assignment.
- To ensure the vaccination data collected and reported by one MCO is comparable to DHS data for the pneumococcal vaccination, the organization should update the programming code used to extract data for reporting based on the target population age of all members age 65 and older as of July 1 of the measurement year.
- To provide assurance that the influenza vaccination data reported one MCO is accurate and free of errors, the organization should implement interventions to reduce inaccurate submissions in the future.

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 18-19, 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 required by 42 CFR 438.358 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 2018, organizations submitted proposals to DHS in January 2018. DHS directed MCOs to submit final reports by December 31, 2018. MetaStar validated one or more PIPs for each organization, for a total of seven 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 18-19 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.	6/7
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.	6/7
Study Indicator(s)		
3	The study used objective, clearly and unambiguously defined, measureable indicators and included defined numerators and denominators.	6/7
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.	6/7
Study Population		
5	The project/study clearly defined the relevant population (all members to whom the study question and indicators apply).	5/7
6	If the entire population was used, data collection approach captured all members to whom the study question applied.	5/6
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.	7/7
10	Staff are qualified and trained to collect data.	7/7
11	The instruments for data collection provided for consistent, accurate data collection over the time periods studied.	7/7
12	The study design prospectively specified a data analysis plan.	7/7
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.	4/7
14	A continuous cycle of improvement was utilized to measure and analyze performance, and to develop and implement system-wide improvements.	5/7
15	Interventions were culturally and linguistically appropriate.	3/3
Data Analysis and Interpretation of Study Results		
16	Analysis of the findings was performed according to the data analysis plan, and included initial and repeat measures, and identification of project/study limitations.	5/7
17	Numerical results and findings were presented accurately and clearly.	5/7
18	The analysis of study data included an interpretation of the extent to which the PIP was successful and defined follow-up activities as a result.	4/7
"Real" Improvement		
19	The same methodology as the baseline measurement was used, when measurement was repeated.	6/7
20	There was a documented, quantitative improvement in processes or outcomes of care.	2/7

FY 18-19 Performance Improvement Project Validation Results		
	Numerator = Number of projects meeting the standard Denominator = Number of projects applicable for the standard	
21	The reported improvement appeared to be the result of the planned quality improvement intervention.	1/4
Sustained Improvement		
22	Sustained improvement was demonstrated through repeated measurements over comparable time periods.	1/1

PROJECT INTERVENTIONS AND OUTCOMES

The following table is organized by topic and lists each project, the interventions selected the project outcomes at the time of the validation, and EQR recommendations. 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..

MCO	Interventions	Outcomes	Validation Result	EQR Recommendations
Dementia Care				
CW	Educated care managers using a dementia e-learning tool and surveyed staff about the results.	The project reached the goal for the first indicator: 96.85% of staff reached the completion rate of the education tool for dementia e-learning. The second indicator of addressing members' living situations did not show improvement.	Partially Met	Include organizational data when describing study topic. Insure both study questions are clearly stated. Describe how interventions were selected to address root causes or barriers identified in the study topic. Develop and implement interventions which are sufficient to be expected to improve outcomes. Take study limitations into consideration in analysis. Include sufficient data to demonstrate effectiveness of the intervention.
Dementia Care				
CCI-FC	Implemented the use of the Virtual Dementia Tour training for care management staff in the test region. Conducted the pre- and post-training surveys to validate training impact.	The project demonstrated "real" improvement: increased the rate of dementia screening in the test region from 30% in 2017 to 36% in 2018. Also, the project demonstrated sustained improvement with repeat measures.	Met	Select new interventions each year for a continuing project. Describe how interventions were selected.

MCO	Interventions	Outcomes	Validation Result	EQR Recommendations
Colorectal Screening				
CCI-FCP	Provided colorectal cancer screening educational brochure to members or legal decision makers. Offered members or legal decision makers additional care coordination to assist in completing a colorectal cancer screening test.	Project demonstrated "real" improvement: increased the rate of colorectal cancer screenings from 55.6% to 63.3% in 2018.	Met	Describe how interventions were selected.
Choking Risk				
Inclusa	Developed and implemented a tool to evaluate the comprehensiveness of member care plans related to choking risk reduction. Created and offered an evidence-based training program for direct care and kitchen staff of residential providers.	Project did not demonstrate improvement.	Partially Met	Ensure a repeat measure is obtained. Fully analyze data to demonstrate confidence in the results.
Reduce Readmission Rate				
*i*Care	Implemented a revised procedure related to transitions of care. Included an acuity assessment and contact expectations as part of the procedure.	Project did not demonstrate improvement.	Partially Met	Clearly and unambiguously define the indicators. Develop and implement interventions which are sufficient to be expected to improve outcomes. Conduct continuous cycles of improvement if interventions are not effective. Clearly and accurately present numerical results.

MCO	Interventions	Outcomes	Validation Result	EQR Recommendations
Advance Care Planning				
LCI	Mailed educational materials to members about the importance of advance directives, the different types of advance directives, and how to obtain the forms. Educated interdisciplinary team (IDT) staff about Power of Attorney for Health Care (POA-HC) and how to facilitate discussions with staff. Conducted face-to-face meetings with members to discuss advance directives and how to complete the POA-HC. Followed up with members within 30 days of the face-to-face meeting to determine if the form had been completed or if assistance was needed.	Project did not demonstrate improvement.	Partially Met	Specify indicators that answer the study question. Define the study population consistently throughout the project. Document a data collection approach that captures all members of the population. Ensure initial and repeat measures are comparable.

MCO	Interventions	Outcomes	Validation Result	EQR Recommendations
Self-Directed Supports				
MCFC	Developed and disseminated educational materials to members and staff regarding the use of self-directed supports (SDS). Updated the SDS training process and retrained all IDT staff. Developed a falls prevention toolkit for IDT staff. Conducted face-to-face member visits to provide education to those using SDS with a fiscal agent who previously experienced a fall, and to develop a falls prevention plan. Deployed a SDS fiscal agent survey to members.	Project demonstrated "real" improvement for two of the three study questions: - Increased the percentage of members self-directing at least one service from 16.79% in 2017 to 17.89% in 2018. - Increased the percentage of members self-directing at least one service through a fiscal agent from 5.24% in 2017 to 6.43% in 2018. The project did not demonstrate quantitative improvement related to the mean falls rate for members self-directing at least one service through a fiscal agent.	Met	Ensure the study population is accurately defined. Continue to sustain the level of improvement that has been demonstrated.

ANALYSIS

All MCOs obtained approvals to conduct the required number of PIPs during calendar year 2018. Projects focused on a variety of topics, with two projects continuing from the prior year, and five 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 two of the seven projects focused on this topic. One of the two dementia projects achieved documented, quantitative improvement which appeared to be the result of the interventions employed, and this project met nearly all applicable validation standards.

For the MCOs with continuing PIPs, one of the two projects achieved documented, quantitative improvement, and the reported improvement appeared to be the result of the planned quality improvement intervention. The other MCO with the continuing PIP added a third study question to the project; the third study question was in the first year of re-measurement. Documented, quantitative improvement was demonstrated for the two continuing study questions and study aims, and the improvement appeared to be the result of the planned interventions. However, since the project did not demonstrate quantitative improvement for all three study questions, sustained improvement could not be assessed.

CONCLUSIONS

Documented, quantitative improvement in processes or outcomes of care was evident in two of the seven validated projects. In one of these projects, improvement was demonstrated to be the result of the interventions employed. Based on validation results, one of seven projects achieved documented, quantitative improvement that was sustained with repeat measures.

The overall validation findings provide an indication of the reliability and validity of the projects' results. Three of the projects received validation findings of fully "met," and four projects received validation findings of "partially met."

A summary of strengths and opportunities for improvement is identified below.

Strengths

- The projects focused on improving key aspects of care.
- The study question was clearly defined.
- Selection of the study topic considered MCO and DHS priorities.
- Organizations took a thoughtful approach to determining the study population.
- Data sources were clearly identified and the data collection approach was consistent.
- A knowledgeable qualified team was selected to conduct the project.
- The project team regularly collected monitoring data.

Opportunities for Improvement

- Specify indicators that answer the study question.
- Document continuous improvement efforts to analyze and determine the effectiveness of interventions as the project progresses.
- Describe how interventions were selected.
- Ensure new interventions are selected for the second year of a multi-year project.
- Obtain a repeat measure for the project.
- Take study limitations into consideration during analysis.

Information Systems Capabilities Assessment

The information systems capabilities assessment (ISCA) is a required part of other mandatory EQR protocols, such as compliance with standards and validation of performance measures, 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 18-19, MetaStar conducted ISCAs for two MCOs selected by DHS; one organization operates only a FC program, while the other operates the FC and FCP programs.

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

Summary 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 produces its encounter files internally, using structured query language (SQL) to query the data warehouse claims data. The other MCO utilizes a DHS approved third party administrator (TPA) to process claims and encounter data for state reporting. The organization compares the claims paid total from the TPA to what is recorded as paid in its electronic care management system to ensure the accuracy of claims paid. 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

Each MCO met all requirements in this area, and described the processes and systems in place to collect, manage, and retain data related to services provided. The organization that utilizes a TPA continues to work closely with the contractor and employs formal and informal communication systems to address all claims issues promptly. The other MCO could continue to improve its rate of auto-adjudicated claims, reported at 17 percent when the review was conducted.

Section IV: Eligibility and Enrollment Data Processing

Both MCOs demonstrated compliance with all requirements in this area. Systems and processes are in place at each organization to accurately collect, manage, and retain the eligibility, enrollment, and disenrollment data. Electronic care management systems hold all member data and allow for multiple enrollment segments per member. Member enrollment and disenrollment information is updated daily and reconciled using *ForwardHealth interchange* and the *Long-Term Care Functional Screen* to ensure accuracy. Discrepancies are researched and resolved with Income Maintenance or the Aging and Disability Resource Centers.

