External Quality Review

Fiscal Year 2015 – 2016

Annual Technical Report

Badger Care Plus and Medicaid Supplemental Security Income Managed Care

Prepared for

Wisconsin Department of Health Services

Division of Health Care Access and Accountability

Bureau of Benefits Management

Prepared by

METASTAR

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EXECUTIVE SUMMARY

The Code of Federal Regulations (CFR) at 42 CFR 438 requires states that operate pre-paid inpatient health plans, such as health maintenance organizations and organizations that provide managed long-term care services, to provide for an external quality review of their managed care organizations (MCOs).

This annual technical report is provided to meet these requirements and to support efforts by the Wisconsin Department of Health Services (DHS) to ensure quality for members enrolled in the following managed care programs:

- BadgerCare Plus, serving low income families and children without access to other health insurance;
- Medicaid Supplemental Security Income, serving elders and persons with disabilities; and
- Special Managed Care Programs, serving children with mental health needs.

The report offers a summary of external quality review findings for both mandatory and optional activities and provides recommendations to DHS. A list of the review activities conducted for each of the MCOs and Special Managed Care Programs during fiscal year 2015-2016 (FY 15-16) is found on pages 8 – 10.

Compliance with Standards Review

A compliance with standards review is a mandatory activity identified in 42 CFR 438.358 and is conducted according to federal protocol standards. In FY 15-16, MetaStar worked in partnership with DHS to continue development of the MCO Accreditation Deeming Plan, which outlines how DHS and MetaStar will ensure compliance of accredited MCOs with the federal Medicaid managed care requirements.

DHS made changes to its DHS-MCO 2016-2017 contract for BadgerCare Plus and Medicaid Supplemental Security Income programs to include the proposed Accreditation Deeming Plan elements, and continues to work with the Centers for Medicare & Medicaid Services to secure approval of the plan. DHS declared its goal to streamline compliance review processes to the greatest degree possible, based in part on feedback from the MCOs. As a result, DHS selected the 2016 MCO certification/re-contracting period to pilot its new compliance with standards review processes.

With direction from DHS, MetaStar completed the following activities:

- Updated an existing crosswalk of federal managed care requirements to the National Committee for Quality Assurance (NCQA) accreditation standards.

- Reviewed DHS certification tools in order to conduct concurrent reviews of required submissions from all MCOs, with DHS staff.
- Documented and communicated results about individual MCO compliance to DHS, which included recommendations for follow-up and remediation.

As DHS continues its work to implement its Accreditation Deeming Plan, MetaStar and DHS intend to evaluate the overall process associated with the activities described above and determine next steps in the next fiscal year. As a first priority for the next scope of work, MetaStar will work with DHS to identify its preferences for compiling and reporting MetaStar's aggregate compliance review results in a format that meets DHS needs.

Additionally, MetaStar conducted a compliance with standards review for three MCOs not accredited by NCQA in FY 15-16. Results varied by MCO; two MCOs met nearly all of the review standards.

All three MCOs fully met the enrollee rights standards and demonstrated a commitment to enrollee rights, focusing on cultural diversity and inclusiveness, and are member-focused in organizational values and operations.

Each MCO has strengths which contributed to meeting several standards in the Quality Assessment and Performance Improvement focus area. Each organization needs to ensure that the quality program effectively evaluates and improves the quality, timeliness, and access to care when needed.

Two MCOs met all the standards in the grievance systems focus area, and all three organizations met the standards that demonstrated value and support members' access to grievance systems in this focus area. One MCO should focus on revising policies and procedures to comply with DHS-MCO contract requirements, and ensure member access to the MCO level appeal committee.

DHS directed MetaStar to conduct an information systems capability assessment for four MCOs. The results indicated two MCOs met all of the requirements, and two MCOs met most of the requirements outlined in the DHS-MCO contract.

Performance Measure Validation

MetaStar validated 2014 performance measures for the BadgerCare Plus and Medicaid Supplemental Security Income programs calculated by the DHS vendor, Hewlett Packard Enterprise The validation review was conducted to evaluate the accuracy of Medicaid performance measures reported, and to determine the extent to which the measures were calculated according to DHS specifications. DHS provided MetaStar with the measure specifications it had established for calculating the performance measures, the data, and the

calculated results. All measures were deemed accurate and follow state specifications for calculation and reporting. In addition, MetaStar staff supported DHS in identifying and ensuring that the technical specifications for measurement year 2015 generally align with NCQA standards, Healthcare Effectiveness Data and Information Set (HEDIS®[1]) standards, and other nationally recognized standards, as well as conducted an assessment to identify the impact of the transition to International Classification of Diseases version 10 on the performance measures.

Performance Improvement Projects

MetaStar reviewed and validated 36 performance improvement projects (PIPs) during FY 15-16. Thirty-four PIPs were conducted during calendar year (CY) 2014 by 17 MCOs participating in the Wisconsin BadgerCare Plus and/or Supplemental Security Income Medicaid programs. The PIPs focused on a variety of health topics, including breast cancer screening, diabetes care, mental health, tobacco cessation, pre-natal and postpartum care, well-child care, immunizations, ambulatory care, and medication management. One PIP each was conducted by two Special Managed Care Programs during CY 2015; the projects focused on advanced care planning and behavioral support for children.

All MCOs submitted their PIP project proposals for feedback on the first 12 standards, which relate to the review areas of topic selection, study question, indicators, study population, sampling methods, and data collection procedures. When the final projects were validated, 14 of 19 MCOs/Special Managed Care Programs fully met the first 12 standards. The most successful projects developed approaches to monitor the effectiveness of interventions, by conducting continuous cycles of improvement and ensuring data collection processes were sound.

The overall validation findings provide an indication of the reliability and validity of the projects' results. Seventeen of the projects were rated fully "met," eighteen projects were rated "partially met," and one project was rated "not met."

Care Management Review – Supplemental Security Income Program

Care management review is an optional activity associated with the DHS pay for performance initiative. MetaStar reviewed 583 records of Supplemental Security Income members enrolled in nine MCOs. MCOs are required to achieve a 50 percent combined average rate of compliance for timeliness and comprehensiveness of health needs assessments to receive a payment incentive. All MCOs except three exceeded the benchmark, and rates ranged from 12.1 percent to 89.7 percent.

MCOs continued efforts to reach members by using multiple strategies and sources of information to facilitate timely completion of assessments, care coordination, and follow-up, and

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

to engage members in their care. Other areas of strengths, progress, and opportunities for improvement were identified among the MCOs and can be found in the related section of the report.

Obstetrics Medical Home/Healthy Birth Outcomes

During FY 15-16, DHS directed MetaStar to perform data abstraction reviews of its Medical Home initiative for pregnant women, implemented in Dane and Rock counties as well as in the southeastern region of Wisconsin. During this fiscal year, the Medical Home program expanded to include nine additional MCOs, bringing the total number participating in the initiative to 12 MCOs. Results from the data abstraction are used by DHS to determine administrative payments to MCOs, based on compliance with specific requirements detailed in the DHS-MCO contract. Due to the timelines associated with this retrospective review, information about this activity is reported separately.

HIV/AIDS Health Home

DHS established the Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS) Health Home in 2012 as a result of funding from the Affordable Care Act. In FY 15-16, MetaStar began working in collaboration with DHS to develop review criteria to evaluate member records to ensure that providers are meeting the DHS requirements. During the next FY, MetaStar will finalize the review tools and implement the record review of the HIV/AIDS Health Home.

Health Needs Assessments

With DHS guidance, MetaStar began development work related to evaluating MCOs' compliance with completing the health needs assessment for the BadgerCare Plus childless adult population. The health needs assessment was introduced as a requirement in the 2014-2015 BadgerCare Plus MCO Contract for newly enrolled childless adult members. The contract specified the elements that needed to be addressed as part of the health needs assessment, the timeframe for completion, and the acceptable modes of contacting members for purposes of completing the assessment. Beginning next year, MetaStar will evaluate MCO performance on timeliness and comprehensiveness of health needs assessments, gather information to describe how MCOs are screening members and utilizing health needs assessments, and identify best practices, among other things.

Introduction and Overview

Purpose of the Report

This is the annual technical report that the contracted External Quality Review Organization (EQRO) must provide to the State of Wisconsin Medicaid agency to meet requirements for external review as specified in the Code of Federal Regulations (CFR) at 42 CFR 438. This report covers external quality review (EQR) activities conducted for the fiscal year from July 1, 2015 to June 30, 2016 (FY 15-16).

The Wisconsin Department of Health Services (DHS) contracted with 19 managed care organizations (MCOs) to provide services for persons enrolled in the BadgerCare Plus (BC+) program in FY 15-16. Nine of the MCOs also provide health care services for persons receiving Supplemental Security Income (SSI) or SSI-related Medicaid. DHS also contracts with two Special Managed Care Programs (SMCPs) to serve children with mental health needs. One MCO provides comprehensive and coordinated health services for children and youth in foster care (Care4Kids, C4K).

DHS contracts with health plans include objectives and standards for quality measurement and improvement that reflect state priorities and areas of concern for the covered populations. At the time of this report, enrollment information was available as of May 2016 and is as follows:

- BC+ program had enrollment of 720,122;
- SSI program had enrollment of 36,239;
- SMCPs had enrollment of 1,254; and
- Care4Kids had enrollment of 3,047.

For current enrollment data, visit the following DHS website: https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/managed%20care%20organization/reports_data/monthlyreports/index.htm.spage.

In accordance with 42 CFR 438.358, the EQR technical report includes results of these mandatory activities designed to evaluate quality, timeliness, and access to care:

(1) Validation of each MCO's and SMCP's performance improvement projects (PIPs) underway during the preceding 12 months, as required by DHS and set forth in 42 CFR 438.240(b)(1);

(2) Validation of the performance measures calculated by DHS for each MCO during the preceding 12 months to comply with requirements in 42 CFR 438.240(b)(2); and

(3) A quality compliance review to determine each MCO's and SMCP's compliance with the applicable standards established by DHS to comply with the requirements of 42 CFR 438.204(g).

DHS requires MCOs and SMCPs to submit each PIP project for pre-approval by providing a preliminary summary which states the proposed topic, study question, and a brief description of the intervention and study design. Both DHS and the EQRO review the PIP preliminary proposals; DHS to determine if the selected topic is aligned with Department goals, and the EQRO to review the methodology and study design proposed by the MCO and SMCP. This activity is described as PIP technical assistance.

The report also provides information about the results of a care management review (CMR) conducted with MCOs operating the SSI program. This is an optional review activity requested and directed by DHS.

The report does not provide information about the optional review activities, Obstetrics Medical Home, development of the HIV/AIDS Health Home, and BC+ childless adults health needs assessment reviews.

Scope of External Review and Methodology

The following table identifies the MCOs and types of reviews completed during the FY 15-16 review cycle. Note that because DHS calculated its own measures, performance measure validation was not conducted for each individual MCO. The review methodology for each review activity is found in Appendix 1.

Scope of External Review Activities FY 15-16

MCOs and Programs	Types of Reviews Performed
Anthem Blue Cross and Blue Shield (Anthem) BC+, SSI	Accreditation Deeming Plan Review Accreditation: Validation of Current Status Healthy Birth Outcomes Medical Home Review PIPs Technical Assistance PIPs Validation
Care Wisconsin (CW) SSI	Accreditation Deeming Plan Review Information Systems Capability Assessment PIPs Technical Assistance SSI Care Management Review
Children's Community Health Plan (CCHP) BC+, C4K	Compliance with Standards Review including Information Systems Capability Assessment Healthy Birth Outcomes Medical Home Review PIPs Technical Assistance PIPs Validation

MCOs and Programs	Types of Reviews Performed
Compcare Health Services (Compcare) BC+, SSI	Compliance with Standards Review including Information Systems Capability Assessment PIPs Technical Assistance PIPs Validation SSI Care Management Review
Dean Health Plan (DHP) BC+	Accreditation Deeming Plan Review Accreditation: Validation of Current Status Healthy Birth Outcomes Medical Home Review PIPs Technical Assistance PIPs Validation
Group Health Cooperative of Eau Claire (GHC-EC) BC+, SSI	Compliance with Standards Review including Information Systems Capability Assessment PIPs Technical Assistance PIPs Validation SSI Care Management Review
Group Health Cooperative of South Central Wisconsin (GHC-SCW) BC+	Accreditation Deeming Plan Review Accreditation: Validation of Current Status Healthy Birth Outcomes Medical Home Review PIPs Technical Assistance PIPs Validation
Gundersen Health Plan (GHP) BC+	Accreditation Deeming Plan Review Accreditation: Validation of Current Status PIPs Technical Assistance PIPs Validation
Health Tradition Health Plan (HTHP) BC+	PIPs Technical Assistance PIPs Validation
Independent Care Health Plan (*i*Care) BC+, SSI	Healthy Birth Outcomes Medical Home Review PIPs Technical Assistance PIPs Validation SSI Care Management Review
MHS Health Wisconsin (MHS) BC+, SSI	Accreditation Deeming Plan Review Accreditation: Validation of Current Status Healthy Birth Outcomes Medical Home Review PIPs Technical Assistance PIPs Validation SSI Care Management Review
MercyCare Health Plans (MCHP) BC+	Accreditation Deeming Plan Review Accreditation: Validation of Current Status Healthy Birth Outcomes Medical Home Review PIPs Technical Assistance PIPs Validation
Molina Healthcare of Wisconsin (MHWI) BC+, SSI	Accreditation Deeming Plan Review Accreditation: Validation of Current Status Healthy Birth Outcomes Medical Home Review PIPs Technical Assistance PIPs Validation SSI Care Management Review

MCOs and Programs	Types of Reviews Performed
Network Health Plan (NHP) BC+, SSI	Accreditation Deeming Plan Review Accreditation: Validation of Current Status PIPs Technical Assistance PIPs Validation SSI Care Management Review
Physicians Plus Insurance Corporation (PPIC) BC+	Accreditation Deeming Plan Review Accreditation: Validation of Current Status Healthy Birth Outcomes Medical Home Review PIPs Technical Assistance PIPs Validation
Security Health Plan (SHP) BC+	Accreditation Deeming Plan Review Accreditation: Validation of Current Status PIPs Technical Assistance PIPs Validation
Trilogy Health Insurance (Trilogy) BC+, SSI	Healthy Birth Outcomes Medical Home Review PIPs Technical Assistance SSI Care Management Review
United Healthcare of Wisconsin (UHC) BC+, SSI	Accreditation Deeming Plan Review Accreditation: Validation of Current Status Healthy Birth Outcomes Medical Home Review PIPs Technical Assistance PIPs Validation SSI Care Management Review
Unity Health Plan (Unity) BC+	Accreditation Deeming Plan Review Accreditation: Validation of Current Status Healthy Birth Outcomes Medical Home Review PIPs Technical Assistance PIPs Validation
Special Managed Care Programs	**Types of Review Performed**
Children Come First (CCF)	PIPs Technical Assistance PIPs Validation
Wraparound Milwaukee (WM)	PIPs Technical Assistance PIPs Validation

COMPLIANCE WITH STANDARDS

Compliance with standards is a mandatory review activity conducted to determine the extent to which MCOs and SMCPs are in compliance with federal quality standards. During FY 15-16, MetaStar collaborated with DHS in further developing and implementing the DHS Accreditation Deeming Plan. The plan focuses on:

- Ensuring MCO compliance with all federal managed care requirements found in 42 CFR 438.358*;*
- Meeting requirements associated with EQR in 42 CFR, 438 SubPart E, *External Quality Review*; and
- Streamlining administrative processes through application of standards found in 42 CFR 438.360, *Non-duplication of mandatory activities*.

DHS made changes to its DHS-MCO 2016-2017 contract for BC+ and SSI programs to include the proposed Accreditation Deeming Plan elements. The plan is outlined in contract Article IX., I. *Accreditation*. DHS is working with the Centers for Medicare & Medicaid Services (CMS) to secure approval for its plan, which deems MCOs with accreditation status from the National Committee for Quality Assurance (NCQA) as compliant with most federal requirements. DHS changed its policy so that it no longer considers accreditation obtained from the Accreditation Association for Ambulatory Health Care (AAAHC) or Utilization Review Accreditation Commission (URAC) as an exemption to the requirement for an external compliance with standards review. The contract article also describes how DHS will:

- Determine compliance through contract certification reviews for all MCOs;
- Evaluate compliance with standards not addressed in the NCQA review processes for MCOs accredited by NCQA; and
- Continue the EQR compliance with standards review for non-accredited MCOs, on a periodic basis.

DEVELOPMENT AND REVIEW ACTIVITIES

Early in the fiscal year, MetaStar updated a crosswalk of federal managed care requirements to NCQA standards to reflect changes found in the NCQA guide, *2016 Standards and Guidelines for the Accreditation of Health Plans, effective July 1, 2016*. Next, MetaStar, completed the "Accreditation: Validation of Current Status" activity by verifying the MCOs' current accreditation status prior to the initiation of DHS contract certification activities. The results of the verification activity are documented in the following table, which provides details about each MCO's current accreditation status and the expiration date for the current accreditation period.

MCOs	Accreditation Current Status
Type of Accreditation - NCQA	
Anthem: BC+ & SSI	Medicaid HMO expires 2/28/18
Compcare: BC+ & SSI	Commercial expires 9/20/2016 Exchange/POS expires 12/16/16
DHP: BC+	Commercial expires 04/13/2019
GHC-SCW: BC+	Commercial expires 8/21/2016
GHP: BC+	Commercial expires 9/11/2016 Exchange/POS expires 9/11/16
MHS: BC+ & SSI	Medicaid expires 9/11/16
MCHP: BC+	Commercial expires 8/12/2016
MHWI: BC+ & SSI	Medicaid expires 4/7/17 Exchange/MCO expires 4/7/17
NHP: BC+ & SSI	Commercial expires 4/14/17 Exchange/MCO/POS expires 4/7/17 Medicare expires 9/11/16
PPIC: BC+	Commercial expires 3/30/18
SHP: BC+	Commercial/MCO/POS expires 3/31/17 Exchange/MCO/POS expires 3/31/17 Medicaid expires 3/31/17 Medicare expires 3/31/17
UHC: BC+ & SSI	Commercial/PPO/POS expires11/04/2018
Unity: BC+	Commercial expires 9/11/16
Type of Accreditation - AAAHC	
GHC-EC	MCO expires 10/10/2017
Type of Accreditation - URAC	
HTHP	Health Insurance Exchange expires 11/1/16
Not Accredited	
CW	Not Accredited
CCHP	Not Accredited[1]
*i*Care	Not Accredited
Trilogy	Not Accredited

1. As of June 2016, CCHP received interim NCQA accreditation and is seeking full NCQA accreditation, which it anticipates to receive in the summer of 2017.

