External Quality Review

Fiscal Year 2019 – 2020

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. Review activities are planned and implemented according to The Centers for Medicare and Medicaid Services (CMS) External Quality Review (EQR) Protocols, which were updated in March of 2020. This report followed the prior EQR protocol in place.

This report covers the external quality review fiscal year from July 1, 2019 to June 30, 2020 (FY 19-20). 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.

Protocol 1: Compliance with Standards - 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 19-20 was the third year of the three-year cycle; compliance standards not fully met in the prior review were reviewed for four managed care organizations. Prior to having quality compliance reviews conducted, two organizations merged and were not

reviewed in FY 19-20. The report only reflects findings from the four organizations that were reviewed in FY 19-20.

All managed care organizations reviewed demonstrated a commitment to enrollee rights, as the majority of corresponding standards were fully met following the prior review. Progress was made by most of the organizations reviewed in FY 19-20, moving this area closer to being fully met by all organizations.

For standards related to the quality assessment and performance improvement focus area, progress was also made by most organizations reviewed. All managed care organizations fully met requirements for the quality management program following the FY 19-20 review. Opportunities for improvement were identified in standards relating to care coordination, service planning, and selection and retention of providers.

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.

Protocol 2: 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 2019. 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 2019. The overall findings were not biased, meaning the rates can be accurately reported. Two organizations merged prior to the conclusion of the immunization measurement period; vaccination data was reported and validated separately for the two organizations. Opportunities for improvement include continuing to implement strategies to increase influenza vaccination rates by educating members on the benefits of the vaccination, and ensuring documentation practices for members contraindicated from receiving influenza and pneumococcal vaccinations align with the technical definitions and MCOs' policies and procedures for each quality indicator.

Protocol 3: 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 19-20, the DHS contract with the managed care organizations required 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 as the point of having implemented at least one intervention and measured its effects on at least one indicator. MetaStar validated one project for each organization, for a total of six validations. During the review period, two organizations merged. Projects conducted prior to the merger were validated for each organization.

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 six validated projects. In one of these projects, improvement was demonstrated to be the result of the interventions employed.

The reliability and validity of the projects' results are reported with an overall validation finding. Four of the projects received validation findings of fully "met," and two projects received validation findings of "partially met." Opportunities for improvement included recommendations to ensure initial and repeat measures are comparable; analyze data for less than optimal improvement; evaluate the effectiveness of the interventions resulting in improvement; and obtain a repeat measure for the project to demonstrate sustainability.

Appendix V: 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 organizations 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 one organization during FY 19-20.

Overall, the review found the managed care organization 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.

Protocol 8: Conducting Focused Studies of Health Care Quality - 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 care 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 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, 2019, to June 30, 2020 (FY 19-20). 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. All programs provide home and community-based services (HCBS) for long-term services and supports (LTSS). FCP and PACE also provide acute and primary care services. Compliance with these review activities provides assurances that MCOs are meeting requirements related to access, timeliness, and quality of services, including health care and LTSS. The analysis included in this section of the report, along with each MCO's summary of findings located in Appendix 2, are intended to provide that assessment. The executive summaries in Appendix 2, which are taken from each MCO's FY 19-20 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 Managed Care Organizations

The table below identifies the programs each MCO operates.

Managed Care Organization	Program(s)
Care Wisconsin (CW)	FC; FCP
Community Care, Inc. (CCI)	FC; FCP; PACE
Inclusa, Inc. (Inclusa)	FC

Managed Care Organization	Program(s)
Independent Care Health Plan (*i*Care)	FCP
Lakeland Care, Inc. (LCI)	FC
My Choice Family Care (MFCF)	FC
My Choice Family Care – Care Wisconsin (MCFC-CW)*	FC; FCP

*Effective January 1, 2020, two separate MCOs, My Choice Family Care (MCFC), operating FC, and Care Wisconsin (CW), operating FC and FCP, merged to create a new organization, My Choice Family Care – Care Wisconsin (MCFC-CW).

In November 2019 DHS approved the merger of two separate MCOs, My Choice Family Care (MCFC) and Care Wisconsin (CW). The newly merged organization, My Choice Family Care – Care Wisconsin (MCFC-CW), was approved to provide Medicaid managed long-term care services through the FC and FCP programs in counties where the two separate MCOs, referred to as legacy MCOs, had previously provided FC and FCP services and supports.

Effective January 1, 2020, DHS certified Inclusa to expand into geographic service region (GSR) 13. CCI was certified to expand into GSR 12 effective May 1, 2020. Both expansions were to provide consumers with a second MCO option for FC services.

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

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

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

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

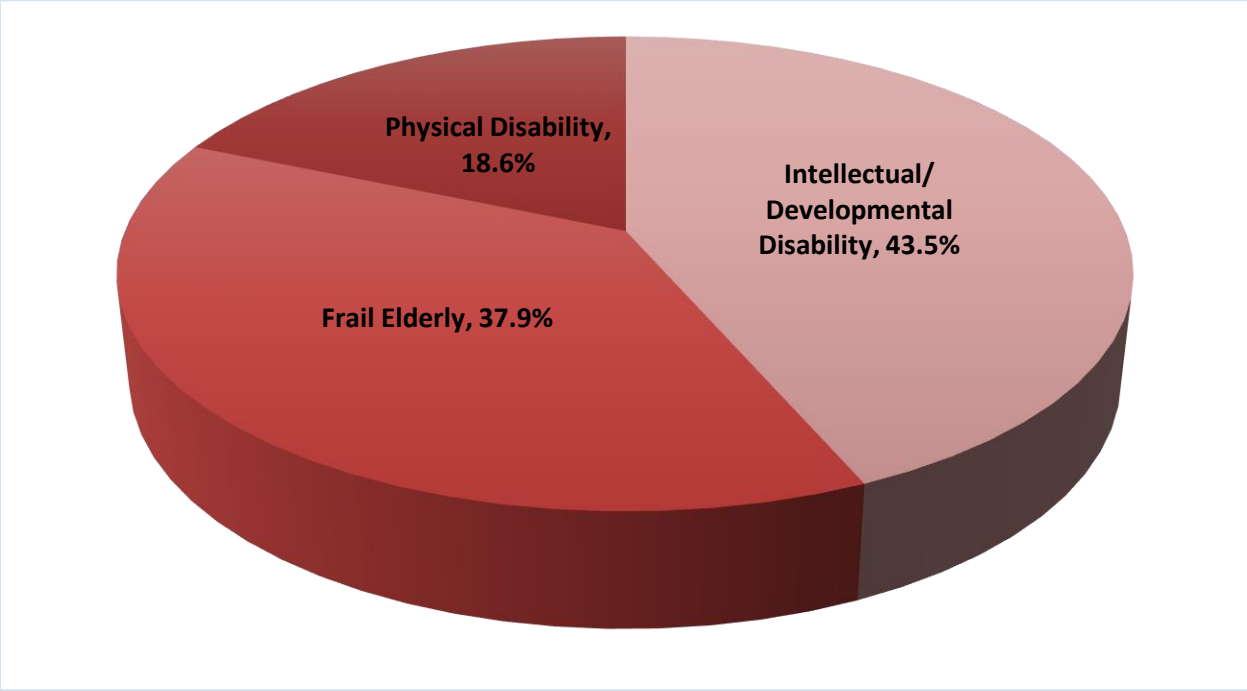
https://www.dhs.wisconsin.gov/familycare/fcp-overview.htm.

As of July 1, 2020, enrollment for all programs was approximately 55,102. This compares to last year's total enrollment of 53,751 as of July 1, 2019. Enrollment data is available at the following DHS website:

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

The following chart 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, 2020



Scope of External Review Activities

In FY 19-20, 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 one MCO during FY 19-20. MetaStar also conducted an optional review activity, care management review (CMR), for all MCOs.

Mandatory Review Activities	Scope of Activities
Protocol 1: Compliance with Standards - 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 19-20 was the third year of the three-year cycle. The number of standards MetaStar reviewed per organization ranged from two to 10.
Protocol 2: 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 19-20, 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.
Protocol 3: 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 19-20, MetaStar validated one PIP for each MCO, for a total of six PIPs. The PIP topics reviewed for each MCO are indicated in the chart on page 12.
Appendix V: 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 one MCO during FY 19-20.
Optional Review Activities	**Scope of Activities**
Protocol 8: Conducting Focused Studies of Health Care Quality - Care Management Review	MetaStar conducts CMR to assess each MCO's level of compliance with its contract with DHS in key areas of care management practice. CMR activities and findings also help support QCR, and are part of DHS' overall strategy for providing quality assurances to CMS regarding the 1915 (c) Waiver, which allows the State of Wisconsin to operate its Family Care programs.

Mandatory Review Activities	Scope of Activities
	During FY 19-20, the EQR team conducted CMR activities during each MCO's annual quality review (AQR), and a total of 1,485 records were reviewed across all three programs. At the request of DHS, MetaStar also reviewed an additional 135 member records separate from the 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)
MCFC-CW/CW	• Improving Care Management for Member Health, Safety, and Risk (FC/FCP)
CCI	• Advance Care Planning (FC/FCP/PACE)
Inclusa	• Choking Risk (FC)
***i*Care**	• Reduce Readmission Rate (FCP)
LCI	• Dementia Care (FC)
MCFC-CW/MCFC	• Reduce Readmission Rate (FC)

Number of Care Management Reviews Conducted by MCO and Program

MetaStar generated a random sample of member records for each MCO and program based on the predetermined sample sizes. See Appendix 3 for more information about the CMR methodology.

MCO/Program	CMR Sample Size
Family Care	
MCFC-CW/CW	210
CCI	215
Inclusa	250
LCI	225
MCFC-CW/MCFC	260
Total: Family Care	**1,160**
Family Care Partnership/PACE	
MCFC-CW/CW	75
CCI - FCP	75
CCI - PACE	75

MCO/Program	CMR Sample Size
*i*Care	100
Total: Family Care Partnership/PACE	**325**
Total: All Programs	**1,485**

Protocol 1: Compliance with Standards – Quality Compliance Review

Compliance with Standards - 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 19-20 was the third year in the three-year cycle. For each MCO that had a QCR, MetaStar reviewed only those compliance standards the MCO did not fully meet during the two previous years.

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 two 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. Appendix 5 details how each organization scored for each standard over the three year cycle.

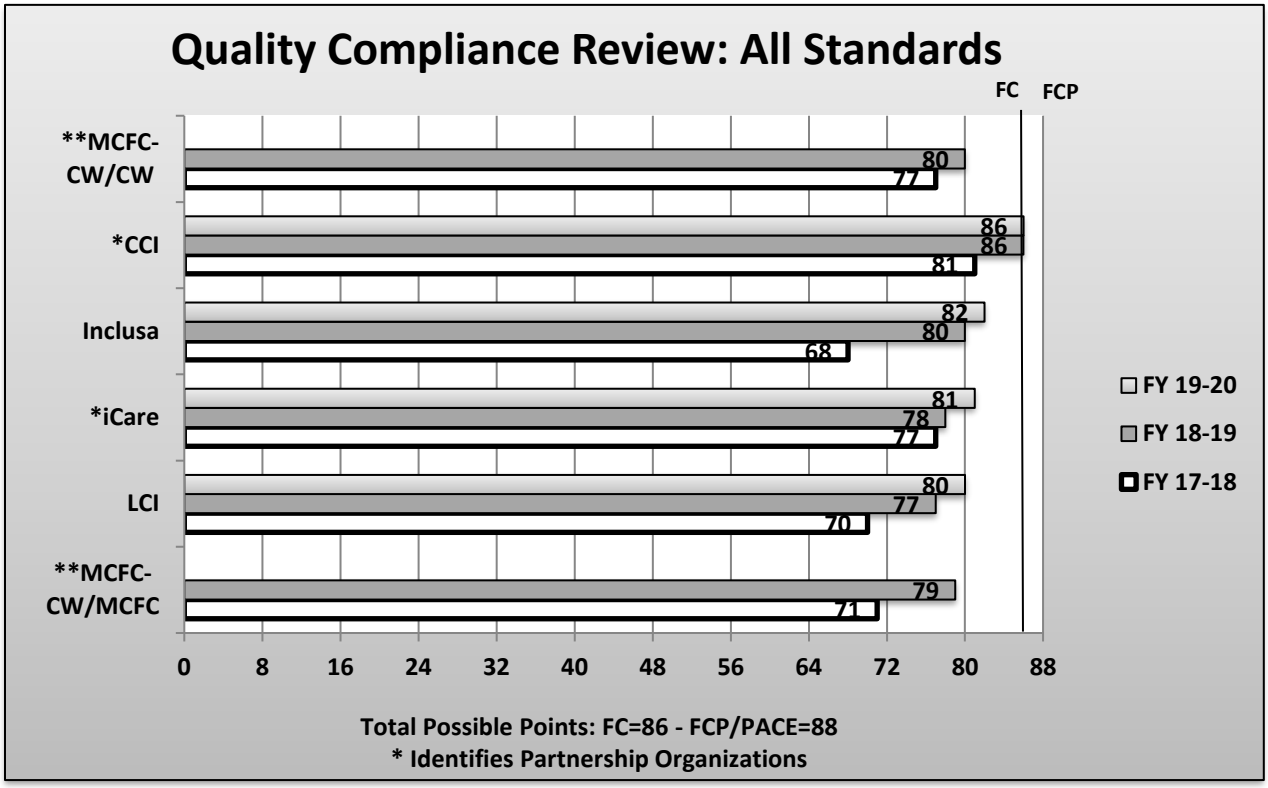
Overall QCR Results by MCO

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 the FY 17-18 and FY 18-19 reviews. This year's results represent the cumulative score each MCO achieved in the third year of the three-year cycle, i.e., any additional points from this year's review were added to the MCO's score from the previous two years.

Readers will note the bar graph does not include FY 19-20 overall results for two organizations, CW and MCFC. CW and MCFC merged in the middle of the review year (effective January 1, 2020), and neither organization had a QCR prior to the time of the merger. The current direction from DHS is for the new organization, MCFC-CW, to receive a QCR in Spring of 2021 to meet CMS reporting requirements.

As explained above, the total possible points for MCOs operating the FCP program is 88; the two organizations reviewed in FY 19-20 are denoted with an asterisk in the graph below. The other two organizations operate the FC program, with a total possible points of 86.



*MCOs operating the FCP program.
**No QCR conducted in FY 19-20 for MCFC-CW/CW and MCFC-CW/MCFC as a result of the January 1, 2020 merger of the two MCOs.

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

Results Enrollee Rights and Protections 42 CFR 438.100

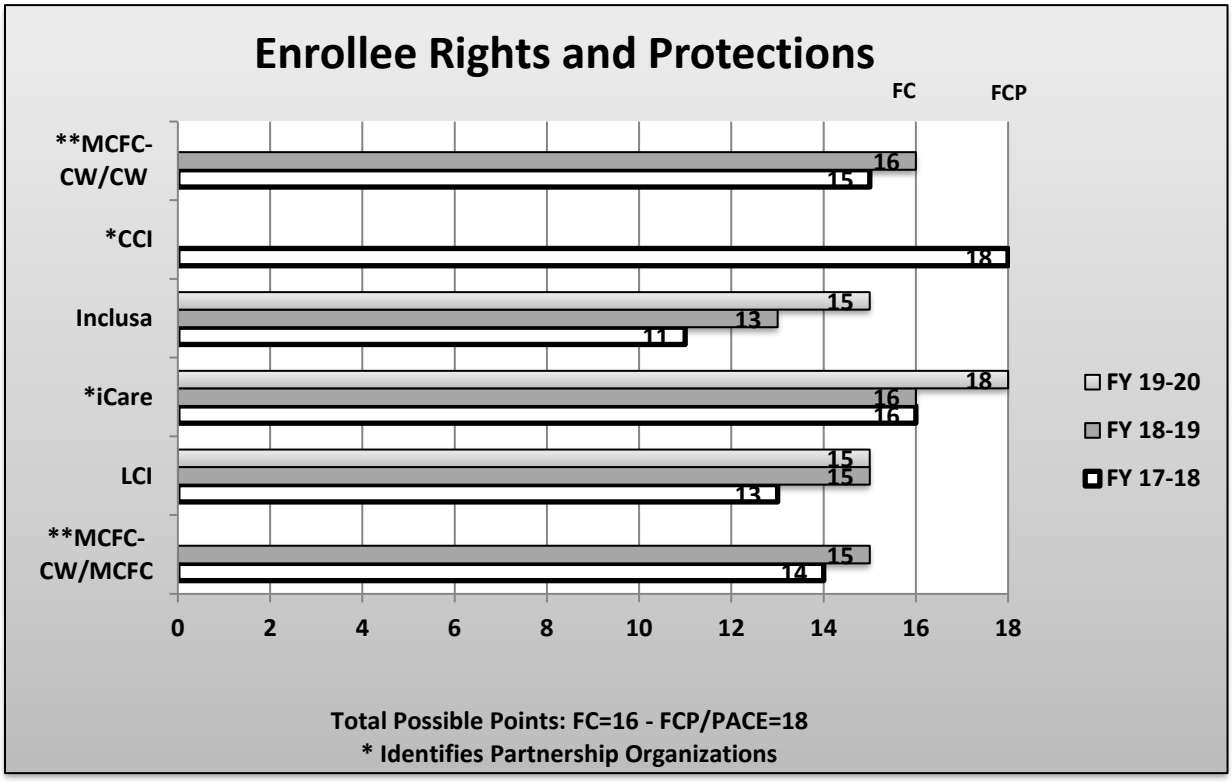
This area of review consists of eight standards applicable to every organization, and one additional standard applicable to organizations operating FCP and PACE (Standards E1 - E9). The standards address members' general rights, such as the right to information, as well as specific rights related to 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 19-20 results shown are cumulative over the current three-year cycle, i.e., any additional points from this year's review were added to the MCO's score from the previous two years. The graph also compares this year's results to the MCO's level of compliance in FYs 17-18 and 18-19.

