External Quality Review

Calendar Year 2019

Annual Technical Report

BadgerCare Plus, Children with Medical Complexities, 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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External Quality Review Organization
MetaStar, Inc. Suite 300 2909 Landmark Place Madison, Wisconsin 53713
Prepared by staff in the Managed Health & Long-Term Care Department
Primary Contacts
Jenny Klink, MA, CSW Vice President 608-441-8216 jklink@metastar.com
Laurie Hintz, MA Project Manager 608-441-8226 lhintz@metastar.com
Don Stanislawski, BA Project Coordinator 608-441-8204 dstanisl@metastar.com

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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, 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 (EQR) calendar year from January 1, 2019, to December 31, 2019 (CY 2019). Mandatory review activities conducted during the year included assessment of compliance with federal regulations, validation of performance measures, validation of performance improvement projects, and information systems capabilities assessments. MetaStar also conducted five optional activities, including:

- Supplemental Security Income care management review;
- Obstetrics Medical Home/Healthy Birth Outcomes record review;
- Foster Care Medical Home care management review;
- Children with Medical Complexity care management review; and
- Childless Adults Health Needs Assessment record review.

The Obstetrics Medical Home/Healthy Birth Outcomes and Children with Medical Complexity reviews are not subject to the requirements of 42 CFR 438.

Following is a brief summary of the review activities and results. A list of the specific review activities conducted for each of the organizations can be found beginning 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.

Compliance with Standards Review

A compliance with standards review is a mandatory EQR activity identified in 42 CFR 438.358 and is conducted according to the federal protocol.

In CY 2019, MetaStar conducted a compliance with standards review for one MCO not accredited by the National Committee for Quality Assurance. MetaStar also conducted an information systems capabilities assessment for the MCO.

The MCO demonstrated a commitment to enrollee rights and met most of the Enrollee Rights and Protections standards. The identified area for improvement was related to restrictive measures policies and procedures. All standards were fully met for the Quality Assessment and

Performance Improvement focus area. The MCO values and supports members' access to grievance systems, but did not fully meet all of the standards in this focus area. The organization should update the written grievance and/or appeal disposition letters template to fully meet the requirements.

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.

MetaStar validated measurement year 2018 performance measures for the BadgerCare Plus and Supplemental Security Income Medicaid programs. 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. Three measures for the BadgerCare Plus population declined while one increased from the previous year. Two measures for the Supplemental Security Income population increased from the previous year. HealthCheck was a new measure during CY 2018 and comparison results were not available.

Validation of Performance Improvement Projects

Validating performance improvement projects (PIPs) is a mandatory EQR activity, required by 42 CFR 438, to determine if a MCO's PIP is designed, conducted, and reported in a methodologically sound manner.

MetaStar reviewed and validated 35 PIPs during CY 2019. All organizations and programs submit project proposals to MetaStar for feedback on the first 12 standards before implementing the projects. The proposals relate to the review areas of topic selection, study question, indicators, study population, sampling methods, and data collection procedures. DHS project approval occurs subsequent to MetaStar's feedback.

Thirty-two PIPs were conducted during CY 2018 by 16 MCOs participating in the Wisconsin BadgerCare Plus and/or Supplemental Security Income Medicaid programs. The projects focused on a variety of health topics, including medication management, immunizations, emergency department utilization, follow-up care after hospitalization for mental illness, health needs assessments, initiation and engagement of alcohol and other drug dependence treatment,

reduction of readmission rates, prenatal and postpartum care, lead screening in children, and tobacco cessation. In addition, one project each was conducted by two Special Managed Care Programs and one PIHP for the foster care medical home benefit during CY 2018. The projects were focused on medication adherence and mental health evaluations.

Twenty-two of 35 projects fully met the first 12 standards when validated in CY 2019; as compared to only nine of 30 projects validated in CY 2018. The most successful projects developed approaches to monitor the effectiveness of interventions, by conducting continuous cycles of improvement and ensuring data collection processes were sound.

The overall validation findings provide an indication of the reliability and validity of the projects' results. Thirteen of the projects received a validation result of fully met, 21 projects received a validation result of partially met, and one projects received a validation result of not met. Five projects fully met all applicable standards; three of these five projects were focused on the Supplemental Security Income Needs Stratification process for reducing readmission rates.

Information Systems Capabilities Assessment

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 an information systems capabilities assessment (ISCA) for one MCO during CY 2019.

Overall, the review found the organization has 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. The MCO demonstrated almost full compliance with the current ISCA review requirements.

Care Management Review – Supplemental Security Income Program

Care management review is an optional external quality review activity requested and directed by DHS. MetaStar and DHS collaborated during CY 2018 to redesign the requirements evaluated during the SSI care management review. As a result, the findings of this review are not comparable to prior years' reviews. The EQR team reviewed 800 records for the eight MCOs serving the SSI population during CY 2019. This was the first review with the revised criteria; therefore, progress from year-to-year is not available.

Record Review – Obstetrics Medical Home/Healthy Birth Outcomes

During CY 2019, DHS directed MetaStar to perform data abstraction reviews of its Medical Home initiative for pregnant women. MetaStar reviewed 1,017 records for the 13 MCOs that currently participate 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.

Record Review – Foster Care Medical Home

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

The PIHP must establish a health care management structure that assures coordination and integration of all aspects of the child's health care needs and promotes effective communication between the individuals who are instrumental to the child's care. The organization implemented programmatic and software updates after MetaStar's review of CY 2018 records. MetaStar reviewed 44 records from the one organization that operates the FCMH in CY 20019. Overall, the organization demonstrated improvement in almost all categories.

Record Review – Children with Medical Complexity

Children with Medical Complexity is a target group covered under the Medicaid-targeted case management benefit. It is administered fee-for-service for all Medicaid-enrolled members who demonstrate medical necessity for covered services. This is a review activity requested and directed by DHS to assess the access, quality and appropriateness of care provided to members. During CY 2019, MetaStar reviewed 60 member records for the two organizations administering the benefit program. Overall, the review found the hospitals have the basic systems, resources, and processes in place to meet Medicaid requirements for oversight and management of services to members, and to support quality care.

Record Review – Childless Adults Health Needs Assessment

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 1,250 records of BadgerCare Plus childless adult recipients enrolled in 15 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. Twelve of the 15 MCOs met or achieved the target compliance rate.

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., for the calendar year from January 1, 2019 to December 31, 2019 (CY 2019). 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 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 15 managed care organizations (MCOs) to provide services for persons enrolled in the BadgerCare Plus (BC+) program in CY 2019. Eight MCOs provide health care services for persons receiving Supplemental Security Income (SSI) or SSI-related Medicaid. DHS also contracts with two Special Managed Care Programs (SMCPs) to serve children with mental health needs. One MCO also provides comprehensive and coordinated health services for children and youth enrolled in the pre-paid inpatient health plan (PIHP) for the foster care medical home benefit.

DHS exempts organizations accredited by the National Committee for Quality Assurance (NCQA) from the Compliance with Standards and Information Systems Capabilities Assessment (ISCA) reviews. Organizations that are not NCQA accredited or accredited by other entities are required by DHS to have the Compliance with Standards and ISCA reviews every three years.

Managed Care Organization	Program(s)	Accrediting Organization	Status
Anthem Blue Cross and Blue Shield Health Plan	BC+, SSI	NCQA	Accredited Expires 2/20/2022
Care Wisconsin	SSI	Not Accredited	Compliance with Standards review conducted every three years. Due in 2021
Children's Community Health Plan Inc.	BC+	NCQA	Commendable Status Expires 12/30/2020
Dean Health Plan, Inc.	BC+	NCQA	Excellent Status Expires 4/8/2022
Group Health Cooperative of Eau Claire	BC+, SSI	Accreditation Association for Ambulatory Health Care (AAAHC)	Compliance with Standards review conducted every three years by EQRO. Due in 2021
Group Health Cooperative of South Central Wisconsin	BC+	NCQA	Excellent Status
Independent Care Health Plan	BC+, SSI	Not Accredited	Compliance with Standards review conducted every three years by EQRO. Due in 2021
MercyCare Health Plans	BC+	NCQA	Accredited
MHS Health Wisconsin	BC+, SSI	NCQA	Accredited Expires 9/6/2022
Molina HealthCare of Wisconsin	BC+, SSI	NCQA	Commendable Status Expires 3/8/2020
Network Health Plan	BC+, SSI	NCQA	Commendable Status Expires 5/23/2020
Physicians Plus Insurance Corporation*	BC+	NA	NA
Quartz Health Solutions, Inc.	BC+	NCQA	Interim Status Expires 2/21/2021
Security Health Plan	BC+	NCQA	Commendable Status Expires 3/22/2020
Trilogy Health Insurance	BC+	Not Accredited	Compliance with Standards review conducted every three years by EQRO. Due in 2021
UnitedHealthcare Community Plan	BC+, SSI	NCQA	Commendable Status Expires 2/14/2020

*PPIC merged with Quartz as of January 1, 2018. However, MetaStar conducted retrospective reviews for this organization during CY 2019.

As of December 2019, enrollment was as follows:

Program	Enrollment
BadgerCare Plus	700,061
Supplemental Security Income Medicaid	54,380
BadgerCare Plus Childless Adults	129,531

Program	Enrollment
Special Managed Care Programs	3,211
Foster Care Medical Home	1,241

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

MetaStar conducted three mandatory review activities in CY 2019 as specified in federal Medicaid managed care regulations found at 42 CFR 438.358:

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

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 an information systems capabilities assessment for one MCO during CY 2019. MetaStar also conducted five optional review activities, including:

- Supplemental Security Income care management review;
- Obstetrics Medical Home/Healthy Birth Outcomes record review;
- Foster Care Medical Home care management review;
- Children with Medical Complexity care management review; and
- Childless Adults Health Needs Assessment record review.

The Obstetrics Medical Home/Healthy Birth Outcomes and Children with Medical Complexity reviews are not subject to the requirements of 42 CFR 438.

The following table identifies the MCOs and types of reviews completed during the CY 2019 review cycle. The review methodology for each review activity is found in Appendix 2.

Scope of External Review Activities CY 2019

MCOs	Types of Reviews Performed
Anthem Blue Cross and Blue Shield (Anthem)	Validation of Performance Improvement Projects Validation of Performance Measures SSI Care Management Review Obstetrics Medical Home/Healthy Birth Outcomes Review Childless Adults Health Needs Assessment Review PIP Technical Assistance

MCOs	Types of Reviews Performed
Care Wisconsin (CW)	Validation of Performance Improvement Projects Validation of Performance Measures SSI Care Management Review PIP Technical Assistance
Children's Community Health Plan (CCHP)	Validation of Performance Improvement Projects Validation of Performance Measures SSI Care Management Review Obstetrics Medical Home/Healthy Birth Outcomes Review Foster Care Medical Home Review Childless Adults Health Needs Assessment Review PIP Technical Assistance
Dean Health Plan (DHP)	Validation of Performance Improvement Projects Validation of Performance Measures Obstetrics Medical Home/Healthy Birth Outcomes Review Childless Adults Health Needs Assessment Review PIP Technical Assistance
Group Health Cooperative of Eau Claire (GHC-EC)	Compliance with Standards Review including Information Systems Capabilities Assessment Validation of Performance Improvement Projects Validation of Performance Measures SSI Care Management Review Childless Adults Health Needs Assessment Review PIP Technical Assistance
Group Health Cooperative of South Central Wisconsin (GHC-SCW)	Validation of Performance Improvement Projects Validation of Performance Measures SSI Care Management Review Obstetrics Medical Home/Healthy Birth Outcomes Review PIP Technical Assistance
Independent Care Health Plan (*i*Care)	Validation of Performance Improvement Projects Validation of Performance Measures SSI Care Management Review Obstetrics Medical Home/Healthy Birth Outcomes Review Childless Adults Health Needs Assessment Review PIP Technical Assistance
MHS Health Wisconsin (MHS)	Validation of Performance Improvement Projects Validation of Performance Measures SSI Care Management Review Obstetrics Medical Home/Healthy Birth Outcomes Review Childless Adults Health Needs Assessment Review PIP Technical Assistance
MercyCare Health Plans (MCHP)	Validation of Performance Improvement Projects Validation of Performance Measures SSI Care Management Review Obstetrics Medical Home/Healthy Birth Outcomes Review Childless Adults Health Needs Assessment Review PIP Technical Assistance
Molina HealthCare of Wisconsin (MHWI)	Validation of Performance Improvement Projects Validation of Performance Measures SSI Care Management Review Obstetrics Medical Home/Healthy Birth Outcomes Review Childless Adults Health Needs Assessment Review

MCOs	Types of Reviews Performed
	PIP Technical Assistance
Network Health Plan (NHP)	Validation of Performance Improvement Projects Validation of Performance Measures SSI Care Management Review Obstetrics Medical Home/Healthy Birth Outcomes Review Childless Adults Health Needs Assessment Review PIP Technical Assistance
Physicians Plus Insurance Corporation (PPIC)	Validation of Performance Measures Childless Adults Health Needs Assessment Review
Quartz Health Solutions, Inc. (Quartz)	Validation of Performance Improvement Projects Validation of Performance Measures Obstetrics Medical Home/Healthy Birth Outcomes Review Childless Adults Health Needs Assessment Review PIP Technical Assistance
Security Health Plan (SHP)	Validation of Performance Improvement Projects Validation of Performance Measures Childless Adults Health Needs Assessment Review PIP Technical Assistance
Trilogy Health Insurance (Trilogy)	Validation of Performance Improvement Projects Validation of Performance Measures Obstetrics Medical Home/Healthy Birth Outcomes Review Childless Adults Health Needs Assessment Review PIP Technical Assistance
United Healthcare of Wisconsin (UHC)	Validation of Performance Improvement Projects Validation of Performance Measures SSI Care Management Review Obstetrics Medical Home/Healthy Birth Outcomes Review Childless Adults Health Needs Assessment Review PIP Technical Assistance

Special Managed Care Programs	Types of Review Performed
Children Come First (CCF)	Validation of Performance Improvement Projects PIP Technical Assistance
Wraparound Milwaukee (WM)	Validation of Performance Improvement Projects PIP Technical Assistance

Hospitals	Types of Review Performed
Children's Hospital of Wisconsin (CHW)	Children with Medical Complexity Review
UW Health - American Family Children's Hospital (AFCH)	Children with Medical Complexity Review

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 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.

The mandatory compliance with standards review activity evaluates policies, procedures, and practices which affect the quality and timeliness of care and services MCO/SMCP/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 protocol, methodology, and three-year review cycle see Appendix 2. During CY 2019, MetaStar completed a compliance with standards review for one MCO, GHC-EC.

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/SMCPs/PIHPs 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 table below is the number assigned to the review standard, the second column is the standard, and the last column is the rating.

Table E1

#	Enrollee Rights and Protections	CY 2019 Rating
	General Rule	
1	**42 CFR 438.100;** The MCO must: • Have written policies regarding member 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.	**Preliminary Finding:** Partially Met **Final Finding:** Remains Partially Met

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.

Review findings indicate that the MCO values and supports member rights, fully meeting eight out of the nine standards.

Conclusions

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

Progress

- In CY 2016, the MCO fully met all standards in this focus area. One standard that was previously met, was partially met this year.

Opportunities for Improvement

- The MCO should develop and implement a policy and procedure to address requesting and approving restrictive measures as well as defining a process for if staff recognize the use of an unapproved restrictive measure.

