External Quality Review

Fiscal Year 2020 – 2021

Annual Technical Report

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

Final Report

Prepared for

Wisconsin Department of Health Services

Division of Medicaid Services

Prepared by

METASTAR

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EXECUTIVE SUMMARY

EXTERNAL QUALITY REVIEW PROCESS

The Code of Federal Regulations (CFR) at 42 CFR 438 requires states that operate pre-paid inpatient health plans and managed care organizations, including Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly (PACE), to provide for external quality review of these organizations and to produce an annual technical report. To meet its obligations, the State of Wisconsin, Department of Health Services (DHS) contracts with MetaStar, Inc. Review activities are planned and implemented according to The Centers for Medicare and Medicaid Services (CMS) External Quality Review (EQR) Protocols.

This report covers the external quality review fiscal year from July 1, 2020 to June 30, 2021 (FY 20-21). Mandatory review activities conducted during the year included assessment of compliance with federal standards, validation of performance measures, validation of performance improvement projects, and information systems capabilities assessments. MetaStar also conducted one optional activity, conducting focused studies of health care quality - care management review. Care management review assesses key areas of care management practice related to assurances found in the 1915(b) and 1915(c) Home and Community Based Services Waivers (HCBS), and also supports assessment of compliance with federal standards. All programs provide home and community-based services for long-term services and supports.

SCOPE OF EXTERNAL REVIEW ACTIVITIES

Protocol 1[1]: Validation of Performance Improvement Projects

Validation of performance improvement projects is a mandatory review activity, required by 42 CFR 438.358, and is conducted according to federal protocol standards. CMS issued the EQR Protocols in 2020 and *Validation of Performance Improvement Projects* is now Protocol 1. To evaluate the standard elements of a Performance Improvement Project, the MetaStar team used the methodology described in the CMS guide, EQR Protocol 3: *Validating Performance Improvement Projects (PIPs), A Mandatory Protocol for External Quality Reviews (EQR), Version 2.0,* as this was the Protocol in effect during the project timeframe. The purpose of a performance improvement project is to assess and improve processes and outcomes of health care provided by the managed care organization. The validation process determines whether projects have been designed, conducted, and reported in a methodologically sound manner.

[1] CMS issued the EQR Protocols in 2020 and the *Validation of Performance Improvement Projects* is now Protocol 1. To evaluate the standard elements of a PIP, the MetaStar team used the methodology described in the CMS guide, EQR Protocol 3: *Validating Performance Improvement Projects (PIPs), A Mandatory Protocol for External Quality Reviews (EQR), Version 2.0,* as this was the Protocol in effect during the project timeframe.

Protocol 2: Validation of Performance Measures

Validation of performance measures is a mandatory review activity, required by 42 CFR 438.358, and is conducted according to federal protocol standards. The review assesses the accuracy of performance measures reported by the managed care organizations, and determines the extent to which performance measures calculated by the managed care organizations follow state specifications and reporting requirements. The DHS contract with the managed care organizations specifies the quality indicators and standard measures organizations must calculate and report. MetaStar validated the completeness and accuracy of organizations' influenza and pneumococcal vaccination data for measurement year 2020. Technical definitions for each measure were provided by DHS.

Protocol 3: Compliance with Medicaid and CHIP Managed Care Regulations - Quality Compliance Review

An assessment of compliance with federal standards, or a quality compliance review, is a mandatory activity, identified in 42 CFR 438.358, and is conducted according to federal protocol standards. Compliance standards are grouped into three general categories: Managed Care Organization Standards; Quality Assessment and Performance Improvement; and Grievance Systems. In this fiscal year, per direction of DHS, the Managed Care Organization Standards were reviewed and next fiscal year will include the review of Quality Assessment and Performance Improvement and Grievance Systems.

Protocol 9: Conducting Focus Studies of Health Care Quality - Care Management Review

Care management review is an optional review activity that assesses key areas of care management practice related to assurances found in the 1915(b) and 1915(c) HCBS Waivers, and helps determine an organization's level of compliance with its contract with DHS.

Appendix V: Information Systems Capabilities Assessment

An assessment of a managed care organization's information system is a part of other mandatory review activities, including validation of performance measures, and ensures organizations have the capacity to gather and report data accurately. The DHS contract with managed care organizations requires organizations to maintain a health information system capable of collecting, analyzing, integrating, and reporting data. Each organization receives an information systems capabilities assessment once every three years.

Analysis: Quality, Timeliness, Access

The table below highlights the assessments of quality, timeliness and access to health care services conducted through each review activity. Compliance with these review activities provides assurances that the state is meeting requirements related to access, timeliness, and quality of services, including health care and long-term services and supports. State level

findings of strengths, progress, and recommendations to address weaknesses are included. Additionally, different aspects of the State's *2021 Medicaid Managed Care Quality Strategy* supported by the review activities are identified.

<table>
<tr><th>Quality</th><th>Timeliness</th><th>Access</th><th colspan="2">Strengths, Progress, and Recommendations and The State Quality Strategy</th></tr>
<tr><td colspan="5">Protocol 1: Validation of Performance Improvement Projects</td></tr>
<tr><td rowspan="8">√</td><td rowspan="8">√</td><td rowspan="8">√</td><td colspan="2">STRENGTHS</td></tr>
<tr><td><u>Review Findings</u></td><td><u>The State Quality Strategy</u></td></tr>
<tr><td>Project topics focused on improving key aspects of care for members.</td><td>Address health disparities.

Foster independence.

Focus on needs of the people being served through HCBS.

Empower people to realize their full potential through access to an array of services and supports.</td></tr>
<tr><td>The most successful projects developed approaches to monitor the effectiveness of interventions, by conducting continuous cycles of improvement and ensuring data collections processes were sound.</td><td>Ensure continuous improvement of high-quality programs to achieve member's identified goals and outcomes.</td></tr>
<tr><td>Knowledgeable, qualified teams were selected to conduct the projects.</td><td>Build collaborative relationships with both internal and external stakeholders and partners.</td></tr>
<tr><td>Cultural and linguistic considerations were addressed when interventions were developed.</td><td>Serve people through culturally competent practices and policies.</td></tr>
<tr><td>Follow-up actions for further improvement were identified as the result of data analysis</td><td>Ensure continuous improvement of high-quality programs to achieve member's identified goals and outcomes.

Ensure the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes.</td></tr>
<tr><td colspan="2">PROGRESS</td></tr>
<tr><td><u>Review Findings</u></td><td><u>The State Quality Strategy</u></td></tr>
</table>

Quality	Timeliness	Access	Strengths, Progress, and Recommendations and The State Quality Strategy	
			Six standards continued to be met at 100 percent and improvement was noted in two additional standards in FY 20-21.	Ensure continuous improvement of high-quality programs to achieve member's identified goals and outcomes.
			When improvement was noted for at least one of the study questions, 50 percent of the projects demonstrated that improvement was the result of the planned quality improvement intervention, as compared to only 20 percent of projects in FY 19-20.	Ensure the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes.
			RECOMMENDATIONS	
			Review Findings	The State Quality Strategy
			Choose performance improvement project topics that align with State and Federal priorities focused on keeping members healthy, safe, and supported in the community when possible.	Address health disparities. Foster independence. Focus on needs of the people being served through HCBS. Empower people to realize their full potential through access to an array of services and supports.
			Ensure initial and repeat measures are comparable to assess improvement in desired outcomes.	Ensure continuous improvement of high-quality programs to achieve member's identified goals and outcomes.
			Conduct analysis to determine reasons for less than optimal improvement.	Ensure the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes.

Quality	Timeliness	Access	Strengths, Progress, and Recommendations and The State Quality Strategy	
Protocol 2: Validation of Performance Measures Validation				
√	√	√	STRENGTHS	
			Review Findings	The State Quality Strategy
			Vaccination rates for each quality indicator have remained steady from year-to-year.	Assess and support all dimensions of holistic health.

Quality	Timeliness	Access	Strengths, Progress, and Recommendations and The State Quality Strategy	
			Organizations continue to educate members on the benefits of the vaccinations, even if they decline to receive the vaccine.	
			PROGRESS	
			Review Findings	The State Quality Strategy
			MCOs improved documentation practices for members contraindicated from receiving influenza and pneumococcal vaccinations; only two records submitted for contraindications did not align with the DHS technical definitions.	Focus on needs of the people being served through HCBS.
			RECOMMENDATIONS	
			Review Findings	The State Quality Strategy
			Continue to focus efforts on educating members on the benefits of receiving vaccinations, specifically influenza immunizations, to ensure members stay as healthy as possible.	Support individuals who use HCBS to actively participate in the design, implementation, and evaluation of the system at all levels.
Protocol 3: Compliance with Managed Care Regulations, Quality Compliance Review				
√	√	√	**STRENGTHS**	
			Review Findings	The State Quality Strategy
			Organizations demonstrated a high level of compliance with managed care regulations and quality.	Ensure member health and safety by the acute care and long-term care programs. Provide equitable access to services and supports. Ensure the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes. Ensure the HCBS workforce is adequate, available, and appropriate to serve the needs of the people who use HCBS. Support individuals who use HCBS to actively participate in the design, implementation, and evaluation of the system at all levels.

Quality	Timeliness	Access	Strengths, Progress, and Recommendations and The State Quality Strategy	
			Robust provider networks were evidenced throughout the organizations.	Ensure member care is delivered in a timely and effective manner. Provide services and supports in a manner consistent with a person's needs, goals, preferences, and values that help the person to achieve desired outcomes. Provide equitable access to services and supports. Ensure the HCBS workforce is adequate, available, and appropriate to serve the needs of the people who use HCBS.
			Efforts to promote cultural diversity were demonstrated through a variety of means by the organizations, such as trainings and community outreach.	Provide services and supports in a manner consistent with a person's needs, goals, preferences, and values that help the person to achieve desired outcomes. Provide the opportunity for people to be integrated into their communities and socially connected, in accordance with their personal preferences.
			PROGRESS	
			Review Findings	The State Quality Strategy
			Efforts to improve the coordination of services and supports to members was evidenced in most organizations.	Focus assessment, planning, and coordination of services and supports on the individual's goals, needs, preferences, and values.
			Recommendations related to provider selection requirements were successfully addressed throughout the state	Ensure the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes. Ensure the HCBS workforce is adequate, available, and appropriate to serve the needs of the people who use HCBS.
			RECOMMENDATIONS	
			Review Findings	The State Quality Strategy
			Implement a standard process to ensure policies and procedures,	

Quality	Timeliness	Access	Strengths, Progress, and Recommendations and The State Quality Strategy	
			and the monitoring of member restrictive measures, are fully merged and implemented during significant changes, like an organization merger	Ensure member health and safety by the acute care and long-term care programs. Ensure the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes. Promote and protect the human and legal rights of individuals who use HCBS.
			Continue efforts to ensure timely follow-up for effectiveness of services.	Focus assessment, planning, and coordination of services and supports on the individual's goals, needs, preferences, and values.
			Ensure debarment verification is conducted for new providers, providers with business names and owner names, and the monitoring for ongoing providers.	Ensure member health and safety by the acute care and long-term care programs. Ensure the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes. Ensure the HCBS workforce is adequate, available, and appropriate to serve the needs of the people who use HCBS.
Protocol 9: Conducting Focused Studies of Health Care Quality				
√	√	√	**STRENGTHS**	
			Review Findings	The State Quality Strategy
			All programs demonstrated the ability to sufficiently support members, as evidenced by no members identified with unaddressed health and safety issues, and only one member out of 1,882 was identified for a complex and challenging situation	Ensure member health and safety by the acute care and long-term care programs. Ensure member care is delivered in a timely and effective manner. Provide services and supports in a manner consistent with a person's needs, goals, preferences, and values that help the person to achieve desired outcomes. Focus assessment, planning, and coordination of services and

Quality	Timeliness	Access	Strengths, Progress, and Recommendations and The State Quality Strategy	
				supports on the individual's goals, needs, preferences, and values. Promote and protect the human and legal rights of individuals who use HCBS.
			PROGRESS	
			Review Findings	The State Quality Strategy
			All programs demonstrated statistically significant progress in member centered planning, timely follow-up, and the protection of member rights, which is likely the result of actions taken by the programs.	Ensure member health and safety by the acute care and long-term care programs. Ensure member care is delivered in a timely and effective manner. Provide services and supports in a manner consistent with a person's needs, goals, preferences, and values that help the person to achieve desired outcomes. Focus assessment, planning, and coordination of services and supports on the individual's goals, needs, preferences, and values. Promote and protect the human and legal rights of individuals who use HCBS.
			RECOMMENDATIONS	
			Review Findings	The State Quality Strategy
			Focus efforts to increase the comprehensiveness of assessments and member-centered plans in the Family Care and Family Care Partnership programs, specifically in Geographical Service Regions 4 and 11 of the Family Care program, and Geographical Service Region 12 of the Family Care Partnership program	Ensure member health and safety by the acute care and long-term care programs. Focus assessment, planning, and coordination of services and supports on the individual's goals, needs, preferences, and values.
			Focus efforts on improving follow-up to ensure member supports and services are adequate in the Family Care Partnership program, specifically in Geographical Service Region 12	Ensure member health and safety by the acute care and long-term care programs. Ensure member care is delivered in a timely and effective manner.

Quality	Timeliness	Access	Strengths, Progress, and Recommendations and The State Quality Strategy	
			Ensure staff are making the minimum member contacts as required by DHS for Family Care Partnership, specifically in Geographical Service Region 12	Ensure member health and safety by the acute care and long-term care programs.
			Ensure timely assessments for Geographic Service Region 6 and 11 of the PACE program.	Ensure member health and safety by the acute care and long-term care programs. Focus assessment, planning, and coordination of services and supports on the individual's goals, needs, preferences, and values.
Appendix V: Information Systems Capabilities Assessments				
√	√	√	**STRENGTHS**	
			Review Findings	The State Quality Strategy
			Excellent processes for validating the encounter data files for accuracy and completeness prior to submission to DHS.	Ensure timely access to complete and accurate health data.
			Strong oversight of vendors.	Ensure member health and safety by the acute care and long-term care programs.
			The ability to produce multiple on-going and ad hoc reports in support of management decisions and care management operations, from a variety of internal and State sources including the encounter and adult functional screen DataMarts.	Evaluate data systems to ensure they effectively support programs and strategies in collecting relevant and adequate clinical and other data from multiple sources. Ensure the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes.
			PROGRESS	
			Review Findings	The State Quality Strategy
			Improvement in efforts to consolidate data sources to the data warehouse.	Ensure the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes.
			Improved accuracy of encounters submitted to DHS.	Ensure the system operates efficiently, ethically, transparently,

Quality	Timeliness	Access	Strengths, Progress, and Recommendations and The State Quality Strategy	
				and effectively in achieving desired outcomes. Evaluate data systems to ensure they effectively support programs and strategies in collecting relevant and adequate clinical and other data from multiple sources.
			RECOMMENDATIONS	
			Review Findings	The State Quality Strategy
			Maintain monitoring and evaluation processes to ensure quality, access, and timeliness of encounter data submissions.	Ensure timely access to complete and accurate health data.
			Continue efforts to consolidate data sources.	Ensure the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes.

Introduction and Overview

Acronyms and Abbreviations

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

Purpose of the Report

This is the annual technical report the State of Wisconsin must provide to the Centers for Medicare & Medicaid Services (CMS) related to the operation of its Medicaid managed health and long-term care programs; 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 and managed care organizations (MCOs) to provide for periodic external quality reviews. This report covers mandatory and optional external quality review (EQR) activities conducted by the external quality review organization (EQRO), MetaStar, Inc., for the fiscal year from July 1, 2020, to June 30, 2021 (FY 20-21). See Appendix 2 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 Managed Care Organizations

The table below identifies the programs each MCO operates.

Managed Care Organization	Program(s)
Community Care, Inc. (CCI)	FC; FCP; PACE
Inclusa, Inc. (Inclusa)	FC
Independent Care Health Plan (*i*Care)	FCP
Lakeland Care, Inc. (LCI)	FC
My Choice Wisconsin (MCW)*	FC; FCP

*Effective January 1, 2020, two separate MCOs, My Choice Family Care (MCFC), operating FC, and Care Wisconsin (CW), operating FC and FCP, merged to create a new organization, My Choice Wisconsin (MCW).

In November 2019 DHS approved the merger of two separate MCOs, My Choice Family Care (MCFC) and Care Wisconsin (CW). The newly merged organization, My Choice Wisconsin (MCW), was approved to provide Medicaid managed long-term care services through the FC and FCP programs in counties where the two separate MCOs, referred to as legacy MCOs, had previously provided FC and FCP services and supports. This report includes the evaluation of MCW and not former CW or MCFC.

Effective April 1, 2021, DHS certified Inclusa to expand into geographic service regions (GSR) 9 and 10. The MCO will provide FC services in these GSRs.

Links to maps depicting the current FC and FCP/PACE GSRs 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.

Details about the core values and operational aspects of these programs are found at the following websites:

https://www.dhs.wisconsin.gov/familycare/whatisfc.htm.

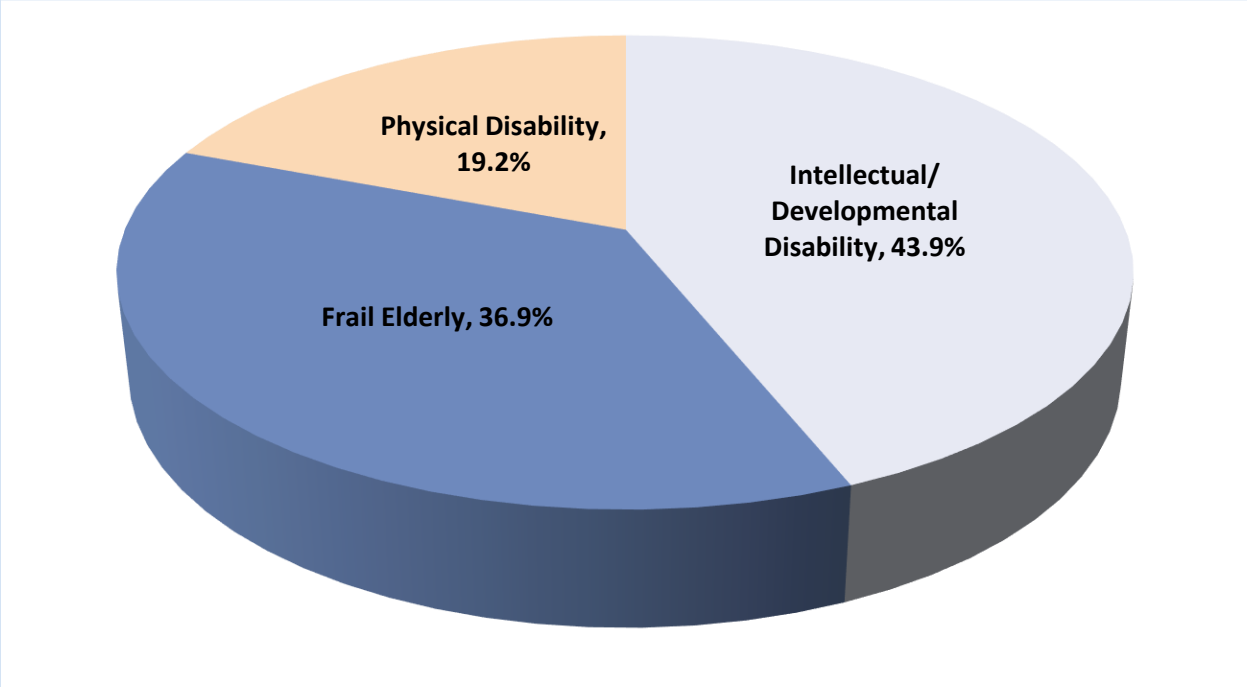
https://www.dhs.wisconsin.gov/familycare/fcp-overview.htm.

As of August 1, 2021, enrollment for all programs was approximately 55,465. This compares to last year's total enrollment of 55,102 as of July 1, 2020. Enrollment data is available at the following DHS website:

https://www.dhs.wisconsin.gov/familycare/enrollmentdata.htm.

The following chart 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: August 1, 2021



Analysis: Quality, Timeliness, and Access

The CMS guidelines regarding this annual technical report direct the EQRO to provide an assessment of each MCOs' strengths and weaknesses with respect to quality, timeliness, and access to health care services. All programs provide home and community-based services for long-term services and supports (LTSS). FCP and PACE also provide acute and primary care services. Compliance with these review activities provides assurances that MCOs are meeting requirements related to access, timeliness, and quality of services, including health care and LTSS. The analysis included in this section of the report provide assessment of strengths, progress and recommendations for improvement for each MCO. The tables below identify the mandatory review activities, scope of activities, and findings from the assessments of quality, timeliness, and access to health care services for the programs each MCO operates.

<table>
<tr><th colspan="3">Community Care, Inc.</th></tr>
<tr><th>Programs Operated</th><th>FY20-21 Enrollment by Program</th><th>GSRs</th></tr>
<tr><td>FC, FCP, PACE</td><td>FC: 12,103 FCP: 715 PACE: 516</td><td>6, 8, 9, 10, 11, 12</td></tr>
<tr><th colspan="3">Findings</th></tr>
<tr><td>Protocol 1: Validation of Performance Improvement Projects
Advance Care Planning
Opioid Risk Reduction</td><td colspan="2">Strengths
– The project topics focused on improving a key aspect of care for members, and were selected through a comprehensive analysis of member needs, care, and services.
– Knowledgeable, qualified teams were selected to conduct each project.
– The study questions identified the focus of the projects and established the framework for data collection and analysis.
– The study indicators were clearly defined for both projects.
– Effective improvement strategies were developed and implemented.
– Analysis and interpretation of the data was based on a continuous quality improvement philosophy.