Graph E.1



*MCOs operating the FCP program.
**No QCR conducted in FY 19-20 for MCFC-CW/CW and MCFC-CW/MCFC as a result of the January 1, 2020 merger of the two MCOs.
*** CCI was fully met in FY 17-18; therefore, no review of the enrollee rights and protections standards occurred in FY 18-19 or FY 19-20. Additionally, CCI operates FCP.

The following table, E.2 lists the comparative findings by each standard. The first column indicates the number assigned to the review standard. The second column indicates the standard description. The remaining columns depict each MCO with its rating for this fiscal cycle, scored

as Met (M), Partially Met (PM), Not Met (NM), or Not Applicable (N/A). Those standards highlighted in gray were scored M in FY 17-18 or FY 18-19 and were not reviewed this cycle. No Review is identified for those standards not fully met by the legacy MCOs, CW and MCFC, prior to the merger.

Table E.2

MCO Comparative Findings by Standard							
		MCFC-CW/CW*	CCI	Inclusa	*i*Care	LCI	MCFC-CW/MCFC*
#	Standard	FY 19-20	FY 19-20	FY 19-20	FY 19-20	FY 19-20	FY 19-20
Enrollee Rights and Protections							
E1	General rule 42 CFR 438.100	M	M	PM	M	M	M
E2	Information requirements: language and format 42 CFR 438.100; 42 CFR 438.10	No Review	M	M	M	M	No Review
E3	Information requirements: general 42 CFR 438.100; 42 CFR 438.10	No Review	M	M	M	M	M
E4	Provider directory 42 CFR 438.100; 42 CFR 438.10	M	M	M	M	PM	M
E5	Enrollee handbook 42 CFR 438.100; 42 CFR 438.10	M	M	M	M	M	M
E6	Advance directives 42 CFR 438.100; 42 CFR 438.10	M	M	M	M	M	M
E7	Specific rights 42 CFR 438.100	M	M	M	M	M	M
E8	Provider-enrollee communications 42 CFR 438.102	M	M	M	M	M	M
E9	Emergency and post-stabilization services (FCP only) 42 CFR 438.114; 42 CFR 422.113	M	M	N/A	M	N/A	N/A

* Effective January 1, 2020, two separate FC, FCP MCOs, MCFC-CW/CW and MCFC-CW/MCFC merged to create a new organization, MCFC-CW. No reviews were conducted for the legacy MCOs.

Analysis

Of the four organizations reviewed this year, one had previously achieved full compliance with the standards in this focus area in the FY 17-18 review. A total of five standards remained partially met among the other three MCOs following the FY 18-19 review: three of the five standards reviewed in FY 19-20 were found to be fully met during the FY 19-20 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 address most of the requirements of this focus area. The general rule standard, E1, was reviewed for one MCO this year and remained partially met. The organization under review was unable to demonstrate that providers were educated on member rights.

Organizations are required to provide informational materials in a manner and format that is easily understood. The standard, E2, 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 partially met organizations in FY 18-19 did not have fully implemented policies or procedures to obtain members' written consent. Three organizations were partially met for this reason following last year's review, though only one was reviewed in FY 19-20. The organization reviewed successfully addressed recommendations to fully implement the process for obtaining members' written consent to receive electronic materials.

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

- One organization was reviewed for E3, which addresses furnishing specific types of information to members. The organization successfully addressed recommendations to fully implement policies and procedures related to this standard.
- Two organizations were reviewed for provider directory requirements, E4. One organization successfully addressed recommendations, while the other continued to have online or printable provider directories that included inaccuracies and/or did not meet all requirements.
- The standard, E6, includes multiple requirements related to advance directives. One organization was reviewed and successfully addressed recommendations to fully implement policies or procedures to achieve compliance.

CONCLUSIONS

The conclusions are based on assessments of the strengths and weaknesses of the MCO related to quality, timeliness, and access to services, including health care and LTSS. The findings are also indicated in bar graph E.1 and table E.2. In this third year of review, no opportunities for improvement were identified related to enrollee rights.

Progress

- One organization fully implemented and met the requirements for providing electronic materials to members (E2).
- One organization effectively addressed recommendations related to furnishing specific types of information to members (E3).

- One organization successfully addressed recommendations related to provider directory requirements (E4).
- One organization achieved full compliance with advance directives requirements (E6).

Strengths

- All organizations that were reviewed fully met seven of the eight standards related to enrollee rights for FC; and seven of the nine standards for FCP and PACE.
- Three of four organizations reviewed fully met requirements related to:
    - The general rules of enrollee rights (E1); and
    - Provider directory information (E4).

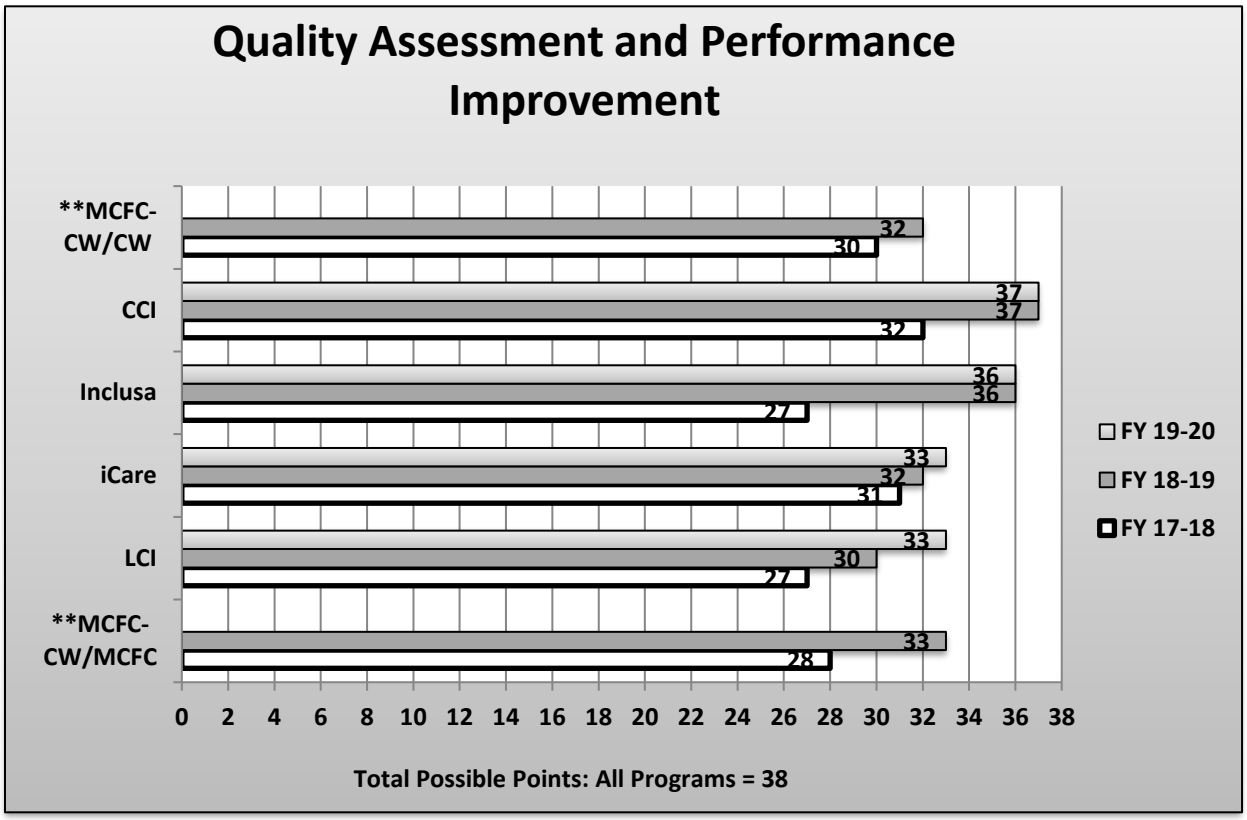
Results Quality Assessment and Performance Improvement 42 CFR 438.206; 42 CFR 438.207; 42 CFR 438.210; 42 CFR 438.214; 42 CFR 438.224; 42 CFR 438.236; 42 CFR 438.240; 42 CFR 438.242

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.

Graph Q.1



*No QCR conducted in FY 19-20 for MCFC-CW/CW and MCFC-CW/MCFC as a result of the January 1, 2020 merger of the two MCOs.

The following table, Q.2, lists the comparative findings by each standard. The first column indicates the number assigned to the review standard. The second column indicates the standard description. The following columns depict each MCO with its rating for this fiscal cycle, scored as M, PM, or NA). Those standards highlighted in gray were scored M in FY 17-18 or FY 18-19 and were not reviewed this cycle. No Review is identified for those standards not fully met by the legacy MCOs, CW and MCFC, prior to the merger.

Table Q.2

MCO Comparative Findings by Standard							
		MCFC-CW/CW*	CCI	Inclusa	*i*Care	LCI	MCFC-CW/MCFC*
#	Standard	FY 19-20	FY 19-20	FY 19-20	FY 19-20	FY 19-20	FY 19-20
Quality Assessment/Performance Improvement							
Q1	Delivery network 42 CFR 438.206	M	M	M	M	M	M
Q2	Second opinion and out-of-network providers 42 CFR 438.206	M	M	M	M	M	M
Q3	Timely access 42 CFR 438.206	M	M	M	M	M	M

MCO Comparative Findings by Standard							
		MCFC-CW/CW*	CCI	Inclusa	*i*Care	LCI	MCFC-CW/MCFC*
#	Standard	FY 19-20	FY 19-20	FY 19-20	FY 19-20	FY 19-20	FY 19-20
Quality Assessment/Performance Improvement							
Q4	**Cultural considerations 42 CFR 438.206**	M	M	M	M	M	M
Q5	**Coordination and continuity of care 42 CFR 438.208**	No Review	PM	PM	PM	PM	No Review
Q6	**Identification, assessment, and service plans 42 CFR 438.208**	M	M	PM	M	PM	No Review
Q7	**Authorization of services 42 CFR 438.210**	No Review	M	M	M	M	M
Q8	**Timeframe for authorization decisions 42 CFR 438.210**	M	M	M	M	M	M
Q9	**Provider selection: credentialing and nondiscrimination 42 CFR 438.214; 42 CFR 438.12**	No Review	M	M	PM	PM	No Review
Q10	**Excluded providers 42 CFR 438.214**	M	M	M	M	M	M
Q11	**State requirements: caregiver background checks 42 CFR 438.214**	M	M	M	PM	PM	M
Q12	**Confidentiality 42 CFR 438.224**	M	M	M	M	M	M
Q13	**Subcontractual relationships and delegation 42 CFR 438.230**	M	M	M	M	PM	M
Q14	**Practice guidelines 42 CFR 438.236**	No Review	M	M	PM	M	No Review
Q15	**Quality assessment and performance improvement (QAPI) program 42 CFR 438.240 (42 CFR 438.330 updated CFR)**	No Review	M	M	M	M	M
Q16	**QAPI program basic elements: detect utilization 42 CFR 438.240**	No Review	M	M	PM	M	No Review
Q17	**QAPI program basic elements: assess quality of care 42 CFR 438.240**	M	M	M	M	M	M
Q18	**Program review: evaluate QAPI program 42 CFR 438.240**	M	M	M	M	M	M
Q19	**Health information systems 42 CFR 438.242**	M	M	M	M	M	M

*Effective January 1, 2020, two separate FC, FCP MCOs, MCFC-CW/CW and MCFC-CW/MCFC merged to create a new organization, MCFC-CW. No reviews were conducted for the legacy MCOs.

ANALYSIS

Access to Services and Provider Network

Eight standards address requirements related to the provider network, including network adequacy; provider selection, retention, and credentialing; subcontracting and delegation; timely

access to care and services; and cultural competency in service provision (Q1-Q4, Q9-Q11, Q13). All MCOs fully met requirements related to network adequacy, timely access to services, and cultural competency in service provisions in the FY 18-19 review. Four standards related to provider selection, retention, credentialing, and subcontracting were reviewed in FY 19-20.

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. Two MCOs were reviewed for these requirements and both remained partially met. Both MCOs had inconsistencies with internal monitoring and policy implementation, as well as discrepancies in the understanding of the requirements.

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. One MCO was reviewed and was found to have successfully addressed the recommendations from the prior review. All MCOs are fully met in this standard.

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. Two MCOs were reviewed and remained 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. One MCO was reviewed, and remained partially met due to discrepancies in monitoring practices.

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 (Q5-Q8, Q12, Q14). Three of the six standards were reviewed in FY 19-20.

MCOs are required to have procedures in place to coordinate services, or a person/entity designated as being responsible for coordinating services furnished to the member, which includes the services a member receives from any other provider. These requirements are evaluated under Q5. All MCOs partially met this standard in the prior reviews, 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 reviewed 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. For several MCOs, interventions did not show improvements at the time of review, but may show progress with more time for implementation. All MCOs reviewed remained 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. Two MCOs were reviewed for this standard in FY19-20. Both MCOs focused efforts on improving the comprehensiveness of MCPs through training and internal monitoring. Care management review results and MCO internal monitoring results indicated a need for continued improvement efforts; the MCOs reviewed remained partially met.

MCOs are required to adopt, disseminate, and apply practice guidelines. One MCO was reviewed for the standard, Q14, and remains partially met. The organization did not demonstrate effective practices for disseminating the guidelines to affected providers.

Quality Assessment and Performance Improvement

Five standards address requirements that MCOs have in place a QAPI program, and that they maintain a health information system that collects, analyzes, and reports data (Q15 – Q19). Two of the five standards were reviewed in FY 19-20.

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. Two MCOs were reviewed for the standard, Q15. Both MCOs had successfully addressed the recommendations and were found fully met. All MCOs reviewed were fully compliant with the requirements of this standard.

MCOs must have mechanisms in effect to detect underutilization and overutilization of services. Two MCOs were reviewed for the standard, Q16. One MCO successfully addressed the recommendations from the prior review and was found fully met. The other MCO remained partially met, primarily related to mechanisms in place not being adequate to detect underutilization of services at a systems level. Additionally, 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.

CONCLUSIONS

The conclusions are based on assessments of the strengths and weaknesses of the MCO related to quality, timeliness, and access to services, including health care and LTSS. The findings are also indicated in bar graph Q.1 and table Q.2, above:

Progress

- One organization successfully addressed recommendations related to debarment and exclusions (Q10).
- One organization reviewed effectively addressed recommendations related to utilization of services (Q16).
- Two organizations reviewed effectively addressed recommendations related to quality assessment and performance improvement (Q15).

Strengths

- All organizations fully met provider network requirements related to network adequacy, timely access to services, and cultural competency in service provisions (Q1-Q4).
- Three of four organizations reviewed fully met provider network requirements related to provider delegations and responsibilities (Q13).
- All organizations reviewed fully met requirements of the QAPI program (Q15).

Opportunities for Improvement

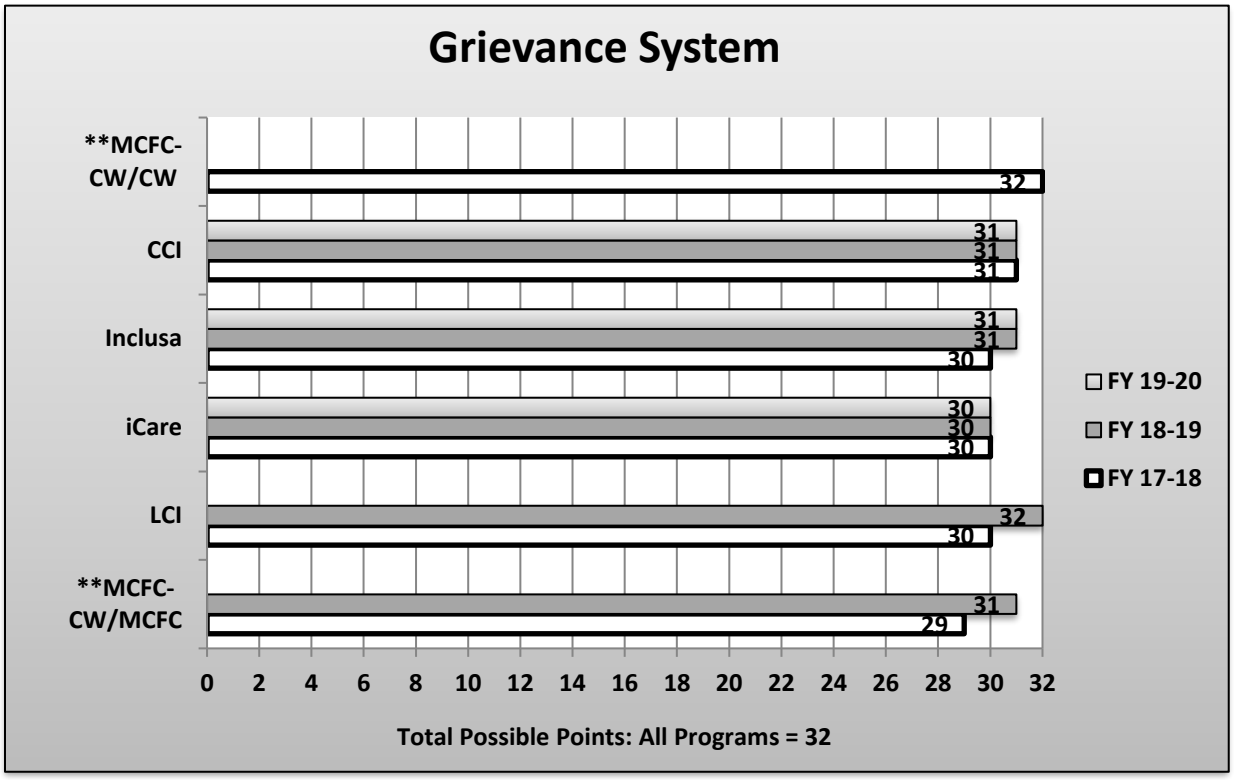
- Focus efforts to improve follow-up with members to ensure services have been received and are effective (Q5);
- Improve the comprehensiveness of MCPs by ensuring all needs identified are addressed on the plan (Q6); and
- Document a process for retention and re-credentialing of providers and ensure monitoring of the process is sufficient for compliance. Focus efforts on ensuring MCOs understand the pertinent regulations (Q9, Q11).

