External Quality Review

July 1, 2017–December 31, 2017

Annual Technical Report

BadgerCare Plus, Medical Homes, and Medicaid Programs

Prepared for

Wisconsin Department of Health Services

Division of Medicaid Services

Prepared by

METASTAR

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EXECUTIVE SUMMARY

The Code of Federal Regulations (CFR) at 42 CFR 438 requires states that operate prepaid inpatient health plans (PIHPs) and managed care organizations (MCOs), such as health maintenance organizations, special managed care programs (SMCPs), and organizations that provide managed care services, to provide for external quality reviews.

MetaStar is the external quality review organization contracted and authorized by the Wisconsin Department of Health Services (DHS) to provide independent evaluation of organizations' compliance with federal Medicaid managed care regulations and the DHS contract. MetaStar conducts external quality review for all organizations that provide managed health or long-term care services to Medicaid recipients in the State of Wisconsin. See the Appendix for information about the external quality review organization and the review team.

This annual technical report is provided to meet external quality review requirements and to support efforts by DHS to ensure quality for members enrolled in the following Medicaid 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;
- Special Managed Care Programs, serving children with mental health needs; and
- Medical or Health Homes.

States are required to post the annual technical report no later than April 30 of each calendar year. In an effort to provide the most current information, DHS has requested MetaStar transition from reporting by fiscal year to reporting by calendar year. This report includes all external quality review activities and findings (both mandatory and optional), providing recommendations to DHS. The timeframe of this report is July 1 through December 31 of calendar year 2017 (CY 2017). Other activities not conducted during the reporting period include:

- Information Systems Capabilities Assessment;
- Compliance with Standards review;
- Medicaid Supplemental Security Income care management review; and
- Special Managed Care Program performance improvement project validations.

These activities will be included in subsequent annual technical reports as required by the CFR.

Following is a brief summary of the review activities and results. A list of the specific review activities conducted for each of the MCOs and SMCPs can be found on pages 10-12. More

detailed information regarding results of the various review activities, including identified progress, strengths, and opportunities for improvement, begins on page 13.

Performance Measure Validation

MetaStar validated measurement year 2016 performance measures for the BadgerCare Plus and Supplemental Security Income Medicaid programs. Validating performance measures is a mandatory review activity identified in federal regulations at 42 CFR 438.358. In addition, MetaStar provided consultation services to DHS, per its request, related to improvements to current measures and development of new measures for its MCO pay for performance initiative for 2018.

The validation review was conducted to evaluate the accuracy of performance measures reported by the MCOs and to determine the extent to which the MCOs and/or DHS' vendor, DXC Technology, collected data and calculated the measures according to specifications established by DHS. DHS provided MetaStar with the measure specifications established for calculating the performance measures, the data, and the calculated results.

MetaStar confirmed that all performance measures were accurately calculated and reported, aligning with state specifications and reporting requirements.

Performance Improvement Projects

DHS requires MCOs, SMCPs, and PIHPs 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. This activity is considered PIP technical assistance.

Validating performance improvement projects is a mandatory review activity identified in 42 CFR 438.358. MetaStar reviewed and validated 39 performance improvement projects during calendar year 2017. Thirty-eight performance improvement projects were conducted during calendar year 2016 by 19 MCOs participating in the Wisconsin BadgerCare Plus and/or Supplemental Security Income Medicaid programs. The projects focused on a variety of health topics including dental visits, medication usage, breast cancer screening, immunizations, diabetes care, controlling blood pressure, ambulatory care, mental health, health needs assessments, alcohol and other drug dependence treatment, postpartum care, tobacco cessation, and spirometry testing. In addition, one project was conducted by a PIHP for the foster care medical home benefit during calendar year 2016; this project focused on health needs assessments. The SMCP performance improvement projects were not validated during the reporting period, but will be included in future annual technical reports.

All MCOs submitted their performance improvement project proposals to MetaStar 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. Subsequent to MetaStar's feedback, organizations submitted their projects to DHS for approval. When the final projects were validated, 20 of 39 projects fully met the first 12 standards.

The overall validation findings provide an indication of the reliability and validity of the projects' results. Seven of the projects received a validation result of fully "met," 29 projects received a validation result of "partially met," and three projects received a validation result of "not met."

Obstetrics Medical Home/Healthy Birth Outcomes

During CY 2017, DHS directed MetaStar to perform data abstraction reviews of its Medical Home initiative for pregnant women. MetaStar reviewed 1,068 records for the 13 MCOs that currently participate in this Medical Home program. This is an optional activity. Results from the data abstraction reviews 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, the results of this optional activity are reported separately.

HIV/AIDS Health Home

The Affordable Care Act of 2010 §2703 and Social Security Act §1945 created an optional Medicaid benefit that allows states to establish health homes to coordinate care for people who have chronic conditions across all healthcare settings and community care settings. The goals of health homes are to improve health outcomes while lowering Medicaid costs, and to reduce preventable hospitalizations, emergency room visits, and unnecessary care for Medicaid members.[1] Member participation is voluntary, and members must have a diagnosis of human immunodeficiency virus (HIV) and at least one other chronic condition, or be at risk of developing another chronic condition. The Health Home provider is accountable for the total care of the member, using a patient-centered model, which includes a care team working with the member to meet his/her medical, dental, behavioral health, pharmacy, care management, and social service needs. This is an optional activity.

One organization provides the HIV/AIDS Health Home in Wisconsin, and works with a variety of managed care organizations to ensure the needs of the members are coordinated. The organization has a well-defined and accurate process to determine a member's eligibility for the program, regardless of where the referral originated. Overall, the 30 records reviewed lacked documentation, and at times contained inconsistent documentation between the two electronic

[1] Wisconsin Department of Health Services, *HIV/AIDS Health Home Reimbursement Guide*, ForwardHealth.

charting systems utilized by the organization, making it difficult to determine if some of the Health Home requirements were being met.

Record Review – Foster Care Medical Home

The Foster Care Medical Home (FCMH) was established in 2014 under an Alternative Benefit Plan State Plan Amendment as allowed in federal law under §1937 of the Social Security Act (2010). The program is a PIHP operated in six counties in southeastern Wisconsin by one managed care organization. The FCMH provides comprehensive and coordinated health care for children in out-of-home care in a way that reflects their unique health needs. Participation in the program is voluntary. All children placed in eligible out-of-home care settings and under the jurisdiction of the child welfare system within the six Wisconsin counties may participate in the program.

The PIHP must establish a health care management structure that assures coordination and integration of all aspects of the child's health care needs and promotes effective communication between the individuals who are instrumental to the child's care. All 44 member records reviewed indicated a potential discrepancy between the printed information provided for the review and the documentation within the organization's electronic medical record (EMR). MetaStar was not able to conduct a comparison between the EMR and the records submitted for review, and as a result could not address the discrepancies more specifically. This may have been a contributing factor in the results of the review.

Record Review - Childless Adults Health Needs Assessment

The health needs assessment was introduced as a requirement in the 2014-2015 DHS-MCO contract for newly enrolled childless adult members. The contract specified the elements that needed to be addressed as part of the assessment, the timeframe for completion, and the acceptable modes of contacting members for purposes of completing the assessment.

The health needs assessment requirements were updated as part of the 2016-2017 DHS-MCO contract. In addition to newly enrolled childless adult members, the health needs assessment population included childless adult members that disenroll from the MCO and reenroll in the same MCO six months or more after their previous disenrollment date. The 2016-2017 DHS-MCO contract also introduced performance benchmarks for timely completion of health needs assessments as well as a penalty for MCOs that fail to meet these benchmarks.

The childless adults health needs assessment review is an optional review activity with a penalty provision. This was a new review activity during CY 2017 and the results reported here are for all reviews conducted in the initial cycle, which is outside of the timeframe for this report. MetaStar reviewed 1,134 records of BadgerCare Plus childless adult recipients enrolled in 18 MCOs. MCOs are required to achieve the lesser of two targets, a 35 percent rate of compliance

or a 10 percent reduction in error from the MCO's self-reported baseline, for timeliness of initial health needs assessments, to avoid paying a penalty.

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. In an effort to provide the most current information, DHS has requested MetaStar transition from reporting by fiscal year to reporting by calendar year. This report covers all external quality review (EQR) activities conducted from July 1 through December 31 of calendar year (CY) 2017. Other activities not conducted during the reporting period include:

- Information Systems Capabilities Assessment;
- Compliance with Standards review;
- Medicaid Supplemental Security Income care management review; and
- Special Managed Care Program performance improvement project validations.

These activities will be included in subsequent annual technical reports as required by the CFR.

The Wisconsin Department of Health Services (DHS) contracted with 18 managed care organizations (MCOs) to provide services for persons enrolled in the BadgerCare Plus (BC+) program (including BC+ childless adults). Ten MCOs 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 also provides comprehensive and coordinated health services for children and youth enrolled in the pre-paid inpatient health plan (PIHP) for the foster care medical home benefit, Care4Kids.

DHS-MCO contracts 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 March 2018 and is as follows:

Program	Enrollment
BadgerCare Plus	714,306
BadgerCare Plus Childless Adults	131,817
HIV/AIDS Health Home*	400
Supplemental Security Income	39,469
Special Managed Care Programs	1,222
Foster Care Medical Home	3,203

*HIV/AIDS Health Home enrollment is not publicly available. This data is based on claims billed as of March 2018 and may not include all health home participants.

For current enrollment data, visit the following DHS website:

https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Enrollment_Information/Reports.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:

- Validation of performance improvement projects (PIPs) underway during the preceding 12 months for each MCO, SMCP, and PIHP, as required by DHS and set forth in 42 CFR 438.240(b)(1);
- Validation of the performance measures calculated by MCOs and/or DHS' vendor, DXC Technology (DXC), during the preceding 12 months to comply with requirements in 42 CFR 438.240(b)(2); and
- A compliance with standards review to determine each MCO's, SMCP's, and PIHP's compliance with the applicable standards established by DHS to comply with the requirements of 42 CFR 438.204(g).

In addition, the report provides information about the results of other optional review activities, including HIV/AIDS Health Home record review, Foster Care Medical Home care management review, and BC+ childless adults Health Needs Assessments reviews.

Scope of External Review and Methodology

The following table identifies the MCOs and types of reviews completed during the CY 2017 review period. The review methodology for each review activity is found in the Appendix.

