MetaStar

External Quality Review

Calendar Year 2023

Prepared for

Wisconsin Department of Health Services

Division of Medicaid Services

Annual Technical Report

BadgerCare Plus, Medical Homes, Prepaid Inpatient Health Plans, and Medicaid Supplemental Security Income Managed Care

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Executive Summary

Background

Wisconsin Medicaid began delivering services through a managed care model in the mid-1980s for acute care needs. Populations and programs expanded to serve individuals with special health care needs, including individuals with disabilities and eligible for Supplemental Security Income. By the early 2000s, Medicaid managed care was expanded statewide. Today, Wisconsin has two primary Medicaid managed care programs, operated by multiple organizations across the state, to support the acute, primary, and behavioral health needs of adults and children. One program is for adults only, while the other includes adults and children and is the state's Children's Health Insurance Program (CHIP). Additional programs were implemented to provide long term services and supports to adults with developmental and physical disabilities, and elderly individuals. All programs in Wisconsin operate with the goals of improving access, member choice, and health equity.

The Code of Federal Regulations (CFR) at 42 CFR 438 requires states that operate pre-paid inpatient health plans and managed care organizations to conduct 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 is the annual technical report that the State of Wisconsin must provide to the CMS related to the operation of its Medicaid managed care programs. Additionally, the report contains results of optional reviews conducted on behalf of DHS for programs that are not Medicaid managed care programs. Programs reviewed include Children with Medical Complexities, Human Immunodeficiency Virus /Acquired Immunodeficiency Syndrome (HIV/AIDS) Health Home, and Obstetric Medical Home. Reviews for the programs, Children with Medical Complexities and HIV/AIDS Health Home, evaluated the practices and requirements related to care management. The review, Obstetric Medical Home, is reported separately. See Appendix 2 for more information about external quality review and a description of the methodologies used to conduct review activities.

Scope of External Quality Review Activities

This report covers the external quality review calendar year from January 1, 2023 - December 31, 2023 (CY 2023). Mandatory review activities conducted during the year included validation of performance improvement projects, validation of performance measures, assessment of

compliance with federal standards, 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 and also supports assessment of compliance with federal standards.

Protocol 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. 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. MetaStar validated the projects conducted by each organization in measurement year 2022.

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.

According to 42 CFR 438.360, states have the option to utilize results from a private accreditation review to avoid duplication if the requirements are comparable to standards identified in the EQR protocols and 42 CFR 438.358. The performance measures identified by the DHS for validation are Healthcare Effectiveness Data and Information Set measures and are validated by a National Committee for Quality Assurance certified auditor, then submitted to DHS. MetaStar did not validate the measures but does conduct an analysis of the reported results.

Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations – Compliance with Standards

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.

According to 42 CFR 438.360, states have the option to utilize results from a private accreditation review to avoid duplication if the requirements are comparable to standards identified in the EQR protocols and 42 CFR 438.358. Using a crosswalk identifying the requirements evaluated through a compliance with standards review compared to those evaluated through the National Committee for Quality Assurance Health Plan Accreditation, MetaStar identified gaps between the sets of requirements. Managed care organizations submitted the remaining documents and results are comparable to compliance with standards general categories of Managed Care Organization Standards; 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 and helps determine an organization's level of compliance with its contract with DHS.

Care Management Review – Supplemental Security Income Program

The goal of the Supplemental Security Income program is to improve the health of its members and enhance quality of care while reducing health care costs. The goal is achieved through a comprehensive, integrated care model; incorporating social, behavioral health, and medical needs for members. Each managed care organization is responsible for establishing a team-based care management model that assures coordination and integration of all aspects of all members' health care needs. The managed care organization must also promote effective communication and shared decision-making between the care management team and the member regarding the member's care. Based on health conditions and social determinants of health, the managed care organization must stratify members into different care management needs groups which must include a Wisconsin Interdisciplinary Care Team structure for members with the highest needs.

Care Management Review – Foster Care Medical Home

The Foster Care Medical Home was established in 2014 under an Alternative Benefit Plan State Plan Amendment as allowed in federal law under Section 1937 of the Social Security Act (2010). The program is a pre-paid inpatient health plan operated in six counties in southeastern Wisconsin by one managed care organization. The program provides comprehensive and

coordinated health care for children in out-of-home care in a way that reflects their unique health needs. Participation in the program is voluntary. All children placed in eligible out-of-home care settings and under the jurisdiction of the child welfare system within the six Wisconsin counties may participate in the program.

The organization must establish a health care management structure that assures coordination and integration of all aspects of the child's health care needs and promotes effective communication between the individuals who are instrumental to the child's care.

Care Management Review – Wraparound Milwaukee

The Wraparound Milwaukee program coordinates behavioral health services for children and youth in Milwaukee County who have a mental health or substance use diagnosis. The program helps children and youth stay in their home or in community care. Each program participant has a team to help develop and successfully carry out their care plan. Team members may include a Wraparound Milwaukee coordinator, family members, social worker, teacher, and/or therapist.

Appendix A: 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.

According to 42 CFR 438.360, states have the option to utilize results from a private accreditation review to avoid duplication if the requirements are comparable to standards identified in the EQR protocols and 42 CFR 438.358. Using a crosswalk identifying the requirements evaluated through an information systems capabilities assessment compared to those evaluated through the National Committee for Quality Assurance Health Plan Accreditation, MetaStar determined that the accreditation review fully evaluates all requirements identified through Appendix A of the CMS EQR Protocol.

Optional Reviews: Other Medicaid Programs

Record Review – Children with Medical Complexity

Children with Medical Complexity is a target group covered under the Medicaid-targeted case management benefit. It is administered fee-for-service for all Medicaid-enrolled members who

demonstrate medical necessity for covered services. The benefit is separate from managed care organizations and prepaid inpatient health plans. This activity was requested and directed by DHS to assess the access, quality, and appropriateness of care provided to members.

Record Review – Human Immunodeficiency Virus /Acquired Immunodeficiency Syndrome Health Home

The Affordable Care Act of 2010 Section 2703 and Social Security Act Section 1945 created an optional Medicaid benefit that allows states to establish health homes to coordinate care for people who have chronic conditions across all healthcare settings and community care settings. The goals of health homes are to improve health outcomes while lowering Medicaid costs, and to reduce preventable hospitalizations, emergency room visits, and unnecessary care for Medicaid members. Member participation is voluntary, and members must have a diagnosis of human immunodeficiency virus and at least one other chronic condition, or be at risk of developing another chronic condition. The health home provider is accountable for the total care of the member, using a patient-centered model, which includes a care team working with the member to meet their medical, dental, behavioral health, pharmacy, care management, and social service needs.

Record Review – Obstetrics Medical Home/Healthy Birth Outcomes

The Obstetrics Medical Home initiative was established in 2011. The program is a patient-centered, comprehensive, coordinated, and team-based care delivery model, focused on reducing poor birth outcome disparities. A key component of the program is enhanced care coordination provided early in the prenatal period through the postpartum period to high-risk pregnant women in eight Wisconsin counties.

During CY 2023, DHS directed MetaStar to perform data abstraction reviews of its Medical Home initiative for pregnant women. Results from the data abstraction are used by DHS to determine administrative payments to organizations, based on compliance with specific requirements detailed in the DHS contract. Due to the timelines associated with this retrospective review, the results of this optional activity are reported separately.

State-Level Analysis: Quality, Timeliness, and Access

The state-level strengths, progress, and recommendations correspond to the quality, timeliness, and access of services provided to members.

- Quality: The degree to which a program increases the likelihood of desired outcomes to its members through (1) its structural and operational characteristics, (2) the provision

of service that are consistent with current professional, evidenced-based knowledge, and (3) interventions for performance improvement.

- Timeliness: Reducing wait and sometimes harmful delays, and is interrelated with safety, efficiency, and patient-centeredness of care.
- Access: The timely use of services to achieve optimal outcomes, as evidenced my managed care plans successfully demonstrating and reporting on outcome information for availably and timeliness elements.

The tables below highlight 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. State level findings of strengths, progress, and recommendations to address weaknesses are included.

Protocol 1: Validation of Performance Improvement Projects			
Quality	**Timeliness**	**Access**	**Strengths, Progress, and Recommendations**
✓	✓	✓	Strengths: – Project topics were selected based on detailed research and its importance to members. – Projects contained clear, concise, measurable and answerable aim statements. – Project populations were clearly identified in relation to aim statements. – Selected project variables and process measures were clear indicators of performance. – Projects documented valid and reliable procedures to collect data and inform its measurements. Progress: – Recommendations from the prior review were not sufficiently addressed. Recommendations: – Ensure each project utilizes appropriate techniques to conduct analysis and interpretation of the results, including an assessment of the extent to which any change in performance is statistically significant. – Ensure each project utilizes evidence-based interventions that are routinely assessed to lead to the desired improvement. – Ensure each project conducts repeated measurements using the same methodology and documents if a significant change in performance relative to the baseline occurred.

Protocol 2: Validation of Performance Measure Validation			
Quality	**Timeliness**	**Access**	**Strengths, Progress, and Recommendations**
✓	✓	✓	Strengths: – Antidepressant Medication Management. – Hemoglobin A1C Control for Patients with Diabetes. Progress: – The Wisconsin Department of Health Services transitioned to weighted rates for statewide quality indicators reported in CY 2023. Performance Measure Validation reporting is based on the new weighted methodology; therefore, the statewide rates are not comparable to previous years. Recommendations: – Improve Childhood Immunizations. – Improve Immunizations for Adolescents. – Improve Lead Screening in Children. – Improve Postpartum Care. – Improve Prenatal Care. – Improve Asthma Medication Ration. – Improve Follow-Up After Hospitalization for Mental Illness. – Improve Follow-Up After Emergency Department Visit for Mental Illness.

Protocol 3: Compliance with Managed Care Regulations			
Quality	**Timeliness**	**Access**	**Strengths, Progress, and Recommendations**
✓	✓	✓	Strengths: – The organizations had strong systems in place to help members understand their rights as well as ensuring those rights are protected. – The organizations demonstrated the ability to ensure availability of accessible, culturally competent services through a network of qualified service providers. Progress: – The prior review, conducted in CY 2021 evaluated all standards and identified recommendations for Grievance Systems only. The review conducted in CY 2023 did not evaluate Grievance Systems. These recommendations will be evaluated in the CY 2024 review. There were no recommendations for the state to address related to the standards evaluated in CY 2023.

Protocol 3: Compliance with Managed Care Regulations			
Quality	**Timeliness**	**Access**	**Strengths, Progress, and Recommendations**
			Recommendations: – Implement procedures that include all state and federal requirements to deliver care to and coordinate services for all managed care organization members. – Develop processes that comply with member disenrollment requirements. – Ensure policies and procedures for service authorizations comply with all requirements. – Adopt clinical practice guidelines that meet state and federal requirements.

Protocol 9: Conducting Focused Studies of Health Care Quality – Care Management Review Supplemental Security Income			
Quality	**Timeliness**	**Access**	**Strengths, Progress, and Recommendations**
✓	✓	✓	Strengths: – Member screens were comprehensive. – Members agreed to their care plans prior to its implementation. Progress: – Following the CY 2021 review, revisions were made at the request of the Wisconsin Department of Health Services. Ratings from the previous reviews are not comparable. Recommendations: – Ensure member screens are completely timely. – Conduct comprehensive care planning by ensuring care plans are completed timely, are comprehensive, and are shared with all required individuals. – Provide strong care coordination by contacting members based on their needs and stratification level and providing timely and ongoing follow-up for members' needs. – Ensure care plans are reviewed and updated at least annually or when a change in members' needs. – Re-stratify members after each critical event. – Conduct timely and comprehensive transition planning for members discharging from an inpatient hospital setting. – Ensure the Wisconsin Interdisciplinary Care Team is comprised of two licensed healthcare professionals, meet weekly to discuss members, and have face-to-face monthly contact with members.

Protocol 9: Conducting Focused Studies of Health Care Quality – Care Management Review Foster Care Medical Home			
Quality	**Timeliness**	**Access**	**Strengths, Progress, and Recommendations**
✓	✓	✓	Strengths: – Out-of-Home Care Health Screens were timely and comprehensive. – Care plans were developed and reviewed timely. – Care plans were comprehensive. Progress: – Following the CY 2022 review, revisions were made at the request of the Wisconsin Department of Health Services. Ratings from the previous reviews are not comparable. Recommendations: – Conduct initial health assessments timely. – Ensure the initial health assessments are comprehensive. – Include input from all required individuals into each care plan review. – Complete timely follow-up for member needs and services. – Ensure transition plans are created timely. – Ensure transition plans are reviewed and updated timely. – Include input from all required individuals into each transition plan review. – Ensure transition plans are comprehensive.

Protocol 9: Conducting Focused Studies of Health Care Quality – Care Management Review Wraparound Milwaukee			
Quality	**Timeliness**	**Access**	**Strengths, Progress, and Recommendations**
✓	✓	✓	Strengths: – Initial screens were conducted timely. – Assessments were conducted timely. – The treatment team was documented. – Input to the care plan was obtained from all required team members. – Transition plans were created timely. Progress: – The care management review was newly created in CY 2023; therefore, no results are available to identify progress.

Protocol 9: Conducting Focused Studies of Health Care Quality – Care Management Review Wraparound Milwaukee			
Quality	**Timeliness**	**Access**	**Strengths, Progress, and Recommendations**
			Recommendations: – Ensure initial eligibility determination is completed timely. – Ensure assessments are comprehensive. – Ensure all required tasks are completed prior to care plan development. – Create and update care plans timely and ensure care plans are comprehensive. – Obtain care plan signatures from all required team members. – Conduct timely follow-up for all member needs and requests. – Obtain transition plan input from all required team members.

Appendix A: Information Systems Capabilities Assessments			
Quality	**Timeliness**	**Access**	**Strengths, Progress, and Recommendations**
✓	✓		Strengths: – Of the organizations reviewed, nine out of eleven organizations fully met the requirements evaluated through the Healthcare Effectiveness Data and Information Set audit. Progress: – Information Systems Capabilities Assessments were not evaluated in previous years; therefore, progress cannot be identified. Recommendations: – The two organizations not fully met for the requirements should ensure supplemental data and data preproduction processing processes are compliant with requirements.

Non-Managed Care Programs – Record Review Children with Medical Complexity			
Quality	**Timeliness**	**Access**	**Strengths, Progress, and Recommendations**
✓	✓	✓	Strengths: – Eligibility requirements and consent to the program was obtained and documented as required. – Assessments were timely and comprehensive. – When services were reduced or terminated, member and family agreement was obtained and advanced notice was given.

Non-Managed Care Programs – Record Review Children with Medical Complexity			
Quality	**Timeliness**	**Access**	**Strengths, Progress, and Recommendations**
			– Involuntary disenrollment requirements were met when a member was involuntarily disenrolled from the program. Progress: – Recommendations from the prior review were not sufficiently addressed. Recommendations: – Complete care plans timely. – Ensure care plans are comprehensive.

Non-Managed Care Programs – Record Review HIV/AIDS Health Home			
Quality	**Timeliness**	**Access**	**Strengths, Progress, and Recommendations**
✓	✓	✓	Strengths: – The organization ensured members served by the program meet eligibility requirements. – Members were informed that participation in the health home program is voluntary Progress: – The record review was revised for CY 2023; therefore, no results are available to identify progress. Recommendations: – Conduct discussions with members regarding the ability to appoint an authorized agent to support the member. – Ensure the timeliness of initial assessments and annual reassessments. – Update assessments to ensure the inclusion of all requirements as outlined in the Medicaid Handbook, including the pharmacist review of medications. – Complete initial care planning and updates to the plan timely. – Prioritize the implementation of a comprehensive care plan. – Implement a process to ensure follow up to community referrals are completed no later than two weeks after the referral. – Develop a systematic approach to ensure regular contact with members including face-to-face contacts.

Non-Managed Care Programs – Record Review HIV/AIDS Health Home			
Quality	**Timeliness**	**Access**	**Strengths, Progress, and Recommendations**
			– Ensure timely and comprehensive follow up for the transition of care following hospitalizations and emergency department visits.

State Quality Strategy

The Wisconsin Medicaid Management Care Quality Strategy (Quality Strategy) outlines the Wisconsin DHS managed care quality goals, objectives, strategies, and programs, and establishes mechanisms for monitoring progress. The Quality Strategy serves as the framework for communicating Wisconsin's approach to assess and improve the quality of managed care services offered to Medicaid beneficiaries.

Wisconsin DHS utilizes three types of strategies[1]:

- Payment – A value-based reimbursement arrangement is used to align payment to outcomes. These arrangements include pay-for-performance initiatives for clinical measures, member satisfaction scores, member engagement in Competitive Integrated Employment, quality of Assisted Living Communities; and reducing potentially preventable hospital readmissions.
- Delivery System and Person-Centered Care - Delivery system strategies focus on the way organizations care for members. These strategies emphasize care management and coordination, use of health homes and medical homes for specific conditions and populations, and continual attention to the health and safety of Medicaid members. Person-centered care strategies focus on building partnerships between members and their care teams and emphasize high-quality, evidence-based, accessible care in which individual needs, preferences, and values of members and caretakers are paramount.
- Member Engagement and Choice - Member engagement and choice are critical strategies for promoting active participation of members in their own health care decisions, encouraging appropriate utilization of benefits, and ensuring that members receive services and supports according to their needs and preferences. These strategies involve providing culturally competent member services, objective information about care options, and support for employment.

[1] *Information sourced from the Wisconsin Department of Health Services 2021 Medicaid Managed Care Quality Strategy*

Each Medicaid managed care program in Wisconsin has a key role in member outcomes and are expected to participate in efforts to achieve the goals of the Quality Strategy. The external quality review activities conducted by MetaStar help support a system of accountability to ensure programs are operating within the framework. The results of these reviews give DHS a sense for the organization's level of infrastructure and consistency necessary to support quality improvement. Review activities assess the extent to which each organization's policies, processes, and procedures meet state standards for compliance and quality improvement. They help determine the level of compliance with the contract with DHS and the organization's ability to safeguard members' health and welfare, as well as the ability to effectively support care management teams in the delivery of cost effective, outcome-based services.

The state must submit the Quality Strategy to CMS, and review and update the strategy every three years, at a minimum. The review must include an evaluation of the effectiveness of the quality strategies. Evaluation was conducted through the CMS EQR Protocols which identified strengths in practice, or effective strategies, and recommendations, or areas that need updated. The table below includes the evaluation for each of the state's quality strategies identified in the *2021 Medicaid Managed Care Quality Strategy*.

The State Quality Strategy Evaluation		
State Quality Strategies	**Strengths**	**Recommendations**
Enhance Value-Based Purchasing	Protocol 2: – The statewide rates for the following measures met or exceeded the national 75th percentile benchmark: ○ Antidepressant Medication Management; and, ○ Hemoglobin A1C Control for Patients with Diabetes.	Protocol 2: – Focus efforts on improving the following rates to meet or exceed the national 75th percentile benchmark: ○ Childhood Immunizations; ○ Immunizations for Adolescents; ○ Lead Screening in Children; ○ Postpartum Care; ○ Prenatal Care; ○ Asthma Medication Ration; ○ Follow-Up After Hospitalization for Mental Illness; and, ○ Follow-Up After Emergency Department Visit for Mental Illness.

The State Quality Strategy Evaluation		
State Quality Strategies	**Strengths**	**Recommendations**
Reduce Avoidable, Non-Value Added Care	Protocol 2: – The organizations facilitated avoidable non-value added care by meeting or exceeding national benchmarks for: ○ Antidepressant Medication Management; and, ○ Hemoglobin A1C Control for Patients with Diabetes. Protocol 3: – The organizations demonstrated the ability to reduce barriers to care by ensuring the availability of accessible, culturally competent services through a network of qualified service providers.	Protocol 2: – To reduce preventable readmissions, organizations should improve rates for: ○ Childhood Immunizations; ○ Immunizations for Adolescents; ○ Lead Screening in Children; ○ Postpartum Care; ○ Prenatal Care; ○ Asthma Medication Ration; ○ Follow-Up After Hospitalization for Mental Illness; and, ○ Follow-Up After Emergency Department Visit for Mental Illness. Protocol 3: – Focus efforts to ensure all organizations' policies and procedures for service authorizations comply with state and federal requirements, to reduce preventable readmissions. Protocol 9: – To reduce avoidable, non-value added care, Supplemental Security Income programs should: ○ Update care plans for members changing needs; ○ Re-stratify members after a critical event; ○ Conduct timely and comprehensive hospital discharge transition planning; and, ○ Ensure members receive the

The State Quality Strategy Evaluation		
State Quality Strategies	**Strengths**	**Recommendations**
		appropriate level of care management such as the Wisconsin Interdisciplinary Care Team program.
Enhance Care Coordination and Person-Centered Care	Protocol 1: – Project topics focused on improving key aspects of care for members. Protocol 2: – The organizations provided person-centered care by meeting or exceeding national benchmarks for: ○ Antidepressant Medication Management; and, ○ Hemoglobin A1C Control for Patients with Diabetes. Protocol 3: – The organizations had strong systems in place to help members understand their rights as well as ensuring those rights are protected. – To support person-centered care, the organizations demonstrated the ability to ensure availability of accessible, culturally competent services through a network of qualified service providers. Protocol 9: – The Supplemental Security Income program ensured appropriate care coordination and person-centered care by: ○ Conducting comprehensive member screens; and, ○ Obtaining member agreement to the care	Protocol 2: – The organizations should improve the following measures to ensure person-centered care: ○ Childhood Immunizations; ○ Immunizations for Adolescents; ○ Lead Screening in Children; ○ Postpartum Care; ○ Prenatal Care; ○ Asthma Medication Ration; ○ Follow-Up After Hospitalization for Mental Illness; and, ○ Follow-Up After Emergency Department Visit for Mental Illness. Protocol 3: – The organizations should implement procedures that include all state and federal requirements to deliver care to and coordinate services for all managed care organization members. – To promote effective care coordination, organizations should develop processes that comply with member disenrollment requirements. Protocol 9: – Supplemental Security Income programs must conduct person-centered care planning by ensuring care plans are completed timely, are

The State Quality Strategy Evaluation		
State Quality Strategies	**Strengths**	**Recommendations**
	plan prior to its implementation.	comprehensive, and are shared with all required individuals. – Supplemental Security Income programs must provide strong care coordination by contacting members based on their needs and stratification level and providing timely and ongoing follow-up for members' needs. – Supplemental Security Income programs should ensure care plans are reviewed and updated at least annually or when a change in members' needs.
Improve Health Homes	Protocol 9: – The HIV/AIDS Health Home ensured members served by the program meet eligibility requirements. – HIV/AIDS Health Home members were informed that participation in the health home program is voluntary	Protocol 9: – The HIV/AIDS Health Home should conduct discussions with members regarding the ability to appoint an authorized agent to support the member. – The HIV/AIDS Health Home should ensure the timeliness of initial assessments and annual reassessments. – The HIV/AIDS Health Home must update assessments to ensure the inclusion of all requirements as outlined in the Medicaid Handbook, including the pharmacist review of medications. – The HIV/AIDS Health Home must complete initial care planning and updates to the plan timely. – The HIV/AIDS Health Home should prioritize the implementation of a comprehensive care plan. – The HIV/AIDS Health Home should implement a process to ensure follow up to community referrals are completed no later than two weeks after the referral.

The State Quality Strategy Evaluation		
State Quality Strategies	**Strengths**	**Recommendations**
		– The HIV/AIDS Health Home should develop a systematic approach to ensure regular contact with members including face-to-face contacts. – The HIV/AIDS Health Home must ensure timely and comprehensive follow up for the transition of care following hospitalizations and emergency department visits.
Ensure Health and Safety	Protocol 1: – Project topics focused on improving key aspects of care for members. Protocol 2: – The organizations ensured member health and safety by meeting or exceeding national benchmarks for: ○ Antidepressant Medication Management; and, ○ Hemoglobin A1C Control for Patients with Diabetes. Protocol 3: – The organizations had strong systems in place to help members understand their rights as well as ensuring those rights are protected. Protocol 9: – The Supplemental Security Income program conducted comprehensive member screens to evaluate members' health and safety needs.	Protocol 2: – To ensure member health and safety, the organizations should improve the following measures: ○ Childhood Immunizations; ○ Immunizations for Adolescents; ○ Lead Screening in Children; ○ Postpartum Care; ○ Prenatal Care; ○ Asthma Medication Ration; ○ Follow-Up After Hospitalization for Mental Illness; and, ○ Follow-Up After Emergency Department Visit for Mental Illness. Protocol 3: – The organizations should adopt clinical practice guidelines that meet state and federal requirements. Protocol 9: – To ensure members' health and safety needs, the Supplemental Security Income program should: ○ Contact members based on their needs

The State Quality Strategy Evaluation		
State Quality Strategies	**Strengths**	**Recommendations**
		and stratification level and providing timely and ongoing follow-up for members' needs; ○ Re-stratify members after each critical event; and, ○ Ensure the case management program for members with the highest needs, the Wisconsin Interdisciplinary Care Team, is comprised of two licensed healthcare professionals, meet weekly to discuss members, and have face-to-face monthly contact with members.
Promote Member Engagement	Protocol 1: – Project topics were selected based on detailed research and its importance to members. Protocol 3: – The organizations had strong systems in place to help members understand their rights as well as ensuring those rights are protected. Protocol 9: – The Supplemental Security Income program promoted member engagement by ensuring member agreement to the care plan prior to implementation.	Protocol 9: – To support member engagement, the Supplemental Security Income programs should provide strong care coordination by contacting members based on their needs and stratification level and providing timely and ongoing follow-up for members' needs.

Introduction and Overview

This report covers mandatory and optional external quality review (EQR) activities conducted by the external quality review organization (EQRO), MetaStar, Inc., for the calendar year from January 1, 2023 - December 31, 2023 (CY 2023).

The following programs are evaluated through this report:

- BadgerCare+ (BC+);
- Supplemental Security Income (SSI);
- Foster Care Medical Home (FCMH);
- Wraparound Milwaukee (WM);
- Children Come First (CCF);
- Children with Medical Complexities (CMC); and
- Human Immunodeficiency Virus /Acquired Immunodeficiency Syndrome (HIV/AIDS) Health Home

Acronyms and Abbreviations

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

Overview of Wisconsin's SSI, BC+, FCMH, WM, AND CCF Organizations

As of December 2023, enrollment was as follows:

Program	Enrollment
Supplemental Security Income Medicaid	57,416
BadgerCare Plus	951,281
Foster Care Medical Home	2,722
Wraparound Milwaukee	604
Children Come First	0

Current enrollment data is available at the following DHS website:

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

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

The following table identifies the programs each organization operates, the accreditation status and accrediting organization (where applicable).

Managed Care Organization	Program(s)	Accreditation Organization and Status
Anthem Blue Cross and Blue Shield Health Plan (Anthem)	BC+ SSI	National Committee for Quality Assurance (NCQA) Medicaid Accreditation Health Equity Accreditation Expires:10/11/2024
Chorus Community Health Plan, Inc. (CCHP)	BC+ FCMH	NCQA Medicaid Accreditation Health Equity Accreditation Expires: 12/18/2026
Dean Health Plan, Inc. (DHP)	BC+	NCQA Medicaid Accreditation Health Equity Accreditation Expires: 5/1/2026
Group Health Cooperative of Eau Claire (GHC-EC)	BC+ SSI	NCQA Medicaid Accreditation Multicultural Healthcare Distinction Expires: 9/5/2026
Group Health Cooperative of South-Central Wisconsin (GHC-SCW)	BC+	NCQA Medicaid Accreditation Health Equity Accreditation Expires: 11/21/2026
Independent Care Health Plan (*i*Care)	BC+ SSI	NCQA Medicaid Accreditation Health Equity Accreditation Expires: 11/29/2026
MercyCare Health Plans (MCHP)	BC+	NCQA Medicaid Accreditation Multicultural Healthcare Distinction Expires: 12/18/2026
MHS Health Wisconsin (MHS)	BC+ SSI	NCQA Medicaid Accreditation Health Equity Accreditation Expires: 8/12/2025
Molina HealthCare of Wisconsin (MHWI)	BC+ SSI	NCQA Medicaid Accreditation Health Equity Accreditation Expires: 6/20/2026

Managed Care Organization	Program(s)	Accreditation Organization and Status
My Choice Wisconsin Health (MCW)	BC+ SSI	NCQA Interim Medicaid Accreditation Health Equity Accreditation Expires: 5/14/2025 *MCW was acquired by MHWI in 2023.
Network Health Plan (NHP)	BC+ SSI	NCQA Medicaid Accreditation Health Equity Accreditation Expires: 9/6/2026
Quartz Health Solutions, Inc. (Quartz)	BC+ SSI	NCQA Medicaid Accreditation Health Equity Accreditation Expires: 11/7/2026
Security Health Plan (SHP)	BC+ SSI	NCQA Provisional Medicaid Accreditation Health Equity Accreditation Expires: 8/12/2024
United Healthcare Community Plan (UHC)	BC+ SSI	NCQA M Medicaid Accreditation Health Equity Accreditation Expires: 2/8/2026
Prepaid Inpatient Health Plan	**Program(s)**	**Accreditation Organization and Status**
Children Come First (CCF)	This program serves children with mental health needs	Not Accredited
Wraparound Milwaukee (WM)	This program serves children with mental health needs	Not Accredited

Organization-Level Analysis: Quality, Timeliness, Access

The Centers for Medicare & Medicaid Services (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. The Medicaid MCOs and prepaid inpatient health plans (PIHP) included in this report do not provide long-term services and supports. Compliance with these review activities provides assurances that MCOs are meeting requirements related to access, timeliness, and quality of services, including health care. The analysis included in this section of the report provides assessment of strengths, progress and recommendations for improvement for each MCO. The following tables 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.

Anthem Blue Cross and Blue Shield Health Plan	
Programs Operated	**CY 2023 Enrollment by Program**
BC+, SSI	BC+: 137,160 SSI: 7,644
Findings	
Protocol 1: Validation of Performance Improvement Projects (PIPs) • *Prenatal and Postpartum Care* • *Comprehensive Diabetes Care*	**Strengths** – The organization conducted and reported detailed research regarding the topic selection and its importance to members for both projects. – The organization established a clear, concise, measurable, and answerable aim statement for both projects. – The organization clearly identified the PIP population in relation to the aim statement for both projects. – The organization selected PIP variables and performance measures that were clear indicators of performance for both projects. – The organization used valid and reliable procedures to collect the PIP data and inform its measurements for both projects. – The organization selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for both projects. **Progress** – No progress was identified in the validation of the projects, and recommendations from the prior review were not successfully addressed in each project submitted. **Recommendations** – Include evidence of statistical analysis to assess differences between the initial and repeat measurements. – Present results that are easily understood and relate to the aim statement. – Include statistical evidence that observed improvement is the result of the interventions.
Protocol 2: Validation of Performance Measures **Although rates have been finalized, Anthem has identified impacts to the calculations of Anthem's final rates that were not fully corrected. This information should be considered when comparing final rates.*	**Strengths** – Childhood Immunizations. – Follow-Up After Hospitalization for Mental Illness. – Hemoglobin A1C Control for Patient with Diabetes. **Progress** – No progress was identified. **Recommendations** – Improve Immunizations for Adolescents. – Improve Lead Screening in Children. – Improve Postpartum Care. – Improve Prenatal Care. – Improve Asthma Medication Ration. – Improve Antidepressant Medication Management. – Improve Follow-Up After Emergency Department Visit for Mental Illness.
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review	**Strengths** – The organization had strong systems in place to help members understand their rights as well as ensuring those rights are protected.

Anthem Blue Cross and Blue Shield Health Plan	
Programs Operated	**CY 2023 Enrollment by Program**
BC+, SSI	BC+: 137,160 SSI: 7,644
Findings	
Accreditation Desk Review	**Progress** – At the direction of DHS, MetaStar revised the standards for CY 2023. Scoring methods from the previous Accreditation Desk Review are not comparable. **Recommendations** – Develop and implement processes to ensure the provider network is sufficient to provide adequate access to all services based on anticipated enrollment and expected utilization of services, and that it includes a sufficient number and type of provider, in terms of training experience and specialization, to furnish the contracted services. – Share member needs with other MCOs to prevent duplication of services. – Ensure exemption request reasons for disenrollment are included in policies and procedures. – Develop and implement a restraint policy. – Develop and implement a process to immediately report the names of practitioners or providers who were terminated from the network due to quality issues to DHS. – Ensure decisions for utilization management, member education, coverage of services, and other areas clinical practice guidelines apply are consistent with the clinical practice guidelines. – Implement a process to ensure all practice guidelines are available on the organization's website.
Protocol 9: Conducting Focused Studies of Health Care Quality *SSI Care Management Review*	**Strengths** – No strengths were identified. **Progress** – Following the CY 2021 review, revisions were made at the request of the Wisconsin Department of Health Services. Ratings from the previous reviews are not comparable. **Recommendations** – Complete member screens timely. – Focus efforts on improving timeliness on completion of member care plans. Ensure care plans are shared with all required persons. – Prioritize efforts on contacting members based on their needs and stratification level. – Provide timely follow-up to member needs, specifically for physical health needs. – Review care plans at least once every 12 months. – Ensure care plans are updated for changing member needs. – Ensure members are re-stratified after a critical event. – Contact members within five business days of discharge from an inpatient facility and address hospital discharge information with the member.
Appendix A: Information Systems Capabilities Assessments	

Anthem Blue Cross and Blue Shield Health Plan	
Programs Operated	**CY 2023 Enrollment by Program**
BC+, SSI	BC+: 137,160 SSI: 7,644
Findings	
	Strengths – The organization was fully met in all Information System Categories evaluated through the organization's annual Healthcare Effectiveness Data and Information Set (HEDIS®)[2] audit. **Progress** – Information Systems Capabilities Assessments were not evaluated in previous years; therefore, progress cannot be identified. **Recommendations** – The organization fully met all requirements. No recommendations were identified.
Conducting Focused Studies of Health Care Quality *Obstetrics Medical Home Record Review*	The results of the Obstetrics Medical Home review are reported separately.

Chorus Community Health Plan	
Programs Operated	**CY 2023 Enrollment by Program**
BC+, FCMH	BC+: 135,859 FCMH: 2,722
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Prenatal and Postpartum Care* • *Childhood Immunization Status* • *Immunizations*	**Strengths** – The organization conducted and reported detailed research regarding the topic selection and its importance to members for all projects. – The organization established a clear, concise, measurable, and answerable aim statement for two projects. – The organization clearly identified the PIP population in relation to the aim statement for all projects. – The organization selected PIP variables and performance measures that were clear indicators of performance for all projects. – The organization used valid and reliable procedures to collect the PIP data and inform its measurements for one project. **Progress** – The organization ensured aim statements were measurable and reflected an improvement from the baseline rate. – The organization conducted statistical analysis to determine the change in rate between baseline and repeat measurements. – The analysis accounted for factors that influenced comparability of baseline and repeat measurements. – The organization ensured improvement strategies were culturally and linguistically appropriate.

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

Chorus Community Health Plan	
Programs Operated	**CY 2023 Enrollment by Program**
BC+, FCMH	BC+: 135,859 FCMH: 2,722
Findings	
	Recommendations – Ensure the aim statement clearly specifies the improvement strategies for the project. – Include all required criteria in the aim statement, ensuring it is answerable. – Specify the frequency of data collection for project measures. – Establish and clearly document the data analysis plan to ensure that appropriate data will be available for the project. – Include a list of data collection personnel and relevant qualifications for staff collecting data from the medical record review. – Conduct an inter-rater and intra-rater reliability process for personnel collecting data from the medical record review. – Ensure a data analysis plan is outlined in the report. – Include evidence of statistical analysis to assess differences between the initial and repeat measurements. – Ensure project results are compared across other entities, such as different organizations or sub-groups. – Present results in a concise and easily understood manner. – Design a strategy that identifies potential project barriers and the plan to address those barriers. – Ensure a Plan-Do-Study-Act approach is used to test the improvement strategies. – Use data analysis and interpretation to assess the extent to which the improvement strategies were successful and identify potential follow-up activities. – Conduct statistical testing to determine if project improvement is the result of the interventions. – Continue to build methodologically sound performance improvement projects to ensure quantitative improvement is demonstrated from baseline to repeat rates. – Continue to build methodologically sound performance improvement projects to ensure project results demonstrate an improvement from the baseline rate each year of a continuing project.
Protocol 2: Validation of Performance Measures *Performance measures were not established in CY 2022 – 2023 for the C4K program. The C4K program established measures in CY 2023 to be validated in CY 2024. The measures will be reported on in the CY 2024 annual technical report.*	**Strengths** – Immunizations for Adolescents. – Lead Screening in Children. – Postpartum Care. **Progress** – Improved Immunizations for Adolescents. – Improved Postpartum Care. **Recommendations** – Improve Childhood Immunizations. – Improve Prenatal Care.

Chorus Community Health Plan	
Programs Operated	**CY 2023 Enrollment by Program**
BC+, FCMH	BC+: 135,859 FCMH: 2,722
Findings	
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review *Accreditation Desk Review*	**Strengths** – The organization demonstrated the ability to ensure availability of accessible, culturally competent services through a network of qualified service providers. **Progress** – At the direction of DHS, MetaStar revised the standards for CY 2023. Scoring methods from the previous Accreditation Desk Review are not comparable. **Recommendations** – Update written guidance to include all member disenrollment requirements and limitations, specifically: o Voluntary disenrollment; o System based disenrollment; o Involuntary disenrollment; o Change in member circumstance resulting in disenrollment; and o Exemption requests. – Provide the member and requesting provider written notice of decisions which include: o Reason; o Member's grievance and appeal rights; and o Denial of payment. – Make decisions on standard service authorization requests within 14 calendar days following receipt of the request for service with a possible extension of up to 14 additional calendar days, if the organization justifies need for additional information and how the extension is in the enrollee's interest. – Make decisions on expedited authorizations no later than 72 hours after receipt of the request for service, unless the organization extended the 72-hour time period by up to 14 calendar days as requested by the member, or the organization justifies the need for more information. – Develop and implement a process to ensure the organization does not prohibit a provider from advising or advocating on behalf of a member/patient. – Ensure policies and procedures include the organization's compliance with all applicable Federal and State laws for the protection of member rights. – Develop and implement a process to immediately report the names of practitioners or providers the organization terminated from the network due to quality issues to the Department of Health Services. – Implement a process to ensure all practice guidelines are available upon request to members and potential members.
Protocol 9: Conducting Focused Studies of Health Care Quality *C4K FCMH Care Management Review*	**Strengths** – Out-of-Home Care Health Screens were conducted timely. – Out-of-Home Care Health Screens were comprehensive.

Chorus Community Health Plan	
Programs Operated	**CY 2023 Enrollment by Program**
BC+, FCMH	BC+: 135,859 FCMH: 2,722
Findings	
	Progress – Following the CY 2022 review, revisions were made at the request of the Wisconsin Department of Health Services. Ratings from the previous reviews are not comparable. **Recommendations** – Conduct initial health assessments timely. – Ensure the initial health assessment is comprehensive. – Include input from all required individuals into each care plan review. – Complete timely follow-up for member needs and services. – Ensure transition plans are created timely. – Ensure transition plans are reviewed and updated timely. – Include input from all required individuals into each transition plan review. – Ensure transition plans are comprehensive.
Appendix A: Information Systems Capabilities Assessments	**Strengths** – The organization was fully met in all Information System Categories evaluated through the organization's annual Healthcare Effectiveness Data and Information Set audit. **Progress** – Information Systems Capabilities Assessments were not evaluated in previous years; therefore, progress cannot be identified. **Recommendations** – The organization fully met all requirements. No recommendations were identified.
Conducting Focused Studies of Health Care Quality *Obstetrics Medical Home Record Review*	The results of the Obstetrics Medical Home review are reported separately.

Dean Health Plan, Inc.	
Programs Operated	**CY 2023 Enrollment by Program**
BC+	BC+: 45,655
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Prenatal and Postpartum Care* • *Immunizations*	**Strengths** – The organization conducted and reported detailed research regarding the topic selection and its importance to members for both projects. – The organization established a clear, concise, measurable, and answerable aim statement for both projects. – The organization clearly identified the PIP population in relation to the aim statement for both projects. – The organization selected PIP variables and performance measures that were clear indicators of performance for both projects.

Dean Health Plan, Inc.	
Programs Operated	**CY 2023 Enrollment by Program**
BC+	BC+: 45,655
Findings	
	– The organization used valid and reliable procedures to collect the PIP data and inform its measurements for both projects. – The organization used appropriate techniques to analyze the PIP data and interpret the results for both projects. – The organization selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for both projects. – The organization demonstrated statistically significant improvement that may be the result of its selected interventions for one project. **Progress** – The organization included evidence of statistical analysis to assess differences between the initial and repeat measurements. – The organization engaged in projects that were methodologically sound that resulted in improvement from the baseline to final rate. – The organization included evidence of statistical testing to determine if any observed improvement is the result of the interventions. **Recommendations** – Ensure sustained improvement is demonstrated through repeated measurements over time for continuing projects.
Protocol 2: Validation of Performance Measures	**Strengths** – Childhood Immunizations. – Immunizations for Adolescents. – Lead Screening in Children. – Postpartum Care. – Prenatal Care. **Progress** – Improved Childhood Immunizations. – Improved Immunizations for Adolescents. – Improved Lead Screening in Children. **Recommendations** – The organization's measures met or exceeded the state rate; therefore, no recommendations were identified.
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review *Accreditation Desk Review*	**Strengths** – No strengths were identified. **Progress** – At the direction of DHS, MetaStar revised the standards for CY 2023. Scoring methods from the previous Accreditation Desk Review are not comparable.

Dean Health Plan, Inc.	
Programs Operated	**CY 2023 Enrollment by Program**
BC+	BC+: 45,655
Findings	
	Recommendations – Amend written guidance related to second opinions to ensure enrollees are able to obtain a second opinion from an in-network or out-of-network provider at no cost. – Develop and implement a process for providing covered services out of network, for as long as the organization's provider network is unable to provide them. – Amend written guidance to ensure network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees. – Ensure policies and procedures include the following criteria: - Coordination of services and follow up with members to ensure services provided best address their needs; and - Share assessment results of members' needs with other managed care organizations to prevent duplication of services. – Update written policies and procedures to include all member disenrollment requirements, specifically: - Voluntary disenrollment requests; - System based disenrollment; - Involuntary disenrollment; - Change in member circumstance disenrollment notification to the Department of Health Services; and - Exemptions requests. – Ensure policies and procedures include emergency and post-stabilization specifications, as indicated: – The organization may not hold the member liable for payment of subsequent screening and treatment to diagnosis or stabilize the member; and – The organization must ensure the attending emergency physician or treating provider determines when the enrollee is stabilized for transfer or discharge. – Create and implement a member rights policy. – Develop and implement a restraint policy. – Create a process to immediately report the names of practitioners or providers the organization terminated from the network due to quality issues to the Department of Health Services. – Develop and implement a process to ensure the organization disseminates practice guidelines to members and potential members.
Appendix A: Information Systems Capabilities Assessments	**Strengths** – The organization was fully met in all Information System Categories evaluated through the organization's annual HEDIS® audit. **Progress** – Information Systems Capabilities Assessments were not evaluated in previous years; therefore, progress cannot be identified.

Dean Health Plan, Inc.	
Programs Operated	**CY 2023 Enrollment by Program**
BC+	BC+: 45,655
Findings	
	Recommendations – The organization fully met all requirements. No recommendations were identified.
Conducting Focused Studies of Health Care Quality *Obstetrics Medical Home Record Review*	The results of the Obstetrics Medical Home review are reported separately.