RESULTS GRIEVANCE SYSTEMS 42 CFR 438.228

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.

The following bar graph G.1, indicates each MCO's level of compliance with the Grievance Systems standards.

Graph G.1



*MCFC-CW/CW was fully met following FY 17-18 review; therefore no review occurred in FY 18-19.
**No QCR conducted in FY 19-20 for MCFC-CW/MCFC as a result of the January 1, 2020 merger of the two MCOs.

The following table, G.2, lists the comparative findings by each standard. The first column indicates the number assigned to the review standard. The second column indicates the standard description. The following columns depict each MCO with its rating for this fiscal cycle, scored as M, PM, or NA). Those standards highlighted in grey were scored M in FY 17-18 or FY 18-19 and were not reviewed this cycle. No Review is identified for those standards not fully met by the legacy MCOs, CW and MCFC, prior to the merger.

Table G.2

MCO Comparative Findings by Standard							
		MCFC-CW/CW*	CCI	Inclusa	*i*Care	LCI	MCFC-CW/MCFC*
#	Standard	FY 19-20	FY 19-20	FY 19-20	FY 19-20	FY 19-20	FY 19-20
Grievance System							
G1	General requirements 42 CFR 438.400; 42 CFR 438.402	M	M	M	M	M	M

MCO Comparative Findings by Standard							
		MCFC-CW/CW*	CCI	Inclusa	*i*Care	LCI	MCFC-CW/MCFC*
#	Standard	FY 19-20	FY 19-20	FY 19-20	FY 19-20	FY 19-20	FY 19-20
Grievance System							
G2	Authority to file 42 CFR 438.402	M	M	M	M	M	M
G3	Procedures 42 CFR 438.402	M	M	M	M	M	M
G4	Notice of action (NOA): language, format, and content 42 CFR 438.404; 42 CFR 438.10	M	M	M	M	M	M
G5	NOA: timing of notice 42 CFR 438.404; 42 CFR 431.210; 42 CFR 431.211; 42 CFR 431.213; 42 CFR 431.214	M	PM	PM	PM	M	No Review
G6	Handling of grievances and appeals: general requirements 42 CFR 438.406	M	M	M	M	M	M
G7	Handling of grievances and appeals: local committee 42 CFR 438.406	M	M	M	M	M	M
G8	Special requirements for appeals 42 CFR 438.406	M	M	M	M	M	M
G9	Resolution timeframes 42 CFR 438.408	M	M	M	PM	M	M
G10	Format and content of notice of resolution 42 CFR 438.408	M	M	M	M	M	M
G11	Expedited resolution of appeals 42 CFR 438.410	M	M	M	M	M	M
G12	Information to providers 42 CFR 438.414	M	M	M	M	M	M
G13	Record keeping and reporting 42 CFR 438.416	M	M	M	M	M	M
G14	Continuation of benefits 42 CFR 438.420	M	M	M	M	M	M
G15	Enrollee responsibility for services furnished 42 CFR 438.420	M	M	M	M	M	M
G16	Effectuation of reversed appeal resolutions 42 CFR 438.424	M	M	M	M	M	M

* Effective January 1, 2020, two separate FC, FCP MCOs, MCFC-CW/CW and MCFC-CW/MCFC merged to create a new organization, MCFC-CW. No reviews were conducted for the legacy MCOs.

Analysis

This area of review consists of sixteen standards applicable to all organizations. The standards comprising this area of review address requirements that MCOs maintain an effective system for members to exercise their rights related to grievances and appeals.

All MCOs reviewed demonstrated compliance with general requirements in FY 17-18 and FY 18-19 reviews. The requirements remaining not fully met that were reviewed in FY 19-20 are related to the handling of the member appeal and grievances.

Notices to members must meet several requirements in standard G5. 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. Three MCOs were reviewed for this standard and remained partially met. The MCOs' monitoring and improvement efforts were not sufficient to ensure effectiveness for issuing notices timely when indicated. For one MCO, interventions did not show improvements at the time of review, but may show progress with more time for implementation.

Requirements related to resolution and notification procedures are addressed in standard G9. 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 remained partially met for this standard.

CONCLUSIONS

The conclusions are based on assessments of the strengths and weaknesses of the MCO related to quality, timeliness, and access to services, including health care and LTSS. The findings are also indicated in bar graph G.1 and table G.2, above.

Progress

- No progress was identified in this review. With being the third year of review, the focus was narrow.

Strengths

- All organizations reviewed fully meet the majority of the requirements related to grievances systems.

Opportunities for Improvement

- Focus efforts on issuing notices timely and when indicated.

Protocol 2: Validation of Performance Measures

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

The MCO quality indicators for measurement year (MY) 2019, which are set forth in Addendum IV. of the 2018 Family Care Programs' contract with DHS, provide standardized information about preventative 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 2019. The MY is defined in the technical definitions provided by DHS for the influenza and pneumococcal vaccination quality indicators. DHS updated the technical definitions in September 2019. The technical specifications can be found in Attachments 1 and 2. The review methodology MetaStar used to validate these performance measures can be found in Appendix 3.

Vaccination Rates by Program and MCO

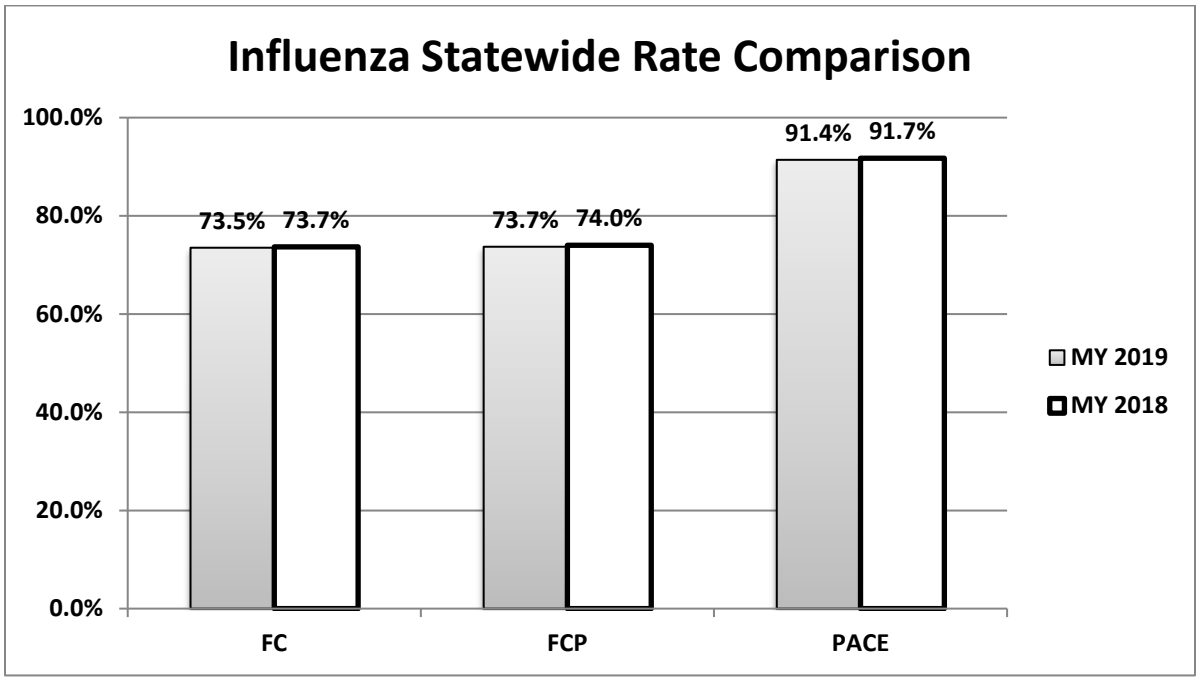
The results of statewide performance for immunization rates in FC, FCP, and PACE are summarized below. As previously identified, the CW and MCFC merger occurred in January 2020, prior to the conclusion of the immunization measurement year. Therefore, the vaccination rates for each legacy MCO are reported separately for each of the two organizations prior to the merger.

Influenza Vaccination Rates

The following table shows information about the influenza vaccination rates, by program, for MY 2019 and compares the 2019 rates to vaccination rates in MY 2018.

Statewide Influenza Vaccination Rates by Program				
	MY 2019			MY 2018
Program	Eligible Members	Number Vaccinated	Vaccination Rate	Vaccination Rate
Family Care	41,583	30,577	73.5%	73.7%
Family Care Partnership	2,954	2,177	73.7%	74.0%
PACE	479	438	91.4%	91.7%

Influenza vaccination statewide rates, by program, for MY 2019 and MY 2018 are shown in the following graph.



The table below shows influenza vaccination rates by program and MCO for MY 2019 and MY 2018.

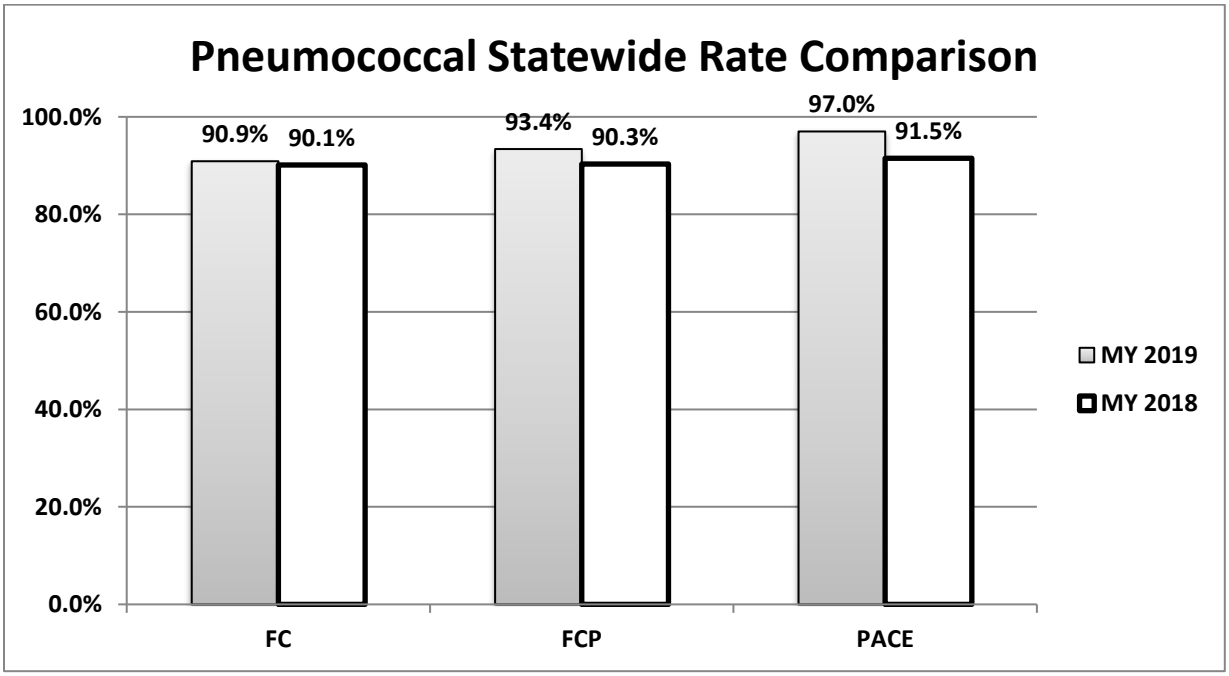
Influenza Vaccination Rates by Program and Measurement Year				
Program/MCO	**MY 2019**			**MY 2018**
	Eligible Members	**Number Vaccinated**	**Vaccination Rate**	**Vaccination Rate**
Family Care				
CCI	9,792	7,223	73.8%	73.1%
MCFC-CW/CW	5,900	4293	72.8%	73.3%
Inclusa	13.008	9,630	74.0%	74.8%
LCI	5,255	3,960	75.4%	75.3%
MCFC-CW/MCFC	7,628	5,471	71.7%	71.8%
Family Care Partnership				
CCI	552	445	80.6%	81.2%
MCFC-CW/CW	1,543	1,195	77.4%	74.1%
*i*Care	859	537	62.5%	69.3%
PACE				
CCI	479	438	91.4%	91.7%

Pneumococcal Vaccination Rates

The table below shows information about the pneumococcal vaccination rates, by program, for MY 2019 and compares the 2019 rates to vaccination rates in MY 2018.

Statewide Pneumococcal Vaccination Rates by Program				
	MY 2019			MY 2018
Program	Eligible Members	Number Vaccinated	Vaccination Rate	Vaccination Rate
Family Care	19,102	17,355	90.9%	90.1%
Family Care Partnership	1,334	1,246	93.4%	90.3%
PACE	402	390	97.0%	91.5%

Pneumococcal vaccination statewide rates, by program, for MY 2019 and MY 2018 are shown in the following graph.



The table below shows pneumococcal vaccination rates by program and MCO for MY 2019 and MY 2018.

Pneumococcal Vaccination Rates by Program and Measurement Year				
Program/MCO	MY 2019			MY 2018
	Eligible Members	Number Vaccinated	Vaccination Rate	Vaccination Rate
Family Care				
CCI	3,857	3,461	89.7%	89.9%

Pneumococcal Vaccination Rates by Program and Measurement Year				
Program/MCO	MY 2019			MY 2018
	Eligible Members	Number Vaccinated	Vaccination Rate	Vaccination Rate
MCFC-CW/CW	2,881	2,621	91.0%	89.1%
Inclusa	5,628	5,111	90.8%	88.0%
LCI	2,408	2,200	91.4%	94.1%
MCFC-CW/MCFC	4,328	3,962	91.5%	91.9%
Family Care Partnership				
CCI	208	190	91.3%	82.7%
MCFC-CW/CW	828	793	95.8%	93.3%
*i*Care	298	263	88.3%	86.8%
PACE				
CCI	402	390	97.0%	91.5%

Results of Performance Measures Validation

Technical Definition Compliance

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

Comparison of MCO and DHS Denominators

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

For all MCOs and quality indicators, more than 97 percent of the total number of unique members included in the MCOs' and DHS' denominator files was common to both data sets. This was the first time all MCOs achieved this threshold on the first submission in last five reviews.

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 2019. Whenever possible, the samples included 25 members reported to have received a vaccination and five members reported to have a contraindication to the vaccination. Three MCOs operated programs for which no members were reported as having contraindications for either one or both of the quality indicators.

As shown in the following tables, MetaStar reviewed a total of 270 member vaccination records for each quality indicator for MY 2019 and MY 2018. The overall findings for both years were not biased, meaning the rates can be accurately reported.

Vaccination Record Validation Aggregate Results

MY 2019 Influenza and Pneumococcal Vaccination Record Validation				
Quality Indicator	**Total Records Reviewed**	**Number Valid**	**Percentage Valid**	**T-Test Result**
Influenza Vaccinations	270	266	98.5%	Unbiased
Pneumococcal Vaccinations	270	269	99.6%	Unbiased

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	100.0%	Unbiased

Vaccination Record Validation Individual MCO Results

The following tables provide information about the validation findings for each MCO in MY 2019.

Results for Influenza Vaccination

MY 2019 Influenza Vaccination Record Validation by Program and MCO				
MCO	**Total Records Reviewed**	**Number Valid**	**Percentage Valid**	**T-Test Result**
Family Care				
CCI	30	29	96.7%	Unbiased
MCFC-CW/CW	30	30	100.0%	Unbiased
Inclusa	30	30	100.0%	Unbiased
LCI	30	29	96.7%	Unbiased
MCFC-CW/MCFC	30	30	100.0%	Unbiased
Family Care Partnership				
CCI	30	30	100.0%	Unbiased
MCFC-CW/CW	30	30	100.0%	Unbiased
*i*Care	30	29	96.7%	Unbiased
PACE				
CCI	30	29	96.7%	Unbiased

Results for Pneumococcal Vaccination

MY 2019 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
MCFC-CW/CW	30	30	100.0%	Unbiased
Inclusa	30	30	100.0%	Unbiased
LCI	30	30	100.0%	Unbiased
MCFC-CW/MCFC	30	30	100.0%	Unbiased
Family Care Partnership				
CCI	30	30	100.0%	Unbiased
MCFC-CW/CW	30	30	100.0%	Unbiased
*i*Care	30	29	96.7%	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 specifications and data submission templates for each immunization. Each MCO submitted policies and procedures detailing guidance for staff related to assessing immunization status, offering the vaccines, providing education about preventive health services, and documenting vaccination data into each respective electronic care management system. In three of the member records submitted for evidence of contraindication to the influenza vaccine, MCO staff did not document the reason for the contraindication or noted a contraindication that did not align with the stated DHS technical definitions. In addition, two of the member records submitted for evidence of receiving a vaccination were not valid:

- One member record submitted for evidence of the influenza vaccine was not valid as the date submitted for the vaccine was prior to the measurement year; and
- One member record submitted for evidence of the pneumococcal vaccine was not valid as the MCO submitted a medical record that noted the immunization with a date that stated "pended" versus "administered."

