External Quality Review Annual Technical Report

Fiscal Year 2014 – 2015

Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly

Prepared for

Wisconsin Department of Health Services

Bureau of Managed Care

Prepared by

METASTAR

AMENDED
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Executive Summary

External Quality Review Process

The Code of Federal Regulations at 42 CFR 438 requires states that operate pre-paid inpatient health plans to provide for an external quality review of their managed care organizations and to produce an annual technical report. Wisconsin's Medicaid managed long-term care programs, Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly (PACE), are considered pre-paid inpatient health plans. To meet its obligations, the State of Wisconsin contracts with MetaStar, Inc.

This report covers the external quality review year from fiscal year July 1, 2014, to June 30, 2015 (FY 14-15). Mandatory review activities conducted during the year included assessment of compliance with federal standards, validation of performance improvement projects, validation of performance measures, and information system capability assessments. Two optional activities were also conducted; encounter data validation and care management review. Care management review assesses key areas of care management practice related to assurances found in the 1915 (b) and (c) Waivers, and also supports assessment of compliance with federal standards.

Summary of Progress

Compliance with federal standards, also called Quality Compliance Review, follows a three-year cycle; one year of comprehensive review and two years of follow-up review. Each organization's results are cumulative over the three-year period. FY 14-15 was the first year of a three-year cycle. Beginning with this cycle, the scoring system for quality compliance standards was changed from percent of standards fully met to a point system. By using this point system, MetaStar was able to recognize not only an organization's full compliance, but also its progress in meeting the requirements of each standard. Forty-four quality compliance standards were applicable to every managed care organization, and carried a maximum possible score of 88 points.

- Individually, four of the eight organizations scored 80 points or above.
- The results for all eight organizations ranged from 62 to 86 points.
- The overall results showed that seven of eight organizations possess the majority of structural and operational characteristics required to deliver quality care and ensure members have timely access to information and services.
- The eighth organization fully met less than half of the quality compliance standards in this year's review. A contributing factor was the limited progress made by this organization in addressing the recommendations it received in the FY 13-14 review.

A specific area of progress identified during Quality Compliance Review was issuing notices to members in a timely manner, when indicated. In FY 13-14, every organization received a recommendation to improve results related to issuing notices to members. During FY 14-15, four organizations effectively addressed this recommendation and met the requirements in this year's review.

Validation of performance improvement projects occurs annually; this activity was previously conducted along with Quality Compliance Review and Care Management Review for each organization. Projects were validated in various stages of completion as a result. The Department of Health Services (DHS) modified its performance improvement project timeline as a result of previous MetaStar recommendations and its own evaluation of project outcomes. In 2014, all projects were conducted on a calendar year basis and were expected to achieve active progress, which was defined as implementing at least one intervention and measuring its effects on at least one indicator. Seven of eight organizations achieved active progress during the first year of the modified timeline.

Validation of performance measures also occurs annually. Last year, five MCOs' vaccination data were found to be compliant with the technical specifications for both quality indicators. This year, all eight MCOs reported vaccination data complied with the technical specifications for both indicators.

Aggregate results for the Family Care program indicated notable progress in five areas of Care Management Review. Analysis indicated the improvement was likely due to actions of the managed care organizations, and was unlikely to be the result of normal variation or chance. Two of these review areas had been identified as opportunities for improvement in last year's review:

- "Comprehensiveness of Most Recent MCP" increased from 67.5 percent to 83.2 percent.
- "Plan Updated for Significant Changes" increased from 68.9 percent to 91 percent.
- "Reassessment Done When Indicated" increased from 91.6 percent to 96.2 percent.
- "Risk Addressed When Identified" increased from 94.4 percent to 97.5 percent.
- "Timely Coordination of Services" increased from 90.5 percent to 95.3 percent.

Notable Strengths

- Across all managed care organizations, staff values and supports the rights of members.
- Six organizations were noted to work with network providers in a way that fosters communication and collaboration, with the goal of improving quality and helping providers succeed.
- All managed care organizations fully met requirements to promote cultural competence in service delivery. However, three organizations stood out for their efforts to explore and

implement creative approaches to providing culturally and linguistically sensitive information and services, and meet the needs of members with diverse backgrounds.

- Six organizations have in place a structured and comprehensive approach to quality management, which includes the use of data and monitoring to assess and improve the quality of member care, cost effectiveness, organizational operations, and program integrity. Staff in multiple departments and levels at these organizations actively participates in improvement activities.
- Seven organizations provide a high level of training and organizational support for care management staff.
- Across all managed care organizations, staff understands and supports the right of members to express dissatisfaction, and to use the processes available to them to grieve and appeal. A strength identified at six organizations was the consistent use of mediation and negotiation to understand the source of members' concerns and resolve disagreements.
- All organizations conducted performance improvement projects focused on improving processes and outcomes of care relevant to the specific needs of members served.
- Most projects were initiated with a methodologically sound structure including a needs assessment, adequate study question(s), clearly defined indicators and population, sound data collection procedures, and sufficient interventions.
- All managed care organizations' influenza and pneumococcal vaccination data met DHS technical specifications. Aggregate program vaccination rates were not biased, meaning they could be accurately reported.
- Overall, the Information System Capability Assessments conducted for two organizations found that both have the basic systems, resources, and processes in place to meet DHS' requirements for oversight and management of services to members, and support of quality and performance improvement initiatives.
    - Positive working relationships with vendors result in timely communications and resolution of any issues.
    - Security and confidentiality is emphasized at each organization through documented policies and procedures, staff training, physical security arrangements, and proactive detection of potential breaches.
- All programs (Family Care, Family Care Partnership, and PACE) achieved aggregate results over 90 percent in the following areas of Care Management Review:
    - "Comprehensiveness of Assessment"
    - "Reassessment Done When Indicated"
    - "Risk Addressed When Identified"
    - "Timeliness of Service Authorization Decisions"
    - "Identified Needs are Addressed"
    - "Member/Guardian/Family/Informal Supports Included."

- The selected encounter data of three organizations included required fields and aligned with DHS specifications for reporting. The data also accurately reflected information about members, providers, and service types as compared to the corresponding documentation in the provider service records.

RECOMMENDATIONS

Quality Compliance Review - Enrollee Rights and Protections

- Follow up with four organizations to ensure they identify barriers related to completing annual renewals of restrictive measures plans and implement improvements focused on increasing timeliness.
- Ensure five organizations implement a policy and process to support requirements to make a good faith effort to give affected members timely written notice of the termination of a contracted provider.
- Maintain oversight of one organization to ensure it revises its member handbook, provider directory, and other written material provided to members to include all required information.

Quality Compliance Review – Quality Assessment and Performance Improvement

- Maintain oversight of two organizations to ensure they act on several recommendations provided by MetaStar related to their Quality Assessment and Performance Improvement programs.
- Ensure five organizations take steps to improve the comprehensiveness of assessments and member-centered plans.
- Ensure four organizations develop and implement policies and procedures for provider credentialing, and include ongoing verification and monitoring of licensure and/or certification of providers.
- Follow up with seven organizations to ensure they develop and implement a disenrollment policy that identifies the impermissible reasons for requesting member disenrollment.
- Maintain oversight of two organizations to ensure they place priority on recommendations provided by MetaStar related to establishing, monitoring, and maintaining a network of qualified providers.
- Maintain oversight of one organization to ensure it develops policies and procedures to address all aspects of enrollment and disenrollment. Provide support to this organization, and other organizations as needed, to engage with Aging and Disability Resource Centers and Income Maintenance agencies in their service areas, in order to develop or revise current Enrollment Plans that address all required elements.

Quality Compliance Review - Grievance Systems

- Oversee the Family Care Partnership program of two organizations to ensure they take action to meet requirements regarding local Grievance and Appeal Committee structure and processes, such as composition, privacy and confidentiality, and other requirements.
- Ensure four organizations enhance monitoring and implement improvement efforts to ensure the timely issuance of notices to members, when indicated. Follow up with four other organizations to ensure they maintain and improve on the progress they have made in this area.

Performance Improvement Projects

- Continue the project approval process which ensures managed care organizations have developed clearly defined projects.
- Consider additional technical support for organizations, related to data analysis and measurement of intervention effectiveness.

Performance Measures Validation

- Ensure all managed care organizations provide adequate training and written guidance that aligns with DHS technical specifications, so that staff are knowledgeable about vaccination requirements and can accurately obtain and enter member immunization information into organizations' systems. Consider requiring managed care organizations to report back to the Bureau of Managed Care regarding any revisions or updates made to their policies and procedures as a result of the measurement year 2014 Performance Measures Validation.
- Follow up with three organizations to determine implementation of improvements related to the resubmission of measurement year 2014 data files, so as to ensure only members continuously enrolled during the respective timeframe are included in the data sets and that the correct vaccination date is reported.
- Ensure that managed care organizations improve the consistency with which they record and report refusals and contraindications in order to identify actionable plans for improvement.

Information Systems Capability Assessment

- DHS should provide increased monitoring and oversight of the managed care organization that had recently transitioned to a new information system (relative to the timing of the review) to ensure continued compliance and ability to meet encounter reporting and performance measurement/improvement requirements.

Care Management Review

DHS should work with managed care organizations to ensure that:

- All programs (Family Care, Family Care Partnership, and PACE) focus improvement efforts in the following areas of care management practice. Results over time identify both as continuing areas of opportunity for improvement:
    - Following up to ensure services have been received and are effective; and
    - Issuing notices to members, when indicated.
- Family Care programs continue to work on improving the comprehensiveness of member-centered plans.
- Family Care Partnership programs improve in the following areas:
    - Timeliness with which member-centered plans are reviewed and signed at the required six months intervals; and
    - Updating member-centered plans when members have significant changes in their condition or situation.
- The PACE program works to ensure care managers update member-centered plans when members have significant changes.

Encounter Data Validation

- Provide ongoing oversight and assistance to MCOs to ensure that encounter data represent accurate timeframes and units of service, with focus on the correct use of the quantity/unit type and impact of "day out" for related services.
- Examine historical encounter data for one managed care organization in order to determine the extent to which members from other programs were erroneously included in Family Care Partnership program encounter data. This organization should remediate/improve the processes which contributed to the errors.

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 that 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; Family Care (FC), Family Care Partnership (FCP), and Program of All-Inclusive Care for the Elderly (PACE). The Code of Federal Regulations (CFR) at 42 CFR 438 requires states that operate pre-paid inpatient health plans (PIHPs) to provide for an external quality review of their managed care organizations. This report covers mandatory and optional external quality review (EQR) activities conducted by MetaStar, Inc., for the fiscal year from July 1, 2014, to June 30, 2015 (FY 14-15). See Appendix 3 for more information about external quality review and a description of the methodologies used to conduct review activities.

Overview of Wisconsin's FC, FCP, and PACE MCOs

During FY 14-15, the Wisconsin Department of Health Services (DHS) contracted with eight managed care organizations (MCOs) to administer these programs, which are considered PIHPs. As noted in the table below, five MCOs operate only FC programs; one MCO operates only a FCP program; one MCO operates FC and FCP programs; one MCO operates programs for FC, FCP, and PACE.

Managed Care Organization	Program(s)
Care Wisconsin (CW)	FC; FCP
Community Care, Inc. (CCI)	FC; FCP; PACE
Community Care Connections of Wisconsin (CCCW)*	FC
ContinuUs	FC
Independent Care Health Plan (*i*Care)	FCP
Lakeland Care District (LCD)	FC
Milwaukee County Department of Family Care (MCDFC)**	FC
Western Wisconsin Cares (WWC)	FC

*Formerly Community Care of Central Wisconsin, the MCO changed its name effective August 1, 2014.
**MCDFC changed its name to My Choice Family Care effective 7/1/15, at the start of FY 15-16.

During FY 14-15, DHS certified three MCOs to expand into additional counties currently served by at least one other MCO, affording consumers in these service areas more choice of MCO providers: Effective January 1, 2015, LCD began operating FC in Calumet, Outagamie, and Waupaca counties, while CCI expanded its FC program to Winnebago, Fond du Lac, and Manitowoc counties. Also on January 1, 2015, *i*Care began operating FCP in Dane county.

Also, as the result of a competitive procurement, DHS certified two MCOs, LCD and CW, to expand FC into a new geographic service region where FC programs had not previously been available. The region consists of seven counties in northeast Wisconsin: Brown, Door, Kewaunee, Marinette, Menominee, Oconto, and Shawano counties. Implementation began in Kewaunee and Oconto counties effective June 1, 2015, with the plan to stagger start-up in the remaining counties during the first half of FY 15-16.

Links to maps depicting the current FC and FCP/PACE geographic service regions and the MCOs operating in the various service regions throughout Wisconsin can be found at the following website: https://www.dhs.wisconsin.gov/familycare/mcos/index.htm

For details about the core values and operational aspects of these programs, visit these websites:

http://www.dhs.wisconsin.gov/LTCare/Generalinfo/WhatisFC.htm and

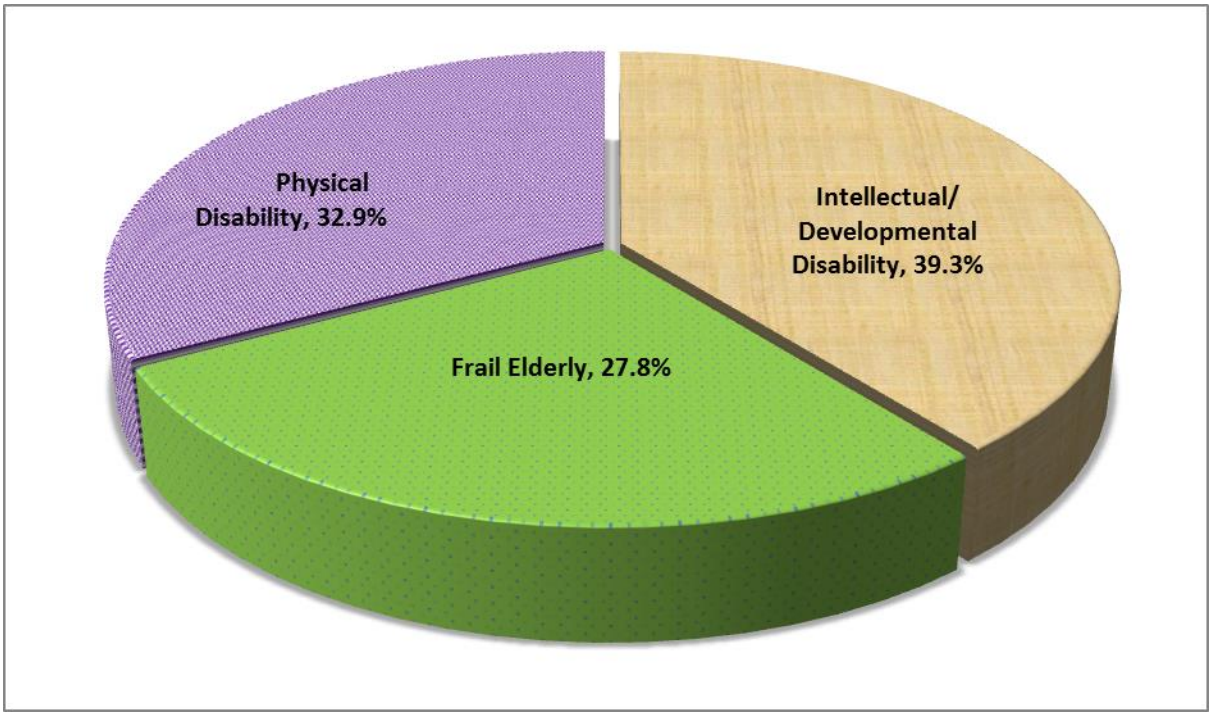
http://dhs.wisconsin.gov/wipartnership/2pgsum.htm

As of June 30, 2015, enrollment for all programs was approximately 42,604. This compares to a total enrollment of 41,352 as of June 30, 2014. Enrollment data is available at the following DHS website:

http://dhs.wisconsin.gov/ltcare/Generalinfo/EnrollmentData.htm

The chart below shows the percent of total enrollment by the primary target groups served by FC, FCP and PACE programs; individuals who are frail elders, persons with intellectual/developmental disabilities, and persons with physical disabilities.

Total Participants in All Programs by Target Group June 30, 2015



SCOPE OF FY 14 – 15 EXTERNAL REVIEW ACTIVITIES

In FY 14-15, MetaStar conducted three mandatory review activities as specified in federal Medicaid managed care regulations found at 42 CFR 438.358: Assessment of compliance with standards, referred to in this report as quality compliance review (QCR); validation of performance improvement projects (PIPs); and validation of performance measures. Federal regulations at 42 CFR 438.242 as well as CMS protocols pertaining to these three activities also mandate that states assess the information system capabilities of MCOs. Therefore, MetaStar conducted some information systems capability assessments (ISCAs) during FY 14-15. MetaStar also conducted an optional review activity, care management review (CMR). Another optional review activity, encounter data validation, had begun in FY 13-14 but was completed and reported in FY 14-15.

Mandatory Review Activities	Scope of Activities
Quality Compliance Review	As directed by DHS, QCR activities generally follow a three-year cycle. The first year, MetaStar conducts a comprehensive review where all QCR standards are assessed; 44 standards for FC, and 45 standards for FCP. This is followed by two years of targeted review or follow-up based on the results of the comprehensive review year. FY 14-15 was a **comprehensive review year**. Therefore, all quality compliance standards were reviewed for each MCO.

Performance Improvement Projects	The 2014 DHS-MCO contract required all MCOs to make active progress each year on at least two PIPs; one with a clinical focus, and one with a non-clinical focus relevant to long-term care. In FY14-15, MetaStar validated two or more PIPs for each MCO, for a total of 18 PIPs. The PIP topics reviewed for each MCO are indicated in the chart on page 14.
Performance Measures Validation	Annually, MCOs must measure and report their performance using quality indicators and standard measures specified in the DHS-MCO contract. For FY 14-15, all MCOs were required to report performance measures data related to care continuity, influenza vaccinations, and pneumococcal vaccinations. MCOs operating FCP or PACE programs were also required to report data on dental visits as well as available measures of members' outcomes (i.e., clinical, functional, and personal experience outcomes) that the MCOs must report to CMS or any other entities with quality oversight authority over FCP and PACE programs. As directed by DHS, MetaStar validated two of these performance measures for every MCO: • Influenza vaccinations • Pneumococcal vaccinations. MCOs were directed to report data regarding the care continuity, dental visits, and other performance measures directly to DHS; MetaStar did not validate these measures.
Information Systems Capability Assessment	ISCAs are a required part of other mandatory EQR protocols. The DHS-MCO contract requires MCOs to maintain a health information system capable of collecting, analyzing, integrating, and reporting data; for example, data on utilization, grievances and appeals, disenrollments, and member and provider characteristics. As directed by DHS, each MCO receives an ISCA once every three years. MetaStar conducted ISCAs for two MCOs during FY 14-15.
Optional Review Activities	**Scope of Activities**
Care Management Review	MetaStar conducts CMR to assess each MCO's level of compliance with its contract with DHS in key areas of care management practice. CMR activities and findings also help support QCR, and are part of DHS' overall strategy for providing quality assurances to CMS regarding the 1915 (b) and (c) Waivers which allow the State of Wisconsin to operate its Family Care programs. During FY 14-15, the EQR team conducted CMR activities during each MCO's annual quality review (AQR), a total of 672 record reviews. At the request of DHS, MetaStar also performed an additional 24 CMRs separate from AQR. These results were reported separately and are not included in the data for this report.

Encounter Data Validation	Encounter data validation determines whether encounter data submitted by MCOs is complete and accurate. Validation results can be used to assess and improve quality, monitor program integrity, and determine capitation payment rates. At the direction of DHS, validation activities were conducted for encounters related to the provision of long-term care services and supports, for three MCOs that received ISCAs in FY 13-14. The review began in FY 13-14, but was completed and reported in FY 14-15.

Scope of each MCO's Annual Quality Review

During FY 14-15, the AQR for every MCO consisted of QCR and CMR. The ISCAs, PIP validation, performance measures validation (PMV) and encounter data validation (EDV) were all conducted and reported separately.

PIP Topics Reviewed for each MCO

MCO	PIP Topic
CW	• Treatment of cardiovascular disease (FC) • Treatment of cardiovascular disease (FCP) • Care transitions (FC, FCP)
CCI	• Treatment of cardiovascular disease (FC) • Treatment of cardiovascular disease (FCP, PACE) • Advance Care Planning (FC, FCP, PACE)
CCCW	• Preventative screening (FC) • Issuance of notices to members (FC)
ContinuUs	• Pneumonia vaccination (FC) • Integrated employment (FC)
***i*Care**	• Comprehensive diabetes care (FCP) • Hospital readmission (FCP)
LCD	• Fall reduction (FC) • Member satisfaction (FC)
MCDFC	• Behavioral health care planning (FC) • Behavioral health assessment (FC)
WWC	• Self-directed supports monitoring (FC) • Depression assessment (FC)

Number of Care Management Reviews Conducted by MCO and Program

MetaStar drew a sample of member records for each MCO and program based on a minimum of one and one-half percent of a program's enrollment or 30 records, whichever was greater. See Appendix 3 for more information about the CMR methodology.

MCO/Program	CMR Sample Size
Family Care	
CW	59
CCI	127
CCCW	81
ContinuUs	71
LCD	37
MCDFC	120
WWC	57
Total: Family Care	**552**
Family Care Partnership	
CW	30
CCI	30
*i*Care	30
Total: Family Care Partnership	**90**
PACE	
CCI	30
Total: PACE	**30**
Total: All Programs	**672**

Quality Compliance Review

QCR is a mandatory activity, conducted to determine the extent to which MCOs are in compliance with federal quality standards. QCR generally follows a three-year cycle: The first year, MetaStar conducts a comprehensive review, where all QCR standards are assessed for each MCO. This is followed by two years of targeted review.

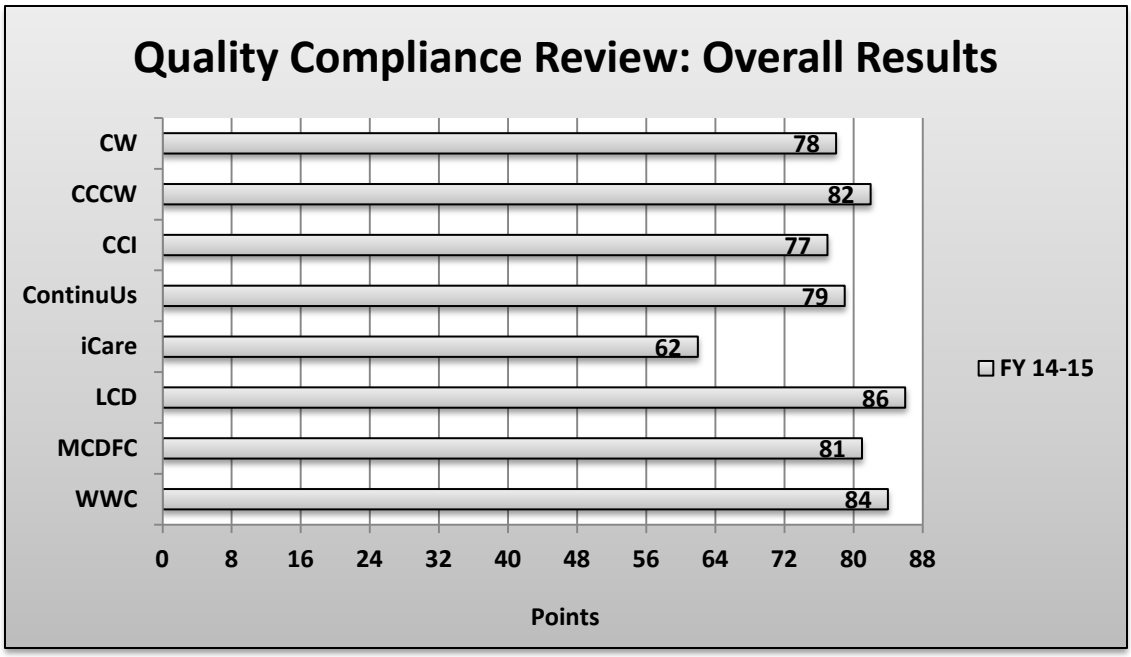
FY 14-15 was a comprehensive review year. Forty-four standards were assessed at every MCO, and for organizations operating FCP or PACE, one additional Enrollee Rights standard was also assessed.

Beginning with this three-year cycle, the QCR standards were scored using a point system: Numeric values were assigned to a standard rating structure, where two points were awarded for a "met" score, and one point was awarded for a "partially met" score. Zero points applied to a score of "not met," although no MCO received a score of "not met" for any QCR standard during FY 14-15. By using this point system, MetaStar was able to recognize not only an organization's full compliance, but also its progress in meeting the requirements of each standard. See Appendix 1 for more information about the scoring methodology.

The 44 standards applicable to every organization carried a maximum possible score of 88 points. The points for the one additional enrollee rights standard, applicable only to FCP/PACE, were removed from the two bar graphs below titled "Quality Compliance Review: All Standards" and "Enrollee Rights and Protections," in order to allow for valid comparisons among all organizations. (It should be noted that every FCP/PACE program fully met the requirements of this one additional standard, as reported in each organization's individual EQR report.)

Overall Results

The following graph indicates each MCO's level of compliance with 44 QCR standards that applied to every organization. Four of the eight MCOs scored 80 points or above, out of the total possible 88 points. The results for all eight MCOs ranged from 62 to 86 points.

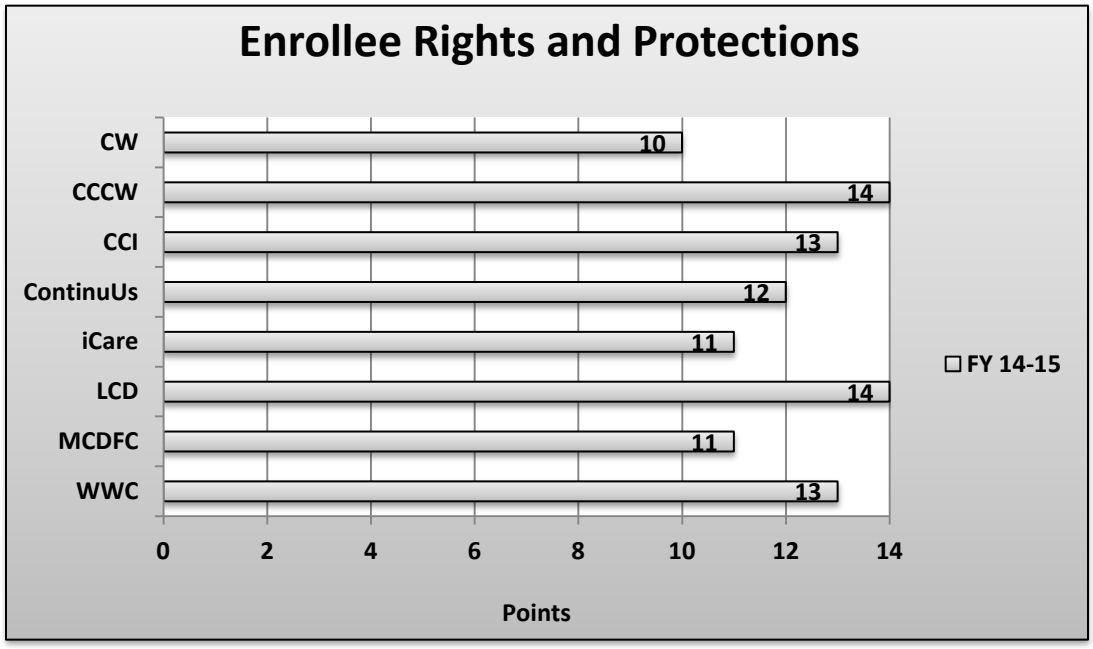


Each section that follows provides a brief explanation of a QCR focus area, followed by a bar graph and a table with additional information. The graph indicates each MCO's level of compliance with the QCR standards comprising each review focus area. The table provides additional information regarding the results for each specific review standard.

Results for Enrollee Rights and Protections

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

The graph below indicates each MCO's level of compliance with the seven QCR standards that applied to every organization.



The first column in the table below is the number assigned to the review standard. The second column is the standard. The last column, which is subdivided, depicts the number of MCOs that received a "met" rating and the number of MCOs that received a "partially met" rating for the standard. No MCO received a "not met" rating.

