External Quality Review

Calendar Year 2020

Annual Technical Report

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

Prepared for

Wisconsin Department of Health Services

Division of Medicaid Services

Prepared by

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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 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 contracts with MetaStar, Inc.

This report covers the external quality review calendar year from January 1, 2020, to December 31, 2020 (CY 2020). Assessment of compliance with federal standards, and information systems capabilities assessments were not conducted during CY 2020 as no non-accredited organizations were due for either mandatory review activity. Mandatory review activities conducted during the year included validation of performance measures and validation of performance improvement projects. 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 MCOs, Special Managed Care Programs, and hospitals can be found on pages 11-13. More detailed information regarding results of the various review activities, including identified progress, strengths, and opportunities for improvement, begins on page 14.

Validation of Performance Improvement Projects

Validating performance improvement projects (PIPs) is a mandatory external quality review (EQR) activity to determine if a MCO's PIP is designed, conducted, and reported in a methodologically sound manner.

MetaStar reviewed and validated 33 performance improvement projects during CY 2020. Thirty performance improvement projects were conducted during CY 2019 by 15 MCOs participating in the Wisconsin BadgerCare Plus and/or Supplemental Security Income Medicaid programs.

The projects focused on a variety of health topics, including ambulatory care, annual dental visits, antidepressant medication management, breast cancer screening, childhood immunization status, comprehensive diabetes care, controlling blood pressure, follow-up after hospitalization for mental illness, initiation and engagement of alcohol and other drug dependence treatment, lead screening, medication adherence, prenatal and postpartum care, hospitalization readmission rates, tobacco cessation, and well-child visits. In addition, one project each was conducted by two Special Managed Care Programs and one prepaid inpatient health plan for the foster care medical home benefit during CY 2019. The projects were focused on improving member satisfaction, ongoing mental health services, and trauma informed care.

All organizations submitted their performance improvement project proposals to MetaStar for feedback on the first 12 standards, which relate to the review areas of topic selection, study question, indicators, study population, sampling methods, and data collection procedures. DHS project approval occurred subsequent to MetaStar's feedback. When the final projects were validated, 19 of 33 projects fully met the first 12 standards. This activity is considered PIP technical assistance. 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. Ten of the projects received a validation result of fully *met*, 22 projects received a validation result of *partially met*, and one project received a validation result of *not met*.

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.

MetaStar validated measurement year 2019 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 the Wisconsin Department of Health Services' (DHS') vendor, Gainwell Technologies (formerly 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 of four measures for the BadgerCare Plus population declined while two improved from the previous year. Both measures

for the Supplemental Security Income population declined from the previous year. The HealthCheck measure was reported aggregately across both programs and demonstrated an improvement.

Compliance with Standards and *Information Systems Capabilities Assessment Reviews*

A compliance with standards or quality compliance review is a mandatory activity and is conducted according to federal protocol standards. Federal regulations as well as the Centers for Medicare & Medicaid Services protocols also mandate that states assess the information systems capabilities of MCOs. 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, including those accredited by other entities, are required by DHS to have a Compliance with Standards and ISCA review every three years. No organizations were due for the Compliance with Standards or ISCA reviews during CY 2020.

Care Management Review – Supplemental Security Income Program

Care management review is an optional external quality review activity requested and directed by DHS. During CY 2020, the EQR team reviewed 800 records for the eight MCOs serving the Supplemental Security Income population. Aggregately, the MCOs demonstrated improvement in four indicators: timeliness of initial assessments, completion of the assessment prior to the care plan, care plan review and update, and restratification after critical events.

Obstetrics Medical Home/Healthy Birth Outcomes

During CY 2020, DHS directed MetaStar to perform data abstraction reviews of its Medical Home initiative for pregnant women. MetaStar reviewed 832 records for the 12 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.

Care Management Review – Foster Care Medical Home

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

home care settings and under the jurisdiction of the child welfare system within the six Wisconsin counties may participate in the program.

The PIHP must establish a health care management structure that assures coordination and integration of all aspects of the child's health care needs and promotes effective communication between the individuals who are instrumental to the child's care. MetaStar reviewed 44 records from the one organization that operates the FCMH in CY 2020. The review period included the declaration of the Coronavirus Disease 2019 (COVID-19) public health emergency (PHE) and Wisconsin's *Safer at Home* order. Exemptions to some program requirements were granted by DHS due to the PHE. The requirements of the *Safer at Home* orders may be a contributing factor in the FCMH's results.

Record Review – Children with Medical Complexities

Children with Medical Complexities 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. This is an optional review activity requested and directed by DHS to assess the access, quality, and appropriateness of care provided to members. During CY 2020 MetaStar reviewed 60 member records for the two hospitals administering the benefit program. Overall, the review found the hospitals continue to 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 1,147 CY 2019 records of BadgerCare Plus childless adult recipients enrolled in 14 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. Beginning in CY 2020, an initial health screening was incorporated into the Medicaid enrollment process and this assessment was considered duplicative. As such, this was the final year of the review. Twelve of the 14 MCOs met or exceeded the target compliance rate.

Care Management Review – HIV/AIDS Health Home

The Affordable Care Act of 2010 §2703 and Social Security Act §1945 created an optional Medicaid benefit that allows states to establish health homes to coordinate care for people who have chronic conditions across all healthcare settings and community care settings. The goals of health homes are to improve health outcomes while lowering Medicaid costs, and to reduce preventable hospitalizations, emergency room visits, and unnecessary care for Medicaid members.[1] Member participation is voluntary, and members must have a diagnosis of human immunodeficiency virus (HIV) and at least one other chronic condition, or be at risk of developing another chronic condition. The health home provider is accountable for the total care of the member, using a patient-centered model, which includes a care team working with the member to meet his/her medical, dental, behavioral health, pharmacy, care management, and social service needs. This is an optional activity. MetaStar began working in collaboration with DHS during CY 2020, developing updated review criteria for evaluating member records, to ensure providers were meeting DHS requirements. Reviews are scheduled to begin in CY 2021.

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

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 prepaid inpatient health plans (PIHPs) 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, 2020 to December 31, 2020 (CY 2020). 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.

Overview of Wisconsin's Medicaid Managed Care Organizations

As noted in the table below, the Wisconsin Department of Health Services (DHS) contracted with 14 MCOs to provide services for persons enrolled in the BadgerCare Plus (BC+) program in CY 2020. 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 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, including those accredited by other entities, are required by DHS to have a Compliance with Standards and ISCA review every three years. No organizations were due for the Compliance with Standards or ISCA reviews during CY 2020.

Managed Care Organization	Program(s)	Accrediting Organization	Status
Anthem Blue Cross and Blue Shield Health Plan	BC+, SSI	NCQA	Accredited Multicultural Health Care Distinction 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	Accredited
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	Accredited Multicultural Health Care Distinction Expires 3/8/2020
Network Health Plan	BC+, SSI	NCQA	Accredited Expires 5/23/2020
Quartz Health Solutions, Inc.	BC+	NCQA	Interim Status Expires 2/21/2021
Security Health Plan	BC+	NCQA	Accredited Expires 3/22/2020
Trilogy Health Insurance	BC+	Not Accredited	Compliance with Standards review conducted every three years by EQRO. Due in 2021.
United Healthcare Community Plan	BC+, SSI	NCQA	Accredited Expires 2/14/2020

As of December 2020, enrollment was as follows:

Program	Enrollment
BadgerCare Plus	893,811
Supplemental Security Income Medicaid	57,696
BadgerCare Plus Childless Adults	192,465
Special Managed Care Programs	1,116
Foster Care Medical Home	3,043

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.

Children with Medical Complexities and the HIV/AIDS Health Home are benefit programs separate from the managed care programs and enrollment numbers are not publicly reported.

Scope of External Review Activities

In CY 2020, MetaStar conducted two mandatory review activities as specified in federal Medicaid managed care regulations found at 42 CFR 438.358:

- Validation of performance measures; and
- Validation of performance improvement projects (PIPs).

Other mandatory review activities not conducted during the reporting period include:

- Assessment of compliance with standards; and
- Information systems capabilities assessments.

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 2020 review cycle. The review methodology for each review activity is found in Appendix 2.

Scope of External Review Activities CY 2020

MCOs	Types of Reviews Performed
Anthem Blue Cross and Blue Shield (Anthem)	PIP Validation Performance Measure Validation Childless Adults Health Needs Assessment Review Healthy Birth Outcomes Medical Home Review Supplemental Security Income Care Management Review PIP Technical Assistance
Care Wisconsin (CW)	PIP Validation Performance Measure Validation Supplemental Security Income Care Management Review

MCOs	Types of Reviews Performed
	PIP Technical Assistance
Children's Community Health Plan, Inc. (CCHP)	PIP Validation Performance Measure Validation Childless Adults Health Needs Assessment Review Foster Care Medical Home Review Healthy Birth Outcomes Medical Home Review PIP Technical Assistance
Dean Health Plan, Inc. (DHP)	PIP Validation Performance Measure Validation Childless Adults Health Needs Assessment Review Healthy Birth Outcomes Medical Home Review PIP Technical Assistance
Group Health Cooperative of Eau Claire (GHC-EC)	PIP Validation Performance Measure Validation Childless Adults Health Needs Assessment Review Supplemental Security Income Care Management Review PIP Technical Assistance
Group Health Cooperative of South Central Wisconsin (GHC-SCW)	PIP Validation Performance Measure Validation Childless Adults Health Needs Assessment Review Healthy Birth Outcomes Medical Home Review PIP Technical Assistance
Independent Care Health Plan (*i*Care)	PIP Validation Performance Measure Validation Childless Adults Health Needs Assessment Review Supplemental Security Income Care Management Review Healthy Birth Outcomes Medical Home Review PIP Technical Assistance
MHS Health Wisconsin (MHS)	PIP Validation Performance Measure Validation Childless Adults Health Needs Assessment Review Healthy Birth Outcomes Medical Home Review Supplemental Security Income Care Management Review PIP Technical Assistance
MercyCare Health Plans (MCHP)	PIP Validation Performance Measure Validation Childless Adults Health Needs Assessment Review Healthy Birth Outcomes Medical Home Review PIP Technical Assistance
Molina HealthCare of Wisconsin (MHWI)	PIP Validation Performance Measure Validation Childless Adults Health Needs Assessment Review Healthy Birth Outcomes Medical Home Review Supplemental Security Income Care Management Review PIP Technical Assistance
Network Health Plan (NHP)	PIP Validation Performance Measure Validation Childless Adults Health Needs Assessment Review Healthy Birth Outcomes Medical Home Review Supplemental Security Income Care Management Review PIP Technical Assistance

MCOs	Types of Reviews Performed
Quartz Health Solutions, Inc. (Quartz)	PIP Validation Performance Measure Validation Childless Adults Health Needs Assessment Review Healthy Birth Outcomes Medical Home Review PIP Technical Assistance
Security Health Plan (SHP)	PIP Validation Performance Measure Validation Childless Adults Health Needs Assessment Review PIP Technical Assistance
Trilogy Health Insurance (Trilogy)	PIP Validation Performance Measure Validation Childless Adults Health Needs Assessment Review Healthy Birth Outcomes Medical Home Review PIP Technical Assistance
United Healthcare Community Plan (UHC)	PIP Validation Performance Measure Validation Childless Adults Health Needs Assessment Review Healthy Birth Outcomes Medical Home Review Supplemental Security Income Care Management Review PIP Technical Assistance

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

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

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 not accredited by NCQA 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 State-developed 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, Gainwell Technologies, collected data and calculated the measures according to specifications established by DHS. Gainwell Technologies was formed following the sale of DXC Technology's U.S. State and Local Services business to Veritas Capital. The rates for performance measures are publicly 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 Healthcare Effectiveness Data and Information Set (HEDIS®)[2] 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) 2019 data, MetaStar validated five performance measures each for 14 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.

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

ANALYSIS

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

For measures that were calculated by Gainwell Technologies, MetaStar evaluated and conducted documentation and data quality reviews with Gainwell Technologies and DHS staff. Gainwell Technologies produced programming based on state specifications and reporting requirements, which had not changed significantly from the prior year. During the audit process, Gainwell Technologies 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. Gainwell Technologies' final documentation was approved and signed by DHS.

MetaStar used available, publicly reported rates and benchmarks as comparisons for validating the Gainwell Technologies 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 State-developed measure calculations that were produced by Gainwell for the MY 2019 P4P initiative. The measure rates were compared to prior years as well as other health plans.

Program: BC+		
Performance Measure	***Benchmark***	***Comparisons to MY 2018***
Annual Dental Visit - Children (Regions 5&6 only)	National benchmarks are not available.	The aggregate MCO rate decreased by 0.3 percent from 58.5 in MY 2018 to 58.2 in MY 2019.
Annual Dental Visit - Adult (Regions 5&6 only)	National benchmarks are not available.	The aggregate MCO rate decreased by 0.1 percent from 34.1 in MY 2018 to 34.0 in MY 2019.
ED Visits (AMB) *sans revenue code 0456 (Urgent Care)*	National benchmarks are not available.	The aggregate MCO rate decreased by 1.0 percent from 56.86 in MY 2018 to 56.31 in MY 2019.

Program: BC+		
Tobacco Cessation - Counseling	National benchmarks are not available.	The aggregate MCO rate decreased by 0.4 percent from 65.8 in MY 2018 to 65.4 in MY 2019.
HealthCheck Screening	National benchmarks are not available.	The aggregate MCO rate increased by 2 percent from 108.0 percent in MY 2018 to 110.0 percent in MY 2019 (note: results are combined for BC+ and SSI).

Program: SSI		
Performance Measure	***Benchmark***	***Comparisons to MY 2018***
ED Visits (AMB) *sans revenue code 0456 (Urgent Care)*	National benchmarks are not available	The aggregate MCO rate increased by 2.1 percent from 110.49 in MY 2018 to 112.87 in MY 2019.
Tobacco Cessation - Counseling	National benchmarks are not available.	The aggregate MCO rate decreased by 0.4 percent from 70.4 in MY 2018 to 70.0 in MY 2019.
HealthCheck Screening	National benchmarks are not available.	The aggregate MCO rate increased by 2 percent from 108.0 percent in MY 2018 to 110.0 percent in MY 2019 (note: results are combined for BC+ and SSI).

CONCLUSIONS

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

Progress

MetaStar identified the following areas of progress, made in response to recommendations from the previous validation review, which was conducted for MY 2018 performance measures:

- The ED Visits (AMB) *sans revenue code 0456 (Urgent Care)* increased by 1.0 percent from MY 2018 for the BC+ population.
- The HealthCheck Screening rate increased by 2 percent from MY 2018.

Strengths

The following strengths were identified in the validation of MY 2019 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, Gainwell Technologies, contributed to the accuracy of calculated rates.
- Gainwell Technologies continued robust testing processes to validate changes to internally developed measures.

Opportunities for Improvement

MetaStar recommends DHS and the MCOs conduct root cause analyses to identify the barriers to success in improving the performance measures and aligning with the state's quality strategy. As interventions are identified, use Plan-Do-Study-Act (PDSA) cycles of improvement to measure the effectiveness of each intervention. The recommended focus areas for improvement include:

- The Annual Dental Visit – Children aggregate rate decreased from MY 2018 by 0.3 percent. This is following a one percent increase in MY 2018 from MY 2017.
- The Annual Dental Visit – Adult aggregate rate decreased from MY 2018 by 0.1 percent. The MY 2018 rate was a decrease of 0.2 percent from MY 2017.
- The Tobacco Cessation – Counseling aggregate rate for the BC+ population decreased by 0.4 percent in MY 2019, following a 0.4 percent increase in MY 2018 from MY 2017. The aggregate rate for the SSI population also decreased by 0.4 percent in MY 2019, following a 1.3 percent increase in MY 2018 from MY 2017.
- DHS should ensure efforts continue to support the MCOs with building and maintaining provider networks to meet the needs of the membership.