Clear expectations and standardized tools have improved the performance measure reporting and validation processes, with validation rates from MY 2018 to MY 2019 remaining stable for the influenza vaccine, and improving slightly for the pneumococcal vaccine. Pneumococcal vaccination rates continue to average 90 percent or higher for all programs, while influenza vaccination rates remain below 75 percent in the FC and FCP programs. Analysis of the data submitted for review indicated the lower influenza vaccination rate is related to members declining to receive the vaccine.

CONCLUSIONS

- Continue efforts to increase influenza vaccination rates by educating FC and FCP members on the benefits of the vaccination.
- Ensure the vaccination data collected and reported by one MCO is comparable to DHS data for the pneumococcal vaccination. Conduct a root cause analysis to determine the reason for individuals in the Intellectual/Developmental Disability target group to be reassigned to the Frail Elder target group, and for members age 65 and older to remain in the Physical Disability target group for the pneumococcal vaccination after DHS implemented the target group assignment automation for the long-term care functional screen in early 2017.
- Ensure Interdisciplinary Team (IDT) staff understand and adhere to the DHS technical definitions and MCOs' policies and procedures for vaccination contraindications. The MCOs should develop a means to verify that IDT documentation for contraindications aligns with DHS technical definitions and MCO policies and procedures.

Protocol 3: Validation of Performance Improvement Projects

The purpose of a performance improvement project (PIP) is to assess and improve processes and outcomes of health care provided by the MCO. For FY 19-20, the DHS-MCO contract required all MCOs to make active progress on at least one clinical or non-clinical project relevant to long-term care. Active progress was defined as progress to the point of having implemented at least one intervention and measured its effects on at least one indicator.

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

The study methodology is assessed through the following steps:

- Review the selected study topic(s);
- Review the study question(s);
- Review the selected study indicators;
- Review the identified study population;
- Review sampling methods (if sampling used);
- Review the data collection procedures;
- Assess the MCO's improvement strategies;
- Review the data analysis and interpretation of study results;
- Assess the likelihood that reported improvement is "real" or true improvement, and not due to chance; 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 2019, organizations submitted proposals to DHS in January 2019. DHS directed MCOs to submit final reports by December 30, 2019. MetaStar validated one PIP for each organization, for a total of six PIPs. As previously identified, the merger of CW and MCFC occurred in January 2020. Projects conducted prior to the merger were validated for each organization, and are reported separately throughout this section. More information about PIP Validation review methodology can be found in Appendix 3.

Project Interventions and Outcomes

The table below 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. Each project listed below applies to adults only.

MCO	Interventions	Outcomes	Validation Result	EQR Recommendations
Advance Care Planning				
CCI	Provided members with educational materials about advance directives. Implemented a process to automatically refer members without advance directives to an Advance Care Planning Specialist. Conducted outreach to obtain or assist to complete the members' advance directives. Conducted follow-up outreach to members who refused to complete advance directives at the time of initial outreach.	Project demonstrated improvement in the rate of complete and valid advance directives; the rate increased from 57.5% in 2018 to 90.7% in 2019. Project did not demonstrate improvement in the six month rate of members with complete and valid advance directives after a repeated intervention; the rate did not change from the baseline of 0%.	Met	Ensure all data is documented accurately. Continue to sustain the level of improvement that has been achieved. Obtain repeat measures to demonstrate sustainability.
Choking Risk				
Inclusa	Implemented a tool to evaluate the comprehensiveness of residential choking-specific care plans for Inclusa members. Offered an evidence-based training program for direct care and kitchen staff of residential providers, which included a continuing education certificate for staff upon completion of the training. Met face-to-face with residential providers to discuss feedback related to the comprehensiveness of the choking-specific care plans. Offered a Quality Outcome Payment to providers participating in the PIP project.	Project demonstrated improvement in two of the three aims: • Improved the rate of comprehensive residential care plans for choking risk from 26% to 67.4%. • 75.4% of training participants improved at least one point from pre-test to post-test. Project did not demonstrate improvement for the study question related to follow up from the 2018 PIP; none of the choking-specific care plans for those members in the 2018 PIP sample were comprehensive at the Level 3 rating.	Met	Continue to sustain the level of improvement that has been demonstrated.

MCO	Interventions	Outcomes	Validation Result	EQR Recommendations
Dementia Care				
LCI	Trained interdisciplinary team staff regarding the importance of dementia screening, best practice methods to discuss the issue with members, and timeline and documentation requirements for the project. Educated members about the importance of dementia screening and conducted dementia screens if the member was in agreement. Offered opportunities to complete the dementia screening if the members were in agreement.	The project demonstrated "real" improvement: increased the rate of dementia screening from 44.4% in 2018 to 90.8% in 2019 for Winnebago County, and from 41.7% in 2018 to 83.0% in 2019 for Fond du Lac County.	Met	Obtain repeat measures to demonstrate sustainability.
Reduce Readmission Rate				
*i*Care	Implemented a Prescription for Readmission Prevention Pilot Program.	Project demonstrated improvement: decreased the rates of 30-day hospital readmissions • All-cause: from 17.5% in 2018 to 15.1% in 2019; • Medical: from 16.6% in 2018 to 15.3% in 2019; and • Psychiatric: from 29.6% in 2018 to 14.1% in 2019. The reported improvements could not be attributed to the planned intervention.	Partially Met	Clearly describe data displayed in graphs and charts. Fully analyze data and include data to demonstrate the effectiveness of the intervention.
MCFC-CW/MCFC	Conducted training for registered nurses (RNs) and lead supervisors on the revised hospitalization and post-discharge care coordination process. Developed and	Project demonstrated improvement in the rate of post-discharge assessment contacts completed with members 65 and older; the rate increased from 66.7% to 67.6%.	Met	Obtain repeat measures to demonstrate sustainability related to the use of the post-

MCO	Interventions	Outcomes	Validation Result	EQR Recommendations
	implemented the *Post-Discharge Telephonic RN Assessment* tool.	Project did not demonstrate improvement in the rate of members 65 and older with post-acute care hospital readmissions; the rate increased from 22.4% to 23.4%.		discharge assessment tool. Analyze readmission data for less than optimal improvement.
Improve Care Management for Member Health, Safety, and Risk				
MCFC-CW/CW	Assessed member risk using the *Risk Stratification Tool* during initial, six-month, and annual member assessments. Used the *Member Intervention Report* to address identified areas of risk on the member centered plan. Completed internal file reviews to determine if identified risks were addressed.	Project did not demonstrate improvement; the change in the internal file review rate of risk being addressed when identified could not be confirmed as the initial and repeat measures were not comparable.	Partially Met	Include measurable goals for all study questions. Ensure initial and repeat measures are comparable. Calculate and present all data clearly, consistently, and accurately throughout the report.

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 19-20 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.	6/6
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.	5/6
Study Indicator(s)		
3	The study used objective, clearly and unambiguously defined, measureable indicators and included defined numerators and denominators.	6/6

FY 19-20 Performance Improvement Project Validation Results		
	Numerator = Number of projects meeting the standard Denominator = Number of projects applicable for the standard	
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.	6/6
Study Population		
5	The project/study clearly defined the relevant population (all members to whom the study question and indicators apply).	6/6
6	If the entire population was used, data collection approach captured all members to whom the study question applied.	4/4
Sampling Methods		
7	Valid sampling techniques were used.	2/2
8	The sample contained a sufficient number of members.	2/2
Data Collection Procedures		
9	The project/study clearly defined the data to be collected and the source of that data.	6/6
10	Staff are qualified and trained to collect data.	6/6
11	The instruments for data collection provided for consistent, accurate data collection over the time periods studied.	6/6
12	The study design prospectively specified a data analysis plan.	4/6
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.	6/6
14	A continuous cycle of improvement was utilized to measure and analyze performance, and to develop and implement system-wide improvements.	6/6
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.	4/6
17	Numerical results and findings were presented accurately and clearly.	6/6
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.	6/6
"Real" Improvement		
19	The same methodology as the baseline measurement was used, when measurement was repeated.	5/6
20	There was a documented, quantitative improvement in processes or outcomes of care.	2/6
21	The reported improvement appeared to be the result of the planned quality improvement intervention.	1/5
Sustained Improvement		
22	Sustained improvement was demonstrated through repeated measurements over comparable time periods.	0/0

Analysis

All MCOs obtained approvals to conduct the required number of PIPs during calendar year 2019. Projects focused on a variety of topics, with two projects continuing from the prior year, and four PIPs addressing new topics.

For the MCO's with continuing PIPs, one of the two projects achieved documented, quantitative improvement for all study questions. The reported improvement could not be attributed to the planned quality improvement intervention; therefore, sustained improvement could not be evaluated. For the other MCO with a continuing PIP, documented, quantitative improvement was achieved for only two of the three study questions, and the reported improvement for those study questions appeared to be the result of the planned quality improvement intervention. However, as improvement was not achieved for all study questions, sustained improvement could not be evaluated.

Beginning in late 2015, DHS encouraged MCOs to develop PIP proposals in alignment with state priorities. One DHS priority area encompassed dementia capable care. While several MCOs focused on this topic in prior years, one organization developed an initiative to improve the rate of dementia screening in 2018 and transitioned it into a formal PIP project in 2019. The MCO's project achieved documented, quantitative improvement which appeared to be the result of the interventions employed, and fully met all applicable validation standards. No other PIP in calendar year 2019 fully met all applicable validation standards.

Conclusions

Documented, quantitative improvement in processes or outcomes of care was evident in two of the six validated projects. In one of these projects, improvement was demonstrated to be the result of the interventions employed. Based on validation results, none of the 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. Four of the projects received validation findings of fully "met" and two projects received validation findings of "partially met."

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

Strengths

- The project topics focused on improving key aspects of care.
- The study topics, indicators, and measures were clearly documented.
- The study questions were clearly defined.
- A knowledgeable qualified team was selected to conduct the project.

- Interventions were developed to address member health and safety.
- Data sources were clearly identified and the data collection approach was consistent.
- Continuous cycles of improvement were used to assess the effectiveness of the interventions.
- Data was presented clearly and accurately throughout the report.
- Data was fully analyzed and the report identified follow-up actions.

Opportunities for Improvement

- Ensure initial and repeat measures are comparable;
- Identify a prospective data analysis plan that details how frequently the data will be reviewed and analyzed to determine the effectiveness of the interventions;
- Analyze data for less than optimal improvement;
- Ensure the data analysis includes an evaluation of the effectiveness of the interventions resulting in the improvement;
- Obtain repeat measures to demonstrate sustainability; and
- Continue to improve or sustain the level of progress that has been achieved.

APPENDIX V: INFORMATION SYSTEMS CAPABILITIES ASSESSMENT

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

During FY 19-20, MetaStar conducted ISCAs for one MCO selected by DHS. The organization, *i*Care, operates only a FCP program.

To conduct the assessment, the 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 the 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

The MCO met all requirements in this focus area. The organization identified and described its core functions as well as its key vendors and the services they provide. Descriptions were provided of key systems, data warehouses, and applications utilized by the MCO's internal staff and its vendors for collecting, processing and storing enrollment and claims data, and for creating the monthly encounter data files for DHS.

Section II: Information Systems - Encounter Data Flow

The MCO met all the requirements in this section. Details were provided of the MCO's testing procedures designed to assure the quality of the encounter data before the encounter file is sent to DHS, and how it resolves and corrects errors identified by DHS during the process of loading, accepting, or rejecting the MCO submissions. The MCO ensures that all vendor data are included and complete, prior to encounter data submission.

Section III: Data Acquisition – Claims and Encounter Data Collection

The MCO met most of the requirements in this focus area. The organization described the process of certifying or validating the monthly encounter file prior to submission to DHS. A small percentage of claims are still being processed via paper forms, but the trend toward the utilization of electronic submissions is increasing. The MCO has a limited ability to break down claim categories by service type into those that are submitted by paper and those submitted electronically. The MCO indicated the ability to provide such breakdown upon request; however, the MCO was not able to provide this for the review.

Section IV: Eligibility and Enrollment Data Processing

The MCO met all requirements in this area. Systems and processes are in place at the 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. Discrepancies are researched and resolved with Income Maintenance or the Aging and Disability Resource Centers (ADRCs). Sufficient interfaces exist with the county ADRCs, and the Client Assistance for Reemployment and Economic Support and ForwardHealth interChange System websites, which result in prompt and verifiable enrollment and disenrollment processes, usually carried out within one to two business days.

Section V: Practitioner Data Processing

The MCO met all requirements in this focus area. The organization utilizes provider management software to maintain provider data related to credentialing, contracting, and provider directories.

Section VI: System Security

The MCO met all the requirements in this area. Processes are in place for daily backup of enrollment, claims, and provider data. Most backup activities take place in-house on the MCO's internal systems, and some are performed by an external contractor. The MCO conducts frequent disaster recovery tests and simulations.

Section VII: Vendor Oversight

The MCO met all requirements in this focus area. The organization provided detailed documentation guiding the oversight of the four primary claims processing vendors.

The MCO's oversight extends to multiple areas of vendor operations and actually begins with a meticulous procurement process. Following the MCO's contracting with its vendors, the focus of the oversight shifts to ensuring data quality through reasonableness checks of service volumes as reflected in the data. While no specific performance goals are set for vendors in the areas of data

gathering and transmission, as part of the encounter records creation process, the MCO's Information System (IS) staff conducts frequent testing to assure the accuracy of vendor data before merging data from all sources and sending it to DHS. The MCO has a well-documented process for the periodic review of vendors' performance, and has established regular channels of communication with its vendors for providing feedback and the prompt resolution of outstanding issues. Since the last review, the MCO has made several changes to its vendors' line up, due mostly to its strategic needs.

Section VIII: Medical Record Data Collection

The MCO does not collect medical record information for its encounter reporting processes; therefore, this section does not apply.

Section IX: Business Intelligence

The MCO met all the requirements in this area. The MCO utilizes the most current version of the Microsoft Office package (primarily Excel), as well as standard query language capabilities to support its management and operational functions and decision-making, including programmatic and fiscal planning, utilization management, and quality assurance and improvement.

The MCO routinely utilizes the DHS Business Object's Adult Functional Screen DataMart, and to a lesser extent, the Long-Term Care Encounter DataMart. These DataMarts are utilized to better understand and align its members' characteristics, including demographics and acuity, with the types and quantities of the services they receive under its FCP program. Results are then utilized to project and predict future demographic and services trends, as well as assess their impact on the organization and improve its planning.

Section X: Performance Measure

The MCO met all requirements in this focus area. The MCO gathers immunization data from the electronic medical record used for care management and the Wisconsin Immunization Registry. The data sets are reconciled, validated, and consolidated for annual submission to DHS.

CONCLUSIONS

Overall, the review found the MCO 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

The MCO addressed recommendations made during the previous ISCA review in FY 16-17. The organization updated its policies, procedures and practices in an effort to:

- Resolve batch and other errors identified by DHS during the process of downloading and accepting the encounter files.
- Integrate provider data into a new, comprehensive system.

Strengths

The FY 19-20 ISCA review found the MCO exhibited strengths in the following areas:

- The MCO has implemented a new comprehensive and state of the art system in support of its provider network operation. The new system has consolidated and streamlined older and more fragmented provider operation systems.
- The organization has a comprehensive and integrated encounter data creation and submission process. The process combines claims data from multiple streams: vendors, providers, and accounts payable; validates the merged data against the MCO's financial systems; and employs checks and edits to ensure data quality and completion.
- The MCO has demonstrated agility and adaption in making the smooth transition to new vendors and providers that are better suited to its evolving IS structure and needs.
- The MCO has demonstrated a commitment to documenting its ISCA related functions. The reviewers received more than 100 well written and easy to understand documents describing diverse policies and procedures.
- The MCO has developed an in-house rate setting methodology for its high cost substitute care settings, namely adult family homes and community based residential facilities. The methodology can assist in better resource allocation by the MCO.

Protocol 8: Conducting Focused Studies of Health Care Quality - Care Management Review

Care management review (CMR) is an optional review activity conducted based on criteria approved by DHS. See the Appendix for more information about external quality review and a description of the methodologies used to conduct review activities. The purpose of the CMR is to provide data to the MCO and DHS about the health, safety, and continuity of care of members. CMR is conducted to assess the adequacy of an MCO's care management function by evaluating processes and outcomes of care, and determining whether the services provided are consistent with the nature and severity of each member's needs, preferences, and outcomes. CMR activities also relate to assurances found in the 1915(c) Waiver and support assessment of compliance with federal standards.

