External Quality Review

Calendar Year 2018

Annual Technical Report

BadgerCare Plus, Medical Homes, Special Managed Care Programs, and Medicaid Supplemental Security Income Managed Care

Prepared for

Wisconsin Department of Health Services

Division of Medicaid Services

Prepared by

METASTAR

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Executive Summary

External Quality Review Process

The Code of Federal Regulations (CFR) at 42 CFR 438 requires states that operate prepaid inpatient health plans (PIHPs) and managed care organizations (MCOs), including health maintenance organizations, special managed care programs (SMCPs), and organizations that provide managed care services, to provide for external quality review of these organizations and to produce an annual technical report. To meet its obligations, the State of Wisconsin, Department of Health Services (DHS) contracts with MetaStar, Inc.

This report covers the external quality review calendar year from January 1, 2018, to December 31, 2018 (CY 2018). Mandatory review activities conducted during the year included assessment of compliance with federal standards, validation of performance measures, validation of performance improvement projects, and information systems capabilities assessments. MetaStar also conducted three optional activities, including Obstetrics Medical Home/Healthy Birth Outcomes record review, Foster Care Medical Home care management review, and Health Needs Assessment record review. In conjunction with DHS, MetaStar completed development work for the Supplemental Security Income and Children with Medical Complexity care management reviews, which will be conducted in CY 2019.

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 begins on page 11. More detailed information regarding results of the various review activities, including identified progress, strengths, and opportunities for improvement, begins on page 14. See Appendix 2 for more information about external quality review and a description of the methodologies used to conduct review activities.

Compliance with Standards Review

A compliance with standards review is a mandatory activity identified in 42 CFR 438.358 and is conducted according to federal protocol standards. In CY 2018, MetaStar conducted compliance with standards reviews for three MCOs and two SMCPs not accredited by the National Committee for Quality Assurance.

All three MCOs and both SMCPs demonstrate a commitment to enrollee rights. One MCO and one SMCP fully met all of the Enrollee Rights and Protections standards. Opportunities to improve were identified for each organization. The identified areas for improvement related to restrictive measures policies and procedures as well as provider directories.

Each of the three MCOs and two SMCPs had strengths which contribute to fully met standards in the Quality Assessment and Performance Improvement (QAPI) focus area. However, MetaStar

recommended all five organizations focus on improving compliance related to service authorizations, QAPI programs, provider network adequacy, and utilization management.

All three MCOs value and support members' access to grievance systems. However, all three should update the written grievance and/or appeal disposition letters. The SMCPs both need to update their respective complaints, grievances, and appeals policies and implement formal appeal and grievance committees.

Validation of Performance Measures

MetaStar validated measurement year 2017 performance measures for the BadgerCare Plus and Supplemental Security Income Medicaid programs. In addition to using this data to meet CMS performance measures requirements, DHS also uses the information to set and monitor quality performance benchmarks with each individual MCO. DHS has established pay for performance incentives as a performance improvement strategy for MCOs, to improve priority Healthcare Effectiveness Data and Information Set (HEDIS®)[1] scores as well as performance for other measures identified by DHS.

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 it had 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.

Validation of Performance Improvement Projects

MetaStar reviewed and validated 30 performance improvement projects (PIP) during CY 2018. Twenty-seven performance improvement projects were conducted during CY 2017 by 18 MCOs participating in the Wisconsin BadgerCare Plus and/or Supplemental Security Income (SSI) Medicaid programs. The DHS-MCO contract requires each organization to conduct two performance improvement projects each year. In lieu of a second project, MCOs participating in the SSI program submitted a PIP-like project, which were reviewed by DHS. The projects validated by MetaStar focused on a variety of health topics, including medication management, 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, lead screening in children, and tobacco cessation. In addition, one project each was conducted by two SMCPs and one PIHP for

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

the foster care medical home benefit during CY 2017. The projects were focused on transitions of care, sleep hygiene, and developmental screening.

All organizations 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. DHS project approval occurred subsequent to MetaStar's feedback. When the final projects were validated, nine of 30 projects fully met the first 12 standards. Of these nine projects, eight were in the second or third year of implementation; however, only one project demonstrated quantitative improvement.

The overall validation findings provide an indication of the reliability and validity of the projects' results. Three of the projects received a validation result of fully "met," 14 projects received a validation result of "partially met," and 13 projects received a validation result of "not met."

Information Systems Capabilities Assessments

Federal regulations at 42 CFR 438.242 as well as the Centers for Medicare & Medicaid Services protocols also mandate that states assess the information systems capabilities of MCOs. Therefore, MetaStar conducted information systems capabilities assessments (ISCAs) for one MCO and two SMCPs during CY 2018. Two MCOs also operate other lines of business (Family Care and/or Family Care Partnership), and their ISCAs are conducted in accordance with the review schedule already established for those programs. Therefore, the ISCA for these organizations was not conducted during CY 2018, and was reported in a separate annual technical report.

Overall, the reviews found all three organizations have the basic systems, resources, and processes in place to meet DHS' requirements for oversight and management of services to members, and to support quality and performance improvement initiatives. One SMCP demonstrated full compliance with all requirements associated with this review. The MCO demonstrated almost full compliance with the current ISCA review requirements. While the other SMCP addressed some of the recommendations made during the CY 2015 ISCA, full compliance was not demonstrated during this review.

Record Review – Obstetrics Medical Home/Healthy Birth Outcomes

During CY 2018, DHS directed MetaStar to perform data abstraction reviews of its Medical Home initiative for pregnant women. MetaStar reviewed 1,000 records for the 13 MCOs that participated in this Medical Home program. This is an optional review activity. Results from the data abstraction are used by DHS to determine administrative payments to MCOs, based on compliance with specific requirements detailed in the DHS-MCO contract. Due to the timelines

associated with this retrospective review, the results of this optional activity are reported separately.

Care Management 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. MetaStar reviewed 44 records from the one organization that operates the FCMH.

Record Review – Health Needs Assessments
The health needs assessment was introduced in the BadgerCare Reform Section 1115(a) demonstration waiver as allowed in federal law under §1115 of the Social Security Act. The requirement applies to all newly enrolled and reenrolled childless adult members.

The childless adults health needs assessment review is an optional review activity with penalty and bonus provisions. MetaStar reviewed 1,373 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. MCOs that achieve a compliance rate of at least 35 percent qualify for the bonus.

Care Management Review – Supplemental Security Income Program
Care management review is an optional activity associated with a DHS pay for performance initiative. This review has undergone changes with additional requirements added to the review criteria. Reviews are scheduled to begin in CY 2019. MetaStar began working in collaboration with DHS during CY 2018 to develop review criteria for evaluating member records, to ensure providers were meeting DHS requirements.

Care Management Review – Children with Medical Complexities
Children with Medical Complexity is a target group covered under the Medicaid-targeted case management benefit. It is administered as a fee-for-service benefit for all Medicaid-enrolled

members who demonstrate medical necessity for covered services. The benefit is separate from MCOs and SMCPs.

Member participation is voluntary, and members must be under age 26 with chronic health conditions involving three or more organ systems and requiring three or more medical or surgical specialists. Additionally, the member must have one or more hospital admissions (totaling five or more days); or ten or more visits to tertiary clinics within the preceding year. Members too young to meet the utilization criteria may be eligible if the health condition criteria is met; and a hospital stay totaling five or more days, or clinicians anticipate ongoing high utilization.

This is an optional review activity. In CY 2018 MetaStar began working in collaboration with DHS to develop review criteria and tools for evaluating member records, to ensure providers were meeting DHS requirements. Reviews are scheduled to begin in CY 2019.

Introduction and Overview

Acronyms and Abbreviations

Please see Appendix 1 for definitions of all acronyms and abbreviations used in this report.

Purpose of the Report

This is the annual technical report the State of Wisconsin must provide to the Centers for Medicare & Medicaid Services (CMS) related to the operation of its Medicaid managed health and long-term care programs. The Code of Federal Regulations (CFR) at 42 CFR 438 requires states that operate pre-paid inpatient health plans and managed care organizations (MCOs) to provide for periodic external quality reviews. This report covers mandatory and optional external quality review (EQR) activities conducted by the external quality review organization (EQRO), MetaStar, Inc., during the calendar year from January 1, 2018 to December 31, 2018 (CY 2018). See Appendix 2 for more information about external quality review and a description of the methodologies used to conduct review activities.

Analysis: Timeliness, Access, Quality

The CMS guidelines regarding this annual technical report direct the EQRO to provide an assessment of the Managed Care Organizations (MCOs') strengths and weaknesses with respect to quality, timeliness, and access to health care services. Compliance with these review activities provides assurances that MCOs are meeting requirements related to access, timeliness, and quality. The analysis included in this section of the report, is intended to provide that assessment.

Overview of Wisconsin's Medicaid Managed Care Organizations

As noted in the table below, the Wisconsin Department of Health Services (DHS) contracted with 19 MCOs to provide services for persons enrolled in the BadgerCare Plus (BC+) program in CY 2018. Eight MCOs provided health care services for persons receiving Supplemental Security Income (SSI) or SSI-related Medicaid. DHS also contracted with two Special Managed Care Programs (SMCPs) to serve children with mental health needs. One MCO also provided 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.

Managed Care Organization or Special Managed Care Program	Program(s)
Anthem Blue Cross and Blue Shield Health Plan (Anthem)	BC+, SSI
Care Wisconsin (CW)	SSI
Children Come First (CCF)	SMCP

Managed Care Organization or Special Managed Care Program	Program(s)
Children's Community Health Plan Inc. (CCHP)	BC+, PIHP
Compcare Health Services (Compcare)*	BC+
Dean Health Plan, Inc. (DHP)	BC+
Group Health Cooperative of Eau Claire (GHC-EC)	BC+, SSI
Group Health Cooperative of South Central Wisconsin (GHC-SCW)	BC+
Gundersen Health Plan (GHP)**	BC+
Health Tradition Health Plan (HTHP)*	BC+
Independent Care Health Plan (*i*Care)	BC+, SSI
MercyCare Health Plans (MCHP)	BC+
MHS of Wisconsin (MHS)	BC+, SSI
Molina HealthCare of Wisconsin (MHWI)	BC+, SSI
Network Health Plan (NHP)	BC+, SSI
Physicians Plus Insurance Corporation (PPIC)	BC+
Quartz Health Solutions, Inc. (Quartz)	BC+
Security Health Plan (SHP)	BC+
Trilogy Health Insurance (Trilogy)	BC+
UnitedHealthcare Community Plan (UHC)	BC+, SSI
Unity Health Insurance (Unity)**	BC+
Wraparound Milwaukee (WM)	SMCP

*Compcare and HTHP contracts with DHS ended as of December 31, 2017. However, MetaStar conducted retrospective reviews for these organizations during CY 2018. **Gunderson and Unity became Quartz as of January 1, 2018. However, MetaStar conducted retrospective reviews for these organizations during CY 2018.

As of January 2019, enrollment was as follows:

Program	Enrollment
BadgerCare Plus	691,806
BadgerCare Plus Childless Adults	127,066
Supplemental Security Income Medicaid	53,796
Special Managed Care Programs	1,211
Foster Care Medical Home	3,324

Current enrollment data is available at the following DHS website:

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

SCOPE OF EXTERNAL REVIEW ACTIVITIES

In CY 2018, MetaStar conducted three mandatory review activities as specified in federal Medicaid managed care regulations found at 42 CFR 438.358:

- Assessment of compliance with standards;
- Validation of performance measures; and
- Validation of performance improvement projects (PIPs).

Federal regulations at 42 CFR 438.242 as well as CMS protocols pertaining to these three activities also mandate that states assess the information systems capabilities of MCOs. Therefore, MetaStar conducted information systems capabilities assessments (ISCAs) for some MCOs and SMCPs during CY 2018. MetaStar also conducted three optional review activities, including Obstetrics Medical Home/Healthy Birth Outcomes record review, Foster Care Medical Home (FCMH) care management review, and Health Needs Assessment (HNA) record review.

The following table identifies the MCOs and types of reviews completed during the CY 2018 review cycle. The review methodology for each review activity is found in Appendix 2.

Scope of External Review Activities CY 2018

MCOs	Types of Reviews Performed
Anthem Blue Cross and Blue Shield (Anthem)	Validation of Performance Measures Validation of Performance Improvement Projects Healthy Birth Outcomes Medical Home Review Childless Adults Health Needs Assessment Review PIP Technical Assistance
Care Wisconsin (CW)	Compliance with Standards Review Validation of Performance Measures Validation of Performance Improvement Projects PIP Technical Assistance
Children's Community Health Plan (CCHP)	Validation of Performance Measure Validation of Performance Improvement Projects Healthy Birth Outcomes Medical Home Review Foster Care Medical Home Review Childless Adults Health Needs Assessment Review PIP Technical Assistance
Compcare Health Services (Compcare)	Validation of Performance Measures Childless Adults Health Needs Assessment Review
Dean Health Plan (DHP)	Validation of Performance Measures Validation of Performance Improvement Projects Childless Adults Health Needs Assessment Review

MCOs	Types of Reviews Performed
	Healthy Birth Outcomes Medical Home Review PIP Technical Assistance
Group Health Cooperative of Eau Claire (GHC-EC)	Validation of Performance Measures Validation of Performance Improvement Projects Childless Adults Health Needs Assessment Review PIP Technical Assistance
Group Health Cooperative of South Central Wisconsin (GHC-SCW)	Validation of Performance Measures Validation of Performance Improvement Projects Healthy Birth Outcomes Medical Home Review Childless Adults Health Needs Assessment Review PIP Technical Assistance
Gundersen Health Plan (GHP)	Validation of Performance Measures Validation of Performance Improvement Projects Childless Adults Health Needs Assessment Review PIP Technical Assistance
Health Tradition Health Plan (HTHP)	Validation of Performance Measures Validation of Performance Improvement Projects Childless Adults Health Needs Assessment Review
Independent Care Health Plan (*i*Care)	Compliance with Standards Review Validation of Performance Measures Validation of Performance Improvement Projects Healthy Birth Outcomes Medical Home Review Childless Adults Health Needs Assessment Review PIP Technical Assistance
MHS Health Wisconsin (MHS)	Validation of Performance Measures Validation of Performance Improvement Projects Healthy Birth Outcomes Medical Home Review Childless Adults Health Needs Assessment Review PIP Technical Assistance
MercyCare Health Plans (MCHP)	Validation of Performance Measures Validation of Performance Improvement Projects Healthy Birth Outcomes Medical Home Review Childless Adults Health Needs Assessment Review PIP Technical Assistance
Molina HealthCare of Wisconsin (MHWI)	Validation of Performance Measures Validation of Performance Improvement Projects Healthy Birth Outcomes Medical Home Review Childless Adults Health Needs Assessment Review PIP Technical Assistance
Network Health Plan (NHP)	Validation of Performance Measures Validation of Performance Improvement Projects Healthy Birth Outcomes Medical Home Review Childless Adults Health Needs Assessment Review PIP Technical Assistance
Physicians Plus Insurance Corporation (PPIC)	Validation of Performance Measures Validation of Performance Improvement Projects Healthy Birth Outcomes Medical Home Review Childless Adults Health Needs Assessment Review PIP Technical Assistance
Quartz Health Solutions, Inc. (Quartz)	Healthy Birth Outcomes Medical Home Review PIP Technical Assistance

MCOs	Types of Reviews Performed
Security Health Plan (SHP)	Validation of Performance Measures Validation of Performance Improvement Projects Childless Adults Health Needs Assessment Review PIP Technical Assistance
Trilogy Health Insurance (Trilogy)	Compliance with Standards Review Validation of Performance Measures Validation of Performance Improvement Projects Information Systems Capabilities Assessment Healthy Birth Outcomes Medical Home Review Childless Adults Health Needs Assessment Review PIP Technical Assistance
United Healthcare of Wisconsin (UHC)	Validation of Performance Measures Validation of Performance Improvement Projects Childless Adults Health Needs Assessment Review Healthy Birth Outcomes Medical Home Review PIP Technical Assistance
Unity Health Plan (Unity)	Validation of Performance Measures Validation of Performance Improvement Projects Healthy Birth Outcomes Medical Home Review Childless Adults Health Needs Assessment Review PIP Technical Assistance

SMCPs	Types of Review Performed
Children Come First (CCF)	Compliance with Standards Review Validation of Performance Improvement Projects Information Systems Capabilities Assessment PIP Technical Assistance
Wraparound Milwaukee (WM)	Compliance with Standards Review Validation of Performance Improvement Projects Information Systems Capabilities Assessment PIP Technical Assistance

Compliance with Standards Review

Compliance with standards is a mandatory review activity conducted to determine the extent to which MCOs, SMCPs, and PIHPs are in compliance with federal quality standards. DHS submitted its Accreditation Deeming Plan to CMS as part of its overall Quality Strategy. The plan deems MCOs, SMCPs, and PIHPs with accreditation status from the National Committee for Quality Assurance (NCQA) as compliant with most federal requirements. DHS directed MetaStar to continue the mandatory EQR compliance with standards review for non-accredited MCOs/SMCPs/PIHPs, and MCOs/SMCPs/PIHPs accredited by a non-recognized accreditation body, according to the usual three-year cycle. Please refer to Appendix 2 for additional information regarding the three-year review cycle.

