# External Quality Review

**Fiscal Year 2021 – 2022**

## 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

**April 12, 2023**

| External Quality Review Organization |
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# Table of Contents

# Executive Summary

## External Quality Review Process

The Code of Federal Regulations (CFR) at 42 CFR 438 requires states that operate pre-paid inpatient health plans 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.

This report covers the external quality review fiscal year from July 1, 2021, to June 30, 2022 (FY 21-22). 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, conducting focused studies of health care quality - 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 Waivers (HCBS) and supports assessment of compliance with federal standards. All programs provide home and community-based services for long-term services and supports.

## Scope of External Review Activities

### *Protocol 1: 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. MetaStar validated the projects conducted by each managed care organization in measurement year 2021.

### *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 review assesses the accuracy of performance measures reported by the managed care organizations and determines the extent to which performance measures calculated by the managed care organizations follow state specifications and reporting requirements. The DHS contract with the managed care organizations specifies the quality indicators and standard measures that organizations must calculate and report. MetaStar validated the completeness and accuracy of organizations'

influenza and pneumococcal vaccination data for measurement year 2021. Technical definitions for each measure were provided by DHS.

### *Protocol 3: Compliance with Medicaid and CHIP Managed Care Regulations - 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: Managed Care Organization Standards; Quality Assessment and Performance Improvement; and Grievance Systems. In this fiscal year, Quality Assessment and Performance Improvement and Grievance Systems Standards were reviewed. Next fiscal year will include a review of the Managed Care Organization Standards.

### *Protocol 9: Conducting Focus 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) HCBS Waivers, and helps determine an organization's level of compliance with its contract with DHS.

### *Appendix A: 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.

### *Analysis: Quality, Timeliness, Access*

The table below highlights the assessments of quality, timeliness and access to health care services conducted through each review activity. Compliance with these review activities provides assurances that the state is meeting requirements related to access, timeliness, and quality of services, including health care and long-term services and supports. State level findings of strengths, progress, and recommendations to address weaknesses are included. Additionally, different aspects of the State's *2021 Medicaid Managed Care Quality Strategy* supported by the review activities are identified.

| Quality | Timeliness | Access | Strengths, Progress, and Recommendations and The State Quality Strategy | |
|---|---|---|---|---|
| **Protocol 1: Validation of Performance Improvement Projects** | | | | |
| √ | √ | √ | **STRENGTHS** | |
| | | | Review Findings | The State Quality Strategy |

| Quality | Timeliness | Access | Strengths, Progress, and Recommendations and The State Quality Strategy | |
|---|---|---|---|---|
| **Protocol 1: Validation of Performance Improvement Projects** | | | | |
| | | | The organizations conducted and reported detailed research regarding the topic selection and its importance to members. | Address health disparities.<br>Foster independence.<br>Focus on needs of the people being served through HCBS.<br>Empower people to realize their full potential through access to an array of services and supports. |
| | | | The project populations were clearly identified in relation to the aim statements. | Focus on needs of the people being served through HCBS. |
| | | | Appropriate sampling methods were utilized in all projects that employed sampling. | Focus on needs of the people being served through HCBS. |
| | | | The organizations selected project variables and performance measures that were clear indicators of performance. | Ensure continuous improvement of high-quality programs to achieve member's identified goals and outcomes.<br>Ensure the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes. |
| | | | Valid and reliable procedures were used to collect the projects' data and inform measurements. | Build collaborative relationships with both internal and external stakeholders and partners. |
| | | | Appropriate, evidence-based interventions were selected and implemented that were likely to lead to the desired improvement. | Ensure continuous improvement of high-quality programs to achieve member's identified goals and outcomes.<br>Serve people through culturally competent practices and policies. |
| | | | **PROGRESS** | |
| | | | Review Findings | The State Quality Strategy |
| | | | All MCOs chose performance improvement project topics that aligned with State and Federal priorities focused on keeping members healthy, safe, and | Address health disparities.<br>Foster independence.<br>Focus on needs of the people being served through HCBS. |

| Quality | Timeliness | Access | Strengths, Progress, and Recommendations and The State Quality Strategy | |
|---|---|---|---|---|
| **Protocol 1: Validation of Performance Improvement Projects** | | | | |
| | | | supported in the community when possible. | Empower people to realize their full potential through access to an array of services and supports. |
| | | | **RECOMMENDATIONS** | |
| | | | Review Findings | The State Quality Strategy |
| | | | Establish clear, concise, measurable, and answerable aim statements for projects. | Address health disparities.<br>Foster independence.<br>Focus on needs of the people being served through HCBS.<br>Empower people to realize their full potential through access to an array of services and supports. |
| | | | Recognize and account for factors that may influence the comparability of initial and repeat measures in order to assess improvement in desired outcomes. | Ensure continuous improvement of high-quality programs to achieve member's identified goals and outcomes. |
| | | | Conduct tests of statistical significance between initial and repeat measures to determine if any observed improvement is the result of the intervention. | Ensure the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes. |
| | | | Conduct analysis to determine reasons for less-than-optimal improvement. | Ensure the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes. |

| Quality | Timeliness | Access | Strengths, Progress, and Recommendations and The State Quality Strategy | |
|---|---|---|---|---|
| **Protocol 2: Validation of Performance Measures Validation** | | | | |
| √ | √ | √ | STRENGTHS | |
| | | | Review Findings | The State Quality Strategy |
| | | | Vaccination rates for each quality indicator have remained steady from year to year.<br>Organizations continue to educate members on the benefits of the vaccinations, even if they decline to receive the vaccine. | Assess and support all dimensions of holistic health. |

| Quality | Timeliness | Access | Strengths, Progress, and Recommendations and The State Quality Strategy | |
|---|---|---|---|---|
| **Protocol 2: Validation of Performance Measures Validation** | | | | |
| | | | **PROGRESS** | |
| | | | Review Findings | The State Quality Strategy |
| | | | MCOs improved documentation practices for members contraindicated from receiving influenza and pneumococcal vaccinations; all records submitted for contraindications aligned with the DHS technical definitions. | Focus on needs of the people being served through HCBS. |
| | | | **RECOMMENDATIONS** | |
| | | | Review Findings | The State Quality Strategy |
| | | | Continue to focus efforts on educating members on the benefits of receiving vaccinations, specifically influenza vaccinations, to ensure members stay as healthy as possible. | Support individuals who use HCBS to actively participate in the design, implementation, and evaluation of the system at all levels. |

| Quality | Timeliness | Access | Strengths, Progress, and Recommendations and The State Quality Strategy | |
|---|---|---|---|---|
| **Protocol 3: Compliance with Managed Care Regulations, Quality Compliance Review** | | | | |
| √ | √ | √ | **STRENGTHS** | |
| | | | Review Findings | The State Quality Strategy |
| | | | Organizations demonstrated a high level of compliance with managed care regulations and quality. | Ensure member health and safety by the acute care and long-term care programs.<br>Ensure the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes.<br>Support individuals who use HCBS to actively participate in the design, implementation, and evaluation of the system at all levels. |
| | | | Organizations have quality management programs that document and monitor required activities, with the purpose of | Ensure member care is delivered in a timely and effective manner.<br>Support individuals who use HCBS to actively participate in the design, |

| Quality | Timeliness | Access | Strengths, Progress, and Recommendations and The State Quality Strategy | |
|---|---|---|---|---|
| **Protocol 3: Compliance with Managed Care Regulations, Quality Compliance Review** | | | | |
| | | | improving the access, timeliness, and quality of supports to members. | implementation, and evaluation of the system at all levels. |
| | | | Effective statewide implementation of grievance systems that provide members with the ability to grieve or appeal actions of the organization. | Ensure the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes.<br>Provide services and supports in a manner consistent with a person's needs, goals, preferences, and values that help the person to achieve desired outcomes.<br>Promote and protect the human and legal rights of individuals who use HCBS. |
| | | | **PROGRESS** | |
| | | | Review Findings | The State Quality Strategy |
| | | | All organizations implemented utilization management processes that produce data that is adequate to detect both underutilization and overutilization of services. | Ensure the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes. |
| | | | All organizations have implemented robust member advisory committees to increase member participation in the quality management programs. | Support individuals who use HCBS to actively participate in the design, implementation, and evaluation of the system at all levels. |
| | | | **RECOMMENDATIONS** | |
| | | | Review Findings | The State Quality Strategy |
| | | | Implement specific monitoring for the quality of care management to include members being afforded choice among covered services and providers. | Provide services and supports in a manner consistent with a person's needs, goals, preferences, and values that help the person to achieve desired outcomes.<br>Support individuals who use HCBS to actively participate in the design, implementation, and evaluation of the system at all levels. |
| | | | Improve the timeliness of issuing notices when indicated by focusing on identifying the need for a decision on a service request, as | Ensure the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes. |

| Quality | Timeliness | Access | Strengths, Progress, and Recommendations and The State Quality Strategy | |
|---|---|---|---|---|
| **Protocol 3: Compliance with Managed Care Regulations, Quality Compliance Review** | | | | |
| | | | well as sending notices when services are reduced or terminated. | Promote and protect the human and legal rights of individuals who use HCBS. |

| Quality | Timeliness | Access | Strengths, Progress, and Recommendations and The State Quality Strategy | |
|---|---|---|---|---|
| **Protocol 9: Conducting Focused Studies of Health Care Quality** | | | | |
| √ | √ | √ | **STRENGTHS** | |
| | | | Review Findings | The State Quality Strategy |
| | | | All programs demonstrated the ability to sufficiently support members, as evidenced by no members identified with unaddressed health and safety issues, and six out of 1,885 members identified for complex and challenging situations. | Ensure member health and safety by the acute care and long-term care programs.<br>Ensure member care is delivered in a timely and effective manner.<br>Provide services and supports in a manner consistent with a person's needs, goals, preferences, and values that help the person to achieve desired outcomes.<br>Focus assessment, planning, and coordination of services and supports on the individual's goals, needs, preferences, and values.<br>Promote and protect the human and legal rights of individuals who use HCBS. |
| | | | **PROGRESS** | |
| | | | Review Findings | The State Quality Strategy |
| | | | Comprehensiveness of care plans improved on a statewide basis. | Ensure member health and safety by the acute care and long-term care programs.<br>Provide services and supports in a manner consistent with a person's needs, goals, preferences, and values that help the person to achieve desired outcomes.<br>Focus assessment, planning, and coordination of services and supports on the individual's goals, needs, preferences, and values. |
| | | | **RECOMMENDATIONS** | |
| | | | Review Findings | The State Quality Strategy |

| Quality | Timeliness | Access | Strengths, Progress, and Recommendations and The State Quality Strategy | |
|---|---|---|---|---|
| **Protocol 9: Conducting Focused Studies of Health Care Quality** | | | | |
| | | | Focus efforts to increase the comprehensiveness of assessments and member-centered plans in the Family Care and Family Care Partnership programs, specifically in Family Care Geographic Service Regions 4 and 7 of the Family Care program; and Family Care Partnership Geographic Service Regions 2, 8, and 11 of the Family Care Partnership program. | Ensure member health and safety by the acute care and long-term care programs.<br>Focus assessment, planning, and coordination of services and supports on the individual's goals, needs, preferences, and values. |
| | | | Focus efforts on improving follow-up to ensure member supports and services are adequate in the Family Care, Family Care Partnership, and PACE programs specifically in Family Care Geographic Service Regions 1, 4, 5, 6, 9, 10, and 14 of the Family Care program; Family Care Partnership Geographic Service Regions 5, 12, and 14 of the Family Care Partnership program; and PACE Geographic Service Region 6 of the PACE program. | Ensure member health and safety by the acute care and long-term care programs.<br>Ensure member care is delivered in a timely and effective manner. |
| | | | Ensure staff are making the minimum member contacts as required by DHS for the Family Care Partnership program, specifically in Family Care Partnership Geographic Service Regions 8, 12, and 14. | Ensure member health and safety through the acute care and long-term care programs. |

<table>
<tr><th>Quality</th><th>Timeliness</th><th>Access</th><th colspan="2">Strengths, Progress, and Recommendations and The State Quality Strategy</th></tr>
<tr><td colspan="5">Appendix A: Information Systems Capabilities Assessments</td></tr>
<tr><td rowspan="8">√</td><td rowspan="8">√</td><td rowspan="8">√</td><td colspan="2">STRENGTHS</td></tr>
<tr><td>Review Findings</td><td>The State Quality Strategy</td></tr>
<tr><td>Strong systems are maintained and updated by a stable and experienced information system department.<br><br>Robust and ongoing training is in place to ensure all Medicaid data is processed accurately and within the expected timeframes.<br><br>Security systems meet or exceed most industry standards, ensuring consistent system and data availability.<br><br>Periodic audits are completed to ensure there are no access violations and that all staff interactions with the various features of internal systems occur within the grids and arrangements that are implemented by the organization’s security and compliance officers.<br><br>Processes and systems for collecting and maintaining administrative data and enrollment information ensure accurate encounter data is provided to the state.<br><br>The organization maintains a dynamic and timely system to ensure complete and updated provider listings and directories.</td><td>Ensure timely access to complete and accurate health data.<br><br>Evaluate data systems to ensure they effectively support programs and strategies in collecting relevant and adequate clinical and other data from multiple sources.<br><br>Ensure the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes.</td></tr>
<tr><td colspan="2">PROGRESS</td></tr>
<tr><td>Review Findings</td><td>The State Quality Strategy</td></tr>
<tr><td>Formalized auditing processes have been implemented to ensure the accuracy of provider data.</td><td>Ensure timely access to complete and accurate health data.</td></tr>
<tr><td colspan="2">RECOMMENDATIONS</td></tr>
<tr><td>Review Findings</td><td>The State Quality Strategy</td></tr>
</table>

| Quality | Timeliness | Access | Strengths, Progress, and Recommendations and The State Quality Strategy | |
|---|---|---|---|---|
| **Appendix A: Information Systems Capabilities Assessments** | | | | |
| | | | Continue with the implementation of the *Federal Information Processing Standards Publication*, which has built in benchmarks/milestones. The organization should review and align its progress with these federal and state benchmarks. | Ensure the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes. |

# 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, 2021, to June 30, 2022 (FY 21-22). See Appendix 2 for more information about external quality review and a description of the methodologies used to conduct review activities.

## Overview of Wisconsin's FC, FCP, and PACE Managed Care Organizations

The table below identifies the programs each MCO operates.

| Managed Care Organization | Program(s) |
|---|---|
| Community Care, Inc. (CCI) | FC; FCP; PACE |
| Inclusa, Inc. (Inclusa) | FC |
| Independent Care Health Plan (*i*Care) | FCP |
| Lakeland Care, Inc. (LCI) | FC |
| My Choice Wisconsin (MCW) | FC; FCP |

Effective August 1, 2021, DHS certified CCI to expand the PACE program into an additional county of geographic service region (GSR) 11. The MCO previously provided PACE services to Racine County only but will now provide PACE services to Racine and Kenosha counties.

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

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

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

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

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

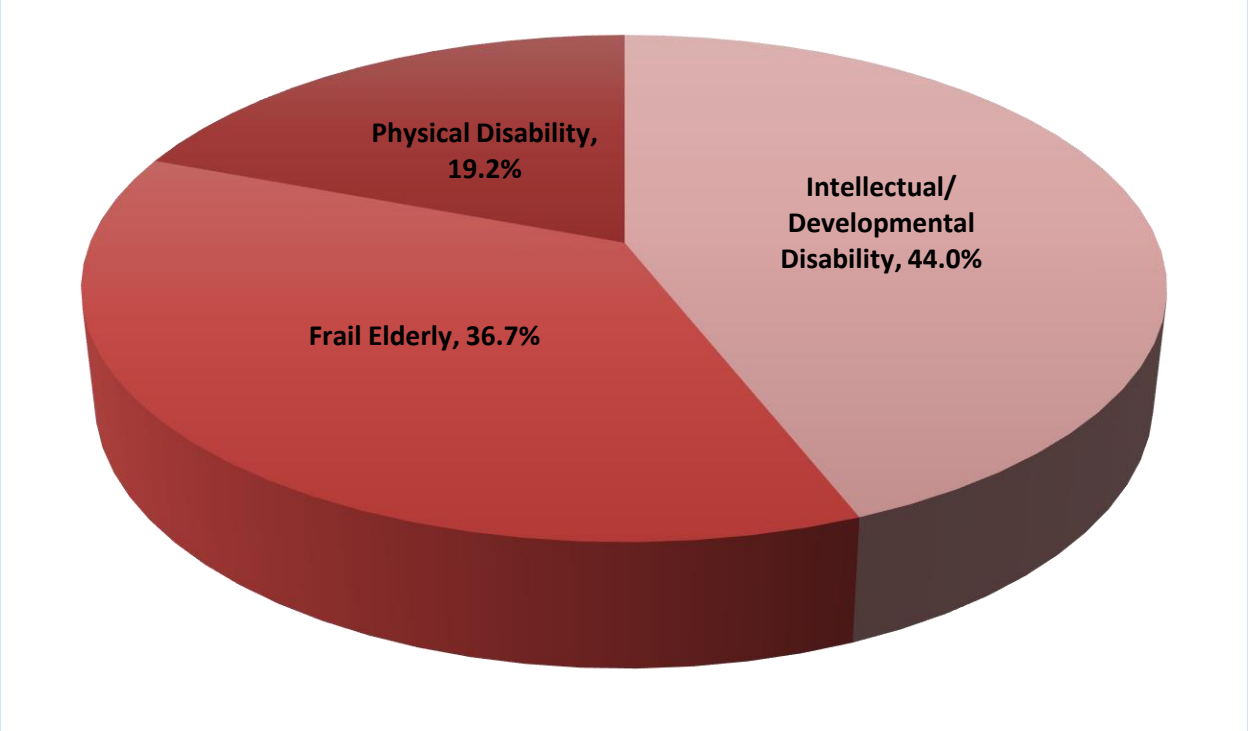
https://www.dhs.wisconsin.gov/familycare/pace.htm.

As of July 1, 2022, enrollment for all programs was approximately 56,636. This compares to last year's total enrollment of 55,465 as of August 1, 2021. Enrollment data is available at the following DHS website:

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

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

**Total Participants in All Programs by Target Group: July 1, 2022**



## Analysis: Quality, Timeliness, and Access

The CMS guidelines regarding this annual technical report direct the EQRO to provide an assessment of each MCOs' strengths and weaknesses with respect to quality, timeliness, and access to health care services. All programs provide home and community-based services 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 provides assessment of strengths, progress, and recommendations for improvement for each MCO. The tables below identify the mandatory review activities, scope of activities, and findings from the assessments of quality, timeliness, and access to health care services for the programs each MCO operates.

<table>
<tr><th colspan="3">Community Care, Inc.</th></tr>
<tr><th>Programs Operated</th><th>FY 21-22 Enrollment by Program</th><th>GSRs</th></tr>
<tr><td>FC, FCP, PACE</td><td>FC: 13,054 FCP: 753 PACE: 512</td><td>6, 8, 9, 10, 11, 12</td></tr>
<tr><th colspan="3">Findings</th></tr>
<tr><td>Protocol 1: Validation of Performance Improvement Projects (PIPs)<ul><li>Clinical PIP: Member Emotional Wellness</li><li>Nonclinical PIP: Member Satisfaction</li></ul></td><td colspan="2">Strengths<br>– Detailed research regarding the topic selection and its importance to members was conducted and reported for both projects.<br>– A clear, concise, measurable, and answerable aim statement was established for one project.<br>– The performance improvement project (PIP) population was clearly identified in relation to the aim statement for both projects.<br>– PIP variables and performance measures selected for both projects were clear indicators of performance.<br>– Valid and reliable procedures were used to collect the PIP data and inform measurements for both projects.<br>– Appropriate, evidence-based interventions were selected and implemented that were likely to lead to the desired improvement for one project.<br><br>Progress<br>– Both projects clearly identified the PIP population in relation to the aim statements.<br>– The PIPs included valid and reliable procedures to collect the PIP data and inform measurements for both projects.<br>– Both projects defined data sources for all measures and ensured initial and repeat measures were comparable.<br><br>Recommendations<br>– Ensure statistical significance and statistical evidence are included in the reports.<br>– For the nonclinical PIP:<br>o Include the time period in future study questions or aim statements.<br>o Develop study questions or aim statements that are concise.<br>o Ensure that the baseline and repeat measures are comparable.<br>o Provide member-facing strategies that are culturally and linguistically appropriate in future project reports.</td></tr>
</table>

| Community Care, Inc. | | |
|---|---|---|
| **Programs Operated** | **FY 21-22 Enrollment by Program** | **GSRs** |
| FC, FCP, PACE | FC: 13,054 FCP: 753 PACE: 512 | 6, 8, 9, 10, 11, 12 |
| **Findings** | | |
| | ○ Develop strategies in the design of the project to have a plan for implementing interventions with enough flexibility that it can be adjusted to overcome barriers. | |
| **Protocol 2: Validation of Performance Measures** | **Strengths**<br>– The MCO collaborated with a pharmacy to provide vaccinations clinics for members and their families.<br>– Influenza vaccination rates for the PACE program are over 90.0 percent.<br>– Pneumococcal vaccination rates for the FCP and PACE programs are over 90.0 percent.<br><br>**Progress**<br>– Improved accuracy of interdisciplinary care team staff documentation of vaccination refusals.<br>– Influenza vaccination rates for the PACE program increased in measurement year (MY) 2021.<br>– Pneumococcal vaccination rates increased in the FCP program from MY 2020 to MY 2021.<br><br>**Recommendations**<br>– Conduct a root cause analysis for the vaccination rates that declined from MY 2020. Identifying the root cause or causes will allow the MCO to focus improvement efforts.<br>– Continue efforts to increase influenza vaccination rates.<br>– Continue efforts to increase pneumococcal vaccination rates in FC.<br>– Review documentation within the *Clinical Practice Guideline Pneumococcal Pneumonia* to ensure documentation aligns with the Department of Health Services (DHS) technical definition. | |
| **Protocol 3: Compliance with Managed Care Regulations, Quality Compliance Review** | **Strengths**<br>– The organization has a quality management program that documents and monitors required activities, with the purpose of improving the access, timeliness, and quality of supports to members.<br><br>**Progress**<br>– The organization did not make progress on the recommendations from the prior review. Recommendations were related to issuing *Notice of Adverse Benefit Determination* letters timely.<br><br>**Recommendations**<br>– Implement specific monitoring for the quality of care management services to include members being afforded choice among covered services and providers.<br>– Improve the timeliness of issuing notices when indicated by focusing on identifying the need for a decision on a service request, as well as sending notices when services are reduced or terminated.<br>– Ensure attempts to resolve grievances and appeals through internal review, negotiation, and mediation are consistently documented.<br>– Focus efforts on improving the timeliness of issuing written notifications to members on decisions to extend the timeframe for appeal resolutions, or | |

| Community Care, Inc. | | |
|---|---|---|
| **Programs Operated** | **FY 21-22 Enrollment by Program** | **GSRs** |
| FC, FCP, PACE | FC: 13,054 FCP: 753 PACE: 512 | 6, 8, 9, 10, 11, 12 |
| **Findings** | | |
| | appropriately document if the extension request is member initiated and a notification is not required.<br>– Update the organization's PACE appeal policy to include the timeframe the MCO has to provide a decision on expedited appeal requests as outlined in the DHS-MCO contract.<br>– Update the organization's grievance and appeal policies and procedures to include the requirement that no punitive action is taken against a provider who requests or supports a member's appeal or grievance.<br>– Update the organization's FCP appeal policy to include the timeframe the member has to request a State Fair Hearing as outlined in the DHS-MCO contract.<br>– Update the organization's FCP appeal policy to include the criteria for when a member does not have the right to continue benefits during an appeal or State Fair Hearing as outlined in the DHS-MCO contract. | |
| **Protocol 9: Conducting Focused Studies of Health Care Quality**<br>*Sample Sizes*<br>*FC: 265*<br>*FCP: 196*<br>*PACE: 182* | **Strengths**<br>– The FC and PACE programs demonstrated strengths related to comprehensive assessment practices.<br>– The FC and PACE programs demonstrated strengths related to care coordination.<br><br>**Progress**<br>– The organization improved the timeliness of assessments for PACE.<br><br>**Recommendations**<br>– Focus efforts on improving the comprehensiveness of assessments in the FCP program.<br>– Focus efforts on improving the comprehensiveness of member-centered plans in FC and FCP programs.<br>– Improve the timeliness of the review of member-centered plans in the FCP program by ensuring inclusion of the legal decision maker.<br>– Continue efforts to ensure timely follow-up for effectiveness of services, especially those related to medical needs, in the FC and FCP programs. | |
| **Appendix A: Information Systems Capabilities Assessments** | Not applicable. Reviewed in FY 20-21. | |

| Inclusa, Inc. | | |
|---|---|---|
| **Programs Operated** | **FY 21-22 Enrollment by Program** | **GSRs** |
| FC | FC: 16,550 | 1, 2, 3, 4, 5, 6, 7, 9, 10, 13,14 |
| **Findings** | | |
| **Protocol 1: Validation of Performance Improvement Projects**<br>• *Clinical PIP: Member Safety*<br>• *Nonclinical PIP: Health Equity* | **Strengths**<br>- Detailed research regarding the topic selection and its importance to members was conducted and reported for both projects.<br>– A clear, concise, measurable, and answerable aim statement was established for one project.<br>– The PIP population was clearly identified in relation to the aim statement for one project.<br>– Appropriate sampling methods were utilized for one project; the other project did not utilize sampling. | |