Scope of External Review Activities CY 2017

Organization and Programs	Types of Reviews Performed
AIDS Resource Center of Wisconsin (ARCW) HIV/AIDS Health Home	HIV/AIDS Health Home Record Review
Anthem Blue Cross and Blue Shield (Anthem) BC+, SSI	Childless Adults Health Needs Assessment Review Healthy Birth Outcomes Medical Home Review Performance Measures Validation PIPs Technical Assistance PIPs Validation
Care Wisconsin (CW) SSI	Performance Measures Validation PIPs Technical Assistance PIPs Validation

Organization and Programs	Types of Reviews Performed
Children Come First (CCF) SMCP	PIPs Technical Assistance
Children's Community Health Plan, Inc. (CCHP) BC+, Foster Care Medical Home	Childless Adults Health Needs Assessment Review Foster Care Medical Home Care Management Review Healthy Birth Outcomes Medical Home Review Performance Measures Validation PIPs Technical Assistance PIPs Validation
Compcare BC+, SSI	Childless Adults Health Needs Assessment Review Performance Measures Validation PIPs Technical Assistance PIPs Validation
Dean Health Plan (DHP) BC+	Childless Adults Health Needs Assessment Review Healthy Birth Outcomes Medical Home Review Performance Measures Validation PIPs Technical Assistance PIPs Validation
Group Health Cooperative of Eau Claire (GHC-EC) BC+, SSI	Childless Adults Health Needs Assessment Review Performance Measures Validation PIPs Technical Assistance PIPs Validation
Group Health Cooperative of South Central Wisconsin (GHC-SCW) BC+	Childless Adults Health Needs Assessment Review Healthy Birth Outcomes Medical Home Review Performance Measures Validation PIPs Technical Assistance PIPs Validation
Gundersen Health Plan (GHP) BC+	Childless Adults Health Needs Assessment Review Performance Measures Validation PIPs Technical Assistance PIPs Validation
Health Tradition Health Plan (HTHP) BC+	Childless Adults Health Needs Assessment Review Performance Measures Validation PIPs Validation
Independent Care Health Plan (*i*Care) BC+, SSI	Childless Adults Health Needs Assessment Review Healthy Birth Outcomes Medical Home Review Performance Measures Validation PIPs Technical Assistance PIPs Validation
MHS Health Wisconsin (MHS) BC+, SSI	Childless Adults Health Needs Assessment Review Healthy Birth Outcomes Medical Home Review Performance Measures Validation PIPs Technical Assistance PIPs Validation
MercyCare Health Plan (MCHP) BC+	Childless Adults Health Needs Assessment Review Healthy Birth Outcomes Medical Home Review Performance Measures Validation PIPs Technical Assistance PIPs Validation

Organization and Programs	Types of Reviews Performed
Molina Healthcare of Wisconsin (MHWI) BC+, SSI	Childless Adults Health Needs Assessment Review Healthy Birth Outcomes Medical Home Review Performance Measures Validation PIPs Technical Assistance PIPs Validation
Network Health Plan (NHP) BC+, SSI	Childless Adults Health Needs Assessment Review Healthy Birth Outcomes Medical Home Review Performance Measures Validation PIPs Technical Assistance PIPs Validation
Physician's Plus Insurance Corporation (PPIC) BC+	Childless Adults Health Needs Assessment Review Healthy Birth Outcomes Medical Home Review Performance Measures Validation PIPs Technical Assistance PIPs Validation
Security Health Plan of Wisconsin, Inc. (SHP) BC+	Childless Adults Health Needs Assessment Review Performance Measures Validation PIPs Technical Assistance PIPs Validation
Trilogy Health Insurance (Trilogy) BC+, SSI	Childless Adults Health Needs Assessment Review Healthy Birth Outcomes Medical Home Review Performance Measures Validation PIPs Technical Assistance PIP Validation
United Healthcare Community Plan (UHC) BC+, SSI	Childless Adults Health Needs Assessment Review Healthy Birth Outcomes Medical Home Review Performance Measures Validation PIPs Technical Assistance PIPs Validation
Unity Health Plans Insurance Corporation (Unity) BC+	Childless Adults Health Needs Assessment Review Healthy Birth Outcomes Medical Home Review Performance Measures Validation PIPs Technical Assistance PIPs Validation
Wraparound Milwaukee (WM) SMCP	PIPs Technical Assistance

VALIDATION OF PERFORMANCE MEASURES

MetaStar reviewed and validated a set of performance measures that was selected by DHS. The measures consisted of Healthcare Effectiveness Data and Information Set (HEDIS®)[2] 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 by the MCOs and to determine the extent to which MCOs' and/or DHS' vendor, DXC Technology (DXC), collected data and calculated the measures according to specifications established by DHS. The rates for performance measures are publically reported; therefore, accuracy and integrity are critical characteristics.

In addition to using this data to meet the Centers for Medicare & Medicaid Services (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 performance measures validation activity described in this report with some of the performance improvement project requirements for MCOs.

For measurement year (MY) 2016 data, MetaStar validated 14 performance measures each for 18 MCOs providing health care services for the BC+ program populations, and nine performance measures each for 10 MCOs providing health care services for those who receive SSI related Medicaid.

In addition, MetaStar provided consultation services to DHS, per its request, related to improvements to current measures and development of new measures for its MCO P4P initiative for CY 2018.

Results

MetaStar confirmed that all performance measures were calculated and reported accurately, aligning with state specifications and reporting requirements. Below is more information about the findings from the review.

For the P4P measures that align with HEDIS measures, the MCOs provided previously audited HEDIS rates for MY 2016. MetaStar reviewed the rates in collaboration with DHS staff and concurred with the results of the NCQA final audit designations. Independent audit results

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

confirmed the MY 2016 performance measures were accurate and followed the NCQA and state specifications for calculation and reporting.

For measures that were calculated by DXC, MetaStar evaluated and conducted documentation and data quality reviews with DXC and DHS staff. Throughout the review process, minor changes were made to DXC source code to ensure appropriate numerator and denominator identifications were captured. DXC suggested changes and engaged in detailed overview discussions with MetaStar and DHS during the review. Documentation discrepancies and/or inconsistencies with measure specifications were managed during data quality review sessions and approval was provided by MetaStar at the time of the review. Following each data quality review, MetaStar made recommendations to support DXC and DHS agreement with the procedural process, source code, and final rates for each measure. DXC's final revised documentation was error-free, and was approved and signed by DHS.

MetaStar used available, publicly reported rates and benchmarks as comparisons for validating the DXC calculated rates of performance for 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 more mature, 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. The results of the comparative analysis of the non-HEDIS measures for the MY 2016 P4P initiative are documented by program in the Appendix.

Conclusions

MetaStar made a number of recommendations following the performance measures validation for MY 2015, and found no new issues with the data quality reviews conducted in CY 2017. Specific progress, strengths, and opportunities for improvement are provided below.

Progress

DXC addressed recommendations from prior reviews related to its work to calculate assigned measures and sustained this progress as follows:

- Incorporated all data requirements, where applicable for HEDIS-like measures;
- Ensured the paid or denied status for claims was considered when calculating specific measures;
- Used International Classification of Diseases, revision 10, (ICD-10) diagnosis codes, if applicable;
- Included the correct populations for specific measures;
- Took steps to use a comprehensive list of members at the time of code review to validate eligibility;

- Considered HEDIS Value Sets for simplification when calculating HEDIS-like measures; and
- Continued to hold collaborative data quality review sessions with DHS and MetaStar on internally developed measures.

In addition, DHS took steps to accept numerator positive claims associated with members' Medicaid fee-for-service participation. DHS also continued its work to review the encounter data submission process to identify opportunities to enhance data quality, and monitored HEDIS measure specifications, with assistance from MetaStar, to determine the impact of measure reporting and comparative analysis.

Strengths

The following strengths were identified in the validation of MY 2016 performance measures:

- DHS continued to engage MCOs in ongoing discussions of its P4P initiatives, which enabled MCOs to provide critical input on measure development and reporting strategies.
- Collaboration between DHS and its vendor DXC contributed to the accuracy of calculated rates.
- DXC updated HEDIS-like measures based on changes to the HEDIS measure specifications, as appropriate.
- DXC incorporated robust testing processes to validate changes to internally developed measures.
- DHS and DXC demonstrated an ongoing detailed understanding of the measures and considered various reporting challenges when suggesting new measures for review.

Opportunities for Improvement:

As a result of the performance measures review and validation, MetaStar recommends the following:

- Foster continued collaboration between DHS, DXC, and MetaStar regarding internally developed measures via periodic data quality review sessions.
- Identify and incorporate changes to the P4P measures through ongoing review of HEDIS measure specifications.
- Evaluate the new 2018 HEDIS measures (MY 2017) after benchmarks have been substantiated by NCQA, for inclusion in the DHS P4P "withhold payments" initiative.

Validation of Performance Improvement Projects

This section of the report aggregates and summarizes the results of 38 PIPs conducted during CY 2016 by 19 MCOs participating in the BC+ and/or SSI Medicaid programs. Also included is one PIP conducted by the foster care medical home PIHP during CY 2016. All 39 PIPs were validated in CY 2017. SMCP PIPs were not validated during the reporting period, but will be included in future annual technical reports.

DHS requires MCOs, SMCPs, and PIHPs 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. This activity is considered PIP technical assistance.

Aggregate Results for Performance Improvement Projects

The table below lists each PIP standard that was evaluated for each MCO/SMCP/PIHP, 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; therefore, the denominator total may vary amongst standards.

CY 2016 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.	34/39
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.	33/39
Study Indicator(s)		
3	The study used objective, clearly and unambiguously defined, measureable indicators and included defined numerators and denominators.	36/39
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.	38/39
Study Population		
5	The project/study clearly defined the relevant population (all members to whom the study question and indicators apply).	29/39
6	If the entire population was used, data collection approach captured all members to whom the study question applied.	35/36

		Numerator = Number of projects meeting the standard Denominator = Number of projects applicable for the standard
Sampling Methods		
7	Valid sampling techniques were used.	5/5
8	The sample contained a sufficient number of members.	5/5
Data Collection Procedures		
9	The project/study clearly defined the data to be collected and the source of that data.	33/39
10	Staff are qualified and trained to collect data.	35/39
11	The instruments for data collection provided for consistent, accurate data collection over the time periods studied.	33/39
12	The study design prospectively specified a data analysis plan.	34/39
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.	25/39
14	A continuous cycle of improvement was utilized to measure and analyze performance, and to develop and implement system-wide improvements.	24/39
15	Interventions were culturally and linguistically appropriate.	24/37
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.	23/39
17	Numerical results and findings were presented accurately and clearly.	34/39
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.	21/39
"Real" Improvement		
19	The same methodology as the baseline measurement was used, when measurement was repeated.	34/39
20	There was a documented, quantitative improvement in processes or outcomes of care.	5/39
21	The reported improvement appeared to be the result of the planned quality improvement intervention.	4/8
Sustained Improvement		
22	Sustained improvement was demonstrated through repeated measurements over comparable time periods.	0/0

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
Annual Dental Visit				
MHS	Conducted member outreach via phone calls and newsletters. Assisted members with scheduling dental appointments. Educated providers about billing and claims submission. Distributed Fluoride Varnish Toolkits and educated providers about its use.	Project demonstrated "real" improvement: increased the rate of child dental visits from 29.80% in 2015 to 43.13% in 2016.	Partially Met	Include MCO data when describing study topic. Select interventions which address root causes or barriers. Clearly and accurately describe data displayed in graphs and charts. Obtain repeat measures over time to demonstrate sustainability.
NHP	Conducted member outreach via phone calls and newsletters. Assisted members with scheduling dental appointments. Educated providers about billing and claims submission. Distributed Fluoride Varnish Toolkits and educated providers about its use.	Project demonstrated "real" improvement: increased the rate of child dental visits from 25.40% in 2015 to 39.62% in 2016.	Partially Met	Include MCO data when describing study topic. Select interventions which address root causes or barriers. Clearly and accurately describe data displayed in graphs and charts. Obtain repeat measures over time to demonstrate sustainability.
Antidepressant Medication Management				
CCHP	Provided members with educational resources and medication refill reminders. Conducted member assessments by outreach coordinators. Developed a pharmacy partnership for providing	Project did not demonstrate improvement.	Partially Met	Include information about responsible staff and qualifications for data collection. Clearly describe the data collection process and instruments used to ensure accuracy. Specify the data analysis plan and analyze data on a

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
	prescription services and member resources.			periodic basis. Address cultural or linguistic appropriateness of all member-related interventions. Continue to measure effectiveness of interventions.
HTHP	Member outreach through periodic mailings of depression-related Krames materials. Education and collaboration with Mayo Clinic Health System-Franciscan Healthcare (MCHS-FH).	Project did not demonstrate improvement.	Partially Met	Describe how interventions were selected. Address cultural or linguistic appropriateness of interventions. Specify a data analysis plan. Document continuous cycles of improvement efforts in the report. Analyze data on a periodic basis. Include interim data. Include numerators and denominators.