In the third quarter of 2015, MetaStar collaborated with DHS to review its DHS-MCO contract certification template to identify focus areas that could be used to evaluate compliance with standards that are not represented in the NCQA accreditation reviews. Prior to the beginning of the DHS certification reviews, MetaStar participated in DHS-MCO conference calls to outline the plan for implementing the deeming plan and to pilot a process of review. MCOs expressed concern related to the administrative burden associated with compliance reviews and in response, DHS declared its objective to streamline the process for document submission and review to the greatest degree possible.

With this goal in mind, MetaStar engaged in the following activities to support the first phase of DHS' implementation of its Accreditation Deeming Plan:

- Conducted concurrent reviews of MCO submissions for certification/re-contracting, as assigned by DHS, regardless of whether the individual elements in a focus area represented a gap in the NCQA accreditation review process.
- Provided feedback to DHS about individual MCO compliance, for each assigned certification focus area.
- Participated in conference calls with DHS MCO contract monitors to discuss MetaStar's feedback about the MCO document submissions, as needed.
- Aggregated the findings from this first phase of the deeming plan review and forwarded it to DHS.

Following the initial cycle of certification review activities, MetaStar did another comparison of certification review elements to the NCQA Accreditation Crosswalk and identified the areas where concurrent review of certification submissions did not align with identified gaps in the NCQA accreditation review process. As a result, MetaStar conducted a second phase of review to address the remaining identified accreditation gaps or omissions in MCO submissions from certification reviews. At the conclusion of the review, MetaStar provided DHS with feedback about individual MCO compliance with submission requests and/or review elements.

Accreditation Deeming Plan Next Steps

MetaStar and DHS intend to evaluate the overall process associated with the activities described above and determine next steps in the next scope of EQRO work. Anticipated activities include:

- Confirming that all accreditation gaps have been fully addressed as a result of phase one and two review cycles;
- Determining DHS needs for compiling and reporting aggregate compliance results, including the format for reporting results;
- Identifying and monitoring remediation activities assigned to individual MCOs, according to DHS needs and direction;

- Securing MCO feedback about the recent certification and deeming plan review process;
- Scheduling meetings to discuss and document thresholds for compliance with individual standards, as needed;
- Evaluating and identifying steps to improve the overall process for review, to further streamline the process in the future; and
- Updating the deeming plan accreditation crosswalk, as needed, for both DHS contract changes and amendments, as well as NCQA accreditation standards updates, prior to the next cycle of DHS certification and/or deeming plan reviews.

Compliance with Standards Review

As noted above in the summary of DHS' Accreditation Deeming Plan, DHS directed MetaStar to continue the mandatory EQR compliance with standards review for non-accredited MCOs and MCOs accredited by a non-recognized accreditation body, according to the usual three-year cycle. Please refer to Appendix 1 for additional information regarding the three-year review cycle.

The mandatory compliance with standards review activity evaluates policies, procedures, and practices which affect the quality and timeliness of care and services that MCO members receive, as well as members' access to services. MetaStar conducts the review using the CMS guide, *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations*.

MetaStar has organized the federal protocols for compliance with standards review into three focus areas:

- Enrollee Rights and Protections;
- Quality Assessment and Performance Improvement: Access to Services, Structure and Operations, Measurement and Improvement; and
- Grievance Systems.

For more information about the review protocols and methodology, see Appendix 1.

During FY 15-16, MetaStar completed a compliance with standards review for three MCOs: CCHP, GHC-EC, and Compcare. With respect for the DHS objective to streamline review activities and reduce administrative burden for the MCOs, results from accreditation deeming plan review activities were considered and incorporated into the document review and onsite discussions for these MCOs.

Each section below provides a brief explanation of a compliance with standards focus area, a table identifying any partially or not met findings by program area (BC+ and C4K), and strengths and opportunities for improvement.

Enrollee Rights and Protections

An MCO is responsible to help members understand their rights as well as to ensure those rights are protected. This requires an adequate organizational structure and sound processes that adhere to program requirements and are capable of ensuring members' rights are protected.

Conclusions

All three MCOs fully met all standards in this focus area. Overall, each organization has practices in place that demonstrate the MCO values and supports members' rights.

Strengths

- All three organizations exhibit a strong organizational focus on cultural diversity and inclusiveness.
- The MCOs are member-focused in organizational values and operations.

Opportunities for Improvement

- One organization should revise its advance directives policy and procedure to include the process for updating written information to reflect changes in state law as soon as possible (but not later than 90 days after the effective date of the change).

Quality Assurance and Performance Improvement

An MCO must provide members timely access to high quality health care services by developing and maintaining the structure, operations, and processes to ensure:

- Availability of accessible, culturally competent services through a network of qualified service providers;
- Coordination and continuity of member care;
- Timely authorization of services and issuance of notices to members;
- Timely enrollments and disenrollments;
- An ongoing program of quality assessment and performance improvement; and
- Compliance with other requirements.

Results

The following table lists the standards in the "Quality Assessment and Performance Improvement" focus area, by program, that were not fully met, along with the number of MCOs with a partially met or not met finding.

Quality Assessment and Performance Improvement Standards Not Fully Met – BC+

#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement	BC+ FY 15-16 Rating and Number of MCOs	
		Partially Met	Not Met
3	**42 CFR 438.206** ***Timely access*** The MCO must: • Require its providers to meet state standards for timely access to care and services, taking into account the urgency of need for services; • Ensure that the network providers offer hours of operation that are not less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees; • Make services available 24 hours a day, 7 days a week when medically necessary; • Establish mechanisms to ensure compliance by providers; • Monitor providers regularly to determine compliance; • Take corrective action if there is a failure to comply.	1	0
7	**42 CFR 438.210** ***Authorization of services*** For processing requests for initial and continuing authorizations of services, the MCO must: • Have in place and follow written policies and procedures; • Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; • Consult with the requesting provider when appropriate; • Ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.	1	0
8	**42 CFR 438.210** Each MCO contract must provide for the following decisions and notices: <u>*Standard authorization decisions:*</u> For standard authorization decisions, provide notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if— • The enrollee, or the provider, requests extension; or • The MCO justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest. <u>*Expedited authorization decisions:*</u>	1	0

#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement	BC+ FY 15-16 Rating and Number of MCOs	
		Partially Met	Not Met
	For cases in which a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 3 working days after receipt of the request for service. • The MCO may extend the 3 working days time period by up to 14 calendar days if the enrollee requests an extension, or if the MCO justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.		
17	**42 CFR 438.240** **DHS-MCO Contract Article IV.** The MCO has an ongoing quality assessment and performance improvement (QAPI) program for the services it furnishes to its enrollees which meets at a minimum the following requirements outlined in the DHS-MCO contract: • Designates a senior executive to be responsible for the operation and success of the QAPI program; • Includes a QAPI Committee, whose membership is interdisciplinary and comprised of both providers and administrative staff including those specializing in mental health or substance abuse and dental care on a consulting basis when an issue related to these areas arises, a variety of medical disciplines, a psychiatrist and an individual with specialized knowledge and experience with persons with disabilities, and MCO management or governing body; • Has a system to receive member input on quality improvement, document the input received, document the MCO's response to the input, including a description of any changes or studies it implemented as a result of the input, and document feedback to members in response to input received; • Integrates QAPI activities of the MCO's providers and subcontractors into the QAPI program, if separate from the MCO's QAPI activities; • Develops a work plan which outlines the scope of activities, goals, objectives, timelines, responsible person, and is based on findings from QAPI program activities; and • Monitors and evaluates the care and services in certain priority clinical and non-clinical areas. • Conducts enrollee satisfaction surveys.	3	0
19	**42 CFR 438.240** The MCO must have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees.	1	0

#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement	BC+ FY 15-16 Rating and Number of MCOs	
		Partially Met	Not Met
20	**42 CFR 438.240** **DHS-MCO Contract Article IV.** The MCO has in effect a process for an annual written evaluation of the impact and effectiveness of its quality assessment and performance improvement program, to determine whether the program has demonstrated improvement, where needed, in the quality of care and service provided to its enrollees.	2	1

Quality Assessment and Performance Improvement Standards Not Fully Met – C4K

#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement	C4K FY 15-16 Rating and Number of MCOs	
		Partially Met	Not Met
1	**42 CFR 438.206** *Delivery network* The MCO maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, the MCO site must consider: • Anticipated Medicaid enrollment; • Expected utilization of services, considering Medicaid enrollee characteristics and health care needs; • Numbers and types (in terms of training, experience and specialization) of providers required to furnish the contracted Medicaid services; • The number of network providers that are not accepting new MCO enrollees; • The geographic location of providers and MCO enrollees, considering distance, travel time, the means of transportation ordinarily used by enrollees, and whether the location provides physical access for enrollees with disabilities; • Experience of providers in caring for children in out-of-home placement; • Ability to provide trauma-informed care in one or more treatment modalities; and • Requirement that it have a written policy for contracting on an ad hoc basis with non-network providers to assure they are Medicaid certified and clear procedures for billing and payment are in place The delivery network provides female enrollees with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.	1	0

#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement	C4K FY 15-16 Rating and Number of MCOs	
		Partially Met	Not Met
3	**42 CFR 438.206** *Timely access* The MCO must: • Require its providers to meet state standards for timely access to care and services, taking into account the urgency of need for services; • Ensure that the network providers offer hours of operation that are not less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees; • Make services available 24 hours a day, 7 days a week when medically necessary; • Establish mechanisms to ensure compliance by providers; • Monitor providers regularly to determine compliance; • Take corrective action if there is a failure to comply.	1	0
7	**42 CFR 438.210** *Authorization of services* For processing requests for initial and continuing authorizations of services, the MCO must: • Have in place and follow written policies and procedures; • Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; • Consult with the requesting provider when appropriate; • Ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.	1	0
8	42 **CFR 438.210** Each MCO contract must provide for the following decisions and notices: <u>*Standard authorization decisions:*</u> For standard authorization decisions, provide notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if— • The enrollee, or the provider, requests extension; or • The MCO justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest. <u>*Expedited authorization decisions:*</u> For cases in which a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum	1	0

#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement	C4K FY 15-16 Rating and Number of MCOs	
		Partially Met	Not Met
	function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 3 working days after receipt of the request for service. • The MCO may extend the 3 working days time period by up to 14 calendar days if the enrollee requests an extension, or if the MCO justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.		
17	42 CFR 438.240 DHS-FCMH Contract Article IX.A. The MCO has a comprehensive quality assessment and performance improvement (QAPI) program that protects, maintains, and improves the quality of care provided to C4K members. The QAPI program should include an ongoing comprehensive QAPI strategy that supports integrated care and comprehensive service delivery, which meets at a minimum the following requirements outlined in the DHS-C4K contract: • Designates a medical director to oversee the C4K QAPI program; • Includes a QAPI Committee, whose membership is interdisciplinary and comprised of both providers and administrative staff including those with expertise in the care of children with chronic conditions, persons who are knowledgeable and familiar with the needs of children in out-of-home placement, qualified professionals specializing in mental health or substance abuse and dental care on a consulting basis when an issue related to these areas arises, a variety of health professionals, a psychiatrist and an individual with specialized knowledge and experience with persons with disabilities, child welfare social workers, other persons who work with children in out-of-home placement in counties in the PIHP's service area, and C4K management or governing body; • Has a system to receive member, out-of-home care providers, and/or birth parents input on quality related issues, document the input received, document the MCO's response to the input, including a description of any changes or studies it implemented as a result of the input, and document feedback to members in response to input received; • Integrates QAPI activities of the MCO's providers and subcontractors into the QAPI program, if separate from the MCO's QAPI activities; • Develops a work plan which outlines the scope of activities, goals, objectives, and timelines for the QAPI program; • Monitors and evaluates important aspects of care and services; and • Demonstrates the capacity to report on enrollee satisfaction, including caregiver, provider, and cross-system level input/feedback where appropriate.	1	0

#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement	C4K FY 15-16 Rating and Number of MCOs	
		Partially Met	Not Met
19	42 CFR 438.240 The MCO must have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees.	1	0
20	42 CFR 438.240 DHS-C4K Contract Article IX.A.(1. and 5.) The MCO has in effect a process for an annual written evaluation of the impact and effectiveness of its quality assessment and performance improvement program, to determine whether the program has demonstrated improvement, where needed, in the quality of care and service provided to its enrollees.	0	1

Conclusions

Findings reflect two of the 21 standards in this focus area were not fully met by any organization, and several other standards were not fully met by one organization. The following recommendations were made to improve structure and operations to address the two standards:

- All three MCOs should ensure the quality program evaluation of the quality, timeliness, and access to care is completed in a timely manner; and
- One MCO should ensure NCQA guidance aligns with DHS-MCO contract requirements prior to revising policies and procedures.

Strengths

- Two organizations use data and results of monitoring to continually assess and improve system performance and member care quality. These organizations also solicited input from staff and providers on a frequent basis, and incorporated feedback into the quality program.
- Open lines of communication exist at all levels within two organizations.
- Two MCOs contract with an external vendor to provide disease management educational materials to members upon request. Each educational module includes a survey for members to complete. Results and feedback are sent to the MCOs for the assessment of member utilization and helpfulness, and identification of member needs for additional information or assistance.
- Since May 2015, two organizations have contracted with a telehealth company, which provides telephone access to physicians for remote medical care. Staff reports the use of this service has facilitated a decrease in emergency room utilization over the past year.
- The provider contracting process at two MCOs incorporates a site visit at least every three years to establish close working relationships with stakeholders, and to provide an opportunity to relay and monitor MCO-provider contract expectations.

- All three MCOs employ a comprehensive approach to verify providers are not excluded from participation in federal health care programs.
- Two MCOs amended the written health needs assessment form (distributed to members when telephonic attempts to complete the form are unsuccessful) to include a list of community and MCO resources along with a request to update contact information, including email addresses, to facilitate member engagement and outreach efforts.
- The process established at one MCO to credential and re-credential providers is thorough, and includes well-documented steps for tracking follow-up actions needed to complete the credentialing or re-credentialing process.
- Another MCO deployed a proactive approach to develop and maintain working relationships with C4K stakeholders to foster collaborative case management efforts.
- The implementation of innovative practices facilitated the improvement of timeliness of care coordination and completion of health needs assessments over the past year at one MCO.
- At one MCO, the use of quality improvement strategies, including root cause analysis, resulted in the identification of opportunities to address barriers to member engagement and outreach efforts.

Opportunities for Improvement

- To fully meet standards related to the quality program, work plan, and annual evaluation, MCOs must comply with the following requirements:
    - All three MCOs should finalize the evaluation of the impact and effectiveness of the quality program prior to the development of the next year's annual quality work plan;
    - All three MCOs should refine goals and objectives for the quality work plan to ensure they are measurable, and progress over time can be quantified; and
    - One MCO should fully implement the use of an audit tool and develop a corresponding procedure to assess the quality and appropriateness of care provided to members, and to ensure consistent application of review criteria for authorization decisions beyond denials.
- One MCO should enhance the quality program description in the following manner:
    - Describe the extensive use of electronic systems to collect and analyze data for process improvement throughout the organization; and
    - Detail the methodology employed to establish goals and objectives for the quality work plan.
- One MCO needs to develop a mechanism to assure a provider's ability to provide trauma-informed care to C4K members.
- Processes need to be amended, established, and/or monitored at one MCO related to the following:

- Alter the decision-making timeframe to align with DHS-MCO contract requirements;
- Formalize the information regarding "just cause" disenrollments into a written policy and procedure; and
- Revise the utilization management policy and procedure to reflect the process for a legal representative of a deceased member's estate to file an appeal.

- Results from an access study need to be analyzed by one MCO to ensure providers are adhering to DHS-MCO contract-specified requirements related to timely access to care and services.
- One MCO should continue to address staffing needs related to the quality improvement department to ensure the organization remains focused on analysis for data driven decisions.

Grievance Systems

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

Results

The table below lists the standards in the "Grievance Systems" focus area, by program, that were not fully met, along with the number of MCOs with a partially met or not met finding.