Group Health Cooperative of Eau Claire	
Programs Operated	**CY 2023 Enrollment by Program**
BC+, SSI	BC+: 51,150 SSI: 3,152
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Prenatal and Postpartum Care* • *Follow-Up for Hospitalization for Mental Illness*	**Strengths** – The organization conducted and reported detailed research regarding the topic selection and its importance to members for both projects. – The organization established a clear, concise, measurable, and answerable aim statement for both projects. – The organization clearly identified the PIP population in relation to the aim statement for both projects. – The organization selected PIP variables and performance measures that were clear indicators of performance for both projects. – The organization used valid and reliable procedures to collect the PIP data and inform its measurements for both projects. – The organization selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for both projects. **Progress** – All aim statements included a goal for improvement. – Efforts were focused on improving results of repeat measurements each year for continuing projects. **Recommendations** – Include evidence of statistical analysis to assess differences between the initial and repeat measurements. – Include statistical evidence that observed improvement is the result of the interventions.
Protocol 2: Validation of Performance Measures	**Strengths** – Postpartum Care. – Prenatal Care. – Asthma Medication Ration. – Follow-Up After Hospitalization for Mental Illness. **Progress** – Improved Postpartum Care.

Group Health Cooperative of Eau Claire	
Programs Operated	**CY 2023 Enrollment by Program**
BC+, SSI	BC+: 51,150 SSI: 3,152
Findings	
	– Improved Prenatal Care. **Recommendations** – Improve Childhood Immunizations. – Improve Immunizations for Adolescents. – Improve Lead Screening in Children. – Improve Antidepressant Medication Management. – Improve Hemoglobin A1C Control for Patients with Diabetes.
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review	The organization's last Compliance with Standards Review was conducted in CY 2022. The organization became Accredited by NCQA in CY 2023 and will participate in the Accreditation Desk Review in CY 2025.
Protocol 9: Conducting Focused Studies of Health Care Quality *SSI Care Management Review*	**Strengths** – The organization demonstrated strengths related to the Wisconsin Interdisciplinary Care Team practices. **Progress** – Following the CY 2021 review, revisions were made at the request of the Wisconsin Department of Health Services. Ratings from the previous reviews are not comparable. **Recommendations** – Complete member screens timely. – Ensure care plans are completed within the required timeframe. – Focus efforts on care plans to include all required elements. – Ensure care plan are shared with all required persons. – Prioritize efforts on contacting members based on their needs and stratification level. – Review care plans at least once every 12 months. – Contact members within five business days of discharge from an inpatient facility and address hospital discharge information with the member. – Ensure the Wisconsin Interdisciplinary Core Team meets weekly to discuss the member.
Appendix A: Information Systems Capabilities Assessments	The organization's last Information Systems Capabilities Assessment was conducted in CY 2022.

Group Health Cooperative of South-Central Wisconsin	
Programs Operated	**CY 2023 Enrollment by Program**
BC+	BC+: 7,676
Findings	
Protocol 1: Validation of Performance Improvement Projects	**Strengths** – The organization conducted and reported detailed research regarding the topic selection and its importance to members for both projects.

Group Health Cooperative of South-Central Wisconsin	
Programs Operated	**CY 2023 Enrollment by Program**
BC+	BC+: 7,676
Findings	
• *Prenatal and Postpartum Care* • *Controlling Blood Pressure*	– The organization established a clear, concise, measurable and answerable aim statement for both projects. – The organization clearly identified the PIP population in relation to the aim statement for both projects. – The organization selected PIP variables and performance measures that were clear indicators of performance for both projects. – The organization used valid and reliable procedures to collect the PIP data and inform its measurements for both projects. **Progress** – No progress was identified in the validation of the projects, and recommendations from the prior review were not successfully addressed in each project submitted. **Recommendations** – Include the qualifications of staff conducting medical record reviews in the project's report. – Conduct statistical testing on the project's baseline and repeat measurements to determine statistical significance. – Conduct statistical testing on the project's baseline and repeat measurements to determine statistical significance. – Design methodologically sound performance improvement projects to demonstrate improvement from baseline to remeasurement. – Include statistical evidence that observed improvement is the result of the interventions.
Protocol 2: Validation of Performance Measures	**Strengths** – Childhood Immunizations – Immunization for Adolescents. – Prenatal Care. **Progress** – Improved Childhood Immunizations. – Improved Immunization for Adolescents. **Recommendations** – Improve Lead Screening in Children. – Improve Postpartum Care.
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review *Accreditation Desk 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.

Group Health Cooperative of South-Central Wisconsin	
Programs Operated	**CY 2023 Enrollment by Program**
BC+	BC+: 7,676
Findings	
	Progress – At the direction of DHS, MetaStar revised the standards for CY 2023. Scoring methods from the previous Accreditation Desk Review are not comparable. **Recommendations** – Focus efforts on developing and implementing procedures to ensure coordination of services for members with other managed care organizations and fee-for-service Medicaid. – Amend decision-making documents to align timeframes for extensions of expedited service authorization decisions to comply with contract requirements. – Develop and implement a process to ensure the organization does not prohibit a provider from advising or advocating on behalf of a member/patient. – Ensure practice guidelines are disseminated to providers, and upon request, to members and potential members.
Appendix A: Information Systems Capabilities Assessments	**Strengths** – The organization was fully met in all Information System Categories evaluated through the organization's annual HEDIS® audit. **Progress** – Information Systems Capabilities Assessments were not evaluated in previous years; therefore, progress cannot be identified. **Recommendations** – The organization fully met all requirements. No recommendations were identified.
Conducting Focused Studies of Health Care Quality *Obstetrics Medical Home Record Review*	The results of the Obstetrics Medical Home review are reported separately.

Independent Care Health Plan	
Programs Operated	**CY 2023 Enrollment by Program**
BC+, SSI	BC+: 29,782 SSI: 9,754
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Prenatal and Postpartum Care*	**Strengths** – The organization conducted and reported detailed research regarding the topic selection and its importance to members for both projects. – The organization established a clear, concise, measurable and answerable aim statement for both projects. – The organization clearly identified the PIP population in relation to the aim statement for both projects.

Independent Care Health Plan	
Programs Operated	**CY 2023 Enrollment by Program**
BC+, SSI	BC+: 29,782 SSI: 9,754
Findings	
• *Supplemental Security Income Health Disparities*	– The organization selected PIP variables and performance measures that were clear indicators of performance for both projects. – The organization used valid and reliable procedures to collect the PIP data and inform its measurements for both projects. – The organization used appropriate techniques to analyze the PIP data and interpret the results for one project. – The organization selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for one project. **Progress** – All data sources were included in the data collection procedures. – The organization established a data collection plan that linked to the data analysis plan to ensure appropriate data was available for each project. – The analysis accounted for factors that may threaten the internal or external validity of the findings. – Lessons learned about less-than-optimal performance were specified. – The improvement strategies were designed to address root causes or barriers identified through data analysis and quality improvement processes. – The organization utilized the same methodology for baseline and repeat measurements. **Recommendations** – Analyze data according to the data analysis plan or explain any deviation from the plan when warranted. – Include evidence of statistical analysis to assess differences between the initial and repeat measurements in future projects. – Ensure PIP findings are presented in an easily understood manner. – Document a continuous cycle of improvement used to test a selected improvement strategy. – Continue to design a methodologically sound performance improvement project to demonstrate improvement from baseline to remeasurement. – Focus efforts on improving results of repeat measurements each year of the project.
Protocol 2: Validation of Performance Measures	**Strengths** – Lead Screening in Children. – Asthma Medication Ration. – Follow-Up After Hospitalization for Mental Illness. – Follow-Up After Emergency Department Visit for Mental Illness. **Progress** – Improved Lead Screening in Children. **Recommendations** – Improve Childhood Immunizations. – Improve Immunizations for Adolescents.

Independent Care Health Plan	
Programs Operated	**CY 2023 Enrollment by Program**
BC+, SSI	BC+: 29,782 SSI: 9,754
Findings	
	– Improve Postpartum Care. – Improve Prenatal Care. – Antidepressant Medication Management. – Hemoglobin A1C Control for Patients with Diabetes.
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review	The organization's last Compliance with Standards Review was conducted in CY 2021. The organization became accredited by NCQA in CY 2023 and will participate in the Accreditation Desk Review in CY 2024.
Protocol 9: Conducting Focused Studies of Health Care Quality *SSI Care Management Review*	**Strengths** – No strengths were identified. **Progress** – Following the CY 2021 review, revisions were made at the request of the Wisconsin Department of Health Services. Ratings from the previous reviews are not comparable. **Recommendations** – Complete member screens timely. – Complete care plans timely. – Ensure care plans include all required elements. – Share care plans with all required individuals. – Ensure members are contacted based on needs and stratification level. – Conduct timely follow-up for member needs and requests. – Complete care plan reviews at least once every 12 months. – Update care plans for changing member needs. – Contact members within five business days of discharge from an inpatient hospital facility. – Ensure transition care follow-up includes the review of hospital discharge information with the member. – Ensure the Wisconsin Interdisciplinary Core Team includes two licensed health care providers. – Ensure the Wisconsin Interdisciplinary Core Team meets weekly to discuss the member. – Conduct monthly face-to-face meetings between at least one member of the Wisconsin Disciplinary Core Team and the member.
Appendix A: Information Systems Capabilities Assessments	The organization's last Information Systems Capabilities Assessment was conducted in CY 2022.
Conducting Focused Studies of Health Care Quality *Obstetrics Medical Home Record Review*	The results of the Obstetrics Medical Home review are reported separately.

MercyCare Health Plans	
Programs Operated	**CY 2023 Enrollment by Program**
BC+	BC+: 14,616
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Prenatal and Postpartum Care* • *Lead Screening*	**Strengths** – The organization conducted and reported detailed research regarding the topic selection and its importance to members for both projects. – The organization established a clear, concise, measurable, and answerable aim statement for both projects. – The organization clearly identified the PIP population in relation to the aim statement for both projects. – The organization selected PIP variables and performance measures that were clear indicators of performance for both projects. – The organization used valid and reliable procedures to collect the PIP data and inform its measurements for both projects. – The organization selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for one project. **Progress** – The organization's aim statement included the underrepresented population the improvement strategies will focus on when completing a Department of Health Services prescribed project. – The organization completed the data analysis according to the data analysis plan. – The organization included an analysis of factors that may influence the comparability of initial and repeat measures. – The organization used a rapid-cycle Plan-Do-Study-Act approach to test the selected improvement strategies during the project. **Recommendations** – Include an analysis of the baseline and repeat measures identified in the project aim statement. – Include evidence of statistical analysis to assess differences between initial and repeat measures. – Ensure results are clear and easily understood in future projects. – Include lessons learned or opportunities for improvement based on the data analysis when the aim is not achieved. – Assess the success of improvement strategies and identify potential follow-up activities. – Continue to build methodologically sound performance improvement projects to demonstrate improvement from baseline to remeasurement. – Include statistical evidence to determine if improvement is due to interventions in future projects. – Continue to build a methodologically sound project to increase the probability of sustained improvement for projects spanning multiple years.
Protocol 2: Validation of Performance Measures	**Strengths** – Postpartum Care. – Prenatal Care.

MercyCare Health Plans	
Programs Operated	**CY 2023 Enrollment by Program**
BC+	BC+: 14,616
Findings	
	Progress – Improved Postpartum Care. – Improved Prenatal Care. **Recommendations** – Improve Childhood Immunizations. – Improve Immunizations for Adolescents. – Improve Lead Screening in Children.
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review *Accreditation Desk Review*	**Strengths** – The organization has strong systems in place to help members understand their rights as well as ensuring those rights are protected. **Progress** – At the direction of DHS, MetaStar revised the standards for CY 2023. Scoring methods from the previous Accreditation Desk Review are not comparable. **Recommendations** – Ensure policies and procedures include coordination of services and follow up for: - Members with other managed care organizations; - Fee-for-service Medicaid; and, - Community and social service providers. – Focus efforts on developing and implementing procedures to ensure the results of any identification and assessment of the member's needs are shared with other managed care organizations serving the member to prevent duplication of those activities. – Establish a process to ensure disenrollment policies and procedures contain all required federal and state requirements when requirements are effective. The organization should ensure: - The organization directs all members with disenrollment requests to the Enrollment Specialist for assistance and choice counseling; - All BadgerCare Plus members have the right to disenroll from the organization unless otherwise limited by a State Plan Amendment; and - Members may request disenrollment upon automatic reenrollment if the temporary loss of BadgerCare Plus has caused the member to miss the annual enrollment period. – Update written policies and procedures to include all member disenrollment requirements, specifically: - System based disenrollment; - Involuntary disenrollment; - Change in member circumstance disenrollment notification to the Department of Health Services; and - Exemptions requests.

MercyCare Health Plans	
Programs Operated	**CY 2023 Enrollment by Program**
BC+	BC+: 14,616
Findings	
	– Ensure policies and procedures for standard service authorization decisions include the requirement for when the member or provider request the extension. – Ensure policies and procedures for expedited authorization decisions include the requirement that the organization may extend the timeframe if the member requests an extension. – Update policies and procedures to include who is responsible to determine when the member is stabilized for emergency services transfer or discharge. – Ensure the organization complies with all Federal and State laws pertinent to the protection of all member rights. – Ensure all federal and state requirements are written into policies and procedures in a timely manner for oversight of activities delegated to any subcontractor/provider, specifically related to: - Confirmation of written agreements specifying the delegated activities of the subcontractor and providing for revocation of the delegation or other sanctions as needed; - Evaluation of the subcontractor's ability to perform the delegated activity; - Monitoring of the subcontractor's performance and ensuring formal review at least once per contract period; - Identification of deficiencies and a process to take corrective action if needed. – Review the process used to update clinical practice guidelines on the organization's website to ensure links are available for providers and members, and are functioning properly
Appendix A: Information Systems Capabilities Assessments	**Strengths** – The organization was fully met in all Information System Categories evaluated through the organization's annual HEDIS® audit. **Progress** – Information Systems Capabilities Assessments were not evaluated in previous years; therefore, progress cannot be identified. **Recommendations** – The organization fully met all requirements. No recommendations were identified.
Conducting Focused Studies of Health Care Quality *Obstetrics Medical Home Record Review*	The results of the Obstetrics Medical Home review are reported separately.

MHS Health Wisconsin	
Programs Operated	**CY 2023 Enrollment by Program**
BC+, SSI	BC+: 53,504 SSI: 6,527
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Prenatal and Postpartum Care* • *Supplemental Security Income Health Disparities*	**Strengths** – The organization conducted and reported detailed research regarding the topic selection and its importance to members for both projects. – The organization established a clear, concise, measurable, and answerable aim statement for both projects. – The organization clearly identified the PIP population in relation to the aim statement for both projects. – The organization selected PIP variables and performance measures that were clear indicators of performance for both projects. – The organization used valid and reliable procedures to collect the PIP data and inform its measurements for both projects. – The organization used appropriate techniques to analyze the PIP data and interpret the results for both projects. – The organization demonstrated statistically significant improvement that may be the result of its selected interventions for both projects. **Progress** – The organization included evidence of statistical analysis to assess differences between the initial and repeat measurements. – The organization utilized a consistent methodology for the baseline and repeat measures. – The organization engaged in projects that were methodologically sound and resulted in improvement in processes or outcomes of care which were likely to be a result of the selected interventions. – The organization documented statistical evidence that the observed improvement was the result of the use of interventions. **Recommendations** – Detail the interrater and intra-rater reliability process for organizational staff conducting medical record review. – Document a continuous cycle of improvement used to test a selected improvement strategy.
Protocol 2: Validation of Performance Measures	**Strengths** – Postpartum Care. – Prenatal Care. – Asthma Medication Ration. – Follow-Up After Hospitalization for Mental Illness. **Progress** – Improved Postpartum Care. – Improved Prenatal Care. **Recommendations** – Improve Childhood Immunizations. – Improve Immunizations for Adolescents. – Improve Lead Screening in Children. – Improve Antidepressant Medication Management.

MHS Health Wisconsin	
Programs Operated	**CY 2023 Enrollment by Program**
BC+, SSI	BC+: 53,504 SSI: 6,527
Findings	
	– Improve Follow-Up After Emergency Department Visit for Mental Illness. – Hemoglobin A1C Control for Patients with Diabetes.
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review *Accreditation Desk Review*	**Strengths** – The organization demonstrated the ability to ensure availability of accessible, culturally competent services through a network of qualified service providers. – The organization has strong systems in place to help members understand their rights as well as ensuring those rights are protected. **Progress** – At the direction of DHS, MetaStar revised the standards for CY 2023. Scoring methods from the previous Accreditation Desk Review are not comparable. **Recommendations** – Implement a process to communicate members' needs with other organizations to prevent duplication of services. – Focus efforts to assure written policies and procedures for member disenrollment include the following contract requirements: – Members may request disenrollment upon automatic reenrollment if the temporary loss of BC+ and/or Medicaid SSI enrollment has caused the member to miss the annual enrollment period; – Loss of eligibility and participation in county case management waiver program or other managed care programs as reasons for disenrollment; – For any request for involuntary disenrollment, the organization must submit a disenrollment request to DHS and include evidence attesting to cause; and – That exemption requests from enrollment in the organization must come from the member, the member's family, or the member's legal guardian. – Ensure all contract required service authorization decision criteria are included in written policies and procedures. – Amend written guidance to include the attending emergency physician or the provider actually treating the member is responsible to decide when the member is stable for transfer or discharge. - Place priority on developing and implementing a written policy and procedure to ensure each member's right to be free from any form of restraint or seclusion.
Protocol 9: Conducting Focused Studies of Health Care Quality *SSI Care Management Review*	**Strengths** – No strengths were identified. **Progress** – Following the CY 2021 review, revisions were made at the request of the Wisconsin Department of Health Services. Ratings from the previous reviews are not comparable. **Recommendations** – Complete member screens timely.

MHS Health Wisconsin	
Programs Operated	**CY 2023 Enrollment by Program**
BC+, SSI	BC+: 53,504 SSI: 6,527
Findings	
	– Focus efforts on improving timeliness on completion of member care plans. – Ensure care plans are shared with all required persons. – Prioritize efforts on contacting members based on their needs and stratification level. – Provide timely follow-up to member needs, specifically for physical health needs. – Review care plans at least once every 12 months. – Contact members within five business days of discharge from an inpatient facility and address hospital discharge information with the member. – Provide Wisconsin Interdisciplinary Care Team monthly face-to-face contact with the member.
Appendix A: Information Systems Capabilities Assessments	**Strengths** The organization was fully met in five Information System Categories evaluated through the organization's annual HEDIS® audit. **Progress** – Information Systems Capabilities Assessments were not evaluated in previous years; therefore, progress cannot be identified. **Recommendations** – Demonstrate effective procedures for submitting measure-relevant information for data entry, including checking procedures for electronic transmissions to ensure accuracy. – Perform consistent oversight and validation of vendors to ensure vendors meet expected performance standards. – Identify and correct incorrect extraction of data fields and delays in recognizing and/or remediating the underlying issues. – Identify and correct issues and delays related to improper identification of populations, utilization data extracts, measure report set selection
Conducting Focused Studies of Health Care Quality *Obstetrics Medical Home Record Review*	The results of the Obstetrics Medical Home review are reported separately.

Molina HealthCare of Wisconsin	
Programs Operated	**CY 2023 Enrollment by Program**
BC+, SSI	BC+: 61,986 SSI: 3,235
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Prenatal and Postpartum Care*	**Strengths** – The organization conducted and reported detailed research regarding the topic selection and its importance to members for both projects. – The organization established a clear, concise, measurable and answerable aim statement for both projects. – The organization clearly identified the PIP population in relation to the aim statement for both projects.

Molina HealthCare of Wisconsin	
Programs Operated	**CY 2023 Enrollment by Program**
BC+, SSI	BC+: 61,986 SSI: 3,235
Findings	
• *Controlling Blood Pressure*	– The organization selected PIP variables and performance measures that were clear indicators of performance for both projects. – The organization used valid and reliable procedures to collect the PIP data and inform its measurements for both projects. – The organization used appropriate techniques to analyze the PIP data and interpret the results for both projects. – The organization selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for both projects. – The organization demonstrated statistically significant improvement that may be the result of its selected interventions for one project. **Progress** – The organization utilized statistical tests to assess the difference between initial and repeat measures. – The organization utilized the same methodology for initial and repeat measures. – The organization designed methodologically sound projects that demonstrated improvement from baseline to remeasurement. **Recommendations** – Focus efforts on improving results of repeat measures each year of a continuing project.
Protocol 2: Validation of Performance Measures	**Strengths** – Immunizations for Adolescents. – Lead Screening in Children. – Postpartum Care. – Prenatal Care. – Asthma Medication Ration. – Follow-Up After Hospitalization for Mental Illness. – Follow-Up After Emergency Department Visit for Mental Illness. – Hemoglobin A1C Control for Patients with Diabetes. **Progress** – Improved Postpartum Care. – Improved Prenatal Care. – Improved Follow-Up After Emergency Department Visit for Mental Illness. **Recommendations** – Improve Childhood Immunizations. – Improve Antidepressant Medication Management.

Molina HealthCare of Wisconsin	
Programs Operated	**CY 2023 Enrollment by Program**
BC+, SSI	BC+: 61,986 SSI: 3,235
Findings	
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review *Accreditation Desk 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. **Progress** – At the direction of DHS, MetaStar revised the standards for CY 2023. Scoring methods from the previous Accreditation Desk Review are not comparable. **Recommendations** – Develop and implement processes to ensure the provider network is sufficient to provide adequate access to all services based on anticipated enrollment and expected utilization of services. – Share with other managed care organizations serving the member, the results of any identification and assessment of the member's needs to prevent duplication of those activities. – Ensure compliance with all member disenrollment requirements and limitations, specifically for system based and involuntary disenrollment. – Implement a process to ensure all practice guidelines are available on the organization's website.
Protocol 9: Conducting Focused Studies of Health Care Quality *SSI Care Management Review*	**Strengths** – The organization demonstrated strengths related to the Wisconsin Interdisciplinary Care Team practices. **Progress** – Following the CY 2021 review, revisions were made at the request of the Wisconsin Department of Health Services. Ratings from the previous reviews are not comparable. **Recommendations** – Complete member screens timely. – Focus efforts on improving timeliness of completion of member care plans. – Develop comprehensive care plans that include all required elements. – Ensure care plans are shared with all required individuals. – Prioritize efforts on contacting members based on their needs and stratification level. – Provide timely follow-up to member needs, specifically for physical health needs. – Review care plans at least once every 12 months. – Contact members within five business days of discharge from an inpatient facility and address hospital discharge information with the member.

Molina HealthCare of Wisconsin	
Programs Operated	**CY 2023 Enrollment by Program**
BC+, SSI	BC+: 61,986 SSI: 3,235
Findings	
Appendix A: Information Systems Capabilities Assessments	**Strengths** – The organization was fully met in all Information System Categories evaluated through the organization's annual HEDIS® audit. **Progress** – Information Systems Capabilities Assessments were not evaluated in previous years; therefore, progress cannot be identified. **Recommendations** – The organization fully met all requirements. No recommendations were identified.
Conducting Focused Studies of Health Care Quality *Obstetrics Medical Home Record Review*	The results of the Obstetrics Medical Home review are reported separately.

My Choice Wisconsin	
Programs Operated	**CY 2023 Enrollment by Program**
BC+, SSI	BC+: 20,879 SSI: 2,931
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Prenatal and Postnatal Care* • *Immunizations*	**Strengths** – The organization conducted and reported detailed research regarding the topic selection and its importance to members for both projects. – The organization established a clear, concise, measurable, and answerable aim statement for one project. – The organization clearly identified the PIP population in relation to the aim statement for both projects. – The organization selected PIP variables and performance measures that were clear indicators of performance for both projects. – The organization used valid and reliable procedures to collect the PIP data and inform its measurements for both projects. – The organization used appropriate techniques to analyze the PIP data and interpret the results for one project. – The organization selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for both projects. – The organization demonstrated statistically significant improvement that may be the result of its selected interventions for one project. **Progress** – The organization included the improvement strategy and numerical goal ensuring the aim statements were answerable. – The organization used statistical testing to assess the significance between initial and repeat measures.

My Choice Wisconsin	
Programs Operated	**CY 2023 Enrollment by Program**
BC+, SSI	BC+: 20,879 SSI: 2,931
Findings	
	– The organization compared PIP results across different member subgroups. – The projects included an analysis of lessons learned when project barriers were identified. – The projects included a strategy to account or adjust for any major confounding variables that could have an impact on PIP outcomes. – The organization used data analysis and interpretation to assess the extent to which the improvement strategy was successful and identified potential follow-up activities. – The same methodology was utilized to calculate the baseline and repeat measures in the projects. **Recommendations** – Ensure aim statements are concise. – Report the PIP results in a concise and easily understood manner. – Develop methodologically sound performance improvement projects to ensure results have quantitative evidence of improvement from the baseline rates that are sustained through repeated measurements.
Protocol 2: Validation of Performance Measures	**Strengths** – Follow-Up After Hospitalization for Mental Illness. – Hemoglobin A1C Control for Patients with Diabetes. **Progress** – No progress was identified. **Recommendations** – Improve Childhood Immunizations. – Improve Immunizations for Adolescents. – Improve Lead Screening in Children. – Improve Postpartum Care. – Improve Prenatal Care. – Improve Asthma Medication Ration. – Improve Antidepressant Medication Management.
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review	Compliance with Standards Reviews were conducted in CY 2021 for Trilogy and Care Wisconsin, the two legacy organizations that merged to form My Choice Wisconsin. In CY 2023, My Choice Wisconsin was acquired by Molina Healthcare, who is accredited by the NCQA and will participate in the Accreditation Desk Review in CY 2024.
Protocol 9: Conducting Focused Studies of Health Care Quality *SSI Care Management Review*	**Strengths** – No strengths were identified. **Progress** – Following the CY 2021 review, revisions were made at the request of the Wisconsin Department of Health Services. Ratings from the previous reviews are not comparable.

My Choice Wisconsin	
Programs Operated	**CY 2023 Enrollment by Program**
BC+, SSI	BC+: 20,879 SSI: 2,931
Findings	
	Recommendations – Complete member screens timely. – Complete member care plans timely. – Ensure care plans are shared with all required individuals. – Contact and connect with members based on member needs and stratification level. – Conduct timely follow-up to ensure member needs are met. – Review care plans at least once every 12 months. – Update care plans for a change in member needs. – Ensure members are re-stratified after a critical event. – Contact members within five business days of discharge from an inpatient hospital facility. – Ensure hospitalization transition care follow-up includes a comprehensive review of hospital discharge information with members. – Ensure the Wisconsin Interdisciplinary Care Team meets weekly to discuss member needs.
Appendix A: Information Systems Capabilities Assessments	The organization's last Information Systems Capabilities Assessment was conducted in CY 2022.
Conducting Focused Studies of Health Care Quality *Obstetrics Medical Home Record Review*	The results of the Obstetrics Medical Home review are reported separately.

Network Health Plan	
Programs Operated	**CY 2023 Enrollment by Program**
BC+, SSI	BC+: 51,712 SSI: 4,332
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Prenatal and Postpartum Care* • *Supplemental Security Income Health Disparities*	**Strengths** – The organization conducted and reported detailed research regarding the topic selection and its importance to members for both projects. – The organization established a clear, concise, measurable, and answerable aim statement for one project. – The organization clearly identified the PIP population in relation to the aim statement for both projects. – The organization selected PIP variables and performance measures that were clear indicators of performance for both projects. – The organization used valid and reliable procedures to collect the PIP data and inform its measurements for both projects. – The organization used appropriate techniques to analyze the PIP data and interpret the results for one project. – The organization demonstrated statistically significant improvement that may be the result of its selected interventions for one project.

Network Health Plan	
Programs Operated	**CY 2023 Enrollment by Program**
BC+, SSI	BC+: 51,712 SSI: 4,332
Findings	
	Progress – The organization included evidence of statistical analysis to assess differences between the initial and repeat measurements. **Recommendations** – Ensure the goal identified for the project is an improvement over the rate obtained during the previous measurement year. – Detail the interrater and intra-rater reliability process for organizational staff conducting medical record review. – Review documentation within the report to ensure the project's results and findings are presented in a concise and easily understood manner. – Detail lessons learned about less-than-optimal performance when rates decline from year to year. – Document a continuous cycle of improvement used to test a selected improvement strategy. – Design a methodologically sound performance improvement project to ensure project results demonstrate an improvement from the baseline rate identified in the project's aim statement. – Focus efforts on improving results of repeat measurements each year of the project.
Protocol 2: Validation of Performance Measures	**Strengths** – Lead Screening in Children. – Prenatal Care. – Asthma Medication Ration. – Follow-Up After Hospitalization for Mental Illness. – Follow-Up After Emergency Department Visit for Mental Illness. – Hemoglobin A1C Control for Patients with Diabetes. **Progress** – Improved Prenatal Care. **Recommendations** – Improve Childhood Immunizations. – Improve Immunizations for Adolescents. – Improve Postpartum Care. – Improve Antidepressant Medication Management.
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review *Accreditation Desk Review*	**Strengths** – The organization demonstrated the ability to ensure availability of accessible, culturally competent services through a network of qualified service providers. – The organization has strong systems in place to help members understand their rights as well as ensuring those rights are protected.

Network Health Plan	
Programs Operated	**CY 2023 Enrollment by Program**
BC+, SSI	BC+: 51,712 SSI: 4,332
Findings	
	Progress – At the direction of DHS, MetaStar revised the standards for CY 2023. Scoring methods from the previous Accreditation Desk Review are not comparable. **Recommendations** – Implement a process to communicate members' needs with other organizations to prevent duplication of services. – Focus efforts to assure written policies and procedures for member disenrollment include the following contract requirements: – Members may request disenrollment upon automatic reenrollment if the temporary loss of BC+ and/or Medicaid SSI enrollment has caused the member to miss the annual enrollment period; – Loss of eligibility and participation in county case management waiver program or other managed care programs as reasons for disenrollment; – For any request for involuntary disenrollment, the organization must submit a disenrollment request to DHS and include evidence attesting to cause; and – That exemption requests from enrollment in the organization must come from the member, the member's family, or the member's legal guardian. – Ensure all contract required service authorization decision criteria are included in written policies and procedures. – Amend written guidance to include the attending emergency physician or the provider actually treating the member is responsible to decide when the member is stable for transfer or discharge. – Place priority on developing and implementing a written policy and procedure to ensure each member's right to be free from any form of restraint or seclusion.
Protocol 9: Conducting Focused Studies of Health Care Quality *SSI Care Management Review*	**Strengths** – No strengths were identified. **Progress** – Following the CY 2021 review, revisions were made at the request of the Wisconsin Department of Health Services. Ratings from the previous reviews are not comparable. **Recommendations** – Complete member screens timely. – Focus efforts on improving timeliness on completion of member care plans. – Ensure care plans are shared with all required persons. – Prioritize efforts on contacting members based on their needs and stratification level. – Provide timely follow-up to member needs, specifically for physical health needs. – Review care plans at least once every 12 months. – Contact members within five business days of discharge from an inpatient facility and address hospital discharge information with the member.

Network Health Plan	
Programs Operated	**CY 2023 Enrollment by Program**
BC+, SSI	BC+: 51,712 SSI: 4,332
Findings	
Appendix A: Information Systems Capabilities Assessments	**Strengths** – The organization was fully met in five Information System Categories evaluated through the organization's annual HEDIS® audit. **Progress** – Information Systems Capabilities Assessments were not evaluated in previous years; therefore, progress cannot be identified. **Recommendations** – Demonstrate effective procedures for submitting measure-relevant information for data entry, including checking procedures for electronic transmissions to ensure accuracy. – Perform consistent oversight and validation of vendors to ensure vendors meet expected performance standards. – Identify and correct incorrect extraction of data fields and delays in recognizing and/or remediating the underlying issues. – Identify and correct issues and delays related to improper identification of populations, utilization data extracts, measure report set selection.
Conducting Focused Studies of Health Care Quality *Obstetrics Medical Home Record Review*	The results of the Obstetrics Medical Home review are reported separately.

Quartz Health Solutions, Inc.	
Programs Operated	**CY 2023 Enrollment by Program**
BC+, SSI	BC+: 48,372 SSI: 242
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Prenatal and Postpartum Care* • *Lead Screening*	**Strengths** – The organization conducted and reported detailed research regarding the topic selection and its importance to members for both projects. – The organization established a clear, concise, measurable and answerable aim statement for one project. – The organization clearly identified the PIP population in relation to the aim statement for both projects. – The organization selected PIP variables and performance measures that were clear indicators of performance for both projects. **Progress** – The organization outlined the personnel and relevant qualifications for all staff completing medical record review in the report. – Data analysis was conducted in accordance with the data analysis plan. – The same methodology was used for the baseline and repeat measurements.

Quartz Health Solutions, Inc.	
Programs Operated	**CY 2023 Enrollment by Program**
BC+, SSI	BC+: 48,372 SSI: 242
Findings	
	Recommendations – Ensure the aim statement is concise. – Ensure the aim statement is measurable by identifying a baseline measurement. – Ensure the project has a baseline measure identified in the report in order to analyze baseline and repeat measurements of project outcomes. – Include evidence of statistical testing to assess differences between the initial and repeat measurements. – For projects that have less-than-optimal performance, ensure the report includes lessons learned in the analysis of the PIP data. – Explain the rationale for the selected improvement strategies, including how the strategies are evidence-based. – Complete and document all stages of a rapid-cycle Plan-Do-Study-Act approach in the projects. – Continue to build methodologically sound performance improvement projects to ensure project results demonstrate an improvement from the baseline rates for projects. – Focus efforts on improving results to gain quantitative evidence of improvement through repeated measurements each year of a continuing project.
Protocol 2: Validation of Performance Measures	**Strengths** – Childhood Immunizations. – Immunizations for Adolescents. – Postpartum Care. – Prenatal Care. – Asthma Medication Ration. **Progress** – Improved Prenatal Care. **Recommendations** – Improve Lead Screening in Children.
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review *Accreditation Desk 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. **Progress** – At the direction of DHS, MetaStar revised the standards for CY 2023. Scoring methods from the previous Accreditation Desk Review are not comparable.

Quartz Health Solutions, Inc.	
Programs Operated	**CY 2023 Enrollment by Program**
BC+, SSI	BC+: 48,372 SSI: 242
Findings	
	Recommendations – Provide information to members on how to contact their designated primary care provider or primary care clinic. – Focus efforts on developing and implementing procedures to ensure coordination of services for members with other managed care organizations and fee-for-service Medicaid. – Ensure the organization assists members in identifying a primary care provider as part of the initial screening process – Share member needs with other managed care organizations to prevent duplication of services. – Ensure all federal and state requirements are written into policies and procedures in a timely manner for notices of decisions, specifically related to the provision of written notice of denial to the member and requesting provider, at the time of any action affecting the claim. – Develop and implement a process to ensure the organization does not prohibit a provider from advising or advocating on behalf of a member or patient. – Ensure credentialing policies and procedures include information identifying the circumstances in which site visits are appropriate in the credentialing process. – Develop a policy and procedure to verify each provider, other than an individual practitioner, is licensed and verify the accreditation status of providers if they claim accreditation. – Focus efforts on developing or adopting best practice guidelines that are based on valid and reliable clinical evidence, consider the needs of the organization's members, are adopted in consultation with contracting health care professionals, and are reviewed and updated periodically as appropriate. – Develop and implement a process to ensure practice guidelines are disseminated to members and potential members, upon request.
Protocol 9: Conducting Focused Studies of Health Care Quality *SSI Care Management Review*	**Strengths** – No strengths were identified. **Progress** – Following the CY 2021 review, revisions were made at the request of the Wisconsin Department of Health Services. Ratings from the previous reviews are not comparable. **Recommendations** – Ensure member screens are completed within 60 days of the member's enrollment. – Ensure member screens include all required assessment elements. – Complete member care plans timely. – Ensure the care plan includes all required elements. – Share the care plan with all required individuals. – Ensure the member agrees to the care plan prior to implementation.

Quartz Health Solutions, Inc.	
Programs Operated	**CY 2023 Enrollment by Program**
BC+, SSI	BC+: 48,372 SSI: 242
Findings	
	– Contact and connect with members based on members' needs and stratification level. – Conduct timely follow-up for all member needs and requests.
Appendix A: Information Systems Capabilities Assessments	**Strengths** – The organization was fully met in all Information System Categories evaluated through the organization's annual HEDIS® audit. **Progress** – Information Systems Capabilities Assessments were not evaluated in previous years; therefore, progress cannot be identified. **Recommendations** – The organization fully met all requirements. No recommendations were identified.
Conducting Focused Studies of Health Care Quality *Obstetrics Medical Home Record Review*	The results of the Obstetrics Medical Home review are reported separately.

Security Health Plan	
Programs Operated	**CY 2023 Enrollment by Program**
BC+, SSI	BC+: 70,839 SSI: 531
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Prenatal and Postpartum Care* • *Preventative Screening*	**Strengths** – The organization conducted and reported detailed research regarding the topic selection and its importance to members for both projects. – The organization established a clear, concise, measurable and answerable aim statement for one project. – The organization clearly identified the PIP population in relation to the aim statement for both projects. – The organization selected PIP variables and performance measures that were clear indicators of performance for both projects. – The organization used valid and reliable procedures to collect the PIP data and inform its measurements for one project. – The organization selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for one project. **Progress** – No progress was identified in the validation of the projects, and recommendations from the prior review were not successfully addressed in each project submitted. **Recommendations** – Include the project's improvement strategy in the aim statement.

Security Health Plan	
Programs Operated	**CY 2023 Enrollment by Program**
BC+, SSI	BC+: 70,839 SSI: 531
Findings	
	– Ensure aim statements are answerable by including all required elements. – Develop measurable aim statements by including a baseline measure for each aim. – Ensure the data collection plan is linked to the data analysis plan. – Ensure data analysis is conducted in accordance with the data analysis plan. – Ensure analysis includes baseline and repeat measures for each aim statement. – Include evidence of statistical analysis to assess differences between initial and repeat measures. – Account for any factors that may influence the comparability of baseline and remeasurement. – Ensure final project results are concise and easily understood. – Ensure improvement strategies are evidence based. – Design a strategy that accounts or adjusts for barriers that may impact project outcomes. – Utilize a Plan-Do-Study-Act approach to test the selected improvement strategies. – Incorporate cultural and linguistic considerations in improvement strategies. – Develop a plan to address variables encountered during the project. – Using data analysis and interpretation, assess the extent to which the improvement strategies were successful. – Ensure the same methodology is used for baseline and repeat measurements. – Continue to develop methodologically sound projects to demonstrate quantitative evidence of improvement. – Focus efforts on improving results of repeat measurements each year of a continuing project.
Protocol 2: Validation of Performance Measures	**Strengths** – Childhood Immunizations. – Immunizations for Adolescents. – Lead Screening in Children. – Postpartum Care. – Prenatal Care. **Progress** – Improved Childhood Immunizations. – Improved Lead Screening in Children. – Improved Postpartum Care. – Improved Prenatal Care. **Recommendations** – The organization's measures exceeded the state rate; therefore, no recommendations were identified.
Protocol 3: Compliance with Managed Care	

Security Health Plan	
Programs Operated	**CY 2023 Enrollment by Program**
BC+, SSI	BC+: 70,839 SSI: 531
Findings	
Regulations, Compliance with Standards Review *Accreditation Desk Review*	**Strengths** – The organization has strong systems in place to help members understand their rights as well as ensuring those rights are protected. **Progress** – At the direction of DHS, MetaStar revised the standards for CY 2023. Scoring methods from the previous Accreditation Desk Review are not comparable. **Recommendations** – Amend written guidance related to second opinions and use of out of network providers to apply to BC+ and SSI enrollees. – Update written guidance to specify the organization will cover services out of network for the enrollee, for as long as its network is unable to provide them. – Amend written guidance for staff to clearly specify the state standards for timely access to care and services according to the contract. – Update written guidance related to ensuring each member has an ongoing primary source of care to apply to members of the BC+ and SSI programs. – Amend written guidance to specify members may request disenrollment upon automatic reenrollment if temporary loss of Medicaid enrollment caused the member to miss the annual enrollment period and to specify the managed care organization's request for involuntary disenrollment must attest to cause. – Update written guidance to specify system disenrollment language related to automatic disenrollments, changes in member's circumstance, and exemption requests from the member; and to specify a member's right to be free from restraints or seclusion. – Implement a process to ensure all practice guidelines are available via Security Health Plan's website.
Protocol 9: Conducting Focused Studies of Health Care Quality *SSI Care Management Review*	**Strengths** – No strengths were identified. **Progress** – Following the CY 2021 review, revisions were made at the request of the Wisconsin Department of Health Services. Ratings from the previous reviews are not comparable. **Recommendations** – Ensure member screens are completed timely. – Focus efforts on member care plans to improve timeliness of completion, comprehensiveness of supports to address all assessed needs, and proper distribution of the plan, specifically to primary care providers. – Focus efforts on contacting members based on their needs and stratifications levels and ensure timely follow-up to member needs, specifically for physical health needs.

Security Health Plan	
Programs Operated	**CY 2023 Enrollment by Program**
BC+, SSI	BC+: 70,839 SSI: 531
Findings	
	– Ensure care plans are updated for changing member needs and that members are re-stratified after critical events; specifically, emergency room visits and unexpected hospitalizations. – Focus efforts on contacting members within five business days of discharge from an inpatient facility and ensure transition care follow-up includes a review of hospital discharge information with the member.
Appendix A: Information Systems Capabilities Assessments	**Strengths** – The organization was fully met in all Information System Categories evaluated through the organization's annual HEDIS® audit. **Progress** – Information Systems Capabilities Assessments were not evaluated in previous years; therefore, progress cannot be identified. **Recommendations** – The organization fully met all requirements. No recommendations were identified.
Conducting Focused Studies of Health Care Quality *Obstetrics Medical Home Record Review*	The results of the Obstetrics Medical Home review are reported separately.

United Healthcare Community Plan	
Programs Operated	**CY 2023 Enrollment by Program**
BC+, SSI	BC+: 222,091 SSI: 19,068
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Prenatal and Postpartum Care* • *Controlling Blood Pressure*	**Strengths** – The organization conducted and reported detailed research regarding the topic selection and its importance to members for both projects. – The organization established a clear, concise, measurable, and answerable aim statement for both projects. – The organization clearly identified the PIP population in relation to the aim statement for both projects. – The organization selected PIP variables and performance measures that were clear indicators of performance for both projects. – The organization used valid and reliable procedures to collect the PIP data and inform its measurements for both projects. – The organization used appropriate techniques to analyze the PIP data and interpret the results for both projects. – The organization selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for both projects. – The organization demonstrated statistically significant improvement that may be the result of its selected interventions for one project.

United Healthcare Community Plan	
Programs Operated	**CY 2023 Enrollment by Program**
BC+, SSI	BC+: 222,091 SSI: 19,068
Findings	
	Progress – No progress was identified in the validation of the projects, and recommendations from the prior review were not successfully addressed in each project submitted. **Recommendations** – Focus efforts on improving results to gain quantitative evidence of improvement through repeated measurements each year of a continuing project.
Protocol 2: Validation of Performance Measures	**Strengths** – Childhood Immunizations. – Lead Screening in Children. – Postpartum Care. – Prenatal Care. – Follow-Up After Hospitalization for Mental Illness. – Follow-Up After Emergency Department Visit for Mental Illness. – Hemoglobin A1C Control for Patients with Diabetes. **Progress** – Improved Childhood Immunizations. **Recommendations** – Improve Immunizations for Adolescents. – Asthma Medication Ration. – Antidepressant Medication Management.
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review *Accreditation Desk Review*	**Strengths** - The organization demonstrated the ability to ensure availability of accessible, culturally competent services through a network of qualified service providers. **Progress** – At the direction of DHS, MetaStar revised the standards for CY 2023. Scoring methods from the previous Accreditation Desk Review are not comparable. **Recommendations** – Focus efforts on developing and implementing procedures to ensure coordination of services for members with other managed care organizations, fee-for-service Medicaid, and between settings of care for appropriate discharge planning. – Share member needs with other managed care organizations to prevent duplication of services. – Update written guidance to include all member disenrollment requirements and limitations, specifically related to: - System based disenrollment; - Change in member circumstances resulting in disenrollment; and - Exemption requests.