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
MCHP	Sent letters and educational materials to members with new antidepressant prescriptions. Sent letters to members who did not refill the antidepressant medication prescriptions.	Project did not demonstrate quantitative improvement.	Not Met	Clearly define the indicators and study population. Describe all aspects of the data collection process and ensure data is accurate. Analyze data throughout the project and specify the data analysis plan. Select interventions based on an analysis of the problem. Conduct and document continuous cycles of improvement. Ensure initial and repeat measures are comparable.
Unity	Conducted member outreach via phone calls and mailings. Partnered with selected primary care provider clinics to implement member outreach via phone calls.	The project did not demonstrate quantitative improvement.	Not Met	Select new interventions each year for a continuing project. Describe how interventions were selected. Document continuous improvement efforts in the report. Measure and analyze the effectiveness of interventions.
Breast Cancer Screening				
GHP	Conducted member outreach, through an educational mailing about the importance of breast cancer screening, to health plan members applicable to the project.	Project did not demonstrate quantitative improvement.	Partially Met	Ensure the indicators are consistent with the study population. Describe how interventions are selected. Conduct and

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
	Conducted telephonic member outreach by a registered nurse.			document continuous cycles of improvement throughout the project. Ensure data is accurately labeled.
Childhood Immunizations				
*i*Care	Conducted member outreach via postcards and phone calls. Completed infant assessments, beginning in September 2016.	Project did not demonstrate quantitative improvement.	Partially Met	Clearly define the sources of data to be collected and utilized. Ensure the data collection methods provide accurate data. Develop and implement interventions which are sufficient to be expected to improve outcomes. Collect and analyze data as planned.
MCHP	Educated physicians on the most frequently missed immunizations. Sent targeted letters to members. Notified providers of members in need of immunizations.	Project did not demonstrate improvement.	Partially Met	Include a clear numerical goal for the study question. Analyze data throughout the project and specify the data analysis plan. Conduct and document continuous cycles of improvement.
SHP	Collaborated with provider partners to: • Conduct member outreach; • Educate primary care providers on strategies to improve immunization rates; and • Offer expanded hours for well-child visits and	Project did not demonstrate improvement.	Met	Develop methods to measure the effectiveness of interventions, and modify them if not effective.

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
	immunizations. Provided member outreach and mailings.			
Trilogy	Disseminated immunization reports and educational materials to primary care providers. Provided care coordination, upon request of the physician.	Project did not demonstrate improvement.	Partially Met	Ensure the study population is clearly defined. Fully describe data collection procedures, and ensure they yield accurate data. Select interventions which are sufficient to be expected to improve outcomes. Fully analyze data and take study limitations into consideration.
Comprehensive Diabetes Care				
CW	Conducted a comprehensive assessment for members who agreed to participate in a Diabetes Management Program. Implemented a revised assessment to be used for all members with diabetes. Provided care management outreach.	Project demonstrated improvement for one of three indicators: eye exam rates increased from 37.6% to 92.2%.	Partially Met	Define all criteria used to identify the study population. Ensure baseline and repeat measures are comparable.
MHWI	Conducted member outreach via phone calls and mailings. Utilized a vendor to conduct in-home visits to perform glycated hemoglobin (HbA1c) tests. Prioritized members for disease management	Project demonstrated improvement for the BC+ population: increased the rate of HbA1c control rates from 45.03% in 2015 to 48.12% in 2016. The project did not demonstrate quantitative improvement for the SSI population.	Partially Met	Include numerator and denominator data in the report. Select interventions which are sufficient to be expected to improve outcomes related to the study question. Document continuous improvement efforts in

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
	programs and referred members to health educators.			the report. Measure and analyze the effectiveness of interventions related to the study topic.
Trilogy	Disseminated educational materials to medical providers. Provided care coordination services to members with HbA1c results greater than eight percent, or upon request of the physician.	HbA1c testing rates improved for BC+ members, from 78.49 percent in CY 2015 to 87.96 percent in CY 2016. Project did not demonstrate improvement in HbA1c testing rates for SSI members. Project did not demonstrate improvement in the HbA1c control rate of less than eight percent for BC+ or SSI members.	Partially Met	Ensure the study population is clearly defined. Fully describe data collection procedures, and ensure they yield accurate data. Select interventions which are sufficient to be expected to improve outcomes. Fully analyze data and take study limitations into consideration.
Controlling Blood Pressure				
UHC	Conducted member outreach with preventative information and resources via newsletters and mailings. Provided consultation visits with providers and shared educational materials. Initiated clinical data integration systems for medical record review and data retrieval.	Project did not demonstrate improvement.	Partially Met	Include periodic data in the report. Fully analyze data and provide reasons for less than optimal performance. Measure and document effectiveness of interventions.
Emergency Department Utilization				
Anthem	Conducted member outreach via phone calls.	Although the ED utilization rate declined slightly from CY 2015 (from 56.63	Partially Met	Include measurable goals for study questions.

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
	Embedded an Anthem employee in a provider's location to conduct member outreach and education. Established relationships with emergency department (ED) providers to alert Anthem about ED usage while it is occurring. Implemented the use of newly acquired access to electronic medical records and data sources to obtain more timely notification of ED usage.	ED visits per 1,000 member months in CY 2015 to 55.93 ED visits per 1,000 member months in CY 2016), quantitative improvement has not been demonstrated.		Ensure the study population is defined accurately. Document continuous improvement efforts in the report. Address cultural or linguistic appropriateness of interventions.
Compcare	Contacted members who went to the ED more than four times per year by phone or targeted letter. Implemented phone call attempts to every member that used the ED regardless of visit frequency or diagnosis code. Coordinated efforts with case managers to enroll SSI members in the case management program if they were not already enrolled. Coordinated efforts with the nurse to ensure SSI members were provided with education about proper ED usage if the member was already	Project did not demonstrate quantitative improvement.	Partially Met	Ensure the study question is clearly stated. Clearly present numerical results.

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
	enrolled in the case management program.			
CW	Contacted new enrollees to provide education.	Project did not demonstrate improvement.	Partially Met	Establish a comparable baseline. Ensure the intervention is sufficient to be expected to improve outcomes. Ensure data analysis accurately interprets the success of the project.
GHC-EC	Contacted members who went to the ED more than four times per year by phone or targeted letter. Implemented phone call attempts to every member that uses the ED regardless of visit frequency or diagnosis code. Coordinated efforts with case managers to SSI enroll members in the case management program if they were not already enrolled. Coordinated efforts with nurses to ensure SSI members were provided with education for proper ED usage if the member was already enrolled in the case management program.	Project did not demonstrate quantitative improvement.	Partially Met	Ensure the study question is clearly stated. Clearly present all numerical results.
Follow-Up After Hospitalization for Mental Illness				
DHP	Partnered with external vendors to implement member outreach via phone calls.	Project did not demonstrate improvement.	Partially Met	Address cultural or linguistic appropriateness of interventions.

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
				Include numerator and denominator data in the report. Analyze data as planned. Report findings from the use of all interventions in the project report.
GHC-SCW	Conducted member outreach via phone calls.	Project did not demonstrate improvement.	Met	Include well-defined measurable goals for the study question.
HTHP	Developed a Mental Health Practitioner list to engage in provider and staff targeted outreach. Assessed access in potentially underserved counties for improved access to qualified behavioral health providers. Worked with the MCO's Medical Director regarding the enhancement/ expansion of the mental health provider network. Collaborated with MCHS-FH Behavioral Health to coordinate behavioral health follow-up appointments for members within the 30 day time frame.	Project did not demonstrate improvement.	Partially Met	Ensure the study population is consistent with the stated indicators. Describe how interventions were selected. Specify the data analysis plan. Display data clearly. Include numerators and denominators in the report.
MHWI	Conducted member outreach via phone calls and mailings. Developed a reference tool of behavioral health facilities for MHWI staff to direct	The organization noted improvement in the follow-up after hospitalization for mental illness rates for both BC+ and SSI members; however, confidence in the data	Partially Met	Ensure the study aim specifies the measure the project is intending on improving. Define sources of all data obtained for the project.

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
	members for follow-up appointments. Hosted a provider fair including an overview of comprehensive community service providers for MHWI staff.	was limited due to the difference in methodologies used to calculate the baseline and re-measurement year one results.		Document continuous improvement efforts in the report. Clearly present numerical results. Ensure initial and repeat measures are comparable.
Unity	Conducted member outreach via phone calls and mailings. Funded a care coordinator position at one of the Unity in-network providers to conduct member outreach.	Project demonstrated improvement: increased the rate of follow-up appointments after a mental health hospitalization from 64.94% in 2014 to 71.64% in 2016.	Partially Met	Document continuous improvement efforts in the report. Describe barriers if unable to analyze data periodically as planned. Measure and analyze the effectiveness of interventions.
Health Needs Assessment				
GHC-SCW	Developed a written health needs assessment form to be mailed to members. Conducted member outreach via phone calls and mailings.	Based on the documentation submitted, quantitative improvement cannot be confirmed.	Met	Clearly describe data displayed in the report narrative and charts. Ensure data calculations are accurate.
Immunizations for Adolescents				
GHP	Conducted member outreach via educational mailings.	Project did not demonstrate improvement.	Partially Met	Ensure the intervention utilized will impact the defined study population. Clearly document a data analysis plan. Describe how interventions are selected. Analyze data on a periodic basis. Document continuous cycles of improvement.

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
SHP	Collaborated with provider partners to: • Conduct member outreach; • Educate primary care providers on strategies to improve immunization rates; and • Offer expanded hours for well-child visits and immunizations. Provided member outreach and mailings.	Project did not demonstrate improvement.	Partially Met	Fully analyze data, including the impact of changes in measure specifications. Develop methods to measure the effectiveness of interventions, and modify them if not effective.
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment				
CCHP	Educated providers to assist with identification of members needing services prior to discharge from inpatient facilities. Increased care management for post discharge follow-up care. Improved coordination for discharge planning between facilities and the managed care organization.	Project did not demonstrate statistically significant improvement.	Met	Obtain repeat measures to demonstrate sustainability.
Compcare	Contacted members by telephone or targeted letter to provide education about the importance of follow-up care related to initiation and engagement of alcohol and other drug dependence treatment and to ensure appointments were scheduled.	The project demonstrated improvement for the BC+ population: rates improved from 10.7 % in 2015 to 12.9% in 2016. The project did not demonstrate improvement for the SSI population: rates declined from 11% in	Partially Met	Ensure data is accurate. Obtain repeat measures to demonstrate sustainability for the BC+ population.