Progress
– The project focused on advance care planning was a continuing project, in its second year of implementation. The MCO met 82.4 percent of the applicable standards in FY 20-21; an improvement from FY 19-20, where only 77.8 percent of applicable standards for the project were fully met.
– The MCO addressed recommendations from FY 19-20, and ensured each project conducted in FY 20-21 specified a data analysis plan, and that the data was analyzed according to the plan.
– Overall, the MCO met 80.0 percent of applicable standards in FY 20-21, compared to 77.8 percent of applicable standards in FY 19-20.

Recommendations
– Both projects should ensure the data collection method accurately captures all members to whom the study population applies.
– One project should implement a mechanism to ensure consistent, accurate data collection which enables the study questions to be answered.
– The other project should define data sources for all measures, and ensure initial and repeat measures are comparable.</td></tr>
<tr><td>Protocol 2: Validation of Performance Measures</td><td colspan="2">Strengths</td></tr>
</table>

Community Care, Inc.		
Programs Operated	**FY20-21 Enrollment by Program**	**GSRs**
FC, FCP, PACE	FC: 12,103 FCP: 715 PACE: 516	6, 8, 9, 10, 11, 12
Findings		
	– The MCO collaborated with representatives from a pharmacy in their service area to provide seven outdoor influenza vaccination clinics in October 2020 for members, their families, and staff members of the MCO's contracted providers. – The provision of the outdoor clinics was reported to alleviate some instances of high anxiety that members expressed about interactions with medical professionals in medical settings. Progress – Influenza vaccination rates declined year-to-year for all programs. – Pneumococcal vaccination rates improved for the FC program from MY 2019 to MY 2020. Recommendations – Develop a means to verify that the interdisciplinary care team staff accurately documents refusals of vaccinations. – Continue efforts to increase influenza vaccination rates, as rates declined from MY 2019 for all programs.	
Protocol 3: Compliance with Managed Care Regulations, Quality Compliance Review	Strengths – The Advance Care Planning Initiative team reviewed all advance directives on file to ensure they meet Wisconsin requirements, and provided guidance and assistance in completing new documents with members, if needed. Focused training was also provided to staff. – The organization demonstrated the ability to ensure availability of accessible, culturally competent services through a network of qualified service providers. – The organization demonstrated the ability to ensure coordination and continuity of member care. – The organization had strong systems in place to help members understand their rights as well as ensuring those rights are protected. Progress – The MCO successfully addressed recommendations related to the coordination of member supports and services. Recommendations – Implement a system to obtain consent prior to sending member materials electronically. – Update internal procedures with additional debarment guidance, specifically related to debarment checks of providers using legal names and business names, when a provider has a change in ownership, and when the organization enters into a Letter of Agreement with a provider. – Update the *Letter of Agreement* to include the necessary requirements and responsibilities of the organization and provider. – Implement systems related to practice guidelines to ensure that all guidelines posted for staff and providers are current; and the links to resources on the provider practice guidelines webpage are functional.	

Community Care, Inc.		
Programs Operated	**FY20-21 Enrollment by Program**	**GSRs**
FC, FCP, PACE	FC: 12,103 FCP: 715 PACE: 516	6, 8, 9, 10, 11, 12
Findings		
	– Update guidance for staff to ensure knowledge that electronic materials can be provided in paper form when requested, without charge, and within five business days. – Update guidance for staff regarding the requirement for the organization to inform members that they may voluntary disenroll from the program if the organization is not able to accommodate a member's choice of provider. – Update guidance for providers to include language about the member's right to refuse treatment and express preferences about future treatment decisions. – Ensure staff are aware of the practice guidelines adopted by the organization.	
Protocol 9: Conducting Focused Studies of Health Care Quality *Sample Sizes* *FC: 265* *FCP: 193* *PACE: 175*	Strengths – Comprehensive assessment practices were strengths for the Family Care program. – PACE had strong practices in place for member-centered planning. – The organization demonstrated strengths related to care coordination for the Family Care and PACE programs. Progress – Completing assessments within required timeframes for the Family Care program. – Ensuring timely review of member-centered plans for the Family Care Partnership program. – Reassessing members for changes in condition for the Family Care and PACE programs. – Timely follow-up with members to ensure effectiveness of services for the Family Care and PACE programs. – Completing contacts with members as required for PACE. Recommendations – Continue efforts to ensure timely follow-up for effectiveness of services, especially in the Family Care Partnership program. – Focus efforts on improving the comprehensiveness of assessments and member-centered plans in the Family Care and Family Care Partnership programs.	
Appendix V: Information Systems Capabilities Assessments	Strengths – Excellent processes for validating the encounter data files for accuracy and completeness prior to submission to DHS. These processes are well documented. – Use of technologies for managing remote work for several years. The use of these technologies has enabled the MCO to continue uninterrupted and normal operations during the Coronavirus Pandemic. – A strong and integrative process to manage cost share determinations and collections. This process utilizes Client Assistance for Re-employment and Economic Support System's Economic Assistance determinations as well as DHS' capitation reports. Dedicated MCO staff utilize the information for the correct prospective billing of members, and for retrospective/retroactive adjustments and reconciliations.	

Community Care, Inc.		
Programs Operated	**FY20-21 Enrollment by Program**	**GSRs**
FC, FCP, PACE	FC: 12,103 FCP: 715 PACE: 516	6, 8, 9, 10, 11, 12
Findings		
	– Maintenance of a comprehensive and operations oriented external web site for its providers. In addition to descriptive information on various provider characteristics, the site includes useful practical information regarding correct billing procedures, good practice expectations, guidelines for creating and writing reports to State entities, and contact information for bringing up questions and concerns. – A strong and close oversight relations with its primary vendor PharmaStar. Oversight includes regular and ad hoc meetings between PharmaStar staff and the MCO's pharmacy director and its staff. There are numerous and detailed reports produced by the vendor, including drug utilization and volumes by drug type. There is real-time trouble shooting and problem resolution via timely assignment of service tickets. – Production of on-going and ad hoc analytic reports covering a wide range of operations, in support of management decisions and care management operations, by using a variety of internal and State data sources. Progress – Reduced the number manual process associated with encounter data preparation by increasing systems edits and internal systems comparisons and reconciliations. – Continued efforts to consolidate data sources to the data warehouse. – Improved accuracy of encounters submitted to DHS. – Improved monitoring of security and confidentiality. Recommendations – Continue efforts to consolidate all data sources to the data warehouse. – Continue efforts to develop role-based system access policies. – The MCO produces updated and complete eligibility reports on a monthly basis while DHS' guidelines call for bi-weekly production of these reports. To better meet DHS' guidelines, the MCO should change the scheduling of these updates.	

Inclusa, Inc.		
Programs Operated	**FY20-21 Enrollment by Program**	**GSRs**
FC	FC: 15,352	1, 2, 3, 4, 5, 6, 7, 9, 10, 13, 14
Findings		
Protocol 1: Validation of Performance Improvement Projects • *Member Safety* • *Health Equity*	Strengths – The project topics focused on improving key aspects or processes of care for members, and were selected through a comprehensive analysis of member needs, care, and services. – The study questions identified the focus of the projects and established the framework for data collection and analysis. – The study indicators were clearly defined for both projects. – The MCO clearly identified the study population in relation to the study question. – Effective improvement strategies were developed and implemented. – Knowledgeable, qualified teams were selected to conduct each project. – The study topics were thoroughly researched and clearly described.	

Inclusa, Inc.		
Programs Operated	**FY20-21 Enrollment by Program**	**GSRs**
FC	FC: 15,352	1, 2, 3, 4, 5, 6, 7, 9, 10, 13, 14
Findings		
	– Cultural and linguistic considerations were addressed when interventions were developed. Progress – One of the two projects conducted in FY 20-21 demonstrated quantitative improvement in processes or outcomes of care that was shown to be the result of the planned quality improvement intervention; an improvement from FY 19-20. – The MCO did not demonstrate overall progress from FY 19-20; the MCO met 86.5 percent of applicable standards in FY 20-21, compared to 89.5 percent of applicable standards in FY 19-20. Recommendations – One project should ensure an adequate study population size is used, and the MCO should continue to sustain the level of improvement that has been achieved. – The other project needs to ensure initial and repeat measures are comparable, accurately present numerical results, and specify the data analysis plan.	
Protocol 2: Validation of Performance Measures	Strengths – No strengths. Progress – Influenza and pneumococcal vaccination rates declined year-to-year. Recommendations – Reference the most updated link to DHS' influenza and pneumococcal technical specifications in the MCO's Immunization Clinical Practice Guidelines. – Continue efforts to educate members on the benefit of the influenza vaccination.	
Protocol 3: Compliance with Managed Care Regulations, Quality Compliance Review	Strengths – The organization's structure promoted cross departmental collaboration and communication at all levels of the organization. – The organization had a proactive monitoring approach to ensure providers are in compliance with contracting requirements demonstrated by the recredentialing of providers at least annually. – The organization had a handbook for interdisciplinary staff to reference for a variety of care management practices. The handbook is organized by topic, and provided instructions and direction for practices beyond the policies and procedures. – The organization had a robust member file review process that is conducted at routine intervals using statistically representative sample sizes and provides feedback to staff at all levels of the organization. The results of the member file review are utilized to improve care management practices. – The organization had strong systems in place to help members understand their rights as well as ensuring those rights are protected.	

Inclusa, Inc.		
Programs Operated	**FY20-21 Enrollment by Program**	**GSRs**
FC	FC: 15,352	1, 2, 3, 4, 5, 6, 7, 9, 10, 13, 14
Findings		
	– The organization demonstrated the ability to ensure availability of accessible, culturally competent services through a network of qualified service providers. – The organization demonstrated the ability to ensure coordination and continuity of member care. Progress – The MCO successfully addressed recommendations for improving the timeliness of member-centered plans, and ensuring providers are informed of member rights that must be observed and protected when furnishing services to members. Recommendations – Update procedures with additional debarment guidance, specifically related to new providers and providers using legal names and business names. – Implement systems to ensure that a self-directed supports guidebook is provided to all members at enrollment. – Update written guidance for providers to include the specific reasons providers may advocate for members, and ensure that staff and providers are educated about this requirement. – Update procedures to add clarity for when a contracted provider is not included in the provider directory; and for how the organization identifies what service categories each provider should be in. – Include written guidance that appeals and grievances must be accepted from members related to a lack of access to culturally appropriate care. – Update internal procedures to include giving the affected providers written notice of the reason for decision if the organization declines to include the provider in the network. – Update guidance for staff to ensure knowledge that electronic materials can be provided in paper form when requested without a charge. – Educate staff regarding the requirement for the organization to inform members that they may voluntarily disenroll from the program if the organization is not able to accommodate a member's choice of provider.	
Protocol 9: Conducting Focused Studies of Health Care Quality *Sample Size* *FC: 266*	Strengths – The organization had strong practices in place for member-centered planning. – The organization demonstrated strengths related to care coordination. Progress – Completing assessments and member-centered plans within required timeframes. – Ensuring contact frequency with members occurs as required. Recommendations – Focus efforts on improving the comprehensiveness of assessments and member-centered plans. – Continue efforts to ensure timely follow-up for effectiveness of services.	

Inclusa, Inc.		
Programs Operated	**FY20-21 Enrollment by Program**	**GSRs**
FC	FC: 15,352	1, 2, 3, 4, 5, 6, 7, 9, 10, 13, 14
Findings		
Appendix V: Information Systems Capabilities Assessment	Strengths – Utilization of up-to-date audio and video technologies that allow its staff to perform all work functions from home during the pandemic and into the foreseeable future. – Established and operates a multi layered and multi stepped approach for collecting and validating accurate and timely enrollment and eligibility information in its MATRIX system. – Developed a comprehensive policy and process for capturing Third Party Liability (TPL) information. Potential TPL payers include Medicare parts A, B, and C, other medical private insurance, dental, and vision. – Robust process for maintaining and updating provider files in real-time, thus facilitating timely and smooth claims processing. – Strong and collaborative vendor oversight. – Analytics staff produce multiple on-going and ad hoc reports in support of management decisions and care management operations, from a variety of internal and State sources including the encounter and adult functional screen DataMarts. Progress – Successfully consolidated the regional operating systems, databases, and associated policies and procedures across the merged organization. – The MCO remedied the challenges and improved the process related to timely and accurate performance measurement reporting. – Continues to make improvements related to vendor management, including the accuracy of submitted claims. Recommendations – Document the steps taken to validate the encounter files prior to submitting to DHS. – Develop and document a written policies and procedures for handling breaks in enrollment, dis-enrollments, and continuations.	

*i*Care		
Programs Operated	**FY20-21 Enrollment by Program**	**GSRs**
FCP	FCP: 1,307	3, 8, 11, 12
Findings		
Protocol 1: Validation of Performance Improvement Projects • *Advance Care Planning* • *Opioid Risk Reduction*	Strengths – The project topics focused on improving a key aspect of care for members, and were selected through a comprehensive analysis of member needs, care, and services. – The study questions identified the focus of the projects and established the framework for data collection and analysis. – The MCO clearly identified the study population in relation to the study question. – Knowledgeable, qualified teams were selected to conduct each project. – One project utilized continuous cycles of improvement to assess the effectiveness of the interventions and attempt to overcome barriers. – The other project based the improvement strategies on a barrier analysis.	

*i*Care		
Programs Operated	**FY20-21 Enrollment by Program**	**GSRs**
FCP	FCP: 1,307	3, 8, 11, 12
Findings		
	Progress – The MCO did not demonstrate overall progress from FY 19-20; the MCO met 62.2 percent of applicable standards in FY 20-21, compared to 84.2 percent of applicable standards in FY 19-20. Recommendations – Both projects should ensure initial and repeat measures are comparable, and that the reports specify the prospective data analysis plan. – One project should ensure the denominator for the baseline measurement and remeasurement are the same, and ensure the data calculations are accurate. – The other project should clearly present numerical results, document continuous improvement efforts, and address cultural or linguistic appropriateness of interventions.	
Protocol 2: Validation of Performance Measures	Strengths – No strengths. Progress – Influenza vaccination rates declined year-to-year. – Pneumococcal vaccination rates improved from MY 2019 to MY 2020. Recommendations – Review the Wisconsin Immunization Registry print outs accurately to report the status of valid vaccinations. – Conduct a root cause analysis to determine the reason for members age 65 and older to remain in the Physical Disability target group for the pneumococcal vaccination after DHS implemented the target group automation for the Long-Term Care Function Screen in early 2017.	
Protocol 3: Compliance with Managed Care Regulations, Quality Compliance Review	Strengths – The organization has strong systems in place to help members understand their rights as well as ensuring those rights are protected. – The organization demonstrated the ability to ensure availability of accessible, culturally competent services through a network of qualified service providers. – The organization demonstrated the ability to ensure coordination and continuity of member care. Progress – The MCO successfully addressed recommendations related to the selection and retention of providers, including training for provider network staff and monitoring to ensure ongoing provider compliance. – The MCO implemented a system to ensure providers have access to the clinical practice guidelines adopted by the organization. Recommendations – Update written guidance to include the requirements for the format and content of electronic materials.	

*i*Care		
Programs Operated	**FY20-21 Enrollment by Program**	**GSRs**
FCP	FCP: 1,307	3, 8, 11, 12
Findings		
	– Update guidance for staff to ensure knowledge that electronic materials can be provided in paper form when requested without a charge and within five business days.	
Protocol 9: Conducting Focused Studies of Health Care Quality *Sample Size* *FCP: 219*	Strengths – Comprehensive assessment practices were strengths for the organization. Progress – Ensuring the self-directed supports (SDS) requirements are reviewed timely improved from the prior review. Recommendations – Continue efforts to ensure timely follow-up for effectiveness of services. – Focus efforts on improving the comprehensiveness of member-centered plans.	
Appendix V: Information Systems Capabilities Assessment	Not applicable. Reviewed in FY 19-20.	

Lakeland Care, Inc.		
Programs Operated	**FY20-21 Enrollment by Program**	**GSRs**
FC	FC: 7,681	4, 9, 10, 13
Findings		
Protocol 1: Validation of Performance Improvement Projects • *Dementia Care* • *Care Management Practices*	Strengths – The project topics focused on improving key aspects or processes of care for members, and were selected through a comprehensive analysis of member needs, care, and services. – The study questions identified the focus of the projects and established the framework for data collection and analysis. – The study indicators were clearly defined for both projects. – The MCO clearly identified the study population in relation to the study question. – Effective improvement strategies were developed and implemented for both projects. – Both projects ensured continuous cycles of improvement were conducted throughout the project as scheduled, and the report identified follow-up actions from the data analysis. – The MCO used valid and reliable methods to collect the data that informed the PIP measurements. Progress – The project focused on dementia care was a continuing project, in its second year of implementation. Quantitative improvement was demonstrated for two of the four study questions in FY 20-21. – The overall percentage of applicable standards met declined to 89.2 percent in FY 20-21 from 100 percent in FY 19-20. Recommendations	

Lakeland Care, Inc.		
Programs Operated	**FY20-21 Enrollment by Program**	**GSRs**
FC	FC: 7,681	4, 9, 10, 13
Findings		
	– One project should analyze data on a periodic basis to understand the causes for less than optimal performance. – The second project should ensure the baseline and repeat measures are comparable.	
Protocol 2: Validation of Performance Measures	Strengths – No strengths. Progress – Influenza vaccination rates remained the same year-to-year. – Pneumococcal vaccination rates improved from MY 2019 to MY 2020. Recommendations – Continue the practices developed, including educating members on the importance of the influenza vaccination, in order to increase influenza vaccination rates.	
Protocol 3: Compliance with Managed Care Regulations, Quality Compliance Review	Strengths – The organization had a best practice guide for interdisciplinary staff to reference for a variety of care management practices. The guide was organized by topic, and provided instructions and direction for practices beyond the policies and procedures. – The organization had strong systems in place to help members understand their rights as well as ensuring those rights are protected. – The organization demonstrated the ability to ensure availability of accessible, culturally competent services through a network of qualified service providers. – The organization demonstrated the ability to ensure coordination and continuity of member care. – The organization improved in their overall care management practices, as evidenced by a statistically significant improvement in overall care management review results. Progress – The MCO successfully addressed recommendations related to provider selection requirements, including monitoring for licensure and caregiver background checks; subcontractual relationships and delegations; and the information in the provider directory. – The MCO made improvements related to the coordination of member supports and services and the timeliness of member-centered plans. Recommendations – Update internal procedures with additional debarment guidance, specifically related to debarment verification of new providers, to include when there is a need for continuation of services and how the organization ensures it does not employ or contract with excluded providers in these circumstances. – Continue efforts on improving the comprehensiveness of assessments and member-centered plans. – Update the organization's disenrollment policy to include the specific requirement that staff shall not counsel or otherwise influence a member	

Lakeland Care, Inc.		
Programs Operated	**FY20-21 Enrollment by Program**	**GSRs**
FC	FC: 7,681	4, 9, 10, 13
Findings		
	due to his/her life situation (e.g., homelessness, increased need for supervision) or condition in such a way as to encourage disenrollment. – Update written guidance to include direction for staff to review and update member contact information as a way to ensure the delivery of electronic materials to members. – Update internal procedures with additional monitoring of providers regulated by the Division of Quality Assurance, specifically related to the monitoring implemented in November 2020. – Ensure that the plan for reviewing and updated clinical practice guidelines is consistent with practice.	
Protocol 9: Conducting Focused Studies of Health Care Quality *Sample Size* *FC: 262*	Strengths – The organization had strong practices in place for member-centered planning. – The organization demonstrated strengths related to care coordination. Progress – Continue efforts on improving the comprehensiveness of assessments and member-centered plans. Recommendations – Ensuring member-centered plans are comprehensive and timely improved from the prior review.	
Appendix V: Information Systems Capabilities Assessment	Not Applicable. Reviewed in FY 18-19.	

My Choice Wisconsin, Inc.		
Programs Operated	**FY20-21 Enrollment by Program**	**GSRs**
FC, FCP	FC: 15,801 FCP: 1,719	1, 2, 3, 5, 6, 8, 11, 12, 14
Findings		
Protocol 1: Validation of Performance Improvement Projects • *Reduce Readmission Rate* • *Care Management Practice (FC program)* • *Care Management Practice (FCP program)*	Strengths – The project topics focused on improving key aspects or processes of care for members, and were selected through a comprehensive analysis of member needs, care, and services. – The study questions identified the focus of the projects and established the framework for data collection and analysis. – The study indicators were clearly defined for both projects. – All projects ensured continuous cycles of improvement were conducted throughout the project as scheduled, and the report identified follow-up actions from the data analysis. Progress – The project focused on reducing readmissions was a continuing project in its second year of implementation. The MCO demonstrated improvement in two of the three study questions in FY 20-21. – One project met all of the applicable standards in FY 20-21.	