United Healthcare Community Plan	
Programs Operated	**CY 2023 Enrollment by Program**
BC+, SSI	BC+: 222,091 SSI: 19,068
Findings	
	– Amend member rights policies and procedures to identify specific member rights. – Ensure policies and procedures include the organization's compliance with all applicable Federal and State laws for the protection of all member rights. – Develop and implement a process to ensure clinical practice guidelines are operational on the organization's website. – Ensure decisions for utilization management, member education, coverage of services, and other areas clinical practice guidelines apply are consistent with the clinical practice guidelines.
Protocol 9: Conducting Focused Studies of Health Care Quality *SSI Care Management Review*	**Strengths** – The organization demonstrated strengths related to the Wisconsin Interdisciplinary Care team practice. **Progress** – Following the CY 2021 review, revisions were made at the request of the Wisconsin Department of Health Services. Ratings from the previous reviews are not comparable. **Recommendations** – Complete member screens timely. – Complete care plans timely. – Share care plans with all required individuals. – Ensure members are contacted based on needs and stratification level. – Conduct timely follow-up for member needs and requests. – Complete care plan reviews at least once every 12 months. – Update care plans for changing member needs. – Contact members within five business days of discharge from an inpatient hospital facility. – Ensure transition care follow-up includes the review of hospital discharge information with the member.
Appendix A: Information Systems Capabilities Assessments	**Strengths** – The organization was fully met in all Information System Categories evaluated through the organization's annual HEDIS® audit. **Progress** – Information Systems Capabilities Assessments were not evaluated in previous years; therefore, progress cannot be identified. **Recommendations** – The organization fully met all requirements. No recommendations were identified.
Conducting Focused Studies of Health Care Quality *Obstetrics Medical Home Record Review*	The results of the Obstetrics Medical Home review are reported separately.

Children Come First	
Programs Operated	**CY 2023 Enrollment by Program**
	The CCF program ceased operations in June 2023.
Findings	
Protocol 1: Validation of Performance Improvement Projects • *School Connectedness*	**Strengths** – The organization conducted and reported detailed research regarding the topic selection and its importance to members for the project. – The organization clearly identified the PIP population in relation to the aim statement for the project. – The organization used valid and reliable procedures to collect the PIP data and inform its measurements for the project. **Progress** – The project's analysis was conducted in accordance with the data analysis plan. **Recommendations** – Identify an improvement strategy as part of the aim statement. – Ensure the aim statement clearly specifies the project's start and end measurement period. – Ensure the aim statement is answerable by including all required components. – Include baseline rates along with the goals for improvement in the aim statement. – Design performance measures to monitor, track, and compare performance over the course of the project timeframe. – Describe and implement an interrater reliability process for manual data entry. – Design performance measures to monitor, track, and compare performance over the course of the project timeframe. – Describe and implement an interrater reliability process for manual data entry. – Include a rapid-cycle Plan-Do-Study-Act approach to evaluate improvement strategies. – Identify variables that may influence the outcome of the project, and ensure strategies are designed to address the identified variables. – Analyze the impact of the interventions on the project and identify follow-up activities based on the analysis of the strategies. – Build a methodologically sound performance improvement project to ensure project results demonstrate an improvement from the baseline rates for each component of the study question or aim statement.
Protocol 2: Validation of Performance Measures	Performance measures were not established and validated in CY 2023. The organization ceased program operations in CY 2023.
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review	The organization's last Compliance with Standards Review was conducted in CY 2021. The organization ceased program operations in CY 2023.

Children Come First	
Programs Operated	**CY 2023 Enrollment by Program**
	The CCF program ceased operations in June 2023.
Findings	
Appendix A: Information Systems Capabilities Assessments	The organization's last Information Systems Capability Assessment was conducted in CY 2021. The organization ceased program operations in CY 2023.

Wraparound Milwaukee	
Programs Operated	**CY 2023 Enrollment by Program**
	604
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Literacy*	**Strengths** – The organization conducted and reported detailed research regarding the topic selection and its importance to members for the project. – The organization clearly identified the PIP population in relation to the aim statement for the project. – The project demonstrated improvement. **Progress** – Built a methodologically sound performance improvement project to ensure project results demonstrated an improvement from the baseline rates for each study question or aim statement. **Recommendations** – Clearly specify the correct time period for the PIP in each aim statement. – Ensure each aim statement is answerable by including accurate criteria for the aim. – Ensure the project includes a strategy for inter-rater reliability for manual data collection. – Provide a description of how data collection from the electronic health record validates the collected data is accurate and complete. – Assess statistical significance between the initial and repeat measures with an established baseline. – Compare multiple entities within the project, such as member subgroups of race, gender, and/or zip code.
Protocol 2: Validation of Performance Measures	DHS did not identify performance measures for the organization in CY 2023. DHS continues ongoing discussions to establish measures.
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review	The organization's last Compliance with Standards Review was conducted in CY 2021.
Protocol 9: Conducting Focused Studies of Health Care Quality	**Strengths** – No strengths were identified. **Progress**

Wraparound Milwaukee	
Programs Operated	**CY 2023 Enrollment by Program**
	604
Findings	
WM Care Management Review	– The care management review was newly created in CY 2023; therefore, no results are available to identify progress. **Recommendations** – Determine initial eligibility within five business days of referral. – Ensure assessments are comprehensive. – Complete all required tasks prior to care plan completion. – Ensure the initial care plan is developed within 30 days of enrollment. – Review and update the care plan at least every three months, or when indicated. – Ensure care plans are comprehensive. – Ensure the care plan is reviewed and signed by all required team members. – Conduct timely follow-up for member needs and services. – Develop the transition plan with input from all required team members.
Appendix A: Information Systems Capabilities Assessments	The organization's last Information Systems Capabilities Assessments was conducted in CY 2021.

DHS directed MetaStar to conduct additional optional reviews for non-managed care benefit programs. The purpose of the reviews was to ensure each organization was adhering to the requirements of the benefit program or health home.

Children's Hospital of Wisconsin	
Programs Operated	**CY 2023 Enrollment by Program**
Children with Medical Complexity	Not publicly reported
Findings	
Record Review	**Strengths** – Program eligibility requirements were strengths for the organization. – The organization demonstrated strengths related to service reduction or termination. **Progress** – No progress was identified. **Recommendations** – Place priority on ensuring care plans are comprehensive by including specific actions to meet goals and writing timeframes for initiating and/or completing the identified actions. – Ensure the family has monthly contact with their primary point of contact and that this is documented.

Marshfield Children's Hospital	
Programs Operated	**CY 2023 Enrollment by Program**
Children with Medical Complexity	Not publicly reported
Findings	
Record Review	**Strengths** – Program eligibility requirements were strengths for the organization. – The organization demonstrated strengths related to the assessment process. – The organization demonstrated strengths related to ongoing monitoring and care coordination **Progress** – No progress was identified. **Recommendations** – Ensure comprehensive care plans by including timeframes for initiating and/or completing the identified actions.

UW-American Family Children's Hospital	
Programs Operated	**CY 2023 Enrollment by Program**
Children with Medical Complexity	Not publicly reported
Findings	
Record Review	**Strengths** – Program eligibility requirements were strengths for the organization. – The organization demonstrated strengths related to comprehensiveness of assessments. – Service reduction or termination requirements were organizational strengths. **Progress** – The organization demonstrated progress in the area of comprehensiveness of care plans. **Recommendations** – Ensure that post-hospitalization follow-up visits with the participant and/or the family occur within three business days.

Vivent Health	
Programs Operated	**CY 2023 Enrollment by Program**
HIV/AIDS Health Home	Not publicly reported
Findings	
Record Review	**Strengths** – The organization ensured members served by the program meet eligibility requirements. – Members were informed that participation in the health home program is voluntary. **Progress**

Vivent Health	
Programs Operated	**CY 2023 Enrollment by Program**
HIV/AIDS Health Home	Not publicly reported
Findings	
	– The record review was revised for CY 2023; therefore, no results are available to identify progress. **Recommendations** – Conduct discussions with members regarding the ability to appoint an authorized agent to support the member. – Ensure the timeliness of initial assessments and annual reassessments. ○ Update assessments to ensure the inclusion of all requirements as outlined in the Medicaid Handbook, including the pharmacist review of medications. – Complete initial care planning and updates to the plan timely. – Prioritize the implementation of a comprehensive care plan. – Implement a process to ensure follow up to community referrals are completed no later than two weeks after the referral. – Develop a systematic approach to ensure regular contact with members including face-to-face contacts. – Ensure timely and comprehensive follow up for the transition of care following hospitalizations and emergency department visits.

Protocol 1: Validation of Performance Improvement Projects

The Validation of Performance Improvement Projects (PIPs) is a mandatory EQR 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 1. Validation of Performance Improvement Projects*. See Appendix 2 for more information about the PIP review methodology.

DHS contractually requires organizations operating BC+, SSI, CCF, WM, and FCMH to make active progress on at least one clinical and one non-clinical PIP annually. 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 PIP topic(s);
- Review the PIP aim statement(s);
- Review the identified PIP population;
- Review sampling methods (if sampling used);
- Review the selected PIP variables and performance measures;
- Review the data collection procedures;
- Review the data analysis and interpretation of PIP results;
- Assess the improvement strategies; and
- Assess the likelihood that significant and sustained improvement occurred.

DHS requires MCOs and PIHPs to submit each PIP project for pre-approval by providing a preliminary summary which states the proposed topic, study question, and a brief description of the planned interventions and study design. Both DHS and the EQRO review the PIP preliminary proposals; DHS determines if the selected topic is aligned with Department goals, and the EQRO reviews the methodology and study design proposed by the MCO. This activity is considered PIP technical assistance. For projects conducted during MY 2022, organizations submitted proposals for all projects to DHS and MetaStar by December 1, 2021. DHS directed MCOs to submit final reports by July 1, 2023.

CMS provided feedback to EQROs to incorporate two PIP rating scales, validity and reliability of the PIP methods and findings. In coordination with DHS, MetaStar has created two ratings

scales to be used during the CY 2024 PIP validations. The validity and reliability of the PIP methods and findings will be assessed to determine whether the EQRO has confidence in the PIP results. The validation ratings reflect the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement. Compliance with PIP requirements is expressed through validation ratings for the project's methodology and evidence of significant improvement.

Overall PIP Results

Compliance with PIP requirements is expressed in terms of a percentage score based on the number of applicable scoring elements, and a validation rating, as identified in the table below. The validation rating reflects the EQRO's confidence in the PIP's methods and findings. The validation rating reflects the EQRO's confidence in the PIP's methods and findings.

Percentage of Scoring Elements Met	Validation Result
90.0% - 100.0%	High Confidence
80.0% - 89.9%	Moderate Confidence
70.0% - 79.9%	Low Confidence
<70.0%	No Confidence

The following table lists each standard that was evaluated for each MCO and PIHP and indicates the total number of scoring elements and percentage of scoring elements met for each standard. The validation result for each standard is also included. Some standards are not applicable to all projects due to study design, results, or implementation stage.

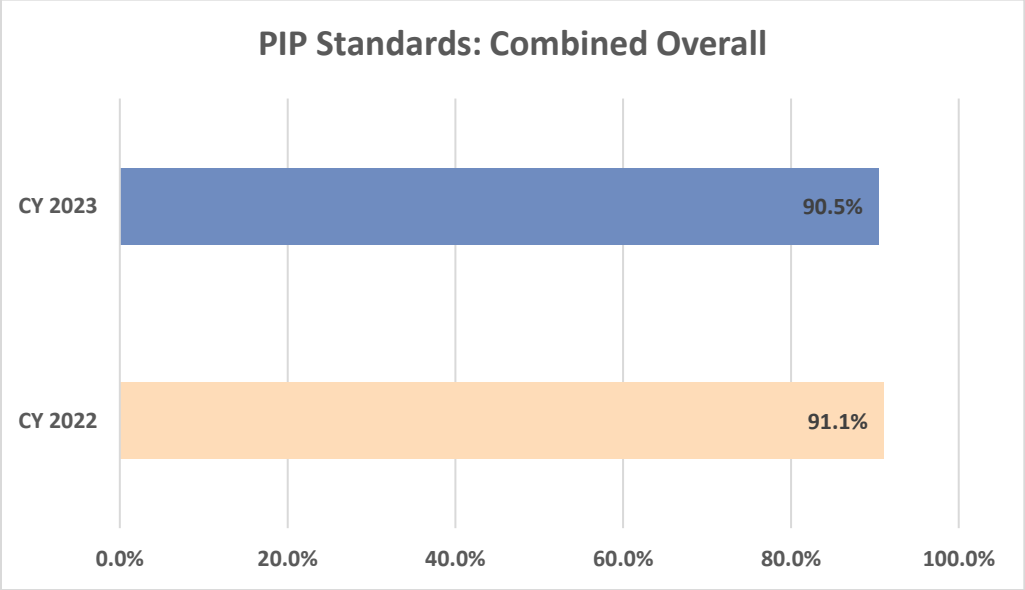
The overall score for all projects validated in CY 2023 was 90.5 percent, with a validation result of High Confidence.

Performance Improvement Project Validation Review CY 2023			
Standard	**Scoring Elements**	**Percentage**	**Validation Result**
Standard 1: PIP Topic	82/82	100.0%	High Confidence
Standard 2: PIP Aim Statement	171/186	91.9%	High Confidence
Standard 3: PIP Population	62/62	100.0%	High Confidence
Standard 4: Sampling Method*	N/A	N/A	N/A
Standard 5: PIP Variables and Performance Measures	195/198	98.5%	High Confidence
Standard 6: Data Collection Procedures	313/328	95.4%	High Confidence

Performance Improvement Project Validation Review CY 2023			
Standard	**Scoring Elements**	**Percentage**	**Validation Result**
Standard 7: Data Analysis and Interpretation of PIP Results	146/183	79.8%	Low Confidence
Standard 8: Improvement Strategies	163/186	87.6%	Moderate Confidence
Standard 9: Significant and Sustained Improvement	83/117	70.9%	Low Confidence
Overall Score	**1,215/1,342**	**90.5%**	**High Confidence**

*No projects utilized sampling for this project; this standard is not applicable.

The graph below illustrates the State's overall compliance with these standards in CY 2023 and compares the score to the same standards reviewed in CY 2022.



Results for each PIP Standard

Each section that follows provides a brief explanation of the PIP standards, including rationale for any areas where the organizations were not fully compliant. Additionally, Appendix 3 includes results for each standard by organization.

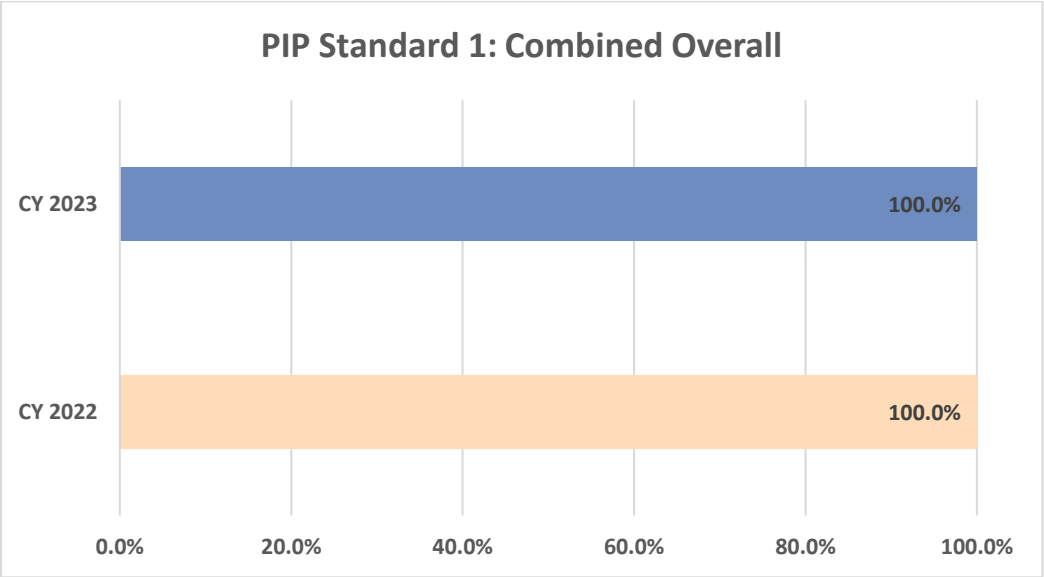
Observation and Analysis: Standard 1. PIP Topic

The organizations should target improvement in relevant areas of clinical and non-clinical services. The topic selection process should consider the national Quality Strategy, CMS Core Set Measures, and DHS priorities. When appropriate or feasible, enrollee and provider input should be obtained. All topics should address areas of special populations or high priority

services. Standard 1 evaluates each PIP on five possible scoring elements. Collectively, the organizations satisfied requirements for 82 out of 82 scoring elements, for a score of 100.0 percent.

All organizations satisfied all scoring elements of this standard. DHS designated the topic of postpartum care for the BC+ programs. Organizations operating SSI, CCF, WM, and FCMH chose topics that focused on health disparities. Each organization demonstrated how the PIP topics aligned with DHS and CMS priority areas.

The graph below illustrates the State's overall compliance with this standard in CY 2023 and compares the score to the same standard reviewed in CY 2022.



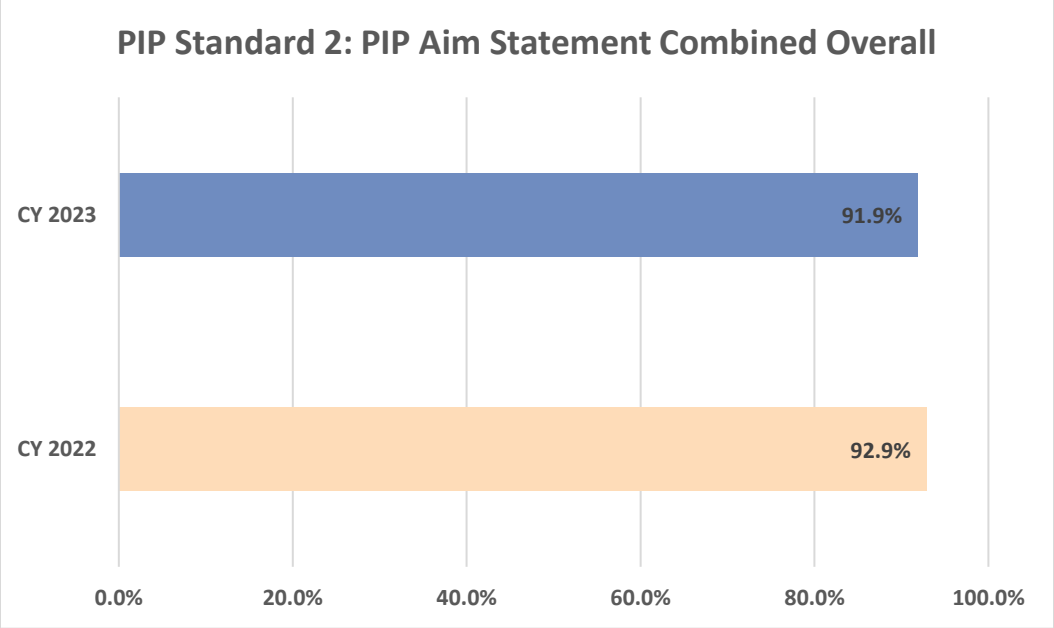
Observation and Analysis: Standard 2. PIP Aim Statement

The PIP aim statement identifies the focus of the PIP and establishes the framework for data collection and analysis. It should be a clear, concise, measurable, and answerable statement or question that identifies the improvement strategy, population, and time period. Standard 2 evaluates each PIP on six possible scoring elements. Collectively, the organizations satisfied requirements for 171 out of 186 scoring elements, for a score of 91.9 percent.

Projects included aim statements that satisfied most scoring elements of this standard. Organizations that operated the BC+ program conducted state-required projects aiming to improve postpartum care rates by reducing health disparities for underrepresented

populations. Other common PIP topics focused on preventative care such as controlling high blood pressure, diabetic care, vaccination rates, and lead screening in children.

The graph below illustrates the State's overall compliance with this standard in CY 2023 and compares the score to the same standard reviewed in CY 2022.

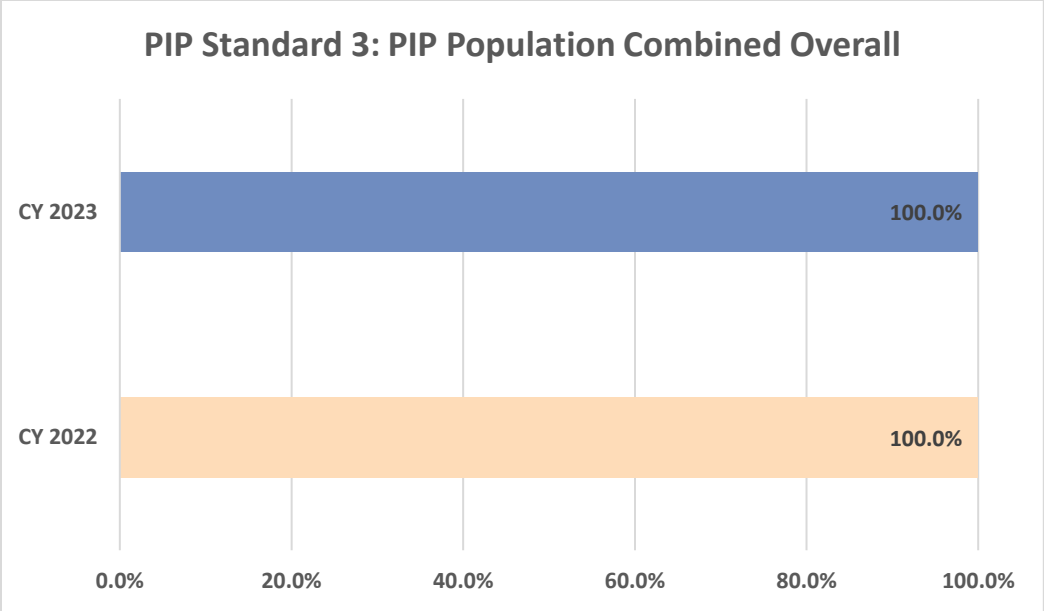


Observation and Analysis: Standard 3. PIP Population

The organizations must clearly define the project's population, identifying all inclusionary and exclusionary criteria. If the entire eligible MCOs population is included in the project, the data collection approach must ensure it captures all applicable members. Standard 3 evaluates each PIP on two possible scoring elements. Collectively, the organizations satisfied requirements for 62 out of 62 scoring elements, for a score of 100 percent.

The organizations clearly defined the projects' populations. Projects that utilized HEDIS® measures utilized appropriate and accurate specifications. Inclusion and exclusion criteria were delineated in the reports to ensure projects included all eligible members specified in the aim statement.

The graph below illustrates the State's overall compliance with this standard in CY 2023 and compares the score to the same standard reviewed in CY 2022.



Observation and Analysis: Standard 4. Sampling Method

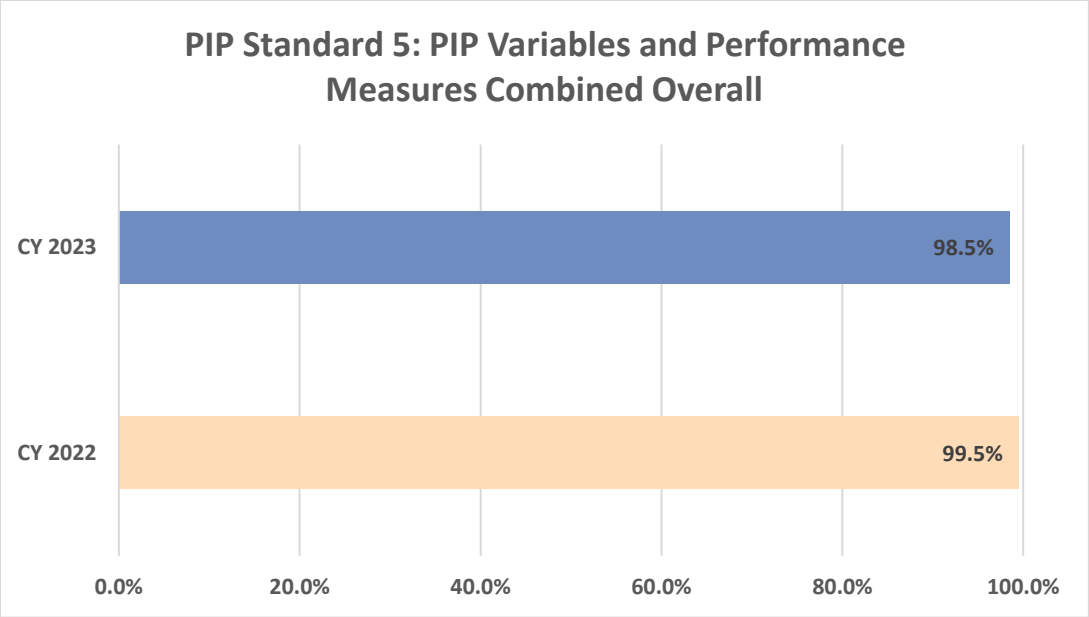
The organizations must have appropriate sampling methods to ensure data collection produces valid and reliable results. Standard 4 evaluates each PIP on five possible scoring elements. None of the organizations utilized sampling for the projects.

Observation and Analysis: Standard 5. PIP Variables and Performance Measures

Organizations must select variables that identify the organizations' performance on the PIP questions objectively and reliably, using clearly defined indicators of performance. The PIP should include the number and type of variables that are adequate to answer the PIP question, can measure performance, and can track improvement over time. Standard 5 evaluates each PIP on 10 possible scoring elements. Collectively, the organizations satisfied requirements for 195 out of 198 scoring elements, for a score of 98.5 percent.

Most organizations utilized HEDIS® measures for the projects. The PIP variables and performance measures were clear indicators of performance that addressed the aim statement. The variables for most projects monitored access to care and improvement of member health outcomes through reduction in health disparities of underrepresented populations. Analysis of the performance measures throughout the project informed the selection or revision of the improvement strategies.

The graph below illustrates the State's overall compliance with this standard in CY 2023 and compares the score to the same standard reviewed in CY 2022.



Observation and Analysis: Standard 6. Data Collection Procedures

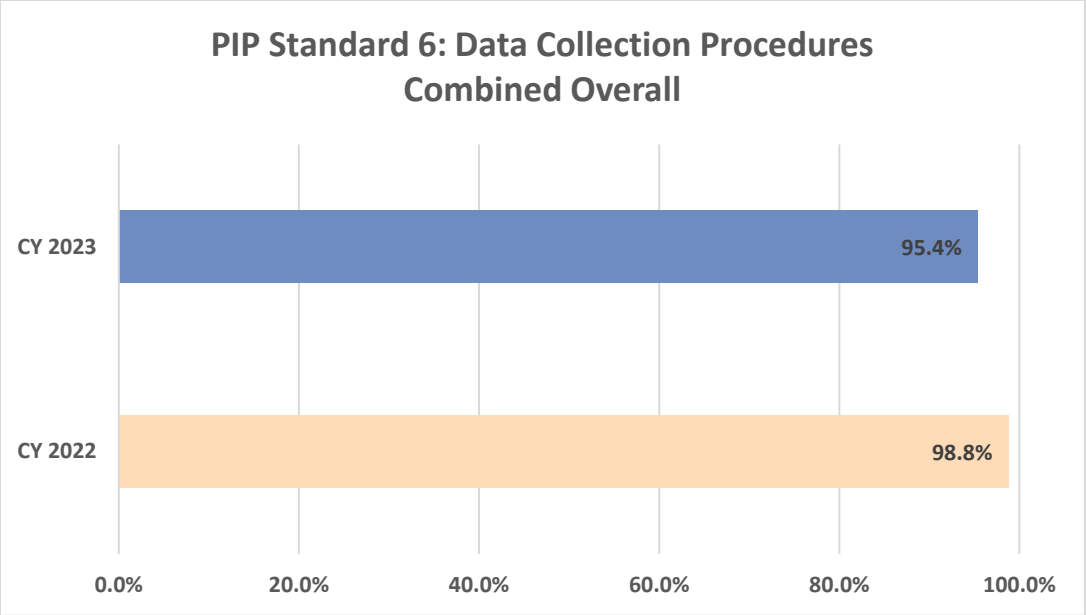
Organizations must establish data collection procedures that ensure valid and reliable data throughout the project. The data collection plan should specify the following:

- Data sources;
- Data to be collected;
- How and when data was collected;
- How often data was collected;
- Who collected the data; and
- Instruments used to collect data.

Standard 6 evaluates each PIP on 16 possible scoring elements. Collectively, the organizations satisfied requirements for 313 out of 328 scoring elements, for a score of 95.4 percent.

Organizations documented project's data collection procedures and ensured the procedures aligned with the data analysis. Organizations utilizing HEDIS® measures used NCQA approved software to collect valid and consistent data. To ensure accuracy and consistency of data collection, most organizations documented the credentials, experience, and inter and intra-rater reliability process for staff collecting data.

The following graph illustrates the State's overall compliance with this standard in CY 2023 and compares the score to the same standard reviewed in CY 2022.



Observation and Analysis: Standard 7. Data Analysis and Interpretation of PIP Results

Organizations must use appropriate techniques to conduct analysis and interpretation of the PIP results. The analysis should include an assessment of the extent to which any change in performance is statistically significant. Standard 7 evaluates each PIP on eight possible scoring elements. Collectively, the organizations satisfied requirements for 146 out of 183 scoring elements, for a score of 79.8 percent.

Scoring element 7.1 assesses if the data analysis was conducted in accordance with the data analysis plan. Several projects did not identify a data analysis plan. This did not satisfy the requirements for scoring element 7.1. MetaStar recommends organizations identify a plan for data analysis.

Scoring element 7.3 evaluates the statistical significance of differences between the initial and repeat measures. Over half of the projects did not include evidence the organization conducted statistical testing for any change between the initial and repeat measurement. This did not satisfy the requirements for scoring element 7.3. MetaStar recommends the organizations include use of a statistical test to analyze and assess for differences between initial and repeat measures.

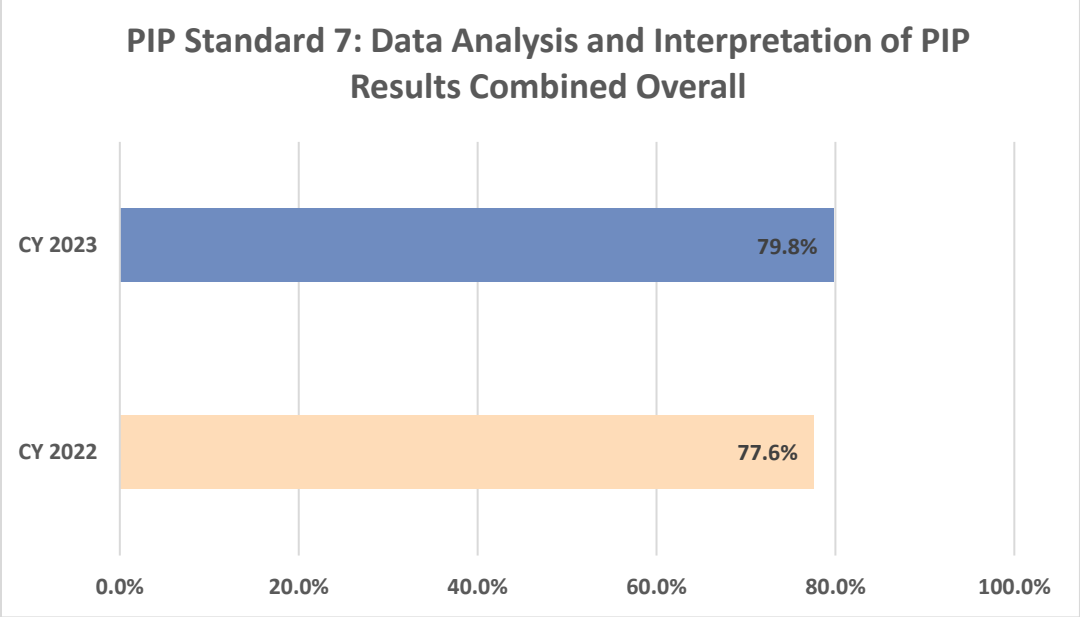
Scoring element 7.6 determines if organizations compared results across multiple entities. Several organizations did not compare their findings with other entities or subgroups. This did

not satisfy the requirements for scoring element 7.6. MetaStar recommends organizations compare findings of the projects with other entities or subgroups.

Scoring element 7.7 assesses if results and findings were presented in a concise and easily understood manner. Many reports included extraneous data and analysis that was not relevant to the outcome of the project. In some reports, discrepancies were found between data tables and report narrative. This did not satisfy the requirements for scoring element 7.7. MetaStar recommends organizations present project outcomes in a clear, concise, and easily understood manner.

Scoring element 7.8 ensures the analysis and interpretation of the PIP data included lessons learned about less-than-optimal performance. Many projects did not meet the goal stated in the aim statement, and the projects' analysis did not include an exploration of why the interventions may not have been effective. This did not satisfy the requirements for scoring element 7.8. MetaStar recommends organizations include an analysis of interventions that did not perform as expected, and the impact of the interventions on the outcome of the project.

The graph below illustrates the State's overall compliance with this standard in CY 2023 and compares the score to the same standard reviewed in CY 2022.



Observation and Analysis: Standard 8. Improvement Strategies

Organizations should select improvement strategies that are evidence-based, suggesting they would likely lead to the desired improvement. The effectiveness of the strategies is determined by measuring the change in performance according to the measures identified in Standard 5. Standard 8 evaluates each PIP on six possible scoring elements. Collectively, the organizations satisfied requirements for 163 out of 186 scoring elements, for a score of 87.6 percent.

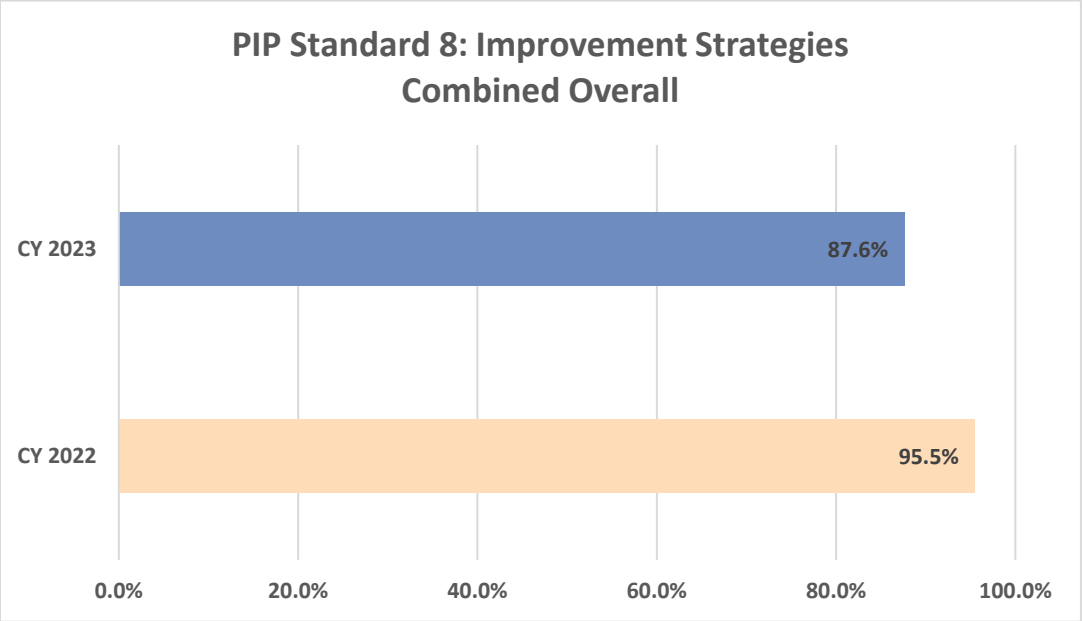
All BC+ projects on postpartum care and all SSI projects included the following state-required PIP interventions:

- Continued partnerships with clinics;
- Expanded partnership activities to an additional clinic;
- Clinic partnerships included the following strategies:
    - Offered services by non-traditional providers, such as doulas or community health workers;
    - Continued an organizational cultural competency and disparities reduction plan;
    - Supplied providers trainings on culturally and linguistically appropriate services targeted to reduce health disparities; and,
    - Implemented the Drivers of Health Improvement Plan;
- Conducted needs assessments to identify highest priority drivers of health needs;
- Partnered with community-based organizations to launch service to address need identified through needs assessment; and,
- Completed partnership assessments.

Scoring element 8.3 assesses if a Plan-Do-Study-Act (PDSA) approach was utilized to test the selected improvement strategies. Many reports did not outline the strategies, such as a PDSA cycle, utilized during the project to evaluate the effectiveness of interventions. This did not satisfy the requirements for scoring element 8.3. MetaStar recommends organizations conduct PDSA cycles throughout a project to determine the effectiveness of improvement strategies.

Scoring element 8.6 evaluates if analysis and interpretation of PIP results were utilized to assess the extent to which the improvement strategy was successful and identify potential follow-up activities. Several organizations reported the PIP project did not achieve the desired result; however, there was no discussion of why the project did not meet the goal, or how strategies may be revised to improve future performance. This did not satisfy the requirements for scoring element 8.6. MetaStar recommends organizations analyze PIP projects to determine opportunities for improvement in the implementation and management of PIPs.

The graph below illustrates the State's overall compliance with this standard in CY 2023 and compares the score to the same standard reviewed in CY 2022.



Observation and Analysis: Standard 9. Significant and Sustained Improvement

An important component of a PIP is to demonstrate sustained improvement. The organizations should conduct repeated measurements using the same methodology and document if a significant change in performance relative to the baseline occurred. Standard 9 evaluates each PIP on five possible scoring elements. Collectively, the organizations satisfied requirements for 83 out of 117 scoring elements, for a score of 70.9 percent.

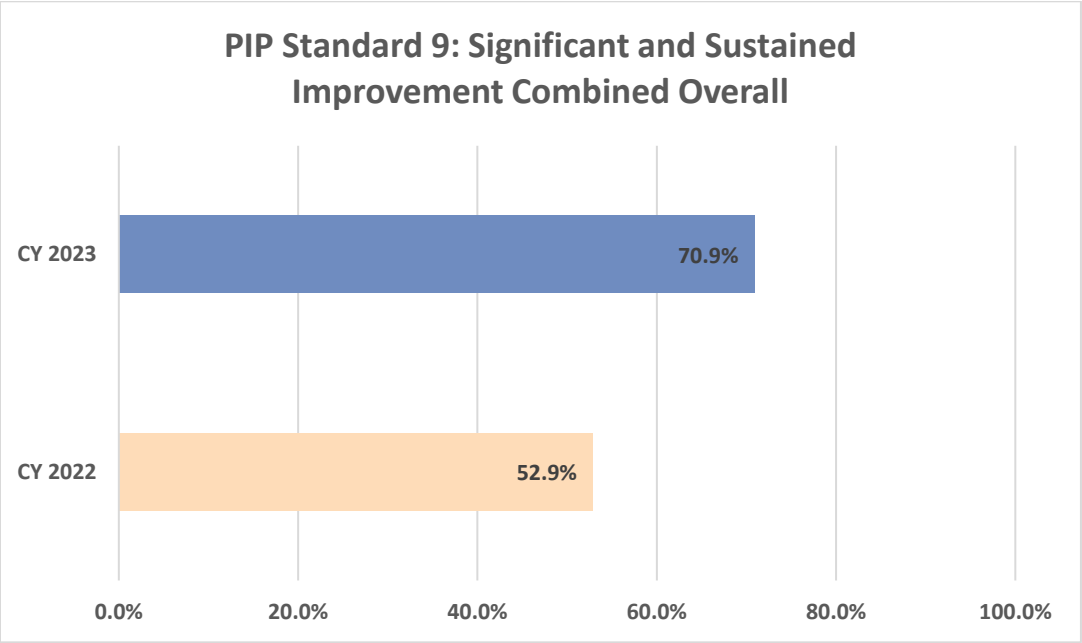
Scoring element 9.2 assesses if there was quantitative evidence of improvement in processes or outcomes of care. Many projects did not achieve the desired goal when barriers were encountered, or there were unexpected variables that affected the validity of the results. This did not satisfy the requirements for scoring element 9.2. MetaStar recommends the organizations design methodologically sound projects to increase the probability of demonstrating improvement.

Scoring element 9.4 ensures there is statistical evidence that any observed improvement is the result of the intervention. Of the projects that demonstrated improvement, many did not conduct a statistical test to determine if the improvement was due to the interventions or normal variance or chance. This did not satisfy the requirements for scoring element 9.4.

MetaStar recommends organizations conduct statistical testing between baseline and repeat measures to demonstrate any improvement is the result of the interventions.

Scoring element 9.5 assesses if sustained improvement was demonstrated through repeated measurements over time. Many projects that were conducted over multiple years did not demonstrate an improvement in rates each year of the project. This did not satisfy the requirement for element 9.5. MetaStar recommends organizations focus efforts on improving results of repeat measurements each year of a continuing project.

The graph below illustrates the State's overall compliance with this standard in CY 2023 and compares the score to the same standard reviewed in CY 2022.



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 (PMV) 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 or reports compliance with the ISCA through the MCO's HEDIS® audit results. The ISCAs and verification of the MCO's HEDIS® audit results are conducted and reported separately.

The MCO quality indicators for CY 2022, reported in CY 2023, are set forth in the annual *Wisconsin 2023 Department of Health Services (DHS) Division of Medicaid Services (DMS) HMO Quality Guide (Quality Guide).* In addition to using this data to meet CMS performance measures requirements, DHS also uses the information to set and monitor quality performance benchmarks with each individual MCO. DHS has established pay for performance (P4P) incentives as a performance improvement strategy for MCOs, to improve priority HEDIS® scores. This strategy is a key component of the *Division of Medicaid Services Medicaid Managed Care Strategy*. The strategy links the mandatory *EQR Protocol 2: Validation of Performance Measures Reported by the MCO* review described in this report with some of the PMV requirements for MCOs.

DHS has identified three composites for the BC+ program and one composite for the SSI program. The BC+ composites were made up of maternal health composite (two the MCO's HEDIS® audit results measures), disease management composite (four the MCO's HEDIS® audit results measures) and a children's composite (four the MCO's HEDIS® audit results measures). The SSI composite included seven the MCO's HEDIS® audit results measures. Each MCO could earn the following points based on the level of performance:

- Four points if the rate was at or above the national 75th percentile for the measure;
- Three points for a rate at or above the 67th percentile;
- Two points for a rate at or above the 50th percentile;

If an MCO does not earn points for the level of performance they may earn points based on a reduction in error.

- Two points if results below the 50th percentile but a 10% or greater reduction in error from the MCO's 2021 performance
- One point if below the 50th percentile but a 5% or greater reduction in error from the MCO's 2021 performance
- Zero points for a rate below the 50th percentile and less than a 5% increase over the MCO's 2021 performance

Each MCO's the MCO's HEDIS® audit results measure results are validated by NCQA certified the MCO's HEDIS® audit results auditor, then submitted to DHS. MetaStar did not validate the CY 2022 measures, following is an analysis of the reported results.

Results

Findings are categorized into strength, compliant, and opportunity for improvement. A strength is identified as a measure rate at or above the 75th percentile and an opportunity for improvement is a measure rate that is the 50th percentile or lower.

The following tables identify statewide rates compared to the 50th and 75th percentile benchmarks by measure.