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

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

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

For more information about the review protocols and methodology, see Appendix 2.

Managed Care Organizations

During CY 2018, MetaStar completed a compliance with standards review for three MCOs, CW, *i*Care, and Trilogy.

Each section below provides a brief explanation of a compliance with standards focus area, a table identifying any "partially met" or "not met" findings, and strengths and opportunities for improvement.

Enrollee Rights and Protections Results

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

The following table lists the Enrollee Rights and Protections standards that were not fully met. The first column in the tables below is the number assigned to the review standard, the second column is the standard, and the last two columns are the number of MCOs with a partially met or not met rating.

Table E1

<table>
<tr><th rowspan="2">#</th><th rowspan="2">Enrollee Rights and Protections</th><th colspan="2">CY 2018 Rating and Number of MCOs</th></tr>
<tr><th>Partially Met</th><th>Not Met</th></tr>
<tr><td>1</td><td>42 CFR 438.100

The MCO must
• Have written policies guaranteeing each member’s rights, and share those written policies with staff and affiliated providers to be considered when providing services to members;
• Comply with any applicable Federal and State laws, including those identified in 42 CFR 438.100 that pertain to member rights;
• Ensure its employees and contracted providers observe and protect those rights; and
• Have written restraint policies guaranteeing each member’s right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.</td><td>2</td><td>0</td></tr>
<tr><td>3</td><td>42 CFR 438.100
42 CFR 438.10
DHS-MCO Contract Article XIII.B.5., Article VI.D.

General information must be furnished to members as required. The MCO must:
• Notify members of their right to request and obtain information at least once a year, including information about member rights and protections, the Member Handbook, and Provider Directory.
• Provide required information to new members within a reasonable time period and as specified by the DHS-MCO contract;
• Provide members at least a 30 day notice, in writing, of any significant changes to the handbook before the intended effective date of the change and work with the Department to review these changes in accordance with the timeline established in Article VI.D.4.
• Make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt of issuance of the termination notice, to members who received services from such provider.</td><td>1</td><td>0</td></tr>
<tr><td>6</td><td>42 CFR 438.100
42 CFR 438.10
42 CFR 438.3
42 CFR 422.128

Regarding advance directives, the MCO must:</td><td>1</td><td>0</td></tr>
</table>

#	Enrollee Rights and Protections	CY 2018 Rating and Number of MCOs	
		Partially Met	Not Met
	• Maintain written policies and procedures in accordance with 42 CFR 422.128 and the DHS-MCO contract; • Provide written information to members regarding their rights under state law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives; • Update written information to reflect changes in state law as soon as possible (but not later than 90 days after the effective date of the change); • Include a clear and precise statement of limitation in its policies if it cannot implement an advance directive as a matter of conscience (the statement must comply with requirements listed in 42 CFR 422.128.); • Provide written information to each member at the time of MCO enrollment (or family/surrogate if member is incapacitated at time of enrollment), and must have a follow-up procedure in place to provide the information to the member when he/she is no longer incapacitated; • Document in the medical record whether or not the individual has executed an advance directive, and must not discriminate based on its presence or absence; • Ensure compliance with the requirements of Wisconsin law (whether statutory or recognized by the courts of Wisconsin); • Provide education for staff and the community on issues concerning advance directives; • Provide staff training about MCO specific policies and procedures related to advance directives; • Inform individuals that complaints concerning non-compliance with any advance directive may be filed with the State of Wisconsin Division of Quality Assurance.		

Analysis

This area of review consists of nine standards. The standards address members' general rights, such as the right to information, as well as specific rights related to dignity, respect, and privacy.

Overall, review findings indicated all three organizations valued and supported members' rights and demonstrated open lines of communication at all levels within the organizations and across subcontractors. One MCO fully met all of the Enrollee Rights and Protection standards, a second MCO met seven of nine standards, and the third MCO met six of nine standards.

Conclusions

The progress, strengths, and opportunities noted below are based on the findings, as indicated in table E1.

Progress

- For two of the organizations, the review in CY 2018 marked only the second review as they both began providing BC+ or SSI services to members in 2014. One organization had one partially met standard during the initial review which was met during this review year; this organization met all of the Enrollee Rights and Protections standards in CY 2018. The other organization did not show improvement since the initial review and the same three standards remain partially met.
- The third organization previously had one partially met standard that was met this review year, but two other standards that were previously met in CY 2015 were partially met this year.

Strengths

- One organization's structure, size, and relationship with its partners promoted open communication across all levels. This resulted in increased responsiveness to member needs.
- Another organization employed a variety of ways to monitor and ensure member rights were protected, including documentation and review of "member feedback notes" detailing any member concern, complaint, or praise for a provider, and initiation of the quality concern referral process to identify and investigate provider contracting concerns via the MCO's provider network development department.

Opportunities for Improvement

- Two organizations need to develop and implement a policy and procedure regarding restrictive measures.
- One MCO should develop a systematic approach for training staff on advance directives and for providing educational opportunities about advance directives to the community.
- One MCO should develop, document and implement a process to ensure members receive written notification at least 15 days in advance of a provider's termination from the network for all provider types.
- The online provider directory for one organization needs to be updated to include non-English languages spoken by ancillary providers.

QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT RESULTS

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

- Availability of accessible, culturally competent services through a network of qualified service providers;
- Coordination and continuity of member care;
- Timely authorization of services and issuance of notices to members;

- Timely enrollments and disenrollments;
- An ongoing program of quality assessment and performance improvement; and
- Compliance with other requirements.

The following table lists the Quality Assessment and Performance Improvement (QAPI) standards that were not fully met. The first column in the tables below is the number assigned to the review standard, the second column is the standard, and the last two columns are the number of MCOs with a partially met or not met rating.

Table Q1

<table>
<tr><th rowspan="2">#</th><th rowspan="2">Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement</th><th colspan="2">CY 2018 Rating and Number of MCOs</th></tr>
<tr><th>Partially Met</th><th>Not Met</th></tr>
<tr><td>1</td><td>42 CFR 438.206

Delivery network
The MCO maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract.

In establishing and maintaining the network, the MCO site must consider:
• Anticipated Medicaid enrollment;
• Expected utilization of services, considering Medicaid member characteristics and health care needs;
• Numbers and types (in terms of training, experience and specialization) of providers required to furnish the contracted Medicaid services;
• The number of network providers that are not accepting new members;
• The geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities.

The delivery network provides female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist.</td><td>1</td><td>0</td></tr>
</table>

<table>
<tr><th rowspan="2">#</th><th rowspan="2">Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement</th><th colspan="2">CY 2018 Rating and Number of MCOs</th></tr>
<tr><th>Partially Met</th><th>Not Met</th></tr>
<tr><td>2</td><td>42 CFR 438.206
DHS-MCO Contract Article V.E.

Second opinion and out-of-network providers
The MCO must have written policies for procedures guaranteeing each member’s right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member’s condition and ability to understand. If an appropriately qualified provider is not available within the network, the MCO must authorize and reimburse for a second opinion outside the network member at no cost to the member, excluding allowable copayments.

If the network is unable to provide necessary services, covered under the contract, to a particular member, the MCO must adequately and timely cover these services out of network for as long as the MCO is unable to provide them.

The MCO must coordinate with out-of-network providers to ensure that the cost of services to members is no greater than they would have been if furnished within the provider network.</td><td>2</td><td>0</td></tr>
<tr><td>7</td><td>42 CFR 438.210

<u>Authorization of services</u>
For processing requests for initial and continuing authorizations of services, the MCO must:
Have in place and follow written policies and procedures;
Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions;
Consult with the requesting provider when appropriate;
Ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in treating the member’s condition or disease.</td><td>1</td><td>0</td></tr>
<tr><td>14</td><td>42 CFR 438.236

The MCO adopts practice guidelines that meet the following requirements:
Are based on valid and reliable clinical evidence or a consensus of providers in the particular field;
Consider the needs of the MCO’s members;
Are adopted in consultation with contracting health care professionals; and
Are reviewed and updated periodically, as appropriate.
The MCO disseminates the guidelines to all affected providers, and as appropriate or upon request, to members.</td><td>1</td><td>0</td></tr>
</table>

#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement	CY 2018 Rating and Number of MCOs	
		Partially Met	Not Met
	Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.		
15	**42 CFR 438.240** **DHS-MCO Contract Article IX.** The MCO has an ongoing comprehensive quality assessment and performance improvement (QAPI) program for the services it furnishes to its members which meets at a minimum the following requirements outlined in the DHS-MCO contract: • Designates a senior executive to be responsible for the operation and success of the QAPI program; • Includes a QAPI Committee, whose membership is interdisciplinary and comprised of both providers and administrative staff including those specializing in mental health or substance abuse and dental care on a consulting basis when an issue related to these areas arises, a variety of medical disciplines, a psychiatrist and an individual with specialized knowledge and experience with persons with disabilities, and MCO management or governing body; • Has a system to receive member input on quality improvement, document the input received, document the MCO's response to the input, including a description of any changes or studies it implemented as a result of the input, and document feedback to members in response to input received; • Integrates QAPI activities of the MCO's providers and subcontractors into the QAPI program, if separate from the MCO's QAPI activities; • Develops a work plan which outlines the scope of activities, goals, objectives, timelines, responsible person, and is based on findings from QAPI program activities; • Monitors and evaluates the care and services in certain priority clinical and non-clinical areas; and • Conducts member satisfaction surveys.	2	0
16	**42 CFR 438.240** The MCO must have in effect mechanisms to detect both underutilization and overutilization of services.	1	0

Analysis

The standards covering this broad area of review can generally be divided into three areas: access to services; structure and operations; and measurement and improvement. The focus area consists of a total of 19 standards.

None of the MCOs met all the QAPI standards. One organization met 17 of 19 standards, and two organizations met 16 of 19 standards. Onsite discussions at one organization revealed the MCO had not optimized the use and interpretation of its data to identify organization-wide patterns and trends related to performance. All three organizations were encouraged to focus on electronic versus manual means to collect data for quality monitoring and improvement initiatives, and to utilize data to identify aggregate trends and inform actions related to key activities, including those for care coordination.

CONCLUSIONS

The progress, strengths, and opportunities noted below are based on the findings, as indicated in table Q1.

Progress

- All three organizations made progress in the QAPI standards since their last review. Improvements were focused on the development and implementation of policies and procedures, mechanisms to assess the quality and appropriateness of care provided to members, and evaluation of the quality program and work plan on an annual basis.

Strengths

- One MCO initiated a process with local hospital staff to collaboratively develop care plans focused on care coordination for specific members that frequent the emergency department.
- A second organization recognized the benefit of increasing member engagement by holding more frequent and regular health fairs, which focus on offering preventive screenings to members and providing education regarding disease management.
- Staff at one MCO identified new methods of contacting members such as in-person visits at alternate locations such as libraries and drop-in centers, in an attempt to address challenges related to completion of assessments and care plans.

Opportunities for Improvement

- One organization should ensure all provider materials and resources contain current references to clinical practice guidelines.
- To fully meet standards related to the quality program, work plan, and annual evaluation, two MCOs must comply with the following requirements:
    - Document and integrate findings from quality initiatives into the QAPI work plan and annual quality evaluation;
    - One MCO should gather member input through development of a member advisory committee, member satisfaction surveys, or incorporation of members on the Quality Improvement Committee; and

- One MCO should reevaluate the timeframe for the QAPI work plan, process, and evaluation of the work plan from the prior year.

- One organization needs to develop a consistent approach or process to detect underutilization of all service types for the enrolled SSI population.
- The results of member record review audits need to be quantified and documented in the quality work plan and annual quality evaluation at one MCO.
- Processes need to be established, documented, updated, and/or monitored at one MCO related to how the organization comprehensively assesses the adequacy of the provider network.
- Two MCOs should update written guidance to identify that out-of-network providers are covered as long as necessary when an in-network provider is not available.
- One organization should document the processes related to the following:
  - Provision of second opinions; and
  - Monitoring efforts related to medical appointments and in-office wait times.
- In addition, one organization needs to ensure the composition of the Quality Management and Improvement Committee includes all provider types as required by the DHS-MCO contract.

Grievance Systems Results

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

The following table lists the Grievance System standards that were not fully met. The first column in the tables below is the number assigned to the review standard, the second column is the standard, and the last two columns are the number of MCOs with a partially met or not met rating.

Table G1

#	Grievance System	CY 2018 Rating and Number of MCOs	
		Partially Met	Not Met
7	**42 CFR 438.406** **DHS-MCO Contract Article VIII.** The MCO process must ensure that individuals who make decisions on grievances and appeals: • Have not been involved in any previous level of review or decision-making related to the issue under appeal; • Include health care professionals with appropriate clinical experience when deciding	2	0

<table>
<tr><th rowspan="2">#</th><th rowspan="2">Grievance System</th><th colspan="2">CY 2018 Rating and Number of MCOs</th></tr>
<tr><th>Partially Met</th><th>Not Met</th></tr>
<tr><td></td><td>Appeal of a denial based on lack of medical necessity;
Grievance regarding denial of expedited resolution of an appeal;
Grievance or appeal involving clinical issues;
The BadgerCare Plus and/or Medicaid SSI MCO Advocate must be a member of the appeal and grievance committee.</td><td></td><td></td></tr>
<tr><td>9</td><td>CFR 438.408

Basic rule
The MCO has a system in place to dispose of each grievance and resolve each appeal as expeditiously as the member's situation and health condition requires, within established timeframes for standard and expedited dispositions of grievances and appeals.

Extension of timeframes
The MCO may extend the timeframes by up to 14 calendar days if:
The member requests the extension;
The MCO shows that there is a need for additional information and how the delay is in the member's interests.
Requirements following extension
If the MCO extends the timeframes, it must give the member written notice of the reasons for the delay.</td><td>1</td><td>0</td></tr>
<tr><td>10</td><td>CFR 438.408
DHS-MCO Contract Article VIII.