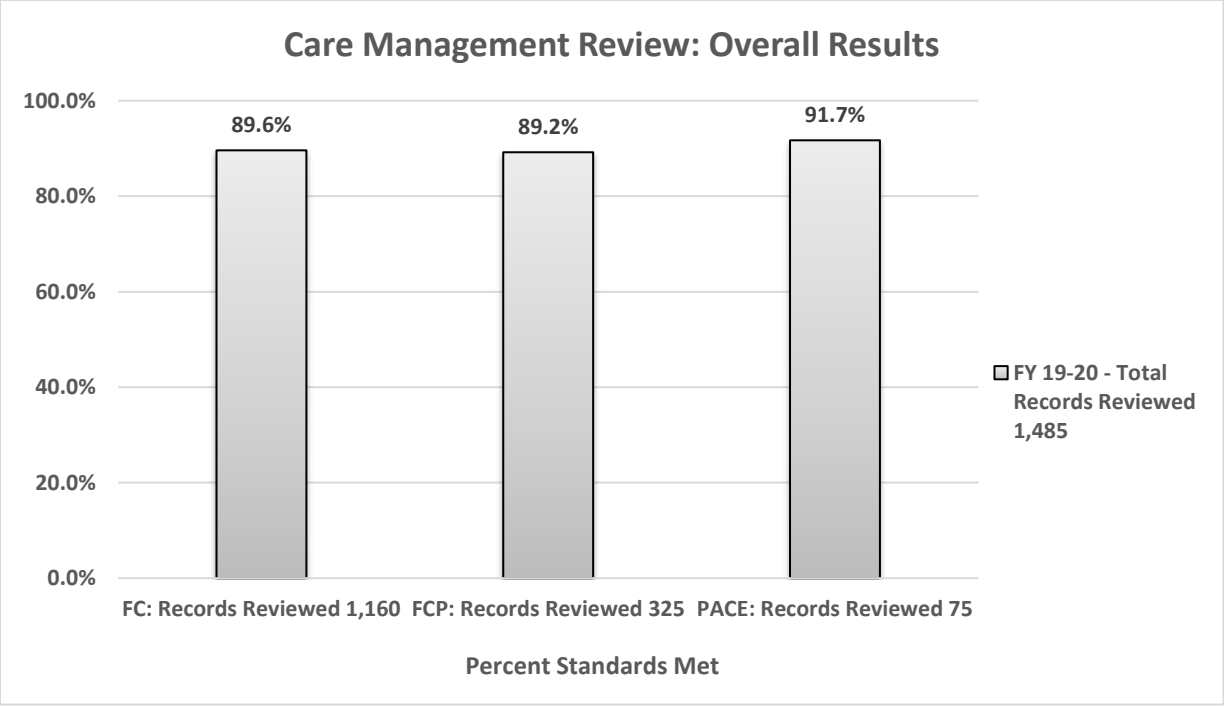
The CMR was conducted using a review tool and reviewer guidelines developed by MetaStar and approved by DHS. The review tool for FY 19-20 was revised to better align with applicable requirements and evaluate changes to the DHS-MCO contract. The revisions to the tool were substantial and CMR results from prior years are no longer comparable. More information about the CMR review methodology can be found in Appendix 3.

Overall Results by Program

Aggregate results for FY 19-20 CMRs conducted as part of each MCO's annual EQR are displayed in several graphs below.

The following graph shows the overall percent of standards met for all review indicators for CMRs conducted during the FY 19-20 review year for organizations operating programs for FC, FCP, and PACE.

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



In addition to the organizational level CMR results described below in the *Results for each CMR Focus Area* section, each MCO was provided a report of each individual record reviewed. MetaStar recommends the MCOs evaluate the results of these individual member reviews and direct care management teams to follow up and take action related to individual situations, as needed.

Results for each CMR Focus Area

Each of the three sub-sections below provides a brief explanation of one of the key categories of CMR, followed by bar graphs which display FY 19-20 CMR results by program (FC, FCP, and PACE) for each review indicator that comprises the category.

Comprehensive Assessment

Interdisciplinary team (IDT) staff must assess each member in order to comprehensively explore and document information, such as:

- Personal experience outcomes;
- Long-term care outcomes;
- Strengths;
- Preferences;
- Natural and community supports;
- Risks related to health and safety; and

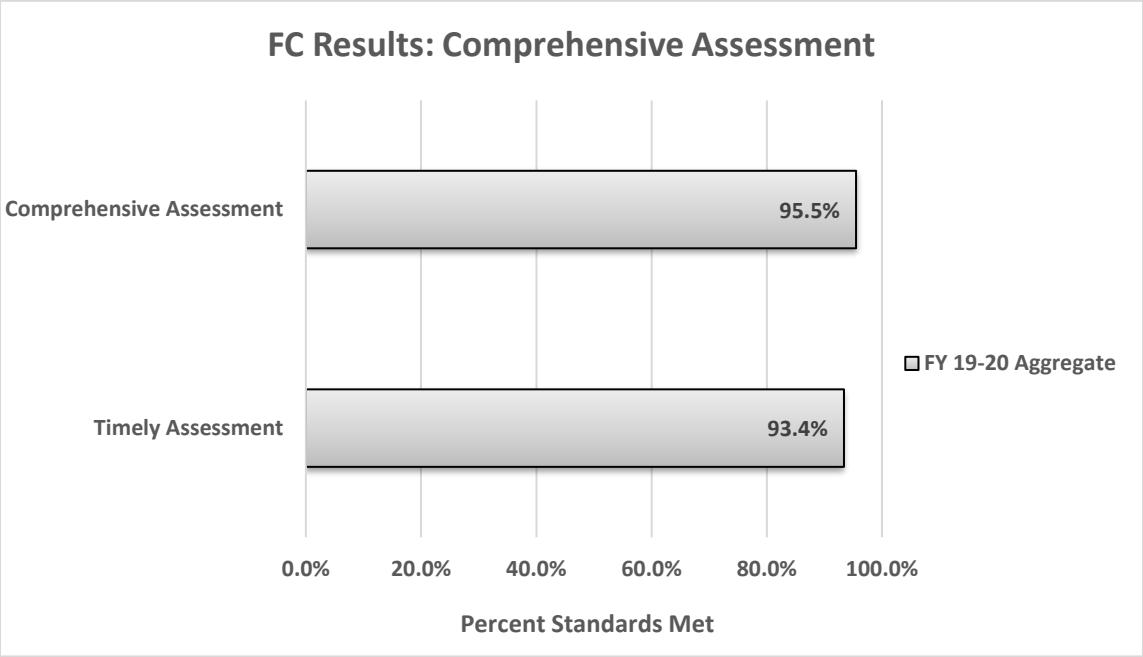
- Ongoing clinical or functional conditions and needs that require long-term care, a course of treatment, or regular care monitoring.

The initial assessment and subsequent reassessments must meet the timelines and other requirements described in the DHS-MCO contract.

FC

The comprehensive assessment category was a strength for the FC programs, with both indicators in this focus area scoring above 90 percent.

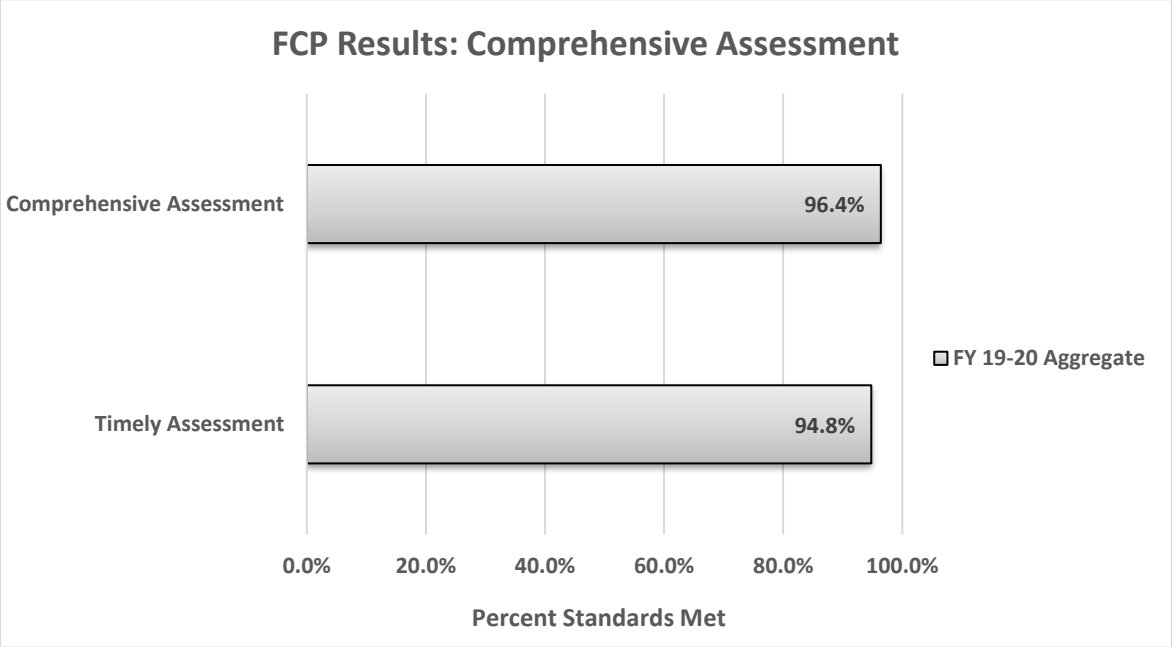
Results for Assessment for MCOs Operating FC:



FCP

The comprehensive assessment category was a strength for the FCP programs, with both indicators in this focus area scoring above 90 percent.

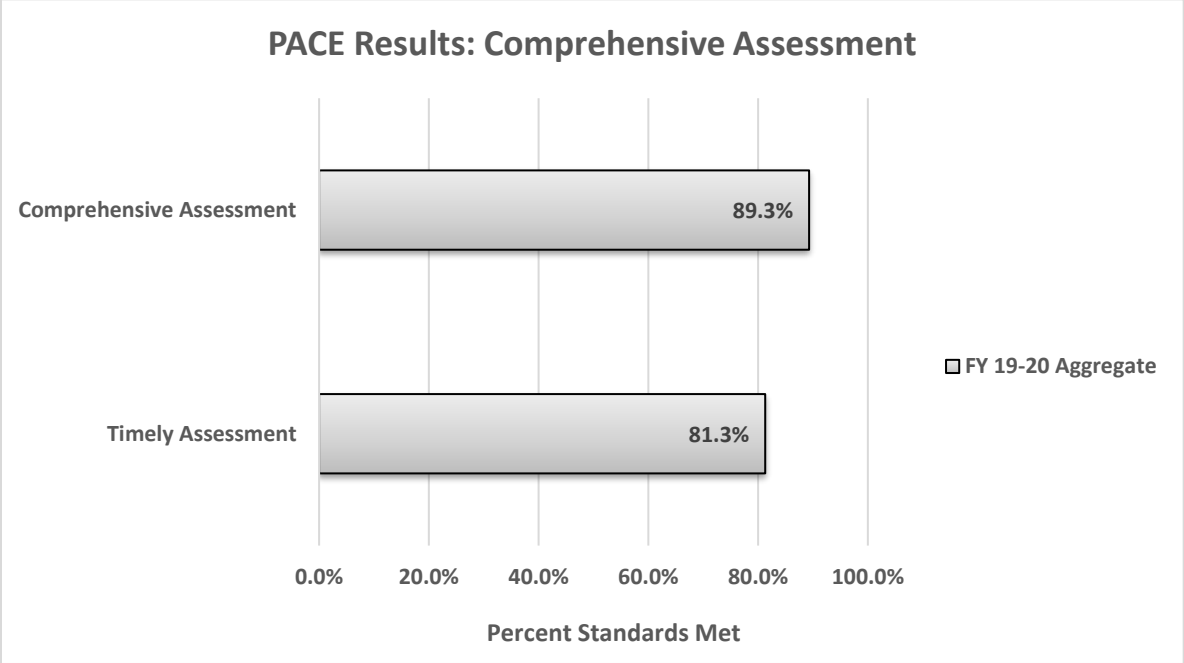
Results for Assessment for MCOs Operating FCP:



PACE

For PACE, some records were found to not have comprehensive assessments, often due to an assessment of an activity of daily living or instrumental activity of daily living not completed by a staff member of the IDT. Additionally, some assessments were completed beyond the required timeframes.

Results for Assessment for the MCO Operating PACE:



MEMBER CENTERED PLANNING

The MCP and Service Authorization document must:

- Identify all services and supports to be authorized, provided, and/or coordinated by the MCO that are consistent with information in the comprehensive assessment, and are
    - Sufficient to ensure the member's health, safety, and well-being;
    - Consistent with the nature and severity of the member's disability or frailty; and
    - Satisfactory to the member in supporting his/her long-term care outcomes.
- Be developed and updated according to the timelines and other requirements described in the DHS-MCO contract.

Additionally, the record must:

- 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; and
- Document that the IDT assessed and responded to members' identified risks.

FC

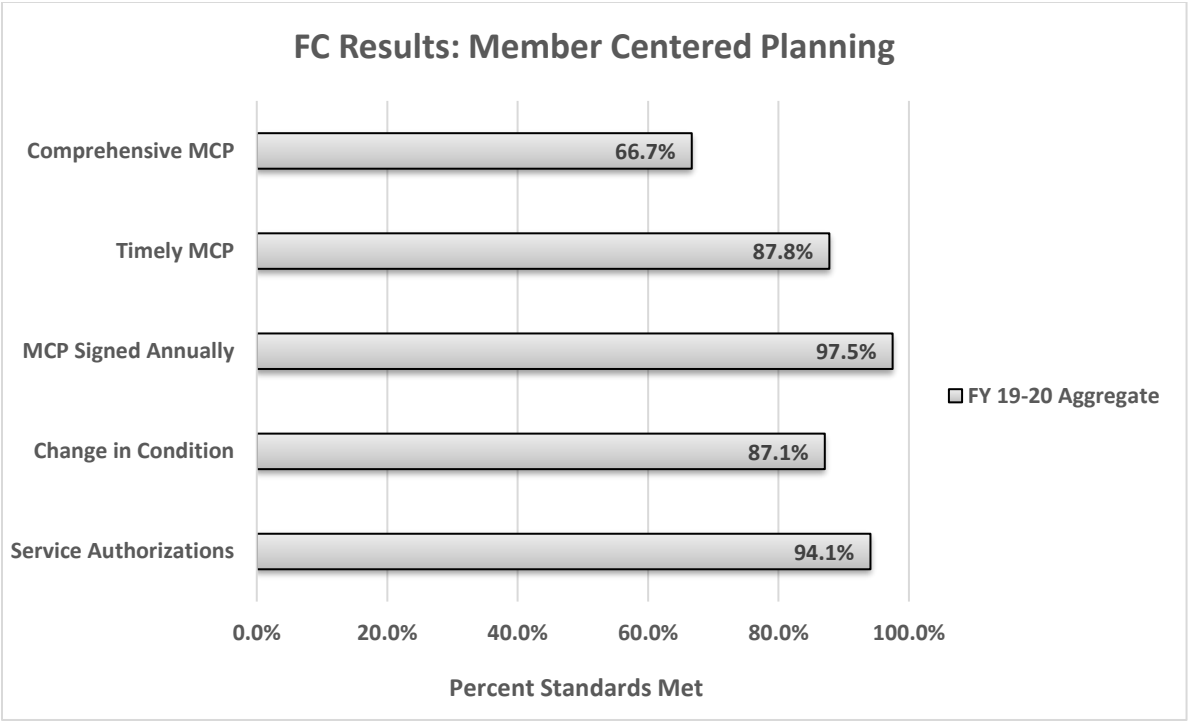
For the indicator *Comprehensive MCP*, which ensures member MCPs include all assessed needs, the FC program results show a need for improvement. The most common reason MCPs were not comprehensive was the plan did not include a service or support for an assessed need, such as durable medical equipment for bathing or toileting. The second most common reason for records being unmet was plans did not fulfill the requirements for the use of behavior modifying medications.

The indicator *Timely MCP* evaluates MCPs being reviewed and signed in accordance with the DHS-MCO contract requirement of every six months. In the majority of the records not fully met for this standard MCPs were reviewed timely, but were not signed within the required timeframes. MCPs were found to be signed at least once annually in 97.5 percent of all FC records.

The indicator *Change in Condition* evaluates the IDTs assessing the member when changes occur and updating the MCP when applicable, which includes the exploration or education of risk interventions. In the majority of the records not fully met for this standard in the FC program, teams did not update the MCP when a change in condition occurred.

The indicator *Service Authorizations* evaluates the IDTs handling of service authorizations, including appropriately responding to member requests and issuing *Notices of Adverse Benefit Determination,* when applicable. Overall, service authorizations were handled appropriately for the FC program. In all FC records reviewed, 392 *Notices of Adverse Benefit Determination* were indicated; and 313 were issued timely, for an issuance rate of 79.8 percent. The rate is mostly due to teams not making decisions on requested services within the required timeframes.

Results for Member Centered Planning for MCOs Operating FC:



*Change in Condition applied to 272 of 1,160 records in FY 19-20.

FCP

For the indicator *Comprehensive MCP*, which ensures member MCPs include all assessed needs, the most common reason MCPs were not comprehensive was the plan did not include a service or support for the member's activity of daily living, or instrumental activity of daily living skills.