Program: BC+ Composite Measures	Statewide Rate	50th Percentile	75th Percentile
BC+ Women's Health Composite			
Timeliness of Prenatal Care (PPC)	85.2%	85.9%	89.3%
Postpartum Care (PPC)	79.5%	76.4%	79.6%
BC+ Children's Health Composite			
Childhood Immunization (CIS)-Combo 3	58.1%	67.9%	72.8%
Immunizations for Adolescents (IMA)-Combo 2	35.3%	36.7%	43.6%
Lead Screening in Children (LSC)	64.9%	71.5%	77.9%

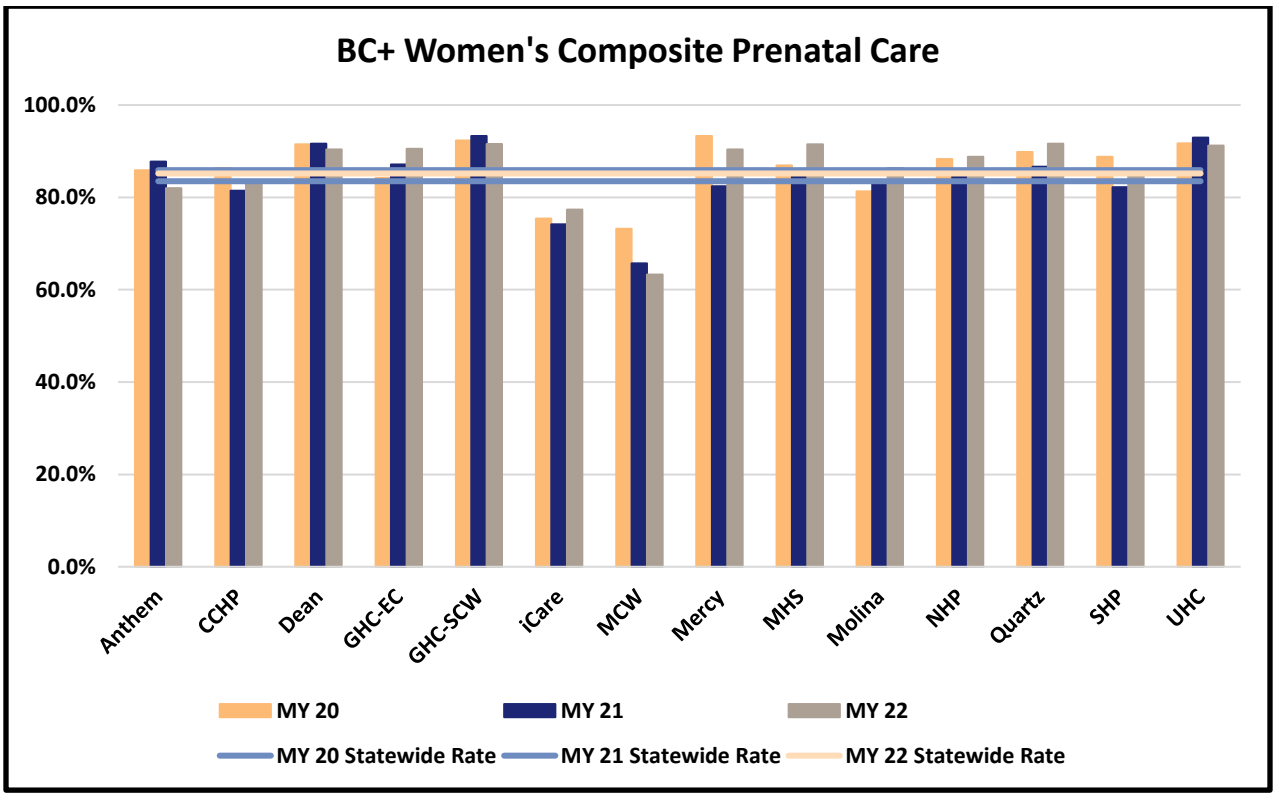
Program: SSI Composite Measures	Statewide Rate	50th Percentile	75th Percentile
Performance Measures			
Antidepressant Medication Measure (AMM) - Continuation	56.9%	40.3%	45.6%
Hemoglobin A1C Control for Patients with Diabetes (HBD)	55.6%	46.8%	51.3%
Asthma Medication Ratio (AMR)-Total	63.9%	64.8%	70.7%
Follow-Up after Emergency Department Visit for Mental Illness (FUM-30)-Total 30 days follow up	57.7%	53.5%	64.6%
Follow-Up after Hospitalization for Mental Illness (FUH-30)-Total 30-day follow-up	31.5%	60.1%	67.5%

The results for each measure reported by MCO compared to the statewide aggregate and national benchmarks of the 50th percentile and 75th percentile are summarized below. See Appendix 4 for State Benchmark and MCO rates.

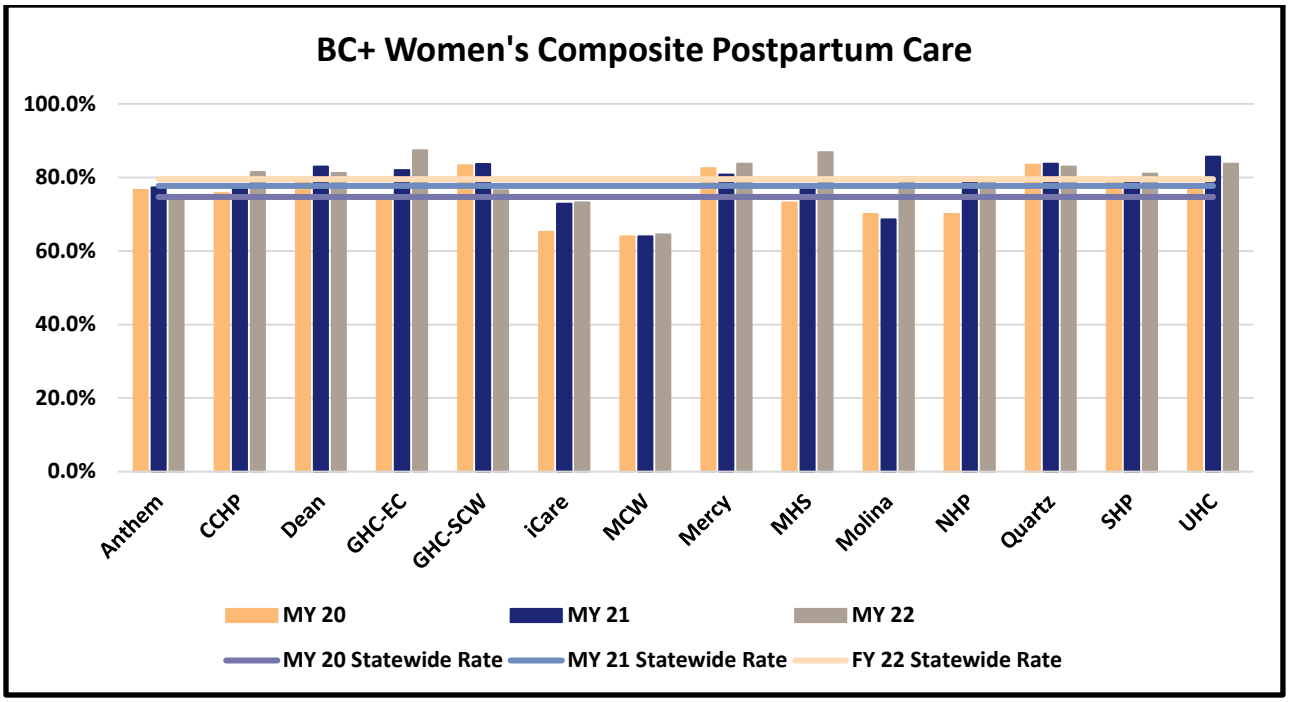
Although rates have been finalized, Anthem has identified impacts to the calculations of Anthem's final rates that were not fully corrected. This information should be considered when comparing final MCO rates.

BC+ Women's Health Composite

The following graph displays the results for Timeliness of Prenatal Care measure by MCO.

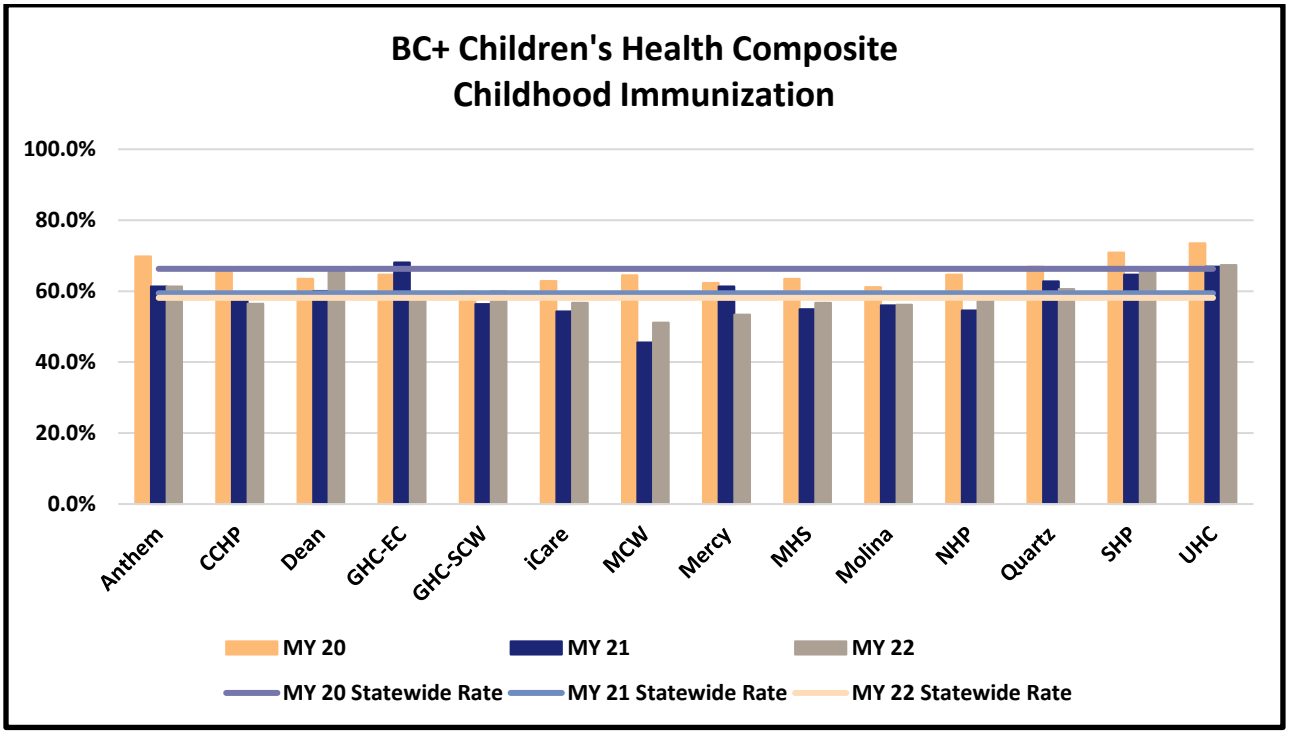


The following graph displays the results for the Postpartum Care measure by MCO.

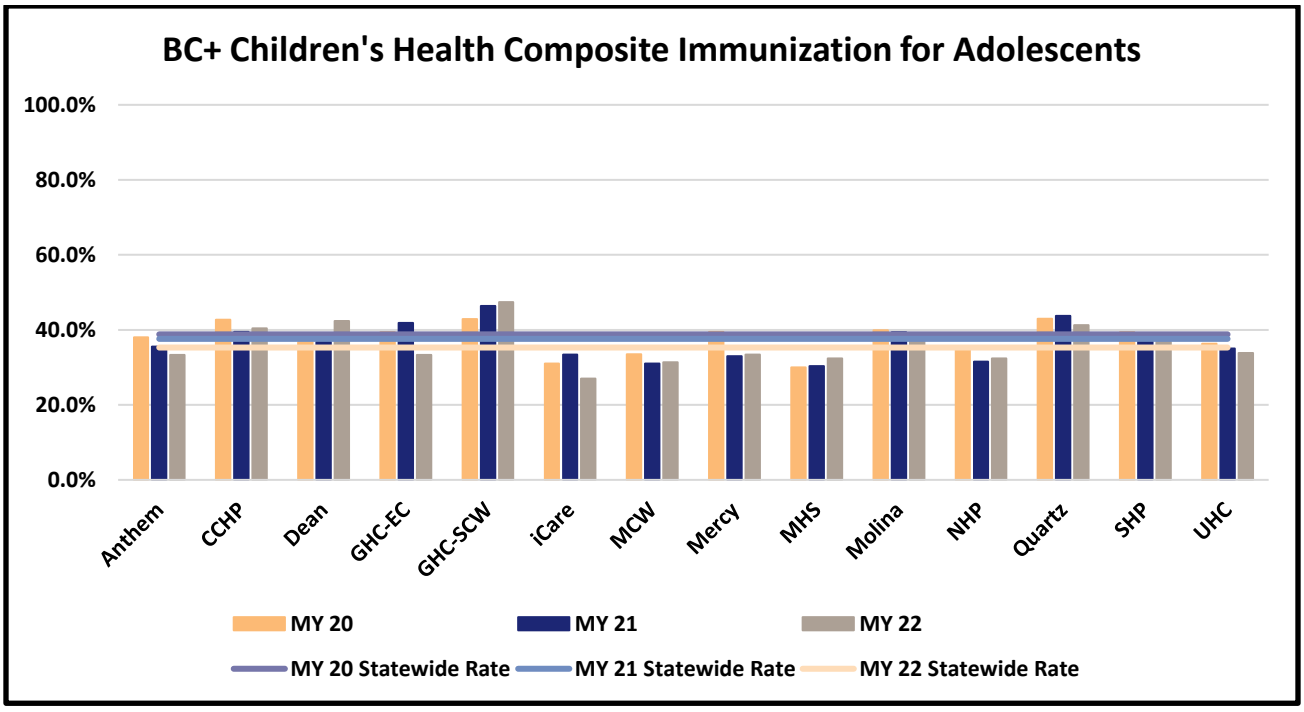


BC+ Children's Health Composite

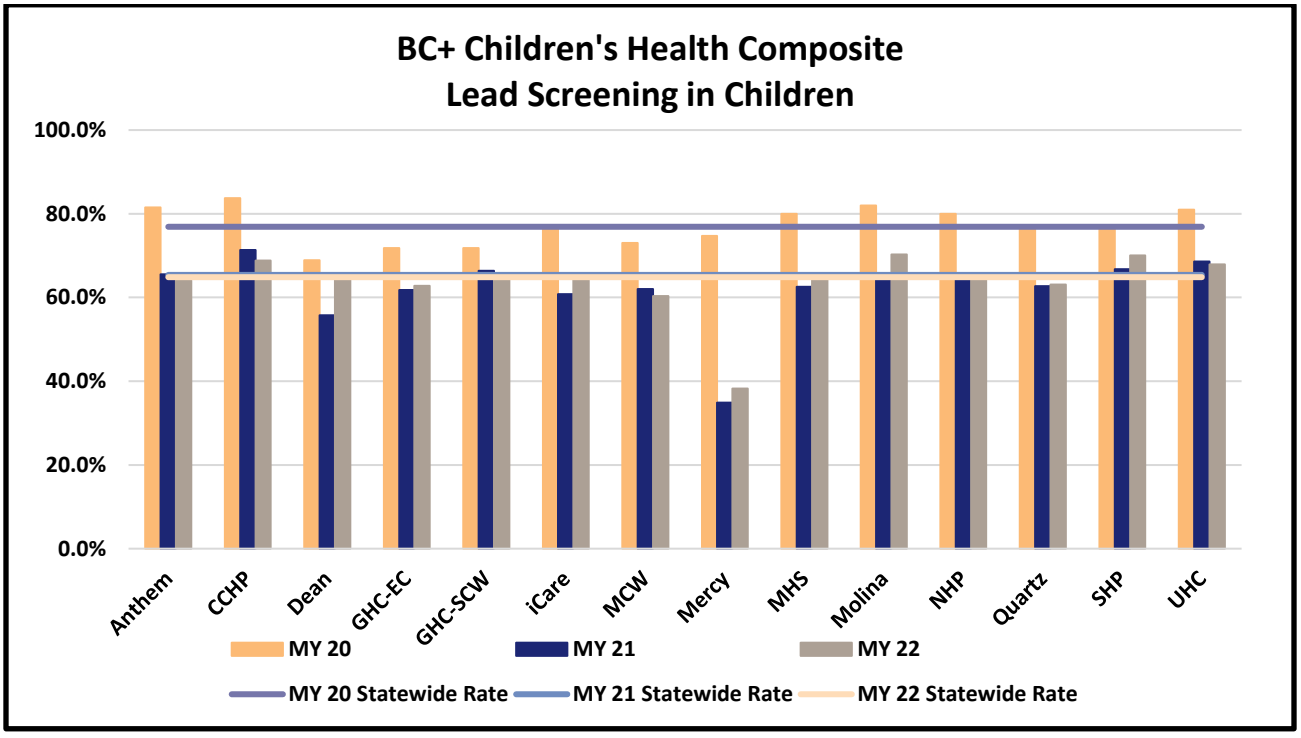
The following graph displays the results for CIS Combo 3 by MCO.



The graph below displays the results for the Immunizations for Adolescents Combo 2 by MCO.

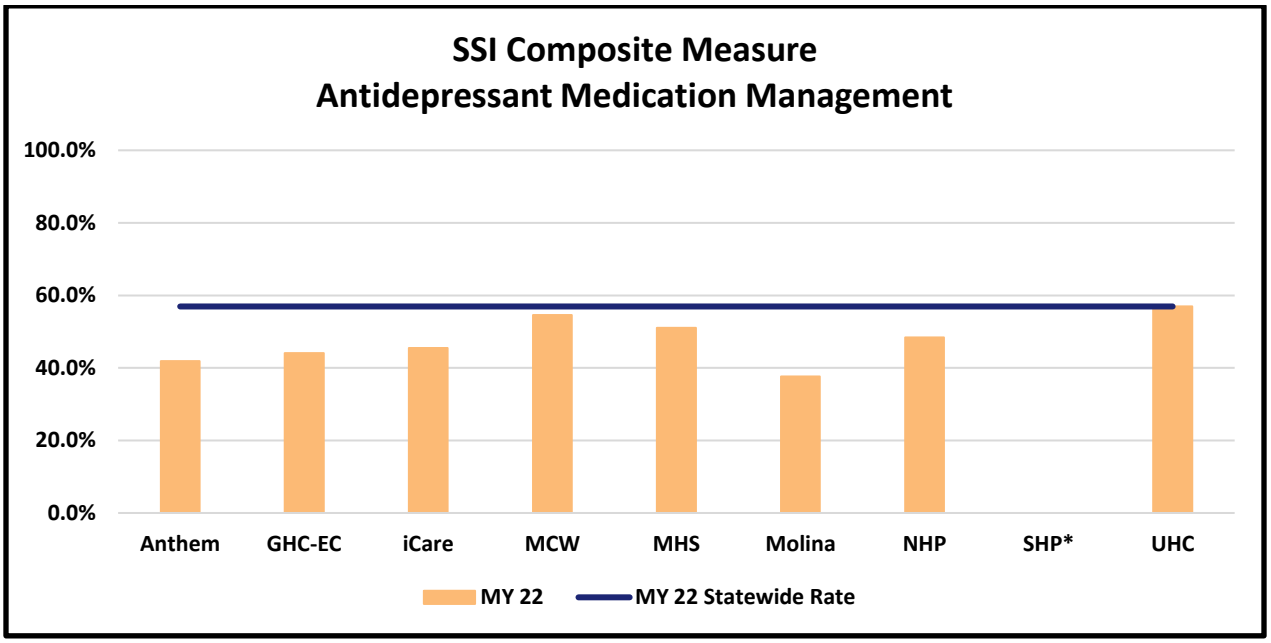


The graph below displays the results for Lead Screening in Children by MCO.



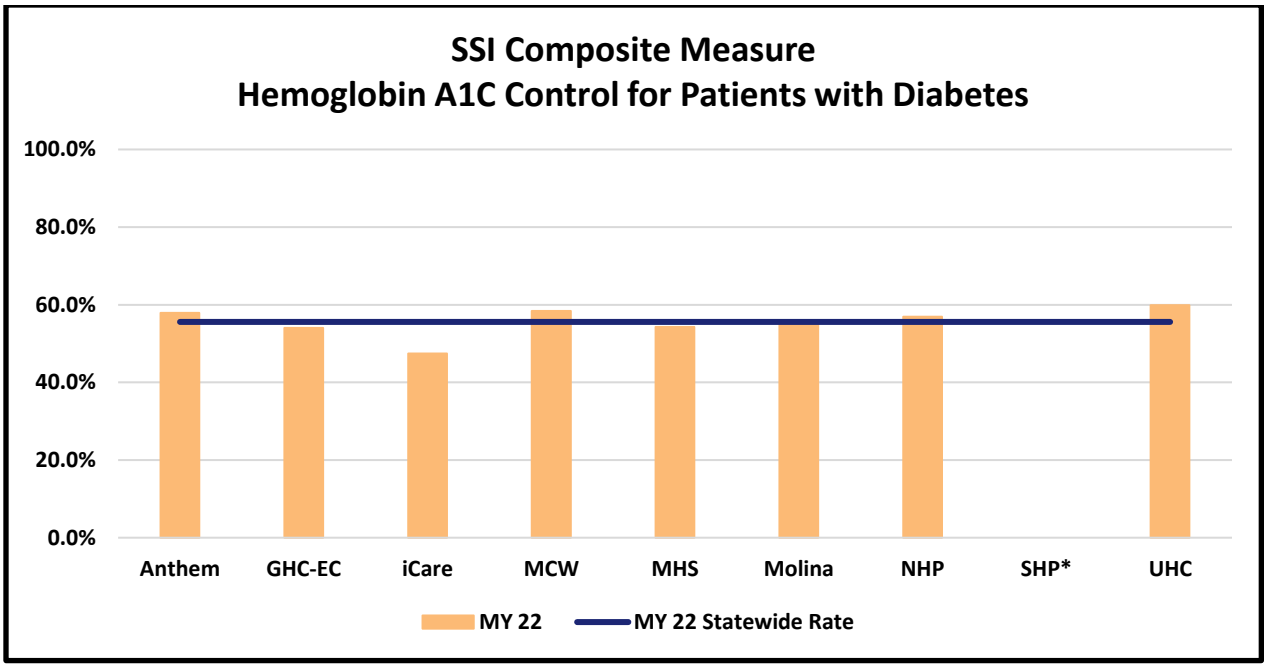
SSI Composite Measures

The following graph displays the results for Antidepressant Medication Measure



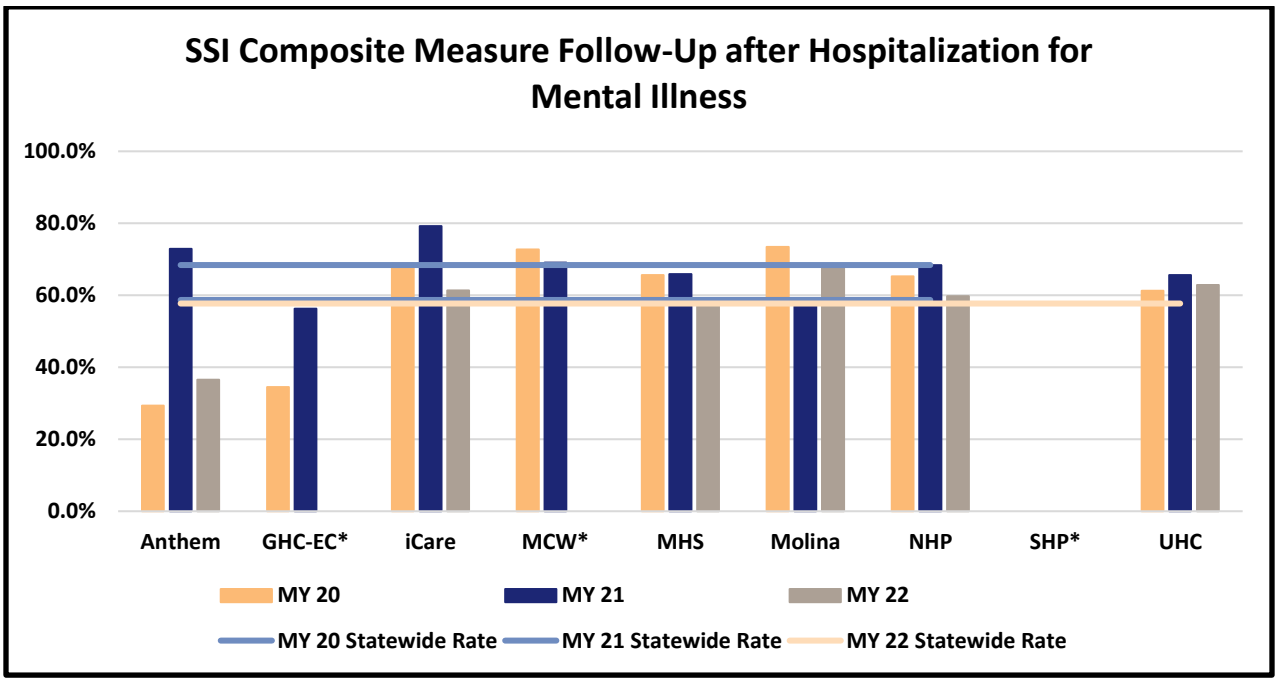
*SHP did not have reported rates due to the number of members being less than 30.

The graph below displays the results for Hemoglobin A1C Control for Patients with Diabetes by MCO.



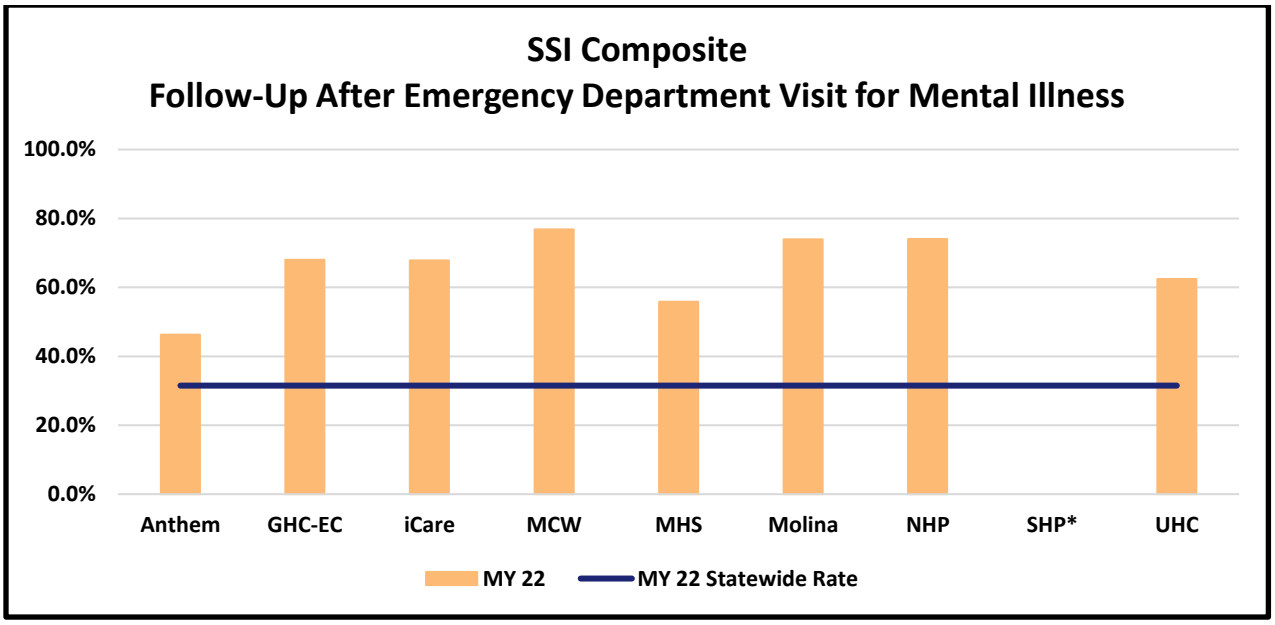
*SHP did not have reported rates due to the number of members being less than 30.

The graph below displays the Follow-Up after Emergency Department Visit for Mental Illness by MCO.



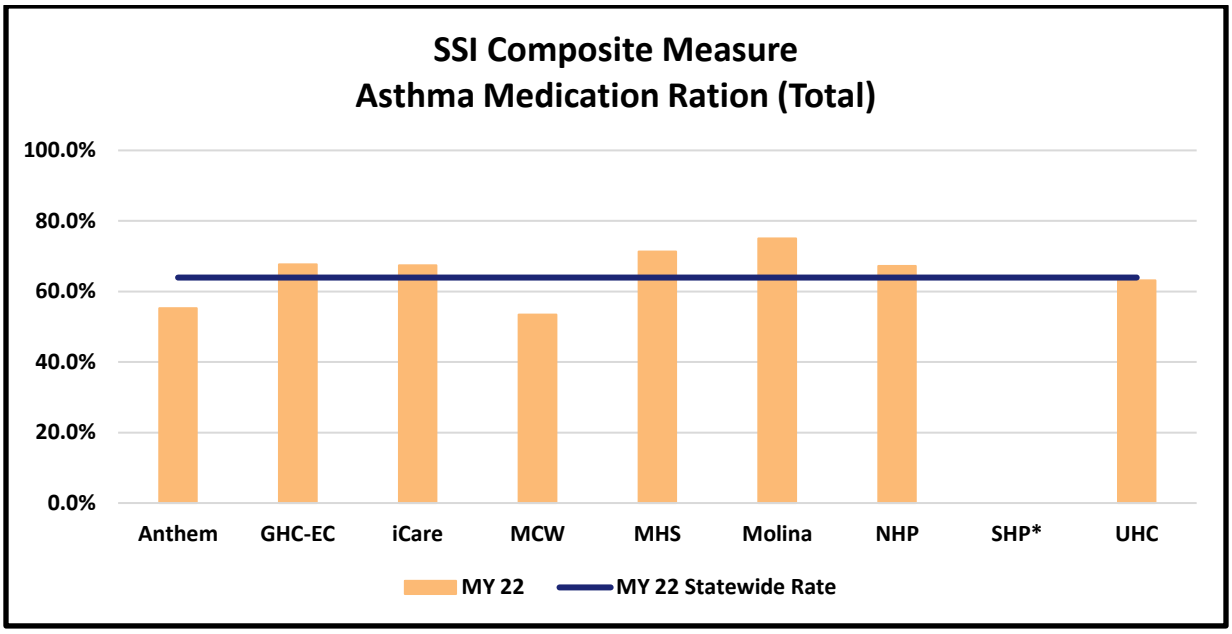
*GHC-EC, MCW, and SHP did not have reported rates due to the number of members being less than 30.

The graph below displays the results for Follow-Up after Hospitalization for Mental Illness by MCO.



*SHP did not have reported rates due to the number of members being less than 30.

The graph below displays the results for Asthma Medication Ratio- Ages 19 to 64 by MCO.



*SHP did not have reported rates due to the number of members being less than 30.

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

Compliance with Standards is a mandatory review activity identified in the Code of Federal Regulations (CFR), 42 CFR 438.358 and is 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 and PIHP related to quality, timeliness, and access to services, including health care and members with special health care needs.

DHS submitted its *Accreditation Deeming Plan* to CMS as an appendix to the *2021 Medicaid managed Care Quality Strategy*. The plan deems MCOs with accreditation status from NCQA as compliant with most federal requirements and conducting a compliance with standards review would be duplicative. MetaStar conducted a desk review of the elements not addressed by NCQA accreditation to ensure full compliance with the managed care regulations. The Accreditation Desk Review (ADR) affirms the MCO's accreditation status and evaluates compliance with the areas of the CFR not addressed by NCQA accreditation.

The ADR aligns with the Centers for Medicare & Medicaid Services External Quality Review Protocol, which defines the review activities for Medicaid Managed Care Programs.

DHS directed MetaStar to continue the mandatory EQR compliance with standards review for non-accredited MCOs and MCOs accredited by a non-recognized accreditation body, according to the usual three-year cycle. Please refer to Appendix 2 for additional information regarding the three-year review cycle and review methodology.

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:

- Accessibility, including physical accessibility of service sites and medical and diagnostic equipment; accessibility of information (compliance with web-based information, literacy levels of written materials, and alternate formats); and other accommodations;
- Credentialing or other selection processes for providers; and
- Person-centered assessment, person-centered care planning, service planning and authorization, services coordination, and care management.

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

Standards are reviewed in a two-year cycle for each organization. The first year of the cycle includes the MCO Standards, followed by QAPI and Grievance Standards in the second year.

This calendar year is the first year of the cycle; therefore, the MCO Standards were reviewed. An overall compliance score will be provided following the second year of the cycle.

Overall Compliance Results by MCO

Compliance is expressed in terms of a percentage identified in the table below.

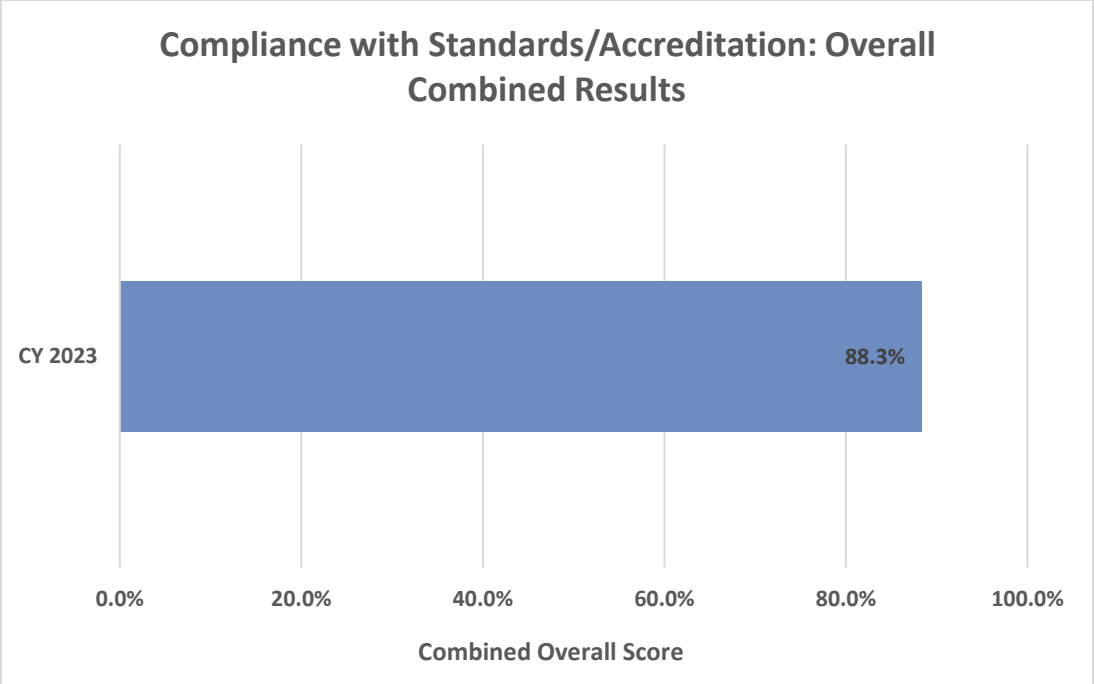
Scoring Legend	
Percentage Met	**Rating**
90.0% - 100.0%	Excellent
80.0% - 89.9%	Very Good
70.0% - 79.9%	Good
60.0% - 69.9%	Fair
< 60.0%	Poor

MetaStar did not conduct a Compliance with Standards review during CY 2023 for any MCOs that were not accredited by NCQA prior to December 31, 2023. The organizations not accredited by NCQA participated in the Compliance with Standards review within the last three years and were not due for a review in CY 2023. MetaStar conducted 11 accreditation desk reviews for MCOs holding NCQA Accreditation. The following table and graphs indicate the MCOs' overall level of compliance in the CY 2023 Compliance with Standards review.

For all MCOs, the statewide compliance score was 88.3 percent, and a rating of Very Good. The score is based on the review of the MCO Standards in CY 2023. Grievance Systems and QAPI standards will be evaluated in CY 2024. The table below indicates the State's overall level of compliance with all standards.

MCO Accreditation Desk Review CY 2023			
Focus Area	**Scoring Elements**	**Percentage**	**Rating**
MCO Standards	870/985	88.3%	Very Good
QAPI	N/A	N/A	N/A
Grievance Systems	N/A	N/A	N/A
Overall	**870/985**	**88.3%**	**Very Good**

The graph on the next page illustrates the State's overall compliance with these standards in CY 2023. At the direction of DHS, MetaStar revised the standards for CY 2023. Scoring methods from the previous Accreditation Desk Review are not comparable.



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 review 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.

Each section that follows provides a brief explanation of a compliance with standards focus area, including rationale for any areas the MCOs were not fully compliant, followed by a table and bar graph. Additionally, Appendix 5 includes results for each standard by MCO.

Results for Compliance with Standards Review Focus Area - MCO Standards

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

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

- Compliance with other requirements.

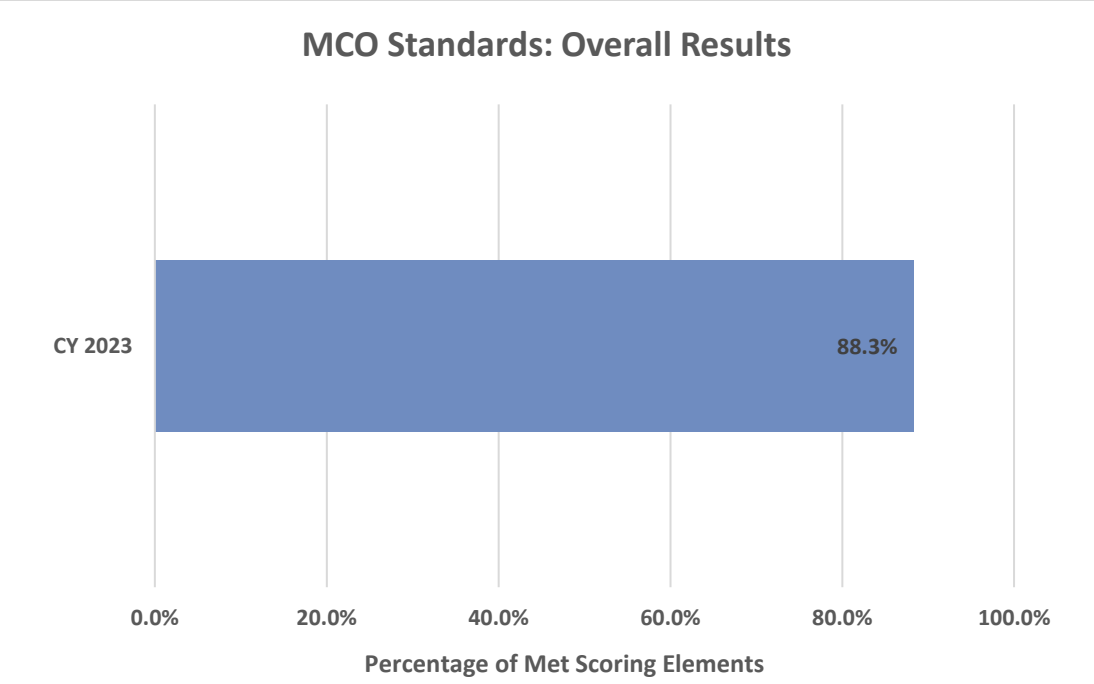
MCOs are also responsible to help members understand their rights as well as to ensure those rights are protected. This requires an adequate organizational structure and sound processes that adhere to federal and state requirements, and are capable of ensuring that members' rights are protected.

The table below indicates the MCOs' overall level of compliance with the MCO Standards in this calendar year.

MCO Standards: Provider Network, Care Management, and Enrollee Rights CY 2023			
Standard	**Scoring Elements**	**Percentage**	**Rating**
M1	72/77	93.5%	Excellent
M2	75/77	97.4%	Excellent
M3	33/33	100.0%	Excellent
M4	72/77	93.5%	Excellent
M5	50/66	75.8%	Good
M6	61/61	100.0%	Excellent
M7	73/110	66.4%	Fair
M8	72/88	81.8%	Very Good
M9	121/121	100.0%	Excellent
M10	30/33	90.9%	Excellent
M11	37/44	84.1%	Very Good
M12	8/11	72.7%	Good
M13	105/110	95.5%	Excellent
M14	40/44	90.9%	Excellent
M15	21/33	63.6%	Fair
M16*	N/A	N/A	N/A
Overall	**870/985**	**88.3%**	**Very Good**

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

The graph below illustrates the State's overall compliance with this focus area in CY 2023. At the direction of DHS, MetaStar revised the standards for CY 2023. Scoring methods from the previous Accreditation Desk Review are not comparable.

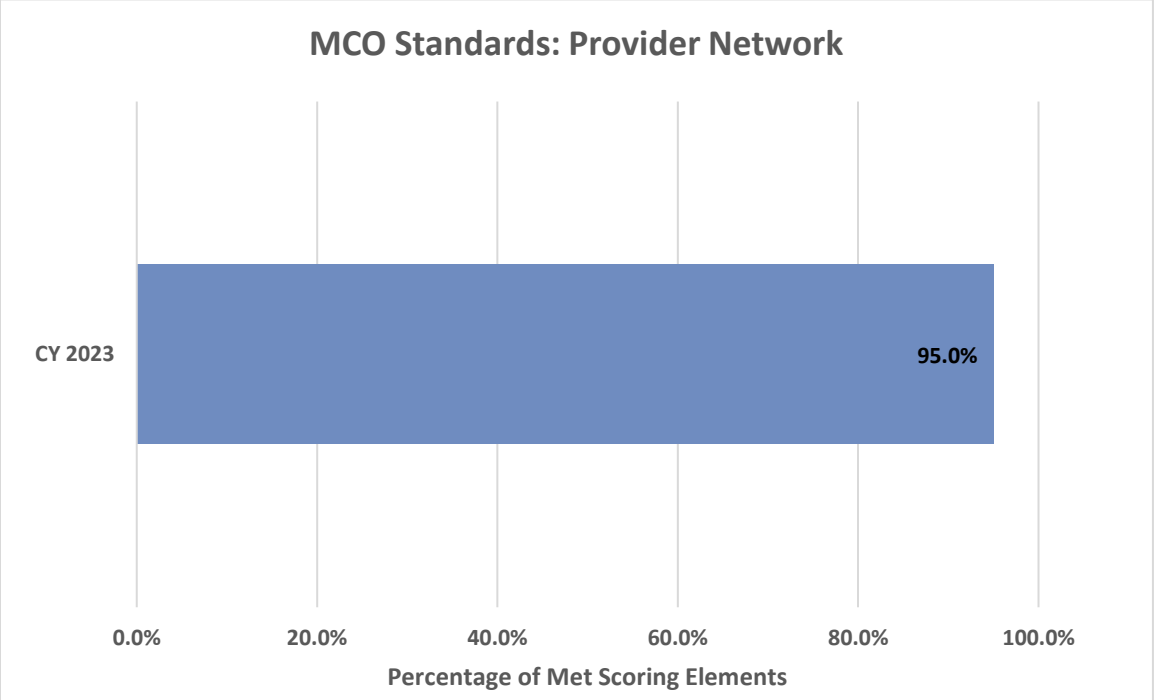


Observation and Analysis: MCO Standards, Provider Network

MCOs must provide members timely access to high quality health care services by developing and maintaining the structure, operations, and processes to ensure availability of accessible, culturally competent services through a network of qualified service providers. Six standards address requirements related to availability of services, provider selection, subcontractual/provider relationships, and delegation. The table below/on the next page indicates the MCOs' compliance with these standards.