Format of notices
The MCO must provide written notice of the disposition of appeals and grievances within required timeframes.

For expedited resolutions, the MCO must also make reasonable efforts to provide oral notice.

Content of notices
The written notice of the appeal resolution must include:
Results of the resolution process and date it was completed;
For appeals not resolved wholly in favor of the member
The right to request a state fair hearing and how to do so;
The right to request to receive benefits while the hearing is pending and how to make the request;
The member may be held liable for the cost of those benefits if the hearing decision upholds the MCO's action.
The written notice of the grievance resolution must include:
Results of the resolution process and date it was completed;</td><td>2</td><td>0</td></tr>
</table>

#	Grievance System	CY 2018 Rating and Number of MCOs	
		Partially Met	Not Met
	• For decisions not wholly in the member's favor, the right to request a DHS review and how to do so.		
11	**CFR 438.410** **DHS-MCO Contract Article VIII.** The MCO must establish and maintain an expedited review process for appeals, when the MCO determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function. The MCO must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. If the MCO denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the timeframe for standard resolution; • Make reasonable efforts to give the member prompt oral notice of the delay; and • Within 2 calendar days, give the member written notice of the reason for the decision to extend or deny the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision.	1	0
13	**CFR 438.416** **DHS-MCO Contract Article VIII.** The MCO must maintain records of grievances and appeals and review the information as part of its Quality Management Program. The MCO shall submit a quarterly grievance and appeal report to DHS.	1	0
15	**CFR 438.420** **DHS-MCO Contract Article IX.** ***Member responsibility for services while the appeal is pending*** If the final resolution of the appeal is adverse to the member, the MCO may recover the cost of services furnished to the member while the appeal is pending to the extent they were furnished solely because of the requirements of this section.	2	0

ANALYSIS

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

All three organizations support and ensure access to grievance systems. One MCO met all but one Grievance Systems standard. The other two organizations met 16 of 19 standards, and 15 of 19 standards. All three organizations need to include DHS-MCO contract language requirements related to the written grievance and appeal disposition notification letters that are sent to members after an internal MCO level hearing has concluded. Two of the three organizations need to update their grievance and appeal policies and procedures, and one organization needs to focus efforts also on training their internal grievance and appeal committee members and ensure the quality plan encompasses the evaluation and monitoring of all grievances and appeals.

Conclusions

The progress, strengths, and opportunities noted below are based on the findings, as indicated in table G1.

Progress

- Since the initial review of the two organizations that began serving SSI and BC+ members in 2014, both have developed and refined policies and procedures related to grievances and appeals. Most notably, these organizations updated notice of action timeframes to ensure compliance with the requirements noted in the DHS-MCO contracts.
    - One of these MCOs addressed all of the partially met or not met findings from the initial review, but three areas that were previously met in CY 2015 were found to be partially met in CY 2018. This organization needs to review the appeal and grievance policy and procedure and the written notice of resolution letter to include DHS-MCO contract requirements.
    - The other organization demonstrated improvement in six of eight areas that were previously partially met or not met; however, one standard that was previously met in CY 2015 was rated partially met during this review period.
- The third organization made improvements in four of five standards that were partially met in the previous review. However, the MCO has not yet incorporated DHS-MCO contract required information into the written disposition notices regarding the right to request continuation of benefits while the State Fair Hearing is pending.

Strengths

- One organization demonstrated a strong organizational focus related to addressing and resolving member complaints before they rise to the level of a grievance or appeal.
- Another organization offered support and assistance to members as they navigated the grievances and appeals processes of fee-for-service providers to address concerns and grievances directly with the providers of service.

Opportunities for Improvement

- The written grievance and/or appeal disposition letters need to be updated or created by all MCOs:
  - Two organizations need to include the required DHS-MCO contract required information about continuation of benefits and the potential liability for the cost of those benefits if the hearing decision upholds the MCO's action;
  - One organization needs to develop and implement a disposition extension letter template; and
  - One organization needs to revise the written grievance disposition letter to remove the ability to request a State Fair Hearing as this option is not available for grievances.
- The grievance and appeal policies and procedures need to be revised by two organizations to include:
  - The criteria used to determine when repayment of services continued during an appeal hearing will be requested or waived;
  - That written notice of extension must include how the delay is in the member's interest; and
  - The DHS-MCO contract required timeframe of two calendar days for notification of a decision to extend or deny a request for an expedited resolution of an appeal.
- One organization should develop standardized training curriculum for all grievance and appeal committee members.
- The quality plan at one organization needs to include evaluation and monitoring for all grievances and appeals.

Special Managed Care Programs

During CY 2018, MetaStar completed a compliance with standards review for two SMCPs: CCF and WM.

Each section below provides a brief explanation of a compliance with standards focus area, a table identifying any "partially met" or "not met" findings, and strengths and opportunities for improvement.

Enrollee Rights and Protections Results

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

The following table lists the Enrollee Rights and Protections standards that were not fully met. The first column in the tables below is the number assigned to the review standard, the second

column is the standard, and the last two columns are the number of SMCPs with a partially met or not met rating.

Table E2

#	Enrollee Rights and Protections	CY 2018 Rating and Number of SMCPs	
		Partially Met	Not Met
1	**42 CFR 438.100** The SMCP must • Have written policies regarding member rights; • Comply with any applicable federal and state laws that pertain to member rights; • Ensure its staff and contracted providers observe and protect those rights; and • Have written restraint policies guaranteeing each member's right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.	1	0
4	**42 CFR 438.100** **42 CFR 438.10** The SMCP provides information about its providers to members as required by 42 CFR 438.10(f)(6) including names, locations, telephone numbers of, and non-English languages spoken by current contracted providers, including identification of providers that are not accepting new members.	1	0

#	Enrollee Rights and Protections	CY 2018 Rating and Number of SMCPs	
		Partially Met	Not Met
6	**42 CFR 438.100** **42 CFR 438.10** **42 CFR 438.6** **42 CFR 422.128** Regarding advance directives for adult enrollees, the SMCP must: • Maintain written policies and procedures in accordance with 42 CFR 422.128 and the DHS-SMCP contract; • Provide written information to members regarding their rights under state law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives; • Update written information to reflect changes in state law as soon as possible (but not later than 90 days after the effective date of the change); • Include a clear and precise statement of limitation in its policies if it cannot implement an advance directive as a matter of conscience (The statement must comply with requirements listed in 42 CFR 422.128.); • Provide written information to each member at the time of SMCP enrollment (or family/surrogate if member is incapacitated at time of enrollment), and must have a follow-up procedure in place to provide the information to the member when he/she is no longer incapacitated; • Document in the medical record whether or not the individual has executed an advance directive, and must not discriminate based on its presence or absence; • Ensure compliance with the requirements of Wisconsin law (whether statutory or recognized by the courts of Wisconsin); • Provide education for staff and the community on issues concerning advance directives; • Inform individuals that complaints concerning non-compliance with any advance directive may be filed with the State of Wisconsin Division of Quality Assurance.	1	0

Analysis

This area of review consists of nine standards. The standards address members' general rights, such as the right to information, as well as specific rights related to dignity, respect, and privacy.

One organization met all nine standards in this focus area. The remaining organization met six of the nine standards in this focus area, some requirements related to the provider directory, restrictive measures, and advanced directives were not fully met. Overall, each organization has practices in place that value and support members' rights.

CONCLUSIONS

The progress, strengths, and opportunities noted below are based on the findings, as indicated in table E2.

Progress

- One organization made progress in the Enrollee Rights and Protections standards since the last review by developing an advance directives policy; this organization met every standard in the current review.
- The other organization now has a process in place for notifying members annually of their right to request and obtain information allowing for a previous score of partially met to be changed to met in this review. This organization now achieved a partially met score on two of the standards that were rated not met in the last review.

Strengths

- The size of both organizations and relationships with its partners help to promote open communication, allowing for each organization to address issues and implement improvements rapidly as well as quickly respond to member needs.

Opportunities for Improvement

- One organization needs to develop a mechanism for tracking the use of restrictive measures and enhance training to staff in regards to restrictive measures.
- The provider directory at one organization needs to include specific non-English languages spoken by contracted providers and identify providers not accepting new patients.
- One organization should update its advance directives policy to ensure it addresses all elements required in the DHS contract. The organization also must ensure resources for community education and advanced directives are accessible for members.
- Though fully met in the review:
    - One organization was advised to consider including the date of DHS approval on its member notice of action template.
    - A recommendation for one organization to develop and implement a process to ensure members receive written notification at least 15 days in advance of a provider's termination from the network.

Quality Assurance and Performance Improvement Results

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

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

The following table lists the QAPI standards that were not fully met. The first column in the tables below is the number assigned to the review standard, the second column is the standard, and the last two columns are the number of SMCPs with a partially met or not met rating.

Table Q2

#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement	CY 2018 Rating and Number of SMCPs	
		Partially Met	Not Met
1	**42 CFR 438.206** ***Delivery network*** The SMCP maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, the SMCP site must consider: • Anticipated Medicaid enrollment; • Expected utilization of services, considering Medicaid member characteristics and health care needs; • Numbers and types (in terms of training, experience and specialization) of providers required to furnish the contracted Medicaid services; • The number of network providers that are not accepting new SMCP members; • The geographic location of providers and SMCP members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities.	**2**	**0**
3	**42 CFR 438.206** ***Timely access*** The SMCP must:	**1**	**0**

#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement	CY 2018 Rating and Number of SMCPs	
		Partially Met	Not Met
	• Require its providers to meet state standards for timely access to care and services, taking into account the urgency of need for services; • Ensure that the network providers offer hours of operation that are not less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service, if the provider serves only Medicaid members; • Make services available 24 hours a day, 7 days a week when medically necessary; • Establish mechanisms to ensure compliance by providers; • Monitor providers regularly to determine compliance; • Take corrective action if there is a failure to comply.		
7	**42 CFR 438.210** ***Authorization of services*** For processing requests for initial and continuing authorizations of services, the SMCP must: • Have in place and follow written policies and procedures; • Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; • Consult with the requesting provider when appropriate; • Ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in treating the member's conditions.	1	0
8	**42 CFR 438.210** Each SMCP contract must provide for the following decisions and notices: *Standard authorization decisions:* For standard authorization decisions, provide notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if— • The enrollee, or the provider, requests extension; or • The SMCP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest. *Expedited authorization decisions:* For cases in which a provider indicates, or the SMCP determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the SMCP must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 3 working days after receipt of the request for service.	1	1

<table>
<tr><th rowspan="2">#</th><th rowspan="2">Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement</th><th colspan="2">CY 2018 Rating and Number of SMCPs</th></tr>
<tr><th>Partially Met</th><th>Not Met</th></tr>
<tr><td></td><td>The SMCP may extend the 3 working day time period by up to 14 calendar days if the enrollee requests an extension, or if the SMCP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.</td><td></td><td></td></tr>
<tr><td>15</td><td>42 CFR 438.240

The SMCP has an ongoing comprehensive quality assessment and performance improvement (QAPI) program for the services it furnishes to its members which meets at a minimum the following requirements outlined in the DHS-SMCP contract:
Is consistent with the utilization control requirements of 42 CFR 456;
Provides for review by appropriate mental health professionals of the process followed in providing mental health services;
Provides for systematic data collection of performance and patient results;
Provides for interpretation of this data to the practitioners;
Provides for making needed changes;
Protects, maintains, and improves the quality of mental health care provided to Wisconsin BadgerCare Plus Program members;
Includes member, staff, and provider participation (at least 50 percent of the QAPI committee should be parents of current or previous members);
Psychiatrists and other mental health care practitioners, and institutional providers must actively cooperate and participate in the County’s quality activities;
Develops a work plan which outlines the scope of activities, goals, objectives, timelines, responsible person, and is based on findings from QAPI program activities;
Monitors and evaluates important aspects of the quality of mental health care and services in certain priority clinical and non-clinical areas as specified;
Facilitates appropriate use of preventive services;
Conducts member satisfaction surveys.</td><td>1</td><td>0</td></tr>
<tr><td>16</td><td>42 CFR 438.240

The SMCP must have in effect mechanisms to detect both underutilization and overutilization of services.</td><td>1</td><td>0</td></tr>
<tr><td>18</td><td>42 CFR 438.240

The SMCP has in effect a process for an annual written evaluation of the impact and effectiveness of its quality assessment and performance improvement program, to determine whether the program has demonstrated improvement, where needed, in the quality of mental health care and services provided to its members.</td><td>0</td><td>1</td></tr>
</table>

Analysis

The standards covering this broad area of review can generally be divided into three areas: access to services; structure and operations; and measurement and improvement. The focus area consists of a total of 19 standards.

Findings reflect that both organizations need to update their service authorization policy to include the DHS-SMCP contract specified standard and expedited authorization decision-making timeframes and extensions as both did not fully meet the requirement. This requirement remained not fully met from the CY 2015 review.

Conclusions

The progress, strengths, and opportunities noted below are based on the findings, as indicated in table Q2.

Progress

- One organization had three standards that were previously partially met in CY 2015 that were met in this year's review. The same organization had two standards that were scored partially met in the last review that were determined to be not met during this review.
- The second organization had one standard with no progress between review periods and one standard that was scored not met compared to a previously partially met score.

Strengths

- Both SMCPs utilized providers already under contract with their respective county to expand the capacity of their provider network when needed.

Opportunities for Improvement

The following recommendations were provided to both organizations:

- Analyze and monitor the geographic location of providers and SMCP members and document the process used to determine network adequacy.
- Include the standard decision-making timeframes and the process for extending authorization decisions in the service authorization policy.

The following recommendations were provided to one SMCP:

- Update the service authorization policy to accurately reflect the practices in place, including a description of the decision-making team and the process for submitting authorization requests.
- Revise the QAPI work plan process to include the findings from quality program activities and to incorporate providers and subcontractors into the work plan.
- Develop a process to measure and analyze the underutilization of services.

- Develop a mechanism to track and trend data over time. Consider utilizing the functions within the SMCP's database to provide more quantifiable data, standardizing the approach for measuring results.
- Implement a process to complete an annual written evaluation of the QAPI program.
- Establish a process to monitor compliance with timely access to care and services for all network providers.

Though fully met in the review:

- One organization should implement regular provider exclusion monitoring to decrease the organization's risk for payments to excluded providers.
- Consider development of a standardized written communication method to serve as a reference and relay expectations for all network providers.
- Update the service authorization policy and procedure to include the following:
    - The mechanisms in place to ensure consistency of decision-making; and
    - The requirement for a health care professional (who has appropriate clinical experience in treating the member's condition or disease) to make decisions on service authorizations that are denied or authorized in an amount, duration, or scope that is less than the original requested.
- Implement a process to track, monitor, and analyze the timeliness of decision-making when service requests are initiated.
- Establish a procedure to verify the accuracy of provider information submitted for inclusion in the organization's provider manual.
- Expand the utilization review and management policy and procedure to include the frequency of and processes followed to conduct utilization review activities.

Grievance Systems Results

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

The following table lists the Grievance System standards that were not fully met. The first column in the tables below is the number assigned to the review standard, the second column is the standard, and the last two columns are the number of SMCPs with a partially met or not met rating.