Quality Assurance and Performance Improvement Results

MCOs/SMCPs/PIHPs 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;
- An ongoing program of quality assessment and performance improvement; and
- Compliance with other requirements.

Analysis

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

Review findings indicate that the MCO fully met all 19 standards, demonstrating it has developed and maintained the structure, operations, and processes to ensure it can meet requirements.

Conclusions

The progress, strengths, and opportunities noted below are based on the findings of the review.

Progress

- In the last review, the MCO met 17 of the 19 standards. The MCO progressed this year to meet all 19 standards in this focus area. Improvements were focused on fully developing and evaluating the quality work plan from the previous year before developing the next plan, as well as evaluating the impact and effectiveness of the previous year's plan.

Opportunities for Improvement

- The MCO reported the quality work plan is evaluated throughout the year. The ongoing results are used to inform the plan for the following year; however, the ongoing evaluation process is not well documented.

Grievance Systems Results

MCOs/SMCPs/PIHPs 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 Systems 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 column is the rating.

Table G1

#	Grievance System	CY 2019 Rating
	Notice to Members	
4	**42 CFR 438.10; 42 CFR 438.404; DHS-MCO Contract Article VIII;** ***Language, content, and format requirements*** The notice must be in writing and must meet language and format requirements to ensure ease of understanding. The MCO must use the DHS-approved notice language	**Preliminary Finding:** Partially Met **Final Finding:** Remains Partially Met
	Resolution and Notification	

10	**42 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;
	• For decisions not wholly in the member's favor, the right to request a DHS review and how to do so.
		Partially Met

Analysis

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

The MCO supports and ensures access to grievance systems and met 14 of 16 standards in this focus area. The organization needs to focus on updates to its letter templates, specifically the denial notification letter and the grievance resolution letter template.

Conclusions

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

Progress

- Two standards that were previously met in CY 2016 were partially met this year. In the last review, the MCO met all 16 standards in this focus area.

Strengths

- The MCO has a strong organizational focus related to promptly addressing member needs and resolving member complaints before they rise to the level of grievance or appeal.
- The MCO's structure and size promote open communication across all levels, which results in increased responsiveness to member needs.

Opportunities for Improvement

- The MCO should revise the denial notification letter template to include a member's option to request an expedited grievance.
- The MCO should update the grievance resolution letter template to include the date the resolution was completed.
- The MCO's process for sending grievance responses to members is mostly automated. The MCO should consider implementing a system to confirm that grievance response letters generated within the electronic medical record are mailed to members, as indicated.

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 Validation of Performance Measures, 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®)[1] measures, HEDIS-like measures, and Medicaid Encounter Data Driven Improvement Core Measure Set (MEDDIC-MS) measures. The validation review was conducted to evaluate the accuracy of Medicaid performance measures reported by the MCOs and to determine the extent to which MCOs and/or DHS' vendor, DXC Technology (DXC), collected data and calculated the measures according to specifications established by DHS. The rates for performance measures are publically reported; therefore, accuracy and integrity are critical characteristics. 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 *EQR Protocol 2: Validation of Performance Measures Reported by the MCO* review described in this report with some of the performance improvement project requirements for MCOs. For measurement year (MY) 2018 data, MetaStar validated five performance measures each for 15 MCOs providing health care services for the BC+ program populations, and three performance measures each for eight MCOs providing health care services for those who receive SSI related Medicaid.

ANALYSIS

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

[1] "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. DXC produced programming based on state specifications and reporting requirements, which had not changed significantly from the prior year. During the audit process, DXC source code and supporting documentation was reviewed to ensure appropriate numerator and denominator identifications were captured. During data quality review sessions, it was confirmed that programming appeared to be correct, and approval was provided by MetaStar. DXC's final documentation 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.

Performance Measures Results

The following table shows a comparison of the non-HEDIS measure calculations that were produced by DXC for the MY 2018 P4P initiative. The measure rates were compared to prior years as well as other health plans.

Program: BC+		
Performance Measure	***Benchmark***	***Comparisons to MY 2017***
Annual Dental Visit - Children (Regions 5&6 only)	National benchmarks are not available.	The aggregate MCO rate increased by 1.0 percent from the prior year.
Annual Dental Visit - Adult (Regions 5&6 only)	National benchmarks are not available.	The aggregate MCO rate decreased by 0.2 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 1.1 percent from the prior year.
Tobacco Cessation - Counseling	National benchmarks are not available.	The aggregate MCO rate decreased by 0.4 percent from the prior year.
HealthCheck Screening	National benchmarks are not available.	The measure was new last year; comparisons were not available. MCOs with both BC+ and SSI contracts met the combined required threshold of 80 percent for screenings.

Program: SSI		
Performance Measure	***Benchmark***	***Comparisons to MY 2017***
ED Visits (AMB) *sans revenue code 0456 (Urgent Care)*	National benchmarks are not available	The aggregate MCO rate increased by 2.6 percent 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.	The measure was new last year; comparisons were not available. All MCOs with both BC+ and SSI contracts met the required threshold of 80 percent for screenings. The MCO that held only an SSI contract without a BC+ contract did not meet the required threshold of 80% for screenings. It was noted that this MCO had very few members, so the percentage achieved was based on a fairly small denominator of 146 members.

CONCLUSIONS

Specific progress, strengths, and opportunities for improvement are provided below.

Progress

This section is intended to report progress made from the previous validation conducted for MY 2017.

- The Annual Dental Visit – Children aggregate rate increased by one percent in MY 2018 from MY 2017. This is in addition to the one and one-half percent increase in MY 2017 from MY 2016.
- The Annual Dental Visit – Adult aggregate rate also increased by 0.2 percent in MY 2018 from MY 2017. The MY 2017 rate was an increase of 0.1 percent from MY 2016.
- The Tobacco Cessation – Counseling aggregate rate for the BC+ population decreased by 0.4 percent in MY 2018 and 0.3 percent in MY 2017. The aggregate rate for the SSI population increased again by 1.0 percent in MY 2018.
- ED Visits (AMB) sans revenue code 0456 (Urgent Care) aggregate rate for the BC+ population decreased by 1.1 percent in MY 2018 and 0.92 percent in MY 2017. The

aggregate rate for the SSI population increased by 2.6 percent in MY 2018 after an increase of 5.28 percent in MY 2017.

- The HealthCheck Screening was a new measure beginning in MY 2017. All MCOs who support both the BC+ and SSI populations met the 80 percent screening requirement. One MCO only supports the SSI population and did not meet the requirement.

Strengths

The following strengths were identified in the validation of MY 2018 performance measures:

- DHS continued to engage MCOs in ongoing discussions of its P4P initiatives, which enabled MCOs to provide critical input on measure development and reporting strategies.
- Collaboration between DHS and its vendor, DXC, contributed to the accuracy of calculated rates.
- DXC continued robust testing processes to validate changes to internally developed measures.

Opportunities for Improvement

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

- Evaluate the new HEDIS 2020 measures after benchmarks have been substantiated by NCQA, for inclusion in the DHS P4P "withhold payments" initiative.
- Conduct a root cause analysis to determine the basis for differences in results between the BC+ and SSI populations for the ED Visits and the Tobacco Cessation measures.
- Assess and account for the impact of populations resulting in smaller denominators for measures, particularly the HealthCheck measure.

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

This section of the report aggregates and summarizes the results of 32 PIPs conducted during CY 2018 by 16 MCOs participating in the BC+ and/or SSI Medicaid programs. Also included is one PIP each conducted by two SMCPs, and one PIP conducted by the foster care medical home PIHP during CY 2018. All 35 PIPs were validated in CY 2019.

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 2019 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.	35/35
Study Question(s)		
2	The problem to be studied was stated as a clear, simple, answerable question(s) with a numerical goal and target date.	35/35
Study Indicator(s)		
3	The study used objective, clearly and unambiguously defined, measureable indicators and included defined numerators and denominators.	29/35
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.	32/35
Study Population		
5	The project/study clearly defined the relevant population (all members to whom the study question and indicators apply).	26/35
6	If the entire population was used, data collection approach captured all members to whom the study question applied.	31/33
Sampling Methods		
7	Valid sampling techniques were used.	1/1
8	The sample contained a sufficient number of members.	1/1
Data Collection Procedures		
9	The project/study clearly defined the data to be collected and the source of that data.	33/35
10	Staff are qualified and trained to collect data.	33/35
11	The instruments for data collection provided for consistent, accurate data collection over the time periods studied.	33/35
12	The study design prospectively specified a data analysis plan.	32/35
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.	30/35
14	A continuous cycle of improvement was utilized to measure and analyze performance, and to develop and implement system-wide improvements.	20/35
15	Interventions were culturally and linguistically appropriate.	26/34
Data Analysis and Interpretation of Study Results		
16	Analysis of the findings was performed according to the data analysis plan, and included initial and repeat measures, and identification of project/study limitations.	23/35
17	Numerical results and findings were presented accurately and clearly.	28/35
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.	23/35
"Real" Improvement		
19	The same methodology as the baseline measurement was used, when measurement was repeated.	26/35
20	There was a documented, quantitative improvement in processes or outcomes of care.	11/35
21	The reported improvement appeared to be the result of the planned quality improvement intervention.	7/13
Sustained Improvement		
22	Sustained improvement was demonstrated through repeated measurements over comparable time periods.	2/2

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
Ambulatory Care				
*i*Care	Offered the *Better Care for You* program to BC+ members. 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. Conducted monthly emergency department (ED) meetings to discuss high ED utilizers and address barriers to proactive prevention of ED visits.	Project demonstrated improvement for the BC+ population: decreased the rate of number of emergency department visits from 80/1,000 member months in 2017 to 79/1,000 member months in 2018. Project did not demonstrate improvement for the SSI population.	Partially Met	Take study limitations into consideration in analysis. Develop and implement interventions which are sufficient to be expected to improve outcomes for all members in the study.
Antidepressant Medication Management				
CCHP	Used an automated telephone call to remind members to refill prescriptions. Conducted telephonic member outreach using a structured medication adherence guideline or teaching tool.	Project demonstrated "real" improvement: increased the rate of the Antidepressant Medication Management engagement measure from 35.8% in 2015 to 36.6% in 2018	Partially Met	Specify a data analysis plan. Document continuous improvement efforts in the report. Identify and describe study limitations.
Breast Cancer Screening				
CW	Provided breast cancer screening education to SSI care management staff.	Project did not demonstrate improvement.	Partially Met	Ensure indicators are defined to measure change in the desired outcome.

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
	Conducted outreach to members still in need of screening. Provided outreach reminders to SSI care management staff through scheduled electronic tasks in the MCO's electronic medical record. Initiated a two part letter campaign to members in need of a breast cancer screen.			Describe how interventions were selected.
DHP	Conducted member outreach through mailings and telephone contacts. Held three events to promote the completion of breast cancer screening for select members.	Project did not demonstrate quantitative improvement.	Partially Met	Accurately define study indicators and study population according to the correct measurement year specifications. Describe study limitations. Ensure initial and repeat measures are comparable.
PPIC	Conducted member outreach through mailings and telephone contacts.	Project did not demonstrate quantitative improvement.	Partially Met	Accurately define study indicators and study population according to the correct measurement year specifications. Conduct continuous cycles of improvement and alter interventions as needed. Analyze data on a periodic basis. Ensure initial and repeat measures are comparable.

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
Childhood Immunizations				
GHC-SCW	Contacted members' parents by telephone to discuss the importance of the 15 and 18 month well child visits, address any barriers, and help schedule the appointments. Offered members an incentive after completion of the immunization visit. Educated members about the importance of attending well child visits and completion of immunizations through monthly mailings.	Project demonstrated real improvement: increased the completion rate from the 2017 rate of 62.75% to the 2018 rate of 77.27%.	Met	Document continuous improvement efforts in the report. Address cultural or linguistic appropriateness of interventions. Document periodic data analysis.
Quartz	Conducted telephonic outreach. Provided educational mailings to parents and legal guardians about the importance of childhood immunizations.	Project did not demonstrate improvement.	Partially Met	Ensure initial and repeat measures are comparable. Document continuous improvement efforts in the report. Analyze data periodically as planned.
SHP	Worked with largest provider system to improve vaccination rates. Sent bi-monthly vaccination reminder mailings to Marshfield Clinic SHP members. Increased data submissions to the software vendor from three times per year to six. Provided member education mailing to all SHP Medicaid members. Conducted chart reviews for supplemental data.	Project demonstrated "real" improvement: increased the rate of immunizations from 70.57% in 2017 to 72.34% in 2018.	Met	Include data to demonstrate effectiveness of the interventions. Continue to sustain the level of improvement that has been achieved.

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
	Provided reports listing patients due for HealthCheck exams to primary care practitioners. Enhanced internal reporting tool for improved vaccination tracking.			
Emergency Department Utilization				
UHC	Initiated a case management referral pilot program focused on the top 15 percent of members with asthma-related ED visits during measurement year 2017. Sent letters to providers identifying members with three or more ED visits within the previous nine months. Provided educational brochures about asthma to primary care providers (PCPs) and clinics. Issued asthma-related metrics to PCPs.	Project did not demonstrate quantitative improvement.	Partially Met	Conduct and document continuous improvement efforts in the report. Ensure variables (such as the number of enrollees with a specific diagnosis) are addressed when analyzing the data year-to-year and determining project success.
Follow-Up After Hospitalization for Mental Illness				
Anthem	Utilized MyHealthDirect follow-up appointment scheduling. Added the follow-up after hospitalization measurement to the Healthy Rewards program. Implemented the WholeHealth Member Incentive collaboration. Enhanced the Interdepartmental Care Coordination program.	The project did not demonstrate improvement for either the BC+ or SSI populations.	Partially Met	Conduct and document continuous cycles of improvement if interventions are not effective. Address cultural or linguistic appropriateness of interventions. Measure effectiveness of interventions. Fully analyze data and identify follow-up actions.

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
	Conducted medical record abstraction.			
MHWI	Offered the Transition of Care Program to members prior to hospital discharge. Developed a Transition of Care Progress Report to track and monitor progress of the Follow Up After Hospitalization (FUH) measure. Distributed a scorecard to providers to share data and educate providers on MHWI's FUH measure performance.	Project did not demonstrate improvement.	Met	Analyze data to discover reasons for less than optimal performance.
Health Needs Assessment				
DHP	Modified completion of the health needs assessment (HNA) with members based on the transition to having DHP staff complete member outreach efforts. The HNA was updated to make it easier for members to read and navigate the form.	The project did not demonstrate quantitative improvement.	Partially Met	Address cultural or linguistic appropriateness of interventions. Describe study limitations. Ensure initial and repeat measures are comparable.
Immunizations for Adolescents				
SHP	Partnered with SHP's largest provider system, who developed a toolkit for providers with tips on improving vaccination rates. Increased data submissions to the software vendor from three to six times per year. Educated members on the importance of establishing care with a PCP. Conducted chart reviews to collect supplemental data.	Project demonstrated improvement: increased the rate of immunizations from 76.4% in 2016 to 79.42% in 2018.	Met	Clearly present numerical results. Include data to demonstrate the effectiveness of interventions. Continue to sustain the level of improvement that has been achieved.