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

This section of the report aggregates and summarizes the results of 30 PIPs conducted during CY 2019 by 15 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 2019. All 33 PIPs were validated in CY 2020.

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* or true improvement, and not due to chance; and
- Assess the sustainability of the documented improvement.

PROJECT INTERVENTIONS AND OUTCOMES

The following table is organized by topic and lists each project; the indicator, measure, or aim; the project outcomes from baseline to final result; and the interventions selected. 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.

MCO	Indicator, Measure, or Aim	Outcomes		Interventions	Validation Result
		Baseline	Final Result		
Ambulatory Care					
*i*Care (BC+)	Reduce emergency department visits.	2,215 visits (2018)	2,099 visits* (2019)	Completed provider and staff education. Conducted mail and telephonic outreach. Continued the *Mobile Integrated Healthcare* and *Better Care for You* programs. Used additional assessment and questionnaire.	Partially Met
Annual Dental Visit (ADV)					
UHC (BC+)	Improve the HEDIS ADV rate.	54.22% (2017)	45.08% (2019)	Conducted member outreach, education, and community-based events. Implemented a dental scorecard for providers. Created a *Dental Care Opportunity Report*. Conducted provider education. Established community partnerships.	Met
Antidepressant Medication Management (AMM)					
CCHP (BC+)	Increase the HEDIS AMM rate.	32.9% (2017)	37.4% (2019)	Conducted automated telephonic outreach. Contracted with external organization to assist with telephonic outreach.	Partially Met
Breast Cancer Screening (BCS)					

MCO	Indicator, Measure, or Aim	Outcomes		Interventions	Validation Result
		Baseline	Final Result		
Anthem (BC+)	Increase the rate for the HEDIS BCS measure.	66.6% (2017)	60.1% (2019)	Utilized field-based care management staff. Continued case management pod system. Offered member incentive. Simplified internal documentation. Conducted automated telephonic outreach. Implemented a gap closure program.	Partially Met
Anthem (SSI)	Increase the rate for the HEDIS BCS measure.	77.3% (2017)	56.4% (2019)		
CW (SSI)	Increase the rate for the HEDIS BCS measure.	58.7% (2017)	56%* (2019)	Continued to utilize internal task reminders. Continued member mailings. Conducted outreach to providers.	Partially Met
Childhood Immunization Status (CIS)					
DHP (BC+)	Improve the HEDIS CIS Combo-3 rate.	70.56% (2017)	72.99% (2019)	Partnered with a clinic system to coordinate efforts. Organized immunization events during non-traditional hours. Offered a gift card incentive.	Partially Met
Quartz (BC+)	Improve the HEDIS CIS Combo-3 rate.	75.3% (2017)	71.05% (2019)	Developed enhanced data sharing. Increased provider education. Expanded member	Partially Met

MCO	Indicator, Measure, or Aim	Outcomes		Interventions	Validation Result
		Baseline	Final Result		
				outreach and education efforts. Expanded provider outreach. Increased provider collaboration.	
Trilogy (BC+)	Improve the HEDIS CIS Combo-3 rate.	29.85% (2017)	64.6%* (2019)	Conducted telephonic outreach.	Partially Met
Comprehensive Diabetes Care (CDC)					
CCHP (BC+)	Increase the rate of diabetic retinal eye exams.	51.58% (2017)	44.53% (2019)	Completed provider notifications and education. Mailed educational materials to members. Conducted telephonic follow-up with members. Started a Facebook campaign. Initiated automated telephone calls.	Partially Met
MHS (BC+)	Increase the hemoglobin A1c (HbA1c) testing rate.	87.1% (2017)	89.78% (2019)	Conducted telephonic and mail outreach. Mailed HbA1c testing kit. Developed a program to enhance chronic condition management referrals. Developed and implemented non-clinical staff education.	Partially Met
	Increase the number of members in active case management.	8 (2018)	4 (2019)		
	Increase the number of HbA1c testing results captured using health information exchange data programs.	20% (2017)	Not Calculated (2019)		

MCO	Indicator, Measure, or Aim	Outcomes		Interventions	Validation Result
		Baseline	Final Result		
				Conducted provider outreach. Implemented automated calls. Created multilingual education materials.	
MHS (SSI)	Increase the HbA1c testing rate.	91.3% (2017)	87.59% (2019)	Conducted telephonic and mail outreach. Mailed HbA1c testing kit. Developed a program to enhance chronic condition management referrals. Developed and implemented a diabetes education module for non-clinical staff. Conducted provider outreach. Implemented automated calls. Created multilingual education materials.	Partially Met
	Increase the number of members in active case management.	14 (2018)	8 (2019)		
	Increase the number of HbA1c testing results captured using health information exchange data programs.	20% (2017)	Not Calculated (2019)		
NHP (BC+)	Increase the HbA1c testing rate.	92.9% (2017)	87.59% (2019)	Conducted telephonic and mail outreach. Mailed HbA1c testing kit. Developed a program to enhance	Partially Met

MCO	Indicator, Measure, or Aim	Outcomes		Interventions	Validation Result
		Baseline	Final Result		
	Increase the number of members in active case management.	1 (2018)	4 (2019)	chronic condition management referrals. Developed and implemented a diabetes education module for non-clinical staff. Conducted provider outreach. Implemented automated calls. Created multilingual education materials.	
	Increase the number of HbA1c testing results captured using health information exchange data programs.	20% (2017)	Not Calculated (2019)		
NHP (SSI)	Increase the HbA1c testing rate.	91.7% (2017)	90.1% (2019)	Conducted telephonic and mail outreach. Mailed HbA1c testing kit. Developed a program to enhance chronic condition management referrals. Developed and implemented a diabetes education module for non-clinical staff. Conducted provider outreach. Implemented automated calls. Created multilingual education materials.	Partially Met
	Increase the number of members in active case management.	2 (2018)	6 (2019)		
	Increase the number of HbA1c testing results captured using health information exchange data programs.	20% (2017)	Not Calculated (2019)		
Controlling Blood Pressure (CBP)					
GHC-SCW (BC+)	Increase the HEDIS CBP measure rate.	61.7% (2018)	61.61% (2019)	Offered member incentive.	Partially Met

MCO	Indicator, Measure, or Aim	Outcomes		Interventions	Validation Result
		Baseline	Final Result		
				Conducted mail and telephonic member outreach.	
Follow-Up After Hospitalization for Mental Illness (FUH)					
Anthem (BC+)	Reach the NCQA 50th percentile for the HEDIS FUH 30-day rate.	59.9% (2017)	56.0% (2019)	Utilized field-based care management staff. Conducted inpatient mental health visit project. Continued case management pod system. Utilized electronic follow-up appointment scheduling. Continued use of a Community Health Worker program. Offered a member incentive. Simplified health risk assessment and notes. Implemented *Housing First* program. Conducted a provider-based compliance analysis provider-specific education. Completed a FUH cost savings study.	Partially Met
Anthem (SSI)	Reach the NCQA 50th percentile for the HEDIS FUH 30-day rate.	52.1% (2017)	57.8% (2019)		

MCO	Indicator, Measure, or Aim	Outcomes		Interventions	Validation Result
		Baseline	Final Result		
CW (SSI)	Improve the HEDIS FUH 30-day rate.	60.5% (2017)	59%* (2019)	Coordinated with the hospital to schedule an appointment prior to the member's discharge. Recommended that hospital discharge planners make a referral to *Resource Bridge*.	Partially Met
DHP (BC+)	Improve the HEDIS FUH 30-day rate.	70.07% (2017)	65.19% (2019)	Transitioned to internal care management. Conducted mail and telephonic member outreach. Offered financial incentives to clinics. Conducted provider education.	Met
MHWI (BC+)	Improve the HEDIS FUH 30-day rate.	65.91% (2018)	69.12% (2019)	Offered a Transition of Care Program. Added a *Preventative Care HEDIS Report* to track data. Distributed a provider scorecard. Contracted with a Behavioral Health Department to provide the *Team Connect* program.	Met
MHWI (SSI)	Improve the HEDIS FUH 30-day rate.	68.75% (2018)	68.03% (2019)		
UHC (BC+)	Increase the HEDIS FUH 7-day rate.	45.79% (2017)	40.46% (2019)	Deployed Behavioral Health Telehealth Toolkit. Utilized predictive analytics to identify member behavioral health risk scores.	Partially Met
UHC (SSI)	Increase the HEDIS FUH 7-day rate.	34.46% (2017)	33.27% (2019)		

MCO	Indicator, Measure, or Aim	Outcomes		Interventions	Validation Result
		Baseline	Final Result		
UHC (BC+)	Increase the HEDIS FUH 30-day rate.	69.74% (2017)	64.83% (2019)	Utilized external services to assist with care management and coordination. Implemented onsite care coordination programs.	
UHC (SSI)	Increase the HEDIS FUH 30-day rate.	55.08% (2017)	55.78% (2019)		
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)					
Quartz (BC+)	Improve the HEDIS IET rate.	12.5% (2017)	14.57% (2019)	Developed a Behavioral Health Workgroup. Expanded provider outreach.	Partially Met
Lead Screening in Children (LSC)					
GHC-SCW (BC+)	Improve the HEDIS LSC rate.	70.87% (2017)	65.43% (2019)	Implemented a member incentive. Conducted outreach by telephone and mail.	Met
SHP (BC+)	Improve the HEDIS LSC rate.	77.24% (2017)	80.14%* (2019)	Provided member education. Distributed reminder materials and gaps in care lists to providers. Collaborated with a clinic.	Partially Met
Medication Adherence					
GHC-EC (BC+ and SSI)	Increase the compliancy in medication adherence of members diagnosed with heart failure.	82.1% (2018)	70.0% (2019)	Implemented a *Medication Therapy Management* program and educated providers about the program. Increased care coordination efforts.	Partially Met
Prenatal and Postpartum Care (PPC)					
MCHP (BC+)	Improve the prenatal HEDIS PPC rate.	80.2% (2017)	97.43%* (2019)	Conducted mail and telephonic member outreach.	Partially Met

MCO	Indicator, Measure, or Aim	Outcomes		Interventions	Validation Result
		Baseline	Final Result		
				Facilitated a process to connect pregnant members with an obstetric provider.	
MHWI (BC+)	Improve the postpartum HEDIS PPC rate.	59.37% (2017)	52.07% (recalculated 2019)	Offered and conducted Community Connector home visits. Conducted telephonic member outreach. Implemented a member incentive.	Met
Trilogy (BC+)	Improve the prenatal HEDIS PPC rate.	76.44% (2017)	62.29%* (2019)	Conducted telephonic outreach.	Partially Met
	Improve the postpartum HEDIS PPC rate.	56.44% (2017)	64.96%* (2019)		
Reduce Readmission Rate					
GHC-EC (SSI)	Decrease the potentially preventable readmission actual to benchmark ratio.	0.95 (2018)	0.98 (2019)	Conducted member outreach and post-hospitalization follow-up activities. Enhanced member communication options. Completed provider education and discussion forums. Increased frequency of care plan updates. Increased care coordination efforts.	Met
Tobacco Cessation					

<table>
<tr><th rowspan="2">MCO</th><th rowspan="2">Indicator, Measure, or Aim</th><th colspan="2">Outcomes</th><th rowspan="2">Interventions</th><th rowspan="2">Validation Result</th></tr>
<tr><th>Baseline</th><th>Final Result</th></tr>
<tr><td>iCare (BC+)</td><td>Increase the rate of tobacco cessation counseling.</td><td>69% (2018)</td><td>70% (2019)</td><td rowspan="2">Conducted staff training.

Conducted telephonic member outreach.

Completed provider mailings.

Referred members to the Wisconsin Tobacco Quit Line.</td><td rowspan="2">Met</td></tr>
<tr><td>iCare (SSI)</td><td>Increase the rate of tobacco cessation counseling.</td><td>71% (2018)</td><td>73% (2019)</td></tr>
<tr><td>MCHP (BC+)</td><td>Increase the rate of tobacco cessation counseling.</td><td>53.6% (2018)</td><td>Not Calculated (2019)</td><td>Conducted member mailings.

Offered an online smoking cessation program.</td><td>Not Met</td></tr>
<tr><th colspan="6">Well-Child Visits (WCV)</th></tr>
<tr><td>SHP (BC+)</td><td>Increase the rate of adolescent WCV.</td><td>51.56% (2017)</td><td>56.14% (2019)</td><td>Provided member education.

Distributed reminder materials and gaps in care lists to providers.

Collaborated with a clinic.</td><td>Met</td></tr>
<tr><th colspan="6">Improving Member Satisfaction – Children Only</th></tr>
<tr><td rowspan="5">WM</td><td rowspan="5">Increase the rate of survey satisfaction for callers to the Resource and Referral Line.</td><td colspan="2">Wraparound and Disabilities Services Division</td><td rowspan="5">Conducted member engagement training for staff.</td><td rowspan="5">Partially Met</td></tr>
<tr><td>50% (12/1/18 – 3/31/19)</td><td>90% (8/1/19 – 11/30/19)</td></tr>
<tr><td colspan="2">Birth to Three</td></tr>
<tr><td>58% (12/1/18 – 3/31/19)</td><td>83% (8/1/19 – 11/30/19)</td></tr>
<tr><td colspan="2">Non-Referrals</td></tr>
<tr><td>42% (4/1/19 – 7/31/19)</td><td>67% (8/1/19 – 11/30/19)</td></tr>
</table>

MCO	Indicator, Measure, or Aim	Outcomes		Interventions	Validation Result
		Baseline	Final Result		
	Increase the percentage of callers that arranged appointments for the intake screening process.	98.85% (12/1/18 – 3/31/19)	99.26% (8/1/19 – 11/30/19)		
Ongoing Mental Health Services – Children Only					
CCHP - C4K (FCMH)	Increase initiation of *Mental Health Assessment* recommendations.	44% (2018)	60% (2019)	Increased parent education. Improved internal communications. Conducted *Mental Health Assessment* training.	Met
	Increase the number of children involved in ongoing therapy.	44% (2018)	67% (2019)		
Trauma Informed Care – Children Only					
CCF	Increase the proportion of members whose plan of care contain strategies for trauma symptom reduction.	22% (4/1/19)	45% (3/1/20)	Completed Adverse Childhood Experiences (ACE) screener training. Conducted the ACE screener. Incorporated results into members' plans of care.	Met

*Note: The initial and repeat measures were not comparable, therefore quantitative improvement could not be confirmed.

Aggregate Results for Performance Improvement Projects

The table below lists each standard that was evaluated for each MCO/SMCP/PIHP, and indicates the number of projects meeting each standard. Some standards were not applicable to all projects, due to the study design or lack of quantitative improvement. CY 2018 project results are provided for comparison.