#	Enrollee Rights and Protections	FY 14-15 Ratings	
		Met	Partially Met
	General Rule		
1	**42 CFR 438.100;** The MCO must: • Have written policies regarding member rights; • Comply with any applicable federal and state laws that pertain to member rights; • Ensure its staff and affiliated providers take those rights into account when furnishing services.	7	1

#	Enrollee Rights and Protections	FY 14-15 Ratings	
		Met	Partially Met
	Information Requirements		
2	**42 CFR 438.100; 42 CFR 438.10; DHS-MCO Contract Article IX.** The MCO must provide all notices, informational materials, and instructional materials relating to members in a manner and format that may be easily understood. The MCO must: • Make its written information available in the prevalent non-English languages in its service area; • Make oral interpretation services available free of charge for all non-English languages (not just those identified as prevalent); • Provide written materials that are in an easily understood language and format; • Make alternative formats available that take into consideration members' special needs; • Notify members of the availability of the above materials and services, including how to access them.	8	0
3	**42 CFR 438.100; 42 CFR 438.10; DHS-MCO Contract Article IX.** General information must be furnished to members as required. The MCO must: • Notify members of their right to request and obtain information at least once a year, including information about member rights and protections, the Member Handbook, and Provider Directory; • Provide required information to new members within a reasonable time period and as specified by the DHS-MCO contract; • Provide at least 30 days written notice when there is a "significant" change (as defined by the state) in the information the MCO is required to provide its members; • Make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to members who received services from such provider.	3	5
4	**42 CFR 438.100; 42 CFR 438.10; DHS-MCO Contract Article IX.** The MCO provides information to members in the Provider Directory as required by 42 CFR 438.10(f)(6) and the DHS-MCO contract.	6	2
5	**42 CFR 438.100; 42 CFR 438.10; DHS-MCO Contract Article IX.** The MCO provides information to members in the Member Handbook, as required by 42 CFR 438.10(f)(6), 42 CFR 438.10(g), and the DHS-MCO contract.	7	1

#	Enrollee Rights and Protections	FY 14-15 Ratings	
		Met	Partially Met
6	**42 CFR 438.100; 42 CFR 438.10; 42 CFR 438.6; 42 CFR 422.128; DHS-MCO Contract Article X.** Regarding advance directives, the MCO must: • Maintain written policies and procedures in accordance with the DHS-MCO contract; • Provide written information to members regarding their rights under the law of the state including the right to formulate advance directives; • Update written information to reflect changes in state law as soon as possible (but not later than 90 days after the effective date of the change); • Include a clear and precise statement of limitation in its policies if it cannot implement an advance directive as a matter of conscience (The statement must comply with requirements listed in 42 CFR 422.128.); • Provide written information to each member at the time of MCO enrollment (or family/surrogate if member is incapacitated at time of enrollment), and must have a follow-up procedure in place to provide the information to the member when he/she is no longer incapacitated; • Document in the medical record whether or not the individual has executed an advance directive, and must not discriminate based on its presence or absence; • Ensure compliance with requirements of state law; • Provide education for staff and the community on issues concerning advance directives; • Inform individuals that complaints concerning non-compliance with any advance directive may be filed with the Division of Quality Assurance.	7	1
	Specific Rights		
7	**42 CRF 438.100; 42 CFR 438.102; DHS-MCO Contract Article X.** The MCO guarantees that its members have the right to: • Be treated with respect and consideration for his/her dignity and privacy; • Receive information on available treatment options and alternatives presented in a manner appropriate to the member's condition and ability to understand; • Participate in decisions regarding his/her health care, including the right to refuse treatment; • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation; • Request and receive a copy of his/her medical records, and to request that they be amended or corrected in accordance with federal privacy and security standards; • Exercise their rights without fear of adverse treatment by the MCO or its providers; • Be free from unlawful discrimination. Healthcare professionals acting within their scope of practice may not be restricted from advising or advocating on behalf of the member.	4	4

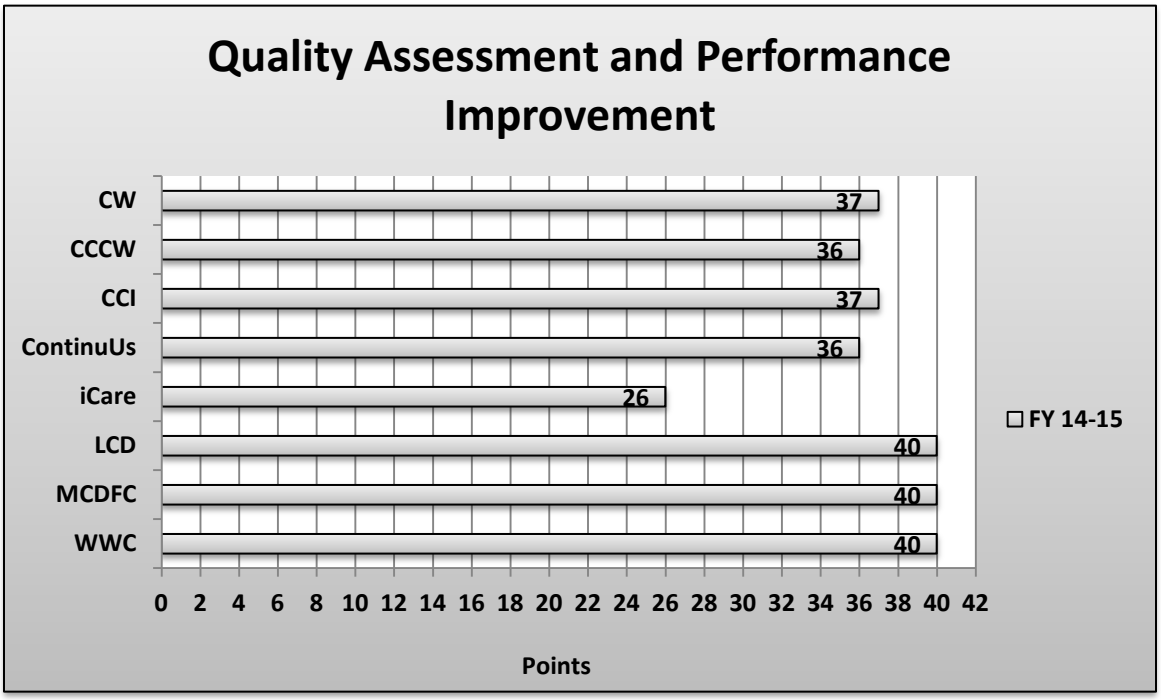
#	Enrollee Rights and Protections	FY 14-15 Ratings	
		Met	Partially Met
	Emergency and Post-stabilization Services		
8	**42 CFR 422.113; 42 CFR 438.114; DHS-MCO Contract Article VII.** ***Applies to Partnership and PACE programs only*** The MCO: • Must cover and pay for emergency services regardless of whether the entity that furnishes the services has a contract with the MCO; • May not deny payment for treatment obtained if a member had an emergency medical condition or a representative of the MCO instructs the member to seek emergency services; • May not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms; • May not refuse to cover emergency services based on lack of notification to MCO within 10 days of presentation for services; • May not hold members liable for payment of subsequent screening or treatment needed to diagnose the specific condition or stabilize the member. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is stabilized for transfer or discharge; • Must cover and pay for post-stabilization care services in accordance with provisions set forth in 42 CFR 422.113(c).	3	0

Results for Quality Assessment and Performance Improvement

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

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

The following graph indicates each MCO's level of compliance with 21 QCR standards that applied to every organization.



The first column in the table below is the number assigned to the review standard. The second column is the standard. The last column, which is subdivided, depicts the number of MCOs that received a "met" rating and the number of MCOs that received a "partially met" rating for the standard. No MCO received a "not met" rating.

#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement	FY 14-15 Scores	
		Met	Partially Met
	Availability of Services		
1	**42 CFR 438.206**; **DHS-MCO Contract Articles VII. and VIII.** ***Delivery network*** The MCO maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, the MCO site must consider: • Anticipated Medicaid enrollment; • Expected utilization of services, considering Medicaid member characteristics and health care needs; • Numbers and types (in terms of training, experience and specialization) of providers required to furnish the contracted Medicaid services; • The number of network providers that are not accepting new MCO members; • The geographic location of providers and MCO members, considering	5	3

#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement	FY 14-15 Scores	
		Met	Partially Met
	distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities. The delivery network provides female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services, when applicable per program benefit package.		
2	**42 CFR 438.206; DHS-MCO Contract Articles VII. and VIII.** ***Second opinion and out-of-network providers*** The MCO provides for a second opinion from a qualified health care professional within the network, or arranges for the member to obtain one outside the network, at no cost to the member, when applicable per program benefit package. If the network is unable to provide necessary services, covered under the contract, to a particular member, the MCO must adequately and timely cover these services out of network for the member as long as the MCO is unable to provide them. The MCO must coordinate with out-of-network providers to ensure that the cost of services to members is no greater than they would have been if furnished within the provider network.	6	2
3	**42 CFR 438.206; DHS-MCO Contract Article VIII.** ***Timely access*** The MCO must: • Require its providers to meet state standards for timely access to care and services, taking into account the urgency of need for services; • Ensure that the network providers offer hours of operation that are not less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service, if the provider serves only Medicaid members; • Make services available 24 hours a day, 7 days a week when medically necessary; • Establish mechanisms to ensure compliance by providers; • Monitor providers regularly to determine compliance; • Take corrective action if there is a failure to comply.	7	1

#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement	FY 14-15 Scores	
		Met	Partially Met
4	**42 CFR 438.206*;* DHS-MCO Contract Article VIII.** ***Cultural considerations*** The MCO must participate in the state's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The MCO must: • Incorporate in its policies, administration, provider contract, and service practice the values of honoring members' beliefs and cultural backgrounds; • Permit members to choose providers from among the MCO's network based on cultural preference; • Accept appeals and grievances from members related to a lack of access to culturally appropriate care.	8	0
	Coordination and Continuity of Care		
5	**42 CFR 438.208; DHS-MCO Contract Article V.** ***Primary care and coordination of health care services*** The MCO must implement procedures to deliver primary care (as applicable for FCP) and coordinate health care services for all MCO members. These procedures must do the following: • Ensure that each member has an ongoing source of primary care appropriate to his/her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member; • Coordinate the services the MCO furnishes to the member with services the member receives from any other provider of health care or insurance plan; • Share with other providers serving the member the results of its identification and assessment of that member's needs to prevent duplication of activities; • Ensure protection of the member's privacy when coordinating care; • Facilitate direct access to specialists as appropriate for the member's special health care condition and identified needs.	7	1
6	**42 CFR 438.208; DHS-MCO Contract Article III.** ***Identification:*** Identification and eligibility of individuals with special health care needs will be in accordance with the Wisconsin Long-Term Care Functional Screen. ***Assessment:*** The MCO must implement mechanisms to assess each member in order to identify special conditions that require treatment and care monitoring. The assessment must use appropriate health care professionals. ***Member-centered plan:*** The treatment plan must be: • Developed to address needs determined through the assessment; • Developed jointly with the member's primary care team with member participation, and in consultation with any specialists caring for the member;	3	5

#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement	FY 14-15 Scores	
		Met	Partially Met
	• Completed and approved in a timely manner in accordance with DHS standards.		
	Coverage and Authorization of Services		
7	**42 CFR 438.210; DHS-MCO Contract Article V.** ***Authorization of services*** For processing requests for initial and continuing authorizations of services, the MCO must: • Have in place and follow written policies and procedures; • Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; • Consult with the requesting provider when appropriate; • Ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.	7	1
8	**42 CFR 438.210; DHS-MCO Contract Article V.** ***Timeframe for decisions of approval or denial*** The interdisciplinary team (IDT) staff shall make decisions on requests for services and provide notice as expeditiously as the member's health condition requires. <u>Standard Service Authorization Decisions</u> ***For Family Care and Partnership:*** • Decisions shall be made no later than fourteen (14) calendar days following receipt of the request for the service unless the MCO extends the timeframe for up to fourteen (14) additional calendar days. If the timeframe is extended, the MCO must send a written notification to the member no later than the fourteenth day after the original request. ***For PACE:*** • Decisions on direct requests for services must be made and notice provided as expeditiously as the member's health condition requires but not more than 72 hours after the date the interdisciplinary team receives the request. The interdisciplinary team may extend this 72-hour timeframe by up to five (5) additional calendar days for either of the following reasons: a) The participant or designated representative requests the extension; or b) The team documents its need for additional information and how the delay is in the interest of the participant. <u>Expedited Service Authorization Decisions:</u> • If following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO shall make an expedited service authorization no later than seventy two (72) hours after receipt of the request for service. • The MCO may extend the timeframes of expedited service authorization decisions by up to eleven (11) additional calendar days if the member or a provider requests the extension or the MCO justifies a need for additional information. For any extension not requested by the member, the MCO must give the member written notice of the reason for delay of decision.	7	1

#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement	FY 14-15 Scores	
		Met	Partially Met
	Provider Selection		
9	**42 CFR 438.214; 42 CFR 438.12; DHS-MCO Contract Article VIII.** The MCO must: • Implement written policies and procedures for selection and retention of providers; • Follow a documented process for credentialing and re-credentialing of providers who have signed contracts or participation agreements; • Implement provider selection policies and procedures to ensure non-discrimination against particular practitioners that serve high risk populations, or specialize in conditions that require costly treatment. If an MCO declines to include individual providers or groups of providers in its network, it must give the affected provider(s) written notice of the reason for its decision.	4	4
10	**42 CFR 438.214; DHS-MCO Contract Article VIII.** MCOs may not employ or contract with providers excluded from participation in federal health care programs under either section 1128 or Section 1128A of the Social Security Act.	5	3
11	**42 CFR 438.214** The MCO must comply: • With any additional requirements established by the state including ensuring providers and subcontractors perform background checks on caregivers in compliance with Wis. Admin. Code Chapter DHS 12. • With all applicable federal and state laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act of 1990, as amended.	6	2
	Confidentiality		
12	**42 CFR 438.224; DHS-MCO Contract Article V.** The MCO must ensure that for medical records and any other health and enrollment information that identifies a particular enrollee, use and disclosure of such individually identifiable health information must be in accordance with the privacy requirements.	8	0

#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement	FY 14-15 Scores	
		Met	Partially Met
	Enrollment and Disenrollment		
13	**42 CFR 438.226; 42 CFR 438.56**; **DHS-MCO Contract Article IV.** ***Disenrollment requested by the MCO*** The MCO must comply with enrollment and disenrollment requirements and limitations. The MCO may request a disenrollment if: • The member has committed acts or threatened to commit acts that pose a threat to the MCO staff, subcontractors, or other members of the MCO. This includes harassing and physically harmful behavior. • The MCO is unable to assure the member's health and safety because: ○ The member refuses to participate in care planning or to allow care management contacts; or ○ The member is temporarily out of the MCO service area. The MCO must have written policies and procedures that identify the impermissible reasons for disenrollment in accordance with the DHS-MCO contract. The MCO shall submit to DHS a written request to process the disenrollment, which includes documentation of the basis for the request, a thorough review of issues leading to the request, and evidence that supports the request.	1	7
14	**42 CFR 438.226; 42 CFR 438.56; DHS-MCO Contract Article IV.** ***Enrollment and disenrollment*** The MCO shall comply with the following requirements and use DHS-issued forms related to disenrollments. <u>*Processing Disenrollments*</u> The enrollment plan, developed in collaboration with the resource center and income maintenance agency, shall be the agreement between entities for the accurate processing of disenrollments. The enrollment plan shall ensure that: • The MCO is not directly involved in processing disenrollments, although the MCO shall provide information relating to eligibility to the income maintenance agency; • Enrollments and disenrollments are accurately entered on CARES so that correct capitation payments are made to the MCO; and • Timely processing occurs, in order to ensure that members who disenroll have timely access to any Medicaid fee-for-service benefits for which they may be eligible, and to reduce administrative costs to the MCO and other service providers for claims processing. <u>*MCO Influence Prohibited*</u> • The MCO shall not counsel or otherwise influence a member due to his/her life situation (e.g., homelessness, increased need for supervision) or condition in such a way as to encourage disenrollment. <u>*Member Requested Disenrollment*</u> • All members shall have the right to disenroll from the MCO without cause at any time. • If a member expresses a desire to disenroll from the MCO, the MCO	6	2

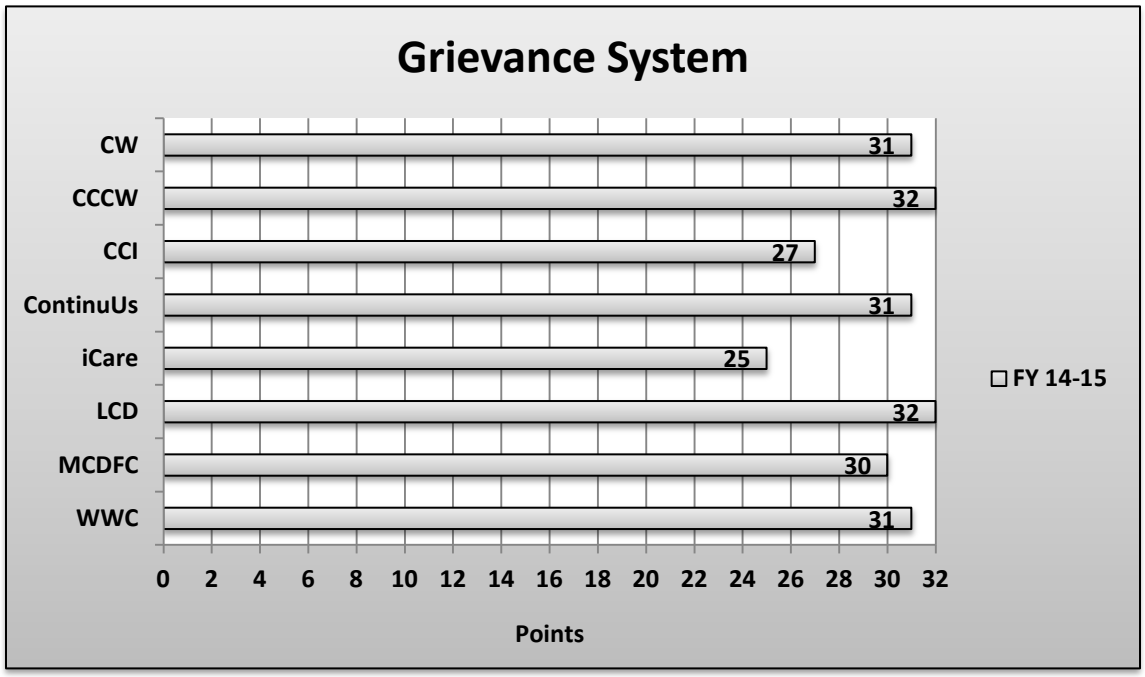
#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement	FY 14-15 Scores	
		Met	Partially Met
	shall provide the member with contact information for the resource center and, with the member's approval, may make a referral to the resource center for options counseling. • The MCO is responsible for covered services it has authorized through the date of disenrollment. *Interactions with Other Agencies Related to Eligibility and Enrollment* • The MCO shall fully cooperate with other agencies and personnel with responsibilities for eligibility determination, eligibility re-determination, and enrollment in the MCO. This includes but is not limited to the resource center, income maintenance, and enrollment consultant if any. • The MCO shall participate with these agencies in the development and implementation of an enrollment plan that describes how the agencies will work together to assure accurate, efficient, and timely eligibility determination and re-determination and enrollment in the MCO. The enrollment plan shall describe the responsibility of the MCO to timely report known changes in members' level of care, financial, and other circumstances that may affect eligibility, and the manner in which to report those changes. • The MCO shall jointly develop with the resource center protocols for disenrollments, per contract specifications.		
	Subcontractor/Provider Relationships and Delegation		
15	**42 CFR 438.230; DHS-MCO Contract Article VIII.** The MCO must: • Oversee and be accountable for any functions and responsibilities that it delegates to any subcontractor/provider; • Before any delegation, evaluate the prospective subcontractor/provider's ability to perform the activities to be delegated; • Have a written agreement that: ○ Specifies the activities and report responsibilities designated to the subcontractor/provider; and ○ Provides for revoking delegation or imposing other sanctions if the subcontractor/provider's performance is inadequate; • Monitor the subcontractor/provider's performance on an ongoing basis, identify deficiencies or areas for improvement, and take corrective action.	7	1
	Practice Guidelines		
16	**42 CFR 438.236; DHS-MCO Contract Article VII.** The MCO adopts practice guidelines which: • Are based on valid and reliable clinical evidence; • Consider the needs of the MCO's members; • Are adopted in consultation with health care professionals; and • Are reviewed and updated periodically. The MCO disseminates the guidelines to all affected providers, and upon request, to members. The MCO applies the guidelines throughout the MCO in a consistent manner, e.g., decisions for utilization management, member education, service coverage.	6	2

#	Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement	FY 14-15 Scores	
		Met	Partially Met
	Quality Assessment and Performance Improvement (QAPI) Program		
17	**42 CFR 438.240; DHS-MCO Contract Article XII.** The MCO has an ongoing quality assessment and performance improvement (QAPI) program for the services it furnishes to its members which meets at a minimum the following requirements outlined in the DHS-MCO contract: • Is administered through clear and appropriate administrative structures; • Includes member, staff, and provider participation; • Develops a work plan which outlines the scope of activities, goals, objectives, timelines, responsible person, and is based on findings from QAPI program activities; • Monitors quality of assessments and member-centered plans; • Monitors completeness and accuracy of functional screens; • Conducts member satisfaction and provider surveys; • Documents response to critical incidents; • Monitors adverse events, including appeals and grievances that were resolved; • Monitors access to providers and verifies that services were provided; • Monitors the quality of subcontractor services.	5	3
	Basic Elements of the QAPI Program		
18	**42 CFR 438.240; DHS-MCO Contract Article XII.** The MCO must have in effect mechanisms to detect both underutilization and overutilization of services.	6	2
19	**42 CFR 438.240; DHS-MCO Contract Article XII.** The MCO must have in effect mechanisms to assess the quality and appropriateness of care furnished to members.	6	2
	Quality Evaluation		
20	**42 CFR 438.240; DHS-MCO Contract Article XII.** The MCO has in effect a process for an evaluation of the impact and effectiveness of its quality assessment and performance improvement program, to determine whether the program has achieved significant improvement in the quality of service provided to its members.	6	2
	Health Information Systems		
21	**42 CFR 438.242; DHS-MCO Contract Article XII.** The MCO maintains a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments (for other than loss of Medicaid eligibility).	8	0

Results for Grievance Systems

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

The graph below indicates each MCO's level of compliance with 16 QCR standards that applied to every organization.



The first column in the table below is the number assigned to the review standard. The second column is the standard. The last column, which is subdivided, depicts the number of MCOs that received a "met" rating and the number of MCOs that received a "partially met" rating for the standard. No MCO received a "not met" rating.

#	Grievance System	FY 14-15 Scores	
		Met	Partially Met
	Definitions and General Requirements		
1	**42 CFR 438.400; 42 CFR 438.402** The MCO must have a grievance and appeal system in place that includes an internal grievance process, an appeal process, and access to the state's Fair Hearing system.	8	0

#	Grievance System	FY 14-15 Scores	
		Met	Partially Met
2	**42 CFR 438.402; DHS-MCO Contract Article XI.** ***Authority to file*** The MCO must accept appeals and grievances from members and their preferred representatives, including providers, with the member's written consent. The MCO must follow the state-specified filing timeframes associated with standard and expedited appeals.	8	0
3	**42 CFR 438.402; DHS-MCO Contract Article XI.** The member may file grievances orally or in writing. The member, representative, or the provider may file an appeal either orally or in writing, and (unless he or she requests expedited resolution) must follow an oral filing with a written, signed, appeal. The MCO must acknowledge in writing receipt of each appeal or grievance within five business days of receipt of the appeal or grievance.	8	0
	Notices to Members		
4	**42 CFR 438.404; 42 CFR 438.10; DHS-MCO Contract Article XI.** ***Language, content, and format requirements*** The notice must be in writing and must meet language and format requirements to ensure ease of understanding. The MCO must use the DHS-issued: • Notice of Action (NOA) template; • Notification of Non-covered Benefit template; and • Notice of Change in Level of Care template.	7	1
5	**42 CFR 438.404; 42 CFR 431.210; 42 CFR 431.211; 42 CFR 431.213; 42 CFR 431.214 DHS-MCO Contract Article V. and XI.** ***Timing of notice*** The notice must be delivered to the member in the timeframes associated with each type of adverse decision: • Termination, suspension, or reduction of service; • Denial of payment for a requested service; • Authorization of a service in an amount, duration, or scope that is less than requested; • Service authorization decisions not reached within the timeframes specified, on the date the timeframes expires; • Expedited service authorization decisions; • Some changes in functional level of eligibility. If the MCO extends the timeframe for the decision making process it must: • Give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees; and	4	4

#	Grievance System	FY 14-15 Scores	
		Met	Partially Met
	• Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.		
	Handling of Grievances and Appeals		
6	**42 CFR 438.406; DHS-MCO Contract Article XI.** The MCO must give members any reasonable assistance in completing forms and taking other procedural steps in the grievances and appeals process. The MCO must designate a "Member Rights Specialist" who is responsible for assisting members when they are dissatisfied. The Member Rights Specialist may not be a member of the MCO grievance and appeal committee or represent the MCO at a State Fair Hearing. The MCO must attempt to resolve issues and concerns without formal hearings or reviews whenever possible through internal review, negotiation, or mediation. The MCO must allow members to involve anyone the member chooses to assist in any part of the grievance or appeal process, including informal negotiations.	7	1

7	**42 CFR 438.406; DHS-MCO Contract Article XI.**
	
	The MCO process must ensure that individuals who make decisions on grievances and appeals:
	• Have not been involved in any previous level of review or decision-making related to the issue under appeal;
	• Include health care professionals with appropriate clinical experience when deciding:
	  ○ Appeal of a denial based on lack of medical necessity;
	  ○ Grievance regarding denial of expedited resolution of an appeal;
	  ○ Grievance or appeal involving clinical issues;
	• Include at least one member (or guardian), or person who meets the functional eligibility requirements (or guardian) who is free of conflict of interest.
	
	The MCO must assure that all members of the grievance and appeal committee have agreed to respect the privacy of members, have received training in maintaining confidentiality, and that members are offered the choice to exclude any consumer representatives from participation in their hearing.
		6	2

#	Grievance System	FY 14-15 Scores	
		Met	Partially Met
8	**42 CFR 438.406;** ***Special requirements for appeals*** The MCO processes for appeals must: • Provide that oral inquires seeking to appeal an action must be confirmed in writing, unless the member or the provider requests expedited resolution; • Give members the opportunity to present evidence, and allegations of fact or law, in person or in writing at all levels of appeal; • Give the member and his/her representative the opportunity to examine the member's case record, including medical records and other documents, before and during the appeals process; • Include the member and/or representative or the legal representative of a deceased member's estate.	8	0
	Resolution and Notification		
9	**CFR 438.408; DHS-MCO Contract Article XI.** ***Basic rule*** The MCO has a system in place to dispose of each grievance and resolve each appeal as expeditiously as the member's situation and health condition requires, within established timeframes for standard and expedited dispositions of grievances and appeals. ***Extension of timeframes*** The MCO may extend the timeframes by up to 14 calendar days if: • The member requests the extension; • The MCO shows that there is a need for additional information and how the delay is in the member's interests. ***Requirements following extension*** If the MCO extends the timeframes, it must give the member written notice of the reasons for the delay.	5	3
10	**CFR 438.408; DHS-MCO Contract Article XI.** ***Format of notices*** The MCO must provide written notice of the disposition of appeals and grievances within required timeframes. If adverse to the member, the MCO must maintain a copy of the notification of appeal rights in the member's record. For expedited resolutions, the MCO must also make reasonable efforts to provide oral notice. ***Content of notices*** The written notice of the appeal resolution must include: • Results of the resolution process and date it was completed; • For appeals not resolved wholly in favor of the member o The right to request a State Fair Hearing and how to do so;	7	1

#	Grievance System	FY 14-15 Scores	
		Met	Partially Met
	○ The right to request to receive benefits while the hearing is pending and how to make the request; ○ The member may be held liable for the cost of those benefits if the hearing decision upholds the MCO's action. The written notice of the grievance resolution must include: • Results of the resolution process and date it was completed; • For decisions not wholly in the member's favor, the right to request a DHS review and how to do so.		
	Expedited Resolution of Appeals		
11	**CFR 438.410; DHS-MCO Contract Article XI.** The MCO must establish and maintain an expedited review process for appeals, when the MCO determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function. The MCO must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. If the MCO denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the timeframe for standard resolution; • Make reasonable efforts to give the member prompt oral notice of the denial and follow up within 72 hours with a written notice.	7	1
	Information About the Grievance System to Providers		
12	**CFR 438.414;** The MCO must provide the information about the grievance system to all providers and subcontractors at the time they enter into a contract.	7	1
	Recordkeeping and Reporting Requirements		
13	**CFR 438.416; DHS-MCO Contract Article XI;** The MCO must maintain records of grievances and appeals and review the information as part of its Quality Management Program. The MCO shall submit a quarterly grievance and appeal report to DHS.	7	1
	Continuation of Benefits While the MCO Appeal and State Fair Hearing are Pending		
14	**CFR 438.420** ***Continuation of benefits*** The MCO must continue the member's benefits if the: • Member or provider files the appeal timely; • Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; • Services were ordered by an authorized provider; • Original authorization has not expired; • Member requests the extension of benefits.	8	0

#	Grievance System	FY 14-15 Scores	
		Met	Partially Met
	Duration of continued benefits or reinstated benefits If the member requests, the MCO must continue or reinstate benefits until: • The member withdraws the appeal; • Ten days pass after the MCO mails the notice which provides the resolution of the appeal adverse to the member; • A State Fair Hearing Office issues a hearing decision adverse to the member; • The time period or service limits of a previously authorized service has been met.		
15	**CFR 438.420; DHS-MCO Contract Article XI.** ***Member responsibility for services while the appeal is pending*** If the final resolution of the appeal is adverse to the member, the MCO may recover the cost of services furnished to the member while the appeal is pending to the extent they were furnished solely because of the requirements of this section, unless DHS or the MCO determines that the person would incur a significant and substantial financial hardship as a result of repaying the cost of the services provided, in which case DHS or the MCO may waive or reduce the member's liability.	7	1
	Effectuation of Reversed Appeal Resolutions		
16	**CFR 438.424; DHS-MCO Contract Article XI.** ***Services not furnished while the appeal is pending*** If the MCO or the State Fair Hearing Officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires. ***Services furnished while the appeal is pending*** If the MCO or the State Fair Hearing Officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCO must pay for those services.	7	1

MCO Comparative Findings: QCR Standards Not Fully Met

The table below shows the QCR topic areas reviewed for every MCO in FY 14-15. Each QCR topic is associated with one or more quality compliance standards. The number in parentheses after each topic tells the number of compliance standards for that area of review. The check mark(s) in each column shows, for each MCO, the corresponding number of compliance standards in the QCR topic area that were not fully met in this year's EQR.