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
	Sent member educational mailings and reminders. Provided reports to PCPs identifying patients due for HealthCheck exams. Conducted clinical coordinator outreach.			
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment				
CCHP	Assigned a second Outreach Coordinator/Case Manager to conduct onsite discharge planning. Implemented a *Transition of Care Guideline* during outreach telephone calls with members. Increased member access to Medication Assisted Therapy and Telemedicine services.	The project demonstrated "real" improvement: increased the rate of engagement of alcohol and other drug dependence treatment from 14.7% in 2016 to an adjusted rate of 20.1% in 2018. Also, the project demonstrated sustained improvement with repeat measures.	Met	Specify a data analysis plan. Document continuous improvement efforts in the report.
GHC-EC	Provided telephonic outreach for follow-up care. Mailed a targeted letter to members if unable to reach them via telephone. Implemented a smartphone application as an option to improve communication with members. Worked with providers to correct any potential errors when diagnosis codes were verified for billing purposes.	Project did not demonstrate quantitative improvement.	Partially Met	Define measurable indicators and the study population accurately, according to the measure specifications. Ensure initial and repeat measures are comparable.

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
Quartz	Conducted outreach to members with an alcohol or other drug abuse (AODA) diagnosis after accessing the University of Wisconsin Hospital emergency department. Provided telephonic assistance to members to enable them to access AODA services. Educated clinic managers and providers about the AODA initiation and engagement of treatment measure.	Project did not demonstrate improvement.	Partially Met	Define measurable indicators, including numerators and denominators. Ensure inclusion of members in the project adheres to the defined study population. Conduct continuous cycles of improvement if interventions are not effective. Measure effectiveness of interventions.
Lead Screening in Children				
PPIC	Conducted member outreach through mailings and telephone contacts.	Project did not demonstrate quantitative improvement.	Partially Met	Document continuous improvement efforts in the report. Analyze data periodically as planned. Ensure initial and repeat measures are comparable.
Prenatal and Postpartum Care				
GHC-SCW	Conducted member outreach by telephone and mailings. Offered members an incentive after completion of the postpartum visit.	Project demonstrated real improvement: improved the rate of postpartum visits from 65.9% in 2017 to 74.4% in 2018.	Met	Continue to sustain the level of improvement that has been achieved.
MCHP	Mailed a targeted letter to newly pregnant members with education for a healthy birth outcome. Provided education to providers through a bulletin focused on the prenatal and postpartum care measure.	Project did not demonstrate improvement.	Partially Met	Define measurable indicators and the study population accurately, according to the measure specifications. Ensure the data collection approach defines the data to be collected in order to

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
				capture all members of the population. Include information about responsible staff and their qualifications for data collection. Describe the data collection instrument. Conduct and document continuous cycles of improvement based on the review and analysis of data. Address cultural or linguistic appropriateness of interventions. Clearly present numerical results. Analyze data to discover reasons for less than optimal performance.
Trilogy	Assigned a Trilogy registered nurse Care Coordinator and Clinical Social Worker to each pregnant member in the study population.	Project demonstrated "real" improvement: • Increased the rate of timeliness of prenatal care from the baseline of 48.9% in 2017 to 65.64% in 2018; • Increased the rate of postpartum care from the baseline of 36.7% in 2017 to	Partially Met	Describe how interventions were selected. Clearly present numerical results. Fully analyze data and identify follow-up actions. Ensure initial and repeat measures are comparable. Measure effectiveness of interventions.

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
		50.92% in 2018.		
Reduce Readmission Rate				
MHS	Implemented a Readmission Risk Score and Post-Hospitalization Outreach program. Contracted with in-home therapy providers for post-discharge follow-up appointments (in-home behavioral health). Provided telehealth to members with certain chronic diseases. Provided tele-psychiatry for follow-up appointments post-discharge. Contracted with a vendor to complete post-hospitalization transitions of care assessments with members. Referred members with high volume or inappropriate emergency department utilization to the Milwaukee Fire Department to increase member engagement.	Project did not demonstrate improvement.	Partially Met	Ensure the identified population captures all members to whom the study question and indicators apply. Document continuous improvement efforts in the report.
NHP	Implemented a Readmission Risk Score and Post-Hospitalization Outreach program. Contracted with in-home therapy providers for post-discharge follow-up appointments (in-home behavioral health). Provided telehealth to members with certain chronic diseases. Provided tele-psychiatry	Project did not demonstrate improvement.	Partially Met	Ensure the identified population captures all members to whom the study question and indicators apply. Document continuous improvement efforts in the report.

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
	for follow-up appointments post-discharge. Contracted with a vendor to complete post-hospitalization transitions of care assessments with members. Referred members with high volume or inappropriate emergency department utilization to the Milwaukee Fire Department to increase member engagement.			
SSI Needs Stratification				
Anthem	Created a SSI Case Management Pod System. Implemented a Community Health Worker Program. Implemented MyHealthDirect follow-up appointment scheduling. Added a field-based Licensed Clinical Social Worker and advocate deployment. Simplified *CareCompass* health risk assessment and notes.	Project improvement could not be confirmed.	Partially Met	Conduct and document continuous cycles of improvement if interventions are not effective. Address cultural or linguistic appropriateness of interventions. Describe study limitations. Clearly present numerical results. Document project success based on analysis of data.
CW	Implemented a new needs stratification tool within the electronic care management system. Resumed the complex care management program.	Project demonstrated "real" improvement: decreased the Potentially Preventable Readmission (PPR) Actual to Benchmark Ratio (ABR) rate from the baseline of 1.2 to 1.05 in 2018.	Met	Continue to sustain the level of improvement that has been achieved.

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
GHC-EC	Conducted member outreach to determine a member's appropriate risk level. Contacted members within five days of a hospital discharge to address follow-up care needs. Updated member care plans after each member contact. Held quarterly meetings with providers to discuss concerns and readmissions. Implemented a smartphone application as an option to improve communication with members.	Project did not demonstrate improvement.	Met	Analyze data to discover reasons for less than optimal performance.
*i*Care	Implemented a Readmission Prevention Program. Ensured members received a *Risk for Readmission Assessment* after a hospital discharge. Completed an *Acuity Assessment* to ensure members were assigned to the most appropriate acuity level after interventions were utilized. Distributed member education materials on self-management techniques for chronic medical conditions.	Project did not demonstrate improvement.	Met	Analyze data to discover reasons for less than optimal performance.
MHS	Implemented an automated stratification tool. Conducted a multidisciplinary rounds	Project demonstrated "real" improvement: decreased the PPR ABR rate	Met	Continue to sustain the level of improvement that has been achieved.

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
	process. Completed a readmission tool audit. Utilized the 3M PPR Dashboard software. Expanded regional offices.	from 1.01 in 2017 to 0.91 in 2018.		
MHWI	Ensured members were assigned to the most appropriate care management level through the use of a risk stratification model. Developed and implemented individualized care plans, and shared them with the members' providers so they could be part of the care management process. Identified possible or actual hospitalizations that could result in a potentially preventable readmission. Embedded transition of care coaches at facilities and hospitals to improve collaborative discharge planning and contact with members.	Project did not demonstrate quantitative improvement.	Partially Met	Clearly present results and findings in the report. Document a final rate for the study question.
NHP	Implemented an automated stratification tool. Conducted a multidisciplinary rounds process. Completed a readmission tool audit. Utilized the 3M PPR Dashboard software. Expanded regional offices.	Project demonstrated “real” improvement: decreased the PPR ABR rate from the baseline of 1.01 in 2017 to 0.72 in 2018.	Met	Continue to sustain the level of improvement that has been achieved.

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
UHC	Developed an enhanced risk stratification modeling process. Expanded the *Readmissions Reduction Pilot Improvement Strategies* program. Hired additional clinical staff to enhance member outreach efforts. Reviewed and updated care plans after every member, provider, and interdisciplinary care team contact.	Project did not demonstrate improvement.	Met	Ensure information in attachments aligns with the PIP report. Analyze data to discover reasons for less than optimal performance.
Tobacco Cessation				
MCHP	Planned interventions were not employed during the project.	Project did not demonstrate improvement.	Not Met	Overcome barriers in order to conduct the project during the measurement year.
Trilogy	Educated clinics about the Wisconsin Tobacco Quit Line. Implemented a standardized process for using a customized referral form. Conducted follow-up with each provider office. Provided member education using standardized educational materials. Monitored the Wisconsin Tobacco Quit Line report for physician participation.	Project did not demonstrate improvement.	Partially Met	Describe how interventions were selected. Clearly present numerical results. Fully analyze data and identify follow-up actions. Ensure initial and repeat measures are comparable. Measure effectiveness of interventions.
Medication Adherence – Children Only				
CCF	Surveyed parents and guardians about prescription medications used to treat their child's mental health symptoms.	Project did not demonstrate improvement.	Partially Met	Ensure inclusion of members in the project adheres to the defined study population.

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
	Trained Care Coordinators (CCs) on medication and advocacy techniques. Developed and distributed a brochure and educational materials to parents/guardians. Provided education to parents/guardians about medication management and advocacy techniques. Reviewed medications during team meetings and CCs offered to accompany parents/guardians to prescriber appointments.			Describe how interventions were selected. Address cultural or linguistic appropriateness of all interventions.
WM	Provided *Orientation to Medications* guidelines to all members. Provided a personalized *Medication Planning Tool* to members. Conducted member outreach with a follow-up phone call after the second and third medication appointments. Completed a *Clinical Rating Scale (CRS)* tool for each member after every appointment. Completed a *Simplified Medication Adherence Questionnaire* for each member.	Project demonstrated "real" improvement for two of the three study questions: - Increased the *CRS* score 2.84% between the control and experimental groups in 2018. - Increased the *CRS* score 9.27% with the addition of telephonic outreach between the control group and experimental group two. Project did not demonstrate quantitative improvement related to the average medication compliance *CRS* score between experimental	Partially Met	Include periodic data in the report. Ensure an adequate and representative population size.

Health Plan	Interventions	Outcomes	Validation Result	EQR Recommendations
		group one and two.		
Mental Health Evaluations – Children Only				
C4K	Trained staff on the proper administration of the *Mental Health Assessment*. Educated staff regarding the *Mental Health Assessment* and the need for signed consent of the parent or guardian. Increased flexibility in the meeting time and location with the member for the assessment. Expanded Behavioral Health Therapist meetings to include Child Welfare and Care4Kids staff.	Project demonstrated real improvement. The rate of timely assessments increased from 73% in 2017 to 84% in 2018, which exceeded the target rate by 4%. Also, the project demonstrated sustained improvement with repeat measures.	Met	Continue to sustain the level of improvement that has been achieved.

ANALYSIS

Thirty-five PIPs were submitted and validated. MCO/SMCP/PIHP projects focused on a variety of health topics, including medication management or adherence, immunizations, emergency department utilization, follow-up care after hospitalization for mental illness, health needs assessments, initiation and engagement of alcohol and other drug dependence treatment, reduction of readmission rates, prenatal and postpartum care, lead screening in children, tobacco cessation, and mental health evaluations.

Twenty-six of the projects were focused on new topics and seven organizations continued one or two of the same topics from the prior year.

The SSI Needs Stratification PIP was a DHS required project for calendar year 2018 for all eight organizations that provide services to SSI members. The topic focused on utilizing the organizations' needs stratification methodologies to reduce Potentially Preventable Readmissions (PPRs). The needs stratification methodologies incorporate the MCO's identified levels of case management based on risk stratification processes. The goal of the projects was to reduce the PPR actual to benchmark ratio (ABR). Three of the eight projects demonstrated quantitative improvement and reduced the PPR ABR from their baseline rates.

CONCLUSIONS

Documented, quantitative improvement in processes or outcomes of care was evident in 11 of the 35 validated projects. In seven of these projects, improvement was demonstrated to be the result of the interventions employed. Based on validation results, two of 11 projects achieved documented, quantitative improvement that was sustained with repeat measures.

The overall validation findings provide an indication of the reliability and validity of the projects' results. Thirteen of the projects received validation findings of fully "met," 21 projects received validation findings of "partially met," and one project received a validation finding of "not met." Five projects fully met all applicable standards; three of these five projects were focused on the SSI Needs Stratification process.

Prior to implementation, all organizations and programs submitted PIP project proposals for feedback on the first 12 standards, which relate to the review areas of topic selection, study question, indicators, and study population, sampling methods, and procedures. When the CY 2018 projects were validated in CY 2019, 22 of 35 projects fully met the first 12 standards; as compared to only nine of 30 CY 2017 projects validated in CY 2018. The most successful projects developed approaches to monitor the effectiveness of interventions, by conducting continuous cycles of improvement and ensuring data collection processes were sound.

In last year's review, nine of the 30 projects focused on the HEDIS Initiation and Engagement of Alcohol and Other Drug Abuse Treatment (IET) measure. 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. Three of the MCOs continued the HEDIS IET projects in MY 2018, and two of the organizations again did not recognize the change in comparability of data to the baseline rate. However, one organization reported results according to the current HEDIS specifications and also recalculated the CY 2017 and CY 2018 results using the HEDIS specifications for CY 2016 to ensure the data was comparable over time.

Less than one third of all projects (11 of 35) demonstrated quantitative improvement in the measure as a result of the PIP project. Validation of the projects identified that rates declined from baseline, initial and repeat measures were not comparable or there was a difference in how the baseline and repeat measures were calculated, or the repeat measurement rate was not documented in the report.

One organization noted that no interventions were deployed during CY 2018 for one of their projects due to barriers in obtaining data in order to conduct the planned outreach. The MCO reported it has addressed the barriers and initiated interventions in CY 2019 for year two of the project.

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 change in the desired outcome.
- Document continuous improvement efforts to analyze and determine the effectiveness of interventions as the project progresses.
- Take study limitations into consideration during analysis.
- Include possible reasons for less than optimal performance in analysis.
- 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.
- For the projects with documented, quantitative improvement in process or outcomes of care, continue to sustain the level of improvement that has been achieved.
- Consider changes to the HEDIS measure and any recommendations for the impact on comparability of results year to year.

Information Systems Capabilities Assessment

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

ISCAs occur every three years for non-accredited MCOs or MCOs accredited by a non-recognized accreditation body. During CY 2019, at the direction of DHS, MetaStar conducted an ISCA for one MCO, GHC-EC.

To conduct the assessment, the 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

The MCO 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 met all requirements in this focus area. The MCO has a documented process for preparing and submitting its encounter data, including the steps for validation and reconciliation, prior to submission.

Section III: Data Acquisition – Claims and Encounter Data Collection

The MCO met almost all requirements in this focus area. The MCO uses standardized forms for billing and accepts only approved claim types. Claims are loaded from the clearinghouse multiple times per day, and reports are in place to track and document rejected claims as well as

rejection patterns. All paper claims are scanned and converted to an electronic format, then subjected to the same edit process as the electronic claims.

Section IV: Eligibility and Enrollment Data Processing

The MCO met all requirements in this focus area. The MCO has processes and systems in place to collect, manage, and retain data related to eligibility and enrollment/disenrollment. This enables the organization to ensure alignment and accuracy in claims processing, and encounter data preparation and submission.

Section V: Practitioner Data Processing

The MCO met all requirements in this focus area and demonstrates a sound process to ensure the completeness, accuracy, and security of its provider data, as well as to share relevant provider information and detail with its members.

Section VI: System Security

The MCO met all requirements in this focus area. System access is restricted based on an employee's role and responsibilities within the organization. The MCO's vendors have contractual requirements for the security of protected information. New employees receive security and privacy training prior to accessing protected information with annual retraining required for all employees. The MCO demonstrated mechanisms in place to prevent and minimize disruptions due to systems' down times and disasters.