Grievance Systems Standards Not Fully Met – BC+

#	Grievance System	BC+ FY 14-15 Rating and Number of MCOs	
		Partially Met	Not Met
1	**42 CFR 438.400** **42 CFR 438.402** The MCO must have a grievance and appeal system in place that includes an internal grievance process, an appeal process, and access to the state's Fair Hearing system.	1	0
2	**42 CFR 438.402** ***Authority to file*** The MCO must accept appeals and grievances from enrollees and their preferred representatives, including providers, with the enrollee's written consent. The MCO must follow the state-specified filing timeframes associated with standard and expedited appeals.	1	0

#	Grievance System	BC+ FY 14-15 Rating and Number of MCOs	
		Partially Met	Not Met
9	**CFR 438.408** ***Basic rule*** The MCO has a system in place to dispose of each grievance and resolve each appeal as expeditiously as the enrollee's situation and health condition requires, within established timeframes for standard and expedited dispositions of grievances and appeals. ***Extension of timeframes*** The MCO may extend the timeframes by up to 14 calendar days if: • The enrollee requests the extension; • The MCO shows that there is a need for additional information and how the delay is in the enrollee's interests. ***Requirements following extension*** If the MCO extends the timeframes, it must give the enrollee written notice of the reasons for the delay.	1	0
11	**CFR 438.410** **DHS-MCO Contract Article IX.** The MCO must establish and maintain an expedited review process for appeals, when the MCO determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health, or ability to attain, maintain, or regain maximum function. The MCO must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a enrollee's appeal. If the MCO denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the timeframe for standard resolution; • Make reasonable efforts to give the enrollee prompt oral notice of the denial and follow up within 72 hours with a written notice.	1	0
14	**CFR 438.420** ***Continuation of benefits*** The MCO must continue the enrollee's benefits if the: • Enrollee or provider files the appeal timely; • Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; • Services were ordered by an authorized provider; • Original authorization has not expired; • Enrollee requests the extension of benefits. ***Duration of continued benefits or reinstated benefits***	1	0

#	Grievance System	BC+ FY 14-15 Rating and Number of MCOs	
		Partially Met	Not Met
	If the enrollee requests, the MCO must continue or reinstate benefits until: • The enrollee withdraws the appeal; • Ten days pass after the MCO mails the notice which provides the resolution of the appeal adverse to the enrollee, unless the enrollee, within the 10-day timeframe, has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached; • A State Fair Hearing Office issues a hearing decision adverse to the enrollee; • The time period or service limits of a previously authorized service has been met.		
15	**CFR 438.420** ***Enrollee responsibility for services while the appeal is pending*** If the final resolution of the appeal is adverse to the enrollee, the MCO may recover the cost of services furnished to the enrollee while the appeal is pending to the extent they were furnished solely because of the requirements of this section.	1	0
16	**CFR 438.424** ***Services not furnished while the appeal is pending*** If the MCO or the State Fair Hearing Officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires. ***Services furnished while the appeal is pending*** If the MCO or the State Fair Hearing Officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the MCO must pay for those services, in accordance with State policy and regulations.	1	0

Grievance System Standards Not Fully Met – C4K

#	Grievance System	C4K FY 14-15 Rating and Number of MCOs	
		Partially Met	Not Met
1	**42 CFR 438.400** **42 CFR 438.402** The MCO must have a grievance and appeal system in place that includes an internal grievance process, an appeal process, and access to the state's Fair Hearing system.	1	0
2	**42 CFR 438.402** ***Authority to file***	1	0

#	Grievance System	C4K FY 14-15 Rating and Number of MCOs	
		Partially Met	Not Met
	The MCO must accept appeals and grievances from enrollees and their preferred representatives, including providers, with the enrollee's written consent. The MCO must follow the state-specified filing timeframes associated with standard and expedited appeals.		
9	**CFR 438.408** ***Basic rule*** The MCO has a system in place to dispose of each grievance and resolve each appeal as expeditiously as the enrollee's situation and health condition requires, within established timeframes for standard and expedited dispositions of grievances and appeals. ***Extension of timeframes*** The MCO may extend the timeframes by up to 14 calendar days if: • The enrollee requests the extension; • The MCO shows that there is a need for additional information and how the delay is in the enrollee's interests. ***Requirements following extension*** If the MCO extends the timeframes, it must give the enrollee written notice of the reasons for the delay.	1	0
11	CFR 438.410 **DHS-C4K Contract Article VIII.B.(1.-2.)** The MCO must establish and maintain an expedited review process for appeals, when the MCO determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health, or ability to attain, maintain, or regain maximum function. The MCO must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an enrollee's appeal. If the MCO denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the timeframe for standard resolution; • Make reasonable efforts to give the enrollee prompt oral notice of the denial and follow up within 72 hours with a written notice.	1	0
14	CFR 438.420 *Continuation of benefits* The MCO must continue the enrollee's benefits if the: • Enrollee or provider files the appeal timely; • Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; • Services were ordered by an authorized provider;	1	0

#	Grievance System	C4K FY 14-15 Rating and Number of MCOs	
		Partially Met	Not Met
	• Original authorization has not expired; • Enrollee requests the extension of benefits. *Duration of continued benefits or reinstated benefits* If the enrollee requests, the MCO must continue or reinstate benefits until: • The enrollee withdraws the appeal; • Ten days pass after the MCO mails the notice which provides the resolution of the appeal adverse to the enrollee, unless the enrollee, within the 10-day timeframe, has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached; • A State Fair Hearing Office issues a hearing decision adverse to the enrollee; • The time period or service limits of a previously authorized service has been met.		
16	CFR 438.424 *Services not furnished while the appeal is pending* If the MCO or the State Fair Hearing Officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires. ***Services furnished while the appeal is pending*** If the MCO or the State Fair Hearing Officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the MCO must pay for those services, in accordance with State policy and regulations.	1	0

Conclusions

Two MCOs met all the standards in the focus area. Overall, review findings indicate all three organizations value and support members' access to grievance systems. However, results identify that one MCO needs to focus on revising policies and procedures to comply with DHS-MCO contract requirements, and ensure member access to the MCO level appeal committee.

Strengths

- Staff at all three organizations described the approach to grievance systems as supportive of members' access to this process and expressed a commitment to negotiation.

Opportunities for Improvement

- One MCO needs to ensure member access to the MCO level appeal committee when services have been denied, limited, terminated, reduced, or suspended.

- Appeal and grievance policies and procedures need to be revised at one MCO to include contract-required elements, and the applicable program/line of business.

Information Systems Capability Assessment

The information systems capability assessment (ISCA) is a mandatory review activity which assesses MCO compliance with federal regulations and DHS-MCO contract expectations that MCOs maintain a health information system which can collect, analyze, integrate, and report data.

ISCAs occur every three years for non-accredited MCOs. During FY 15-16, at the direction of DHS, MetaStar conducted an ISCA for CW, CCHP, GHC-EC, and Compcare. One MCO, CW, also operates other Medicaid programs (Family Care and Family Care Partnership).

To conduct the assessment, each MCO (and its vendors, if applicable) completed a standardized ISCA tool, and provided data and documentation to describe its information management systems and practices. Reviewers evaluated this information and visited each MCO to conduct staff interviews and observe demonstrations. See Appendix 1 for more information about the review methodology.

Results and Conclusions

Overall, the reviews found all four MCOs have the basic systems, resources, and processes in place to meet DHS' requirements for oversight and management of services to members and support of quality and performance improvement initiatives.

Progress

One organization was new to serving SSI members and therefore this was its first ISCA. Three organizations demonstrated progress from their previous ISCA in different areas of the review as follows:

- One MCO:
  - Resolved enrollment count differences/lags, and aligned member numbers with those of DHS;
  - Increased the rate of electronic submission from 87 percent to a range of 93 to 96 percent, depending on the provider type;
  - Developed better linkages between in-house databases and a third party administrator claim processing system, to ensure synchronization of provider information and improve claims processing;
  - Identified hierarchies and relationships in flowcharts; and
  - Developed policies and procedures for destruction and shredding of discarded hard drives and paper documents.
- Two other MCOs implemented processes to ensure enrollment accuracy.

Strengths

The 2016 ISCA review found the MCOs exhibited strengths in the following areas:

- All four MCOs indicated a smooth transition from International Classification of Diseases (ICD) version 9 to ICD-10.
- Three MCOs implemented standardized, automatic volume checks and other comparisons to ensure the completeness of data before and after encounter data submission to DHS.
- Three MCOs implemented security features:
    - One MCO implemented a triage for identifying and prioritizing external threats to its electronic mail and other communications;
    - Two MCOs implemented processes to proactively deter breaches of protected health information (PHI) using a variety of approaches, such as:
        - Deployed a systematic, manual processes to review outgoing staff email for PHI, and implemented a high threshold for what is considered PHI, such as claims numbers, via email;
        - Removed the ability for employees to access web-based file sharing providers; and
        - Added preventing targeted/spear phishing attacks to employee security training.
- Three MCOs updated their staffing models to supplement existing positions:
    - Two MCOs created an encounter data specialist position to correct errors found in the *Acknowledgement for Health Care Insurance* (999) report, the Health Insurance Portability and Accountability Act (HIPAA) transaction that identifies the syntactical and relational analysis of HIPAA guidelines or acknowledges the receipt of an error-free transaction; and
    - One MCO created a mobile device manager position responsible for mobile security, to accommodate the expanding utilization of mobile devices by their decentralized staff.
- One MCO proactively monitored vendor relationships and capabilities, and made changes in vendors when needed.
- One MCO updated policies and procedures to ensure all portable media containing PHI, including paper documents, are used and handled in compliance with federal and state privacy and security requirements.
- One MCO proactively evaluated its systems' performance, capacity, and cost-effectiveness against internal and external needs and requirements.
- Two MCOs maintain all member information in one system to reduce data interfacing and merging.
- Two MCOs generate and send notification letters to members at risk of losing Medicaid eligibility.

- Two MCOs implemented a process for expediting claims processing for urgent claims when the national provider identifier (NPI) number is missing; staff fill in the NPI number overnight to resolve the issue so that the claim can be processed.
- One MCO developed a plan for integrating physical health services care management data with behavioral health care management.
- One MCO created tip sheets with step-by-step instructions for providers who utilize or plan to utilize the organization's provider portal.

Opportunities for Improvement

The MCOs' information systems are architected and implemented differently by each organization; therefore, opportunities for improvement are individualized to each MCO as follows:

- One MCO should:
    - Consider creating and maintaining a security access matrix by function, unit, and other applicable parameters.
    - Conduct a primary source check on a sample of providers to verify vendor findings.
    - Document, through policies and/or procedures, the following:
        - Checking the accuracy of eligibility and enrollment/disenrollment;
        - Training for encounter data file creation;
        - Creating reports for results of any reconciliation with source systems and data entry audits;
        - Retaining records beyond the record retention schedule;
        - Developing vendor oversight policies and procedures related to vendor staff turnover; and
        - Ensuring timely entry of data into a credentialing system and the claims processing system.
- One MCO should:
    - Evaluate processes to identify automation opportunities to further validate the encounter files; and
    - Develop documentation that clearly depicts and describes the roles and responsibilities of staff in management and operation of its programs, including:
        - Representation of the relationships among key individuals/departments, and oversight of contracted vendors; and
        - An encounter data flowchart that documents the responsibilities of all relevant parties and ensures the processes are clearly understood.
- One MCO should:
    - Document, through policies and/or procedures, the following:

        - Collecting member co-payments and incorporating them into the encounter data submission;
        - Standard onboarding and ongoing training for encounter data staff; and
        - Implementing policy and procedures for internal audits of the encounter data created and submitted by the third party administrator.
    - Strengthen vendor oversight though performance guarantees, including assurances and benchmarks for performance quality.
    - Reconcile paid claims with the encounter data sent by the third party administrator to DHS.
    - Consider implementing preventive edits to reduce the number of rejected claims and rejected encounters due to missing critical information such as NPI, taxonomy, tax ID, and procedure and diagnosis codes.

VALIDATION OF PERFORMANCE MEASURES

MetaStar validated a set of performance measures that were selected by DHS. These measures consisted of Healthcare Effectiveness Data and Information Set (HEDIS) measures, HEDIS-like measures, and Medicaid Encounter Data Driven Improvement Core Measure Set (MEDDIC-MS) measures. The validation review was conducted to evaluate the accuracy of Medicaid performance measures reported, and to determine the extent to which the measures were calculated according to specifications established by DHS. The performance measures are publically reported; therefore, accuracy and integrity are critical characteristics. Please refer to Appendix 1 for more information about the review methodology.

In addition to using this data to meet CMS performance measures requirements, DHS also uses the information to set and monitor quality performance benchmarks with each individual MCO. DHS has established pay for performance (P4P) incentives as a performance improvement strategy for MCOs to improve priority HEDIS scores as well as performance for other measures identified by DHS. This strategy is a key component of the DHS annual quality plan. The strategy links the mandatory Protocol 2 review described in this report with some of the performance improvement project (PIP) requirements for MCOs.

For measurement year 2014 (MY 14) data, MetaStar validated 13 performance measures each for 16 MCOs providing health care services for the BC+ program populations, and eight performance measures each for seven MCOs providing health care services for those who receive SSI-related Medicaid.

Results

MetaStar found that all performance measures were accurately reported and followed State specifications and reporting requirements. Below is more information about the findings from the review.

Performance Measure Documentation Review

MetaStar reviewed information related to encounter data, eligibility and enrollment data, provider databases, and the Wisconsin Immunization Registry, and found that all critical elements for HEDIS, HEDIS-like, and MEDDIC-MS performance measure calculations are present.

MetaStar received and reviewed all related performance measure documentation from Hewlett Packard Enterprise (HPE), the vendor of the Medicaid Management Information System, which included Project Charters, data extraction and analysis plans, member output files, work flow diagrams, measure rate calculations and other related documentation. The information in the Project Charter, source code, data extraction and analysis plan, and measure technical

specifications should align. Throughout the review process, MetaStar and DHS reviewed and compared the current rates to the rates from the previous two years. As a result of this work, a minor discrepancy was found with the Ambulatory Care (AMB) measure; denied claims were not excluded, which led to a higher than expected rate. Findings were communicated to and addressed by DHS and HPE. Prior to performance measure calculation, HPE's revised documentation was reviewed by MetaStar, and approved and signed by DHS.

Measure Specifications, Calculated Rates, and Comparisons

MCOs provided certain performance measure data and rates that were previously audited through the HEDIS process. For these measures, each MCO provided DHS with its HEDIS reports, data sets, and audit review tables. DHS then provided this information to MetaStar for review. The information was reviewed to determine if there was a potential for any negative impact on the reported measures. The validated HEDIS performance measure data was analyzed and aggregated to draw conclusions on trends and outliers. MetaStar confirmed that the HEDIS measures reported by MCOs met specifications and were appropriately calculated.

As mentioned earlier in this report, HPE calculated HEDIS-like measures for BC+ and all measures for SSI. MetaStar confirmed that measures calculated by HPE met specifications for the appropriate MY.

MetaStar used available, publicly reported rates and benchmarks as comparisons for validating the HPE calculated rates of performance measures. Whenever possible, nationally recognized NCQA data is used. However, submission of HEDIS data to NCQA is a voluntary process; therefore, health plans that submit HEDIS data are not fully representative of the industry. Health plans participating in NCQA HEDIS reporting tend to be older, are more likely to be federally qualified, and are more likely to be affiliated with a national managed care company than the overall population of health plans in the United States. Comparative findings were reported to DHS and HPE, and are listed in Appendix 1.

Conclusions

The performance measures for MY 14 are accurate and follow state specifications for calculation and reporting. Specific progress, strengths, and opportunities for improvement are provided below.

Progress

- HPE continued to create Data Extraction and Analysis Plans for each measure under review. Electronic flowcharts, data dictionaries, and specific information, such as numerator-compliant definitions, were included for each measure. The numerator-compliant definitions were an additional source MetaStar used to determine validity in

the eligible population for numerator compliance that increased the confidence in the appropriate coding methodologies.
- MetaStar and HPE continued to communicate with DHS early in the review process. Measures were reviewed during ongoing code review sessions, which enhanced performance measure specification knowledge among all parties and ensured that final calculations met specifications.

Strengths

The following strengths were identified in the validation of MY 14 performance measures:

- Similar to last year, DHS provided a comprehensive programming guide for each measure under review, including coding methodology, measurement targets, and operational details needed for calculating and reporting performance measures.
- HPE continued to provide Project Charters for each measure and each charter was reviewed by the group, approved, and signed by DHS.
- DHS, MetaStar, and HPE used a structured process for document review and communication with defined roles, responsibilities, and timelines.
- While some of the HPE programmers were new to their roles, they had several years' experience in program development, and provided a comprehensive system demonstration and process walkthrough.
- HPE provided DHS and MetaStar with complete programming code for each measure. Coding specifications were reviewed during data quality reviews.

Opportunities for Improvement

Following are recommendations to improve performance measure calculation and reporting:

- As recommended last year, continue to improve and standardize naming conventions for all documents exchanged during the validation process. Include the correct measure abbreviation, measurement, and reporting years when naming files and labeling fields in documents.
- Incorporate all data requirements, such as claims paid or denied status, when calculating specific measures.
- Include only the required populations in the reported measures.
- Provide a comprehensive list of members in the numerator at the time of the code review to validate eligibility.
- If possible, include numerator positive claims, in order to conduct primary source verification for each measure.
- Continue to use HEDIS Value Sets for simplification when calculating HEDIS-specific measures.

- DHS should ensure that both ICD-9 and ICD-10 diagnosis codes are being captured for the review in subsequent years.
- DHS should continue to monitor HEDIS measure specification changes and determine the impact to performance measure reporting and comparisons, especially related to ICD-10 implementation.
- DHS should continue to monitor developments in other measure reporting initiatives to identify opportunities to create efficiencies for performance measure calculation and reporting, as well as opportunities related to quality of care oversight.

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

This section of the report aggregates and summarizes the results of 34 PIPs conducted during calendar year 2014 (CY 14) by 17 MCOs participating in the Wisconsin BC+ and/or SSI Medicaid program. Also included is one PIP each conducted by two SMCPs during CY 15. All 36 PIPs were validated in FY 15-16.

DHS requires MCOs and SMCPs to submit each PIP project for pre-approval by providing a preliminary summary which states the proposed topic, study question, and a brief description of the planned interventions and study design. Both DHS and the EQRO review the PIP preliminary proposals; DHS determines if the selected topic is aligned with Department goals, and the EQRO reviews the methodology and study design proposed by the MCO.

Two additional MCOs began serving members in April 2014; CW (SSI) and Trilogy (SSI and BC+). The MCOs are not listed in the table below, as DHS did not require them to complete PIPs during CY 14. Both MCOs submitted PIP proposals, received approval, and began implementation. The projects continued for CY 15 and will be validated during the next fiscal year.

AGGREGATE RESULTS FOR PERFORMANCE IMPROVEMENT PROJECTS

The table below lists each PIP standard that was evaluated for each MCO and SMCP and indicates the number of projects meeting each standard. Some standards were not applicable to all projects, due to the study design or lack of quantitative improvement.

FY 15 -16 Performance Improvement Project Validation Results

		Numerator = Number of projects meeting the standard Denominator = Number of projects applicable for the standard
Study Topic(s)		
1	The topic was selected through MCO data collection and analysis of important aspects of member needs, care, or services.	34/36
Study Question(s)		
2	The problem to be studied was stated as a clear, simple, answerable question(s) with a numerical goal and target date.	35/36
Study Indicator(s)		
3	The study used objective, clearly and unambiguously defined, measureable indicators and included defined numerators and denominators.	34/36
4	Indicators are adequate to answer the study question, and measure changes in any of the following: health or functional status, member satisfaction, processes of care with strong associations with improved outcomes.	35/36
Study Population		
5	The project/study clearly defined the relevant population (all members to whom the study question and indicators apply).	34/36
6	If the entire population was used, data collection approach captured all members to whom the study question applied.	32/36

	Numerator = Number of projects meeting the standard Denominator = Number of projects applicable for the standard	
Sampling Methods		
7	Valid sampling techniques were used.	1/1
8	The sample contained a sufficient number of members.	1/1
Data Collection Procedures		
9	The project/study clearly defined the data to be collected and the source of that data.	35/36
10	Staff are qualified and trained to collect data.	34/36
11	The instruments for data collection provided for consistent, accurate data collection over the time periods studied.	35/36
12	The study design prospectively specified a data analysis plan.	31/36
Improvement Strategies		
13	Interventions were selected based on analysis of the problem to be addressed and were sufficient to be expected to improve outcomes or processes.	32/36
14	A continuous cycle of improvement was utilized to measure and analyze performance, and to develop and implement system-wide improvements.	22/36
15	Interventions were culturally and linguistically appropriate.	28/36
Data Analysis and Interpretation of Study Results		
16	Analysis of the findings was performed according to the data analysis plan, and included initial and repeat measures, and identification of project/study limitations.	25/36
17	Numerical results and findings were presented accurately and clearly.	29/36
18	The analysis of study data included an interpretation of the extent to which the PIP was successful and defined follow-up activities as a result.	29/36
"Real" Improvement		
19	The same methodology as the baseline measurement was used, when measurement was repeated.	28/36
20	There was a documented, quantitative improvement in processes or outcomes of care.	16/36
21	The reported improvement appeared to be the result of the planned quality improvement intervention.	10/21
Sustained Improvement		
22	Sustained improvement was demonstrated through repeated measurements over comparable time periods.	4/10

PROJECT INTERVENTIONS AND OUTCOMES

The table below is organized by topic and lists each health plan's project, the interventions selected, project outcomes at the time of the validation, an overall validation result, and EQR recommendations. Additional information may be found in each organization's PIP validation report.