Table G2

#	Grievance System	CY 2018 Rating and Number of SMCPs	
		Partially Met	Not Met
5	**42 CFR 438.404** **42 CFR 431.210, 211, 213, and 214** ***Timing of notice*** The Notice must be delivered to the member in the timeframes associated with each type of adverse decision: • Termination, suspension, or reduction of service; • Denial of payment for a requested service; • Authorization of a service in an amount, duration, or scope that is less than requested; • Service authorization decisions not reached within the timeframes specified, on the date the timeframes expires; and • Expedited service authorization decisions. If the SMCP extends the timeframe for the decision making process it must: • Make reasonable efforts to provide oral notice of the delay and within two calendar days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees; and • Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.	2	0
7	**42 CFR 438.406** The SMCP process must ensure that individuals who make decisions on grievances and appeals: • Have not been involved in any previous level of review or decision-making related to the issue under appeal; • Include health care professionals with appropriate clinical experience when deciding o Appeal of a denial based on lack of medical necessity; o Grievance regarding denial of expedited resolution of an appeal; o Grievance or appeal involving clinical issues;	2	0
8	**42 CFR 438.406** ***Special requirements for appeals*** The SMCP processes for appeals must: • Provide that oral inquires seeking to appeal an action must be confirmed in writing, unless the member or the provider requests expedited resolution; • Give members the opportunity to present evidence, and allegations of fact or law, in person or in writing at all levels of appeal; • Give the member and his/her representative the opportunity to examine the member's case record, including medical records and other documents, before and during the appeals process;	1	0

#	Grievance System	CY 2018 Rating and Number of SMCPs	
		Partially Met	Not Met
	• Include the member and/or representative or the legal representative of a deceased member's estate.		
9	**42 CFR 438.408** ***Basic rule*** The SMCP has a system in place to dispose of each grievance and resolve each appeal as expeditiously as the member's situation and health condition requires, within established timeframes for standard and expedited dispositions of grievances and appeals. ***Extension of timeframes*** The SMCP may extend the timeframes by up to 14 calendar days if: • The member requests the extension; • The SMCP shows that there is a need for additional information and how the delay is in the member's interests. ***Requirements following extension*** If the SMCP extends the timeframes, it must give the member written notice of the reasons for the delay.	2	0

10	**42 CFR 438.408**
	
	Format of notices
	The SMCP must provide written notice of the disposition of appeals and grievances within required timeframes.
	
	For expedited resolutions, the SMCP must also make reasonable efforts to provide oral notice.
	
	Content of notices
	The written notice of the appeal resolution must include:
	• Results of the resolution process and date it was completed;
	• For appeals not resolved wholly in favor of the member
	  ○ The right to request a State Fair Hearing and how to do so;
	  ○ The right to request to receive benefits while the hearing is pending and how to make the request;
	  ○ The member may be held liable for the cost of those benefits if the hearing decision upholds the SMCP's action.
		1	0

14	**42 CFR 438.420** ***Continuation of benefits*** The SMCP must continue the member's benefits if the: • Member or provider files the appeal timely; • Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; • Services were ordered by an authorized provider; • Original authorization has not expired; • Member requests the extension of benefits.	1	0

#	Grievance System	CY 2018 Rating and Number of SMCPs	
		Partially Met	Not Met
	Duration of continued benefits or reinstated benefits If the member requests, the SMCP must continue or reinstate benefits until: • The member withdraws the appeal; • Ten days pass after the SMCP mails the notice which provides the resolution of the appeal adverse to the member, unless the enrollee, within the 10-day timeframe, has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached; • A State Fair Hearing Office issues a hearing decision adverse to the member; • The time period or service limits of a previously authorized service has been met.		
15	**42 CFR 438.420** ***Member responsibility for services while the appeal is pending*** If the final resolution of the appeal is adverse to the member, the SMCP may recover the cost of services furnished to the member while the appeal is pending to the extent they were furnished solely because of the requirements of this section.	1	0

Analysis

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

The results of MetaStar's review activities demonstrate that the SMCPs value and support members' access to grievance systems. However, the organizations should both focus improvement efforts in the areas related to the timing of their notice, formulating a formal appeal and grievance committee, and updating their policy to include that members may request an extension for the disposition of an appeal or grievance.

Conclusions

The progress, strengths, and opportunities noted below are based on the findings, as indicated in table G2.

Progress

- Neither organization made progress related to areas that were not fully met in the last review. Additional areas that were previously met were found to be partially met in this review for both organizations.

Opportunities for Improvement

The following recommendations were provided to both organizations:

- Update the complaint, grievance, and appeal policy to align with the DHS-MCO requirement to include information regarding a member's ability to request an extension to the SMCP's timeframe for disposition of an appeal or grievance of up to 14 calendar days.
- Develop and implement a formal appeal and grievance committee.
- Create a letter template to inform members in writing when the SMCP requests an extension to the appeal or grievance disposition timeframes.

The following recommendations were provided to one of the SMCPs:

- Implement a process to issue notices related to adverse actions as identified in the DHS-SMCP contract.
- Update the complaint, grievance, and appeal policy to include the following requirements:
  - The member's representative or representative of a deceased member's estate can file appeals;
  - The process used when members ask to continue or reinstate benefits during an appeal;
  - The criteria used to determine when repayment will be requested and when approval of a member's request to waive or reduce liability will be granted; and
  - The timeframes for when a notice of action should be sent to a member with each type of adverse decision.
- Update the service authorization policy with information regarding extensions in the decision-making timeframe made by the organization.
- Develop a resolution letter template for appeals and grievances that contains all required information.

Validation of Performance Measures

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

MetaStar reviewed and validated a set of performance measures selected by DHS. The measures consisted of Healthcare Effectiveness Data and Information Set (HEDIS®)[2] -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. Please refer to Appendix 2 for more information about the review methodology.

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

For this contract period, DHS required MCOs to submit encounter data used to calculate performance measure data for some measures and to submit data that was associated with MCO HEDIS audits. DHS contracted with DXC, its Medicaid Management Information System (MMIS) vendor, to calculate performance measure rates for HEDIS-like measures and MEDDIC-MS measures for the BC+ and SSI programs.

Analysis

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

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

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. Documentation of discrepancies and inconsistencies with measure specifications were managed during data quality review sessions and approval was provided by MetaStar at the time of the review. 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 frequently 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 all measures to state specified standards for the measurement year 2017 (MY 2017) P4P initiative are documented by program in Appendix 2.

Conclusions

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 as follows:

- DXC continued to collaborate with MetaStar regarding internally developed measures via periodic data quality review sessions.
- DXC identified and incorporated changes to the P4P measures through ongoing review of HEDIS measure specifications.
- DXC evaluated the new 2018 HEDIS measures after benchmarks were substantiated by NCQA, for inclusion in the DHS P4P "withhold payments" initiative.

Strengths

- DHS engaged 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

- Foster continued collaboration between 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 2019 HEDIS measures 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 MetaStar's evaluation of 27 PIPs conducted by 18 MCOs participating in the BC+ and/or SSI Medicaid programs for CY 2017. The DHS-MCO contract requires each organization to conduct two performance improvement projects each year. In lieu of a second project, MCOs participating in the SSI program submitted a PIP-like project, which was reviewed by DHS. Also included is MetaStar's evaluation of one PIP each conducted by two SMCPs, and one PIP conducted by the FCMH PIHP during CY 2017. All 30 PIPs were validated in CY 2018.

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.

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

The study methodology is assessed through the following steps:

- Review the selected study topic(s);
- Review the study question(s);
- Review the selected study indicators;
- Review the identified study population;
- Review sampling methods (if sampling used);
- Review the data collection procedures;
- Assess the MCO's improvement strategies;
- Review the data analysis and interpretation of study results;
- Assess the likelihood that reported improvement is "real" improvement; and
- Assess the sustainability of the documented improvement.

Aggregate Results for Performance Improvement Projects

The table below lists each 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.

CY 2018 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.	25/30
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.	28/30
Study Indicator(s)		
3	The study used objective, clearly and unambiguously defined, measureable indicators and included defined numerators and denominators.	15/30
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.	27/30
Study Population		
5	The project/study clearly defined the relevant population (all members to whom the study question and indicators apply).	19/30
6	If the entire population was used, data collection approach captured all members to whom the study question applied.	25/29
Sampling Methods		
7	Valid sampling techniques were used.	2/2
8	The sample contained a sufficient number of members.	2/2
Data Collection Procedures		
9	The project/study clearly defined the data to be collected and the source of that data.	24/30
10	Staff are qualified and trained to collect data.	28/30
11	The instruments for data collection provided for consistent, accurate data collection over the time periods studied.	26/30
12	The study design prospectively specified a data analysis plan.	24/30
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.	19/30
14	A continuous cycle of improvement was utilized to measure and analyze performance, and to develop and implement system-wide improvements.	10/30
15	Interventions were culturally and linguistically appropriate.	16/27
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.	11/30
17	Numerical results and findings were presented accurately and clearly.	22/30
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.	7/30
"Real" Improvement		
19	The same methodology as the baseline measurement was used, when measurement was repeated.	8/30
20	There was a documented, quantitative improvement in processes or outcomes of care.	1/30
21	The reported improvement appeared to be the result of the planned quality improvement intervention.	1/3
Sustained Improvement		
22	Sustained improvement was demonstrated through repeated measurements over comparable time periods.	1/1

Project Interventions and Outcomes

The table below is organized by topic and lists each health plan, the interventions selected, the project outcomes at the time of the validation, and EQR recommendations. An overall validation result is also included to indicate the level of confidence in the organizations' reported results. See Appendix 2 for additional information about the methodology for this rating.

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
Antidepressant Medication Management				
CCHP	Conducted member outreach via phone calls to encourage medication compliance. Added support services for members with a diagnosis of major depression, based on specific risk factors.	Project did not demonstrate improvement.	Partially Met	Document continuous improvement efforts in the report. Address cultural or linguistic appropriateness of interventions. Analyze data periodically as planned. Take study limitations into consideration in analysis.
MHWI	Placed three phone calls to members identified as non-compliant with medication and assisted with making follow-up appointments. Informed members via telephone about Hayat Pharmacy's medication home delivery service. Sent a postcard about Hayat Pharmacy's home delivery service to all members in Milwaukee and Fond du Lac counties.	Project demonstrated "real" improvement for the SSI population: compliance increased from 19.7% in 2016, to 32.88% in 2017. Project did not demonstrate improvement for the BC+ population, remaining constant at 35.4% for both 2016 and 2017.	Met	Take all study limitations into consideration in analysis. Ensure initial and repeat measures are comparable. Measure effectiveness of interventions.
Childhood Immunizations				
SHP	Produced reminder cards for primary care providers to use for patient outreach. Implemented a reporting tool which provided	Project did not demonstrate improvement.	Partially Met	Conduct continuous cycles of improvement, and develop additional interventions as needed. Fully analyze data and

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
	additional member information for outreach. A partner health system hired additional clinical quality coordinators to conduct member outreach. Continued targeted educational mailings. Continued sending reports to primary care providers.			identify follow-up actions. Measure effectiveness of the interventions.
Comprehensive Diabetes Care				
Anthem	Provided member incentives to obtain Hemoglobin A1c (HbA1c) screening. Conducted member outreach calls to encourage diabetic testing. Utilized care gap alert system within Care Compass. Conducted provider meetings and created partnerships to increase HbA1c testing of members. Conducted member outreach from provider offices. Held *Anthem Member Days* at select provider locations. Created HEDIS provider education training sessions. Collaborated with the MyHealthDirect Appointment Scheduling provider.	Project demonstrated improvement for HbA1c testing in both populations. The project demonstrated improvement for HbA1c control in the SSI population, but not for the BC+ population.	Partially Met	Include MCO data when describing the study topic. Include the applicable HEDIS specifications with the final report. Address the cultural or linguistic appropriateness of interventions.

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
	Implemented a Community Health Worker program.			
MCHP	The planned intervention was not implemented; the organization continued its established care management program with no changes.	Project did not demonstrate improvement.	Not Met	Clearly define the study indicators. Fully describe all data collection procedures and ensure data is accurate. Select interventions based on an analysis of the problem to be addressed. Conduct and document continuous cycles of improvement. Fully analyze data and identify follow-up actions. Ensure initial and repeat measures are comparable.
Trilogy	Sent diabetic education booklets to members. Provided care coordination services via telephone.	Project did not demonstrate improvement.	Not Met	Clearly define the study indicators. Fully describe all data collection procedures and ensure they yield accurate data. Select interventions based on an analysis of the problem to be addressed. Fully analyze data and take study limitations into consideration. Ensure initial and repeat measures are comparable.

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
Controlling Blood Pressure				
UHC	Developed a project to identify, contact, and distribute blood pressure monitors to targeted members. Initiated collaboration with outside public health providers. Improved clinical data integration systems for medical record review and data retrieval. Continued to provide consultation visits with providers and shared educational materials.	Project did not demonstrate improvement.	Met	Analyze data on a periodic basis to discover reasons for less than optimal performance.
Emergency Department Utilization				
*i*Care	Implemented the *Better Care for You* program Conducted monthly emergency department (ED) meetings to discuss high ED utilizers and address barriers to proactive prevention of ED visits. Partnered with the Milwaukee Fire Department for the *Mobile Integrated Health Program* to provide support services, wellness checks, and member education about appropriate access to health care services	Project did not demonstrate improvement.	Partially Met	Ensure indicators are defined to measure change in the desired outcome. Describe how interventions were selected. Clearly present numerical results. Fully analyze data and identify follow-up actions. Ensure initial and repeat measures are comparable.
Follow-Up After Hospitalization for Mental Illness				
Unity	Conducted member outreach via phone calls and mailings. Provided outreach, scheduling, and monitoring appointments for members to ensure that they received the	Project did not demonstrate improvement.	Not Met	Ensure indicators and study populations are defined to measure change in the desired outcome. Document continuous improvement efforts in the report.

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
	recommended follow-up treatment. No new interventions were reported for this repeat project.			Describe barriers if unable to analyze data periodically as planned. Measure and analyze the effectiveness of interventions. Take study limitations into consideration in analysis.
Health Needs Assessment				
DHP	Conducted member outreach via telephone calls and mailings.	Project did not demonstrate improvement.	Partially Met	Define data sources for all measures. Describe how interventions were selected. Ensure initial and repeat measures are comparable. Clearly present and describe numerical results.
HTHP	Conducted additional member outreach attempts when monthly Health Needs Assessment completion rates were below 38 percent.	The project did not demonstrate quantifiable improvement.	Partially Met	Include organization specific data when describing study topic. Insure indicators are defined to measure change in the desired outcome. Ensure data is accurate. Specify the data analysis plan for all study questions. Develop and implement interventions which are sufficient to be expected to improve outcomes. Document continuous

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
				improvement efforts in the report. Ensure initial and repeat measures are comparable. Include data to demonstrate effectiveness of the intervention.
Immunizations for Adolescents				
GHP	Conducted member outreach via mailings.	Project did not demonstrate quantitative improvement.	Partially Met	Conduct and document continuous improvement efforts in the report. Take study limitations into consideration during analysis. Ensure initial and repeat measures are comparable.
MCHP	Notified primary care providers of members aged 12.5 who were missing immunizations. Sent letters to parents or guardians of members aged 12 who were overdue for immunizations. Sent educational material annually.	Project did not demonstrate quantitative improvement.	Not Met	Include MCO data when describing the study topic. Include a study question with a numerical goal. Clearly define accurate indicators. Describe all data collection procedures. Describe how interventions were selected. Conduct continuous cycles of improvement. Analyze data in consideration of any study limitations. Ensure initial and repeat measures are comparable.