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
	Partnered with a mental health clinic, beginning in October 2015, to provide member outreach. Coordinated efforts with case managers to enroll SSI members in the case management program if they were not already enrolled. Coordinated efforts with nurses to ensure SSI members were provided with education about the importance of receiving treatment if the member was already enrolled in the case management program.	2015 to 8% in 2016.		
DHP	Partnered with external vendors to implement member outreach via phone calls.	Project demonstrated "real" improvement: increased the rate of engagement of alcohol and other drug dependence treatment from 9.76% in 2014 to 13.11% in 2016.	Met	Address cultural or linguistic appropriateness of interventions. Include numerator and denominator data in the report. Analyze data as planned. Report findings from the use of all interventions in the project report.
GHC-EC	Contacted members by telephone or targeted letter to provide education about the importance of follow-up care and to ensure appointment scheduling.	The project demonstrated improvement for the BC+ population: rates improved from 12.4% in 2015 to 15.6% in 2016	Partially Met	Ensure data is accurate. Obtain repeat measures to demonstrate sustainability for the BC+ population.

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
	Partnered with a mental health clinic, beginning in October 2015, to provide member outreach. Coordinated efforts with case managers to enroll SSI members in the case management program if they were not already enrolled. Coordinated efforts with nurses to ensure SSI members were provided with education about the importance of receiving treatment if the member was already enrolled in the case management program.	The project did not demonstrate improvement for the SSI population: rates declined from 10.6% in 2015 to 6.9% in 2016.		
MHS	Conducted member outreach via member calendars, newsletters, brochures, face-to-face meetings, and peer support groups. Provided staff training on approaching members and materials for educational use. Educated providers through webinars, newsletters, and face-to-face and group meetings.	Project did not demonstrate improvement.	Partially Met	Select interventions based on analysis of root cause and which address barriers. Conduct continuous cycles of improvement if interventions are not effective. Include periodic data in the report. Measure effectiveness of interventions.
NHP	Conducted member outreach via member calendars, newsletters, brochures, face-to-face meetings, and peer support groups.	Project did not demonstrate improvement.	Partially Met	Select interventions based on analysis of root cause and which address barriers. Conduct continuous cycles of improvement

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
	Provided staff training on approaching members and materials for educational use. Educated providers through webinars, newsletters, and face-to-face and group meetings.			if interventions are not effective. Include periodic data in the report. Measure effectiveness of interventions.
PPIC	Identified barriers causing missed appointments. Addressed barriers through member outreach. Focused on work flow modifications with Journey Mental Health Center for appointment scheduling.	Project did not demonstrate improvement.	Partially Met	Ensure inclusion of members in the project adheres to the defined study population. Address cultural or linguistic appropriateness of interventions. Ensure initial and repeat measures are comparable.
Prenatal and Postpartum Care				
UHC	Provided transportation vouchers for postpartum care. Conducted member outreach via phone and text messaging. Offered care coordination utilizing Healthy First Steps and Obstetrics Medical Home programs. Educated providers about initiatives to improve quality measures and documentation of outcome data.	Project did not demonstrate improvement.	Partially Met	Ensure the study question includes a numerical target or goal for the project measurement year. Conduct and document continuous cycles of improvement. Include data in the report and analyze periodically as planned. Clearly present numerical results and accurately describe data displayed in graphs and charts. Measure effectiveness of interventions.

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
Tobacco Cessation				
Anthem	Conducted member outreach via phone calls and mailings. Educated providers. Embedded an Anthem employee in a provider's location to conduct member outreach and education. Built a network of relationships with external providers to build a referral system to identify potential smokers.	The organization noted improvement; however, confidence in the data was limited due to the lack of information describing the methodologies and study populations used to calculate the CY 2015 and CY 2016 results.	Not Met	Include measurable goals for study questions. Ensure the study population is defined accurately. Document continuous improvement efforts in the report. Address cultural or linguistic appropriateness of interventions. Collect, analyze, and report data according to the defined study indicators and study question. Ensure initial and repeat measures are comparable.
PPIC	Identified barriers to smoking cessation. Conducted member outreach via mailings. Conducted telephonic outreach to non-compliant members. Mailed a letter to the member's primary care provider encouraging them to provide tobacco use counseling to members at their next visit.	Project did not demonstrate improvement.	Met	Measure effectiveness of interventions and address barriers to achieve improvement. Report final measure for the data upon conclusion of the project.
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease				
*i*Care	Conducted assessments and implemented care plans.	Project did not demonstrate improvement.	Partially Met	Ensure the data collection methods provide accurate data. Develop and

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
	Implemented care management strategies to secure spirometry testing.			implement interventions which are sufficient to be expected to improve outcomes. Collect and analyze data as planned.
Health Screens – Children Only				
CCHP-C4K	Developed screening and data collection tools. Trained staff for effective and consistent completion of developmental/ mental health screens. Educated providers on importance of timely screening. Adjusted workflow by adding intake care coordinator staff at facility locations.	Project demonstrated "real" improvement: increased the rate of completion of developmental/mental health screens from the 2015 baseline of 30-40% to 65% in 2016.	Met	Obtain repeat measures to demonstrate sustainability.

Conclusions

Thirty-nine PIPs were submitted and validated. Organizations' projects focused on a variety of health topics, including annual dental visit, medication usage, breast cancer screening, immunizations, diabetes care, controlling blood pressure, emergency department utilization, follow up care after hospitalization for mental illness, health needs assessments, initiation and engagement of alcohol and other drug dependence treatment, postpartum care, tobacco cessation, and spirometry testing.

Twenty-two of the projects were focused on new topics and 12 organizations continued the same topic from prior years. Two MCOs conducted Tobacco Cessation 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 five of the 39 validated projects. In four of these projects, improvement was demonstrated to be the result of the interventions employed. Based on validation results, none of the projects achieved documented, quantitative improvement that was sustained with repeat measures. The overall

validation findings provide an indication of the reliability and validity of the projects' results. Seven of the projects received validation findings of fully "met," 29 projects received validation findings of "partially met," and three projects received validation findings of "not met."

Prior to implementation, all organizations 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, 20 of 39 MCOs/PIHPs 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

The following strengths were identified during the validation of CY 2016 PIPs:

- The projects focused on improving key aspects of care.
- A knowledgeable qualified team was selected to conduct the project.
- Continuous cycles of improvement were performed.
- The study topic, indicators, and measures were clearly documented.
- The data collection approach was consistent.

Opportunities for Improvement

As a result of the PIP review and validation, MetaStar recommends the MCOs engage in the following opportunities for improvement:

- Identify a prospective data analysis plan that details how frequently the data will be reviewed and analyzed to determine the effectiveness of the interventions.
- Ensure initial and repeat measures are comparable.
- Document continuous improvement efforts in the report.
- 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.
- Ensure that numerical data is displayed accurately in the report, and include numerators and denominators for all data in the report.
- Develop interventions that are culturally and linguistically appropriate, and include relevant documentation in the report.
- Obtain repeat measures to demonstrate sustainability.

CARE MANAGEMENT REVIEW – FOSTER CARE MEDICAL HOME

The Foster Care Medical Home (FCMH) is a PIHP operated in six counties in southeastern Wisconsin by one managed care organization. The FCMH provides comprehensive and coordinated health care for children in out-of-home care in a way that reflects their unique health needs. The FCMH review provides an evaluation of the Medical Home provider's compliance with DHS requirements for the optional Medicaid benefit, and an assessment of its required care coordination systems.

MetaStar reviewed 44 enrollee records of members participating in the FCMH. The record reviews were conducted using criteria and guidelines agreed upon with DHS, and based on the DHS-FCMH contract requirements. DHS solicited input from the Department of Children and Families who oversees the foster care system in Wisconsin, prior to finalizing the review criteria

Records chosen for review included members who enrolled January 1, 2017 or later, and remained enrolled at least 60 days as of the time of the review. Additional information can be found in the "Review Methodologies" section of the Appendix.

Results

SCREENING

Timeliness of Out-of-Home Care (OHC) Health Screen

Timeliness of OHC Screen

Exempt from OHC Screen	1-2 Business Days	3 or More Business Days	OHC Screen Not completed
2	27	13	2

Comprehensiveness of OHC Health Screen

Of the 40 records containing an OHC Health Screen regardless of completion within the required timeframe, 19 were comprehensive. Twenty-one records that were not comprehensive lacked a documented triage score. Of the two records exempted from an OHC Health Screen, neither record documented a triage score.

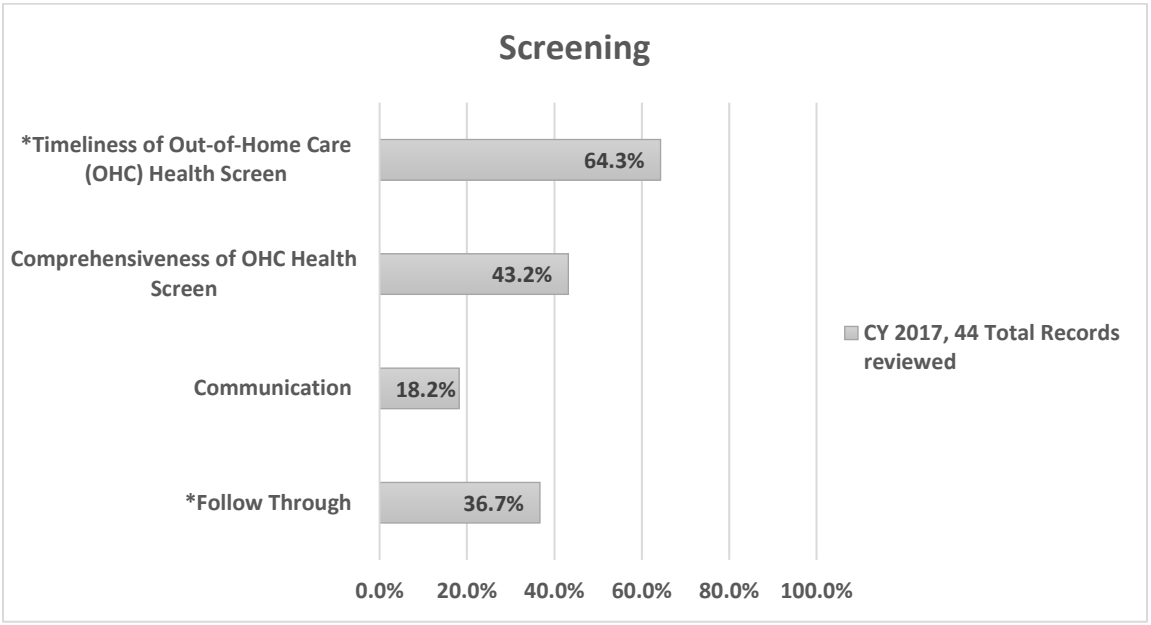
Communication

Evidence of communication with the required parties was present in eight of the 44 records reviewed.

Follow Through

Of the 44 records reviewed, 14 records did not identify any immediate health needs on the member's OHC Health Screen. Eleven of the 30 records with immediate health needs identified did not contain documentation of follow through for at least one of the identified needs.

The following bar graph represents the percentage at which the program met each standard.



*Note: "Timeliness of Out-of-Care (OHC) Health Screen" applied to 42 records. "Follow Through" applied to 30 records.