<table>
<tr><th colspan="3">Inclusa, Inc.</th></tr>
<tr><th>Programs Operated</th><th>FY 21-22 Enrollment by Program</th><th>GSRs</th></tr>
<tr><td>FC</td><td>FC: 16,550</td><td>1, 2, 3, 4, 5, 6, 7, 9, 10, 13,14</td></tr>
<tr><th colspan="3">Findings</th></tr>
<tr><td></td><td colspan="2">– Appropriate, evidence-based interventions were selected and implemented that were likely to lead to the desired improvement for one project.<br><br>Progress<br>– Both projects specified a data analysis plan.<br>– The same methodology for the baseline and repeat measurements was utilized for both projects.<br>– The PIP results and findings were presented in a concise and easily understood manner.<br>– Quantitative evidence of improvement in processes or outcomes of care was demonstrated for both projects.<br><br>Recommendations<br>– Include time periods for all aim statements to ensure they are measurable.<br>– Adhere to defined inclusion and exclusion criteria for the study population throughout the project, to ensure the data collection approach captures all members to whom the aim statement applies.<br>– Establish performance indicators or variables that are adequate to answer the PIP aim statement.<br>– Specify the processes and timeframes related to monitoring, tracking, and comparing performance of each variable or study indicator during the measurement year.<br>– Detail the processes and data sources for collecting data that represents the study population.<br>– Detail the planned and actual frequency of data analysis.<br>– Conduct tests of statistical significance:<br>o Between initial and repeat measurements to evaluate whether project improvements or declines are attributable to actions of the organization; and<br>o To determine if any observed improvement is the result of the interventions.<br>– Analyze the impact of a small study population size when determining whether findings can be generalized to the entire MCO population, and to evaluate the impact of interventions.<br>– Conduct and document continuous cycles of improvement that occur during the measurement year.<br>– Only include aim statements relevant to the current measurement year of the project.<br>– Incorporate a process to validate data that is manually collected from the organization’s electronic care management system for accuracy and completeness.</td></tr>
<tr><td>Protocol 2: Validation of Performance Measures</td><td colspan="2">Strengths<br>– Pneumococcal vaccinations rates are over 90.0 percent.<br><br>Progress<br>– Pneumococcal vaccination rates increased from MY 2020.<br>– The MCO’s Immunization Clinical Practice Guidelines were updated to reference the appropriate technical specifications.</td></tr>
</table>

| Inclusa, Inc. | | |
|---|---|---|
| **Programs Operated** | **FY 21-22 Enrollment by Program** | **GSRs** |
| FC | FC: 16,550 | 1, 2, 3, 4, 5, 6, 7, 9, 10, 13,14 |
| **Findings** | | |
| | **Recommendations**<br>– Continue efforts to educate members on the benefit of the influenza vaccination.<br>– Conduct a root cause analysis for the vaccination rates that declined from MY 2020. | |
| **Protocol 3: Compliance with Managed Care Regulations, Quality Compliance Review** | **Strengths**<br>– The organization has a quality management program that documents and monitors required activities, with the purpose of improving the access, timeliness, and quality of supports to members.<br>– The organization demonstrated the implementation of a grievance system that provides members with the ability to grieve or appeal actions of the organization, including access to a DHS review for grievances and to the State Fair Hearing process for appeals, when decisions are adverse to the member.<br>– The organization's accessibility and use of data, as well as implementation of clear guidelines for how to utilize the data, were evidenced throughout the activities of the quality work plan.<br>– The organization demonstrated a robust member file review process. Member file review results are disseminated throughout the organization and utilized to enhance care management practices.<br><br>**Progress**<br>– There were no recommendations made in the prior review related to the standards reviewed; therefore, there is no progress to report.<br><br>**Recommendations**<br>– Update written guidance to include the requirement that financial eligibility decisions and cost share calculations can only be contested through the State Fair Hearing process and cannot be reviewed by the MCO's internal appeal system.<br>– Focus efforts on improving issuing timely *Notice of Adverse Benefit Determination* forms to members when indicated.<br>– Update written guidance and letter template language for when a request for an expedited resolution is denied to include the member's right to file a grievance if the member disagrees with the decision. | |
| **Protocol 9: Conducting Focused Studies of Health Care Quality**<br>*Sample Size*<br>*FC: 260* | **Strengths**<br>– The organization demonstrated consistent practices related to care coordination.<br><br>**Progress**<br>– No progress was made on the recommendations from the prior review.<br><br>**Recommendations**<br>– Focus efforts on improving the comprehensiveness of assessments through ensuring assessment of member educational experiences and preferences.<br>– Focus efforts on improving comprehensiveness of member-centered plans by including services and supports for assessed needs, and risks related to the use of side/bed rails. | |

| Inclusa, Inc. | | |
|---|---|---|
| **Programs Operated** | **FY 21-22 Enrollment by Program** | **GSRs** |
| FC | FC: 16,550 | 1, 2, 3, 4, 5, 6, 7, 9, 10, 13,14 |
| **Findings** | | |
| | – Continue efforts to ensure timely follow-up for effectiveness of services for covered benefits and health related services, specifically related to durable medical equipment and medical appointments. | |
| **Appendix A: Information Systems Capabilities Assessment** | Not applicable. Reviewed in FY 20-21. | |

| Independent Care Health Plan | | |
|---|---|---|
| **Programs Operated** | **FY 21-22 Enrollment by Program** | **GSRs** |
| FCP | FCP: 1,416 | 3, 8, 11,12 |
| **Findings** | | |
| **Protocol 1: Validation of Performance Improvement Projects**<br>• *Clinical PIP: Opioid Risk Reduction*<br>• *Nonclinical PIP: Advance Care Planning* | **Strengths**<br>– Detailed research regarding the topic selection and its importance to members was conducted and reported for both projects.<br>– The PIP population was clearly identified in relation to the aim statement for both projects.<br>– The PIP variables and performance measures selected for both projects were clear indicators of performance.<br>– Valid and reliable procedures were used to collect the PIP data and inform its measurements for both projects.<br>– Appropriate techniques were used to analyze the PIP data and interpret the results for one project.<br><br>**Progress**<br>– Both projects used valid and reliable procedures to collect the PIP data and inform its measurements.<br>– Both projects specified the prospective data analysis plan.<br>– Both projects presented numerical results clearly.<br>– Both projects documented continuous improvement efforts.<br>– Both projects addressed cultural or linguistic appropriateness of interventions.<br><br>**Recommendations**<br>– For the nonclinical PIP, ensure that the goal for the project exceeds the baseline.<br>– For the clinical PIP, the MCO should:<br>○ Ensure consistency is maintained in the aim statement when changes are made during the project.<br>○ Clearly describe all aspects of the data analysis plan.<br>○ Assess statistical significance of any differences between initial and repeat measures.<br>○ Account for factors that may influence comparability of initial and repeat measures.<br>○ Include all information related to the project in the report or appropriately reference as an attachment.<br>○ Assess all variables when analyzing the success of the improvement strategies and potential follow-up activities.<br>○ Ensure the same methodology is used for baseline and repeat measurements. | |

| Independent Care Health Plan | | |
|---|---|---|
| **Programs Operated** | **FY 21-22 Enrollment by Program** | **GSRs** |
| FCP | FCP: 1,416 | 3, 8, 11,12 |
| **Findings** | | |
| **Protocol 2: Validation of Performance Measures** | **Strengths**<br>– The MCO hosted an onsite vaccine clinic and health fair for members and staff.<br><br>**Progress**<br>– The accuracy of vaccinations reported through the *Wisconsin Immunization Registry* was sufficiently addressed.<br><br>**Recommendations**<br>– Conduct a root cause analysis to determine the reason for members age 65 and older to remain in the physical disability target group for the pneumococcal vaccination. DHS implemented the target group automation for the *Long Term Care Function Screen* in early 2017.<br>– Conduct a root cause analysis for the pneumococcal vaccination rate that declined from MY 2020. Identifying the root cause or causes will allow the MCO to focus improvement efforts.<br>– Continue efforts to increase influenza and pneumococcal vaccination rates. | |
| **Protocol 3: Compliance with Managed Care Regulations, Quality Compliance Review** | **Strengths**<br>– The organization has a quality management program that documents and monitors required activities, with the purpose of improving the access, timeliness, and quality of supports to members.<br>– The organization demonstrated the implementation of a grievance system that provides members with the ability to grieve or appeal actions of the organization, including access to a DHS review for grievances and to the State's Fair Hearing system for appeals, when decisions are adverse to the member.<br><br>**Progress**<br>– The organization successfully implemented utilization management processes that produce data that is adequate to detect both underutilization and overutilization of services to identify trends at the organization or system level.<br><br>**Recommendations**<br>– Implement specific monitoring for the quality of care management to include members being afforded choice among covered services and providers.<br>– Enhance internal file review guidance to ensure all required monitoring activities are accounted for.<br>– Ensure monitoring systems include mechanisms to identify and analyze notices that are indicated, but not issued.<br>– Continue efforts to improve the issuing of notices timely when indicated.<br>– Ensure member grievances not resolved to the members' satisfaction are heard by the managed care organization's local grievance and appeal committee. | |
| **Protocol 9: Conducting Focused Studies of Health Care Quality**<br>*Sample Size*<br>*FCP: 225* | **Strengths**<br>– The organization did not demonstrate strengths related to this review.<br><br>**Progress** | |

| Independent Care Health Plan | | |
|---|---|---|
| **Programs Operated** | **FY 21-22 Enrollment by Program** | **GSRs** |
| FCP | FCP: 1,416 | 3, 8, 11,12 |
| **Findings** | | |
| | – The organization improved the comprehensiveness of member-centered plans from the prior review.<br><br>**Recommendations**<br>– Continue efforts to improve the comprehensiveness of member-centered plans.<br>– Ensure member-centered plans are reviewed according to contract requirements.<br>– Focus efforts to improve the timeliness for new and ongoing service authorization decisions.<br>– Ensure services and supports to members are received and effective through timely follow-up.<br>– Focus efforts to ensure minimum contact requirements with members are completed as required. | |
| **Appendix A: Information Systems Capabilities Assessment** | Not applicable. Reviewed in FY 19-20. | |

| Lakeland Care, Inc. | | |
|---|---|---|
| **Programs Operated** | **FY 21-22 Enrollment by Program** | **GSRs** |
| FC | FC: 7,435 | 4, 9, 10,13 |
| **Findings** | | |
| **Protocol 1: Validation of Performance Improvement Projects**<br>• *Clinical PIP: Comprehensive Diabetes Care*<br>• *Nonclinical PIP: Member Satisfaction* | **Strengths**<br>– Detailed research regarding the topic selection and its importance to members was conducted and reported for both projects.<br>– Clear, concise, measurable, and answerable aim statements were established for both projects.<br>– The PIP population was clearly identified in relation to the aim statement for both projects.<br>– The PIP variables and performance measures selected for one project were clear indicators of performance.<br>– Valid and reliable procedures were used to collect the PIP data and inform its measurements for one project.<br>– Appropriate, evidence-based interventions were selected and implemented that were likely to lead to the desired improvement for both projects.<br>– Statistically significant improvement was demonstrated that may be the result of the selected interventions for one project.<br><br>**Progress**<br>– Both projects included the routine analysis of data to understand the causes for less-than-optimal performance.<br>– Both projects ensured the baseline and repeat measures were comparable.<br><br>**Recommendations**<br>– Ensure that statistical significance and statistical evidence are included in the reports for both PIPs.<br>– Provide a detailed description of the sampling frame for the nonclinical PIP. | |

| Lakeland Care, Inc. | | |
|---|---|---|
| **Programs Operated** | **FY 21-22 Enrollment by Program** | **GSRs** |
| FC | FC: 7,435 | 4, 9, 10,13 |
| **Findings** | | |
| | – Identify a prospective data collection and analysis plan that details how frequently the data will be reviewed and analyzed to determine the effectiveness of the interventions for the nonclinical PIP. | |
| **Protocol 2: Validation of Performance Measures** | **Strengths**<br>– Pneumococcal vaccinations rates are over 90.0 percent and remained the same year to year.<br><br>**Progress**<br>– There was no progress to report.<br><br>**Recommendations**<br>– Conduct a root cause analysis for the vaccination rates that declined from MY 2020. Identifying the root cause or causes will allow the MCO to focus improvement efforts.<br>– Continue the practices developed, including educating members on the importance of the influenza vaccination, in order to increase influenza vaccination rates.<br>– Consider the implications of utilizing a more restrictive threshold than those identified in the influenza vaccination technical definitions, specifically, the MCO's practice of using February 28 as the cut-off date for documenting vaccinations versus March 31, and not allowing members to self-report vaccination status. | |
| **Protocol 3: Compliance with Managed Care Regulations, Quality Compliance Review** | **Strengths**<br>– The organization has a quality management program that documents and monitors required activities, with the purpose of improving the access, timeliness, and quality of supports to members.<br>– The organization demonstrated the implementation of a grievance system that provides members with the ability to grieve or appeal actions of the organization, including access to a DHS review for grievances and to the State's Fair Hearing system for appeals, when decisions are adverse to the member.<br>– The organization's accessibility, use, and dissemination of data were evidenced throughout the activities of the quality work plan.<br>– The organization demonstrated a member-centered approach and efforts to resolve appeals and grievances informally.<br><br>**Progress**<br>– The organization increased member participation in the member advisory committee.<br>– Recommendations to identify the process used by quality staff for reviewing the quality progress table and how this review interfaces with the Quality Management Committee meetings were successfully addressed.<br><br>**Recommendations**<br>– Implement specific monitoring for the quality of care management to include members being afforded choice among covered services and providers.<br>– Continue efforts to improve the issuing of notices timely when indicated. | |

| Lakeland Care, Inc. | | |
|---|---|---|
| **Programs Operated** | **FY 21-22 Enrollment by Program** | **GSRs** |
| FC | FC: 7,435 | 4, 9, 10,13 |
| **Findings** | | |
| | – Develop systems to identify and track the organization's date of determining when an extension is needed for an appeal or grievance, to ensure that the written notice to the member is issued within two calendar days. | |
| **Protocol 9: Conducting Focused Studies of Health Care Quality**<br>*Sample Size*<br>*FC: 260* | **Strengths**<br>– The organization demonstrated strengths related to care coordination.<br><br>**Progress**<br>– The organization improved the comprehensiveness of assessments through ensuring member's educational preferences were adequately assessed.<br>– The organization's practices related to ensuring member rights were upheld demonstrated improvements from the prior review.<br><br>**Recommendations**<br>– Ensure assessments are conducted in-person and by each member of the interdisciplinary team.<br>– Improve the comprehensiveness of member-centered plans through ensuring assessed durable medical equipment is included on the plan.<br>– Focus efforts to ensure interdisciplinary teams follow up with members regarding medical appointments and durable medical equipment needs. | |
| **Appendix A: Information Systems Capabilities Assessment** | **Strengths**<br>– The organization has a strong system that is maintained and updated by a stable and experienced information system department.<br>– The organization provided evidence of a robust, ongoing training program to ensure all Medicaid data is processed accurately and within the expected timeframes.<br>– The organization's security systems meet or exceed most industry standards, ensuring consistent system and data availability.<br>– The organization performs periodic audits to ensure there are no access violations and that all staff interactions with the various features of internal systems occur within the grids and arrangements that are implemented by the organization's security and compliance officers.<br>– The organization's processes and system for collecting and maintaining administrative data and enrollment information ensure accurate encounter data is provided to the state.<br>– The organization maintains a dynamic and timely system to ensure complete and updated provider listings and directories.<br>– To transition to a new information system, the organization tested for six months prior to retiring the previous system and completed the transition successfully with no issues.<br><br>**Progress**<br>– The organization implemented a formalized auditing process to ensure the accuracy of provider data.<br><br>**Recommendations**<br>– Continue with the implementation of the *Federal Information Processing Standards Publication*, which has built in benchmarks/milestones. The | |

| Lakeland Care, Inc. | | |
|---|---|---|
| **Programs Operated** | **FY 21-22 Enrollment by Program** | **GSRs** |
| FC | FC: 7,435 | 4, 9, 10,13 |
| **Findings** | | |
| | organization should review and align its progress with these Federal and State benchmarks. | |

| My Choice Wisconsin | | |
|---|---|---|
| **Programs Operated** | **FY 21-22 Enrollment by Program** | **GSRs** |
| FC, FCP | FC: 15,389 FCP: 1,527 | 1, 2, 3, 5, 6, 8, 11, 12,14 |
| **Findings** | | |
| **Protocol 1: Validation of Performance Improvement Projects**<br>• *Clinical PIP: Chronic Heart Failure (FCP)*<br>• *Clinical PIP: Chronic Heart Failure (FC)*<br>• *Nonclinical PIP: Care Management Practices* | **Strengths**<br>– Detailed research regarding the topic selection and its importance to members was conducted and reported for all projects.<br>– A clear, concise, measurable, and answerable aim statement was established for all projects.<br>– The PIP population was clearly identified in relation to the aim statement for all projects.<br>– Appropriate sampling methods were used for both projects that utilized sampling.<br>– The PIP variables and performance measures selected for two projects were clear indicators of performance.<br>– Valid and reliable procedures were used to collect the PIP data and inform measurements for one project.<br>– Appropriate techniques were used to analyze the PIP data and interpret the results for two projects.<br>– Appropriate, evidence-based interventions were selected and implemented that were likely to lead to the desired improvement for all projects.<br>– Statistically significant improvement was demonstrated that may be the result of the selected interventions for one project.<br><br>**Progress**<br>– The PIP population was clearly defined in terms of the identified PIP question for all projects.<br>– All three of the PIP projects assessed the extent to which the improvement strategy was successful and identified potential follow-up activities.<br>– All projects answered the study question as written.<br>– The data collection approach captured the members as defined in the study question for all projects.<br>– All projects took study limitations into consideration during analysis.<br><br>**Recommendations**<br>– Incorporate a process to validate data that is manually collected from the organization's electronic care management system for accuracy and completeness.<br>– Conduct tests of statistical significance to determine if any observed improvement is the result of the interventions.<br>– Establish performance indicators or variables that are adequate to answer the PIP aim statement.<br>– Consider and analyze the impact of claims lag on the comparability of data between initial and repeat measurements. | |

| My Choice Wisconsin | | |
|---|---|---|
| **Programs Operated** | **FY 21-22 Enrollment by Program** | **GSRs** |
| FC, FCP | FC: 15,389 FCP: 1,527 | 1, 2, 3, 5, 6, 8, 11, 12,14 |
| **Findings** | | |
| | – Design PIP projects to account for barriers to producing a true final rate for the project and ensure initial and repeat measures use the same methodology in order to be comparable.<br>– Ensure PIP reports include the process and data sources related to collecting data that represents the study population.<br>– Clearly define terms used in performance variables and indicators to ensure data is being collected accurately. | |
| **Protocol 2: Validation of Performance Measures** | **Strengths**<br>– Pneumococcal vaccination rates are over 90.0 percent and remained the same year to year for both programs.<br>– FCP influenza rates remained the same year to year<br><br>**Progress**<br>– There was no progress to report.<br><br>**Recommendations**<br>– Conduct a root cause analysis for the vaccination rates that declined from MY 2020. Identifying the root cause or causes will allow the MCO to focus improvement efforts.<br>– Continue the practices developed, including educating members on the importance of the influenza vaccinations to increase influenza vaccination rates in both programs. | |
| **Protocol 3: Compliance with Managed Care Regulations, Quality Compliance Review** | **Strengths**<br>– The organization has a quality management program that documents and monitors required activities, with the purpose of improving the access, timeliness, and quality of supports to members.<br>– The organization demonstrated the implementation of a grievance system that provides members with the ability to grieve or appeal actions of the organization, including access to a DHS review for grievances and to the State's Fair Hearing system for appeals, when decisions are adverse to the member.<br><br>**Progress**<br>– The organization successfully implemented 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.<br><br>**Recommendations**<br>– Implement specific monitoring for the quality of care management to include members being afforded choice among covered services and providers.<br>– Document the data sources applied for utilization management monitoring to ensure consistent data collection and analysis.<br>– Review and edit the grievance and appeal policy to ensure the process is clear and free from grammatical and typing errors.<br>– Ensure the appeal process reflects the current DHS-MCO contract requirements throughout the policy.<br>– Focus efforts on improving the timeliness of issuing a *Notice of Adverse Benefit Determination* letter when indicated. | |

| My Choice Wisconsin | | |
|---|---|---|
| **Programs Operated** | **FY 21-22 Enrollment by Program** | **GSRs** |
| FC, FCP | FC: 15,389 FCP: 1,527 | 1, 2, 3, 5, 6, 8, 11, 12,14 |
| **Findings** | | |
| | – Implement a systematic approach to tracking informal resolution attempts of member appeals and grievances. | |
| **Protocol 9: Conducting Focused Studies of Health Care Quality**<br>*Sample Sizes*<br>*FC: 266*<br>*FCP: 231* | **Strengths**<br>– Comprehensive assessment practices were strengths for the FC program.<br>– The FC program demonstrated strengths related to care coordination.<br><br>**Progress**<br>– No progress was made on the recommendations from the prior review.<br><br>**Recommendations**<br>– Improve timeliness of assessment for the FCP program.<br>– Focus efforts on improving the comprehensiveness of member-centered plans in the FC and FCP programs.<br>– Improve timeliness of member-centered plans in the FC and FCP programs.<br>– Continue efforts to ensure timely follow-up for effectiveness of services, especially in the FCP program.<br>– Continue efforts to improve member contacts by the interdisciplinary team in the FCP program. | |
| **Appendix A: Information Systems Capabilities Assessment** | Not Applicable. Two MCOs merged in 2020 to form the MCO. The newly formed organization has not been reviewed since the merger. | |

# PROTOCOL 1: VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

The Validation of Performance Improvement Projects (PIPs) is a mandatory EQR activity identified in the Code of Federal Regulation (CFR) 42 CFR 438.358 and conducted according to federal protocol standards, *CMS External Quality Review (EQR) Protocols, Protocol 1. Validation of Performance Improvement Projects*. See Appendix 2 for more information about the PIP review methodology.

DHS contractually requires organizations operating Family Care (FC), Family Care Partnership (FCP), and/or Program of All-Inclusive Care for the Elderly (PACE) to annually make active progress on at least one clinical and one non-clinical PIP relevant to long-term care. MCOs operating more than one of these programs may fulfill this PIP requirement by conducting one or both of the required PIPs with members from any or all programs. If the MCO chooses to combine programs in a single PIP, the baseline and outcome data must be separated by program enrollment.

The study methodology is assessed through the following steps:

- Review the selected PIP topic(s);
- Review the PIP aim statement(s);
- Review the identified PIP population;
- Review sampling methods (if sampling used);
- Review the selected PIP variables and performance measures;
- Review the data collection procedures;
- Review the data analysis and interpretation of PIP results
- Assess the improvement strategies; and
- Assess the likelihood that significant and sustained improvement occurred.

MCOs must seek DHS approval prior to beginning each project. For projects conducted during 2021, organizations submitted proposals to DHS in January 2021. DHS directed MCOs to submit final reports by December 30, 2021. MetaStar validated at least one clinical and at least one non-clinical PIP for each organization, for a total of 11 PIPs.

Following the measurement year (MY) 2020 PIP validations, the review was revised to align with the updated CMS EQR Protocol 1. The revision to the review changed the scoring methodology, making the scores from the prior review not comparable to the current review.

## OVERALL PIP RESULTS

Compliance with PIP requirements is expressed in terms of a percentage score based on the number of applicable scoring elements, and a validation rating, as identified in the table below.

The validation rating reflects the EQRO's confidence in the PIP's methods and findings. The validation rating reflects the EQRO's confidence in the PIP's methods and findings. See Appendix 2 for more information about the scoring methodology.

| Percentage of Scoring Elements Met | Validation Result |
|---|---|
| 90.0% - 100.0% | High Confidence |
| 80.0% - 89.9% | Moderate Confidence |
| 70.0% - 79.9% | Low Confidence |
| <70.0% | No Confidence |

The following table lists each standard that was evaluated for each MCO and indicates the total number of scoring elements met for each standard and the percentage of met scoring elements for each standard. Some standards are not applicable to all projects due to study design, results, or implementation stage.

| Performance Improvement Project Validation Review FY 21-22 | | |
|---|---|---|
| **Standard** | **Scoring Elements** | **Percentage** |
| Standard 1: PIP Topic | 34/34 | 100.0% |
| Standard 2: PIP Aim Statement | 59/66 | 89.4% |
| Standard 3: PIP Population | 17/18 | 94.4% |
| Standard 4: Sampling Method | 19/20 | 95.0% |
| Standard 5: PIP Variables and Performance Measures | 57/62 | 91.9% |
| Standard 6: Data Collection Procedures | 81/89 | 91.0% |
| Standard 7: Data Analysis and Interpretation of PIP Results | 57/69 | 82.6% |
| Standard 8: Improvement Strategies | 60/65 | 92.3% |
| Standard 9: Significant and Sustained Improvement | 26/44 | 59.1% |

## Results for each PIP Standard

Each section that follows provides a brief explanation of the PIP standard, including rationale for any areas that the MCOs were not fully compliant. Additionally, Appendix 3 includes results for each standard by MCO and project.

### Observation and Analysis: Standard 1. PIP Topic

The MCOs should target improvement in relevant areas of clinical and non-clinical services. The topic selection process should consider the national Quality Strategy, CMS Core Set Measures, and DHS priorities. When appropriate or feasible, enrollee and provider input should be obtained. All topics should address areas of special populations or high priority services. Standard 1 contains four scoring elements for projects focused on DHS or CMS priority areas, and three scoring elements for projects that are not focused on DHS or CMS priority areas, for a

total of 34 scoring elements. The MCOs satisfied requirements for 34 out of 34 scoring elements, for a score of 100.0 percent.

MCOs clearly documented the rationale for selection of the PIP topics, taking into consideration DHS, CMS, or MCO priority areas, and enrollee or provider input when appropriate. All MCOs satisfied the applicable requirements for this standard.

### Observation and Analysis: Standard 2. PIP Aim Statement

The PIP aim statement identifies the focus of the PIP and establishes the framework for data collection and analysis. It should be a clear, concise, measurable, and answerable statement or question that identifies the improvement strategy, population, and time period. Standard 2 contains six scoring elements for each MCO, for a total of 66 scoring elements. The MCOs satisfied requirements for 59 out of 66 scoring elements, for a score of 89.4 percent.

Scoring element 2.3 is about identifying the time period for the project as part of the aim statement. Three projects did not include or clearly specify the projects' time period in the aim statement for all of the study questions. One of these projects included an aim statement that did not state it only applied to the first year of the two-year project.

Scoring element 2.5 is about the study questions being answerable. In order for this element to be met, the aim statement must clearly specify the improvement strategy, the PIP population, and the time period for the project (scoring elements 2.1, 2.2, and 2.3). Since the time period for two projects was not included, the aim statements could not be evaluated as answerable.

### Observation and Analysis: Standard 3. PIP Population

The MCOs must clearly define the project's population, identifying all inclusionary and exclusionary criteria. If the entire eligible MCOs population is included in the project, the data collection approach must ensure it captures all applicable members. Standard 3 contains one scoring element for MCOs that employed sampling of the project's population, and two scoring elements for MCOs that did not utilize sampling, for a total of 18 scoring elements. The MCOs satisfied requirements for 17 out of 18 scoring elements, for a score of 94.4 percent.

The study population was clearly defined for all PIP projects, specifying any exclusions or continuous enrollment criteria. For the projects that did not employ sampling, most projects ensured the data collection approach captured all enrollees to whom the study question or aim statement applied.

### Observation and Analysis: Standard 4. Sampling Method

The MCOs must have appropriate sampling methods to ensure data collection produces valid and reliable results. Standard 4 contains five scoring elements for each project that employed

sampling, for a total of 20 scoring elements. The MCOs satisfied requirements for 19 out of 20 scoring elements, for a score of 95.0 percent.

Four projects employed sampling techniques to establish the study population. All projects contained a sufficient number of members to ensure the PIP findings were applicable to the overall MCO population. Most projects ensured the sampling frame was fully defined. The sampling methodology specified the confidence interval and acceptable margin of error for all projects.

### Observation and Analysis: Standard 5. PIP Variables and Performance Measures

MCOs must select variables that identify the MCO's performance on the PIP questions objectively and reliably, using clearly defined indicators of performance. The PIP should include the number and type of variables that are adequate to answer the PIP question, can measure performance, and can track improvement over time. Standard 5 contains up to 10 scoring elements for each MCO based on the type of variables or performance measures used in each project. The MCOs satisfied requirements for 57 out of 62 scoring elements, for a score of 91.9 percent.

Most of the projects identified PIP variables and performance measures that were adequate to answer the study questions, and assessed important aspects of care to make a difference in a member's health or functional status. Performance measures were appropriate based on the availability of data and resources to collect the data, and most of the PIP reports documented the processes for reviewing and monitoring data throughout the measurement year.

### Observation and Analysis: Standard 6. Data Collection Procedures

MCOs must establish data collection procedures that ensure valid and reliable data throughout the project. The data collection plan should specify the following:

- Data sources;
- Data to be collected;
- How and when data was collected;
- How often data was collected;
- Who collected the data; and
- Instruments used to collect data.

Standard 6 contains up to 17 scoring elements for each MCO based on the type of administrative data collected and if the MCO is requesting and reviewing medical records from external sources. The MCOs satisfied requirements for 81 out of 89 scoring elements, for a score of 91.0 percent.

Most of the PIP reports identified the data used for each project, including the data sources, the data collection instruments, and person's responsible for determining the eligible population. The data collection plan linked to the data analysis plan for the majority of the projects, to ensure appropriate data would be available for the PIP.

### Observation and Analysis: Standard 7. Data Analysis and Interpretation of PIP Results

MCOs must use appropriate techniques to conduct analysis and interpretation of the PIP results. The analysis should include an assessment of the extent to which any change in performance is statistically significant. Standard 7 contains up to 8 scoring elements for each MCO based on whether the projects demonstrated improvement or included measures that could be compared to additional benchmarks. The MCOs satisfied requirements for 57 out of 69 scoring elements, for a score of 82.6 percent.