CY 2019 Performance Improvement Project Validation Results

Standards and Elements		CY 2019	CY 2018
Study Topic(s)			
1	The topic was selected through MCO data collection and analysis of important aspects of member needs, care, or services.	30/33 (90.9%)	35/35 (100.0%)
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.	31/33 (93.9%)	35/35 (100.0%)

Standards and Elements		CY 2019	CY 2018
Study Indicator(s)			
3	The study used objective, clearly and unambiguously defined, measureable indicators and included defined numerators and denominators.	29/33 (87.9%)	29/35 (82.9%)
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.	32/33 (97.0%)	32/35 (91.4%)
Study Population			
5	The project/study clearly defined the relevant population (all members to whom the study question and indicators apply).	29/33 (87.9%)	26/35 (74.3%)
6	If the entire population was used, data collection approach captured all members to whom the study question applied.	26/27 (96.3%)	31/33 (93.9%)
Sampling Methods			
7	Valid sampling techniques were used.	6/6 (100.0%)	1/1 (100.0%)
8	The sample contained a sufficient number of members.	5/6 (83.3%)	1/1 (100.0%)
Data Collection Procedures			
9	The project/study clearly defined the data to be collected and the source of that data.	28/33 (84.8%)	33/35 (94.3%)
10	Staff are qualified and trained to collect data.	30/33 (90.9%)	33/35 (94.3%)
11	The instruments for data collection provided for consistent, accurate data collection over the time periods studied.	32/33 (97.0%)	33/35 (94.3%)
12	The study design prospectively specified a data analysis plan.	27/33 (81.8%)	32/35 (91.4%)
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.	30/33 (90.9%)	30/35 (85.7%)
14	A continuous cycle of improvement was utilized to measure and analyze performance, and to develop and implement system-wide improvements.	28/33 (84.8%)	20/35 (57.1%)
15	Interventions were culturally and linguistically appropriate.	23/33 (69.7%)	26/34 (76.5%)
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.	19/33 (57.6%)	23/35 (65.7%)
17	Numerical results and findings were presented accurately and clearly.	27/33 (81.8%)	28/35 (80.0%)
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.	22/33 (66.7%)	23/35 (65.7%)
"Real" Improvement			
19	The same methodology as the baseline measurement was used, when measurement was repeated.	25/33 (75.8%)	26/35 (74.3%)
20	There was a documented, quantitative improvement in processes or outcomes of care.	7/33 (21.1%)	11/35 (31.4%)

Standards and Elements		CY 2019	CY 2018
21	The reported improvement appeared to be the result of the planned quality improvement intervention.	6/14 (42.9%)	7/13 (53.8%)
Sustained Improvement			
22	Sustained improvement was demonstrated through repeated measurements over comparable time periods.	1/1 (100.0%)	2/2 (100.0%)

ANALYSIS

Improvement was noted from CY 2018 to CY 2019 in 45.5 percent of the standards, and two standards continued to be met 100 percent of the time. The most notable improvement was the increase in the percentage of projects detailing continuous cycles of improvement to measure and analyze performance, and implement system-wide improvements. This improvement was likely attributable to actions of the MCOs, and is unlikely to be the result of normal variation or chance. The year-to-year difference in rates for all other standards was likely due to normal variation or chance.

Prior to implementation, all organizations submitted their PIP project proposals for feedback on the first 12 standards, which relate to the review areas of topic selection, study question, indicators, study population, sampling methods, and procedures. When the final projects were validated, 57.6 percent of the projects fully met these first 12 standards in CY 2019, as compared to 62.9 percent of projects in CY 2018. Although the *Study Topic* and *Study Question* standards were both met in 100 percent of the projects in CY 2018, validation of the CY 2019 projects indicated only 90.9 and 93.9 percent of projects respectively met these requirements. In addition, the percentage of projects meeting the requirements for three of the four elements related to the *Data Collection* standard declined from CY 2018 to CY 2019.

Based on validation results, one project demonstrated quantitative improvement that was sustained with repeat measures. This project fully met all applicable standards, and was in the fourth year of the project.

Documented, quantitative improvement in processes or outcomes of care was evident in 21.2 percent of the validated projects, a decline from 31 percent of projects in CY 2018. Of these projects, improvement was demonstrated to be the result of the interventions employed 85.7 percent of the time. Several projects included more than one study question or aim. The MCOs concluded that improvement was not demonstrated for one or more of the aims for 45.5 percent of projects, and the MCOs failed to document the repeat measurement rate or answer the study question in 9.1 percent of the projects. While an MCO may have reported an improvement in the measured rate for the project, the validation process did not always confirm the MCO's conclusion. In 21.2 percent of the projects, initial and repeat measures were not comparable or there was a difference in how the baseline and repeat measures were calculated. In addition, one

project failed to establish a baseline measurement prior to implementing the project to ensure the study topic pertained to the current membership.

The overall validation findings provide an indication of the reliability and validity of the projects' results. CY 2018 project results are provided for comparison.

CY 2019 Performance Improvement Project Overall Validity Results

Validation Finding	CY 2019 (n=33)	CY 2018 (n=35)
Met	10 (30.3%)	13 (37.1%)
Partially Met	22 (66.7%)	21 (60.0%)
Not Met	1 (3.0%)	1 (2.9%)

Thirty percent of the projects in CY 2019 received validation findings of fully *met*, as compared to 37 percent of projects in 2018. One MCO continued a project from CY 2018 that received a validation finding of *not met*; it also received a validation finding of *not met* for CY 2019. The project did not implement any interventions in CY 2018 and did not report a final rate for the project. Interventions were deployed in CY 2019; however, the MCO relied on data provided by DHS, and did not develop an internal mechanism to collect or analyze data during the project's timeframe. In addition, the MCO did not report a final CY 2019 project rate.

CONCLUSIONS

Thirty-three PIPs were submitted and validated. The projects focused on a variety of health topics, including medication management or adherence, immunizations, comprehensive diabetes care, emergency department utilization, annual dental visits, follow-up care after hospitalization for mental illness, breast cancer screening, controlling blood pressure, initiation and engagement of alcohol and other drug dependence treatment, reduction of readmission rates, prenatal and postpartum care, lead screening in children, tobacco cessation, well-child visits, improving member satisfaction, ongoing children's mental health services, and trauma informed care.

Sixty-seven percent of the projects were focused on new topics and 10 organizations continued one or two of the same topics from the prior year. One of eight organizations continued the SSI Needs Stratification PIP focused on reducing hospital readmission rates, which was a DHS required project for CY 2018 for all organizations that provide services to SSI members. Quantitative improvement as a result of the interventions was not demonstrated for either year of the project.

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

Progress

- Improvement was noted in 45.5 percent of the standards in CY 2019 from CY 2018, and two standards continued to be met 100 percent of the time in both review years.

- Almost all (97 percent) projects identified indicators that were sufficient to answer the study question, and the data collection approach captured the entire applicable study population in 96 percent of the projects. Both of these standards reflected improvement from CY 2018 findings of 91.4 percent and 93.9 percent respectively.
- MCOs utilized instruments for consistent, accurate data collection in 97 percent of the projects.
- Of the six projects with sampling in place for the project population, all (100 percent) used valid sampling techniques; this standard was also met for 100 percent of projects that employed sampling in CY 2018.

Strengths

- 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.
- GHC-SCW formed a Lead Screening Committee to address identified barriers.
- MHWI corrected the baseline measure when an error was discovered, to enable the baseline and re-measurement rates to be compared year-to-year.
- MHWI identified the HEDIS specification changes for CY 2019, and reflected CY 2019 data without the specification changes to ensure results could be compared year-to-year.

Opportunities for Improvement

The review team provided related recommendations to DHS and the MCOs to support future project improvements and align with the state's quality strategy.

- DHS should continue using standard project topics in an effort to:
    - Reduce health disparities;
    - Improve health outcomes for individuals and populations; and
    - Reduce potentially preventable readmissions.

As a result of its validations, MetaStar identified the following opportunities for each PIP standard. Organizations may have received the same recommendation for both projects. Unless noted as such, the recommendations below only applied to one project per organization.

Study Topic:

- CCHP should include the impact on member care or services when describing the study topic.
- DHP should include member outcomes when describing the study topic.

- GHC-EC should establish a baseline measurement prior to implementing a project to ensure the study topic pertains to the current membership, and that analysis can occur over the course of the measurement year.

Study Question:

- Both projects for MHS and NHP should document a rate for all study questions applicable to the defined population.
- CCF should ensure the study question includes a baseline rate and target date for the project.

Study Indicators:

- GHC-EC and Trilogy should define measurable indicators, including numerators and denominators, to measure change in the desired outcome.
- DHP, MCHP, and MHWI should ensure the correct HEDIS measurement year specifications are referenced and attached to the report.

Study Population:

- GHC-EC should ensure the study population is clearly defined with inclusion and exclusion criteria.
- Both MCHP projects should ensure the data collection approach defines the data to be collected in order to capture all members of the population.
- Trilogy should ensure inclusion of members in the project adheres to the defined study population.

Sampling:

- GHC-EC should ensure the sampling methodology includes an adequate and representative sample of members for project participation.

Data Collection:

- CW should clearly define the data collected from all data sources.
- GHC-EC and MHWI should define the data sources for all measures.
- GHC-EC should clearly define the data collection process.
- MHWI and both MCHP projects should specify the staff responsible for data collection along with the qualifications.
- CCHP, GHC-SCW, CW, and both SHP projects should specify the data analysis plan.

Improvement Strategies:

- CW should describe how interventions were selected.

- GHC-SCW and WM should develop and implement interventions which are sufficient to be expected to improve outcomes.
- CCHP and both Anthem projects should document continuous improvement efforts in the report.
- GHC-SCW, MCHP, and Quartz should conduct continuous cycles of improvement during the project to analyze and determine effectiveness of the interventions.
- CCHP, C4K, DHP, GHC-SCW, MCHP, UHC, and all projects for Anthem and CW should address cultural or linguistic appropriateness of interventions.

Data Analysis:

- MHS, Quartz, UHC, WM, and all projects for GHC-EC, GHC-SCW, and MHWI, should analyze data on a periodic basis to discover reasons for less than optimal performance.
- All projects for Anthem, MHS, and NHP should fully analyze data. Both Anthem projects should also identify follow-up actions.
- CCHP, Quartz, and UHC should analyze data periodically as planned.
- CCHP and both DHP projects should describe study limitations.
- SHP, Trilogy, WM, and all projects for MHS and NHP should take study limitations into consideration in analysis.
- DHP and both projects for Anthem should include interim data in the report.
- Both projects for DHP should include numerator and denominator data when presenting results.
- SHP and all projects for MHS and NHP should clearly present numerical results.

Real Improvement:

- *i*Care, SHP, MCHP, and all projects for CW and Trilogy should ensure initial and repeat measures are comparable.
- MCHP should consider changes to the HEDIS measure and any recommendations for the impact on comparability of results year to year.
- MCHP and WM should document a re-measurement rate for the project.
- Quartz, UHC, and both projects for Anthem should measure the effectiveness of the interventions.
- CCHP should continue to explore reasons for less than optimal performance of the interventions.

Sustained Improvement:

- DHP, MHWI, *i*Care, SHP, CCHP-C4K, CCF each had one project with documented, quantitative improvement in process or outcomes of care. All seven organizations should continue to sustain the level of improvement that has been achieved.

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. Please refer to Appendix 2 for additional information regarding the three-year review cycle.

The mandatory compliance with standards review activity evaluates policies, procedures, and practices which affect the quality and timeliness of care and services MCO/SMCP, PIHP members receive, as well as members' access to services. MetaStar conducts the review using the CMS guide, *EQR Protocol 3: Review of Compliance with Medicaid and CHIP Managed Regulations*.

For more information about the review protocols and methodology, see Appendix 2. No organization was due for a compliance with standards review during CY 2020 due to the three-year cycle of reviews; therefore, this report does not detail a compliance with standards review for any organization.

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. No organization was due for an ISCA review during CY 2020 due to the three-year cycle of reviews; therefore, this report does not detail an ISCA review for any organization.

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

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.

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
CW	100
GHC-EC	100
*i*Care	100
MHS	100
MHWI	100
NHP	100
UHC	100

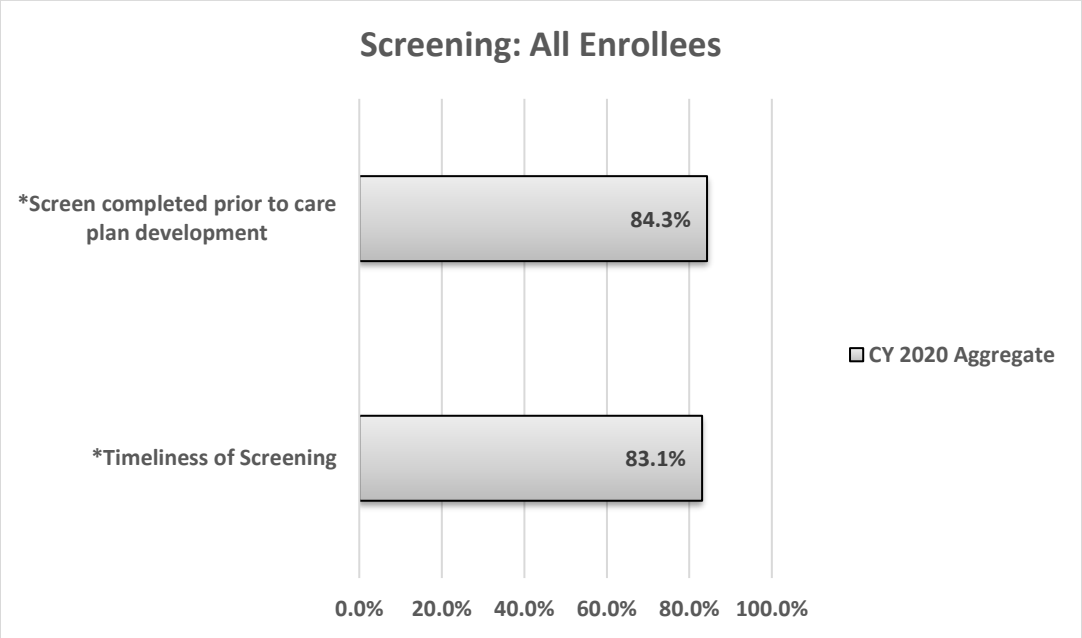
Results for each CMR Focus Area

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 2020 results for each indicator that comprises the category. CY 2019 results are provided for comparison.

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.

The following graph displays the aggregate MCO rate at which the standards were met in CY 2020. This indicator includes both new members who enrolled during CY 2019 and ongoing members who enrolled prior to the review period. During the prior review these indicators were evaluated for only new enrollees; therefore, results are not comparable.

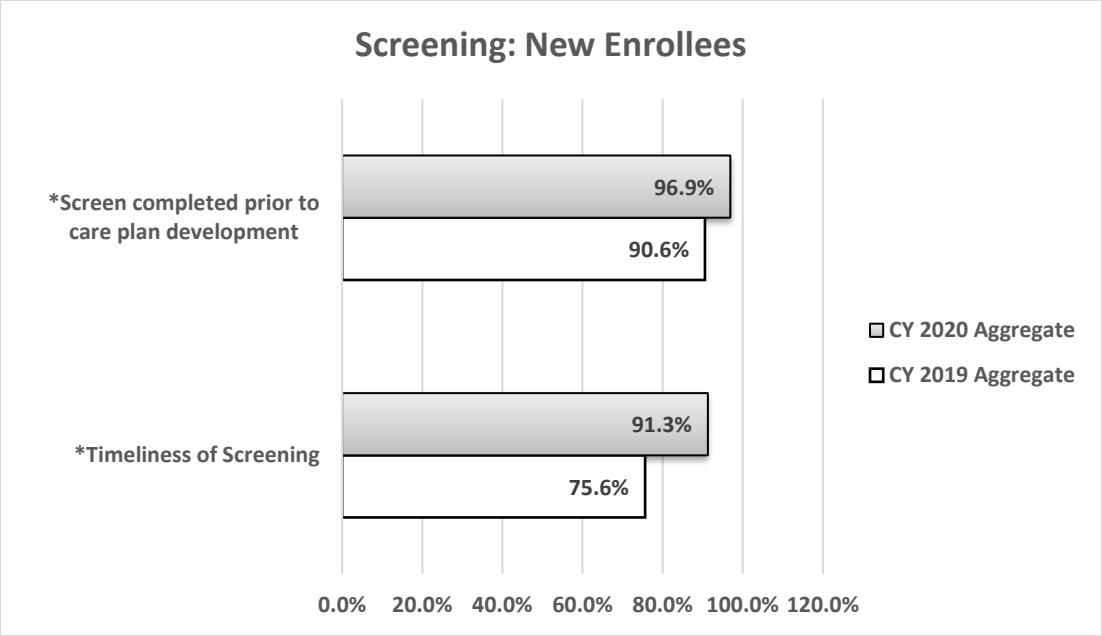


*Note: The review indicators *Screen completed prior to care plan development* and *Timeliness of Screening a*pplied to 765 of 800 records in CY 2020.