Project Interventions and Outcomes

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
Ambulatory Care - Adults and Children				
GHC-SCW	Conducted member outreach via phone calls and mailings.	Project did not demonstrate improvement.	Not Met	Include data from the organization when describing study topic. Identify indicators that accurately reflect the

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
				study question and can be used effectively for data analysis. Specify the data analysis plan. Address cultural or linguistic appropriateness of interventions. Ensure that all data figures are presented clearly and accurately throughout the report.
PPIC	Provided telephonic outreach to members for assessment and education.	MCO reported improvement; however, study limitations were not taken into consideration in data analysis. Quantitative improvement cannot be confirmed.	Partially Met	Conduct continuous cycles of improvement if interventions aren't effective. Analyze data periodically as planned, taking study limitations into consideration. Ensure repeat measures are comparable to initial measures.
Antidepressant Medication Management – Adults Only				
GHC-SCW	Conducted member outreach via phone calls and mailings. Contacted providers to determine if intervention would be inappropriate or contraindicated.	Project demonstrated improvement: improved the antidepressant medication management rates for effective continuation phase, from 25 percent in 2012 to 49 percent in 2014.	Partially Met	Include information about responsible staff and qualifications for data collection. Specify the data analysis plan. Address cultural or linguistic appropriateness of interventions.

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
Breast Cancer Screening – Adults Only				
Compcare	Conducted member outreach via phone calls and mailings. Implemented incentive gift cards for completing mammography screening.	Although the project did not demonstrate quantitative improvement, it was methodologically sound.	Met	Ensure population size provides adequate numbers to show significant improvement.
DHP	Implemented and expanded telephonic and written outreach. Engaged with Wisconsin Breast Cancer Task Force. Mailed mammogram publications.	The project did not demonstrate improvement.	Partially Met	Conduct ongoing continuous cycles of improvement if interventions are not effective. Ensure baseline and repeat measurement data are comparable.
GHC-EC	Conducted member outreach via phone calls and mailings. Implemented incentive gift cards for completing mammography screening.	Project demonstrated "real" improvement: increased mammography screening rates in SSI population from 59 to 71.75 percent, and in BC+ population from 61.70 to 69.81 percent.	Met	Measure effectiveness of each intervention. Repeat measures after quantitative improvement has been achieved to demonstrate sustainability.
HTHP	Conducted member outreach via phone calls, mailing, and community events. Educated providers and shared member-specific results via letters and phone contact.	Project demonstrated "real" improvement: increased the percent of BC+ females who received their mammogram from 63.14 percent to 71.76 percent.	Met	Include data to demonstrate improvement was a result of the interventions. Continue implementation of additional interventions as planned, to demonstrate sustained improvement.
PPIC	Conducted outreach via phone calls and reminder letters to members.	Project reported improvement in screening rates from 81.97 percent in 2013 to 87.88 percent in 2014. However, confidence in results is limited, due to small study population and inability to determine	Partially Met	Ensure data collection approach captures all members of the population. Document continuous improvement efforts in the report.

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
		consistent methodology.		Fully analyze data and identify follow-up actions. Include data to demonstrate effectiveness of the intervention.
Unity	Implemented a process for enhanced tracking and reporting. Conducted member outreach via phone calls, mailings, and home or clinic visits. Surveyed members to gather information about the effectiveness of interventions.	Project demonstrated "real" improvement: increased screening rates from 60.81 percent in 2011 to 70.0 percent in 2014. Also, demonstrated sustained improvement with repeat measures.	Met	Continue to sustain the level of improvement that has been achieved.
Childhood Immunization Status – Children Only				
Anthem	Conducted member outreach via phone calls and mailings. Implemented an incentive program for well-child visits that included completing immunizations. Shared member-specific results regarding immunization status with providers.	Project demonstrated "real" improvement: increased the rate of immunizations from 72.85 percent to 76.57 percent.	Met	Identify follow-up actions or next steps for the project. Include data to demonstrate the effectiveness of the interventions. Document continuous improvement efforts in the report. Obtain repeat measures after quantitative improvement has been achieved to demonstrate sustainability.
Comprehensive Diabetes Care - Adults only				
Compcare	Conducted diabetic member outreach via phone calls and mailings. Implemented incentive gift cards for completing low density	Project demonstrated "real" improvement: increased LDL screening rates in SSI population from 75 to 85 percent, and in BC+ population from 69.3 to 81.2 percent.	Met	Measure effectiveness of each intervention. Repeat measures after quantitative improvement has been achieved to

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
	lipoprotein (LDL) testing.			demonstrate sustainability.
GHC-EC	Conducted diabetic member outreach via phone calls and mailings. Implemented incentive gift cards for completing LDL testing.	Project demonstrated "real" improvement: increased LDL screening rates in SSI population from 69.5 to 85.3 percent, and in BC+ population from 71.10 to 83.62 percent.	Met	Measure effectiveness of each intervention. Repeat measures after quantitative improvement has been achieved to demonstrate sustainability.
*i*Care	Outreached to members via letters and general information.	Project did not demonstrate improvement.	Partially Met	Select interventions which address root causes or barriers. Conduct continuous cycles of improvement if interventions are not effective. Address cultural and linguistic appropriateness of interventions.
MHS	Encouraged compliance with LDL-C screening. Referred members to telephonic disease management program. Provided telephonic outreach and in-home lab draws.	The LDL-C screening rates improved from baseline 2012, but did not improve compared to 2013 rates.	Partially Met	Document continuous cycles of improvement in the report. Ensure data is accurate. Include data to demonstrate the effectiveness of the interventions.
MHWI	Conducted member outreach via mailings and phone calls. Engaged with and provided education to physicians. Held member outreach events with onsite services and giveaways.	Hemoglobin (HbA1c) and LDL testing rates improved for the BC+ population from 2013 to 2014 (HbA1c: 80.5 percent to 86.2 percent; LDL: 67.1 percent to 75.3 percent). The HbA1c and LDL testing rates declined for the SSI population from 2013 to 2014 (HbA1c: 71.65 percent to 69.71 percent; LDL:	Partially Met	Include measurable goals for all study questions. Define indicators, including numerators, denominators, and the study population. Define data sources for all measures. Specify the data analysis plan.

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
		61.83 percent to 59.13 percent).		Fully analyze data and identify follow-up actions. Ensure repeat measures are comparable to initial measures.
NHP	Encouraged by Case Manager to comply with LDL-C screening. Referred members to telephonic disease management program. Provided telephonic outreach and in-home lab draws.	The LDL-C screening rates improved from baseline 2012, but did not improve compared to 2013 rates.	Partially Met	Document continuous improvement efforts in the report. Ensure data is accurate. Include data to demonstrate effectiveness of the interventions.
SHP	Conducted member outreach via phone and mailings. Educated members and providers through newsletter articles.	Project did not demonstrate improvement.	Partially Met	Describe how interventions were selected. Conduct continuous cycles of improvement if interventions are not effective. Analyze effectiveness of interventions.
UHC	Conducted member outreach via phone calls and mailings. Educated providers and shared member-specific results. Implemented member and provider incentive programs for successful LDL screening. Offered home lab draws for LDL screening.	Project did not demonstrate improvement.	Partially Met	Analyze data on a periodic basis and relate analysis to the study question. Measure effectiveness of interventions.
Unity	Developed a process to enhance tracking and reporting.	Project demonstrated “real” improvement by improving the screening rate from 72.65 to 83.16	Met	Include all data measures in the report.

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
	Conducted member outreach via phone calls, mailings, and clinic or home visits. Worked with providers to obtain doctor orders for testing. Implemented member incentive programs.	percent, surpassing the goal of 80.2 percent. Also, demonstrated sustained improvement with repeat measures.		Continue to sustain the level of improvement that has been achieved.
Follow-up after Hospitalization for Mental Illness – Adults and Children				
*i*Care	Continued strategies from prior years such as operation of dedicated team, coordination of care, and education of providers. Enhanced electronic documentation to capture additional member outreach to members 19 years of age and older. Engaged network development staff to expand network and educate providers.	Although the project did not demonstrate quantitative improvement, it was methodologically sound.	Met	Select additional interventions which address root causes or barriers. Address cultural and linguistic appropriateness of the interventions.
MCHP	Focused on scheduling follow-up appointments prior to hospital discharge for members six years and older.	Project demonstrated "real" improvement: increased follow-up within 30 days from 76.92% in 2013 to 82.56% in 2014, exceeding the 90th percentile for this measure.	Met	Address cultural or linguistic appropriateness of interventions during the PIP project period.
SHP	Educated staff and providers regarding timely communication and follow-up. Contacted members/parents of members six years of age and older by phone, to encourage follow-up and assist	Project demonstrated "real" improvement: increased follow-up after hospitalization for mental illness within seven days, from 43.97 percent in 2013 to 47.83 percent in 2014.	Met	Continue implementation of additional interventions as planned, to demonstrate sustained improvement.

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
	with arranging appointments. Developed and implemented an intensive behavioral health management system beginning September 2014. Embedded a social work care manager in a network clinic beginning September 2014.			
Prenatal and Postpartum Care – Adults and Pregnant Women				
Anthem	Conducted member outreach via phone calls and mailings. Implemented an incentive program to complete post-partum visits.	Project did not demonstrate improvement.	Partially Met	Clearly and accurately display data. Ensure baseline and repeat measures are comparable. Document continuous improvement efforts in the report. Identify follow-up actions or next steps for the project.
CCHP	Pregnant members were enrolled in a Prenatal Care Coordination program. Reminder postcards and incentives were provided to pregnant members by mail and through key clinics.	Project did not demonstrate improvement.	Partially Met	Conduct a root cause and/or barrier analysis prior to continuing the same interventions for the project.
DHP	Established an Obstetrics Medical Home. Provided mailed publications and web based information to members.	Although the project did not demonstrate quantitative improvement, it was methodologically sound.	Met	Take study limitations into consideration in analysis.
HTHP	Conducted member outreach via phone calls and mailings,	Project demonstrated "real" improvement: increased postpartum	Met	Continue implementation of additional interventions

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
	including a "final outreach attempt" to help coordinate appointments. Collaborated with providers on changing postpartum care practice protocols to align timing of visits with HEDIS specifications. Implemented an incentive program for postpartum visits.	visits, from 81.82 percent in 2012 to 83.49 percent in 2014.		as planned, to demonstrate sustained improvement.
MHWI	Conducted member outreach via phone calls and mailings. Educated providers and held collaborative education sessions. Implemented a Pregnancy Rewards incentive program.	Project did not demonstrate improvement.	Partially Met	Clearly define all indicators. Ensure data collection approach captures all members of the population. Specify a prospective data analysis plan, and analyze data according to the plan. Document continuous improvement efforts in the report. Ensure repeat measures are comparable to initial measures.
Tobacco Cessation – Adults and Pregnant Women				
CCHP	A Striving to Quit informational flyer was included in welcome packets for new members. Members identified as smokers received personal telephone calls.	The study demonstrated sustained improvement by increasing enrollment in Striving to Quit from 152 members in 2013, to 283 by the end of the MY in 2014.	Met	Continue to sustain the level of improvement that has been achieved.
GHP	Conducted member outreach via mailings and newsletters.	Project did not demonstrate improvement.	Partially Met	Define indicators, including numerators and denominators.

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
	Educated and collaborated with providers			Describe how interventions were selected. Conduct and document continuous cycles of improvement. Fully analyze data and identify follow-up actions.
MCHP	Sent one mailing to smokers. Oriented two clinics to the Striving to Quit program.	Project did not demonstrate improvement.	Partially Met	Specify the data analysis plan. Document continuous improvement efforts in the report. Address cultural or linguistic appropriateness of interventions. Develop and implement interventions that are sufficient to be expected to improve outcomes.
MHS	Conducted member outreach via phone calls, welcome packets, mailings, community events, and individual contact. Conducted provider outreach via website, mail, and direct contact from Provider Relations staff.	Striving to Quit enrollment increased from 26 members at the end of 2013 to 61 members at the end of 2014. The project did not demonstrate sustained improvement as a result of the interventions.	Partially Met	Define indicators, including numerators and denominators. Document continuous improvement efforts in the report. Clearly display data.
NHP	Conducted member outreach via phone calls, welcome packets, mailings, community events, and individual contact. Conducted provider outreach via website, mail, and direct	Striving to Quit enrollment increased from 15 members at the end of 2013, to 66 members at the end of 2014. The project did not demonstrate sustained improvement as a	Partially Met	Define indicators, including numerators and denominators. Document continuous improvement efforts in the report. Clearly display data.

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
	contact from Provider Relations staff.	result of the interventions.		
UHC	Conducted member outreach via phone calls and mailings. Educated providers and shared member-specific results. Implemented an incentive program for smoking cessation.	Project demonstrated "real" improvement: by increasing enrollment in Striving to Quit from 121 members in 2013 to 260 by the end of 2014, substantially over the goal. Also, demonstrated sustained improvement with repeat measures.	Met	Continue to sustain the level of improvement that has been achieved.
Well-Child Visits, Advanced Care Planning, and Behavioral Support –Children Only				
GHP	Conducted member outreach via mailings.	Project demonstrated improvement: improved the rate of well-child HealthCheck visits for those members aged 6 to 21, from 59 percent in 2013 to 69 percent in 2014.	Partially Met	Define indicators, including numerators and denominators. Describe how interventions were selected. Document continuous improvement efforts in the report. Analyze data periodically, as planned.
CCF	Educated staff about the interconnectedness of preventative health care and members' care planning. Training emphasized documentation of interactions with the members on plans of care and case notes.	Project did not demonstrate statistically significant improvement in the occurrence of Wellness Keywords in CCF members' plans of care or case notes.	Met	Conduct continuous cycles of improvement if interventions are not effective. Analyze data on a periodic basis.
WM	Revised Provider Resource Guide to increase user friendliness and accessibility to care coordinators and families. Conducted training	Project demonstrated "real" improvement: from 18 (0.009 percent) to 93 (11 percent) families accessing the new guide for increased use of provider resources. However,	Met	Address cultural or linguistic appropriateness of interventions. Analyze data on a periodic basis. Obtain repeat

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
	and orientation for families to increase awareness on use of the Provider Network Resource Guide.	the project did not demonstrate improvement on all three study questions.		measures after quantitative improvement has been achieved to demonstrate sustainability.

Conclusions

Thirty-six PIPs were submitted and validated. MCO projects focused on a variety of health topics, including breast cancer screening, diabetes care, mental health, tobacco cessation, postpartum care, well-child care, immunizations, ambulatory care, and medication usage. SMCP projects focused on advanced care planning and behavioral support for children. Twenty-five of the projects were focused on new topics and 11 continued the same topic from prior years. Five MCOs conducted *Striving to Quit* projects as part of an initiative to target smoking cessation among BC+ members in collaboration with DHS.

Documented, quantitative improvement in processes or outcomes of care was evident in 16 of the 36 validated projects. In 10 of these projects, improvement was demonstrated to be the result of the interventions employed. Based on validation results, four of 36 projects achieved documented, quantitative improvement that was sustained with repeat measures. The overall validation findings provide an indication of the reliability and validity of the projects' results. Seventeen of the projects were rated fully "met," 18 projects were rated "partially met," and one project was rated "not met."

Prior to implementation, all MCOs submitted their PIP project proposals for feedback on the first 12 standards, which relate to the review areas of topic selection, study question, indicators, and study population, sampling methods, and procedures. When the final projects were validated, 14 of 19 MCO/SMCPs fully met these first 12 standards. The most successful projects developed approaches to monitor the effectiveness of interventions, by conducting continuous cycles of improvement and ensuring data collection processes were sound.

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

Strengths

- Projects focused on improving key aspects of care for members.
- The study indicators and study populations were clearly defined overall; standards were fully met for these topics in 15 of 19 organizations' PIPs.
- Standards for data collection procedures were met in 15 of the 19 MCOs, indicating that most projects collected data that was valid and reliable.

- Thirty-four projects described selection of a knowledgeable, qualified team to conduct the study.
- Twenty projects effectively utilized continuous improvement cycles to modify interventions:
    - Fifteen of the 16 projects that accomplished real improvement utilized this practice;
    - Ten of the same projects successfully measured improvement which was the result of the deployed interventions.

Opportunities for Improvement

- When describing the reason for selecting the study topic, include data and information specific to the MCO's members.
- Identify a data analysis plan including interim measures, and specify the frequency data is to be reviewed and by whom.
- Conduct a root cause and/or barrier analysis prior to selecting interventions for the project, in order to choose individualized interventions that are sufficient to achieve the desired outcome.
    - Develop and utilize a quantitative approach for monitoring the effectiveness of interventions.
    - If data shows interventions are not effective, conduct continuous cycles of improvement to identify possible causes, and implement solutions.
- Ensure that numerical data is displayed accurately in the report to reflect any variations in methodology.
- Develop interventions that are culturally and linguistically appropriate, and include relevant documentation in the report.

Care Management Review – Supplemental Security Income Program

Objectives

The CMR portion of the annual quality review determines a MCO's level of compliance with its contract with DHS; ability to safeguard members' health and welfare; and ability to effectively deliver cost effective, outcome-based services. The information gathered during CMR activities helps assess the timeliness and comprehensiveness of the initial health risk assessment (HRA), creation of an individual care plan, member/guardian participation, and services provided for each SSI member. In addition, SSI MCOs are required by contract to meet the minimum threshold of 50 percent combined average rate of timeliness and comprehensiveness for SSI care management assessments.

Scope of the Review and Review Methodology

MetaStar conducted a total of 583 SSI CMRs across all MCOs, per the direction of DHS and according to the sampling methodology used for the reviews. The table below shows the number of CMRs conducted for each organization. CW and Trilogy began operating SSI Medicaid in April 2014. This is the first year that a full sample of records was reviewed for each of these organizations; therefore, no FY 14-15 comparative data for the performance measures are available for these two MCOs.

Records Reviewed for each MCO Serving SSI Recipients in Wisconsin

MCO	Number of Records
CW	87
Compcare	29
GHC-EC	38
*i*Care	85
MHS	83
MHWI	60
NHP	78
Trilogy	58
UHC	65

The CMRs were conducted based on criteria, a review tool, and guidelines approved by DHS. The FY 15-16 review timeframe was extended from nine months to 15 months, so that all members enrolled during the CY would be included in the random sample.

Reviewers conducted the CMRs from December 2015 through February 2016. The time period reviewed was July 1, 2014 to September 30, 2015. The record review did not exceed six months from the date of enrollment for any individual member. Additional information can be found in the "Review Methodologies" section of Appendix 1.