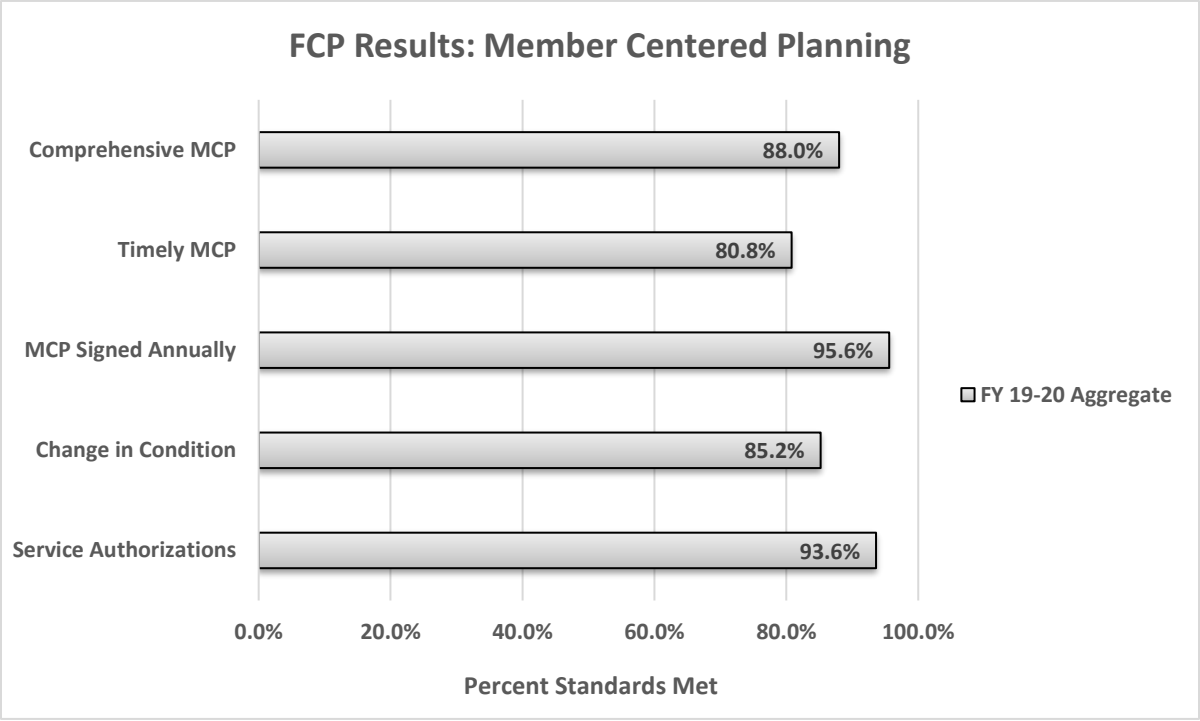
The indicator *Timely MCP* evaluates MCPs being reviewed and signed in accordance with the DHS-MCO contract requirement of every six months. In the majority of the records not fully met for this standard the MCPs were reviewed timely, but were not signed within the required timeframes. In other cases, the legal decision maker did not sign the plan. MCPs were found to be signed at least once annually in 95.6 percent of all FCP records.

The indicator *Change in Condition* evaluates the IDTs assessing the member when changes occur and updating the MCP when applicable, which includes the exploration or education on risk interventions. In the majority of the FCP records not fully met for this standard, teams did not update the MCP when a change in condition occurred.

The indicator *Service Authorizations* evaluates the IDTs handling of service authorizations, including appropriately responding to member requests and issuing *Notices of Adverse Benefit Determination* when applicable. Overall, service authorizations were handled appropriately for

the FCP. In all FCP records reviewed, 71 *Notices of Adverse Benefit Determination* were indicated, and 48 were issued timely, for an issuance rate of 67.6 percent. The rate is mostly due to teams not making decisions on requested services within the required timeframes.

Results for Member Centered Planning for MCOs Operating FCP:



*Change in Condition applied to 81 of 250 records in FY 19-20.

PACE

For the indicator *Comprehensive MCP* in PACE, this indicator was a strength, scoring over 90 percent.

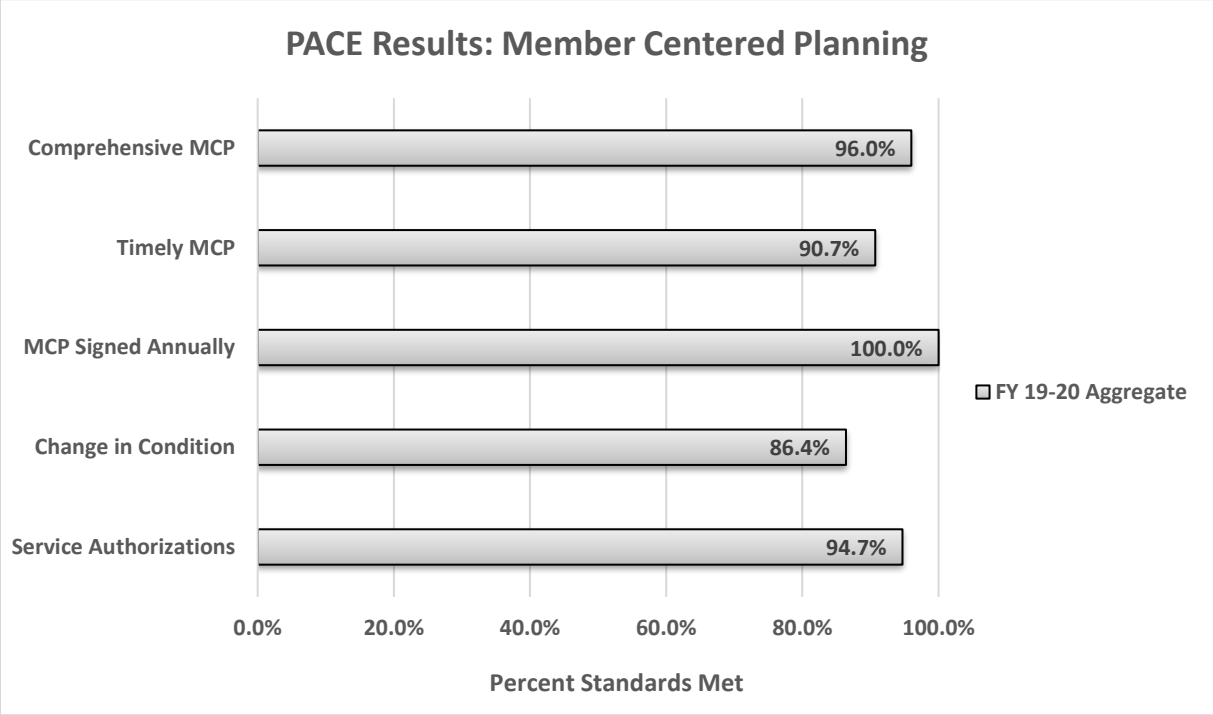
The indicator *Timely MCP* evaluates MCPs being reviewed and signed in accordance with the DHS-MCO contract requirement of every six months. This indicator was a strength for PACE, scoring over 90 percent. MCPs were found to be signed at least once annually in 100 percent of all records.

The indicator *Change in Condition* evaluates the IDTs assessing the member when changes occur and updating the MCP when applicable, which includes the exploration or education on risk interventions. In the records not fully met for this standard in PACE, teams did not update the MCP when a change in condition occurred.

The indicator *Service Authorizations* evaluates the IDTs handling of service authorizations, including appropriately responding to member requests and issuing *Notices of Adverse Benefit*

Determination when applicable. Overall, service authorizations were handled appropriately in PACE. In several cases, *Notices of Adverse Benefit Determination* were indicated but not issued. In all records reviewed, 17 *Notices of Adverse Benefit Determination* were indicated, with 12 being issued timely, for an issuance rate of 70.6 percent.

Results for Member Centered Planning for the MCO Operating PACE:



*Change in Condition applied to 22 of 75 records in FY 19-20.

CARE COORDINATION

The IDT is formally designated as being primarily responsible for authorizing, providing, arranging, or coordinating the member's long-term care and health care. The record must document that:

- The IDT staff coordinated the member's services and supports in a reasonable amount of time;
- 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
- All of the member's identified needs have been adequately addressed.

FC

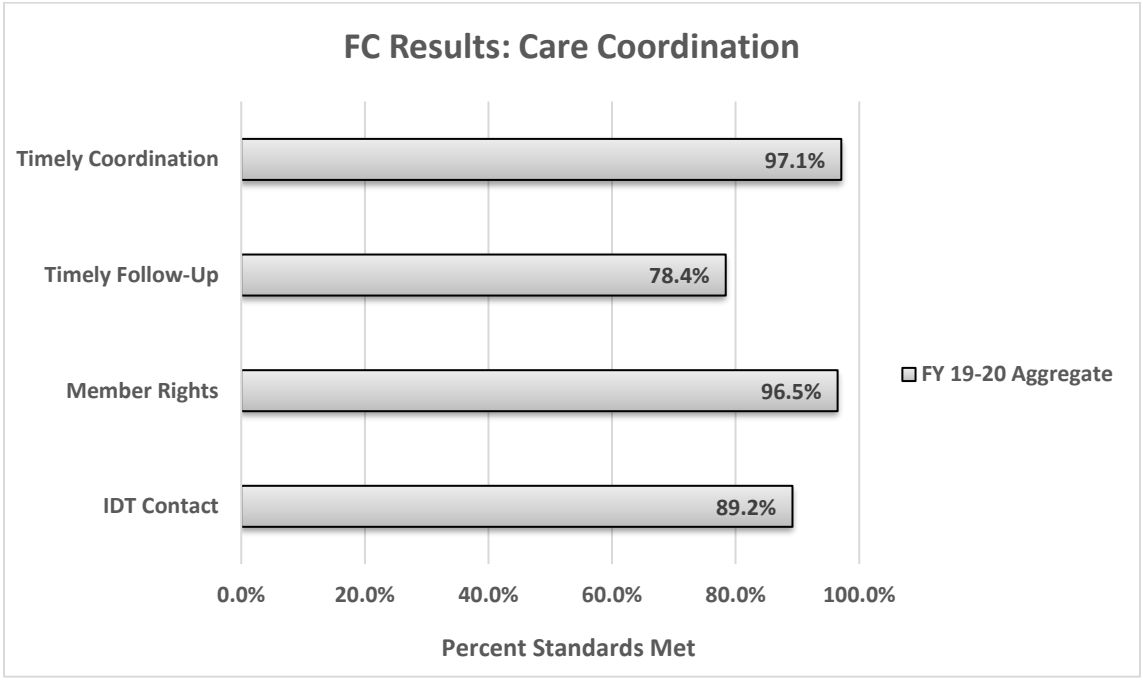
The *Timely Coordination* indicator evaluates plans put in place by the IDT to ensure member needs and supports are coordinated effectively and in timely manner. This indicator was a strength for the FC programs, scoring over 90 percent.

The indicator *Timely Follow-Up* evaluates whether the IDT followed up with members to confirm services and supports were received and effective. Results indicated a need for improvement in the FC programs. Records found unmet for this indicator were due to a lack of documented follow-up for covered services and health related services.

The indicator *Member Rights* evaluates the protection of member rights, such as IDT staff including the member and his/her supports in care management processes; offering and explaining the self-directed supports (SDS) option to the member; and following applicable guidelines for restrictive measures and rights limitations. This indicator was a strength for the FC program, scoring over 90 percent.

The evaluation of IDT contact requirements under the indicator *IDT Contacts*, included monthly collateral contacts, quarterly face-to-face contacts with the member, and an annual home visit with the member by the care manager and registered nurse care manager. Records found unmet for this indicator usually lacked evidence of a monthly contact with the member, legal decision maker, or other appropriate party.

Results for Coordination for MCOs Operating FC:



FCP

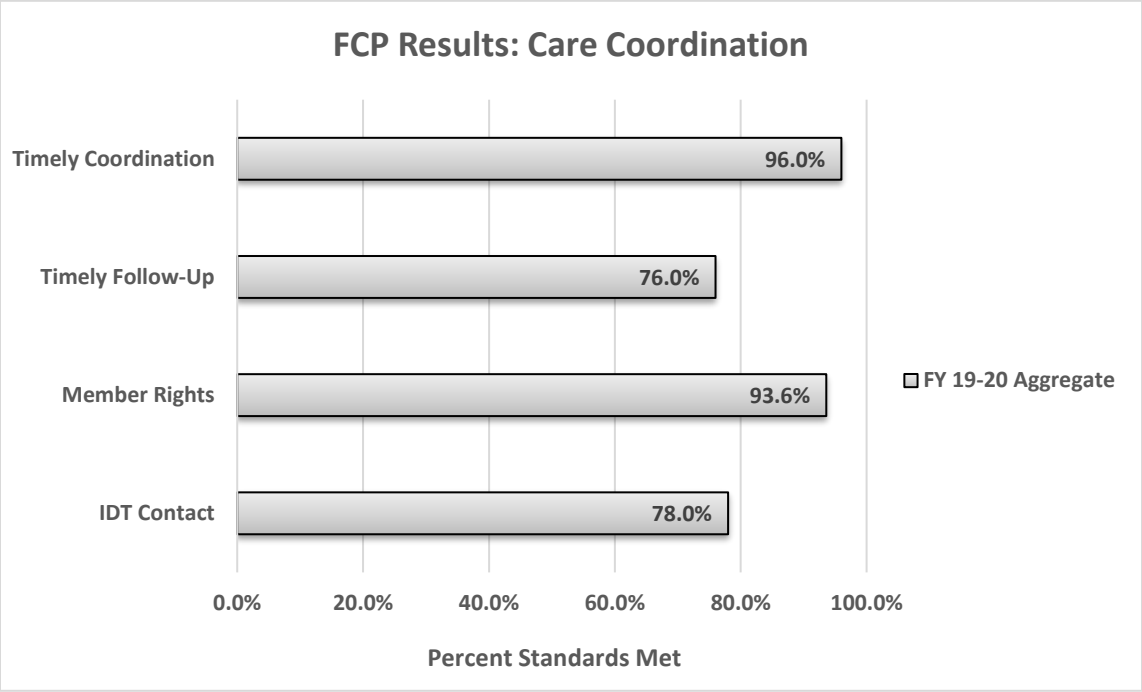
The *Timely Coordination* indicator evaluates plans put in place by the IDT to ensure member needs and supports are coordinated effectively and in timely manner. This indicator was a strength for the FCP programs, scoring over 90 percent.

The indicator *Timely Follow-Up* evaluates whether the IDT followed up with members to confirm services and supports were received and effective. Results indicated a need for improvement in the FCP programs. Records found unmet for this indicator were due to a lack of documented follow-up for covered services and health related services.

The indicator *Member Rights* evaluates the protection of member rights, such as IDT staff including the member and his/her supports in care management processes; offering and explaining the SDS option to the member; and following applicable guidelines for restrictive measures and rights limitations. This indicator was a strength for the FCP programs, scoring over 90 percent.

The evaluation of IDT contact requirements under the indicator *IDT Contacts*, included monthly collateral contacts, quarterly face-to-face contacts with the member, and an annual home visit with the member by the care manager and registered nurse care manager. Results indicated a need for improvement in the FCP programs. Records found unmet for this indicator usually lacked evidence of a monthly contact with the member, legal decision maker, or other appropriate party.

Results for Coordination for MCOs Operating FCP:



PACE

The *Timely Coordination* indicator evaluates plans put in place by the IDT to ensure member needs and supports are coordinated effectively and in timely manner. This indicator was a strength for PACE, scoring over 90 percent.

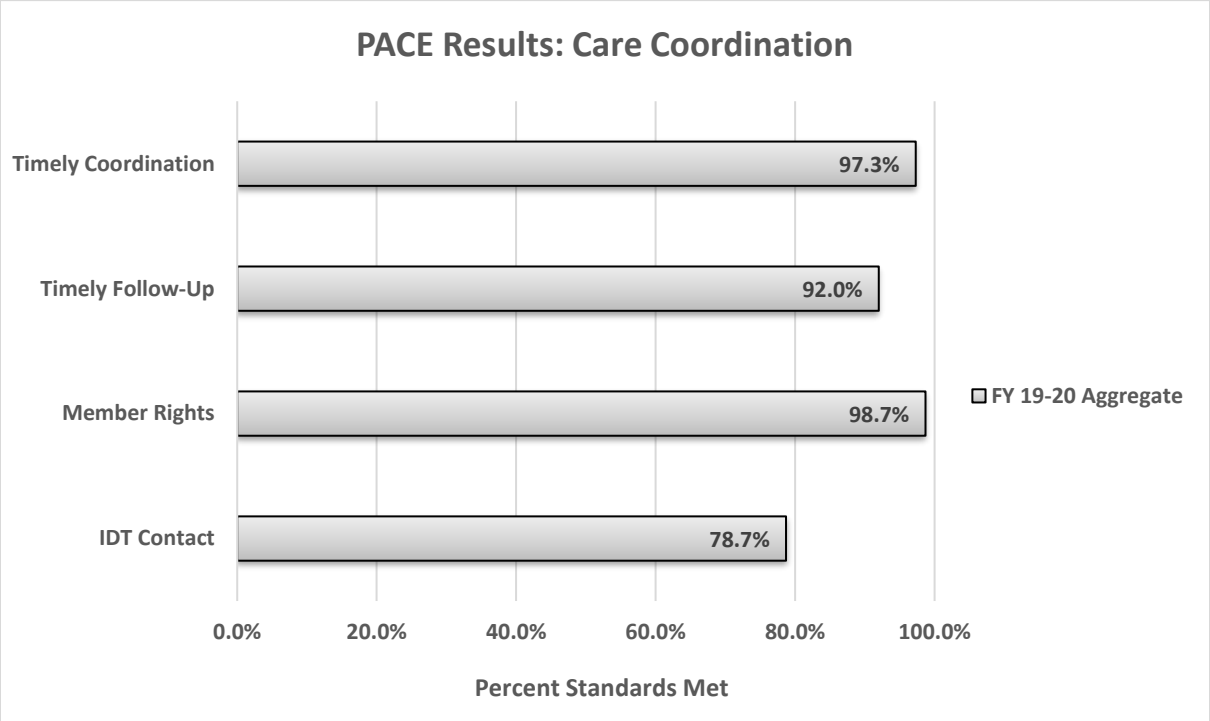
The indicator *Timely Follow-Up* evaluates whether the IDT followed up with members to confirm services and supports were received and effective. This indicator was a strength for PACE, scoring over 90 percent.

The indicator *Member Rights* evaluates the protection of member rights, such as IDT staff including the member and his/her supports in care management processes; offering and explaining the SDS option to the member; and following applicable guidelines for restrictive measures and rights limitations. This indicator was a strength for PACE, scoring over 90 percent.

The evaluation of IDT contact requirements under the indicator *IDT Contacts*, included monthly collateral contacts, quarterly face-to-face contacts with the member, and an annual home visit with the member by the care manager and registered nurse care manager. In the records unmet for this indicator in PACE, there was a lack of evidence of a home visit with the member annually by the care manager and registered nurse care manager. In most cases a home visit

occurred with a different member of the IDT, which did not meet the DHS-MCO contract requirements.