Scoring element 7.3 requires the MCO to assess the statistical significance of any differences between the initial and repeat measurements. Seven of the eleven projects did not include statistical analysis of improvement or decline from baseline to remeasurement.

Scoring element 7.4 requires the MCO's analysis to account for factors that may influence the comparability of initial and repeat measurements. One MCO did not recognize the use of a different data source for the repeat measure from the baseline measure, which affected the comparability of the measures. Another MCO did not update the aim statements for one of the goals when the measurement periods were changed to allow for a larger population size and did not accurately account for the change in the definition of an indicator for a second goal. A third MCO did not consider the impact of the claims lag on the comparability of data between initial and repeat measures for the project, and was only able to report a preliminary rate as the remeasurement rate for the project.

Scoring element 7.5 assesses whether the analysis accounted for factors that may threaten the internal or external validity of the findings. While one organization identified the study population declined over time from 75 members at baseline to 19 members after year two of the project, the PIP report did not identify the small study population as a potential barrier to the reliability of the results of the project.

### Observation and Analysis: Standard 8. Improvement Strategies

MCOs should select improvement strategies that are evidence-based, suggesting they would likely lead to the desired improvement. The effectiveness of the strategies is determined by measuring the change in performance according to the measures identified in Standard 5. Standard 8 contains six scoring elements for each MCO. However, one MCO only had five

scoring elements applicable; thus, there are a total of 65 scoring elements for this standard. The MCOs satisfied requirements for 60 out of 65 scoring elements, for a score of 92.3 percent.

MCOs identified the basis for selecting improvement strategies, which were evidence-based and likely to lead to the desired improvement in the project. Plan-Do-Study-Act cycles of improvement were documented for most projects, which resulted in adjustments to the interventions as necessary. The majority of projects assessed the extent to which improvement strategies were successful and all projects identified potential follow-up activities.

### Observation and Analysis: Standard 9. Significant and Sustained Improvement

An important component of a PIP is to demonstrate sustained improvement. The MCOs should conduct repeated measurements using the same methodology and document if a significant change in performance relative to the baseline occurred. Standard 9 contains four scoring elements for each MCO, for a total of 44 scoring elements. The MCOs satisfied requirements for 26 out of 44 scoring elements, for a score of 59.1 percent.

Scoring element 9.1 is about using the same methodology for the baseline and remeasurement. The change in methodology for one goal and the inclusion and exclusion criteria for another goal for one project resulted in the baseline and repeat measure no longer being comparable. Another MCO was not able to report a final rate to one project due to a claims lag in obtaining data. The repeat measure for this project was reported as a preliminary rate and thus it was not comparable to the baseline rate.

Scoring element 9.2 is about whether there was quantitative evidence of improvement in processes or outcomes of care. Two projects identified improvement occurred; however, the initial and repeat measures were not comparable as noted above for scoring element 9.1. In addition, one MCO's project did not demonstrate improvement.

Scoring element 9.3 evaluates if the reported improvement in performance was likely to be a result of the selected intervention. As noted above for scoring element 9.2, three projects did not demonstrate or report improvement from baseline rates for the PIP project. One additional MCO reported that although improvement was reported, the small study population along with other variables could have affected the outcome of the study, and it could not conclude that the selected interventions positively impacted the study.

Scoring element 9.4 assesses if there is statistical evidence that any observed improvement is the result of the intervention. In addition to the four projects that did not demonstrate improvement as the result of interventions as detailed in scoring element 9.3, five other projects did not include statistical evidence that the demonstrated improvement was the result of the interventions.

## CONCLUSIONS

A summary of strengths, progress, and recommendations is noted in the *Executive Summary* and *Introduction and Overview* sections above.

# Protocol 2: Validation of Performance Measures

Validation of performance measures is a mandatory review activity identified in the Code of Federal Regulations (CFR) 42 CFR 438.358 and conducted according to federal protocol standards, *CMS External Quality Review (EQR) Protocols, Protocol 2: Validation of Performance Measure*. The review assesses the accuracy of performance measures reported by the MCO, and determines the extent to which performance measures calculated by the MCO follow state specifications and reporting requirements. Assessment of an MCO's information system is required as part of performance measures validation (PMV) and other mandatory review activities. To meet this requirement, each MCO receives an Information Systems Capabilities Assessment (ISCA) once every three years as directed by DHS. The ISCAs are conducted and reported separately.

The MCO quality indicators for MY 2021, which are set forth in Addendum III of the 2020 DHS-MCO contract, provide standardized information about preventive health services and continuity of care. As directed by DHS, MetaStar validated the completeness and accuracy of MCOs' influenza and pneumococcal vaccination data for MY 2021. The technical definitions provided by DHS for the MY influenza and pneumococcal vaccination quality indicators include a definition of the MY. The technical definitions can be found in Attachments 1 and 2. The review methodology MetaStar used to validate these performance measures are in Appendix 2.

Acute and primary care services, including vaccinations, are included in the FCP and PACE benefit package but are not among the services covered in the FC benefit package. However, in all three programs, coordination of long-term care with preventive health services is required. The role of care managers includes assistance with coordination of members' health services, such as vaccinations, to promote preventive care and wellness to ensure members stay as healthy as possible.

## Vaccination Rates by Program and MCO

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

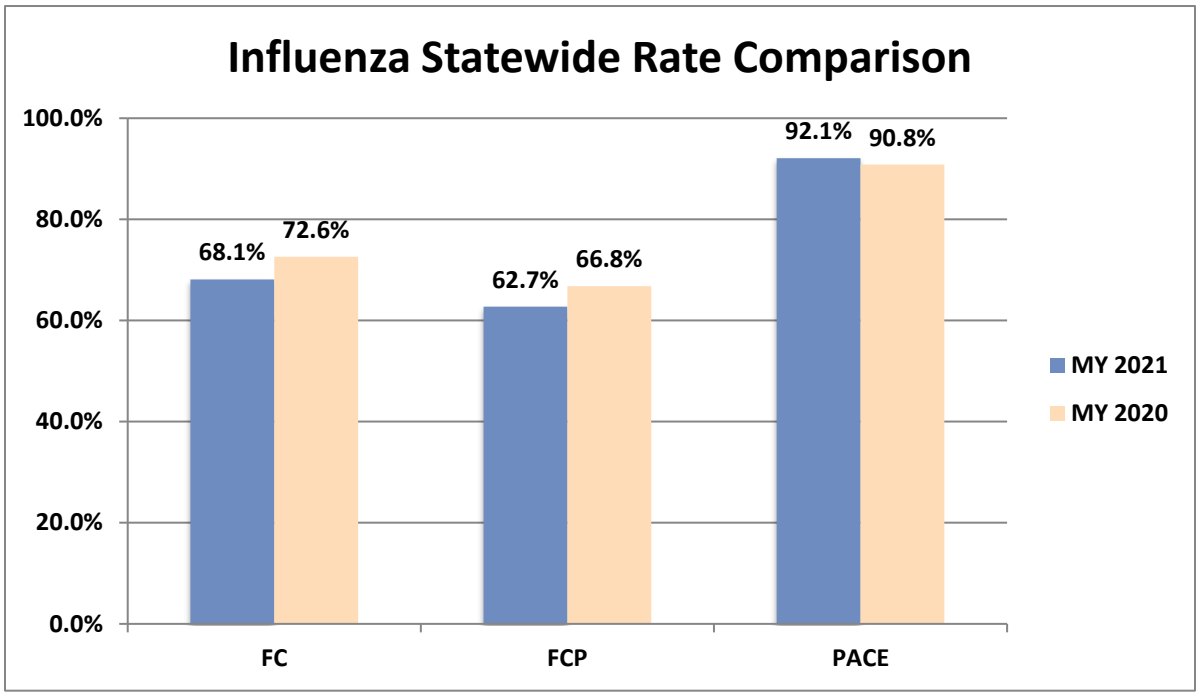
### Influenza Vaccination Rates

The following table shows information about the influenza vaccination rates, by program, for MY 2021 and compares the MY 2021 rates to vaccination rates in MY 2020.

| Statewide Influenza Vaccination Rates by Program | | | | |
|---|---|---|---|---|
| | MY 2021 | | | MY 2020 |
| Program | Eligible Members | Number Vaccinated | Vaccination Rate | Vaccination Rate |
| Family Care | 44,486 | 30,281 | 68.1% | 72.6% |

| Statewide Influenza Vaccination Rates by Program | | | | |
|---|---|---|---|---|
| | MY 2021 | | | MY 2020 |
| Program | Eligible Members | Number Vaccinated | Vaccination Rate | Vaccination Rate |
| Family Care Partnership | 3,157 | 1,981 | 62.7% | 66.8% |
| PACE | 429 | 395 | 92.1% | 90.8% |

Influenza vaccination statewide rates, by program, for MY 2021 and MY 2020 are shown in the following graph.

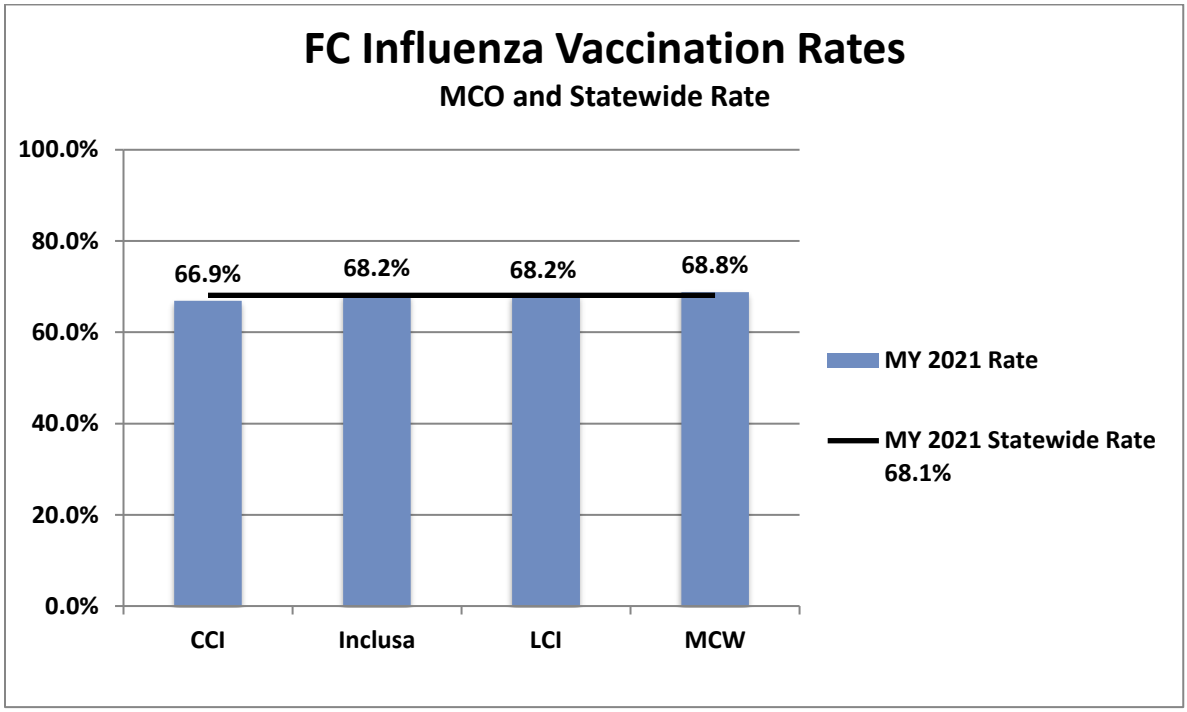



The following table shows influenza vaccination rates by program and MCO for MY 2021 and MY 2020. MY 2020 influenza vaccination rates were amended after the issuance of the final reports due to an error in the data. Rates reflected in this report are the amended rates.

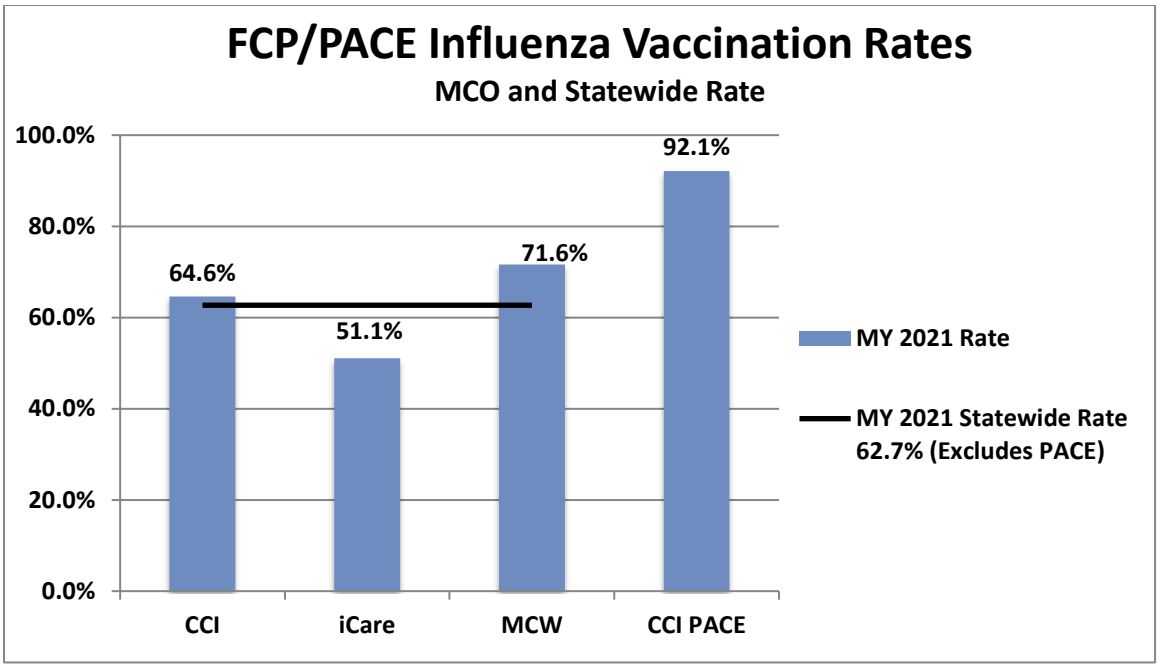
| Influenza Vaccination Rates by Program and Measurement Year | | | | |
|---|---|---|---|---|
| Program/MCO | MY 2021 | | | MY 2020 |
| | Eligible Members | Number Vaccinated | Vaccination Rate | Vaccination Rate |
| **Family Care** | | | | |
| CCI | 10,615 | 7,097 | 66.9% | 71.1% |
| Inclusa | 13,667 | 9,323 | 68.2% | 73.2% |
| LCI | 6,624 | 4,520 | 68.2% | 75.4% |
| MCW | 13,580 | 9,338 | 68.8% | 71.9% |

| Influenza Vaccination Rates by Program and Measurement Year | | | | |
|---|---|---|---|---|
| Program/MCO | MY 2021 | | | MY 2020 |
| | Eligible Members | Number Vaccinated | Vaccination Rate | Vaccination Rate |
| **Family Care Partnership** | | | | |
| CCI | 627 | 405 | 64.6% | 73.8% |
| *i*Care | 1,145 | 585 | 51.1% | 54.1% |
| MCW | 1,385 | 991 | 71.6% | 71.8% |
| **PACE** | | | | |
| CCI | 429 | 395 | 92.1% | 90.8% |

The graph below includes the influenza vaccination rates among the FC MCOs.




The graph on the next page compares the influenza vaccination rates among the MCOs operating FCP and PACE. Only one MCO operates the PACE program; therefore, here and in subsequent graphs in this report, no PACE statewide rate is available for comparison.



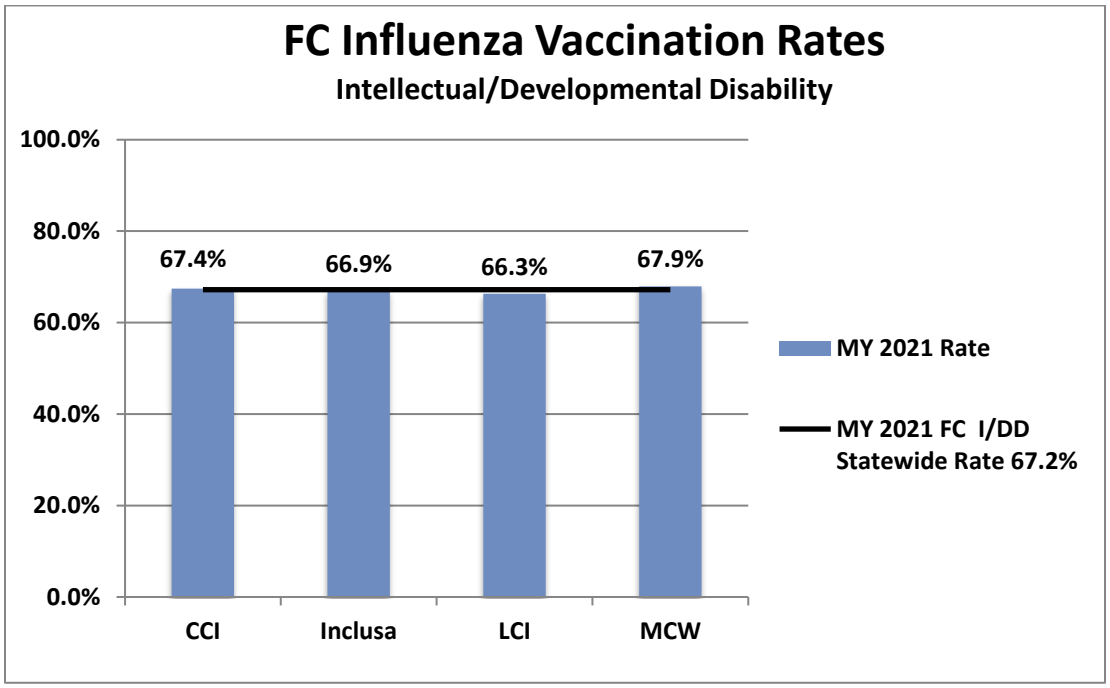

## Influenza Vaccination Rates by Target Group

For each program (FC, FCP, and PACE), influenza vaccination rates varied by target group as shown in the table below.

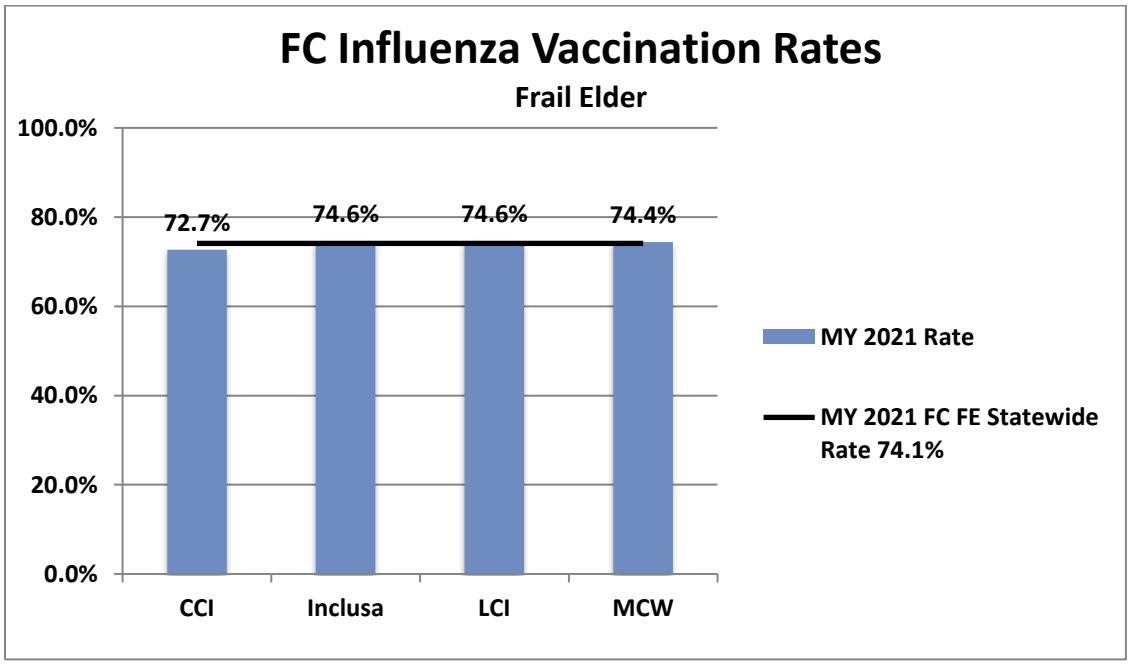
| MY 2021 Influenza Vaccination Rates by Program and Target Group | | | |
|---|---|---|---|
| **Program/Target Group** | **Eligible Members** | **Number Vaccinated** | **Vaccination Rate** |
| **Family Care** | | | |
| Intellectual/Developmental Disability | 21,841 | 14,681 | 67.2% |
| Frail Elder | 15,122 | 11,202 | 74.1% |
| Physical Disability | 7,523 | 4,399 | 58.5% |
| **Family Care Partnership** | | | |
| Intellectual/Developmental Disability | 825 | 499 | 60.5% |
| Frail Elder | 1,129 | 811 | 71.8% |
| Physical Disability | 1,203 | 671 | 55.8% |
| **PACE** | | | |
| Intellectual/Developmental Disability | 50 | 44 | 88.0% |
| Frail Elder | 350 | 330 | 94.3% |
| Physical Disability | 29 | 21 | 72.4% |

## FAMILY CARE

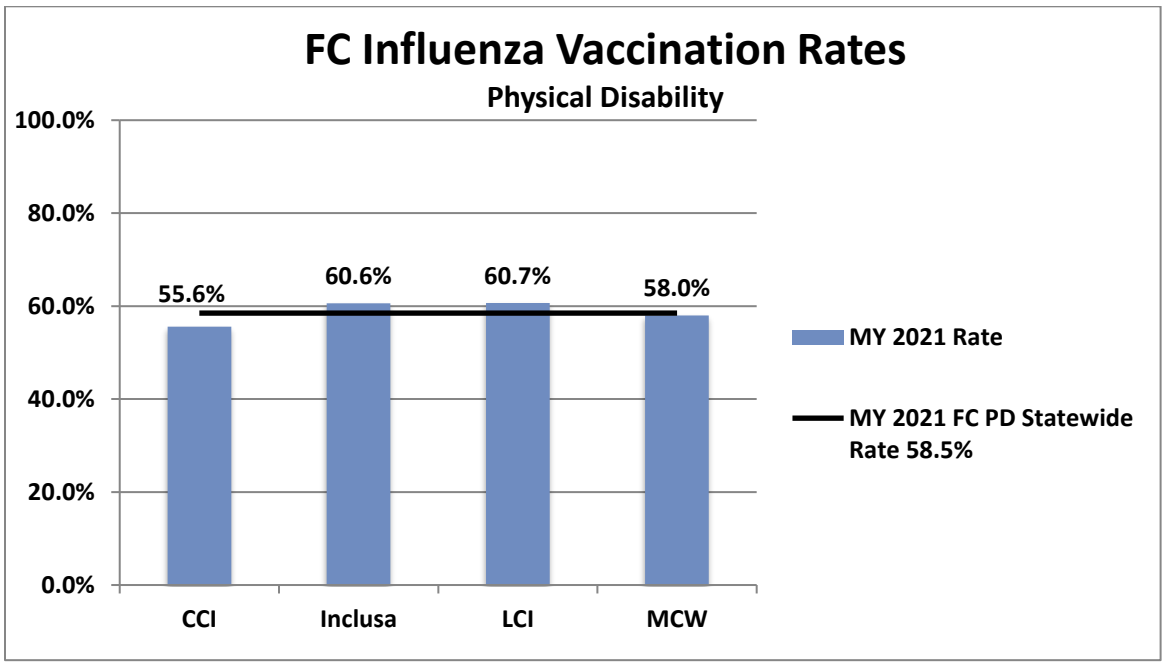
The graph below shows influenza vaccination rates for FC members in the Intellectual/Developmental Disability target group, by MCO, for MY 2021.




The graph below shows influenza vaccination rates for FC members in the Frail Elder target group, by MCO, for MY 2021.

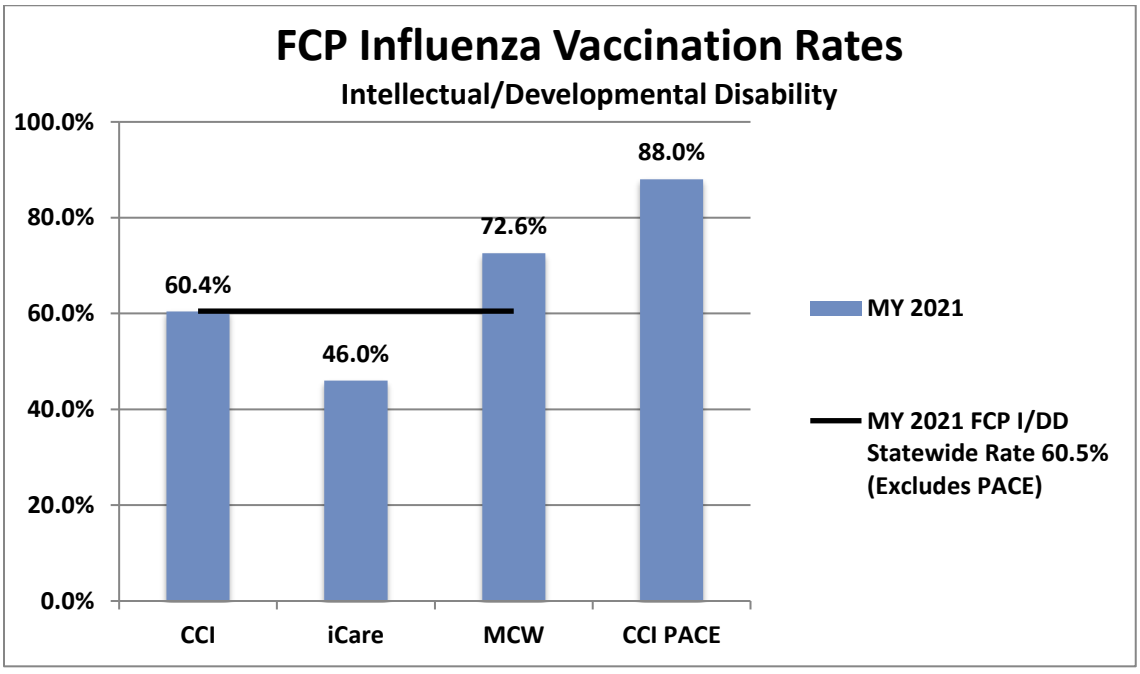


The graph below shows influenza vaccination rates for FC members in the Physical Disability target group, by MCO, for MY 2021.