The MCOs consistently completed new enrollee screenings within the required timeframes and prior to creating a care plan. However, the results indicate that these processes may not be as strong for continuing enrollees as the rates decline from approximately 94 percent for new enrollees to just under 84 percent for all enrollees in both timeliness and completion prior to the care plan.

The following graph displays the aggregate MCO rate at which the standards were met for new enrollees in CY 2020 and CY 2019.

Analysis indicated the year-to-year difference in the new enrollee screening completed prior to the care plan rates and timeliness of the screening rates is likely attributable to actions of the MCOs, and is unlikely to be the result of normal variation or chance.



*Note: The review indicators *Screen completed prior to care plan development* and *Timeliness of Screening* applied to 120 of 800 records in CY 2020 and 381 of 800 records in CY 2019.

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 change and engagement;
- 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 87.8 percent of care plans telephonically, 6.8 percent were completed in-person, and none were completed via interactive video. Five percent did not identify the mechanism used to complete the care plan.

Almost 88 percent of the records had a care plan developed with the member. Thirty-three records were excluded from the denominator because the member disenrolled before the end of the calendar year. Of the records scored not met under care plan development:

- Almost 58 percent did not contain evidence that the care plan was shared with the member; and

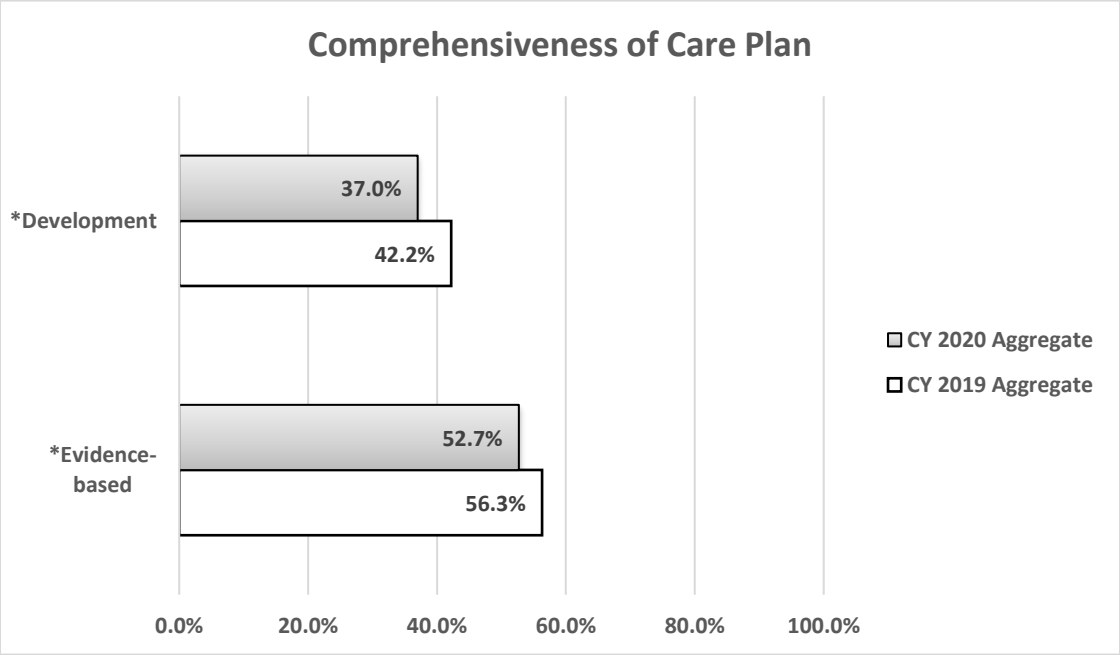
- Eighty-three percent did not contain evidence that the care plan was shared with the primary care provider (PCP) as required.

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

- Fifty-nine percent did not contain prioritized goals;
- Thirty-seven percent did not include goals that addressed the members' needs;
- Thirty-nine percent did not include goals to address gaps in care; and
- Thirty-five percent did not include chronic conditions or acute illnesses.

The following graph compares the aggregate MCO rate at which the standards were met in CY 2020 and CY 2019.

Analysis indicated the year-to-year difference in the development rates is unlikely to be the result of normal variation or chance. However, the year-to-year difference in the evidence-based rates is likely due to normal variation or chance.



*Note: The review indicator *Development* applied to 767 of 800 records in CY 2020, and 771 of 800 records in CY 2019. The review indicator *Evidence-based* applied to 767 of 800 records in CY 2020 and 772 of 800 records in CY 2019.

Care Management Service Delivery (Follow-Up)

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

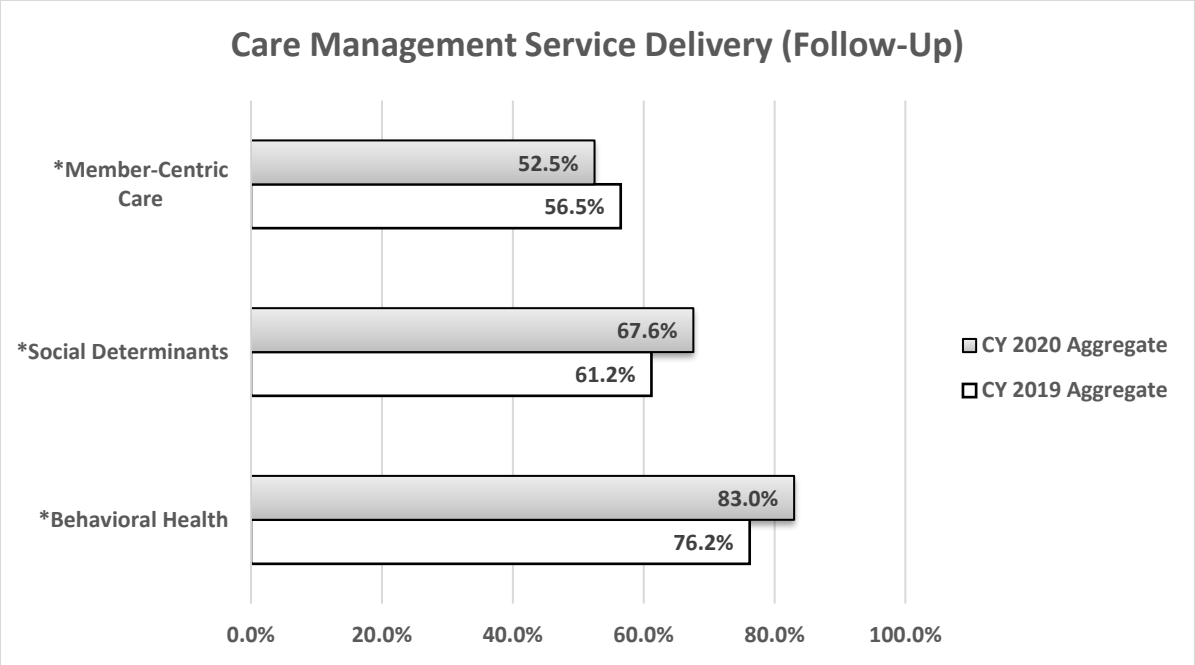
- Regularly assess a member's readiness to change and engagement;
- Assess if the member's needs are being addressed according to the member; and
- Occur as frequently as needed to meet the member's needs.

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 53 percent of the records had evidence of follow-up activities. Of the remaining records that did not meet the requirement, 88 percent did not indicate regular follow-up aligned with the MCOs' policies occurred. Social determinant issues or concerns were identified for 67.6 percent of members during screening, but follow-up activities for 32.4 percent of these members were not documented. Almost 70 percent of members' records indicated behavioral health needs; however, 17 percent did not contain evidence of follow-up.

The following graph compares the aggregate MCO rate at which the standards were met in CY 2020 and CY 2019.

Analysis indicated the year-to-year difference in the behavioral health rates is likely attributable to actions of the MCOs, and is unlikely to be the result of normal variation or chance. The year-to-year difference in the member-centric and social determinants rates is likely due to normal variation or chance.



*Note: The review indicator *Member-Centric Care* applied to 798 of 800 records in CY 2020 and all 800 records in CY 2019. The review indicator *Social Determinants* applied to 374 of 800 records in CY 2020 and 441 of 800 records in CY 2019. The review indicator *Behavioral Health* applied to 559 of 800 records in CY 2020 and 606 of 800 records in CY 2019.

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 restratified after a critical event occurs. Changing needs may include:

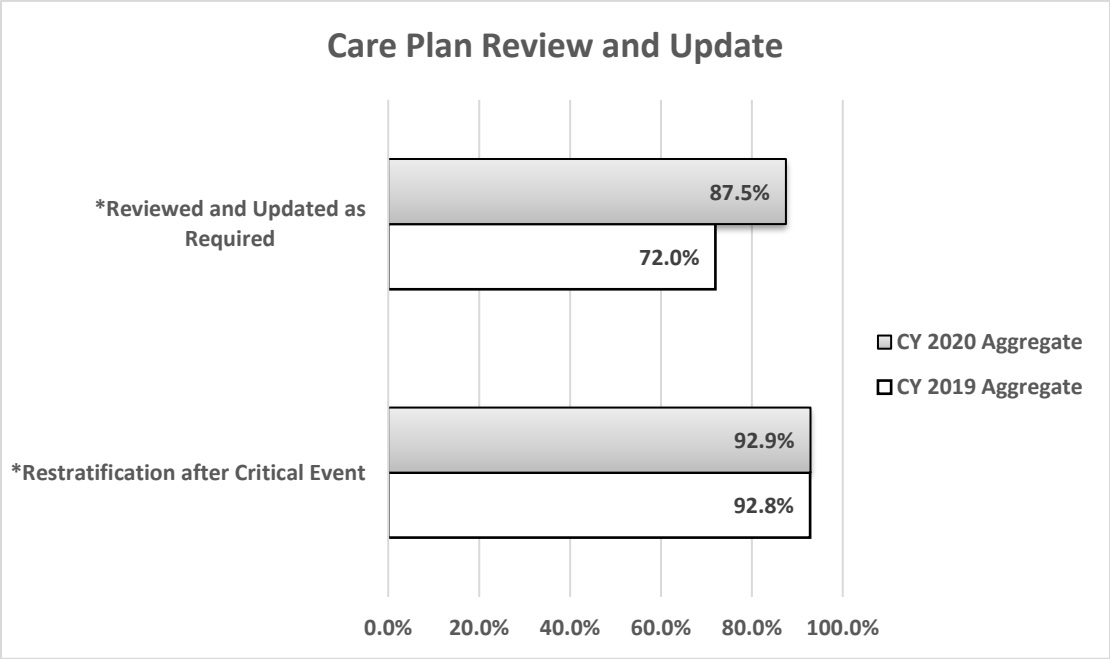
- Significant changes to medical and/or behavioral health needs;
- Changes in needs strata;
- Member non-responsiveness to the care plan;
- Frequent transitions between care settings; and
- Member request or identification of a problem/gap not previously addressed.

Care plan review and update applied to 80.1 percent of records. Of those, 87.5 percent 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, 97.5 percent did not contain evidence of an annual review and update.

Restratification after a critical event applied to 19.2 percent of records. Seven percent of those records did not include evidence of restratification.

The following graph compares the aggregate MCO rate at which the standards were met in CY 2020 and CY 2019.

Analysis indicated the year-to-year difference in the care plan review rates is likely attributable to actions of the MCOs, and is unlikely to be the result of normal variation or chance. The year-to-year difference in the restratification rates is likely due to normal variation or chance.



*Note: The review indicator *Reviewed and Updated as Required* applied to 641 of 800 records in CY 2020 and 543 of 800 records in CY 2019. The review indicator *Restratification after Critical Event* applied to 154 of 800 records in CY 2020 and 139 of 800 records in CY 2019.

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 confirming the hospital completed);
- Reviewing discharge information with the member; and
- Providing assistance with scheduling follow-up appointments.

Please note that this indicator is scored on a per record basis. This means, for example, if a record identifies that three hospitalizations occurred, and the transitional care follow-up is not documented after one of the three hospitalizations, the indicator would be scored as *not met*. This result is represented in the graph on the following page. MetaStar also collects and provides information to DHS and the MCOs about the total number of hospitalizations and how many

hospitalizations had documented transitional care follow-up activities; however, this result is not represented in the graph.

The rate of compliance for documenting transitional care follow-up after a hospitalization *on a per record basis* was 31.9 percent. The rate of compliance for documenting transitional care follow-up after a hospitalization *in every instance* was 40.9 percent. During the prior review this indicator was only reported aggregately.

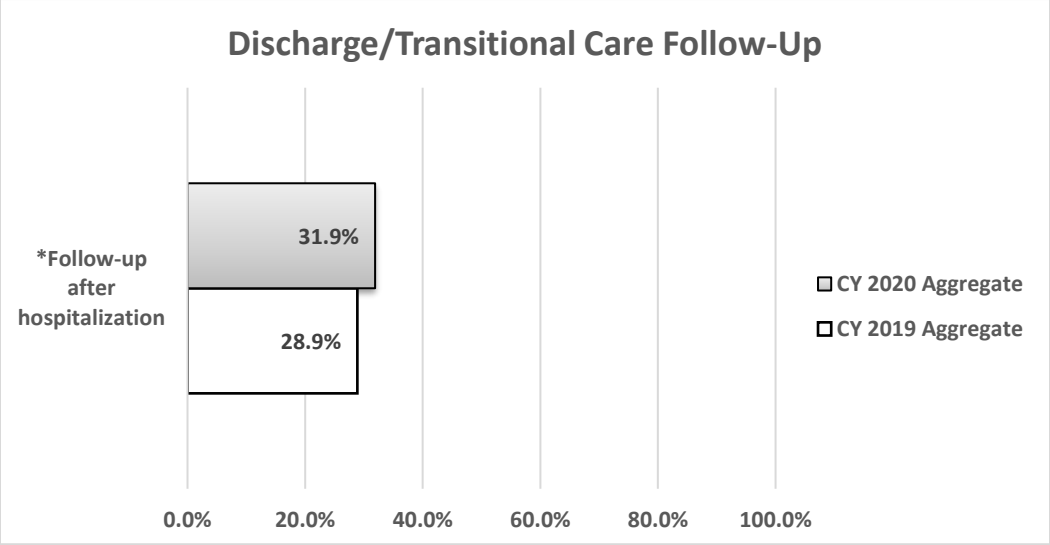
During the review period, 32.9 percent of members had at least one hospitalization during the review period requiring transitional care follow-up activities; however, 68.1 percent of those did not contain evidence of all required follow-up activities.

There were 575 total hospitalizations for 263 members. When follow-up activities were conducted, the MCOs completed 69.7 percent telephonically, 4.9 percent were completed in-person, and less than one percent were completed via interactive video. Of the records not meeting the requirement:

- 54.3 percent did not contain documentation of medication reconciliation completed by the hospital or the MCO; and
- 41.6 percent did not include documentation of a discharge instruction review.

The following graph compares the aggregate MCO rate at which the standards were met in CY 2020 and CY 2019.

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



*Note: The review indicator *Follow-up after hospitalization* applied to 263 of 800 records in CY 2020 and 211 of 800 records in CY 2019.