QCR TOPIC	CW	CCI	CCCW	ContinuUs	*i*Care	LCD	MCDFC	WWC
Enrollee Rights and Protections (7 standards FC; 8 standards FCP/PACE)								
General Rule (1)							√	

QCR TOPIC	CW	CCI	CCCW	ContinuUs	*i*Care	LCD	MCDFC	WWC
Information Requirements (5)	√√√	√		√	√√√		√	
Specific Rights (1)	√			√			√	√
Emergency and Post-stabilization Services (1) **(Applies to FCP and PACE only)**								
Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement (21 standards)								
Availability of Services (4)	√	√		√	√√√			
Coordination and Continuity of Care (2)	√		√√		√	√	√	
Coverage and Authorization of Services (2)					√		√	
Provider Selection (3)			√√√	√√	√√√			√
Confidentiality (1)								
Enrollment and Disenrollment (2)	√	√	√	√√	√√	√		√
Subcontractual Relationships and Delegation (1)					√			
Practice Guidelines (1)	√				√			
Quality Assessment and Performance Improvement Program (1)	√	√			√			
Basic Elements of the QAPI Program (2)		√		√	√√			
Quality Evaluation (1)		√			√			
Health Information Systems (1)								

QCR TOPIC	CW	CCI	CCCW	ContinuUs	*i*Care	LCD	MCDFC	WWC
Grievance Systems (16 standards)								
Definitions and General Requirements (3)								
Notices to Members (2)	√	√		√	√√			
Handling of Grievances and Appeals (3)		√√			√			
Resolution and Notification (2)					√√		√	√
Expedited Resolution of Appeals (1)							√	
Information about Grievance System to Providers (1)					√			
Recordkeeping and Reporting (1)					√			
Continuation of Benefits While Appeal is Pending (2)		√						
Effectuation of Reversed Appeal Resolutions (1)		√						
Total QCR Standards Not Fully Met For Each MCO	**10**	**11**	**6**	**9**	**26**	**2**	**7**	4

CONCLUSIONS

Enrollee Rights and Protections

The results for all eight MCOs in this area of review ranged from 10 to 14 points for seven Enrollee Rights standards that applied to every organization.

Strengths

- Two MCOs fully met the requirements of these seven Enrollee Rights standards, and scored 14 of a total possible 14 points.

- All eight organizations fully met requirements related to providing all notices, informational materials, and instructional materials to members in a manner and format they can easily understand (e.g., non-English languages, large print, etc.).
- All three FCP organizations fully met requirements related to coverage and payment of emergency and post-stabilization services.
- Seven of eight organizations fully met requirements related to:
    - Having written policies and processes in place to ensure staff and providers take members' rights into account when furnishing services;
    - Providing information to members in a Member Handbook; and
    - Having policies and processes in place to provide members with information regarding Advance Directives.

Opportunities

- Based on the findings, areas of opportunity for improvement where half or more of MCOs did not fully meet requirements include the need to:
    - Develop standard processes for giving timely written notice of termination of a contracted provider to members who received services from such provider; and
    - Ensure applications for renewal of restrictive measures plans are completed and submitted to DHS in a timely manner.

Quality Assessment and Performance Improvement

While no MCO fully met the requirements in this area of review, three MCOs scored 40 of a total possible 42 points. The results for all eight MCOs ranged from 26 to 40 points.

Strengths

- All eight organizations fully met requirements related to:
    - Promoting the delivery of services in a culturally competent manner to all members;
    - Ensuring the confidentiality of members' protected health and enrollment information; and
    - Maintaining a health information system that collects, analyzes, integrates, and reports data.
- Seven of eight organization fully met requirements related to:
    - Timely access to care and services;
    - Service coordination;
    - Service authorization, and timeliness of service authorization decisions; and
    - Subcontractual relationships and delegation of functions/responsibilities.

Opportunities

- Based on the findings, areas of opportunity for improvement where half or more of MCOs did not fully meet requirements include the need to:
    - Improve the comprehensiveness of assessments and member-centered plans;
    - Ensure policies and processes are in place for provider credentialing, as well as the ongoing verification and monitoring of licensure and/or certification of providers; and
    - Develop and implement a disenrollment policy that identifies the impermissible reasons for requesting member disenrollment.

Grievance System

The results for all eight MCOs in this area of review ranged from 25 to 32 points.

Strengths

- Two MCOs fully met the requirements of these 16 standards, and scored 32 of a total possible 32 points.
- Three additional MCOs each scored 31 points.

Opportunities

- Based on the findings, an area of opportunity for improvement where half or more of MCOs did not fully meet the requirement includes the need to:
    - Ensure notices are issued to members and are issued in a timely manner, when indicated.

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

The purpose of a PIP is to assess and improve processes and outcomes of health care provided by the MCO. For FY 14-15, the DHS-MCO contract required all MCOs to make active progress on at least one clinical project and one non-clinical project. Active progress was defined as progress to the point of having implemented at least one intervention and measured its effects on at least one indicator.

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

The study methodology is assessed through the following steps:

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

MCOs must seek DHS approval prior to beginning each project. For 2014, DHS modified the PIP timeline, requiring all projects to be conducted on a calendar year basis. For projects conducted during 2014, MCOs submitted proposals to DHS in February 2014. DHS directed MCOs to submit final reports in January 2015. MetaStar validated two or more PIPs for each MCO, for a total of 18 PIPs. More information about PIP Validation review methodology can be found in Appendix 3.

AGGREGATE RESULTS FOR PERFORMANCE IMPROVEMENT PROJECTS

The table below lists each standard that was evaluated and indicates the number of projects meeting each standard. Some standards are not applicable to all projects due to study design, results, or implementation stage.

FY 14-15 Performance Improvement Project Validation Results		
	Numerator = Number of projects meeting the standard Denominator = Number of projects applicable for the standard	
Study Topic(s)		
1	The topic was selected through MCO data collection and analysis of important aspects of member needs, care, or services.	18/18

FY 14-15 Performance Improvement Project Validation Results		
	Numerator = Number of projects meeting the standard Denominator = Number of projects applicable for the standard	
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.	17/18
Study Indicator(s)		
3	The study used objective, clearly and unambiguously defined, measureable indicators and included defined numerators and denominators.	17/18
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.	18/18
Study Population		
5	The project/study clearly defined the relevant population (all members to whom the study question and indicators apply).	18/18
6	If the entire population was used, data collection approach captured all members to whom the study question applied.	13/15
Sampling Methods		
7	Valid sampling techniques were used.	3/4
8	The sample contained a sufficient number of members.	4/4
Data Collection Procedures		
9	The project/study clearly defined the data to be collected and the source of that data.	18/18
10	Staff are qualified and trained to collect data.	18/18
11	The instruments for data collection provided for consistent, accurate data collection over the time periods studied.	13/17
12	The study design prospectively specified a data analysis plan.	18/18
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.	17/18
14	A continuous cycle of improvement was utilized to measure and analyze performance, and to develop and implement system-wide improvements.	16/18
15	Interventions were culturally and linguistically appropriate.	10/14
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.	14/18
17	Numerical results and findings were presented accurately and clearly.	13/18
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.	11/18
"Real" Improvement		
19	The same methodology as the baseline measurement was used, when measurement was repeated.	10/18
20	There was a documented, quantitative improvement in processes or outcomes of care.	5/18
21	The reported improvement appeared to be the result of the planned quality improvement intervention.	4/10
Sustained Improvement		
22	Sustained improvement was demonstrated through repeated measurements over comparable time periods.	2/2

Project Interventions and Outcomes

The table below lists each project, its aim, the interventions selected, and the project outcomes at the time of the validation. An overall validation result is also included to indicate the level of confidence in the organizations reported results. See Appendix 3 for additional information about the methodology for this rating.

Aim	Interventions	Outcomes	Validation Result	EQR Recommendations
MCO – Care Wisconsin				
Increase use of angiotensin converting enzyme (ACE) inhibitors and angiotensin receptor blockers (ARB) therapy for members with diabetes and hypertension (FC)	Identified members with diabetes and hypertension, and not currently taking ACE or ARB medication. Contacted primary care physicians (PCP) to encourage adding ACE or ARB therapy when indicated.	Project did not demonstrate improvement.	Partially Met	Ensure data is accurate. Clearly report data. Conduct continuous cycles of improvement if interventions not successful.
Increase use of ACE and ARB therapy for members with diabetes and hypertension (FCP)	Sent letters from medical director to PCPs encouraging ACE or ARB therapy. Modified registered nurse (RN) assessments to capture newly diagnosed members.	Project did not demonstrate improvement.	Partially Met	Clearly report data, including baseline and repeat measures. Monitor effectiveness of interventions.
Decrease incidents related to care transitions (FC, FCP)	Developed a *Care Transitions Guide* to clarify follow-up requirements. Added Transitions Support RN position. Collaborated with county Care Transitions Coalition.	Project did not demonstrate improvement.	Partially Met	Include measurable goals for all study questions. Analyze effectiveness of interventions. Include baseline and repeat measures.
MCO – Community Care, Inc.				
Decrease blood pressures (BP) to the goal range of less than 140/90 (FC)	Increased frequency of member outreach. Developed member educational materials. Provided education for RNs, including BP competency.	Project demonstrated improved BP control in the study population. Though, interventions were not shown to be more effective than	Met	Select interventions which address root causes. Further analyze the impact of more frequent BP assessment on the attainment of control.

Aim	Interventions	Outcomes	Validation Result	EQR Recommendations
	Emphasized communication with PCPs.	"usual care".		
Decrease BP to the goal range of less than 140/90 (FCP, PACE)	Sent letters from pharmacy to PCPs encouraging ACE or ARB therapy. Expanded Dietary Approaches to Stop Hypertension (DASH) diet training. Conducted BP competency training.	Project did not clearly demonstrate improvement.	Partially Met	Select interventions which address root causes or barriers. Analyze data at the member level. Clearly display data, including numerators and denominators.
Increase percent of members who complete an advance directive after participation in a facilitated discussion (FC, FCP, PACE)	Implemented process of facilitated advance care planning conversations in expanded geographic area. Refined process and trained additional facilitators.	Project met goals, though did not use a valid sampling technique. 60% of members developed a written plan.	Partially Met	Utilize valid sampling methods. Fully analyze data. Ensure initial and repeat measures are comparable.
MCO – Community Care Connections of Wisconsin				
Decrease percent of female members over 18 with an intellectual disability who have not completed Pap screening (FC)	Developed toolkit to educate staff, members, their representatives, and providers.	Interventions have not yet been implemented.	Partially Met	Implement interventions and measure effectiveness.
Increase percent of notices issued to members when warranted (FC)	Developed educational tools and *Quick Resource Guide.*	Interventions have not yet been implemented.	Partially Met	Implement interventions and measure effectiveness.
MCO - ContinuUs				
Increase pneumonia vaccination rates for non-vaccinated members (FC)	Developed toolkit to educate members, staff and providers. Offered prize drawing to members who self-reported obtaining the vaccination.	Project resulted in vaccination of 15-28% of members in 3 cohorts; though, effectiveness of interventions not demonstrated for all.	Partially Met	Ensure data is accurate. Take study limitations into consideration in analysis. Measure effectiveness of interventions.

Aim	Interventions	Outcomes	Validation Result	EQR Recommendations
Increase percent of members with a physical disability who pursue integrated employment (FC)	Developed toolkit for staff and member education.	Pilot project demonstrated some improvement.	Partially Met	Ensure the project design allows adequate time for periodic monitoring.
MCO – Independent Care Health Plan				
Maintain rate of low density lipoprotein cholesterol (LDL-C) screening rate and increase LDL-C control rate in members with diabetes (FCP)	Educated members and providers via newsletters. Coordinated care through care management services. Added a home testing kit option.	LDL-C screening rate increased from 74.8% to 83.3%. LDL-C control rate was not able to be measured.	Partially Met	Ensure data collection procedures are effective. Fully analyze data and measure effectiveness of the interventions.
Reduce hospital readmission rate (FCP)	Developed standardized process, including nurse practitioner visit within three days of discharge.	Project likely achieved some improvement; though, the study had limitations.	Partially Met	Describe how interventions were selected. Ensure initial and repeat measures are comparable. Take study limitations into consideration in analysis.
MCO – Lakeland Care District				
Reduce rate of falls for members residing in community based residential facilities	Implemented Vitamin D supplementation. Provided education to staff and providers.	Project demonstrated “real” and sustained improvement for members ages 65 and older. Fall rate declined from .20 to .10. Project did not demonstrate improvement for members ages 18 – 64.	Partially Met	Ensure baseline and repeat measures are comparable.

Aim	Interventions	Outcomes	Validation Result	EQR Recommendations
Increase member satisfaction related to a prompt message response	Educated and engaged staff regarding customer service. Retrained staff using care management resources.	Project demonstrated "real" and sustained improvement.	Met	Identify cultural or linguistic appropriateness of interventions.
MCO – Milwaukee County Department of Family Care				
Increase development of behavior support plans (BSPs) and crisis plans (CPs) for members relocated from an institutional setting to a community setting. Decrease the number of restrictive measures needed for the same population.	Trained staff and direct care providers. Revised care management processes. Enhanced clinical oversight for members with challenging behaviors.	Project achieved "real" improvement. The rate of members with BSPs and CPs increased. The rate of members with restrictive measures decreased.	Met	Clearly describe the data collection process. Define all numerators and denominators.
Increase the rate of consistent reporting of behaviors. Increase the number of members with BSPs.	Educated interdisciplinary team staff. Conducted targeted file reviews.	Project achieved "real" improvement. Consistent reporting of behaviors improved. The percent of members with BSPs increased.	Met	Continue efforts to improve accuracy of reporting behaviors.
MCO – Western Wisconsin Cares				
Decrease rate of self-directed support fraud.	Provided education and resources to staff. Implemented additional monitoring and changes to claims processing system.	Project identified most issues were administrative and not actual fraud. Project did not demonstrate quantitative improvement due to the small numerator.	Partially Met	Continue ongoing analysis and expand to other office locations.

Aim	Interventions	Outcomes	Validation Result	EQR Recommendations
Increase rate of staff utilizing depression guideline and assessment tools. Decrease number of critical incidents for members with diagnosis of depression.	Educated staff regarding *Depression Clinical Guidelines.*	Project demonstrated improvement in rate of staff following the guideline. Project did not achieve improvement in the number of critical incidents.	Partially Met	Ensure interventions are culturally and linguistically appropriate. Evaluate other relevant clinical outcomes.

CONCLUSIONS

All MCOs obtained project approvals to conduct the required number of PIPs. Active progress was made in sixteen of eighteen projects, during this first year of the modified PIP timeline.

Four projects achieved documented, quantitative improvement which appeared to be the result of the interventions employed. Two of those four projects demonstrated sustained improvement with repeat measures.

Strengths

- Study topics were selected based on MCO-specific data and needs analysis.
- The study indicators and study populations were clearly defined overall; standards were met for these steps at a rate of 96 percent.
- Standards for data collection procedures were met at a rate of 94 percent, indicating that most projects collected data which was valid and reliable.
- Most projects employed interventions which were sufficient to improve outcomes, and utilized continuous cycles of improvement.

Opportunities for Improvement

- Establish a project timeframe which allows adequate time to implement at least one intervention and measure its effectiveness.
- Ensure data collection methods result in consistent, accurate data collection and capture all members of the study population.
- Develop interventions which are culturally and linguistically appropriate and include relevant documentation in the report.
- Present numerical findings accurately and clearly.
- Analyze and address the impact of all study limitations or barriers.
- Utilize the same methodology for baseline and repeat measures.

- Measure and analyze the effectiveness of the interventions employed.
- Use continuous cycles of improvement to adjust interventions as needed to achieve improvement.

Validation of Performance Measures

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

As directed by DHS, MetaStar validated the completeness and accuracy of MCOs' influenza and pneumococcal vaccination data for measurement year (MY) 2014. The MY is defined in the technical definitions provided by DHS for the influenza and pneumococcal vaccination quality indicators. DHS updated the technical definitions in September 2014. The technical specifications can be found in Attachments 1 and 2. The review methodology MetaStar used to validate these performance measures can be found in Appendix 3.

Vaccination Rates by Program and MCO

The results of statewide performance for immunization rates in FC, FCP, and PACE are summarized below.

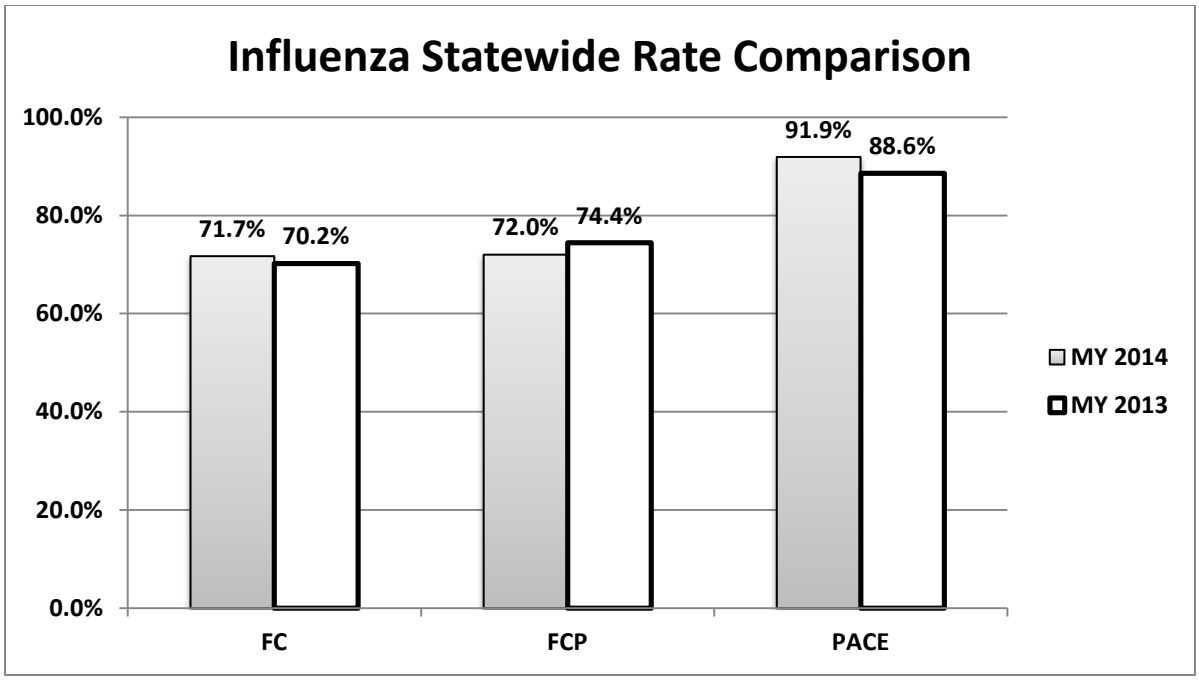
Influenza Vaccination Rates

The following table shows information about the influenza vaccination rates, by program, for MY 2014 and compares the 2014 rates to vaccination rates in MY 2013, which:

- Increased by 1.5 percentage points for FC members;
- Decreased by 2.4 percentage points for FCP members; and
- Increased by 3.3 percentage points for PACE members.

Statewide Influenza Vaccination Rates by Program				
	MY 2014			MY 2013
Program	Eligible Members	Number Vaccinated	Vaccination Rate	Vaccination Rate
Family Care	33,011	23,684	71.7%	70.2%
Family Care Partnership	2,460	1,770	72.0%	74.4%
PACE	596	548	91.9%	88.6%

Influenza statewide vaccination rates, by program, for MY 2014 and MY 2013 are shown in the following graph.



As shown in the table below, among MCOs that operate FC, the MY 2014 influenza vaccination rates ranged from 69.4 percent to 79.8 percent. Among MCOs that operate FCP, the 2014 rates ranged from 57.2 percent to 88.3 percent. The 2014 rate for the one MCO that operates the PACE program was 91.9 percent.

It should be noted that CCCW's MY 2013 rates had been submitted and reported separately by the MCO's two service regions in the previous report, due to the timing of a competitive procurement and contract. At the direction of DHS and agreement of the MCO, the rates were combined into a single MY 2013 rate reported here.

Influenza Vaccination Rates by Program and MCO in MY 2014 and MY 2013			
Program/MCO	**MY 2014 Rate**	**MY 2013 Rate**	**Percentage Point Change**
Family Care			
CCCW	69.4%	63.3%	6.1%
CCI	69.8%	66.1%	3.7%
ContinuUs	74.3%	73.7%	0.6%
CW	74.4%	75.1%	(0.7%)
LCD	79.8%	79.5%	0.3%
MCDFC	69.9%	70.6%	(0.7%)
WWC	71.9%	72.9%	(1.0%)

Family Care Partnership			
CCI	88.3%	81.7%	6.6%
CW	71.7%	78.5%	(6.8%)
*i*Care	57.2%	60.1%	(2.9%)
PACE			
CCI	91.9%	88.6%	3.3%

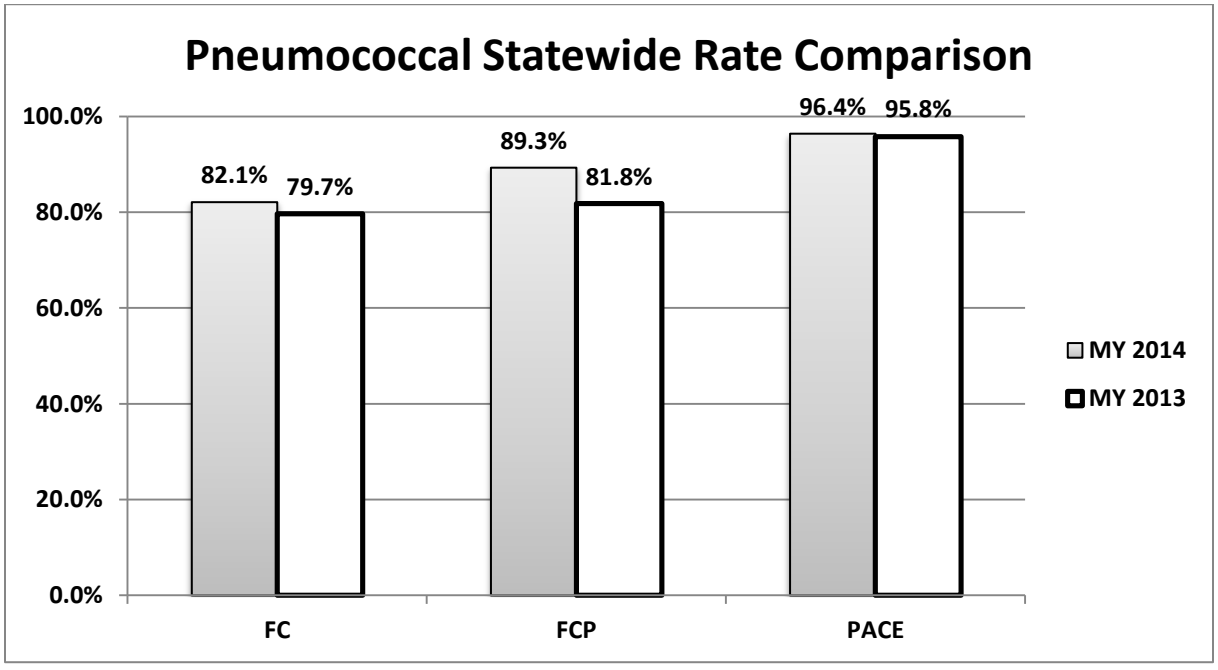
Pneumococcal Vaccination Rates

The table below shows information about the pneumococcal vaccination rates, by program, for MY 2014 and compares the 2014 rates to vaccination rates in MY 2013, which:

- Increased by 2.4 percentage points for FC members;
- Increased by 7.5 percentage points for FCP members; and
- Increased by 0.6 percentage points for PACE members.

Statewide Pneumococcal Vaccination Rates by Program				
	MY 2014			MY 2013
Program	**Eligible Members**	**Number Vaccinated**	**Vaccination Rate**	**Vaccination Rate**
Family Care	15,231	12,507	82.1%	79.7%
Family Care Partnership	1,173	1,048	89.3%	81.8%
PACE	472	455	96.4%	95.8%

Pneumococcal statewide vaccination rates, by program, for MY 2014 and MY 2013 are shown in the following graph.



As shown in the table below, among MCOs operating FC, the MY 14 pneumococcal vaccination rates ranged from 72.4 percent to 92.4 percent. Among MCOs that operate FCP, the 2014 rates ranged from 82.1 percent to 91.2 percent. The 2014 rate for the one MCO that operates PACE was 96.4 percent.

Pneumococcal Vaccination Rates by Program and MCO in MY 2014 and MY 2013			
Program/MCO	**MY 2014 Rate**	**MY 2013 Rate**	**Percentage Point Change**
Family Care			
CCCW	72.4%	69.5%	2.9%
CCI	68.8%	64.2%	4.6%
ContinuUs	88.8%	84.4%	4.4%
CW	72.9%	81.7%	(8.8%)
LCD	86.7%	84.0%	2.7%
MCDFC	84.6%	84.7%	(0.1%)
WWC	92.4%	92.5%	(0.1%)
Family Care Partnership			
CCI	88.7%	88.9%	(0.2%)
CW	91.2%	79.8%	11.4%
*i*Care	82.1%	76.3%	5.8%
PACE			
CCI	96.4%	95.8%	0.6%

Results of Performance Measures Validation

Technical Specification Compliance

For each quality indicator, MetaStar reviewed the vaccination data submitted by each MCO for compliance with the technical specifications established by DHS. All MCOs' vaccination data were found to be compliant with the technical specifications for both quality indicators.

Comparison of MCO and DHS Denominators

For each quality indicator and program, MetaStar evaluated the extent to which the members the MCOs included in their eligible populations were the same members that DHS determined should be included.

For all MCOs and both quality indicators, more than 99.5 percent of the total number of unique members included in the MCOs' and DHS' denominator files was common to both data sets. However, it should be noted that three MCOs were required to resubmit data for one indicator because their initial submissions were outside the five percentage point threshold established by DHS.

VACCINATION RECORD VALIDATION

To validate the MCOs' influenza and pneumococcal vaccination data, MetaStar requested 30 records for randomly selected members per quality indicator for each program the MCO operated during MY 2014. Whenever possible, the samples included 25 members reported to have received a vaccination and five members reported to have a contraindication to the vaccination. Five MCOs operated programs for which no members were reported as having contraindications for either one or both of the quality indicators.

As shown in the following tables, MetaStar reviewed a total of 330 member vaccination records for each quality indicator for MY 2014, and 360 records for each quality indicator for MY 2013. The aggregate results for both years were not biased, meaning the rates can be accurately reported.

Vaccination Record Validation Aggregate Results

MY 2014 Influenza and Pneumococcal Vaccination Record Validation				
Quality Indicator	**Total Records Reviewed**	**Number Valid**	**Percentage Valid**	**T-Test Result**
Influenza Vaccinations	330	315	95.4%	Unbiased
Pneumococcal Vaccinations	330	319	96.7%	Unbiased

MY 2013 Influenza and Pneumococcal Vaccination Record Validation				
Quality Indicator	**Total Records Reviewed**	**Number Valid**	**Percentage Valid**	**T-Test Result**
Influenza Vaccinations	360	351	97.5%	Unbiased
Pneumococcal Vaccinations	360	355	98.6%	Unbiased

Vaccination Record Validation MCO Results

The following tables provide information about the validation findings for each MCO in MY 2014.