Results

This report aggregates and summarizes the results of FY 15-16 CMR activities and provides comparisons to the results from last year when applicable. The review focuses on three areas of care management practice related to serving new members:

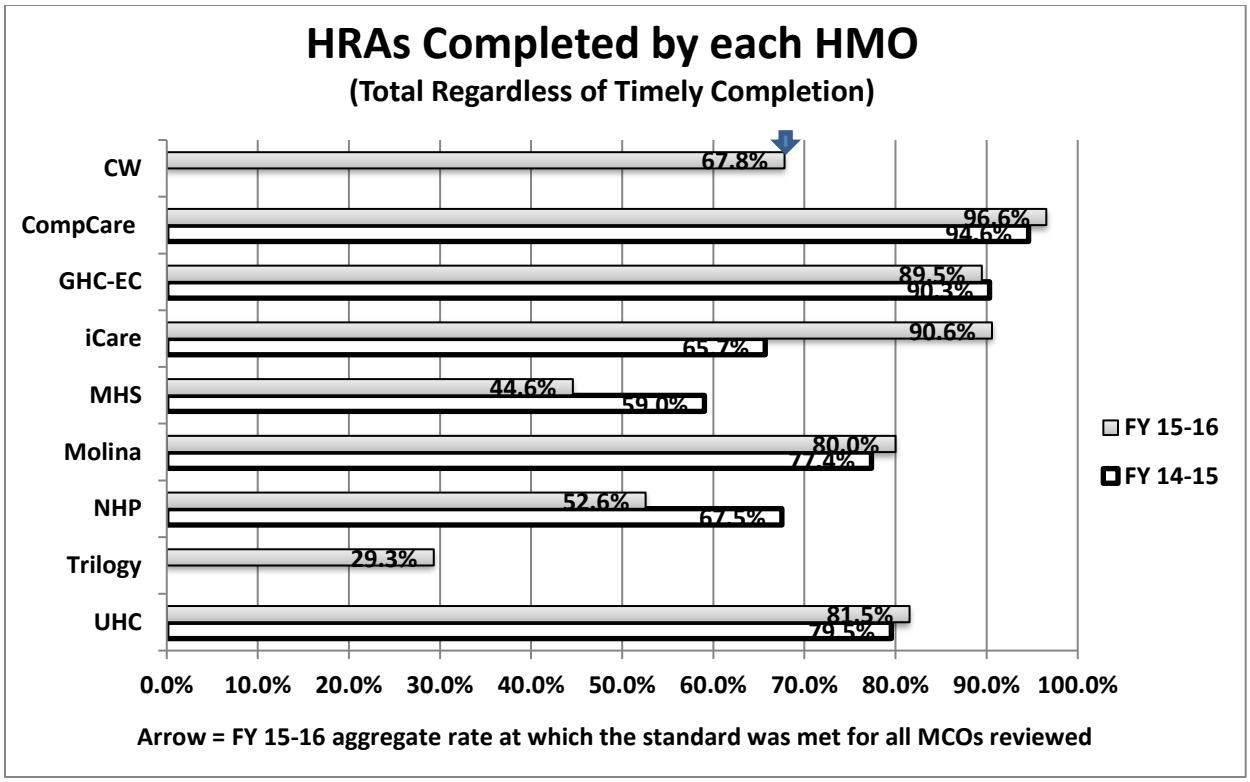
- Assessment;
- Service planning; and
- Service coordination and delivery.

Each section below provides a brief explanation of each CMR measure, followed by a bar graph. The review methodology approved by DHS requires the MCOs to complete an initial HRA within the required timeframe, even when the MCO is unable to contact the member, or a "not met" score is applied by default to the remaining review criteria. Thus, when reviewing and comparing results, the reader needs to consider that the rate of HRA completion affects all of the measures noted in this report.

The number of assessments completed was 394 of 583; 189 assessments were not completed. (The percentages below are rounded to the nearest whole number.)

- One hundred one records (53%) indicated members did not respond after reasonable efforts to contact them were made;
- Nineteen records (10%) noted having inaccurate member contact information and indicated reasonable efforts were made to locate and contact the members;
- Sixty-seven member records (35%) showed minimal effort to complete the assessment within the 60 day timeframe; and
- Two records (1%) contained a case note that an initial HRA was completed, but the MCO could not provide documentation of the actual HRA.

The following graph shows the number of assessments completed regardless of timely completion, and compares the FY 15-16 "HRA completion" rate to the FY 14-15 rate for seven of the nine MCOs. The arrow represents the aggregate rate at which the standard was met in FY 15-16 for all MCOs, a "HRA completion" rate of 68 percent. Analysis indicated the year-to-year difference in the rates for *i*Care is likely attributable to actions of the MCO, and is unlikely to be the result of normal variation or chance.



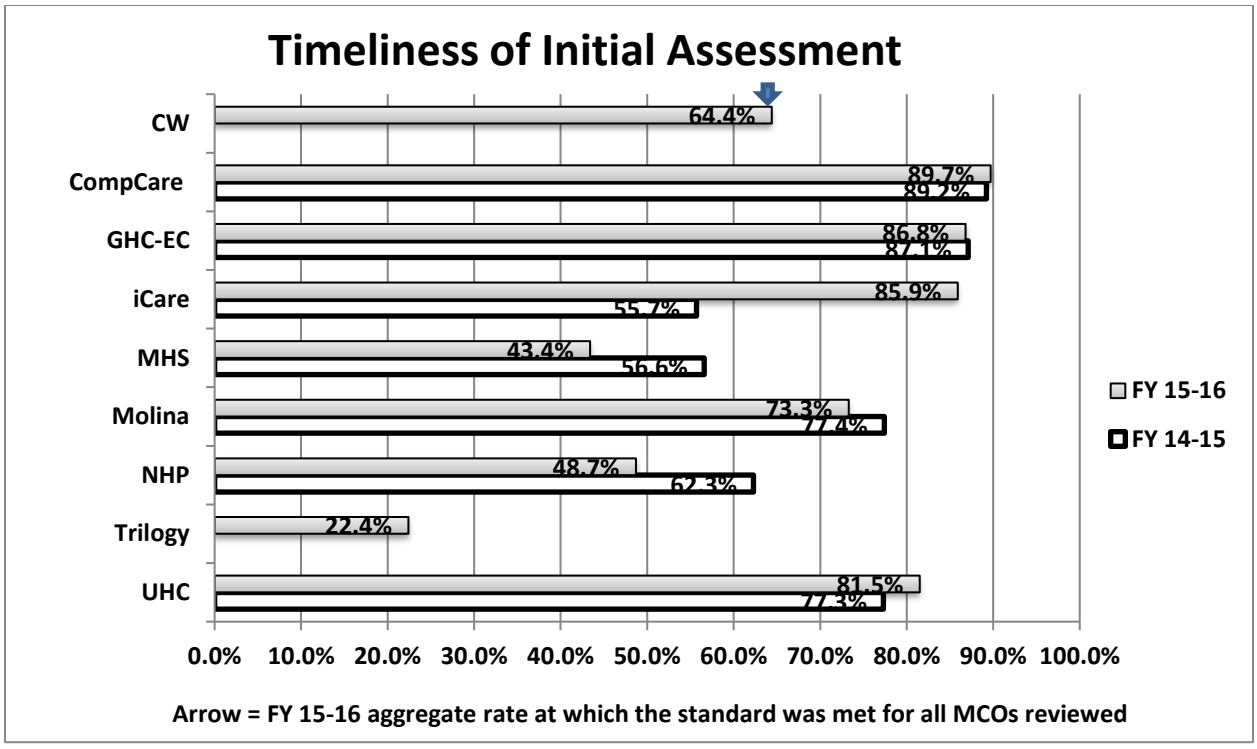
ASSESSMENT

Timeliness and comprehensiveness of initial HRAs are evaluated in the Assessment category. Additionally, these review elements, when combined, represent a P4P measure contained in the DHS-MCO contract.

Timeliness of Initial Assessment

The initial HRA must be completed within 60 days of enrollment using a form approved by DHS.

The graph on the following page depicts the rate of compliance achieved by each MCO in FY 15-16 for the review element, "Timeliness of Initial Assessment," and compares it to the compliance rate achieved for FY 14-15 for seven of the nine MCOs. The arrow represents the aggregate rate at which the standard was met in FY 15-16 for all MCOs, a "Timeliness of Assessment" rate of 64 percent. Analysis indicated the year-to-year difference in the rates for *i*Care is likely attributable to actions of the MCO, and is unlikely to be the result of normal variation or chance.



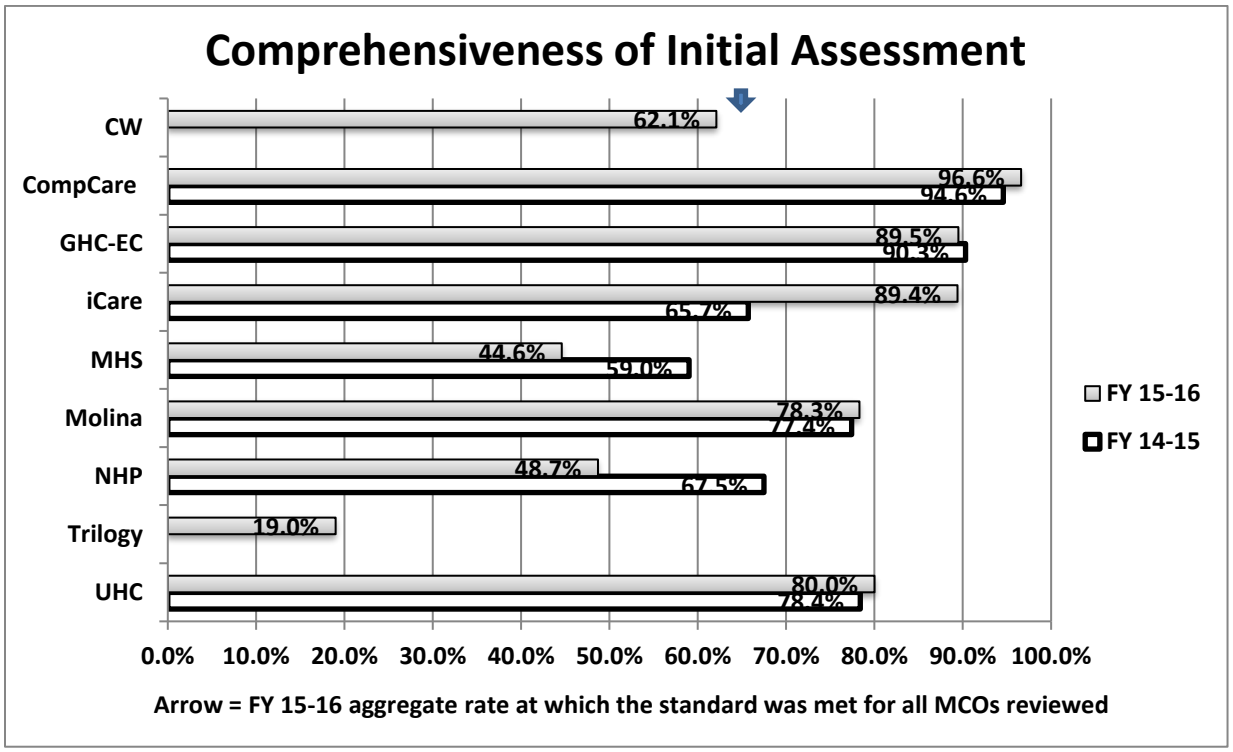
Comprehensiveness of Initial Assessment

The assessment process must be comprehensive. The DHS-MCO contract specifies the elements that must be included in the HRA when assessing members:

- Diagnoses and health-related services;
- Mental health and substance use;
- Demographic information, including ethnicity, education, living situation/housing, legal status;
- Activities of daily living, (including bathing, dressing, eating);
- Instrumental activities of daily living, (including medication management, money management, and transportation);
- Overnight care;
- Employment;
- Communication and cognition (ability to communicate, memory);
- Indirect supports (family, social, and community network); and
- General health goals.

The following graph depicts each MCO's rate of compliance in FY 15-16 for the review element, "Comprehensiveness of Initial Assessment," and compares it to the compliance rate for FY 14-15 for seven of the nine MCOs. The arrow represents the aggregate rate at which the standard

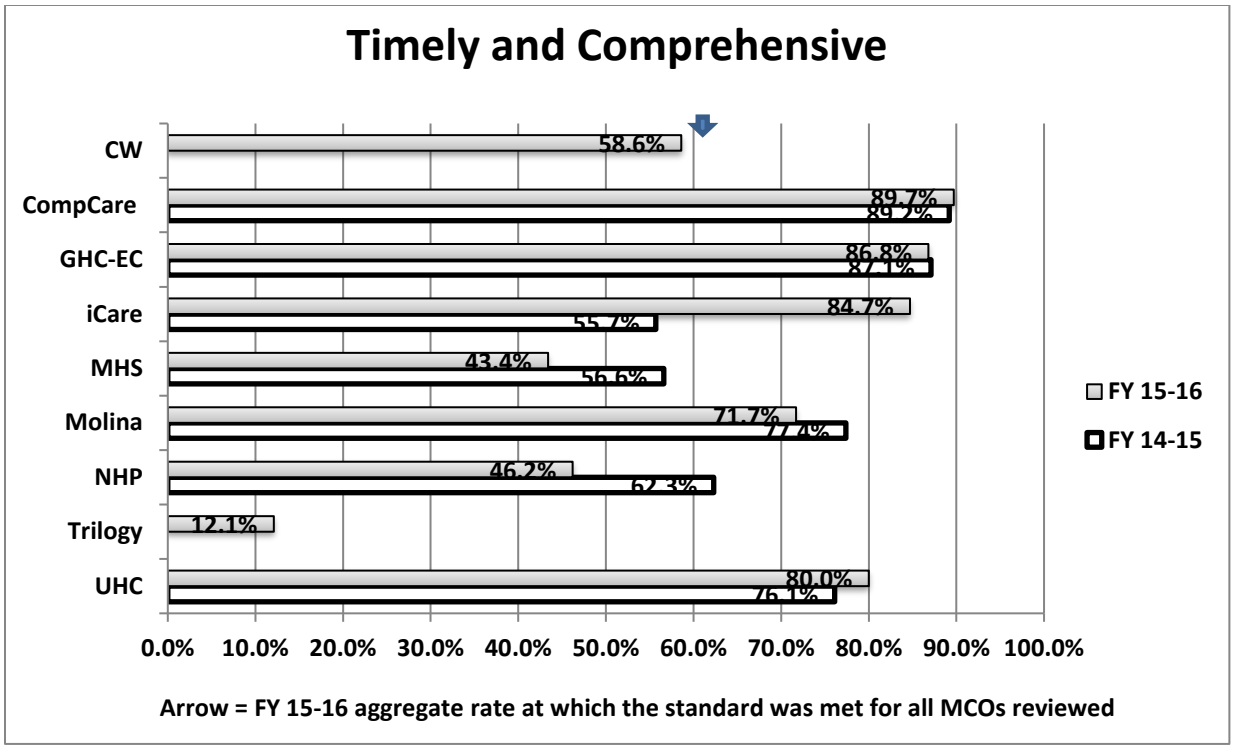
was met in FY 15-16 for all MCOs, a "Comprehensiveness of Initial Assessment" rate of 65 percent. Analysis indicated the year-to-year difference in the rates for *i*Care is likely attributable to actions of the MCO, and is unlikely to be the result of normal variation or chance. The year-to-year difference in the rates for NHP is unlikely to be the result of normal variation or chance.



Both Timely and Comprehensive/Pay for Performance Findings

MCOs are required by the DHS contract to achieve a 50 percent combined rate for timeliness and comprehensiveness of assessments in order to qualify for a P4P incentive.

The following graph depicts each MCO's rate of compliance in FY 15-16 for the review element, "Both Timely and Comprehensive," and compares it to the compliance rate for FY 14-15 for seven of the nine MCOs. The arrow represents the aggregate rate at which the standard was met in FY 15-16 for all MCOs, a "Both Timely and Comprehensive" rate of 61 percent. Analysis indicated the year-to-year difference in the rates for *i*Care is likely attributable to actions of the MCO, and is unlikely to be the result of normal variation or chance. The year-to-year difference in the rates for NHP is unlikely to be the result of normal variation or chance.



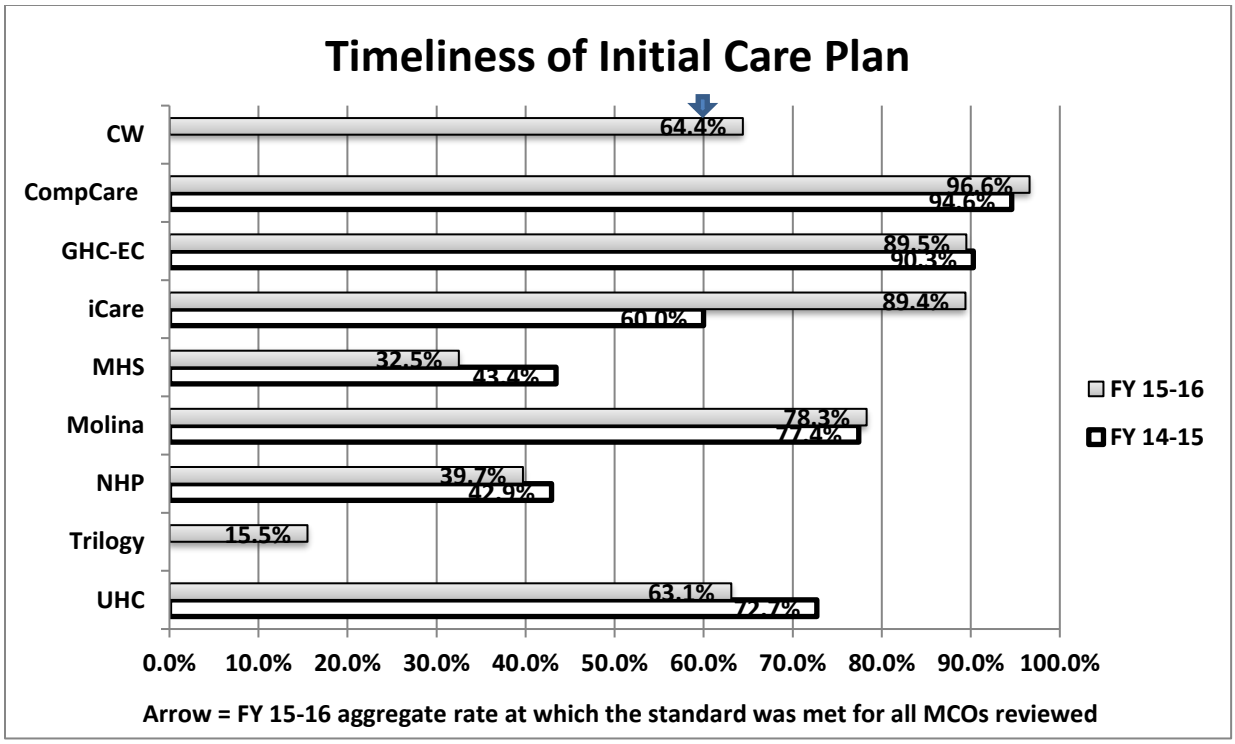
SERVICE PLANNING

Similar to requirements for assessments, timeliness and comprehensiveness are two key expectations for MCOs when developing care plans.