Section V: Practitioner Data Processing

Both organizations met all requirements in this area. One MCO delegates most credentialing to outside organizations, internally credentialing only facility-based providers. Both organizations enter provider information into their respective electronic care management system, and providers at the MCOs have read-only access to view authorizations and claims information. Changes to provider information are managed by staff in the MCO's provider services department.

Section VI: System Security

Both MCOs demonstrated compliance with all requirements in this area. All information access is role-based at each organization. Access levels are granted as requested by the human resources departments, and new employees receive security and privacy training within one week of employment at one organization and within 60 days of employment at the other organization. Disaster recovery systems were in place and tested routinely by each organization.

Section VII: Vendor Oversight

The two organizations met all requirements in this section. All contracted vendors are experienced and understand the requirements necessary for MCO compliance. Regular meetings occur between each organization and the vendors, with additional informal contacts occurring as

circumstances necessitate. Each vendor contract/agreement includes specific performance and quality standards, which each MCO monitors regularly.

Section VIII: Medical Record Data Collection

This section does not apply as neither organization collects medical record information for its encounter reporting processes.

Section IX: Business Intelligence

Both MCOs demonstrated compliance with all requirements in this area. Each organization utilized 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

Each MCO demonstrated compliance with all requirements in this area. Both organizations produced yearly performance reports for the required performance measures: influenza and pneumococcal vaccinations. Both MCOs gather immunization data from the Wisconsin Immunization Registry and their electronic care management systems. Processes are in place at both organizations to extract, manipulate, and validate data from the data sets prior to submission to DHS.

CONCLUSIONS

Both organizations 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

Each MCO made the following progress in response to MetaStar's recommendations from the previous ISCA reviews conducted in FY 15-16, and the changes implemented resulted in both organizations' full compliance with this current ISCA review requirements:

- One organization addressed all recommendations from its previous ISCA review.
- The other organization addressed many of the recommendations made during the previous ISCA review by updating its policies, procedures, and practices in an effort to:
    - Increase vendor oversight;
    - Strengthen information technology security; and
    - Increase consistency in claims processing and encounter data submission.

Strengths

The FY 18-19 ISCA reviews found the MCOs exhibited strengths in the following areas:

- One organization developed systems and measures to assess provider information accuracy and completeness via geocoding.
- One organization has meticulous procedures in place to ensure proper integration of data from multiple sources and processes.
- This same organization added provider data fields in its electronic provider management system to streamline processing and enhance member access to additional provider information.
- One MCO completes encounter file validation checks in addition to the validation performed by the TPA, which minimizes data submission errors.

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 continue to implement formalized auditing processes to ensure the accuracy of provider data entered into its electronic system.
- The other MCO should continue efforts to improve its auto-adjudication rate, which is lower than other MCOs.

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

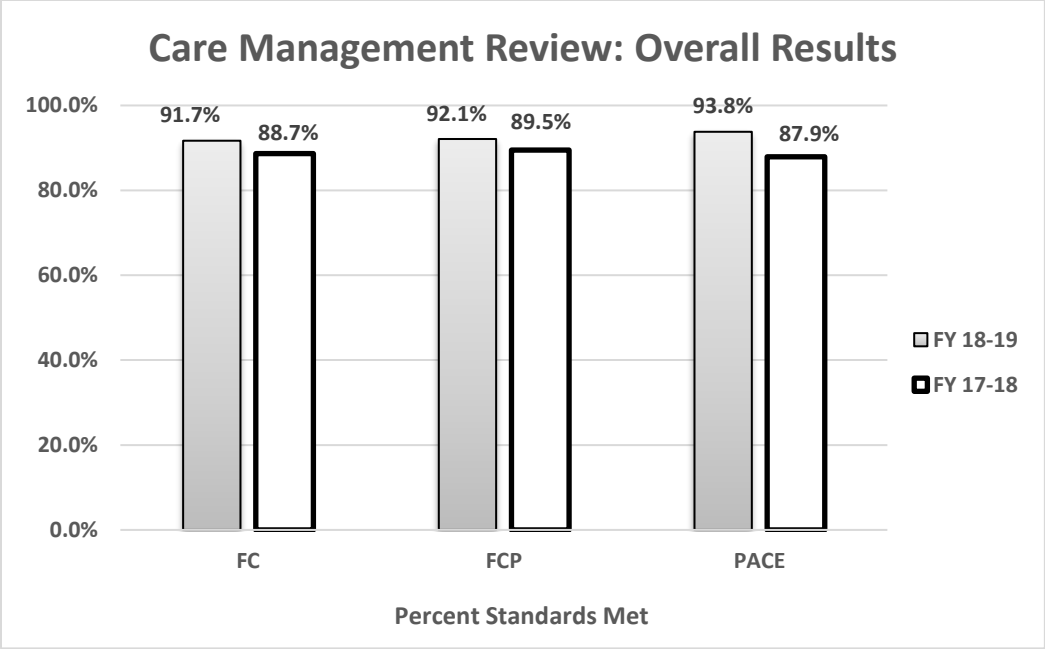
The four categories include a total of 14 review indicators. More information about the CMR review methodology can be found in Appendix 3.

Aggregate results for FY 18-19 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 18-19 review year for organizations operating programs for FC, FCP, and PACE. FY 17-18 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.



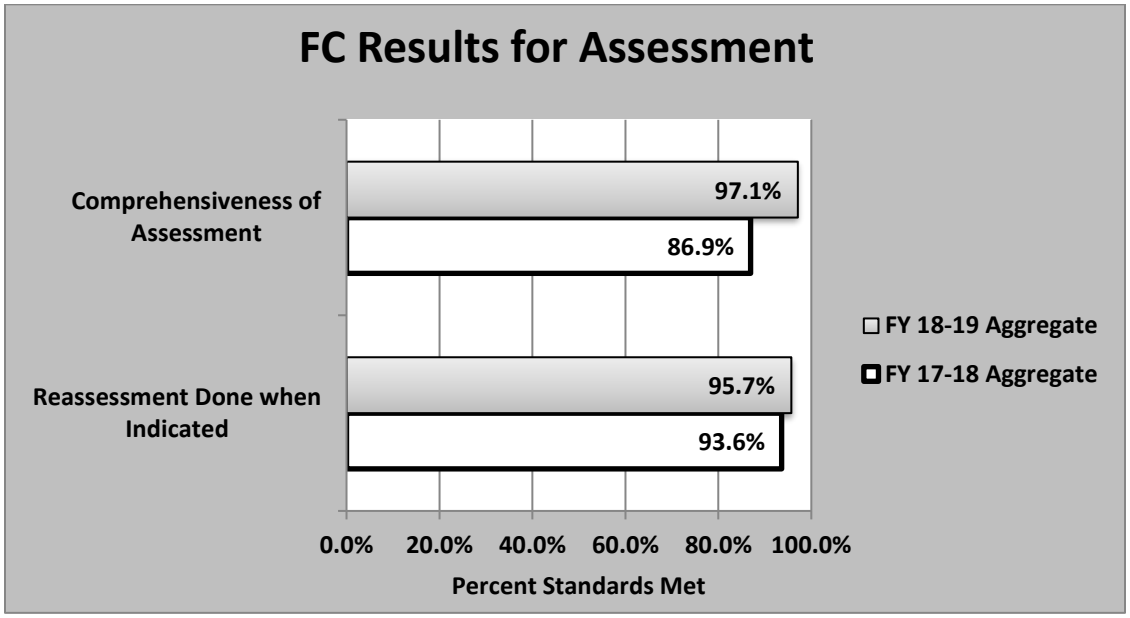
Results for each CMR Focus Area

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 18-19 CMR results by program (FC, FCP, and PACE) for each review indicator that comprises the category. FY 17-18 results are also provided for comparison.

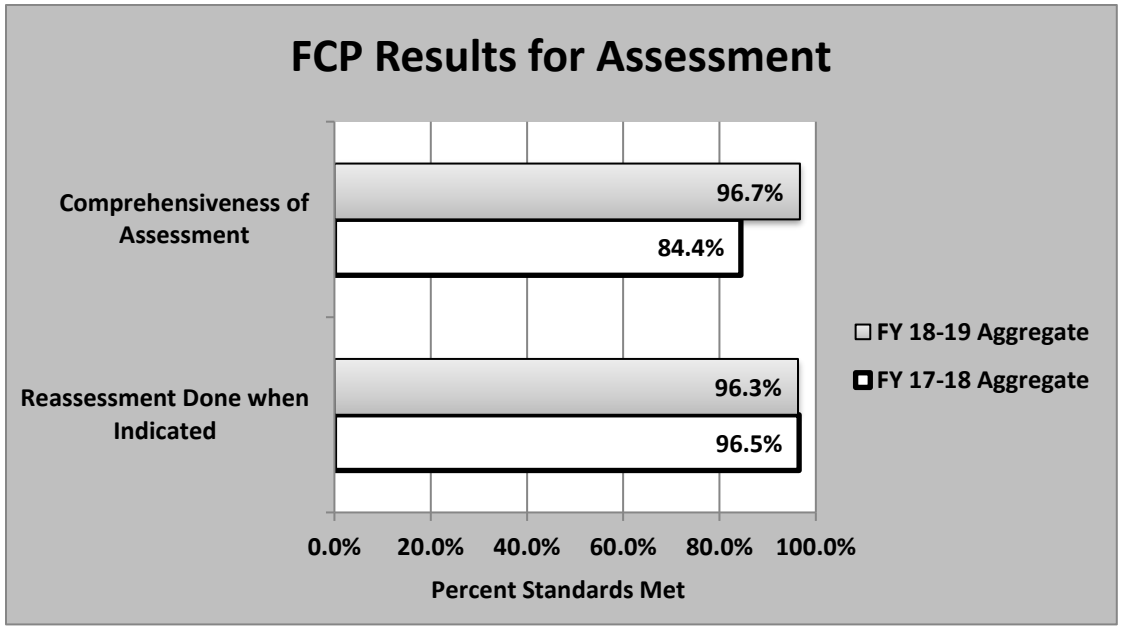
Assessment Focus Area

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.