Results for Influenza Vaccination

MY 2014 Influenza Vaccination Record Validation by Program and MCO				
MCO	**Total Records Reviewed**	**Number Valid**	**Percentage Valid**	**T-Test Result**
Family Care				
CCCW	30	30	100.%	Unbiased
CCI	30	29	96.7%	Unbiased
ContinuUs	30	30	100%	Unbiased
CW	30	26	86.7%	Unbiased
LCD	30	30	100%	Unbiased
MCDFC	30	29	96.7%	Unbiased
WWC	30	30	100%	Unbiased

Family Care Partnership				
CCI	30	28	93.3%	Unbiased
CW	30	26	86.7%	Unbiased
*i*Care	30	30	100%	Unbiased
PACE				
CCI	30	27	90.0%	Unbiased

Results for Pneumococcal Vaccination

MY 2014 Pneumococcal Vaccination Record Validation by Program and MCO				
MCO	**Total Records Reviewed**	**Number Valid**	**Percentage Valid**	**T-Test Result**
Family Care				
CCCW	30	30	100%	Unbiased
CCI	30	26	86.7%	Unbiased
ContinuUs	30	30	100%	Unbiased
CW	30	25	83.3%	Biased
LCD	30	30	100%	Unbiased
MCDFC	30	30	100%	Unbiased
WWC	30	30	100%	Unbiased
Family Care Partnership				
CCI	30	30	100%	Unbiased
CW	30	30	100%	Unbiased
*i*Care	30	30	100%	Unbiased
PACE				
CCI	30	28	93.3%	Unbiased

It should be noted that CW originally reported seven exclusions/contraindications in the FCP pneumococcal data set. During the review process, the MCO discovered that these seven members actually received the vaccine. Upon direction from DHS, the MCO submitted documentation that supported receipt of the vaccine. The members' status was changed to "vaccinated."

One MCO's FC pneumococcal dataset included 23 members reported to be contraindicated from receiving the vaccine. MetaStar selected five of these 23 members for the validation sample. As the MCO was unable to provide documentation to verify the contraindications, the rate was found to be biased. Upon direction from DHS, the status of all 23 FC members originally reported to have contraindications was changed to "not vaccinated." The rates in this report reflect that change.

CONCLUSIONS

- MCOs should provide staff with adequate written guidance that aligns with DHS technical specifications, in order to ensure staff is knowledgeable about vaccination requirements, and can accurately obtain and enter member immunization information into MCO systems. DHS could consider requiring the MCOs to report back to the Bureau of Managed Care on any revisions or updates the MCOs made to their policies and procedures as a result of the MY 2014 Performance Measures Validation.
- To reduce data resubmissions, MCOs should implement lessons learned to ensure only members continuously enrolled during the respective timeframe are included in the data sets.
- Evaluate data queries to ensure they include the correct vaccination date that aligns with DHS technical specifications.
- Explore the reasons why members are not vaccinated when the refusal field is left blank, in order to identify actionable plans for improvement.

Information Systems Capability Assessment

ISCAs are a required part of other mandatory EQR protocols, required by 42 CFR 438, which help determine whether MCOs' information systems are capable of collecting, analyzing, integrating, and reporting data. ISCAs were conducted during FY 14-15 for two MCOs selected by DHS. One MCO operates only a FC program, and the other operates programs for FC, FCP, and PACE.

To conduct the assessment, each MCO (and its vendors, if applicable) completed a standardized ISCA tool, and provided data and documentation to describe its information management systems and practices. Reviewers evaluated this information and visited each MCO to conduct staff interviews and receive demonstrations. See Appendix 3 for more information about the review methodology.

Aggregate Results

Section I: General Information

Both MCOs provided required information. One MCO should update its organization chart to reflect administrative and functional changes that have occurred as a result of its expansion into a new service area.

Section II: Information Systems - Encounter Data Flow

Both MCOs met nearly all requirements in this area. One MCO needs to enhance its processes for testing and analyzing encounters, due to a higher than acceptable volume of encounter reporting issues as identified by DHS. The other MCO should take additional steps to monitor and quantify the rate of defects in its encounter reporting cycles. This MCO should also train additional staff, in order to ensure continuity in the event of staffing changes.

Section III: Claims and Encounter Data Collection

Both MCOs demonstrated compliance with most requirements in this focus area. One MCO should work to improve the rate of electronic claims for nursing home, residential, and dental services, as it is less than DHS' desired rate of 80 percent. The other MCO should work with DHS to determine the appropriate rate of electronic claims submissions for mental health/substance abuse and nursing home services.

Section IV: Eligibility

One MCO met all requirements in this area. The other MCO met most of the requirements and should improve its documented procedures by including details about verification and reconciliation of information, such as third party liability and Medicare eligibility, especially when these steps may vary by members' program affiliations.

This MCO should also ensure it maximizes the use of information found in DHS electronic reports, rather than relying on paper forms.

Section V: Practitioner Data Processing

Both MCOs met all requirements of this focus area; however, one MCO conducts limited edit checks, which could potentially lead to errors and delays in claims processing and payment.

Section VI: System Security

Both MCOs met nearly all requirements related to system security. One MCO should develop a records retention policy to fully meet all requirements. The other MCO should verify its communication and monitoring practices to ensure all security and confidentiality concerns are addressed and trended. This MCO also has the opportunity to streamline its policies and procedures so the same expectations are applied across all of its programs.

Section VII: Vendor Oversight

Both MCOs met all requirements of this focus area. One MCO could strengthen its internal auditing and monitoring process, rather than relying primarily on external audits and reports.

Section VIII: Medical Record Data Collection

This section did not apply to either MCO as they do not collect medical record information for encounter reporting purposes.

Section IX: Business Intelligence

One MCO met all requirements. The other MCO met all requirements but one, and should take steps to reconcile its claims, accounting systems data, and encounter submissions to ensure completeness and accuracy for reporting and other business purposes.

Section X: Performance Measure

Both MCOs met the requirements for this focus area. One MCO could improve its performance measure data collection by segmenting the information by population characteristics, such as target group or ethnicity. The other MCO could improve its documented processes by detailing all of the steps for extracting data from its system in order to complete the DHS performance measures spreadsheet, as well as the steps for testing and validating data prior to submission.

CONCLUSIONS

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

However, one MCO recently transitioned its information system relative to the timing of the review. As a result, MetaStar recommended increased monitoring and oversight by DHS to ensure continued compliance and ability to meet encounter reporting and performance measurement/improvement requirements.

Strengths

- Both MCOs continue to manage growth in key areas, including claims processing and encounter data reporting. While growth circumstances have been different (one MCO has absorbed the operations of an MCO going out of business, while the other has increased membership through outreach efforts in its existing service area), both have accommodated this growth through upgrading and enhancing systems capabilities.
- Both MCOs have documented expectations and processes regarding security and confidentiality, and deploy these through on-going staff training, physical security arrangements, detection and stoppage of potential breaches, and preparedness for disaster and other potential adverse events.
- Both MCOs communicate with their vendors in a manner which facilitates timely feedback and problem solving. (One MCO relies solely on external vendors, while the other utilizes an external vendor for its pharmacy operations only.)

Opportunities for Improvement

- Both MCOs should continue testing, monitoring, and evaluating their new/enhanced information systems, in order to ensure that their systems continue to operate smoothly, and create complete, accurate, and timely claims and encounter data.
- Both MCOs should work to reduce the volume of paper claims in certain service areas to shorten the time spans from claims submission to payment, improve standardization, and reduce errors in claims processing and encounter data submissions.
- Both MCOs should continue to improve the quality of encounter data creation and submission and address any issues, with the goal of minimizing defects and batch data rejections by DHS.

Care Management Review

CMR is an optional activity which helps determine a MCO's level of compliance with its contract with DHS; ability to safeguard members' health and welfare; and ability to effectively support care management teams in the delivery of cost effective, outcome-based services. As directed by DHS, four review categories were used to evaluate care management practice:

- Assessment
- Care planning
- Service coordination and delivery
- Member-centered focus

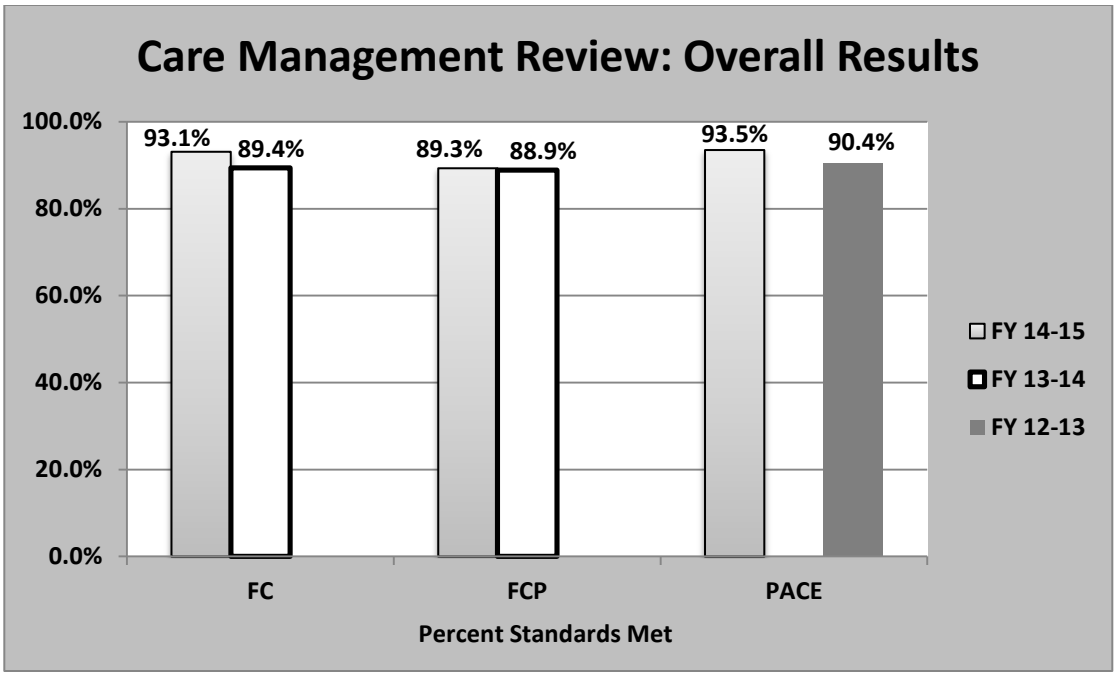
The four categories consisted of a total of 14 review indicators. More information about the CMR review methodology can be found in Appendix 3.

Aggregate results for FY 14-15 CMRs conducted as part of each MCO's annual EQR are displayed in several graphs below and compared to results from the previous review year. When reviewing and comparing results, the reader should take into account the size of the total sample of records reviewed by MetaStar may vary year to year. Additionally, not all review indicators necessarily apply to every record in the review sample. This means that even if the size of the CMR sample is the same from one year to the next, the number of records to which a specific review indicator applies will likely differ.

Overall Results by Program

The following three graphs show the overall percent of standards met for all review indicators for CMRs conducted during the FY 14-15 review year for organizations operating programs for FC, FCP and PACE. FY 13-14 results are provided for comparison for FC and FCP. FY 12-13 results are provided for comparison for PACE. MetaStar did not conduct a PACE CMR in FY 13-14 as CMS reviewed the program.

The overall rate of standards met for each program was calculated by dividing the total number of review indicators scored "yes" (meaning the indicator was met), by the total number of applicable indicators.



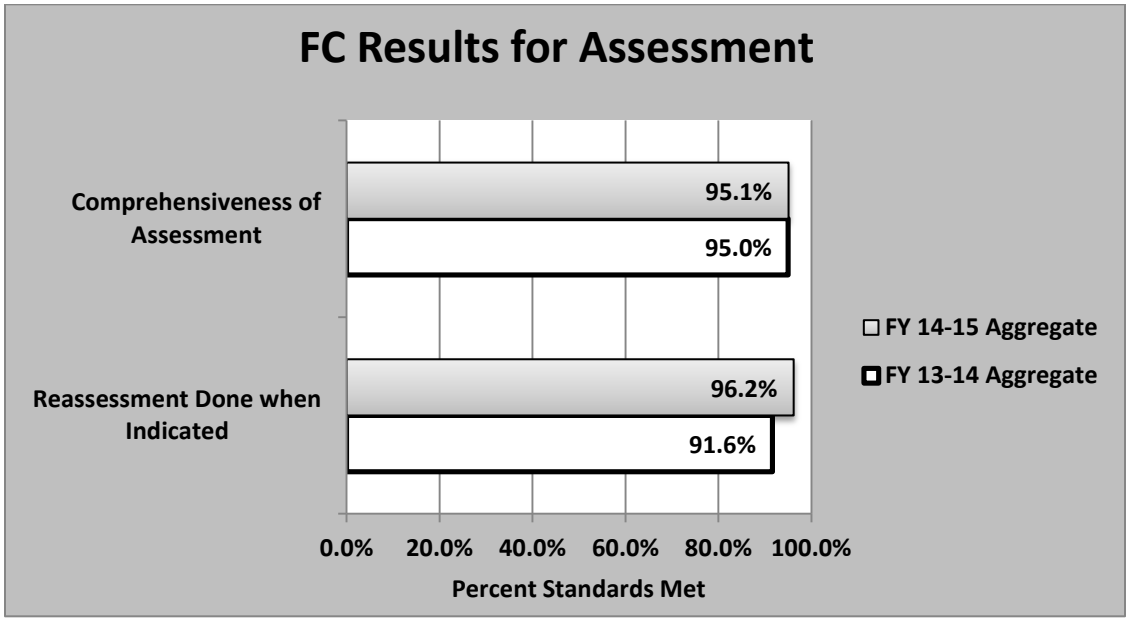
Results for each CMR Focus Area

Each of the four sub-sections below provides a brief explanation of one of the key categories of CMR, followed by bar graphs which display FY 14-15 CMR results by program (FC, FCP, and PACE) for each review indicator that comprises the category. FY 13-14 results are provided for comparison for FC and FCP. FY 12-13 results are provided for comparison for PACE. MetaStar did not conduct a PACE CMR in FY 13-14 as CMS reviewed the program.

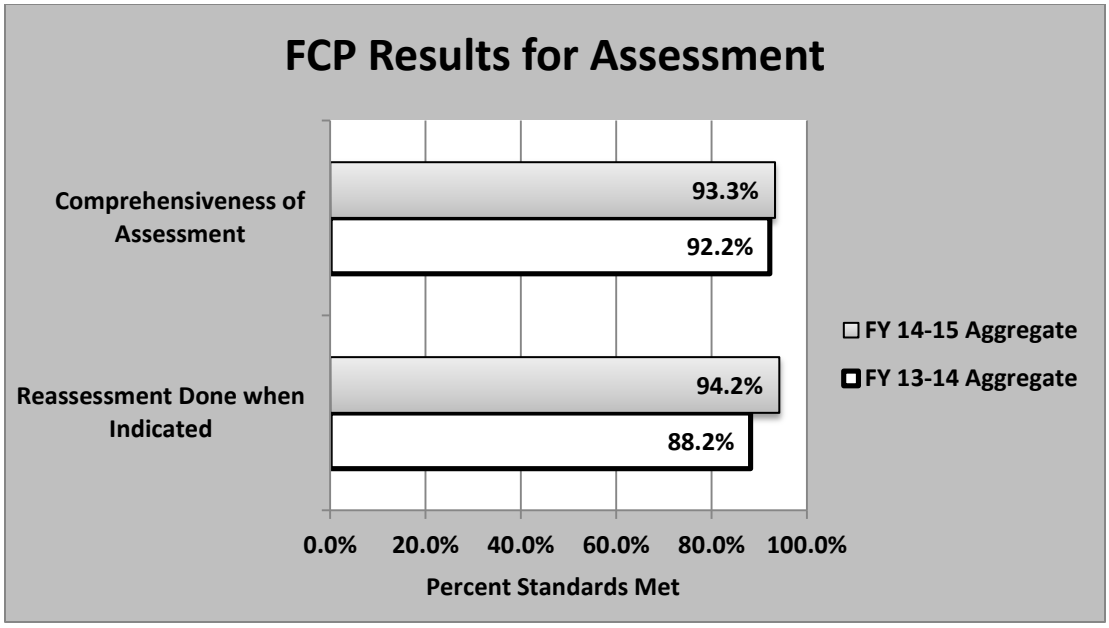
Assessment Focus Area

IDT staff must comprehensively explore and document each member's personal experience and long-term care outcomes, strengths, preferences, informal supports, and ongoing clinical or functional needs that require a course of treatment or regular care monitoring. The initial assessment and subsequent reassessments must meet the timelines and conditions described in the DHS-MCO contract.

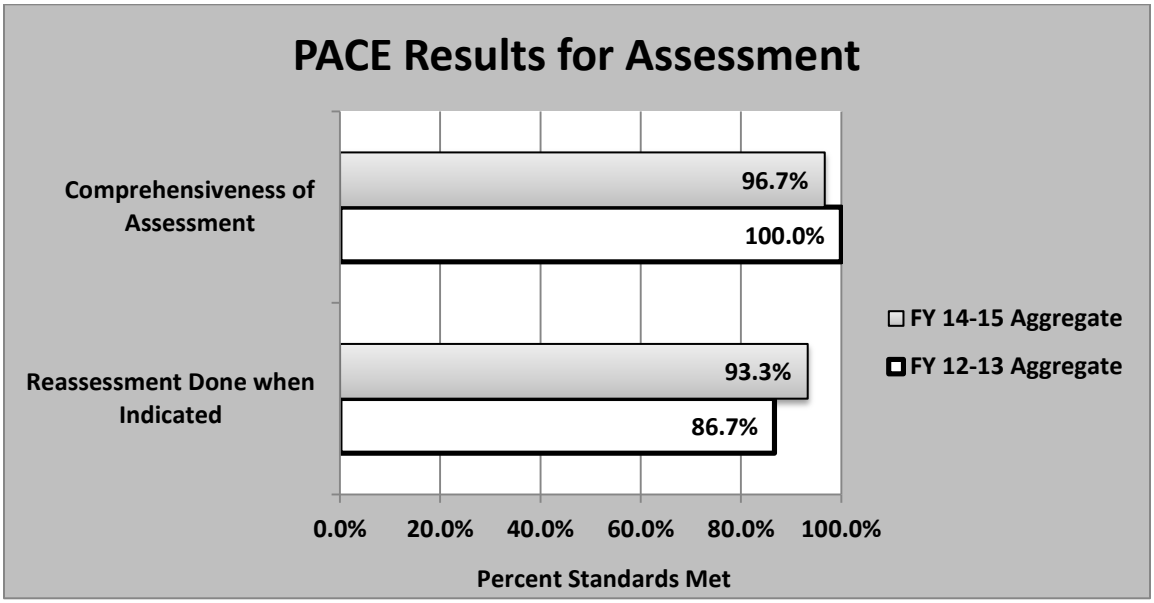
Results for Assessment for MCOs Operating FC:



Results for Assessment for MCOs Operating FCP:



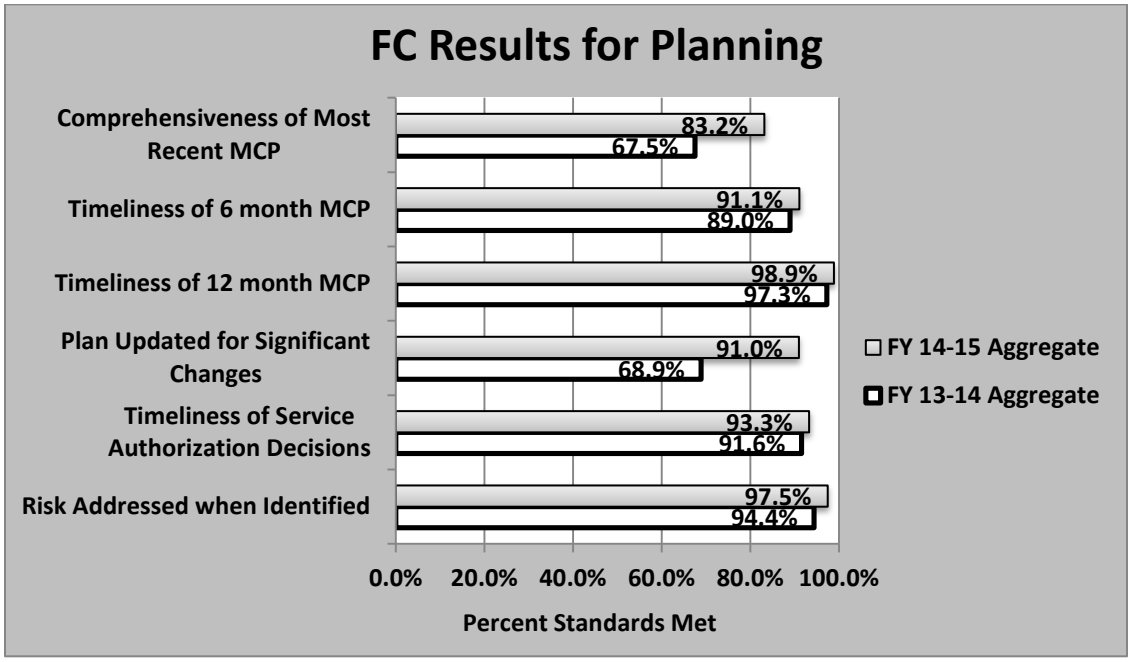
Results for Assessment for MCOs Operating PACE:



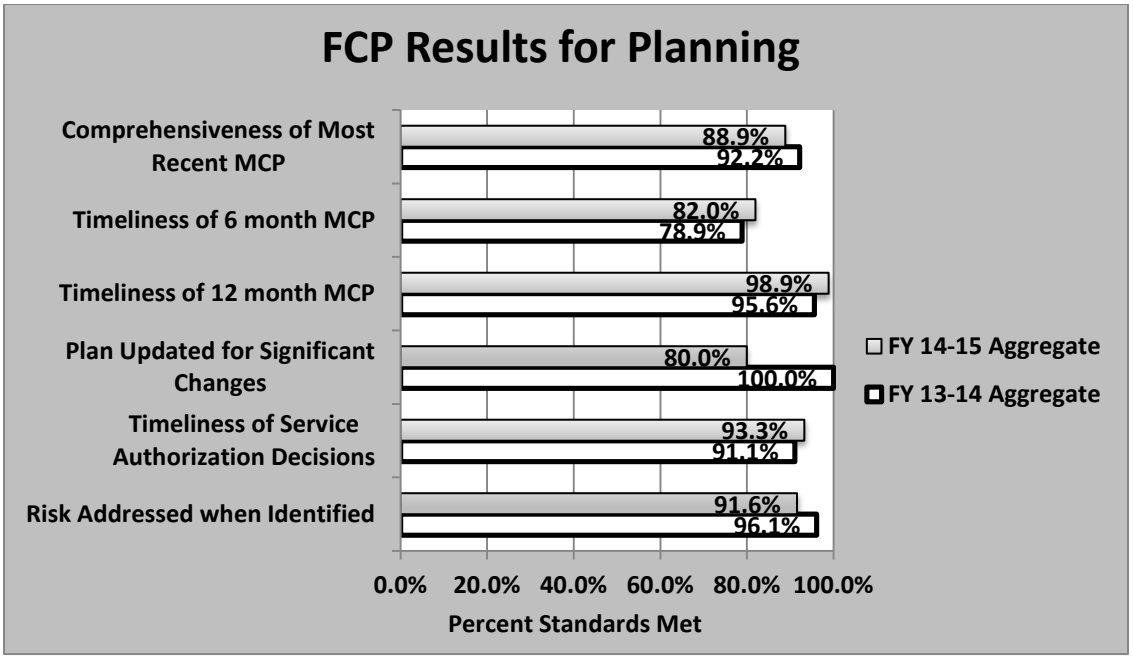
CARE PLANNING FOCUS AREA

The MCP and Service Authorization document must identify all services and supports to be coordinated consistent with information in the comprehensive assessment, and must be developed and updated according to the timelines and conditions described in the DHS-MCO contract. Additionally, the record must document that the IDT adequately addressed any risks related to the actions or choices of the member. The record should show that decisions regarding requests for services and decisions about member needs identified by IDT staff were made in a timely manner according to contract requirements.

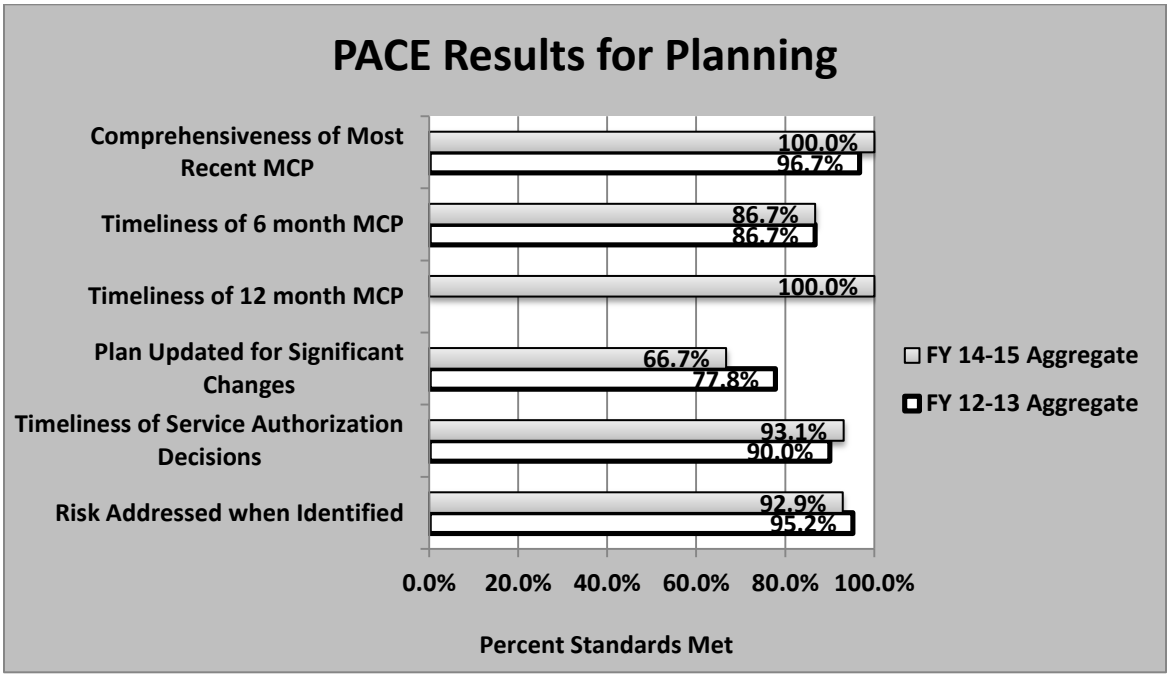
Results for Care Planning for MCOs Operating FC:



Results for Care Planning for MCOs Operating FCP:



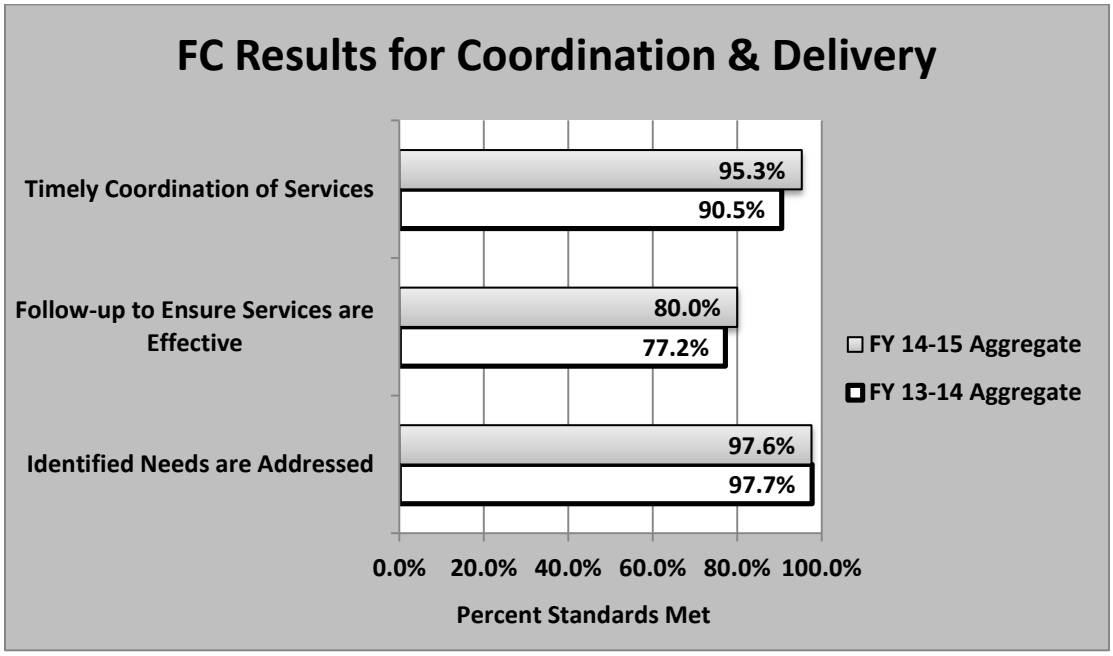
Results for Care Planning for MCOs Operating PACE:



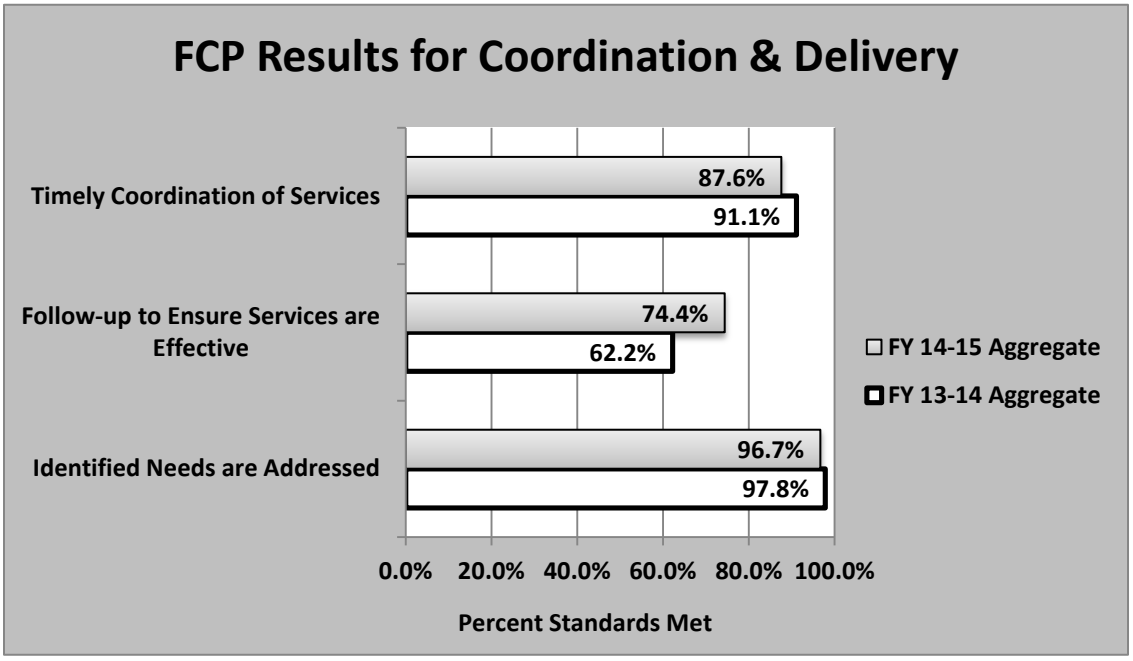
Coordination and Delivery Focus Area

The record must document that the member's services and supports were coordinated in a reasonable amount of time; that the IDT staff followed up with the member in a timely manner to confirm the services/supports were received and were effective for the member; and that all of the member's identified needs have been adequately addressed.