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
SHP	Produced reminder cards for primary care providers to use for patient outreach. Implemented a reporting tool which provided additional member information for outreach. A partner health system hired additional clinical quality coordinators to conduct member outreach. Continued targeted educational mailings. Continued sending reports to primary care providers.	Project did not demonstrate improvement.	Partially Met	Conduct continuous cycles of improvement, and develop additional interventions as needed. Fully analyze data. Measure effectiveness of the interventions.
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment				
CCHP	Hired additional staff to conduct onsite discharge planning. Initiated post hospitalization discharge transition phone calls to address member needs and assist members in understanding their aftercare. Enrolled members identified as needing more intensive services in Behavioral Health case management. Implemented a *Transition Guideline* for care managers.	Project did not demonstrate improvement.	Not Met	Specify the data analysis plan. Document continuous improvement efforts in the report. Address cultural or linguistic appropriateness of interventions. Analyze data periodically and include in the report. Take study limitations into consideration when defining the study indicators and study populations, and during analysis. Ensure initial and repeat measures are comparable.
CW	Conducted member outreach via phone calls and mailings.	Project did not demonstrate quantitative improvement.	Not Met	Ensure indicators are defined to measure change in the desired outcome.

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
				Ensure inclusion of members in the project adheres to the defined study population. Ensure data collection approach captures all members of the population. Develop and implement interventions which are sufficient to be expected to improve outcomes. Address cultural or linguistic appropriateness of interventions. Ensure initial and repeat measures are comparable.
DHP	The PIP report did not describe any interventions that occurred during the project.	Project did not demonstrate improvement.	Not Met	Clearly document and describe all interventions utilized during the project. Conduct and document continuous cycles of improvement. Analyze data according to the data analysis plan. Take study limitations into consideration when defining the study indicators and study populations, and during analysis. Ensure initial and repeat measures are comparable.
GHC-EC	Provided telephonic outreach for follow-up care.	Project did not demonstrate	Partially Met	Define measurable indicators, including numerators and

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
	Mailed a targeted letter to members if unable to reach them via telephone. Conducted two additional telephonic outreach attempts after the initial phone call and letter.	quantitative improvement.		denominators. Document continuous improvement efforts in the report. Describe study limitations. Take study limitations into consideration in analysis. Ensure initial and repeat measures are comparable.
HTHP	Conducted member outreach via mailings to emphasize the importance of follow-up appointments.	Project did not demonstrate quantitative improvement.	Not Met	Define measurable indicators, including numerators and denominators. Document continuous improvement efforts in the report. Specify the data analysis plan. Take study limitations into consideration in analysis. Ensure initial and repeat measures are comparable.
MHS	Developed and disseminated educational information to high volume in-network providers. Offered a quality incentive payment to providers. Continued outreach to members with ED visits for a behavioral health diagnosis. Expanded the availability of in-home behavioral health visits.	Project did not demonstrate improvement.	Not Met	Include MCO data when describing study topic. Ensure the study indicators and study population are clearly and accurately defined. Conduct continuous cycles of improvement if interventions are not effective. Fully analyze data in consideration of study

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
				limitations and lack of improvement. Ensure initial and repeat measures are comparable.
NHP	Developed and disseminated educational information to high volume in-network providers. Offered a quality incentive payment to providers. Continued outreach to members with ED visits for a behavioral health diagnosis. Expanded the availability of in-home behavioral health visits.	Project did not demonstrate improvement.	Not Met	Include MCO data when describing study topic. Ensure the study indicators and study population are clearly and accurately defined. Conduct continuous cycles of improvement if interventions are not effective. Fully analyze data in consideration of study limitations and lack of improvement. Ensure initial and repeat measures are comparable.
PPIC	Educated providers and shared member-specific results. Initiated face-to-face meeting with the provider groups and their quality staff.	Project did not demonstrate improvement.	Not Met	Ensure study indicators and populations are defined to measure change in the desired outcome. Document analysis of continuous improvement efforts in the report. Analyze data periodically as planned. Clearly and accurately present numerical results. Take study limitations into consideration when defining the

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
				study indicators and study populations, and during analysis. Ensure initial and repeat measures are comparable.
Unity	Conducted member outreach via phone calls and mailings. Implemented an incentive program for members who received care and successfully completed the study measure criteria.	Project did not demonstrate improvement.	Not Met	Insure indicators and the study population is defined to measure change in the desired outcome. Conduct additional continuous cycles of improvement if interventions are not effective. Analyze data periodically as planned. Take study limitations into consideration in analysis. Ensure initial and repeat measures are comparable.
Lead Screening in Children				
GHC-SCW	Automated the order of a blood lead screening if the anemia screen was ordered at the 12 month well-child visit, for members who utilize the GHC-SCW staff model clinics.	Project did not demonstrate improvement.	Partially Met	Define data sources for all measures. Clearly describe the data collection process for aspects of the project. Fully describe the intervention. Document the impact or result of continuous cycles of improvement. Clearly describe data displayed in graphs and charts.
Tobacco Cessation				
GHC-SCW	Conducted member outreach to a subset of the	Based on the documentation	Partially Met	Collect and report data for the entire study

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
	study population via phone calls and electronic health record messaging to offer tobacco cessation counseling from a GHC-SCW tobacco cessation counselor. Mailed letters to members informing them of tobacco cessation options and resources.	submitted, quantitative improvement cannot be confirmed.		population according to the defined study indicators. Describe the rationale for deploying interventions only to a subset of the study population. Conduct and document continuous improvement efforts in the report. Ensure initial and repeat measures are comparable. Fully analyze data according to the stated baseline measurement year results.
GHP	Conducted member outreach via mailings and newsletters. Informed providers of the benefit coverage of tobacco cessation in provider newsletters.	Project did not demonstrate quantitative improvement.	Partially Met	Conduct and document continuous improvement efforts in the report. Fully analyze the data and identify study limitations. Ensure initial and repeat measures are comparable.
PPIC	Conducted member outreach via bi-annual text messaging and letter campaigns. Educated providers and shared member-specific results.	Project did not demonstrate improvement.	Not Met	Document and analyze continuous improvement efforts in the report. Analyze data periodically as planned. Take study limitations into consideration in analysis. Ensure initial and repeat measures are comparable.

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
				Include data to demonstrate effectiveness of the intervention.
Developmental Screens – Children Only				
CCHP (FCMH)	Hired additional staff to efficiently deliver assessment services to children according to their developmental screens. Updated procedures for initial member intake to strive for developmental screens to be completed within 30 days of enrollment. Educated staff on how to properly administer screens using a validated tool.	Project demonstrated "real" improvement: increased the rate of developmental assessments from 49% in 2015 to 74% in 2017. Also, demonstrated sustained improvement with repeat measures.	Met	Continue to sustain the level of improvement that has been achieved.
Sleep Hygiene – Children Only				
CCF	Educated care coordination staff about the importance of sleep and sleep hygiene for adolescents with mental health needs. Created a standardized survey tool to measure sleep and sleep hygiene. Developed and distributed sleep hygiene educational materials to members and their families.	Project did not demonstrate improvement.	Partially Met	Consider population size when selecting the study topic. Specify the data analysis plan. Conduct data analysis throughout the project.
Transitional Care – Children Only				
WM	Conducted member outreach via telephone calls and text messages. Updated disenrollment process. Contacted family members and/or former Care Coordinators when disenrollees could not be reached.	Project did not demonstrate improvement.	Partially Met	Consider population size when selecting study topic. Specify the data analysis plan.

ANALYSIS

Thirty PIPs were submitted and validated by MetaStar. MCO/SMCP/PIHP projects focused on a variety of health topics, including medication management, 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, lead screening in children, tobacco cessation, transitions of care, sleep hygiene, and developmental screening.

Seventeen of the projects were focused on new topics and 11 organizations continued one or two of same PIP topics from prior years. Nine MCOs conducted HEDIS Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) projects as part of a P4P initiative.

CONCLUSIONS

Documented, quantitative improvement in processes or outcomes of care was evident in only one of the 30 validated projects. In this project, improvement was demonstrated to be the result of the interventions employed, and the project achieved documented, quantitative improvement that was sustained with repeat measures.

The overall validation findings provide an indication of the reliability and validity of the projects' results. Three of the projects received validation findings of fully "met," 14 projects received validation findings of "partially met," and 13 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, study indicators, study population, sampling methods, and procedures. When the final projects were validated, nine of 30 projects fully met these first 12 standards. Of these nine projects, eight were in the second or third year of implementation; however, only one project demonstrated quantitative improvement.

One third of the projects (10/30), documented continuous cycles of improvement based on the review and analysis of data. The remaining 20 projects did not include an analysis of the data that resulted in either a decision to continue or modify the interventions. Conducting cycles of improvement will enable organizations to develop and implement system-wide improvements, which may lead to more successful projects.

As noted above, nine of the 30 projects focused on the HEDIS IET measure. Seven of the nine projects identified improvement during the measurement year over the baseline rate. However, quantitative improvement could not be verified for any of the projects due to a change in the HEDIS technical specifications which affected the comparability of data over time. HEDIS

technical specifications are updated annually, and the description of each measure includes a summary of changes for that measurement year. The timeframe for the engagement portion of the HEDIS IET measure was revised for MY 2017 and increased from 30 days after the initiation visit to 34 days. None of the organizations included or referenced the updated HEDIS technical specifications in their PIP report or recognized that the change in specifications affected the comparability of data to the baseline rate.

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

Strengths

- The projects focused on improving key aspects of care.
- The study questions were clearly defined.
- Knowledgeable qualified teams were selected to conduct the projects.
- Data sources were clearly identified and the data collection approaches were consistent.

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.
- Ensure indicators and study populations are defined using the correct HEDIS specifications to measure changes in the desired outcomes.
- Document continuous improvement efforts to analyze and determine the effectiveness of interventions as the projects progress.
- Take study limitations into consideration during analysis.
- Include possible reasons for less than optimal performance in analysis.
- Describe how interventions were selected.
- Include documentation of any consideration given to ensure all interventions related to members are culturally and linguistically appropriate.
- Ensure all data figures are presented clearly and accurately throughout the report, and that all calculations are completed to fully analyze data.

Information Systems Capabilities Assessment

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

ISCAs occur every three years for non-accredited MCOs or those accredited by a non-recognized accreditation body. During CY 2018, at the direction of DHS, MetaStar conducted an ISCA for one MCO, Trilogy, and two SMCPs, WM and CCF. Two MCOs, *i*Care and CW, also operate other lines of business (Family Care and/or Family Care Partnership). ISCAs are conducted for these two MCOs in accordance with the review schedule already established for those programs and are reported in a separate annual technical report.

To conduct the assessment, each organization (and its vendors, if applicable) completed a standardized ISCA tool, and provided data and documentation to describe its information management systems and practices. Reviewers evaluated this information and visited the MCO to conduct staff interviews and observe demonstrations. See the Appendix 2 for more information about the review methodology.

Summary and Analysis of Aggregate Results

This review evaluated the following categories: general information; information systems - encounter data flow; claims and encounter data collection; eligibility; practitioner data processing; system security; vendor oversight; and medical record data collection.

Section I: General Information

Each organization provided all of the requested information for this section and met all requirements in this focus area.

Section II: Information Systems - Encounter Data Flow

The MCO and one SMCP met all requirements in this focus area, while the other SMCP met most requirements. Although all three organizations have documented procedures for preparing and submitting the encounter data, one SMCP's process does not include data submission production logs or run controls.

Section III: Data Acquisition – Claims and Encounter Data Collection

One SMCP met all requirements in this focus area while the other SMCP and the MCO met most requirements to collect and maintain claims and encounter data. Although the MCO reported a 100 percent auto-adjudication rate for its claims, it appears this was based on a different internal definition of adjudication, focusing on claims status rather than processing, and the MCO has not clearly calculated its true auto-adjudication rate. One SMCP could strengthen its processes regarding claims tracking and validating claims billing codes.

Section IV: Eligibility and Enrollment Data Processing

One SMCP and the MCO met all requirements in this focus area while the other SMCP met most requirements. Each organization has processes and systems in place to collect, manage, and retain data related to eligibility and enrollment/disenrollment. A SMCP uses a member's date of birth and Social Security number to prevent duplicate entries, but does not proactively check for duplicate or multiple Medicaid identification (MAID) numbers.

Section V: Practitioner Data Processing

Each organization met all requirements in this focus area. All three organizations demonstrate the ability to identify the processes in place to obtain and properly utilize data from the provider networks or systems.

Section VI: System Security

The MCO and one SMCP met all requirements in this focus area, while the other SMCP met most requirements. All three organizations have security policies and practices generally in alignment with industry standards. However, one SMCP has not implemented a disaster recovery plan or policy. The same SMCP has also not conducted a full disaster recovery test since its last ISCA review.

Section VII: Vendor Oversight

Neither SMCP contracts with vendors for claims processing or encounter data management; therefore, this section does not apply to those organizations. The MCO met all requirements in this focus area. The MCO's vendor contracts/agreements include specific performance and quality standards, which the organization monitors regularly.

Section VIII: Medical Record Data Collection

None of the organizations collect medical record information for its encounter reporting processes; therefore, this section does not apply.

Conclusions

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

Progress

Since the previous ISCAs in 2015, the organizations have demonstrated progress as follows:

The MCO addressed all recommendations made during the previous ISCA review. The changes implemented over the last three years resulted in almost full compliance with this current ISCA review requirements. The organization updated its documented policies, procedures, and practices to improve the following:

- Vendor oversight;
- Definition of roles and responsibilities of each entity; and
- Consistency and accuracy in claims processing and encounter data submission.

One SMCP addressed most of the recommendations made during the previous ISCA review. The changes implemented resulted in full compliance with all requirements associated with this review. Policies, procedures, and practices were updated to improve the following:

- Information Technology security and infrastructure;
- Vendor oversight; and
- Claims processing.

One SMCP addressed some of the recommendations made during the previous ISCA review. The organization strengthened its security and confidentiality requirements with the exception of disaster recovery planning.

Strengths

- Member eligibility and enrollment information is reconciled by the MCO with the State provided enrollment reports three times each month. The frequency of reconciliation is greater than that recommended by DHS.
- The MCO and both SMCPs continue to upgrade the claims processing and encounter data creation systems as needed.
- One SMCP used its home-grown electronic systems to manage enrollment, authorizations, provider network, claims, and encounter data. This system centralized all functions and allowed for information availability with minimal delay.
- Strong processes are in place at two organizations to monitor subcontractors, promoting quality assurance and performance improvement efforts across the continuum of services.
- The MCO and its subcontractor have a timely process that ensures all active and practicing providers meet all of DHS' requirements.

- A SMCP demonstrated a thorough provider rate setting methodology and used a combination of Medicaid fee-for-service rate comparisons, provider input, and locale, as well as statewide rate comparison for ancillary services.
- One SMCP continued to provide opportunities for service verification through its report of services provided, which is shared regularly with the enrollees' family.
- The home-grown electronic system used by one SMCP enables a significant percent of claims and encounters to be processed electronically. System enhancements include:
    - System drop-down boxes to facilitate claims submissions and reduce the potential for data entry errors;
    - Common claim denial reasons (over 100) for providers; and
    - Feedback for corrective action by providers at both the claim and system levels.
- In addition to the system enhancements, the SMCP disseminated to its providers a clear, step-by-step instruction manual for submitting claims. The manual has the potential to expedite claims, reduce errors, and improve the accuracy and completeness of the encounter data.
- All three organizations have a well-documented process for cleaning the claims data prior to the creation of encounter submission.