Timeliness of Initial Care Plan

The initial care plan must be completed within 30 calendar days of the initial HRA or within 90 calendar days of enrollment, whichever comes first. Nearly all care plans are created by MCOs immediately following the completion of the HRAs. As a result, the rates of compliance for timely care plans are close to those for timely assessments.

The following graph depicts each MCO's rate of compliance in FY 15-16 for the review element, "Timeliness of Initial Care Plan," and compares it to the compliance rate for FY 14-15 for seven of the nine MCOs. The arrow represents the aggregate rate at which the standard was met in FY 15-16 for all MCOs, a "Timeliness of Initial Care Plan" rate of 60 percent. Analysis indicated the year-to-year difference in the rates for *i*Care is likely attributable to actions of the MCO, and is unlikely to be the result of normal variation or chance.



Comprehensiveness of Initial Care Plan

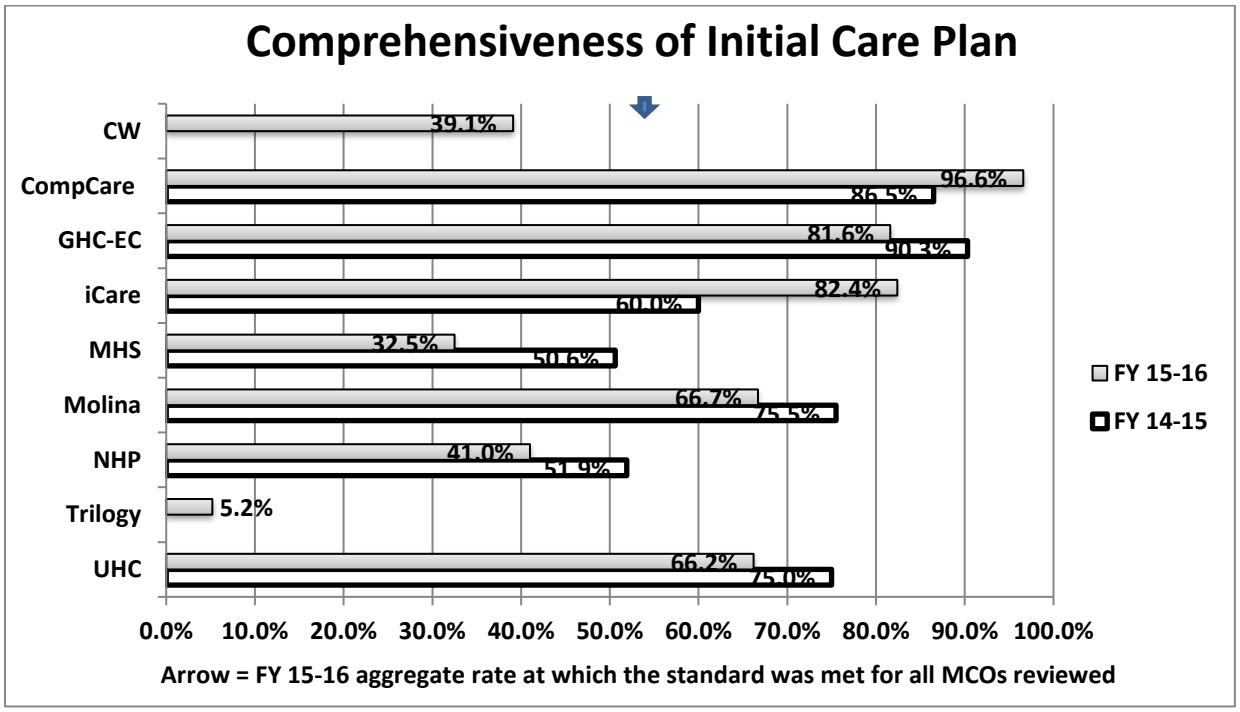
By contract, the care plan is comprehensive when it contains all of the following information:

- Appropriate medical and social services that are consistent with the primary care physician's (PCP's) clinical treatment plan and medical diagnoses;
- Reflection of the principles of recovery (self-direction, individualized and member centric, empowerment, holistic, nonlinear, strengths-based, peer support, respect, responsibility, and hope);
- Cultural sensitivity; and
- Member's health preference(s)/goal(s).

The following graph depicts each MCO's rate of compliance in FY 15-16 for the review element, "Comprehensiveness of Initial Care Plan," and compares it to the compliance rate for FY 14-15 for seven of the nine MCOs. The arrow represents the aggregate rate at which the standard was met in FY 15-16 for all MCOs, a "Comprehensiveness of Initial Care Plan" rate of 53 percent. Analysis indicated the year-to-year increase the rates for *i*Care is likely attributable to actions of the MCO, and is unlikely to be the result of normal variation or chance. The year-to-year difference in the rates for MHS is unlikely to be the result of normal variation or chance.

Please note last year's review included results for an additional indicator, "Member Preferences/Goals Related to Health." For FY 15-16, DHS directed MetaStar to incorporate this

previously separate measure into the indicator, "Comprehensiveness of Initial Care Plan," and evaluate whether members' health-related goals and preferences were included in the initial plan of care. To reliably compare the results from last year to this year, MetaStar combined last year's results for the two separate measures and created a new FY 14-15 rate for "Comprehensiveness of Initial Care Plan" for use in this report. The arrow represents the aggregate rate at which the standard was met in FY 15-16 for all MCOs, a "Comprehensiveness of Initial Care Plan" rate of 53 percent.



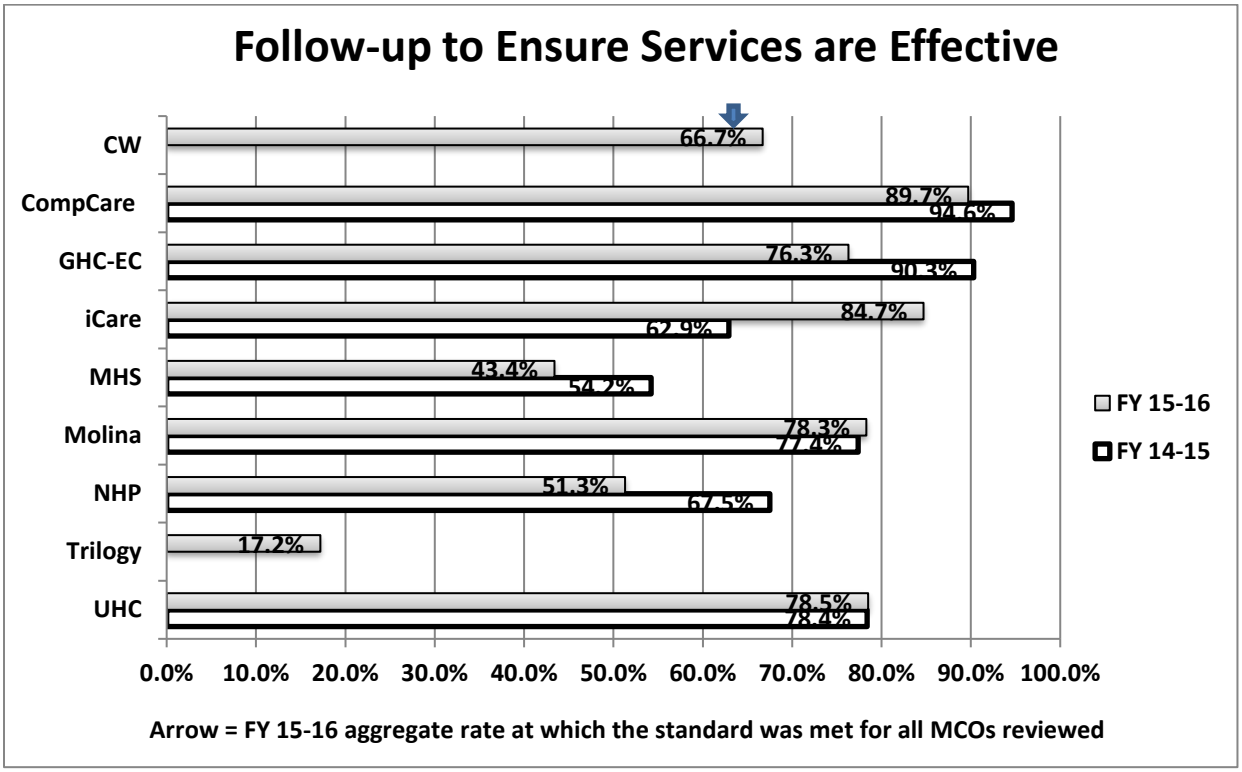
Service Coordination and Delivery

Follow-up to Ensure Covered Services are Effective

Care managers/care coordinators must follow up with members to ensure that covered services have been received and are effective. Like the challenges identified in conducting the initial HRA, lack of member responsiveness and/or incorrect demographic information can contribute to lower rates of performance for this indicator. The review criteria take into consideration reasonable attempts to contact the member for follow-up.

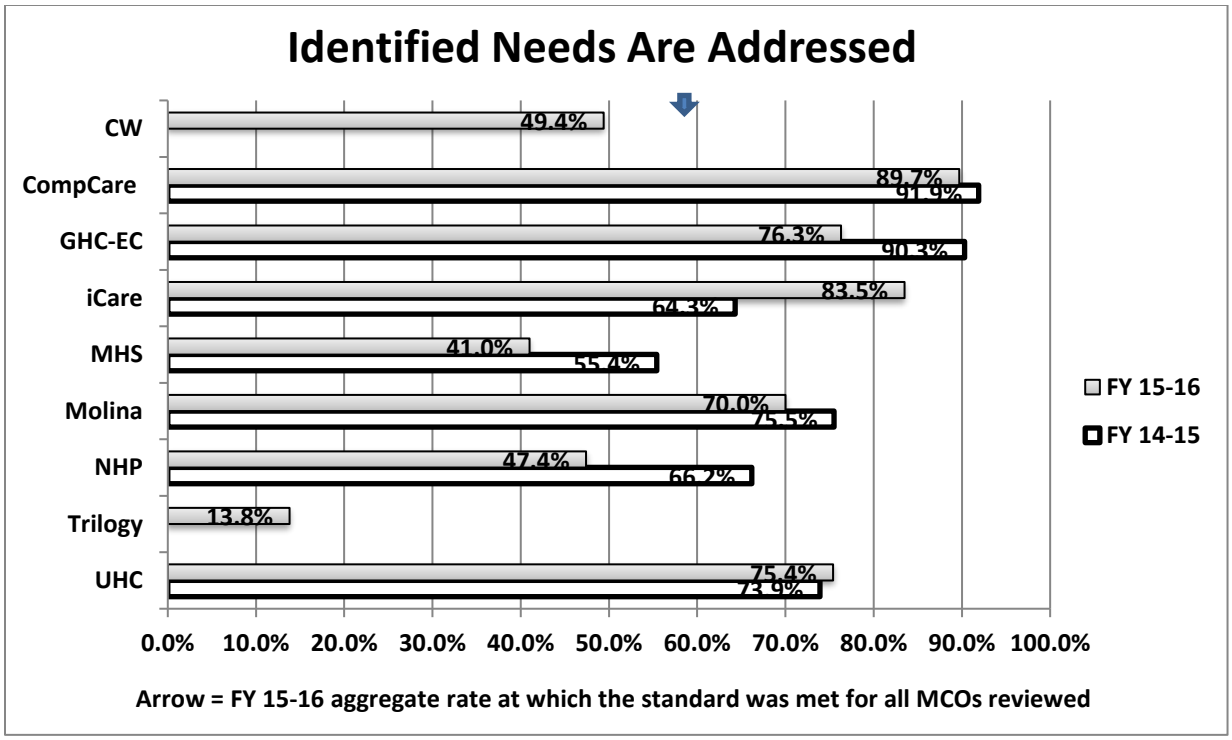
The following graph depicts each MCO's rate of compliance in FY 15-16 for the review element, "Follow-up to Ensure Services are Effective," and compares it to the compliance rate for FY 14-15 for seven of the nine MCOs. The arrow represents the aggregate rate at which the standard was met in FY 15-16 for all MCOs, a "Follow-up to Ensure Services are Effective" rate of 63 percent. Analysis indicated the year-to-year difference in the rates for *i*Care is likely attributable

to actions of the MCO, and is unlikely to be the result of normal variation or chance. The year-to-year difference in the rates for NHP is unlikely to be the result of normal variation or chance.



Identified Needs are Addressed

MCOs must address all needs identified during the initial HRA. The following graph depicts each MCO's rate of compliance in FY 15-16 for the review element, "Identified Needs are Addressed," and compares it to the compliance rate for FY 14-15 for seven of the nine MCOs. The arrow represents the aggregate rate at which the standard was met in FY 15-16 for all MCOs, an "Identified Needs are Addressed" rate of 58 percent. Analysis indicated the year-to-year increase in performance for *i*Care is likely attributable to actions of the MCO, and unlikely to be the result of normal variation or chance. The decrease in performance for NHP is unlikely to be the result of normal variation or chance.



Conclusions

The P4P initiative sets a requirement for MCOs to achieve a 50 percent combined aggregate average rate for timelines and comprehensiveness of the HRA. Six MCOs had an aggregate average rate for timeliness and comprehensiveness above the 50 percent requirement, while three MCOs did not meet the benchmark.

One MCO that scored below the 50 percent combined rate for timeliness and comprehensiveness of the HRA is in its second year of providing services for SSI members, and scored well below the average for all of the review indicators. Recommendations to address deficiencies noted during the CMR are included in the "Recommendations" section of this report.

The two remaining MCOs that scored below the 50 percent combined rate for timeliness and comprehensiveness of the initial HRA also had a decrease in other review indicators, and analysis indicated the decrease was not likely to be due to normal variation or chance. A contributing factor to the overall decrease for these two organizations was the results for timely completion of initial assessments. As noted earlier, DHS requires MCOs to complete initial HRAs within the required timeframe, or a "not met" score is applied by default to the remaining review criteria. One of the MCOs was also noted to show a decrease for "Follow-up to Ensure Services are Effective" and "Identified Needs Are Addressed. Another MCO showed a decrease in "Comprehensiveness of Initial Care Plan." These decreases were not likely to be the result of normal variation or chance. Additional contributing factors to these decreases include the MCOs' process to contact the member once to conduct assessments and a second time to review/develop

the initial care plan. When a new member cannot be reached a second time to review and complete the care plan, the review indicators for "Timeliness of Initial Care Plan" and "Comprehensiveness of Initial Care Plan" are scored as "not met." The review indicator for "Identified Needs are Addressed" may also be scored "not met" for this reason. During the past year, the MCOs reported offering a warm transfer following the initial assessment so the care plan could be developed during a single contact. However, this approach appeared to have limited success. Since there was an increase in assessments not completed, it negatively impacted all of the other review indicators.

The inability to contact members for the initial HRA continues to be problematic, although has decreased compared to the previous three years. The percent of HRAs not completed over the past four years because members could not be contacted due to issues with demographic information is listed below:

- FY 15-16, 10 percent;
- FY14-15, 16 percent;
- FY 13-14, 15 percent; and
- FY 12-13, 21 percent.

Despite the inability to contact members within the expected timeframe, the MCOs generally continued to take steps to conduct outreach, monitor claims, and conduct utilization reviews to find members and conduct assessments. Last year, one MCO demonstrated a decline in performance for all review indicators related to not completing timely HRAs for members who resided in a new service area. As a result of last year's findings, the organization conducted a root cause analysis and identified barriers to successful completion of the HRA. The intervention implemented included expanding staff capacity to conduct the initial HRA. This year, the MCO demonstrated an improvement in contacting members to conduct the initial HRA that is likely attributable to actions of the MCO, and unlikely to be the result of normal variation or chance. Since the number of members contacted to complete the initial HRA greatly increased, all of the other review indicators also showed improvement attributable to actions of the MCO, and unlikely to be the result of normal variation or chance.

Four MCOs score consistently high in all of the review indicators. Practices that were recognized as strengths during the review for these MCOs are noted in the following "Strengths" section of this report.

Strengths

As previously mentioned, contacting members to complete the initial HRA continues to be a barrier, although several strengths related to member outreach were noted. Most MCOs reported having a detailed process which employs multiple strategies to contact members to complete initial HRAs. Most MCOs complete the initial HRA and develop/review the initial care plan

during a single contact with the member. This practice was noted to contribute to timely completion of the initial care plan with members.

The following strengths related to member outreach were noted:

- All MCOs were noted to use narrative information fields or case notes in their electronic medical record systems to further explain and summarize assessment information, which helps to assure assessments are comprehensive.
- One MCO continues to focus on member engagement by having a live staff person answer the phone when a member returns a call. When auto dialer technology is used, a live staff person joins the call when a member answers the phone.
- Another MCO uses a "Difficult to Reach" protocol for newly enrolled members who cannot be contacted initially. Further searches for member contact information are conducted. A system alert notifies staff in the event the member contacts the MCO. Continued attempts to contact the member are made.
- Two MCOs continue to use strategies to promote member engagement in management of their heath as follows:
    - Sending members definitions for the care plan terms, "problem," "interventions," and "goals;"
    - Consistently providing members a 24-hour phone service that enables access to a nurse or physician for health-related questions; and
    - Reporting future plans to provide members with electronic access to a variety of health condition-related educational videos for members to view as they desire.
- One MCO was noted to use comment fields on the care plan to further define problem statements and use case notes to supplement the plan information, which helps to assure the comprehensiveness of care plans.
- Strengths related to following up with members to ensure services are effective were noted as follows:
    - One MCO uses the level of care intensity score as a guide to anticipate future needs of the member and conducts follow-up at more frequent intervals.
    - Five MCOs regularly review claims data to monitor members for change of condition and follow up with members when a change of condition is noted.
- Strengths related to ensuring member needs are addressed were noted as follows:
    - Two MCOs demonstrated consistent care coordination efforts to assist members in obtaining needed health resources and also provided members with educational materials related to their health care needs.
    - One MCO routinely sends a letter to members' PCPs documenting the health care issues that need to be addressed.

- One MCO used Community Connector staff to conduct unannounced home visits to conduct initial HRAs, coordinate services, and follow up on service and resource effectiveness.