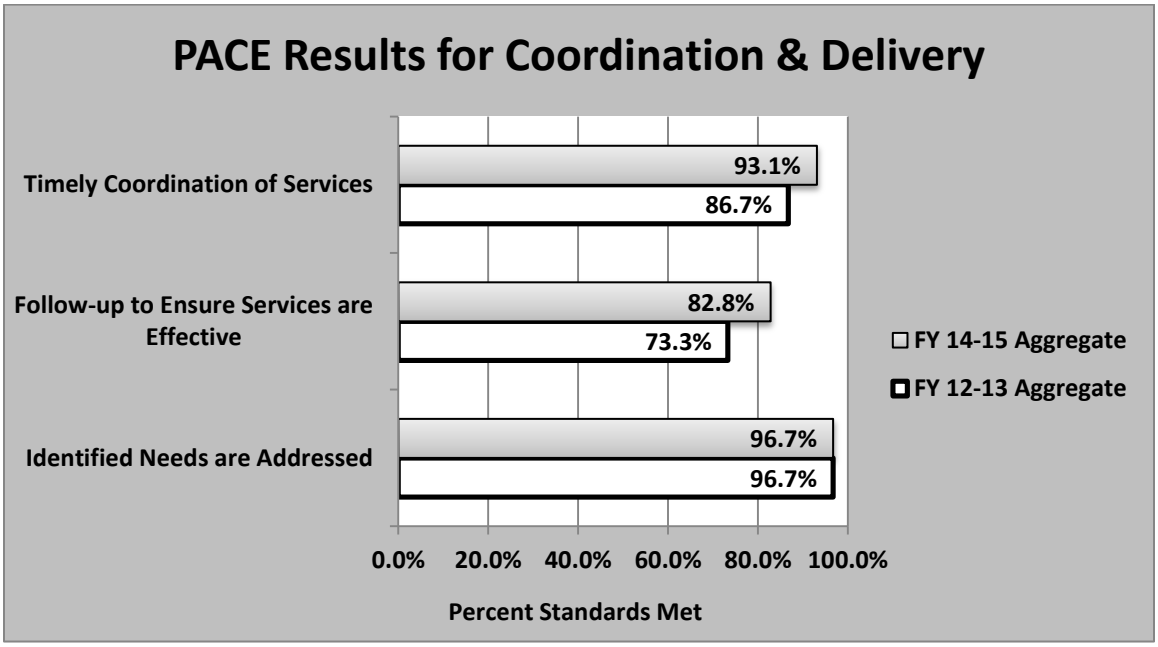
Results for Coordination and Delivery for MCOs Operating FC:



Results for Coordination and Delivery for MCOs Operating FCP:



Results for Coordination and Delivery for MCOs Operating PACE:



MEMBER-CENTEREDNESS FOCUS AREA

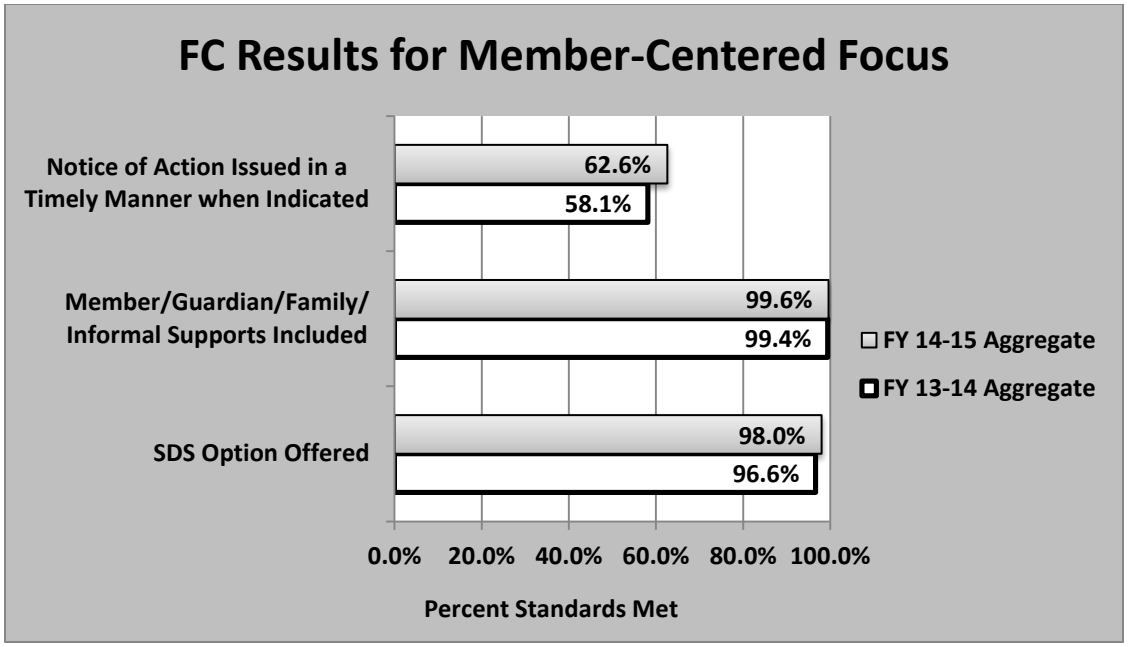
The record should document the IDT staff includes the member and his/her supports in care management processes; that staff protects member rights by issuing notices in accordance with requirements outlined in the DHS-MCO contract; and that the self-directed supports (SDS) option has been explained and offered to the member.

In reviewing results in the three graphs below, readers should be aware that the indicator, "Notices Issued in a Timely Manner When Indicated" is scored on a per record basis. This means, for example, that if a record contains three instances where a notice is indicated, and the IDT issues a timely notice in two instances but not the third, the indicator would be scored as "not met."

In FY 14-15, MetaStar also collected and provided information to DHS and the MCOs about the total number of notices indicated and issued in the random sample of records reviewed; that rate is not represented in the following graphs.

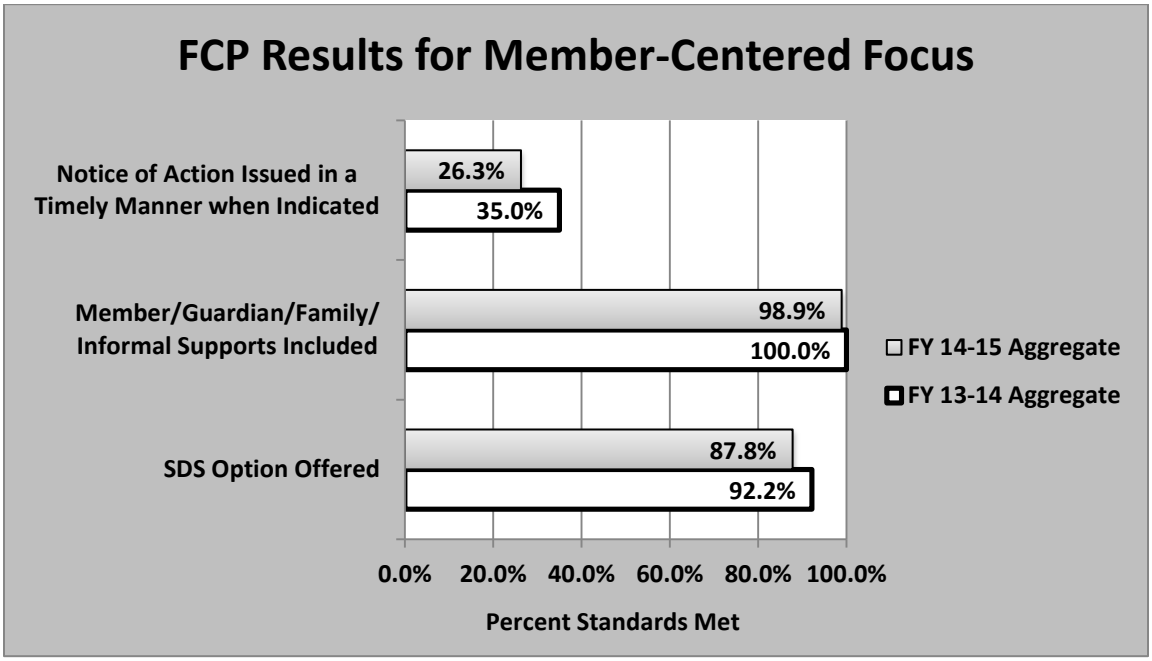
For FC, the aggregate rate of compliance for issuing notices on a *per record* basis was 62.6 percent. The rate for issuing a notice *in every instance* was 67.6 percent.

Results for Member-Centered Focus for MCOs Operating FC:



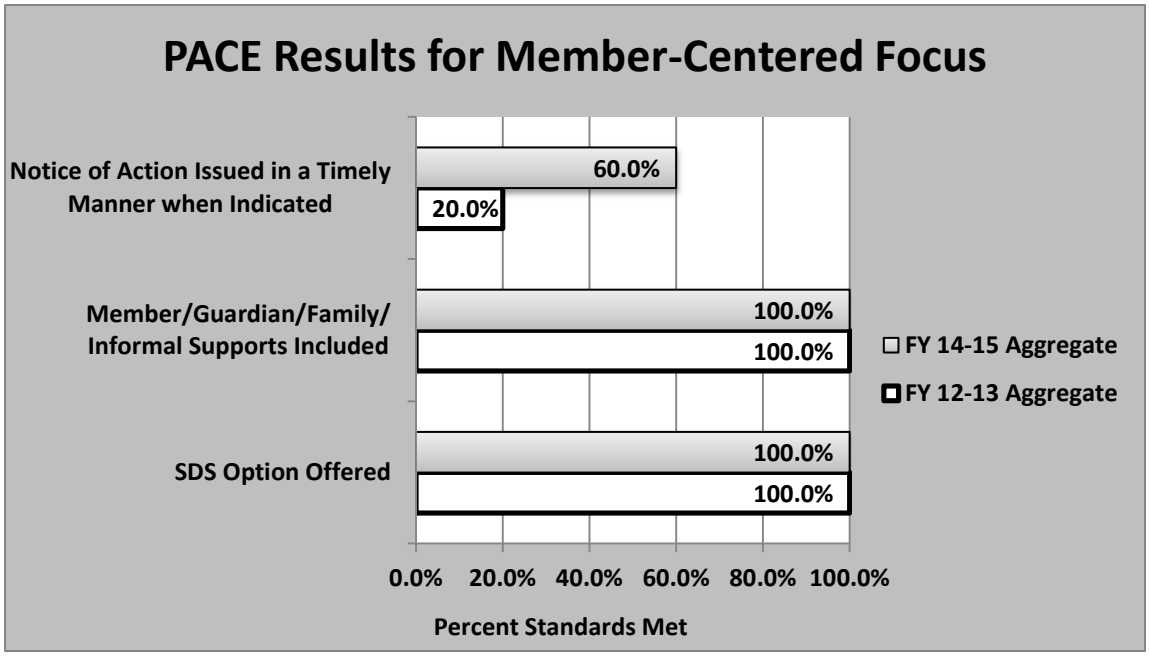
For FCP, the aggregate rate of compliance for issuing notices on a *per record* basis was 26.3 percent. The rate for issuing a notice *in every instance* was 30.2 percent.

Results for Member-Centered Focus for MCOs Operating FCP:



For PACE, the rate of compliance for issuing notices on a *per record* basis was 60 percent. The rate of compliance for issuing a notice *in every instance* was 42.9 percent.

Results for Member-Centered Focus for MCOs Operating PACE:



CONCLUSIONS

The overall results show the FC program achieved progress compared to its results in FY 13-14. Analysis indicated the year-to-year difference in the overall rates was likely attributable to actions of the MCOs, and was unlikely to be the result of normal variation or chance. While the overall results for FCP and PACE also showed some positive change since each program's previous CMR, analysis indicated the year-to-year difference in the overall rates for these programs was likely due to normal variation or chance.

Progress

- FY 14-15 aggregate results for the FC program were over 90 percent for 11of 14 CMR indicators. In FY 13-14 aggregate results were 90 percent or higher for nine of 14 CMR indicators.
- Aggregate results for the FC program indicated notable progress in five areas of CMR, which was likely attributable to actions of the MCOs and unlikely to be the result of normal variation or chance. Two were identified as areas of opportunity for improvement in last year's review:

- "Comprehensiveness of Most Recent MCP" increased from 67.5 percent to 83.2 percent.
- "Plan Updated for Significant Changes" increased from 68.9 percent to 91 percent.

The remaining three areas of notable progress for FC were:

- "Reassessment Done When Indicated" increased from 91.6 percent to 96.2 percent.
- "Risk Addressed When Identified" increased from 94.4 percent to 97.5 percent.
- "Timely Coordination of Services" increased from 90.5 percent to 95.3 percent.

- FY 14-15 aggregate results for the FCP program were over 90 percent for seven of 14 CMR indicators. In FY 13-14, aggregate results were over 90 percent for 10 of 14 CMR indicators.
- Though some indicators for the FCP program demonstrated positive change, analysis of the year-to-year differences indicated it was likely the result of normal variation or chance. One indicator declined significantly; see the Opportunities section for more information.
- FY 14-15 results for the one PACE program were over 90 percent for 10 of 14 CMR indicators. In FY 12-13, the last time MetaStar conducted a CMR for PACE, aggregate results were 90 percent or higher for seven of 13 CMR indicators.

Strengths

- All programs (FC, FCP and PACE) achieved aggregate results over 90 percent for the following review indicators:
  - "Comprehensiveness of Assessment"
  - "Reassessment Done When Indicated"
  - "Risk Addressed When Identified"
  - "Timeliness of Service Authorization Decisions"
  - "Timeliness of 12 month MCP"
  - "Identified Needs are Addressed"
  - "Member/Guardian/Family/Informal Supports Included."

Opportunities

- All programs (FC, FCP and PACE) should focus on improving in the follow areas of care management practice. Results over time identify both as continuing areas of opportunity for improvement:
  - Following up to ensure services have been received and are effective; and
  - Issuing notices to members, when indicated.

- FC has the opportunity to continue to improve results related to the indicator, "Comprehensiveness of Most Recent MCP," which was also identified as an area for improvement in last year's review.
- The compliance rate for one FCP indicator declined significantly, and analysis of the year-to-year difference found that the change was unlikely to be the result of normal variation or chance:
    - "Plan Updated for Significant Changes" decreased from 100 percent to 80 percent.
- FCP also has the opportunity to improve the timeliness with which MCPs are reviewed and signed by members or their legal decision makers within required six month intervals. This was also identified as an area for improvement in last year's review. Results were 82 percent in FY 14-15, and 78.9 percent in FY 13-14; analysis indicated the year-to-year difference in the rate was likely due to normal variation or chance.
- PACE has the opportunity to improve the timeliness with which MCPs are reviewed and signed by members or their legal decision makers within required six month intervals.
- PACE also has the opportunity to continue to improve results related to updating plans for significant changes.

Encounter Data Validation

Encounter data are the electronic records of services or items that have been provided to FC, FCP, or PACE members. Encounter data validation (EDV) is an optional activity which assesses the completeness and accuracy of encounter data submitted to DHS by an MCO. Valid encounter data helps with assessing and improving quality, monitoring program integrity, and determining capitation payment rates.

At the direction of DHS, MetaStar conducted encounter data validation activities focused on long-term care services and supports, for three MCOs. Two of the MCOs operate only FC programs, and one MCO operates only a FCP program. The reviews began in FY 13-14, and were completed and reported during FY 14-15. See Appendix 3 for information about the review methodology.

Evaluation of the Data Extract

DHS provided MetaStar with encounter and eligibility data for one MCO, and MetaStar retrieved the data extract directly from the DHS Data Warehouse for the other two MCOs. Due to the large enrollment and high volume of claims and encounters for the two FC MCOs, data extraction was limited to three months. Six months of data were extracted for the FCP MCO; however, data for the sixth month deviated from the average monthly submissions for the other five months and were excluded.

MetaStar evaluated the data extracts for the three MCOs to ensure required values were present, and that the data were valid (i.e., followed DHS specifications), consistent across fields, and typical of the reporting periods.

- For one FC MCO, targeted case management volumes dropped 40 percent in three months.
- For the other FC MCO, targeted case management volumes varied which, appeared to be due to the timely creation and submission of this encounter type.

For the FCP MCO, encounters from the sixth month were substantially lower than the previous five months, possibly due to payment or submission lag time, and were excluded (see above). MetaStar also compared each data extract with DHS enrollment data:

- For the two FC MCOs, the extracts reflected the MCOs' membership. MetaStar found no evidence the organizations had submitted encounter data for ineligible individuals.
- For the FCP MCO, the extract was found to be reasonably representative of the MCO's membership, but also included more than 30 persons who had never been enrolled in the organization's FCP program.

- MetaStar did not research why these individuals were included in the data set, but noted some were enrolled in other managed care programs operated by the organization.

Selection of Services for Validation

MetaStar analyzed each MCO's encounter data extract and identified the 10 long-term care services and supports with high utilization and/or cost. For each MCO, five of the 10 services/supports were selected for validation. Other factors were also considered in the selection, such as findings from the MCO's ISCA, the programmatic significance for members in all target groups, and the desire to replicate at least one service, targeted case management, for all three of the MCOs subject to the EDV. With the assistance of MetaStar's biostatistician, a sampling methodology was developed to meet DHS expectations regarding significance and efficiency. As a result, the sample sizes differed among the three organizations. See the methodology section for more information.

Validation Results

Each MCO submitted documentation in the form of provider service records to support the service encounters identified in the random samples. Two MCOs provided supporting documentation for 100 percent of the encounter records in their samples, while the third MCO provided documentation for 98.3 percent of the encounters in its sample. To complete the validation activity, MetaStar compared the selected encounter records to the MCOs' provider service records in the following areas:

- Member and provider;
- Date range and quantity of services; and
- Type of service.

The table below provides information about the results of the encounter data validation for the three MCOs combined, for eight logical service areas. The table identifies the services selected for validation, the number of encounters and the number of members in each sample, and the rate of agreement between the encounter data and documentation in the provider service record for the three validation criteria.

Validation Results for All MCOs, by Service Area

Service and Procedure or Revenue Code	Number of Encounters in Sample	Number of Members in Sample	% Encounters Met Member and Provider Validation Criteria	% Encounters Met Date and Quantity Validation Criteria	% Encounters Met Service Validation Criteria
Targeted Case Management (T1017)	135	75	100.0%	98.5%	100.0%

Service and Procedure or Revenue Code	Number of Encounters in Sample	Number of Members in Sample	% Encounters Met Member and Provider Validation Criteria	% Encounters Met Date and Quantity Validation Criteria	% Encounters Met Service Validation Criteria
Ancillary Services CBRF >8 Beds (243)	44	36	100.0%	93.2%	100.0%
Attendant/Personal Care 15 Minutes (S5125/T1019)	127	40	100.0%	29.9%	100.0%
Transportation (T2003/A0100)	119	41	100.0%	96.7%	100.0%
Adult Day Care (S5102)	26	17	100.0%	80.7%	100.0%
Supportive Home Care-Homemaker (S5130)	25	12	100.0%	80.00%	92.0%
Day Habilitation/Habilitation Prevocational (S2021/T2015)	45	27	95.60%	60.%%	97.8%
Home Health Visit/Medication Administration Visit (570/T1502)	126	62	100%	33.70%	100.0%
Total Encounters	**647**				

CONCLUSIONS

Information about members, providers, and service types was accurate between encounter data submitted to DHS and the corresponding documentation in the provider service records. The area of greatest mismatch was with regard to date and quantity of services:

- High levels of agreement were found for targeted case management, ancillary services-CBRF, and transportation.
- Moderate levels of agreement were found for adult day care and supportive home care-homemaker.
- Relatively low or low levels of agreement were found for home health/medication administration visit, day habilitation/habilitation prevocational, and attendant/personal care.

Strengths

- MCOs have systems and processes in place to track and report member and provider information, as well as to correctly and consistently link providers with services.
- In five of the eight service areas: targeted case management, ancillary services-CBRF, supportive home care-homemaker, adult day care, and transportation, providers seem to keep detailed records of the services they provide, including the dates and correct amounts and types of the units/quantities of service.

Opportunities

- All MCOs must take action to ensure they correctly report timeframes and units of service.
- One MCO should examine historical encounter data in order to determine the extent to which non-FCP members were included in FCP encounter data. The MCO should evaluate processes related to program enrollment verification and remediate those steps which contributed to the erroneous reports.
- MCOs should verify, and DHS should clarify as needed, the encounter data expectations regarding calculation of service quantity:
    - For residential and institutional services, clarify use of "day out" (last day in the service interval) in the calculation;
    - For personal care, home health, habilitation and other related services, ensure use of the correct unit type for each service (15 minutes, hour, day, item, trip, etc.) as outlined in encounter/coding DHS materials and guidance.

ANALYSIS

TIMELINESS, ACCESS, QUALITY

The CMS guidelines regarding this annual technical report direct the external quality review organization (EQRO) to provide an assessment of the MCOs' strengths and weaknesses with respect to quality, timeliness, and access to health care services. A high level of compliance with these review activities provides assurances that MCOs are meeting requirements related to access, timeliness, and quality. A summary of each MCO's findings can be found in Appendix 2, including MetaStar's assessment of key strengths and recommendations for improvement for each MCO. The information in Appendix 2 and the analysis included in this section of the report are intended to provide that assessment.

As noted earlier in this report, QCR follows a three-year cycle. The first year MetaStar conducts a comprehensive review, where all QCR standards are assessed for each MCO. This is followed by two years of targeted review. FY 14-15 was a comprehensive review year. Forty-four standards were assessed at every MCO, and for organizations operating FCP or PACE, one additional standard was also assessed.

Beginning with this three-year cycle, the QCR standards were scored using a point system. The 44 standards applicable to every organization carried a maximum possible score of 88 points. Individually, four of the eight MCOs scored 80 points or above. The results for all eight MCOs ranged from 62 to 86 points. The overall results showed that seven of eight organizations possess the majority of structural and operational characteristics required to deliver quality care and ensure members have timely access to information and services. One organization did not fully meet a majority of the QCR standards, and needs to make progress in all three areas of QCR. Some key areas on which the organization should focus include improving its structure and operations related to maintaining a network of appropriate and qualified providers; and taking steps to ensure its QAPI Program effectively monitors the organization's processes and outcomes of care, and demonstrates improvement in quality, timeliness, and access to care where needed.

In previous years, MetaStar had recommended that DHS standardize the timeline across MCOs related to conducting and reporting PIPs, in order to facilitate active progress on PIPs during each reporting period. DHS acted on this recommendation beginning in calendar year 2014. Seven of eight organizations achieved active progress on their projects during the first year of the modified timeline.

Findings from influenza and pneumococcal vaccination measure validation indicate that all MCOs followed DHS' specifications and reporting requirements. One MCO's FC influenza vaccination rate was biased, i.e., the reported exclusions/contraindications were unable to be validated.

Upon direction of DHS, these members were considered "not vaccinated" in final rates, which are therefore accurate.

ISCAs conducted at two MCOs indicate they have the basic systems, resources, and processes in place to meet DHS' requirements for oversight and management of services to members and supporting quality and performance improvement initiatives. Findings from encounter data validation were mixed; MCOs accurately reported member and provider information, but were inconsistent in reporting correct service dates and quantities.

Quality Compliance Review

Enrollee Rights and Protections

This area of review consists of seven standards applicable to every organization, and one additional standard applicable to organizations operating FCP and PACE. The standards address members' general rights, such as the right to information, as well as specific rights related to dignity, respect, and privacy. Overall results indicated most of the MCOs' policies, procedures, and practices regarding enrollee rights and protections are aligned to meet requirements, the practices are implemented, and monitoring is in place. Across organizations, valuing and supporting the rights of members was identified as an area of strength.

Individually, two MCOs fully met the requirements for all of the standards in this area of review. In aggregate, the findings identified two areas in need of improvement where at least half of the MCOs did not meet the requirement; one relates to notifying affected members regarding the termination of a contracted provider, and the other relates to restrictive measures.

Documentation and onsite discussions confirmed all MCOs have implemented a member rights policy and provide training, support, and monitoring to ensure staff understand and respect the rights of members. Nearly all MCOs also have approaches in place to ensure providers take member rights into account when furnishing services; however, one MCO did not fully meet this requirement and needs to implement a standard procedure for educating contracted providers on all member rights. Every MCO met requirements related to ensuring the confidentiality of health and enrollment information.

Documentation and onsite discussions confirmed all MCOs have implemented policies, procedures, training, and monitoring related to providing members with required information in a timely manner, and in accessible languages and formats. Only one organization did not fully meet requirements for information that must be included in the Member Handbook/Evidence of Coverage and Provider Directory, and needs to revise these and other materials it provides to members to ensure they include all required information. Another organization needs to improve the functioning of its online, searchable FC and FCP provider directories, to ensure the availability of any alternate languages(s) is consistently and correctly displayed.

This organization also needs to revise its advance directives policy, procedure, and related materials, to ensure members are informed about the right to file a complaint regarding non-compliance with an advance directive.

In onsite discussions, staff across organizations understood the contact timelines for newly enrolled members; described the information provided to and reviewed with members at the time of initial enrollment; and reported they continue to review and/or offer both written and online information to members at periodic intervals. Staff at each MCO understood the requirement to offer members information in alternate languages and formats and arrange for interpreter services, as appropriate, and was able to describe the organizational processes and resources available to meet members' information needs. Staff understood members' privacy rights and was able to describe policies and processes related to ensuring the privacy and confidentiality of members' personal and health information.

The standards related to providing information to members include the requirement that MCOs make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to members who received services from that provider.

Five MCOs did not fully meet this requirement for various reasons:

- Two organizations reported they have no process for written notification, but that care managers verbally notify their assigned members.
- One MCO's guidance limited the situations where written notice would be provided.
- Another MCO developed a letter template, though guidance for using the template as a mechanism to notify members was not present in its policies/procedures.
- One organization's policy indicated sending the written notice to members is a standard process; however, the MCO did not provide documentation of a procedure or process to support the policy statement.

These five MCOs need to develop or revise policies, procedures, and practices to address this requirement.

The standard related to the specific rights of members includes the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. Documentation and onsite discussions confirmed all MCOs have implemented policies, procedures, training, resources, and internal supports related to the use of restraints and restrictive measures.