Results for Coordination for the MCO Operating PACE:



ANALYSIS

Member Health and Safety

Over the course of FY 19-20, MetaStar did not identify any members with unaddressed health and safety concerns during CMR, out of 1,485 total member records selected and reviewed during this year's EQR activities. One member with complex situations involving medical, mental health, behavioral, cognitive, and/or social issues was identified, and brought to the attention of the MCO 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 19-20, DHS also directed MetaStar to re-review the records of five members identified in last year's review as having health and safety concerns 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 five member records re-reviewed in FY 19-20, all demonstrated the MCOs had sufficiently addressed the issues or situations.

Over the course of the fiscal year, MetaStar also reviewed another 130 member records outside of annual EQR activities, and followed the referral process described above for any member identified as having health and safety issues and/or complex and challenging situations. Again, these reviews were not included in the results for this report.

Overall Results

Aggregate results for all programs was 89.6 percent, indicating a high level of compliance. Aggregate results for individual programs ranged from 89.2 percent to 91.7 percent.

CONCLUSIONS

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

Strengths

- All organizations demonstrate the ability to sufficiently support members, as evidenced by no members identified with unaddressed health and safety issues, and only one identified for a complex and challenging situation.
- Comprehensive assessments were a strength for the FC and FCP programs, with all indicators in this area scoring over 90 percent.
- Member-centered planning were a strength for PACE with four of five indicators in this area scoring over 90 percent.
- Care coordination were a strength for PACE with three of four indicators in this area scoring over 90 percent.

Opportunities for Improvement

- Increase the comprehensiveness of MCPs in the FC program;
- Focus efforts on improving follow-up to ensure member supports and services are adequate in the FC and FCP programs; and
- Ensure the IDTs are making the minimum member contacts as identified in the DHS-MCO contract for FCP and PACE.

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 (Validation of Performance Improvement Projects)
PMV	Performance Measures Validation (Validation of Performance Measures)
QAPI	Quality Assessment and Performance Improvement
QCR	Quality Compliance Review
SDS	Self-Directed Supports
SMCP	Special Managed Care Program
TPA	Third Party Administrator

APPENDIX 2 – EXECUTIVE SUMMARIES

Community Care, Inc. (CCI) – Executive Summary

This section of the report summarizes the results of the fiscal year 2019-2020 (FY 19-20) external 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 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 19-20 Results	Comparison to FY 18-19 Results
Quality Compliance Review	• 2 standards reviewed • 0 standards received "met" rating • 86: Compliance score out of a possible 88 points in the third year of three-year review cycle	• 7 standards reviewed • 5 standards received "met" rating • 86: Compliance score out of a possible 88 points in the second year of three-year review cycle
Care Management Review	<u>Family Care</u> • 8 of 11 standards met at a rate of 90 percent or higher • 90.0 percent: Overall rate of standards met by this organization for all review indicators <u>Family Care Partnership</u> • 7 of 11 standards met at a rate of 90 percent or higher • 88.5 percent: Overall rate of standards met by this organization for all review indicators <u>PACE</u> • 7 of 11 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	• Note: The review tool for FY 19-20 was revised to better align with applicable requirements and evaluate changes to the contract. The revisions to the tool were substantial and CMR results from prior years are no longer comparable.

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 18-19 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. FY 19-20 was a follow-up review year and with a narrow scope of review. Community Care, Inc. focused efforts in response to MetaStar's recommendations from FY 18-19; however, improvement in the standards reviewed has not yet been fully realized at the time of the FY 19-20 review.

CCI – Strengths
This section is intended to report on strengths of the managed care organization that are beyond basic compliance. FY 19-20 was a follow-up review year and had a narrow focus. No strengths were identified related to the standards reviewed.

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:

- Continue to focus efforts on monitoring and improving the following areas of care management practice:
    - Completion and documentation of follow-up with members and their supports to ensure services have been received and are effective; and
    - Issuance of notices, including *Notice of Adverse Benefit Determination*, in a timely manner when indicated.

Inclusa, Inc. (Inclusa) – Executive Summary
This section of the report summarizes the results of the fiscal year 2019-2020 (FY 19-20) external 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 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 19-20 Results	Comparison to FY 18-19 Results
Quality Compliance Review	• 6 standards reviewed • 2 standards received "met" rating • 82: Compliance score out of a possible 86 points in third year of three-year review cycle	• 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
Care Management Review	Family Care • Six of 11 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	Note: The review tool for FY 19-20 was revised to better align with applicable requirements and evaluate changes to the DHS-MCO contract. The revisions to the tool were substantial and CMR results from prior years are no longer comparable.

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 18-19 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.

Inclusa, Inc. effectively addressed the following recommendations:

- The organization updated written guidance and policies with the requirement to provide written notice of termination of a contracted provider to members within required timeframes, and to ensure all relevant staff are aware of their roles in the process.
- Inclusa, Inc. updated the *Advance Directives* policy to include written guidance to ensure members are informed that complaints concerning non-compliance with any advance directive may be filed with the State of Wisconsin/Division of Quality Assurance.
- The MCO's website was updated to include information about advance directives on its community resources page, which includes links to forms and information for who can assist in completing advance directives in the community.

Inclusa – Strengths

This section is intended to report on strengths of the managed care organization that are beyond basic compliance. FY 19-20 was a follow-up review year and had a narrow focus. No strengths were identified related to the standards reviewed.

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 that existing providers are informed of the general member rights they must observe, protect, and take into account when furnishing services.
- Focus efforts on monitoring and improving the following areas of care management practice:
    - Issuance of notices in a timely manner when indicated;
    - Follow-up with members and their supports to ensure services have been received and are effective;
    - Comprehensiveness of member-centered plans; and
    - Timeliness of the most recent member-centered plan.

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

This section of the report summarizes the results of the fiscal year 2019 – 2020 (FY 19-20) 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 19-20 Results	Comparison to FY 18-19 Results
Quality Compliance Review	• 10 standards reviewed • 3 standards received "met" rating • 81: Compliance score out of a possible 88 points in the third year of three-year review cycle	• 11 standards reviewed 1 standard received "met" rating • 78: Compliance score out of a possible 88 points in the second year of three-year review cycle
Care Management Review	<u>Family Care Partnership</u> • 6 of 11 standards met at a rate of 90 percent or higher • 88.6 percent: Overall rate of standards met by this organization for all review indicators	• Note: The review tool for FY 19-20 was revised to better align with applicable requirements and evaluate changes to the contract. The revisions to the tool were substantial and CMR results from prior years are no longer comparable.

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 18-19 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 recommendations:

- The organization updated and implemented written guidance for sending electronic materials to members.
- The organization updated and fully implemented its *Provider Directory Maintenance Policy* to ensure the provider directory is accessible, current, and includes all required information.
- The organization facilitated opportunities for Family Care Partnership providers to actively participate in the organization's quality program.
- Data was collected and used for quality improvement regarding monitoring the accuracy of long-term care functional screens and provider survey results.

iCare – Strengths

This section is intended to report on strengths of the managed care organization that are beyond basic compliance. FY 19-20 was a follow-up review year and had a narrow focus. No strengths were identified related to the Quality Compliance Standards reviewed.

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:

- Update and implement all relative provider credentialing and re-credentialing policies and procedures for clarity and include current practices and methods.
- Ensure providers meet all service related requirements, including caregiver background checks and licensure or certification.
- Evaluate the organization's current practices of re-credentialing providers every three years to determine if it is appropriate for all provider types.
- Enhance monitoring efforts by clearly differentiating between initially credentialed and re-credentialed providers on audit reports.
- Ensure the organization's provider network staff have a consistent understanding and application of the following provider expectations and monitoring practices:
    - Monitor provider credentials to ensure ongoing compliance, and document needed follow-up and actions taken related to the verification; and

    - Monitor and document needed follow-up and actions taken related to caregiver background check verification for all applicable providers.
- Implement systems to ensure providers have direct access to the practice guidelines adopted by the organization.
- Fully implement utilization management processes which produce data that is adequate to detect both underutilization and overutilization of services to identify trends at the organization or system level.
- Continue to focus efforts to improve care management in the area of timely follow-up to ensure services are received and effective.
- Focus efforts on monitoring and improving the following areas of care management practice:
    - Ensure members are offered the option to self-direct services at least annually; and
    - Ensure member contact requirements are met.

Lakeland Care, Inc. (LCI) – Executive Summary

This section of the report summarizes the results of the fiscal year 2019-2020 (FY 19-20) 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 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 19-20 Results	Comparison to FY 18-19 Results
Quality Compliance Review	• 9 standards reviewed • 3 standards received “met” rating • 80: Compliance score out of a possible 86 points in the third year of three-year review cycle	• 16 standards reviewed 7 standards received “met” rating • 77: Compliance score out of a possible 86 points in the second year of three-year review cycle

Review Activity	FY 19-20 Results	Comparison to FY 18-19 Results
Care Management Review	Family Care • 4 of 11 standards met at a rate of 90 percent or higher • 85.7 percent: Overall rate of standards met by this organization for all review indicators	• Note: The review tool for FY 19-20 was revised to better align with applicable requirements and evaluate changes to the contract. The revisions to the tool were substantial and CMR results from prior years are no longer comparable.

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 18-19 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:

- Assured all provider types within the benefit package were included in the monthly debarment verification and that the verification was conducted monthly.
- The organization provided evidence of active participation from members and providers in the MCO's Quality Program.
- A provider survey was conducted as required by the DHS-MCO contract.
- Consistent approaches were implemented for monitoring and detecting potential underutilization of services, which included the development of an underutilization plan.

LCI – Strengths

This section is intended to report on strengths of the managed care organization that are beyond basic compliance. FY 19-20 was a follow-up review year and had a narrow focus. No strengths were identified related to the Quality Compliance Standards reviewed.

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 systems are in place for members to access complete and accurate provider directory information.
- 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, and document needed follow-up and actions taken related to the verification; and
    - Monitor and document needed follow-up and actions taken related to caregiver background check verification for all applicable providers.
- Ensure the new electronic provider management system is fully implemented to track all provider related incidents.
- Continue to focus efforts on monitoring and improving the following areas of care management practice:
    - Ensure comprehensive and timely member-centered plans;
    - Completion and documentation of follow-up with members and their supports to ensure services have been received and are effective; and
    - Ensure member contact requirements are met.

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:

- Explore additional methods to increase member participation in the member advisory committee.
- Clearly identify the process used by quality staff for reviewing the quality progress table and how this review interfaces with the Quality Management Committee meetings.

APPENDIX 3 – REQUIREMENT FOR EXTERNAL QUALITY REVIEW AND REVIEW METHODOLOGIES

REQUIREMENT FOR EXTERNAL QUALITY REVIEW

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

MetaStar - Wisconsin's External Quality Review Organization

The State of Wisconsin contracts with MetaStar, Inc. to conduct EQR activities and produce reports of the results. Based in Madison, Wisconsin, MetaStar has been a leader in health care quality improvement, independent quality review services, and medical information management for more than 40 years, and represents Wisconsin in the Lake Superior Quality Innovation Network, under the Centers for Medicare & Medicaid Services (CMS) Quality Improvement Organization Program.

MetaStar conducts EQR of MCOs operating Medicaid managed long-term programs, including Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly. In addition, the company conducts EQR of MCOs serving BadgerCare Plus, Supplemental Security Income, Special Managed Care, Foster Care Medical Home Medicaid recipients, and the Children with Medical Complexity (CMC) program 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 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,

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

schools, home health agencies, community-based residential settings, and the Wisconsin Department of Health Services (DHS). Some reviewers have worked in skilled nursing and acute care facilities and/or primary care settings. The EQR team also includes reviewers with quality assurance/quality 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://www.dhs.wisconsin.gov/familycare/mcos/index.htm ;
- The previous external quality review report; and
- DHS communication with the MCO about expectations and performance during the previous 12 months.

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

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

MetaStar also conducted some onsite verification activities, and requested and reviewed additional documents, as needed, to clarify information gathered during the onsite visit. Data from some Care Management Review 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 – **9 Standards**	• General Rule 42 CFR 438.100 • Information Requirements 42 CFR 438.100; 42 CFR 438.10 • Specific Rights 42 CFR 438.100 • Provider-Enrollee Communications 42 CFR 438.102 • Emergency and Post-stabilization Services 42 CFR 438.114; 42 CFR 422.113
Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement – **19 Standards**	• Availability of Services 42 CFR 438.206 • Coordination and Continuity of Care 42 CFR 438.208 • Coverage and Authorization of Services 42 CFR 438.210 • Provider Selection 42 CFR 438.214; 42 CFR 438.12 • Confidentiality 42 CFR 438.224 • Subcontractual Relationships and Delegation 42 CFR 438.230 • Practice Guidelines 42 CFR 438.236 • QAPI Program 42 CFR 438.240 • Health Information Systems 42 CFR 438.242

Focus Area	Related Sub-Categories in Review Standards
Grievance System – 16 Standards	• General Requirements 42 CFR 438.400; 42 CFR 438.402 • Notices to Members 42 CFR 438.404; 42 CFR 438.10 • Handling of Grievances and Appeals 42 CFR 438.406 • Resolution and Notification 42 CFR 438.408 • Expedited Resolution of Appeals 42 CFR 438.410 • Information about the Grievance System to Providers 42 CFR 438.414 • Recordkeeping and Reporting Requirements 42 CFR 438.416 • Continuation of Benefits while the MCO Appeal and State Fair Hearing are Pending 42 CFR 438.420 • Effectuation of Reversed Appeal Resolutions 42 CFR 438.424

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

Met:

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

Partially Met:

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

Not Met:

- The MCO did not meet the requirements in practice and had not developed policies or procedures.

For findings of "partially met" or "not met," the EQR team documented the missing requirements related to the findings and provided recommendations, as indicated. In some instances, recommendations were made for requirements met at a minimum.

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

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

The number of points were added and reported relative to the total possible points for each focus area, and as an overall score. The maximum possible points are 86 for FC, and 88 for FCP/PACE.

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

Validation of Performance Measures

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

MetaStar reviewed the most recent Information Systems 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) 2019. 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 definition 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 definition 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 2019 to both the statewide rates for MY 2019 and the MCO's rates for MY 2018.
- 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 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 was 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 were 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 used sound methodology in its design, implementation, analysis, and reporting. CMS issued the EQR Protocols in 2020 and the *Validation of Performance Improvement Projects* is now Protocol One. 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,* as this was the Protocol in effect during the project timeframe.

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 contract, other reporting technical references, and the Code of Federal Regulations at 42 CFR 438.242. Prior to the review, MetaStar met with DHS to develop the review methodology and tailor the review activities to reflect DHS expectations for compliance. MetaStar used a combination of activities to conduct and complete the Information Systems Capabilities Assessment (ISCA), including reviewing the following references:

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

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

MetaStar visited the MCO to perform staff interviews to:

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

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

Section I: General Information

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

Section II: Information Systems – Encounter Data Flow

MetaStar identifies the types of data collection systems that are in place to support the operations of the MCO as well as technical specifications and support staff. Reviewers assess how the MCO

integrates claims/encounter, membership, Medicaid provider, vendor, and other data to submit final encounter data files to DHS.

Section III: Data Acquisition - Claims and Encounter Data Collection

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

Section IV: Eligibility and Enrollment Data Processing

MetaStar assesses information on the MCO's enrollment/eligibility data systems and processes. The review team focuses on accuracy of that data found through MCO reconciliation practices and linkages of encounter data to eligibility data for encounter data submission. The review team also focuses on the timeliness of the enrollment processes and on how the MCO handles breaks in enrollment within its systems.

Section V: Practitioner Data Processing

MetaStar reviewers ask the MCO to identify the systems and processes in place to obtain, maintain, and properly utilize data from the practitioner/provider network.

Section VI: System Security

MetaStar reviewers assess the IS security controls. The MCO must provide a description of the security features it has in place and functioning at all levels. Reviewers obtain and evaluate information on how the MCO manages its encounter data security processes and ensures data integrity of submissions. The reviewers also evaluate the MCO's data backing and disaster recovery procedures including testing.

Section VII: Vendor Oversight

MetaStar reviews MCO oversight and data collection processes performed by service providers and other information technology vendors/systems (including internal systems) that support MCO operational functions, and provide data which relate to the generation of complete and accurate reporting including encounter data creation. 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. Reviewers also look for comprehensive and well documented policies and procedures that govern the procurement process as well the on-going monitoring and communications to improve coordination and resolution of vendors' issues as they occur.

Section VIII: Medical Record Data Collection

MetaStar reviews the MCO's system and process for data collected from medical record chart abstractions to include in encounter data submissions to DHS, if applicable.

Section IX: Business Intelligence

MetaStar assesses the decision support capabilities of the MCO's business information and data needs, including utilization management, outcomes, quality measures, and financial systems. (The review of this section is only for FC, FCP, and PACE programs at the request of DHS.) Reviewers also look at the extent to which the MCO's analysts utilize the two datamart data bases that DHS makes available to the MCO through Business Objects.