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. Documentation of the meeting must identify:

- Who on the WICT Core Team is conducting the meeting;
- Where the meetings took place; and
- The care plan need discussed during the meeting.

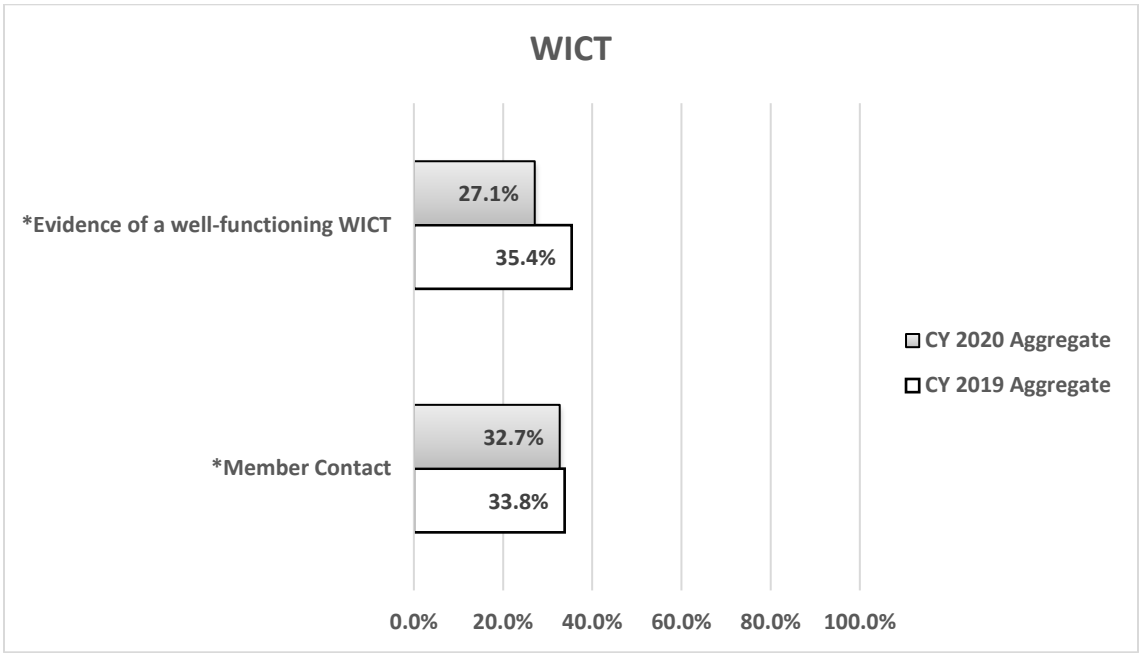
Please note that the face-to-face visit indicator is scored on a per record basis. This means, for example, if a record identifies that four face-to-face visits are required, and the visit requirements are not documented for one of the visits, the indicator would be scored as *not met*. This result is represented in the graph on the following page. MetaStar also collects and provides information to DHS and the MCOs about the total number of face-to-face visits and how many had met all visit requirements; however, this result is not represented in the graph.

The rate of compliance for documenting monthly face-to-face visits *on a per record basis* was 32.7 percent. The rate of compliance for documenting face-to-face visit requirements *in every instance* was 53.0 percent. During the prior review this indicator was only reported aggregately.

Nineteen percent of members received WICT care management services during the review period. Of those, 72.9 percent did not contain evidence of a well-functioning WICT and 67.3 percent of applicable WICT records did not contain evidence of all required face-to-face contact during WICT participation as required. Twenty-eight percent were scored as *not applicable* for face-to-face visits because WICT participation was less than a calendar month.

The following graph compares the aggregate MCO rate at which the standards were met in CY 2020 and CY 2019.

Analysis indicated the year-to-year difference in the WICT function and member contact rates is likely due to normal variation or chance.



*Note: The review indicator *Evidence of a well-functioning WICT* applied to 155 of 800 records in CY 2020 and 130 of 800 records in CY 2019. The review indicator *Member Contact* applied to 113 of 800 records in CY 2020 and 130 of 800 records in CY 2019.

ANALYSIS

Timely screenings were identified in over 90 percent of records for two MCOs. An additional five MCOs met the requirement in more than 80 percent of records. One MCO met the requirement in less than half of the records reviewed. When examining only new enrollees, the rate at which standards were met improved. Two MCOs demonstrated 100 percent completion rates for timeliness of screenings for new enrollees. Three other MCOs met the requirement in more than 90 percent of the records reviewed. No MCO was under 80 percent in this standard.

Evidence-based care plans were identified in more than 80 percent of the records for two MCOs. However, three MCOs met this requirement in less than 50 percent of the records.

Follow-up activities were documented in 80 percent of records for one MCO. 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 two MCOs and less than 60 percent of the records for three other MCOs. All MCOs documented follow-up for behavioral health needs in more than 60 percent of the records, with documentation found in more than 80 percent of records for five MCOs.

Five MCOs met the annual care plan update requirements in more than 95 percent of the records. One MCO met the requirements in just over half of the records.

Restratification after a critical event was the strongest indicator with two MCOs meeting the requirement in all of the applicable records and three over 90 percent. However, follow-up after hospitalization, including medication reconciliation, was found in less than 35 percent of the applicable records for half of the MCOs. No MCOs met the follow-up requirements in more than 55 percent of the applicable records.

Only one MCO met the WICT requirements for team function in more than 60 percent of the applicable records. One MCO met the requirements in 45 percent of the records. Six MCOs met the requirements in less than 30 percent of the applicable records. The WICT requirement for member contacts was met in at least half of the records for three MCOs. Three MCOs demonstrated compliance in less than 30 percent of the applicable records. One of the three did not meet the requirement in any of the records reviewed.

CONCLUSIONS

The MCOs have the systems, policies, and processes in place to meet the SSI care management requirements. Analysis indicates that conducting the screening prior to creation of the care plan for new enrollees is the area of highest compliance for the MCOs, followed by restratification after a critical event, and timeliness of the new enrollee screening. The WICT team function has the greatest opportunity for improvement with an aggregate rate of only 27.1 percent. Follow-up after hospitalization and WICT member contact requirements are additional areas for improvement with aggregate compliance rates of 31.9 and 32.7 percent respectively.

Progress

- Since the previous review, the MCOs aggregately demonstrated improvement in the completion of the initial screening prior to care plan development and within the required timeframes.
- Improvements were documented for ensuring social determinant and behavioral health needs were addressed when identified.
- The MCOs aggregately demonstrated improvement in the completion of care plan review and update as required.
- Restratification after a critical event demonstrated a slight increase aggregately year-to-year.

Strengths

- Anthem, CW, MHS, Molina, and UHC had processes in place to complete the screening prior to development of the care plan for new enrollees.

- *i*Care had processes in place to complete the screening prior to care plan development for continuing enrollees.
- GHC-EC and NHP had processes in place to complete the screening prior to development of the care plan for nearly all members in the review period.
- Anthem and MHS had processes in place to complete almost all screenings timely for new enrollees.
- GHC-EC and *i*Care had processes in place to complete timely screenings for new and continuing enrollees.
- GHC-EC, *i*Care, Molina, and UHC consistently ensured behavioral health needs were addressed and follow-up activities were conducted.
- Anthem, GHC-EC, *i*Care, Molina, and UHC had processes and practices in place to ensure care plans were reviewed and updated as required.
- Anthem, GHC-EC, *i*Care, MHS, NHP, and UHC consistently completed restratification after identified critical events.

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 and align with the state's quality strategy.

- DHS should ensure efforts continue to support the MCOs with building and maintaining provider networks to meet the behavioral health needs of the SSI membership.
- DHS should continue efforts to reduce health disparities and improve engagement for members' care and experience.
- DHS should consider increased monitoring of post-discharge follow-up and use of the WICT level of service to help mitigate potentially preventable rehospitalizations and improve cost control.

MetaStar recommended the MCOs conduct root cause analyses to identify the barriers to success in meeting the SSI Care Management requirements. As interventions are identified, use PDSA cycles of improvement to measure the effectiveness of each intervention. The recommended focus areas for improvement include:

- CW and GHC-EC should increase documentation of member agreement with the care plan.
- CW, GHC-EC, MHS, and NHP should ensure care plans are shared with the member and PCP as required.
- Anthem, CW, GHC-EC, and MHS need to ensure care plans are evidence-based and address the member's needs, including goals and interventions for each identified need.

- MHS and NHP should ensure care managers confirm member needs are being met according to the member.
- MHS, NHP, and UHC should increase documented outreach attempts to ensure efforts align with the MCO's identified contact requirements for each stratification level.
- Anthem, CW, *i*Care, MHS, Molina, NHP, and UHC should conduct and document post-hospitalization follow-up that includes all required activities.
- GHC-EC, *i*Care, MHS, NHP, and UHC need to complete weekly core team meetings and documenting evidence of collaboration between core WICT team members.
- Anthem, CW, GHC-EC, *i*Care, Molina, and UHC need to complete face-to-face member contacts as required for the highest needs (WICT) members.

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 key CMR category, followed by bar graphs which display CY 2020 results for each indicator that comprises the category. CY 2019 results are provided for comparison.

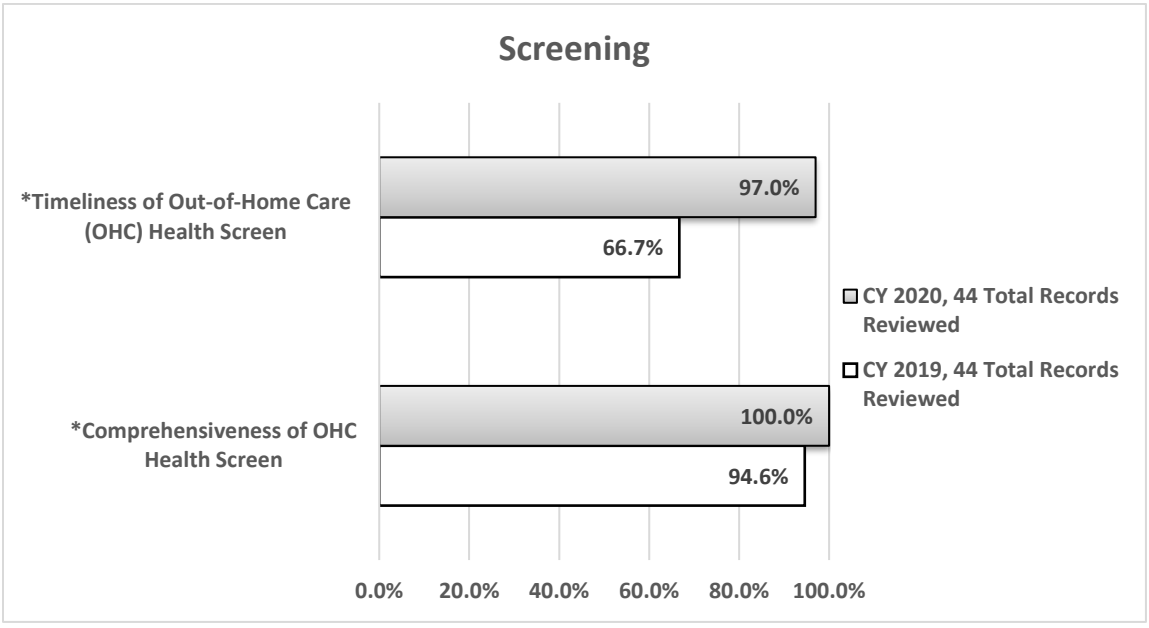
The review period included the declaration of the COVID-19 public health emergency (PHE) and Wisconsin's *Safer at Home* order. Exemptions to some program requirements were granted by DHS due to the PHE, and are described in the following sections.

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.

Twenty-five percent of children were exempt from the OHC Health Screen. They were exempt either because a forensic exam was conducted after removal from the home, or because the children were removed directly from the hospital after birth. Seventy-three percent of children had OHC Health Screens completed timely. OHC Health Screen completion extensions were found in 43.2 percent of records. One member did not receive an OHC Health Screen. All completed screens were comprehensive.

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. However, the year-to-year difference in the comprehensiveness rates is likely due to normal variation or chance.



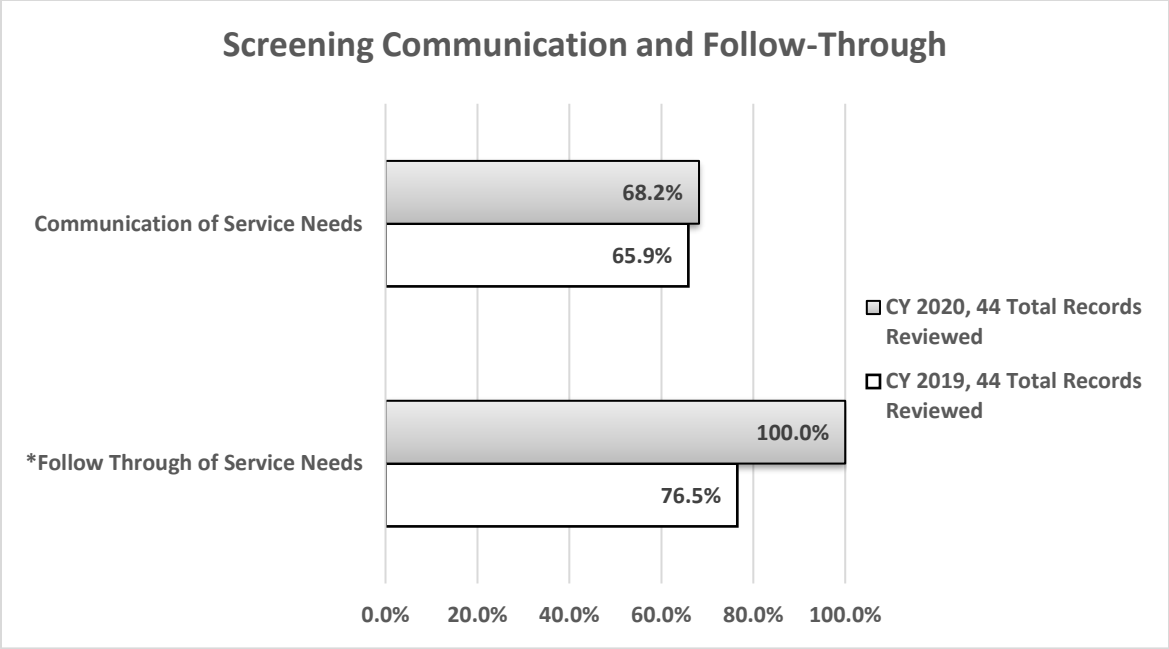
*Note: The review indicators *Timeliness of Out-of-Home Care (OHC) Health Screen* and *Comprehensiveness of OHC Health Screen* applied to 33 of 44 records for CY 2020 and 36 of 44 records for CY 2019.

The communication of needs identified in the OHC Health Screen increased in CY 2020 to 68.2 percent. In 46.7 percent of the records that did not meet the requirements, documentation indicated that primary reason was due to not sharing the information 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. Ninety-three percent of records did not identify any immediate or emergent needs. All of the remaining records included evidence of the required follow-through to address the needs. Immediate needs identified included weight concerns, mental health medication refills, and continued treatment for withdrawal symptoms.

The following graph compares the PIHP's rate at which the standards for communication and follow-through of service needs were met in CY 2020 and CY 2019.

Analysis indicated the year-to-year difference in the communication and follow-through rates is likely due to normal variation or chance.



*Note: The review indicator *Follow-Through of Service Needs* applied to 3 of 44 records for CY 2020 and 17 of 44 records for CY 2019.