MCO Standards: Provider Network CY 2023			
Standard	**Scoring Elements**	**Percentage**	**Rating**
M1	72/77	93.5%	Excellent
M2	75/77	97.4%	Excellent
M3	33/33	100.0%	Excellent
M4	72/77	93.5%	Excellent
M13	105/110	95.5%	Excellent
M14	40/44	90.9%	Excellent
Overall	**397/418**	**95.0%**	**Excellent**

The graph below illustrates the State's overall compliance with this focus area in CY 2023. At the direction of DHS, MetaStar revised the standards for CY 2023. Scoring methods from the previous Accreditation Desk Review are not comparable.



M1 Availability of services - 42 CFR 438.206

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, evaluated each MCO on seven possible scoring elements. Collectively, the MCOs satisfied requirements for 72 out of 77 scoring elements, for a score of 93.5 percent, and a rating of Excellent.

The MCOs' documents demonstrated compliance with this scoring element. Additionally, enrollees are allowed access to a women's health specialist within the network, without a referral, in addition to their primary care provider.

Scoring element M1.3 requires MCOs to have written policies and procedures to provide for a second opinion from a network provider or arrange for the enrollee to obtain one outside the network at no cost to the enrollee. Two MCOs did not meet this scoring standard. Documentation from one MCO did not reflect that second opinions can be obtained outside the

network at no cost to the enrollee. Another MCO submitted documentation that was only applicable to its BC+ enrollees and not its SSI enrollees. This did not satisfy the requirements for scoring element M1.3. MetaStar recommends the MCOs amend written guidance related to second opinions to ensure all enrollees are able to obtain a second opinion from an in-network or out-of-network provider at no cost.

Scoring element M1.4 requires the MCOs to adequately and timely cover and arrange for services with non-network providers, for as long as the provider network is unable to provide the covered necessary services. Two MCOs did not meet this scoring element as the length of time services from out-of-network providers will be authorized was not specified or was time-limited. This did not satisfy the requirements for scoring element M1.4. MetaStar recommends the MCOs develop and implement a process for providing covered services out of network, for as long as the organizations' provider network is unable to provide them.

M2 Timely access to services - 42 C.F.R. 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, evaluated each MCO on seven possible scoring elements. Collectively, the MCOs satisfied requirements for 75 out of 77 scoring elements, for a score of 97.4 percent, and a rating of Excellent.

The MCOs' documentation demonstrated the organizations require its providers to meet state standards; ensure services included in the benefit package are available 24 hours a day, seven days a week, when medically necessary; and have processes in place to take corrective action if there is a failure to comply by a network provider. The NCQA accreditation documents submitted by the MCOs demonstrated the organizations have written standards for the accessibility of care and services that are communicated to providers, and monitored to ensure compliance by network providers.

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, including those with limited English proficiency and diverse cultural and ethnic background, disabilities, and regardless of sex. The standard, M3, evaluated each MCO on three possible scoring elements. Collectively, the MCOs satisfied requirements for 33 out of 33 scoring elements, for a score of 100.0 percent, and a rating of Excellent.

The NCQA accreditation documents submitted by the MCOs demonstrated the organizations incorporated National Culturally and Linguistically Appropriate Services (CLAS) Standards into organizational practices, encouraged and fostered cultural competency among providers, and ensured enrollees are linked to a primary care provider or primary care clinic that provides culturally appropriate care. All MCOs met all of the scoring elements of this standard.

M4 Network adequacy - 42 CFR 438.207

The MCOs must ensure its delivery network is sufficient to provide adequate access to all services. The standard, M4, evaluated each MCO on seven possible scoring elements. Collectively, the MCOs satisfied requirements for 72 out of 77 scoring elements, for a score of 93.5 percent, and a rating of Excellent.

Documentation submitted by the MCOs identified the organizations have procedures in place to meet the requirements of the standard. The MCOs have processes in place to ensure network providers demonstrate the ability to communicate with limited English proficient members in their preferred language, and that they provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities.

The NCQA accreditation documents submitted by the MCOs demonstrated the organizations ensure its delivery network is sufficient by monitoring the number of network providers not accepting new patients, and the geographic location of providers and members, according to the distance, travel time, and normal means of transportation used by members.

Scoring element M4.1 requires MCOs to ensure the delivery network is sufficient to provide adequate access to all services based on the anticipated BC+ or SSI enrollment. Two MCOs did not satisfy the requirement for this scoring element as policies and procedures did not describe the process used to address or account for anticipated enrollment. This did not satisfy the requirements for scoring element M4.1. MetaStar recommends the MCOs develop and implement processes to ensure the provider network is sufficient to provide adequate access to all services based on anticipated enrollment.

Scoring element M4.2 requires MCOs to ensure the provider network is sufficient to address expected utilization of services based on member characteristics and health care needs. Two MCOs did not meet this scoring element as documents did not identify the methods used by the organizations to account for expected utilization of services. This did not satisfy the requirements for scoring element M4.2. MetaStar recommends the MCOs develop and

implement processes to ensure the provider network is sufficient to provide adequate access to all services based on expected utilization of services.

M13 Provider selection - 42 CFR 438.214

The MCOs must have a written process for the selection and periodic evaluation of qualified providers. The MCOs are responsible for ensuring all applicable provider requirements are met at initial contracting and throughout the duration of the contract. The standard, M13, evaluated each MCO on 10 possible scoring elements. Collectively, the MCOs satisfied requirements for 105 out of 110 scoring elements, for a score of 95.5 percent, and a rating of Excellent.

The MCOs' documents defined the organizations' selection and retention processes, including the process to recredential providers at least every three years, and to monitor providers to ensure they are not excluded form participation in Federal health care programs. The MCOs' credentialing committee along with the peer review committee monitors the selection and retention process.

Scoring element M13.10 requires the MCO to immediately report the names of individual practitioners and institutional providers who have been terminated from the provider network as a result of quality issues to DHS and other entities as required by law. Three MCOs did not meet this scoring element as the requirement to report this information immediately to DHS was not specified in documents the MCO submitted. This did not satisfy the requirements for scoring element M13.10. MetaStar recommends the MCOs develop and implement processes to immediately report the names of practitioners and providers who were terminated from the network due to quality issues to DHS.

M14 Subcontractual relationships and delegation - 42 CFR 438.230

The MCOs must oversee and be accountable for functions and responsibilities that it delegates to any subcontractor/provider. The MCOs must monitor the subcontractor/provider's performance, and take corrective action if needed. The standard, M14, evaluated each MCO on four possible scoring elements. Collectively, the MCOs satisfied requirements for 40 out of 44 scoring elements, for a score of 90.9 percent, and a rating of Excellent.

MCOs subcontract with providers for credentialing services, and some MCOs also subcontract with providers for claims processing. Documents submitted by each MCO detail the processes for evaluating the prospective subcontractor's ability to perform the activities identified for delegation, along with processes to monitor the subcontractors on an ongoing basis. Most

organizations conduct at least an annual review or audit of the delegated entities to ensure compliance with the scope of services contained in each entity's written contract with the MCO.

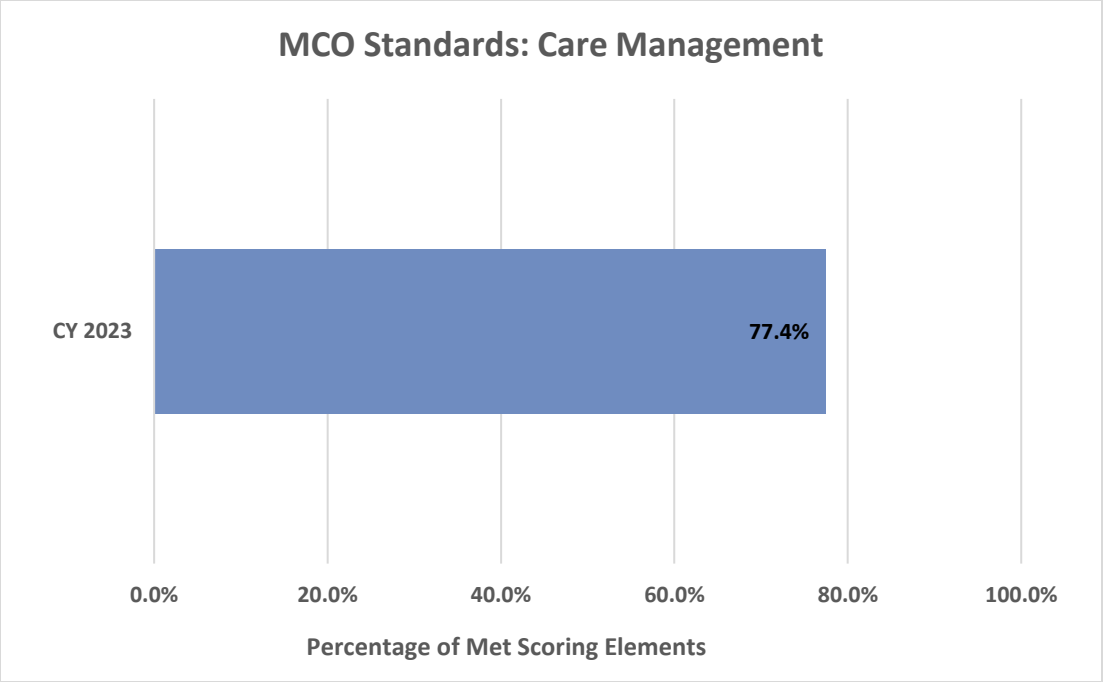
Observation and Analysis: MCO Standards, Care Management

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 MCO's compliance with these standards.

MCO Standards: Care Management CY 2023			
Standard	**Scoring Elements**	**Percentage**	**Rating**
M5	50/66	75.8%	Good
M6	61/61	100.0%	Excellent
M7	73/110	66.4%	Fair
M8	72/88	81.8%	Very Good
M15	21/33	63.6%	Fair
M16*	N/A	N/A	N/A
Overall	**277/358**	**77.4%**	**Good**

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

The following graph illustrates the State's overall compliance with this focus area in CY 2023. At the direction of DHS, MetaStar revised the standards for CY 2023. Scoring methods from the previous Accreditation Desk Review are not comparable.



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

Two standards address requirements related to coordination and continuity of care. Both standards address the requirement to maintain the confidentiality of member information. The MCOs must implement procedures to deliver care to and coordinate services for all MCO members (M5). The standard, M5, evaluated each MCO on six possible scoring elements. Collectively, the MCOs satisfied requirements for 50 out of 66 scoring elements, for a score of 75.8 percent, and a rating of Good.

The NCQA accreditation documents submitted by the MCOs demonstrated that the organizations have processes in place to ensure the protection of member information during care coordination by the MCOs and providers.

Scoring element M5.1 requires MCOs to ensure each member has an ongoing source of care appropriate to their needs and a person or entity formally designated as responsible for coordinating the member services. Documents from one MCO did not include information directed to the member on how to contact the primary care physician (PCP) or primary care clinic (PCC). Another MCO submitted documentation that was only applicable to its BC+ enrollees and not its SSI enrollees. This did not satisfy the requirements for scoring element

M5.1. MetaStar recommends the organizations provide information to all members on how to contact their designated PCP or PCC.

Scoring element M5.2 requires the MCO to ensure coordination of services and follow up with members to ensure services provided best address their needs. Three MCOs did not satisfy requirements for this scoring element as documents submitted by the organizations did not address requirements to ensure coordination of services the member receives from any other MCO or from fee-for-service (FFS) Medicaid. Another organization updated documents during the review period, and evidence was not provided to ensure this requirement was implemented during the entire review period. This did not satisfy the requirements for scoring element M5.2. MetaStar recommends the organizations focus efforts on developing and implementing procedures to ensure coordination of services for members with other MCOs and FFS Medicaid, and to assure documents contain all required federal and state requirements when requirements are effective.

Scoring element M5.4 requires MCOs to share with other MCOs serving the member the results of any identification and assessment of the member's needs to prevent duplication of those activities. Eight of 11 MCOs did not include this requirement in the documents submitted for review, and thus did not satisfy requirements for this scoring element. This did not satisfy the requirements for scoring element M5.4. MetaStar recommends MCOs develop and implement procedures to ensure sharing of members' needs with other MCOs to prevent duplication of services.

Each MCO must implement mechanisms to comprehensively assess each Medicaid enrollee identified by the State and identified to the MCO by the State as having special health care needs to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring (M6). The standard, M6, evaluated each BC+ MCO on four possible scoring elements, and each SSI MCO on seven possible scoring elements. Collectively, the MCOs satisfied requirements for 61 out of 61 scoring elements, for a score of 100.0 percent, and a rating of Excellent.

The NCQA accreditation documents submitted by the MCOs demonstrated the organizations have defined the procedures and expectations for member assessment and care planning, including periodic reassessments and continual monitoring focused on improving the health outcomes for members. The MCOs met all of the scoring elements of this standard.

M7 Disenrollment: requirements and limitations - 42 CFR 438.56

The MCOs must comply with requirements for member disenrollment. The standard, M7, evaluated each MCO on 10 possible scoring elements. Collectively, the MCOs satisfied requirements for 73 out of 110 scoring elements, for a score of 66.4, and a rating of Fair.

Scoring element M7.2 requires the MCO allow all BC+ members the right to disenroll unless otherwise limited by the State Plan Amendment. One MCO did not include this requirement in documents submitted for review. Another organization updated documents during the review period, and evidence was not provided to ensure this requirement was implemented during the entire review period. This did not satisfy the requirements for scoring element M7.2. MetaStar recommends the MCOs include the requirement allowing BC+ members to disenroll unless limited by the state Plan in written documentation, and assure documents contain all required federal and state requirements when requirements are effective.

Scoring element M7.3 specifies members may request disenrollment upon automatic reenrollment if temporary loss of BC+ and/or Medicaid SSI enrollment has caused the member to miss the annual enrollment period. Five MCOs did not include this requirement in documents submitted for review. This did not satisfy the requirements for scoring element M7.3. MetaStar recommends the MCOs include disenrollment request requirements in written documents.

Scoring element M7.7 indicates system disenrollments happen automatically in the DHS system based on changes to the member's eligibility for several reasons. Eight of 11 MCOs did not specify loss of eligibility and participation in county care management waiver programs or other managed care programs as reasons for disenrollment. This did not satisfy the requirements for scoring element M7.7. MetaStar recommends the MCOs amend written documents to include system disenrollment requirements.

Scoring element M7.8 specifies for any request for involuntary disenrollment, the MCO must submit a disenrollment request to DHS and include evidence attesting to cause. This may include, but is not limited to, just cause or nursing home placement. Three MCOs did not meet this requirement as the documents submitted for review did not include just cause or nursing home placement requirements. Two MCOs updated documents during the review period, and evidence was not provided to ensure this requirement was implemented during the entire review period. Two MCOs did not incorporate all requirements in written documents until after the review period. This did not satisfy the requirements for scoring element M7.8. MetaStar recommends MCOs update written documents to include involuntary disenrollment for just

cause or nursing home placement, and assure documents contain all required federal and state requirements when requirements are effective.

Scoring element M7.9 indicates when a member's change in circumstance has been identified and verified by the MCO, the MCO must provide prompt written notification and proof of the change to DHS or the appropriate entity as designated by DHS. Documents submitted by three MCOs did not include this requirement. This did not satisfy the requirements for scoring element M7.9. MetaStar recommends the MCOs include member change in circumstance notification requirements in written documents.

Scoring element M7.10 requires that exemption requests from MCO enrollment must come from the member, the member's family, or legal guardian and include several reasons for exemptions. Eight MCOs did not meet this requirement, as documents did not include DHS-MCO contract specified exemption reasons or that exemption requests from MCO enrollment can be made by the member, legal decision maker, or the family. This did not satisfy the requirements for scoring element M7.10. MetaStar recommends the MCOs amend written documents to include all exempt request requirements related to MCO enrollment.

M8 Coverage and authorization of services - 42 CFR 438.210(a–e)*, 42 CFR 440.230, 42 CFR Part 441, Subpart B, 42 CFR 438.114

MCO policies and procedures for service authorizations must comply with required standards. The standard, M8, evaluated each MCO on eight possible scoring elements. Collectively, the MCOs satisfied requirements for 72 out of 88 scoring elements, for a score of 81.8 percent, and a rating of Very Good.

The NCQA accreditation documents submitted by the MCOs demonstrated the organizations have effective processes in place to ensure consistency in the MCOs' authorization decisions.

Scoring element M8.2 requires the MCO to give the member and requesting provider written notice of decisions within the required timeframes. Written notice of decisions to deny, limit, reduce, delay or terminate services, the member's grievance and appeal rights, and denial of payment must be given to the member and requesting provider within the specified timeframes. Three MCOs did not include these requirements in written documents. One MCO updated documents during the review period, and evidence was not provided to ensure this requirement was implemented during the entire review period. This did not satisfy the requirements for scoring element M8.2. MetaStar recommends the MCOs include all decision-

making timeframe criteria in written documents, and assure documents contain all required federal and state requirements when requirements are effective.

Scoring element M8.3 requires the MCO to make decisions on standard service authorization requests within 14 calendar days following receipt of the request for service with a possible extension of up to 14 additional calendar days. Documents submitted by four MCOs did not include all requirements related to when extensions were possible. This did not satisfy the requirements for scoring element M8.3. MetaStar recommends the MCOs update documents to include the required language for standard service authorization timeframes and extensions.

Scoring element M8.4 requires the MCO to make expedited authorization decisions and provide notices as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service, with a possible extension of up to 14 additional calendar days. Three MCOs did not meet all the requirements for this scoring element, as submitted documents did not specify a member was able to request an extension, the MCO needed to justify the need for more information, or the timeframe for extensions did not align with the requirement. This did not satisfy the requirements for scoring element M8.4. MetaStar recommends the organizations amend documents to align with state and federal requirements for expedited service authorization decisions and extensions.

Scoring element M8.8 requires the MCO to ensure the attending emergency physician or treating provider determines when the enrollee is stabilized for transfer or discharge. Two MCOs did not include this requirement in written documents, and two MCOs did not identify the professional responsible to decide when the member is stable for transfer or discharge. This did not satisfy the requirements for scoring element M8.8. MetaStar recommends the MCOs include required elements related to emergency and post-stabilization of care in written documents.

M15 Practice guidelines - 42 CFR 438.236

MCOs are required to adopt, apply, and disseminate practice guidelines based on the needs of its members. The standard, M15, evaluated each MCO on three possible scoring elements. Collectively, the MCOs satisfied requirements for 21 out of 33 scoring elements, for a score of 63.6 percent, and a rating of Fair.

Soring element M15.2 requires the MCO to disseminate the guidelines to all providers and, upon request, to members and potential members. Most MCOs demonstrated practice guidelines are disseminated and accessible to providers. MetaStar verified practice guideline

links were functional on each MCO's website. MetaStar found nonfunctional practice guidelines links on five MCOs' websites. In addition, documents submitted by four MCOs did not evidence the MCOs disseminate practice guidelines to members. This did not satisfy the requirements for scoring element M15.2. MetaStar recommends the MCOs develop and implement a process to ensure practice guidelines are disseminated to members and potential members, and ensure clinical practice guidelines are operational on the MCOs' websites.

Scoring element M15.3 requires the MCO ensure the guidelines are consistent with utilization management decisions, member education, coverage of services and other areas to which the guidelines apply. Documents submitted by two MCOs did not include these requirements. This did not satisfy the requirements for scoring element M15.3. MetaStar recommends the MCOs ensure decisions for utilization management, member education, coverage of services, and other areas clinical practice guidelines apply are consistent with clinical practice guidelines.

M16 Health information systems – 42 CFR 438.242

The MCO 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 the MCO's Information Systems Capability Assessment (ISCA), conducted once every three years. The ISCA occurs separate from the Compliance review.

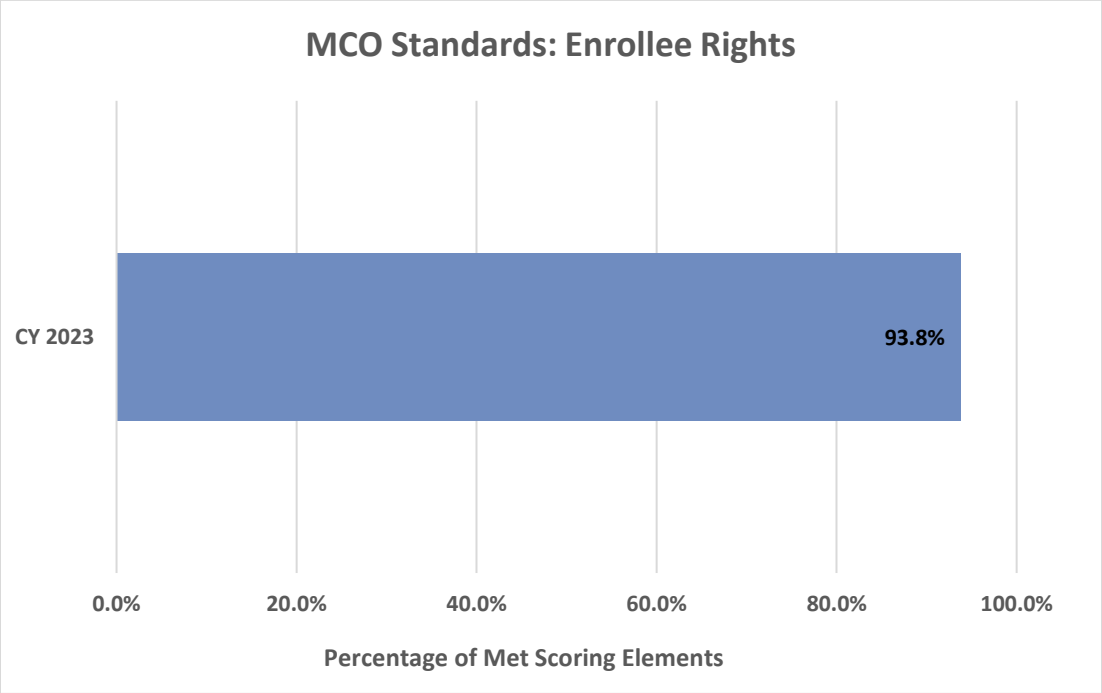
Observation and Analysis: MCO Standards, Enrollee Rights

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, such as those related to dignity, respect, and privacy. The table below indicates the MCO's compliance with these standards.

MCO Standards: Enrollee Rights CY 2023			
Standard	**Scoring Elements**	**Percentage**	**Rating**
M9	121/121	100.0%	Excellent
M10	30/33	90.9%	Excellent
M11	37/44	84.1%	Very Good

MCO Standards: Enrollee Rights CY 2023			
Standard	**Scoring Elements**	**Percentage**	**Rating**
M12	8/11	72.7%	Good
Overall	**196/209**	**93.8%**	**Excellent**

The graph below illustrates the State's overall compliance with this focus area in CY 2023. At the direction of DHS, MetaStar revised the standards for CY 2023. Scoring methods from the previous Accreditation Desk Review are not comparable.



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, evaluated each MCO on 11 possible scoring elements. Collectively, the MCOs satisfied requirements for 121 out of 121 scoring elements, for a score of 100.0 percent, and a rating of Excellent.

The NCQA accreditation documents submitted by the MCOs demonstrated the organizations provide information to members, including the member handbook and provider directory, electronically on the websites, or in paper format, upon request. In addition, the NCQA

accreditation documents reflect that all member materials are written for ease of understanding, and provided in alternate formats and languages as required, including auxiliary aids and the use of oral interpretation services. All MCOs met all of the scoring elements of this standard.

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, evaluated each MCO on three possible scoring elements. Collectively, the MCOs satisfied requirements for 30 out of 33 scoring elements, for a score of 90.9 percent, and a rating of Excellent.

The NCQA accreditation documents submitted by the MCOs demonstrated the organizations ensured members receive information on available treatment options and alternatives presented in manner appropriate to the member's condition and ability to understand; and offer each member the opportunity to choose a primary care provider.

Scoring element M10.2 indicates the MCO may not prohibit, or otherwise restrict a provider from advising or advocating on behalf of a member who is the provider's patient. Documents submitted by three MCOs did not outline the provider's ability to advise or advocate on behalf of a member related to the risks, benefits, and consequences of treatment and non-treatment; and the member's right to participate in decisions regarding health care, including the right to refuse treatment, and to express preferences about future treatment decisions. This did not satisfy the requirements for scoring element M10.2. MetaStar recommends the MCOs include provider advocacy requirements in written documentation for providers.

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)

MCOs 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. The standard, M11, evaluated each MCO on four possible scoring elements. Collectively, the MCOs satisfied requirements for 37 out of 44 scoring elements, for a score of 84.1 percent, and a rating of Very Good.

The NCQA accreditation documents submitted by the MCOs demonstrated organizations ensure members have the right to participate in decisions regarding their care, and the right to

refuse treatment. The NCQA accreditation documents submitted by the MCOs also demonstrated organizations have written policies and procedures for advance directives which include all requirements.

Scoring element M11.1 requires MCOs to have written policies guaranteeing each member's rights, and to share those written policies with staff and affiliated providers to be considered when providing services to members. One MCO did not submit a member's rights policy for review. Another MCO submitted a written member's rights policy which outlined the process for reviewing, updating, publishing, and disseminating member rights; however, the policy did not include a list of specific member rights. This did not satisfy the requirements for scoring element M11.1. MetaStar recommends the MCOs develop and implement a member rights policy that identifies specific member rights.

Scoring element M11.2 requires MCOs to have written restraint policies guaranteeing each member's right to be free from any form of restraint or seclusion as a means of coercion, discipline, convenience or retaliation. Four MCOs did not submit a restraints policy for review. In addition, one MCO updated the restraints policy to include the SSI line of business during the review period, and evidence was not provided to ensure this requirement was implemented during the entire review period for all BC+ and SSI members. This did not satisfy the requirements for scoring element M11.2. MetaStar recommends the MCOs develop and implement a restraints policy, and assure documents are updated in a timely manner when adding additional lines of business to the organization.

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

MCOs must comply with all applicable Federal and State laws for the protection of member rights. The standard, M12, evaluated each MCO on one possible scoring element. Collectively, the MCOs satisfied requirements for eight out of 11 scoring elements, for a score of 72.7 percent, and a rating of Good.

Scoring element M12.1 requires MCOs to comply with any other applicable Federal and State laws. One MCO's documents noted members have rights as required by Federal and State law, but did not identify the specific laws the MCO is required to comply with. Another MCO's documents did not include the requirements for this scoring element. A third MCO's documents focused only on Federal and State laws and regulations regarding non-discrimination, and did not include requirements for other applicable laws. This did not satisfy the requirements for scoring element M12.1. MetaStar recommends the MCOs include requirements in written

documents to ensure compliance with Federal and State laws pertinent to the protection of member rights.

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 (CMR) – Supplemental Security Income

The goal of the Supplemental Security Income program is to improve the health of its members and enhance quality of care while reducing health care costs. The goal is achieved through a comprehensive, integrated care model; incorporating social, behavioral health, and medical needs for members. Each MCO is responsible for establishing a team-based care management model that assures coordination and integration of all aspects of all SSI members' health care needs. The MCO must also promote effective communication and shared decision-making between the care management team and the member regarding the member's care. Based on health conditions and social determinants of health, the MCO must stratify members into different care management needs groups which must include a Wisconsin Interdisciplinary Care Team (WICT) structure for members with the highest needs.

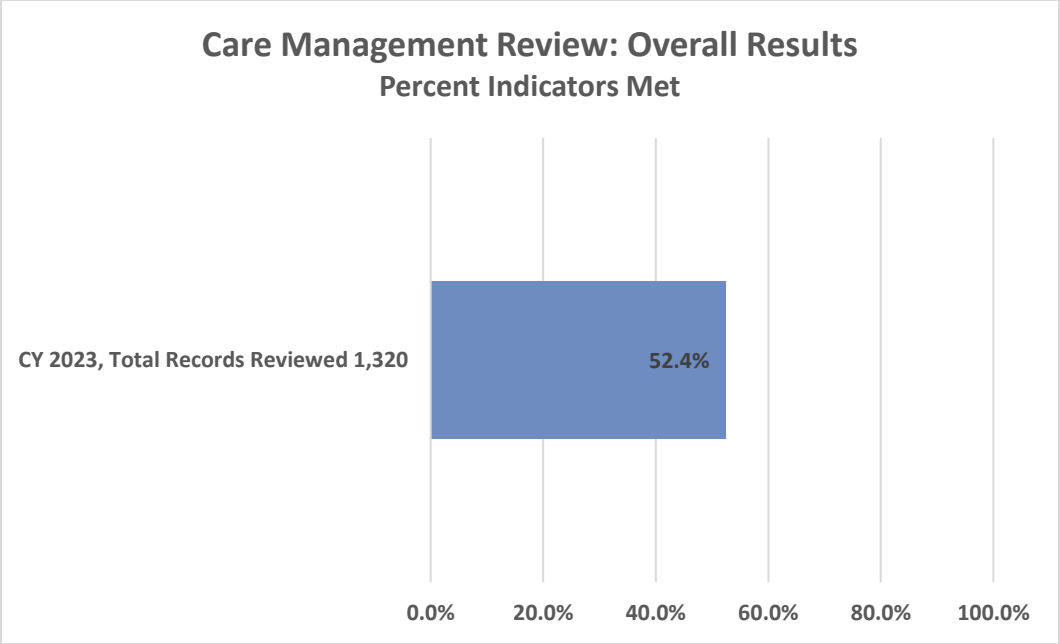
The review focused on six categories to evaluate program compliance:

- Screening;
- Care Planning;
- Care Coordination;
- Care Plan Review and Update;
- Transition Planning; and
- Wisconsin Interdisciplinary Care Team.

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

Overall Results

The following bar graph represents the overall percent of CMR standards met by the MCOs in CY 2023 for all 16 review indicators. Additionally, Appendix 6 includes results for each indicator by MCO.



Observations and Analysis for each CMR Focus Area

Each of the six sub-sections below provides a brief explanation of a key CMR category, followed by bar graphs which display CY 2023 results for each indicator that comprises the category. Following the CY 2021 care management review, the review was paused at the request of DHS in order to realign review criteria with the DHS-MCO contract. DHS solicited feedback from MetaStar, the MCOs that operate the program, and held stakeholder meetings to evaluate the clarity of review requirements.

Observations and Analysis: Screening

The member screen is a comprehensive tool used to evaluate the member's strengths, preferences, and needs. The screen is used to drive member-centered care planning and an evidenced based approach to care.

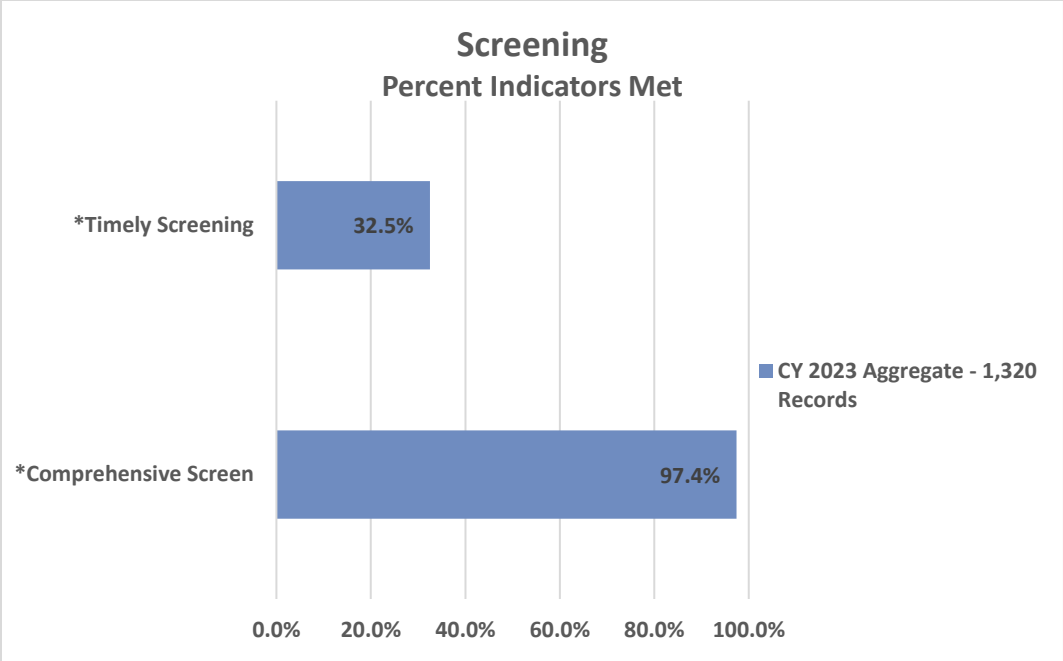
The initial screen and subsequent rescreens must meet the timelines and other requirements described in the DHS-MCO contract. The care management team must comprehensively screen each member and document information, such as:

- The member's chronic physical health needs (including dental);
- The member's chronic mental and behavioral health needs (including alcohol and other drug abuse);
- The member's perception of their strengths and general well-being;
- If the member has a usual source of care;

- Any indirect supports the member may have;
- Any relationships the member may have with community resources;
- Any immediate and/or long-term member concerns about their overall well-being including social determinants of health (SDOH);
- Activities of daily living needs; and
- Instrumental activities of daily living needs.

The indicator *Timely Screening* evaluates if screens were conducted within 60 days of member enrollment or re-enrollment and once every 12 months. If a member disenrolls during the review period and the member's screen was completed prior to the review period, the timeliness of the screen cannot be evaluated and that indicator will not be applicable. This indicator applied to 1,309 of 1,320 records. The results indicated a need for improvement. The most common reason screens were not timely was the screen was not updated once every 12 months for ongoing enrollees.

The indicator *Comprehensive Screen* ensures the MCO evaluates member needs based on the DHS-MCO contract requirements. If a screen was not completed, then it cannot be evaluated for comprehensiveness and that indicator will not be applicable. This indicator applied to 574 of 1,320 records. Of the screens reviewed, 97.4 percent were comprehensive. Of all applicable assessment elements reviewed, 99.7 percent were found to be assessed. The organizations ensured most member screens were comprehensive.



*Note: The review indicator Timely Screening applied to 1,309 of 1,320 records in CY 2023. The review indicator *Comprehensive Screen* applied to 574 of 1,320 records in CY 2023.

Observations and Analysis: Care Planning

The comprehensive care plan ensures appropriate care delivery to a member by following an evidence-based, member-centric treatment plan that addresses the identified unique needs. Plans must be agreed upon with the member prior to implementation. The care plan must:

- Address all identified needs;
- Measure the member's readiness to change and engagement;
- Establish and prioritize specific short and long-term goals that are appropriate to address the member's needs; and
- Describe and sequence the interventions to address the identified needs.

After it is developed, the care plan must be shared with the member, the primary care provider (PCP), and others as identified in the care plan.

If the member does not have a care plan completed, then it cannot be evaluated for care plan comprehensiveness, distribution, and agreement; therefore, those indicators will not be applicable.

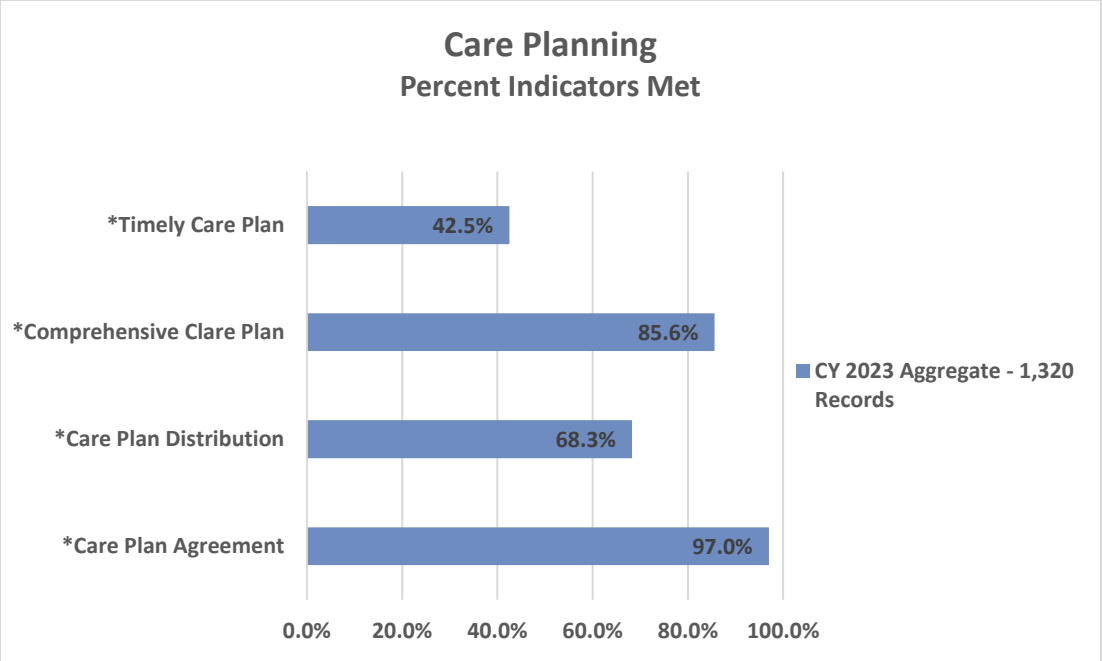
The indicator *Timely Care Plan* evaluates if care plans are completed within 30 days of the completed screen or 90 days after enrollment, whichever comes first. If a member does not

have a care plan review due during the review period due to disenrollment, this indicator is not applicable. This indicator applied to 1,307 of 1,320 records. The results indicated a need for improvement. The majority of records unmet for this indicator did not include a care plan during the review period.

The indicator *Comprehensive Care Plan* ensures member care plans include all assessed needs. Of the care plans reviewed, 85.6 percent were comprehensive. Of the required care plan elements, 98.3 percent were found to be included on the plan. Four hundred eighty-nine of five hundred and seventy-one applicable records demonstrated a completed care plan and were evaluated for comprehensiveness. The results indicated a need for improvement. The most common reason the care plans were not comprehensive was related to missing elements of mental and behavioral health conditions and social determinants of health.

The indicator *Care Plan Distribution* evaluates if the care plan was shared with all required persons. Of the records reviewed, 571 demonstrated a completed care plan to be distributed. The results indicated a need for improvement. The majority of records not fully met for this indicator did not demonstrate the care plan was shared with the member's PCP.

The indicator *Care Plan Agreement* evaluates if the member agreed to the care plan prior to its implementation. Of the records reviewed, 571 demonstrated a completed care plan that a member could agree to. The results indicated compliance with this indicator.



*Note: The review indicator *Timely Care Plan* applied to 1,307 of 1,320 records in CY 2023. The review indicator *Comprehensive Care Plan* applied to 571 of 1,320 records in CY 2023. The review indicator *Care Plan Distribution* applied to 571 of 1,320 records in CY 2023. The review indicator *Care Plan Agreement* applied to 571 of 1,320 records in CY 2023.

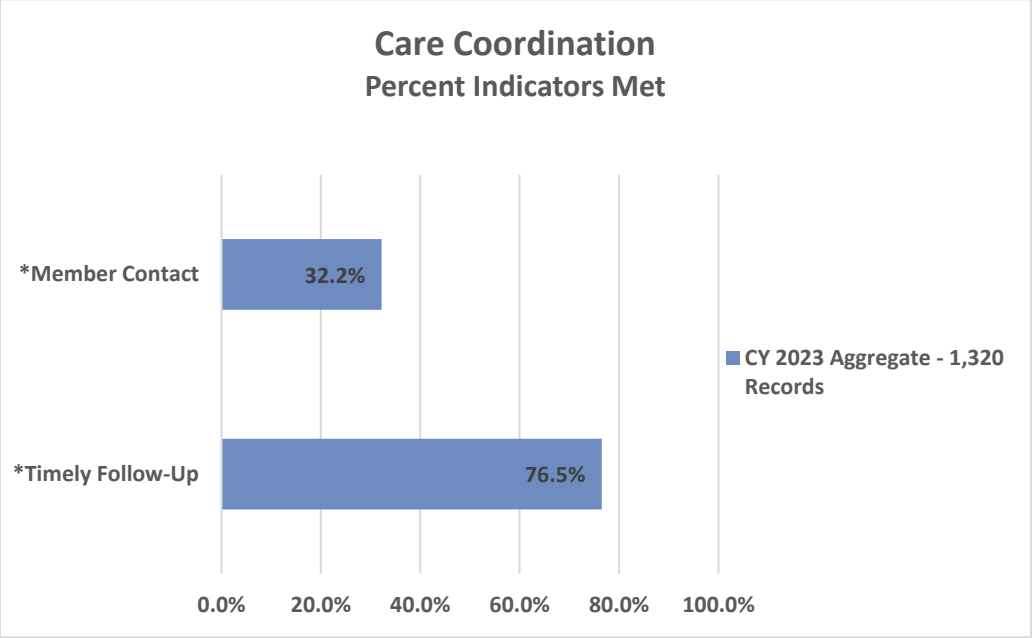
Observations and Analysis: Care Coordination

The care management team must have contact with the member once every 12 months or more frequently based on the member's needs and stratification level. Additionally, the care management team must address and provide timely follow-up for all identified member needs and requests.

The indicator *Member Contact* evaluates if the member was contacted once every 12 months or more frequently based on the member's needs and stratification level to ensure member health and safety. If a member was not enrolled during the entire review period and did not require annual contact, this indicator will not be applicable. One thousand two-hundred eight-six of 1,320 records required, at minimum, annual contact. The results indicated a need for improvement. The majority of records not fully met for this indicator demonstrated the organizations' care management teams attempted to contact member at the designated timeframe based on stratification level; however, care teams were unable to connect with members.

The indicator *Timely Follow-Up* evaluates whether the care management team followed up with members to confirm identified needs or requests were addressed. If the member does not have

identified follow-up needs during the review period, this indicator will not be applicable. Of the records reviewed, 422 included a follow-up need. The results indicated a need for improvement. The records found unmet for this indicator were due to a lack of documented follow-up for members' physical health needs.



*Note: The review indicator *Member Contact* applied to 1,286 of 1,320 records in CY 2023. The review indicator *Timely Follow-Up* applied to 422 of 1,320 records in CY 2023.

Observations and Analysis: Care Plan Review and Update

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

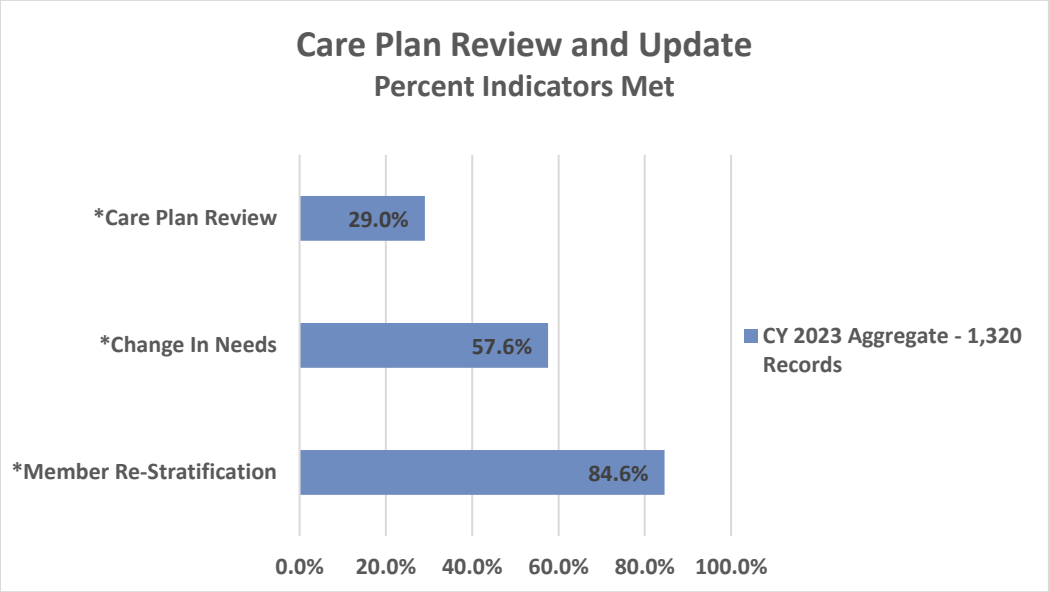
- Significant changes to medical and/or behavioral health needs;
- Changes in needs strata;
- Member non-responsiveness to the care plan;
- Frequent transitions between care settings; and
- Member request or identification of a problem/gap not previously addressed.