ASSESSMENT

Timeliness of Initial Health Assessment

Timeliness of Initial Health Assessment

Timely	Not Timely	No Assessment	Exempt from Assessment
25	8	11	0

Completion of Initial Health Assessment

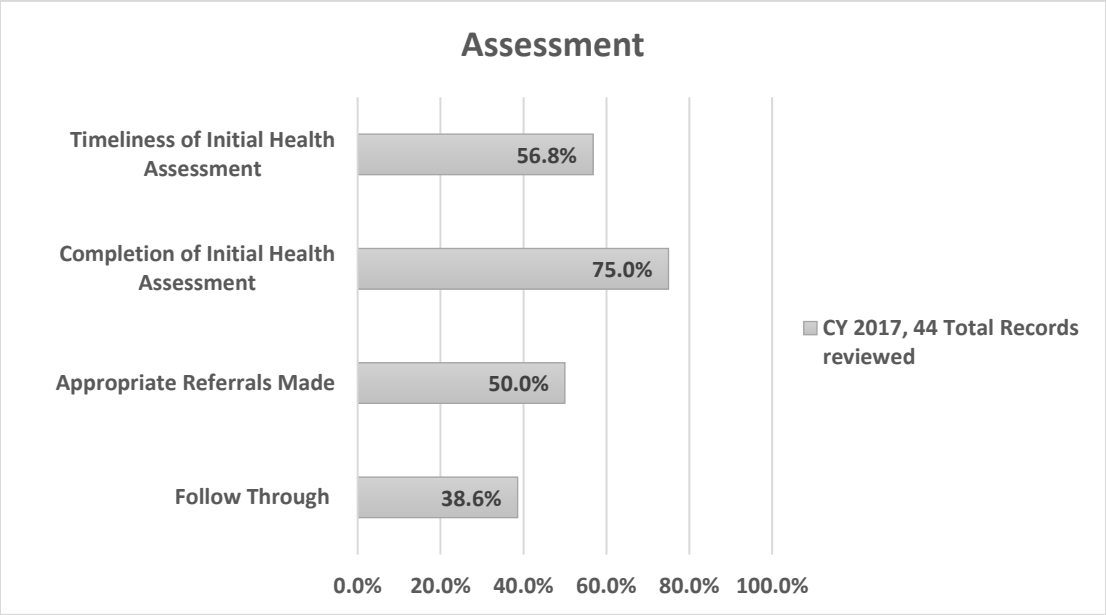
No children in the sample of records reviewed were exempt from the assessment. Initial health assessments were completed in 33 of the 44 records reviewed. All 33 records included evidence of a HealthCheck exam. Eighteen records indicated that there was no need for additional mental health or developmental assessments. Six records did not contain evidence of a parent or legal guardian consent for mental health or developmental assessments.

Appropriate Referrals Made/Follow Through

Of the 44 records reviewed, 22 documented that all referrals were made based on the member's needs identified in the assessment. The remaining 22 records did not contain evidence of compliance with this requirement.

Seventeen records contained evidence that timely follow-through was conducted to confirm the member had received the services/supports recommended in the assessment or an appropriate alternative, and the services/supports were effective in addressing the member's needs. Twenty-seven records did not meet this requirement.

The following bar graph represents the percentage at which the program met each standard.



CARE PLANNING

Timeliness of Initial Care Plan

Timeliness of Care Plan

60 Calendar Days	61+ Calendar Days	Care Plan Not completed
38	2	4

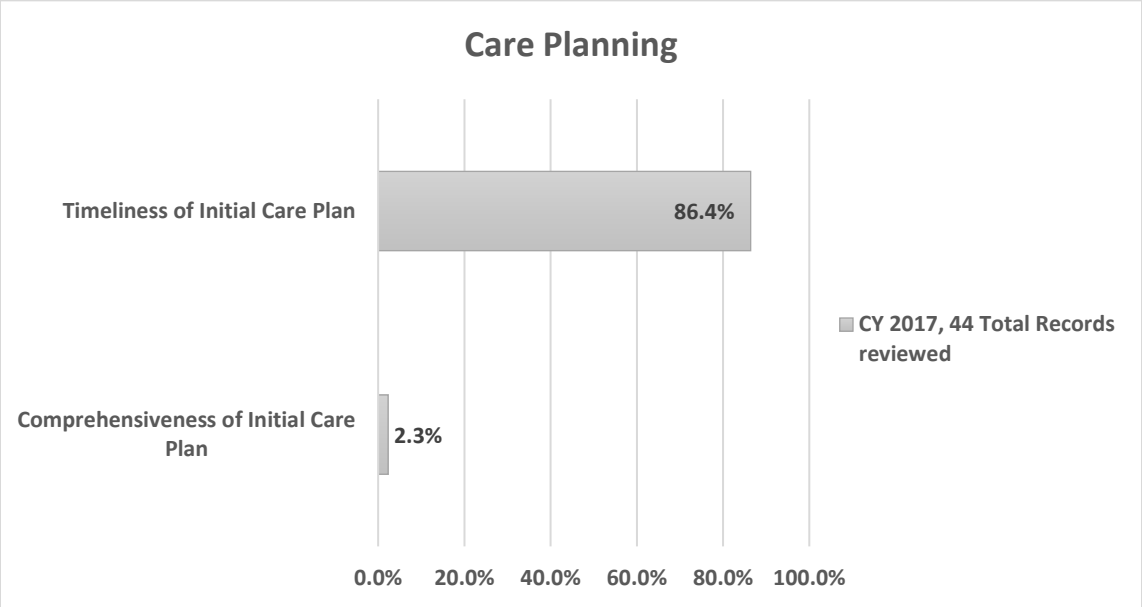
Comprehensiveness of Initial Care Plan

Of the 44 records reviewed, only one initial care plan was comprehensive. The reasons for care plans not being comprehensive included:

- Documentation did not provide evidence of parent/legal guardian input, review, and sign-off (39 records);

- Documentation did not reflect collaboration (38 records);
- Care plans did not include short- and long-term treatment goals as evidence of child-centeredness (35 records);
- Documentation did not provide evidence the member's primary care provider (PCP) and child welfare caseworker were primary participants in development of the plan (28 records); and
- Care plans did not include identification of barriers to care for the social/emotional, physical, informal/formal supports or child centeredness domains (17 records).

The following bar graph represents the percentage at which the program met each standard.

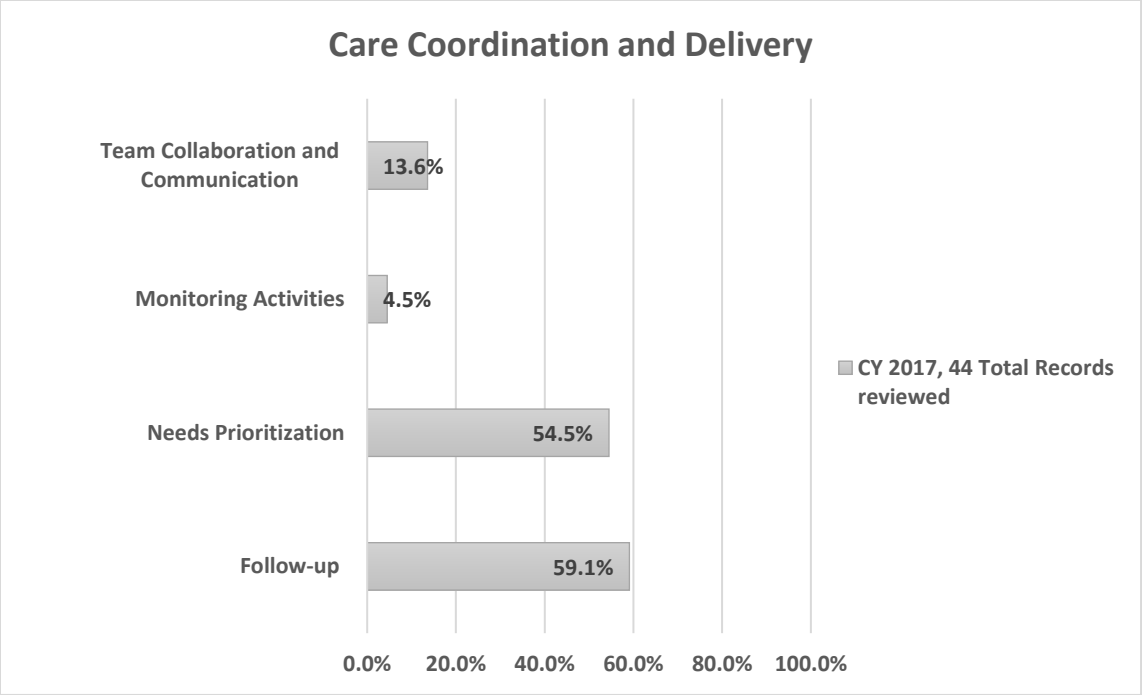


Care Coordination and Delivery

Care Coordination and Delivery

Requirement	Met	Not Met
Team Collaboration and Communication	6	38
Monitoring Activities	2	42
Needs Prioritization	24	20
Follow-Up	26	18

The following bar graph represents the percentage at which the program met each standard.



TRANSITIONAL HEALTH CARE PLANNING

Evidence of Transitional Health Care Planning

This requirement was not applicable to 37 of the total 44 records reviewed. Of the remaining seven records, one record documented a transitional health care plan that met the contract requirements. The member transitioned from the FCMH to another case management program. Six records did not fully meet the requirement.

Transitional Care Planning

Transitional Care Planning Completed	Transitional Care Planning Not Completed	No Care Transitions in Review Period
1	6	37

Conclusions

- The organization has a clear process with well-defined roles that demonstrates a seamless transition from the intake coordinator to the ongoing healthcare coordinator and outreach coordinator.
- The team consists of internal FCMH staff and external providers, including PCPs, dental and mental health professionals, child welfare workers, out-of-home care providers, and parents. As all of the program requirements are not under the direct control of FCMH staff, a high level of coordination and collaboration amongst team members is required.

Opportunities

As a result of its review, MetaStar identified the following opportunities for improvement for the FCMH provider:

- Conduct a root cause analysis of the protocols, policies, and staff training practices regarding documentation to identify barriers to recording all information from the OHC Health Screen within the records. Implement interventions to ensure all required elements are noted in the member's record.
- Conduct a root cause analysis to identify barriers to completing comprehensive care plans. Implement and assess interventions to ensure DHS-FCMH contract requirements are met.

Record Review – HIV/AIDS Health Home

The HIV/AIDS Home Health record review activity provides an evaluation of the Health Home provider's compliance with DHS requirements for the optional Medicaid benefit, and an assessment of its required care coordination systems.

MetaStar reviewed 30 fee-for-service enrollee records of members participating in the HIV/AIDS Health Home. The record reviews were conducted using criteria and guidelines approved by DHS, and based on the current Medicaid and BadgerCare Plus handbook. The time period reviewed was July 1, 2016 to December 31, 2016. 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 the Appendix.

Results

The HIV/AIDS Health Home review evaluated the following three focus areas:

- Member Outreach;
- Core Team of Health Professionals; and
- Comprehensive Care Management.

The three focus areas were made up of ten indicators that reviewers used to evaluate care management performance.

Member Outreach

Informed Consent

Each record reviewed contained some elements of the requirements for documentation of informed consent to participate in the Health Home program, but no records fully met the requirement. Of the records with informed consent documented:

- Three records documented the member/alternate legal decision maker accepted responsibility to participate and maintain contact;
- Eight records documented the member/alternate legal decision maker received an explanation/education regarding the enrollment process, and
- Eight records documented an explanation or discussion about the Health Home model of care.

Records that did not meet this indicator had no information indicating completion of any factor included as part of the informed consent process.

The most common elements not met were:

- No records documented an opt-out discussion was held with the member/alternate legal decision maker; and
- No records documented the member/alternate legal decision maker received an explanation/education regarding the freedom of choice.