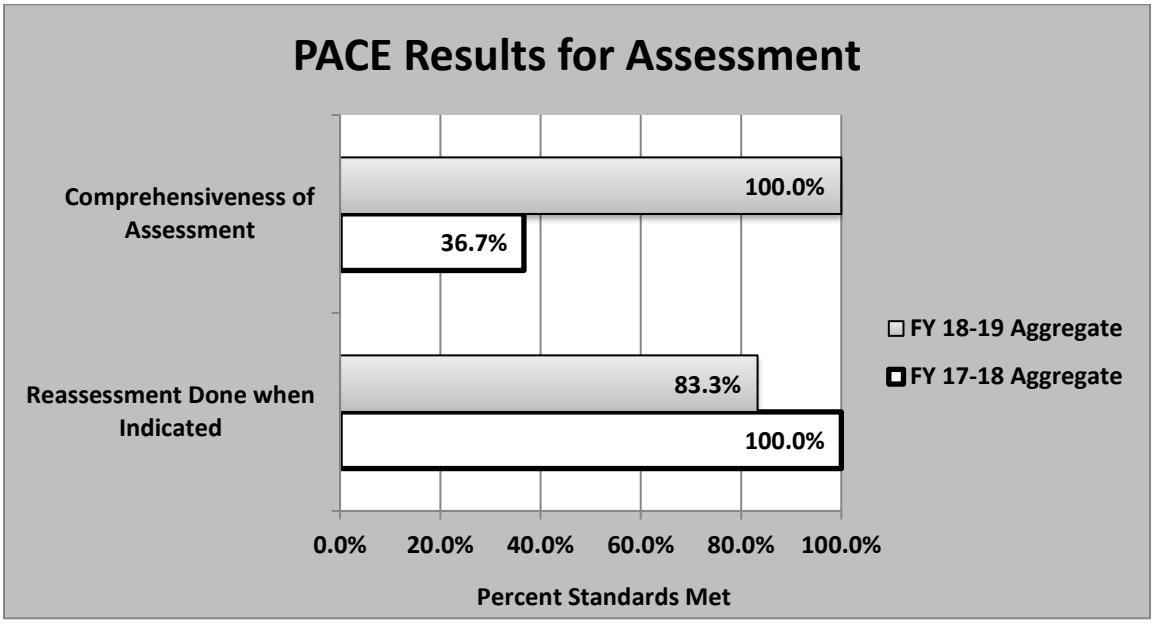
Results for Assessment for MCOs Operating FC:



Results for Assessment for MCOs Operating FCP:



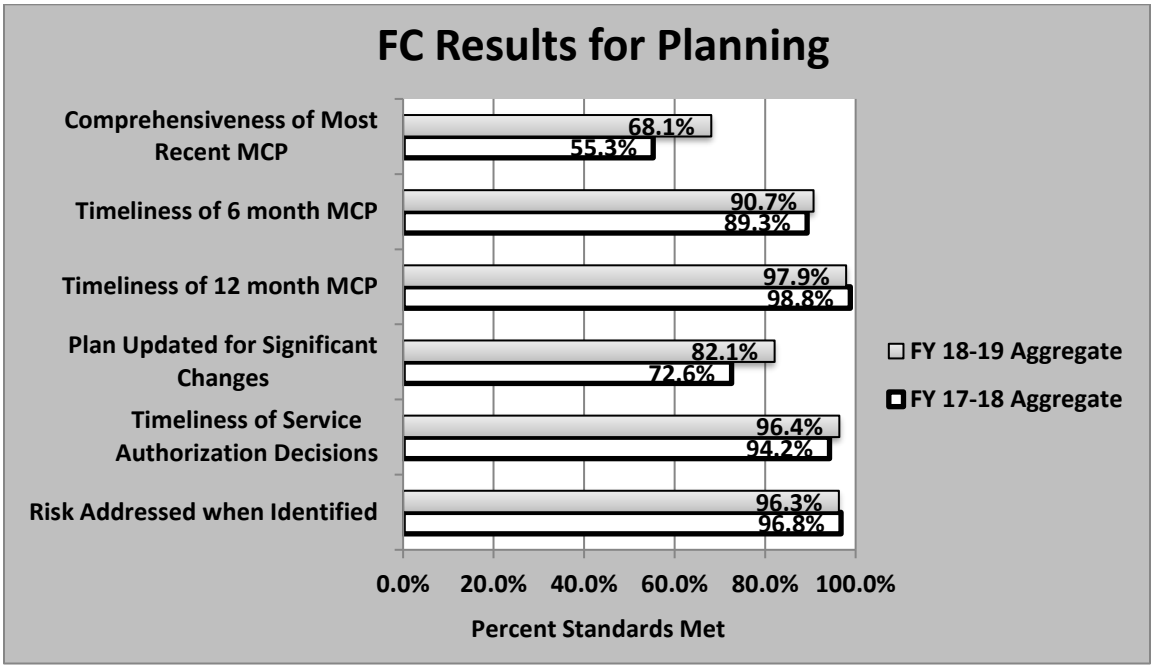
Results for Assessment for the MCO Operating PACE:



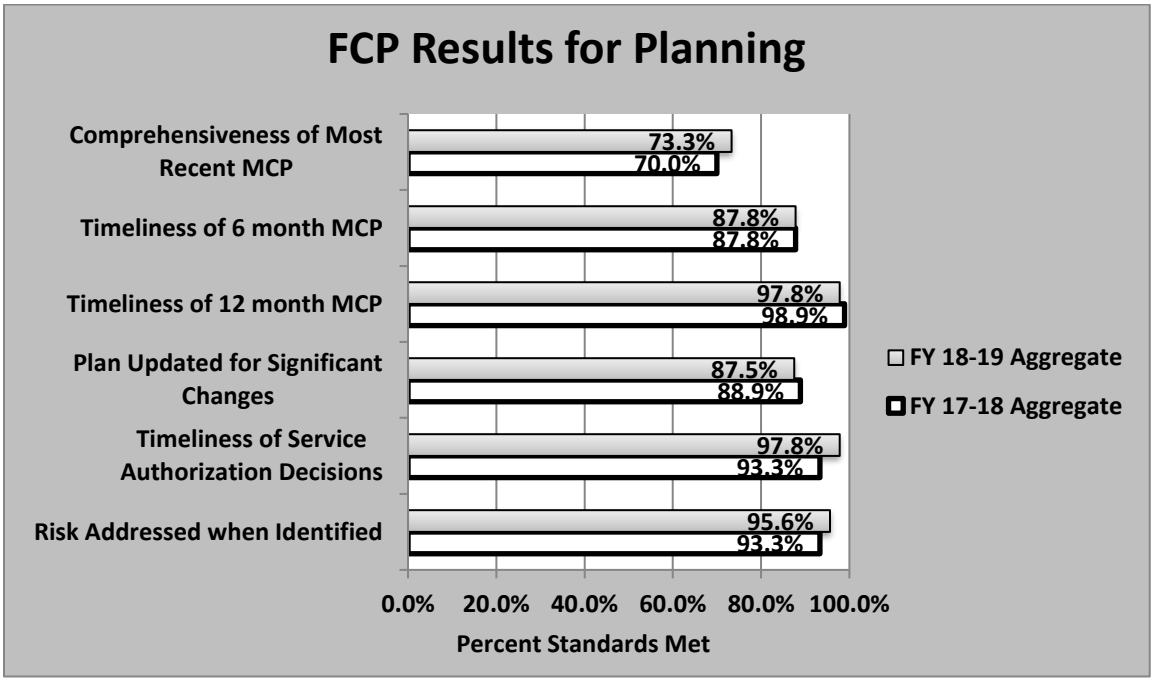
CARE PLANNING FOCUS AREA

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.

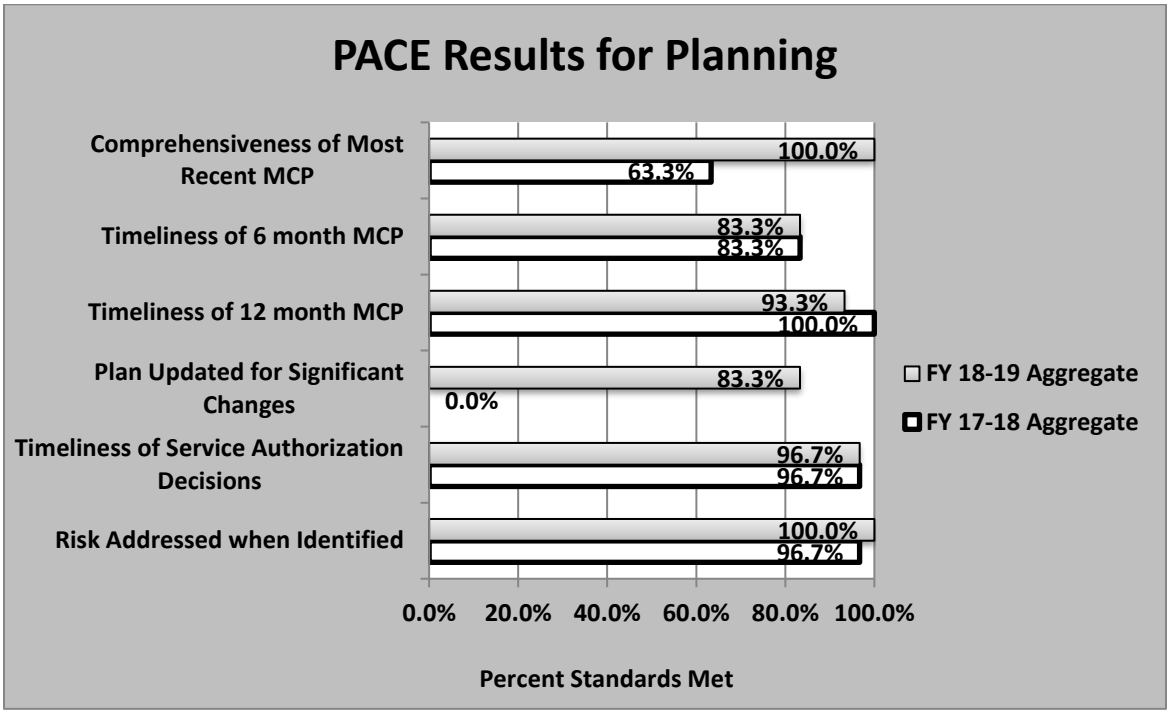
Results for Care Planning for MCOs Operating FC:



Results for Care Planning for MCOs Operating FCP:



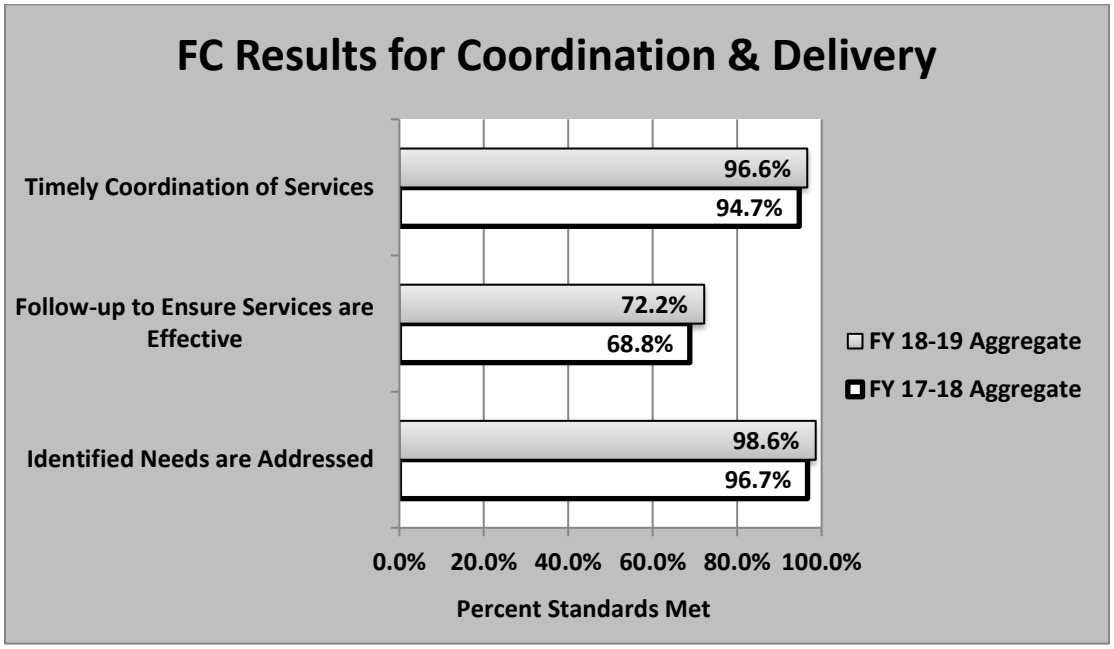
Results for Care Planning for the MCO Operating PACE:



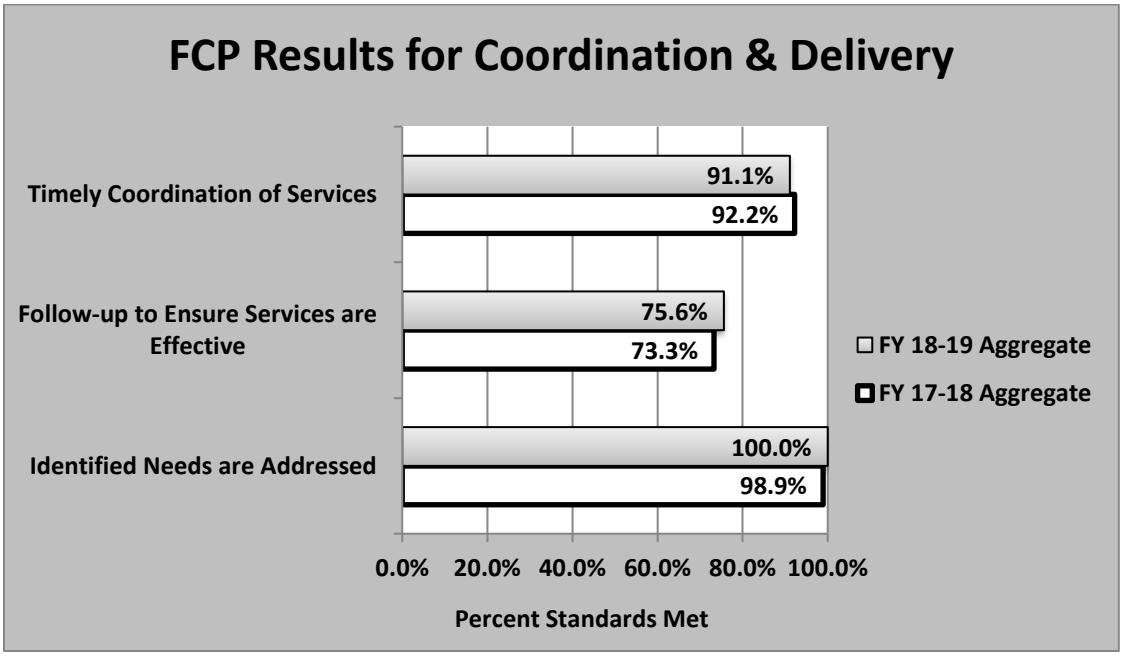
Coordination and Delivery Focus Area

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.

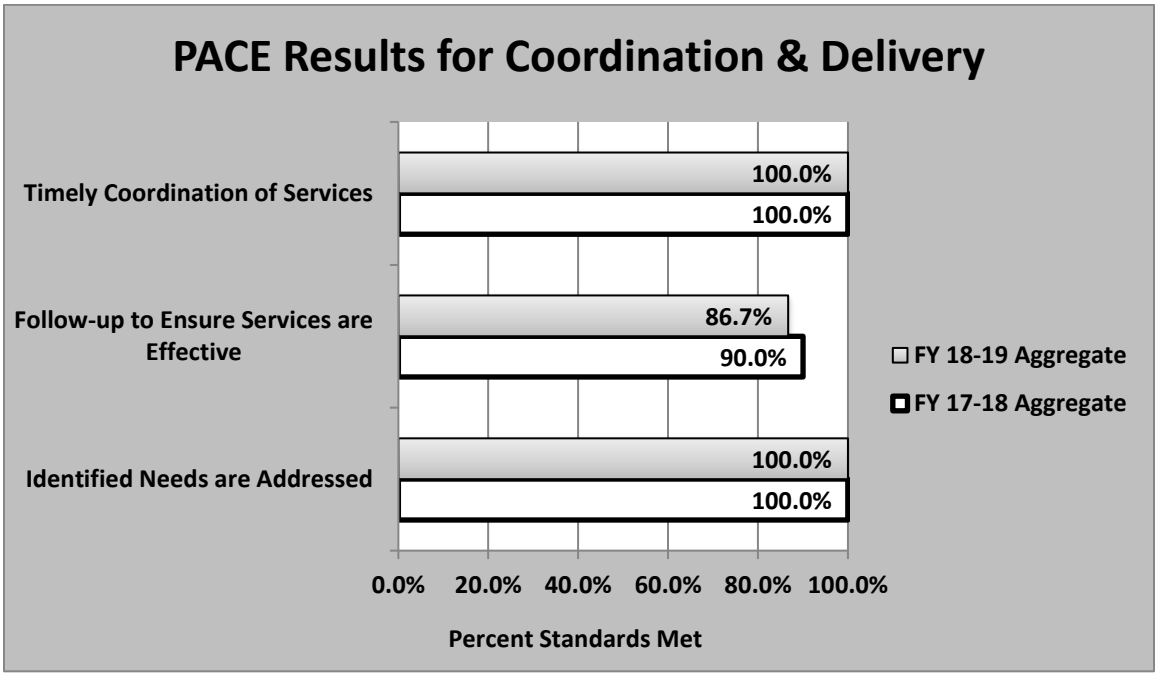
Results for Coordination and Delivery for MCOs Operating FC:



Results for Coordination and Delivery for MCOs Operating FCP:



Results for Coordination and Delivery for the MCO Operating PACE:

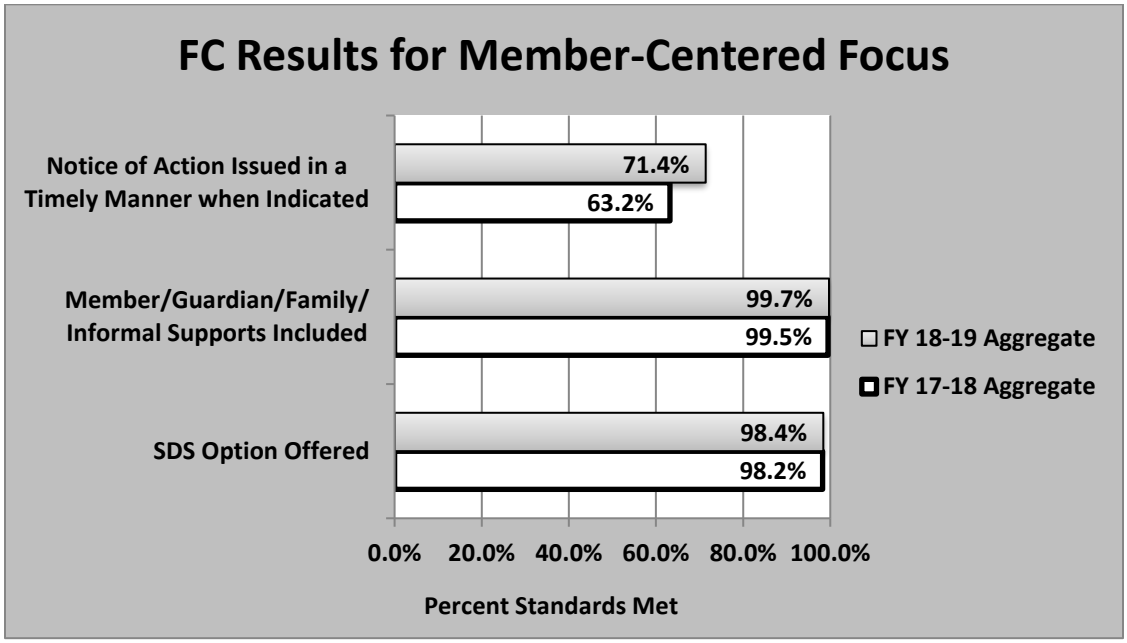


MEMBER-CENTEREDNESS FOCUS AREA

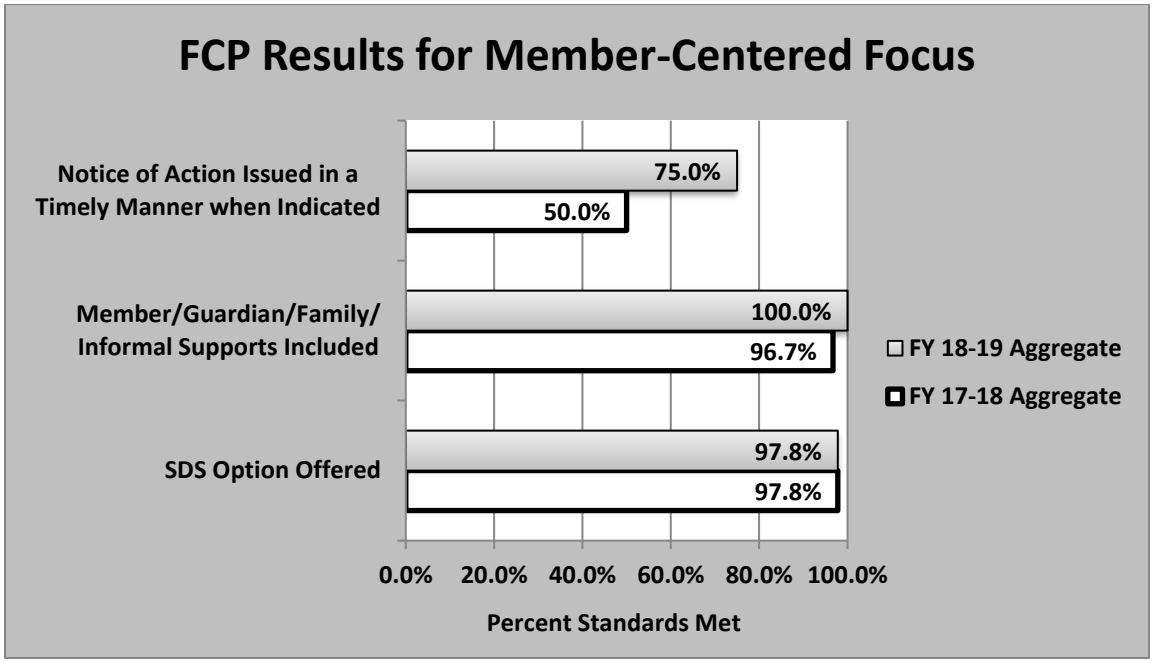
The record should document that the IDT staff includes the member and his/her supports in the care management processes; that staff protects member rights by issuing notices in accordance with requirements outlined in the DHS-MCO contract; and that the self-directed supports (SDS) option has been explained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

When 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, 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).

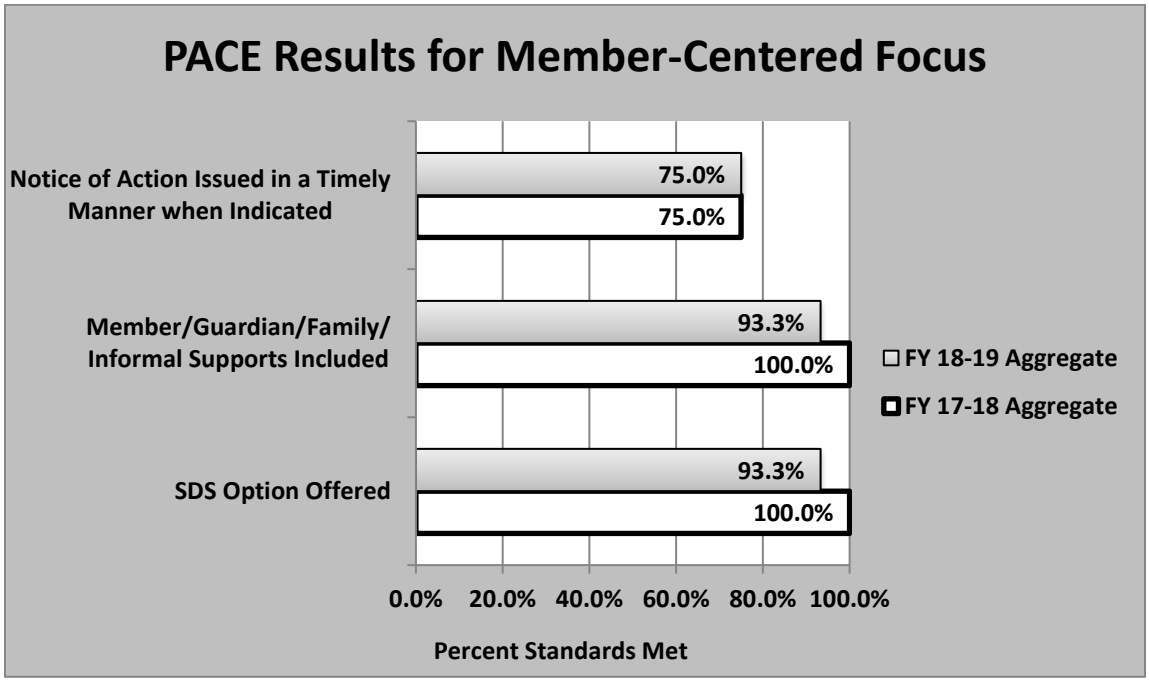
Results for Member-Centered Focus for MCOs Operating FC:



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 18-19, MetaStar did not identify any members with unaddressed health and safety issues during CMR, out of the 818 total member records selected and reviewed during this year's EQR activities. Five 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 18-19, 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 18-19, all demonstrated the MCOs had sufficiently addressed the issues or situations.

Overall Results

During the FY 18-19, each FC, FCP, and PACE organization took action to respond to the CMR recommendations received in FY 17-18. All organizations were able to achieve overall improvement.

For FC, the percent of all CMR standards met in FY 18-19, aggregated across five FC organizations was 91.7 percent. This compares to 88.7 percent in FY 17-18. FY 18-19 aggregate results for FC showed compliance rates over 90 percent for 10 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 18-19, aggregated across three FCP organizations was 92.1 percent. This compares to 89.5 percent in FY 17-18. FY 18-19 aggregate results for FCP showed compliance rates over 90 percent for nine 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 standards met in FY 18-19, for the one organization operating a PACE program, was 93.8 percent. This compares to 87.9 percent in FY 17-18. FY 18-19 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 attributable to actions of the MCOs, and is unlikely to be the result of normal variation or chance.

Recommendations for FC, FCP, and PACE in the FY 17-18 annual technical report addressed the need for all programs to focus improvement efforts on improving the comprehensiveness of MPCs; updating the MCP when there are significant changes; issuing notices to members in a timely manner when indicated; and improving timeliness with which MCPs are reviewed and signed at the required six-month intervals. The FC and FCP programs also received a recommendation to focus on improving results for the indicator *Follow-up to Ensure Services are Effective*. Actions MCOs took to address the recommendation included:

- Provided staff training;
- Conducted internal file reviews and monitoring activities;
- Revised tracking tools, internal file review processes, MCP templates; and
- Completed root cause analysis to determine cause.

All programs improved compliance rates in comprehensiveness of MCPs. For FC and PACE, 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, analysis indicated the year-to-year difference in the overall rates is likely due to normal variation or chance.

FC improved compliance in improving timeliness with which MCPs are reviewed and signed at the required six-month intervals. FCP and FC improved compliance issuing notices to members in a timely manner; analysis indicated the year-to-year difference in the overall rates is likely due to normal variation or chance for both indicators. FC and PACE improved compliance in updating the MCP when there are significant changes. For the PACE program, analysis indicated the year-to-year difference in the overall rates is likely attributable to actions of the MCO, and is unlikely to be the result of normal variation or chance. The change is likely due to normal variation or chance for the FC program.

Results for all programs identified a decline for the indicator, *Risk Addressed when Identified*. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance.

FCP and PACE programs identified a decline for the indicator, *Re-Assessment Done when Indicated*. For 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.

Other indicator declines included, *Follow-up to Ensure Services are Effective* and *SDS Option Offered* for the PACE program. For FC, *Timeliness of 12 Month MCP*. For FCP, *Plan Updated for Significant Changes* and *Timely Coordination of Services*. Analysis indicated the year-to-year difference in the overall rates is likely due to normal variation or chance for all indicators.