Section VII: Vendor Oversight

The MCO met all requirements in this focus area. The MCO has a robust process in place to determine the capability and capacity of its information technology (IT) vendors or systems to perform the necessary functions, both prior to procurement and ongoing. The process includes a comprehensive review of the contract terms and conditions, including business reputation; completion of an IT risk assessment and security review; and a review of the licensure and regulatory requirements. The MCO has policies and procedures in place for ongoing communications with its vendors for resolving potential issues that could impact operations.

Section VIII: Medical Record Data Collection

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

CONCLUSIONS

The MCO met almost all requirements associated with this review. Based on its findings, MetaStar identified the following progress since the previous review, as well as strengths and opportunities for improvement.

Progress

- The organization has addressed most recommendations made by MetaStar, in the areas of enhanced documentation and automation since the previous ISCA in 2016. The changes and improvements made over the last three years in response to these recommendations contributed to the nearly full compliance with this current ISCA review requirements.

Strengths

The CY 2019 ISCA review found the organization exhibited strengths in the following areas:

- The MCO employs a comprehensive vetting process, involving multiple departments and staff members within the MCO, prior to procurement and re-procurement, to ensure all IT vendors are able, qualified, and certified to perform all required IT functions.
- The MCO's provider system includes a robust process and edit checks to ensure the accuracy of data entry and to enhance the agreement between the provider database and the electronic eligibility and enrollment system. More specifically, the *Provider Maintenance* system includes checks for duplicate National Provider Identifier numbers, data entry validations to ensure only acceptable values are entered, validations to confirm required fields are filled out before submitting to the database, and reports that list potential missing data elements such as Drug Enforcement Administration numbers. The process to update the organization's claims adjudication electronic system has become automated with no manual intervention, and occurs nightly.

Opportunities for Improvement

Based on the results of the ISCA, the organization has the following opportunities for improvement:

- MetaStar recommends that the MCO continue collaborative efforts between the IT and claims department to increase the claims auto-adjudication rate.

Care Management Review – Supplemental Security Income Program

Care management review (CMR) assesses a MCO's ability to safeguard members' health and welfare; and ability to effectively deliver cost effective, outcome-based services. It also determines the level of compliance with the DHS-MCO contract.

DHS and MetaStar collaborated to redesign the requirements evaluated during the SSI care management review. As a result, the findings of this review are not comparable to prior years' reviews.

MetaStar reviewed a total of 800 records across all MCOs, per the direction of DHS, and according to the sampling methodology used for the reviews. The table below shows the number of records reviewed for each organization.

Records Reviewed for each MCO Serving Wisconsin SSI Recipients

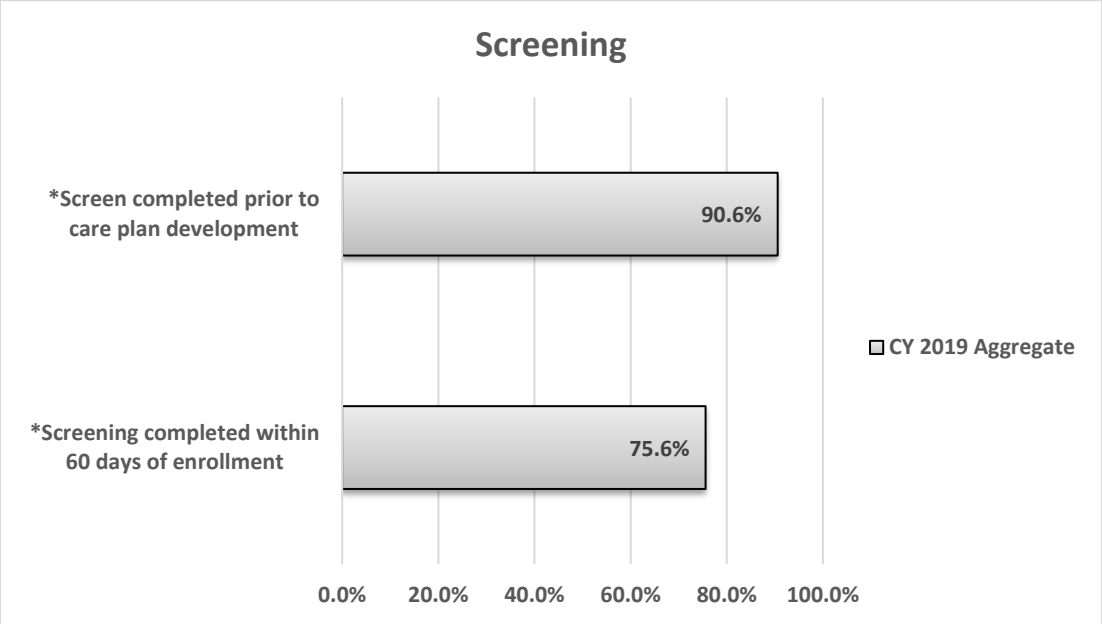
Managed Care Organization	Number of Records
Anthem	100
GHC-EC	100
*i*Care	100
Mercy	100
MHS	100
MHWI	100
NHP	100
UHC	100
Total	**800**

Results for each CMR Focus Area

Each of the six sections below provides a brief explanation of a key SSI CMR category, followed by bar graphs which display the aggregated CY 2019 results for each indicator that comprises the category. This was the first year of the revised SSI review criteria, so comparison results are not available.

Screening

The MCO must identify all medical, dental, mental and behavioral health, or social needs of its members. The initial screening must meet the timelines and conditions described in the DHS-MCO contract. For the purpose of this review, and based on the templates of the MCOs, DHS did not request an evaluation of the screening's comprehensiveness.



*Note: The review indicators *Screen completed prior to care plan development* and *Screening completed within 60 days of enrollment* applied to 381 of 800 records.

Comprehensiveness of Care Plan

The comprehensive care plan ensures appropriate care delivery to a member by following an evidence-based, member-centric treatment plan that addresses the identified unique needs. Plans must be developed with the member face-to-face, telephonically, or via interactive video. The care plan must:

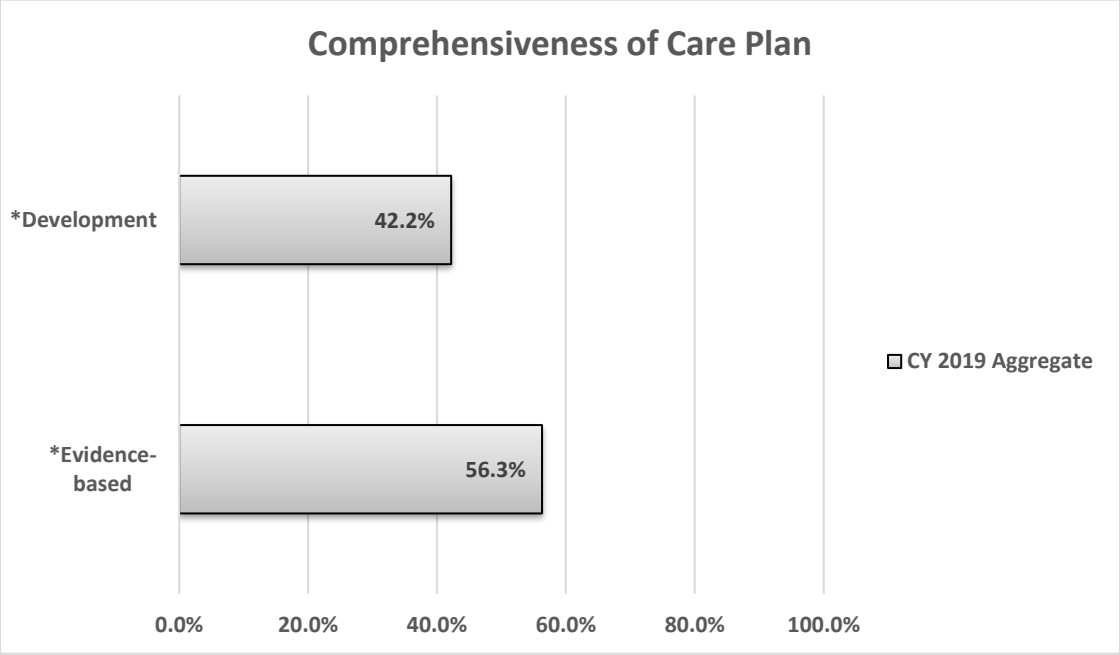
- Address all identified needs;
- Measure the member's readiness to self-manage their care and willingness to adopt healthy behaviors;
- Establish and prioritize specific short and long-term goals that are appropriate to address the member's needs; and
- Describe and sequence the interventions to address the identified needs.

The MCOs completed 93.2 percent of care plans telephonically, 5.2 percent were completed in-person, and 0.1 percent was via interactive video.

Almost 88 percent of the records had a care plan developed with the member. Twenty-eight records were excluded from the denominator because the member disenrolled before the end of the calendar year or declined care management. Of the records scored not met under care plan development, 51.8 percent did not contain evidence that the care plan was shared with the primary care provider (PCP) as required.

Forty-three percent of the records did not have an evidenced-based care plan. Of the records without an evidence-based care plan:

- Twenty-nine percent did not contain goals appropriate to meet the members' needs;
- Twenty-seven percent did not include or sequence interventions; and
- Twenty-two percent did not contain a specific goal identified by the member.



*Note: The review indicators *Development* and *Evidence-based* applied to 772 of 800 records.

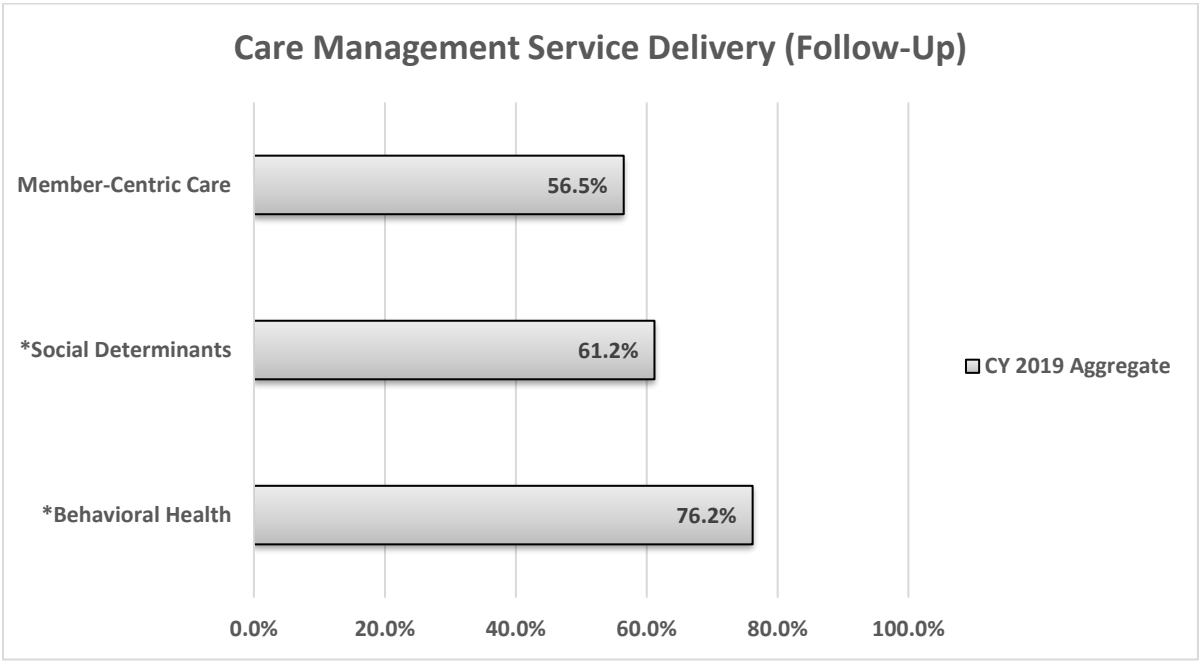
Care Management Service Delivery (Follow-Up)

The MCO care management team is responsible for conducting follow-up activities. The follow-up must:

- Regularly assess a member's readiness to change and engagement;
- Assess if the member's needs are being addressed according to the member; and
- Occur as frequently as needed to meet the member's needs.

The follow-up must also assure all identified behavioral health issues are addressed and any social determinant issues have actions in place until the need is addressed.

Almost 57 percent of the records had evidence of follow-up activities. Twenty-seven percent of the records scored not met under this indicator did not have a completed or updated care plan during the review period. Of the remaining records that did not meet the requirement, 58 percent did not indicate regular follow-up aligned with the MCOs' policies occurred. Social determinant issues or concerns were identified for 55.1 percent of members during screening, but follow-up activities for 38.8 percent of these members were not documented. Seventy-six percent of members' records indicated behavioral health needs; however, 23.8 percent did not contain evidence of follow-up.



*Note: The review indicator *Social Determinants* applied to 441 of 800 records. The review indicator *Behavioral Health* applied to 606 of 800 records.

Care Plan Review and Update

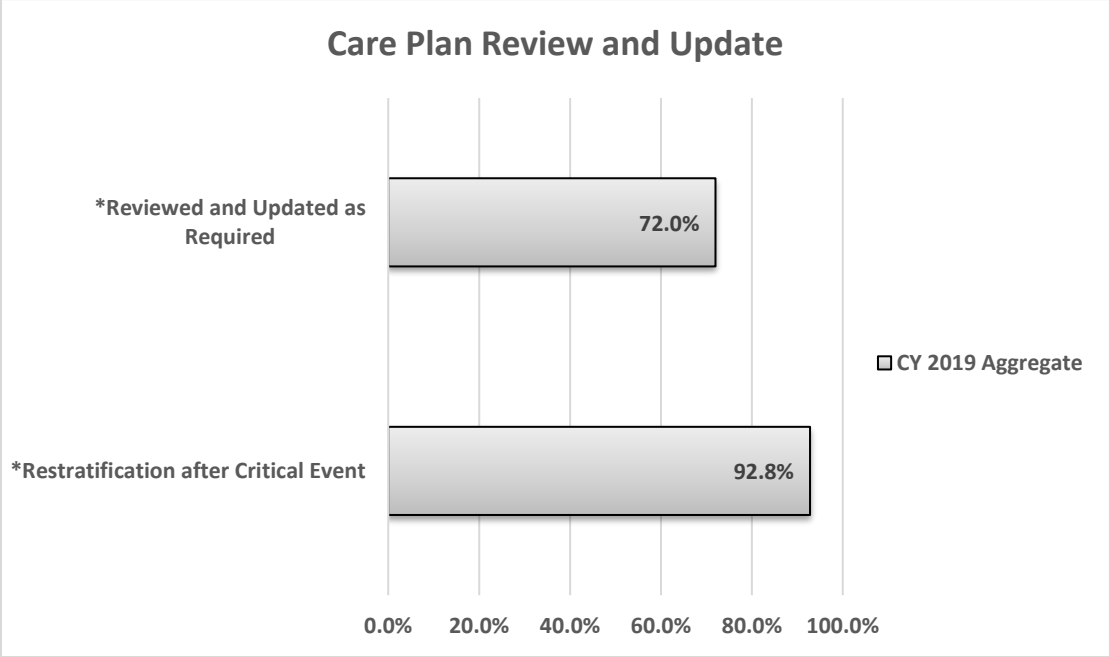
Member care plans must be updated as a member's needs change, but no less than once each calendar year. Members must also be re-stratified after a critical event occurs. Changing needs may include:

- Significant changes to medical and/or behavioral health needs;
- Changes in needs strata;
- Member non-responsiveness to the care plan;
- Frequent transitions between care settings; and

- Member request or identification of a problem/gap not previously addressed.