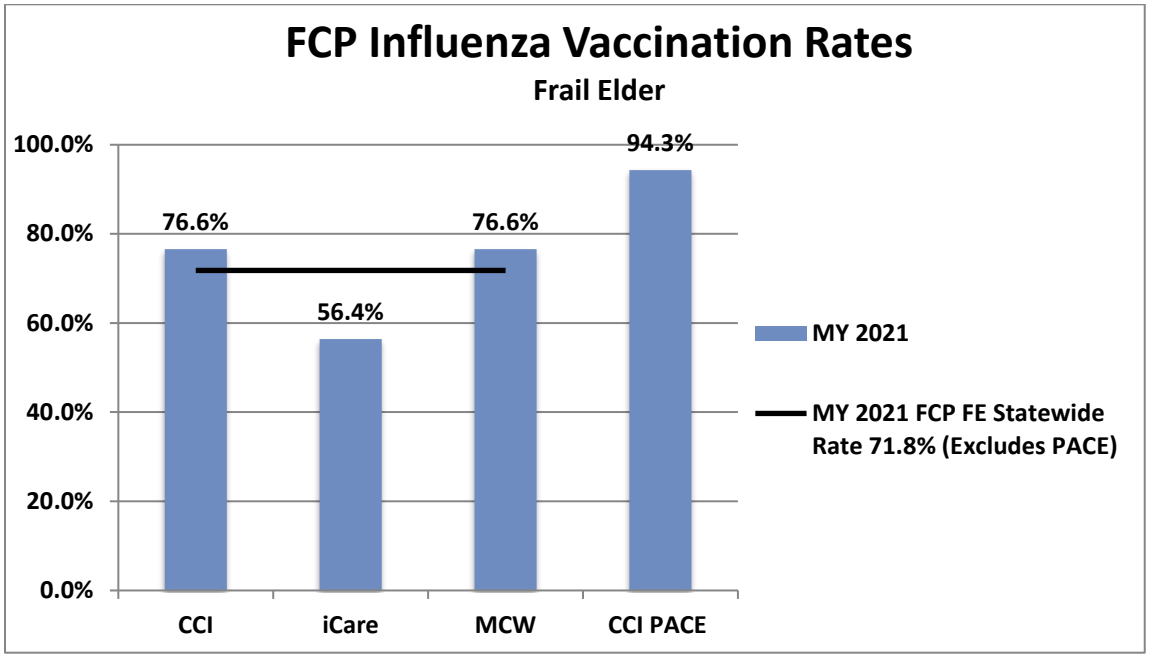



## Family Care Partnership/PACE

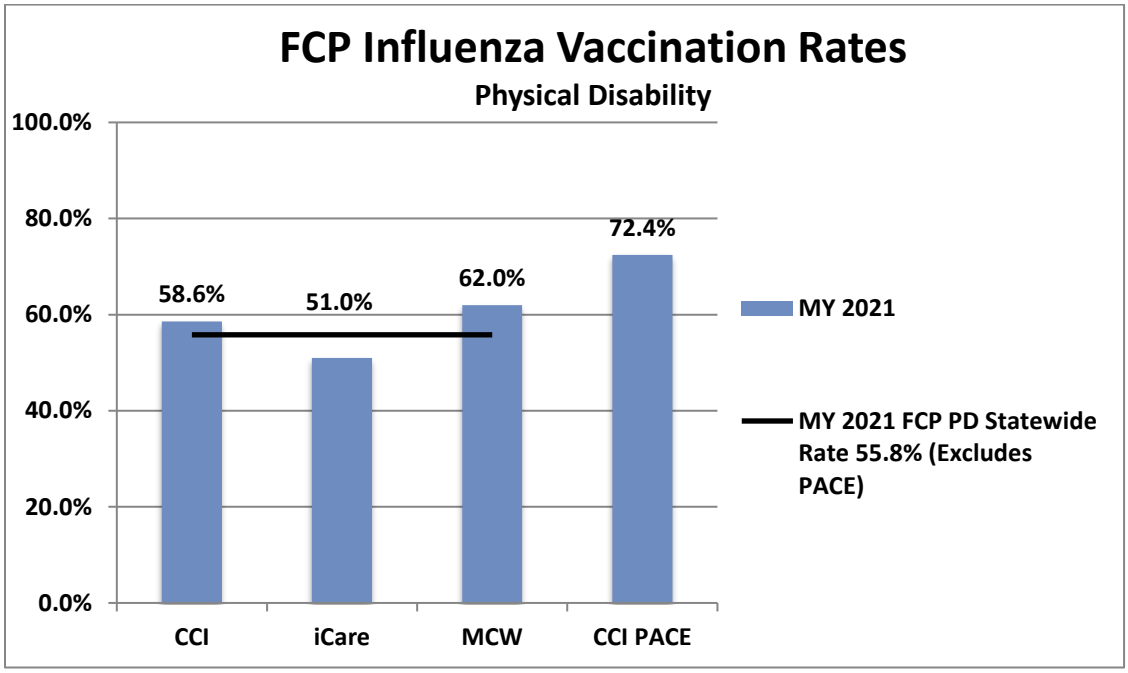
The graph below shows influenza vaccination rates for FCP and PACE members in the Intellectual/Developmental Disability target group, by MCO, for MY 2021.



The graph below shows influenza vaccination rates for FCP and PACE members in the Frail Elder target group, by MCO, for MY 2021.




The graph below shows influenza vaccination rates for FCP and PACE members in the Physical Disability target group, by MCO, for MY 2021.

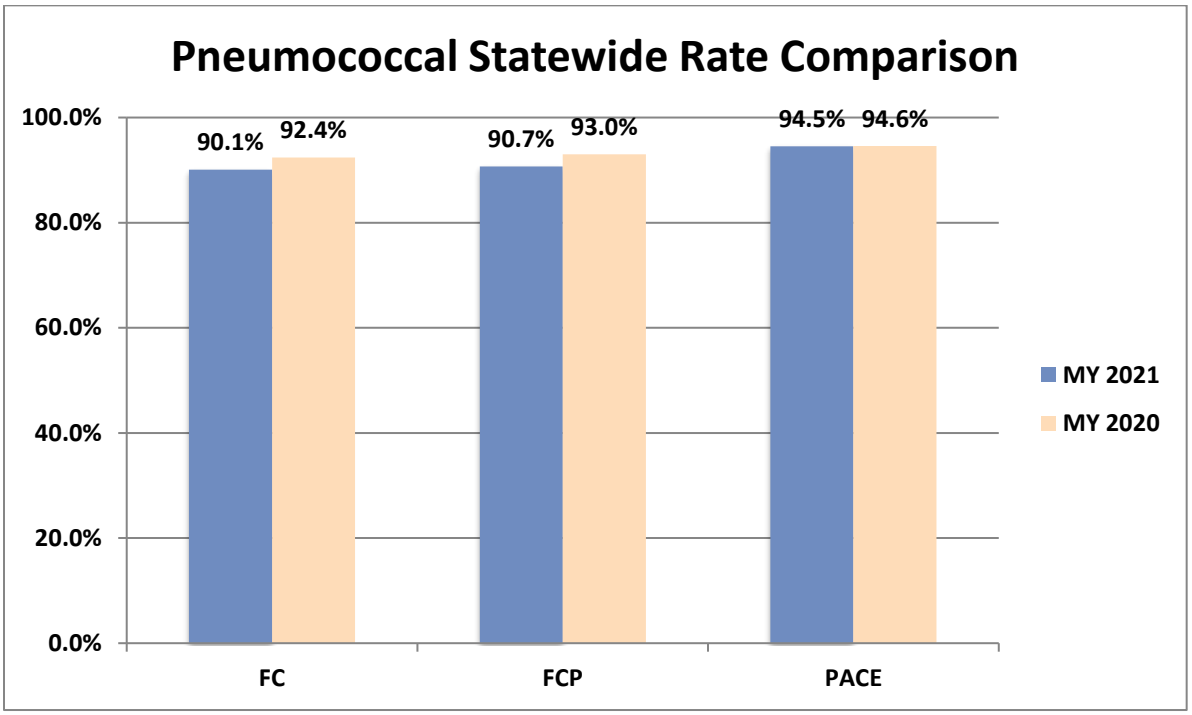


## Pneumococcal Vaccination Rates

The following table shows information about the pneumococcal vaccination rates, by program, for MY 2021 and compares the MY 2021 rates to vaccination rates in MY 2020.

| Statewide Pneumococcal Vaccination Rates by Program | | | | |
|---|---|---|---|---|
| | MY 2021 | | | MY 2020 |
| Program | Eligible Members | Number Vaccinated | Vaccination Rate | Vaccination Rate |
| Family Care | 19,967 | 17,989 | 90.1% | 92.4% |
| Family Care Partnership | 1,391 | 1,261 | 90.7% | 93.0% |
| PACE | 401 | 379 | 94.5% | 94.6% |

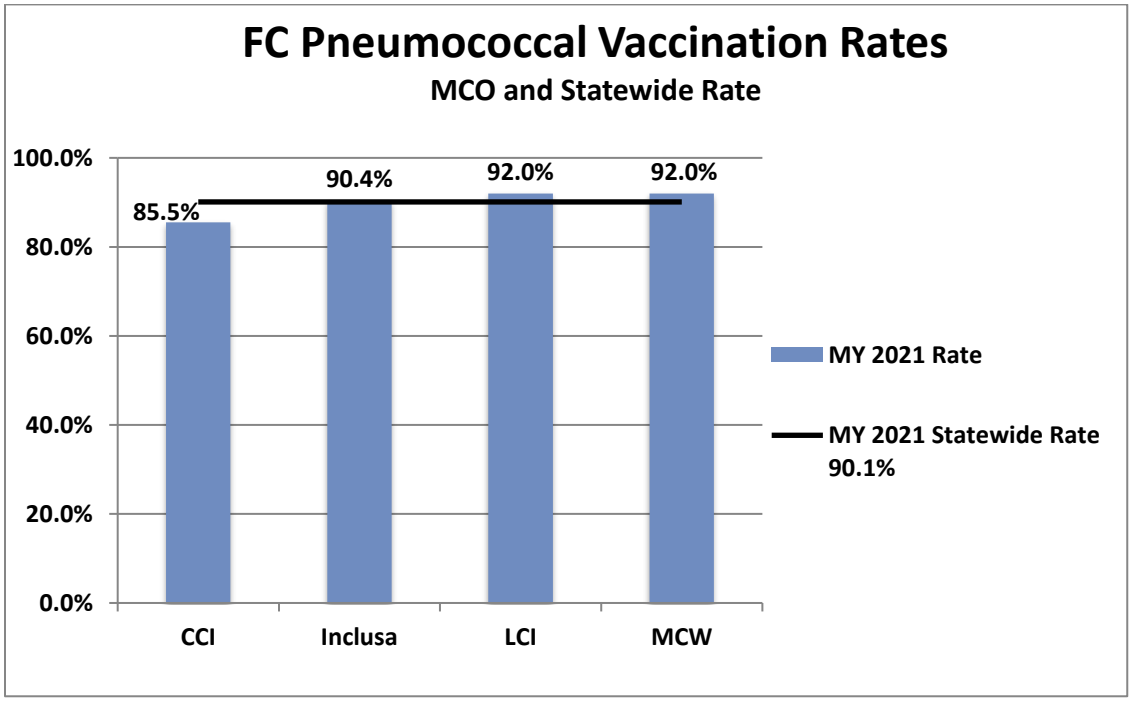
Pneumococcal vaccination statewide rates, by program, for MY 2021 and MY 2020 are shown in the following graph.



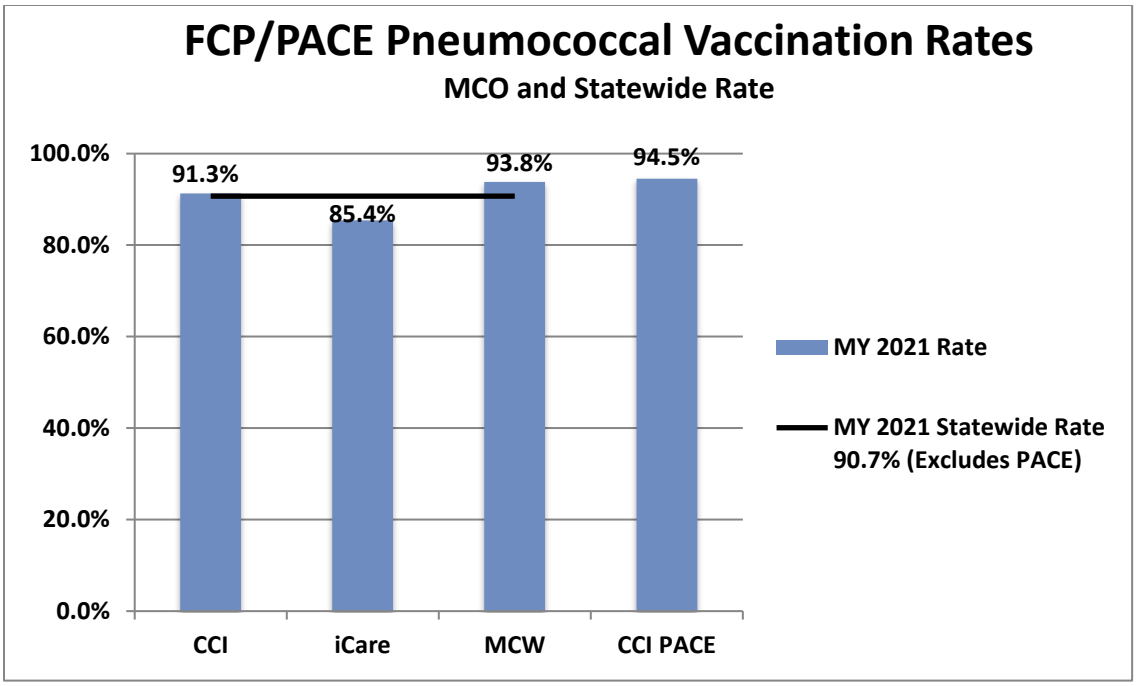

The table on the next page shows pneumococcal vaccination rates by program and MCO for MY 2021 and MY 2020.

| Pneumococcal Vaccination Rates by Program and Measurement Year | | | | |
|---|---|---|---|---|
| Program/MCO | MY 2021 | | | MY 2020 |
| | Eligible Members | Number Vaccinated | Vaccination Rate | Vaccination Rate |
| **Family Care** | | | | |
| CCI | 4,407 | 3,768 | 85.5% | 96.7% |
| Inclusa | 5,822 | 5,263 | 90.4% | 89.9% |
| LCI | 2,931 | 2,696 | 92.0% | 92.8% |
| MCW | 6,807 | 6,262 | 92.0% | 91.9% |
| **Family Care Partnership** | | | | |
| CCI | 230 | 210 | 91.3% | 89.6% |
| *i*Care | 426 | 364 | 85.4% | 90.3% |
| MCW | 832 | 780 | 93.8% | 94.9% |
| **PACE** | | | | |
| CCI | 401 | 379 | 94.5% | 94.6% |

The graph below includes the pneumococcal vaccination rates among the FC MCOs.




The graph on the next page includes the pneumococcal vaccination rates among the MCOs operating FCP and PACE. As noted earlier in this report, only one MCO operates the PACE program; therefore, no PACE statewide rate is available for comparison.




## Pneumococcal Vaccination Rates by Target Group

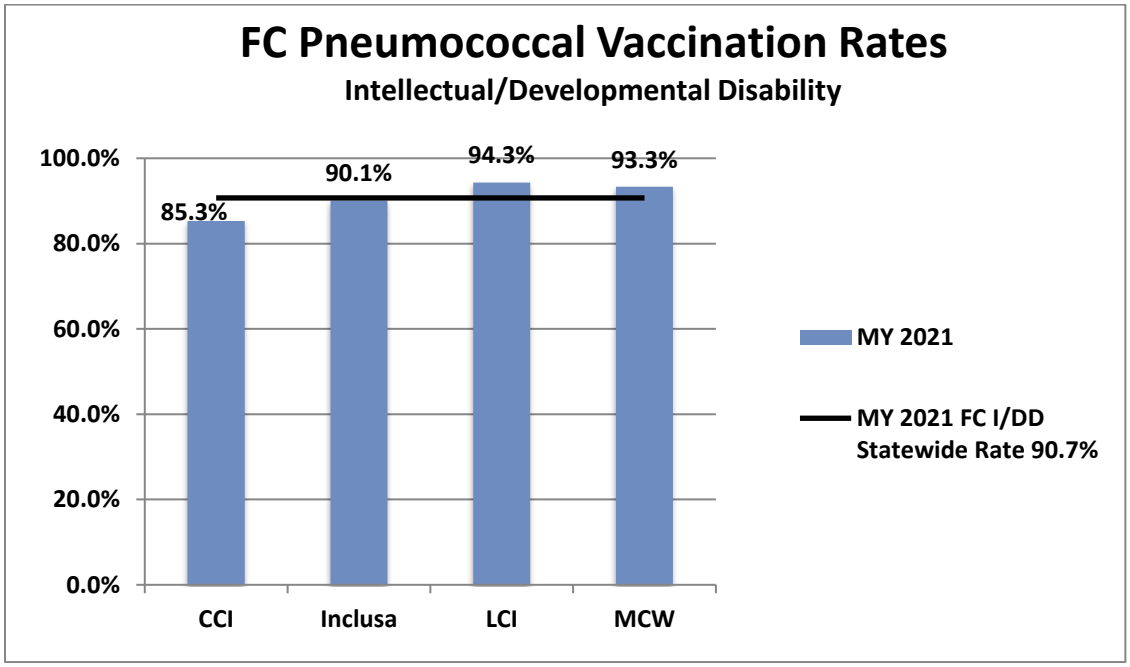
For each program (FC, FCP, and PACE), vaccination rates varied by target group as shown in the table below. All people who have a physical disability (PD) target group and are age 65 or older are assigned to the frail elder (FE) target group. People who are in the intellectual/developmental disability (I/DD) target group remain in the I/DD target group regardless of age. This is due to the target group automation for the *Adult Long Term Care Functional Screen* (LTCFS) implemented by DHS in 2017. There is no PD target group for the pneumococcal vaccination rates, as all included members are over the age of 65, per the DHS technical definitions. Any members incorrectly assigned to the PD target group by the MCOs were reassigned to the FE target group by MetaStar for this report.

| MY 2021 Pneumococcal Vaccination Rates by Program and Target Group | | | |
|---|---|---|---|
| **Program/Target Group** | **Eligible Members** | **Number Vaccinated** | **Vaccination Rate** |
| **Family Care** | | | |
| Intellectual/Developmental Disability | 3,918 | 3,553 | 90.7% |
| Frail Elder | 16,049 | 14,436 | 89.9% |
| **Family Care Partnership** | | | |
| Intellectual/Developmental Disability | 171 | 157 | 91.8% |
| Frail Elder | 679 | 603 | 88.8% |
| **PACE** | | | |
| Intellectual/Developmental Disability | 35 | 35 | 100.0% |

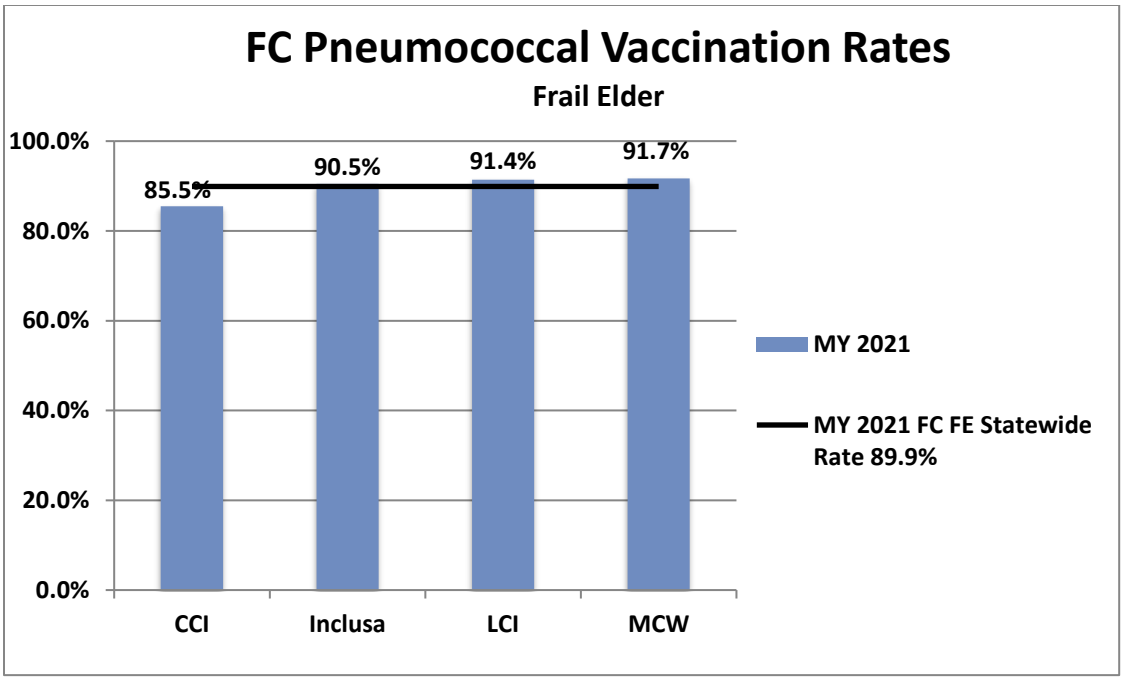
| MY 2021 Pneumococcal Vaccination Rates by Program and Target Group | | | |
|---|---|---|---|
| **Program/Target Group** | **Eligible Members** | **Number Vaccinated** | **Vaccination Rate** |
| Frail Elder | 266 | 344 | 94.0% |

## Family Care

The graph below shows pneumococcal vaccination rates for FC members in the Intellectual/Developmental Disability target group, by MCO, for MY 2021.

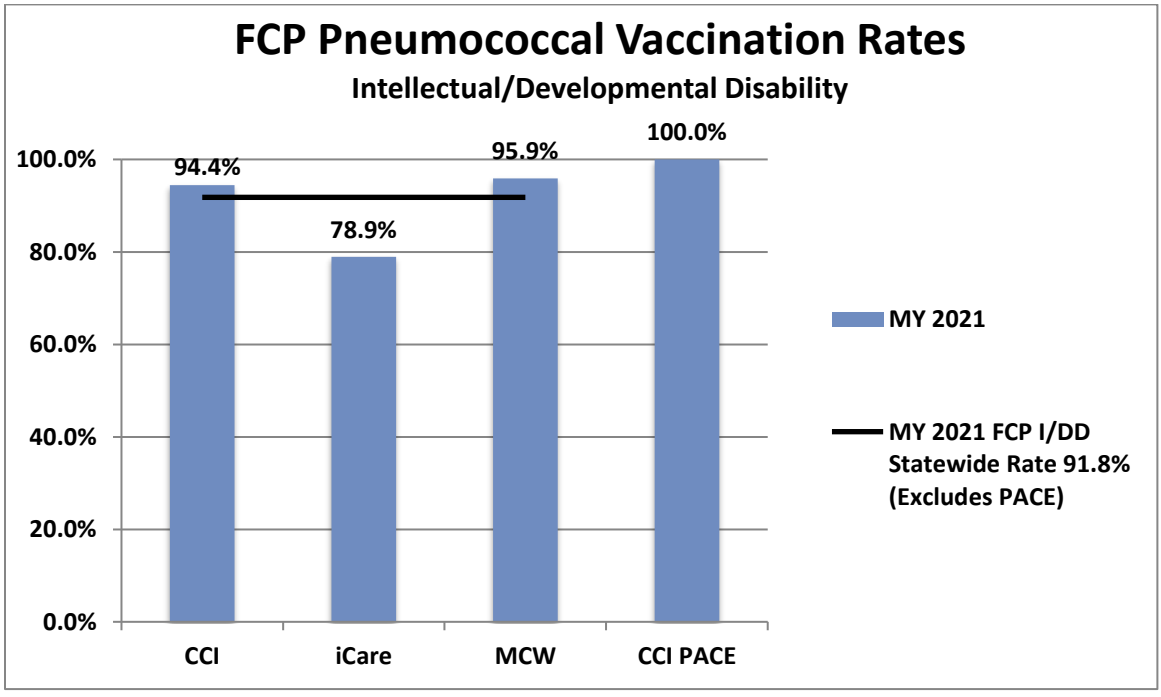



The graph on the next page shows pneumococcal vaccination rates for FC members in the Frail Elder target group, by MCO, for MY 2021.

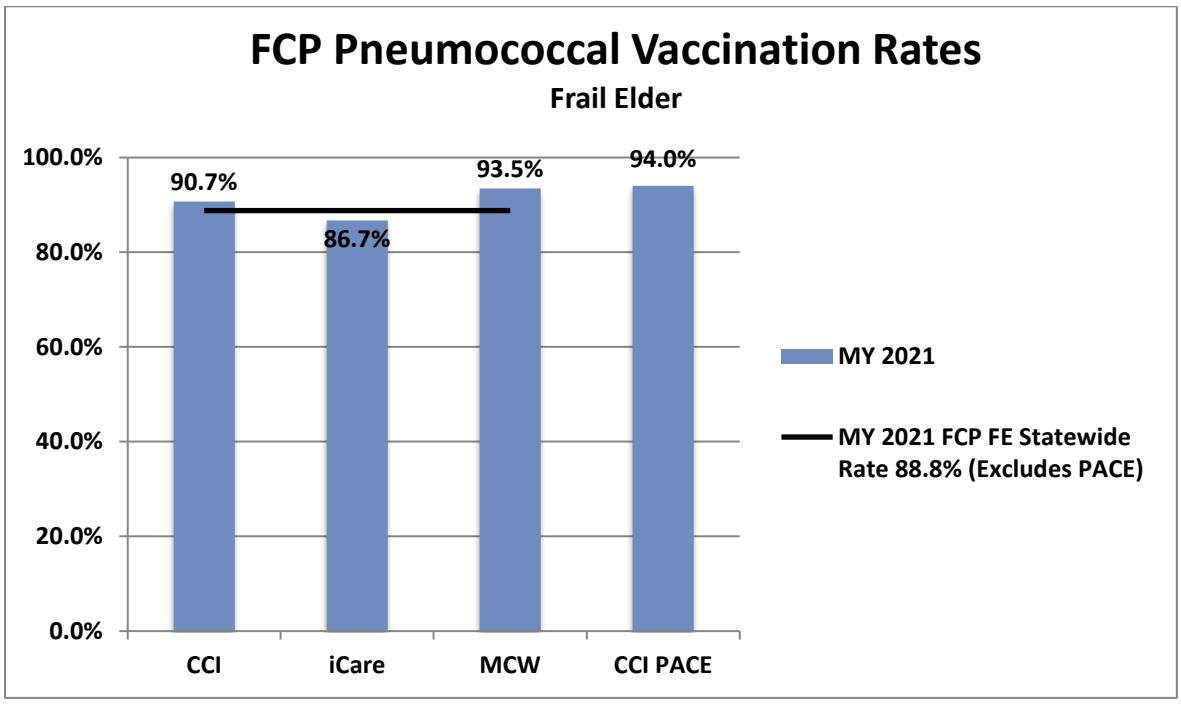



## Family Care Partnership/PACE

The graph below shows pneumococcal vaccination rates for FCP and PACE members in the Intellectual/Developmental Disability target group, by MCO, for MY 2021.



The graph below shows pneumococcal vaccination rates for FCP and PACE members in the Frail Elder target group, by MCO, for MY 2021.




## 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 97.8 percent of the total number of unique members included in the MCOs' and DHS' denominator files were common to both data sets.

## 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 2020. 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 240 member vaccination records for each quality indicator for MY 2021, and 240 member vaccination records for each quality indicator for MY 2020. The member records were reviewed to verify documentation of vaccinations, exclusions and contraindications as defined by the technical definitions. The records were determined to be valid for accurate documentation, or invalid for inaccurate documentation. A T-test, a type of statistical test, was conducted to determine if the data was biased or not biased. The overall findings for the influenza vaccinations for both years, and the pneumococcal vaccinations for MY 2021 were not biased, meaning the rates can be accurately reported. The pneumococcal vaccinations for MY 2020 were biased, meaning they cannot be accurately reported.

### *Vaccination Record Validation Aggregate Results*

| MY 2021 Influenza and Pneumococcal Vaccination Record Validation | | | | |
|---|---|---|---|---|
| **Quality Indicator** | **Total Records Reviewed** | **Number Valid** | **Percentage Valid** | **T-Test Result** |
| Influenza Vaccinations | 240 | 240 | 100.0% | Unbiased |
| Pneumococcal Vaccinations | 240 | 240 | 100.0% | Unbiased |

| MY 2020 Influenza and Pneumococcal Vaccination Record Validation | | | | |
|---|---|---|---|---|
| **Quality Indicator** | **Total Records Reviewed** | **Number Valid** | **Percentage Valid** | **T-Test Result** |
| Influenza Vaccinations | 240 | 237 | 98.7% | Unbiased |
| Pneumococcal Vaccinations | 240 | 237 | 98.7% | Biased |

### *Vaccination Record Validation Individual MCO Results*

The following tables provide information about the validation findings for each MCO in MY 2021.