Progress

The following recommendations were made in FY 14-15. The recommendations are followed by a statement describing the changes observed since last year's review, in records and/or by interviewing MCO staff in FY 15-16.

In FY 14-15 MetaStar recommended three MCOs should consider changes to documentation to improve accuracy, consistency, and comprehensiveness:

- *FY 14-15 recommendations:* One MCO should clarify expectations for how staff should document a member's cognition when unable to directly assess a member.
  FY 15-16 observations: All assessments reviewed were noted to include assessment of cognition and memory.
- *FY 14-15 recommendations:* Two MCOs should evaluate and implement the most effective method to address the variability of documentation of interventions, identified needs, and goals related to care plan documentation.
  FY 15-16 observations: One MCO was noted to improve by four percent compared to FY 14-15, by including members' stated goals on their care plans. One MCO reported creating new templates for initial and ongoing contact with members, conducted training with staff, and implemented auditing of staff telephone conversations with members. Observations from CMR noted that all care plans reviewed contained member preferences and outcomes.
- *FY 14-15 recommendations:* One MCO should further explore and address the contributing factors for lack of documented attempts to contact members. Focused monitoring should be conducted to ensure that the interventions are effective.
  FY 15-16 observations: When staff was interviewed concerning the MCO's efforts to address this recommendation, no response was provided. During CMR, a small number of records demonstrated a lack of documented attempts to contact members, which is addressed in the recommendation section of this report.
- *FY 14-15 recommendations:* Two MCOs should further assess members' desire for more information concerning advance directives and provide this information as needed.
  FY 15-16 observations: The MCOs made a revision to their electronic medical record to include a link to files, information, and forms related to advance directives. CMR found that the presence of advance directives was assessed, and information was provided to members, when desired.

- *FY 14-15 recommendations:* All MCOs should continue outreach efforts, sharing information with DHS and others if possible, to address the common challenge of establishing contact with members.
  FY 15-16 observations: All MCOs were noted to continue outreach efforts to establish contact with members.
- *FY 14-15 recommendations:* One MCO should evaluate its newest service area in order to successfully identify barriers to timely completion of initial HRAs. The MCO should then implement improvement strategies and conduct focused monitoring to ensure effectiveness.
  FY 15-16 observations: The MCO made notable progress, as the rate of HRAs completed increased from 66 percent in FY 14-15 to 91 percent in FY 15-16.
- *FY 14-15 recommendations:* To improve the timeliness of initial care plans, two MCOs should consider changes to the current process requiring two separate contacts with the member; one to conduct the initial assessment, and a second to review/develop a care plan.
  FY 15-16 observations: The MCOs reported making efforts to complete the HRA and initial care plan during a single contact beginning January 1, 2015, by offering members a "warm transfer" to the MCO after the assessment by a contracted agency, in order to review/develop the care plan. The MCOs reported that 110 members participated in the "warm transfer" offer and evidence of this practice was found in the records. Due to the low number of members accepting the warm transfer option, this improvement action appeared to have limited success.

As previously mentioned, two MCOs began serving SSI Medicaid members in April 2014. MetaStar conducted a CMR in FY 14-15 using a small sample of records (five). Recommendations were provided to these MCOs in FY 14-15 based on observations made during the record review. As in the format above, the recommendations made in FY 14-15 are followed by a statement describing the progress or lack of progress observed in records and/or by interviewing MCO staff in FY 15-16.

One MCO received several recommendations in FY 14-15 as follows:

- *FY 14-15 recommendations*: Continue to develop its outreach practices to promote completion of the initial HRA.
- *FY 15-16 observations*: The MCO reported working with its IT department to develop an automatic mechanism to identify members requiring a HRA. Meanwhile, the MCO is using a manual system to alert the customer service department, utilization review, and the member advocate of members who require a HRA to be completed, in the event the member contacts the MCO for other reasons. No evidence of this practice was observed in the records reviewed.

- *FY 14-15 recommendations*: Revise policies and procedures to reflect that a care plan should be developed within 30 days of assessment or 90 days from the date of enrollment in accordance with the requirements in the contract with DHS.
- *FY 15-16 observations*: Although the MCO revised its policies and procedures, it still directed that a care plan should only be developed if a member agreed to participate in care management.
- *FY 14-15 recommendations*: Revise polices and procedure to reflect that care plans should be developed after the assessment is completed for all members.
- *FY 15-16 observations*: The care management policy and procedure was updated to direct that care plans are to be developed after the assessment is completed. Review of records found no instances of care plans being developed prior to the completion of the initial assessment.
- *FY 14-15 recommendations*: Enhance the assessment template to include explicit assessment of memory and money management.
- *FY 15-16 observations*: The MCO reported making this recommended change on January 1, 2016. The result of this improvement was not observed in records reviewed due to the timing of the change relative to the timeframe of the review.
- *FY 14-15 recommendations*: Add the level of care intensity to the organization's assessment of care plans to assure the information is used to deliver the right quantity and quality of care.
- *FY 15-16 observations*: The level of care intensity (High, Medium, and Low) was added to the care plan template in a prominent place.
- *FY 14-15 recommendations*: Continue to implement the MCO's disease management program.
- *FY 15-16 observations*: The MCO reported providing self-management/educational booklets for preventive health care services and several chronic conditions to network providers. The provider is then asked to follow up with the member. The care manager then communicates with the provider about the member's progress or lack of progress in understanding his or her disease state. Review of records did not identify documentation of situations in which this process was utilized.

One MCO received recommendations in FY 14-15 as follows:

- *FY 14-15 recommendations*: The MCO should further assess members' desire for more information concerning advance directives and provide this information as needed.
- *FY 15-16 observations*: The MCO reported that staff inquires if members without advance directives would like additional information. If they do, the information is added to their care plans. The MCO is working with its IT department to configure an electronic notification within its information system to provide prompts to care managers to assess if members want or need additional information to implement an advance directive, and

provide information as indicated. This addition was expected to be implemented early in 2016. Review of records found that members without advance directives were offered additional information.

- *FY 14-15 recommendations*: The MCO should develop a process for using claims and pharmacy data to assist in stratifying risk, conducting member assessments and follow-up, and identifying episodes of change of condition for members.
- *FY 15-16 observations*: The MCO has developed and deployed a process to use claims and pharmacy data to assign a level of care intensity after the initial HRA, to support or supplement member assessments and follow-up, as well as to identify changes of condition. Currently the MCO's IT department provides claims and pharmacy data to care management staff using a stand-alone report. The MCO plans to automate the import of claims data into the care management system to enable ready access to the information. The sample of records reviewed verified that claims information was being used in care management processes.

Opportunities for Improvement

As a result of its review, MetaStar identified the following opportunities. For each area of opportunity, the review team provided related recommendations to DHS and the MCOs to support improvements in the quality of care management services provided to SSI members.

While all MCOs should continue their outreach efforts and sharing information with DHS and others if possible to address this common challenge, three MCOs that scored below the 50 percent combined rate for timeliness and comprehensiveness of the initial assessment received recommendations to improve their outreach processes.

- Two MCOs should consistently attempt to contact all members.
- One MCO should determine if the current outreach process is successful. If the outreach efforts are not successful, consider expanding the process to include other strategies to obtain accurate contact information and engage members in completion of the assessment and care plan, using best practices from other MCOs and DHS as available.
- Three MCOs should consider changes to documentation to improve accuracy, consistency, and comprehensiveness of the initial assessment.
    - One MCO should assure all questions are answered on the assessment form.
    - One MCO should revise the assessment tool to include the assessment of indirect supports. Implement a practice to further assess the nature of an identified need and how it impacts the functional abilities of the member. Also, monitor assessments to ensure they meet requirements and include information regarding level of care intensity, cognition, money management, and indirect supports.
    - One MCO should ensure assessments include a level of care intensity score, and readiness for tobacco cessation for members using tobacco products.

- One MCO should further evaluate members' needs if cognitive screening indicated further testing was needed.
    - Conduct additional review to ensure that failed cognitive screens result in further testing and that member needs are met.
- Four MCOs should improve the timeliness of initial care plans.
    - One MCO should develop a care plan within 30 days of the member's initial assessment, or 90 days from the date of enrollment. Revise the organization's policies and procedures to clarify this expectation.
    - One MCO should evaluate its current process for opportunities to minimize the number of times a member must be contacted to complete the assessment and develop/review the care plan. This MCO should also assess its outreach and contact efforts, and employ those methods determined to be most successful for its members.
    - Two MCOs have plans to begin completing the assessment and care plan during a single contact in 2016. It was recommended that the MCOs monitor the rate of timely and comprehensive assessments and care plans on an ongoing basis, to evaluate the effectiveness of the improvement plan.
- Four MCOs should address variability in care plan documentation.
    - One MCO should evaluate and implement the most effective method to address the variability of care plan documentation, and ensure plans include all of the member's health-related preferences/outcomes and identified needs.
    - One MCO should implement a process to promote consistent use of features that make care plans comprehensive, such as comment fields and case notes.
    - One MCO should ensure that care plans consistently include information necessary to accurately reflect members' individual needs and goals, as well as interventions to address them.
    - One MCO should monitor care plans to identify variations in comprehensiveness and assure care plans address all needs identified in the assessment. Utilize care plans that contain clear problem statements addressing each member's needs identified in the assessment. Lastly, determine if the label or identification of the level of care intensity is problematic within the organization or among care managers, and if so, relabel it.
- Four MCOs should improve the consistency of conducting follow-up with members to ensure services are effective.
    - Two MCOs should evaluate and improve processes to ensure that efforts are made and documented to contact members and determine that services are effective in meeting identified needs.
    - One MCO should implement a method to ensure consistent follow-up efforts per its policies and procedures.

    - One MCO should monitor to ensure that follow-up occurs as outlined in its policies, and is consistently documented to ensure member needs are addressed. Implement actions to improve follow-up and evaluate the effectiveness of the actions.
- Two MCOs should provide members with electronic access to health-related educational information to promote members' engagement in management of their health, evaluate the success of this new initiative, and share results with DHS and others as appropriate.
- Two MCOs should further study instances in which records did not show efforts to contact a member to complete the HRA. In the past, these MCOs reported encountering difficulties matching enrollment information provided by DHS with its own systems. Conduct additional reviews to determine if other new SSI enrollees were not contacted. Determine the causes and contributing factors and take action to remediate the issue or issues. Lastly, conduct ongoing reviews to ensure that actions are effective, in order to prevent future occurrences.
- One MCO should clarify the need to conduct a HRA for members already enrolled and previously assessed as a member of the Medicare Special Needs Program (SNP). Assure the SNP assessment addresses all the requirements for a comprehensive Medicaid SSI assessment and work with DHS to address items that may not be addressed. Consider a step to ensure that members' needs have not changed since the previous assessment.

Appendix 1 – Requirement for External Quality Review and Review Methodologies

Requirement for External Quality Review

The Code of Federal Regulations at 42 CFR 438 requires states that operate pre-paid inpatient health plans to provide for external quality review (EQR) of their managed care organizations (MCO), and to produce an annual technical report that describes the way in which the data from all EQR activities was reviewed, aggregated, and analyzed, and conclusions drawn regarding the quality, timeliness, and access to care provided across MCOs. To meet these obligations, states contract with a qualified External Quality Review Organization.

MetaStar - Wisconsin's External Quality Review Organization

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

MetaStar conducts EQR of MCOs serving BadgerCare Plus (BC+) and Supplemental Security Income (SSI) Medicaid recipients. In addition, the company conducts EQR of MCOs operating managed long-term programs, including Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly in Wisconsin. MetaStar also provides services to some private clients as well as the State. MetaStar also operates the Wisconsin Medicaid Health IT Extension Program in partnership with the Department of Health Services (DHS), which provides information, technical assistance, and training to support the efforts of health care providers to become meaningful users of certified electronic health record technology.

MetaStar Review Team

The MetaStar EQR team is comprised of registered nurses, a nurse practitioner, a physical therapist, licensed and/or certified social workers, and other degreed professionals with extensive education and experience working with the target groups served by the MCOs. The EQR team is supported by other members of MetaStar's Managed Health and Long-Term Care Department as well as staff in other departments, including a data analyst with an advanced degree, a licensed HEDIS auditor, certified professional coders, and information technologies staff. Review team experience includes professional practice and/or administrative experience in managed care health and long-term care programs as well as in other settings, including community programs, home health agencies, community-based residential settings, and DHS. Some reviewers have worked in skilled nursing and acute care facilities and/or primary care settings. The EQR team

also includes reviewers with quality assurance/quality improvement education and specialized training in evaluating performance improvement projects.

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

Review Methodologies

Compliance with Standards Review

Compliance with Standards, 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 the Code of Federal Regulations (CFR) at 42 CFR 438, Subpart E using the CMS guide, *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations, A Mandatory Protocol for External Quality Reviews (EQR), Version 2.0.*

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

Compliance with Standards reviews are conducted on a three-year review cycle. Results are not comparable to reviews conducted in FY 13-14 due to a change in the EQR protocol.

Non-Accredited MCO/SMCP Three Year Review Cycle and Results

MCO/SMCP	FY 13-14	FY 14-15	FY 15-16
Anthem Blue Cross and Blue Shield	Reviewed		
Health Tradition Health Plan*	Reviewed		
Care Wisconsin		28/45 standards met	
Independent Care Health Plan		32/45 standards met	
Trilogy Health Insurance		23/45 standards met	
Children Come First		32/45 standards met	
Wraparound Milwaukee		41/45 standards met	
Children's Community Health Plan			32/45 standards met (BC+) 32/45 standards met (C4K)

MCO/SMCP	FY 13-14	FY 14-15	FY 15-16*
Group Health Cooperative of Eau Clare+			43/45 standards met
Compcare Health Services+			43/45 standards met

* Health Tradition Health Plan held conditional accreditation from URAC at the time of the FY 13-14 review. In light of this and in anticipation of a change to its Accreditation Incentive program, DHS directed MetaStar to conduct a compliance with standards review for Health Tradition Health Plan.

+ Group Health Cooperative of Eau Clare and Compcare Health Services hold accreditation from Accreditation Association for Ambulatory Health Care; however, in FY 15-16, DHS no longer recognized this accrediting body as an exemption to the requirement for a compliance with standards review. DHS directed MetaStar to conduct a compliance with standards review for these organizations.

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

Onsite group discussions were held to collect additional information necessary to assess the MCO's compliance with federal and state standards. Participants in the sessions included MCO administrators, supervisors and other staff responsible for supporting care managers, and staff responsible for improvement efforts. MetaStar also requested and reviewed additional documents, as needed, to clarify information gathered during the onsite visit.

Focus Area	Related Sub-Categories in Review Standards
Enrollee Rights and Protections	• General Rule Regarding Member Rights • Information Requirements • Specific Rights • Emergency and Post-stabilization Services

Focus Area	Related Sub-Categories in Review Standards
Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement	• Availability of Services • Coordination and Continuity of Care • Coverage and Authorization of Services • Provider Selection • Confidentiality • Enrollment and Disenrollment • Subcontractual Relationships and Delegation • Practice Guidelines • QAPI Program • Basic Elements of the QAPI Program • Quality Evaluation • Health Information Systems
Grievance System	• Definitions and General Requirements • Notices to Members • Handling of Grievances and Appeals • Resolution and Notification • Expedited Resolution of Appeals • Information About the Grievance System to Providers • Recordkeeping and Reporting Requirements • Continuation of Benefits While the MCO Appeal and State Fair Hearing are Pending • Effectuation of Reversed Appeal Resolutions

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

- **Fully Met** – policies, procedures, and practices all align to meet the specified requirement.
- **Partially Met** – requirements are met in practice, even though the organization does not have directly relevant written policies or procedures.
- **Not Met** – the requirement is not met in practice, nor addressed in policy or procedure.

For findings of "partially met" or "not met," the EQR team documented the missing requirements related to the finding and provided recommendations, as indicated.

During FY 15-16, MetaStar continued to support DHS in developing and implementing the DHS Accreditation Deeming Plan. For the first phase of the review, MetaStar reviewed documents for the following sections in the certification application:

Section 6: Access to Care – Coordination and Continuity
Section 9: Subcontracts
Section 10: MOUs and MOAs
Section 11: Quality Improvement and Accreditation
Section 15: Member Complaint and Grievance System
Section 16: HMO Member Advocate
Section 22: Language Access
Section 23: Care Management System and Continuity of Care

For the second phase of Accreditation Deeming Plan review, MetaStar reviewed any document that the MCO did not submit for the certification sections noted above and focused on evaluation of compliance with the remaining Federal managed care requirements that are not fully addressed in the NCQA accreditation process. This second phase review focus areas include the following sections in the DHS certification application and other Federal requirements:

Section 12 – Member Outreach and Communication
Section 14 – Member Rights
Section 19 – Encounter Data from Third Party Vendors (if applicable)
Section 20 – Computer and Data Processing System
42 CFR 438.224 - Confidentiality

MetaStar documented its results from the reviews using the DHS certification template checklist. MetaStar communicated whether the MCO complied with Federal and DHS requirements outlined in the DHS-MCO contract. If insufficient information was available to determine compliance, MetaStar made recommendations to DHS to secure additional documentation or clarification. In some instances, DHS asked MCOs to submit additional information and asked MetaStar to review it during the second phase reviews described above. Findings from these reviews also communicated MCO compliance, when identified, and provided additional recommendations for remediation and follow-up.

Information Systems Capability Assessment

As a required part of other mandatory EQR protocols, information systems capability assessments (ISCAs) help ensure that each MCO maintains a health information system that can accurately and completely collect, analyze, integrate, and report data on member and provider characteristics, and on services furnished to members. The MetaStar team based its assessment on information system requirements detailed in the DHS-MCO contract; other technical references, such as DHS encounter reporting reference materials; the CMS guide, *EQR Protocol Appendix V: Information Systems Capability Assessment – Activity Required for Multiple Protocols*; and the Code of Federal Regulations at 42 CFR 438.242.

Prior to the review, MetaStar met with DHS to develop the review methodology and tailor the review activities to reflect DHS expectations for compliance.

MetaStar used a combination of activities to conduct and complete the ISCA, including reviewing the following references:

- DHS-MCO contract;
- EQR Protocol *Appendix V: Information Systems Capability Assessment – Activity Required for Multiple Protocols*, found at the following link: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html; and
- Encounter reporting reference materials: https://www.forwardhealth.wi.gov/WIPortal/Home/Managed%20Care%20Login/tabid/38/Default.aspx.

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

MetaStar visited the MCO to perform staff interviews to:

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

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

Section I: General Information

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

Section II: Information Systems – Encounter Data Flow

MetaStar identifies the types of data collection systems that are in place to support the operations of the MCO as well as technical specifications and support staff. Reviewers assess how the MCO integrates claims/encounter, membership, Medicaid provider, vendor, and other data to submit final encounter data files to DHS.