My Choice Wisconsin, Inc.		
Programs Operated	**FY20-21 Enrollment by Program**	**GSRs**
FC, FCP	FC: 15,801 FCP: 1,719	1, 2, 3, 5, 6, 8, 11, 12, 14
Findings		
	– The MCO addressed recommendations from FY 19-20 and ensured all study questions were stated as clear, simple, answerable questions with a numerical goal and target date. – Overall, the MCO met 88.9 percent of applicable standards in FY 20-21, compared to 86.5 percent of applicable standards in FY 19-20. Recommendations – Two projects should ensure initial and repeat measures are comparable and answer the study question as written – One project should continue to sustain the level of improvement that has been achieved. – One project should ensure the data collection approach only captures the members as defined in the study question. – One project needs to take study limitations into consideration during analysis.	
Protocol 2: Validation of Performance Measures	Strengths – No strengths. Progress – Influenza vaccination rates declined for both programs from MY 2019. – Pneumococcal vaccination rates improved for the FC program from MY 2019 to MY 2020. Recommendations – Continue the practices developed, including educating members on the importance of the influenza and pneumococcal vaccinations, to increase influenza vaccination rates in both programs.	
Protocol 3: Compliance with Managed Care Regulations, Quality Compliance Review	Strengths – The organization demonstrated the ability to ensure availability of accessible, culturally competent services through a network of qualified service providers. – The organization demonstrated the ability to ensure coordination and continuity of member care. Progress – The organization was newly formed in January 2020. The evaluation conducted in FY20-21 is the first evaluation conducted for the MCO. Recommendations – Update written guidance to include the specific reasons providers may advise or advocate for members, and educate staff and providers about this requirement. – Ensure current and future restrictive measures tracking systems are monitored and that applications are sent to DHS in a timely manner. – Implement a member rights and advance directives policy that includes all requirements outlined in the DHS-MCO contract. – Ensure advance directives education is provided to the community.	

My Choice Wisconsin, Inc.		
Programs Operated	**FY20-21 Enrollment by Program**	**GSRs**
FC, FCP	FC: 15,801 FCP: 1,719	1, 2, 3, 5, 6, 8, 11, 12, 14
Findings		
	– Ensure written information regarding advance directives reflect changes in state law as soon as possible, but no later than 90 calendar days after the effective date of the change. – Ensure written guidance of advance directives is not construed to prohibit the application of any Wisconsin law which allows for an objection on the basis of conscience for any health care provider or any agent of such provider who, as a matter of conscience, cannot implement an advance directive. – Implement processes to ensure a network of appropriate long-term care service providers is monitored and maintained. – Develop clear documentation and implement a procedure for verifying certification/licensure of all applicable ongoing providers to ensure compliance with DHS-MCO contract requirements. – Update internal procedures with additional debarment guidance, specifically related to debarment verification of new providers, providers with business names and owner names, and the monitoring process for ongoing providers. – Update internal procedures to clarify the process for when a provider is affiliated with more than one name, to ensure consistency with how the providers are identified in the directory. – Include written guidance that appeals and grievances must be accepted from members related to a lack of access to culturally appropriate care. – Review policies concerning network adequacy to reflect current and applicable contract citations. – Develop and implement a Memorandum of Understanding template and written guidance to avoid variation and to ensure consistency in use throughout the organization. – Include “Clinical Practice Guideline” as a document type in the search feature of the provider resource library page of the website, to further aid providers in accessing the guidelines. – Merge legacy MCO’s disenrollment policies and procedures into one single, comprehensive policy and procedure for the organization. – Add guidance to policies and procedures to ensure staff inform members of the option to voluntarily disenroll from the program if the organization is not able to accommodate a member’s choice of provider.	
Protocol 9: Conducting Focused Studies of Health Care Quality *Sample Sizes* *FC: 267* *FCP: 235*	Strengths – Comprehensive assessment practices were strengths for the Family Care and Family Care Partnership programs. – The Family Care program had strong practices in place for member centered planning. – The Family Care program demonstrated strengths related to care coordination. Progress – Completing and reviewing comprehensive member-centered plans with the member for the Family Care program; – Timely follow-up with members to ensure effectiveness of services for the Family Care program; and – Ensuring member rights are followed for the Family Care program.	

My Choice Wisconsin, Inc.		
Programs Operated	**FY20-21 Enrollment by Program**	**GSRs**
FC, FCP	FC: 15,801 FCP: 1,719	1, 2, 3, 5, 6, 8, 11, 12, 14
Findings		
	Recommendations – Focus efforts on improving the comprehensiveness of assessments in the Family Care and Family Care Partnership programs. – Focus efforts on improving the comprehensiveness of member-centered plans in the Family Care and Family Care Partnership program. – Continue efforts to ensure timely follow-up for effectiveness of services, especially in the Family Care Partnership program. – Continue efforts to improve member contacts by the interdisciplinary team in the Family Care Partnership program.	
Appendix V: Information Systems Capabilities Assessment	Not Applicable. The MCO was formed in 2020 and has not been reviewed.	

PROTOCOL 1[2]: VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

The review of MCOs' Performance Improvement Projects (PIPs) is a mandatory EQR activity identified in the Code of Federal Regulations (CFR) at 42 CFR 438.358. CMS issued the EQR Protocols in 2020 and *Validation of Performance Improvement Projects* is now Protocol One. To evaluate the standard elements of a PIP, the MetaStar team used the methodology described in the CMS guide, EQR Protocol 3: *Validating Performance Improvement Projects (PIPs), A Mandatory Protocol for External Quality Reviews (EQR), Version 2.0,* as this was the Protocol in effect during the project timeframe. See Appendix 2 for more information about the PIP review methodology.

DHS contractually requires organizations operating Family Care (FC), Family Care Partnership (FCP), and/or Program of All-Inclusive Care for the Elderly (PACE) to annually make active progress on at least one clinical and one non-clinical PIP relevant to long-term care. MCOs operating more than one of these programs may fulfill this PIP requirement by conducting one or both of the required PIPs with members from any or all programs. If the MCO chooses to combine programs in a single PIP, the baseline and outcome data must be separated by program enrollment.

The study methodology is assessed through the following steps:

- Review the selected study topic(s);
- Review the study question(s);
- Review the selected study indicators;
- Review the identified study population;
- Review sampling methods (if sampling used);
- Review the data collection procedures;
- Assess the MCO's improvement strategies;
- Review the data analysis and interpretation of study results;
- Assess the likelihood that reported improvement is "real" or true improvement, and not due to chance; and
- Assess the sustainability of the documented improvement.

MCOs must seek DHS approval prior to beginning each project. For projects conducted during 2020, organizations submitted proposals to DHS in January 2020. DHS directed MCOs to submit

[2] CMS issued the EQR Protocols in 2020 and the *Validation of Performance Improvement Projects* is now Protocol 1. To evaluate the standard elements of a PIP, the MetaStar team used the methodology described in the CMS guide, EQR Protocol 3: *Validating Performance Improvement Projects (PIPs), A Mandatory Protocol for External Quality Reviews (EQR), Version 2.0,* as this was the Protocol in effect during the project timeframe.

final reports by December 30, 2020. MetaStar validated at least one clinical and at least one non-clinical PIP for each organization, for a total of 11 PIPs.

Project Outcomes and Interventions

The table below is organized by topic and lists each project; the indicator, measure, or aim; the project outcomes from baseline to final result; and the interventions selected. An overall validation result is also included to indicate the level of confidence in the organizations' reported results. See Appendix 2 for additional information about the methodology for this rating. Each project listed below applies to adults only.

MCO	Indicator, Measure, or Aim	Outcomes		Interventions	Validation Result
		Baseline	Final Result		
Advance Care Planning					
CCI (FC, FCP, PACE)	Increase the rate of invalid advance directives in member records. (Decrease the rate of invalid advanced directives in the record).	0.0% (2019)	Not Calculated (2020)	Continued the automatic referral of members to Advance Care Planning (ACP) Specialists if they did not have an advance directive. Created an ACP Expert email address for staff to submit advance directives to be validated. Modified internal documentation forms and trained staff on the new processes for documenting information regarding advance directives. Developed a standardized location and process for scanning advance directives into the member's record.	Partially Met
	Increase the rate of newly enrolled members who had an invalid advance directive that resulted in a documented and scanned valid advance directive.	0.0% (2019)	Not Calculated (2020)		
*i*Care (FCP)	Increase the rate of members who receive an Advance Directives Assessment.	0.0% (1/1/19 – 1/1/20)	99.13* (1/1/20 – 11/1/20)	Developed and implemented an *Advance Directive Assessment* in the	Partially Met

MCO	Indicator, Measure, or Aim	Outcomes		Interventions	Validation Result
		Baseline	Final Result		
	Decrease the rate of members reporting they do not have or do not know if they have an advance directive.	68% (1/1/19 – 1/1/20)	55.9* (1/1/20 – 11/1/20)	electronic health record.	
Care Management Practices					
LCI (FC)	Improve the Quality Focused Audit rate by improving the consistency of activity of daily living data between the long-term care functional screen and the member record.	28.6% (5/27/20)	50.3%* (5/1/20 – 10/31/20)	Trained IDTs on the connection between the long-term care functional screen (LTCFS) and the member record (the assessment and Member Centered Plan, including common discrepancies between the LTCFS and member record, the project timeline, and documentation requirements. Implemented a process for the functional eligibility specialist to hold a discussion with IDTs regarding a member's assessed level of need and/or durable medical equipment. Identified and provided additional follow-up training to staff as needed.	Partially Met
MCW (FC, FCP)	Increase the member record consistency score for FC members in Geographic Service Region (GSR) 1.	0% (2019)	72.97% (2020)	Provided *Consistency Training* to staff. Conducted *Record Consistency* audits.	Met
	Increase the member record consistency score for FCP members in GSR 12.	0% (2019)	95.35% (2020)		
MCW (FCP)	Increase the number of members with diabetes	56.1% (2019)	58.3%* (2020)	Developed and provided diabetic	Partially Met

MCO	Indicator, Measure, or Aim	Outcomes		Interventions	Validation Result
		Baseline	Final Result		
	who fill at least two angiotensin converting enzyme inhibitor/ angiotensin receptor blocker prescriptions.			complications training for staff. Completed chart audits for diabetic members. Conducted diabetic complications retraining for staff as needed.	
	Increase the number of members with diabetes who fill at least two statin prescriptions.	71.9% (2019)	72.7%* (2020)		
Dementia Care					
LCI (FC)	Maintain the rate of dementia screening for defined target group #1.	90.0% (5/1/19 – 8/1/19)	60.8% (1/1/20 – 9/30/20)	Trained IDTs on dementia prevalence, the benefits of memory screening, the evidence-based dementia screening tools, talking points for gaining member buy in, the project timeline, and documentation requirements. Discussed the benefits of dementia screening with members. Requested member's permission to administer the dementia screens. Identified and provided additional individual or follow-up training to staff, as needed.	Met
	Maintain the rate of dementia screening for defined target group #2.	80.0% (7/1/19 – 9/30/19)	46.8% (1/1/20 – 9/30/20)		
	Increase the rate of dementia screening for defined target group #3.	40.0% (1/1/20 – 4/30/20)	84.6% (5/1/20 – 9/30/20)		
	Increase the rate of dementia screening for defined target group #4.	29.6% (1/1/20 – 4/30/20)	40.4% (5/1/20 – 9/30/20)		
Health Equity					
Inclusa (FC)	Improve the rate of members with a fully completed data collection document.	0.0% (1/22/20)	39.18%* (11/30/20)	Developed a demographic questionnaire to capture comprehensive member information. Standardized the introduction of the	Partially Met

MCO	Indicator, Measure, or Aim	Outcomes		Interventions	Validation Result
		Baseline	Final Result		
				demographic questionnaire utilizing a script. Completed the demographic questionnaire with members during the annual or change in condition LTCFS.	
Member Safety					
Inclusa (FC)	Improve the rate of members able to describe two safety interventions via teach back.	0.0% (10/1/20)	100.0% (11/30/20)	Developed a *Comprehensive Safety Toolkit*. Conducted outreach by telephone. Educated members on the importance of safety in the home.	Met
Opioid Risk Reduction					
CCI (FC, FCP, PACE)	Increase the rate of members with an opioid antagonist available in their place of residence, if they have a Morphine Equivalent Dosing daily intake criteria that places them at risk of overdosing.	0.0% (2019)	20.8%* (2020)	Developed an *Opioid Education and Wellness Toolkit*. Deployed Opioid Education and Wellness Trainings. Implemented a care management newsletter series regarding the opioid epidemic and the benefits of Narcan/Naloxone. Created an assessment to be completed with all members who may be at risk of overdosing on opioids.	Partially Met
*i*Care (FCP)	Increase the rate of high-risk members who have access to Naloxone.	25% (1/1/19 – 12/31/19)	52%* (1/1/20 – 11/30/20)	Developed and implemented an *Opioid Risk*	Partially Met

MCO	Indicator, Measure, or Aim	Outcomes		Interventions	Validation Result
		Baseline	Final Result		
	Increase the rate of high-risk members who received targeted education on opioid risk reduction methods and proper use of Naloxone.	0.0% (2019)	97% (2020)	*Reduction Assessment*.	
Reduce Readmission Rate					
MCW (FC)	Increase the percentage of timely post-discharge assessment contacts completed with MCFC legacy members age 65 and older.	64.7% (2019)	84.1%* (2020)	Revised the post-discharge telephonic assessment and auditing tools. Revised the hospitalization and post-discharge care coordination policy. Developed a physician letter template to enhance communication. Conducted staff training. Completed record audits.	Partially Met
	Increase the percentage of all post-discharge telephonic assessments completed with a scheduled post-discharge follow-up appointment within 30 days of hospital discharge.	56.8% (2019)	68.7%* (2020)		

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

Aggregate Results for Performance Improvement Projects

The following table lists each standard that was evaluated for each MCO, 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 19-20 project results are provided for comparison.

Please note the FY 20-21 DHS-MCO contract contained changes related to the number of PIPs each organization was required to conduct and subsequently submit for validation. Previously, each MCO was only required to conduct and submit at least one PIP per MCO; thus, only six projects were validated in FY 19-20. The DHS-MCO contract specified that MCOs were required to make active progress on at least one clinical and one non-clinical PIP in FY 20-21. One organization elected to submit three projects in FY 20-21; therefore, 11 projects were validated this fiscal year and are reflected in the table below.

FY 20-21 Performance Improvement Project Validation Results

Standards and Elements		FY 20-21 (n=11)	FY 19-20 (n=6)
Study Topic(s)			
1	The topic was selected through MCO data collection and analysis of important aspects of member needs, care, or services.	11/11 100.0%	6/6 100.0%
Study Question(s)			
2	The problem to be studied was stated as a clear, simple, answerable question(s) with a numerical goal and target date.	11/11 100.0%	5/6 83.3%
Study Indicator(s)			
3	The study used objective, clearly and unambiguously defined, measurable indicators and included defined numerators and denominators.	10/11 90.9%	6/6 100.0%
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.	10/11 90.9%	6/6 100.0%
Study Population			
5	The project/study clearly defined the relevant population (all members to whom the study question and indicators apply).	11/11 100.0%	6/6 100.0%
6	If the entire population was used, data collection approach captured all members to whom the study question applied.	6/9 66.7%	4/4 100.0%
Sampling Methods			
7	Valid sampling techniques were used.	2/2 100%	2/2 100.0%
8	The sample contained a sufficient number of members.	2/2 100%	2/2 100.0%
Data Collection Procedures			
9	The project/study clearly defined the data to be collected and the source of that data.	10/11 90.9%	6/6 100.0%
10	Staff are qualified and trained to collect data.	11/11 100.0%	6/6 100.0%
11	The instruments for data collection provided for consistent, accurate data collection over the time periods studied.	10/11 90.9%	6/6 100.0%
12	The study design prospectively specified a data analysis plan.	8/11 72.7%	4/6 66.7%
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.	11/11 100.0%	6/6 100.0%
14	A continuous cycle of improvement was utilized to measure and analyze performance, and to develop and implement system-wide improvements.	10/11 90.9%	6/6 100.0%
15	Interventions were culturally and linguistically appropriate.	7/8 87.5%	3/3 100.0%
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.	8/11 72.7%	4/6 66.7%
17	Numerical results and findings were presented accurately and clearly.	9/11 81.8%	6/6 100.0%

Standards and Elements		FY 20-21 (n=11)	FY 19-20 (n=6)
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.	9/11 81.8%	6/6 100.0%
"Real" Improvement			
19	The same methodology as the baseline measurement was used, when measurement was repeated.	4/11 36.4%	5/6 83.3%
20	There was a documented, quantitative improvement in processes or outcomes of care.	2/11 18.2%	2/6 33.3%
21	The reported improvement appeared to be the result of the planned quality improvement intervention.	2/4 50.0%	1/5 20.0%
Sustained Improvement			
22	Sustained improvement was demonstrated through repeated measurements over comparable time periods.	0/0 0.0%	0/0 0.0%

Analysis

Eleven PIPs were submitted and validated. The DHS-MCO contract specifies MCOs are to design PIPs to achieve significant improvement in clinical care and non-clinical care areas that are expected to have a favorable effect on member outcomes or satisfaction. Since 2015, DHS has encouraged MCOs to develop PIP proposals in alignment with state priorities. One of the state priorities identified in the Wisconsin Department of Health Services *2021 Medicaid Managed Care Quality Strategy* is to keep members healthy, safe, and supported in the community for as long as possible. The FY 20-21 projects focused on improving key aspects of care for members, including advance care planning, care management practices, dementia care, health equity, member safety, opioid risk reduction, and reduction of readmission rates.

Six standards continued to be met at 100 percent and improvement was noted in two additional standards from FY 19-20 to FY 20-21. The percent of projects stating clear, simple, and answerable study questions with numerical goals and target dates improved from FY 19-20; all projects in FY 20-21 met this standard. In addition, the percentage of projects where improvement was the result of the planned quality improvement intervention improved from the prior review.

Four of the PIP topics were continued from FY 19-20. Three of the four projects did not demonstrate quantitative improvement in any of the study questions, and one project demonstrated improvement in two of the four study questions. However, none of the projects demonstrated improvement that was sustained with repeat measures.

Documented, quantitative improvement in processes or outcomes of care was only evident in 18.2 percent of the validated projects. Several projects included more than one study question or aim. One MCO concluded that improvement was not demonstrated for one or more of the aims, and one MCO failed to document the repeat measurement rates for two of the study questions.

While an MCO may have reported an improvement in the measured rate for the project, the validation process did not always confirm the MCO's conclusion. In 63.6 percent of the projects, initial and repeat measures were not comparable or there was a difference in how the baseline and repeat measures were calculated.

Several MCOs identified the Coronavirus Disease-2019 (COVID-19) public health emergency as a barrier to implementing planned interventions, or the ability to fully analyze data. The organizations adjusted face-to-face interventions with members to a virtual platform, when members had the technology available to them. However, significant barriers were noted related to difficult to contact members, and the MCOs reported that some interventions were not possible via telephonic or video conferencing.

The overall validation findings provide an indication of the reliability and validity of the projects' results. FY 19-20 project results are provided for comparison.

FY 20-21 Performance Improvement Project Overall Validity Results

Validation Finding	FY 20-21 (n=11)	FY 19-20 (n=6)
Met	3 (27.3%)	4 (66.7%)
Partially Met	8 (72.7%)	2 (33.3%)
Not Met	0 (0.0%)	0 (0.0%)

Twenty-seven percent of the projects in FY 20-21 received validation findings of fully *met*, as compared to almost 67 percent of projects in FY 19-20.

Eight projects received a partially met validation finding in FY 20-21. In seven of these projects the MCOs failed to recognize that the initial and repeat measures were based on different methodologies, which was evaluated as a barrier to the validity of the projects.

As noted earlier, MCOs continued four PIP topics from FY 19-20. The overall validity finding for one of the continuing projects changed from met in FY 19-20 to partially met in FY 20-21. The MCO noted a limitation related to collecting accurate data for year two of the project; the true final rates for both study questions were unknown and not calculated.

CONCLUSIONS

A summary of strengths, progress, and recommendations is noted in the *Executive Summary* and *Introduction and Overview* sections above.

Protocol 2: Validation of Performance Measures

Validation of performance measures is a mandatory review activity identified in the Code of Federal Regulations (CFR), 42 CFR 438.358 and conducted according to federal protocol standards, *CMS External Quality Review (EQR) Protocols, Protocol 2: Validation of Performance Measure*. The review assesses the accuracy of performance measures reported by the MCO, and determines the extent to which performance measures calculated by the MCO follow state specifications and reporting requirements. Assessment of an MCO's information system is required as part of performance measures validation and other mandatory review activities. To meet this requirement, each MCO receives an Information Systems Capabilities Assessment (ISCA) once every three years as directed by DHS. The ISCAs are conducted and reported separately.

The MCO quality indicators for MY 2020, which are set forth in Addendum III of the 2020 DHS-MCO contract, provide standardized information about preventive health services and continuity of care. As directed by DHS, MetaStar validated the completeness and accuracy of MCOs' influenza and pneumococcal vaccination data for MY 2020. The technical definitions provided by DHS for the MY influenza and pneumococcal vaccination quality indicators include a definition of the MY. The technical definitions can be found in Attachments 1 and 2. The review methodology MetaStar used to validate these performance measures are in Appendix 2.

Acute and primary care services, including vaccinations, are included in the FCP and PACE benefit package but are not among the services covered in the FC benefit package. However, in all three programs, coordination of long-term care with preventive health services is required. The role of care managers includes assistance with coordination of members' health services, such as vaccinations, to promote preventive care and wellness to ensure members stay as healthy as possible.