### Results for Influenza Vaccination

| MY 2020 Influenza Vaccination Record Validation by Program and MCO | | | | |
|---|---|---|---|---|
| **MCO** | **Total Records Reviewed** | **Number Valid** | **Percentage Valid** | **T-Test Result** |
| **Family Care** | | | | |
| CCI | 30 | 30 | 100.0% | Unbiased |
| Inclusa | 30 | 30 | 100.0% | Unbiased |
| LCI | 30 | 30 | 100.0% | Unbiased |
| MCW | 30 | 30 | 100.0% | Unbiased |
| **Family Care Partnership** | | | | |
| CCI | 30 | 30 | 100.0% | Unbiased |

| MY 2020 Influenza Vaccination Record Validation by Program and MCO | | | | |
|---|---|---|---|---|
| **Family Care Partnership** | | | | |
| *i*Care | 30 | 30 | 100.0% | Unbiased |
| MCW | 30 | 30 | 100.0% | Unbiased |
| **PACE** | | | | |
| CCI | 30 | 30 | 100.0% | Unbiased |

**Results for Pneumococcal Vaccination**

| MY 2020 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 |
| Inclusa | 30 | 30 | 100.0% | Unbiased |
| LCI | 30 | 30 | 100.0% | Unbiased |
| MCW | 30 | 30 | 100.0% | Unbiased |
| **Family Care Partnership** | | | | |
| CCI | 30 | 30 | 100.0% | Unbiased |
| *i*Care | 30 | 30 | 100.0% | Unbiased |
| MCW | 30 | 30 | 100.0% | Unbiased |
| **PACE** | | | | |
| CCI | 30 | 30 | 100.0% | Unbiased |

## Analysis

Overall, MCO vaccination data was compliant with the DHS technical definitions for both quality indicators, and the MCO denominator files for members eligible for the vaccinations matched the DHS denominator file at a rate higher than 95 percent.

Pneumococcal vaccination rates continue to average 90 percent or higher, while influenza vaccinates rates remain below 75 percent in the FC and FCP programs. Influenza and pneumococcal vaccination rates for FC and FCP had a statistically significant decline from the prior measurement year. The changes in these rates is unlikely due to normal variation or chance and likely attributed to a cause or causes.

Declines in rates may be related to the public health emergency (PHE). In 2020, the State of Wisconsin was impacted by the coronavirus pandemic, a global pandemic caused by the Coronavirus Disease 2019 (COVID-19). COVID-19 caused an outbreak of respiratory illnesses, putting many individuals at risk, especially older adults and people who have chronic medical conditions. In an effort to curb the spread of the virus, face-to-face interactions were limited, including interactions between members and MCO staff. The PHE also had an impact on the workforce, creating numerous barriers and higher levels of staff turnover.

MetaStar recommends the following:

- Conduct a root cause analysis for the vaccination rates that declined from MY 2020. Identifying the root cause or causes will allow the state to focus improvement efforts on the cause of the decline.
- Continue efforts to increase influenza vaccination rates by educating FC and FCP members on the benefits of the vaccination.

## CONCLUSIONS

A summary of strengths, progress, and recommendations is noted in the *Executive Summary* and *Introduction and Overview* sections above.

# PROTOCOL 3: COMPLIANCE WITH STANDARDS – QUALITY COMPLIANCE REVIEW

Compliance with Standards - Quality Compliance Review (QCR) is a mandatory review activity identified in the Code of Federal Regulations (CFR) 42 CFR 438.358 and conducted according to federal protocol standards, *CMS External Quality Review (EQR) Protocols, Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations*. The review assesses the strengths and weaknesses of the MCO related to quality, timeliness, and access to services, including health care and LTSS.

DHS has expanded the compliance review beyond the requirements specified in 42 CFR 438, and includes other state statutory, regulatory, and contractual requirements related to the following areas:

- Availability and use of HCBS as alternatives to institutional care, so individuals can receive the services they need in the most appropriate integrated setting;
- Credentialing or other selection processes for LTSS providers, including those required where the enrollee can choose their caregiver (such as verification of completion of caregiver background checks); and
- Person-centered assessment, person-centered care planning, service planning and authorization, service coordination, and care management for LTSS. This includes authorization/utilization management for LTSS and any beneficiary rights or protections related to care planning and service planning such as conflict-free case management, self-direction of services, and appeal rights related to person-centered planning.

The QCR was revised at the start of FY 20-21 to align with the Centers for Medicare & Medicaid Services External Quality Review Protocol, which defines the review activities for Medicaid Managed Care Programs. The revision to the review changed the scoring process, making the numeric scores from prior review not comparable to the current review.

The review is divided into three groups of standards:

Managed Care Organization (MCO) Standards which include provider network, care management, and enrollee rights:

- Enrollee rights and protections 42 CFR 438.100
- Availability of services 42 CFR 438.206
- Assurances of adequate capacity and services 42 CFR 438.207
- Coordination and continuity of care 42 CFR 438.208
- Coverage and authorization of services 42 CFR 438.210
- Provider selection 42 CFR 438.214
- Confidentiality 42 CFR 438.224

- Subcontractual relationships and delegation 42 CFR 438.230
- Practice guidelines 42 CFR 438.236
- Health information systems 42 CFR 438.242

Quality Assessment and Performance Improvement (QAPI):

- Quality assessment and performance improvement program 42 CFR 438.330

Grievance Systems:

- Grievance and appeal systems 42 CFR 438.228

Standards are reviewed in a two-year cycle for each MCO. The first year of the cycle includes the MCO Standards, followed by QAPI and Grievance Standards in the second year. This fiscal year is the second year of the cycle; therefore, QAPI and Grievance Systems Standards were reviewed. The combined compliance score of all standards is presented in the *Overall Results* section of this report.

## Overall QCR Results by MCO

Compliance is expressed in terms of a percentage score and star rating that correlates with the *DHS Score Card*, identified in the table below. See Appendix 2 for more information about the scoring methodology.

| Scoring Legend | | |
|---|---|---|
| **Percentage Met** | **Stars** | **Rating** |
| 90.0% - 100.0% = 5 Stars | ★★★★★ | EXCELLENT |
| 80.0% - 89.9% = 4 Stars | ★★★★ | VERY GOOD |
| 70.0% - 79.9% = 3 Stars | ★★★ | GOOD |
| 60.0% - 69.9% = 2 Stars | ★★ | FAIR |
| < 60.0% = 1 Star | ★ | POOR |

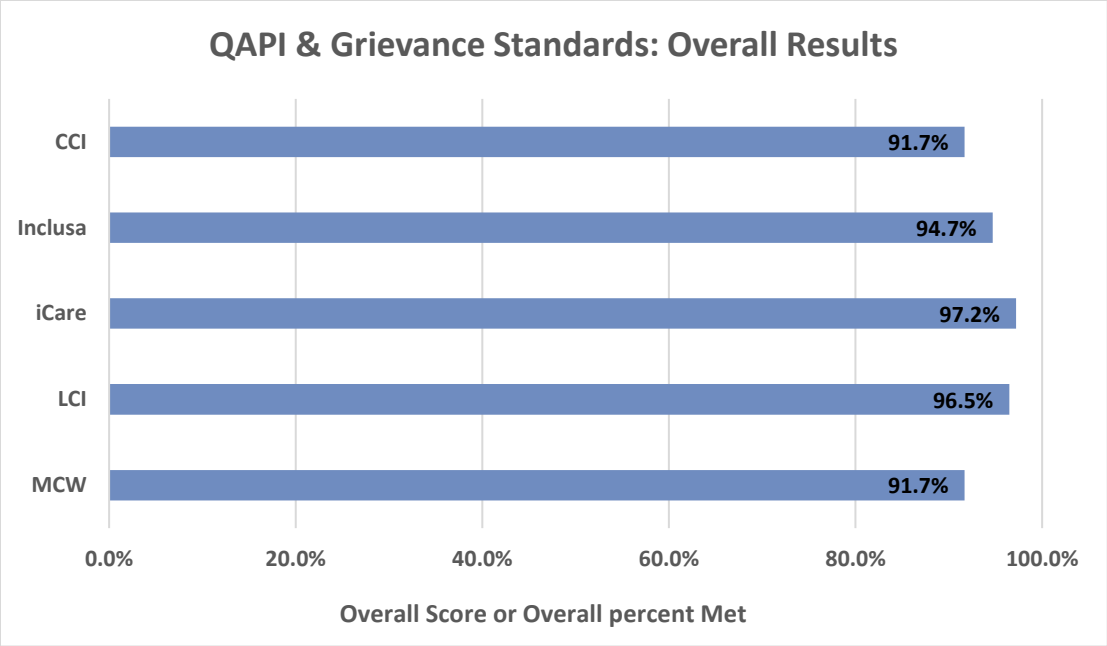
For all MCOs, the statewide overall compliance score is 94.3 percent, and a star rating of Excellent. The score is based on the review of the MCO Standards in FY 20-21 and the QAPI and Grievances Systems standards in FY 21-22. The table below indicates the State's overall level of compliance with all standards.

| MCO Standards: Provider Network, Care Management, and Enrollee Rights Reviewed in FY 20-21 | | | | |
|---|---|---|---|---|
| **Standard** | **Scoring Elements** | **Percentage** | **Stars** | **Rating** |
| **M1** | 34/34 | 100.0% | ★★★★★ | EXCELLENT |
| **M2** | 35/35 | 100.0% | ★★★★★ | EXCELLENT |
| **M3** | 20/20 | 100.0% | ★★★★★ | EXCELLENT |
| **M4** | 28/30 | 93.3% | ★★★★★ | EXCELLENT |
| **M5** | 58/60 | 96.7% | ★★★★★ | EXCELLENT |
| **M6** | 42/50 | 84.0% | ★★★★ | VERY GOOD |
| **M7** | 20/20 | 100.0% | ★★★★★ | EXCELLENT |

| MCO Standards: Provider Network, Care Management, and Enrollee Rights Reviewed in FY 20-21 | | | | |
|---|---|---|---|---|
| **Standard** | **Scoring Elements** | **Percentage** | **Stars** | **Rating** |
| **M8** | 50/50 | 100.0% | ★★★★★ | EXCELLENT |
| **M9** | 58/60 | 96.7% | ★★★★★ | EXCELLENT |
| **M10** | 18/20 | 90.0% | ★★★★★ | EXCELLENT |
| **M11** | 50/55 | 90.9% | ★★★★★ | EXCELLENT |
| **M12** | 10/10 | 100.0% | ★★★★★ | EXCELLENT |
| **M13** | 60/65 | 92.3% | ★★★★★ | EXCELLENT |
| **M14** | 39/40 | 97.5% | ★★★★★ | EXCELLENT |
| **M15** | 18/20 | 90.0% | ★★★★★ | EXCELLENT |
| **M16*** | N/A | N/A | N/A | N/A |
| **Quality Assessment and Performance Improvement Standards Reviewed in FY 21-22** | | | | |
| **Standard** | **Scoring Elements** | **Percentage** | **Stars** | **Rating** |
| **Q1** | 40/40 | 100.0% | ★★★★★ | EXCELLENT |
| **Q2** | 36/40 | 90.0% | ★★★★★ | EXCELLENT |
| **Q3*** | N/A | N/A | N/A | N/A |
| **Q4*** | N/A | N/A | N/A | N/A |
| **Q5** | 10/10 | 100.0% | ★★★★★ | EXCELLENT |
| **Grievance Systems Standards Reviewed in FY 21-22** | | | | |
| **Standard** | **Scoring Elements** | **Percentage** | **Stars** | **Rating** |
| **G1** | 19/20 | 95.0% | ★★★★★ | EXCELLENT |
| **G2** | 34/35 | 97.1% | ★★★★★ | EXCELLENT |
| **G3** | 15/20 | 75.0% | ★★★ | GOOD |
| **G4** | 43/45 | 95.6% | ★★★★★ | EXCELLENT |
| **G5** | 32/35 | 91.4%% | ★★★★★ | EXCELLENT |
| **G6** | 18/20 | 90.0% | ★★★★★ | EXCELLENT |
| **G7** | 9/10 | 90.0% | ★★★★★ | EXCELLENT |
| **G8** | 5/5 | 100.0% | ★★★★★ | EXCELLENT |
| **G9** | 18/20 | 90.0% | ★★★★★ | EXCELLENT |
| **G10** | 13/13 | 100.0% | ★★★★★ | EXCELLENT |
| **Overall** | **832/882** | **94.3%** | **★★★★★** | **EXCELLENT** |

* M16, Q3, and Q4 are evaluated through reviews that occur separate from the QCR.

The graph on the next page illustrates the State's overall compliance with these standards.




The definition of a scoring element rated as compliant can be found in Appendix 2, which includes the full implementation of written policies and procedures, education of relevant staff, and sufficient monitoring. MetaStar uses a retrospective review period of 12 months prior to each MCO's QCR to evaluate compliance. When documents were finalized and/or education occurred after the review period, the policies or procedures were considered not fully implemented, or not implemented at the time of the review. See Appendix 2 for more information about the scoring methodology.

## Results for QCR Focus Area-MCO Standards

Each section that follows provides a brief explanation of a QCR focus area, including rationale for any areas the MCOs were not fully compliant. Additionally, Appendix 4 includes results for each standard by MCO.

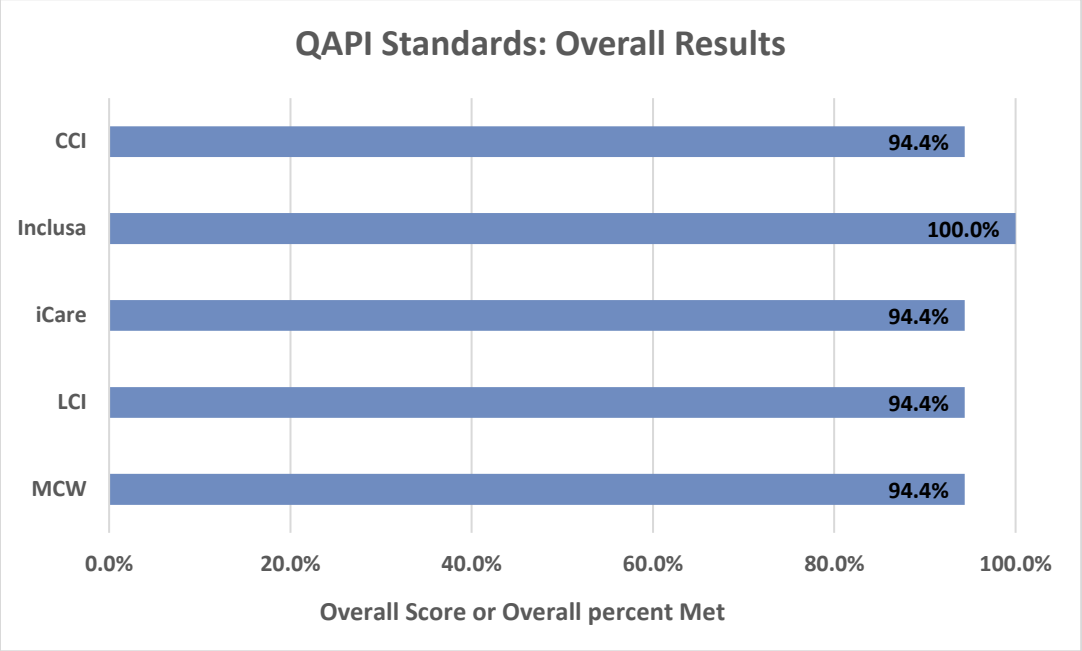
### Observation and Analysis: QAPI Standards

MCOs are required to have a quality management program that documents and monitors required activities, with the purpose of improving the access, timeliness, and quality of supports. Five standards address the requirements related to the Quality Management program. Two standards, Q3 and Q4, are evaluated as part of the MCO's performance measure validation and performance improvement project validation, which occur separate from the QCR. The table on the next page indicates the MCOs' compliance with these standards.

| Quality Assessment and Performance Improvement Standards | | | | |
|---|---|---|---|---|
| **Standard** | **Scoring Elements** | **Percentage** | **Stars** | **Rating** |
| **Q1** | 40/40 | 100.0% | ★★★★★ | EXCELLENT |
| **Q2** | 36/40 | 90.0% | ★★★★★ | EXCELLENT |
| **Q3*** | N/A | N/A | N/A | NA |
| **Q4*** | N/A | N/A | N/A | NA |
| **Q5** | 10/10 | 100.0% | ★★★★★ | EXCELLENT |
| **Overall** | **86/90** | **95.6%** | **★★★★★** | **EXCELLENT** |

*Q3 and Q4 are evaluated as part of the organization's performance measure validation and performance improvement project validation. These reviews occur separate from the QCR.

The graph below illustrates the MCO's overall compliance with this focus area.




### *Q1 General rules - 42 CFR 438.330(a)*

MCO's quality managements programs shall be administered through clear and appropriate structures and include member, staff, and provider participation. The standard, Q1, contains eight scoring elements for each MCO reviewed. The MCOs satisfied requirements for 40 out of 40 scoring elements, for a score of 100.0 percent, and a star rating of Excellent.

All MCOs have quality management programs with sound structures that facilitate participation from members, staff, and providers. Practices were evidenced through meeting minutes and interview sessions with MCO staff. All MCOs discussed outreach efforts to increase member and provider participation in the quality management program.

### *Q2 Basic elements of the quality assessment and performance improvement program - 42 CFR 438.330(b)*

MCOs shall maintain documentation and monitoring of the required activities of the Quality Management program. The standard, Q2, contains eight scoring elements for each MCO reviewed. The MCOs satisfied requirements for 36 out of 40 scoring elements, for a score of 90.0 percent, and a star rating of Excellent.

Documents submitted and the interview sessions with MCO staff, confirmed processes for maintaining documentation and monitoring of quality management program activities. Requirements for the documentation of the quality management activities, findings, and results include:

- Annual review and evaluation of the quality management work plan and its approval by the governing board;
- Monitoring the completeness and quality of functional screens;
- Monitoring the member's long-term care and personal experience outcomes;
- Member satisfaction surveys;
- Provider surveys;
- Incident management systems;
- Appeals and grievances that were resolved as requested by the member;
- Monitoring the quality and standards of sub-contracted services, including access to providers and verification that services were provided;
- Monitoring of restrictive measures through policies and procedures;
- Performance improvement projects;
- Monitoring of care management practices, such as the quality of assessments, member-centered plans and practices related to the support of vulnerable high-risk members; and
- Monitoring to detect under and over utilization of services.

Scoring element Q2.2 requires the MCOs to monitor whether members are afforded choice among covered services and providers. All MCOs could speak to how this requirement could be monitored through various mechanisms already in place; however, four of five MCOs did not demonstrate specific monitoring to assure members are afforded choice among covered services and providers. MetaStar recommends the MCOs implement monitoring for this requirement.

### *Q3 Performance measurement - 42 CFR 438.330(c)*

These requirements are evaluated through the Performance Measure Validation (PMV) activity, which is conducted on a different cycle than the QCR.

### *Q4 Performance improvement projects - 42 CFR 438.330(d)*

These requirements are evaluated through the Performance Improvement Project (PIP) activity, which is conducted on a different cycle than the QCR.

### *Q5 QAPI evaluations review - 42 CFR 438.330(e)(2)*

Each MCO must create and evaluate the quality work plan annually. The standard, Q5, contains two scoring elements for each MCO reviewed. The MCOs satisfied requirements for 10 out of 10 scoring elements, for a score of 100.0 percent, and a star rating of Excellent.

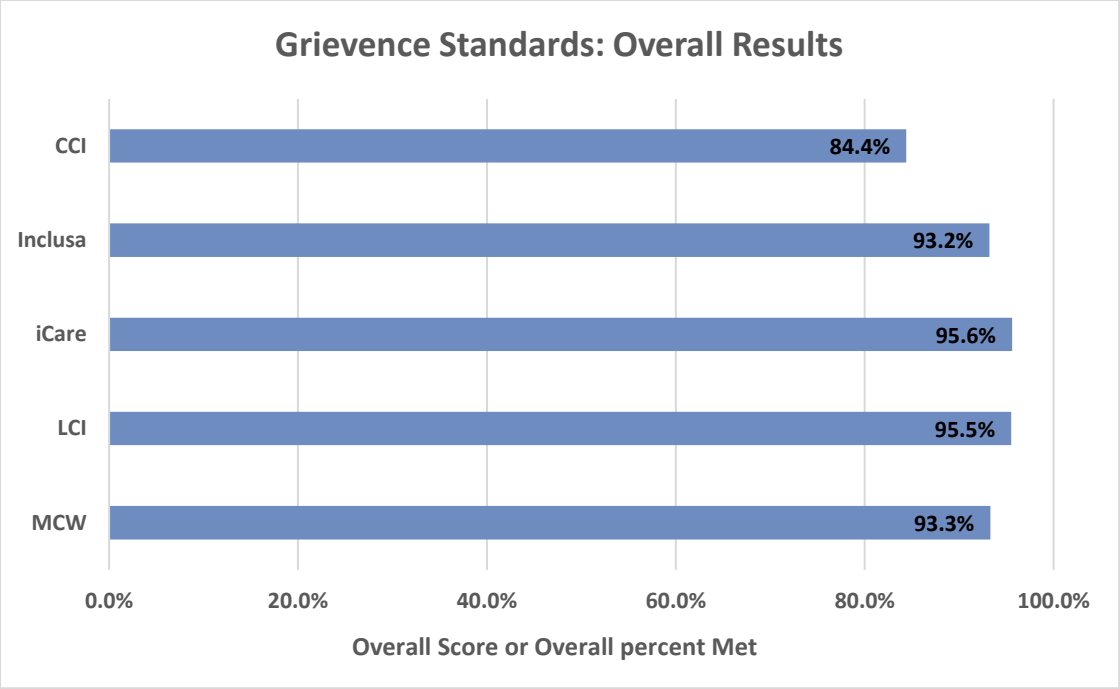
All MCOs' quality management plans and evaluations met requirements of this standard. Documents submitted confirmed the MCOs have a systematic, collaborative approach for the creation and evaluation of the quality management plan. Creating the quality management plans for the coming year was determined by a variety of factors including an analysis of goals, objectives, and outcomes. The organizations also considered factors such as program membership, member risk, and the impact of the COVID-19 pandemic. Evidence of teamwork within each organization was demonstrated through committee meeting minutes and confirmed with the interview sessions.

## Observation and Analysis: Grievance Systems

MCOs are required to maintain a grievance system that provides members the ability to grieve or appeal actions of the organization and provides access to the State's Fair Hearing system. Ten standards address the requirements related to the required grievance systems. The table below indicates the MCOs' compliance with these standards.

| Grievance Systems Standards | | | | |
|---|---|---|---|---|
| **Standard** | **Scoring Elements** | **Percentage** | **Stars** | **Rating** |
| **G1** | 19/20 | 95.0% | ★★★★★ | EXCELLENT |
| **G2** | 34/35 | 97.1% | ★★★★★ | EXCELLENT |
| **G3** | 15/20 | 75.0% | ★★★ | GOOD |
| **G4** | 43/45 | 95.6% | ★★★★★ | EXCELLENT |
| **G5** | 32/35 | 91.4% | ★★★★★ | EXCELLENT |
| **G6** | 18/20 | 90.0% | ★★★★★ | EXCELLENT |
| **G7** | 9/10 | 90.0% | ★★★★★ | EXCELLENT |
| **G8** | 5/5 | 100.0% | ★★★★★ | EXCELLENT |
| **G9** | 18/20 | 90.0% | ★★★★★ | EXCELLENT |
| **G10** | 13/13 | 100.0% | ★★★★★ | EXCELLENT |
| **Overall** | **206/223** | **92.4%** | **★★★★★** | **EXCELLENT** |

The graph on the next page illustrates the MCO's overall compliance with this focus area.




***G1 Grievance systems - 42 CFR 438.228***

MCOs 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. The standard, G1, contains four scoring elements for each MCO reviewed. The MCOs satisfied requirements for 19 out of 20 scoring elements, for a score of 95.0 percent, and a star rating of Excellent.

Document review evidenced systems in place. Interview sessions with MCO staff confirmed compliance with this standard.

***G2 General requirements - 42 CFR 438.402***

MCOs must adhere to requirements for the member's authority, process, and timing to file grievances and appeals. The standard, G2, contains seven scoring elements for each MCO reviewed. The MCOs satisfied requirements for 34 out of 35 scoring elements, for a score of 97.1 percent, and a star rating of Excellent.

Document review and interviews with MCO staff confirmed the use of policies to ensure the appropriate individual has authority to file a grievance or appeal, and for all processes and timeframes to be adhered to. Scoring elements related to filing were validated through a verification activity conducted by MetaStar for each MCO. The verification activity included a random sample of the MCO's local appeals and grievances.

### *G3 Timely and adequate notice of adverse benefit determination - 42 CFR 438.404*

MCOs must comply with content requirements and timing of *Notices of Adverse Benefit Determination*. The standard, G3, contains four scoring elements for each MCO reviewed. The MCOs satisfied requirements for 15 out of 20 scoring elements, for a score of 75.0 percent, and a star rating of Good.

The DHS-MCO contract outlines specific requirements for the content and timing of issuing *Notice of Adverse Benefit Determinations* to members. MetaStar confirmed the use of the most current templates of these notices. The verification activity confirmed members received written notification of appeal rights when appropriate. Trainings and monthly care management team meetings had a regular focus on providing reminders and education for issuing notices timely when indicated.

Scoring element G3.3 requires the MCOs to mail or hand deliver the *Notice of Adverse Benefit Determination* letter as expeditiously as the member's condition requires and within the required timeframes. Results from MetaStar's Care Management Review (CMR) and the MCOs' internal monitoring data are used in the evaluation of this scoring element. Four of five MCOs indicated a need for improvement. MetaStar recommends the MCO focus efforts on improving the timeliness of issuing a *Notice of Adverse Benefit Determination*, specifically the recognition of when notices are indicated.

### *G4 Handling of grievances and appeals - 42 CFR 438.406*

MCOs must comply with requirements for handling of grievances and appeals, including acknowledgement, local committee composition and requirements, and special requirements for appeals. The standard, G4, contains nine scoring elements for each MCO reviewed. The MCOs satisfied requirements for 43 out of 45 scoring elements, for a score of 95.6 percent, and a star rating of Excellent.

Document review and interviews with MCO staff confirmed that each MCO has a member rights specialist (MRS) who collaborates with interdisciplinary team (IDT) staff to support members as needed for grievances and appeals. Several scoring elements related to these requirements were validated through the verification activity conducted by MetaStar.

Scoring element G4.2 asserts the MCO should attempt to resolve issues and concerns without formal hearings or whenever possible. When a member presents an appeal or grievance, the MCO must attempt to resolve the issue or concern through internal review, negotiation, or mediation, if possible. Two of five MCOs did not have adequate documentation to evidence attempts to resolve the member's issue or concern informally, when possible. MetaStar recommends these MCOs implement a systemic process for tracking the informal resolution attempts.

### *G5 Resolution and notification - 42 CFR 438.408*

MCOs must comply with requirements for the resolution and notification requirements for grievances and appeals. The standard, G5, contains seven scoring elements for each MCO reviewed. The MCOs satisfied requirements for 32 out of 35 scoring elements, for a score of 91.4 percent, and a star rating of Excellent.