Care plan review and update applied to 67.9 percent records. Seventy-two percent of the records contained evidence that the care plan was reviewed and updated with the member at least once during the review period. However, of the records that did not meet this requirement, 35.5 percent did not contain evidence of an annual review and update.

Re-stratification after a critical event applied to 139 records. Seven percent of records did not include evidence of re-stratification.

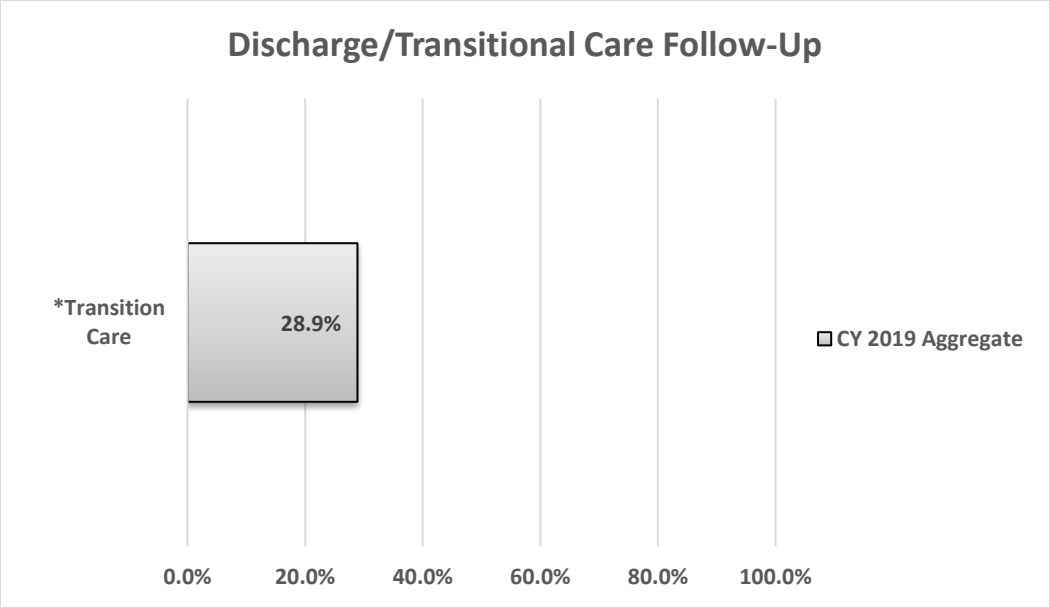


*Note: The review indicator *Reviewed and Updated as Required* applied to 543 of 800 records. The review indicator *Restratification after Critical Event* applied to 139 of 800 records.

Discharge/Transitional Care Follow-Up

The MCO is responsible for having appropriate transitional care procedures to assist its members after discharge from a hospital. The follow-up activities should include conducting a medication reconciliation (or confirmation the hospital completed), reviewing discharge information with the member, and providing assistance with scheduling follow-up appointments.

Twenty-six percent of members had at least one hospitalization during the review period requiring transitional care follow-up activities; however, 71.1 percent did not contain evidence of the required follow-up activities. Of the records not meeting the requirement, 98.7 percent did not contain documentation of medication reconciliation completed by the hospital or the MCO.



*Note: The review indicator *Transition Care* applied to 211 of 800 records.

Wisconsin Interdisciplinary Care Team

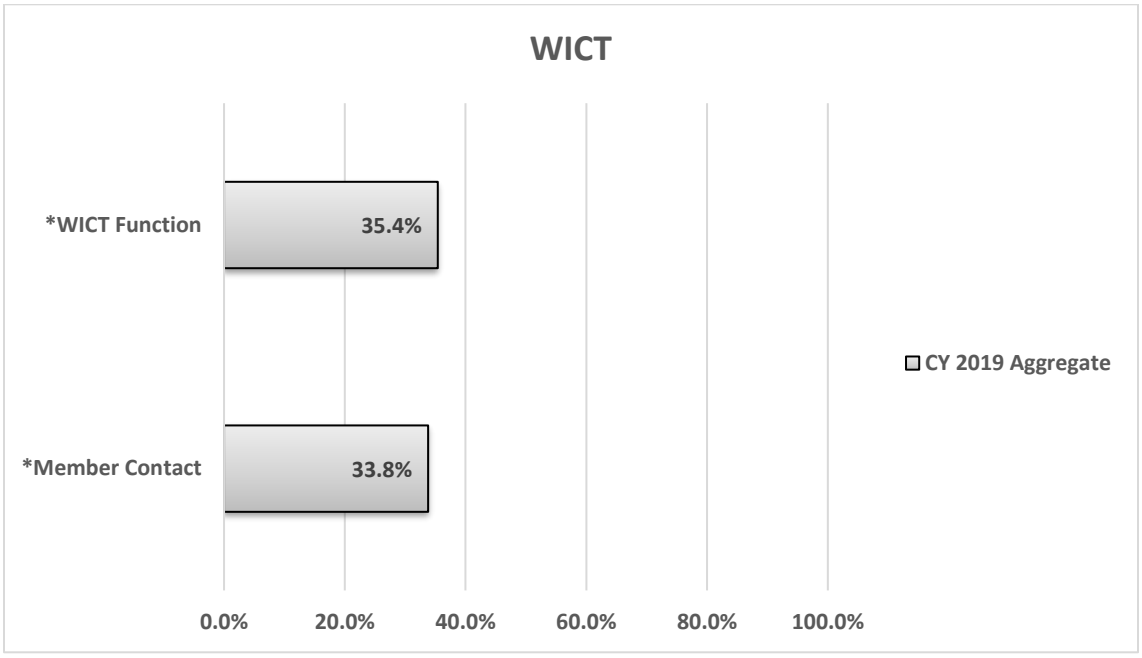
In addition to the care management requirements above, the MCO Care Management Model must include a Wisconsin Interdisciplinary Care Team (WICT) to provide member-centered care management services for members with the highest needs. The WICT must engage the member's caregivers/family supports and other resources instrumental to the member's care. Evidence of a well-functioning WICT includes:

- At least two licensed health care professionals (with access to multiple disciplines);
- Weekly WICT Core Team meetings to discuss the entirety of their shared caseload;
- Evidence of collaboration between the two individuals (routine communication and joint decision-making);
- Access to a larger team of interdisciplinary team professionals; and
- Coordination with applicable health care providers and other community resources.

Minimally, a team member of the WICT Core Team must meet once a month face-to-face with the member to discuss the member's care. Members should transition from the WICT to a lower intensity of ongoing care management as they become more stable; however, members may need to return to the WICT in the future if their needs change. The WICT is intended to be a short-term, intensive intervention.

Sixteen percent of members received WICT care management services during the review timeframe/period. Of those members, 64.6 percent did not contain evidence of a well-functioning

WICT and 66.2 percent did not contain evidence of the monthly face-to-face contact with the member as required.



*Note: The review indicators *WICT Function* and *Member Contact* applied to 130 of 800 records.

ANALYSIS

Two MCOs demonstrated completion rates greater than 80 percent and one MCO at greater than 90 percent for timeliness of initial screenings. Another MCO met the requirement in less than 60 percent of the records reviewed.

Evidence-based care plans were identified in 91.7 percent of the records for one MCO. However, two MCOs met this requirement in less than 50 percent of the records.

Follow-up activities were documented in 80 percent of records for two MCOs. Three other MCOs met the follow-up requirements in less than half of the records reviewed.

Follow-up of identified social determinants was found in more than 80 percent of records reviewed for three MCOs and less than half of the records for two other MCOs. All MCOs documented follow-up for behavioral health needs in more than half of the records, with documentation found in more than 80 percent of records for four MCOs.

Three MCOs met the annual care plan update requirements in more than 90 percent of the records, with one of them greater than 95 percent. Two MCO met the requirements in less than 40 percent of the records.

Re-stratification after a critical event was the strongest indicator with five MCOs meeting the requirement in all of the applicable records. However, follow-up after hospitalization, including medication reconciliation, was found in less than 35 percent of the applicable records for six of eight MCOs.

Only one MCO met the WICT requirements for team function in more than half of the applicable records. Two MCOs met the requirements in over 45 percent of the records. Five MCOs met the requirements in less than 35 percent of the applicable records. The WICT requirement for member contacts was met in over half of the records for three MCOs, but no MCO met the requirement in more than 60 percent of the records. Four MCOs demonstrated compliance in less than 25 percent of the applicable records.

CONCLUSIONS

The MCOs have the systems, policies and processes in place to meet the updated SSI care management requirements. Analysis indicates that re-stratification after a critical event is the area of highest compliance for the MCOs followed by behavioral health follow-up and timeliness of the initial screening. The follow-up after hospitalization requirement has the greatest opportunity for improvement with an aggregate completion rate of only 28.9 percent. WICT team function and member contact requirements are additional areas for improvement with aggregate compliance rates of 35.4 and 33.8 percent respectively.

Strengths

- One MCO demonstrated consistent evidence of multiple attempts made by the care management team to connect with members after an emergency room visit or hospitalization.
- Another MCO encourages its WICT members to participate in the weekly WICT meetings.
- Records reviewed at a third MCO demonstrated consistent evidence of attempts made by the care management team to connect with difficult to reach members by meeting them at community locations such as emergency departments, provider appointments, and day service centers.

Opportunities for Improvement

As a result of its review, MetaStar identified the following opportunities. For each area of opportunity, the review team provided related recommendations to DHS and the MCOs to support program improvements.

- Seven MCOs were given recommendations related to completion of the required WICT monthly face-to-face meeting with the member.

- Six MCOs should conduct a root cause analysis to identify the barriers to documenting and/or completing the medication reconciliation after a hospitalization.
- Five organizations were given recommendations to consistently conduct and document the weekly WICT core team meetings as required.
- Five MCOs did not send completed care plans to the member's PCP and a recommendation was given to ensure plans were shared as required.
- Two MCOs did not review and update the members' care plan when a change in stratification occurred.
- Two MCOs were given recommendations related to care plan comprehensiveness requirements of identifying and prioritizing goals and including sequenced interventions.

Care Management Review – Foster Care Medical Home

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

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 17 review indicators. More information about the review methodology can be found in Appendix 2.

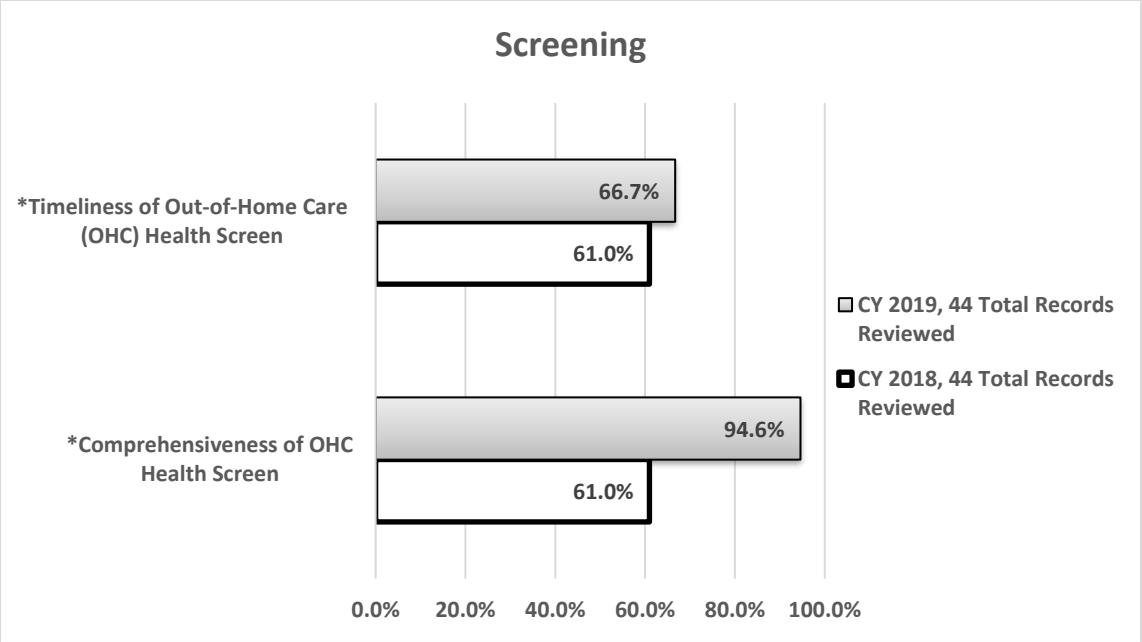
Results for each CMR Focus Area

Each of the five sub-sections below provides a brief explanation of a CMR category, followed by bar graphs which display CY 2019 results for each indicator that comprises the category. CY 2018 results are provided for comparison.

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.

An OHC Health Screen was required in 81.1 percent of records reviewed. Of those, almost 28 percent were not timely and five percent did not have an OHC Health Screen completed. Almost 95 percent of completed OHC Screens were comprehensive.

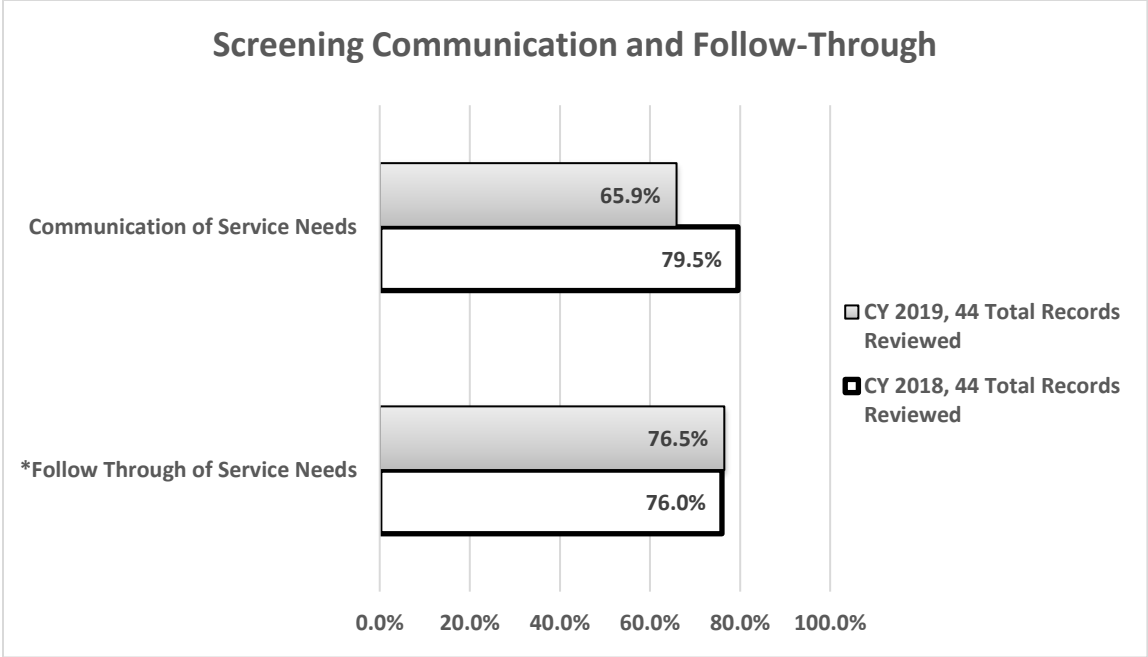


*Note: The review indicators *Timeliness of Out-of-Home Care (OHC) Health Screen* and *Comprehensiveness of OHC Health Screen* applied to 36 of 44 records for CY 2019 and 41 of 44 records for CY 2018.