CONCLUSIONS

A summary of strengths and opportunities for improvement is identified below.

Strengths

In FY 18-19, FC and FCP programs had aggregate results over 90 percent for the following review indictors;

- *Comprehensiveness of Assessment;*
- *Re-Assessment Done when Indicated;*
- *Timeliness of 12 month MCP;*
- *Timeliness of Service Authorization Decisions;*
- *Risk Addressed when Identified;*
- *Timely Coordination of Services;*
- *Identified Needs are Addressed*;
- *Member/Guardian/Informal Supports Included;* and
- *SDS Options Offered*.

In FY 18-19, the PACE program maintained aggregate results over 90 percent for the following review indicators, and five indicators had aggregate results at 100 percent;

- *Comprehensiveness of Assessment;*
- *Comprehensiveness of Most Recent MCP;*
- *Timeliness of 12 month MCP;*
- *Timeliness of Service Authorization Decisions;*
- *Risk Addressed when Identified;*
- *Timely Coordination of Services;*
- *Identified Needs are Addressed;*
- *Member/Guardian/Informal Supports Included;* and
- *SDS Options Offered.*

Opportunities for Improvement

- All programs should focus on improving in the following areas of case management:
  - *Plan Updated for Significant Changes*;
  - *Follow-up to Ensure Services are Effective*; and
  - *Notices of Action Issued in a Timely Manner when Indicated*.
- The FC and FCP should focus on improving results for *Comprehensiveness of Most Recent MCP*.
- FCP and PACE should focus improving results for *Timeliness of 6 month MCP*.
- PACE should focus improving results for *Reassessment Done when Indicated*.

APPENDIX 1 – LIST OF ACRONYMS

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
GSR	Geographic Service Region
HEDIS[1]	Healthcare Effectiveness Data and Information Set
*i*Care	Independent Care Health Plan, Managed Care Organization
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
M	Met
MY	Measurement Year
NCQA	National Committee for Quality Assurance
NOA	Notice of Action
N/A	Not Applicable

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

NM	Not Met
PACE	Program of All-Inclusive Care for the Elderly
PM	Partially Met
PIP	Performance Improvement Project
PMV	Performance Measures Validation
POA-HC	Power of Attorney for Health Care
QAPI	Quality Assessment and Performance Improvement
QCR	Quality Compliance Review
SDS	Self-Directed Supports
SMCP	Special Managed Care Program
SQL	Structured Query Language
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) 18-19 external 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 18-19 Results	Comparison to FY 17-18 Results
Quality Compliance Review	• 11 standards reviewed • 3 standards received "met" rating • 80: Compliance score out of a possible 88 points in second year of three-year review cycle	• 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
Care Management Review	Family Care • 11 of 14 standards met at a rate of 90 percent or higher • 95.2 percent: Overall rate of standards met by this organization for all review indicators Family Care Partnership • 9 of 14 standards met at a rate of 90 percent or higher • 91.1 percent: Overall rate of standards met by this organization for all review indicators	Family Care • 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 Family Care Partnership • 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

CW – Conclusions

The conclusions section is intended to report on the managed care organization's progress, strengths, and to provide recommendations. As mentioned above, this is a targeted review year and applies to any standards not fully met during the FY 17-18 Quality Compliance Review.

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.

Care Wisconsin effectively addressed the following recommendations:

- The organization has the most current version of the Family Care Partnership Member Handbook for people enrolled in Medicaid only, on its website.
- The organization ensured the contract requirement to assess members for vulnerable high risk was fully implemented and effectively addressed the comprehensiveness of assessments and member-centered plans.
- The organization developed a process for routinely monitoring all applicable providers for compliance with caregiver background checks.

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 has a strong commitment to developing training and resources for staff.

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:

- Fully implement consistent policies and procedures to obtain members' consent to receive electronic materials, as required by the organization's contract with the Wisconsin Department of Health Services.
- Complete the implementation of systems to inform members of their right to request and obtain, at least once per year, the member handbook and provider directory.
- Ensure care management staff are involved in, or made aware or, all service authorizations to ensure authorization, coordination, and follow-up of all services.
- Implement monitoring practices for provider credentialing to ensure ongoing compliance of all providers.
- Ensure practice guidelines are disseminated to affected providers as required.
- Ensure the organization's Quality Assessment and Performance Improvement program meets all requirements:
    - Identify and clearly document the administrative structures of the Quality Program, and ensure they are effective for communication and coordination throughout the organization.

- Provide opportunities for members and providers to actively participate in the organization's Quality Program, and maintain documentation of these efforts.

- Develop utilization management monitoring processes, focused on the collection and analysis of data, which are sufficient to identify potential overutilization and underutilization of services.

Community Care, Inc. (CCI) – Executive Summary

This section of the report summarizes the results of the fiscal year (FY) 18-19 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 18-19 Results	Comparison to FY 17-18 Results
Quality Compliance Review	• 7 standards reviewed • 5 standards received "met" rating • 86: Compliance score out of a possible 88 points in second year of three-year review cycle	• 44 standards reviewed 37 standards received "met" rating • 81: Compliance score out of a possible 88 points in the first year of three-year review cycle
Care Management Review	<u>Family Care</u> • 9 of 14 standards met at a rate of 90 percent or higher • 91.1 percent: Overall rate of standards met by this organization for all review indicators <u>Family Care Partnership</u> • 10 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>PACE</u> • 9 of 14 standards met at a rate of 90 percent or higher	<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> • 9 of 14 standards met at a rate of 90 percent or higher

Review Activity	FY 18-19 Results	Comparison to FY 17-18 Results
	• 93.8 percent: Overall rate of standards met by this organization for all review indicators	• 87.9 percent: Overall rate of standards met by this organization for all review indicators

CCI – Conclusions

The conclusions section is intended to report on the managed care organization's progress, strengths, and to provide recommendations. As mentioned above, this is a targeted review year and applies to any standards not fully met during the FY 17-18 Quality Compliance Review.

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.

Community Care, Inc. effectively addressed the following recommendations:

- The organization developed and implemented the *Provider Network Adequacy* policy and procedure for assessing their network adequacy, which included monitoring of long-term care providers.
- Community Care, Inc. revised provider credentialing policies to include details on monitoring processes related to licensure, certification, debarment, and caregiver background checks.
- Additional methods for members, staff, and providers to actively participate in the Quality Program were implemented.
- The organization conducted monitoring of care management practice related to the support provided to vulnerable high risk members.

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:

- Leadership's collaboration with the training department to identify new ways to teach care management staff.
- The Quality Department conducts onsite visits with care management staff to review internal file review results and other quality improvement activities to enhance participation in the quality program at all levels of the organization.

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:

- Focus efforts on monitoring and improving the following area of care management practice:
    - Following up with members 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:

- Ensure the organization continues to monitor and report on care management practices related to the support provided to vulnerable high-risk members.

Inclusa, Inc. (Inclusa) – Executive Summary

This section of the report summarizes the results of the fiscal year (FY) 18-19 annual quality review conducted by MetaStar, Inc., for the managed care organization, Inclusa, 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 18-19 Results	Comparison to FY 17-18 Results
Quality Compliance Review	• 18 standards reviewed • 12 standards received “met” rating • 80: Compliance score out of a possible 86 points in second year of three-year review cycle	• 43 standards reviewed • 25 standards received “met” rating • 68: Compliance score out of a possible 86 points in the first year of three-year review cycle
Care Management Review	<u>Family Care</u> • 10 of 14 standards met at a rate of 90 percent or higher	<u>Family Care</u> • 9 of 14 standards met at a rate of 90 percent or higher

Review Activity	FY 18-19 Results	Comparison to FY 17-18 Results
	• 90.7 percent: Overall rate of standards met by this organization for all review indicators	• 88.5 percent: Overall rate of standards met by this organization for all review indicators

Inclusa – Conclusions

The conclusions section is intended to report on the managed care organization's progress, strengths, and to provide recommendations. As mentioned above, this is a targeted review year and applies to any standards not fully met during the FY 17-18 Quality Compliance Review.

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 related to standards that were not fully met during the FY 17-18 Quality Compliance Review.

Inclusa, Inc. effectively addressed the following recommendations:

- The organization fully implemented policies regarding the provision of informational materials in a manner and format that may be easily understood, and developed a process to obtain members' written consent to receive electronic materials.
- Inclusa fully implemented its restrictive measures policy and procedure, which includes processes to ensure renewal applications are submitted to DHS in a timely manner.
- The organization fully implemented policies and procedures related to the following areas:
    - Maintaining and monitoring a network of appropriate providers;
    - Coordinating services from an out-of-network provider;
    - Selection and retention of providers;
    - Ensuring the organization does not employ or contract with providers excluded from participation in federal health care programs;
    - Ensuring provider compliance with caregiver background checks and other applicable federal and state laws; and
    - Monitoring contracted provider quality.
- Inclusa implemented statewide monitoring systems for provider credentialing and quality to ensure practices are effective.
- Inclusa fully implemented its policies and procedures addressing confidentiality and privacy requirements.
- The organization implemented an organization-wide approach to the adoption and use of practice guidelines, including a mechanism to disseminate the guidelines to providers.
- Inclusa implemented an effective administrative structure for the Quality Management Program, which includes a member advisory committee, as well as opportunities for staff and

providers to participate in the program. The organization also conducted the required monitoring activities.

- The organization updated the provider subcontract to ensure providers are informed about member grievance systems at the time they enter into a contract. In addition, the information was provided to existing providers through a provider newsletter.