Vaccination Rates by Program and MCO

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

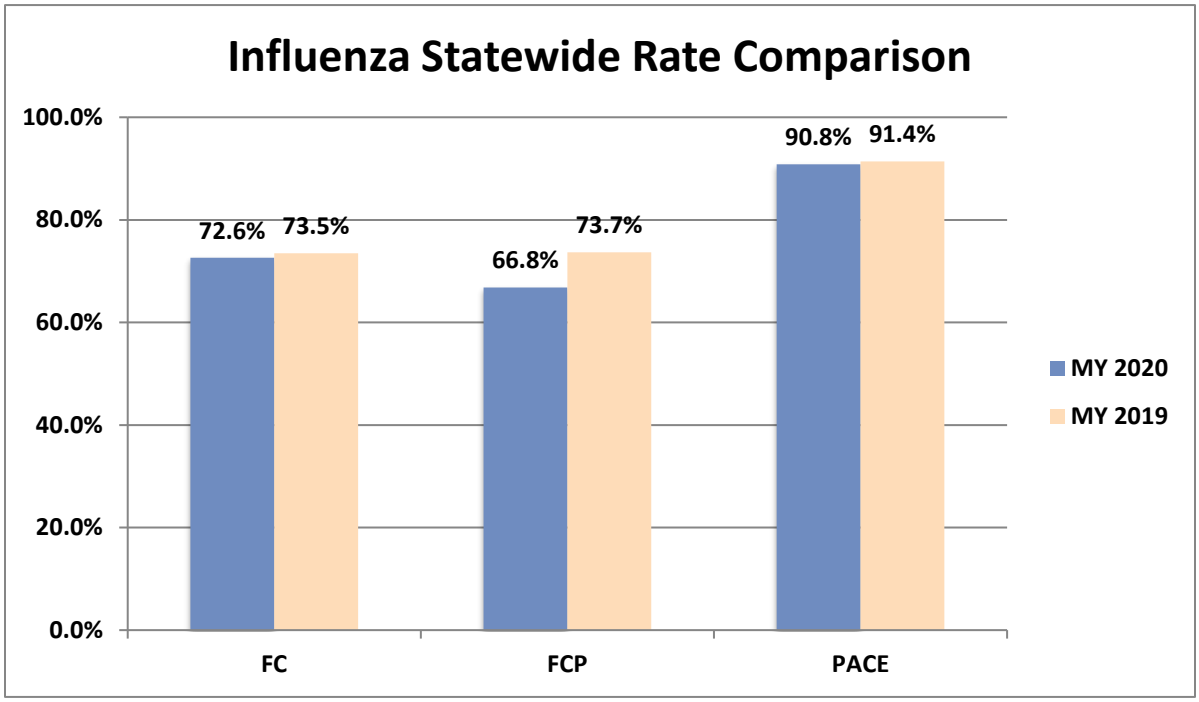
Influenza Vaccination Rates

The following table shows information about the influenza vaccination rates, by program, for MY 2020 and compares the 2020 rates to vaccination rates in MY 2019.

Statewide Influenza Vaccination Rates by Program				
	MY 2020			MY 2019
Program	Eligible Members	Number Vaccinated	Vaccination Rate	Vaccination Rate
Family Care	43,840	31,840	72.6%	73.5%

Statewide Influenza Vaccination Rates by Program				
Family Care Partnership	2,911	1,944	66.8%	73.7%
PACE	445	404	90.8%	91.4%

Influenza vaccination statewide rates, by program, for MY 2020 and MY 2019 are shown in the following graph.



The table below shows influenza vaccination rates by program and MCO for MY 2020 and MY 2019.

Influenza Vaccination Rates by Program and Measurement Year				
Program/MCO	MY 2020			MY 2019
	Eligible Members	Number Vaccinated	Vaccination Rate	Vaccination Rate
Family Care				
CCI	10,159	7,216	71.0%	73.8%
Inclusa	13,325	9,749	73.2%	74.0%
LCI	6,631	5,003	75.4%	75.4%
MCW	13,725	9,872	71.9%	72.2%
Family Care Partnership				
CCI	593	435	73.8%	80.6%
*i*Care	883	478	54.1%	62.5%
MCW	1,435	1,031	71.8%	77.4%

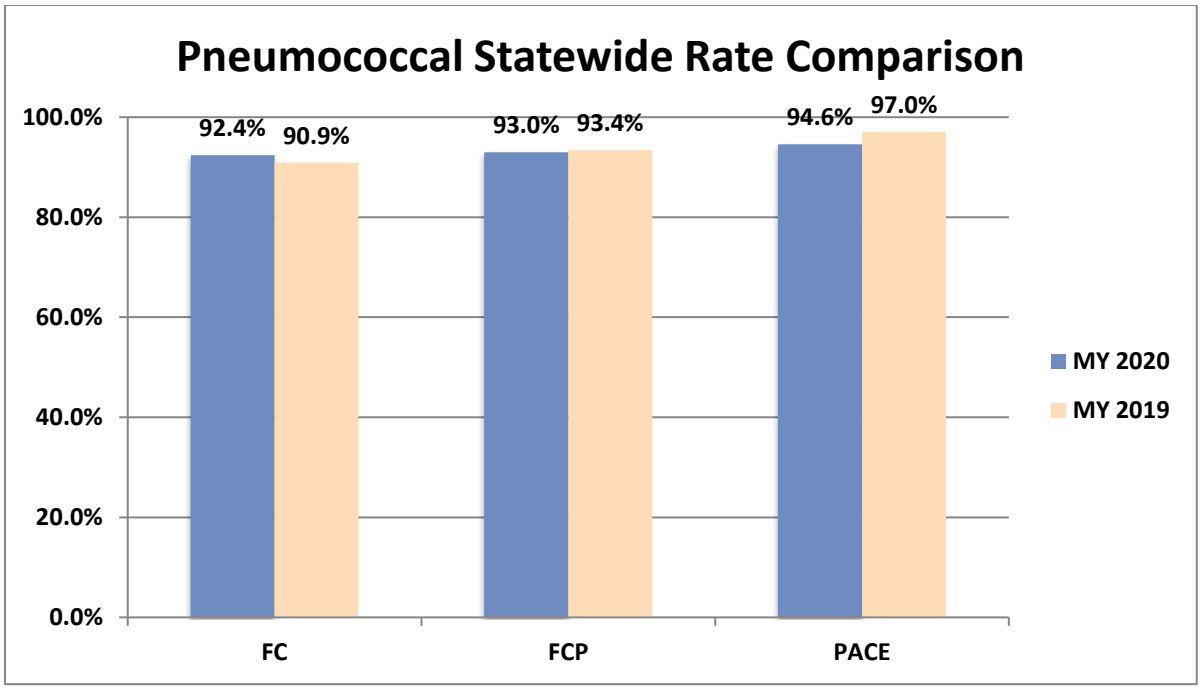
Influenza Vaccination Rates by Program and Measurement Year				
PACE				
CCI	445	404	90.5%	91.4%

Pneumococcal Vaccination Rates

The table below shows information about the pneumococcal vaccination rates, by program, for MY 2020 and compares the 2020 rates to vaccination rates in MY 2019.

Statewide Pneumococcal Vaccination Rates by Program				
	MY 2020			MY 2019
Program	**Eligible Members**	**Number Vaccinated**	**Vaccination Rate**	**Vaccination Rate**
Family Care	19,720	18,222	92.4%	90.9%
Family Care Partnership	1,532	1,425	93.0%	93.4%
PACE	428	405	94.6%	97.0%

Pneumococcal vaccination statewide rates, by program, for MY 2020 and MY 2019 are shown in the following graph.



The following table shows pneumococcal vaccination rates by program and MCO for MY 2020 and MY 2019.

Pneumococcal Vaccination Rates by Program and Measurement Year				
Program/MCO	MY 2020			MY 2019
	Eligible Members	Number Vaccinated	Vaccination Rate	Vaccination Rate
Family Care				
CCI	4,012	3,879	96.7%	89.7%
Inclusa	5,807	5,218	89.9%	90.8%
LCI	2,904	2,695	92.8%	91.4%
MCW	6,997	6,430	91.9%	91.3%
Family Care Partnership				
CCI	230	206	89.6%	91.3%
*i*Care	372	336	90.3%	88.3%
MCW	930	883	94.9%	95.8%
PACE				
CCI	428	405	94.6%	97.0%

Results of Performance Measures Validation

Technical Definition Compliance

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

Comparison of MCO and DHS Denominators

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

For all MCOs and quality indicators, more than 99.1 percent of the total number of unique members included in the MCOs' and DHS' denominator files were common to both data sets. All MCOs were within the five percentage point threshold established by DHS in their initial submissions. This was the second consecutive year that all MCOs achieved this threshold on the first submission in the last six reviews.

Vaccination Record Validation

To validate the MCOs' influenza and pneumococcal vaccination data, MetaStar requested 30 records of randomly selected members per quality indicator for each program the MCO operated during MY 2020. Whenever possible, the samples included 25 members reported to have received a vaccination and five members reported to have a contraindication to the vaccination.

Three 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 240 member vaccination records for each quality indicator for MY 2020, and 270 member vaccination records for each quality indicator for MY 2019. The overall findings for the influenza vaccinations for both years, and the pneumococcal vaccinations for MY 2019 were not biased, meaning the rates can be accurately reported. The pneumococcal vaccinations for MY 2020 were biased, meaning they cannot be accurately reported.

Vaccination Record Validation Aggregate Results

MY 2020 Influenza and Pneumococcal Vaccination Record Validation				
Quality Indicator	**Total Records Reviewed**	**Number Valid**	**Percentage Valid**	**T-Test Result**
Influenza Vaccinations	240	237	98.7%	Unbiased
Pneumococcal Vaccinations	240	237	98.7%	Biased

MY 2019 Influenza and Pneumococcal Vaccination Record Validation				
Quality Indicator	**Total Records Reviewed**	**Number Valid**	**Percentage Valid**	**T-Test Result**
Influenza Vaccinations	270	266	98.5%	Unbiased
Pneumococcal Vaccinations	270	269	99.6%	Unbiased

Vaccination Record Validation Individual MCO Results

The following tables provide information about the validation findings for each MCO in MY 2020.

Results for Influenza Vaccination

MY 2020 Influenza Vaccination Record Validation by Program and MCO				
MCO	**Total Records Reviewed**	**Number Valid**	**Percentage Valid**	**T-Test Result**
Family Care				
CCI	30	30	100.0%	Unbiased
Inclusa	30	29	96.7%	Unbiased
LCI	30	30	100.0%	Unbiased
MCW	30	29	96.7%	Unbiased
Family Care Partnership				
CCI	30	29	96.7%	Unbiased
*i*Care	30	30	100.0%	Unbiased
MCW	30	30	100.0%	Unbiased
PACE				
CCI	30	30	100.0%	Unbiased

Results for Pneumococcal Vaccination

MY 2020 Pneumococcal Vaccination Record Validation by Program and MCO				
MCO	**Total Records Reviewed**	**Number Valid**	**Percentage Valid**	**T-Test Result**
Family Care				
CCI	30	28	93.3%	Biased
Inclusa	30	30	100.0%	Unbiased
LCI	30	30	100.0%	Unbiased
MCW	30	30	100.0%	Unbiased
Family Care Partnership				
CCI	30	30	100.0%	Unbiased
*i*Care	30	29	96.7%	Unbiased
MCW	30	30	100.0%	Unbiased
PACE				
CCI	30	30	100.0%	Unbiased

Analysis

Accurate and reliable performance measures inform stakeholders about access and quality of care provided by MCOs. MetaStar validated two performance measures; influenza and pneumococcal vaccination rates. Influenza and pneumococcal vaccines prevent the unnecessary transmission of certain viral and bacterial infections to those at higher risk of complications from the diseases.

Consistent with the past several years, DHS provided MCOs with current technical specifications and data submission templates for each immunization. Each MCO submitted policies and procedures detailing guidance for staff related to assessing immunization status, offering the vaccines, providing education about preventive health services, and documenting vaccination data into each respective electronic care management system.

Conclusions

A summary of strengths, progress, and recommendations is noted in the *Executive Summary* and *Introduction and Overview* sections above.

PROTOCOL 3: COMPLIANCE WITH STANDARDS – QUALITY COMPLIANCE REVIEW

Compliance with Standards - Quality compliance review (QCR) is a mandatory review activity identified in the Code of Federal Regulations (CFR), 42 CFR 438.358 and conducted according to federal protocol standards, *CMS External Quality Review (EQR) Protocols, Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations*. The review assesses the strengths and weaknesses of the MCO related to quality, timeliness, and access to services, including health care and LTSS.

DHS has expanded the compliance review beyond the requirements specified in 42 CFR 438, and includes other state statutory, regulatory, and contractual requirements related to the following areas:

- Availability and use of HCBS as alternatives to institutional care, so individuals can receive the services they need in the most integrated setting appropriate;
- Credentialing or other selection processes for LTSS providers, including those required where the enrollee can choose their caregiver (such as verification of completion of caregiver background checks); and
- Person-centered assessment, person-centered care planning, service planning and authorization, service coordination and care management for LTSS. This includes authorization/utilization management for LTSS and any beneficiary rights or protections related to care planning and service planning such as conflict-free case management, self-direction of services, and appeal rights related to person-centered planning.

The QCR was revised at the start of this fiscal year to align with the Centers for Medicare & Medicaid Services External Quality Review Protocol, which defines the review activities for Medicaid Managed Care Programs. The revision to the review changed the scoring process, making the numeric scores from prior review not comparable to the current review.

The review is divided into three groups of standards:

Managed Care Organization (MCO) Standards which include provider network, care management, and enrollee rights:

- Enrollee rights and protections 42 CFR 438.100
- Availability of services 42 CFR 438.206
- Assurances of adequate capacity and services 42 CFR 438.207
- Coordination and continuity of care 42 CFR 438.208
- Coverage and authorization of services 42 CFR 438.210
- Provider selection 42 CFR 438.214
- Confidentiality 42 CFR 438.224

- Subcontractual relationships and delegation 42 CFR 438.230
- Practice guidelines 42 CFR 438.236
- Health information systems 42 CFR 438.242

Quality Assessment and Performance Improvement (QAPI):

- Quality assessment and performance improvement program 42 CFR 438.330

Grievance Systems:

- Grievance and appeal systems 42 CFR 438.228

In this fiscal year, the MCO Standards were reviewed. Next fiscal year will include the review of QAPI and Grievance Systems. DHS received approval from CMS in April of 2020 to conduct the review in this manner to align with the revised review process in the state and as a flexibility for the Public Health Emergency related to the Coronavirus Pandemic.

Overall QCR Results by MCO

Compliance is expressed in terms of a percentage score and star rating that correlates with the DHS Score Card, identified in the table below. See Appendix 2 for more information about the scoring methodology.

Scoring Legend		
Percentage Met	**Stars**	**Rating**
90.0% - 100.0% = 5 Stars	★★★★★	EXCELLENT
80.0% - 89.9% = 4 Stars	★★★★	VERY GOOD
70.0% - 79.9% = 3 Stars	★★★	GOOD
60.0% - 69.9% = 2 Stars	★★	FAIR
< 60.0% = 1 Star	★	POOR

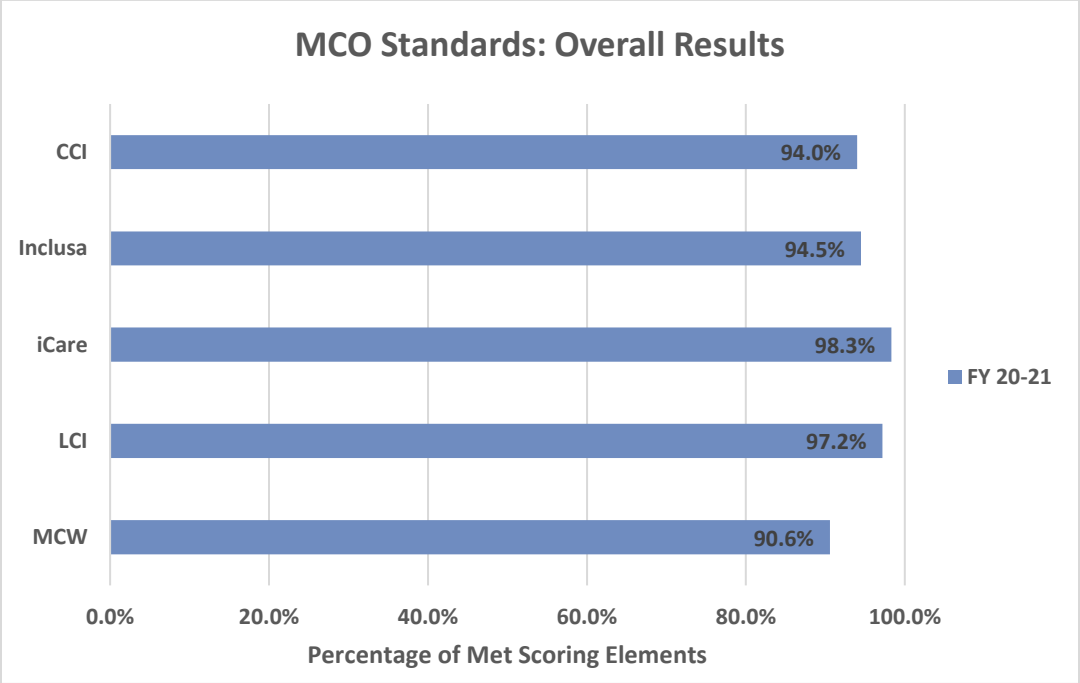
For all MCOs, the statewide overall compliance score is 94.9 percent, and a star rating of Excellent. The table below indicates the overall level of compliance with the MCO Standards in this fiscal year.

MCO Standards: Provider Network, Care Management, and Enrollee Rights				
Standard	**Scoring Elements**	**Percentage**	**Stars**	**Rating**
M1	34/34	100.0%	★★★★★	EXCELLENT
M2	35/35	100.0%	★★★★★	EXCELLENT
M3	20/20	100.0%	★★★★★	EXCELLENT
M4	28/30	100.0%	★★★★★	EXCELLENT
M5	58/60	98.7%	★★★★★	EXCELLENT
M6	42/50	84.0%	★★★★	VERY GOOD
M7	20/20	100.0%	★★★★★	EXCELLENT
M8	50/50	100.0%	★★★★★	EXCELLENT

MCO Standards: Provider Network, Care Management, and Enrollee Rights				
Standard	**Scoring Elements**	**Percentage**	**Stars**	**Rating**
M9	58/60	96.7%	★★★★★	EXCELLENT
M10	18/20	90.0%	★★★★★	EXCELLENT
M11	50/55	90.9%	★★★★★	EXCELLENT
M12	10/10	100.0%	★★★★★	EXCELLENT
M13	60/65	92.3%	★★★★★	EXCELLENT
M14	39/40	97.5%	★★★★★	EXCELLENT
M15	18/20	90.0%	★★★★★	EXCELLENT
M16*	NA	NA	NA	NA
Overall	**540/569**	**94.9%**	**★★★★★**	**EXCELLENT**

* M16 is evaluated as part of the MCO's ISCA, conducted once every three years. The ISCA occurs separate from the QCR.

The graph below illustrates each MCO's overall compliance with these standards.



The definition of a scoring element rated as compliant can be found in Appendix 2 which includes the full implementation of written policies and procedures, education of relevant staff, and sufficient monitoring. MetaStar uses a retrospective review period of 12 months prior to each MCO's QCR to evaluate compliance. When documents were finalized and/or education occurred after the review period, the policies or procedures were considered to be not fully implemented, or not implemented at the time of the review. See Appendix 2 for more information about the scoring methodology.

Results for QCR Focus Area-MCO Standards

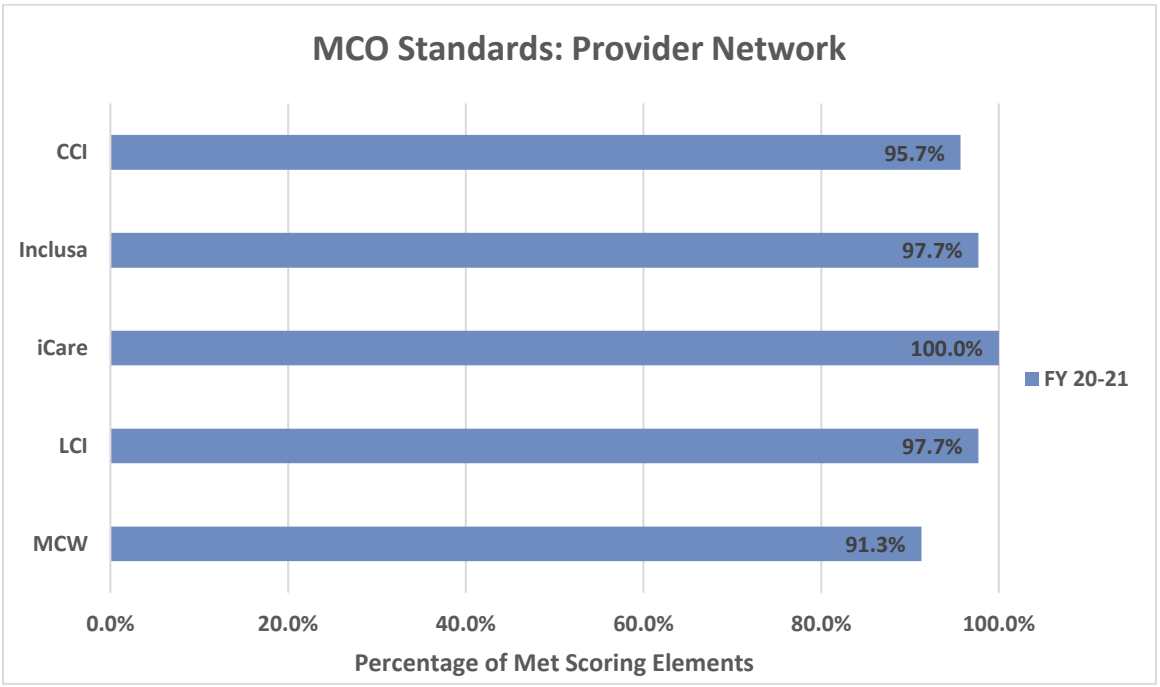
Each section that follows provides a brief explanation of a QCR focus area, including rationale for any areas the MCO is not fully compliant. Additionally, Appendix 3 includes results for each standard by MCO.