Document review and interviews with MCO staff confirmed compliance with this standard. Several scoring elements related to resolution and notification requirements were validated through the verification activity conducted by MetaStar. The MCOs demonstrated sufficient practices related to the standard timeframes for resolution and notification for grievances and appeals.

Scoring element G5.1 indicates that the MCO's grievance and appeal committee must issue a written decision on member grievances. The grievance verification for one MCO found the MCO's grievance resolution letter did not include the grievance and appeal committee's decision, or indicate that the local committee reviewed any member grievances. MetaStar recommends the MCO ensure that all member grievances that are not informally resolved to the member's satisfaction are heard by the MCO's grievance and appeal committee before the grievance can be referred for a DHS level review.

Scoring element G5.4 requires the MCOs to provide written notice of reason for the extension within two calendar days, if the MCO extends the timeframe. The results of the verification activity demonstrated that two of five MCOs did not track the date the extension was initiated by the MCO; therefore, MetaStar was unable to validate if a written notice of extension was sent within two calendar days to ensure compliance with this requirement. MetaStar recommends these MCOs develop and implement a system to document when a decision to extend the issuance of a notice is made by the organization to ensure requirements are met.

### *G6 Expedited resolution of appeals - 42 CFR 438.410*

MCOs must comply with requirements for an expedited review process for appeals. The standard, G6, contains four scoring elements for each MCO reviewed. The MCOs satisfied requirements for 18 out of 20 scoring elements, for a score of 90.0 percent, and a star rating of Excellent.

Document submission and interviews with MCO staff confirmed compliance with this standard for most MCOs. Staff interviews described the practice of giving oral notice for all appeals, standard and expedited, including notifying the member in writing within 72 hours.

### *G7 Information about grievance and appeal system to providers and subcontractors - 42 CFR 438.414*

MCOs must provide information about the grievance and appeal system to providers and subcontractors. The standard, G7, contains two scoring elements for each MCO reviewed. The MCOs satisfied requirements for nine out of 10 scoring elements, for a score of 90.0 percent, and a star rating of Excellent.

Most MCOs evidenced subcontracts or provider handbooks that included the required information. The information is given to providers at the time they enter into the subcontract.

### *G8 Record keeping requirements - 42 CFR 438.416*

MCOs must comply with record keeping requirements for grievances and appeals. The standard, G8, contains one scoring element for each MCO reviewed. The MCOs satisfied requirements for five out of five scoring elements, for a score of 100.0 percent, and a star rating of Excellent.

All MCOs submitted policies that included all of the record keeping requirements for grievances and appeals. Interviews with MCO staff indicated the MRS utilizes the logs and other tracking tools to ensure record keeping adheres to requirements.

### *G9 Continuation of benefits while the local appeal and the State Fair Hearing are pending - 42 CFR 438.420*

MCOs must comply with requirements for continuation of benefits, duration, and member responsibility for costs. The standard, G9, contains four scoring elements for each MCO reviewed. The MCOs satisfied requirements for 18 out of 20 scoring elements, for a score of 90.0 percent, and a star rating of Excellent.

Document submission and interviews with MCO staff confirmed compliance with this standard for most MCOs. All MCOs allow members to continue services through the local MCO appeal and the State's Fair Hearing process when the applicable criteria are met.

### *G10 Effectuation of reversed appeal resolution - 42 CFR 438.424*

MCOs must comply with requirements to reinstate benefits for reversed denials. The standard, G10, contains two scoring elements for each FC MCO and three scoring elements for each FCP and PACE MCO reviewed. The MCOs satisfied requirements for 13 out of 13 scoring elements, for a score of 100.0 percent, and a star rating of Excellent.

Document submission and interviews with MCO staff confirmed compliance with this standard for all MCOs.

## CONCLUSIONS

A summary of strengths, progress, and recommendations is noted in the *Executive Summary* and *Introduction and Overview* sections above.

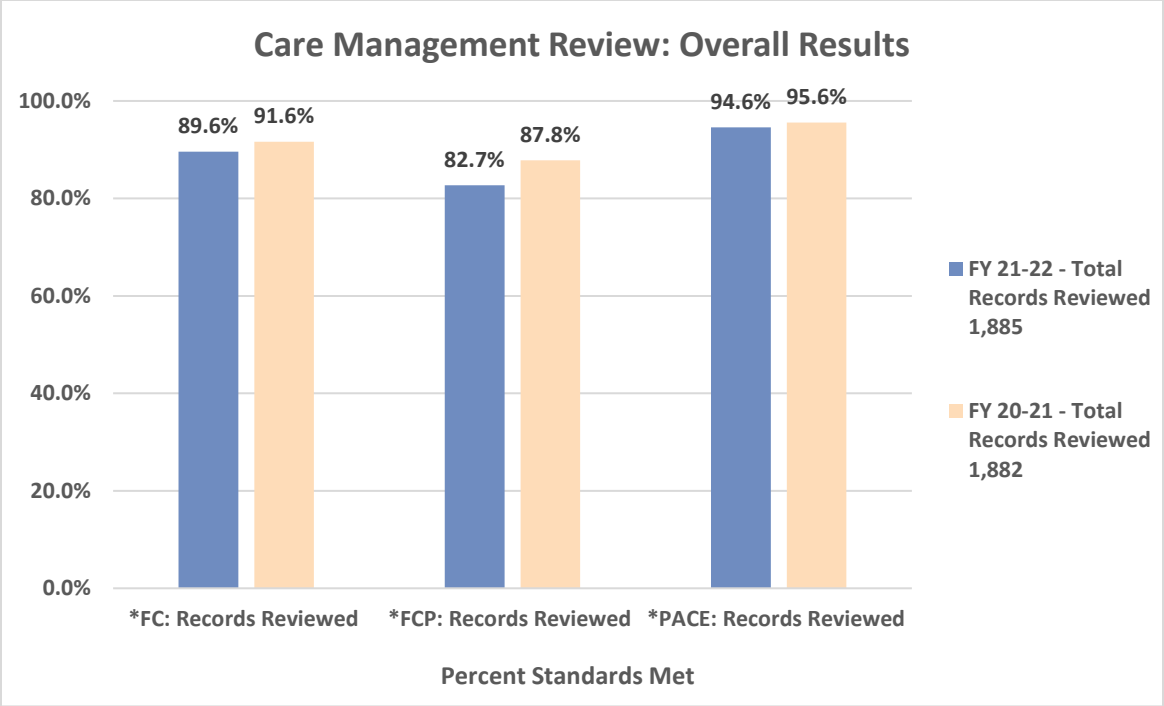
# Protocol 9: Conducting Focused Studies of Health Care Quality - Care Management Review

Care management review (CMR) is an optional activity, *CMS External Quality Review (EQR) Protocols, Protocol 9: Conducting Focus Studies of Health Care Quality*, which determines a MCO's level of compliance with the DHS-MCO contract. The information gathered during CMR helps assess the access, timeliness, quality, and appropriateness of care a MCO provides to its members. CMR activities and findings are part of DHS' overall strategy for providing quality assurances to the Centers for Medicare & Medicaid Services regarding the 1915(c) Home and Community Based Services Waivers, which allow the State of Wisconsin to operate its Family Care programs.

The CMR was conducted using a review tool and reviewer guidelines developed by MetaStar and approved by DHS. In 2020, the State of Wisconsin was impacted by the coronavirus pandemic, a global pandemic caused by the coronavirus (COVID-19). COVID-19 caused an outbreak of respiratory illnesses, putting many individuals at risk, especially older adults and people who have chronic medical conditions. In an effort to curb the spread of the virus, face-to-face interactions were limited, including interactions between members and MCO staff. DHS implemented a number of flexibilities to the DHS-MCO contract requirements in response to the pandemic. These flexibilities were incorporated into CMR reviewer guidance, effective March 1, 2020 – May 31, 2021 and January 1, 2022 – February 28, 2022. More information about the CMR review methodology can be found in Appendix 2.

## Overall Results by Program

The following bar graph below represents the overall percent of CMR standards met by MCOs in FY 21-22 for all 11 review indicators. Analysis indicated the year-to-year difference in the overall rates for FC and FCP is unlikely to be the result of normal variation or chance. The year-to-year difference in the overall PACE results is likely attributed to normal variation or chance.




*FC Records Reviewed: FY 21-22 1,051 and FY 20-21 1,060
*FCP Records Reviewed: FY 21-22 625 and FY 20-21 647
*PACE Records Reviewed: FY 21-22 182 and FY 20-21 175

In addition to the organizational level CMR results described below in the *Results for each CMR Focus Area* section, the MCO was provided a report of each individual record review. MetaStar recommends the MCOs evaluate the results of the 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 section below provides a brief explanation of a key category of CMR, followed by a bar graph for each program (FC, FCP, and PACE) which represents the MCO's FY 21-22 results for each of the review indicators comprising the CMR category. The notes below each bar graph specify the number of applicable records when it is less than the total number reviewed.

### 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.

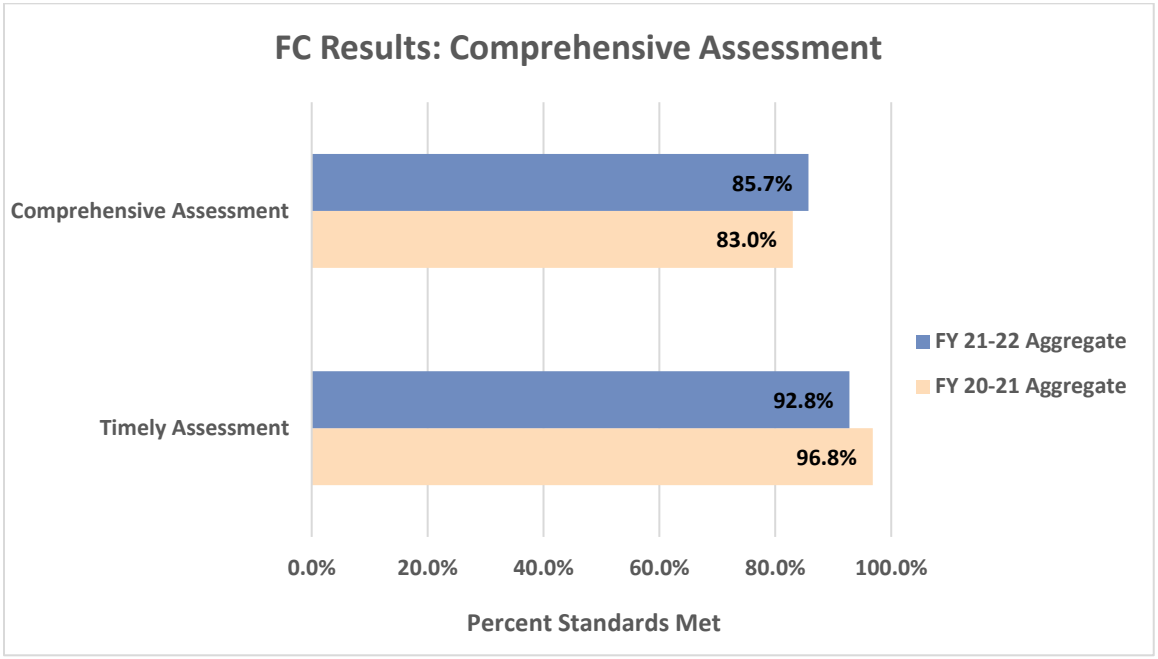
The initial assessment and subsequent reassessments must meet the timelines and other requirements described in the DHS-MCO contract.

**FC**

The indicator *Comprehensive Assessment* ensures the MCO evaluates member needs based on the DHS-MCO contract requirements. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. In all assessment elements reviewed, 99.4 percent were found to be assessed. The results on a per record basis indicated opportunities for improvement. The most common reason assessments were not comprehensive was related to a lack of a detailed description of behaviors in the assessment when members were taking behavior modifying medications.

The indicator *Timely Assessment* evaluates assessments conducted by both members of the IDT in accordance with the DHS-MCO contract requirement of every six months. Overall results for the indicator declined from the prior review, and analysis indicated the year-to-year difference in the rates is unlikely to be the result of normal variation or chance. The decline in the rate may be related to the change to the COVID-19 flexibilities for in-person assessment requirements. In-person assessments were expected for assessments when flexibilities were not in place. Lack of evidence of an in-person assessment by both IDT was the primary reason for untimely assessments.

**Results for Comprehensive Assessment for MCOs Operating FC:**

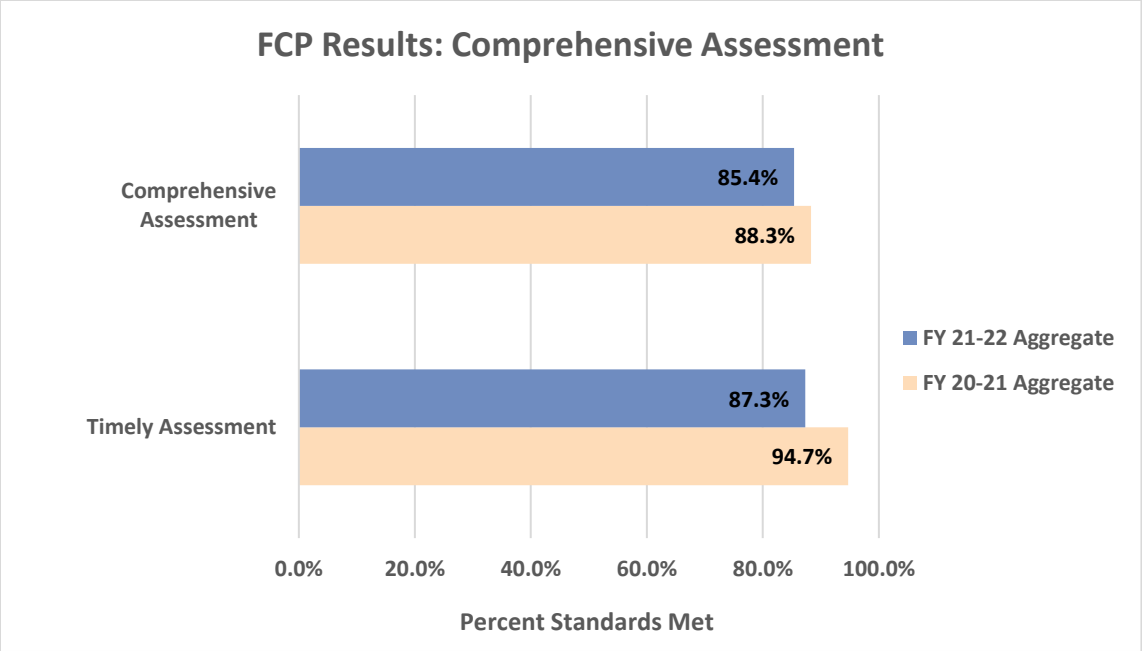



## FCP

The indicator *Comprehensive Assessment* ensures the MCO evaluates member needs based on the DHS-MCO contract requirements. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. In all assessment elements reviewed, 97.1 percent were found to be assessed. The results on a per record basis indicated opportunities for improvement. The most common reason assessments were not comprehensive was related to a lack of a detailed description of behaviors in the assessment when members were taking behavior modifying medications.

The indicator *Timely Assessment* evaluates assessments conducted by both members of the IDT in accordance with the DHS-MCO contract requirement of every six months. Overall results for the indicator declined from the prior review, and analysis indicated the year-to-year difference in the rates is unlikely to be the result of normal variation or chance. The decline in the rate may be related to the change to the COVID-19 flexibilities for in-person assessment requirements. In-person assessments were expected for assessments when flexibilities were not in place. Lack of evidence of an in-person assessment by both IDT was the primary reason for untimely assessments.

**Results for Comprehensive Assessment for MCOs Operating FCP:**

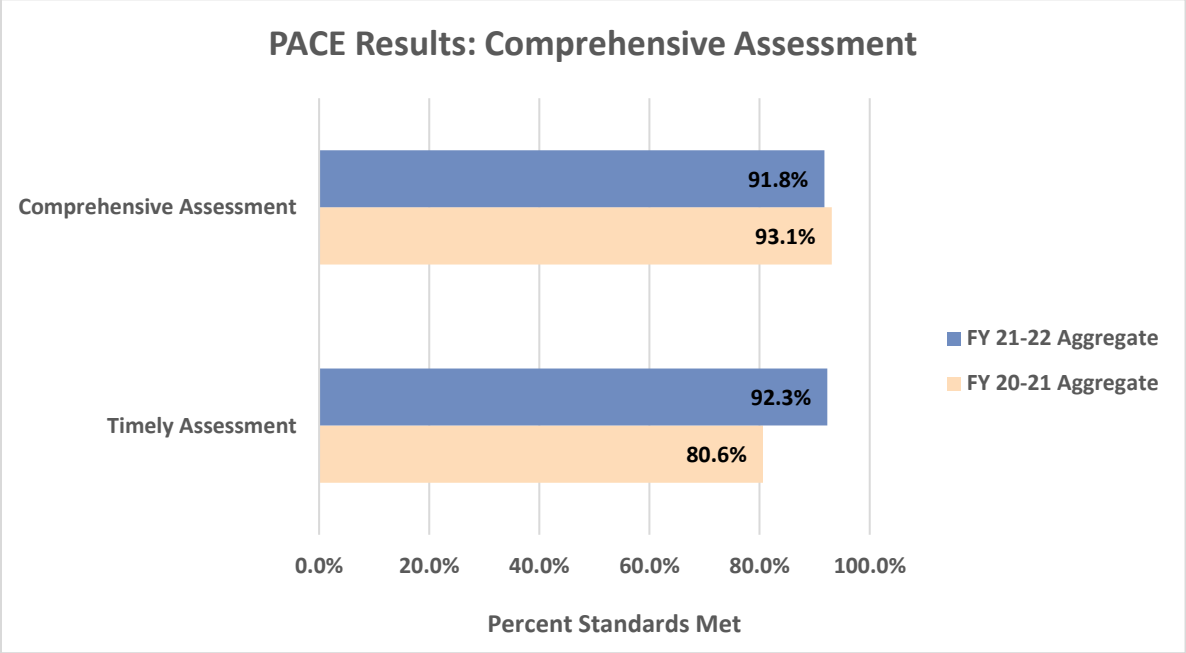



## PACE

The indicator *Comprehensive Assessment* ensures the MCO evaluates member needs based on the DHS-MCO contract requirements. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. In all assessment elements reviewed, 99.7 percent were found to be assessed. The results on a per record basis indicated strong assessment practices, with the indicator scoring above 90 percent.

The indicator *Timely Assessment* evaluates assessments conducted by both members of the IDT in accordance with the DHS-MCO contract requirement of every six months. Overall results for the indicator increased from the prior review. Analysis indicated the year-to-year difference in the rates is likely attributable to actions of the MCO, and is unlikely to be the result of normal variation or chance.

**Results for Comprehensive Assessment for the MCO Operating PACE:**




## Member Centered Planning

The Member-Centered Plan (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**

The indicator *Comprehensive MCP* ensures member MCPs include all assessed needs. In all MCP elements reviewed, 96.8 percent were found to be included on the plan. The results on a per record basis indicated opportunities for improvement. The most common reason MCPs were

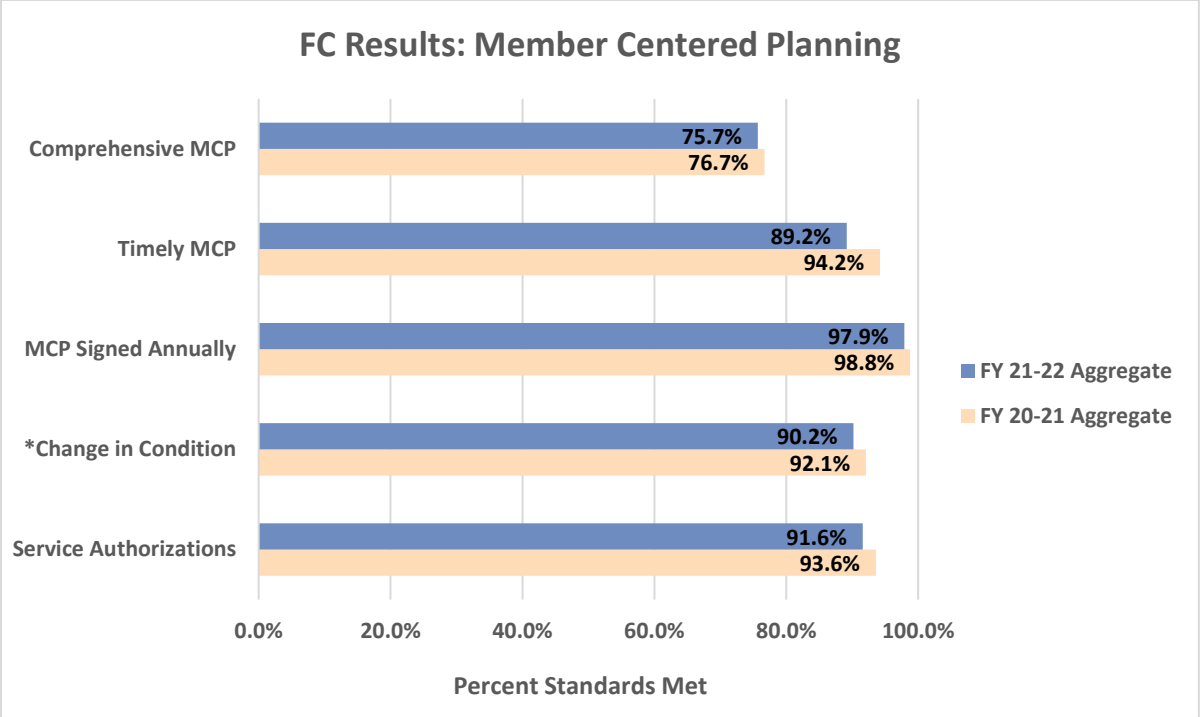
not comprehensive was related to services and supports for assessed toileting and bathing needs not being included on the MCP. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance.

The indicator *Timely MCP* evaluates MCPs being reviewed and signed in accordance with the DHS-MCO contract requirement of every six months. Overall results for the indicator declined from the prior review. Analysis indicated the year-to-year difference in the rates is unlikely to be the result of normal variation or chance. The decline may be related to the change in COVID-19 flexibilities. Signatures from the member or legal decision maker were expected when the flexibilities ended, and the majority of records unmet for this indicator were not signed within the required timeframe. MCPs were found to be signed at least once annually in 97.9 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. This indicator continues to be a strength of the FC program, scoring over 90.0 percent in the prior two reviews. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance.

The indicator *Service Authorizations* evaluates the IDTs handling of service authorizations, including appropriately responding to member requests, and issuing *Notice of Adverse Benefit Determination* letters when applicable. This indicator continues to be a strength of the FC program, scoring over 90.0 percent in the prior two reviews. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. Overall, service authorizations were handled appropriately. In several cases, *Notice of Adverse Benefit Determination* letters were indicated but not issued. This was most often related to the IDT not making a decision on a member's request, or not issuing a notice when a service was reduced, suspended, or terminated. In all records reviewed, 305 *Notice of Adverse Benefit Determination* letters were indicated, with 186 being issued timely, for an issuance rate of 61.0 percent.

**Results for Member Centered Planning for MCOs Operating FC:**




* The review indicator *Change in Condition* applied to 387 of 1,051 records in FY 21-22, and 318 of 1,060 records in FY 20-21.

## FCP

The indicator *Comprehensive MCP* ensures member MCPs include all assessed needs. In all MCP elements reviewed, 97.1 percent were found to be included on the plan. The results on a per record basis indicated opportunities for improvement, though, overall results for the indicator per record increased from the prior review. Analysis indicated the year-to-year difference in the rates is likely attributable to actions of the MCO, and is unlikely to be the result of normal variation or chance. The most common reasons MCPs were not comprehensive was the plan did not include a service for assessed toileting, bathing, or meal preparation needs.

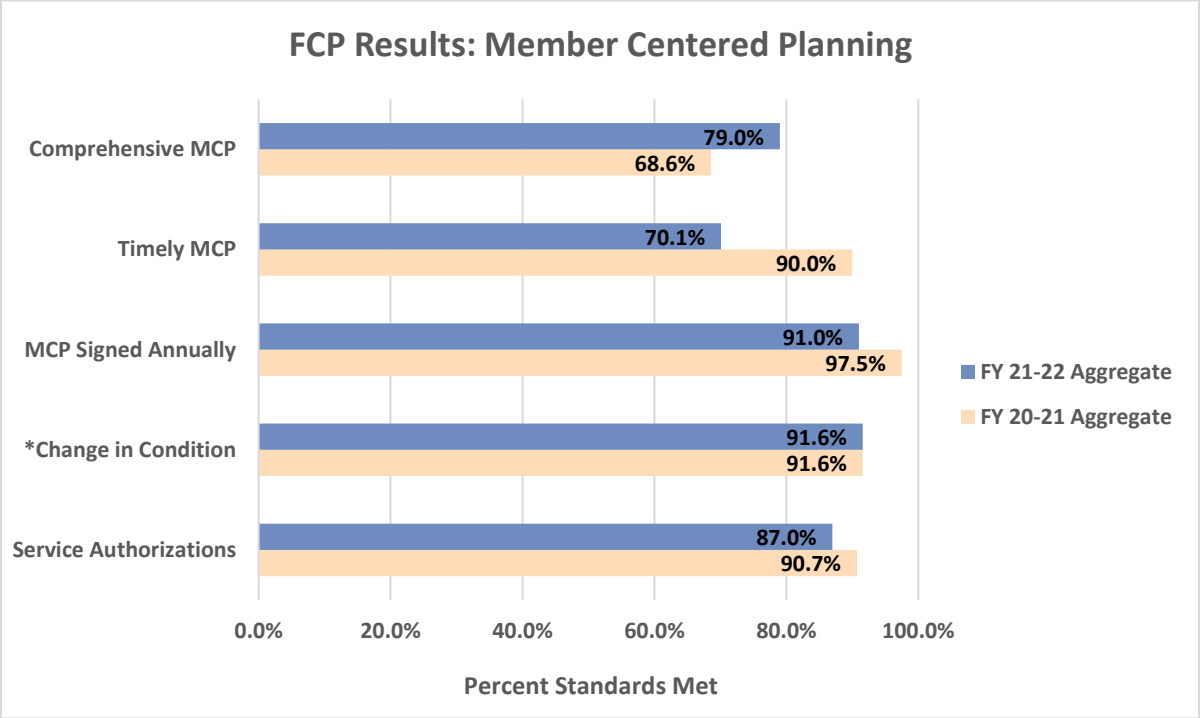
The indicator *Timely MCP* evaluates MCPs being reviewed and signed in accordance with the DHS-MCO contract requirement of every six months. Overall results for the indicator declined from the prior review and reflect a need for improvement. Analysis indicated the year-to-year difference in the rates is unlikely to be the result of normal variation or chance. The primary reason records were found unmet was related to the prior MCP not being signed by the appropriate legal decision maker. MCPs were found to be signed at least once annually in 91.0 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. This indicator continues to be a strength of the FCP program, scoring over 90.0 percent in the prior two reviews. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance.

The indicator *Service Authorizations* evaluates the IDTs handling of service authorizations, including appropriately responding to member requests, and issuing *Notice of Adverse Benefit Determination* letters when applicable. Overall results for the indicator declined from the prior review. Analysis indicated the year-to-year difference in the rates is unlikely to be the result of normal variation or chance. Overall, service authorizations were handled appropriately. In several cases, *Notice of Adverse Benefit Determination* letters were indicated but not issued, often related to the IDT not making a decision on a member's request. In all records reviewed, 238 *Notice of Adverse Benefit Determination* letters were indicated, with 124 being issued timely, for an issuance rate of 52.1 percent.

**Results for Member Centered Planning for MCOs Operating FCP:**




* The review indicator *Change in Condition* applied to 320 of 652 records in FY 21-22, and 238 of 647 records in FY 20-21.