Section III: Claims and Encounter Data Collection

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

Section IV: Eligibility/Enrollment Data Processing

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

Section V: Practitioner Data Processing

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

Section VI: System Security

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

Section VII: Vendor Oversight

MetaStar reviews MCO oversight and data collection processes performed by service providers and other information technology vendors/systems (including internal systems) that support MCO operational functions and provide data which relate to the generation of complete and

accurate reporting. This includes information on stand-alone systems or benefits provided through subcontracts, such as medical record data, immunization data, or behavioral health/substance abuse data.

Section VIII: Medical Record Data Collection

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

Validation of Performance Measures

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

The CMS Protocol allows states to require MCOs to calculate and report their own performance measures, or to contract with another entity to calculate and report the measures on the MCO's behalf. For MY 2014, MCOs calculated and reported some measures and Hewlett Packard Enterprise Services (HPE) calculated and reported others.

In preparation for MY 2014, the EQR team communicated with staff from DHS/Division of Health Care Access and Accountability along with staff from HPE. The purpose of the consultation was to finalize selection of the performance measures to be calculated, confirm the technical specifications, data collection sources, and reporting method required by DHS for each of the performance measures, and set the stage for a collaborative approach to conducting the validation review.

HPE calculated the performance measures using source data extracted from Wisconsin's ForwardHealth *i*nterChange system in August 2014. Additional data sources for the performance measures included in the Wisconsin Immunization Registry.

DHS did not direct MetaStar to perform any Information Systems Capability Assessments prior to conducting performance measure validation. To conduct the validation review, the EQR team obtained and assessed documents describing the plan, systems, and processes HPE used to collect and store the data, calculate the performance measures, and produce the results.

The EQR team also obtained and assessed the HEDIS-audited information submitted by MCOs to DHS. Documentation included:

- HPE Small Project Charter
- HPE Data Extraction and Analysis Plan
- HPE Source Code – SQL
- Technical Specifications for the Performance Measures
- HPE Measure Results
- National Drug Codes List, if applicable; and
- NCQA HEDIS Data submission documents for MY 2014:
    - Data from the NCQA Interactive Data Submission System (IDSS) site containing the required data elements for each measure, downloaded as a comma separated value (CSV) text file (other options such as XML will not be accepted).
    - Data Filled Workbook, including Audit Review Table (ART) format downloaded from the NCQA IDSS site (with evidence that the auditor lock has been applied).
    - The Audit Report produced by a NCQA Licensed HEDIS Auditor.

Periodic meetings and conference calls with DHS and HPE were used as venues for identifying any concerns regarding the capture and integrity of encounter, eligibility, enrollment, and provider data.

MetaStar also employed an interactive approach throughout the validation review process, engaging with DHS and/or HPE staff responsible for measure calculation, as needed, to ask questions, address data concerns, and clarify technical specifications. If any issues were identified, the EQR team worked with HPE to correct the problem. If reviewers identified areas where documents used to produce a measure deviated from the technical specifications, this was shared with DHS and HPE, in order to evaluate the need to remediate the issue and resubmit documents prior to measure validation.

For each performance measure, the EQR team examined the resulting numerator and denominator, and checked the rate for internal consistency of the measure results compared to the results of previous years. Results for each measure were also compared to external data, such as NCQA benchmarks.

MetaStar provided feedback to DHS and HPE after each measure review. HPE corrected any deviations from the technical specifications and re-submitted the performance measure calculation.
MetaStar re-reviewed the information and performed benchmarking and reasonability tests. MetaStar communicated to DHS and HPE when each measure was determined valid and the review was complete.

Performance Measures

The following table provides information about the source for performance measures, the technical specifications for each measure, and the Medicaid program population for which the measures were validated. The measures included in the report are NCQA and HEDIS measures, HEDIS-like measures, or DHS measures using the specifications from the 2008 MEDDIC-MS specifications with procedure and drug code modifications for 2014.

SOURCE	PERFORMANCE MEASURES	POPULATION VALIDATED	
		BC+	SSI
HEDIS	**Antidepressant Medication Management – Continuation (AMM)** The percentage of members 18 years of age or older with a diagnosis of major depression and were treated with antidepressant medication, and who remained on an antidepressant medication for at least 180 days (6 months).	Y	Y
HEDIS	**Breast Cancer Screening (BCS)** The percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.	Y	Y
HEDIS	**Comprehensive Diabetes Care – Hemoglobin (HbA1c) Testing (CDC)** The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had a HbA1c testing.	Y	Y
HEDIS	**Comprehensive Diabetes Care – LDL-C Screening (CDC)** The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had a LDL-C screening.	Y	Y
HEDIS	**Childhood Immunization Status – Combination 2 (CIS)** The percentage of children two years of age who had received the following type and number of vaccines: four diphtheria, tetanus, and acellular pertussis (DTaP); three polio; one measles, mumps, and rubella (MMR); three H Influenza type B (HiB); three hepatitis B; and one chicken pox (VZV).	Y	N

SOURCE	PERFORMANCE MEASURES	POPULATION VALIDATED	
		BC+	SSI
HEDIS	**Follow-Up After Hospitalization for Mental Illness – 30 days After Discharge (FUH)** The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner who received follow-up within 30 days of discharge.	N	Y
HEDIS	**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – Engagement (IET)** The percentage of adolescent and adult members with a new episode of alcohol or other drug AOD dependence who initiated treatment and who had two or more additional services through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 30 days of the initiation visit.	Y	Y
HEDIS	**Prenatal and Postpartum Care – Timeliness of Prenatal Care (PPC)** The percentage of deliveries of live births between November 6 of the year prior to the MY and November 5 of the MY. For these women, the measure assesses who received prenatal care visit as a member of the MCO in the first trimester or within 42 days of enrollment in the MCO.	Y	N
HEDIS	**Prenatal and Postpartum Care – Postpartum Care (PPC)** The percentage of deliveries of live births between November 6 of the year prior to the MY and November 5 of the MY. For these women, the measure assesses who had a postpartum visit on or between 21 and 56 days after delivery.	Y	N
HEDIS-Like	**Annual Dental Visit - Children**	Y	N

SOURCE	PERFORMANCE MEASURES	POPULATION VALIDATED	
		BC+	SSI
	Percent of members 2-21 years age (as of December 31 of the MY) who were enrolled in the MCO for at least 11 months during the MY with an anchor date of December 31 and had any of the following: CPT Codes: 70300, 70310, 70320, 70350, 70355. CDT Codes: D0120-D0999; D1110; D1120; D1204-D2999; D3110-D3999; D4210-D4999; D5110-D5899; D6010-D6205; D 7111-D7999; D8010-D8999; D9110-D9999.		
HEDIS-Like	**Annual Dental Visit - Adults** Percent of members 22-64 years of age (as of December 31 of the MY) who were enrolled in the MCO for at least 11 months during the MY with an anchor date of December 31 and had any of the following: CPT Codes: 70300, 70310, 70320, 70350, 70355. CDT Codes: D0120-D0999; D1110; D1120; D1204-D2999; D3110-D3999; D4210-D4999; D5110-D5899; D6010-D6205; D 7111-D7999; D8010-D8999; D9110-D9999.	Y	N
HEDIS-Like	**Number of Emergency Department Visits** Number of total emergency department (ED) visits that members who were continuously enrolled in a MCO for 11 months had during the MY.	Y	Y
DHS MEDDIC-MS	**Tobacco Cessation Therapy- Counseling and Pharmacotherapy** The percentage of members 18-64 years of age who were identified as tobacco users and who received counseling and tobacco cessation medication to quit smoking during the MY.	Y	Y

Performance Measures Results

This table provides information about the benchmarks used to evaluate the measure calculations and the results of those comparisons.

Several important considerations exist to understanding reported DHS performance measure results. These are necessary to ensure audiences understand the proper interpretation of the results and comparability or non-comparability of data to other performance measure systems. DHS' encounter rate and an MCO's rate may significantly differ if the MCO includes medical record data in the calculation.

Also, a MCO may have access to administrative data that are not submitted to DHS through the encounter process. A MCO may include information from its internal case, disease, or utilization management programs. For example, a diabetic case management database could be the source for the HbA1c testing and result. The MCO may also receive information from hospitals, laboratories, or individual providers showing adherence to specific numerator criteria.

Another reason for difference between DHS and the MCO's self-identified rate is due to a member's enrollment history. The HEDIS definition of member continuous enrollment is based on the total months enrolled in the MCO regardless of product line. Therefore, if an individual transferred from a commercial plan to the MCO's Medicaid census during the year, the individual would be considered continuously enrolled for the MY. DHS would not consider the individual continuously enrolled. Thus, the number of individuals meeting denominator or numerator criteria will differ when DHS and MCO results are compared.

NCQA reports the national results as a mean and at the 10th, 25th, 50th, 75th, 90th and 95th percentiles for the participating plans.

Program: BadgerCare Plus		
Performance Measure	***Benchmark***	***Comparisons to Benchmarks***
Antidepressant Medication Management – Continuation (AMM)	NCQA calculated percentiles.	Almost all of the MCOs' rates were between the 25th and 75th percentiles for NCQA benchmarks. Five exceeded the 90th percentile.
Breast Cancer Screening (BCS)	NCQA calculated percentiles.	Almost all of the MCOs' rates were above the national NCQA benchmarks of the 50th percentile, with only one MCO falling in the 25th percentile.

Program: BadgerCare Plus		
Childhood Immunization Status (CIS) Combo 2	NCQA calculated percentiles.	The majority of MCOs fell between NCQA's national benchmarks of the 50th and 75th percentiles.
Comprehensive Diabetes Care – HbA1c Testing (CDC)	NCQA calculated percentiles.	All, except one, of the MCOs' rates were between the national NCQA benchmarks of the 50th and 95th percentiles. The majority of MCOs fell at or above the 75th percentile. The overall MCO average was above the NCQA mean.
Comprehensive Diabetes Care –LDL-C Screening (CDC)	NCQA calculated percentiles.	This measure is no longer required by NCQA and was reported by HPE for BC+; however, NCQA benchmarks were still available All of the MCOs' rates were below the national NCQA benchmarks of the 70th percentile, without applying the exclusion criteria for the measure. Additionally, the overall MCO average was below the NCQA mean.. The MCOs fared better when applying the exclusion criteria and the range increased between the 5th and 90th percentiles. Seven MCOs improved their percentile ranks using the exclusions methodology.
Prenatal and Postpartum Care – Timeliness of Prenatal Care (PPC)	NCQA calculated percentiles.	The majority of the MCOs fell at or above the 50th percentile and four plans fell below the 10th percentile.

Program: BadgerCare Plus		
Prenatal and Postpartum Care – Postpartum Care (PPC)	NCQA calculated percentiles.	The majority of the MCOs' rates were between the national NCQA benchmarks of the 25th and 90th percentiles, with overall average above the NCQA mean.
Annual Dental Visit - Children	National benchmarks are not available.	The overall combined MCO rate increased from the prior year. The MCOs' combined regions rates ranged from 29.4 to 74 percent.
Annual Dental Visit - Adult	National benchmarks are not available.	Three of the MCOs in regions 5 & 6 were at or above the target of 30 percent for this measure. The remaining MCO was below 30 percent. All regions combined average fell slightly below the target at 27.7 percent.
AMB- ED Visits per 1000 Member Months (not %)	National benchmarks are not available.	Seven of the MCOs were above the targeted rate in 2014. The remaining MCOs were below the target rate. The rates were consistent with expectations based on eligible population sizes in each MCO. The combined rate for all MCOs was above the targeted rate, but was less than two visits per 1000 member months above the target.
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – Engagement (IET)	NCQA calculated percentiles	Overall, almost all MCOs were at the 25th or 50th percentiles. Two MCOs were at the 90th percentile.
Follow-Up After Hospitalization for Mental Illness – 30 days After Discharge (FUH)	NCQA calculated percentiles	Overall, the MCOs' rates were found at every NCQA benchmark percentile. The majority of the MCOs fell

		between the 25th and 75th percentiles.

Program: Supplemental Security Income		
Performance Measure	***Benchmark***	***Comparisons to Benchmarks***
Antidepressant Medication Management – Continuation (AMM)	NCQA calculated percentiles.	All MCOs fell below the 10th percentile for NCQA benchmarks with the exception of two. One MCO was at the 10th percentile and one was at the 50th percentile. However, the majority of the MCOs hovered around the DHS target. Five MCOs met or exceeded the target and had a substantial increase from year to year. Only two MCOs had a year-to-year decrease.
Breast Cancer Screening (BCS)	NCQA calculated percentiles.	All MCOs fell between the 5th and 75th percentiles. Three MCOs were at or below the 5th percentile, one at the 10th, one at the 25th, one at the 50th, and one at the 75th percentile. The combined rate of all MCOs was at the 25th percentile.
Comprehensive Diabetes Care – HbA1c Testing (CDC)	NCQA calculated percentiles.	All MCOs' rates showed an increase year to year without exclusions. MCOs' rates fell between the 50th and 90th percentile, with the majority of MCOs falling in the 50th percentile. Two MCOs were at the 25th percentile, as was the overall combined rate. Two MCOs were above the 75th percentile with one of them being above the 90th percentile. There were no significant differences in rates

		with exclusions versus without exclusions.

Program: Supplemental Security Income		
Comprehensive Diabetes Care –LDL-C Screening (CDC)	NCQA calculated percentiles.	Overall, all MCOs' rates showed a year-to-year increase. Almost all MCOs' rates increased more than five percent, with the exception of two. All other rate changes were consistent with those from prior years. The overall average was at the national NCQA benchmark at the 25th percentile. There were no significant changes in rates with or without exclusions.
AMB- ED Visits per 1000 Member Months (not %)	National benchmarks are not available	Seven out of nine MCOs were below the state targeted rate. Only two MCOs were above that target, but were within 5 visits per 1000 member months of the target. The combined MCO rate was also below the target. All MCOs' rates decreased from year to year.
Follow-Up After Hospitalization for Mental Illness – 30 days After Discharge (FUH)	NCQA calculated percentiles.	Nearly all MCOs' rates were below the NCQA benchmark at the 10th percentile.
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – Engagement (IET)	NCQA calculated percentiles	Overall, results were mixed. Four MCOs had a substantial rate decrease of more than five percent, and three MCOs had substantial increases. All MCOs but one had rates above the NCQA average.

Program: Supplemental Security Income		
Tobacco Cessation - Counseling Only	National benchmarks are not available.	Overall, four MCOs' rates met the DHS target for Tobacco Counseling. The rates of four MCOs increased from year to year. Two MCOs' rates increased more than five percent from the prior year. All MCOs' combined regions rates fell below the state targeted rate.

Validation of Performance Improvement Projects

The purpose of a PIP is to assess and improve the processes and outcomes of health care provided by an MCO. PIP validation, a mandatory EQR activity, documents that a MCO's PIP is designed, conducted, and reported in a methodologically sound manner. To evaluate the standard elements of a PIP, the MetaStar team used the methodology described in the CMS guide, EQR Protocol 3: *Validating Performance Improvement Projects (PIPs), A Mandatory Protocol for External Quality Reviews (EQR), Version 2.0.*

MetaStar reviewed the PIP design and implementation using documents provided by the MCO. Document review may have been supplemented by MCO staff interviews, if needed.

Findings were analyzed and compiled using a three-point rating structure (met, partially met, and not met) to assess the MCO's level of compliance with the PIP protocol standards, although some standards or associated indicators may have been scored "not applicable" due to the study design or phase of implementation at the time of the review. For findings of "partially met" or "not met," the EQR team documented rationale for standards that were scored not fully met.

The EQRO also assessed the validity and reliability of all findings to determine an overall validation result as follows:

- Met: High Confidence or Confidence in the reported PIP results.
- Partially Met: Moderate or Low Confidence in the reported PIP results.
- Not Met: Reported PIP results that were not credible.

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

Care Management Review – Supplemental Security Income

Prior to conducting the first care management review for the review year 2015-2016, each MCO was asked to respond in writing to a survey approved by DHS, which asked the organization to describe its processes for:

- Identifying and contacting members;
- Closing cases and risk;
- Care management structure;
- Methods used in assessment ad care planning that contribute to culturally competent care; and
- Progress in addressing MetaStar's recommendations from the previous year.

MetaStar also obtained and reviewed MCO documents in order to familiarize reviewers with the MCO's practices, including policies, procedures, and/or forms related to member outreach, assessment and care planning, member acuity or level of care intensity for care management, and care coordination activities such as follow-up.

Per DHS direction, MetaStar randomly selected a sample of SSI members who were newly enrolled between July 1, 2014 and June 30, 2015, and who were enrolled at least 90 consecutive days between July 1, 2014 and September 30, 2015.

The review team used a review tool and reviewer guidelines based on the DHS-MCO contract and approved by DHS. The review evaluated the following three categories of care coordination and care management. The three categories were made up of six indicators that reviewers used to evaluate care management performance:

1. Assessment
    a. Timeliness of initial assessment*
    b. Comprehensiveness of initial assessment*

2. Service Planning
    a. Timeliness of initial care plan
    b. Comprehensiveness of initial care plan

3. Service Coordination and Delivery
    a. Follow up to ensure that covered services are effective
    b. Identified needs are addressed

If reviewers identified that a member had refused to participate in the assessment, the member's record was not reviewed and a replacement member from an over-sample was added to the sample. The record was also discarded if the assessment was not completed with the member via telephone or face-to-face, or if information was recorded from contact with someone without legal authorization (legal guardian) or permission of the member.

MetaStar used a binomial scoring system (met and not met) to evaluate the presence of each required element in the sample of member records. For findings of "not met," the reviewers noted the key areas related to the finding and provided comments to identify the missing requirements. In addition, when an initial health risk assessment (HRA) was not completed, all elements were scored "not met."
At the end of the record review, MetaStar gave the MCO and DHS the findings from each individual record review as well as a report regarding the organization's overall performance.

*Related to its P4P initiative, DHS provided MetaStar with the MCO's expected rate of performance for the timeliness and comprehensiveness of initial HRAs. MetaStar used the combined average rate of compliance for review elements 1.(a.) and 1.(b.) to assess the MCO's rate of compliance relative to its benchmark.

The Chi-Square test was used to assess the statistical significance of the change in compliance rates from review year 2014-2015 to 2015-2016. The degree to which a comparison of one rate to another is statistically significant is jointly proportional to the magnitude of the difference between the two rates and the sample sizes upon which each rate is based. A large improvement in the compliance rate, based on fairly large samples, is likely to be statistically significant. In general, a statistically significant finding is one that is not likely to have arisen by chance. A non-significant result is one that might have easily come about by chance, as a reflection of common cause variation. Non-significant changes are usually characterized by small changes in compliance rates and/or small sample sizes on which those rates are based.