However, four MCOs did not fully meet this requirement:

- The restrictive measures policy of one of these MCOs did not describe how restrictive measures are reviewed and approved annually, and needs to be revised to include this information.
- In addition, review of the restrictive measures tracking log for each of these four organizations showed members whose current restrictive measures plans had expired without new approved plans in place. The MCOs need to conduct analysis, in order to identify barriers and implement strategies to improve the timeliness of restrictive measures plan renewals.

Quality Assessment and Performance Improvement: Access, Structure and Operation, Measurement and Improvement

This broad area of review consists of 21 standards that can generally be divided into three areas: access to services and provider network; care coordination and service authorization; and quality assessment and performance improvement.

Overall results in this area of review were mixed. Individually, no MCO fully met the requirements for all of the standards in this area of review, although three MCOs met 19 of these 21 standards. One MCO fully met only five standards and received "partially met" scores for 16 of the 21 standards. In aggregate, the findings identified three areas in need of improvement where at least half of the MCOs did not fully meet the requirement; provider selection, retention, and credentialing; member assessment and planning; and disenrollment.

Access to Services and Provider Network

Ten standards address requirements related to service access covering the adequacy of the service delivery network; provider selection, retention and credentialing; subcontracting and delegation; timely access to care and services; cultural competency in service provision; and processes for timely enrollment/disenrollment.

Documentation, onsite verification activities, and discussions with MCO staff indicated nearly every organization has policies, procedures, contract templates, and monitoring in place to maintain an adequate service delivery network and ensure members have timely access to services. The comprehensive approach used to develop, maintain, and monitor their provider networks was identified as an area of strength at three MCOs, and also noted in the review findings of two other organizations. However, across all organizations, some of the policies or practices related to these 10 standards were not fully compliant with requirements, or in some instances, were not fully implemented. There were also some instances where policies or processes had yet to be developed. Two organizations were advised to place priority on recommendations they received related to maintaining and monitoring their provider networks.

In onsite discussions, staff at various organizations described the systems and processes they use to analyze the adequacy and capacity of their provider networks and identify service gaps. Staff also described mechanisms for monitoring network quality and responding to concerns about providers, and often characterized provider quality activities as involving staff from multiple areas and levels of the organization. Staff also talked about ways they provide information, training, and technical assistance to providers. At several organizations staff described working with providers in a way that fosters communication and collaboration, with the goal of improving quality and helping providers succeed. This approach was identified as an area of strength at four MCOs, and also noted in the review findings of at least two other organizations.

Five MCOs fully met requirements to maintain and monitor a network of appropriate service providers, supported by written agreements and the use of data and analysis, to ensure the adequacy of the network and provide sufficient access to all services covered under the DHS-MCO contract.

Three MCOs did not meet all of the criteria related to the delivery network:

- While one organization met most aspects of the standard, its policy and procedure regarding women's health services did not align with the requirement to provide direct access to women's health specialists, and needs to be revised.
- Two other organizations did not demonstrate the use of data and analysis to measure and assess the adequacy of their provider networks.
    - One MCO did not provide evidence it had obtained and analyzed data since its last review, and was advised to analyze the adequacy of its provider network using data, such as anticipated enrollment, service utilization, and types and geographic locations of providers.
    - The other organization had not yet implemented a method using data to establish and monitor network adequacy. This organization was advised to develop and implement methods to measure and monitor network adequacy and timely access for both long-term care and acute and primary care services.

Maintaining a network of appropriate and qualified service providers requires having systems and processes in place related to provider selection, retention, and credentialing. Four MCOs fully met requirements for provider credentialing, while the other four MCOs did not.

- Two of these MCOs have policies and procedures in place for provider selection, retention, and credentialing. However, verification activities conducted onsite identified areas of noncompliance:
    - One organization was not always following some of its procedures and needs to ensure provider credentialing processes are consistently applied.

    - The process used by the other organization did not include actual verification of all practitioners' licenses, and the MCO did not have a procedure in place to monitor a sample. This MCO needs to update related policies and procedures to include a process to ensure all relevant providers and practitioners have and maintain current licensure or certification.
- Two other MCOs did not have clearly defined processes for ongoing verification and monitoring of licensure and/or certification of providers.
    - MetaStar had previously advised one of these MCOs to institute a process to ensure long-term care service providers maintain licensure. However, the onsite verification activity and discussions with staff at this organization revealed this recommendation had not been implemented. This MCO needs to institute a process to ensure all relevant providers have and maintain appropriate licensure or certification.
    - Review findings indicated the other organization does not have written policies for selection and retention of providers. This MCO needs to implement written policies and procedures and follow a documented process for credentialing and re-credentialing of providers.

Two other standards for provider selection and retention pertain to requirements that MCOs have policies and processes in place to ensure they do not employ or contract with providers that have been excluded/debarred from participating in federal health care programs; and comply with additional state requirements to ensure providers and subcontractors perform periodic background checks on caregivers.

While five MCOs met requirements to ensure providers have not been excluded from participating in federal health care programs, three MCOs did not fully meet these requirements.

- One organization employed a monthly monitoring procedure to verify providers were not excluded from participating in federal health care programs. However, the MCO needs to revise its process, as the organization has been limiting searches to providers with a Wisconsin address and may not be identifying all relevant providers.
- Two other organizations did not demonstrate the processes they currently have in place are effective in monitoring providers for exclusion/debarment.
    - One organization was advised to evaluate its exclusion review process, and ensure investigations related to exclusion/debarment are adequate and clearly documented.
    - The other MCO needs to update its current policy and practice to ensure its debarment verifications meet contract requirements.

Six MCOs fully met additional requirements related to ensuring providers and subcontractors perform caregiver background checks. Two MCOs did not fully meet this standard.

- Documentation and onsite verification activities for one organization did not confirm the MCO's processes are fully implemented for monitoring provider and subcontractor compliance with caregiver background check requirements. The organization was advised to modify its current process to ensure providers complete all background checks in a timely manner and apply the results to hiring decisions.
- The other organization had received several recommendations in last year's review related to fully implementing a consistent caregiver background check monitoring process. While the MCO took some steps to improve its processes and ensure compliance with background check requirements, documentation and onsite verification activities did not provide assurance the improved processes have been fully implemented. This organization still needs to fully implement a comprehensive, consistent caregiver background check monitoring process.

Standards related to service access require MCOs to ensure members have timely access to care and services, including regularly monitoring providers to determine compliance with state standards for timely access. Seven organizations met these requirements. Only one organization did not fully meet the requirements. While this MCO has a procedure in place for monitoring timely access to certain types of care and services, it had not conducted monitoring during the past year.

Six organizations met requirements related to providing members access to a second opinion from a qualified health care professional and access to out-of-network providers, as appropriate. Two organizations did not fully meet the requirements regarding access to second opinions:

- The member handbook submitted by one of these organizations appeared to limit when members could request a second opinion to "prior to surgery."
- Neither organization had written policies or procedures to provide staff with consistent guidance related to obtaining second opinions, and need to develop such guidance.

One of these organizations also failed to fully meet requirements regarding access to out-of-network providers. This MCO had recently implemented an out-of-network policy that appeared to conflict with its other written guidance as well as with the practices staff described during onsite discussions. This MCO needs to ensure its policies and practices are consistent and meet all requirements.

Every organization met requirements to promote the delivery of services in a culturally competent manner to all members. Exploring and implementing creative approaches to providing culturally and linguistically sensitive information and services, and the ability to provide services

to meet the needs of members with diverse cultural and ethnic background was identified as an area of strength for three organizations.

MCOs must comply with enrollment and disenrollment requirements and limitations, including the requirement to have in place written policies and procedures that identify the impermissible reasons for disenrollment. Only one MCO fully met this requirement. The other seven MCOs did not meet the requirement.

- While six organizations had policies and procedures in place to guide other aspects of enrollment and disenrollment, the policies/procedures did not specify the impermissible reasons for requesting disenrollment, and need to be revised to include this required guidance.
- The policies and procedures submitted by the remaining organization were limited and did not address all aspects of enrollment and disenrollment. This organization needs to develop and implement written policies and procedures to guide all aspects of enrollment and disenrollment, including a policy which indicates the impermissible reasons for requesting a member's disenrollment.

MCOs are also required to make good faith efforts to work collaboratively with Aging & Disability Resource Centers (ADRCs) and Income Maintenance (IM) agencies to develop and maintain an "enrollment plan," which describes agreed to processes for communication and coordination, in order to ensure accurate and timely eligibility determinations, redeterminations, enrollments and disenrollments. Six MCOs met the minimum requirements of this standard. However, these organizations can improve further by working together with the ADRCs and IM agencies in their service areas to review and update current enrollment plans, and work towards plans that fully reflect the role of all parties to the agreement and include all elements required by the DHS-MCO contract. Two MCOs did not fully meet this standard:

- One MCO did not have signed and implemented enrollment plans in several counties in its service area, and needs to collaborate with ADRC and IM agencies in those counties to develop and implement enrollment plans. Review findings indicated this MCO also needs to work with ADRCs and IM agencies in other parts of its service area to review and update the enrollment plans that are currently in place in those areas.
- Enrollment plans submitted by the other MCO were out-of-date and did not address all elements referenced by the DHS-MCO contract. As this organization also does not have other policies and procedures to address all aspects of enrollment and disenrollment, written guidance was not present to identify current roles, procedures, and communication processes to ensure accurate, efficient, and timely eligibility determinations, redeterminations, enrollments, and disenrollments.

Care Coordination and Service Authorization

Five standards address requirements related to coordination and continuity of care, coverage and authorization of services, and practice guidelines.

Documentation, onsite discussions, and the results of CMR activities confirmed that all MCOs have implemented policies, procedures, assessment tools, and other guidance related to care coordination and service authorization, and have training and monitoring in place. A strength identified at seven MCOs was the level of training and organizational support available for care management staff. Results indicated that nearly every organization met requirements related to coverage and authorization of services, service coordination, and practice guidelines. However, review activities also identified over half of MCOs were not fully compliant with all of the requirements related to assessment and member-centered planning.

In onsite discussions, staff at various organizations provided examples of how care management staff communicates with members and providers to coordinate health care and care transitions. At every MCO, staff gave examples of the venues for education and support provided by their organizations, which typically included approaches such as staff meetings, supervisory meetings with individual staff or care management teams, the availability of internal experts and mentors, and on-line training. Care management staff confirmed knowledge of assessment, planning, and decision-making timeframes, and provided examples of the tools, templates, and guidelines available to support care management practice. Overall, staff understood their responsibility to include members in assessment, planning, and decision-making processes, and confirmed practices related to privacy and confidentiality of members' protected information. Staff at various organizations also described internal file review and other methods for monitoring care management.

Two of the five standards in this area of review address coordination and the continuity of member care. One standard includes requirements for FCP and PACE to implement procedures for the delivery of primary health care services to members, and also requires all three programs to ensure members have an ongoing source of primary care, to coordinate member's health and long-term care services, and to meet other requirements. Seven organizations met this standard. One MCO did not fully meet the requirements as evidenced by a significant decline since last year in its CMR results for follow-up, a key aspect of care coordination.

The other standard requires MCOs to have mechanisms in place for assessing members and developing plans of service based on the assessments. Three MCOs fully met the requirements of this standard, while five MCOs did not.

- One MCO' policy regarding assessment and member-centered planning did not align with contract-required timeframes for completing assessments and plans for new members and needs to be revised to reflect DHS-MCO contract requirements.

- CMR results indicated the other four MCOs all need to improve the comprehensiveness of members' assessments and MCPs. Individual results for three of these organizations also identified the need to improve related aspects of care management practice. For example:
    - One MCO needs to take steps to ensure MCPs are reviewed and signed in a timely manner, and are signed by the appropriate legal decision maker.
    - Another MCO needs to ensure that members who experience changes in condition or situation are promptly reassessed.
    - The FCP program of a third MCO needs to improve care management practice related to addressing members' identified risks.

Two standards address coverage and authorization of services. Six MCOs met these requirements, while the other two organizations did not fully meet these two standards:

- One MCO's service authorization policies did not meet contract requirements regarding decisions made outside of the interdisciplinary care management team, and use of the Resource Allocation Decision Method (RAD) with members during the decision-making process.
- CMR results indicated the other MCO needs to improve the timeliness of service authorization decisions.

One standard relates to practice guidelines. Six organizations fully met requirements for adopting practice guidelines, applying guidelines in a consistent manner throughout the organization, and disseminating the guidelines to providers and members. Two MCOs did not fully meet the requirements. These organizations did not have specific processes in place to systematically consider the needs of their members when adopting guidelines, ensure periodic review, or disseminate guidelines to providers or members.

Quality Assessment and Performance Improvement

Five standards address requirements that MCOs have in place a QAPI program, and that they maintain a health information system that collects, analyzes, integrates, and reports data.

Results indicated most MCOs' policies, procedures, and practices in this review area are aligned to meet the requirements. Individually, four MCOs fully met all five of these standards, while two other MCOs met four of the five standards. Common strengths identified in these six organizations include:

- A structured and comprehensive approach to quality management, which includes the use of data and monitoring to assess and improve the quality of member care, cost effectiveness, organizational operations, and program integrity; and

- Active participation in improvement activities and initiatives by staff in multiple departments and levels of the organization.

The remaining two MCOs took some steps to address the QAPI recommendations they received from last year's review. However, one organization did not fully meet three of the five QAPI standards in this year's review, and the other organization did not fully meet four standards. These two organizations were advised to place priority on the recommendations they have received related to their QAPI programs. See Appendix 2 for more information about the observations and recommendations, as well as identified strengths, for each MCO related to the results of FY 14-15 EQR activities.

Documentation submitted by MCOs described quality program organizational structures, policies and procedures, activities, data, and results. In onsite discussions, staff at various MCOs was able to confirm and expand upon the approaches used by their organizations to assess and improve the quality of care provided to members. Staff also talked about the processes in place for members, providers, and staff to participate in QAPI activities and described improvement initiatives undertaken by their organizations over the past year.

Five MCOs met the minimum requirements for a QAPI program as outlined in the regulations and DHS-MCO contract. Three MCOs did not fully meet this standard:

- The quality work plans for two MCOs did not address all of the required elements or priority improvement areas based on the prior year's quality evaluation. In addition, member and/or provider participation in quality activities was not clearly evidenced.
- Another MCO's quality work plan did not fully outline the scope of activities, goals, timelines, or clear connection to QAPI program activities.

Six MCOs met the requirement to have mechanisms in place to detect both under- and over-utilization; however, the remaining two MCOs did not fully meet these requirements.

- One MCO's utilization management (UM) activities were primarily focused on monitoring high cost services and the organization did not clearly demonstrate how data is analyzed in order to detect under- and over-utilization.
- The level of monitoring and analysis conducted by another MCO had been limited since its last review and was not adequate to detect both under- and over-utilization. The organization was in the process of transitioning its UM program from a primary focus on financial analysis to a more comprehensive perspective; a factor which contributed to its limited monitoring and data analysis.

Six MCOs met requirements to have mechanisms in place to assess the quality and appropriateness of care furnished to members. Two MCOs did not fully meet the requirements:

- While one organization uses various methods to monitor member care and care management practices, some key monitoring processes, such as the full file review, have produced limited data due to the use of a small sample size. Other monitoring methods vary widely by supervisor or are still in development, and do not yield data for systemic analysis and implementation of interventions to improve the quality of care.
- The other organization had conducted limited structured monitoring during the past year. While this MCO implemented a consistent supervisory oversight process, it does not produce data for improvement activities.

An MCO must have a process in place to evaluate the impact and effectiveness of its QAPI program. Six MCOs fully met this requirement, while two MCOs did not.

- One MCO's process does not synthesize information from all required and priority areas, in order to demonstrate the overall effectiveness and impact of the program on improving member care.
- The other MCO did not complete its 2013 quality evaluation in a timely manner; thus, the process did not ensure all areas needing improvement were included in the quality plan for 2014.

Every MCO met requirements related to maintaining a health information system.

Grievance Systems

Sixteen standards comprising this area of review address requirements that MCOs maintain an effective system for members to exercise their rights related to grievances and appeals. Overall results indicated MCOs' policies, procedures, and practices are aligned to meet requirements, the practices are implemented, and monitoring is in place. Review activities indicated that across organizations, staff encourages and assists members to exercise their grievance and appeal rights. While most MCOs performed strongly in this area of review, MetaStar also identified instances at every organization where the opportunity exists to improve further, by clarifying the information in policies and/or more fully aligning organizational policies and practices.

Individually, two MCOs fully met the requirements for all of the standards in this area of review. In aggregate, the findings identified one area in need of improvement where at least half of the MCOs did not meet the requirement; issuing notices to members.

In FY 13-14, every MCO received a recommendation to improve results related to issuing notices to members in a timely manner, when indicated. This has been a long standing area for improvement across organizations. Most MCOs took some focused action to improve, such as

enhancing staff education, developing or improving tools and guidance, and increasing monitoring. As a result, four MCOs effectively addressed this recommendation and met the requirements in this year's review. The remaining four MCOs did not fully meet the requirements for various reasons. These organizations did not conduct sufficient monitoring, and/or did not provide evidence of any specific focused improvement efforts based on the results of monitoring. All four MCOs need to enhance monitoring and implement improvement efforts to ensure the timely issuance of notices to members, when indicated.

Documentation, onsite discussions, and verification activities confirmed all MCOs have a grievances and appeals system in place, as well as related staff training, support, and monitoring. In onsite discussions, staff across organizations consistently reported informing members about their appeal rights, both at the time of initial enrollment and on an ongoing basis. Staff clearly understood and supported the right of members to express dissatisfaction, and to use the processes available to them to grieve and appeal. A strength identified at most organizations was the consistent use of mediation and negotiation when members are dissatisfied, in order to understand the source of their concerns and resolve disagreements. In onsite discussions, member rights specialists were often identified as a valuable resource related to their role of engaging with members to facilitate communication, mediation, and negotiation.

Each organization met the basic requirement to provide an internal grievance process, an appeal process, and access to the state's Fair Hearing system, and also met other general requirements related to accepting appeals, following filing timeframes, and acknowledging the receipt of grievances and appeals in a timely manner.

Six MCOs met all of the standards regarding the handling of grievances and appeals, which include requirements related to assisting members; making attempts to resolve issues and concerns informally; and allowing members to include others they choose in grievance and appeal processes. These standards also include requirements regarding individuals who make decisions on grievances and appeals, privacy and confidentiality, and other special requirements.

Two MCOs operating FCP programs did not fully meet requirements regarding the handling of grievances and appeals:

- One MCO's policies did not include guidance regarding the requirement to attempt to resolve issues and concerns informally through internal review, negotiation, or mediation. Review activities indicated efforts to mediate and negotiate may not be as consistent at this organization as at other MCOs. Review of the organization's grievance and appeal log showed negotiation is often not documented. The MCO should add clear guidance to its policies regarding attempts to resolve issues through negotiation, and include direction to document such efforts.

- Neither of these MCOs has a policy/process in place related to the requirement that MCO grievances not resolved through internal review, negotiation, or mediation must be reviewed by the organization's grievance and appeal committee. Onsite verification activities and review of these organizations' appeal and grievance logs showed no grievances had been taken to their local committees.
- One of these MCO's grievance and appeal committee did not include a member or member representative, as required. In addition, this organization's FCP program policy and practice:
    - Did not ensure all members of the local Grievance and Appeal Committee receive confidentiality training and agree to respect the privacy of members; and
    - Did not offer members the choice to exclude any consumer representatives on the Grievance and Appeal Committee from participating in their hearings.

This MCO needs to take steps to ensure its local grievance and appeal committee structure and processes meets expectations related to composition, privacy and confidentiality, and other requirements.

Every organization met requirements related to continuing benefits during the time an appeal is pending. Five MCOs met all requirements regarding the resolution of standard grievances and appeals, resolution of expedited appeals, extension of timeframes for resolution, and timely notice to members regarding the extension and disposition of grievances and appeals.

Three organizations did not fully meet these requirements:

- At two MCOs, review activities identified instances where the disposition of local grievances/appeals was outside the required timeframe. While lack of adequate monitoring was noted to be a contributing factor at one MCO, both organizations need to conduct further analysis and intervention in this area. One of these MCOs had already started this process prior to the conclusion of its EQR.
- The third MCO's notification letter acknowledging receipt of a local appeal did not align with the requirement to inform members the appeal is to be completed within 20 business days, and needs to be revised.
- In addition, one of these MCOs did not fully meet requirements regarding the expedited resolution of appeals, as it does not have a standardized process for determining when an expedited appeal is warranted. To ensure consistent practice, the MCO should develop a standard process for making this determination.

Nearly every organization met the requirement to provide information about the grievance system to providers, maintain records of grievances and appeals, and review the information as part of its quality management program. However, one MCO did not provide evidence that

providers are notified they can file appeals and grievances on behalf of a member, with the member's written consent. This MCO was also the sole organization that did not meet the requirement to review grievance information as part of its quality management program.

The regulations allow the MCO to recover the cost of services furnished to the member during the time the appeal is pending, if the final appeal decision is adverse to the member. During onsite discussions, seven organizations reported it is not their practice to recover the cost of services from members, and some of these MCOs were provided the recommendation to document this practice in their grievances and appeals policies. One organization does attempt to recover the cost of services but did not fully meet the requirement, because it does not have a standard process for:

- Determining whether the member would incur a significant and substantial financial hardship as a result of repaying the cost of the services provided; and
- Waiving or reducing the member's liability if financial hardship is identified.

This MCO invoices members, but the collection process varies based on the members' responses and other factors. To ensure all members are treated fairly and consistently, the organization needs to develop a standard procedure for determining when members will incur a "significant and substantial financial hardship" should they have to repay the cost of services provided during the time an appeal was pending, including a consistent approach to waiving or reducing liability when financial hardship is identified.

If the MCO or state Fair Hearing Officer makes a decision in the member's favor, the MCO must authorize or provide the disputed service promptly, and if the member was receiving the services while the appeal was pending, the MCO must pay for them. One MCO's FCP and PACE policies did not include these basic requirements and need to be revised. All of the other MCOs met these requirements.

Performance Improvement Projects

MetaStar previously validated PIPs at their current stage of implementation in conjunction with the annual EQR, as directed by DHS. No standard timeline existed and projects were in various stages of completion at the time they were validated. MetaStar had recommended that DHS standardize project timelines in order to ensure organizations make active progress during each contract period. Beginning in calendar year 2014, DHS implemented a required timeframe for project approval and final report submissions. Proposals were submitted to DHS in February of 2014, with final reports for validation due January 2015.

For 2014, the DHS-MCO contract required all organizations to conduct at least two projects; one with a clinical topic and one with a non-clinical topic. This was the first year that two projects were required for all organizations. Eight MCOs submitted a total of 18 projects for validation. A

variety of study topics were selected based on MCO priorities and data analysis. Six projects were continuing from prior years, while 12 projects addressed new topics.

All MCOs were successful in securing pre-approval for the specified number of projects during this cycle of review. The DHS pre-approval process focuses on the initial steps of the project, and most MCOs demonstrated strength in developing clearly defined projects through the first six steps related to:

- Study topic;
- Study question;
- Study indicators;
- Study population;
- Sampling methods (if applicable): and
- Data collection procedures.

Seven of eight MCOs achieved active progress by implementing at least one intervention and measuring its effectiveness. The remaining MCO gathered baseline data and developed interventions for its two projects, but delayed implementation due to conversion to a new electronic documentation system. DHS directed MetaStar to consider validation standards related to data analysis and improvement to be "not met" as a result. Several other projects were also impacted by the new timeline and requirement to conduct at least two projects. Some examples include: limited time to apply interventions, small study populations, and data collection difficulties that were not remediated.

Four projects from two organizations achieved improvement that appeared to be the result of the interventions employed. In addition to the issues noted above, some factors which affected the achievement of improvement included:

- Data collection or sampling problems limiting confidence in results;
- Inconsistent methodology used for baseline and repeat measures;
- Lack of measurement of the effectiveness of interventions; or
- Achieving improvement for only one of multiple indicators.

For calendar year 2015, a similar timeframe will be utilized for conducting and reporting PIPs. MCOs are only required to conduct one project during 2015 if members from all programs operated are included. As organizations adapt to the timeframe and with specific feedback provided as a result of the validation process, it is expected that more projects will achieve improvement in the future.

Performance Measures Validation

DHS directed MetaStar to validate two performance measures; influenza and pneumococcal vaccination rates. Accurate and reliable performance measures inform stakeholders about access and quality of care provided by MCOs.

All eight MCOs' vaccination data were found to be compliant with the technical specifications for both quality indicators. After three organizations resubmitted data for one indicator, all complied with the denominator thresholds established by DHS. One MCO's FC pneumococcal rate was found to be biased; the organization was unable to provide documentation to support contraindications to the vaccine. As a result, the MCO's reported FC pneumococcal contraindications were changed to non-vaccinated. The final rates reported are reflective of that change and are therefore accurate.

As mentioned above, three MCOs resubmitted data files due to denominators that exceeded the similarity threshold established by DHS. MCOs reported that most of the discrepancies were a result of their query structures. Some MCOs also included an incorrect vaccination date in the data file, though those members did receive vaccinations within the designated timeframe. MetaStar recommended that MCOs modify queries as a result of lessons learned during this review.

While the PMV activity resulted in rates that are accurate, some opportunities to improve were identified. The level of detail and alignment with DHS expectations in MCO policies and procedures for collecting, tracking, and reporting member vaccination data were varied. One MCO reported it did not have related policies or procedures. MetaStar made recommendations to MCOs to improve the associated documents and/or ensure guidance aligns with the technical specifications.

MCOs also vary with regard to tracking and reporting vaccination exclusions and refusals. As a result, MetaStar made recommendations to evaluate these situations in order to identify actionable plans to improve vaccination rates.

Consistent with the past two years, DHS provided MCOs with current technical specifications and data submission templates. Clear expectations and standardized tools have improved the performance measure reporting and validation processes.

Information Systems Capability Assessment

This review activity was conducted for two MCOs; one operates FC only and one operates FC, FCP, and PACE. The review found that these MCOs have the basic systems, resources, and processes in place to meet DHS' requirements for oversight and management of services to members, and to support quality and performance improvement initiatives.

Both MCOs experienced information systems transitions or enhancements prior to the review, and reported enrollment growth over time. The information systems provide the MCOs with the capabilities to manage operations associated with their respective growth. However, one MCO's system transition was very recent relative to the timing of the review. As a result, MetaStar recommended that DHS increase its monitoring and oversight to ensure continued compliance. The other MCO was experiencing a higher than acceptable volume of encounter reporting issues, per DHS, and should enhance its processes for testing and analyzing encounters, adjusting service authorization timeframes and units, and ensuring revenue codes are consistent with standard procedure codes.

Both MCOs possessed thorough documentation or use of software and encryption technology which met the standards relative to system security. Communication practices between MCOs and their vendors also contributed positively to review findings. While each MCO's documentation aligned with nearly all review standards, both organizations have the opportunity to enhance their documentation to accurately and fully represent practices, processes, structures, or functions. Each MCO should continue work to increase the volume of electronic claims in certain areas and consult with DHS about appropriate rate of electronic claims submissions for service types that require coordination of benefits, such as nursing home or mental health/substance abuse services.

Care Management Review

Member Health and Safety

Over the course of the fiscal year, MetaStar identified one member with unaddressed health and safety issues during CMR, out of 672 total records reviewed. The member was promptly brought to the attention of the MCO and referred to DHS for follow-up.

MetaStar also identified seven additional members with complex situations involving medical, mental health, behavioral, cognitive, and/or social issues. These members were also brought to the attention of the MCOs and referred to DHS. This proactive approach was implemented in FY 10-11, and gives DHS the opportunity to engage with the MCO and provide any needed guidance related to the specific member. This approach also allows the MCO and DHS to assess current care management practice, identify potential systemic improvements related to member care quality, and prevent the development of health and safety issues.

For FY 14-15, DHS directed MetaStar to review the records of members identified in last year's review as having health and safety issues, and/or complex and challenging situations. This was an additional step to ensure that MCOs continued to address quality of care concerns following initial remediation efforts. The individual record review results were provided to DHS and to the MCO, but not included in the aggregate results in this report. Of the 13 members identified in FY

13-14 year, 12 records were reviewed (one member had disenrolled). Of the 12 member records, nine demonstrated the MCO had sufficiently addressed the issues or situations. Three records demonstrated that the complex and challenging situations were continuing, and these members were referred to DHS again for additional oversight, assistance, and monitoring.

Overall Results

During FY 14-15, every organization took some action to respond to the recommendations they received related to FY 13-14 CMR results, although not all organizations were able to achieve overall improvement.

For FC, the percent of all CMR standards met in FY 14-15, aggregated across the seven FC organizations, was 93.1 percent. This compares to an aggregate rate in FY 13-14 of 89.4 percent. MetaStar's analysis indicated the year-to-year difference in the aggregate rate was likely due to actions taken by the MCOs and was not likely to have occurred by normal variation or chance.

Individual results for five of the seven FC MCOs indicated the overall CMR compliance rate at these organizations showed real improvement in FY 14-15 compared to last year's results, i.e., the year-to-year difference in each MCO's overall results was likely due to the actions the MCO had taken.