## PACE

The indicator *Comprehensive MCP* ensures member MCPs include all assessed needs. In all MCP elements reviewed, 99.1 percent were found to be included on the plan. The results on a per record basis indicated strengths in comprehensive MCP practices, scoring above 90.0

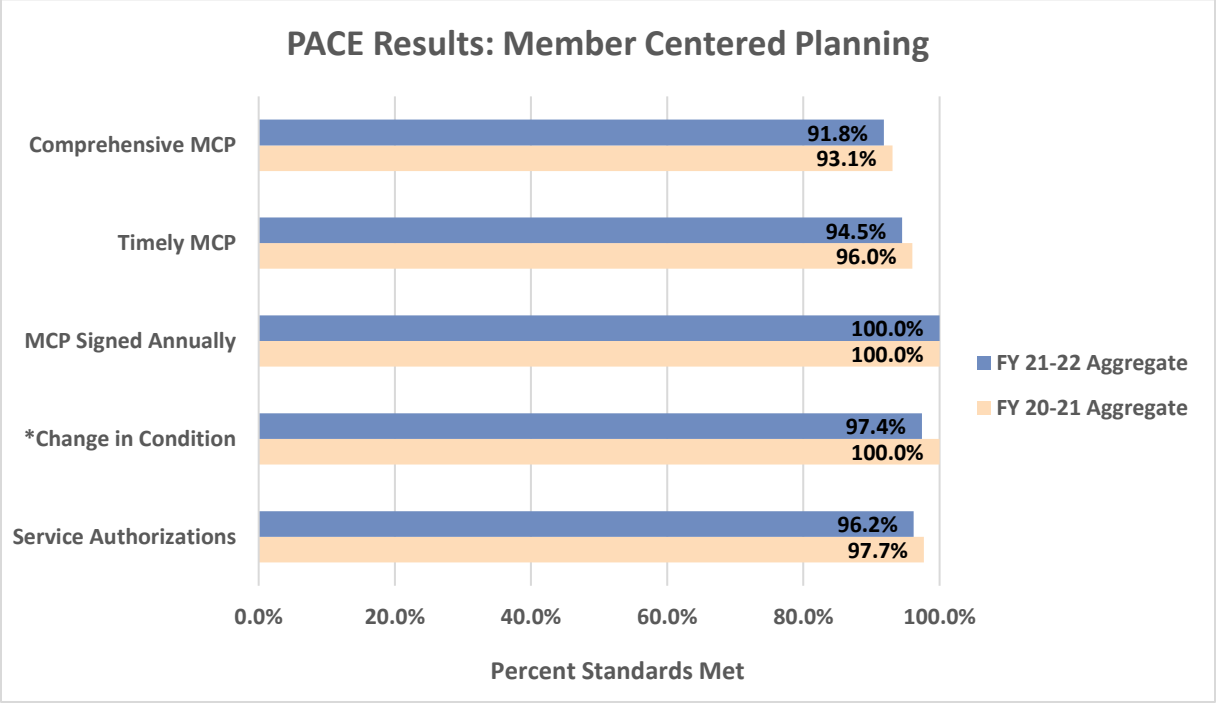
percent. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance.

The indicator *Timely MCP* evaluates MCPs being reviewed and signed in accordance with the DHS-MCO contract requirement of every six months. This area was a strength for the PACE program, scoring over 90.0 percent in the prior two reviews. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. MCPs were found to be signed at least once annually in 100.0 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. This area was a strength for the PACE program, scoring over 90.0 percent in the prior two reviews. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance.

The indicator *Service Authorizations* evaluates the IDTs handling of service authorizations, including appropriately responding to member requests, and issuing *Notice of Adverse Benefit Determination* letters when applicable. This indicator continues to be a strength of the PACE program, scoring over 90.0 percent in the prior two review. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. Overall, service authorizations were handled appropriately. In several cases, *Notice of Adverse Benefit Determination* letters were indicated but not issued, often related to the IDT not making a decision on a member's request. In all records reviewed, 31 *Notice of Adverse Benefit Determination* letters were indicated, with 24 being issued timely, for an issuance rate of 77.4 percent.

**Results for Member Centered Planning for the MCO Operating PACE:**




* The review indicator *Change in Condition* applied to 77 of 182 records in FY 21-22, and 76 of 175 records in FY 20-21.

## 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 a timely manner. This indicator continues to be a strength for the FC program, scoring over 90.0 percent in the prior two reviews. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance.

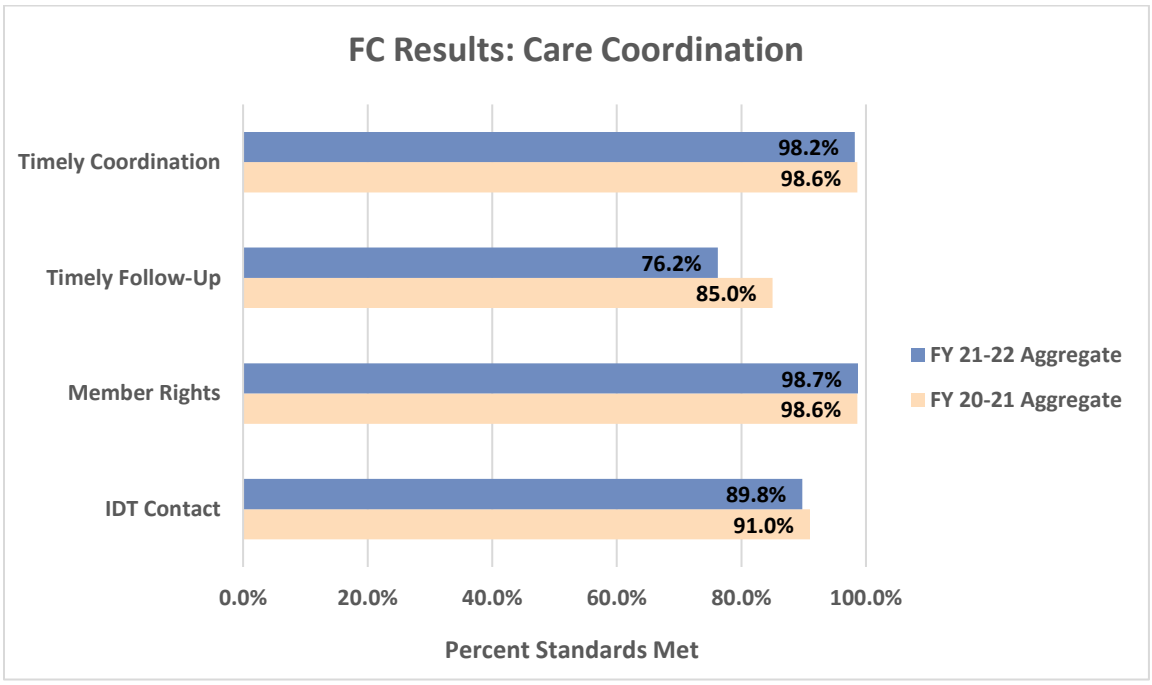
The indicator *Timely Follow-Up* evaluates whether the IDT followed up with members to confirm services and supports were received and effective. Overall results for the indicator

declined from the prior review and reflect a need for improvement. Analysis indicated the year-to-year difference in the rates is unlikely to be the result of normal variation or chance. The majority of records found unmet did not include any evidence of follow-up to a member's service or support. Lack of follow-up was most often related to medical appointments.

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. Upholding member rights continues to be strength for the FC program, scoring above 90.0 percent in the prior two reviews. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance.

The evaluation of IDT contact requirements under the indicator *IDT Contact* included monthly collateral contacts, face-to-face contact every three months with the member, and an annual home visit with the member by the care manager and registered nurse care manager. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. Missed monthly collateral contacts was the most common reason for this indicator being unmet, followed by a lack of an in-person visit with the member every three months.

**Results for Coordination for MCOs Operating FC:**



**FCP**

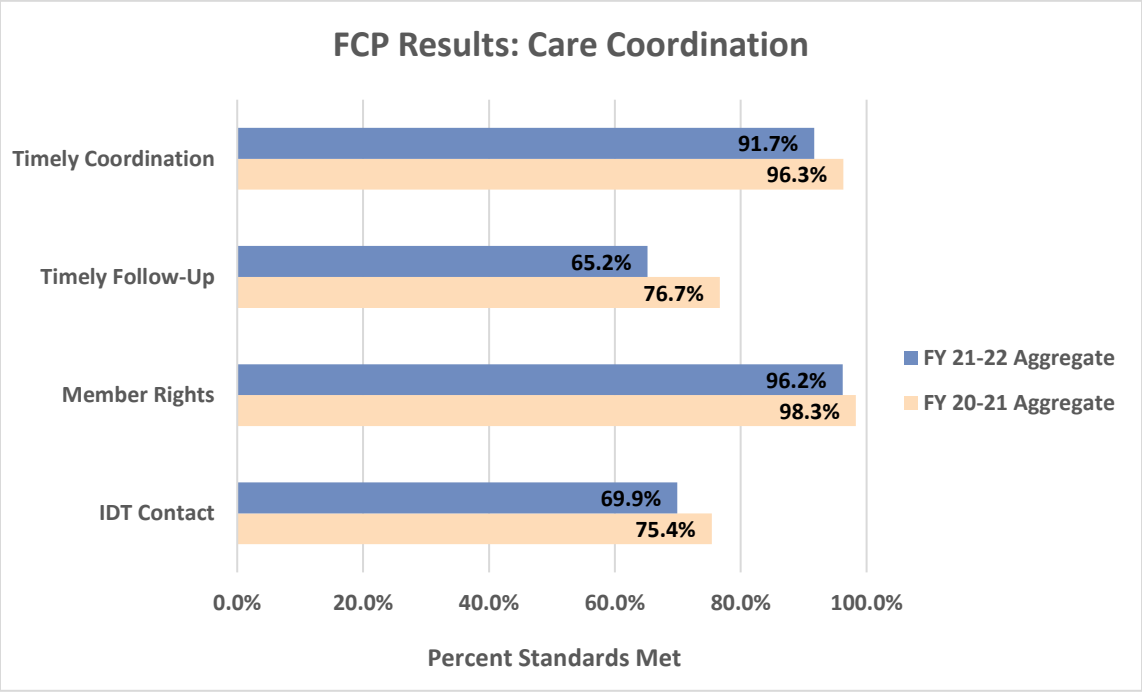
The *Timely Coordination* indicator evaluates plans put in place by the IDT to ensure member needs and supports are coordinated effectively and in a timely manner. Although this area continued to be strength for the FCP program, overall results for the indicator declined from the prior review. Analysis indicated the year-to-year difference in the rates is unlikely to be the result of normal variation or chance.

The indicator *Timely Follow-Up* evaluates whether the IDT followed up with members to confirm services and supports were received and effective. Overall results for the indicator declined from the prior review and reflect a need for improvement. Analysis indicated the year-to-year difference in the rates is unlikely to be the result of normal variation or chance. The majority of records found unmet did not include any evidence of follow-up to a member's service or support. Lack of follow-up was most often related to medical appointments.

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. Although this area continued to be strength for the FCP program, overall results for the indicator declined from the prior review. Analysis indicated the year-to-year difference in the rates is unlikely to be the result of normal variation or chance.

The evaluation of IDT contact requirements under the indicator *IDT Contact* included monthly collateral contacts, face-to-face contact every three months with the member, and an annual home visit with the member by the care manager and registered nurse care manager. Overall results for the indicator declined from the prior review and reflect a need for improvement. Analysis indicated the year-to-year difference in the rates is unlikely to be the result of normal variation or chance. Missed monthly collateral contacts was the most common reason for this indicator being unmet, followed by a lack of an in-person visit with the member every three months.

**Results for Coordination for MCOs Operating FCP:**




## PACE

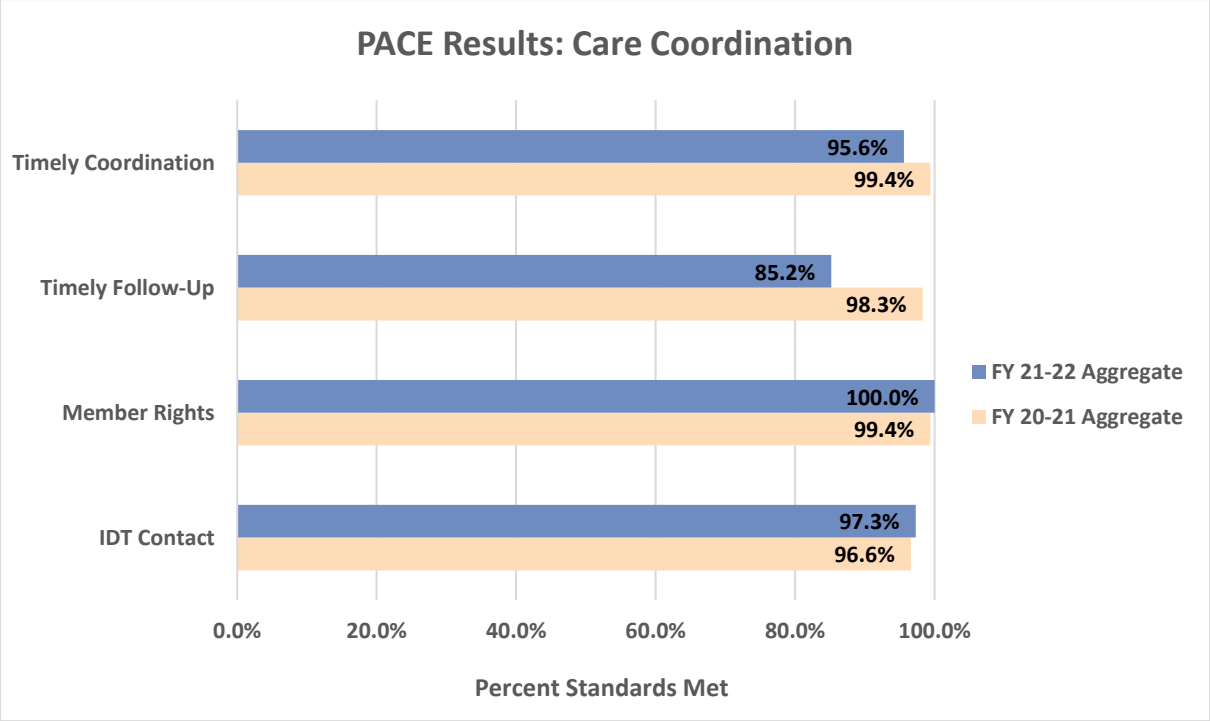
The *Timely Coordination* indicator evaluates plans put in place by the IDT to ensure member needs and supports are coordinated effectively and in a timely manner. Although this area continued to be strength for the PACE program, overall results for the indicator declined from the prior review. Analysis indicated the year-to-year difference in the rates is unlikely to be the result of normal variation or chance.

The indicator *Timely Follow-Up* evaluates whether the IDT followed up with members to confirm services and supports were received and effective. Overall results for the indicator declined from the prior review. Analysis indicated the year-to-year difference in the rates is unlikely to be the result of normal variation or chance. The majority of records found unmet did not include any evidence of follow-up to a member's service or support. Lack of follow-up was most often related to medical appointments.

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. Upholding member rights continues to be a strength for the PACE program, scoring over 90.0 percent in the prior two reviews. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance.

The evaluation of IDT contact requirements under the indicator *IDT Contact* included monthly collateral contacts, face-to-face contact every three months with the member, and an annual home visit with the member by the care manager and registered nurse care manager. Maintaining contact with members continues to be a strength for the PACE program scoring over 90.0 percent in the prior two reviews. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance.

**Results for Coordination for the MCO Operating PACE:**




## ANALYSIS

Aggregate results for all programs was 87.7 percent, indicating compliance. Aggregate results for individual programs ranged from 82.7 percent to 94.6 percent. In addition to analyzing results by MCO and program, MetaStar reported data by GSR. Results identified which regions in the state were below the statewide rates. This analysis allows the state to identify potential trends in compliance based on location. Further analysis regarding geographic barriers may be warranted, such as MCO staffing patterns and provider network issues. Lastly, a review of member health and safety indicators demonstrate that MCOs are providing the necessary supports to assure member needs are being met.

***Statewide Analysis***

**FC**

The FC program scores were lowest in areas of *Comprehensive Assessment*, *Comprehensive MCP*, and *Timely Follow-Up*. Analysis by GSR identifies areas of focus for each CMR indicator. Using the statewide rates for FC as the benchmark:

- The results for five GSRs are below the statewide rate for *Comprehensive Assessment* (85.7 percent): GSRs 1, 3, 4, 7, and 14.
- The results for seven GSRs are below the statewide rate for *Comprehensive MCP* (75.7 percent): GSRs 2, 4, 7, 8, 9, 10, and 11.
- The results for seven GSRs are below the statewide rate for *Timely Follow-Up* (76.2 percent): GSRs 1, 4, 5, 6, 9, 10, and 14.

GSR 4 is a contributing factor in all three focus areas. GSRs 1, 7, and 14 contributed to the low scores in two of the three focus areas.

**FCP**

The FCP program scores were lowest in areas of *Comprehensive Assessment, Comprehensive MCP, Timely MCP, Timely Follow-Up,* and *IDT Contact*. Analysis by GSR identifies areas of focus for each CMR indicator. Using the statewide rates for FCP as the benchmark:

- The results for three GSRs are below the statewide rate for *Comprehensive Assessment* (85.4 percent): GSRs 2, 8, and 11.
- The results for six GSRs are below the statewide rate for *Comprehensive MCP* (79.0 percent): GSRs 2, 3, 8, 11, 12, and 14.
- The results for two GSRs are below the statewide rate for *Timely MCP* (70.1 percent): GSRs 12 and 14.
- The results for three GSRs are below the statewide rate for *Timely Follow-Up* (65.2 percent): GSRs 5, 12, and 14.
- The results for four GSRs are below the statewide rate for *IDT Contact* (69.9 percent): GSRs 8, 12, and 14.

GSRs 12 and 14 contributed to the lower results in four of the five focus areas.

**PACE**

The PACE program scored lowest in *Timely Follow-Up*. All other areas are above 90 percent. Analysis by GSR identifies areas of focus for the CMR indicator. Using the overall rate for PACE as the benchmark:

- The result for one GSR is below the statewide rate for *Timely Follow-Up* (85.2 percent): GSR 6.

### *Member Health and Safety Analysis*

No members with health and safety issues were discovered in the random sample of records reviewed. Six members with complex or challenging situations were referred to DHS for additional oversight, assistance, and monitoring.

Over the course of the fiscal year, MetaStar also reviewed another 30 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. These reviews were not included in the results for this report.

## CONCLUSIONS

A summary of strengths, progress, and recommendations is noted in the *Executive Summary* and *Introduction and Overview* sections above.

# APPENDIX A: INFORMATION SYSTEMS CAPABILITIES ASSESSMENT

The information systems capabilities assessment (ISCA) is a required part of other mandatory EQR protocols, such as compliance with standards and Performance Measure Validation (PMV), and the review helps 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 21-22, MetaStar conducted an ISCA for one MCO selected by DHS. The organization was LCI, which operates the FC program only.

As a guide for conducting the ISCA, MetaStar used the *CMS External Quality Review (EQR) Protocols Appendix A. Information Systems Capabilities Assessment.* MetaStar reviewers collected information about the effect of the MCO's information management practices on data submitted to DHS. In addition to completing the ISCA scoring tool, MetaStar asked the MCO to submit documentation specific to its information systems (IS) and operations used to collect, process, and report data. Reviewers also conducted staff interviews and observed demonstrations of the MCO's systems. For more detailed information about the review methodology, please see Appendix 2.

The ISCA review was revised at the start of this fiscal year to align with the Centers for Medicare & Medicaid Services External Quality Review Protocols, which define the review activities for Medicaid Managed Care Programs. This review was organized around and focused on the following categories:

- Section 1: Background Information;
- Section 2: Information Systems: Data Processing & Personnel;
- Section 3: Staffing;
- Section 4: Security; and
- Section 5: Data Acquisition Capabilities including:
    - Administrative Data;
    - Enrollment System;
    - Ancillary Systems;
    - Additional Data Sources that Support Quality Reporting; and
    - Integration and Control of Data and Performance Measure Reporting.

## Overall Results

Compliance with ISCA requirements is expressed in terms of a percentage score and rating, as identified in the table below. See the Appendix for more information about the scoring methodology.

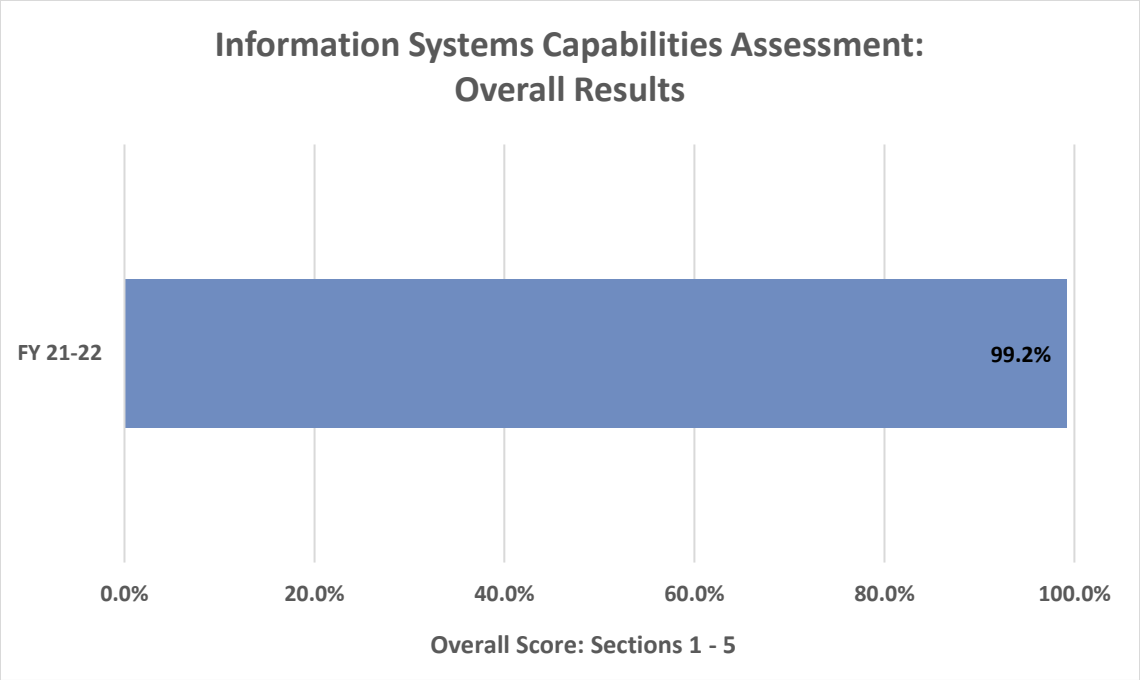
| Scoring Legend | | |
|---|---|---|
| **Percentage Met** | **Stars** | **Rating** |
| 90.0% - 100.0% = 5 Stars | ★★★★★ | EXCELLENT |
| 80.0% - 89.9% = 4 Stars | ★★★★ | VERY GOOD |
| 70.0% - 79.9% = 3 Stars | ★★★ | GOOD |
| 60.0% - 69.9% = 2 Stars | ★★ | FAIR |
| < 60.0% = 1 Star | ★ | POOR |

LCI had an overall score of 99.2 percent, and a rating of Excellent.

| Information Systems Capabilities Assessment FY 21-22 | | | | |
|---|---|---|---|---|
| **Focus Area** | **Scoring Elements** | **Percentage** | **Stars** | **Rating** |
| Section 1: Background Information* | N/A | N/A | N/A | N/A |
| Section 2: Information Systems | 24/24 | 100.0% | ★★★★★ | EXCELLENT |
| Section 3; Staffing | 2/2 | 100.0% | ★★★★★ | EXCELLENT |
| Section 4: Security | 26/27 | 96.3% | ★★★★★ | EXCELLENT |
| Section 5: Data Acquisition | 71/71 | 100.0% | ★★★★★ | EXCELLENT |
| **Overall** | **123/124** | **99.2%** | **★★★★★** | **EXCELLENT** |

*Section 1: Background Information is not scored, and therefore is not applicable.

The graph on the next page illustrates the MCO's overall compliance with these standards.




## Results for each ISCA Focus Area

### Observation and Analysis: Section 1. Background Information

The MCO detailed the type of managed care program it operates, the year it was incorporated, average enrollment, and when the previous ISCA was conducted. This section is for informational purposes only and is not included in the scoring calculations. The following table includes the background information provided by LCI.

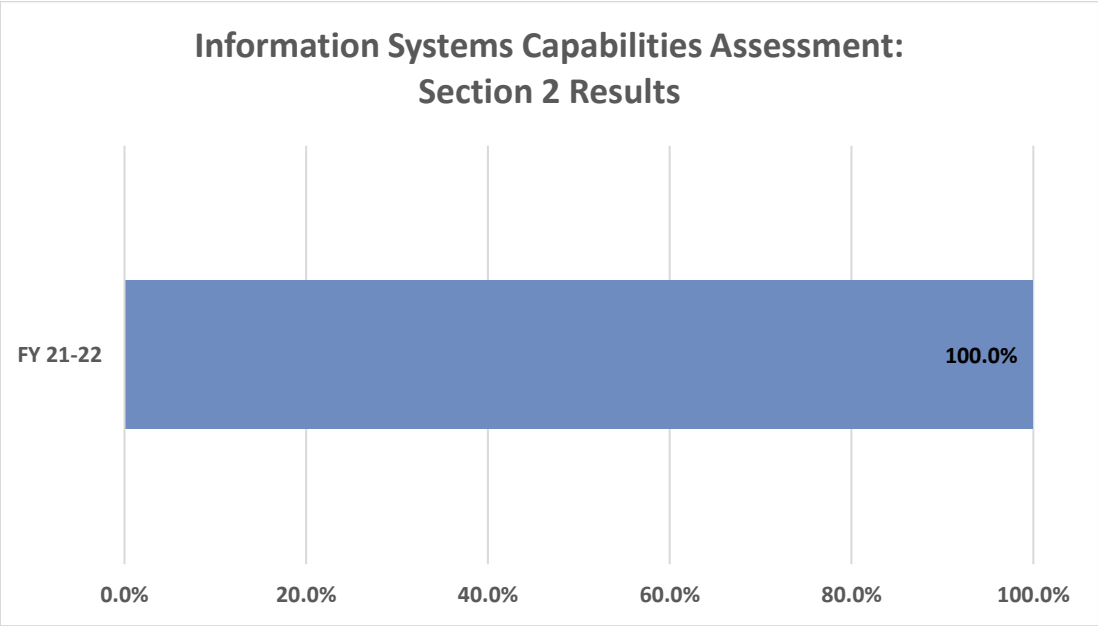
| MCO Background Information | |
|---|---|
| Date of Incorporation: | 2010 |
| Date of Prior ISCA: | November 2018 |
| Current Enrollment: | 7689 |

### Observation and Analysis: Section 2. Information Systems - Data Processing & Personnel

The MCO must have a system or repository used to store Medicaid claims and encounter data supported by stable and experienced IS staff. The IS department should follow a standardized process when updating and revising code. This process should include safeguards that ensure that the correct version of a program is in use. Section 2 contains 24 scoring elements. The MCO

satisfied requirements for 24 out of 24 scoring elements, for a score of 100.0 percent, and a rating of Excellent.

The graph below illustrates the MCO's overall compliance with these requirements.