The indicator *Care Plan Review* evaluates if the care plan was reviewed at least once every 12 months. If a member newly enrolls in the SSI program during the review period, an annual care plan review is not expected. Of the records reviewed, 1,127 of 1,320 records required a care

plan review every 12 months. The results indicated a need for improvement. Most care plans were not reviewed at least once every 12 months.

The indicator *Change in Needs* evaluates whether the care management team updated the care plan when there was a change in member needs. If a member does not have changes in needs that require a care plan update during the review period, this indicator is not applicable. Sixty-six records demonstrated a change in member needs. The results indicated a need for improvement. The records found unmet for this indicator did not include an updated care plan for frequent transitions between care settings and significant changes to medical or behavioral health needs.

The indicator *Member Re-Stratification* evaluates if the member was re-stratified after a critical event. If a member does not experience a critical event during the review period, member re-stratification is not required. Of the records reviewed, 78 of 1,320 records indicated the need for re-stratification. The results indicated a need for improvement. The records found unmet for this indicator did not include re-stratification for emergency room visits.



*Note: The review indicator *Care Plan Review* applied to 1,127 of 1,320 records in CY 2023. The review indicator *Change in Needs* applied to 66 of 1,320 records in CY 2023. The review indicator *Member Re-Stratification* applied to 78 of 1,320 records in CY 2023.

Observations and Analysis: Transition Planning

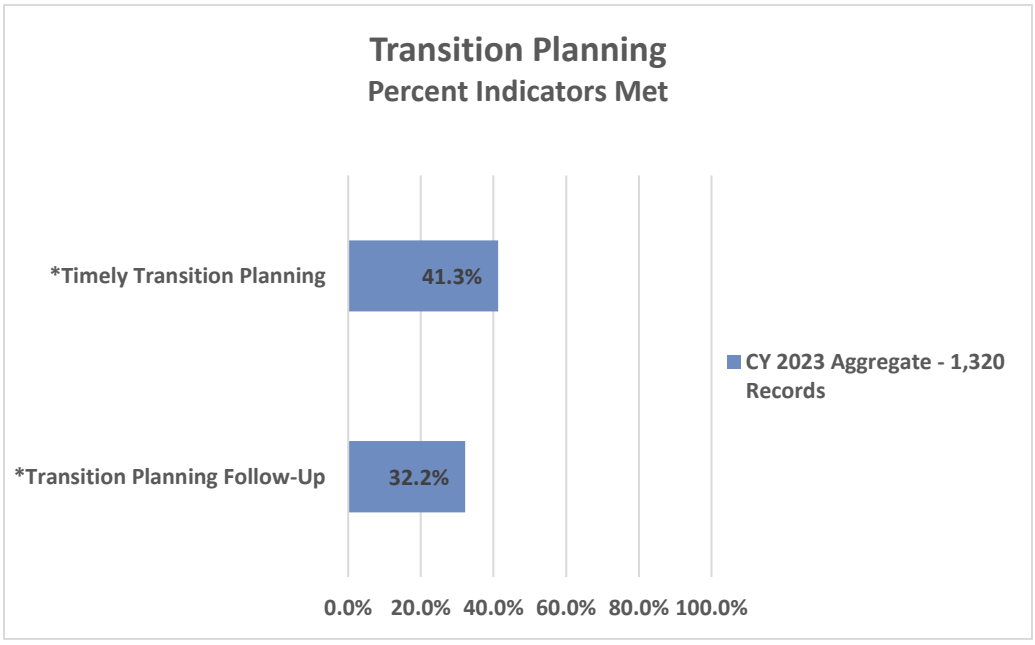
The MCO is responsible for having appropriate transitional care procedures to assist its members after discharge from a hospital. Follow-up must occur within five business days of a hospital discharge. The follow-up activities should include:

- Conduct a medication reconciliation (or confirm the hospital completed);
- Evaluation of the member's ability to manage their medications;
- Help the member understand their medication and medication schedule, their treatment or discharge plan, and how to best manage their conditions.

If a member does not have any hospitalizations during the review period, this section will not be applicable. One hundred forty-three of 1,320 records indicated a member hospitalization during the review period.

The indicator *Timely Transition Planning* ensures the member was contacted timely by the care management team after discharge from an inpatient hospital facility. The results indicated a need for improvement. The records found unmet for this indicator did not demonstrate members were contacted within five business days of discharge from an inpatient setting.

The indicator *Transition Planning Follow-Up* ensures the care management team conducted all follow-up activities with the member after discharge from an inpatient hospital facility. The results indicated a need for improvement. The records found unmet for this indicator did not demonstrate the care management teams reviewed all required hospital discharge information when contacting the member within five business days of hospital discharge.



*Note: The review indicator *Timely Transition Planning* applied to 143 of 1,320 records in CY 2023. The review indicator *Transition Planning Follow-Up* applied to 143 of 1,320 records in CY 2023.

Observations and Analysis: Wisconsin Interdisciplinary Care Team

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

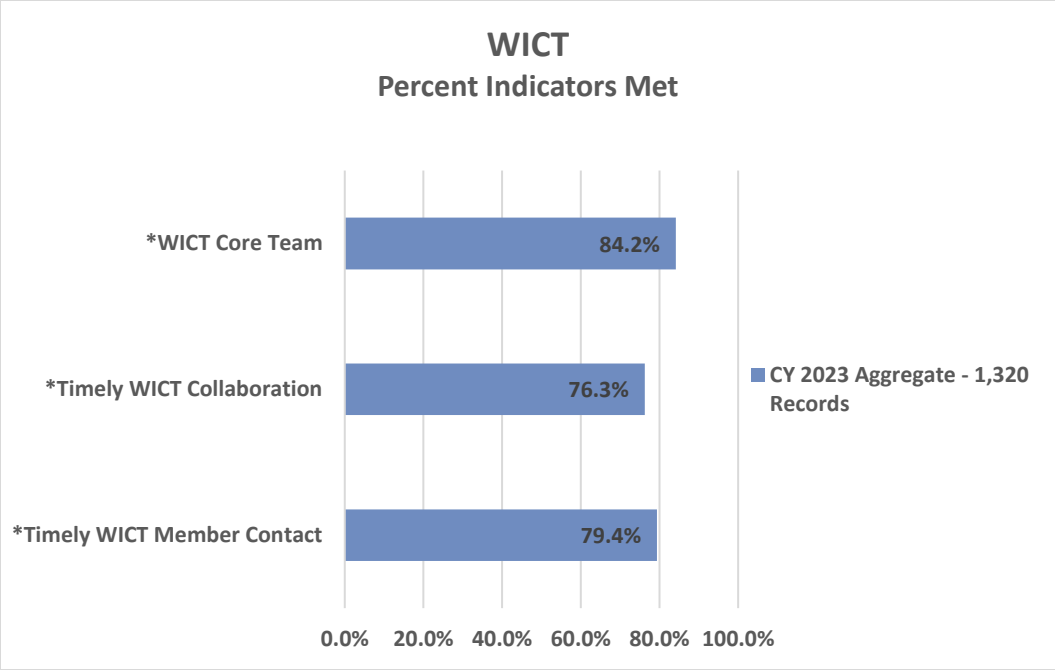
- At least two licensed health care professionals (with access to multiple disciplines);
- Weekly WICT Core Team meetings to discuss the entirety of their shared caseload; and
- A monthly face-to-face meeting between a member of the WICT Core Team and the member.

If a member is not stratified as WICT during the review period, this section will not apply. Thirty-eight of 1,320 members were re-stratified as WICT at least once during the review period.

The indicator *WICT Core Team* ensures the care management team includes two licensed professionals. The results indicated a need for improvement. Many records did not demonstrate this requirement.

The indicator *Timely WICT Collaboration* ensures the WICT Core Team meet at least weekly to discuss the member's needs and care. The results indicated a need for improvement. Many records did not demonstrate weekly meetings.

The indicator *Timely WICT Member Contact* ensures the WICT Core Team meets with the member, face-to-face, at least monthly. The results indicated a need for improvement. Many records did not demonstrate monthly face-to-face contact with members.



*Note: The review indicator *WICT Core Team* applied to 38 of 1,320 records in CY 2023. The review indicator WICT Core Team Collaboration applied to 38 of 1,320 records in CY 2023.
Note: The review indicator WICT Core Team Member Contact applied to 34 of 1,320 records in CY 2023.

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 – Foster Care Medical Home

The Foster Care Medical Home is a PIHP operated in six southeastern Wisconsin counties by one managed care organization, Chorus Community Health Plan – Care4Kids (C4K). The FCMH provides comprehensive and coordinated health care for children in out-of-home care in a way that reflects their unique health needs. The FCMH review provides an evaluation of the Medical Home provider's compliance with DHS requirements for the optional Medicaid benefit, and an assessment of its required care coordination systems.

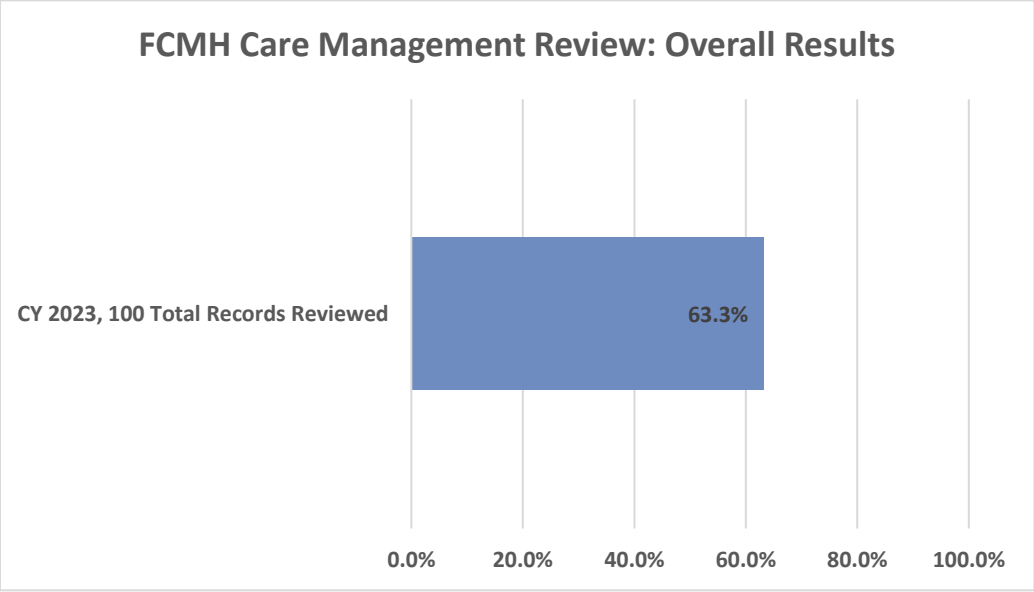
The review focused on five categories to evaluate program compliance:

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

The five categories included a total of 14 review indicators. More information about the review methodology can be found in Appendix 2.

Overall Results

The following bar graph represents the overall percent of CMR standards met by the PIHP in CY - 2023 for all 14 review indicators.



In addition to the organizational level CMR results described below in the *Results for each CMR Focus Area* section, the PIHP was provided with results for each individual record review. MetaStar recommends the PIHP evaluate the results of these individual member reviews and care coordination teams to follow up and work to address any concerns identified during the review.

Observations and Analysis for each CMR Focus Area

Each section below provides a brief explanation of a key category of CMR, followed by a bar graph which represents the PIHP's CY 2023 results for each of the review indicators comprising the CMR category. Following the CY 2022 care management review, DHS and MetaStar revised the record review to better align with contract requirements. Results from the previous year are not comparable to the current year's results. The notes below each bar graph specify the number of applicable records when it is less than the total number reviewed.

Observations and Analysis: Screening

The Out-of- Home (OHC) Health Screen must be completed within two business days of the member's out-of-home placement. The OHC Health Screen is comprehensive when it includes all of the following:

- Identification of health conditions that require prompt medical attention;
- Unclothed, symptom-targeted physical examination, including injury surveillance; and
- Identification of medical treatment and/or follow up that may be required prior to the comprehensive initial health assessment

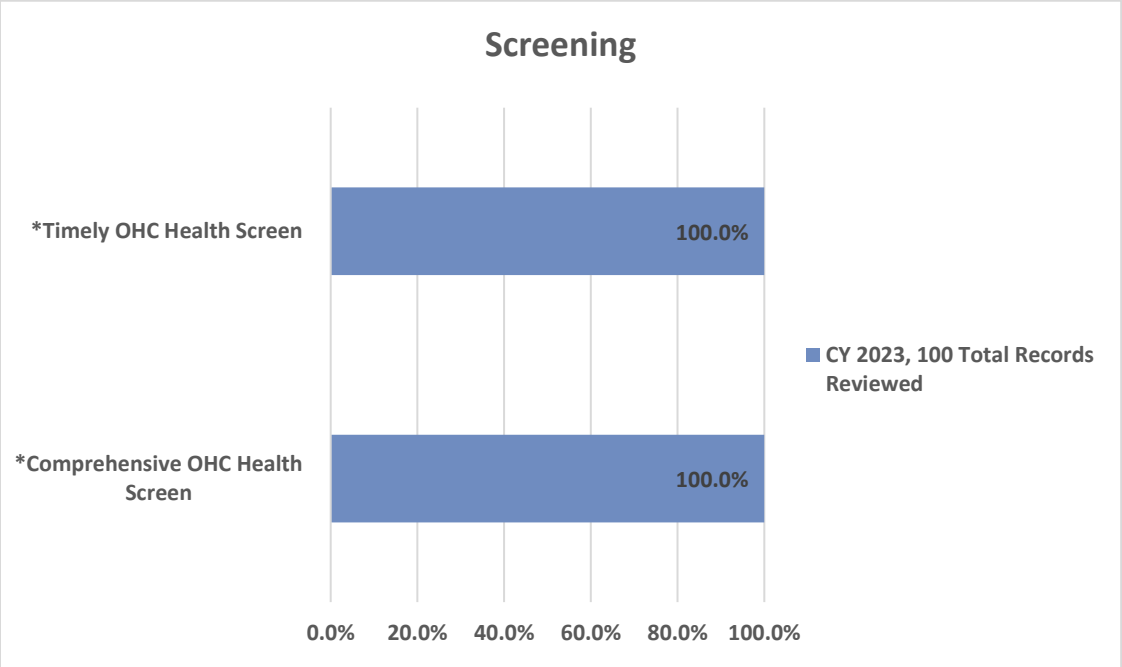
Members may be exempt from the OHC Health Screen. The PIHP is not required to complete the screen under the following circumstances:

- Newborns detained directly from the hospital;
- Children detained during an inpatient hospitalization;
- Children who are detained at the time of a forensic exam;
- Children who are detained subsequent to a forensic exam but meet the criteria for an exemption; or,
- Other unique case scenarios may be reviewed by the C4K Medical Director(s) and exemptions may be granted on a case by case basis if performing the Out-of-Home Care Health Screen would be duplicative of services recently provided.

The section *Screening* is only applicable to members who newly enrolled in the C4K program during the review period. This section applied to 10 of 100 records. If the screen was not completed, comprehensiveness of that screen could not be evaluated. Of the records reviewed, six records were exempt from the OHC Health Screen. The most common exemptions included newborns detained directly from the hospital, children detained at the time of a forensics exam, and other unique case scenarios identified by the organization's Medical Director.

The indicator Timely OHC Health Screen ensures the OHC Health Screen was completed within two business days of entry into out-of-home care. The organization demonstrated strong practices to ensure OHC Health Screens were completed timely.

The indicator *Comprehensive OHC Health Screen* ensures the OHC Health Screen was comprehensive. The organization demonstrated strong practices to ensure OHC Health Screens were comprehensive.



*Note: The review indicators *Timely OHC Health Screen* applied to 10 of 100 records in CY 2023. The review indicator *Comprehensive OHC Health Screen* applied to 10 of 100 records in CY 2023.

Observations and Analysis: Assessment

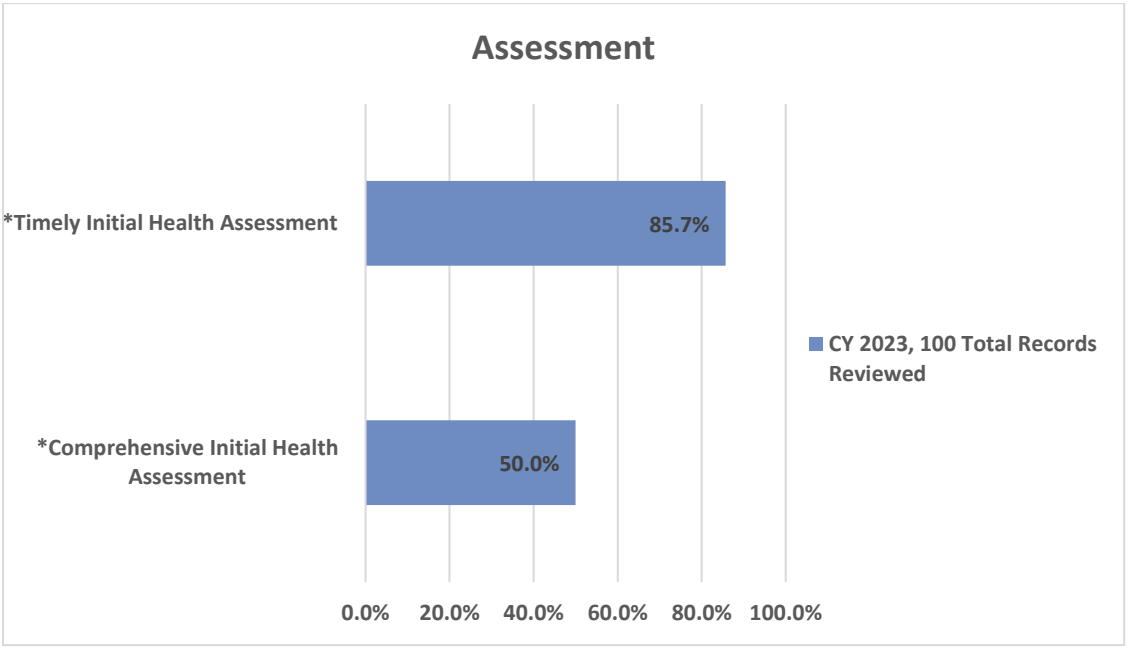
The initial health assessment must be completed within 30 calendar days of enrollment. The assessment must include the review of the member's physical health, behavioral health, oral health, and developmental problems.

The section *Assessment* is only applicable to members who newly enrolled in the C4K program during the review period. This section applied to 14 of 100 records. If an assessment was not completed within the review period, comprehensiveness of that assessment could not be evaluated.

The indicator Timely Initial Health Assessment ensures the initial health assessment was completed within 30 days of enrollment. The results indicated a need for improvement. One record did not evidence a completed initial health assessment, and one initial health assessment was not completed within 30 days of the member's enrollment.

The indicator Comprehensive Initial Health Assessment ensures the OHC Health Screen was comprehensive. The results indicated a need for improvement. The most common reason this requirement was not met was an assessment of the member's oral health needs was not documented in the record.

The following graph demonstrates the PIHP's rate at which the standards were met for each indicator in CY 2023.



*Note: The review indicators *Timely Initial Health Assessment* applied to 14 of 100 records in CY 2023. The review indicator *Comprehensive Initial Health Assessment* applied to 12 of 100 records in CY 2023.

Observations and Analysis: Care Planning

The initial care plan must be completed within the first 60 calendar days of enrollment. Ongoing care plans must be reviewed and updated at least once every six months, when

indicated, and within 30 days of discharge from an inpatient mental health hospitalization. The care plan review must include the member, Primary Care Provider (PCP), OHC provider(s), parent/legal guardian, and child welfare case worker. A comprehensive care plan is evident when all required elements are documented.

The indicator Timely Initial Care Plan ensures the initial care plan was developed within 60 days of enrollment. This indicator applied to 16 of 100 records. The organization demonstrated strong practices to ensure initial care plans were completed timely.

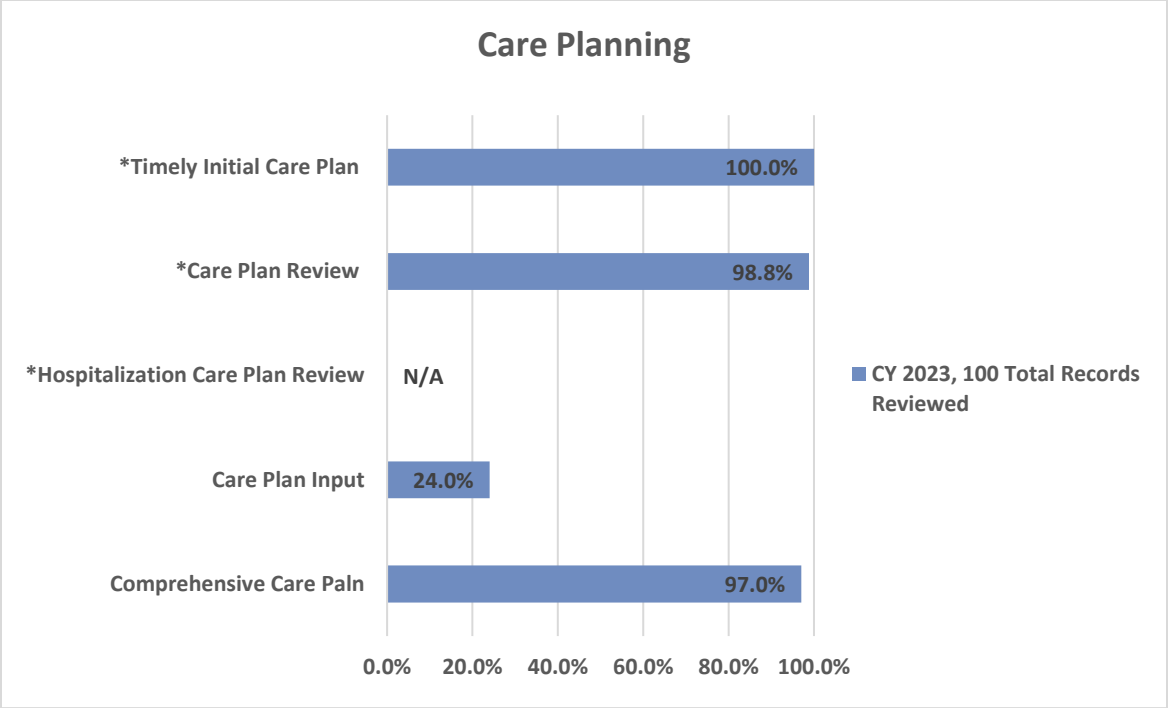
The indicator Care Plan Review ensures the care plan was reviewed and updated at least once every six months or when indicated. If a member disenrolled during the review period and a care plan review was not due, this indicator was not evaluated. This indicator applied to 81 of 100 records. The organization demonstrated strong practices to ensure care plans were reviewed and updated as required.

The indicator Hospitalization Care Plan Review ensures the care plan was reviewed and updated within 30 days of discharge from an inpatient mental health hospitalization. This indicator was not applicable, as no members were hospitalized for mental health needs during the review period.

The indicator Care Plan Input ensures the most recent care plan evaluated during the review period included input from all required persons. The results indicated a need for improvement. The most common reasons this requirement was not met was input from the parent/legal guardian, child welfare caseworker, and the member was not newly obtained for each care plan review evaluated during the review period.

The indicator Comprehensive Care Plan ensure the most recent care plan was comprehensive. The organization demonstrated strong practices to ensure care plans were comprehensive.

The following graph demonstrates the PIHP's rate at which the standards were met for each indicator in CY 2023.



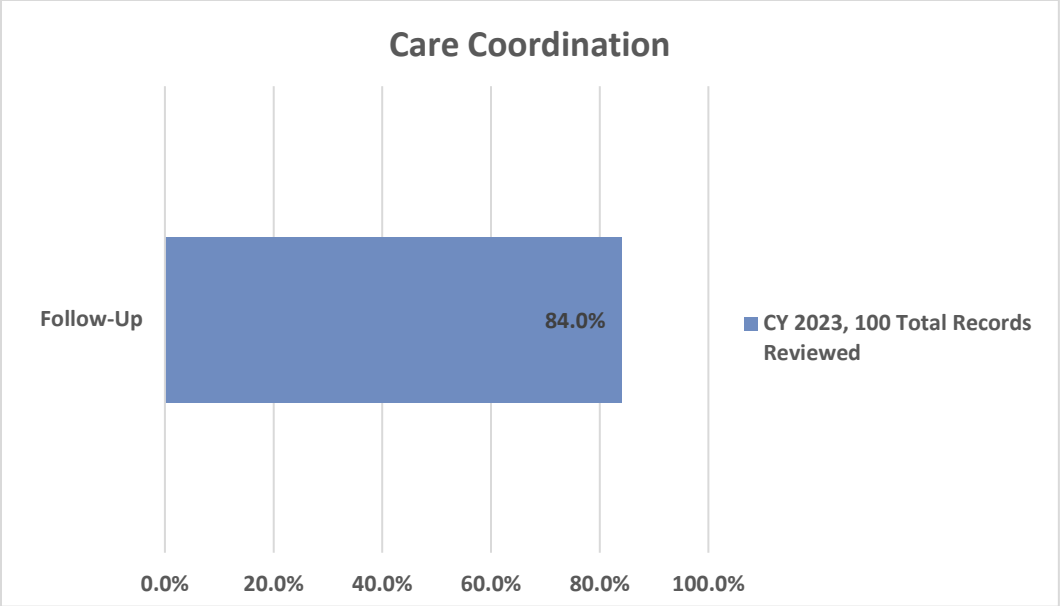
*Note: The review indicators *Timely Initial Care Plan* applied to 16 of 100 records in CY 2023. The review indicator *Care Plan Review* applied to 81 of 100 records in CY 2023. The review indicator *Hospitalization Care Plan Review* applied to no records in CY 2023.

Observations and Analysis: Care Coordination

The PIHP should ensure are implemented to address all of the member's identified needs. Both ongoing and emergent needs must have a documented plan to address each need, and identify a team member responsible for coordination and follow-up activities. The services and supports must be coordinated in a reasonable amount of time.

The indicator *Follow-Up* ensures ongoing and timely monitoring and follow-up of the member's needs and services. The results indicated a need for improvement. The most common reasons this requirement was not met was timely follow-up was not demonstrated for members' physical and oral health needs. Of the needs that did not receive timely follow-up, most were identified during the OHC Health Screen.

The following graph demonstrates the PIHP's rate at which the standards were met for each indicator in CY 2023.



Observations and Analysis: Transition Planning

Each member must have a comprehensive transition plan created at the time of the initial care plan. Transition plans must be updated at least every six months, and include input from all required persons from the member's team.

Transition planning requirements went into effect January 1, 2022 and only apply to members who enrolled on or after that date. For members who enrolled prior to January 1, 2022, this section was not evaluated.

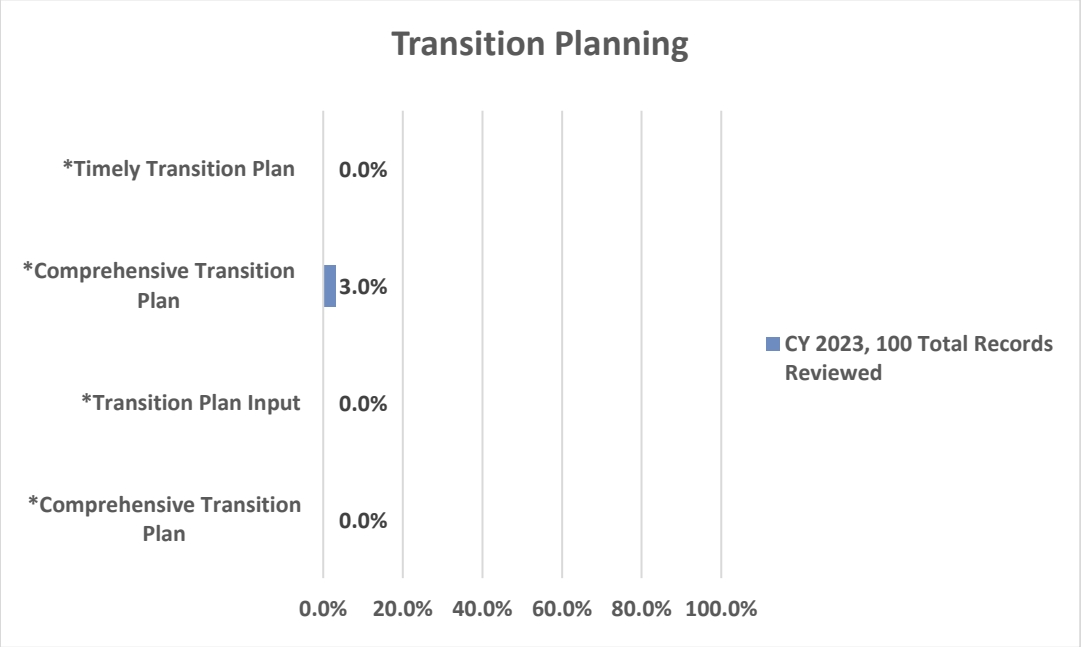
The indicator *Timely Transition Plan* ensures the initial transition plan was created timely. The results indicated a need for improvement. Most records did not include a transition plan. Of the records that contained transition plans, all were not created at the same time as the initial care plan.

The indicator *Transition Plan Review* ensures the transition plan was reviewed and updated at least once every six months. The results indicated a need for improvement. Most records did not include a transition plan. Of the records that contained transition plans, most were not reviewed and updated at least once every six months.

The indicator Transition Plan Input ensures the most recent transition plan reviewed during the review period included input from the required persons. The results indicated a need for improvement. The most common reason this requirement was not met was lack of parent/legal guardian input during each transition review.

The indicator *Comprehensive Transition Plan* ensures the most recent transition plan reviewed during the review period was comprehensive. The results indicated a need for improvement. The most common reasons this requirement was not met was transition plans did not include the member's current or assumed insurance coverage, a medical summary of treatment provided, list of maintenance needs, and medical education materials for new providers, caregivers, and parents with a summary of all relevant information for the member.

The following graph demonstrates the PIHP's rate at which the standards were met for each indicator in CY 2023.



*Note: The review indicators *Timely Transition Plan* applied to 51 of 100 records in CY 2023. The review indicator *Transition Plan Review* applied to 33 of 100 records in CY 2023. The review indicators *Transition Plan Input* applied to 5 of 100 records in CY 2023. The review indicator *Comprehensive Transition Plan* applied to 5 of 100 records in CY 2023.

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 – Wraparound Milwaukee

The Wraparound Milwaukee PIHP coordinates mental health services for children and youth in Milwaukee County who have a mental health or substance use diagnosis. The program helps children and youth stay in their home or in community care. Each program participant has a team to help develop and successfully carry out their care plan. Team members may include a WM coordinator, family members, social worker, teacher, and/or therapist.

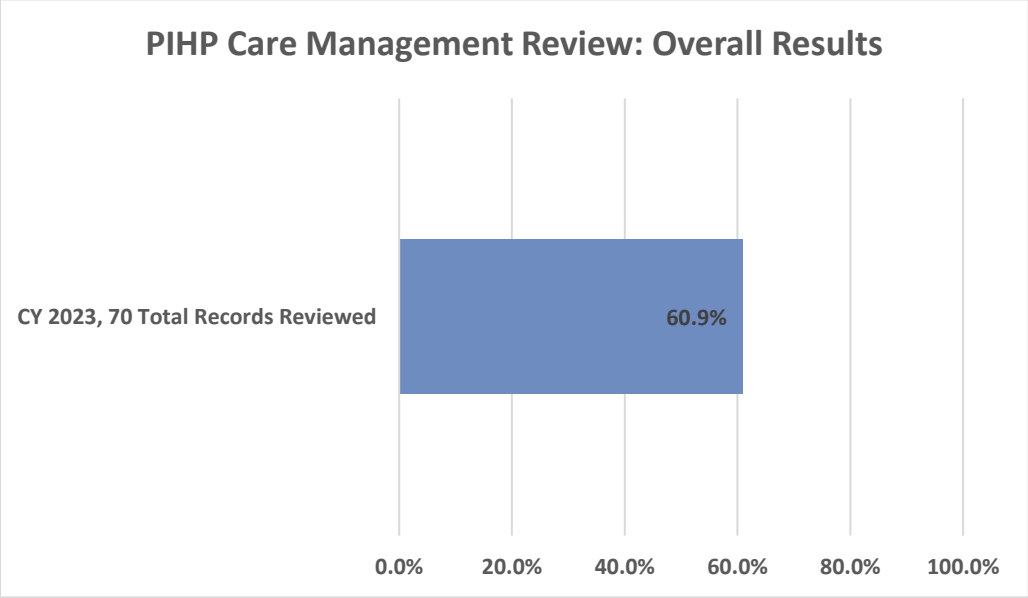
The review focused on five categories to evaluate program compliance:

- Enrollment;
- Assessment;
- Comprehensive Care Plan;
- Follow-Up; and
- Transitional Planning.

The five categories included a total of 14 review indicators. More information about the review methodology can be found in Appendix 2.

Overall Results

The following bar graph represents the overall percent of CMR standards met by the PIHP in CY 2023 for all 14 review indicators.



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

Observations and Analysis for each CMR Focus Area

Each of the five sub-sections below provides a brief explanation of a key CMR category, followed by bar graphs which display CY 2023 results for each indicator that comprises the category. The WM care management review was newly created in CY 2023; therefore, no results are available for comparison.

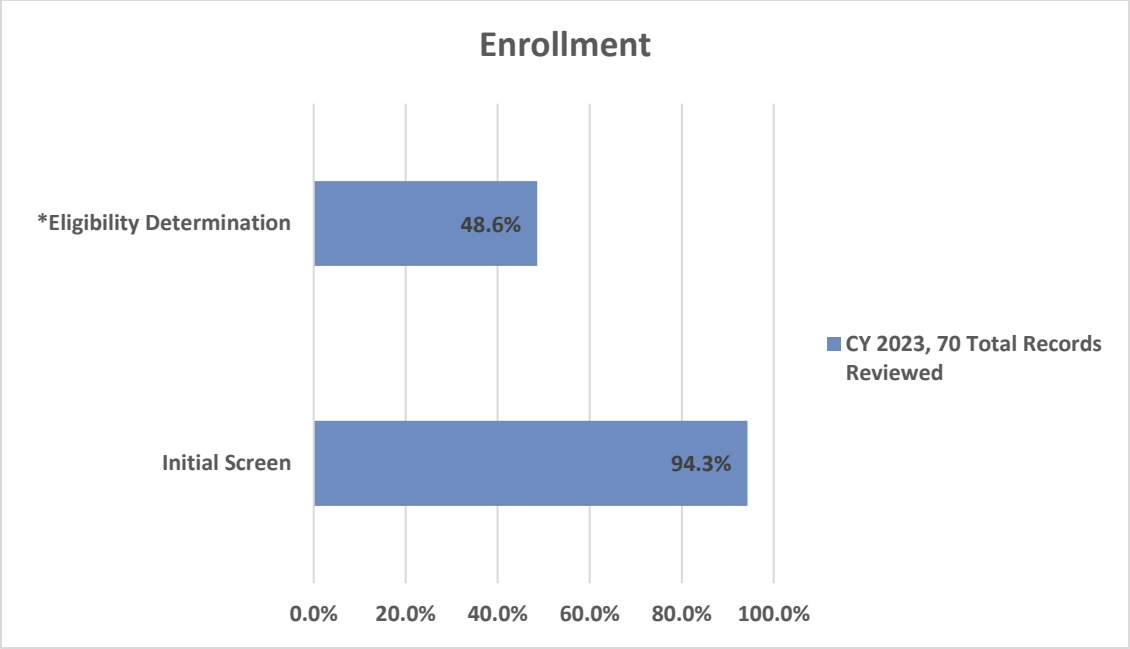
Observations and Analysis: Enrollment

Initial eligibility determination for the WM program must be completed within five business days of referral. The PIHP should determine whether the member referred meets eligibility requirements and complete an intake update information sheet approved by DHS. After initial eligibility determination, the PIHP must conduct the initial screen with 90 days of enrollment. Enrollment practices are only applicable to members who enrolled during the review period Enrollment practices applied to 35 records during the review period.

The indicator Eligibility Determination ensures the initial eligibility determination was completed within five business days of referral. The results indicated a need for improvement. The most common reason this indicator was not met was the eligibility intake information sheet was not found in the record.

The indicator Initial Screen ensures the PIHP conducts an initial screen of each member's needs within 90 days of enrollment for all new members. The PIHP demonstrated compliance with this indicator. Most initial screens were completed within 90 days of enrollment.

The following graph demonstrates the PIHP's rate at which the standards were met for each indicator in CY 2023.



*Note: The review indicator *Eligibility Determination* applied to 35 of 70 records in CY 2023. The review indicator *Initial Screen* applied to 35 of 70 records in CY 2023.

Observations and Analysis: Assessment

The care coordinator must make exhaustive efforts to obtain relevant documentation and conduct an initial comprehensive member assessment. The outcome of such informational gathering activities informs the course of action and the prioritization of services in the member's initial care plan.

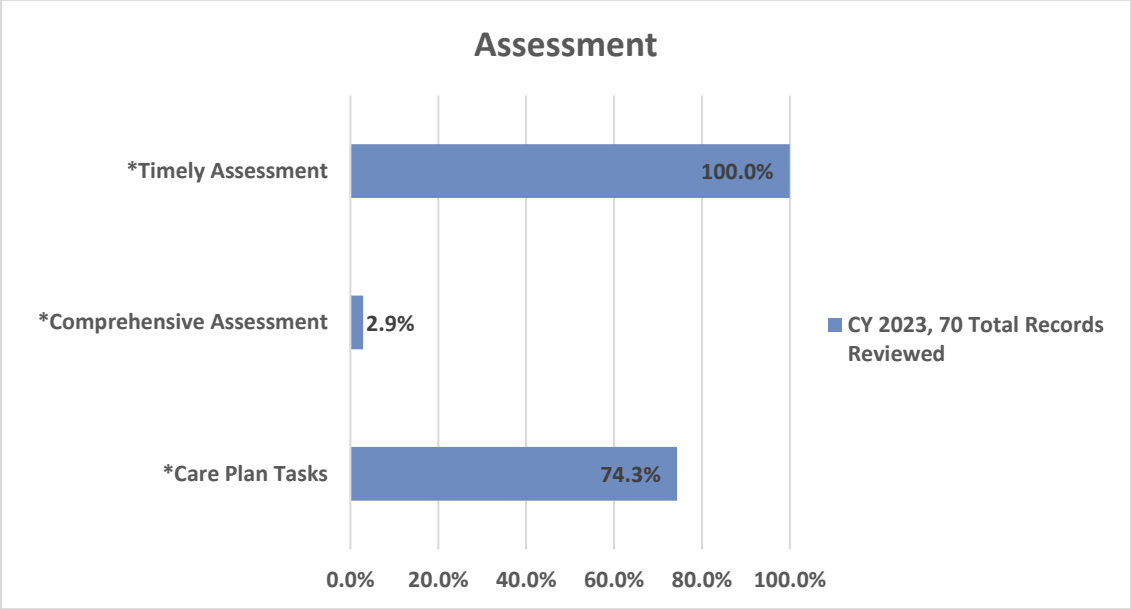
Assessment practices applied to 35 records during the review period. Assessment practices only applied to members who newly enrolled in the program during the review period.

The indicator *Timely Assessment* ensures the assessment was completed prior to the development of the initial care plan. The PIHP demonstrated strong practices with this indicator. All assessments were completed before the development of the care plan.

The indicator *Comprehensive Assessment* ensures the assessment was comprehensive. The results indicated a need for improvement. Commonly, assessments did not include an evaluation of the member's need for immediate appointment scheduling and referrals and the PIHP's need for open and flexible scheduling, including the need to go beyond the PIHP's provider network to meet the member's needs.

The indicator Care Plan Tasks ensures the care coordinator conducted all required tasks prior to the development of the initial care plan. The results indicated a need for improvement. Commonly, the PIHP did not evidence a review of relevant assessments such as developmental screenings and Individualized Education Plans.

The following graph demonstrates the PIHP's rate at which the standards were met for each indicator in CY 2023.



*Note: The review indicator *Timely Assessment* applied to 35 of 70 records in CY 2023. The review indicator *Comprehensive Assessment* applied to 35 of 70 records in CY 2023.

Observations and Analysis: Comprehensive Care Plan

The initial care plan must be completed within 30 days of enrollment. Care plans should be reviewed and updated at least once every three months or after a change in placement setting. The care plan is based on information collected during the assessment process, ensuring comprehensiveness. The child and family treatment team must be documented in the care plan. All required individuals should provide input into the care plan and sign the care plan when required.

The indicator *Timely Care Plan* ensures the initial care plan was developed timely. This indicator applied to 35 members who newly enrolled in the program during the review period. The results indicated a need for improvement. Most initial care plans were created more than 30 days after enrollment.

The indicator *Care Plan Update* ensures the care plan was reviewed and updated as required by the DHS-PIHP contract. This indicator did not apply to 15 members who newly enrolled in the program and had less than 90 days of enrollment during the review period. The results indicated a need for improvement. Most care plans were not reviewed and updated within the required three-month timeframe.

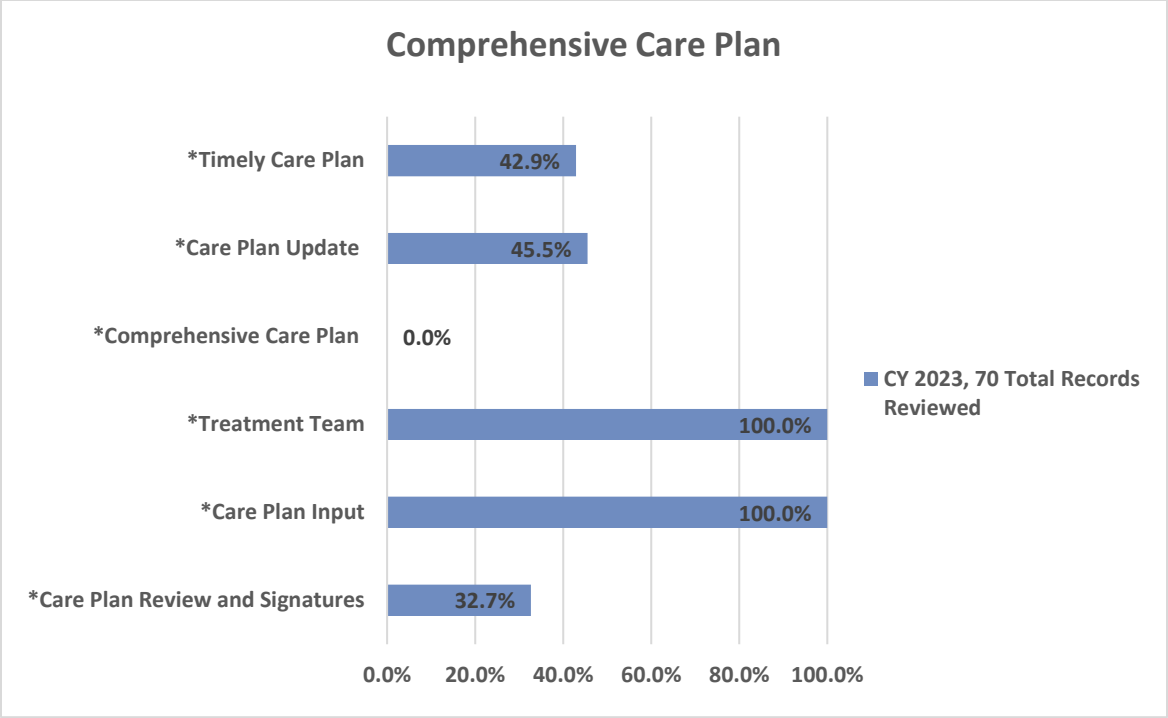
The indicator *Comprehensive Care Plan* ensures the care plan was comprehensive. If a care plan was not completed during the review period, this indicator was not applicable. This indicator applied to 55 of 70 records. The results indicated a need for improvement. Most commonly, care plans did not address barriers to care, self-identified and measurable program completion criteria, and tracking and timely follow-up on referrals.