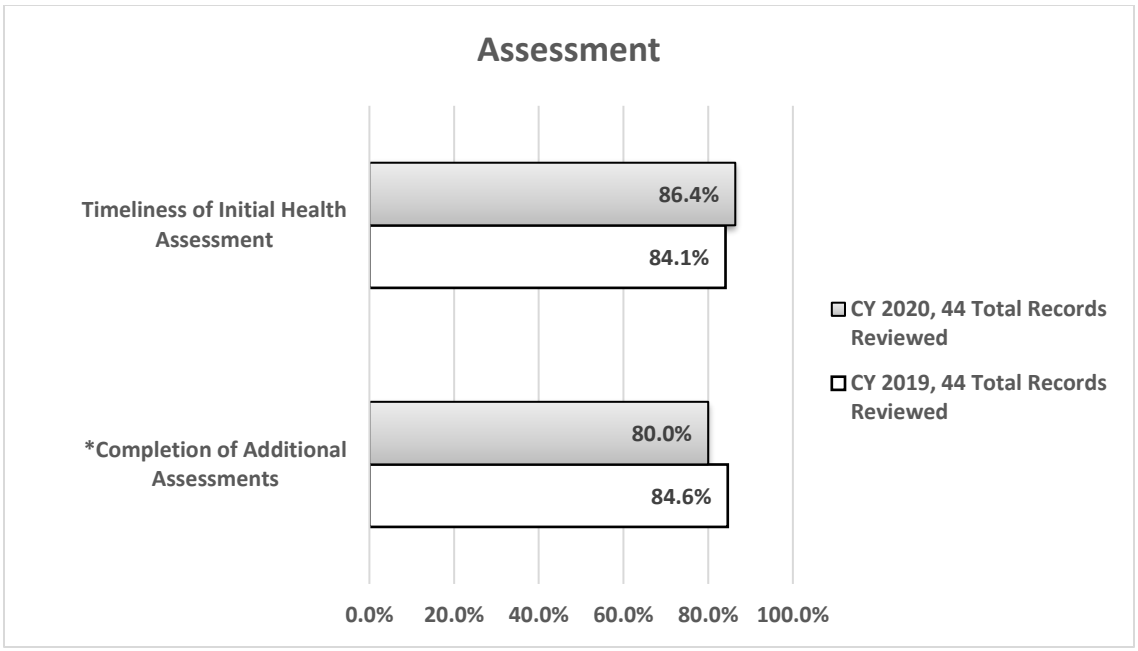
Assessment

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.

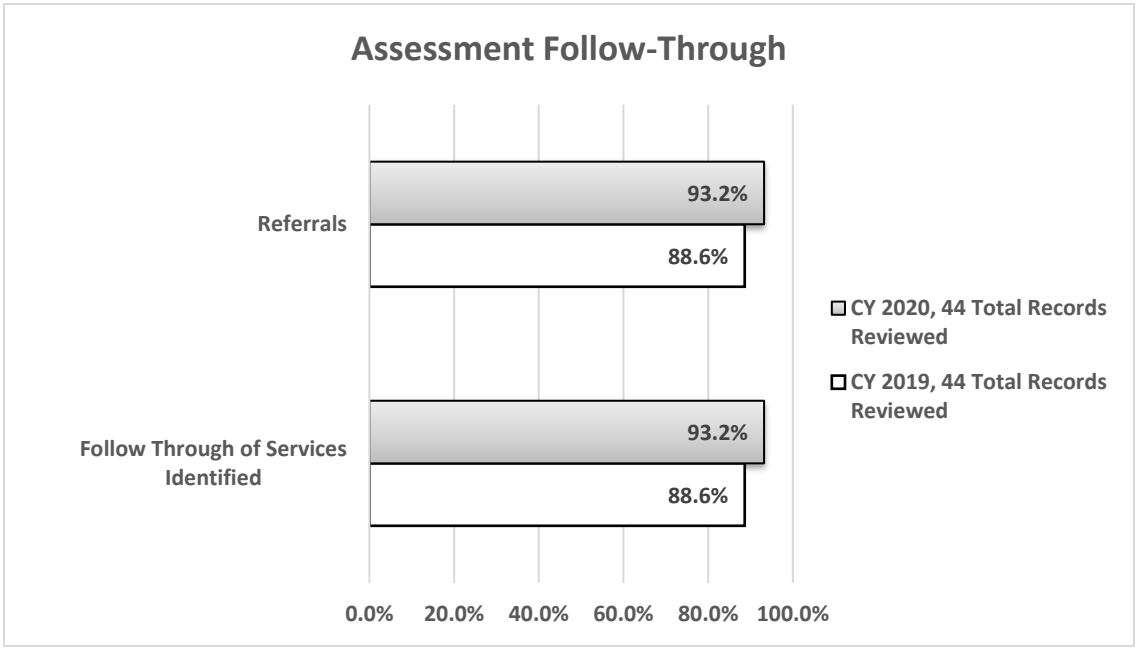
Eighty-six percent of records had a timely initial health assessment completed. Thirty-four percent identified additional assessments were needed. Of those, 80 percent contained evidence of the completion of additional assessments as indicated. Twenty percent needed mental health assessments, but they were not completed as parent or guardian consent could not be obtained. Documentation of referrals made and subsequent follow-through were found in 93.2 percent of the records.

The following graph compares the PIHP's rate at which the standards were met in CY 2020 and CY 2019.

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



*Note: The review indicator *Completion of Additional Assessments* applied to 15 of 44 records for CY 2020 and 13 of 44 records for CY 2019.



Care Planning

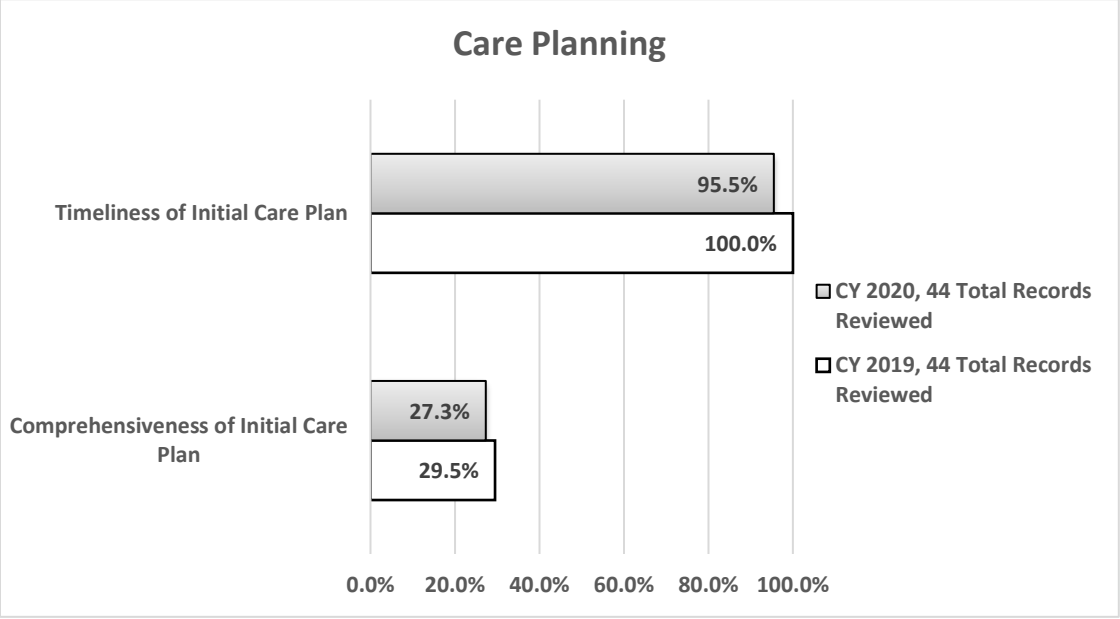
The care plan must identify the services and supports to be coordinated consistent with information in the initial comprehensive assessment; and must be developed and updated according to the timelines and conditions described in the DHS-FCMH contract.

Ninety-five percent of care plans were completed timely. Of the records reviewed, 72.7 percent did not meet the requirements for comprehensiveness of the initial care plan. The contributing factors identified by reviewers included:

- When OHC Health Screens, initial health assessments, or mental health or developmental screens were not completed, or the medical records were not available at the time of the care plan, that information could not be included in the initial care plan as required;
- There was no evidence of parent/legal guardian input, review, and sign off of the care plan; and
- Short- or long-term treatment goals were missing from the care plan.

The following graph compares the PIHP's rate at which the standards were met in CY 2020 and CY 2019. The comprehensiveness rate reflects the rate of comprehension of the care plan regardless of timeliness.

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



Care Coordination

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.

Eighty-six percent of the records reviewed contained documentation of care coordination to address all of the member's identified needs. Fourteen percent did not document coordination or follow-up for all needs. There was evidence missing in the following areas:

- Ongoing collaboration and communication with the child welfare worker;
- Collaboration regarding child welfare goals/permanency plan; and
- Other reasons not listed.

The record must contain documentation of regular monitoring to identify changes in the child's health care status, prioritize the child's health care needs and the services necessary to address or further assess the needs, and ensure that acute needs are addressed in a timely manner.

Evidence of prioritizing identified needs was found in all records. Forty records contained evidence of monitoring and responding to ongoing or emerging needs as required. Ninety-one percent of records did not complete coordination and follow-up for all identified needs.

Records should contain evidence of care coordination to address all of the child's identified needs. Both ongoing and emergent needs must have a documented plan for addressing each need, and identify a team member responsible for each need. The services and supports must be coordinated in a reasonable amount of time. The records must also document that timely follow-up is conducted to ensure services are received and effective to meet the identified needs. Coordination and follow-up after change in placement, guardianship, or permanency plan was identified in all records. All records also contained evidence of required follow-up activities.

The care plan must be reviewed and updated at minimum every six months, and when the child has a significant change in situation or condition (e.g., the child has a hospitalization, a change in placement, is diagnosed with a new chronic condition, etc.). Care plans were updated as required during the review period in 75 percent of records. Although the Initial HealthCheck was granted an extension up to 90 days from enrollment, the initial care plan was still required to be completed within the first 60 days of enrollment. Of those scored as not met, 72.7 percent were not updated to include the information from the Initial HealthCheck exam.

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 84 percent of the records reviewed.

Almost 16 percent of records indicated a need for transitional health care planning during the review period. Transitioning health care providers, engaging or disengaging parents, and the mechanism for notifying child welfare was found in 57 percent of records that required transition planning. The need for a separate transitional plan and evidence of clear communication prior to disenrollment applied to nine percent of all records, and this information was missing in all of these records.

Analysis

Although the FCMH demonstrated continued improvement for six indicators in four categories over the last two years, several areas demonstrated a decline in CY 2020 from CY 2019. The following areas demonstrated a decline:

- Completion of additional assessments;
- Timely and comprehensive initial care plans;
- Documentation of monitoring activity completion;
- Evidence of collaboration with the child welfare worker or others;
- Care plan reviews and updates; and
- Transitional health planning.

As described further in the following section, these rates may have been impacted by the COVID-19 PHE.

Conclusions

The review period included the declaration of the COVID-19 PHE and Wisconsin's *Safer at Home* order. Exemptions to some program requirements were granted by DHS due to the PHE. A virtual (telehealth) format was permitted for both OHC Health Screens and Initial HealthCheck exams beginning in March 2020. OHC Health Screens could be postponed beyond the two business days as needed. The Initial HealthCheck exam requirement was extended from within 30 days of enrollment to within 90 days of enrollment. Seventy percent of the children in the sample enrolled immediately prior to or during the PHE. OHC Health Screens and Initial HealthCheck exam extensions were found in 61.2 and 51.6 of new enrollee records respectively. During the *Safer at Home* order, all routine dental visits were considered nonessential and cancelled by the dental clinics. Routine visits resumed based on each dental clinic's reopening

plan. The requirements of the *Safer at Home* orders may be a contributing factor in the FCMH's results.

Progress

- Timeliness of the OHC Health Screen increased from 66.7 percent in CY 2019 to 97 percent in CY 2020
- Comprehensiveness of the OHC Health Screen increased in CY 2020, from 94.6 percent in CY 2019 to 100.0 percent.
- Communication of the OHC Health Screen results increased from 65.9 percent in CY 2019 to 68.2 percent in CY 2020.
- Timeliness of the initial health assessment increased in CY 2020, from 84.1 percent in CY 2019 to 86.4 percent.
- Referral completion for services identified increased in CY 2020, from 88.6 percent in CY 2019 to 93.2 percent.
- Follow-through of services identified increased in CY 2020, from 88.6 percent in CY 2019 to 93.2 percent.
- Prioritization of needs increased from 42.9 percent in CY 2019 to 100.0 percent in CY 2020.
- Monitoring and responding emergent or ongoing needs increased from 42.9 percent in CY 2019 to 78.9 percent in CY 2020.

Strengths

The FCMH exhibited strengths in the following areas:

- Completion and comprehensiveness of the OHC Health Screen;
- Follow-through of service needs identified; and
- Timeliness of care planning.

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 FCMH provider to support program improvements and align with the state's quality strategy.

- DHS should continue efforts to reduce health disparities related to health care planning.

MetaStar recommended the FCMH conduct root cause analyses to identify the barriers to success in meeting the SSI Care Management requirements. As interventions are identified, use PDSA cycles of improvement to measure the effectiveness of each intervention. The recommended focus areas for improvement include:

- Completing care plan reviews and updates when indicated;
- Communicating the service needs identified in the OHC Health Screen to all required team members;
- Creating comprehensive care plans;
- Conducting all monitoring activities; and
- Completing transitional health care planning.

Care Management Review – Children with Medical Complexities

Children with Medical Complexities (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 13 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 aggregate CY 2020 results for each indicator that comprises the category. CY 2019 aggregate results are provided for comparison.

Eligibility

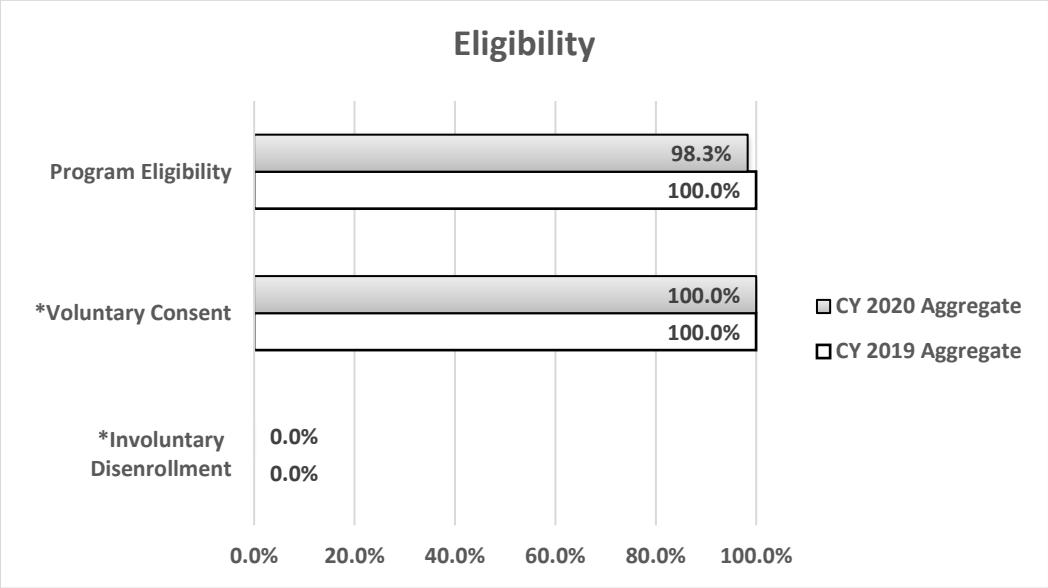
Members must meet all eligibility requirements as described in the *ForwardHealth Online Handbook*. The handbook includes alternate criteria for members too young to meet the utilization criteria.