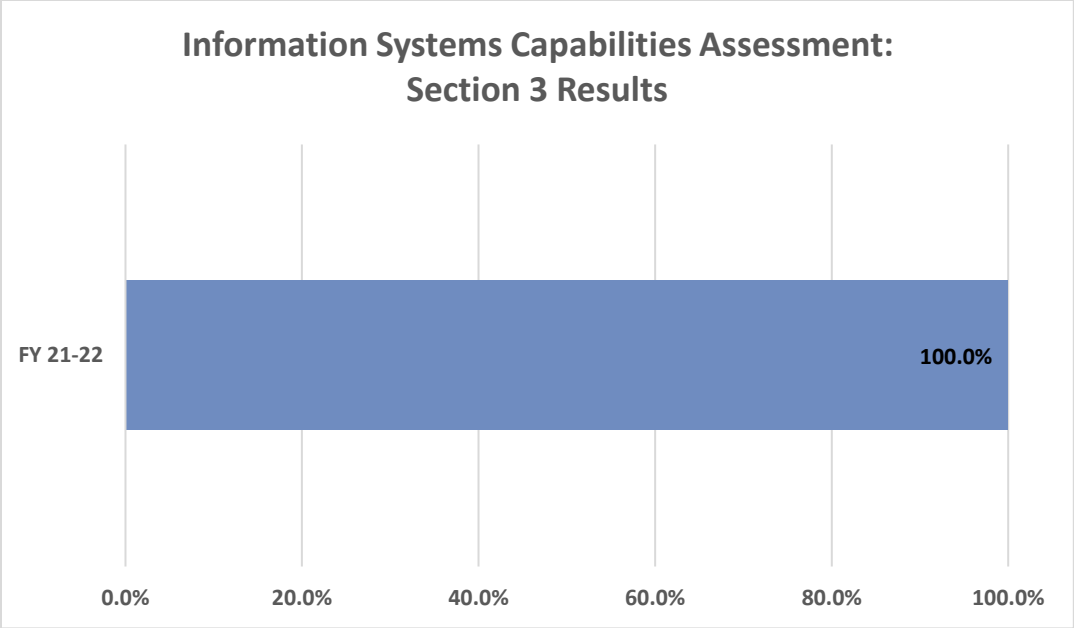

The responses submitted and the interview sessions with the MCO staff satisfied requirements of this focus area. Since the prior ISCA, LCI made a major system conversion in November 2019, and implemented an internally developed system, *DataClarity*. The system transition took approximately six months and involved a coordinated effort across the MCO to test the accuracy of data transition to the new system.

LCI contracts with a vendor to manage and process claims, and to create the monthly encounter data files. The MCO compares the claims paid total from the vendor to what is recorded as paid in the *DataClarity* system to ensure they match. The multiple checks ensure accuracy of claims paid and encounter file submissions. The cost share data is extracted from *DataClarity* and LCI verifies the accuracy of the extracted information prior to invoicing.

### Observation and Analysis: Section 3. Staffing

The MCO's IS department must provide its new employees with on-the-job training and supervision. Supervisors should closely audit the work of new hires before concluding the training process. Seasoned processors should have occasional refresher courses and training concerning any system modifications. Expected productivity goals should not be unusually high, thus having a negative impact on the accuracy and quality of a processor's work. Section 3 contains two scoring elements. The MCO satisfied requirements for two out of two scoring elements, for a score of 100.0 percent, and a rating of Excellent.

The graph below illustrates the MCO's overall compliance with these requirements.

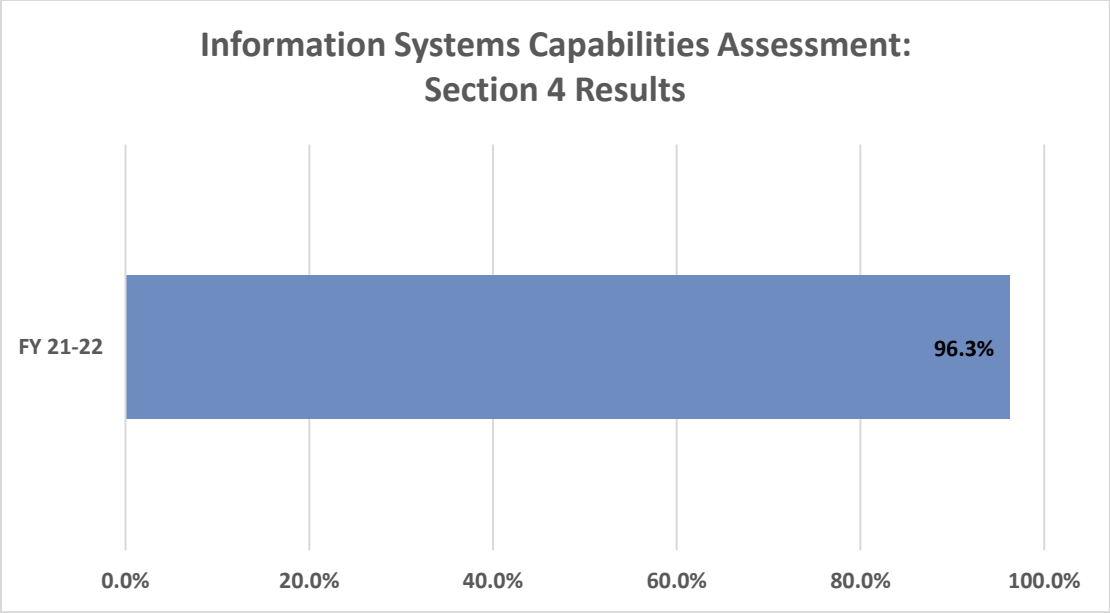



The responses submitted and interview sessions with the MCO staff satisfied requirements of this focus area. LCI indicated the IS department has stable staffing with very little staff turnover. On-the-job training is provided for new hires and as needed for existing staff. The MCO also has a training department that the IS staff can access for additional training, such as when significant process changes are implemented.

### Observation and Analysis: Section 4. Security

The MCO must have strong IS security controls that protect from both unauthorized usage and accidental damage. Practices must be in place to manage its encounter data security processes and ensure the data integrity of submissions. MCOs should have data backing and disaster recovery procedures, including testing. Section 4 contains 27 scoring elements. The MCO satisfied requirements for 26 out of 27 scoring elements, for a score of 96.3 percent, and a rating of Excellent.

The following graph illustrates the MCO's overall compliance with these requirements.



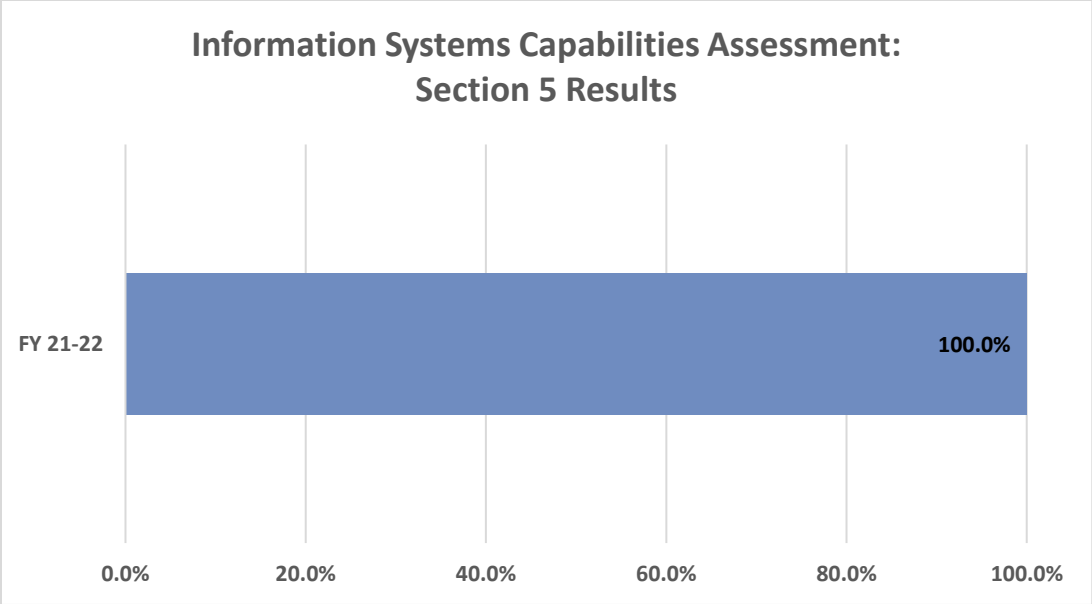

The responses submitted and interview sessions with the MCO staff satisfied most requirements of this focus area. LCI's security practices align with industry standards. All information access is role-based. LCI employees are granted access levels as assigned by the human resources department. New employees receive security and privacy training upon hire and annually thereafter for all employees. LCI continues to analyze its security systems, deploying process, and system or software updates as determined necessary.

Scoring element 4.12a requires completed testing of the *Federal Information Processing Standards Publication* (FIPS), which are federally established standards and guidelines for use in computer systems for non-military government agencies and government contractors. Although the organization uses FIPS-compliant software, it had not conducted a FIPS 140-2 test at the time of the ISCA. The MCO indicated that the implementation and testing of FIPS is in progress, but not yet fully implemented. The MCO did not satisfy the requirements of this scoring element. MetaStar recommends the MCO continue to implement the established standards, including required testing.

### Observation and Analysis: Section 5. Data Acquisition Capabilities

MCOs must have consistent processes for collecting and maintaining administrative data (claims and encounter data), enrollment data, ancillary services data, and data related to performance rates reporting. Section 5 contains 71 scoring elements. The MCO satisfied requirements for 71 out of 71 scoring elements, for a score of 100.0 percent, and a rating of Excellent.

The following graph illustrates the MCO's overall compliance with these requirements.




### *5A. Administrative Data (Claims and Encounter Data)*

This section focuses on input data sources, such as electronic and paper claims, and on the transaction systems utilized by the MCO. The responses submitted and interview session met requirements of this focus area. LCI's contracted vendor receives and processes provider claims. LCI's case management claims are generated through *DataClarity*, and then submitted to the vendor for processing. The vendor and the MCO continue to work closely via formal and informal communications to address all claims issues promptly. LCI meets regularly with the vendor as part of vendor oversight, in addition to monitoring a dashboard and several metrics provided by the vendor.

### *5B. Enrollment System*

This section focuses on the processing and management of enrollment data. The responses submitted and interview sessions with the MCO staff satisfied requirements of this focus area. LCI has the systems and processes in place to accurately collect, manage, and retain the eligibility, enrollment, and disenrollment data. *DataClarity* holds all member data and allows for multiple enrollment segments per member. The accuracy of member information is verified using both ForwardHealth and the *Long Term Care Functional Screen* data warehouse.

### *5C. Ancillary Systems*

This section focuses on use and oversight of third-party data. This section is not applicable to LCI.

### *5D. Additional Data Sources that Support Quality Reporting*

This section focuses on data sources beyond third party collection of claims or encounter data that support quality reporting. This section is not applicable to LCI.

### *5E. Integration and Control of Data for Performance Measure Reporting*

This section focuses on how the MCO integrates Medicaid claims, encounter, membership, provider, third-party, and other data to calculate performance rates. The responses submitted and interview sessions with MCO staff satisfied  requirements of this focus area. Since the last ISCA, LCI has gained the ability for on-demand reporting, which has improved the MCO's ability to report on performance measures. The MCO met all requirements in this focus area for calculating and reporting measures. *DataClarity* holds all LCI member immunization data. Immunization reports are run monthly in *DataClarity*, with data validated against the state immunization registry. The procedures in place contribute to the MCO's ability to provide valid and accurate reports.

## CONCLUSIONS

A summary of strengths, progress, and recommendations is noted in the *Executive Summary* and *Introduction and Overview* sections above.

# 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 |
| COVID-19 | Coronavirus Disease-2019 |
| 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 |
| HCBS | Home and Community Based Services Waivers |
| 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 |
| ISCA | Information Systems Capabilities Assessment |
| IS | Information Systems |
| LCI | Lakeland Care, Inc., Managed Care Organization |
| LTSS | Long-term services and supports |
| MCO | Managed Care Organization |
| MCP | Member-Centered Plan |
| MCW | My Choice Wisconsin, Inc., Managed Care Organization |
| MY | Measurement Year |
| NCQA | National Committee for Quality Assurance |
| PACE | Program of All-Inclusive Care for the Elderly |

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

| | |
|---|---|
| PIP | Performance Improvement Project (Validation of Performance Improvement Projects) |
| PMV | Performance Measures Validation (Validation of Performance Measures) |
| PIHP | Prepaid Inpatient Health Plan |
| PHE | Public Health Emergency |
| QAPI | Quality Assessment and Performance Improvement |
| QCR | Quality Compliance Review |
| RAD | Resource Allocation Decision |
| SDS | Self-Directed Supports |

# APPENDIX 2 – 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 (PIHPs) and managed care organizations (MCOs) to provide for external quality reviews (EQRs). 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 Superior Health Quality Alliance, 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, Pre-paid Inpatient Health Plans, 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 physical therapist, a recreational therapist, a school 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 External Quality Review 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

### *CMS External Quality Review (EQR) Protocols, Protocol 1: Validation of Performance Improvement Projects (PIP)*

Validation of PIPs, a mandatory EQR activity, assesses if a MCO used sound methodology in the design, implementation, analysis and reporting of its PIPs. The MetaStar team evaluated the MCO PIPs according to the methodology described in the CMS guide, *EQR Protocol 1: Validating Performance Improvement Projects (PIPs), A Mandatory EQR-Related Activity.*

Reviewers evaluated the PIP's design, implementation, analysis and reporting using each of the following standards for the MCO's submitted PIP report.

1. Standard 1: PIP Topic
2. Standard 2: PIP Aim Statement
3. Standard 3: PIP Population
4. Standard 4: Sampling Method
5. Standard 5: PIP Variables and Performance Measures
6. Standard 6: Data Collection Procedures
7. Standard 7: Data Analysis and Interpretation of PIP Results
8. Standard 8: Improvement Strategies
9. Standard 9: Significant and Sustained Improvement

Findings were analyzed and compiled using a binomial structure (*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 any findings of *not met*, the EQR team documented the missing requirements related to the findings and provided recommendations.

Interview sessions were conducted to collect additional information necessary to assess the MCO's compliance with federal and state standards. Participants in the interview 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.

Each section has a specified number of scoring elements, which correlate with the *CMS EQR Protocol 1, Validation of Performance Improvement Projects.* Standard scores are presented as the number of compliant elements out of the total number of scoring elements possible for each standard. This provides a percentage score for each standard.

In addition, the validity and reliability of the PIP methods and findings are assessed to determine whether the EQRO has confidence in the PIP results. The validation rating reflects the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement. The validation result is based on the overall percentage of standards met for each project as follows:

| Percentage of Standards Met | Validation Result |
|---|---|
| 90.0% - 100.0% | High Confidence |
| 80.0% - 89.9% | Moderate Confidence |
| 70.0% - 79.9% | Low Confidence |
| <70.0% | No Confidence |

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

### *CMS External Quality Review (EQR) Protocols, Protocol 2: 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), October 2020.*

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 the specified measurement year (MY). 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 the current MY to both the statewide rates for the current MY and the MCO's rates for prior MY.
- 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.)

### *CMS External Quality Review (EQR) Protocols, Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations - 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, *CMS External Quality Review* (*EQR) Protocols, Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations, A Mandatory Protocol for External Quality Reviews (EQR).*

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 and performance expectations through the following sources of information:

- 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.

The review assesses the strengths and weaknesses of the MCO related to quality, timeliness, and access to services, including health care and LTSS. MetaStar conducted a document review to evaluate policies, procedures, and practices within the organization. The review assessed information about the MCO's structure, operations, and practices, including organizational charts, results and analysis of internal monitoring, and staff training

Interview sessions were then held onsite or by video conference to collect additional information necessary to assess the MCO's compliance with federal and state standards. Participants in the interview 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 verification activities and requested and reviewed additional documents, as needed, to clarify information gathered during the onsite visit. Data from Care Management Review elements were considered when assigning compliance ratings for some focus areas and sub-categories.

MetaStar worked with DHS to identify 31 standards that include federal and state requirements applicable to FC, FCP, and PACE. Standards are reviewed in a two-year cycle for each MCO. The first year of the cycle includes the MCO Standards, followed by QAPI and Grievance Standards in the second year. At the discretion of DHS, additional standards may be reviewed in any year of the cycle.

| Focus Area | Related Sub-Categories in Review Standards |
|---|---|
| **MCO Standards – 16 Standards** | • Enrollee Rights and Protections - 42 CFR 438.100<br>• Availability of Services - 42 CFR 438.206<br>• Assurance of Adequate Capacity and Services - 42 CFR 438.207<br>• Coordination and Continuity of Care - 42 CFR 438.208<br>• Disenrollment 42 CFR 438.56<br>• Coverage and Authorization of Services - 42 CFR 438.210<br>• Provider Selection - 42 CFR 438.214<br>• Confidentiality - 42 CFR 438.224<br>• Subcontractual Relationships and Delegation - 42 CFR 438.230<br>• Practice Guidelines - 42 CFR 438.236<br>• Health Information Systems - 42 CFR 438.242 |
| **Quality Assessment and Performance Improvement (QAPI) – Five Standards** | Quality Assessment and Performance Improvement Program 42 CFR 438.330:<br>• Quality Management Program Structure<br>• Documentation and monitoring of required activities in the Quality Management Program<br>• Annual Quality Management Program Evaluation<br>• Performance Measure Validations<br>• Performance Improvement Projects |
| **Grievance System – 10 Standards** | Grievance and Appeal Systems 42 CFR 438.228 and 42 CFR 438.400:<br>• General Process Requirements<br>• Filing Requirements for Grievances and Appeals<br>• Content and Timing for Issuing Notices to Members<br>• Handling of Local Grievances and Appeals<br>• Resolution and Notification Requirements<br>• Expedited Resolution of Appeals<br>• Information about the Grievance and Appeal System to Providers<br>• Recordkeeping Requirements<br>• Continuation of Benefits while the MCO Appeal and State Fair Hearing are Pending<br>• Effectuation of Reversed Appeal Resolutions |

Each standard has a specified number of scoring elements, which correlate with the DHS-MCO Contract requirements. Standard scores are presented as the number of compliant elements out of the total number of scoring elements possible for each standard. This provides a percentage score, which correlates with the DHS Score Card Star Ratings:

| Scoring Legend | | |
|---|---|---|
| **Percentage Met** | **Stars** | **Rating** |
| 90.0% - 100.0% = 5 Stars | ★★★★★ | EXCELLENT |
| 80.0% - 89.9% = 4 Stars | ★★★★ | VERY GOOD |
| 70.0% - 79.9% = 3 Stars | ★★★ | GOOD |
| 60.0% - 69.9% = 2 Stars | ★★ | FAIR |
| < 60.0% = 1 Star | ★ | POOR |

The following definitions are used to determine compliance for each scoring element:

**Compliant:**

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

**Not Compliant:**

- 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.

For findings of non-compliance, the EQR team documented the missing requirements related to the findings and provided recommendations.

***CMS External Quality Review (EQR) Protocols, Protocol 9: Conducting Focus Studies of Health Care Quality- 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 21-22 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, when needed;
- Schedule times to speak with care management staff, when 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.

***EQR Protocols Appendix A: Information Systems Capabilities Assessment***

Information Systems Capabilities Assessment evaluates the strength of each organization's information system capabilities. The MetaStar team evaluated the information systems according to 42 CFR 438.242 Health Information Systems using the CMS guide, EQR Protocols Appendix A Information Systems Capabilities Assessment.

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

The review assesses the strengths, progress, and recommendations of the MCO related to the ability of its information systems to collect, analyze, integrate, and report data for multiple purposes including utilization, claims, grievances and appeals, disenrollment for reasons other than loss of Medicaid eligibility, rate setting, risk adjustment, quality measurement, value-based purchasing, program integrity, and policy development.

To conduct the assessment, MetaStar used the Information Systems Capabilities Assessment (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 additional supplemental documentation specific to the MCO's IS and organizational operations used to collect, process, and report claims and encounter data.

Interview sessions were then held onsite or by video conference to collect additional information necessary to assess the MCO's compliance with federal and state standards. Participants in the interview sessions included MCO administrators, supervisors and other staff responsible for the organization's information systems.

Each section has a specified number of scoring elements, which correlate with the *CMS External Quality Review (EQR) Protocol Appendix A. Worksheet A.1 Information System Capabilities Assessment (ISCA) Tool*. Standard scores are presented as the number of compliant elements out of the total number of scoring elements possible for each standard. This provides a percentage score:

| Scoring Legend | | |
|---|---|---|
| **Percentage Met** | **Stars** | **Rating** |
| 90.0% - 100.0% = 5 Stars | ★★★★★ | EXCELLENT |
| 80.0% - 89.9% = 4 Stars | ★★★★ | VERY GOOD |
| 70.0% - 79.9% = 3 Stars | ★★★ | GOOD |
| 60.0% - 69.9% = 2 Stars | ★★ | FAIR |
| < 60.0% = 1 Star | ★ | POOR |

The following definitions are used to determine compliance for each scoring element:

**Compliant:**

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

**Not Compliant:**

- 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.

For findings of non-compliance, the EQR team documented the missing requirements related to the findings and provided recommendations.

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

**Section 1: Background Information**

MetaStar confirms the type of managed care program operated by the MCO, the year it was incorporated, average enrollment, and when the previous ISCA was conducted. This section is for informational purposes only and is not included in the scoring calculations.

**Section 2: Information Systems: Data Processing & Personnel**

MetaStar assesses the MCO's system or repository used to store Medicaid claims and encounter data. The information submitted by the MCO/PIHP described the foundation of its Medicaid data systems, processes and staffing. MetaStar also assesses the stability and expertise of the MCO's information system department.

**Section 3: Staffing**

MetaStar assesses the MCO's IS department staff training and expected productivity goals.

**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 4: 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 5: Data Acquisition Capabilities

MetaStar assesses information on the MCO's processes for collecting and maintaining administrative data (claims and encounter data), enrollment data, ancillary services data and data related to performance rates reporting.

# Appendix 4 – Quality Compliance Review: MCO Comparative Scores

| Standard | Citation | Managed Care Programs FY 20-21 | | | | |
|---|---|---|---|---|---|---|
| | | CCI | Inclusa | *i*Care | LCI | MCW |
| M1 | Availability of services - 42 CFR 438.206 | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| M2 | Timely access to services - 42 CFR 438.206(c)(1) | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| M3 | Cultural considerations in services - 42 CFR 438.206(c)(2) | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| M4 | Network adequacy - 42 CFR 438.207 | 100.0% | 100.0% | 100.0% | 100.0% | 66.7% |
| M5 | Coordination and continuity of care, and confidentiality - 42 CFR 438.208, 42 CFR 438.224 | 100.0% | 91.7% | 91.7% | 100.0% | 100.0% |
| M6 | Coordination and continuity of care, and confidentiality - 42 CFR 438.208, 42 CFR 438.224 | 80.0% | 80.0% | 90.0% | 80.0% | 90.0% |
| M7 | Disenrollment: requirements and limitations - 42 CFR 438.56 | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| M8 | Coverage and authorization of services - 42 CFR 438.210, 42 CFR 440.230, 42 CFR 438.441 | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| M9 | Information requirements for all enrollees - 42 CFR 438.100(b)(2)(i), 42 CFR 438.10 | 91.7% | 91.7% | 100.0% | 100.0% | 100.0% |
| M10 | Enrollee right to receive information on available provider options - 42 CFR 438.100(b)(2)(iii), 42 CFR 438.102 | 100.0% | 75.0% | 100.0% | 100.0% | 75.0% |
| M11 | Enrollee right to participate in decisions regarding his or her care and be free from any form of restraint - 42 CFR 438.100(b)(2)(iv) and (v), 42 CFR 438.3(j) | 100.0% | 100.0% | 100.0% | 100.0% | 54.5% |
| M12 | Compliance with other federal and state laws - 42 CFR 438.100(d) | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| M13 | Provider selection - 42 CFR 438.214 | 92.3% | 92.3% | 100% | 92.3% | 84.6% |
| M14 | Subcontractual relationships and delegation - 42 CFR 438.230 | 87.5% | 100.0% | 100.0% | 100.0% | 100.0% |
| M15 | Practice guidelines - 42 CFR 438.236 | 50.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| M16* | Health information systems – 42 CFR 438.242 | N/A | N/A | N/A | N/A | N/A |
| **Overall** | | **94.0%** | **94.5%** | **98.3%** | **97.2%** | **90.6%** |

*M16, is evaluated through reviews that occur separate from the QCR.

| Standard | Citation | Managed Care Programs FY 21-22 | | | | |
|---|---|---|---|---|---|---|
| | QAPI Standards | CCI | Inclusa | *i*Care | LCI | MCW |
| Q1 | Quality Assessment and Performance Improvement: General rules Medicaid: 42 C.F.R. § 438.330(a): General rules | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Q2 | Basic elements of quality assessment and performance improvement program Medicaid: 42 C.F.R. § 438.330(b): Basic elements of quality assessment and performance improvement programs | 87.5% | 100.0% | 87.5% | 87.5% | 87.5% |
| Q3* | Performance measurement Medicaid: 42 C.F.R. § 438.330(c): Performance measurement | NA | NA | NA | NA | NA |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Q4*** | Performance improvement projects Medicaid: 42 C.F.R. § 438.330(d) | NA | NA | NA | NA | NA |
| **Q5** | QAPI evaluations review Medicaid: 42 C.F.R. § 438.330(e)(2): Program and review by the state | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| **QAPI Overall** | | **94.4%** | **100.0%** | **94.4%** | **94.4%** | **94.4%** |

*Q3 and Q4, are evaluated through reviews that occur separate from the QCR.

| Standard | Citation | Managed Care Programs FY 21-22 | | | | |
|---|---|---|---|---|---|---|
| | **Grievance Systems Standards** | **CCI** | **Inclusa** | ***i*Care** | **LCI** | **MCW** |
| **G1** | Grievance Systems Medicaid: 42 C.F.R. § 438.228: Grievance and appeal systems | 100.0% | 75.0% | 100.0% | 100.0% | 100.0% |
| **G2** | General requirements Medicaid: 42 C.F.R. § 438.402: General requirements | 100.0% | 100.0% | 100.0% | 100.0% | 85.7% |
| **G3** | Timely and Adequate Notice of Adverse Benefit Determination Medicaid: 42 C.F.R. § 438.404: Timely and adequate notice of adverse benefit determination | 75.0% | 75.0% | 75.0% | 75.0% | 75.0% |
| **G4** | Handling of Grievances and Appeals Medicaid: 42 C.F.R. § 438.406: Handling of grievances and appeals | 88.9% | 100.0% | 100.0% | 100.0% | 88.9% |
| **G5** | Resolution and notification: Grievances and appeals Medicaid: 42 C.F.R. §438.408: Resolution and notification, Grievances and appeals | 85.7% | 100.0% | 85.7% | 85.7% | 100.0% |
| **G6** | Expedited resolution of appeals Medicaid: 42 C.F.R. § 438.410: Expedited resolution of appeals | 75.0% | 75.0% | 100.0% | 100.0% | 100.0% |
| **G7** | Information about the grievance and appeal system to providers and subcontractors Medicaid: 42 C.F.R. § 438.414: Information about the grievance and appeal system to providers and subcontractor | 50.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| **G8** | Recordkeeping requirements Medicaid: 42 C.F.R. § 438.416: Recordkeeping requirements | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| **G9** | Continuation of benefits while the MCP appeal and the state Fair Hearing are pending 42 C.F.R. § 438.420: Continuation of benefits while the MCO, PIHP, or PAHP appeal and the state fair hearing are pending | 50.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| **G10** | Effectuation of reversed appeal resolutions Medicaid: 42 C.F.R. § 438.424: Effectuation of reversed appeal resolution | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| **Grievance Systems Overall** | | **84.4%** | **93.2%** | **95.6%** | **95.5%** | **93.3%** |
| | | | | | | |
| **Overall Compliance** | | **91.7%** | **94.7%** | **97.2%** | **96.5%** | **91.7%** |