The indicator *Treatment Team* ensures the child and family treatment team was documented in the care plan. If a care plan was not completed during the review period, this indicator is not applicable. This indicator applied to 55 of 70 records. The PIHP demonstrated strong practices with this indicator. All applicable records documented the child and family treatment team.

The indicator *Care Plan Input* ensures all required individuals provided input into the care plan. If a care plan was not completed during the review period, this indicator is not applicable. The indicator applied to 55 of 70 records. The PIHP demonstrated strong practices with this indicator.

The indicator *Care Plan Review and Signatures* ensures the care plan is required and signed by all required persons. If a care plan was not completed during the review period, this indicator is not applicable. This indicator applied to 55 of 70 records. The results indicated a need for improvement. Most commonly, a licensed psychiatrist or psychologist did not review and sign the care plan.

The following graph demonstrates the PIHP's rate at which the standards were met for each indicator in CY 2023.



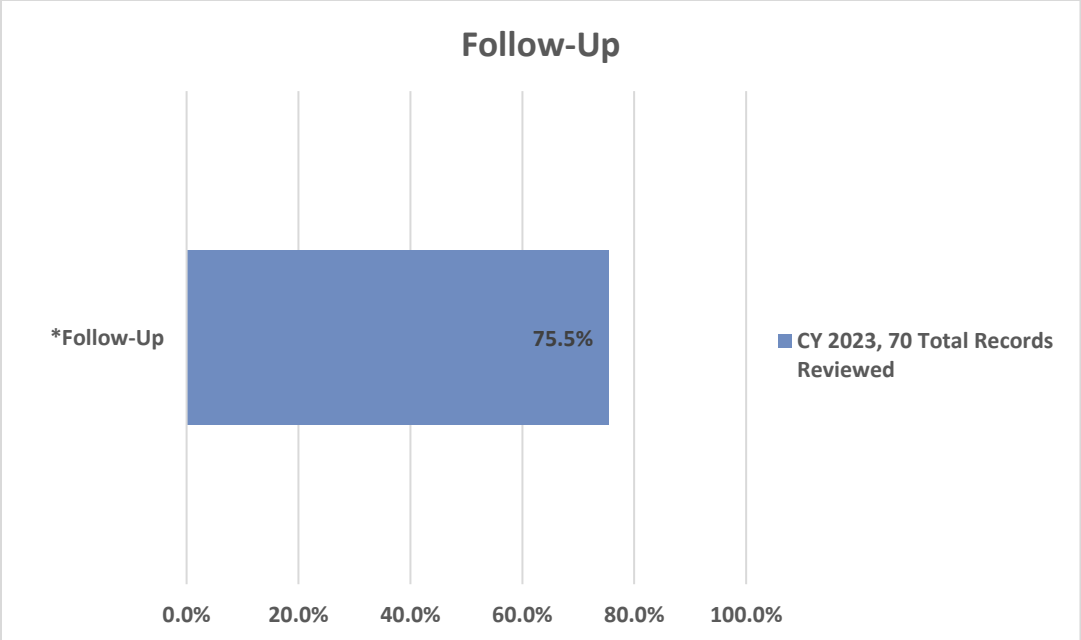
*Note: The review indicator *Timely Care Plan* applied to 35 of 70 records in CY 2023. The review indicator *Care Plan Update* applied to 55 of 70 records in CY 2023. The review indicator *Comprehensive Care Plan* applied to 55 of 70 records in CY 2023. The review indicator *Treatment Team* applied to 55 of 70 records in CY 2023. The review indicator *Care Plan Input* applied to 55 of 70 records in CY 2023. The review indicator *Care Plan Review and Signatures* applied to 55 of 70 records in CY 2023.

Observations and Analysis: Follow-Up

The record should contain evidence of care coordination and follow-up for all identified member needs. Both ongoing and emergent needs must have a documented plan to address each need. The services and supports must be coordinated in a reasonable amount of time.

The indicator *Timely Follow-Up* ensures the member's needs and services receive ongoing monitoring and follow-up. Of the records reviewed, 53 records required follow-up. The results indicated a need for improvement. Most commonly, the PIHP did not evidence timely follow-up to address the member's mental health needs.

The following graph demonstrates the PIHP's rate at which the standards were met for each indicator in CY 2023.



*Note: The review indicators *Follow-Up* applied to 53 of70 records in CY 2023.

Observations and Analysis: Transition Planning

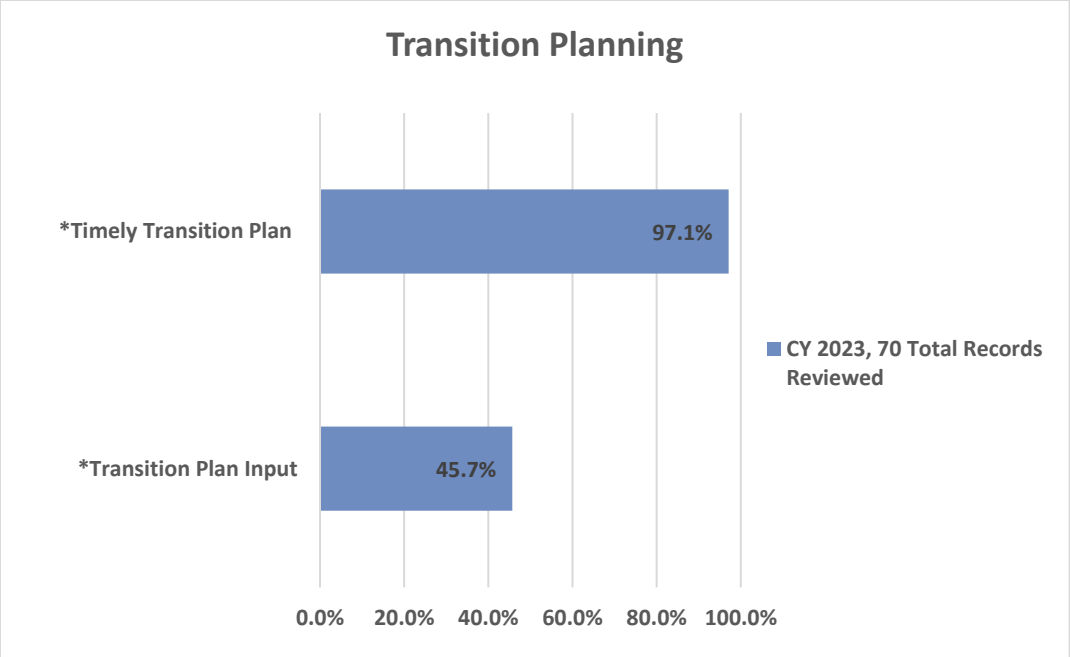
The record must contain documentation of a transitional health care plan that meets DHS-PIHP contract requirements. A transition plan must be created prior to program disenrollment, and include input from all required persons.

Transition planning applied to 35 members during the review period. Transition planning only applies to member who disenroll from the program during the review period.

The indicator *Timely Transition Plan* ensures the transition plan was created prior to disenrollment. The PIHP demonstrated compliance with this indicator. Most transition plans were created prior to program disenrollment.

The indicator *Transition Plan Input* ensures the all required persons provided input into the transition plan. The results indicated a need for improvement. Most frequently, the members, primary caregiver, parents, or legal guardians did not provide input into transition plans.

The following graph demonstrates the PIHP's rate at which the standards were met for each indicator in CY 2023.



*Note: The review indicator *Timely Transition Plan* applied to 35 of 70 records in CY 2023. The review indicator Transition Plan Input applied to 35 of 70 records in CY 2023.

Conclusions

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

Appendix A: 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 the review helps determine whether MCOs' information systems are capable of collecting, analyzing, integrating, and reporting data. ISCA requirements are detailed in 42 CFR 438.242, the DHS-MCO contract, and other DHS references for encounter reporting and third-party claims administration. DHS assesses and monitors the capabilities of each MCO's information system as part of initial certification, contract compliance reviews, or contract renewal activities, and directs MetaStar to conduct the ISCAs every three years.

Information system (IS) requirements are detailed in 42 CFR 438.242, the DHS-MCO contract, and other DHS references for managed care quality assessment and reporting. DHS assesses and monitors the capabilities of each MCO's IS as part of contract compliance reviews, or contract renewal activities, and directs MetaStar to conduct the ISCA every three years. An external assessment may not be necessary if DHS completes its own assessment, if the MCO receives accreditation through a private sector process, or if the MCO undergoes a performance measures validation that gathers information the same as, or consistent with, ISCA requirements.

DHS directed MetaStar to continue the mandatory EQR ISCAs for non-accredited MCOs and MCOs accredited by a non-recognized accreditation body every three years. Please refer to Appendix 2 for additional information regarding the reviews.

Each plan's annual HEDIS® audit, as well as the plan's ability to report HEDIS® measures encompass these requirements. A copy of each plan's Final Audit Statement (FAR) was obtained to confirm compliance.

Managed Care Organization	Program(s)	HEDIS Compliance Audit™ - MY 2022
Anthem Blue Cross and Blue Shield Health Plan (Anthem)	BC+ SSI	HEDIS LO: Attest Health Care Advisors FAR Date: July 15, 2023
Children's Community Health Plan, Inc. (CCHP)	BC+ FCMH	HEDIS LO: HealthcareData Company, LLC FAR Date: July 14, 2023
Dean Health Plan, Inc. (DHP)	BC+	HEDIS LO: HealthcareData Company, LLC FAR Date: July 14, 2023
Group Health Cooperative of Eau Claire (GHC-EC)	BC+ SSI	The organization's last ISCA was conducted by MetaStar in CY 2022.
Group Health Cooperative of South-Central Wisconsin (GHC-SCW)	BC+	HEDIS LO: Advent Advisory Group LLC FAR Date: June 20, 2023

Managed Care Organization	Program(s)	HEDIS Compliance Audit™ - MY 2022
Independent Care Health Plan (*i*Care)	BC+ SSI	The organization's last ISCA was conducted by MetaStar in CY 2022.
MercyCare Health Plans (MCHP)	BC+	HEDIS LO: Health Services Advisory Group, Inc. FAR Date: July 14, 2023
MHS Health Wisconsin (MHS)	BC+ SSI	HEDIS LO: Attest Health Care Advisors FAR Date: July 15, 2023
Molina HealthCare of Wisconsin (MHWI)	BC+ SSI	HEDIS LO: Advent Advisory Group LLC FAR Date: June 20, 2023
My Choice Wisconsin Health (MCW)	BC+ SSI	The organization's last ISCA was conducted by MetaStar in CY 2022.
Network Health Plan (NHP)	BC+ SSI	HEDIS LO: Attest Health Care Advisors FAR Date: July 15, 2023
Quartz Health Solutions, Inc. (Quartz)	BC+ SSI	HEDIS LO: Advent Advisory Group LLC FAR Date: June 20, 2023
Security Health Plan (SHP)	BC+ SSI	HEDIS LO: HealthcareData Company, LLC FAR Date: July 15, 2023
United Healthcare Community Plan (UHC)	BC+ SSI	HEDIS LO: Attest Health Care Advisors FAR Date: July 15, 2023

Results

BadgerCare Plus (BC+) and Supplemental Security Income (SSI) Medicaid managed care programs that are accreditation through the National Committee for Quality Assurance (NCQA) Health Plan Accreditation receive an annual compliance audit conducted by a NCQA certified Healthcare Effectiveness Data and Information Set (HEDIS®) Licensed Organization (LO). The BC+ and SSI Medicaid managed care programs not accredited by NCQA also participate in an annual compliance audit conducted by a NCQA certified HEDIS® LO.

42 CFR 438.242 identifies the basic elements required of health information systems:

- Collect data on enrollee and provider characteristics as specified by the State, and on all services furnished to enrollees through an encounter data system, or other method as specified by the State.
- Ensure that data received from providers is accurate and complete.
- Make all collected data available to the State and upon request to CMS.

Below are the categories and standards established by NCQA that each MCO was evaluated for compliance with IS requirements.

IS Requirement Standards		
IS Category 1	Medical Services Data – Sound Coding Methods, Data Capture, Transfer and Entry	7 Standards

IS Requirement Standards		
IS Category 2	Enrollment Data – Data capture, Transfer and Entry	4 Standards
IS Category 3	Practitioner Data – Data Capture, Transfer and Entry	5 Standards
IS Category 4	Medical Record Review Processes –Sampling, Abstraction and Oversight	5 Standards
IS Category 5	Supplemental Data – Capture, Transfer and Entry	7 Standards
IS Category 6	Data Preproduction Processing – Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity	6 Standards
IS Category 7	Data Integrity and Reporting – Accurate Reporting, Control Procedures That Support Measure Reporting Integrity	4 Standards

The table below identifies compliance for each MCO in each category evaluated during the information systems evaluation portion of the annual HEDIS audit.

MCO	IS Category 1	IS Category 2	IS Category 3	IS Category 4	IS Category 5	IS Category 6	IS Category 7
Anthem	Met	Met	Met	Met	Met	Met	Met
CCHP	Met	Met	Met	Met	Met	Met	Met
DHP	Met	Met	Met	Met	Met	Met	Met
GHC-SCW	Met	Met	Met	Met	Met	Met	Met
MCHP	Met	Met	Met	Met	Met	Met	Met
MHS	Met	Met	Met	Met	Partially Met	Partially Met	Met
MHWI	Met	Met	Met	Met	Met	Met	Met
NHP	Met	Met	Met	Met	Partially Met	Partially Met	Met
Quartz	Met	Met	Met	Met	Met	Met	Met
SHP	Met	Met	Met	Met	Met	Met	Met
UHC	Met	Met	Met	Met	Met	Met	Met

Observation and Analysis

Most organizations fully met requirements for the seven IS categories. Two organizations, MHS and NHP, received partially met scores in two categories.

The category, IS Category 5 evaluated supplemental data. MHS and NHP did not fully demonstrate effective procedures for submitting measure-relevant information for data entry, including checking procedures for electronic transmissions to ensure accuracy. MHS and NHP also did not perform consistent oversight and validation of vendors to ensure vendors met expected performance standards.

The category, IS Category 6, ensured data reproduction processing. The review noted multiple issues were encountered when evaluating MHS and NHP. Issues included incorrect extraction of

data fields and delays in recognizing and/or remediating the underlying issues were noted. Additionally, numerous issues and delays were encountered due to improper identification of populations, utilization data extracts, measure report set selection.

Conclusions

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

Record Review – Children with Medical Complexity

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

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

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

The CMC CMR is an optional activity. MetaStar reviewed 70 records of CMC participants enrolled through three hospitals. The review focused on five categories:

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

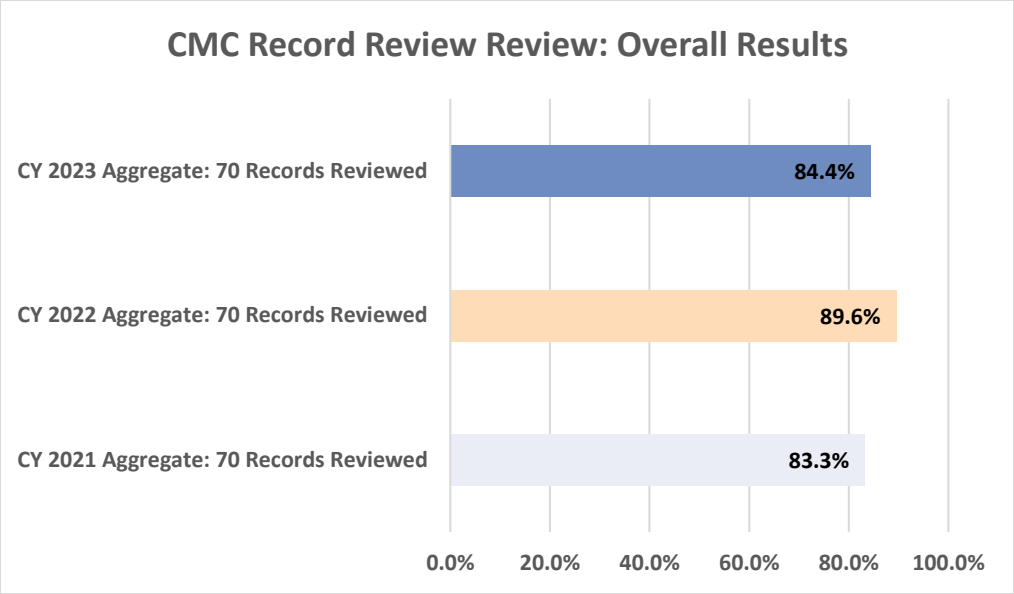
More information about the review methodology can be found in Appendix 2 and hospital comparative scores in Appendix 7.

Overall Results

Aggregate results for all CMR focus areas was 84.4 percent.

The results declined from the prior review and analysis indicated the year-to-year difference in the rates is unlikely to be the result of normal variation and chance.

The following bar graph represents the overall percent of CMR standards met by the hospitals operating the CMC program, which is the State's overall compliance rate.



Results for each CMR Focus Area

Each section below provides a brief explanation of a key category of CMR, followed by a bar graph which displays CY 2023 results for each indicator that comprises the CMR category. CY 2022 and CY 2021 aggregate results are provided for comparison. An additional bar graph is included to compare the results of each hospital reviewed in CY 2023.

Observations and Analysis: Eligibility

Members must meet all eligibility requirements as described in the *ForwardHealth Online Handbook*. The handbook includes alternate criteria for members too young to meet the utilization criteria. Members must be under age 26 with chronic health conditions involving three or more organ systems and requiring three or more medical or surgical specialists. Additionally, the member must have one or more hospital admissions (totaling five or more days), or at least ten visits to tertiary clinics within the preceding year. Members too young to meet the utilization criteria may be eligible if the child meets the health condition criteria, and either has a hospital stay totaling five or more days, or the member's clinicians anticipate ongoing high utilization. The records of new members must contain evidence of voluntary participation in the benefit program.

The indicator *Program Eligibility* ensures all members who receive services are eligible for the program. Analysis indicated that results were similar to the prior year. This indicator continues

to be a strength for the CMC program, scoring over 90.0 percent in the prior two reviews. The organizations had processes in place to ensure all members met eligibility requirements.

The indicator *Voluntary Consent* ensures the member's legal guardian voluntarily consents to participate in the program. Analysis indicated that results were similar to the prior year. This indicator continues to be a strength for the CMC program, scoring 100.0 percent in the prior two reviews. The organizations had strong methods in place to ensure the voluntary consent was obtained when applicable.

The following graph illustrates the State's overall compliance with the eligibility standards.

*Note: The review indicator *Voluntary Consent* applied to three of 70 records in CY 2023, seven of 70 records in CY 2022, and eight of 70 records in CY 2021

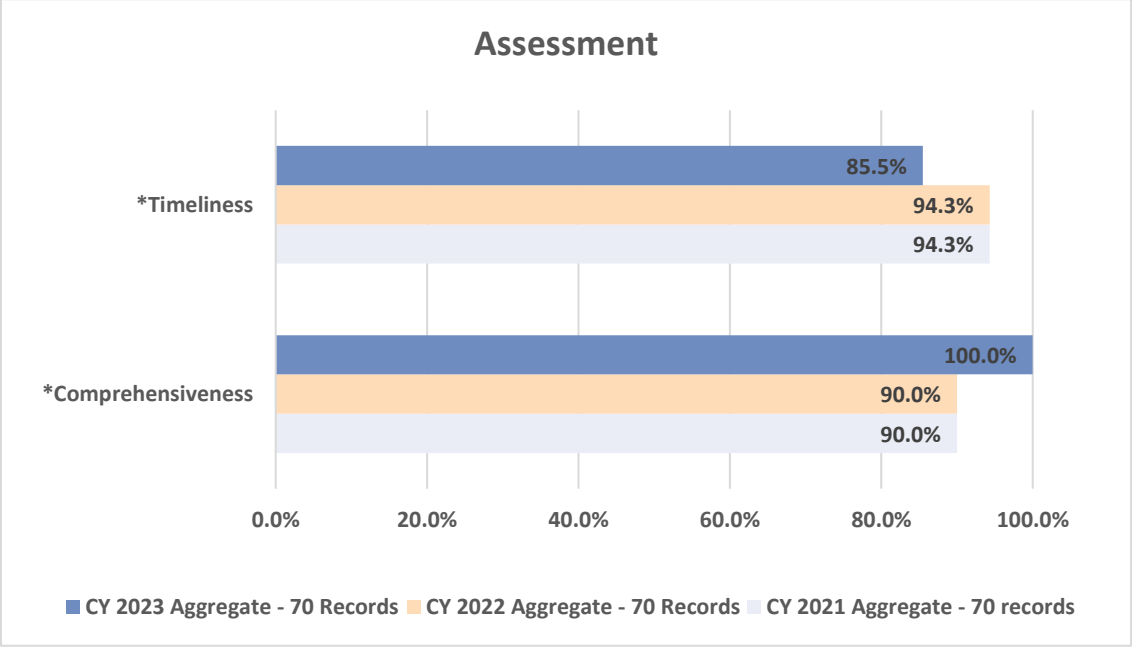
Observations and Analysis: Assessment

Each member must have a comprehensive assessment that determines the member's need for medical, educational, social, or other services. The assessment should occur close to the date of enrollment and at least every six months thereafter. An assessment is comprehensive when it contains evidence of information from other sources (e.g. family members, educational providers, etc.), includes the member's history, and identifies the member's needs and strengths.

The indicator *Timeliness* ensures initial and periodic assessments are completed within the required timeframes outlined in the DHS-MCO contract requirements. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. Overall results for this indicator decreased from the prior review. Most records found unmet for this indicator did not meet requirements for a timely periodic assessment.

The indicator *Comprehensiveness* ensures the MCO evaluates member needs based on the DHS-MCO contract requirements. Analysis indicated results were the same as the prior year. This indicator continues to be a strength for the CMC program, scoring 100.0 percent in the prior two reviews. The organizations developed comprehensive assessments.

The following graph illustrates the State's overall compliance with the assessment standards.



*Note: The review indicator *Timeliness* applied to 69 of 70 records in CY 2023, 70 of 70 records in CY 2022, and 70 of 70 records in CY 2021.The review indicator *Comprehensiveness* applied to 61 of 70 records in CY 2023, 67 of 70 records in CY 2022, and 70 of 70 records in CY 2021.

Observations and Analysis: Care Plans

Each member must have a comprehensive care plan completed within 30 days of enrollment and initial assessment. A comprehensive care plan includes:

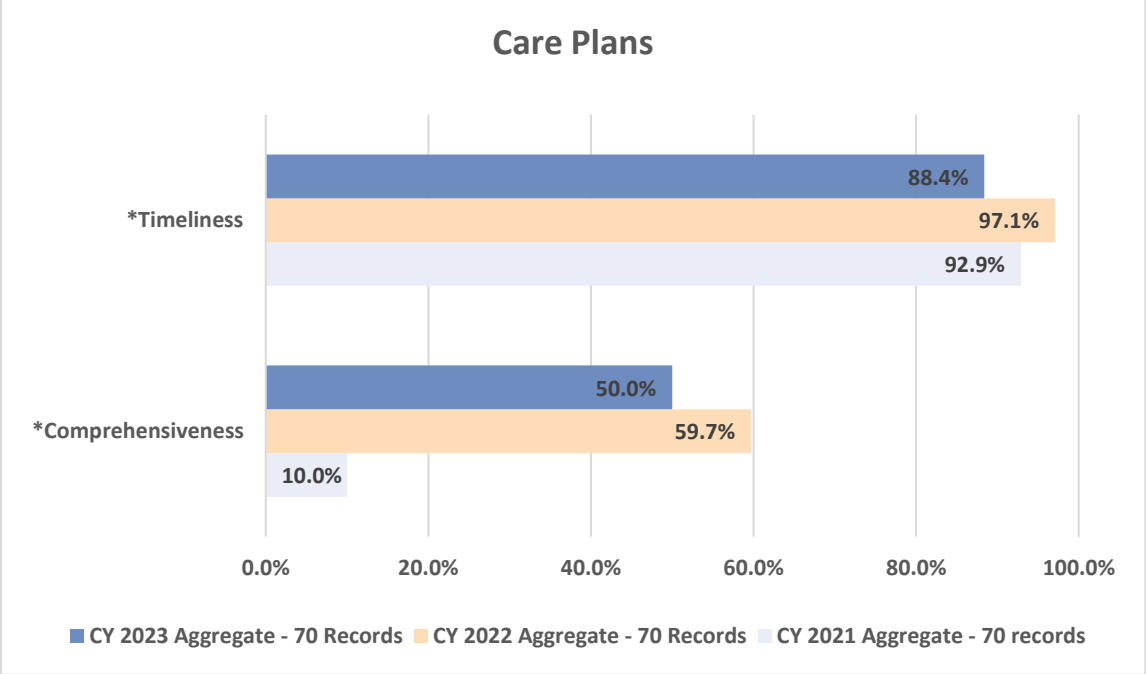
- The member's needs and goals (medical, social, and educational);
- Actions or interventions to meet the goals; and
- Timeframes for the interventions.

The initial care plan must also contain evidence that development occurred during a face-to-face meeting between the member, family and physician or advanced practitioner. Care plans must be reviewed at least every six months or as a member's needs change.

The indicator *Timeliness* ensures initial and periodic care plans are completed within the required timeframes outlined in the DHS-MCO contract requirements. Analysis indicated the year-to-year difference in the rates is unlikely to be the result of normal variation or chance. Overall results for this indicator decreased from the prior review. Records not met for this indicator did not evidence timely periodic care plans.

The indicator *Comprehensiveness* ensures member care plans include all assessed needs. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. Overall results for this indicator decreased from the prior review. Most records scored as unmet for this indicator did not include timeframes for initiating and/or completing the identified actions.

The following graph illustrates the State's overall compliance with the care plan standards.



*Note: The review indicator *Timeliness* applied to 69 of 70 records in CY 2023, 70 of 70 records in CY 2022, and 70 of 70 records in CY 2021. The review indicator *Comprehensiveness* applied to 60 of 70 records in CY 2023, 67 of 70 records in CY 2022, and 70 of 70 records in CY 2021.

Observations and Analysis: Service Reduction or Termination

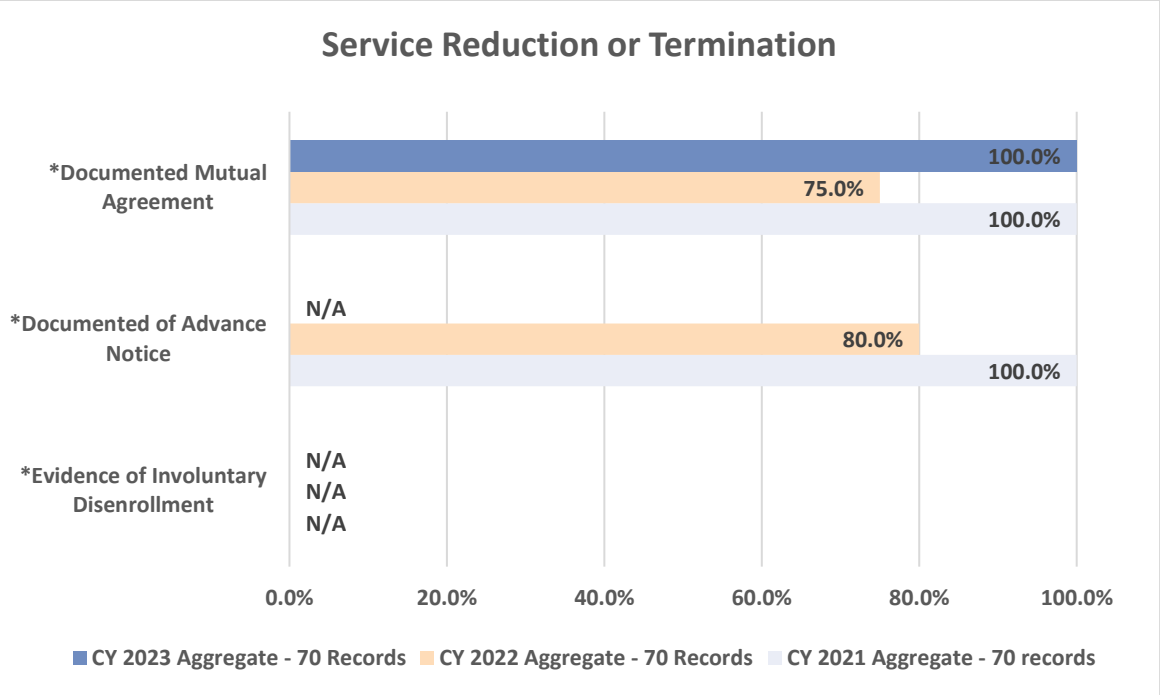
Service reductions or terminations must be mutually agreed upon and the changes communicated to the legal decision maker in advance of implementing the change. When a member or family cannot be contacted, or refuses to adhere to the program's requirements, the member may be involuntarily disenrolled from the benefit program. However, the record must include evidence of the loss of contact or refusal to meet program requirements.

Indicator *Documented Mutual Agreement* ensures the member and legal guardian are in agreement with service reductions and/or the termination of services. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. Overall results for this indicator increased from the prior review. This indicator is a strength for the CMC program with a score of 100.0 percent.

Indicator *Documentation of Advance Notice* ensures the member and legal guardian are given notice for change in level of services. No records were applicable for this indicator in CY 2023; therefore, comparisons to previous years cannot be made.

Indicator *Evidence of Involuntary Disenrollment* ensures the organization only involuntarily disenrolls a member from the program when the member and/or family refuses to meet program requirements and/or the organization loses contact with the member. Of the records reviewed, one member involuntarily disenrolled from the program during the review period. There were no involuntary disenrollments in CY 2022; therefore, no comparisons can be made.

The following graph illustrates the State's overall compliance with the service reduction or termination standards.



*Note: The review indicator *Documented Mutual Agreement* applied to seven of 70 records in CY 2023, four of 70 records in CY 2022, and five of 70 records in CY 2021.The review indicator *Documentation of Advance Notice* applied to zero of 70 records in CY 2023, five of 70 records in CY 2022, and one of 70 records in CY 2021. The review indicator Evidence of Involuntary Disenrollment applied to one of 70 records in CY 2023, zero of 70 records in CY 2022, and zero of 70 records in CY 2021.

Observations and Analysis: Monitoring and Service Coordination

Care teams are required to conduct ongoing service coordination activities to ensure all identified needs are addressed. This includes, conducting ongoing supportive contacts, coordinating referrals and completing follow-up after a hospitalization. Monitoring activities should be conducted as frequently as necessary, but must occur at least once annually to determine services are adequate to meet the member's needs and are being provided in accordance with the member's care plan.

Indicator *Ongoing Supportive Contacts* ensures that the member is able to access services and/or is receiving the services and care specified in the care plan. Analysis indicated the year-to-year difference in the ongoing supportive contacts rates are likely due to normal variation or chance. Overall results for this indicator decreased from the prior review. Most records found unmet for this indicator did not include contact with the RN Care Coordinator.

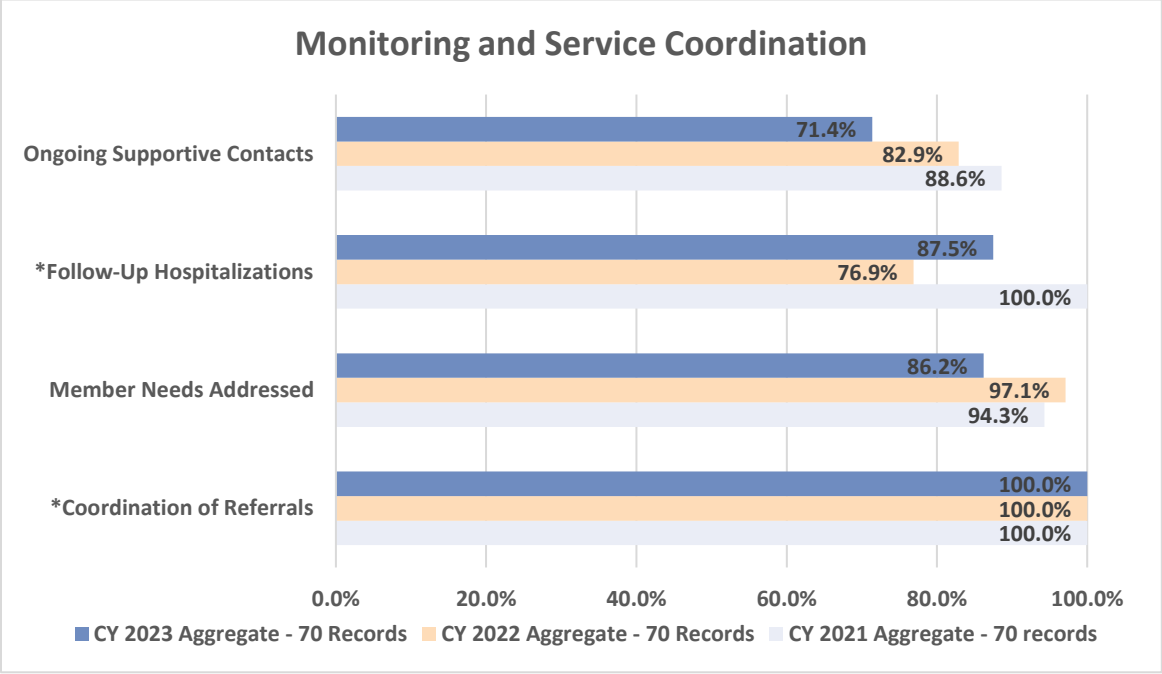
Indicator *Follow-Up Hospitalizations* ensures the MCO conducted follow-up with the member and legal guardian within three business days of hospital discharge. Analysis indicated the year-

to-year difference in the rates is likely due to normal variation or chance. Overall results for this indicator increased from the prior review. Records found unmet for this indicator did not include hospitalization follow-up within the required timeframe.

Indicator *Member Needs Addressed* ensures the MCO conducted follow-up for identified member needs. Analysis indicated the year-to-year difference in the rates is unlikely to be the result of normal variation or chance. Overall results for this indicator decreased from the prior review. Most records scored unmet for this indicator did not evidence that the member's medical needs were addressed and one record did not evidence that social needs were met.

Indicator *Coordination of Referrals* ensures the MCO provides coordination and follow-up on all member referrals. Analysis indicated scores were the same as the prior review. This indicator continues to be a strength for the CMC program, scoring 100.0 percent in the prior two reviews. The organizations demonstrated strong practices in ensuring appropriate coordination of referrals.

The following graph illustrates the State's overall compliance with the monitoring and service coordination standards.



*Note: The review indicator *Hospitalization Follow-Up* applied to 16 of 70 records in CY 2023, of 26 of 70 records in CY 2022, and 15 of 70 records in CY 2021. The review indicator *Coordination of Referrals* applied to 23 of 70 records in CY 2023, 23 of 70 records in CY 2022, and 31 of 70 records in CY 2021. The review indicator *Member Needs Addressed* applied to 58 of 70 records in CY 2023, 70 of 70 records in CY 2022, and 70 of 70 records in CY 2021.

Conclusions

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

Record Review – HIV/AIDS Health Home

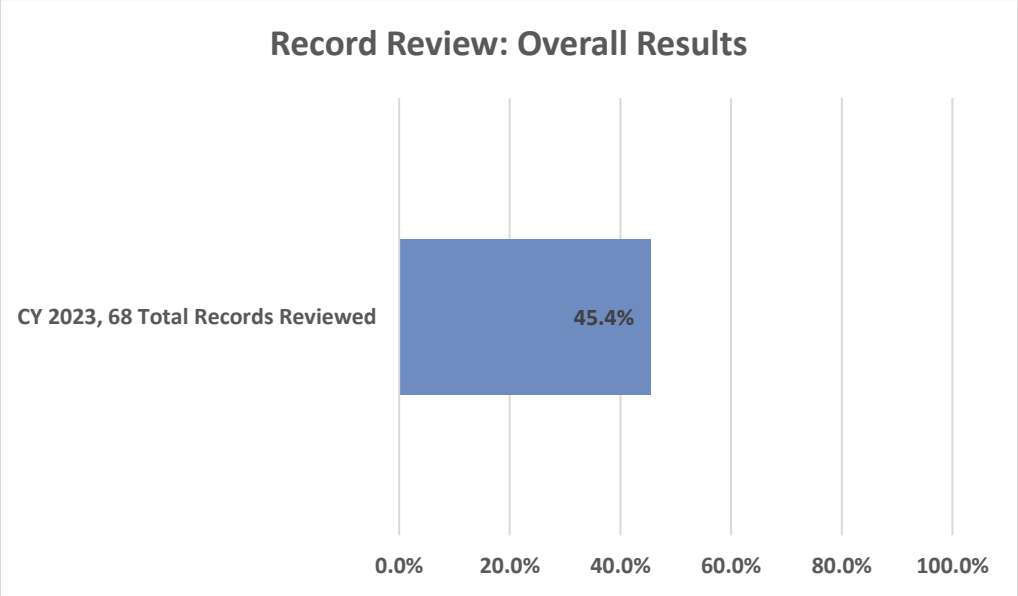
The HIV/AIDS Health Home program provides comprehensive care coordination for individuals with HIV infections or AIDS and chronic conditions. The program uses a member-centered approach for the coordination of care across all health care settings and community care settings. Each member has a core team to help develop and successfully carry out their care plan.

Record review is an optional activity which determines an organizations level of compliance with the ForwardHealth Handbook. The information gathered during record review helps assess the access, timeliness, quality, and appropriateness of care an organization provides to its members. Record review activities and findings are part of DHS' overall strategy for providing quality assurance its HIV/AIDS Health Home program is operating as intended.

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

Overall Results

The bar graph below represents the overall percent of record review standards met by the health home organization in CY 2023 for all 13 review indicators.



Results for Each Record review Focus Area

Each section below provides a brief explanation of a key category of record review, followed by a bar graph which represents the organization's results for each of the review indicators comprising the record review category.

Observations and Analysis: Eligibility and Enrollment

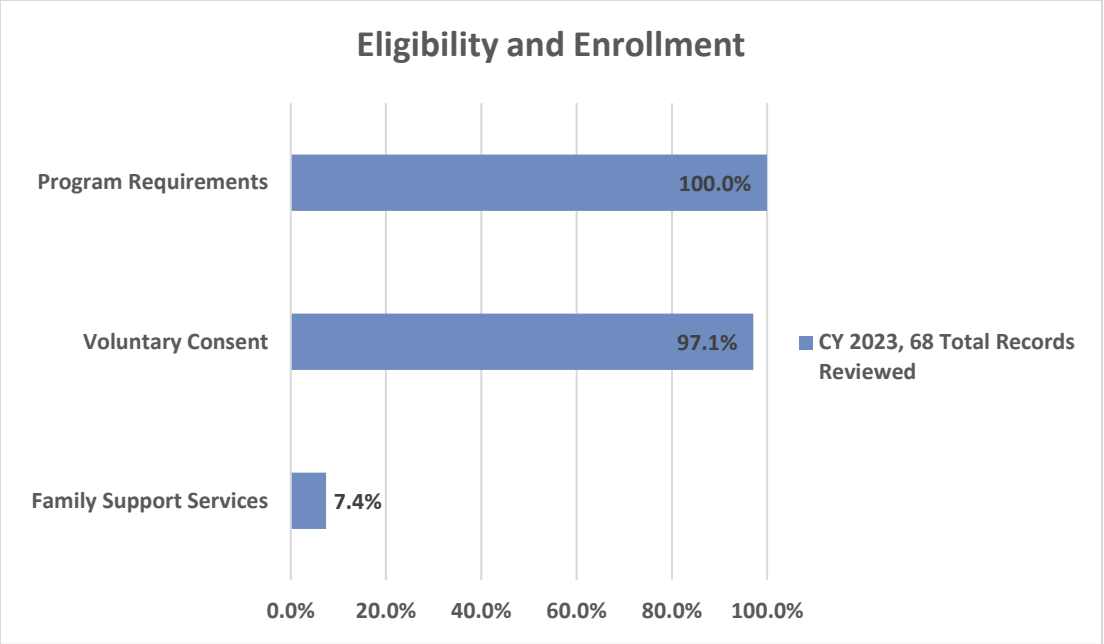
Individuals must have a diagnosis of HIV or AIDS and another chronic health condition or at risk of developing a secondary chronic condition to be eligible for the program. Program members must accept responsibility to participate in the program. Members must be informed of the right to opt out of the program. The health home team is responsible to discuss the option of identifying an authorized agent and member choice with each program member.

The indicator Program Requirements ensures the member meets the diagnoses requirements to qualify for the program. The organization ensured all members met the eligibility requirements.

The indicator Voluntary Consent ensures the organization educates members that participation in the program is voluntary. Over 90 percent of members had the program participation rights reviewed with the member either verbally or in writing. Participation in the program is voluntary and members have the right to "opt out" at any time.

The indicator Family Support Services ensures the organization discusses the member's right to appoint an authorized agent. The health home organization did not demonstrate discussions with 63 members regarding the ability to appoint an authorized agent of the member's choosing. This was met for five members.

The following graph demonstrates the organization's rate at which the standards were met for each indicator in CY 2023.



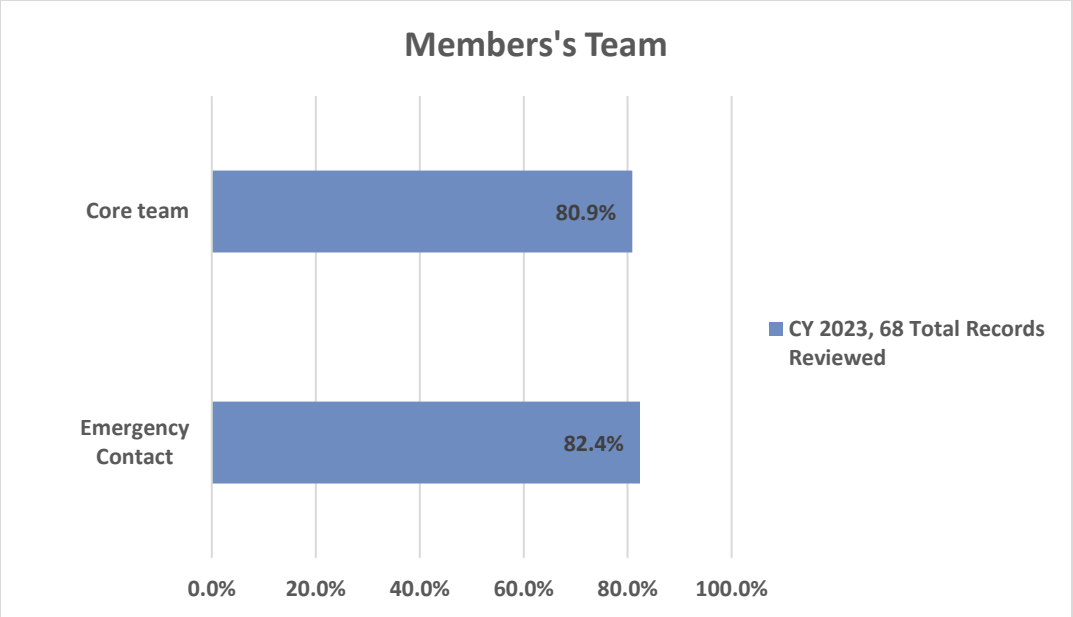
Observation and Analysis: Member's Team

The member has a core team of professionals to support members. The team must include a registered nurse, a primary care physician, a case manager, a mental health or substance abuse professional, a dentist, and a pharmacist. A team lead and care coordinator must be designated as roles within the core team.