Strategies MCOs used to facilitate improvement efforts included:

- Providing staff education/training;
- Conducting increased and/or focused monitoring;
- Developing or improving care management tools and guidance;
- Developing policies and procedures; and
- Working to streamline current processes.

The overall CMR compliance rate for a sixth FC MCO remained similar to its results in FY 13-14, and analysis indicated any year-to-year change was likely due to normal variation or chance.

Overall compliance results for the seventh FC MCO decreased, and analysis indicated the decrease was not likely due to normal variation or chance. This MCO had recently expanded into a new service area and had also recently switched to a new electronic health record system. These were likely among the contributing factors to its CMR results.

For FCP, the overall percent of CMR standards met in FY 14-15, aggregated across the three FCP MCOs, was 89.3 percent. This compares to an aggregate rate in FY 13-14 of 88.9 percent. Analysis indicated the year-to-year difference in the rate was likely to have occurred by normal variation or chance.

The aggregate results did not reflect improvement across FCP programs. Though, one of the three FCP MCO's overall compliance rate showed real improvement compared to its previous year's results, i.e., the year-to-year difference in its overall CMR results was likely due to actions of the MCO and not a result of normal variation or chance. Examples of actions taken by this MCO to facilitate improvement included:

- Systematically transitioning to a new supervisory structure to provide more consistent support for care management staff;
- Updating training modules for new staff ; and
- Providing ongoing staff training at least monthly.

The overall compliance rates for the other two FCP MCOs remained similar to their results in FY 13-14, and analysis indicated any year-to-year change was likely due to normal variation.

FY 14-15 overall CMR rate of compliance for the one organization operating a PACE program was 93.5 percent. This compares to 90.4 percent in FY 12-13, the last time MetaStar conducted a CMR for PACE. Similar to FCP, analysis showed the difference in PACE CMR results from one year to the other is likely to have occurred by normal variation or chance.

Encounter Data Validation

Results for the two FC MCOs were largely positive, while results for the FCP MCO were mixed. Both FC MCOs use the Member Information, Documentation and Authorization System (MIDAS) to record and report dates and units of service. ISCA assessments have found that the MIDAS system possesses many of the desired information system capabilities.

All three MCOs were able to identify the members who were included in the samples quickly and accurately, as reflected in the near perfect agreement between the members' identifiers in the supporting documentation and those in DHS' encounter records. Similarly, the three MCOs were able to identify the correct providers for the member services in their notes, e.g., the provider names that were indicated in the provider case notes were always the same as those showing as the rendering providers in the encounter records.

Among all three MCOs, the greatest difference in the rates of agreement related to service dates and units. MCOs should analyze these differences to ensure that they do not under- or over-report actually provided units of service. Service dates and units varied by service type. Targeted case management, ancillary services-CBRF, and transportation had high agreement rates. CBRFs report units of services as whole days. As a result, there is less probability for errors in quantities to occur than when quantities are reported in hours, or fractions of hours. For the MCOs with transportation encounter data validated, providers had automated and clear, printed records that provided exact details for each trip, including times and addresses for each pick-up and drop-off of member passengers.

In the areas of adult day care and day habilitation/habilitation prevocational, there were moderate rates of agreement for service dates and units. Units were not consistently reported and reporting of lunch and other breaks appeared to be problematic. Service units should be reported in 15 minutes intervals for this type, but it was difficult to ascertain during the validation process whether the units reported were in whole hours or 15 minutes intervals.

In the areas of home health visit/medication administration visit and attendant/personal care, accounting methods for the last day of service contributed to some of the mismatches between the two MCOs' notes and DHS' encounter records, and resulted in both under- and over-reporting of units. For example, when the service interval for personal care in the encounter record was 9/1/13 to 9/6/13, the encounter record showed five, 15-minute days, while the provider case notes showed six 15-minute days. The encounter record did not consider the "day out" (last day of service), while the provider notes correctly did. Inconsistent reporting of service units also contributed to mismatches in the area of attendant/personal care. Cases where there was no agreement between the number of units reported by the MCOs in their notes and those showing in the encounter data were shared with MCOs and DHS. For example, in one case, the MCO reported 80 units of personal care, while the encounter record showed 52 units. In this and similar situations, it was difficult to explain the discrepancy by using a 15 minute interval, or any other logical time unit, as a multiplier.

APPENDIX 1 – LIST OF ACRONYMS

AQR	Annual Quality Review
BMC	Bureau of Managed Care
CBRF	Community-Based Residential Facility
CCI	Community Care, Inc., Managed Care Organization
CCCW	Community Care Connections of Wisconsin, Managed Care Organization
CFR	Code of Federal Regulations
CMR	Care Management Review
CMS	Centers for Medicare & Medicaid Services
CW	Care Wisconsin, Managed Care Organization
DHS	Wisconsin Department of Health Services
EDV	Encounter Data Validation
EQR	External Quality Review
EQRO	External Quality Review Organization
FC	Family Care
FCP	Family Care Partnership
FY	Fiscal Year
HEDIS[1]	Healthcare Effectiveness Data and Information Set
*i*Care	Independent Care Health Plan, Managed Care Organization
IDT	Interdisciplinary Team
IS	Information System
ISCA	Information System Capability Assessment
LCD	Lakeland Care District, Managed Care Organization
MCDFC	Milwaukee County Department of Family Care, Managed Care Organization
MCO	Managed Care Organization
MCP	Member-Centered Plan
MY	Measurement Year

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

MIDAS	Member Information, Documentation and Authorization System, Electronic Health Record
NCQA	National Committee for Quality Assurance
NOA	Notice of Action
PACE	Program of All-Inclusive Care for the Elderly
PMV	Performance Measures Validation
PHI	Protected Health Information
PIHP	Pre-paid Inpatient Health Plan
PIP	Performance Improvement Project
QAPI	Quality Assessment and Performance Improvement
QCR	Quality Compliance Review
RAD	Resource Allocation Decision Method
SDS	Self-Directed Supports
UM	Utilization Management
WWC	Western Wisconsin Cares, Managed Care Organization

APPENDIX 2 – EXECUTIVE SUMMARIES

Care Wisconsin – Executive Summary

This section of the report summarizes the results of the fiscal year (FY) 14-15 annual quality review conducted by MetaStar, Inc., for the managed care organization, Care Wisconsin. MetaStar is the external quality review organization contracted and authorized by the Wisconsin Department of Health Services to provide independent evaluations of managed care organizations that operate Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly.

Care Wisconsin operates the Family Care program in 21 counties and the Family Care Partnership program in five counties. Its service area includes portions of southeast, south-central, and northwest Wisconsin.

Key findings from the review activities discussed in this report are summarized below. Additional, detailed information can be found in the body of the report.

Review Activity	FY 14-15 Results	Comparison to FY 13-14 Results
Quality Compliance Review	• 45 Total standards reviewed resulting in a score of 80 of a total possible 90 points • 35 Standards received "met" ratings • 10 Standards received "partially met" ratings	Quality Compliance Review follows a three-year review cycle; one year of comprehensive review followed by two years of follow-up. FY 14-15 is the first year in a new review cycle; last year's results are not comparable.
Care Management Review	<u>Family Care</u> • 11 of 14 Standards met at a rate of 90 percent or higher • 92 percent: Overall rate of standards met by *this organization* for all review indicators <u>Family Care Partnership</u> • 8 of 14 Standards met at a rate of 90 percent or higher • 87.6 percent: Overall rate of standards met by *this organization* for all review indicators	<u>Family Care</u> • 8 of 14 Standards met at a rate of 90 percent or higher • 89.4 percent: Overall rate of standards met *across all Family Care managed care organizations* <u>Family Care Partnership</u> • 10 of 14 Standards met at a rate of 90 percent or higher • 88.9 percent: Overall rate of standards met *across all Family Care Partnership managed care organizations*

CW – Progress Related to Compliance with Standards

This section is intended to report about progress the MCO made in response to MetaStar's recommendations from the FY 13-14 Quality Compliance Review.

Since its last review, the MCO effectively addressed a recommendation to conduct regular monitoring related to service coordination and follow-up. Documentation provided by the organization indicated regular monitoring is being conducted through internal file reviews.

CW - Strengths

- Care Wisconsin strongly values staff development and provides a variety of training and other professional growth opportunities for staff at all levels.
- The organization values and supports member rights.
- Staff consistently engages in mediation and negotiation with members who have grievances or appeals, in order to understand the source of their concerns and resolve disagreements.
- The organization has in place a comprehensive approach for developing, maintaining, and monitoring its provider network.
    - Staff seeks to work with providers in a way that fosters learning, quality improvement, and collaboration.
    - A Provider Quality Committee integrates staff from multiple departments and levels of the organization.
- Care Wisconsin has a structured quality management system which includes consistent monitoring, collection and analysis of data, and development of strategies to improve the quality of member care and organizational operations.
    - Staff, members, and providers are engaged in the quality management program in a variety of ways.

CW – Recommendations

Following are recommendations related to Quality Compliance Review Standards that were not fully met and Care Management Review results in need of improvement:

- Develop a policy and procedure addressing the requirement to make a good faith effort to provide written notice of the termination of a contracted provider within required timelines, to members who had been receiving services from that provider.
- Work with the organization's vendor to improve the functioning of the online, searchable Family Care and Partnership provider directories, to ensure the availability of any alternate languages(s) consistently and correctly shows for each provider entry.
- Revise the organization's policy and procedure regarding advance directives to include expectations and a standard process for informing members that complaints concerning

non-compliance with an advance directive may be filed with the state's Division of Quality Assurance.

- Identify barriers related to completing annual renewals of restrictive measures plans, and implement improvements focused on increasing timeliness. Monitor to ensure that restrictive measures plan renewals are submitted to the Department of Health Services at least 30 days prior to the expiration of the current plan.
- Develop a policy and procedure to provide staff with consistent guidance for responding to members' requests for a second opinion.
- Revise the *Disenrollment from the Partnership or Family Care Program Policy & Procedure* to ensure it specifies the impermissible reasons for requesting member disenrollment, as required.
- Develop and implement systematic processes for adopting, using, and disseminating practice guidelines which include:
    - Considering the needs of members when selecting practice guidelines;
    - Ensuring the periodic review of practice guidelines;
    - Consistently applying the guidelines throughout the organization; and
    - Disseminating the guidelines to providers and members, as indicated.
- Ensure the organization develops and implements an annual quality work plan which includes sufficient detail for all required and priority areas, to clearly outline the scope of activities, goals, objectives, timelines, and responsible person(s).
- For Family Care Partnership, focus efforts on improving results in the following areas of care management practice:
    - Improving the comprehensiveness of assessments and member-centered plans;
    - Updating plans when members have significant changes;
    - Addressing members' identified risks;
    - Following up with members and their supports to ensure services have been received and are effective;
    - Ensuring members' identified needs are addressed; and
    - Issuing notices to members in a timely manner, when indicated.
- For Family Care, focus efforts on improving results in the following areas of care management practice:
    - Improving the comprehensiveness of assessments and member-centered plans;
    - Ensuring members' identified needs are addressed; and
    - Ensuring members and their supports are included in care management processes.
- Regularly monitor documentation practices of care management staff and continue improvement efforts, in order to ensure practices align with professional and contract standards, as well as the MCO's own expectations.

The additional recommendations identified below are opportunities for continued improvement in areas of the review where Care Wisconsin fully met the requirements:

- Review the Language and Interpreter Use Policy & Procedure as well as all "vital documents" listed in the policy, and take steps to ensure the vital documents are in alignment with the policy and procedure. Also consider whether the Family Care and Partnership member handbooks should be included in the list of vital documents.
- Develop a policy and procedure to provide consistent guidance regarding coverage and payment of emergency and post-stabilization services for members.
- Work collaboratively with Aging & Disability Resource Centers and Income Maintenance agencies in the organization's service area to review, update, and implement current enrollment plans that contain clear processes for communication and coordination, reflect the role of all parties to the agreement, and contain all required elements.
- Devote continued attention to systematically monitoring for potential under-utilization, and ensure results and conclusions are consistently documented.
- Document the following practices relative to the appeals and grievance system:
    - Confidentiality training for appeals and grievances committee members; and
    - Processes for ensuring members are offered the choice to exclude any consumer representatives from participation in local appeals and grievances hearings.
- Update the Grievances and Appeals Policy & Procedure to include several recommendations identified in the "Quality Compliance Review Findings" section of this report.

Community Care Connections of Wisconsin – Executive Summary

This section of the report summarizes the results of the fiscal year (FY) 14-15 annual quality review conducted by MetaStar, Inc., for the managed care organization, Community Care Connections of Wisconsin. MetaStar is the external quality review organization contracted and authorized by the Wisconsin Department of Health Services to provide independent evaluations of managed care organizations that operate Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly.

Community Care Connections of Wisconsin operates the Family Care program in 16 counties in central and northwest Wisconsin.

Key findings from the review activities discussed in this report are summarized below. Additional, detailed information can be found in the body of the report.

Review Activity	FY 14-15 Results	Comparison to FY 13-14 Results
Quality Compliance Review	• 44 Total standards reviewed resulting in a score of 82 out of a total possible 88 points • 38 Standards received "met" ratings • 6 Standards received "partially met" ratings	Quality Compliance Review follows a three-year review cycle; one year of comprehensive review followed by two years of follow-up. FY 14-15 is the first year in a new review cycle; last year's results are not comparable.
Care Management Review	<u>Family Care</u> • 9 of 14 Standards met at a rate of 90 percent or higher • 92.3 percent: Overall rate of standards met by *this organization* for all review indicators	<u>Family Care</u> • 12 of 14 Standards met at a rate of 90 percent or higher* • 89.4 percent: Overall rate of standards met *across all Family Care managed care organizations*

*Per the organization's request, FY 13-14 Care Management Review results from the annual quality review and an additional expansion review were combined in this comparison.

CCCW – Progress Related to Compliance with Standards

This section is intended to report about progress the MCO made in response to MetaStar's recommendations from the FY 13-14 Quality Compliance Review.

Community Care Connections of Wisconsin met all of the compliance standards in FY 12-13. Therefore, MetaStar did not conduct a Quality Compliance Review or make recommendations related to compliance with standards in FY 13-14.

CCCW – Strengths

- Community Care Connections of Wisconsin values and supports members' self-direction, responsible citizenship, and involvement in their communities.
- Interdisciplinary team staff consistently follows the Resource Allocation Decision process, and engages in mediation and negotiation with members who are dissatisfied to resolve disagreements.
- Interdisciplinary team staff reported a high level of engagement and collaboration from departments throughout the organization, especially the Member Services Department, in resolving member concerns.
- Community Care Connections of Wisconsin has a structured quality management system which includes systematic collection, analysis, and utilization of data that uses a fact-based approach to improve the quality of member care and organizational operations.

- Staff, members, and providers are engaged in the Quality Management Department in a variety of work groups and ad hoc committees:
    - Staff members participate in the development and implementation of Performance Improvement Projects.
    - Members are able to use video conferencing technology to participate in quality committees activities from home or from laptops set up at satellite offices.
    - A provider workgroup is assisting the organization to develop quality indicators by which to gauge provider quality.
- Community Care Connections of Wisconsin also promotes staff development and engagement through its ongoing training and participation in community groups and activities.

CCCW – Recommendations

Following are recommendations related to Quality Compliance Review standards that were not fully met and Care Management Review results in need of improvement:

- Continue efforts to ensure the organization's new information technology system, CareDirector, supports ongoing compliance with care management, quality oversight, and provider network standards.
- Place priority on recommendations related to maintaining and monitoring your provider network:
    - Implement written policies and procedures for selection and retention of providers.
    - Follow a documented process for credentialing and re-credentialing of providers who have signed contracts or participation agreements.
    - Institute a process to ensure all relevant providers have and maintain appropriate licensure or certification.
    - Update the current *Provider Certification for Federal Health Care Program Policy* and MCO practice to ensure debarment verifications meet contract requirements. Modify the current process for evaluating provider compliance with caregiver and criminal background checks to ensure compliance by providers in completing all checks timely and applying results of the background checks for hiring decisions.
- Focus improvement in the following areas of care management practice:
    - Completing assessments that are comprehensive and reflective of members' current conditions and situations, and include a review of the financial resources and associated risks/vulnerabilities.
    - Ensuring member-centered plans are comprehensive; identifying all needs, services, and current member situations.

    - Following up regarding service delivery and quality, and ensuring staff consistently documents follow-up actions and results in member records.
- Revise the written disenrollment procedure in the IDT Staff Handbook to include the impermissible reasons for requesting member disenrollment.

The additional recommendations identified below are opportunities for continued improvement in areas of the review where the MCO fully met requirements:

- Update the *Appeal and Grievance Policy* to include details regarding the criteria and process for determination about seeking repayment for the cost of services provided during the time the appeal was pending when the decision is adverse to the member.
- Ensure the process for notification of a significant change is documented and followed for sending written notices to members about the change.

Community Care, Inc. – Executive Summary

This report summarizes the results of the fiscal year (FY) 14-15 annual quality review conducted by MetaStar, Inc., for the managed care organization, Community Care, Inc. MetaStar is the external quality review organization contracted and authorized by the Wisconsin Department of Health Services to provide independent evaluations of managed care organizations that operate Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly (PACE).

Community Care operates Family Care in 11 counties, Family Care Partnership in nine counties, and PACE in two counties in southeast and east central Wisconsin.

Key findings from the review activities discussed in this report are summarized below:

Review Activity	FY 14-15 Results	Comparison to FY 13-14 Results
Quality Compliance Review	• 45 Total standards reviewed resulting in a score of 79 of a total possible 90 • 34 Standards received "met" ratings • 11 Standards received "partially met" ratings	Quality Compliance Review follows a three-year review cycle; one year of comprehensive review followed by two years of follow-up. FY 14-15 is the first year in a new review cycle; last year's results are not comparable.
Care Management Review	<u>Family Care</u> • 12 of 14 Standards met at a rate of 90 percent or higher • 95.8 percent: Overall rate of standards met by this MCO for all review indicators <u>Family Care Partnership</u> • 8 of 14 Standards met at a rate of 90 percent or higher	<u>Family Care</u> • 9 of 14 Standards met at a rate of 90 percent or higher • 91.3 percent: Overall rate of standards met *across all Family Care MCOs* <u>Family Care Partnership</u> • 10 of 14 Standards met at a rate of 90 percent or higher

	• 90.2 percent: Overall rate of standards met by this MCO for all review indicators <u>PACE</u> • 10 of 14 Standards met at a rate of 90 percent or higher • 93.5 percent: Overall rate of standards met by this MCO for all review indicators	• 92.0 percent: Overall rate of standards met across all Family Care Partnership MCOs <u>PACE * (Compared to FY 12-13)</u> • 7 of 13 Standards met at a rate of 90 percent or higher • 90.4 percent: Overall rate of standards met by this MCO for all review indicators

* Care Management Review was not conducted for PACE in FY 13-14, due to a program review by the Centers for Medicare & Medicaid Services; therefore, this year's results were compared to FY 12-13.

CCI – Progress Related to Compliance with Standards

This section is intended to report about progress the MCO made in response to MetaStar's recommendations from the FY 13-14 Quality Compliance Review.

Community Care effectively addressed recommendations made in the FY 13-14 Quality Compliance Review related to ensuring members are free from restraints and restrictive measures, disseminating practice guidelines, and monitoring for underutilization and overutilization of services.

CCI – Strengths

- The organization values and supports member rights, and has developed a strong program focused on member rights preservation.
- Multiple processes are in place for staff education and communication.
- Care managers and supervisors work together to ensure quality member-centered care is provided in diverse settings, using a variety of creative approaches.
- A quality provider network is maintained and supported through organized processes and technological systems. Information is accessible to care management staff.
- Community Care values innovation and seeks to improve its organizational processes and services to members.

CCI – Recommendations

Following are recommendations related to Quality Compliance Review Standards that were not fully met and Care Management Review results in need of improvement:

- Develop written guidance and procedures to provide a good faith effort to give written notification of termination of a contracted provider to members who received services from such providers.
- Update the *Provision of Family Planning and Women's Health Services Policy* and related procedures to ensure direct access to women's health services.

- Revise the *Member Disenrollment Policy and Procedure* to include the impermissible reasons for requesting member disenrollment.
- Place priority on recommendations related to the organization's Quality Assessment and Performance Improvement (QAPI) program:
    - Clearly include all required and prioritized monitoring activities in the organization's quality plan, as well as remediation efforts for those areas in need of improvement.
    - Ensure that mechanisms to monitor member care and care management practices collect data and are implemented consistently throughout the organization as needed, to have the capacity to measure and improve the quality of care.
    - Improve mechanisms to evaluate and clearly report the impact and overall effectiveness of the QAPI program on the quality of service provided to members, as a result of various initiatives throughout the organization.
    - Ensure that the quality program is overseen through clear administrative structures throughout the organization.
    - Ensure the QAPI program structure includes a means for members of all programs to actively participate, and clearly document this participation.
- Enhance efforts to monitor and improve the timely issuance of notices to members in all programs.
- Revise appeal and grievance policies and procedures to ensure all requirements are included:
    - Add clear guidance regarding attempts to resolve issues and concerns through negotiation, including documentation of such efforts.
    - Ensure that members from all programs have the option to appear before a committee if grievances are not resolved through internal review or negotiation.
    - Include a defined procedure to determine when a member would have a "significant and substantial financial hardship" if required to repay costs of services provided while an appeal was pending.
    - Add language to include the MCO's requirement to provide services or pay for services when a decision is made in favor of the member.
- Ensure that the updated appeal and grievance policies and procedures are fully implemented and monitored to ensure effectiveness.
- Focus improvement efforts in the following areas of care management for Family Care Partnership:
    - Completing member-centered plan reviews in a timely manner;
    - Coordinating services in a timely manner;
    - Offering the Self-Directed Supports option consistently;
    - Updating member-centered plans when significant changes in situation or condition occur.

- Focus improvement efforts in the following areas of care management for PACE:
    - Updating member-centered plans when significant changes in situation or condition occur.

The additional recommendations identified below are opportunities for continued improvement in areas of the review where the MCO met requirements:

- Continue efforts to integrate policies and procedures for all three programs and ensure all required elements are addressed, especially those related to grievances and appeals.
- Fully implement practices to require timely provider signatures on new or updated contracts.

ContinuUs – Executive Summary

This section of the report summarizes the results of the fiscal year (FY) 14-15 annual quality review conducted by MetaStar, Inc., for the managed care organization, ContinuUs. MetaStar is the external quality review organization contracted and authorized by the Wisconsin Department of Health Services to provide independent evaluations of managed care organizations that operate Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly.

ContinuUs operates the Family Care program in 21 Wisconsin counties, including in the southwest, northwest, southeast and east-central parts of the state.

Key findings from the review activities discussed in this report are summarized below. Additional, detailed information can be found in the body of the report.

Review Activity	FY 14-15 Results	Comparison to FY 13-14 Results
Quality Compliance Review	• 44 Total standards reviewed resulting in a score of 79 of a total possible 88 points • 35 Standards received "met" ratings, • 9 Standards received "partially met" ratings	Quality Compliance Review follows a three-year review cycle; one year of comprehensive review followed by two years of follow-up. FY 14-15 is the first year in a new review cycle; last year's results are not comparable.
Care Management Review	<u>Family Care</u> • 10 of 14 Standards met at a rate of 90 percent or higher • 94.8 percent: Overall rate of standards met by *this organization* for all review indicators	<u>Family Care</u> • 8 of 14 Standards met at a rate of 90 percent or higher • 89.4 percent: Overall rate of standards met *across all Family Care managed care organizations*

ContinuUs – Progress Related to Compliance with Standards

This section is intended to report about progress the MCO made in response to MetaStar's recommendations from the FY 13-14 Quality Compliance Review.

ContinuUs addressed, effectively, recommendations made in the FY 13-14 Quality Compliance Review as follows:

- Improvement efforts were focused on comprehensiveness of member-centered plans, and other aspects of the assessment and planning process; and
- The organization evaluated and is in the process of addressing barriers related to service authorization decision timeliness.

ContinuUs – Strengths

- The organization values and supports member rights.
- ContinuUs has strong systems and practices in place to maintain the security and privacy of members' health, enrollment, and other confidential information.
- Input from and engagement of the organization's members, providers, and employees is valued and actively sought.
- The organization takes an integrated and structured approach to quality improvement which focuses on improving member care and organization processes through data and analysis.
- The grievance and appeal system is member-centered and employs tools and processes to ensure requirements are met.
- ContinuUs uses varied approaches to training and support of care management staff.
- Provider quality monitoring processes are consistent, include input from care management staff, and endeavor to increase collaboration with providers.
- Care managers and supervisors work together to ensure quality care is provided throughout the organization's geographic area.

ContinuUs – Recommendations

Following are recommendations related to Quality Compliance Review Standards that were not fully met and Care Management Review results in need of improvement:

- Ensure the organization's policy, procedure, and practice regarding termination of a service provider contract reflects requirements that managed care organizations make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to members who received services from that provider.

- Identify barriers related to completing annual renewals of restrictive measures plans, and implement improvements focused on increasing timeliness. Monitor to ensure that restrictive measures plan renewals are submitted to the Department of Health Services at least 30 days prior to the expiration of the current plan.
- Obtain and analyze data regarding anticipated enrollment, utilization of services, types, and geographic locations of providers to evaluate adequacy of the service delivery network.
- Update policies and procedures as needed to ensure all relevant providers and practitioners maintain licensure or certification.
- Evaluate and revise the organization's monthly process for identifying providers that have been excluded from participation in federal health care programs, in order to ensure it includes investigation of all potentially excluded providers.
- Develop a disenrollment policy or revise a current policy to specify the impermissible reasons for requesting member disenrollment, as required.
- Collaborate with Aging & Disability Resource Centers and Income Maintenance agencies in the ContinuUs service area to develop Enrollment Plans in counties where a plan is not currently in place. In addition, work with these agencies to update Enrollment Plans in the counties where these agreements are currently in place. Work towards achieving plans that fully reflect the role of all parties to the agreement, and contain all elements required by the contract between the Department of Health Services and ContinuUs.
- Establish consistent mechanisms to detect both underutilization and overutilization of services.
- Consider the need for additional monitoring and improvement efforts to ensure the timely issuance of notices to members when indicated.

The additional recommendations identified below are opportunities for continued improvement in areas of the review where ContinuUs fully met requirements:

- Update the *Provider Network Listing Creation and Maintenance Policy* to include guidance about how often the printed version of the Provider Network Directory is updated.
- Include the office hours for each of the ContinuUs locations listed in the Member Handbook.
- Ensure written information about advance directives provided to members aligns with the organization's *Advance Directives Procedure*, including notice that complaints concerning non-compliance with any advance directive may be filed with the Division of Quality Assurance.

- Revise the *Comprehensive Assessment Policy and Procedure* to include specific guidance to explore the member's cultural and religious background and preferences, including interest in receiving services from culturally knowledgeable providers.
- Update written guidance for staff related to coordination of health care services to address all aspects of the requirement, and include coordination of all types of services and supports for members in all settings.
- Continue to focus attention on monitoring assessment and planning processes to ensure improvement trends continue and current written guidance is sufficient.
- Revise the caregiver background check monitoring procedures to include sole proprietors.
- Revise the policies/procedures related to disenrollments requested by ContinuUs to include situations where the organization cannot assure the member's health and safety because the member refuses to participate in care planning or to allow care management contacts; or the member is temporarily out of the service area.
- Add information to the Provider Handbook regarding the availability of the clinical practice guidelines, since all providers do not have access to the information on the provider portal.
- Enhance data collection and documentation related to these required areas of the Quality Assessment and Performance Improvement program: conducting provider surveys, monitoring access to providers and verifying that services were provided.
- Update the *Grievance and Appeal Policy and Procedure* to include several recommendations identified in the "Quality Compliance Review Findings" section of this report.

Independent Care Health Plan – Executive Summary

This section of the report summarizes the results of the fiscal year (FY) 14-15 annual quality review conducted by MetaStar, Inc., for the managed care organization, Independent Care Health Plan. MetaStar is the external quality review organization contracted and authorized by the Wisconsin Department of Health Services to provide independent evaluations of managed care organizations that operate Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly.

Independent Care Health Plan operates the Family Care Partnership program in four counties in southern Wisconsin.

Key findings from the review activities discussed in this report are summarized below. Additional, detailed information can be found in the body of the report.

Review Activity	FY 14-15 Results	Comparison to FY 13-14 Results
Quality Compliance Review	• 45 Total standards reviewed resulting in a score of 64 of a total possible 90 points • 19 Standards received "met" ratings • 26 Standards received "partially met" ratings	Quality Compliance Review follows a three-year review cycle; one year of comprehensive review followed by two years of follow-up. FY 14-15 is the first year in a new review cycle; last year's results are not comparable.
Care Management Review	<u>Family Care Partnership</u> • 9 of 14 Standards met at a rate of 90 percent or higher • 90.2 percent: Overall rate of standards met by *this organization* for all review indicators	<u>Family Care Partnership</u> • 7 of 14 Standards met at a rate of 90 percent or higher • 88.9 percent: Overall rate of standards met *across all Family Care Partnership managed care organizations*

iCare – Progress Related to Compliance with Standards

This section is intended to report about progress the organization made in response to MetaStar's recommendations from the FY 13-14 Quality Compliance Review.