The communication of needs identified in the OHC Health Screen declined in CY 2019. In 86.7 percent of the records that did not meet the requirements, documentation indicated that the information was not shared with the member's PCP.

Documentation in the member record must also indicate prompt and adequate follow through occurred in relation to any immediate or emergent physical, mental/behavioral, and oral health needs identified during the OHC screening.

Sixty-one percent of records did not identify any immediate or emergent needs. Almost 39 percent identified immediate needs in the OHC Health Screen, and over 75 percent of those contained evidence of the necessary follow through to address the needs.

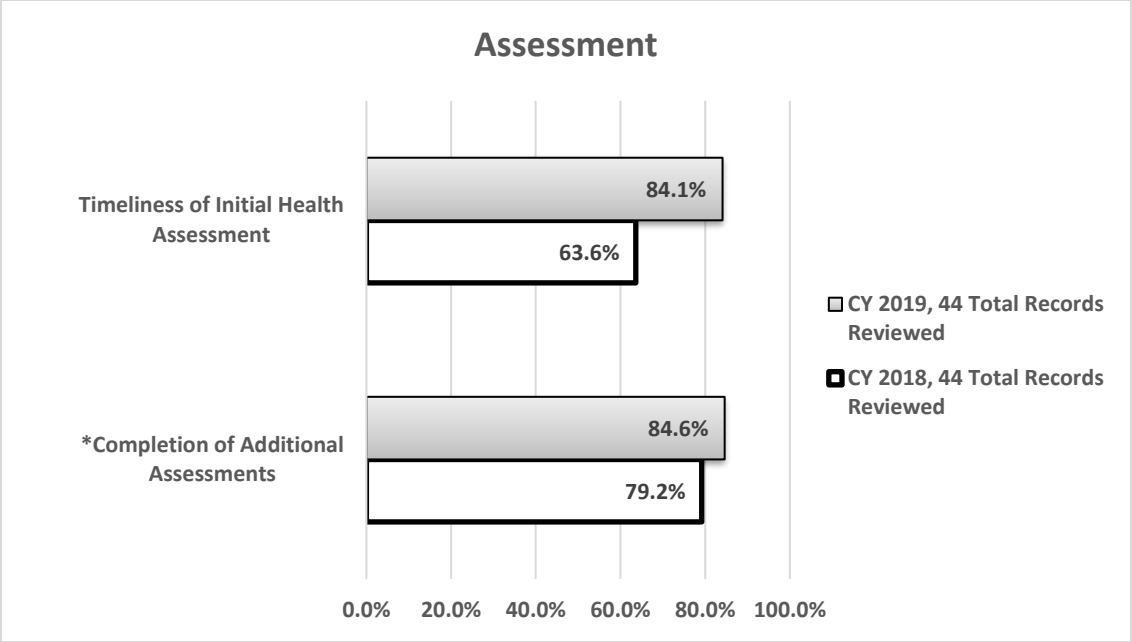


*Note: The review indicator *Follow Through of Service Needs* applied to 17 of 44 records for CY 2019 and 25 of 44 records for CY 2018.

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.

Timely initial health assessments were found in 84.1 percent of the records reviewed. Almost 16 percent were not timely and 4.5 percent of all records reviewed did not contain evidence of the completion of additional assessments as indicated. Documentation of referrals made and subsequent follow-through were found in 88.6 percent of the records.

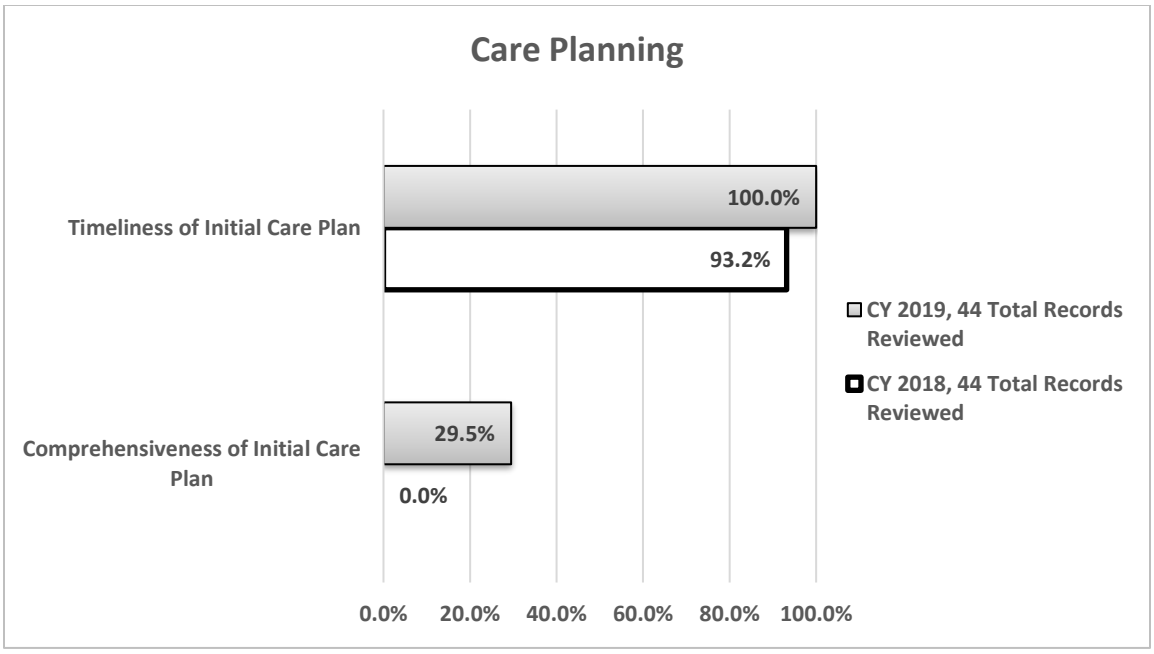


*Note: The review indicator *Completion of Additional Assessments* applied to 13 of 44 records for CY 2019 and 24 of 44 records for CY 2018.

Care Planning

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

Seventy percent did not meet the requirements for comprehensiveness of the initial care plan. Of those, 87.1 percent did not include evidence of parent or legal guardian input into the care plan. This was frequently attributed to an inability to locate or make contact with these individuals prior to the completion of 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.

Ninety-three percent of the records reviewed contained documentation of care coordination to address all of the member's identified needs. Seven percent did not document coordination or follow-up for all needs.

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 36 of the records reviewed.

Eighteen percent of the records contained evidence of a need for transitional health care planning. Of those, 37.5 percent did not meet the requirements. One member left out-of-home care, remained enrolled in the FCMH, and then disenrolled from the program. In that instance, requirements for both situations were not met. Two additional members disenrolled from the FCMH medical home, but did not have a transitional plan in place prior to enrollment.

Analysis

Both the timeliness and comprehensiveness rates for OHC Health Screens improved from CY 2018 to CY 2019. Further analysis indicates the year-to-year difference in timeliness rates is likely due to normal variation or chance. However, the year-to-year difference in the comprehensiveness rates is likely attributable to the actions of the PIHP and is unlikely to be the result of normal variation or chance. The rate for communication declined while follow-through of service needs identified on the OHC Health Screen improved year-to-year. Analysis indicated the difference in both rates was likely due to normal variation or chance.

The timeliness of initial health assessments and completion of additional assessments as indicated improved from CY 2018 to CY 2019. Analysis indicated the year-to-year difference in the timeliness rates is likely attributable to actions of the PIHP, and is unlikely to be the result of normal variation or chance. Analysis indicated the year-to-year difference in the completion rates is likely due to normal variation or chance. Analysis also indicated an improvement from CY 2018 to CY 2019 in the referral and follow-through rates of needs identified on the initial health assessment. The year-to-year differences are likely attributable to actions of the PIHP, and unlikely to be the result of normal variation or chance.

The timeliness and comprehensiveness rates for initial care plans also improved from CY 2018 to CY 2019. Further analysis indicates the year-to-year difference in timeliness rates is likely due to normal variation or chance. However, the year-to-year difference in the comprehensiveness rates is likely attributable to the actions of the PIHP and is unlikely to be the result of normal variation or chance.

Conclusions

The PIHP began programmatic and software updates after the record review conducted in CY 2018. The organization updated and expanded the format of the care plan within its electronic medical record. The changes implemented may have contributed to the overall improvement in care plan comprehensiveness.

The organization influences each of its partners, but cannot direct them. The partners can affect the compliance of the FCMH program, 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 or initial health assessment. Lack or delay of consent for mental health assessments could result in the member not receiving the needed assessment.

Progress

- Comprehensiveness of the OHC Health Screen increased from 61 percent in CY 2018 to 94.6 percent in CY 2019.
- Timeliness of the initial health assessment increased from 63.6 percent in CY 2018 to 84.1 percent in CY 2019.
- Referral of services identified increased from 65.9 percent in CY 2018 to 88.6 percent in CY 2019.
- Follow-through of services identified increased from 56.8 percent in CY 2018 to 88.6 percent in CY 2019.
- Comprehensiveness of initial care plan increased from zero percent in CY 2018 to 29.5 percent in CY 2019.
- The rate of completion for communication of needs identified in the OHC Health Screen declined in CY 2019. In 86.7 percent of the records that did not meet the requirements, documentation indicated that the information was not shared with the member's PCP.

Opportunities for Improvement

As a result of its review, MetaStar identified the following opportunity. For each area of opportunity, the review team provided related recommendations to DHS and the FCMH provider to support program improvements.

- Conduct a root cause analysis to identify barriers and implement strategies to overcome the inability to engage members' parents or legal guardians and barriers to consistently communicate OHC Health Screen results with the members' PCPs.

Care Management Review – Children with Medical Complexities

Children with Medical Complexity (CMC) is a target group covered under the Medicaid-targeted case management benefit. It is administered fee-for-service for all Medicaid-enrolled members who demonstrate medical necessity for covered services. The benefit is separate from managed care organizations and special managed care programs.

The CMC review assessed the access, quality, and appropriateness of care provided to enrollees. The information gathered also helped to:

- Assess the level of compliance with the requirements outlined in the *ForwardHealth Online Handbook*;
- Ensure care management systems are working as intended; and
- Evaluate whether the organizations are communicating member needs with each representative on the greater health care team.

The CMC CMR is an optional activity. MetaStar reviewed 60 records of CMC participants enrolled through two hospitals. The review focused on five categories:

- Eligibility;
- Assessment;
- Care Planning;
- Service Reduction or Termination; and
- Monitoring and Service Coordination.

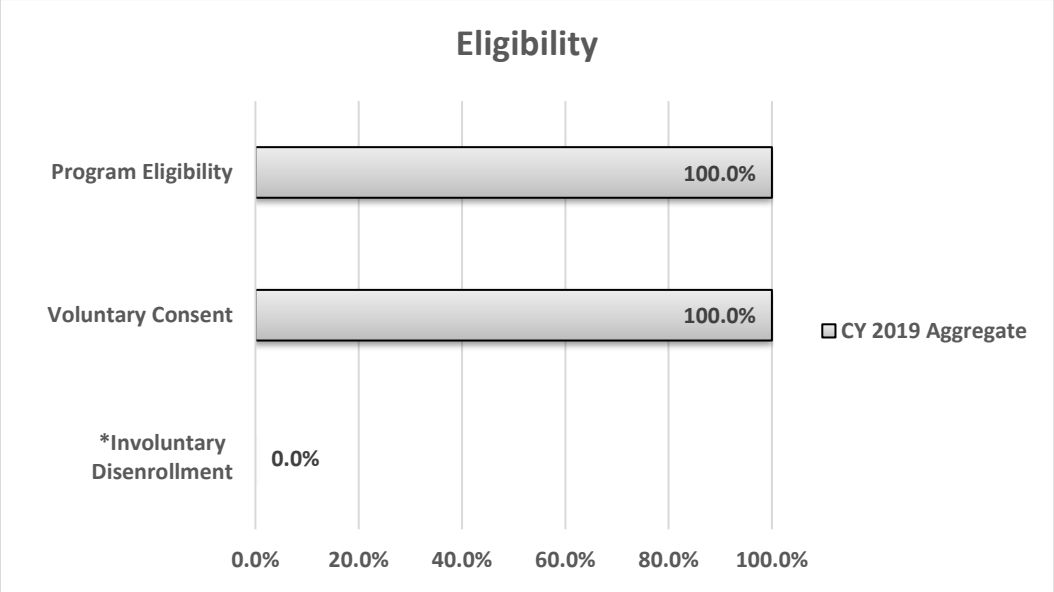
The five categories included a total of 16 review indicators. More information about the review methodology can be found in Appendix 2.

Results for each CMR Focus Area

Each of the five sub-sections below provides a brief explanation of a key CMR category, followed by bar graphs which display CY 2019 results for each indicator that comprises the category. This was the first year of the CMC review, so comparison results are not available.

ELIGIBILITY

Members must meet all eligibility requirements as described in the *ForwardHealth Online Handbook*. The handbook includes alternate criteria for members too young to meet the utilization criteria.

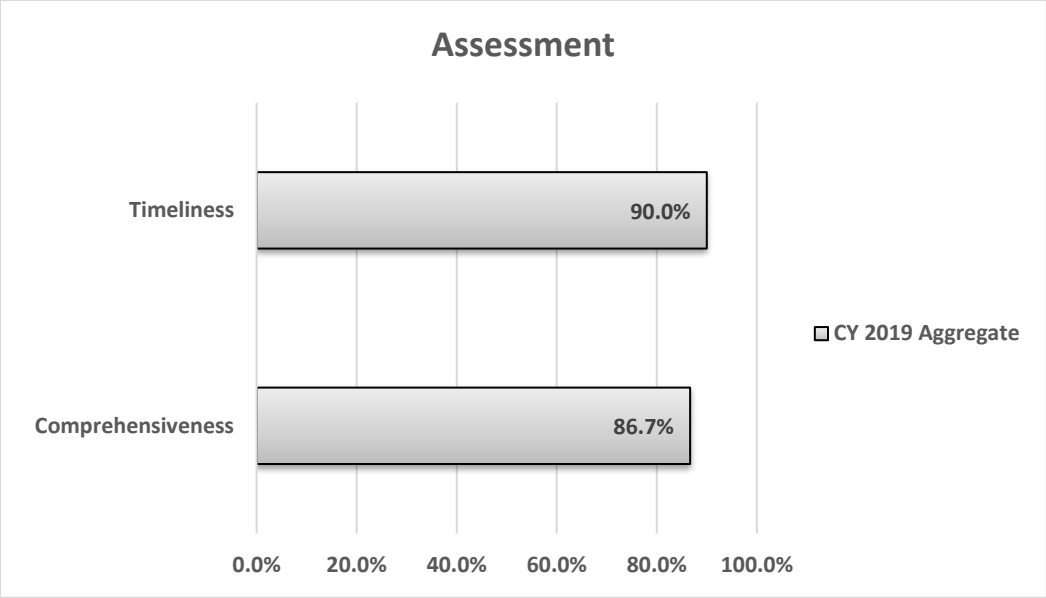


*Note: The review indicator *Involuntary Disenrollment* did not apply to any records during the review period.

All records reviewed for both hospitals met the eligibility and consent requirements. No members were involuntarily disenrolled during the review period; therefore, the *Involuntary Disenrollment* indicator was not applicable.