Opportunities for Improvement

- Develop a process to calculate and monitor the auto-adjudication rate.
- Revise policies and procedures to ensure all employees receive required annual security and privacy training.
- Develop formal auditing programs to monitor the accuracy of membership and provider manual data entry.
- Increase, formalize, and document the processes for both provider submitted and internal data entry validation, and decrease reliance on vendors to validate the data.
- Consider increasing reporting options and opportunities within the organizations' electronic care management record systems for automation of all data validation and other system functions.
- Consider additional monitoring and reporting of claim processing timeliness. Although the MCO reported all claims are processed within seven days, there are no reports produced or other monitoring activities conducted to confirm this information.
- Continue automating the provider directory updates from the provider information to the SMCP's contractor, eliminating duplicate data entry.
- Develop a process to create production logs for the encounter file data runs.
- Consider changing the claims field name from HCPCS to a more inclusive label that reflects all the possible code sets such as CPT and revenue codes.

- Develop and document the process to track claims payment timeliness, including documenting the date each claim is received.
- Develop a disaster recovery plan and implement disaster recovery testing.
- Implement a process to track database changes.

CARE MANAGEMENT REVIEW – FOSTER CARE MEDICAL HOME

The FCMH is a PIHP operated in six counties in southeastern Wisconsin by one managed care organization, CCHP. 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. Records chosen for review were members who enrolled January 1, 2017 or later and were enrolled at least 60 days at the time of the review. A total of 44 records were reviewed.

The review focused on five categories to evaluate program compliance:

- Screening;
- Assessment;
- Care Planning;
- Care Coordination and Delivery; and
- Transitional Health Care Planning.

The five categories included a total of 10 review indicators. More information about the review methodology can be found in Appendix 2.

RESULTS FOR EACH FOCUS AREA

Each of the five sub-sections below provides a brief explanation of a key focus area category, followed by bar graphs which display CY 2018 results for each indicator that comprises the category.

SCREENING

An Out-of-Home Care (OHC) Health Screen must be completed, communicated, and followed-through within the timelines and conditions described in the DHS-FCMH contract. Newborns; children detained from an inpatient hospital setting; and children taken into protective custody around the time of a forensic evaluation are exempt from the OHC Health Screen. However, the identified needs and required follow-through must be communicated. Of the 44 records reviewed, 41 cases required OHC screening. OCH Health Screens not completed are included as not comprehensive.

Timeliness of OHC Health Screen

The OHC Health Screen must be completed within two business days of the member's out-of-home placement. Timely initial OHC Health Screens were documented in 25 records. Fifteen records indicated the OHC Health Screen was completed outside of the required timeframe. One record did not contain documentation of a completed OHC Health Screen. Contributing factors that may have resulted in late or missed screening identified in the record included late

notification of a new enrollee, availability of out-of-home care providers to attend appointments, and inability to locate members.

Comprehensiveness of OHC Health Screen

The OHC Health Screen is considered comprehensive when it includes a triage score (risk stratification), identification and documentation of any immediate medical and dental health needs and urgent mental/behavioral health needs, identification and documentation of any additional health conditions/needs, and documentation of developmental and mental/behavioral health screening, as appropriate. An OHC Health Screen was documented in 40 of the 44 records reviewed. Twenty-five of the 40 completed OHC Health Screens were comprehensive. The main reason an OHC Health Screen was not comprehensive was due to a triage score (risk stratification) not being documented. One record did not contain evidence of a completed OHC Health Screen and was considered not comprehensive.

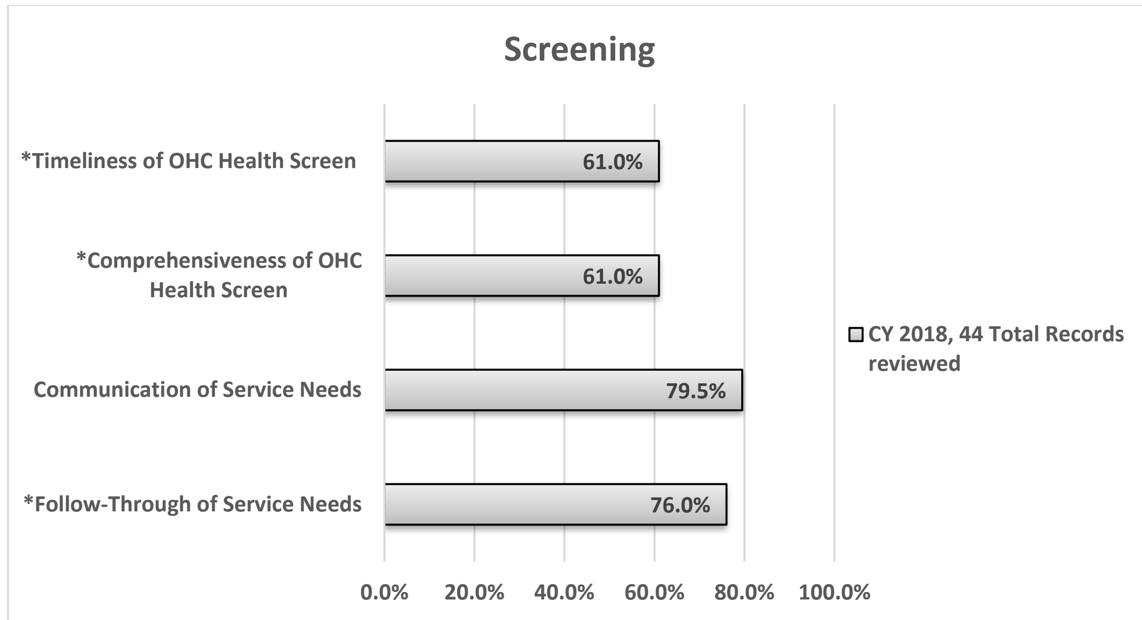
Communication of Service Needs

Documentation in the member record must indicate the out-of-home caregiver is being provided with information to meet the identified needs of the member. The record must also show the OHC Health Screen information is shared with the member's out-of-home caregiver and child welfare case manager, and is sent to the care coordination team and primary care provider (PCP).

The communication requirement applied to the entire sample of 44 records. Evidence of communication with the out-of-home caregiver, health care providers, and child welfare staff was documented in 35 of the 44 records reviewed. Nine records did not contain evidence of effective communication with all of the parties instrumental to the member's care, mainly the PCP.

Follow-Through of Service Needs

Documentation in the member record must indicate prompt and adequate follow-through occurred to address any immediate or emergent physical, mental/behavioral, and oral health needs identified during the OHC screening. The OHC Health Screen identified immediate health needs warranting follow-through in 25 of the total 44 records reviewed. Twenty-two records identified immediate physical health needs with documented prompt and adequate follow-through. Twenty-three records identified immediate mental/behavioral health needs with documented prompt and adequate follow-through.



*Note: "Timeliness of OHC Health Screen" and "Comprehensiveness of OHC Health Screen" applied to 41 records. "Follow-Through of Service Needs" applied to 25 records.

Assessment

Records must contain evidence of a timely initial health assessment, including a HealthCheck exam. The records must also contain evidence that referrals were made and follow-through occurred for each identified need.

Timeliness of Initial Health Assessment

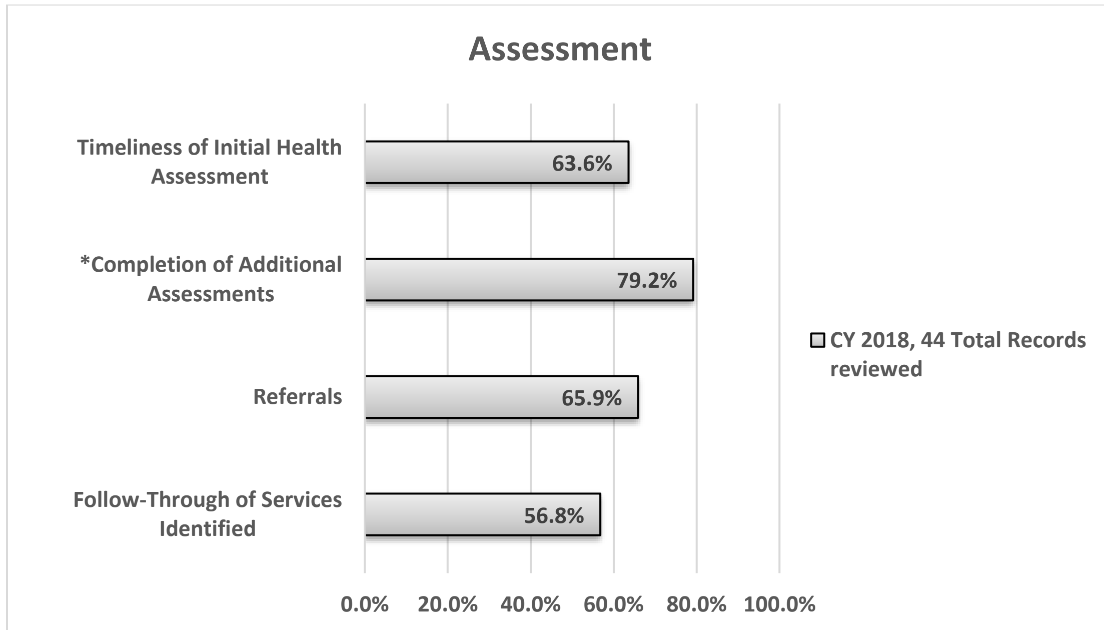
The initial health assessment must be completed within 30 calendar days of enrollment. Timely initial health assessments were completed in 28 of the 44 records reviewed. The identified barriers to timely completion of the initial health assessment included late notification of a new enrollment, out-of-home care provider availability for appointments, appointment availability, inability to locate members, and children who remained enrolled but were reunified with biological parents and parents were nonresponsive to contacts to coordinate the assessment.

Completion of Additional Assessments

The initial health assessment must include a comprehensive HealthCheck exam as well as mental/behavioral health and/or developmental assessments, as indicated. Twenty records did not require a mental/behavioral health and/or developmental assessment. Nineteen records included the additional assessments as indicated. Five records did not meet the requirement. Records indicated that obtaining parental consent to complete a mental health assessment was difficult at times. Case notes included multiple attempts to contact the biological parent or guardian with no documented response from the parent or guardian.

Referrals
The record must document that appropriate referrals are made in a timely manner, based on the member's needs identified in the initial assessment. If a member is not eligible for a specific referral/service, the record should show evidence of referral to an appropriate alternate service. Twenty-nine records documented that all appropriate referrals were made based on the member's needs identified in the assessment. Fifteen records did not fully meet the requirement, as they did not show evidence that all appropriate referrals were made related to the member's identified needs, or were not made in a timely manner. Twelve of these 15 records indicated the member was not referred to an appropriate alternate service as needed.

Follow-Through of Services Identified
The record must document that follow-through is conducted in a timely manner to confirm the services and supports being coordinated are in place, and the member's identified needs are being effectively addressed. Twenty-five 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. Reasons this requirement was not met were due to a lack of follow-through related to the services/supports being coordinated and no indication the member received all of the services recommended in the assessment, or an appropriate alternative.



*Note: "Completion of Additional Assessments" applied to 24 records.

Care Planning

The care plan must identify the services and supports to be coordinated consistent with information in the initial comprehensive assessment, and must be developed and updated according to the timelines and conditions described in the DHS-FCMH contract.

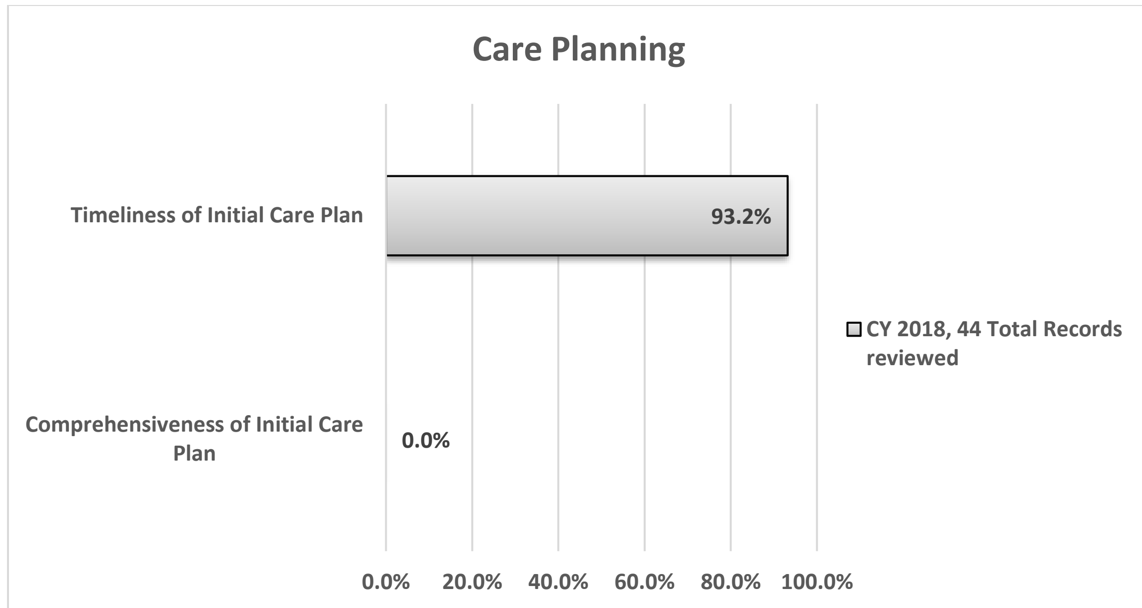
Timeliness of Initial Care Plan

The initial care plan must be completed within the first 60 calendar days of enrollment. Timely initial care plans were completed in 41 of the 44 records reviewed. Barriers identified for instances in which a care plan was missing included inability to locate a member and program disenrollments.

Comprehensiveness of Initial Care Plan

None of the 44 records reviewed met the requirements for comprehensiveness of the initial care plan. The contributing factors included:

- No care plans included parent or legal guardian signatures. The organization reported its electronic health record *Epic* currently lacks a mechanism to capture this requirement;
- Care plans did not include goals;
- Evidence of collaboration with members, out-of-home caregivers, parents or legal guardians, and child welfare workers was not found in any records;
- Barriers to care, even when barriers could be identified in the record, were not included in any care plans reviewed;
- When OHC Health Screens or Initial Health Assessments were not completed, or the records were not available at the time of the care plan, this information could not be included in the initial care plan as required; and
- In some instances, members refused mental health treatment, so an assessment could not be completed, thus resulting in missing information on the care plan.



Care Coordination and Delivery

The record must document that services and supports were coordinated in a reasonable amount of time, that follow-up with the member occurred in a timely manner to confirm the services/ supports were received and were effective, and that all identified needs were adequately addressed.

Ongoing Collaboration and Communication

The record must meet contract requirements related to collaborating and communicating with individuals instrumental to the member's support. None of the records reviewed contained evidence of collaboration and communication with all parties instrumental to the member's support. The records did not include the child welfare goals and permanency plans and many lacked adequate evidence of collaboration and communication with the child welfare worker or out-of-home care provider.

Monitoring for Emergent Needs

The record must contain documentation of regular monitoring to identify changes in the member's health care status, the services necessary to address or further assess the needs, and ensure that acute needs are addressed in a timely manner. Of the total 44 records reviewed, 21 records indicated regular monitoring was occurring to identify changes in the member's health care status and prioritize his/her needs. Twenty-three records did not meet this requirement.