Observation and Analysis: MCO Standards, Provider Network

MCOs 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. Six standards address requirements related to availability of services, provider selection, sub-contractual/provider relationships, and delegation. The table below indicates the MCOs' compliance with these standards.

MCO Standards: Provider Network				
Standard	**Scoring Elements**	**Percentage**	**Stars**	**Rating**
M1	34/34	100.0%	★★★★★	EXCELLENT
M2	35/35	100.0%	★★★★★	EXCELLENT
M3	20/20	100.0%	★★★★★	EXCELLENT
M4	28/30	93.3%	★★★★★	EXCELLENT
M13	60/65	92.3%	★★★★★	EXCELLENT
M14	39/40	97.5%	★★★★★	EXCELLENT
Overall	**216/224**	**96.4%**	**★★★★★**	**EXCELLENT**

The graph below illustrates the MCOs' overall compliance with this focus area.



M1 Availability of services - 42 CFR 438.206

The MCOs must maintain and monitor a network of appropriate providers, sufficient to provide adequate access to all services under the contract. The information is provided to members through a provider directory maintained by the MCO. The standard, M1, contains five scoring elements for each FC only MCO and eight scoring elements for each MCO that operate FCP and PACE, for a total of 34 scoring elements. The MCOs satisfied requirements for 34 out of 34 scoring elements, for a score of 100 percent, and a star rating of Excellent.

All MCOs demonstrated robust provider networks and systems in place to ensure adequate access to services as well as electronic provider directories on the organization's websites. Processes for members to access services outside the provider network were confirmed for each MCO. All MCOs satisfied requirements for this standard.

M2 Timely access to services - 42 CFR 438.206(c)(1)

To ensure timely access to care and services, the MCOs require its providers to meet state standards. The MCOs must monitor compliance, and take corrective action if needed. The standard, M2, contains seven scoring elements per MCO reviewed, for a total of 35 scoring elements. The MCOs satisfied requirements for 35 out of 35 scoring elements, for a score of 100 percent, and a star rating of Excellent.

All MCOs had mechanisms in place to ensure timely access to services, such as after-hours lines, regular reporting, and monitoring. Examples of monitoring included member contacts, data collection through an incident management system, and internal meetings. All MCOs satisfied requirements for this standard.

M3 Cultural considerations in services - 42 CFR 438.206(c)(2)

The MCOs must participate in the state's efforts to promote the delivery of services in a culturally competent manner to all members. The standard, M3, contains four scoring elements per MCO reviewed, for a total of 20 scoring elements. The MCOs satisfied requirements for 20 out of 20 scoring elements per MCO reviewed, for a score of 100 percent, and a star rating of Excellent.

All MCOs demonstrated efforts to ensure cultural diversity in a variety of ways, including diversity trainings for organizational staff, translation of documents into different languages, coordination of interpreter services for members, incorporation of cultural preferences into assessments, utilizing technology to connect members with their culture, educational materials for providers, and community outreach. Each MCO satisfied requirements for this standard.

M4 Network adequacy - 42 CFR 438.207

The MCOs must demonstrate how they maintain and monitor a network of appropriate providers, sufficient to provide adequate access to all services under the contract. The standard, M4, contains six scoring elements per MCO reviewed, for a total of 30 scoring elements. The MCOs satisfied requirements for 28 out of 30 scoring elements, for a score of 93.3 percent, and a star rating of Excellent.

Scoring element M4.1 requires MCOs to ensure there is an appropriate range of services to make all services in the benefit package readily available to all members, including those with limited English proficiency or physical or mental disabilities. Four of five MCOs met the requirements of this standard. One MCO was not able to demonstrate an appropriate range of services for members, specifically related to long-term care providers.

Scoring element M4.2 requires the MCO to ensure a sufficient number, mix, and geographic distribution of providers of all services. Four of five MCOs met the requirements of this standard. One MCO did not demonstrate sufficient mechanisms in place to monitor long-term care service providers.

M13 Provider selection - 42 CFR 438.214

The MCOs must have a written process for the selection and retention of qualified providers. The MCOs are responsible for ensuring all applicable provider requirements are met at initial contacting and throughout the duration of the contract. The standard, M13, contains 13 scoring elements per MCO reviewed, for a total of 65 standards. The MCOs satisfied requirements for 60 out of 65 scoring elements, for a score of 92.3 percent, and a star rating of Excellent.

Scoring element M13.5 requires the MCO to utilize providers that meet Department requirements. Overall, the MCOs demonstrated robust processes for determining provider qualifications upon entry into the provider network as well as ongoing once established in the network. Four out of five MCOs satisfied the requirements of this element. One MCO did not demonstrate compliance with this element. Although verification processes to ensure applicable provider requirements were evident for some provider types, verification of required credentialing compliance was not demonstrated with others. Therefore, it could not be determined that the MCO's monitoring process was fully implemented.

Scoring element M13.6 requires that all providers utilized by the MCO must not be excluded from participation in federal health care programs under either section 1128 or section 1128A of the Social Security Act. Except for emergency services, Medicaid payment is not available for excluded providers. All five MCOs demonstrated processes in place concerning verification that providers are not excluded from participating in federal health programs; however, four out of five MCOs were missing essential components to ensure compliance with this element. For example, three MCOs were provided with recommendations to update internal procedures with

additional debarment guidance related to new providers and how exclusion verification is conducted for providers with business names and owner names.

M14 Subcontractual relationships and delegation - 42 CFR 438.230

The MCOs must oversee and be accountable for functions and responsibilities that they delegate to any subcontractor/provider. The MCOs must monitor the subcontractor/provider's performance, and take corrective action if needed. The standard, M14, contains eight scoring elements per MCO reviewed, for a total of 40 scoring elements. The MCOs satisfied requirements for 39 out of 40 scoring elements, for a score of 97.5 percent, and a star rating of Excellent.

Scoring element M14.1 requires the MCOs and the subcontractors or providers have a written agreement that specifies the activities and reporting responsibilities delegated to the subcontractor, and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. All MCOs utilized a robust contract with expectations and responsibilities of providers. Some MCOs also incorporated agreements for anticipated short-term services, as well as attestations of the provider's acceptance of responsibilities and requirements. Four out of five MCOs satisfied the requirements of this element. One MCO was not able to demonstrate reporting responsibilities delegated to providers or actions to be taken if provider performance is inadequate, in all subcontractor agreements.

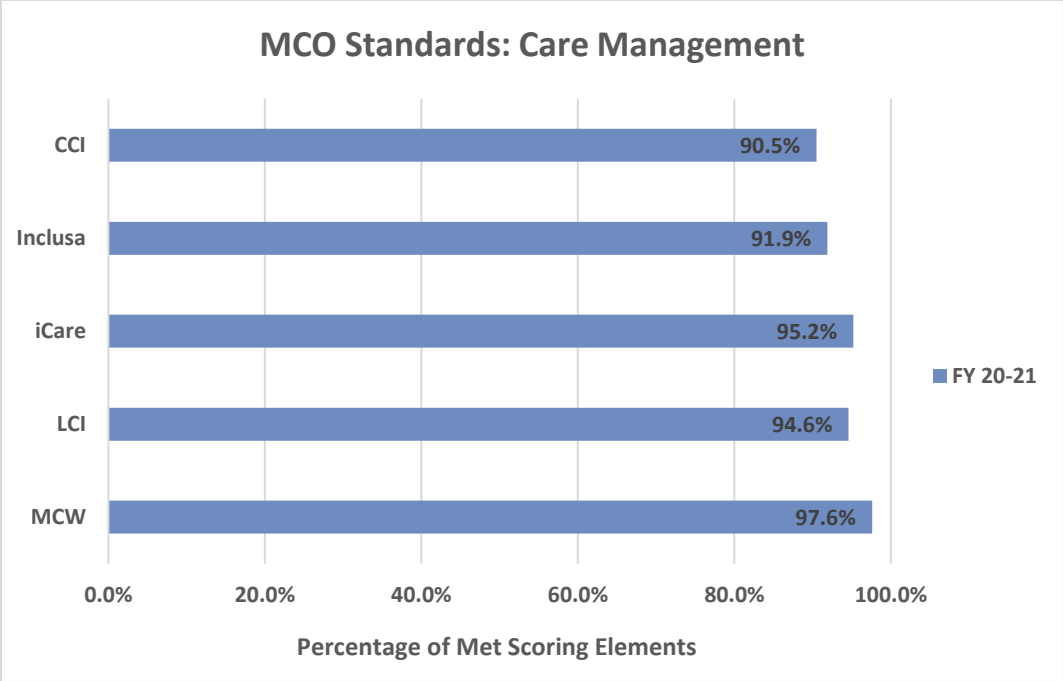
Observation and Analysis: MCO Standards, Care Management

MCOs 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 coordination and continuity of member care, timely authorization of services and issuance of notices to members. Five standards address requirements related to coordination and continuity of care, and coverage and authorization of services. The table below indicates the MCOs' compliance with these standards.

MCO Standards: Care Management				
Standard	**Scoring Elements**	**Percentage**	**Stars**	**Rating**
M5	58/60	96.7%	★★★★★	EXCELLENT
M6	42/50	84.0%	★★★★	VERY GOOD
M7	20/20	100%	★★★★★	EXCELLENT
M8	50/50	100%	★★★★★	EXCELLENT
M15	18/20	90.0%	★★★★★	EXCELLENT
M16*	NA	NA	NA	NA
Overall	**188/200**	**94.0%**	**★★★★★**	**EXCELLENT**

* M16 is evaluated as part of the MCO's ISCA, conducted once every three years. The ISCA occurs separate from the QCR.

The following graph illustrates the MCO's overall compliance with this focus area.



Overall, policies and procedures submitted by the MCOs met requirements and interview sessions with interdisciplinary team (IDT) staff and supervisory and support staff confirmed implementation of practices. Training plans submitted by the MCOs demonstrated IDT staff are trained on requirements when initially hired, with refresher trainings occurring annually, and as needed. Most MCOs also utilize aptitude tests to demonstrate the application of training to solidify learning. The use of a mentoring program is a common practice, where staff are assigned a mentor, an experienced IDT staff who serves as a resource and support to the new employee. Through document review and interview sessions, a number of resources were identified that support care management practices, including guides, tip sheets, and newsletters. IDT staff from all MCOs indicated the ability to seek supervisory support and support from other departments when needed. All MCOs utilize different features in their electronic health record to aid IDT staff in their daily work, such as fields that auto-populate or auto-reminders to staff of different tasks. This demonstrates that the MCOs are making use of available technologies to support care management practices. All MCOs had a system in place to monitor care management practices, typically through an internal file review process, which was identified as a mechanism for providing feedback on care management practices, and described as a collaborative process, focused on learning.

M5 and M6 Coordination and continuity of care, and confidentiality - 42 CFR 438.208, 42 CFR 438.224

Two standards address requirements related to coordination and continuity of care. MCOs are responsible for providing, arranging, coordinating, and monitoring services for members, and adhering to all confidentiality requirements (M5). The standard, M5, contains 12 scoring elements per MCO reviewed, for a total of 60 scoring elements. The MCOs satisfied requirements for 58 out of 60 scoring elements, for a score of 96.7 percent, and a star rating of Excellent.

Scoring element M5.1 requires the MCOs to ensure coordination of long-term care services with health care services received by the member, as well other services available from natural and community supports. Three of five MCOs satisfied requirements for this scoring element. Results from two MCO's internal monitoring, as well as MetaStar's care management review show a need for improvement related to follow-up. These MCOs did not satisfy requirements for scoring element M5.1.

The MCOs are responsible for ensuring member centered planning processes are implemented and monitored (M6). The standard, M6, contains 10 scoring elements per MCO reviewed, for a total of 50 scoring elements. The MCOs satisfied requirements for 42 out of 50 scoring elements, for a score of 84.0 percent, and a star rating of Very Good.

Scoring element M6.1 requires that the MCOs use an assessment protocol that includes a face-to-face interview in the member's current residence by the IDT care manager and registered nurse. Two of five MCOs satisfied requirements for this scoring element. Internal monitoring results related to comprehensive assessments for three MCOs indicated a need for additional improvement, as did the MetaStar CMR results. A change to the DHS-MCO contract in 2020 related to behavior modifying medications may be the likely cause. Previously, the requirements were evaluated under the member-centered plan (MCP), and are now evaluated under the comprehensive assessment. Assessments found to not be comprehensive during the CMR often did not include a detailed description of behaviors, which indicate the need for behavior modifying medications. Three MCOs did not satisfy requirements for scoring element M6.1.

Scoring element M6.5 requires the MCP to be based on the comprehensive assessment. IDT staff shall involve the member and other parties in accordance with the member's preference and the parties' ability to contribute to the development of the MCP. Internal monitoring results related to comprehensiveness of MCPs for all MCOs indicated a need for additional improvement, as did the MetaStar CMR results. MCPs found to not be comprehensive during the CMR were often lacking a service or support for a member's assessed needs with an activity of daily living or instrumental activity of daily living. No MCO satisfied requirements for scoring element M6.5.

M7 Disenrollment: requirements and limitations - 42 CFR 438.56

The MCOs must comply with requirements for member disenrollment. The standard, M7, contains four scoring elements per MCO reviewed for a total of 20 scoring elements. The MCOs satisfied requirements for 20 out of 20 scoring elements, for a score of 100 percent, and a star rating of Excellent. All MCOs satisfied requirements for this standard.

M8 Coverage and authorization of services - 42 CFR 438.210, 42 CFR 440.230, 42 CFR 438.441

MCO policies and procedures for service authorizations must comply with required standards. The standard, M8, contains eight scoring elements for each FC only MCOs and 12 scoring elements for each MCO that operate FCP and PACE, for a total of 50 scoring elements. The MCOs satisfied requirements for 50 out of 50 scoring elements, for a score of 100 percent, and a star rating of Excellent.

All MCOs demonstrated the use of the DHS Resource Allocation Decision (RAD) process. The RAD process provides a consistent and methodical approach to making decisions regarding service authorizations. All MCOs satisfied requirements for this standard.

M15 Practice guidelines - 42 CFR 438.236

MCOs are required to adopt, apply, and disseminate practice guidelines based on the needs of its members (M15). The standard, M15, contains four scoring elements per MCO reviewed for a total of 20 scoring elements. The MCOs satisfied requirements for 18 out of 20 scoring elements, for a score of 90.0 percent, and a star rating of Excellent.

Scoring element M15.2 requires adopted practice guidelines to be reviewed and updated periodically, as appropriate. Four of five MCOs satisfied these requirements. One MCO was not able to demonstrate that adopted practice guidelines were reviewed periodically.

Scoring element M15.4 requires MCOs to disseminate or make available the practice guidelines to providers for whom the guidelines apply, and upon request, to members. Four of five MCOs satisfied these requirements. All MCOs utilize a provider section on their websites to make guidelines available to providers; however, the links to the practice guidelines for one MCO were outdated, or did not work for several of the guidelines. This MCO did not satisfy the requirements for this scoring element.

M16 Health information systems – 42 CFR 438.242

The MCOs must maintain 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 disenrollment, for other than loss of Medicaid eligibility.

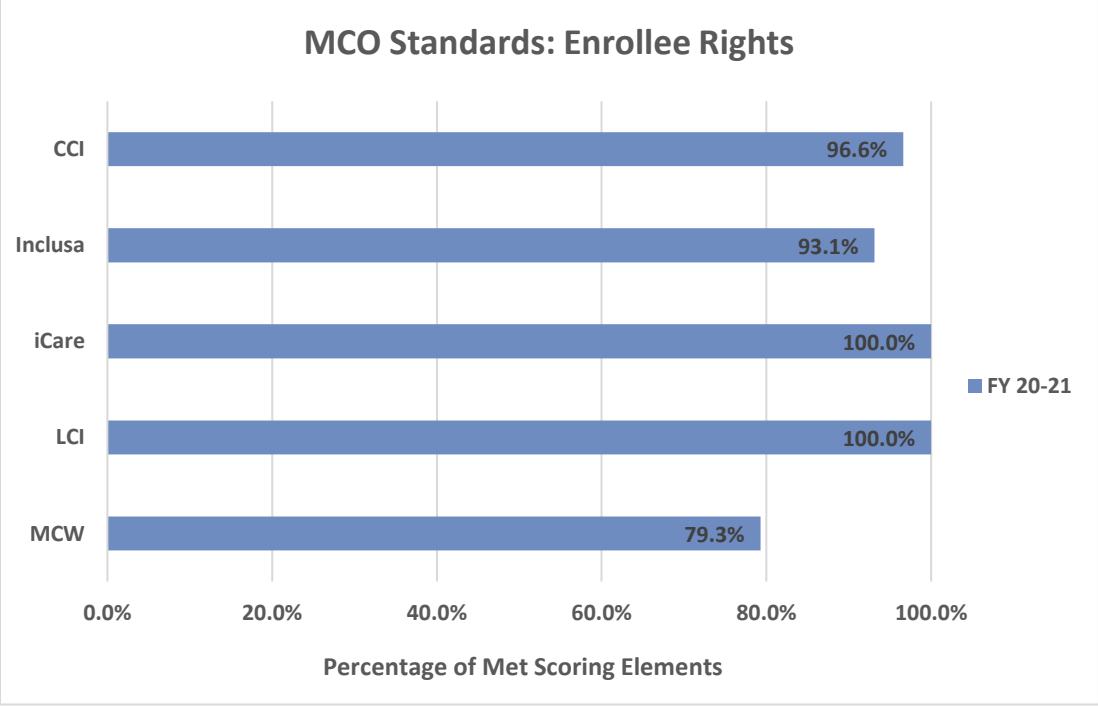
This standard is evaluated as part of each MCOs' ISCA, conducted once every three years. The ISCA occurs separate from the QCR.

Observation and Analysis: MCO Standards, Enrollee Rights

MCOs are responsible to help members understand their rights as well as to ensure those rights are protected. This requires an adequate organizational structure and sound processes that adhere to federal and state requirements and ensure that members' rights are protected. Four standards comprise this review focus area. The standards in this area of review address members' general rights, such as the right to information, as well as a number of specific rights, including those related to dignity, respect, and privacy. The table below indicates the MCOs' compliance with these standards.

MCO Standards: Enrollee Rights				
Standard	**Scoring Elements**	**Percentage**	**Stars**	**Rating**
M9	58/60	96.7%	★★★★★	EXCELLENT
M10	18/20	90.0%	★★★★★	EXCELLENT
M11	50/55	90.9%	★★★★★	EXCELLENT
M12	10/10	100.0%	★★★★★	EXCELLENT
Overall	**136/145**	**93.79%**	★★★★★	EXCELLENT

The following graph illustrates the MCO's overall compliance with this focus area.



M9 Information requirements for all enrollees - 42 CFR 438.100(b)(2)(i), 42 CFR 438.10

Organizations are required to provide readily accessible written information to members in a manner and format that is easily understood. The standard, M9, contains 12 scoring elements, per MCO reviewed, for a total of 60 scoring elements. The MCOs satisfied requirements for 58 out of 60 scoring elements, for a score of 96.7 percent, and a star rating of Excellent.

The documentation submitted and onsite discussions with MCO staff indicated that organizations provide members with written materials in a manner and format that is easily understood. All MCOs demonstrated, in both documentation and staff interviews, that member materials can be provided in alternative formats and languages when needed. Organizations have implemented safeguards and a consent process when members request materials be provided in an electronic format. All MCOs demonstrated all required new materials are provided to members in a timely manner, including the most up to date member handbook.

M10 Enrollee right to receive information on available provider options - 42 CFR 438.100(b)(2)(iii), 42 CFR 438.102

Members must receive information on available provider options. Additionally, MCOs will not restrict a provider acting within the lawful scope of practice, or from advising or advocating on behalf of a member. The standard, M10, contains four scoring elements, per MCO reviewed, for a total of 20 scoring elements. The MCOs satisfied requirements for 18 out of 20 scoring elements, for a score of 90.0 percent, and a star rating of Excellent.

Organizations demonstrated through document submission and onsite discussions that available provider options and the right to change providers is given to members upon enrollment and as needed. In general, MCOs have written guidance in place to ensure MCOs do not prohibit or restrict a provider from acting within the lawful scope of practice, or from advising or advocating on behalf of a member.

M11 Enrollee right to participate in decisions regarding his or her care and be free from any form of restraint - 42 CFR 438.100(b)(2)(iv) and (v), 42 CFR 438.3(j)

The MCO will have written policies and procedures for member rights and advance directives, which include the right to participate in decisions regarding his or her care, the right to refuse treatment, and be free of any form of restraint. The standard, M11, contains 11 scoring elements, per MCO reviewed, for a total of 55 scoring elements. The MCOs satisfied requirements for 50 out of 55 scoring elements, for a score of 90.9 percent, and a star rating of Excellent.

Overall, MCOs have written policies and procedures for member rights and advance directives, including the right to be free of any form of restraint. Each MCOs' restrictive measures log was reviewed to ensure standard systems are in place for restrictive measure renewals, timely submissions to the DHS, and awareness of practice requirements if a restrictive measure is

expired. During the FY 20-21 review, two legacy MCOs merged their organizations into one entity. This newly formed organization demonstrated opportunities for improvement in this area as many of its policies and procedures were not merged and fully implemented during the review period. This review also determined that for a period of time during the review period, the newly merged MCO did not demonstrate adequate restrictive measures monitoring of one legacy MCO. MetaStar recommends the state implement a standard process to ensure policies and procedures, and the monitoring of member restrictive measures, are fully merged and implemented during significant MCO changes, like an organization merger.