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)

MetaStar randomly selected a sample of member records. 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 19-20 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:

- Comprehensive Assessment
- Member Centered Planning
- Care Coordination
- Quality of Care

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 2019 – 2020

#	Enrollee Rights and Protections
	General Rule
1	**42 CFR 438.100; DHS-MCO Contract Article X.** The MCO must: • Have written policies regarding member rights • Comply with any applicable federal and state laws that pertain to member rights • Ensure its employees and contracted providers observe and protect those rights, and take those rights into account when furnishing services.
	Information Requirements
2	**42 CFR 438.100; 42 CFR 438.10; DHS-MCO Contract Article IX.** The MCO must provide all notices, informational materials, and instructional materials relating to members in a manner and format that may be easily understood. The MCO must: • Make its written information available in the prevalent non-English languages in its service area; • Make oral interpretation services available free of charge for all non-English languages (not just those identified as prevalent); • Provide written materials that are in an easily understood language and format; • Make alternative formats available that take into consideration members' special needs; • Make reasonable efforts to locate and use culturally appropriate materials; • Notify members of the availability of the above materials and services, including how to access them. Member materials shall be available to members in paper form, unless electronic materials are available and the member/legal decision maker has given prior consent to receiving materials electronically. The MCO must document the member's/legal decision maker's consent and meet other requirements specified in the DHS-MCO contract.
3	**42 CFR 438.100; 42 CFR 438.10; DHS-MCO Contract Article IX.** General information must be furnished to members as required. The MCO must: • Notify members of their right to request and obtain information at least once a year, including information about member rights and protections, the Member Handbook, and Provider Directory; • Provide required information to new members within a reasonable time period and as specified by the DHS-MCO contract; • Provide at least 30 days written notice when there is a "significant" change (as defined by the state) in the information the MCO is required to provide its members; • Make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to members who received services from such provider.
4	**42 CFR 438.100; 42 CFR 438.10; DHS-MCO Contract Article IX.** The MCO provides information to members in the Provider Directory as required by 42 CFR 438.10(f)(6) and the DHS-MCO contract.

#	Enrollee Rights and Protections
5	**42 CFR 438.100; 42 CFR 438.10; DHS-MCO Contract Article IX.** The MCO provides information to members in the Member Handbook, as required by 42 CFR 438.10(f)(6), 42 CFR 438.10(g), and the DHS-MCO contract.
6	**42 CFR 438.100; 42 CFR 438.10; 42 CFR 438.3; 42 CFR 422.128; DHS-MCO Contract Article X.** Regarding advance directives, the MCO must: • Maintain written policies and procedures in accordance with 42 CFR 422.128 and the DHS-MCO contract; • Provide written information to members regarding their rights under state law to make decisions concerning their medical care, accept or refuse treatment, and formulate advance directives; • Update written information to reflect changes in state law as soon as possible (but not later than 90 days after the effective date of the change); • Provide members written information with respect to the MCO's policies regarding the above rights, including a clear and precise statement of limitation if it cannot implement an advance directive as a matter of conscience. The statement must comply with requirements listed in 42 CFR 422.128(b)(1)(ii)(A-C); • Provide written information to each member at the time of MCO enrollment (or family/surrogate if member is incapacitated at time of enrollment), and must have a follow-up procedure in place to provide the information to the member when he/she is no longer incapacitated; • Document in the medical record whether or not the individual has executed an advance directive; • Not condition the provision of care or otherwise discriminate based on whether or not a member has completed an advance directive; • Ensure compliance with requirements of state law regarding advance directives; • Provide education for staff on the MCO's advance directives policies/procedures; • Provide community education on advance directives and document these efforts. (MCO can provide directly or in concert with other providers/entities); • Inform individuals that complaints concerning non-compliance with any advance directive may be filed with the State of Wisconsin/Division of Quality Assurance.
	Specific Rights
7	**42 CFR 438.100; DHS-MCO Contract Article X.** The MCO guarantees that its members have the right to: • Be treated with respect and consideration for his/her dignity and privacy; • Receive information on available treatment options and alternatives presented in a manner appropriate to the member's condition and ability to understand; • Participate in decisions regarding his/her health care, including the right to refuse treatment; • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation; • Request and receive a copy of his/her medical records, and to request that they be amended or corrected in accordance with federal privacy and security standards; • Be furnished health care services in accordance with 438.206 through 438.210. • Exercise their rights, and that the exercise of those rights does not adversely affect the way the MCO and its network providers treat members; • Be free from unlawful discrimination as specified in federal and state laws (including: Title VI of the Civil Rights Act of 1964; Age Discrimination Act of 1975; Rehabilitation Act of

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

#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement
	Availability of Services
1	**42 CFR 438.206; DHS-MCO Contract Articles VII. and VIII.** ***Delivery network*** The MCO maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract.

#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement
	In establishing and maintaining the network, the MCO site must consider: • Anticipated Medicaid enrollment; • Expected utilization of services, considering Medicaid member characteristics and health care needs; • Numbers and types (in terms of training, experience and specialization) of providers required to furnish the contracted Medicaid services; • The number of network providers that are not accepting new MCO members; • The geographic location of providers and MCO members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities. The delivery network provides female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services, when applicable per program benefit package.
2	**42 CFR 438.206; DHS-MCO Contract Articles VII. and VIII** ***Second opinion and out-of-network providers*** The MCO provides for a second opinion from a qualified health care professional within the network, or arranges for the member to obtain one outside the network, at no cost to the member, when applicable per program benefit package. If the network is unable to provide necessary services, covered under the contract, to a particular member, the MCO must adequately and timely cover these services out of network for the member as long as the MCO is unable to provide them. The MCO must coordinate with out-of-network providers to ensure that the cost of services to members is no greater than they would have been if furnished within the provider network.
3	**42 CFR 438.206; DHS-MCO Contract Article VIII.** ***Timely access*** The MCO must: • Require its providers to meet state standards for timely access to care and services, taking into account the urgency of need for services; • Ensure that the network providers offer hours of operation that are not less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service, if the provider serves only Medicaid members; • Make services available 24 hours a day, 7 days a week when medically necessary; • Establish mechanisms to ensure compliance by providers; • Monitor providers regularly to determine compliance; • Take corrective action if there is a failure to comply.
4	**42 CFR 438.206*;* DHS-MCO Contract Article VIII.** ***Cultural considerations*** The MCO must participate in the state's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The MCO must: • Incorporate in its policies, administration, provider contract, and service practice the values of honoring members' beliefs and cultural backgrounds;

#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement
	• Permit members to choose providers from among the MCO's network based on cultural preference; • Accept appeals and grievances from members related to a lack of access to culturally appropriate care.
	Coordination and Continuity of Care
5	**42 CFR 438.208 (b. 1-4); DHS-MCO Contract Article V.** ***Primary care and coordination of health care services*** The MCO must implement procedures to deliver primary care (as applicable for FCP) and coordinate health care services for all MCO members. These procedures must do the following: • Ensure that each member has an ongoing source of primary care appropriate to his/her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member; • Coordinate the services the MCO furnishes to the member with services the member receives from any other provider of health care or insurance plan, including mental health and substance abuse services; • Share with other providers serving the member the results of its identification and assessment of that member's needs to prevent duplication of activities; • Ensure protection of the member's privacy when coordinating care; • Facilitate direct access to specialists as appropriate for the member's special health care condition and identified needs.
6	**42 CFR 438.208; DHS-MCO Contract Article III.** ***Identification:*** Identification and eligibility of individuals with special health care needs will be in accordance with the Wisconsin Long-Term Care Functional Screen. ***Assessment:*** The MCO must implement mechanisms to assess each member in order to identify special conditions that require treatment and care monitoring The assessment must use appropriate health care professionals. ***Member-centered plan:*** The treatment plan must be: • Developed to address needs determined through the assessment; • Developed jointly with the member's primary care team with member participation, and in consultation with any specialists caring for the member; • Completed and approved in a timely manner in accordance with DHS standards.
	Coverage and Authorization of Services
7	**42 CFR 438.210; DHS-MCO Contract Article V.** ***Authorization of services*** For processing requests for initial and continuing authorizations of services, the MCO must: • Have in place and follow written policies and procedures; • Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; • Consult with the requesting provider when appropriate; • Ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a health care

#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement
	professional who has appropriate clinical expertise in treating the member's condition or disease.
8	**42 CFR 438.210; DHS-MCO Contract Article V.(K)(9)** ***Timeframe for decisions of approval or denial*** The IDT staff shall make decisions on requests for services and provide notice as expeditiously as the member's health condition requires. <u>Standard Service Authorization Decisions</u> ***For Family Care and Partnership:*** • Decisions shall be made no later than fourteen (14) calendar days following receipt of the request for the service unless the MCO extends the timeframe for up to fourteen (14) additional calendar days. If the timeframe is extended, the MCO must send a written notification to the member no later than the fourteenth day after the original request. ***For PACE:*** • Decisions on direct requests for services must be made and notice provided as expeditiously as the member's health condition requires but not more than 72 hours after the date the interdisciplinary team receives the request. The interdisciplinary team may extend this 72-hour timeframe by up to five (5) additional calendar days for either of the following reasons: a) The participant or designated representative requests the extension; or b) The team documents its need for additional information and how the delay is in the interest of the participant. <u>Expedited Service Authorization Decisions:</u> • If following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO shall make an expedited service authorization no later than seventy two (72) hours after receipt of the request for service. • The MCO may extend the timeframes of expedited service authorization decisions by up to eleven (11) additional calendar days if the member or a provider requests the extension or the MCO justifies a need for additional information. For any extension not requested by the member, the MCO must give the member written notice of the reason for delay of decision.
	Provider Selection
9	**42 CFR 438.214; 42 CFR 438.12; DHS-MCO Contract Article VIII.** The MCO must: • Implement written policies and procedures for selection and retention of providers; • Follow a documented process for credentialing and re-credentialing of providers who have signed contracts or participation agreements; • Implement provider selection policies and procedures to ensure non-discrimination against particular practitioners that serve high-risk populations, or specialize in conditions that require costly treatment. If an MCO declines to include individual providers or groups of providers in its network, it must give the affected provider(s) written notice of the reason for its decision.
10	**42 CFR 438.214; DHS-MCO Contract Article VIII.**

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

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

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

#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement
	• The MCO shall use practice guidelines for prevention and wellness services that include member education, motivation and counseling about long-term care and health care related services.
	Quality Assessment and Performance Improvement (QAPI) Program
15	**42 CFR 438.240; DHS-MCO Contract Article XII.** The MCO has an ongoing quality assessment and performance improvement (QAPI) program for the services it furnishes to its members which meets at a minimum the following requirements outlined in the DHS-MCO contract: • Is administered through clear and appropriate administrative structures; • Includes member, staff, and provider participation; • Develops a work plan which outlines the scope of activities, goals, objectives, timelines, responsible person, and is based on findings from QAPI program activities; • Monitors quality of assessments and member-centered plans; • Monitors completeness and accuracy of functional screens; • Monitors results of care management practice related to the support provided to vulnerable high-risk members. • Conducts member satisfaction and provider surveys; • Documents incident management system activities; • Monitors appeals and grievances that were resolved; • Monitors access to providers and verifies that services were provided; • Monitors the quality of subcontractor services.
16	**42 CFR 438.240; DHS-MCO Contract Article XII.** The MCO must have in effect mechanisms to detect both underutilization and overutilization of services.
17	**42 CFR 438.240; DHS-MCO Contract Article XII.** The MCO must have in effect mechanisms to assess the quality and appropriateness of care furnished to members.
18	**42 CFR 438.240; DHS-MCO Contract Article XII.** The MCO has in effect a process for an evaluation of the impact and effectiveness of its quality assessment and performance improvement program, to determine whether the program has achieved significant improvement in the quality of service provided to its members.
	Health Information Systems
19	**42 CFR 438.242; DHS-MCO Contract Article XII.** The MCO maintains a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments (for other than loss of Medicaid eligibility).

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

#	Grievance System
	The MCO must have a grievance and appeal system in place that includes an internal grievance process, an appeal process, and access to the state's Fair Hearing system.
2	**42 CFR 438.402; DHS-MCO Contract Article XI.** ***Authority to file*** The MCO must accept appeals and grievances from members and their preferred representatives, including providers with the member's written consent. The MCO must follow the state-specified filing timeframes associated with standard and expedited appeals.
3	**42 CFR 438.402; DHS-MCO Contract Article XI.** The member may file grievances orally or in writing. The member, or member's legal decision maker, or anyone acting on the member's behalf with the member's written permission, the provider may file an appeal either orally or in writing, and (unless he or she requests expedited resolution) must follow an oral filing with a written, signed, appeal The MCO must acknowledge in writing receipt of each appeal or grievance within five business days of receipt of the appeal or grievance.
	Notices to Members
4	**42 CFR 438.404; 42 CFR 438.10; DHS-MCO Contract Article XI.** ***Language, content, and format requirements*** The notice must be in writing and must meet language and format requirements to ensure ease of understanding. The MCO must use the DHS-issued**:** • Notice of Action template; • Notification of Non-covered Benefit template; and • Notice of Change in Level of Care template.
5	**42 CFR 438.404; 42 CFR 431.210; 42 CFR 431.211; 42 CFR 431.213; 42 CFR 431.214; DHS-MCO Contract Article V. and XI.** ***Timing of notice*** The Notice must be delivered to the member in the timeframes associated with each type of adverse decision: • Termination, suspension, or reduction of service; • Denial of payment for a requested service; • Authorization of a service in an amount, duration, or scope that is less than requested; • Service authorization decisions not reached within the timeframes specified, on the date the timeframes expires; • Expedited service authorization decisions; • Some changes in functional level of eligibility. If the MCO extends the timeframe for the decision making process it must: • Give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees; and • Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

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

7	**42 CFR 438.406; DHS-MCO Contract Article XI.**
	
	The MCO process must ensure that individuals who make decisions on grievances and appeals:
	• Have not been involved in any previous level of review or decision-making related to the issue under appeal;
	• Include health care professionals with appropriate clinical experience when deciding
	  ○ Appeal of a denial based on lack of medical necessity;
	  ○ Grievance regarding denial of expedited resolution of an appeal;
	  ○ Grievance or appeal involving clinical issues;
	• Include at least one member (or guardian), or person who meets the functional eligibility requirements (or guardian) who is free of conflict of interest.
	
	The MCO must assure that all members of the grievance and appeal committee have agreed to respect the privacy of members, have received training in maintaining confidentiality, and that members' are offered the choice to exclude any consumer representatives from participation in their hearing.

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

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

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

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

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

APPENDIX 5 – QUALITY COMPLIANCE REVIEW COMPARATIVE SCORES

	CW	CCI	Inclusa	*i*Care	LCI	MCFC	CW	CCI	Inclusa	*i*Care	LCI	MCFC	CCI	Inclusa	*i*Care	LCI
	FY 17 - 18						FY 18 - 19						FY 19 - 20			
Enrollee Rights and Protections																
E1	M	M	PM	M	M	PM	M	M	PM	M	M	M	M	PM	M	M
E2	PM	M	PM	PM	PM	PM	PM	M	M	PM	M	PM	M	M	M	M
E3	PM	M	PM	M	M	M	PM	M	PM	M	M	M	M	M	M	M
E4	M	M	M	PM	PM	M	M	M	M	PM	PM	M	M	M	M	PM
E5	PM	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
E6	M	M	PM	M	M	M	M	M	PM	M	M	M	M	M	M	M
E7	M	M	PM	M	M	M	M	M	M	M	M	M	M	M	M	M
E8	M	M	M	M	PM	M	M	M	M	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	M	N/A	M	N/A
Quality Assessment/Performance Improvement																
Q1	M	PM	PM	M	PM	M	M	M	M	M	M	M	M	M	M	M
Q2	M	M	PM	M	M	M	M	M	M	M	M	M	M	M	M	M
Q3	M	M	M	M	PM	PM	M	M	M	M	M	M	M	M	M	M
Q4	M	M	M	M	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	PM	PM	PM	PM
Q6	PM	PM	PM	M	PM	PM	M	M	PM	M	PM	PM	M	PM	M	PM
Q7	PM	M	M	M	M	M	PM	M	M	M	M	M	M	M	M	M
Q8	M	M	M	M	M	PM	M	M	M	M	M	M	M	M	M	M
Q9	PM	PM	PM	PM	PM	PM	PM	M	M	PM	PM	PM	M	M	PM	PM
Q10	M	PM	PM	M	PM	M	M	M	M	M	PM	M	M	M	M	PM
Q11	PM	M	PM	PM	PM	PM	M	M	M	PM	PM	M	M	M	PM	PM
Q12	M	M	PM	M	M	M	M	M	M	M	M	M	M	M	M	M
Q13	M	M	PM	M	PM	PM	M	M	M	M	PM	M	M	M	M	PM
Q14	PM	M	PM	PM	M	PM	PM	M	M	PM	M	PM	M	M	PM	M
Q15	PM	PM	PM	PM	PM	PM	PM	M	M	PM	PM	M	M	M	M	M
Q16	PM	M	M	PM	PM	PM	PM	M	M	PM	PM	PM	M	M	PM	M
Q17	M	M	M	PM	PM	M	M	M	M	M	M	M	M	M	M	M
Q18	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
Q19	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M

	CW	CCI	Inclusa	*i*Care	LCI	MCFC	CW	CCI	Inclusa	*i*Care	LCI	MCFC	CCI	Inclusa	*i*Care	LCI
	FY 17 - 18						FY 18 - 19						FY 19 - 20			
Grievance System																
G1	M	M	M	M	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	M	M	M	M
G3	M	M	M	M	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	M	M	M	M
G5	M	PM	PM	PM	PM	PM	M	PM	PM	PM	M	PM	PM	PM	PM	M
G6	M	M	M	M	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	M	M	M	M
G8	M	M	M	M	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	M	M	PM	M
G10	M	M	M	M	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	M	M	M	M
G12	M	M	PM	M	M	M	M	M	M	M	M	M	M	M	M	M
G13	M	M	M	M	M	PM	M	M	M	M	M	M	M	M	M	M
G14	M	M	M	M	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	M	M	M	M
G16	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M

*Effective January 1, 2020, two separate FC, FCP MCOs, MCFC-CW/CW and MCFC-CW/MCFC merged to create a new organization, MCFC-CW. No reviews were conducted for the legacy MCOs.