Prioritizing Needs

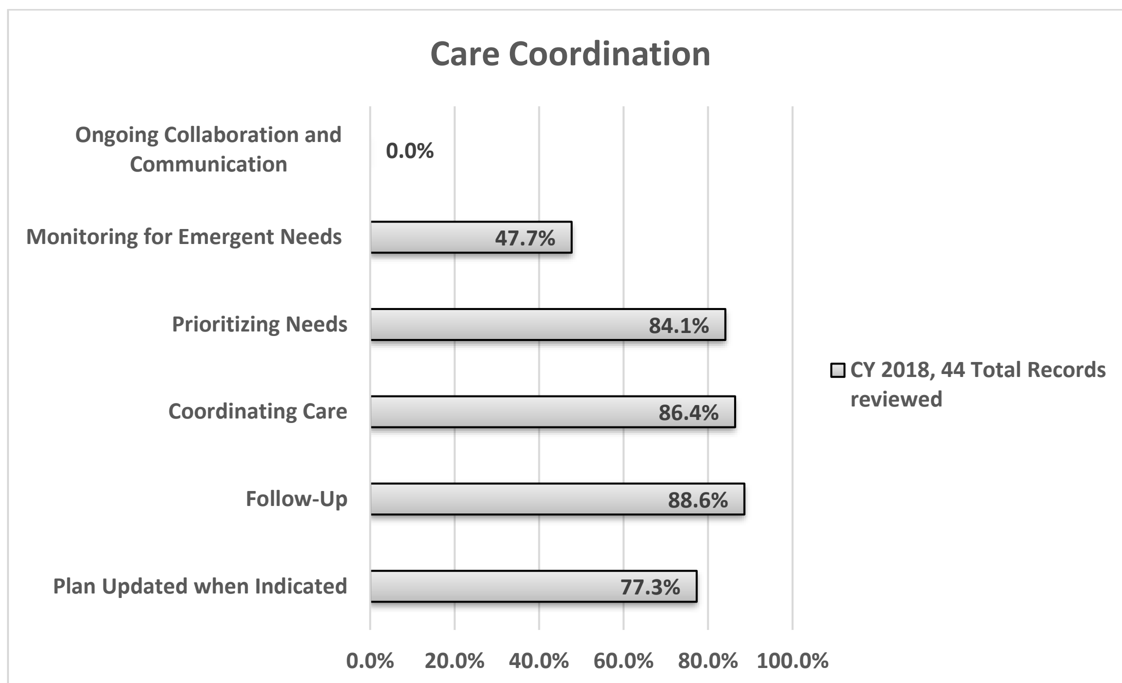
The record must contain documentation of regular needs prioritization of acute and non-acute needs. Thirty-seven records indicated acute and non-acute needs were prioritized, with acute

needs addressed in a timely manner. During the period under review, one or more acute needs of the member were identified in 39 records. Five records did not meet this requirement.

Coordinating Care
The record should contain evidence of care coordination to address all of the member's identified needs. Of the total 44 records reviewed, 38 records contained documentation of care coordination to address all of the member's identified needs.

Follow-Up
The record must document timely follow-up is conducted to ensure the member is receiving all of the services identified in the care plan, and to determine whether the services are adequately meeting his/her needs. Of the total 44 records reviewed, 39 records contained documentation of follow-up for all of the services identified on the member's care plan. Five records did not meet the requirement.

Plan Updated when Indicated
The plan must be reviewed and updated at minimum every six months, and when the member has a significant change in situation or condition (e.g., member has a hospitalization, a change in placement, is diagnosed with a new chronic condition, etc.). Of the 44 records reviewed, 34 records indicated the member's care plan was reviewed and updated when indicated.



Transitional Health Care Planning

Evidence of Transitional Health Care Planning

The record should document that transitional care planning occurred prior to a child leaving the FCMH. This requirement was not applicable to 41 of the records reviewed. Of the remaining three records, no records documented a transitional health care plan that met the contract requirements.

Analysis

Currently the FCMH is operated by one organization. The organization reported that enrollments in 2017 were higher than anticipated, which may have impacted the timeliness and comprehensiveness of care management activities. The organization works with many partners and can influence each of its partners, but cannot direct them. The partners can affect the program compliance, as they have a direct impact on whether contractual deadlines are met. For example, the schedule availability of an out-of-home caregiver could result in late completion of the OHC Health Screen.

Case notes and care plans were sparse, making it difficult to determine a complete picture of the case management services provided to members. While communication efforts were evident in the records, documentation demonstrating collaboration was missing. Evidence of contact attempts made by the coordinator was present, but contained limited details of the reason for the contact.

Recommendations were noted for members during the two-day OHC Health Screen or Initial Health Assessment, but documentation did not include the follow-up action that was taken to verify the recommended services were received or needed.

Care plans located in *Epic* do not meet contractual requirements. Examples include the lack of goals, no identification of barriers, and no parent/guardian signature on the plan.

Conclusions

The organization focused on providing comprehensive and coordinated health care for children in out-of-home care using a medical home health model that reflects the unique health needs of these children. This includes comprehensive and timely health services for physical, behavioral, and dental services. 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.

MetaStar made a number of recommendations following the CY 2017 FCMH evaluation. Specific progress, strengths, and opportunities for improvement are provided below.

Strengths

- The records showed evidence of problem-solving and innovation. For example, in 2017 the program piloted having an Initial Outreach Coordinator for each member to bridge the gap between Intake Worker and long-term Outreach Coordinator. While it was not determined to be successful, it was evidence of continued cycles of improvement.

Opportunities for Improvement

- Review policies, internal procedures, and training to ensure documentation practices reflect the work being done.
- Conduct audits of case notes and care plans to ensure care plans contain documentation of members' identified needs and actions to address the needs.
- Implement monitoring activities to ensure follow-up occurs as outlined in the organization's policies, and is consistently documented in records to assure member needs are addressed. Implement actions to improve and evaluate the effectiveness of the actions.
- Conduct a root cause analysis to identify the barriers within the *Epic* system to fully meet contract requirements for care plans, and work with the organization's leadership to determine the best options to overcome the barriers.

Record Review – Childless Adults Health Needs Assessment

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 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 1,373 records of BC+ CLA recipients enrolled in 18 MCOs.

MetaStar reviewed a total of 1,373 records across all MCOs, per the direction of DHS, and according to the sampling methodology used for the reviews. Sampling methodology changed from year one to year two. The year two sample was weighted by quarter to reflect the fluctuation of enrollment numbers throughout a calendar year. 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 CY 2017	Number of Records CY 2018
Anthem	74	84
CCHP	36	84
Compcare	74	81
DHP	79	56
GHC-EC	80	63
GHC-SCW	83	89
GHP	78	67
HTHP	48	74
*i*Care	68	82
Mercy	77	30
MHS	48	88
MHWI	64	90
NHP	52	81
PPIC	55	91

Managed Care Organization	Number of Records CY 2017	Number of Records CY 2018
SHP	82	72
Trilogy	40	79
UHC	40	81
Unity	86	81

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

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

Additional information can be found in Appendix 2.

Results for Initial HNA

The sections below provide 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. CY 2017 and CY 2018 results are provided for comparison.

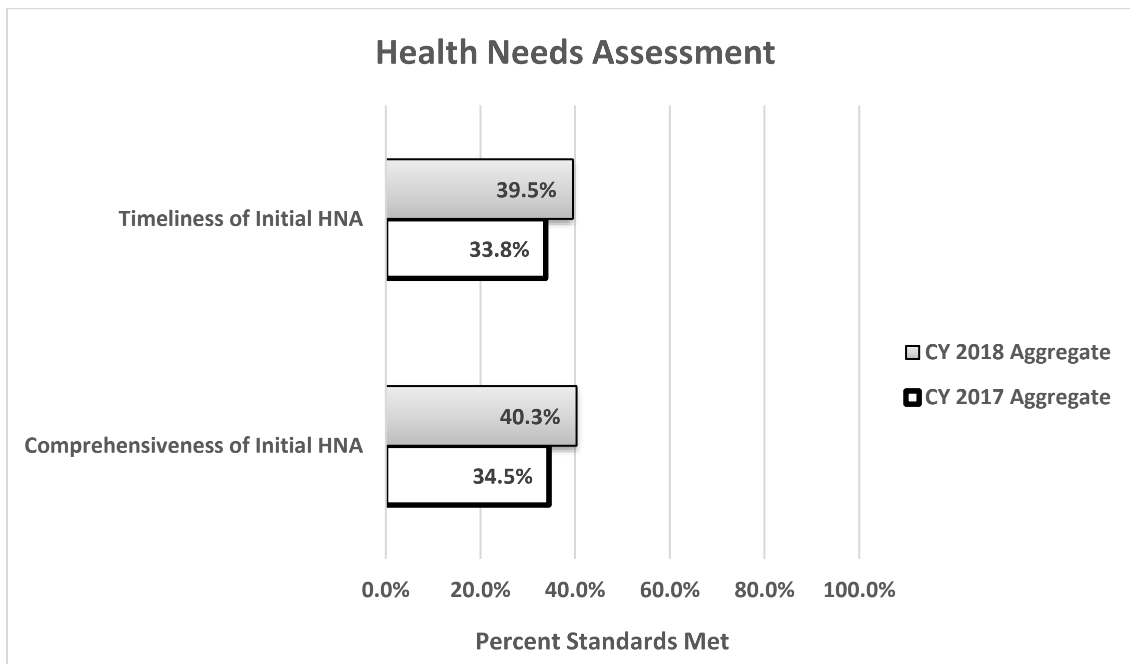
Timeliness and Comprehensiveness

The initial HNA must be completed within two calendar months of enrollment, covering eight elements outlined by DHS. The HNA is comprehensive if it includes the member's history of chronic physical and mental health illness, and at least three additional elements. Contact efforts were also documented when an assessment was not timely or not completed.

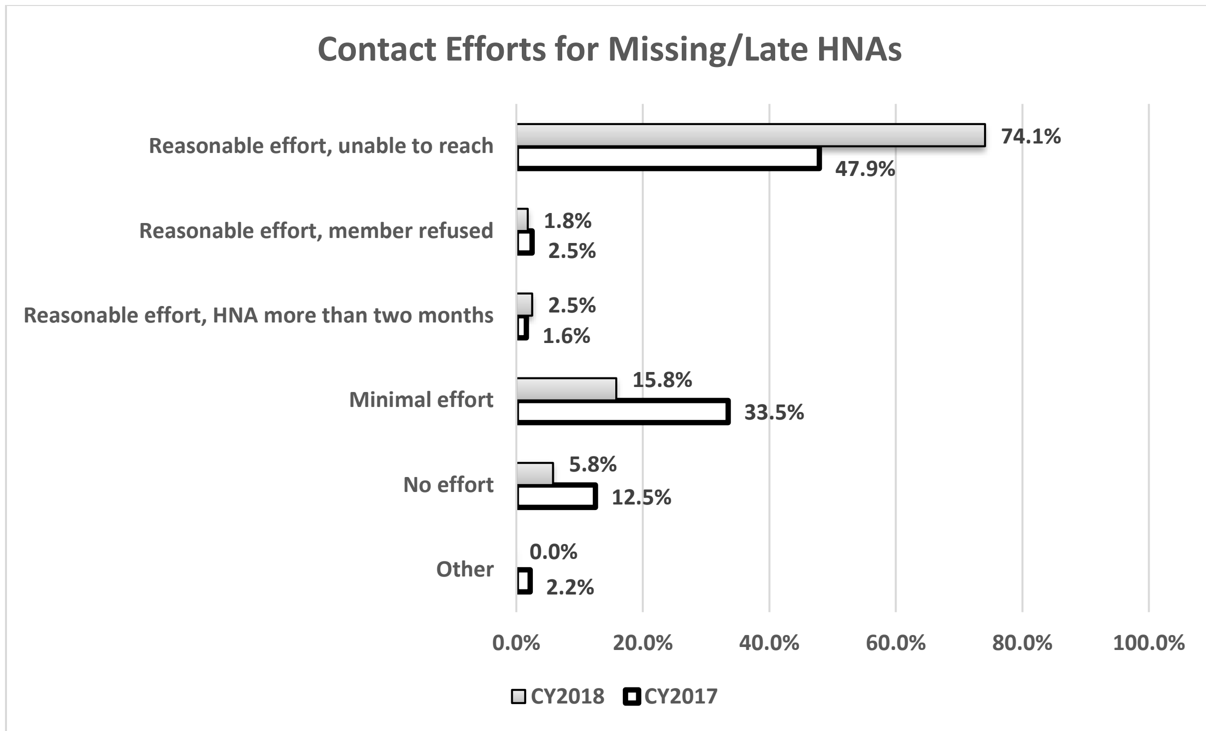
The graph below depicts the aggregate rates of compliance in CY 2017 and CY 2018 for the review elements "Timeliness of Initial HNA" and "Comprehensiveness of Initial HNA".

The aggregate timeliness rate for all MCOs was 33.8 percent for CY 2017 and 39.5 percent for CY 2018. Nine MCOs scored greater than 39.5 percent in CY 2018 while nine scored below the aggregate. Eleven MCOs showed improvement as compared to CY 2017. Analysis indicated the year-to-year difference in the improvement rates for "Timeliness of HNA Completion" for three MCOs was likely attributable to actions of the MCO, and was unlikely to be the result of normal variation or chance. Seven MCOs did not show improvement as compared to CY 2017. Eight MCOs did not meet the HNA completion rate target of 35 percent or a 10 percent reduction in error.

The aggregate comprehensiveness rate for all MCOs was 34.5 percent in CY 2017 and 40.3 percent in CY 2018. This rate reflects the rate of comprehensiveness of the HNA regardless of timeliness. Assessments not completed are included as not comprehensive. When assessments were completed, the majority were considered comprehensive as they were found to include the member's history of chronic physical and mental health illness and at least three additional elements. Assessment of urgent medical and behavioral symptoms was the assessment element that was found most often not consistently addressed.



The following graph depicts the contact efforts made by the MCOs for HNAs not completed or not completed timely. Of the 830 records in which the HNA was not completed or completed beyond two months in CY 2018, 21.6 percent demonstrated either minimal or no effort to contact members after the initial MCO enrollment. Comparing CY 2017 scores to CY 2018 shows an improvement in reasonable efforts to contact members to complete the HNA. The incidence of minimal to no effort to contact members to complete the HNA was reduced by about 50 percent.



Analysis

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 timeliness of initial HNAs rate from the previous year. Ten MCOs had an average rate for timeliness at or above the requirement, while eight MCOs did not meet the benchmark.

DHS provides MCOs with member contact information at the time of enrollment by a report named the "834 file." MetaStar did not encounter cases in which the MCO documented the initial contact information was inaccurate based on the information provided from the "834 file." Information about the types of member outreach attempted by MCOs was as follows: 58 percent by telephone, 41 percent by mail, and one percent in person.

While 10 MCOs met the requirement for "Timeliness of initial HNA Completion," by meeting the 35 percent or a 10 percent reduction in error threshold, eight MCOs did not. Improvement was noted in "Timeliness of initial HNA Completion" as compared to the prior year for 11 MCOs. Following analysis, three MCOs' improvement rate was likely attributable to actions of the MCO, and was unlikely to be the result of normal variation or chance. Seven MCOs showed a reduction in "Timeliness of initial HNA Completion" as compared to the prior year.

HNAs were usually comprehensive when completed; however, the formatting of some HNA templates did not encourage a response to all questions. Recommendations were made to four MCOs related to improvement of the "Comprehensiveness of the HNA."