Eligibility

The organization's established process to determine a member's eligibility is well defined and accurate regardless of where the referral originated as evidenced by the 100 percent met "Eligibility" standard.

Core Team of Health Professionals

Team Members

The records reviewed did not fully meet the standard for documenting all core members of the care team. Documentation identifying members of the core team of health professionals was found 152 times in the 30 records reviewed. Of the team members identified, the most common were:

- Primary care provider (28 records);
- Primary nurse (23 records);
- Care manager, a behavioral health/alcohol or other drug abuse (AODA) professional, and dentist (20 records each); and
- Care coordinator (18 records).

Of the team members not identified in a record, the most common were:

- Pharmacist (21 records);
- Care coordinator (12 records); and
- Care manager, behavioral health/AODA professional, and dentist (10 records each).

Comprehensive Care Management

Member Contact Standards

The records reviewed did not fully meet the standard for documentation demonstrating that care team contacts are occurring with the member. The care team contacts documented include:

- Twenty face-to-face contacts within the required timeframe; and
- Ten member/collateral contacts within the required timeframe.

Of the records that did not meet the member contact standards, 20 records did not include documentation of a member/collateral contact at least monthly, and 10 records did not include a documented face-to-face contact at least once every three months.

Assessment

Documentation demonstrating the record contains an initial comprehensiveness assessment conducted as required was not present in any of the 30 records reviewed. Two records included documentation of a comprehensive case management assessment, but did not include the medical assessment.

Of the records reviewed, some of the most common components missing included:

- Dental exam and medical history (no records contained this information);
- Falls and safety assessment (no records contained this information);
- Documentation of a pharmacist's medication review (28 records);
- Member strengths, coping behaviors, and strategies (22 records);
- Sexual practices/concerns assessment (16 records); and
- High risk/injection risk assessment (20 records).

Documentation demonstrating that a comprehensive reassessment was conducted annually was not present in any of the 30 records reviewed.

Plan of Care

Each record reviewed contained some elements of the requirements for a comprehensive care plan, but no records contained all of them. As a result, no records were considered comprehensive. The most frequent components included were:

- Plan is accessible to all core team members (25 records);
- Health promotion and self-care (23 records);
- Identification of frequency and method of contacts (21 records); and
- Identification of all services related to the member's assessed needs (18 records).

Documentation of the plan of care components was not met 116 times in the 30 records reviewed. Please note records may have not met the standard for more than one element. The components most commonly not met were:

- Evidence of service integration (28 records);
- Multidisciplinary plan (16 records);
- Identification of all team members involved (14 records); and
- Care and treatment goals, including non-medical (14 records).

Care Coordination
The records reviewed did not fully meet the standard for documentation demonstrating care coordination. The documentation was found 18 times in the 30 records reviewed. Of the care coordination documentation:

- Eleven records included evidence of follow-up; and
- Seven records included evidence of care coordination.

Of the records that did not demonstrate care coordination:

- Nineteen did not include evidence of follow-up; and
- Twenty-three did not include evidence of care coordination across all specialties.

Health Promotion and Self-Care
The records reviewed did not fully meet the standard for documentation demonstrating health promotion and self-care. This documentation was found 61 times in the 30 records reviewed. Of the 61 occurrences:

- Twenty included a risk assessment;
- Twenty-three included medication monitoring; and
- Eighteen included HIV risk reduction.

Of the records that did not have any documentation of health promotion or self-care discussions during the review period:

- Twelve did not include HIV risk reduction;
- Ten did not include a risk assessment; and
- Seven did not include medication monitoring.

Transitional Care
The records reviewed did not fully meet the standard for documentation demonstrating continuity of care during care transitions. This documentation was found five times in the 30 records reviewed. Of the five occurrences that did have care transition documentation:

- One record indicated contact with the member within 24 hours and evidence of collaboration with the team;
- Three records documented a review of the discharge summary with the member; and
- One record included documentation of a comprehensive transitional plan.

Of the records that did not have care transition documentation, 14 had no care transitions recorded or reported within the review period, so no documentation was necessary. Records may

have had more than one care transition element scored as not met. The most common reasons for this element being scored as not met in the remaining records include a lack of documentation of:

- Face-to-face contact within 24 hours of an emergency room visit or discharge from a hospital or nursing home (16 records);
- Contact with the member or institution within 24 hours of the care transition and evidence of collaboration with the PCP (15 records); and
- A comprehensive transitional care plan (15 records).

Individual/Family Support Services

Documentation demonstrating a discussion about the benefits of designating an authorized agent was found in one of 30 records reviewed.

The 29 records that did not meet this requirement did not include any documentation about this discussion or the member's decision.

Conclusions

The AIDS Resource Center of Wisconsin (ARCW) is the only qualified HIV/AIDS Health Home in Wisconsin. The organization is flexible and adaptable to work with a variety of MCOs who may have different practices and procedures. Overall, the 30 records reviewed lacked documentation, and at times contained inconsistent documentation between the two electronic charting systems utilized by the organization, making it difficult to determine if Health Home requirements were being met.

Opportunities for Improvement

As a result of its review, MetaStar identified the following opportunities for the Health Home:

- Conduct a root cause analysis to identify barriers and remediate the underlying causes of absent documentation in member records.
- Evaluate the case management and electronic health record charting systems and processes in place to enable full utilization and cross-references between the two charting systems.
- Evaluate assessment tools and processes to confirm they include all required assessment elements.
- Analyze current policies, procedures, and practices for identifying who fills the coordinator role and make any needed improvements, in order to ensure a core coordinator is assigned for each member, that the assignment is clearly documented, and that care coordinators fully understand their role/responsibilities.
- Evaluate current practices for documentation of enrollment and disenrollment dates to ensure they are clearly and consistently updated in the member record.

- Review and update documentation practices as necessary to include clear documentation of the required annual dental exam, including details about what occurred during the visit.

Record Review – Childless Adults Health Needs Assessment

Objectives

The BC+ childless adults (CLA) health needs assessment (HNA) review assesses a MCO's level of compliance with requirements contained in its contract with DHS and verifies that initial HNA data meets performance benchmarks. Information gathered during the CLA HNA review helps to assess the timeliness and comprehensiveness of the initial HNA for applicable members. In addition, MCOs are required to achieve the lesser of two targets, a 35 percent rate of compliance or a 10 percent reduction in error from the MCO's self-reported baseline, for timeliness of initial HNAs, to avoid a financial penalty. The CLA HNA review is an optional activity with a penalty provision. MetaStar reviewed 1,164 records of BC+ CLA recipients enrolled in 18 MCOs. This was a new review activity during CY 2017 and the results reported here are for the full activity, not just the reporting timeframe.

Scope of the Review and Review Methodology

MetaStar reviewed a total of 1,164 records 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 records reviewed for each organization.

Records Reviewed for each MCO Serving Childless Adults in Wisconsin

Managed Care Organization	Number of Records
Anthem	74
CCHP	36
Compcare	74
DHP	79
GHC-EC	80
GHC-SCW	83
GHP	78
HTHP	48
*i*Care	68
Mercy	77
MHS	48
MHWI	64

Managed Care Organization	Number of Records
NHP	52
PPIC	55
SHP	82
Trilogy	40
UHC	40
Unity	86

The reviews were conducted based on DHS-MCO contract criteria and guidelines agreed upon with DHS. Reviewers conducted the reviews from May 2017 through September 2017. The period of record documentation reviewed was January 1, 2016 to December 31, 2016 and 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 the Appendix.

Results

The review focused on two indicators related to serving newly enrolled members:

- Timeliness of HNA completion; and
- Comprehensiveness of initial HNA.

Each section below provides a brief explanation of each indicator, followed by a bar graph. The review methodology agreed upon with DHS requires the MCOs to complete an initial HNA within two calendar months of enrollment. When the MCO is unable to contact the member, 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 timeliness of HNA completion affects the comprehensiveness of the initial HNA.

ASSESSMENT

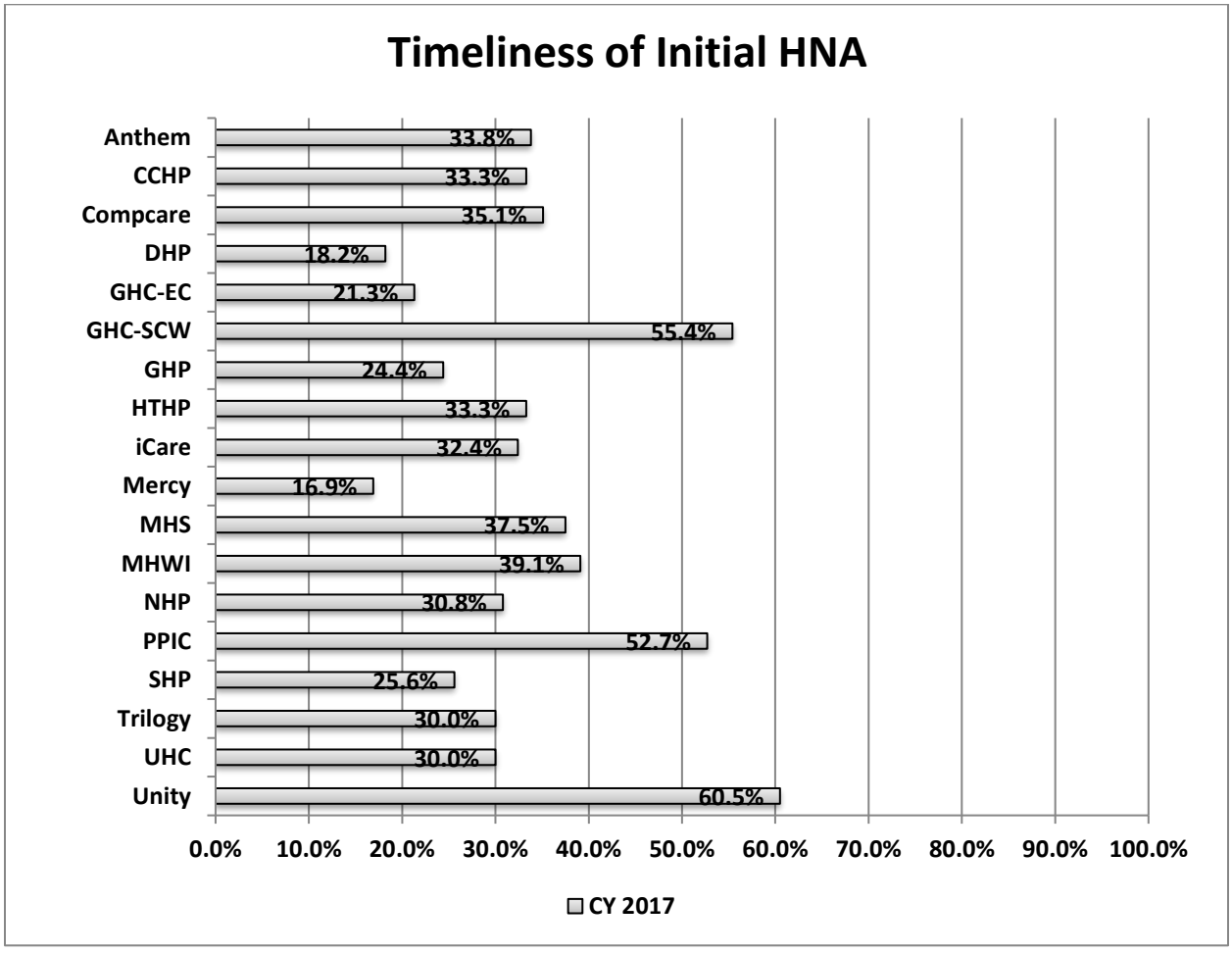
Timeliness of Initial HNA

The initial HNA must be completed within two calendar months of enrollment, covering eight elements outlined by DHS.