M12 Compliance with other federal and state laws - 42 CFR 438.100(d)

The MCO will have written safeguards for the protection of member rights. The language and practices of the MCO shall recognize each member as an individual and emphasize each member's capabilities. The standard, M12, contains two scoring elements, per MCO reviewed, for a total of 10 scoring elements. The MCOs satisfied requirements for 10 out of 10 scoring elements, for a score of 100 percent, and a star rating of Excellent.

All MCOs demonstrated the practice of protecting member rights through both written guidance and onsite discussions. Each MCO ensures staff and providers demonstrate dignity and respect in all interactions with members.

CONCLUSIONS

A summary of strengths, progress, and recommendations is noted in the *Executive Summary* and *Introduction and Overview* sections above.

Protocol 9: Conducting Focused Studies of Health Care Quality - Care Management Review

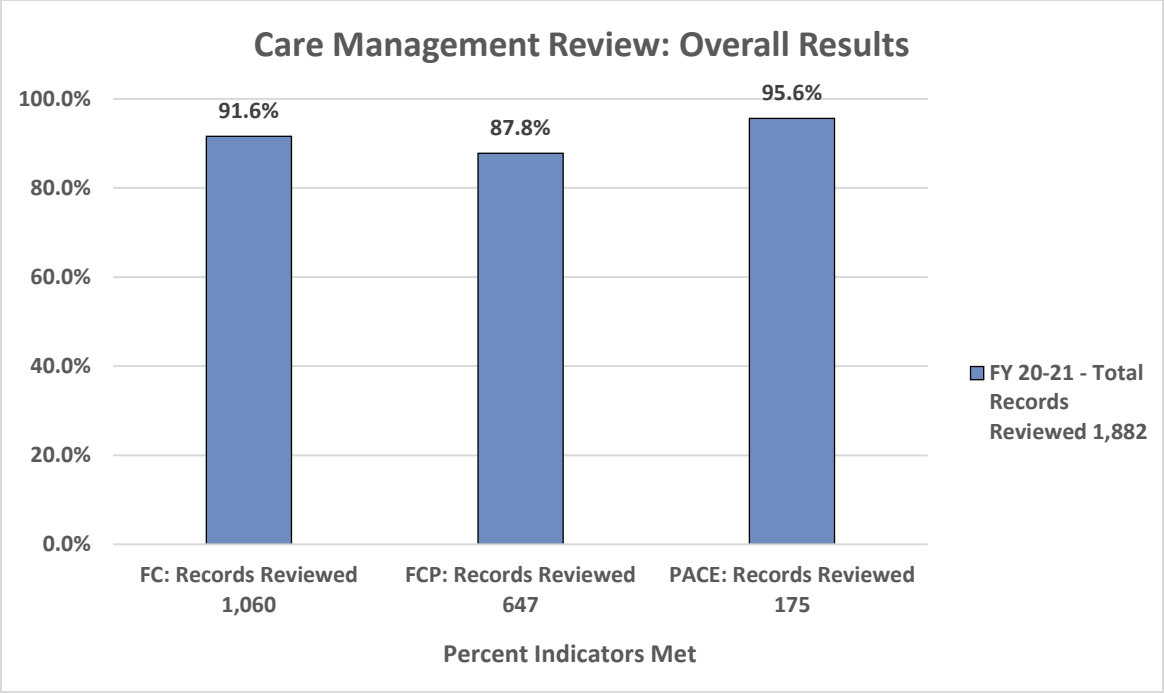
Care management review (CMR) is an optional activity, *CMS External Quality Review (EQR) Protocols, Protocol 9: Conducting Focus Studies of Health Care Quality*, which determines a MCO's level of compliance with the DHS-MCO contract. The information gathered during CMR helps assess the access, timeliness, quality, and appropriateness of care a MCO provides to its members. CMR activities and findings are part of DHS' overall strategy for providing quality assurances to the Centers for Medicare & Medicaid Services regarding the 1915(c) Home and Community Based Services Waivers which allow the State of Wisconsin to operate its Family Care programs.

The CMR was conducted using a review tool and reviewer guidelines developed by MetaStar and approved by DHS. In 2020, the State of Wisconsin was impacted by the coronavirus pandemic, a global pandemic caused by COVID-19. COVID-19 caused an outbreak of respiratory illnesses, putting many individuals at risk, especially older adults and people who have chronic medical conditions. In an effort to curb the spread of the virus, face-to-face interactions were limited, including interactions between members and MCO staff. DHS implemented a number of flexibilities to the DHS-MCO contract requirements in response to the pandemic. These flexibilities were incorporated into CMR reviewer guidance, effective March 1, 2020. More information about the CMR review methodology can be found in Appendix 2.

Overall Results by Program

The three bar graphs below represent the overall percent of CMR standards met by the MCO in FY 20-21 for all 11 review indicators.

Analysis indicated the year-to-year difference in the overall rates is likely attributable to actions of the MCO, and is unlikely to be the result of normal variation or chance.



In addition to the organizational level CMR results described below in the *Results for each CMR Focus Area* section, the MCO was provided a report of each individual record review. MetaStar recommends the MCO evaluate the results of these individual member reviews and direct care management teams to follow up and take action related to individual situations, as needed.

Results for each CMR Focus Area

Each section below provides a brief explanation of a key category of CMR, followed by a bar graph for each program (FC, FCP, and PACE) which represents the MCO's FY 20-21 results for each of the review indicators comprising the CMR category. The notes below each bar graph specify the number of applicable records when it is less than the total number reviewed.

Comprehensive Assessment

Interdisciplinary team (IDT) staff must assess each member in order to comprehensively explore and document information, such as:

- Personal experience outcomes;
- Long-term care outcomes;
- Strengths;
- Preferences;
- Natural and community supports;
- Risks related to health and safety; and

- Ongoing clinical or functional conditions and needs that require long-term care, a course of treatment, or regular care monitoring.

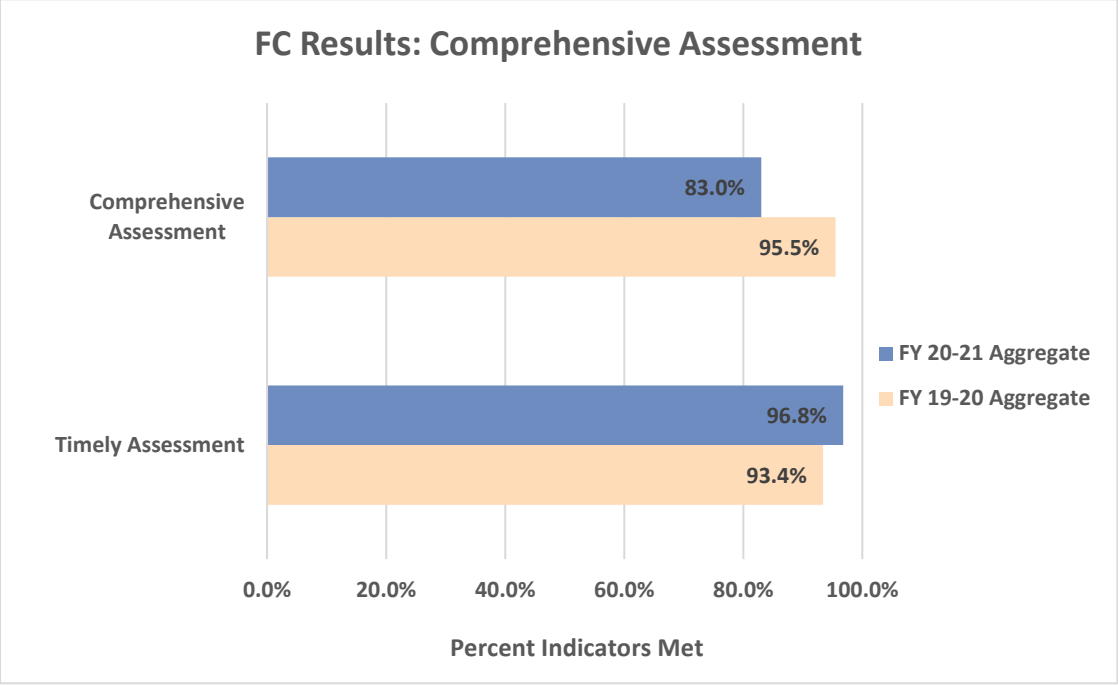
The initial assessment and subsequent reassessments must meet the timelines and other requirements described in the DHS-MCO contract.

FC

The indicator *Comprehensive Assessment* ensures the MCO evaluates member needs based on the DHS-MCO contract requirements. In all assessment elements reviewed, 99.2 percent were found to be assessed. Overall results for the indicator per record (83.0 percent) declined from the prior review. Analysis indicated the year-to-year difference in the rates is unlikely to be the result of normal variation or chance. The most common reason assessments were not comprehensive was due to not including an assessment of the member's education preferences and a detailed description of behaviors for members taking behavior modifying medications. In prior reviews, a detailed description of behaviors indicating the need for behavior modifying medications was required to be on the MCP. The 2020 DHS-MCO contract changed where these requirements were evaluated, and are now part of the member's comprehensive assessment. The contract change is the likely cause for the decline in this indicator.

The indicator *Timely Assessment* evaluates assessments conducted by both members of the IDT in accordance with the DHS-MCO contract requirement of every six months. This indicator continues to be a strength for FC, scoring above 90 percent. Overall results for the indicator increased from the prior review and analysis indicated the year-to-year difference in the rates is likely attributable to actions of the MCOs, and is unlikely to be the result of normal variation or chance. The flexibilities to the face-to-face assessment requirement as a result of COVID-19 may be a contributing factor to the improvement.

Results for Comprehensive Assessment for MCOs Operating FC:

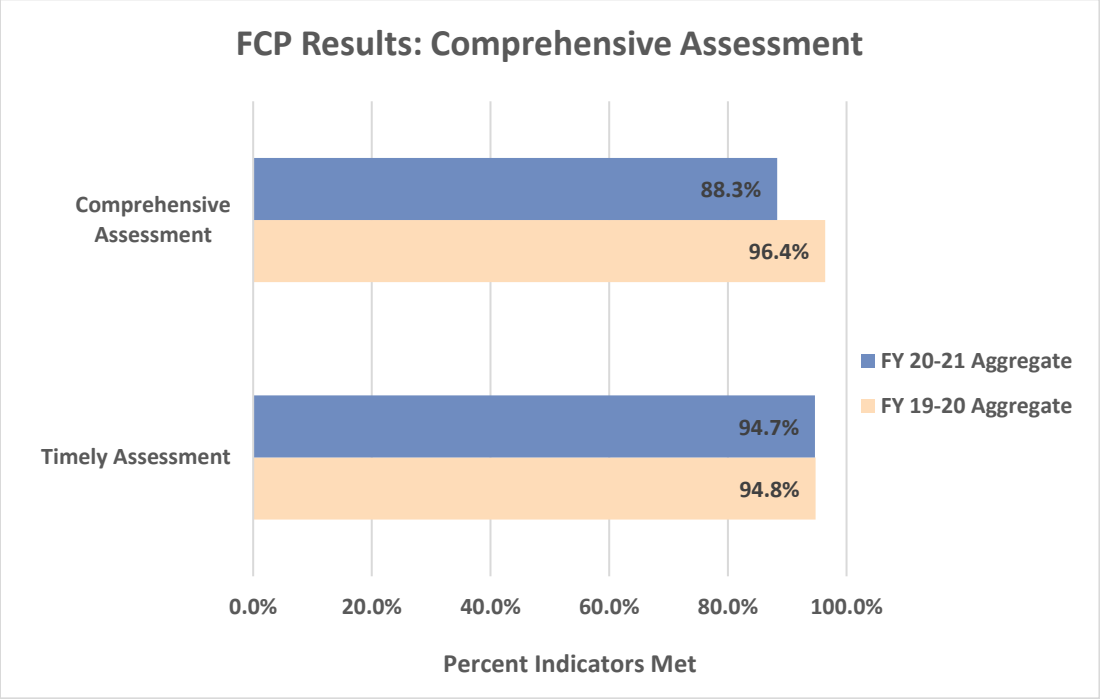


FCP

The indicator *Comprehensive Assessment* ensures the MCO evaluates member needs based on the DHS-MCO contract requirements. In all assessment elements reviewed, 99.3 percent were found to be assessed. Overall results for the indicator per record (88.3 percent) declined from the prior review. Analysis indicated the year-to-year difference in the rates is unlikely to be the result of normal variation or chance. The most common reason assessments were not comprehensive was due to not including a detailed description of behaviors for members taking behavior modifying medications. In prior reviews, a detailed description of behaviors indicating the need for behavior modifying medications was required to be on the MCP. The 2020 DHS-MCO contract changed where these requirements were evaluated, and are now part of the member's comprehensive assessment. The contract change is the likely cause for the decline in this indicator.

The indicator *Timely Assessment* evaluates assessments conducted by both member of the IDT in accordance with the DHS-MCO contract requirement of every six months. This indicator continues to be a strength for FCP, scoring above 90 percent. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance.

Results for Comprehensive Assessment for MCOs Operating FCP:

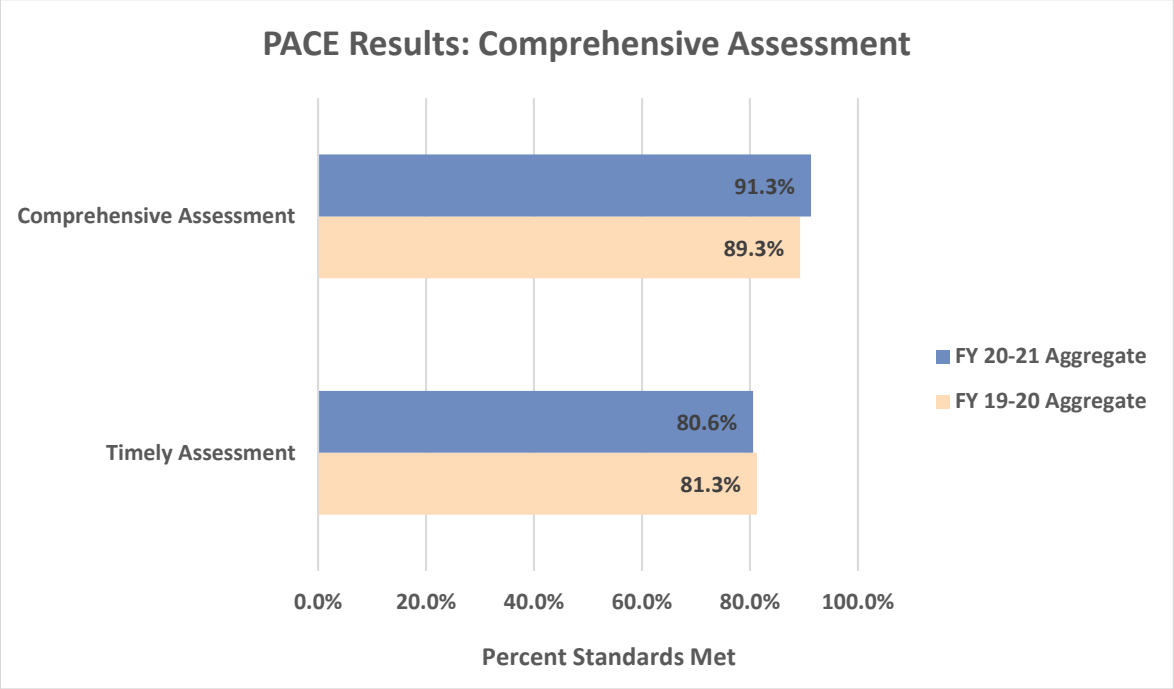


PACE

The indicator *Comprehensive Assessment* ensures the MCO evaluates member needs based on the DHS-MCO contract requirements. In all assessment elements reviewed, 99.7 percent were found to be assessed. This indicator is a strength for PACE, scoring above 90 percent. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance.

The indicator *Timely Assessment* evaluates assessments conducted by both member of the IDT in accordance with the DHS-MCO contract requirement of every six months. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. The most common reason for assessments to not be timely was due to one or both (health or social) IDT assessments completed beyond the required timeframe.

Results for Comprehensive Assessment for the MCO Operating PACE:



Member Centered Planning

The MCP and Service Authorization document must:

- Identify all services and supports to be authorized, provided, and/or coordinated by the MCO that are consistent with information in the comprehensive assessment, and are
    - Sufficient to ensure the member's health, safety, and well-being;
    - Consistent with the nature and severity of the member's disability or frailty; and
    - Satisfactory to the member in supporting his/her long-term care outcomes.
- Be developed and updated according to the timelines and other requirements described in the DHS-MCO contract.

Additionally, the record must:

- 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; and
- Document that the IDT assessed and responded to members' identified risks.

FC

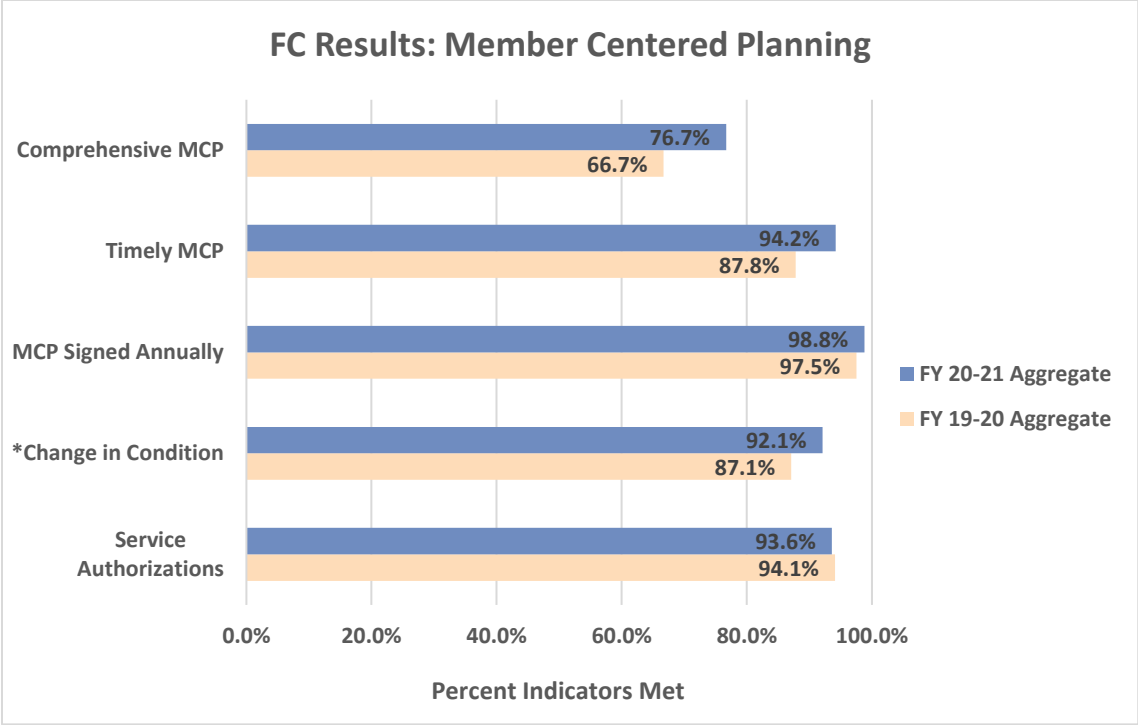
The indicator *Comprehensive MCP* ensures member MCPs include all assessed needs. In all MCP elements reviewed, 97.2 percent were found to be included on the plan. Overall results for the indicator per record (76.7 percent) increased from the prior review and analysis indicated the year-to-year difference in the rates is likely attributable to actions of the MCOs, and is unlikely to be the result of normal variation or chance. This improvement is likely related to changes in the scoring of the detailed description of behaviors for behavior modifying medications, which in FY 19-20, was scored under this indicator. The 2020 DHS-MCO contract changed where these requirements were evaluated, and are now part of the member's comprehensive assessment. Improvements were identified in including supports and services for assessed needs on the MCP, specifically durable medication equipment for activities of daily living.

The indicator *Timely MCP* evaluates MCPs being reviewed and signed in accordance with the DHS-MCO contract requirement of every six months. This indicator is a strength for FC, scoring above 90 percent. MCPs were found to be signed at least once annually in 98.8 percent of all records. Overall results for the indicator increased from the prior review and analysis indicated the year-to-year difference in the rates is likely attributable to actions of the MCOs, and is unlikely to be the result of normal variation or chance. The improvements may be related to the flexibilities to signature requirements on the MCP during the COVID-19 pandemic. The CMR only evaluated evidence that the MCP was reviewed timely with the member or legal decision maker, and did not evaluate signature requirements for the MCP.

The indicator *Change in Condition* evaluates the IDTs assessing the member when changes occur and updating the MCP when applicable, which includes the exploration or education on risk interventions. This indicator is a strength for FC, scoring above 90 percent. The indicator is not applicable to all records, applying to 318 of 1,060 records in FY 20-21. Overall results for the indicator increased from the prior review and analysis indicated the year-to-year difference in the rates is likely attributable to actions of the MCOs, and is unlikely to be the result of normal variation or chance.

The indicator *Service Authorizations* evaluates the IDTs handling of service authorizations, including appropriately responding to member requests and issuing *Notices of Adverse Benefit Determination* when applicable. Overall, service authorizations were handled appropriately, with the indicator scoring over 90 percent. In all records reviewed, 352 *Notices of Adverse Benefit Determination* were indicated, with 243 being issued timely, for an issuance rate of 69.0 percent. Overall results for the indicator declined from the prior review. Analysis indicated the year-to-year difference in the rates is unlikely to be the result of normal variation or chance.