Almost all records reviewed for both hospitals contained evidence that the members met the eligibility requirements. Eight percent of members were newly enrolled during the review period

and all records included documentation of voluntary consent to participate in the program. No members were involuntarily disenrolled during the review period; therefore, the *Involuntary Disenrollment* indicator was not applicable.

The following graph compares the aggregate rate at which the eligibility standards were met in CY 2020 and CY 2019.

Analysis indicated the year-to-year difference in the eligibility rates is likely due to normal variation or chance. There was no change in the voluntary consent rates year-to-year.



*Note: The review indicator *Voluntary Consent* applied to 5 of 60 records in CY 2020 and all 60 records in CY 2019. The review indicator *Involuntary Disenrollment* did not apply to any records in CY 2020 or CY 2019.

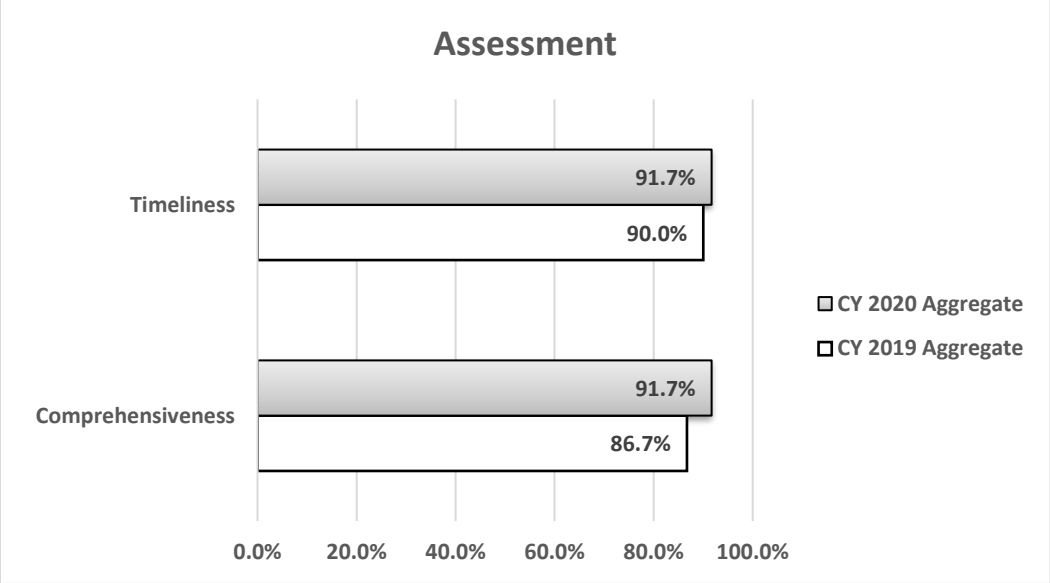
ASSESSMENT

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.

Completion of timely assessments were documented in 91.7 percent of records reviewed. The remaining records did not contain documentation of a completed assessment during the review period. More than half of those records indicated parent or guardian request for assessment appointments outside of the review period. All assessments completed were comprehensive.

The following graph compares the aggregate rate at which the standards were met in CY 2020 and CY 2019. The comprehensiveness rate reflects the rate of comprehension of the assessment regardless of timeliness.

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



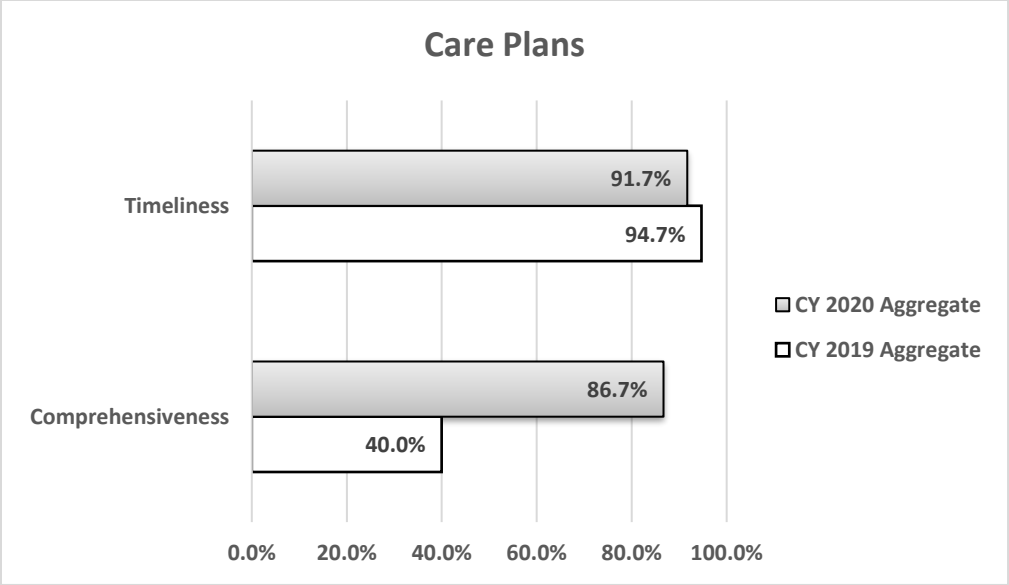
Care Planning

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*.

Although the timeliness of care plans declined from year-to-year, the comprehensiveness rates increased from 40.0 percent in CY 2019 to 86.7 percent in CY 2020.

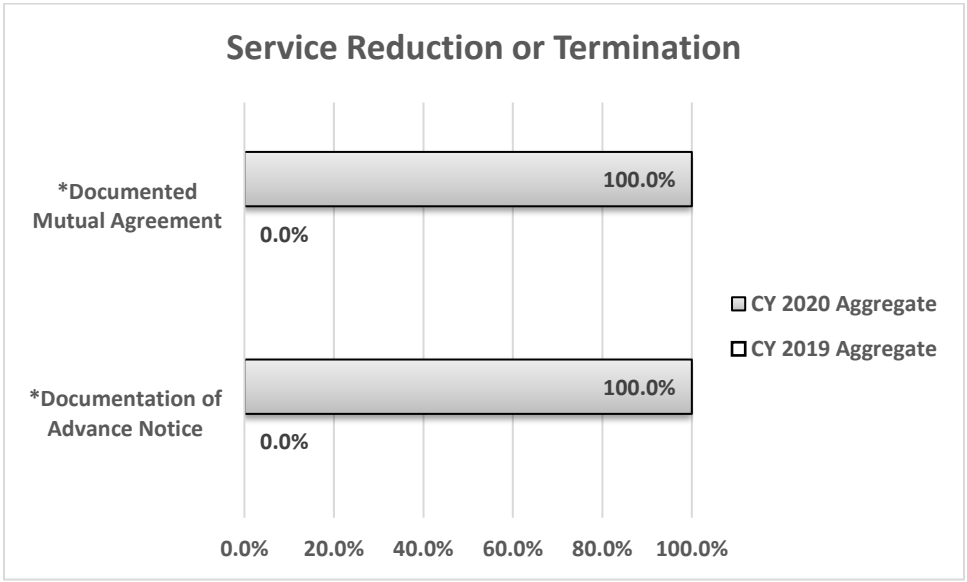
The following graph compares the aggregate rate at which the standards were met in CY 2020 and CY 2019. The comprehensiveness rate reflects the rate of comprehension of the care plan regardless of timeliness.

Analysis indicated the year-to-year difference in the comprehensiveness rates is likely attributable to actions of the hospitals, and is unlikely to be the result of normal variation or chance. However, the year-to-year difference in the timeliness rates is likely due to normal variation or chance.



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 applied to only one record in CY 2020 and it met all requirements for mutual agreement and advance notice provided.



*Note: The review indicators *Documented Mutual Agreement* and *Documentation of Advance Notice* applied to 1 of 60 records in CY 2020 and no records in CY 2019.

Monitoring and Service Coordination

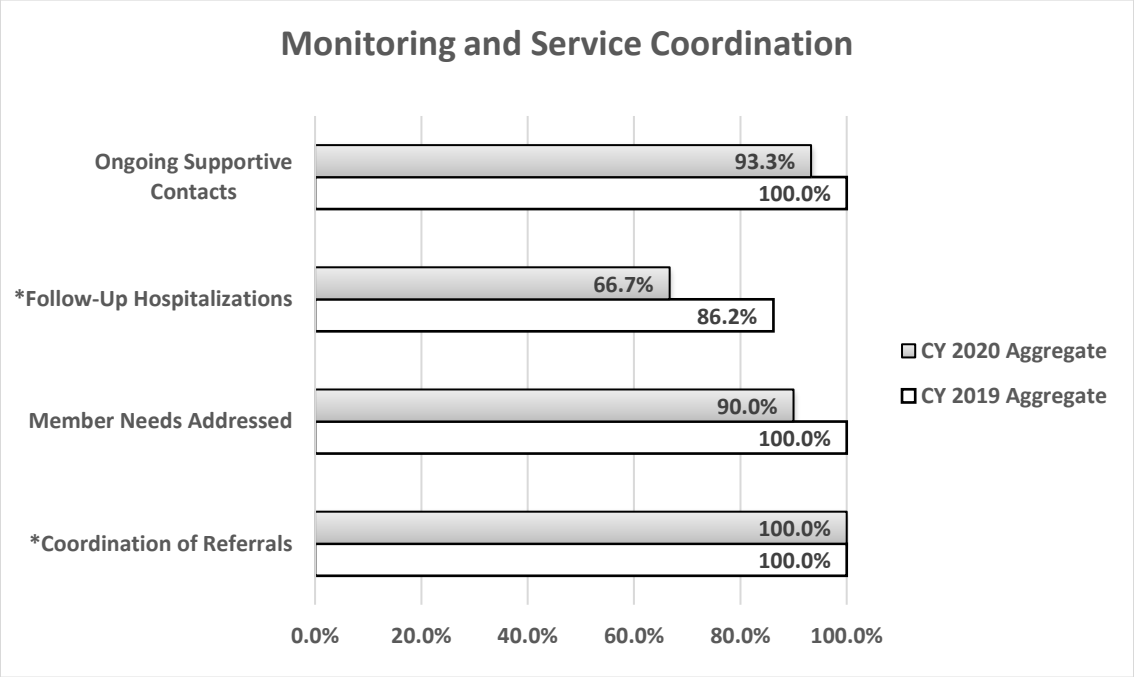
Care teams are required to conduct ongoing service coordination activities to ensure all identified needs are addressed. This includes ongoing supportive contacts, coordination of referrals and follow-up after hospitalization.

Ongoing supportive contacts were documented in 93.3 percent of records. Documentation demonstrating member needs were addressed was found in 90 percent of records.

Follow-up after hospitalization applied to 30 percent of the records. Of those, 66.7 percent met the requirement. The remaining records did not contain evidence of the required follow-up after hospitalization or contained evidence that follow-up was not timely.

Coordination of referrals applied to 33.3 percent of the records. Of those, all met the requirements. The remaining records did not indicate a referral was needed during the review period.

Analysis indicated the year-to-year difference in the ongoing supportive contacts and member needs addressed rates are unlikely to be the result of normal variation or chance. The year-to-year difference in the follow-up after hospitalizations rates are likely due to normal variation or chance. There was no change in the coordination of referrals rates year-to-year.



*Note: The review indicator *Follow-Up Hospitalizations* applied to 18 of 60 records in CY 2020 and 29 of 60 records in CY 2019. The review indicator *Coordination of Referrals* applied to 20 of 60 records in CY 2020 and 30 of 60 records in CY 2019.

Analysis

Both hospitals continue to provide high-contact care coordination to the CMC members. A nurse care coordinator/care coordinator assistant dyad model is used by both hospitals. The dyad assists families in scheduling complex care clinic appointments in conjunction with pediatric specialty clinic visits. This reduces the need for multiple visits to the same location and streamlines member care.

Conclusions

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

Progress

- Aggregately, the hospitals continued to meet the voluntary participation requirements for the benefit program.
- Since the previous review, the hospitals demonstrated improvement in both the timeliness and comprehensiveness of assessments.
- Improvement was demonstrated aggregately in the comprehensiveness of care plans.

Strengths

- Documentation indicated the care team members at AFCH maintained close contact with members and their families, routinely exceeding the amount of contact identified in the care plan.

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 providers to support program improvements and align with the state's quality strategy.

- DHS should continue efforts to reduce health disparities and improve engagement for members' care and experience.

MetaStar recommended both hospitals conduct root cause analyses to identify the barriers to success in meeting the CMC requirements. As interventions are identified, use PDSA cycles of improvement to measure the effectiveness of each intervention. The recommended focus areas for improvement include:

- Completing timely assessments and care plans;
- Documenting evidence of contacting members as frequently as required and assuring member needs are addressed; and

- Conducting and documenting post-hospitalization follow-up within the required timeframe.

Record Review – Childless Adults Health Needs Assessment

The BC+ childless adults (CLA) health needs assessment (HNA) review assesses a MCO's level of compliance with requirements contained in its contract with DHS and verifies that initial HNA data meets performance benchmarks. Information gathered during the CLA HNA review helps to assess the timeliness and comprehensiveness of the initial HNA for applicable members. In addition, MCOs are required to achieve the lesser of two targets, a 35 percent rate of compliance or a 10 percent reduction in error from the MCO's baseline, for timeliness of initial HNAs, to avoid a financial penalty. The CLA HNA review is an optional activity with a penalty provision. Beginning in CY 2020, an initial health screening was incorporated into the Medicaid enrollment process and this assessment was considered duplicative. As such, this was the final year of the CLA HNA review.

The CLA HNA review is an optional activity. MetaStar reviewed a total of 1,147 CY 2019 records across 14 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	75
DHP	77
GHC-EC	92
GHC-SCW	86
*i*Care	85
MCHP	31
MHS	95
MHWI	94
NHP	94
Quartz	89
SHP	81

Managed Care Organization	Number of Records
Trilogy	91
UHC	66
Total	1,147

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

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

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

Results for Initial HNA

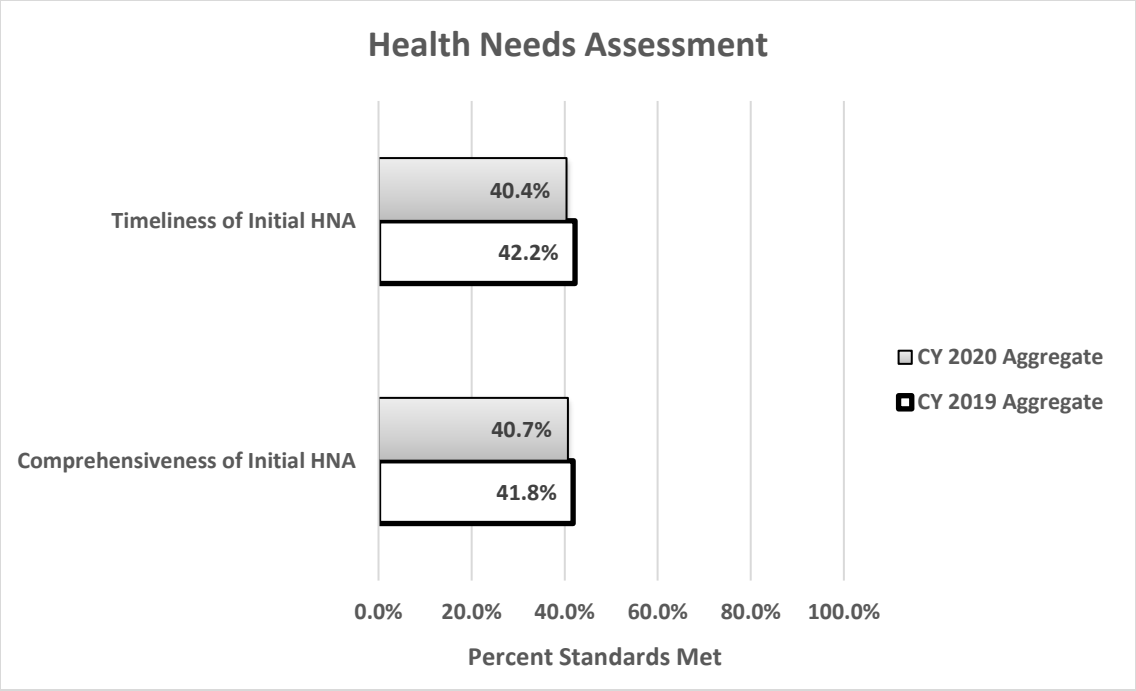
The section below provides a brief explanation of each indicator, followed by a bar graph. CY 2019 aggregate results are provided for comparison.