The number of timely assessments completed was 393 of 1,164; 771 assessments were not completed or not completed timely. Contact efforts were also documented when an assessment was not timely or not completed. (The percentages below are rounded to the nearest whole number.)

- 369 records (48 percent) indicated the MCO made reasonable effort, but was unable to reach the member;
- 19 records (2 percent) documented that the MCO made reasonable effort and the member refused;
- 12 member records (2 percent) showed the MCO made reasonable effort and the HNA was completed outside of the two calendar month timeframe; and
- 354 member records (46 percent) indicated minimal or no effort to complete the assessment within the required timeframe.

The graph below depicts the rate of compliance achieved by each MCO in CY 2016 for the review element "Timeliness of Initial HNA." The average rate for all MCOs was 34 percent. Twelve MCOs scores are less that the average rate while six MCOs scores are greater than the average rate. Three MCOs had a timely completion rate of over 50 percent.

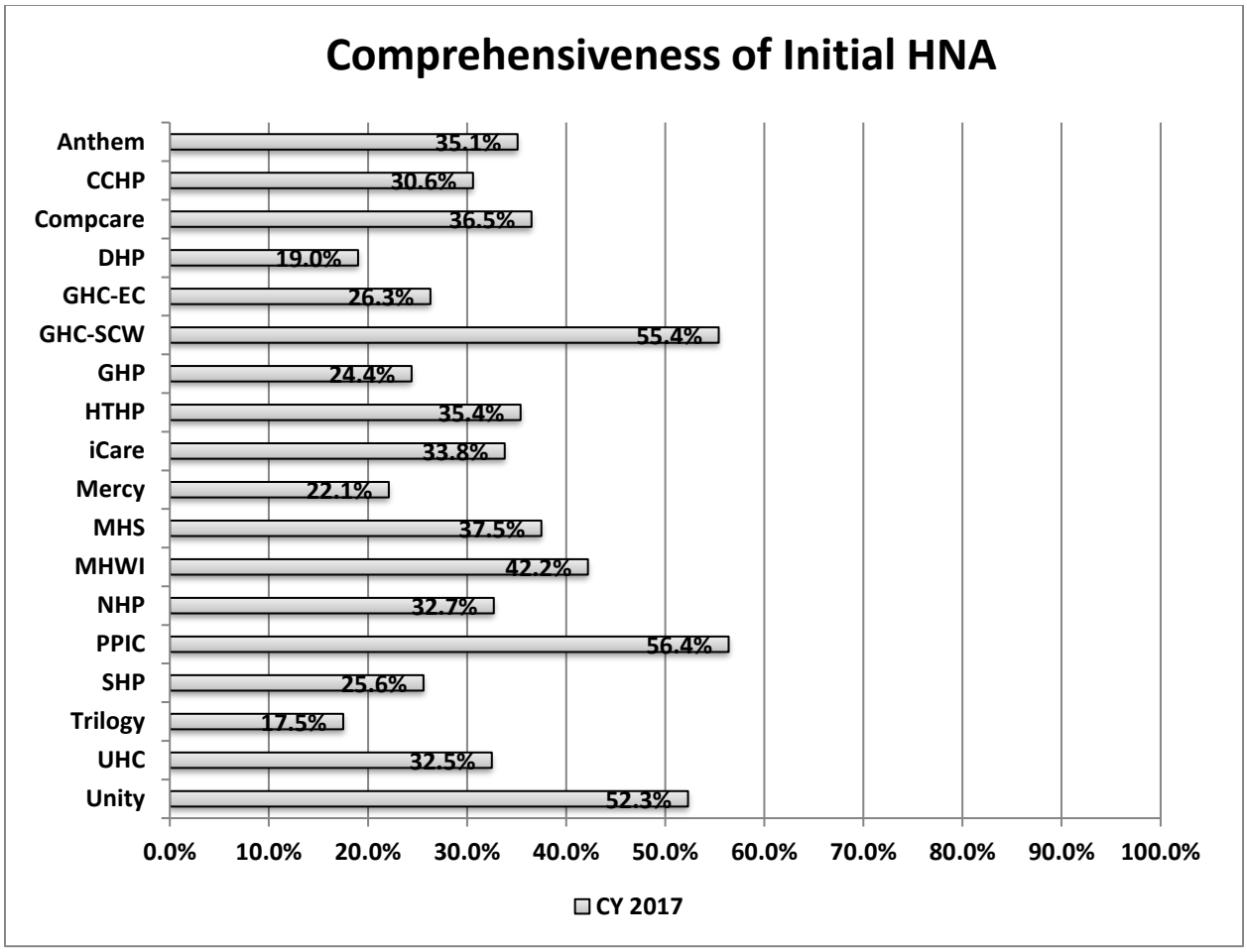


Comprehensiveness of Initial HNA

The assessment must be comprehensive. The HNA is comprehensive if it includes the member's history of chronic physical and mental health illness (item e. below), and at least three additional elements of the following information:

a. Urgent medical and behavioral symptoms;
b. Member's perception of his/her general well-being;
c. Identify usual sources of care (e.g. primary care provider, clinic, specialist and dental provider);
d. Frequency in use of emergency and inpatient services;
e. History of chronic physical and mental health illness (e.g. respiratory disease, heart disease, stroke, diabetes/pre-diabetes, back pain and musculoskeletal disorders, cancer, overweight/obesity, severe mental illnesses, substance abuse);
f. Number of prescription medications used monthly;
g. Socioeconomic barriers to care (e.g. stability of housing, reliable transportation, nutrition/food resources, availability of family/caregivers to provide support); and
h. Behavioral and medical risk factors including the member's willingness to change his/her behavior such as:
    i. Symptoms of depression;
    ii. Alcohol consumption and substance use; and
    iii. Tobacco use.

The following graph depicts each MCO's rate of compliance in CY 2016 for the review indicator "Comprehensiveness of Initial HNA;" the rate for all MCOs for this indicator was 35 percent. This rate reflects the rate of comprehensiveness of the HNA regardless of timeliness. Assessments not completed are included as not comprehensive. However, when assessments are completed, almost all of the assessment elements are addressed. Of the 419 assessments completed across all MCOs, 96 percent were comprehensive. Assessment of urgent medical and behavioral symptoms was the assessment element that was most often not consistently addressed.



Conclusions

The penalty provision included in the DHS-MCO contract sets a requirement for MCOs to achieve a 35 percent rate for timelines or a 10 percent reduction in error from the MCO's self-reported baseline, for timeliness of initial HNAs from CY 2015. Thirteen MCOs had an average rate for timeliness at or above the requirement, while five MCOs did not meet the benchmark.

The following observations were made related to member outreach and comprehensiveness of the HNA:

- MCOs used a variety of approaches to facilitate timely completion of the HNA such as automated phone systems, live person calls, mailing introductory letters with the HNA to members, incentives for completing the HNA, and home visits.
- The use of telephone and mail to contact members accounted for 98 percent of contact methods. Member populations included both rural and urban.

- Due to the variety of member population and approaches used to facilitate the HNA completion, data was not sufficient to determine which approach or combination of approaches was most successful.
- When assessments were completed they were generally found to be comprehensive. When assessments were not found to be comprehensive, it was due to item "e;" that is, history of chronic physical and mental health illness not being assessed.

Review of the three MCOs achieving a timely HNA completion rate of greater than 50 percent showed that one MCO used an incentive based strategy of a $10.00 gift card for members completing the HNA, while the others relied on member outreach by phone and mail to complete the HNA. These three MCOs demonstrated consistency in attempts to contact members. Documentation supported that adequate attempts to contact members were completed for every case.

The lack of adequate attempts to contact members was a barrier to completing a timely HNA with members. Record review did not support the 834 file was inaccurate, (i.e., member demographic information supplied by DHS). Of the 1,164 records reviewed, 46 percent showed lack of documentation to support evidence of reasonable effort to contact members after initial MCO enrollment.

Contributing factors for lack of adequate attempts to contact members included inconsistencies between written policies and procedures and actual practices for member outreach as follows:

- Three MCOs had policies and procedures stating a home visit would be done as an attempt to complete the HRA but record review found documentation of home visit attempts were not present; and
- MetaStar identified instances of the policies and procedures not consistently being followed resulting in gaps between the outreach policies and procedures and actual practice.

Use of automated systems for identifying and contacting members was identified as a barrier in some instances as follows:

- Computer systems did not recognize a member transferring from one line of business into CLA, or a member disenrolling and returning to the CLA line of business more than six months later;
- Some issues were noted with lack of documentation of automated mail sent out and/or returned as undeliverable, and
- Some automated phone systems identified disconnected or out-of-service numbers as "bad" with no further attempts to contact.

Strengths

MetaStar identified organizational capabilities beyond basic compliance with contract compliance as follows:

- Three MCOs demonstrated consistency in making adequate attempts to contact and engage members to complete the HNA, and had HNA completion rates greater than 50 percent;
- Four MCOs implemented incentive programs for CLA members for completion of a timely HNA;
- Four MCOs included a narrative summary of the HNA findings in the member's care management records in addition to the completed HNA form which provided an opportunity to succinctly capture the member's needs; and
- One MCO provided evidence of home visits for HNA completion.

Opportunities for Improvement

As a result of its review, MetaStar identified the following opportunities for improvement for MCOs:

- Analyze the member engagement process to determine barriers to successfully contacting and engaging members to complete a timely HNA;
- Evaluate and address barriers to making adequate attempts to contact members;
- Identify discrepancies between actual practice and written guidance related to contacting members to complete the HNA and implement interventions to assure consistency between expectations identified in guidance and actual practice;
- Evaluate automated systems used to identify members in need of HNA completion for potential barriers; and
- Evaluate automated systems used to contact members for HNA completion for potential barriers.

APPENDIX – REQUIREMENT FOR EXTERNAL QUALITY REVIEW AND REVIEW METHODOLOGIES

REQUIREMENT FOR EXTERNAL QUALITY REVIEW

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

MetaStar - Wisconsin's External Quality Review Organization

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

MetaStar conducts EQR of MCOs operating Medicaid managed long-term programs, including Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly. In addition, the company conducts EQR of MCOs serving BadgerCare Plus, Supplemental Security Income, Special Managed Care, and Foster Care Medical Home Medicaid recipients in the State of Wisconsin. MetaStar also conducts EQR of Home and Community-based Medicaid Waiver programs that provide long-term support services for children with disabilities. MetaStar provides other services for the state as well as for private clients. For more information about MetaStar, visit its website at www.metastar.com.