Results for Member Centered Planning for MCOs Operating FC:



*Note: The review indicator *Change in Condition* applied to 318 of 1060 records in FY 20-21, and 272 of 1160 records in FY 19-20.

FCP

The indicator *Comprehensive MCP* ensures member MCPs include all assessed needs. In all MCP elements reviewed, 95.9 percent were found to be included on the plan. Overall results for the indicator per record (68.6 percent) declined from the prior review. Analysis indicated the year-to-year difference in the rates is unlikely to be the result of normal variation or chance. The most common reason MCPs were not comprehensive was related to not identifying services and supports for assessed needs.

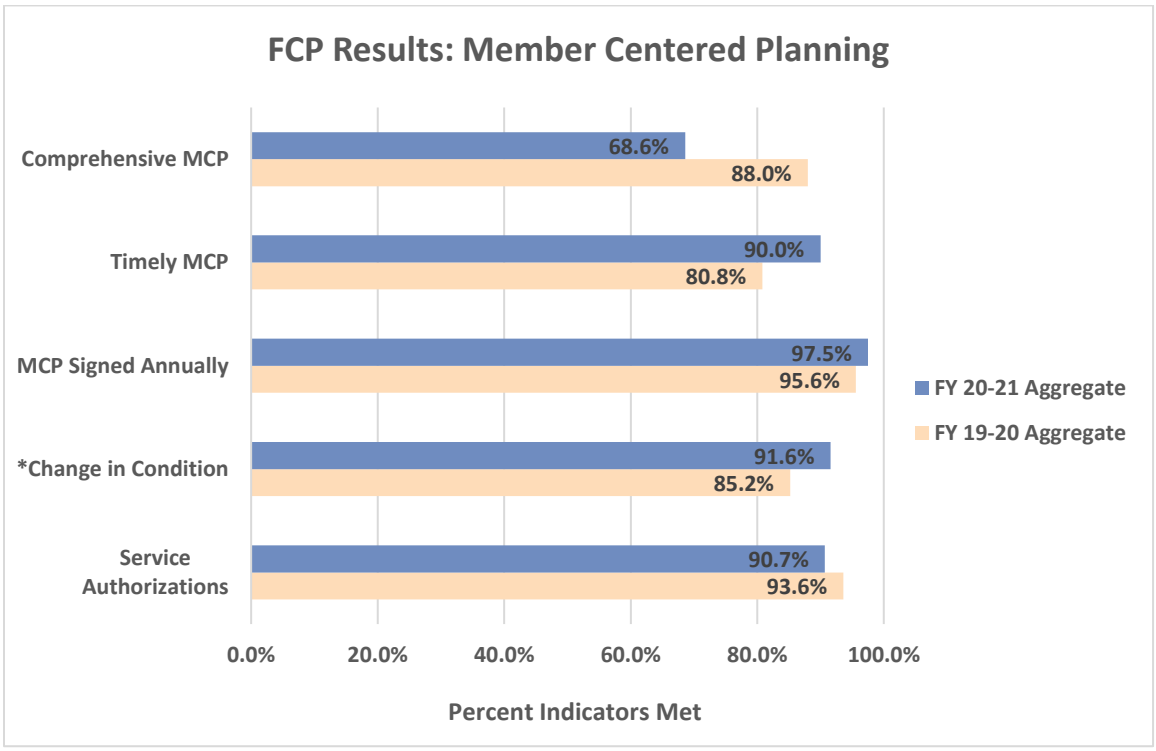
The indicator *Timely MCP* evaluates MCPs being reviewed and signed in accordance with the DHS-MCO contract requirement of every six months. This indicator is a strength for FCP, scoring at 90 percent. MCPs were found to be signed at least once annually in 97.5 percent of all records. Overall results for the indicator increased from the prior review and analysis indicated the year-to-year difference in the rates is likely attributable to actions of the MCOs, and is unlikely to be the result of normal variation or chance. The improvements may be related to the flexibilities to signature requirements on the MCP during the COVID-19 pandemic.

The CMR only evaluated evidence that the MCP was reviewed timely with the member or legal decision maker, and did not evaluate signature requirements for the MCP.

The indicator *Change in Condition* evaluates the IDTs assessing the member when changes occur and updating the MCP when applicable, which includes the exploration or education on risk interventions. This indicator is a strength for FCP, scoring above 90 percent. The indicator is not applicable to all records, applying to 238 of 647 records in FY 20-21. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance.

The indicator *Service Authorizations* evaluates the IDTs handling of service authorizations, including appropriately responding to member requests and issuing *Notices of Adverse Benefit Determination* when applicable. Overall, service authorizations were handled appropriately, with the indicator scoring over 90 percent. In all records reviewed, 260 *Notices of Adverse Benefit Determination* were indicated, with 148 being issued timely, for an issuance rate of 56.9 percent. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance.

Results for Member Centered Planning for MCOs Operating FCP:



*Note: The review indicator *Change in Condition* applied to 238 of 647 records in FY 20-21, and 81 of 250 records in FY 19-20.

PACE

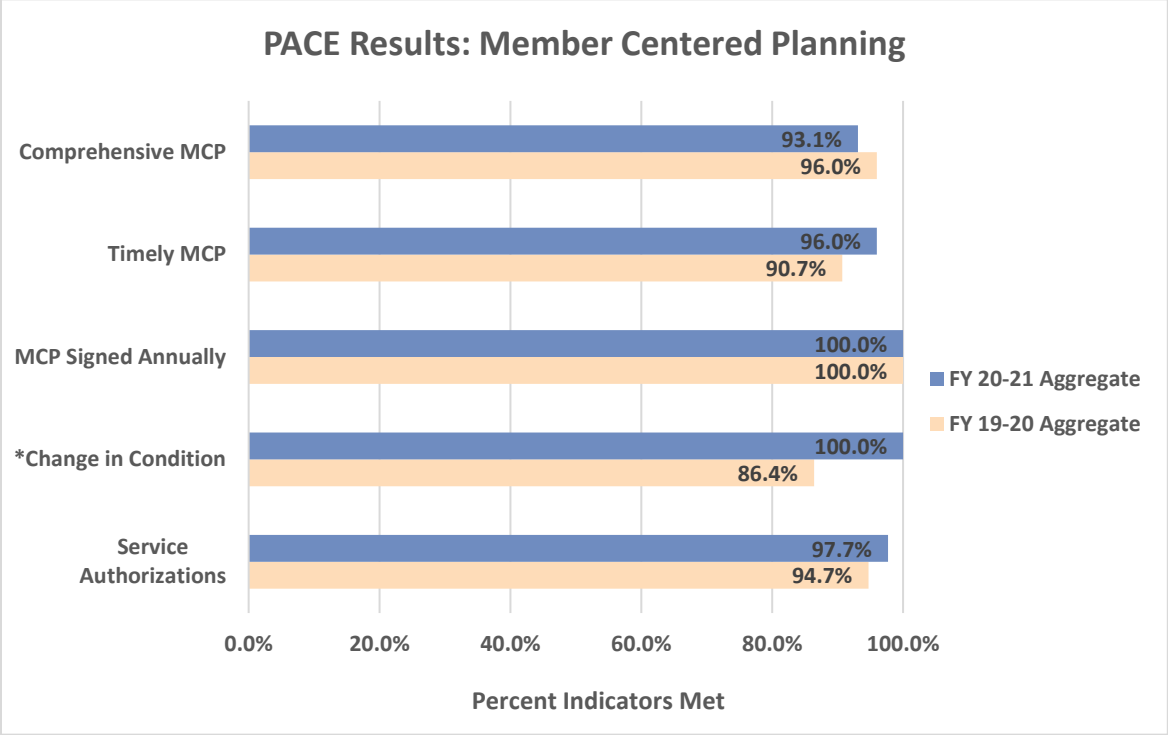
The indicator *Comprehensive MCP* ensures member MCPs include all assessed needs. In all MCP elements reviewed, 99.2 percent were found to be included on the plan. This indicator continues to be a strength for PACE. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance.

The indicator *Timely MCP* evaluates MCPs being reviewed and signed in accordance with the DHS-MCO contract requirement of every six months. This indicator continues to be a strength for PACE, scoring above 90 percent. MCPs were found to be signed at least once annually in 100 percent of all records. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance.

The indicator *Change in Condition* evaluates the IDTs assessing the member when changes occur and updating the MCP when applicable, which includes the exploration or education on risk interventions. This indicator was a strength for PACE, scoring 100 percent. The indicator is not applicable to all records, applying to 76 of 175 records in FY 20-21. Overall results for the indicator increased from the prior review and analysis indicated the year-to-year difference in the rates is likely attributable to actions of the MCO, and is unlikely to be the result of normal variation or chance.

The indicator *Service Authorizations* evaluates the IDTs handling of service authorizations, including appropriately responding to member requests and issuing *Notices of Adverse Benefit Determination* when applicable. Overall, service authorizations were handled appropriately, with the indicator scoring over 90 percent. In all records reviewed, 35 *Notices of Adverse Benefit Determination* were indicated, with 30 being issued timely, for an issuance rate of 85.7 percent. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance.

Results for Member Centered Planning for the MCO Operating PACE:



*Note: The review indicator *Change in Condition* applied to 76 of 175 records in FY 20-21, and 22 of 75 records in FY 19-20.

Care Coordination

The IDT is formally designated as being primarily responsible for authorizing, providing, arranging, or coordinating the member's long-term care and health care. The record must document that:

- The IDT staff coordinated the member's services and supports in a reasonable amount of time;
- 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
- All of the member's identified needs have been adequately addressed.

FC

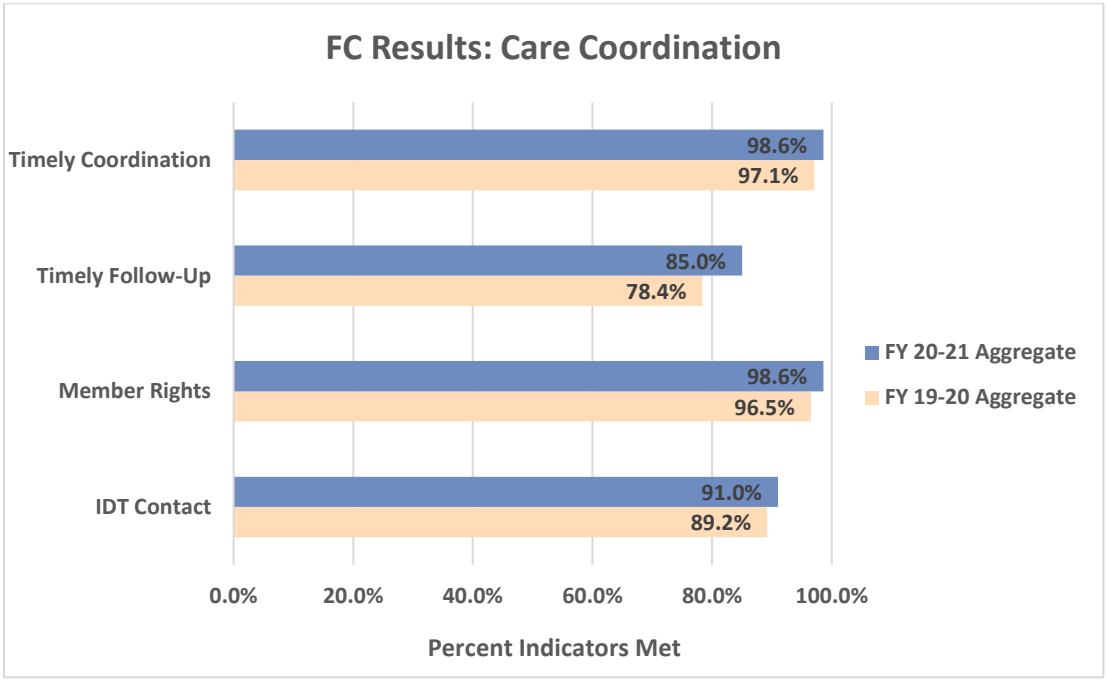
The *Timely Coordination* indicator evaluates plans put in place by the IDT to ensure member needs and supports are coordinated effectively and in a timely manner. This indicator is a strength for FC, scoring above 90 percent. Overall results for the indicator increased from the prior review and analysis indicated the year-to-year difference in the rates is likely attributable to actions of the MCOs, and is unlikely to be the result of normal variation or chance.

The indicator *Timely Follow-Up* evaluates whether the IDT followed up with members to confirm services and supports were received and effective. Overall results for the indicator increased from the prior review and analysis indicated the year-to-year difference in the rates is likely attributable to actions of the MCOs, such as ongoing focused training with IDT staff to identify and document follow-up needs and monitoring to support the focused efforts. Records found unmet for this indicator were due to a lack of documented follow-up for covered services and health related services.

The indicator *Member Rights* evaluates the protection of member rights, such as IDT staff including the member and his/her supports in care management processes; offering and explaining the self-directed supports (SDS) option to the member; and following applicable guidelines for restrictive measures and rights limitations. This indicator is a strength for FC, scoring above 90 percent. Overall results for the indicator increased from the prior review and analysis indicated the year-to-year difference in the rates is likely attributable to actions of the MCOs, and is unlikely to be the result of normal variation or chance. The improvement is likely related to the SDS requirements, which were flexible during the COVID-19 pandemic. The review of the MCP with the member or legal decision maker was considered sufficient for meeting this requirement.

The evaluation of IDT contact requirements under the indicator *IDT Contact*, included monthly collateral contacts, face-to-face contact every three months with the member, and an annual home visit with the member by the care manager and registered nurse care manager. This indicator is a strength for FC, scoring above 90 percent. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance.

Results for Coordination for MCOs Operating FC:



FCP

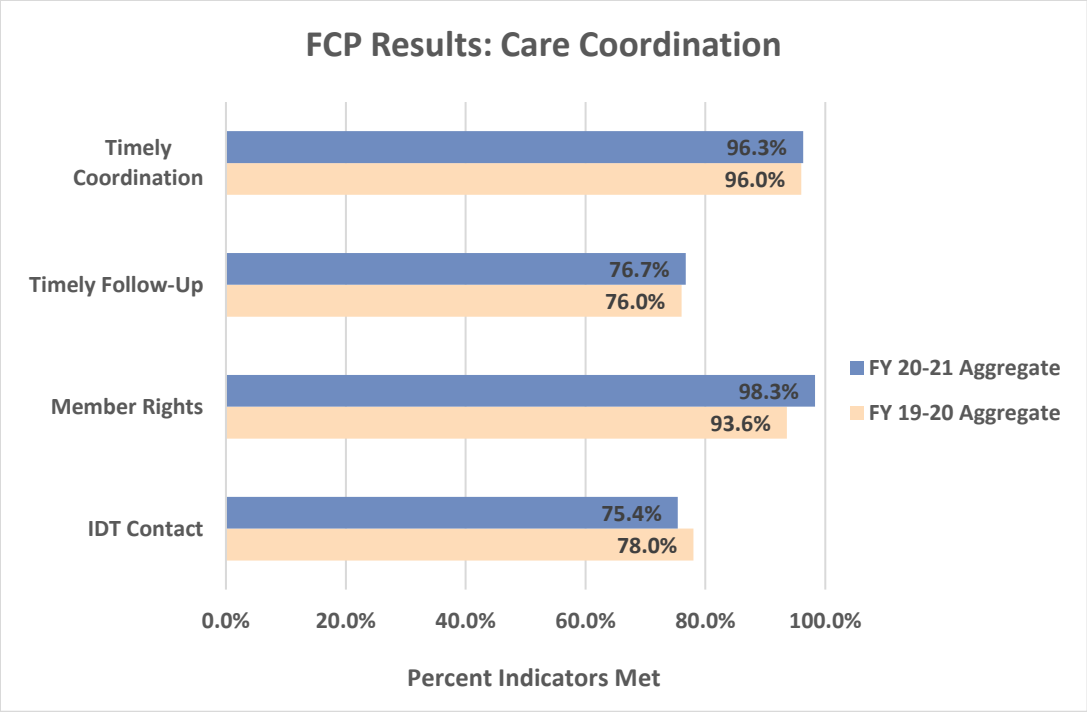
The *Timely Coordination* indicator evaluates plans put in place by the IDT to ensure member needs and supports are coordinated effectively and in a timely manner. This indicator is a strength for FCP, scoring above 90 percent. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance.

The indicator *Timely Follow-Up* evaluates whether the IDT followed up with members to confirm services and supports were received and effective. Overall results for the indicator increased from the prior review. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. Records found unmet for this indicator were due to a lack of documented follow-up for covered services and health related services.

The indicator *Member Rights* evaluates the protection of member rights, such as IDT staff including the member and his/her supports in care management processes; offering and explaining the SDS option to the member; and following applicable guidelines for restrictive measures and rights limitations. This indicator is a strength for FCP, scoring above 90 percent. Overall results for the indicator increased from the prior review and analysis indicated the year-to-year difference in the rates is likely attributable to actions of the MCOs, and is unlikely to be the result of normal variation or chance. The improvement is likely related to the SDS requirements, which were flexible during the COVID-19 pandemic. The review of the MCP with the member or legal decision maker was considered sufficient for meeting this requirement.

The evaluation of IDT contact requirements under the indicator *IDT Contact*, included monthly collateral contacts, face-to-face contact every three months with the member, and an annual home visit with the member by the care manager and registered nurse care manager. Overall results for the indicator declined from the prior review. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. Missed monthly collateral contacts was the most common reason for this indicator being unmet, followed by lack of a face-to-face contact with the member every three months, or appropriate documentation the member declined a face-to-face contact due to the COVID-19 pandemic.

Results for Coordination for MCOs Operating FCP:



PACE

The *Timely Coordination* indicator evaluates plans put in place by the IDT to ensure member needs and supports are coordinated effectively and in a timely manner. This indicator is a strength for PACE, scoring above 90 percent. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance.

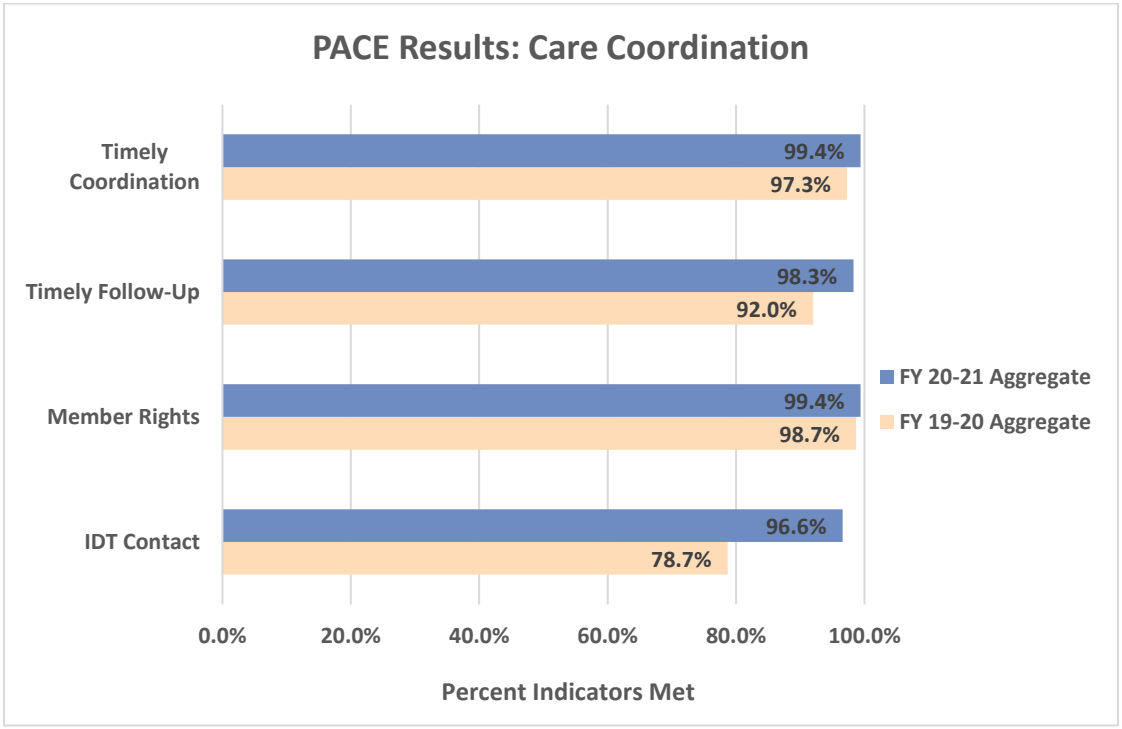
The indicator *Timely Follow-Up* evaluates whether the IDT followed up with members to confirm services and supports were received and effective. This indicator is a strength for PACE, scoring above 90 percent. Overall results for the indicator increased from the prior review and analysis indicated the year-to-year difference in the rates is likely attributable to actions of the

MCO, such as ongoing focused training with IDT staff to identify and document follow-up needs and monitoring to support the focused efforts.

The indicator *Member Rights* evaluates the protection of member rights, such as IDT staff including the member and his/her supports in care management processes; offering and explaining the SDS option to the member; and following applicable guidelines for restrictive measures and rights limitations. This indicator is a strength for PACE, scoring above 90 percent. Overall results for the indicator increased from the prior review and analysis indicated the year-to-year difference in the rates is likely attributable to actions of the MCO, and is unlikely to be the result of normal variation or chance.