Almost 22 percent of records reviewed in which the HNA was not completed or completed late demonstrated minimal to no effort to contact the member in CY 2018 compared to the CY 2017 rate of 47.7 percent. The incidence of cases found to have minimal or no effort to contact members to complete the HNA was reduced by approximately 50 percent as compared to CY 2017. The four MCOs with highest scores for "Timelines of initial HNA Completion" all demonstrated from zero to eight percent incidence of minimal or no effort to contact members. While this represents an improvement in member outreach efforts as compared to the previous year, it indicates an ongoing opportunity for improvement.

CONCLUSIONS

Progress

- Improvement was demonstrated in the number of cases showing minimal or no effort to contact members to complete the HNA as compared to the previous year. The number of cases found to have minimal or no effort to contact members to complete the HNA declined by approximately 50 percent as compared to CY 2017.
- Three MCOs demonstrated improvement in "Timeliness of initial HNA Completion" rates. Analysis indicated the year-to-year difference in the rates are likely attributable to actions of the MCOs, and are unlikely to be the result of normal variation or chance.
- The percent of cases reviewed in which the HNA was not completed or completed late with minimal to no effort to contact the member was 21.6 percent. While an improvement occurred, as compared to the previous year, this continues to be an area for further improvement.
- While ten MCOs met the HNA completion target rate in CY 2018, seven MCOs declined indicating an opportunity for improvement.

Strengths

- Two MCOs implemented incentive programs for CLA members to complete HNAs, which may have contributed to greater completion rates.
- Three MCOs included a narrative summary of the HNA findings in the member's care management records. The narrative provided additional information and details not included on the HNA form and contributed to an improved comprehensiveness rate.
- One MCO documented evidence of home visits for HNA completion.
- Six MCOs revised the assessment process by updating telephone scripts, utilizing electronic assessments, including post cards, and mailing paper assessments to members in attempts to improve the HNA completion rates.

Opportunities for Improvement

- Recommendations were made to 12 MCOs to analyze their member engagement process to determine barriers to successfully contacting and engaging members and to consider alternative methods of member outreach.
- Recommendations were made to four MCOs to revise their HNA templates so the document encourages a response to each question.

Appendix 1 – List of Acronyms

AMB	Ambulatory Care
Anthem	Anthem Blue Cross and Blue Shield Health Plan, Managed Care Organization
BC+	BadgerCare Plus
CCF	Children Come First, Special Managed Care Program
CCHP	Children's Community Health Plan, Inc., Managed Care Organization
CFR	Code of Federal Regulations
CLA	Childless Adults
CMS	Centers for Medicare & Medicaid Services
Compcare	Compcare Health Services, Managed Care Organization
CW	Care Wisconsin, Managed Care Organization
CY	Calendar Year
DHP	Dean Health Plan, Inc., Managed Care Organization
DHS	Wisconsin Department of Health Services
DXC	DXC Technology
ED	Emergency Department
EQR	External Quality Review
EQRO	External Quality Review Organization
FCMH	Foster Care Medical Home
GHC-EC	Group Health Cooperative of Eau Claire, Managed Care Organization
GHC-SCW	Group Health Cooperative of South Central Wisconsin, Managed Care Organization
HbA1c	Hemoglobin A1c
HEDIS[3]	Healthcare Effectiveness Data and Information Set
HNA	Health Needs Assessment
HTHP	Health Tradition Health Plan, Managed Care Organization
*i*Care	Independent Care Health Plan, Managed Care Organization
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

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

IS	Information System
ISCA	Information Systems Capabilities Assessment
MAID	Medicaid Identification Number
MCHP	MercyCare Health Plans, Managed Care Organization
MCO	Managed Care Organization
MEDDIC-MS	Medicaid Encounter Data Driven Improvement Care Measure Set
MHS	MHS of Wisconsin, Managed Care Organization
MHWI	Molina HealthCare of Wisconsin
MMIS	Medicaid Management Information System
MY	Measurement Year
NCQA	National Committee for Quality Assurance
NHP	Network Health Plan, Managed Care Organization
OHC	Out-of-Home Care
P4P	Pay for performance
PCP	Primary Care Provider
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PMV	Performance Measures Validation
PPIC	Physicians Plus Insurance Corporation, Managed Care Organization
QAPI	Quality Assessment and Performance Improvement
Quartz	Quartz Health Solutions, Inc., Managed Care Organization
RIE	Reduction in Error
SHP	Security Health Plan, Managed Care Organization
SMCP	Special Managed Care Program
SSI	Supplement Security Income
TPA	Third Party Administrator
Trilogy	Trilogy Health Insurance, Managed Care Organization
UHC	UnitedHealthcare Community Plan, Managed Care Organization
Unity	Unity Health Insurance, Managed Care Organization
WIR	Wisconsin Immunization Registry

WM	Wraparound Milwaukee, Special Managed Care Program

Appendix 2 – Requirement for External Quality Review and Review Methodologies

Requirement for External Quality Review

The Code of Federal Regulations (CFR) at 42 CFR 438 requires states that operate pre-paid inpatient health plans 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 (BC+), Supplemental Security Income (SSI), Special Managed Care Programs (SMCPs), and Foster Care Medical Home (FCMH) Medicaid recipients in the State of Wisconsin. MetaStar also conducts EQR of Home and Community-Based Medicaid Waiver programs that provide long-term support services for children with disabilities. MetaStar provides other services for the state as well as for private clients. For more information about MetaStar, visit its website at www.metastar.com.

MetaStar Review Team

The MetaStar EQR team is comprised of registered nurses, a clinical nurse specialist, a physical therapist, a recreational therapist, a counselor, licensed and/or certified social workers and other degreed professionals with extensive education and experience working with the target groups served by the MCOs. The EQR team is supported by other members of MetaStar's Managed Health and Long-Term Care Department as well as staff in other departments, including a data analyst with an advanced degree, a licensed Healthcare Effectiveness Data and Information Set (HEDIS®)[4] auditor, certified professional coders, and information technologies staff. Review team experience includes professional practice and/or administrative experience in managed health and long-term care programs as well as in other settings, including community programs, schools, home health agencies, community-based residential settings, and the Wisconsin

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

Department of Health Services (DHS). Some reviewers have worked in skilled nursing and acute care facilities and/or primary care settings. The EQR team also includes reviewers with quality assurance/quality improvement education and specialized training in evaluating performance improvement projects.

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

Review Methodologies

Compliance with Standards Review

Compliance with Standards, a mandatory EQR activity, evaluates policies, procedures, and practices which affect the quality and timeliness of care and services provided to MCO members, as well as members' access to services. The MetaStar team evaluated MCOs' compliance with standards according to 42 CFR 438, Subpart E using the CMS guide, *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations, A Mandatory Protocol for External Quality Reviews (EQR), Version 2.0.*

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

Compliance with standards reviews are conducted on a three-year review cycle for organizations not accredited by the National Committee for Quality Assurance (NCQA) and organizations accredited by a non-recognized accreditation body. Each organization is evaluated on 44 standards.

Non-Accredited MCO/SMCP/PIHP Three Year Review Cycle and Results (n=44)

MCO/SMCP/PIHP	FY 15-16	FY 16-17	CY 2018*
Health Tradition Health Plan**		35 standards met	
Care Wisconsin			38 standards met
Independent Care Health Plan			38 standards met
Trilogy Health Insurance			35 standards met
Children Come First			28 standards met
Wraparound Milwaukee			38 standards met
Children's Community Health Plan	32 standards met (BC+) 32 standards met (FCMH)		

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MCO/SMCP/PIHP	FY 15-16	FY 16-17	CY 2018*
Group Health Cooperative of Eau Claire+	43 standards met		
Compcare Health Services+**	43 standards met		

Note: * In an effort to provide the most current information, DHS has requested MetaStar transition from reporting by fiscal year to reporting by calendar year. ** Compcare and HTHP contracts with DHS ended as of December 31, 2017.

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

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

The EQR team evaluated 44 standards in three focus areas that included federal and state requirements.

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

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

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

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

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 2017, MCOs calculated and reported some measures and DXC Technology (DXC) calculated and reported others.

In preparation for MY 2017, the EQR team communicated with staff from DHS/Division of Medicaid Services 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 – SQL
- Technical Specifications for the Performance Measures
- DXC Measure Results
- National Drug Codes List, if applicable; and

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 HEDIS-like measures-DHS MEDDIC-MS measures. 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-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-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	Y	N

SOURCE	PERFORMANCE MEASURES	POPULATION VALIDATED	
		BC+	SSI
	anchor date of December 31 and had at least one dental visit with a dental practitioner.		
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.	Y	N
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
HEDIS-Like	**HealthCheck Screening** For members under 21 years of age during the measurement year, the number of HealthCheck visits given to these members while enrolled in the HMO.	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: BadgerCare Plus		
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 1.5 percent from the prior year.
Annual Dental Visit - Adult (Regions 5&6 only)	National benchmarks are not available.	The aggregate MCO rate increased by 0.1 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 0.92 from the prior year.
Tobacco Cessation - Counseling	National benchmarks are not available.	The aggregate MCO rate decreased by 0.3 percent from the prior year.
HealthCheck Screening	National benchmarks are not available.	First year measure.

Program: Supplemental Security Income		
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 5.28 from the prior year.
Tobacco Cessation - Counseling	National benchmarks are not available.	The aggregate MCO rate increased by 1.0 percent from the prior year.
HealthCheck Screening	National benchmarks are not available.	First year measure.

Validation of Performance Improvement Projects

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

MetaStar reviewed the Performance Improvement Project (PIP) design and implementation, using documents provided by the MCO and discussion with MCO staff.

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

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

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

Findings were initially compiled into a preliminary report. The MCOs/SMCPs/PIHPs had the opportunity to review prior to finalization of the report.

Information Systems Capabilities Assessment

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

MetaStar's assessment was based on information system requirements detailed in the DHS-MCO or SMCP contract, other reporting technical references, and the Code of Federal Regulations at 42 CFR 438.242. Prior to the review, MetaStar met with DHS to develop the review methodology and tailor the review activities to reflect DHS expectations for compliance. MetaStar used a combination of activities to conduct and complete the Information Systems Capabilities Assessment (ISCA), including reviewing the following references:

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

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

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

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

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

Section I: General Information

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

Section II: Information Systems – Encounter Data Flow

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

Section III: Data Acquisition - Claims and Encounter Data Collection

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

Section IV: Eligibility and Enrollment Data Processing

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

Section V: Practitioner Data Processing

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

Section VI: System Security

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

Section VII: Vendor Oversight

MetaStar reviews MCO or SMCP oversight and data collection processes performed by service providers and other information technology vendors/systems (including internal systems) that support MCO or SMCP operational functions, and provide data which relate to the generation of complete and accurate reporting. This includes information on stand-alone systems or benefits provided through subcontracts, such as medical record data, immunization data, or behavioral health/substance abuse data.

Section VIII: Medical Record Data Collection

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

Care Management 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 17 indicators that reviewers used to evaluate care management performance:

1. Screening
    a. Timeliness of Initial Out-of-Home Care (OHC) Health Screen
    b. Comprehensiveness of OHC Health Screen
    c. Communication of Service Needs
    d. Follow-Through of Service Needs
2. Assessment
    a. Timeliness of Initial Health Assessments
    b. Completion of Additional Assessments
    c. Referrals
    d. Follow-through of Services Identified
3. Care Planning
    a. Timeliness of Initial Care Plan
    b. Comprehensiveness of Initial Care Plan

4. Care Coordination
    a. Ongoing Collaboration and Communication
    b. Monitoring for Emergent Needs
    c. Prioritizing Needs
    d. Coordinating Care
    e. Follow-Up
    f. Plan Updated when Indicated
5. Transitional Health Care Planning
    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 Health 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 – Health Needs Assessments

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, 2017 through December 31, 2017, 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

The initial HNA is considered timely when it is completed within two calendar months of enrollment. 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.

If reviewers identified a member had previously enrolled in the MCO as a commercial member, 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, potential penalties and potential bonuses 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 (RIE) 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 25 percent of the monthly administrative capitation rate for the proportion of the CLA membership for whom the MCO failed to meet the HNA performance target.

   Penalty Example:
   a. Assume that a MCO's 2017 HNA performance target is 35% and its 2017 performance is 25%.
   b. Therefore, the MCO failed to meet their 2017 HNA performance target by 10%, also known as the "HNA performance gap."
   c. Further assume that in 2017:
      i. The MCO had a total of 10,000 member months.
      ii. The MCO received a total of $400,000 in administrative capitation payments for its CLA membership.
   d. To calculate the penalty:
      i. DHS multiplies the total CLA administrative capitation payments by both the HNA penalty of 25% of CLA administrative capitations as well as the MCO's HNA performance gap:

         $400,000 (total CLA administrative capitation payments) *25% (HNA penalty based on CLA administrative capitations) *10% (HNA performance gap) = $10,000.

Since this amount is less than $250,000, the MCO would be assessed a penalty of $10,000 for not meeting the 2017 HNA performance target.

3. Bonus: MCOs that in 2017 perform at or above the 35% HNA performance target will qualify for a bonus in the following way:

   a. The bonus pool will be funded from forfeitures from health plans that failed to meet their 2017 HNA targets.
   b. Contingent upon the total monies forfeited from other MCOs, the total bonus earned by a MCO will be capped at $250,000, which is the maximum HNA penalty amount.
   c. Eligible MCOs will share the bonus pool in proportion to their CLA member months in 2017.

Bonus Example:

a. Assume the total bonus pool is worth $700,000 for 2017 and four MCOs performed at or above the 35% HNA performance target and qualify for a bonus:

MCO	Total # of CLA member months	% share based on CLA membership size	Bonus amount
A	500	= (500 / 4,000) = 12.5%	= 12.5% of $700,000 = $87,500
B	400	= (400 / 4,000) = 10%	= 10% of $700,000 = $70,000
C	2,000	= (2,000 / 4,000) = 50%	= 50% of $700,000 = $350,000
D	1,100	= (1,100 / 4,000) = 27.5%	= 27.5% of $700,000 = $192,500
Total	**4,000**	**100%**	**$700,000**

b. Because of the HNA bonus cap, MCO C would only receive $250,000 instead of the $350,000 and the initial bonus amount distributed to MCOs performing at or above the 35% HNA performance target would be $600,000.

MCO	A	B	C	D	Total
Bonus amount	$87,500	$70,000	$250,000	$192,500	**$600,000**

c. There is $100,000 in leftover bonus monies that DHS would need to reallocate: $700,000 - $600,000 = $100,000.
d. The remaining $100,000 of the leftover bonus would be distributed among MCOs that meet their 2017 HNA RIE target, but perform below the 35% HNA performance target.

e. The leftover bonus amount would be distributed among qualifying MCOs based on their CLA member months.
f. Assume there are five MCOs that met their 2017 HNA RIE target, but perform below the 35% HNA performance target.

MCO	Total # of CLA member months	% share based on CLA membership size	Leftover Bonus Amount
E	1,500	=1,500/7,200 = 20.8%	=20.8% * $100,000 = $20,833
F	2,000	=2,000/7,200 = 27.8%	=27.8% * $100,000 = $27,778
G	3,000	=3,000/7,200 = 41.7%	=41.7% * $100,000 = $41,667
H	500	=500/7,200 = 6.9%	=6.9% * $100,000 = $6,944
I	200	=200/7,200 = 2.8%	=2.8% * $100,000 = $2,778
Total	**7,200**	**100%**	**$100,000**

Related to the penalties that could be imposed or bonuses that could be received, MetaStar used the 2016 results as the baseline to calculate the expected rate of performance for the timeliness of initial HNAs. MetaStar used the rate of compliance for review element 1. to assess the MCO's rate of compliance relative to its benchmark.