Independent Care Health Plan made limited progress in addressing the recommendations in the FY 13-14 Quality Compliance Review. Improvement was noted in two areas that support requirements for coordination and continuity of care:

- Following up to ensure that services and supports are adequate to meet members' needs; and
- Completing member-centered plans in a timely manner every six months.

iCare – Strengths

- The organization used a systematic process for restructuring its care management staffing model to a new supervisory structure that provides more consistent support for care management staff.
- Independent Care Health Plan consistently engages in mediation and negotiation with members who have grievances or appeals, in order to understand the concerns and resolve disagreements.
- Independent Care Health Plan's overall score for Care Management Review was above the FY13-14 statewide aggregate for Family Care Partnership programs.

iCare – Recommendations

Following are recommendations related to Quality Compliance Review Standards that were not fully met and Care Management Review results in need of improvement:

- Place priority on recommendations related to the organization's Quality Assessment and Performance Improvement Program:
    - Implement a quality planning process which ensures that all areas prioritized for improvement and all required monitoring activities are addressed.
    - Continue implementation of structured note reporting and carefully evaluate its effectiveness as a tool for care management monitoring.
    - Ensure that monitoring mechanisms are adequate to assess and improve the quality of care furnished to members.
    - Complete the quality evaluation process in a timely manner.
    - Establish methods to monitor for and analyze potential over-utilization and under-utilization in the Family Care Partnership program.
    - Provide opportunities for members and providers to participate in the organization's quality program.
    - Review grievance information as part of the quality program.
- Also place priority on recommendations related to establishing, monitoring, and maintaining a network of qualified providers for both long-term care and acute and primary services:
    - Develop methods to measure and monitor network adequacy and timely access to services. Consistently implement monitoring.
    - Institute a process to ensure all relevant providers have and maintain appropriate licensure or certification.
    - Evaluate the exclusion review process and ensure that investigation is adequate and clearly documented.
    - Fully implement a comprehensive, consistent caregiver background check monitoring process.
    - Develop systematic methods to monitor provider quality.
    - Ensure that written guidance for staff is clear, and is consistent with requirements.
- Utilize the Code of Federal Regulations for Medicaid managed care and the organization's contract with the Department of Health Services to ensure that all policies, procedures, practices and forms are in compliance with requirements.
- Revise the member handbook, provider directory, and written information provided to members to include all required information.
- Focus improvement in the following areas of care management:
    - Ensure member-centered plans are updated to reflect changes in situation, preference, and condition.

    - Improve timeliness of service authorization decisions and coordination of member services.
- Enhance efforts to monitor and improve the timely issuances of notices to members.
- Develop written policies and procedures related to enrollment and disenrollment which outline Independent Care Health Plan's responsibilities in collaboration with other agencies.
- Work with Aging and Disability Resource Centers and Income Maintenance agencies in the organization's service area to review, update, and implement current Enrollment Plans as needed.
- Expand processes to adopt, review, and disseminate practice guidelines.
- Ensure composition of the local grievance and appeal committee meets requirements.
- Inform providers that they can file appeals and grievances on behalf of members with the members' written consent.

The additional recommendations identified below are opportunities for continued improvement in areas of the review where the MCO met requirements:

- Review and revise specific policies identified during the review, to ensure they are clear and contain all required elements.
- Place efforts in stabilizing care management team assignments to promote continuity of care for members.
- Disseminate information located in the *Restrictive Measures Policy* to providers.
- Identify the barriers for completing local appeals within the standard timeframes.
- Revise the restrictive measures log to include additional elements to improve tracking.

Lakeland Care District – Executive Summary

This report summarizes the results of the fiscal year (FY) 14-15 annual quality review conducted by MetaStar, Inc., for the managed care organization, Lakeland Care District. MetaStar is the external quality review organization contracted and authorized by the Wisconsin Department of Health Services to provide independent evaluations of managed care organizations that operate Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly.

Lakeland Care District operates the Family Care program in three counties in east central Wisconsin. Key findings from the review activities discussed in this report are summarized below:

Review Activity	FY 14-15 Results	Comparison to FY 13-14 Results
Quality Compliance Review	• 44 Total standards reviewed resulting in a score of 86 of a total possible 88	Quality Compliance Review follows a three-year review cycle; one year of comprehensive review followed by two

	• 42 Standards received "met" ratings, 2 Standards received "partially met" ratings	years of follow-up. FY 14-15 is the first year in a new review cycle; last year's results are not comparable.
Care Management Review	<u>Family Care</u> • 9 of 14 Standards met at a rate of 90 percent or higher • 94.1 percent: Overall rate of standards met *by this MCO* for all review indicators	<u>Family Care</u> • 8 of 14 Standards met at a rate of 90 percent or higher • 89.4 percent: Overall rate of standards met *across all Family Care MCOs*

LCD – Progress Related to Compliance with Standards

This section is intended to report about progress the MCO made in response to MetaStar's recommendations from the FY 13-14 Quality Compliance Review.

Lakeland Care District met all of the compliance standards in FY 12-13. Therefore, MetaStar did not conduct a Quality Compliance Review or make recommendations related to compliance with standards in FY 13-14.

LCD – Strengths

- A focus on members and the rights of members is integral to Lakeland Care District's organizational values and structure, and is practiced by staff in their day-to-day work.
- The organization makes extensive use of data collection, analysis, and monitoring to assess and improve service quality, cost effectiveness, operations, and program integrity.
- Lakeland Care District's commitment to continuous quality improvement is integrated throughout the organization; staff across departments, and at all levels of the organization, participate in improvement activities and initiatives.
- Organizational processes and expectations promote a high level of internal communication and collaboration across departments and staff at all levels. The practice of open communication and partnering extends beyond staff to network providers, community organizations, and government agencies, as well as to members and their supports.
- Lakeland Care District provides a wealth of resources and support for care management staff.
- Staff consistently engages in mediation and negotiation with members who have grievances or appeals, in order to understand the source of the concerns and resolve disagreements.

LCD – Recommendations

Following are recommendations related to Quality Compliance Review Standards that were not fully met and Care Management Review results in need of improvement:

- Revise the MCO *Requested Disenrollment Procedure* to ensure it specifies all of the impermissible reasons for requesting member disenrollment, as required.
- Continue monitoring and improvement efforts in the following areas of care management practice:
    - Completing assessments and member-centered plans that are comprehensive;
    - Conducting reassessments, when indicated;
    - Following up to ensure services have been received and are effective; and
    - Issuing notices to members in a timely manner, when indicated.

The additional recommendations identified below are opportunities for continued improvement in areas of the review where the MCO fully met the standard:

- Revise the organization's policy and procedure regarding member rights and responsibilities to indicate members are notified at least once a year about their right to request and obtain information about member rights and protections, the Member Handbook, and the Provider Network Directory.
- Continue to improve the comprehensiveness and consistency of listings in the Provider Network Directory.
- Continue efforts to work collaboratively with Aging and Disability Resource Centers and Income Maintenance agencies in Lakeland Care District's service area to review, update, and implement current Enrollment Plans.
- Review restrictive measures documents to ensure they are consistent in describing the composition of the Restrictive Measures Review Committee.
- Revise policies and procedures to reflect the continuation, duration, and reinstatement of benefits during an appeal or State Fair Hearing.
- Update the *Appeal and Grievance System Policy* to include the organization's practice that, when an appeal decision is unfavorable to the member, Lakeland Care District does not seek repayment for the cost of services that were provided during the time the appeal was pending.

Milwaukee County Department of Family Care – Executive Summary

This section of the report summarizes the results of the fiscal year (FY) 14-15 annual quality review conducted by MetaStar, Inc., for the managed care organization, Milwaukee County Department of Family Care. MetaStar is the external quality review organization contracted and authorized by the Wisconsin Department of Health Services to provide independent evaluations

of managed care organizations that operate Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly.

Milwaukee County Department of Family Care operates the Family Care program in eight counties in southeastern Wisconsin.

Key findings from the review activities discussed in this report are summarized below. Additional, detailed information can be found in the body of the report.

Review Activity	FY 14-15 Results	Comparison to FY 13-14 Results
Quality Compliance Review	• 44 Total standards reviewed resulting in a score of 81 of a total possible 88 points. • 37 Standards received "met" ratings 7 Standards received "partially met" ratings	Quality Compliance Review follows a three-year review cycle; one year of comprehensive review followed by two years of follow-up. FY 14-15 is the first year in a new review cycle; last year's results are not comparable.
Care Management Review	<u>Family Care</u> • 8 of 14 Standards met at a rate of 90 percent or higher • 90.1 percent: Overall rate of standards met by *this organization* for all review indicators	<u>Family Care</u> • 8 of 14 Standards met at a rate of 90 percent or higher • 89.4 percent: Overall rate of standards met *across all Family Care managed care organizations*

MCDFC – Progress Related to Compliance with Standards

This section is intended to report about progress the MCO made in response to MetaStar's recommendations from the FY 13-14 Quality Compliance Review.

Milwaukee County Department of Family Care met all of the quality compliance standards as a result of the review in FY 13-14. Therefore, MetaStar did not make any recommendations related to compliance with Quality Compliance Review standards in FY 13-14.

MCDFC – Strengths

- The organization has a structured quality management system which includes consistent monitoring, collection and analysis of data, and development of strategies to improve the quality of member care and organizational operations.
- Milwaukee County Department of Family Care provides a wealth of resources, decision making tools, education, and support for care management staff.

- The MCO is able to provide services in a culturally competent manner and meet the needs of members with diverse cultural and ethnic backgrounds by providing ongoing education to staff and contracting with specialty care management units.
- An effective provider network is maintained and supported through a systematic selection process, ongoing analysis of provider quality indicators, and monitoring.
- The member liaison serves as a resource to staff and members by communicating with and empowering members to exercise their rights, supporting members through the appeal and grievance process, and assisting staff in negotiations with members.

MCDFC - Recommendations

Following are recommendations related to Quality Compliance Review Standards that were not fully met and Care Management Review results in need of improvement:

- Implement a standard procedure for educating contracted providers on all member rights.
- Develop a written policy and procedure that ensures a good faith effort to provide written notification of termination of a contracted provider to members who received services from such providers.
- Identify barriers and implement improvement efforts to ensure timely resolution of local grievances/appeals.
- Ensure that annual restrictive measures renewal applications are completed timely.
- Develop a standardized procedure for MCO determination of when to expedite an appeal to ensure the member's life or health, or ability to attain, maintain or regain maximum function.
- Focus improvement efforts in the following areas of care management practice:
    - Improve the comprehensiveness of member-centered plans, including ensuring all identified needs and services are addressed.
    - Ensure member-centered plans are reviewed and signed timely by the appropriate legal decision maker at the required six month intervals.
    - Determine root cause of barriers to staff providing timely service authorization decisions and following up with members.

The additional recommendations identified below are opportunities for continued improvement in areas of the review where the MCO fully met requirements:

- Consider documenting the follow up actions taken by the MCO and the results on the centralized tracking form, when a provider is not compliant with meeting the background check requirement.

- Continue efforts to work collaboratively with Aging and Disability Resource Centers and Income Maintenance agencies in the organization's service area to ensure review, update, and implementation of current Enrollment Plans.
- Update the *Appeals and Grievance Guideline* to include:
    - The current practice of sending acknowledgments and how the MCO assists members in getting the written form back to the MCO when needed;
    - Information that the MCO must allow members to involve anyone the member chooses to assist in any part of the grievance or appeal process, including informal negotiations;
    - Information that members are offered the choice to exclude any consumer representatives from participation in their hearing;
    - Clear language that the legal representative of a deceased member's estate may file an appeal;
    - Information that clearly identifies the requirements for duration of continued or reinstated benefits;
    - That when an appeal decision is unfavorable to the member, the MCO does not seek repayment for the cost of services provided during the time the appeal was pending; and
    - Information that the MCO must pay for the services if the MCO or the State Fair Hearing Officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending.
- Update the *Advance Directive Policy* to clearly identify the follow-up procedure for providing the information to the member when he/she is no longer incapacitated.
- Ensure monitoring of all covered, non-covered, health-related, and community services is sufficient to ensure effective follow-up.
- Continue efforts to improve the consistency with which notices are issued to members timely.

Western Wisconsin Cares – Executive Summary

This report summarizes the results of the fiscal year (FY) 14-15 annual quality review conducted by MetaStar, Inc., for the managed care organization, Western Wisconsin Cares. MetaStar is the external quality review organization contracted and authorized by the Wisconsin Department of Health Services to provide independent evaluations of managed care organizations that operate Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly.

Western Wisconsin Cares operates the Family Care program in eight counties in western Wisconsin. Key findings from the review activities discussed in this report are summarized on the following page:

Review Activity	FY 14-15 Results	Comparison to FY 13-14 Results
Quality Compliance Review	• 44 Total standards reviewed resulting in a score of 84 out of a total possible 88 • 40 Standards received "met" scores • 4 Standards received "partially met" scores	Quality Compliance Review follows a three-year review cycle; one year of comprehensive review followed by two years of follow-up. FY 14-15 is the first year in a new review cycle; last year's results are not comparable.
Care Management Review	• 10 of 14 Standards met at a rate of 90 percent or higher • 93.4 percent: Overall rate of standards met by this MCO for all review indicators	• 10 of 14 Standards met at a rate of 90 percent or higher • 89.4 percent: Overall rate of standards met across all Family Care MCOs

WWC – Progress Related to Compliance with Standards

This section is intended to reflect on any progress the MCO made in response to MetaStar's recommendations from the FY-13-14 Quality Compliance Review.

Western Wisconsin Cares met all of the compliance standards in FY 12-13. Therefore, MetaStar did not conduct a Quality Compliance Review or make recommendations related to compliance with standards in FY 13-14.

WWC – Strengths

- A focus on members and the rights of members is a core value of the organization, and is practiced by staff in their daily work.
- A high level of communication and collaboration exists among MCO staff across all organizational levels and departments.
- WWC has effective mechanisms in place to facilitate communication and coordination with providers and other community stakeholders.
- The MCO makes extensive use of data and monitoring to assess system performance and uses the findings to improve the quality of member care and organizational operations.
- Staff across departments, and at all levels of the organization, participate in continuous quality improvement activities.
- The MCO provides a wealth of resources and support for care managers.
- The organization actively explores new ways to provide culturally and linguistically sensitive information and services.

WWC – Recommendations

Following are recommendations related to Quality Compliance Review standards that were not fully met and Care Management Review results in need of improvement:

- Identify barriers related to completing annual renewals of restrictive measures plans, and implement improvements focused on increasing timeliness. Monitor to ensure that restrictive measures plan renewals are sent to DHS at least 30 days prior to the expiration of the current plan.
- Identify barriers related to timely resolution of local grievances/appeals, implement improvements focused on increasing timeliness, and conduct periodic monitoring to ensure grievances/appeals are resolved as expeditiously as possible.
- Continue efforts to improve results in the following areas of care management practice:
    - Following up to ensure services have been received and are working effectively for the member; and
    - Issuing notices to members in a timely manner, when indicated.
- Ensure that provider credentialing processes are followed consistently.
- Revise the *Disenrollment Policy* to ensure it specifies the impermissible reasons for requesting member disenrollment, as required.

The additional recommendations identified below are opportunities for continued improvement in areas of the review where the MCO met the requirements:

- Review and revise specific policies identified during the review, to ensure they are clear and consistent throughout.
- To better reflect the role of the MCO with regard to member enrollment and disenrollment, incorporate WWC's *Disenrollment Policy* into the Enrollment Plan between the MCO, Aging & Disability Resource Center, and Income Maintenance.
- Develop a coordinated approach to the dissemination of practice guidelines to affected providers and members.

APPENDIX 3 – REQUIREMENT FOR EXTERNAL QUALITY REVIEW AND REVIEW METHODOLOGIES

REQUIREMENT FOR EXTERNAL QUALITY REVIEW

The Code of Federal Regulations at 42 CFR 438 requires states that operate PIHPs to provide for EQR of their MCOs, and to produce an annual technical report that describes the way in which the data from all EQR activities was reviewed, aggregated, and analyzed, and conclusions drawn regarding the quality, timeliness, and access to care provided across MCOs. To meet these obligations, states contract with a qualified 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 CMS Quality Improvement Organization Program.

MetaStar conducts EQR of MCOs operating managed long-term programs, including FC, FCP, and PACE. In addition, the company conducts EQR of health maintenance organizations serving BadgerCare Plus and Supplemental Security Income Medicaid recipients in the State of Wisconsin. MetaStar also provides services to private clients as well as the State. MetaStar also operates the Wisconsin Medicaid Health IT Extension Program in partnership with DHS, which provides information, technical assistance, and training to support the efforts of health care providers to become meaningful users of certified electronic health record technology.

MetaStar Review Team

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

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

Review Methodologies

Compliance with Standards Review/Quality Compliance Review

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

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

MetaStar also obtained information from DHS about its work with the MCO. The following sources of information were reviewed:

- The MCO's current Family Care Program contracts with DHS, Division of Long-Term Care;
- Related program operation references found on the DHS website:
  - https://www.dhs.wisconsin.gov/familycare/mcos/index.htm
- FY 13-14 external quality review report; and
- DHS communication with the MCO about expectations and performance during the previous 12 months.

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

Onsite group discussions were held to collect additional information necessary to assess the MCO's compliance with federal and state standards. Participants in the sessions included MCO administrators, supervisors and other staff responsible for supporting care managers, staff responsible for improvement efforts, and social work and RN care managers.

MetaStar also conducted some onsite verification activities, and requested and reviewed additional documents, as needed, to clarify information gathered during the onsite visit. Data from some CMR elements were considered when assigning compliance ratings for some focus areas and sub-categories.

MetaStar worked with DHS to identify 45 standards that include federal and state requirements; 44 of the standards were applicable to FC, and all 45 standards were applicable to FCP and PACE.

Focus Area	Related Sub-Categories in Review Standards
Enrollee Rights and Protections – 7 or 8 Standards	• 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 – 21 Standards	• Availability of Services • Coordination and Continuity of Care • Coverage and Authorization of Services • Provider Selection • Confidentiality • Enrollment and Disenrollment • Subcontractual Relationships and Delegation • Practice Guidelines • QAPI Program • Basic Elements of the QAPI Program • Quality Evaluation • Health Information Systems
Grievance System – 16 Standards	• 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.

Met:

- All policies, procedures, and practices were aligned to meet the requirement, **and**
- Practices were implemented, **and**
- Monitoring was sufficient to ensure effectiveness.

Partially Met:

- The MCO met the requirements in practice but lacked written policies or procedures, **or**
- The organization had not finalized or implemented draft policies, **or**
- Monitoring had not been sufficient to ensure effectiveness of policies, procedures and practices.

Not Met:

- The MCO did not meet the requirements in practice and had not developed policies or procedures.

For findings of "partially met" or "not met," the EQR team documented the missing requirements related to the finding and provided recommendations, as indicated. In some instances, recommendations were made for requirements met at a minimum.

Results were reported by assigning a numerical value to each rating:

- Met: 2 points
- Partially Met: 1 point
- Not Met: 0 points

The number of points were added and reported relative to the total possible points for each focus area, and as an overall score.

Validation of Performance Improvement Projects

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

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

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

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

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

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

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.*

Each MCO submitted data to MetaStar using standardized templates developed by DHS. The templates included vaccination data for all members that the MCO determined met criteria for inclusion in the denominator.

MetaStar reviewed the validity of the data and analyzed the reported vaccination rates for each quality indicator and program the MCO administered during MY 2014. To complete the validation work, MetaStar:

- Reviewed each data file to ensure there were no duplicate records;
- Confirmed that the members included in the denominators met the technical specification requirements established by DHS, including ensuring:
    - members reported to have contraindications were appropriately excluded from the denominator; and
    - when applicable, vaccination data were only reported for members who met specified age requirements;

- Confirmed that the members included in the numerators met the technical specification requirements established by DHS, including ensuring, when applicable, that vaccinations were given within the allowable time period;
- Determined the total number of unique members in the MCO and DHS denominators and calculated the number and percentage that were included in both data sets;
- Calculated the vaccination rates for each quality indicator by program and target group;
- Compared the MCO's rates for MY 2014 to both the statewide rates for MY 2014 and the MCO's rates for MY 2013; and
- When necessary, MetaStar contacted the MCO to discuss any data errors or discrepancies.

MetaStar then randomly selected 30 members per indicator from each program operated by the MCO, to verify the accuracy of the MCO's reported data. MetaStar took the following steps:

- Checked each member's service record to verify that it clearly documents the appropriate vaccination in the appropriate time period, or appropriately documents any exclusion/contraindication to receiving the vaccination.
- Documented whether the MCO's report of the member's vaccination or exclusion is valid or invalid (the appropriate vaccination was documented in the appropriate time period or the MCO provided documentation for the exclusion).

Conducted statistical testing to determine if rates are unbiased, meaning that they can be accurately reported. (The logic of the t-test is to statistically test the difference between the MCO's estimate of the positive rate and the audited estimate of the positive rate. If MetaStar validated a sample [subset] from the total eligible population for the measure, the t-test was used to determine bias at the 95 percent confidence interval.)

Information Systems Capability Assessment

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

MetaStar used a combination of activities to conduct and complete the ISCA.

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

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

MetaStar visited the MCO to perform staff interviews to:

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

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

Section I: General Information

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

Section II: Information Systems – Encounter Data Flow

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

Section III: Claims and Encounter Data Collection

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

Section IV: Eligibility/Enrollment Data Processing

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

Section V: Practitioner Data Processing

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

Section VI: System Security

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

Section VII: Vendor Oversight

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

Section VIII: Medical Record Data Collection

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

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.

Care Management Review

CMR is an optional activity which determines a MCO's level of compliance with its contract with DHS; ability to safeguard members' health and welfare; and ability to effectively support IDTs in the delivery of cost effective, outcome-based services. The information gathered during CMR helps assess the access, timeliness, quality, and appropriateness of care a MCO provides to its members. CMR activities and findings help support QCR, and are part of DHS' overall strategy for providing quality assurances to CMS regarding the 1915 (b) and (c) Waivers which allow the State of Wisconsin to operate its Family Care programs. The EQR team conducted CMR activities using a review tool and reviewer guidelines developed by MetaStar and approved by DHS.

MetaStar randomly selected a sample of member records based on a minimum of one and one-half percent of total enrollment or 30 records, whichever is greater.

The random sample included a mix of participants who enrolled during the last year, participants who had been enrolled for more than a year, and participants who had left the program since the sample was drawn. In addition, members from all target populations served by the MCO were included in the random sample; frail elders, and persons with physical and intellectual/developmental disabilities, including some members with mental illness, traumatic brain injury, and Alzheimer's disease.

For each MCO, DHS also directed MetaStar to review the records of any members identified in last year's CMR as having health and safety issues and/or complex and challenging situations. The results of these individual record reviews were provided to DHS and to the MCO, but were not included in the FY 14-15 aggregate results.

Prior to conducting the CMR, MetaStar obtained and reviewed policies and procedures from the MCO, to familiarize reviewers with the MCO's documentation practices.

During the review, MetaStar scheduled regular communication with quality managers or other MCO representatives to:

- Request additional documentation if needed;
- Schedule times to speak with care management staff, if needed;
- Update the MCO on record review progress; and
- Inform the MCO of any potential or immediate health or safety issues or members of concern.

The care management review tool and reviewer guidelines are based on DHS contract requirements and DHS care management trainings. Reviewers are trained to use DHS approved review tools, reviewer guidelines, and the review database. In addition to identifying any immediate member health or safety issues, MetaStar evaluated four categories of care management practice:

- Assessment
- Care planning
- Service coordination and delivery
- Member-centered focus

The four categories are made up of 14 indicators that reviewers used to evaluate care management performance during the six months prior to the review. MetaStar also compared information from each member's record in the sample with the member's most recent Long-Term Care Functional Screen and provided the comparisons to DHS.

Results for each indicator were compared to the results from the MCO's previous review to statistically evaluate whether any changes were likely attributable to an intrinsic change at the MCO, or were likely to have come about by normal variation or chance. The Chi-Square test was used to assess the statistical significance of the year-to-year change.

The table below provides specific information by program regarding the FY 13-14 aggregate rate for each of the 14 CMR standards.

CMR Measure	FY 13-14 FC Aggregate Rate	FY 13-14 FCP Aggregate Rate
1A-Comprehensiveness of Assessment	95.0%	92.2%
1B-Re-Assessment done when indicated	91.6%	88.2%
2A-Comprehensiveness of plan	67.5%	92.2%
2B-Timeliness of most recent plan (6 months)	89.0%	78.9%
2F-Timeliness of Member Centered Plan in Past 12 Months	97.3%	95.6%
2C-Plan updated for changes	68.9%	100.0%
2D-Timeliness of Service Auth Decisions	91.6%	91.1%
2E-Risk Addressed	94.4%	96.1%
3A-Timely Coordination of Services	90.5%	91.1%
3B-Follow up done	77.2%	62.2%
3C-Identified needs addressed	97.7%	97.8%
4A-NOA issued	58.1%	35.0%
4B- Member/ Grd/Supports Included	99.4%	100.0%
4C-SDS offered	96.6%	92.2%

MetaStar initiated a Quality Concern Protocol if there were concerns about a member's immediate health and safety, or if the review identified complex and/or challenging circumstances that warranted additional oversight, monitoring, or assistance. MetaStar communicated findings to DHS and the MCO if the Quality Concern Protocol was initiated.

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

Encounter Data Validation

EDV is an optional activity which assesses the completeness and accuracy of encounter data submitted to DHS by the MCO. Valid encounter data helps with assessing and improving quality, monitoring program integrity, and determining capitation payment rates. The MetaStar team conducted validation activities according to 42 CFR 438, Subpart E, as outlined in the CMS guide, *EQR Protocol 4: Validation of Encounter Data Reported by the MCO, Version 2.0*.

Prior to the review, MetaStar met with DHS to review information about state requirements for collecting and submitting encounter data. Requirements for collection and submission of encounter data, along with a data dictionary can be found on the following DHS website:

http://www.dhs.wisconsin.gov/ltcare/ies/index.htm

During the first phase of the review, MetaStar reviewed the results of the MCO's ISCA to determine whether the MCO's information system was likely to capture complete and accurate encounter data.

MetaStar retrieved long-term care encounter and eligibility data directly from the DHS' Data Warehouse using Business Objects (BO) queries. Data elements used in the queries included: member identifiers and demographics, record identifiers, service identifiers, service date ranges, provider identifiers for different provider types, and resource descriptors including quantities and MCO paid amounts.

MetaStar verified the integrity of the data extract to ensure that required data were present, valid, and consistent across fields. MetaStar also conducted an analysis to determine whether the data were reasonably representative of the MCOs' target group populations. To this end, the review team engaged in the following sequence of activities:

- To ensure the accuracy and integrity of the data used to create the samples, Metastar ensured that the queries conducted to retrieve the data were compared against the authoritative sources: the LTC Encounter Datamart universe (for the encounter data) and the Managed Care universe (for the corroborating member eligibility and demographic data). No other universes or external data were used for the project. The acceptance and inclusion of data in the DHS encounter reporting system, still ensures that the data met the basic edits and specifications and were certified by the MCO (e.g. were correct at the time of the extract's production). The review team verified that all in DHS' dataset were Family Care eligible members of the MCO during the period covered the encounter data submission. It did so by comparing members in the encounter data with members' eligibility segments.
- The final record was used in the dataset review, which included only original and corrected records (Record Type = O or C). Reversed records with negative paid amounts

that were used by the MCO to adjust the data were not included in the final dataset. Reviewers used database transformations of record IDs (Maximum Record ID) and other identifiers to ensure that no duplicate records were included in the final dataset.

The second phase of the review involved the selection of the sample. This phase included the following activities:

- The data validated in the first phase was analyzed to identify service areas representing high utilization and/or high cost.
- The analysis led to the selection of five leading service areas that combine the highest levels of utilization and cost. The time period that was used to analyze utilization included months with typical encounter volumes.
- A sample, of a sufficient number to ensure statistical significance, was selected for each of the five service areas. Metastar's biostatistician was consulted regarding the sample size and statistical significance. Next, records were randomly selected. The randomization process consisted of two layers. First, members who received one or more of the five focal services were selected. Next, individual encounter records were randomly chosen for members selected as part of the first step.

The last phase was the validation of the encounters to ensure that the services were actually provided in line with the information and detail that appear in the encounter data.

- MetaStar requested and the MCO delivered provider service records for the members in the random sample. The sample records that were sent to the MCO to facilitate the request included demographic information verifying each member's identity, service description and code, service provider, and service dates and units.

Each record was examined to ensure that the event reported in the provider service record occurred for the correct member and agreed with the unit amount and time frame in the encounter record. Findings were recorded on a standardized tool, created by MetaStar.