MetaStar Review Team

The MetaStar EQR team is comprised of registered nurses, a clinical nurse specialist, a nurse practitioner, a physical therapist, a recreational therapist, a school counselor, licensed and/or certified social workers and other degreed professionals with extensive education and experience working with the target groups served by the MCOs. The EQR team is supported by other members of MetaStar's Managed Health and Long-Term Care Department as well as staff in other departments, including a data analyst with an advanced degree, a licensed Healthcare Effectiveness Data and Information Set (HEDIS®)[3] auditor, certified professional coders, and information technologies staff. Review team experience includes professional practice and/or administrative experience in managed health and long-term care programs as well as in other

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

settings, including community programs, schools, home health agencies, community-based residential settings, and the Wisconsin Department of Health Services (DHS). Some reviewers have worked in skilled nursing and acute care facilities and/or primary care settings. The EQR team also includes reviewers with quality assurance/quality improvement education and specialized training in evaluating performance improvement projects.

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

Review Methodologies

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 2016, MCOs calculated and reported some measures and DXC Technology (DXC) calculated and reported others.

In preparation for MY 2016, the EQR team communicated with staff from DHS along with staff from DXC. 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.

DXC calculated the performance measures using source data extracted from Wisconsin's ForwardHealth interChange system and data submitted by MCOs. An additional data source for the performance measures included the Wisconsin Immunization Registry (WIR).

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 DXC 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:

- DXC Small Project Charter
- DXC Data Extraction and Analysis Plan
- DXC Source Code – Structured Query Language (SQL)
- Technical Specifications for the Performance Measures
- DXC Measure Results
- National Drug Codes List, if applicable; and
- National Committee for Quality Assurance (NCQA) HEDIS Data submission documents for MY 2016:
    - 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 Extensible Markup Language (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); and
    - The Audit Report produced by a NCQA Licensed HEDIS Auditor.

Periodic meetings and conference calls between DHS and DXC 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 DXC 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 DXC 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 DXC, in order to evaluate the need to remediate the issue and resubmit documents prior to measure validation.

For each internally developed 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 where applicable, such as NCQA benchmarks.

MetaStar provided feedback to DHS and DXC after each measure review. DXC 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 DXC 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, with procedure and drug code modifications for 2016. MCOs submitted HEDIS data and documentation for validation for those measures labeled "HEDIS" below. MCOs submitted data and DXC calculated rates for the HEDIS-like measures and the single DHS measure related to tobacco cessation identified in the table.

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 – HbA1c Testing (CDC)** The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had a Hemoglobin A1c (HbA1c) test.	Y	Y
HEDIS	**Comprehensive Diabetes Care – HbA1c Control < 8%** (NQF 0575); (P4R – pay for reporting only for MY2016)	Y	Y
HEDIS	**Childhood Immunization Status –**	Y	N

SOURCE	PERFORMANCE MEASURES	POPULATION VALIDATED	
		BC+	SSI
	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).		
HEDIS	**Controlling Blood Pressure < 140/90 mmHg (NQF 0018)**; (pay for reporting only for MY2016).	Y	Y
HEDIS-Like	**ED Visits (AMB)** ***sans revenue code 0456 (Urgent Care)*** The number of Emergency Department visits per 1000 member months; this is a utilization measure.	Y	Y
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.	Y	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**	Y	N

SOURCE	PERFORMANCE MEASURES	POPULATION VALIDATED	
		BC+	SSI
	of Prenatal Care (PPC) The percentage of deliveries of live births between November 6 of the year prior to the measurement year (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.		
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** 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 at least one dental visit with a dental practitioner, as noted by any of the following: CPT Codes: 70300, 70310, 70320, 70350, 70355, 99188. CDT Codes: : D0120-D0999; D1110-D1999; D2140-D2999; D3110-D3999; D4210-D4999; D5110-D5899; D6010-D61999; D6205-D6999; D7111-D7999; D8010-D8999; D9110-D9975, D9999 (exclude: D0145, D1353, D5900-D5999, D9985-D9987).	Y	N
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 at least one dental visit with a dental practitioner, as noted by any of the following: CPT Codes: 70300, 70310, 70320, 70350, 70355, 99188.	Y	N

SOURCE	PERFORMANCE MEASURES	POPULATION VALIDATED	
		BC+	SSI
	CDT Codes: : D0120-D0999; D1110-D1999; D2140-D2999; D3110-D3999; D4210-D4999; D5110-D5899; D6010-D61999; D6205-D6999; D7111-D7999; D8010-D8999; D9110-D9975, D9999 (exclude: D0145, D1353, D5900-D5999, D9985-D9987).		
DHS MEDDIC-MS	**Tobacco Cessation - Counseling** For BC+, members 12 years of age or older during the measurement year. For SSI Managed Care, members 19 years of age or older during the measurement year.	Y	Y

Performance Measures Results

This table provides a comparison of the non-HEDIS measure calculations that were produced by DXC. The measure rates were compared to prior years as well as other health plans.

Program: BC+		
Performance Measure	***Benchmark***	***Comparisons to Benchmarks***
Annual Dental Visit - Children (Regions 5&6 only)	National benchmarks are not available.	The aggregate MCO rate increased by 7.0 percent from the prior year.
Annual Dental Visit - Adult (Regions 5&6 only)	National benchmarks are not available.	The aggregate MCO rate increased by 5.0 percent from the prior year.
ED Visits (AMB) *sans revenue code 0456 (Urgent Care)*	National benchmarks are not available.	The aggregate MCO rate decreased by 0.7 percent from the prior year.
Tobacco Cessation - Counseling	National benchmarks are not available.	The aggregate MCO rate increased by 3.3 percent from the prior year.
Program: SSI		
Performance Measure	***Benchmark***	***Comparisons to Benchmarks***
ED Visits (AMB) *sans revenue code 0456 (Urgent Care)*	National benchmarks are not available	The aggregate MCO rate increased by 2.5 percent from the prior year.

Tobacco Cessation - Counseling	National benchmarks are not available.	The aggregate MCO rate increased by 3.2 percent from the prior year.

Validation of Performance Improvement Projects

The purpose of a performance improvement project (PIP) is to assess and improve the processes and outcomes of health care provided by a MCO/SMCP/PIHP. PIP validation, a mandatory EQR activity, documents that an organization'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/SMCP/PIHP. The document review may have been supplemented by staff interviews, if needed.

Findings were analyzed and compiled using a three-point rating structure (met, partially met, and not met) to assess the organization'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/SMCP/PIHP had the opportunity to review prior to finalization of the report.

Record Review – Foster Care Medical Home

Prior to conducting the review, MetaStar obtained and reviewed the organization's documents to familiarize reviewers with the practices, including policies, procedures, and/or forms related to member assessment and care planning, member acuity or level of care intensity, and care coordination activities such as follow-up.

Per DHS direction, MetaStar randomly selected a sample of FCMH members who were newly enrolled on or after January 1, 2017 and who were enrolled at least 60 consecutive days.

The review team used a review tool and reviewer guidelines based on the DHS-MCO contract and agreed upon with DHS. The review evaluated the following five categories of care coordination and management. The five categories were made up of eleven indicators that reviewers used to evaluate care management performance:

1. Screening
    a. Timeliness of initial OHC Screen
    b. Comprehensiveness of OHC Screen
2. Assessment
    a. Timeliness of initial Health Exam
    b. Comprehensiveness of initial Health Exam
3. Service Planning
    a. Timeliness of initial care plan
    b. Comprehensiveness of initial care plan
4. Service Coordination and Delivery
    a. Follow up to ensure that services are effective
    b. Identified needs are prioritized
    c. Identified needs are addressed
5. Transitional Care
    a. Planning for members returning to parents, but remaining in the FCMH
    b. Planning for members disenrolling from the FCMH

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 OHC screen, Health Assessment or Care Plan was not completed, all elements were scored "not met."

At the end of the record review, MetaStar gave the organization and DHS the findings from each individual record review as well as a report regarding the organization's overall performance.

Record Review –HIV/AIDS Health Home

Prior to conducting the record review, MetaStar worked with DHS to identify the guidelines and criteria for review. Per DHS direction, MetaStar randomly selected a sample of Health Home members who were enrolled since inception of the program, and who were enrolled for at least six months after enrollment.

The review team used a review tool and reviewer guidelines based on the DHS contract and approved by DHS. The review evaluated the following three focus areas:

- Member Outreach;
- Core Team of Health Professionals; and
- Comprehensive Care Management.

The three focus areas are made up of ten indicators that reviewers used to evaluate care management performance.

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.

At the end of the record review, MetaStar gave the Health Home and DHS the findings from each individual record review as well as a report regarding the organization's overall performance.

Record Review – Childless Adults Health Needs Assessment

Prior to conducting the review of initial Health Needs Assessments (HNAs) for BC+ members served in the Childless Adults Program, MetaStar asked each MCO to respond in writing to a survey approved by DHS, which asked the organization to describe its processes for:

- Identifying and contacting members, including those who are difficult to reach; and
- Utilizing the HNA results, particularly in care planning.

MetaStar also obtained and reviewed MCO documents to familiarize reviewers with the MCO's practices, including policies, procedures, and/or forms related to member outreach, assessment and care planning.

Per DHS direction, MetaStar randomly selected a sample of BC+ childless adult members who were newly enrolled during the period from January 1, 2016 through December 31, 2016, and who remained continuously enrolled in the same MCO for two continuous calendar months.

The review team used a review tool and reviewer guidelines based on the DHS-MCO contract and approved by DHS. The review evaluated two indicators that reviewers used to evaluate compliance with the HNA completion requirements:

1. Timeliness of initial HNA*
2. Comprehensiveness of initial HNA*

If reviewers identified a member had previously enrolled in the MCO as a commercial member or as a BC+ member with an HNA completed in the previous 12 months, the member's record was not reviewed and a replacement member from an over-sample was added to the sample. The reviewers also discarded a record if the member:

- Did not have two continuous calendar months of enrollment;
- Was retroactively enrolled;
- Disenrolled, then reenrolled within the same six month period and with the same MCO; or
- Disenrolled, then re-enrolled with the same MCO six months or more from the disenrollment date and did not remain continuously enrolled for two calendar months after the reenrollment date.

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 HNA 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. The benchmarks and potential penalties established by DHS are:

1. Goal: BC+ MCOs are required to meet the lesser of the following targets of timely HNA screenings:
   a. Performance Level Target: 35% rate of timely HNA screenings in calendar year 2016-2017; OR
   b. Reduction in Error Target: 10% improvement from baseline.

   Reduction in Error Example:
   i. Assume a MCO has a 2016 baseline of 20%;
   ii. 2016 Error: 100% - 20% = 80%;
   iii. 2016 Reduction in Error Target: 100% - [80% * (100% -10%)] = 28%;
   iv. In this example, the MCO 2016 target for timely HNA screenings would be 28%, not 35%.

2. Penalty: MCOs that do not meet the HNA target will be subject to liquidated damages. The amount will be the lesser of either $250,000 or $40 per BC+ Childless Adult member for whom the MCO failed to meet the target in the calendar year.

   Penalty Example:

a. Assume that an HMO's 2016 HNA performance is 25% and the denominator was 1,000 members who needed a timely HNA screening in 2016.
b. Based on the 2016 denominator of 1,000, the MCO needed:
   28% * 1,000 = 280 timely HNA screenings completed to meet its target.
c. In this example, assume that the MCO had 250 timely HNA screenings completed in 2016 and fell short by 30 HNA screenings: 280 - 250 = 30.
d. The 2016 penalty would be 30 * $40 = $1,200.

Related to the penalties that could be imposed, DHS provided MetaStar with the expected rate of performance for the timeliness and comprehensiveness of initial HNAs. MetaStar used the combined rate of compliance for review elements 1. and 2. to assess the MCO's rate of compliance relative to its benchmark.