According to the DHS-MCO contract, MCOs are required 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.

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 aggregate rate of compliance achieved by the MCOs in CY 2020 for the timeliness and comprehensiveness of the initial HNA. The aggregate timeliness rate for all MCOs was 40.4 percent. Eight MCOs had timeliness scores less than the aggregate rate, while six MCOs had timeliness scores higher than the aggregate rate. Two MCOs had a timely completion rate of 50 percent or greater.

The rate of comprehensiveness of the initial HNA for all MCOs for this indicator was 40.7 percent. This rate reflects the rate of comprehensiveness of the HNA regardless of timeliness. Assessments not completed are included as not comprehensive. When assessments were completed, almost all of the assessment elements were addressed. Of the 467 assessments completed across all MCOs, 100 percent were comprehensive. Assessment of urgent medical and behavioral symptoms remained the assessment element that was most often not consistently addressed in both CY 2020 and CY 2019.



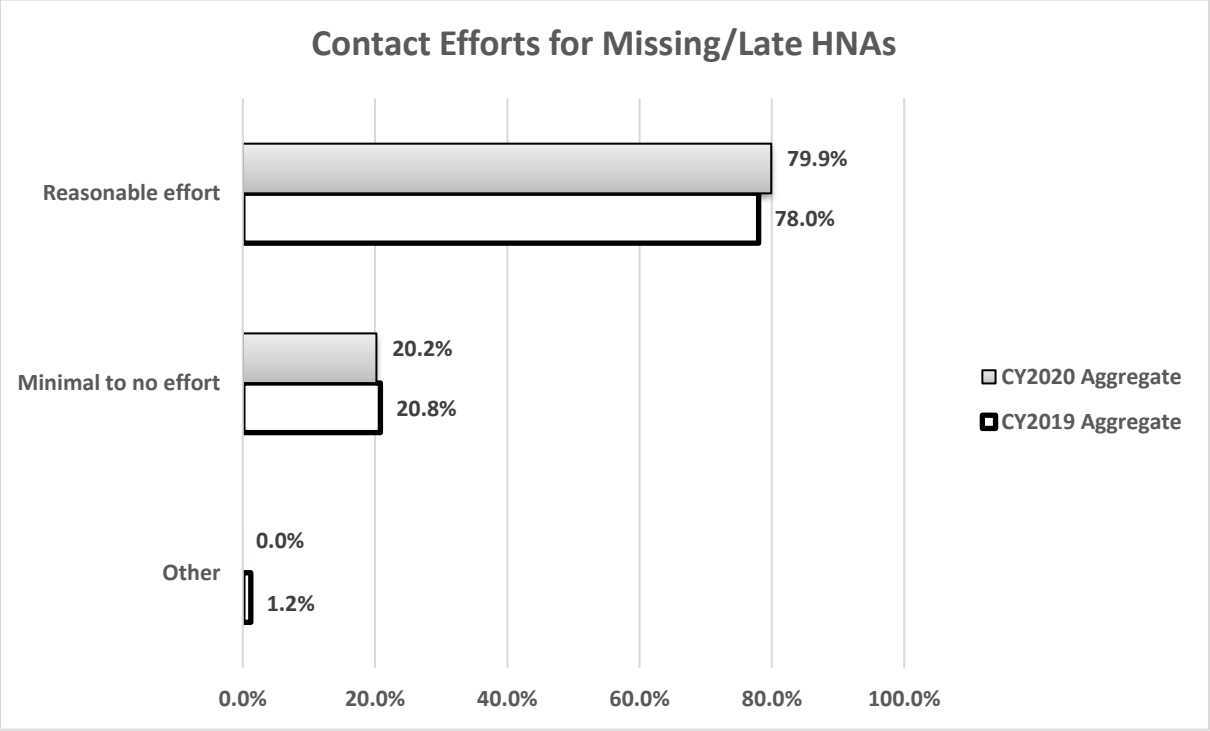
ANALYSIS

The penalty provision included in the DHS-MCO contract sets a requirement for MCOs to achieve a 35 percent rate for timelines or a 10 percent reduction in error from the MCO's baseline timeliness rate. Twelve MCOs had an aggregate rate for timeliness at or above the requirement, while two MCOs did not meet the benchmark (MHWI and Quartz).

DHS provides MCOs with member contact information at the time of enrollment. Less than five 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: 66.6 percent by telephone, 32.1 percent by mail, and one percent in person. Fifteen member outreach attempts (0.3 percent) were completed using a Web tool. Outreach attempts by telephone included the use of automated call systems by five MCOs (UHC, SHP, Anthem, MHS, and NHP). One MCO utilized an automated call system which was noted to have some limitations in contacting members (SHP).

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, two MCOs did not. Improvement was noted in *Timeliness of Initial HNA Completion* as compared to the prior year for 50 percent of the MCOs. 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.

Twenty percent of records in which the HNA was not completed or completed late demonstrated minimal or no effort to contact the member in CY 2020; this compares to almost 21 percent in CY 2019. Almost all MCOs were recommended to identify and address barriers related to member engagement. Four MCOs demonstrated the highest incidence of minimal or no contact attempts with rates ranging from 26 percent to 95 percent (Quartz 95.2 percent, *i*Care 53.2 percent, Anthem 37.8 percent, and UHC 26.2 percent).



CONCLUSIONS

Two MCOs had HNA completion rates of 50 percent of higher (Anthem and GHC-EC). While 12 MCOs met the HNA completion target rate for CY 2020, five MCOs showed a reduction in timeliness of the HNA as compared to the baseline (DHP, GHC-SCW, MHS, NHP and Trilogy). However, the reduction was not great enough to impose the penalty provision. Two MCOs (MHWI and Quartz) showed a large enough reduction in timeliness as compared to the baseline to impose the penalty provision.

Significant improvement in MCOs' ability to contact members to complete the HNA has not occurred. Some MCOs have greater success in contacting members to complete the HNA than others. Inaccurate member contact information on the DHS enrollment file was not a significant barrier to contacting members; however, completing or documenting adequate efforts to contact

members within the first 60 days remains a barrier. Four MCOs had a greater number of cases reflecting inadequate attempts to contact members as compared to other MCOs.

Progress

- Fifty percent of MCOs improved the rate of HNA completion and comprehensiveness in CY 2020 as compared to CY 2019.

Strengths

- CCHP implemented changes to its outreach process in an attempt to provide more options for members to complete the HNA. Using multiple methods to complete the HNA could lead to a higher HNA completion rate. This MCO also had no incidents of inadequate attempts to contact members to complete the HNA.
- CCHP and MCHP provide a small monetary incentive to members who complete the HNA.

Opportunities for Improvement

As a result of its review, MetaStar identified the following opportunities. For each area of opportunity, the review team provided related recommendations to DHS and the MCOs to support improvements and align with the state's quality strategy.

- DHS should continue efforts to reduce health disparities and provide consistent initial health screening information of new enrollees to the MCOs.
- All MCOs except CCHP received recommendations to identify and address barriers to member engagement.
- CCHP, Quartz, and UHC should ensure new members' urgent medical and behavioral needs are identified and can be addressed.
- *i*Care and MHWI should ensure member outreach practices align with established policies and procedures to ensure timely contact efforts occur.
- MCHP, MHS, and NHP should explore and implement alternate methods of member outreach. In addition, MCHP should perform a root cause analysis to identify barriers affecting identification of newly enrolled members requiring an initial HNA.
- SHP should consider outreach limitations posed by its automated call system used to engage members in completion of the HNA, and implement strategies to overcome the barriers.

APPENDIX 1 – LIST OF ACRONYMS

AAAHC	Accreditation Association for Ambulatory Health Care
ADV	Annual Dental Visit
ACE	Adverse Childhood Experiences
AFCH	UW Health – American Family Children's Hospital
AMM	Antidepressant Medication Management
Anthem	Anthem Blue Cross and Blue Shield Health Plan
BC+	BadgerCare Plus
BCS	Breast Cancer Screening
CBP	Controlling Blood Pressure
CCF	Children Come First
CCHP	Children's Community Health Plan, Inc.
CDC	Comprehensive Diabetes Care
CFR	Code of Federal Regulations
CHW	Children's Hospital of Wisconsin
CIS	Childhood Immunization Status
CLA	Childless Adults
CMC	Children with Medical Complexities
CMR	Care Management Review
CMS	Centers for Medicare & Medicaid Services
COVID-19	Coronavirus Disease 2019
CW	Care Wisconsin, Managed Care Organization
CY	Calendar Year
DHP	Dean Health Plan, Inc.
DHS	Wisconsin Department of Health Services
EQR	External Quality Review
EQRO	External Quality Review Organization
FCMH	Foster Care Medical Home
FUH	Follow-Up After Hospitalization for Mental Illness

GHC-EC	Group Health Cooperative of Eau Claire
GHC-SCW	Group Health Cooperative of South Central Wisconsin
HbA1c	Hemoglobin A1c
HEDIS[3]	Healthcare Effectiveness Data and Information Set
HIV	Human Immunodeficiency Virus
HNA	Health Needs Assessment
*i*Care	Independent Care Health Plan
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
ISCA	Information Systems Capabilities Assessment
LSC	Lead Screening in Children
MCHP	MercyCare Health Plans
MCO	Managed Care Organization
MEDDIC-MS	Medicaid Encounter Data Driven Improvement Core Measure Set
MHS	MHS Health Wisconsin
MHWI	Molina Healthcare of Wisconsin
MY	Measurement Year
NCQA	National Committee for Quality Assurance
NHP	Network Health Plan
OHC	Out-of-Home Care
P4P	Pay For Performance
PCP	Primary Care Provider
PDSA	Plan-Do-Study-Act
PHE	Public Health Emergency
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PPC	Prenatal and Postpartum Care
Quartz	Quartz Health Solutions, Inc.

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

SHP	Security Health Plan
SMCP	Special Managed Care Program
SSI	Supplemental Security Income
Trilogy	Trilogy Health Insurance
UHC	United Healthcare of Wisconsin
WCV	Well-Child Visits
WICT	Wisconsin Interdisciplinary Care Team
WM	Wraparound Milwaukee

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 prepaid inpatient health plans, managed care organizations (MCOs), and special managed care programs (SMCPs) to provide for external quality reviews (EQRs). To meet these obligations, states contract with a qualified external quality review organization (EQRO).

MetaStar - Wisconsin's External Quality Review Organization

The State of Wisconsin contracts with MetaStar, Inc. to conduct EQR activities and produce reports of the results. Based in Madison, Wisconsin, MetaStar has been a leader in health care quality improvement, independent quality review services, and medical information management for more than 40 years, and represents Wisconsin in the 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, Foster Care Medical Home Medicaid recipients, and the Children with Medical Complexity (CMC) program in the State of Wisconsin. MetaStar also conducts EQR of Home and Community-based Medicaid Waiver programs that provide long-term support services for children with disabilities. MetaStar provides other services for the state as well as for private clients. For more information about MetaStar, visit its website at www.metastar.com.

MetaStar Review Team

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

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

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

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

Review Methodologies

Validation of Performance Measures

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

The CMS Protocol allows states to require MCOs to calculate and report their own performance measures, or to contract with another entity to calculate and report the measures on the MCO's behalf. For MY 2019, MCOs calculated and reported some measures and Gainwell Technologies calculated and reported others.

In preparation for MY 2019, the EQR team communicated with staff from DHS/Division of Medicaid Services along with staff from Gainwell Technologies. 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.

Gainwell Technologies 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.

DHS did not direct MetaStar to perform any information systems capabilities 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 Gainwell Technologies used to collect and store the data, calculate the performance measures, and produce the results. Documentation included:

- Gainwell Technologies Small Project Charter
- Gainwell Technologies Data Extraction and Analysis Plan
- Gainwell Technologies Source Code – SQL
- Technical Specifications for the Performance Measures
- Gainwell Technologies Measure Results
- National Drug Codes List, if applicable; and
- Periodic meetings and conference calls between DHS and Gainwell Technologies 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 Gainwell Technologies 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 Gainwell Technologies 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 Gainwell Technologies, 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 Gainwell Technologies after each measure review. Gainwell Technologies 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 Gainwell Technologies when each measure was determined valid and the review was complete.

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 used sound methodology in its design, implementation, analysis, and reporting. CMS issued the EQR Protocols in 2020 and the *Validation of Performance Improvement Projects* is now Protocol One. 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,* as this was the Protocol in effect during the project timeframe.

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.

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 3: Review of Compliance with Medicaid Managed Care Regulations, A Mandatory Protocol for External Quality Reviews (EQR).* The previous reviews were conducted using *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.

MetaStar also obtained information from DHS about its work with the MCO and performance expectations through the following sources of information:

- The MCO's current contracts with DHS;
- The previous external quality review report; and
- DHS communication with the MCO about expectations and performance during the previous 12 months.

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 was previously evaluated on 44 standards. No organizations were due for a compliance review during CY 2020.

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

MCO/SMCP/PIHP	CY 2018	CY 2019	CY 2020
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		
Group Health Cooperative of Eau Claire[+]		41 standards met	

Note: [+] 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.

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 A: 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. No organizations were due for an ISCA review during CY 2020.

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 2020, 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, 2019 and December 31, 2019.

The review team used a tool and 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 twelve indicators that reviewers used to evaluate care management performance:

1. Screening
    a. Timeliness of screening for new and continuing enrollees
    b. Screening completion prior to care plan creation
2. Comprehensiveness of Care Plan
    a. Development of care plan
    b. Evidence based
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 January 1, 2020 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
    c. Timeliness of Initial Health Assessments
    d. Completion of Additional Assessments
    e. Referrals
    f. 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 equired 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 September 30, 2019, 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 – Childless Adults Health Needs Assessment

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

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

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

Per DHS direction, MetaStar randomly selected a sample of BC+ childless adult members who were newly enrolled during the period from January 1, 2019 through December 31, 2019, 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 a 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 2019; OR
b. Reduction in Error Target: 10% improvement from baseline.

Reduction In Error Example:

i. Assume a HMO has a 2019 baseline of 20%.
ii. 2019 Error: 100% - 20% = 80%.
iii. 2019 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 2019 HNA performance target is 35% and its 2018 performance is 25%.
b. Therefore, the MCO failed to meet their 2019 HNA performance target by 10%, also known as the "HNA performance gap."
c. Further assume that in 2019:
   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 2019 HNA performance target.

3. Bonus: MCOs that in 2019 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 2019 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 2019.

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**

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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 2019 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
A	1,500	=1,500/7,200 = 20.8%	=20.8% * $100,000 = $20,833
B	2,000	=2,000/7,200 = 27.8%	=27.8% * $100,000 = $27,778
C	3,000	=3,000/7,200 = 41.7%	=41.7% * $100,000 = $41,667
D	500	=500/7,200 = 6.9%	=6.9% * $100,000 = $6,944
E	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 2017 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.