The indicator Core Team ensures the member has all required professionals and roles on their core team. Results indicated an opportunity for improvement. Of the 13 records which did not meet this requirement, 10 records did not include a registered nurse as part of the core team.

The indicator Emergency Contact ensures an emergency contact has been identified and is documented in the record or discussed and declined by the member. Over 80 percent of records reviewed contained evidence of the identification of an emergency contact by the member.

The following graph demonstrates the organization's rate at which the standards were met for each indicator in CY 2023.



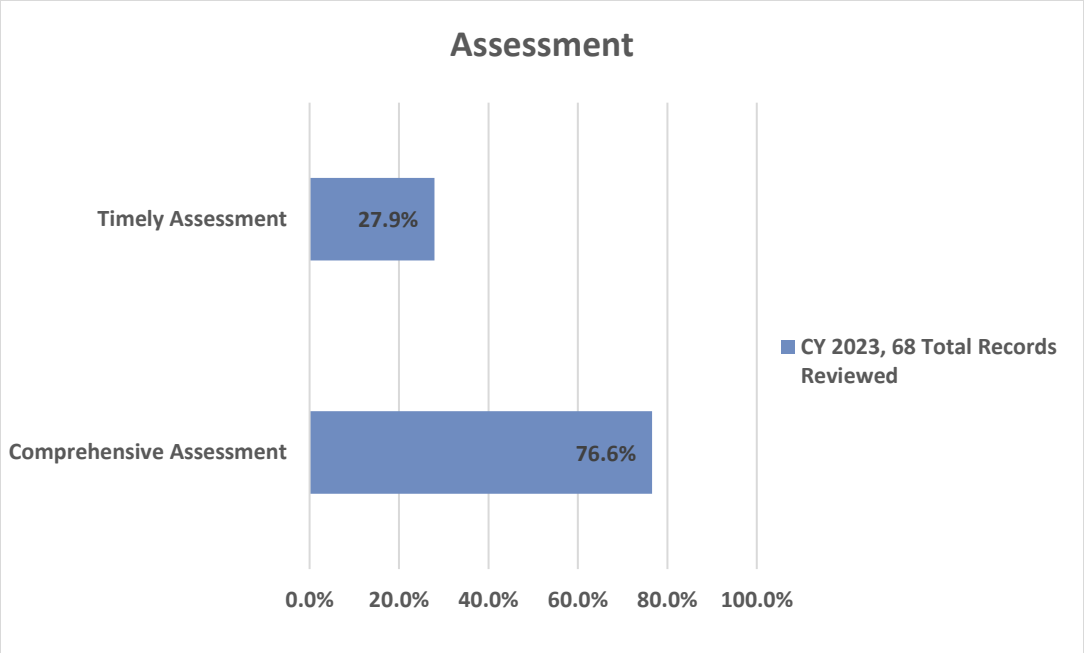
Observation and Analysis: Assessment

The care coordinator works with the member to conduct an assessment within 30 days of enrollment and then every 12 months. The information gathered during the assessment informs the needs and supports included in the care plan.

The indicator Timely Assessment ensures the assessment was completed prior to the development of the care plan. Results indicated a need for improvement. In most cases not meeting requirements, more than 12 months occurred between assessments.

The indicator Comprehensive Assessment ensures the assessment was comprehensive. Results indicate an opportunity for improvement. Of the 49 records not containing comprehensive assessments, the most common reason the requirement was not met is due to the absence of documentation of an annual pharmacist's evaluation of medications.

The following graph demonstrates the organization's rate at which the standards were met for each indicator in CY 2023.



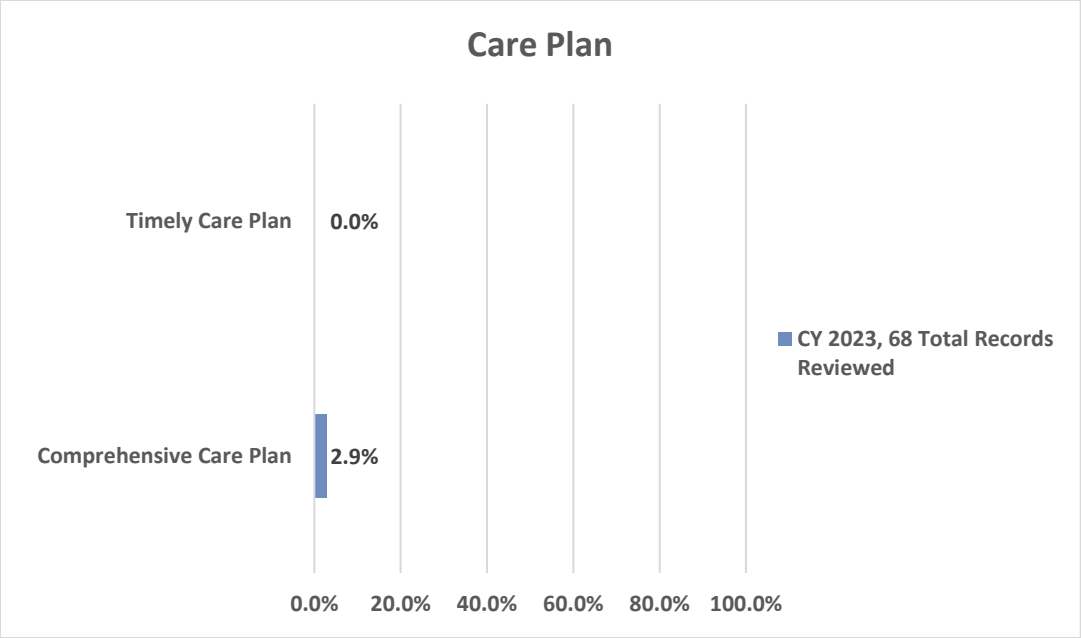
Observation and Analysis: Care Plan

The initial care plan must be completed within 30 days of enrollment. Care plans should be reviewed and updated at least once every six months. The care plan is based on information collected during the assessment process, ensuring its comprehensiveness. The member and core team should participate in care planning. The primary care physician, team lead, and care coordinator must be documented in the care plan. The frequency of contacts and frequency and method of communication among providers should be documented in the care plan.

The indicator Timely Care Plan ensures the plan was developed timely. Results indicated an opportunity for improvement. Of the 68 records reviewed no care plans were completed timely.

The indicator Comprehensive Care Plan ensures the care plan was comprehensive. Results indicated an opportunity for improvement. The health home organization did not complete comprehensive care plans in 66 of the 68 records reviewed. Most commonly, the care plan was not completed which resulted in this measure not being met.

The following graph demonstrates the organization's rate at which the standards were met for each indicator in CY 2023.



Observation and Analysis: Care Coordination, Monitoring, and Follow-Up

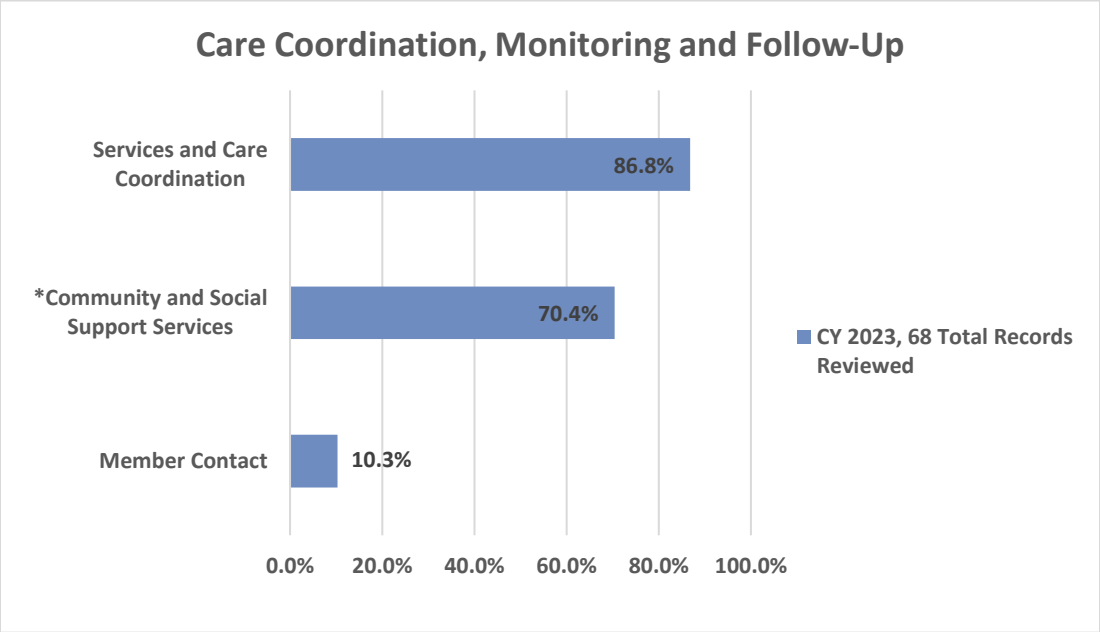
The record should contain evidence of care coordination, monitoring, and follow-up for all identified member needs. Both ongoing and emergent needs must be addressed in a timely manner. The services and supports must be coordinated in a reasonable amount of time.

The indicator Services and Care Coordination ensures the member's needs and services receive ongoing monitoring and follow-up. Results indicated an opportunity for improvement. This indicator was met for 59 of the 68 records reviewed. The organization did not document if services were received were effective for nine members.

The indicator Community and Social Support Services ensures referrals are completed in writing and followed up on within two weeks. Results indicated an opportunity for improvement. Of the 27 records that were applicable to this indicator, 19 met the criteria. Of the eight that were not compliant, seven were due to a lack of follow up within two weeks of a referral.

The indicator Member Contact ensures monthly contact with members or collateral contacts and quarterly face-to-face visits with members. Results indicated an opportunity for improvement. Seven records included evidence of monthly member or collateral contacts and quarterly face-to-face visits. A total of 61 records reviewed did not meet requirements resulting in 61 members not receiving monthly member or collateral contact and 44 not receiving quarterly face to face contact. All records included limited contacts with the assigned case manager.

The following graph demonstrates the organization's rate at which the standards were met for each indicator in CY 2023.



*Note: The review indicator *Community and Social Support Services* applied to 27 of 68 records in CY 2023.

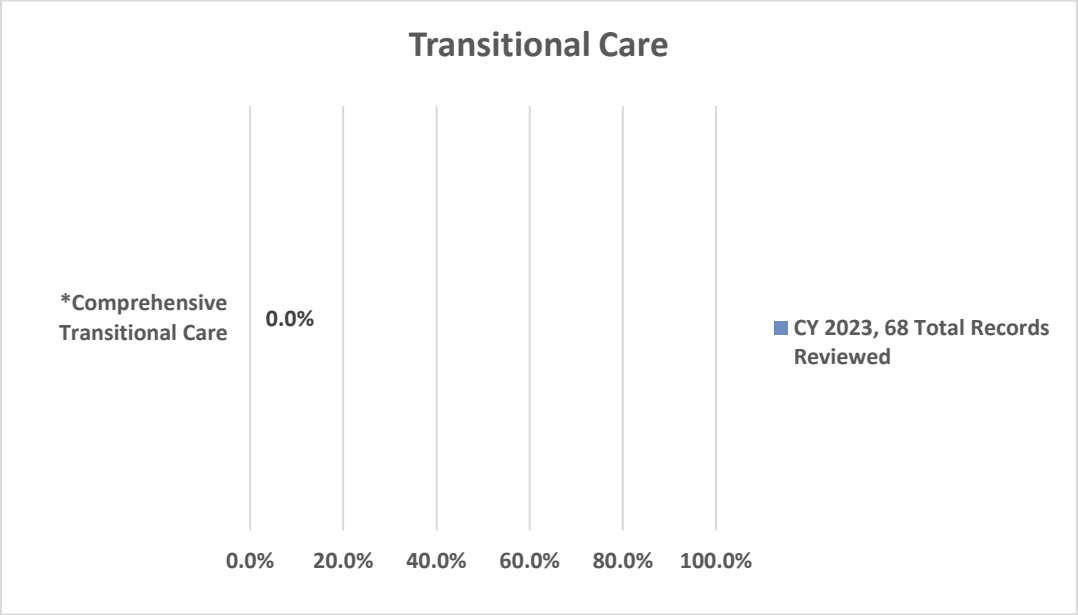
Observation and Analysis: Transition Care

The record must contain documentation of a transition requirements that meet the ForwardHealth requirements. Follow-up must occur 24 hours following hospital discharge including the review of the discharge information with the member. Follow-up with the primary care provider must occur as well as a review of discharge instructions with the member. Additional requirements are self-education for the member and a review of the medication schedule adherence.

Transition care applied to 12 members during the review period.

The Indicator Comprehensive Transitional Care ensures the transition for members following an emergency room or hospitalization. Results indicated an opportunity for improvement. Of the 12 members who required transition care during the review period, no records demonstrated compliance with all requirements. The follow-up not conducted most frequently was due to a lack of direct follow-up with the member and a review of the discharge instructions with the member.

The following graph demonstrates the organization's rate at which the standards were met for each indicator in CY 2023.



*Note: The review indicator *Comprehensive Transition Care* applied to 12 of 68 records in CY 2023.

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

AFCH	UW Health – American Family Children's Hospital
AIDS	Acquired Immunodeficiency Syndrome
ADR	Accreditation Desk Review
Anthem	Anthem Blue Cross and Blue Shield Health Plan
BC+	BadgerCare Plus
C4K	Care4Kids
CBP	Controlling Blood Pressure
CCF	Children Come First
CCHP	Chorus Community Health Plan, Inc.
CHIP	Children's Health Insurance Program
CFR	Code of Federal Regulations
CHW	Children's Hospital of Wisconsin
CIS	Childhood Immunization Status
CMC	Children with Medical Complexity
CMR	Care Management Review
CMS	Centers for Medicare & Medicaid Services
CY	Calendar Year
DHP	Dean Health Plan, Inc.
DHS	Wisconsin Department of Health Services
EQR	External Quality Review
EQRO	External Quality Review Organization
FCMH	Foster Care Medical Home
FUH	Follow-Up After Hospitalization for Mental Illness
GHC-EC	Group Health Cooperative of Eau Claire
GHC-SCW	Group Health Cooperative of South Central Wisconsin

HEDIS[3]	Healthcare Effectiveness Data and Information Set
HIV	Human Immunodeficiency Virus
*i*Care	Independent Care Health Plan
ISCA	Information Systems Capabilities Assessment
LSC	Lead Screening in Children
MCHP	MercyCare Health Plans
MCO	Managed Care Organization
MCH	Marshfield Children's Hospital
MHS	MHS Health Wisconsin
MHWI	Molina Healthcare of Wisconsin
MY	Measurement Year
MCW	My Choice Wisconsin
NCQA	National Committee for Quality Assurance
NHP	Network Health Plan
OHC	Out-of-Home Care
P4P	Pay For Performance
PMV	Performance Measure Validation
PCC	Primary Care Clinic
PCP	Primary Care Physician and Primary Care Provider
PDSA	Plan-Do-Study-Act
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PPC	Prenatal and Postpartum Care
QAPI	Quality Assessment and Performance Improvement
Quartz	Quartz Health Solutions, Inc.

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

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

Appendix 2 – Requirement for External Quality Review and Review Methodologies

Requirement for External Quality Review

The Code of Federal Regulations (CFR) at 42 CFR 438 requires states that operate 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 50 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, HIV/AIDS Health Home members, 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 physical therapist, counselors, 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 External Quality Review 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, and information technologies staff.

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

MetaStar also contracts with a coding company with certified and/or credentialed coders. Review team experience includes professional practice and/or administrative experience in managed health and long-term care programs as well as in other settings, including community programs, schools, home health agencies, community-based residential settings, and the Wisconsin 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: Validation of Performance Improvement Projects (PIP)

Validation of PIPs, a mandatory EQR activity, assesses if a MCO or PIHP used sound methodology in the design, implementation, analysis and reporting of its PIPs. The MetaStar team evaluated the organization's PIPs according to the methodology described in the CMS guide, *EQR Protocol 1: Validating Performance Improvement Projects (PIPs), A Mandatory EQR-Related Activity.*

Reviewers evaluated the PIP's design, implementation, analysis and reporting using each of the following standards for the organization's submitted PIP report.

1. Standard 1: PIP Topic
2. Standard 2: PIP Aim Statement
3. Standard 3: PIP Population
4. Standard 4: Sampling Method
5. Standard 5: PIP Variables and Performance Measures
6. Standard 6: Data Collection Procedures
7. Standard 7: Data Analysis and Interpretation of PIP Results
8. Standard 8: Improvement Strategies
9. Standard 9: Significant and Sustained Improvement

Findings were analyzed and compiled using a binomial structure (*met* and *not met*) to assess the organization'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 any findings of *not met,* the EQR team documented the missing requirements related to the findings and provided recommendations.

Each section has a specified number of scoring elements, which correlate with the *CMS EQR Protocol 1, Validation of Performance Improvement Projects.* 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 for each standard.

In addition, the validity and reliability of the PIP methods and findings are assessed to determine whether the EQRO has confidence in the PIP results. The validation rating reflects the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement. The validation result is based on the overall percentage of standards met for each project as follows:

Percentage of Scoring Elements Met	Validation Result
90.0% - 100.0%	High Confidence
80.0% - 89.9%	Moderate Confidence
70.0% - 79.9%	Low Confidence
<70.0%	No Confidence

Findings were initially compiled into a preliminary report. The organization 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).*

The CMS Protocol allows states to require MCOs to calculate and report their own performance measures, or to contract with another entity to calculate and report the measures on the MCO's behalf. For MY 2022 DHS identified three BC+ composite measures and four areas of care for the SSI measures. The BC+ composites were made up of a children's composite (four HEDIS measures), maternal health composite (two HEDIS measures) and a disease management composite (four HEDIS measures). The SSI areas of care included behavioral health (three HEDIS measures), chronic conditions (two HEDIS measures), and preventative health (two HEDIS measures).

DHS outlined the expectations for data submission in the *Wisconsin Department of Health Services (DHS) Division of Medicaid Services (DMS) HMO Quality Guide (Quality Guide)*. MCOs were required to submit the following information to DHS:

- Data from the NCQA Interactive Data Submission System (IDDS) site ensuring the required elements including the numerators and denominators for each measure were included in the data-filled workbook (export) in an Excel format;
- Data filled workbook including the Audit Review Table (ART) format validation review with evidence that the auditor lock was applied;
- The audit report produced by an NCQA Licensed HEDIS Auditor;
- HEDIS measures with age stratification must include results in IDDS and ART table by age strata and other sub-populations as well as the overall population.

DHS did not direct MetaStar to perform any information systems capabilities assessments prior to conducting performance measure validation.

DHS used the validated results from each MCO to calculate the statewide rate for each measure which are included in this report. DHS transitioned to weighted rates for statewide quality indicators report in CY 2023 to ensure each MCO is represented in the overall Wisconsin rate. The CY 2023 measure reporting is based on the new weighted methodology; therefore, statewide rates are not comparable to previous years.

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

Compliance with Standards review, 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).

MCOs accredited by NCQA are exempt from a full Compliance with Standards review under 42 CFR 438.360 Nonduplication of mandatory activities with Medicare or accreditation review. The accreditation review affirms the MCO's accreditation status and evaluates compliance with the areas of the Compliance with Standards review not addressed by NCQA accreditation. During CY 2021 MetaStar completed an *Accreditation Crosswalk* (crosswalk) as part of *DHS's Accreditation Deeming Plan* in the *Managed Care Quality Strategy*. The *Accreditation Deeming Plan* deems that a full Compliance with Standards review is duplicative for organizations with full NCQA Accreditation. The crosswalk compares the CFR Managed Care requirements to the NCQA accreditation standards, the DHS-MCO contract and annual DHS Certification Application to identify gaps in assuring full compliance with the regulations. The 2021 Medicaid Managed Care Quality Strategy is located at: 2021 Medicaid Managed Care Quality Strategy (wisconsin.gov.).

The crosswalk review assesses the strengths and opportunities for improvement of the MCO related to quality, timeliness, and access to services, including health care and members with special health care needs. MetaStar conducted a document review to evaluate policies, procedures, and practices within the organization. The review assessed information about the MCO's NCQA accreditation results, as well as its structure, operations, and practices related to the gaps identified through the crosswalk.

The requirements were then connected to the Compliance with Standards focus areas and sub-categories to allow comparability in results across all MCOs, regardless of accreditation status. The following table identifies the focus areas and corresponding CFR citations.

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.

The review assesses the strengths and weaknesses of the MCO related to quality, timeliness, and access to services, including health care. 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 are 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 worked with DHS to identify 31 standards that include applicable federal and state requirements.

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
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

Focus Area	Related Sub-Categories in Review Standards
	• 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:

Scoring Legend	
Percentage Met	**Rating**
90.0% - 100.0%	Excellent
80.0% - 89.9%	Very Good
70.0% - 79.9%	Good
60.0% - 69.9%	Fair
< 60.0%	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.

Compliance with standards reviews are conducted on a three-year review cycle for organizations not accredited by NCQA and organizations accredited by an accrediting body not accepted by DHS.

MCO	Last Compliance Review	Next Compliance Review
GHC-EC	2022	GHC-EC obtained NCQA accreditation in 2023 and will participate in the ADR activity in 2025.
***i*Care**	2021	*i*Care obtained NCQA accreditation in 2023 and will participate in the ADR activity in 2024.
MCW	2021	Molina Healthcare, Inc. acquired MCW in 2023, and will participate in the ADR activity in 2024.
WM	2021	2024

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

Care management review is an optional review activity that assesses key areas of care management practice and helps determine an organization's level of compliance with its contract with DHS. The MetaStar team conducted care management review activities as outlined in the *CMS* guide, *EQR Protocol 9: Conducting Focus Studies of Health Care Quality, An Optional EQR-Related Activity*.

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 90 consecutive days, and participants who had left the program since the sample was drawn.

MetaStar obtained information from each MCO via a survey, which asked the organization to describe its processes for:

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

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

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

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 six categories of care management practice:

- Screening
- Care Planning
- Care Coordination
- Care Plan Review and Update
- Transition Planning
- Wisconsin Interdisciplinary Care Team

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, Protocol 9: Conducting Focus Studies of Health Care Quality – Care Management Review – Foster Care Medical Home

Care management review is an optional review activity that assesses key areas of care management practice and helps determine an organization's level of compliance with its contract with DHS. The MetaStar team conducted care management review activities as outlined in the *CMS* guide, *EQR Protocol 9: Conducting Focus Studies of Health Care Quality, An Optional EQR-Related Activity*.

Prior to conducting the CMR, MetaStar discussed documentation practices with the PIHP with familiarize reviewers with organizational practices prior to the review.

MetaStar randomly selected a sample of member records. The random sample included member who had been enrolled for at least sixty days during the review period, and may include participants who had left the program since the sample was drawn.

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. MetaStar evaluated five categories of care management practice:

- Screening
- Assessment
- Care Planning
- Care Coordination
- Transition Planning

CMS External Quality Review (EQR) Protocols, Protocol 9: Conducting Focus Studies of Health Care Quality – Care Management Review – Wraparound Milwaukee

Care management review is an optional review activity that assesses key areas of care management practice and helps determine an organization's level of compliance with its contract with DHS. The MetaStar team conducted care management review activities as outlined in the *CMS* guide, *EQR Protocol 9: Conducting Focus Studies of Health Care Quality, An Optional EQR-Related Activity*.

Prior to conducting the CMR, MetaStar discussed documentation practices with the PIHP to familiarize reviewers with organizational practices prior to the review.

MetaStar selected a sample of members which included members who newly enrolled in the program during the review period, and members who disenrolled from the program during the review period. Each member sampled had at least 90 days of enrollment in the program. Both sample subsets were randomized prior to review.

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. MetaStar evaluated five categories of care management practice:

- Enrollment
- Assessment
- Comprehensive Care Plan
- Follow-Up
- Transition Planning

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

Information Systems Capabilities Assessment evaluates the strength of each organization's information system capabilities. The MetaStar team evaluated the information systems according to 42 CFR 438.242 Health Information Systems using the CMS guide, *EQR Protocols Appendix A Information Systems Capabilities Assessment.*

Prior to conducting review activities, MetaStar worked with DHS to identify its expectations for MCOs, including compliance thresholds and rules for scoring for each requirement. DHS informed MetaStar of any MCOs that are accredited through NCQA and receive an annual compliance audit conducted by a NCQA certified HEDIS® Licensed Organization (LO). DHS also informs MetaStar of the MCOs not accredited by NCQA who also participate in an annual compliance audit conducted by a NCQA certified HEDIS® LO. MetaStar requests copies of each MCO's *HEDIS Compliance Audits*™[5]. A copy of each plan's *Final Audit Statement* (FAR) for the *HEDIS Compliance Audit*™ is obtained to confirm compliance.

DHS directed MetaStar to continue the mandatory EQR ISCAs for non-accredited MCOs and MCOs accredited by a non-recognized accreditation body every three years.

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

The review assesses the strengths, progress, and recommendations of the MCO related to the ability of its information systems to collect, analyze, integrate, and report data for multiple purposes including utilization, claims, grievances and appeals, disenrollment for reasons other than loss of Medicaid eligibility, rate setting, risk adjustment, quality measurement, value-based purchasing, program integrity, and policy development.

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

[5] NCQA HEDIS Compliance Audit is a trademark of the National Committee for Quality Assurance (NCQA).

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 the organization's information systems.

Each section has a specified number of scoring elements, which correlate with the *CMS External Quality Review (EQR) Protocol Appendix A. Worksheet A.1 Information System Capabilities Assessment (ISCA) Tool*. 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:

Scoring Legend	
Percentage Met	**Rating**
90.0% - 100.0%	Excellent
80.0% - 89.9%	Very Good
70.0% - 79.9%	Good
60.0% - 69.9%	Fair
< 60.0%	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.

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

Section 1: Background Information

MetaStar confirms the type of managed care program operated by the PIHP, the year it was incorporated, average enrollment and when the previous ISCA was conducted. This section is for informational purposes only and is not included in the scoring calculations.

Section 2: Information Systems: Data Processing & Personnel

MetaStar assesses the PIHP's system or repository used to store Medicaid claims and encounter data. The information submitted by the MCO/PIHP described the foundation of its Medicaid data systems, processes and staffing. MetaStar also assesses the stability and expertise of the PIHP's information system department.

Section 3: Staffing

MetaStar assesses the PIHP's IS department staff training and expected productivity goals.

Data Acquisition - Claims and Encounter Data Collection

MetaStar assesses the PIHP and vendor claims/encounter data system and processes, in order to obtain an understanding of how the PIHP 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 PIHP.

Section 4: Security

MetaStar reviewers assess the IS security controls. The PIHP 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 PIHP 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 5: Data Acquisition Capabilities

MetaStar assesses information on the PIHPs processes for collecting and maintaining administrative data (claims and encounter data), enrollment data, ancillary services data and data related to performance rates reporting.

Non-Managed Care Reviews – Record Review – Children with Medical Complexity

Prior to conducting the review, MetaStar obtained and reviewed the organization's documents to familiarize reviewers with the practices, including policies, procedures, and/or forms related

to member assessment and care planning, member acuity or level of care intensity, and care coordination activities such as follow-up.

Per DHS direction, MetaStar randomly selected a sample of 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.

The review team used a review tool and reviewer guidelines based on the *ForwardHealth Online Handbook* and agreed upon with DHS. The review evaluated the following five categories of care coordination and management. The review team used five categories to evaluate care management performance:

- Eligibility
- Assessment
- Care Plans
- Service Reduction or Termination
- Monitoring and Service Coordination

Non-Managed Care Reviews – Record Review – HIV/AIDS Health Home

MetaStar randomly selected a sample of member records. The random sample included members who had been enrolled for at least ninety days during the review period, and may include members who had left the program since the sample was drawn.

Prior to conducting the record review, MetaStar discussed documentation practices with the health home provider to familiarize reviewers with organizational practices.

The record review tool and reviewer guidelines are based on DHS Medicaid handbook requirements. Reviewers are trained to use DHS approved review tools, reviewer guidelines, and the review database. MetaStar evaluated six categories of care management practice:

- Eligibility and Enrollment
- Member's Team
- Assessment
- Care Plan
- Care Coordination, Monitoring and Follow-Up
- Transition Care

Appendix 3 – Validation of Performance Improvement Projects: CY 2023 (MY 2022) MCO Comparative Scores

Section	Description	BC+ and SSI Managed Care Programs CY 2023 (MY 2022)								
		Anthem	GHC-EC	*i*Care	MCW	MHS	Molina	NHP	SHP	UHC
1	*PIP Topic*	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
2	*PIP Aim Statement*	100.0%	100.0%	100.0%	91.7%	100.0%	100.0%	91.7%	75.0%	100.0%
3	*PIP Population*	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
4	*Sampling Method*	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
5	*PIP Variables and Performance Measures*	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
6	*Data Collection Procedures*	100.0%	100.0%	100.0%	100.0%	91.7%	100.0%	91.3%	95.0%	100.0%
7	*Data Analysis and Interpretation of PIP Results*	72.7%	80.0%	78.6%	91.7%	100.0%	100.0%	81.8%	50.0%	100.0%
8	*Improvement Strategies*	100.0%	100.0%	91.7%	100.0%	83.3%	100.0%	83.3%	50.0%	100.0%
9	*Significant and Sustained Improvement*	77.8%	80.0%	33.3%	71.4%	100.0%	88.9%	71.4%	20.0%	87.5%

Section	Description	BC+ Managed Care Programs CY 2023 (MY 2022)				
		CCHP	DHP	GHC-SCW	MCHP	Quartz
1	*PIP Topic*	100.0%	100.0%	100.0%	100.0%	100.0%
2	*PIP Aim Statement*	100.0%	100.0%	100.0%	100.0%	83.3%
3	*PIP Population*	100.0%	100.0%	100.0%	100.0%	100.0%
4	*Sampling Method*	N/A	N/A	N/A	N/A	N/A
5	*PIP Variables and Performance Measures*	100.0%	100.0%	100.0%	100.0%	100.0%
6	*Data Collection Procedures*	91.3%	100.0%	95.5%	100.0%	78.9%
7	*Data Analysis and Interpretation of PIP Results*	84.6%	100.0%	83.3%	64.3%	66.7%
8	*Improvement Strategies*	83.3%	100.0%	83.3%	91.7%	83.3%
9	*Significant and Sustained Improvement*	57.1%	88.9%	57.1%	62.5%	33.3%

Section	Description	PIHP Managed Care Programs CY 2023 (MY 2022)		
		C4K	CCF	WM
1	*PIP Topic*	100.0%	100.0%	100.0%
2	*PIP Aim Statement*	66.7%	33.3%	66.7%
3	*PIP Population*	100.0%	100.0%	100.0%
4	*Sampling Method*	N/A	N/A	N/A
5	*PIP Variables and Performance Measures*	100.0%	66.7%	83.3%
6	*Data Collection Procedures*	75.0%	100.0%	85.7%
7	*Data Analysis and Interpretation of PIP Results*	40.0%	66.7%	66.7%

Section	Description	PIHP Managed Care Programs CY 2023 (MY 2022)		
		C4K	CCF	WM
8	*Improvement Strategies*	66.7%	50.0%	100.0%
9	*Significant and Sustained Improvement*	75.0%	50.0%	100.0%

Appendix 4 – Validation of Performance Measures: CY 2023 (MY 2022) State Benchmark and MCO Rates

State Benchmark Rates			
Measure	**50th Percentile**	**67th Percentile**	**75th Percentile**
BC+ Women's Health Composite			
Timeliness of Prenatal Care (PPC)	85.9%	88.3%	89.3%
Postpartum Care (PPC)	76.4%	78.4%	79.6%
BC+ Children's Health Composite			
Childhood Immunization (CIS)-Combo 3	67.9%	71.3%	72.8%
Immunizations for Adolescents (IMA)-Combo 2	36.7%	41.8%	43.6%
Lead Screening in Children (LSC)	71.5%	74.7%	77.9%
SSI Composite			
Antidepressant Medication Measure (AMM) - Continuation	40.3%	43.0%	45.6%
Asthma Medication Ratio (AMR)-Total	64.8%	68.2%	70.7%
Follow-Up after Emergency Department Visit for Mental Illness (FUM-30)-Total 30 days follow up	53.5%	60.9%	64.6%
Follow-Up after Hospitalization for Mental Illness (FUH-30)-Total 30-day follow-up	60.1%	60.1%	64.6%
Hemoglobin A1C Control for Patients with Diabetes (HBD)	46.8%	49.6%	51.3%

BC+ Managed Care Programs CY 2023 (MY 2022)					
MCO	MCO Rate	MCO Rate	MCO Rate	MCO Rate	MCO Rate
	CIS	IMA	LSC	PPC	Prenatal
Anthem	61.3%	33.3%	64.1%	74.0%	82.0%
CCHP	56.4%	40.4%	68.9%	81.5%	83.2%
Dean	66.4%	42.3%	65.2%	81.2%	90.4%
GHC-EC	57.9%	33.3%	62.8%	87.3%	90.5%
GHC-SCW	60.0%	47.4%	64.5%	76.5%	91.6%
*i*Care	56.7%	27.0%	65.7%	73.2%	77.4%
MCW	51.1%	31.3%	60.3%	64.5%	63.3%
MCHP	53.4%	33.4%	38.2%	83.7%	90.4%
MHS	56.7%	32.3%	64.7%	86.9%	91.5%
Molina	56.2%	38.2%	70.3%	80.0%	86.4%
NHP	57.4%	32.4%	65.5%	78.8%	88.8%
Quartz	60.6%	41.2%	63.1%	82.9%	91.7%
SHP	65.7%	36.8%	70.0%	81.0%	85.3%
UHC	67.4%	33.8%	67.9%	83.7%	91.2%

SSI Managed Care Programs CY 2023 (MY 2022)					
MCO	MCO Rate	MCO Rate	MCO Rate	MCO Rate	MCO Rate
	AMR	AMM	FUH	FUM	HBD
Anthem	55.2%	41.9%	46.3%	36.6%	57.9%
GHC-EC	67.7%	44.1%	68.0%	N/A	54.0%
*i*Care	67.4%	45.5%	67.9%	61.4%	47.4%
MCW	53.4%	54.5%	76.8%	N/A	58.4%
MHS	71.3%	51.0%	55.8%	57.5%	54.3%
Molina	75.0%	37.6%	73.9%	68.4%	56.0%
NHP	67.3%	48.4%	74.0%	59.8%	56.9%
SHP	N/A	N/A	N/A	N/A	N/A
UHC	63.1%	56.9%	62.5%	62.9%	59.9%

Appendix 5 – Compliance with Standards Review: CY 2023 MCO Comparative Scores

Standard	Citation	BC+ and SSI Managed Care Programs CY 2023						
		Anthem	MHS	Molina	NHP	Quartz	SHP	UHC
M1	*Availability of services - 42 CFR 438.206*	100.0%	100.0%	100.0%	100.0%	100.0%	57.1%	100.0%
M2	*Timely access to services - 42 CFR 438.206(c)(1)*	100.0%	100.0%	100.0%	100.0%	100.0%	85.7%	100.0%
M3	*Cultural considerations in services - 42 CFR 438.206(c)(2)*	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
M4	*Network adequacy - 42 CFR 438.207*	57.1%	100.0%	71.4%	100.0%	100.0%	100.0%	100.0%
M5	*Coordination and continuity of care, and confidentiality - 42 CFR 438.208, 42 CFR 438.224*	83.3%	83.3%	83.3%	83.3%	33.3%	83.3%	66.7%
M6	*Coordination and continuity of care, and confidentiality - 42 CFR 438.208, 42 CFR 438.224*	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
M7	*Disenrollment: requirements and limitations - 42 CFR 438.56*	90.0%	60.0%	80.0%	60.0%	100.0%	50.0%	70.0%
M8	*Coverage and authorization of services - 42 CFR 438.210, 42 CFR 440.230, 42 CFR 438.441*	100.0%	62.5%	100.0%	62.5%	87.5%	100.0%	100.0%
M9	*Information requirements for all enrollees - 42 CFR 438.100(b)(2)(i), 42 CFR 438.10*	100.0%	100.0%	100.0%	100.0%	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%	100.0%	100.0%	100.0%	66.7%	100.0%	100.0%
M11	*Enrollee right to participate in decisions regarding his or her care and be free from any form of restraint -*	75.0%	75.0%	100.0%	75.0%	100.0%	75.0%	75.0%

Standard	Citation	BC+ and SSI Managed Care Programs CY 2023						
		Anthem	MHS	Molina	NHP	Quartz	SHP	UHC
	42 CFR 438.100(b)(2)(iv) and (v), 42 CFR 438.3(j)							
M12	*Compliance with other federal and state laws - 42 CFR 438.100(d)*	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%
M13	*Provider selection - 42 CFR 438.214*	90.0%	100.0%	100.0%	100.0%	80.0%	100.0%	100.0%
M14	*Subcontractual relationships and delegation - 42 CFR 438.230*	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
M15	*Practice guidelines - 42 CFR 438.236*	33.3%	100.0%	66.7%	100.0%	33.3%	66.7%	33.3%
M16*	*Health information systems – 42 CFR 438.242*	N/A	N/A	N/A	N/A	N/A	N/A	N/A

* M16, is evaluated through reviews that occur separate from the Accreditation and Compliance with Standards Reviews

Standard	Citation	BC+ Managed Care Programs CY 2023			
		CCHP	DHP	GHC-SCW	MCHP
M1	*Availability of services - 42 CFR 438.206*	100.0%	71.4%	100.0%	100.0%
M2	*Timely access to services - 42 CFR 438.206(c)(1)*	100.0%	85.7%	100.0%	100.0%
M3	*Cultural considerations in services - 42 CFR 438.206(c)(2)*	100.0%	100.0%	100.0%	100.0%
M4	*Network adequacy - 42 CFR 438.207*	100.0%	100.0%	100.0%	100.0%
M5	*Coordination and continuity of care, and confidentiality - 42 CFR 438.208, 42 CFR 438.224*	100.0%	66.7%	83.3%	66.7%
M6	*Coordination and continuity of care, and confidentiality - 42 CFR 438.208, 42 CFR 438.224*	100.0%	100.0%	100.0%	100.0%
M7	*Disenrollment: requirements and limitations - 42 CFR 438.56*	50.0%	40.0%	100.0%	30.0%
M8	*Coverage and authorization of services - 42 CFR 438.210, 42 CFR 440.230, 42 CFR 438.441*	62.5%	75.0%	87.5%	62.5%

Standard	Citation	BC+ Managed Care Programs CY 2023			
		CCHP	DHP	GHC-SCW	MCHP
M9	*Information requirements for all enrollees - 42 CFR 438.100(b)(2)(i), 42 CFR 438.10*	100.0%	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*	66.7%	100.0%	66.7%	100.0%
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%	50.0%	100.0%	100.0%
M12	*Compliance with other federal and state laws - 42 CFR 438.100(d)*	0.0%	100.0%	100.0%	0.0%
M13	*Provider selection - 42 CFR 438.214*	90.0%	90.0%	100.0%	100.0%
M14	*Subcontractual relationships and delegation - 42 CFR 438.230*	100.0%	100.0%	100.0%	0.0%
M15	*Practice guidelines - 42 CFR 438.236*	66.7%	66.7%	66.7%	66.7%
M16*	*Health information systems – 42 CFR 438.242*	N/A	N/A	N/A	N/A

*M16, is evaluated through reviews that occur separate from the Accreditation and Compliance with Standards Reviews

Appendix 6 – Conducting Focused Studies of Health Care Quality – SSI Care Management Review: CY 2023 MCO Comparative Scores

Indicator #	Indicator Description	SSI Managed Care Programs CY2023									
		Anthem	**GHC-EC**	***i*Care**	**MCW**	**MHS**	**MHWI**	**NHP**	**Quartz**	**SHP**	**UHC**
1.1	Timely Screening	24.1%	58.7%	46.2%	28.2%	42.4%	6.4%	33.6%	40.0%	30.72%	21.5%
1.2	Comprehensive Screen	98.6%	100.0%	90.6%	100.0%	98.7%	100.0%	98.5%	25.0%	92.3%	100.0%
2.1	Timely Care Plan	44.9%	73.7%	53.2%	39.7%	43.0%	17.3%	42.5%	40.0%	30.2%	30.7%
2.2	Comprehensive Care Plan	84.5%	79.2%	75.9%	93.7%	92.5%	82.1%	95.4%	75.0%	69.2%	94.3%
2.3	Care Plan Distribution	78.9%	73.3%	71.3%	0.0%	79.1%	75.0%	78.5%	75.0%	100.0%	81.1%
2.4	Care Plan Agreement	100.0%	97.5%	95.4%	90.5%	100.0%	100.0%	98.5%	25.0%	100.0%	100.0%
3.1	Member Contact	32.5%	25.5%	46.3%	43.6%	37.4%	17.7%	34.7%	30.0%	7.0%	27.2%
3.2	Timely Follow-Up	67.6%	85.5%	80.0%	76.8%	66.7%	82.1%	62.7%	75.0%	61.5%	88.0%
4.1	Care Plan Review	20.1%	63.4%	44.1%	27.0%	29.4%	5.6%	23.9%	N/A	N/A	19.2%
4.2	Change in Needs	66.7%	100.0%	64.3%	38.5%	100.0%	50.0%	100.0%	N/A	0.0%	28.6%
4.3	Member Re-Stratification	75.0%	100.0%	100.0%	57.1%	90.9%	100.0%	100.0%	N/A	33.3%	83.3%
5.1	Timely Transition Planning	33.3%	62.5%	15.4%	56.3%	42.3%	10.0%	50.0%	N/A	50.0%	42.1%

Indicator #	Indicator Description	SSI Managed Care Programs CY2023									
		Anthem	**GHC-EC**	***i*Care**	**MCW**	**MHS**	**MHWI**	**NHP**	**Quartz**	**SHP**	**UHC**
5.2	Transition Planning Follow-Up	33.3%	56.3%	23.1%	25.0%	38.5%	20.0%	28.6%	N/A	25.0%	26.3%
6.1	WICT Core Team	N/A	100.0%	69.2%	100.0%	50.0%	100.0%	N/A	N/A	N/A	100.0%
6.2	Timely WICT Collaboration	N/A	78.6%	76.9%	50.0%	50.0%	100.0%	N/A	N/A	N/A	100.0%
6.3	Timely WICT Member Contact	N/A	100.0%	53.8%	100.0%	75.0%	100.0%	N/A	N/A	N/A	100.0%

Appendix 7 – Record Review – Children with Medical Complexity: CY 2023 Hospital Comparative Scores

Indicator #	Indicator Description	Hospitals CY 2023		
		AFCH	CHW	MCH
Eligibility				
1A	Program Eligibility	100.0%	96.7%	100.0%
1B	Voluntary Consent	100.0%	100.0%	100.0%
Assessment				
2A	Timeliness	86.2%	80.0%	100.0%
2B	Comprehensiveness	100.0%	100.0%	100.0%
Care Plans				
3A	Timeliness	89.7%	83.3%	100.0%
3B	Comprehensiveness	80.8%	8.0%	77.8%
Service Reduction Termination				
4A	Documented Mutual Agreement	100.0%	100.0%	N/A
4B	Documentation of Advance Notice	N/A	N/A	N/A
4C	Evidence of Involuntary Disenrollment	100.0%	N/A	N/A
Monitoring / Service Coordination				
5A	Ongoing Supportive Contacts	86.7%	50.0%	90.0%
5B	Follow-Up Hospitalizations	66.7%	100.0%	100.0%
5C	Member Needs Addressed	92.3%	80.0%	85.7%
5D	Coordination Referrals	100.0%	100.0%	100.0%