Inclusa – 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:

- Inclusa utilizes a systematic monitoring approach to ensure provider compliance annually.
- Inclusa's commitment to ensuring a member centered approach is conveyed through the organization's communication and training with staff, the use of member relations and member support departments, and engaging members in member advisory committees throughout the organization.
- The organization has a strong approach to quality improvement, which is integrated throughout the organization, and engages members, staff, and providers in a variety of ways.
- The organization has a clearly defined communication protocol to ensure timely and consistent communication throughout the organization.

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:

- Ensure providers are informed about all the general and specific member rights they must observe and protect, and take into account when furnishing services.
- Revise written guidance addressing the requirement to give written notice of termination of a contracted provider to members to ensure policies are consistent and reflect terminations initiated by the MCO, as well as the provider. Ensure all relevant staff are aware of their roles in the process.
- Achieve compliance with requirements related to advance directives:
    - Ensure Inclusa participates in efforts to provide community education and maintains documentation of these efforts.
    - Update written guidance to include the requirement to inform members that complaints concerning non-compliance with any advance directive may be filed with the State of Wisconsin/Division of Quality Assurance.
    - If using internet links as part of the written information provided to members, ensure all links are functional and provide options for members who may not have access to the internet to obtain the information.

- 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;
    - Comprehensiveness of member-centered plans; and
    - Issuing notices in a timely manner when indicated.
- Ensure that data and results from quality monitoring activities, such as the member record review, are collected, analyzed, and reported in a manner that is adequate to measure and achieve improvement 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 staff has received training on the process to obtain consent prior to members receiving materials electronically.
- Revise written guidance regarding specific member rights to include the statement that members must be assured that exercise of their rights cannot adversely affect the way they are treated by network providers.
- Update the *Provider Development Policy & Procedure* to indicate that if the organization declines to include individual providers or groups of providers in its network, it will provide written notice of the reason for its decision to the affected providers.
- Ensure documentation of provider committee and workgroup activities.
- Take action on the following recommendations related to the organization's Quality Management Program:
    - Ensure documentation of workgroup activities are maintained, including evidence of the analysis of data and actions taken as a result;
    - Clearly document methods for provider participation in the program, and expand those opportunities in the future, as indicated;
    - Ensure the quality plan clearly includes the responsible person for each initiative or describes where that information may be found;
    - Consider defining the volume and sampling method for functional screen reviews in the organization's written guidance; and
    - Ensure the requirement to monitor timely access to services is listed as a responsibility of the program.

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

This section of the report summarizes the results of the fiscal year (FY) 18-19 external 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 follow-up review of any standards the organization did not fully meet the previous year. FY 17-18 was a comprehensive review year.

Review Activity	FY 18-19 Results	Comparison to FY 17-18 Results
Quality Compliance Review	• 11 standards reviewed • 1 standard received "met" rating • 78: Compliance score out of a possible 88 points in second year of three-year review cycle	• 44 standards reviewed 33 standards received "met" rating • 77: Compliance score out of a possible 88 points in the first year of three-year review cycle
Care Management Review	<u>Family Care Partnership</u> • 11 of 14 standards met at a rate of 90 percent or higher • 93.7 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 • 91.4 percent: Overall rate of standards met by this organization for all review indicators

iCare – Conclusions

The conclusions section is intended to report on the managed care organization's progress, strengths, and to provide recommendations. As mentioned above, this is a targeted review year and applies to any standards not fully met during the FY 17-18 Quality Compliance Review.

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.

Independent Care Health Plan effectively addressed the following recommendation:

- The organization revised its internal file review data collection process to be able to utilize data to identify areas needing improvement, as well as to measure effectiveness of improvement efforts.

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:

- Ensure written guidance for receiving and documenting the member's consent prior to providing any member materials electronically addresses any potential documents that may be requested, and includes information regarding required safeguards.
- Maintain all versions of the provider directory with complete, accurate, and up-to-date information.
- Focus efforts to improve care management follow-up of covered services to ensure services are effective.
- Update and implement all relative provider credentialing and re-credentialing policies and procedures to include current practices and methods, as well sufficient detail to ensure the appropriate requirements are reviewed for different provider types.
- Evaluate the organization's current practices of re-credentialing providers every three years to determine if it is appropriate for all provider types, as well as identify and address discrepancies with the implementation of the practice.
- Enhance monitoring efforts for requirement compliance of current providers by increasing the number of existing providers in the quarterly provider audits, differentiating between new and existing providers on the audit report. Clearly identify the course of action to be taken when discrepancies are identified with credentialing requirements, including caregiver background checks.
- Ensure understanding of Wisconsin Caregiver Background Check requirements and include written guidance for consistency in implementation of the process.
- Revise and implement policies, procedures, and practices to ensure all requirements are met related to the adoption, dissemination, and application of clinical practice guidelines.
- Enhance opportunities for Family Care Partnership providers to actively participate in the organization's quality program.
- Ensure the following required activities collect data that can be used for quality improvement purposes: monitoring the accuracy of functional screens and conducting provider surveys.
- Fully implement utilization management processes which produce data that is adequate to detect both overutilization and underutilization of services. Conduct analysis to identify trends at the organization or system level.
- Expand monitoring of notice related to adverse benefit determinations to include notices of non-covered benefits, and monitoring for notices that are indicated but not identified or issued.
- Ensure that written decisions for local grievances and appeals are issued within the required contract timeframes.

The additional recommendation offered below reflects an opportunity for continued improvement in area of the quality compliance review where the managed care organization fully met the standard, and/or other observations related to care management review:

- Enhance written guidance for scoring consistency in the internal file review process.

Lakeland Care, Inc. (LCI) – Executive Summary

This section of the report summarizes the results of the fiscal year (FY) 18-19 external 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 18-19 Results	Comparison to FY 17-18 Results
Quality Compliance Review	• 16 standards reviewed • 7 standards received "met" rating • 77: Compliance score out of a possible 86 points in second year of three-year review cycle	• 43 standards reviewed • 27 standards received "met" rating • 70: Compliance score out of a possible 86 points in the first of three-year review cycle
Care Management Review	Family Care • 10 of 14 standards met at a rate of 90 percent or higher • 91.7 percent: Overall rate of standards met by this organization for all review indicators	Family Care • 10 of 14 standards met at a rate of 90 percent or higher • 89.4 percent: Overall rate of standards met by this organization for all review indicators

LCI – Conclusions

The conclusions section is intended to report on the managed care organization's progress, strengths, and to provide recommendations. As mentioned above, this is a targeted review year and applies to any standards not fully met during the FY 17-18 Quality Compliance Review.

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.

Lakeland Care, Inc. effectively addressed the following recommendations:

- Policies and procedures to receive and document the member's consent prior to providing materials electronically were developed and implemented.
- Lakeland Care, Inc. added written guidance for providers and staff related to provider-enrollee communication.
- The organization utilized data to assess the adequacy of the provider network.
- The organization identified barriers and addressed provider performance concerns related to timely access to services.
- Lakeland Care, Inc. implemented monitoring methods with adequate sample sizes and used the data for improvement efforts in the quality of care furnished to members.
- The organization updated its Notice of Non-Covered Benefit template letter to align with the required Department of Health Services template.
- Lakeland focused efforts on monitoring and improving issuing notices timely when indicated which resulted in an improving trend.

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:

- Ensure policies and procedures are adequate to maintain complete and up-to-date provider directory information on the organization's website that is accessible to members, including accurately reflecting the service type for which the provider is contracted.
    - Additionally, organize the Portable Document Format version of the provider directory in a manner that is useful for members; and
    - Align the policy timeframes for updating the provider directory with those stated in the current Department of Health Services-Managed Care Organization contract.
- Ensure the organization's provider network staff have a consistent understanding and application of the following provider expectations and monitoring practices:
    - Verify and monitor provider credentials to ensure ongoing compliance;
    - Assure all provider types within the benefit package are included in the monthly debarment verification and that the verification is conducted monthly; and
    - Monitor completion of caregiver background checks for all applicable providers based on the member and situation, and not exclude entire provider categories.
- Assure monitoring practices for delegated responsibilities are implemented and evaluated to assure compliance for all subcontractors.
- Focus efforts on monitoring and improving the following areas of care management practice:

    - Follow up with members and their supports to ensure services have been received and are effective; and
    - Ensure member-centered plans are comprehensive.
- Ensure the organization's Quality Assessment and Performance Improvement Program meets all requirements:
    - Ensure providers have consistent opportunities to actively participate in the organization's Quality Program and maintain documentation of these efforts;
    - Ensure provider surveys are completed; and
    - Continue to focus efforts to increase members' active participation in the organization's Quality Program and ensure the participation is documented.
- Implement consistent approaches for monitoring and analysis to identify potential underutilization of services, and take any needed actions as a result.

My Choice Family Care (MCFC) – Executive Summary

This section of the report summarizes the results of the fiscal year (FY) 18-19 external 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 18-19 Results	Comparison to FY 17-18 Results
Quality Compliance Review	• 15 standards reviewed • 8 standards received "met" rating • 79: Compliance score out of a possible 86 points in the second year of three-year review cycle	• 43 standards reviewed 28 standards received "met" rating • 71: Compliance score out of a possible 86 points in the first year of three-year review cycle
Care Management Review	Family Care • 9 of 14 standards met at a rate of 90 percent or higher • 90.8 percent: Overall rate of standards met by this organization for all review indicators	Family Care • 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

MCFC – Conclusions

The conclusions section is intended to report on the managed care organization's progress, strengths, and to provide recommendations. As mentioned above, this is a targeted review year and applies to any standards not fully met during the FY 17-18 Quality Compliance Review.

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.