ASSESSMENT

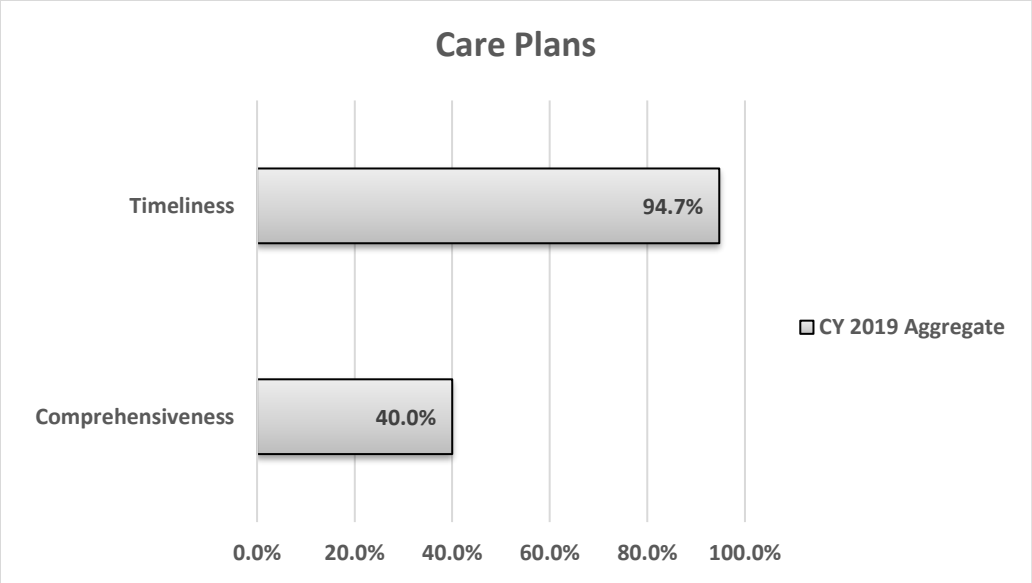
Each member must have a timely and comprehensive assessment that determines the member's need for medical, educational, social, or other services. Each assessment must be updated periodically thereafter.



Timely assessments were completed in 90 percent of the records reviewed. Ten percent of records did not contain documentation of a completed assessment during the review period. In half of those records, documentation identified multiple hospitalizations, multiple attempts to contact the family to schedule an assessment, and attendance at other appointments as potential barriers to completing an assessment. Of the records that contained assessments, 96.3 percent were comprehensive. Almost four percent of records did not identify the members' needs or strengths.

Care Planning

The care plan must contain the member's needs and goals; identify actions or interventions to meet the goals; and include timeframes for the interventions. Care must be developed and updated according to the timelines and conditions described in the *ForwardHealth Online Handbook*.



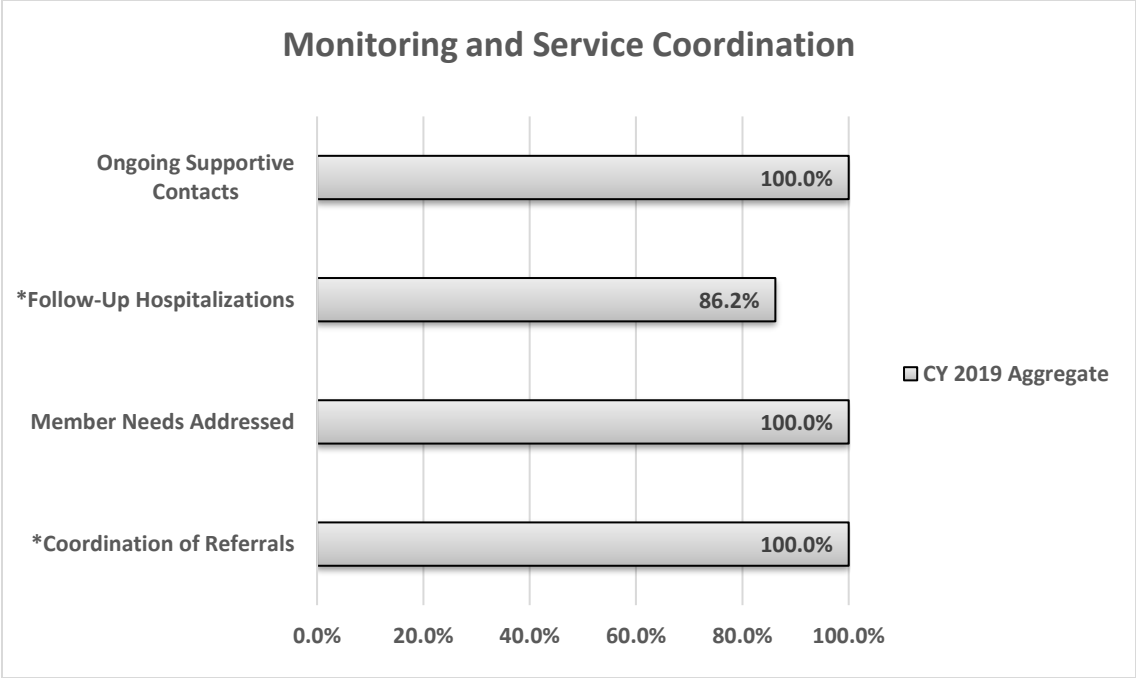
Of the records that contained care plans, 44.4 percent were comprehensive. Of the records that were not comprehensive, 96.7 percent did not contain actions/interventions or timeframes for meeting a goal. Ten percent of records did not contain a care plan during the review period and one care plan did not contain any goals.

Service Reduction or Termination

All service reductions or terminations must be mutually agreed upon and the changes communicated to the legal decision maker in advance. This requirement did not apply to any of the records, as no services were reduced or terminated during the review period.

Monitoring and Service Coordination

Care teams are required to conduct ongoing service coordination activities to ensure all identified needs are addressed. This includes ongoing supportive contacts, coordination of referrals, and follow-up after hospitalization.



*Note: The review indicator *Follow-Up Hospitalizations* applied to 29 of 60 records. The review indicator *Coordination of Referrals* applied to 30 of 60 records.

Ongoing supportive contacts and assessment of member needs were completed as required in 100 percent of records.

Follow-up after hospitalization applied to 48.3 percent of the records. Of those, 86.2 percent met the requirement. Almost 14 percent of these records did not contain evidence of the required follow-up after hospitalization or contained evidence of follow-up that was not timely. The remaining records did not contain evidence of a hospitalization during the review period.

The coordination of referrals applied to half of the records. Of those, all met the requirement. The other half of the records did not indicate a referral was needed during the review period.

ANALYSIS

The CMC program provides a high level of care coordination to program members. The hospitals have a documented CMC screening and enrollment process, and member records reflected adherence to this process. Contact is maintained on at least a monthly basis with the member and/or family by the nurse care coordinator or care coordinator assistant. In most records, documentation showed that there were more contacts than required with the member and his/her family. Phone calls, emails, and electronic health record messages from the legal decision-makers were returned the same day they were received or the day after receipt at the latest. In addition, evidence was present in the records that nurse care coordinator consulted with

physicians within one day to obtain answers to legal decision-makers' questions. Ongoing communication and collaboration among the CMC staff allows the teams to respond to member needs and implement improvement processes rapidly.

Care plans lacked comprehensiveness as evidenced by not containing actions/interventions to meet all identified goals and timeframes to complete actions/interventions that needed additional development. The areas of ongoing supportive contacts, addressing member needs, and coordination of referrals demonstrated that members are receiving a high level of monitoring and service coordination.

CONCLUSIONS

Overall, the review found the hospitals have the basic systems, resources, and processes in place to meet Medicaid requirements for oversight and management of services to members, and to support quality care.

Strengths

- Records demonstrated care coordination and education prior to members' transition to adult care providers.
- Care coordinators collaborated closely with hospital social workers to ensure all member needs were identified.
- Although not a program requirement, many records contained a crisis plan.
- Evidence of coordination with providers both inside and outside of the hospital was evident in records.

Opportunities for Improvement

As a result of its review, MetaStar identified the following opportunities. For each area of opportunity, the review team provided related recommendations to DHS and the CMC provider to support program improvements.

- Conduct a root cause analysis to identify barriers to fully meet contract requirements for care plans, and implement interventions to improve the comprehensiveness of care plans.
- Review and update policies, internal procedures, and training to ensure documentation practices meet requirements.
- Consider implementing an internal file review process to ensure care plans contain documentation of members' identified needs and actions to address the needs.

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 self-reported baseline, for timeliness of initial HNAs, to avoid a financial penalty. The CLA HNA review is an optional activity with a penalty provision.

MetaStar reviewed 1,250 records across 15 MCOs, per the direction of DHS, and according to the sampling methodology used for the reviews. The table below shows the number of records reviewed for each organization.

Records Reviewed for each MCO Serving Childless Adults in Wisconsin

Managed Care Organization	Number of Records
Anthem	91
CCHP	77
DHP	83
GHC-EC	94
GHC-SCW	87
*i*Care	86
MCHP	30
MHS	95
MHWI	94
NHP	94
PPIC	86
Quartz	92
SHP	82
Trilogy	93
UHC	66

Managed Care Organization	Number of Records
Total	**1,250**

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

- Timeliness of 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 2018 results are provided for comparison.

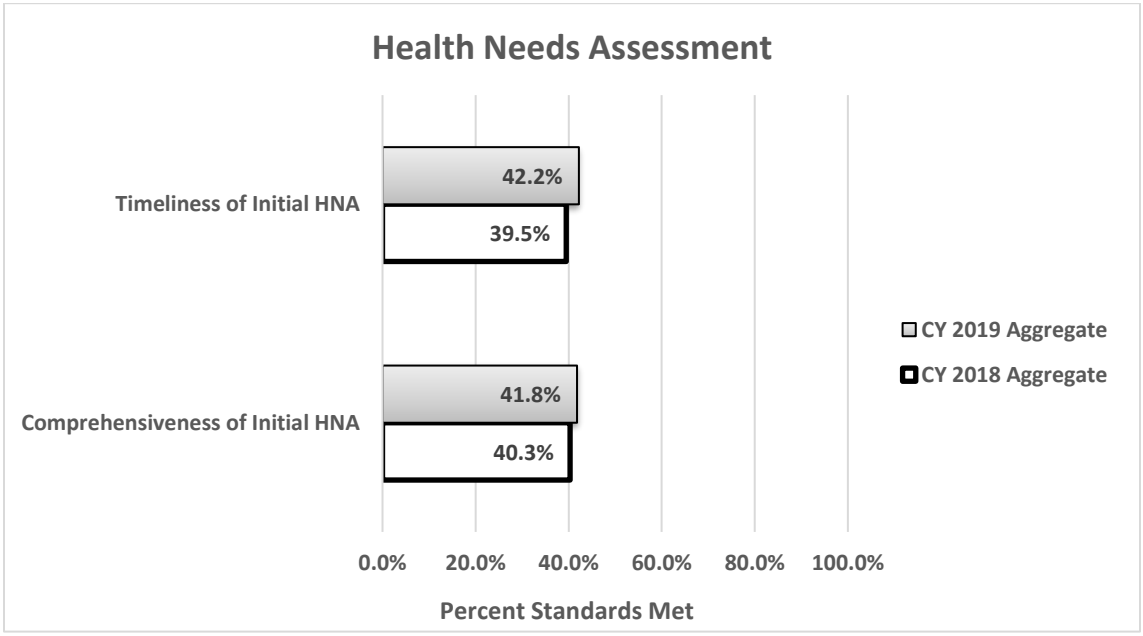
The initial HNA is to be completed within two calendar months of enrollment. The HNA is comprehensive when it documents the member's history of chronic physical and mental health illness, and at least three additional elements. Contact efforts were also documented when an assessment was not timely or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

The following graph depicts the rate of compliance achieved by each MCO in CY 2019 for the timeliness and comprehensiveness of the initial HNA. The aggregate timeliness rate for all MCOs was 42.2 percent. Eleven MCOs had timeliness scores that were less than the aggregate rate while four MCOs had scores that were greater than the aggregate rate. Three MCOs achieved a timely completion rate of over 50 percent. Comparing the CY 2019 timely HNA completion to CY 2018 results shows eight MCOs increased rates while seven MCOs did not increase rates. Analysis indicated the year-to-year difference in the timely completion of the HNA for all MCOs was likely due to normal variation or chance.

The rate of comprehensiveness of the initial HNA for all MCOs for this indicator was 41.8 percent. This rate reflects the rate of comprehensiveness of the HNA regardless of timeliness. Assessments not completed are included as not comprehensive. Nine MCO's scores were less that the aggregate rate while six MCO's scores were greater than the aggregate rate. Three MCOs had comprehensive scores above 50 percent. Comparing the CY 2019 comprehensive HNA rates to CY 2018 results reflects that eight MCOs increased rates while seven MCOs did not increase rates. Analysis indicated the year-to-year difference in the comprehensiveness of the

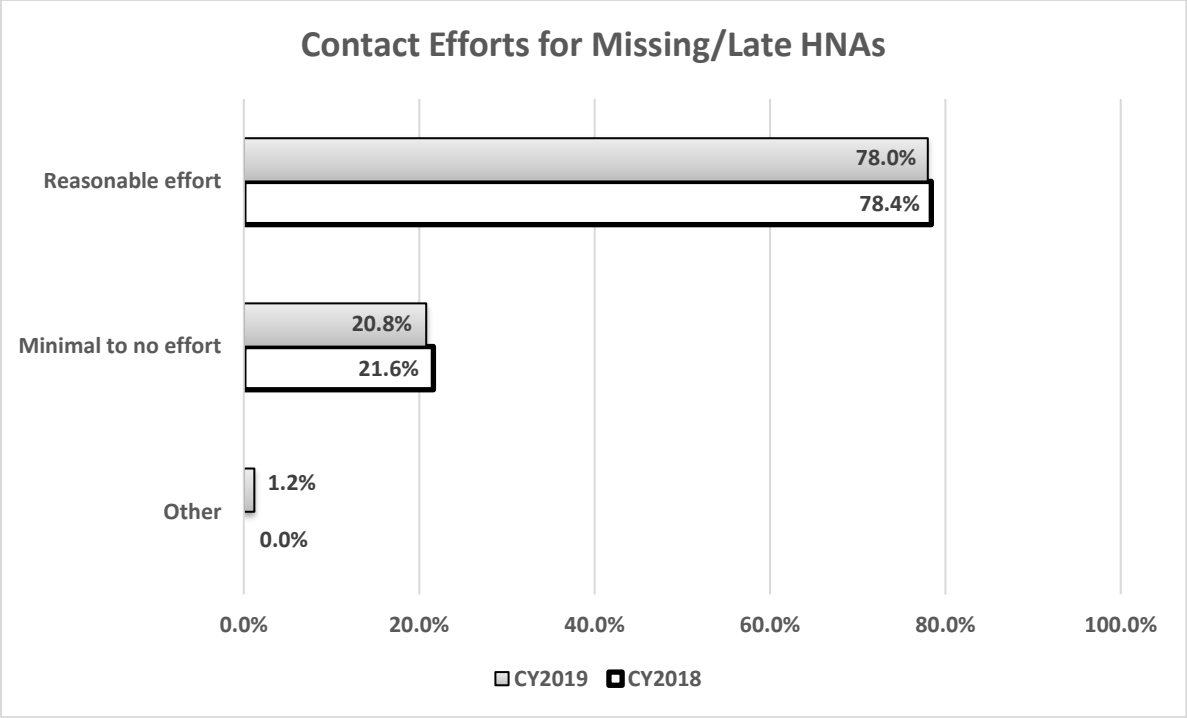
HNA for MCOs indicated one MCO demonstrated improvement that was statistically significant and was likely attributable to the actions by the MCO. Changes in comprehensiveness rates for the remaining MCOs were likely due to normal variation or chance.