The evaluation of IDT contact requirements under the indicator *IDT Contact*, included monthly collateral contacts, face-to-face contact every three months with the member, and an annual home visit with the member by the care manager and registered nurse care manager. The indicator is a strength for PACE, scoring above 90 percent. Overall results for the indicator increased from the prior review and analysis indicated the year-to-year difference in the rates is likely attributable to actions of the MCO, and is unlikely to be the result of normal variation or chance. The improvement may be related to the COVID-19 flexibilities, as requirements for the IDT staff to complete an annual home visit were waived during the FY 20-21 review, which was the *not met* rationale that had the greatest improvement from FY 19-20.

Results for Coordination for the MCO Operating PACE:



ANALYSIS

Aggregate results for all programs was 90.7 percent, indicating a high level of compliance. Aggregate results for individual programs ranged from 87.8 percent to 95.6 percent. In addition to analyzing results by MCO and program, MetaStar reported data by GSR. Results identified which regions in the state were below the statewide rates. This analysis allows the state to identify potential trends in compliance based on location. Further analysis regarding geographic barriers may be warranted, such as MCO staffing patterns and provider network issues. Lastly, a review of member health and safety indicators demonstrate that MCOs are providing the necessary supports to assure member needs are being met.

Statewide Analysis

FC

The FC program scores lowest in areas of *Comprehensive Assessment*, *Comprehensive MCP*, and *Timely Follow-Up*. Analysis by GSR identifies areas of focus for each CMR indicator. Using the statewide rates for FC as the benchmark:

- The results for seven GSRs are below the statewide rate for *Comprehensive Assessment* (83.0 percent): GSRs 2, 4, 9, 10, 11, 12, and 13.
- The results for seven GSRs are below the statewide rate for *Comprehensive MCP* (76.7 percent): GSRs 1, 4, 6, 8, 9, 10, and 11.
- The results for six GSRs are below the statewide rate for *Timely Follow-Up* (85.0 percent): GSRs 1, 2, 3, 4, 11, and 13.

GSRs 4 and 11 are contributing factors in all three focus areas. GSRs 2, 10, and 13 contributed to the low scores in two of the three focus areas.

FCP

The FCP program scores lowest in areas of *Comprehensive MCP*, timely follow-up and *IDT Contact*. Analysis by GSR identifies areas of focus for each CMR indicator. Using the statewide rates for FCP as the benchmark:

- The results for three GSRs are below the statewide rate for *Comprehensive MCP* (68.6 percent): GSRs 5, 8, and 12.
- The results for three GSRs are below the statewide rate for *Timely Follow-Up* (76.7 percent): GSRs 3, 10, and 12.
- The results for two GSRs are below the statewide rate for *IDT Contact* (75.4 percent): GSRs 3 and 12.

GSR 12 contributed to the lower results in all three focus areas. GSR 3 contributed to two of the three areas.

PACE

The PACE program scores lowest in timely assessment. All other areas are above 90 percent. Analysis by GSR identifies areas of focus for the CMR indicator. Using the statewide rate for PACE as the benchmark:

- The results for two GSRs are below the statewide rate for timely assessment (80.6 percent): GSRs 6 and 11.

Member Health and Safety Analysis

No members with health and safety issues was discovered in the random sample of records reviewed. One member with a complex or challenging situation was referred to DHS for additional oversight, assistance, and monitoring.

DHS directed MetaStar to re-review the records of members with health and safety issues and/or complex and challenging situations identified in last year's review. For CCI, this was four members. The individual record review results were provided to DHS and to the MCO, but are not included in the aggregate results in this report. Of the four members identified last year, all member records demonstrated the MCO has sufficiently addressed the issues or situations.

Over the course of the fiscal year, MetaStar also reviewed another 211 member records outside of annual EQR activities, and followed the referral process described above for any member identified as having health and safety issues and/or complex and challenging situations. Again, these reviews were not included in the results for this report.

CONCLUSIONS

A summary of strengths, progress, and recommendations is noted in the *Executive Summary* and *Introduction and Overview* sections above.

APPENDIX V: INFORMATION SYSTEMS CAPABILITIES ASSESSMENT

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

During FY 20-21, MetaStar conducted ISCAs for two MCOs selected by DHS. The organizations were CCI and Inclusa. CCI operates FC, FCP and PACE. Inclusa operates the FC program only.

As a guide for conducting the ISCA, MetaStar used CMS' *EQR Protocol Appendix V: Information Systems Capability Assessment – Activity Required for Multiple Protocols.* Prior to the review, MetaStar and DHS staff met to develop the review methodology and tailor the review activities to reflect DHS expectations for compliance. DHS also directed MetaStar to collect information for specific focus areas that may not be included in the EQR ISCA Protocol.

MetaStar reviewers used an ISCA scoring tool to collect information about the effect of a MCO's information management practices on data submitted to DHS. In addition to completing the ISCA scoring tool, MetaStar asked the MCO to submit documentation specific to its information system and operations used to collect, process, and report data. Reviewers also conducted MCO staff interviews and observed demonstrations of the MCOs' systems. For more detailed information about the review methodology, please see Appendix 2.

SUMMARY AND ANALYSIS OF AGGREGATE RESULTS

This review evaluated the following categories:

- General information;
- Information systems - encounter data flow;
- Data acquisition capabilities - claims and encounter data collection;
- Eligibility and enrollment data processing;
- Practitioner data processing;
- System security;
- Vendor oversight;
- Medical record data collection, if applicable;
- Business intelligence; and
- Performance measures.

Section I: General Information

CCI and Inclusa provided all requested information for this section.

Section II: Information Systems - Encounter Data Flow

The MCOs met all requirements in this focus area. CCI and Inclusa each have thoroughly documented protocols for encounter file production. All necessary data sources are included and validated. The MCOs have detailed and methodical processes for validating the encounter files, researching any data discrepancies and ensuring that no data are lost.

Section III: Data Acquisition – Claims and Encounter Data Collection

The MCOs met all requirements in this focus area. CCI and Inclusa each had processes in place for processing electronic and paper claims, timely and accurately. Appropriate validation checks are in place and no issues or delays with the file transmissions were evidenced.

Section IV: Eligibility and Enrollment Data Processing

The MCOs met all requirements in this focus area. CCI and Inclusa both utilized internal systems to capture and maintain enrollment and eligibility information. The MCOs utilize automated and manual processes to prevent member duplications in the systems and ensures that the information that is maintained is timely, complete, and comprehensive. The information is updated frequently and is validated against external sources, such as the DHS' 834 reports and ForwardHealth web site, as well as the Client Assistance for Re-employment and Economic Support system. The systems also have the ability to gather members' third-party liability (TPL) information including Medicare eligibility, as well as cost-share liability, through State and Federal sources, on an ongoing and real time basis.

Section V: Practitioner Data Processing

The MCOs met all requirements in this focus area. CCI and Inclusa have a provider network system that gathers, stores, operates, and maintains the MCO's provider/practitioner information in support of its care management, provider, and claims processing functions, as well as member/customer relations and contact information. Each system is dynamic and can follow each provider from the time of application, through the process of vetting and credentialing, and through relevant changes such as the addition (or removal) of covered services, disbarment, and changes in contact information. A provider directory, generated by the provider network systems, is available on each MCO's website and reflects current and prospective members of the MCO. CCI and Inclusa both maintain support mechanisms including a help desk for its providers, where practical issues relating to the claims process can be resolved in real time.

Section VI: System Security

CCI and Inclusa met all requirements in this focus area. Neither MCO had issues with system breeches, security concerns, or data corruption. Health Insurance Portability and Accountability Act (HIPAA) training is provided to all new employees. Current employees are required to complete annual compliance training that includes HIPAA training. Additional security measures include secure entry via electronic keycards, malware protection, encrypted email and nightly data back-up.

Section VII: Vendor Oversight

The MCOs met all requirements in this focus area. CCI and Inclusa both demonstrated strong oversight with their vendors, which included routine and ad hoc communication and meetings to address any concerns. Feedback mechanisms such as performance reports, which focus on the accuracy, timing, and completeness of claims processing, are on-going practices for both MCOs.

Section VIII: Medical Record Data Collection

This section only applied to one of the two MCOs reviewed, CCI, which met all requirements in this focus area. The MCO extracts internal encounters from medical records within its software system for all disciplines on the interdisciplinary team. This data extraction is only for the FCP and PACE programs. Volume checks as well as comparison of initial data pulls and final encounter data are completed to ensure accuracy of the data.

Section IX: Business Intelligence

The MCOs met all requirements in this focus area. CCI and Inclusa each perform extensive reconciliations and other comparison activities between its submitted encounter data, and the financial information independently produced off the financial department's general ledger. MCO analytics staff produce multiple reports in support of management decisions and care management operations. The reports are utilized by administrators and care mangers and include information such as, acuity levels, average costs, and utilization rates for high and low-cost services.

Section X: Performance Measure

The MCOs met all requirements in this focus area. CCI and Inclusa review and adhere to the yearly updated DHS technical specifications and follows a process to create a denominator report for each vaccination. Each process includes identifying all members who should receive the influenza and pneumococcal vaccinations based on their age, and length of continued enrollment during the review period, as well as consulting with the Wisconsin Immunization Registry for evidence, including dates, of influenza and pneumococcal vaccinations. All data collected is stored in the MCO's internal systems and used to create the denominator files.

CONCLUSIONS

A summary of strengths, progress, and recommendations is noted in the *Executive Summary* and *Introduction and Overview* sections above.

APPENDIX 1 – LIST OF ACRONYMS

CCI	Community Care, Inc., Managed Care Organization
CFR	Code of Federal Regulations
CMR	Care Management Review
CMS	Centers for Medicare & Medicaid Services
CW	Care Wisconsin, Managed Care Organization
COVID-19	Coronavirus Disease-2019
DHS	Wisconsin Department of Health Services
EQR	External Quality Review
EQRO	External Quality Review Organization
FC	Family Care
FCP	Family Care Partnership
FY	Fiscal Year
GSR	Geographic Service Region
HCBS	Home and Community Based Services Waivers
HEDIS[3]	Healthcare Effectiveness Data and Information Set
*i*Care	Independent Care Health Plan, Managed Care Organization
IDT	Interdisciplinary Team
Inclusa	Inclusa, Inc., Managed Care Organization
ISCA	Information Systems Capabilities Assessment
LCI	Lakeland Care, Inc., Managed Care Organization
LTSS	Long-term services and supports
MCO	Managed Care Organization
MCP	Member-Centered Plan
MCFC	My Choice Family Care, Managed Care Organization
MCW	My Choice Wisconsin, Inc., Managed Care Organization
MY	Measurement Year
NCQA	National Committee for Quality Assurance

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

NOA	Notice of Action
PACE	Program of All-Inclusive Care for the Elderly
PIP	Performance Improvement Project (Validation of Performance Improvement Projects)
PMV	Performance Measures Validation (Validation of Performance Measures)
PIHP	Prepaid Inpatient Health Plan
QAPI	Quality Assessment and Performance Improvement
QCR	Quality Compliance Review
RAD	Resource Allocation Decision
SDS	Self-Directed Supports
TPA	Third Party Administrator
TPL	Third-party liability

APPENDIX 2 – REQUIREMENT FOR EXTERNAL QUALITY REVIEW AND REVIEW METHODOLOGIES

REQUIREMENT FOR EXTERNAL QUALITY REVIEW

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

MetaStar - Wisconsin's External Quality Review Organization

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

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

MetaStar Review Team

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

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

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

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

Review Methodologies

CMS External Quality Review (EQR) Protocols, Protocol 1[5]: Validation of Performance Improvement Projects (PIP)

The purpose of a PIP is to assess and improve the processes and outcomes of health care provided by an MCO. PIP validation, a mandatory EQR activity, documents that a MCO's PIP used sound methodology in its design, implementation, analysis, and reporting. CMS issued the EQR Protocols in 2020 and the *Validation of Performance Improvement Projects* is now Protocol 1. To evaluate the standard elements of a PIP, the MetaStar team used the methodology described in the CMS guide, EQR Protocol 3: *Validating Performance Improvement Projects (PIPs), A Mandatory Protocol for External Quality Reviews (EQR), Version 2.0,* as this was the Protocol in effect during the project timeframe.

MetaStar reviewed the PIP design and implementation, using documents provided by the MCO and discussion with MCO staff.

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

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

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

[5] CMS issued the EQR Protocols in 2020 and the *Validation of Performance Improvement Projects* is now Protocol 1. To evaluate the standard elements of a PIP, the MetaStar team used the methodology described in the CMS guide, EQR Protocol 3: *Validating Performance Improvement Projects (PIPs), A Mandatory Protocol for External Quality Reviews (EQR), Version 2.0,* as this was the Protocol in effect during the project timeframe.

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

CMS External Quality Review (EQR) Protocols, Protocol 2: 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).*

MetaStar reviewed the most recent Information Systems Capabilities Assessment (ISCA) report for each MCO in order to assess the integrity of the MCO's information system. The ISCA is conducted separately, every three years, as directed by DHS.

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 measurement year (MY) 2019. 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 definition requirements established by DHS, including:
    - Ensuring members reported to have contraindications were appropriately excluded from the denominator; and
    - Confirming vaccination data reported for members that met specified age requirements.
- Verified that members included in the numerators met the technical definition requirements established by DHS, ensuring that vaccinations were given within the identified timeframe.
- 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. If the denominator was not within five percentage points of DHS' denominator, the MCO was required to resubmit data.

- Calculated the vaccination rates for each quality indicator by program and target group.
- Compared the MCO's rates for the current MY to both the statewide rates for the current MY and the MCO's rates for prior MY.
- When necessary, MetaStar contacted the MCO to discuss any data errors or discrepancies.

MetaStar 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:

- Reviewed each member's care management record to verify documentation of vaccinations, exclusions, and contraindications as defined by the technical definitions.
- Documented whether the MCO's report of the member's vaccination or exclusion was valid or invalid (the appropriate vaccination was documented for the current measurement year or the MCO provided documentation for the exclusion).

Conducted statistical testing to determine if rates were 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 determined bias at the 95 percent confidence interval.)

CMS External Quality Review (EQR) Protocols, Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations - Quality Compliance Review (QCR)

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, *CMS External Quality Review (EQR) Protocols, Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations, A Mandatory Protocol for External Quality Reviews (EQR).*

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

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

- The MCO's current Family Care Program contracts with DHS;
- Related program operation references found on the DHS website:
    - https://www.dhs.wisconsin.gov/familycare/mcos/index.htm;
- The previous external quality review report; and

- DHS communication with the MCO about expectations and performance during the previous 12 months.

The review assesses the strengths and weaknesses of the MCO related to quality, timeliness, and access to services, including health care and LTSS. MetaStar conducted a document review to evaluate policies, procedures, and practices within the organization. The review assessed information about the MCO's structure, operations, and practices, including organizational charts, results and analysis of internal monitoring, and staff training.

Interview sessions were then held onsite or by video conference to collect additional information necessary to assess the MCO's compliance with federal and state standards. Participants in the interview sessions included MCO administrators, supervisors and other staff responsible for supporting care managers, staff responsible for improvement efforts, and social work and registered nurse care managers.

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

MetaStar worked with DHS to identify 31 standards that include federal and state requirements applicable to FC, FCP and PACE. At the direction of DHS, the first year the MCO Standards are assessed. The second year, the QAPI and Grievance standards are assessed.

Focus Area	Related Sub-Categories in Review Standards
MCO Standards – 16 Standards	• Enrollee Rights and Protections - 42 CFR 438.100 • Availability of Services - 42 CFR 438.206 • Assurance of Adequate Capacity and Services - 42 CFR 438.207 • Coordination and Continuity of Care - 42 CFR 438.208 • Disenrollment 42 CFR 438.56 • Coverage and Authorization of Services - 42 CFR 438.210 • Provider Selection - 42 CFR 438.214 • Confidentiality - 42 CFR 438.224 • Subcontractual Relationships and Delegation - 42 CFR 438.230 • Practice Guidelines - 42 CFR 438.236 • Health Information Systems - 42 CFR 438.242

Focus Area	Related Sub-Categories in Review Standards
Quality Assessment and Performance Improvement (QAPI) – Five Standards	Quality Assessment and Performance Improvement Program 42 CFR 438.330: • Quality Management Program Structure • Documentation and monitoring of required activities in the Quality Management program • Annual Quality Management Program Evaluation • Performance Measure Validations • Performance Improvement Projects
Grievance System – 10 Standards	Grievance and Appeal Systems 42 CFR 438.228 and 42 CFR 438.400: • General Process Requirements • Filing Requirements for Grievances and Appeals • Content and Timing for Issuing Notices to Members • Handling of Local Grievances and Appeals • Resolution and Notification Requirements • Expedited Resolution of Appeals • Information about the Grievance and Appeal System to Providers • Recordkeeping Requirements • Continuation of Benefits while the MCO Appeal and State Fair Hearing are Pending • Effectuation of Reversed Appeal Resolutions

Each standard has a specified number of scoring elements, which correlate with the DHS-MCO Contract requirements. Standard scores are presented as the number of compliant elements out of the total number of scoring elements possible for each standard. This provides a percentage score, which correlates with the DHS Score Card Star Ratings:

Scoring Legend		
Percentage Met	**Stars**	**Rating**
90.0% - 100.0% = 5 Stars	★★★★★	EXCELLENT
80.0% - 89.9% = 4 Stars	★★★★	VERY GOOD
70.0% - 79.9% = 3 Stars	★★★	GOOD
60.0% - 69.9% = 2 Stars	★★	FAIR
< 60.0% = 1 Star	★	POOR

The following definitions are used to determine compliance for each scoring element:

Compliant:

- All policies, procedures, and practices were aligned to meet the requirements, **and**

- Practices were implemented, **and**
- Monitoring was sufficient to ensure effectiveness.

Not Compliant:

- 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.

For findings of non-compliance, the EQR team documented the missing requirements related to the findings and provided recommendations.

CMS External Quality Review (EQR) Protocols, Protocol 9: Conducting Focus Studies of Health Care Quality- Care Management Review (CMR)

MetaStar randomly selected a sample of member records. 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.

As directed by DHS, MetaStar also reviewed 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 20-21 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:

- Comprehensive Assessment
- Member Centered Planning
- Care Coordination
- Quality of Care

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.

CMS External Quality Review (EQR) Protocols, Appendix V: Information Systems Capabilities Assessment

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

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

- DHS-MCO contract;

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

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

MetaStar visited the MCO to perform staff interviews to:

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

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

Section I: General Information

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

Section II: Information Systems – Encounter Data Flow

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

Section III: Data Acquisition - Claims and Encounter Data Collection

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

Section IV: Eligibility and Enrollment Data Processing

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

Section V: Practitioner Data Processing

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

Section VI: System Security

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

Section VII: Vendor Oversight

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

Section VIII: Medical Record Data Collection

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

Section IX: Business Intelligence

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

Section X: Performance Measure

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

Appendix 3 – Quality Compliance Review: FY 20-21 MCO Comparative Scores

Standard	Citation	Managed Care Programs FY 20-21				
		CCI	Inclusa	*i*Care	LCI	MCW
M1	*Availability of services - 42 CFR 438.206*	100.0%	100.0%	100.0%	100.0%	100.0%
M2	*Timely access to services - 42 CFR 438.206(c)(1)*	100.0%	100.0%	100.0%	100.0%	100.0%
M3	*Cultural considerations in services - 42 CFR 438.206(c)(2)*	100.0%	100.0%	100.0%	100.0%	100.0%
M4	*Network adequacy - 42 CFR 438.207*	100.0%	100.0%	100.0%	100.0%	66.7%
M5	*Coordination and continuity of care, and confidentiality - 42 CFR 438.208, 42 CFR 438.224*	100.0%	91.7%	91.7%	100.0%	100.0%
M6	*Coordination and continuity of care, and confidentiality - 42 CFR 438.208, 42 CFR 438.224*	80.0%	80.0%	90.0%	80.0%	90.0%
M7	*Disenrollment: requirements and limitations - 42 CFR 438.56*	100.0%	100.0%	100.0%	100.0%	100.0%
M8	*Coverage and authorization of services - 42 CFR 438.210, 42 CFR 440.230, 42 CFR 438.441*	100.0%	100.0%	100.0%	100.0%	100.0%
M9	*Information requirements for all enrollees - 42 CFR 438.100(b)(2)(i), 42 CFR 438.10*	91.7%	91.7%	100.0%	100.0%	100.0%
M10	*Enrollee right to receive information on available provider options - 42 CFR 438.100(b)(2)(iii), 42 CFR 438.102*	100.0%	75.0%	100.0%	100.0%	75.0%
M11	*Enrollee right to participate in decisions regarding his or her care and be free from any form of restraint - 42 CFR 438.100(b)(2)(iv) and (v), 42 CFR 438.3(j)*	100.0%	100.0%	100.0%	100.0%	54.5%
M12	*Compliance with other federal and state laws - 42 CFR 438.100(d)*	100.0%	100.0%	100.0%	100.0%	100.0%
M13	*Provider selection - 42 CFR 438.214*	92.3%	92.3%	100%	92.3%	84.6%
M14	*Subcontractual relationships and delegation - 42 CFR 438.230*	87.5%	100.0%	100.0%	100.0%	100.0%
M15	*Practice guidelines - 42 CFR 438.236*	50.0%	100.0%	100.0%	100.0%	100.0%
M16*	*Health information systems – 42 CFR 438.242*	NA	NA	NA	NA	NA
Overall		**94.0%**	**94.5%**	**98.3%**	**97.2%**	**90.6%**

*M16, is evaluated through reviews that occur separate from the QCR