My Choice Family Care effectively addressed the following recommendations:

- Several mechanisms to educate contracted providers regarding member rights were implemented.
- Routine monitoring of timely access to services was conducted.
- The organization focused efforts on monitoring and improving the area of care management practice related to timeliness of service authorization decisions.
- The MCO demonstrated documented evaluation of caregiver background checks with serious charges.
- Quality monitoring was demonstrated through aggregation and analysis of provider concerns.
- Data from all required monitoring activities was used for quality improvement as indicated and was reported as part of the Quality Management Program.
- The grievance and appeals committee ensured that a member representative was present for local committee hearings.
- The data and analysis of grievances and appeals was reviewed as part of the Quality Management Program.

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:

- The organization's support of the member advisory committee resulted in an active group with regular meetings that provides input and feedback to the MCO.

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:

- Complete implementation of the revised *Member Rights* policy and procedure.
- Ensure required safeguards for the provision of materials electronically are reflected in written guidance.

- Focus efforts on monitoring and improving the following areas of care management practice:
    - The completion and documentation of follow-up with members and their supports to ensure services have been received and are effective; and
    - The comprehensiveness and timeliness of member-centered plans.
- Develop and implement a written process for re-credentialing all applicable providers and demonstrate monitoring of the process.
- Complete the review and revision schedule for clinical practice guidelines to ensure they are based on current evidence, adopted in consideration of the needs of the MCO's members, used for prevention and wellness services, and disseminated as needed.
- Fully implement the Utilization Review Committee to ensure utilization management processes are sufficient to detect both underutilization and overutilization of services for the organization overall. Ensure that results, analysis, and actions taken to address issues or trends are documented.
- Continue to focus efforts on improving the issuance of 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 *Member Rights* policy and procedure to clearly state the organization must comply with any applicable federal and state laws that pertain to enrollee rights.
- Ensure provider resources include all member rights that must be protected, in addition to those related to grievance and appeal rights.

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 (FC), Family Care Partnership (FCP), and Program of All-Inclusive Care for the Elderly (PACE). In addition, the company conducts EQR of MCOs serving BadgerCare Plus, Supplemental Security Income, Special Managed Care, and Foster Care Medical Home Medicaid recipients in the State of Wisconsin. MetaStar also 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

Focus Area	Related Sub-Categories in Review Standards
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.

Fully 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:

- Fully 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 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 technical definitions 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 Capabilities 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 definitions.
- 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).

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 and discussion with MCO staff.

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.

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 or Special Managed Care Program (SMCP) 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 ISCA including reviewing the following references:

- DHS-MCO or SMCP 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.

To conduct the assessment, MetaStar used the ISCA scoring tool to collect information about the effect of the MCO's or SMCP'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/SMCP, and submitted to MetaStar. Some sections of the tool may have been completed by contracted vendors, if directed by the MCO or SMCP. Reviewers also obtained and evaluated documentation specific to the MCO's or SMCP's information systems (IS) and organizational operations used to collect, process, and report claims and encounter data.

MetaStar visited the MCO or SMCP to perform staff interviews to:

- Verify the information submitted by the MCO/SMCP in its completed ISCA scoring tool and in additional requested documentation;
- Verify the structure and functionality of the MCO's or SMCP'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 or SMCP's IS and business operations.

Section I: General Information

MetaStar confirms MCO or SMCP contact information and obtains descriptions of the organizational structure, enrolled population, and other background information, including information pertaining to how the MCO or SMCP 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 or SMCP as well as technical specifications and support staff. Reviewers assess how the MCO or SMCP 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 or SMCP and vendor claims/encounter data system and processes, in order to obtain an understanding of how the MCO or SMCP 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 or SMCP.

Section IV: Eligibility and Enrollment Data Processing

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

Section V: Practitioner Data Processing

MetaStar reviewers ask the MCO or SMCP 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 or SMCP 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 or SMCP manages its encounter data security processes and ensures data integrity of submissions.

Section VII: Vendor Oversight

MetaStar reviews MCO or SMCP oversight and data collection processes performed by service providers and other information technology vendors/systems (including internal systems) that support MCO or SMCP 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 or SMCP'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 1915(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 17-18 statewide aggregate rate for each of the 14 CMR standards.

CMR Measure	FY 17-18 FC Aggregate Rate	FY 17-18 FCP Aggregate Rate
1A-Comprehensiveness of Assessment	86.9%	84.4%
1B-Re-Assessment Cone When Indicated	93.6%	96.5%
2A-Comprehensiveness of Plan	55.3%	70.0%
2B-Timeliness of Most Recent Plan (6 months)	89.3%	87.8%
2F-Timeliness of Member-Centered Plan in Past 12 Months	98.8%	98.9%
2C-Plan Updated for Changes	72.6%	88.9%
2D-Timeliness of Service Authorization Decisions	94.2%	93.3%
2E-Risk Addressed	96.8%	93.3%
3A-Timely Coordination of Services	94.7%	92.2%
3B-Follow-Up Completed	68.8%	73.3%
3C-Identified Needs Addressed	96.7%	98.9%

CMR Measure	FY 17-18 FC Aggregate Rate	FY 17-18 FCP Aggregate Rate
4A-Notice of Action Issued	63.2%	50.0%
4B-Member/ Guardian/Supports Included	99.5%	96.7%
4C-Self-Directed Supports Offered	98.2%	97.8%
CMR Overall Results	**88.7%**	**89.5%**

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 2018 – 2019

#	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 438.100 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 438.100, 42 CFR 438.10, 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.** 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.**

#	Grievance System
	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.
	Handling of Grievances and Appeals
6	**42 CFR 438.406; DHS-MCO Contract Article XI.**

#	Grievance System
	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*** The MCO may extend the timeframes by up to 14 calendar days if: • The member requests the extension;

#	Grievance System
	• 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.** 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

#	Grievance System
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.

APPENDIX 5 – QUALITY COMPLIANCE REVIEW COMPARATIVE SCORES

	CW	CCI	Inclusa	*i*Care	LCI	MCFC	CW	CCI	Inclusa	iCare	LCI	MCFC
#	FY 17-18	FY 17-18	FY 17-18	FY 17-18	FY 17-18	FY 17-18	FY 18-19	FY 18-19	FY 18-19	FY 18-19	FY 18-19	FY 18-19
Enrollee Rights and Protections												
E1	M	M	PM	M	M	PM	M	M	PM	M	M	M
E2	PM	M	PM	PM	PM	PM	PM	M	M	PM	M	PM
E3	PM	M	PM	M	M	M	PM	M	PM	M	M	M
E4	M	M	M	PM	PM	M	M	M	M	PM	PM	M
E5	PM	M	M	M	M	M	M	M	M	M	M	M
E6	M	M	PM	M	M	M	M	M	PM	M	M	M
E7	M	M	PM	M	M	M	M	M	M	M	M	M
E8	M	M	M	M	PM	M	M	M	M	M	M	M
E9	M	M	N/A	M	N/A	N/A	M	M	N/A	M	N/A	N/A
Quality Assessment/Performance Improvement												
Q1	M	PM	PM	M	PM	M	M	M	M	M	M	M
Q2	M	M	PM	M	M	M	M	M	M	M	M	M
Q3	M	M	M	M	PM	PM	M	M	M	M	M	M
Q4	M	M	M	M	M	M	M	M	M	M	M	M
Q5	PM	PM	PM	PM	PM	PM	PM	PM	PM	PM	PM	PM
Q6	PM	PM	PM	M	PM	PM	M	M	PM	M	PM	PM
Q7	PM	M	M	M	M	M	PM	M	M	M	M	M
Q8	M	M	M	M	M	PM	M	M	M	M	M	M
Q9	PM	PM	PM	PM	PM	PM	PM	M	M	PM	PM	PM
Q10	M	PM	PM	M	PM	M	M	M	M	M	PM	M
Q11	PM	M	PM	PM	PM	PM	M	M	M	PM	PM	M
Q12	M	M	PM	M	M	M	M	M	M	M	M	M
Q13	M	M	PM	M	PM	PM	M	M	M	M	PM	M
Q14	PM	M	PM	PM	M	PM	PM	M	M	PM	M	PM
Q15	PM	PM	PM	PM	PM	PM	PM	M	M	PM	PM	M
Q16	PM	M	M	PM	PM	PM	PM	M	M	PM	PM	PM
Q17	M	M	M	PM	PM	M	M	M	M	M	M	M
Q18	M	M	M	M	M	M	M	M	M	M	M	M

	CW	CCI	Inclusa	*i*Care	LCI	MCFC	CW	CCI	Inclusa	iCare	LCI	MCFC
#	FY 17-18	FY 17-18	FY 17-18	FY 17-18	FY 17-18	FY 17-18	FY 18-19	FY 18-19	FY 18-19	FY 18-19	FY 18-19	FY 18-19
Q19	M	M	M	M	M	M	M	M	M	M	M	M
Grievance System												
G1	M	M	M	M	M	M	M	M	M	M	M	M
G2	M	M	M	M	M	M	M	M	M	M	M	M
G3	M	M	M	M	M	M	M	M	M	M	M	M
G4	M	M	M	M	PM	M	M	M	M	M	M	M
G5	M	PM	PM	PM	PM	PM	M	PM	PM	PM	M	PM
G6	M	M	M	M	M	M	M	M	M	M	M	M
G7	M	M	M	M	M	PM	M	M	M	M	M	M
G8	M	M	M	M	M	M	M	M	M	M	M	M
G9	M	M	M	PM	M	M	M	M	M	PM	M	M
G10	M	M	M	M	M	M	M	M	M	M	M	M
G11	M	M	M	M	M	M	M	M	M	M	M	M
G12	M	M	PM	M	M	M	M	M	M	M	M	M
G13	M	M	M	M	M	PM	M	M	M	M	M	M
G14	M	M	M	M	M	M	M	M	M	M	M	M
G15	M	M	M	M	M	M	M	M	M	M	M	M
G16	M	M	M	M	M	M	M	M	M	M	M	M