When assessments were completed, almost all were considered comprehensive as they were found to include the member's history of chronic illness and at least three additional elements. Of the 528 assessments completed across all MCOs, 99 percent were comprehensive. While nearly all of the completed assessments were considered comprehensive, assessment of urgent medical and behavioral symptoms was the assessment element most often not consistently addressed with a completion rate of 91.9 percent.



Note: MetaStar reviewed 1,373 records in CY 2018 and 1,250 records in CY 2019.

The following graph depicts the contact efforts made by the MCOs for HNAs not completed or not completed timely. Of the 722 records in which the HNA was not completed or completed beyond two months in CY 2019, 20.8 percent demonstrated either minimal or no effort to contact members after the initial MCO enrollment. The CY 2018 rate for minimal or no effort to contact was nearly identical at 21.6 percent. Examination of reasonable efforts to contact member to complete the HNA by comparing CY 2018 to CY 2019, again shows a nearly identical rate, that is; 78.4 percent and 78 percent respectively.



ANALYSIS

The penalty provision included in the DHS-MCO contract sets a requirement for MCOs to achieve a 35 percent rate for timeliness or a 10 percent reduction in error from the MCO's timeliness of initial HNAs rate from CY 2016. Twelve MCOs had an aggregate rate for timeliness at or above the requirement, while three MCOs did not meet the benchmark.

DHS provides MCOs with member contact information at the time of enrollment. Less than two percent of the records reviewed included documentation of inaccurate contact information in the enrollment file provided by DHS. Information about the types of member outreach attempted by MCOs was as follows: 59.7 percent by telephone, 39.6 percent by mail, and 0.7 percent in person. One member outreach attempt (less than 0.1 percent) was completed using a Web tool.

While 12 MCOs met the requirement for *Timeliness of initial HNA Completion* by meeting the 35 percent or a 10 percent reduction in error threshold, three MCOs did not. Improvement was noted in *Timeliness of initial HNA Completion* as compared to the prior year for eight MCOs. Seven MCOs showed a reduction in *Timeliness of initial HNA Completion* as compared to the prior year. Analysis indicated the year-to-year difference in the timely completion of the HNA for all MCOs was likely due to normal variation or chance.

HNAs were usually comprehensive when completed; however, one HMO revised the HNA template from the previous year and an assessment element was not included on the revised HNA template. A recommendation was made related to improvement of the *Comprehensiveness of the HNA*.

Almost 21 percent of records in which the HNA was not completed or completed late demonstrated minimal or no effort to contact the member in CY 2019. Comparison of this rate to the CY 2018 was nearly identical at 21.6 percent. Most MCOs were found to have opportunities for improvement related to member outreach that included adequate attempts to contact member to complete the HNA. Five MCOs demonstrated the highest incidence of minimal or no contact attempts with rates ranging from 20 percent to 93 percent.

CONCLUSIONS

Progress

- While 14 MCOs met the HNA completion target rate in CY 2019, seven MCOs declined, which indicates an opportunity for improvement.
- 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 20.8 percent. This rate, as compared to the previous year was nearly identical. This continues to be an area for further improvement.
- Two MCOs utilized an incentive program to encourage completion of the HNA. One MCO gave members a chance to win a $100.00 drawing for completion of the HNA. This MCO achieved a 10 percent reduction in error for timeliness of the HNA as compared to the previous year. Another MCO continued to offer a $5.00 gift card to members completing the HNA. This MCO achieved the highest reduction in error for timeliness of the HNA at 25.4 percent as compared to the prior year.
- One MCO was noted to revise its HNA form to include urgent medical and behavioral symptoms per a recommendation made the previous year.

Strengths

- One MCO implemented an outreach practice that increased member contact attempts well beyond what is considered adequate attempts, in an effort to increase timely HNA completion rates. The practice was implemented in September 2018 and showed a trend of increased timely HNA completion rates after implementation.
- Another MCO implemented an incentive program that entered members into a monthly drawing for an opportunity to win a $100.00 gift card.

Opportunities for Improvement

As a result of its review, MetaStar identified the following opportunities for improvement. For each area of opportunity, the review team provided related recommendations to DHS and the MCOs to support improvements in the completion of initial HNAs for CLA members.

- Conducting a root cause analysis to identify member engagement barriers was recommended to 10 MCOs.
- Three MCOs should evaluate barriers to making contact attempts that comply with its member outreach policies and procedures.
- One MCO's auto-dialer system created barriers to member outreach. It was recommended the MCO identify the barriers and conduct continuous cycles of improvement to overcome the barriers.
- One MCO should more accurately transcribe member HNA responses and/or lack of response from a paper HNA form to an electronic database.
- Another MCO needs to continue monitoring increased member outreach attempts to validate the change implemented remained effective in increasing HNA completion rates.

APPENDIX 1 – LIST OF ACRONYMS

ABR	Actual to Benchmark Ratio
AMB	Ambulatory Care
Anthem	Anthem Blue Cross and Blue Shield Health Plan, Managed Care Organization
AODA	Alcohol and Other Drug Abuse
BC+	BadgerCare Plus
CC	Care Coordinator
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 Adult
CMC	Children with Medical Complexity
CMR	Care Management Review
CMS	Centers for Medicare & Medicaid Services
CRS	Clinical Rating Scale
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
FUH	Follow Up after Hospitalization
GHC-EC	Group Health Cooperative of Eau Claire, Managed Care Organization
GHC-SCW	Group Health Cooperative of South Central Wisconsin, Managed Care Organization

HEDIS[2]	Healthcare Effectiveness Data and Information Set
HNA	Health Needs Assessment
*i*Care	Independent Care Health Plan, Managed Care Organization
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
ISCA	Information Systems Capabilities Assessment
IT	Information Technology
MCHP	MercyCare Health Plans, Managed Care Organization
MCO	Managed Care Organization
MEDDIC-MS	Medicaid Encounter Data Driven Improvement Care Measure Set
MHS	MHS Health Wisconsin, Managed Care Organization
MHWI	Molina HealthCare of Wisconsin
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
PPIC	Physicians Plus Insurance Corporation, Managed Care Organization
PPR	Potentially Preventable Readmission
Quartz	Quartz Health Solutions, Inc., Managed Care Organization
SHP	Security Health Plan, Managed Care Organization
SMCP	Special Managed Care Program
SSI	Supplement Security Income
Trilogy	Trilogy Health Insurance, Managed Care Organization
UHC	UnitedHealthcare Community Plan, Managed Care Organization

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

WICT	Wisconsin Interdisciplinary Care Team
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, Supplemental Security Income, Special Managed Care, and Foster Care Medical Home Medicaid recipients in the State of Wisconsin. MetaStar also conducts EQR of Home and Community-Based Medicaid Waiver programs that provide long-term support services for children with disabilities. MetaStar provides other services for the state as well as for private clients. For more information about MetaStar, visit its website at www.metastar.com.

MetaStar Review Team

The MetaStar EQR team is comprised of registered nurses, a clinical nurse specialist, a 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®)[3] auditor, certified professional coders, and information technologies staff. Review team experience includes professional practice and/or administrative experience in managed health and long-term care programs as well as in other settings, including community programs, schools, home health agencies, community-based residential settings, and the Wisconsin

[3] "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 45 standards.

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

MCO/SMCP/PIHP	FY 16-17	CY 2018*	CY 2019
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	

MCO/SMCP/PIHP	FY 16-17	CY 2018*	CY 2019
Group Health Cooperative of Eau Claire+			41 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. ** Health Tradition Health Plan's contract with DHS ended as of December 31, 2017. + Group Health Cooperative of Eau Claire holds accreditation from Accreditation Association for Ambulatory Health Care.

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 2018, MCOs calculated and reported some measures and DXC Technology (DXC) calculated and reported others.

In preparation for MY 2018, 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

- National Committee for Quality Assurance (NCQA) HEDIS Data submission documents for MY 2018:
    - Data from the NCQA Interactive Data Submission System (IDSS) site containing the required data elements for each measure, downloaded as a comma separated value (CSV) text file (other options such as XML will not be accepted);
    - Data Filled Workbook, including Audit Review Table (ART) format downloaded from the NCQA IDSS site (with evidence that the auditor lock has been applied); and
    - The Audit Report produced by a NCQA Licensed HEDIS Auditor.

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

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

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

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

Performance Measures

The following table provides information about the source for performance measures, the technical specifications for each measure, and the Medicaid program population for which the measures were validated. The measures included in the report are HEDIS-like measures and 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 anchor date of December 31 and had at least one dental visit with a dental practitioner.	Y	N
HEDIS-Like	**Annual Dental Visit - Adults** Percent of members 22-64 years of age (as of December 31 of the MY) who were enrolled in the MCO for at least 11 months during the MY with an anchor date of December 31 and had at least one dental visit with a dental practitioner.	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

Validation of Performance Improvement Projects

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

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

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

To conduct the assessment, MetaStar used the ISCA scoring tool to collect information about the effect of the MCO's information management practices on encounter data submitted to DHS. Reviewers assessed information provided in the ISCA scoring tool, which was completed by the MCO and submitted to MetaStar. Some sections of the tool may have been completed by contracted vendors, if directed by the MCO. Reviewers also obtained and evaluated additional/

supplemental documentation specific to the MCO's information systems (IS) and organizational operations used to collect, process, and report claims and encounter data.

MetaStar visited the MCO to perform staff interviews to:

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

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

Section I: General Information

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

Section II: Information Systems – Encounter Data Flow

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

Section III: Data Acquisition - Claims and Encounter Data Collection

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

Section IV: Eligibility and Enrollment Data Processing

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

Section V: Practitioner Data Processing

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

Section VI: System Security

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

Section VII: Vendor Oversight

MetaStar reviews MCO oversight and data collection processes performed by service providers and other information technology vendors/systems (including internal systems) that support MCO operational functions, and provide data which relate to the generation of complete and accurate reporting including encounter data creation. This includes information on stand-alone systems or benefits provided through subcontracts, such as medical record data, immunization data, or behavioral health/substance abuse data. Reviewers also look for comprehensive and well documented policies and procedures that govern the procurement process as well the on-going monitoring and communications to improve coordination and resolution of vendors' issues as they occur.

Section VIII: Medical Record Data Collection

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

Section IX: Business Intelligence

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

Section X: Performance Measure

MetaStar gathers and evaluates general information about how measure production and source code development is used to prepare and calculate the measurement year measure report. (The review of this section is only for FC, FCP, and PACE programs at the request of DHS.)

Care Management Review – Supplemental Security Income Program

Prior to conducting care management review in calendar year 2019, each MCO was asked to respond in writing to a survey, which asked the organization to describe its processes for:

- Identifying and contacting members;
- Needs stratification;
- Care management structure;
- Care planning process;
- Transitional care; and
- Wisconsin Interdisciplinary Care Team (WICT) structure and processes.

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, member acuity or level of care intensity for care management, and care coordination activities such as follow-up.

Per DHS direction, MetaStar randomly selected a sample of new and continuing SSI members who were enrolled for at least 90 consecutive days between January 1 2018 and December 31, 2018.

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 six categories of care coordination and care management. The six categories were made up of 12 indicators that reviewers used to evaluate care management performance:

1. Screening
    a. Timeliness of initial screening for members newly enrolled in 2018
    b. Screening completion prior to care plan creation
2. Comprehensiveness of Care Plan
    a. Development of initial care plan
    b. Needs identification
3. Care Management Service Delivery (Follow-Up)
    a. Member-centric care
    b. Social determinants
    c. Behavioral health
4. Care Plan Review and Update
    a. Reviewed and updated as required
    b. Restratification after a critical event
5. Discharge/Transitional Care Follow-Up
    a. Follow-up after hospitalization

6. WICT
    a. Evidence of a well-functioning WICT
    b. Member contact

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 screening or annual care plan 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.

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 February 1, 2019 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) Screen
    b. Comprehensiveness of OHC 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 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.

Care Management Review – Children with Medical Complexities

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 CMC members who were enrolled as of December 15, 2018 and who were enrolled at least 60 consecutive days.

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

1. Eligibility
    a. Eligibility requirements
    b. Voluntary participation
    c. Involuntary disenrollment
2. Assessment
    a. Timeliness of initial Assessment
    b. Comprehensiveness of initial Assessment

3. Care Plans
    a. Timeliness of initial care plan
    b. Comprehensiveness of initial care plan
4. Service Reduction or Termination
    a. Mutual agreement
    b. Advance notice
5. Monitoring and Service Coordination
    a. Contact requirements
    b. Follow up after hospitalization
    c. Identified needs are addressed
    d. Coordination of referrals

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 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 Assessment

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

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

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

Per DHS direction, MetaStar randomly selected a sample of BC+ childless adult members who were newly enrolled during the period from January 1, 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 or as a BC+ member with an HNA completed in the previous 12 months, the member's record was not reviewed and a replacement member from an over-sample was added to the sample. The reviewers also discarded a record if the member:

- Did not have two continuous calendar months of enrollment;
- Was retroactively enrolled;
- Disenrolled, then reenrolled within the same six month period and with the same MCO; or

- Disenrolled, then re-enrolled with the same MCO six months or more from the disenrollment date and did not remain continuously enrolled for two calendar months after the reenrollment date.

MetaStar used a binomial scoring system ("met" and "not met") to evaluate the presence of each required element in the sample of member records. For findings of "not met," the reviewers noted the key areas related to the finding and provided comments to identify the missing requirements. In addition, when an initial HNA was not completed, all elements were scored "not met."

At the end of the record review, MetaStar gave the MCO and DHS the findings from each individual record review as well as a report regarding the organization's overall performance. The benchmarks, potential penalties and potential bonuses established by DHS are:

1. Targets: BadgerCare Plus HMOs 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 2018; OR
    b. Reduction in Error Target: 10% improvement from baseline.

    Reduction In Error Example:
        i. Assume a HMO has a 2018 baseline of 20%.
        ii. 2018 Error: 100% - 20% = 80%.
        iii. 2018 Reduction In Error Target:
        100% - [80% * (100% -10%)] = 28%.
        iv. In this example, the HMO 2018 target for timely HNA Screenings would be 28%, not 35%.

2. Penalty: HMOs that do not meet the HNA target will be subject to financial performance penalties. The penalty amount will be the lesser of either $250,000 or 25% of the monthly administrative capitation rate for the proportion of the BadgerCare Plus Childless Adult (CLA) membership for whom the HMO failed to meet the HNA performance target in the calendar year.
    Penalty Example:
    a. Assume that a MCO's 2018 HNA performance target is 35% and its 2018 performance is 25%.
    b. Therefore, the MCO failed to meet their 2018 HNA performance target by 10%, also known as the "HNA performance gap."
    c. Further assume that in 2018:
        i. The MCO had a total of 10,000 CLA 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 2018 HNA performance target.

3. Bonus: MCOs that in 2018 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 2018 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 2018.

Bonus Example:

a. Assume the total bonus pool is worth $700,000 for 2018 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 2018 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 2018 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.